CBO
TESTIMONY

Statement of
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The Magnitude of the Financial Crisis in Medicare

before the
Subcommittee on Health Care
Committee on Finance
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NOTICE
This statement is not available for public release until it is delivered at 2:00 p.m. (EST), Wednesday, February 12, 1997

Mr. Chairman and Members of the Committee, I appreciate the opportunity to discuss with you the outlook for Medicare spending and options for slowing its growth. Continued rapid growth in spending for Medicare means continued pressure on the budget in the short term, with the problem getting much worse when the baby-boom generation retires. In my remarks today, I will briefly summarize projections by the Congressional Budget Office (CBO) for the next decade and then focus on options for the long term.

CBO's PROJECTIONS THROUGH 2007

Although the growth in Medicare spending has slowed since the late 1980s and early 1990s, CBO projects that it will continue to outpace the growth in resources that finance it (see Table 1). Total outlays for Medicare under current law will increase from $212 billion in 1997 to $317 billion in 2002, an average annual increase of 8.4 percent. By 2007, outlays will reach $469 billion, an average annual increase of 8.3 percent over the 1997-2007 period. Spending for Medicare will grow nearly twice as fast as gross domestic product (GDP) over the next decade.

TABLE 1.
CBO's PROJECTIONS OF MEDICARE OUTLAYS AND GROSS DOMESTIC PRODUCT (By fiscal year in billions of dollars)

				Annual Growth Rates (In percent)	
	1997	2002	2007	1997-2002	1997-2007
Medicare Total	212	317	469	8.4	8.3
Hospital Insurance	137	202	290	8.0	7.7
Supplementary Medical Insurance	75	116	179	9.2	9.1
Gross Domestic Product	7,829	9,870	12,379	4.7	4.7

SOURCE: Congressional Budget Office.

Spending for the Hospital Insurance (HI) program is expected to increase at an average annual rate of 7.7 percent between 1997 and 2007. By contrast, HI noninterest receipts (primarily payroll taxes from current workers) will grow by 4.8 percent over that period. CBO expects the imbalance between outlays and receipts for HI to deplete the HI trust fund during 2001 (see Table 2). By 2007, outlays will exceed receipts by $130 billion, and the trust fund will have a negative balance of $556 billion. Postponing depletion of the HI trust fund through 2007 will require a cumulative combination of spending and receipt changes of more than $450 billion over the 1998-2007 period.

TABLE 2.
STATUS OF THE HOSPITAL INSURANCE TRUST FUND (By fiscal year in billions of dollars)

	1997	2002	2007
Income[a]	128	147	160
Outlays	137	202	290
Surplus (Income minus outlays)	-10	-54	-130
Trust Fund Balance (End of year)	116	-59	-556
Memorandum:			
Noninterest Receipts	118	148	189
Interest	10	-1	-29

SOURCE: Congressional Budget Office.

a. Income includes noninterest receipts (primarily payroll taxes) plus interest received on positive balances or paid on negative balances in the trust fund.

Spending for the Supplementary Medical Insurance (SMI) program is expected to increase at an annual rate of 9.1 percent between 1997 and 2007, whereas SMI premium receipts will grow by only 4.5 percent a year. The SMI program is funded primarily by general revenues, with enrollees' premiums currently covering about 25 percent of the costs. The percentage of costs paid from general revenues will steadily increase after 1998 when, under current law, the cost-of-living adjustment to Social Security benefits will limit future premium increases. The SMI program is no more financially sound than the HI program, in the sense that both components of Medicare are growing more rapidly than the economy's capacity to finance them.

CBO continues to project relatively rapid growth in spending because Medicare's current reimbursement rules in the fee-for-service sector--which covers nearly 90 percent of beneficiaries--give neither beneficiaries nor providers much incentive to limit costs. Further, Medicare's payments to health maintenance organizations (HMOs) that enroll beneficiaries are directly linked to its costs in the fee-for-service sector, thereby preventing the program from realizing savings from managed care. A variety of well-known policy options could be used in the short term to slow the growth in Medicare spending by enough to postpone depletion of the HI trust fund. However, if the options adopted leave Medicare's current structure intact, they are likely to prove insufficient for the long term, when Medicare will face unprecedented demands from the aging baby-boom generation.

THE LONG-TERM OUTLOOK

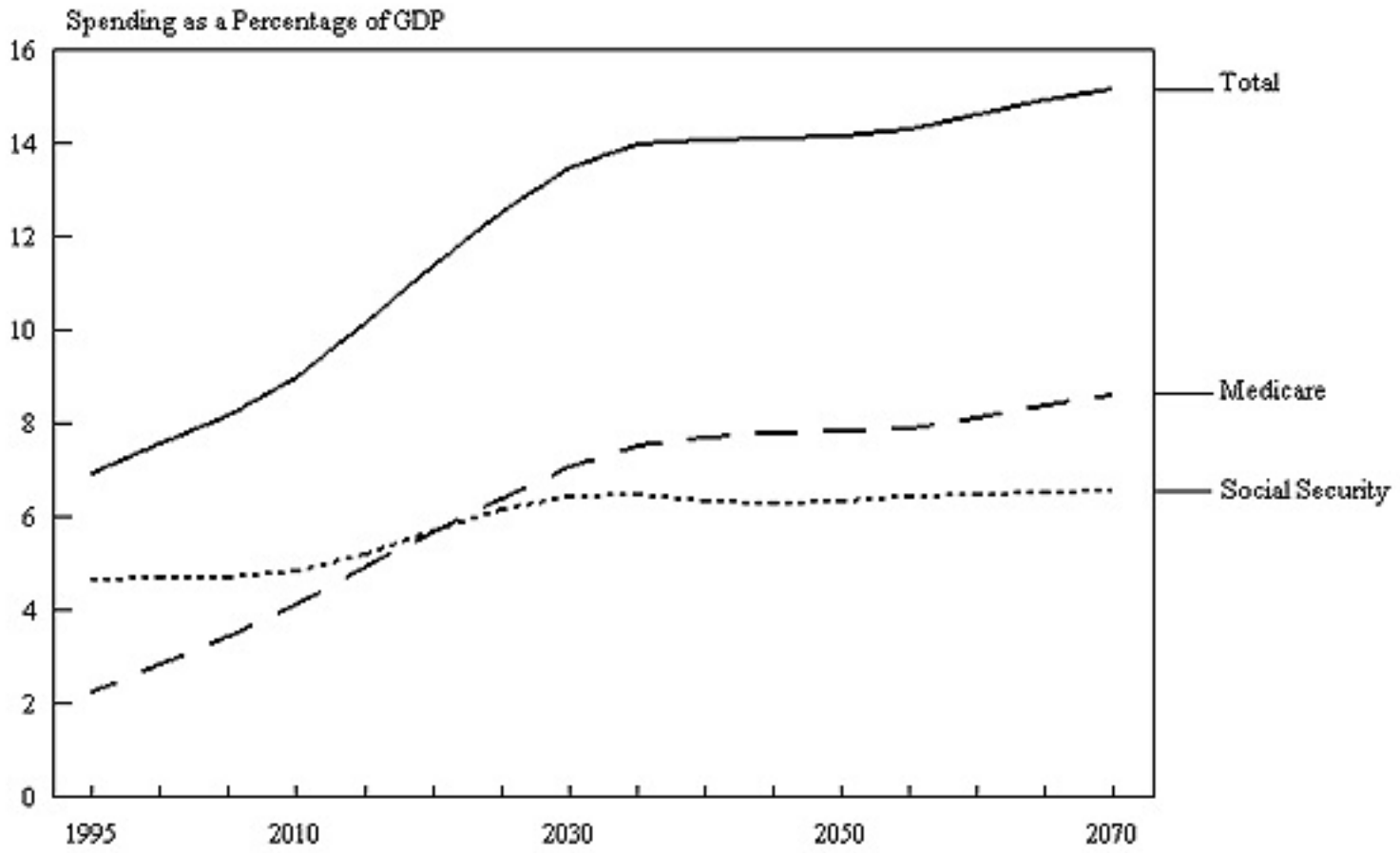
My remarks about the long-term outlook are based on Chapter 7 in CBO's August 1996 report, *Reducing the Deficit: Spending and Revenue Options,* which examined a range of approaches for reducing future spending commitments for Social Security and Medicare. Next month, CBO will publish a revision of that analysis, incorporating the latest projections from the programs' trustees. The estimates I will be presenting today use the new projections.

Although the federal deficit as a share of GDP has fallen to a 22-year low, that good budgetary news should not make us complacent because the retirement of the large baby-boom generation looms just over the horizon. Their retirement will greatly increase the costs of two government programs that are already large--Social Security and Medicare--unless changes in the programs are made.

In 1996, federal spending for Social Security and Medicare exceeded $500 billion, which was about 7 percent of GDP. By 2030, when most baby boomers will have retired, those two programs will consume nearly twice as large a portion of national income as they do today--almost 14 percent. Nearly all of the increase in Social Security's share of GDP between now and 2030, and almost two-thirds of the increase in Medicare's share, will occur after 2010 as baby boomers become eligible for those programs.

The projected increase in spending for Social Security is entirely the result of the expected surge in the number of people eligible for benefits. Spending on Medicare, however, is already growing much more rapidly than national income because of steep increases in costs per enrollee. Unless ways are found to reduce the growth in Medicare's per capita costs, the addition of the baby boomers to the Medicare rolls will place an enormous burden on the federal budget and the economy. Indeed, federal spending on Medicare is projected to overtake spending on Social Security within 30 years (see Figure 1).

Figure 1.
Projected Growth in Spending for Social Security and Medicare, Calendar Years 1995-2070



SOURCE: Congressional Budget Office based on intermediate assumptions from the 1996 reports on the boards of trustees of the Social Security and Medicare trust funds.

NOTES: GDP=gross domestic produce.

Data are plotted at five-year intervals. Medicare spending is shown net of premium receipts.

My remarks today deal only with approaches that might slow the growth of Medicare spending. Options that would reduce growth in spending for Social Security, however, are substitutes in the sense that a dollar saved in either program reduces the federal deficit by a dollar. The two programs have essentially the same beneficiaries, but there is an important

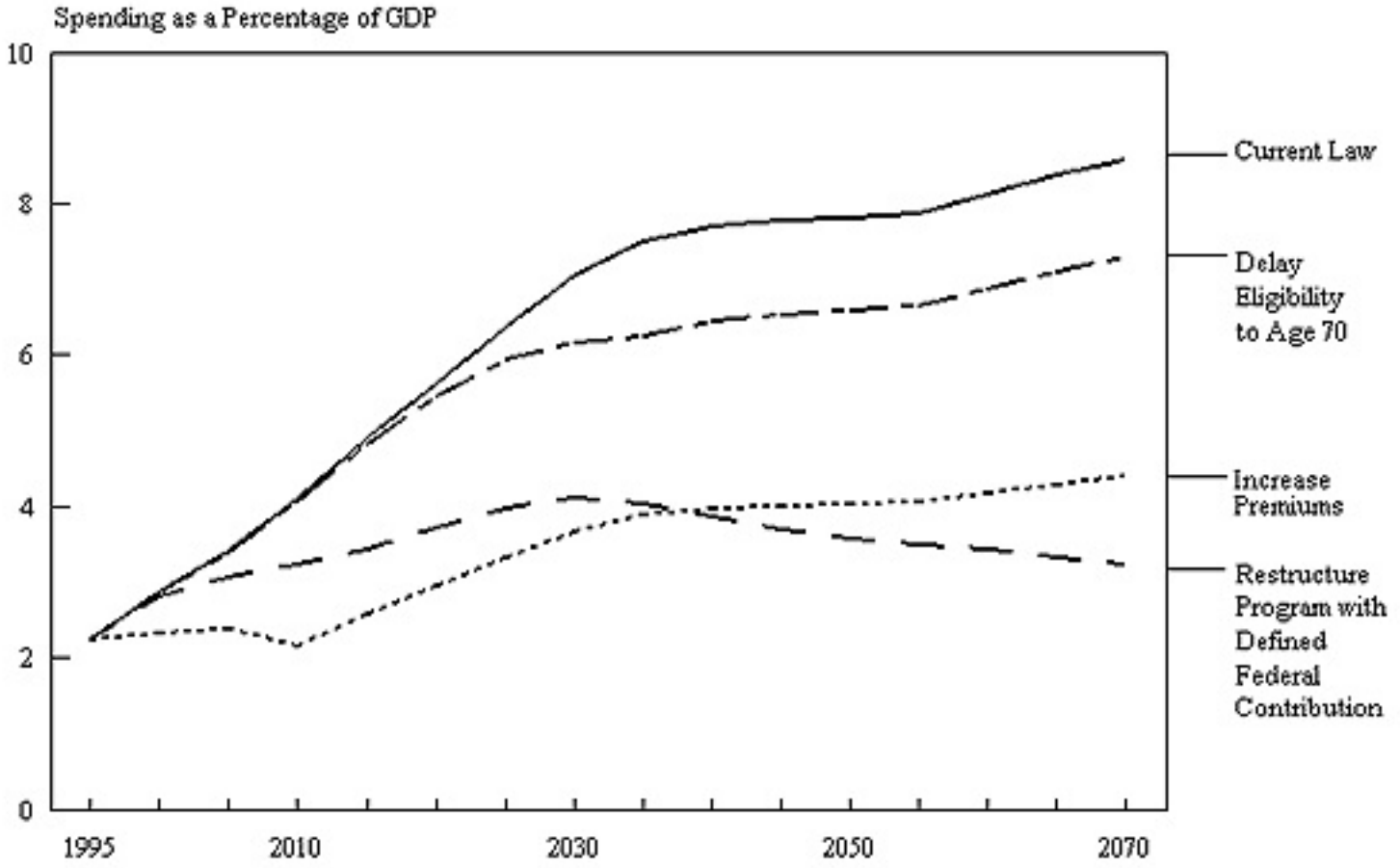
difference between the two. Although federal savings from a change in the Social Security program translate directly into lower benefits paid to recipients, that is not necessarily so for federal savings achieved by changes in the Medicare program. In particular, changes that would reduce payments to health care providers would not necessarily reduce health care benefits for enrollees if those payments were used to deliver health care more efficiently.

If federal spending for Medicare could be kept from growing more rapidly than the economy when the baby boomers become eligible, the long-term outlook for the federal deficit and for the economy would improve dramatically. The illustrative goal used to develop the options that I will discuss today was to prevent net federal spending for Medicare as a percentage of GDP from exceeding 4.1 percent--its projected level in 2010 under current law. Stabilizing the ratio of spending to GDP provides a convenient yardstick. Yet, in view of the magnitude of the demographic shift that will take place, it is not necessarily an appropriate goal. Reasonable people may differ about what proportion of GDP is appropriately spent on health care for the Medicare population. To achieve similar effects on the deficit, smaller reductions in Medicare spending than those discussed here could be combined with reduced spending in other government programs or with tax increases.

Medicare has been highly successful in achieving its original objective--ensuring access to mainstream medical care for the aged and (later) the disabled. Unfortunately, though, Medicare's costs have become increasingly burdensome to the economy. In 1996, Medicare's spending--net of premiums paid by enrollees--was 2.4 percent of GDP. If no changes are made in current law, net spending would reach 8.6 percent of GDP by 2070, according to projections made by Medicare's trustees. Underlying those projections is an assumption that growth in Medicare's spending per beneficiary will gradually slow between 2005 and 2020 to be more in line with growth in national income per capita. That assumption may be optimistic, though, since no policies designed to achieve that result are currently in place.

Three fundamental approaches exist for slowing the long-term growth in federal spending for Medicare. The Congress could reduce the number of people eligible for benefits, collect more of the costs from beneficiaries without changing Medicare's structure, or restructure Medicare to reduce total health care costs per beneficiary (see Figure 2 for the estimated effects on net Medicare spending under a specific example for each of those approaches).

Figure 2.
Net Medicare Spending as a Percentage of GDP Under Alternative Options



SOURCE: Congressional Budget Office based on the Medicare trustees' reports for 1996.

NOTES: GDP=gross domestic product.

Data are plotted at five-year intervals.

One way to reduce the number of people eligible for benefits would be to increase the age of eligibility from 65 to 70. That approach would ultimately reduce federal spending for Medicare by about 15 percent compared with current law. Despite those considerable savings, net spending would continue to grow after 2010 as a percentage of GDP, reaching 7.3 percent of GDP by 2070. Further, that approach would do little to lower total health care costs, and it would lengthen the period of time in which people who opted for early retirement under Social Security might have difficulty getting private insurance coverage.

Under the second approach, premiums collected from beneficiaries could be increased to cover 50 percent of Medicare's costs (for both Parts A and B). Nearly all of those collections would represent federal savings because enrollees' premiums cover only about 10 percent of costs now, and that share will fall steadily after 1998 under current law. Using that approach would keep net Medicare spending as a share of GDP from rising above the target level until 2060. However, increasing premiums would shift costs to beneficiaries rather than constrain the growth in total health care costs. Without any changes to improve the efficiency of the Medicare program, premiums would consume an ever larger share of enrollees' income.

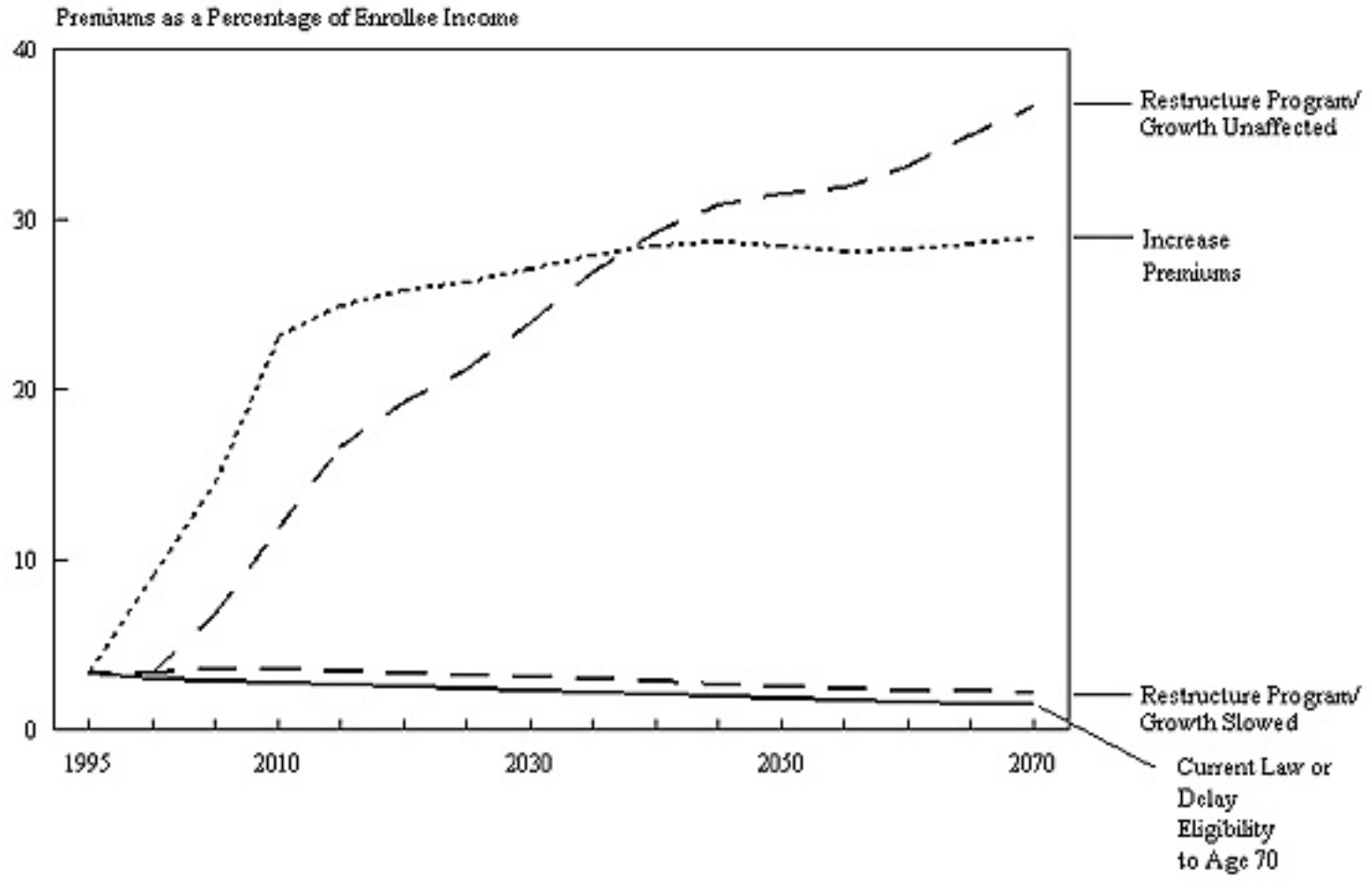
Indeed, Medicare premiums would equal nearly 30 percent of enrollees' income by 2070, compared with 3.4 percent in 1995.

A third approach to slow the growth of federal Medicare spending would be to restructure the program, giving patients and providers greater incentives to make cost-effective choices. One way to do that would be to set up a system of competing health care plans and limit growth in the amount that Medicare would contribute toward the premiums charged by the various plans. In such a restructured system, Medicare's fee-for-service sector could be one of the plans, competing for enrollees on the same basis as all other plans. Because enrollees would be responsible for any excess premium amounts (and would receive rebates for plans costing less than Medicare's contribution), they would have financial incentives to be prudent purchasers of health plans. Also, because plans would be at risk for any costs above their predetermined premium collections, they would have financial incentives to operate efficiently. Control of federal Medicare spending would be assured because the financial risks from higher growth in health care costs would be shifted to health plans and enrollees. Although the federal subsidy per enrollee would be smaller than it is under current law, competition among plans and providers could spur efficiency and increase real health benefits per dollar spent.

For example, Medicare's defined contribution could be set to equal net spending per enrollee in 2000, increased by 6 percent a year through 2005, 5 percent a year through 2010, and 4.2 percent a year thereafter. Under that option, federal savings would amount to 42 percent of currently projected spending by 2030 and 62 percent by 2070. That approach would keep federal spending from exceeding the target through 2030, and would keep it below the target in later years. Consequently, growth in the federal contribution might be increased (up to 4.9 percent a year) once the baby-boom generation had been fully absorbed.

However, the effects of that approach on total costs for a basic benefit package--and therefore on the costs that beneficiaries would face--are uncertain. If the incentives that would be generated for more cost-conscious behavior reduced annual growth in total costs per enrollee only to the rate assumed by Medicare's trustees under current law, premiums paid by enrollees would steadily increase--reaching 37 percent of their average income by 2070 (see Figure 3). If, instead, growth in costs per enrollee was slowed to match the annual growth in the federal defined contribution, premiums would represent only 2.2 percent of the average income of enrollees in 2070.

Figure 3.
Premiums as a Percentage of Enrollee Income Under Alternative Options



SOURCE: Congressional Budget Office based on the Medicare trustees' reports for 1996.

NOTE: Data are plotted at five-year intervals.

In practice, the effects would probably differ among various enrollee groups. Some basic plans would keep their costs low enough to avoid having to charge supplemental premiums, but access to providers and quality of services available in those plans might limit their appeal primarily to low-income enrollees. Higher-income enrollees might gravitate instead to plans that charged supplemental premiums and provided better access and quality.

Costs must be reduced substantially if net federal spending for Medicare is to be limited as a percentage of GDP (see Table 3). To keep net spending at or below 4.1 percent of GDP, savings equal to about 50 percent of currently projected spending must be generated annually from 2010 onward. By contrast, the maximum savings expected from the Balanced Budget Act of 1995 were only about 20 percent of projected Medicare spending for the 1996-2002 period.

TABLE 3.
EFFECTS OF THREE ILLUSTRATIVE OPTIONS FOR REDUCING GROWTH IN NET SPENDING

FOR MEDICARE (In percent)

Option	2010	2030	2050	2070
Net Federal Spending as a Percentage of GDP				
Continue Current Law	4.1	7.1	7.8	8.6
Delay Eligibility to Age 70[a]	4.1	6.2	6.6	7.3
Collect 50 Percent of Costs from Premiums[b]	2.2	3.7	4.1	4.4
Restructure the Program and Limit Growth in Defined Contribution to 4.2 Percent a Year[c]	3.3	4.1	3.6	3.2
Savings as a Percentage of Projected Spending				
Delay Eligibility to Age 70[a]	1	13	16	15
Collect 50 Percent of Costs from Premiums[b]	47	48	48	49
Restructure the Program and Limit Growth in Defined Contribution to 4.2 Percent a Year[c]	21	42	54	62

SOURCE: Congressional Budget Office based on the Medicare trustees' reports for 1996.

a. The age of eligibility for Medicare would be increased to 70 by 2032, phased in from 2003.

b. Premiums for Medicare enrollees would be increased to cover 50 percent of total Medicare (HI and SMI) costs by 2010.

c. Medicare's per-enrollee contribution in 2000 would be set at total per capita costs less 25 percent of Part B costs. That amount would be increased by 6 percent a year through 2005, 5 percent a year through 2010, and 4.2 percent a year thereafter.

CONCLUSION

Exactly how much budgetary stringency is needed and how to achieve it are open to debate. What is clear is that Medicare must prepare for the unprecedented demands that the baby-boom generation will soon impose on it. Policies put in place over the next several years could provide necessary deficit reduction in the short term and start the restructuring needed for the longer term.

Although federal spending for Medicare could be reduced by increasing the premiums or cost-sharing requirements imposed on beneficiaries, that approach by itself, without changing the options available, could threaten access to medical care for some enrollees. It would reduce federal costs by shifting them to beneficiaries (or to Medicaid, for dually-eligible beneficiaries) with little improvement in the mechanisms that might limit growth in the total costs of care.

Broader policy goals would be served by putting policies in place that would slow the growth in total (not just federal) costs of services used by Medicare beneficiaries. Such

policies would encourage both beneficiaries and health care providers to make more cost-effective choices than many do now. If successful, that approach would reduce the resources used for health care while ensuring that enrollees would have continued access to medical care. Whether such efficiencies would be achieved, however, is uncertain and would depend on the policies adopted. The one certainty is that Medicare will come to consume an enormous share of national income unless significant changes are made in the program.