Deficits, Debt, and Health Care: What Budgetary Pressures Could Mean for Provider Payments

The Paul Merage School of Business
University of California at Irvine

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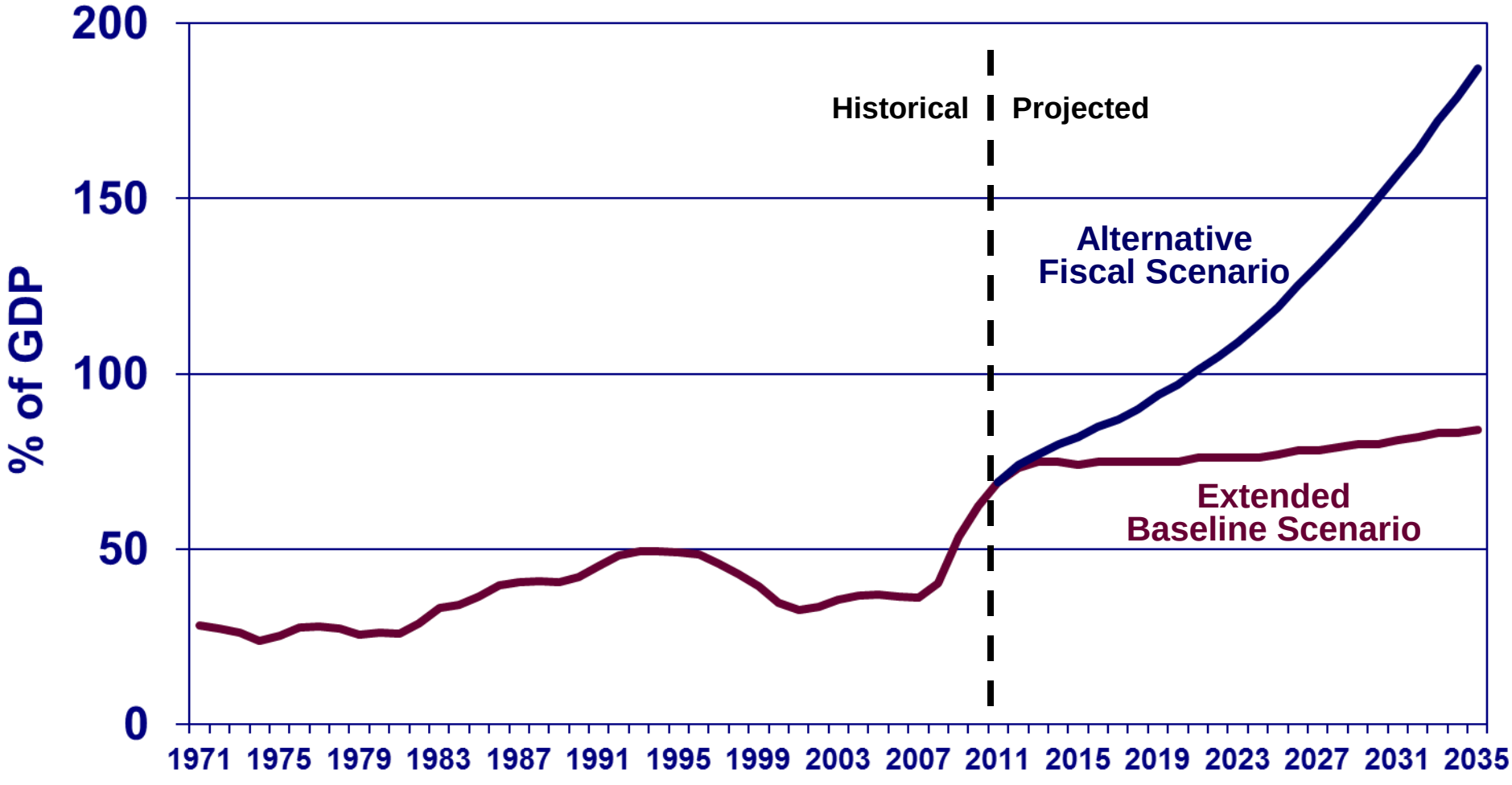
Debt Held by the Public



Source: Congressional Budget Office, Historical Tables and CBO's 2011 Long-Term Budget Outlook, June 2011

The Near-Term Budget Outlook

	% of GDP				
	1971-2010 Avg.	CBO August Baseline 2021	CBO Alt. Baseline 2021	Pres. Budget 2021	Ryan Budget 2022
Revenues	18.1	20.9	18.4	19.3	18.5
Outlays	20.8	22.7	23.8	24.2	20.25
Deficit	2.8	1.2	4.7	4.9	~2

Source: CBO

CBO's Updated Baseline (Summer 2011)

	$ Billions		
	2011	2015	2021
Deficit excluding Budget Control Act	-1,284	-395	-592
Effect of BCA Provisions Excluding Joint Committee	0	+73	+182
Deficit Reduction from Joint Committee/Sequester	0	+117	+161
CBO's Projected Deficits	-1,284	-205	-279
Effect of Extending Current Law Tax Provisions (not 2011 payroll tax cut)	*0*	*-402*	*-778*
Effect of Freezing Medicare Physician Fees at 2011 Levels	*0*	*-27*	*-59*

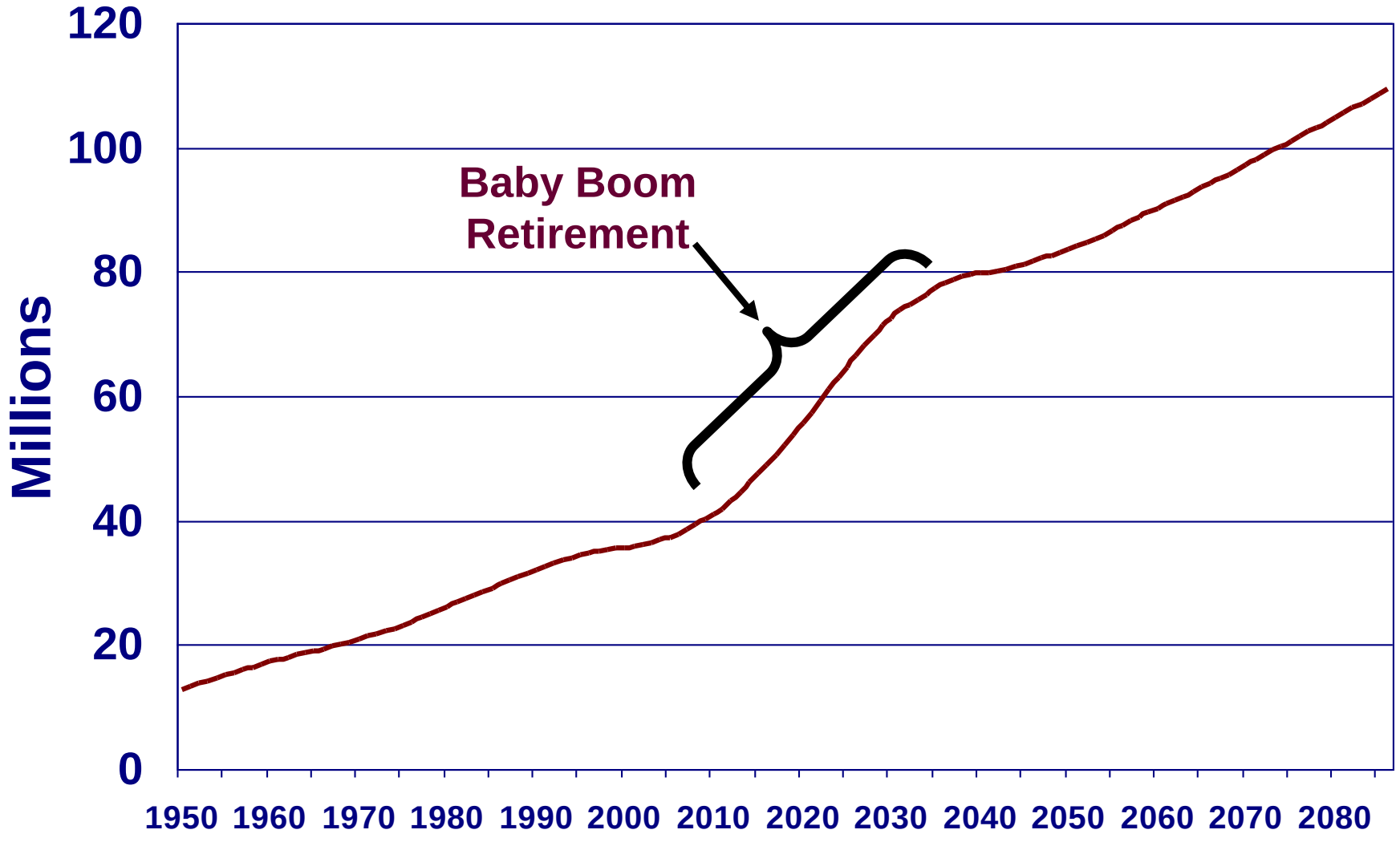
Historical Per Capita Health Spending

	"Excess Cost Growth"*			
	1975-2007	1980-2007	1985-2007	1990-2007
Medicare	2.4%	2.2%	1.4%	1.6%
Medicaid	2.0%	1.7%	1.3%	1.1%
Other	1.9%	2.0%	1.9%	1.5%
Total	2.0%	2.0%	1.7%	1.5%

*Excess Cost Growth is the average annual per capita spending growth rate in excess of average annual per capita GDP growth.

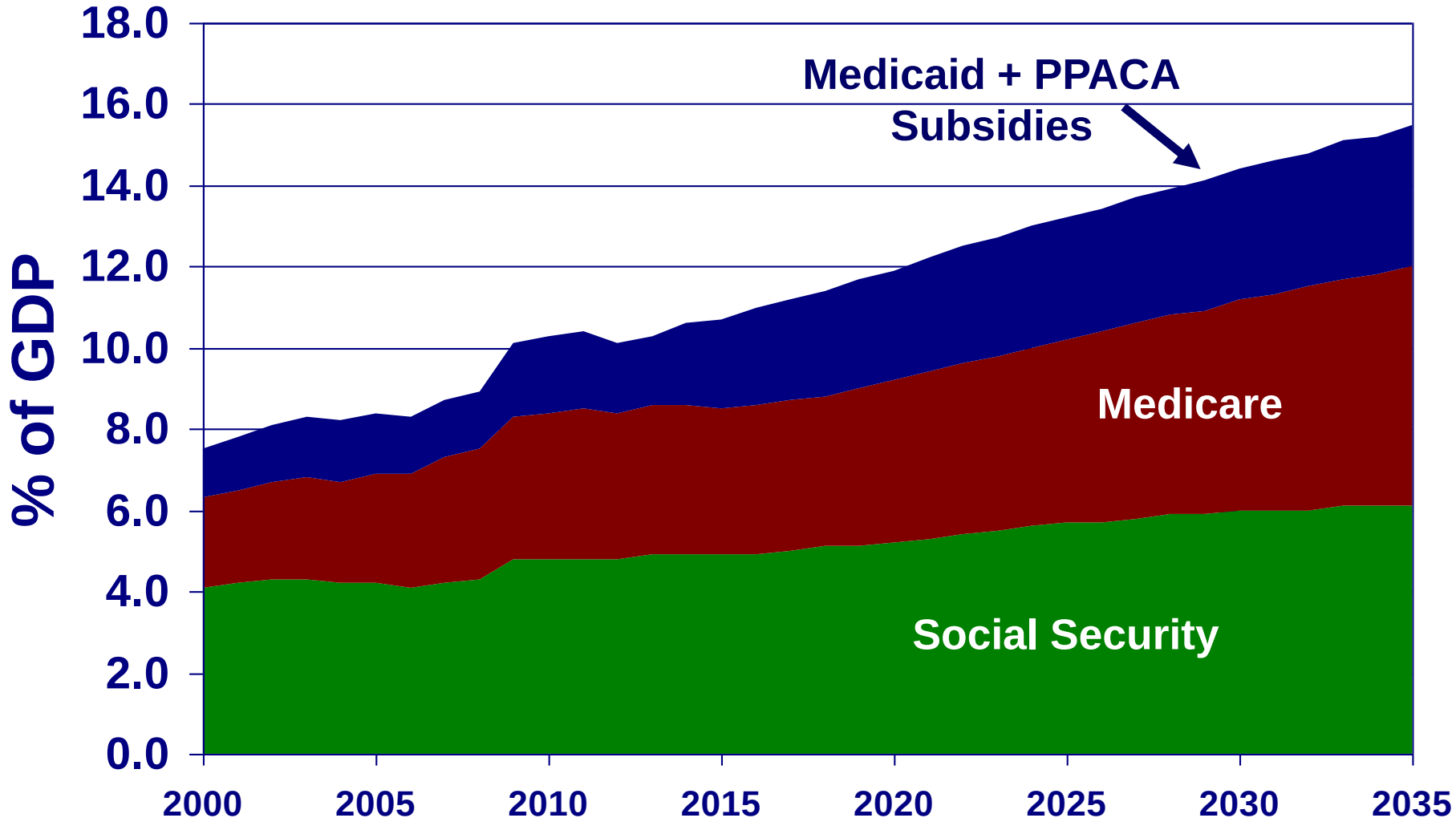
Source: CBO's 2011 Long-Term Budget Outlook, Congressional Budget Office, June 2011

Population Age 65 and Older



Source: 2011 Social Security Trustees' Report (intermediate assumption)

The Big Three



Source: CBO's 2011 Long-Term Budget Outlook, Congressional Budget Office, June 2011 (extended baseline scenario)

Final CBO Cost Estimate of PPACA

PPACA Effect on the Federal Budget Deficit*	$ Billions 2010-2019
Coverage Provisions (including tax credits)	936
Other Spending	30
Medicare/Medicaid Cuts	-455
CLASS Act	-70
Tax Increases	-563
Net Effect on Federal Budget Deficit	-124

*Excludes the effect of the legislation's student loan provisions.

Source: CBO Letter to House Speaker Nancy Pelosi, March 20, 2010

Some Key Budgetary Assumptions

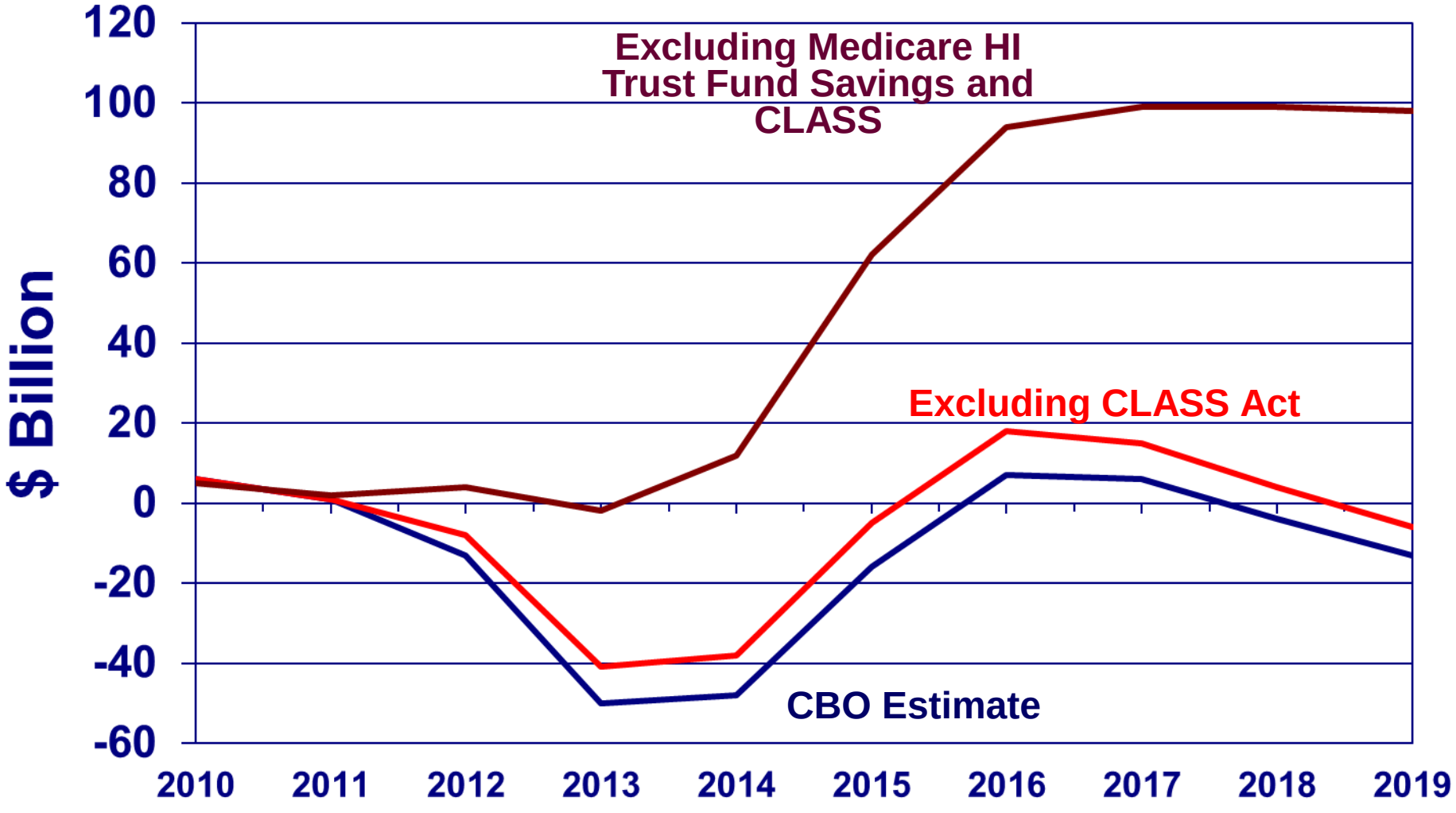
1. **CLASS Act: Program for long-term care insurance. Supposed deficit reduction of $70 billion in first ten years from start-up premiums, even though funds will be spent on claims later and consensus is the program is actuarially unsound (administration recently cancelled the program).**

2. **Independent Payment Advisory Board: Charged with enforcing a new cap on the growth rate of Medicare. Only changes it can recommend *are more provider payment rate reductions*.**

3. **Medicare Cuts for Medicare and PPACA: Proponents claim the Medicare savings will both extend the life of the Medicare trust fund and pay for PPACA's other entitlements. Same dollars are planned to be spent twice.**

4. **Omission of Medicare Physician Fees: The administration wants to add $300 billion plus to the debt for physician fees. In the past, Congress has tried to pay for "doc fix" with offsets. Congress used all of the Medicare cuts to pay for a new entitlement instead.**

Near-Term Deficit Impact of PPACA

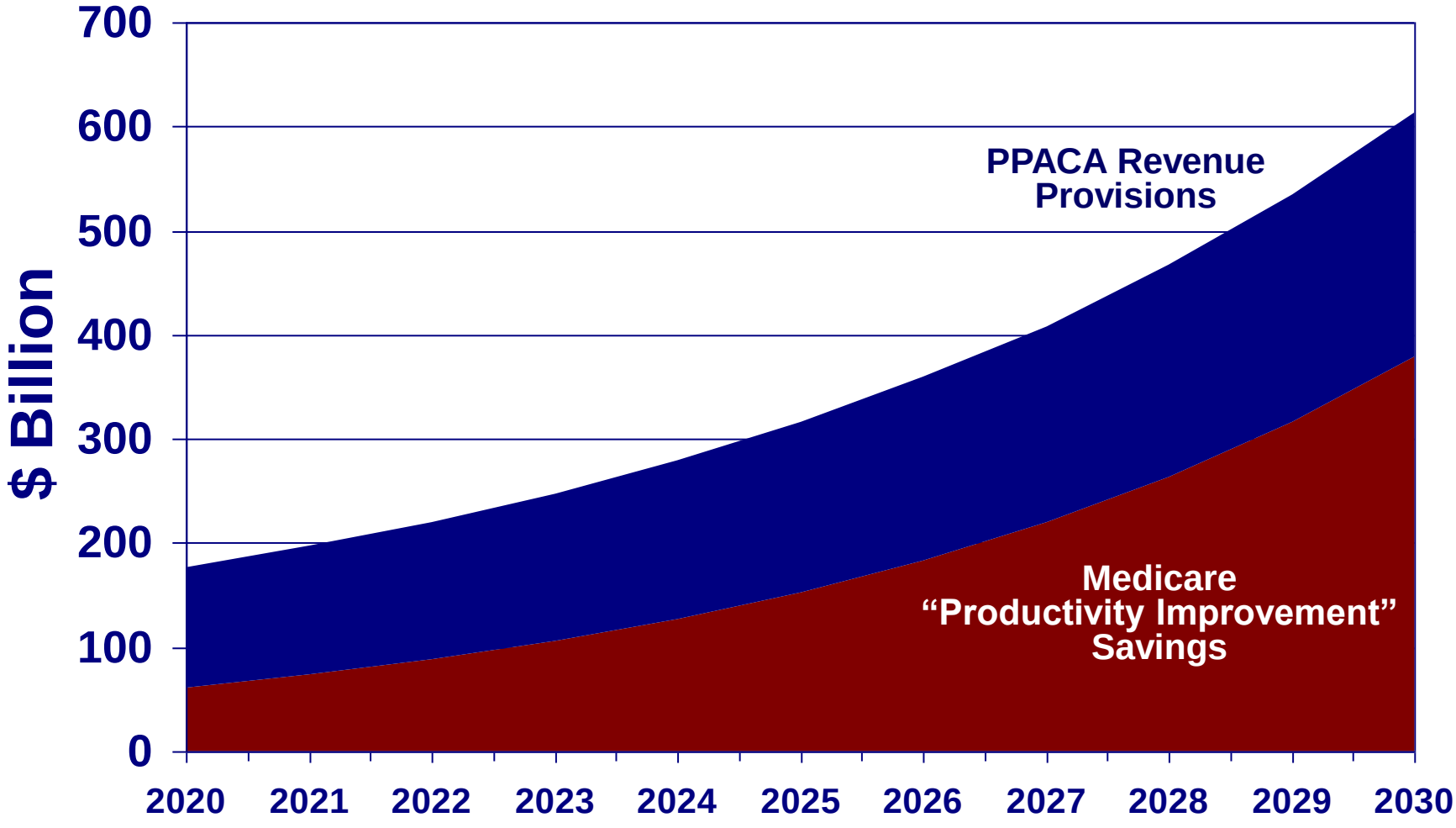


Source: CBO Letter to House Speaker Nancy Pelosi, March 20, 2010 and Author's Calculations Based on CBO Note on Health Reform's Impact on HI Solvency, December 23, 2009

The Key Long-Term Indexing Provisions

High-Cost Insurance Tax	• **Starts in 2018 at $10,200 (individual)/$27,500 (family); indexed to CPI+1% in 2019 and *CPI every year thereafter*.**
Medicare Tax Increases	• **Two taxes start in 2013, apply to workers with wages exceeding $200k (individual), $250k (couples).** • **The wage thresholds are not indexed.** • **0.9% added tax on wages** • **3.8% tax on unearned income (capital gains, dividends, interest income, rent).**
Medicare Provider "Productivity Improvement" Factor	• **Permanent ~0.5 percent reduction in the annual inflation increases for hospitals, nursing homes, hospices, home health payments**
Premium Credits in the Exchanges	• **Limit premiums to a % of income beginning in 2014.** • **Credits are (effectively) indexed to income growth from 2015 to 2018, and CPI thereafter.**

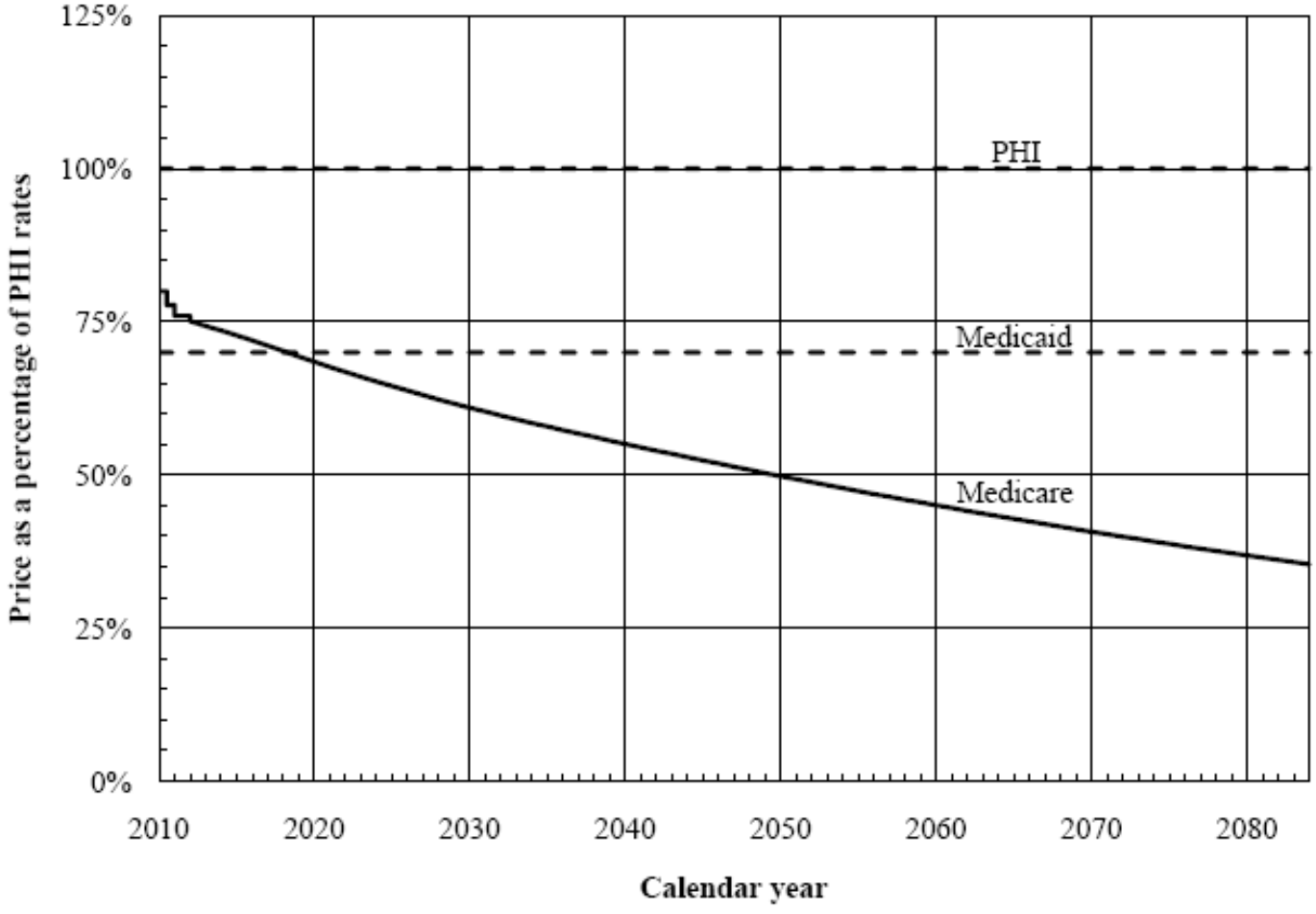
Effects of Certain Indexing Provisions



Source: Author's Rough Calculations based on CBO Long-Term Projections and PPACA Estimate

Comparison of Provider Payment Levels

Figure 1. Simulated comparison of relative Medicare, Medicaid, and private health insurance prices under current law



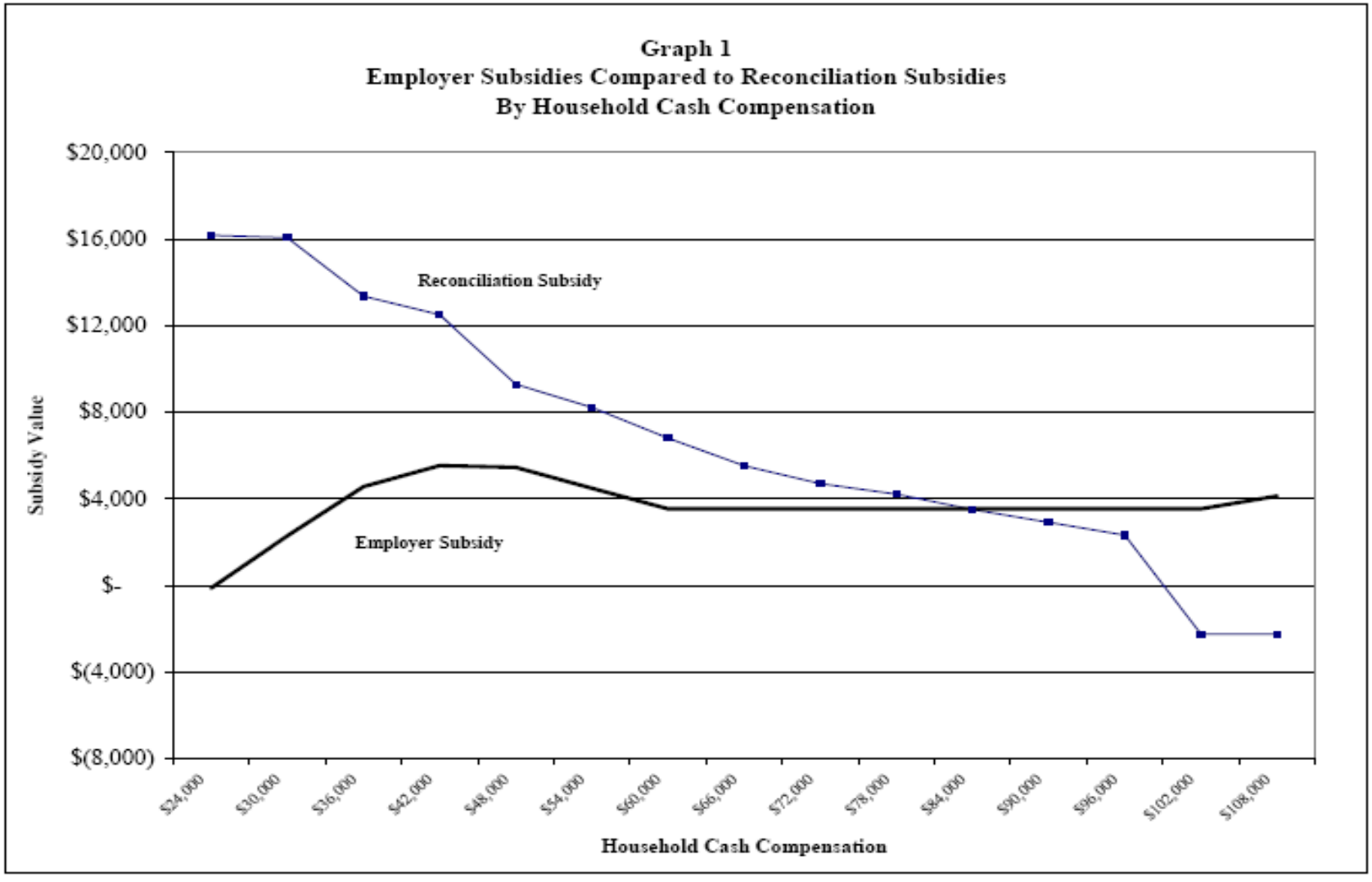
Source: "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," CMS OACT Memorandum, August 5, 2010

What the Actuaries Have Said…

"…we believe that the multifactor productivity adjustments to Medicare payment updates are very unlikely to be viable indefinitely. Accordingly, projections based on the permanent application of this new component of current law are very likely to seriously understate actual Medicare costs in the long-range future."

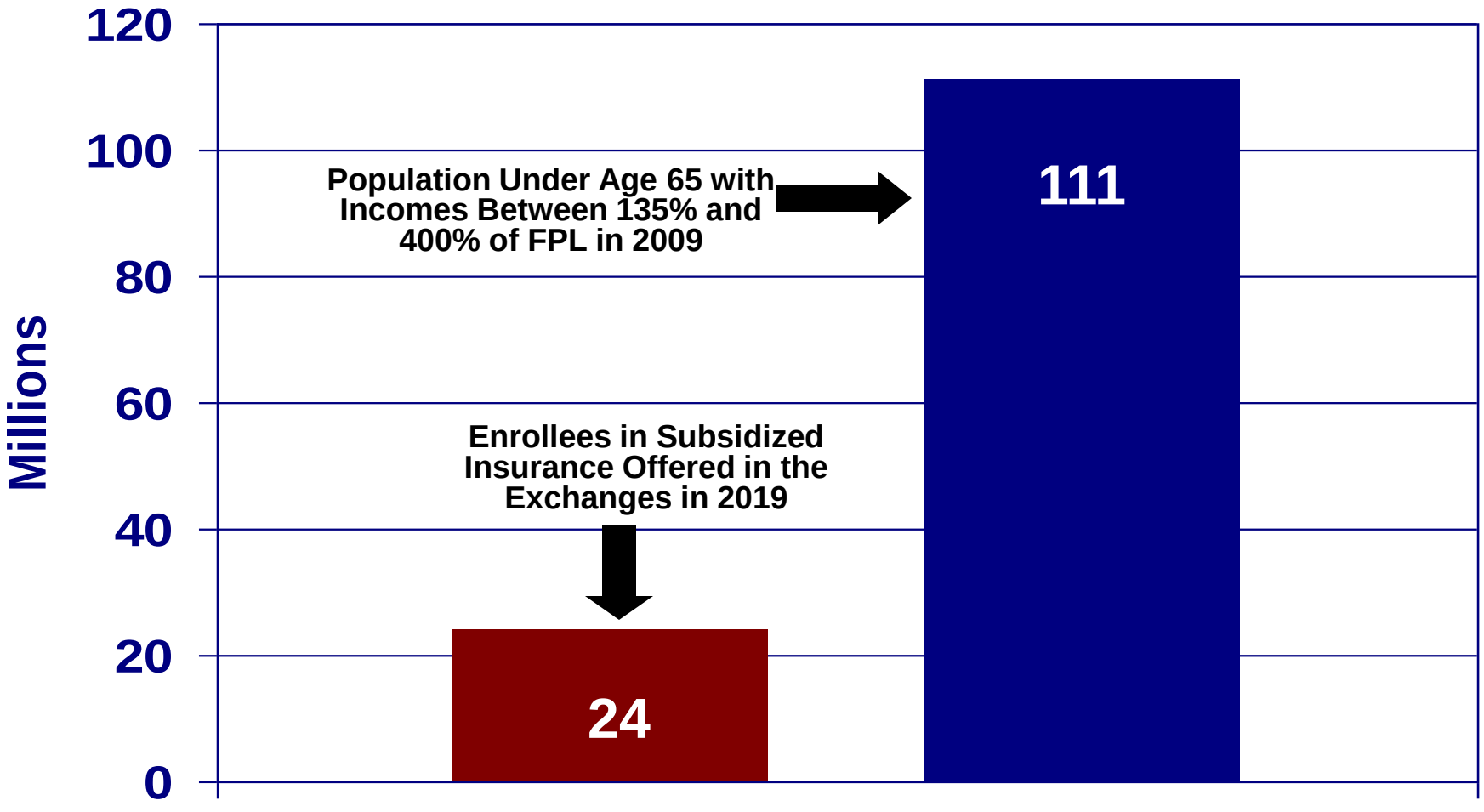
CMS Office the Actuary Memo
August 5, 2010

Disequilibrium in Federal Insurance Support



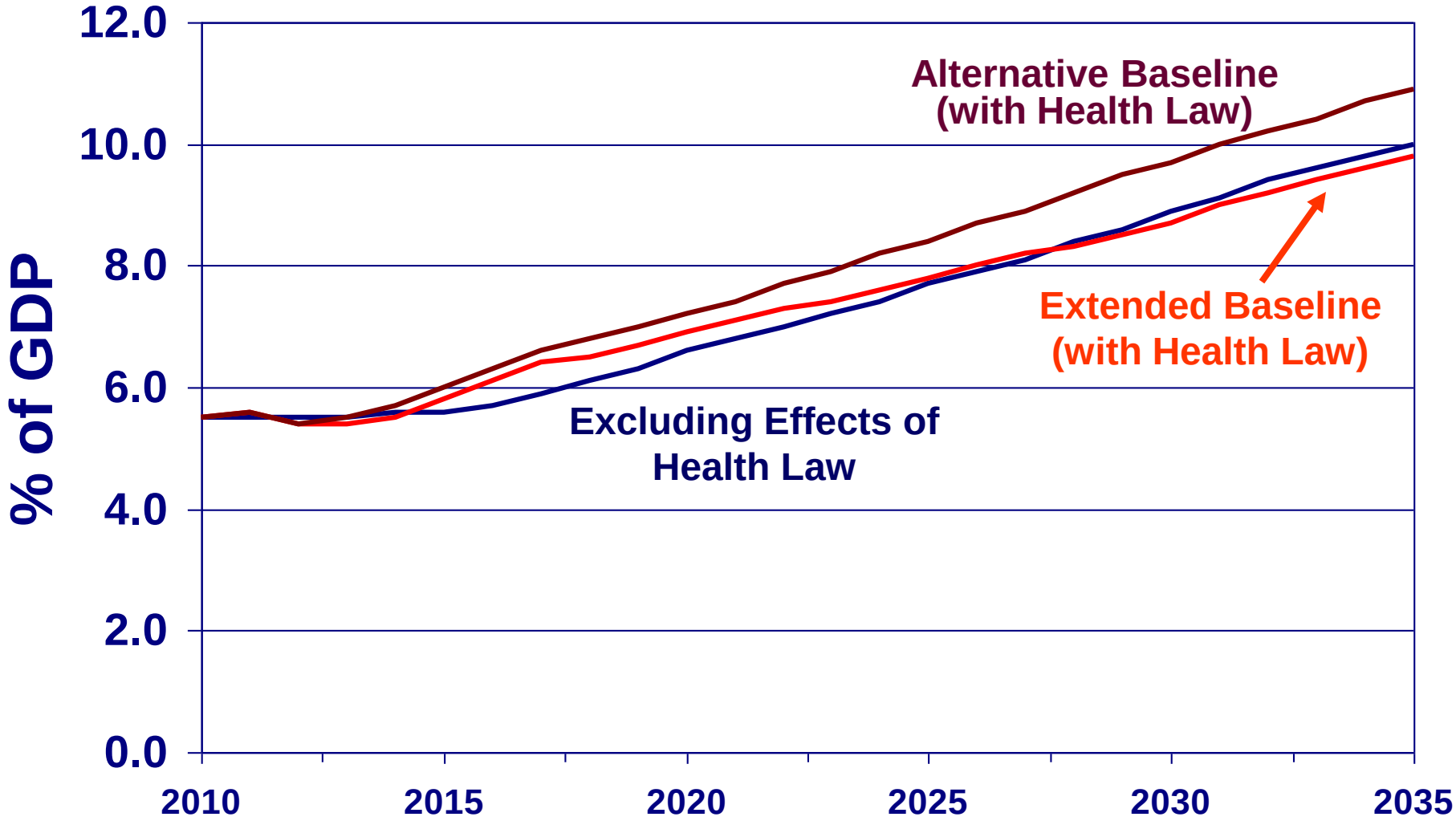
Source: "Health Reform: A Two-Subsidy System," Stephanie Rennane and C. Eugene Steuerle, Tax Policy Center, April 2010

Exchange Enrollment vs. Eligible Population



Sources: CBO, Census Bureau

CBO's Long-Term Federal Health Projections



Source: The Long-Term Budget Outlook, CBO, June 2010

What the Debate Is Really All About

The Key Question	What *process* has the best chance of bringing about continual improvement in the productivity and quality of patient care?	
Competing Views	**A Governmental Process**	**A Market-Based Process**
Solutions	• Health Information Technology • Comparative Effectiveness Research • Medicare-led payment reforms to encourage more efficient delivery (Accountable Care Organizations, Bundling of Payments) • Medicare Commission	• Move toward defined contribution financing systems in tax and entitlement programs • Foster cost-conscious consumers and incent doctors and hospitals to re-organize for efficiency • Government provides oversight but does not allocate resources • More Medicare Part D than Medicare Parts A & B
Criticisms	• Governmental process always devolves into across-the-board price setting that drives out willing suppliers and makes no distinctions based on quality • Cost control by supply control (queues)	• Patients with serious ailments cannot make rational decisions about use of services • Relying entirely on markets and prices to allocate resources is inequitable to those with less ability to pay

PPACA's "Delivery System" Reforms

Accountable Care Organizations	• Provide full range of Medicare covered services • Capacity to track Medicare beneficiaries in different provider settings • Expectation of hospital-centric, vertical integration (buying physician practices) • Beneficiaries assigned to ACOs
CMS Innovation Center	• $10 B to spend every ten years • Test "innovative" payments which lower costs without "harming" quality
Independent Payment Advisory Board (IPAB)	• 15 members, Senate-confirmed • Charged with enforcing a new cap on annual Medicare spending growth rate in 2015 • Hospitals exempt through 2019 • Physicians presumed to be exempt due to SGR problems • Targets? – Rx drugs, medical devices

Medicare FFS' Political Economy

- **Can the political/regulatory administrators of Medicare FFS make distinctions among hospitals, physicians, and others based on quality and cost metrics?**
- **Long, four-decade history indicates the answer is very probably no.**
  - **Centers of Excellence example**
- **Key roadblock: incapable of excluding licensed and otherwise qualified providers from "preferred" Medicare FFS payment (Lake Wobegon effect).**
- **Much easier to apply uniform, across-the-board payment rate reductions to hit budget targets (see PPACA).**

Assignment of Beneficiaries to ACOs

- **Section 3022 of PPACA establishes a new section 1899 of the Social Security Act (SSA) for a "Shared Savings" Program for ACOs.**

- **Section 1899(c) of the SSA now reads as follows:**

> ***"(c) ASSIGNMENT OF MEDICARE FEE-FOR-SERVICE BENEFICIARIES TO ACOS.—The Secretary shall determine an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services provided under this title by an ACO professional described in subsection (h)(1)(A)."***

Joint Select Committee on Deficit Reduction

- **Goal: $1.5 trillion in additional deficit reduction over ten years (including debt service savings).**

- **Membership:**

Republicans	Democrats
Rep. Jeb Hensarling (Co-Chair)	Sen. Patty Murray (Co-Chair)
Rep. Dave Camp	Sen. Max Baucus
Rep. Fred Upton	Sen. John Kerry
Sen. Jon Kyl	Rep. James Clyburn
Sen. Rob Portman	Rep. Xavier Becerra
Sen. Pat Toomey	Rep. Chris Van Hollen

- **Joint Committee recommendations need the support of seven members to become privileged legislation in House and Senate (guaranteed to come to an up or down vote, with no amendments, and no filibuster in the Senate).**

The Sequester Fall-Back

- **Joint Committee Target: Recommendations of at least $1.2 T in deficit reduction signed into law by December 23rd.**

- **Back-Up Sequester: If target is not met, automatic sequester cuts spending to ensure achievement of $1.2 T in deficit reduction over the nine year period 2013 to 2021 (any deficit reduction achieve by the Joint Committee is subtracted from the $1.2 T sequester).**

- **Sequester Mechanics: 50 percent will come out of defense discretionary spending and 50 percent out of non-defense discretionary plus selected entitlement programs.**

- **Treatment of Health Care: Medicare included in the sequester, but only 2% of provider payments; most of PPACA is exempt but not cost-sharing subsidies, high risk pool funds, public health funds, and perhaps risk adjustment payments.**

Proposals for Additional Health Care Savings

Proponents	Proposals
President Obama	• Total of $320 Billion over ten years in additional cuts • Rebates on part D drugs for dual eligibles • Hospital bad debt payments • Rural hospital payments • Medicaid/SCHIP Matching Rates • Post-acute care payment reductions • Small Medigap reform
“Democratic Offer”	• $475 Billion in additional Medicare and Medicaid savings over ten years • Half from providers and half from beneficiaries
Misc.	• Lieberman/Coburn • Major Medigap Reform • Retirement Age • Means-Testing