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Health Care Spending: Context and Policy

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Summary

The United States spends a large and growing share of national income on health care. In 2005, health spending was expected to be about $1.9 trillion, more than 15% of gross domestic product (GDP). We spend substantially more than other developed countries, both per capita and as a share of GDP. However, given our wealth, such spending is not necessarily a problem. On the one hand, depending on our preference for health care compared with other things, we may wish to spend even more. On the other hand, regardless of the preferred level for national spending, our nation might use available resources more efficiently and equitably.

Health care costs put significant pressure on the federal budget — both directly, through spending on Medicare, Medicaid, and other federal benefits, and indirectly, through tax expenditures for health insurance and expenses. The Congressional Budget Office reports that spending for Medicare, Medicaid, and the State Children's Health Insurance Program totaled $520 billion and accounted for about 21% of federal spending in 2005. Federal tax expenditures for health benefits; health coverage for military personnel, veterans, and federal employees; and spending by Public Health Service agencies were expected to add $231 billion in costs. Given competing constituent interests and the complex interdependence of public and private benefits and actors, policymakers face difficult challenges in helping to ensure access to health care and health insurance without exacerbating federal budget pressures or contributing to marketwide inflation.

Three broad policy directions have both promise and limitations for addressing health spending: (1) changing health care, (2) changing federal programs, and (3) using tax policy to make health care more affordable for individuals and families. The first, changing health care, focuses on what government might do to help improve the production and delivery of health services. This direction focuses on innovations that could improve quality and potentially reduce costs throughout the health care system. A key limitation comes from uncertainty about whether any particular innovation will reduce or increase health spending.

The second direction, changing federal programs, focuses more narrowly on federal spending for federal benefits. To influence federal spending, policymakers can set budgets for programs, services, or beneficiaries. They can change eligibility rules or program benefits. And they can change other program features, including payment methods and amounts, and how beneficiaries obtain coverage. In this category, the primary challenge is balancing explicit tradeoffs between competing goals regarding access and spending.

The final direction, using tax policy to make health care more affordable for individuals and families, focuses on helping consumers pay for health insurance and health care. Tax exclusions, credits, and deductions, and tax-advantaged accounts are examples of subsidies in this category. The promise of these tools relates to flexibility: In general, they help consumers buy the health insurance and health care they prefer. An important limitation is that tax subsidies drive up consumer demand, health care prices, and both public and private spending. This report will be updated.

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Health care costs and spending are persistent concerns for the Congress. On one hand, policymakers worry about access to care and the burden of health costs on household and employer budgets. On the other hand, rising costs put growing pressure on the federal budget from Medicare, Medicaid, and tax expenditures for private health insurance. This report seeks to put health spending in context. How much does this nation spend, and is it too much? Why is policy action so difficult? And what types of policies can the Congress pursue in seeking to balance concerns regarding spending and access?

Given the breadth of the topic, this report is not intended to be comprehensive. Instead, it introduces selected issues and policy strategies, using examples from a variety of federal programs and policies to make ideas more concrete.

Health Spending: The Big Picture

Health spending in the United States was expected to be about $1.9 trillion in 2005, an estimated $6,423 per capita, according to the Centers for Medicare and Medicaid Services (CMS). As **Table 1** shows, although growth in spending has been slowing, the rate continues to outpace change in gross domestic product (GDP) by a healthy margin.

Table 1. National Health Expenditures and Gross Domestic Product

	2002	2003	2004[a]	2005[a]
National Health Expenditures (NHE, in billions)[b]	$1,559	$1,679	*$1,805*	*$1,937*
NHE per capita[b]	$5,317	$5,671	*$6,040*	*$6,423*
NHE growth from prior year	9.3%	7.7%	*7.5%*	*7.3%*
GDP growth from prior year	3.5%	4.9%	*6.5%*	*5.6%*
NHE as percent of GDP	14.9%	15.3%	*15.4%*	*15.6%*

Sources: Stephen Heffler et al., "U.S. Health Spending Projections for 2004-2014," *Health Affairs — Web Exclusive*, Feb. 23, 2005, at [http://content.healthaffairs.org/webexclusives/index.dtl?year=2005], pp. W5-75 and W5-76. Cynthia Smith et al., "Health Spending Growth Slows in 2003," *Health Affairs*, vol. 24, no. 1 (Jan./Feb. 2005), pp. 186 and 188.

a. Projected.
b. Amounts include spending for health services and supplies, and investment (research and construction).

Much like national spending, growth in spending for individuals with private health insurance is slower than a few years ago, but still rapid compared with changes in personal income. In 2004, spending on health care services — including hospital inpatient and outpatient services, physician services, and prescription drugs — rose by 8.2% per capita. This rate compares with spending growth of 8.4% in 2003, 10.7% in 2002 and 11.3% in 2001.[1] By contrast, personal income grew 4.9% during 2004 and at an average annual rate of 1.8% over the 2001-2003 period.[2]

Is the U.S. spending level a problem? What about the rate of growth?[3]

International Perspective

Compared with other developed countries, the United States spends both more per capita and a greater share of its national income on health care. According to data from the Organization for Economic Cooperation and Development (OECD), in 2003, per capita health spending in the United States was about two-and-one-half times the OECD median.[4]

Also based on OECD data, U.S. health spending consumed 15.0% of GDP in 2003, compared with median spending of 8.3% of GDP for OECD countries.[5] After

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[1] Center for Studying Health System Change, *Tracking Health Care Costs: Spending Growth Stabilizes at High Rate in 2004*, Data Bulletin no. 29, Jun. 2005. Growth in spending for outpatient hospital care continues to outpace growth in spending for other services. Rates of growth by service for 2004 are: hospital outpatient (11.3%), prescription drugs (7.2%), physician (6.4%), and hospital inpatient (6.2%).

[2] Bureau of Economic Analysis, "National Income and Product Accounts, Table 7.1 — Selected Per Capita Product and Income Series in Current and Chained Dollars," last revised Aug. 31, 2005, at [http://www.bea.gov/bea/dn/nipaweb/SelectTable.asp?Selected=Y]. Annual growth rates for personal income were: 2.2% in 2003, 0.8% in 2002, and 2.4% in 2001.

[3] For additional information on health spending, see CRS Report RL31374, *Health Expenditures in 2003*, and CRS Report RL31094, *Health Care Spending: Past Trends and Projections*, both by Paulette C. Morgan.

[4] Organization for Economic Cooperation and Development, "OECD Health Data 2005 — Frequently Requested Data, Table 7: Total health expenditure per capita, US$ PPP," at [http://www.oecd.org/document/16/0,2340,en_2649_37407_2085200_1_1_1_37407,00.html], visited Sep. 2, 2005. U.S. spending in purchasing-power-parity international dollars was $5,635, compared with median spending in OECD countries of $2,269. OECD countries include Australia, Austria, Belgium, Canada, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Japan, Korea, Luxembourg, Mexico, the Netherlands, New Zealand, Norway, Poland, Portugal, Slovak Republic, Spain, Sweden, Switzerland, Turkey, and the United Kingdom.

[5] Organization for Economic Cooperation and Development, "OECD Health Data 2005 — Frequently Requested Data, Table 6: Total expenditure on health, % of gross domestic product," at [http://www.oecd.org/document/16/0,2340,en_2649_37407_2085200_1_1_1_37407,00.html], visited Sep. 2, 2005. OECD and CMS report slightly different estimates of health spending as a share of GDP in 2003 (15.0% vs. 15.3%). Given uncertainty in

(continued...)

America, countries spending the highest shares of GDP were: Switzerland (11.5%), Germany (11.1%), Iceland (10.5%), Norway (10.3%), France (10.1%), Canada (9.9%), Greece (9.9%), and the Netherlands (9.8%). The U.S. spending level is not necessarily too high. Most of the variation in health spending across OECD countries can be explained by differences in GDP per capita, suggesting that countries with higher national income are able and willing to spend this income on more health care.[6]

Valuing Spending on Health Care

Criticism of U.S. spending levels generally boils down to the argument that Americans benefit little from the additional money they spend on health care. Despite paying more than twice as much per capita as other OECD countries, basic health statistics for the United States are worse than OECD averages.[7] In 2003, the U.S. infant mortality rate of 7.0 deaths/1000 live births was higher than the mean rate of 6.1 deaths/1,000 live births for all OECD countries. In the same year, U.S. life expectancy at birth also was below OECD averages. U.S. females were expected to live 79.9 years, compared with 80.7 years for females in all OECD countries; for males, the U.S. and OECD numbers were 74.5 and 74.9 years, respectively.

Another argument regarding the uncertain value of health spending points to variation within the United States itself that cannot be explained fully by differences in health status or prices, and that is not correlated with better outcomes or satisfaction with care.[8] For example, according to the Medicare Payment Advisory Commission (MedPAC), in 2000, Medicare spending per beneficiary varied from about $3,500 in Santa Fe, New Mexico, to almost $9,200 in Miami, Florida.[9] Many factors contribute to such differences in spending, including variation in the supply

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[5] (...continued)
estimating both health spending and GDP, this difference is not meaningful.

[6] Uwe E. Reinhardt, Peter S. Hussey, and Gerard F. Anderson, "U.S. Health Care Spending in an International Context," *Health Affairs*, vol. 23, no. 3 (May/June 2004), p. 12. Using 2001 OECD data, Reinhardt and colleagues estimate that about 90% of cross-national variation in health spending can be explained by differences in GDP. Said another way, as income increases, spending on health care increases both absolutely and as a proportion of income. This characteristic implies, in economic jargon, that health care is a luxury good.

[7] Organization for Economic Cooperation and Development, "OECD Health Data 2005 — Frequently Requested Data, Table 1: Life expectancy (in years)" and "Table 2: Infant mortality rate, deaths per 1000 live births," data released Jun. 5, 2005, at [http://www.oecd.org/document/16/0,2340,en_2649_37407_2085200_1_1_1_37407,00.html], visited Sep. 2, 2005.

[8] See, for example, Fisher et al., "The Implications of Regional Variations in Medicare Spending, part 2: Health Outcomes and Satisfaction with Care," *Annals of Internal Medicine*, vol. 138, no. 4 (Feb. 18, 2003), pp. 288-298.

[9] Medicare Payment Advisory Commission, "Geographic Variation in Per Beneficiary Medicare Expenditures," *Report to the Congress: Variation and Innovation in Medicare*, (Washington: MedPAC, June 2003), p. 4.

of medical resources; in how physicians practice medicine; and in the economic, social, and cultural characteristics of communities.[10]

Unfortunately, variation in measures of health on the one hand and spending on the other are difficult to interpret. In the former case, many things besides health care affect mortality and life expectancy, including nutrition, sanitation and hygiene, housing, and the prevention and control of infectious disease. In the latter case, although more spending on health care is not necessarily better,[11] it also is not necessarily worse. Some differences in spending may be the appropriate result of differences across markets in the cost of inputs for producing health services. In addition, although overuse of health care may be wasteful, underuse of services also can be a problem. It may not be clear whether any given spending level is too high, too low, or about right.

Economics and Valuing Spending

Economics offers additional concepts for thinking about whether U.S. spending levels are desirable or affordable. Despite high spending, we may conclude as a society that it is worthwhile to devote the same, or even more, resources to health care. This conclusion depends on preferences for health care, relative to other things. If we value health care more than what we would otherwise produce with the same resources, diverting resources to health care from other uses will increase social welfare.

We also may conclude that spending levels are affordable based on the observation that it is possible, in a growing economy, to spend more both on health care *and* on other goods and services. As **Table 2** shows, over the 1960-1999 period, increasing national income was sufficient to support both rapid growth in per capita spending for health care and growth in spending for items other than health care. Whether our economy will be able to support a similar trend in the future depends on the extent to which increases in health spending continue to outpace change in GDP.[12]

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[10] Victor R. Fuchs, "More Variation in Use of Care, More Flat-of-the-Curve Medicine," *Variations Revisited, Web-Exclusive Collection 2004, A Supplement to Health Affairs*, (2004), p. VAR-104. (Article originally published as a Web-Exclusive on Oct. 7, 2004.)

[11] More spending on health care is not better if it fails to improve health or otherwise offer benefits that exceed costs. In "More Variation in Use of Care, More Flat-of-the-Curve Medicine," Fuchs asserts that a "considerable" amount of the care in the U.S. provides "no incremental health benefit."

[12] Michael E. Chernew, Richard A. Hirth, and David M. Cutler, "Increased Spending on Health Care: How Much Can the United States Afford?" *Health Affairs*, vol. 22, no. 4 (July/Aug. 2003), pp. 15-25. Based on simulation analysis, the authors conclude health spending will continue to be affordable through 2075 if real per capita growth in health care costs exceeds real growth in GDP by 1%. If the gap is instead 2%, spending would be affordable only through 2039.

Table 2. U.S. Spending on Health Care and Other Items
(in 1996 dollars)

	1960	1970	1980	1990	1999
Per capita GDP (sum of spending on health care and items other than health care)	$12,764	$17,022	$21,271	$26,388	$31,962
Per capita spending on health care	646	1,197	1,870	3,165	4,192
Per capita spending on items other than health care	12,118	15,825	19,401	23,223	27,770

Source: Chernew et al., "Increased Spending on Health Care: How Much Can the United States Afford?" *Health Affairs*, vol. 22, no. 4 (July/Aug. 2003), p. 19.

Distribution Matters

Even if health spending is generally affordable for society, the cost of health insurance and health care may be too much for certain individuals and families. For example, in 2004 about 17.8% of Americans under age 65 went without health insurance for the entire year. Low income individuals were more likely to be uninsured: about one-third of those earning less than 150% of the poverty level, and more than one-quarter of those with income between 150 and 199% were uninsured, compared with just over one in ten people earning at least 200% of poverty.[13]

Given the cost of health insurance, these rates are not surprising. In 2005, the average annual premium for individual coverage under an employer-sponsored plan was $4,024, with the workers' share of this amount averaging $610. For a family of four, the average premium and workers' share were $10,880 and $2,713, respectively.[14] For comparison, in 2004 the average poverty threshold was $9,645 for an individual and $19,307 for a family of four.[15]

Having insurance may not guarantee ready access to health care. For example, according to MedPAC, although Medicare beneficiaries enjoy good access overall, population subgroups report delaying care because of cost. Even after controlling for income, health status, and other demographic variables, beneficiaries with only

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[13] CRS Report 96-891, *Health Insurance Coverage: Characteristics of the Insured and Uninsured Populations in 2004*, by Chris L. Peterson. Based on data from the Mar. Supplement to the Current Population Survey, 33.7% of those earning less than 100% of the poverty level were uninsured in 2004. Rates for other income groups were: 30.9% (100-149% of poverty), 28.0% (150-199%), and 11.9% (200% or more).

[14] The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits, 2005 Annual Survey*, Henry J. Kaiser Family Foundation, 2005, p. 62.

[15] U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2004*, Current Population Report No. P60-229, Aug. 2005, p. 45. For information on poverty rates and distribution, see CRS Report RL33069, *Poverty in the United States: 2004*, by Thomas Gabe.

Medicare are more likely to delay care than those with Medicare and supplemental coverage of some sort. This finding is statistically significant for all reported sources of supplemental coverage, including Medicaid, Medigap, employer-sponsored, and health maintenance organization (HMO).[16]

Key Issue for the Congress

Regardless of whether America can afford to spend more of its national income on health care, health spending is a key issue for the Congress both because it constitutes a substantial share of federal spending and because it affects all constituents in one way or another.

Federal Spending

Medicare and Medicaid generally top the list of concerns about federal health spending. According to the Congressional Budget Office, Medicare spending was $333 billion in 2005, and the federal shares of spending for Medicaid and the State Children's Health Insurance Program were $182 billion and $5 billion, respectively. The sum of these amounts, $520 billion, represents about 21% of estimated federal outlays ($2.5 trillion) for 2005.[17] Costs for Medicare and Medicaid are expected to grow significantly as the population ages.

Federal tax expenditures for health benefits are also substantial. Although difficult to measure, estimates by the Joint Committee on Taxation suggest personal income tax expenditures for health benefits were about $90 billion in 2005.[18] Most of this amount represents forgone revenue because employer-provided health benefits are excluded from federal income and employment taxes. Other tax expenditures include the itemized deduction for unreimbursed medical and dental expenses above 7.5% of adjusted gross income, the deduction for health insurance for the self-employed, and the deduction and exclusion for health savings accounts.

Federal spending on health benefits for military personnel, veterans, and federal employees was expected to total $89 billion in 2005. This amount comprises outlays

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[16] Medicare Payment Advisory Commission, "Access to Care in the Medicare Program," *Report to the Congress: Medicare Payment Policy*, (Washington: MedPAC, Mar. 2003), p. 167. For significance testing, MedPAC calculated adjusted odds ratios using pooled data (1996-1999) from the Medicare Current Beneficiary Survey. The Commission also reported the unadjusted proportion of beneficiaries delaying care because of cost, noted here for a sense of magnitude. Of beneficiaries with only Medicare, 16.1% reported delaying care because of cost, compared with 7.9% of beneficiaries with both Medicare and Medicaid. Rates of delay for those with other sources of supplemental coverage were: 3.8% (Medicare and Medigap), 2.9% (Medicare and employer-sponsored insurance), and 2.7% (HMO).

[17] U.S. Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2007 to 2016*, Jan. 2006, pp. 52 and 56, at [http://cbo.gov/ftpdocs/70xx/doc7027/01-26-BudgetOutlook.pdf].

[18] Joint Committee on Taxation (JCT), *Estimates of Federal Tax Expenditures for Fiscal Years 2005-2009*, Joint Committee Print #JCS-1-05, Jan. 12, 2005, pp. 37-38.

of $31.5 billion for defense health benefits, $26.6 billion for veterans medical care, and $30.7 billion for federal employees health benefits.[19]

In addition to the health and tax benefits noted already, program budgets for Public Health Service agencies summed to $52 billion in FY2005. This amount includes $28.7 billion for the National Institutes of Health, $7.4 billion for the Health Resources and Services Administration, $6.3 billion for the Centers for Disease Control and Prevention, $3.8 billion for the Indian Health Service, $3.4 billion for the Substance Abuse and Mental Health Services Administration, $1.8 billion for the Food and Drug Administration, and $0.3 billion for the Agency for Healthcare Research and Quality.[20]

Constituents and Complexity

Influencing health spending is complicated. Broadly, the Congress faces the challenge of balancing fiscal constraints against the desire to help constituents. Beyond this general challenge, the details can be mind-numbing: constituent groups often have competing objectives, or at least different priorities; public and private actions are highly interdependent; and policy actions inevitably have both intended and unintended consequences.

For example, health spending and cost trends affect:

- **Taxpayers**, who pay for public benefits and tax subsidies;
- **Individuals and families**, who may receive coverage through public programs, benefit from tax subsidies for health insurance, or find themselves uninsured or underinsured because of the high cost of health care;
- **Employers**, who must balance providing an attractive compensation package, including health insurance, for employees against the need to keep labor costs under control;
- **States**, who share responsibility with the federal government to provide coverage for certain vulnerable populations;
- **Insurers and health plans**, who must balance offering attractive products at reasonable prices against profit goals and the risk of financial loss; and
- **Health care providers**, whose income depends on insurance coverage and a functioning market for health care.

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[19] Executive Office of the President, Office of Management and Budget, *Historical Tables, Budget of the United States Government, Fiscal Year 2006* (Washington: U.S. Government Printing Office, 2005), p. 308.

[20] Executive Office of the President, Office of Management and Budget, *Budget of the United States Government, Fiscal Year 2006* (Washington: U.S. Government Printing Office, 2005), p. 148. For this accounting, program budgets include both agency appropriations and funding from other sources, including user fees, transfers between Public Health Service agencies, and transfers both from the Department-level budget for Health and Human Services, and from other federal Departments.

Together, these actors make up a complex market in which it is hard to discern the beginning or end of public and private influences. Public programs depend on private providers to deliver health care services; and they depend on private entities to administer benefits, whether by processing claims or by providing private health plan options for beneficiaries. The private insurance market in turn depends on substantial tax subsidies to increase demand for coverage and make the price of insurance more affordable for purchasers. Public subsidies — such as Medicare and Medicaid payment add-ons for hospitals that train physicians or treat low-income people — help ensure access to care not only for beneficiaries of public programs, but also for uninsured and privately insured individuals. Ultimately, all policies affecting public benefits influence the private market, and vice versa.

Given the complicated interdependence of actors, unintended consequences are inevitable. For example, although Medicare and Medicaid have provided both financial protection and access to care for millions of beneficiaries, the programs also contribute to health care inflation because insured consumers are less price sensitive. Similarly, expanding public benefits, as the Congress has done in enacting drug coverage under Medicare and creating the State Children's Health Insurance Program, inevitably crowds out private spending, regardless of efforts by policymakers to prevent this substitution. Maximizing the benefits while minimizing the costs of any policy action is a difficult challenge.

Three Policy Directions

Rapid growth in health spending makes considering policy strategy both more difficult, and more important. Accordingly, the following pages introduce three broad approaches for using policy to influence health costs and spending: changing health care, changing federal programs, and using tax policy to make health care more affordable.

These broad directions are neither mutually exclusive nor exhaustive. In addition, controlling spending — whether national spending or federal spending — is not assumed to be their only objective. As discussed above, devoting a high share of national income to health care is not necessarily a problem. Nevertheless, policymakers generally are concerned about whether health services are worth their cost, as well as about how benefits and subsidies are distributed.

Changing Health Care

This broad direction — changing health care to increase its value and potentially reduce its underlying cost — focuses on the health system. The basic idea is that policy might help improve quality and efficiency in the production and delivery of health care, and in so doing lower the cost of health services. If realized, lower costs would affect both public and private health spending.

If health care were a car, policy goals might be building a better car for the same cost, building the same car at a lower cost, or getting the car from factory to customer more efficiently. For cars, the "invisible hand" of the market helps make these things

happen; but health care is different, its market complicated by insurance coverage, poor information, and other problems.

Two hot policy topics: evidence-based medicine[21] and health information technology, are examples of promising tools for helping produce better health care at the same cost, the same health care at a lower cost, and a more efficient delivery system. Both offer the potential to improve quality by providing information, including general information about effective treatment strategies, and specific information about patients. Both also might help reduce spending by encouraging cost-effective care and more efficient administrative systems.

However, given America's fragmented and competitive health care system, private entities generally have been unwilling or unable to invest sufficient capital to realize the potential of these tools. Government might help by subsidizing research and the development of systems, by disseminating information, and by establishing standards to facilitate coordination.

This policy direction offers both promise and risk. Investment in the tools described above and in other types of information, technology, and systems is likely to improve quality, but its potential impact on costs is uncertain. On one hand, although technological change tends to lower the cost of most products, new discoveries in health care tend to have the opposite effect. On the other hand, inefficiency and waste in the U.S. health care system (like that implied by relatively poor health statistics and regional variation in health spending) suggest opportunities for improvement relative to multiple objectives, including enhancing value, slowing growth in spending, and possibly also rationalizing the distribution of resources.

Changing Federal Programs

Whereas strategies to change health care focus on the health system generally, a second broad direction — changing federal programs — focuses on federal spending for federal benefits.

Given growing costs and limited resources, many policymakers note the need to control spending on federal programs. But other goals, such as improving program benefits and ensuring adequate payments for health care providers, are also important. Medicare illustrates the tension from competing objectives. Over the past decade, repeated legislative efforts alternately have emphasized limiting spending or increasing spending, with most bills including provisions for doing both.

Whether the Congress seeks to reduce spending or not, policymakers have different types of options for changing federal programs, including specifying

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[21] According to the Oxford Centre for Evidence-Based Medicine, "evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research."

budgets, changing eligibility and/or benefits, and changing features that define how programs work.

Program Budgets. In a way, the simplest tool for influencing federal spending on health care is to set a budget. For example, the Congress limits outlays on health benefits for veterans by specifying a budget through the appropriations process. By changing the appropriation, Congress can reduce or increase spending for this population.

The appropriation for veterans' health care is an example of a program-level budget, but other possibilities include budgets for certain services or beneficiaries. For example, the Congress has attempted to control spending for physician services under Medicare through the sustainable growth rate system, which more or less sets a budget for Medicare spending on physician services. Policymakers also could limit federal spending for individuals in entitlement programs through capitation payments. Two examples of this type of approach: converting Medicare to a "premium support" system, under which beneficiaries would purchase coverage much like federal employees do today; and changing Medicaid from a program with federal matching payments for services to a program in which states receive fixed payments for enrollees.

The details matter. Setting a budget can restrict spending, but if set too high, it also can lead to higher spending than would occur otherwise. In addition, a mismatch between funding, demand, and supply can lead to access problems. In the veterans case, some argue that queuing for services is the result of appropriations that have failed to grow in tandem with rising enrollment and health care costs. In the Medicare case, some physicians have threatened to stop seeing beneficiaries in response to recent and expected future payment cuts.

Eligibility and Benefits. Another tool for influencing federal spending is changing eligibility and benefits under entitlement programs. The Congress can use this tool to reduce spending, but usually it has done the opposite. For example, over the years, policymakers have expanded eligibility for Medicare and Medicaid, notably in the former case to certain disabled persons and individuals with end-stage renal disease, and in the latter case to successive subgroups of pregnant women and children.

The Congress also has expanded benefits. Examples in Medicare include coverage for hospice services and, more recently, for various clinical preventive services and outpatient prescription drugs. In Medicaid, most new benefits have been optional for states. Mandatory additions have included limited coverage for professional services by non-physician providers (dentists, nurse midwives, and nurse practitioners), coverage for care provided in rural health clinics and federally qualified health centers, and coverage for family planning and pregnancy-related services.

Changing cost sharing is another way policymakers can modify benefits. For example, under the Balanced Budget Act of 1997 (P.L. 105-33, BBA), policymakers in effect increased coverage for hospital outpatient services under Medicare by reducing beneficiaries' liability for coinsurance. In contrast, the Congress slightly

reduced Medicare benefits when it required future increases in the Part B deductible under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Changes to eligibility and benefits have fairly straightforward tradeoffs. In general, expansions increase access, but also spending. Restrictions reduce spending, but may limit access. Distribution and incentives matter. While a policy change to reduce covered services or increase cost sharing requirements might seriously limit access for some beneficiaries, the same cutback likely would encourage others to be appropriately prudent in seeking health services.

Other Program Features. The Congress can influence spending under entitlement programs by changing program features other than eligibility or benefits. Key tools include changing payment methods and amounts, and changing how beneficiaries obtain coverage.

For example, over the years policymakers have changed payment methods for most Medicare services. Beginning in 1983 and accelerating with the BBA, cost-based payment has been abandoned in favor of prospectively determined rates for hospital, physician, skilled nursing facility, home health, and other services. Under prospective payment, providers have a greater incentive to be efficient because they are at risk for costs above payments amounts, and can profit if costs are below payment amounts.

In addition to encouraging efficiency through payment methods, policymakers can influence spending by changing payment updates. For example, under the BBA, Congress restricted payment updates for most Medicare services to control rapid growth in spending. Since the BBA, Congress has increased updates on multiple occasions to ensure adequate payments for providers.

Increasingly, policymakers have looked to private health plans to provide benefits under public programs, including Medicare, Medicaid, and the State Children's Health Insurance Program. Some people emphasize the inherent value of offering different coverage options for beneficiaries. Others argue that greater reliance on private plans will reduce program spending because the plans can provide benefits more efficiently. That outcome depends, among other things, on how much private plans are paid.

Like changes in eligibility and benefits, changes in other program features must balance competing goals regarding spending and access to care. Payment amounts, whether for particular services or for all services under a health plan, must cover the cost of efficiently caring for beneficiaries; and payment methods should encourage the provision of adequate, but not wasteful, care.

Using Tax Policy to Make Health Care More Affordable

A third broad direction — using tax policy to make health care more affordable for individuals and families — focuses more on consumers, compared with strategies to change health care or federal programs. In this area, limiting tax expenditures

generally has not been a policy priority; instead, tax policies emphasize helping consumers pay for health insurance and health care.

Insurance Subsidies. The subsidy for employer-provided health benefits is by far the largest tax expenditure for private insurance. Payments for health insurance are excluded from the income and employment tax base, effectively lowering the price of insurance for those obtaining coverage under employer-sponsored plans.[22] With the annual cost of such plans averaging $4,024 for individuals and $10,880 for a family of four in 2005,[23] and with most households facing marginal income tax rates of 15 or 25%, savings can be substantial.

Although tax savings make insurance more affordable, the subsidy encourages people to purchase more insurance than they would otherwise. Having more insurance drives up demand for health care, which in turn drives up health care prices and spending. In addition, the exclusion for employer-provided benefits disproportionately helps those who least need assistance: high-income workers who face high marginal tax rates.

Increasingly, policymakers have shown interest in another type of subsidy for purchasing insurance — tax credits. Depending on the details, tax credits offer potential advantages compared with the exclusion for employer-provided benefits. First, credits are less regressive because subsidies are not a function of marginal income tax rates. Second, because tax credits need not be tied to employment, they provide a tool for expanding insurance coverage that can reach a larger population.

Key disadvantages relate to access and complexity. Even credits of $1000 or more may not be enough to make insurance affordable for the unemployed or lower-income workers, especially if they must purchase insurance in the nongroup market, which generally is more expensive than employment-based coverage. In addition, unless tax credits are carefully targeted, subsidies may crowd out private spending without expanding coverage. Finally, ensuring that low-income individuals receive subsidies when premiums are due (as opposed to as much as a year later, when they file their taxes) is complicated. Tax credits can be paid in advance, but doing so requires both more administrative resources and sufficient knowledge and sophistication among potential beneficiaries.

Other Subsidies. In addition to helping consumers purchase insurance, tax subsidies — including the itemized deduction for unreimbursed medical and dental expenses, and several tax-advantaged accounts — help consumers pay for health expenses not covered by insurance. Like insurance subsidies, these subsidies reduce the apparent cost of health care, and have the same unintended impact: increasing demand, prices, and spending. They also provide larger benefits to taxpayers in the highest brackets.

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[22] For more information on this tax subsidy and others, see CRS Issue Brief IB98037, *Tax Benefits for Health Insurance and Expenses: Current Legislation*, by Bob Lyke.

[23] The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits, 2005 Annual Survey*. Annual premium costs include both employer and worker contributions.

The deduction for unreimbursed medical and dental expenses is less regressive than the subsidy for employer-provided insurance because eligibility is related to income (taxpayers who itemize deductions can deduct expenses exceeding 7.5% of adjusted gross income). In addition, because the deduction covers catastrophic costs, some might regard it a higher-priority use of limited public dollars.

The policy trend favors tax-advantaged accounts to help consumers pay for unreimbursed expenses. These accounts — health care Flexible Spending Accounts (FSAs), Health Reimbursement Accounts (HRAs), Archer Medical Savings Accounts (Archer MSAs), and Health Savings Accounts (HSAs) — differ on various dimensions.[24] But they are more similar than different, offering account holders significant flexibility in using balances to cover health care expenses.

Two of the accounts, HSAs and Archer MSAs, were crafted with an eye to limiting the impact of insurance coverage on demand. Because the accounts must be used in conjunction with high-deductible health insurance plans, some believe the combination will encourage consumers to be more prudent in seeking health services.

The underlying assumption — that consumers with savings accounts and high-deductible plans will think twice before seeking discretionary health services — is worth evaluation, although incentives under this arrangement are not completely obvious. If consumers accrue large account balances over time, will they continue to be price sensitive, or will they instead act as if they have first-dollar coverage? And will high-deductible plans affect spending at all among consumers with health care expenses that easily exceed even high deductibles?

Few consumers established MSAs, but interest in HSAs has been greater. Regardless of how HSAs play out, the idea of influencing consumer demand by favoring certain types of insurance coverage merits further analysis. Next steps might include evaluating consumer behavior under different types of arrangements, and developing strategies that target subsidies according to need.

Conclusion

The good news is that policymakers have a full toolbox for pursuing goals regarding health care costs and spending. They can use government resources and leadership to help improve health care. They can change federal programs to influence both access to care and federal spending. And they can use tax policy to support and shape the market for health insurance and health care.

The bad news is that both problems and solutions are complicated. Does the United States spend too much on health care, or not? How should society allocate its resources among members? And how should policymakers set priorities among competing goals and interests? Even assuming agreement on these questions, the Congress faces difficult challenges in choosing the best combination of policy tools for achieving whatever objective is adopted

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[24] For more information, see CRS Report RS21573, *Tax-Advantaged Accounts for Health Care Expenses: Side-by-Side Comparison*, by Bob Lyke and Chris L. Peterson.