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CBO Sets the Record Straight on Demographics and Health Care

ISSUE IN FOCUS
by Neil Howe and Richard Jackson

There is a growing awareness that a paradox lies at the heart of the Democrats' strategy on long-term fiscal control. The administration and congressional leadership are passionate in asserting that the unsustainable growth in federal entitlement spending must be reined in—and that this is why we need to enact sweeping health-care reform. Yet the health-care proposals now working their way through Congress are struggling just to be deficit neutral. Meanwhile, no other long-term reform of entitlement programs seems to be under serious consideration.

How do the architects of the reform proposals explain this paradox? Very often they make a two-part argument. The first part is that our fiscal problem is entirely a health cost problem. As evidence, they cite a November 2007 CBO report which pronounced that, contrary to common wisdom, the aging of America is only a minor contributor to the projected explosion in entitlement spending. Almost all of the increase, the report said, is attributable to "excess growth" in health costs. The second part is that much of this excess cost growth is in fact pure waste, and that vast and painless savings can be achieved by identifying the waste and eliminating it. Put the two parts of the argument together and the implication is that the whole long-term budget problem could be solved without giving anything up. Indeed, perhaps we could afford to have a little more and pay less for it.

When this argument first surfaced, the Concord Coalition pointed out that both parts were fatally flawed.* First, the impact of demographic aging was hardly trivial. According to our own projections, it accounted for roughly three-fifths of the growth in entitlement spending through the 2030s and two-fifths through the 2070s. Second, the claim that vast savings in health care could be achieved by eliminating waste was dubious. Unless reform compelled patients and providers to confront difficult trade offs, we warned, it would be more likely to add to costs than to reduce them.

The CBO has now set the record straight. In its most recent *Long-Term Budget Outlook*, released in June, it concludes that aging is, after all, a major contributor to our long-term fiscal problem—and that, over the next several decades, it will be a more important contributor than excess cost growth. CBO's new estimates actually attribute a somewhat larger share of the problem to demographics than Concord's did. Meanwhile, in other recent reports, the CBO has thrown cold water on the notion that painless efficiency gains can achieve substantial health-care savings.

With health-care legislation on hold over the August recess, it's a good time to step back and reexamine the basic premises behind the push for reform. In our next issue, we will look more closely at the claim that reform can painlessly "bend the health cost curve." But first, we want to focus attention on CBO's new estimates of the impact of aging on the budget. They make it clear that health-care reform alone, even if it is successful at controlling costs, cannot substitute for a broader strategy of entitlement reform.

Simple Arithmetic

Let's start with the latest long-term entitlement projections. According to the CBO, federal spending on Medicare and Medicaid will nearly double from 5.3 percent of GDP in 2009 to 9.7 percent in 2035—then triple to 17.2 percent in 2080, the CBO's projection horizon. Meanwhile, spending on Social Security will grow from 4.8 percent of GDP in 2009 to 6.0 percent in 2035 and 6.1 percent in 2080. All told, we are looking at an extra 5.6 percent of GDP in spending on the three major entitlement programs over the next 25 years and an extra 13.2 percent over the next 70 years.

There is no dispute that the explosive growth in Medicare and Medicaid accounts for most of the increase. But how much of this growth is due to demographic aging and how much to excess growth in health costs? To answer this question, we need to take into account two distinct demographic drivers: the growth in the number of elderly relative to the total population, or what we might call the "age wave" effect, and the rising average age of the elderly, often referred to as the "aging of the aged." The growth in the number of elderly adds to spending by increasing the number of federal beneficiaries, totally apart from any increase in per capita health costs. The rising average age of the elderly also adds to it by increasing average costs per beneficiary. It does so because per capita health costs rise steeply with age, even among the elderly themselves.

We must also agree on a benchmark for what constitutes "normal" growth in average costs per beneficiary at any given age—that is, in the age-adjusted cost per beneficiary. The usual benchmark, used by both the CBO and the

* "Honey, I Shrunk the Demographics!" *Facing Facts Quarterly*, III.3 (December 2007).

Medicare Trustees, is the rate of growth in per capita GDP. One justification for the benchmark is that much of health-care spending consists of labor-intensive services, and so can be expected to increase along with income. Another is that, in a population with a stable age structure, health-care spending will remain unchanged as a share of GDP if the age-adjusted per capita cost rises at the same rate as per capita GDP.

With this benchmark, assessing the impact of demographic aging is a simple matter of arithmetic. According to the new CBO report, it will account for 44 percent of the growth in Medicare and Medicaid between now and 2035. Including Social Security, whose growth is entirely driven by demographic aging, it will account for 64 percent of the total growth in entitlements between now and 2035. As the CBO points out, this should surprise no one. After all, the number of Social Security and Medicare beneficiaries will roughly double over the next 25 years as the massive baby boom generation reaches old age.

Beyond the next 25 years, excess cost growth looms larger in the projections. Between now and 2080, the CBO calculates that demographic aging will account for 30 per cent of the growth in Medicare and Medicaid. Including Social Security, it will account for 44 percent of the total growth in entitlements—still an important driver, but no longer the dominant one. This too is hardly surprising. Any excess cost growth, if it continues long enough, will eventually swamp the demographics—and the CBO assumes that excess cost growth will continue at a blistering pace for decades to come.

The Necessity of Entitlement Reform

The key conclusion of the new CBO report is that demographics will play a far more important role than excess cost growth in driving up entitlement spending over the next 25 years. The fact that excess cost growth ultimately overtakes demographics in importance is significant, but less relevant, since the impact of demographics threatens to overwhelm the budget long before that happens. This fact was obscured by the 2007 CBO report, which not only understated the impact of demographics on health-care spending, but prominently highlighted the projection results for the out years, when the contribution of demographics is smallest.

Focus a moment on the magnitude of the demographic challenge. Over the next 25 years, the aging of America alone will add 3.6 percent of GDP to federal spending—almost the equivalent of today's entire domestic discretionary budget. Or look at the challenge another way. Nearly half of the projected increase in the cost of Medicare and Medicaid between now and 2035 is due to demographic aging. This means that nearly half of the increase is needed simply to keep delivering the same level of care to each beneficiary, at each age, as we do today. As for Social Security, all of the projected increase is needed to deliver benefits that—due to the hike in the normal retirement age—will actually be less generous than today's.

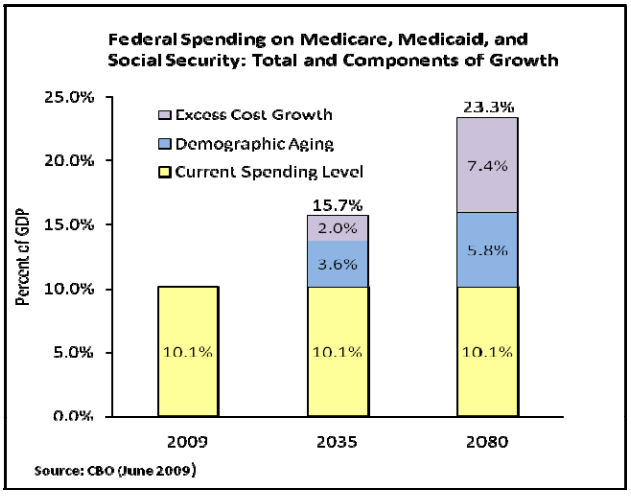
The demographics themselves are set in stone over the next 25 years, since everyone who will become eligible for benefits is already alive and can be counted. The only way to reduce demographically driven spending growth is to change the terms of the current benefits deal—for instance, by raising eligibility ages, indexing benefits to life expectancy, or means-testing them. In other words, the only way is to enact a broad strategy of entitlement reform.

The Painful Prescription

None of this is to say that excess cost growth in Medicare and Medicaid is unimportant—or that it is impossible to design reforms capable of controlling it. But it is vital to understand that this growth is driven by forces nearly as ineluctable as the demographics themselves. There are the ongoing advances in medical testing, screening, diagnostics, pharmaceuticals, and surgery that are pushing up the cost of the research, technology, and skilled labor underlying every medical visit. There is also the steady rise in the standard of "health" that Americans expect their doctors and hospitals to deliver, which now includes everything from good looks and good sex to a better mood and a better golf swing.

Yes, it is well documented that there is much waste in the U.S. health-care system. And yes, computerized medical records, outcomes research, and the enforcement of best-practice guidelines could surely eliminate some of it without sacrificing quality of care. But here too the CBO has recently sounded a cautionary note by pointing out that this savings is highly uncertain and, even if it materializes, will only kick in gradually over many decades.

"The painful prescription," to borrow Brookings scholar Henry Aaron's apt phrase, is inescapable. Reducing health costs substantially beneath current projections will require denying payment to some patients and some providers, whether directly or indirectly, for some services they would otherwise want. In the next issue we will look at what this means for health-care reform and why neither party is facing up to the truth.■



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Federal Budget: Debt & Deficits	Bil $	% GDP
Gross Federal Debt: End of June 2009	$11,545	82.1%
Statutory Debt Limit	$12,104	NA
Publicly Held Debt: End of June 2009	$7,175	51.0%
Debt Held by Foreigners: End of May 2009	$3,293	46.4%*
Budget Balance in FY 2008	-$459	-3.2%
Budget Balance in FY 2009: CBO Baseline	-$1,667	-11.9%
Budget Balance in FY 2009: President's Budget†	-$1,825	-13.0%
10-yr Budget Balance: CBO Baseline	-$4,441	NA
10-yr Budget Balance: President's Budget†	-$9,139	NA
Budget Balance in FY 2019: CBO Baseline	-$423	-2.0%
Budget Balance in FY 2019: President's Budget†	-$1,163	-5.5%

Fed Outlays: FY 2008	Bil $	% Budg
Social Security	$612	20.5%
Medicare	$456	15.3%
Medicaid	$201	6.7%
Other Entitlements	$519	17.4%
Domestic Discretionary	$519	17.4%
Defense	$613	20.5%
Net Interest	$253	8.5%
Offsetting Receipts	-$193	-6.5%
TOTAL OUTLAYS	$2,983	100%
TOTAL REVENUES	$2,524	NA
TOTAL DEFICIT	-$459	NA

*Percent of publicly held debt. †June 2009 CBO estimate of President's budget.

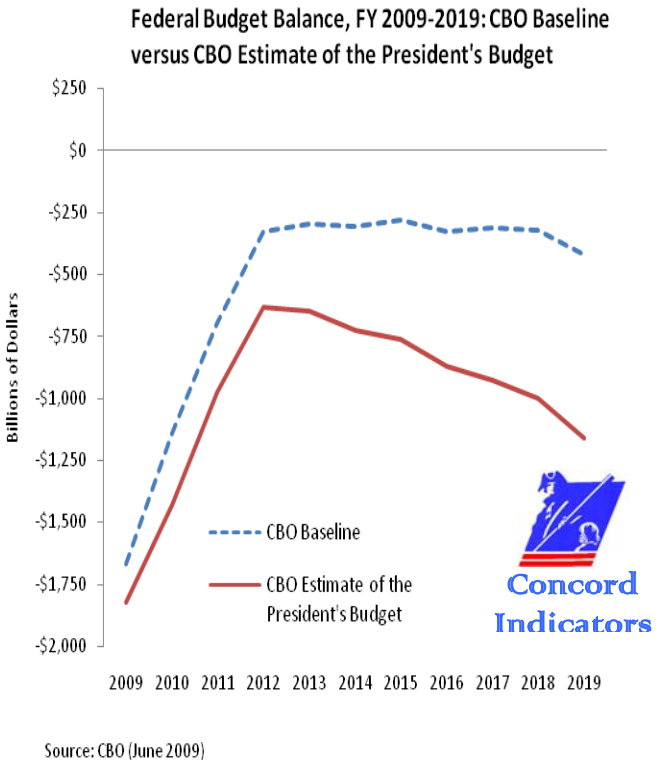
GAO's Long-Term Budget Scenario* (% GDP)

	1962	1980	2000	2020	2040
Discretionary	12.7%	10.1%	6.3%	8.5%	8.5%
Entitlements*	4.9%	9.6%	9.8%	13.8%	18.9%
Net Interest	1.2%	1.9%	2.3%	4.2%	12.3%
Revenue	17.6%	19.0%	20.9%	18.4%	18.6%
Budget Balance	-1.3%	-2.7%	2.4%	-8.0%	-21.0%
Pub Held Debt	43.7%	26.1%	35.1%	91.2%	266.4%

*GAO March 2009 update. Assumes discretionary spending grows with GDP and all expiring tax provisions are extended; entitlements are net of offsetting receipts.

National Savings (% GDP)	2008	1st QTR 2009
Personal Savings Rate*	1.8%	4.3%
Net Private Savings	3.3%	5.1%
State & Local Savings	-0.6%	-0.6%
Federal Savings	-3.7%	-5.9%
Net National Savings	-1.0%	-1.4%
Current Account Balance	-4.6%	-2.0%
Intl Investment Position	-24.6%	NA

*Percent of disposable income.



Source: CBO (June 2009)

Social Security & Medicare*	Social Security	Medicare HI	Medicare SMI	Social Security & Medicare
Payroll Cost Rate in 2009	12.4%	3.6%	3.0%†	19.0%†
Payroll Cost Rate in 2040	17.0%	7.6%	7.7%†	32.3%†
75-Year Unfunded Liability (PV $)**	$7.7 TRILLION	$13.8 TRILLION	$24.4 TRILLION	$45.9 TRILLION
Infinite-Horizon Unfunded Liability (PV $)**	$17.5 TRILLION	$36.7 TRILLION	$52.5 TRILLION	$106.7 TRILLION
Date of First Cash Deficit	2016	2008	NA	NA
Date of Trust-Fund Insolvency	2037	2017	NA	NA
Cash Deficit in Year of Insolvency (2009 $)	$-338 BILLION	$-63 BILLION	NA	NA

*Data are from 2009 Trustees reports. **Figures are not offset by trust-fund assets. †Figures for Medicare SMI are net of beneficiary premiums. Although SMI is not financed with payroll taxes, net expenditures are shown here as a percent of payroll to facilitate comparison.