

# Federal Healthcare Programs

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**Gail R. Wilensky**

Project HOPE

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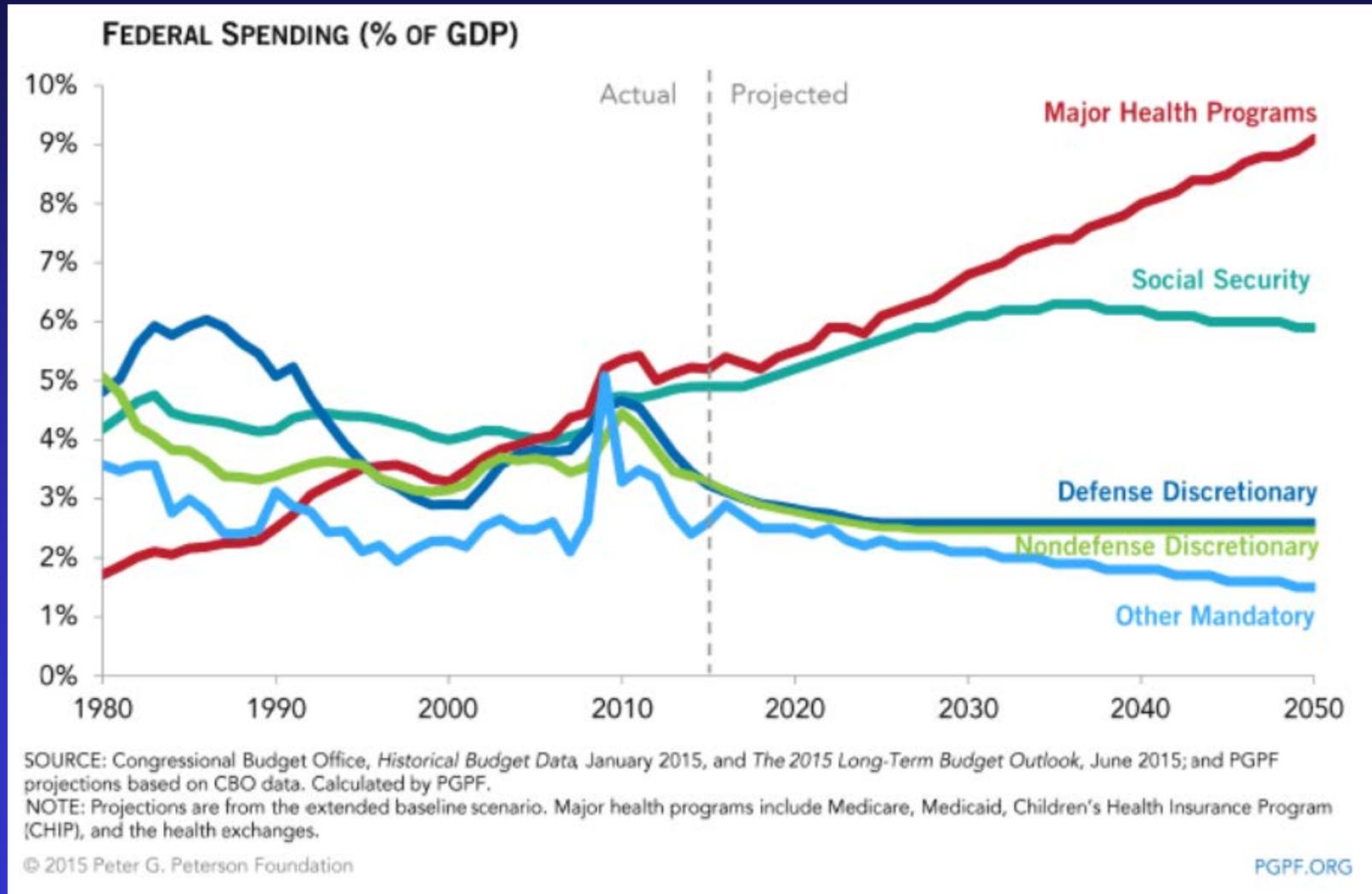


# Spending on Healthcare has a Major Effect on the Federal Budget

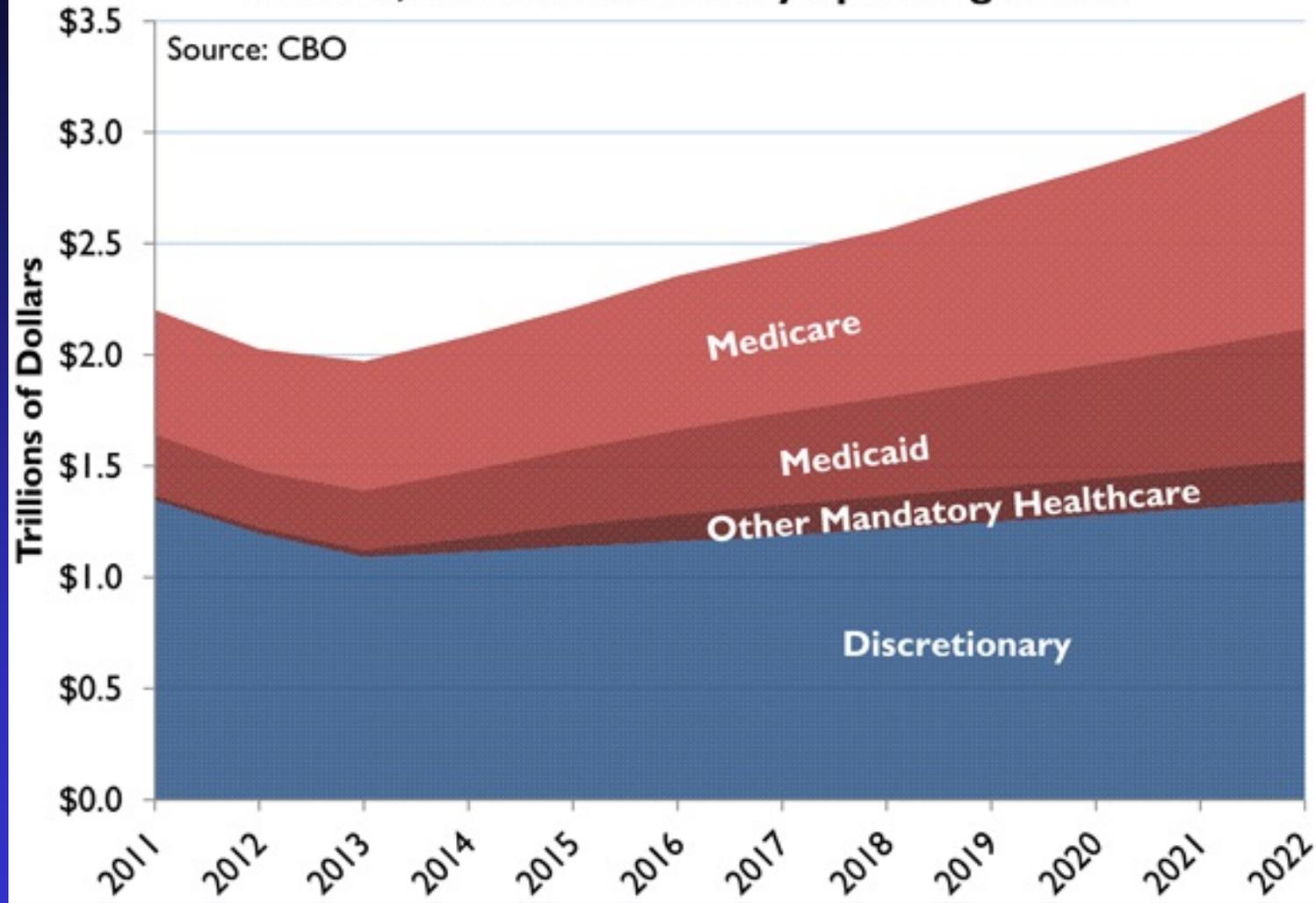
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- Can see this relative to Social Security and Defense
- Can see effect on discretionary spending
- Impact of Federal healthcare spending will get worse over time
- Entitlement spending (especially health) affects future borrowing needs as well

# Healthcare Projected Growth Relative to the Federal Spending over the Long Term

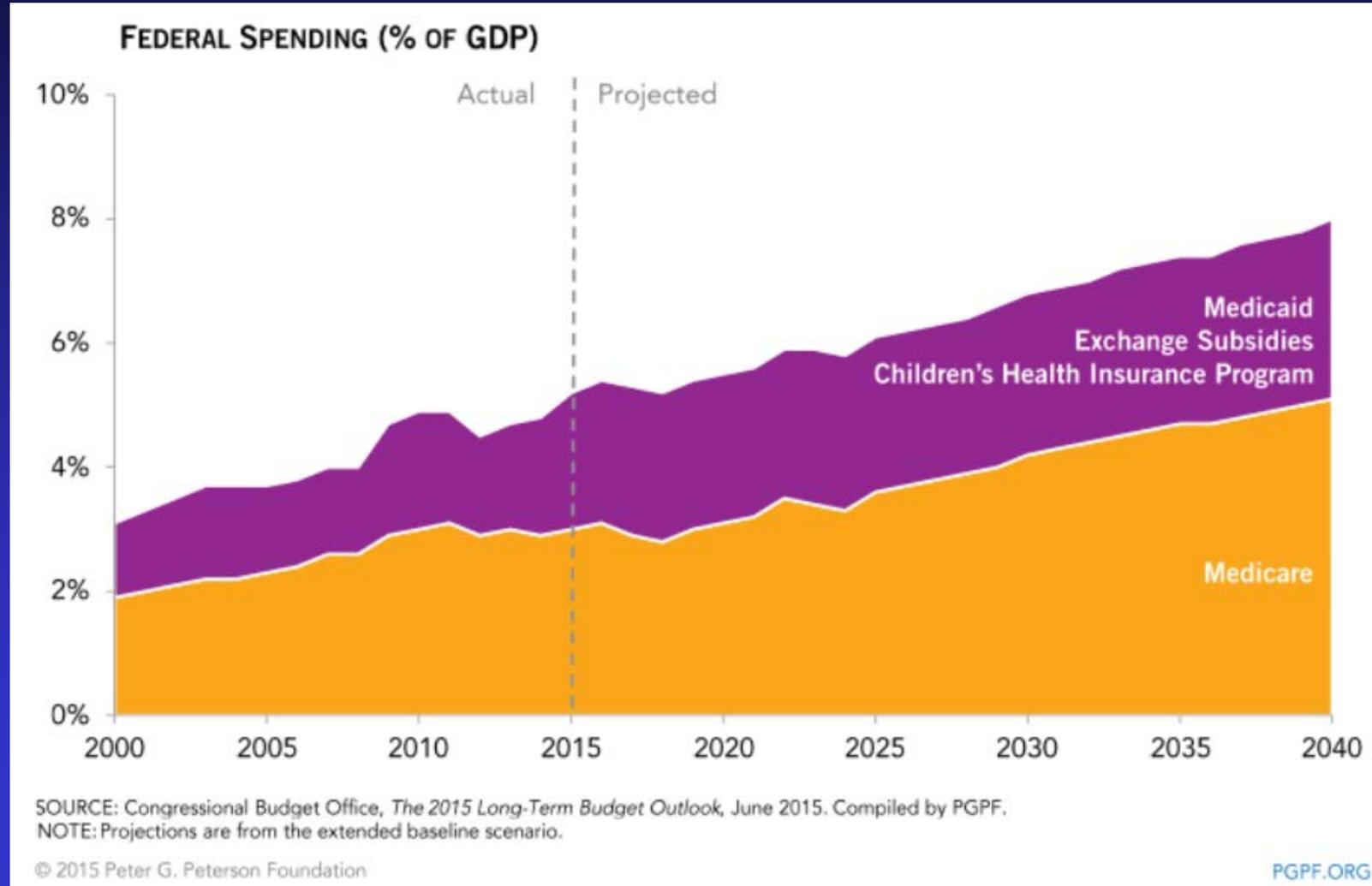


## Federal Healthcare Spending to Double over the Next Decade, while Discretionary Spending is Flat

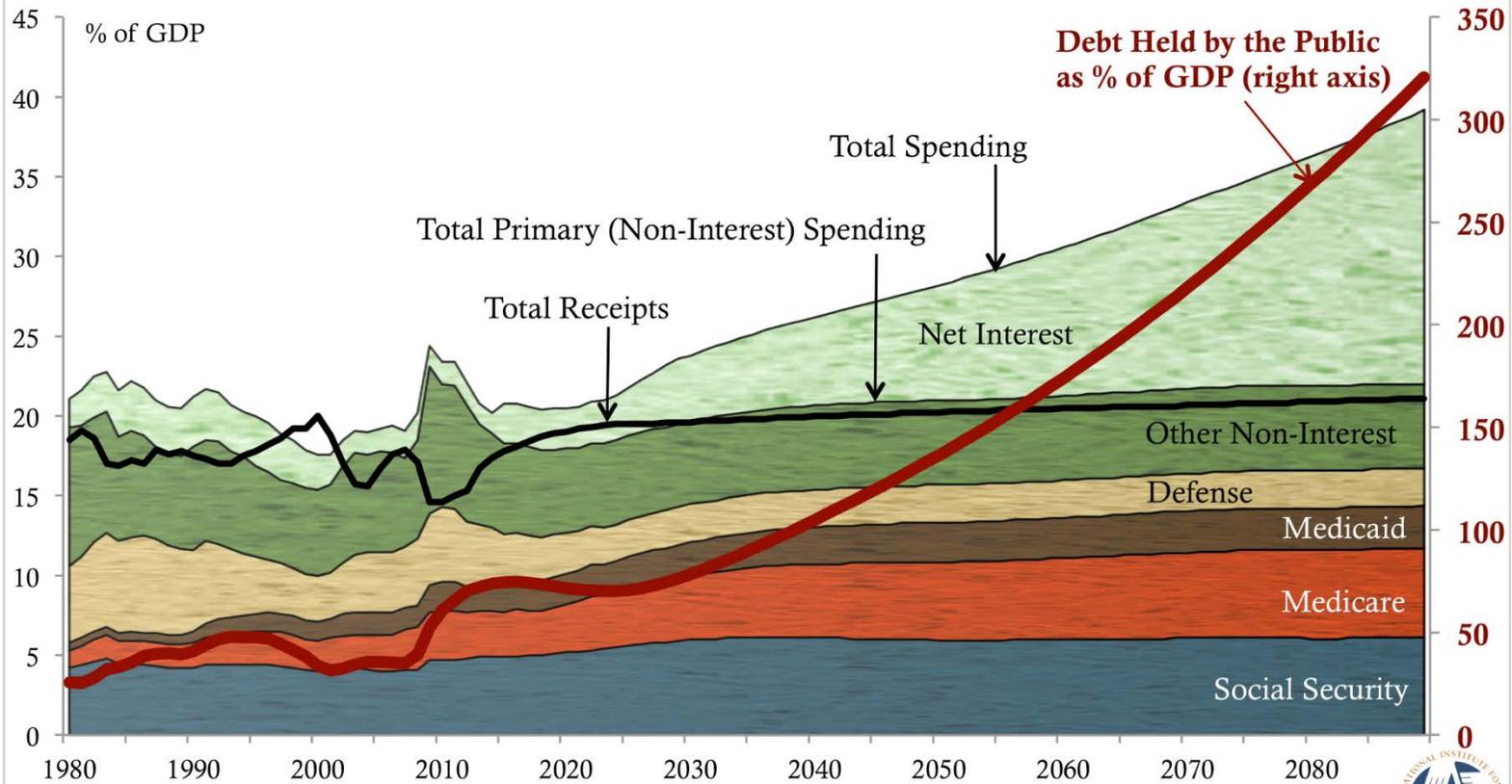


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# Between 2000 and 2040, Spending on Federal Health Programs is Projected to More Than Double



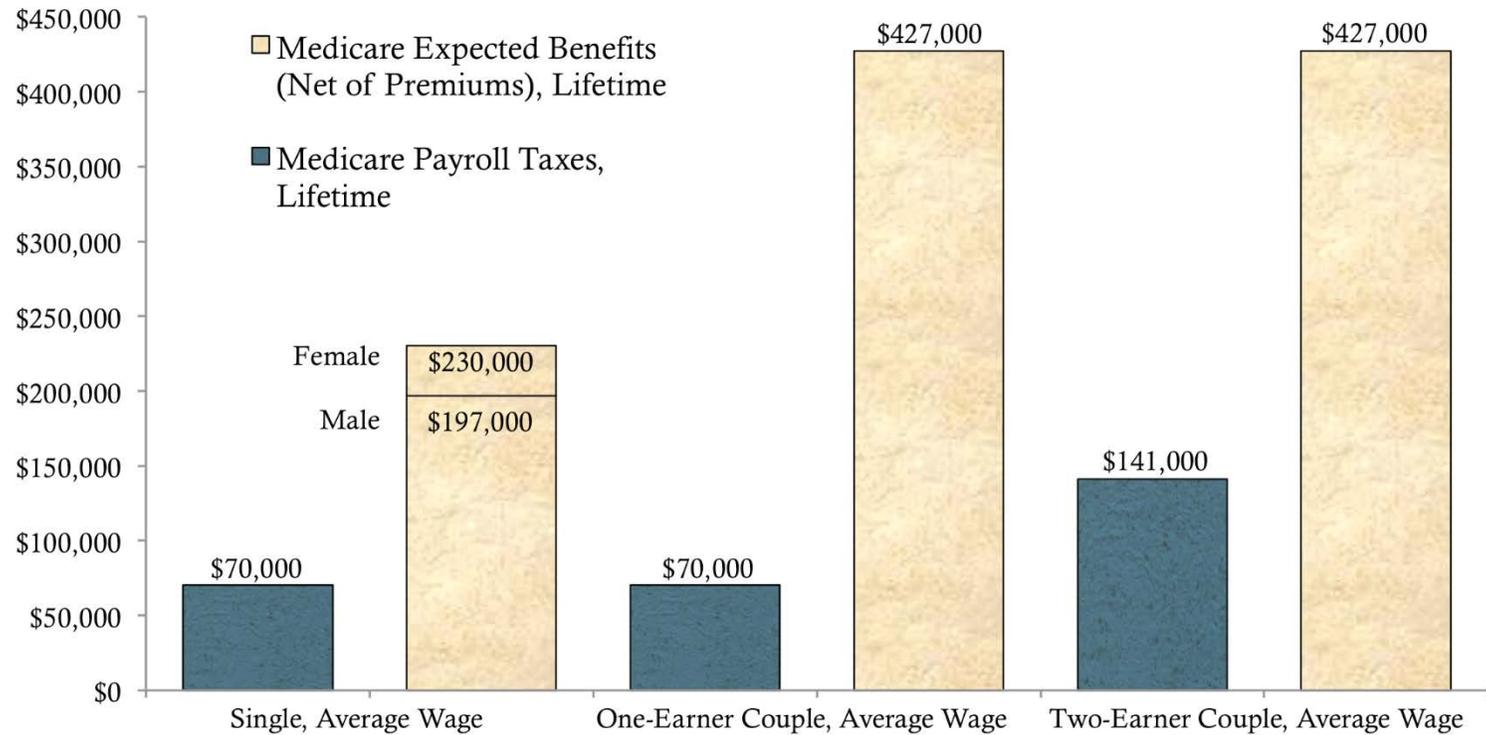
# Over Time, Interest Payments & Debt Are Projected to Soar



Source: U.S. Treasury. "Financial Report of the United States, Fiscal Year 2014." February 2015.



# Over Their Lifetimes, Medicare Beneficiaries Can Expect to Draw Significantly More in Program Benefits than They Have Contributed Directly

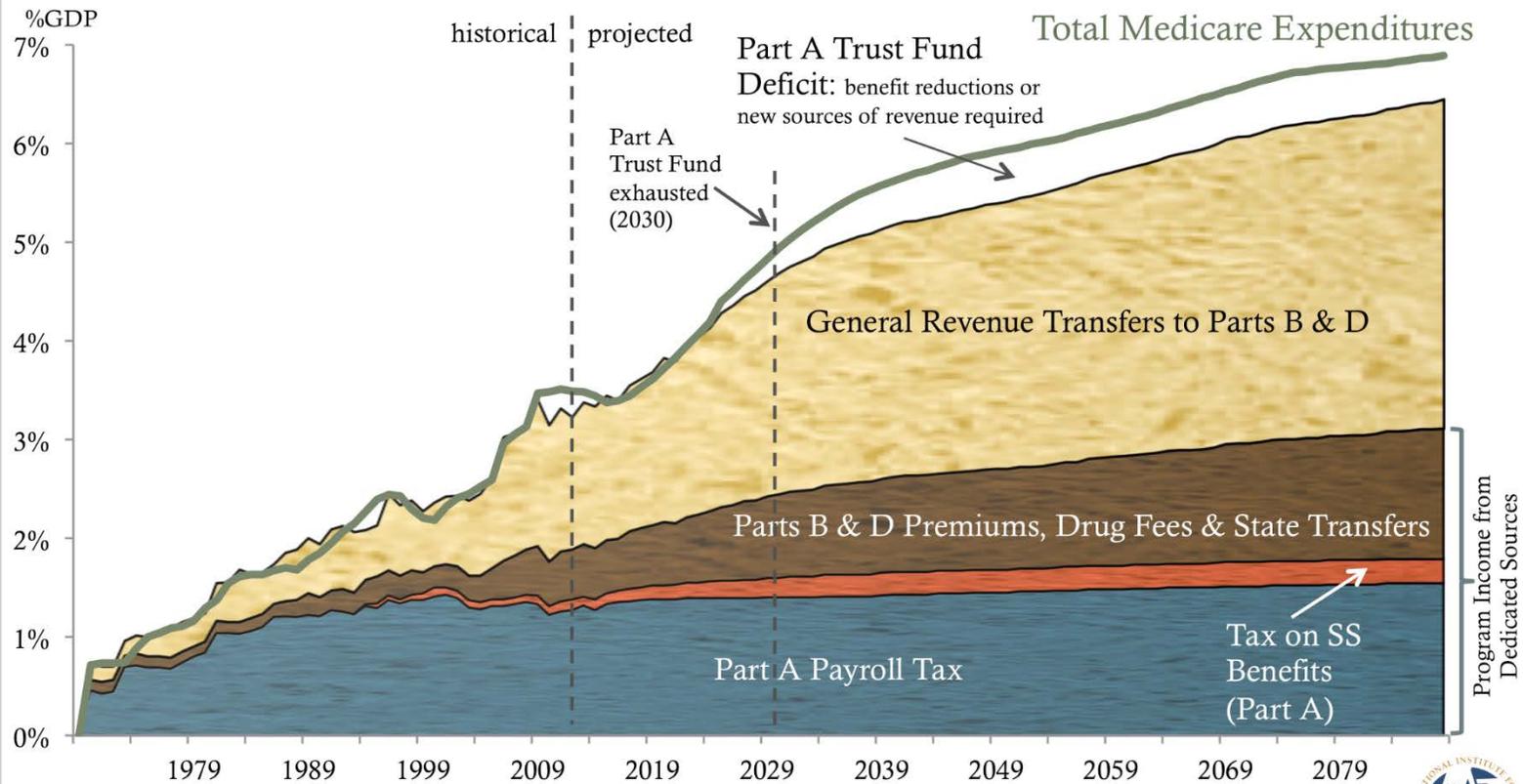


Source: Steuerle CE and Quakenbush C. "Social Security and Medicare Taxes and Benefits Over a Lifetime: 2013 Update." Washington, DC: The Urban Institute. November 2013.



# Therefore, Medicare Expenditures Greatly Exceed Dedicated Program Revenue

Large and Growing Transfers from General Revenue Are Needed



Source: A Summary of the 2014 Annual Reports, Social Security and Medicare Boards of Trustees, [www.ssa.gov/OACT/TRSUM](http://www.ssa.gov/OACT/TRSUM)



# A Lot of Debate About the “Spending Slowdown”

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- ◆ It’s true – spending has been growing at historically low levels and it’s made a difference in out-year projections

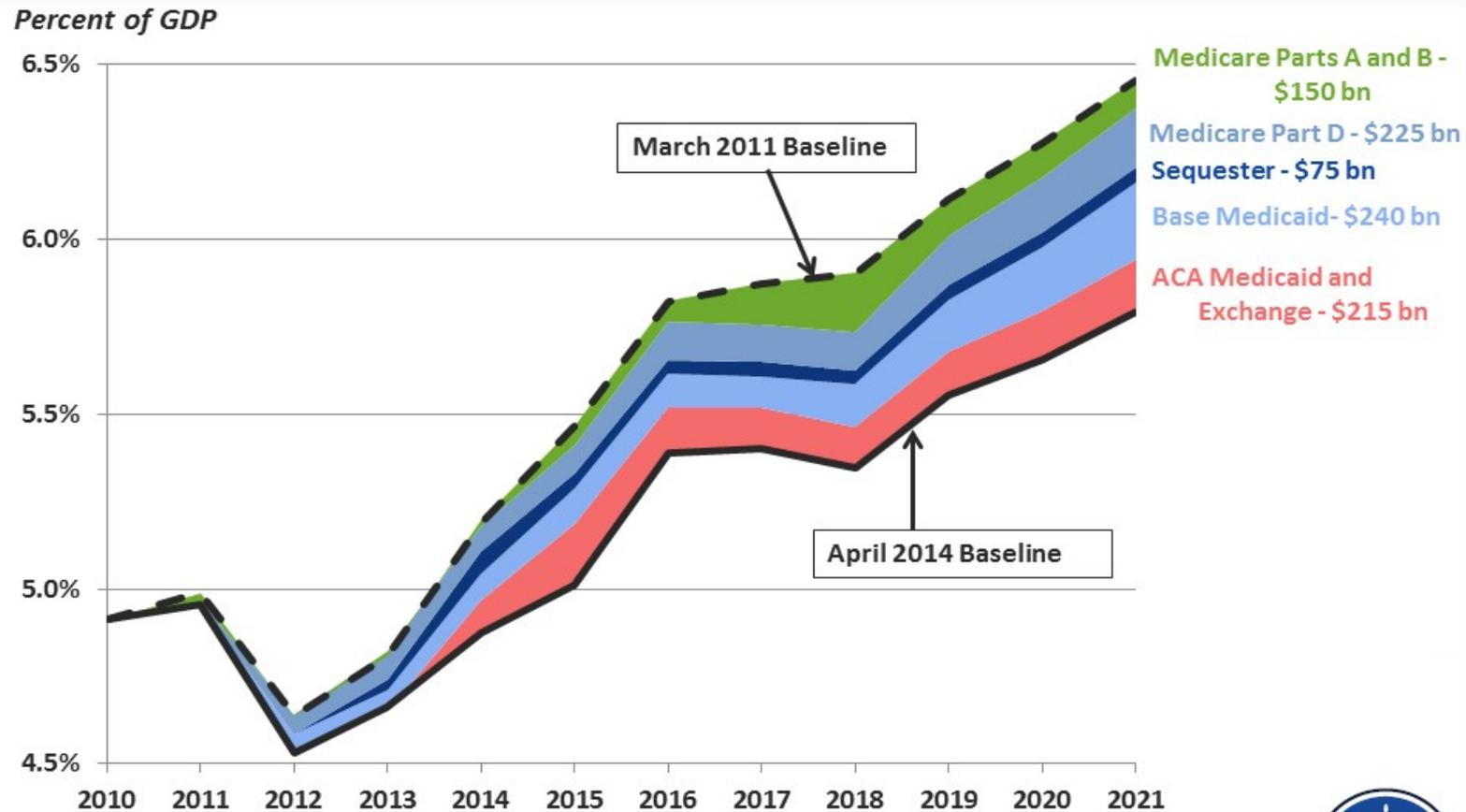
*But ...*

- ◆ Its mainly reduced the *baseline*; not the *growth rate*

*And ...*

- ◆ It’s *not* likely to continue

## The Health Care Slowdown Since March 2011



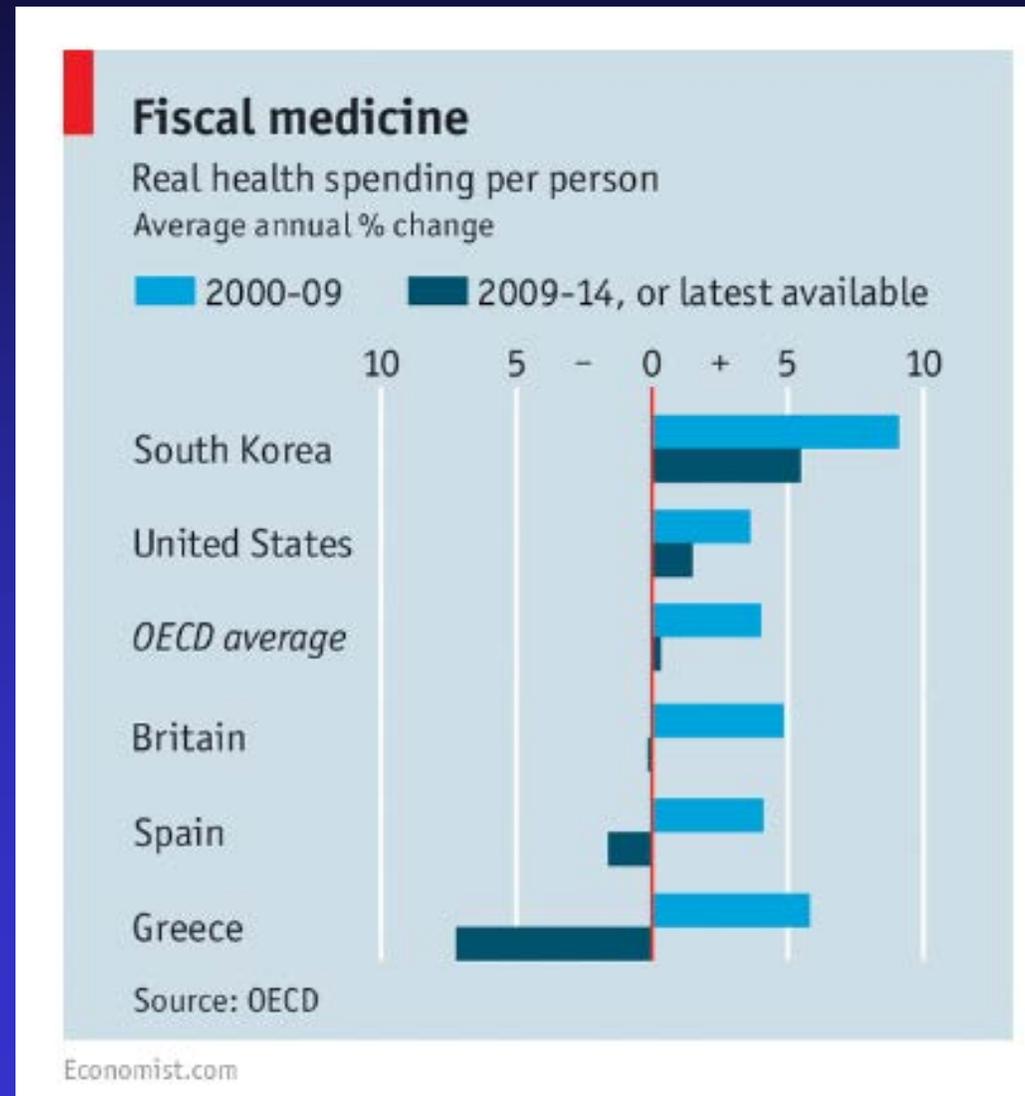
Source: CBO, CRFB calculations

Note: All lines use April 2014 CBO GDP estimates and actual data for years prior to 2014.

CRFB.org



# Unusually Slow Spending Has Occurred Everywhere



# Medicare Has Been Changing How Providers are Paid

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- ◆ Has moved away from small-unit fee for service
  - mostly bundled payments, (DRGs, episode payments)
  - physicians will have incentives to join alternative delivery systems or meet prospective metrics (2019)
- ◆ Moving towards “value-based purchasing”
  - mostly limited to updates, not the base

# Medicare is Still in Flux



- ◆ Many pilot projects are underway
  - Mainly involve changes to provider payment
- ◆ ACO results are “*mixed*” at best
- ◆ Beneficiaries not directly involved in most pilots
- ◆ Share of seniors choosing private plans to traditional Medicare is > 30%
  - complicated benchmarking strategies

# More Change is Ahead for Medicare

- ◆ Doubling of population on Medicare 2010-2030 guarantees financial stress
- ◆ Resumption of increased spending growth will accelerate the problem
- ◆ Longer Congress waits, the shorter the transition allowable transition time
- ◆ GRW preference – “*premium support*”/*FEHB model*; subsidy set at cost of 2<sup>nd</sup> lowest plan and  with income (sound familiar?)

# TRICARE

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- ◆ Provides civilian health care benefits for military, retirees and dependents; managed by Defense Health Agency
- ◆ Includes *three* main plans
  - *TRICARE prime*, HMO type plan; no enrollment fee for active duty; \$550 for family (non-Medicare Retiree); must enroll with primary care doc; need referral for specialists
  - *TRICARE standard* and *TRICARE Extra* (PPO), no required enrollment; annual deductible (\$50-\$300) and coins. out of pocket limits, civilian providers paid under TRICARE regs

# Current Tricare Strategy

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- ◆ Control reimbursements
  - use of Medicare reimbursement rates
  - minimal focus on provider net value or utilization
- ◆ Mimics Medicare FFS
  - pressures only on provider; minimal patient engagement
- ◆ Misses important opportunities
  - better outcomes with greater savings but ...  
*politically easier*

# Military Compensation and Retirement Modernization Commission

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- ◆ Final report – Jan, 2015; submitted to President and Congress
- ◆ Nine commissioners (4 former members of Congress, 2 retired Flag/General officers, 3 former DOD executives)
- ◆ Among commission's recommendations: to ↑ access, choice, value -- allow beneficiaries to choose from a selection of commercial ins. plans offered thru DOD health benefit plan

# The Attraction of a FEHBP-Type Option

- ◆ Recognizes “different strokes for different folks”
- ◆ Requires *defined contribution model*
  - allows for enrollees to pay more for more expensive plans
- ◆ Plans with “*better value*” – lower costs/better outcomes
  - can do better but enrollees retain choices
- ◆ Requires good information and reliable metrics
  - about plan costs, plan outcomes, consumer satisfaction

# Why “FEHBP-Like and Not FEHBP?”



- ◆ Military would overwhelm FEHBP
  - similar size
  - different risk pool; would *overwhelm* it
- ◆ Military has more control over the options offered with its own program
- ◆ DHA has much of the expertise needed (or could have) as a result of Tricare experience
- ◆ Three Tricare carriers could form basis of offerings but open to others as well

# Change is *Always* Politically Challenging

- ◆ Entitlement spending pressures will force changes in Medicare/Medicaid/Social Security
  - Medicare will be the most challenging
- ◆ Pressure on Defense Department \$ will ↑ pressure on TRICARE
- ◆ Budget and delivery-adequacy challenges are likely to continue for the VA

None of these challenges are likely to go away anytime soon

# Relevance of Other Federal Programs to the VA

- ◆ Medicare is a *mix* of FFS *traditional* Medicare and *private plans*
  - ◆ DOD is a mix of *direct care* and *private care* using mostly Medicare rules
  - ◆ VA is *mostly direct* care with *some private* care
- ➡ Mix of private care and direct care requires ↑ed coordination and designation of accountability; interoperable EHR's
- ➡ Important to *resolve VA's role* in future care delivery of veterans