Order Code RL32545

CRS Report for Congress

Health Care Spending: Context and Policy

Updated October 2, 2007

Jennifer Jenson
Specialist in Health Economics
Domestic Social Policy Division

Congressional Research Service

Prepared for Members and Committees of Congress

Health Care Spending: Context and Policy

Summary

The United States spends a large and growing share of national income on health care. In 2007, health spending is expected to approach $2.3 trillion and account for more than 16% 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 projects that spending for Medicare, Medicaid, and the State Children's Health Insurance Program will total $634 billion and account for about 23% of federal outlays in 2007. Federal tax expenditures for health benefits; health coverage for military personnel, veterans, and federal employees; and spending by Public Health Service agencies are expected to add $272 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) changing tax policy. The first, changing health care, considers the potential for influencing spending by improving the quality and delivery of health care services. A key limitation of this direction is uncertainty about whether any particular change will reduce or increase health spending.

The second direction, changing federal programs, focuses more narrowly on federal spending for federal benefits. To influence 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, changing tax policy, focuses both on making health care more affordable for individuals and families, and on influencing consumers' choices as they purchase health insurance and health care. A key benefit of tax subsidies — including exclusions, credits, deductions, and tax-advantaged accounts — relates to flexibility. In general, these tools help consumers buy the health insurance and health care they prefer. A drawback is that tax subsidies may drive up consumer demand and spending on the one hand, while failing to help ensure access to health coverage on the other. *This report will be updated.*

Contents

Health Spending: The Big Picture 1
International Perspective 2
Valuing Spending on Health Care 3
Economics and Valuing Spending 4
Distribution Matters 5

Key Issue for the Congress 6
Federal Spending 6
Constituents and Complexity 7

Three Policy Directions 8
Changing Health Care 8
Research 8
Information Technology 9
Leadership 9
Changing Federal Programs 10
Program Budgets 10
Eligibility and Benefits 11
Other Program Features 11
Changing Tax Policy 12
Insurance Subsidies 12
Other Subsidies 13
Conclusion 14

List of Tables

Table 1. National Health Expenditures and Gross Domestic Product 1
Table 2. U.S. Spending on Health Care and Other Items 4

Health Care Spending: Context and Policy

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 is projected to be nearly $2.3 trillion in 2007, an estimated $7,498 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).

Table 1. National Health Expenditures and Gross Domestic Product

	2003	2004	2005	2006[a]	2007[a]
National Health Expenditures (NHE, in billions)[b]	$1,733	$1,859	$1,988	*$2,123*	*$2,262*
NHE per capita[b]	$5,952	$6,322	$6,697	*$7,092*	*$7,498*
NHE growth from prior year	8.1%	7.2%	6.9%	*6.8%*	*6.6%*
GDP growth from prior year	4.7%	6.9%	6.3%	*6.4%*	*5.3%*
NHE as percent of GDP	15.8%	15.9%	16.0%	*16.0%*	*16.2%*

Source: Centers for Medicare and Medicaid Services, "NHE Web Tables," at [http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage]; and John A. Poisal et al., "Health Spending Projections Through 2016: Modest Changes Obscure Part D's Impact," *Health Affairs — Web Exclusive*, Feb. 21, 2007, at [http://content.healthaffairs.org/webexclusives/index.dtl?year=2007], pp. W243-W244.

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

Growth in spending for individuals with private health insurance has stabilized but is still rapid compared with changes in personal income. In 2005, spending on health care services — including hospital inpatient and outpatient services, physician services, and prescription drugs — rose by 7.4% per capita. This rate is similar to the 2004 growth rate of 7.5%, and down from a high of 10.4% in 2001.[1] By contrast, personal income grew 4.2% during 2005 and at an average annual rate of 2.6% over the 2001-2004 period.[2]

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

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 2005, per capita health spending in the United States was more than double the OECD median.[3]

Also based on OECD data, U.S. health spending consumed 15.3% of GDP in 2005, compared with median spending of 9.1% of GDP for OECD countries.[4] After America, countries spending the highest shares of GDP were Switzerland (11.6%), France (11.1%), Germany (10.7%), Belgium (10.3%), Austria (10.2%), Portugal (10.2%), Greece (10.1%), and Canada (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.[5]

---

[1] Center for Studying Health System Change, *Tracking Health Care Costs: Spending Growth Remains Stable at High Rate in 2005*, Data Bulletin no. 33, October 2006. In 2005, growth in spending for outpatient hospital care (10.4%) continued to outpace the rates for other services: hospital inpatient (7.1%), physician (7.1%), and prescription drugs (4.8%).

[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," revised March 29, 2007, at [http://www.bea.gov/national/nipaweb/SelectTable.asp?Selected=Y].

[3] Organization for Economic Cooperation and Development, "OECD Health Data 2007 — Frequently Requested Data," at [http://www.oecd.org/dataoecd/46/36/38979632.xls], visited September 27, 2007. U.S. spending in purchasing-power-parity international dollars was $6,401, compared with median spending in OECD countries of $2,918 (based on countries reporting data for 2005). 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.

[4] Organization for Economic Cooperation and Development, "OECD Health Data 2007 — Frequently Requested Data." OECD and CMS report different estimates of health spending as a share of GDP in 2005 (15.3% vs. 16.0%). Given uncertainty in estimating both health spending and GDP, this difference is not meaningful.

[5] Uwe Reinhardt, Peter Hussey, and Gerard Anderson, "U.S. Health Care Spending in an (continued...)

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.[6] In 2004, the U.S. infant mortality rate of 6.8 deaths/1000 live births was higher than the median rate of 4.3 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 80.4 years, compared with median life expectancy of 81.5 years for females in all OECD countries; for males, the U.S. and OECD numbers were 75.2 and 76.5 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.[7] 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.[8] Many factors contribute to such differences in spending, including variation in the supply of medical resources; in how physicians practice medicine; and in the economic, social, and cultural characteristics of communities.[9]

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 infant 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,[10] it also is not

---

[5] (...continued)
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 GDP increases, spending on health care increases both absolutely and as a proportion of GDP.

[6] Organization for Economic Cooperation and Development, "OECD Health Data 2007 — Frequently Requested Data.

[7] 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 (February 18, 2003), pp. 288-298.

[8] 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.

[9] 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.

[10] More spending on health care is not better if it fails to improve health or otherwise offer benefits that exceed costs. Fuchs asserts (see cite above) that a "considerable" amount of
(continued...)

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.[11]

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.

[10] (...continued)
the care in the U.S. provides "no incremental health benefit."

[11] 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/August 2003), pp. 15-25. Based on simulation analysis, the authors conclude that 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.

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 2006, 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.[12]

Given the cost of health insurance, these rates are not surprising. In 2006, the average annual premium for individual coverage under an employer-sponsored plan was $4,242, with the workers' share of this amount averaging $627. For a family of four, the average premium and workers' share were $11,480 and $2,973, respectively.[13] For comparison, in 2006 the average poverty threshold was $10,294 for an individual and $20,614 for a family of four.[14]

Having coverage does 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 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).[15]

---

[12] CRS Report 96-891, *Health Insurance Coverage: Characteristics of the Insured and Uninsured Populations in 2006*, by Chris L. Peterson and April Grady. Based on data from the March Supplement to the Current Population Survey, 34.3% of those earning less than 100% of the poverty level were uninsured in 2006. Rates for other income groups were: 32.1% (100-149% of poverty), 28.9% (150-199%), and 11.7% (200% or more).

[13] The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits, 2006 Annual Survey*, Henry J. Kaiser Family Foundation, 2006, p. 62. The amounts for 2007 are $4,479 individual ($3,785 employer + $694 worker contribution) and $12,106 family ($8,824 employer + $3,281worker contribution). Data on poverty thresholds for 2007 are not yet available.

[14] U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2006*, Current Population Report No. P60-233, August 2007, p. 43. For information on poverty rates and distribution, see CRS Report RL33069, *Poverty in the United States: 2006*, by Thomas Gabe.

[15] Medicare Payment Advisory Commission, "Access to Care in the Medicare Program," *Report to the Congress: Medicare Payment Policy*, (Washington: MedPAC, March 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

(continued...)

Having coverage also does not guarantee low out-of-pocket costs. In 2003, 9% of people with private health insurance — almost one in ten — reported spending more than 5% of family income on health care, not including health insurance premiums. The burden was predictably higher for people without health benefits: 21% of the uninsured spent more than 5% of family income on health care.[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 is projected to be $436 billion in 2007, and the federal shares of spending for Medicaid and the State Children's Health Insurance Program are expected to be $192 billion and $6 billion, respectively. The sum of these amounts, $634 billion, represents about 23% of estimated federal outlays ($2.7 trillion) for 2007.[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 could approach $120 billion in 2007.[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 is expected to total $103 billion in 2007. This amount comprises outlays

---

[15] (...continued)
and Medigap), 2.9% (Medicare and employer-sponsored insurance), and 2.7% (HMO).

[16] Center for Studying Health System Change, *Rising Health Costs, Medical Debt, and Chronic Conditions*, Issue Brief no. 88, September 2004.

[17] U.S. Congressional Budget Office, *The Budget and Economic Outlook: An Update*, August 2007, pp. x and 12-13.

[18] Joint Committee on Taxation (JCT), *Estimates of Federal Tax Expenditures for Fiscal Years 2007-2011*, Joint Committee Print #JCS-3-07, September 24, 2007, pp. 33-34.

of $39.5 billion for defense health benefits, $30.5 billion for veterans' medical care, and $33.2 billion for federal employees health benefits.[19]

In addition to the health and tax benefits noted already, program budgets for Public Health Service agencies sum to $49 billion for FY2007. This amount includes $28.5 billion for the National Institutes of Health, $6.5 billion for the Health Resources and Services Administration, $5.8 billion for the Centers for Disease Control and Prevention, $3.2 billion for the Substance Abuse and Mental Health Services Administration, $3.1 billion for the Indian Health Service, $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.

---

[19] Executive Office of the President, Office of Management and Budget, *Historical Tables, Budget of the United States Government, Fiscal Year 2008* (Washington: U.S. Government Printing Office, 2007), p. 322.

[20] Executive Office of the President, Office of Management and Budget, *Budget of the United States Government, Fiscal Year 2008* (Washington: U.S. Government Printing Office, 2007), p. 72. 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

The following sections introduce three broad approaches for using policy to influence health costs and spending: changing health care, changing federal programs, and changing tax policy. These approaches 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.

Research. High-quality health care depends on information: about health and illness, about medical treatments, and about patients. Federal policy has long influenced health care delivery by supporting the development and dissemination of information. For example, the National Institutes of Health supports basic science and clinical research, the Agency for Healthcare Research and Quality analyzes the effectiveness of different treatments and clinical practices, and the Centers for Disease Control and Prevention monitors the incidence and prevalence of health risk

factors and illness in communities. Government support of these research functions benefits both private actors, who use the information, and society more broadly (because absent government support, the private market would produce and share less information).

Information Technology. Beyond supporting research and surveillance, the government can facilitate the use of information in health care by developing data and communication standards, and by creating incentives for adopting information tools. For example, policymakers have moved to support the use of health information technology (IT) by establishing standards for data exchange among the Departments of Health and Human Services, Defense, and Veterans Affairs. In addition to promoting information sharing across these federal departments that deliver health care, the initiative is meant to serve as a model for the private sector.[21]

Policymakers also have supported financial incentives for implementing health IT. For example, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) authorized grants to physicians to help defray the cost of purchasing, installing, and using computer systems for electronic prescriptions.

Health IT offers the potential to improve health care quality by providing both specific information about patients, and general information about effective treatment strategies. Electronic health records and clinical decision support systems can help physicians and other clinicians provide integrated, evidence-based care; computerized physician order entry systems can help prevent medical errors; and interconnected systems can facilitate the exchange of information about patients and populations. Over time, these tools might help reduce health care spending by encouraging cost-effective care and streamlining administrative processes, but current evidence is inconclusive.[22]

Leadership. More generally, government influences the health care system by sometimes leading and sometimes reinforcing change. Policy support of research and health IT are just two examples of this influence. During the past decade, both public and private efforts to rein in health care spending have shifted from focusing on managed care and integrated delivery systems to focusing on changing incentives for health care consumers (through so-called consumer-directed strategies) and providers (through pay-for-performance). This evolution reflects a mix of public and private initiative. For example, federal policy has supported the market for managed care plans through Medicare payment rates and Medicaid policy changes that make it easier for states to provide benefits through health plans and primary care case management arrangements. Similarly, tax subsidies for health savings accounts and policy interest in tying Medicare payments to providers' performance are examples

---

[21] For more information about this initiative specifically and health IT more generally, see CRS Report RL32858, *Health Information Technology: Promoting Electronic Connectivity in Health Care*, by C. Stephen Redhead.

[22] See the thematic issue of *Health Affairs*, vol. 24, no. 5 (September/October 2005), which includes a series of articles on the economics of health IT.

of federal efforts that both reflect and shape ongoing change in the market for private health insurance.

Efforts to change the health care system offer both promise and risk. Investment in research, policies to support health information technology, and other efforts may improve the quality of care, but their potential impact on spending is uncertain. On one hand, although new discoveries and technology tend to lower the cost of most products, innovation in health care tends 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, whether this means slowing growth in health care spending or at least getting a better value for what we spend.

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 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 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 include 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 could 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 (BBA, P.L. 105-33), 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 MMA.

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. Over several years following passage of the BBA, Congress essentially reversed course, increasing Medicare payments on multiple occasions — under the Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113); the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554); and the MMA — to ensure adequate reimbursement for health care providers. More recently, the Congress cut payments for various Medicare services under the Deficit Reduction Act of 2005 (DRA, P.L. 109-171).

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.

Changing Tax Policy

A third broad direction — changing tax policy — focuses more on consumers, compared with strategies to change health care or federal programs. The tax code currently includes a variety of subsidies to help individuals and families pay for health insurance and health care. Limiting tax expenditures generally has not been a policy priority, although some tax-related policy proposals seek to influence consumers' use of health care by making them more price-sensitive.

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, in effect lowering the price of insurance for those obtaining coverage under employer-sponsored plans.[23] With the annual cost of such plans averaging $4,479 for individuals and

[23] For more information on this tax subsidy and others, see CRS Report RL33505, *Tax Benefits for Health Insurance and Expenses: Overview of Current Law and Legislation*, by Bob Lyke and Julie M. Whittaker.

$12,106 for a family of four in 2007,[24] 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 tax exclusion for employer health benefits provides the largest savings to those who least need assistance: high-income workers who face high marginal tax rates.

To address issues regarding demand and equity, policymakers and analysts have proposed various changes to tax subsidies for insurance, including limiting the exclusion for employer-provided benefits, increasing tax benefits for high-deductible health plans, and offering tax credits for the purchase of nongroup health coverage.

Two of these approaches might influence health care spending by changing demand for health insurance and health care. Limiting the exclusion for employer-provided benefits could affect the type of coverage employers provide, and it could reduce employees' demand for policies that are generous compared with the tax threshold. Similarly, increasing tax benefits for high-deductible plans (and associated savings accounts) may change consumer preferences regarding health coverage. In both cases, the assumption is that people with less generous coverage will use less health care.

The third approach, offering tax credits for the purchase of nongroup coverage, is more about making insurance affordable than it is about influencing health spending. Depending on the details, such 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 subsidizing insurance coverage that can reach a larger population.

Potential disadvantages of tax credits relate to affordability and access. Even healthy people may find that credits of $1,000 or more are not enough to make insurance affordable. In addition, because of their health or risk profile, some people may not be able to purchase nongroup coverage at any price.

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.

---

[24] The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits, 2007 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.

A variety of tax-advantaged accounts 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.[25] 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?

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.

---

[25] 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.