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UNITED STATES GOVERNMENT ACCOUNTABILITY OFFICE

Fiscal and Health Care Challenges

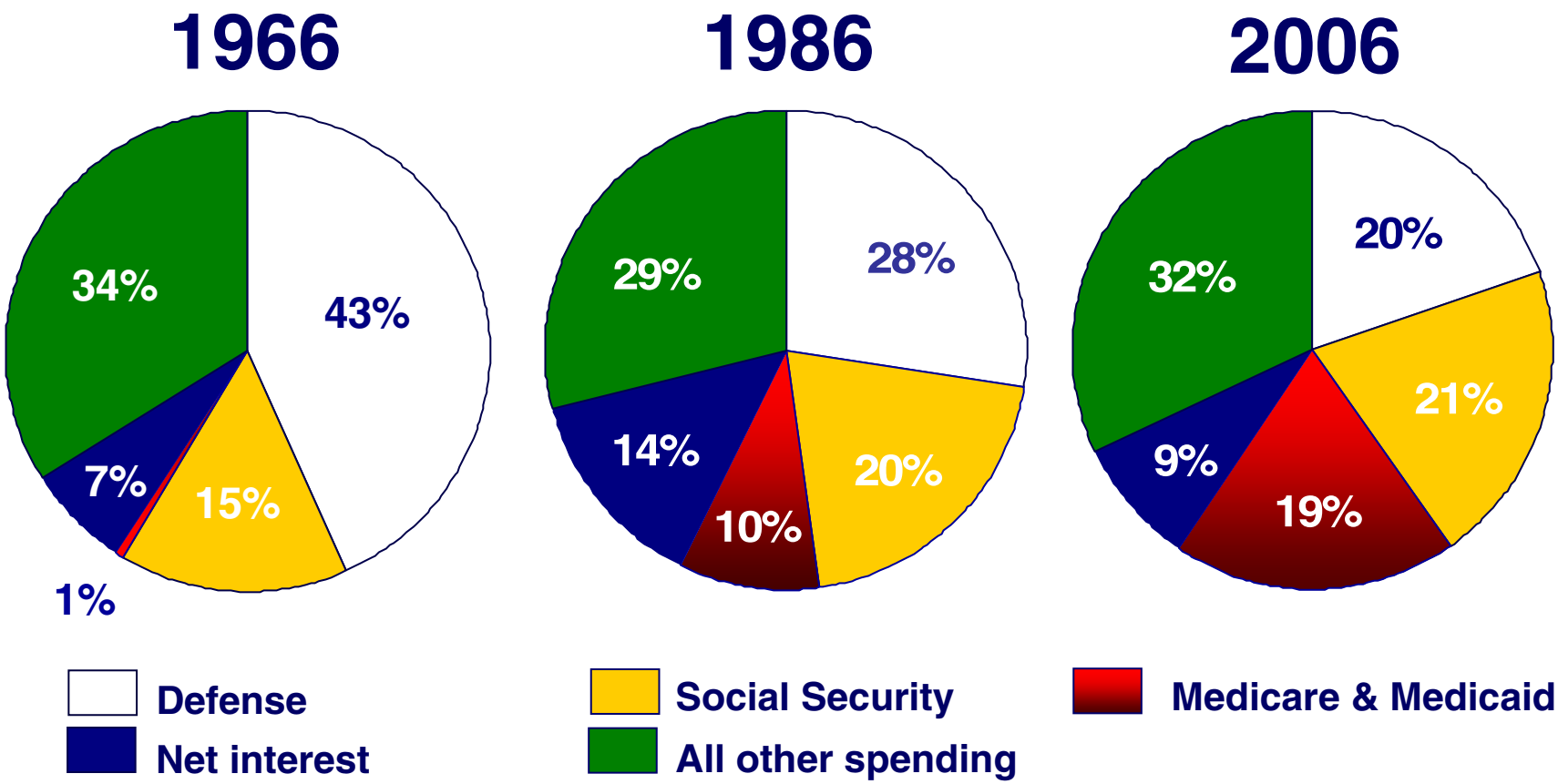
The Honorable David M. Walker
Comptroller General of the United States

National Conference on Health Care Consumerism

December 5, 2007

GAO-08-338CG

Composition of Federal Spending



Source: Office of Management and Budget.
Note: Numbers may not add to 100 percent due to rounding.

Major Fiscal Exposures ($ trillions)

	2000	2006	% Increase
• **Explicit liabilities**	**$6.9**	**$10.4**	**52**
• Publicly held debt			
• Military & civilian pensions & retiree health			
• Other			
• **Commitments & contingencies**	**0.5**	**1.3**	**140**
• E.g., PBGC, undelivered orders			
• **Implicit exposures**	**13.0**	**38.8**	**197**
• Future Social Security benefits	3.8	6.4	
• Future Medicare Part A benefits	2.7	11.3	
• Future Medicare Part B benefits	6.5	13.1	
• Future Medicare Part D benefits	--	7.9	
Total	**$20.4**	**$50.5**	**147**

Source: 2000 and 2006 Financial Report of the United States Government.

Note: Totals and percent increases may not add due to rounding. Estimates for Social Security and Medicare are at present value as of January 1 of each year and all other data are as of September 30.

How Big is Our Growing Fiscal Burden?

This fiscal burden can be translated and compared as follows:

Total –major fiscal exposures	**$50.5 trillion**
Total household net worth[1]	**$53.3 trillion**
Burden/Net worth ratio	**95 percent**
Burden[2]	
Per person	**$170,000**
Per full-time worker	**$400,000**
Per household	**$440,000**
Income	
Median household income[3]	**$46,326**
Disposable personal income per capita[4]	**$31,519**

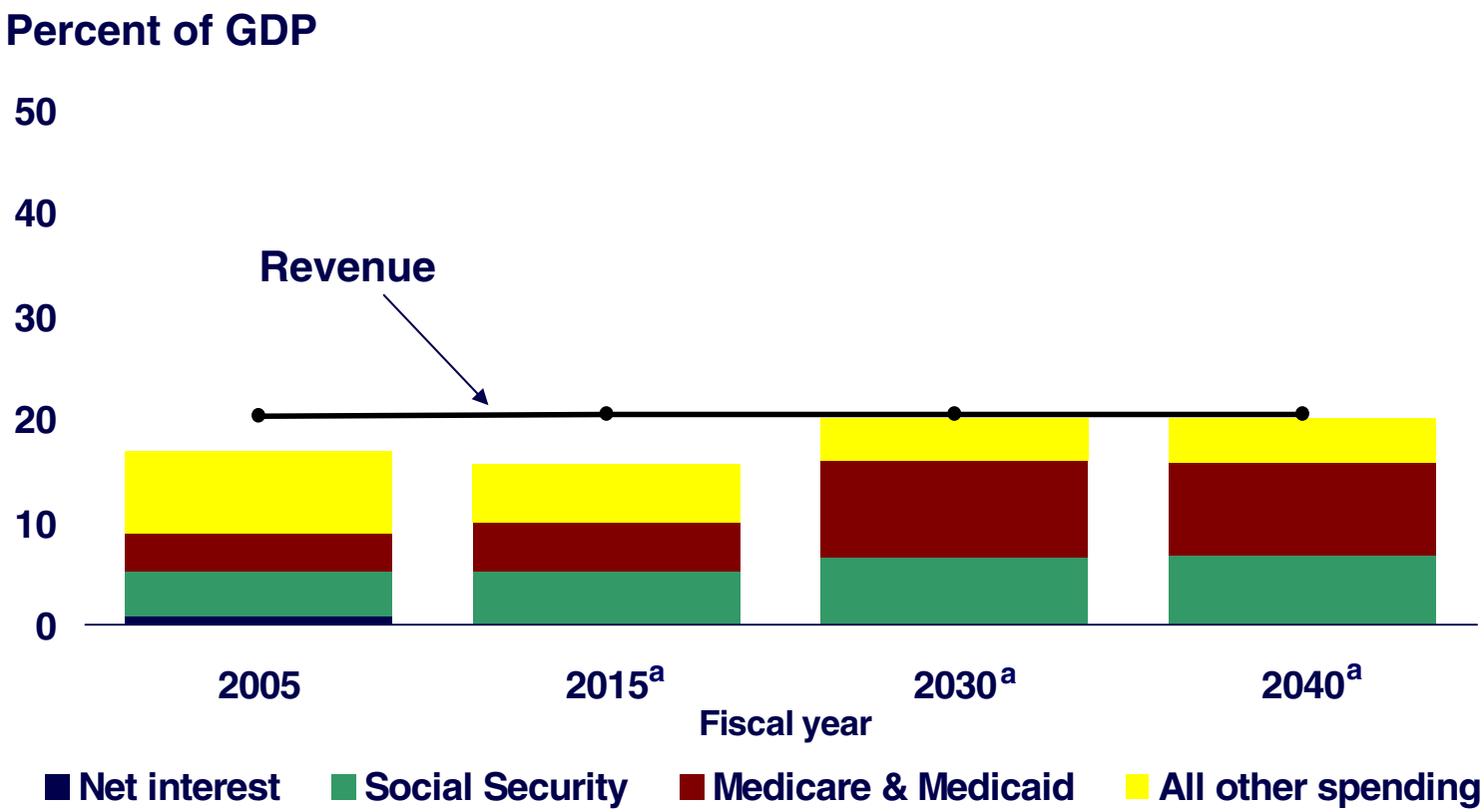
Source: GAO analysis.

Notes: (1) Federal Reserve Board, Flow of Funds Accounts, Table B.100, 2006:Q2 (Sept. 19, 2006); (2) Burdens are calculated using estimated total U.S. population as of 9/30/06, from the U.S. Census Bureau; full-time workers reported by the Bureau of Economic Analysis, in NIPA table 6.5D (Aug. 2, 2006); and households reported by the U.S. Census Bureau, in Income, Poverty, and Health Insurance Coverage in the United States: 2005 (Aug. 2006); (3) U.S. Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States: 2005 (Aug. 2006); and (4) Bureau of Economic Analysis, Personal Income and Outlays: October 2006, table 2, (Nov. 30, 2006).

Potential Fiscal Outcomes

Under Baseline Extended (January 2001)

Revenues and Composition of Spending as a Share of GDP



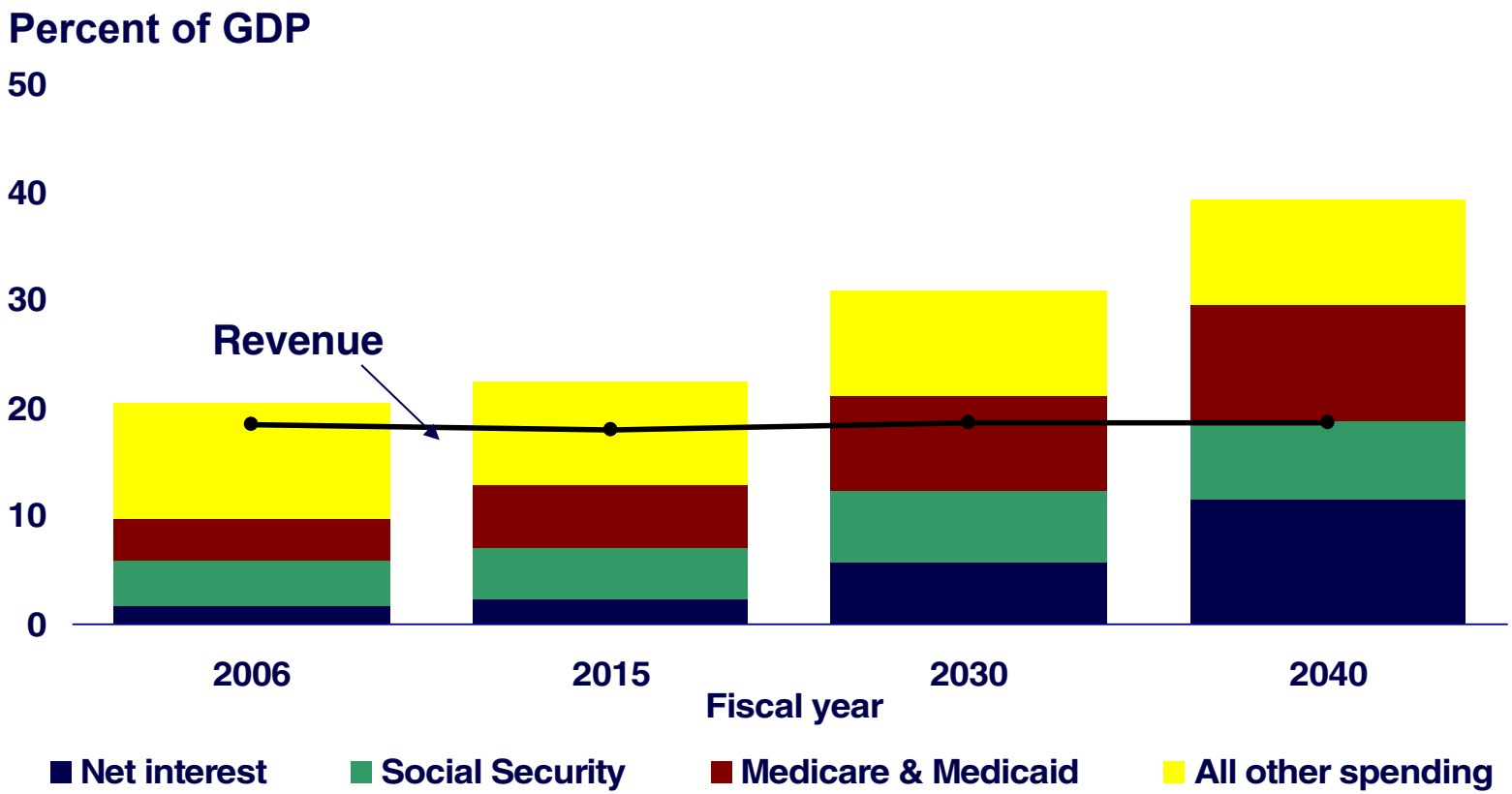
Source: GAO's January 2001 analysis.

[a]All other spending is net of offsetting interest receipts.

Potential Fiscal Outcomes

Under Alternative Simulation

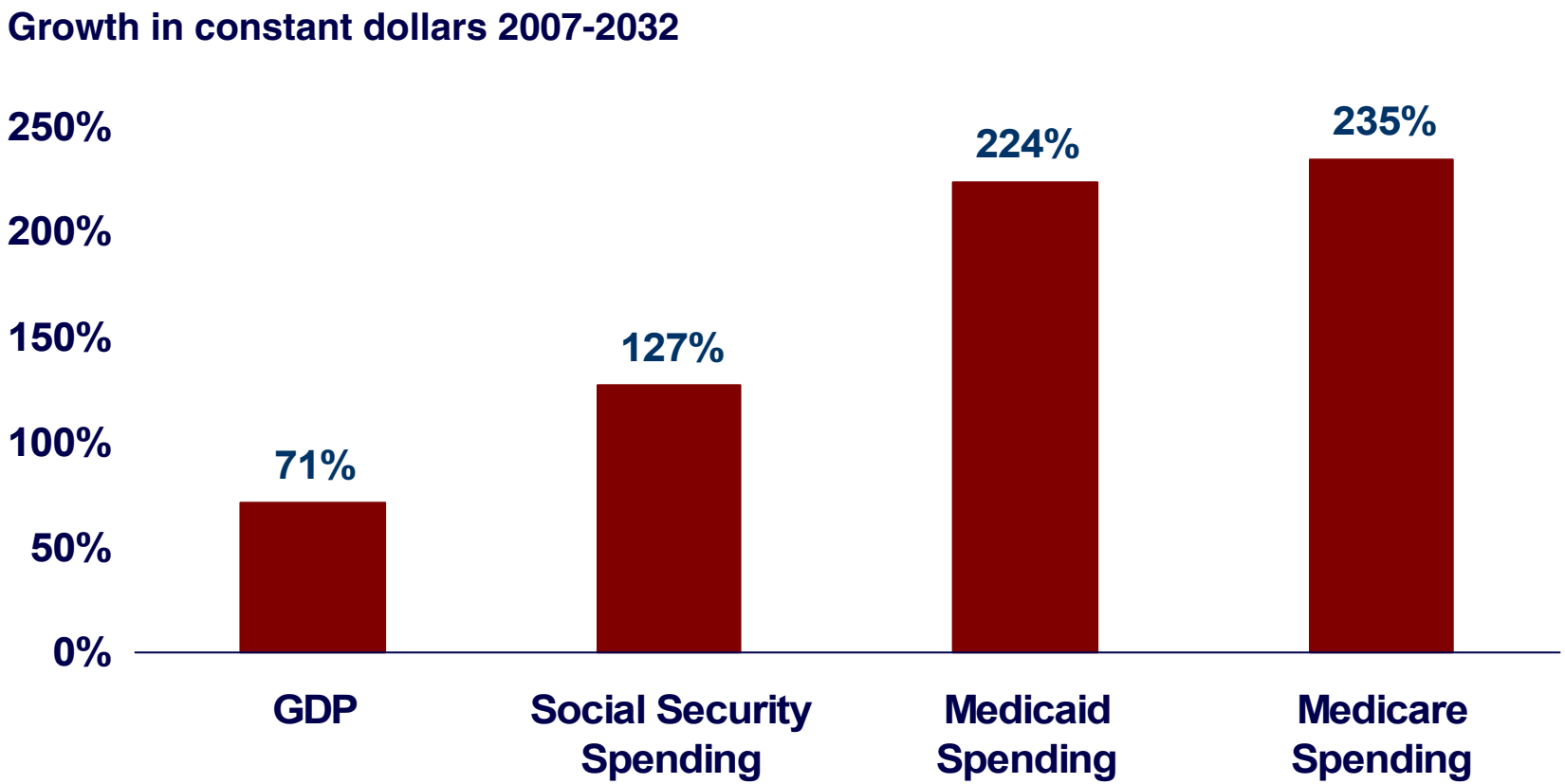
Revenues and Composition of Spending as a Share of GDP



Source: GAO's August 2007 analysis.

Notes: AMT exemption amount is retained at the 2006 level through 2017 and expiring tax provisions are extended. After 2017, revenue as a share of GDP returns to its historical level of18.3 percent of GDP plus expected revenues from deferred taxes, i.e. taxes on withdrawals from retirement accounts. Medicare spending is based on the Trustees April 2007 projections adjusted for the Centers for Medicare and Medicaid Services alternative assumption that physician payments are not reduced as specified under current law.

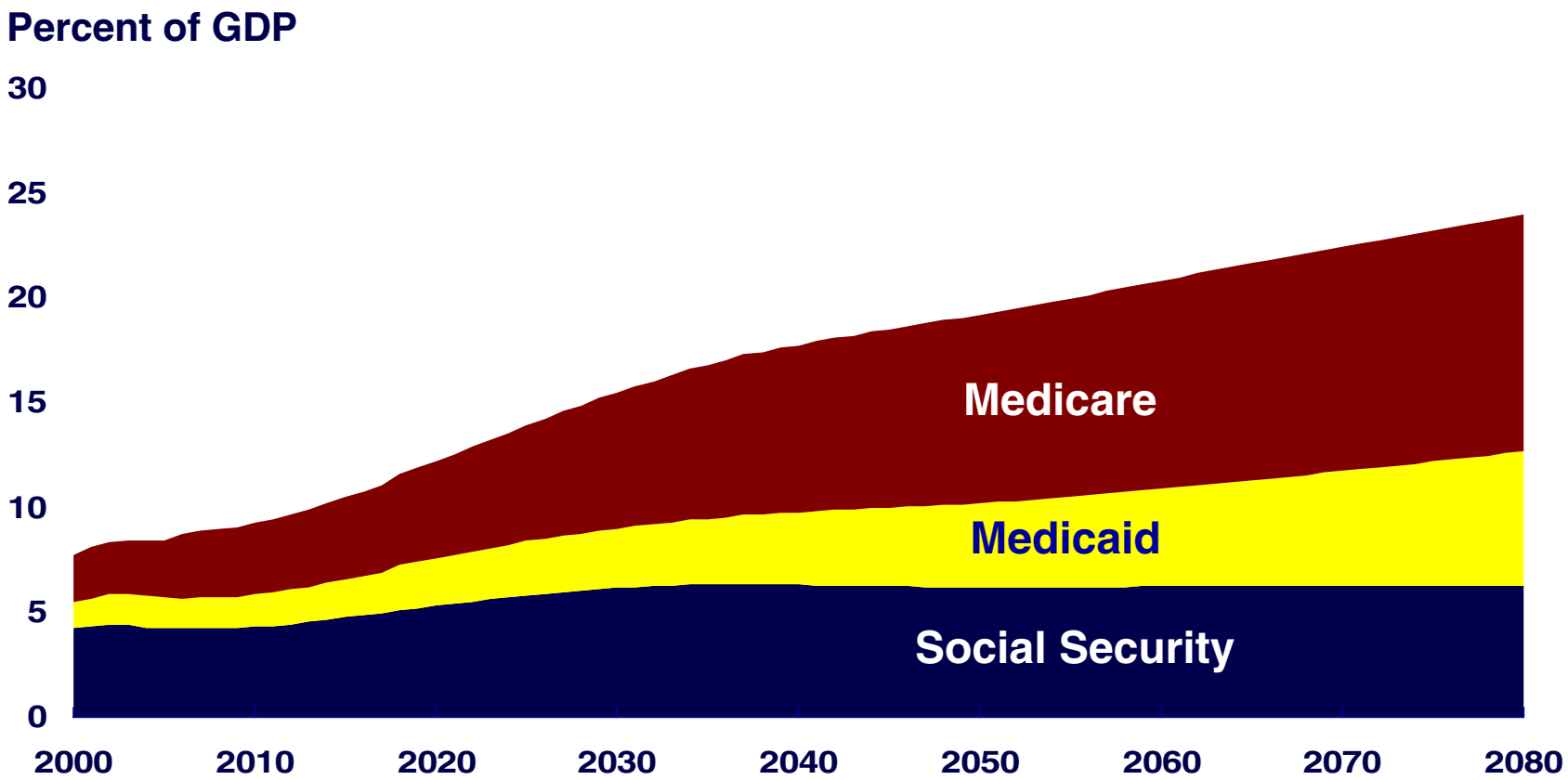
Growth in Spending for Social Security, Medicare, and Medicaid Expected to Outpace Economic Growth



Source: 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.

Notes: Social Security and Medicare projections based on the intermediate assumptions of the 2007 Trustees' Reports. Medicaid projections based on CBO's August 2007 short-term Medicaid estimates and CBO's December 2005 long-term Medicaid projections under mid-range assumptions.

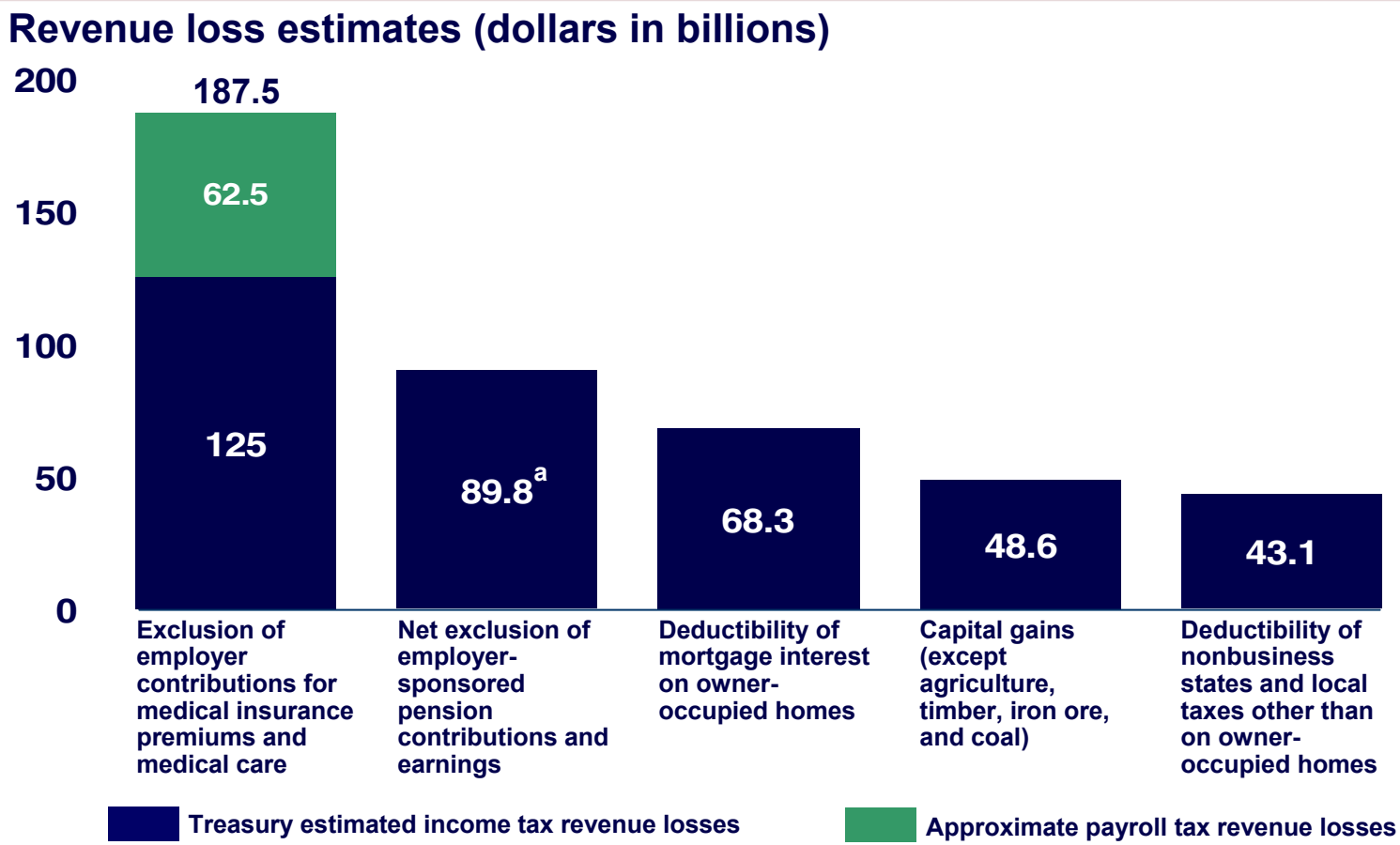
Social Security, Medicare, and Medicaid Spending as a Percent of GDP



Source: 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 based on the intermediate assumptions of the 2007 Trustees' Reports. Medicaid projections based on CBO's August 2007 short-term Medicaid estimates and CBO's December 2005 long-term Medicaid projections under mid-range assumptions.

Revenue Loss Estimates for the Largest Tax Expenditures Reported for Fiscal Year 2006



Source: GAO analysis of OMB, *Analytical Perspectives, Budget of the United States Government, Fiscal Year 2008.*

[a]The value of employer-provided health insurance is excluded from Medicare and Social Security payroll taxes. Some researchers have estimated that payroll tax revenue losses amounted to more than half of the income tax revenue losses in 2004, and we use this estimate for 2006. The research we are aware of dealt only with health care, therefore the 50 percent figure may not apply to other items that are excluded from otherwise applicable income and payroll taxes.

Current Fiscal Policy Is Unsustainable

- **The "Status Quo" is Not an Option**
  - We face large and growing structural deficits largely due to known demographic trends and rising health care costs.
  - GAO's simulations show that balancing the budget in 2040 could require actions as large as
    - Cutting total federal spending by 60 percent or
    - Raising federal taxes to 2 times today's level
- **Faster Economic Growth Can Help, but It Cannot Solve the Problem**
  - Closing the current long-term fiscal gap based on reasonable assumptions would require real average annual economic growth in the double digit range every year for the next 75 years.
  - During the 1990s, the economy grew at an average 3.2 percent per year.
  - As a result, we cannot simply grow our way out of this problem. Tough choices will be required.

The Way Forward: A Three-Pronged Approach

1. **Improve Financial Reporting, Public Education, and Performance Metrics**

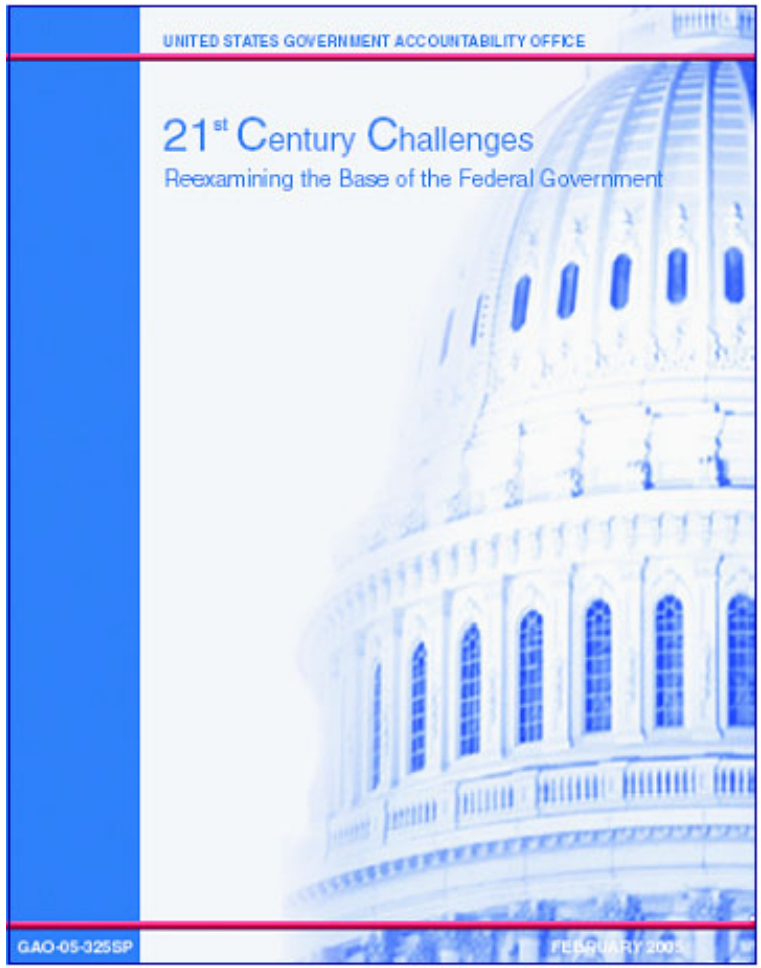
2. **Strengthen Budget and Legislative Processes and Controls**

3. **Fundamentally Reexamine & Transform for the 21st Century (i.e., entitlement programs, other spending, and tax policy)**

Solutions Require Active Involvement from both the Executive and Legislative Branches

21st Century Challenges Report

- Provides background, framework, and questions to assist in reexamining the base
- Covers entitlements & other mandatory spending, discretionary spending, and tax policies and programs
- Based on GAO's work for the Congress



Source: GAO.

Twelve Reexamination Areas

MISSION AREAS

- Defense
- Education & Employment
- Financial Regulation & Housing
- **Health Care**
- Homeland Security
- International Affairs
- Natural Resources, Energy & Environment
- Retirement & Disability
- Science & Technology
- Transportation

CROSSCUTTING AREAS

- Improving Governance
- Reexamining the Tax System

Illustrative 21st Century Questions:
Health Care

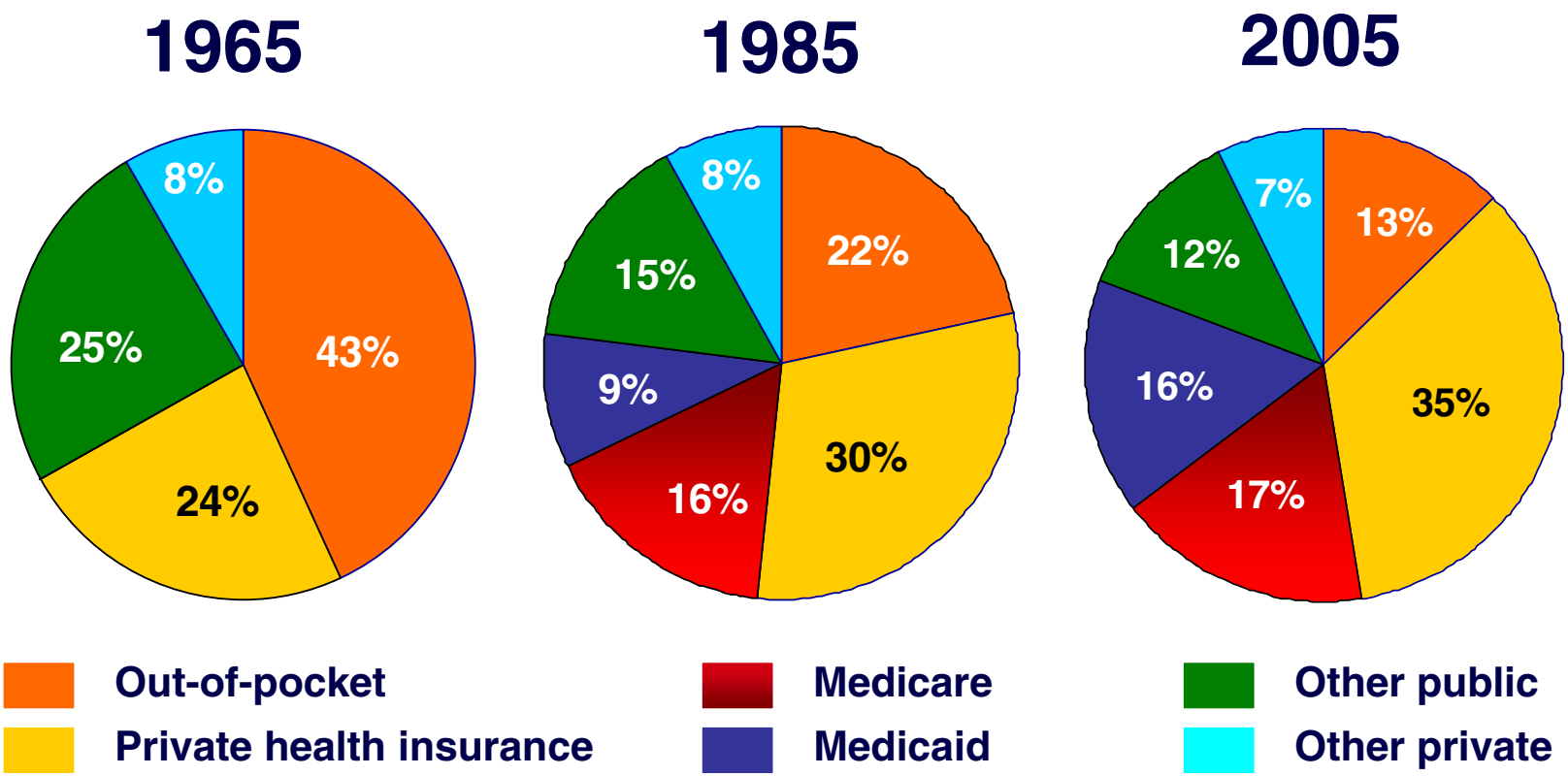
- How can we make our current **Medicare and Medicaid** programs sustainable? For example, should the eligibility requirements (e.g., age, income requirements) for these programs be modified?
- How can we perform a **systematic reexamination of our current health care system**? For example, could public and private entities work jointly to establish formal reexamination processes that would (1) define and update as needed a minimum core of essential health care services, (2) ensure that all Americans have access to the defined minimum core services, (3) allocate responsibility for financing these services among such entities as government, employers, and individuals, and (4) provide the opportunity for individuals to obtain additional services at their discretion and cost?

Key Dates Highlight Long Term Challenges of the Medicare Program

Date	Event
2007	Medicare Part A outlays exceed cash income
2007	Estimated trigger date for "Medicare funding warning"
2013	Projected date that annual "general revenue funding" for Part B will exceed 45 percent of total Medicare outlays
2019	Part A trust fund exhausted, annual income sufficient to pay about 80% of promised Part A benefits

Source: *2007 Annual Report of The Boards of Trustees of The Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, DC, April 2007).

Health Care Spending by Source of Funds, 1965-2005

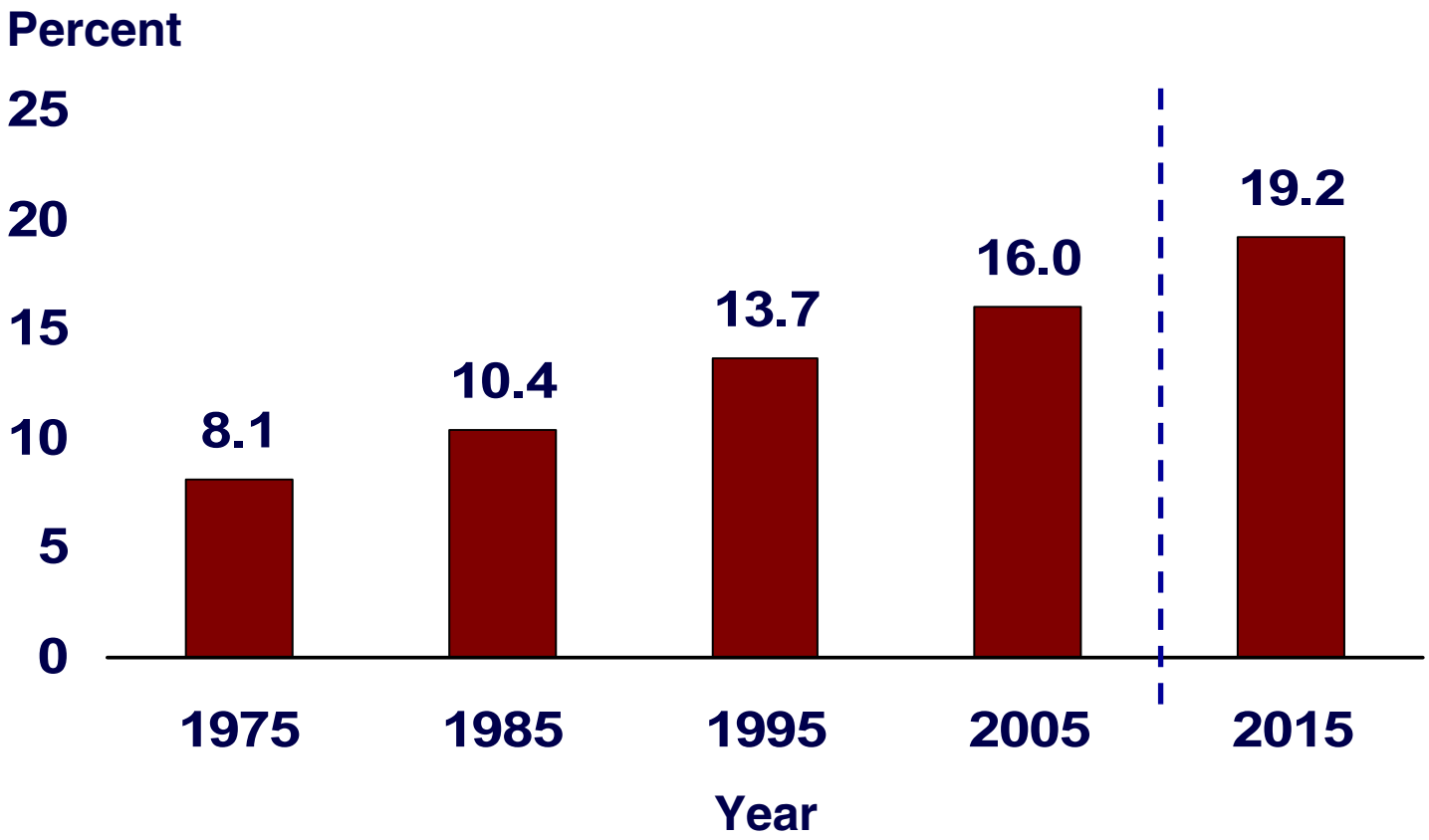


Source: The Centers for Medicare & Medicaid Services, Office of the Actuary.

Notes: The most current data available on health care spending are for 2005. Out-of-pocket spending includes direct spending by consumers on coinsurance, deductibles, and any amounts not covered by insurance. Out-of-pocket premiums paid by individuals are not counted here but are counted as part of Private Health Insurance. Percentages may not add to 100 due to rounding.

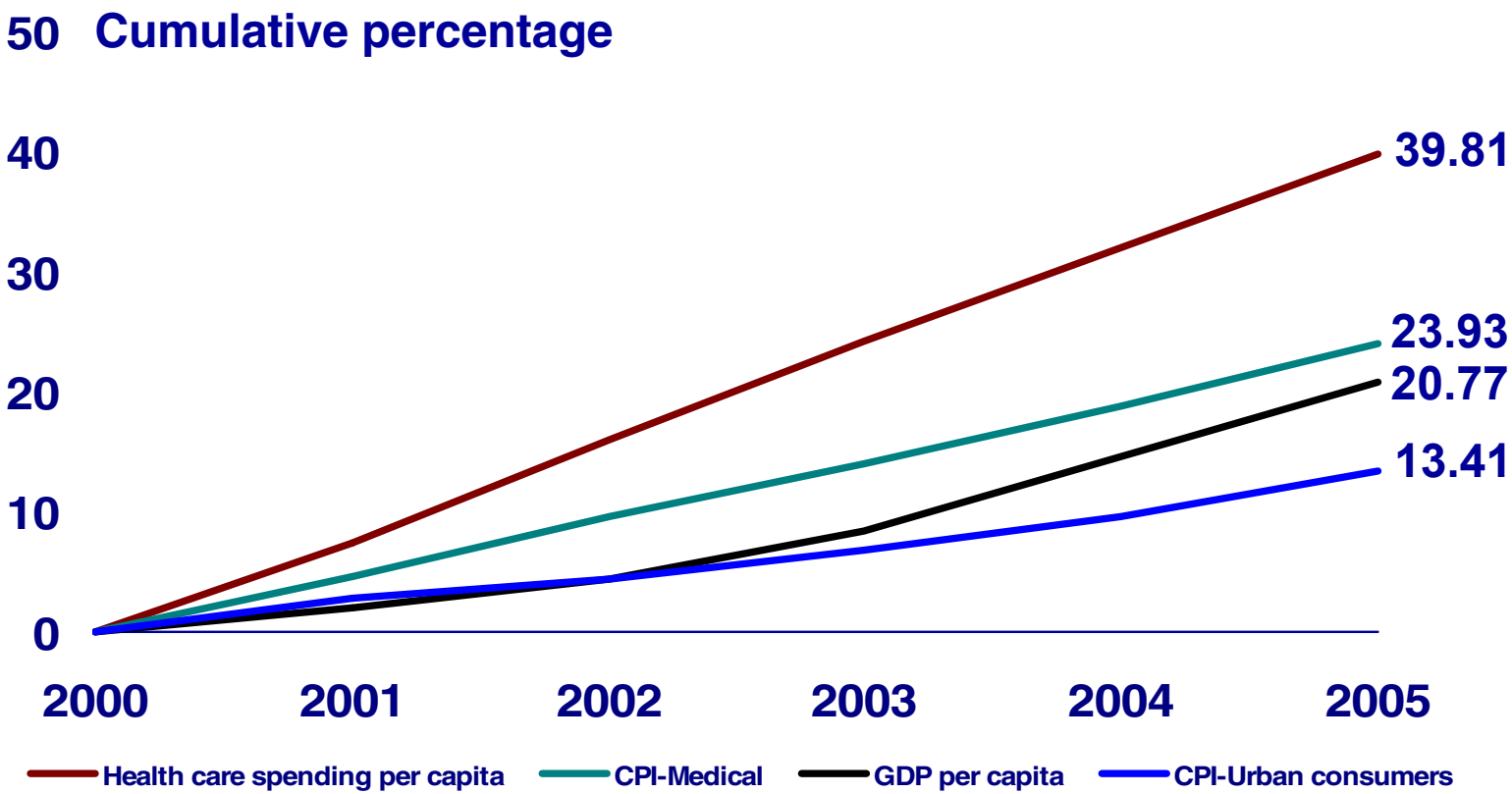
Growth in Health Care Spending

Health Care Spending as a Percentage of GDP



Source: The Centers for Medicare & Medicaid Services, Office of the Actuary.
Notes: The most current data available on health care spending are for 2005. The figure for 2015 is projected.

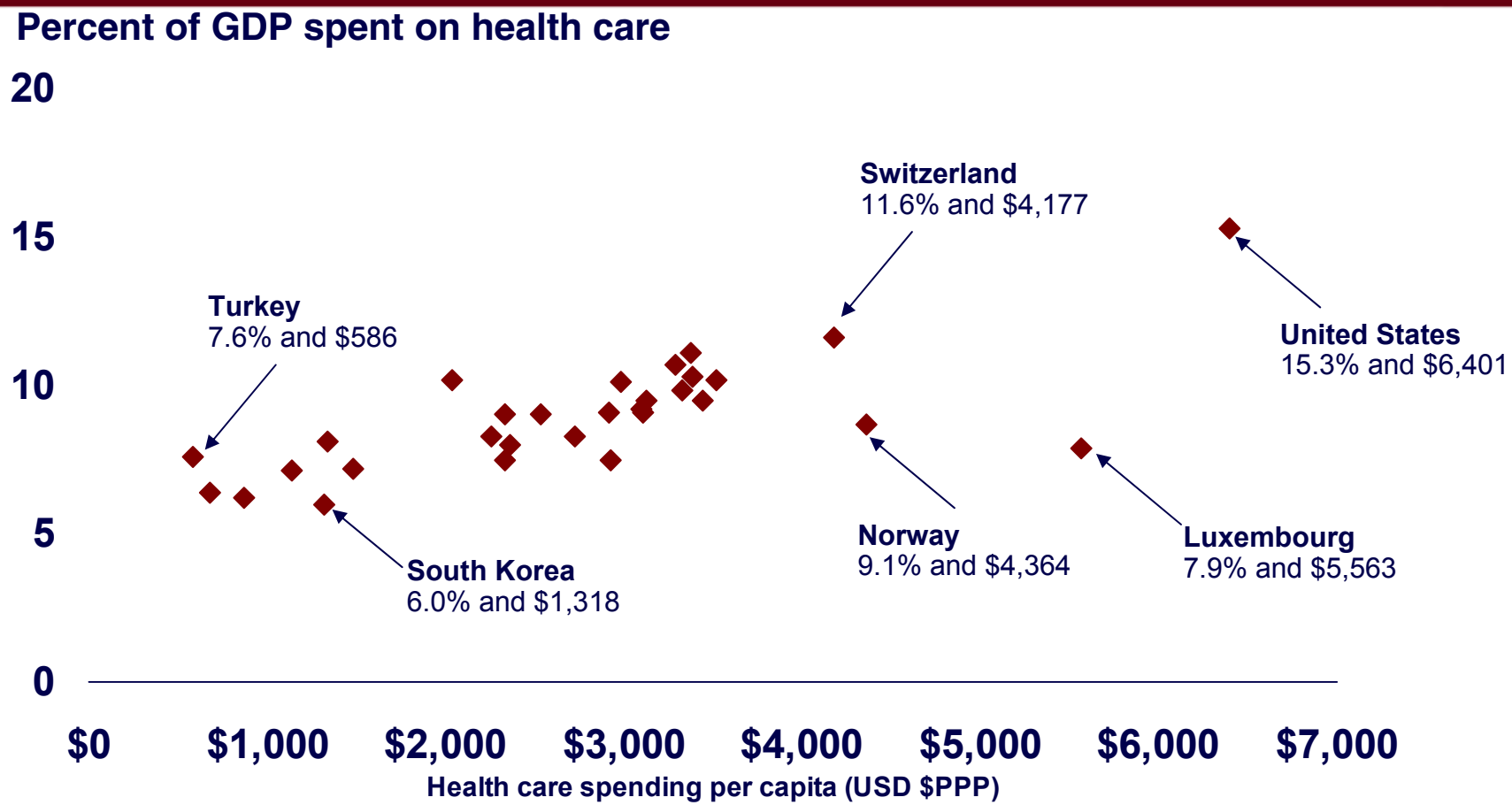
Cumulative Growth in Health Care Spending Per Capita, Medical Inflation, GDP Per Capita, and General Inflation, 2000-2005



Source: Bureau of Labor Statistics, The Centers for Medicare & Medicaid Services, Office of the Actuary, and the Bureau of Economic Analysis.

Note: The most current data available on health care spending per capita are for 2005.

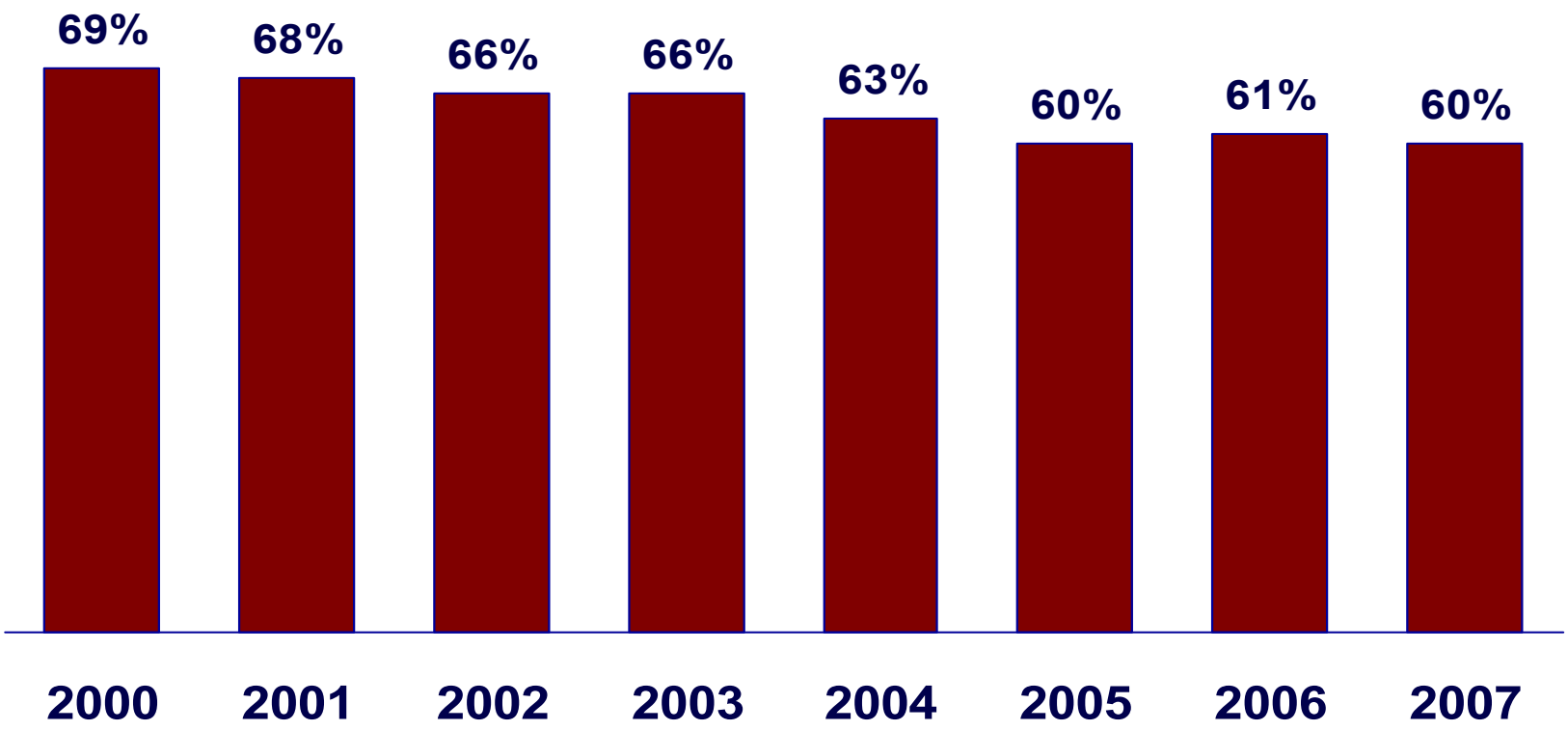
Growth in Health Care Spending:
U.S Compared to Other OECD Countries, 2005



Source: *OECD Health Data, 2007*

Notes: All of the data on per capita spending and GDP have been translated into U.S. dollar equivalents, with exchange rates based on purchasing power parities (PPPs) of the national currencies. Data for Australia, Hungary, Japan, and the Netherlands are for 2004.

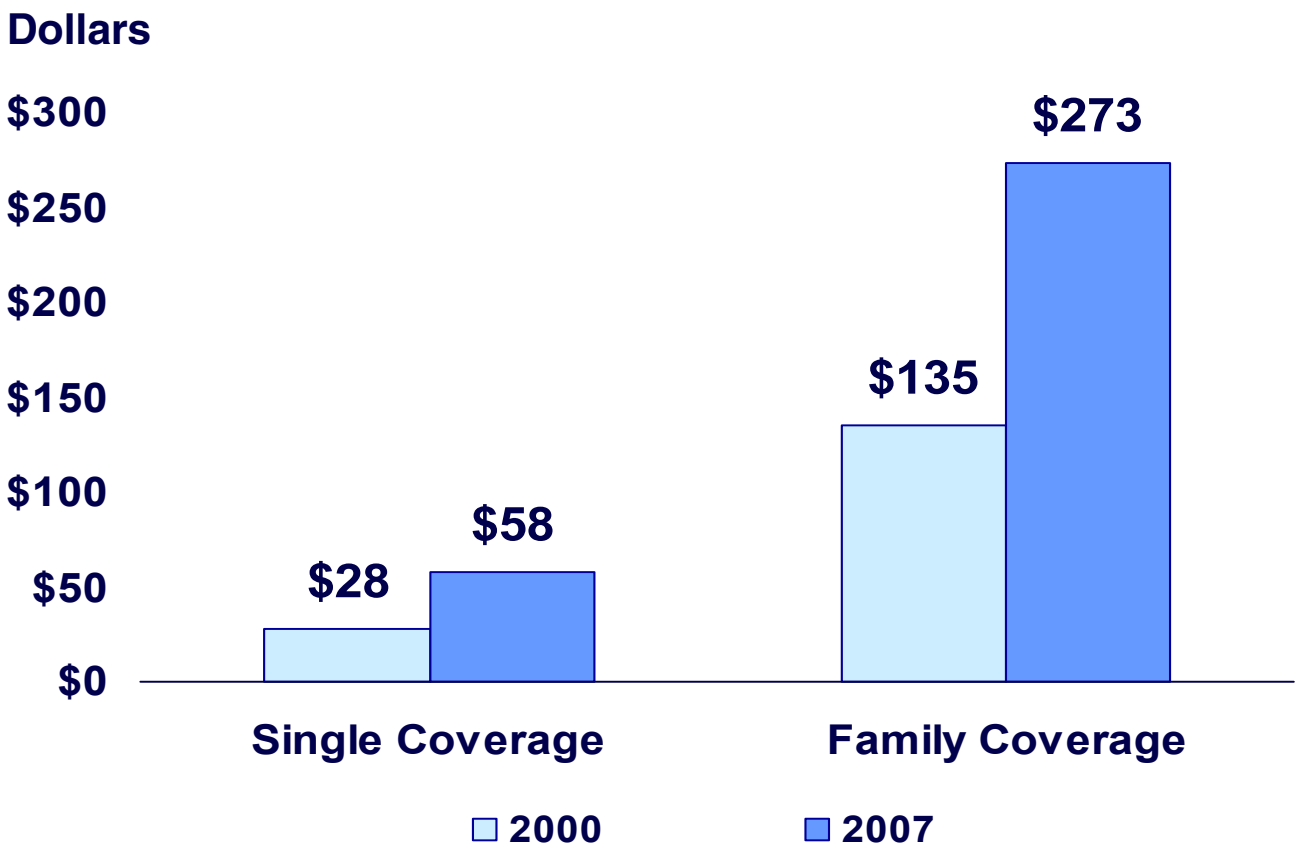
Percentage of Firms Offering Health Benefits, 2000-2007



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits.

Notes: The survey results are based on a sample of 3,159 firms and include both small firms (3-199 workers) and large firms (200+ workers). While the year to year changes in the percentage of firms offering benefits have not been statistically significant, the cumulative effect has been a large and statistically significant change over this 7 year period.

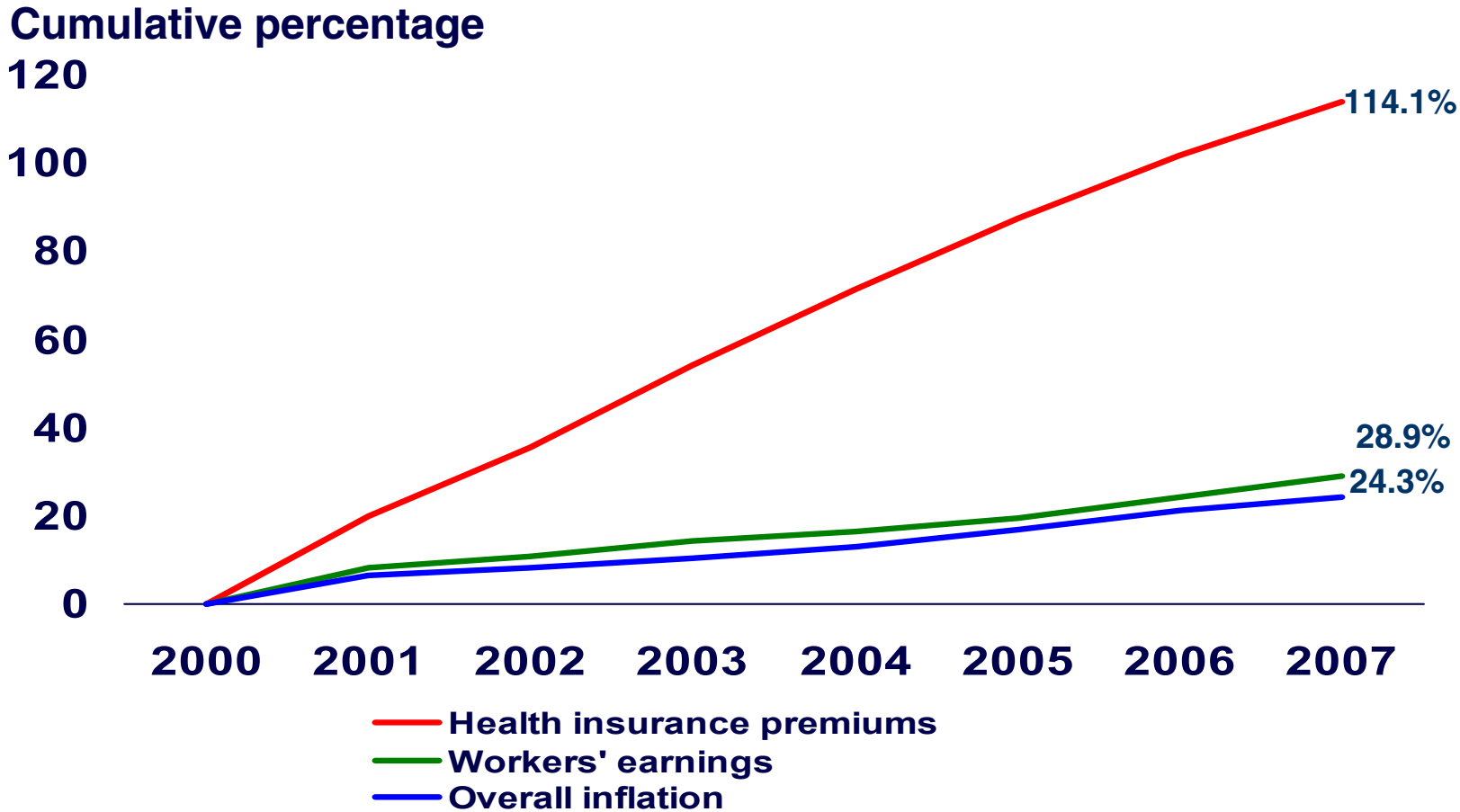
Change in Average Monthly Worker Premium Contributions Paid by Covered Workers for Single and Family Coverage, 2000 to 2007



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits.
Note: Premium contributions are reported in nominal dollars.

Growth in Health Insurance Premiums for Employer-Sponsored Health Insurance:

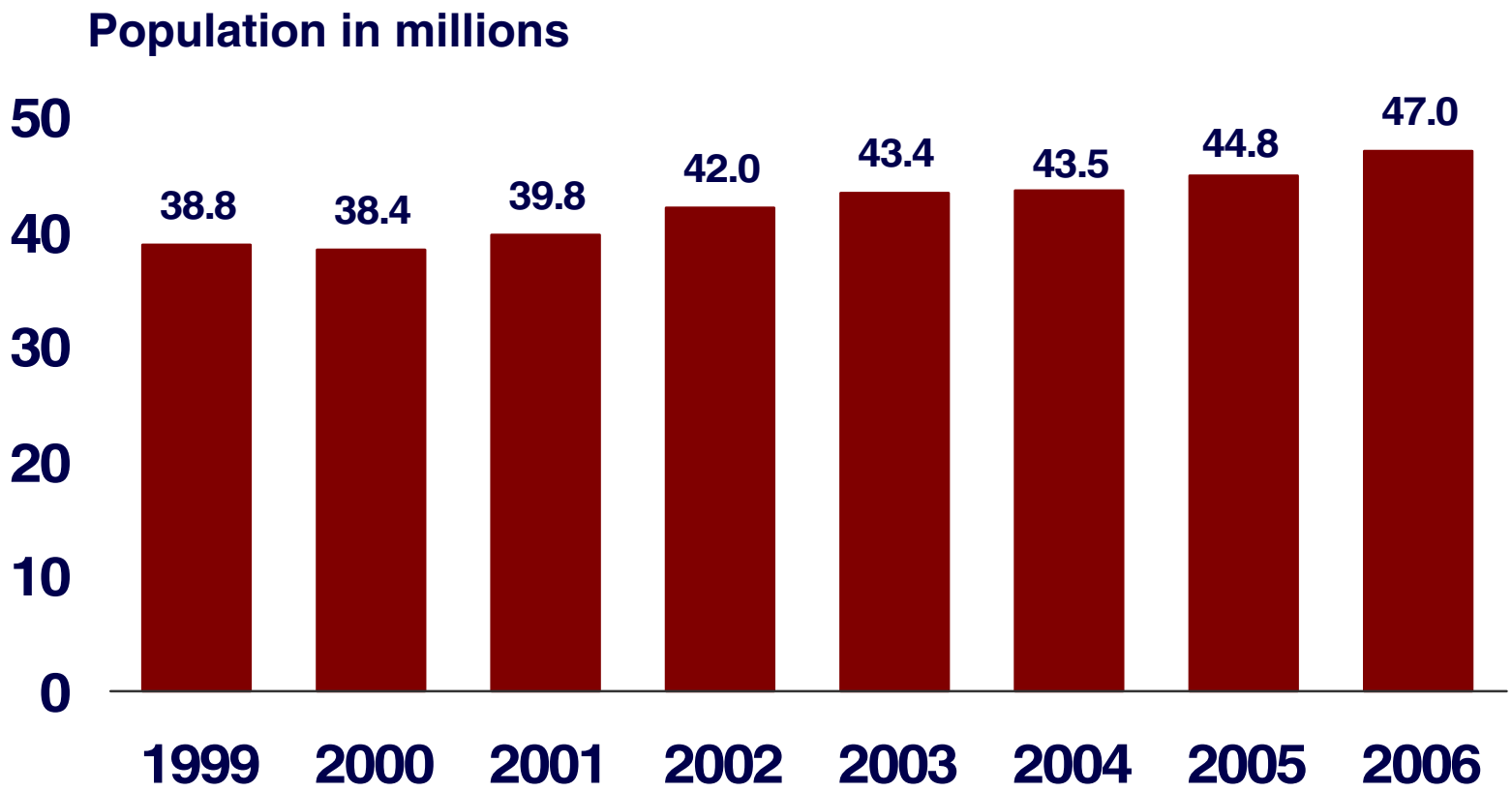
Cumulative Growth in Health Insurance Premiums, Overall Inflation, and Workers' Earnings, 2000-2007



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, Bureau of Labor Statistics.

Note: Data on premium increases reflect the employer's and employee's cost of health insurance premiums for a family of four.

Number of Non-elderly Uninsured Americans, 1999-2006



Source: U.S. Census Bureau, Current Population Survey, 2000-2007 Annual Social and Economic Supplements.
Notes: Estimates for 1999-2005 were revised to reflect the results of a change to the survey process that assigns insurance coverage to dependents.

Where the United States Ranks on Selected Health Outcome Indicators

Outcome	Rank
Life expectancy at birth *U.S. = 77.5 years in 2003*	**23 out of 30 in 2003**
Infant Mortality *U.S. = 6.9 deaths in 2003*	**25 out of 30 in 2003**
Potential Years of Life Lost *U.S. = 5,066 in 2002*	**23 out of 26 in 2002**

Source: *OECD Health Data 2006*
Notes: Data are the most recent available for all countries. Life expectancy at birth for the total population is estimated by the OECD Secretariat for all countries, as the unweighted average of the life expectancy of men and women. Infant mortality is measured as the number of deaths per 1,000 live births. Potential years of life lost (PYLL) is the sum of the years of life lost prior to age 70, given current age-specific death rates (e.g., a death at 5 years of age is counted as 65 years of PYLL).

Issues to Consider in Examining Our Health Care System

- The public needs to be educated about the differences between **wants, needs, affordability**, and **sustainability** at both the individual and aggregate level
- Ideally, health care reform proposals will:
  - **Align Incentives** for providers and consumers to make prudent decisions about the use of medical services,
  - **Foster Transparency** with respect to the value and costs of care, and
  - **Ensure Accountability** from insurers and providers to meet standards for appropriate use and quality.
- Ultimately, we need to address four key dimensions: **access, cost, quality,** and **personal responsibility**

Selected Potential Health Care Reform Approaches

Reform Approach	Short-term action	Long-term action
Revise the government's payment systems and leverage its purchasing authority to foster value-based purchasing for health care products and services	✓	
Consider additional flexibility for states to serve as models for possible health care reforms	✓	
Consider limiting direct advertising and allowing limited importation of prescription drugs	✓	
Foster more transparency in connection with health care costs and outcomes	✓	
Create incentives that encourage physicians to utilize prescription drugs and other health care products and services economically and efficiently	✓	
Foster the use of information technology to increase consistency, transparency, and accountability in health care	✓	
Encourage case management approaches for people with chronic and expensive conditions to improve the quality and efficiency of care delivered and avoid inappropriate care	✓	
Reexamine the design and operational structure of the nation's health care entitlement programs—Medicare and Medicaid, including exploring more income-related approaches	✓	✓

Selected Potential Health Care Reform Approaches

Reform Approach	Short-term action	Long-term action
Revise certain federal tax preferences for health care to encourage more efficient use of health care products and services.	✓	✓
Foster more preventative care and wellness services and capabilities, including fighting obesity and encouraging better nutrition	✓	✓
Promote more personal responsibility in connection with health care	✓	✓
Limit spending growth for government-sponsored health care programs (e.g., percentage of the budget and/or economy)		✓
Develop a core set of basic and essential services. Create insurance pools for alternative levels of coverage, as necessary		✓
Develop a set of evidence-based national practice standards to help avoid unnecessary care, improve outcomes, and reduce litigation		✓
Pursue multinational approaches to investing in health care R&D		✓

Moving the Debate Forward

- **The Sooner We Get Started, the Better**
  - The miracle of compounding is currently working against us
  - Less change would be needed, and there would be more time to make adjustments
- Our demographic changes will serve to make reform more difficult over time
- **Need Public Education, Discussion, and Debate**
  - The role of government in the 21st Century
  - Which programs and policies should be changed and how
  - How government should be financed

Three Key Illnesses

- ***Myopia***
- ***Tunnel Vision***
- ***Self-Centeredness***

Four National Deficits

- ***Budget***
- ***Balance of Payments***
- ***Savings***
- ***Leadership***

Key Leadership Attributes Needed for These Challenging and Changing Times

- *Courage*
- *Integrity*
- *Creativity*
- *Partnership*
- *Stewardship*

Three Key Groups That Need to Increase Their Influence and Involvement

- ***The Business and Professional Community***
- ***Young Americans***
- ***The Media***

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On the Web

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