Long-Term Fiscal Gap and Health Care Costs

Percentage Share of GDP

Source: CBO (2007)
### Table 2.

**Estimated Contributions of Selected Factors to Growth in Real Health Care Spending Per Capita, 1940 to 1990**

(Percent)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Aging of the Population</td>
<td>2</td>
<td>2</td>
<td>2(^{\text{a}})</td>
</tr>
<tr>
<td>Changes in Third-Party Payment</td>
<td>10</td>
<td>13</td>
<td>10(^{\text{b}})</td>
</tr>
<tr>
<td>Personal Income Growth</td>
<td>11–18</td>
<td>5</td>
<td>&lt;23</td>
</tr>
<tr>
<td>Prices in the Health Care Sector</td>
<td>11–22</td>
<td>19</td>
<td>*</td>
</tr>
<tr>
<td>Administrative Costs</td>
<td>3–10</td>
<td>13</td>
<td>*</td>
</tr>
<tr>
<td>Defensive Medicine and Supplier-Induced Demand</td>
<td>0</td>
<td>*</td>
<td>0</td>
</tr>
<tr>
<td>Technology-Related Changes in Medical Practice</td>
<td>38–62</td>
<td>49</td>
<td>&gt;65</td>
</tr>
</tbody>
</table>

**Sources:** Congressional Budget Office based on Sheila D. Smith, Stephen K. Heffler, and Mark S. Freeland, "The Impact of Technological Change on Health Care Cost Increases: An Evaluation of the Literature" (working paper, 2000); David M. Cutler, "Technology, Health Costs, and the NIH" (paper prepared for the National Institutes of Health Economics Roundtable on Biomedical Research, September 1995); and Joseph P. Newhouse, "Medical Care Costs: How Much Welfare Loss?" *Journal of Economic Perspectives*, vol. 6, no. 3 (Summer 1992), pp. 3–22.

**Notes:** Amounts in the table represent the estimated percentage share of long-term growth that each factor accounts for.

- < = less than; > = greater than; * = not estimated.


<table>
<thead>
<tr>
<th>Number of Deaths Prevented/Postponed</th>
<th>Percent of Total Mortality Decline</th>
<th>Type of Medical/Surgical Treatment or Risk Factor Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>209,000</td>
<td>61.2%</td>
<td>Health risk reduction: Declines in prevalence of smoking, hypertension, cholesterol, physical inactivity</td>
</tr>
<tr>
<td>-59,370</td>
<td>-17.4%</td>
<td>Health risk increase: Rise in prevalence of body-mass index (BMI) and diabetes</td>
</tr>
<tr>
<td><strong>149,630</strong></td>
<td><strong>43.8%</strong></td>
<td><strong>Subtotal: Deaths prevented or postponed because of health risk factors</strong></td>
</tr>
<tr>
<td>83,285</td>
<td>21.9%</td>
<td>Category I: Aspirin, heparin, warfarin, anti-hypertensives, β-blockers, diuretics</td>
</tr>
<tr>
<td>45,225</td>
<td>13.2%</td>
<td>Category I+: Statins, ACE Inhibitors, IIb/IIIa antagonists, thrombolics</td>
</tr>
<tr>
<td>30,830</td>
<td>11.5%</td>
<td>Category II: Angioplasty/stents, bypass surgery (CABG), cardio-pulmonary resuscitation, cardiac rehabilitation</td>
</tr>
<tr>
<td><strong>159,340</strong></td>
<td><strong>46.6%</strong></td>
<td><strong>Subtotal: Deaths prevented or postponed by medical/surgical treatments</strong></td>
</tr>
<tr>
<td>32,775</td>
<td>9.6%</td>
<td>Unexplained by model</td>
</tr>
<tr>
<td><strong>341,745</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>Total deaths prevented or postponed</strong></td>
</tr>
</tbody>
</table>

Political polarization

Party Polarization 1879-2010
Distance Between the Parties First Dimension

R = .90

House

Senate
Two Conceptual Approaches
(Need Not Be Mutually Exclusive)

• Consumer directed

• Provider value
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

Ryan Proposal
- Government’s share: $8,000
- Beneficiary’s share: $12,500
- Total: $20,500

Current Medicare
- Government’s share: $8,600
- Beneficiary’s share: $6,150
- Total: $14,750


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
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?
Crucial “details”

• Sufficient data to do CER well? PCORI implementation
• Quality metrics
• Specific design:
  – Pearson/Bach
  – ASMR
  – United Health and other “performance-based reimbursement” approaches