STATEMENT OF

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MEDICARE FINANCING PROBLEMS[1]

Medicare provides coverage of acute health care expenditures for 29 million elderly and disabled individuals. It consists of two separate programs. Hospital Insurance (HI) pays for inpatient hospital care, stays in skilled nursing facilities, and home health services, whereas supplementary medical insurance (SMI) pays for all other services covered by Medicare, principally physician and hospital outpatient services. The programs are financed through separate trust funds, with distinct sources of revenues. In fiscal year 1983, Medicare outlays totaled almost $57 billion, of which nearly $39 billion was for HI.

Total Medicare expenditures have been growing at an average annual rate of 17.7 percent since 1970 and the program faces serious financing problems for the foreseeable future. Under current policies, the HI trust fund could be depleted as early as the end of the decade, and revenue contributions required to support physician benefits will continue to rise as a proportion of general revenues.

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. This testimony was prepared by Marilyn Moon of the Human Resources and Community Development Division, Congressional Budget Office.

THE NATURE AND SCOPE OF THE PROBLEM

Health care spending in the United States has been growing rapidly both in absolute terms and as a percentage of gross national product (GNP). National health spending rose from 7.5 percent of GNP in 1970 to 10 percent in 1983. Projections show national health spending reaching 12 percent of GNP by the end of the decade.[2]

The financing problems in both parts of Medicare stem from the fact that payments to medical providers are expected to grow much faster than the federal revenues available to support them. The projected growth in outlays is attributable primarily to rising medical care costs, and to a lesser extent to the aging of the population.

The Hospital Insurance Problem

In HI, the year-end balances will decline each year as annual outlays exceed annual income. Deficits will be small at first but will then increase rapidly. The cumulative deficit could total over $200 billion by 1995.[3] These projections all assume that present policies remain unchanged, and hence can be used as a "baseline" from which to judge potential changes in the Medicare program.

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2. Mark S. Freeland and Carol Ellen Schendler, "National Health Expenditure Growth in the 1980's: An Aging Population, New Technologies and Increasing Competition," Health Care Financing Review (March 1983), vol. 4, pp. 1-58.

3. The projected deficits depend importantly on economic conditions, hospital prospective payment rates, and other factors influencing health care spending.

The source of the HI problem is the gap between outlays and revenues. Over the 1982 to 1995 period, HI outlays are projected to increase at a 12.4 percent annual rate while revenues are expected to rise at only 8.7 percent per year. Changes enacted since 1982 in the way hospitals are reimbursed, and scheduled increases in the payroll tax earmarked for the HI trust fund, which are reflected in these figures, have slowed the onset of the problem but have not eliminated it.

The Supplemental Medical Insurance Problem

The rapid growth expected in SMI raises a somewhat different problem. Since, by law, appropriations from general revenues to SMI must be sufficient to guarantee the 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 rate of growth of SMI is so much higher than the rate of growth in general revenues--that is, federal tax revenues not earmarked for specific purposes.[4]

As with HI, outlays under SMI are projected to increase rapidly--by almost 16 percent per year through 1988. To finance this increase, general revenue contributions would have to rise even faster--at about 17 percent per year.[5] Thus, the share of federal tax revenues not earmarked for other

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4. These primarily include personal and corporate income taxes, but not payroll taxes such as those used to support Social Security and unemployment insurance.

5. This figure is higher than the projected increase in outlays because premiums paid by SMI enrollees 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. H.R. 4170, now being considered by the House of Representatives, would permanently tie the SMI premium to 25 percent of the costs incurred by an elderly beneficiary.

purposes going to the SMI trust fund would rise from 3.7 percent to 5.7 percent between 1982 and 1988. If the proportion of general revenues going to SMI were held constant at the 1982 level, outlays would have to be reduced by almost $27 billion over the 1984 to 1988 period.

OPTIONS FOR SOLVING THE PROBLEM

Given the magnitude of the problems facing Medicare in the next decade, incremental approaches are unlikely to provide solutions. Moreover, any single change in Medicare large enough to solve the problem might have to be so substantial as to be politically unacceptable. Consequently, some combination of available options will likely be required, affecting three basic groups--providers, beneficiaries, and taxpayers.

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

Hospital Reimbursement. In the last two years, the Congress has enacted major revisions in Medicare hospital reimbursement.[6] This new

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6. 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 system establishes strong incentives for hospitals to contain costs, since hospitals that provide less expensive care can keep the difference between their reimbursements and actual costs, while less efficient hospitals do not recoup all their expenses. 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. While successive tightening of reimbursements would cut federal outlays substantially, it would run a substantial risk of reducing beneficiaries' access to quality care.

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, physicians' reimbursement rates could be frozen for a time. Alternatively, more basic changes could be made in the structure of reimbursements for particular services or types of physicians, emphasizing options that might focus on the volume of services as well as their unit costs.

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--a portion of budget savings from reduced reimbursements would probably be achieved at the expense of higher costs for some beneficiaries. To avoid this, limits on growth in physicians' fees could be combined with a change in rules concerning assignment, although this could 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 $75 deductible has been met.

Beneficiaries could pay a greater share of the costs of Medicare-covered services--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 higher premiums--would affect large numbers of beneficiaries, but each by only a small amount. 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.

Higher Taxes

A third approach to maintain the solvency of the HI trust fund would be increased tax support for the fund--through higher payroll taxes or transfers from general revenues. Reliance on higher taxes would avoid increasing beneficiaries' out-of-pocket costs for medical services or reducing their access to quality care. But any tax increase implies that current taxpayers would be supporting a level of benefits for Medicare

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

participants that already is well in excess of contributions made by the participants. Moreover, payroll tax contributions by employees and employers are already scheduled to increase by 1.9 percentage points between 1975 and 1990--a 31 percent increase--and general revenue contributions for SMI are increasing at 16 percent a year. Further payroll tax increases could cover the HI trust fund deficit, but might have adverse effects on employment, since the costs to employers of hiring workers might rise. Reliance on other revenues would not necessarily change the overall tax burden, but could cause higher deficits or reduce funds available for spending on other programs.

CONCLUSION

The projected growth in Medicare outlays poses problems for controlling the federal deficit and for ensuring the solvency of the HI trust fund--problems which, without changes in current law, will continue 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 taxpayers. 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 system.