

THE CONCORD COALITION



Escalating Health Care Costs and the Federal Budget

April 2, 2009

Overview

The United States health care system, with annual expenditures of more than \$2.4 trillion, is larger than the gross domestic product of all but five other nations. The implications of its continued growth now extend well beyond traditional health care concerns, such as availability and delivery of medical services, making it a major factor in national economic policy. Over the past several decades, health care costs have outpaced economic growth, inflation, and personal incomes. One out of every six dollars of the nation's annual production of goods and services is now devoted to health care. Within 10 years, that ratio is projected to be one in five dollars with total costs topping \$4 trillion

Numerous problems come from such a large, costly, and growing health care system. In the private sector, health care costs are eroding business's bottom-lines. Americans fortunate enough to have employer-sponsored health insurance increasingly are paying a greater share of their premiums and absorbing higher out-of-pocket costs because of rising cost-sharing and coinsurance provisions. Furthermore, in the increasingly global marketplace, American employers are losing their competitive edge against foreign companies that do not have to account for providing health insurance in their labor costs.

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 cost of health care is perhaps 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.

Yet, despite the vast resources dedicated to health care our nation lags behind many others in key outcome measures and 46 million Americans lack health insurance at some point during the year, a figure that has had a steady upward trajectory for years.

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

While we have the capacity to provide the most advanced medical care in the world despite our problems, few would contest that our medical care is also the most expensive, the most complicated, the most overlade with bureaucracy, and the most mind boggling system for those who find themselves needing major or chronic medical services.

It is little wonder that health care reform has moved to the top of the political agenda, although it is far from clear that the political will exists to confront anything that requires hard choices and sacrifice. Many questions remain:

- Should the primary focus of reform be expanded coverage or cost control?
- Should reforms of Medicare and Medicaid lead the way, or would it be better to pursue system wide reforms first?
- Would a capped health care budget help to bring about necessary changes or would it lead to inequities?
- Is the problem overpayment of providers, overtreatment of patients, or both?
- To what extent should tax increases, including reduced subsidies, 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?
- Should a government sponsored insurance plan be created for those under age 65?
- 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?
- Should effectiveness research include cost effectiveness?
- 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?
- Are we going to have to accept limits on what is covered and, if so, who should make those decisions?

The coming health care reform debate will need to grapple with these and many other questions.

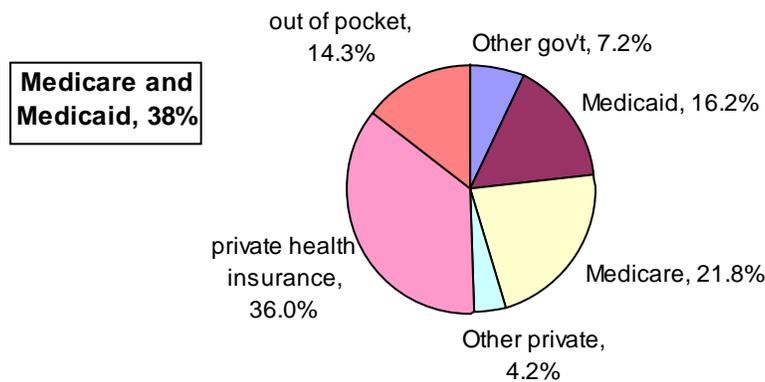
The Role of Medicare and Medicaid

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.

Medicare is the nation’s largest single source of health care funding. Last year it spent \$210 billion more than it brought in through payroll taxes and beneficiary premiums. Medicaid, the nation’s second largest source of health care funding, has grown 13-fold since 1980. As a joint federal-state program, Medicaid cost increases strain state budgets as expenditures exceed one-fifth of overall state government spending. Together, the \$657 billion spent by the federal government last year on Medicare and Medicaid exceeded spending on national defense and represented almost a quarter of the Treasury’s total budget outlays.

Sources of Payments for Medical Care, 2007



Spending on these two programs will only be amplified by the population trends emerging over the next two decades. The population age 65 and older is projected to grow from 38 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. In contrast, the number of people in their work prone years, age 20 to 64, will climb by only 18 million (10 percent). Consequently, where there are approximately five people in their work prone years for every senior today, there will be only three then. As the senior numbers go up, the cost of government will climb accordingly with rapidly escalating expenditures on Medicare, Medicaid and Social Security. But with the slower growth in the workforce, revenue growth will lag.

Demographics, however, is only part of the problem. Over the long-term rising costs per beneficiary contributes much more to the programs’ unsustainable growth. Implications for the federal budget are many, but certainly, everything labeled as discretionary spending—such as defense spending, education assistance, roads and bridge construction, and environmental programs—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.

Past Trends—The Baseline For Future Forecasts

Health care has become an increasingly large share of our gross domestic product (GDP), having grown from 5.2 percent of GDP in 1960 to 16.2 percent in 2007.² Spending on health care averaged \$7,421 per person in the U.S. in 2007 and in the aggregate, national health expenditures, totaled \$2.4 trillion.

The most commonly discussed measure of increasing health care costs is called *excess cost growth*. This measure describes “the extent to which growth in per capita spending on health care exceeds the growth in per capita GDP.”³ It is a measure of health care cost inflation that demonstrates that as health spending grows faster than the economy, the total share of the economy taken up just by health care spending rises.

| The Rapid Rise in Per Capita Health Care Spending | | | | |
|--|---------------------------------|---|-------------------|----------------------------|
| Year | Per Capita Health Care Spending | Increase in Per Capita Health Care Spending | General Inflation | Increase in Per Capita GDP |
| | | (Increase over prior decade, in percent) | | |
| 1970 | \$356 | 141% | 33% | 74% |
| 1980 | \$1,100 | 209% | 96% | 142% |
| 1990 | \$2,813 | 156% | 51% | 89% |
| 2000 | \$4,790 | 70% | 23% | 50% |
| 2007 | \$7,421 | 55% | 20% | 32% |
| Source: Centers for Medicare and Medicaid Services, National Health Expenditures, historical series, and the 2008 Economic Report of the President, February 2008. | | | | |
| a. 2007 figures represent increase over prior 6-year period. | | | | |

In its most recent long-term budget projections, the Congressional Budget Office (CBO) describes the main factors affecting the rise in health care costs this way:

Most analysts agree that the most important factor contributing to the growth in health care spending in recent decades has been the emergence, adoption, and widespread diffusion of new medical technologies and services. Major advances in medical science allow providers to diagnose and treat illnesses in ways that

² 2007 is the most recent year for which we have complete health expenditure data. See the Centers for Medicare and Medicaid Services, National Health Expenditures, historical series, February 2009.

³ “When analyzing historical trends in the growth of health care spending, it is useful to disaggregate the various components. Factors that affect spending on health care include general inflation; growth in the size of the population; and, to a lesser extent, changes in the age distribution of the population. Removing their effects reveals the amount of spending growth that is attributable to factors beyond inflation and demographics.” The term “excess cost growth” refers to (The phrase is not intended to imply that growth in per capita spending on health care is necessarily excessive. It simply measures that growth relative to the growth of the economy.) See CBO, “The Long Term Budget Outlook,” December 2007.

were previously impossible. Many of those innovations rely on costly new drugs, equipment, and skills. Other innovations are relatively inexpensive, but their costs add up quickly as growing numbers of patients make use of them. Although technological innovation can sometimes reduce spending, in medicine such advances and the resulting changes in clinical practice have generally increased it.

Other factors that have contributed to the growth of health care spending include increases in personal income and the growth of insurance coverage. Demand for medical care tends to rise as real (inflation-adjusted) family income increases. Moreover, the growth of insurance coverage in recent decades, as evidenced by the substantial reduction in the percentage of health care spending that is paid out of pocket, has also increased the demand for medical care, because coverage reduces the cost of care for consumers. However, according to the best available evidence, increasing income and insurance coverage cannot explain much of the growth in health care spending in recent decades.

Another source of spending growth has been the aging of the population. Among adults, average medical spending generally increases with age, so as the population becomes older, health care spending per capita rises. However, over the past three decades, the effect of aging on health care spending has been relatively modest.⁴

| Excess Cost Growth Per Capita in Total Health Care Spending, Medicare, Medicaid, and All Other Categories | | | | |
|--|-------|----------|-----------------------|-----------|
| Period | Total | Medicare | Medicaid ^a | All Other |
| (Percentage Points above GDP Growth Rate) | | | | |
| 1975 to 1990 | 2.6 | 2.9 | 2.9 | 2.4 |
| 1990 to 2005 | 1.5 | 1.8 | 1.3 | 1.4 |
| 1975 to 2005 | 2.1 | 2.4 | 2.2 | 2.0 |
| Source: Congressional Budget Office. "The Long Term Outlook for Health Care Spending," November, 2007. | | | | |
| Note: Excess cost growth refers to the number of percentage points by which the growth of spending on Medicare, Medicaid, or health care generally (per enrollee or per capita) exceeded the growth of nominal gross domestic product (per capita). Figures are annual averages. | | | | |
| a. For Medicaid, data are available through 2004. | | | | |

Over the past four decades, Medicare and Medicaid have grown in significance as a part of the nation's health care bill. The two programs do not own or operate hospitals or health facilities and do not employ doctors. Instead, they pay health care providers to furnish services to eligible participants. They are intertwined with the nation's system of medical care in that much of their fee and payment schedules are derived and driven by what doctors and hospitals

⁴ CBO, "The Long Term Budget Outlook," December 2007.

charge for health care services. Hence, they contribute to and are affected by the overall trends in the cost of health care services.

| The Growth of Medicare and Medicaid Expenditures, 1970-2007 | | | | | |
|--|----------|----------|------------------------------|--|---|
| Year | Medicare | Medicaid | Medicare & Medicaid Combined | Aggregate Expenditures fore Medical Care | Medicare and Medicaid as Share of Aggregate Expenditures for Medical Care |
| \$s in billions | | | | | |
| 1970 | 7.3 | 5.0 | 12.3 | 62.9 | 19.6% |
| 1980 | 36.1 | 24.7 | 60.8 | 214.8 | 28.3% |
| 1990 | 106.6 | 69.7 | 176.3 | 607.5 | 29.0% |
| 2000 | 215.9 | 187.0 | 402.9 | 1,139.6 | 35.4% |
| 2007 | 409.6 | 303.9 | 713.5 | 1,878.3 | 38.0% |
| Source: Centers for Medicare and Medicaid Services, National Health Expenditures, 2007 | | | | | |
| Note: Figures represent spending for medical care directly (which is labeled as personal health care spending in national health care tabulations); they exclude various items captured in national health care expenditure tables such as certain administrative costs. | | | | | |

Personal out-of-pocket spending accounted for nearly half of all national health expenditures in 1960. Today, third-party payments through Medicare, Medicaid, and private insurance finance nearly 70 percent. Out-of-pocket spending has fallen to 12 percent. In dollar terms, Medicare is the largest single payer. Its expenditures in 2008 of \$461 billion represented 15 percent of the total Federal budget and 3.3 percent of GDP. State-run Medicaid programs, financed jointly by the Federal and State governments, had expenditures of \$361 billion, and as a group were the second largest source of funding.

| How Paying for National Health Expenditures Has Changed, 1960-2007 | | | | | | | |
|--|-------|-------------------------|----------|------------------|---------------|------------------|---------------|
| Year | Total | Share of Payments From: | | | | | |
| | NHE | Medicare | Medicaid | Private Insurers | Out of Pocket | Other Government | Other Private |
| 1960 | | -0- | -0- | 21.5% | 46.9% | 24.4% | 7.3% |
| 1970 | 100% | 10.3% | 6.9% | 20.7% | 33.2% | 20.3% | 8.5% |
| 1980 | 100% | 14.7% | 10.3% | 27.2% | 22.9% | 17.1% | 7.9% |
| 1990 | 100% | 15.3% | 10.3% | 32.7% | 19.1% | 14.5% | 8.1% |
| 2000 | 100% | 16.6% | 14.8% | 33.6% | 14.3% | 12.7% | 8.1% |
| 2007 | 100% | 19.2% | 14.7% | 34.6% | 12.0% | 12.3% | 7.2% |
| Share of GDP | | | | | | | |
| 2007 | 16.2% | 3.1% | 2.4% | 5.6% | 1.9% | 1.9% | 1.2% |
| Source: Centers for Medicare and Medicaid Services, National Health Expenditures, historical series, 2009. | | | | | | | |

Together, Medicare and Medicaid expenditures now exceed the payouts for the total of all medical claims made to private insurers and account for \$2 out of every \$5 spent for medical care. For the nation's health care providers, the two programs paid for half of the services furnished by non-Federal hospitals in 2008 and \$3 out of every \$10 for services furnished by physicians.⁵

Many factors unrelated to privately funded medical care affect Medicare and Medicaid—notably public policy—however, in CBO's examination of past trends, the agency attributes the principal growth to the same factors that have affected health care prices generally—

Between 1975 and 2005, federal Medicare spending rose from 1.0 percent to 2.7 percent of GDP. Spending has grown in part because of increased enrollment in the program (from 25 million in 1975 to 43 million this year). However, the main factor driving Medicare's cost growth has been that costs per beneficiary—once the effects of demographic changes are removed—grew 2.4 percentage points faster than per capita GDP between 1975 and 2005. That "excess cost growth" in Medicare has been due primarily to the same factors that have led to increases in health care spending in the nation as a whole—most notably, greater use of new medical technologies (in part because neither doctors nor patients have strong incentives to control costs). Legislative and administrative changes have also contributed to the growth in Medicare's costs per enrollee...

Federal spending for Medicaid rose from 0.3 percent to 1.4 percent of GDP. Increased enrollment in the program and growth in the costs per beneficiary were the principal factors in that rise. Excess cost growth in Medicaid averaged 2.2 percentage points over the 1975–2004 period.

The U.S. is not alone in experiencing health care spending that exceeds the growth of its economy and workers' incomes, but other countries provide health care for their populations with much less of their resources. Moreover, by various indicators of well-being, the U.S. falls behind many countries that spend far less than we do.⁶

National health expenditure projections made by the government's Centers for Medicare and Medicaid Services (CMMS) are issued periodically and have traditionally covered a 10-year future period. The most recent projections show health care spending doubling by 2018, rising from \$2.4 trillion in 2007 to \$4.4 trillion in 2018, and its share of GDP rising from 16.6 percent in 2007 to 20.3 percent in 2018. Through 2018, per capita growth is expected to outpace that of GDP

⁵ CBO, 2009 Budget Update, and Centers for Medicare and Medicaid Services, National Health Expenditures, historical series and projection series for 2008-2018).

⁶ An OECD study released this past February concluded "the overall health status of the US population, as reflected in variables such as life expectancy and potential years of life lost, appears to rank among the lower third of OECD countries, despite much higher health expenditure *per capita* than in any other country." See David Carey, Bradley Herring and Patrick Lenain, "Health Care Reform In The United States," Economics Department Working Paper No. 665, OECD, February 6, 2009.

by an annual average rate of 2.1 percentage points. And with pressure on Medicare spending arising from the retirement of the aging baby boom generation, the share of national health expenditures financed by the public sector will rise from 46 percent in 2007 to 52 percent in 2018.

| Comparison of National Health Expenditures in the U.S. and Other Selected Countries in 2003 | | | |
|--|---|---|--------------------------------|
| Country | National Expenditures as a Share of GDP | Percentage Point Increase in GDP Devoted to Health Expenditures from 1980 to 2003 | Per Capita Health Expenditures |
| United States | 15.2% | 6.4 | \$6,711 |
| Australia | 9.2% | 2.4 | \$2,886 |
| Belgium | 10.1% | 3.8 | \$3,044 |
| Canada | 9.9% | 2.8 | \$2,998 |
| France | 10.4% | 3.4 | \$3,048 |
| Italy | 8.4% | n/a | \$2,314 |
| Japan | 8.0% | 1.5 | \$2,249 |
| Luxembourg | 7.7% | 2.5 | \$4,611 |
| Switzerland | 11.5% | 4.1 | \$3,847 |
| United Kingdom | 7.8% | 2.2 | \$2,317 |

Source: Snapshots: Health Care Costs, "Health Care Spending in the United States and OECD Countries," Kaiser Family Foundation, January 2007.

In a report issued in November 2007, CBO made a number of longer-range projections extending out for a 75-year period. They projected that spending would double by 2035, to 31 percent of GDP. Thereafter, national health expenditures would continue to account for a steadily growing share of GDP, reaching 41 percent by 2060 and 49 percent by 2082, the end of the 75-year projection period.

Long-term Projections of Health Care Spending

| CMMS's Projected Growth of National Health Expenditures, 2007-2018 | | | | |
|---|-------|-------|-------|-------|
| 2007 | 2008 | 2010 | 2015 | 2017 |
| \$s in trillions | | | | |
| \$2.2 | \$2.4 | \$2.7 | \$3.8 | \$4.3 |
| Share of GDP | | | | |
| 16.2% | 16.6% | 17.1% | 18.8% | 19.5% |

Source: Centers for Medicare and Medicaid Services, National Health Expenditures, historical series and projection series for 2008 and 2018.

CBO's projections assume that the average rate of excess cost growth of the past 30 years would continue through 2018, followed by a gradual slowing thereafter. The following table shows the underlying assumptions.

What happens if there is no abatement of cost growth? Under one CBO long-range scenario, excess cost growth of the past 30 years is assumed to continue indefinitely. By 2052, half the economy would be devoted to health care under that scenario. By 2075, the figure rises

to 85 percent. It is hard to conceive of this as a likely, or even a possible scenario. However, it provides a sense of the corrosive effects on the economy if health care costs are not reined in.

| CBO's Long-Term Projections of National Health Expenditures, 2007-2082 | | | |
|---|--------------|-------|-------|
| | 2035 | 2060 | 2082 |
| | Share of GDP | | |
| National Health Expenditures | 30.7% | 40.8% | 48.9% |
| Medicare | 6.5% | 10.6% | 14.8% |
| Medicaid | 2.7% | 3.3% | 3.7% |
| All Other Spending on Health Care | 21.5% | 26.9% | 30.4% |
| CBO, "The Long Term Outlook for Health Care Spending," November, 2007. | | | |

The one thing that can be said with some certainty about long-range projections is that they will be wrong. However, the likelihood that they will improve on their own without far-reaching policy changes by governments at all levels seems highly remote. Even if the "excess cost growth" of health care were eliminated immediately, the cost of health care would still comprise a growing share of the economy. CBO's projections suggest Medicare's and Medicaid's share of GDP could grow by 26 percent by 2025 (from 5.4 percent this year to 6.8 percent then), driven by the rapid aging of society as the baby boomers enter their senior years. The point is that the economic and fiscal strains we face will confront us relatively soon—in the next decade or two—not 50 or 75 years from now. All that the longer range numbers do is extend what shows up in the earlier years.

| CBO's Assumptions About Excess Cost Growth Over the Long Term | | | |
|--|---|----------------------------|--------------|
| | 2007 through 2018 (Historical Average) | Average Rate, 2018–2082 | Rate in 2082 |
| | (Percentage points above GDP Growth Rate) | | |
| Medicare | 2.4 | 1.7 | 1.1 |
| Medicaid | 2.2 | 0.9 | 0.2 |
| All Other Spending on Health Care | 2.0 | 0.6 | 0.1 |
| CBO, "The Long Term Outlook for Health Care Spending," November, 2007. | | | |
| Note: Excess cost growth refers to the number of percentage points by which the growth of spending on Medicare, Medicaid, or health care generally (per beneficiary or per capita) is assumed to exceed the growth of nominal gross domestic product (per capita). | | | |

The President's Budget and Health Care Reform

Achieving a sustainable fiscal policy will require us to slow the growth rate of health care costs. Recent talk of health care reform focuses on expansion of health care coverage. While this is an important goal, it would not, by itself, lower health care costs or their rate of growth. Yet, expanding coverage, as a politically popular reform, might provide the momentum for other

health care reforms that could slow cost growth. A linkage between broader coverage and tougher cost control will be crucial for those seeking a fiscally responsible path for the federal budget.

The President's new budget presents health care reform as a \$634 billion "reserve fund." This mechanism is used to identify budgetary savings "dedicated towards financing reforms to our health care system."

The President's budget is advisory. Actual details of health care reform will be negotiated in the coming months with Congress, but the budget makes clear that the reserve fund amount "is not sufficient to fully fund comprehensive reform." Benefit expansion and additional savings are labeled as "yet to be determined."

The main significance of the health care reserve fund is not so much its size or the specifics of its policy proposals -- these are only intended to be markers -- but that it imposes a deficit neutral-framework for health reform over the 10-year budget window. Deficit neutrality-the idea that the deficit would not grow because of increased spending on health care reform- is an extremely important commitment, and a minimum requirement for fiscal responsibility. However, given that health care spending in the budget is already on an unsustainable path, deficit-neutrality is not a sufficient long-term fiscal goal for health care reform. The commitments that have already been made are unsustainable. Simply adding more, even deficit-neutral ones, would not change that fact.

Furthermore, there is a substantial risk that Congress will enact politically popular new commitments without offsets or solid proposals to achieve cost control. Maintaining a commitment to both during the coming debate over reform will be essential to achieving President Obama's short-term deficit reduction goals and will be a crucial test for the administration's dedication to long-term budget sustainability.

The administration is already facing pressure from members of Congress and outside groups to jettison even the goal of deficit neutrality.⁷ Some object to the specific offsets suggested in the budget. One offset is actually a grouping of Medicare cuts that primarily come from recommendations by the non-partisan Medicare Payment Advisory Commission (MedPAC). The largest of the recommended program changes would attempt to reduce Medicare's payments to its private group-health contractors (Medicare Advantage) through a new competitive bidding process. Savings of \$175 billion are estimated to result over the next 10 years. Other measures would bring down spending on drugs under Medicaid by increasing a legislatively-prescribed drug rebate for brand-name drugs (increasing it from 15.1 percent to 22.1 percent of the average manufacturers price); incentivize health care practices that lower hospital readmission rates; expand a Hospital Quality Improvement Program; improve Medicare and Medicaid payment accuracy; and reduce drug prices by allowing more generic drugs on the market.

⁷ Letter to Budget Chairmen and Ranking members Senators Conrad and Gregg, Representatives Spratt and Ryan (March 9, 2009).

The other offset specified is a limit in the rate at which itemized deductions can reduce tax liability, to 28 percent, which would reduce the tax benefit to upper-income households who fall in marginal tax rate brackets above 28 percent. The Administration anticipates that this would raise \$318 billion over 10 years. The answer to those who specifically criticize these offsets should be to find others of similar size—not to drop the effort altogether.

Another objection to paying for health care reform is that finding offsets is politically difficult and has the potential to upset any fragile bargain between the multitude of coalitions involved in the reform discussion—either the bi-partisan groups of legislators writing the legislation, or the cross-cutting alliances of business, labor, and health care industry groups that have gathered together to work for reform. The problem with this argument is that these groups believe now is the time for health care reform because their business models require reform, or because the country’s economic growth is being impeded by health care costs, or because they object to the large number of Americans without health insurance. If now is such an important time for health care reform and it is such a high priority, these groups should support paying for the effort by recognizing items in the budget or tax code that are of lower priority, instead of loading the burden on future generations.

Furthermore, if a coalition makes it through the incredibly difficult process of producing health care legislation with enough votes to pass through Congress, it is hard to believe that it would break up over what appears to be much more incremental changes to the tax code or Medicare payments.

Unfortunately, the fact that these groups are already attempting to duck relatively minimal hard choices before the details of legislation have been put to paper does not bode well for the ultimate reform process. Real and necessary health care reform will require hard choices in order to constrain costs and provide better and more accessible care. If these groups cannot accept that reality, it is hard to see any positive movement on comprehensive reform.

A third and more seductive objection to paying for health care reform is that it will pay for itself at some point beyond the 10-year budget window by bringing efficiencies that will lower overall health care costs for the government and everyone else. The problems with this argument are specificity of savings and timing. From a specificity standpoint, in order for the “paying for itself” logic to work, the details of the reform plan are crucial in that they would have to include major attempts at cost control that involve a degree of certainty in their payoff. From a timing standpoint, the plan would need to start lowering costs quite rapidly in order for the increase in indebtedness to not swamp the ship-of-state before we achieve any savings.

While the Obama budget provides details of where partial funding for the 10-year start-up costs could come from to pay for reform, the budget does not specify the details of a reform plan. The big goals are only identified as “constraining costs, expanding access and improving quality.”

Improving quality and expanding access are important goals for health care reform and represent the “sweeteners” in the ultimate momentum driving reform. If accomplished by themselves, however, these goals would only lead to higher health care spending in the future.

Insuring all Americans would cut down on expensive emergency care and increase usage of preventative care, but the net costs to the system would still increase. As such, there is an even greater imperative that this expansion of coverage be paid for, because unlike an investment -- which one could argue leads to lower costs down the road and “pays for itself”-- the same cannot be said of a permanent new insurance initiative. And while research shows that spending more on health care does not necessarily improve health outcomes, it does not follow that reform only focused on better quality would lower costs. That is why these sweeteners need to be paired with the more difficult choices to constrain costs--the first goal stated by the administration. This is where tough choices have to be made and where the administration will have to be forceful in order to produce a fiscally responsible outcome.

| Estimated Growth of National Health Expenditures, 2008-2018 | | | |
|--|---|---------------------------------------|-------------------------|
| | Total National Expenditures (\$ in trillions) | National Expenditures as Share of GDP | Per Capita expenditures |
| 2008 | 2.379 | 16.6% | \$7,804 |
| 2009 | 2.510 | 17.6% | \$8,160 |
| 2010 | 2.624 | 17.7% | \$8,459 |
| 2011 | 2.770 | 17.9% | \$8,851 |
| 2012 | 2.931 | 18.0% | \$9,282 |
| 2013 | 3.111 | 18.2% | \$9,767 |
| 2014 | 3.313 | 18.5% | \$10,312 |
| 2015 | 3.541 | 18.9% | \$10,929 |
| 2016 | 3.790 | 19.3% | \$11,598 |
| 2017 | 4.062 | 19.8% | \$12,325 |
| 2018 | 4.353 | 20.3% | \$13,100 |

Source: Centers for Medicare and Medicaid Services, National Health Expenditures, projection series for 2008-2018.

The specifics of the plan, then, are crucial in determining the true cost of the reform effort not only over 10 years, but over the long term. At this point, however, it is impossible to say what those specifics will be.

Over the long term, the administration is heavily banking on health care IT, comparative effectiveness research, prevention, and care coordination to ultimately bring costs down. The budget increases spending on these initiatives, but there is no estimate of how much money would be saved over time or when the savings would occur. More details will be forthcoming, but so far the administration has not laid out a strategy for translating comparative effectiveness and IT into savings. It is not enough to simply gather information, although that is a necessary first step. The information gathered must be put to use in altering coverage or payment decisions for things that are found to confer little benefit. Provider practices and patient expectations must change, and Medicare must have the tools it now lacks to enforce standards. Right now, the explanation on how to get from here to there is missing. There is clearly a potential for savings but there is also great difficulty in realizing those savings.

Yet, we know the problem of demographically-driven cost growth is certain as opposed to the more speculative savings from reducing per-beneficiary growth. That is why paying for reform now is imperative. If we do not start accumulating savings now, the resulting rate of cost growth could destroy the budget before long-term savings arrive. Moreover, the unabated growth in health care spending is a fiscal yoke around the neck of future generations. Absent containment, it will cause the federal debt to rise; future taxes to go up; and pre-empt future government spending on things vital to fostering growth—a modern infrastructure, better education, technological advancement, cheaper energy, and promotion of research.

Conclusion

Under long-range federal budget projections prepared by the Congressional Budget Office, 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 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. 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 be indifferent about. 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.

| 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 | <u>1.7</u> | <u>4.8</u> | <u>13.6</u> |
| | Total spending | 20.0 | 29.0 | 41.8 |
| Revenue: | | <u>18.8</u> | <u>18.9</u> | <u>19.4</u> |
| 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 | | | | |

Spending on health care will continue to increase unabated so long as we pretend that costs can be controlled without any sacrifice. Costs are not rising because of the proliferation of useless medical services but rather because medical technology and innovation has expanded exponentially in recent decades and will continue to do so. What medicine can do to cure the sick or combat acute and chronic ailments often comes with an expensive price tag and is ever in demand, even when the outcomes of medical intervention are unknown or the benefits incremental, at best. To help control these costs information about the benefits of new procedures and technologies are needed and their limitations understood.

There is no question that if health care in America grows as currently projected, the government will be forced to take on unprecedented levels of debt and put the nation's standing as an economic superpower at risk. To avoid such fate, our nation must make policy decisions about the level of health care it will provide in its entitlement programs, and how many taxpayer dollars will be dedicated to these program.

Little will happen to contain the nation's health care costs that doesn't address the ill-managed proliferation of new technology and the propensities of the fee-for-service insurance structure to promote more services. More importantly, little substantive will happen until there is an acceptance all around—by the public, providers, insurers, and others in the health care industry—that sacrifice must be shared. Until the message is given and understood that all must yield something, it is hard to see how the parties will coalesce. Paying for expanded or universal health care—the pinnacle of the Obama plan—requires more than balancing new expenditures with new revenues or other savings, whatever possible resources are identified and earmarked. It's a commendable track relative to past efforts to expand health care benefits, which pushed much of the payment onto future generations. But it still avoids the larger question of how to manage the nation's spiraling health care spending so that the whole system doesn't implode some day.

APPENDIX A: Concord Criteria for Medicare Reform

Here are some criteria The Concord Coalition has suggested for evaluating Medicare reform proposals:

—**Scope of benefits.** Medicare should cover a level of care commensurate with the care available to working-age people. This does not mean that taxpayers must be expected to finance a high-option insurance plan for all seniors.

—**Fiscally responsible.** A fiscally responsible program is one that can reasonably be expected to operate within the resources available to finance it. A program that assumes a perpetually open spigot from the Treasury is not fiscally responsible.

—**Income-related cost sharing.** As a group, seniors enjoy a better income and less poverty than do other age groups, particularly children. Therefore, Medicare's premiums, which help fund Parts B (physician care) and D (prescription drugs), should be geared to income levels. Currently, premiums cover only 25 percent of program costs. General tax revenues cover the rest. Given this large subsidy and the need for long-term program savings, beneficiaries who can afford to pay more of their fair share should do so.

—**Efficient provision of medical care.** Whatever new system of medical insurance for the elderly is devised, it should contain incentives for both providers and patients to use resources cost-effectively. Treatments that have little or no promise of achieving any appreciable improvement in a patient's well-being should not be financed with taxpayer dollars.

Ultimately, the growth in Medicare costs must be addressed through fundamental health care reform. That is no reason, however, to avoid incremental steps that make sense on their own and that can achieve substantial savings. Medicare is quite influential, accounting for 20 percent of the nation's total spending on health care. If the next president can agree with Congress on meaningful Medicare reforms, it may well lead the way for necessary reforms of the broader health care system.