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# TESTIMONY

Statement of
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Director
Congressional Budget Office

before the
Subcommittee on Health and the Environment
Committee on Energy and Commerce
U.S. House of Representatives

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NOTICE

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**CONGRESSIONAL BUDGET OFFICE**
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Mr. Chairman, I appreciate the opportunity to appear before this Subcommittee to discuss trends in the number of people without insurance and the costs of health care. In addition, I will describe the effectiveness of various strategies for controlling health care costs in the United States.

## OVERVIEW OF THE HEALTH CARE SYSTEM

The U.S. health care system has many strengths. Because of the resources devoted to research and because our current financing system encourages the rapid dissemination of new technologies, we are able to provide the highest quality care in the world. The substantial majority of the population--those with health insurance-have access to care without waiting and there are few limits on our choices of providers, types of health coverage, and alternatives for treatment.

Yet, over the past two decades, criticisms of the health care system have grown: substantial numbers of people remain without health insurance, either private or public, and health care spending per person is much higher than in other countries and is rising faster than the gross national product. Since policies to address one of these problems may cause a worsening of the other one, we may anticipate further deterioration of insurance coverage or continued rapid increases in spending for health care.

In March 1990, 70 percent of the nonaged population had health insurance through an employment-based group, either because their own employer offered it or because they were insured as a dependent of a worker whose employer offered group coverage (see Appendix Table 1). Another 8.5 percent of the nonaged population were insured through a public program--Medicaid (6.7 percent), Medicare (1.4 percent), or the VA (0.4 percent). Nearly 7 percent were insured through individual insurance policies unrelated to employment. The remaining 15.3 percent of the nonaged population--about 33 million people--were without insurance coverage. (Because more than 99 percent of the elderly participate in Medicare, they make up a negligible proportion of the uninsured.)

Three-fifths of the uninsured were poor or near-poor--those with incomes less than 200 percent of poverty (see Appendix Table 2). Children were somewhat less likely than others to be uninsured--13.3 percent of children were uninsured versus 15.3 percent of the nonaged population overall. Moreover, although white people account for 78 percent of the uninsured, nonwhite people are much more likely to lack coverage.

## Employment-Based Insurance

Excluding employer-paid fringe benefits from the taxable income of the employee encourages the substantial reliance on employment-based group insurance to provide financial protection against health care costs. For example, an employee with a marginal federal income tax rate of 15 percent, a federal payroll tax rate of nearly 8 percent, and a state income tax rate of 5 percent, is able to obtain $1 worth of health insurance coverage paid by an employer at a marginal cost to the employee that is equivalent to about 67 cents of after-tax income.

Excluding the employer-paid share of health insurance from taxable income provides a federal subsidy for group insurance of about $48 billion in 1991. Estimates show that similar provisions in state income tax codes provide another $8 billion to $10 billion in subsidy annually. Despite these subsidies, not all employers offer health insurance. About 80 percent of the uninsured are in the workforce or are in a family where at least one person is employed. Only 19.4 percent of the uninsured have no family connection to the employed labor force (see Appendix Table 3).

A major factor affecting the availability of employment-based group insurance is the size of the employing firm. Only 39 percent of firms with

fewer than 25 workers offer insurance, but virtually all firms with 100 or more workers do so (see Appendix Table 4). Moreover, regardless of their size, firms that do not offer health insurance have substantially higher proportions of low-income workers than firms that do offer health insurance. In addition, the decline in the proportion of full-time workers with employment-based health insurance--from 77.2 percent in 1982 to 73.8 percent in 1987--appears to have primarily affected low- and moderate-wage workers. With health care costs rising much more rapidly than wages, this gradual erosion of health insurance coverage is likely to continue. It may be offset in part, however, by Medicaid eligibility continuing to expand, which will occur through the beginning of the next century.

One reason that small firms are less likely to offer insurance may be that the administrative costs associated with small groups are very high. Firms with fewer than 50 employees face administrative costs of at least 25 percent of the cost of benefits, compared with 12 percent or less for groups with 500 or more employees.

## Consequences and Possible Responses

People without insurance use fewer services than do the insured and, although some of the forgone services may be of limited value, important ones are apparently also not obtained. A recent study of five medical procedures that are expensive and have a substantial discretionary element found that, among the hospitalized, those without insurance were 29 percent to 75 percent less likely to undergo the procedures, even though the uninsured were sicker when they were admitted. Uninsured patients were also significantly more likely to die in the hospital, even after adjusting for factors such as their poorer health. Clearly, the consequences of being uninsured can be severe, both for the individual and for society.

In response to concerns about the problems the uninsured face in obtaining access to health care, a number of options to expand coverage to more people have been considered. They include:

- Establishing new tax subsidies that would provide incentives for individuals to purchase insurance;

- Changing federal regulations to increase the availability of health insurance for small groups and for high-risk individuals;

- Mandating that employers provide health insurance to their workers;

- Expanding the Medicaid program to cover all people under the federal poverty level and to permit other low-income people to "buy-in" to Medicaid; and

- Establishing a universal health plan that would cover everyone under one program.

CBO is releasing today a study titled Options to Expand Health Insurance Coverage, which was prepared at the request of this Subcommittee, that examines several of these options.

Because all of these proposals would raise national health spending and the federal budget deficit, enacting any of them at a time when spending for health is growing at an annual rate of 10 percent to 12 percent a year would be difficult, unless policies that would effectively control costs were also put in place. To date, however, our varied efforts to contain health care costs have been notably ineffective.

In 1989, the United States spent $604 billion on health care--or about $2,400 per person. The annual rate of increase in real per capita spending between 1980 and 1989 was 4.4 percent. Even if we assume that the annual rate of increase will be considerably lower in the 1990s--for example, 3.3 percent--we would spend almost $3,400 per person (in 1989 dollars) on health care in the year 2000. Moreover, the United States already spends much more on health than do other developed countries--11.8 percent of gross domestic product in 1989, compared with 8.7 percent in Canada, 8.2 percent in the former West Germany, 6.7 percent in Japan, and 5.8 percent in the United Kingdom (see Appendix Figure 1).

As health spending has risen, its distribution by payer has also changed. The share of personal health spending that householders pay out-of-pocket declined from 39.5 percent to 23.5 percent between 1970 and 1989. In contrast, private insurance payers and governments have taken on an increasing share. Private insurance accounted for 23.4 percent of health spending in 1970 and 32.6 percent in 1989, while federal, state, and local governments paid for 34.6 percent in 1970, before Medicare and Medicaid were enacted, but 40.6 percent in 1989 (see Appendix Figure 2).

## Impact on Consumers

Even though out-of-pocket spending has declined as a share of total health expenditures, it was relatively stable as a percentage of after-tax income--just below 5 percent over the past two decades (see Appendix Figure 3). Medicare beneficiaries, however, not only spend a much higher proportion of their income on health care than the average household, but they have also seen this proportion rise fairly steadily--from 7.8 percent in 1972 to 1973 to 11.5 percent in 1989.

In fact, a small fraction of the population each year accounts for an exceptionally high proportion of total spending for health care. In 1980, the 50 percent of the population with the lowest health bills accounted for only 2 percent of total health spending, while the 10 percent with the highest expenditures accounted for 75 percent. This pattern holds for the population under age 65, not just for the aged population.

## Impact on Providers

During the past decade, much of the effort to control health care costs has focused on hospital spending--both through managed care that attempts to

control hospital admissions and lengths of stay and through Medicare's Prospective Payment System. Nevertheless, during that period, hospital spending continued to rise. For example, in 1980, we spent $154 billion (in 1989 dollars) on hospital care, compared with $233 billion in 1989. This growth was the result of a striking 64 percent increase in real spending per admission between 1980 and 1989, which more than offset the 13 percent drop in admissions.

Higher spending for hospital care went hand in hand with higher hospital margins on total revenues over much of this period. Although hospital margins declined from 5.9 percent to 4.8 percent between 1985 and 1990, these margins are still substantially higher than those present between 1965 and 1975 (see Appendix Figure 4).

Spending for physicians' services increased even more rapidly than spending for hospital services over the past decade. In 1980, we spent $268 per person (in 1989 dollars) on physicians' services; by 1989, we were spending $458 per person--a 70 percent increase in real spending per person over a nine-year period.

Physicians' incomes, after expenses, also rose during the 1980s--nearly 20 percent in real terms between 1981 and 1987. U.S. physicians earn

considerably more than their colleagues in other countries, both in absolute and in relative terms--around 50 percent more than physicians in Canada and West Germany, and nearly three times as much as physicians in the United Kingdom and Japan. While U.S. physicians earned five times the average compensation of all U.S. workers in 1986, physicians in other countries earned only two to four times the average worker's compensation (see Appendix Figure 5).

## Impact on the Federal Budget

The rapid growth of national spending for health care, overall and per capita, also has significant implications for the federal budget. In 1970, spending on health constituted 7.1 percent of the federal budget. By 1990, that share had grown to 13.4 percent. Even more disturbing, CBO is projecting that health care will account for 19.5 percent of federal spending by 1996 (see Appendix Table 5).

Medicaid. The fastest growing component of federal health expenditures is the Medicaid program. After taking general inflation into account, we project that real federal Medicaid expenditures will rise at an average annual rate of 10.5 percent between 1990 and 1996. The corresponding growth rates

projected for Medicare and all other federal health expenditures are 6.1 percent and 4.4 percent, respectively. Consequently, Medicaid, which accounted for 24.5 percent of federal health expenditures in 1990, will account for nearly 30 percent of federal health expenditures by 1996.

Rising Medicaid expenditures also affect state budgets. According to the National Association of State Budget Officers, Medicaid expenditures increased on average from 10.2 percent of state budgets in 1987 to 12 percent in 1990.

Several factors may have contributed to the recent rapid rise in Medicaid expenditures, including the options and mandates to expand eligibility for pregnant women, infants, children, the elderly, and the disabled, and state initiatives to enroll more eligible people. The recession could also lead to increases in the eligible population, although data are not yet available to assess its impact.

Estimating the budgetary impact of changes in eligibility for different groups is difficult because states have varied widely in the timing, nature, and magnitude of their responses. Nonetheless, Medicaid expenditures rose significantly for adults and children in low-income families in 1989, only a portion of which was because of the larger numbers of program participants

(see Appendix Table 6). After taking general inflation into account, expenditures for adults and children in low-income families grew by 12 percent and 12.6 percent, respectively, but the actual numbers of recipients in both categories rose by 3.9 percent and 2.8 percent. Thus, higher expenditures per person accounted for the greater part of the increase in expenditures. Preliminary data for 1990 suggest that this pattern is continuing.

In spite of the recent rapid growth in expenditures for pregnant women, infants, and children, total Medicaid expenditures are still dominated by spending for the elderly and the disabled (see Appendix Table 7). In 1989, almost 70 percent of Medicaid recipients were adults and children in low-income families. Yet, they accounted for only about one-quarter of Medicaid payments, if only because the average Medicaid payment per person in low-income families was less than $1,000 compared with almost $6,000 per person for the elderly and the disabled. This difference largely reflects the extensive use of long-term care services by the elderly and the disabled. In 1989, for example, approximately 40 percent of all payments for Medicaid-covered services went to nursing homes.

Medicare. The annual rate of real growth in Medicare spending per enrollee was also substantially higher than growth rates in health spending per person in the nation throughout the 1970s and in the first half of the 1980s. But

Medicare's real growth in spending per enrollee moderated during the last half of the 1980s to 3.2 percent--a figure considerably less than the 4.6 percent the nation experienced (see Appendix Figure 6).

Most of the decline in growth in the last half of the 1980s stemmed from a substantial drop in the rate of increase in Medicare's spending for hospital services. While the real rate of growth in physician spending also declined somewhat, it continued at a 7.2 percent annual rate per enrollee during the 1985-89 period compared with 0.5 percent for hospital spending (see Appendix Figure 7).

The average annual real rate of growth of per capita spending for hospital care in the nation, however, was essentially stable over the 1980s, even though the rate of growth in Medicare's spending dropped substantially. This pattern illustrates a major factor in our inability to gain better control over health spending. In our multiple-payer system, successful efforts by one payer to reduce the growth in costs appear to be offset by more rapid increases in costs for other payers.

## EVIDENCE ON COST CONTROL POLICIES

A number of strategies might be used to control health care costs, including:

- Greater cost-sharing by consumers;
- Managed care and other forms of controls on use;
- Price controls;
- Increased competition among providers and insurers; and
- Regulatory policies, such as hospital rate-setting and certificate-of-need programs.

### Cost Sharing

Policymakers have frequently discussed--though not expanded--cost-sharing as a means to increase control over health care costs. In fact, the proportion of expenditures on personal health that consumers paid out-of-pocket declined over the past decade, thereby actually contributing to the increase in health

spending. Even so, the United States remains significantly different from most other countries. For example, out-of-pocket costs were 7 percent in the former West Germany in 1985 and 3 percent in the United Kingdom in 1987. Evidence from studies of the effect of cost sharing on spending for health services does suggest that, if out-of-pocket costs were raised, use of services and total spending on health would decline. Such a reduction in spending would probably have a greater impact on low-income people than on others.

## Managed Care

Managed care attempts to reduce inappropriate and unnecessary care by reviewing treatment decisions for specific individuals and, in some cases, limiting the patient's choice of providers. During the 1980s, the proportion of the population in managed care grew dramatically. In 1988, 48 percent of those with traditional insurance had some degree of managed care as part of their insurance package, 35 million were in health maintenance organizations (HMOs), and 18 million were in preferred provider organizations.

As for the impact of managed care, evidence indicates that only staff and group model HMOs--where the doctors are part of the HMO and have no independent practice--are clearly effective in reducing use and costs. Most

people are in much more loosely structured managed care arrangements, which have not consistently had a significant effect on spending. In addition, although the health care of nearly half the privately insured population is now subject to some type of review, its expansion appears to have had little or no effect on the overall level of spending on health. Furthermore, the administrative costs of monitoring individual patients and decisions about treatment can be high. Other countries do not monitor individual patients and procedures, but instead monitor and review providers, using data systems that include all patients. This process makes it possible to identify physicians who routinely deviate from standard practices.

## Price Controls

Price controls are another method for controlling health costs. They have been used over the past decade, particularly by Medicare and Medicaid. When price controls are imposed, however, the volume of services rises. Controls may also adversely affect access to care if they are imposed for only one group, while providers can obtain higher prices for serving other groups. If price controls were applied uniformly to the whole health care system, they would have greater potential to control health care costs, although responses

in volume would still occur unless uniform monitoring of providers was also instituted.

Another approach to controlling prices is the all-payer hospital rate-setting strategy that has been tried for various periods in Maryland, Massachusetts, New York, and New Jersey. These states set the payment levels that hospitals received for providing services and required that all payers in the state--both private and public--use those rates. Studies of all-payer systems have shown that they generated a significant one-time drop in hospital spending of between 2 percent and 13 percent and also lowered the rates of growth in spending.

## Competition

Another strategy for controlling health care costs that has been widely advocated is increased competition. Competition did increase among insurers and providers during the 1980s, but costs have not been reduced. Because consumers directly pay only a fraction of the full cost of their health insurance premiums and of the health services they use, most competition is apparently on the basis of generosity of benefits, amenities, and quality rather than on

price. Increased competition appears to have made consumers better off by giving them more choices, but it has had little effect on spending.

## Regulatory Policies

A substantial amount of the growth in spending for health care--as much as 10 percent to 15 percent-appears to be associated with new technologies. Indeed, some have suggested that, if health care costs were to be controlled, it would be essential to limit the growth of technology. The health planning and certificate-of-need programs that the federal government required of the states in the late 1970s and 1980s, however, were ineffective in controlling growth in capital and new technologies, perhaps because they were applied in a nonsystematic way in most states. Other countries, however, do impose limits on capital and new technologies that seem to be effective--Canada, for example, had only 1 piece of magnetic resonance imaging (MRI) equipment for every 2 million people in 1989, compared with 7.4 for every 2 million people in the United States in 1987.

Finally, imposing limits on expenditures is a strategy that has been used in other countries and by Medicare for spending on physicians' services. Limits could be established in several ways:

- Global budgeting for hospitals would set hospital budgets prospectively, so hospitals would not gain from admitting more people or from doing more than necessary;

- Targets for spending on physicians' services would set penalties for exceeding targets, usually in the form of lower fees in the future; and

- Expenditure caps would place absolute limits on spending.

All of these strategies could control spending, but their effectiveness would depend on how the limits were set and how stringently they were enforced.

## CONCLUSION

Controlling costs in the United States is more difficult than in other countries that have coordinated health care policies or centralized health care systems. But one could achieve greater control over costs through a combined strategy that might include: eliminating first-dollar insurance coverage; monitoring medical care at the provider level; setting uniform payment levels for providers; controlling the growth of capital and technology, with goals set at

a national or regional level; and establishing effective national and regional expenditure limits.

Without significant changes, we are unlikely to achieve greater control over health care spending than we did in the 1980s, when real spending per person increased at an annual rate of 4.4 percent. Also, without cost containment, it will be more difficult to address the other major failure of our health care system-the large and growing number of people in the United States without health insurance coverage.

But to control costs we would have to make concessions regarding some elements of our present system that many perceive as desirable. Such concessions are likely to have adverse impacts on research and development, access to new technologies and treatments, and the freedom to choose insurance coverage, providers, and alternative treatments. Whether these trade-offs are desirable would depend on the priority the nation places on controlling costs as against maintaining these other characteristics of our current health care system.

# APPENDIX TABLES AND FIGURES

**TABLE A-1.** HEALTH INSURANCE COVERAGE OF THE NONAGED POPULATION, BY SOURCE OF COVERAGE, 1990

| Insurance Status and Source of Coverage | Number of of People (Millions) | Percentage of Nonaged Population |
|---|---|---|
| Total | 216.7 | 100.0 |
| Insurance Status | | |
| Insured | 183.6 | 84.7 |
| Not insured | 33.1 | 15.3 |
| Source of Insurance Coverage [a] | | |
| Employment-based | 150.6 | 69.5 |
| Other private | 14.6 | 6.7 |
| Public | 18.4 | 8.5 |
| Medicaid | 14.6 | 6.7 |
| Medicare | 3.0 | 1.4 |
| Veterans Affairs | 0.8 | 0.4 |

SOURCE: Congressional Budget Office calculations based on data from the Current Population Survey, March, 1990.

a. "Source of Insurance Coverage" refers to the individual's primary insurance coverage when there are multiple sources of insurance coverage.

TABLE A-2. CHARACTERISTICS OF THE NONAGED UNINSURED POPULATION, MARCH 1990

| Characteristics | Number of Uninsured People (Millions) | Percentage of Uninsured People | Percentage of the Nonaged Population With These Characteristics Who Are Uninsured |
|---|---|---|---|
| Total Uninsured | 33.1 | 100.0 | 15.3 |
| Age and Sex | | | |
| Children under age 18 | 8.5 | 25.7 | 13.3 |
| Young adults, ages 18 to 24 | 6.4 | 19.2 | 25.1 |
| Adults, 25 to 54 | 15.7 | 47.0 | 14.9 |
| Adults, 55 to 64 | 2.5 | 7.4 | 11.6 |
| Income Level | | | |
| Below the poverty level | 9.5 | 28.8 | 33.4 |
| 100 percent to 199 percent of poverty | 10.5 | 31.8 } 60.6 | 28.5 |
| 200 percent of poverty and above | 13.0 | 39.3 | 8.6 |
| Race | | | |
| White | 25.6 | 77.5 | 11.1 |
| Black | 5.8 | 17.5 | 14.1 |
| Other | 1.7 | 5.0 | 20.1 |

SOURCE: Congressional Budget Office calculations based on data from the Current Population Survey, March, 1990.

NOTE: Details may not add to totals because of rounding.

TABLE A-3. WORK FORCE CONNECTIONS OF THE NONAGED UNINSURED, MARCH 1990

| Relationship to Work Force | Number of Uninsured People (Millions) | Percentage of Uninsured People | Percentage of the Nonaged Population With These Characteristics Who Are Uninsured |
|---|---|---|---|
| | Total | | |
| Total Uninsured | 33.1 | 100.0 | 100.0 |
| | **Work Force Connection** | | |
| Employed | 16.1 | 48.7 } 80.6 | 14.2 |
| Dependent of employed person | 10.6 | 31.9 | 14.4 |
| Unemployed or not in labor force | 6.4 | mm | 21.6 |
| | **Employment Level** | | |
| Full-time workers | 13.4 | 40.4 | 12.6 |
| Dependents of full-time workers | 9.0 | 27.2 | 13.3 |
| Part-time workers | 2.7 | 8.2 | 34.2 |
| Dependents of part-time workers | 1.6 | 4.7 | 28.7 |
| None | 6.4 | 19.4 | 21.6 |

SOURCE: Congressional Budget Office calculations based on data from the Current Population Survey, March, 1990.

NOTES: Workers include anyone reporting that they were employed during the survey week, including those not at work.

The allocation among workers, dependents of workers, and those with no connection to the work force is based on the status of the individual. However, for those with a work force connection, the connection is classified as full time if anyone in the family works full time.

Full-time work is defined as 35 hours or more per week.

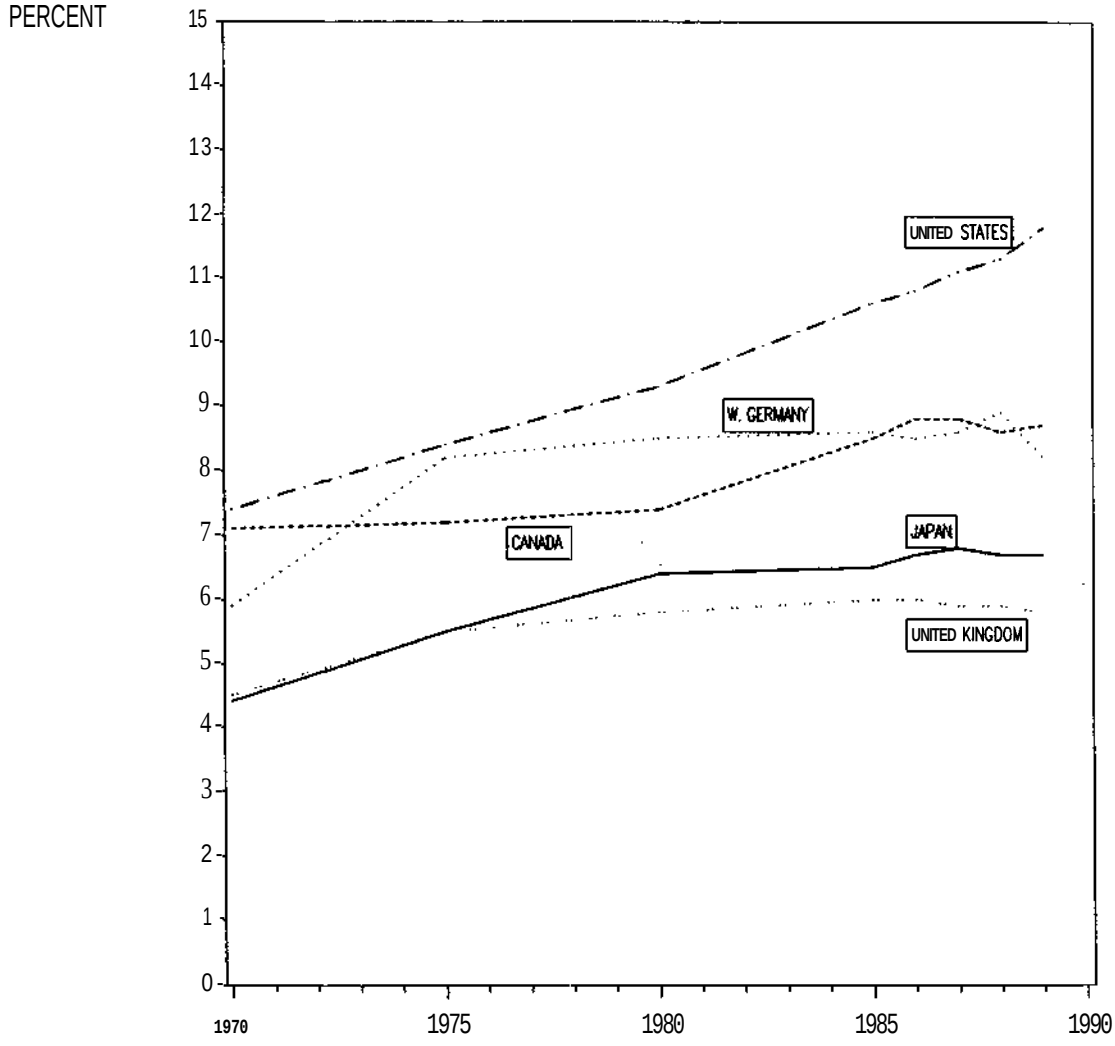
TABLE A-4. AVAILABILITY OF EMPLOYMENT-BASED INSURANCE PLANS, BY FIRM SIZE, 1989

| Size of Firm (Number of employees) | Percentage of Firms Offering Insurance | Percentage of Employees in Firms Offering Insurance |
|---|---|---|
| Under 25 | i | 55 |
| Under 10 | 33 | 42 |
| 10-24 | 72 | 70 |
| 25-99 | 94 | 94 |
| 100-499 | 99 | 97 |
| 500-999 | 100 | 100 |
| 1,000 and Over | 100 | 100 |
| Total | 43 | 77 |

SOURCE: Congressional Budget Office from the 1989 Employer Survey by Health Insurance Association of America.

FIGURE A-1.

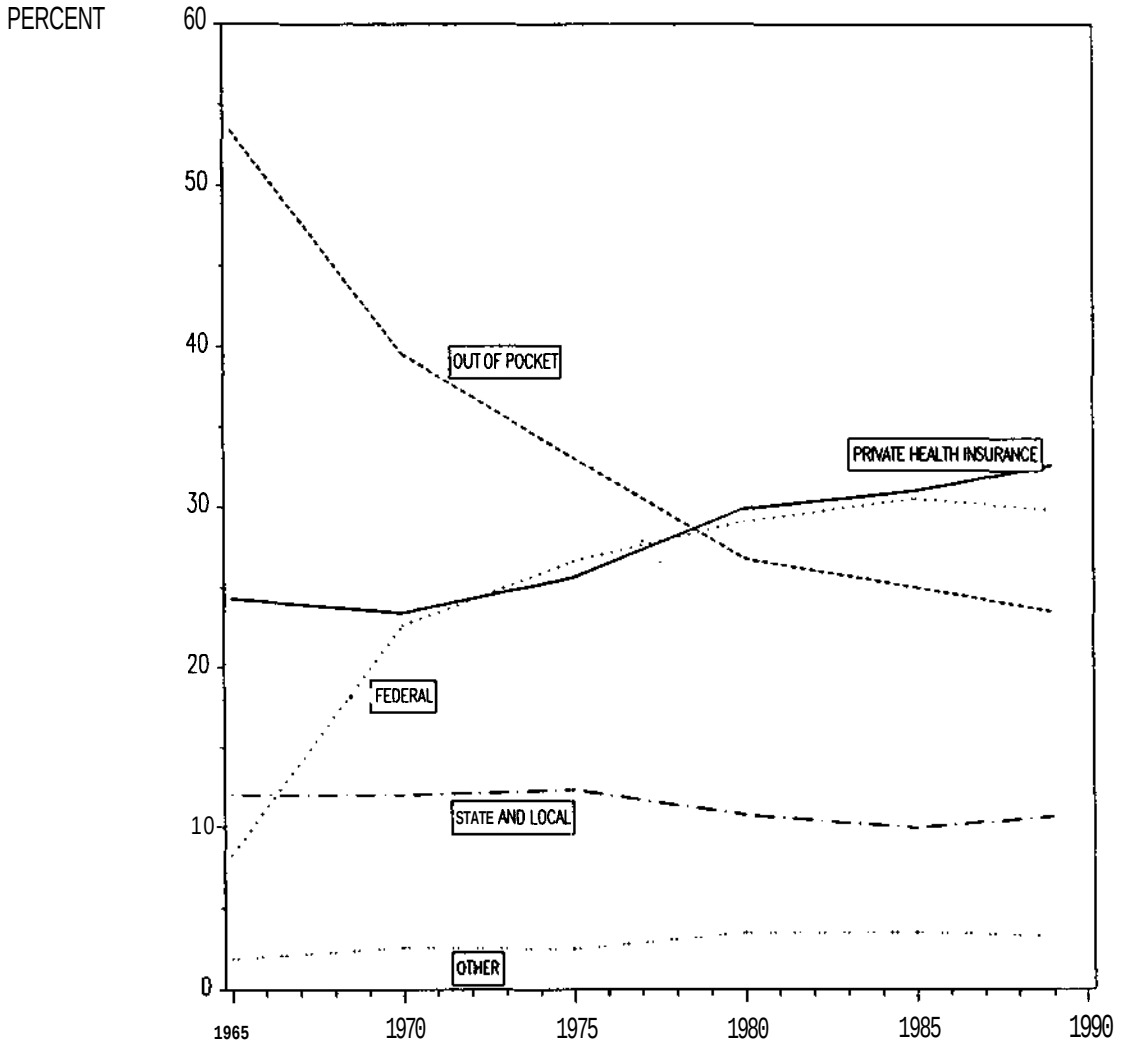
HEALTH EXPENDITURES AS A PERCENTAGE OF GROSS DOMESTIC PRODUCT, IN THE UNITED STATES AND SELECTED COUNTRIES, 1970-1989




SOURCE: Congressional Budget Office calculations based on data from G. Schieber and J.-P. Poullier "International Health Spending: Issues and Trends", *Health Affairs*, Spring 1991.

NOTE: Gross domestic product (GDP) is equal to gross national product less net property income from abroad. Use of GDP for international comparisons of health spending eliminates variations arising from differences in the role of foreign transactions in different economies.

FIGURE A-2.
DISTRIBUTION OF PERSONAL HEALTH CARE EXPENDITURES BY SOURCE OF PAYMENT, 1965-1989

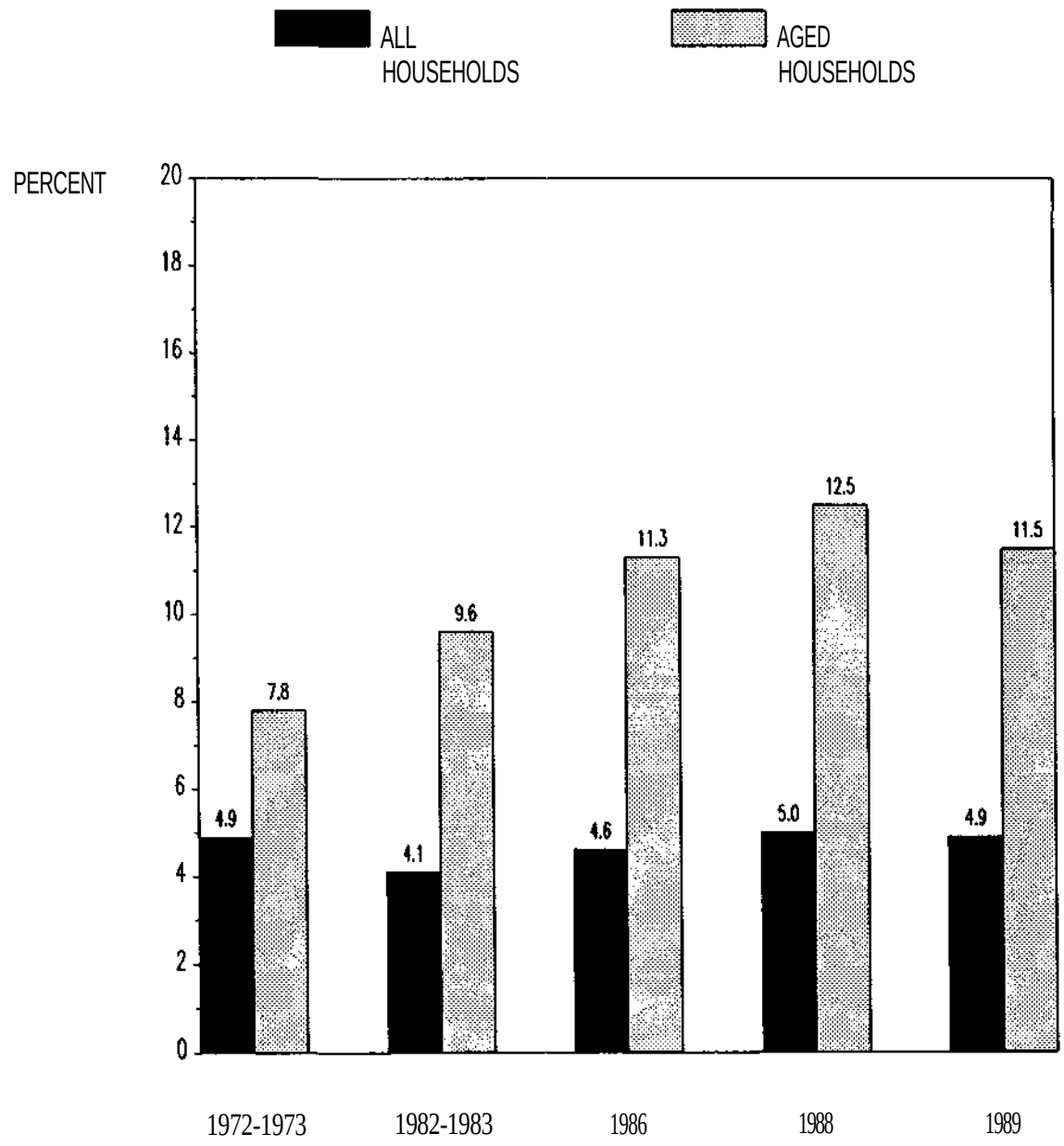



SOURCE: Congressional Budget Office calculations based on data from the Health Care Financing Administration, Office of the Actuary, 1991.

NOTES: Personal health care expenditures are equal to national health expenditures less spending for research, construction, and administrative costs.

The "other" category includes philanthropy and industrial in-plant spending for health.

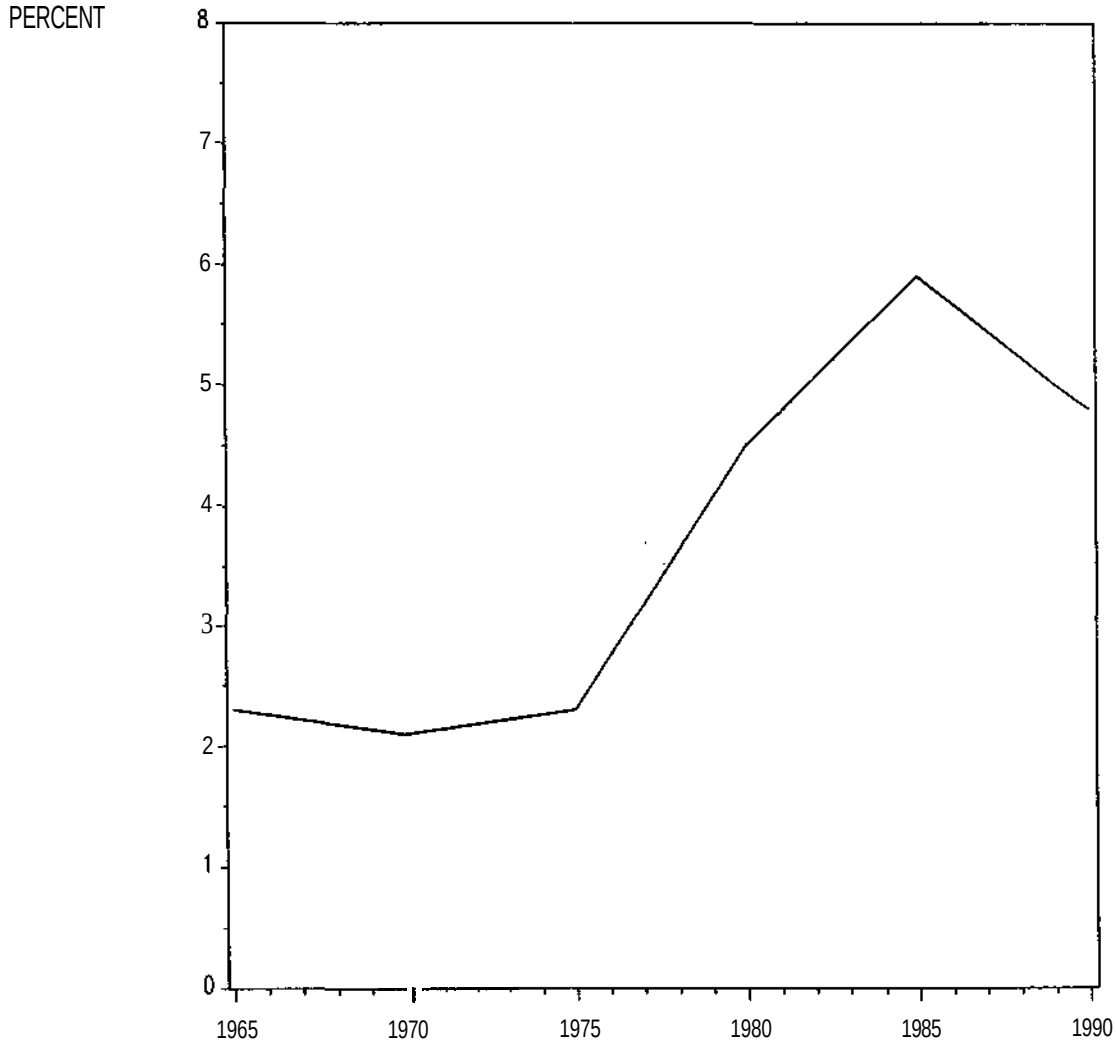
FIGURE A-3,
DIRECT OUT-OF-POCKET SPENDING FOR HEALTH AS A PERCENTAGE OF AFTER-TAX INCOME




SOURCE: Congressional Budget Office calculations, using data from the Consumer Expenditure Survey of the Bureau of Labor Statistics.

NOTE: Data are tabulated by age of surveyed person. Aged households are those in which the surveyed person is age 65 or over. Such households may include some individuals under age 65. The decline in direct out-of-pocket spending as a share of after-tax income for aged households between 1988 and 1989 may be due, in part, to the Medicare Catastrophic Coverage Act of 1988 which was partially in place in 1989, but repealed subsequently.

FIGURE A-4.
HOSPITAL MARGINS BASED ON TOTAL REVENUES, 1965-1990

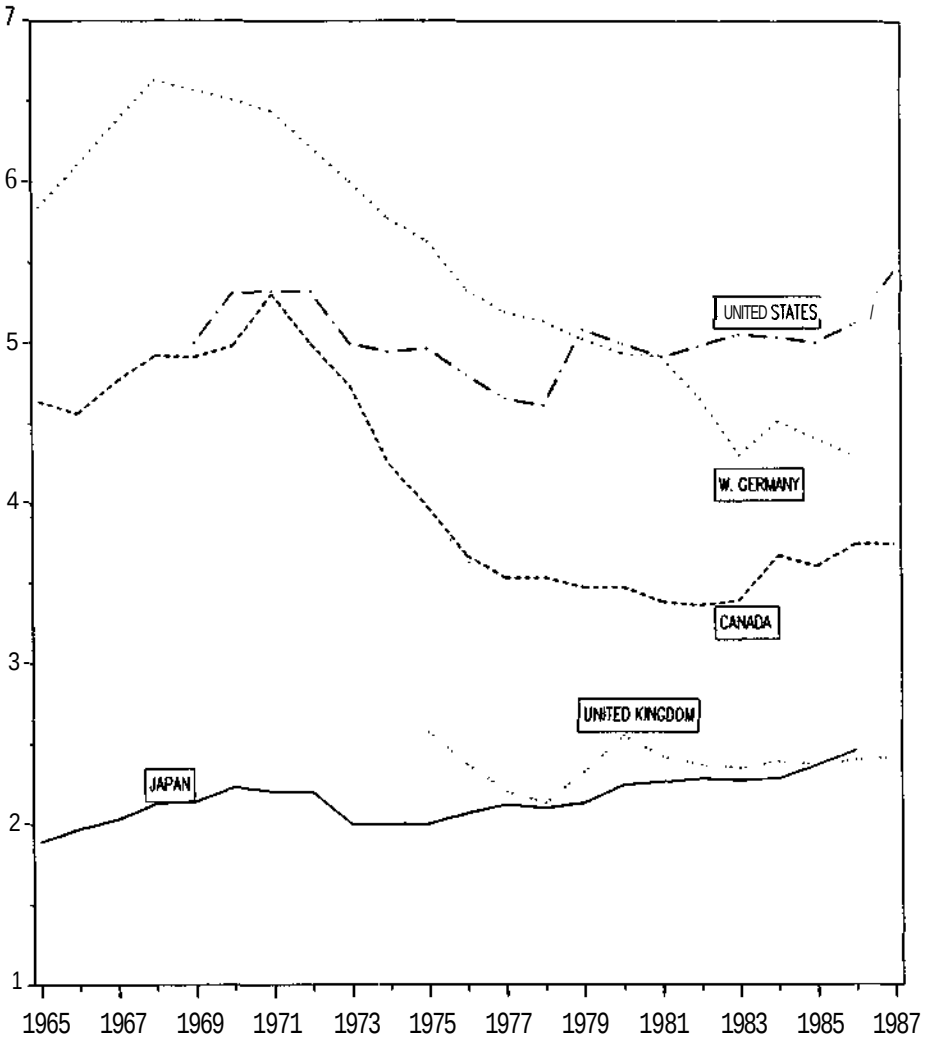



SOURCE: Congressional Budget Office calculations based on data from the American Hospital Association, National Hospital Panel Surveys, 1965-1990.

NOTE: The total margin is defined as the ratio of aggregate total revenues minus aggregate total costs to aggregate total revenues.

**FIGURE** A-5.

RATIO OF AVERAGE INCOME OF **PHYSICIANS** TO AVERAGE COMPENSATION OF ALL **EMPLOYEES**, UNITED STATES AND SELECTED **COUNTRIES**, 1965-1987




SOURCE: Congressional Budget Office calculations based on data from the Organization for Economic Cooperation and Development, Health Data File, 1989, as reported in the *Health Care Financing Review, 1989 Annual Supplement.*

NOTES: Data for the following years were missing and values were imputed by the Congressional Budget Office: 1971, 1976, 1980, and 1984 for the United States; 1966, 1967, 1969, 1970, 1972, and 1973 for West Germany; and 1985 for Japan. Data missing at the beginning and end of the time periods were not imputed.

The concepts and methods of estimating used to compile average compensation per employee are not the same across countries, nor necessarily within each country over time. Among the issues that cannot be taken fully into account are the regional or national basis of the estimates, whether or not both salaried and self-employed professionals are included in the figures, the exact nature of the professional groups covered, the treatment of part-time workers, and whether or not the income definitions used reflect income-tax, census, or national-accounts concepts.

TABLE A-5. FEDERAL SPENDING ON HEALTH, FISCAL YEARS 1965-1996

| | 1965 | 1970 | 1975 | 1980 | 1985 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | In Billions of Dollars | | | | | | |
| Total Federal Spending | 118.2 | 195.6 | 332.3 | 590.9 | 946.3 | 1,251.7 | 1,401.6 | 1,476.2 | 2,493.2 | 1,548.4 | 1,549.1 | 1,632.3 |
| Federal Health Spending | 3.1 | 13.9 | 29.5 | 61.8 | 108.9 | 168.0 | 188.6 | 214.0 | 235.3 | 259.3 | 286.2 | 318.4 |
| Medicare | n.a. | 6.2 | 12.9 | 32.1 | 65.8 | 98.1 | 104.7 | 116.9 | 128.3 | 142.1 | 157.7 | 176.7 |
| Medicaid | 0.3 | 2.7 | 6.8 | 14.0 | 22.7 | 41.1 | 50.8 | 58.7 | 66.2 | 74.7 | 84.1 | 94.7 |
| Veterans Affairs | 1.3 | 1.8 | 3.7 | 6.5 | 9.5 | 12.1 | 12.5 | 13.9 | 14.4 | 15.3 | 16.0 | 16.9 |
| Other | 1.5 | 3.2 | 6.1 | 9.2 | 10.9 | 16.6 | 20.6 | 24.4 | 26.3 | 27.2 | 28.3 | 30.1 |
| | | | | | | **As a Percent of Total** Federal Spending | | | | | | |
| Federal Health Spending | 2.6 | 7.4 | 8.9 | 10.5 | 11.5 | 13.4 | 13.5 | 14.5 | 15.8 | 16.7 | 18.5 | 19.5 |
| | | | | | | **As a Percentage of Federal Spending on Individual Health Programs a/** | | | | | | |
| Federal Health Spending | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Medicare | n.a. | 44.6 | 43.7 | 51.9 | 60.4 | 58.4 | 55.5 | 54.5 | 54.5 | 54.8 | 55.1 | 55.5 |
| Medicaid | 9.7 | 19.4 | 23.1 | 22.7 | 20.8 | 24.5 | 26.9 | 27.4 | 28.1 | 28.8 | 29.4 | 29.7 |
| Veterans Affairs | 41.9 | 12.9 | 12.5 | 10.5 | 8.7 | 7.2 | 6.6 | 6.5 | 6.1 | 5.9 | 5.6 | 5.3 |
| Other | 48.4 | 23.0 | 20.7 | 14.9 | 10.0 | 9.9 | 10.9 | 11.4 | 11.2 | 10.5 | 9.9 | 9.4 |

SOURCE: Congressional Budget Office calculations and projections.

NOTES: Medicare expenditures are shown net of premium income.
"Other" includes federal employee and annuitant health benefits, as well as other health spending.
"Total health spending" excludes spending for the CHAMPUS program.

The baseline numbers shown do not take into account discretionary caps. A small portion of the increase in share of the federal spending accounted for by health in 1990 to 1996 is the result of substantial spending for deposit insurance in the first years of this period and which will be recovered during the latter years.

a. May not add to 100.0, because of rounding.

TABLE A-6. AVERAGE ANNUAL RATES OF GROWTH OF REAL MEDICAID PAYMENTS AND RECIPIENTS, FISCAL YEARS 1975 TO 1989 (In percent)

| Eligibility Category | 1975-1981 | 1982-1988 | 1988-1989 |
|---|---|---|---|
| All | | | |
| Payments | 6.2 | 5.0 | 6.9 |
| Recipients | .0 | 0.6 | 2.6 |
| Aged | | | |
| Payments | 6.7 | 4.3 | 3.5 |
| Recipients | -1.2 | -0.9 | -0.9 |
| Disabled and Blind | | | |
| Payments | 11.7 | 6.3 | 7.3 |
| Recipients | 3.8 | 1.8 | 3.0 |
| Children in Low-Income Families | | | |
| Payments | 0.6 | 5.2 | 12.6 |
| Recipients | .0 | 0.7 | 2.8 |
| Adults in Low-Income Families | | | |
| Payments | 2.8 | 2.5 | 12.0 |
| Recipients | 2.3 | 0.8 | 3.9 |

SOURCE: Congressional Budget Office calculations based on data from the Health Care Financing Administration (HCFA) 2082 Reports.

NOTES: These data show federal and state expenditures for *Medicaid-covered services*. They exclude Medicare Part A and Part B premiums for dually enrolled people, premiums for capitation plans, program administration and training costs, and payments for state-only enrollees or services. The exclusion of Medicare premiums is particularly problematic and results in an underestimate of expenditures for the elderly and disabled.

Recipients are Medicaid enrollees for whom a payment was made during the reporting period for a Medicaid-covered service.

The GNP fixed-weight deflator was used to calculate Medicaid payments adjusted for inflation.

TABLE A-7. MEDICAID PAYMENTS AND RECIPIENTS, FISCAL YEAR 1989

| Eligibility Category | Payments (Millions of dollars) | Recipients (Millions of people) | Payment Per Recipient |
|---|---|---|---|
| All | 54,500 | 23.5 | 2,300 |
| Aged | 18,560 | 3.1 | 5,900 |
| Blind | 410 | 0.1 | 4,300 |
| Disabled | 20,480 | 3.5 | 5,900 |
| Children in Low-Income Families | 6,890 | 10.3 | 700 |
| Adults in Low-Income Families | 6,900 | 5.7 | 1,200 |
| Other and Unknown | 1,270 | 1.2 | 1,100 |

SOURCE: Congressional Budget Office calculations based on data from the Health Care Financing Administration (HCFA) 2082 Reports.

NOTES: These data show federal and state expenditures for *Medicaid-covered services*. They exclude Medicare Part A and Part B premiums for dually enrolled people, premiums for capitation plans, program administration and training costs, and payments for state-only enrollees or services. The exclusion of Medicare premiums is particularly problematic and results in an underestimate of expenditures for the elderly and disabled.

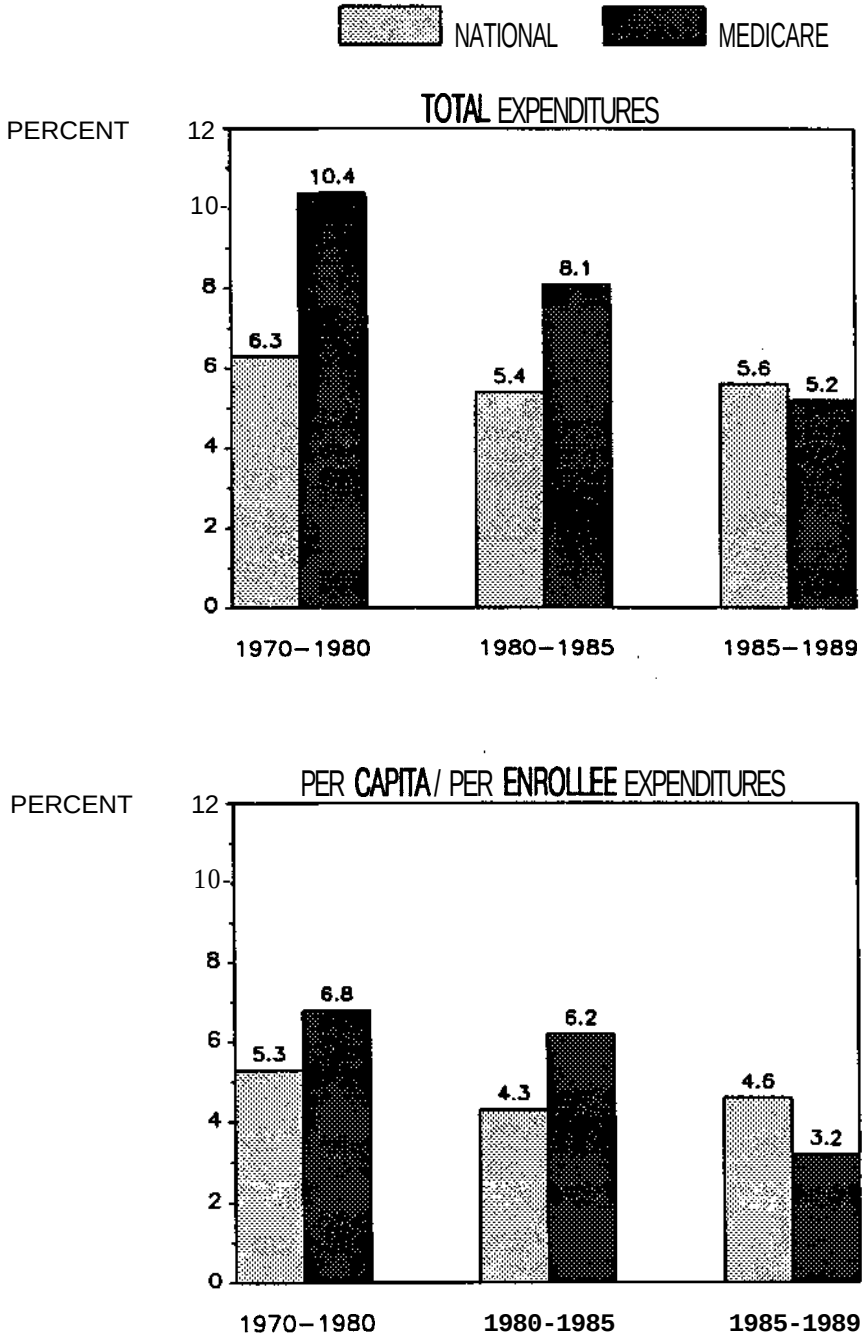
Recipients are Medicaid enrollees for whom a payment was made during the reporting period for a Medicaid-covered service.

The 2082 reports break out the numbers of Medicaid recipients by eligibility category. If a recipient's eligibility category changes during the year, that individual will be counted in more than one category. The total number of recipients is, however, unduplicated. This means, for example, that the percentage of Medicaid recipients who are children in low-income families cannot be estimated exactly, although the built-in error is small.

Components may not add to "All," because of rounding.

FIGURE A-6.

AVERAGE ANNUAL GROWTH RATES OF REAL NATIONAL AND MEDICARE EXPENDITURES FOR HEALTH, TOTAL AND PER CAPITA, 1970-1989

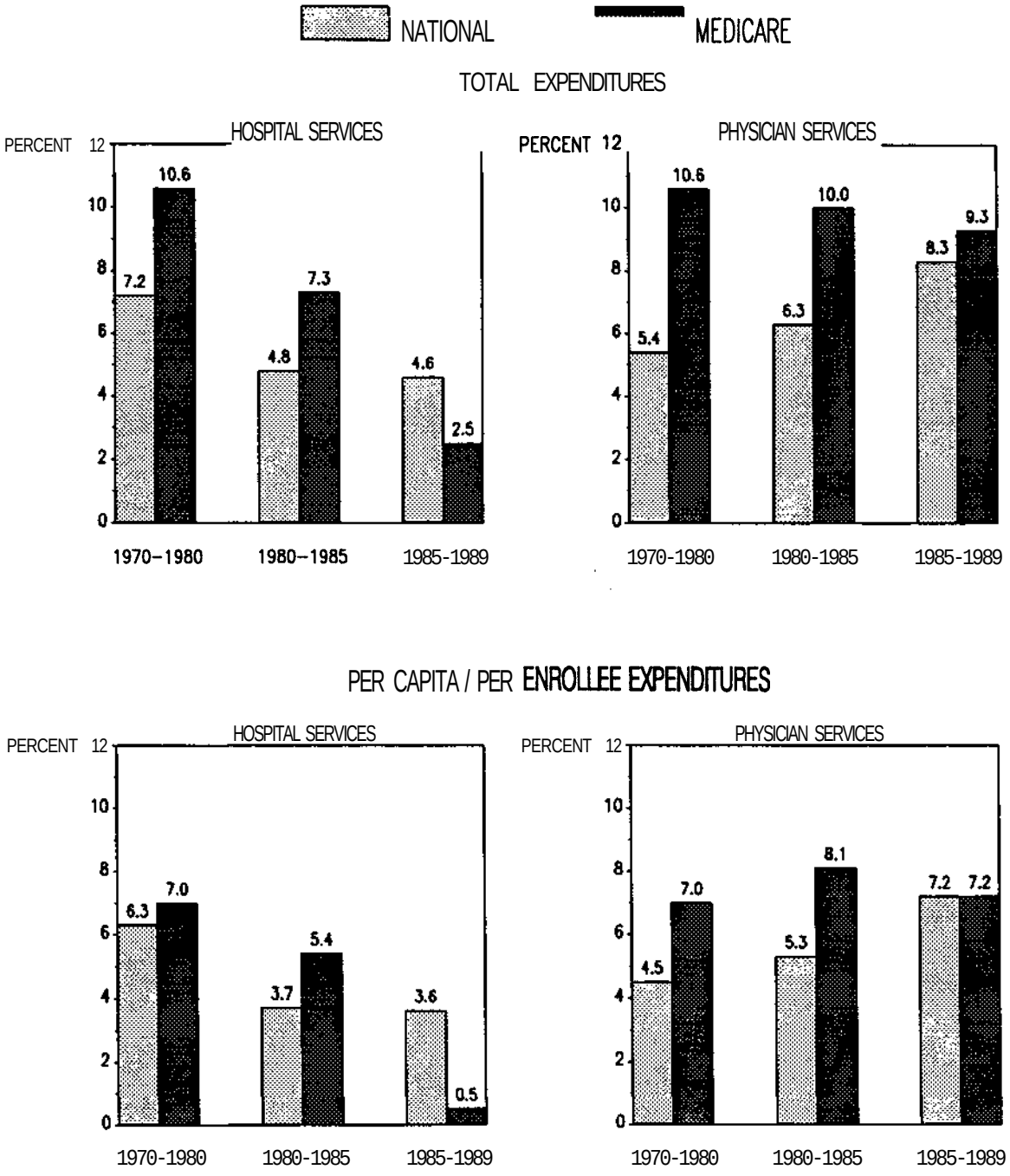



SOURCE: Congressional Budget Office calculations based on data from the Health Care Financing Administration, Office of the Actuary, 1991.

NOTE: Real expenditures are calculated using the GNP fixed-weighted deflator.

FIGURE A-7.

AVERAGE ANNUAL GROWTH RATES OF REAL NATIONAL AND MEDICARE EXPENDITURES FOR HOSPITAL AND PHYSICIAN SERVICES, TOTAL AND PER CAPITA, 1970-1989




SOURCE: Congressional Budget Office calculations based on data from the Health Care Financing Administration, Office of the Actuary, 1991.

NOTE: Real expenditures are calculated using the GNP fixed-weighted deflator.