Dead Men Ruling: Tax & Spending Policy in the Long Run

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- Fundamental agreement with the theme of the book, especially the 3 elements of the real grand bargain:
  1. Limiting automatic growth in spending % tax programs
     - But in this regard, I suggest that caps on discretionary spending (& PAYGO, & even sequesters) worked, so why not add caps on entitlements & tax expenditures?
       - ➢ Sweden's experience is positive: 3-year caps on 27 expenditure areas, including health care, disability, and unemployment benefits, and interest on debt!
         - ✓ Budget margins of 1.5/2/2.5% of spending in years 1, 2, and 3
         - ✓ Then enforced by look back sequesters
         - ✓ Flexibility below caps: "Each Minister is his own Finance Minister"
  2. Pay bills as we go along (in good times)
     - Again PAYGO generally worked.
  3. Make policymakers accountable for changes they passively accept
- Two additional comments:
  1. Health care costs are eating us alive: see next slides.
  2. One disagreement: "Require presidents to propose, & Congress to enact, budgets that reach balance at least over a business cycle …".
     - We don't know where we are in the business cycle and can never really tell.
     - Ripe for gimmicking: the UK experience.

Health Care Costs Will Claim More of Additional Revenues: US Health Costs Are Far Higher than Other Countries

Health Expenditures as a % of GDP, 2012

Country	Public	Total
United States	**8.0**	**16.9**
France	9.0	11.6
Germany	8.6	11.3
Canada	7.7	10.9
Denmark	9.4	11.0
Switzerland	7.5	11.4
United Kingdom	7.8	9.3
OECD Average	**6.5**	**9.3**

Source: OECD Health Data 2014.

Health Costs Projected to Continue to Grow After Implementation of the ACA

US National Health Expenditures as a % of GDP. Source: Sean Keehan, et al. of HHS's Center for Medicare & Medicaid Service, "National Health Expenditure Projections", *Health Affairs*, 2010-14.

Calendar Years	2010 Projection Before ACA	2011 Projection After ACA	2012 Projection After ACA	2013 Projection After ACA	2014 Projection After ACA
2009	17.3	17.6	17.9	17.9	--
2010	17.3	17.6	17.9	17.9	--
2011	17.3	17.7	17.9	17.9	--
2012	17.2	17.6	17.9	17.9	17.2
2013	17.3	17.6	17.8	18.0	17.2
2014	17.4	18.1	18.2	18.3	17.6
2015	--	--	--	18.4	17.6
2019	19.3	--	--	--	18.1
2020	--	19.8	--	--	--
2021	--	--	19.6	--	--
2022	--	--	--	19.9	--
2023	--	--	--	--	19.3

Options to Lower Health Care Costs

- **Reduce fee-for-service (FFS); replace with systems of care (SoC)**
  - FFS creates incentives for providers to function as revenue centers & promote unneeded services
  - SoC can create incentives for outcomes & not reward either volume or stinting
    - Methods can involve partial capitation, episode pricing, shared savings, & high-cost reinsurance
- **Create larger provider systems**
  - More patients with comprehensive services permits better measurement of performance
- **Rely on competition to set prices**
  - Administratively-set prices, even if “right”, create lobbying pressures
- **Reform legal impediments**
  - Malpractice; product liability; corporate practice of medicine
- **Review administrative costs**
- **Address data availability, prevention, caps, & everything else**