

*April 2009*

*Most of the growth in our nation's long-term budget projections has little to do with the country's current financial crisis – and everything to do with Medicare and Medicaid spending – said Peter Orszag, the new Director of the federal Office of Management and Budget. In fact, he said, our nation's overall, long-term fiscal path will be determined primarily by government spending on health care.*

## **Federal Health Spending Reductions Will Likely Fund Health Reform**

Over 44 million elderly and disabled Americans receive health care through Medicare, which now accounts for 22 percent of all U.S. health care spending<sup>1</sup>. Medicaid – health care for the very poor – serves 50 million people and represents an additional 14.8 percent of U.S. health care spending.<sup>2</sup>

Reducing Medicare and Medicaid spending is the primary way to fund health reform, according to key federal leaders including President Barack Obama. They cite the following “opportunities” to save government dollars while expanding health coverage for uninsured Americans:

- In 2007, Medicare spending totaled \$440 billion, or 16 percent of total federal spending. Medicare spending was exceeded only by Social Security (\$577 billion) and military (\$530 billion) spending.
- The Medicaid share of the federal budget will grow from 7.0 percent in 2007 to 8.4 percent by 2013.
- At its current growth rate, health spending will be 20 percent of the Gross Domestic Product by 2016<sup>3</sup>.
- Without changes, the Medicare Trust Fund will be totally depleted in just 10 years.

### ***Medicare Trust Fund Solvency***

---

<sup>1</sup> Medicare Spending and Financing. Henry J. Kaiser Foundation, September 2008.

<sup>2</sup> "2008 Actuarial Report on the Financial Outlook for Medicaid," Congressional Budget Office, October 2008.

<sup>3</sup> "Health Spending Projections Through 2016," *Health Affairs* web exclusive, Feb. 21, 2007.

Medicare is financed by two trust funds. The Hospital Insurance (HI) Trust Fund covers hospital inpatient stays. The Supplementary Medicare Insurance (SMI) Trust Fund covers physician visits and prescriptions.

The solvency of the HI Trust Fund is considered the long-term measure of Medicare's financial health. In the most recent projections by the Medicare Board of Trustees, annual payments from the HI Trust Fund will begin to exceed its income in 2011. Unless cost-saving measures are implemented, Medicare spending will accelerate rapidly and deplete the HI Trust by 2019.

Under federal law, the SMI Trust cannot be depleted but, without spending reductions, it will require rapidly increasing federal tax contributions.

### ***Medicaid***

Medicaid provides health care for low-income people through a federal-state match. While Medicaid is the federal government's largest health care expenditure, state governments are struggling to meet their share of Medicaid – which now averages 20 percent of their total state budgets. Many states, including Florida, actually leave federal dollars on the table because they cannot fund the entire match. In addition to Medicaid, federal and state governments fund the Children's Health Insurance Program (CHIP) for low-income children.

“High and increasing Medicaid spending clearly leaves states less able to fund other priorities,” said Acting CMS Administrator Kerry Weems in 2008. “As a nation we must [bring] health care costs under control and assure that our health care dollars are buying the highest quality, most efficient health care services.”

### ***Factors Driving Medicare & Medicaid Spending***

In October 2008<sup>4</sup>, Peter Orszag, the new Director of the federal Office of Management & Budget, said that health care costs offer “massive” opportunities to improve efficiency and manage costs.

That is because, said Orszag, most of the growth in spending comes from rising costs per Medicare beneficiary, not – as commonly believed – from our aging population. Not until the baby boomers reach age 85 (between 2040 and 2050) will age mix seriously impact program spending.

The two main causes of rising Medicare (and Medicaid) costs are new medical technologies and the rise of lifestyle-related chronic diseases, said a 2008 Congressional Budget Office (CBO) report issued under Orszag's leadership<sup>5</sup>.

---

<sup>4</sup> “Beyond Economics 101: Insights into Healthcare Reform from the Congressional Budget Office,” 2008 Kaufman Hall Financial Leadership Conference, October 2008.

<sup>5</sup> Orszag was appointed to the OMB post by President Barack Obama after serving as Director of the Congressional Budget Office under President George W. Bush.

The CBO also cited prescription drug coverage, Medicare HMOs, regional practice variations, and physician reimbursement<sup>6</sup> as cost drivers. Specifically, said the CBO:

- Medicare Part D prescription coverage accounted for \$72 billion of the increase in Medicare expenditures from 2005 to 2006.
- Annual premiums for Medicare Advantage HMOs, through which private Medicare health plans contract with the federal government, cost 13 percent more per beneficiary.
- Variations in practice patterns show that patients in certain regions of the country have more medical procedures than patients in other areas – for the same conditions. The variations cannot be explained by geography, and the higher cost regions do not necessarily generate better health outcomes.
- Scheduled cuts in physician reimbursement, designed to save Medicare dollars, have been continually delayed by Congress – without changes to the underlying formula that determines physician payments.

### ***“Massive” Opportunities for Improvement in Medicare & Medicaid***

Orszag said that health care costs offer “massive” opportunities to improve efficiency and manage costs and, ultimately, expand health coverage for Americans. His recommendations fall into three categories:

1. Dramatically expand Health Information Technology and electronic health records (EHRs). This could minimize expensive tests like MRIs and improve provider efficiency. Rather than massive subsidies for compliance, the federal government should set penalties for organizations that do not implement EHRs.
2. Use the information from the IT system to implement Comparative Clinical Effectiveness (CCE) efforts that scientifically compare the effectiveness of certain diagnostic and treatment options. For example, how many times should a patient need to go back to the physician after surgery? In some communities, patients return three or four times a month; in others, they go twice a month. Why?
3. Change payment incentives to encourage efficient care – not more care. Use CCE to reward providers who do this, and penalize those who do not.

*The variation in the way health care is delivered in the United States across regions, across hospitals in a region, is not driven by medical science. Too much of the health care delivered in the United States is of the ilk, “That is how we do it here...”*

Peter Orszag, PhD  
Director, U.S. Office of  
Management & Budget

“We know that hospitals will need to support and even lead efforts to measure and improve quality, reduce costs, and improve overall health in their communities. If we are to maintain control of our future health spending, we will need to reduce dependence on our sick-care system and become a healthier population. Florida Hospital’s vision fully embraces this conviction,” said Lars Houmann CEO of Florida Hospital.