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CRISIS IN THE FUTURE: LONG-RUN DEFICITS AND DEBT

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BEFORE THE

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CRISIS IN THE FUTURE: LONG-RUN DEFICITS AND DEBT

TUESDAY, JUNE 17, 2008

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:05 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Rockefeller, Conrad, Wyden, and Salazar.

Also present: Democratic Staff: Bill Dauster, Deputy Staff Director and General Counsel; Alan Cohen, Senior Budget Analyst; Shawn Bishop, Professional Staff (Health); and Suzanne Payne, Detailee. Republican Staff: Steve Robinson, Chief Social Security Advisor; and Paraskevi Maddox, Detailee.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The hearing will come to order.

The Chicago columnist Sidney J. Harris once wrote, "An idealist believes the short run doesn't count. A cynic believes the long run doesn't matter. A realist believes that what is done or left undone in the short run determines the long run."

Today we will look at the long run. We will examine the huge Federal budget deficits that the Congress projects for decades to come, and we will look at the causes of those deficits.

CBO projects that, unless we act, in 2030 the Federal budget deficit will grow to more than 10 percent of the economy. In 2050, it will be more than 22 percent of the economy. And by 2082, it will exceed 54 percent of the economy. These deficits, of course, will dwarf the post-World War II record deficit of 6.3 percent in 1983.

Why are these projected deficits so high? Until a few years ago, people would often point to retirement and the baby boom generation. The increased number of older people eligible for Social Security, Medicare, and Medicaid would dramatically drive up expenditures for the Federal Government. But beginning a few years ago, CBO, GAO, and others demonstrated that the primary source of high long-term deficits is the rapid growth in health care costs. The bigger problem is not that we have too many enrollees in Medicare and Medicaid. The bigger problem is that health care costs per enrollee are growing so rapidly.

Health care costs are growing faster than the economy, and this same problem is occurring in the private sector. Since 1975, per capita Medicare costs have grown 2.4 percent faster a year than

the economy, Medicaid costs have grown 2.2 percent faster, and all other health care spending has grown 2.0 percent faster.

Unfortunately, we have no good reason to expect these high rates to abate. There is no reason except, of course, we will not be able to afford them.

As a result of rapid health care cost growth, CBO projects that, between 2007 and 2082, Medicare and Medicaid's annual costs will grow from 4 percent of the economy to more than 19 percent; of that growth, 86 percent will come from rapid health care cost growth and 14 percent comes from demographic changes.

For comparison, Social Security's costs will grow from 4 percent of the economy in 2007 to 6.5 percent of GDP in 2082. If you add together the cost of Medicare, Medicaid, and Social Security, more than three-fourths of the increase between 2007 and 2082 is due to rapidly growing health care costs.

Thus, if you want to prevent huge Federal budget deficits in the long run, you will need to significantly lower the rate of growth in health care costs. If we control health care costs, then along with prudent policies for the rest of the budget, we will be able to control the Federal budget deficits. But if we fail to control health care costs it will not matter what else we do in the rest of the budget, we would have no hope of keeping Federal budget deficits under control.

We will succeed. Why? Because we must. If we as a society do not control health care costs, people will not have enough income left to buy the other things that we need to live. Many of the solutions that will control health care costs in the private sector will work in Medicare and Medicaid, and the reverse is true as well.

The problem that we face is a health care problem in both the private and public sectors, and to beat that problem we need a solution that works in both the private and public sectors.

How are we going to control health care costs without reducing quality? We need to reform the system. With regards to cost, reform will follow from several elements. We need a greater focus on improving the quality of care, on improving health outcomes, and on increasing prevention and wellness. We need to reduce unnecessary utilization of health care, and we need to increase efficiencies in the system, both without reducing quality. We'll need to build in more patient safety measures to avoid medical errors that drive up costs. We need to thoroughly explore all potential areas of health care cost reduction.

Some of this work is already occurring. I commend Peter Orszag and the Congressional Budget Office for the work that they have been doing, and encourage them on the work that they are planning, to find ways that we can reduce health care costs without sacrificing quality.

Health care reform will not be easy, but I have made it a priority for the Finance Committee. Already this year we have had three hearings on health care reform. We will continue with more next month. Yesterday, we had a day-long summit on health care reform over at the Library of Congress. Frankly, I thought it was very, very good and it helped a lot. I think it will be a foundation on which we can build and find some solutions.

I know that, if we work together, we can find answers to the tough questions about health care reform. I know that we can deliver high-quality, affordable health care to all Americans. I know that we can bring down the overall cost of providing for that care.

The cynic might say that we can never succeed in health care reform. An idealist might say that we have to wait for the perfect solution. But as a realist, I say that what we do or leave undone on health care reform next year may well determine our future for a long time to come.

Now I would like to introduce our witnesses. The first witness is Peter Orszag, the Director of the Congressional Budget Office. Our second witness is Gene Dodaro, Acting Comptroller General. Thanks for coming, both of you. You know the drill: 5-minute statements, and your printed one will automatically be included in the record.

STATEMENT OF DR. PETER R. ORSZAG, DIRECTOR, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC

Dr. ORSZAG. Thank you very much, Mr. Chairman, and other Senators.

I am going to make three points today, and you should have a chart packet in front of you.

The CHAIRMAN. Is this it here?

Dr. ORSZAG. Yes.

[The charts appear in the appendix starting on p. 55.]

Dr. ORSZAG. We are on a clearly unsustainable path, most of which is associated with health care costs. Second, there are very significant opportunities to improve the efficiency of the health care system. Third, there are important political economy questions surrounding how we can capture those opportunities, and on that dimension I just wanted to commend the chairman and other members of the committee. I, too, thought that yesterday was a phenomenal day, and exactly the kind of thing that we need to be doing.

So on the first point, the first chart in your packet shows you the path that we are on, with rapidly rising costs, especially with our entitlement programs, concentrated especially in Medicare and Medicaid. As you can see, spending would rise to unprecedented levels over the next 75 years under our projections.

If you combine that spending path, as the next chart shows, with something on the revenue side that basically reflects the current tax system which is embodied in the so-called alternative fiscal scenario, you can clearly see an explosion of deficits and debt that occurs. In particular, by 2050 the deficit would reach 23 percent of the economy and debt would reach almost 300 percent of the economy.

The economic cost associated with that kind of scenario would be so much larger than any economic difficulties that we are currently experiencing. In our estimation, for example, real GNP, real national income, would be reduced by 25 percent in 2050, and beyond 2062 we cannot even compute the results. This course is clearly unsustainable.

Why is the course unsustainable? Most of it does have to do with health care. As the chairman already mentioned, the next chart

shows you that most of the growth in health care costs has to do with rising costs per beneficiary, that so-called excess cost growth which you see in the light shaded part of the chart, and only a smaller part has to do with the pure effects of demographics. I would be happy to answer more questions about that.

Now, embodied in that central long-term fiscal challenge that we face is, as I think is now well understood, a very substantial opportunity to reduce health care costs without impairing health outcomes. In particular, as much as 30 percent of the health care services delivered in the United States, according to expert analysis, do not improve health outcomes. Thirty percent of health care services is 30 percent of 16 percent of GDP, which is 5 percent of GDP. That is $700 billion a year in health care services delivered that do not improve health outcomes.

I will just walk very quickly through that opportunity. This map shows you that costs per beneficiary vary substantially across parts of the United States, for reasons that the team up at Dartmouth cannot explain based on underlying riskiness of the patients, or the cost of building a hospital, or other factors across the U.S. Even at our top medical centers there are very substantial costs that are occurring.

So at UCLA Medical, for a beneficiary in the last 6 months of life, the average cost per beneficiary is $50,000 a year; at the Mayo Clinic it's $26,000 a year. There is no appreciable difference in quality. If anything, the quality indicators are better at the Mayo Clinic. The best medical care in the world should not be costing us twice as much as the best medical care in the world, and you and I, through our payroll taxes, are paying for that today.

You similarly see very significant—the last chart—variation in the number of days in the hospital that beneficiaries in the last 6 months of life spend at different leading medical centers. We are practicing medicine in vastly different ways, even at our top medical centers across different parts of the United States, in ways that do not correlate—they correlate with higher costs, but not with higher quality.

That brings me to my final point, which is, what do we do about all of this? As I said yesterday, it appears to me that our political system does not deal well with gradual, long-term problems. As you can see from this chart, we face a gradual, long-term problem which will eventually become a crisis if we do not deal with it.

However, there are significant aspects of the core problem that we face—which involves health care—that are already affecting us today. Health care costs are, to a degree that is under-appreciated and unnecessarily large, reducing workers' take-home pay. Health care costs are consuming, already, a quarter of the Federal budget. Health care costs at the State government level, evidence suggests, are crowding out other State government priorities, including especially higher education, thereby driving up tuition and impairing quality at our Nation's higher education facilities. That is happening today.

A final point which, Mr. Chairman, you already noted, I would just emphasize what Chairman Bernanke said yesterday, which is, the best way to reduce the fiscal burdens of health care is to deliver cost-effective health care throughout the entire system, and I

hope we can talk more about that during the question-and-answer period.

Thank you very much.

The CHAIRMAN. Thank you very much.

[The prepared statement of Dr. Orszag appears in the appendix.]

The CHAIRMAN. Mr. Dodaro?

STATEMENT OF GENE DODARO, ACTING COMPTROLLER GENERAL, GOVERNMENT ACCOUNTABILITY OFFICE, WASHINGTON, DC

Mr. DODARO. Good morning, Mr. Chairman and members of the committee. I am very pleased to be here today to discuss the long-term fiscal outlook for the Federal Government.

Simply put, from GAO's perspective, the long-term path is unsustainable, and it is a matter of the utmost concern. Health care costs are the principal driver for this situation, but demographic changes also play a role and are a contributing factor to the situation.

Reform of the health care system is essential to dealing with this problem, but we believe the scope and magnitude of this issue confronting the country requires looking at all aspects of the Federal Government's operations, both on the revenue and the spending sides, in order to deal with this situation.

Additionally, the window of opportunity to deal with the significant issues confronting policymakers on these subjects is shrinking, and the ability to gradually phase in adjustments, for individuals, private sector, and government institutions is shrinking.

I have three charts I would like to show you to illustrate this point. You have them before you. The first chart—Figure 3 in my written testimony—talks about the combined Federal, State, and local fiscal imbalance. This one shows—based on GAO's simulations—what the deficit trend would be in the out-years for the Federal Government. It is an ominous trend. The deficits are large and grow steadily in the out-years, contributing to what Dr. Orszag talked about in terms of the explosion of debt.

We have also done a simulation of the State and local sector. The dashed line shows the combined Federal, State and local government deficits. State governments will also face an increasing gap between their expenditures and receipts in dealing with issues.

One of the primary reasons for the gap in terms of the situation that the States face is rising health care costs, both for Medicaid for their employees, and for dealing with the post-retirement health care costs for their employees. As you can see, at the same time the Federal Government is going to be facing large and growing structural deficits, so will the States; this is going to complicate finding solutions and equitably distributing changes that will need to take place.

The second chart is Figure 2 from my submitted statement. This shows some of the magnitude of the programmatic decisions that confront the Congress and the country going forward. What this shows is that, if you hold revenue constant in the out-years at about 18.3 percent of the Gross Domestic Product—which is about the 40-year historic average—that by 2030, revenues would only cover interest on the debt, the Social Security, Medicare, and Medicaid payments. At that level, there would be no revenue for any

other government operations. If you go out 10 more years, at that level of revenue, there is not enough to make the payments for Social Security, Medicare and Medicaid, and interest on the debt.

Now, obviously this is not going to happen. Action will have to take place. But it illustrates the magnitude of the problem and the size of the adjustments that are going to have to take place. Right now, the net present value of excess projected expenditures over revenues is $41 trillion; it is $34 trillion for Medicare, $7 trillion for Social Security. So, it is a significant problem.

My final point is that this is not an out-year issue alone. We are already starting to see the squeeze. Figure 5 from my written testimony shows the historic rise in the debt level that we have seen from 2003 to 2007; it shows that debt held by the public has increased significantly to fund our previous and current annual deficits. But in the white bar at the top it also shows the debt that is held by the government itself largely from excess revenues in the Social Security program that are now being used to fund current government operations. That excess of Social Security taxes over the benefits being paid is going to start to shrink in 2011, and in 2017 the Social Security program will shift to a net cash deficit position.

Right now, in 2008, the Medicare program is in a net cash flow problem. In fiscal year 2009, the Congress is going to have to raise the debt ceiling again. So the need for change is already evident, and the pressures that the Federal Government will feel just in funding its current operations are going to be unfolding in the next few years, even before the dramatic changes that are likely, going forward.

I commend this committee for holding this hearing and for holding the summit yesterday, and we look forward to working with you to help deal with these issues going forward.

[The prepared statement of Mr. Dodaro appears in the appendix.]

The CHAIRMAN. Thank you both, very much.

Dr. Orszag, I am just curious about the components or the breakdown of the 30 percent of health care expenditures that do not improve outcomes. Are you in a position to kind of break that down a little bit and tell us what the main components of those inefficiencies are?

Dr. ORSZAG. Yes and no. It comes, again, from that map, basically, showing the higher-cost regions not generating better health outcomes. Then the question is, why is that variation occurring? The variation tends to be largest in the areas where we know less about what should happen. So, for example, we know that someone suffering a heart attack should be administered an aspirin associated with hospital admission. There is not a lot of variation in that practice.

Another example is imaging and diagnostic tests—think about an MRI, for example, and when it should or should not be applied. There is not as much guidance on that or as much information, and there is a huge amount of variation. Similarly, how many times you should go back and see your doctor after surgery, no one can tell you. There is a lot more variation in those kinds of settings, so it is precisely where we know least about what should happen

that the variation is greatest, and that is where I think most of the efficiency gains could come.

The CHAIRMAN. So that is where most of the 30 percent occurs?

Dr. ORSZAG. I think most of the 30 percent is coming from those areas where it is less clear what should happen, where there is less clear medical guidance on what should happen. Yes.

The CHAIRMAN. But are you also saying that——

Dr. ORSZAG. I am sorry. You also see that in the variation we see across the leading medical centers. Beneficiaries in the last 6 months of life are being treated in completely different ways across some of our Nation's leading medical centers for reasons that we do not understand.

The CHAIRMAN. Yes. That is the chart, this one here.

Dr. ORSZAG. That one and the one before it. Yes, sir.

The CHAIRMAN. Right. But you say, for reasons we do not understand. You have looked at this a little bit. Do you have any sort of clues?

Dr. ORSZAG. Yes.

The CHAIRMAN. What might come to mind?

Dr. ORSZAG. There is a lot more stuff that happens to you. If you go to UCLA Medical rather than the Mayo Clinic, you are much more likely to spend a lot more time in the hospital, you are much more likely to have lots of tests done to you, and you are much more likely to see lots of specialists, none of which we have any information actually improves your outcome.

The CHAIRMAN. Again, any indication of why, at UCLA Medical, you are more than likely to see so many more?

Dr. ORSZAG. Well, there are two basic theories. One is that you build it and they will come, so the greater availability of beds, and supply, basically, creates its own demand. The second thing is just social norms among medical practitioners. Zeke Emanuel's new book on health care opens with a test that was applied at much different thresholds at two hospitals that he worked at. He said at his new hospital, he asked why is it being applied at this looser level, and they said, that is what we do here.

I am surprised as I explore health care more and more the degree to which that is true: that is just the way we do it here. It is not backed by any specific evidence that it works better than anything else, but it is the way we do it here. A lot of inertia.

The CHAIRMAN. Does that get a little bit into comparative effectiveness?

Dr. ORSZAG. Absolutely. So then the question is, how do you change that? I think the way you change that is—and there is evidence that establishing practice guidelines and tying financial incentives to those guidelines changes doctors' and medical providers' behavior. Very clear evidence, in my opinion. You need to do both, though.

The CHAIRMAN. Is there a role for Congress, through Medicare, to try to set up some practice patterns that are more uniform or get at the disparity?

Dr. ORSZAG. I think there is huge potential for the government to lead by either financing or playing an active role in conducting the research. Then the key is, we need to change the way we reimburse—the financial incentives that face providers. Right now we

pay for more care rather than better care, and that fundamentally has to change or we are not going to get anywhere.

The CHAIRMAN. You know, as I picture this, maybe we ought to have a hearing here on that subject, get some hospital administrators in high-cost areas and some in low-cost areas and look at those practice patterns and see whether there is any justification for the variation.

Dr. ORSZAG. And the other interesting idea that came out yesterday, and that you asked Mr. Bernanke about, involves some sort of institutional body that could play a larger role in those sorts of questions.

The CHAIRMAN. Right. But your thoughts about that?

Dr. ORSZAG. I think it is a very interesting idea.

The CHAIRMAN. And how far would you go in pursuing that?

Dr. ORSZAG. I have already said that I think the political system does not deal well with gradual, long-term problems. This, again, strikes me as a gradual, long-term problem. So I am going to have to defer to you on the exact structure, but it does strike me that thinking through things like that is probably an auspicious path to be pursuing.

The CHAIRMAN. Another reason, too, as I said there at the summit yesterday, none of us here are competent to decide what reimbursement rates should be for X, Y, or Z. What do we know?

Dr. ORSZAG. And you get lobbied heavily on it, too.

The CHAIRMAN. We are just Senators and we are lobbied heavily. Exactly.

Dr. ORSZAG. Yes.

The CHAIRMAN. Thank you very much. I appreciate it. I am sorry I did not get a chance to question you, Mr. Dodaro. Next time around.

Senator Conrad, you are next.

Senator CONRAD. Thank you, Mr. Chairman.

The CHAIRMAN. Do you have some charts?

Senator CONRAD. I am only going to use one. [Laughter.] I am only going to use one.

First of all, I want to thank you, Mr. Chairman, for holding this hearing. I especially appreciate it. I also very much appreciated yesterday. As I said yesterday, I really thought, that is the way the Senate should function. When I came here 22 years ago, I really thought that is the way it would be. You bring in the experts from around the country and it would be deliberative and you would really search for a solution.

The CHAIRMAN. I did too, when I came here. [Laughter.] I sat in the room for the first time and I said, boy, that is the kind of thing I would like to do.

Senator CONRAD. I just thought yesterday was outstanding, and really a good model for things we could do around here.

Let me just make this point, if I can. This is the long-term scenario according to CBO, long-term budget scenario. If we make all the tax cuts permanent, if we indexed the AMT for inflation, this is where we are headed. And it is not the sweet by and by. You can see, this trajectory on debt as a share of GDP takes off like a scalded cat in about 2012. So, this is not far down the road.

The question I would have for the witnesses is: so what? Are these not just numbers on a page, and is this not just an academic exercise, balancing budgets? Is that not just for the green eyeshade types? Should we be concerned about what this would do if this path were pursued? Should we be concerned about the effect on people's lives in this country and, if so, how?

Dr. Orszag?

Dr. ORSZAG. Yes. And I think this is a very important point. Right now we are borrowing a lot of capital from abroad, and the effect may be masked in terms of what the ultimate impact is. But just like the subprime crisis came home to roost when it was unsustainable, when you are on an unsustainable path, bad things will happen.

I have heard this likened to a dysfunctional relationship. So something that is unsustainable like a dysfunctional relationship can go on longer than you expect, and end faster and messier than you think. We are on an unsustainable path and bad things will happen, including a collapse in GDP and an explosion in debt. We would not be able to sell the debt on your chart. We would literally not be able to sell debt at those kinds of levels, as Mr. Bernanke and others have suggested. So, significant economic costs that far exceed what we are facing today unless we get at the heart of this problem.

Senator CONRAD. Mr. Dodaro, what would your answer be?

Mr. DODARO. This is a very serious situation. If it is not addressed, it will have an impact on the public, on the potential standard of living, and the amount of funds that will have to be generated in order to offset this. We have estimated the current fiscal exposures that already exist for what is projected in Medicare, in Social Security, and other contingencies and liabilities, at about $54 trillion.

Senator CONRAD. When you say standard of living, I think part of the problem is, numbers mean a lot to you, they mean a lot to me, but I find with my constituents, we say these big numbers, $45 billion, $54 billion, it has no meaning. You said it is going to affect the standard of living in our country.

Mr. DODARO. Right.

Senator CONRAD. How can that be? What difference does it make to the standard of living?

Mr. DODARO. Well, the government provides a lot of essential services to individuals, and the ability to fund those services is going to have an impact both on individuals and on the government's ability to deal with emergency situations. The figures that you are showing in your chart and that Dr. Orszag and I have been showing in our charts do not even consider emergencies that might happen, such as hurricanes or floods.

Basically the services that the Federal Government and the State and local governments are going to be able to provide will be under a great deal of stress, even without considering potential unmet needs that people want the government to respond to. There will also be a question of what people are going to be willing to pay in terms of revenue for a certain level of services going forward.

Senator CONRAD. All right.

Dr. Orszag, what would you say?

Dr. ORSZAG. I would just add, I already said that the path that we were on would reduce national income by one-quarter in out-years, in 2050, and after that we cannot even compute the number. So a quarter for the typical family in terms of household income is north of $10,000 a year, even at today's income levels. So the kinds of economic effects we are talking about are just so much larger than anything we are experiencing in terms of current economic difficulties.

I would also point out there are things that involve this fiscal problem that are affecting households today. I mean, most workers, I do not think, appreciate the fact that their take-home pay is being reduced by $7,000 or $10,000 a year to finance their employer-sponsored insurance. They probably do not make the connection, as much as the evidence suggests, between the high tuition that they are facing for the kids at college and rising Medicaid costs. There are huge parts of this problem that are affecting people today and are not just this thing down the road.

Senator CONRAD. Sweet by and by. Thank you.

Dr. ORSZAG. Thank you, Senator.

The CHAIRMAN. Senator Salazar?

Senator SALAZAR. Thank you very much, Chairman Baucus. Thank you for the witnesses and your statements today.

Following up, Dr. Orszag, on Senator Conrad's questions to you on the mountain of debt that we have, I think we have a disconnect between what we are talking about here in the Finance Committee this morning and what the people of America really see. I know some of us have been over to the White House at different times and we have heard from the leadership of this country that debt does not really matter, that deficits do not really matter as a percentage of our GDP.

I heard you in your last response to Senator Conrad saying, well, if you look at the year 2015, what you are looking at is essentially that any one family, by 2015, is going to be making $10,000 less. I am not exactly sure what your number was.

Dr. ORSZAG. It was 2050.

Senator SALAZAR. 2050. All right. It is going to be a significant reduction in how much money people are making here in America.

Is it possible for you at CBO, and for you at GAO, to come up with a scenario for us that tells us what this rising mountain of debt will mean to the typical American family, say by the year 2015? Because I think, when you look at the chart that Senator Conrad just had and the charts we have here, this is not a problem that is off at 2050, this is one that we are going to be seeing very soon here at 2010, 2012—we are seeing it already.

But if we were to ask you, give us a set of realities of the typical American family of four, what does this mean to them by the year 2015? Is that something that you could do?

Dr. ORSZAG. Yes. Now, I would say, though, the effects are not going to be as massive as you might think and that might motivate action. It is like we are running up this credit card debt. And while you are spending on the credit card and the interest payments are building, it does not look that painful, and it can go on for some

period of time. Ultimately, because of the power of compound interest and because it is not a sustainable situation, you face a crisis.

I do not want to say the crisis will not happen before 2015, but the probabilities are such that it may not happen before 2015, and therefore while you are in that running up stage and you are just running up your credit card bill, things can look artificially good. That is sort of the analogy of the dysfunctional relationship: it can go on longer than you think and then it can become a complete mess.

Senator SALAZAR. All right. We have a real challenge, though, Dr. Orszag, in terms of explaining this problem to the American people.

Dr. ORSZAG. Yes. I agree.

Senator SALAZAR. Because I would bet you, 99 percent of them say, it does not affect me today and it is not going to affect me in 2012. So these guys and I come up and say we need some more revenue or whatever it is, all of a sudden people do not get it.

Dr. ORSZAG. That may be why it would be useful to focus on some parts of the problem that are occurring today: $700 billion in health care services delivered today that are unnecessary.

Senator SALAZAR. Let me switch over then to health care on that. This map is very, very interesting. It shows some parts of the country where we are spending $10,000 to $13,900 per Medicaid beneficiary and, in other parts, only $6,900. I think your statement was, we essentially have the same quality being delivered in different places, but we have very disparate costs with respect to the delivery of those services.

So the question for you would be—and for all of us is—what do we do about that? What do we do with this runaway train? I heard one idea, and that is the idea of comparative effectiveness and that maybe we look at the possibility of this board that Senator Baucus and others talked about yesterday. What else would you do? How do we get a hold of this runaway train?

Dr. ORSZAG. There are lots of ideas out there. I would now say four key things. The first is, comparative effectiveness. The second is, we absolutely need to change the financial incentives for providers. Third is, we can do a lot more to encourage healthier living, and we can talk about that. The fourth is, we need to be experimenting much more, including through the Medicare demonstration projects, on what works and what does not in terms of coordinated care, in terms of accountable care organizations, in terms of pay-for-performance and what have you, all of which we could be doing today.

Senator SALAZAR. Go back to the four points.

Dr. ORSZAG. All right. Comparative effectiveness research, what works and what does not. Pay for the stuff that works and do not pay for the stuff that does not. Encourage healthier living, and we can flesh that out a little bit more. Then use Medicare and other public programs to be experimenting with what works and what does not in terms of the delivery system—so, accountable care organizations, coordinated care, disease management, pay-for-performance incentives, and what have you so that we have a sort of active learning system for what works and what does not, because it is going to take a lot of experimentation to bend this curve.

Senator SALAZAR. Thank you very much.

Senator CONRAD. Changing incentives.

Dr. ORSZAG. That was the second. Absolutely key.

Mr. DODARO. Also, the one thing that I would add to that list, and to go back to your comment, Mr. Chairman, that we may not have the expertise at the Senate to deal with this, but you could think about creating a structure that sets standards of care in some of these areas and what kind of information reporting should come on a regular basis so people have the information. In other words, there need to be tools that are put into the system, both in standards and information reporting, that provide a regular amount of data to feed into the type of research that Dr. Orszag is talking about and the decisions that have to be made over time. In other words, to put a structure in place to help facilitate this, I think would be something—should be something—the Congress considers.

Dr. ORSZAG. It may make sense for you or others to ask GAO or us to try to flesh out the Federal health board structure and the pros and cons of different structures that could be thought about.

The CHAIRMAN. Great minds think alike. That very concept was going through my mind, of asking you to do just that.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I have a couple of things that go through my mind as I listen to you. One, if you go over what I would call, in my bipartisan nature, the absolute disaster of tax cuts, Iraq, and no attention to any infrastructure ability, no attention to anything that relates to the future, like, NIH can produce things which could reduce—but you cannot get grants for them now—the National Science Foundation, not for health, but for other things.

I started out with the premise that Medicare and Medicaid should not be cut to the extent that it affects health care needs that people actually have. All right? I also put Medicare and Medicaid in the long-term context of the budget debt out in the future. I am not quite as radical as my friend Mr. Conrad over here. What difference does it make? I think it does make some. But he is usually right.

So we have, as a Nation, magnificently and totally ignored long-term care policy. The only place we have it is in the VA system, and that is on an outpatient basis. It is obviously a different situation. We have ignored end-of-life care, which we have discussed now 4 or 5 times in the last day. It is a huge expense.

The Hippocratic Oath does not say we are going to cure you, it says we are not going to do harm to you and we are going to maintain your quality of life. We are doing neither, not just in the last year of life, but in the case of some kinds of chronic diseases, in the last 5, 8, 10 years of life where people basically are not there, and huge amounts of money are being spent on them.

So I am really for the idea of taking Medicare and Medicaid and looking at hospitals, like this one chart that someone gave me on spending in the last 6 months of life, and then showing UCLA, Massachusetts General Hospital, and the Mayo Clinic, and the enormous variation in what they treat. I had an operation at Johns

Hopkins. Johns Hopkins can do no wrong. That is what you are saying: this is the way we do it.

I am not sure we should let people get away with that. Part of institution building in health care is their self-esteem, their sense of morale, and all of that. They do compete. They like that. They have to track doctors. That is important. How they are seen affects that. So, my second point would be, having said that, there is an enormous amount of work we can do in this Congress, I think, on regulating behavior.

I do not mean that in a bad way, but simply, rationally, reasonably looking at the differences of what people's outcomes are and saying, that is not sufficient. We just tell them and they will hate it, and it will be called socialism, and all the rest of it. So be it. You can do that across the board in Medicaid and Medicare: better outcomes, do not waste the money, $700 billion that does not do any good, or whatever it was that you said.

The other thing is, I remember RBRVS so well, the Resource-Based Relative Value Scale, and the attempt to try to make more sense out of primary care, pediatric care, preventive care which would come with the pediatric, and all the rest of it. That was 1989, 100 years ago. That has been replaced by a system in which lobbyists in this town swamp our offices with their special niches because they are not looking at what used to be a chart up there. They are not looking at that, they are looking at their share of the pie and their share of the pie only.

I sat last night at a dinner at the Alliance for Health Reform between the head of a major medical association in this country and the head of a major foundation on health care in this country, and they were furious about that. They said, we are being done in by specialties, or niches, or durable medical equipment people, whoever it is, who come in for their own purposes and care not a whit about the long-term effects, much less anything called universal health care or a rational system.

So I just want to make the point—I am not asking a question because I have talked too long. I am unwilling, in my State of West Virginia, to see Medicaid or Medicare cut to the disadvantage of my people. I am willing and very anxious to see new practice techniques and technology, and end-of-life care, and long-term care, and all kinds of things where maybe you have to spend a little bit more to save money later, but you do those things and you do not let hospitals—and you get those statistics. That is a superb idea. I mean, this is revolutionary to me. There is no excuse that they can make, and we do not hold them accountable because we do not know what they are doing.

So I will continue on this in the next round, but I really feel that there is a lot that we can do here to cut the costs, and then also looking at the larger picture of the national economy, this business of tax cuts and this absolutely essential war that we fought in Iraq for all these years. I mean, it is just horrendous, what that also does to where your charts end up.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman. I do not want to make this a bouquet-tossing contest, but yesterday's program was terrific, and we sure need a lot more of that kind of work.

I want to start with you, Dr. Orszag, because I believe that central to holding down health costs is to adopt new policies that empower Americans to be smarter shoppers for health care so that they can get more value for their health care dollar, and providers and payers see that, if they do not squeeze out some of that $700 billion you say is wasted, in effect they go somewhere else. We tried to do that in the Healthy Americans Act, and we were pleased about the scoring that said it was budget-neutral in the short term and could actually help to hold down the rate of growth in the 3rd year.

Tell me a little bit about your thinking at page 8, because we subscribe to that where you say making the underlying costs associated with employment-based insurance more transparent might provide an opportunity to contain health costs.

Dr. ORSZAG. Yes. The basic thought there is that one of the things that perpetuates inefficiency in the health system is that workers do not demand as much from the system as they would if they knew how much it was actually costing them.

The economic evidence is overwhelming, the theory is overwhelming, that when your firm pays for your health insurance you actually pay through reduced take-home pay. The firm is not giving that to you for free. Your other wages, or what have you, are reduced as a result. I do not think most workers realize that. The backlash that you all hear about out-of-pocket spending, which is significant, is striking when you realize that out-of-pocket spending is only 15 percent of the total.

So coming back to a point I made earlier, imagine what the world would be like if workers realized that, today, it was costing them $10,000 a year in take-home pay for their employer-sponsored insurance, and that could be $7,000 and they could have $3,000 more in their pocket today if we could wring these efficiencies out of the health system. Making those costs more transparent may generate demand for efficiency, and yes, your legislation does make those costs more transparent.

Senator WYDEN. How, in your analysis of that legislation, did the cash-out, the transparency, figure in to the scoring that you did, the report you gave us?

Dr. ORSZAG. The budget neutrality actually was accomplished without that channel really operating. I think that over the long term that channel may turn out to be as important, if not more important, than the sort of traditional economics that reflects the initial guidance that you received.

Senator WYDEN. And then as people are smarter shoppers—and what we do is we make sure everybody is in a pool, we make sure it is not connected to risk, and there are insurance reform subsidies for the low-income people. We also have people say, that is good, we like it, but we want to be rewarded for preventive kinds of approaches. So what we said is, as the families take their kids to preventive kinds of services, they would get reductions in their premiums. Do you think that has the potential for the kinds of savings that you talk about down the road?

Dr. ORSZAG. I think prevention has significant potential to improve the quality of our health. The evidence on the degree to which prevention itself saves money, especially in the short run, is much more mixed and in general is not as strong as many proponents think, although I would note, even there, there are things—for example, vaccinations for flu during flu season for Medicare beneficiaries—that probably would save money even in the 5- or 10-year window, and we are not at 100-percent take-up for those kinds of things, so there are preventative steps that would save money even within 5 or 10 years. But most of the payoff, especially in terms of quality, would be longer-term, and the effect on cost is a little bit more ambiguous.

Senator WYDEN. And what about reforming the tax code? I mean, we have essentially a system today in 2008 that is not very different than 1948. The consumer, again, is in the dark. In the Healthy Americans Act we want to make sure people know what employers are spending. You talk about the transparency argument. Would tax reform in this area not also be another one that sheds some light for individuals, that they have a stake in this and they are not divorced from it as they are in today's system?

Dr. ORSZAG. Economists have long had concerns about the structure of the tax incentive for employer-sponsored insurance, which, according to traditional economic thinking, creates an incentive for employer-sponsored insurance as opposed to other forms of insurance, creates an incentive for gold-plated plans as opposed to other kinds of health insurance plans, and creates job lock in the sense that workers are worried about moving from job to job because of the loss of health insurance. In addition to that, there is also the sort of cost consciousness that we were just discussing.

Senator WYDEN. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

I would just be curious how these alarming cost curves in the United States compare with cost curves in other countries, and in terms of the Federal budget deficit. I presume that some would project other countries' expenditures off into the future, because they have lower health care costs per capita compared with the United States—dramatically lower—that the curves would not look so alarming in those countries.

Dr. ORSZAG. Health care costs, even though they are lower in other countries, are rising across the industrialized world. In terms of the overall fiscal burden, a larger share of the long-term fiscal problems that, for example, continental European countries face is associated with their pension plans, their equivalent of Social Security, both because their populations are aging more rapidly than ours are, and because their pension plans tend to be more generous than the Social Security system here is. Most industrialized countries face some long-term problem. There are some that look pretty good. The U.K., for example, is in decent shape. But I would say our problem is among the larger problems, both in magnitude and in terms of share of GDP.

The CHAIRMAN. And Japan and the Asian countries—let us say, Taiwan—about the same?

Dr. ORSZAG. Most countries, including Japan, face significant long-term fiscal problems. The share that is attributable to aging

varies across countries, but it is more prominent in many other countries than it is here.

The CHAIRMAN. You touched on this. Actually, I just said it. All these charts somewhat assume a static analysis, that is, they do not take into account all you have talked about, a collapse. They just assume that they go along——

Dr. ORSZAG. Those are the good scenarios.

The CHAIRMAN. Those are the good scenarios. As bad as they are, they are good scenarios.

Dr. ORSZAG. Yes.

Mr. DODARO. It is very conservative.

The CHAIRMAN. They are good scenarios. The bad scenario is, something just collapses, something breaks. As you said, whenever something is unsustainable, something bad happens. In my judgment, it happens sooner rather than later. It reminds me of a Japanese poem which I learned a long, long time ago, in English. [Laughter.] Which is, "I always knew one day I'd travel down this road, only I didn't know it would be so soon." I just sense, it's like a lot of bubbles. Subprime, everyone knew that was a problem. The dot-com bubble. This was kind of a bubble here too, and something bad is going to happen earlier rather than later if we do not address it more quickly.

Mr. DODARO. Along the lines of your questions about other countries, Mr. Chairman: a number of other countries have put in place fiscal sustainability reporting where they do run alternative scenarios that would be along the lines of what you talked about. We have recommended that we consider doing that here in the United States as well.

The CHAIRMAN. We talked on this a bit, too, Dr. Orszag. What kinds of studies would you like to see us, the Finance Committee, the Congress, ask you to do, CBO or GAO? You kind of know what the problem is here. Are there some components or aspects of it that perhaps we should ask you to focus on, both to get the facts and also to dramatize and highlight what some of the problems are?

Dr. ORSZAG. And you are asking me this in front of my staff? [Laughter.]

The CHAIRMAN. I am. [Laughter.]

Dr. ORSZAG. Maybe we can have a discussion later.

The CHAIRMAN. All right.

While I am talking, Mr. Dodaro, you can consult with your staff. [Laughter.]

Mr. DODARO. A couple of things come immediately to mind, Mr. Chairman. One, there are a lot of activities in the States, in Massachusetts and other States, that are trying different models. How well are those models working? Are there lessons to be learned from the State activities? That would be one thing that could be shared.

Second, I believe that you are talking about a situation where there is really a structural problem and there is not a lot in the way of standards or good information readily available. I think looking at that issue and what are the options for the Congress, to put in place a systematic set of standards and information is the only way you are ever going to get ahead of this situation. Cer-

tainly, you can do targeted studies, but time goes by, and a lot of expenditures take place. You need more regularized reporting, analysis, and transparency to be able to deal with this.

The CHAIRMAN. Well, that is a very good point. Sometimes, it occurs to me, there is just not enough data on subject A, B, or C. Is there something that we can do here in the Congress to ask for agencies or the private sector, somebody, to provide more data in certain areas? If so, at this point, what comes to mind?

Dr. ORSZAG. I would identify two things, in particular. I should say, by the way, I think in terms of CBO, perhaps the best thing we could do, in addition to perhaps the study we have already discussed, is these two major reports that we are currently working on that will be out within the year on health options.

The CHAIRMAN. Right. Right.

Dr. ORSZAG. With regard to data, you can have more reporting of the data that is actually out there already, and some of the part D data comes to mind.

The CHAIRMAN. Right.

Dr. ORSZAG. I know that there is discussion going on. And Medicare Advantage is also a big area where we could be getting more reporting from the plans in terms of what they are doing and not doing.

The CHAIRMAN. Right.

Dr. ORSZAG. And then in terms of building out the data in the future, health information technology could provide a significant backbone for providing data. The approaches that have been adopted so far in policies I have seen involve subsidies for health information technology which will work for providers that are close to adopting it on their own. There are alternatives that would probably get widespread adoption much faster than small subsidies, but I know they are dicier.

The CHAIRMAN. My time has expired. Thank you very much.

Senator Conrad?

Senator CONRAD. Let me ask you this. When politicians—and I count myself as one—hear that we have a serious problem out in 2050, boy, we are not going to be here in 2050, so we can just kick that can down the road. So why can we not just kick this can down the road before we do something? It sounds to me from what I heard here today that we could wait 4 or 5 years before we do anything. Is that the case?

Dr. ORSZAG. I do not think so. Here is the basic problem. If you waited, first of all, it is not going to be as long as the projection suggests because the system will collapse before then. But more importantly, there is so much infrastructure that needs to be built in order to make sound judgments, that the longer you wait the harder it is going to be to do.

So we do not have a comparative effectiveness entity, we do not have the demonstration projects in place to be figuring out what works and what does not. We do not have the structures in place to make intelligent decisions. The longer you wait to start doing that, you are just going to be shooting in the dark.

Senator CONRAD. Let me ask you this. The conversation this morning mostly has focused on health care, because we all know that is the 800-pound gorilla. But that is not the only gorilla in the

room. We have Social Security. That is headed for a circumstance in which it goes cash negative in 2017. Right now it is throwing off $200 billion a year that we are using to pay operating expenses. I heard that in your testimony, Mr. Dodaro.

Mr. DODARO. Right. That is correct.

Senator CONRAD. But that is going to change, and going to start to change quite soon because that surplus that we are using to pay operating expenses is going to start to decline in about 2011. Then it is going to go cash negative in 2017, and then we are going to have to start borrowing money from the general fund, right? We are going to have to be having money from the general fund go over into Social Security. So that is a situation that we are going to face quite soon, is it not?

Mr. DODARO. That is correct. In 2011—in fact, that chart—Figure 5 again, if I could put it back up there—shows that the reason that Congress had to raise the debt ceiling is not only from borrowing from the public to finance the unified Federal deficit. In addition, it is going up because the Federal Government is using the Social Security surplus of payroll tax receipts over benefit costs to fund current operations. That changes in 2011, when the cash surplus starts shrinking. Then in 2017, Social Security's cash flow turns negative, and we will have to turn it around.

Senator CONRAD. So, boy, are we in for a big surprise around here. We have been having a growing Social Security surplus that we were able to use to pay operating expenses. Now that is going to start declining as soon as 2011, and by 2017, instead of having $200 billion that actually sort of works as a bonus around here, it is going to start going the other way and we are going to have to be drawing money out of general fund expenditures. Now, that is only 9 years away, and in budget years it is only 8 years away.

Mr. DODARO. Right.

Senator CONRAD. So, if I could ask Dr. Orszag, how soon do we need to take action, in your judgment?

Dr. ORSZAG. I would agree with Chairman Bernanke, that "10 years ago" would be the appropriate response to that question.

Senator CONRAD. Ten years ago. And what if we do not act now to meaningfully reduce this trajectory?

Dr. ORSZAG. Every year that goes by, you are increasing the risk of the collapse that the chairman mentioned.

Senator CONRAD. And what kind of a collapse are we talking about?

Dr. ORSZAG. When things go wrong, they can go wrong in such a wide array of ways that it is hard to play out all the possible scenarios. But what we are really talking about is, for example, if the very significant purchases of government debt from abroad that are currently occurring dried up, you would see a very sharp increase in interest rates in the United States. You would see a collapse in confidence—that is possible. You would see a significant reduction in economic activity and a significant hit to household incomes as a result. Again, that could pale—that could just make our current economic difficulties look tiny. That is not a scenario we want to live through.

Senator CONRAD. A number of years ago, former Secretary Rubin asked me to lunch. He said to me, don't they get it down there?

Don't they understand the risks that are being run, that if the kind of adverse scenario that you outlined were to begin, there are not good alternatives, because the only way then you could attract capital is to significantly raise interest rates, and that would have a severe effect on the economy.

My time has expired.

The CHAIRMAN. Senator Rockefeller?

Senator ROCKEFELLER. Thank you.

A very famous doctor by the name of Orszag [laughter] said back in 2007, June 21st, 3 days after my birthday——

Senator CONRAD. Would that make your birthday the 24th?

Senator ROCKEFELLER [continuing.] And you run the Budget Committee? [Laughter.]

Senator CONRAD. No wonder we are in trouble.

Senator ROCKEFELLER. Many analysts believe that significantly constraining the growth of cost for Medicare and Medicaid over long periods of time while maintaining broad access to health care providers under those programs can only occur in conjunction with slowing cost growth in the health care system as a whole; ultimately, therefore, restraining costs in Medicare and Medicaid requires restraining overall health care costs.

Now, this is to both of you. In my first round of questions I suggested a whole series of things in this incredible piece of data from UCLA, Massachusetts General, and the Mayo Clinic. I mean, it is just stunning, what we do not know. One of you said that you do not think the Senate has the capacity to judge these things.

I would argue with that. If we had the data, there are superb health care staffers all over both sides of the Congress. But the data, I think, is one of the answers. I go back to my statement, that efficiencies in Medicare and efficiencies in Medicaid, provided they do not affect the quality of the care that people are getting, I will fight that unless we have a plan to do that.

Now, my question to you—both of you—is, what are some of the things you would do to bring down the overall costs of health care or that you would suggest that we do?

Dr. ORSZAG. Well, again, I think the first place to start is exactly that kind of variation you have highlighted from this chart on UCLA Medical versus the Mayo Clinic. And by the way, I guess I have made myself unpopular with the folks at UCLA Medical. If I ever get sick in Los Angeles, I am not going there. [Laughter.] But coming back to the exchange with Senator Salazar, I think the way to get at this involves much more information, something that you have already identified, and that will likely require health information technology. If we were serious about——

Senator ROCKEFELLER. And which we could do together, right?

Dr. ORSZAG. Yes. And if we were serious about that, you could get health information technology systems dramatically expanded throughout the health system if you tied it to Medicare reimbursement. If we really wanted to do this, if you simply said in order to be reimbursed under Medicare you have to have a system that meets the following qualifications, it would happen virtually overnight. The second thing we need to do is we need to change the financial incentives so that we are not just paying for more of this

stuff to happen at UCLA Medical if there is no evidence that it works.

Senator ROCKEFELLER. Can I just put an implant there?

Dr. ORSZAG. Sure.

Senator ROCKEFELLER. Ophthalmologists, RBRVS. They were using the totally new laser technology and charging prices that were based upon it before that even existed, so we took them down somewhat in RBRVS. It did not have any effect. It did not have any effect.

So we are talking about hospitals. We also talk about doctors. They practice and sometimes they pull out of hospital systems and go off on their own, and we do not like that because we say that is depriving people of general hospital care. The hospitals certainly say that. But behavior modification—and that is not a moral judgment, it is simply a clinical judgment about what works and what does not, what is fair and what is not fair, to charge within some flexibility—I think is a fair point we ought to be putting pressure on the medical community about, and we are not. Do you agree with that?

Dr. ORSZAG. Yes.

Mr. DODARO. I agree. That was one of the points I made earlier about standard setting. There needs to be more standard setting, and then you can judge adherence to the standards and development.

The other issue is, with the advent of bringing on technology, there is really not a requirement for a cost-effectiveness evaluation of bringing the technology on board by some of the Federal agencies that look at it from a safety standpoint. That is another potential opportunity to look at so you introduce a little bit more rigor into that process.

Senator ROCKEFELLER. And do you think the combination of the technology, the much greater oversight based upon much better knowledge of data, et cetera, about both hospitals, doctors, and practices—yet understanding you just cannot say, this is it and that is all—do you think that that would have a substantial enough effect on Medicare and Medicaid so that people would still continue to get it, but they would get it more efficiently, but not without the same, or maybe better, quality? The quality has to be good. That cannot be compromised. We cannot cut back on a program just for the sake of doing it.

Mr. DODARO. Right. I think those items would be a good start, but we have to wait and see how they would be implemented over time. There needs to be some transparency about outcomes as well, and we need to educate consumers as part of the discussion that occurred before. But I think it would be a start.

Senator ROCKEFELLER. And medical associations have to get involved in this, too.

Mr. DODARO. Yes.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman.

Both of you have been very professional and certainly have rung the alarm bell. What I want to do is ask about an area that I think gives us real grounds to be optimistic as we walk out. It seems to me what is clear in what you both have said is, on health care, if you reorganized the delivery system, if you changed the incentives that keep people from being smart shoppers, if you make changes in the tax code, for example, which drive so much of Federal spending, you can not only deal with a lot of these cost questions, but based on the reports that you sent to me, Dr. Orszag, you can get everybody in the United States good-quality, affordable coverage. That is essentially what you said to me in that report.

Is it not correct that, if you are bold here and you make the kinds of changes you are talking about, that you can actually get to universal coverage? Is that not what you essentially told us in the report you gave us on the Healthy Americans Act?

Dr. ORSZAG. What the letter to you said was, given all the changes in your legislation, that, yes, you would get to nearly universal coverage in a budget-neutral way.

Senator WYDEN. And what I think is striking about it, because Chairman Baucus always highlights the fact that this is going to have to be a team approach to get to universal coverage, I think there are other approaches that can get us there as well. I just appreciate the way you all have provided the wake-up call to the U.S. Senate, because clearly, if you do nothing, it is going to be bedlam.

My own view is, health costs and economic well-being are two sides of the same coin. I mean, the reason people's take-home pay does not go up is because it all is left on the floor with health costs. But I want people to walk out of here being optimistic, and you just gave us that reason again, Dr. Orszag. If you are willing to make bold changes in the delivery system, in the incentives, in the areas that drive Federal cost, not only can you start turning out the growth curve, but you can actually get to where people want to go in this country, which is to fix the system, which means covering everybody.

Both of you have been very professional, as has been the Joint Committee on Taxation. I just wanted to highlight, for my last question, Mr. Chairman, I think, if we follow your model of a teamwork kind of approach that is bipartisan, that last answer that Dr. Orszag gave us gives us real grounds to be optimistic that in 2009, with your leadership, Chuck Grassley's leadership, we can deal with the premier domestic issue of our time.

I thank both of our witnesses. That allows me to walk out of this room saying I think there is a lot of reason to be optimistic, and I thank you.

The CHAIRMAN. Thank you, Senator, very much. I agree with you. I think, with the hearings we have had, the summit yesterday, and the tone of this hearing today, searching for the truth, that the prospects are quite good. We do not have much choice, but they are quite good, nevertheless. I very much appreciate this hearing. I wish there had been a few more on the other side of the aisle here, but that will happen. That will come.

So, thank you all very much. Thank you both very, very much for your contribution here. I have a hunch we will be talking a lot more. We will also be asking you to give us some reports, and

maybe, after our staffs talk a little more, we can figure out which ones will be the most effective. Thank you very much.

The hearing is adjourned.

[Whereupon, at 11:13 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

United States Government Accountability Office

GAO

Testimony
Before the Committee on Finance,
U.S. Senate

For Release on Delivery
Expected at 10:00 a.m. EDT
Tuesday, June 17, 2008

LONG-TERM FISCAL OUTLOOK

Long-Term Federal Fiscal Challenge Driven Primarily by Health Care

Statement of Gene L. Dodaro
Acting Comptroller General of the United States

GAO-08-912T

GAO
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Highlights

Highlights of GAO-08-912T, a testimony to the Committee on Finance, U.S. Senate

Why GAO Did This Study

GAO was asked to provide its views on the long-term fiscal outlook. This statement addresses four key points: (1) the federal government's long-term fiscal outlook is a matter of utmost concern; (2) this challenge is driven primarily by health care cost growth; (3) reform of health care is essential but other areas also need attention which requires a multipronged solution; and (4) the federal government faces increasing pressures yet a shrinking window of opportunity for phasing in needed adjustments.

GAO's simulations of the federal government's long-term fiscal outlook were updated with the Trustees 2008 intermediate projections and continue to indicate that the long-term outlook is unsustainable. This update combined with GAO's analysis of the fiscal outlook of state and local governments demonstrates that the fiscal challenges facing all levels of government are linked and should be considered in a strategic and integrated manner.

Since 1992, GAO has published long-term fiscal simulations of what might happen to federal deficits and debt levels under varying policy assumptions. GAO developed its long-term model in response to a bipartisan request from Members of Congress who were concerned about the long-term effects of fiscal policy. Information about GAO's model and assumptions can be found at http://www.gao.gov/special.pubs/longterm/.

To view the full product, including the scope and methodology, click on GAO-08-912T. For more information, contact Susan J. Irving at (202) 512-9142 or irvings@gao.gov or Marjorie Kanof at (202) 512-7114 or kanofm@gao.gov.

June 17, 2008

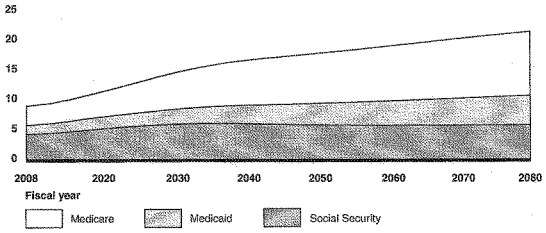
LONG-TERM FISCAL OUTLOOK

Long-Term Federal Fiscal Challenge Driven Primarily by Health Care

What GAO Found

Long-term fiscal simulations by GAO, the Congressional Budget Office (CBO), and others all show that despite a decline in the federal government's unified budget deficit between fiscal years 2003 and 2007, it still faces large and growing structural deficits driven primarily by rising health care costs and known demographic trends. Simply put, the federal government is on an unsustainable long-term fiscal path. Although Social Security is important because of its size, over the long term health care spending is the principal driver—Medicare and Medicaid are both large and projected to continue growing rapidly in the future.

Social Security, Medicare, and Medicaid Spending as a Percentage of GDP



Source: GAO analysis.

Rapidly rising health care costs are not simply a federal budget problem. Growth in health-related spending is the primary driver of the fiscal challenges facing state and local governments as well. Unsustainable growth in health care spending also threatens to erode the ability of employers to provide coverage to their workers and undercuts their ability to compete in a global marketplace. Public and private health care spending continues to rise because of several key factors: (1) increased utilization of new and existing medical technology; (2) lack of reliable comparative information on medical outcomes, quality of care, and cost; and (3) increased prevalence of risk factors such as obesity that can lead to expensive chronic conditions.

Addressing health care costs and demographics—and their interaction—will be a major societal challenge. The longer action on reforming heath care and Social Security is delayed, the more painful and difficult the choices will become. The federal government faces increasing pressures yet a shrinking window of opportunity for phasing in adjustments. In fact, the oldest members of the baby-boom generation are now eligible for Social Security retirement benefits and will be eligible for Medicare benefits in less than 3 years. Additionally, in addressing this fiscal challenge it will be important to review other programs and activities on both the spending and revenue sides of the budget.

Chairman Baucus, Senator Grassley, and Members of the Committee:

I appreciate this invitation to talk with you about the federal government's long-term fiscal outlook. Under any plausible scenario, the federal budget is on an unsustainable path. Long-term fiscal simulations by GAO, the Congressional Budget Office (CBO), and others all show that despite a decline in the federal government's unified budget deficit between fiscal years 2003 and 2007, it still faces large and growing structural deficits. This long-term path is driven primarily by rising health care costs and known demographic trends. In fact, the oldest members of the baby-boom generation are now eligible for Social Security retirement benefits and will be eligible for Medicare benefits in less than 3 years. According to the Social Security Administration, nearly 80 million Americans will become eligible for Social Security retirement benefits over the next two decades—an average of more than 10,000 per day. Although Social Security is important because of its size, the principal driver of the long-term fiscal outlook is health care spending. Medicare and Medicaid are both large and projected to continue growing rapidly in the future.

Today, I will emphasize a few key points:

- the federal government's long-term fiscal outlook is a matter of utmost concern,
- this challenge is driven primarily by health care cost growth,
- reform of health care is essential but other areas also need attention—this is a multipronged problem that requires a multipronged solution, and
- the federal government faces increasing pressures yet a shrinking window of opportunity for phasing in adjustments needed by individuals in the public and private sectors.

My remarks are based on GAO's previous work on a variety of issues, including various reports and testimonies on our nation's long-term fiscal challenges, health care, and the need for budget process reform. These efforts were conducted in accordance with generally accepted government auditing standards.

The Long-Term Fiscal Outlook Remains Unsustainable

The unified budget deficit declined between fiscal years 2003 and 2007, but this did not change the long-term path: it remains unsustainable. Moreover, while the recent past shows some progress in the annual unified deficit figures, any assessment of the federal government's long-term fiscal outlook also needs to recognize the fact that the Social Security cash surplus has been used to offset spending in the rest of government

for many years. In fiscal year 2007, for example, the "on-budget" deficit—the deficit excluding the Social Security surplus[1]—was $344 billion, more than double the size of the unified deficit of $163 billion. There is a limit to how long the Social Security surplus will offset other spending. The rest of the budget will feel the pressure when the Social Security cash surplus begins to decline starting in 2011—less than 3 years from now. In 2017 the Social Security cash flow turns negative—at that point the choices will be increased borrowing from the public, reduced spending, or increased revenue.

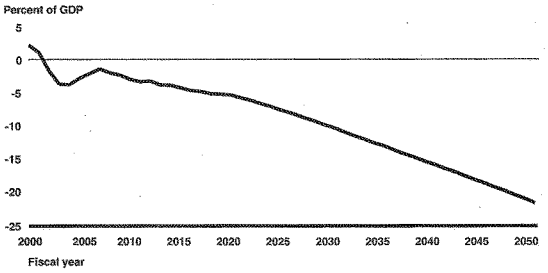
These dates call attention to the narrowing window. The real challenge then is not this year's deficit or even next year's; it is how to change the current fiscal path so that growing deficits and debt levels do not reach unsustainable levels. By definition something that is unsustainable will stop—the challenge is to take action before being forced to do so by some sort of crisis. Health care costs are growing much faster than the economy, and the nation's population is aging. These drivers will soon place unprecedented, growing, and long-lasting stress on the federal budget. Absent action, debt held by the public will grow to unsustainable levels.

Figure 1 shows GAO's simulation of the deficit path based on recent trends and policy preferences. In this simulation, we start with CBO's baseline and then assume that (1) all expiring tax provisions are extended through 2018—and then revenues are brought to their historical level as a share of gross domestic product (GDP) plus expected revenue from deferred taxes—(2) discretionary spending grows with the economy, and (3) no changes are made to Social Security, Medicare, or Medicaid.[2]

[1]The Postal Service is also off-budget, but it had a deficit of $5 billion in fiscal year 2007.

[2]Social Security and Medicare spending are based on the programs' 2008 Trustees' intermediate projections. Medicare spending is adjusted using the Centers for Medicare and Medicaid Services' estimates assuming that physician payments are not reduced as required under current law. Medicaid spending is based on CBO's December 2007 long-term projections adjusted to reflect excess cost growth consistent with the Trustees' intermediate projections. Additional information about GAO's simulation model, assumptions, data, and results can be found at http://www.gao.gov/special.pubs/longterm/.

Figure 1: Unified Federal Surpluses and Deficits under GAO's Alternative Simulation



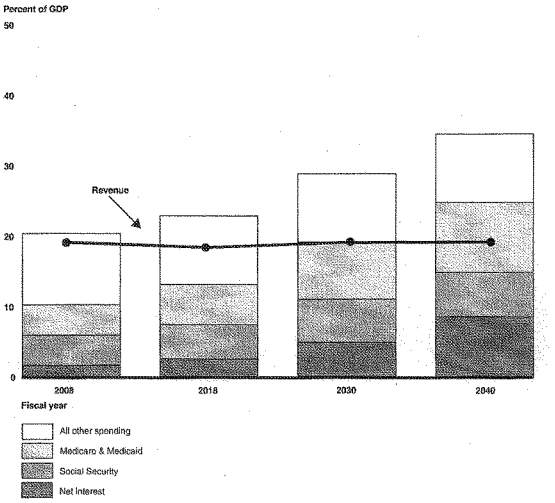
Source: GAO's April 2006 analysis.

Note: Assumes currently scheduled Social Security and Medicare Part A benefits are paid in full throughout the simulation period.

Figure 2 looks behind the deficit path to the composition of federal spending. It shows that the estimated growth in Medicare, Medicaid, and to a lesser extent Social Security leads to an unsustainable fiscal future. In this figure the category "all other spending" includes much of what many think of as "government"—discretionary spending on such activities as national defense, homeland security, veterans health benefits, national parks, highways and mass transit, and foreign aid, plus mandatory spending on the smaller entitlement programs such as Supplemental Security Income, Temporary Assistance for Needy Families, and farm price supports.[3] The growth in Social Security, Medicare, Medicaid, and interest on debt held by the public dwarfs the growth in all other types of spending.

[3]Discretionary spending refers to spending based on authority provided in annual appropriations acts. Mandatory spending refers to spending that Congress has authorized in legislation other than appropriations acts that entitles beneficiaries to receive payment or that otherwise obligates the government to make payment.

Figure 2: Potential Fiscal Outcomes under GAO's Alternative Simulation: Revenues and Composition of Spending as Shares of GDP



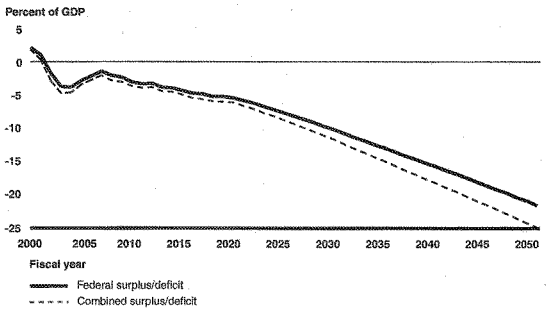
Source: GAO's April 2008 analysis.

Notes: Discretionary spending grows with GDP after 2008. The Alternative Minimum Tax (AMT) exemption amount is retained at the 2007 level through 2018 and expiring tax provisions are extended. After 2018, revenue as a share of GDP returns to its historical level of 18.3 percent plus expected revenues from deferred taxes (i.e., taxes on withdrawals from retirement accounts). Medicare spending is based on the Trustees' 2008 projections adjusted for the Centers for Medicare and Medicaid Services' alternative assumption that physician payments are not reduced as specified under current law.

Rapidly rising health care costs are not simply a federal budget problem; they are a problem for other levels of government and other sectors. As shown in figure 3, GAO's fiscal model demonstrates that state and local governments—absent policy changes—will also face large and growing

fiscal challenges beginning within the next few years.[4] As is true for the federal budget, growth in health-related spending—Medicaid and health insurance for state and local employees and retirees—is the primary driver of the long-term fiscal challenges facing the state and local governments. These simulations imply that state and local fiscal challenges will add to the nation's fiscal difficulties and suggest that the nation's fiscal challenges cannot be remedied simply by shifting the burden from one sector to another.

Figure 3: Federal and Combined Federal, State, and Local Fiscal Imbalance



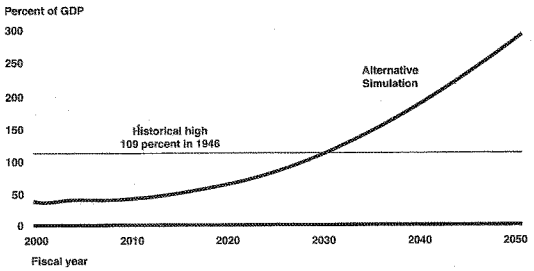
Source: GAO's April 2008 analysis.

Note: Federal surpluses and deficits are from GAO's alternative simulation.

If unchanged, the federal government's increased spending and rising deficits will drive a rising debt burden. At the end of fiscal year 2007, federal debt held by the public exceeded $5 trillion. Figure 4 shows that this growth in the federal government's debt cannot continue unabated without causing serious harm to the economy. In the last 200 years, only during and after World War II has debt held by the public exceeded 50 percent of GDP.

[4]See GAO, *State and Local Governments: Growing Fiscal Challenges Will Emerge during the Next 10 Years*, GAO-08-317 (Washington, D.C.: Jan. 22, 2008), and *State and Local Governments: Persistent Fiscal Challenges Will Likely Emerge within the Next Decade*, GAO-07-1080SP (Washington, D.C.: July 18, 2007).

Figure 4: Debt Held by the Public under GAO's Alternative Simulation

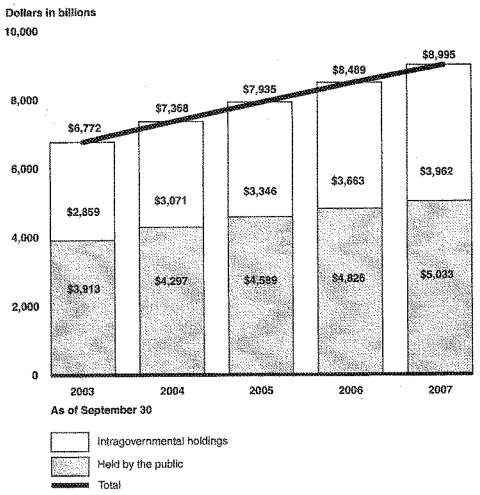


Source: GAO's April 2008 analysis.

Note: Assumes currently scheduled Social Security and Medicare Part A benefits are paid in full throughout the simulation period.

But this is only part of the story. The federal government for years has been borrowing the surpluses in the Social Security trust funds and other similar funds and using them to finance federal government costs. When such borrowings occur, the Department of the Treasury issues federal securities to these government funds that are backed by the full faith and credit of the U.S. government. Although borrowing by one part of the federal government from another does not have the same economic and financial implications as borrowing from the public, it represents a claim on future resources and hence a burden on future taxpayers and the future economy. If federal securities held by those funds are included, the federal government's total debt is much higher—about $9 trillion as of the end of fiscal year 2007. As shown in figure 5, total federal debt increased over each of the last 4 fiscal years.

Figure 5: Total Federal Debt Outstanding



Source: The Department of the Treasury.

On September 29, 2007, the statutory debt limit had to be raised for the third time in 4 years in order to avoid being breached; between the end of fiscal year 2003 and the end of fiscal year 2007, the debt limit had to be increased by about one-third. It is anticipated that actions will need to be taken in fiscal year 2009 to avoid breaching the current statutory debt limit of $9,815 billion.

While today's debt numbers are large, they do not represent a measure of all future claims. They exclude a number of significant items, such as the gap between currently scheduled Social Security and Medicare benefits and the revenues earmarked for these programs as well as the likely cost of veterans' health care and a range of other commitments and contingencies that the federal government has pledged to support. For example, the Statement of Social Insurance in the 2007 *Financial Report*

of the United States Government disclosed that as of September 30, 2007, for Social Security and Medicare alone, projected expenditures for scheduled benefits exceed earmarked revenues (i.e., dedicated payroll taxes and premiums) by approximately $41 trillion over the next 75 years in present value terms. Of that amount, $34 trillion is related to Medicare and $7 trillion to Social Security. While Social Security, Medicare, and Medicaid dominate the long-term outlook, policymakers need to look at other policies that limit flexibility—not necessarily to eliminate them but to at least be aware of them and make a conscious decision about them. Several years ago, we developed the term "fiscal exposures" to provide a framework for considering the wide range of responsibilities, programs, and activities that may explicitly or implicitly expose the federal government to future spending.[5]

Fiscal exposures vary widely as to source, extent of the government's legal obligation, likelihood of occurrence, and magnitude. They include not only liabilities, contingencies, and financial commitments that are identified on the balance sheet or accompanying notes, but also responsibilities and expectations for government spending that do not meet the recognition or disclosure requirements for that statement. By extending beyond conventional accounting, the concept of fiscal exposure is meant to provide a broad perspective on long-term costs and uncertainties. Fiscal exposures include items such as retirement benefits, environmental cleanup costs, the funding gap in Social Security and Medicare, and the life cycle-cost for fixed assets. Given this variety, it is useful to think of fiscal exposures as lying on a spectrum extending from explicit liabilities to the implicit promises embedded in current policy or public expectations.

Many ways exist to assess the long-term fiscal challenge. One quantitative measure is called "the fiscal gap." This measures the amount of spending cuts or tax increases that would be needed to keep debt as a share of GDP at or below today's ratio. The fiscal gap is an estimate of the action needed to achieve fiscal balance over a certain time period such as 75 years. Another way to say this is that the fiscal gap is the amount of change needed to prevent the kind of debt explosion shown in figure 4. The fiscal gap can be expressed as a share of the economy or in present value dollars.

[5]GAO, *Fiscal Exposures: Improving the Budgetary Focus on Long-Term Costs and Uncertainties*, GAO-03-213 (Washington, D.C.: Jan. 24, 2003).

For example, under our alternative simulation closing the fiscal gap would require spending cuts or tax increases equal to 6.7 percent of the entire economy over the next 75 years, or about $54 trillion in present value terms. To put this in perspective, closing the gap would require an increase in today's federal tax revenues of more than one-third or an equivalent reduction in today's federal program spending (i.e., in all spending except for interest on the debt held by the public, which cannot be directly controlled) and maintained over the entire period. Table 1 shows the changes necessary to close the fiscal gap over the next 75 years.

Table 1: Federal Fiscal Gap 2008–2082

	Fiscal gap		Change required to close gap compared to today's levels		
	Trillions of 2008 dollars	Share of GDP	Percentage increase in revenue	Percentage increase in individual income taxes	Percentage decrease in noninterest spending
Alternative	$54.0	6.7%	35.8%	78.3%	35.5%

Source: GAO's April 2008 analysis.

Policymakers could phase in the policy changes so that the tax increases or spending cuts would grow over time and allow people to adjust. The size of these annual tax increases and spending cuts would be more than five times the fiscal year 2007 deficit of 1.2 percent of GDP. Delaying action would make future adjustments even larger. Under our alternative simulation, waiting even 10 years would require a revenue increase of about 45 percent or noninterest spending cuts of about 40 percent. This gap is too large to grow out of the problem. To be sure, additional economic growth would certainly help the federal government's financial condition, but it will not eliminate the need for action.

The Federal Government's Long-Term Fiscal Outlook Is Driven Primarily by Health Care

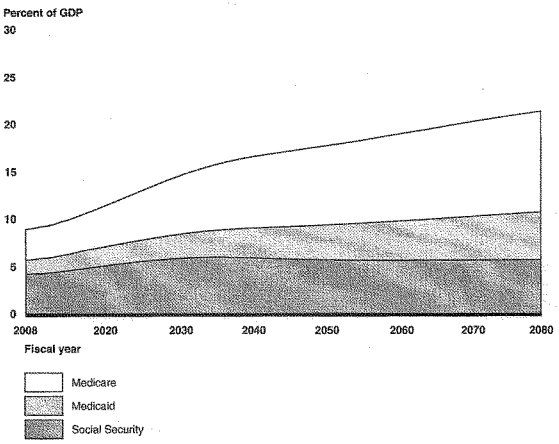
The large fiscal gap is primarily the result of spending on Medicare and Medicaid, which continue to consume ever-larger shares of both the federal budget and the economy. Federal expenditures on Medicare and Medicaid represent a much larger, faster-growing, and more immediate problem than Social Security. Medicare and Medicaid are not unique in experiencing rapid spending growth, but instead this growth largely mirrors spending trends in other public health care programs and the overall health care system. A number of factors contribute to the rise in spending, including the use of new medical technology and market

dynamics that do not encourage the efficient provision of health care services. Addressing these challenges will not be easy.

Health Care Costs Have Outpaced Economic Growth

Federal health care spending comprises a myriad of programs, but federal obligations are driven by the two largest programs, Medicare and Medicaid. Spending for these two programs threatens to consume an untenable share of the budget and economy in the coming decades. Figure 6 shows the total future draw on the economy represented by Social Security, Medicare, and Medicaid. While Social Security will grow from 4.3 percent of GDP today to 5.8 percent in 2080, Medicare and Medicaid's burden on the economy will more than triple—from 4.7 percent to 15.7 percent of the economy. Although some of the increased burden is due to the aging of the population, the majority is due to increased costs per beneficiary, some of which is the result of interaction between demographics and health care spending. Consequently, unlike Social Security, which will level off after growing as a share of the economy, Medicare and Medicaid will continue to grow. The projections for Medicaid spending assume a long-term cost growth rate consistent with the long-term growth rate assumption of the Medicare Trustees—GDP per capita plus about 1 percent on average. This growth rate, which would represent a slowing of the current trend, is well below recent historical experience of about 2.5 percent above GDP per capita.

Figure 6: Social Security, Medicare, and Medicaid Spending as a Percentage of GDP



Source: GAO analysis.

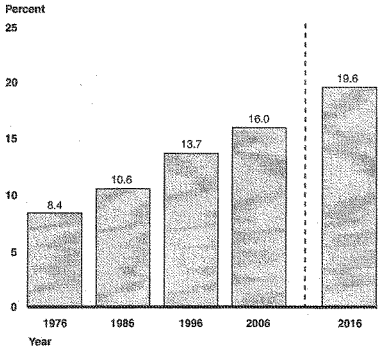
Note: Social Security and Medicare projections are from the Office of the Chief Actuary, Social Security Administration, and Office of the Actuary, Centers for Medicare and Medicaid Services under the intermediate assumptions of the 2008 Trustees. Medicaid projections based on CBO's January 2008 short-term Medicaid estimates and CBO's December 2007 long-term Medicaid projections adjusted to reflect excess cost growth consistent with the 2008 Trustees intermediate assumptions.

The federal government and other public payers are not the only ones facing rapidly rising health care expenses. Private payers face the same challenges. As shown in figure 7, total health care spending from both public and private payers is absorbing an increasing share of our nation's GDP. From 1976 through 2006, spending on health care grew from about 8 percent of GDP to 16 percent, and it is projected to grow to about 20 percent of GDP by 2016. While growth in public spending strains government budgets, growth in private sector health care costs erodes employers' ability to provide coverage to their workers and undercuts their ability to compete internationally.

When compared with other nations, the United States is an outlier in its high level of health care spending. For example, in 2005, health care

accounted for about 15 percent of GDP in the United States, the largest share among developed nations who are members of the Organization for Economic Co-operation and Development (OECD). The United States also ranks far ahead of other OECD countries in terms of per capita health spending. In that same year, the United States spent $6,401 per person, a level nearly twice that found in France, Canada, and Germany, and about two and a half times higher than the levels found in Italy, Japan, and the United Kingdom. Despite this higher level of health care spending, the United States still fares poorly on many health measures. Compared to other nations, the United States has above-average infant mortality, below-average life expectancy, and the largest percentage of uninsured individuals. For example, according to the most recent published data from OECD, the United States ranked 27 out of 30 in infant mortality and 24 out of 30 in life expectancy.[6]

Figure 7: Health Care Spending as a Percentage of GDP



Source: Centers for Medicare and Medicaid Services, Office of the Actuary.

Notes: The figure for 2016 is projected. The most current data available on health care spending are for 2006.

[6]Data for most OECD countries are for 2005. Data on life expectancy and infant mortality in the United States are for 2004 and 2002 respectively. Recent preliminary data show a slight improvement in life expectancy in the United States for 2006.

Systemwide Growth in Health Care Spending Is Driven by Certain Key Factors

Public and private health care spending continues to rise because of several key factors, including the following:

- **Medical technology.** While new and existing medical technology can lead to medical benefits, in some cases technology can lead to the excessive use of resources. On the one hand, experts agree that technology's contributions over the past 20 years—new pharmaceuticals, diagnostic imaging, and genetic engineering, among others—have been, on the whole, of significant value to the nation's health. Such advances in medical science have allowed providers to treat patients in ways that were not previously possible or to treat conditions more effectively. On the other hand, experts note that the nation's general tendency is to treat patients with available technology even when there is little chance of benefit to the patient and without consideration of costs.[7]
- **Market dynamics.** Another cost-containment challenge for all payers relates to the market dynamics of health care compared with other economic sectors. In an ideal market, informed consumers prod competitors to offer the best value. However, without reliable comparative information on medical outcomes, quality of care, and cost, consumers are less able to determine the best value. Insurance masks the actual costs of goods and services, providing little incentive for consumers to be cost-conscious. Many insured individuals pay relatively little out of pocket for care at the point of delivery because of comprehensive health care coverage. Current federal tax policies encourage such comprehensive coverage, for example, by excluding employers' contribution for premiums from employees' taxable income. These tax exclusions represent a significant source of forgone federal revenue and work at cross-purposes to the goal of moderating health care spending. Furthermore, clinicians must often make decisions in the absence of universal medical standards of practice. Under these circumstances, medical practices vary across the nation, as evidenced by wide geographic variation in per capita spending and outcomes, even after controlling for patient differences in health status.
- **Population health.** Obesity, smoking, and other population risk factors can lead to expensive chronic conditions, such as diabetes and heart disease. The increased prevalence of such conditions drives spending as the utilization of health care resources rises. For example, one study indicated that the rising prevalence of obesity and higher relative per capita health care spending among obese individuals resulted in 27

[7]GAO, *Health Care: Unsustainable Trends Necessitate Comprehensive and Fundamental Reforms to Control Spending and Improve Value*, GAO-04-793SP (Washington, D.C.: May 2004).

percent of the growth in inflation-adjusted per capita health care spending from 1987 through 2001.[8]

Addressing these drivers will be a major societal challenge. Solving the problem of the federal government's escalating health care costs is especially difficult, since changing programs such as Medicare and Medicaid will involve changes, not just within these federal programs, but to our country's health care system as a whole. However, many experts have recommended that the federal government could help drive improvement in the health care system. For example, experts note the need for strong financial incentives to overcome a lack of systems—including information systems—to reduce error and reinforce best practices. Medicare—the single, largest purchaser of health care services in the United States—could play a more active role in promoting a market that rewards better performance through payment incentives that promote the pursuit of improved quality and efficiency.

The Window of Opportunity Is Narrowing

Here in the first half of 2008, the long-term fiscal challenge is not in the distant future. The first baby boomers have already retired. (See table 2.) The budget and economic implications of the baby-boom generation's retirement have already become a factor in CBO's 10-year baseline projections and that effect will only intensify as the baby boomers age. As the share of the population over 65 climbs, demographics will interact with rising health care costs. The longer action on reforming heath care and Social Security is delayed, the more painful and difficult the choices will become. Simply put, the federal budget is on an unsustainable long-term fiscal path that is getting worse with the passage of time.

The window for timely action is shrinking. Albert Einstein said the most powerful force in the universe is compound interest, and today the miracle of compounding is working against the federal government. After 2011 the Social Security cash surplus—which has cushioned and masked the effect of the federal government's fiscal policy—will begin to shrink, putting pressure on the rest of the budget. The Medicare Hospital Insurance trust fund is already in a negative cash-flow situation. Demographics narrow the window for other reasons as well. People need time to prepare for and

[8]Kenneth E. Thorpe et al., "The Impact of Obesity on Rising Medical Spending," *Health Affairs Web Exclusive*, (Oct. 20, 2004) http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w4.480.

adjust to changes in benefits. There has been general agreement that there should be no change in Social Security benefits for those currently in or near retirement. If changes are delayed until the entire baby-boom generation has retired, that becomes much harder and much more expensive.

Table 2: The Long-Term Fiscal Challenge Has Begun

2008—Oldest members of the baby-boom generation eligible for Social Security
2008—Medicare Hospital Insurance (HI) outlays exceed cash income
2009—Debt ceiling will need to be raised
2011—Oldest members of the baby-boom generation eligible for Medicare
2011—Social Security cash surplus begins to decline
2017—Annual Social Security benefits exceed cash income
2019—Medicare HI trust fund exhausted, income sufficient to pay about 79 percent of promised benefits
2026—Youngest members of the baby-boom generation eligible for Social Security
2030—Debt held by the public under GAO's Alternative simulation exceeds the historical high reached in the aftermath of World War II
2041—Social Security trust fund exhausted income sufficient to pay about 75 percent of promised benefits

Source: GAO.

Meeting this long-term fiscal imbalance is the nation's largest sustainability challenge. Aligning the federal government to meet the challenges and capitalize on the opportunities of the 21st century will require a fundamental review of what the federal government does, how it does it, and how it is financed. Attention should be focused not only on the spending side of the budget but also on the revenue side. Tax expenditures,[9] for example, should be reexamined with the same scrutiny as spending programs. Moving forward, the federal government needs to start making tough choices in setting priorities and linking resources and activities to results.

[9]Tax expenditures are revenue losses attributable to provisions of the federal tax laws that allow a special exclusion, exemption, or deduction from gross income or that provide a special credit, a preferential rate of tax, or a deferral of liability. These exceptions may be viewed as alternatives to other policy instruments, such as spending or regulatory programs.

Meeting the nation's long-term fiscal challenge will require a multipronged approach bringing people together to tackle health care, Social Security, and the tax system as well as

- strengthening oversight of programs and activities, including creating approaches to better facilitate the discussion of integrated solutions to cross-cutting issues; and
- reengineering and reprioritizing the federal government's existing programs, policies, and activities to address 21st century challenges and capitalize on related opportunities.

There are also some process changes that might help the discussion by increasing the transparency and relevancy of key financial, performance, and budget reporting and estimates that highlight the fiscal challenge. Stronger budget controls for both spending and tax policies to deal with both near-term and longer-term deficits may also be helpful.

As we recently reported,[10] several countries have begun preparing fiscal sustainability reports to help assess the implications of their public pension and health care programs and other challenges in the context of overall sustainability of government finances. European Union members also annually report on longer-term fiscal sustainability. The goal of these reports is to increase public awareness and understanding of the long-term fiscal outlook in light of escalating health care cost growth and population aging, to stimulate public and policy debates, and to help policymakers make more-informed decisions. These countries used a variety of measures, including projections of future revenue and spending and summary measures of fiscal imbalance and fiscal gaps, to assess fiscal sustainability. Last year, we recommended that the United States should periodically prepare and publish a long-range fiscal sustainability report.[11] I am pleased to note that the Federal Accounting Standards Advisory Board (FASAB) is considering possible changes to social insurance reporting and has initiated a project on fiscal sustainability reporting.

[10]GAO, *Budget Issues: Accrual Budgeting Useful in Certain Areas but Does Not Provide Sufficient Information for Reporting on Our Nation's Longer-Term Fiscal Challenge*, GAO-08-206 (Washington, D.C.: Dec. 20, 2007).

[11]GAO, *Long-Term Fiscal Challenge: Additional Transparency and Controls Are Needed*, GAO-07-1144T (Washington, D.C.: July 25, 2007) and *Long-Term Budget Outlook: Deficits Matter—Saving Our Future Requires Tough Choices Today*, GAO-07-389T (Washington, D.C.: Jan. 23, 2007).

Mr. Chairman, Senator Grassley, members of the committee—health care may be the principal driver of the long-term fiscal outlook, but that does not mean government should ignore other drivers. Demographics are a smaller component than rapid health care cost growth, but the two interact, and aging is not a trivial contributor to the federal government's long-term fiscal condition. We have suggested that to right the fiscal path will require discussing health care and Social Security and looking at both the spending and tax sides of the budget. Although these entitlements and revenue drive the overall fiscal trends, it is also important that the federal government look at other programs and activities. Reexamining what government does and how it does business can help government meet the challenges of this century in providing some specific and practical steps that Congress can take to help address these long-term challenges. In this effort Congress may find a report we published in December 2007 useful. The report is entitled, *A Call for Stewardship: Enhancing the Federal Government's Ability to Address Key Fiscal and Other 21st Century Challenges.*[12]

Thank you Mr. Chairman, Senator Grassley, and members of the committee for having me today. We at GAO, of course, stand ready to assist you and your colleagues as you tackle these important challenges.

Contacts and Acknowledgments

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[12]GAO-08-93SP (Washington, D.C.: Dec. 17, 2007).

Congressional Budget Office

Testimony

Statement of
Peter R. Orszag
Director

The Long-Term Budget Outlook and Options for Slowing the Growth of Health Care Costs

before the
Committee on Finance
United States Senate

June 17, 2008

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Mr. Chairman, Senator Grassley, and Members of the Committee, I appreciate the opportunity to appear before you to discuss the long-term fiscal outlook and approaches to addressing future budgetary imbalances.

Significant uncertainty surrounds long-term fiscal projections, but under any plausible scenario, the federal budget is on an unsustainable path—that is, federal debt will grow much faster than the economy over the long run. In the absence of significant changes in policy, rising costs for health care and the aging of the U.S. population will cause federal spending to grow rapidly. If federal revenues as a share of gross domestic product (GDP) remain at their current level, that rise in spending will eventually cause future budget deficits to become unsustainable. To prevent deficits from growing to levels that could impose substantial costs on the economy, revenues must rise as a share of GDP, or projected spending must fall—or some combination of the two outcomes must be achieved.

Future growth in spending per beneficiary for Medicare and Medicaid—the federal government's major health care programs—will be the most important determinant of long-term trends in federal spending. Changing those programs in ways that reduce the growth of costs—which will be difficult, in part because of the complexity of health policy choices—is ultimately the nation's central long-term challenge in setting federal fiscal policy. There may be ways, however, in which policymakers can reduce costs without harming the health of Medicare and Medicaid beneficiaries.

Our political system arguably is not particularly effective at addressing gradual long-term problems such as rising health care costs and aging. But the problems caused by rising health care costs are not just long-term ones. In fact, some of them are already having significant effects on various aspects of our society. Health care costs are already reducing workers' take-home pay to a degree that is both underappreciated and at least partially unnecessary, consuming roughly a quarter of the federal budget, and putting substantial pressure on state budgets (mostly through the Medicaid program), thereby constraining funding for other governmental priorities. Identifying and addressing inefficiencies in the nation's health care system can yield significant benefits, even in the short term, and focusing attention on those effects that are already occurring may be helpful in developing the consensus necessary to make the needed changes.

Long-Term Projections of Spending, Revenues, and Debt

The Congressional Budget Office (CBO) projects that total federal Medicare and Medicaid outlays will rise from 4 percent of GDP in 2007 to 12 percent in 2050 and 19 percent in 2082—which, as a share of the economy, is roughly equivalent to the total amount that the federal government spends today. The bulk of that projected increase in health care spending reflects higher costs per beneficiary rather than an increase in the number of beneficiaries associated with an aging population.

The aging of the population, though not the primary factor driving higher government spending in the future, will nonetheless exacerbate fiscal pressures. Future growth in spending on Social Security, for example, will largely reflect demographic changes; CBO projects that such spending will increase from about 4 percent of GDP today to 6 percent in 25 years and then will roughly stabilize at that rate thereafter. Under current policies, federal spending on programs other than Medicare, Medicaid, and Social Security—including national defense and a wide variety of domestic programs—is likely to contribute far less, if anything, to the upward trend in federal outlays as a share of GDP.

Long-term projections rely on numerous assumptions about economic and fiscal factors, and many different assumptions are possible. In *The Long-Term Budget Outlook* (December 2007), CBO presented two scenarios that are based on different assumptions about the federal budget over the next 75 years (see Table 1).[1]

- The "extended-baseline scenario" adheres most closely to current law, following CBO's 10-year baseline for the first decade and then extending the baseline concept beyond that 10-year window.[2] The scenario's

1. The projections in this testimony are taken from that report and do not reflect subsequent changes in law or in CBO's 10-year baseline.

2. CBO's baseline is a benchmark for measuring the budgetary effects of proposed changes in federal spending or revenues. The projections of budget authority, outlays, revenues, and the deficit or surplus that it comprises are calculated according to rules set forth in the Balanced Budget and Emergency Deficit Control Act of 1985.

Table 1.

Assumptions About Spending and Revenue Sources Underlying CBO's Long-Term Budget Scenarios

	Extended-Baseline Scenario	Alternative Fiscal Scenario
	Assumptions About Spending	
Medicare	As scheduled under current law	Physician payment rates grow with the Medicare economic index (rather than using the lower growth rates scheduled under the sustainable growth rate mechanism)
Medicaid	As scheduled under current law	As scheduled under current law
Social Security	As scheduled under current law	As scheduled under current law
Other Spending Excluding Interest[a]	As projected in CBO's 10-year baseline through 2017, then remains at the projected 2017 level as a share of GDP	Remains at the 2007 share of GDP
	Assumptions About Revenue Sources	
Individual Income Taxes	As scheduled under current law	2007 law with AMT parameters indexed for inflation after 2007
Corporate Income Taxes	As scheduled under current law	As scheduled under current law
Payroll Taxes	As scheduled under current law	As scheduled under current law
Excise and Estate and Gift Taxes	As scheduled under current law	Constant as a share of GDP for the entire period
Other Revenues	As scheduled under current law through 2017; constant as a share of GDP thereafter	As scheduled under current law through 2017; constant as a share of GDP thereafter

Source: Congressional Budget Office.

Notes: The extended-baseline scenario adheres closely to current law, following CBO's 10-year baseline budget projections from 2008 to 2017 and then extending the baseline concept in its projections for the rest of the years in the 75-year projection period, to 2082. The alternative fiscal scenario deviates from CBO's baseline projections even during the next 10 years, incorporating some changes in policy that are widely expected to occur and that policymakers have regularly made in the past.

GDP = gross domestic product; AMT = alternative minimum tax.

a. Federal spending on the refundable portions of the earned income tax credit and the child tax credit is not held constant as a percentage of GDP but is instead modeled with the revenue portion of the scenarios.

assumption of current law implies that many policy adjustments that lawmakers have routinely made in the past will not occur.

- The "alternative fiscal scenario" represents one interpretation of what it would mean to continue today's underlying fiscal policy. This scenario deviates from CBO's baseline even during the next 10 years because it incorporates some changes in policy that are widely expected to occur and that policymakers have regularly made in the past. Different analysts may perceive the underlying intention of current policy differently, however, and other interpretations are possible.

For decades, spending on Medicare and Medicaid has been growing faster than the economy, as has health care spending in the private sector. The rate at which health care costs grow relative to national income—rather than the aging of the population—will be the most important determinant of future federal spending. For its long-term projections, CBO assumed that even in the absence of changes in federal law, rates of spending growth in the Medicare and Medicaid programs would probably moderate to some degree.[3] As costs continue to rise, regulatory changes are likely at the federal level. At the state level, both legal and regulatory changes will probably occur; those changes would directly affect Medicaid, which is a joint federal–state program. And actions by employers, households, and insurance firms to slow the rate of health care cost growth in the private sector are likely to affect the public insurance programs to some extent. Nevertheless, spending for Medicare and Medicaid is likely to continue to grow faster than the economy over the long term.

Spending under the extended-baseline scenario would be somewhat lower than under the alternative fiscal scenario for two reasons. First, under the extended-baseline scenario's assumption that current law remains in place, the sustainable growth rate (SGR) mechanism for updating Medicare's payment rates for physicians would reduce those rates by about 4 percent or 5 percent annually for at least the next several years. However, since 2003, the Congress has acted to prevent such reductions. Therefore, for the alternative fiscal scenario, CBO assumed that those rates would grow with the Medicare economic index (which measures inflation in the inputs used for physicians' services). The difference in spending for Medicare under the two scenarios is less than 1 percent of GDP in all 75 years of the projection period.

A second and larger difference between the scenarios involves the assumption about other federal spending—that is, spending for programs other than Medicare, Medicaid, and Social Security but excluding interest on the public debt. Under the extended-baseline scenario, other federal spending in 2018 and later would equal about 7.7 percent of GDP, consistent with the projections for fiscal year 2017 in CBO's March 2007 baseline and projected levels of refundable tax credits. Under the alternative fiscal scenario, other spending during the projection period would remain about at its current level of 9.8 percent of GDP.

Spending for Medicaid and Social Security would be identical under both scenarios. In addition, both scenarios incorporate the assumption that the Medicare and Social Security programs will continue to pay benefits as currently scheduled, notwithstanding the projected insolvency of the programs' trust funds.

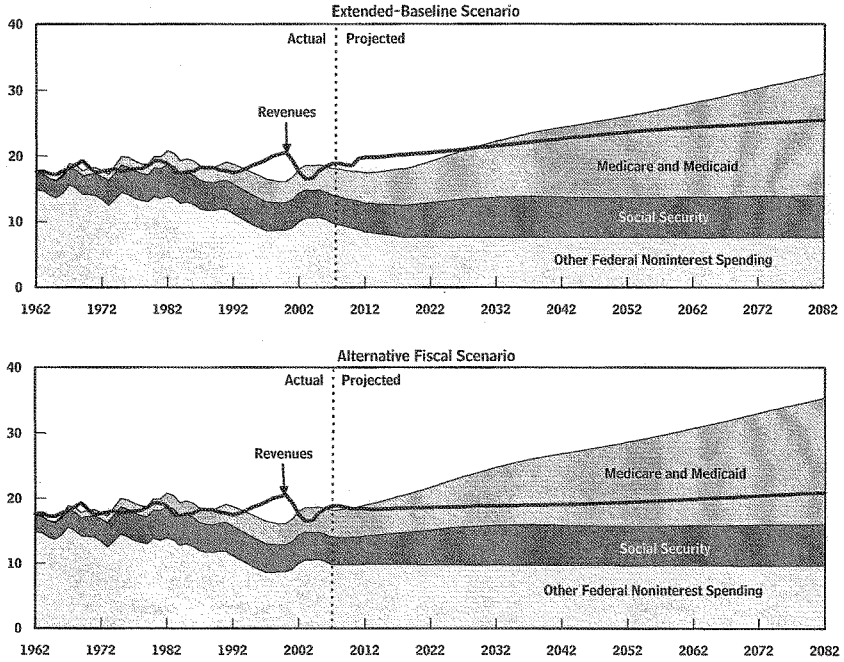
Despite those differences, under both scenarios total primary spending (all spending except interest payments on federal debt) would grow sharply in coming decades, CBO estimates, rising from its current level of 18 percent of GDP to more than 30 percent by 2082, the end of the 75-year period that CBO's long-term projections span (see Figure 1). If spending policy did not change and outlays did indeed grow to such levels relative to the economy, maintaining a sustainable budgetary path would require that federal taxation rise similarly. In the past half-century, total federal revenues have averaged 18 percent of GDP and peaked at nearly 21 percent, well below projected levels of future spending.

3. See Congressional Budget Office, *The Long-Term Outlook for Health Care Spending* (November 2007).

Figure 1.

Revenues and Spending Excluding Interest, by Category, as a Percentage of Gross Domestic Product Under CBO's Long-Term Budget Scenarios

(Percent)

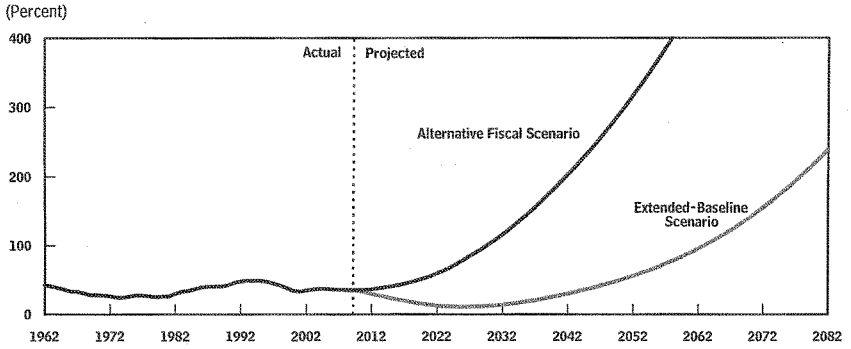


Source: Congressional Budget Office.

Note: The extended-baseline scenario adheres closely to current law, following CBO's 10-year baseline budget projections from 2008 to 2017 and then extending the baseline concept in its projections for the rest of the years in the 75-year projection period, to 2082. The alternative fiscal scenario deviates from CBO's baseline projections even during the next 10 years, incorporating some changes in policy that are widely expected to occur and that policymakers have regularly made in the past.

Figure 2.

Federal Debt Held by the Public as a Percentage of Gross Domestic Product Under CBO's Long-Term Budget Scenarios



Source: Congressional Budget Office.

Note: The extended-baseline scenario adheres closely to current law, following CBO's 10-year baseline budget projections from 2008 to 2017 and then extending the baseline concept in its projections for the rest of the years in the 75-year projection period, to 2082. The alternative fiscal scenario deviates from CBO's baseline projections even during the next 10 years, incorporating some changes in policy that are widely expected to occur and that policymakers have regularly made in the past.

Ultimately, both scenarios involve an unsustainable fiscal path, but they differ significantly in their projections of revenues and in the extent and timing of substantial increases in federal debt:

- Under the extended-baseline scenario, revenues would reach substantially higher levels than have ever been recorded during the nation's history.[4] Under this scenario, the 2001 and 2003 legislation that lowered tax rates would expire as scheduled at the end of 2010, and the impact of the alternative minimum tax (AMT) would expand substantially over time (because its parameters, unlike most parts of the tax system, are not indexed to inflation).[5] In addition, ongoing increases in real income (that is, income after an adjustment for inflation) would push taxpayers into higher income tax brackets. As a result, by 2082, federal revenues would reach 25 percent of GDP.

  With the projected revenue increases and substantial reduction in other spending as a share of GDP embodied in this scenario, federal debt held by the public would fall relative to GDP until 2026. But after that, the combined effect of increased revenues and reduced spending for programs other than Medicare, Medicaid, and Social Security would be overwhelmed by growth in health care costs. Debt would start to climb, and if federal spending was allowed to grow as projected, policymakers would have to raise revenues further to keep the growth of debt from outpacing the growth of the economy (see Figure 2 and Table 2).

4. The projections that make up CBO's baseline are not intended to be predictions of future budgetary outcomes; rather, they represent CBO's best judgment of how economic and other factors would affect federal spending and revenues if current laws and policies remained in place.

5. The AMT is a parallel income tax system with fewer exemptions, deductions, and rates than the regular income tax. Households must calculate their tax liability (the amount they owe) under both the AMT and the regular income tax and pay the larger of the two amounts.

Table 2.

Spending and Revenues as a Percentage of Gross Domestic Product Under CBO's Long-Term Budget Scenarios

(Percent)

	2007[a]	2030	2050	2082
		Extended-Baseline Scenario		
Primary Spending				
Social Security	4.3	6.1	6.1	6.4
Medicare[b]	2.7	5.6	8.9	14.8
Medicaid	1.4	2.5	3.1	3.8
Other noninterest	9.9	7.7	7.6	7.6
Subtotal, Primary Spending	18.2	21.8	25.7	32.5
Interest	1.7	0.6	2.3	11.0
Total Federal Spending	20.0	22.4	28.1	43.6
Revenues	18.8	21.4	23.5	25.5
Deficit (-) or Surplus				
Primary deficit (-) or surplus	**0.5**	**-0.4**	**-2.3**	**-7.1**
Total deficit	**-1.2**	**-1.0**	**-4.6**	**-18.1**
		Alternative Fiscal Scenario		
Primary Spending				
Social Security	4.3	6.1	6.1	6.4
Medicare[b]	2.7	5.9	9.4	15.6
Medicaid	1.4	2.5	3.1	3.7
Other noninterest	9.9	9.8	9.7	9.6
Subtotal, Primary Spending	18.2	24.2	28.3	35.3
Interest	1.7	4.8	13.6	40.1
Total Federal Spending	20.0	29.0	41.8	75.4
Revenues	18.8	18.9	19.4	20.9
Deficit (-) or Surplus				
Primary deficit (-) or surplus	**0.5**	**-5.3**	**-8.9**	**-14.4**
Total deficit	**-1.2**	**-10.1**	**-22.5**	**-54.5**

Source: Congressional Budget Office.

Note: The extended-baseline scenario adheres closely to current law, following CBO's 10-year baseline budget projections from 2008 to 2017 and then extending the baseline concept in its projections for the rest of the years in the 75-year projection period, to 2082. The alternative fiscal scenario deviates from CBO's baseline projections even during the next 10 years, incorporating some changes in policy that are widely expected to occur and that policymakers have regularly made in the past.

a. For 2007, numbers are actual and on a fiscal year basis.

b. Spending for Medicare beneficiaries is net of premiums.

Table 3.

The Federal Fiscal Imbalance Under CBO's Long-Term Budget Scenarios

(Percentage of gross domestic product)

Projection Period	Revenues	Outlays	Fiscal Gap
	Extended-Baseline Scenario		
25 Years (2008-2032)	20.2	19.5	-0.7
50 Years (2008-2057)	21.3	21.9	0.6
75 Years (2008-2082)	22.1	23.8	1.7
	Alternative Fiscal Scenario		
25 Years (2008-2032)	18.6	21.4	2.8
50 Years (2008-2057)	18.8	24.1	5.2
75 Years (2008-2082)	19.2	26.1	6.9

Source: Congressional Budget Office.

Note: The extended-baseline scenario adheres closely to current law, following CBO's 10-year baseline budget projections from 2008 to 2017 and then extending the baseline concept in its projections for the rest of the years in the 75-year projection period, to 2082. The alternative fiscal scenario deviates from CBO's baseline projections even during the next 10 years, incorporating some changes in policy that are widely expected to occur and that policymakers have regularly made in the past.

- Under the alternative fiscal scenario, by contrast, none of the changes to tax law scheduled after 2007 would take effect, and the AMT would be indexed to inflation. As a result, revenues would remain roughly constant as a share of GDP. The combination of roughly constant revenues and significantly rising expenditures would quickly create an unstable fiscal situation.

A useful metric for the size of the adjustments in either spending or revenues required to avoid unsustainable increases in government debt is provided by the so-called fiscal gap. The gap measures the immediate change in spending or revenues necessary to generate a stable fiscal trajectory over a given period.

Under the extended-baseline scenario, the fiscal gap would amount to 0.6 percent of GDP through 2057 and 1.7 percent of GDP through 2082 (see Table 3). In other words, under that scenario, an immediate and permanent reduction in spending or an immediate and permanent increase in revenues of 1.7 percent of GDP—or an even larger percentage, if the change in policy was delayed—would be necessary to create a sustainable fiscal path through 2082.

Under the alternative fiscal scenario, the fiscal gap would be much larger, amounting to 5.2 percent of GDP through 2057 and 6.9 percent through 2082.

The Effects of Rising Federal Debt on the Economy

Growth in debt is not necessarily a problem. As long as the economy is also expanding just as fast and interest rates are stable, the ratio of debt to GDP and the share of GDP that must be devoted to paying interest on the debt will remain stable. Under CBO's long-term projections, deficits of about 1.4 percent of GDP would result in a stable ratio. Moreover, even if debt grows faster than GDP for a limited time, difficulties do not always arise.

But sustained and rising budget deficits would absorb funds from the nation's pool of savings and reduce investment in the domestic capital stock and in foreign assets. As capital investment dwindled, the growth of workers' productivity and of real wages would gradually slow and begin to stagnate. As capital became scarce relative to labor, real interest rates would rise. In the near term, foreign investors would probably increase their financing of investment in the United States, which would help soften the impact of rising deficits on productivity in the United States. However, borrowing from abroad would not be without its costs. Over time, foreign investors would claim larger and larger shares of the nation's output, and fewer resources would be available for domestic consumption.

Under both the extended-baseline and alternative fiscal scenarios, growing budget deficits and the resulting increases in federal debt could lead to slower economic growth. The effects would be most striking under the alternative fiscal scenario: Debt would begin to climb rapidly and would reach roughly 300 percent of GDP by 2050. In CBO's estimation, that rising federal debt would reduce the capital stock—compared with what it would be if deficits were held to their share of the economy in 2007—by 40 percent in 2050 and would lower

real gross national product by 25 percent.[6] Although the outlook for the economy under the extended-baseline scenario would be more auspicious in the near term, over the long run, rising deficits would also lead to significant economic harm.

Differences between the economic costs of one policy for achieving long-term fiscal sustainability and those of another are generally modest in comparison with the costs of allowing deficits to grow to unsustainable levels. In particular, the difference in economic costs between acting to address projected deficits (by either reducing spending or raising revenues) and failing to do so is generally much larger than the cost implications of pursuing one approach to deficit reduction rather than another. Nonetheless, a policy of reducing the growth of spending would in general impose smaller macroeconomic costs than one of increasing tax rates, although the economic effects would depend in part on the specific measures that were adopted.

Policy Options to Constrain Future Spending on Health Care

The most significant cause of future long-term spending growth—health care costs—is also particularly complicated to address. Policymakers face both challenges and opportunities in trying to reduce those costs. Over long periods, cost growth per beneficiary in the Medicare and Medicaid programs has tended to track cost trends in private-sector markets for health care. Many analysts therefore believe that significantly constraining the growth of costs for Medicare and Medicaid is possible only in conjunction with slowing the growth of costs in the health sector as a whole.

A variety of evidence suggests that opportunities exist to constrain costs without adversely affecting health outcomes—and even perhaps to simultaneously reduce cost growth and improve health. So a central challenge will be to restrain the growth of costs without harming the incentives to provide appropriate care and develop valuable new treatments. Moving the nation toward that possibility—which will inevitably be an iterative process in which policy steps are tried, evaluated, and perhaps reconsidered—is essential to moving the country toward a sounder long-term fiscal footing.

Increasing the Salience of Costs and Improving Efficiency

One factor perpetuating inefficiencies in health care is a lack of clarity regarding the cost of health insurance and who bears that cost, especially employment-based health insurance. Employers' payments for employment-based health insurance and nearly all payments by employees for that insurance are excluded from individual income and payroll taxes. Although both theory and evidence suggest that workers ultimately finance their employment-based insurance through lower take-home pay, the cost is not evident to many workers.

Workers may demand less efficiency from the health system than they would if they knew the full cost that they pay via forgone wages for coverage or if they knew the actual cost of the services being provided. Making the underlying costs associated with employment-based insurance more transparent might prove to be quite important in containing health care costs. For workers and dependents with employment-based insurance, deductibles and copayments account for only about a fifth of their health care spending. The remainder comes from insurance premiums, only a quarter of which is paid directly by workers. If transparency increases and workers see how much their income is being reduced for employers' contributions and what those contributions are paying for, there might be a broader change in cost-consciousness that shifts demand.

Generating More Information About Effectiveness and Changing Incentives

Straightforward changes to the Medicare and Medicaid programs—such as more stringent eligibility criteria, greater cost sharing, or changes in payments to providers—could reduce federal spending in part by shifting costs from the federal government to households or other sectors. Efforts to control federal spending alone would

6. The capital stock consists of businesses' equipment and structures as well as housing. Gross national product (GNP) measures the income of residents in the United States after deducting net payments to foreigners. Gross domestic product, by contrast, measures the income that is generated by the production on U.S. soil, including the production that is financed by foreign investors. Because rising deficits can increase borrowing from foreigners, GNP is a better measure of the economic effects of deficits than is GDP.

Table 4.

Estimated Contributions of Selected Factors to Growth in Real Health Care Spending per Capita, 1940 to 1990

(Percent)

	Smith, Heffler, and Freeland (2000)	Cutler (1995)	Newhouse (1992)
Aging of the Population	2	2	2[a]
Changes in Third-Party Payment	10	13	10[b]
Personal Income Growth	11–18	5	<23
Prices in the Health Care Sector	11–22	19	*
Administrative Costs	3–10	13	*
Defensive Medicine and Supplier-Induced Demand	0	*	0
Technology-Related Changes in Medical Practice	**38–62**	**49**	**>65**

Source: Congressional Budget Office based on Sheila D. Smith, Stephen K. Heffler, and Mark S. Freeland, "The Impact of Technological Change on Health Care Cost Increases: An Evaluation of the Literature" (working paper, 2000); David M. Cutler, "Technology, Health Costs, and the NIH" (paper prepared for the National Institutes of Health Economics Roundtable on Biomedical Research, September 1995); and Joseph P. Newhouse, "Medical Care Costs: How Much Welfare Loss?" *Journal of Economic Perspectives*, vol. 6, no. 3 (Summer 1992), pp. 3–22.

Notes: Amounts in the table represent the estimated percentage share of long-term growth that each factor accounts for.

< = less than; > = greater than; * = not estimated.

a. Represents data for 1950 to 1987.

b. Represents data for 1950 to 1980.

have some effect but would be most sustainable to the extent that they succeeded in constraining cost growth in the rest of the health care system.

The general consensus among health economists is that the large increase in health care spending over the past several decades was principally the result of the emergence of new medical technologies and services and their adoption and widespread diffusion by the U.S. health care system (see Table 4).[7] Advances in medical science have made available to patients and physicians a wealth of new medical therapies, many unheard of in even the relatively recent past. Some of the advances permit the treatment of previously untreatable conditions, introducing new categories of spending. Others, relative to older modes of treatment, improve medical outcomes at added cost, expanding existing spending.

Future increases in spending could be moderated if costly new medical services were adopted more selectively in the future than they have been in the past and if the diffusion of existing costly services was slowed. Although that approach would mean fewer medical services, evidence suggests that savings are possible without a substantial loss of clinical value. Currently, the added clinical benefits of new medical services are not always weighed against added costs before those services enter common clinical practice. And newer, more expensive services are sometimes used in cases in which older, cheaper alternatives could offer comparable outcomes for patients.

Two potentially complementary approaches to reducing total spending on health care—rather than simply reallocating spending among different sectors of the economy—involve generating more information about the relative effectiveness of medical treatments and changing the incentives for providers and consumers of health care. In addition to those changes, a variety of approaches to changing health-related behavior could improve health outcomes at a given level of costs.

The current financial incentives for both providers and patients tend to encourage or at least facilitate the adop-

7. Congressional Budget Office, *Technological Change and the Growth of Health Care Spending* (January 2008).

tion of expensive treatments and procedures, even if evidence about their effectiveness relative to existing therapies is limited. Costly services that are known to be highly effective for some types of patients are sometimes provided to others for whom clinical benefits have not been rigorously demonstrated. More information on the "comparative effectiveness" of alternative medical treatments could offer a basis for ensuring that future technologies and existing costly services are used only in cases in which they confer clinical benefits that are superior to those of other, cheaper services.[8]

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

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

Even in the absence of more information about comparative effectiveness, changes in incentives could help control health care costs, but such measures would be more likely to maximize the health gains obtained for a given level of spending if they were combined with improved information. On the provider side, greater bundling of payments to cover all of the services associated with a treatment, disease, or patient could reduce or eliminate incentives to provide additional services that might be of low value. Such approaches, however, might raise concerns about the financial risk that providers faced and about their incentives to provide too little care. On the consumer side, a landmark health insurance experiment by RAND showed that higher cost sharing reduces spending—particularly when compared with a plan offering free care—with few or no adverse effects on health.[9] However, compared with more typical health insurance plans (which do not offer free care), high-deductible designs have more modest effects on health care spending; such approaches also raise concerns about the financial burden on people with significant health problems (again reflecting trade-offs between providing insurance protection and maintaining incentives to control costs).[10]

Adopting Measures to Promote Healthier Living

Finally, the ultimate objective of any health care system is to promote health, whether by treating diseases that arise or by preventing them from occurring in the first place. Despite the cost of the nation's health care system, many concerns exist about the degree to which it is attaining that objective. Indeed, concerns about rising health care costs might not be so prominent if more evidence showed that those expenditures were yielding commensurate gains in health. In part, those shortcomings in the system's performance relate to the concerns noted above about whether patients are receiving the most effective or most cost-effective treatments—reflecting a lack of information, among other factors. Concerns also exist, though, about steps that are not being taken today to pre-

8. For a discussion of comparative effectiveness, see Congressional Budget Office, *Research on the Comparative Effectiveness of Medical Treatments: Issues and Options for an Expanded Federal Role* (December 2007).

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

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

vent the onset of disease, even when clear evidence is available about their benefits. Proposals that encourage more prevention and healthy living can help promote better health outcomes, although their net effects on federal and total health care spending are uncertain. Moreover, bringing about substantial changes in behavior could require actions outside the formal health care sector, and even then might be very difficult to achieve.

Nonetheless, policy changes could encompass preventive measures and efforts to encourage healthier lifestyles. Broadly speaking, three basic policy approaches could be adopted. First, *more information* about the consequences of unhealthy behavior or the factors contributing to it could be made available, in forms that could affect individual behavior or even social norms. (Nutritional information, for example, is readily available for packaged foods but more difficult to come by for other sources, such as restaurant meals.) Second, *financial incentives* could be modified to encourage healthier living and to discourage unhealthy activities. For example, cigarette taxes could be increased, which would discourage smoking, especially among teenagers. While those two types of measures are necessary and valuable, recent evidence suggests that a third approach could prove to be the most important channel for affecting health behavior: *Default options* in various realms could be established, and other steps could be taken to encourage healthy behavior and discourage poor health habits.[11]

In terms of their health, less educated and poorer groups exhibit worse behaviors and have worse outcomes than do more educated and richer groups. For example, less advantaged groups smoke more and have higher rates of obesity. That observation raises the issue of whether well-designed defaults could help to narrow the differences in health behaviors. If so, defaults may also help to reduce the growing gap in life expectancy by education and income (see Figure 3).[12]

11. See Peter R. Orszag, Director, Congressional Budget Office, "Health Care and Behavioral Economics: A Presentation to the National Academy of Social Insurance" (Washington, D.C.: May 29, 2008).

12. Congressional Budget Office, *Growing Disparities in Life Expectancy* (April 17, 2008).

What sorts of defaults may matter? As just one example, a growing body of research demonstrates that eating habits are strongly affected by the environment and presentation.[13] About 20 percent of Americans participate in federal nutrition programs, so restructuring those programs could have a considerable effect.[14] The school lunch program, in which governments can determine the food served to children, may be most amenable to presentational changes. But related strategies could be adopted for other federal nutrition programs, such as the Women, Infants, and Children program and the Supplemental Nutrition Assistance Program, formerly called the Food Stamp program.

CBO's Activities

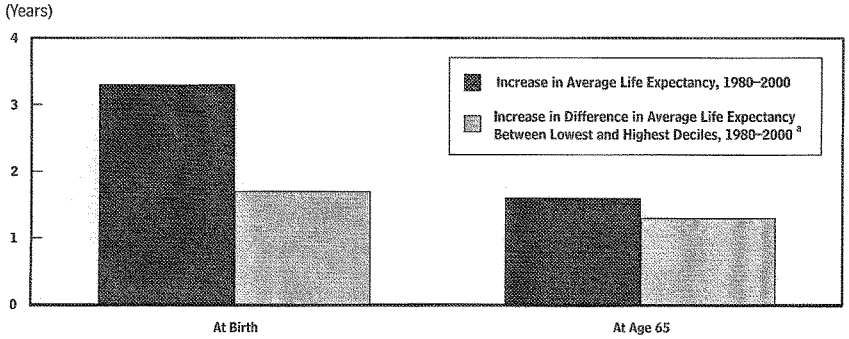
Because future health care spending is the single most important factor determining the nation's long-term fiscal condition, CBO is devoting increasing resources to assessing options for reducing such spending in the future. The agency has expanded the number of full-time-equivalent staff analyzing health care issues from 30 at roughly this time last year to 44 now, with 6 more coming on board within the next four months. Last year, CBO established a panel of health advisers (experts from academia, industry, and independent research organizations), which meets periodically to examine frontier research in health policy and to advise the agency on its analyses of health care issues. As part of its work generally, CBO continually reviews research conducted both in and outside of government. Late this year, the agency plans to release two reports on health policy: One will present budget estimates for numerous specific policy options, and the other will address critical topics related to proposals to make major changes in the health care system. We hope these efforts will be of significant value to the Congress and to this Committee in assessing ways to address these critical policy issues.

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

14. David R. Just, Lisa Mancino, and Brian Wansink, "Could Behavioral Economics Help Improve Diet Quality for Nutrition Assistance Program Participants?" (U.S. Department of Agriculture, Economic Research Service, Economic Research Report No. 43, June 2007).

Figure 3.

Increase in Life Expectancy, and Increase in Difference in Life Expectancy by Economic Status



Source: Congressional Budget Office using data from Gopal K. Singh and Mohammad Siahpush, "Widening Socioeconomic Inequalities in U.S. Life Expectancy, 1980–2000," *International Journal of Epidemiology*, vol. 35, no. 4 (2006), pp. 969–979; and National Center for Health Statistics, *Health, United States, 2007* (Hyattsville, Md., 2007), Table 27.

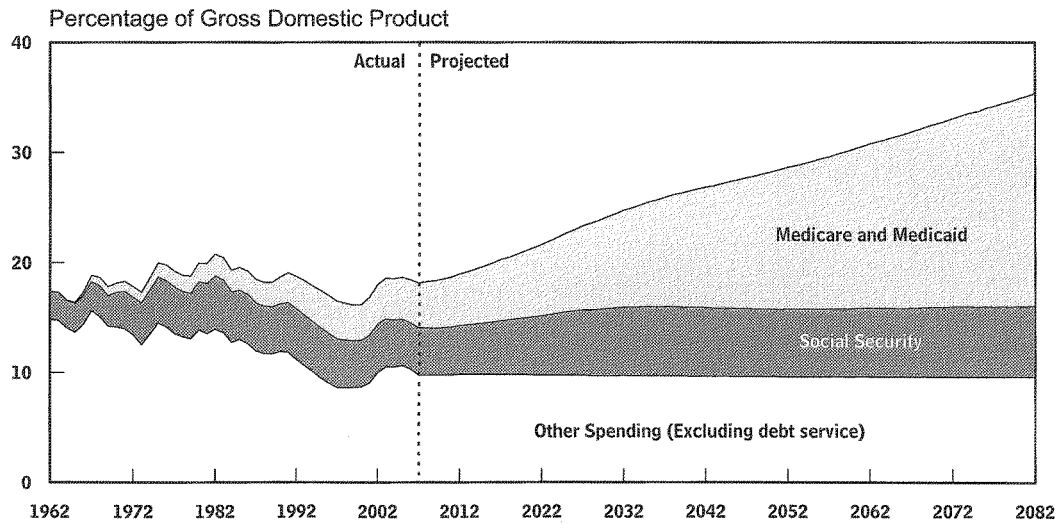
a. Socioeconomic groups are defined using county-level indicators of education, occupation, unemployment, wealth, income, and housing conditions.

Congressional Budget Office

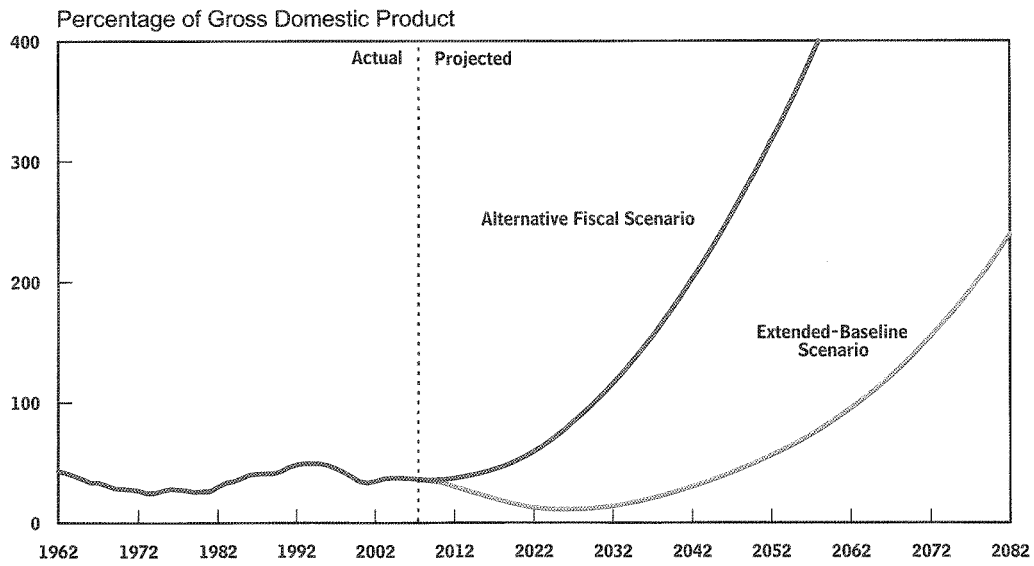
The Long-Term Budget Outlook and Options for Slowing the Growth of Health Care Costs

June 17, 2008

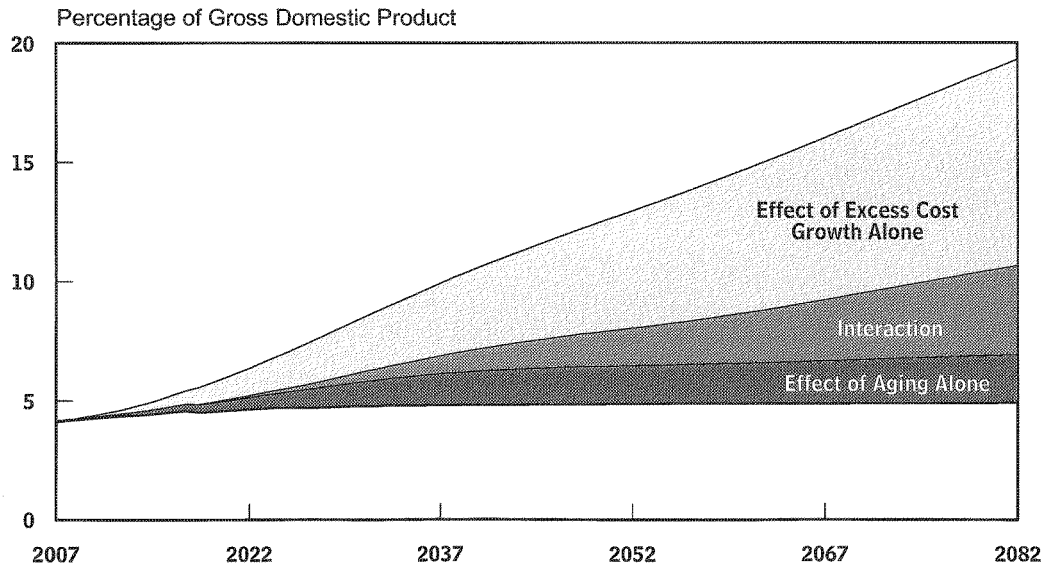
Federal Spending Under CBO's Alternative Fiscal Scenario

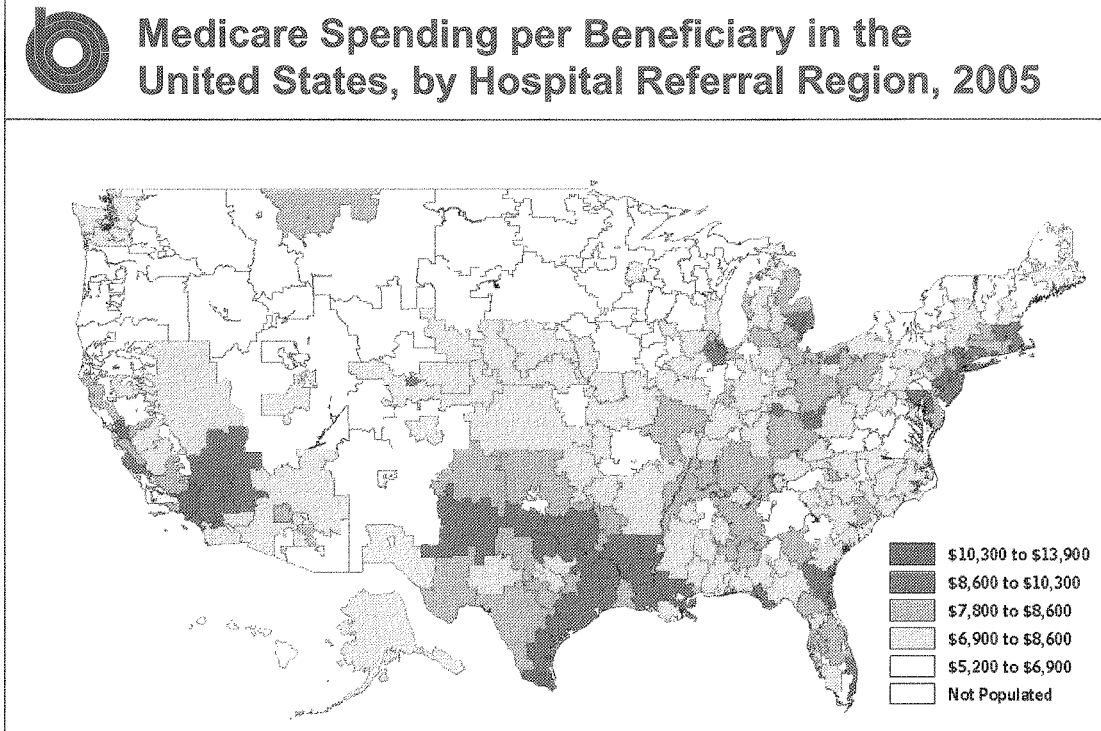


Federal Debt Held by the Public Under CBO's Long-Term Budget Scenarios



Sources of Growth in Projected Federal Spending on Medicare and Medicaid





Medicare Spending per Beneficiary in the United States, by Hospital Referral Region, 2005

Source: Data from CMS and Dartmouth Atlas of Health Care.

Variations Among Academic Medical Centers

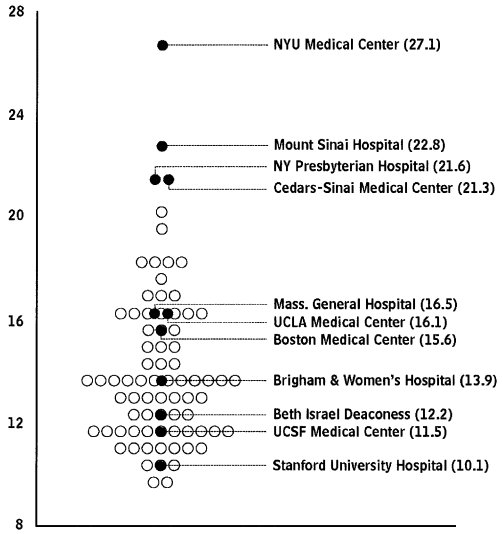
Use of Biologically Targeted Interventions and Care-Delivery Methods Among Three of U.S. News and World Report*'s "Honor Roll" AMCs*

	UCLA Medical Center	Massachusetts General Hospital	Mayo Clinic (St. Mary's Hospital)
Biologically Targeted Interventions: Acute Inpatient Care			
CMS composite quality score	81.5	85.9	90.4
Care Delivery—and Spending—Among Medicare Patients in Last Six Months of Life			
Total Medicare spending	50,522	40,181	26,330
Hospital days	19.2	17.7	12.9
Physician visits	52.1	42.2	23.9
Ratio, medical specialist / primary care	2.9	1.0	1.1

Source: Elliot Fisher, Dartmouth Medical School.

Variations Among Academic Medical Centers

Supply-Sensitive Care: Days in the Hospital for Patients During the Last Six Months of Life



Source: John Wennberg, Dartmouth Medical School.