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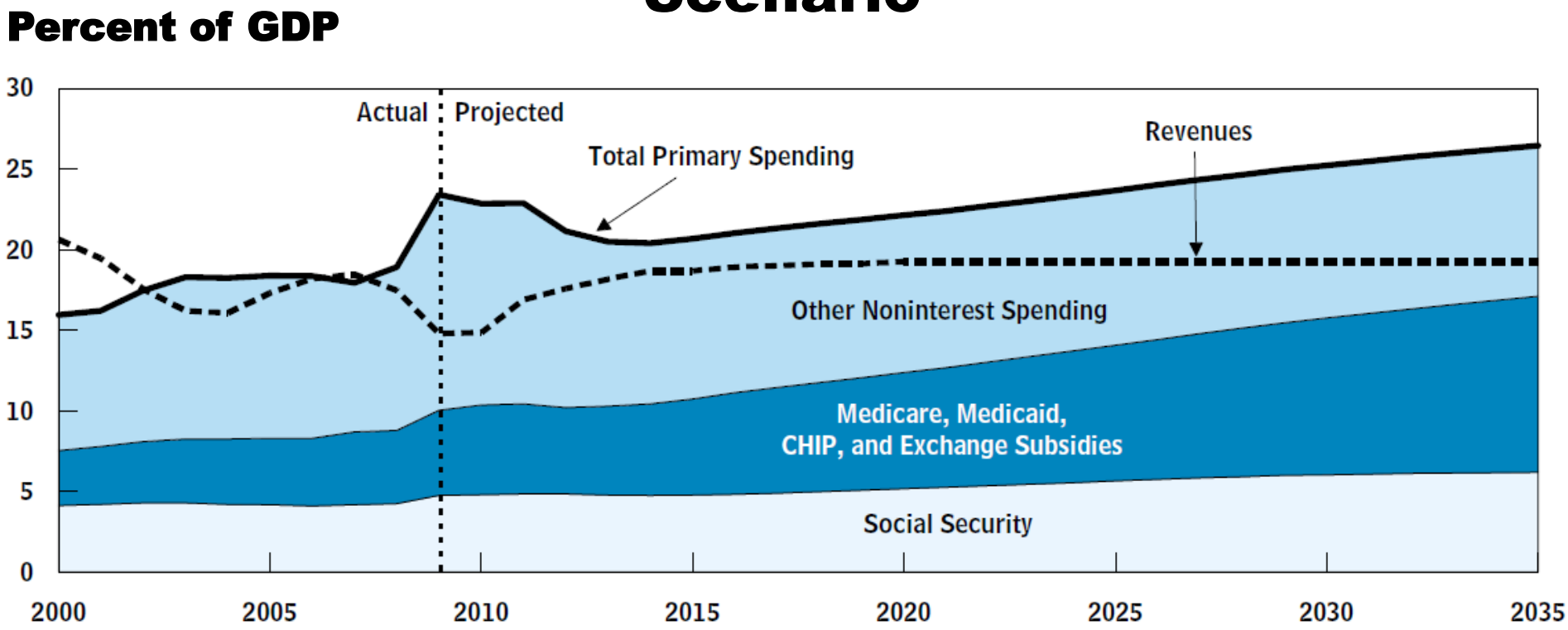
Health Spending and the Federal Budget

Stuart Guterman
Vice President, Payment and System Reform
Executive Director, Commission on a High Performance Health System
The Commonwealth Fund

18th Annual Princeton Conference
The Future of Health Spending
Princeton, NJ
May 24, 2011

We’re in a Lot of (Budgetary) Trouble

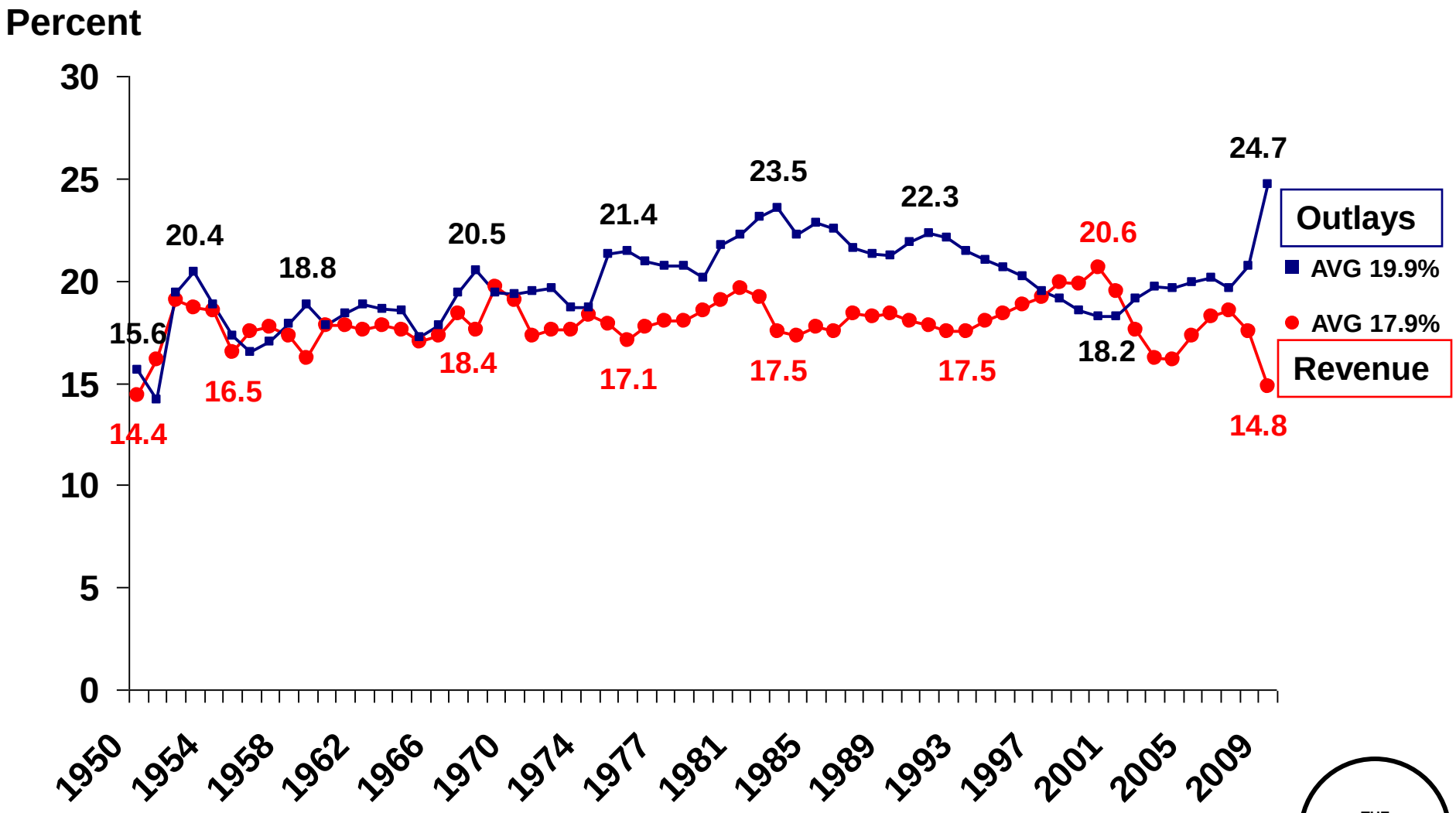
Federal Revenues and Primary Spending, by Category, Under CBO's Long-Term Budget Scenario



Source: Congressional Budget Office, The Long-Term Budget Outlook, June 2010, revised August 2010.

Note: This alternative fiscal scenario follows adheres closely to current law and follows CBO's 10-year baseline budget projections through 2020 and extending the baseline concept through 2035, however this estimate incorporates a number of assumed exceptions to current law as of the August 2010 revision, including: (1) Medicare physician payment rates continue to grow at the Medicare economic index rather than following the SGR, (2) several policies to restrain spending after 2020 do not go into effect, i.e., IPAB recommendations do not go into effect, (3) health insurance premium subsidy cuts scheduled for 2020 do not take effect, and (4) the tax relief policies known as the "Bush tax cuts" are extended through 2020 after which individual income taxes are adjusted to keep total revenue constant as a share of GDP.

Historic Patterns: Federal Revenue and Outlays as a Percentage of GDP, 1950-2009



Source: Office of Management and Budget.

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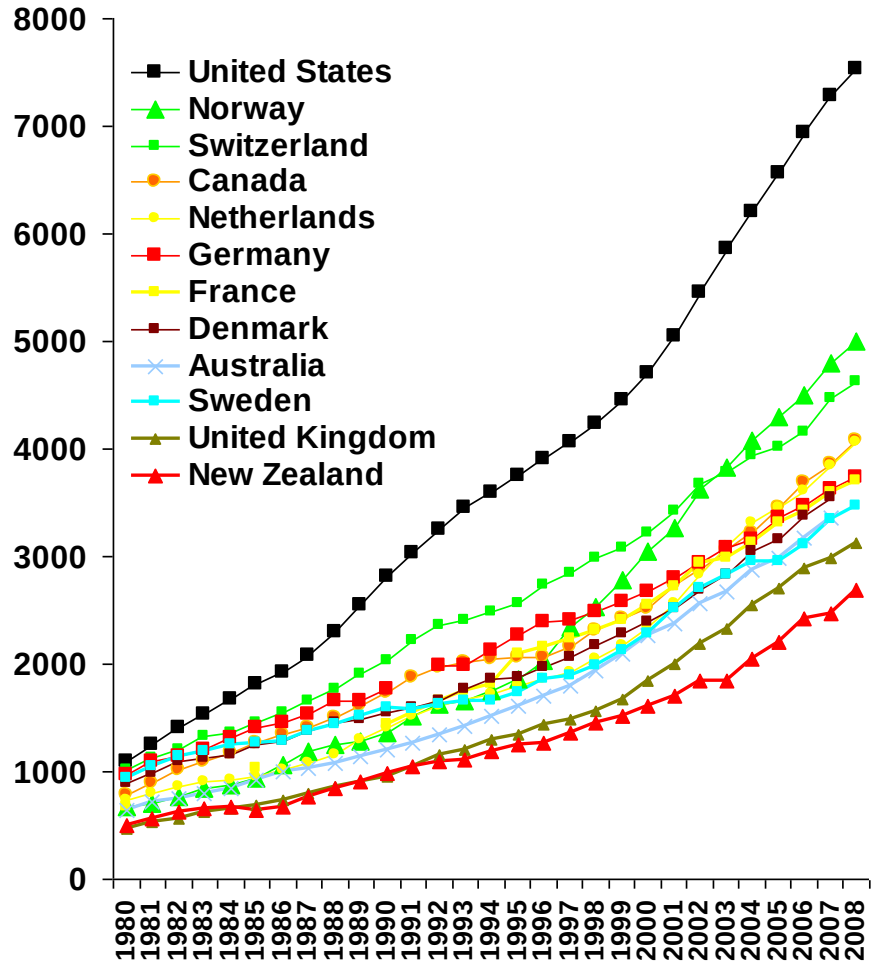
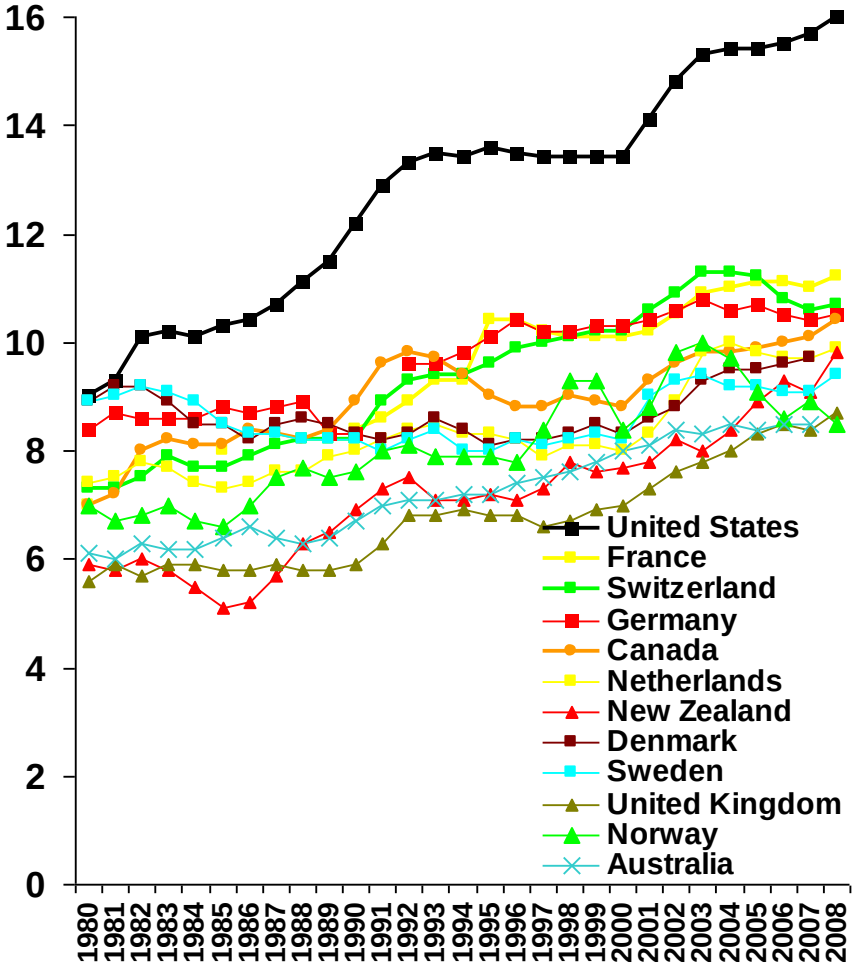
What Role Does Health Care (and Medicare and Medicaid, in Particular) Play in This Situation?

International Comparison of Spending on Health, 1980–2008

Average spending on health per capita ($US PPP)



Total expenditures on health as percent of GDP



SOURCE: OECD Health Data 2010 (June 2010).

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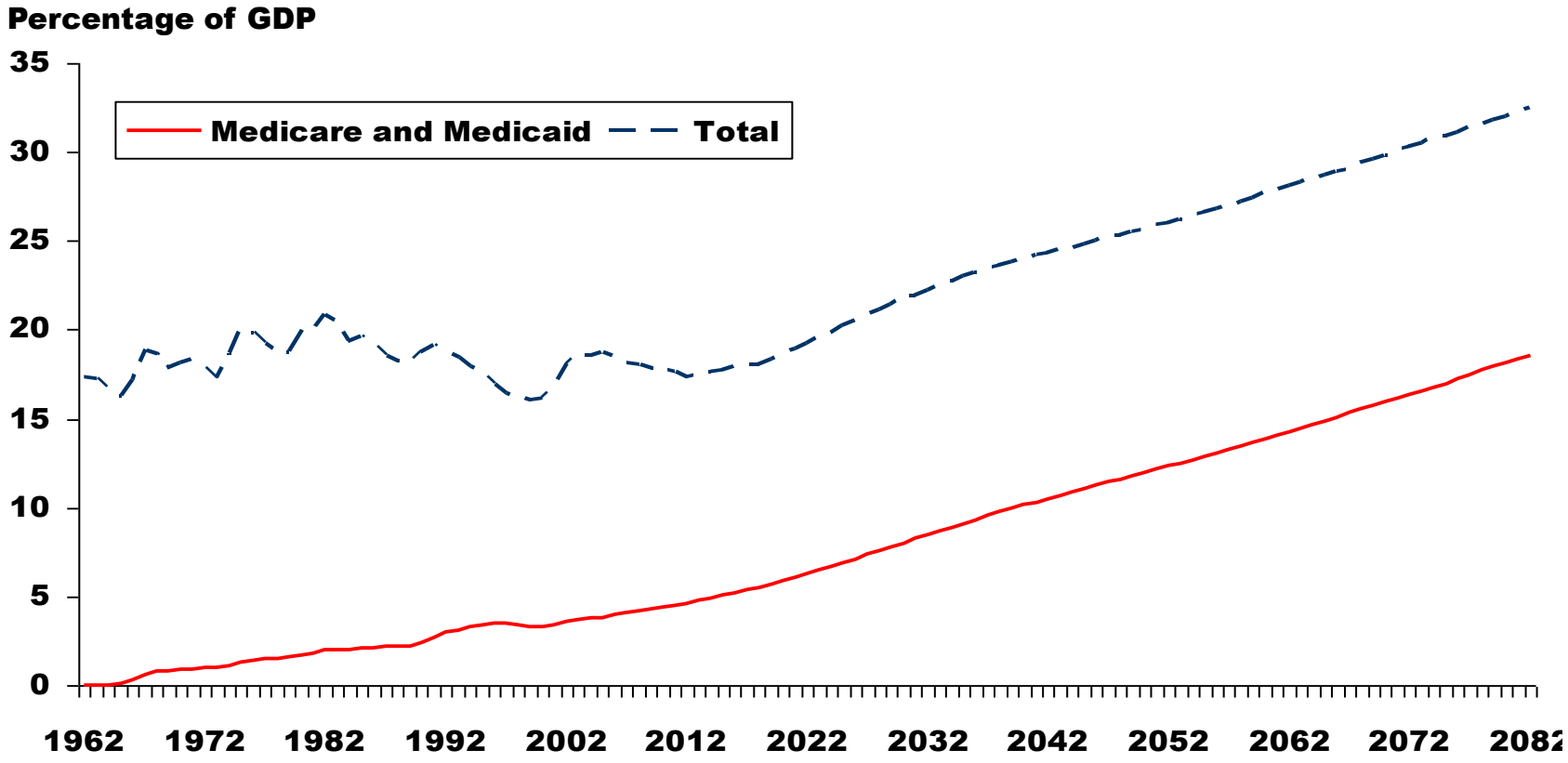
Federal Spending on Medicare and Medicaid and Total Federal Spending as a Percentage of GDP, 1962-2082



NOTE: Figures for 2007-2082 are projections; Total federal spending includes all federal non-interest spending.
SOURCE: Congressional Budget Office. *Budget Outlook, 2009.*

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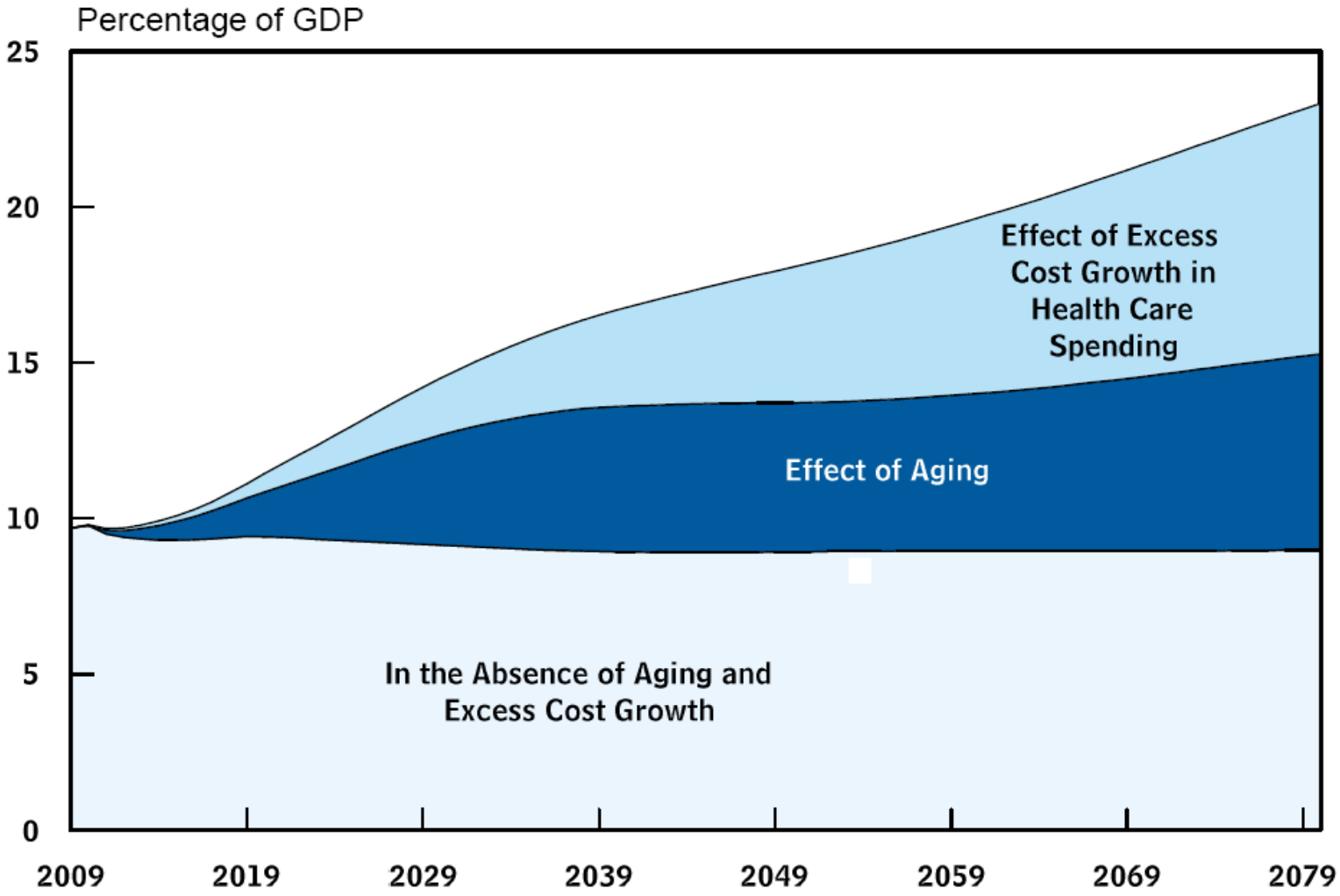
Sources of Growth in Projected Federal Spending on Medicare, Medicaid and Social Security, 2010 to 2080



NOTE: Excess cost growth refers to the extent to which growth in health spending per Medicare or Medicaid beneficiary exceeds the growth rate of per capita GDP.
SOURCE: Presentation by Robert A. Sunshine, CBO Deputy Director, in a presentation on Mandatory Spending to the National Commission on Fiscal Responsibility and Reform, May 12, 2010.

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Proportion of Projected Growth in Federal Spending on Major Health Care Programs and Social Security Attributable to Aging and Excess Cost Growth

Time Period	Aging	Excess Cost Growth
	Major Health Programs and Social Security	
2010-2035	63	37
2010-2080	44	56
	Major Health Programs	
2010-2035	45	55
2010-2080	29	71

NOTE: Excess cost growth refers to the extent to which growth in health spending per Medicare or Medicaid beneficiary or per other person exceeds the growth rate of per capita GDP.
SOURCE: Congressional Budget Office, *The Long-Term Budget Outlook*, June 2010 (Revised August 2010).

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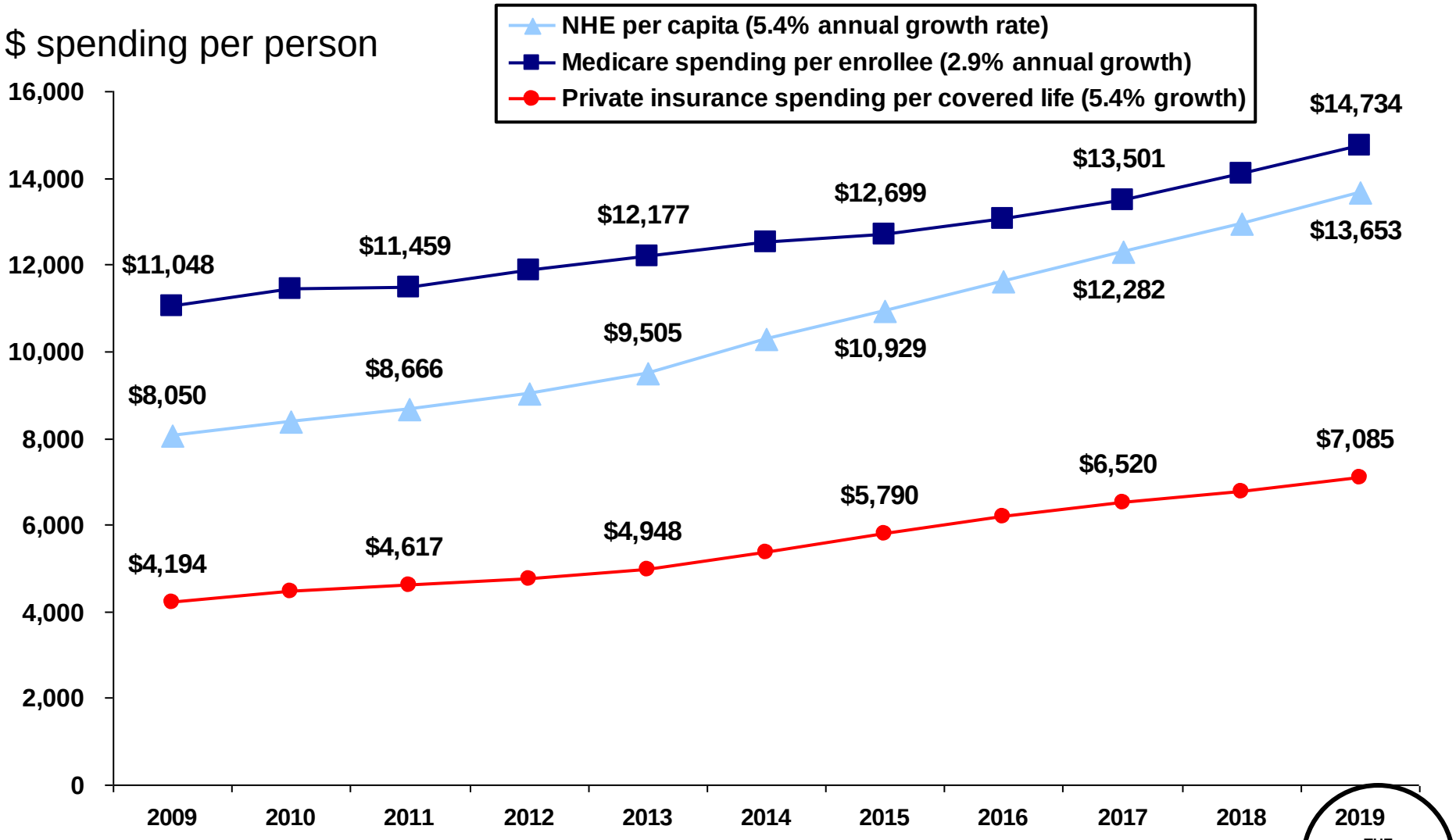
Rising Cost of Care is a Shared Concern: Public and Private

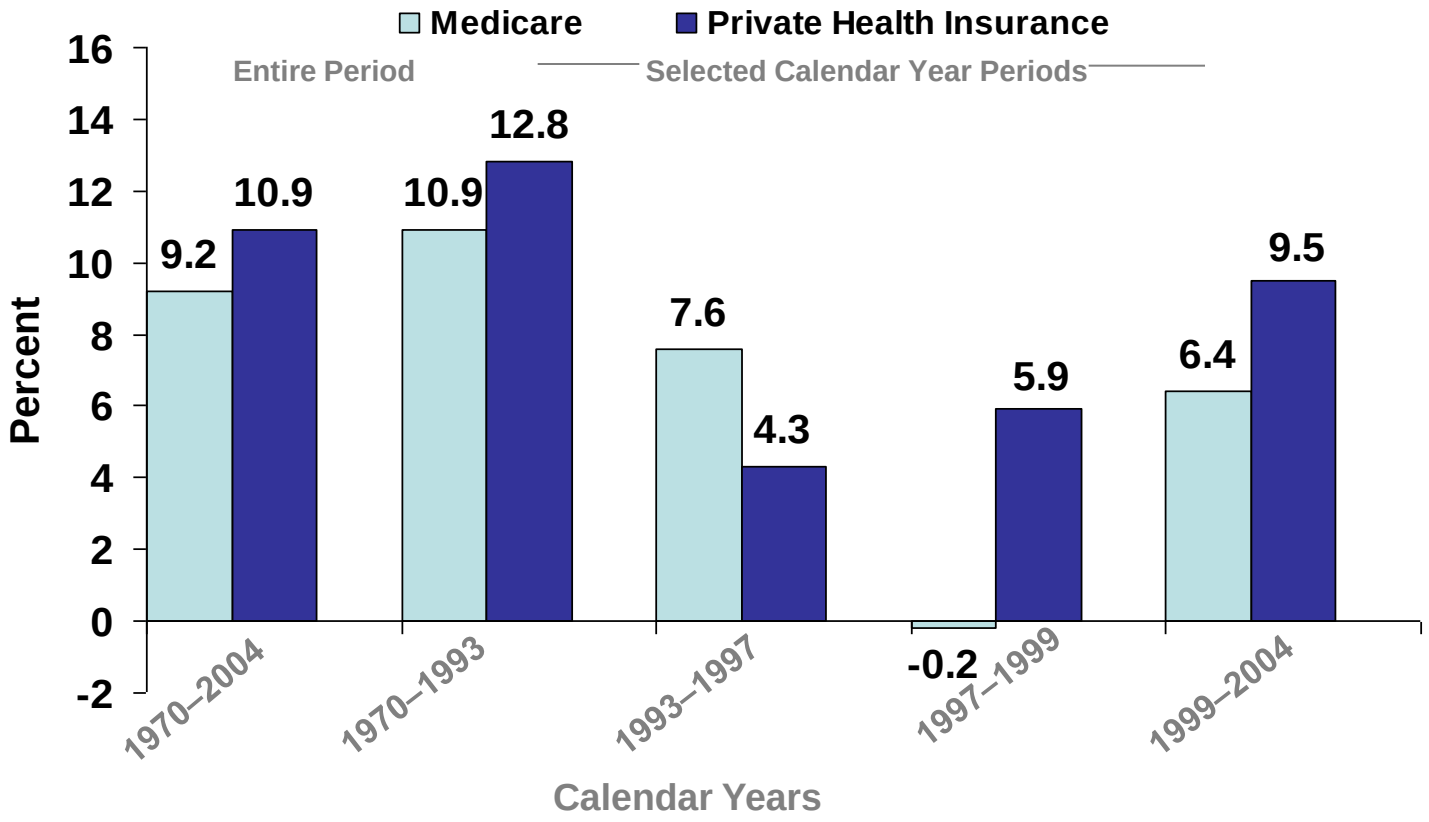
Growth In Private Spending per Person Projected to Exceed Medicare, 2009-2019



Source: Commonwealth Fund analysis of CMS, Office of the Actuary, National Health Statistics Group, National Health Expenditures Projections 2009-2019, September 2010.

Average Annual Growth in Medicare and Private Health Insurance Benefits Per Enrollee: Selected Periods

Except for 1993–1997, Medicare has grown slightly more slowly than private health insurance.



Source: CMS, Office of the Actuary, National Health Statistics Group; from presentation by Marilyn Moon to AcademyHealth Health Policy Orientation, October 2009..

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Proposals to Slow Down (Federal) Health Spending

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Major Health Policies Proposed in Deficit Reduction Proposals (Round I)

National Commission on Fiscal Responsibility and Reform (Simpson-Bowles)		Bipartisan Policy Center Debt Reduction Task Force (Domenici-Rivlin)
Reform Sustainable Growth Rate mechanism for determining Medicare physician fee updates (costs $240B)	Enact premium support pilot for federal employees (saves $18B)	Phase out tax exclusion for employer-sponsored health insurance beginning in 2018 (saves $113B)
Reform or repeal CLASS Act (costs $76B)	Reduce Medicare fraud (saves $9B)	Raise Medicare Part B premiums (saves 123B)*
Extend Medicaid rebates to Medicare/Medicaid dual eligibles in Medicare Part D (saves $49B)	Cut Medicare payments to providers for bad debts (saves $23B)	Increase rebates for Part D drugs (saves $100B)*
Reduce Medicare payments to hospitals for graduate medical education (saves $60B)	Accelerate home health payment changes in the ACA (saves $9B)	Redesign Medicare cost-sharing (saves $14B)*
Reform Medicare cost-sharing rules, cap beneficiary out-of-pocket spending, restrict first-dollar coverage in Medicare supplemental insurance (saves $110B)	Place dual eligibles in Medicaid managed care ($12B)	Bundle Medicare payment for acute and post-acute care (saves $5B)*
Restrict first-dollar coverage in TRICARE for Life (saves $38B)	Reduce funding for Medicaid administrative costs ($2B)	Transition Medicare to premium support, beginning in 2018 (saves $172B)
Enact malpractice reform (saves $17B)	Broaden scope of Independent Payment Advisory Board to all federal health spending	Eliminate barriers to enrollment in managed care options for dual eligibles (saves $5B)*
		Incentivize government to control Medicaid cost growth (saves $20B)
		Cap non-economic and punitive damages for malpractice (saves $48B)
		Introduce excise tax on sweetened beverages (saves $156B)

Major Health Policies Proposed in Deficit Reduction Proposals (Round II)

House Republican Budget Resolution	President's Framework
Assumes "doc fixes" are continued and fully offset Repeals the tax and coverage provisions from health care reform, but keeps most Medicare savings (but not the Independent Payment Advisory Board) Block-grants Medicaid in 2013 and holds growth to rate of inflation plus population growth Enacts tort reform Transforms Medicare to premium support program in 2022 and limits per beneficiary growth of premium support inflation	Assumes continuation of "doc Fixes" Proposes health care savings from standardizing the Medicaid matching rate, prescription drug reforms, patient safety initiatives, and anti-fraud measures Strengthens Independent Payment Advisory Board by broadening its mandate and limiting Medicare per beneficiary growth to GDP+0.5% instead of GDP+1%

SOURCE: Committee for a Responsible Federal Budget, Summary Table of Fiscal Plans, April 2011, available at http://crfb.org/sites/default/files/CRFB_Fiscal_Plans_Summary_Table.pdf

But Focusing Only on Federal Budget Outlays Won't Solve the Problem

- **Rising health spending is putting increasing pressure not only on the federal budget but also on state and local budgets, businesses, and households**
  - **Median out-of-pocket spending by Medicare beneficiaries was 16.2% of household income in 2006, and has been rising; much higher for low-income, older, and sicker beneficiaries**
  - **Medicaid pressure on state budgets**
  - **"GM spends more on health care than on steel" and "Starbucks spends more on health care than it does on coffee beans"**
  - **Although out-of-pocket spending on health care is a smaller proportion of the total, it has been growing much faster than workers' wages**
- **The driving factor in both public and private health spending growth is excess cost growth**
- **We need policies that address underlying cost growth, rather than just shifting the burden of dealing with it from the federal government to others**

So What Can Be Done?

Source: 2010 Commonwealth Fund International Health Policy Survey in Eleven Countries.

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Slowing Health Spending Growth in the Context of the Federal Deficit: Guiding Principles

- **Focus on total costs, not just federal**
  - **Same factors contribute to rising private and public costs**
- **Enhance and/or protect access and quality**
- **Pay attention to distributional effects**
  - **Medicare and Medicaid insure vulnerable: income and health**
  - **Historic rationale for programs remains**
- **Emphasize need to improve performance**
  - **Should expect more for current investment**
  - **Value based benefits and purchasing policies**
- **Need all-payer coherence/leverage to align incentives**
  - **Payment methods *AND* levels matter**
  - **Move away from fee for service and toward accountability**
  - **Medicare acting alone has unintended consequences**

Finding a Way Forward in Context of Federal Deficit

- **Develop integrated set of policies that blend market oriented approaches and social insurance values**
  - **Draw from ideas across policy spectrum where of potential value**
  - **Emphasis on reducing federal, state/local and private health care costs compared to projected trends**
  - **Willingness to be bold**
- **Mixed public and private—align payment policies**
  - **All payer: national and regional**
    - **Budget targets and authority**
  - **IPAB jurisdiction expanded to private and Medicaid**
    - **Regional target growth rates**
    - **Design to reduce price spread and align methods**
- **More integrated insurance markets with transparency**
- **Align incentives in health care markets**
- **Medicare and Medicaid policy reforms (next chart)**

Medicare and Medicaid Policy Reforms

- **Medicare**
  - **Integrated benefits: value based design and reference pricing**
    - **Eliminate need for Medigap and Part D; Modest cost-sharing**
    - **Waivers from copayments if designate medical home, accountable care organization (ACO)**
  - **Medicaid "wrap-around" for low income beneficiaries**
  - **Payment policy: move rapidly to more bundled payment**
    - **Primary care medical home, ACOs**
    - **Expand acute care bundle to 30-days post-discharge**
    - **Revised physician fee schedule, rewards for high performance**
- **Medicaid**
  - **Acute care payment policy aligned with Medicare**
  - **Align with exchanges**
    - **Medicaid covered through exchanges: platinum plus?**
    - **Wrap around policy for supplemental—including long term care**
  - **Personal care/home health linked to organized care systems**