Statement of

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Total Medicare outlays have been growing at an average annual rate of 17.7 percent since 1970, largely because of rapidly rising medical care costs, and Congressional Budget Office (CBO) projections suggest continued high growth. This projected growth in outlays threatens the solvency of the Hospital Insurance (HI) trust fund, which is financed almost exclusively by payroll taxes. As indicated in a CBO report prepared for this Committee, without changes in current law the HI trust fund would be depleted by 1988 and, by the end of 1995, would have a cumulative deficit of about $300 billion (see Figure 1).[1]

The urgency of the HI financing problem has overshadowed the equally serious problems in the other part of Medicare--Supplementary Medical Insurance (SMI). Although SMI does not face insolvency in its trust fund, because transfers from general revenues are required by law, its increased outlays--which account for about one-third of total Medicare expenditures--are adding significantly to the federal deficit.

My testimony today will discuss:

- the factors that contribute to growth in Medicare outlays and the scope of the problem facing both portions of Medicare in the next few years; and
- the tradeoffs among general options for dealing with the problem.

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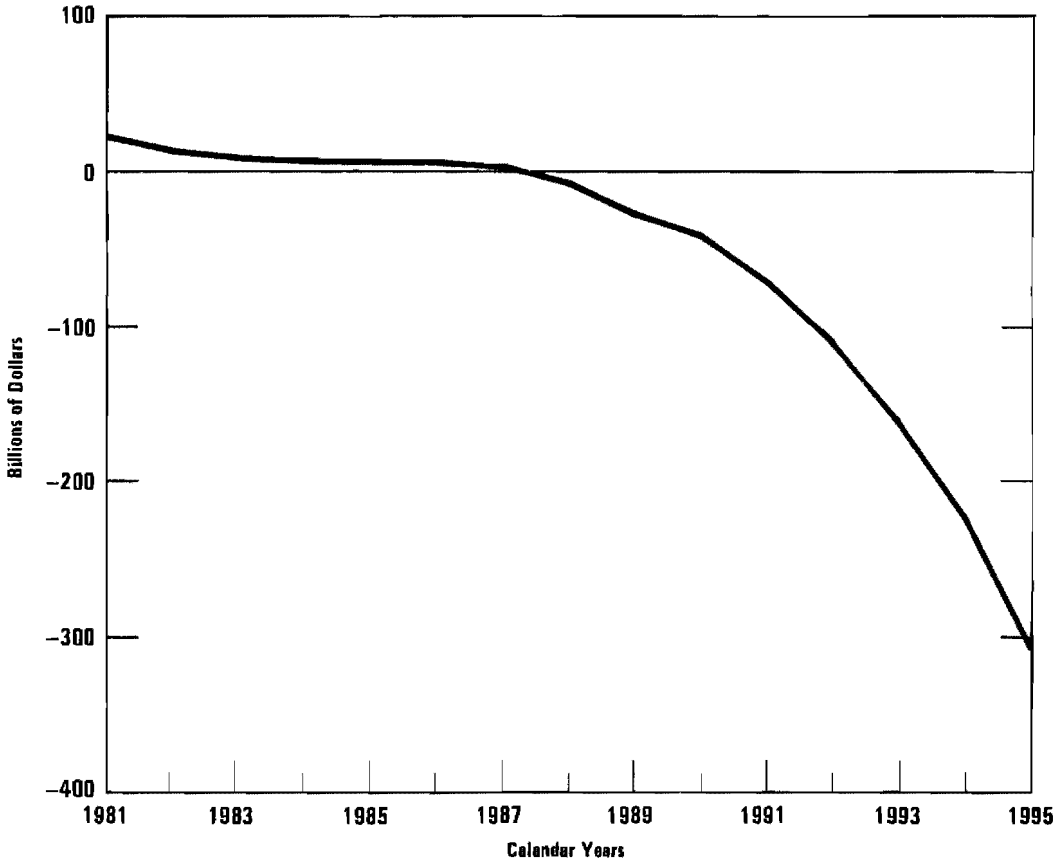
1. The recent passage of the Social Security Amendments of 1983 has resolved some of the uncertainty about the projected size of the deficit, making the $300 billion estimate contained in the CBO report more relevant than the report's $400 billion estimate. For a discussion of the general HI financing problem, see Special Committee on Aging, U.S. Senate, Prospects for Medicare's Hospital Insurance Trust Fund, 98:1 (March 1983).

Figure 1.

End-of-Year Balances in the Hospital Insurance Trust Fund



SOURCE: Preliminary CBO estimates.

NOTE: The figures presented here assume that the hospital reimbursement payment rates created under the Social Security Amendments of 1983 will be updated yearly so as to maintain the same level of stringency as would have occurred if the Tax Equity and Fiscal Responsibility Act of 1982 had been extended.

THE NATURE AND SCOPE OF THE PROBLEM

Medicare serves as the principal insurer of acute health care expenditures for 29 million elderly and disabled persons. It reimburses hospitals and most other providers directly for the costs of covered services used by enrollees--with HI paying for short-stay hospital inpatient care and SMI covering physician visits, outpatient services, and other miscellaneous medical care. In fiscal year 1982, Medicare outlays totalled $50 billion, $35 billion of which was for HI.

Hospital Insurance

In HI, most of the projected growth in outlays stems from higher expenditures per person, rather than growth in the number of beneficiaries.[2] For example, over the 1982-1995 period, hospital costs attributable to Medicare beneficiaries are projected to grow at an average annual rate of 13.2 percent, of which growth in the number of beneficiaries and their increasing age explain only 2.2 percentage points. Slightly over half of the higher per capita expenditures is expected to come from rising prices that hospitals pay for labor and other inputs. The remainder is due to increased services provided per patient and higher rates of admissions to hospitals.

The projected HI deficit results from the fact that the earnings that are taxed to provide the fund's revenues are projected to grow much more slowly than hospital costs--7.0 percent per year compared to 13.2 percent.

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2. The term "beneficiaries" is used here to refer to all those enrolled in Medicare and not just those actually receiving covered services.

As a consequence, despite the significant program cuts enacted in 1981 and 1982, balances in the HI trust fund will start declining in 1984 and be depleted within four years.

Supplementary Medical Insurance

Like HI, outlays under SMI are also projected to increase rapidly, by almost 16 percent per year through 1988. This growth is expected to result from increases in the amount paid for each service, more services delivered per beneficiary, and changes in the mix of services toward more costly procedures.

Financing for SMI--in contrast to HI--is based on premiums paid by enrollees and on appropriations from general revenues. The monthly premiums (now at $12.20) are currently set so as to ensure that beneficiaries pay approximately 25 percent of the costs of SMI. After 1985, however, the premium increases will again be limited to the increase in the Consumer Price Index. Between 1972 and 1982, this limitation led to a decline in the share of SMI outlays covered by premiums from the originally legislated 50 percent to the current share of 25 percent. Since, by law, appropriations from general revenues to SMI must be sufficient to guarantee solvency of the trust fund, SMI does not face a financing crisis per se. Rather, concern arises over this part of Medicare because the projected growth of SMI is so much higher than the growth of general revenues--that is, federal tax revenues not earmarked for specific purposes.[3]

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3. This primarily includes personal and corporate income taxes and excludes payroll taxes used to support Social Security and unemployment insurance, for example.

Under current projections, general revenue contributions would have to rise about 17 percent per year to finance the growth in SMI (Figure 2 illustrates the projected growth in SMI outlays and premiums).[4] Such growth would increase the share of these revenues from 3.7 percent to 5.7 percent of federal tax revenues not earmarked for other uses. If general revenue contributions to SMI were restricted to a rate of growth that would leave their share of general revenues unchanged, outlays would have to be reduced by almost $27 billion over the 1984 to 1988 period.

OPTIONS FOR MEDICARE

Medicare's financing problems reflect the increasing medical care costs occurring throughout the health care system. In 1982, 10 percent of the gross national product was devoted to medical care, up from only 6 percent in 1965. Since Medicare finances services purchased from the private sector without any restriction on the beneficiary's choice of provider, systemwide changes in the delivery of medical care may be necessary to slow the growth of Medicare outlays.

Since most broad reforms that would control system costs are not likely to have a major impact on Medicare outlays in the short run, it will also be necessary to make program changes that directly affect outlays or revenues. Moreover, the deficit in the HI trust fund is of such a magnitude

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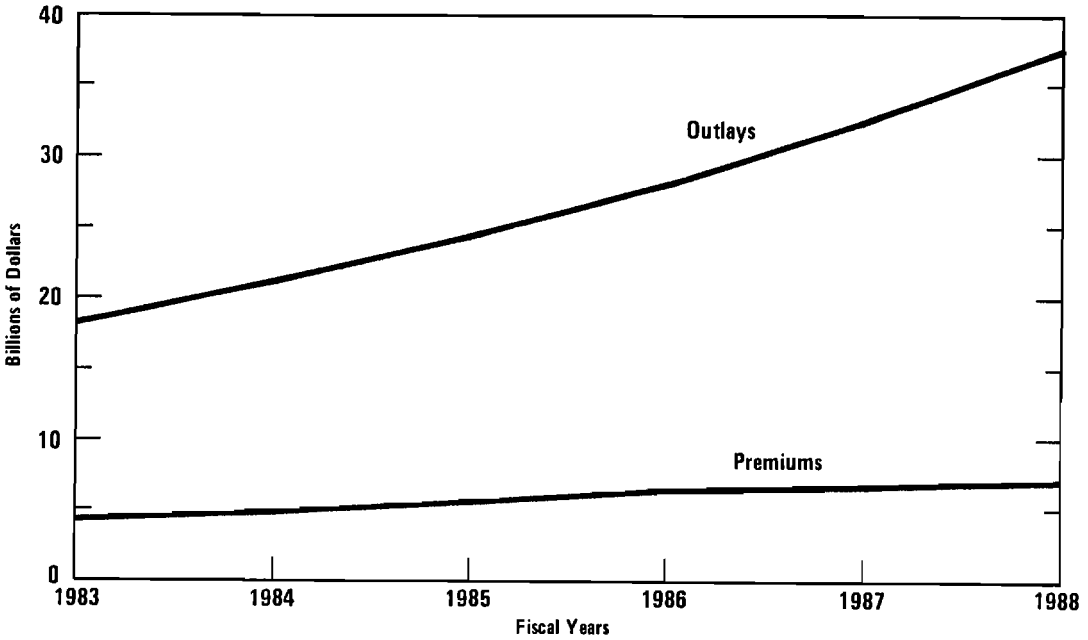
4. The 17 percent figure is higher than the projected increase in outlays of 16 percent because SMI premiums are scheduled to grow at a slower rate after 1985 when, under current law, they will again be limited by the growth in the Social Security cost-of-living increase. For the three-year period 1983-1985, premiums will be set to fund 25 percent of incurred costs.

Figure 2.
Projected Growth in SMI Outlays and Premiums



SOURCE: Congressional Budget Office.

that resolving it through any single change in Medicare is unlikely to be politically acceptable. Some combination of available options will likely be required, affecting three basic groups--providers, beneficiaries, and taxpayers.[5]

Reductions in Reimbursement to Providers

One major strategy for reducing the growth of Medicare outlays would limit the amounts that Medicare pays providers--that is, hospitals and physicians. To the extent that costs of providing services would be shifted

5. The impacts on the federal budget of various illustrative options are shown in the Appendix.

to other payers, however, this approach would pass the effects of the cuts onto other users of health care.

Changes in Hospital Reimbursement. In the last year, the Congress has enacted major revisions in Medicare hospital reimbursement. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) reduced reimbursements substantially and initiated a transition toward a prospective reimbursement system. The 1983 Social Security Amendments speeded the move to prospective reimbursement and chose diagnostic related groups (DRGs) as the basis of payment. Prospective reimbursement carries strong incentives for hospitals to contain costs, since hospitals that provide less costly care can keep the difference between their reimbursements and actual costs, while less efficient hospitals do not recoup all their costs.

But the legislation left unresolved a major question--how tight the prospective rates are to be after 1985. This is to be decided by the Secretary of Health and Human Services, advised by an independent Commission. By 1985, reimbursements are projected to be about 9 percent below the level they would have been if they had continued to be based on actual costs. The Secretary might choose to maintain this 9 percent gap, or might continue to tighten the limits further, for example by continuing the formula specified for 1984 and 1985.[6] While successive tightening of reimbursements would cut federal outlays substantially, if applied only to

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6. This formula of "market basket plus one" allows reimbursements to increase at the rate of growth of increases in hospital input prices plus 1 percent.

Medicare reimbursements and not to those of other payers, it would run a substantial risk of reducing beneficiaries' access to quality care.

Changes in Physician Reimbursement. Currently, the level of reimbursement received by physicians under SMI is based on "reasonable" charges, which may not exceed the lowest of physicians' actual charges, their customary charges for that service, or the applicable prevailing charges in the locality. Since 1976, annual increases in prevailing charges have been limited by an economic index designed to cut growth of physicians' reimbursements. By 1981, average reimbursable charges were 32 percent lower than actual submitted charges.

One way to cut federal costs further would be to apply more stringent limits to the growth of "reasonable" charges. For example, the Administration has proposed freezing all physicians' reimbursement rates for one year.

Alternatively, there could be more basic changes in the structure of reimbursements for particular services or types of physicians. For example, the growth in fees for surgery could be limited for several years. Many contend that our medical care system overemphasizes surgery and other acute procedures relative to primary care. Changing relative reimbursements could influence this mix of medical services.

As long as physicians are not required to accept assignment, however--that is, as long as they are permitted to charge patients in excess of

"reasonable" charges--budget savings from reduced reimbursements might be achieved mostly at the expense of higher costs for beneficiaries. To avoid this, limits on growth in physicians' fees could be combined with a change in rules concerning assignment. Physicians could be required to accept assignment or encouraged to do so by paying higher reimbursements to those who do. While these options could limit the additional charges that would be passed on to beneficiaries, they could also result in some physicians refusing to participate in Medicare, thereby limiting beneficiaries' access to care.

Changes in the Benefit Structure

Beneficiaries are now required--under both portions of Medicare--to share some of the costs of covered services. Hospitalized beneficiaries must pay a deductible amount in each benefit period, but are not liable for additional cost-sharing until they have been confined more than 60 days. Under SMI, the most important cost-sharing is the 20 percent of each covered service that must be paid by the beneficiary once a relatively small deductible has been met.

Beneficiaries could pay a greater share of the costs of Medicare-covered services, however--through higher premiums, deductible amounts, or coinsurance,[7] for example. Such changes could generate large amounts of federal savings, although they would do so by substantially increasing out-

7. Coinsurance refers to a beneficiary's liability for a percentage of the costs of each unit of medical care.

of-pocket costs for the elderly and disabled.[8] While beneficiaries have not been subject to major increases in cost-sharing to date, they already pay about one-fourth of the rapidly rising costs of Medicare-covered services, and even more for other health services not covered by Medicare.

In general, choosing among strategies for having beneficiaries pay a greater share of costs involves important tradeoffs. For example, increases in costs to beneficiaries across-the-board--such as through premiums--would affect large numbers of beneficiaries, but each by a small amount. HI currently has no premium, and if the goal is to spread the costs among beneficiaries, such a premium might be considered.

On the other hand, options that are tied to the use of medical care services--such as a required payment for each day of hospitalization--might result in somewhat lower use of health-care services, but would concentrate the additional liability on the small portion of beneficiaries who already have the highest medical expenses. Such persons might be protected through catastrophic limits on the liability of any one beneficiary, but this would diminish substantially the federal savings from cost-sharing.

The Administration has proposed several changes that would directly affect beneficiaries, including an increase in the SMI premium and an expansion of hospital coinsurance combined with a catastrophic cap on liability for hospital bills. The SMI premium would rise gradually over time

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8. A wide range of such options is discussed in Changing the Structure of Medicare Benefits: Issues and Options, Congressional Budget Office (March 1983).

to a maximum of 35 percent of average SMI benefits, reducing general revenues required for SMI by $8.6 billion over the 1984-1988 period.

The coinsurance proposal would effectively shift the burden of costs from those who have very long hospital stays to those with shorter periods of hospitalization. The proposal's catastrophic protection would substantially decrease costs for less than 1 percent of Medicare beneficiaries, while increasing coinsurance to the nearly one-fourth of Medicare beneficiaries with hospital stays of less than 60 days. The net result of these effects would be five-year budget savings of $8.4 billion.

Higher Taxes

A third approach to maintain the solvency of the HI trust fund would be increased taxes--higher payroll taxes or transfers from general revenues. But any tax increase implies that current taxpayers would be supporting a level of benefits for Medicare participants that already is well in excess of contributions made by such individuals. Further, if SMI outlays were not also reduced, increased individual and corporate income tax revenues would be required to help finance those benefits. On the other hand, this approach would avoid increasing beneficiaries' out-of-pocket costs for medical services or reducing their access to quality care.

The Payroll Tax. Payroll tax contributions by employees and employers are now scheduled to rise from the current 1.30 percent of covered wages to 1.35 percent in 1985 and 1.45 percent in 1986. Combined with other scheduled increases in Social Security payroll taxes, this means

that rates will increase by 1.9 percentage points, or 31 percent, between 1975 and 1990. Further increases could cover the HI trust fund deficit, but might have adverse effects on employment, since the costs to employers of hiring workers would rise. Moreover, Social Security payroll taxes are already accounting for an increasing share of total federal revenues--rising from 26 percent in fiscal year 1980 to 33 percent in 1988--and this approach would exacerbate this trend.

General Revenue Financing. General revenues could be used to aid HI, as well as to maintain SMI at its projected levels. Medicare benefits, unlike Social Security retirement benefits, are not related to the amount of payroll contributions made by beneficiaries, and hence might appropriately be financed by taxes from all sources. This approach would not change the overall tax burden compared to increased payroll tax rates, however; it would merely redistribute it. Moreover, the projections of continued high federal deficits imply that higher taxes of various sorts might be needed to replace revenues used to finance Medicare.

CONCLUSION

The projected growth in Medicare outlays poses problems for controlling the federal deficit and for ensuring the solvency of the HI trust fund--a problem whose magnitude, without changes in current law, will continue to expand for the foreseeable future. The size of reductions in outlays or increases in taxes that would be required to bring HI into balance over time suggest the importance of considering a combination of approaches to spread the burden among providers, beneficiaries, and tax-

payers. For example, if the HI deficit were to be eliminated only through lower benefits, Medicare beneficiaries would have to pay a coinsurance rate of 33 percent on hospital days 2 through 60 by 1995--a retrenchment in Medicare that few would support.

In addition to these Medicare-oriented approaches, a long-term solution to the problem of rising medical care costs would probably require changes affecting the entire medical care system. Efforts to enhance competition--even if not directly affecting Medicare--might ultimately accomplish some systemwide cost reductions. For example, limits on the amount of tax-free medical benefits that employers may provide could help discourage excessive use of medical services and lead to slower growth in prices for all users of medical care. In addition, paying hospitals through some form of prospective system could be instituted for all payers--rather than just for Medicare. Such approaches would add an additional set of options--but ones that would affect all participants in the health care system.

Thus, the available options can be placed in three groups, each of which poses difficult tradeoffs. Raising taxes could leave Medicare intact but only at considerable cost to taxpayers. Obtaining savings exclusively through increased Medicare cost-sharing or reduced reimbursements could lead to a second-class system of care for the aged and disabled. Systemwide attempts to contain medical care costs could ultimately result in slower expansion in services to most users of health care, although the impact on health care is unpredictable.

APPENDIX

The following table displays a number of options for reducing HI and SMI outlays from the Congressional Budget Office publication Reducing the Federal Deficit: Strategies and Options, as well as preliminary CBO reestimates of the Administration's budget proposals that were discussed in the text. These alternatives are meant to be illustrative; in practice, the stringency of the options could be varied to produce more or less savings.

The savings resulting from the different options cannot be added to a grand total. Many of them are alternatives, only one of which could be enacted. Furthermore, even if a nonoverlapping group of them were enacted, some would interact with others in ways that would produce results different from those estimated for each option separately.

APPENDIX TABLE. BUDGET SAVINGS FROM PROGRAM CHANGES IN MEDICARE (Outlays in billions of dollars)

Options	1984	1985	1986	1987	1988	Cumulative Five-Year Savings
Change Physician Reimbursement						
Limit Reasonable Charge Growth[a]	b	0.2	0.6	1.1	1.7	3.6
Adopt Fee Schedules for Surgical Procedures[c]	0.2	0.7	0.8	0.9	1.1	3.6
Administration's Proposal for Freezing Physican Reimbursement[d]	0.9	1.1	1.2	1.4	1.6	6.1
Increase Beneficiary Cost-Sharing						
Expand Hospital Coinsurance Days 2-30[e]	2.0	3.0	3.4	3.8	4.3	16.5
Expand Hospital Coinsurance with Cap on Out-of-Pocket Costs for Some[f]	1.2	1.8	2.1	2.3	2.6	10.0
Administration's Proposal to Expand Hospital Coinsurance[g]	0.9	1.5	1.8	2.0	2.3	8.4
Increase SMI Premiums[h]	0.9	1.1	1.7	2.5	3.4	9.6
Increase SMI Premiums for High-Income Families Only[i]	0.2	0.3	0.5	0.7	0.9	2.5
Administration's Proposal to Increase SMI Premiums[j]	-0.2	0.2	1.3	2.8	4.5	8.6
Increase Taxes[k]						
Raise Payroll Taxes[l]	--	--	--	2.9	4.0	6.9

Footnotes to Appendix Table.

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a. Growth in reasonable charges would be limited to the rate of increase in the overall Consumer Price Index.

b. Less than $50 million.

c. Fee schedules for surgical procedures would be set so that allowed charges were reduced by 10 percent.

d. Reimbursements for physicians' services would be frozen in 1984 at their 1983 levels.

e. Hospital coinsurance would be set at 10 percent of the deductible for days 2 through 30, replacing current coinsurance; there would be no limit on the number of covered hospital days.

f. Hospital coinsurance would be set at 10 percent of the deductible for all hospital days after the first, and total HI and SMI cost-sharing liability for beneficiaries with family incomes of less than $20,000 would be limited to $2,000.

g. Hospital coinsurance would be set at 8 percent or 5 percent on days 2 through 60 in a given year, replacing current coinsurance; there would be no limit on the number of covered hospital days.

h. SMI premiums would be increased to 30 percent of average incurred costs for an elderly beneficiary.

i. SMI premiums would be increased to 30 percent of average incurred costs only for beneficiaries with family incomes in excess of $20,000.

j. SMI premiums would be increased gradually to 35 percent of incurred costs, but with an initial delay in any change until January 1, 1984.

k. Similar levels of tax increases could be achieved through general revenues.

l. Payroll taxes would be increased in 1987 by 0.1 percentage point, to 1.55 percent each, for employers and employees.