CBO TESTIMONY

Statement of
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on
The Financial Status of the Medicare Program

before the
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NOTICE

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Mr. Chairman and Members of the Committee, it is my pleasure to be here today to discuss the financial status of the Medicare program. Continuing growth in the cost of providing Medicare coverage to each beneficiary, coupled with a steady increase in the number of beneficiaries, is eroding the financial viability of the program. If left unchecked, those trends will create a problem of major proportions when the baby-boom generation begins to reach retirement age in the year 2010. Addressing the short-term and long-term financing problems of the Medicare program presents a serious challenge for the nation.

The *1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*, released last month, indicates that under intermediate assumptions, the Hospital Insurance (HI) Trust Fund will be depleted in 2002. In other words, unless changes in policy are made, the HI program will only be able to pay fully for services provided to beneficiaries for about the next seven years. Indeed, even under the trustees' most optimistic assumptions, the HI trust fund will be exhausted by 2006--11 years from now.

Based on the Congressional Budget Office's (CBO's) analysis of the trustees' projections and our independent analysis of the Medicare program, we find ample reason to agree with the broad conclusions of the trustees regarding the short-range adequacy of HI funding. But those projections of HI insolvency address only part of Medicare's overall financial outlook. The Supplementary Medical Insurance

(SMI) program, which pays for physician and outpatient services for Medicare beneficiaries, is also experiencing rapid growth in costs.

Moreover, the Medicare program is absorbing a growing share of the nation's resources. Combined spending for HI and SMI has increased from 0.8 percent of gross domestic product (GDP) in 1974 to 2.4 percent of GDP in 1994. It is expected to increase to about 3.5 percent of GDP by 2002. Program revenues, however, are not increasing nearly as rapidly. The evidence strongly supports the conclusion of the trustees that "prompt, effective, and decisive action is necessary" by the Congress to avert a financial crisis in the Medicare program.

My statement today covers four topics:

- An overview of the Medicare program,
- Trends in program spending and in the trust fund balance,[1]
- Medicare's cost containment measures to date, and
- Options for responding to the fiscal crisis in the Medicare program.

1. See the appendix tables for detailed information on trends in Medicare spending.

OVERVIEW OF THE MEDICARE PROGRAM

Medicare is the nation's major program providing medical services to the elderly and disabled populations. It offers two different types of insurance coverage, which are financed and administered separately.

The Hospital Insurance program pays for inpatient hospital care and related care for people 65 and older and for the long-term disabled. Payroll taxes primarily finance the program, with the taxes being paid by current workers and their employers. Those tax receipts are mainly used to pay for benefits to current beneficiaries. Income not currently needed to pay for benefits and related expenses is credited to the HI trust fund. In 1994, the HI program covered about 32 million aged and about 4 million disabled enrollees at a cost of $103 billion.

The Supplementary Medical Insurance program pays for physician and outpatient services. Although it is optional, most individuals eligible for Medicare enroll in SMI. Currently, premiums paid by enrollees finance about 31 percent of SMI program costs. But that share is projected to decline significantly under current law--to 25 percent in 1996 and lower after 1998. General revenues finance the remaining costs. The SMI program is not intended to accumulate funds for the

payment of future benefits. In 1994, the SMI program covered about 31 million aged and about 4 million disabled enrollees at a total cost of $60 billion.

Payroll tax rates for the HI program are set at 1.45 percent of taxable earnings each for workers and their employers. However, the consensus among economists is that most of the tax charged to employers is indirectly paid by workers, whose earnings are ultimately reduced by the amount of the employer's contribution. Self-employed workers pay 2.9 percent of taxable earnings. No cap is placed on taxable earnings subject to the HI payroll tax. In 1994, approximately 141 million workers (and their employers) paid $92 billion to the HI trust fund.

As the baby-boom generation reaches retirement age, the number of workers available to support each HI enrollee is projected to drop. Currently about four covered workers support each HI enrollee. The trustees project that this ratio will decline rapidly early in the next century. They expect that only two covered workers will be available to support each enrollee by mid-century.

In 1994, the Medicare program spent $162 billion, including both HI and SMI. Between 1985 and 1994, Medicare expenditures increased at an average annual rate of 9.6 percent. Under current law, CBO projects that Medicare spending will continue to grow at a similar rate, rising from $181 billion in 1995 to $463 billion in 2005. That increase represents an average annual rate of growth of 9.8 percent. By contrast, cash benefits for Social Security recipients will increase at only about half that rate.

Inflation in medical prices and increases in use of services account for most of the projected rapid increase in Medicare spending. Medicare enrollment of the elderly and disabled combined is projected to increase at an average annual rate of only slightly more than 1 percent over the 1995-2005 period.

CBO projects that Medicare will absorb a growing share of the federal budget over the next 10 years. In fact, under current law, outlays for Medicare (net of SMI premiums) will increase from 11 percent of federal outlays in 1995 to 16 percent of outlays in 2005.[2] Medicare and Medicaid are the fastest growing of the major entitlement programs, and as such, they are major contributors to the escalating budget deficits that face the country.

2. Those estimates assume that discretionary spending rises with inflation after 1998.

The Medicare trustees report 75-year projections of the financial status of the HI trust fund. Projections made by the trustees of the adequacy of HI funding to support program costs in the future are based on three alternative sets of assumptions about future economic and demographic trends: low-, intermediate-, and high-cost. Under their intermediate-cost assumptions, the HI trust fund will be exhausted in 2002.

According to the trustees, HI outlays began to exceed income from the payroll tax in 1992. They project that HI outlays will begin to exceed all sources of income to the program (including interest on the trust fund balance) in 1996. As a result of that annual deficit in the HI account, the balance in the HI trust fund will begin to erode, and by 2002 it will be depleted.

CBO's projections of the HI trust fund balance only cover the 1995-2005 period. Those projections support the trustees' estimates concerning the depletion of the HI trust fund in 2002. Moreover, CBO's analysis provides ample reason to agree with the broad conclusions of the trustees regarding the short-range adequacy of HI funding.

It is useful to consider what trust fund depletion in 2002 means for the operation of the HI program. Under current-law assumptions, HI payroll taxes would continue to be collected from all covered workers (and their employers) throughout

the year. According to CBO's assumptions, total HI income in fiscal year 2002 would be $153 billion. The total amount in the trust fund at the beginning of that fiscal year would be about $16 billion. Projected disbursements for the full year equal $199 billion. Consequently, the HI program would have a shortfall of $30 billion in fiscal year 2002. Thus, without some Congressional action to provide it with additional financial resources, the HI program would be unable to pay for all of the services Medicare beneficiaries are expected to receive in that year.

MEDICARE'S COST CONTAINMENT MEASURES TO DATE

The rate of growth in Medicare's costs has caused concern almost from the program's inception. The Congress has made repeated attempts to slow that growth, but with limited success.

Early efforts, in the 1970s, relied on price controls and relatively weak utilization review programs. It became apparent, however, that much of the potential savings to Medicare from price controls was lost, offset by an increase in the volume or intensity of services provided despite utilization review. Subsequent cost control efforts sought to introduce mechanisms that focused not just on price but on spending--the product of service price and volume.

The prospective payment system (PPS) for hospital services was established in 1984 to replace retrospective cost-based reimbursement. Under the PPS, hospitals are paid a fixed amount for each inpatient case, based on the patient's diagnosis. Under that payment system, hospitals are given strong incentives to avoid unnecessary services during a patient's stay and to discharge patients as soon as possible, since extra services or days in the hospital would increase hospitals' costs but not their reimbursement from Medicare. By contrast, under the previous payment system, Medicare paid hospitals for the costs of whatever services they provided.

Changes in the physician payment system were implemented in 1992 to replace charge-based reimbursement for physicians' services. The new system includes an explicit fee schedule along with an updating mechanism intended to generate lower fee increases when growth in the volume of physicians' services is large. Unlike the earlier changes in the hospital payment system, these changes did little to alter incentives for physicians. The method of setting fees was changed, but it remains a fee-for-service system that rewards physicians for providing more services.

One can see some indication of the effects of those changes for hospital and physician payment in the fee-for-service sector by comparing the rates of growth in Medicare's spending by service category for different time periods. Between 1985 and 1990, the rate of growth in Medicare's total costs was nearly half the rate for the

preceding decade--annual growth of 9.0 percent, down from 17.1 percent. That slowdown was mostly the result of sharply lower growth for hospital inpatient costs over the five-year period immediately following implementation of the prospective payment system. The growth rate for hospital inpatient spending rose somewhat after 1990.

By contrast, the freezes on and cuts in physicians' fees that took place during the latter part of the 1980s had little effect on the growth rate in spending for physicians' services because those measures were largely offset by an increase in the volume of services. Although the rate of growth in physicians' costs was lower between 1990 and 1995 than it had been before the fee schedule and its volume-based update system were introduced, the slowdown may reflect the low level at which the initial rates under the fee schedule were set. Projections for the 1995-2000 period assume a return to pre-1990 rates of growth.

Another significant change to Medicare during the 1980s was development of a mechanism whereby health maintenance organizations (HMOs) could enroll Medicare beneficiaries on a risk basis--receiving a capitation payment from Medicare for each enrollee. Until then, HMOs were able to serve Medicare enrollees only on a cost basis--a payment system not consistent with the way HMOs operate. Since 1985, Medicare enrollment in risk-based HMOs has grown steadily, increasing more rapidly than private-sector HMO enrollment has since 1989. Nevertheless,

Medicare's risk-based HMO enrollment rate is still low--at 7 percent--compared with the privately insured population. In 1992, almost 20 percent of people with private insurance were in HMOs.

Currently, Medicare beneficiaries pay no more to enroll in fee-for-service Medicare than to enroll in an HMO. They often, however, receive supplementary benefits--such as prescription drug coverage and waiver of cost-sharing requirements--for little or no extra premium if they enroll in an HMO, whereas they pay a substantial premium for medigap coverage to receive those benefits in the fee-for-service sector. For some Medicare beneficiaries, those financial incentives appear to be outweighed by the desire to be able to choose physicians outside the HMO's network. Others may not enroll in managed care plans simply because they are unaware of all the options that are available to them. In the future, both stronger financial incentives and better information would be necessary to encourage more Medicare beneficiaries to enroll in managed care plans.

The most effective HMOs share the insurance risk for enrollees with their providers, thereby reversing or counteracting the incentive providers have to provide unnecessary services that is characteristic of the fee-for-service sector. As a result, an HMO's cost of caring for a given patient is generally lower than the costs incurred by an indemnity plan in the fee-for-service sector.

Despite apparent evidence that the overall resource cost of services used by Medicare beneficiaries falls when they move from the fee-for-service sector to an effective HMO, higher HMO enrollment may have the perverse effect of increasing Medicare's costs--not lowering them--under Medicare's current payment system. That effect occurs for two reasons. First, risk-based HMOs are paid 95 percent of Medicare's fee-for-service cost to provide care to a beneficiary, as measured by the average adjusted per capita cost (AAPCC). That link to fee-for-service costs means that Medicare pays a fixed capitation amount for each Medicare beneficiary enrolled in an HMO, regardless of the actual resource cost of the services provided. Second, Medicare's capitation rates do not fully adjust for the generally healthier group of people who are likely to choose the HMO option compared with those who remain in fee-for-service, nor do they account for the greater efficiency of managed care. If the service costs are lower than the capitation amount, Medicare does not recover any of the savings. The fee-for-service link also means that Medicare payments to HMOs would increase if per capita costs in the fee-for-service sector rose, even if HMO per capita costs fell.

Medicare's HMO enrollment could generate savings, however, if the method of setting capitation rates was changed. A number of possible alternatives exist. But significant savings would not be generated unless the payment link between fee-for-service and managed care was broken. One way to break the link would be to allow the capitation rates to be set by competitive bidding in areas with enough HMOs to

make that approach viable. That market-based approach could encourage stronger price competition among Medicare risk-based HMOs in a market area. However, generating more savings for the Medicare program could reduce the additional benefits that HMOs currently offer to beneficiaries, blunting incentives to enroll in HMOs.

Many analysts attribute the recent slowdown in the rate of growth of private health insurance spending to more aggressive price competition among health plans. Between 1990 and 1993, private health insurance spending grew at an average annual rate of 7.7 percent compared with 11.2 percent for Medicare. As it is currently structured, the Medicare program cannot take advantage of the recent competitive developments in the private health care market.

OPTIONS FOR RESPONDING TO THE FISCAL CRISIS IN MEDICARE

If nothing is done and Medicare continues to grow at its current rate, the program will consume an increasing share of the nation's resources. It will also continue to be a major cause of the rising federal budget deficit and the increasingly burdensome federal debt. Those outcomes raise concern about the efficient allocation of the nation's scarce resources and about the long-run prosperity of the nation. If Medicare absorbed less of the nation's output, more could be spent on investment to improve

the productivity of current and future workers. Moreover, a growing economy could be more dependably counted on to pay for the benefits of current and future retirees.

Fixing Medicare's financing problems will not be easy. As the reports of the trustees make clear, those problems are of both a short-term and a long-term nature. Either taxes must be increased, expenditures reduced, or both, and the orders of magnitude involved are large. (A third approach that is sometimes suggested to address shortfalls in the HI trust fund would be to transfer funds to it from the Old-Age and Survivors Insurance (OASI) trust fund. That strategy, however, would merely postpone rather than address the funding shortfall and would hasten the depletion of the OASI trust fund.)

The tax alternative, in isolation, would require an increase in the HI payroll tax of 1.3 percentage points--more than 40 percent--over the next 25 years to ensure that HI financing covered program costs. Although such an increase in the HI payroll tax would secure the HI portion of Medicare outlays, it would do nothing to improve the overall efficiency of the Medicare program.

Two broad approaches would achieve slower growth in Medicare outlays: budgetary reductions and program restructuring. Those approaches are not mutually exclusive. With or without a tax increase, a combination of them would probably be needed to address Medicare's immediate and longer-term financing problems.

Budgetary reductions--exemplified by the options included in CBO's 1995 report *Reducing the Deficit: Spending and Revenue Options*--represent the traditional approach to containing Medicare's costs. Such options, which typically lower payments for providers or raise the amounts that beneficiaries must pay, offer immediate short-term savings in the Medicare program. Although both types of policies are likely to be part of a more thorough reform of Medicare, they are not necessarily designed to improve the efficiency of the program or to address the underlying long-term structural problems of spending growth.

Slowing the long-term rate of growth of overall Medicare spending and ensuring the solvency of the HI trust fund would probably require major restructuring of the Medicare program. Three basic tenets underlie most redesign proposals: Medicare beneficiaries would have meaningful choices among a range of health plans, including a fee-for-service option; beneficiaries would also have financial incentives to select efficient health plans; and health plans would have strong incentives to compete for Medicare beneficiaries.

Several possible models for restructuring the Medicare program along those lines have been proposed. Frequently, such competitive market approaches offer beneficiaries more choices and clear financial incentives to choose less costly options. A key feature of those approaches is the notion of Medicare making a defined contribution on behalf of each beneficiary. Beneficiaries could then put

those contributions toward the cost of the health plan of their choice. Beneficiary choice and limits on the government's contribution are important elements of the design of the health insurance program for federal employees.

A competitive redesign of Medicare is a possible strategy for addressing the long-term fiscal problems of the program. Major restructuring, however, would take time to develop and could not therefore address the short-term financing issues. Establishing a competitive system could be a major undertaking. Moreover, full implementation all at one time would be difficult; a phased-in approach, starting with younger Medicare beneficiaries, might be more feasible. But potential savings would accrue more slowly under that approach.

One thing is certain: postponing decisions about Medicare's financing will only make the necessary policy actions in the future more severe. Without a tax increase, ensuring that the HI trust fund remains solvent will almost certainly require immediate spending cuts as well as reductions in the underlying rate of growth of spending. Any delay will require more dramatic cuts and program changes in the future.

Appendix Tables

TABLE A-1. OUTLAYS FOR MEDICARE BENEFITS, SELECTED FISCAL YEARS 1970-1993

	1970	1975	1980	1985	1990	1993
			Billions of Dollars			
Total	6.8	14.1	33.9	69.6	107.4	143.1
Hospital Insurance	4.8	10.4	23.8	47.8	65.9	90.7
Inpatient	4.5	9.9	22.9	45.2	59.4	75.0
Skilled nursing facility	0.3	0.3	0.4	0.6	2.8	5.0
Home health	0.1	0.1	0.5	1.9	3.3	9.5
Other	0	0	a	0.2	0.5	1.2
Supplemental Medical Insurance	2.0	3.8	10.1	21.8	41.5	52.4
Physician	1.8	3.1	7.8	16.8	29.0	34.4
Outpatient	0.1	0.5	1.8	3.9	8.4	11.2
Group practice prepayment plans	a	0.1	0.2	0.6	2.6	4.7
Other	a	0.1	0.3	0.5	1.5	2.2
			Average Annual Rate of Growth from Previous Year Shown (In percent)			
Total	n.a.	15.8	19.2	15.5	9.1	10.0
Hospital Insurance	n.a.	16.6	18.1	15.0	6.6	11.2
Inpatient	n.a.	17.4	18.1	14.6	5.6	8.1
Skilled nursing facility	n.a.	-1.7	7.5	7.0	38.0	22.2
Home health	n.a.	19.8	31.6	29.5	11.6	42.5
Other	n.a.	n.a.	n.a.	63.8	25.3	31.6
Supplemental Medical Insurance	n.a.	13.7	21.9	16.5	13.7	8.1
Physician	n.a.	11.1	20.6	16.5	11.5	5.9
Outpatient	n.a.	39.5	27.8	16.8	16.4	10.1
Group practice prepayment plans	n.a.	19.0	25.1	24.6	35.9	20.8
Other	n.a.	22.4	25.9	9.5	23.3	12.5

SOURCE: Congressional Budget Office calculations based on data from the Health Care Financing Administration.

NOTE: n.a. = not applicable.

a. Less than $50 million.

TABLE A-2. PROJECTIONS OF MEDICARE OUTLAYS, FISCAL YEARS 1995-2005 (In billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Average Annual Rate of Growth, 1995-2005 (In percent)
Total Outlays	181.1	202.2	222.7	243.9	267.0	291.9	319.2	349.5	383.3	421.1	463.2	9.8
Hospital Insurance	113.6	125.4	136.8	148.3	160.2	172.5	185.5	199.1	213.8	229.9	247.4	8.1
Supplementary Medical Insurance	67.6	76.8	85.9	95.6	106.8	119.4	133.8	150.4	169.5	191.2	215.8	12.3
Premium Receipts	-20.1	-20.3	-22.0	-24.5	-26.1	-27.3	-28.7	-30.1	-31.6	-33.2	-34.4	5.5
Net Outlays	161.1	181.9	200.7	219.4	241.0	264.6	290.6	319.4	351.7	387.9	428.8	10.3

SOURCE: Congressional Budget Office.

TABLE A-3. MEDICARE OUTLAYS PER ENROLLEE UNDER ALTERNATIVE GROWTH ASSUMPTIONS (By fiscal year)

Percentage Growth in Total Medicare Outlays	Medicare Outlays per Enrollee (In dollars)			Total Savings[a] (In billions of dollars)
	1995	1998	2002	
9.8 (Baseline)	4,833	6,214	8,456	n.a.
7.0	4,833	5,655	7,038	219.0
5.0	4,833	5,343	6,167	347.8

SOURCE: Congressional Budget Office.

NOTE: n.a. = not applicable.

a. Total savings are measured over the 1995-2002 period.