Statement of
Edward M. Gramlich
Acting Director
Congressional Budget Office

before the
Committee on Ways and Means
U.S. House of Representatives

September 30, 1987

NOTICE

This statement is not available for public release until it is delivered at 9:30 a.m. (EDT), Wednesday, Sept. 30, 1987.

The Administration has just announced that the 1988 premium for Medicare's Supplementary Medical Insurance (SMI) program will be $24.80 a month, an increase of $6.90 a month over its 1987 value. A relatively large increase had already been anticipated for 1988. This expected raise in premiums was to have resulted partly from increases in payment rates following termination of the SMI physicians' fee freeze, and partly from the artificially low premiums set in 1987 to complete the trustees' deliberate reduction of large reserves in the SMI trust fund. The 38.5 percent increase just announced, however, is considerably larger than the projections both the Health Care Financing Administration (HCFA) and the Congressional Budget Office (CBO) made earlier this year.

My testimony today will cover:

- o The factors that influence the level of the SMI premium, and difficulties in forecasting them;
- o The underlying causes of rapid growth in SMI costs; and
- o The impact of the announced increase on enrollees, as well as possible Congressional responses.

FACTORS THAT INFLUENCE THE LEVEL OF THE SMI PREMIUM 1/

Current law requires that the 1988 SMI premium be set at 25 percent of the average monthly benefit per aged enrollee. Beginning in 1989, however, the SMI premium cannot rise faster in percentage terms than the most recent

1. This section refers to calendar years.

cost-of-living adjustment (COLA) provided for Social Security beneficiaries. 2/ Because the COLA is projected to be noticeably lower than the increase in average SMI costs, this limitation means that after 1988 the increase in the premium will be determined by the COLA.

Because the SMI premium is set in advance each year, the 1988 value must be based on an estimate of the average benefit in the coming year. Further, this estimate must be based on incomplete information about what has occurred in preceding years. 3/ Consequently, considerable uncertainty surrounds any estimate. As will become clear, an appropriate premium, based on the latest information available, could range from nearly $23 to nearly $27 a month.

The SMI Trust Fund

To understand the specific issues involved in choosing a value for the 1988 premium, some background on the operations of the SMI trust fund in recent years is useful. It is especially important to understand how the trust fund's reserve—defined as assets less unpaid expenses—has influenced decisions about the premium.

---

2. The average monthly benefit includes related administrative costs and is adjusted for interest receipts and a contingency allowance that compensates for past projection errors. It is twice the monthly actuarial rate promulgated by HCFA.

3. Currently, near the end of 1987, only information for calendar year 1984 is considered final. Claims for 1986 and, to a lesser extent, for 1985 are still incomplete. Therefore, only estimates of spending are available for those years.

By law, the operations of the SMI trust fund are on an incurred basis—that is, premiums are set so that receipts (enrollees' premiums plus related government contributions) each year will equal the expected costs of services provided during that year. As a result, the trust fund's assets at the end of each year would be just enough to cover anticipated unpaid expenses.

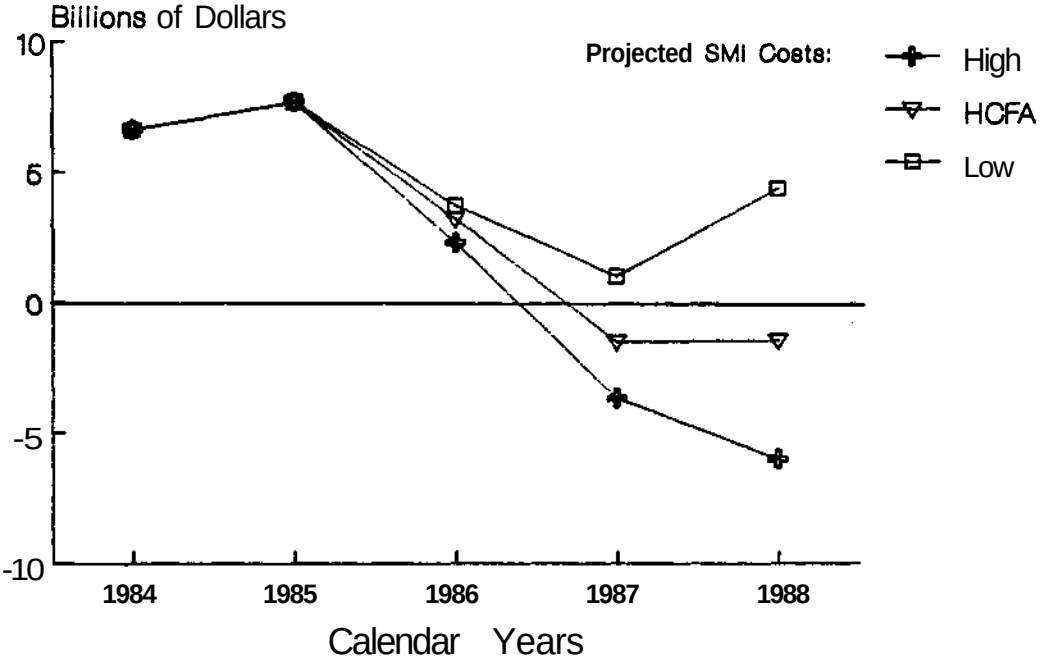
Because projections are subject to error, the trust fund's reserve at the end of the year is not necessarily zero. It is either positive or negative, depending on whether actual costs were lower or higher than projected. In subsequent years, then, the trustees generally incorporate a contingency margin to amortize the cumulative result of previous errors in projection.

The trust fund can accommodate a negative reserve to some extent because of the "float." In particular, revenues flow evenly into the trust fund during the year, roughly matching the rate at which costs for benefits are incurred, but payments for those benefits occur with a lag. Consequently, even when the reserve is about zero, the fund has a positive cash balance of 10 percent to 15 percent of annual payments. A succession of years in which receipts were less than costs would eventually exhaust this trust fund.

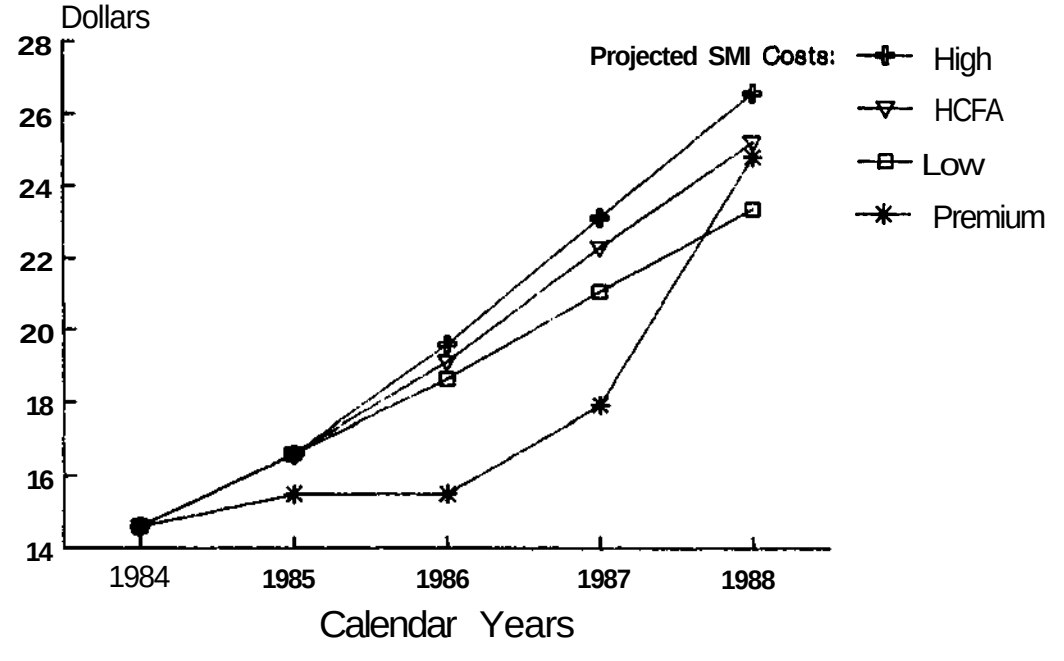
Figure 1 illustrates these concepts by showing the actual experience of the SMI program for 1984 and 1985, as well as alternative projections for 1986 through 1988. Because costs were less than projected for some years

Figure 1.

SMI Trust Fund's Reserve, 1984-1988
(Excess of Assets Over Unpaid Expenses)



SMI Costs Per Enrollee and SMI Premiums, 1984-1988
(Costs Scaled to Match 1984 Premium)



Source: Congressional Budget Office

in the early 1980s, the trust fund's reserve at the end of calendar year 1984 was large. As the top panel of the figure shows, the reserve equaled $6.6 billion, which represented more than 25 percent of expected liabilities for 1985. The bottom panel indicates that, to reduce this surplus, premiums for 1985 through 1987 were raised less rapidly than the growth in costs per aged enrollee.

The 1987 premium was set so that, if actual costs matched the projected ones, the reserve at the end of 1987 would be near zero. It appears, however, that costs for 1987 will be from 6 percent to 16 percent higher than was expected when the 1987 premium was set. As a result, the trust fund's reserve will probably be negative at the end of 1987. In other words, the fund's cash balance, although positive, will be less than unpaid expenses.

Uncertainties in Setting the Premium

Table 1 illustrates some of the uncertainties that enter into setting the premium for 1988. The assumptions underlying the first column would generate a relatively low premium; the second column shows HCFA's estimates; and the third column represents a relatively high premium.

An estimate of future costs is typically based on the latest available information about past costs, but even the value of incurred costs for 1986

TABLE 1. SMI PREMIUM UNDER ALTERNATIVE ASSUMPTIONS, 1988 (In dollars)

	Low	HCFA a/	High
25 Percent of Estimated Incurred Expenditures for 1986	18.30	18.77	19.24
times			
Multiplicative Growth Factor for 1987	1.13	1.17	1.18
equals			
25 Percent of Estimated Incurred Expenditures for 1987	20.67	21.88	22.70
times			
Multiplicative Growth Factor for 1988	1.11	1.13	1.15
equals			
25 Percent of Estimated Incurred Expenditures for 1988	22.95	24.77	26.11
plus			
Value of Interest	-0.05	-0.03	-0.02
plus			
Contingency Margin	0.00	0.07	0.80
equals			
1988 Premium	22.90	24.80	26.89

SOURCE: Congressional Budget Office and Health Care Financing Administration.

a. As announced on September 30, 1987.

is not yet known. 4/ Because enrollees may delay submitting claims for up to 12 months after the end of a given benefit year, a firm assessment of incurred costs for 1986 will not be possible until early in 1988. The only data available promptly are on outlays from the trust fund, which may differ significantly from incurred costs. Thus, the top row of Table 1 gives a range of alternative values for the "premium base" for 1986—that is, for one-fourth of the costs that were incurred in 1986.

Another uncertain factor is the rate of growth in costs since 1986. Estimates of growth during 1987 are influenced by the change in outlays observed in 1987 relative to a comparable period in 1986, but this change may or may not accurately reflect growth in incurred costs. The second row of Table 1 indicates that the 1987 growth rate could be as low as 13 percent; about 17 percent, as assumed by HCFA; or as high as 18 percent. 5/ The third row of the table shows the 1987 base for projecting the 1988 premium that results from these assumptions.

---

4. Because HCFA's current estimate of incurred costs for 1986 is nearly 7 percent higher than it was a year ago, it raises estimates of incurred costs for all future years, including 1987.

5. The range of estimates for growth in incurred costs during 1987 reflects alternative sources of information about current spending that show growth rates for SMI outlays of 19 percent to 22 percent, implying growth rates per enrollee from 17 percent to 20 percent. In addition, some of the observed growth in outlays may reflect carriers having reduced the lag between receipt of claims and payment during 1987. CBO estimates that, because of a speedup in payments, incurred costs have grown two percentage points to four percentage points more slowly than outlays.

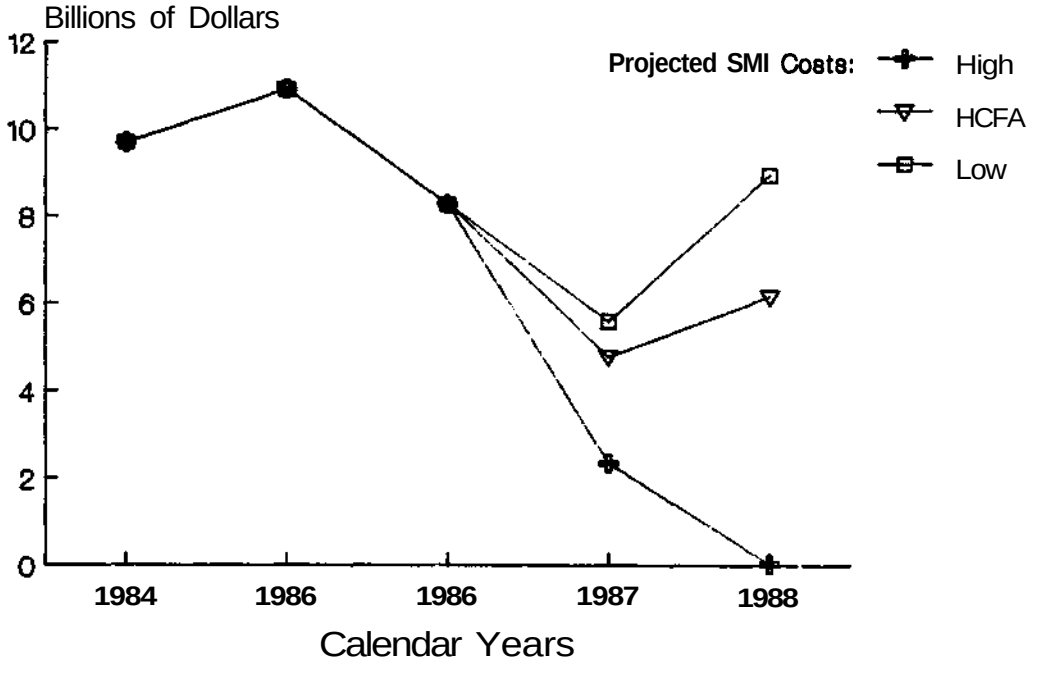
The growth in incurred costs that will occur in 1988 is even more uncertain. As shown in the fourth row of Table 1, HCFA's projection for 1988 is 13 percent, but growth rates of 11 percent to 15 percent are plausible. Note that all of these values are less than the corresponding growth rates in 1987, reflecting an assumed return toward historical growth patterns subsequent to the freeze period. The fifth row in the table shows the 1988 base that would result under each of these assumptions, and the sixth row displays an adjustment to reflect interest that would be earned on the trust fund's assets during the year.

The final decision in setting the 1988 premium concerns the contingency margin—that is, what portion, if any, of the shortfall in premium receipts for 1987 should be recovered during 1988. The seventh row of Table 1 shows three possibilities: none of the projected 1987 shortfall would be recovered in 1988; based on a margin of 7 cents, about 3 percent of the shortfall would be recovered, as assumed by HCFA; and, based on a margin of 80 cents, about 25 percent would be recovered.

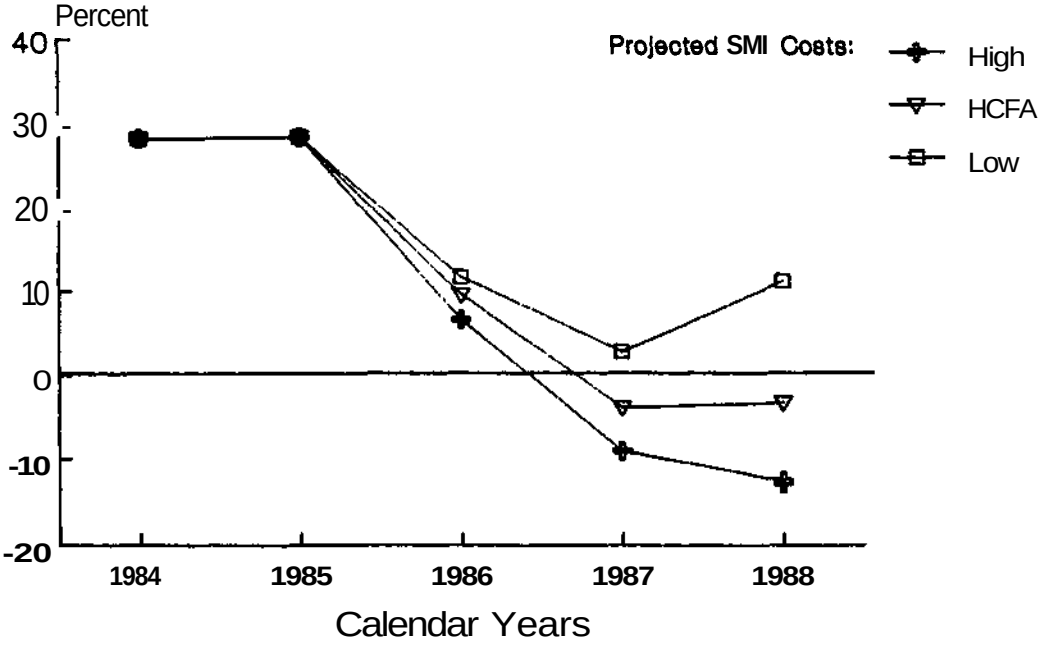
The upper panel of Figure 2 shows that if the low-cost projection is accurate, the announced premium of $24.80 would bring in enough income (over and above costs incurred in 1988) to recover more than the 1987 shortfall in receipts, increasing the trust fund's balance to about $9 billion and, as shown in the lower panel, raising the reserve ratio to about 11

Figure 2.

SMI Trust Fund's Balance, 1984-1988
(Assets On Hand)



SMI Trust Fund's Reserve Ratio, 1984-1988
(Reserve Over Expected Expenses)



Source: Congressional Budget Office

percent. 6/ On the other hand, if HCFA's projections are accurate, the 1988 premium would do little to improve the trust fund's balance and the reserve ratio would remain negative. If the high-cost projection is accurate, the trust fund will be nearly depleted by the end of 1988.

THE UNDERLYING CAUSES OF INCREASES IN THE COST OF SMI BENEFITS PER ENROLLEE 7/

At this point, let me explore briefly the reasons why SMI costs have grown. Higher SMI costs per enrollee are the combined result of increases in the fees paid per service (price) and increases in the quantity or intensity of services provided (volume). Historically, higher prices have accounted for more than half of the growth in costs for physicians' services, which account for 80 percent of SMI costs. Yet, higher volume was the primary reason for growth in costs during the SMI fee freeze in effect from July 1984 through December 1986.

The top portion of Figure 3 shows how costs for physicians' services per aged enrollee have grown over the years from 1976 through 1986, as well as the relative importance of three contributing factors. 8/ The impact

---

6. The trust fund's reserve ratio is the amount of the reserve at the end of one year divided by the costs expected to be incurred in the following year.

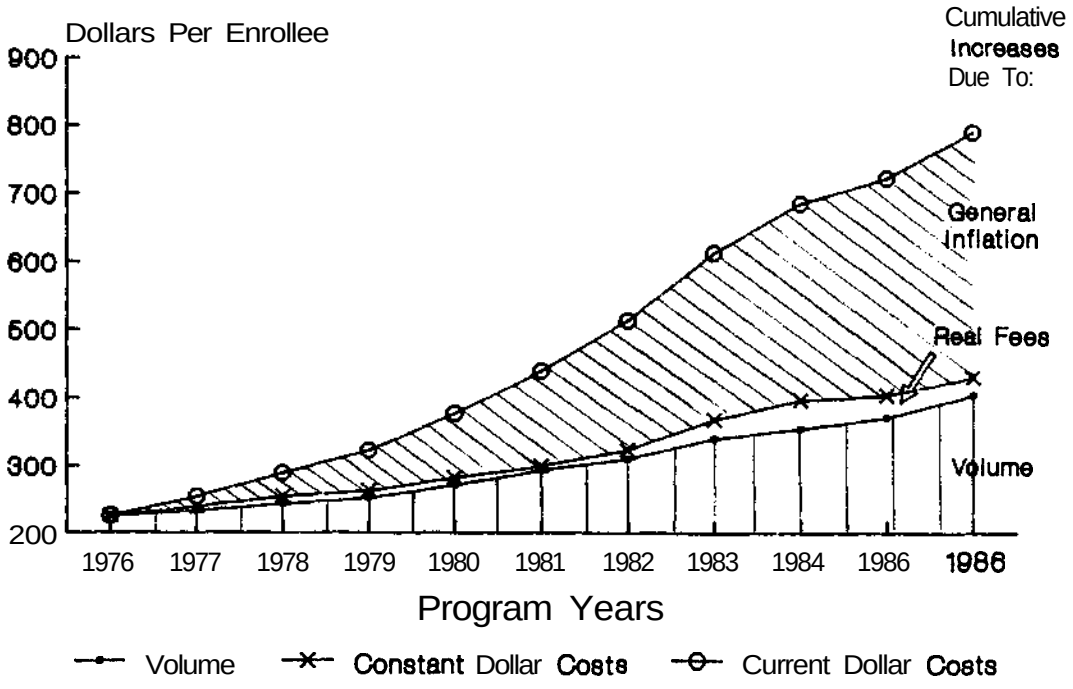
7. This section refers to program years (July through June).

8. Costs used here are reasonable charges--that is, the amounts allowed by Medicare for covered services--and do not include any additional amounts (above the Medicare copayments) that patients may have been billed. A more detailed discussion of Figure 3 appears in the Appendix.

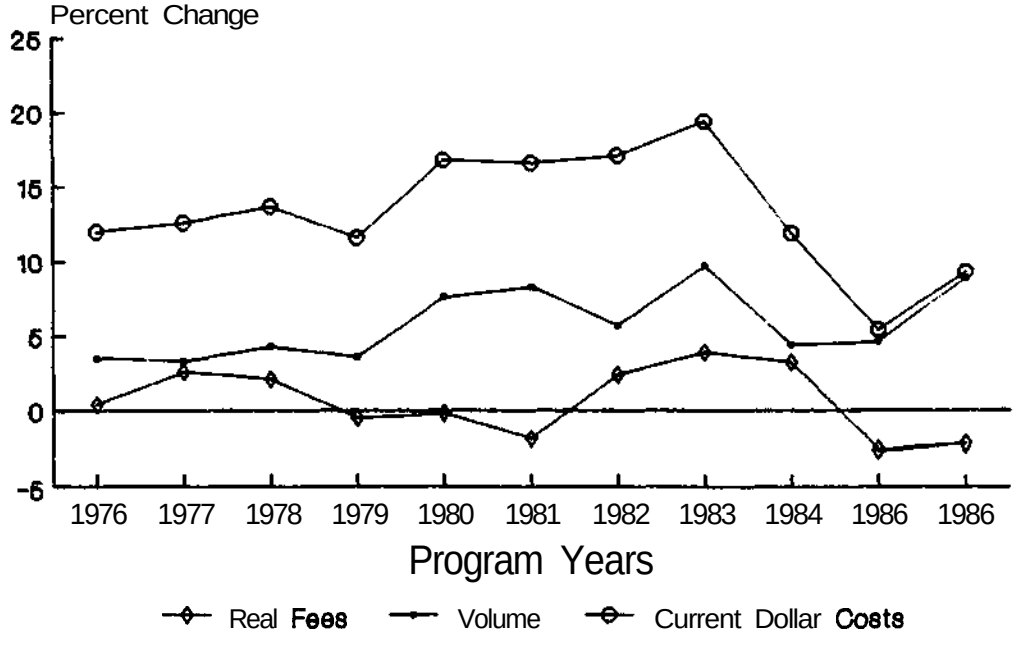
Figure 3.

Physicians' Costs Per Enrollee, 1976-1986

(In Current and Constant Dollars)



Percentage Change in Physicians' Costs Per Enrollee, Volume, and Real Fees, 1976-1986



Source: Congressional Budget Office

of higher prices has been divided into two parts—one that reflects general inflation as measured by the GNP deflator, which is shown by the top area; and one that represents higher real fees, which is shown by the middle area. The impact of rising volume is represented by the lowest area. Thus, the growth in costs for physicians' services that exceeds general inflation has resulted almost entirely from increases in the volume of services provided and only marginally from rising real fees.

As the bottom portion of Figure 3 indicates, the rate of growth in volume generally increases during periods when real fees are declining. Apparently, physicians attempt to offset losses in their income that would otherwise occur by expanding services to beneficiaries more quickly in periods of constant or falling real fees than they do in periods of rising real fees. This behavior would be consistent with evidence from the period of wage-price controls in the early 1970s. That evidence indicates that physicians responded to fee constraints by increasing the services for which they billed.

It is important to bear in mind that these spikes in the growth rate for volume have occurred against a background of steady increases in services per enrollee, much of which may be desirable. For example, recent advances in medical technology have greatly expanded the ability of physicians to respond to the needs of enrollees. In addition, the need for medical services among the Medicare population has been growing slowly as

the average age of enrollees has gradually risen. Finally, the decline in real fees that occurred in 1985 and 1986 has probably improved access to services for Medicare enrollees, perhaps making them more likely to seek necessary care. 9/

IMPACT ON ENROLLEES AND POSSIBLE RESPONSES 10/

With the announced premium increase, enrollees will pay $298 in 1988 for SMI premiums, or $83 more than the $215 they pay this year. The annual premium will represent 2.9 percent of median per capita income for Medicare enrollees, which is estimated to be about $10,400. Although the premium increase is small relative to income for most Medicare enrollees, it could represent a significant amount for enrollees with low incomes who are not protected by other government programs.

About 9 percent of enrollees--about 2.9 million people--will be protected because they are also eligible for Medicaid, which typically pays their SMI premiums along with most other out-of-pocket costs. Another 1.6

---

9. An additional factor is that improvements in medical technology have combined with pressures by Medicare and other insurers to shift minor procedures out of hospitals--to outpatient departments and to physicians' offices. The net effect of this shift on SMI costs is uncertain, though. Hospitals' outpatient departments would certainly receive higher SMI payments. Physicians' bills might also show some increases for certain ancillary services--such as laboratory tests--that would have been billed by the hospital if the procedures had been done in the hospital. These factors increasing SMI costs, though, would be at least partially offset by fewer physicians' bills for inpatient visits, especially given the shorter average length of stay for beneficiaries who are still hospitalized.

10. This section refers to federal fiscal years.

percent of enrollees (about 0.5 million people) will be partially protected by the "hold-harmless" provisions of P.L. 98-369, which stipulate that the dollar increase in the SMI premium for an enrollee cannot exceed the increase in Social Security benefits that the beneficiary would receive as a result of the annual cost-of-living adjustment. 11/ In other words, individuals are guaranteed that the additional amount they pay for SMI coverage will not exceed the increase in their Social Security benefits, so that at least the nominal amounts of their checks will not be reduced. Approximately 9 percent of enrollees (2.9 million people) with per capita incomes of less than $5,000 in 1988, and an additional 15 percent (4.8 million people) with per capita incomes less than $7,500, would not be protected by Medicaid or by the hold-harmless provisions, however.

Options for 1988

If the Congress wishes to reduce the impact of the premium increase on enrollees in 1988, it has two options: it could shift costs to nonMedicare groups, or it could shift costs to Medicare enrollees in later years. In either case, the federal budget deficit for 1988 would be increased unless taxes were raised by enough to offset the costs. Furthermore, special appropriations to the SMI trust fund (in addition to the appropriations provided under current law) might be required to ensure timely payment of claims. Finally, because the new SMI premium and the Social Security

11. For Social Security beneficiaries, SMI premiums are deducted automatically from their monthly Social Security checks. The expected COLA increase for Social Security benefits on January 1, 1988, is 4.3 percent. Enrollees with monthly checks of less than $160 would, therefore, have partial real protection from the "hold-harmless" provision, because (0.043)($160)(12) = $83, or the amount the annual SMI premium will rise between 1987 and 1988.

COLA both go into effect in January 1988, consultations with officials of the Social Security Administration to determine the administrative feasibility of any particular option would have to begin immediately.

One possible response, proposed by Congressman Pepper in H.R. 3291, would be to limit the percentage increase in the premium to the estimated cost-of-living adjustment to be provided for 1988 Social Security benefits. In this case, the premium would rise by only 4.3 percent, to $18.70. This option would protect all Social Security recipients, regardless of their incomes, but it would raise the federal deficit by an estimated $1.7 billion in fiscal year 1988, and by $12 billion over the next five years, relative to current law. 12/

A less costly alternative would be to limit the premium increase only for enrollees with low benefits. The current hold-harmless provision could be modified to assure that each beneficiary would receive a Social Security check (net of the deduction for the new SMI premium) that was higher by at least $7 a month, or by the full amount of their COLA, whichever was lower. 13/ In 1988, this option would increase the number of enrollees who

---

12. This estimate assumes that premium increases for 1989 and thereafter will be limited by the COLA increase for the preceding year, as required under current law. If the 1988 premium increase were limited by the 1987 COLA, the premium would increase by 1.3 percent, to $18.10. This alternative would reduce federal receipts by $1.8 billion in 1988, and by $13 billion over the next five years.

13. For each affected beneficiary, the monthly subsidy of the SMI premium that would be provided in 1988 would continue at the same nominal level in future years.

would receive some subsidy of their SMI premium from about 0.5 million enrollees with Social Security benefits of $160 or less, to nearly 7 million enrollees receiving benefits of no more than $330—a level that approximates the income guarantee provided under the federal Supplementary Security Income program. This option would raise the federal deficit by about $200 million in 1988 and by nearly $1.5 billion over the 1988-1992 period. A disadvantage stems, however, from the fact that some recipients of low Social Security benefits have sizeable incomes from other sources. Thus, about 47 percent of those who would gain from this option will have per capita incomes over $10,000 in 1988.

Options for the Long Term

A major concern about the premium increase just announced is the size of the one-year jump—more than 38 percent. Yet, because premium increases had been held down for the previous three years, the average rate of growth in the SMI premium from 1984 through 1988 is a more moderate 14 percent, closely tracking the expected average growth in costs per aged enrollee over the same period.

It might have been better to reach the 1988 premium in more gradual steps—by having larger premium increases in the two preceding years. That approach would have required maintaining a larger trust fund reserve in 1985 and 1986 to use as a cushion for 1987 and 1988. In this light, the decision of the trustees in 1987 to reduce the expected trust fund reserve to

zero, with no contingency for errors in projections, seems imprudent in retrospect.

Under current law, large one-year increases in the SMI premium are unlikely to occur in the future, because growth in the premium will be limited by the COLA beginning in 1989. But if the Congress continues each year to extend the period during which the SMI premium is set at 25 percent of costs per aged enrollee, as it has since 1984, future increases would probably be volatile.

Under the latter circumstance, volatility in the size of future SMI premium increases could be reduced over the long term by instructing the trustees to build up a larger reserve than has been their goal in recent years. This action would necessitate higher premiums, on average, than would otherwise be required over the next several years, while the surplus was being built up. Once in place, though, the trustees could use the flexibility provided by the larger reserve to dampen premium increases in periods of unusually rapidly rising costs, and then replace the reserve through higher premiums in periods of slower growth in costs.

In principle, the trustees have this flexibility now, but it was partly concern about a negative public reaction to their maintaining a large reserve that led to its rapid reduction from 1985 through 1987. Explicit instructions by the Congress to maintain a positive, but flexible, reserve

could prevent such a situation in the future. For example, the Congress could provide specific guidelines regarding minimum and maximum desirable values for the trust fund's reserve.

The more fundamental solution for rapidly rising premiums, however, is to contain costs. Efforts to do so have focused only on price restraint to date, but containing costs requires placing limits on the volume of services as well. Control of both price and volume might be achieved in alternative ways, including establishing stringent utilization review programs under the current fee-for-service payment system, or introducing a capitated payment system. The issues involved are complex, however, and beyond the scope of this statement. My understanding is that testimony of the Physician Payment Review Commission will focus on this topic.

APPENDIX

BACKGROUND INFORMATION ON PRICE AND VOLUME INCREASES

As the top panel of Figure 3 illustrates, average costs per enrollee have grown from $225 in 1976 to $792 in 1986, an annual growth rate of 13.4 percent. On average over this period, increases in the volume of services accounted for about 46 percent of the growth, while price increases accounted for the remaining 54 percent. Most of the price growth, however, reflected the general rate of inflation. Increases in real fees were less than 0.7 percent a year.

The rate of growth of costs dropped dramatically in 1984, and slowed further in 1985. The 1984 slowdown probably stemmed largely from the prospective payment system under Medicare's Hospital Insurance program, which quickly resulted in shorter hospital stays for Medicare patients, thereby reducing the number of hospital visits for which physicians could bill.

For 1985—the first year of a physician fee freeze—costs grew by only 5.4 percent. About 85 percent of the growth was attributable to increases in volume, while only 15 percent was the result of price increases. During this year, fees grew by less than general price inflation, so that real fees paid for physicians' services under the SMI program declined by 2.6 percent.

The freeze continued through program year 1986, when costs grew by 9.3 percent; 95 percent of that growth stemmed from increases in volume. Again, real fees for physicians' services fell under the SMI program, by about 2.2 percent.

Early indications for program year 1987 are that costs per enrollee will increase by 14 percent to 16 percent, with about 40 percent of that growth attributable to the fee increases that were permitted after the physician fee freeze ended. The remaining 60 percent of the 1987 growth is expected to be the result of further increases in the volume of services.