



March 8, 2007

Honorable Jeb Hensarling
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Hensarling:

This letter responds to your inquiry regarding the state of America's entitlement programs and the effect of the future growth of those programs on the economy.

In fiscal year 2007, spending by the federal government will amount to \$2.7 trillion, or one-fifth of the nation's economic output, the Congressional Budget Office (CBO) projects. The three major federal entitlement programs—Medicare, Medicaid, and Social Security—will account for about 45 percent of those outlays, or about 9 percent of gross domestic product (GDP). If policymakers leave current laws unchanged, federal outlays will claim a sharply increasing share of the nation's output over coming decades, driven primarily by growth in the health-related entitlement programs.¹

Many observers have noted that the aging of the population increases spending in all three major entitlement programs. Today, for every person age 65 or older, there are five people 20 to 64 years old. That figure is projected to fall to below three by 2030. Even after the retirement of the baby-boom generation, the population will continue to age, demographers project, as life expectancy continues to increase and fertility rates remain low by historical standards.

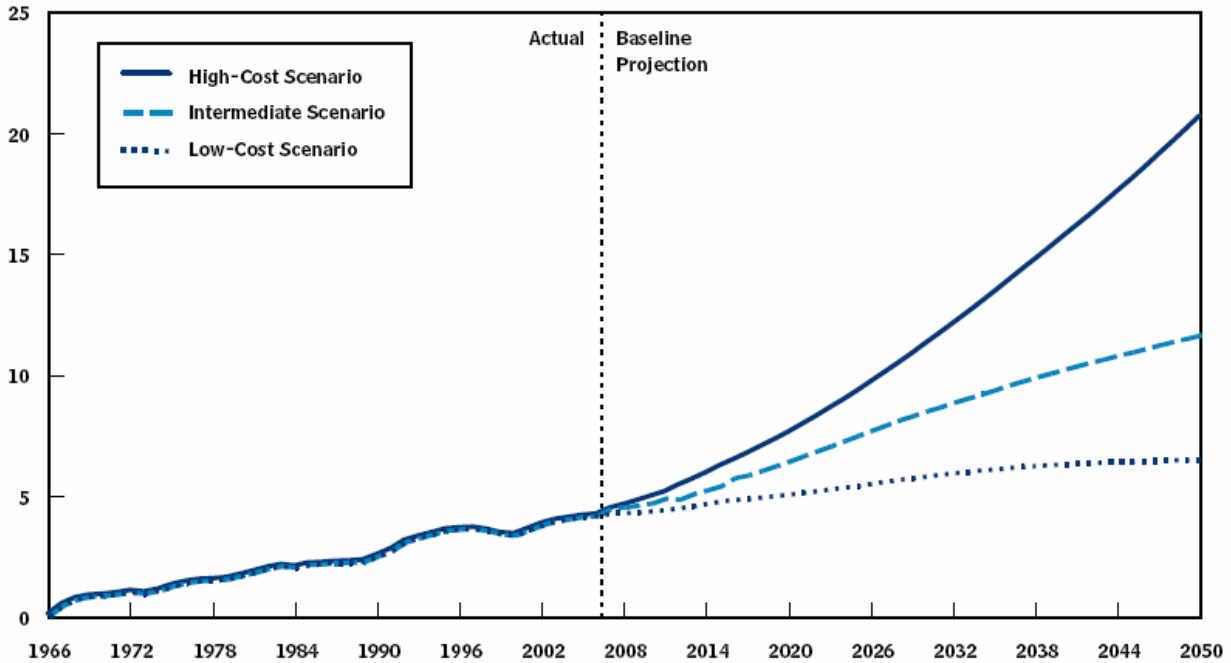
The aging of the population is not the primary factor affecting the growth of entitlement programs, however. Instead, the most important cause is the projected increase in health care costs. Federal health spending, mostly in the Medicare and Medicaid programs, has been consuming a growing share of the nation's economic output for several decades. Costs per beneficiary, even after adjusting for changes in the population, have, on average, increased about 2.5 percentage points faster than has average per capita GDP.² The rate of growth in health costs is unusually difficult to project, but even if growth falls well below historical levels, spending on Medicare and Medicaid will continue to grow faster than the economy and faster than other major government programs.

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1. See Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2008 to 2017* (January 2007) and *The Long-Term Budget Outlook* (December 2005).
 2. See "The Growth of Health Care Costs," Box 1-3 in CBO's *The Long-Term Budget Outlook*.

Figure 1.

Total Federal Spending for Medicare and Medicaid Under Various Scenarios

(Percentage of gross domestic product)



Source: Congressional Budget Office.

CBO has produced estimates of long-term outlays and revenues under various scenarios, most recently in its December 2005 *Long-Term Budget Outlook*. That report included three scenarios for the rates of increase in Medicare and Medicaid spending. The low-cost scenario illustrates the relatively small increase that will result from only the aging of the population. The intermediate scenario assumes that expenditures per beneficiary will continue to grow but slow from current rates to 1 percentage point above per capita GDP growth, a level consistent with the intermediate assumption used by the Medicare trustees. Under that scenario, Medicare and Medicaid spending would grow from about 4.5 percent of GDP today to about 9 percent of GDP in 2030. And the high-cost scenario assumes that future growth will be consistent with the historical average, with costs growing at 2.5 percentage points above the growth in per capita GDP. Outlays on Medicare and Medicaid would then approach 12 percent of GDP in 2030. (See Figure 1.)

Relative to the range of projected increases for Medicare and Medicaid, projected spending increases for Social Security as a share of the economy are smaller; they are driven primarily by aging. CBO projects that those costs will grow from 4.3 percent of GDP today to 6.2 percent in 2030.

Those projections, and particularly those for the health programs, raise fundamental questions of economic sustainability. If outlays increased as projected and revenues did not grow at a corresponding rate, federal debt would grow substantially. Significant budget deficits would reduce national saving; slow private capital formation and/or increase borrowing from abroad; lower economic growth; and, in the extreme, produce a sustained economic contraction. Alternatively, policymakers could pay for additional spending with additional revenues. The economic effects of revenue increases would depend in part on the specific measures adopted; however, especially in light of the scale of projected increases in spending over the long term, a policy that relied exclusively or perhaps even primarily on increased revenues to restore fiscal balance could significantly impair economic growth by distorting economic decisions and reducing incentives for people to work and save.

Limiting growth in entitlement programs would require changes in federal law. The most significant cause of the projected growth is also the most complicated to address: health care costs. Policymakers face both challenges and opportunities in addressing those costs. Over long periods of time, cost growth per beneficiary in Medicare and Medicaid has tended to track cost trends in private-sector health markets. Many analysts therefore believe that significantly constraining the growth of costs for Medicare and Medicaid is likely to occur only in conjunction with slowing cost growth in the health sector as a whole. A variety of evidence suggests opportunities to constrain health care costs without adverse consequences.³ So a central challenge will be to restrain cost growth without harming incentives for innovation or Americans' health (and perhaps even improving it). 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 putting the country on a sounder long-term fiscal path.

One option for discouraging overuse of care under Medicare's fee-for-service system is to shift the method for compensating physicians—moving the system toward payments tied to quality or efficiency. For example, doctors could be required or encouraged to participate in a system that evaluated usage patterns and provided feedback to individual doctors on their practice patterns relative to their peers'. Another option involves grouping physicians into multispecialty units that would share some financial responsibility with Medicare for the utilization of care

3. See, for example, John E. Wennberg, Elliot S. Fisher, and Jonathan S. Skinner, "A Geography and the Debate Over Medicare Reform," *Health Affairs* (February 13, 2002), available at www.healthaffairs.org; and Willard G. Manning and others, "A 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. For a summary of those studies, see Congressional Budget Office, *Consumer-Directed Health Plans: Potential Effects on Health Care Spending and Outcomes* (December 2006), pp. 52–57.

by patients served by the group. Some proposals envision placing doctors in a virtual group based on the hospital that their patients use (or on some other criterion); utilization across groups could then be aggregated and compared, and incentives might be created for physicians to economize in the services provided.

Systems for shifting incentives toward higher-value care would require better information, which could be generated by two changes to the underlying health infrastructure. The first is an information infrastructure to collect data on patients' conditions, the services ordered by physicians, and health outcomes and to distribute information back to individual doctors or groups. The second is an adequately funded effort, whether inside the government or outside it, to analyze the data, evaluate comparative effectiveness, and perhaps design and implement payment systems that reward the more efficient practice of medicine. CBO will examine both of those key steps in future reports. Even with such systems in place, shifting the incentives for providers would necessarily be an iterative process, in which both innovative medical interventions and payment mechanisms were tried, evaluated, and recalibrated. As a result, such a process would be unlikely to generate significant savings in the near term.

Federal outlays could also be reduced by simply shifting costs to state and local governments or to beneficiaries. But such cost shifting, by itself, seems unlikely to address overall trends in health care costs and thus may not ultimately address the underlying issues.⁴

Compared to restraining health care cost growth, options for reducing projected Social Security outlays are relatively straightforward. Policymakers could either reduce monthly benefit levels, or they could reduce the number of months that beneficiaries receive payments.⁵ Such measures could be combined with steps to increase revenue available to the Social Security system.

In your letter, you also asked how the growth of entitlement spending compares with other long-term threats to the economy. As you can imagine, comparing the risks posed by other specific threats and the economic pressures related to growth in entitlement spending is difficult. Nonetheless, several other potential threats to long-term economic performance may warrant policymakers' attention. For example, climate change, which could result in rising sea levels and damage to ecosystems, could reduce economic activity or require resources to be diverted to

4. For a number of options for reducing Medicare and Medicaid outlays, see Congressional Budget Office, *The Long-Term Budget Outlook*, pp. 32–36, and *Budget Options*, pp. 145–194.

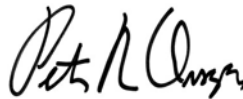
5. See Congressional Budget Office, “Menu of Social Security Options” (May 25, 2005); *The Long-Term Budget Outlook*, pp. 21–25; and *Budget Options* (February 2007), pp. 211–225.

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fund countermeasures.⁶ Sustained and significant terrorist activity or other military threats could disrupt the economy and result in increased expenditures on homeland security and other military operations. In addition, the nation's low national saving rate, itself tied in part to the federal fiscal imbalance, reduces long-term growth. Finally, a prolonged slowdown in productivity growth, whether reflecting low national saving, inadequate investment in human capital, or some other cause, would directly reduce economic growth.

I hope this analysis is helpful to you. If you would like additional information on this subject, CBO would be pleased to provide it. The staff contact for this analysis is Noah Meyerson.

Sincerely,



Peter R. Orszag
Director

cc: Honorable John M. Spratt, Jr.
Chairman
House Committee on the Budget

Honorable Paul Ryan
Ranking Member
House Committee on the Budget

Honorable Kent Conrad
Chairman
Senate Committee on the Budget

Honorable Judd Gregg
Ranking Member
Senate Committee on the Budget

6. See Congressional Budget Office, *The Economics of Climate Change: A Primer* (April 2003).