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## HEALTH CARE SPENDING

# Public Payers Face Burden of Entitlement Program Growth, While All Payers Face Rising Prices and Increasing Use of Services

Statement of A. Bruce Steinwald,  
Director, Health Care



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Mr. Chairman and Members of the Subcommittee:

I am pleased to be here as you consider the challenges involved in financing health care. We at GAO have been particularly concerned about the federal government's long-term fiscal sustainability and the contribution of health care spending to this troubling picture. For the past several years, we have consistently reported that in just a few decades, the government will face a serious fiscal imbalance driven by known demographic trends and escalating health care cost growth.<sup>1</sup> Over the next several decades, growth in spending on federal retirement and health entitlements will encumber an escalating share of the government's resources. These entitlement programs primarily include Social Security, which provides, among other things, retirement income to individuals aged 62 and older; Medicare, which provides health care coverage primarily for individuals 65 and older; and Medicaid, which is a joint federal-state program providing health care and long-term care for low-income individuals.

This Subcommittee's concern about the challenges involved in financing health care is consistent with the fact that certain spending pressures faced by Medicare and Medicaid are faced by all health care payers, including the Departments of Veterans Affairs (VA) and Defense, as well as private payers of health care. To provide an overview of the situation, my remarks will focus on (1) the long-term outlook for the federal budget and implications for the national economy, (2) health care spending increases system-wide and drivers of spending growth, and (3) cost containment challenges health care payers face now and in the future. My remarks are based largely on issued GAO work and relevant literature on health care spending.<sup>2</sup> In February 2007, we updated prior work by including more recent data from GAO's budget simulation model, the Centers for Medicare & Medicaid Services, and the U.S. Census Bureau. All of our

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<sup>1</sup>GAO, *Long-Term Budget Outlook: Deficits Matter—Saving Our Future Requires Tough Choices Today*, [GAO-07-389T](#) (Washington, D.C.: Jan. 23, 2007); *Long-Term Budget Outlook: Saving Our Future Requires Tough Choices Today*, [GAO-07-342T](#) (Washington, D.C.: Jan. 11, 2007); *21st Century: Addressing Long-Term Fiscal Challenges Must Include a Re-examination of Mandatory Spending*, [GAO-06-456T](#) (Washington, D.C.: Feb. 15, 2006); and *Long-Term Care Financing: Growing Demand and Cost of Services Are Straining Federal and State Budgets*, [GAO-05-564T](#) (Washington, D.C.: Apr. 27, 2005).

<sup>2</sup>[GAO-07-389T](#); [GAO-07-342T](#); [GAO-05-564T](#); GAO, *The Nation's Long-Term Fiscal Outlook: September 2006 Update*, [GAO-06-1077R](#) (Washington, D.C.: September 2006); and *Health Care: Unsustainable Trends Necessitate Comprehensive and Fundamental Reforms to Control Spending and Improve Value*, [GAO-04-793SP](#) (Washington, D.C.: May 2004).

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work was done in accordance with generally accepted government auditing standards.

In summary, projections show that the federal budget is on a path that is fiscally unsustainable, in large part because of growth in spending for Medicare and Medicaid. Mandatory spending for these entitlements, together with spending for Social Security, threatens to crowd out discretionary spending for a vast array of domestic programs. It is largely the public payers who will bear the cost burden associated with the baby boom generation, whereas both public and private payers must contend with the escalating costs associated with medical technology, population risk factors leading to expensive chronic conditions, and an imperfect market in which consumers and providers lack the information and incentives needed to achieve the best value for the dollars spent.

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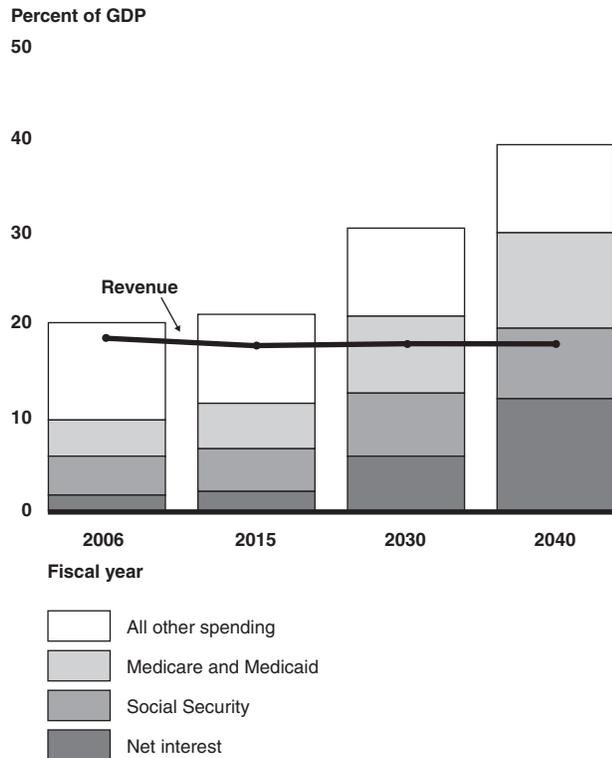
## Burden of Entitlement Growth Worsens Long-Term Federal Fiscal Outlook

Since 1992, we have provided the Congress with simulations of the long-term fiscal outlook, projecting spending as a share of the nation's output, or gross domestic product (GDP), and revenues for several decades, using certain assumptions. One simulation assumes that all expiring tax provisions are extended, revenue remains constant as a share of GDP, and federal discretionary spending keeps pace with the economy. Under these assumptions, we project that, by 2040, federal revenues may be adequate to pay little more than interest on the federal debt and a fraction of entitlements.<sup>3</sup> Figure 1 shows the substantial contribution of outlays for Social Security, Medicare, and Medicaid to this problem.

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<sup>3</sup>For more information about GAO's simulations see [www.gao.gov/special.pubs/longterm/](http://www.gao.gov/special.pubs/longterm/).

**Figure 1: Composition of Spending as a Share of GDP Assuming Discretionary Spending Grows with GDP After 2007 and All Expiring Tax Provisions Are Extended**

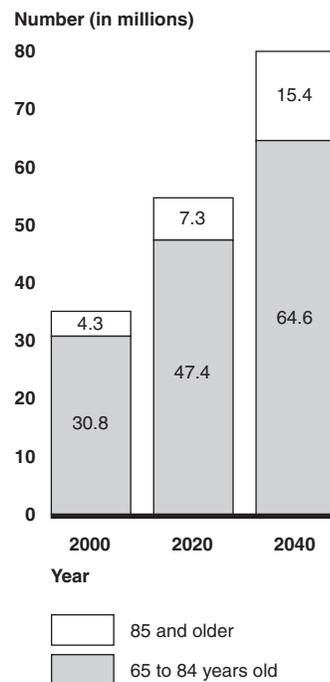


Source: GAO's January 2007 analysis.

Absent substantive reform of entitlement programs, federal spending will grow to unprecedented levels. Our projections are in part driven by demographic trends in coming decades. In 2000, individuals aged 65 and older numbered about 35 million people—about 12 percent of our nation's total population. By 2020, that percentage will increase to about 16 percent—1 in 6 Americans—and will represent nearly 20 million more elderly than there were in 2000. By 2040, the number of elderly aged 85 years and older is projected to increase more than 250 percent, from slightly over 4 million in 2000 to slightly over 15 million (see fig. 2). Social Security and a large portion of Medicare are financed as pay-as-you-go systems in which current workers' payroll taxes pay current retirees'

benefits.<sup>4</sup> Therefore, these programs are directly affected by the relative size of populations of covered workers and beneficiaries. Historically, this relationship has been favorable. In the future, however, the overall worker-to- retiree ratio will change in ways that threaten the financial solvency and sustainability of these entitlement programs. In 2000, there were 4.7 working-age persons (20 to 64 years) per elderly person, but by 2040, this ratio is projected to decline to 2.6.

**Figure 2: Elderly Population, 2000 through 2040**

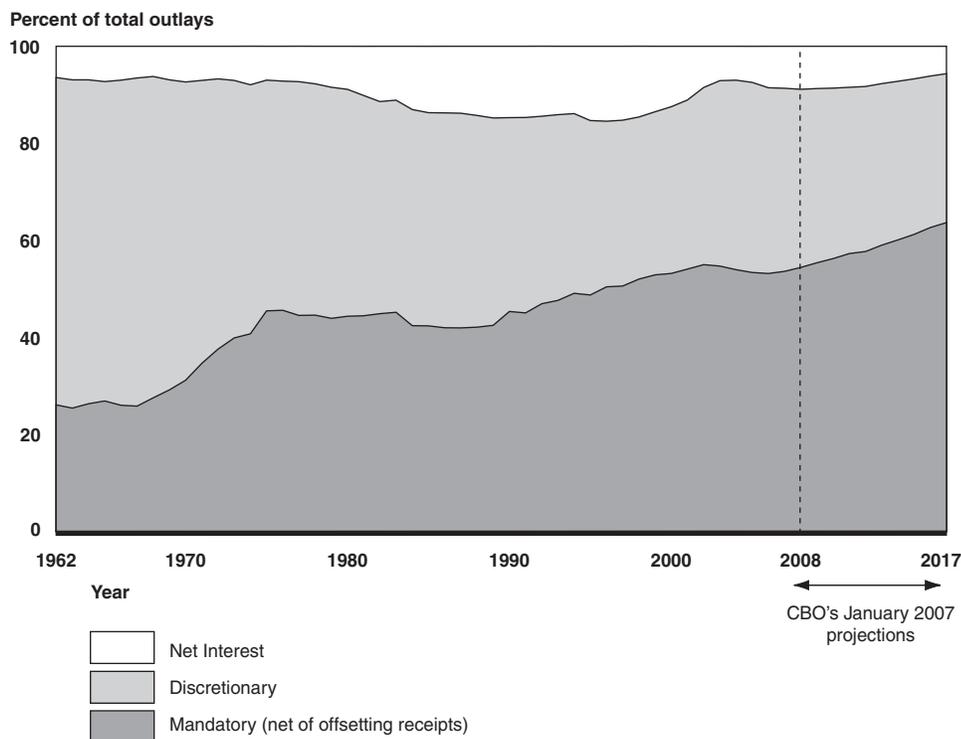


Sources: U.S. Census Bureau, *Annual Estimates of the Population by Sex and Five-Year Age Groups for the United States: April 1, 2000, to July 1, 2003* (NC-EST2003-01) (June 2004), and *U.S. Interim Projections by Age, Sex, Race and Hispanic Origin* (March 2004).

<sup>4</sup>Financial transactions of the Medicare program operate through two trust funds, the Federal Hospital Insurance (HI) trust fund and the Supplementary Medical Insurance (SMI) trust fund. For both Social Security and Medicare’s HI trust fund, the main source of income is taxes on wages and self-employment income. Medicare’s SMI trust fund is financed by a combination of general revenues and beneficiary premiums.

Absent significant policy changes in federal spending, federal revenue, or both, the growth in mandatory spending on federal retirement (Social Security) and especially health entitlements (Medicare and Medicaid) will encumber an escalating share of the government's resources, leaving fewer and fewer dollars for spending on discretionary programs, including the health care provided by VA. (See fig. 3.)

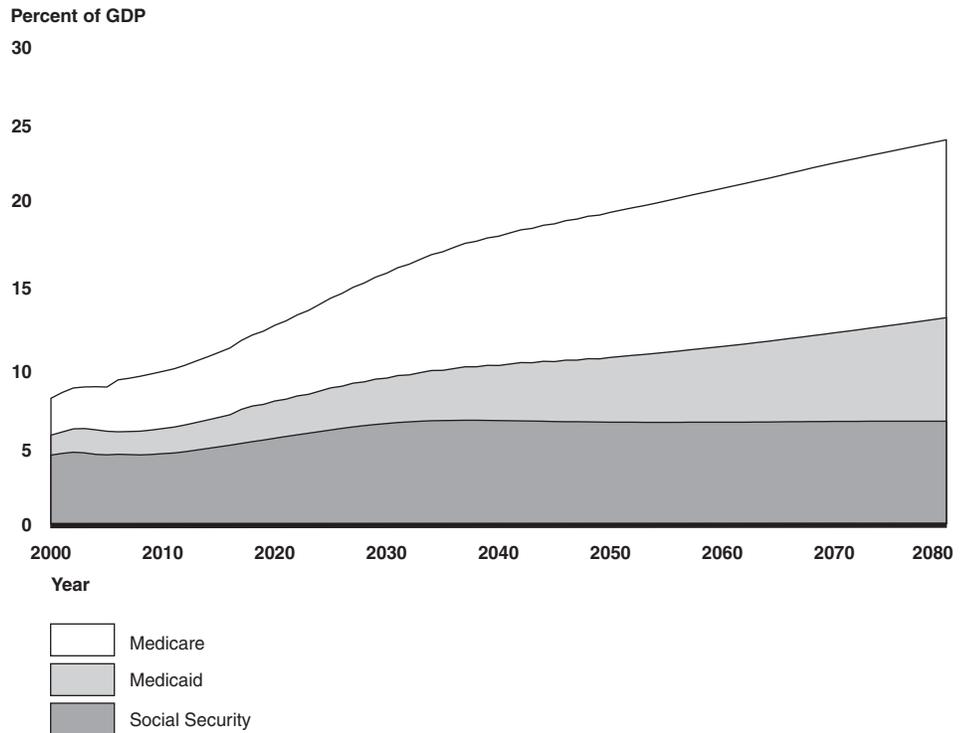
**Figure 3: Federal Spending for Mandatory and Discretionary Programs, 1962-2017**



Sources: Office of Management and Budget and the Congressional Budget Office.

Figure 3 suggests that this current fiscal path will increasingly constrain the government's ability to address emerging and unexpected budgetary needs and increase the burdens that will be faced by future generations. Indeed, entitlement spending will have significant implications for the economy as a whole. Figure 4 shows the total future draw on the economy represented by federal spending for Social Security, Medicare, and Medicaid. Federal spending for these entitlement programs combined is projected to grow to 15.5 percent of GDP in 2030 from today's 9 percent.

**Figure 4: Social Security, Medicaid, and Medicare as Share of GDP, 2000-2080**



Sources: GAO analysis based on data from the Office of the Chief Actuary, Social Security Administration; Office of the Actuary, Centers for Medicare and Medicaid Services; and the Congressional Budget Office.

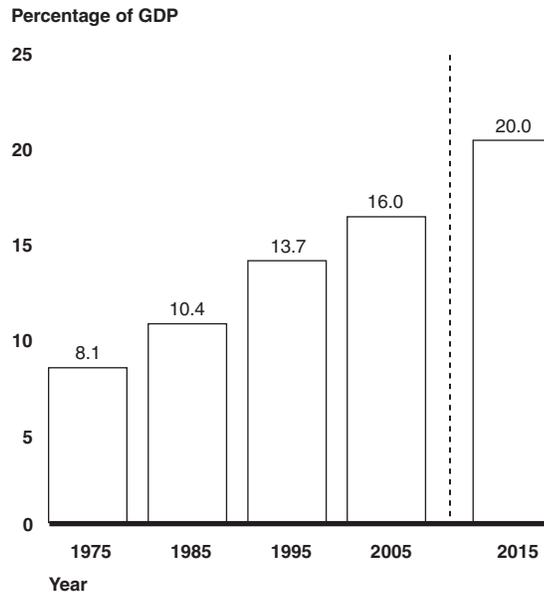
Note: Social Security and Medicare projections are based on the intermediate assumptions of the 2006 Trustees' Reports. Medicaid projections are based on CBO's January 2007 short-term Medicaid estimates and CBO's December 2005 long-term Medicaid projections under midrange assumptions.

Although Social Security is a major part of the fiscal challenge, it is far from our biggest challenge. Over the past several decades, health care spending on average has grown much faster than the economy, and this rapid growth is projected to continue. As figure 4 shows, Social Security grows as a share of the economy and then levels off, whereas Medicare and Medicaid growth continues to rise without abatement.

## Growth in Health Care Spending System-wide Driven by Certain Factors

Health care spending system-wide—that is, for both public and private payers—is absorbing an increasing share of GDP. As shown in figure 5, from 1975 through 2005, aggregate public and private spending on health care grew from about 8 percent to 16 percent of GDP. In 2005, public and private spending totaled \$2 trillion. Aggregate health care spending is projected to grow to 20 percent of GDP by 2015.

**Figure 5: Aggregate Public and Private Health Care Spending, as a Percentage of GDP**



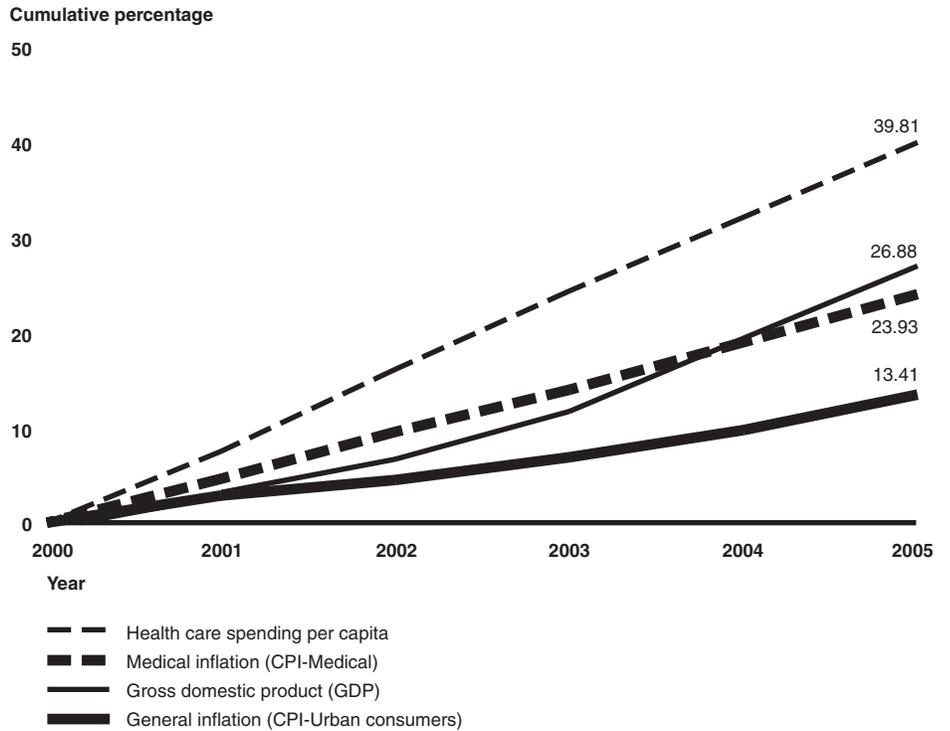
Source: The Centers for Medicare & Medicaid Services, Office of the Actuary.

Note: The figure for 2015 is projected.

Such health care spending increases threaten the ability of the nation to remain competitive in the global economy.

Aggregate health care spending continues to rise because of increased medical prices and increased utilization due to growth in the number, or volume, of services per capita, and use of more intense, or complex, services. Figure 6 shows the relative importance of price and utilization with respect to spending growth. From 2000 through 2005, inflation in medical prices—as represented by the medical component of the Consumer Price Index (CPI)—grew by 4.4 percent on average, whereas health care spending per capita—which includes increases in both medical prices and utilization—grew by 6.9 percent on average. By comparison, during this time, GDP grew at an average annual rate of 4.9 percent. These rates of growth suggest that growth in the economy cannot offset the growth in health care spending per capita.

**Figure 6: Comparison of Cumulative Growth in General Inflation, Medical Inflation, Gross Domestic Product, and Health Care Spending Per Capita, 2000-2005**



Sources: GAO analysis of data from the Bureau of Labor Statistics, the Centers for Medicare & Medicaid Services, Office of the Actuary, and the Bureau of Economic Analysis.

Medical technology is a major contributor to growth in health care spending. For example, one study found that the average amount spent per heart attack case increased nearly \$10,000 per case after controlling for inflation, or 4.2 percent per year between 1984 and 1998.<sup>5</sup> Nearly half of the cost increases resulted from people getting more intensive technologies—such as cardiac catheterization—over time. Moreover, the proportion of people receiving catheterization in the surgical treatment of heart attacks rose from slightly over 10 percent in 1984 to slightly over 50 percent in 1998. Another study discusses what we characterize as a multiplier effect.<sup>6</sup>

<sup>5</sup>David M. Cutler and Mark McClellan, “Is Technological Change in Medicine Worth It?” *Health Affairs*, vol. 20, no. 5 (September/October 2001).

<sup>6</sup>See Richard A. Deyo, “Cascade Effects of Medical Technology,” *Annual Review of Public Health*, vol. 23 (May 2002).

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That is, the diffusion of new diagnostic technology, such as advances in imaging, increases diagnostic capability, which, in turn, increases the identification and treatment of diseases or conditions. In some cases, the multiplier effect can lead to overdiagnosis and the excessive use of resources. The study cites the use of spinal magnetic resonance imaging (MRI) as one example. Researchers find that diagnostic spinal MRI sometimes reveals abnormalities (such as bulging discs) having no clinical relevance. Some physicians, the study contends, act on this information and perform unnecessary surgery, which can sometimes lead to complications.

Obesity, smoking, and other population risk factors can lead to expensive chronic conditions; the increased prevalence of such conditions—for example, diabetes and heart disease—drives growth in the utilization of health care resources and therefore in spending. Obesity has been the subject of several recent studies focusing on associated health care cost increases.<sup>7</sup> For example, one study attributes 27 percent of the growth in inflation-adjusted per capita spending between 1987 and 2001 to the rising prevalence of obesity and higher relative per capita spending among obese individuals.<sup>8</sup> Specifically, these factors accounted for slightly over 38 percent of the rise in spending for diabetes and 41 percent of the rise in spending for heart disease. Other studies focus on the effect of population risk factors on utilization of services. For example, one study found that obese patients had significantly higher numbers of primary care visits and diagnostic services compared to nonobese patients.<sup>9</sup>

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<sup>7</sup>See Kenneth E. Thorpe, “The Rise in Health Care Spending and What to Do About It,” *Health Affairs*, vol. 24, no. 6 (November/December 2005); Roland Sturm, “The Effects of Obesity, Smoking, and Drinking on Medical Problems and Costs,” *Health Affairs*, vol. 21, no. 2 (March/April 2002); Kenneth E. Thorpe et al., “The Impact of Obesity on Rising Medical Spending,” *Health Affairs Web Exclusive*, <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w4.480> (Oct. 20, 2004); and Marsha A. Raebel et al., “Health Service Use and Health Care Costs of Obese and Nonobese Individuals,” *Archives of Internal Medicine*, vol. 164, no. 19 (Oct. 25, 2004).

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

<sup>9</sup>Klea D. Bertakis and Rahman Azari, “The Influence of Obesity, Alcohol Abuse, and Smoking on Utilization of Health Care Services,” *Family Medicine*, vol. 38, no. 6 (June 2006).

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## Health Care Payers Face Challenges System-wide

Both public and private payers face fundamental challenges in the struggle to contain health care spending growth. One of the challenges involves the unbridled use of technology and society's unmanaged expectations. For example, cutting-edge drugs and other medical technologies can be very expensive but offer no advantage over their alternatives. Experts note that the nation's general tendency is to treat patients with available technology when there is the slightest chance of benefit to the patient, even though the costs may far outweigh the benefit to society as a whole. They note that the discipline of technology assessment has not kept pace with technology advancements.<sup>10</sup>

Today's employers, which finance a substantial share of the health care of the privately insured population, are seeking more information on health care technology costs and benefits. Public agencies seldom use such information in discharging their responsibilities and lack an independent source of cost-benefit analyses. Although the Food and Drug Administration (FDA), for example, evaluates new medical products based on safety and efficacy data submitted by manufacturers, it does not evaluate whether the new products are cost-effective compared with existing products used for the same treatment indications. In turn, Medicare, which generally relies on FDA approval decisions, does not evaluate whether new technologies are superior, either clinically or economically, compared with technologies already covered and paid for by the program.

Another cost containment challenge for all payers relates to the market dynamics of health care compared with other economic sectors. In an ideal market, informed consumers prod competitors to offer the best value. Without good comparative information, however, consumers are less able to determine the best value. Insurance masks the actual costs of goods and services, providing little incentive for consumers to be cost-conscious. Similarly, clinicians must often make decisions in the absence of universal medical standards of practice. Under these circumstances, medical practices vary across the nation, as evidenced by wide geographic variation in per capita spending, even after controlling for patient differences in health status. A seminal study on Medicare spending shows that, counterintuitively, Medicare beneficiaries living in higher-spending areas appear to experience slightly worse outcomes relative to

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<sup>10</sup>[GAO-04-793SP](#).

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beneficiaries in lower-spending areas.<sup>11</sup> At the same time, to the extent that providers are paid for each service rendered, an incentive exists to maximize revenue through increased volume. Together, the lack of transparency with regard to cost and quality and perverse incentives with regard to the use of care combine in the health care system to preclude market forces from achieving the best value for the dollars spent. As a consequence, health care spending continues to experience annual inflation that threatens the economic prosperity of the nation in both public and private sectors.

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Mr. Chairman, this concludes my prepared remarks. I will be happy to answer any questions you or other Members of the Subcommittee may have.

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## Contact and Acknowledgments

For future contacts regarding this testimony, please call A. Bruce Steinwald at (202) 512-7101 or at [steinwalda@gao.gov](mailto:steinwalda@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Other individuals who made key contributions include Phyllis Thorburn, Assistant Director; Jessica Farb; Hannah Fein; and Gregory Giusto.

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<sup>11</sup>For example, in a cohort of Medicare beneficiaries treated for hip fractures, the study found that beneficiaries in three regions with higher end-of-life spending had a higher risk for death than beneficiaries living in regions with lower spending. E.S. 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 (2003).

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