



Congressional Budget Office

Testimony

**Statement of
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Director**

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

**before the
Committee on Finance
United States Senate**

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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.
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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.

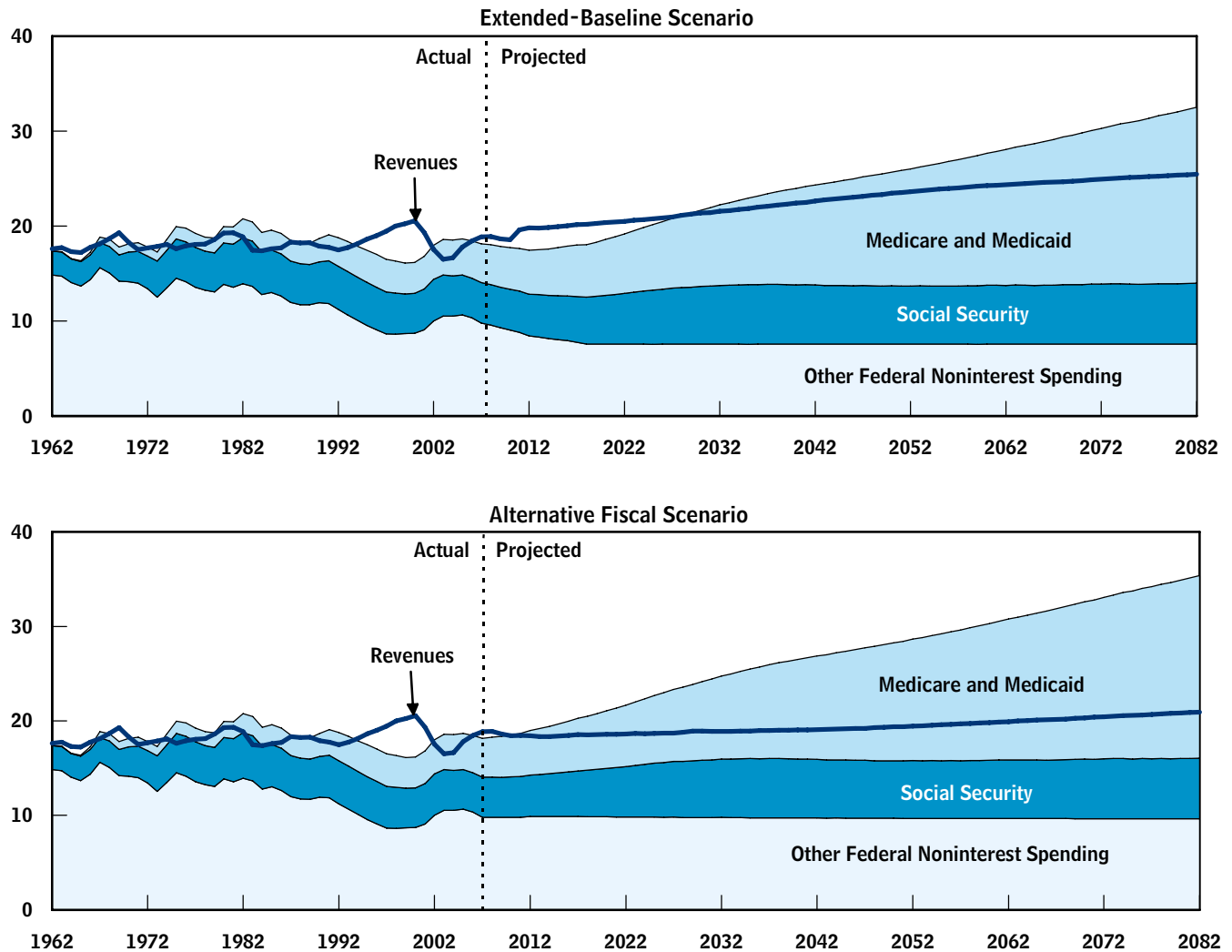
Despite those differences, under both scenarios total primary spending (all spending except interest payments on federal debt) would grow sharply in coming decades, CBO estimates, rising from its current level of 18 percent of GDP to more than 30 percent by 2082, the end of the 75-year period that CBO’s 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)



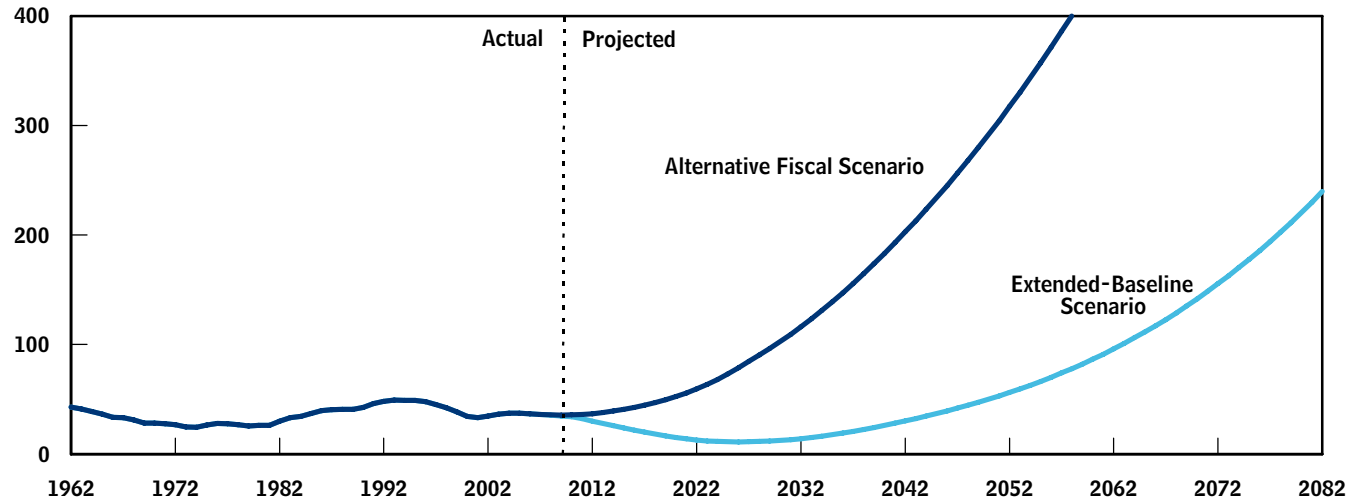
Source: Congressional Budget Office.

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

(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.

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 re-allocating 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).

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).

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-

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.

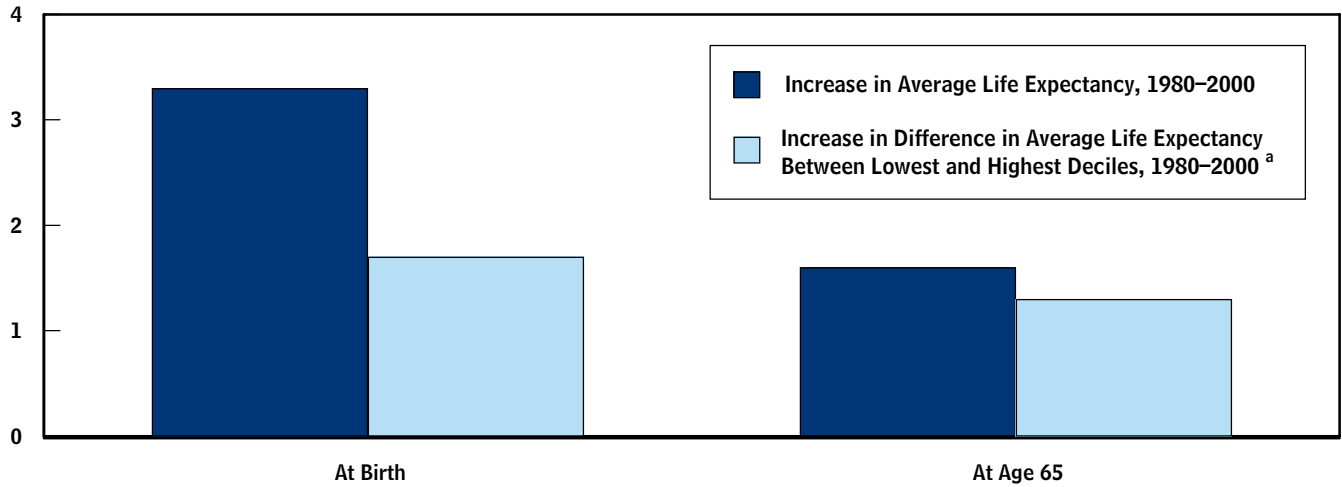
13. See Brian Wansink, *Mindless Eating: Why We Eat More Than We Think* (New York: Bantam Dell, 2006).

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

(Years)



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.