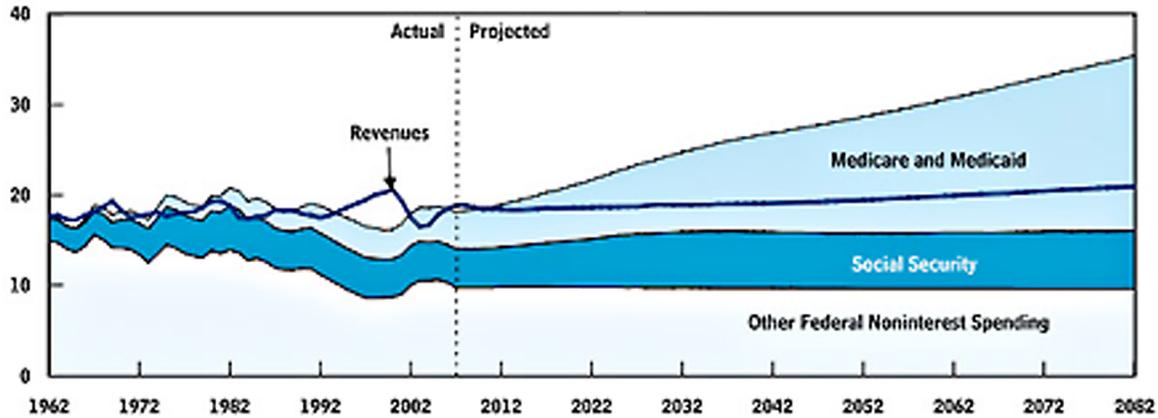


# HEALTH CARE: THE KEY TO LONG TERM FISCAL AND ECONOMIC HEALTH

## A Crisis in the Making

Health care costs are greatest single obstacle to long-term deficit reduction. The magnitude of this problem cannot be overstated. The following CBO chart tells the story:

### Alternative Fiscal Scenario



These costs, if unchecked, are a long-term financial catastrophe that threatens both government solvency and the entire U.S. economy.

No deficit plan is meaningful unless it takes bold steps to address this problem. While the **Patient Protection and Affordable Care Act (PPACA)** was a good first step, much more remains to be done. If uncorrected, Medicare and Medicaid costs will exceed those of all other government spending in the next 25 years. When it comes to long-term deficit reduction, health care is the problem. Attempts to balance the budget merely by cutting the portion of these costs paid by government will fail, exacting an enormous human toll in the process.

## A Broken System

The United States differs from that of all other developed nations in its reliance on private-sector, employer-sponsored health insurance. Other differences include regulatory structure, provider payment systems, and physician compensation levels. The results are plainly visible in the chart (Figure 2):

The United States spent 16 percent of its GDP on health care in 2007, far higher than the average of 8.9 percent spent by other developed countries, and will continue to lead the pack in forty years. This cost isn't explained by age differences, as many people assert, since the U.S. has a smaller elderly population (as a percentage of the total) than Europe or Japan<sup>13</sup>. The conclusion is plain: If the U.S. spent the same percentage of its GDP as the typical developed country with universal coverage, it would have no long-term deficit problem.

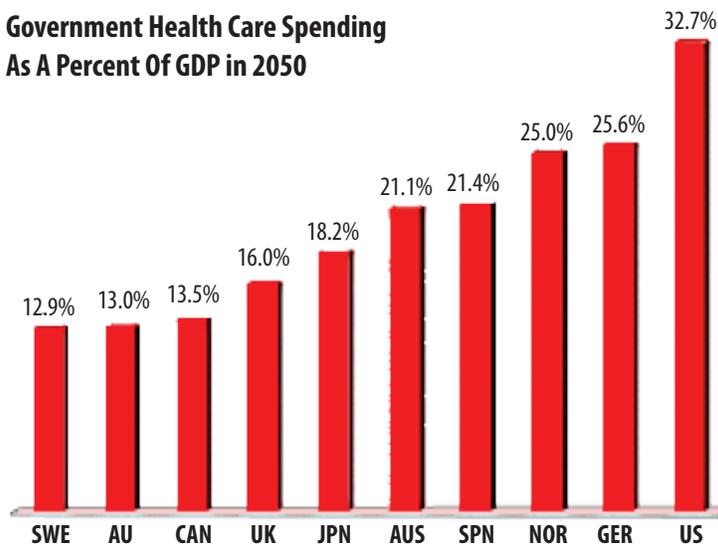
### Shifting the Cost Isn't the Answer

Many of the current deficit reduction proposals being discussed (e.g. Bowles/Simpson, Rivlin/Domenici) substitute cost-shifting for cost reduction. Spending caps, premium increases and additional out-of-pocket costs for patients do not address the global cost problem.<sup>14</sup> They merely shift these costs to elderly

13 Pearson, Mark. Written Statement to Senate Special Committee on Aging. OECD, September 2009.

14 Many private-sector health plans relied heavily on a RAND Corporation study which suggested that patients who

## Government Health Care Spending As A Percent Of GDP in 2050



Note: Numbers rounded.

Source: Authors' calculations based on Laurence Kotlikoff and Christian Hagist, "Who's Going Broke?" National Bureau of Economic Research, Working Paper No. 11833, December 2005, p. 25.

individuals who will often lack the means to pay for them. In some cases, these cuts will also shift costs from the federal government to the states by increasing Medicaid costs for low-income seniors (so-called "dual eligibles").

### Harming the Health of Seniors

In cases where cost-cutting measures are successful in reducing government expenditures, they exact a toll in human suffering that countries with more fiscally prudent programs find unnecessary. Studies have shown that the elderly will reduce their use of certain health services if out-of-pocket costs rise<sup>15</sup>. But the same studies have found an increase in hospital use, which suggests a severe health impact of some older Americans. It is not

clear that recent proposals have considered the added cost of hospitalization in their savings estimate.

### Added Hardship for Older Americans

The elderly already spend a greater percentage of their income on health care<sup>16</sup> than other Americans. One study<sup>17</sup> showed that a retired couple aged 65 can expect to pay \$197,000 in lifetime out-of-pocket costs, and a private financial firm<sup>18</sup> estimated that elderly health care costs rose 56 percent between 2002 and 2010. It is reasonable to question whether proposals that would add to this burden through cost-shifting are fair or humane, especially when the same proposals would also reduce Social Security retirement benefits for the same population. The sharp increase in bankruptcies among the elderly<sup>19</sup> only underscores the dangers and hardships these proposals present, since Social Security is the largest source of income for both men and women over the age of 65<sup>20</sup>.

### Less Purchasing Power Means Less Growth

Under these proposals, older Americans will bear an increasing percentage of skyrocketing costs. That will deprive them of funds needed to pay for food, housing, and other goods. That will have a depressive effect on economic growth, as cash-strapped seniors pay less for goods and services as they struggle to meet increasing medical bills.

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paid more in out-of-pocket cost for their care reduced medical usage with no adverse health effects. That study has come under recent challenge, however, and excluded the elderly. and other studies focusing on elderly populations offer convincing evidence that these measures are counterproductive for elderly populations.

15 See Chandra, A; Gruber, J; and McKnight, R. Patient Cost-Sharing, Hospitalization Offsets, and the Design of Optimal Health Insurance for the Elderly. NBER Working Paper, 2007. See also Goldman, D et al. 2006.

16 Desmond, K. et al. Medicare Issue Brief. Kaiser Family Foundation. September 2007. Cost ratios have shifted due to reforms after the paper was written, but it is assumed that the elderly still pay a greater portion of income on health care.

17 Center for Retirement Research, Boston College

18 Fidelity Investments

19 See, for example, Thorne, Warren, Sullivan. The Increasing Vulnerability of Older Americans: Evidence From the Bankruptcy Court. Harvard Law and Policy Review, 2009.

20 See Hartmann, H, and Lee, S. Social Security: The Largest Source of Income ... IWDPR Pub D455.

## The Wrong Priorities

We find that many deficit proposals include some useful ideas but fail to address long-term costs. Indeed, they mostly kick the can down the road. Bowles and Simpson, for example, simply suggest that Congress “consider” the public option if their ideas fail. While their acknowledgement of this idea’s importance is laudable, their priorities are backward: They propose to start the process with counterproductive cost-shifting measures while deferring cost-saving measures.

The Bowles/Simpson plan’s strongest cost-cutting proposals involve steep reductions in provider payments, which will have a dislocating effect when a) many providers refuse to serve Medicare enrollees and b) providers shift the lost revenue onto private insurers. Their tort reform proposal will likely have some effect on costs, but not as much as many people believe. The alleged costs of “defensive medicine” are far less than typically assumed, so the savings will not be significant.<sup>21</sup>

A package that relies on caps, premium increases and other cost-shifting techniques will impede growth, cost jobs and impose painful hardship while failing to address the underlying problem.

### A Better Health Care Plan

Our proposal addresses costs in a comprehensive way:

**Implement public option health plan.** Create a truly robust public option plan that is available to all Americans, without the restrictions to access proposed earlier this year.

Annual Savings: \$35 billion<sup>22</sup>

**Establish a Medicare Part D public plan to compete with private plans.** The legislation that created the “Part D” drug program mandated that drug benefits be offered only through private companies (“nongovernmental entities”). A Medicare drug plan should be established to compete with private-sector plans.

Annual Savings: \$6 billion<sup>23</sup>

**Pharmaceutical Negotiations.** The Department of Veterans’ Affairs pays 58 percent less for prescription drugs than Medicare<sup>24</sup> because it is not prohibited by law from negotiating with pharmaceutical manufacturers. That prohibition should be lifted for the Department of Health and Human Services, which should then be directed to immediately begin direct negotiations with pharmaceutical companies.

Annual Savings: \$40 billion<sup>25</sup>

**Study additional cost-saving options.** Implement high-level studies of additional cost-containment / quality-improvement measures such as evidence-based medicine and all-payer programs through grants to the Agency for Health Care Policy and Research, the Centers for Medicare & Medicaid Services, and other agencies and private research firms.

Cost/Savings: To be determined.

**Medicare for All.** Lastly, we should set cost containment targets and target dates for health cost reduction that apply to both private and public spending. Such global spending targets will assure that costs are not simply shifted from the public to the private sector. Cost containment goals should be set, with target dates

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21 See Mello, M. “Defensive medicine” accounted for 2.4% of health care costs. This practice will never be fully eliminated. While it can and should be reduced, too much reliance should not be placed on this approach.

22 Lewin Group, “Cost Impact Analysis for the ‘Health Care for America’ Proposal,” February 2008, <http://www.sharedprosperity.org/hcfa/lewin.pdf>, 12.

23 Per Schakowsky proposal

24 No Bargain: Medicare Drug Plans Deliver High Prices. Families USA, 2007.

25 Gellad, Walid et al. What if the Federal Government Negotiated Pharmaceutical Prices for Seniors? An Estimate of National Savings. *J Gen Intern Med.* 2008 September; 23(9): 1435–1440 (expanded for all populations and consistent w/Dean Baker estimate) <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2517993/>

for achieving them. If these targets are not met, work should begin on cost-benefit and implementation studies of “Medicare for All” and other more robust options for controlling health costs.

Cost/Savings: To be determined.

### Setting Achievable and Balanced Targets

The president’s National Commission on Fiscal Responsibility and Reform has set a goal of eliminating the primary deficit (before interest expense on the debt) by 2015. Meeting this arbitrary target will likely damage the recovery and even increase deficits. We believe we can assure fiscal sustainability in a more constructive way. But the deficit reduction we propose should not begin until the economic recovery brings the nation much closer to full employment. This is not likely to occur until 2014 or 2015 under the best of circumstances.

The most important question is this: What will drive economic growth, job creation and widely shared prosperity in the years to come? Conservatives argue that we should simply reduce deficits and wait for the next economic boom. But the last economic expansion rode on a bubble, inflated by unsustainable household debt and financial speculation.

President Obama has called on us to build a new foundation for the economy. This requires making investments vital to our future—in education and training, in research and development, in a modern infrastructure for the 21st century. It requires ending our addiction to oil, and capturing a lead role in the green industrial revolution, creating the next generation of green jobs. It also means ensuring that the new Dodd-Frank financial regulations are implemented in effective ways, to prevent the return of excessive speculation and financial bubbles as our dominant engine of economic growth.

Study after study demonstrates that America has a huge “public investment deficit” in areas vital to our economy. Some estimates suggest a shortfall in public investment of as much as \$500 billion a year in traditional infrastructure and the green economy. As long as we have unacceptably high unemployment, outlays for additional investment can easily be deficit-financed. But even once we achieve a robust recovery, our country can pay for productive public investment by borrowing moderately.

We must have the confidence to forge our future. At the end of World War II, the U.S. was burdened with debt that totaled over 120 percent of GDP. But we made the investments vital to a new economy—the GI Bill, housing subsidies, the Interstate Highway System, the conversion of military plants, and the Marshall plan. We did not adopt austerity economics. We ran modest annual deficits over most of the next two-and-a-half decades and the debt grew in absolute size, but the economy and the broad middle class grew faster. By 1970, the debt had been reduced to 35 percent of GDP. The better way to reduce the deficit as a percent of GDP is to increase GDP.

### Taking the high road to fiscal balance

We believe there are three essential guidelines for America’s future budget policy.

The right way—in fact, the only way—to guarantee the nation’s fiscal sustainability, in the short run and the long run, is by creating jobs, not destroying jobs. The most fiscally responsible path requires substantial fiscal stimulus now. A new round of spending cuts will be self-defeating. The fiscal stimulus should also

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be accompanied by vigorous monetary and credit market policy measures to encourage private-sector spending in job-creating investments.

In the long run, the central concern for Americans is rapidly rising health care costs and their impact on Medicare and Medicaid. Health care in America must be reformed significantly over time. Social Security is not contributing to the deficit and can be made solvent with modest changes, an exercise that should not be part of deficit-reduction efforts.

The nation's long-term economic growth, and therefore its fiscal balance, can only be sustained by serious public investment in education; transportation infrastructure; energy-technology development; and scientific, technological and medical research. These publicly financed investments create jobs and provide the necessary conditions for future rapid economic growth.