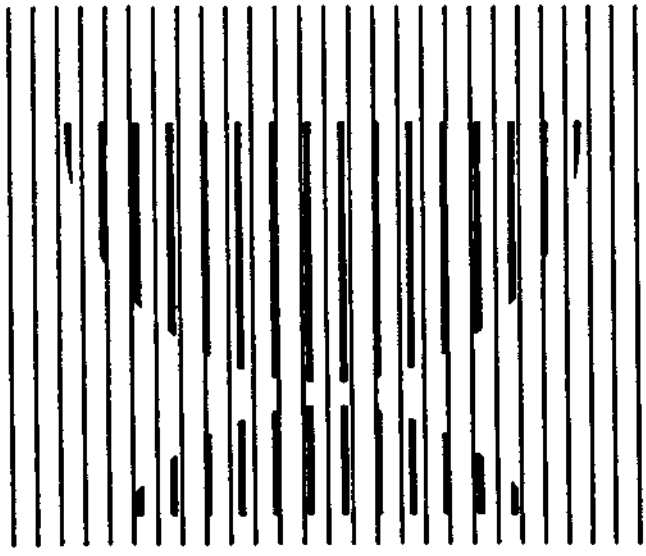
CBO STAFF MEMORANDUM

MANDATORY SPENDING:
TRENDS
AND
SOURCES OF GROWTH

July 1992



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This Congressional Budget Office (CBO) Staff Memorandum was prepared in response to inquiries from the House and Senate Committees on the Budget about the sources of growth of mandatory spending and the potential impact on federal spending of capping the growth of these programs. The memorandum summarizes recent trends in the growth of mandatory spending, presents CBO's estimates of mandatory spending for the next five years, and describes the sources of growth in mandatory spending programs. It also discusses recent proposals for capping the growth of mandatory spending, presents estimates of the savings that would result from several such caps, and points out that if such caps were adopted, the specific means of implementing them would need to be developed. Finally, the paper presents several options for achieving savings in the largest mandatory program, Social Security, and the two fastest growing mandatory programs, Medicare and Medicaid. In keeping with CBO's mandate to provide objective and impartial analysis, the memorandum contains no recommendations.

This memorandum was prepared by Patrick Purcell of CBO's Budget Analysis Division under the direction of Chuck Seagrave and Paul Van de Water. Nancy Gordon and Kathryn Langwell of CBO's Human Resources and Community Development Division, and Jim Horney, C. G. Nuckols, and Kathy Ruffing of the Budget Analysis Division, provided valuable comments. Chris Spoor edited the manuscript. Emma Tuerk prepared the final version of the manuscript. Questions about the analysis may be addressed to Patrick Purcell at (202) 226-2820.

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INTRODUCTION

In fiscal year 1991, federal spending for entitlements and other mandatory programs, excluding deposit insurance and net interest, reached $636 billion, almost half of all net federal outlays.[1] (Mandatory outlays are payments that the federal government must make under current law.) All other activities of the federal government-comprising defense, domestic discretionary spending, international discretionary spending, deposit insurance payments, and net interest payments-accounted for $794 billion in federal outlays last fiscal year.

Entitlements and other mandatory spending, especially the Medicare and Medicaid programs, constitute the fastest growing segment of federal spending. The Congressional Budget Office (CBO) estimates that outlays for mandatory programs under current law will increase at an average rate of 7.4 percent a year from 1991 through 1997, while the balance of federal spending will rise by an average of 1.5 percent a year during the same period.[2] Managing the growth of federal spending therefore will be largely a matter of controlling the growth of mandatory spending. Gaining control of this spending will require an understanding of why outlays for mandatory programs are growing so rapidly.

Entitlement programs make payments to any person, business, or unit of government that seeks the payments and that meets eligibility criteria established in law. The Congress controls these programs indirectly by defining eligibility and setting the benefit or payment rules, rather than directly through the annual appropriation process. There are two categories of entitlement programs: means-tested and non-means-tested. Means-tested programs provide benefits only to people whose income and other financial resources are below the levels set by the rules of each program. The major means-tested entitlement programs are Medicaid, Food Stamps, Aid to Families with Dependent Children (AFDC), Supplemental Security Income, and veterans' pensions.[3] Means-tested programs account for about 20 percent of all mandatory federal spending.

By far the greater portion of mandatory federal spending, 80 percent, comprises programs that are not means-tested. Most non-means-tested mandatory programs are social insurance programs that are funded at least in part by contributions from the covered population. The largest of these

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1. Gross federal outlays in fiscal year 1991 were $1,431 billion. Offsetting receipts of $106 billion reduced net outlays to $1,323 billion.

2. CBO estimate, assuming current law.

3. Not all means-tested programs are entitlements. Some federal housing programs and social service programs that are funded through discretionary appropriations are also means-tested. These programs are relatively small compared with means-tested entitlements.

programs are Social Security and Medicare, which together account for about three-fifths of mandatory expenditures. Another 10 percent of mandatory spending consists of retirement and disability programs for federal employees and the military, and the remainder comprises Unemployment Compensation, Veterans' Compensation, farm price supports, social services, and other, smaller programs.

Two other categories of spending are also controlled only indirectly by Congress and therefore can be classified as mandatory spending. These are net interest payments and deposit insurance payments. Net interest is the interest that the federal government pays to the owners of U.S. Treasury securities, net of interest income the government receives on loans it has made to people, businesses, or foreign countries. Interest payments are a contractual obligation of the federal government to the owners of Treasury securities and are therefore mandatory outlays. Deposit insurance payments are federal funds paid to the depositors of federally insured banks or savings and loans that have become insolvent, or to institutions that have purchased insolvent banks and thrifts from the federal government. Because deposit insurance payments represent an obligation of the federal government to the depositors of federally insured financial institutions, they too are considered mandatory spending. The analysis in this paper will focus on mandatory spending other than net interest payments and deposit insurance payments.

MANDATORY OUTLAYS FROM 1965 THROUGH 1990

Examining federal expenditures since 1965 reveals two trends in mandatory spending. First, mandatory spending grew more rapidly relative to gross domestic product (GDP) in the 1965-1975 period than it has since then (see Table 1). Second, even though the growth of total mandatory spending relative to GDP has slowed since the mid-1970s, expenditures for Medicare and Medicaid have continued to increase as a share of GDP.

Three programs--Medicare, Medicaid, and Social Security--caused most of the growth in federal spending relative to GDP from 1965 through 1990. In 1965, Medicare and Medicaid had just been created and had negligible outlays; Social Security spending in that year was equal to just 2.4 percent of GDP. Twenty-five years later, the combined spending of these three programs equaled 7.1 percent of GDP. Spending for other mandatory programs, in contrast, was only slightly greater as a share of GDP in 1990 than it had been in 1965, and it has fallen steadily since reaching a peak relative to GDP in the mid-1970s.

TABLE 1. FEDERAL OUTLAYS FOR SELECTED FISCAL YEARS, 1965-1990

	1965	1970	1975	1980	1985	1990
			In Billions of Dollars			
Mandatory Programs						
Social Security	17	30	64	117	186	247
Medicare	0	7	14	34	70	107
Medicaid	0	3	7	14	23	41
Other mandatory outlays*	19	30	80	127	171	111
Subtotal	36	69	164	292	450	567
Deposit Insurance	0	-1	1	0	-2	58
Net Interest	9	14	23	53	130	184
Discretionary Spending	82	125	163	277	416	502
Offsetting Receipts	-8	-12	-18	-29	-47	-58
Total Outlays	118	196	332	591	946	1,252
Gross Domestic Product	703	1,011	1,586	2,708	4,039	5,514
			As a Percentage of GDP			
Mandatory Programs						
Social Security	2.4	2.9	4.0	4.3	4.6	4.5
Medicare	0	0.7	0.9	1.3	1.7	1.9
Medicaid	0	0.3	0.4	0.5	0.6	0.7
Other mandatory outlays*	2.7	2.9	5.0	4.7	4.2	3.1
Subtotal	5.2	6.8	10.4	10.8	11.1	10.3
Deposit Insurance	-0.1	0	0	0	-0.1	1.1
Net Interest	1.2	1.4	1.5	1.9	3.2	3.3
Discretionary Spending	11.6	12.3	10.2	10.2	10.3	9.1
Total Outlays	16.8	19.4	20.9	21.8	23.4	22.7

SOURCE: Congressional Budget Office.

NOTE: Numbers may not add to totals because of rounding. Total outlays are net of offsetting receipts.

a. Consists mainly of food stamps, Supplemental Security Income, family support payments, child nutrition programs, student loans, the earned income tax credit, agricultural price supports, federal civilian and military retirement benefits, unemployment compensation, veterans' benefits, and other social services.

The composition of mandatory spending has changed noticeably since the mid-1970s. In 1975, Social Security, Medicare, and Medicaid accounted for slightly more than 50 percent of mandatory spending. By 1990, these three programs made up just under 70 percent of mandatory spending. Most of this growth occurred in Medicare and Medicaid, which doubled from 1.3 percent of mandatory outlays and 1.3 percent of GDP in 1975 to 2.6 percent of mandatory outlays and 2.6 percent of GDP in 1990.

PROJECTIONS OF MANDATORY SPENDING AND OTHER OUTLAYS THROUGH 1997

Looking ahead to the next five years, CBO estimates that under current laws and policies total net federal spending will peak as a percentage of GDP at 24.9 percent in 1992 and then fall to 22 percent by 1995 (see Table 2).[4] Discretionary spending is projected to continue to decline as a share of GDP through 1997 (assuming that it is constrained by the legal limits on discretionary spending through 1995 and that it grows at the rate of inflation thereafter). Spending on mandatory programs, however, is projected to increase moderately through 1997, rising from 11.3 percent of GDP and 48 percent of federal outlays in 1991 to 12.4 percent of GDP and 57 percent of outlays in 1997.

Although CBO estimates that mandatory spending will increase only moderately as a share of GDP through 1997, outlays for Medicare and Medicaid will continue to rise sharply, both as a percentage of mandatory spending and as a percentage of GDP. CBO estimates that Medicare and Medicaid will increase from 2.9 percent of GDP in 1991 to 4.4 percent in 1997, a 52 percent increase in just six years. As a proportion of mandatory spending, Medicare and Medicaid will rise from 26 percent in 1991 to 35 percent in 1997.

In contrast, Social Security is expected to remain virtually unchanged as a share of GDP through 1997, while falling slightly as a share of mandatory spending, from 42 percent in 1991 to 38 percent in 1997. Entitlements other than Social Security, Medicare, and Medicaid are projected to decline from 3.6 percent of GDP in 1991 to 3.3 percent in 1997, and to fall from 32 percent of all mandatory outlays to 26 percent.

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4. Three factors will contribute to the decline in federal spending as a share of GDP after 1992: the economy's recovery from recession, falling outlays for deposit insurance, and the effect on discretionary outlays of the caps put in place by the Budget Enforcement Act, (Title XIII of the Omnibus Budget Reconciliation Act of 1990).

TABLE 2. CBO BASELINE PROJECTION OF FEDERAL OUTLAYS THROUGH 1997 (By fiscal year)

	Actual 1991	1992	1993	1994	1995	1996	1997
In Billions of Dollars							
Mandatory Programs							
Social Security	267	285	301	318	335	354	374
Medicare	114	128	143	159	177	198	220
Medicaid	53	68	80	89	100	113	126
Other mandatory outlays[a]	202	229	227	231	236	238	256
Subtotal	636	710	751	797	848	903	977
Deposit Insurance	66	65	69	33	-17	-45	-29
Net Interest	196	201	214	232	246	262	280
Discretionary Spending	532	548	543	536	539	556	575
Offsetting Receipts	-108	-69	-67	-69	-73	-74	-77
Total Outlays	1,323	1,455	1,510	1,529	1,543	1,602	1,726
Gross Domestic Product	5,627	5,846	6,237	6,621	7,004	7,414	7,849
As a Percentage of GDP							
Mandatory Programs							
Social Security	4.7	4.9	4.8	4.8	4.8	4.8	4.8
Medicare	2.0	2.2	2.3	2.4	2.5	2.7	2.8
Medicaid	0.9	1.2	1.3	1.3	1.4	1.5	1.6
Other mandatory outlays[a]	3.6	3.9	3.6	3.5	3.4	3.2	3.3
Subtotal	11.3	12.1	12.0	12.0	12.1	12.2	12.4
Deposit Insurance	1.2	1.1	1.1	0.5	-0.2	-0.6	-0.4
Net Interest	3.5	3.4	3.4	3.5	3.5	3.5	3.6
Discretionary Spending	9.5	9.4	8.7	8.1	7.7	7.5	7.3
Total Outlays	23.5	24.9	24.2	23.1	22.0	21.6	22.0

SOURCE: Congressional Budget Office.

NOTE: Numbers may not add to totals because of rounding.
Total outlays are net of offsetting receipts.

a. Consists mainly of food stamps, Supplemental Security Income, family support payments, child nutrition programs, student loans, the earned income tax credit, agricultural price supports, federal civilian and military retirement benefits, unemployment compensation, veterans' benefits, and other social services.

These figures illustrate a long-term trend in which mandatory programs--and especially Social Security, Medicare, and Medicaid--have become the most significant contributors to the growth of federal spending. CBO's projections indicate that mandatory spending will continue to grow as a share of total federal spending in the 1990s and that Medicare and Medicaid will fuel this growth. Social Security outlays, however, will rise only slightly faster than overall government spending, and Social Security spending should remain fairly stable as a share of GDP through the late 1990s.

PROJECTIONS FOR INDIVIDUAL MANDATORY PROGRAMS THROUGH 1997

From 1991 through 1997, mandatory spending is projected to increase by $341 billion, from $636 billion to $977 billion (see Table 3). This reflects an average annual rate of growth in nominal outlays of 7.4 percent, about 25 percent faster than the growth rate from 1985 through 1991 (see Table 4). (In contrast, average yearly growth rates for net federal outlays and for nominal GDP are projected to be 4.5 percent and 5.7 percent, respectively, during the 1991-1997 period, assuming current laws.) Two programs-Medicare and Medicaid--are projected to exceed the average rate of growth of all entitlement spending in each year of the projection period.

More than half of the projected increase in mandatory spending through 1997 is directly attributable to increased spending for Medicare and Medicaid. Nominal outlays for Medicare are projected to rise at an average annual rate of 11.6 percent from 1991 through 1997, even faster than between 1985 and 1991 when they rose by an average rate of 8.6 percent a year. Medicaid outlays are also expected to continue to rise rapidly--by an average of 15.8 percent per year, from $53 billion in 1991 to $126 billion in 1997. By 1997, according to CBO's estimates, nominal expenditures for Medicaid will have risen an astounding 450 percent since 1985, increasing from $23 billion to $126 billion. In the same period, Medicaid will have risen from 5.1 percent of mandatory spending and 2.4 percent of all federal outlays to 13 percent of mandatory spending and 73 percent of federal outlays.

In comparison, Social Security spending will rise by an average of 5.8 percent a year from 1991 through 1997, slightly less than the 6.2 percent average annual increase from 1985 through 1991. Nevertheless, Social Security and government retirement and disability programs for the civil service, military, and railroads will account for an estimated 38 percent of the growth in mandatory outlays from 1991 through 1997.

TABLE 3. CBO BASELINE PROJECTION OF MANDATORY OUTLAYS THROUGH 1997 (By fiscal year, in billions of dollars)

	Actual 1991	1992	1993	1994	1995	1996	1997	Change 1991-1997
Social Security	267	285	301	318	335	354	374	107
Medicare	114	128	143	159	177	198	220	106
Part A	69	76	84	92	102	112	123	54
Part B	46	52	59	67	76	86	97	52
Medicaid	53	68	80	89	100	113	126	73
Civil Service, Military, and Railroad Retirement	64	66	68	72	75	81	86	22
Unemployment Compensation	25	35	26	25	26	26	27	2
Food Stamps	19	22	22	22	22	23	24	5
Supplemental Security Income[a]	15	17	18	21	22	21	25	10
Family Support Payments	14	15	16	16	17	18	18	4
Veterans' Compensation and Pensions[a]	16	16	17	19	18	17	19	3
Farm Price Supports[b]	10	9	11	10	9	9	9	-1
Other Mandatory Spending	39	48	49	46	47	42	48	9
Total Mandatory Outlays	636	710	751	797	848	903	977	341

SOURCE: Congressional Budget Office.

a. In 1994, Supplemental Security Income and Veterans' Compensation and pensions will have 13 payments. In 1996, these programs will have 11 payments. In these programs, payments are shifted to the prior fiscal year whenever the first day of the fiscal year falls on a weekend or a holiday.

b. Data are discontinuous from previous yean due to the effects of credit reform beginning in 1992.

TABLE 4. AVERAGE ANNUAL RATE OF GROWTH OF MANDATORY SPENDING, 1985-1997

	Average Annual Percentage Change	
	1985-1991	1991-1997
Social Security	6.2	5.8
Medicare	8.6	11.6
Part A	6.2	10.2
Part B	13.0	13.5
Medicaid	15.0	15.8
Civil Service, Military, and Railroad Retirement	6.0	5.2
Unemployment Compensation	8.0	0.7
Food Stamps	8.1	4.0
Supplemental Security Income	9.1	9.4
Family Support Payments	7.8	5.3
Veterans' Compensation and Pensions	2.2	2.7
Farm Price Supports	-9.0	-1.4
Other Mandatory Spending	-4.8	3.5
Total Mandatory Outlays	5.9	7.4

SOURCE: Congressional Budget Office.

Mandatory programs other than Social Security, government retirement benefits, Medicare, and Medicaid are expected to grow more slowly than spending on health and retirement programs in the 1991-1997 period, increasing by an average of 3.5 percent a year compared with a projected average increase of 83 percent a year for all health and retirement entitlements combined. These other entitlement programs--family support payments, Supplemental Security Income (SSI), Food Stamps, Unemployment Compensation, Veterans' Compensation, agricultural price supports, and all other noninterest and non-deposit-insurance mandatory programs-will account for only 10 percent of the growth in entitlement spending from 1991 through 1997, according to CBO's estimates. To be sure, some of the programs, such as family support payments and SSI, will grow steadily through this period, but their growth will be partly offset by the declining outlays projected in some years for Unemployment Compensation, farm price supports, and some other programs. Overall, however, declines in other mandatory programs will not be nearly enough to compensate for the significant growth in spending for Medicare, Medicaid, Social Security, and government retirement benefits.

In the light of large and continuing federal deficits and the continuing growth of mandatory programs relative to the rest of the budget, these programs are attracting greater attention as a potential source of savings. Slowing the growth of mandatory spending could reduce the deficit or provide funds for additional discretionary spending. Effectively controlling the growth of mandatory spending will require an understanding of the factors driving the growth of these programs.

SOURCES OF GROWTH IN MANDATORY SPENDING

CBO estimates that by 1997 spending for entitlements will be $267 billion higher than in 1992, an increase of 38 percent. One-quarter of that increase, $69 billion, will result from cost-of-living adjustments (COLAs) in Social Security, civil service and military pensions, Supplemental Security Income, and other indexed programs (see Table 5). (Social Security alone will account for almost three-fourths of the increase in spending because of COLAs.) These estimates assume that cost-of-living adjustments will average roughly 3.5 percent per year over the next five years.

TABLE 5. SOURCES OF CHANGE IN TOTAL MANDATORY SPENDING, FISCAL YEARS 1992-1997 (In billions of dollars)

	1992	1993	1994	1995	1996	1997
Baseline Outlays for Mandatory Programs	710	751	797	848	903	977
Change in Outlays Attributable to Each Source						
Cost-of-living adjustments		9	23	37	52	69
Change in number of recipients		2	11	21	31	41
Increased cost of medical care[a]		6	13	22	31	43
Utilization and intensity of medical care		14	28	45	65	85
Higher initial benefits for new Social Security beneficiaries[b]		5	8	11	14	17
Other causes		5	4	2	-1	12
Total Changes from 1992 Baseline		41	87	138	193	267

SOURCE: Congressional Budget Office.

NOTE: Numbers do not include deposit insurance or net interest payments.

a. Represents program growth resulting from higher medical reimbursement rates.

b. Growth caused by rising real wages and changes in the composition of the beneficiary population.

Another $41 billion of the $267 billion increase in mandatory spending from 1992 through 1997 is expected to result from an increase in the number of people eligible for entitlement programs. By 1997, the number of people receiving unemployment benefits is expected to drop significantly (from 12.6 million to 9.8 million) because of a projected improvement in economic growth and the termination of the temporary extension of unemployment benefits put into effect in 1991. The number of food stamp recipients is also expected to decline, though not as dramatically (from 24.9 million to 22.7 million). The effect of these decreases, however, is expected to be outweighed by increases in the number of recipients of Social Security, SSI, Medicare, and Medicaid.

Nearly half of the projected increase in entitlement spending from 1992 through 1997 is expected to result from increases in the cost of medical care or increases in the utilization and intensity of medical care. "Utilization" of medical services refers to the number of visits to medical providers--mainly the number of hospital admissions, visits to hospital outpatient facilities or clinics, and visits to physicians' offices. "Intensity" refers to the process of providing medical care, including the procedures, equipment, and Pharmaceuticals used in providing that care. As new technologies and procedures have been developed and adopted by the medical profession, the intensity of medical services has increased.

The effect of improved technologies and procedures on the value of medical care is very difficult to capture in price indexes. To the extent that increases in the price of medical care are the result of improvements in the effectiveness of medical treatment, these higher prices represent an increase in the value of medical care rather than inflation. Despite the cost containment strategies adopted by Medicare in recent years and the efforts of states to control Medicaid expenditures, spending for these two programs has not been insulated from the effects of inflation and greater utilization and intensity of medical goods and services.

Most of the remaining growth in entitlement spending from 1992 through 1997 will come from higher initial benefits for new Social Security beneficiaries, who will generally have higher real earnings than workers who retired earlier. As an example, workers who retired in December 1985 received average monthly Social Security benefits of $538 in 1990 dollars; workers who retired in December 1990 received average monthly benefits of $559. The difference is due mainly to the higher real earnings of workers who retired in 1990.

These sources of growth play differing roles in the various entitlement programs, as Table 6 shows. For instance, outlays for COLAs have a relatively large impact on spending for Social Security and government retirement plans ($62 billion over five years), compared with increases in the number of beneficiaries ($27 billion) and rising real benefit levels ($21 billion).

In the Medicare and Medicaid programs, there are two striking features of the sources of growth. First, increases in enrollment account for about one-fifth of the projected rise in Medicaid spending, compared with about one-tenth of the projected rise in Medicare (Parts A and B combined). Since the economy is projected to grow fairly steadily throughout the 1992-1997 period and unemployment is projected to decline, economic conditions will probably not be the driving force behind rising Medicaid enrollment. It is more likely that expanding Medicaid enrollment will result from the expansions in Medicaid eligibility enacted since the mid-1980s and the continuing decline in the percentage of the population covered by employer-based group health insurance.

Another notable characteristic of the Medicare and Medicaid programs is the share of growth caused by rising reimbursements for medical care and by greater utilization and intensity of services. CBO estimates that from 1992 through 1997 the consumer price index for medical services will rise at an average rate of 7.2 percent per year, twice as fast as the general rate of inflation. Although reimbursement rates in the Medicare program are set by the federal government and Medicaid rates are set by the state governments, and neither is tied directly to the consumer price index for medical services, reimbursement rates in both programs are influenced by inflation in the market for medical services. CBO's projections also assume a continued rapid increase in the utilization and intensity of Medicare and Medicaid services over the next five years. More than half of the projected combined increase in Medicare and Medicaid expenditures from 1992 through 1997 is attributable to increased utilization and intensity of medical services.

About 34 percent of the increase in Medicaid spending from 1992 through 1997 is expected to result from rising reimbursements for medical services, and about 47 percent from increased utilization and intensity of medical care. Part A of the Medicare program, which pays for inpatient hospital services, is expected to follow a similar pattern: about 40 percent of its projected spending increase results from higher medical prices, and about 47 percent from increased utilization and intensity of medical services. (In both programs, the remaining increase will come mainly from larger caseloads.)

TABLE 6. SOURCES OF CHANGE IN SPENDING FOR INDIVIDUAL MANDATORY PROGRAMS, FISCAL YEARS 1992-1997 (In billions of dollars)

	1992 Outlays	1997 Outlays	Change 1992-1997	Sources of Change				
				COLAs	Caseload	Price of Medical Care[a]	Use of Medical Care[b]	Other[c]
Social Security	285	374	89	50	23	0	0	17
Medicare Part A	76	123	47	0	6	19	22	0
Medicare Pan B	52	97	45	0	4	5	36	0
Medicaid	68	126	58	0	11	20	27	0
Civil Service, Military, and Railroad Retirement	66	86	20	12	4	0	0	4
Unemployment Compensation	35	27	-8	0	-12	0	0	4
Food Stamps	22	24	2	0	-2	0	0	4
Supplemental Security Income	17	25	8	4	4	0	0	0
Family Support Payments	15	18	3	0	1	0	0	2
Veterans' Compensation and Pensions	16	19	2	3	0	0	0	0
Other Mandatory Programs	57	57	0	0	2	0	0	-2
Total	710	977	267	69	41	43	85	29

SOURCE: Congressional Budget Office.

NOTES: Numbers may not add to totals because of rounding. COLAs are cost-of-living adjustments.

a. Reflects growth resulting from higher medical reimbursement rates.

b. Reflects growth resulting from greater utilization and intensity of medical services.

c. In Social Security, this category reflects rising real wages and the changing composition of the beneficiary population. In Civil Service, Military, and Railroad Retirement, it primarily reflects real wage growth. In family support payments, it reflects increases in nominal benefits and increasing average family size in the program.

In Part B of the Medicare program, which pays for physician services, only 11 percent of the increase in outlays from 1992 through 1997 is projected to result from higher prices for medical services, largely because of limits on fees paid to physicians by Medicare. Nevertheless, the percentage increase in total Part B expenditures by 1997 is projected to exceed that of either Part A or Medicaid. Eighty percent of the projected increase in Part B spending is expected to come from increasing utilization and intensity of services. (In its estimate of Part B expenditures, CBO has assumed that limiting increases in physician reimbursements will not be sufficient to control the growth of total expenditures in the Medicare Supplementary Medical Insurance program.)

MANDATORY CAPS AS A MEANS OF CONTROLLING ENTITLEMENT SPENDING

The Budget Enforcement Act of 1990 (BEA) placed caps on the level of discretionary spending through fiscal year 1995 and required increases in revenue or reductions in outlays to pay for new mandatory spending. The BEA placed no constraints, however, on the growth of mandatory programs as they exist in current law. Persistent large budget deficits since the passage of the BEA have focused increased attention on the growth of mandatory spending. The President's 1993 budget included a proposal to cap the growth of mandatory spending, and bills introduced in both the House and Senate in 1992 would implement this policy. These bills would limit the annual increase in spending on mandatory programs to the percentage change in the number of beneficiaries, plus the percentage increase in the consumer price index, plus an additional fixed percentage. All mandatory spending except Social Security would be subject to the cap, and any spending in excess of the cap would cause a sequestration of funds that would reduce outlays in each direct spending account by a uniform percentage in order to cut mandatory outlays to the level permitted by the cap.

CBO estimates that under such a cap mandatory spending would not be affected until 1997, when it would be reduced by $15 billion (see Table 7). If, however, the cap were set to equal only the percentage increase in enrollment plus inflation, mandatory outlays would fall by $11 billion in 1993, $20 billion in 1994, and $76 billion in 1997.

5. H.R. 4150 and S. 2217, 102nd Congress, second session.

TABLE 7. PROJECTED MANDATORY SPENDING UNDER A CAP ON GROWTH (By fiscal year, in billions of dollars)

	1993	1994	1995	1996	1997
All Mandatory Spending Except Social Security					
Baseline Outlays	450	479	513	549	602
Projected Outlays with Cap Equal to:					
Enrollment, Inflation, Plus 2.5 Percent	450	479	**513**	549	**587**
Estimated Savings	0	0	**0**	**0**	**15**
Enrollment, Inflation, Plus 2 Percent	448	477	**510**	544	**579**
Estimated Savings	2	2	**3**	**5**	**23**
Enrollment, Inflation, Plus 1 Percent	443	468	495	524	552
Estimated Savings	7	11	18	25	50
Enrollment Plus Inflation	439	459	**481**	504	526
Estimated Savings	11	20	32	45	76
All Mandatory Spending, Including Social Security					
Baseline Outlays	751	797	848	903	977
Projected Outlays with Cap Equal to:					
Enrollment, Inflation, Plus 2.5 Percent	751	797	848	903	968
Estimated Savings	0	0	0	0	9
Enrollment, Inflation, Plus 2 Percent	751	797	848	903	964
Estimated Savings	0	0	0	0	13
Enrollment, Inflation, Plus 1 Percent	746	788	834	883	934
Estimated Savings	5	9	14	20	43
Enrollment Plus Inflation	739	773	811	850	891
Estimated Savings	12	24	37	53	86

SOURCE: Congressional Budget Office.

NOTES: Caps limit the growth of outlays to the percentage growth in enrollment, plus the percentage change in the consumer price index, plus a fixed add-on percentage.

Including Social Security in the various caps shown in Table 7 would increase the amount of mandatory spending permitted under three of the options because Social Security outlays are growing at a slower rate than the caps permit. Only a cap that limited growth to the increase in enrollment plus inflation would reduce mandatory spending more if Social Security were included under the cap than if it were not.[6] If Social Security were included, its outlays would be subject to sequestration just like any other mandatory program. In other words, if total mandatory spending exceeded the amount permitted under the cap, Social Security outlays would be cut, whether or not growth in Social Security outlays exceeded the amount implied by the cap for that program.

Proposals to cap the growth of mandatory programs raise many questions. For instance, how would such a cap be implemented? Would benefit amounts and reimbursement rates be reduced, or would new applicants be denied access to the programs once the cap on expenditures was reached? If the latter, how would this be accomplished? Not all mandatory programs are likely to grow faster than the proposed cap would permit. Should outlays be cut for all programs if spending for a few programs pushed total mandatory spending over the limit? Or should spending be cut only in those programs growing faster than the cap prescribes? Would caps on Medicare and Medicaid spending merely shift more of the cost of medical care to private payers, nonprofit organizations, and state and local governments?

Because of their rapid growth, Medicare and Medicaid are the programs most likely to cause mandatory spending to exceed the amount permitted by a cap of the type proposed in the Congress (see Table 4). Capping the growth of all mandatory spending may appear to be one way to control the growth of Medicare and Medicaid without debating the thorny issues of what services to eliminate, what payments to health care providers to reduce, which beneficiaries to cut from the rolls, or what premiums, coinsurance, or other fees to raise. Even an across-the-board cap on mandatory spending, however, does not obviate the need to decide how to implement the caps within each program. Because such a cap would limit the growth of Medicare and Medicaid, the means to control the growth of these two programs would still have to be put in place.

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6. A cap that limited the growth of outlays to the percentage change in enrollment plus the percentage change in prices would make no allowance for the growth in Social Security benefits caused by rising real wages, which have increased by an average of about 1 percent a year since the mid-1970s. It should also be noted that the expenditure caps in S. 2217 and H.R. 4150 would not limit the growth of each mandatory program to the rate of growth of enrollment in that program plus the rate of inflation. Rather, these growth rates would be used to set an overall cap on mandatory expenditures. If mandatory expenditures exceeded the cap, spending on all mandatory programs would be reduced by a uniform percentage.

OPTIONS FOR SLOWING THE GROWTH OF SOCIAL SECURITY, MEDICARE, AND MEDICAID

The Congressional Budget Office has prepared estimates for many proposals that would reduce spending for mandatory programs or tax some of the benefits paid by these programs.[7] A thorough discussion of these proposals is beyond the scope of this memorandum, but it may be useful to describe briefly some of the options most often suggested for reducing the rate of growth in expenditures for Social Security, the biggest entitlement program, and for Medicare and Medicaid, the two fastest growing entitlements.

Social Security

Among the most frequently proposed options for reducing spending for Social Security and the civil service and military retirement programs are limiting annual cost-of-living adjustments, increasing the age of eligibility for full benefits, adjusting the benefit formula to lower the initial benefit amount, and subjecting a greater proportion of benefits to income tax.[8] All of these options involve trade-offs in terms of ease of implementation, fairness for people at the same income level (horizontal equity), fairness for people at different income levels (vertical equity), and the amount by which the options would either cut spending or raise revenue.

Reducing COLAs, for example, could save a significant amount of money. CBO has estimated that eliminating COLAs for one year in the Social Security and Railroad Retirement programs would save $41 billion over five years, and limiting the COLAs to two-thirds of the increase in the consumer price index each year for five years would save $46 billion.[9] Reducing COLAs, however, would place a relatively greater financial burden on Social Security recipients at the low end of the income distribution, for whom COLAs represent a larger share of total income, than on better-off beneficiaries. Furthermore, if COLAs were eliminated or permanently reduced to a level below the general increase in inflation, the real value of Social Security benefits would erode over time, forcing more older retirees into poverty as they depleted their savings and other assets and came to rely on Social Security to meet more of their expenses. (Most private pension

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7. See Congressional Budget Office, *Reducing the Deficit: Spending and Revenue Options* (February 1992).

8. Estimated savings from reducing Social Security COLAs, altering the benefit formula, and taxing more benefits can be found in CBO, *Reducing the Deficit.*

9. Ibid.

benefits are not fully indexed to inflation, so these too erode in value over time.) Some of the savings to the Social Security program from cutting COLAs could be lost if, as a consequence, more elderly people fell into poverty and became eligible for Supplemental Security Income and Medicaid.

The age at which a person is eligible for full Social Security benefits has already been raised (prospectively), and some policy analysts believe it should be raised further. Under the 1983 amendments to the Social Security Act, the age of eligibility for full benefits will rise to 65 years and two months in the year 2000 and will increase in a series of steps in later years, reaching age 67 in the year 2022. A further increase in the retirement age would reduce Social Security expenditures, either by reducing the number of years over which full benefits would be paid, or, for early retirees, by paying a lower percentage of the full benefit. Because of increases in longevity and the large number of new beneficiaries beginning around 2008, when the first of the baby-boom generation will retire, the ratio of workers to retirees will begin to drop early in the next century. This drop will necessitate increases in the payroll tax or other taxes in order to maintain the level of retirement benefits. Raising the age of eligibility for full benefits would lessen the need to raise taxes to maintain the level of Social Security benefits. Increasing the age of eligibility is also likely to induce workers to postpone retirement, thereby raising the levels of national income and output.

Raising the age of eligibility for full Social Security benefits does have disadvantages. The long delay before the retirement age can be raised would postpone savings until well into the future, but it is necessary to allow current workers to plan and prepare adequately for their retirement. Also, the incentive to continue working that raising the age of eligibility provides is likely to fall disproportionately on low-income workers, for whom Social Security constitutes a greater percentage of retirement income. They would be less likely than high-income workers to have other financial resources to replace the Social Security benefits lost by reducing benefits paid to early retirees.

Altering the benefit formula to lower the initial Social Security benefit would offer at least one advantage over cutting COLAs or raising the age of eligibility: it could easily be designed so that the burden of reduced initial benefits would not be borne more heavily by low-income retirees than by high-income ones. A new benefit formula could also be flexible in terms of the amount of savings it would generate, and if COLAs were left in place, the value of the benefit would not erode over time. CBO has estimated that reducing the benefits of newly eligible retired workers by 3 percent beginning in 1993 would save $4.7 billion in Social Security outlays over five years.

Increasing the amount of Social Security benefits subject to income tax could also generate significant savings. For instance, the Congressional Joint Committee on Taxation (JCT) has estimated that including 50 percent of all Social Security benefits in adjusted gross income (rather than 50 percent of benefits over a threshold amount, as under current law), would raise tax revenues by almost $45 billion over five years. The JCT has also estimated that if the threshold level were retained but the amount of benefits over the threshold included in adjusted gross income were raised to 85 percent, income tax revenue would rise by $29 billion over five years.

Besides generating substantial revenue from Social Security benefits, the income tax system allows for progressive taxation that would help avoid placing an excessive burden on low-income retirees, and its system of rates and deductions would allow flexibility in adjusting the amount of revenue generated. If COLAs were retained, benefits would be protected from inflation because income tax brackets are indexed to the consumer price index. Taxation of benefits is also more consistent with the social insurance concept underlying Social Security than is the type of means-testing used in welfare programs. Nevertheless, because the formula used to calculate Social Security benefits replaces a higher percentage of earnings for low-wage workers than for high-wage workers, some higher-income retirees might believe that they would be overtaxed if income taxes on their benefits were increased.

Medicare

The most frequently discussed proposals for cutting the rate of growth of Medicare spending fall into four broad categories: reducing the rate of reimbursement to providers of Medicare services; cutting the number of services covered by Medicare; increasing beneficiaries' financial liability for medical care through higher premiums, deductibles, or copayments; and tightening eligibility standards in order to slow the growth of Medicare enrollment. CBO has published estimates of potential savings for many variants of these proposals.[10] Although specific proposals for reducing the growth of Medicare expenditures are too numerous and complex to be discussed here fully, several factors are common to most such proposals. Any option for reducing Medicare spending must be evaluated with regard to its effects on access to care, quality of care, quantity of care, and costs in other sectors of the Medicare program or in Medicaid.

10. Estimated savings for many of the proposals are provided in CBO, *Reducing the Deficit.*

One way to cut the growth of Medicare spending is simply to make fewer people eligible. For instance, reduced Social Security retirement benefits now begin at age 62, but Medicare coverage is not available to retirees until age 65, so early retirees do not have access to the program. However, the age at which retirees are eligible for full Social Security benefits is scheduled to begin rising in the year 2000. If the age of eligibility for Medicare also rose, some savings would be realized in the Medicare program. Some of that savings would be lost, however, if people made ineligible for Medicare became eligible for Medicaid.

Some proposals to reduce Medicare spending could have unintended effects on access to health care, which could further reduce Medicare costs but might have unintended effects on the health of the program's beneficiaries. If reimbursements to health care providers were cut below the point at which it is economical for physicians to treat Medicare patients, for instance, some providers might begin to reduce the number of Medicare patients they treat. If access to primary care physicians were impeded, Medicare beneficiaries might begin to receive more of their care in hospital inpatient and outpatient settings, where treatment tends to be more costly than in a physician's office. Proposals to cut Medicare costs must therefore be evaluated with respect to their effect on access to care as well as their effect on the program's cost.

Proposals to cut Medicare costs could also indirectly affect quality of care. Although the requirements of civil and criminal law, as well as the professional ethics of health care providers, might seem sufficient to guarantee that Medicare enrollees would receive the same treatment as other patients regardless of the generosity of the program relative to other insurers, experience with the Medicaid program indicates that access and quality may indeed suffer when reimbursement rates are relatively low.[11]

Sometimes it is difficult to discern whether a cost-cutting measure has also affected quality of care. For example, since Medicare adopted a prospective payment system based on diagnosis-related groups (DRGs) for hospital reimbursement in 1983, the quantity of inpatient hospital care provided per Medicare enrollee, as measured in terms of the average number of inpatient days per year, has fallen. The DRG system also appears to have reduced the level of expenditure per enrollee per hospital admission from

11. See Physician Payment Review Commission, *Annual Report to Congress, 1991* (March 1991), Chapters 15 and 16; Institute of Medicine, *Improving the Quality of Care in Nursing Homes* (Washington, D.C: National Academy Press, 1986); and B. Yudkowsky and others, "Pediatrician Participation in Medicaid: 1978 to 1989," *Pediatrics*, vol. 85, no. 4 (April 1990).

what it would otherwise have been.[12] Evidence is mixed, however, on whether the shorter hospital stays under the DRG system have adversely affected patients' health.[13]

In summary, efforts to reduce the cost of Medicare can have implications for access to care, quality of care, and quantity of care. Also, reducing expenditures in one area of the program can raise costs elsewhere in the program or in other programs, such as Medicaid. These few examples underscore the complicated interactions resulting from efforts to control the growth of Medicare expenditures, especially when such efforts are made without complementary reforms in Medicaid and other types of health insurance.

Medicaid

At least two of the proposals for reducing Medicare expenditures--namely, cutting reimbursements and increasing cost sharing--have little relevance for the Medicaid program. Medicaid reimbursement rates are in general already lower than the rates paid by Medicare, which in turn are lower than reimbursement rates typically paid by private insurers. Some studies have indicated that Medicaid's low rates of reimbursement limit the health care services available to Medicaid enrollees from hospitals, physicians, and nursing homes.[14] Some providers have claimed that Medicaid reimburses them at rates below the cost of care, that it pays claims more slowly than other insurers, and that it denies payment more frequently than other insurers. All of these factors can dissuade health care providers from participating in Medicaid. In recent years, health care providers in many states have sued state Medicaid agencies on the grounds that the reimbursements paid by Medicaid are not "reasonable and adequate" as required by law. Many of these suits are still pending, but several have been successful in forcing state Medicaid agencies to raise the reimbursements paid to hospitals and nursing homes.

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12. Admissions per enrollee are also down from the early 1980s, indicating that shorter stays are not resulting in more admissions. It is not known, however, whether shorter hospital stays are affecting the number of outpatient visits or physician visits, both of which have increased on a per-enrollee basis since the early 1980s. (One reason for instituting the Medicare DRG system of reimbursement was to shift some inpatient hospital care to these less costly settings.) Use of both nursing home care and home health care also rose after the implementation of the DRG system, partially offsetting the savings in hospital expenditures.

13. R. Coulam and G.Gaumer, "Medicare's Prospective Payment System: A Critical Appraisal," *Health Cart Financing Review,* Annual Supplement, 1991.

14. See Physician Payment Review Commission, *Annual Report to Congress, 1991;* Institute of Medicine, *Improving the Quality of Care in Nursing Homer,* and Yudkowsky and others, "Pediatrician Participation in Medicaid."

Shifting more of the cost of medical care to Medicaid recipients would be as difficult as cutting reimbursements because most recipients have incomes below the poverty line and have little money available to pay medical expenses. Some states require nominal copayments for Medicaid services, but these copayments are not ever likely to become a significant offset to Medicaid expenditures. Since it is unlikely that Medicaid savings could be generated by reducing payments to health care providers or by increasing fees for Medicaid enrollees, other options must be found if the increase in Medicaid spending is to be slowed.

One proposal for cutting Medicaid expenditures is to pay for fewer services, or to pay for services only under certain conditions or in specific settings. Federal law lays out a core set of required Medicaid services, including inpatient hospital care, physician services, and nursing facility services, and a group of optional services, including optometry services, dental services, prescription drugs, and many others. One way to reduce spending would be for states to drop optional services and pay only for required services, or for the federal government to reduce the number of services eligible for Medicaid reimbursement. A variation on this option would be to pay for some services only in certain circumstances or settings (as outpatient procedures rather than inpatient procedures, for example).

Just as the Medicaid statute requires that some services be covered while leaving coverage of others to the discretion of individual states, it also requires that specific groups of people be covered but lets the states decide whether to cover others. Medicaid's eligibility rules are notoriously complex, but in general Medicaid is an insurance program for poor elderly or disabled people and for poor children and their mothers. In recent years, several expansions of Medicaid eligibility have been enacted, some of which states have been required to adopt and others of which states have had the option of adopting. Because Medicaid is often the only medical insurance available to those who are enrolled in the program, and because access to health care can be a matter of life and death, it is politically difficult for states or the federal government to take Medicaid coverage away from those to whom it has already been extended.

Although curtailing eligibility would reduce Medicaid spending somewhat, it would reduce national health expenditures and the government's share of those expenditures by a lesser amount. The reason is that uncompensated care provided by hospitals and physicians generally ends up being added to the fees charged to people who have other health insurance or being paid for through government appropriations for public hospitals and clinics. State and local governments absorb much of the cost of health care for the uninsured through expenditures for public hospitals and clinics, and

the Medicaid program also pays billions of dollars each year to hospitals that serve a disproportionate share of the Medicaid population and the medically uninsured. Cutting enrollment in Medicaid could increase these costs.

CONCLUSION

In recent years, experiments in controlling government spending for health care, particularly in the Medicare program, have shown that piecemeal approaches to the problem are unlikely to enjoy broad or enduring success. The process of cutting the growth in health expenditures has been likened to squeezing a balloon--if you squeeze it in one place, it just bulges out in another. It may be that controlling the growth of Medicare and Medicaid can be accomplished only in the context of a more comprehensive reform of the health care system--one that provides access to adequate health care services to all who need them and that provides the means for controlling the nation's total health care expenditures more effectively.

Medicare and Medicaid are not the only sectors of the health care economy that are growing rapidly. Almost every year for the last three decades, health care has consumed a larger share of the nation's total output of goods and services. Yet a large segment of the population, the uninsured, is denied adequate access to care. Many people are beginning to question what riie continued rapid growth of national health spending is costing in terms of forgone output in other sectors of the economy. Controlling the growth of Medicare and Medicaid in a manner that is effective, efficient, equitable, and enduring will require that the nation address health care and its place in the economy more broadly than just in the context of these two government programs. The issues of access to health care and the quality, quantity, and cost of that care will have to be resolved, not just as they relate to Medicare and Medicaid but as they affect other forms of health insurance and the economy at large.