Department of Health and Human Services

Proposed Spending Cuts

by Chris Edwards

September 2010

The Department of Health and Human Services encompasses a giant and sprawling collection of agencies and programs. Its 2010 budget of $869 billion represents almost one-quarter of total federal spending. The department operates more than 400 different subsidy programs, including the massive and fast-growing Medicare and Medicaid programs.

The projected growth in Medicare and Medicaid will create a national fiscal disaster in coming decades unless the programs are restructured and cut. Unfortunately, the 2010 health care law expanded federal health spending and will likely make America's looming fiscal crisis worse.[1]

Eventually, policymakers will have to control rising federal debt, and that means they will have to downsize HHS programs. Medicare should be converted to a system based on individual vouchers and competitive coverage options. Medicaid should be turned into a state block grant with a fixed level of federal funding. The 2010 health care law should be repealed and other HHS programs should be terminated, as listed below.

Medicare and Medicaid

Rep. Paul Ryan (R-WI) has proposed a detailed plan to convert Medicare and Medicaid into consumer-directed health systems by replacing current programs with tax credits and vouchers.[2] Rather than the government reimbursing doctors and hospitals, the government would provide payments directly to individuals, who would purchase health insurance in private markets. The Ryan plan incorporates refundable tax credits for all Americans under age 65 and vouchers for the elderly and low-income populations. The budget effects of the proposal were examined by the Congressional Budget Office, and so the plan provides a useful illustration of the cost savings possible from market-oriented health reforms.[3]

The Ryan plan would repeal the current tax exclusion for employer-provided health insurance and replace it with a refundable tax credit of $2,300 per adult, $1,700 per child, and a maximum of $5,700 per family. The tax credit would be used to cover the costs of either individual or employer-based health insurance for people under age 65.

Individuals age 65 and over would purchase private health insurance with the aid of a federal voucher. Individuals with lower incomes would purchase private health insurance with the aid of the federal tax credit and a voucher. The reforms would essentially convert Medicare and Medicaid from defined benefit to defined contribution plans. That would allow policymakers to directly restrain program costs without having the government ration health care services.

If individuals receiving tax credits and vouchers purchased health insurance costing less than the federal payment, they would put the excess in a tax-free medical savings account. If individuals purchased an insurance plan costing more than the federal payment, they would chip in the extra. Either way, individuals would be encouraged to make efficient purchasing decisions.

To restructure Medicare, the Ryan plan would provide retirees with a voucher averaging $11,000, which is the current average Medicare spending per beneficiary. The reform would only affect people who are age 55 and younger today. When those individuals start reaching age 65 after 2020, they would receive the Medicare voucher instead of benefits under the current program structure.

The Medicare voucher would grow in value after 2010 based on the average growth rate of general inflation and medical inflation. The dollar values of the vouchers would be adjusted to reflect the age of a beneficiary, income level, and health status. Poorer and sicker persons would receive higher subsidies. The low-income elderly under the Ryan plan would receive an additional payment to their medical savings accounts to cover out-of-pocket health expenses.[4]

To restructure Medicaid, the Ryan plan would provide low-income individuals with both a refundable tax credit and a voucher to purchase private health insurance. People below the poverty line would receive a $5,000 voucher, while those with incomes between the poverty line and twice the poverty line would receive a smaller voucher amount. State taxpayers—who currently pay a portion of the costs of Medicaid—would pay a portion of the costs of the new Medicaid vouchers.

An alternative approach to reforming Medicaid would be to convert it to a block grant for the states. The states would receive a fixed grant from the federal government with few strings attached, allowing them to experiment with more efficient ways of delivering health subsidies to low-income families. This approach is probably preferable to the Ryan voucher approach because it would likely result in less federal micromanagement of state health care markets and more state innovation.

However, both the voucher and block-grant approaches to reforming Medicaid would create strong incentives to improve efficiency in health care markets, and both reform approaches would allow federal policymakers to directly clamp down on explosive Medicaid spending growth.

Other HHS Spending

Aside from Medicare and Medicaid, HHS operates a huge array of health and nonhealth programs. Essays on this website describe the problems with some of these programs and the advantages of terminating them. As Medicare and Medicaid spending expand, taxpayers will be less able to afford funding all the other HHS subsidy programs.

Table 1 lists HHS programs aside from Medicare and Medicaid that could be terminated. These programs have one thing in common: they are all state grant programs. The federal government raises the money from taxpayers who live in the 50 states and then dispenses it back to the states to administer these programs. That roundabout way of financing government programs makes no sense. Why don't the states just fund their own programs and cut out the inefficient middleman in Washington?

Elsewhere I have examined why federal grants to state governments are an ineffective and bureaucratic way to try and solve society's problems.[5] For example, an authoritative HHS report on Head Start in 2010 conceded that the program produced few if any long-term benefits to participating children.[6] The HHS activities listed in Table 1 that are worthwhile would be better handled by state and local governments or the private sector.

The proposed terminations in Table 1 would save taxpayers $81 billion annually. Even with these cuts, HHS would still spend about $61 billion annually aside from Medicare and Medicaid. Remaining HHS activities would include the Centers for Disease Control, the National Institutes of Health, and the Food and Drug Administration. These agencies could probably use reforms as well, and thus the cuts in Table 1 are not the only possible reforms to the HHS budget.

Table 1. Proposed Spending Cuts to HHS Programs Other Than Medicare and Medicaid

Program	Spending in 2010 ($ million)
Temporary Assistance for Needy Families	$17,754
Children's Health Insurance Program	$8,903
Foster care grants	$7,403
Head Start	$7,235
Low income energy assistance	$4,993
Child support grants	$4,710
Child care development grant	$3,394
Substance abuse	$3,349
Child care entitlement	$2,925
Social services grant	$2,118
Administration on Aging	$1,600
Other state grant programs	$16,961
Total proposed cuts	$81,345
HHS outlays (excluding Medicare/Medicaid)	$142,379

Source: Author, based on estimated fiscal year outlays from the *Budget of the U.S. Government, FY2011*.

Long-Term Projections

Table 2 shows projected HHS spending in coming decades as a share of gross domestic product. The top rows of the table show CBO projections of business-as-usual spending with no major policy changes.[7] The bottom rows of the table show the effects of the reforms discussed here.

Under a business-as-usual scenario, the CBO projects that Medicare and Medicaid spending will explode as a share of GDP in coming decades. By contrast, under the Ryan reforms for those two programs outlined here, the CBO projects that spending growth would be dramatically slowed.[8]

The cost of the 2010 health care legislation is listed as a separate line item. By 2020, the CBO expects that the legislation will increase net government spending by about 0.4 percent of GDP.[9] I have assumed—probably optimistically—that the cost of the legislation would remain at a constant share of GDP after that.

Without reforms, I've assumed that "Other HHS Spending" would remain at 1.0 percent of GDP in future years. For the reform scenario, I've assumed that the cuts listed in Table 1 would be phased in by 2020, which reduces this portion of the budget to about 0.4 percent of GDP by 2020 and beyond.

For the tax-credit part of Ryan's plan, the table shows only the outlay portion, meaning the cash payments to individuals who don't have any tax liability. The outlay portion is about one-third the overall value of the tax credits under his plan.

The tax credits and vouchers under the Ryan plan would grow at the average rate of the consumer price index and the inflation rate for medical care. That would restrain the growth rate in federal subsidies below the currently projected growth rates of Medicare and Medicaid, thus producing large savings over time. Medicare spending would continue rising as a share of the economy under the Ryan plan for a few decades, but then start falling. Medicaid spending would start falling as a share of the economy right away.

Note that similar Medicaid savings could be achieved by turning the program into a state block grant, which is probably a preferable reform. Block grants could be set to grow at the same overall rate as the vouchers under the Ryan plan or at a slower rate. Both the voucher and block grant reform approaches would allow policymakers to directly restrain the growth of federal Medicaid subsidies, while creating incentives to improve efficiency in low-income health care delivery.

Without federal spending reforms, budget projections show federal government debt soaring in coming decades to multiple times the size of the U.S. economy, which would be disastrous. The key driver of the debt explosion will be federal health programs unless they are restructured. The reforms proposed here would help avert a fiscal calamity and create a sustainable path for federal debt, while improving the quality and efficiency of the nation's health care system.

Table 2. HHS Spending as a Percentage of GDP

	2010	2020	2040	2060
Spending Without Reforms				
Medicare	3.1%	4.2%	8.1%	10.9%
Medicaid	1.9%	2.1%	3.0%	3.4%
2010 Health Act	0.0%	0.4%	0.4%	0.4%
Other HHS Spending	1.0%	1.0%	1.0%	1.0%
Total HHS Spending	6.0%	7.7%	12.5%	15.7%
Spending With Reforms				
Medicare (Ryan plan)	3.1%	3.7%	5.1%	3.8%
Medicaid (Ryan plan)	1.9%	1.6%	1.3%	1.1%
Tax credit (Ryan plan)	0.0%	0.6%	0.6%	0.5%
2010 Health Act	0.0%	0.0%	0.0%	0.0%
Other HHS Spending	1.0%	0.4%	0.4%	0.4%
Total HHS Spending	6.0%	6.3%	7.4%	5.8%

Source: Author, based on Congressional Budget Office projections.

---

[1] See the related essay by Michael Tanner at www.downsizinggovernment.org/hhs/legislation.

[2] Rep. Paul Ryan (R-WI), House Committee on the Budget, "A Roadmap for America's Future, Version 2.0," January 2010.

[3] Douglas Elmendorf, Congressional Budget Office, Analysis of the "Roadmap for America's Future," Letter to Rep. Paul Ryan, January 27, 2010.

[4] For ways to improve the Ryan plan, see the "Medicare Reforms" essay on this website.

[5] Chris Edwards, "Federal Aid to the States: Historical Cause of Government Growth and Bureaucracy," Cato Institute Policy Analysis no. 593, May 22, 2007.

[6] See U.S. Department of Health and Human Services, "Head Start Impact Study: Final Report," January 2010.

[7] This is the Congressional Budget Office's "alternative fiscal scenario" presented in Douglas Elmendorf, Congressional Budget Office, Analysis of the "Roadmap for America's Future," Letter to Rep. Paul Ryan, January 27, 2010, Table 2.

[8] Douglas Elmendorf, Congressional Budget Office, Analysis of the "Roadmap for America's Future," Letter to Rep. Paul Ryan, January 27, 2010. The CBO's figures for Medicare and Medicaid reflect a number of changes proposed in the Ryan plan that are not discussed here, such as raising the Medicare retirement age.

[9] Congressional Budget Office, Cost Estimate of H.R. 3590 and H.R. 4872, Letter to House Speaker Nancy Pelosi from CBO Director Douglas Elmendorf, March 20, 2010, Table 2.

Cato Institute
1000 Massachusetts Avenue N.W.
Washington D.C. 20001-5403
Telephone (202) 842-0200
Fax (202) 842-3490
