

CBO TESTIMONY

Statement of
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Health Care and the Budget: Issues and Challenges for Reform

before the
Committee on the Budget
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Chairman Conrad, Ranking Member Gregg, and other Members of the Committee, thank you for inviting me to testify this morning on the U.S. health care system and the major budgetary and policy issues associated with that system. Rising health care costs and their consequences for federal health insurance programs constitute the nation's central fiscal challenge. Rising costs also represent a critical issue for employers—who sponsor most private health insurance coverage—and for the enrollees and patients who ultimately bear the costs of health insurance and health care. At the same time, substantial concerns exist about the number of individuals who lack health insurance, about the quality of care that is provided both to the uninsured and to the insured, and about trends in health such as the growing prevalence of obesity.

In light of those challenges, my testimony today makes four main points:

- **Health Care Costs.** The nation's long-term fiscal balance will be determined primarily by the future rate of health care cost growth. If health care costs continued growing at the same rate over the next four decades as they did over the past four decades, federal spending on Medicare and Medicaid alone would rise to about 20 percent of gross domestic product (GDP) by 2050—roughly the share of the economy now accounted for by the entire federal budget. Furthermore, controlling those federal costs over the long term will be very difficult without addressing the underlying forces that are also causing private costs for health care to rise. A variety of evidence, however, suggests that opportunities exist to constrain health care costs both in the public programs and in the rest of the health care system without adverse health consequences. Capturing those opportunities to reduce costs without harming health outcomes involves many challenges, including the time that may be necessary to generate significant savings—but even if reforms take time to generate savings, acting sooner rather than later can ultimately make a substantial difference.
- **Employer-Sponsored Insurance.** Most Americans get their primary health insurance through an employer—either their own or that of a family member. Many employers have expressed serious concerns about rising health care costs; to date, however, aggregate data indicate that any reductions in employers' offers of insurance or the scope of coverage they provide have been modest. An employer-based system has both advantages (for example, workers' risks are pooled together) and disadvantages (for example, workers often have to change their health plan when they change jobs). A key issue for broad health reform proposals is whether they are based upon an employer-sponsored system: if so, whether they retain the significant existing tax incentives for employer-based insurance, and if not, how they create the pooling mechanisms essential for effective health insurance markets.

- **Lack of Insurance.** The most recent estimates indicate that about 45 million people were uninsured at any given point in 2005. Both the high cost of health care and the evolution of employer-based health insurance affect the number of people who have coverage. Higher premiums discourage people—especially those who have lower income and who perceive themselves as healthy—from purchasing insurance. People who are not employed or who choose to work at a firm not offering insurance may have to seek coverage in the individual market, where policy terms and tax benefits are generally much less attractive than those for employer-sponsored plans. Federal and state expansions of coverage over the past 25 years—particularly through Medicaid and the State Children’s Health Insurance Program (SCHIP)—have significantly reduced uninsurance rates among eligible populations. Many proposals aim to reduce the number of uninsured further, through either direct spending or tax credits, but such proposals typically generate budgetary costs that must ultimately be financed by higher revenues or offset by lower spending elsewhere—and almost invariably cause at least some substitution of public funds for private funds.

- **Prevention and Healthy Living.** The ultimate objective of the health care system is to improve health. Despite the resources that the nation devotes to treating diseases, the results in terms of health gains are mixed, and many investments that can foster better health—such as preventive medicine—are underused. At the same time, various types of unhealthy behavior—such as smoking, poor diets, and a lack of regular exercise—remain relatively common. Although proposals that encourage more prevention and healthy living can help to promote better health outcomes, their effects on federal and total health spending are uncertain.

Rising Health Care Costs

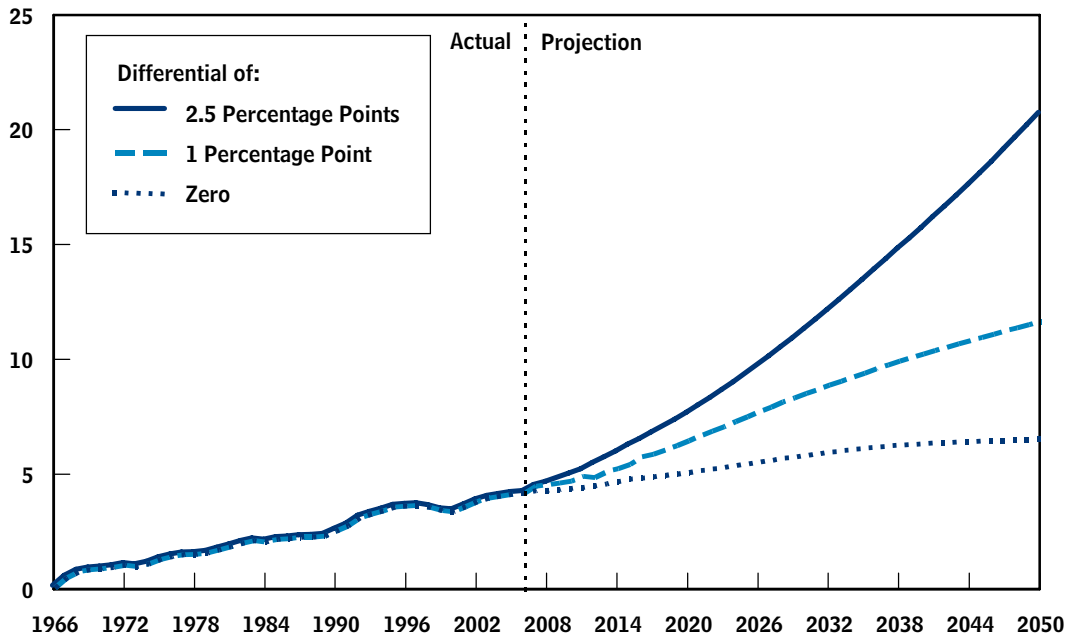
Over the past four decades, Medicare’s and Medicaid’s costs per beneficiary have increased about 2.5 percentage points faster per year than has per capita gross domestic product (GDP).¹ If those costs continued growing at the same rate over the next four decades, federal spending on those two programs alone would rise from 4.5 percent of GDP today to about 20 percent by 2050 (see Figure 1); that amount would represent roughly the same share of the economy as the entire federal budget does today. If, instead, those costs grew at the same rate as income—a scenario that illustrates the pure effect of demographic changes on the two programs—then the change in spending by 2050 would be much smaller. Indeed, that change would be substantially smaller than the difference between the two scenarios. That observation underscores that the rate at which health care costs grow relative to income is the most important determinant of the long-term fiscal balance;

1. See Congressional Budget Office, *The Long-Term Budget Outlook* (December 2005), pp. 6–7 and 31–32.

Figure 1.

Total Federal Spending for Medicare and Medicaid Under Assumptions About the Health Cost Growth Differential

(Percentage of gross domestic product)



Source: Congressional Budget Office.

Note: The health cost growth differential refers to the number of percentage points by which the growth of annual health care spending per beneficiary is assumed to exceed the growth of nominal gross domestic product per capita, after an adjustment for the growth and aging of the Medicare and Medicaid populations.

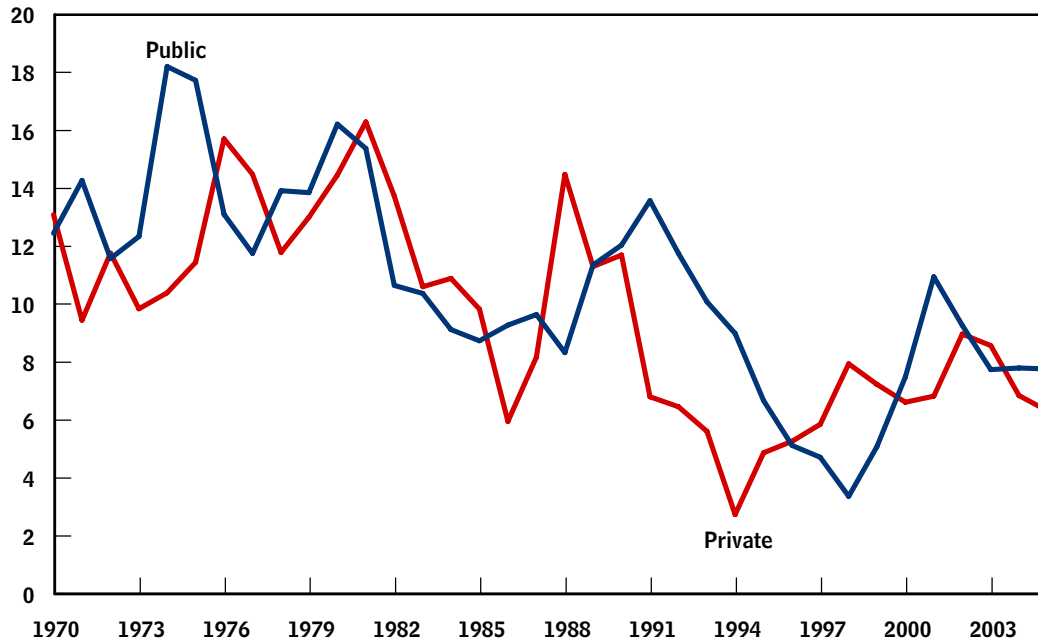
it exerts a significantly larger influence on the budget over the long term than other commonly cited factors, such as the aging of the population.

Rising health care costs represent a challenge not only for the federal government but also for private payers. Indeed, the trends for both largely reflect the same underlying forces—the spread of costly new medical technologies, limited cost-sharing requirements, and other factors—and cost growth per beneficiary in Medicare and Medicaid has tracked that in the rest of the health system over long periods of time (see Figure 2). Total health care spending, which consumed about 8 percent of the U.S. economy in 1975, currently accounts for about 16 percent of GDP, and that share is projected to reach nearly 20 percent by 2016. About half of that spending is now publicly financed, and half is privately financed.

Figure 2.

Annual Growth Rates of Private and Public Health Care Spending

(Change in total nominal spending from previous year)



Source: Congressional Budget Office based on Centers for Medicare and Medicaid Services' data on national health expenditures.

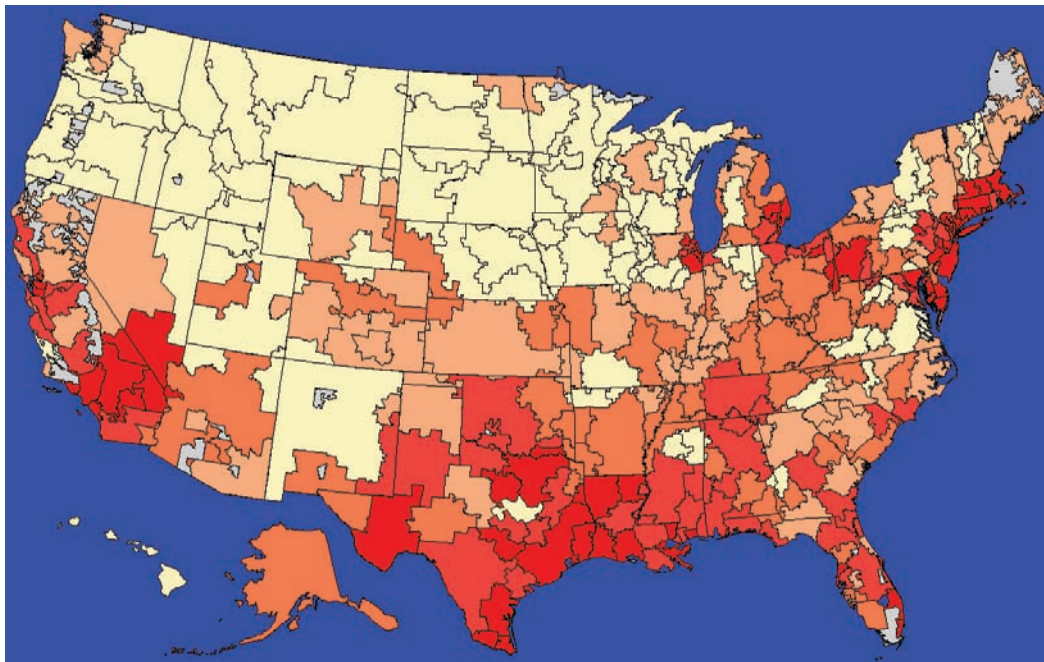
Reasons for Cost Growth and the Relationship Between Cost and Quality

In order to see what options may exist to limit future cost growth, it is useful to review the main factors contributing to that growth—as well as past efforts at cost control. Many analysts attribute the bulk of the growth in health care spending to the development and diffusion of new medical technology, or, as one leading observer has described it, “the increased capabilities of medicine.”² Recent medical advances have made a wealth of new medical therapies available to physicians and patients. Some advances permit the treatment of previously untreatable conditions, which can confer substantial benefits but also introduces new categories of spending. Others advances may improve medical outcomes (compared with those provided by older treatments) but at added costs. Some studies have found that the spread of new medical technology has yielded benefits that clearly justify the added costs on average, but other evidence also strongly suggests that additional

2. Joseph P. Newhouse, “An Iconoclastic View of Health Cost Containment,” *Health Affairs*, vol. 12, Supplement (1993), pp. 152–171.

Figure 3.

Medicare Spending per Capita in the United States, by Hospital Referral Region, 2003



■ \$7,000 to \$11,352 (64)	■ \$6,000 to <\$6,500 (56)	■ \$4,272 to <\$5,500 (70)
■ \$6,500 to <\$7,000 (53)	■ \$5,500 to <\$6,000 (64)	■ Not Populated

Source: *The Dartmouth Atlas of Health Care*.

Note: Numbers in parentheses refer to the number of hospital referral regions with per capita spending in each interval.

treatments and services are being provided broadly to patients who could do just as well with less-expensive care.³

Significant evidence exists that more-expensive care need not mean higher-quality care—suggesting an opportunity to reduce costs without impairing health outcomes. Perhaps the most compelling evidence of that opportunity comes from the substantial geographic differences in spending on health care within the United States—and the fact that they do not translate into higher life expectancy or measured advantages in other health statistics in the higher-spending regions.⁴ For example, Medicare’s costs per enrollee vary significantly from regions to region: from as low as \$4,000 to more than \$11,000 in 2003 (see Figure 3). Research has

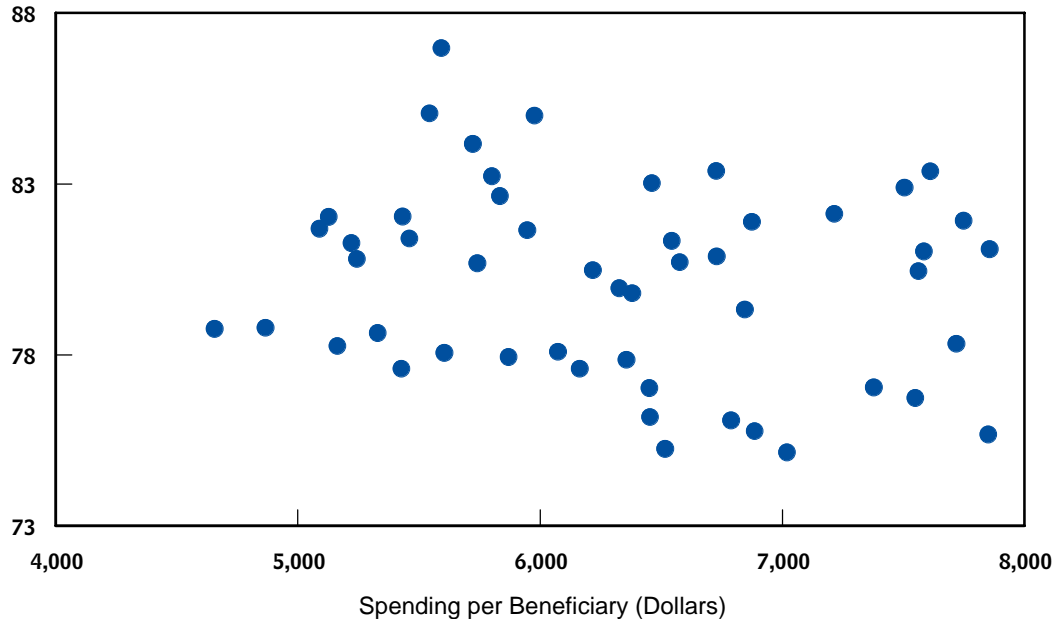
3. See David M. Cutler, *Your Money or Your Life: Strong Medicine for America’s Health Care System* (New York: Oxford University Press, 2004).

4. Comparisons among countries also support that conclusion. For a recent comparison of health spending and outcomes in the United States and other countries, see McKinsey Global Institute, *Accounting for the Cost of Health Care in the United States* (San Francisco: McKinsey & Company, January 2007).

Figure 4.

The Relationship Between Quality and Medicare Spending, by State, 2004

(Composite measure of quality of care)



Source: Congressional Budget Office based on data from Agency for Healthcare Research and Quality, *National Healthcare Quality Report, 2005*, Appendix: Data Tables, available at www.ahrq.gov/qual/nhqr05/index.html, and data from the Centers for Medicare and Medicaid Services' Continuous Medicare History Sample.

Note: The composite measure of the quality of care, based on Medicare beneficiaries in the fee-for-service program who were hospitalized in 2004, conveys the percentage who received recommended care for myocardial infarction, heart failure, and pneumonia.

Spending figures convey average amounts by state.

shown that much of that variation in spending cannot be explained by differences in the population or medical prices and that the higher-spending regions do not generate better health outcomes than the lower-spending regions.⁵ Furthermore, differences in spending are not correlated with measures of the quality of care that enrollees receive (see Figure 4). Concerns about that regional variation are buttressed by the fact that hard evidence is often unavailable about 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

5. See John E. Wennberg, Elliot S. Fisher, and Jonathan S. Skinner, "Geography and the Debate Over Medicare Reform," *Health Affairs*, Web Exclusive (February 13, 2002), pp. w96–w114; and Elliot S. Fisher and others, "The Implications of Regional Variations in Medicare Spending, Part 1: The Content, Quality, and Accessibility of Care," *Annals of Internal Medicine*, vol. 38, no. 4 (February 18, 2003), pp. 273–287.

cases, the variation in treatments is greatest for those types of care for which evidence about relative effectiveness is lacking.

Another important factor affecting the level and potentially the growth rate of health care costs is the manner in which insurers reimburse and oversee the delivery of health care. Up through the 1980s, private health insurance coverage in the United States typically took the form of an “indemnity” policy, which reimbursed enrollees for their incurred costs, left it to them and their doctors to determine what care to provide, and largely allowed doctors and hospitals to set prices for those services. Rapidly rising health costs and concerns about the incentives that those arrangements provided led to increased enrollment in managed care plans, such as health maintenance organizations. Those plans used various methods to reduce both the prices and the quantity or intensity of health care services, including limited networks of providers and requirements to obtain a referral from a primary care physician in order to see a specialist. Their adoption played an important role in controlling U.S. health care costs during the 1990s. Private payments for health care grew at the same rate as the overall economy between 1992 and 2000, and total spending for health care as a share of GDP remained constant at about 14 percent between 1993 and 2000. By the end of the 1990s, however, the increasing objections of enrollees and providers to the constraints of managed care—which often included restrictions on treatments that were not based on medical evidence—led health plans to adopt less aggressive forms of management and produced shifts in enrollment toward more loosely managed plans. Fee-for-service reimbursement remains the predominant form of payment in private health insurance as well as Medicare.

Spending is the product of prices and quantities, so concerns about rising health care costs also raise questions about the prices that are paid for services. Measuring prices in the health sector can be difficult, however, both because it can be hard to control for changes over time in the quality of the products being compared (which makes historical price comparisons misleading) and because discounts negotiated by private insurers are typically confidential. Despite those challenges, some observers have suggested that, properly measured, many prices for health care have actually grown at rates comparable to general inflation and that prices have not played a substantial role in the growth of U.S. health costs over time.⁶

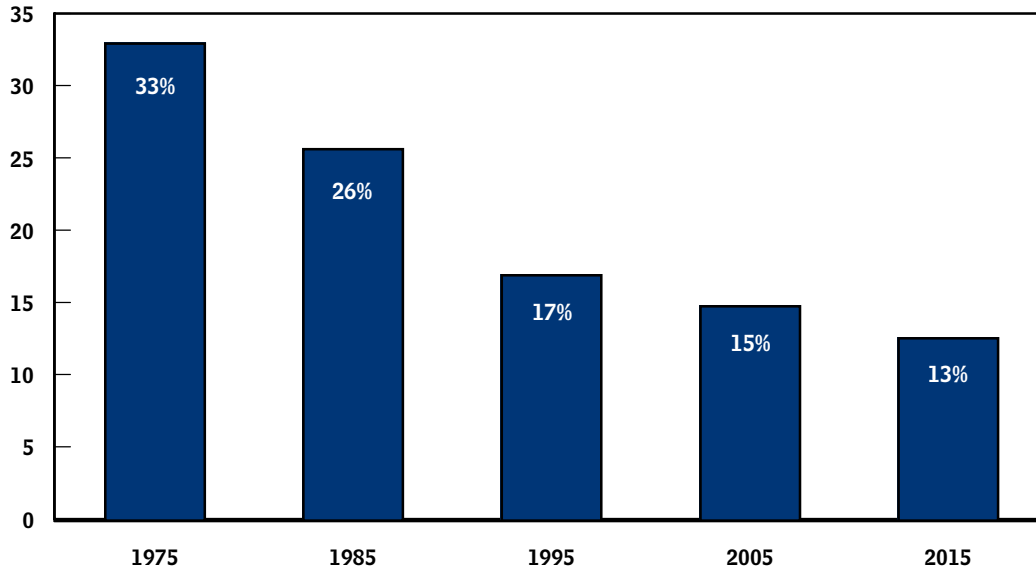
Even so, price levels affect total spending, and in some cases private insurers may have difficulty negotiating low prices for health care items and services—whereas public purchasers have sometimes intervened to obtain relatively low prices. In the case of doctors and hospitals, limited competition in some parts of the country acts

6. See David M. Cutler and others, “Are Medical Prices Falling? Evidence from Heart Attack Treatments,” *Quarterly Journal of Economics*, vol. 113, no. 4 (November 1998), pp. 991-1024; and Joseph P. Newhouse, “Medical Care Costs: How Much Welfare Loss?” *Journal of Economic Perspectives* vol. 6, no. 3 (Summer 1992), pp. 3–21.

Figure 5.

Share of Personal Health Care Expenditures Paid Out of Pocket

(Percentage)



Source: Congressional Budget Office based on the Centers for Medicare and Medicaid Services' data on national health expenditures.

Note: Spending on personal health care excludes administrative costs for health insurance, public and private spending for medical research and construction of facilities, and government spending for public health agencies, such as the Centers for Disease Control and Prevention and state health departments.

as a constraint on private negotiations; in the case of prescription drugs, public policy (through patents) gives manufacturers monopoly power—which leads to higher drug prices but also encourages the development of new drugs that can be patented. Federal and state purchasers have established mechanisms that yield prices that are below private-sector levels for drugs (under Medicaid and the health program for military veterans) and for doctors and hospitals (under Medicare and particularly Medicaid), but such approaches can also raise various concerns (including concerns about access to providers).

Another important factor that both reflects and has contributed to rising health costs is the declining proportion of those costs that are paid out of pocket. Out-of-pocket payments accounted for 33 percent of all personal health care expenditures in 1975, but by 2005, that share had fallen to 15 percent (see Figure 5). It is projected to decline a little more in the future, reaching 13 percent in 2015. Consumers facing lower out-of-pocket costs tend to demand more health care services than consumers facing higher out-of-pocket costs. At the same time, rising health care costs (as a share of income) have probably led individuals to seek more extensive

insurance in order to keep the variability of their out-of-pocket expenses from increasing.

Options for Controlling Health Care Costs

A number of programmatic changes within Medicare and Medicaid, including changes in payments to providers and eligibility rules, could be implemented to reduce federal spending.⁷ Those options have different implications for overall health spending, however. Some would simply result in a reallocation of total costs among different sectors (the federal government, the corporate sector, households, and state and local governments) rather than a reduction in overall costs; others would involve some combination of shifting among sectors and reduction in total costs; and still others would reduce both federal and total health spending in parallel. Many analysts believe that significantly constraining the growth of costs for Medicare and Medicaid over long periods of time, while maintaining broad access to health providers under those programs, can occur only in conjunction with slowing cost growth in the health care sector as a whole.

Ultimately, therefore, restraining costs in Medicare and Medicaid requires restraining overall health care costs. Two potentially complementary approaches to reducing total health spending—rather than simply reallocating spending among different sectors of the economy—involve generating more information about the relative effectiveness of medical treatments and changing the incentives for providers and consumers in the supply and demand of health care.

The current financial incentives facing both providers and patients tend to encourage or at least facilitate the adoption of expensive treatments and procedures, even if evidence about their effectiveness relative to existing therapies is limited. For doctors and hospitals, those incentives stem from fee-for-service reimbursement. Such payments can encourage health care providers to deliver a given service in an efficient manner but also provide an incentive to supply additional services—as long as the payment exceeds the costs of the services. For their part, insured individuals generally face only a portion of the costs of their care and, consequently, have only limited financial incentives to seek a lower-cost treatment—a trade-off inherent in having insurance protection. Private health insurers have incentives to limit the use of ineffective care but are also constrained by a lack of information about what treatments work best for which patients.

7. See Congressional Budget Office, *Budget Options* (February 2007); and Statement of Donald B. Marron, Acting Director, Congressional Budget Office, *Medicaid Spending Growth and Options for Controlling Costs*, before the Senate Special Committee on Aging (July 13, 2006).

Many analysts believe that expanded research on “comparative effectiveness” offers a promising mechanism to address some of those concerns.⁸ Analysis of comparative effectiveness is simply a comparison of the impact of different options that are available for treating a given medical condition for a particular set of patients. Such studies may compare similar treatments, such as competing drugs, or they may analyze very different approaches, such as surgery and drug therapy. The analysis may focus only on the relative medical benefits and risks of each option, or it may go on to weigh both the costs and the benefits of those options. In some cases, a given treatment may be found more effective for all types of patients, but more commonly a key issue is determining which specific types would benefit most from it. An expanded research effort could be organized in various different ways. In response to a request from the Senate Budget and Finance Committees, the Congressional Budget Office (CBO) will issue a report on those options in the near future.

Comparative effectiveness research could be facilitated by having more health records available in electronic form, assuming privacy concerns were appropriately addressed.⁹ That format makes it easier to collect detailed data on the health status and the clinical characteristics of patients, which in some cases could be used to compare treatments in a rigorous way without having to conduct full-scale clinical trials. Indeed, despite somewhat exaggerated claims about direct cost savings from investments in health information technology, one reason those investments might have a long-term impact on health costs is because of their potential to expand and improve comparative effectiveness research.

To affect medical treatment and reduce health care spending, the results of comparative effectiveness analyses would ultimately have to change the behavior of doctors and patients—that is, to get them to use fewer services or less intensive and less expensive services than are currently projected. Bringing about those changes would probably require action by public and private insurers to incorporate the results into their coverage and payment policies in order to affect the incentives facing doctors and patients.

Although private insurers could choose not to cover drugs, devices, or procedures that were found to be less effective or less cost-effective, the insurers would have a number of additional options as well. They could simply provide more information to patients and doctors, which could improve compliance with treatment guidelines. Alternatively, insurers could adjust payments to doctors and hospitals to

8. For an analysis of the issue, see Statement of Peter R. Orszag, Director, Congressional Budget Office, *Research on the Comparative Effectiveness of Medical Treatments: Options for an Expanded Federal Role*, before the Subcommittee on Health, House Committee on Ways and Means (June 12, 2007).

9. See Jean R. Slutsky, “Moving Closer to a Rapid-Learning Health Care System,” *Health Affairs*, Web Exclusive (January 26, 2007), pp. w122-w124; and related articles in that issue on rapid learning and electronic medical records.

encourage the use of more-effective care. Or insurers could require enrollees to pay some or all of the additional costs of more-expensive treatments that were shown to be less effective or less cost-effective (in which case enrollees would have to decide whether the added benefits were worth the added costs). Indeed, some recent proposals call for “value-based” insurance design that encourages the use of services when the clinical benefits exceed the costs and likewise discourages the use of services when the benefits do not justify the costs.¹⁰ Although insurance plans generally vary cost sharing by the type of service provided—with lower cost-sharing requirements for hospital care and higher obligations for outpatient services—that new approach would be tailored to the patient and the treatment.

The Medicare program has not taken costs into account in determining what services are covered and has made only limited use of comparative effectiveness data in its payment policies—but if statutory changes permitted it, Medicare could use information about comparative effectiveness to promote higher-value care. For example, Medicare could tie its payments to providers to the cost of the most effective or most efficient treatment. If that payment was less than the cost of providing a more expensive service, then doctors and hospitals would probably elect not to provide it—so the change in Medicare’s payment policy would have the same practical effect as a coverage decision. Alternatively, enrollees could be required to pay for the additional costs of less effective procedures (although the impact on incentives for patients and their use of care would depend on whether and to what extent they had supplemental insurance coverage that paid some or all of Medicare’s cost-sharing requirements).

More modest steps that Medicare could be authorized to take would include smaller-scale financial inducements to doctors and patients to encourage the use of cost-effective care. Doctors and hospitals could receive modest bonuses for practicing effective care or modest cuts in their payments for using less effective treatments. Likewise, enrollees could be asked to pay a portion of the additional costs of less efficient procedures (rather than the full difference in costs). Or Medicare could provide information to doctors and their patients about doctors’ treatment patterns, which would create some pressure for doctors to use more-efficient approaches. Adopting more modest measures to incorporate the findings of comparative effectiveness research, however, is likely to yield smaller savings for the program.

Even in the absence of more information about comparative effectiveness, changes in incentives could help to control health care costs—but such measures would be more likely to maximize the health gains obtained for a given level of spending if they were combined with improved information. On the provider side, greater

10. Michael E. Chernew, Allison B. Rosen, and A. Mark Fendrick, “Value-Based Insurance Design,” *Health Affairs*, Web Exclusive (January 30, 2007), pp. w195–w203.

bundling of payments to cover all of the services associated with a treatment, disease, or patient could reduce or eliminate incentives to provide additional services that might be of low value. Such approaches, however, can raise concerns about the financial risk that providers face and about their incentives to provide too little care. On the consumer side, a landmark health insurance experiment by RAND showed that higher cost sharing reduces spending—particularly when compared to a plan offering free care—with little or no adverse effects on health.¹¹ However, compared with more typical health insurance plans (which do not offer free care), high-deductible designs have more modest effects on health care spending; such approaches also raise concerns about the financial burden on individuals with more health problems (again reflecting trade-offs between providing insurance protection and maintaining incentives to control costs).¹²

The broad options of generating more information and of changing incentives do not represent an exhaustive list of proposals intended to reduce health costs. Some analysts have advocated significant expansions of disease management and care coordination as mechanisms for reducing costs—proposals that reflect the increasing prevalence of many chronic conditions, the large share of health care spending that is incurred by individuals with those conditions, and lack of care coordination systems in many public and private health insurance plans. The top 25 percent of Medicare beneficiaries, for example, account for 85 percent of Medicare costs (see Figure 6), and more than three-quarters of those expensive beneficiaries had one or more of seven prominent chronic conditions (including coronary artery disease, diabetes, and congestive heart failure).¹³ However, the evidence to date—including the findings of several demonstration projects conducted under Medicare—suggests that disease management and care coordination may raise the quality of health care provided but do not significantly reduce costs among a broad array of patients.¹⁴ As more empirical evidence on the approaches develops, identifying specific ways to reduce costs, especially for targeted subsets of beneficiaries, may become possible; for now, the possibility and scope of savings remain unclear. In

11. See Willard G. Manning and others, “Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment,” *American Economic Review*, vol. 77, no. 3 (June 1987), pp. 251–277.

12. See Congressional Budget Office, *Consumer-Directed Health Plans: Potential Effects on Health Care Spending and Outcomes* (December 2006).

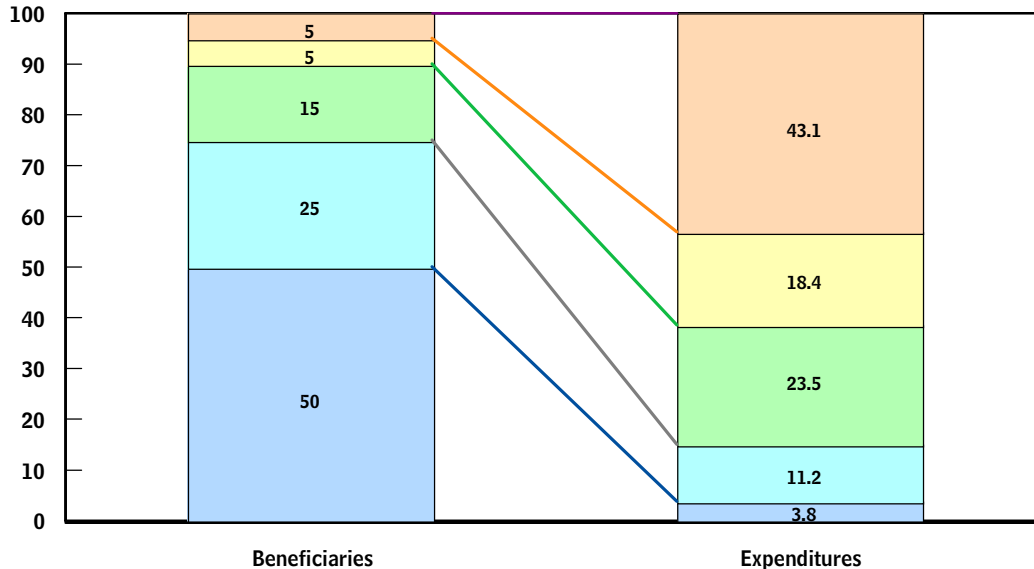
13. See Congressional Budget Office, *High-Cost Medicare Beneficiaries* (May 2005).

14. See Congressional Budget Office, *An Analysis of the Literature on Disease Management Programs* (October 13, 2004); Randall Brown and others, “The Evaluation of the Medicare Coordinated Care Demonstration: Findings for the First Two Years,” (Mathematica Policy Research, Inc., March 21, 2007), available at www.mathematica-mpr.com/publications; and Statement of Stuart Guterman, Senior Program Director, Program on Medicare’s Future, The Commonwealth Fund, *Enhancing Value in Medicare: Chronic Care Initiatives to Improve the Program*, before the Senate Special Committee on Aging (May 9, 2007).

Figure 6.

Concentration of Total Annual Medicare Expenditures Among Beneficiaries, 2001

(Percent)



Source: Congressional Budget Office based on data from the Centers for Medicare and Medicaid Services.

future months and years, CBO will be expanding its work to provide the Congress with more analysis of various options for controlling health care costs.

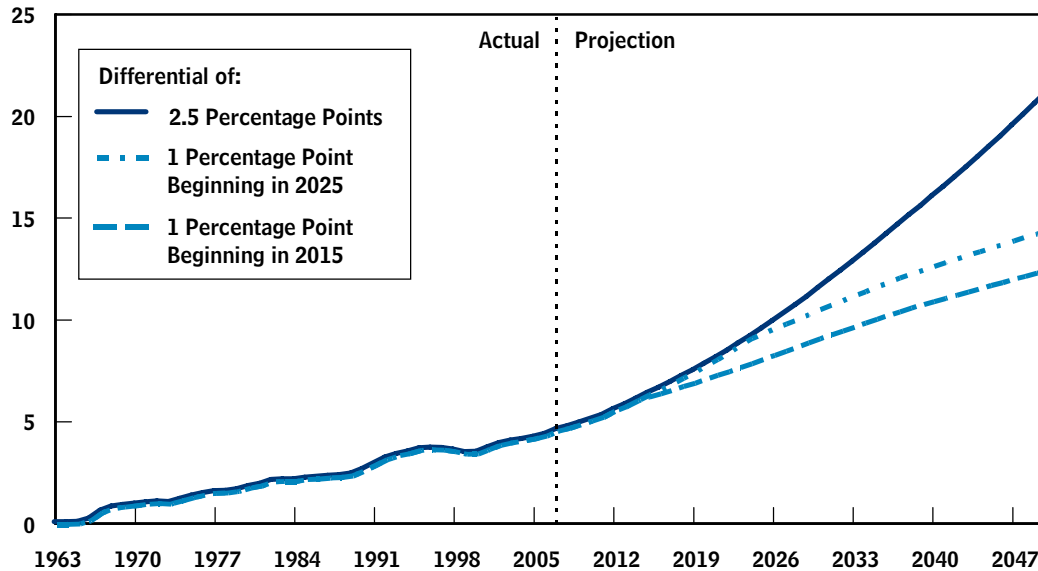
Whichever approaches are taken, the overall impact of steps to control costs will be greater the sooner that they are taken—particularly if they reduce the growth rate of health care costs and not just the level of those costs. For example, if costs per beneficiary in Medicare and Medicaid grew 1 percentage point faster than per capita GDP starting in 2025—rather than growing at the long-term historical rate of 2.5 percentage points faster—then the share of the economy devoted to those two programs in 2050 would shrink by nearly 7 percent of GDP, from 21 percent to about 14 percent (see Figure 7). If that slower growth rate were instead obtained starting in 2015, the projected spending for those programs in 2050 would be reduced by nearly 9 percent of GDP (from 21 percent to about 13 percent).¹⁵

15. Similarly, if costs per enrollee continued to grow 2.5 percentage points faster than per capita GDP, the present value of Medicare and Medicaid spending over the next 50 years would equal almost 11 percent of the present value of GDP over that period. If that difference in growth rates were reduced to 1 percentage point starting in 2025, the present value of outlays would decline to about 9 percent of GDP. And if the slower growth rate were obtained starting in 2015, the present value of outlays would fall to about 8 percent of GDP.

Figure 7.

Effects of Slowing the Growth of Spending for Medicare and Medicaid

(Percentage of gross domestic product)



Source: Congressional Budget Office.

Note: The health cost growth differential refers to the number of percentage points by which the growth of annual health care spending per beneficiary is assumed to exceed the growth of nominal gross domestic product per capita, after an adjustment for the growth and aging of the Medicare and Medicaid populations.

In considering those potential savings, it is important to note that they are merely illustrative and do not represent CBO's estimates of the effects that any specific proposal or combination of options would have. As the challenges touched on in the preceding discussion suggest, reducing the growth rate of health costs over an extended period of time will be a complicated endeavor.

Employer-Sponsored Insurance

Concerns about the operation of private insurance markets have given rise to various proposals that seek to improve the efficiency of those markets and that could also affect health care spending. Because of the central role that employer-sponsored coverage currently plays, a key issue for broad health reform proposals is whether they are based upon an employer-sponsored system, and if not, how they create the pooling mechanisms essential for effective health insurance markets. Other key budgetary and policy issues include any requirements for employers' contributions and the treatment of existing tax subsidies for employer-sponsored insurance.

Issues with Current System

Most Americans get their primary health insurance through an employer—either their own or that of a family member. By CBO’s estimates, 165 million nonelderly individuals are currently covered by employer-based insurance, with 140 million obtaining that coverage through a large or medium-sized employer (one with 50 or more workers) and 25 million obtaining that coverage through a small employer. Although employer-based insurance has advantages, particularly when provided through a larger employer, that arrangement also has limitations, and many employers have expressed serious concerns about the rising costs of providing coverage. Employers’ concerns are presumably a proxy for the underlying issue, which is how well the employer-based system functions for the American public: Ultimately, workers pay for their coverage directly or through reduced wages, and the advantages and disadvantages of that system accrue to them.

One advantage of employer-based insurance is that it can facilitate the pooling of risks. Although employees will vary in their use of health services from year to year, the average health costs of a large group of employees tend to be quite stable—because higher-than-expected costs for some workers are offset by lower-than-expected costs for others. As a result, employees can be offered insurance that reduces their exposure to high medical costs without posing substantial financial risks for their employer (and, indeed, many large employers choose to assume those risks themselves rather than contracting with an insurance company to bear them). Employers typically foster risk pooling by offering to cover a majority of the total premiums; even though a firm’s workers (as a group) ultimately pay for that subsidy, employers’ contributions lower the price of insurance that individual workers see and thus encourage broad participation. Another advantage of employer-based coverage is its reduced administrative costs—compared with those that would be incurred if employees purchased their own policies in the individual insurance market—which in turn lower the premiums.

At the same time, several concerns about employer-based coverage have been raised. For one, the advantages related to risk pooling and administrative costs are less evident for smaller firms, which employ about one-fourth of all workers. As a result, premiums for small employers are typically higher (for the same level of coverage) and can also be more volatile—factors which contribute to the lower likelihood that small employers offer insurance. In addition, the link between employment and insurance coverage typically means that when workers change jobs, they also have to change their insurance plan. Over time, the resulting turnover of enrollees may discourage insurers from subsidizing health investments that take a long time to pay off, because the initial insurers may not be the ones to realize the benefits from them. Finally, other observers object to the limited range of choices provided by many employers—at least a third of workers have no choice of health plan—and to the role that employers play in selecting which types of coverage are made available (even though over the long term, employers’ offerings presumably evolve to reflect the collective preferences of their workers).

Another key feature of the U.S. health care system is that insurance purchased through employers receives favorable treatment under the tax code—which encourages enrollment in such coverage but also tends to drive up health costs. Employers may deduct the costs of providing that coverage as a business expense (just as they deduct employees’ wages and other forms of compensation), and thus those payments avoid corporate taxes on profits. But unlike wages, the costs that employers pay for health insurance are excluded from the taxable income of the policyholders (and most employee contributions are similarly excluded). As a result, that portion of employees’ compensation avoids individual income and payroll taxes as well. For a typical worker, those tax preferences amount to a subsidy from the government of more than 30 percent toward the costs of health care services covered by employer-sponsored insurance. By reducing the price of that insurance, the tax subsidy also encourages workers to secure more extensive policies through their employers, increasing the share of costs that is covered and decreasing the share that is paid out of pocket. In turn, that more extensive coverage puts upward pressure on total health spending.

Rising health costs in recent years have generated concerns that employers will cease offering coverage or make their coverage less comprehensive. However, aggregate data indicate that such effects have been modest to date. The share of workers who have employer-sponsored health insurance has decreased somewhat since 2000, but according to surveys of employers, that development largely reflects a decline in the percentage of smaller firms that are offering insurance; coverage rates at larger firms have fluctuated over time but were comparable in 2000 and 2006.¹⁶ There is also some evidence that in recent years, employment has shifted somewhat to smaller firms and to industries that are less likely to offer coverage. Even with the recent decline in smaller firms’ rates of offering insurance, their overall “offer rate” remains comparable to that in 1996.

Amounts that enrollees have to pay out of pocket in premiums and cost-sharing have risen significantly in absolute terms, but for the most part those increases are in line with rising health costs overall. On average, the share of health costs that enrollees pay directly has not changed much (and the longer-term trend in the share of health care paid out of pocket, as indicated above, has been a substantial decline). Between 2000 and 2006, employees’ average contributions to health insurance premiums—the amount they pay directly, net of any employers’ contributions—rose about 85 percent. The overall costs of their insurance plans rose about 75 percent over that same period, yielding only slight changes in the share of premiums paid directly by enrollees.

16. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2006 Annual Survey* (Washington, D.C., September 2006).

Options for Reforming Employer-Sponsored Insurance

Proposals to replace or significantly modify the current system of employer-sponsored insurance vary widely in their design. Some would establish a single-payer system in which all workers and dependents would participate, as under proposals to allow or require all individuals to enroll in Medicare. Others would move in essentially the opposite direction, shifting to a system in which insurance was typically purchased in the individual market (perhaps accompanied by additional regulation of that market). Still others would build on the existing employment-based system but use subsidies or mandates to increase the number of workers and dependents who had insurance, such as “pay or play” proposals that would require most employers either to offer health insurance or to contribute to a fund that would subsidize insurance purchases.

A full analysis of those options is beyond the scope of my testimony today, but a few key considerations can be highlighted. One is the impact each option might have on the pooling of risks. By their nature, single-payer systems pool all participants together. By contrast, options that emphasize the individual insurance market may require further regulation—such as limits on the degree to which premiums may vary and on the factors (such as age) that may affect premiums—to maintain current levels of pooling, as most supporters of such options recognize. In principle, all enrollees in a given insurer’s policy are pooled together even though they purchased their coverage individually. In practice, however, those who have health problems will generally find changing insurers or plans more difficult, so, over time, as healthier enrollees gravitate toward less expensive policies, the degree of pooling that occurs will tend to decline.

Another significant issue involved in any reform of the employer-provided system is the short- and medium-term impact on employers’ contributions to health insurance. Over time, any changes in those contributions, which are substantial, should be reflected in workers’ wages or other benefits, but the speed of that adjustment could vary. Alternative systems for employers’ payments—including new taxes or other mandatory contributions—could also have significant macroeconomic effects on incentives to work and on the formation and organization of businesses (if, for example, contributions were tied to the size of firms). The specific effects of any proposal, however, would depend importantly on the details of the new system that would be established.

A closely related question is whether proposals modify or repeal the tax exclusion for employer-sponsored insurance. Replacing the tax exclusion for employment-based health plans with a deduction or tax credit that could be used in either the employment-based or individual market would make employment-based plans less attractive (relative to individually purchased plans) than they are now. As a result, the number of people insured through employment-based plans would decline. Although some of the people losing coverage in the employment-based market would become uninsured, the bulk of them would be insured through the

individual market instead. Moving from the current system—in which the tax exclusion creates a bigger tax subsidy for larger health insurance expenditures—to a fixed deduction or credit independent of the cost of a health plan would cause people to buy plans with less extensive benefits, on average.¹⁷

Lack of Insurance

The most recent estimates available indicate that about 45 million individuals lacked health insurance at any given point in 2005; a larger number were uninsured at some point during that year.¹⁸ In some respects, the uninsured are a heterogeneous group: Some are young and healthy and may not perceive a need to purchase health insurance, while others are older and have health problems that make insurance expensive to obtain. Many of the uninsured lack coverage for a relatively short time, but others are chronically uninsured.

Even so, a common characteristic of the uninsured is that they tend to have low income. Depending on whether the analysis looks at all uninsured or is weighted toward those with longer spells, the share of the uninsured who live in families with income below 200 percent of the poverty level is between two-thirds and three-quarters. Studies also indicate that about 80 percent of the uninsured live in families with at least one worker (usually with a full-time job). In most cases, however, those workers are either employed by firms that do not offer health insurance, or they are not eligible to enroll in the health insurance plans that their employer offers.

Factors Affecting the Number of Uninsured

Both the high cost of health care and the evolution of employer-based health insurance affect the number of people who have coverage. Higher premiums discourage people from purchasing insurance—especially those who have lower income or who perceive little risk of incurring a costly illness. (Rising health care costs can also make insurance protection more valuable, but that consideration may not substantially affect the behavior of lower-income or younger and healthier people.) Those who are not employed or who choose to work at a firm not offering insurance—and who do not have coverage through a spouse’s policy—have to seek insurance in the individual market, where policy terms and tax benefits are generally much less attractive than they are for employer-sponsored plans. As a result, many such people (and their family members) are uninsured.

17. For an analysis of the President’s proposal to create a standard tax deduction for health insurance, see Congressional Budget Office, *An Analysis of the President’s Budgetary Proposals for Fiscal Year 2008* (March 2007), pp. 57–62.

18. For a discussion of different measures of the uninsured population, see Congressional Budget Office, *How Many People Lack Health Insurance and For How Long?* (May 2003).

Federal programs have reduced significantly the number of people who would otherwise be uninsured. The Medicare program provides nearly universal coverage to the elderly, a substantial share of whom lacked health insurance (or had very limited coverage) at the time of its enactment. Medicaid offers health insurance coverage to a variety of low-income individuals—primarily poor children and their mothers, pregnant women, the disabled, and the elderly. In 2006, about 30 million nondisabled children in low-income families were enrolled in Medicaid. At the same time, surveys indicate that several million people are eligible for Medicaid and otherwise uninsured but not enrolled in the program. Such individuals may simply be unaware of Medicaid or their eligibility for it, or they may be dissuaded from enrolling by various factors, including the stigma that is sometimes associated with means-tested programs. In many cases, individuals may be enrolled into Medicaid when they need expensive services; thus, those who are eligible for but not enrolled in the program have some protection against financial loss but do not obtain the full benefits of participation.

The State Children’s Health Insurance Program (SCHIP), enacted in 1997, also provides health insurance coverage to uninsured children living in families with income that is relatively low—but too high to qualify for Medicaid. During 2006, nearly 7 million children were enrolled in SCHIP at a total cost to the federal government of about \$5 billion.¹⁹

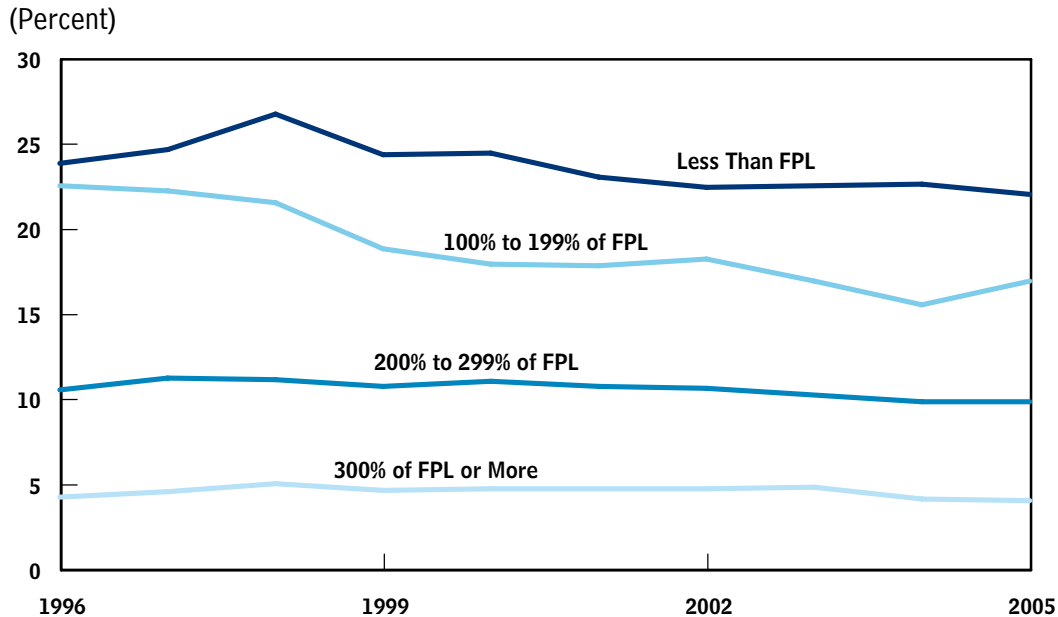
SCHIP has significantly reduced the number of low-income children who are uninsured. CBO estimates that, among children living in families with income between 100 percent and 200 percent of the poverty threshold, the uninsurance rate fell from 22.5 percent in 1996 (the year before SCHIP was enacted) to 16.9 percent in 2005, a reduction of 25 percent. In contrast, the uninsurance rate among children in higher-income families remained relatively stable during that period (see Figure 8). As with Medicaid, estimates indicate that a substantial number of children are eligible for SCHIP but not enrolled in it. Although SCHIP and Medicaid have significantly reduced the number of uninsured children in low-income families, the net effect on the extent of coverage is smaller than the number of children who have been enrolled in public coverage because the increase in public coverage has been partially offset by a reduction in private coverage.

Concerns about the uninsured include the financial risk they face and the prospect that their health will be adversely affected. According to one recent study, people who are uninsured for a full year receive about half as much care as continuously insured individuals—partly reflecting the fact that many uninsured individuals are relatively young and healthy but also a result of the higher costs they face for

19. See Congressional Budget Office, *The State Children’s Health Insurance Program* (May 2007). The figure for the number of people enrolled in 2006 reflects enrollment at any time during the year. The number of people enrolled in an average month would be about 60 percent of that total.

Figure 8.

Percentage of Children Who Were Uninsured, by Family Income as a Percentage of the Federal Poverty Level



Source: Congressional Budget Office based on data from the Current Population Survey for 1996 to 2005.

Note FPL = federal poverty level.

services.²⁰ Several studies have found that, when they have a serious disease, the uninsured are less likely to have received a prompt diagnosis of their condition and are less likely to receive expensive treatments.²¹ The majority of the care that the uninsured do receive is provided free of charge or at a substantially reduced cost, either because they receive services from clinics or other sources that are subsidized by the government or because private providers are unable to collect payment.

To address such concerns, several states have taken or are contemplating their own initiatives targeting the uninsured. For example, Massachusetts enacted a program in 2006 aimed at providing nearly universal health insurance coverage for its residents. The legislation generally requires individuals to purchase insurance and includes increasing penalties for those who do not obtain coverage (in 2008, they

20. Jack Hadley and John Holahan, "How Much Medical Care Do the Uninsured Use, and Who Pays for It?" *Health Affairs*, Web Exclusive (February 12, 2003), pp. W3-66–W3-81.

21. For a review of those studies, see Institute of Medicine, *Care Without Coverage: Too Little, Too Late* (Washington, D.C.: National Academy Press, 2002), available at www.iom.edu/Object.File/Master/4/160/Uninsured2FINAL.pdf.

will have to pay roughly half of the cost of the least expensive health plan offered in their region); additional penalties apply to employers who do not offer coverage. To make it easier for individuals without access to employer-based plans to obtain coverage, an insurance exchange (known as the Connector) has been established. To help lower-income individuals obtain coverage, the state will fully subsidize insurance for those with income below 150 percent of the poverty level and will offer smaller subsidies to those with somewhat higher income. Even so, some individuals have been exempted from the coverage mandate because they have been deemed unable to find low-cost sources of coverage. Other states, including California (which has a much larger uninsured population), are considering similar approaches.

Options for Expanding Insurance Coverage

Although reductions in overall health costs would tend to lower health insurance premiums—and thus could reduce the number of people without insurance—a substantial number of people were uninsured even when health care costs were lower. Substantially reducing the number of uninsured individuals would therefore probably require a mandate to purchase insurance (or similar penalties for not having coverage), a set of subsidies for low-income people, or some combination of those approaches. The share of people who are uninsured tends to decline as their income rises, so subsidies of premiums could be set on a sliding scale. A tradeoff exists in the size of the subsidy: larger subsidies would increase voluntary purchases of insurance but would also be more costly to provide. A mandate to purchase insurance combined with a penalty for not doing so also provides an impetus to obtain coverage, but in the form of a stick rather than a carrot.

Subsidies could take the form of tax rebates or credits or direct support through a government program like Medicaid (in which the enrollee's premiums cover less than the average cost of the policy). Because the uninsured tend to have lower income and therefore face lower marginal income tax rates, tax credits tend to be a more effective means of providing subsidies than tax deductions (whose value increases with the marginal tax rate). For the same reason, tax credits are even more valuable to low- and moderate-income recipients if they are refundable, because that feature makes the full value of the credit available even if it exceeds recipients' income tax liability. An inevitable trade-off is that providing new government subsidies to expand insurance coverage will displace some private spending—because it is difficult to prevent people with low-income who already have health insurance from qualifying for the newly offered subsidies.

Here too a full consideration of the advantages and disadvantages of those options would require much more extensive analysis than can be presented in this testimony, but a few key points can be covered regarding administrative costs and overall health care costs. Administrative costs could be affected if options for expanding insurance coverage also included reforms of the individual insurance market (as discussed above in connection with changes to the employer-sponsored

insurance system) as well as mechanisms to oversee the insurance policies offered and to facilitate enrollment in a plan (as under the Massachusetts initiative). Insurance market reforms have the potential to reduce or eliminate some administrative costs now incurred by private insurers. For example, community rating requirements—under which all enrollees pay the same premium, at least within an age range—or limits on the factors that can be used to adjust premiums could reduce costs that insurers now incur to enroll beneficiaries and underwrite their policies. At the same time, providing information and conducting outreach to individuals involves administrative costs that may be difficult to avoid under any system that provides a choice of insurance plans. Administrative costs could be reduced further under a single-payer system, but trade-offs would arise between achieving those savings, running the plan efficiently, and limiting choices for enrollees.

Several factors would affect the overall impact that expanding insurance coverage would have on total health care spending—first and foremost being the net increase in coverage and the type and extent of insurance provided. Health spending associated with individuals who were newly covered would be expected to increase because coverage would encourage greater use of services (indeed, that would be one of the objectives of expanding coverage). A shift in measured spending would also occur, because the services used by newly covered beneficiaries would be paid for by their insurer rather than becoming uncompensated care. Some of that increase would be offset by reductions in government spending that now goes to provide free or subsidized care, and it is also possible that reductions in uncompensated care could reduce costs for other private payers (if doctors and hospitals lowered their fees to private insurers as a result of receiving higher payments on behalf of formerly uninsured individuals). The extent of such effects is highly uncertain, however.

Prevention and Healthy Living

The ultimate objective of any health care system is to promote health, whether by treating diseases that arise or by preventing them from occurring in the first place. Despite the cost of the nation's health care system, many concerns exist about the degree to which it is attaining that objective. Indeed, concerns about rising health care costs might not be so prominent if more evidence showed that those expenditures were yielding commensurate gains in health. In part, those shortcomings in the system's performance relate to the questions noted above about whether patients are receiving the most effective or most cost-effective treatments—reflecting a lack of information, among other factors. Concerns also exist, though, about steps that are *not* being taken today to prevent the onset of disease, even when clear evidence is available about their benefits. In that context, proposals that encourage more prevention and healthy living can help to promote better health outcomes, although their net effects on federal and total health spending are uncertain. Moreover, bringing about substantial changes in behavior could require

actions outside the formal health care sector, and even then might be very difficult to achieve.

Issues Regarding Preventive Care and People’s Behavior

The health of the American public, on average, is lower than it could be because steps that can foster better health—such as preventive medicine—appear to be underused, and various types of unhealthy behavior—in particular, those contributing to recent increases in obesity—remain relatively common.

Preventive services encompass several distinct types of care: immunizations and other interventions that actually prevent diseases from arising; screening tests that can determine the presence of a disease; and counseling to encourage healthy behavior or discourage unhealthy habits. The U.S. Preventive Services Task Force, an arm of the Department of Health and Human Services, has analyzed the cost-effectiveness of many preventive services and has developed a recommended list of interventions that should be routinely provided. (In some cases, the evidence necessary to make a recommendation is not available—a situation analogous to the uncertainties about which treatments work best.) According to one study, however, adults receive only about half of the recommended preventive services.²²

Various reasons have been cited for the low use of preventive services, including a lack of awareness about their benefits among consumers and a focus on treatment rather than prevention among doctors. Another source of concern has been the extent to which insurance plans cover preventive care and the cost-sharing requirements for that care. The majority of private insurers appear to cover immunizations and various screening tests—and about half of the plans that require a deductible exempt at least some preventive services from it—but coverage of counseling services is much more limited; low reimbursements to physicians for counseling services also discourage their provision.²³ Coverage of preventive care under Medicare requires specific legislative authority, and thus varies from service to service. Medicaid covers childhood immunizations on a consistent basis, but coverage for screening and diagnostic services for children and adults varies from state to state. To address that situation, some health researchers have recently put forward proposals to expand the use of preventive care using federal subsidies.²⁴

22. See Elizabeth A. McGlynn and others, “The Quality of Health Care Delivered to Adults in the United States,” *New England Journal of Medicine*, vol. 348, no. 26 (June 26, 2003), pp. 2635–2645. That study also found that adults receive about half of the recommended services for acute and chronic health problems.

23. See Eileen Salinsky, *Clinical Preventive Services: When Is the Juice Worth the Squeeze?* Issue Brief No. 806 (Washington, D.C.: National Health Policy Forum, August 24, 2005); and Kaiser Family Foundation, *Employer Health Benefits: 2006 Annual Survey*.

24. See, for example, Jeanne M. Lambrew, *A Wellness Trust to Prioritize Disease Prevention*, Hamilton Project Discussion Paper 2007-04 (Washington, D.C.: Brookings Institution, April 2007).

Such steps could improve health, but the net effect of greater use of preventive care on health spending is uncertain. In some cases, preventive care can help avoid more costly treatments that may be required after a disease has developed further. In other cases, though, increased use of preventive care could increase other health care spending—to treat newly discovered diseases or to address complications arising from testing, for example. Additional costs are associated with treating people who have received “false positives”—that is, who are incorrectly identified as having a given disease. Furthermore, screening tests are typically performed on people with no symptoms, so the number of people tested may be quite large compared with the number who will have a disease discovered. As a result, one older study found, the use of preventive care usually adds to overall medical spending, once the cumulative costs of screening individuals who are found not to have the disease in question are included.²⁵ A more recent review of the evidence concluded that, “with the exception of some immunizations, most preventive services do not ‘save’ money.”²⁶ The extent to which electronic health records and other information technology advances could allow more precise targeting of screening tests remains unclear.

Perhaps an even more important determinant of health than the health care system is an individual’s behavior. In particular, obesity and smoking have substantial health consequences.

Obesity. The share of Americans who are overweight or obese has risen dramatically over the past three decades, from about one-half to roughly two-thirds—with the share who are obese accounting for the entire increase (see Figure 9). According to one recent study, the rise in obesity rates in the United States is related mostly to an increase in caloric intake—and in particular, an increase in calories from snacks—rather than a decline in caloric expenditures—that is, reduced activity.²⁷

Obesity is associated with many serious medical conditions, including diabetes, heart disease, and high blood pressure. According to another recent study, obese people incurred medical costs in 2001 that were 37 percent higher than those for people of normal weight—a difference of about \$1,000 per person.²⁸ That study also found that the increased prevalence of obesity between 1987 and 2001 accounted for 12 percent of the overall growth in real (inflation-adjusted) medical spending per capita that occurred over that period. Another study found even more

25. Louise B. Russell, *Is Prevention Better Than Cure?* (Washington, D.C.: Brookings Institution, 1986).

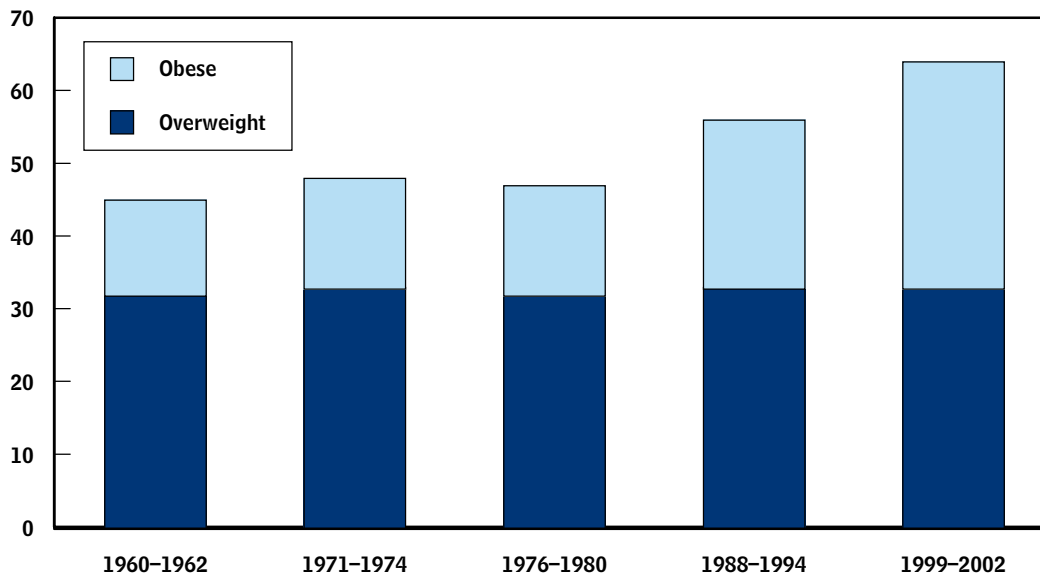
26. Salinsky, *Clinical Preventive Services*, p. 7.

27. David M. Cutler, Edward L. Glaeser, and Jesse M. Shapiro, “Why Have Americans Become More Obese?” *Journal of Economic Perspectives*, vol. 17, no. 33 (Summer 2003), pp. 93–118.

28. Kenneth E. Thorpe and others, “The Impact of Obesity on Rising Medical Spending,” *Health Affairs*, Web Exclusive (October 20, 2004), pp. W4-480–W4-486.

Figure 9.

Percentage of Individuals Ages 20 to 74 Who Are Overweight or Obese



Source: Congressional Budget Office based on Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, *Health, United States, 2006*.

Note: Individuals who are overweight are defined as having a body mass index (BMI) of 25 or more but less than 30; obese, a BMI of 30 or more. By comparison, people with a healthy weight have a BMI of 18.5 to less than 25.

significant implications for Medicare: The share of spending attributable to obese enrollees increased from about 9 percent in 1987 to about 25 percent in 2002, a substantially larger increase than was seen in the obesity rate for the Medicare population.²⁹

Smoking. Smoking rates have declined in the United States, but roughly one-fifth of the population still smokes. Smoking rates among pregnant women have also shown a steady decline, but about 10 percent of expectant mothers still smoke despite the substantial health risks that smoking poses to their babies (see Figure 10).

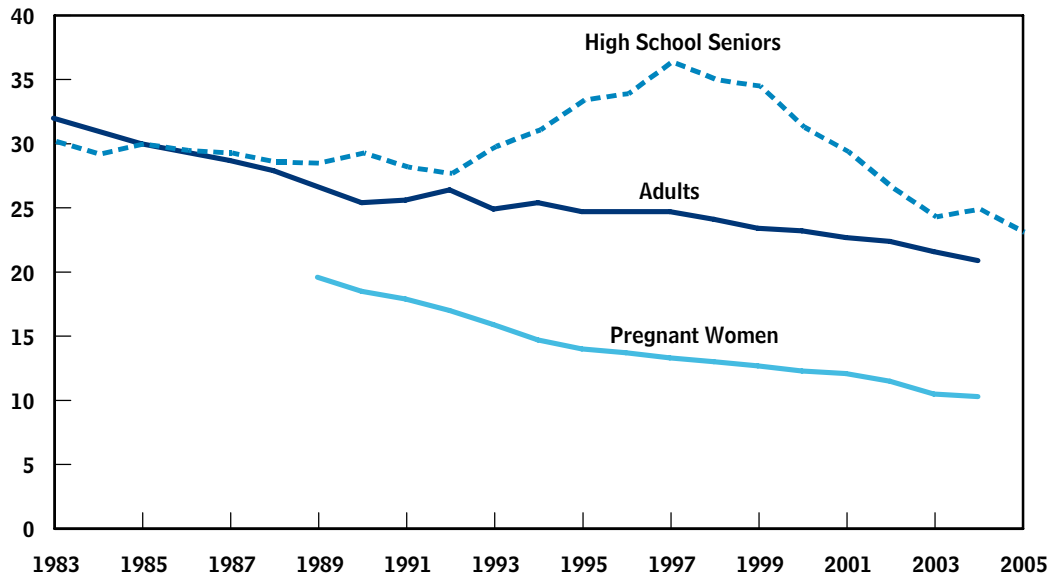
Smoking rates began to fall following the Surgeon General's 1964 report on smoking, which stated definitively that smoking causes cancer. Since that time, additional information about the adverse health effects of smoking has been developed and disseminated—which has probably contributed to the steady decline in smok-

29. Medicare Payment Advisory Commission, *Report to the Congress: Promoting Greater Efficiency in Medicare* (June 2007), p. 9.

Figure 10.

Cigarette Smoking by Various Groups

(Percentage)



Source: Congressional Budget Office based on Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, *Health, United States, 2006*.

ing rates. (For example, smoking is associated with a significantly increased risk of developing heart disease and emphysema and of having a stroke) Other factors affecting smoking rates are regulations such as bans on smoking in certain areas and limits on how cigarettes can be sold and, more importantly, the rise in the real price of cigarettes. Federal excise taxes and most state taxes on tobacco have been raised periodically over the years, and those increases are passed on to consumers, boosting the retail price of cigarettes. Each 10 percent increase in price, research has shown, causes the use of cigarettes to fall by 2.5 percent to 5 percent.

In general, the fact that taxing an item can cause consumers to buy less of it than they might otherwise can result in a less efficient allocation of society's resources (unless some of the costs associated with the taxed item are not reflected in its price). But the use of cigarettes creates "external costs" for society that are not paid by smokers or tobacco producers, such as higher costs for health insurance (to cover the higher medical expenses incurred by smokers) and the damaging effects of cigarette smoke on the health of nonsmokers. Furthermore, people may underestimate the harm they do to themselves by smoking or the addictive power of nicotine. Teenagers in particular may not be capable of evaluating the long-term effects of beginning to smoke. For reasons that are not entirely clear, the smoking rate for teens (which had been comparable to the rate for adult men) increased in the early 1990s. But that rate fell substantially following the significant increases

in cigarette prices that accompanied a multibillion-dollar settlement agreement between major tobacco companies and the states.

Options Regarding Prevention and Healthy Living

Reform proposals could encompass preventive measures and efforts to encourage healthier lifestyles. Broadly speaking, three basic policy approaches could be adopted. First, more information about the consequences of unhealthy behavior or the factors contributing to it could be made available, in forms that could affect individual behavior or even social norms. (Nutritional information, for example, is readily available for packaged foods but more difficult to come by for other sources—such as restaurant meals). Second, financial incentives could be modified to encourage healthier living and to discourage unhealthy activities. For example, cigarette taxes could be increased, which would discourage smoking, especially among teenagers. In addition, an increase in the federal tax on cigarettes of 50 cents per pack would raise about \$5 billion per year, according to the Joint Committee on Taxation. Third, regulatory steps could be taken to encourage healthy behavior and discourage poor health habits. For example, recent efforts have been aimed at improving the nutrition and reducing the calories of school lunches and snacks available in schools. Some research suggests that changing the presentation of food choices can encourage healthy eating.³⁰

In considering those options, it is important to recognize that there are costs to imposing regulations and levying taxes and that in many cases the benefits of specific options to promote healthy living are uncertain. For example, no consensus exists about the size of smoking's external costs, which makes determining the appropriate level of tobacco taxes difficult. Some analysts estimate that those costs are significantly lower than the taxes and settlement fees now levied. Others maintain that the external costs are greater or that the failure of people to anticipate the future effects on themselves (rather than on other people) justifies a higher tax rate on cigarettes. Technical issues complicate the debate; for example, the effects of secondhand smoke are uncertain. An argument against raising cigarette taxes is their regressivity: Such taxes take up a larger percentage of the earnings of low-income families than of middle- and upper-income families. Similarly, providing additional information about the caloric content of restaurant meals could be expensive, and it is not clear how much that information would change people's behavior or whether the benefits of those changes would exceed the costs of producing them.

More broadly, information about the benefits of eating right, exercising, and not smoking is widely available, and bringing about changes in people's behavior represents a substantial challenge. The growing field of behavioral economics is beginning to examine how the combination of information, incentives, and regula-

30. See Brian Wansink, *Mindless Eating: Why We Eat More Than We Think* (New York: Bantam Dell, 2006).

tions—as well as people’s inertia and biases—affects their behavior. That research may ultimately help inform efforts to make various policy changes to promote health. As the nation struggles to address the cost, quality, and access to its health care system, developments and policy changes outside the system itself will continue to exert an important influence on Americans’ health, which in turn will affect the system.