

## HEALTH CARE AND THE LOOMING FISCAL CRISIS IN THE UNITED STATES\*

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### Resumen

*Los Estados Unidos gastan un sexto de su PIB para entregar cuidado médico a sus ciudadanos. Los costos de Medicare y Medicaid han crecido a la par del costo de los cuidados médicos generales en los Estados Unidos. El artículo aborda el problema de la brecha presupuestaria que emergerá, debido a Medicare y Medicaid, en las próximas décadas. Se describen las finanzas de los programas y algunas de sus características importantes, además de presentarse proyecciones realizadas por la Oficina de Presupuesto del Congreso de los Estados Unidos y por el Board of Trustees of Social Security, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. Finalmente, se discuten medidas que podrían ser tomadas para disminuir la brecha presupuestaria que Medicare y Medicaid crean en un contexto de alza de los costos de salud.*

*Palabras Claves: Medicare, Medicaid, Brecha Presupuestaria, Costos de Salud.*

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### Abstract

*The United States spends a sixth of its GDP on health care. The costs of Medicare and Medicaid have grown along with the cost of health care in general in the United States. The paper addresses the large budget gap that will emerge in Medicare and Medicaid in the decades to come. It describes program financing and some of their main features and explains the projections of the U.S. Congressional Budget Office as well as those of the U.S. appointed Board of Trustees of Social Security, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. Finally, the article discusses measures that might be taken to close the budget gap facing the Medicare and Medicaid Programs.*

*Keywords: Medicare, Medicaid, Budget Gap, Health Costs.*

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## 1. Introduction

The United States spends a sixth of its GDP to deliver health care to its citizens. Health care is provided through private physicians, pharmaceutical companies, private and public hospitals, nursing homes and other private entities. Many households finance health care expenses through a combination of employer-based private insurance and consumer out-of-pocket funds. Starting in 1965, The United States introduced two programs to address a growing need to provide health insurance coverage to groups left out of the employer-based health insurance market: persons older than 65 years of age and retired and the non-elderly poor population. These programs are known as Medicare and Medicaid, respectively. In 1972, disabled Americans were added to the Medicare program<sup>1</sup>. Together, over 100 million American participate in these programs.

The costs of Medicare and Medicaid have grown along with the cost of health care in general in the United States. Since 1991, on average, health care expenses have grown 1.9 percentage points faster than U.S. GDP, which accounts for health care's growing share of GDP over time. Experts attribute our eager adoption of ever advancing medical technology to the large increase in health care expenses over time. As a consequence, the cost of providing employer-based health insurance has also increased at rapid rates. Employers, feeling the strain of added costs, have required employees to pay a larger share of their health insurance premiums. In addition, to maintain lower insurance rates, employers have opted for insurance policies wherein patients pay higher co-pays for doctor visits and other medical care. Other employers are dropping or drastically reducing insurance coverage, and many smaller employers are providing little or no health insurance for their workers. A growing number of Americans do not have health insurance; they neither receive coverage from employers nor do they qualify for Medicaid or Medicare<sup>2</sup>.

The steeply rising cost of medical care is driving Medicare and Medicaid costs ever higher, and the United States Government has not fully addressed the future costs of these programs. Although the press and politicians say a great deal about the rising cost of Social Security and that program's continued fiscal viability, the far greater fiscal challenge will be sustaining Medicare and Medicaid. Yet, we have not come to terms either with rising health care costs in general or with the cost of financing Medicare and Medicaid in particular.

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1 The origins of government-provided health insurance date back to 1945, when President Truman proposed a universal health care plan. Twenty years later that plan was trimmed to Medicare and Medicaid, and the retired President Truman became Medicare's first enrollee.

2 One trend is that older workers with higher incomes are relatively more likely to have employer-based health insurance coverage over time (Keenan, Cutler, and Chernew. 2006).

Medical costs and the finance or redesign of health care programs are complicated issues, and that may account for a public that is less than willing to grapple with complicated reforms. Sensing a public overwhelmed by the complexity, politicians and other leaders do not address issues for which there is little public appetite or understanding<sup>3</sup>.

In this paper, I want to address the large budget gap that will emerge in Medicare and Medicaid in the decades to come. In subsequent sections of the paper, I will briefly describe the finances of the programs and some of their major features. I will then explain the projections done by the U.S. Congressional Budget Office and by the U.S. appointed Board of Trustees of Social Security, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. The final sections of the paper will discuss measures that might be taken to close the budget gap which Medicare and Medicaid create in the context of rising health care costs in the United States.

## 2. Features of Medicare and Medicaid

Medicare is available to all retirees, 65 years or older, who qualify for Social Security benefits. In December 2006, 43 million people participated in the Medicare program (Social Security and Medicare Board of Trustees, 2007). The program has three components. Part A covers hospitalization services, and all retired person over 65 years of age are covered. This component of Medicare is financed from a payroll tax on all wage and salaries, with employers and employees each paying 1.45 percent of total earnings into a trust fund that is used to finance the ongoing costs of the program. There is no other source of funds for Medicare Part A. When revenues paid into the program exceed expenses, the surplus is retained as a Health Insurance Trust Fund.

The two other components of Medicare are: Part B, which covers the cost of physicians' services, and Part D, introduced in 2006 to cover the cost of prescription drugs. Recipients of Part A may at their option purchase coverage under Parts B and D. Participants pay a monthly premium that covers about 25 percent of the costs of services covered under Parts B and D. The balance of the costs for Parts B and D are financed from general tax revenues<sup>4</sup>.

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3 George Marshall believed that the public's inability to grasp complex issues impeded resolving those issues. In urging the Marshall Plan for Europe in 1947 he said, "I think one difficulty is that the problem is one of such enormous complexity that the very mass of facts presented to the public by press and radio make it exceedingly difficult for the man in the street to reach a clear appraisalment of the situation. It is virtually impossible at this distance to grasp at all the real significance of the situation". The foregoing statement was cited by Bill Gates in his commencement address at Harvard University, June 7, 2007.

4 In 2007, monthly insurance premiums for most enrollees are \$93.50 per month for Part B and \$27.35 per month for Part D.

Medicaid is a joint state and federal program designed to provide health care for low-income populations and children; the program has over 57 million participants. (Congress of the United States 2005: 28). States administer the program to their low-income populations and determine coverage limits subject to specified federal minimum standards. The federal government matches state expenditures, using matching rates of between 50 percent and 76 percent depending on the per capita income of each state<sup>5</sup>.

Medicaid covers medical services for low-income individuals and households. Elderly persons can be covered under Medicaid if they do not qualify to receive Social Security and are therefore not eligible for Medicare. In addition, while Medicare does not cover nursing home care, many elderly poor (who sometimes become impoverished by giving away their assets to children) qualify for nursing home care under Medicaid.

According to the U.S. Congressional Budget Office, an analytical arm of the legislative branch of the federal government, about 75 percent of Medicaid recipients are low-income children or their parents or pregnant women. Due to its youth this population typically requires few major medical procedures and, therefore, overall receives about 30 percent of the expenditure made in the Medicaid program. The balance of Medicaid expenses supports elderly and disabled populations for whom medical care is more costly and for whom advanced medical technology plays a more prominent role in treatments (Congress of the United States 2005: 28-29).

The federal government pays only a share of Medicaid's expenses and can control its outlays by reducing the matching rates it pays to states, as it has done recently. States face more severe Medicaid budget challenges as the federal government reduces its financial participation in Medicaid (Congress of the United States 2005: 29).

### 3. Long-Term Forecasts of Medical Expenses

Two organizations conduct long-term forecasts of both Medicare and Social Security finances: the Congressional Budget Office and the Social Security and Medicare Board of Trustees. The former entity's forecasting is done as part of ongoing budget work for the U.S. Congress which includes expenditure forecasts for Medicaid as well as for other areas of the federal budget. The Board of Trustees by statute forecasts Social Security and Medicare

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<sup>5</sup> For example, states with the lowest per capita incomes will have about 76 percent of its Medicaid costs covered by the federal government, while a state with a higher per capita income, such as New York, will have a 50 percent federal government matching rate.

expenses and revenues. Board of Trustees projections for Medicare are presented in this section.

One of the issues facing forecasters in health care and other areas is determining what the current trend in expenditures portends for future expenses. Medicaid and Medicare expenses can be expected to grow in response to increases in the number of patients, i.e., low-income individuals and impoverished elderly persons in nursing care in the case of Medicaid and Social Security recipients in the case of Medicare. More importantly, for both Medicaid and Medicare expenses, the increases in health care cost overall drive the large increases in program spending. As an example, in 1970, Medicaid and Medicare spending combined accounted for 1 percent of GDP. By 2006, the combined spending on these two programs accounted for 4.2 percent of GDP, according to figures issued by the Congressional Budget Office. Medicare alone accounted for 3.1 percent of GDP, according to figures issued by the Social Security and Medicare Board of Trustees. Over that same period, expenditure on health care has increased as a whole from 6 percent of GDP to 16 percent of GDP. Medicaid and Medicare budgets may be contained in the shorter run; but in the longer run, growth in expenses for these programs is linked to the growth in health care expenses overall.

With regard to Medicare and Medicaid expenses, forecasters need to grapple with the sustainability of recent growth rates in key health care areas. For example, according to the Social Security and Medicare Trustee report to Congress, spending on health care overall has grown 2 to 3 percentage points faster than GDP; spending on physicians services (Part B) has grown 10.8 percent annually over the past five years; and spending on pharmaceutical drugs is projected to grow 12.6 percent annually during the 2006 to 2016 period, due in part to expected large increases in number of Part D participants. (U. S. Congress, 2007a: 20, 23).

The Board of Social Security and Medicare Trustees regularly produces a 75-year forecast as required by law. The forecast for the first ten years uses a finely grained analysis of each medical service (physician services, out-patient care, assisted care, etc.) and projects growth for each service<sup>6</sup>. Growth in expenditures is also affected by the average number of beneficiaries in the system (characterized by an aging population), increases in the number of services

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6 Forecasts may differ from trends when current payment schedules for services are lower than what experts may project. In these cases, current laws that govern how fast congress will allow expenditures for certain services to grow may constrain the forecasted expenditures. In such cases, forecasts would understate the rates of increase in expenses.

used per beneficiary, and increases in the average complexity of services, as well as price increases for services.

Looking beyond the initial ten-year period covered by its forecast, the Board of Trustees reasoned that medical expenses would eventually grow at the same rate as GDP, and the Board chose the year after the 75-year forecast period as the convergence point for the growth rates in health expense and GDP. Accordingly, the Board of Trustees' forecast assumes that the growth rate of expenses for medical services exceeds GDP growth by only 1.4 percentage points by 2031, by only 0.8 percentage points by 2051, and by only 0.2 percentage points by 2081. Even under these growth assumptions, Medicare expenses alone are projected to grow from 3.1 percent of GDP in 2006 to 7.3 percent of GDP by 2035. By 2081 projected Medicare expenses increase to 11.3 percent of GDP<sup>7</sup>.

Forecasts of Medicare expenses made by the U.S. Congressional Budget Office (CBO) follow a similar, but not the same, methodology as the Board of Trustee estimates (Congress of the United States. Congressional Budget Office. 2006). CBO make three different forecasts: Growth in spending for Medicare and Medicaid is due solely to growth in the number beneficiaries over time (demographic growth) with the costs of medical services growing at the same rate as GDP. Growth in spending is due both to demographic growth and to the cost of medical services growing 1 percentage point faster than GDP; and growth in spending is due both to demographic growth and to the cost of medical services growing 2.5 percentage points faster than GDP. The last forecast is in line with historical cost increases in the Medicare and Medicaid programs. The intermediate forecast is roughly in line with the Trustees estimates for the same period. But the Trustees update their forecast annually, while CBO's long-range budget forecast is published bi-annually. As a result of the different timing of the forecasts, the assumptions that underlie the CBO forecasts lag behind the assumptions underlying the current Trustees' forecasts. In addition, the CBO forecasts only to the year 2050 instead of the 75-year forecast period that the Trustees' forecast must cover.

Demographic changes alone – an aging population and the changes in the gender ratios of older Americans that lead to longer overall life expectancy – result in projected Medicare expense rising to 5.1 percent of GDP in 2050 from its current level of 3.2 percent of GDP.

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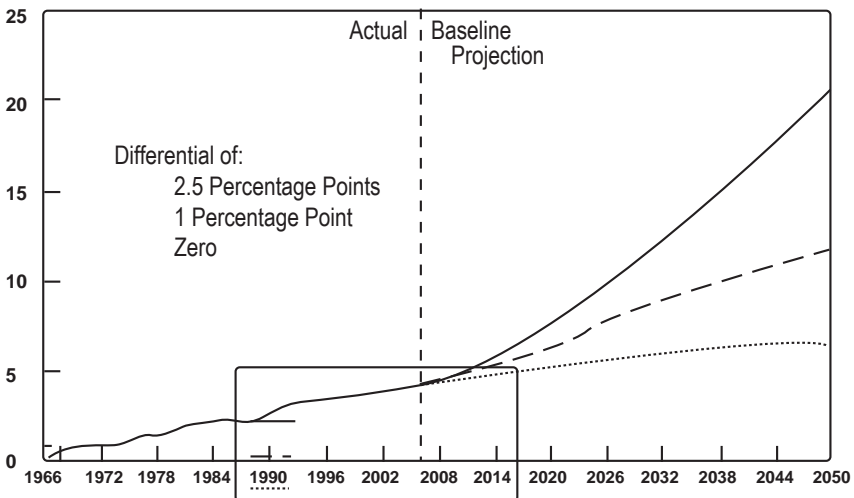
7 Actuarial estimates have made ten-year forecasts of physicians' services expenses when the constrained 6.6 percent rate of increase is eliminated, as Congress has relaxed this constraint in past years. Thus, they estimate that physicians' services expenses will increase between 7 and 9 percent more by 2010 and between 25 and 40 percent more by 2030. (U.S. Congress, 2007a: 141-142). See <http://www.cms.hhs.gov/ReportsTrustFunds/downloads/AlternativePhysicianUpdate.pdf> for the actuarial estimates.

Demographic factors alone imply that the Medicaid and Medicare programs together will account for 7.0 percent of GDP by 2050. Using the intermediate assumption that medical care will grow one percentage point faster than GDP growth leads to the combined costs of Medicare (8.6 percent) and Medicaid (4.0 percent) reaching 12.6 percent of GDP by 2050.

If medical costs overall continue to rise at their historical rate (2.5 percentage points faster than GDP growth) since 1950, the cost of the two programs will reach 21.9 percent of GDP by 2050. These results are illustrated in Figure 1 supplied by the U.S. Congressional Budget Office.

Two comparisons will place these figures in perspective. CBO forecasts Social Security to rise from its current 4.2 percent of GDP to 6.4 percent of GDP by 2050 – small relative to the growth of Medicare and Medicaid and not nearly as difficult to contain or finance. Secondly, the ratio of U.S. central government tax revenue to GDP has historically been about 18 percent of GDP. By 2050, Social Security, Medicaid and Medicare alone could cost 18 percent of our GDP.

**FIGURE 1:** Total Federal Spending for Medicare and Medicaid Under Assumptions About the Health Cost Growth Differential (Percent of gross domestic product)



Note: The health cost growth differential refers to the number of percentage points by which the growth of annual health care spending per beneficiary is assumed to exceed the growth of nominal gross domestic product per capita.

Source: Congress of the United States. Congressional Budget Office (2007b)

#### 4. Health Care Spending in the U.S. and Developed Countries

The United States spends more on health care overall than any other developed country. McKinsey and Associates (2007) reason that this could occur for one of three broad reasons or for some combination thereof: the U.S. population is sicker than populations of other countries and therefore consumes a greater quantity of health care; the United States, being wealthier than other countries, has a greater demand for health care, uses more services, and is overall healthier; or the price of health care in the U.S. is higher than in other countries.

McKinsey and Associates then examine 130 different diseases and conclude that more illness does not characterize the U.S. population. We are not more ill than other populations; so if we consume more medical services, it is not because we are inherently more ill.

The United States is wealthier overall than many OECD countries. Health care is a superior good, as evidenced by our willingness to devote an ever greater share of our GDP to health care. David Cutler articulates this point of view.

McKinsey (2007); Anderson and Reinhardt et al. (2003); Anderson, Hussey et al. (2005); and others show that prices for health services are much higher in the U.S. than in other countries. McKinsey analysts estimate that, even accounting for more consumption of health care services due to our higher income, the U.S. would spend half a trillion dollars less than it does currently if its medical care prices were comparable to those in OECD countries. Such a reduction in spending would reduce our overall spending on health care from its current level of 16 percent of GDP to 12 percent of GDP.

The McKinsey study concludes that the U.S. spends relatively more of its resources than OECD countries to deliver hospital care, outpatient care, drugs, and administration and insurance, while spending relatively less on long-term care and durable medical equipment. Moreover, 80 percent of the expense differential between the U.S. and OECD countries is explained by prices of hospital care, outpatient care, operational expenses and medical labor.

#### 5. Restraining Future Growth of Medical Expenses

As illustrated in the figure presented earlier, growth in Medicare and Medicaid expenses is largely affected by the growth of medical care overall. The aging of the population explains only a small portion of the growth of expenses in the programs.

Still, Freund and Smeeding (2001) caution that the aging of the U.S. population as well as longer life expectancy will increase the number of enrollees in Medicare over time. They are also among the first to express the view that the large increases in medical costs may be due to widespread use of ineffective medical procedures and pharmaceutical drugs. They



propose that insurance companies develop “negative lists” or lists of ineffective procedures and drugs that would not be covered by insurance payments. This practice, Freund and Smeeding argue, should reduce the costs of medical care overall.

Freund and Smeeding also express the idea that gene therapy and biotechnology may stimulate more medical procedures and continue to raise costs of medical care. Countering that trend is the potential for gene therapy to increase the effectiveness of procedures and thus reduce per-patient care costs. Gene therapy may also lead to pharmaceuticals tailored to individual patients to address critical illnesses. Better matching of pharmaceuticals to specific diseases might reduce the need for relatively more expensive medical procedures and act to dampen cost increases of medical care.

The Congressional Budget Office (CBO) recently proposed a series of steps to control costs of medical care. All of these involve rethinking how we deliver health care in the United States. CBO Director Peter Orzag suggests the need to move in the direction of applying benefit-cost analysis to medical procedures. Other countries, he argues, set a budget constraint on medical expenses overall, and assess the “comparative effectiveness” of treatments and procedures to determine whether to reimburse health care providers for specific treatments and procedures. Lack of reimbursement for ineffective treatments should spur their replacement with more effective alternatives.

Applying that model in the U.S. would require insurance companies and Medicare and Medicaid to inform health care practitioners of ineffective procedures for which insurance firms and government programs would no longer pay. Orzag raises the question of how to gather information on ineffective procedures. He considers establishing an oversight agency that performs clinical trials for procedures and pharmaceuticals. Clinical trials are expensive to perform and they also raise serious ethical questions when patients receive placebos rather than being treated for their diseases. Proposing an alternative approach, Orzag suggests using extant research results to make decisions about comparative effectiveness of medical procedures. As to pharmaceuticals, he suggests that since these are responsible for only 15 percent of health care costs, and the potential cost savings of applying comparative effectiveness protocols to pharmaceuticals will yield fewer savings and may not be worth the expense.

## **6. U.S. Response to the Fiscal Crisis**

The conclusion from a large body of research is that the bigger share of GDP that the U.S. spends on health care in comparison to other developed countries does not lead to better health outcomes for America’s citizens. We are not healthier than people living in other developed countries; and the fiscal implication of our current delivery system for health care has been rapid growth in health care expenses overall and in publicly funded programs such

as Medicare and Medicaid. There is little dispute among politicians and policy makers that rapid growth in health care expenses means that the United States faces a looming fiscal crisis in coming decades. Politicians disagree on what to do about this situation.

It is clear that if we do nothing we will need to tax ourselves much more to finance the growing costs of medical care. And that is of course one alternative. But stemming the rising costs of health care will require large reforms in U.S. health care delivery. Major interventions in the U.S. health care systems will be needed to address the relatively high and rising prices for medical services and the use of ineffective medical technologies.

Comparative effectiveness assessment will likely be part of the policy remedy to contain health care costs. Eliminating ineffective treatments will save not only fiduciary costs, but will reduce the number of patients who receive sometimes invasive and painful remedies that prove ineffective, only to be treated again (sometimes using other methods) in hopes of better outcomes. Other proposed measures to address increasing costs are raising the age when people become eligible for Medicare, increasing the premiums the elderly pay for Parts B and D of Medicare coverage, and reducing the rates of reimbursement that doctors and hospitals receive when Medicare patients are treated.

Restricting the reimbursement rates for doctors and hospitals would respond to the research findings that prices of medical services in the United States are higher than those charged in other developed countries. However, past attempts to limit Medicaid and Medicare reimbursements to hospitals and doctors resulted in some physicians refusing Medicare patients or at least turning away new patients - as one example, see Fuhrmans., 2007: A1-A12) -. Addressing the high prices of medical care will likely require the cooperation of private insurers as well as government programs.

The United States health care system faces other challenges. A significant and growing portion of the U.S. population does not have health insurance and cannot afford to self-insure for medical expenses. Uninsured individuals pay for some treatments themselves, or in many instances go untreated. Some of the uninsured access medical care through emergency rooms at public hospitals<sup>8</sup>. Extending health care insurance coverage to those currently not covered is a significant challenge in the United States, and one that we must address even though it will increase overall expenses on health care.

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8 A superior good has the characteristic that its income elasticity is larger than unity. This implies that the quantity consumed of the good grows faster than income, or the share of income spent on the good increases as income rises. By implication, the share spent on all other goods falls as a percent of income, but the amount of the all other goods consumed may still increase with income.

Innovative treatments afforded by biotechnology, gene therapy and new pharmaceuticals that may be developed as scientists gain understanding of gene networks could raise the expense of medical care in some respects. But greater understanding of gene networks could also eliminate ineffective treatments, which would have the opposite effect and reduce some health care costs.

A hopeful aspect of the evolution of medical technology is the potential to reduce the relative amount of invasive surgery, to secure more accurate diagnoses, and to increase the likelihood of early treatment. Some think these developments will lead to decreases in the costs of medical care by reducing the number of ineffective treatments. For example, microsurgery is often less expensive and requires shorter hospital stays than more invasive traditional surgery. Heart attacks are more often effectively treated with stents rather than by performing bypass surgery. In general, the use of better and more effective technology could help to reduce the overall costs of medical care.

## 7. Another More Nuanced Point of View

David Cutler (2004), one of the most knowledgeable experts on health care economics, has a different perspective. While not supporting ineffective treatments and ever higher prices for services, he articulates the view that the wealth in the United States has driven its citizens and governments to seek better health care and to spend a greater share of GDP on health care. In economic terms, health care services are a superior good to United States citizens, and the implication is that expenditures on health care may continue to increase as a share of our GDP<sup>9</sup>. He suggests that behavioral evidence in the United States suggests that we are willing to pay for more health care, and that the value we place on medical services far exceeds the extra costs.

He notes that in 1950 we spent 5 percent of our GDP on health care. At that time, heart attacks were more often fatal. Most of the advances in life span since 1950 occurred because heart attacks became less fatal, as the medical profession learned to treat them more effectively. Furthermore, Cutler reasons that our willingness to pay for safety devices that protect life, such as airbags in cars, implies that our valuation of an extra year of life is about \$100,000. Given this value, the U. S. expenditure on added health care is well above the costs associated with extending life by one year.

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Cutler also notes that molecular biology and engineering biology are likely to lead to improved treatments for cancer, diabetes and Alzheimer's, extending life farther or improving its quality. Given our above noted valuation of life, continued medical advance may continue to yield favorable benefit-cost comparisons, and health care expenses may indeed continue to grow faster than GDP. Cutler, as noted above, suggests that health care will continue to be a superior good and that Americans will spend enough to finance their appetite for more health care.

By my own calculation, the elasticity of health care expenditure to GDP since 1950 is 1.33, which implies that for every one percent increase in GDP, health care expenditures grow by 1.33 percent. Even that elasticity and the implied rate of increase in health care expenditure allows for significant growth in the consumption of other goods and services. Or, as Cutler (2004) suggests, consumption of other goods and services will grow with GDP, but at a rate less than GDP growth. In effect, Cutler argues that medical services are a superior good that the U.S. population has expressed a willingness to pay more to obtain. Moreover, the benefits gained from increases in life expectancy through more health care expenditure far exceed the costs of extending life. He reasons that we are willing to tax ourselves to finance the added medical care.

In conclusion, we are a long way from addressing our rising costs of health care. Ensuring the use of effective medical technology and dealing with high prices for care will require fundamentally rethinking health care delivery. Comparative effectiveness and cost control are certainly worthy ideas to pursue, but Cutler's point is that we can afford to pay an even greater share of our income on health care (2004). And apparently we are willing to do so. The looming fiscal crises in Medicaid and Medicare will test the limits of our resolve to pay more for health care. Another challenge for the U.S. is extending health care coverage to all Americans, as increasing numbers of us are without even basic health insurance. Determining what model to use to cover more Americans will be a crucial part of the health care debate.

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