CBO
TESTIMONY

Statement of
Joseph R. Antos
Assistant Director for Health and Human Resources
Congressional Budget Office

2010 and Beyond: Preparing Medicare for the Baby Boomers

before the
Special Committee on Aging
United States Senate
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NOTICE
This statement is not available for public release until it is delivered at 1:30 p.m. (CDT), Monday, August 25, 1997.

Mr. Chairman and Members of the Committee, thank you for the opportunity to discuss the challenge of preparing Medicare for the influx of new beneficiaries when the baby-boom generation begins to reach age 65. The recently enacted Balanced Budget Act of 1997 represents a significant effort to place Medicare financing on a sound basis for the next 10 years. But it only begins to address the much larger financing problems that Medicare will face after 2010. More fundamental program reforms will surely be required to meet those challenges.

MEDICARE FINANCING THROUGH 2007

The Medicare program finances the health care of 38 million elderly and disabled

Americans, spending over $200 billion for benefits in 1997. It is the second largest entitlement program; only Social Security is larger. The growth of Medicare spending has long been substantially faster than that of other major federal programs and of the economy. Although the growth of Medicare spending has slowed since the late 1980s and early 1990s, the Congressional Budget Office (CBO) projects that it will continue to outpace the growth of resources that finance it.

Financial Soundness of the Medicare Program

The Congress and the President have taken steps in the Balanced Budget Act of 1997 to slow the growth of Medicare spending. That act reduces Medicare spending by $385 billion over the next 10 years--a cut that will lower the growth of spending for Medicare benefits to about 7.4 percent a year on average between 1997 and 2007. Unfortunately, Medicare will continue to grow faster than the overall federal budget or the economy (see Table 1). Over the next 10 years, Medicare spending will total more than $3 trillion.

Table 1.
Medicare Spending Compared with Total Federal Outlays and the Economy (By selected fiscal year)

	Outlays (Billions of dollars)				Average Annual Rate of Growth (Percent)		
	1980	1990	1997	2007	1980-1990	1990-1997	1997-2007
Medicare Mandatory Outlays[a]	34	107	209	428	12.2	10.0	7.4
Total Federal Outlays	591	1,253	1,612	2,361	7.8	3.7	3.9
Gross Domestic Product[b]	2,719	5,683	7,955	12,379	7.7	4.9	4.5

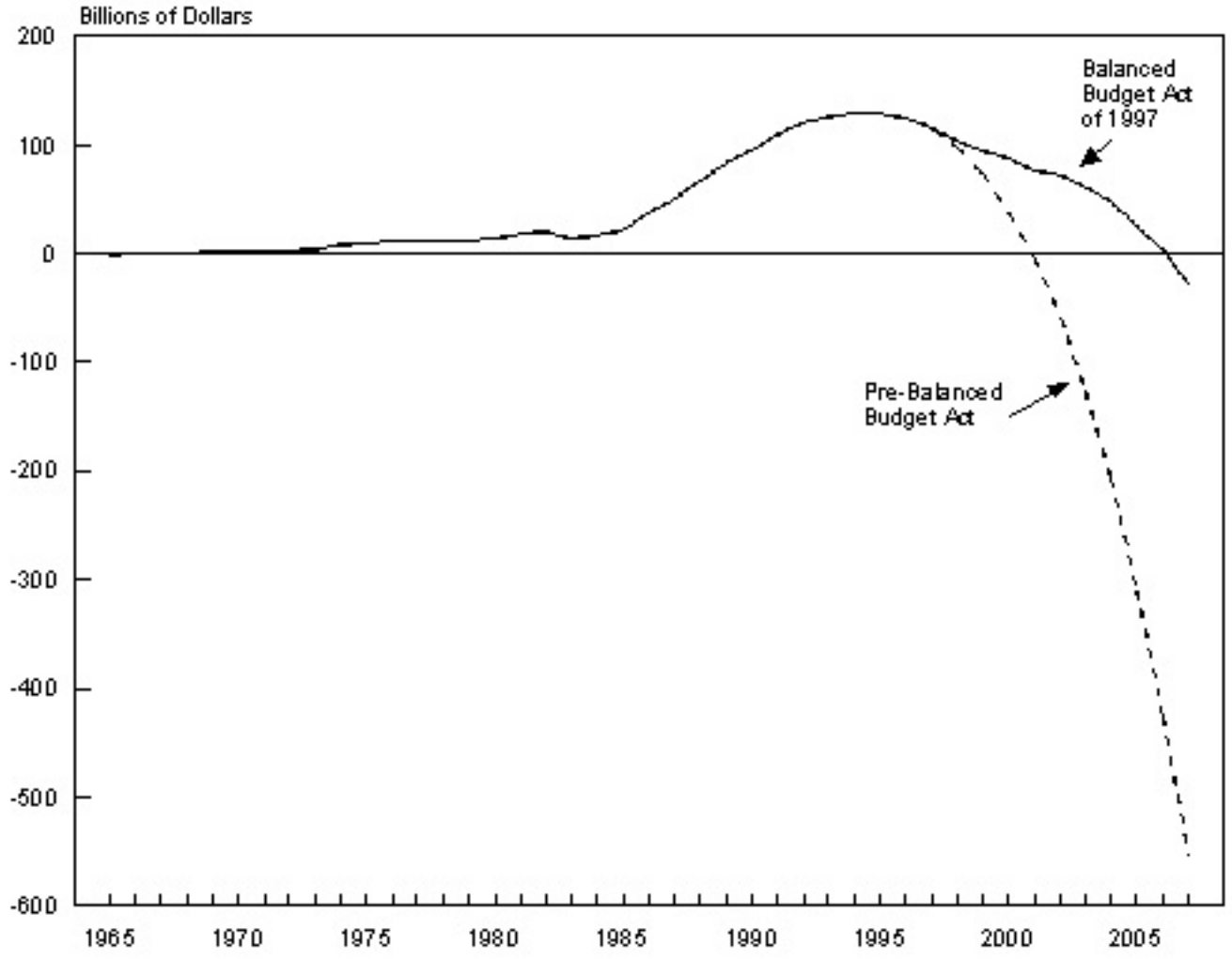
SOURCE: Congressional Budget Office.

a. Includes benefits plus mandatory outlays for administration.

b. Gross domestic product for 2007 is based on current law before the Balanced Budget Act of 1997 was enacted.

The Balanced Budget Act also extends the solvency of the Hospital Insurance (HI, or Part A) trust fund. HI is financed through a payroll tax paid by current workers and their employers, and the HI trust fund represents the accumulated flows of HI payroll taxes and payments for HI benefits and other expenses. CBO previously projected that the HI trust fund would be depleted--that is, the trust fund balance would fall to zero--in 2001. That depletion date has now been extended to 2007 (see Figure 1). In other words, major policy changes must be made within a scant 10-year period if Medicare is to be a fully functioning program when the baby-boom generation first becomes eligible for benefits.

Figure 1.
Hospital Insurance Trust Fund Balance, Fiscal Years 1965-2007



SOURCE: Congressional Budget Office based on intermediate assumptions from the 1997 Medicare trustees' report.

The solvency of the HI trust fund is, of course, only a partial indicator of Medicare's financial health. Supplementary Medical Insurance (SMI, or Part B) is funded by premiums and general tax revenues. Since general-revenue financing is uncapped, the SMI trust fund cannot be depleted. But SMI outlays have grown faster than general revenues and are projected to continue that faster growth. Consequently, SMI is no more financially sound than is HI.

Sources of Spending Growth

The rapid growth in Medicare spending that has occurred since the 1980s, and that is projected over the next 10 years, reflects increases in three factors: the number of beneficiaries, the volume of medical services delivered to beneficiaries, and the costs of those services. Most of the spending growth stems from the rise in the volume and costs of medical services, which increases Medicare spending per beneficiary, rather than exceptional growth in the number of beneficiaries.

Indeed, the number of Medicare beneficiaries will be growing at a historically slow rate over the next 10 years (see Table 2). At the same time as a relatively small cohort of Depression-era babies are retiring, a much larger group of baby boomers will be in their prime earning years. Those demographic trends provide very favorable circumstances over the next decade for financing Medicare and, in particular, the HI trust fund.

Table 2.
Medicare Enrollment and Workers per Enrollee (By selected calendar year)

	1975	1985	1995	2005	2010	2030
Enrollment (Millions)	24.2	30.2	37.1	42.5	46.7	75.1
Workers per Enrollee	4.1	4.0	3.8	3.6	3.4	2.2
Average Annual Rate of Growth in Enrollment from Preceding Year Shown (Percent)	n.a.	2.2	2.1	1.4	1.9	2.4

SOURCES: Congressional Budget Office and Medicare Board of Trustees (using the intermediate assumptions).

NOTE: n.a. = not applicable.

Incentives built into traditional Medicare are driving the rapid growth in program spending. Despite recent growth in enrollment in Medicare health maintenance organizations (HMOs), most beneficiaries remain in fee-for-service Medicare, which provides only limited financial incentives to encourage prudent use of services. Cost-sharing requirements are fairly low, and most beneficiaries have supplemental coverage that pays that cost sharing. Providers have little incentive to limit the number or cost of the services they provide under the fee-for-service system, and they know that insurance is picking up all or most of the bill. Moreover, Medicare does not realize the savings possible from managed care because federal payments to HMOs are linked to costs in the fee-for-service sector.

Key Provisions of the Balanced Budget Act of 1997

The Balanced Budget Act changes some of the current program incentives for spending growth and lays the groundwork for future Medicare restructuring. The act gives Medicare beneficiaries new opportunities to enroll in a variety of health plans under Medicare+Choice or remain in the traditional fee-for-service program. Medicare+Choice plans encompass the whole range of plans now available to privately insured people, including HMOs, point-of-service (POS) plans, preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service plans, and plans operated in conjunction with medical savings accounts (MSAs). The act establishes an annual open-enrollment process, and beneficiaries will receive comparative information about the options available to them.

Payment rates to Medicare+Choice plans are adjusted to reduce the current large differences in payment between plans in high-cost urban areas and those in lower-cost rural settings. But those payments remain linked to costs in the fee-for-service sector, which blunts the

incentive for plans to operate efficiently and limits the ability of Medicare to realize savings from those efficiencies.

Payments to health care providers in fee-for-service Medicare are scaled back from the levels anticipated under prior law. In addition, the act establishes new payment methods for nursing facilities, rehabilitation hospitals, outpatient hospital and therapy services, and home health services. Prospective payment will replace cost reimbursement, which may provide some incentives for providers to furnish services in a more efficient manner.

The act shifts over $170 billion in home health spending from HI to SMI between 1998 and 2007. That step is an accounting change rather than a reduction in Medicare spending or a restriction on home health services. Coupled with reductions in payments to hospitals and other providers of services covered by HI, however, the shift extends the depletion of the HI trust fund to 2007. Beneficiaries receiving home health visits under SMI will not be subject to a copayment.

In addition, premiums paid by beneficiaries for SMI will increase, reflecting two changes. First, the premium will be maintained at 25 percent of program costs after 1998, rather than declining as a share of costs as it would under prior law. Second, the shift of some home health services from HI to SMI will cause the premium to increase gradually over seven years.

THE LONG-TERM OUTLOOK

Although the federal budget will be balanced in 2002 as a result of the Balanced Budget Act, 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.

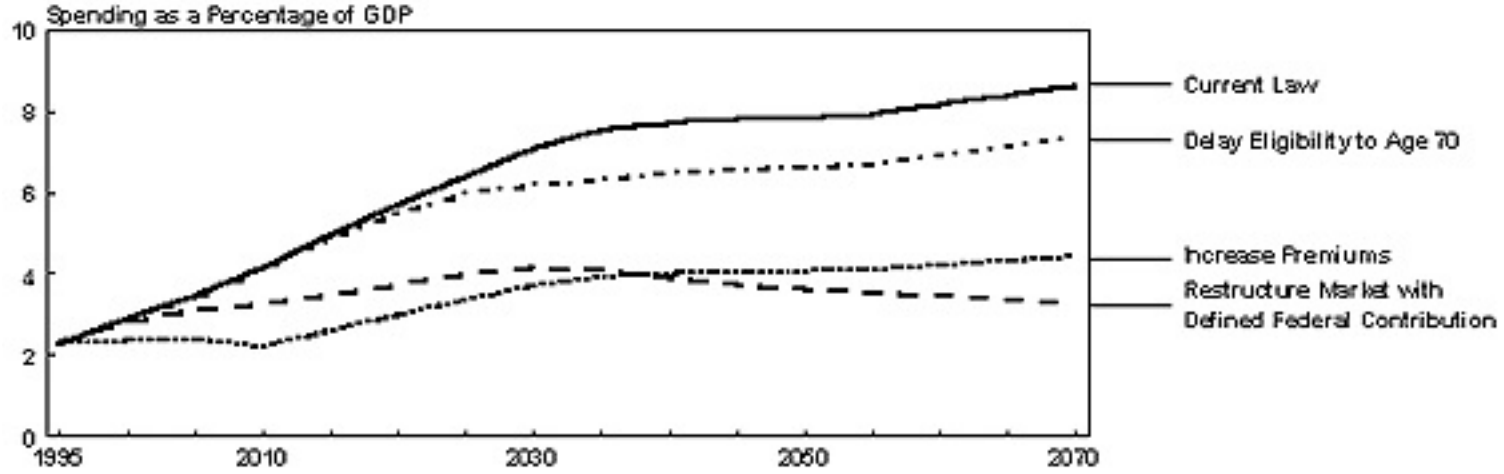
In 1996, federal spending for Social Security and Medicare exceeded $500 billion, which was about 7 percent of gross domestic product (GDP). By 2030, when most baby boomers will have retired, those two programs will consume nearly twice as large a portion of national income as they do today--almost 14 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 at a much brisker pace 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.

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. The following discussion focuses

on the estimated effects on net Medicare spending under a specific example for each of those approaches (see Figure 2). (The estimates were completed before the Balanced Budget Act was passed, and thus they overstate spending levels somewhat.)

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: Estimates based on current law before the Balanced Budget Act of 1997 was enacted.
GDP = gross domestic product. Data are plotted at five-year intervals.

CBO's yardstick for comparison was whether the options would keep federal spending on Medicare from growing more rapidly than the economy. Specifically, we used the illustrative goal of limiting net federal spending for Medicare to 4.1 percent of GDP--roughly the level projected for 2010. That yardstick is somewhat arbitrary and does not represent a judgment regarding the desirable level of Medicare spending over the long term.

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 almost 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.

Substantially increasing premiums collected from beneficiaries would also limit federal spending for Medicare. The option we examined was to increase premiums enough to cover 50 percent of Medicare's costs (for both Parts A and B). That would represent a dramatic, perhaps unacceptable, increase: enrollees' premiums cover only about 10 percent of total costs now. Using that approach would keep net Medicare spending as a share of GDP from rising above the target level until 2060. However, raising premiums would shift costs to beneficiaries rather than constrain the growth in total health care costs. Without any changes

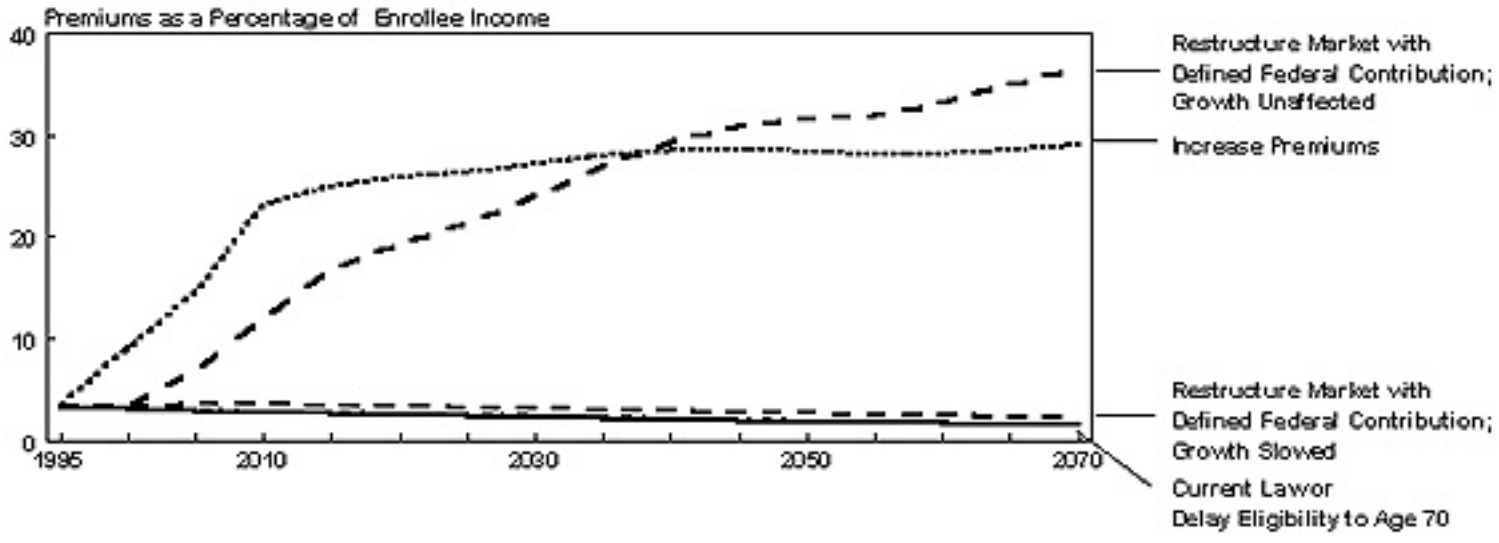
to improve the efficiency of the Medicare program, premiums would consume an ever larger share of enrollees' income. Indeed, Medicare premiums would equal nearly 30 percent of enrollees' income by 2070, compared with 3.4 percent in 1995.

A third approach to slowing 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 to 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 not anticipated when they determined their premiums, 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.

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 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, the 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: Estimates based on current law before the Balanced Budget Act of 1997 was enacted.
Data are plotted at five-year intervals.

In practice, the premiums paid by various enrollee groups would vary depending on their choice of health plan. Some basic plans would keep their costs low enough to avoid having to charge supplemental premiums but would undoubtedly tightly restrict access to providers and services. Other plans that charged supplemental premiums could provide wider access and more services. Low-income beneficiaries, including those who are eligible for Medicaid, would find their choices limited to lower-cost plans.

In any case, 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 savings expected from the Balanced Budget Act of 1997 are only about 13 percent of projected Medicare spending for the 1998-2007 period.

Table 3.
Effects of Three Illustrative Options for Reducing Growth in Net Spending for Medicare (In percent, by calendar year)

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.

NOTE: Estimates based on current law before the Balanced Budget Act of 1997 was enacted.

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

Taming the acceleration in Medicare spending has been a long-standing focus of policymakers. The sharp debates over the past three years reflect how difficult it is to limit growth of that large and popular program. But financing problems in the near term will be dwarfed by the crisis that could occur as the baby-boom generation reaches age 65.

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) without establishing mechanisms that might limit growth in the total costs of care.

Broader policy goals would be served by putting policies in place that would lower 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.