CBO TESTIMONY

Statement of
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Director
Congressional Budget Office

before the
Committee on the Budget
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NOTICE

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Mr. Chairman, I appreciate the opportunity to testify before the Committee on the effect of health care spending on the federal deficit. I will also provide more detailed information on the Medicare and Medicaid programs and the factors that are causing spending for these programs to rise so swiftly. Finally, my testimony will examine the relationship between federal and overall spending for health care in the United States.

HEALTH CARE SPENDING AND THE FEDERAL BUDGET

Over the next five years, the federal budget deficit is projected to increase, and the major factor driving that growth is entitlement programs for health care. Spending on health was 13.4 percent of the federal budget in 1990; it will be approximately 17.5 percent in 1993, and the Congressional Budget Office (CBO) projects that health expenditures will account for nearly one-quarter of the budget by 1998 (see Table 1).

Health care is by far the most rapidly growing component of the federal budget. In fact, every other major component of the federal budget is either declining or growing more slowly. CBO projects that growth in spending on health within the federal budget will average more than 11 percent a year between 1993 and 1998. This growth rate, which represents more than 8 percent after adjusting for projected inflation, is considerably

TABLE 1. FEDERAL SPENDING ON HEALTH, FISCAL YEARS 1965-1998

	1965	1970	1975	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997	1998
In Billions of Dollars														
Total Federal Spending	118.2	195.6	332.3	590.9	946.3	1,251.7	1,323.0	1,381.9	1,452.9	1,506.8	1,574.5	1,642.8	1,733.0	1,839.1
Federal Health Spending	3.1	13.9	29.5	61.8	108.9	168.0	188.6	222.7	254.2	286.1	320.2	355.5	393.2	434.2
Medicare	n.a.	6.2	12.9	32.1	65.8	98.1	104.5	119.0	134.1	152.3	171.7	192.7	215.3	239.3
Medicaid	0.3	2.7	6.8	14.0	22.7	41.1	52.5	67.8	80.3	91.9	105.0	117.7	131.0	145.9
Veterans Affairs	1.3	1.8	3.7	6.5	9.5	12.1	12.9	14.1	14.9	15.7	16.2	16.7	17.2	18.0
Other	1.5	3.2	6.1	9.2	10.9	16.6	18.7	21.8	24.9	26.2	27.3	28.4	29.7	31.0
As a Percentage of Total Federal Spending														
Federal Health Spending	2.6	7.1	8.9	10.5	11.5	13.4	14.3	16.1	17.5	19.0	20.3	21.6	22.7	23.6
As a Percentage of Federal Spending on Health														
Federal Health Spending	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Medicare	n.a.	44.6	43.7	51.9	60.4	58.4	55.4	53.4	52.7	53.2	53.6	54.2	54.8	55.1
Medicaid	9.7	19.4	23.1	22.7	20.8	24.5	27.8	30.4	31.6	32.1	32.8	33.1	33.3	33.6
Veterans Affairs	41.9	12.9	12.5	10.5	8.7	7.2	6.8	6.3	5.9	5.5	5.1	4.7	4.4	4.1
Other	48.4	23.0	20.7	14.9	10.0	9.9	9.9	9.8	9.8	9.2	8.5	8.0	7.5	7.1

SOURCE: Congressional Budget Office calculations and projections, January 1993.

NOTES: Medicare expenditures are shown net of premium income from beneficiaries.
"Other" includes federal employee and annuitant health benefits, as well as other health services and research.
"Federal health spending" excludes spending for the military's CHAMPUS program.

Spending for discretionary programs in the 1993-1998 period is increased each year to reflect projected inflation, starting from the 1993 appropriated levels. Although CBO's projections of total federal spending assume compliance with the discretionary spending limits for the 1993-1995 period, the Budget Enforcement Act does not specify programmatic changes to achieve those limits. Thus, it is not possible to adjust projections for individual programs to reflect the overall limits.

Details may not add to totals because of rounding. n.a. = not applicable.

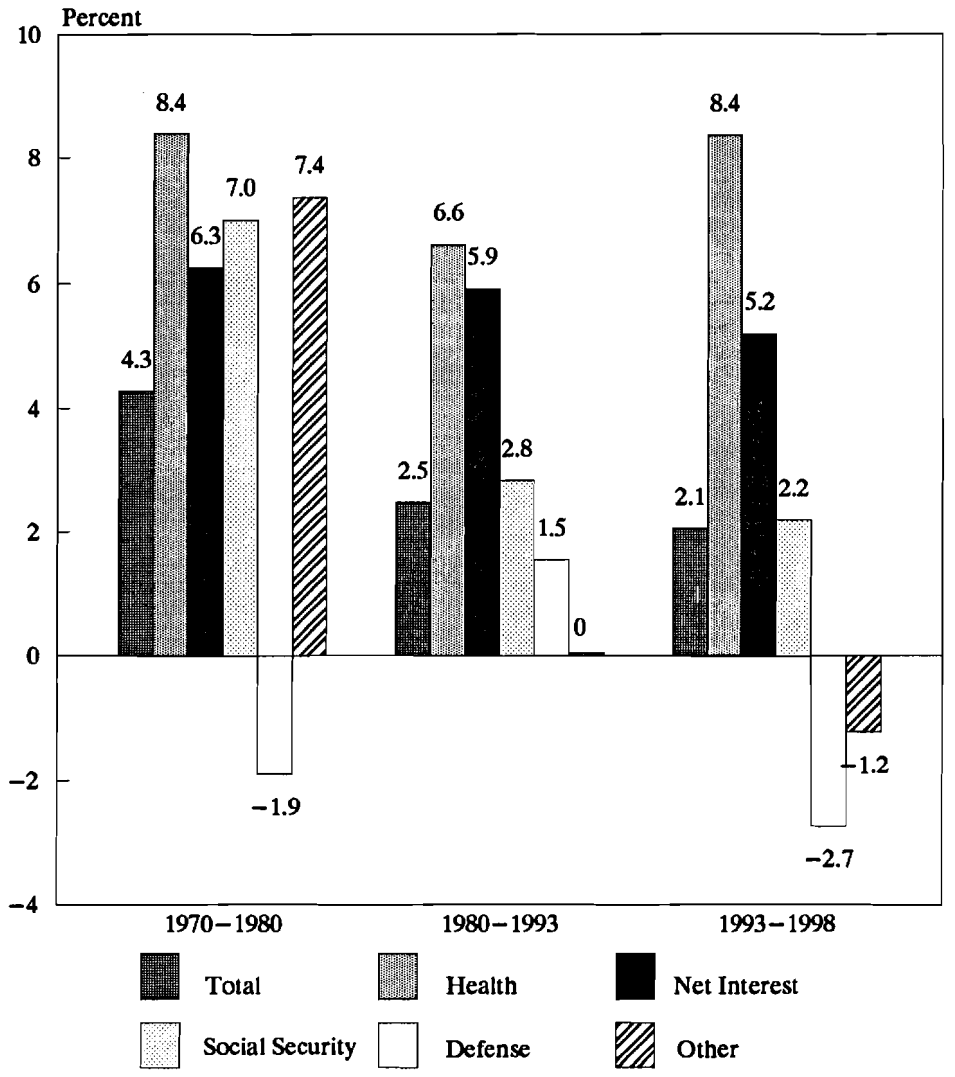
higher than that projected for other components of the budget (see Figure 1). Net interest and Social Security are projected to increase at inflation-adjusted annual rates of about 5 percent and 2 percent, respectively. The other components of the federal budget are projected to decline.

Clearly, controlling federal spending and reducing the budget deficit will be extremely difficult--if not impossible--if no change takes place in current patterns of spending on health care. Since about 85 percent of federal spending on health is for Medicare and Medicaid--and they are growing much more rapidly than any other health programs--this testimony will concentrate primarily on these two entitlement programs.

THE MEDICARE PROGRAM

Medicare was enacted in 1965 and put into place in July 1966. The program was designed to ensure that older Americans would have access to health care after they were no longer working. Anyone who is age 65 and eligible for Social Security benefits is automatically eligible for Hospital Insurance (HI), which covers acute care services provided in hospitals, hospices, and skilled nursing facilities, as well as some home health care. Supplementary Medical Insurance (SMI), which covers physician services, outpatient hospital services,

Figure 1.
Average Annual Growth Rates of Real Federal Outlays, Selected Components, 1970–1998



SOURCE: Congressional Budget Office calculations, January 1993, based on actual outlays in 1970 and 1980 and projections of federal outlays for 1993 through 1998.

NOTES: The word "real" is used here to mean adjusted for general inflation rather than for inflation in the prices of health services, which is almost certainly different. Outlays are adjusted to 1991 dollars using the consumer price index for all urban consumers (CPI–U).

Years are fiscal years.

Health care outlays exclude those in the Department of Defense.

The "Other" category includes, for example, spending for food stamps, federal deposit insurance, education, transportation, and housing.

The estimate of defense spending for 1998 is based on the Bush Administration's proposal of January 1992.

and other ambulatory care, covers individuals who are at least 65 and elect to participate in the program. In addition to the aged, many people who are severely disabled or who have end-stage renal disease are eligible for Medicare, under provisions enacted in 1972 that extended the program.

In 1993, approximately 31.5 million people age 65 and older and 3.5 million disabled people are covered under the HI program. About 31 million aged and 3.2 million disabled people are enrolled in SMI. The number of Medicare enrollees is projected to increase about 2 percent a year over the next five years.

Because Medicare is available to nearly all people age 65 or older, only about 300,000 elderly people were uninsured in 1992. Thus, the Medicare program accomplishes its intended objective--to extend access to health care to older Americans.

Although nearly every worker has contributed to the HI trust fund, current Medicare enrollees receive a substantial subsidy under that program. CBO estimates that for the cohort of people who became 65 in 1992, Medicare will pay at least 60 percent more per person for HI benefits over their lifetimes than the value of their contributions and those made by their employers. In 1992 dollars, this amount represents an annual subsidy of about

$2,000 per enrollee. In addition to the HI subsidy, those enrolled in the SMI program pay only about one-quarter of the costs of the benefits they receive under SMI.

Spending for Medicare

HI spending is estimated to be about $91 billion in 1993, rising to almost $149 billion in 1998. Although hospital benefits account for more than 80 percent of HI spending, the costs of other services have risen much more dramatically in the past year--for example, hospital spending is estimated to have increased about 8 percent between fiscal year 1992 and fiscal year 1993 compared with nearly 38 percent for home health care, 22 percent for hospice care, and 28 percent for skilled nursing facility care. After adjusting for inflation, hospital spending growth was estimated to be nearly 5 percent, with home health care, hospice care, and skilled nursing facility care growing about 34 percent, 18 percent, and 25 percent, respectively. The reasons for such rapid growth vary and are not fully understood. CBO's projections assume that it will not continue over the 1993-1998 period.

During the 1993-1998 period, HI payments are projected to increase more than twice as fast as revenues, however, and beginning in 1994 they will

exceed revenues from the HI payroll tax (2.9 percent on earnings up to $134,700 in 1993). In fact, the $127 billion projected balance in the HI trust fund at the end of 1993 will decline rapidly, and the trust fund is expected to be exhausted during 2001.

Overall SMI spending--including the portion paid by enrollees' premiums--is projected to increase from $58 billion in 1993 to $113 billion in 1998. Spending for physician services--which accounts for about 54 percent of SMI--is projected to rise at an average annual rate of nearly 13 percent over the 1993-1998 period, and spending for outpatient hospital services--which accounts for 21 percent of SMI--is projected to grow an average of nearly 18 percent annually. After adjusting for projected inflation over the 1993-1998 period, physician and outpatient spending are expected to rise about 10 percent and 14 percent a year, respectively.

The premium paid by those voluntarily enrolled in SMI--$36.60 per month in 1993--is set by law at a level intended to cover 25 percent of the program's cost through 1995. In 1996 and beyond, increases in premiums are limited to the percentage increase in the Social Security cost-of-living adjustments. The remaining financing comes from general tax revenues. In 1993, more than $46 billion in general revenues will be necessary; by 1998, that amount is projected to reach $91 billion.

Medicare's Payment System for Hospitals

In the Social Security Amendments of 1983, the Congress replaced retrospective, cost-based reimbursement for inpatient hospital services provided to Medicare beneficiaries with the prospective payment system (PPS). Under this system, hospitals are paid a predetermined amount for each Medicare patient, based on the patient's diagnosis and treatment and on certain characteristics of the hospital. If the expenses associated with treating the patient are less than the payment, the hospital can keep the surplus. If the cost exceeds the payment, however, then the hospital incurs a loss.

The payment rates used by the PPS reflect the variations in costs among hospitals that result from factors considered to be beyond the hospital's control and not related to its efficiency. Payments are therefore adjusted for certain cost-related factors, such as labor costs in the local area. The PPS currently applies separate rates to hospitals in large urban areas (those with populations of more than 1 million), other urban areas, and rural areas. The difference in rates between other urban areas and rural areas is gradually being phased out, however, and will be eliminated by 1995.

The PPS provided hospitals with incentives for efficiency that did not exist under the previous cost-reimbursement system. Following the introduc-

tion of the PPS, the growth rate in inflation-adjusted spending for hospital care per enrollee dropped rapidly, from an increase of around 4 percent between 1983 and 1984 to less than 1 percent annually between 1985 and 1987. Growth has been somewhat higher since then--about 1.5 percent annually between 1987 and 1991, after adjusting for inflation.

CBO's projections for the 1993-1998 period indicate that hospital spending will rise at an average annual rate of nearly 8 percent per enrollee in nominal terms, and 5 percent per enrollee after adjusting for inflation. This higher growth is expected, in part, because Medicare admissions to hospitals are rising. In addition, PPS rates were initially set at a level that exceeded hospitals' average costs per case, partly as a result of an error in the methodology. Consequently, for several years, updates to the payment levels were held below the level that would have been justified by increases in hospitals' costs. For the 1993-1998 period, however, increases in payment levels to cover the rise in hospitals' costs are projected.

Medicare's Payment System for Physicians

Based on legislation enacted in 1989, the new Medicare Fee Schedule (MFS) for physician services was put in place on January 1, 1992. The MFS replaced

a payment system under which Medicare's rates were set separately for each physician at the lowest of the actual charge, the physician's customary charge, or the locally prevailing charge for that service.

The new fee schedule reflects a resource-based relative value scale developed by a research group at Harvard University in consultation with the Health Care Financing Administration (HCFA) and the Physician Payment Review Commission (PPRC). The value of each procedure is ranked relative to all other procedures and is uniform for all specialties. The resulting fees, however, vary among 233 payment localities based on a geographic index of medical practice costs.

Overall payment rates under the MFS were 6.5 percent lower in 1992 than they would otherwise have been, although according to HCFA's estimates, total payments to physicians were to be unchanged as required by the legislation. HCFA's calculation assumed that an increase in the volume of services would occur as a result of the MFS, making a reduction in the payment rates necessary to achieve budget neutrality.

The MFS rates are updated each year based on growth in an index of practice costs (the Medicare Economic Index). These rates are adjusted up or down depending on whether growth in the volume of services two years

earlier fell below or above a target rate for growth in expenditures set by Medicare's volume performance standard (VPS). The Congress sets the VPS, based on recommendations from the Department of Health and Human Services and PPRC. If the Congress fails to act, the VPS is set by a default formula that reflects payment rates, growth in enrollment, and the volume of services per enrollee; adjustments are made to reflect the effects of any enacted legislation.

Medicare spending for physician services grew at an inflation-adjusted rate of 8 percent per enrollee annually between 1980 and 1985 and 5.6 percent annually between 1985 and 1991. CBO's projections for the 1993-1998 period suggest that Medicare's spending for physician services will continue to grow rapidly, by about 11 percent annually per enrollee averaged over that period, in nominal terms, and by more than 8 percent annually after adjusting for inflation. This higher growth rate occurs in part because the 1992 physician expenditures came in under the VPS targets. As a result, physicians will receive a significant increase in fees in 1994.

THE MEDICAID PROGRAM

Medicaid is the state-administered program that, since 1966, has operated under federal guidelines to provide medical care to certain low-income people. Federal and state governments jointly fund the program with federal financial participation rates that currently range from 50 percent to 79 percent, based on a formula that takes into account the ability of the state to finance the program. The states have considerable discretion in establishing the criteria on income and assets for program eligibility; setting the amount, duration, and scope of covered services; and determining methods for reimbursing providers.

Eligibility

Under federal rules, states are required to provide Medicaid coverage for some groups of the population and may cover additional groups for which they also receive federal matching funds. Recipients of Aid to Families with Dependent Children (AFDC) are entitled to Medicaid benefits, as, in general, are recipients of Supplemental Security Income (SSI). Thus, changes in AFDC or SSI enrollment also affect the number of Medicaid beneficiaries. (In the context of the Medicaid program, the term "beneficiaries" denotes

people who receive services paid for by Medicaid.) More than 60 percent of Medicaid beneficiaries receive cash assistance from AFDC or SSI and are considered to be "categorically needy."

The remaining 40 percent of Medicaid beneficiaries include other low-income people who are aged, blind, disabled, or members of families with dependent children, plus other low-income children and pregnant women. Some of these groups are also considered to be categorically needy. They include potential recipients of AFDC and SSI, plus pregnant women and children entitled to coverage under the recently legislated expansions. Others are medically needy; that is, they meet the nonfinancial criteria for categorical eligibility and become eligible for Medicaid when, after subtracting their incurred medical expenses, their income and resources fall below limits set by the state. In addition, some elderly and disabled beneficiaries have partial Medicaid protection in the form of assistance that pays for Medicare's premiums and cost sharing.

The proportion of Medicaid beneficiaries who do not receive cash grants has grown as legislation in recent years has loosened the link between Medicaid and cash assistance, especially for low-income children and pregnant women. The most recent expansion of benefits eventually will cover all children under age 19 in families with income below the federal poverty level.

This expansion is being phased in, with children up to age nine now covered, and will not be fully completed until 2002. States are now also required to pay Medicare premiums and cost sharing for Medicare beneficiaries with income below the poverty level and resources less than twice the asset level for SSI. Further coverage of low-income Medicare beneficiaries is also being phased in. Commencing in January 1993, states must pay SMI premiums for Medicare beneficiaries with income less than 110 percent of the poverty level and resources less than twice the SSI asset level; the income criterion for eligibility will be raised to 120 percent of the poverty level in 1995.

Benefits

The federal government mandates some benefits under Medicaid, with states having the option to cover other specified services. Mandatory benefits for the categorically needy include hospital services; physician services; laboratory and X-ray services; family planning services; nursing facility (NF) services for people over age 21; home health care for people entitled to NF services; Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program services for people under 21 years old; services provided by rural health clinics and federally qualified health centers; and the services of nurse midwives,

certified pediatric nurse practitioners, and certified family nurse practitioners (in states in which those providers are authorized to practice).

Mandatory services for the medically needy population are less comprehensive than the benefits that must be provided to the categorically needy. At a minimum, however, states with programs for the medically needy must provide ambulatory care for children and prenatal and delivery services for pregnant women.

States may, at their option, provide additional services. In October 1991, most states chose to offer at least the following services to categorically needy people: podiatry; optometry; clinic services; dental services; physical therapy; services for people with speech, hearing, and language disorders; transportation; intermediate care facility services for the mentally retarded (ICF-MR); nursing facility services for people under 21 years old; rehabilitative services; prescription drugs; inpatient hospital services for elderly people in mental institutions; emergency hospital services; case management; prosthetic devices; and eyeglasses. Some states offered several additional services. Thus, in most states, Medicaid provides comprehensive coverage that exceeds many private health insurance packages, with no requirements (or minimal requirements) for cost sharing on the part of beneficiaries.

Medicaid and Poverty

Despite the increasing number of people eligible for the Medicaid program, only about half of the population with income at or below the poverty level was covered by Medicaid in 1991. Some of those who are living in poverty have private insurance through employment or another source. Many, however, are not eligible for Medicaid and are uninsured. If all uninsured people below the poverty level had been eligible in 1991, about 10 million more people would have been covered by Medicaid. Expanding Medicaid eligibility to include all children under age 19 in families with income below the federal poverty level by 2002 will lower the number of uninsured poor people, but a substantial number of uninsured low-income adults will remain ineligible for Medicaid.

Medicaid Spending

Medicaid expenditures have grown dramatically in recent years, reaching $119 billion in 1992. Federal spending made up 57 percent of this amount, with state and local spending accounting for the balance. Total Medicaid spending includes both payments for services provided directly to beneficiaries and other costs. Payments for services provided to Medicaid beneficiaries were

about 90 percent of total Medicaid spending throughout most of the 1980s. By 1991, however, payments for services had dropped to 83 percent of total spending, reflecting in part changes in the financing of the program that are discussed below.

After adjusting for inflation, the average annual rate of growth in total Medicaid spending from 1980 to 1989 was about 5 percent a year. From 1989 through 1991, however, real growth averaged almost 17 percent and rose a further 25 percent in 1992.

That unprecedented growth stemmed mainly from three factors. First, enrollment rose rapidly, largely because of the weak economy, legislation expanding eligibility for the Medicaid program, and subsequent efforts by states to enroll low-income pregnant women and infants. Second, medical prices increased significantly in 1990 and 1991. Third, in 1991 and 1992, states dramatically expanded their use of financing mechanisms that enabled them to boost the federal government's matching payments.

Spending by Eligibility Group. In 1991, there were 28 million Medicaid beneficiaries--19.5 million children and adults in low-income families, 3.3 million people 65 years of age and older, 4 million disabled people, and about

1 million others. Thus, more than two-thirds of Medicaid beneficiaries are low-income children and adults (see Table 2).

Spending under Medicaid for services provided directly to beneficiaries, however, goes disproportionately to the aged and disabled populations. Although these groups represented only 30 percent of the Medicaid population, they accounted for 70 percent of total payments in 1991. Average Medicaid payments for aged beneficiaries were $7,600; for disabled beneficiaries, payments were $7,000. In contrast, low-income children and adults incurred average costs of $900 and $1,600, respectively.

One reason that Medicaid spending is so high for aged and disabled beneficiaries is that Medicaid, unlike Medicare, pays for long-term care. The average payment per user of ICF-MR nursing home services in 1991 was $52,600; for Medicaid beneficiaries who used other nursing home services, the average payment was lower but was still $13,800 in that year. Moreover, those amounts do not include the other services used by nursing home residents for which Medicaid paid. Nearly 40 percent of Medicaid payments in 1991 were for nursing home services.

TABLE 2. MEDICAID BENEFICIARIES AND PAYMENTS ADJUSTED FOR INFLATION, BY ELIGIBILITY GROUP, SELECTED FISCAL YEARS[a]

Eligibility Group	1975	1981	1988	1990	1991
All[b]					
Payments	30.5	41.7	56.3	68.1	76.9
Beneficiaries	22.0	22.0	22.9	25.3	27.9
Payment per beneficiary[c]	1,400	1,900	2,500	2,700	2,800
Aged					
Payments	10.9	15.2	19.8	22.6	25.4
Beneficiaries	3.6	3.4	3.2	3.2	3.3
Payment per beneficiary[c]	3,000	4,500	6,300	7,100	7,600
Disabled[d]					
Payments	7.8	14.5	21.5	25.6	28.2
Beneficiaries	2.5	3.1	3.5	3.7	4.0
Payment per beneficiary[c]	3,200	4,700	6,200	6,900	7,000
Children in Low-Income Families					
Payments	5.4	5.4	6.8	9.6	11.6
Beneficiaries	9.6	9.6	10.0	11.2	12.8
Payment per beneficiary[c]	600	600	700	900	900
Adults in Low-Income Families					
Payments	5.1	5.8	6.8	9.0	10.4
Beneficiaries	4.5	5.2	5.5	6.0	6.7
Payment per beneficiary[c]	1,100	1,100	1,200	1,500	1,600
Other					
Payments	1.2	0.8	1.4	1.1	1.2
Beneficiaries	1.8	1.4	1.3	1.0	1.0
Payment per beneficiary[b]	700	600	1,000	1,100	1,200

SOURCE: Congressional Budget Office calculations based on data for selected years from the HCFA Form-2082, "Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services," compiled by the Health Care Financing Administration.

NOTES: Payments are in 1991 dollars, calculated using the consumer price index for all urban consumers (CPI-U). The HCFA Form-2082 Medicaid payment amounts are based on all claims adjudicated or paid during the fiscal year covered by the report. They do not include all Medicaid expenditures. Excluded are HI and SMI premiums that states paid for the dually enrolled, premiums for capitation plans, payments for state-only enrollees and services, program administration and training costs, and other adjustments that are part of total spending.

Beneficiaries include all people who had services paid for by Medicaid during the fiscal year. Because double counting occurred in some states in the 1980s, the sum of beneficiaries in all eligibility groups exceeds the (unduplicated) total in 1981 and 1988. See "Factors Contributing to the Growth of the Medicaid Program," CBO Staff Memorandum (May 1992) for a more detailed discussion of reporting inconsistencies.

The table is based on payments and beneficiary counts from 49 states, the District of Columbia, and Puerto Rico. The state of Arizona is not included.

a. Payments in billions of 1991 dollars; number of beneficiaries in millions; and payment per beneficiary in 1991 dollars.
b. Includes beneficiaries whose eligibility group is unknown.
c. Rounded to the nearest $100.
d. Includes the blind.

Voluntary Donations and Taxes on Health Care Providers. Faced with burgeoning Medicaid costs and pressures to increase their reimbursement rates, states turned increasingly to voluntary donations and taxes on health care providers (primarily hospitals and nursing homes) to finance their share of Medicaid expenditures. Through the use of these devices, states could generate additional federal matching dollars without corresponding expenditures of state funds, thereby raising the overall federal matching rate from its nominal level of 57 percent. By July 1991, the majority of states had adopted donation or provider-specific tax programs, and the Department of Health and Human Services was concerned that these initiatives were threatening the financial stability of Medicaid.

The Inspector General estimated that provider donation and tax programs would cost the federal government almost $3.8 billion in fiscal year 1991, and that the figure could rise to $12.1 billion in fiscal year 1993. In October 1991, therefore, HCFA issued interim final regulations to restrict federal matching for state Medicaid expenditures financed through voluntary donations or taxes on health care providers.

By effectively eliminating provider donation and tax programs, the HCFA regulations would probably have compounded the severe fiscal problems many states faced. In November 1991, therefore, the Congress

enacted legislation to nullify the HCFA regulations and also to place some restrictions on the use of provider donations and taxes. The act, titled the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, represents a compromise by the Administration, the Congress, and the states. It bars federal matching for most provider donations but allows the states to use intergovernmental transfers and some types of tax revenues from providers to finance part of their share of the Medicaid program.

Payments to Disproportionate Share Hospitals. The act also has important implications for Medicaid's reimbursement of disproportionate share hospitals, those institutions that serve disproportionately large numbers of low-income patients with special needs. When setting Medicaid hospital payment rates, states are required to take the costs incurred by disproportionate share hospitals into account. The Congress has established minimum criteria for defining these hospitals and for determining the rates at which they must be paid.

States may, however, use alternative methods to define disproportionate share hospitals and to set the additional payment amounts they receive, provided the total payment adjustment is at least as great as under the statutory options. Some states have taken advantage of this flexibility to increase their payments to disproportionate share hospitals dramatically in the

last two years. Furthermore, they have frequently used voluntary donations and taxes on health care providers to pay all or part of their share. HCFA issued regulations limiting such payments in October 1991, but the Congress also nullified those regulations.

Instead, the November 1991 legislation creates a national cap on payment adjustments to disproportionate share hospitals of 12 percent of Medicaid expenditures. States whose disproportionate share payments are already above this cap can continue to make payments at the higher level but cannot increase them until they fall below the 12 percent cap. As national Medicaid expenditures rise, states that are below the 12 percent cap will be allowed to increase their disproportionate share payments using a redistributive approach that ensures that the national cap remains at 12 percent. In addition, the act bars HCFA from restricting a state's authority to designate disproportionate share hospitals. In November 1992, HCFA published an interim final rule carrying out the 1991 legislation. According to that rule, all disproportionate share allotments to states for fiscal year 1993 would be frozen at their 1992 amounts because total disproportionate share payments were already at the 12 percent level.

Projections of Medicaid Spending. CBO estimates that Medicaid spending will grow by about 18 percent in 1993, to more than $140 billion, of which the

federal government will pay about $80 billion. This estimate represents an annual increase of 15 percent after adjusting for inflation. The annual rate of growth will be somewhat lower between 1993 and 1998, averaging about 13 percent in nominal terms or about 10 percent after adjusting for inflation.

Growth in Medicaid spending over the next five years will primarily be the result of increased spending per beneficiary rather than the larger number of people who are eligible for Medicaid. CBO projects that, on average, the number of beneficiaries will grow by 2 percent to 3 percent a year between 1993 and 1998. Total spending per beneficiary, which includes payments for services, costs of administration, and other non-service-related spending, however, is projected to increase at an average annual rate of almost 10 percent in nominal terms, or 7 percent after adjusting for inflation.

The factors contributing to such rapid growth include increases in medical care prices that exceed general inflation and changes in the number and complexity of services provided to the Medicaid population. In addition, as a result of recent and pending judicial decisions interpreting Medicaid statutes, states are facing growing pressures to increase reimbursement rates for institutional providers and physicians.

FEDERAL AND OVERALL SPENDING FOR HEALTH CARE

Private spending and payments by public programs for health care are interdependent, since policies designed to constrain costs by one payer often have profound implications for the level and rate of growth of spending by other payers. Without concurrent and uniform policies that affect the entire health sector, whatever is done to control federal spending for health care would almost certainly result in higher spending by private payers. Moreover, if enacted in isolation, policies to extend coverage to the uninsured would increase health spending, most likely both at the national level and within the federal budget.

In 1991, national health expenditures were $752 billion, accounting for more than 13 percent of the gross domestic product (GDP). CBO's revised winter 1993 projections of national health expenditures indicate that, by 2000, the United States will spend nearly 19 percent of GDP on health care under current policies. The federal government's share of spending is projected to rise from about 30 percent in 1991 to 36 percent in 2000.

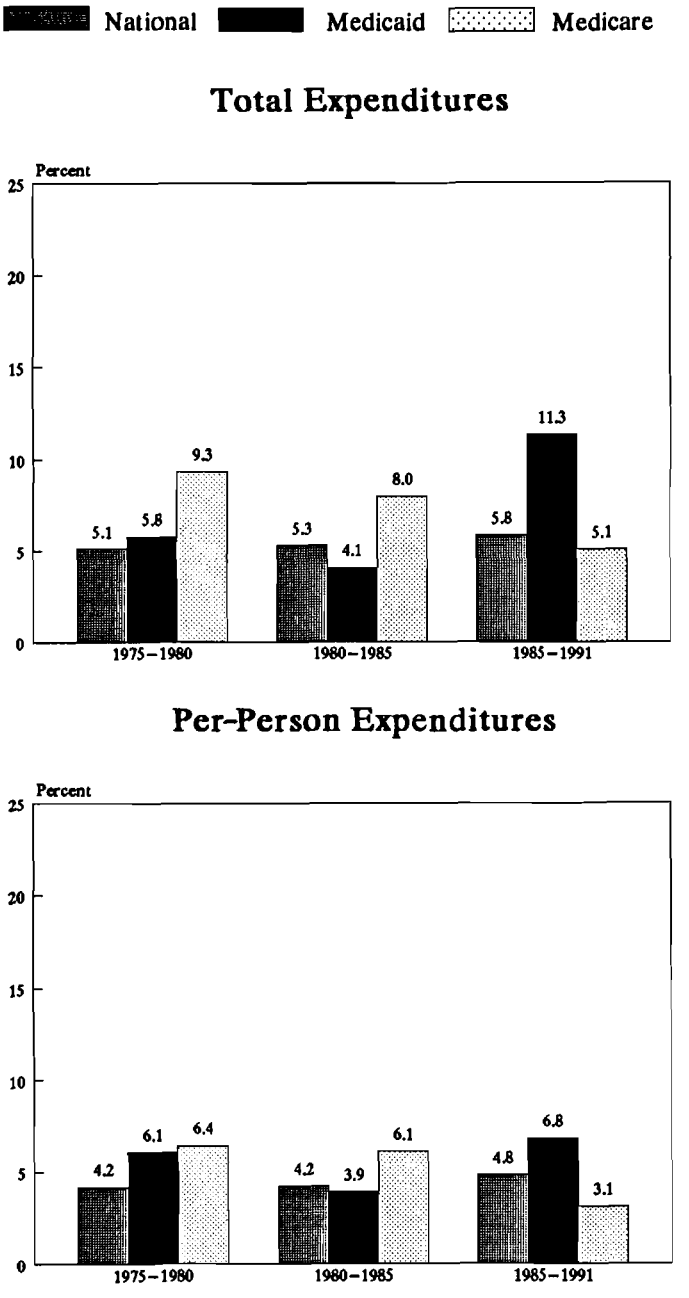
In addition to its direct spending for health care, the federal government also provides a substantial subsidy for private employment-based health insurance because payments by employers are excluded from

employees' income that is subject to federal taxation. Both income and payroll taxes are lower because of this exclusion--by a total of $70 billion in 1991--although higher payroll taxes would be offset by higher Social Security payments in future years.

Even though there have been numerous and intensive efforts over the past two decades to control the growth in health expenditures, inflation-adjusted spending per person in the nation has continued to rise. Between 1980 and 1985, spending per person in the nation increased at an average annual rate of 4.2 percent; between 1985 and 1991, this rate increased to 4.8 percent annually, as shown in Figure 2.

The trends for Medicaid and Medicare spending per person are different from the trend in total health spending. After adjusting for inflation, total Medicaid expenditures per beneficiary grew at an annual rate of about 4 percent between 1980 and 1985, which was somewhat lower than the rate of growth of national health expenditures per person. Between 1985 and 1991, however, Medicaid expenditures per beneficiary grew at an average annual inflation-adjusted rate of almost 7 percent. This growth primarily reflected the large 1991 increase in program costs that were not related to the direct provision of services.

Figure 2.
Average Annual Growth Rates of Real National, Medicaid, and Medicare Expenditures for Health, Total and Per Person, 1961–1991



SOURCE: Congressional Budget Office calculations based on data from the Health Care Financing Administration (HFCA), Office of the Actuary, 1992. The number of Medicaid beneficiaries is based on HCFA Form–2082.

NOTES: The word "real" is used here to mean adjusted for general inflation rather than for inflation in the prices of health services, which is almost certainly different. Health expenditures are adjusted to 1991 dollars using the consumer price index for all urban consumers (CPI–U).

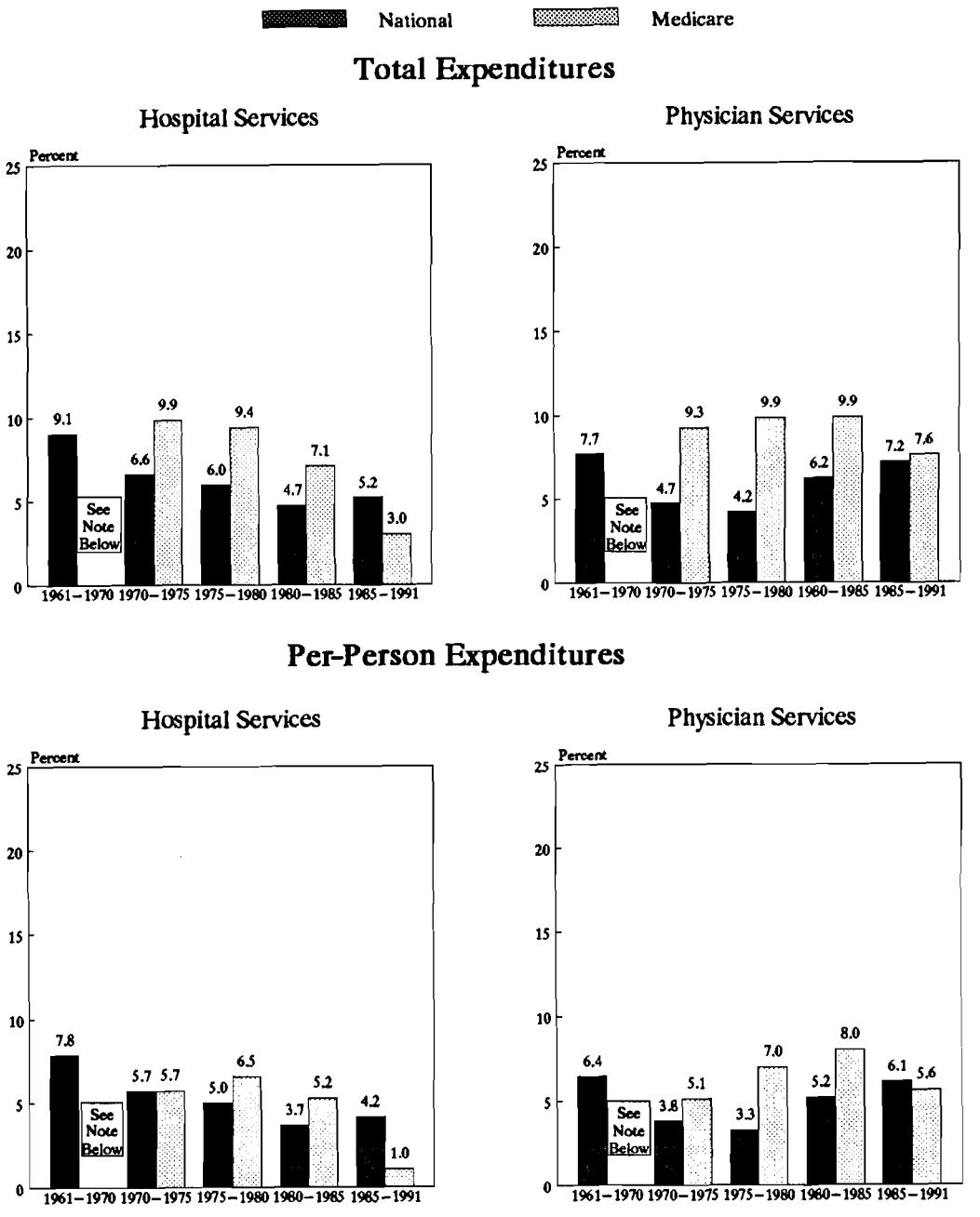
Growth rates are not available for total and per-enrollee Medicare expenditures during the 1961–1970 period as the Medicare program was not enacted until the mid–1960s.

Over most of the years that Medicare has been operating, spending per enrollee grew more rapidly, after adjusting for inflation, than did spending per person in the nation. Between 1980 and 1985, inflation-adjusted spending per enrollee grew about 6.1 percent a year, considerably higher than the 4.2 percent annual increase in per capita national spending. The Medicare per-enrollee growth rate dropped significantly over the 1985-1991 period to slightly more than 3 percent annually--which is considerably lower than the rate for per capita national health expenditures. Most of the decline in the growth per enrollee of Medicare spending stemmed from a substantial drop in the rate of increase in Medicare's spending for inpatient hospital services (see Figure 3).

This pattern illustrates a major factor in this country's inability to gain better control over total health spending. In a multiple-payer system, successful efforts by one payer to reduce the growth in costs--such as Medicare's prospective payment system for hospitals in the mid-1980s--appear to be offset by more rapid increases in costs for other payers.

Preliminary results from a CBO study that is under way depict these interrelationships vividly. In 1990, hospitals provided $12 billion in uncompensated care and received payments that were only 80 percent of estimated costs for Medicaid enrollees and 90 percent of estimated costs for

Figure 3.
Average Annual Growth Rates of Real National and Medicare Expenditures for Hospital and Physician Services, Total and Per Person, 1961–1991



SOURCE: Congressional Budget Office calculations based on data from the Health Care Financing Administration, Office of the Actuary, 1992.

NOTES: The word "real" is used here to mean adjusted for general inflation rather than for inflation in the prices of health services, which is almost certainly different. Health expenditures are adjusted to 1991 dollars using the consumer price index for all urban consumers (CPI–U).

Growth rates are not available for total and per-enrollee Medicare expenditures during the 1961–1970 period as the Medicare program was not enacted until the mid–1960s.

Medicare enrollees (see Table 3). Uncompensated care and unreimbursed public program costs totaled $25 billion, or 12 percent of hospitals' total costs.

Most hospitals, however, were able to recover the bulk of these unreimbursed costs through three mechanisms: subsidies from state and local governments, other nonpatient-care sources of revenues, and surplus revenues (or profits) from private payers. In fact, CBO estimates that in 1989 hospitals recovered about 95 percent of their uncompensated care and unreimbursed public program costs. Surplus revenues from private payers accounted for more than 50 percent of this recovery.

In 1990, the ratio of revenues to costs for private payers was 1.28--in other words, the payments to hospitals from private payers exceeded the costs of treating those patients by about 28 percent. Moreover, private payers were charged substantially more than their costs in spite of the many efforts of private payers to control hospital spending over the same period.

CONCLUSION

Health care costs are increasing far more rapidly than inflation and show no signs of abating despite the many attempts to control costs made by both

TABLE 3. HOSPITAL REVENUES AND COSTS, BY PAYER OR OTHER SOURCE, 1990

Payer or Other Source	Revenues		Costs		Ratio of Revenues to Costs
	In Billions of Dollars	As a Percentage of Total	In Billions of Dollars	As a Percentage of Total	
Total	210.6	100.0	203.2	100.0	1.04
Medicare	69.8	33.2	78.0	38.4	0.90
Medicaid	18.4	8.7	23.0	11.3	0.80
Other Government Payers	3.4	1.6	3.2	1.6	1.06
Uncompensated Care[a]	2.5	1.2	12.1	5.9	0.21
Private Payers	104.1	49.5	81.6	40.1	1.28
Nonpatient Sources[b]	12.4	5.8	5.5	2.7	2.25

SOURCE: Congressional Budget Office estimates using data from Prospective Payment Assessment Commission, *Medicare and the American Health Care System: Report to the Congress* (June 1992).

NOTE: The underlying data are from the American Hospital Association's *Annual Survey of Hospitals for 1990*. They correspond to hospitals' fiscal years ending during calendar year 1990.

a. Uncompensated care is defined as charity care plus bad debt. The revenues shown are operating subsidies from state and local governments.

b. Includes operating revenues and costs from sources other than patient care, such as profits from cafeterias and gift shops, plus nonoperating revenues such as contributions, grants, and earnings on endowments.

public and private payers. CBO projects that, by 1998, more than 17 percent of GDP will be absorbed by spending on health and nearly 24 percent of the federal budget will be spent on health programs under current policies. Without a reduction in the rate of growth in health care spending, cutting the federal budget deficit will be extremely difficult.

Other consequences of the continued rise in health spending are also of concern. Not only would more people be uninsured, but new policies to extend coverage to the uninsured would increase health expenditures even more. In addition, further growth in health insurance premiums would mean that workers would receive smaller increases in wages and salaries as more of their compensation came in the form of health insurance.

Addressing the problems of the nation's health care system is a formidable task. If we control only federal spending, then spending by the private sector will almost certainly increase more rapidly. But greater control over total health spending would probably mean less spending on research and development, longer waiting times for use of some technologies, and some limits on existing choices of providers, health care coverage, and alternatives for treatment. Finally, unless efforts to reduce health spending were combined with new policies to cover the uninsured, success in controlling health care costs would almost certainly create additional barriers to access for the uninsured.