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CBO's Analysis of Health Care Spending and Policy Proposals

Presentation for staff of the U.S. Department of Commerce

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CBO's General Approach to Policy Analysis

CBO was created by the **Congressional Budget and Impoundment Control Act of 1974**. The agency started operating in February 1975.

CBO has about **230 full-time staff**, more than three-fourths of whom hold advanced degrees in economics, public policy, or related fields.

CBO provides **objective, nonpartisan** information to the Congress.

The agency makes **baseline projections** of federal spending, revenues, and deficits under current law.

CBO produces **estimates of the effects of changes in federal policies**, including:

- legislation being developed by Congressional committees; and
- conceptual proposals being discussed in the Congress or elsewhere.

CBO makes **no recommendations**.

CBO's estimates focus on the **next 10 years** but sometimes look out 20 years or more.

The estimates are meant to reflect the **middle of the distribution** of possible outcomes, and they incorporate **behavioral responses** to the extent feasible.

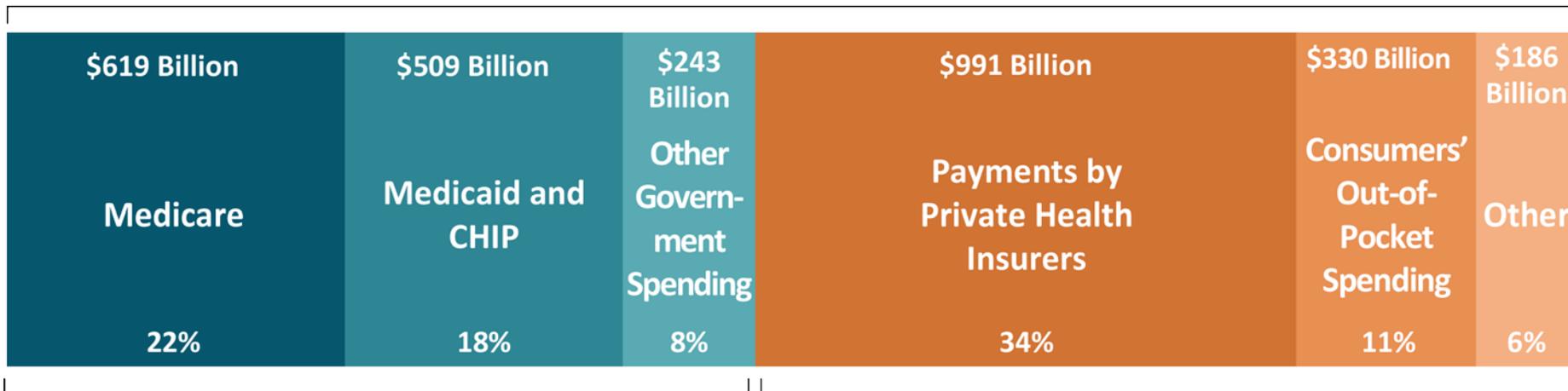
CBO's estimates use **whatever evidence can be brought to bear**, given available resources and time.

The estimates can **change in response to new analysis** by CBO and others, and the agency **provides explanations** of the analysis to the extent feasible.

CBO's Analysis of Federal Spending on Health Care

National Spending for Health Care, 2014

Total Health Care Spending: \$2.9 Trillion

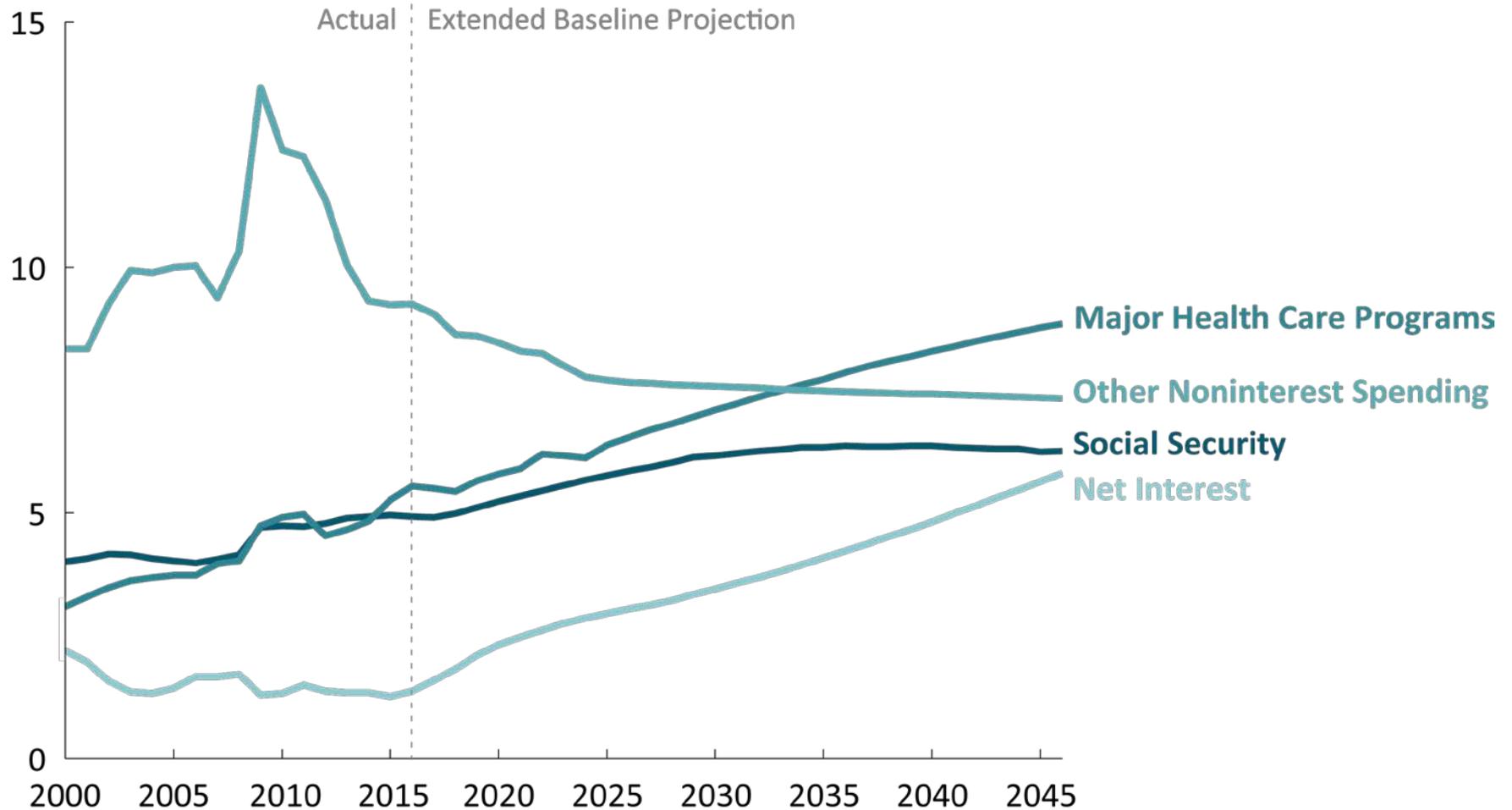


Public Spending: \$1.4 Trillion, or 48 Percent

Private Spending: \$1.5 Trillion, or 52 Percent

Components of Federal Spending

Percentage of Gross Domestic Product



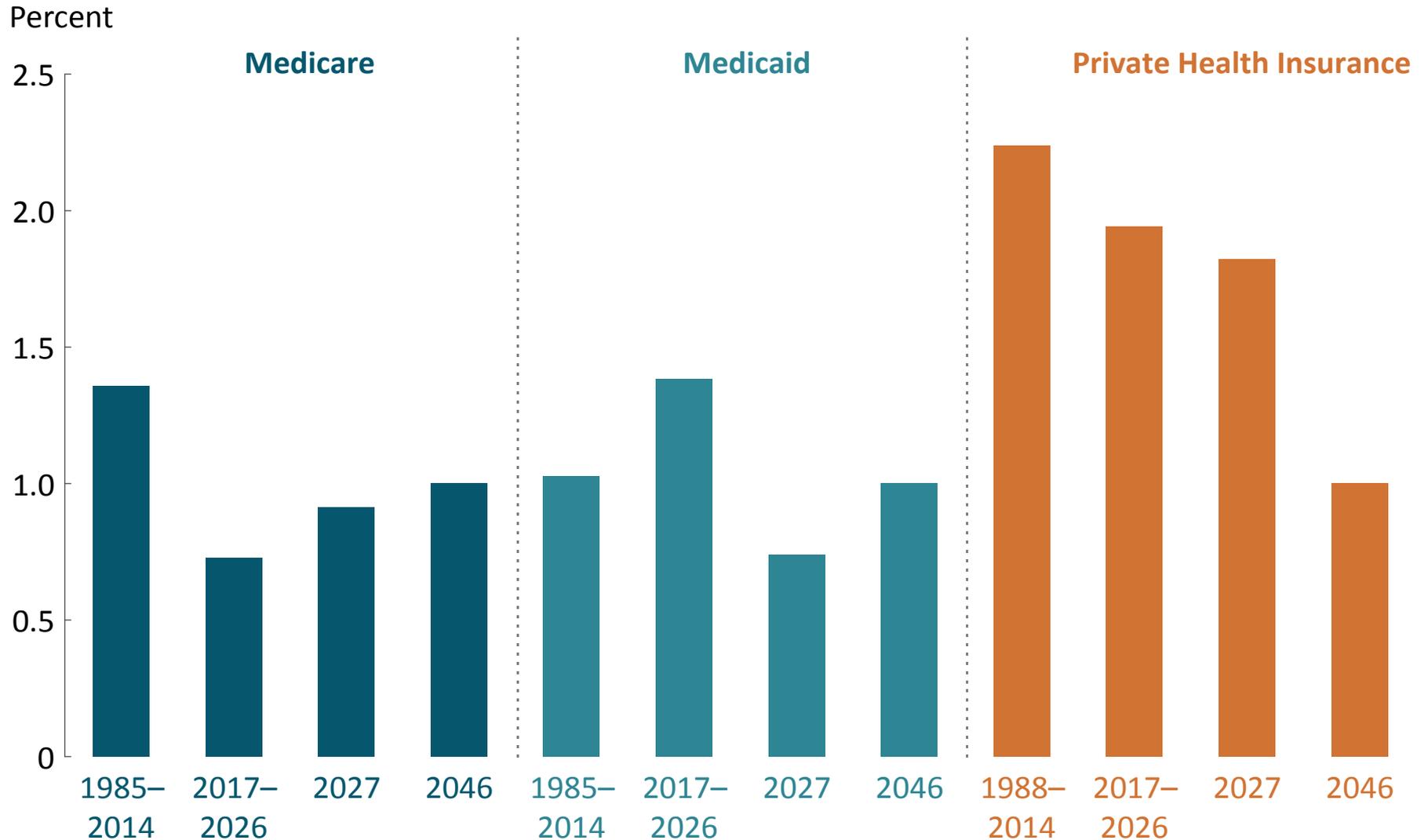
“Major health care programs” consists of spending on Medicare (net of offsetting receipts), Medicaid, and the Children's Health Insurance Program, as well as outlays to subsidize health insurance purchased through the marketplaces established under the Affordable Care Act and related spending.

CBO expects that, between 2016 and 2046, **gross federal spending** on major health care programs as a share of GDP will **increase by 4 percentage points**, from 6.1 percent to 10.1 percent.

1.8 percentage points come from **population aging**, mostly because aging makes more people eligible for Medicare and increases costs per enrollee.

2.2 percentage points come from **excess cost growth**, meaning that spending per beneficiary, adjusted for demographic changes, will grow more quickly than potential GDP per capita.

Estimated and Projected Rates of Excess Cost Growth in Spending for Health Care



Comparing CBO's Projections of Medicare's Fee Schedule Updates to Estimates of Price Inflation

Percentage Points

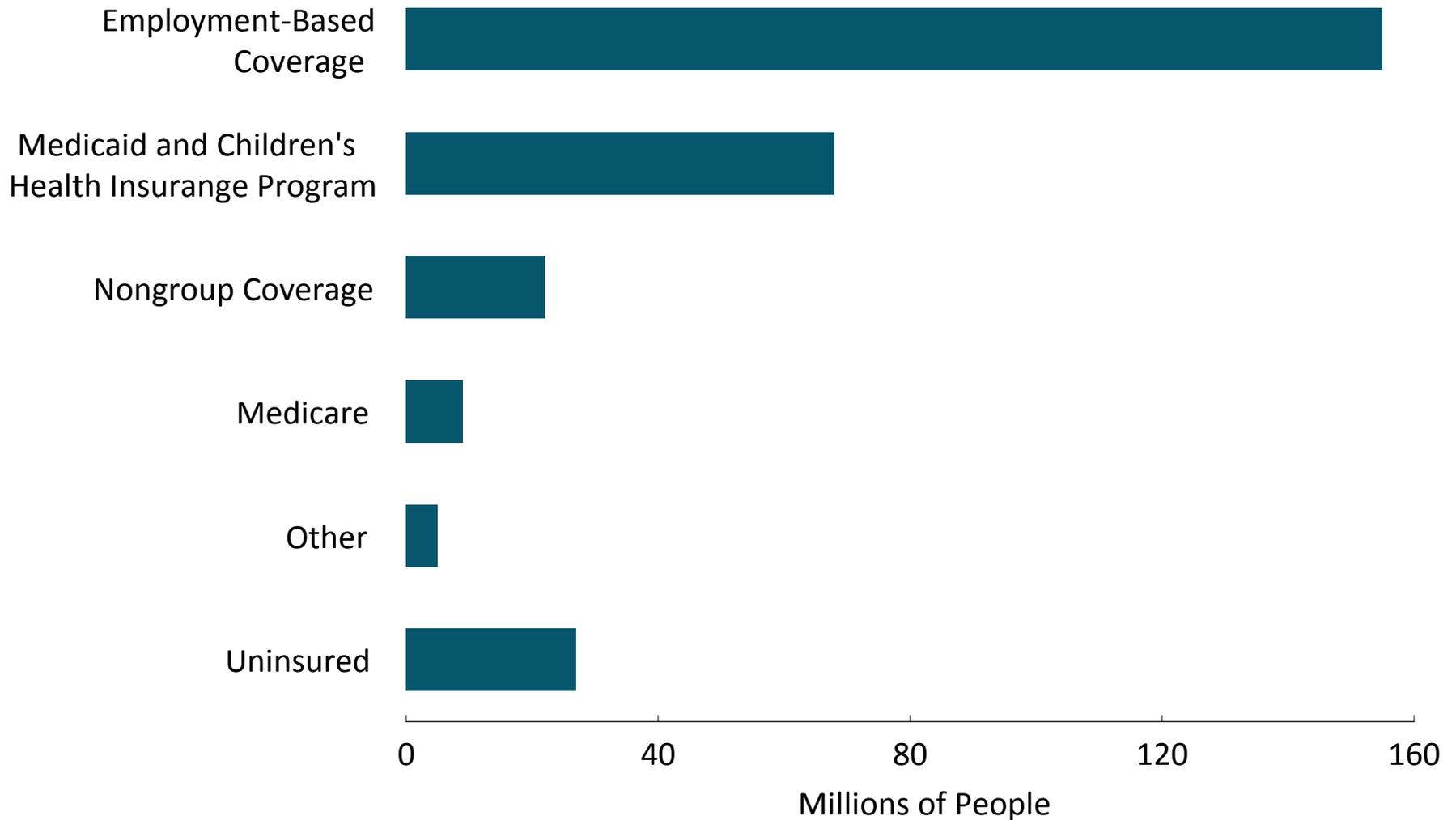
	2017	2020	2023	2026
Hospital Market Basket Increase ^a	2.7	3.2	3.1	3.0
Hospital Fee Schedule Update ^b	0.15	2.7	2.7	1.9
Physician Fee Schedule Update ^c	0.5	0.0	0.0	0.25 or 0.75
Consumer Price Index for Urban Consumers (by calendar year)	0.3	2.4	2.4	2.4

a. The market basket increase measures changes in the average prices of goods and services that hospitals use to provide care.

b. Applies only to hospitals paid under Medicare's inpatient prospective payment system.

c. Annual updates are specified in law. Between 2019 and 2024, physicians participating in an "alternative payment model" (as defined in law and regulation) may receive a bonus payment from Medicare each year; starting in 2026, fees for those physicians are scheduled to increase by 0.75 percent per year and fees for other physicians are scheduled to increase by 0.25 percent per year.

Health Insurance Coverage in 2016 for People Under Age 65



Net Federal Subsidies for Health Insurance for People Under 65

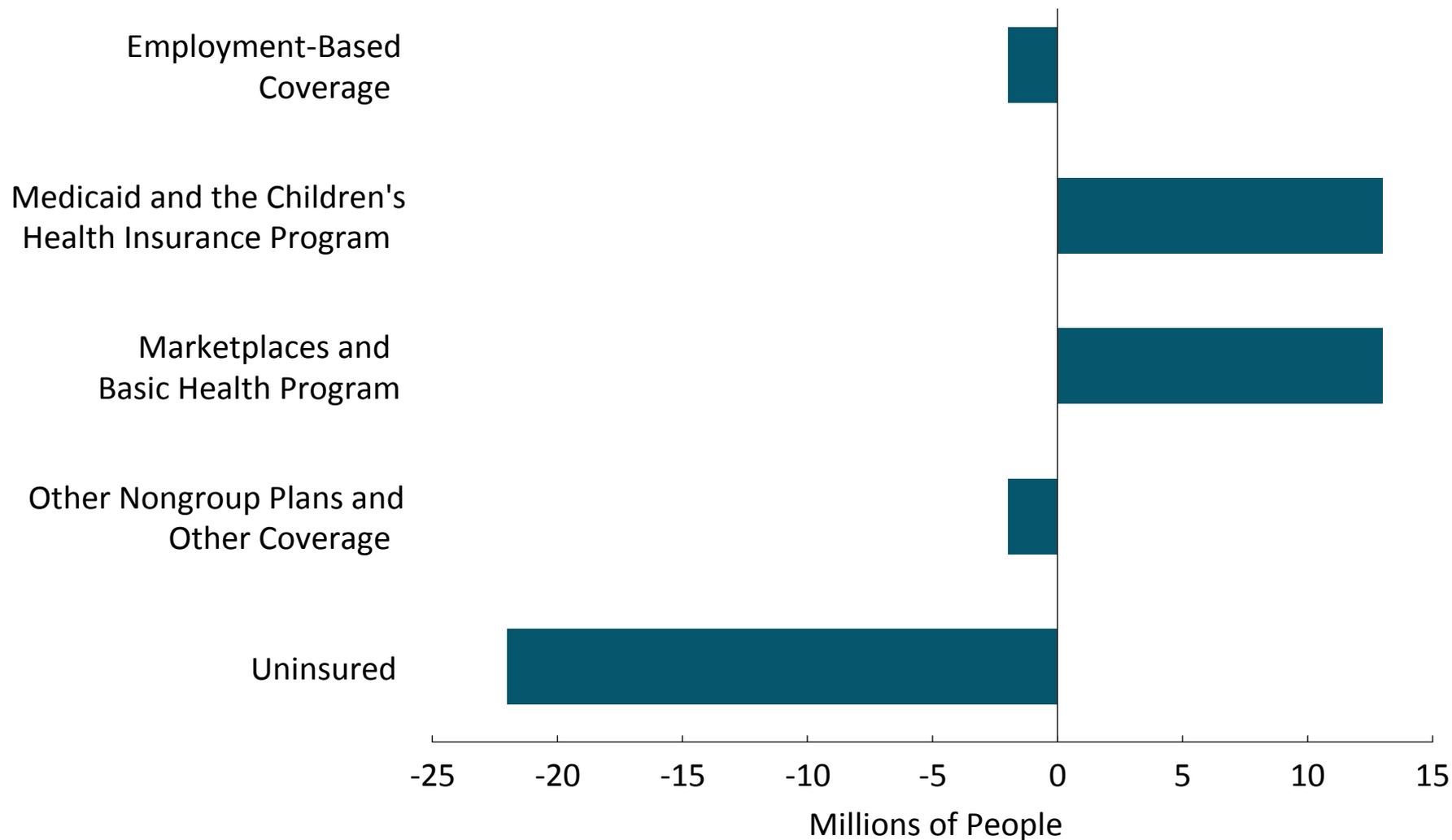
Billions of Dollars

	2016	2017–2026
Employment-Based Coverage	268	3,629
Medicaid and CHIP ^a	279	3,790
Nongroup Coverage and Basic Health Plan	48	919
Medicare ^b	80	979
Taxes and Penalties Related to Coverage	-15	-441
Net Subsidies	660	8,877

a. For Medicaid, includes only outlays for medical services for noninstitutionalized enrollees under age 65 who have full benefits.

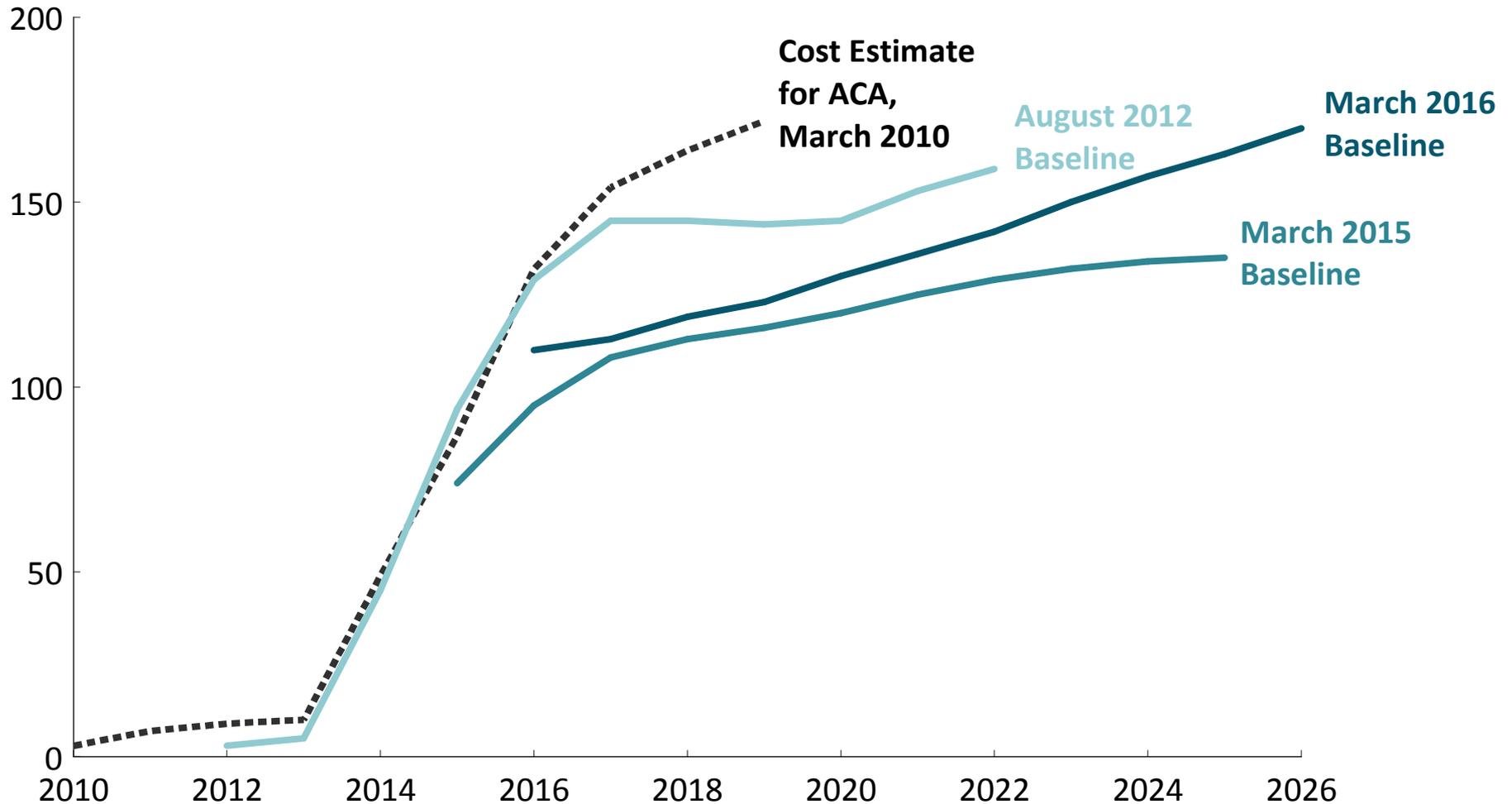
b. Outlays for benefits net of offsetting receipts (such as premiums) for noninstitutionalized Medicare beneficiaries under age 65.

Estimated Effects of the ACA on Health Insurance Coverage in 2016 for People Under Age 65



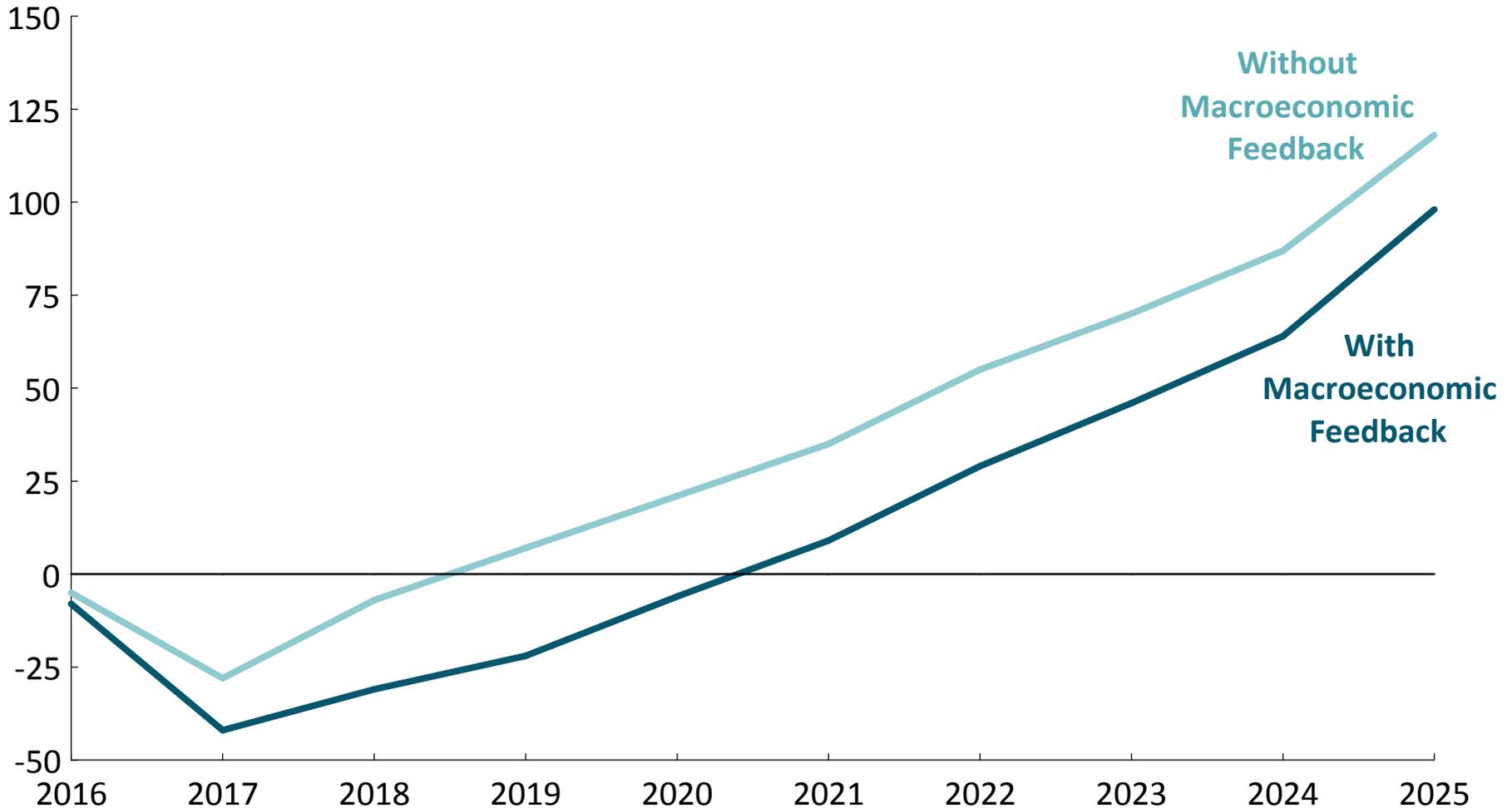
CBO and JCT's Estimates of the Net Budgetary Effects of the Insurance Coverage Provisions of the Affordable Care Act

Billions of Dollars, by Fiscal Year

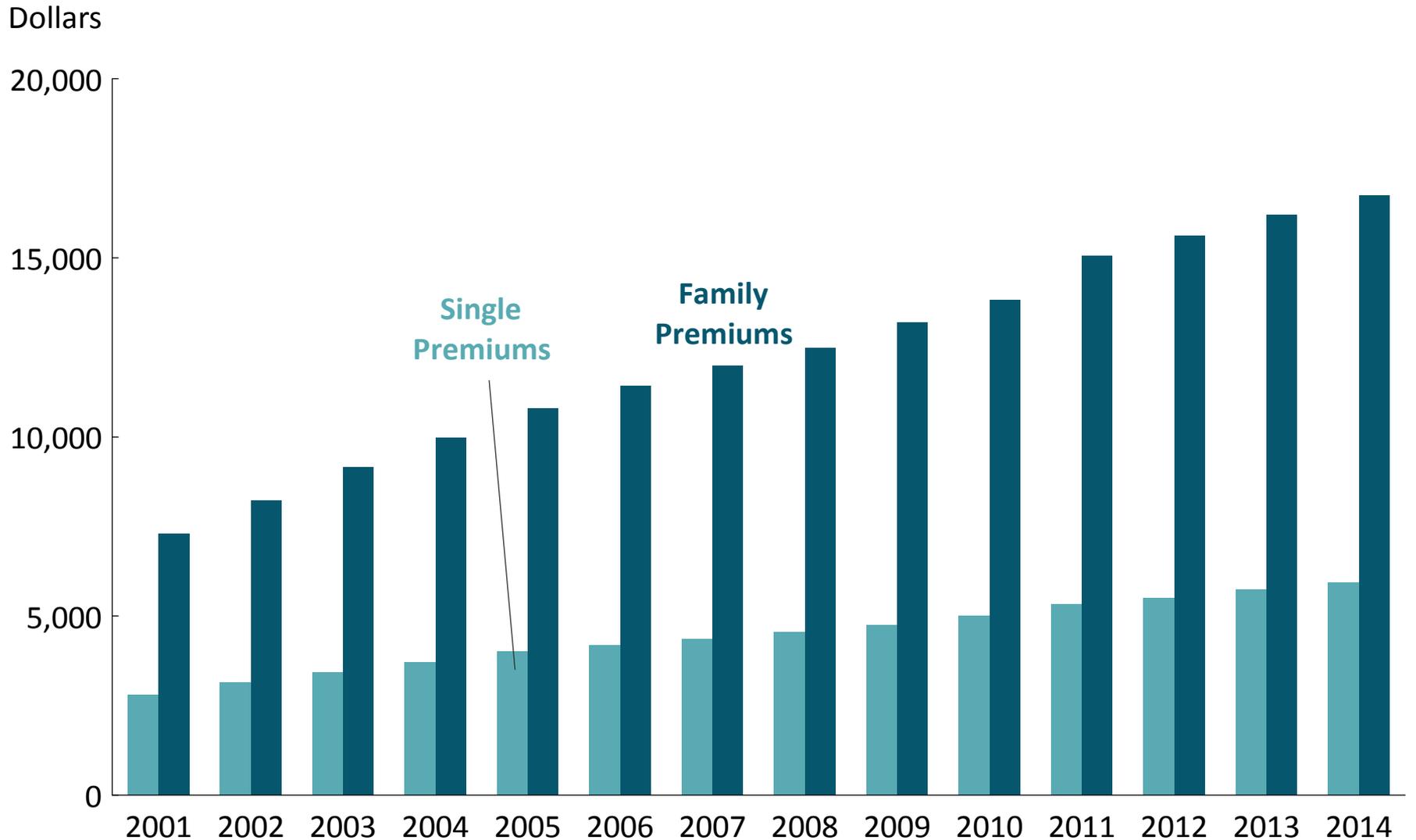


Estimated Effects on Deficits of Repealing the Affordable Care Act

Billions of Dollars, by Fiscal Year



Average Premiums for Employment-Based Plans



Examples of Policy Proposals and Approaches that CBO Has Analyzed Recently

CBO has analyzed **a broad range of possible approaches** designed to reduce spending, including:

- Reducing federal subsidies
- Paying Medicare providers in different ways
- Making broader structural changes in Medicare or Medicaid
- Improving the health of the population

Cutting federal subsidies for health insurance would help the budget but would leave affected people to bear higher costs.

Federal policies could:

- Narrow eligibility for ACA subsidies or repeal them
- Reduce the ACA subsidy per enrollee
- Reduce the tax subsidy for employment-based health insurance
- Raise the eligibility age for Medicare
- Increase premiums for Medicare
- Increase Medicare's cost-sharing requirements

Paying Medicare providers in different ways could help the budget but would have a range of effects on providers and beneficiaries.

Possible federal policies include shifting to **new payment models** and **bundling payments** for related services.

Federal savings would be achieved only if **providers were 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.

Making larger structural changes to federal health care programs could help the budget but would have a range of effects on providers and beneficiaries.

One option is to **cap payments to states** for Medicaid; federal payments could be a block grant or a per capita amount and could be indexed in various ways.

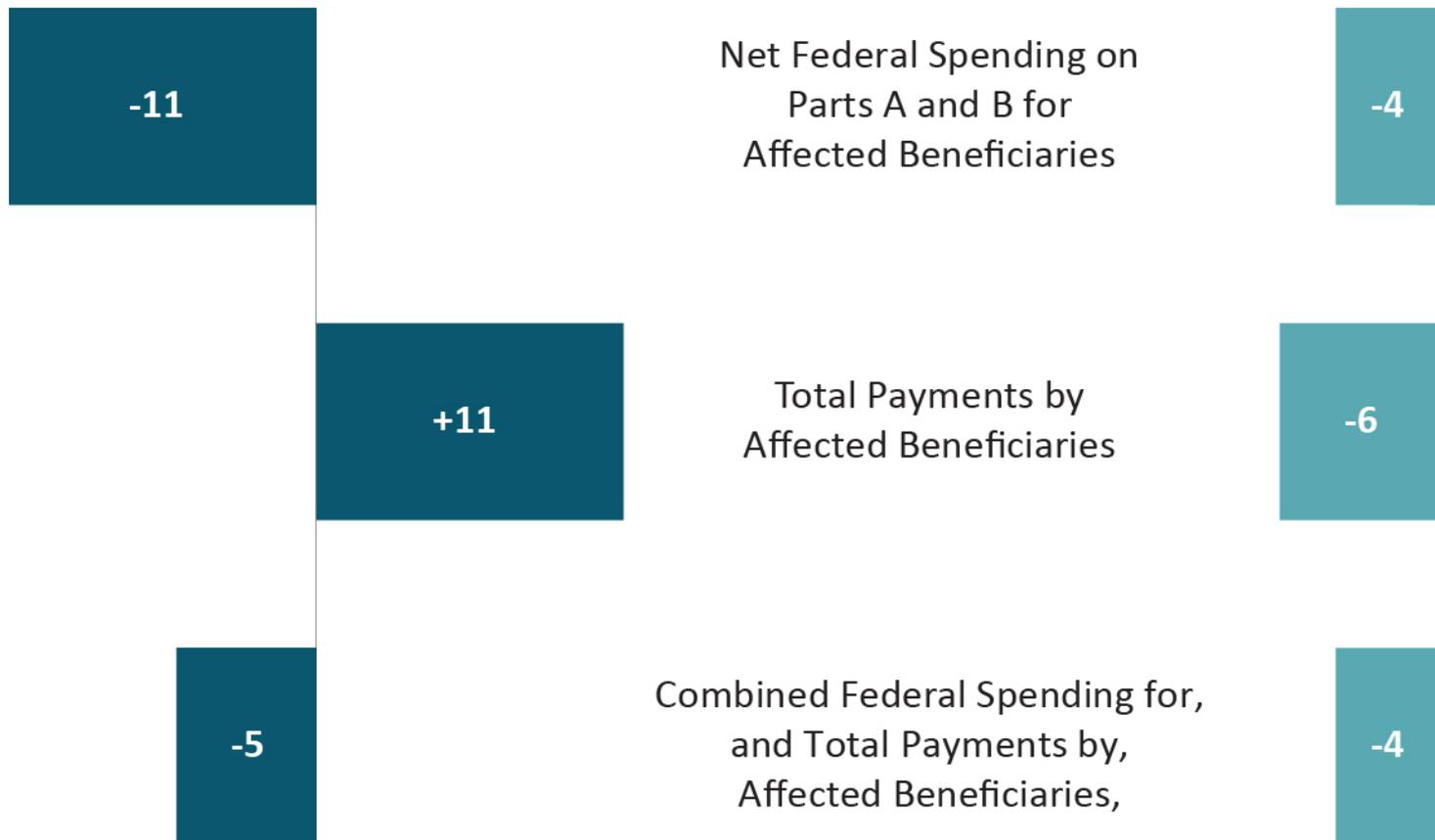
Another is to adopt a “**premium support**” system for Medicare; benchmarks could be set in various ways and people near retirement could be “grandfathered” into the current system.

Effects of Illustrative Premium Support Systems on Spending for Medicare Benefits

Percent

Second-Lowest-Bid Option

Average-Bid Option



Policy initiatives that **improved health** would help people but might or might not produce savings for the federal budget.

There are many steps between a policy initiative aimed at improving health and its budgetary effects.

In general, the policy would need to **change people's behavior**, which could be difficult.

Changes in behavior would then need to **improve people's health**, which could take some time.

Improvements in health would then need to **reduce health care costs**, which could also take some time.

The budgetary effects of policy initiatives depend on a combination of factors:

- Any reduction in annual health care costs per person
- Any increase in tax revenues from better health and increases in federal spending from people living longer
- Any budgetary cost or savings of the policy itself

Conclusion

Federal lawmakers often strive for policies that both **reduce the growth** of federal health care spending and **improve the effectiveness** of the national health care system.

Designing federal policies **to achieve both of those goals** is challenging. Most policies have significant disadvantages as well as advantages.

How health insurers, health care providers, and individuals **would respond** to most policies is uncertain.