

The Long-Term Budget Outlook in the United States and the Role of Health Care Entitlements

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Abstract

If current laws and policies remain in place, federal debt in the United States will continue to grow much faster than the economy over the long run. Although long-term budget projections are highly uncertain, under any plausible scenario rising costs for health care and the aging of the U.S. population will cause federal spending to increase rapidly. The growth of health care spending in the long term will be determined primarily by growth in the cost of medical care per person. The aging of the population will also contribute to future spending growth, especially for Medicare, which will cover a growing number of beneficiaries as baby boomers become eligible for the program and life expectancy continues to rise. Large reductions in spending for health care will not actually be achieved without fundamental changes in the financing and delivery of health care. The government can spur those changes by transforming payment policies in federal health care programs and by providing incentives to individuals to choose less costly care. Those approaches could directly lower federal spending on health care and indirectly lower private spending on it as well. One broad long-range approach for reform would combine specific policy actions—to generate near-term savings and provide experience that would lay the groundwork for future savings—with a mechanism or framework to impose ongoing pressure for achieving efficiencies in the delivery of health care.

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I. Introduction

In the absence of significant changes in policy, rising costs for health care will cause federal spending to grow much faster than the economy, putting the federal budget on an unsustainable path. The Congressional Budget Office (CBO) has prepared budgetary projections through 2080 under two different sets of assumptions about federal laws and policies. Those projections indicate that, under either set of assumptions, federal debt will continue to grow much faster than the economy over the long run.

Although long-term budget projections are highly uncertain, under any plausible scenario rising costs for health care and the aging of the U.S. population will cause federal spending to increase rapidly. Unless revenues increase just as rapidly, the rise in spending will produce growing budget deficits and accumulating debt. To keep deficits and debt from reaching levels that could cause substantial harm to the economy, policymakers will need to increase revenues significantly as a percentage of gross domestic product (GDP), decrease projected spending sharply, or implement some combination of the two.

Federal spending on health care drives much of the increase in total government spending. By 2035, CBO projects that the share of total government spending for health care will nearly double to 31 percent of GDP, up from 16 percent of GDP in 2008. Reducing the growth in government spending will be difficult in the absence of slowing the growth of health care spending.

Many experts agree on some general directions in which the government's health policies should

move—typically involving changes in the information and incentives that doctors and patients have when making decisions about health care. Large reductions in spending will not actually be achieved without fundamental changes in the financing and delivery of health care. The government can spur those changes by transforming payment policies in federal health care programs and by significantly limiting the current tax subsidy for health insurance. Those approaches could directly lower federal spending on health care and indirectly lower private spending on it as well. Yet, many of the specific changes that might ultimately prove most important cannot be foreseen today and could be developed only over time through experimentation and learning. Modest versions of such efforts—which would have the desirable effect of allowing policymakers to gauge their impact—would probably yield only modest results in the short term.

Therefore, one broad long-range approach for reform that has drawn interest recently would combine specific policy actions—to generate near-term savings and provide experience that would lay the groundwork for future savings—with a mechanism or framework to impose ongoing pressure for achieving efficiencies in the delivery of health care. The effectiveness of that path would depend ultimately on the willingness of federal policy to maintain significant and systematic pressure over time and would require tough choices to be made. Without meaningful reforms, the substantial costs of many current proposals to expand federal subsidies for health insurance would be much more likely to worsen the long-run budget outlook than to improve it.

The Congressional Budget Office (CBO) has issued a number of reports that detail the unsustainable nature of the nation’s current fiscal path. In this paper, we summarize much of that

work. We begin by outlining CBO’s long-term budget projections, detailing the current state of the federal budget. In recent years, CBO has presented two fiscal scenarios for budget analysis: one that adheres most closely to current law and another that represents one interpretation of what it would mean to continue today’s underlying fiscal policy. We use a metric often used by CBO to gauge the federal government’s financial status—the fiscal gap—which summarizes the government’s expected long-term flows of revenues and spending in a single number. In the third section, we discuss the long-term outlook for Medicare and Medicaid spending and show that under various assumptions about future health cost growth, slowing the growth of government spending requires slowing the growth of government spending on health care. In section IV, we provide some options that might help to slow the long-term growth in health spending. Section V concludes the paper.

II. CBO’s Long-Term Budget Projections

Long-term projections rely on numerous assumptions about economic and fiscal factors, and many different assumptions are possible.¹ For its long-term budget projections, CBO presents two scenarios that are based on alternative assumptions about the federal budget over the long term:

- The “extended-baseline scenario” adheres most closely to current law, following CBO’s 10-year baseline budget projections for the next decade and then extending the baseline concept beyond that 10-year window.² The scenario’s assumption of current

¹ The analysis here is based on two publications by the Congressional Budget Office: *The Long-Term Budget Outlook* (June 2009), updated where possible to reflect *The Economic and Budget Outlook* (August 2009).

² CBO’s baseline is a benchmark for measuring the budgetary effects of proposed changes in federal revenues or spending. It comprises projections of budget authority, outlays, revenues, and the deficit or surplus calculated according to rules set forth in the Balanced Budget and Emergency Deficit Control Act of 1985. Those projections

law implies that many policy adjustments that lawmakers have routinely made in the past will not occur.

- The “alternative fiscal scenario” represents one interpretation of what it would mean to continue today’s underlying fiscal policy. This scenario deviates from CBO’s baseline even during the next 10 years because it incorporates some policy changes that are widely expected to occur and that policymakers have regularly made in the past.

Different analysts might perceive the underlying intention of current policy differently, however, and other interpretations are possible.

CBO projects that under both scenarios, primary spending—all spending except interest payments on federal debt—would grow sharply in coming decades relative to its historical relationship to GDP. Stimulus legislation and efforts to stabilize the financial markets pushed primary spending up to 23 percent of GDP in fiscal year 2009, the highest level since World War II; primary spending is projected to decline to 20 percent of GDP by fiscal year 2013.³

For the most part, total spending for health care in the United States—that is, private and public spending—has risen steadily as a share of GDP over the past several decades. Between fiscal years 1975 and 2008, federal spending for Medicare rose from 0.8 percent of GDP to 2.7 percent, in part because of increased enrollment, which climbed from 25 million in 1975 to 45 million in 2008.⁴ Between fiscal years 1975 and 2008, total spending for Medicaid, including spending by the states, increased from 0.8 percent of GDP to 2.5 percent. Over that same period, federal

are not intended to be predictions of future budgetary outcomes; rather, they represent CBO’s best judgment of how economic and other factors would affect federal revenues and spending if current laws and policies did not change.

³ See CBO, *Long-Term Budget Outlook*, June 2009 and Office of Management and Budget, “Table 1.2—Summary of Receipts, Outlays, and Surpluses or Deficits (-) as Percentages of GDP: 1930–2014,” available at <http://www.whitehouse.gov/omb/budget/Historicals/>.

⁴ Those figures for spending are net of Medicare beneficiaries’ premiums and, beginning in 2006, amounts paid by the states from savings on prescription drug costs in the Medicaid program. In fiscal year 2008, those offsetting receipts from premiums and states’ payments equaled 0.5 percent of GDP.

spending for the program increased from 0.4 percent of GDP to 1.4 percent. (See Figure 1).

Under the extended-baseline scenario, primary (noninterest) spending would edge down further as a share of GDP from between about 2012 to 2020, to 20 percent. (See Figure 2). It would then begin a long-term upward trajectory, reaching 24 percent of GDP in 2035 and 32 percent in 2080.

Under the alternative fiscal scenario, by comparison, primary spending would be about 2 percentage points higher as a share of GDP than in the extended-baseline scenario throughout the projection period. (See Figure 3).

If spending policies did not change and outlays indeed grew to the projected levels relative to the size of the economy, maintaining a sustainable budget path would require a similar rise in federal taxation. The recession temporarily depressed revenues to a projected level of 15 percent of GDP in the 2009 fiscal year. But even typical revenue levels would be too low to support projected spending. Over the past half-century, total federal revenues have averaged about 18 percent of GDP—well below the level of projected spending under either scenario.

Under the extended-baseline scenario, revenues would reach higher levels relative to the economy than ever recorded in the nation's history. That scenario assumes that reductions in tax rates enacted in 2001 and 2003 will expire at the end of 2010 as scheduled under current law. It also assumes that the alternative minimum tax (AMT) will not be changed, and because its parameters are not indexed to inflation like most of the tax code, its reach would expand substantially over

time.⁵ In addition, ongoing increases in real (inflation-adjusted) income would push taxpayers into higher income tax brackets. For all of those reasons, the extended-baseline scenario implies that federal revenues will grow somewhat faster, on average, than the economy—increasing from 20 percent of GDP in fiscal year 2012 to 22 percent by 2035 and 26 percent by 2080. But even if revenues rose to those unprecedented levels, they would not be sufficient to keep the budget in balance over the long term in that scenario. Federal debt held by the public would stay near 60 percent of GDP during the coming decade but then would turn upward and reach 79 percent of GDP by 2035. In the absence of policy changes, by 2046 the ratio of debt to GDP would be higher than the level that the United States experienced shortly after World War II.

Under the alternative fiscal scenario, by contrast, expiring tax provisions in the Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA) and the Jobs and Growth Tax Relief Reconciliation Act of 2003 (JGTRRA) would be extended, and the AMT would be indexed to inflation. (See Figure 3). As a result, revenues would grow only slightly faster than the economy, equaling 22 percent of GDP by 2080. Slowly growing revenues combined with sharply rising expenditures would create an explosive fiscal situation. Under the spending and revenue policies incorporated in this scenario, federal debt would surpass 100 percent of GDP in 2023 and exceed 200 percent of GDP by the late 2030s. (See Figure 4).

Returning the Budget to a Sustainable Path

How much would policies have to change to avoid unsustainable increases in government debt?

⁵ The AMT is a parallel income tax system with fewer exemptions, deductions, and rates than the regular income tax. Households must calculate the amount of tax they owe under both the AMT and the regular income tax and pay the larger of the two amounts.

A useful answer comes from looking at the so-called fiscal gap. The gap measures the immediate change in spending or revenues that would be necessary to produce the same debt-to-GDP ratio at the end of a given period as prevailed at the beginning of the period. Under the extended-baseline scenario, the fiscal gap would amount to 2.1 percent of GDP over the next 25 years and 3.2 percent of GDP over the next 75 years. (See Table 1). In other words, under that scenario (ignoring the effects of debt on economic growth), an immediate and permanent reduction in spending or an immediate and permanent increase in revenues equal to 3.2 percent of GDP would be needed to create a sustainable fiscal path for the next three-quarters of a century. If the policy change was not immediate, the required percentage would be greater. The fiscal gap is much larger under the alternative fiscal scenario: 5.4 percent of GDP over the next 25 years and 8.1 percent over the next 75 years.

The choice facing policymakers is not whether to address rising deficits and debt but when and how to do so. If policymakers wanted to close the fiscal gap in 2020 by altering spending (and economic effects were ignored in the calculation), they would have to reduce noninterest outlays permanently by 10 percent of GDP. If they waited until 2040 to close the fiscal gap, they would have to reduce noninterest outlays permanently by almost 16 percent of GDP. Incorporating the effects of deficits and debt on economic growth (which are excluded from these simulations) would make the impact of delaying policy changes even more severe.

Long-term budget projections require a stable economic backdrop. For these projections, CBO assumed that even a large increase in federal debt would not affect economic growth or real rates

of interest after the first 10 years.⁶ However, if debt actually increased as projected under either scenario, interest rates would be higher than otherwise and economic growth would be slower. The rising debt would reduce the size of the domestic capital stock (businesses' equipment and structures as well as housing) and decrease U.S. ownership of assets in other countries while increasing foreign ownership of assets in the United States. Those changes would slow the growth of gross national product (GNP) and, as the debt burden rose, could eventually lead to a decline in economic output.⁷ The effects would be most striking under the alternative fiscal scenario. In CBO's estimation, the increase in debt under that scenario would reduce the capital stock by more than 20 percent and real GNP by 9 percent in 2035, compared with the levels that would occur if the debt remained roughly at its current size relative to the economy. Under the extended-baseline scenario, federal debt would be less threatening in the near term but would lead to significant economic harm in the long run. Those economic effects mean that actual fiscal pressures under current laws and policies would be even greater than CBO's long-term budget projections suggest, because slower growth would limit revenues and a smaller capital stock would imply higher interest rates on government debt and other financial instruments.

Holding down the spiraling levels of debt projected under either scenario could therefore result in significant economic benefits. However, accomplishing that goal would require some combination of substantial revenue increases and substantial spending decreases relative to current law. Those changes would have their own economic and social costs.

⁶ For a description of the model underlying CBO's projections, see the June 2009 background paper *CBO's Long-Term Model: An Overview*.

⁷ Gross national product measures the income of residents in the United States after deducting net payments to foreigners. Gross domestic product, by contrast, measures the income that is generated by the production of goods and services on U.S. soil, including production financed by foreign investors. Because rising deficits generally increase borrowing from foreigners, GNP is a better measure of the economic effects of deficits than is GDP.

One policy that would prevent the increase in debt would be to raise revenues in line with the projected rise in spending. As evidenced by the estimated fiscal gap, the required increase in revenues under that approach would be large. If the increase occurred through higher marginal tax rates, incentives to work and save would be reduced and economic growth would slow. An alternative policy would be to hold the growth of spending in line with the growth of the economy. That approach would require significant changes in the Medicare and Medicaid programs. Many experts believe that reducing the growth rate of spending on Medicare and Medicaid will ultimately depend on policymakers' willingness to put ongoing pressure on the health sector to achieve efficiencies in the delivery of health care. Various approaches to reducing the growth rate of health care spending are explored in Section IV.

Reducing other federal spending significantly below the baseline levels would be difficult as well. Spending on Social Security has risen from almost 4 percent of GDP in the 1970s to almost 5 percent today and will increase to 6 percent in 2035 as the baby boomers retire. Other nonhealth, noninterest spending averaged almost 14 percent of GDP in the 1970s but has shrunk to about 10 percent of GDP over the past 15 years—aside from the current burst of spending in response to the recession and the financial crisis. Such spending is projected to decline further over time in CBO's 10-year baseline.

From a purely economic perspective, slowing the growth of spending would generally impose smaller costs than boosting tax rates, although that conclusion is somewhat sensitive to the specific measures that would be adopted. From a broader social perspective, citizens and

policymakers need to judge the importance of various government programs and the costs of restraining spending on health care, retirement benefits, defense, and so on. That is, lower levels of spending would help address the fiscal sustainability problem, but society would have to make difficult choices about which programs to scale back. The difficulty of the choices notwithstanding, CBO's long-term budget projections make clear that doing nothing is not an option: Legislation must ultimately be adopted that raises revenue or reduces spending or both. Moreover, delaying action simply exacerbates the challenge, as is discussed below.

The Accumulation of Federal Debt

For a path of spending and revenues to be sustainable, debt must eventually grow no faster than the economy. Persistent annual deficits lead to larger and larger amounts of debt, which in turn require more spending for interest payments on that debt. Thus, even moderate primary deficits (deficits excluding interest costs) can lead to unsustainable growth in federal debt. Such large deficits could result in capital flight from the United States and result in a precipitous drop in the value of the dollar and an associated increase in interest rates, which could create pressure on the Federal Reserve to control inflation. Furthermore, there are ongoing costs of debt: tax revenues would be needed to pay interest rather than to finance government programs, and reductions in savings, investment, output, wages and incomes would result relative to what would occur otherwise.

A useful barometer of fiscal policy is the amount of government debt held by the public as a percentage of GDP. (See Figure 4). That debt stood at 41 percent of GDP at the end of fiscal year 2008, a little above the 40-year average of 36 percent, and rose to 54 percent of GDP at the end

of fiscal year 2009. CBO projects that in the next few years, deficits will remain high by historical standards—almost 10 percent of GDP in fiscal year 2010 and about 6 percent in fiscal year 2011. As a result, debt will grow to 65 percent of GDP by the end of fiscal year 2011.

Under the assumptions of the extended-baseline scenario, annual deficits would fall to about 3 percent of GDP by fiscal year 2013. Debt would remain roughly stable as a share of GDP for the next decade. After that, however, growing spending on Medicare, Medicaid, and Social Security would lead to higher deficits, and debt would once again increase faster than the economy. By 2035, it would equal 79 percent of GDP. Federal debt peaked at 113 percent of GDP shortly after the end of World War II, a mark that would be passed in 2046 under the extended-baseline scenario.

Under the alternative fiscal scenario, deficits would decline for a few years after 2009 but then grow quickly again. By 2019, debt would reach 83 percent of GDP; thereafter, the spiraling costs of interest payments would swiftly push debt to unsustainable levels. Debt would exceed its historical peak of 113 percent of GDP by 2026 and would reach 200 percent of GDP in 2038.

Many budget analysts believe that the alternative fiscal scenario presents a more realistic picture of the nation's underlying fiscal policy than the extended-baseline scenario does—because, for example, it does not allow the impact of the AMT to expand substantially. To the extent that such a belief is valid, the explosive path of federal debt under the alternative fiscal scenario underscores the need for large and rapid corrective steps to put the nation on a sustainable fiscal course.

Moreover, CBO's projections understate the debt that would accumulate under the two scenarios. Long-term budget projections require a stable economic backdrop; thus, for the purpose of the projections, CBO made assumptions that generated a stable real interest rate and stable growth in real wages and output. In effect, the analysis omitted the pressures that a rising ratio of debt to GDP would have on real interest rates and economic growth. Changes in the demographic structure of the population are likely to offset somewhat the effects of high debt levels on real interest rates. In the end, however, ever-growing deficits and debt would lead to higher interest rates and slower economic growth.

III. The Long-Term Outlook for Medicare, Medicaid and Total Health Care Spending

Spending for health care in the United States has been growing faster than the economy for many years, posing a challenge not only for the federal government's two major health insurance programs, Medicare and Medicaid, but also for the private sector. Measured as a percentage of the nation's gross domestic product, total spending for health care increased from 4.7 percent in 1960 to 15.2 percent in 2007, the most recent year for which data are available.⁸ Total spending for Medicare and Medicaid (which for the latter includes both federal and state spending) rose from 1.7 percent of GDP in fiscal year 1975 to 5.7 percent in fiscal year 2008. Over the same period, net federal spending for the two programs rose from 1.2 percent of GDP to 4.1 percent.⁹

⁸ National health expenditures in 2007 totaled 16.2 percent of GDP. However, the concept of "total spending for health care" used in this report comprises spending for health services and supplies as defined in the national health expenditure accounts maintained by the Centers for Medicare and Medicaid Services. That spending includes all expenditures on personal health care, governments' administrative costs and public health activities, and the net costs of private health insurance. It excludes two categories of spending that are part of national health expenditures: amounts invested in research and in structures and equipment.

⁹ Those figures are net of premiums paid by Medicare beneficiaries and amounts paid by the states representing part of their share of the savings from shifting some Medicaid spending for prescription drugs to Part D of Medicare.

The growth of health care spending in the long term will be determined primarily by growth in the cost of medical care per person. The aging of the population will also contribute to future spending growth, especially for Medicare, which will cover a growing number of beneficiaries as baby boomers become eligible for the program and life expectancy continues to rise. Those demographic trends are also projected to increase costs for Medicaid by boosting the demand for long-term care. CBO projects, however, that spending for Medicare and Medicaid will increase much more rapidly than will their enrollments—because the programs’ costs per beneficiary are growing faster than the economy.

Underlying Assumptions for CBO’s Projections of Health Care Spending

To estimate the federal government’s net long-term spending for Medicare and Medicaid, CBO first projects total spending for the two programs and then subtracts the nonfederal components—for Medicare, the premiums paid by beneficiaries and amounts paid by the states from savings on prescription drug costs in the Medicaid program; and for Medicaid, the amount of states’ spending. In its projections, CBO calculates premiums for Medicare as a flat percentage of gross spending for Part B and Part D and holds constant the share of Medicaid’s spending paid for by the states.¹⁰ Spending for Medicare and Medicaid beneficiaries that is not financed through the programs, such as out-of-pocket payments and payments resulting from individually purchased Medigap insurance, is not federal spending, so it is included instead in the category of other health care spending.

¹⁰ CBO uses the typical average share of 57 percent for projections over the long term after expiration of the temporary increase enacted in the American Recovery and Reinvestment Act of 2009.

In order to estimate the long-term growth of health care spending, CBO incorporated assumptions about how health care spending for an individual increases relative to the growth of GDP per capita. That concept—which is commonly referred to as “excess cost growth”—effectively removes general inflation, the size of the population, and changes in the population’s age composition from the overall growth in health care costs.¹¹ In the near term (the next ten years), CBO uses historical patterns in excess cost growth as a baseline. In the long-term, CBO assumes slowdowns in excess cost growth across Medicare, Medicaid, and all other health care spending.¹² From 1975 to 2007, overall excess cost growth amounted to 1.9 percentage points. That measure captures the growth of total spending for health care, including payments from all private and public sources. As shown in Table 2, excess cost growth during that period was 2.3 percentage points for Medicare, 1.9 percentage points for Medicaid, and 1.8 percentage points for all other health care spending (that is, spending by the private sector and by federal, state, and local governments for health care programs other than Medicare and Medicaid).

The rate of overall excess cost growth was faster during the earlier part of the 1975–2007 period and slower during the second half, averaging 2.6 percentage points from 1975 to 1990 but only 1.4 percentage points from 1990 through 2007. Since 1993, overall excess cost growth exceeded

¹¹ The effect of general inflation is removed from excess cost growth because the growth of spending for health care is measured relative to the growth of per capita GDP, both of which are affected by general inflation. The phrase “excess cost growth” is not intended to imply that growth in per capita spending for health care is necessarily excessive or undesirable. It simply measures the extent to which the growth in such spending exceeds the growth in per capita GDP, after adjustments for changes in the age composition of the population. See CBO, *The Long-Term Budget Outlook* (June 2009), and CBO, *The Long-Term Outlook for Health Care Spending* (November 2007), for more details about how CBO estimates rates of excess cost growth.

¹² In computing historical rates of overall cost growth, CBO removes the effects of changes in the age composition and size of the relevant population. Thus, for Medicare and Medicaid, CBO excludes the effect of increases in the number of beneficiaries in the programs. For Medicare and for the overall growth of health care spending, it also removes the effect of changes in the age composition of the population. In contrast, for its projections of Medicare’s spending, CBO takes into account the projected life expectancy (time until death) of beneficiaries as well as their age and sex (see Sabelhaus et al, 2004). For Medicaid, CBO removes the effect of changes in the composition of the program’s case-load—that is, changes in the portions of beneficiaries who are children, disabled people, elderly people, and other adults.

1 percentage point only from 2001 through 2003. (During that three-year period, it averaged 4.4 percentage points.) It is difficult to determine, however, to what extent the slower growth experienced in the past 15 years or so reflects one-time changes (for instance, the spread of managed care) and to what extent the underlying trend has changed. Another consideration is that rates of excess cost growth in the Medicare and Medicaid programs are driven partly by changes in law and policy, which have expanded the programs and tried to limit the growth of their costs. Most notably, in 1983, Medicare implemented a prospective payment system under which hospitals are paid a predetermined rate for each admission, an approach that has reduced some of the program's costs.

In its projection methodology, CBO's approach to developing its long-term estimates differs from the treatment of the first 10 years of the projection period—2009 to 2019. For that initial 10-year span, a detailed analysis of each program is used to estimate outlays from the system. In that initial period, payment rates for most Medicare services are adjusted each year on the basis of the estimated rate of inflation and growth rates of the relevant populations.¹³

For its projections covering 2020 to 2083, CBO combined assumptions about excess cost growth in health care spending with projections of the growth and aging of the population and the growth of per capita GDP. CBO assumed that in 2020, the rate of excess cost growth for Medicare would be 2.3 percentage points and the rate for Medicaid, 1.9 percentage points—the average excess cost growth rates for the programs from 1975 to 2007. (See Tables 2 and 3). The rate for all other health care spending from 2009 through 2020 was assumed to equal its

¹³ See, for example, Congressional Budget Office, *A Preliminary Analysis of the President's Budget and an Update of CBO's Budget and Economic Outlook*, March 2009.

historical average of 1.8 percentage points.

CBO assumed that in later years of the 2020–2083 period, even in the absence of changes in federal law, excess cost growth would slow. As health care expenditures continued to increase as a share of GDP, they would disproportionately absorb people’s income, allowing only slow growth in the consumption of goods and services besides health care. As a result, pressure to slow the growth of costs would mount as health care accounted for a larger and larger share of the American economy. The private sector and state governments would probably respond by instituting various changes. Employers would quite likely intensify their efforts to reduce the costs of the plans they sponsored—for example, by working with insurers to make health care more efficient or by reducing insurance coverage. Insurers would also probably raise premiums and increase out-of-pocket charges. Employees would then react to the higher charges either by shifting to plans with lower premiums—and more restrictive coverage or benefits management—or by directly limiting their consumption of health care in response to their higher out-of-pocket spending.

It is impossible to predict with any confidence how such a process would unfold and how much cost growth might slow. One simple and transparent approach is to set a path of excess cost growth that is consistent with a rule about patterns of households’ consumption. In particular, households overall would be unwilling to spend so much more on health care that, from one year to the next, the increase in such spending alone was greater than the total increase in consumption. By the end of the projection period, per capita expenditures on items besides health care would be stable. As a consequence of that approach, CBO assumed that the rate of excess

cost growth for other health spending in the last year of the 75-year projection period would be 0.1 percentage point. (See Table 3).

Based on the assumption about excess cost growth in other health care spending, CBO used the relationships between the excess cost growth rates for Medicare, Medicaid, and other health care spending to determine the projected cost growth rates for Medicare and Medicaid and thus the growth of total health care spending. On the basis of its own analysis and discussion with health policy experts, CBO assumed that without changes in federal law, the combined effects of the pressures discussed above would be to reduce Medicare's excess cost growth by one-third of the reduction that took place in the growth of non-Medicare spending. In other words, under a scenario in which the rate of growth of health care spending outside that of Medicare declined from 2.0 percent to 1.0 percent annually, Medicare's spending growth would decline from 2.0 percent to about 1.7 percent per year. Therefore, if federal law remained unchanged, the growth of spending for Medicare could continue to outpace the overall growth of health care spending.

In summary, CBO's methodology for its projections of health care spending is based on a detailed analysis of Medicare and Medicaid spending from 2009 through 2019; excess cost growth in all other spending for health care is equal to its historical average of 1.8 percentage points. In 2020, excess cost growth in spending for Medicare and for Medicaid is set equal to the programs' average historical cost growth of 2.3 percentage points and 1.9 percentage points, respectively. In 2021, excess cost growth in all three categories—Medicare, Medicaid, and other health spending—begins to slow.¹⁴ Over the very long term, excess cost growth for other (non-Medicare, non-Medicaid) health spending declines from 1.8 percentage points in 2020 to 0.1

¹⁴ The slowdown in Medicare's spending is one-third the rate of the slowdown in non-Medicare spending.

percentage point in 2083. Under this set of assumptions, the rate of excess cost growth for Medicare drops from 2.3 percentage points in 2020 to 0.9 percentage points in 2083 and the rate for Medicaid falls from 1.9 percentage points to 0.1 percentage point and as a result, average excess growth for all health care spending declines from 1.9 percentage points in 2020 to 0.4 percentage points in 2083, averaging 0.8 percent over that period. (See Tables 2 and 3).

Long-Term Projections of Spending for Medicare and Medicaid

Over the past 30 years, total spending for health care has more than doubled as a share of GDP. According to CBO’s projections, under the extended-baseline scenario, that share will double again by 2035, to 31 percent of GDP. Thereafter, health care costs will continue to account for a steadily growing share of the economy, reaching 37 percent of GDP by 2050 and 46 percent by 2080. (See Figure 1).¹⁵

In 2009, Medicare’s and Medicaid’s total spending was each about 3 percent of GDP. By 2035, spending for Medicare will have more than doubled, in CBO’s estimation, to 8 percent; by 2080, it will have grown to 15 percent. CBO projects that the growth of spending for Medicaid will be slower than Medicare’s spending growth, because it assumes that the rate of excess cost growth will be lower and that the aging of the population will affect Medicaid to a lesser extent than it

¹⁵ Under the *extended-baseline scenario* the assumption that current law does not change implies that the existing formula for determining the payment rates for physicians under Medicare (the “sustainable growth rate” formula) will continue to apply and will necessitate large reductions in those payments over the next several years. Under the *alternative fiscal scenario*, CBO assumed that Medicare’s payment rates for physicians will grow with inflation. Under both scenarios, CBO assumed that Medicare benefits would continue to be paid in full regardless of the financial status of the Hospital Insurance Trust Fund. Projected spending for Medicare under the alternative fiscal scenario is slightly greater than under the extended-baseline scenario, but the difference is small. Projected health care spending other than that for Medicare—including federal spending for Medicaid—differs only slightly under the two scenarios.

does Medicare. CBO estimates that total spending for Medicaid will grow to 5 percent of GDP by 2035 and 7 percent by 2080.

Although the *rate* of cost growth is projected to slow over the 2009–2083 period, the annual increase in the *level* of spending is expected to remain high. For example, for the five years beginning in 2015, CBO projects that total health care spending under the extended-baseline scenario will increase from 19.2 percent of GDP to 21.8 percent. For another five-year period, from 2035 to 2040, CBO projects that health care spending will rise from 30.8 percent of GDP to 33.3 percent. From one perspective, the percentage change during the latter period is much slower—8 percent rather than 14 percent. But in both periods, health care spending increases by about 2.5 percent of GDP.

Excess cost growth is not the only factor that drives increases in federal spending on Medicare, Medicaid, and Social Security; the aging of the population also serves to push spending higher. CBO compared future federal spending under two scenarios: one with an aging population but no excess cost growth for health programs and one with no aging but with excess cost growth (see CBO, *Long-Term Budget Outlook*, June 2009). Aging is the more important factor over the next 25 years or so, accounting for 56 percent of the projected growth in spending by 2035. Excess cost growth accounts for another 32 percent, and the interaction between the two factors causes the remaining 11 percent. For the period through 2080, the picture changes, as aging accounts for 32 percent of the increase in spending, excess cost growth accounts for 41 percent, and the interaction effect contributes 32 percent. (See Figure 5).

CBO projects that over the next 75 years, total spending for Medicare and Medicaid will account for a growing share of total health care spending—because the assumed rates of excess cost growth for Medicare will slow less quickly than will the rate for other health care spending and because a larger share of the population will be older than 65. In 2009, total spending for Medicare and Medicaid is projected to make up 37 percent of total health care spending. CBO projects that under the extended-baseline scenario, that ratio will grow to 41 percent by 2035 and to nearly half of all health care spending by 2080.

As a result of the relatively fast growth projected for total Medicare and Medicaid spending, net federal health care spending over the coming decades—that is, spending for Medicare excluding beneficiaries’ premiums and amounts paid by the states from prescription drug savings for Medicaid, together with the federal share of Medicaid’s spending—will also make up a larger share of total spending for health care. The federal share will increase from 29 percent in 2009 to about 31 percent in 2035 and to 37 percent in 2080. As a share of GDP, federal spending for Medicare and Medicaid will grow from 5 percent in 2009 to 10 percent in 2035 and to 17 percent in 2080.¹⁶

IV. Slowing the Growth of Health Care Costs

Given the long-term fiscal challenges, very significant and fundamental changes in health care will be required to truly improve the long-run budget outlook. Of course, projecting the effect of health policy changes into the distant future is very difficult, partly because predicting how the

¹⁶ In CBO’s projections, federal outlays under the alternative fiscal scenario would be slightly higher than under the extended-baseline scenario. The small difference arises because the alternative fiscal scenario’s assumption that Medicare’s physician fees are updated to account for inflation has a minor effect over the long term: Throughout the projection period, outlays under the two scenarios differ by less than 1 percent of GDP.

practice of medicine would evolve in the absence of those changes is difficult. Therefore, experts generally focus on ways to reduce the growth of health care spending over the next decade or two rather than over the very long run.¹⁷

Policy changes that reaped significant savings quickly would lessen the medium-term impact on the deficit that a large-scale expansion of insurance coverage would have and could lay the groundwork for greater savings later. For example, if the growth rate of federal health care spending was trimmed by 1 percent per year during the next 20 years, the savings would roughly match the cost of an expansion of insurance coverage by the end of the decade and would exceed that cost in the next decade.

Policy Options That Could Produce Budgetary Savings in the Long Run

In a number of recent publications, CBO analyzed a variety of reform options, including creating so-called accountable care organizations, bundling payments to hospitals and other providers, providing additional information about effective medical treatments, expanding the use of preventive and wellness services and primary care, increasing cost sharing by patients, and modifying the tax treatment of employment-based health insurance.¹⁸ We briefly summarize those six options below.

¹⁷ The interested reader is encouraged to read a number of CBO documents that describe a variety of policies that could help to slow health cost growth. In particular, see *Key Issues in Analyzing Major Health Insurance Proposals and Budget Options, Volume 1: Health Care*.

¹⁸ One general point worth emphasizing is that reform options may have different effects on health and on the federal budget. Some policies, such as the increased use of preventive services and the coordination of care, would have clearer positive effects on health than on the federal budget balance. Other policies, such as certain changes in Medicare's payment methods, would have a direct impact on federal spending, but their effect on health outcomes would be less clear. In part, that uncertainty reflects the difficulty of measuring the quality of health care—a situation that is likely to improve but which will take time to do so. See also CBO, *Budget Options, Volume 1: Health Care* (December 2008).

Create Accountable Care Organizations

In Medicare's traditional fee-for-service program, providers have little or no financial incentive to coordinate the care their patients receive across different treatment settings or to be accountable for the costs and quality of that care. One prominent example of a structure that may function better would be accountable care organizations formed by physicians and other health care providers. Under this model, providers would receive bonuses if they held down the total cost of the services their patients received during a year while also meeting requirements for the quality of the care; some versions would also impose penalties on doctors who did not meet those targets.

Bundle Payments to Hospitals and Other Providers

Another option would have hospitals receive a single bundled payment from Medicare for both the hospital services they provide and the care that their patients receive in a post-acute setting in the 30 days following their discharge. Hospitals already receive a fixed payment per admission, but this arrangement would provide hospitals with a new incentive to coordinate the care their patients receive after they are discharged and to economize in the use of post-acute care. The payment amount would be adjusted over time to capture part of the anticipated reduction in costs. CBO estimated that this option would save about \$19 billion over the 2010–2019 period.

Provide Additional Information About Treatments' Effectiveness

Concerns about the limited evidence that is available to determine which treatments are most effective for which patients has generated considerable interest in expanding the supply and use

of information that compares the effectiveness of treatment options. Merely conducting and disseminating additional research is unlikely to have major effects on patterns of clinical practice or health care spending, however. For new research to have a significant impact, providers' financial incentives would need to be aligned with the results. For example, legislation could allow the Medicare program to limit or deny coverage for treatments that were found to be less clinically effective or less cost-effective than other interventions. Alternatively, Medicare could tie its payments to providers to the cost of the most effective treatment, or patients could be required to pay for at least a portion of the additional cost of less effective treatments. In all of those approaches, patients and physicians could still choose the course of treatment they preferred, but Medicare's payments would depend on the broad results of research.

Expand the Use of Preventative and Wellness Services and Primary Care

Many proposals to modify the health insurance system include provisions to expand the use of preventive and wellness services and the use of primary care. Those changes could improve people's health and the quality of care they receive. For example, vaccines can prevent the spread of diseases; screening tests may be able to detect illnesses at earlier and more treatable stages; and greater focus on primary care can foster healthier behavior and better coordination of care. Although those policies could also lead to less spending on health care, the impact of specific preventive and wellness services on spending varies, depending on the disease being targeted and the population receiving the services.

Increase Cost Sharing by Patients

Increasing the cost-sharing obligations that individuals face in government health programs and

private insurance would strengthen the incentives for them to use medical care prudently. Research has shown that patients are responsive to the price they pay for many aspects of care (Newhouse, 1993). To be sure, the rationale for insurance is to limit patients' out-of-pocket costs, so people with significant health problems or with low income and few assets could not pay a large share of their health costs themselves; cost sharing could be designed to maintain appropriate financial protection while still creating some sensitivity to cost. In addition, maintaining lower cost sharing for certain preventive services, medications to treat chronic conditions, and other care that would reduce future spending (which falls under the rubric of "value-based insurance design") may make sense. Still, ensuring that patients have some financial stake in decisions about treatment methods would lead them to ask their doctors more questions about the effectiveness of different tests and treatments and to make better-informed and more cost-sensitive decisions about their care.

Modify the Tax Treatment of Employment-Based Health Insurance

Nearly all analysts agree that the current tax treatment of employment-based health insurance—which exempts most payments for such insurance from both income and payroll taxes—dampens incentives for cost control because it is open-ended. Those incentives could be changed by restructuring the tax exclusion to encourage workers to join health plans with lower premiums; those lower premiums would arise through a combination of higher cost-sharing requirements and tighter management of benefits. One reform option would replace the current tax exclusion with a refundable but more limited tax credit (see CBO, *Budget Options, Volume 1: Health Care*, December 2008). Another option would limit the amount of health insurance premiums that could be excluded from income and payroll taxes to specific dollar amounts that represented the

75th percentile of premiums paid by or through employers.¹⁹ These approaches would change workers' incentives about how much insurance to purchase and how much care to demand, and they would increase federal revenues by several hundred billion dollars over 10 years.

Imposing Ongoing Pressure to Increase Efficiency in the Health Care System

Vigorous implementation of those six specific reforms could save money for the federal government in the medium term; they could also lay the groundwork for long-term savings. However, many of the reforms would only reach fruition with substantial changes in how medicine is practiced. Therefore, the largest savings would be reaped slowly, as experts learn more from experience with innovative approaches to financing and delivering care and as payment rules are adjusted to shift behavior further and capture savings for the federal government. To ensure that the federal budget follows a more sustainable path will probably require creating a framework for federal health care spending that imposes ongoing pressure to increase efficiency over time—particularly but not exclusively in the case of providers. Such pressure could be imposed in several ways, including reducing Medicare's payment updates automatically to take account of expected productivity gains; reducing Medicare payments in higher-spending areas of the country; giving the Secretary of Health and Human Services broad discretion to change Medicare to produce savings, but imposing an across-the-board reduction in payments to providers if savings are not achieved in other ways; and limiting the growth of Medicare's implicit subsidy of premiums. In this section, we summarize those four ways to increase efficiency over time.

¹⁹ The dollar amounts in 2010 would be about \$17,300 a year for family coverage and about \$6,800 a year for individual coverage.

Reduce Annual Updates in Medicare’s Payments to Reflect Expected Productivity Gains

Under current law, Medicare’s fee-for-service payments to caregivers in a variety of facilities (including acute care and long-term care hospitals, outpatient facilities, skilled nursing facilities, and home health agencies) are determined according to preset fee schedules. As use of information technology increases, some experts maintain the health sector will undergo substantial productivity gains. Some of those gains may appear as reductions in the quantity of services and thus yield savings automatically for the government. However, most of the gains are likely to take the form of reduced costs per service, which would cut government spending only if the government cut the prices it pays. Imposing slower growth in payments would create ongoing pressure on providers to identify and adopt efficiencies; it would also, however, create risks for providers and patients if the efficiency gains were not achieved. More generally, reducing payment updates in the fee-for-service Medicare system could also prove to be a powerful mechanism for shifting providers into new payment schemes and organizational arrangements. Anticipated large reductions in payments to physicians under the sustainable growth rate mechanism, for example, could provide an impetus to physicians to join accountable care organizations, where they might receive bonuses for low-cost high-quality care.

Reduce Medicare Payments in Higher-Spending Areas

Another tack for applying ongoing pressure to restrain spending would be to reduce Medicare payments, or the growth in those payments, in higher-spending areas of the country. This approach would focus directly on reducing the geographical disparities that currently exist in health care spending, although it would not target specific medical providers or types of services that might be most responsible for the differences in spending. As with reductions in payment

updates, this approach would create risks for providers and patients in higher-spending areas if the efficiency gains were not achieved. The overall challenge in reducing the use of care that seems to be wasteful is trying to distinguish that care from necessary care, and that task is made only somewhat easier by focusing attention on geographic areas where wasteful spending is more likely to be occurring.

Combine Increased Discretion to Change Medicare with a Fallback If Savings Were Not Obtained

Another way to ensure significant savings in Medicare would be to give the Secretary of Health and Human Services, the Administrator of the Centers for Medicare and Medicaid Services, or some governmental entity broad discretion to make changes in Medicare to produce savings—but also to impose an across-the-board reduction in payments to providers if sufficient savings were not achieved in other ways.

Many experts think that broader discretion for the administrators of Medicare would help to encourage innovation and enhance efficiency in any event. However, the fallback reductions in payments to providers would be crucial in encouraging providers to accept other changes in the program instead. Moreover, as noted above, this mechanism and others in this section would only be effective in the end if the Congress let the legislated reductions in payments take effect.

Limit the Growth of Medicare's Subsidy of Premiums

One other mechanism for imposing ongoing pressure to achieve efficiencies in Medicare would be to limit the growth of the program's implicit subsidy of premiums. If increases in medical

costs beyond some threshold were borne at least partly by Medicare beneficiaries rather than the government, the government's financial burden could be reduced. In addition, beneficiaries would then face strong incentives to make informed, cost-sensitive decisions about their medical care. Such changes could be designed to maintain greater protection for older beneficiaries or beneficiaries with lower income.

V. Conclusion

Under any plausible scenario, rising costs for health care and the aging of the U.S. population will cause federal spending to increase rapidly. The growth of health care spending in the long term will be determined primarily by growth in the cost of medical care per person. The aging of the population will also contribute to future spending growth, especially for Medicare, which will cover a growing number of beneficiaries as baby boomers become eligible for the program and life expectancy continues to rise.

Large reductions in spending for health care will not actually be achieved without fundamental changes in the financing and delivery of health care. The government can spur those changes by transforming payment policies in federal health care programs and by providing incentives to individuals to choose less costly care. Those approaches could directly lower federal spending on health care and indirectly lower private spending on it as well. One broad long-range approach for reform would combine specific policy actions—to generate near-term saving and provide experience that would lay the groundwork for future savings—with a mechanism or framework to impose ongoing pressure for achieving efficiencies in the delivery of health care.

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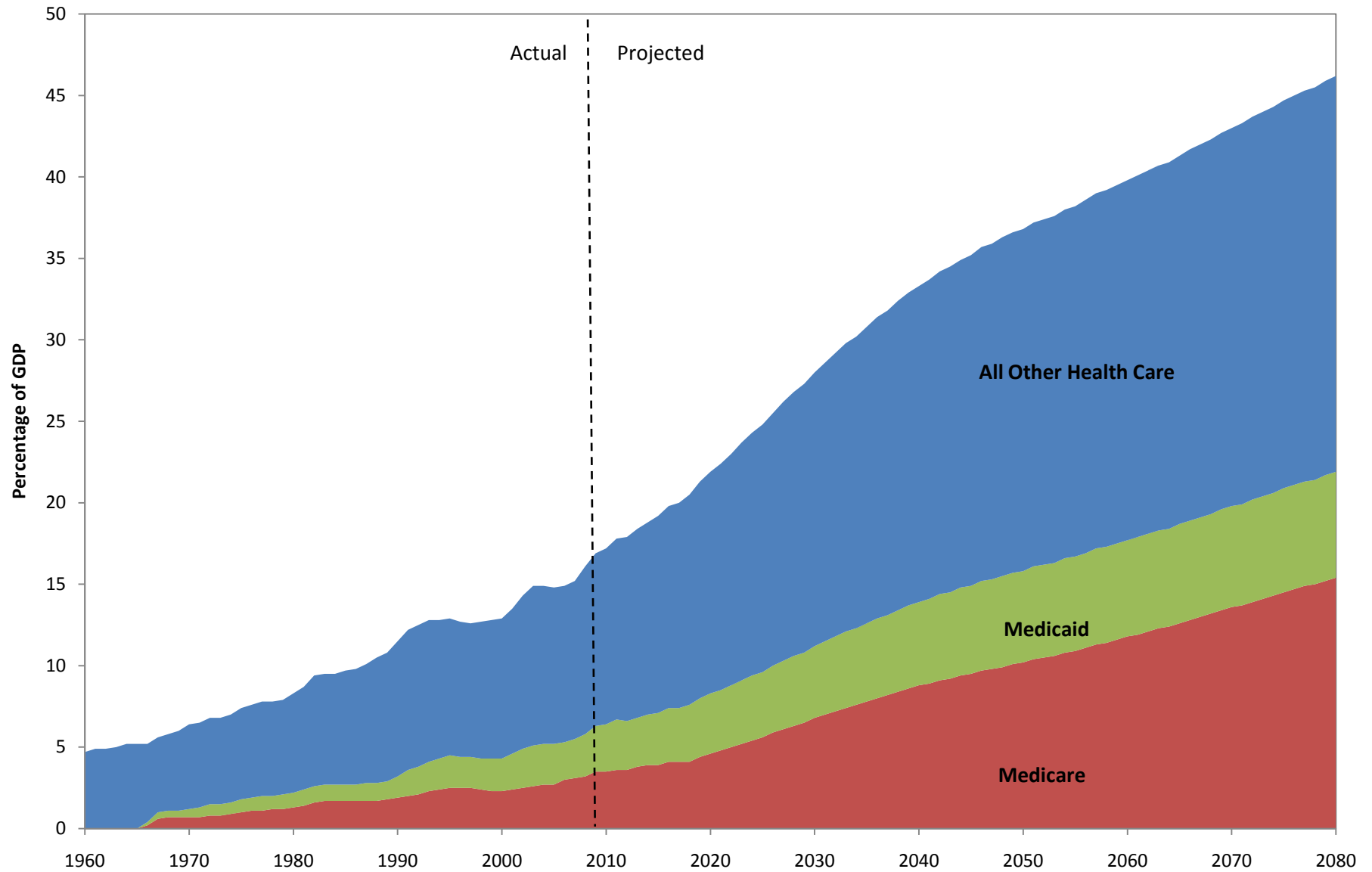
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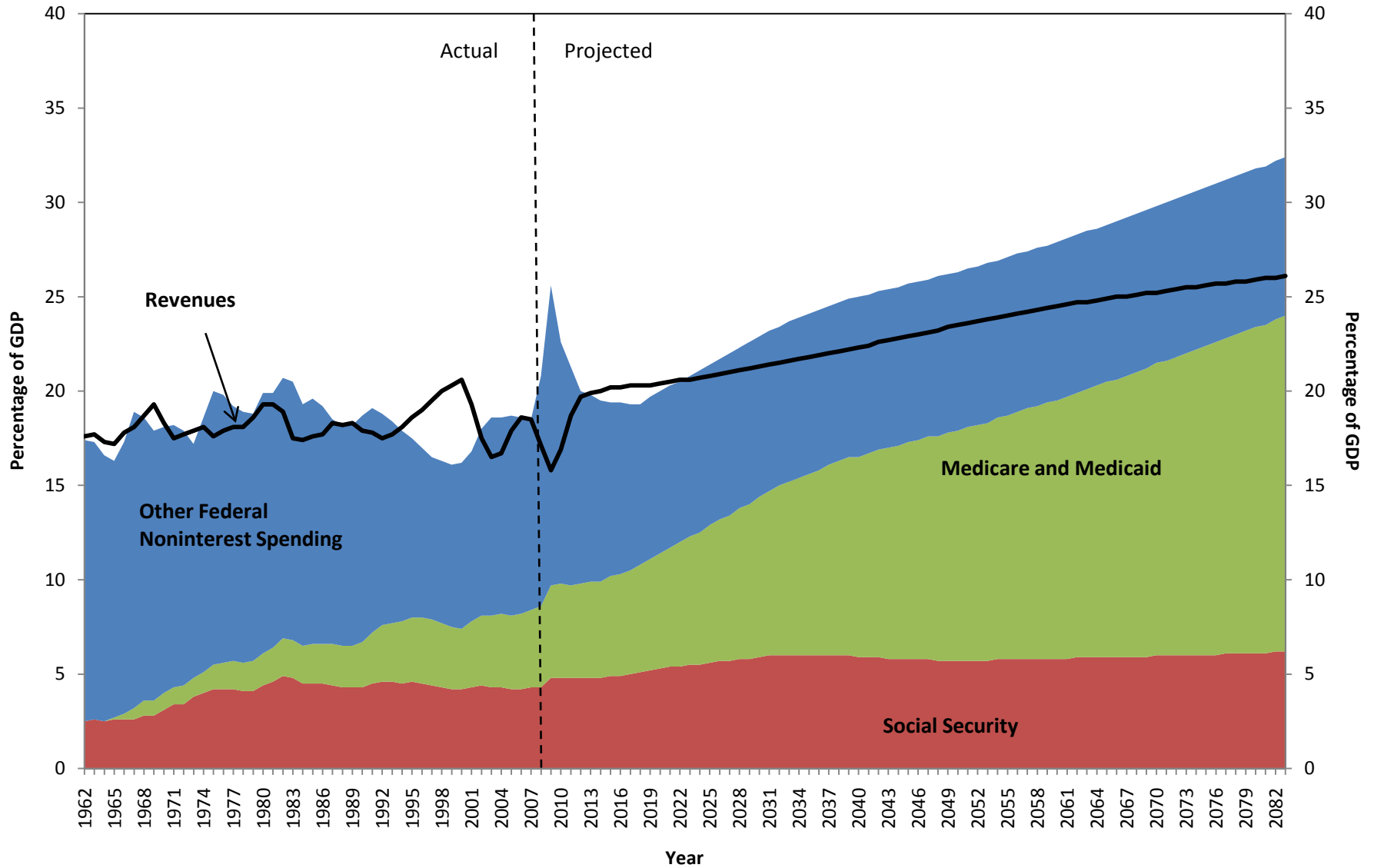
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Figure 1. Total Spending for Health Care Under CBO's Extended-Baseline Scenario



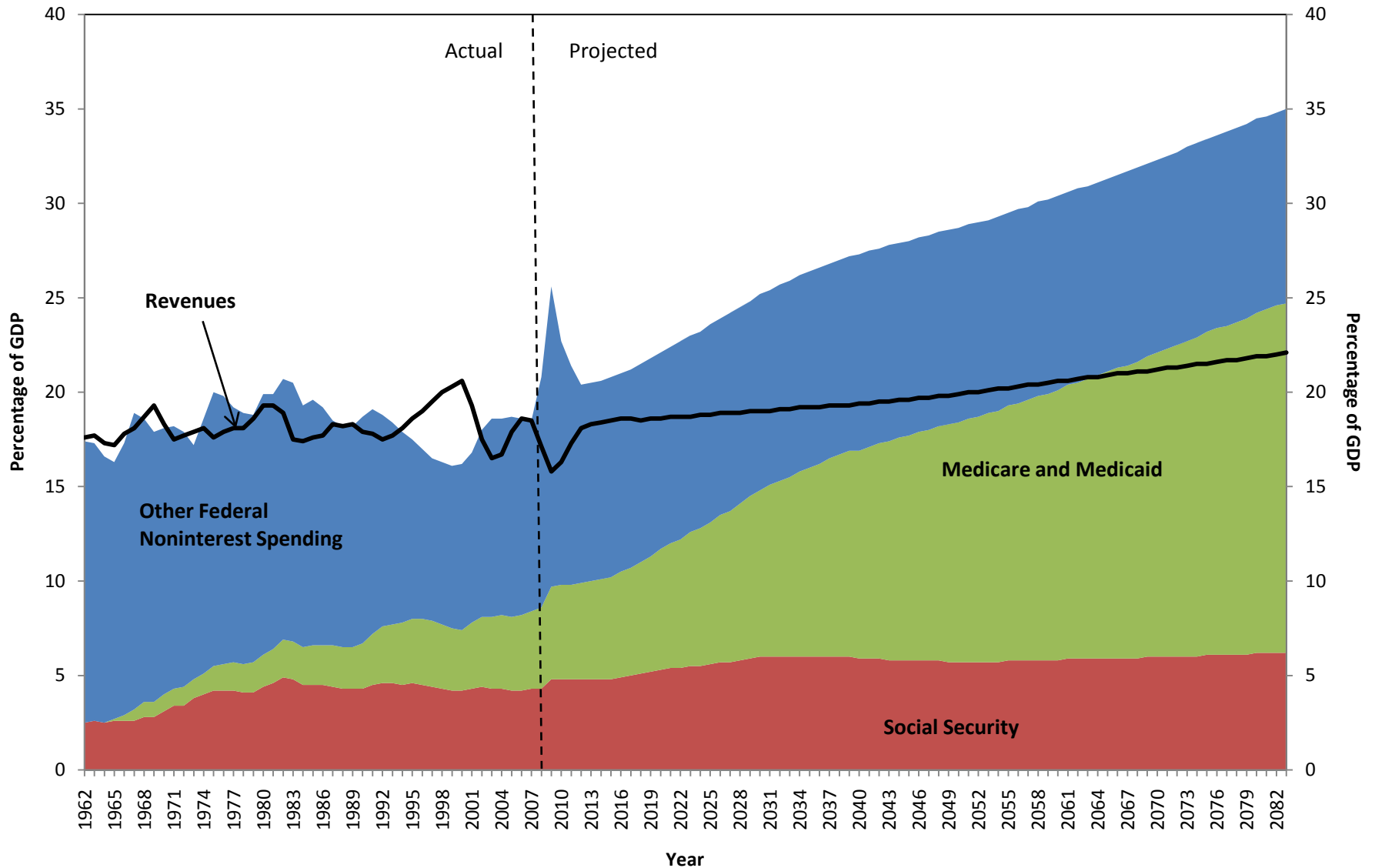
Source: Congressional Budget Office, *Long-Term Budget Outlook*, Figure 2-1. June 2009.

Figure 2. Federal Revenues and Noninterest Spending, by Category, Under CBO's Extended-Baseline Scenario



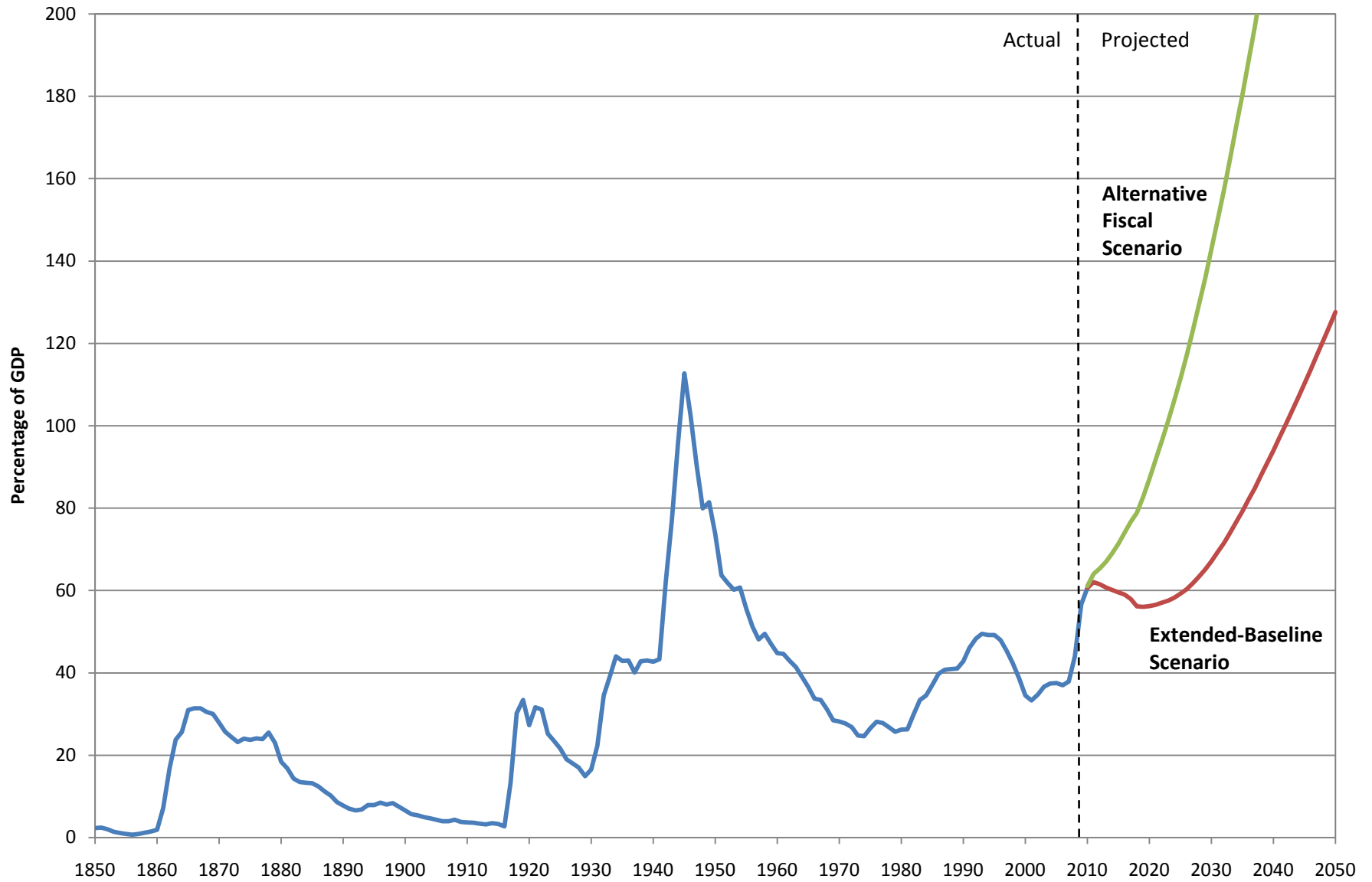
Source: Congressional Budget Office, *Long-Term Budget Outlook*, Figure 1-1. June 2009.

Figure 3. Federal Revenues and Noninterest Spending, by Category, Under CBO's Alternative Fiscal Scenario



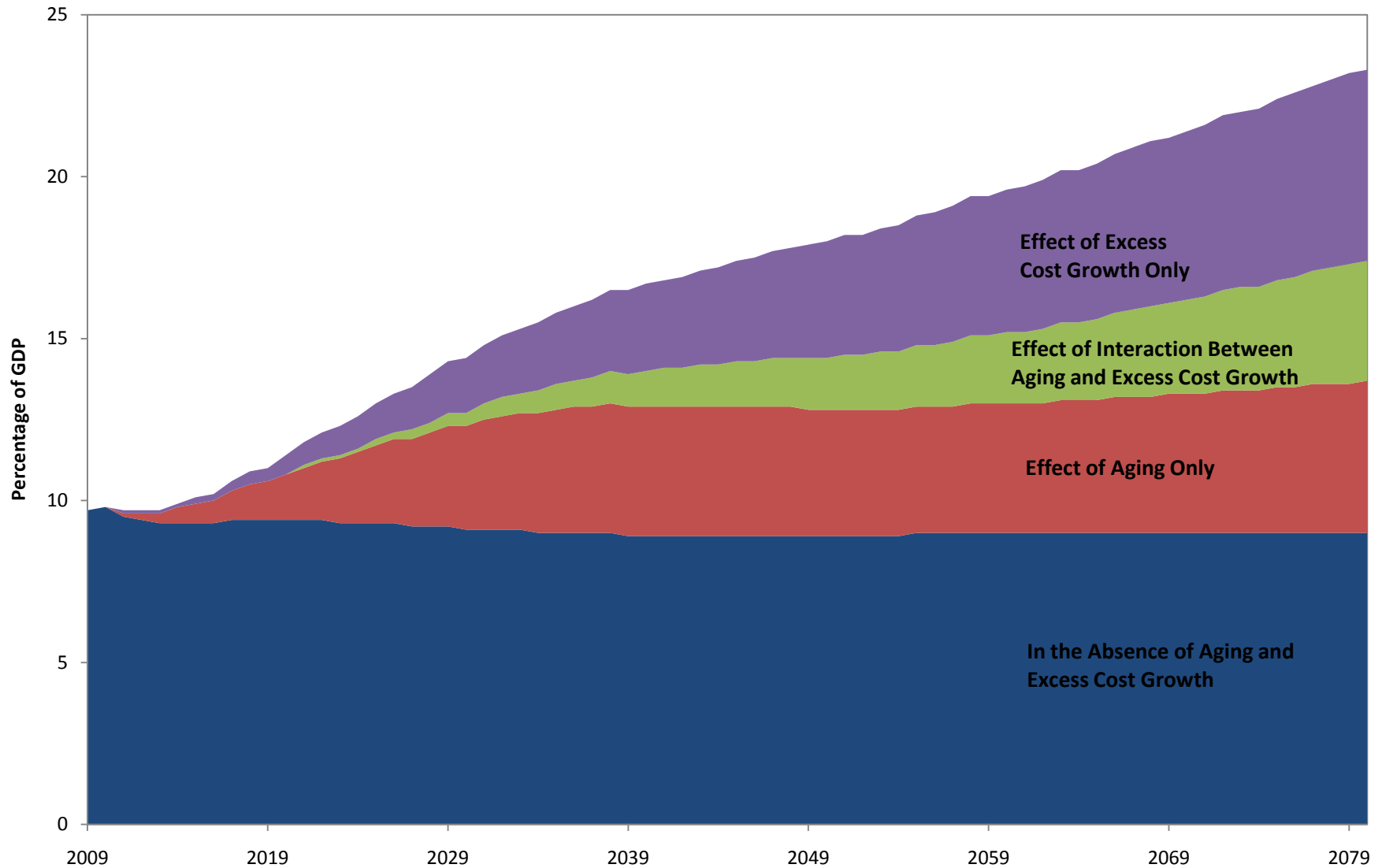
Source: Congressional Budget Office, *Long-Term Budget Outlook*, Figure 1-2. June 2009.

Figure 4. Federal Debt Held by the Public as Percentage of GDP



Source: Congressional Budget Office, *Long-Term Budget Outlook*, June 2009.

Figure 5. Factors Explaining Future Federal Spending on Medicare, Medicaid, and Social Security



Source: Congressional Budget Office, *Long-Term Budget Outlook*, June 2009.

Table 1. Federal Fiscal Imbalance Under CBO's Long-Term Budget Scenarios
(Percentage of GDP)

Projection Period	Revenues	Outlays	Fiscal Gap
Extended-Baseline Scenario			
25 Years (2009-2033)	21.6	23.7	2.1
50 Years (2009-2058)	22.0	24.6	2.6
75 Years (2009-2083)	22.7	25.9	3.2
Alternative Fiscal Scenario			
25 Years (2009-2033)	19.9	25.3	5.4
50 Years (2009-2058)	19.6	26.5	6.9
75 Years (2009-2083)	19.9	28.0	8.1

Source: Congressional Budget Office, *Long-Term Budget Outlook*, June 2009.

Table 2. Excess Cost Growth in Spending for Health Care
(Percentage Points)

	Medicare	Medicaid	All Other	Total
1975 to 1990	2.9	3.2	2.3	2.6
1990 to 2007	1.7	0.8	1.3	1.4
1975 to 2007	2.3	1.9	1.8	1.9

Source: CBO, *Long-Term Budget Outlook*, Table 2-3 (June 2009).

Table 3. Assumptions About Excess Cost Growth in Spending for Health Care Over the Long Term

(Percentage Points)

	Rate in 2020 (Historical Average, 1975- 2007)	Annual Decline in Rate, 2020- 2083 (Percent)	Average Rate, 2020-2083	Rate in 2083
Medicare	2.3	1.5	1.5	0.9
Medicaid	1.9	4.5	0.6	0.1
All Other Spending for Health Care	1.8	4.5	0.5	0.1

Source: CBO, *Long-Term Budget Outlook*, Table 2-4, June 2009.