

HEALTH CARE BASICS AND THE BUDGET: Featuring Health Reform and Bending the Cost Curve

By: Carol Lewis and W. Bartley Hildreth

Health care is a significant share of the nation's economy and a large and growing part of federal and state government expenditures. Most politicians recognize the need for reform, but differ greatly on what and how to reform the health care system that all Americans depend upon throughout their lives. A brief review of health care basics and the budget is followed by key issues surrounding major health reform enacted in 2010.

In 2008, health care represented 16 percent of the U.S. gross domestic product. Government finances almost one-half (46 percent) of all spending in the United States on health care, compared to 25 percent before Medicare was introduced in 1965. Medicare accounted for 17 percent of the almost \$1.9 trillion spent on health care in 2004. Medicaid and SCHIP (State Children's Health Insurance Program) accounted for another 16 percent, and other public sources for 13 percent (CMS, 2007).

Because Medicare and Medicaid are the most rapidly growing programs for the federal and state governments, they often are a focus of political debate. Medicare, the federal entitlement program that provides health insurance to people over 65 years old and disabled people under age 65, is financed through a payroll tax but also draws on general revenues for funding. The Medicare Modernization Act of 2003 added prescription drug coverage and requires the Medicare trustees to issue a warning when general revenue Medicare funding is projected to exceed 45 percent of Medicare's total expenditures. The Medicare funding warning was triggered in the 2007 Medicare Trustees' Report (OMB, 2008, p. 215). The Medicare program served more than 43 million people in 2006 and paid out more than \$400 billion in benefits. A federal and state entitlement program targeting low-income people, Medicaid is funded entirely by general tax revenues.

“The demand for health care is unlike the demand for most consumer products and services because while the desire for consumer products and services comes from direct consumption, the desire for health care is not derived directly from the consumption of the medical procedures themselves; rather, it comes from the direct value of improved health that is produced by health care. For example, demand for an MP3 player is based on the enjoyment that an MP3 player brings to a consumer, but few would choose to get a laparoscopic cholecystectomy for the same reason. Rather, a consumer's desire to have her gallbladder removed is directly related to the positive impact the operation is likely to have on her health. Understanding how health is produced, demanded, and valued is a useful starting point for evaluating the health care system and health care policy.

Demand for Health

People demand health because of its role in facilitating and providing happiness. Health can be defined along two dimensions: the length of life (longevity) and the

quality of life. A person derives value from the quality of life directly and indirectly: directly because one's level of health affects the enjoyment of goods and leisure and indirectly because one's level of health enhances productivity. ... Enhanced productivity can be rewarded in the labor market through higher wages. The indirect effect of health on productivity suggests that health is an important component of human capital investment. Consistent with the basic principle of our economic system, consumers exercise choice in purchasing health care and other goods and services.

Trends in Health Spending

Americans are investing more in their health as measured by health care expenditure. In 2006, Americans spent over \$7,000 per capita on health care, up from \$2,400 in 1980 and \$800 in 1960 (all in 2006 dollars). National health care spending has grown more rapidly than the economy as a whole, so health care accounts for an increasing share of the overall economy. ... National health care spending now accounts for about 16 percent of gross domestic product (GDP), up from 9.1 percent in 1980 and only 5.2 percent in 1960.

Government Health Care Programs

About 46 percent of health care spending is funded by federal and state governments through various health programs. The main government-funded health programs are designed to serve specific populations and include Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and the Veterans Health Administration (VHA).

Medicare was enacted in 1965 and covers nearly all individuals aged 65 and older (as well as some younger individuals with disabilities or specific illnesses). Medicare today consists of three basic parts. Part A is hospital insurance, which covers stays in hospitals and nursing facilities.

Part A is primarily funded by a 2.9 percent payroll tax (1.45 percent each for workers and employers). Part A is generally provided automatically and without premiums for persons age 65 and older who are eligible for Social Security or Railroad Retirement benefits. Part B is supplementary medical insurance which covers doctor visits and other outpatient services. Part B is voluntary and enrollees pay a monthly premium, yet 94 percent of those eligible elect to enroll. Part D, Medicare's prescription drug benefit which started in 2006, is available on a voluntary basis to individuals who qualify for Medicare Part A, and requires a monthly premium for those beneficiaries who do not qualify for the low-income subsidy. Unlike other parts of Medicare, Part D is administered by a partnership between private insurers and Medicare officials to provide choice of prescription drug plans to beneficiaries and to allow for price competition. Part B and Part D are funded by a combination of premiums from beneficiaries and government revenues (Part D also receives some resources from the states). In 2007, there

were 43.4 million beneficiaries enrolled in Part A, 40.6 million in Part B, and 24.4 million in Part D.

Under Fee-for-Service Medicare, health care providers are reimbursed by the federal government at predetermined rates for services provided. However, Medicare beneficiaries can opt to enroll in a private Medicare plan under Medicare Advantage through local coordinated care plans offered mostly by local health maintenance organizations (HMOs) and preferred provider organizations (PPOs), regional PPOs, and private fee-for-service providers. Local coordinated care plans make up 72 percent, regional PPO plans 3 percent, and private fee-for-service plans 21 percent of Medicare Advantage plans.

Medicaid was also established in 1965 as a health care program for low-income individuals, in particular those with children. Medicaid is administered by the states, and is funded by both the federal government and the states. Like traditional Medicare, Medicaid also reimburses private providers for services at predetermined rates and allows recipients to enroll in Medicaid managed care plans in many states. However, unlike Medicare, these predetermined rates are determined at the state level. In 2006, there were 45.7 million enrollees in Medicaid, of whom 65 percent were in managed care plans. The State Children's Health Insurance Program (SCHIP) was created in 1997 to cover children from low-income families who do not qualify for Medicaid. SCHIP is also administered by the states and funded by both federal and state governments, but the federal contribution towards spending is higher for SCHIP than for Medicaid. In 2006, there were 6.6 million enrollees in SCHIP.

While Medicare, Medicaid, and SCHIP are publicly funded programs, most health care services are delivered by private providers not employed by the government. In contrast, the Veterans Health Administration (VHA) delivers health care to veterans through a system that is run by the Department of Veterans Affairs. The VHA is a truly public health care system in the sense that the federal government owns the VHA hospitals and employs the health care providers. Rising health care costs are creating budget pressures for government health care programs. Currently, federal spending on Medicare and Medicaid totals about 4 percent of GDP, or about 20 percent of the federal budget. Rising health care costs, however, will likely raise those figures in coming decades. If spending grows 1 percent per year faster than GDP (which is somewhat slower than the historical rate of growth over the past 40 years), for example, the Office of Management and Budget projects that in 25 years, spending on these two programs alone could reach 8 percent of GDP. Such spending growth, if it came to pass, would require either unprecedented levels of taxation or dramatic reductions in other government activities.”

Source: Economic Report of the President, 2008,
<http://origin.www.gpoaccess.gov/eop/index.html>, pp. 98, 100, 104–106.
[Capitalization changed to conform to standard style.]

Health Reform: Bending the Cost Curve?

Congress passed and the president signed on March 23, 2010 the Patient Protection and Affordability Care Act, and, a few days later, certain amendments as part of the Health Care and Education Reconciliation Act. This legislation calls for far-reaching reforms of the nation's primary care system and reduce the long-term growth in health care costs. Critics were quick to give it a name: ObamaCare.

During the often-times heated debate over this legislation, questions arose on how reform would "bend the cost curve" of spending on health care by consumers, businesses, and government. Policy makers faced indicators showing that:

- health expenditures accounted for 16 percent of Gross Domestic Product,
- millions of Americans were being priced out of the market for health insurance,
- businesses were dropping private health insurance for its employees or shifting more of the premium burden to the individual,
- state governments' budget growth was driven by hard-to-control Medicaid expenses, and,
- federal health care spending was touted as "the single greatest threat to (federal) budget stability" (CBO, 2010c, p. 3).

To its advocates, health care reform had to address system-wide problems and slow or reduce the cost curve of health expenditures.

Which Cost Curve?

Responding to a legislative request, the Congressional Budget Office (CBO, 2009a, p.7) tackled the cost curve question this way:

The question often arises: How does CBO evaluate whether health care reform proposals "bend the curve"? But that question raises another one: Which curve? Several cost trends are of interest to policymakers, and even though they are related, proposals might not have the same effects on each one. One such curve is the federal budget deficit as a whole, and another is the federal budgetary commitment to health care. A third is the trajectory of national health expenditures (NHE), and a fourth might be the premiums charged for health insurance.

Moreover, what does it mean to "bend the curve"? If a proposal makes the expected budget deficit 20 years from now smaller than it is expected to be without any policy changes, then the deficit curve is clearly being bent downward, on average, during the next 20 years; that is, the average growth rate of the deficit during those two decades would be lower. On the other hand, if the expected deficit is larger, then the deficit curve is being bent upward, and the average growth rate of the deficit in that period would be higher. Would that slower or

faster growth rate continue indefinitely? That sort of extrapolation might seem natural, but it may not be appropriate. Distinguishing between a series of shifts in the level of the deficit and permanent changes in the growth rate of the deficit is difficult. Although CBO can provide a rough indication of a proposal's effect on the level of the budget deficit 20 years ahead, the agency does not have an analytic basis for projecting the proposal's effect on the growth rate of the deficit at that point, much less for evaluating whether that growth rate will continue in future years. Those same considerations apply to the agency's analysis of the federal budgetary commitment to health care. Therefore, CBO has concluded that it is more appropriate to talk about whether proposals would "lower" or "raise" the curve of the federal budget deficit or budgetary commitment to health care 10 to 20 years from now than to discuss those proposals' effects on the shape of the curve in that time period or the level or slope of the curve beyond that period. Major proposals to reform health care would affect not only the federal budget but also spending for health care by individuals, firms, and other levels of government. A broad measure encompassing these effects would be the impact on total national health expenditures. However, CBO does not analyze NHE as closely as it does the federal budget, and at this point CBO has not assessed the net effect of health care reform proposals on those expenditures, either within the 10-year budget window or for the subsequent decade. That is, CBO has not evaluated whether reform proposals would lower or raise—or bend down or up—the "curve" of national health expenditures.

The Legislation

Despite the complexity, the March 2010 laws are mostly health insurance reforms. As enacted, these laws:

- provide insurance coverage for 32 million currently uninsured Americans,
- mandate the purchase of health insurance by everyone (except low income) or pay a fine,
- require minimum coverage requirements,
- end insurance companies' practice of excluding coverage for pre-existing medical conditions from health plans,
- create state-based insurance exchanges or marketplaces so consumers can connect with insurers in a way that should reduce the cost of purchasing coverage, and
- enact changes in Medicare to reduce costs.

While far-reaching, this legislation does not mandate a national health care system, as found in Canada. Rather, it continues the American model of consumer choice in dealing with health providers and the primacy of private health insurance.

Early Cost Curve Estimates

A new national program like this does not come without costs.

Insurance regulation has traditionally been left up to the states. Interstate commerce and the mobility of individuals over a work career called this historic framework into question. Thus,

federal health reform significantly alters the federal presence in the health insurance market. Several states challenge this federal intervention, with the U.S. Supreme Court likely to render the final judgment.

Health reform has an impact on insurance premiums with estimates varying by type of insured group (CBO, 2009b).

To expand health coverage and mandate minimum insurance packages requires an offsetting payment mechanism. The law responds by requiring everyone to have health insurance or to pay a fine for not having coverage. This use of federal taxing power is also called into question by opponents of the law. Other taxing mechanisms include a tax on high-cost or “Cadillac” health plans (until 2018, this is defined as with plans valued at \$10,200 for individual plans and \$27,500 for a family plan). In 2018, a 40 percent excise tax will be levied on such high-cost plans. Industry and labor are not particularly pleased with a tax on generous benefit programs. State Medicaid programs have to expand to cover low-income adults. Therefore, the law expands Medicaid eligibility to all legal residents under 133 percent of the federal poverty level (that is \$29,327 for a current family of four). Coverage for children expands to higher income levels, too. Because states have to pay a share of the cost of the Medicaid program, the law significantly increases federal support. It covers 100 percent of the match for the “newly eligible” group for three years before declining to 90 percent later. For the currently eligible group, the law includes an increase in the federal match.

Federal health care reform influences both the revenue and spending of the federal government. New taxes and charges flow into government, tighter program efficiencies reduce costs, while Medicare and Medicaid initiatives require new spending. Early estimates peg the federal budgetary commitment to health care increasing to about \$180 billion over the first decade after which it drops (CBO 2010a and 2010b).

A key concern during the legislative debate was the impact of federal health reform on future federal deficits (the difference between revenues and outlays). Federal budget deficits are the result of many budgetary elements not related to health care, such as spending on two wars and economic recovery, and reduced revenues from anemic economic behavior generally. At passage, the law was estimated to cut \$124 billion in federal deficits over the ten-year planning horizon (2010-2019) required for congressional budget enforcement procedures.

The CBO’s director sketched out the reform’s likely budgetary impact (CBO, 2010b, pp. 2 and 13):

Rising health costs will put tremendous pressure on the federal budget during the next few decades and beyond. In CBO’s judgment, the health legislation enacted earlier this year does not substantially diminish that pressure.... Putting the federal budget on a sustainable path would almost certainly require a significant reduction in the growth of federal health spending relative to current law (including this year’s health legislation).

According to the chief actuary of the Medicare and Medicaid programs, “overall national health expenditures under the health reform act would increase by a total of \$311 billion (0.9 percent)

during calendar years 2010-2019....Although several provisions would help to reduce health care cost growth, their impact would be more than offset through 2019 by the higher health expenditures resulting from the coverage expansion” (Office of the Actuary, 2010:4). National health expenditures as a percent of Gross Domestic Product is estimated at 17.8 percent in 2010 under the pre-reform law (not the 16 percent used in early debates), rising to 20.8 percent in 2019 using the same baseline, as compared to 21.0 percent in 2019 under the new law. Accordingly, the chief actuary estimates the cost curve of national health expenditures bending up through 2019.

Policy Diagnosis

Should quality health care for all Americans be reduced to a cost curve question? Why or why not?

What are the likely political implications of the 2010 health care legislation? In the short term? Long term?

Health Care Reform and the States

Federal health care reform has implications for state budgets. Here are two resources, both from the Georgia Health Policy Center.

“An Overview of Health Reform”

http://aysps.gsu.edu/ghpc/images/ghpc_images/An_Overview_of_Health_Reform_web.pdf

“State Implications of Health Reform in Georgia”

[http://aysps.gsu.edu/ghpc/images/ghpc_images/State_Implications_of_Health_Reform_in_Georgia\(2\).pdf](http://aysps.gsu.edu/ghpc/images/ghpc_images/State_Implications_of_Health_Reform_in_Georgia(2).pdf)

Exercise

1. Look at your state’s budget or supplementary documents (such as the governor’s economic report).

State _____

Url or document _____

a. What proportion of total spending is spent on health services and programs? _____ %

b. Is this proportion increasing or decreasing? How do you know?

c. How does this change affect the state budget and the politics of budgeting in your state?

2. Look at the budget of a county, city, or school district in your area.

County, city, or school district _____

Url or document _____

- a. What proportion of total spending is spent on employee health care benefits?
- b. Is this proportion increasing or decreasing? How do you know?

The cost of health care for retirees is a potentially explosive issue for state and local budgets and the politics of budgeting. (See chapter 3 on budgetary IOUs.)

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Further Resources

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