In spite of all the negative rhetoric of this presidential election cycle one issue sure to attract renewed attention is health care policy. This atypical election cycle has diverted attention from the growing evidence that premiums for health insurance sold on the exchanges are rising while options have declined. Health expenditures are also again growing faster than the economy. The health care market garners constant political interest because some 45% of direct health care spending is paid through Medicare, Medicaid and CHIP, all public programs.

In addition to direct government outlays, the Congressional Budget Office estimates that in 2016 the tax exclusion extended to employer provided health insurance will amount to over $260 billion in tax expenditures (foregone tax revenues). Further, the new health insurance exchanges will produce another $43 billion in spending.¹

Health care spending growth has outpaced economy-wide growth since the end of 2014. This renewed higher relative growth followed several years during which health care spending per capita increased at about the same pace as per capita Gross Domestic Product (GDP). But, since the 1960s, health care spending has generally increased at a faster rate than the economy.

The long history of faster growth of health care spending has been attributed variously to population aging, to the falling share of spending paid by patients, to the tax preference afforded employer provided health insurance, to the expansion of public insurance programs, to rising incomes, and to technological advances. All of these factors will influence future growth.

Health care spending as a share of GDP is shown in Figure 1.² The figure illustrates that health care spending’s share of GDP rose from just over 5% of GDP in 1960 to over 18% in the second quarter of this year. Also of note are several periods during which the share remained relatively stable. These periods, 1982-1984, 1992-2000, 2003-2007, and 2009-2014, coincide with economic expansions when the growth in per capita GDP kept up with per capita health care spending. Over time the difference between per capita health care spending growth and per capita GDP growth has declined. This difference is often referred to as the “excess cost growth.” Accounting for the effects of changes in the age structure of the population, the “excess cost growth” rate averaged 2.7% annually between 1960 and 1985 and 1.5% from 1985 to the present.

How fast will health care spending grow in future? Numerous factors suggest that health care spending will grow faster than other consumption for years to come. The excess cost growth rates mentioned above accounted for population ageing separately. By itself, without adding in excess cost growth, population ageing will increase real spending by 10% over the next two decades. The share of spending paid by patients is expected to decline on net due to increased insurance coverage

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through the expansion of Medicaid and exchange purchased insurance. This will increase spending growth. Rising real incomes will lead to both greater spending on health care and on all other goods, but with increasing allocations toward health care. Further, new expensive technologies continue to be produced in response to the third-party payment mechanism and rising incomes.

Other factors suggest that the excess cost growth rate may decline. Many observers point out that technologies have increased health care productivity. Diagnostics, lab work results, and doctor/patient consultations are now communicated through digital media. Pharmaceuticals have replaced more expensive procedures. Many surgeries are now less invasive than in the past and are conducted on an outpatient basis.

But these observations could be made about other consumer goods as well. Today’s automobiles are a far cry from the autos of just a few decades ago: they are safer, longer lasting, more efficient, faster, and handle better. What we consume when we buy a car is quite different than in the past; we’re buying more quality and advanced technology. The same is true for health care. So, labor saving technological advances in health care do not necessarily translate into lower relative health care spending growth.

Additional observations are relevant regarding the future growth in health care spending. The share of spending paid for by patients out-of-pocket has declined since 1960, and as mentioned, will decline further in the near future as a result of the expansion of Medicaid and through increased insurance coverage. This near-term reduction will increase expenditure growth for a time, but the out-of-pocket share is already only 11% of total spending and thus future declines are limited.

In considering the future path health care spending may take, it is important to review how other consumption has changed as the share devoted to health care spending has risen. Figure 2 illustrates this dynamic. Health care expenditures grew from 6% to over 22% of personal consumption expenditures between 1960 and 2015. During the same period, food products and services fell from about 25% to 13%.

Other sectors’ shares have also declined through time with nondurable goods falling from almost 20% to 11%, and durable goods falling from 14% to 11%. The share of consumption allocated to the other sectors has remained more or less static through time. The point here is that thinking about the future of the health care sector cannot be...
done in isolation. Other consumption must also rise as income rises, though shares of consumption can change.

Market forces as well as current public policies, as they apply to government health care spending, influence forecasts of future spending. A case in point is the forecast of Medicare’s expenditures. For many years now, the Centers for Medicare and Medicaid Services (CMS) has made two forecasts of Medicare spending: one that assumes the current law remains in place including the ACA provisions intended to constrain spending, and an alternative forecast that assumes the constraints are not realized. The alternative forecast is the more realistic of the two given that the ACA’s spending constraints are essentially the same type of mechanism as the ineffective and now replaced sustainable growth rate (SGR) for physician reimbursement.

Figure 3 presents two illustrative estimates of health care spending as a share of GDP. The lower estimate includes the effects of population ageing and assumes that the excess cost growth rate declines from the post 1985 average of 1.5% to zero by 2050 following the historical trend in excess cost growth. The higher estimate assumes that the excess cost growth rate declines at its historical rate for the next 20 years and then remains constant at about 0.6% for all future years. Based on this assumption about excess cost growth, total health care spending would reach 25% of GDP by 2040 and 29% in 50 years. This estimate is quite similar in the long run to a recent (CMS) forecast that assumes the Medicare expenditure constraining provisions under the ACA are not achieved.³

The way health care consumption is financed and regulated will continue to be debated. The ACA has expanded insurance coverage through Medicaid expansion, subsidies, and mandates, ensuring that health care spending will proceed to grow as a share of the economy and at the same time ensuring that an increasing share of the spending is paid for through direct government spending and tax incentives.

Difficult choices must be addressed once the dust clears following the election. Limiting the growth of government spending on health care to the growth in the economy is the implicit goal of most recent proposals regardless of the political leaning of the group making the proposal.

One route follows the ACA’s provisions to constrain Medicare’s payments to hospitals. But such a constraint will either be overridden—as was the SGR—or if effective, will result in lower spending on behalf of program beneficiaries leading to lower quality and restricted access.

An alternative to the regulated route is increasing consumers’ direct role in financing the care they receive through limiting tax expenditures, increased cost sharing and in the case of Medicare increased means-testing. Both paths provoke strong opposition, but the latter brings more market forces to bear on limiting growth and allocating resources more efficiently.

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