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The Challenge of Rising Health Care Costs — A View from the Congressional Budget Office

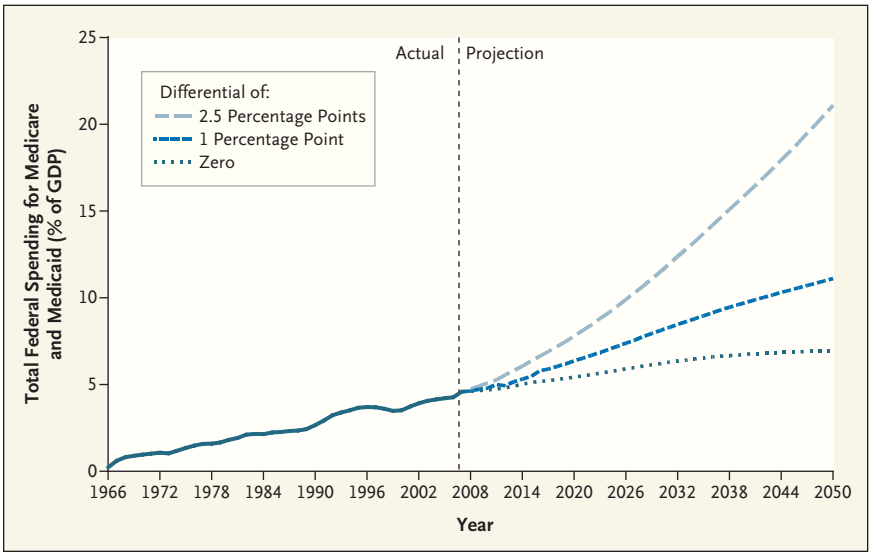
Peter R. Orszag, Ph.D., and Philip Ellis, Ph.D.

The long-term fiscal condition of the United States has been largely misdiagnosed. Despite all the attention paid to demographic challenges, such as the coming retirement of the baby-boom generation, our country's financial health will in fact be determined primarily by the growth rate of per capita health care costs. Yet discussions of Medicare and Medicaid policy as well as broader health care reforms have not seriously addressed the issue of how to slow growth in spending. Instead, recent debates have focused on how much to increase spending for the Medicare prescription-drug benefit, how to expand coverage for children, and how to avoid scheduled cuts in Medicare physician fees.

Those proposals address important objectives, but putting the United States on a sound fiscal footing will require a clearer understanding of the role of health care costs in the long-term budgetary outlook. Federal spending on Medicare and Medicaid is expected to total 4.6% of the gross domestic product (GDP) this year, and the Congressional Budget Office projects that without changes in laws, such spending will reach 5.9% of the GDP by 2017 — an increase of nearly 30% in 10 years. Over the same period, Social Security spending is predicted to increase from 4.2% of the GDP to 4.8%.

Beyond 2017, these trends are poised to accelerate — driven primarily by rising costs per enrollee for health care. Over the past four decades, costs per beneficiary for Medicare and Medicaid have increased about 2.5 percentage points faster per year than per capita GDP. If costs continued to grow at the same rate over the next four decades, federal spending on Medicare and Medicaid would reach about 20% of the GDP by 2050 — roughly the same share of the economy that the entire federal budget accounts for today (see graph). If, instead, costs per enrollee tracked the growth of the GDP per capita, spending on Medicare and Medicaid would reach about 7% of the GDP by 2050, owing to demographic changes alone. In other words, of the 15-percentage-point increase that would occur if historical trends continued, less than one fifth would be due to aging.

Increasing health care costs represent a challenge for private as well as governmental payers, and the trends in both sectors largely reflect the same underlying forces. Total health care spending, which consumed about 8% of the U.S. economy in 1975, currently accounts for about 16% of the GDP, and the share is projected to reach nearly 20% by 2016. About half of



Projected Federal Spending for Medicare and Medicaid under Various Assumptions about the Growth Differential between Health Care Costs and the Gross Domestic Product per Capita.

that spending is now publicly financed, and half privately. Increasing costs will eventually create pressures to reduce private-sector growth rates, and states, which finance roughly half of Medicaid spending, may also act to rein in growth. At the same time, the dramatic increase in obesity over the past 30 years has already put upward pressure on health care spending in both sectors and will probably continue doing so.

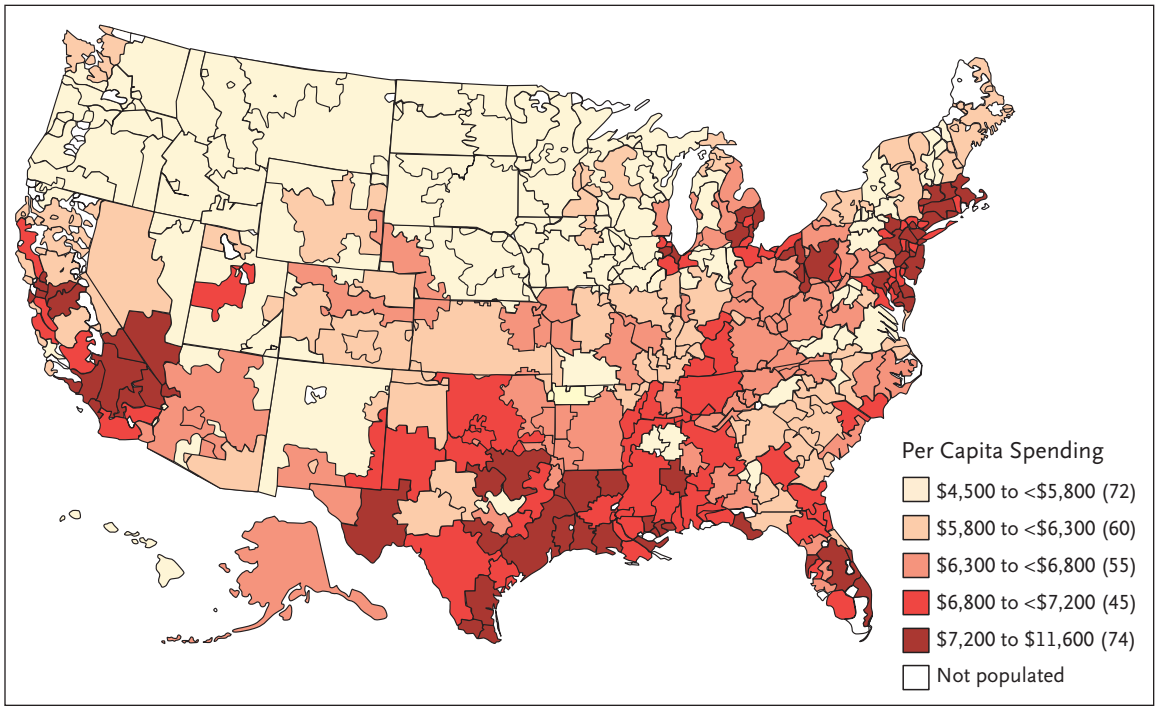
The bulk of this spending growth, however, appears to result not from increasing disease prevalence but from the development and diffusion of new medical technologies and therapies.[1] Some advances permit the treatment of previously untreatable conditions, which can confer substantial benefits but also introduces new categories of spending. Other advances may improve medical outcomes but entail added costs. Some studies have found that the benefits of medical advances justify the added costs on average, but other evidence strongly suggests that many treatments and services are provided to patients who could do just as well with less expensive care.

Another important factor affecting costs is the manner in which insurers pay for and oversee health care delivery. Fee-for-service reimbursements encourage providers to deliver each service efficiently but also create an incentive to supply additional or more expensive services — as long as the payments exceed the costs. During the 1990s, managed-care plans helped to reduce the growth of health care costs, both by requiring referrals for specialty care and other forms of prior authorization and by negotiating price discounts and capitated payments with their networks' providers. Private spending for health care grew at the same rate as the overall economy between 1992 and 2000, and total costs for health care as a share of the GDP remained constant at about 14% between 1993 and 2000. By the end of the 1990s, however, enrollees and providers increasingly objected to the constraints of managed care, leading health plans to adopt less aggressive forms of management. Fee-for-service reimbursement remains the predominant form of payment in private insurance and Medicare.

Another factor that both reflects and contributes to rising health care costs is the declining proportion paid by recipients of the services. Out-of-pocket payments accounted for 33% of personal health care expenditures in 1975, but by 2005, that share had fallen to 15%, and it is projected to drop to 13% by 2015. (Deductibles and copayments have increased, but in the aggregate those changes have not kept pace with total spending on health care.) Not surprisingly, consumers tend to demand more services when they pay a lower share of the costs. RAND's health insurance experiment of the 1970s and early 1980s found that higher cost sharing generally did not lead to worse health outcomes, although participants reduced their use of effective types of care along with ineffective types.[2] Studies based on RAND's data indicate that cost-sharing changes have played a relatively minor role in overall cost growth, although some recent research suggests that widespread changes in cost sharing could have a somewhat larger effect.

Meanwhile, despite the high cost of the U.S. health care system, the degree to which it promotes the population's health remains unclear. Indeed, there might be less concern about increasing costs if they yielded commensurate gains in health. Instead, substantial evidence exists that more expensive care doesn't always mean higher-quality care. Consequently, embedded in the country's fiscal challenge is the opportunity to reduce costs without impairing overall health outcomes.

Perhaps the most compelling evidence of that opportunity lies in the substantial geographic differ-



Medicare Spending per Capita, According to Hospital Referral Region, 2003.

Data are from the Dartmouth Atlas of Health Care. Numbers in parentheses are the numbers of hospital referral regions with that level of per capita spending.

ences in health care spending within the United States — and the fact that higher-spending regions do not have higher life expectancies or show significant improvement on other measures of health.[3] For example, Medicare's costs per enrollee vary substantially from region to region — even after adjustment for enrollee age, sex, and race — from $4,500 to nearly $12,000 in 2003 (see map). Much of that variation cannot be explained by differences in the health of the population or in medical prices.

Furthermore, interstate differences in Medicare spending are not correlated with simple measures of the quality of the care received (such as the proportion of patients with myocardial infarction given prescriptions for beta-blockers).[4] Concerns about regional variation are buttressed by the fact that hard evidence is often unavailable as to which treatments work best for which patients or whether the added benefits of more effective but more expensive services are sufficient to warrant their added costs — and in many cases, the variation in treatments is greatest for the types of care for which we lack evidence about relative effectiveness.

Similarly, spending may vary from country to country for myriad reasons — including differences in income, provider payment rates, and preferences about care. However, the substantially higher costs in the United States are not accompanied by measurable advantages in overall health outcomes.[5]

Fortunately, some research does suggest that there may be substantial opportunities to address many of these issues in a way that reduces health care costs without harming health outcomes. The potential savings, however, may be difficult to realize. The key challenge is thus to identify the specific steps that could be taken to capture those opportunities; we will discuss some possible steps in our November 8 Perspective article.

Dr. Orszag is the director of the Congressional Budget Office (CBO), where Dr. Ellis is a senior analyst. The CBO is a nonpartisan agency that provides budgetary and economic analyses to Congress.

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