Stanford University • July 2011

SIEPR policy brief

Stanford Institute for Economic Policy Research

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Health Care Spending and the Federal Budget

By Gopi Shah Goda

The Long-Term Budget Problem Is a Health Care Problem

The federal government has recently recorded the largest budget deficits as a share of the economy since the end of World War II, and as a result federal debt held by the public has increased dramatically. A substantial factor in the recent increase was lower tax revenues and higher federal spending that resulted from the Great Recession.

However, the long-term outlook, even after the economy is assumed to rebound, is equally bleak. Figure 1 shows the Congressional Budget Office's (CBO) projections of federal debt as a percentage of GDP held by the public under two different scenarios along with historical debt levels since 1940. The two scenarios represent: (1) an extended baseline scenario that assumes current laws stay in effect; and (2) an alternative fiscal scenario that represents one interpretation of what it would mean to continue today's underlying fiscal policy.

While the extended baseline scenario shows debt levels stabilizing over the forecast window, the assumption that current laws stay in effect implies that the Bush tax cuts of the early 2000s fully expire, the alternative minimum tax is not adjusted each year, and cuts to Medicare physician payments take effect as legislated. Under this scenario, tax revenues are set to increase to 23 percent of GDP by 2035, a level more than 25 percent higher than the historical average of 18 percent of GDP over the last few decades.

Under the alternative fiscal scenario, debt as a percentage of GDP is projected to approach levels seen in Greece and

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Iceland within 15 years. When projecting spending and revenues under this scenario, the CBO assumes that changes that have been made in the past, like those made to the alternative minimum tax and Medicare physician payments, will continue, as widely expected.

The long-term budget problem is largely a health care problem. Under both CBO scenarios, federal spending on Medicare, Medicaid, and subsidies for health insurance provided under the recent Patient Protection and Affordable Care Act passed last year grow substantially as a percentage of total spending. Therefore, policies that reduce federal health care spending can go a long way in improving the long-term budget situation.

Restraining Federal Health Care Spending

"If something cannot go on forever, it will stop."

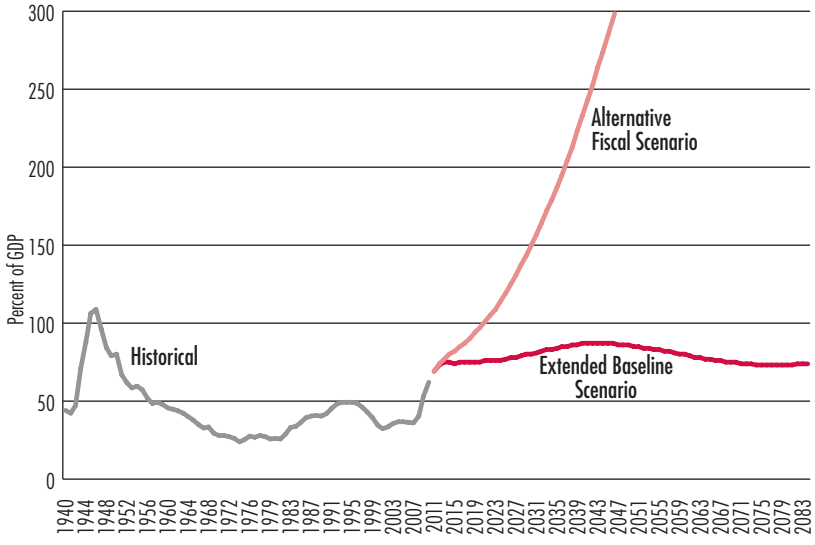
This famous quote from the late economist Herbert Stein is often conjured in conversations about future health care spending. Health care costs have historically increased relative to GDP and comprise a growing share of the federal budget; a continuation of these trends would eventually lead to health care crowding out all other federal spending and overtaking the entire U.S. economy. Therefore, health care cost growth cannot continue on its current trajectory forever.

Mechanically, there are only two ways to reduce federal health care spending as a percentage of GDP: reduce the number of beneficiaries of federal health care spending or drive the growth in health care spending per beneficiary to a rate below the growth of GDP. Reducing the number of beneficiaries of federal health care spending is straightforward: Policies that would achieve this outcome include increasing the age of Medicare eligibility or eliminating the subsidies for health insurance provided under the recent Affordable Care Act.

Reducing health care spending growth requires more creative solutions. Few would object to policy solutions that reduce health care spending without worsening (or possibly even improving) the health of Americans. While many agree that inefficiencies exist in the health care system, there are differences of opinion as to both the extent to which they exist and ways to eliminate them.

One philosophy is that inefficiencies can be addressed by a top-down approach, where an independent, government-appointed panel of experts

Figure 1.
Actual and Projected Federal Debt Held by the Public as a Percentage of GDP, 1940-2084



Source: CBO Long-Term Budget Outlook, June 2011, Figure B-2; Office of Management and Budget, Budget for FY 2012, Historical Tables, Table 7.1.

makes decisions regarding whether to approve various medical procedures and how to pay for them. On the other end of the spectrum is the view that the most effective way to reduce waste is to empower consumers in health care decision making, allowing market competition to cut costs.

If eliminating inefficiencies does not achieve sufficiently large reductions in health care spending growth, more difficult choices will need to be made. Medical treatments may need to be rationed in some form. Rationing by price means that individuals would be required to pay higher amounts to receive certain treatments and not everyone would choose to or be able to afford every procedure. Rationing access to care could also be in the form of waiting lists for treatments or specialists. While these types of rationing are undesirable, it is important to note that rationing exists in the current system: Medicare deductibles and co-payments can be prohibitively high, and current Medicare reimbursement rates are often less than those paid by private insurers, leading providers to deny access for Medicare beneficiaries.

Four Proposals to Address Future Health Care Cost Growth

Recently, several plans that aim to reduce federal health care spending have emerged. Four proposals that have gained attention are as follows:

- Bipartisan Policy Center's *Restoring America's Future* (Rivlin-Domenici), November 17, 2010
- National Commission on Fiscal Reform and Responsibility (Bowles-Simpson), December 1, 2010
- Chairman Paul Ryan's *Path to Prosperity: Restoring America's Promise,* April 8, 2011
- President's Framework for Shared Prosperity and Shared Fiscal Responsibility, April 13, 2011

There are several distinct features of the four plans as well as some overlapping ideas. Perhaps the most extreme comparison can be found between President Obama's and Chairman Ryan's proposals. The Obama plan relies on a strengthened version of the Independent Payment Advisory Board (IPAB) created by the Affordable Care Act to control cost growth. The target growth rate under the president's proposal is GDP + 0.5 percent, which means that should Medicare growth per beneficiary exceed this target, the members of IPAB must recommend policies that reduce Medicare spending below the target. Congress must either institute the IPAB recommendations or enact policies that achieve equivalent savings.

On the other hand, the Ryan plan repeals most aspects of the Affordable Care Act, including the creation of the IPAB. Ryan's proposal transforms Medicare into a "premium-support" program that designates an amount that each senior would receive to purchase a private policy in lieu of traditional Medicare. Costs are controlled by setting the level of the premium support. The Ryan plan designates the rate of growth of premium support to be the overall rate of inflation, far lower than health care costs have grown historically. Thus, the premium support payments would likely cover a smaller and smaller percentage of total health care costs for seniors over time.

The two plans with bipartisan authorship, Rivlin-Domenici and Bowles-Simpson, have more moderate proposals. While the Rivlin-Domenici plan would also favor transforming Medicare into a premium-support program similar to the Ryan plan, it designates the rate of growth as GDP + 1 percent and maintains traditional Medicare as the default option. The Bowles-Simpson plan

gives the IPAB more authority and suggests several policy options, including a premium-support model and raising the Medicare eligibility age, to keep health care costs from growing above their target. Most of the plans include a provision to reform medical malpractice by instituting tort reform, though the specific recommendations vary across plans. A brief summary of some of each plans' components is provided in Figure 2.[1]

Is Debt Reduction an Appropriate Goal?

While many of the plans outlined were spurred by calls for reduction in federal spending, it is important to note that there are several other factors that may determine which proposals are sound policy decisions. One important objective is to maintain (and ideally improve) the health of the beneficiaries of federal health care spending, largely low-income Medicaid and elderly Medicare recipients. Reducing spending, either by prohibiting coverage of treatments or reducing payments to health care providers, thereby reducing access, could very well have an adverse impact on health.

Equity is an important concern in the health care sector. Many would argue that access to basic health care needs should not be determined by one's ability to pay. However, it is not clear what health care services should be deemed basic. If potentially life-saving treatments are denied by Medicare because they are judged to be too expensive relative to their benefit, the wealthiest may have access to vastly different health care services relative to the rest of the population.

The introduction of Medicare was associated with a 40 percent reduction in out-of-pocket expenditure risk for seniors in the top quartile of the distribution of out-of-pocket spending (Finkelstein and McKnight 2008). Reforming Medicare simply to shift costs to consumers, rather than to make the overall health

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Figure 2.
Summaries of Medicare Proposals in Deficit Reduction Plans

Rivlin-Domenici	Bowles-Simpson	Ryan Plan	Obama Plan
• Gradually transforms to premium support, keeping traditional Medicare as default • Reforms Medicare cost-sharing rules • Cost target: GDP + 1% • Institutes tort reform	• Strengthens IPAB • Reforms Medicare cost-sharing rules • Cost target: GDP + 1% • Institutes tort reform	• Repeals most provisions of Affordable Care Act (including IPAB) • Gradually transforms Medicare to premium support, eliminating traditional Medicare • Raises Medicare eligibility age from 65 to 67 • Cost target: inflation • Institutes tort reform	• Strengthens IPAB • Cost target: GDP + 0.5%

1 Note that these descriptions and Figure 2 do not entail a comprehensive list of the four plans' components; each plan's website, included in the references, provides more details.

care system more efficient, could reverse this outcome, leading seniors more likely to become impoverished by increasing health care premiums or other out-of-pocket expenditures.

Finally, it is worth noting that while spending 100 percent of GDP on health care is clearly not optimal, there is no set percentage that should always be spent on health care. As standards of living rise, it may be optimal to spend a higher portion of our nation's wealth on health care. In general, policymakers should focus on the marginal value of each additional dollar of health care spending. If the last dollar of health care spending provides more value relative to the last dollar of spending on other sectors, economic theory suggests spending on health care should increase, not decrease. However, if the last dollar provides no added benefit, the opposite conclusion would prevail. Therefore, determining the extent and source of inefficiencies in health care spending will continue to be an important issue for researchers and policymakers alike.

References

Bipartisan Policy Center (2010), "Restoring America's Future," *http://bipartisanpolicy.org/projects/debt-initiative/about*.

CBO (2011), "Long-Term Analysis of a Budget Proposal by Chairman Ryan," *http://www.cbo.gov/doc.cfm?index=12128*.

CBO (2011), "Long-Term Budget Outlook," *http://www.cbo.gov/doc.cfm?index=12212*.

Finkelstein, Amy, and Robin McKnight (2008), "What Did Medicare Do? The Initial Impact of Medicare on Mortality and Out of Pocket Medical Spending," *Journal of Public Economics*, 92(7), pp. 1644-1669.

National Commission on Fiscal Reform and Responsibility (2010), "The Moment of Truth," *http://www.fiscalcommission.gov/news/moment-truth-report-national-commission-fiscal-responsibility-and-reform*.

Office of the White House Press Secretary (2011), "Fact Sheet: President's Framework for Shared Prosperity and Shared Fiscal Responsibility," *http://www.whitehouse.gov/the-press-office/2011/04/13/fact-sheet-presidents-framework-shared-prosperity-and-shared-fiscal-resp*.

SIEPR *policy brief*

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366 Galvez Street
Stanford, CA 94305
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A publication of the
Stanford Institute for
Economic Policy Research

Non-Profit Org.
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