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PROSPECTS FOR MEDICARE'S HOSPITAL INSURANCE TRUST FUND

AN INFORMATION PAPER

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PREFACE

The financial health of the medicare program is an urgent concern for those interested in the continued access to health care and protection from ruinous medical expenses that medicare helps provide. No other program so widely serves older Americans. Over 95 percent of individuals 65 and over are covered by medicare, and the program paid an average of 45 percent of those persons' annual health care bills in 1980.

This staff information print was prepared at the request of the committee by the Congressional Budget Office. It projects, for the first time in a Government report, the magnitude of the changes that will be necessary to maintain the HI trust fund if increases in hospital costs continue to substantially outpace the overall rate of inflation.

According to the projections in this study, we have at most until the end of the decade to remedy the growing disparity between the costs of health care and the revenues committed to pay for it. Although the projections are indeed sobering, the challenge is clear: Health policymakers, the Congress, and the American public must begin to face the need for health care financing reform, and we have relatively little time in which to do so successfully. This report is a first step to that end.

JOHN HEINZ,
Chairman.
JOHN GLENN,
Ranking Minority Member.

CONTENTS

PROSPECTS FOR MEDICARE'S HOSPITAL INSURANCE TRUST FUND

A. INTRODUCTION

Medicare is comprised of two programs—hospital insurance (HI), which pays for inpatient hospital care, stays in skilled nursing facilities, and home health services, and supplementary medical insurance (SMI), which pays for all other services covered by medicare, principally physician services. The programs are financed through separate trust funds, with distinct sources of revenues.

Revenues for HI come almost exclusively from a portion of the social security payroll tax. Employers and employees covered by the program each contribute 1.3 percent of earnings up to a maximum of $35,700, and the rate is scheduled to increase to 1.35 percent in 1985, and 1.45 percent in 1986.[1] Under current law, general revenues cannot be used to make up any shortfall between outlays required to pay benefits and trust fund balances.

In contrast, SMI revenues are obtained from both premiums and general revenues. The premium amount ($12.20 per month now, and $13.50 per month after July 1, 1983) is set by law, with a contribution from general revenues making up the difference between premium income and outlays. In 1983, general revenues required to meet SMI outlays will total $14.2 billion, or 74 percent of SMI funding.

Projections of outlays and income for the HI trust fund indicate serious financing problems later in this decade. Continued solvency of this program through 1995 will require either outlay reductions that are much larger than any program options currently under discussion, or very substantial increases in revenues. Projections of growth in SMI outlays are also alarming. Though the solvency of SMI is not at issue because of the program's ability to tap general revenues, the appropriation required by 1988 is expected to amount to $31.9 billion a year.

This memorandum presents projections of the HI trust fund through 1995 and explains the factors causing the imbalance between income and outlays. It then illustrates the magnitude of the imbalance by estimating the degree of outlay reduction and tax increase options required to avoid depletion of the trust fund. All of the numbers that follow are for calendar years.

B. PROJECTIONS OF HI TRUST FUND BALANCES

Balances in the HI trust fund are projected to be exhausted during 1987. Though the HI balance was a substantial $18.7 billion at the end of 1981, borrowing by the old-age and survivors insur-

[1] The maximum increases each year in accordance with the increase in average wages.

ance (OASI) trust fund reduced the HI balance to $8.3 billion at the end of 1982 (see table 1 and figure 1). This already low balance is projected to decline slowly through 1986 and rapidly in ensuing years, as outlays exceed income by a widening margin.[2] Annual program deficits—that is, the excess of a year's outlays over that same year's income—will reach $8.6 billion in 1987, when the balance is exhausted, and they will increase to $24.2 billion in 1990 and to $73.8 billion in 1995 (see figure 2).[3] Though CBO's projection period ends in 1995, deficits under current law are likely to continue to grow thereafter.

TABLE 1.—PROJECTIONS OF HOSPITAL INSURANCE TRUST FUND OUTLAYS, INCOME, AND BALANCES

[In billions of dollars]

Calendar year	Outlays	Income [1]	Annual surplus [2]	Yearend balance
1981	$30.7	$35.7	$5.0	$18.7
1982	36.0	25.6	−10.4	8.3
1983	41.1	41.6	−0.5	8.8
1984	46.2	44.8	−1.4	7.5
1985	51.0	49.5	−1.5	5.9
1986	60.0	56.3	−3.7	2.2
1987	68.5	59.7	−8.6	−6.5
1988	77.0	63.1	−12.9	−20.4
1989	86.6	66.3	−18.1	−40.7
1990	97.4	69.2	−24.2	−68.9
1991	109.5	71.7	−31.6	−106.7
1992	123.0	73.5	−40.0	−156.3
1993	138.2	74.7	−49.7	−219.8
1994	155.4	75.1	−60.9	−300.1
1995	174.8	74.1	−73.8	−400.9

[1] Income to the trust funds is budget authority. It includes payroll tax receipts, interest on balances, and certain general fund transfers. In years when balances are negative, income includes negative interest, which is the amount that would be paid by the trust fund on hypothetical borrowings required to continue benefit payments. Income in 1982 reflects $12.4 billion in interfund transfers from the HI trust fund to the OASI trust fund.

[2] Excluding any negative interest.

Note.—Minus signs denote deficits.

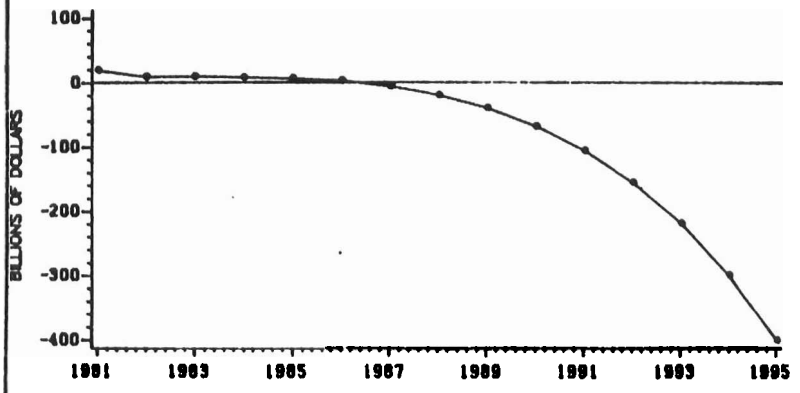
Source: Preliminary CBO estimates.

[2] These estimates assume that no additional interfund borrowing by the old-age and survivors insurance trust fund (OASI) (beyond the $12.4 billion conducted through December 31, 1982) will occur, but that past borrowing will not be repaid. Any additional interfund borrowing from HI to OASI that is not repaid by 1987 would hasten the depletion of balances, whereas repayment of the entire borrowing by that date would delay depletion only until 1988.

[3] These estimates of annual deficits exclude negative interest, which is the amount that would be paid by the trust fund on hypothetical borrowings after 1986 required to continue benefit payments.

FIGURE 1

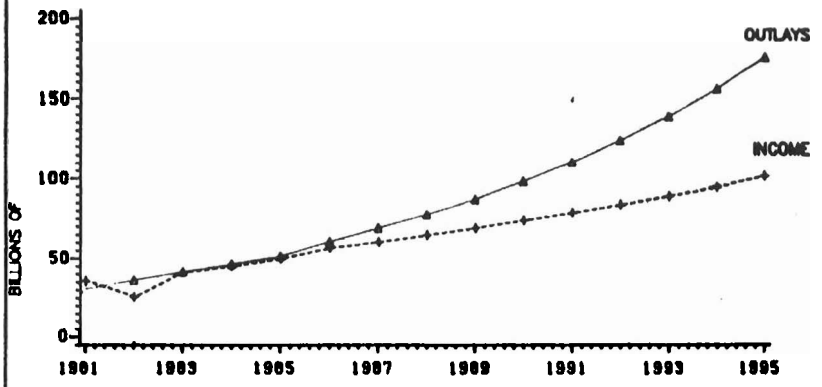
H.I. TRUST FUND BALANCES



NOTES: SEE TABLE 1

FIGURE 2

H.I. TRUST FUND INCOME AND OUTLAYS



NOTES: SEE TABLE 1

These projections assume that hospital reimbursement growth rate limits enacted in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) will not be extended past their scheduled expiration in 1985 and 1986. The committee report indicated, however, that these growth rate limits were interim steps in the direction of adopting a prospective reimbursement system.[4] Future legislation might replace these growth rate limits with other reimbursement changes that would reduce outlays past 1986 as well.

If the TEFRA restrictions were extended so that percentage reductions in reimbursements achieved by the third year—approximately 9 percent below prior law—were continued, depletion of the HI balance would be delayed, but only by 1 year (see table 2). By 1988, the HI trust fund would still be exhausted, with the cumulative negative balance reaching $310 billion by 1995.

TABLE 2.—PROJECTIONS OF HOSPITAL INSURANCE TRUST FUND BALANCES IF TEFRA REIMBURSEMENT LIMITS ARE EXTENDED

[In billions of dollars]

Calendar year	Outlays [1]	Income [2]	Annual surplus [3]	Yearend balance
1985	$50.9	$49.5	$−1.4	$6.0
1986	57.1	56.4	−0.6	5.4
1987	64.3	60.3	−4.0	1.4
1988	72.3	63.9	−8.2	−7.0
1989	81.3	67.5	−12.8	−20.8
1990	91.5	70.9	−18.3	−41.4
1991	102.9	74.0	−24.9	−70.3
1992	115.6	76.5	−32.5	−109.3
1993	129.9	78.6	−41.3	−160.5
1994	146.0	80.1	−51.4	−226.5
1995	164.2	80.4	−63.2	−310.3

[1] Assumes extension of TEFRA growth rate limits past their scheduled expiration in 1985 and 1986, so that the third-year percentage reductions in reimbursements below prior law (about 9 percent) are continued.

[2] Income to the trust funds is budget authority. It includes payroll tax receipts, interest on balances, and certain general fund transfers in years when balances are negative; income includes negative interest, which is the amount that would be paid by the trust fund on hypothetical borrowings required to continue benefit payments. Income in 1982 reflects $12.4 billion in interfund transfers from the HI trust fund to the OASI trust fund.

[3] Excluding any negative interest.

Note.—Minus signs denotes a deficit.

Source: Preliminary CBO estimates.

The HI financing problems stem from the fact that outlays are affected by hospital costs that are growing much more rapidly than the earnings to which the HI tax is applied. Hospital costs attributable to medicare beneficiaries are projected to increase over the 1982–95 period at an average annual rate of 13.2 percent, while covered earnings are projected to grow at an annual rate of only 6.8 percent.[5] With a difference of 6 percentage points per year between the key determinants of HI outlays and income, serious financing problems seem inevitable.

[4] See Tax Equity and Fiscal Responsibility Act of 1982, H. Rept. 97-760, 97th Cong., 2d Sess. (1982).

[5] The projection of hospital costs has three major components: Prices paid by hospitals for labor, capital, and supplies; the resources used per medicare enrollee; and the number of medicare enrollees. The first component is estimated in a straightforward manner from CBO economic assumptions. The second is based on an extrapolation of trends over the last 10 years. The third is based on population projections of the Social Security Administration.

This estimate abstracts from any reductions in hospital costs induced by the reimbursement provisions in TEFRA, focusing only on the underlying cost increases.

1. Outlays

The projected growth in hospital reimbursements is attributable primarily to rising hospital costs, and to a lesser extent, to the aging of the population. Rising hospital costs account for 10.8 percentage points of the 13.2 percent annual projected growth in hospital costs attributable to medicare beneficiaries; aging of the population accounts for 2.2 percentage points.

General inflation is projected to account for a significant portion of the increase in hospital costs. Over the 1982-95 period, an index of hospital input price increases—that is, the prices paid by hospitals for labor, capital goods, and supplies—is projected to increase at an average rate of 6 percent a year. General inflation is not a particular problem for the HI trust fund, however, because it is also reflected in the earnings that are taxed to provide income to the fund.

Another important component of rising costs—roughly 4.4 percentage points per year—reflects changes in practice of medical care affecting the elderly. This includes both a higher hospital admission rate for the elderly and more resources applied per hospital stay. New procedures are continually entering mainstream medical care, and many of them are expensive. For example, coronary artery bypass surgery, experimental in 1970, is now a common procedure. Medicare reimbursements for hospital care alone (excluding surgeons' and anesthesiologists' fees) for this procedure exceeded $15,000 per case in Maryland in 1980, and will probably reach $20,000 in 1983.[6]

Some expensive new procedures have questionable medical effectiveness, let alone cost-effectiveness, however. Examples of new procedures whose effectiveness in certain applications has been questioned by some, include therapeutic plasmapheresis, radial keratotomy, and a number of imaging procedures in cardiology, such as nuclear magnetic resonance, ultrasound, radionuclide scanning, and digital subtraction angiography.

Although aging of the population also accounts for some of the increase in HI outlays, the contribution of this factor is somewhat smaller than is commonly believed. The number of persons aged 65 and over is expected to grow by 2 percent a year over the 1982-95 period,[7] and the average age of the elderly population is also expected to increase. HI reimbursements increase with age, with beneficiaries aged 85 and older accounting for almost double the reimbursements per enrollee of those aged 65 to 69.[8] Nevertheless, the aging of the elderly population is a slow process, and it explains only 0.2 percent per year of reimbursement growth. Combining the growth in enrollment by the elderly with the cost implications of the aging of this population accounts for reimbursement growth of 2.2 percent a year.

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[6] See Harold Cohen, Margaret Skolnick, and Arlene Stephenson, "The Financing of Coronary Artery Bypass Surgery," Circulation, vol. 66, No. 5 (November 1982), pp. III-49 to III-55.

[7] Calculated from the "1981 Social Security Trustees Report, Alternative II."

[8] See Health Care Financing Administration, "Medicare Summary: Use and Reimbursement by Person, 1976-1978" (August 1982).

2. INCOME

Turning to the income side of the HI problem, the projection of an average 6.8 percent growth rate in earnings that are subject to the HI payroll tax reflects a forecast of the near-term performance of the economy and assumptions of moderate growth thereafter. Though the estimates for 1983 and 1984 were developed using the most recent CBO economic forecast, which reflects the current recession, those for later years assume moderate noncyclical growth with gradually declining inflation. Whether the projected growth path is attainable with tax and spending policies now in place is uncertain, however.[9]

Though the current recession is reducing income to the HI trust fund, it does not account for the long-term financing problem. Unemployment reduces HI income by diminishing the earnings pool that is taxed. Each 1 percent increase in the unemployment rate reduces HI income by about $1 billion in 1984, or 2.5 percent. Thus, if the current recession had not occurred, the balance in the HI trust fund would have been higher, and its depletion would not be projected to occur quite so soon. But the basic financing problem of HI derives from the large gap between the rate of growth in hospital costs attributed to medicare beneficiaries and the earnings that are taxed to support HI.

C. MAGNITUDE OF THE TRUST FUND DEFICIT

The HI trust fund deficit is so large that treating the underlying problem of rapidly rising medical-care costs will probably have to be an important part of any long-run solution to medicare's financing problems. If costs are not controlled, a difficult choice between substantial retrenchments in the program and large tax increases will be necessary.

To gain an understanding of how large the HI deficits shown in tables 1 and 2 are, this section examines the trust fund impact of four medicare options that are often discussed:

—Increased hospital coinsurance.
—Prospective reimbursement.
—Payroll tax increases; and
—General revenue financing.

For each case, CBO has calculated the magnitude of the policy change required to maintain solvency and examined the implications of such changes. To simplify, the term "solvent" is used here to denote a trust fund balance that is not negative.

Many additional policy options are likely to be considered by the Congress when it takes up the long-term medicare financing issue, some of which may be preferred to the ones considered here. The options examined here to illustrate the magnitude of the financing problem were chosen because they are well known, the magnitude of their trust fund impact is relatively easy to estimate, and the degree of their stringency can be varied.

The projected differences between outlays and revenues are so large, however, that the illustrative options would have to be im-

[9] For more detail, see Congressional Budget Office, "The Outlook for Economic Recovery" (February 1983), chapter III.

plemented with much greater degrees of stringency than is contemplated in current discussions. Combining a number of options would, of course, reduce the required stringency for any one option, but still leave each harsher than current discussions have contemplated—if not by 1995, then only a few years later.

1. Increased Coinsurance

Under current law, beneficiaries admitted to a hospital, pay a first-day deductible amount ($304 in 1983) once for each spell of illness; this deductible amount represents the average cost to medicare of a hospital day. Beyond that, they have no responsibility for the cost of medicare-covered services for the next 59 days. This deductible amount represents the average cost to medicare of a hospital day. Outlays could be reduced by requiring the beneficiary to pay a proportion of the cost of days after the first. The administration, for example, has proposed coinsurance for the second through 15th day of care equal to 8 percent of the deductible, and for the 16th through 60th day of care equal to 5 percent.[10]

Coinsurance, through a combination of transferring costs to beneficiaries and adding incentives to discourage hospital use, could reduce outlays enough to maintain solvency throughout the period under study (see table 3), but the amount required would be very large—much larger than the degree proposed in the President's budget. By 1995, a coinsurance rate of 36 percent of the deductible amount would be required (or 33 percent, if the TEFRA limits are extended).[11] If catastrophic protection were offered, or if low-income beneficiaries were required to pay only part of the copayment, the coinsurance rate would have to be substantially higher.[12] Alternatively, the same reduction in outlays could be achieved by a $167 monthly HI premium per enrollee. But either approach would require even greater cuts in benefits each year after 1995. Many would regard this as a major retrenchment in medicare's provision of both financial protection and access to care for the elderly and disabled.

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[10] See Budget of the United States Government, Fiscal Year 1984, p. 5–105. The administration also proposed to improve catastrophic coverage by limiting required deductibles and coinsurance to 60 days per calendar year.

[11] This estimate assumes that coinsurance reduces use of hospital services for those without private supplemental coverage or medicaid. The 36-percent rate discussed might reduce hospital days per capita for those without supplemental coverage by about one-third. The proportion of beneficiaries with private coverage would probably change in response to high coinsurance requirements, but the direction, let alone the magnitude, is difficult to predict. The analysis assumes that the proportion of beneficiaries with either private coverage or medicaid would remain unchanged.

The estimate also assumes that increased coinsurance would have no effect on the medical care system. By reducing medicare beneficiaries' use of hospital services, coinsurance might slow the rise in the cost of hospital care. This would lower the required coinsurance rate somewhat.

[12] For additional discussion of coinsurance options, see the forthcoming CBO study of the medicare benefit structure.

TABLE 3.—HOSPITAL COINSURANCE REQUIRED TO MAINTAIN SOLVENCY IN HI TRUST FUND THROUGH 1995, IN PERCENTAGES OF THE FIRST-DAY DEDUCTIBLE AMOUNT[1]

Calendar year	No extension of reimbursement limits [2]			Extension of reimbursement limits [2]		
	Coinsurance rate [3]	Average additional beneficiary liability [4]	Outlay reduction (billions of dollars)	Coinsurance rate [3]	Average additional beneficiary liability [4]	Outlay reduction (billions of dollars)
1987	9	$240	$7.6			
1988	14	400	12.9	10	$250	$8.1
1989	18	550	18.1	13	390	12.8
1990	21	725	24.2	17	550	18.3
1991	25	930	31.6	21	730	24.9
1992	28	1,150	40.0	24	940	32.5
1993	31	1,400	49.7	27	1,170	41.3
1994	33	1,690	60.9	30	1,420	51.4
1995	36	2,000	73.8	33	1,720	63.2

[1] While some working balances are required to pay claims in a timely manner, the definition of solvency used for this analysis is avoidance of a negative trust fund balance

[2] See table 2 for definition

[3] Percent of the 1-day deductible applied to second through sixtieth day of a spell of illness

[4] Average over all beneficiaries. For those with a spell of illness, the average additional liability would be about four times the number in the table

2. Prospective Reimbursement

Under prospective reimbursement, medicare would determine in advance the rate at which hospitals are paid. A major step in that direction was taken in TEFRA and, in a recent report to the Congress, then-Secretary of Health and Human Services Schweiker proposed a prospective system based on diagnostic related groups.[13]

Though the administration's prospective reimbursement proposal does not include enough detail to project its long-run impact on the HI trust fund, calculations similar to those for hospital coinsurance can be made to estimate how tight the prospective rates would have to be if negative trust fund balances were to be avoided. Maintaining solvency by prospective reimbursement alone would require hospital payments to average 42 percent less by 1995 than they would have been under cost reimbursement, or 38 percent less than if the TEFRA limits had been extended. Looked at from another viewpoint, if prospective reimbursement began in 1985 and the rates were set to require the same outlays as under TEFRA in that year, the rates per hospital admission could then increase at only the rate of general inflation (as measured by the "hospital market basket") less 1.6 percentage points per year. This would be 5 percentage points per year less than projected under cost reimbursement.[14]

The feasibility and desirability of such restraint in the growth of reimbursement is questionable. If prospective reimbursement were limited to medicare, a large gap would occur between what hospitals would get paid for serving private patients and what they would get paid for serving medicare patients. By making medicare

[13] See Richard S. Schweiker, "Report to Congress: Hospital Prospective Payment for Medicare," U.S. Department of Health and Human Services (December 1982).

[14] These estimates assume that prospective reimbursement would cover all costs, including those for capital and for teaching. While current proposals such as the administration's exclude the latter two, most analysts regard their inclusion as necessary over the long term to avoid significant distortions in the use of capital.

patients financially unattractive to hospitals, this would reduce access. Hospitals might specialize, with some providing the standard of care permitted by private reimbursements, and others providing the lower standard of care permitted by medicare reimbursements.

Alternatively, prospective reimbursement could be applied to all payers, as is now done in a few States (for example Maryland and New Jersey) under waivers from medicare. In this case, the problem of two standards of care would be avoided, but the question of the desirability of the standard of care that is permitted by the reimbursement rates would have to be addressed. Though many analysts believe that economies could be found in hospital functions that would not sacrifice the quality of care, there is a point at which further rate reductions would lower the effectiveness of services.

3. Coinsurance and Prospective Reimbursement

Combining these two approaches could allow solvency to be maintained with lesser stringency in each. Combinations are possible because coinsurance tends to reduce the number of hospital admissions while prospective reimbursement reduces costs per admission. To the extent that each would shorten length of stay, however, the reduction in the stringency of each option if they were combined would not be so great as it might appear on the surface.[15]

If half of the required outlay reductions were obtained from each approach, the required coinsurance rate would be 18 percent by 1995, while the prospective rates per admission would increase by general inflation plus 1.6 percentage points per year.[16] The latter would represent an annual 1.7-percentage-point reduction from the rate projected under cost reimbursement.

4. Higher Payroll Tax Rate

Alternatively, HI solvency could be maintained by raising the payroll tax rate. Under current law, the HI tax paid by both employer and employees is scheduled to rise from its current rate of 1.30 percent of covered earnings to 1.35 percent in 1985, and to 1.45 percent in 1986. As is shown in table 4, maintaining solvency through tax increases alone would require a steadily increasing tax rate, reaching 2.54 percent by 1995, or 2.38 percent if the TEFRA reimbursement limits were extended.[17] The required rate would continue to increase thereafter. When added to the 6.2 percent tax rate now scheduled for the two social security trust funds that provide cash benefits, a payroll tax rate substantially larger than has been experienced in this country would be required, raising questions about employment and inflationary effects and about the impact on workers' take-home earnings.

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[15] If coinsurance reduced the average length of stay, then earlier discharge would be less available as an option to hospitals looking for ways to reduce costs in response to the incentives of prospective reimbursement.

[16] The required coinsurance rates and average liability per beneficiary can be obtained by taking one-half of the respective amounts in table 3.

[17] The calculations do not take into account any employment effects, or impacts on inflation, of the higher tax rates.

TABLE 4.—HI TAX INCREASES REQUIRED TO MAINTAIN TRUST FUND SOLVENCY THROUGH 1995, IN PERCENTAGES OF COVERED EARNINGS AND BILLIONS OF DOLLARS[1]

Calendar year	Current law tax rate[2]	No extension of reimbursement limits[3]		Extension of reimbursement limits[3]	
		Required tax rate	Additional revenues	Required tax rate	Additional revenues
1987	1.45	1.64	$7.6	1.45	
1988	1.45	1.75	12.9	1.64	$8.1
1989	1.45	1.85	18.1	1.73	12.8
1990	1.45	1.95	24.2	1.83	18.3
1991	1.45	2.06	31.6	1.93	24.9
1992	1.45	2.17	40.0	2.04	32.5
1993	1.45	2.29	49.7	2.15	41.3
1994	1.45	2.41	60.9	2.26	51.4
1995	1.45	2.54	73.8	2.38	63.2

[1] While some working balances are required to pay claims in a timely manner, the definition of solvency used in this analysis is avoidance of a negative trust fund balance.
[2] Percent of covered earnings paid each by employer and employee. Current rate is 1.30 percent, scheduled to increase under current law to 1.35 percent in 1985 and 1.45 percent in 1986.
[3] See table 2 for definition.

5. General Revenue Financing

Instead of a higher payroll tax rate, general revenues could be used to make up the difference between currently scheduled revenues and outlays. Given the deficit problem in the Federal budget as a whole, however, and the large size of the required infusion of revenues—$73.8 billion per year by 1995 ($63.2 billion if the TEFRA limits are extended) and more each year thereafter—this option would require increased general tax revenues. Thus, the major differences between raising the HI tax rate and using general revenue financing would come down to who pays the additional taxes.[18]

6. Increased Coinsurance, Prospective Payment, and Higher Payroll Tax Rates

Less stringent versions of these three options could be combined to achieve trust fund solvency. If each closed one-third of the gap between outlays and revenues, the required coinsurance rate would be 12 percent by 1995, the prospective reimbursement formula would allow payments per admission to increase by general inflation plus 2.4 percentage points per year, and the HI tax rate would be 1.76 percent by 1995.

D. CONCLUSION

Under current law, balances in the HI trust fund are expected to be depleted by 1987 or 1988. Because the cumulative projected deficit is so large—$300 to $400 billion by 1995—maintaining solvency through 1995 will require substantial policy changes. Avoiding deficits through policies to reduce outlays would require actions significantly more stringent than any being discussed today. Alternative-

[18] A comparison of the relative merits of payroll taxes versus general revenues is beyond the scope of this memo. For a discussion, see John A. Brittain, "Payroll Taxes for Social Security," Brookings, 1972.

ly, taxes could be increased, but the magnitude of the rate increases would have to be very large. Even solving the medicare financing problem by combining a number of such options would require greater changes than many observers now contemplate.

Alternatively, steps might be taken outside of the program to slow the rate of increase in medical costs. This, in turn, would reduce the magnitude of the required program changes. Possible measures range from those that would increase the degree of competition between medical providers—such as changing the tax treatment of employer-paid health insurance—to more comprehensive regulation than prospective reimbursement applied to all payers. To solve the problem in this way, however, would also require bolder measures than contemplated today.

O