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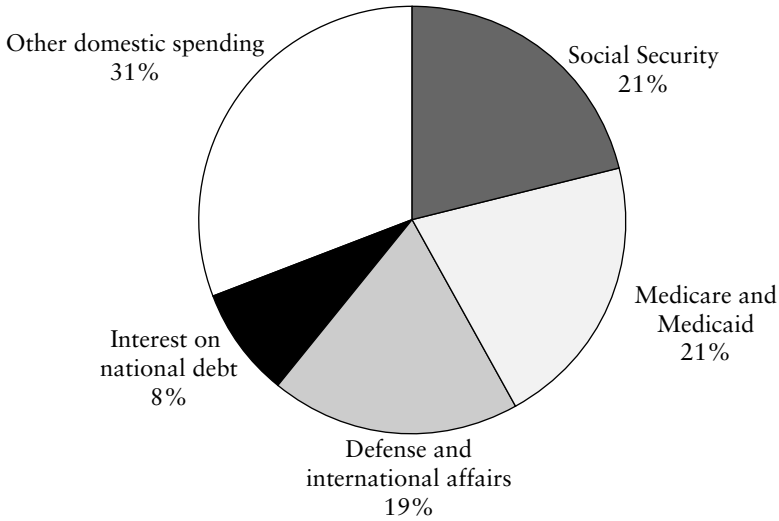
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## *Rising Health Care Spending— Federal and National*

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The fact that Americans are spending a growing portion of their income for health care and will spend even more in the future is not necessarily alarming. However, it forces us to face two important questions: How can we be sure we are getting our money's worth? And how will we pay the health care bill? Before we tackle those questions we must understand health care spending trends as well as possible. In this chapter we focus on the growth of the federal government's spending for health care and why we believe it to be unsustainable. We also show that the federal dilemma is just a piece of the bigger picture: total spending on health care is growing rapidly, both in the United States and elsewhere in the world. The two challenges are closely intertwined.

Federal health spending, estimated to be about \$676 billion in 2006,<sup>1</sup> is dominated by two major entitlement programs primarily benefiting senior citizens. The largest, Medicare, pays for hospital and physician care and prescription drugs for seniors and the disabled. The other, Medicaid, is a joint federal-state program that provides health coverage for low-income people. About two-thirds of Medicaid spending is devoted to

Figure 1-1. *Composition of Federal Spending, 2006 Projection*

Source: Office of Management and Budget, Historical Tables, *Budget of the United States Government: Fiscal Year 2006* (Government Printing Office, 2006).

health care for the elderly and disabled.<sup>2</sup> Federal spending on these two programs alone is estimated at \$538 billion in 2006—more than defense and about the same as Social Security (figure 1-1).<sup>3</sup> This amount is 21 percent of the federal budget, and nearly 35 percent of everything Americans spend for health care.<sup>4</sup>

If current trends continue, Medicare and Medicaid will grow considerably faster than Social Security and far more rapidly than federal revenues at current tax rates. The Congressional Budget Office (CBO) projects that by 2050 the continuation of current trends in medical spending per capita combined with the aging of the population could drive spending for these two entitlements alone to 22 percent of total national spending.<sup>5</sup> That is more than the proportion of total national spending currently allocated to *all* federal programs. In other words, to pay for Medicare and Medicaid in 2050, the rest of the government would have to close down completely or the size of government and the taxes that pay for it would have to increase greatly. Without a radical change in attitudes toward taxes and the role of government, current trends are clearly unsustainable.

Such mechanical trend projections are mindless. By definition, unsustainable growth is bound to slow. Nevertheless, they illustrate some important points. First, future growth in overall federal spending depends almost entirely on decisions about federal health benefits. Other spending programs, including Social Security, will have far less impact on future budgets. Second, the growth of federal spending for Medicare and Medicaid will force stark budgetary choices in the future, even if their rates of growth slow considerably. Tax revenues under the current tax system rise as the economy grows, but not much faster. If spending for federal health care continues to rise substantially faster than tax revenues do, policymakers will have to cut deeply and continuously into all other federal spending or raise tax rates continuously, or both. These stark choices dramatize the importance of exploring ways to slow the growth of federal health spending.

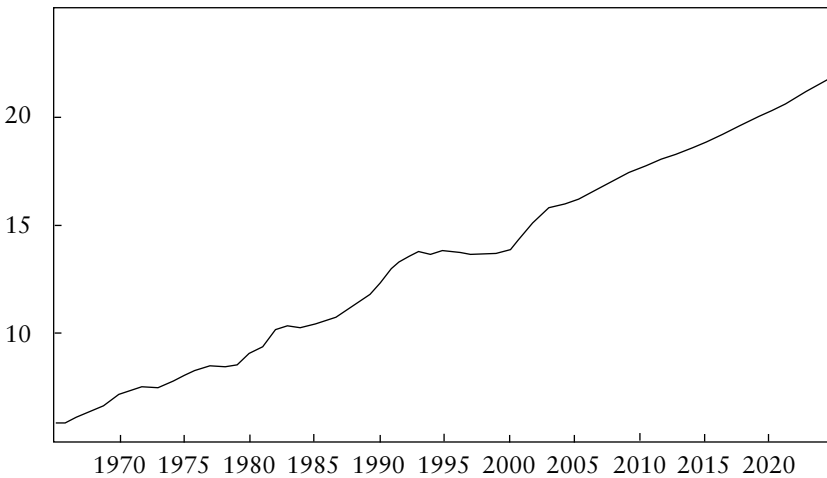
### **Not Just a Federal Budget Problem**

The federal budget dilemma dramatically illustrates the far more fundamental fact that Americans devote a high proportion of their total spending to health care and that the proportion is growing. That spending now totals more than 16 percent of gross domestic product (GDP), up from only 7 percent in 1970. The President's Council of Economic Advisors projects that under current trends health spending will exceed 20 percent of all American spending by 2015 (figure 1-2). In other words, if health care spending rises at historical rates, it will grow as a share of everyone's budgets—public and private. That is not necessarily a bad thing. The medical professions are more and more effective in curing disease and extending life, and Americans may well feel that health care is an increasingly desirable expenditure. But the rising share of income devoted to health will force families and businesses, as well as governments, to make difficult choices between health care and other priorities, such as education, housing, and environmental protection.

Moreover, if they are going to spend an ever-increasing portion of their total income on health care, Americans will want to be sure they are getting their money's worth. The American health care delivery system has many strong points. Wealthy foreigners, who could afford to go

Figure 1-2. *National Health Expenditures as a Percentage of GDP*

Percentage of GDP



Source: U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Office of the Actuary, "National Health Care Expenditures Projections: 2005–2015"; Council of Economic Advisers.

anywhere in the world for treatment, often seek care in the best American hospitals to get the benefit of the world's most advanced treatment techniques and technology. But the American system has serious downsides as well. It delivers care of uneven quality at high average cost compared with other countries and leaves some 46 million people without health care insurance.<sup>6</sup>

Such shortcomings complicate the problem of reducing the growth of federal health programs. If the federal health budget were the only concern, the problem would be conceptually simple: the growth of federal health care spending could be slowed by reducing benefits, reimbursement rates, or eligibility for federal programs. For example, the types of health benefits paid for by Medicaid could be narrowed or the minimum age for Medicare could be raised. But such actions would only shift costs to the private sector and other levels of government, likely increase the number of people without health care coverage, and do nothing to improve the quality of care or the efficiency of delivery. Hence, the challenge to federal decisionmakers is to find ways of moderating the rise of federal health

spending that move the whole system toward higher quality, greater efficiency, broader coverage, and slower overall health spending growth.

Most providers of health care are affected by both federal and non-federal health spending and policies. Patients move back and forth between public and private health insurance as their age and circumstances change, and many people have both types of insurance. Hence federal programs play a pivotal role in the health system and often exert considerable influence on the rest of the system. For example, Medicare's shift to prospective payments for hospitals in the 1980s appears to have accelerated the shortening of hospital stays, not just for Medicare patients but for other patients. Since federal health care spending is large and growing, the federal government has the potential to exert leadership and leverage on the rest of the health care delivery system. In this book we try to answer the question: can federal health care programs be reformed in ways that slow their future spending growth and move the whole health care system toward greater efficiency, effectiveness, and fairness?

## **Why Health Care Spending Is Growing So Fast— Here and Elsewhere**

Americans devote a larger proportion of their total spending to health care than do other advanced countries, but they do not have better health outcomes to show for this higher spending. In 2003, when the United States was devoting 15 percent of its GDP to health, the average for Organization for Economic Cooperation and Development (OECD) countries—30 democracies located mainly in Europe and North America—was 8.8 percent. In Switzerland, the next highest spender after the United States, health expenditures represented 11.5 percent of GDP, while several other wealthy countries of western Europe, together with Canada, spent around 10 percent of their GDP for health, and Japan and the United Kingdom spent less than 8 percent (table 1-1).<sup>7</sup> These countries have populations that are aging faster than the U.S. population, and their health outcomes—measured by life expectancy, infant mortality, and other measures—are considerably better than those of Americans.

The reasons for the higher level of spending on health care in the United States are varied and not totally understood. Despite its higher

Table 1-1. *OECD Health Spending and Outcomes, 2003*

<i>Country</i>	<i>Health spending as percentage of GDP</i>	<i>Life expectancy (years)</i>	<i>Infant mortality (deaths per 1,000 live births)</i>
United States	15.0	77.2	6.9
Switzerland	11.5	80.4	4.3
Canada	9.9	79.7	5.4
Japan	7.9	81.8	3.0
United Kingdom	7.7	78.5	5.3
OECD average	8.8	77.8	6.1

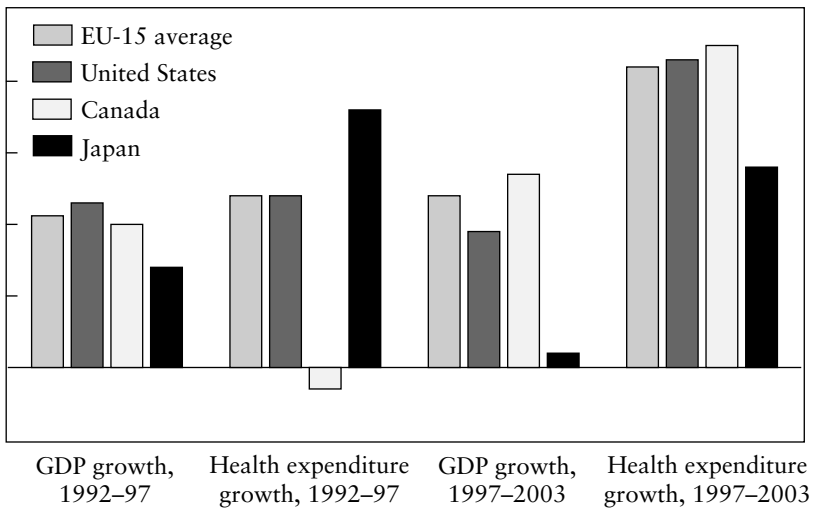
Source: Organization for Economic Cooperation and Development, *Health at a Glance: OECD Indicators 2005* (Paris, 2005).

spending, the United States lags behind many other advanced countries on measures of utilization of health resources. In 2003 the United States had fewer practicing physicians, fewer nurses, and fewer days spent in acute care hospital beds per capita than the median advanced country.<sup>8</sup> Expensive equipment, such as CT scanners and MRI devices, which used to be more widely available in the United States than in other advanced countries, now seem to be at least equally prevalent in European countries.<sup>9</sup> Part of the difference is attributable to more intensive treatment of some conditions, for example, more joint replacements for arthritis and more by-pass surgeries to improve heart functioning. Part is because of higher costs of treatment in the U.S. health system. The United States pays higher compensation to doctors and other highly skilled medical personnel, higher prices for hospital stays, and higher drug costs than most other developed countries.<sup>10</sup> The highly complex and fragmented American health care delivery system also generates very high administrative costs. In 2003 total health administrative costs in the United States were estimated to be \$111 billion; these costs are growing at a rate of 11.2 percent annually and are projected to double, to \$223 billion, by 2012.<sup>11</sup> Higher health care expenses do allow Americans greater choice of health providers, quicker access to the newest drugs and treatments, and a variety of care management approaches—but the cost may be higher than necessary.

Despite their lower level of health spending, other advanced countries are also experiencing rapid growth in their health care spending. From 1992 to 1997, growth in health expenditures in OECD member countries

Figure 1-3. *Growth in GDP and Health Expenditures, 1992–2003*

Real annual growth (percent)



Source: OECD, *Health at a Glance: OECD Indicators 2005*.

closely matched economic growth, in part the result of deliberate efforts in the United States and Europe to contain health costs. In the late 1990s, however, health expenditures surged, substantially outpacing GDP growth. The fifteen original members of the European Union (EU-15) experienced on average a 4.2 percent increase in health expenditures from 1997 to 2003, compared with average GDP growth of 2.4 percent.<sup>12</sup> During this same time period, U.S. health expenditures grew 4.3 percent, more than double the 1.9 percent growth in GDP. Health expenditures also grew more rapidly than GDP in Canada (4.5 percent compared with 2.7 percent) and Japan (2.8 percent compared with 0.2 percent) (figure 1-3).<sup>13</sup>

Common forces are pushing health spending to higher levels in all industrial countries. First, rapid medical innovation has made medical care far more effective. More efficacious drugs and innovative medical and surgical techniques are prolonging life and curing diseases once thought to be hopeless. Many of these innovations, such as cancer treatments and joint or organ replacement, involve costly new drugs, skills, and equipment that add substantially to health care spending. Others,

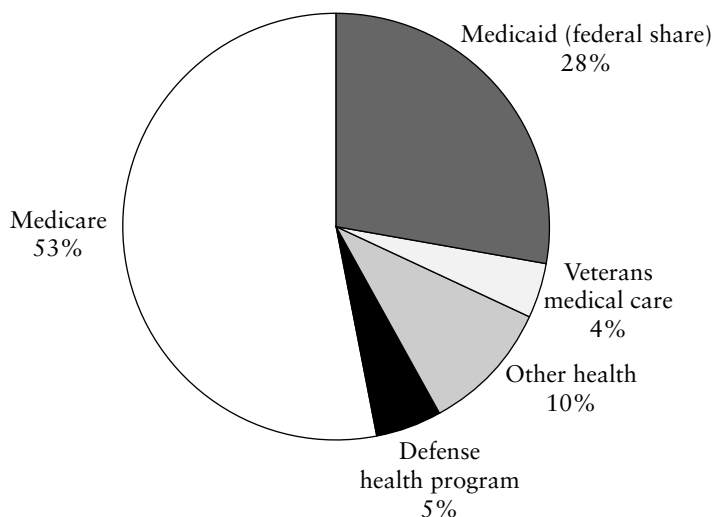
such as new techniques for removing cataracts, have dramatically reduced the cost of treating certain conditions. In these cases, however, the availability of cheaper and more effective interventions encourages far greater use of care. Total spending for the procedure often rises even when the cost per patient is plummeting. Second, rising incomes have increased the demand for care. With more discretionary income, people increase their health care spending. Moreover, while health care prices have been rising rapidly, third-party payment (by the government or insurer) of most of the bill reduces the impact of price on demand. Third, demographic shifts increase the demand for care. People are living longer in all advanced countries, and older people tend to use more care. For all of these reasons, the rapid rise in health care spending is a problem facing all advanced countries, even those that currently have lower average health care spending than the United States.

Increasing the efficiency of the American health care delivery system might not change the underlying forces pushing health care spending upward over the longer term. Getting waste out of the system, however, would mitigate near-term rates of growth, reduce the extent to which other priorities have to be sacrificed for health care, and reassure taxpayers and private payers that they are getting value for dollars expended.

## **Federal Spending for Health Care**

Medicare and Medicaid dominate federal spending for health care (figure 1-4). Spending under both programs has been growing rapidly in recent decades and is projected to grow faster as the baby boom generation reaches retirement age, the proportion of older beneficiaries continues to increase, and per beneficiary spending continues to rise. The recent expansion of Medicare to include a prescription drug benefit has added to the budgetary demands made by that program.

Medicare and Medicaid are both entitlement programs. In other words, spending in a given year is determined by the number of people entitled to benefits, the health services covered under the program, and the cost of those services. Entitlement spending (sometimes called mandatory spending) is automatically funded in the budget unless Congress takes action to change the law governing who is eligible, what is covered,

Figure 1-4. *Federal Outlays for Health Programs in 2006*

Source: OMB, Historical Tables, *Budget of the United States Government: Fiscal Year 2006*.

or how providers are reimbursed. Reducing benefits, eligibility, or reimbursement invites enormous political opposition and is infrequently attempted. Hence, quasi-automatic entitlement spending tends to drive out spending for programs—defense, national parks, education, and the like—that are funded with annual appropriations. Since Medicare and Medicaid benefit seniors, and seniors are a strong political force, the entitlement nature of these programs tends to increase the share of federal spending devoted to older people.<sup>14</sup> In 1970 the joint share of Medicare and Medicaid in the federal budget was 5.2 percent; in 2000 this share had jumped to 18.4 percent of federal outlays. By the end of this decade, these two programs alone are projected to make up over 25 percent of total federal outlays (table 1-2).

Moreover, the same phenomenon plays out in state capitols. Medicaid, which is a joint federal-state program, is the fastest-growing item in state budgets and threatens to displace other state spending. The federal matching formula, which makes each additional state Medicaid dollar cost the state 50 cents or less, adds to the incentives for spending growth. In 2004 Medicaid represented on average 16.9 percent of states' general

Table 1-2. *Increasing Health Entitlement Program Share of Federal Outlays, 1970–2010*

Percentage of federal outlays

<i>Program</i>	<i>1970</i>	<i>1980</i>	<i>1990</i>	<i>2000</i>	<i>2010</i>
Medicaid	1.6	2.3	3.2	6.5	10.5
Medicare	3.6	5.6	8.7	11.9	15.7
Total	5.2	7.9	11.9	18.4	26.2

Source: Congressional Budget Office, “A 125-Year Picture of the Federal Government’s Share of the Economy, 1950 to 2075,” Long-Range Fiscal Policy Brief no. 1 (CBO: June 14, 2002, revised July 3, 2002).

fund expenditures, making it the second highest such expenditure behind elementary and secondary education (figure 1-5).

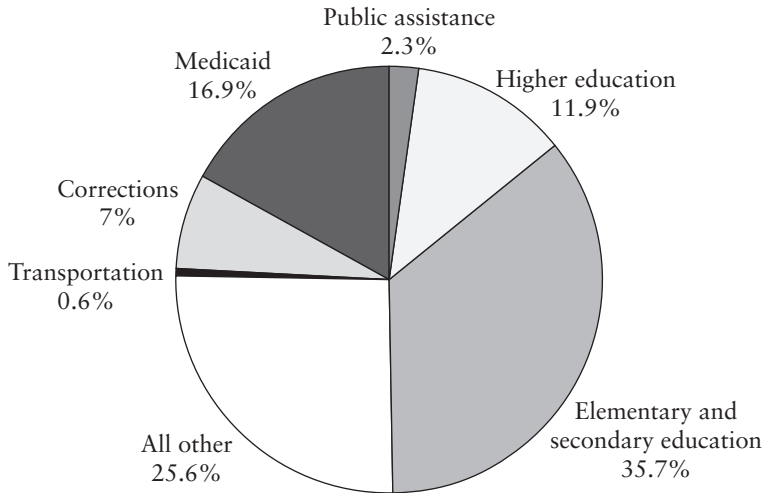
In addition to Medicare and Medicaid, other federal health programs face spending pressures. These programs include the health programs of the Department of Defense and the Veterans Administration (VA), research programs of the National Institutes of Health (NIH), and public health programs, such as the Centers for Disease Control and Prevention (see figure 1-4). Increasing demand for VA health care by veterans has led to cost overruns, and the rising cost of health care for the military is also a concern. After doubling NIH funding levels in the past few years, the recent proposal for level funding has been criticized as unduly restricting federal health research. Funding for studies of the effectiveness of health care services has been modest (compared with the cost of health care), despite the growing realization that public and private health insurance pays for both effective and ineffective treatments.

Moreover, not all federal subsidies for health care involve federal spending. Subsidies administered through the tax system place considerable pressure on the revenue side of the budget. The exclusion from income and payroll taxes of employer contributions for health insurance premiums represented more than \$225 billion in forgone tax revenues in 2006.<sup>15</sup> These tax preferences are in effect entitlements, automatically increasing as health costs rise without explicit discussion or decisions by policymakers.

## Projections of Federal Health Care Spending

Projections of past trends show spending for the three biggest federal entitlements—Social Security, Medicare, and Medicaid—rising rapidly in the

Figure 1-5. *General Fund Expenditures, 2004*



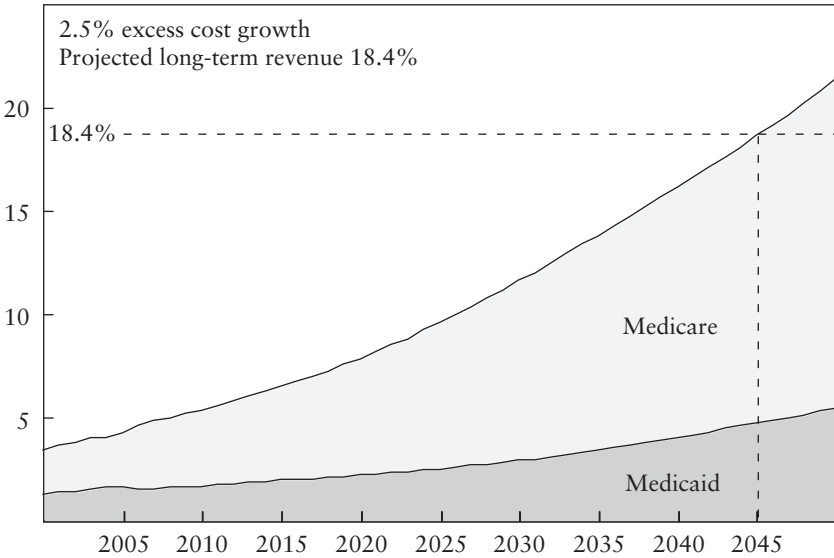
Source: National Association of State Budget Officers, “State Expenditure Report 2004” (Washington, 2005).

future.<sup>16</sup> Since these programs reflect promises to the elderly, the primary reason for their projected growth is often assumed to be demographic: that is, the retirement of the large baby boom population and lengthening life expectancy. However, demographics actually account for a fairly small part of the anticipated increases. The growth of Social Security spending—which is dominated by demographic changes—is projected to be relatively modest and temporary compared with projected growth of health care entitlements. If all benefits promised to current and future beneficiaries under Social Security were paid, spending under the program would rise from about 4 percent of GDP to about 6 percent and then level off as the baby-boom generation passes from the scene. Medicaid and Medicare, by contrast, are projected to continue to grow faster than Social Security and faster than federal revenues. How much faster depends on assumptions about the extent to which the growth in health spending nationally exceeds the growth in total spending.

Over the last four decades health spending has grown about 2.5 percentage points faster than the economy.<sup>17</sup> If these excess growth rates continue, Medicare and Medicaid alone would exceed the historic average of

Figure 1-6. *Federal Health Programs Projected to Absorb Almost All Revenues by 2045*

Percentage of GDP



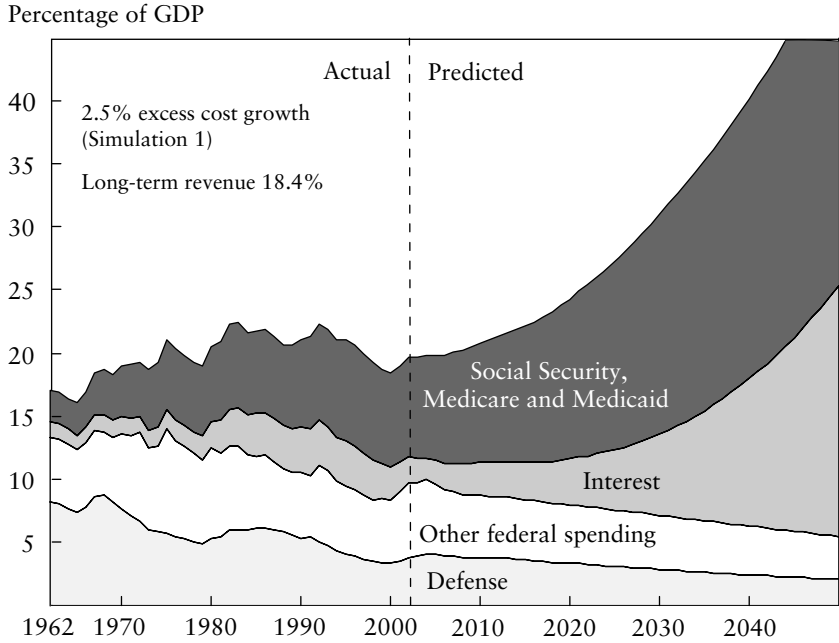
Source: Congressional Budget Office, "The Long-Term Budget Outlook" (December 2005), Appendix: Scenario 1.

total federal revenues sometime in the 2040s (figure 1-6). Although health spending slowed relative to GDP during the mid-1990s, the growth of National Health Expenditures (NHE) accelerated compared with GDP growth at the start of the twenty-first century, with an average differential of 3.3 percentage points between 2000 and 2004.<sup>18</sup>

As long as health spending is growing faster than other spending, the share of GDP devoted to health will rise. However, if the rate of excess health spending were less than the historical average—say 2 percentage points faster or 1.5 percentage points faster than GDP growth—pressure on the federal budget would be less. Slowing down health spending growth would make it far easier to finance the promises made to seniors under Medicare and Medicaid. One objective of this volume is to explore policies that could make such a slowdown a reality.

Other purchasers of health care services will also face rising costs if current trends continue, and that will have further consequences for the

Figure 1-7. *CBO Historical and Projected Components*



Source: CBO, "The Long-Term Budget Outlook."

budget. Employers will see escalating health costs for active employees and retirees, which translates into ever-larger tax expenditures. States also will face serious budget crunches attributable to Medicaid and state-only health programs (including public health programs).

### Why Federal Health Care Spending Increases are Unsustainable

The increase in federal health care spending is not new. Indeed, since the mid-1960s, when Medicare and Medicaid were enacted, health spending has been growing faster than other spending. As may be seen in figure 1-7, the three major entitlements have risen rapidly as a share of GDP, while the share of other spending has declined. The fact that defense spending fell as the cold war wound down facilitated increases in the major entitlement programs without increases in total spending as a share of GDP.

But projected increases in health spending cannot be accommodated by cutting other spending—there simply is not enough other spending left. Nor can increases in health spending of the projected magnitudes be financed by continuous borrowing or continuous tax increases. Large sustained deficits will require devoting larger and larger portions of federal revenue just to servicing federal debt. Upward pressure on interest rates will retard economic growth. Policies intended to reduce those deficits may have their own adverse economic side effects. Big tax increases might increase revenues initially, but they can also discourage work and investment, which could have negative long-term consequences. Poorly designed program reductions might only shift the burden of health spending away from the federal government to other payers, rather than increasing the efficiency of the health system.

Policymakers cannot simply tax their way out of the problem. While taxes may well rise to subsidize the health care of a growing cohort of older and low-income people, they cannot rise continuously to cover a permanent excess of health spending growth over revenues. Similarly, policymakers cannot simply shift the excess cost burden to states or to private payers, who will also face rising health costs and limited resources. As a society we must seek ways to slow the growth of federal health care spending while promoting better value for that expenditure. A plausible approach is to use the leverage of federal spending and influence to transform the whole health care system in ways that lead to more cost-effective spending, better care, and a slower rate of spending growth.

## **Turning Crisis into Opportunity**

Rising federal spending for health care creates a looming budget crisis that cannot be resolved with conventional tools. However, it also creates an opportunity to reform the whole national health system in ways that make it more efficient and effective. The realization that federal health spending is indeed exploding and cannot easily be cut without exacerbating pressure on the nonfederal sector may change the political dynamic and the system's tolerance for change. In the next chapter we explore options for reforming federal programs in ways that will put the whole health care system onto a more sustainable track.

## Notes

1. Office of Management and Budget, *Budget of the United States Government: Fiscal Year 2006* (Government Printing Office, 2006), Historical Tables.

2. Kaiser Commission on Medicaid and Uninsured estimates, in Diane Rowland, “Medicaid at Forty,” *Health Care Financing Review* 27 (Winter 2005-2006): 63–77.

3. Office of Management and Budget, Historical Tables.

4. Office of Management and Budget, Historical Tables; U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Office of the Actuary, “National Health Expenditures Projections: 2005–2015” ([www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2005.pdf](http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2005.pdf)).

5. Congressional Budget Office, “The Long-Term Budget Outlook” (December 2005), Appendix: Scenario 1: Higher Spending/Lower Revenues.

6. U.S. Census Bureau, “Income, Poverty, and Health Insurance Coverage in the United States, 2005,” *Current Population Reports* (GPO, August 2006): 20–21.

7. Organization for Economic Cooperation and Development, *Health at a Glance: OECD Indicators 2005* (Paris, 2005).

8. Gerard F. Anderson, Bianca K. Frogner, Roger A. Johns, and Uwe E. Reinhardt, “Health Care Spending and Use of Information Technology in OECD Countries,” *Health Affairs* 25 (May-June 2006): 819–31.

9. Gerard F. Anderson, Peter S. Hussey, Bianca K. Frogner, and Hugh R. Waters, “Health Spending in the United States and the Rest of the Industrialized World,” *Health Affairs* 24 (July-August 2005): 903–14.

10. Uwe E. Reinhardt, Peter S. Hussey, and Gerard F. Anderson, “U.S. Health Care Spending in an International Context,” *Health Affairs* 23 (May-June 2004): 10–25; Anderson and others, “Health Care Spending and Use of Information Technology.”

11. Karen Davis, and Barbara S. Cooper of the Commonwealth Fund, “American Health Care: Why So Costly?” Testimony before the Senate Appropriations Subcommittee, June 11, 2003.

12. These fifteen countries—Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, and the United Kingdom—are, on average, wealthier and have more developed economies than the ten countries that joined the EU in 2004.

13. OECD, *Health at a Glance: OECD Indicators 2005*.

14. Medicaid is a means-tested program that benefits low-income children (and some parents), the elderly, and disabled adults. Although children make up 48 percent of Medicaid enrollees and seniors only 9 percent, according to government data for 2004, seniors take up 26 percent of Medicaid expenditures, while children take up only 19 percent of expenditures. See Kaiser Commission on Medicaid and the Uninsured estimates in Diane Rowland, “Medicaid at Forty.”

15. Personal communication with John Sheils. Estimation methodology based on John Sheils and Randall Haught, “The Cost of Tax-Exempt Health Benefits in 2004,” *Health Affairs* web exclusive, February 25, 2004: W4-106–W4-112.

16. CBO, “The Long-Term Budget Outlook.”

17. “The Long-Term Budget Outlook” prepared by the Congressional Budget Office in 2005 documents an average annual growth in national health expenditures that was 2.6 percentage points higher than growth of the economy as a whole between 1960 and 2003.

18. National Health Expenditures stayed stable as a percentage of GDP from 1993 to 2000, then began rising rapidly again. See Centers for Medicare & Medicaid Services, “National Health Care Expenditures Projections: 2005–2015.”