Moving Toward a Value-Based Health System

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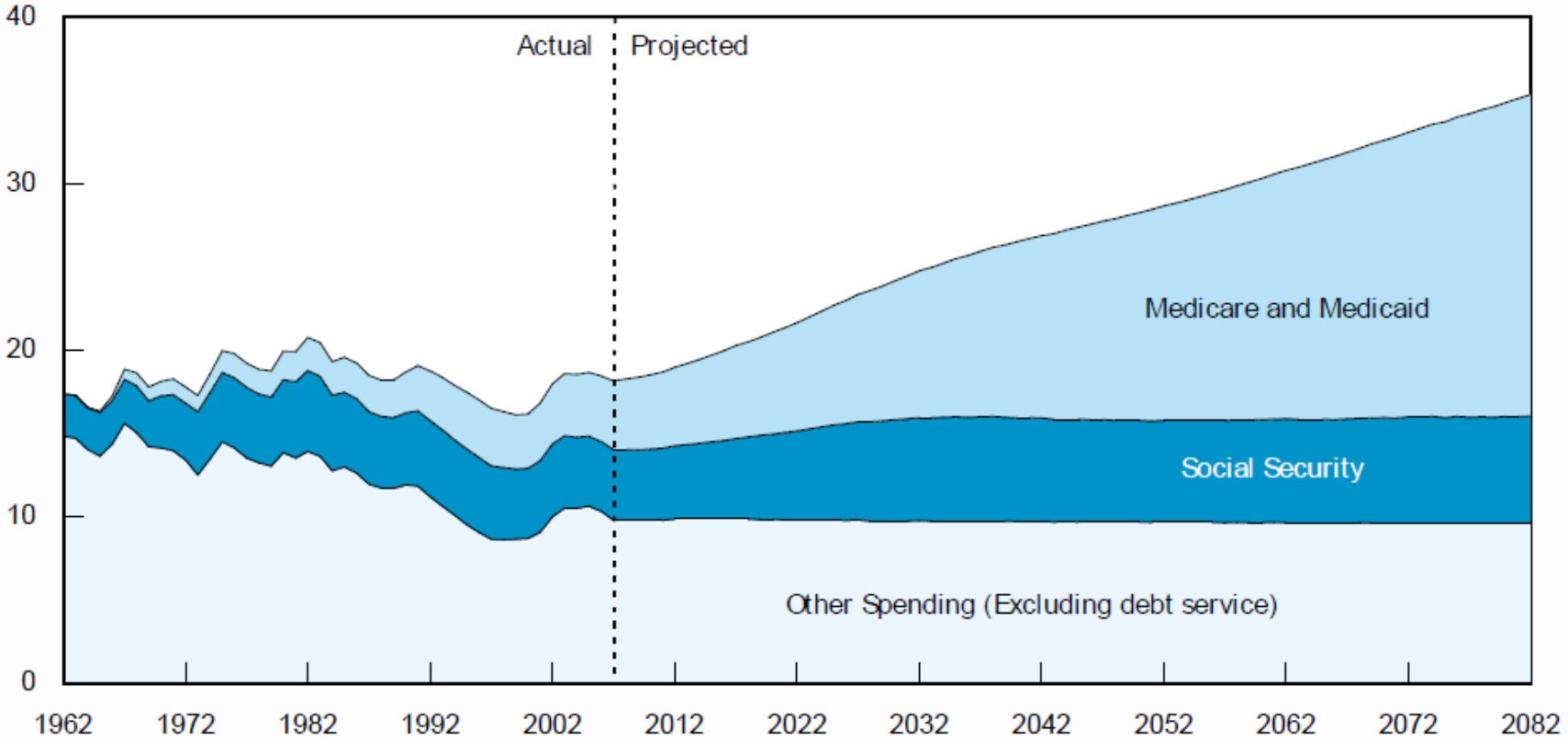
Long-Term Fiscal Gap and Health Care Costs

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)

	Smith, Heffler, and Freeland (2000)	Cutler (1995)	Newhouse (1992)
Aging of the Population	2	2	2[a]
Changes in Third-Party Payment	10	13	10[b]
Personal Income Growth	11–18	5	<23
Prices in the Health Care Sector	11–22	19	*
Administrative Costs	3–10	13	*
Defensive Medicine and Supplier-Induced Demand	0	*	0
Technology-Related Changes in Medical Practice	**38–62**	**49**	**>65**

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.

a. Represents data for 1950 to 1987.

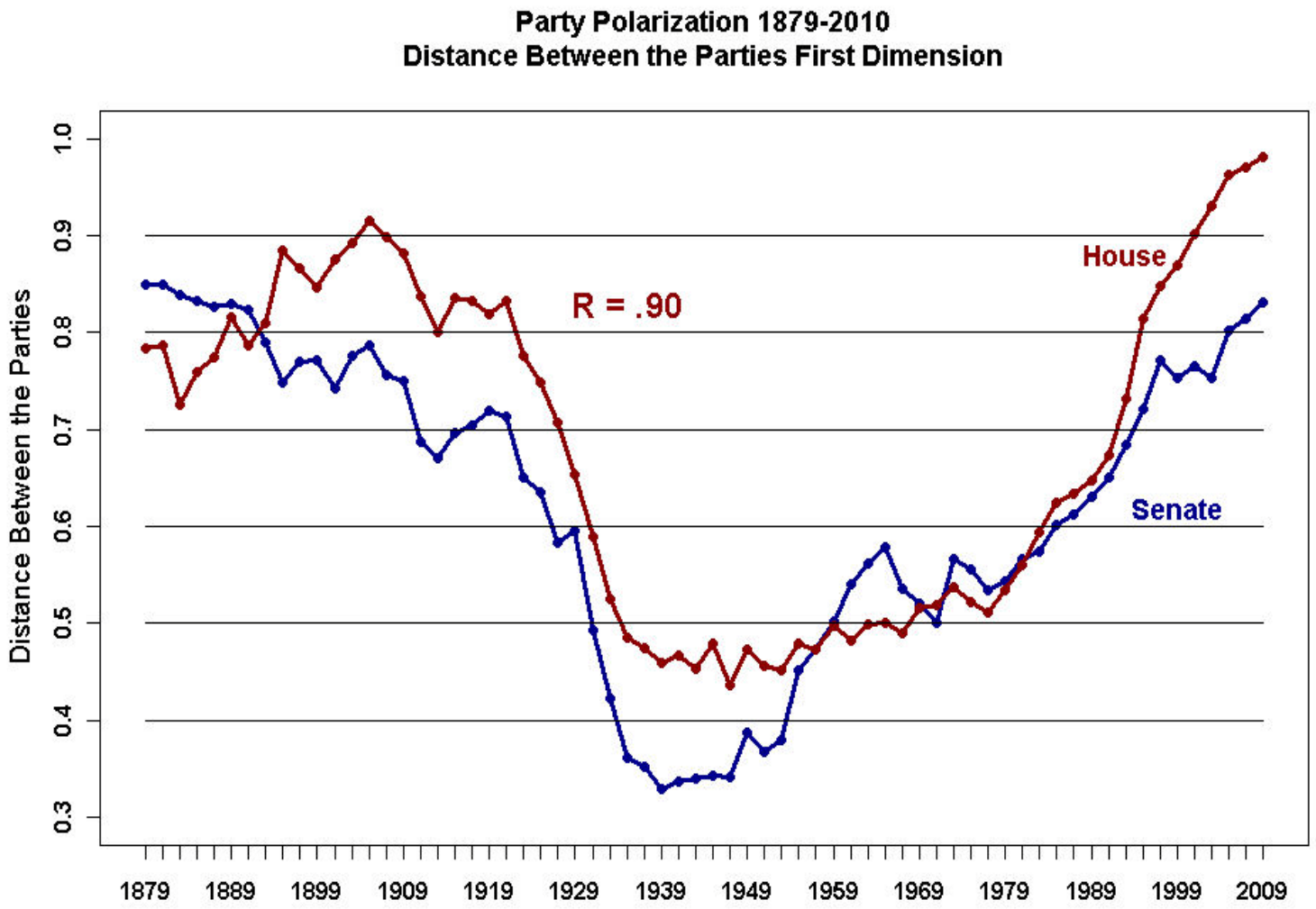
b. Represents data for 1950 to 1980.

Table 2: Accounting for the Decline in U.S. Deaths from Coronary Disease: 1980-2000

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

Source: Ford, et al., 2007.

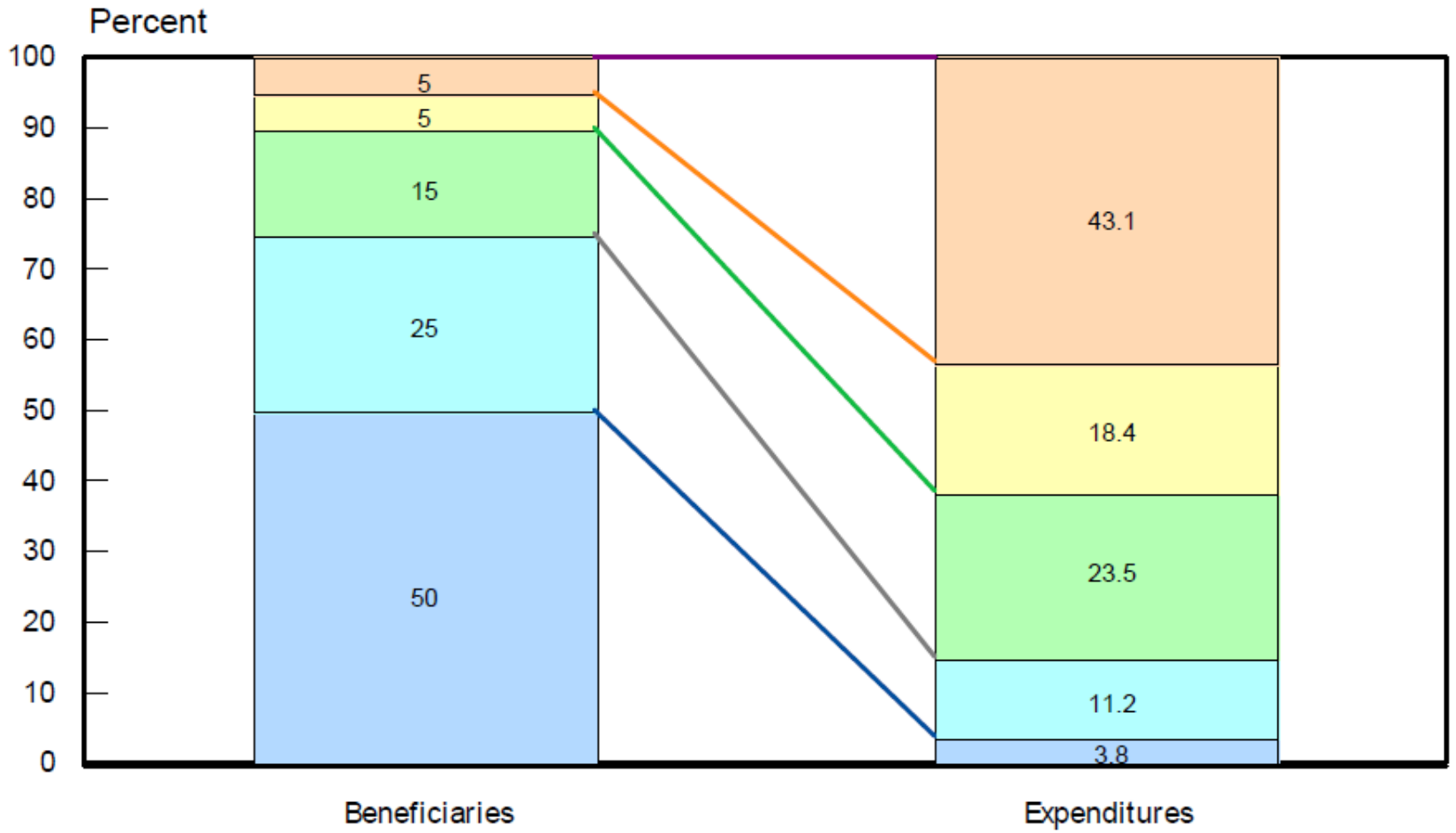
Political polarization



Two Conceptual Approaches (Need Not Be Mutually Exclusive)

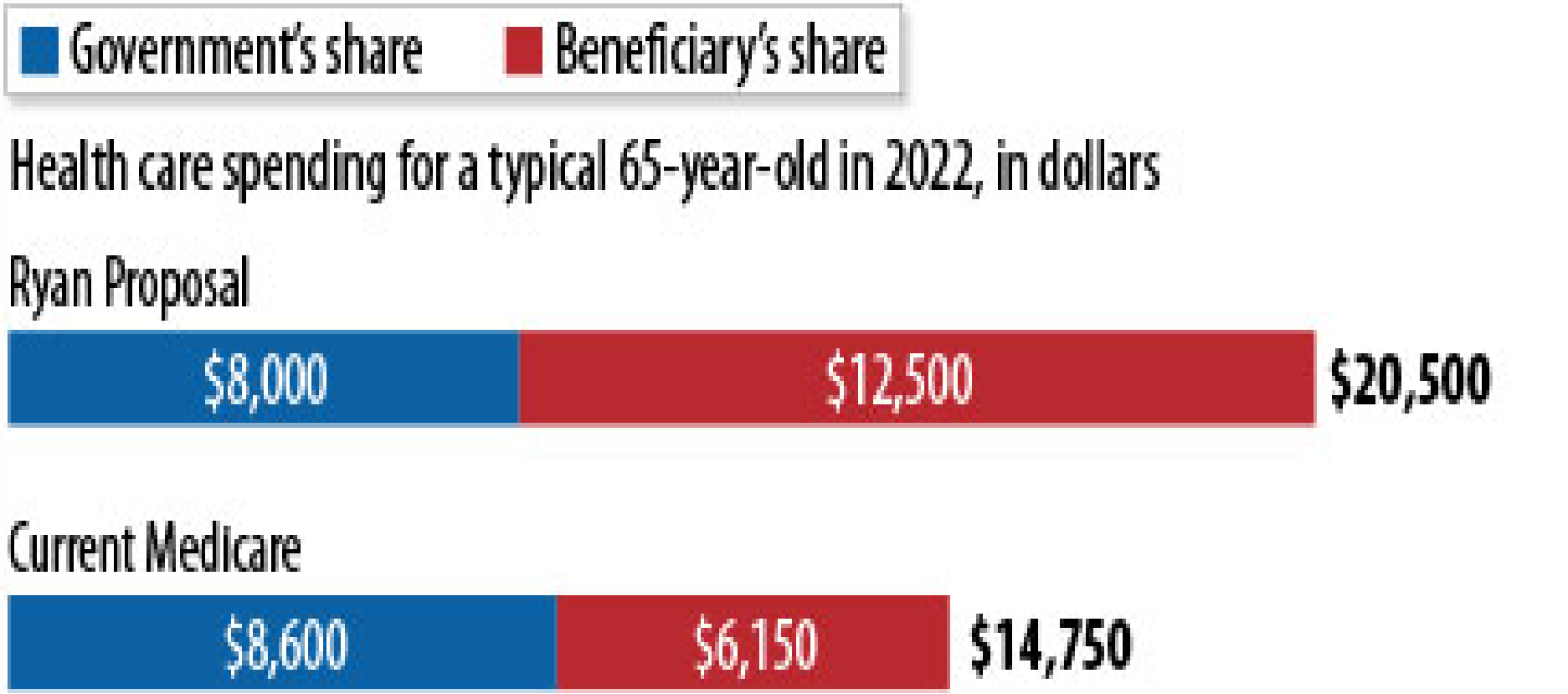
- Consumer directed
- Provider value

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

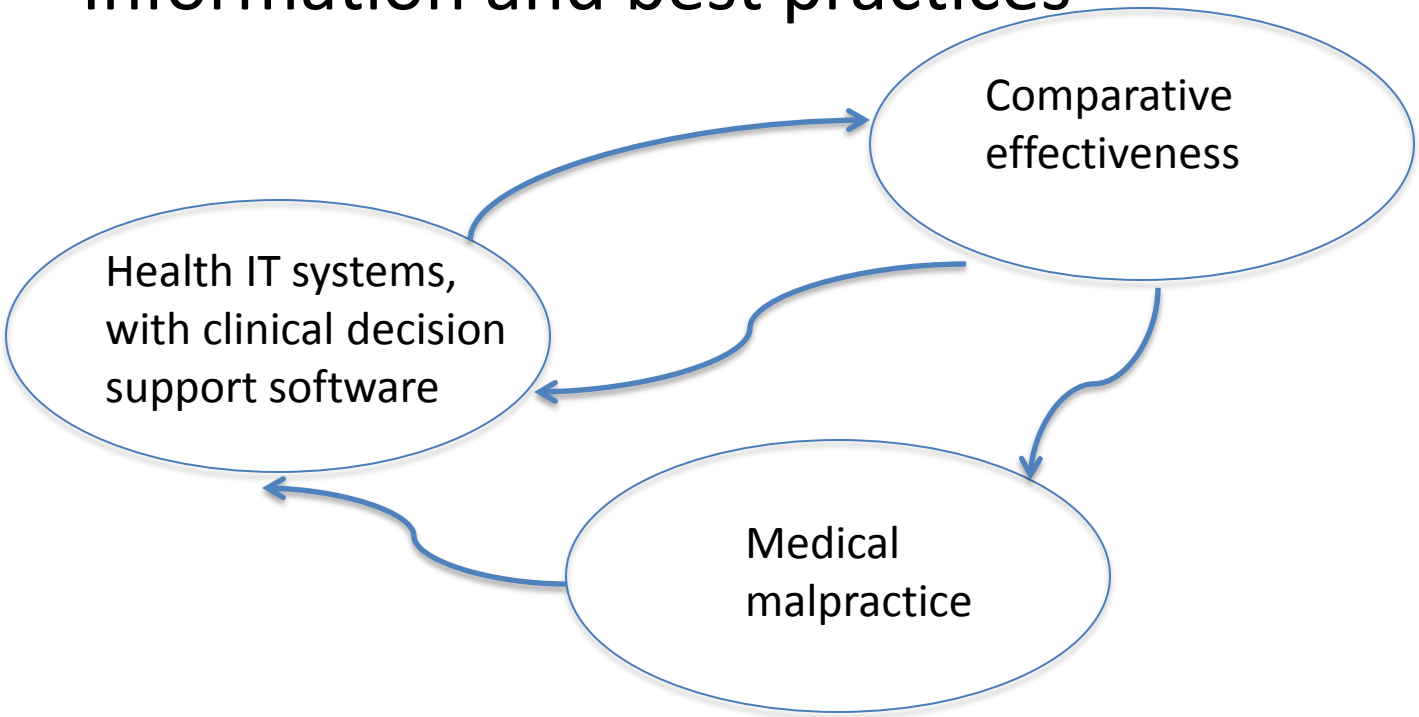


Source: Douglas W. Elmendorf, Director, Congressional Budget Office, Letter to the Honorable Paul Ryan, April 5, 2011, and CBPP calculations. Current Medicare is CBO's alternative fiscal scenario.

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



- 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