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EYE ON WASHINGTON

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changes in healthcare financing
a retrospective of the past decade

To have a clear idea of where you are going, it's a good idea to take a look at where you've been.

As we await the beginning of a new administration and a new Congress, it seems appropriate to think back about how healthcare spending and financing have changed over the past decade.

Where Have We Been?

The short answer is that it's been a tough decade for healthcare spending—both in absolute terms and relative to the economy. According to the data from the Centers for Medicare & Medicaid Services (CMS), U.S. healthcare spending in 1999 constituted about 13.7 percent of the GDP on health care, approaching $1.3 trillion.[a] CMS's 2006 data indicate a continuing rise in healthcare spending to around $2.2 trillion, or about 16 percent of the GDP.

For most of the past decade, both the numerator (healthcare spending) and the denominator (the economy) have been growing in unhelpful directions, compared with their growth in the 1990s. During much of 2000 to the present, healthcare spending has been growing relatively rapidly while the economy's growth has been slowing; in the 1990s, the opposite was true.

The 1990s warrant a closer look, as this decade represents an anomaly. Unlike most years since the 1960s, the 1990s started and ended with the country spending about the same share of the GDP, roughly 13 percent, on health care. The period from 1991 to 1997 was dominated by aggressive actions by employers and payers as each took advantage of excess capacity in the system to push down prices and spending. This has sometimes been characterized as the era of managed care, but in truth, it was more often the aggressive promotion of "mindless" fee-for-service as opposed to much actual "managing of care." This first period was followed by the 1997 Balanced Budget Act (BBA), which reduced payment for all providers of services to the Medicare population, abruptly slowing Medicare spending for three years. In fact, in 1998, the BBA produced the only actual reduction in Medicare spending in its history.

Few would want to have a repeat of the specifics of the 1990s, but the decade did demonstrate the possibility of slowing the growth of health spending relative to the growth of the economy, an event made easier by the economy's robust growth. Given that we can't sustain the current healthcare spending growth rate—which has been 2 percent to 2.5 percent faster, on average, than the growth rate of the overall economy in real terms per capita—perhaps there is something more to learn from the 1990s, especially because information suggests that the country's rapid growth rates in spending have been accompanied by serious problems with both patient safety and clinical appropriateness.

Changes in Medicare

The big change in Medicare since the BBA has been the passage of the Medicare Modernization Act in 2003 with the introduction of the Part D outpatient prescription drug benefit. Even before this new legislation, the growth in Medicare

a. To read CMS's official estimates of total healthcare spending in the United States, go to www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp.

spending had returned to projected levels of spending of about 7.5 percent per year—helped in part by the passage of a couple of "give-back" pieces of legislation, including the 1999 Balanced Budget Refinement Act (BBRA), which undid some of the BBA savings.

The passage of the Part D benefit represents both good and bad news for Medicare. Good news because Part D fixed what has widely been regarded as a major missing component of coverage for seniors—outpatient prescription drug coverage. Bad news because Part D exacerbated the problems facing Medicare, already an "over-promised and underfunded" program, to the point that unfunded liabilities associated with the program have been estimated to be more than $40 trillion. Although Part D did not change the fundamentals of Medicare, it did introduce a component of private-sector competition, which, at least to date, has helped produce spending levels that are far less than the estimates of either CMS or the Congressional Budget Office.

The most broken part of Medicare is the physician fee schedule. The use of a resource-based relative value scale (RBRVS) combined with the sustainable growth rate, which ties overall Part B spending to the growth in the economy, has produced the worst of all worlds: high spending rates for Part B overall and a decade with no change in the fees paid to physicians for individual services provided to seniors. As a result, there is no way that a conservatively practicing physician could have his or her costs covered.

Fixing this problem will take a major change in how Medicare pays physicians. I believe that this change will likely involve moving to a system of more bundled payments for physician services, which would bring physician payments more in line with how Medicare pays for other medical services.

Non-Medicare Changes

With regard to the under-65 population, the percentage of the population with insurance coverage is more or less the same as it was a decade ago (about 85 percent of the population), but the mix of insurance is slowly changing. Employer-sponsored insurance has continued its two-decade history of erosion, now covering just under 60 percent of the population, with the State Children's Health Insurance Program (SCHIP) and other public insurance taking up the difference.

Most of the discussion during the run-up to the election was on how to bring the other 15 percent of the population into coverage, although some attention also was given to the need to make health care more affordable. Finding more money for health care is going to be a challenge, given the focus on expanding the economy and stabilizing the financial markets, and in the short term, the new administration may begin where the Congress left off—expanding SCHIP.

Reason for Hope

Despite all these challenges, I am cautiously optimistic about the future. Even during the election cycle, attention was being given to many of the cost drivers in health care, and some consensus is now developing with respect to the important delivery system reforms that are needed. There is wide recognition about the importance of changing the payment system to reward the behavior that we want—behavior that improves both quality and cost-effectiveness. The importance of producing more and better information and making it more easily accessible is widely acknowledged, and increased attention is being given to developing a center or institute for comparative clinical effectiveness.

The United States must slow the rate of spending on health care. If we continue spending at the current pace—at least for much longer—we will have little success dealing with the other challenges facing our healthcare system. If, however, we can figure out how to slow spending, everything else will be much easier to resolve. The key will be to slow spending without sacrificing medically useful services. It won't be easy. ●

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