The Concord Coalition Series On

Health Care & Medicare

Issue #1 | By David Koitz | May 15, 2009

The Nation's Health Care Conundrum: Where Do We Go From Here?

The cost of health care in the United States continues its rapid multi-decade rise unabated, far outstripping inflation and the rise in personal incomes. The implications of its growth now extend well beyond traditional health care concerns such as availability and delivery of medical services, making it a major factor in the determination of national economic policy.

With spending on health accounting for one out of six dollars of the nation's annual production of goods and services, employers are finding it increasingly hard to meet foreign competition because of the rising premiums they pay for their employees' health insurance. Workers are increasingly losing insurance coverage because of their employers' need to contain costs. They are also paying a greater share of health care premiums, and are absorbing higher out-of-pocket costs because of rising cost-sharing and coinsurance provisions in their health insurance policies. And employer-sponsored retiree health benefits are rapidly becoming an anachronism.

On the provider side, hospitals are being forced to merge, drop services, or close altogether. Physicians are struggling under a maze of changing insurance rules and reimbursement constraints imposed by federal, state and local health care programs caught by tight budgets and shrinking tax revenues. And the aged and disabled are increasingly finding it harder to be seen by physicians willing to accept payment from Medicare and Medicaid.

In the public sector, state and local budgets are also feeling the pinch. A 2007 report by the Government Accountability Office (GAO) concluded, "it is the growth in health-related costs that is a primary driver of the fiscal challenges facing the state and local government sector. In particular, two types of state and local expenditures will likely rise quickly because of escalating medical costs. The first is Medicaid expenditures, and the second is the cost of health insurance for state and local employees and retirees."[1]

The growing public sector cost of health care is most ominous in Medicare and Medicaid, the two largest sources of payment for the nation's health care bills. Projected cost growth for these programs is the single largest contributor to our nation's unsustainable fiscal outlook.

---

[1] Persistent Fiscal Challenges Will Likely Emerge within the Next Decade, July 18, 2007. GAO-07-1080SP.

We have the most expensive health care system in the world, spending roughly $8,000 per person. This is twice the average of other developed nations and yet there is little evidence that we get better results. In fact, on many key measures of quality, we lag behind other nations. Summing up the worst of conditions, 46 million people across the nation now lack health insurance, a figure that has had a steady upward trajectory for years.

While we have the capacity to provide the most advanced medical care in the world, few would contest that our medical care is also the most expensive, the most complicated, the most bureaucratic, and the most mind boggling system.

As Washington gears up for another try at comprehensive health care reform, policymakers face a major conundrum: how to reduce costs while expanding coverage and improving quality?

The Illusive Path to Health Care Reform

While health care reform has a top spot on the political agenda, there are many fundamental questions still to be addressed:

- Should the primary focus be expanded coverage or cost control?
- Is the problem overpayment of providers, overtreatment of patients, or both?
- To what extent should new revenues be part of the solution?
- Would consumer driven reforms hold down costs and expand coverage or is a larger role for the government necessary to achieve these goals?
- Would increased spending now on computerized records, wellness programs, care coordination and comparative effectiveness research bring down costs in the future or simply lead to greater utilization and even higher costs?
- Even if savings can be anticipated from these investments, would they arrive in time to avoid a projected fiscal meltdown in the coming decades?
- Should public dollars be more narrowly targeted to those in need?
- And, perhaps most importantly, do we have the political will to do anything that requires choices and sacrifice?

The emerging reform debate will need to grapple with these and many other questions. However, one thing is certain. The unsustainable path of the federal government’s two largest health care programs, Medicare and Medicaid, must be an integral part of the debate. Their size, influence on the overall health care system, and rapid growth rates cannot be ignored.

The economic stress affecting Medicare and Medicaid is immediate, and has been steadily intensifying for years. Medicare, which serves 44 million people and is the nation’s largest single source of health care funding, already spends more than the taxes and premiums it brings into the Treasury—$210 billion more last year.

Medicaid, the nation's second largest source of health care funding, has grown 13-fold since 1980 and now provides health benefits for approximately 60 million people, about one-fifth of the total population. With expenditures exceeding one-fifth of overall spending by state governments, Medicaid has been straining the budgets of most states for years.

Coupled with Medicare, the $657 billion spent by the federal government in 2008 for the two programs exceeded spending on national defense and represented almost a quarter of the Treasury's total budget outlays.

Growth of Medicare and Medicaid as Payers of Medical Care*

	Medicare Spending	Medicaid Spending	Total National Spending on Medical Care	Medicare & Medicaid share of Medical Care Spending
	$s in billions			
1970	5.0	5.3	62.9	16.4%
1980	24.7	26.0	214.8	23.6%
1990	106.6	69.7	607.5	29.0%
2000	215.9	187.0	1139.6	35.4%
2007	409.6	303.9	1878.3	38.0%

Source: Centers for Medicare and Medicaid Services, National Health Expenditures, historical series.
*Note: consists of spending for "personal health care," which is a subset of national health expenditures

Changes in Average Annual Per Capita Medical Care Spending, 1970-2007

	Under Medicare	Under private health insurance
1970-1993	11.0%	12.8%
1993-1997	7.3%	4.4%
1997-1999	-0.3%	5.8%
1999-2002	6.4%	9.7%
2002-2007	8.4%	6.9%
1970-2007	9.2%	10.4%

Source: Centers for Medicare and Medicaid Services, National Health Expenditures, historical series.

Medicare is a federally managed and funded program, financed heavily by payroll taxes paid by workers and their employers and premiums paid by people enrolled in the program (i.e., the aged and disabled). Medicaid is a shared federal-State funded program operated by State governments, serving primarily the lowest-income segments of the population. Medical care funded by the two programs is mostly provided through the non-governmental sector of the nation's health care system, and their payment rates are set by the respective governments. Periodically, the federal or state governments attempt to constrain one form of payment or another, whether it be to hospitals or physicians, but in due course political and pragmatic pressures cause the programs to adjust such that their costs generally track with other health care costs.

While the two programs' expenditures generally track with private sector costs, exactly how they affect that trajectory is uncertain. Clearly, they do not function in isolation. They fund health care by utilizing the nation's vast health care resources. And being the

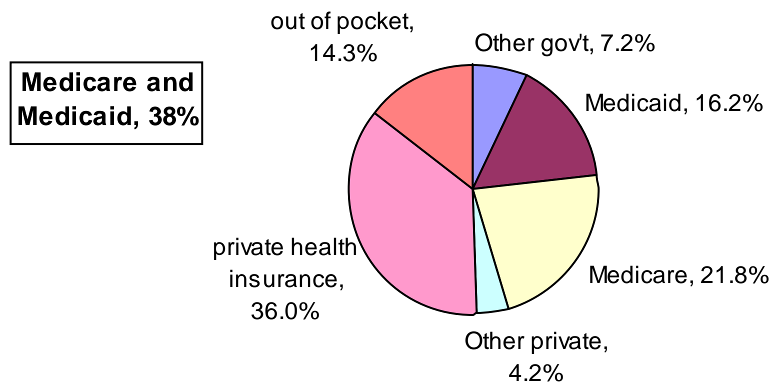
nation's largest payers of medical care—financing more than one-third of all medical care expenditures—they are the big gorillas in the room.

Since their creation four decades ago, they have both increased demand for health care and stimulated supply. Being third-party payment mechanisms (falling between the consumer of service and the provider), they have eroded users' sensitivity to the price of the medical care they receive. Much of the higher costs is due to technological advancements, new medicines, and new treatments that increase the quality of medical care.

There is increasing concern, however, that not all of these advances in medical technology confer commensurate benefits for patients. As the CBO stated in a December 2008 report, "Evidence suggests that a substantial share of spending on health care contributes little if anything to the well being of the nation, but finding ways to reduce such spending without also affecting features that improve health will be difficult."[2]

Through their amalgamation in the nation's health care system, Medicare and Medicaid contribute to and are affected by the national rise in health care costs.

Sources of Payments for Medical Care, 2007



It is this amalgamation that gives rise to the suggestion that the only way to deal with the rapid rise in their expenditures is through a broad national approach, not simply constraining Medicare and Medicaid expenses alone. The thinking is that only through a national system of financing and managing health care—a national health insurance program or some facsimile thereof—can health care costs be reined in. The analogy often used is that health care is like a large balloon; squeeze it at one end and it will only expand at the other. As the reasoning goes, squeezing public funding will only put greater pressure on providers of service (hospitals and doctors), private insurers (thus the premiums the insured pay), and those directly seeking the services (forcing them to spend higher amounts out-of-pocket). Proponents contend that only an aggregated strategy linking health care financing and the source of the rising costs (how and what services are

[2] CBO, Key Issues in Analyzing Major Health Insurance Proposals, December 2008, p. IX.

provided) can compel the measures that will eliminate waste and inefficiencies in the delivery of medical care (high insurance based paper work and excessive testing for instance), and force greater attention to outcomes that improve the effectiveness of medical care in the most economical way.

If we accept this premise, the fundamental question is how do we move forward? The nation's health care system, with estimated expenditures of $2.5 trillion, is larger than the gross domestic product of all but five other countries. It is a monolith of economic activity. How do we reasonably transition from a multi-trillion dollar way of doing "health care business" to a single national system in a non-disruptive way? Add to this the politics of bringing together the hospital sector, the insurance sector, the education sector, the nation's doctors and their various interest groups, the HMO system, and the multitude of advocacy groups from AARP to the Chamber of Commerce and the task becomes daunting.

Then, there is the issue of timing. Even if the diverse factions could coalesce, how long can we wait to transition? It's one thing to agree in concept; it's another when the conversion starts and people and institutions feel the consequences of what they've agreed to. Could a nationalized system really stick? How does a potentially lengthy meditative process mesh with the fact that federal spending will soar over the next two decades in large measure because of Medicare and Medicaid? If we wait for a "global fix" of the entire health care system before tackling the unsustainable growth rate of federal health care programs, we may find that it will come too late to avoid major budgetary and economic strains.

The Practical Window for Reform

It seems clear that eventually system-wide health care reforms will be needed, but that does not mean we must wait to fix everything before we fix anything. Medicare and Medicaid already provide large centralized devices for addressing the rising cost of health care. True, they don't serve the entire population. But their recipient populations are huge, they permeate all facets of the health care economy, and most importantly, their policymaking is concentrated within the governmental bodies that fund them.

We could try system-wide incremental reforms that use national data to better identify and reward the most effective treatments and medical providers, change the incentive structure for payment of service to get the most bang for the buck, or increase incentives for the use of technology to attack the maze of rules and paperwork that plagues the system. However, ultimately it may be that constraints on spending will have to be placed where they will have the greatest and most direct reach – the federal government's own programs. Payment constraints can affect patient and provider behavior. The balloon analogy ignores this. Moreover, with the large body of medical information that Medicare and Medicaid gather, they can be the source of demonstrative reforms that show the way and promote the best medical and administrative practices—practices that show the most promise in achieving better patient outcomes at reasonable prices.

Per Enrollee Spending on Health Services and Supplies, 2007	
Medicare	Private Health Insurance
$10,003	$3,946
Source: Centers for Medicare and Medicaid Services, National Health Expenditures, historical series.	

For other reasons, the federal government is the logical place to start. All told the feds finance directly or indirectly 60 percent of the nation's health care costs (including other elements such as NIH research, veterans' care, and counting tax preferences for health insurance premiums and expenditures). And while the rise in health care costs is a broad phenomenon affecting all segments of the population, it is the recipient populations of Medicare and Medicaid who consume the largest per capita share of the health care dollar.

Personal Health Care Spending By Age, 2004		
Spending per capita for population--		
65+	Working Age	Children
$14,797	$4,511	$2,650
Source: U.S. Health Spending By Age, Selected Years Through 2004, *Health Affairs*, November, 2007		

The aggregate expenditures of these two programs driven by the rapid rise in health care costs will only be amplified by the population trends emerging over the next two decades. The oldest baby boomers, born in 1946, will become eligible for Medicare in 2011… just two years from now. The population age 65 and older is projected to grow from 39 million people today to 54 million in 2020, and 63 million by 2025—an increase of 25 million people (65 percent) in just 16 years. Over the following 20 years, the baby boom generation will swamp Medicare and Medicaid and other entitlement programs such as Social Security and SSI.

While the excessive price growth of medical care is the real culprit in the long run, one only needs to recognize the rapidly emerging, and permanent, shift to an older population to understand the inevitability of an enormous struggle future lawmakers will confront over the shrinking availability of federal resources. Certainly, everything we label as discretionary—defense spending, education assistance, roads and bridge construction, NIH research, environmental programs, public assistance, housing, airports, etc.—will be threatened. Maintaining spending on these programs without serious health care cost control would inevitably lead to much higher levels of taxation than Americans have traditionally tolerated or a spiraling escalation of debt. Either scenario would shrink the take-home pay of our children. In short, the swelling of health care costs threatens the core of our economic system.

The Nation's Long-Range Economic Outlook Trumps The Issues

In today's political arena, there is a determined effort underway to extend health insurance to the uninsured … 46 million by latest count ... as well as to lessen the insurance inefficiencies that deny coverage, block access to a multitude of treatments (mental health care for instance or new or experimental drugs or procedures), or otherwise limit reimbursement for covered services.

All serve the noble goal of better meeting the nation's medical needs. But we are entering a period that is not financially conducive to spending more public dollars to get those results. Regrettably, the political climate is such that when there is any discussion of reducing spending or limiting tax breaks, it typically is cast as a means of financing new or expanded benefits. The health care financing issue, however, is much greater than figuring out how the government can pay for new benefits. Politicians are reluctant to talk about reform as anything but "giving more," but in so doing they fail to prepare the public for the inevitable end to the period of open-ended entitlements.

As the senior numbers go up, the cost of government would climb accordingly with rapidly escalating entitlement expenditures. In contrast, the number of people in their work prone years grows much more slowly, and with the slower growth in the workforce, revenue growth will lag.

Long-Range Projections of the Federal Budget

		2007	2030	2050
		Spending, Revenue and Deficits as a Share of Gross Domestic Product		
		In percent		
Spending:	Social Security	4.3	6.1	6.1
	Medicare	2.7	5.9	9.4
	Medicaid	1.4	2.5	3.1
	Other	9.9	9.8	9.7
	Interest on debt	1.7	4.8	13.6
	Total spending	20.0	29.0	41.8
Revenue:		18.8	18.9	19.4
Deficits:		**-1.2**	**-10.1**	**-22.5**

Source: CBO, The Federal Budget Outlook Over the Long Run, December 2007.

Note: scenario assumes revenues remain in the historical post-war range of 19 percent of GDP

Under long-range federal budget projections prepared by the Congressional Budget Office's, Medicare and Medicaid are the largest contributors to the expenditure growth. And in a little more than a decade they would become the biggest elements of the federal budget, surpassing even Social Security. With the aggregate rise in federal spending and slower revenue growth, the large budget deficits we see today will pale in comparison to those that could emerge in the future.

To avoid them, someone will have to pay. If not through payroll taxes levied on workers earnings, then it will be income taxes. That would inevitably trigger a debate about who bears the burden. As one version of the old saying goes, "we won't tax you, we won't tax me, we'll tax the man behind the tree." If the expenditure projections materialize, there will be no escaping the burden imposed on the future economy. Ultimately, we will all be the "man behind the tree."

For most of the past half century, we have been accustomed to hiding those burdens by borrowing more. But the potential magnitude of what lies ahead is too big to borrow our way through. The size of the potential long-range budget deficits is critical. Deficits mean more debt. More debt means greater interest expense. The more we spend on interest the less there is to meet entitlement obligations and the other governmental functions that society has come to rely on.

Excess cost growth in health care services is built into those future projections, but nobody really knows what is likely or even reasonable. Most projections build off of past trends, not some unique insights about where health care costs are likely to go. It's possible that market forces will some day bring health care costs under control, but a realistic perspective is to recognize that those costs have risen sharply for decades, and to plan for the future based on the hope of containment is a risky proposition. It's always easier for politicians to spend an economic windfall; it's much harder for them to take things back when economies don't perform as wished for.

What's needed today is a heavy dose of realism. The federal debt equals about 55 percent of what we produce each year, representing a steady climb up from 25 percent in 1975. What will happen if it climbs to 100 percent? It's like doubling a family's mortgage without their income doing the same. From an even broader perspective, the federal debt held by the public and other countries now equals 10 percent of the world's annual economic output. What will happen if and when it grows to 20 or 30 percent? It may seem inconceivable, but someday people may not want buy our debt.

Budgeteers label entitlement spending as permanent and nondiscretionary outlays, but it is only as inevitable as we let it be. It was created by laws and can be amended by laws. Our long-term economic outlook is predicated on issuing more debt … lots more debt. For policymakers to ignore that condition or pass the buck to future generations to make the hard choices is simply irresponsible.