CBO TESTIMONY

Statement of
Paul N. Van de Water
Assistant Director
for Budget Analysis
Congressional Budget Office

on
Federal Entitlement Spending

before the
Committee on the Budget
United States Senate

February 1, 1995

NOTICE

This statement is not available for public release until it is delivered at 9:30 a.m. (EST), Wednesday, February 1, 1995.

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

Mr. Chairman, I welcome this opportunity to appear before your Committee to describe the outlook for federal entitlement spending and national health expenditures over the coming decade. My presentation today will address three major themes.

- Entitlement spending now represents more than one-half of the budget, and its share will continue to grow for the foreseeable future. Medicare and Medicaid account for virtually all of the projected increase.

- U.S. spending on health will continue to increase as a share of gross domestic product (GDP), with public spending rising more rapidly than private costs.

- Although the spread of managed care appears to have slowed the rate of growth of private health spending, Medicare and Medicaid have yet to reap similar returns.

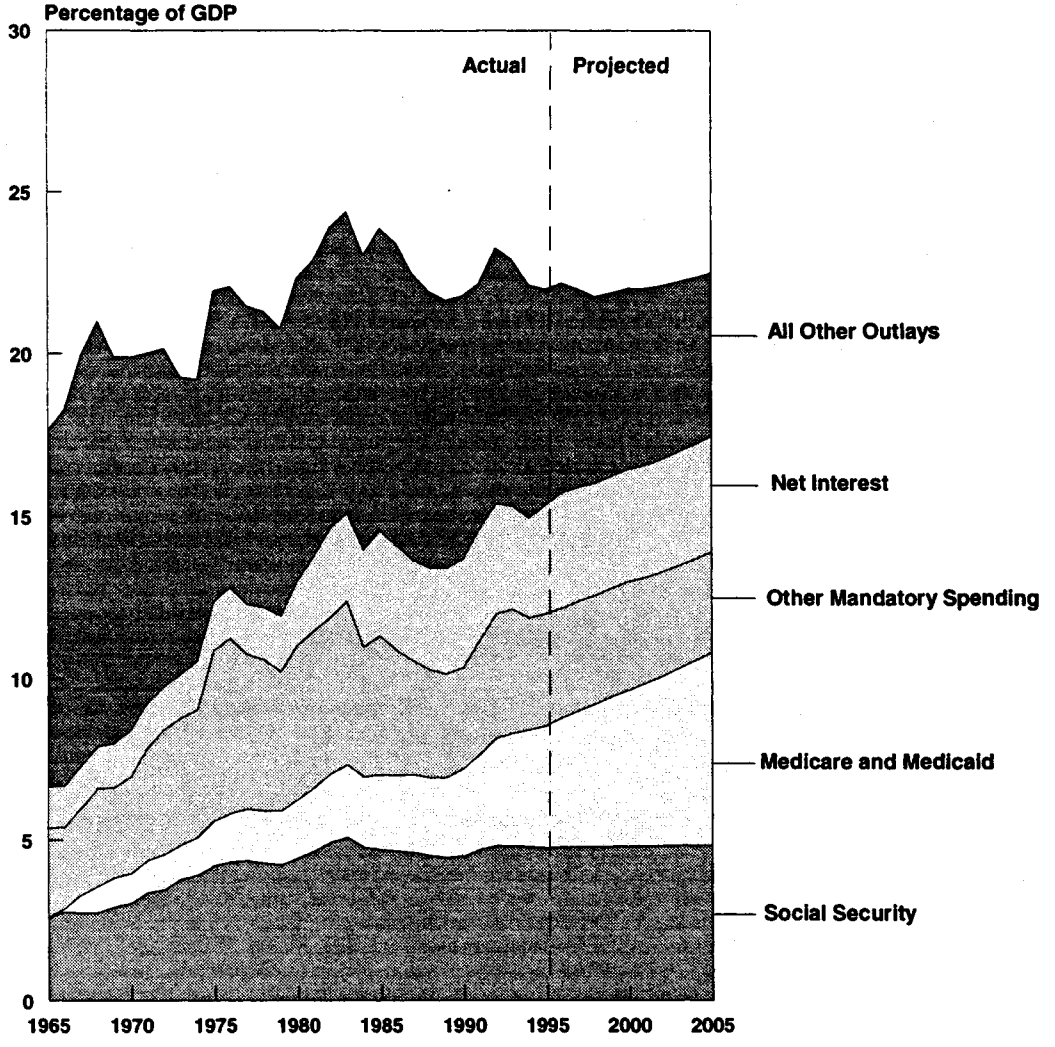
FEDERAL SPENDING ON ENTITLEMENTS

Rapid growth in entitlements and other mandatory spending has been a budgetary concern for some time. Federal entitlement spending now represents more than one-half of total federal outlays and is projected to

constitute more than 60 percent by 2005 (see Figure 1). Most of those payments are made to or on behalf of individuals regardless of economic need. Such payments for the elderly and disabled, including Social Security, Medicare, and federal military and civilian retirement programs, absorb nearly $600 billion, or more than two-thirds of entitlement spending (see Table 1). In contrast, means-tested benefits such as Aid to Families with Dependent Children, Supplemental Security Income, and Medicaid will total less than $200 billion in 1995, or 23 percent of entitlement spending. A myriad of other programs, including unemployment compensation and farm price supports, constitute the remainder of entitlement spending. The Congressional Budget Office (CBO) projects that total entitlement spending will grow from 12 percent of GDP in 1995 to 13 percent in 2000 and 14 percent in 2005.

Although the growth in entitlement spending has put pressure on the budget, it has also had favorable outcomes. Over the past three decades, Social Security has raised the living standards of millions of aged and disabled Americans. Indeed, it has helped to reduce the poverty rate for the aged by more than half over the period. Enacting and expanding Medicare and Medicaid have done much to limit the catastrophic financial risk of severe illnesses for tens of millions of Americans. The introduction of the earned

Figure 1.
Composition of Federal Outlays, 1965-2005 (By fiscal year)



SOURCE: Congressional Budget Office.

NOTES: Totals exclude deposit insurance.

Projections through 1998 assume compliance with the discretionary spending caps in the Balanced Budget Act. Discretionary outlays are assumed to keep pace with inflation after the caps expire in 1998.

Table 1.
CBO Baseline Projections for Mandatory Spending
(By fiscal year, in billions of dollars)

	Actual 1994	1995	1996	1997	1998	1999	2000
Means-Tested Programs							
Medicaid	82	90	100	111	123	136	149
Food Stamps[a]	25	26	27	29	30	32	32
Supplemental Security Income	24	24	24	29	32	35	40
Family Support	17	18	18	19	19	20	20
Veterans' Pensions	3	3	3	3	3	3	3
Child Nutrition	7	8	8	9	9	10	10
Earned Income Tax Credit	11	17	20	23	24	25	26
Student Loans[b]	3	4	3	3	3	3	3
Other	3	3	4	4	5	5	5
Total, Means-Tested Programs	177	194	208	229	248	268	290
Non-Means-Tested Programs							
Social Security	317	334	352	371	390	411	433
Medicare	160	176	196	217	238	262	286
Subtotal	476	510	548	587	628	673	720
Other Retirement and Disability							
Federal civilian[c]	40	42	43	46	48	50	53
Military	27	28	29	31	32	35	37
Other	5	5	5	5	5	5	6
Subtotal	72	75	77	81	85	90	96
Unemployment Compensation	26	22	23	24	26	27	28
Other Programs							
Veterans' benefits[d]	18	17	17	18	19	20	21
Farm price supports	10	10	9	9	8	8	8
Social services	6	6	6	6	6	6	6
Credit reform liquidating accounts	-7	1	e	-2	-3	-6	-6
Other	11	11	11	10	10	11	9
Subtotal	37	45	43	41	39	39	39
Total, Non-Means-Tested Programs	612	651	691	733	778	829	882
Total							
Total Mandatory Spending	789	845	899	962	1,026	1,097	1,173

SOURCE: Congressional Budget Office.

NOTE: Spending for major benefit programs shown in this table includes benefits only. Outlays for administrative costs of most benefit programs are classified as domestic discretionary spending; Medicare premium collections are classified as offsetting receipts.

a. Includes nutrition assistance to Puerto Rico.

b. Formerly known as Guaranteed Student Loans.

c. Includes Civil Service, Foreign Service, Coast Guard, and other retirement programs, and annuitants' health benefits.

d. Includes veterans' compensation, readjustment benefits, life insurance, and housing programs.

e. Less than $500 million.

income tax credit and its recent expansions have raised the disposable income of many workers and their families with low and moderate earnings. And federally guaranteed and direct student loans have helped many younger people to obtain the skills that the workforce of the future will require.

Despite those achievements, however, many people now believe that the United States has a more generous set of entitlement commitments than its taxpayers are willing to pay for. Several factors are responsible. Health costs have risen rapidly as the demands on and capabilities of the medical care sector have expanded. Some cash entitlement programs have become more generous over time. The elderly population--to whom many federal benefits are directed--has grown because of increasing longevity and will swell even further after 2010 with the retirement of the baby-boom generation.

Although cash benefit programs including Social Security currently account for two-thirds of all mandatory spending, more than one-half of the spending growth in this budgetary component over the next five years will come from two noncash programs--Medicare and Medicaid. Those two programs alone account for the increasing share of GDP devoted to entitlement spending. Despite a recent slowdown in the growth of both public and private spending, health care costs in general--and Medicare and

Medicaid spending in particular--are still expected to grow faster than the rest of the economy.

Over the 1995-2000 period, overall mandatory spending is projected to rise by $327 billion, or nearly 40 percent. As Table 2 shows, the growth of entitlement spending can be broken down into several factors, including escalating caseloads, automatic increases in cash benefits, and annual adjustments in reimbursement rates. About one-fifth of the growth derives from increasing numbers of beneficiaries, and one-quarter flows from automatic price adjustments for cash benefits. Most of the remaining growth relates to the increase in use and intensity of medical services provided under Medicare and Medicaid.

Consider the sources of growth in the Medicare (Parts A and B) and Medicaid programs (see Table 3). Only a small portion of the escalation in Medicare spending stems from growing enrollment--about 10 percent. Similarly, automatic adjustments in reimbursement rates--with their associated effects on the volume of services provided--account for only about 25 percent of spending growth. The majority of the increased outlays consists of spending attributable to the increased use of services. In Part A, the Hospital Insurance program, those effects are reflected in rapid increases in payments

Table 2.
Sources of Growth in Mandatory Spending (By fiscal year, in billions of dollars)

	1996	1997	1998	1999	2000
Projected 1995 Spending	845	845	845	845	845
Sources of Growth					
Growth in caseloads	15	28	41	55	68
Cost-of-living adjustments	10	26	43	62	80
Other automatic increases in benefits[a]	6	15	24	32	41
Other increases in Medicaid and Medicare[b]	20	38	60	85	112
Other growth in average Social Security benefits[c]	5	8	11	15	20
Irregular number of benefit payments[d]	-3	0	0	0	5
Change in outlays of credit reform liquidating accounts	-1	-3	-4	-6	-7
Other	2	3	5	9	9
Total	53	117	181	252	327
Projected Spending	899	962	1,026	1,097	1,173

SOURCE: Congressional Budget Office.

a. Automatic increases in Food Stamp benefits, Medicare reimbursement rates, and earned income tax credit under formulas specified by law.

b. All growth not attributed to caseloads and automatic increases in reimbursement rates.

c. All growth not attributed to caseloads and cost-of-living adjustments.

d. Supplemental Security Income and veterans' compensation and pensions will pay 11 months of benefits in 1996, 13 in 2000, and 12 in other years.

Table 3.
Sources of Growth in Medicare and Medicaid (By fiscal year, in billions of dollars)

	1996	1997	1998	1999	2000
Projected 1995 Spending	266	266	266	266	266
Sources of Growth					
Growth in caseloads					
Medicare	3	5	8	10	12
Medicaid	4	8	11	15	18
Subtotal	6	13	19	25	30
Automatic reimbursement increases in Medicare[a]	4	10	16	22	27
Other increases					
Medicare	13	25	38	54	71
Medicaid	6	13	22	31	41
Subtotal	20	38	60	85	112
Total	30	61	95	131	170
Projected Spending	296	328	361	398	436

SOURCE: Congressional Budget Office.

a. No across-the-board change occurs in reimbursement schedules in Medicaid; rather, the government agrees to pay a share of the bills submitted to it by state and local governments. Thus, the effect of inflation on Medicaid outlays is indirect and is part of "other increases."

for home health and skilled nursing facility care rather than hospitals. The growth in Part B of Medicare, the Supplementary Medical Insurance program, is largely fed by the increased use of hospital outpatient procedures--a shift that is clearly tied to the reduced rate of growth in inpatient hospital services.

Although many fees for Medicare services are automatically adjusted under statutory formulas, the states determine reimbursement rates under Medicaid, and the federal government simply pays each state a fixed share of program costs. The reimbursement rates are, however, subject to the Boren Amendment, which requires payments to hospitals and nursing homes to reflect the reasonable and adequate costs of providing services. The rates are also subject to legislation requiring that provider payments be high enough to ensure access.

The federal government therefore has little flexibility to change Medicaid spending except through changing the matching formula, restricting eligibility, or limiting services. CBO expects growth in the number of beneficiaries to be much more important in explaining spending growth in Medicaid than in Medicare. Expansions in current law, which will not be fully implemented until 2002, and rapidly growing numbers of disabled people help to explain why the number of Medicaid beneficiaries is projected to climb by

20 percent over the next five years. Growth in caseloads accounts for about one-third of the projected increase in outlays for Medicaid.

PROJECTIONS OF NATIONAL HEALTH EXPENDITURES

The growing claim on resources by the health care sector is by no means only an issue of governmental finance. Private-sector health spending has also escalated rapidly over the past 30 years. Moreover, although that growth has moderated somewhat since 1990, private health spending is still likely to command a growing share of national income over the decade ahead. The rapidly changing health care environment raises questions about whether the United States has entered a new era of moderate growth in health spending or is simply experiencing a relatively brief respite from higher growth rates.

The increasing cost of private health insurance premiums has slowed in part because the spread of managed care has injected a measure of price competition in a sector of the economy that had previously experienced little such competition. During the 1980s, managed care plans expanded steadily, but did not attempt to compete aggressively on the basis of price with the traditional indemnity plans. Managed care plans could expand enrollment and profits at a steady pace by offering premiums slightly below the major

fee-for-service plans, and there seemed to be little difference in the rate of premium growth among the different types of plans.

Recently, however, several factors ushered in a period of more intense price competition among plans. First, U.S. economic growth was weak in the 1990-1993 period. The recession of 1990-1991, like the previous recession of 1981-1982, highlighted the need for efforts to control health payments. The continued expansion of the economy, however, might provide an impetus to faster spending growth.

Second, by the early 1990s, enrollment in managed care plans had grown to levels that providers of health care services found increasingly difficult to ignore, improving the ability of plans to contract with hospitals and doctors at favorable terms. Those price discounts, combined with the potential that managed care plans have to reduce the use of health services below what would be expected under fee-for-service reimbursement, have led managed care plans to provide significant cost advantages over traditional insurance plans.

Third, as some businesses have used managed care to help slow the premium increases faced by their workers, other businesses have felt pressure to keep up. If a company finds that its employees are amenable to managed

care, it can use the savings to pay its workers more, leaving businesses that do not find ways to slow premium growth at a competitive disadvantage in attracting and retaining a skilled workforce.

Finally, plans found that they could establish and expand the looser independent practice association (IPA) or preferred provider organization (PPO) forms of health maintenance organization (HMO) much more rapidly than the traditional group- or staff-model HMOs. Those new plans found a climate fertile for price competition, and their market share expanded rapidly. Compared with traditional group- or staff-model HMOs, those newer forms of managed care have not proven as capable of controlling their enrollees' use of health services, but they seem to be adept at contracting for hospital and physician services on favorable terms.

In CBO's view, the outlook for public health spending has improved in part because the changes spearheaded by the private sector will spill over to the Medicare and Medicaid programs. But there are some limitations on how effectively public programs can replicate the cost savings in the private sector. The open-ended nature of fee-for-service Medicare and the formula that Medicare uses to pay HMOs (discussed below) prevent the program from taking full advantage of the changes taking place in the private sector. Medicaid probably has greater latitude for using managed care plans, but

many of the states' efforts in that direction also include expansions of coverage and improved access to care, making the trend in total outlays extremely uncertain.

Before going into more detail about CBO's projections of national health expenditures, it must be emphasized that projecting national health spending involves a good deal of judgment in interpreting the recent data. Rapid expansion of managed care plans and provider networks is reconfiguring the U.S. health care delivery system. Whether those changes and others in the health care market will continue to moderate the growth of health spending, as during the past several years, is uncertain. CBO's projections assume continued moderate growth in 1995 and 1996 and a rebound to somewhat higher growth rates thereafter. Such a pattern mirrors the cycle of health spending that occurred during and following the Carter Administration's efforts at hospital cost containment, as well as in the mid-1980s, when the Medicare prospective payment system was introduced and inflation in health care costs subsequently rebounded. Because of the change in the competitive climate of the health care market, however, CBO does not project health spending to rebound as high as in previous cycles.

CBO estimates that health spending in 1995 will amount to about $1 trillion, or 14 percent of GDP, up from about 6 percent of GDP 30 years

ago (see Table 4). Assuming current policy continues, CBO projects that national health expenditures will absorb a growing share of the economy and exceed $2 trillion by 2005, or 18 percent of GDP. The share of health costs financed by all levels of government is projected to climb from 45 percent in 1995 to over 50 percent by 2005.[1]

CBO estimates that spending for health care grew about 6 percent in 1994, the slowest rate in 30 years, and will grow about 7 percent in 1995. CBO's projections of private health insurance premiums show correspondingly slow growth: 5 percent in 1994 and 6 percent in 1995. CBO projects that the growth of private health insurance premiums will average about 7.4 percent a year between 1995 and 2000. Federal spending for Medicare and Medicaid, however, is projected to grow by 10 percent a year.

Of course, all projections of health spending are uncertain. Although CBO has lowered its projections of health spending, national health expenditures could still reach 20 percent of GDP by 2005, as CBO projected 15 months ago. However, if health spending were to continue its current

1. See the forthcoming CBO Paper, "Projections of National Health Expenditures: 1995-2005."

Table 4.
Projections of National Health Expenditures, by Source of Funds (By calendar year)

Source of Funds	1965	1980	1985	1990	1995[a]	2000[a]	2005[a]
In Billions of Dollars							
Private	31	146	259	410	552	770	1,051
Public							
Federal	5	72	123	196	334	528	821
State and local	5	33	52	91	121	174	247
Total, National Health Expenditures	42	251	434	697	1,008	1,472	2,119
As a Percentage of Total							
Private	75.3	58.1	59.7	58.9	54.8	52.3	49.6
Public							
Federal	11.6	28.7	28.4	28.1	33.2	35.8	38.8
State and local	13.2	13.3	11.9	13.0	12.0	11.8	11.6
Total, National Health Expenditures	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Average Annual Growth Rate from Previous Year Shown (Percent)							
Private	n.a.	10.8	12.2	9.6	6.1	6.9	6.4
Public							
Federal	n.a.	19.7	11.4	9.7	11.3	9.6	9.3
State and local	n.a.	12.8	9.2	11.9	5.9	7.5	7.2
Total, National Health Expenditures	n.a.	12.7	11.6	9.9	7.7	7.9	7.6
Memoranda:							
Gross Domestic Product (Billions of dollars)	703	2,708	4,039	5,546	7,127	9,128	11,772
Average Annual Growth of Gross Domestic Product (Percent)	n.a.	9.4	8.3	6.5	5.1	5.1	5.2
Ratio of National Health Expenditures to Gross Domestic Product	5.9	9.3	10.8	12.6	14.1	16.1	18.0

SOURCE: Congressional Budget Office.

NOTE: n.a. = not applicable. Numbers may not add to totals because of rounding.

a. Projected.

moderate growth rate, its share of GDP in 2005 would be significantly below our currently projected level of 18 percent of GDP.

CBO'S ASSUMPTIONS ABOUT MANAGED CARE

The potential for cost savings in the Medicare and Medicaid programs from increased use of managed care is not easily quantifiable. Managed care plans take a variety of forms. The most tightly managed plans tend to be group- and staff-model health maintenance organizations, whose physicians serve the plan's enrollees exclusively.

The independent practice association is a more loosely organized form of HMO whose panel of physicians serves the IPA's enrollees along with other patients. Most indemnity plans also now incorporate some elements of managed care--through utilization review, case management, and in some cases designation of a panel of preferred providers who practice in a cost-conscious way.

CBO continues to assess the extent to which various forms of managed care reduce the use of health care services, compared with unmanaged indemnity plans in the fee-for-service sector. Our most recent analysis finds that the most effective HMOs reduce use of services by about 22 percent,

while IPAs, PPOs, and indemnity plans with effective utilization review reduce use by 2 percent to 4 percent, on average.[2]

Because almost all private health insurance plans now include some elements of managed care, moving people from indemnity plans to HMOs would reduce the use of services by somewhat lower amounts. The use of services would fall by about 20 percent, on average, for people moving from the typical indemnity plan to a group/staff HMO. For those moving to an IPA, use of services would fall by less than 1 percent on average. The estimated average effect of all types of HMOs is to reduce use of services by 8 percent, compared with the current mix of indemnity plans. Those differentials are broadly consistent with the savings assumptions used by CBO last year in its estimates of health reform proposals.

The small average effect for IPAs reflects their highly variable performance. The best-managed IPAs can achieve savings comparable to group/staff HMOs, but many IPAs operating today have not yet developed the characteristics necessary to achieve their full potential. The IPAs that are most likely to approach the effectiveness of the best group/staff HMOs use cost-conscious providers, maintain an effective network for information and control, place providers at financial risk, and generate a substantial portion

---

2. See the forthcoming CBO Memorandum, "The Effects of Managed Care and Managed Competition."

of each provider's patient load. However, the spread of any willing provider laws (which require network plans to include any providers in an area who are willing to meet the plan's terms) may prevent IPAs from developing the characteristics necessary for effective control.

Note that the savings to be expected from expanding managed care depend on a number of factors in addition to the differences among various kinds of health plans in their expected use of services. Health plans also differ in the prices they pay providers for services and in their costs of administration. Further, enrollees will not voluntarily move to more tightly managed plans unless they will save enough in out-of-pocket costs to offset the disadvantages of more restrictive plans. In fact, very little of the recent growth in HMO enrollment has occurred among closed-panel plans, which restrict patients to a specified panel of providers. Most growth has occurred among point-of-service (POS) or open-panel plans, which permit patients to seek care from out-of-plan providers if they pay a larger share of the costs.

Despite the cost-saving potential of managed care plans, expanding enrollment in such plans among the Medicare population would be unlikely to reduce Medicare's costs under the current system. The available research indicates that Medicare pays more for enrollees in HMOs than it would have paid had they remained in the fee-for-service sector, even though Medicare

pays HMOs in each geographic area only 95 percent of the average costs of Medicare enrollees in the fee-for-service sector. One reason is that Medicare enrollees are permitted to enroll or disenroll from HMOs at any time during the year, instead of only during an annual open-enrollment period as is typical for non-Medicare enrollees. It appears that HMOs attract healthier members of the Medicare population. There may also be a tendency for HMO enrollees to switch to the fee-for-service alternative when severe health problems arise.

To generate savings to Medicare from expanded enrollment in HMOs, changes in Medicare's enrollment conditions and payment system for HMOs would have to be made. Medicare's enrollment requirements would be relatively easy to redesign, but appropriate changes in the payment system would be more difficult to specify. For example, an annual open-enrollment period along with a point-of-service requirement could replace today's continuous open enrollment. The POS option would permit Medicare enrollees to go to providers outside the HMO's panel when they wanted to, and yet it need not increase benefit costs for either the HMO or Medicare. The HMO could offset the potential increase in costs from the POS option by setting its cost-sharing requirements for out-of-plan care sufficiently high. Medicare's capitation payment to the HMO would then be unaffected by enrollees who chose to use the POS option.

To ensure that Medicare neither overpays nor underpays HMOs for their Medicare enrollees, Medicare's capitation payments to HMOs would have to reflect the HMO's true costs of serving its Medicare enrollees better than current payments do. One way to accomplish that would be to improve the current method of adjusting the average fee-for-service payment rate by expanding the adjustment factors used. However, defining a set of additional factors that would improve the accuracy of the payment rate without generating undesirable incentives for HMOs has proved to be a difficult task.

CONCLUSION

The growth of entitlement spending in general and of health care costs in particular continues to attract the attention of policymakers. An ever-increasing share of public and private spending is being claimed by health care costs, making choices about how to allocate scarce resources more and more difficult. Although CBO has shaved its projections of health spending growth for the coming decade, that slowdown does not alter the fundamental choices facing the United States. Hard decisions will have to be made if the growth in entitlement spending and health care costs is to be curbed.