



Congressional Budget Office

Federal Health Care Spending: Why Is It Growing? What Could Be Done About It?

Presentation to the University of Pennsylvania Wharton School

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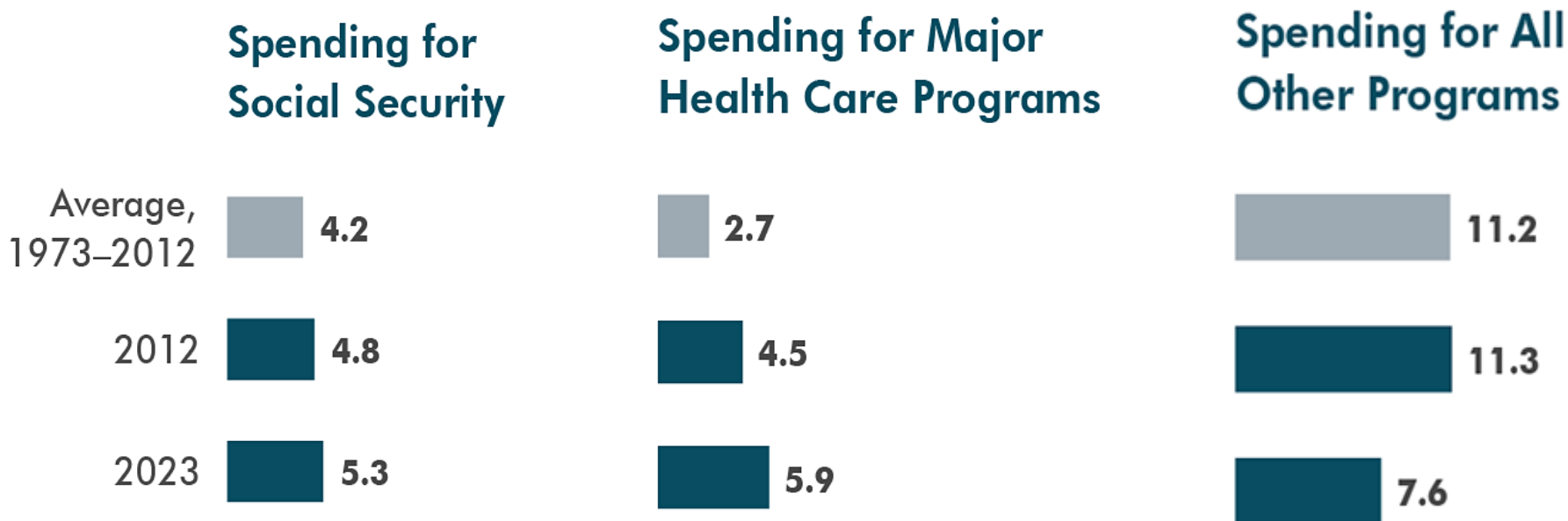
Director

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The Challenge

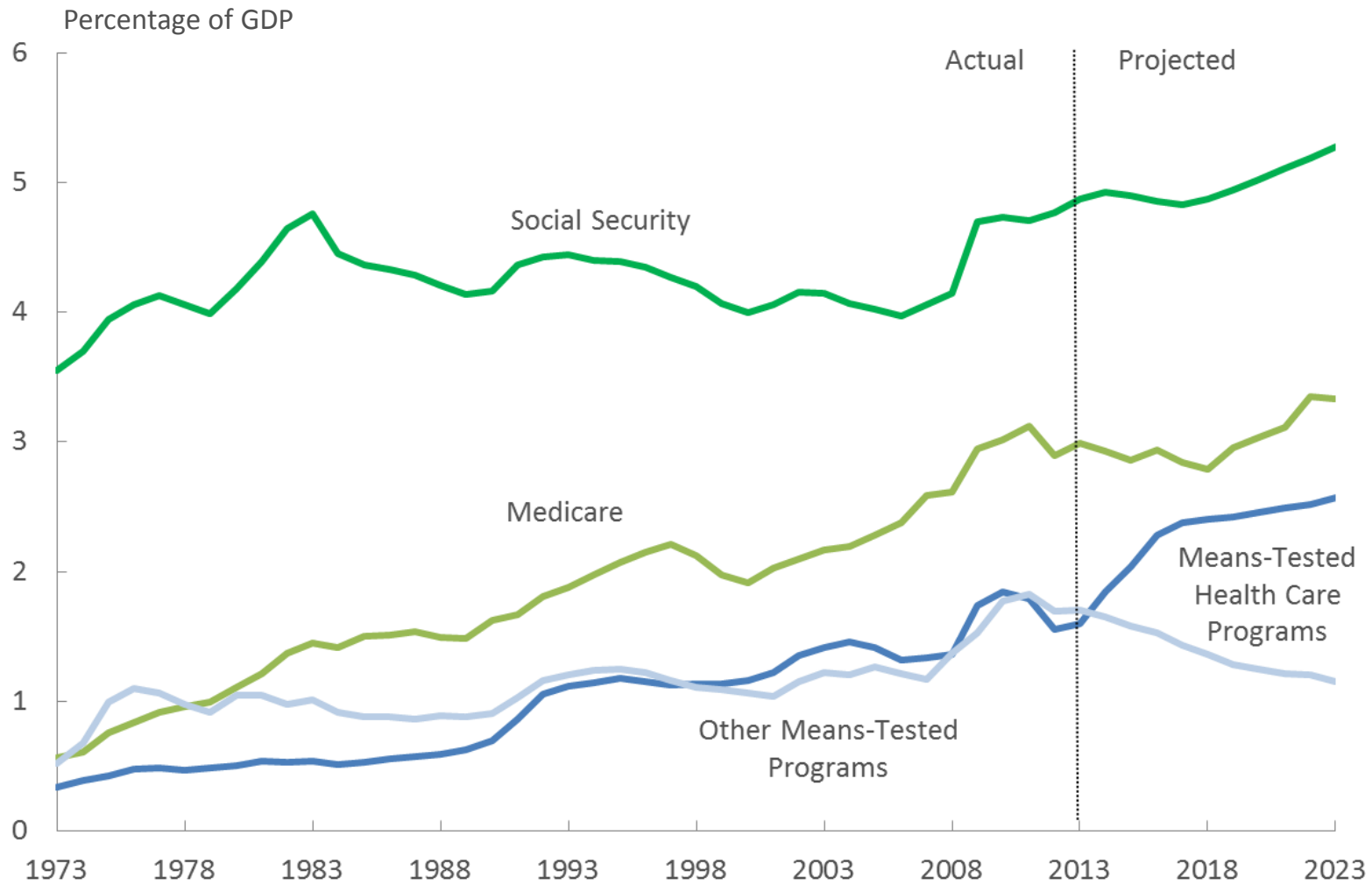
Federal Spending for Health Care Programs Is Growing Much Faster Than Other Federal Spending and the Economy as a Whole

Percentage of GDP



Major health care programs are Medicare, Medicaid, the Children's Health Insurance Program, and subsidies offered through new health insurance exchanges and related spending. Data reflect recent revisions by the Bureau of Economic Analysis to estimates of gross domestic product (GDP) in past years and CBO's extrapolation of those revisions to projected future GDP.

Federal Spending for Health Care Programs Has Grown Faster Than Federal Spending for Other Programs With Similar Beneficiaries



Data reflect recent revisions by the Bureau of Economic Analysis to estimates of gross domestic product (GDP) in past years and CBO's extrapolation of those revisions to projected future GDP.

Medicare spending is net of offsetting receipts.

Those Projections Incorporate CBO's Reaction to the Slowdown in Health Care Spending During the Past Several Years

Revisions to CBO's Projections of Medicare and Medicaid Spending Between March 2010 and May 2013 Apart From Changes Due to Overall Economic Conditions and Legislation:

	Medicare ^a		Medicaid ^b	
	Technical Revisions (Billions of dollars)	Percent Change	Technical Revisions (Billions of dollars)	Percent Change
2013	-45	-8%	-17	-6%
2020	-137	-15%	-85	-16%
Total 2010-2020	-785	-11%	-445	-11%

a. Medicare spending is net of offsetting receipts.

b. The comparison for the Medicaid baseline is to August 2010, as the March 2010 baseline did not include the effects of the Affordable Care Act (ACA). Only minor changes were made in that August baseline beyond those related to the ACA.

Federal Spending for Major Health Care Programs Will Increase Relative to GDP for Three Main Reasons

Percentage of Projected Growth in Federal Spending for Major Health Care Programs Through:

	2023	2038
Population Aging	21	35
Expansion of Federal Subsidies for Health Insurance Through Medicaid and Exchanges	53	26
Rising Costs of Health Care Per Person (“Excess Cost Growth”)	26	40

Major health care programs are Medicare, Medicaid, the Children's Health Insurance Program, and subsidies offered through new health insurance exchanges and related spending.

Even After the Affordable Care Act Is Fully Implemented, Most Federal Dollars for Health Care Will Support Care for Older People

CBO's projections for 2023:

- Net federal spending for Medicare: \$903 billion
- Federal spending for Medicaid and CHIP: \$578 billion
- Federal spending for exchange subsidies and related items: \$134 billion

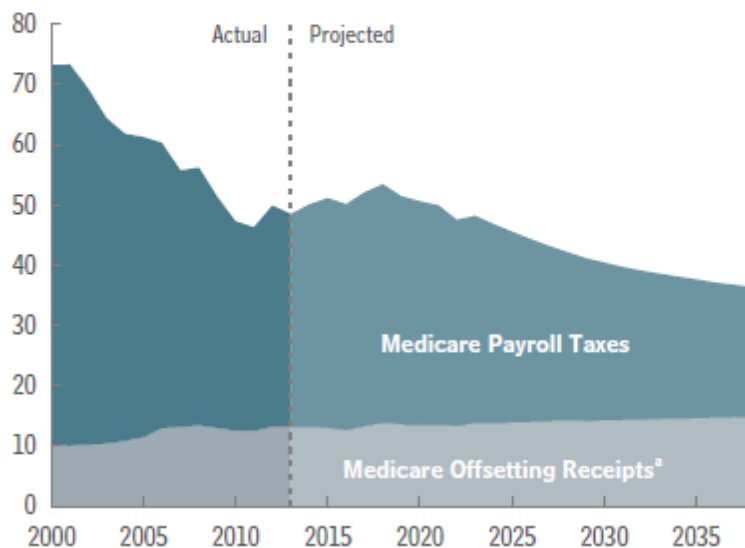
Of all federal spending for the major health care programs projected for 2023:

- Three-fifths will finance care for people over age 65;
- One-fifth will finance care for the blind and disabled; and
- One-fifth will finance care for able-bodied nonelderly people.

Payroll Taxes and Premiums Cover Only Part of the Overall Costs of Medicare

Medicare Payroll Taxes and Offsetting Receipts Under CBO's Extended Baseline

(Percentage of gross Medicare benefits)



Median Lifetime Medicare Payroll Taxes and Benefits for Various Cohorts, by Decade of Birth

(Thousands of 2013 dollars)



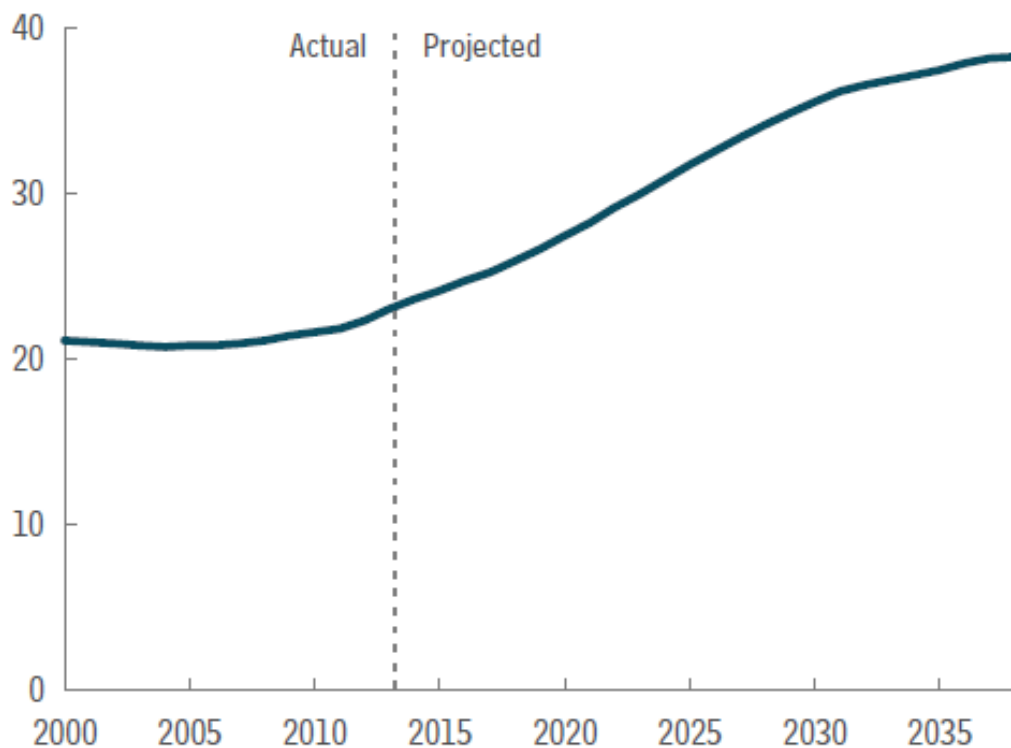
a. Premium payments for beneficiaries and amounts paid by states from savings on Medicaid's prescription drug costs. The extended baseline generally adheres closely to current law, following CBO's 10-year baseline budget projections through 2023 and then extending the baseline concept for the rest of the long-term projection period. The benefits shown in the right panel are net of premiums paid by beneficiaries. The amounts shown in that panel are present values, adjusted to remove the effects of inflation and discounted to the value for beneficiaries at age 65. For more information, see CBO's *The 2013 Long-Term Budget Outlook* (November 2013).

Population Aging

The Share of the Population Age 65 or Older Is Rising Substantially

Population Age 65 or Older as a Share of the Population Ages 20 to 64

(Percent)



For more information, see CBO's *The 2013 Long-Term Budget Outlook* (November 2013).

What Could Be Done About Growth in Federal Health Care Spending Due to Population Aging?

Nothing. Indeed, a central goal of policies regarding health and health care is to reduce disease, injury, and disability so that people are healthier and live longer. The more successful our policies are, the more population aging we will have. Hence, efforts to reduce federal health care spending need to be directed elsewhere.

Expansion of Federal Subsidies for Health Insurance

A caveat: This material draws on CBO's projections from May, with an update in July in response to regulatory changes. We have not updated our projections based on new information this fall.

We Estimate that ACA Coverage Provisions Will Have a Significant Effect on Some People but Little Effect on Most People: Part 1

CBO and JCT's projections for 2023 for people under age 65 relative to prior law:

- About 25 million more people will have health insurance, as the number of uninsured will fall from 56 million to 31 million.
- Of those 31 million:
 - About 30% will be unauthorized immigrants and thereby ineligible for almost all Medicaid benefits and exchange subsidies;
 - About 20% will be eligible for Medicaid but choose not to enroll;
 - About 5% will not be eligible for Medicaid because their state chose not to expand coverage; and
 - About 45% will have access to insurance through an employer or could buy it through an exchange or directly from an insurer.

JCT refers to the staff of the Joint Committee on Taxation.

We Estimate that ACA Coverage Provisions Will Have a Significant Effect on Some People but Little Effect on Most People: Part 2

CBO and JCT's projections for 2023 for people under age 65 relative to prior law:

- About 7 million fewer people will have employment-based health insurance. (That is the net decline: More people who would have had such insurance will not have it under the ACA, but others who would not have had such insurance will gain it under the ACA.)
- About 10 to 15 million people who would have bought insurance in the nongroup market without the ACA will face higher premiums before subsidies, on average, primarily because insurance policies will be required to cover a much larger share of health care costs. Some but not all of those people will receive subsidies through the exchanges.
- About 200 million other people who would have had employment-based health insurance or been covered by Medicaid without the ACA will have the same source of coverage and face similar costs for insurance (apart from any effects of the future excise tax on high-premium plans).

We Estimate that ACA Coverage Provisions Will Have a Significant Federal Cost That Will Be More Than Offset by ACA Spending Cuts and Revenue Increases

Projected federal cost of the ACA coverage provisions from 2014 to 2023

\$1.4 trillion

Projected impact on the deficit of the direct spending and revenue effects of *all* of the provisions of the ACA from 2013 to 2022*

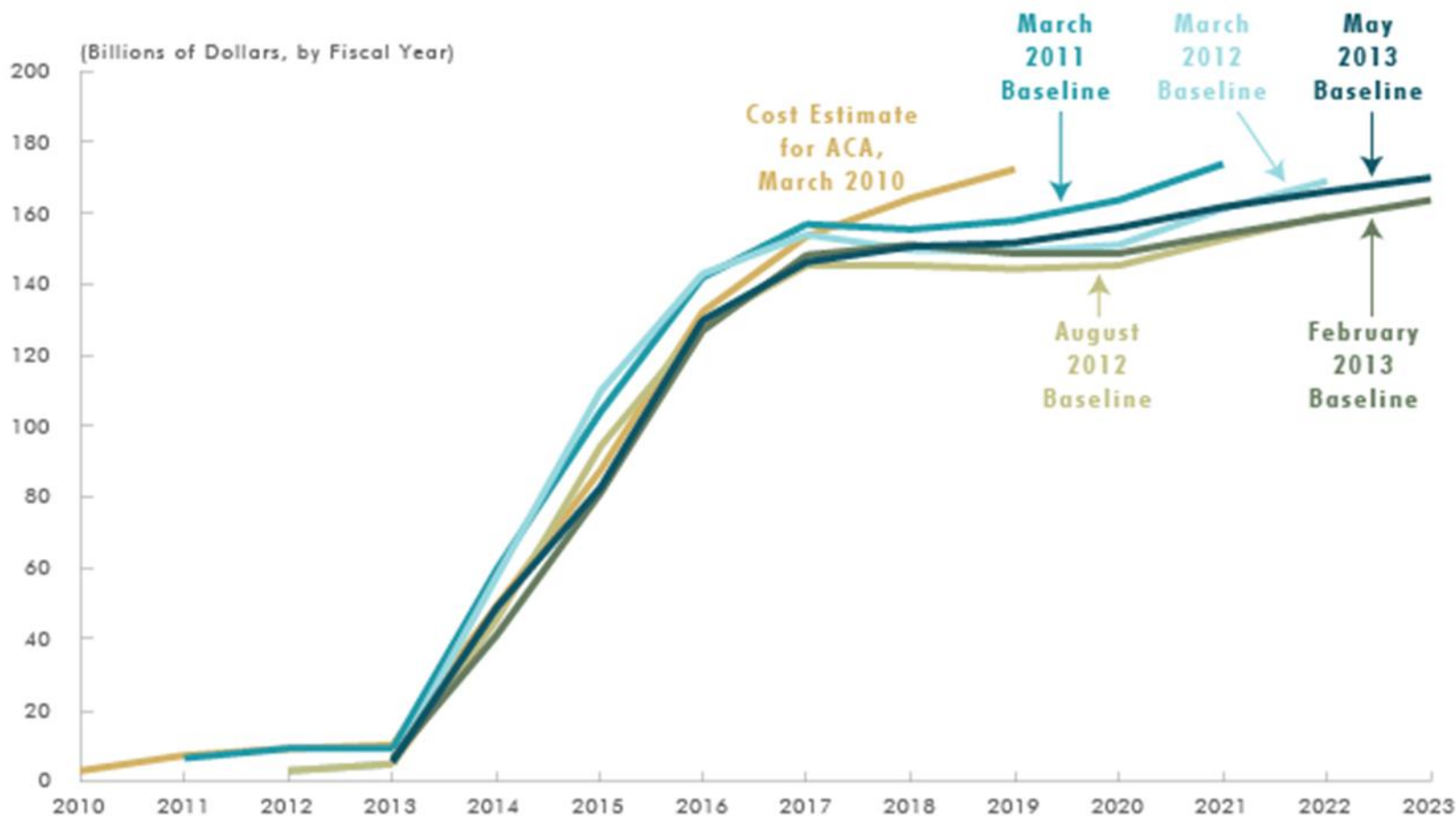
-\$109 billion

Projected impact on the deficit of those effects during the following decade—including “policies that might be difficult to sustain over a long period”

-½ percent of GDP

* Based on CBO and JCT’s July 2012 estimate of repeal, which is our most recent estimate for the overall legislation.

For Any Given Year, Our Estimate of the Cost of ACA Coverage Provisions Has Not Changed Much Since March 2010



What Could Be Done About Growth in Federal Health Care Spending Due to An Expansion of Federal Subsidies?

Lawmakers could roll back all or part of the expansion under the Affordable Care Act, or they could narrow the group of people eligible for other federal subsidies for health insurance or reduce the size of those subsidies. Such changes would reduce federal spending but would also leave the affected people to bear higher costs, to lose health insurance in some cases, and to receive less health care in some cases.

CBO analyzed several possible approaches of this sort in *Options for Reducing the Deficit: 2014 to 2023*.

For more information, see CBO's *Options for Reducing the Deficit: 2014 to 2023* (November 2013).

CBO Examined Some Illustrative Reductions in Federal Subsidies for Health Insurance

For example, CBO and JCT's estimates of the savings for the federal budget between 2015 and 2023 from:

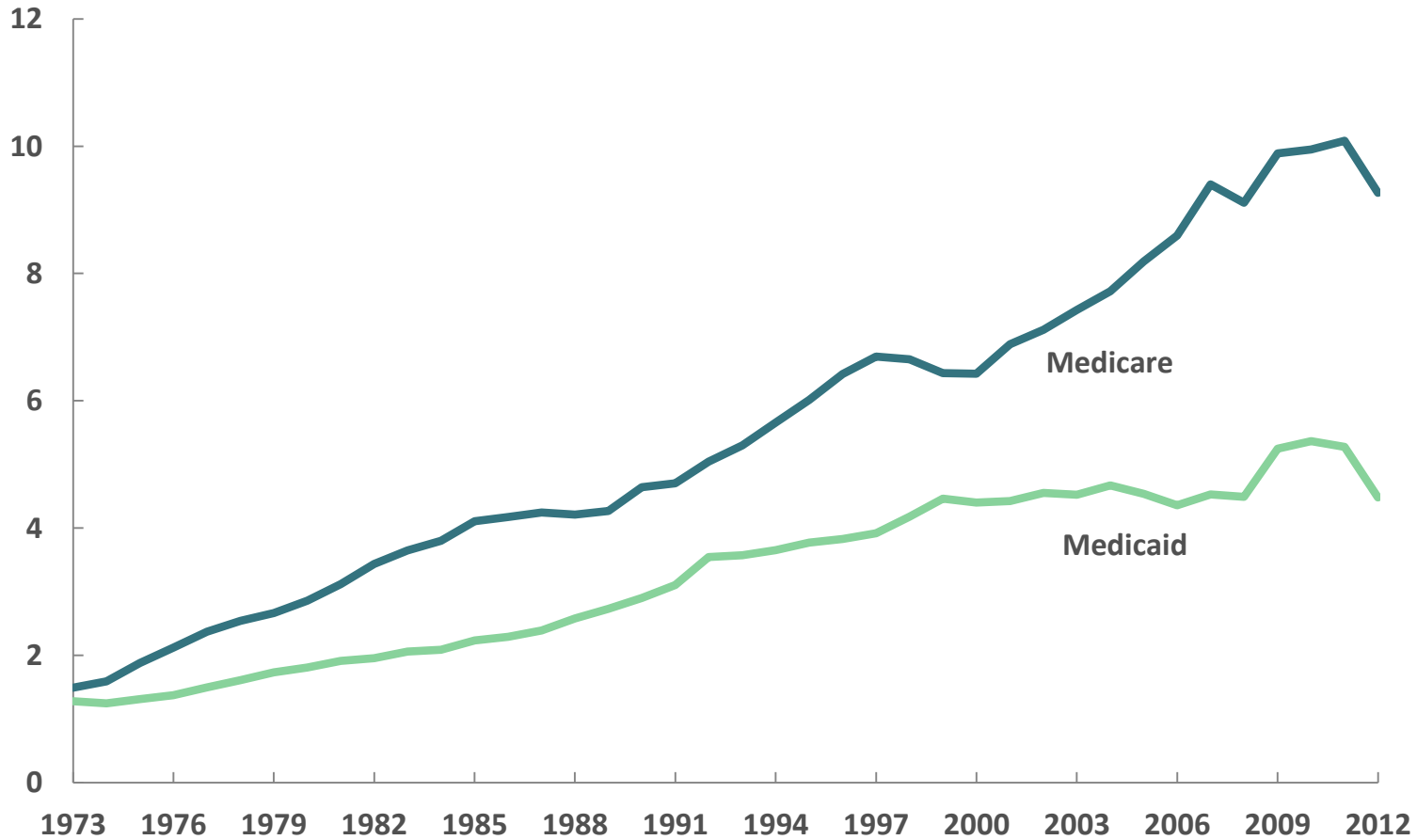
- Repealing the coverage provisions of the Affordable Care Act: about \$1.4 trillion (\$170 billion in 2023)
- Eliminating exchange subsidies for people with income over 300 percent of the poverty level: \$109 billion (\$15 billion in 2023)
- Raising the Medicare eligibility age to 67: \$19 billion (\$7 billion in 2023)
- Increasing premiums for Medicare Parts B and D from about 25 percent of costs to 35 percent: \$274 billion (\$56 billion in 2023)

For more information, see CBO's *Options for Reducing the Deficit: 2014 to 2023* (November 2013).

Rising Costs of Health Care Per Person

Health Care Costs per Person Have Risen Significantly Faster Than Inflation

(Average federal spending per participant, in thousands of 2012 dollars)



Medicare spending is net of offsetting receipts.

What Could Be Done About Growth in Federal Health Care Spending Due to Rising Costs of Health Care Per Person?

CBO analyzed a broad range of possible approaches in *Options for Reducing the Deficit: 2014 to 2023*.

Five of those approaches are reviewed here:

- Improving the health of the population
- Paying Medicare providers in different ways
- Increasing beneficiaries' out-of-pocket costs in Medicare
- Creating a competitive market for private insurers in Medicare
- Capping the amount that each state receives for Medicaid

Other approaches in our report include changing the tax treatment of employment-based health insurance, adding a public plan to the exchanges, limiting medical malpractice claims, and more.

Changes in Federal Health Care Policy Could Have Many Different Types of Effects

On the federal budget (including changes in sources of insurance coverage)

On state governments' budgets

On beneficiaries' costs

On health care (reflecting providers' and beneficiaries' behavior)

On people's health

Policy Initiatives That Improved Health Would Help People but Might Not Produce Savings for the Federal Budget

The links between a policy aimed at improving health and its budgetary effects:

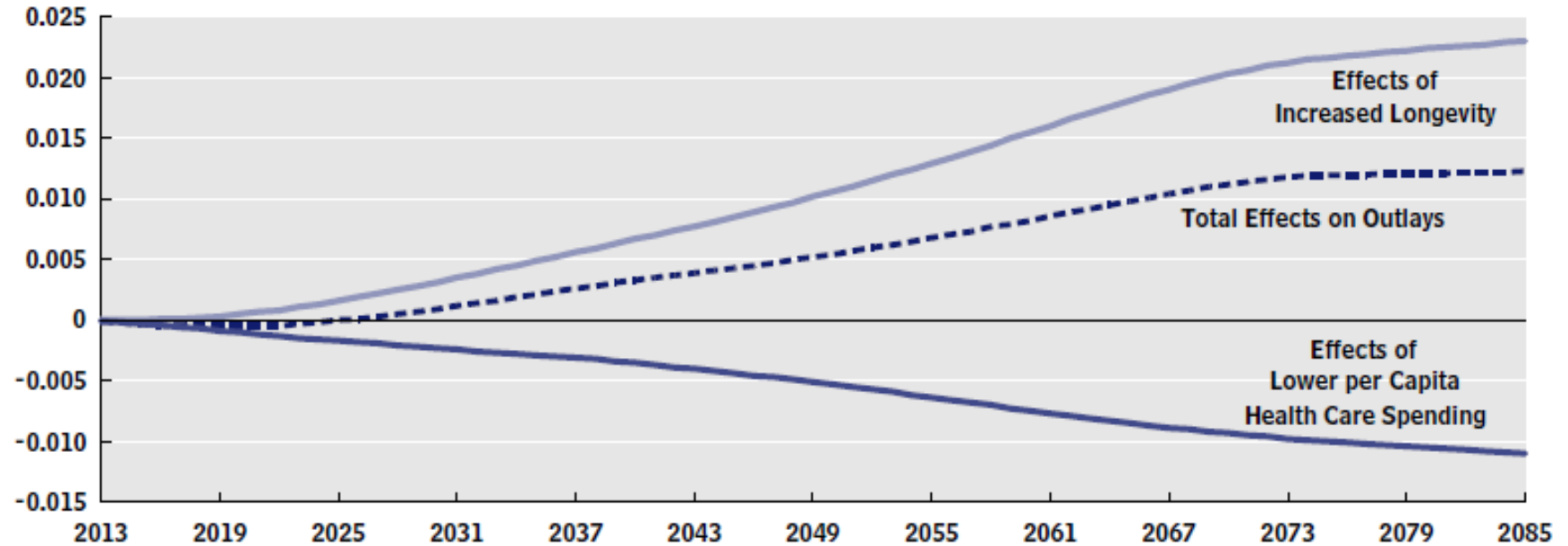
- The policy would need to change people’s behavior—which could be difficult.
- Changes in behavior would need to improve people’s health—which could take some time.
- Improvements in health would need to reduce health care costs—which could also take some time.

The budgetary effects depend on the combination of:

- Any reduction in annual health care costs per person,
- Any increase in tax revenues from better health, and
- Any increase in costs for Social Security and health care benefits from people living longer,
- Any budgetary cost or savings of the policy itself.

CBO Examined an Illustrative Increase in Cigarette Tax, Including Effects on Outlays (Shown Here) and Revenues (Not Shown)

(Percentage of gross domestic product)



Source: Congressional Budget Office.

Notes: The illustrative tax increase modeled in this analysis is a 50-cent per pack rise in the federal excise tax on cigarettes and small cigars, beginning in 2013 and indexed each year thereafter to keep pace with inflation (and, after 2021, to keep pace with the growth of inflation-adjusted income).

The outlay effects of the tax increase all result from improvements in health. The effects shown here apply only to mandatory outlays.

For more information, see CBO's *Options for Reducing the Deficit: 2014 to 2023* (November 2013) and *Raising the Excise Tax on Cigarettes: Effects on Health and the Federal Budget* (June 2012).

Paying Medicare Providers for “Bundles” of Services Could Enhance Care Coordination but Would Achieve Federal Savings Only If Payment Amounts Were Restrained

Currently, most payments for health care involve separate payments for each service. Instead, payments could be made for groups of related services—such as all or most of the services received from various providers related to a particular disease or treatment over a defined period.

Reducing federal spending through bundled payments would require providers to be paid less in total than under current law—either because they would be delivering fewer and less complex services or because they would be receiving less money per service. (Allocating payments among providers would be one of the challenges.)

CBO Examined Two Illustrative Versions of Bundling Medicare Payments

CBO's estimates of the savings for the federal budget between 2017 and 2023 from bundling for certain types of episodes:

- Bundling payments provided by hospitals and doctors during an initial hospital stay and any related readmissions within 30 days, with payments cut 3% below current law: \$17 billion (\$4 billion in 2023)
- Bundling payments provided by hospitals and doctors during an initial hospital stay and any related readmissions plus any postacute care (such as in skilled nursing facilities) within 90 days, with payments cut 5% below current law: \$47 billion (\$10 billion in 2023)

For more information, see CBO's *Options for Reducing the Deficit: 2014 to 2023* (November 2013).

Making Medicare Beneficiaries Bear More Costs Out of Pocket Would Reduce Health Care Spending but Also Could Impose Burdens on Some Beneficiaries

For people with health insurance, payments generally consist of premiums and cost sharing. The amount of cost sharing paid by an enrollee depends on the deductible, catastrophic cap, and share of costs paid between the deductible and catastrophic cap—and on a person’s use of health care.

Medicare has separate deductibles for care from hospitals and doctors, and it has no catastrophic cap. In those ways, it is more complicated and provides less protection from financial risk than many private insurance plans. However, most Medicare enrollees have supplemental coverage (such as “medigap”) that reduces cost sharing.

CBO Examined Three Illustrative Changes in Medicare Cost Sharing

CBO's estimates of the savings for the federal budget between 2015 and 2023 from:

- Changing Medicare's cost sharing in certain ways: \$52 billion (\$7 billion in 2023)
- Restricting medigap policies in certain ways: \$58 billion (\$9 billion in 2023)
- Changing Medicare's cost sharing and restricting medigap in certain ways: \$114 billion (\$16 billion in 2023)

Subjecting Medicare beneficiaries to more cost sharing would reduce their use of medical care—including both effective and less effective care. The third alternative has a cap on out-of-pocket spending, so enrollees who use a lot of care would pay less in cost sharing than under current law, but enrollees who use a small amount of care would pay more.

For more information, see CBO's *Options for Reducing the Deficit: 2014 to 2023* (November 2013).

Adopting a Premium Support System for Medicare Could Reduce Federal Spending but Also Could Raise Costs for Beneficiaries

A premium support system would have beneficiaries buy insurance coverage from competing plans—potentially including the existing fee-for-service (FFS) program—with the federal government paying part of the cost of coverage. This could be viewed as an expansion of the existing Medicare Advantage program (currently used by about 30 percent of Medicare beneficiaries) with different rules to strengthen competitive forces.

There are many crucial design choices, including setting the formula for the federal contribution, determining whether the FFS program would be included as a competing plan, setting eligibility rules, and specifying features that would influence beneficiaries' choices among plans.

CBO Examined Four Illustrative Premium Support Systems

CBO's estimates of the savings for the federal budget between 2018 and 2023 (for certain specifications):

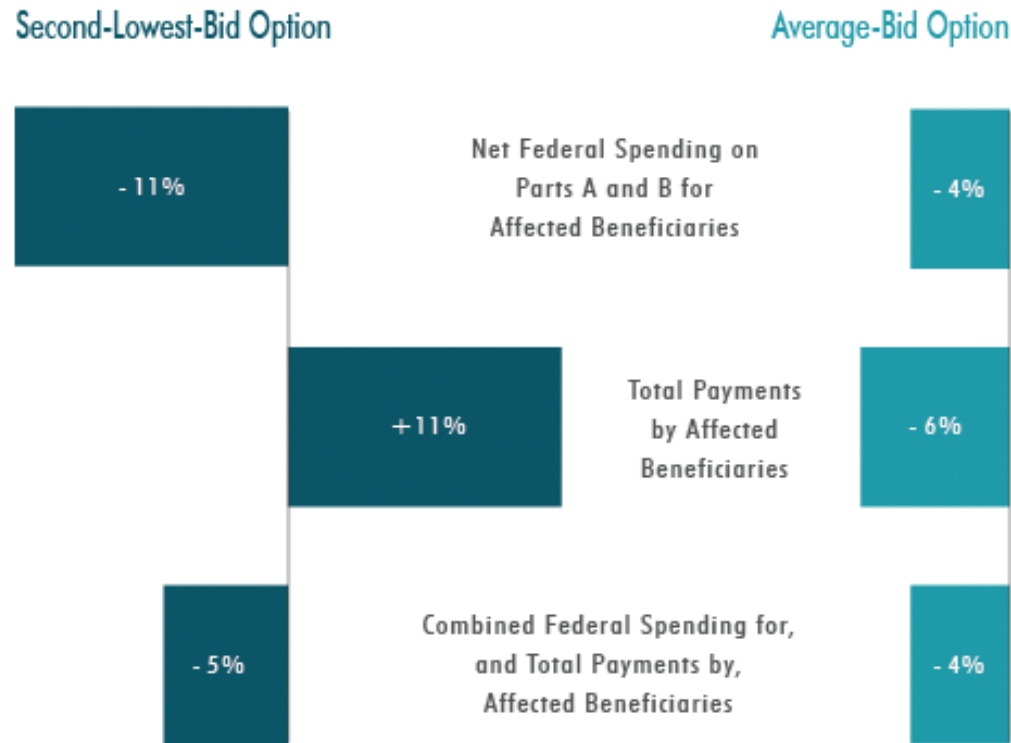
- Without grandfathering current enrollees:
 - Setting the federal contribution equal to the lower of the second-lowest private bid and the FFS bid: \$275 billion (\$56 billion in 2023)
 - Setting the federal contribution equal to the weighted average of all bids: \$69 billion (\$17 billion in 2023)

- With grandfathering current enrollees:
 - Setting the federal contribution equal to the lower of the second-lowest private bid and the FFS bid: \$61 billion (\$20 billion in 2023)
 - Setting the federal contribution equal to the weighted average of all bids: \$22 billion (\$7 billion in 2023)

For more information, see CBO's *Options for Reducing the Deficit: 2014 to 2023* (November 2013) and *A Premium Support System for Medicare: Analysis of Illustrative Options* (September 2013).

Effects of Illustrative Premium Support Systems on Spending for Medicare Benefits

Effects of Options on Spending for Medicare Benefits



For more information, see CBO's *A Premium Support System for Medicare: Analysis of Illustrative Options* (September 2013).

Capping the Amount That Each State Receives for Medicaid Could Reduce Federal Spending but Also Could Impose Burdens on States and Reduce Care for Beneficiaries

Currently, federal Medicaid funding is provided on an open-ended basis, so increases in the number of enrollees or in costs per enrollee automatically generate larger payments to states. Instead, Medicaid funding could be capped.

If the caps were set low enough to achieve substantial federal savings, they would shift substantial costs to states. Then states would have to commit more of their own revenues, reduce services offered or eligibility, cut payment rates for health care providers (although rates are already much lower, on average, than through Medicare or private insurance), deliver services more efficiently (which might be helped by giving states more flexibility), or some combination.

CBO Examined Four Illustrative Ways to Cap Payments to States for Medicaid

CBO's estimates of the savings for the federal budget between 2016 and 2023 from:

- Capping overall spending:
 - With growth of caps based on inflation: \$450 billion (\$106 billion in 2023)
 - With growth of caps based on growth of per capita national health expenditures: \$105 billion (\$20 billion in 2023)

- Capping spending per enrollee:
 - With growth of caps based on inflation: \$606 billion (\$124 billion in 2023)
 - With growth of caps based on growth of per capita national health expenditures: \$282 billion (\$46 billion in 2023)

Conclusion

Why Is Federal Health Care Spending Growing?

Federal health care spending is growing because of a combination of the aging of the population, an expansion of federal subsidies for health insurance, and rising health care costs per person.

What Could Be Done About the Growth of Federal Health Care Spending?

There are a number of policy options, but they all have disadvantages as well as advantages.

Reducing the number of people eligible for federal health care subsidies or the size of subsidies would be a straightforward way to reduce federal spending—but it also would cause the affected people to bear higher costs, to lose health insurance in some cases, and to receive less health care in some cases.

Restructuring federal payments in ways designed to reduce health care costs per person holds the promise of encouraging greater efficiency in the delivery of care or better choices about the use of care—but it also would present risks of the same shifting of costs and loss of access to insurance and care.