CBO TESTIMONY

Statement of
Robert D. Reischauer
Director
Congressional Budget Office

before the
Subcommittee on Health
Committee on Ways and Means
U. S. House of Representatives

March 2, 1993

NOTICE

This statement is not available for public release until it is delivered at 10:30 a.m. (EST), Tuesday, March 2, 1993.

CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

Mr. Chairman, I appreciate the opportunity to appear today before this Subcommittee to discuss the economic implications of rising health care costs.

The United States spent 14 percent of its gross domestic product (GDP) on health care in 1992, more than double the proportion devoted to health care as recently as 1965. Unless current trends are altered, either in government policies or in private behavior, spending on health care will grow to 19 percent of GDP by the year 2000 (see Table 1).

Should we be concerned about such dramatic increases or that the nation spends nearly twice as much on health care as it spends on education? After all, dramatic structural changes have been a familiar feature of our country's economic development. Growth in incomes, differences in the rates of advances in productivity among industries, and the opening of the economy to world trade can all bring substantial changes. For example, over the past 40 years, agriculture's share of gross national product (GNP) has fallen from 7 percent to 2 percent, while the productivity of American farmers has soared. Over the same period, the share of income spent on all services (not just health) has also gone up relative to that spent on manufacturing, simply because the productivity of services has grown more slowly. Furthermore, in a free marketplace such as ours, allocation of resources primarily reflects consumer preferences. For example, the share of income consumers devoted to airline travel increased two and one-half times during the 1965-1990 period

TABLE 1.
PROJECTIONS OF NATIONAL HEALTH EXPENDITURES, BY TYPE OF SPENDING

Type of Spending	Selected Calendar Years								
	1965	1980	1985	1990	1991	1992[a]	1993[a]	1995[a]	2000[a]
	Billions of Dollars								
Hospital	14	102	168	258	289	321	351	421	644
Physician	8	42	74	129	142	156	171	205	309
Drugs, Other Nondurables	6	22	36	56	61	66	71	83	117
Nursing Home	2	20	34	53	60	67	75	91	137
All Other	12	64	110	179	201	222	244	290	425
Total	42	250	423	675	752	832	912	1,089	1,631
	Average Annual Growth Rate from Previous Year Shown (Percent)								
Hospital		14.2	10.4	8.9	11.8	11.4	9.3	9.4	8.9
Physician		11.5	12.1	11.7	10.2	9.6	9.9	9.5	8.5
Drugs, Other Nondurables		9.1	10.8	9.0	9.0	8.2	8.1	7.9	7.2
Nursing Home		17.9	11.3	9.3	12.4	12.1	11.4	10.2	8.5
All Other		12.0	11.4	10.2	12.0	10.8	9.9	9.0	7.9
National Health Expenditure		12.7	11.1	9.8	11.4	10.7	9.6	9.3	8.4
Memoranda:									
Gross Domestic Product (Billions of dollars)[b]	703	2,708	4,039	5,522	5,677	5,943	6,255	6,942	8,627
Average Annual Growth of Gross Domestic Product (Percent)	n.a.	9.4	8.3	6.5	2.8	4.7	5.2	5.3	4.4
Ratio of National Health Expenditures to Gross Domestic Product	5.9	9.2	10.5	12.2	13.2	14.0	14.6	15.7	18.9

SOURCE: Congressional Budget Office.
NOTES: n.a. = not applicable. Details may not add to totals because of rounding.

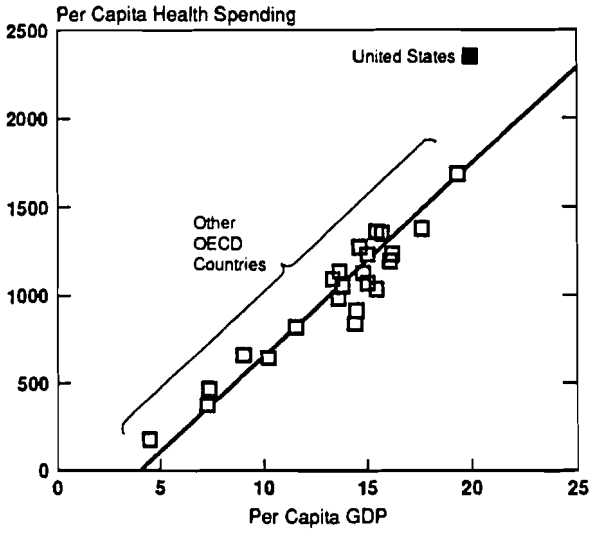
a. Projected.
b. Economic assumptions reflect the Congressional Budget Office baseline of January 1993.

in which the share going to health care "only" doubled. And not surprisingly, in this rich country, people place a high value on good health and high-quality medical care.

Yet, compared with other industrialized countries, the United States spends a much greater proportion of GDP on health than would be expected from its per capita income (see Figure 1). But surprisingly it does not appear to have a substantially healthier population. Moreover, although there are some good reasons to expect health care spending to be important in our society, the large and continually rising proportion of national income going to the health sector is cause for considerable concern to many economists and policymakers. Behind that concern stands the realization that health care is not provided in a truly competitive marketplace and, therefore, the resulting spending may not reflect the preferences of either consumers or society.

Several factors distort the efficient workings of the health care market. First, the prevalence of health insurance insulates consumers from the full cost of health care, which leads to an excessive use of covered medical services. Second, informational obstacles make the market work less efficiently. Treatment costs--both total and those not covered by insurance--are difficult to obtain in advance, and comparison shopping can be costly and impractical for many sick people. Third, the technical nature of many medical

Figure 1.
Health Spending and Income in Countries of the Organization for Economic Cooperation and Development, 1989



SOURCE: George Schieber and others, "Health Care Systems in Twenty-Four Countries," *Health Affairs*, vol. 10, no. 3 (Fall 1991), pp. 7-21.

NOTES: Health spending and gross domestic product are converted to dollars using purchasing power parities. Per capita gross domestic product is expressed in thousands of dollars. Per capita health spending is expressed in dollars.

services makes consumers poor judges of the appropriateness and efficacy of alternative treatments, leading them to delegate decisionmaking to the provider, who has an incentive to provide more services from the standpoint of both professional training and economic self-interest.

Another reason for concern is that the escalating cost of health care has exacerbated the problem of access that, given the high cost of care, depends crucially on having insurance. Growing numbers of the nonelderly

lack health insurance in part because soaring premiums have reduced the availability of employment-related insurance; individual policies have also become prohibitively expensive for many people of modest means, particularly those with health problems.

The dual problems of high and escalating costs and inadequate access have convinced many Americans that fundamental reform of the health care system is necessary. But the debate over what direction these reforms should take has been both contentious and confused. Part of the difficulty stems from some widespread misunderstandings that exist about basic economic aspects of the current health care system. These misconceptions have distracted and misdirected much of the debate on reform. Unless they are dispelled and the American public and policymakers gain a better understanding of the economic forces underlying the current health care system, policies for reform could prove to be either misguided or woefully inadequate.

WHO PAYS FOR HEALTH CARE?

The first of the pervasive misconceptions involves confusion about who is paying the tab under the current system. Many Americans believe that a

substantial portion of the costs of health care is being borne--not by the American consumer, worker, or taxpayer--but by some ill-defined third party. That conviction makes the public reluctant to consider directly bearing the full costs of a reformed system even when those costs are no more than those of the current system.

Americans are, of course, well aware of the 35 percent of health spending they themselves pay for directly in the form of insurance premiums, out-of-pocket medical expenses, and Medicare's Hospital Insurance (HI) taxes and Medicare premiums. But they often act as if the less visible 65 percent is manna from heaven. For the nonelderly, the majority of whom receive health insurance as an employment-related fringe benefit, the prevalent belief is that this insurance does not cost employees much because employers initially pick up an average of about 80 percent of the premium costs. Nothing could be further from the truth.

In the long run, workers--not businesses--bear most of the costs of employment-related health insurance in the form of lower real wages and reduced nonmedical fringe benefits. The growing costs of health insurance have absorbed a large portion of the recent increase in total compensation (wages, employer payroll taxes, and fringe benefits). Between 1973 and 1989, both years in which the economy was operating at close to full capacity,

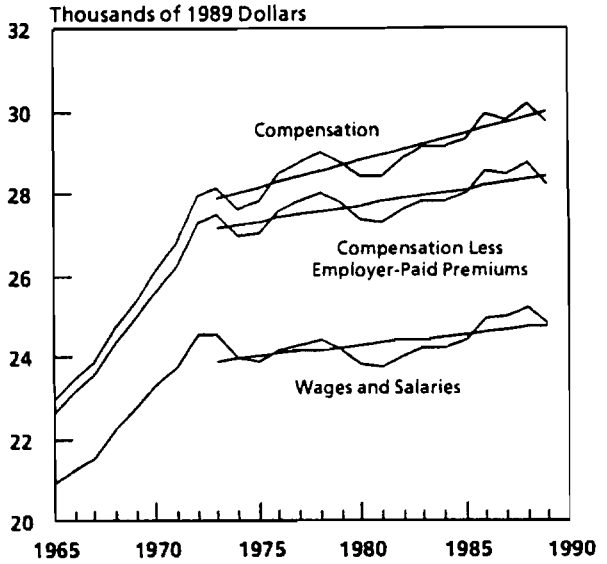
employers' contributions to group health insurance absorbed more than half of the increase in real compensation per full-time employee, even though it represented 5 percent or less of the total (see Figure 2).

This squeeze on real wages has meant that workers have had less to spend on everything else--particularly frustrating for wage earners who have had trouble making ends meet. These frustrations have probably added to tensions between labor and management as well.

The widespread misconception that businesses, not workers, are shouldering the bulk of the costs of employment-related health insurance has fostered two other misunderstandings that have muddled the debate on health care reform. The first of these is that the rising cost of employment-based health insurance makes it difficult for U.S. companies to compete in the world marketplace. In fact, health insurance has little long-run effect on the competitiveness of U.S. companies, regardless of how much health care costs go up, since workers bear most of these costs.

I do not want to imply, however, that health costs have no effects on businesses. Clearly, because wages and prices do not adjust immediately to changes in the economic environment, unexpected increases in costs can temporarily affect employment, profits, and international competitiveness.

Figure 2.
Inflation-Adjusted Compensation, Health Premiums, and Wages per Full-Time Employee: Actual Data and 1973-1989 Trends



SOURCE: Congressional Budget Office based on data from the Department of Commerce, Bureau of Economic Analysis.

NOTE: Deflated by the consumer price index for all urban consumers.

Furthermore, certain firms, such as those with abnormally high health costs for retirees, may find themselves at a disadvantage because they might have a difficult time shifting such costs onto their current labor force.

The belief that workers bear only a small share of the costs of employment-related health insurance has also fostered the notion that this insurance must be financed in a fairly progressive fashion--much of it coming out of profits. But to the extent that these costs are shifted back to workers in the form of reduced wages and salaries, quite the opposite is the case.

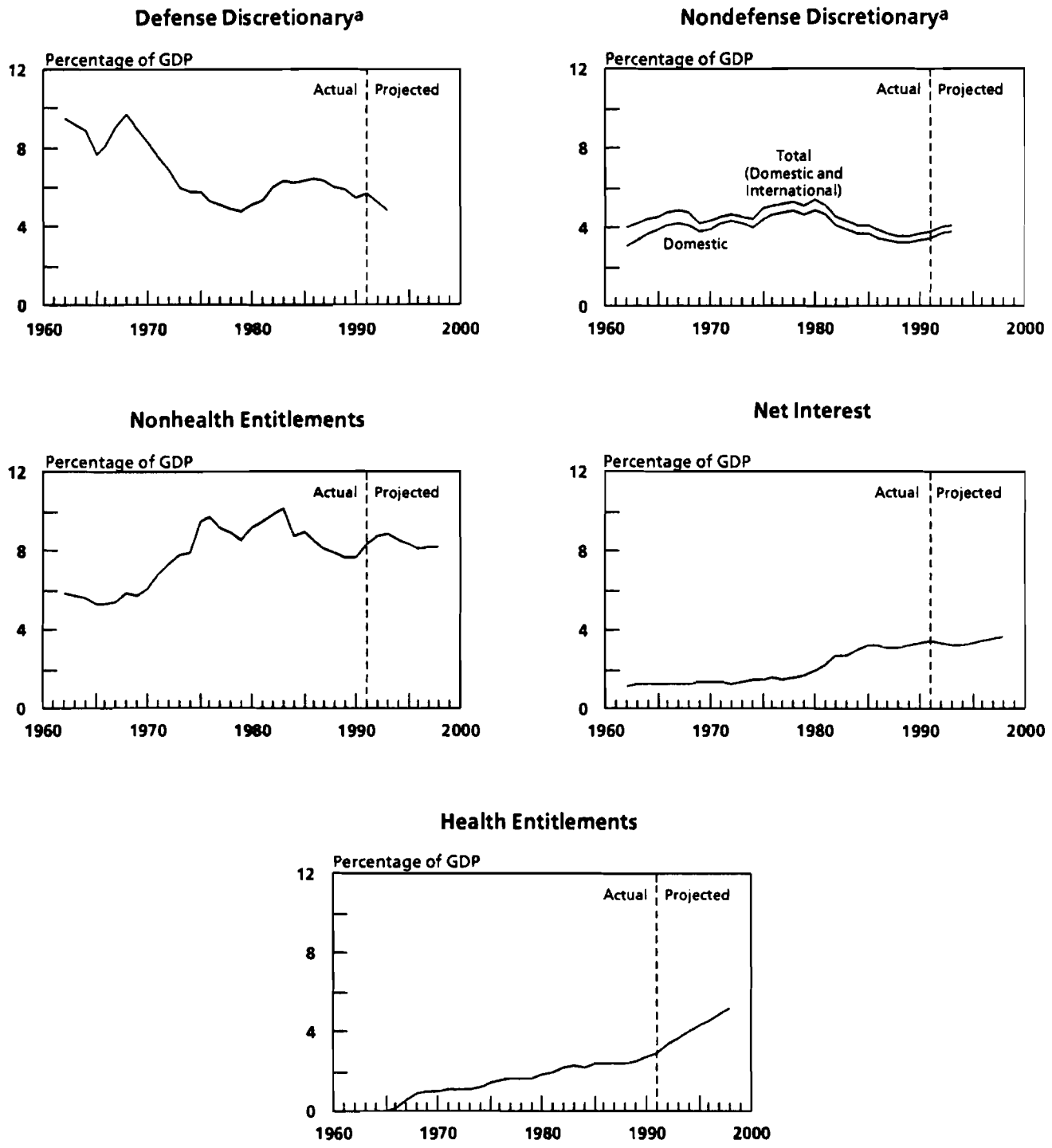
Within a single firm, the burden looks much like a regressive head tax because the health insurance premiums that a business pays for its highly paid executive and its low-wage custodial worker are much the same. In this context, almost any financing alternative--even a payroll tax or a tax on consumption--is likely to be more progressive than the current system.

The misconceptions of Americans about how health care is paid for are not restricted to employment-related insurance; they extend to the 45 percent of the total that government pays for as well. Although most workers feel the sting of the payroll tax, and beneficiaries are familiar with the monthly Medicare premiums they must pay, these costs are but the tip of the iceberg.

At the federal level, an additional $39 billion in general revenues was spent subsidizing Medicare in 1992, and $116 billion more was needed for Medicaid, veterans' health benefits, and other health programs. State and local governments spent roughly $123 billion more on health-related activities in 1992.

Over the past decade, health care has been the fastest growing major component of government budgets, absorbing resources that could have been devoted to other needed services, deficit reduction, or tax relief (see Figure 3). If current policies are not changed, the past will be prologue, and other

Figure 3.
Federal Outlays as a Share of Gross Domestic Product



SOURCE: Congressional Budget Office.

NOTE: GDP = gross domestic product.

a. Assumes compliance with discretionary spending caps in the Budget Enforcement Act. Caps are not specified in detail after 1993.

priorities will again be sacrificed to the relentless increase in spending by the public sector on health.

The skyrocketing costs for Medicare and Medicaid will translate into larger budget deficits if the projected increases in federal health spending are not offset by increases in taxes or cuts to other federal spending. Under current law, however, federal tax revenue is expected to remain at roughly 19 percent of GDP and, although the share of nonhealth spending will fall, it will not fall enough to offset the expanding share for health care.

The Congressional Budget Office (CBO) projects that, if policymakers do nothing, the federal budget deficit will increase from its current level of about $300 billion to about $650 billion in the year 2003. And even with the spending cuts and tax increases proposed by the President (but without any health reforms), the deficit would still be around $300 billion in 10 years by the Administration's calculations.

Foreign capital will be needed to finance such huge deficits. Moreover, as exports of government debt grow, exports of U.S. goods and services will be crowded out. By pushing up the exchange value of the dollar, the budget deficit will raise the costs of U.S. goods on world markets. Thus, because rising health costs add to the federal budget deficit, they have a significant

effect on the competitiveness of all U.S. businesses--both those that provide health insurance for their employees and those that do not. These effects, however, stem solely from the budget deficit, not from increases in the cost of employment-based health insurance.

WHAT IS DRIVING UP HEALTH COSTS?

A second area of misunderstanding and misconception involves inflation in medical prices. The general perception is that much of the increase in health care spending comes from the rampant growth of medical care prices that only serve to fatten the profits of health care providers. If medical inflation could be curbed, so the argument goes, spending could be brought under control with little effect on the quality and quantity of medical care that consumers receive.

This perception is perpetuated by statistics that have recorded a relentless rise in the prices of medical care. For example, over the decade from 1982 through 1991, the medical care component of the consumer price index (CPI) rose at almost twice the rate of the overall CPI (7.9 percent versus 4.1 percent). But the measures of medical prices that the public is bombarded with are seriously flawed. The CPI for medical care, for example,

does not measure the total costs of medical care, but only the consumer's out-of-pocket expenses, which have declined significantly over the past 30 years. Moreover, medical price indices measure intermediate outputs, such as the cost of a day in the hospital, rather than the final product, which would be the cost for treating a disease.

Thus, when technological improvements reduce the length of hospital stays or allow a disease to be treated in a cheaper, outpatient setting, the economies are not adequately reflected in price indices though they may reduce the consumer's total costs for treating the illness. Similarly, the prices in the CPI are generally list prices and do not reflect the growing importance of discounts that many patients now receive through their health plan.

Most important, however, the CPI does not adequately adjust for the dramatic improvements that have taken place in the quality of medical care over recent decades. New, more accurate diagnostic tools such as Magnetic Resonance Imaging and amniocentesis are now routine. Less invasive and less risky surgical techniques are now the norm. Although these improvements have generally pushed up spending, it is impossible to disentangle the portion of those cost increases that reflect higher prices without undertaking the nearly impossible job of accurately measuring the improvement in quality that has taken place.

The bottom line is that we just do not know how fast medical prices are rising, and efforts to curb costs through rigid price controls could significantly affect the pace at which qualitative advances take place. Hence, cost controls are likely to be more painful than many envision, requiring consumers to accept some real limits on the quality or quantity of medical care that is available.

ARE THERE ANY SILVER BULLETS TO CONTROL COSTS?

A third widespread misconception that has influenced the reform debate is the notion that by modifying some aspect of the health care system, spending could be effectively controlled and the resources needed to address the access problem could be freed up without adversely affecting the quantity or quality of care received by consumers. Managed care, malpractice reform, and administrative simplifications have all been championed on these grounds. Certainly, some savings could be realized from each of these areas, but the dividends are likely to be modest in size.

Managed care is a key component of many reform proposals; it is argued that this form of delivery will eliminate unnecessary and inappropriate care, saving substantial costs without forcing consumers to give up beneficial

services. Certain approaches--staff and group model health maintenance organizations (HMOs)--have shown that they can significantly reduce health care use and costs. Some other forms of managed care seem capable of achieving modest cost reductions as well, but the evidence on their effectiveness is mixed.

However, most Americans do not consider such HMOs an attractive option, and many of the proposals for reform rely on looser forms of managed care. If everyone could be cajoled into enrolling in a staff or group model HMO, national health expenditures could drop by as much as 10 percent, and insurable personal health care spending could drop more than 10 percent. Although substantial, that amount represents roughly one year's increase in health care spending. Thus, although managed care could lower the level of current health expenditures, it probably would not affect the long-term growth of those costs.

Reforming the medical malpractice system is another strategy for controlling costs, and it shows up frequently in proposals for health reform. Changing this system may well be a desirable thing to do, but it is unlikely to have much effect on either the level or rate of growth of health care spending in the nation. Overall, malpractice premiums amounted to less than 1 percent of national health expenditures in 1991. Many argue that the indirect costs

of our malpractice system, which have been labeled defensive medicine, are where the large savings would be realized.

The evidence on the extent of defensive medicine and its effect on spending, however, is limited and uncertain. Many of the procedures and tests that are characterized as defensive medicine would probably be undertaken for other reasons, and different services would be substituted for many of those that were dropped. Moreover, the threat of malpractice suits may have improved the quality of medical practice in the nation.

Eliminating administrative waste is a third cost-cutting strategy, one that advocates of a government-run, single-payer health care system argue will pay for much or all of the expansion of services implied by a national health insurance system. To be sure, administrative costs are far higher in the United States than they are in many other countries. However, the potential administrative savings that would result from substituting a single-payer system for the current system with its thousands of insurance carriers and individual billing practices have often been greatly exaggerated.

Unrealistic assumptions and weak data are behind the appraisals claiming that more than $100 billion could be saved on insurance administration and providers' administrative costs. More conservative

estimates, including those produced at CBO, suggest that potential savings in administrative costs from a single-payer system are more likely to be around $30 billion to $35 billion.

Contrary to popular impressions, some of the so-called "administrative waste" may indeed be reducing overall health care spending. For example, the system of copayments and deductibles that drives up administrative costs at the same time makes consumers more sensitive to the prices of the services they receive. Utilization reviews also add to the cost of administration, but they do attempt to reduce unnecessary care. Such administrative costs can be viewed as substitutes for the explicit rationing and supply controls that countries with lower administrative costs use to keep health spending in check.

There are no easy or painless ways to control health care costs--spending less means that revenues to providers are reduced and that consumers receive fewer and a different mix of services and amenities. Effective control over costs would almost certainly involve giving up some aspects of our current system that many people find desirable, such as rapid access to new technologies, freedom of choice of provider, and extensive research and development.

WILL HEALTH CARE REFORM REDUCE THE FEDERAL BUDGET DEFICIT?

Many Americans believe that effective reform of the nation's health care system will help to control federal health care costs in the next few years. The Administration projects tentative deficit reductions from health care reform of about $200 billion at the end of 10 years.

Yet, the notion that reforming the system will quickly yield significant savings on the spending side of the federal budget is probably optimistic. Fundamental reform of the system is obviously essential if the growth in health costs is to be stemmed in the long run. But in the short run--say, over the next 10 years--it will be exceedingly difficult to realize significant budgetary savings as long as any reform proposal extends coverage to the uninsured, reduces the high costs facing privately insured people, and maintains all of the other desirable aspects of the current system. That is a tall order.

The uninsured currently number about 35 million people and, although they have access to some medical care now, the uninsured, on average, receive about 50 percent to 70 percent of the medical care provided to people who are fully insured. Reform is likely to seek to eliminate this disparity. But unless the insured population is willing to accept less care, raising the level

of care available to the uninsured will boost overall health costs. The net increase in national health spending of providing the uninsured with coverage similar to private insurance policies could be about $33 billion in 1994. Furthermore, if reform exempts the uninsured from the copayments that are common in most private policies, national health spending could increase by about $50 billion by 1994. Someone will have to pay these additional costs.

The services now received by the uninsured are paid for through various mechanisms. Most hospitals are able to recover the bulk of these unreimbursed costs through subsidies from state and local governments, other nonpatient sources of revenues, and surplus revenues (or profits) from private payers. Surplus revenues from private payers accounted for more than half of the recovery of unreimbursed costs.

This pattern is reflected in the relative reimbursement rates among different payers. In 1990, hospitals were able to charge roughly 28 percent more than their treatment costs for private patients, even though private payers at the same time were making many efforts to control their hospital spending. By contrast, hospitals received payments that were only 80 percent of estimated costs for Medicaid enrollees and 90 percent of estimated costs for Medicare enrollees (see Table 2).

TABLE 2.
HOSPITAL REVENUES AND COSTS, BY PAYER OR OTHER SOURCE, 1990

Payer or Other Source	Revenues: In Billions of Dollars	Revenues: As a Percentage of Total	Costs: In Billions of Dollars	Costs: As a Percentage of Total	Ratio of Revenues to Costs
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.

If health care reform involves a leveling of the reimbursement playing field so that payments by all public and private payers more closely follow costs, the federal government may be able to realize few of the savings from reduced cost growth in the near term. Successful health care reform should improve the efficiency of the nation's health care system and, by focusing providers on cost control, may be able to generate significant cost savings over the long run. But if the savings from health care reform are used first to

cover the uninsured and then to reduce the high costs of private payers, not much will be left to reduce the costs of the federal programs.

Of course, some reform options could increase federal tax revenues significantly. Taxing the employer-paid portion of health insurance, for example, could raise $262 billion over a five-year period. But ending the tax subsidy for health insurance could also raise the number of uninsured.

Although health care reform may not bring budgetary benefits in the near term, it will surely help improve the budgetary and economic outlook in the next century. The main reason for undertaking such reform is that we currently have no control over health spending--neither a market control that balances spending on health against other kinds of purchases in the marketplace nor an administrative control, such as many other advanced countries have, that does the same balancing through the political process. Indeed, right now, we have no process at all for deciding how much to spend on health.

Moreover, with no such decisionmaking process, there is a strong presumption that 14 percent, rising to 19 percent and beyond, is too much of our national income to spend on health. Thus, although health care reform may not solve the nation's problem with the budget deficit, policymakers may

still judge it a success if it could cover the uninsured, reduce the costs to privately insured patients, and maintain high-quality care.

CONCLUSIONS

Should policymakers be concerned about the rapid growth in health care costs? There are many reasons to answer yes. First, health care markets are not truly competitive and therefore do not work very well. Because health care spending does not have to meet the usual market tests, health resources are not allocated in ways that reflect either individual or social preferences. As a result, the nation's health system is prone to spend too much money on tests and procedures that have too little value.

Second, rising health care costs have significantly reduced many people's access to medical care and seem to be creating a dual system of medical treatment in the United States. Although most people enjoy access to the best and latest care in the world, an increasing number of people are shut out.

Third, rising costs place significant burdens on workers. Wages and salaries are lower because more compensation is taken in the form of health

insurance. And labor markets are distorted by the complex rules of employment-based health coverage. Because the costs of insurance are now so high, the availability of health insurance is becoming a more important factor in choosing a job.

Fourth, rising health costs have also put substantial pressures on government budgets. Health programs are gobbling up a large portion of government resources and are threatening to crowd out other priorities, too. At the state level, increases in Medicaid costs will make it more difficult for states to fund other programs or provide tax relief. At the federal level, health spending is the only category of the budget, with the exception of net interest, that is rising as a share of GDP. These budgetary pressures make it difficult for policymakers to deal with the nation's gargantuan federal budget deficit, which diminishes the economic prospects of the nation's children and grandchildren.

Whether the nation wants to undertake a fundamental restructuring of its health care system or tinker around with incremental reforms is a decision that is yet to be made. Fundamental health care reform is a difficult and complex undertaking, one that would involve a good deal of redistribution and some wrenching institutional restructuring.

We are only in the initial stages of considering the issue. Beginning the debate with a clear understanding of the current system--how it works, its strengths and weaknesses, its economic ramifications--will increase the odds that health reform, as it eventually develops, will not be based on misconception and misunderstanding and therefore will be successful.