Health Care, Political Polarization, and Our Fiscal Future

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London School of Economics

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Citigroup
Long-Term Fiscal Gap and Health Care Costs

Percentage Share of GDP

Source: CBO (2007)
### Excess Cost Growth in Medicare, Medicaid, and All Other Spending on Health Care

#### Percentage Points

<table>
<thead>
<tr>
<th></th>
<th>Medicare</th>
<th>Medicaid</th>
<th>All Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1975 to 1990</td>
<td>2.9</td>
<td>2.9</td>
<td>2.4</td>
<td>2.6</td>
</tr>
<tr>
<td>1990 to 2005</td>
<td>1.8</td>
<td>1.3</td>
<td>1.4</td>
<td>1.5</td>
</tr>
<tr>
<td>1975 to 2005</td>
<td>2.4</td>
<td>2.2</td>
<td>2.0</td>
<td>2.1</td>
</tr>
</tbody>
</table>
Exhibit 2

BREAKDOWN OF ADDITIONAL SPENDING IN US HEALTH CARE SYSTEM
$ billion, 2003

- 1,679: Total health care expenditure
- 561: Hospital care
- 488: Outpatient care
- 224: Drugs
- 178: Long-term and home care
- 212: Durable medical equipment
- 85: Health administration and insurance
- 150: Public investment in health

- 477: Gap as a % of cost base

- 28%: Above ESAW
- 40%: Below ESAW
- 36%: Gap as a % of cost base

* Estimated spending according to wealth
Source: OECD; MGI analysis
Medicare Spending per Capita, by Hospital Referral Region, 2006

Source: www.dartmouthatlas.org (2009)
MEDPAC ANALYSIS OF REGIONAL VARIATION

The Relationship Between Quality and Medicare Spending, by State, 2004

Composite Measure of Quality of Care, 100 = Maximum

Source: CBO (2008)
What Additional Services Are Provided in High-Spending Regions?

Discrete: Effective Care
- Reperfusion in 12 hours (Heart attack)
- Aspirin at admission (Heart attack)
- Mammogram, Women 65–69
- Pneumococcal immunization (Ever)

Discrete: Preference-Sensitive Care
- Total hip replacement
- Total knee replacement
- Back surgery
- CABG following heart attack

Care Delivery: Who / How Often / Where
- Total inpatient days
- Inpatient days in ICU or CCU
- Evaluation and management (Visits)
- Imaging
- Diagnostic tests

Source: Elliot Fisher, Dartmouth Medical School.
Possible Solutions

1. Price reductions
2. Rationing
3. Consumer directed health care
4. Provider information and incentives
Changes in Direct Spending, 2010-2019

$ Billions

-196
-136
-36

- Reductions in Annual Updates to Medicare FFS Payment Rates
- Medicare Advantage Rates based on Fee-for-Service Rates
- Medicare and Medicaid DSH Payments
Concentration of Total Annual Medicare Expenditures Among Beneficiaries, 2001

Source: Data from CMS.
Ryan Proposal Would Double Health Care Spending of Typical 65-Year-Old

Health care spending for a typical 65-year-old in 2022, in dollars

<table>
<thead>
<tr>
<th>Ryan Proposal</th>
<th>Current Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>$8,000</td>
<td>$8,600</td>
</tr>
<tr>
<td>$12,500</td>
<td>$6,150</td>
</tr>
<tr>
<td><strong>$20,500</strong></td>
<td><strong>$14,750</strong></td>
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</tbody>
</table>


Note: Beneficiary's share of spending includes premiums, out-of-pocket costs for covered services, and any payments for supplemental insurance.
Addressing High Cost Cases: Provider Value Emphasis

• Information and best practices

Health IT systems, with clinical decision support software

Comparative effectiveness

Medical malpractice

• Delivery system structure and incentives
Stimulus Bill
Health Information Technology (IT)

• Provides about $19 billion for Medicare and Medicaid health IT incentives over 5 years
• Codifies the Office of the National Coordinator for Health Information Technology to promote a nationwide infrastructure
• Provides financial incentives to encourage physicians and hospitals to use certified electronic health records (EHRs)

Source: AMA
Stimulus Bill
Comparative Effectiveness Research (CER)

• Invested $1.1 billion in CER
  – $400 million for HHS
  – $400 million for NIH
  – $300 million for AHRQ

• Federal Coordinating Council for CER
  – Coordinates the CER activities of federal agencies
  – Advises President and Congress on infrastructure needs

Source: AMA
Delivery System Reforms

a. **Accountable care organizations (ACOs)**
   Groups of health care providers who take responsibility for the cost and quality of care of a population of patients. If ACOs provide quality care and reduce costs, they can keep some of the savings.

b. **Pay for performance**
   Value-Based Purchasing program in Medicare to promote higher quality outcomes. High performing hospitals will be paid more than low performing hospitals.

c. **Bundling**
   Health care providers are paid a flat rate for an episode of care, rather than billing separately for each service. Can help to align the incentives of all providers to improve coordination and quality.

d. **Hospital readmissions and hospital-acquired infections**
Center for Medicare and Medicaid Innovation

• Tasked with testing new payment and delivery systems to reduce costs and improve quality
• Requires HHS to test and evaluate “Phase I” models using certain selection criteria
• Provides for “Phase II” expansion of models
• Must be operational by January 1, 2011
• Funding: $5 million for the “design, implementation, and evaluation of models” and $10 billion for CMI activities from 2011 to 2019
Independent Payment Advisory Board

• IPAB will have 15 members appointed by the President to 6 year terms
• The IPAB must put forward proposals that Medicare spending growth stays within a certain target (1 percent excess cost growth in outyears)
• Beginning in 2015 the IPAB must make recommendations to reduce Medicare spending when it is expected to exceed a target level
• Power of default and inertia
• Will it realize its potential?
Perceptions and Reality?

• First impressions matter – crucial summer of 2009

• CBO scoring versus campaign scoring
CMS Projections of Medicare Expenditures

% of GDP

Source: CMS

2009 Report

2010 Report

2011 Report
HI 75 Year Actuarial Balance
% of Taxable Payroll

Source: CMS
Figure 2-4.
Comparison of CBO’s 2009 and 2010 Projections of Mandatory Federal Spending on Health Care Under the Extended-Baseline Scenario

(Percentage of gross domestic product)

Source: Congressional Budget Office.

Note: The extended-baseline scenario adheres closely to current law, following CBO’s 10-year baseline budget projections through 2020 (with adjustments for the recently enacted health care legislation) and then extending the baseline concept for the rest of the long-term projection period. (For details, see Table 1-1 on page 3.)
Primary Fiscal Gap, % of GDP
CBO Extended Baseline Scenario

Source: CBO

- June 2009 Report
- June 2010 Report
Figure 5
NOMINATE Versus District Characteristics, 1973

RAND OP291-5
Figure 6
NOMINATE Versus District Characteristics, 2003

RAND OP291-6
Figure 7
Polarization in 90th, 100th, and 110th Congresses

SOURCE: Carroll et al., 2008.
Figure 8
Party Polarization, 1879–2007

Distance between the parties

SOURCE: McCarty, Poole, and Rosenthal, “Polarized America” Web site, no date.
RAND OP291-8
Figure 11
1976 U.S. Election, by County

RAND OP391-11
Figure 12
2008 U.S. Election, by County

SOURCE: Bishop, personal communication. Used with permission.
RAND CP291-12