Committee for a Responsible Federal Budget

Health Care and The Federal Budget

July 2009

Summary

The nation's 2009 annual health care bill: **$2.5 trillion**—$18 out of every $100 produced by the domestic economy (gross domestic product or GDP).[1]

Projected health expenditures in 2018: **$4.4 trillion**—$1 out of every $5 produced domestically.

Health care cost for each man, woman and child: **$8,050** in 2009; $12,104 in 2018 (adjusted for inflation).

Health-related spending in the federal budget: **$870 billion** in 2009—21 percent of total spending—more than amounts projected for Social Security ($680 billion) or national defense ($645 billion, excluding defense health care costs).

The federal budget's share of the national health care bill: **35 percent** in 2009.

Health care's rank within overall consumption: **#1**—Americans spend more for health care than for any other type of good or service including housing, food, or transportation. The health care industry is the second largest private employer after retail operations.

Despite the sizable level of resources devoted to health care in the United States, there are serious problems:

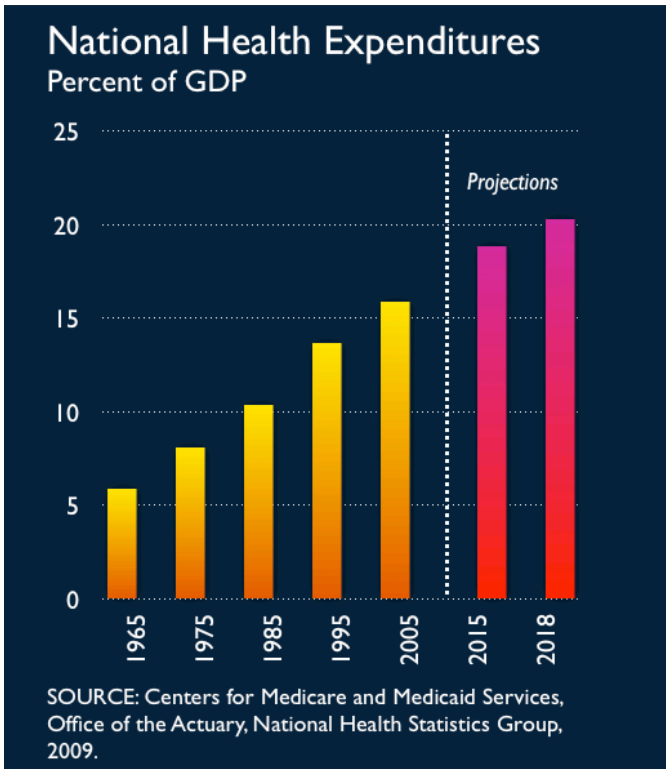
- Compared with other industrialized nations, the United States spends the most per person but ranks at the bottom of health indicators including infant mortality rates and life expectancy at age 60.

- 46 million people living in the United States did not have health insurance in 2007. Another 17 million may be underinsured. Those statistics point to inequities in access to and the affordability of health care.

- The high rate of growth in annual health care spending strains public and private budgets. The excessive growth in costs also raises serious concerns about the efficiency and equity of the nation's health care system.

- According to opinion polls, more than four out of 10 Americans rate national health care quality as only "fair" or "poor," and about twice as many—eight out of 10—are dissatisfied with the total cost of healthcare. Yet when it comes to their own health care experience, people are generally positive about its quality, and most report that they are satisfied with the amount they pay.[2] [3]

The health care economy involves tangled and competing incentives. Most Americans (59 percent) are covered through their employers. As patients, they usually do not decide what services to buy. Because patients rarely pay the full bill directly, they have few opportunities and little apparent need to comparison shop. Employers, who buy health insurance on behalf of their employees and are concerned about workers' welfare, must also pay attention to their balance sheets. Governments, in the design and operation of public programs, must respond to political and economic pressures as well as policy imperatives. The suppliers of health care services—physicians, hospitals, and other health care providers—must balance their economic well being with the health needs of their patients and customers.



The U.S. health care system is complex, inefficient, and hard to understand for most of its stakeholders. It encourages the overuse and misuse of services. Many patients do not receive the type of well-coordinated and managed care that provides the best opportunities for good health outcomes. Efforts to contain costs in any one area can cause costs in other areas to grow.

The truth is that most Americans have no idea how much the current system costs them. Until they do, they have little reason to support the types of reforms required to make the nation's health care more affordable—and to keep it from consuming increasingly greater shares of our economic resources.

Opportunities

Health care reform has the attention of Washington policy makers. The President and congressional leaders are engaged in serious efforts to enact legislation that would change the health care system to meet three goals: better quality;improved access; and lower cost.

Studies by the Congressional Budget Office (CBO) and other analysts indicate that there are opportunities to do more with less. Health care researchers believe that a significant portion of the resources devoted to health care may not contribute to a healthier population. If so, reforms could produce sizable savings for public and private budgets without harming health outcomes.

Clearly, controlling the growth in health care costs is essential to prevent more people from losing their health insurance. CBO estimates that if costs continue on their current path, in 10 years the number of people without insurance could grow to 54 million, compared with 45 million in 2009.[4] Is it possible that eliminating overuse, underuse, and misuse of health care services could rein in cost growth *and* free up enough resources to cover the entire population?

> *"...The health care system suffers from serious and pervasive problems; access to health care is constrained by high and rising costs; and the quality of care is not consistent and must be improved, in order to improve the health of our citizens and our economic security."*
>
> **Executive Order No. 13507**
> **April 8. 2009**

To no small extent, expanding access and controlling costs are competing objectives. While there are savings opportunities from universal coverage, they would, by themselves, be insufficient to pay for the added costs of broader coverage. According to the CBO, it would take 10 years before savings from comprehensive health care reform offset the cost of expanded coverage. Only in the following 10 years would systemic changes be large enough to "bend the curve," or reduce overall health spending below its current, unsustainable trajectory—but not even then if the commitment to constrain costs is not maintained.[5]

No Easy Answers

Successful health care reform will require major changes in the way medicine is practiced in the United States, with corresponding changes in the way the nation finances health care. The country relies on a patchwork of public and private insurance and individual payments to pay its health care bills. Most people have health insurance, but 15 percent of the population does not.

"The available evidence also suggests that a substantial share of spending on health care contributes little if anything to the overall health of the nation, but finding ways to reduce such spending without also affecting services that improve health will be difficult."

Congressional Budget Office
February 2009

The absence of insurance for some creates problems for all. People without insurance may delay seeking care, which could result in poorer health, delayed and more costly treatment, and greater potential for individual illness to turn into public health problems. In addition, the uninsured become "free-riders" in a system that relies on contributions from many to keep rates affordable. Finally, lack of coverage leads to inefficient, indirect, and opaque payment methods that undermine the public's confidence in the fairness of the system and that add to overall costs.

More access and broader coverage do not save money, however. Greater coverage will increase health spending. Unless major changes are successfully implemented in health care delivery and payment systems, costs will continue to rise from a larger base at a rapid pace. Moreover, potential savings are speculative, while costs are far more certain. That imbalance suggests that unless there is broad popular support for the measures that will be required to achieve savings, the nation's health care bill could become that much more unaffordable.

Health care reform presents an extremely challenging set of issues for policy makers and the public. Everyone wants to fix the system. Few, however, want their own health care services to be disrupted, and no one wants to pay more. Over half of Americans think that the federal government has the responsibility for making sure that everyone has health insurance coverage, but that does not mean they support a government-run system.[6]

While most reform options would add $100 billion a year or more in federal subsidies for health care, the federal budget is already overcommitted. Simulations of the current budget outlook already show large and growing deficits and debt if tax and spending policies are left unchanged over the coming decades. Worse still, those "current policy" projections are conservative. They already assume that health care spending will grow more slowly than today's rate.

Fiscal prospects are even worse when projections are adjusted to reflect near-term changes to Medicare and tax policies that lawmakers seem likely to adopt. That alternative scenario shows federal debt rising much more rapidly to unsustainable levels.

Although the President and congressional leaders have adopted "budget neutrality" as their standard for health care reform, that is not an adequate goal from a fiscal policy perspective. If policy makers use hard-earned savings and new revenues to finance new benefits, they risk:

- Adding hard-to-control cost pressures to a budget that is already seriously out of long-term balance;
- Failing to achieve meaningful progress on existing fiscal problems; and
- Making it that much more difficult to address other public needs and priorities.

About *Health Care and the Federal Budget*

Susan Tanaka wrote this report. Marc Goldwein provided helpful comments on the draft. The report and other publications can be found at www.crfb.org.

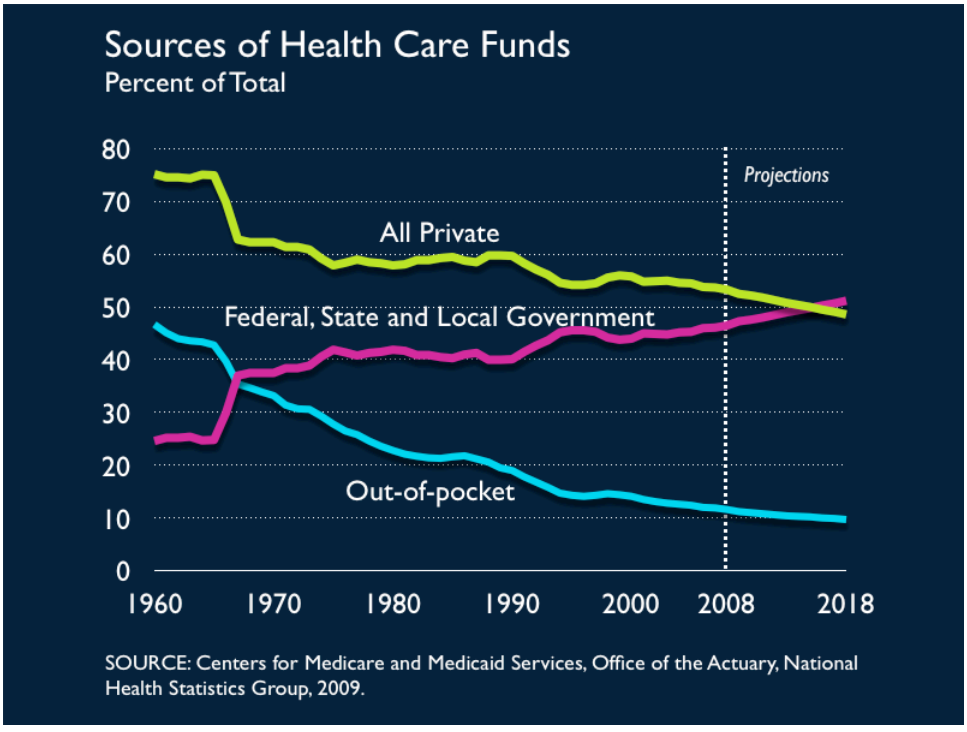
Health Care and the Economy

IN 2016 FINANCING FROM PUBLIC SOURCES WILL EXCEED PRIVATE FINANCING.

The responsibility for paying for health care has gradually shifted from private to public sources. Along the way, it has become more difficult to control costs and to maintain access.

Health care is financed through multiple channels. Most funds flow through a system of private and public insurers, or third-party payers, making it hard for patients (consumers) to get a full picture of their total costs. Easily ignored are the employer contributions in the form of health insurance benefits. Those benefits represent a form of compensation and come out of employee wages or owner or shareholder profits. In addition, governments use tax dollars to finance public insurance programs.

Due to the complex system of financial intermediaries, it may not always be obvious to individuals and families that they pay the nation's health care bills. Although out-of-pocket spending is most visible to them, it accounted for only 12 percent of total health spending in 2008 and its share has been declining.



Source of Funds

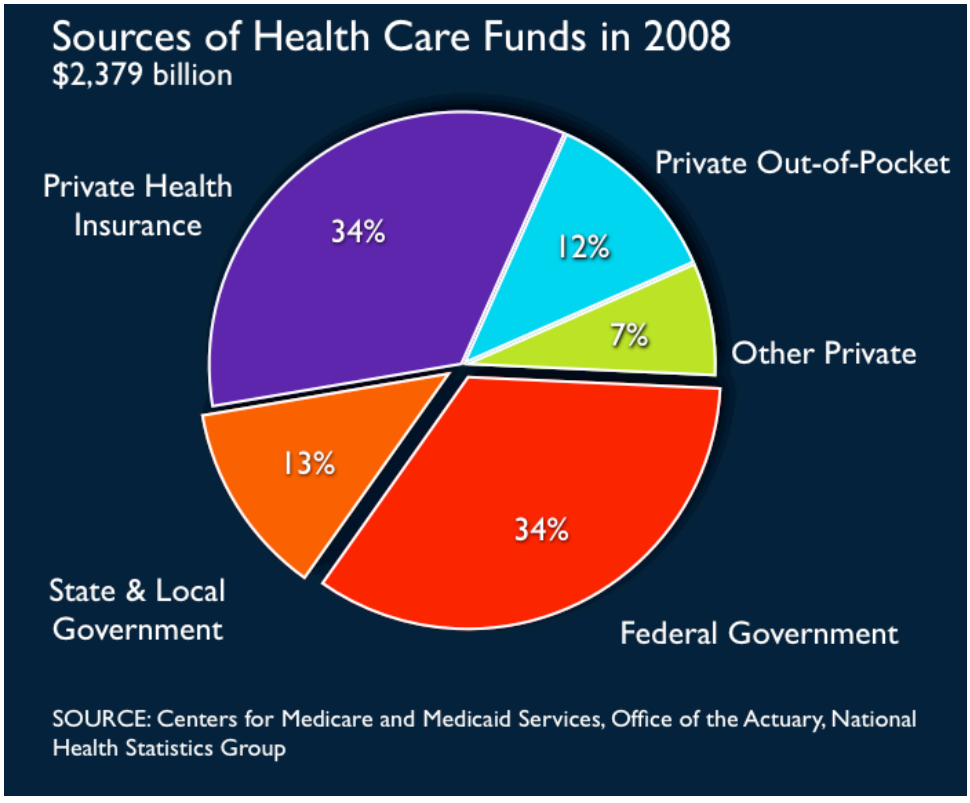
The most common way of looking at the allocation of health care costs is to consider who directly pays the provider's bill.

In 2008, by source of funds or type of payer:

- Private payers, including private insurance (sponsored by employers or bought directly by individuals), out-of-pocket spending and other private sources accounted for 53 percent of total spending.
- Federal, state, and local government resources contributed 47 percent of health care spending.

Over time, public sources of funding have become more important. Before Medicare, private payers covered more than 75 percent of total costs, while government payments covered less than one-fourth.

Patient-consumers are largely insulated from the full cost of their care. The most visible type of financing —out-of-pocket spending for insurance premiums, co-payments, deductibles, and direct buys of health care services and supplies—covered only 12 percent of health care costs in 2008. In 1965, out-of-pocket spending paid for 43 percent of total health expenditures. Since then, payments through private and public insurers have grown. That makes it more difficult for consumers to appreciate the full cost of their health care.



Sponsors of Health Care Expenditures

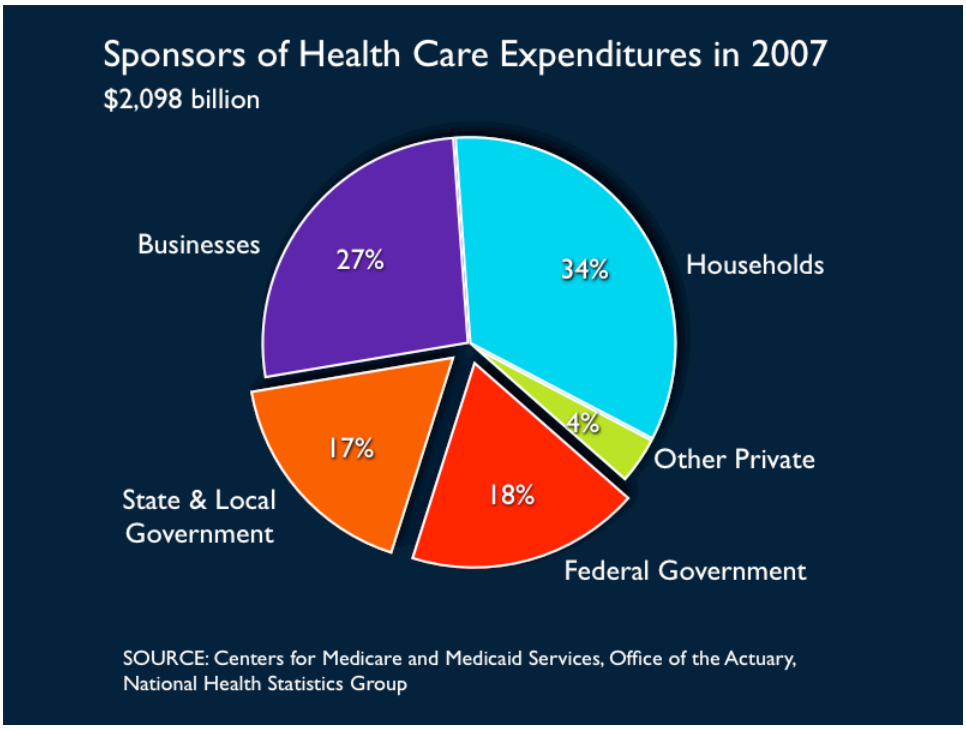
Another way of looking at health care finances is to examine contributions by sponsor. Sponsors provide the underlying financing for the bill payer.

The sponsors of health care spending pay insurance premiums and Medicare taxes and make direct expenditures. They are businesses, households, and government employers. (Medicare spending is split between government and households, with the shares that are financed by general tax revenues allocated to government and by payroll taxes and premiums to households.)

Over time, businesses' share of health care expenditures has held steady. Businesses have been able to control their health insurance costs by negotiating with health insurers over premiums, imposing higher cost-sharing arrangements on employees, and reducing or dropping coverage.

The household share has declined over time due to the growth in managed-care plans in the 1990s and a continuing decline in out-of-pocket payments since then.

By contrast, the share financed through general revenues of federal, state, and local governments has increased. Medicare costs are growing faster than beneficiary premiums and dedicated payroll tax revenues. Medicaid costs have also risen faster than privately-financed health care.



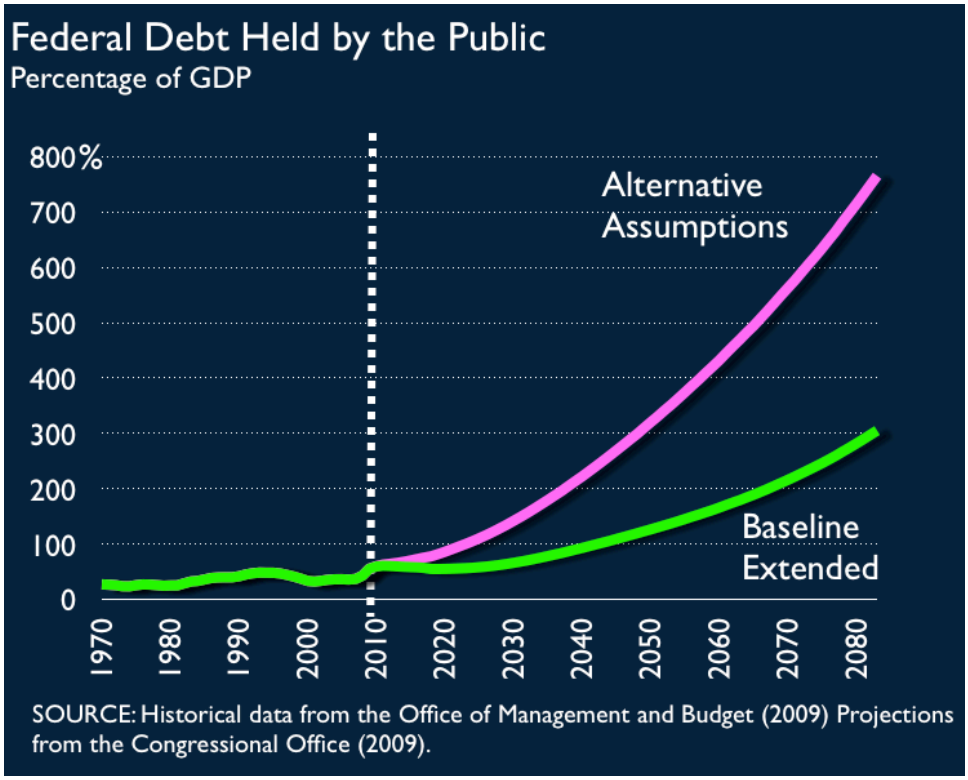
Health Care and the Budget

THE PROJECTED GROWTH IN HEALTH CARE COSTS IS THE SINGLE GREATEST CHALLENGE FACING THE FEDERAL BUDGET.

Spending for health care programs is growing faster than for all other programs in the budget and faster than federal revenues. The result is an ever-widening gap between federal commitments and the resources available to pay for them.

As rising costs threaten to make health care unaffordable for increasing numbers of Americans, most proposals to reform the health care system look to the federal government to provide financial relief while enhancing and preserving access to care. However, the federal budget is already under serious pressure as a result of existing health programs.

CBO's projections, which were released in June 2009, show federal debt levels rising to unsustainable levels of more than 300 percent of GDP if current baseline policies continue. Debt levels would be even higher—nearly 770 percent of GDP—under alternative assumptions that reflect likely changes to current policies.[7]

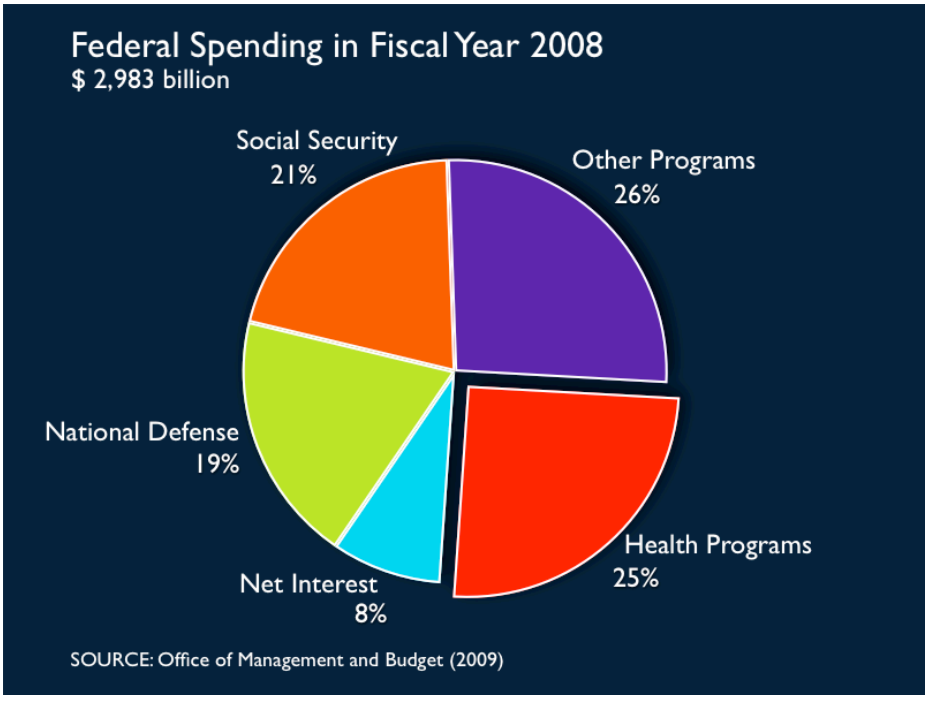


Budget Trends

In 2008, the federal government collected $2.5 trillion and spent about $3 trillion, resulting in a deficit of $459 billion. For 2009, CBO projections, which reflect the economic recession, financial bailouts, and fiscal stimulus, show a deficit of $1.7 trillion—nearly 12 percent of GDP. Although budget analysts expect that the gap between revenues and spending will narrow in the near term as the economy recovers, the federal government faces significant fiscal challenges over the long term if current policies do not change.

Health care programs play a major role in the budget's outlook:

- In 2008, $25 out of every $100 in federal spending was related to health programs. By comparison, $19 out of every $100 was for defense (excluding health costs), $9 for non-medical assistance for low-income families, and $2 for education.
- Federal health care dollars paid more than one-third of the nation's medical bills.
- The federal budget is especially sensitive to the rising cost of health care. Medicare and Medicaid cover people ages 65 and older and people with disabilities. Individuals in those groups are the most likely to have high medical needs.
- The federal government also is an employer. It covers the health care costs for active-duty military, their dependents, many veterans, and civilian federal employees.
- Besides direct spending programs, the federal government uses the tax code to subsidize private employer-sponsored health insurance benefits. Employers can deduct the cost of employee health benefits from business income, and the value of insurance is not included in employees' taxable income. In 2007, that favorable tax treatment was worth an estimated $145 billion in income taxes plus another $100 billion in payroll taxes. The health care exclusion is the largest single tax expenditure in the U.S. tax code. Because there is no limit on the exclusion, the revenue loss to the Treasury grows as health care costs grow.



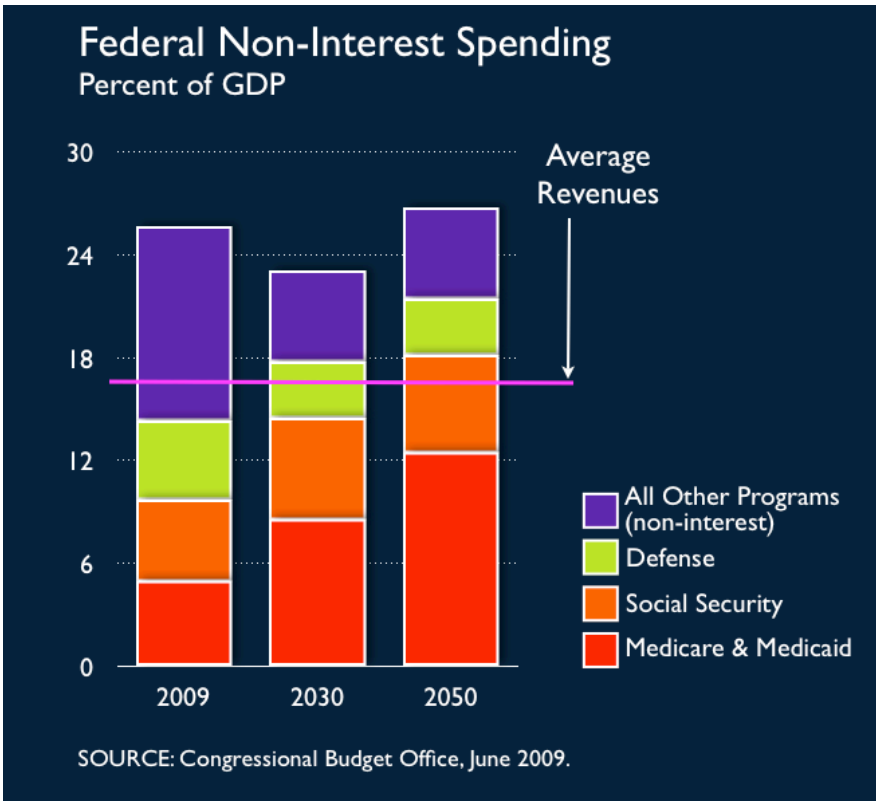
Over the long term, the growth in health care spending will create even greater pressure within the budget. The combination of aging baby boomers, increasing longevity and overall increases in health care costs will be unsustainable. If taxes do not rise proportionately and current spending policies do not change, the projected rise in federal debt could slow the future growth of the economy and lower standards of living for younger generations.

Federal Support for Health Care in 2007

	Number of Beneficiaries (millions)	Estimated Cost ($ in billions)
Medicare	41	375
Medicaid	40	191
Defense and Veterans Health Care	11	75
Income Tax Benefits		
Employment-based insurance	177	145
Other tax benefits (deductibility of premiums paid by the self-employed, medical savings accounts, medical expenses)	n.a.	17

SOURCES: U.S. Census Bureau (2008), Office of Management and Budget (2009), and Joint Committee on Taxation (2008).

Future policy makers and taxpayers will face the choice of higher taxes, steep cuts in other programs, or deficits and debt that grow so fast that they could create serious economic consequences. CBO projections show that if current policies do not change, spending for Medicare and Medicaid alone will double—measured as a percentage of GDP—within 30 years and will be nearly two and one-half times larger by 2050.[8] Meanwhile, total revenues have remained relatively constant, averaging a little more than 18 percent of GDP in the past 40 years. That is barely enough to pay for current federal program costs, let alone the net interest expense that would result from annual deficits and accumulating debt and the expected growth in Social Security, Medicare, and Medicaid.



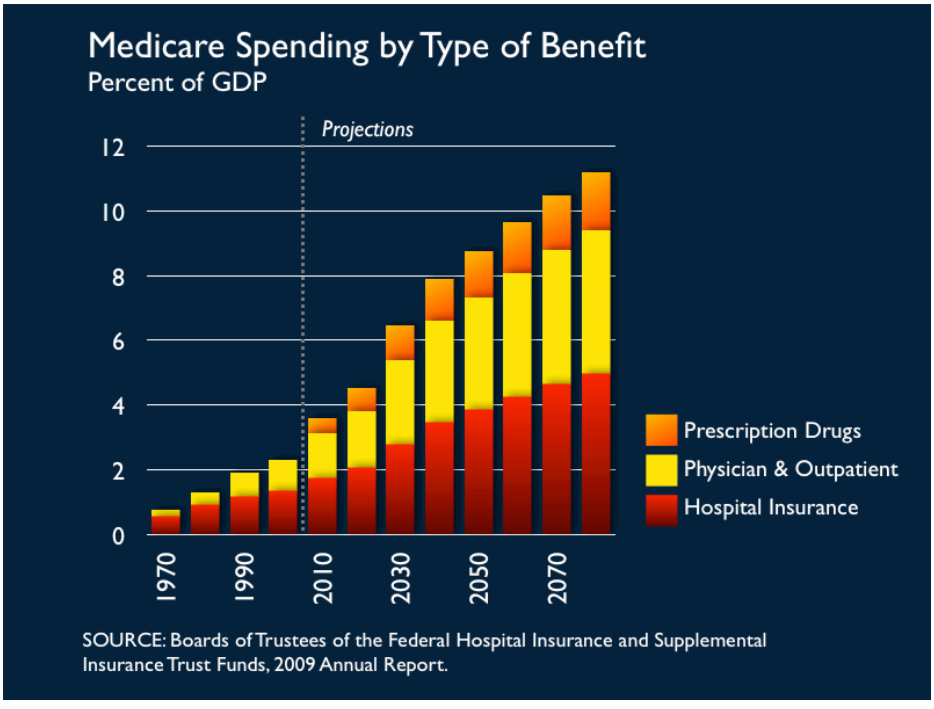
Medicare

Medicare provides health insurance to more than 44 million people, including 95 percent of individuals ages 65 and older and many people with disabilities. It provides fee-for-service coverage for inpatient hospital care (Part A), physician services and other non-acute care (Part B), and prescription drugs (Part D). (Medicare Part C —or Medicare Advantage— refers to privately-sponsored plans that provide coverage for hospital, physician and outpatient services through networks of health care providers.) The Medicare program began in 1965 when retirees were left without health insurance as the working age population increasingly gained coverage through employment.

Medicare is currently the third largest category of spending in the federal budget after Social Security and national defense. It provided $454 billion in benefits in 2008. Under its baseline assumption of no change to current policies, CBO estimates that total Medicare spending will surpass defense spending in six years (2014). CBO also projects that total Medicare spending will surpass Social Security to become the largest federal program in 2026.

Over the next 10 years, CBO projects that Medicare will grow about 6.6 percent a year, more than 2 percent a year faster than the overall economy. That growth reflects increases in the number of beneficiaries, expansion in benefits, and "excess" growth in overall health care costs.

Long-term projections show that under current law, total Medicare spending will rise from 4 percent of GDP today to 11 percent in 2050 and about 15 percent in 2080. That is a conservative estimate. Current law reduces physician reimbursement rates to unsustainably low levels, a requirement that has been overturned by lawmakers in recent years. As a result, over the long-term, Part B costs could be 20 to 30 percent higher than currently projected.



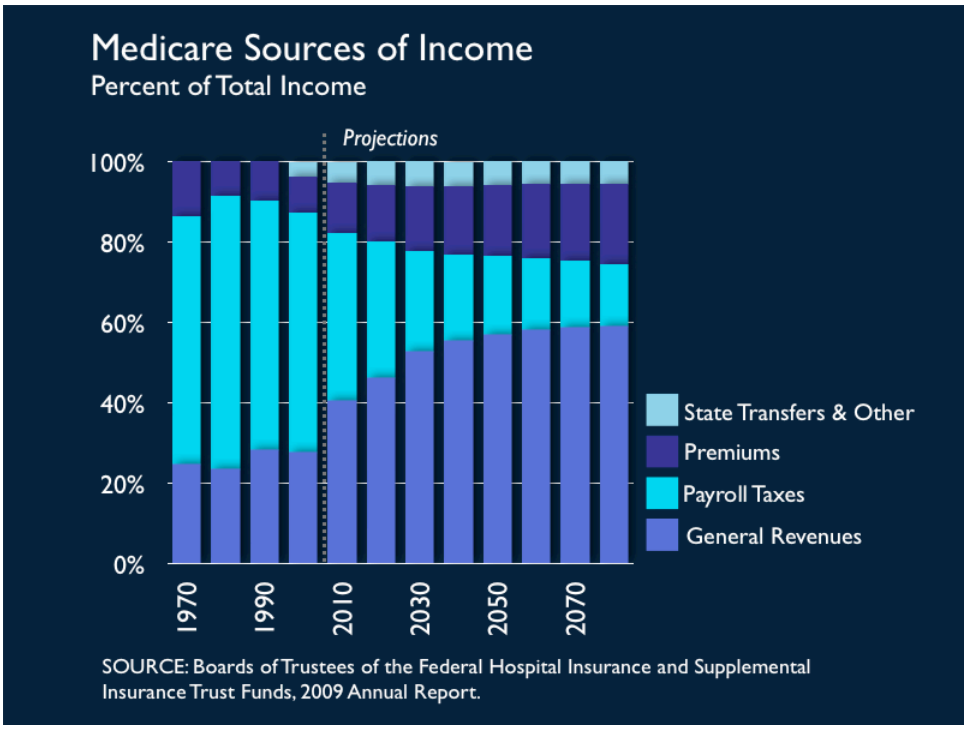
Medicare is financed through a combination of workers' payroll taxes, general revenues and beneficiary premiums, co-pays and deductibles. Payroll taxes fund Part A. Initially beneficiary premiums and general revenues shared the cost of benefits covered under the Part B program. In the mid-1970s, the share of premiums to Part B costs began to decline. Premiums now cover about 25 percent of Part B costs. Part D premiums average about 25 percent of basic drug plan costs. General revenues pay the remaining costs.

Over time, Medicare costs have outstripped the program's dedicated sources of revenues. Although the overall program was never designed to be fully self-supporting, it has become increasingly dependent on general revenues and, with each passing year, places more pressure on the overall budget.

In 1970, general revenues provided 25 percent of Medicare's total income. In 2008, that share had risen to more than 40 percent. Under current policies, if benefits do not change, Medicare actuarial projections show that 57 percent of the program's income in 2050 will have to come from general revenues.

In 2008, the amount of general revenue needed to support Medicare exceeded 13 percent of individual and corporate income tax collections. In 2019, Medicare will require 19 percent of projected income taxes. By 2050, if policies do not change, Medicare's claim could more than double to 38 percent of total income taxes collected.

Despite its rapid growth in costs, Medicare exposes its beneficiaries to significant financial risks. Gaps in coverage and high co-payments and deductible requirements leave beneficiaries with median out-of-pocket costs of more than 15 percent of income, with people ages 85 and older facing even greater burdens. (The median represents the point at which half of beneficiaries experience lower costs and half experience higher costs.)



Medicaid and the Children's Health Insurance Program (CHIP)

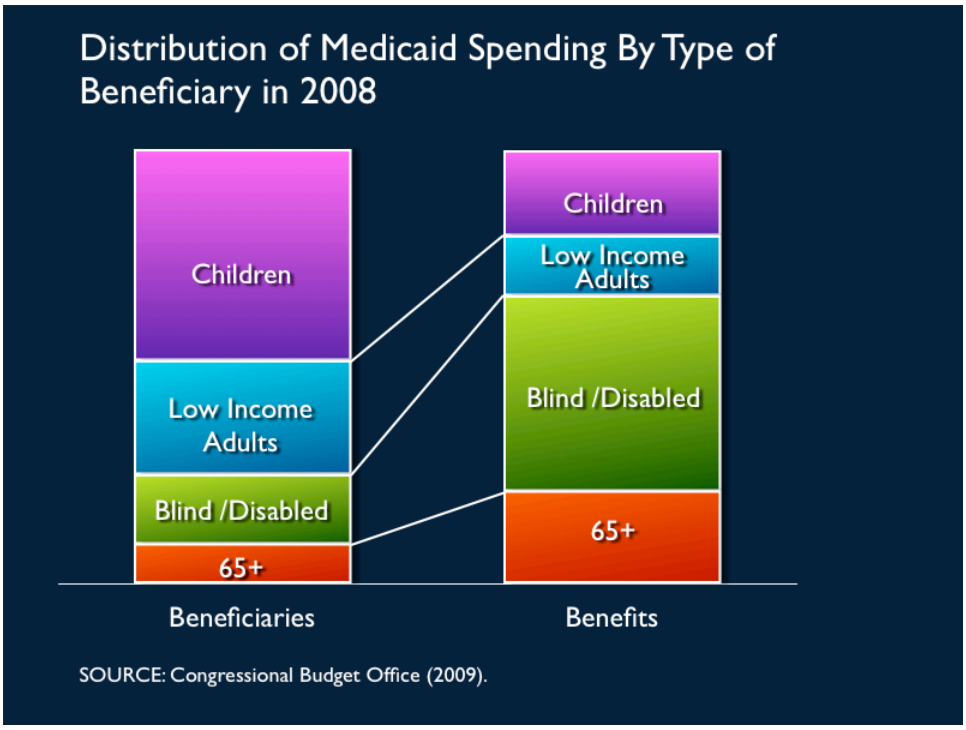
Medicaid and the State Children's Health Insurance Program (SCHIP)—reauthorized in 2009 as the Children's Heath Insurance Program or CHIP—are means-tested programs designed to provide health insurance for children and adults who meet income eligibility requirements. (Means-tested programs are available to people who have incomes at or below specified levels. Those income ceilings are frequently expressed as a percentage of the official poverty level for given family size.)

In 2008, Medicaid covered about 63 million people who have diverse health care needs:

- Children make up the largest group of beneficiaries —just under half of the total—but their health care represents only 20 percent of program benefit payments.
- Two-thirds of Medicaid benefit payments are made on behalf of the 25 percent of beneficiaries who are ages 65 and older, blind or disabled.

States administer the Medicaid program and share in its costs. The federal government matches states' spending for Medicaid. The amount of the federal match varies according to each state's per capita income. The match rate ranges from 50 percent for higher-income states to 76 percent for states with lower incomes, averaging 57 percent nationwide. States are required to cover certain populations (e.g., children under age 19 from families with incomes under the poverty level—$21,200 for a family of four in 2008—or pregnant women with family incomes up to 133 percent of poverty). States can choose to expand coverage to more people and provide broader benefits.

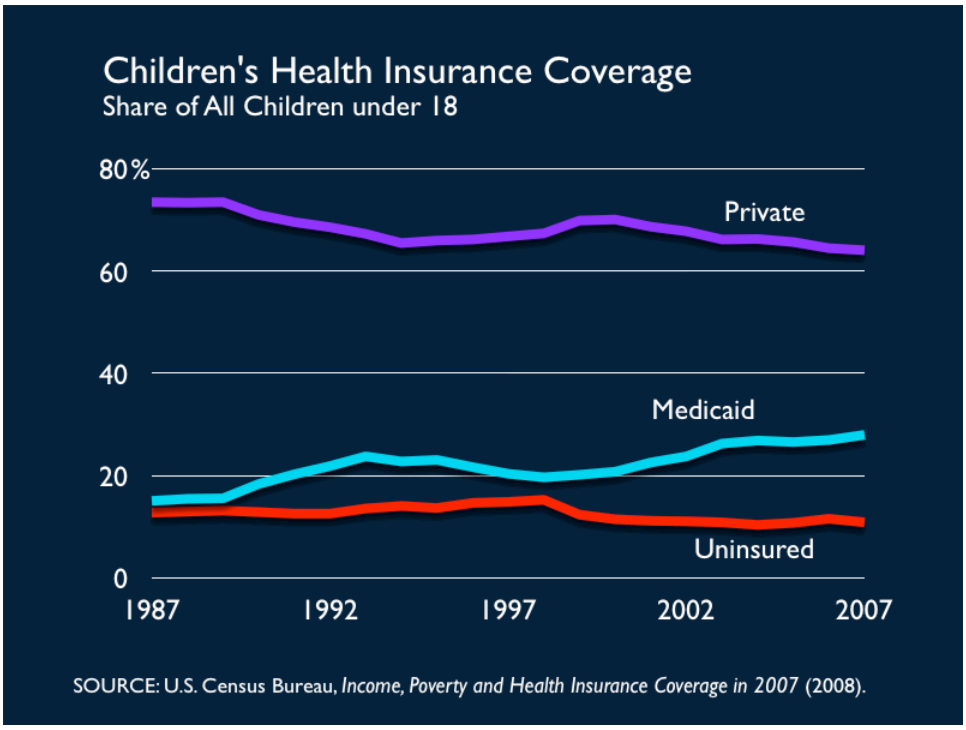
In 2008 the federal share of Medicaid was $201 billion. As with other health care expenses, Medicaid costs are expected to grow faster than the economy. Between 2008 and 2050, Medicaid spending will more than double, rising from 1.5 percent of GDP to 3.2 percent, according to CBO's long-range budget projections.



Medicaid fills an important and costly role in health care financing. Medicare provides limited coverage for skilled nursing facilities. Medicaid, however, covers nursing home care and is the largest third-party payer for those services. Medicaid benefits represented 42 percent of total expenditures for nursing homes, compared with 38 percent from private sources. In all, Medicaid spent $62 billion on long-term care in 2008.

SCHIP—now CHIP—was created to cover children in families whose incomes are too high to qualify for Medicaid. Within federal limits, states determine how to use CHIP grants. They can expand Medicaid eligibility or create separate programs to cover those children. CBO estimates that a monthly average of 6 million children, parents, pregnant women, and other adults will be enrolled in CHIP in 2009, rising to more than 8 million next year.

The federal government spent $7 billion for SCHIP in 2008. CHIP was recently reauthorized through 2013 at more than double the program's earlier funding level of $5 billion. Unlike Medicare and Medicaid, the amount of CHIP funding remains limited, although states have access to additional federal funds through 2013. If the higher funding levels are not extended, CBO estimates that the average monthly number of CHIP enrollees would then decline to around 2 million to 3 million, less than half of today's enrollment.



Health Insurance & the Uninsured

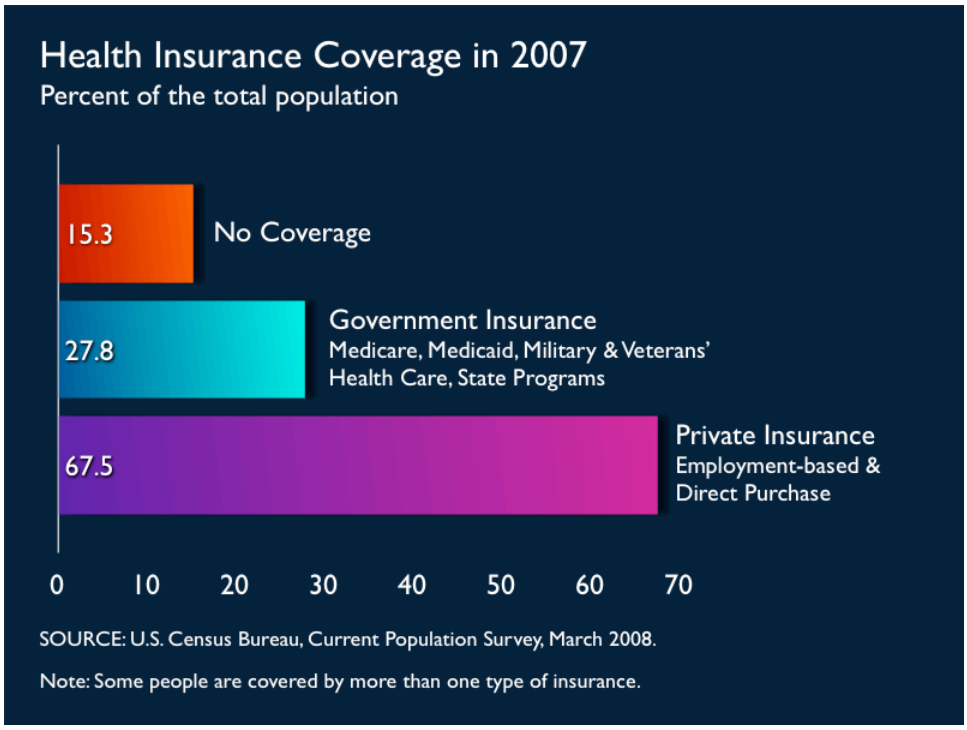
ALTHOUGH MOST PEOPLE HAVE PRIVATE OR PUBLIC HEALTH INSURANCE, APPROXIMATELY 46 MILLION—15 PERCENT OF THE POPULATION—DO NOT.

Health Insurance Snapshot

In 2007, public and private health insurance covered 253 million people, or 85 percent of the U.S. population.[9] Approximately 46 million—more than 15 percent of the population—were uninsured. Among adults ages 19 to 64 who had insurance coverage, about 17 million were "underinsured" or exposed to out-of-pocket costs of 10 percent or more of after-tax income.[10]

Most people—nearly 60 percent of the population—are insured through employer-sponsored health plans. For working-age adults—and therefore their dependents—health insurance coverage is a form of non-cash compensation. As a result, higher-wage earners with steady jobs are more likely to be covered than lower-wage earners who move between employers or who are in and out of the workforce.

Public health insurance programs cover about 28 percent of the population, including about 94 percent of people ages 65 and older and 31 percent of children under the age of 18.



An Accidental System

Insurance provides a way to share financial risks across a large number of people so that no one has to bear expensive costs from accidents and illness all alone. The cost of insurance is a function of the number of people "pooled" together by the plan, the health costs incurred by members of the pool, the strength of the plan's ability to manage costs, and its administrative and overhead costs.

Over the past three decades, the percentage of the population with private insurance has declined from 75 percent to 68 percent while public coverage increased from 23 percent to 27 percent. The percentage without health insurance has increased gradually.

Employers began to serve as the pooling mechanism during World War II. Wage and price controls restricted their ability to compete for scarce workers by offering higher wages. Those controls, however, exempted health benefits. What began as historical accident has become so deeply embedded in the employment landscape of the United States that many, including employers, assume that employers should be responsible for providing health insurance coverage.

Tying insurance coverage to employment creates significant problems:

- Workers can become "job-locked" and unable to move freely between employers because doing so would disrupt their insurance and health care services.
- Small employers do not have enough employees to be able to diversify risks sufficiently, which leads to prohibitively high premium costs and lower employee coverage.
- Enterprising individuals may be deterred from "striking out" on their own because self-employed people must pay directly for the cost of coverage, and the individual coverage available to them is more expensive and generally less comprehensive than group plans.
- Low-wage workers have no room to trade cash wages for health benefits. Because their employers are unlikely to raise total compensation costs higher than the value of the work performed, these workers are more likely to be uninsured.

Employers are concerned about the impact of rising health insurance premiums on their bottom lines. Employment-based plans may attempt to control costs through measures like imposing long waiting periods to exclude people with pre-existing conditions and high health care costs, limiting workers' choice of care providers by creating networks of preferred providers who accept lower payments, and offering plans that deny coverage for costly procedures.

Individuals face a different set of incentives than insurers. Healthy people may be tempted to go without insurance, especially when their incomes are limited. Or they may delay enrolling in plans until they anticipate the need for services. Conversely, people who need health care seek the best coverage they can afford. But if the people who need health care were the only ones to obtain insurance, the price of insurance would be unaffordable.

Public health insurance programs, such as Medicare, Medicaid and CHIP are designed to meet social goals. They address the need for coverage of those who are unable to obtain coverage on their own due to high health care costs, chronic conditions or disability, or because they lack enough income.

Government-financed programs may seem to have deep pockets, but public programs are subject to

political risk. Policy makers' priorities shift and, when they do, policies that determine who is eligible for public programs and that define other terms can change in ways that reduce enrollments.

A Profile of the Uninsured

People who do not have health insurance are a diverse group, but they share common characteristics:

- More than half of uninsured workers worked, but their employers did not offer insurance. About one out of five was not eligible for employment-based plans. About 10 percent of workers were eligible for coverage, but declined due to its cost.
- Large employers are more likely to sponsor health insurance benefits than small employers.
- Higher-wage workers are more likely to have access to employer-sponsored health benefits than lower-wage workers.
- Workers in service-sector and blue-collar occupations are more likely to be uninsured.
- Nearly four out of five of the uninsured are citizens. About 21 percent are non-citizens. Because legal immigrants are ineligible for Medicaid for the first five years of their U.S. residency, and undocumented and temporary immigrants are generally ineligible for Medicaid regardless of the length of residency, immigrants are more likely to be uninsured. (Note: When reform proposals set a goal of "universal coverage," most exclude undocumented residents. Undocumented residents are counted among the number of people who lack health insurance but they are generally ineligible for federal programs.)
- Due to Medicare, retirees (ages 65 and older) and qualifying disabled individuals, populations that are the most likely to use the most health care, are also the most likely to have insurance.

The uninsured tend to be younger workers with lower incomes. Adults between the ages of 18 and 44 represent 57 percent of the uninsured. Young adults between the ages of 18 and 24 are disproportionately uninsured. They represent 10 percent of the population, but 17 percent of the uninsured. Young adults become ineligible for coverage under their parents' policies once they leave school and age out of Medicaid coverage. In addition, they have lower incomes and are less likely to qualify for employment-based coverage.

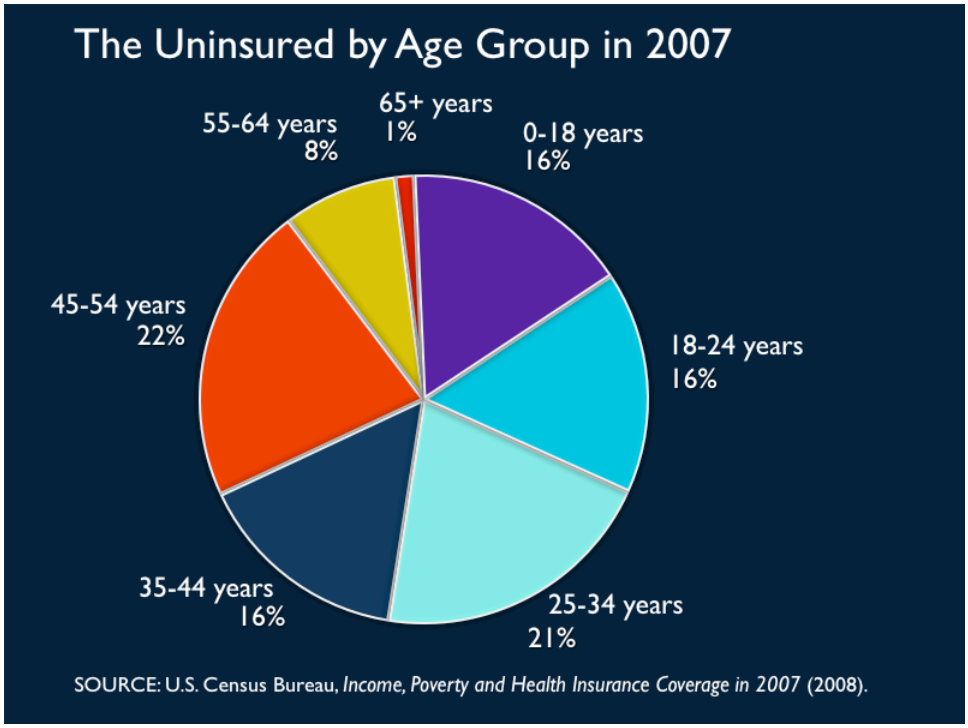
- More than half (58 percent) of uninsured adults work full time, and another 16 percent work part-time.
- Nearly one-fourth of people living in households with incomes below $25,000 are uninsured, compared with 8 percent of people with household incomes of $75,000 and above.

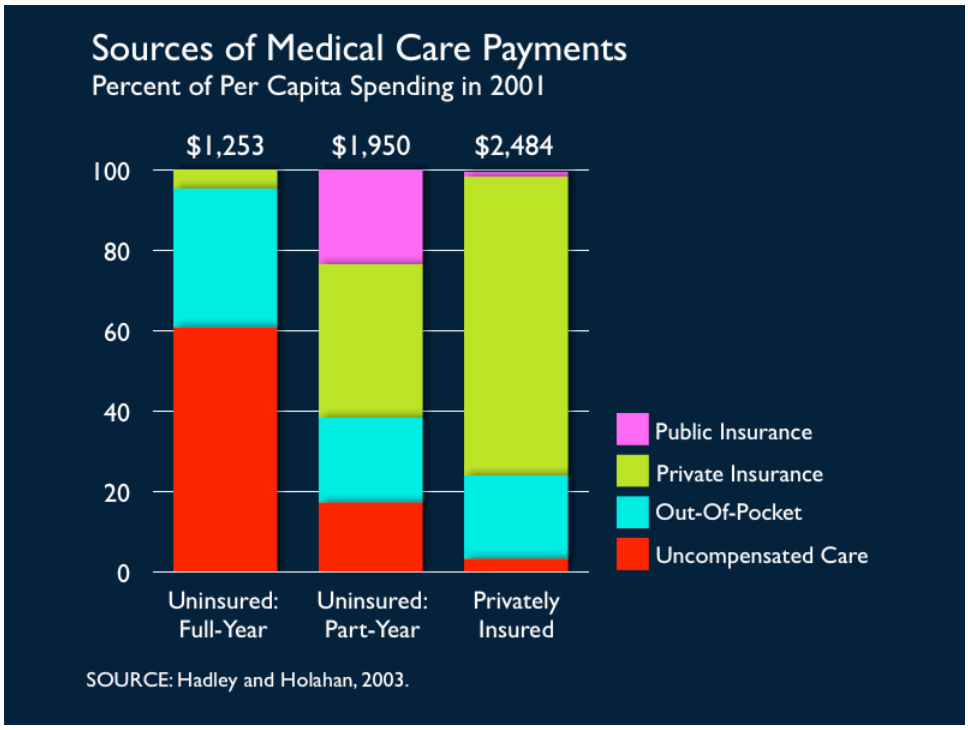
The Uninsured in 2007

	Number (millions)	Percent
Total Uninsured People	**45.7**	**100%**
By Age		
Under 18 years	8.1	18
18 to 34	19.0	40
35 to 64	18.8	41
65 and older	0.5	2
By Household Income		
Less than $25,000	13.5	30
$25,000 to $49,999	14.5	32
$50,000 to $74,999	8.5	19
$75,000 and more	9.1	20
By Work Experience		
Worked full time	21.1	46
Worked part time	5.6	13
By Nativity		
Native	33.2	73
Naturalized citizen	2.7	6
Non-citizen	9.7	21

SOURCE: U.S. Census Bureau, Current Population Survey (2008).

Children represent a different set of concerns. In two decades, the number of children covered through Medicaid doubled from fewer than 10 million to more than 21 million. Despite efforts to reduce the number of uninsured children, nearly 8.1 million children—11 percent of all children—are uninsured. As many as two-thirds of these uninsured children are eligible for public programs. Better outreach, removal of language and cultural barriers, and improved administrative procedures could help increase enrollment of eligible children and, once they are enrolled, help to maintain their coverage under the public programs that are intended to help them.





Health Care Reform & the Budget

WITHOUT REFORM, RISING COSTS PUT THE BUDGET ON AN UNSUSTAINABLE PATH. WITH REFORM, THE FEDERAL ROLE IN HEALTH CARE IS EXPECTED TO EXPAND.

.. because health care reform is no longer just a moral imperative, it is a fiscal imperative. If we want to create jobs and rebuild our economy, then we must address the crushing cost of health care this year, in this Administration. Making investments in reform now, investments that will dramatically lower costs, won't add to our budget deficits in the long-term—rather, it is one of the best ways to reduce them.

President Barack Obama, March 5, 2009

....a large-scale expansion of insurance coverage would represent a permanent increase of roughly 10 percent in the federal budgetary commitment to health care. Improving the budget outlook therefore would require that other aspects of an initiative on health care reduce the federal resources devoted to it by more than that amount (or that other federal spending or revenues be adjusted to accomplish the same end).

Congressional Budget Office, June 16, 2009

Health care reform proposals can affect the budget in many ways, some more immediate and transparent than others. Estimating the near-term impact of such proposals, which affect more than one-sixth of the economy, is a difficult task that relies on conceptual and technical assumptions and analytic judgment. Long-term projections of the impact of reform on national health spending and the federal budget are even more uncertain. Direct actions of the federal government are easier to estimate, while measurements of the responses of consumers, health care providers and other government entities are more speculative. As a result, budget analysts are conservative. They measure the impact of new federal subsidies on the budget with more certainty than potential savings that might be achieved through systemic reform.

Major legislative proposals would expand coverage by providing tax subsidies, premium subsidies, or both to make insurance more affordable. Some would couple subsidies with mandates for individuals to obtain insurance and for employers to offer it to their employees. Mandates raise questions about whether such transactions should be considered as private, and therefore non-budgetary, or as public, and included in the budget. CBO has indicated that the decision would depend on the degree of federal regulation and control over activities to satisfy the mandate. The greater the regulation and control, the more likely CBO would be to consider a mandate a governmental program even if operated through nonfederal entities.[11]

The most analytically challenging questions involve assumptions about how businesses, individuals, the health care system, and future lawmakers and taxpayers will react. Fundamental reform proposals are also likely to result in economy-wide changes in people's decisions to work, save, and invest that would produce results that cannot be projected or measured accurately.

For budget purposes, analysts focus on the most direct consequences of proposed changes. For example:

- **Tax subsidies reduce tax liabilities and lower overall federal revenues.** To reduce the cost of privately-purchased health insurance, many proposals would increase amounts that individuals can deduct from taxable income when they buy insurance (known as a tax exemption) or would provide tax credits, which offset taxes owed.

  Because low-income taxpayers tend to pay little or no income tax, some proposals would provide refundable tax credits, which would send the taxpayer a check for the difference when the amount of the tax credit due exceeds the amount of income taxes owed. In the budget, refundable tax credits count as government spending.

  Some proposals would offer tax credits to small employers to encourage them to sponsor insurance for their employees. Such employer-based incentives could have a double impact on projected revenues: Businesses would pay lower income taxes and individuals would pay lower individual income taxes as a portion of their compensation shifts from taxable wages to untaxed health benefits.

- **Expansions of existing federal programs add to federal spending**: Proposals to change eligibility requirements to allow more people to enroll in federal programs such as Medicaid, CHIP and Medicare would increase the cost of those programs.

- **Public Insurance Plan**: Other proposals would create new programs to provide coverage directly (like Medicare) or to subsidize the purchase of private insurance through payment to or on behalf of individuals and employers. Such proposals would increase federal spending, reduce revenues or both.

- **Employer mandates:** Some proposals—known as "pay or play"—would require employers that do not offer health insurance to their workers to pay into a centralized fund that would finance workers' health insurance. Many employer mandate proposals are paired with subsidy arrangements to reduce the cost of insurance for small employers. Depending on how the mandates are imposed and enforced and the characteristics of the entity charged with handling employers' contributions and workers' health insurance policies, some or all of the transactions could be considered as federal (treated similarly to programs financed with payroll taxes) and be included in the budget.

- **Individual mandates:** Some proposals would require individuals to obtain health insurance coverage either by participating in employer-sponsored insurance arrangements or by buying insurance on their own. To reduce the cost of coverage, individual mandates are paired with tax or premium subsidies and insurance pooling arrangements (see next bullet). Depending on the design of the mandate and the characteristics of the entity responsible for collecting payments and managing health insurance enrollment, some or all of the transactions could be considered as federal and included in the budget.

- **Health insurance exchanges could be included in the federal budget:** Some reform efforts would change the way private insurance operates by creating insurance pools or exchanges that are not tied to employers. Those proposals seek to overcome the drawbacks of employment-based coverage by providing individuals, who would cover their own families, with access to larger insurance pools. Insurance pools or exchanges would create markets to bring together individual purchasers with insurance plans that meet minimum coverage standards. The federal budget would reflect the cost of individual tax or premiums subsidies as well as any federal payments to setup and operate the insurance exchanges. If the amount of federal control and involvement in the exchanges is significant, the exchanges themselves could be considered as federal activities and included in the budget.

How Much Would Health Care Reform Cost?

The short answer is, no one really knows. The cost of health care reform will depend on:

- How the ***supply*** of health care services changes. Efforts to control costs, whether through changing the way in which physicians and other professionals practice medicine or through outright price controls and limits on the number of procedures or services, if effective, will decrease the volume of services delivered.

- How the ***demand*** for health care services changes. Newly-insured people will use more health care.

In addition, because reform could redistribute costs now borne outside the federal government, the federal budget could bear a larger portion of the costs.

Changing the Supply of Health Care

The other primary goal of reform is to reduce the growth in health care costs. That objective is likely to require a lower volume of services.

One approach is to establish a system that enforces a global budget for health care. By placing a cap on the total amount of national spending for health care, a global budget would limit payments for procedures and services. As a result, the volume of service would be lower than if no cap were imposed and the number of health care providers would decline.

Alternatively, a three-step process could reduce the rate of growth in health care costs by making the system more efficient. It would:

- Improve knowledge of what constitutes high quality, effective and efficient medical practice and patient care;

- Reduce or eliminate wide variations in costs for the same procedures that cannot be explained by differences in regional cost-of-living, health status, or health outcomes;

- Find ways to change the incentives for providers and patient-consumers so that they act in more cost-effective ways.

Neither of the two approaches is guaranteed to control health care costs over the long term. Any cost-containment effort will require that all involved —patients and providers—change their behavior and their attitudes toward health care and recognize the need to make tradeoffs.

Changing the Demand for Health Care

While the uninsured do use some health care, they are likely to use more if they gain coverage. One study estimated that people who lack health insurance use about one-half to two-thirds of the amount of health care as someone who is insured for the full year.[12]

Some of the variation in the use of health care services is attributable to differences in individual characteristics. The uninsured tend to be younger, and younger people generally have fewer needs. But the difference in spending is also due to affordability. The uninsured have lower incomes than those with insurance, and pay out of pocket for as much as 35 percent of the cost of the health care they use.

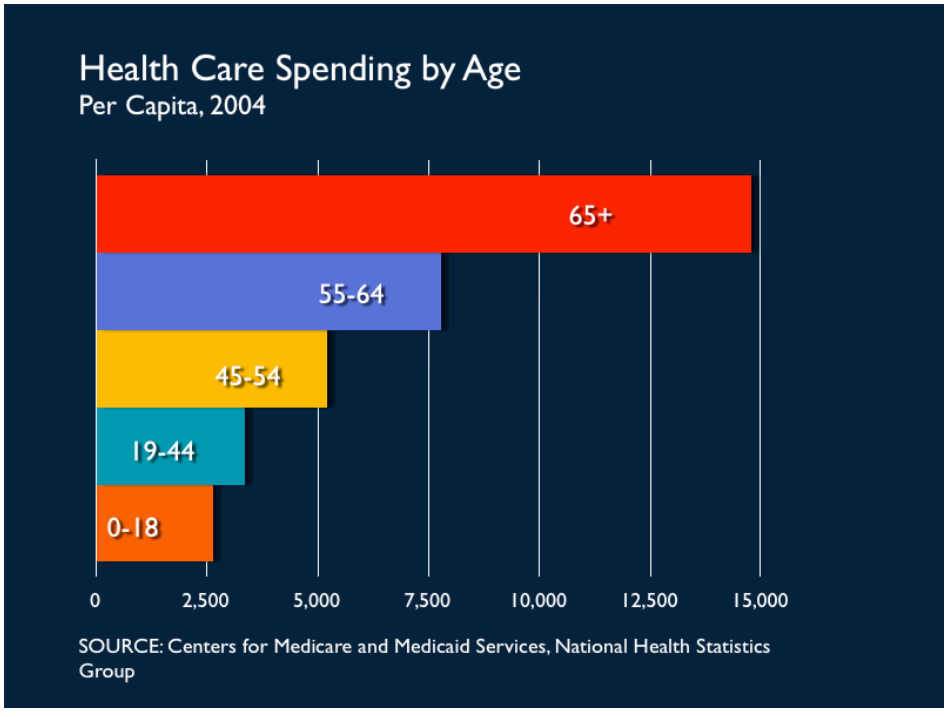
A recent study estimated that universal health insurance coverage could add approximately $123 billion a year (2008 dollars), or about 5 percent, to the nation's health spending.[13] That estimate assumes that the health care use of the newly insured will be similar to that of people who are insured and have incomes below 400 percent of the poverty level.

The estimate does not take into account differences in characteristics between the uninsured and the insured such as health status and age. In addition, some analysts believe that because lower-income people with insurance may be underinsured, assuming that same, inadequate level of health coverage for the newly insured lowballs the cost.

Estimating the Cost of Health Care Reform

Analysts require detailed information about coverage levels, eligibility requirements, payment limitations, administrative structures and requirements, and other important factors before they can estimate how much a legislative reform proposal would cost or save.

In addition, analysts must incorporate numerous assumptions into their estimates. Among the most important is an assumption about how much additional health care those gaining coverage will use. Generally, analysts assume that the newly



insured will use the same level of care as people of similar age with comparable levels of coverage. Consequently, the age characteristics of uninsured people are important because people are more likely to use health care as they get older. For example:

- People aged 65 and older represent more about 1.5 percent of the uninsured because Medicare covers nearly all of them. As a result, members of the age group that has the highest health care costs are already covered.

- Eighteen percent of the uninsured are children, but two-thirds of those children are eligible for Medicaid and CHIP. Children are the least expensive age group. They are 25 percent of the population, but their health care represents only about 13 percent of the nation's expenditures.

- Uninsured working-age adults are the most difficult challenge. They make up 81 percent of the uninsured population. While about 15 percent of working-age adults may be eligible for public programs, the majority are not eligible for public assistance. Their circumstances vary by age. About 28 percent of the youngest age group (18 to 24) are uninsured, while 12 percent of the oldest age group (55 to 64) are uninsured.

As people approach retirement age, their health care spending increases substantially. Health care spending for individuals ages 45 to 64 is more than twice as high as spending for people between the ages of 19 and 44.

Additional Factors Affecting the Budgetary Impact of Reform

CBO bases its cost estimates on assumptions about the level of coverage that would be subsidized under a public program, who would be eligible to participate, how many people who already have health insurance might drop their current coverage (or be dropped by their employers) in order to take advantage of new federal subsidies (called "substitution effects" or "crowd out"), and how many of the federal dollars already used to provide health care for the uninsured could be redirected into the new program.[14] (See "What Is Uncompensated Care?" in the box below.)

CBO's estimates for proposed legislation reflect the pace at which changes are scheduled or assumed to take place over a 10-year period. Given the complexity of reform proposals, the 10-year window almost certainly will not provide full estimates of the likely impacts on the budget over coming decades. As a result, CBO cautions that "budget neutrality" in the first 10 years cannot be guaranteed over the long term.[15]

Absent from CBO's cost estimates is political judgment about the actions of future policy makers. Keeping health care costs under control will require limitations on the level of payments to health care providers and subsidies to the public. If future policy makers are unwilling to maintain that type of restraint, reform will be more costly than CBO estimates.

What Is Uncompensated Care?

Health care bills that the patient cannot pay are called "uncompensated care." In 2008, uncompensated care amounted to an estimated $56 billion, about 31 percent of the cost of health care used by the uninsured and about 2 percent of national health spending that year. (Hadley, Holahan, Coughlin and Miller, 2008)

Conclusion

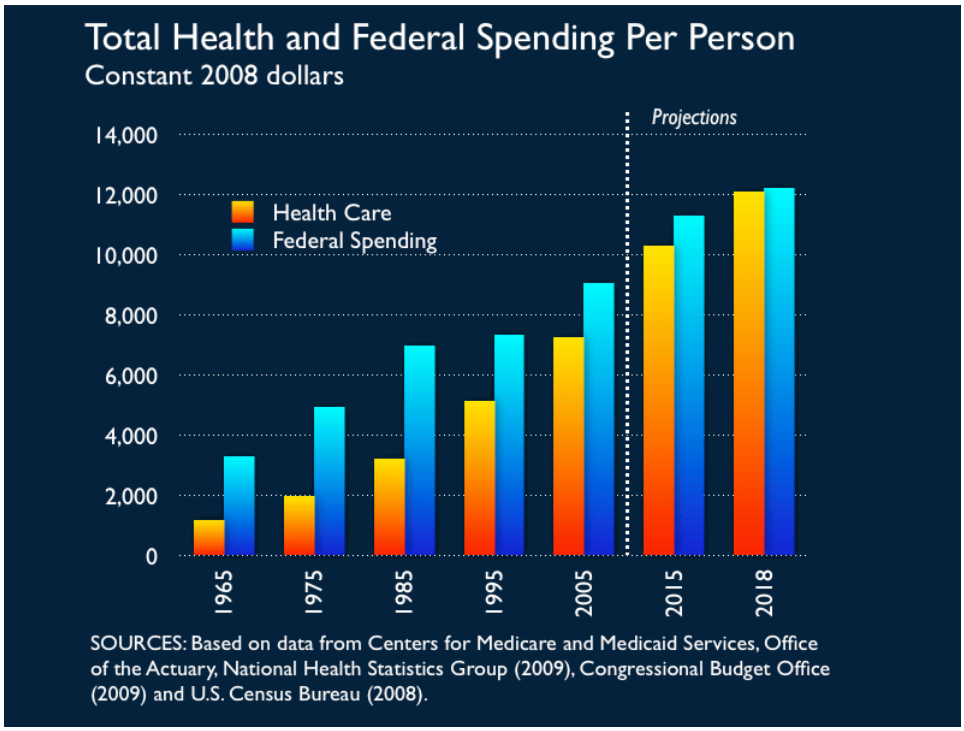
DEFICIT-NEUTRAL HEALTH CARE REFORM IS NOT ENOUGH. POLICY MAKERS MUST ALSO ADDRESS LONG-TERM FISCAL GAPS.

"... any savings in existing federal programs that were used to finance a significant expansion of health insurance would not be available to reduce future budget deficits. In light of the unsustainable path of the federal budget under current law, using savings to finance new programs instead of reducing the deficit would necessitate even stronger policy actions in other areas of the budget."

Congressional Budget Office, June 16, 2009[16]

With the federal budget already facing short-term deficits and long-term structural imbalances, expanding the federal role in financing coverage will have to compete with other important federal priorities. Before the federal budget can take on new responsibilities, the public—and their elected officials—must be willing to acknowledge the obligation to provide the taxes required to pay for health care reform. To do otherwise would further imperil future standards of living by driving the federal government deeper in debt.

There are many potential benefits from health care reform. Society gains when its citizens are healthy and productive. One study estimated that the lack of insurance represented a cost of $122 billion (2009 dollars) in health foregone—primarily in the form of poorer health and shorter lives of the uninsured.[17]



Without reform, within 10 years the nation will spend almost as much on health care per person as it will for all federal activities.[18] That type of growth will place serious constraints on the economy's ability to meet alternative needs of the population and make it that much more difficult to improve overall standards of living.

Certainly investing in improvements in children's health seems worthwhile and offers the longest potential payback. But the nation also faces other pressing needs.

The challenge facing the country is not only deciding what kind of reforms will be acceptable to control rising costs, but also how to pay for the goal of expanded access. Inevitably, as the rising cost of medical care puts increasing pressure on the finances of individuals, families, businesses, and all levels of government, many reform proposals will focus on the federal budget.

However, it would be economically risky to assume that reform measures that increase the federal government's role for the financing of health care would reduce costs elsewhere. When enacting reform, policy makers should also provide procedural safeguards to protect the budget and force a reconsideration of benefits and financing if fiscal gaps worsen.

The federal budget already faces serious structural problems that stem from more promises than it has revenues to pay for. Adding health care spending, without a proportional and broad-based commitment to pay the taxes necessary to finance new spending would cause the budget's outlook to deteriorate even further.

The history of the federal budget is full of examples where policy makers deferred the hard work of fiscal responsibility while enjoying the immediate rewards of enacting popular benefits. Social Security and Medicare are prime examples of programs that already pose fiscal challenges. The addition of any new, underfunded programs would serve to increase the competition for political and financial resources and could potentially make it that much more difficult to make existing programs sustainable over the long term.

That is not to say that health care reform should be ruled out as unaffordable. The responsible course would be to consider health reform within the overall context of the budget's short- and long-term horizons. Only then will policy makers and the public be able to evaluate the benefits and costs of alternative approaches, establish priorities, and make necessary hard choices.

Endnotes

[1] National Health Expenditure data used in this report are from the Centers for Medicare and Medicaid Services. Office of the Actuary, January 2009.

[2] See for example, Lydia Saad, Americans Rate National and Personal Health Care Differently, Gallup. December 4, 2008, http://www.gallup.com/poll/112813/Americans-Rate-National-Personal-Healthcare-Differently.aspx

[3] See also, New York Times CBS New Poll, June 12-16, 2009, http://documents.nytimes.com/latest-new-york-times-cbs-news-poll-on-health#p=1.

[4] Congressional Budget Office, *Options for Expanding Health Insurance Coverage and Controlling Costs*, Testimony of Director Douglas W. Elmendorf before the Senate Committee on Finance, February 25, 2009.

[5] Congressional Budget Office, *Health Care Reform and the Budget, Letter to Senators Kent Conrad and Judd Gregg*, June 16, 2009, http://cbo.gov/doc.cfm?index=10311.

[6] Gallup Poll, Healthcare System, http://www.gallup.com/poll/4708/Healthcare-System.aspx

[7] The 'baseline extended" projections assume CBO's March 2009 baseline through 2019, including the expiration of 2001 and 2003 tax cuts as scheduled. Beyond 2019, other non-interest spending and revenues remain at the projected 2019 level as a share of GDP. The "alternative assumptions" scenario assumes other spending at the baseline level through 2011, continuing thereafter at the 2009 level as a share of GDP, minus stimulus and related spending. Medicare physician payment rates grow at the rate of the Medicare index (rather than the lower current law rate). The revenue projections assume: the 2001 and 2003 expiring tax cuts are extended; AMT parameters are indexed for inflation; corporate and payroll taxes as scheduled under current law; estate, excise and gift taxes constant as a share of GDP; and other revenues as scheduled under current law through 2019, then constant as a share of GDP. .

[8] Congressional Budget Office, *The Long-Term Budget Outlook, June 2009*, extended baseline scenario.

[9] Information regarding insurance coverage and the uninsured from U. S. Census Bureau, *Income Poverty and Health Insurance Coverage in the United States: 2007*, P60-235, August 2008.

[10] Cathy Schoen, Sara R. Collins, Jennifer L. Kriss and Michelle M. Doty, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 And 2007," *Health Affairs*, Web Exclusive, June 10, 2008.

[11] Congressional Budget Office, *The Budgetary Treatment of Proposals to Change the Nation's Health Insurance System*, May 27, 2009.

[12] Jack Hadley, John Holahan, Teresa Coughlin, and Dawn Miller, "Covering the Uninsured in 2008: Current Costs, Sources of Payment and Incremental Costs," *Health Affairs* Web Exclusive, August 25, 2008.

[13] Hadley, Holahan, Coughlin and Miller, 2008.

[14] Jack Hadley and John Holahan, *The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?*, The Kaiser Commission on Medicaid and the Uninsured, May 10, 2004.

[15] Congressional Budget Office, Conrad and Gregg *Letter*, June 16, 2009.

[16] Congressional Budget Office, Conrad and Gregg *Letter*, June 16, 2009.

[17] Jack Hadley and John Holahan, 2004.

[18] There is overlap between the two categories. In 2018, almost 38 percent of health spending will originate from the federal budget.