It's Health Care, Stupid! Why Control of Health Care Spending Is Vital for Long-Term Fiscal Stability

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As the United States looks ahead to the fiscal challenges of population aging, two facts stand out. First, the United States faces far smaller pension problems from population aging than do most other developed nations. Our combined fertility and immigration rates are higher than those of all other developed nations, and life expectancy is lower and projected to remain lower than in most other developed nations. Our pension system is less generous than those of nearly all other developed nations.[1] As a result, meeting the added costs of pensions, public and private, is not technically difficult. The added costs of Social Security benefits—a bit more than 2 percent of gross domestic product (GDP) over the next 35 years—is less than past increases in pension costs, which have accrued over many fewer years.

Second, total health care spending in the United States is vastly higher than in any other nation. It is so much higher, in fact, that although the U.S. government is responsible for a smaller share of total health care spending than the government of any other developed nation, government-financed health care spending in the United States approximates that of other nations as a share of GDP (Reinhardt, Hussey, and Anderson 2004). Furthermore, the U.S. government bears fiscal responsibility for the parts of health care spending that will increase because of technological change and population aging. These two forces are multiplicative, one pushing up per capita expenditures and the other pushing up the number of "capitas." Of these two forces, increases in per capita spending resulting largely from advances in medical technology (see Murphy and Topel 2003; Cutler and McClellan 2001; and Berndt et al. 2000) are by far the more powerful. As a result of these two trends, health care

spending financed by governments—federal and state—is projected to rise by roughly 12 percent of GDP over the next 35 years if the historical gap between growth of health care spending and income persists. Total health care spending would rise even more—by 20 percent of GDP under the same assumptions (Congressional Budget Office 2003, 2005).

Such projections call to mind the famous quip of the late Herb Stein: "If something can't possibly happen, it won't." But that quip should not be allowed to obscure a far more serious issue: How can such increases be avoided without seriously eroding the protections that the nation provides to its most vulnerable citizens—the aged, disabled, and poor? Indeed, how can such increases be avoided without seriously limiting access to enormously beneficial emerging technologies for the well insured?

I wish that I could promise to answer these questions, but I cannot. I can, however, indicate why we cannot escape the need to make some very hard choices, and why some commonly advanced ways to painlessly avoid those hard choices will not, in fact, succeed in doing so.

What the Future Holds

Health care spending has grown faster than income in the United States for the past half-century by an average of 2.5 percentage points annually—not every year, but with few extended interruptions. It is generally agreed that the major source of this gap has been the particularly rapid advance of medical technology, although population aging and the extension of health insurance coverage have also been significant factors.

Studies of past medical advances indicate that the welfare gains from improvements in health care rival those from all other advances in productivity combined. The vistas opened up by recent advances in molecular biology, aided by advances in computation, promise future welfare gains that are at least as important. Cures for major killer diseases and ways of forestalling the causes of physical and mental decline have become realistic prospects. But the lax way in which health care is now financed means that people will have every incentive to demand not only care that provides benefits at least equal to cost, but also care that provides any benefit at all, regardless of cost.

To those who are unfamiliar with the tectonic power of compound interest, a gap of "just" 2.5 percent a year between the growth of health

care spending and the growth of income may seem derisory. But a continuation of this gap in total health care spending will generate steady and large increases in the share of incomes devoted to health care. The implications of a continuation of these trends are shown in Table 6.1.

Because Medicare and Medicaid are designed to assure that the elderly, disabled, and poor receive health care similar in quality to that available to those who enjoy decent private insurance, growth of per capita spending on these programs has approximated growth in per capita spending for the rest of the population. If these vulnerable populations continue to enjoy "standard" health care, the divergence between growth of per capita Medicare and Medicaid spending and the growth in per capita health care spending of the rest of the population is unlikely to be large. Table 6.2 shows the implications for spending on these two programs if the 2.5 percent margin persists for these programs as well.

What Should We Do?

Such trends portend major increases in taxes and the diversion of an increasing share of economic growth to pay for health care. A variety of responses to such trends is possible.

Table 6.1
Projections of National Health Care Spending as a Percent of GDP under Two Scenarios

Year	Historical Trend: Healthcare spending grows annually 2.5 percentage points faster than GDP	Reduced Growth: Healthcare spending grows annually 1 percentage point faster than GDP
2005	15.6*	15.6*
2010	17.3*	17.3*
2020	21.6	19.8
2030	27.6	21.9
2040	35.2	24.1

*Estimates of the Centers for Medicare & Medicaid Services (CMS) (2005) and author's calculations; assumed growth rates apply after the end of the CMS projection period.

Table 6.2
Projections of Medicare and Medicaid Expenditures as a Percent of Federal Outlays and GDP

	Percent of Federal Outlays		Percent of GDP	
Year	Historical Trend*	Slowed Growth*	Historical Trend*†	Slowed Growth*†
2005	19.6	19.6	4.2	4.2
2010	32.2	22.5	5.3	4.8
2020	28.9	27.7	7.8	6.5
2030	33.6	30.8	11.5	8.4
2040	36.1	32.2	16.1	10.1

*Estimates of the Centers for Medicare & Medicaid Services (2005) and author's calculations; historical trend and slowed growth as in Table 6.1.
†Includes state spending on Medicaid.

Doing Nothing

The simplest response would be to shrug one's shoulders and pay the bill. After all, medical advances have produced benefits worth far more than their cost. This happy relationship is likely to continue. Furthermore, if productivity growth persists at rates similar to those in the past, we will be able to afford to pay the health care bill and still have more consumption of other forms.

This outcome is conceivable, if only because agreement on how to change our health care system in any fundamental way has been so elusive in the United States. But it is neither desirable nor likely. It is not desirable because, as welfare-increasing outlays grow, welfare-reducing expenditures on health care that are not worth their cost also tend to increase. Every well-insured patient has every incentive to seek—and every health care provider paid on a fee-for-service basis has every incentive to provide—all the care that provides any benefits at all, however costly. Furthermore, if health care spending grows at past rates, higher taxes and health care spending will claim half of all economic growth by 2023 and all of it by 2045. This is not likely to happen, because a tax-phobic nation would have to accept huge tax increases to sustain protections for the aged, disabled, and poor; because rising health outlays would put enormous pressure on everything else that government does; and because

workers would assuredly react in a hostile manner to seeing a smaller and smaller share of the fruits of rising productivity available to raise cash wages or other forms of compensation.

General Reforms

The second approach would be to try to find ways to curtail the growth of health care spending that would save money without sacrificing beneficial care or undermining public protections of vulnerable populations. Many studies document that the American health care system, in general, and Medicare, in particular, generate considerable amounts of care that produce few medical benefits, and some that are downright harmful.[2]

The health care system in the United States is not unique, but certain features of our system may encourage inefficiency. As noted, the payment system rewards people for doing more. The threat of litigation may frighten them into doing more. Most procedures have not been subject to careful evaluation. Inefficiencies in hospitals and physicians' offices contribute to medical errors. Modern information technology has not been well exploited. A review of 48 articles that appeared in leading professional journals found that 20 percent of patients received unnecessary or "contraindicated" chronic care, and 30 percent received contraindicated acute care. While the problem of overprovision was serious, the problem of underprovision was worse. Thirty percent of patients studied did not receive recommended acute care, 40 percent did not receive recommended chronic care, and 50 percent did not receive recommended preventive care (Schuster, McGlynn, and Brook 1998). And an Institute of Medicine study found that overuse of services is more likely to be detected than underuse, because noticing an error that is memorialized in medical records is easier than pinpointing where more should have been done (Institute of Medicine 2001). Those who allege that waste is rampant are more punctilious in citing statistics on overuse than on underuse. Malpractice reforms that do no more than cap damages may reduce somewhat the incentive, created by the threat of large judgments, to overprovide care. They may also lead some providers to offer less care than they should and thereby reduce needed care.

That medical care is often misdirected is obvious. That expenditures would be lower in a system that accurately delivered care to all who need it, but not to those who do not, is far from clear. Recent research

indicates that Medicare expenditures could be reduced by 29 percent without affecting health outcomes if per capita spending in high-expenditure regions could be reduced to equal per capita spending in low-expenditure regions (Wennberg, Fisher, and Skinner 2002; and Fisher et al. 2004). Such findings hold the tantalizing prospect of major savings.

This research carries two lessons. The first is that it will take time and upfront investments to simultaneously curtail waste and ensure that needed care is provided. Persuading physicians and hospitals in higher-cost cities like New York and Miami to practice medicine the way it is done in lower-cost cities like Minneapolis and Seattle is not easy, and may take many years to accomplish. The second lesson is that precisely because such investments will take time to bear fruit, they should begin immediately. Among these investments should be the immediate revival, with federal support, of an agency charged with evaluating new, as well as existing, medical technologies.

Inefficiencies and inappropriate care could also be reduced by revising payment incentives and reorganizing the delivery of care into competing integrated-delivery networks with limited provider panels. The Medicare Modernization Act of 2003 contained a provision that, with appropriate safeguards, holds some promise of reducing the level of health care spending. Under that provision, people who purchase high-deductible insurance may deposit sums not greater than the deductible into accounts whose balances may be used for health expenses at any time during the account holders' lives without tax liability on deposits, account earnings, or withdrawals.[3] While these health savings accounts (HSAs) have some promise of slowing, at least temporarily, the growth of health care spending, they also carry a number of risks, particularly if they cause employers to drop sponsorship of group health insurance, or if employers fail to use the savings from the premium reductions resulting from increased deductibles to provide financial protection for low-wage employees. If the existence of HSAs tends to shift healthier-than-average people from group plans to individual insurance plans, the average price of traditional group insurance could rise. Should such shifts cause the demise of group insurance, HSAs would force older people and those with chronic illnesses into the individual insurance market, where they would face very high premiums.

Medicare Modifications: Raising the Age of Eligibility

The Medicare entitlement age was set in 1965, when the age for payment of "full Social Security benefits" was age 65. Under current legislation, the "full benefits age" is gradually being raised to age 67.[4] Additional increases might conceivably be part of a proposal to restore long-term financial balance to Social Security. On this logic, some people have suggested raising the age of eligibility for Medicare, in line with (or independently of) the modifications in Social Security, to age 67 or later.

Increasing the age of eligibility for Medicare would save less than many suppose, because the young elderly account for only a small share of total Medicare spending. Raising the age of eligibility to age 67 (68), for example, would currently lower Medicare spending by 5.8 (8.8) percent, given the current age distribution of the population receiving Medicare outlays (see Table 6.3).[5] The case for linking the age of eligibility for Medicare to the age of eligibility for "full Social Security benefits" rests precariously on political history and semantics. The age at which American workers most commonly claim Social Security is 62, not 65 or 67. The median age for claiming benefits is below age 64. Maximum benefits are not paid until age 70, when actuarial adjustments cease. Nothing in current law "justifies" raising the age of eligibility for Medicare to age 67; nor, for that matter, is there justification other than the political inertia of current law for retaining it at age 65. If linkage to the modal or median age at which Social Security benefits are claimed is viewed as controlling, the age for Medicare eligibility should be reduced. In my view, the decision about whether to keep Medicare's eligibility age at 65 or to change it should be based not on history or alleged linkages to Social Security that do not bear scrutiny, but on considerations of medical need, the effects of public policy on labor supply (raising the age of eligibility for Medicare would encourage later actual retirement ages), and fiscal capacity.[6]

Deductibles, Premiums, and Other Cost Sharing

Increasing cost sharing for Medicare services could have a powerful effect on the use of services and on Medicare outlays. The RAND Health Insurance Experiment showed clearly that increased cost sharing significantly deters health care spending—by as much as 30 percent over the range tested in the experiment. Furthermore, the effects on health status were

Table 6.3
Impact on Medicare Outlays of Increasing Medicare Age of Eligibility*

Age of Eligibility	Reduction in Medicare outlays, relative to age 65 eligibility
66	3.0
67	5.8
68	8.8
69	11.9
70	15.1
71	18.6
72	22.3

**Source:* Author's calculations based on data on relative Medicare spending by age of beneficiary for the year 1999, supplied by Tom Bradley of the Congressional Budget Office.

not large among experimental subjects. Whether the savings and small health effects would both carry over to the elderly and disabled populations is unclear, however. Both groups were excluded from the RAND experiment, and their health problems and economic status differ in relevant ways from the population studied by RAND (Keeler 1992).

Furthermore, Medicare already requires considerable cost sharing. Part A, which covers hospital and skilled nursing facility stays, imposes higher deductibles and more cost sharing than do most private plans and provides no protection for very long hospital stays. Enrollees must pay sizeable premiums for Part B—Supplemental Medical Insurance (SMI)—which covers physicians' services, durable medical equipment, and the new drug benefits.

Raising the proportion of Medicare outlays paid by all enrollees would reduce both budget outlays and consumption of medical services. It would also create two problems. First, increased premiums could impose hardship on all but the upper-income elderly and disabled. This risk increases if Social Security benefits are reduced. Second, demand for preventive care, such as screening tests and maintenance therapies to slow the development of progressive conditions, are reportedly quite sensitive to price. For that reason, some analysts recommend providing such services free of deductibles and cost sharing.

Reform of the complex pattern of Medicare deductibles probably makes good sense. Combining the mixture into a single deductible covering all services would be just such a simplification. Cost sharing for various services could be increased, in combination with income-graduated waivers for low- and middle-income beneficiaries. A stop-loss limit should be added to Medicare to preclude the possibly devastatingly large charges that can be imposed on the seriously ill under the current system.

The Medicare Modernization Act took a step toward introducing income-related premiums. However, that step was very small: increased premiums will apply only to couples (single persons) with incomes of $160,000 ($80,000) a year or more, and the maximum is reached only when incomes exceed $400,000 ($200,000) a year. The case for raising premiums for those elderly who can pay them without hardship is strong, as Medicare beneficiaries receive benefits far in excess of the payroll taxes they have paid.[7] The case for redistributing income to Medicare beneficiaries with above-average incomes is hard to perceive. On the other hand, the potential of income-related premiums to offset rising Medicare spending should not be exaggerated. Only 15 percent of those over age 65 in 2002 lived in households with incomes of $50,000 a year or more (Social Security Administration 2001). The degree to which premium increases can offset growing Medicare outlays is, therefore, quite limited.

Pay for Insurance, Not for Care

Medicare now pays directly for services for 88 percent of beneficiaries. Medicare could instead pay a flat sum, adjusted for each patient's age and health status, updated annually by increases in average per capita health care expenditures, to a health plan of the enrollee's choice. This arrangement would be similar to that for the minority of current Medicare beneficiaries enrolled in prepaid group plans. Available choices could include HMOs, PPOs, point-of-service plans, or fee-for-service care. Under one model, similar to the Federal Employee Health Benefit Plan (FEHBP), the federal government could contribute a flat amount equal to a fixed percentage of a weighted average of premiums of the various participating plans. The current FEHBP share is 72 percent.

Because enrollees would pay all of the additional cost of plans that are priced above the federal allotment, advocates of this approach believe that enrollees will shop carefully for cost-effective plans, thereby encouraging plans to compete to improve quality and hold down prices. Critics of this approach fear that Congress will not raise the federal payment as fast as health expenditures increase, thus eroding Medicare coverage. They also point to the fact that Medicare enjoys considerable bargaining leverage in setting prices that no private plan would match and that costs might actually be higher, rather than lower, under this arrangement.

Medicaid

Most of Medicaid expenditures go to support acute and long-term care for the aged and disabled, not for acute care of the non-elderly, able-bodied poor. The aged, blind, and disabled constitute only 27 percent of Medicaid recipients, but they account for 70 percent of program expenditures.[8] For this reason, Medicaid will be subject to demographic pressures similar to those confronting Medicare. The major difference is that Medicaid finances half of nursing home care and 43 percent of all long-term care, while Medicare covers little of these services.

The Medicaid program is jointly financed by the federal and state governments. Most states pay 45 to 50 percent of total expenditures. Federal law requires the coverage of certain services and certain groups, but most Medicaid expenditures are incurred either for people who are covered only at state option or for optional services. Medicaid is the most rapidly increasing component of state budgets. Because states are subject to rating by bond agencies, they cannot run deficits without incurring increased borrowing costs; and states fear that high taxes will drive out the well-to-do. The recent recession put states in a fiscal bind: revenues fell, per capita health care expenditures continued to rise, and enrollments jumped. States responded by curtailing coverage in diverse ways. The current recovery and resurgent revenues provide some relief, but fiscal pressure on the states will intensify as the aging baby boomers require nursing home and other forms of long-term care.

The potential for curtailing Medicaid outlays without denying services to the poor is extremely limited. Few Medicaid recipients have much

capacity to bear increased cost sharing. The only ways to reduce total Medicaid spending significantly are to cut people off the program and narrow the range of covered services, to buy services more cheaply or use them more efficiently, to encourage people to buy long-term care insurance before they are old or disabled, or to reduce fraud. Shifting spending to the states could lower federal outlays.

As noted, states have been using the first approach. They are also trying to buy services more cheaply. The fact that per capita Medicaid expenditures are now below those of per capita private insurance, after adjustment for coverage and patient characteristics, testifies to the success of these efforts. Some additional savings may be achievable if Medicaid recipients can be shifted out of emergency rooms for routine care. Several states have begun to buy health care at discounted prices for low-income populations from one or a small number of providers, under contracts that often include quality indicators to show whether the organizations provide appropriate care in a timely fashion. States have also experimented with paying the employee's share of employer-sponsored health coverage for low-income workers and adding coverage when the employer's plan is narrower than the Medicaid benefit package. This approach spares Medicaid the full cost of coverage.

Another way to hold down public Medicaid expenditures would be to encourage people to buy long-term care insurance to protect themselves from nursing home costs. A nursing home bed in a custodial facility currently costs more than $60,000 annually for semi-private accommodations (MetLife Mature Market Institute 2004), and skilled care is even more expensive. The prospect that private insurance will materially improve the budget outlook of the federal or state governments is slight.[9] Insurers have been loathe to provide complete coverage because of uncertainty about cost trends over the many years, or even decades, that long-term-care insurance contracts run. On the buyers' side, demand has been weak, in part, because the quality of insurance products has not been high, and, in part, because of buyer myopia. Large tax incentives could cause sales of long-term care insurance to increase, but these added sales would do little to reduce Medicaid outlays unless the incentives were refundable credits. Nonrefundable credits or deductions would not appeal much to the majority of filers who face low marginal tax rates—

the low- and moderate-income households who eventually become the elderly populations from which Medicaid recipients are drawn. Furthermore, immediate revenue reductions from tax incentives would offset some or all of the hoped-for, eventual reductions in Medicaid outlays for long-term care.

Federal prosecution of fraud by health care providers under both Medicare and Medicaid has intensified in recent years. The targets have been so-called Medicaid mills and "up-coding" under Medicare (whereby providers bill for services that carry reimbursements higher than those for services actually rendered). There is no doubt that such fraud occurs, but it is equally certain that it accounts for little of the growth in program outlays and virtually none of the prospective increases in spending under both programs.

I know of no way to estimate accurately how much all of these measures in combination might reduce the growth of Medicare and Medicaid spending. Potential savings would almost certainly run to many billions of dollars a year. Expenditures on enforcement are well justified, but they are not the answer to the fiscal challenge of rising health outlays. The largest savings would result from increased cost sharing under Medicare. I believe that such cost sharing makes sense for those who can afford it. Raising the age of eligibility for Medicare may also make sense as part of a broad strategy designed to encourage older workers to remain economically active until later ages than now is common. It would also reduce budget outlays, but would threaten problems at least as serious as those it would relieve. All of the measures described above would take years to implement. Meanwhile, the population will be aging, consumption of health care will be increasing, and the range of new, beneficial—and costly—medical interventions will be growing. In brief, painless ways to prevent health expenditures from rising significantly do not exist. Some painful trade-offs are inescapable.

Three Budget Options

I now turn to three broad alternative approaches that would prevent increasing federal health care spending from producing large and sustained deficits. Under the first scenario, the age of eligibility for Medi-

care remains 65. The principal features of both Medicare and Medicaid, including coverage and benefits, are unchanged. In the first scenario, per capita health outlays continue to grow at the historical trend rate of 2.5 percentage points a year more than per capita income and wages. This trend could also continue if some of the expenditure-reducing measures described above were implemented and produced savings that were then used to underwrite improvements in coverage, such as the addition of long-term care benefits to Medicare.

Under the second scenario, new technology and population tend to drive up health care spending by 2.5 percentage points a year more than income. But some combination of increases in the age of eligibility, enhanced cost sharing, or other measures holds the annual growth of Medicare and Medicaid spending to just 1 percentage point above income growth. Alternatively, general health care rationing might become the norm.

Under the third scenario, per capita spending on Medicare and Medicaid is held to the same growth rate as that of per capita income and wages. What sorts of program changes could achieve these outcomes? By how much would growth of total spending on these two programs exceed income growth as a result of increases in the eligible population?

Scenario 1: No Reduction in Growth of per Capita Health Care Spending

The share of total federal spending and of GDP that Medicare and Medicaid would jointly absorb is shown in Table 6.2. On the assumption that other government spending remains an approximately unchanging share of GDP and that taxes return to their historical average of roughly 18.5 percent of GDP, essentially all of the increase in federal health care spending would have to be covered by additional taxes.[10] If payroll and income taxes were used to cover the added outlays under Medicare and Medicaid shown in Table 6.2 ("Historical Trend" columns), it would be necessary to nearly double the Medicare payroll tax and to increase personal income tax collections by more than 70 percent by 2030. By 2040, payroll taxes would be two-and-one-half times higher than they are now, and income tax collections would need to more than double. Alternatively, revenue from a new revenue source, such as a value-added tax, could be used.

Scenario 2: Slowed Growth of Health Care Expenditures per Beneficiary

The tax increases under Scenario 1 are so massive as to seem implausible. The second scenario assumes that growth of health care spending is somehow restrained so that it increases by "only" 1 percentage point a year more than income growth. This assumption is the baseline used in Medicare projections. The results are also shown in Table 6.2 ("Slowed Growth" columns).

Precisely how such a slowdown might be achieved is unclear, although aggressive action would almost certainly be necessary. The menu would most likely include most, or all, of the measures listed in the previous section, including increases in the age of eligibility and increased cost sharing for Medicare, heavy use of information technology, and such other measures as selective purchasing and selective contracting with managed care plans that provide care efficiently and that, perhaps, ration care. Again, one should recognize that seemingly drastic moves save less than one might suppose—raising the eligibility for Medicare to age 70 would reduce spending by about 1.3 percent of GDP by 2030, and by about 1.5 percent of GDP by 2040 (about one-eighth of the projected growth based on historical trends).

A wild card in the preceding story revolves around the possible use of HSAs. The potential for HSAs to have a material effect on Medicare spending depends on two big "ifs"—they could have a material effect *if* these accounts are widely used and *if* enough account holders have enough unspent deposits when they become eligible for Medicare to permit major cost sharing. HSAs are unlikely to have any material effect on Medicaid spending, because few Medicaid-eligible families have had much capacity to build up sizeable financial assets.

If the growth of Medicare and Medicaid spending can somehow be slowed to 1 percentage point more than the growth of GDP, taxes would still have to be increased by 4 percentage points of GDP by 2030, and by 6 percentage points of GDP by 2040, just to cover added federal spending on health care. This increment to taxes does not include any other tax increases to close the current budget gap (about 5 percent of GDP if one excludes current cash flow surpluses being accumulated in the Social Security, Medicare Hospital Insurance, and Federal Employees Pension

Trust funds), to finance long-term care, or to deal with future military emergencies. Still, a reduction of the historical trend growth of per capita Medicare and Medicaid spending from a rate that is 2.5 percentage points faster than GDP growth to a rate "only" 1 percentage point a year faster would be a monumental achievement. Given the dynamics of medical technology, this possibility is very far from certain without seriously compromising the protections afforded by Medicare and Medicaid.

Scenario 3: GDP and per Capita Spending on Medicare and Medicaid Rise at the Same Rate

The third scenario embodies the assumption that sufficient changes are made in Medicare and Medicaid so that per beneficiary spending grows no faster than per capita income, even though trend growth of general health care spending continues to outpace income growth by 2.5 percentage points a year. Even with such a slowdown in per capita spending, increases in the populations served by these two programs would push up total spending from the current 4.2 percent of GDP to 5.7 percent in 2030, and to 6.2 percent in 2040.

Making assumptions about a slowdown in the growth of federal health care spending is easy, but what exactly would it take to achieve such economies? If the slowdown in Medicare per capita spending were achieved solely by raising the age of eligibility, it would take an increase from age 65 today to age 79 by 2030, and to age 83 by 2040. If the spending target were achieved exclusively by increasing cost sharing, it would be necessary to reduce the share of health care spending by people eligible for Medicare who are covered by Medicare from just under 60 percent today to 29 percent in 2030, and to 23 percent in 2040.

These projections are subject to many uncertainties and qualifications. First, the proportions of Medicare spending accounted for by people of particular ages and by Medicare's particular benefit package may change, because both depend on technological change and public policy. For example, advances in technology boosted drug spending from 5.6 percent of total health care spending in 1980 to 12.4 percent in 2003. That technological shift tended to reduce the share of spending covered by Medicare. However, that trend will be partly reversed by the drug benefit that will take effect next year. Second, a continuation of either

trend or any combination of the two would doubtless reduce health care spending in total, but might increase health care spending by other federal programs, such as by the Veterans Administration and Medicaid. Hence, budget savings would be less than Medicare savings. Whether the proportion of total outlays covered out-of-pocket by individuals would rise proportionately more or less than total health care spending would fall is unclear. Whether the total reduction in federal spending would be larger or smaller than current fractions covered by Medicare suggest is also unclear.[11]

Many people will find either of these cutbacks, or a combination of the two, repellant. But unless use of services can be curtailed by more benign means, these modifications, or ones like them, will have to be implemented in order to avoid large tax increases to fund Medicare.

I have so far made no reference to what it would take to hold per capita Medicaid spending to the growth of per capita income. Imposing premiums, deductibles, or cost sharing equal to any significant share of Medicaid spending would effectively deny coverage to Medicaid recipients. Furthermore, little of Medicaid expenditure is incurred on behalf of recipients who would be screened out by the raising age of eligibility. If cuts in Medicaid spending are proportionately smaller than those in Medicare, holding growth of overall federal health care spending to what results from growth of the population served would require even larger Medicare cuts than those I have indicated. Even with such formidable reductions, federal health care spending would increase by 2 to 3 percent of GDP because of demographic forces—about the same as the projected increase in Social Security payments if current benefit formulas remain in force.

The Rest of Health Care Spending

Federal, state, and local health care programs now pay for nearly half of all health care spending (Centers for Medicare & Medicaid Services 2005). The public share will tend to keep rising because of population aging. But the forces driving up per capita spending will operate with similar force on both private and public spending, absent some technological shift that skews spending growth toward a particular part of the age distribution or toward or away from services covered by public pro-

grams. If current trends continue, total health care spending will absorb more than one-fourth of national income by 2030, and more than one-third by 2040. As far as the working age population is concerned, higher per capita private health care spending would be in addition to increased taxes required to support benefits for growing dependent populations.

These circumstances are likely to intensify pressures to ration care, even if, as seems quite likely, the increase in total benefits from added health care spending dwarfs the increase in total spending. Even if every penny spent on health care yielded benefits equal to or greater than cost, the large shift in spending from private to public budgets would create difficult tensions because taxes would have to rise so much that other forms of consumption would be squeezed. But, as noted, many dollars spent on health care yield meager benefits, because our current financing system encourages patients to seek all care providing any benefit at all, however expensive it may be. As the menu of services grows, the potential for low-benefit health care spending is almost certain to grow. Piling the cost of such low- or no-benefit care on top of the growing health care bill carries a serious risk that, in the name of weeding out "waste," private or public policymakers will use blunt instruments to control expenditures. Today, the very consideration of health care rationing offends most Americans. However, intelligent rationing should be seen as a device that curtails the use of services that well-insured patients now have incentives to seek, but that provide benefits worth less than their cost. In this light, intelligent rationing should be recognized as a device for improving welfare.[12]

Any nation can restrict health expenditures in three ways: by limiting demand, by slowing the advance of technology, or by restricting the use of available technologies.

The United States already denies care to those who are not well insured and do not have the means to pay for it. The 45 million people without insurance, for example, are estimated to consume, on the average, about half the health care services that the insured use. Research indicates that the uninsured frequently forgo high-benefit services. Yet, when seriously ill, uninsured patients are likely to receive care according to protocols developed for the well insured, including the intensive use of services, many of which have never been evaluated for efficacy. There is little reason to believe that the denial of care to the uninsured is carried out rationally, in the sense that the services producing the smallest benefit per

dollar spent are eliminated, while those providing the largest benefit per dollar spent are assured.

Many advocates of controlling health care spending by reducing demand wish to increase the proportion of the cost of care for which patients are directly responsible. Exposing patients to a larger share of costs would surely lower the level of spending. How much and for how long is less clear, however. Research has shown that patients should not have to pay for certain services, including inoculations and well-baby care. Furthermore, higher payments should not apply to those, including the poor or the severely disabled, for whom significant charges would effectively preclude care. The largest "wild card," however, concerns the effect of changed economic incentives on the focus of medical research. To what extent would scientists turn their energies to developing cost-reducing, as opposed to quality-enhancing and cost-increasing, technology? The simple answer is that, at this point, no one knows. Scientists already have such incentives from the large markets in health-constrained health care systems throughout much of the developed world. The U.S. market is large and would provide added incentives, but claims that higher cost sharing would shift the focus of research remain just that—claims.

The second approach to controlling growth of health care spending would be to explicitly try to slow the principal engine driving health care spending by curtailing spending for the development of new medical technology or by weakening incentives for its development. Examples include cutting the budget of the National Institutes of Health, shortening patent lives, or mandating the licensing of patented technologies at low prices. I believe that this approach would not work and that, if it did work, it would be a calamitous blunder. The strategy would not work, because not all scientific work is done in the United States; indeed, other nations are fighting hard to reclaim the scientific leadership that the United States has enjoyed for the past half-century. Furthermore, much U.S. research is funded privately and would be difficult for public policy to control. Curtailing the advance of medical technology would be a calamity because abundant evidence suggests that medical research is in the early stages of an era during which it will generate enormous net benefits, even if considerable waste occurs at the margin (see Murphy and Topel 2003; Cutler and McClellan 2001; and Berndt et al. 2000).

The third approach is the most promising—to limit the supply of care based on expenditure limits backed by evidence-based research. The failure of the United States to provide massive financial support for an organization analogous to Great Britain's National Institute for Clinical Excellence is, I believe, a tragic blunder. Such information would have only limited value if it were not backed up by private or public regulation to limit total health care spending.

Such limits are sustainable, in my view, only if steps are taken to assure that essentially all Americans are covered by health insurance that meets certain minimum standards. Without near-universal coverage, the framework of cross-subsidies that enables providers to offer the uninsured large amounts of health care and to recover costs from the well insured would collapse. Such an eventuality would give a whole new, and terrifying, meaning to being uninsured. Put simply, near-universal coverage is becoming essential for cold, dry, cost control, not "merely" as a matter of social justice.

Unfortunately, Congress remains as far from consensus on how to extend coverage as it has been for the past 60 years, as encapsulated in the comment, "the status quo is everyone's second choice." Because national consensus is lacking, it is time, I believe, for Congress to encourage individual states to pursue any of a wide range of approaches to extending health insurance that might win state approval. Some states will likely turn to approaches dear to conservatives, such as tax credits, association plans, or individual mandates. Other states will try out plans that appeal to liberals, such as single-payer plans, employer mandates, or expanded Medicare. Whatever the approach, federal guidelines would require that insurance coverage meet minimum standards and that the numbers or proportion of uninsured be reduced as a condition for receiving federal grants sufficient to defray a large part of the state spending. This federalist approach has been advanced in various forms over the years, most recently by the odd couple of Stuart Butler, research director at the Heritage Foundation, and me (Aaron and Butler 2004). Stuart and I do not agree on much, but we do share the belief that the disarray in U.S. health insurance is too important to wait for the political rapture of Washington consensus around the one true health care plan.

My reasoning is simple: limits on health care spending will be essential for the nation's political and economic health; near-universal coverage is the necessary pre-condition for effective expenditure control; if the national legislature will not or cannot move us to increased coverage, then let the states do it. Things may be a bit chaotic for a while, but we just might learn something; and, meanwhile, we will be making some progress in dealing with the most fundamental fiscal and social policy challenge we are likely to see in the twenty-first century.

■ *This paper draws heavily on the chapter "Health" by Henry J. Aaron and Jack Meyer, in Restoring Fiscal Sanity: 2005—Meeting the Long-Run Fiscal Challenge, edited by Alice M. Rivlin and Isabel Sawhill, Brookings Institution, 2005. The views expressed here are the author's and do not necessarily reflect those of the trustees, officers, or other staff of the Brookings Institution. This paper omits numerous source references, which can be found in Restoring Fiscal Sanity.*

Notes

1. Social Security in the United States replaced an average of 36.5 percent of average earnings, compared with 52.7 percent in France, 42.6 percent in Germany, 77.2 percent in Italy, and 68.5 percent in Sweden (Organisation for Economic and Community Development 2005, Table 7.1, p. 67).

2. See Cutler and McClellan (2001). More generally, see the Center for the Evaluative Clinical Sciences (1999).

3. For a detailed explanation of HSAs, see Aaron (2004).

4. Implementation of this change was delayed, however, so that the first affected workers were those turning age 62 in 2000. They were eligible to receive full benefits at age 65 and two months. Only in 2022 will the full benefits age reach age 67 for workers turning age 62 (Social Security Administration 2003).

5. Whether the savings in the future would be larger or smaller depends on changes in the proportion of Medicare spending accounted for by the elderly (as opposed to the disabled), on the age distribution of the elderly, and on the age-specific distribution of changes in Medicare technology or practice that may occur in the future. If, as seems likely, the age distribution of medical outlays is related more closely to "time until death" than to "time since birth," the proportion of medical outlays accounted for by the young elderly is likely to fall with time.

6. One of the most effective ways to lower the fiscal and economic burdens on working cohorts arising from population aging would be to induce workers to remain economically active until later ages than they now do. Deferral of retirement would run counter to historical trends. In many cases, deferral of retirement would cause significant physical hardship. But public policy should be structured, at a minimum, not to encourage early retirement. This standard is now widely recognized with respect to pensions. But the fact that Medicare health care benefits not claimed at age 65 are lost continues to subsidize retirement not later than age 65. Because Medicare "saves" money when workers remain covered by employment-based insurance and active workers continue to contribute to both Social Security and Medicare, it would "level" the playing field if Medicare defrayed part of the cost of employment-based insurance for workers who remain employed after their 65th birthdays.

7. This statement will not hold in the future for elderly persons who have had very high incomes during their working lives, as the Medicare payroll tax applies to all earnings without limit. One can argue that since Part B is mostly financed by general revenues, the very wealthy have even now paid for their benefits because they bear the lion's share of personal income taxes, representing the large majority of federal revenues other than payroll taxes.

8. Total spending on the aged, blind, and disabled in 2000 was $117.2 billion; of this, $44.5 billion was spent on other identified beneficiaries (Committee on Ways and Means of the U.S. House of Representatives 2004).

9. Several states have introduced programs to encourage people to purchase private long-term care insurance. For people who purchase a qualifying long-term care policy, states waive the requirement that they must completely spend down their assets in order to qualify for Medicaid. On retention, see McNamara and Lee (2004).

10. The long-term budget projections of the Congressional Budget Office assume that government spending, other than that on health care and debt service, will remain approximately constant. Increases in Social Security outlays are just about offset by assumed declines in other mandatory and all discretionary spending (including national defense), all measured as a share of GDP. The tax increase necessary to return revenues to their historical share is 2 to 3 percent of GDP. The additional taxes mentioned in the text are distinct from these increases.

11. Two offsetting effects would be at work. If Medicare paid for a reduced fraction of currently covered services, the effective price to those currently eligible for Medicare would go up and less care would be consumed. This reduction in consumption of health care would lower federal spending more than estimates based on current consumption would suggest. On the other hand, some demand would spill over into other programs financed in total (Veterans Administration) or in part (Medicaid) by the federal government.

12. For a fuller presentation of this line of argument, see Aaron, Schwartz, and Cox (2005).

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It's Technology (and What It Is or Isn't Worth), Stupid! Comments on Aaron's "It's Health Care, Stupid! Why Control of Health Care Spending Is Vital for Long-Term Fiscal Stability"

Mark V. Pauly

Introduction

The answer is almost always 15 percent. By this I mean that, with one notable exception, my judgment is that the answer to almost all empirical normative questions in health economics is about 15 percent. What proportion of the population is insured? About 15 percent. How much will a group-staff model HMO save over conventional insurance with modest cost sharing? Fifteen percent. How much will a plan with catastrophic health insurance and a spending account save over the same plan? Fifteen percent. What fraction of medical care spending is covered by Medicare (before drug benefits)? About 15 percent. What proportion of a physician's patients need to be enrolled in a health plan using evidence-based or other managed care rules before she notices? Fifteen percent. What proportion of medical care resource use is economically wasteful (marginal benefit less than marginal cost)? Fifteen percent. What portion of new technology is similarly wasteful? Fifteen percent. What proportion of Henry Aaron's paper do I disagree with? Fifteen percent.

Let me begin with the complement of the last statement (which is meant to be a compliment). I agree with the great bulk—85 percent, in fact—of what Henry has to say. I could not agree more with the main theme: getting control (or at least a stronger feeling of control) over medical care spending is critical not only to the future of medical provision and insurance, both public and private, but also to the future of the entire public budget and the national economy. By an iron law of arithmetic, if medical

care spending continues to grow more rapidly than real GDP—which it has, with only a few blips, as far back as we have data—the proposition that such spending will hit any ridiculously high share of GDP of your own choosing is not a matter of whether, but only of when.

I agree that Stein's Law decrees that things cannot go on like this forever, so it is absolutely crucial that we start thinking now of how we might make a graceful transition from what we need to stop doing to what we can possibly do, and that we do so in a way that does as little harm as possible to the vulnerable minority of poor and sick, and to the welfare of the remaining population. I also agree that I do not now know either how this transition should take place or how it will take place if we let things ride. But I do know *where* it must take place—that it must be in the rate, form, and composition of beneficial but costly *new* medical technology. I can be as upset as the next management consultant at the overuse of old MRI scans or branded heartburn medicines, or at the underuse of antidepressants, but that is so "last year." More to the point, fixing it is extraordinarily hard and will not make more than an amazingly temporary contribution to the fundamental issue of long-term spending growth.

I certainly agree that moral hazard—here called "the motive for fee-for-service insureds" (which, however, now only exists for Medicare patients and CEOs) "to seek all care that provides any benefit, however costly" (to which I would add only any "*expected* benefit, based on the information available at the time decisions are made")—does not include after-the-fact mistakes (like Vioxx).

I strongly agree that the possibility to "curtail spending growth" while preserving quality and coverage for any but a brief period of time (if that) is quite low. I have been spending a mini-sabbatical looking for evidence of economic inefficiency (not doctors criticizing other doctors) in the system. I may still get a revelation, but at the moment I would put the amount of spending that meets the twin criteria of economic inefficiency—benefits fall short of cost and a feasible plan exists to change things so this stops happening—at 15 percent at most (and maybe more like 10 percent). At historical rates of spending growth, even deleting all of this waste would give us two or three good years of low spending growth.

The futility of "saving" Medicare by expanding the age of dependents, means-testing premiums, or raising cost sharing for conventional medical care also reflects my shared despair.

Disagreements

Now for the discussant's major job: to disagree. I begin with a data point. Comparing the spending levels in the United States and other countries, as Henry does, largely tells us that people who work in or provide products to health care in the United States get paid much better than in other countries. It is useless as an indicator of "efficiency," but it does say that, in a sense, our major tax problem compared to that of other countries is in figuring out how to fund larger transfers to nurses, technicians, and phlebotomists. But the rate of growth of spending is much more similar across countries than the level of spending, so cross-national comparisons tell us little about the major problem.

Another point that is both small and large is that changing the tax treatment of employment-based insurance, now made even more baroque with tax-subsidized spending accounts, would still only give our usual 15 percent savings, but might make insurance more affordable for the lower-middle class (who are the bulk of the uninsured). It might even slow the rate of technological change, though the jury is definitely out on this and may not reach a verdict any time soon.

I have proposed to ameliorate Medicare's funding problem by providing what is essentially a defined contribution plan for future middle-class retirees that will grow fast enough to keep real benefits as they are today, but that will require these beneficiaries to finance their own new technology above today's benefits (if they want it enough) in excess of that level (Pauly 2004). This limitation is not intended for additional cost shifting, although it may require selective cost sharing. I could see using evidence-based medicine to help people decide what they really want to buy with their own money. I am not as sanguine as Henry in believing that evidence-based medicine is "most promising" as a way to limit the supply of care, unless we use evidence in a biased way only to curtail spending on the slightly helpful but not to increase spending on the underused,

and unless the evidence gets a lot better and broader than it is at present. Most "evidence" in medicine is probabilistic anyway and depends on the value people attach to taking or not taking risks; so I am not sure how it could work to limit spending for people with different views on risk. If we assume that we could generate real evidence, it might help to allow the emergence of a variety of health plans with competing, transparent, and lawyer-proof rationing rules (Pauly 2005). I would think that giving a monopoly on generating this information to a group like England's National Institute for Health and Clinical Excellence would be a blunder, however, although public financing for competing technology assessors may be called for.

The Really Serious Issues

One serious consequence of the growth in medical spending is its distributional impact. I expect the share of GDP going to medical care to hit 20 percent or even 25 percent in my lifetime. (That is the exception to the 15 percent rule.) Personally, unless my CREF fund crashes, I will not mind that because I may prefer to spend my wealth on health and still have some left over. But lower-middle-income people already do not have this ability, and therefore are dropping the Lexus-quality health insurance that seems to be the only serious option in the private sector. [I do not think that health savings accounts (HSAs) are really going to change the quality that much.] We do need a cheaper and slower-growing basic policy ("The Prudent Health Plan That Waits a Couple of Years to See How New Technology Pans Out"), and I have written at the Lansdowne meeting on how such a set of plans might work.

The most painful thing about this to me is the need to accept multi-tier medicine, to accompany our multi-tier income distribution. But if, despite my own personal preferences, we are not going to do anything about the latter, we are going to have to accept the former. It will be even worse if government continues to devote its additional funds to health care for old people, who already have the best deal in town.

There is a final, deeper issue involved, as Henry recognizes. The trends showing faster growth of medical spending than of GDP are obviously not sustainable. Even getting the growth rate "down," as he discusses,

so that other spending stays where it is, rather than falling, is not to me that happy a prospect; I would like to step up from rice and beans as my income grows (figuratively speaking).

Maybe the following reflections will help. No good can be a super-luxury good (with income elasticity much greater than one) forever, because eventually it will consume income. But we know that there have been luxury goods in the world and the sun still rises every morning. So, somehow Stein's Law does kick in.

What seems to have happened historically (in my nonexpert review) is two things. One is that the efficiency in production of other commodities has risen dramatically (think agriculture), thus creating room for the relative growth of the services sector, including but not limited to medical care. Indeed, it may be that our country spends so much on medical care because it can, in the sense that the high efficiency in the rest of the economy permits it to do so. The Japanese have a low share of medical care spending, one might hypothesize, because they have a high share of housing spending (although also spending on seafood, which is better for your health than much of medical care). If our housing were as expensive as theirs, we might economize and go for five-minute physician office visits, too.

The other observation is that historically there have been one-time luxuries that ceased to be so. Beefsteaks, air conditioning, and paid child care used to be reserved for the rich, but now the middle class can have them, too. It is surely possible that the real absolute amount of growth in medical spending can continue to rise without necessarily having the percentage rate remain so high (as the base expands). What I have in mind here is a Greenspanish "smooth landing" in which medical spending continues to grow in real terms through new technology, but in which the percentage rate of growth tails off. Maybe we can live healthy and die cheap.

The wild card here is science—what if they do discover a cure for cancer or a vaccine for Alzheimer's? That would be terrible news for cost containment. Recent RAND research says the experts do not see slowing ahead—they continue to see great, but probably expensive, discoveries on the horizon. I am not sure what constitutes optimism here, but I am far from despair. I do think that the best tool we know for muddling

through is going to be the market and not some kind of collective medical-industrial policy, and I do think that we have to be prepared for painful rationing. But maybe we will be lucky, or redefine what it means to be lucky in health.

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Comments on Aaron's "It's Health Care, Stupid! Why Control of Health Care Spending Is Vital for Long-Term Fiscal Stability"

C. Eugene Steuerle

I always find conferences on health care fascinating. Although health care is one of the plushest and fastest-growing sectors of the American economy, it is in health that you always hear the most pessimism about what can be done. Based on my calculations, the tax subsidy for employer-provided health insurance is going to increase by $100 billion annually within about the next five years. Add to that the many hundreds of billions more being spent for Medicare within a few years, and then try to explain why the conventional wisdom is that we can't afford to achieve our major health policy goals. Is it a problem of resources? Or, is it one of an inability to make basic decisions on how to use those resources—an inability derived from a straightjacket we tied around ourselves in the first place in the way we have designed health policy?

As a public finance economist, I get to go to conferences on a variety of policy issues. At the welfare conferences, by comparison to those on health care, the participants often fight over the budget leftovers. For instance, big debates occur over whether the government should spend $300 million on providing marriage advice to young people. That's not even pocket change in the health budget.

We don't need to be so pessimistic about our ability to channel health care spending more productively and fairly. Most of our fiscal constraints in health care are due to politics, not economics. We may achieve many things without ever knowing how we are going to control entirely this huge health share of the U.S. economy—a share bigger than the entire economy of most countries around the world. We don't know what any other major industry is going to look like in 50 years, but that doesn't mean we can't develop an investment strategy. Henry Aaron identifies a

number of things we can do, none of which would solve everything. So what? We should start with his list, and then add to it.

The pressure to act now on rising health costs arises because of implications for the rest of the public budget—including the budget for children, for homeland security, for education, and a whole host of other programs. Health costs are also putting pressure on the nonhealth part of the private economy.

To improve efficiency and equity, we need to make explicit many of the hidden costs in the system. We need to move in the right direction to reduce the bias in our payment system toward costly technology relative to other technological innovations. We need to cut back on the extraordinary shift of costs, especially Medicare, to future generations. None of us, rich or poor, are coming close to paying for the benefits promised to us.

Analysts easily get suckered, when we start talking about policy, into playing the politicians' game of trying to offer only free lunches. Since politicians almost never want to talk about who pays for government, the temptation for analysts is to do likewise. Suggestions get confined to pretending there is some free lunch, like "pay for performance" or electronic health records. Despite being fine initiatives, they don't really drive home that somebody, somewhere, has to make a decision. So, yes, we should work on efficiency improvements, but that's true of every industry. Every industry has efficiency-improving efforts worth pursuing, but it still must decide who bears what costs, what prices it is going to pay, and what it is going to buy and not buy.

My fundamental point is that we must make choices about what services are reasonable at different costs, and we must have processes that place responsibility on different people and institutions to make those choices. Start with government. In Medicare, one must set rules on what is purchased and at what price. Government must also deal with the upside-down design of its tax incentives, which favor higher-income employees, leave out much of the population, and for marginal subsidies probably increase the number of uninsured.

Next consider the consumer. We inevitably have to make decisions about how to implement consumer-driven choices, whatever share of the future health care economy they will comprise. Where should

those choices be made? Are they better made for first dollar or last dollar expenses or at the time of insurance purchase? Are deductibles better than co-payments? Since part of this health economy will be consumer-driven, we must come to grips with a viable decision-making process.

Consider lastly how to enhance the power of a third group of decision-makers—health industry intermediaries. How well can we set up processes for them? Spending can be channeled and controlled in part through the use of vouchers and capitation payments. Alain Enthoven's argument—that people make explicit choices if they understand the costs—is a powerful one. The issue is not whether reform would ultimately create future cost containment, only that it would likely lead to improvement.

Behind many of these tougher choices lies a set of budget principles that no longer can be violated. Simply put, if health care is to adhere to proper budget principles, it cannot be left as an open-ended system. In budget policy today, health care automatically drives out other spending. Most spending under programs like Medicare does not have to go through a discretionary decision-making process every year, as Congress does for other parts of the budget. That bias against discretionary choices, whether in education or in remaining parts of health care or anywhere else, is a crucial, elemental part of the entitlement debate. It's not just the greater permanence granted to entitlements, it's that several of them—mainly health and retirement programs—are scheduled to grow automatically over time faster than the growth rate of the economy. As a result, they are not only affecting how health spending is evolving, but also squeezing out funding for other programs.

Some Empirical Evidence

Empirical evidence backs up my claims. Let's begin by reflecting on the current budgetary squeeze. The top line in Figure 6.1 shows projected receipts of the U.S. government as a percent of GDP. The projected spending line on the bottom is driven mainly by health care, but also by retirement programs like Social Security. That line also adds in defense at an arbitrarily assumed lower percentage of GDP than where it is today

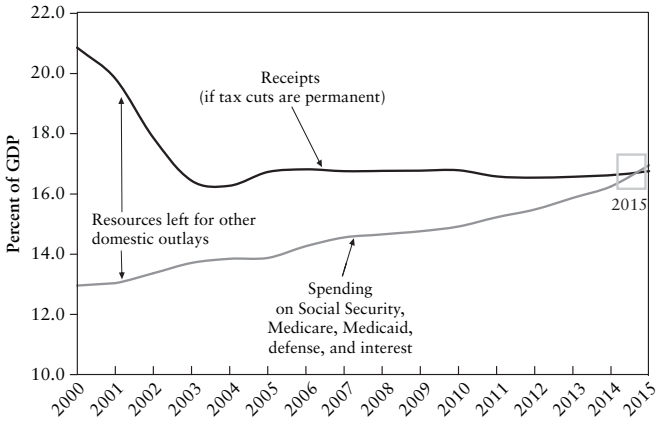

Figure 6.1
The Current Squeeze
Source: C. Eugene Steuerle, Adam Carasso, and Elizabeth Bell, The Urban Institute, 2005. Authors' calculations based on data from the U.S. Congressional Budget Office and The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

and adds in interest costs. As you can see, within a few years, these two lines cross, and there's nothing left in the budget for anything else—not for programs for children, not for wage subsidies, not for environmental protection, not even for IRS agents. There's nothing left for the basic functions of government if the United States continues to spend revenues the way it has scheduled them in current law. That squeeze is not waiting for some day in the future. It's occurring now.

Rapid growth of health costs also places a squeeze on the nonhealth part of the economy. Figure 6.2 shows how more of per capita income growth is being spent on health every decade, placing constantly growing pressures on the nonhealth part of the economy. The point is that, if health care is projected to maintain a constant rate of growth greater than the growth rate of the economy, then there cannot be a constant growth rate in the nonhealth part of the economy; but, rather, a constantly declining rate. This is not just an abstraction; health costs can put a squeeze on employees, for instance, when they bargain for higher cash

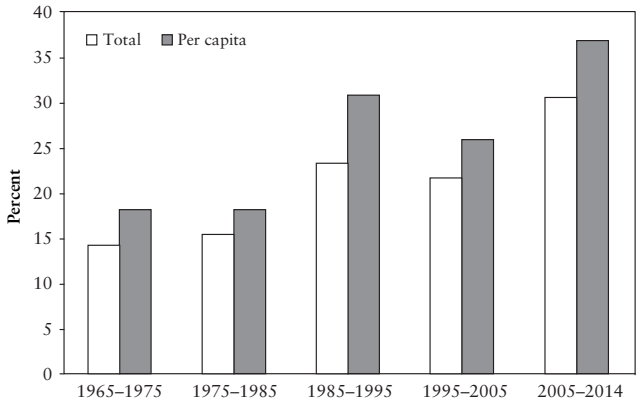

Figure 6.2
Health Spending Growth as a Share of Total Growth, 1965–2014
Source: The Urban Institute, 2005. Based on data from the Office of the Actuary, Centers for Medicare & Medicaid Services, the Bureau of Economic Analysis, and the Bureau of the Census.

wages. The ultimate counter-pressure from these other parts of the economy, including those that arise in wage bargaining sessions, ultimately must reverberate back and put pressure on the rate of growth in health costs and on the institutions—government, employers, insurance companies—that determine what health payments will be made.

We know that efficiency can be improved by having people recognize the cost of their care. Today people recognize very little in the way of that cost. The amount of personal contributions for health insurance is only about 9 percent of the total cost; out-of-pocket payments are about 13 percent. Follette and Sheiner, in a paper that I recommend to you, show that when people actually face costs, these out-of-pocket costs have a much slower growth rate (Follette and Sheiner 2005). Figure 6.3 shows that, between taxes and tax subsidies and reduced wages, most people do not see the cost of health care. Even health analysts, I have found, often do not know the average cost of health care per household. In 2003, it was about $16,000 per household, and it is growing. The government is already contributing about $9,000 per year per household for health

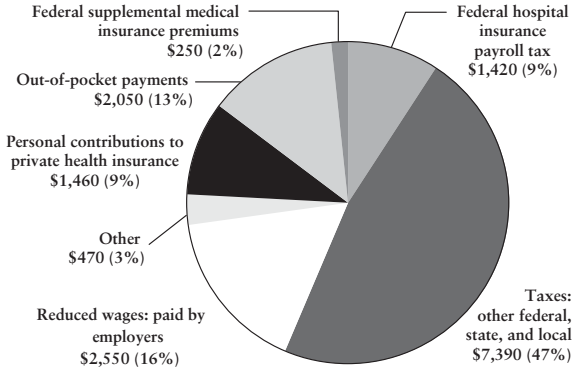

Figure 6.3
Average Health Care Costs per Household by Source, 2003 (Total = $15,590)
Source: C. Eugene Steuerle, The Urban Institute, 2003. Based on data from the Centers on Medicare & Medicaid and the Budget of the U.S. Government, FY 2004.

care, and the amount has been growing much faster than the economy recently. The more we spend and the faster the rate of increase, the more that we proclaim we can't control. A very first step toward reform is simply to make these costs much more explicit.[1]

I also don't accept the excuse made in different ways by Henry Aaron and Mark Pauly—that health costs are driven so high because technology is changing the rules of the game daily. Most rapid growth curves in economics—including growth rates of industries considered advanced at different points in history—eventually convert to sigmoidal or S curves, and often toward relative decline. That is, they do not and cannot forever grow faster than the economy. The issue in health care is not really technology, but how technology interacts with health care financing rules—in particular, that we and the doctor bargain at a zero or very low cost to both of us for what is provided. That type of rule not only opens the door to less valuable technological improvements, but also creates a bias in favor of cost-increasing technology—for instance, for a drug company to investigate drugs for chronic care rather than a cure for AIDS—since the former are likely to be more profitable in an open-ended system.

Figures 6.4 and 6.5 provide partial evidence for the different way this health technology sector operates. These figures are based on Bureau of Economic Analysis (BEA) data that demonstrate quantity and price increases in various sectors of the economy over the half-century from 1950 to 2000. Many people say the quality of what we are getting in health care isn't measured very well, and I agree with this. But I don't think that our conclusions would change all that much if the quality of health care (as well as other goods and services) were measured more accurately.

In these charts, every industry with relatively high quantitative growth has relatively low price growth. The one exception, as you might guess, is health. Even if the measured price increases for medical care were to drop substantially because of improvements in the way that quality is measured, it would in all likelihood still be an industry with much higher relative price increases than other rapidly growing industries. Just by way of anecdote, in case one needs informal confirmation of the formal economic analysis of BEA, a notice on the radio yesterday indicated that the

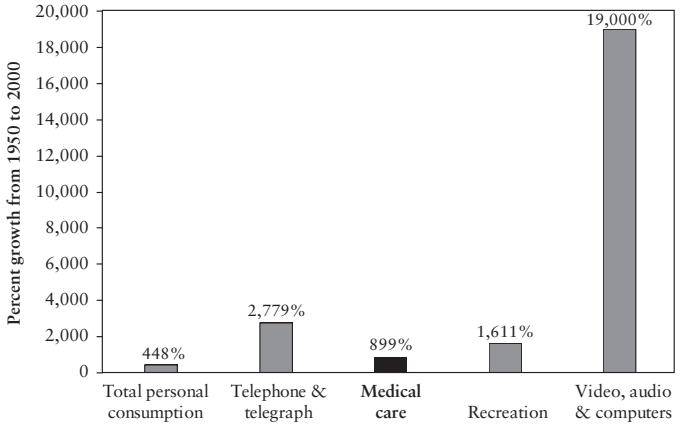

Figure 6.4
Quantity Increases Over Time: Medical Care versus Other Consumption Categories
Source: The Bureau of Economic Analysis.

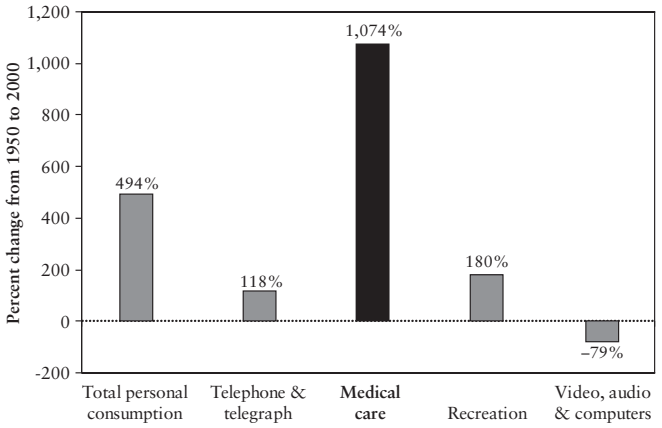

Figure 6.5
Price Increases Over Time: Medical Care versus Other Consumption Categories
Source: The Bureau of Economic Analysis.

prices of some drugs already on the market for two years are going up. I can think of very few cases in other growth industries where the prices of existing technology—computers or anything else—go up for a while for their older, unimproved goods and services.

Figure 6.6 shows the extraordinary extent to which, even in areas like Medicare, almost everyone who is age 30 and over is shifting the cost of health care to future generations. Right now, the 30-and-over set gets some new benefit in Medicare and immediately shifts the cost to other generations. For example, under current projections, everyone who is 40 years old is promised about $1.1 million in Social Security and Medicare benefits, of which they will pay about $600,000. As their personal demand for health care improvements expands, why should they have the automatic right to buy it with their children's money? This shifting of responsibility needs to be tackled, whether by increasing the age eligibility threshold for Medicare and Social Security or through other entitlement reform.

In conclusion, we do know a lot of things that we could and should do to deal with the growth in the cost of health care. In particular, we know a number of things we should stop doing, regardless of how the health sector ultimately evolves. I think the failure to act is in many cases caused

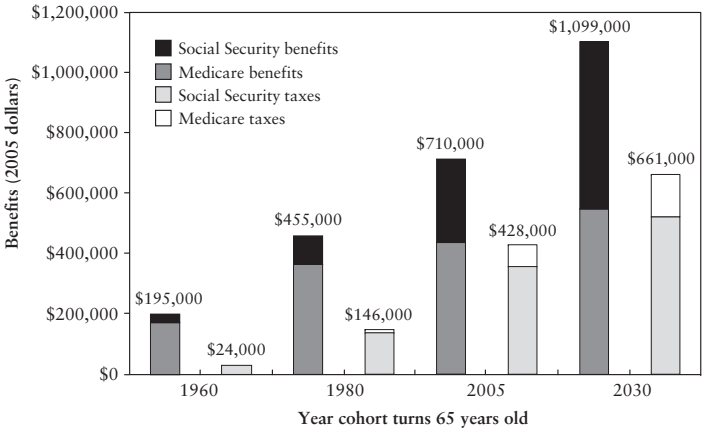

Figure 6.6
Estimated Social Security and Medicare Benefits and Taxes for Average-Wage, Two-Earner Couple ($36,000 each)
The "high" and "average" wage profiles are those hypothetical profiles routinely employed by the Social Security Administration in its analyses. Lifetime amounts, rounded to the nearest thousand, are discounted to present value at age 65 using a 2 percent real interest rate and adjusted for mortality. Projections based on intermediate assumptions of the 2004 Old Age, Survivors, and Disability Insurance (OASDI) and Hospital Insurance/Supplementary Medical Insurance (HI/SMI) Trustees Reports. Includes Medicare Part D.
Source: Adam Carasso and C. Eugene Steuerle, The Urban Institute, 2005.

by a lack of political will, not by a failure of understanding or analysis. At a minimum, good health policy and good budget policy both require creating slack for deciding tomorrow's spending according to tomorrow's needs, not according to some formula derived yesterday—long before those needs were known or fully understood.

Notes

1. My more recent projections have indicated that government subsidies equaled $9,000 in 2006, and are projected to rise to $11,000 in 2010 (in 2006 dollars).

References

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Comments on Aaron's "It's Health Care, Stupid! Why Control of Health Care Spending Is Vital for Long-Term Fiscal Stability"

Alan R. Weil

Henry Aaron is certainly right that health care costs pose the greatest challenge to the nation's fiscal health. My response focuses on the aspect of his paper that is tied to my area of expertise: the role of the states. States face rapidly growing health care costs for their employees, their retirees, and their prison populations, but the overwhelming share of state health spending is for Medicaid.

While the federal government's fiscal future will be strained by health care costs, the fiscal future of states could be broken by them. There are many reasons states face larger challenges than the federal government. State sales and use taxes cannot keep up with the shift to a more service-based economy and Internet-based, out-of-state sales. Interstate competition for businesses and taxpayers places pressure on states to keep tax rates low. All states except for one must balance their budgets annually, so economic downturns hit the revenue and cost sides of state budgets simultaneously. In those states that have voter-imposed tax or revenue limitations, the growth rates in those limits are substantially lower than projected growth in health care costs. Much of the last few decades of growth in federal health spending has been offset by declining defense spending, but states have no comparable budget area that is shrinking. Indeed, governors and voters are particularly interested in increasing spending on education—a traditional state and local responsibility. So, states are at least as interested as the federal government in attending to the fiscal pressure created by rapidly growing health costs.

Aaron notes that government programs face high rates of cost growth due in part to demographic trends. It is worth noting that demographic and health care trends likely will have a larger effect on Medicaid than

Medicare. Forty-three percent of Medicaid spending is on behalf of people with disabilities, a population that is growing and that relies particularly heavily on new medical technologies.

While all payers face rising health care costs, public policy choices are in part responsible for the fact that the share of health care spending borne by government is increasing, making our fiscal challenges greater than our economic ones. For example, we provide substantial, uncapped tax benefits to employers that provide health insurance, but make no requirements that they do so. Thus, in the most recent economic downturn, fewer employees were in jobs that provided health insurance coverage, and Medicaid picked up much of the slack. Higher levels of cost sharing save employers money, and most of the cost is shifted to employees, but some of that cost is transferred to Medicaid. In recent years, we have also observed the rapid exit of private firms from providing comprehensive retiree benefits, leaving another group of Americans uninsured or dependent upon Medicaid.

Federal law bars states from requiring employers to offer health insurance coverage to their employees or defining the structure of coverage should employers choose to offer it. The federal government shows no interest in taking these steps. I am not arguing that an employer mandate is the best approach for covering the uninsured, but the upshot of these policies is that states are essentially bystanders watching their Medicaid rolls and costs rise as employers cut back on coverage. Thus, our fiscal problem arises from a combination of a health care cost problem and a public policy choice to permit the private sector to shift health care costs to the public sector at will. Aaron notes growing state interest in "premium assistance" programs in which states finance a portion of private coverage for employees of firms that offer coverage. This is an understandable response, but one that portends continued growth in Medicaid costs as private coverage continues to erode.

States also pay for federal policy choices, particularly in the area of Medicare. Forty-two percent of Medicaid's costs are already associated with the "dual eligibles"—those eligible for both Medicaid and Medicare. Medicaid has become the default payer for long-term care services because Medicare largely excludes coverage for these services, and their

cost is so high that even middle-class families become impoverished by them and therefore qualify for Medicaid.

There is a substantial risk that future steps to address the fiscal burden of Medicare will increase the burden on Medicaid, which will then be borne in part by states. Aaron mentions the possibility of increasing the eligibility age for Medicare. Such a change would create a large group of moderate-income people without employer-sponsored health insurance, many of whom would have health conditions that would make purchasing their own coverage either impossible or unaffordable. While Aaron notes that these younger-elders do not account for a large share of Medicare's costs, it is the more expensive of them who would likely end up on Medicaid.

Similarly, proposals to move Medicare to a "premium support" or defined contribution model would impose new costs on Medicaid. Low-income Medicare enrollees are eligible for Medicaid assistance to fill in the gaps in their coverage. Limiting growth in spending on Medicare to less than the increase in health care costs would increase the size of these gaps.

Aaron is certainly right that the opportunity for savings by shifting costs to Medicaid enrollees through premiums, co-payments, and deductibles is quite limited. The reasons for this are straightforward but worth noting. First, because Medicaid is means tested, shifting costs to enrollees places a financial burden on them that they cannot bear—yielding either forgone services or enrollees' inability to meet other basic needs. Second, in order for savings to amount to much, these cost burdens must be imposed on those who use the most services, namely, the chronically ill, for whom reduced service use is likely to have the most dire consequences.

I agree with Aaron that approaches such as Health Savings Accounts (HSAs) combined with high-deductible plans that have been proposed for higher-income people are inappropriate for the Medicaid population. In addition to the reasons he gives, there is a political impediment to their success. I do not believe modest-income taxpayers will look kindly upon the building up of sizeable government-funded savings accounts by poor people while many of the taxpayers themselves remain uninsured.

Aaron places some hope in having the federal government invest in assessing the efficiency and use of technology in health care, since most health analysts ascribe a large share of growing health care costs to technological advances. Such an investment certainly makes sense—and the federal government is the right level to make that investment—but even here a role for states may be necessary. Despite their mechanistic-sounding names, efforts such as technology assessment and evidence-based medicine are infused with value choices. As Aaron illustrates, the goal is to identify the point of diminishing returns, not zero returns; but how far must those returns diminish before we deem them to be not worth making? This is squarely a choice of values—values that should be informed by information—but values nonetheless.

While it had its flaws, Oregon undertook such an effort to define social values in its Medicaid program. When I speak about Medicaid around the country, I am almost always asked about the status of the Oregon model, despite the fact that the experiment began more than a decade ago and I do not bring it up in my remarks. Despite this interest, no other state has replicated the Oregon approach, and I attribute that in large part to the challenge of having a serious conversation about values in general, and value in health care in particular. A national technology assessment initiative would be valuable, but only if it occurred in conjunction with a much more local discussion of the results.

Absent from Aaron's prescription are some other steps the federal government could take that might have similar positive consequences. How about a national initiative on price transparency? Such an endeavor is particularly important if we are moving to a more consumer-directed system of purchasing health care. But even if not, all purchasers would benefit from better information on the actual prices being paid in the health care system. Transparency should extend to the pricing of all health care services and insurance products. While technological advances may account for the rapid rate of growth in American health care costs, high prices play a substantial role in the difference between health care spending in the United States and such spending in other countries.

Aaron proposes a major role for states in helping the nation move forward on insurance coverage. In a paper he wrote with Stuart Butler, he proposed a new covenant between the federal government and the states

to enable states to move forward in a variety of ways that federal officials would be unwilling to consider for the nation as a whole. While I have been a longstanding advocate for states, I do not consider this approach likely to succeed. My work has led me to the conclusion that states have a great deal to offer in the way of experimentation and innovation when it comes to how we deliver health care. They are also the right locus for true experiments involving modest variations in a well-defined policy, such as insurance regulation or tort laws. But these positive roles for states do not apply equally in the area of expanding insurance coverage. State variation on the basis of political values, fiscal resources, and the starting point of private coverage is so great that allowing each state to go its own way does not yield experimentation, but a jumbled mess that leaves millions of Americans without health insurance coverage. We have myriad examples of coverage initiatives that work but that are not replicated. As eager as I am to embrace Aaron's (or almost any) creative idea designed to move the country to universal coverage, I do not believe a state-led approach is realistic.