CBO TESTIMONY

Statement of
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on
The Financial Status of Medicare

before the
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NOTICE

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Mr. Chairman and Members of the Committee, I am pleased to be here today to discuss the financial status of Medicare. My statement will highlight information from the Congressional Budget Office (CBO) on Medicare spending and enrollment patterns in recent years and over the next decade. I will also review the Medicare proposals in the President's budget as well as some of the issues associated with offering a prescription drug benefit in Medicare.

Medicare is the second largest federal entitlement program after Social Security. This year the program will pay for the health care of some 39 million elderly and disabled people at a cost of $216 billion, or 13 percent of federal outlays. Despite its high cost, however, Medicare's benefits are not as generous as those of the majority of private health insurance plans. The program does not cover outpatient prescription drugs, routine physical exams, or dental care. Nor does it cap the amount that beneficiaries pay out of pocket. With prescription drugs, in particular, becoming an increasingly important part of modern medicine, pressure to expand Medicare's benefits is growing, even as policymakers struggle to contain the program's costs.

The rapid growth of Medicare spending, which has remained substantially above growth in the economy, has been a continuing concern of policymakers since the program's creation in 1965. The primary factor driving recent spending growth has been the rise in costs per beneficiary; the eligible population has expanded only slowly. But with the looming retirement of the baby-boom generation, Medicare

faces a major demographic challenge that will add significantly to the growth of expenditures. Even if spending per enrollee stabilized, Medicare outlays would rise sharply after 2010. Without significant restructuring, therefore, the program is unlikely to achieve financial stability in the long term.

TRENDS IN MEDICARE SPENDING

The patterns of growth for Medicare and private-sector health spending diverged in the 1990s after both had grown at double-digit rates in the 1980s. A dramatic slowdown in the growth of private health spending in the mid-1990s was not matched until recently by Medicare. Private health insurance spending increased by less than 4 percent a year between 1993 and 1997, while Medicare spending continued to rise at an annual rate of almost 9 percent.

The growth of Medicare spending slowed sharply, however, in 1998. Total outlays, which increased by more than 8 percent in 1997, rose by only 1.5 percent in 1998, and growth continues to be extremely slow in 1999. Part of that slowdown was anticipated; the Balanced Budget Act of 1997 (BBA) lowered the projected growth of Medicare spending by 4 percentage points in 1998. The BBA reduced payment rates for many services and restrained the update factors for payments

through 2002. Both fee-for-service providers and Medicare+Choice plans are experiencing lower payment increases as a result.

But actual spending growth has fallen considerably lower than the BBA provisions alone were expected to produce. Several other factors appear to have contributed to this sudden flattening of Medicare expenditures.

- Widely publicized efforts to clamp down on fraud and abuse in the program have resulted in greater compliance by providers with Medicare's payment rules. Those efforts include more rigorous screening of claims by Medicare contractors and tougher enforcement of Medicare laws by the Departments of Justice and Health and Human Services.

- The average time for processing Medicare claims rose dramatically in 1998. Expanded compliance activities combined with major efforts to prepare computer systems for the year 2000 contributed to longer payment lags, which can have a substantial effect on Medicare outlays. An increase of one week, for example, in the average time for processing claims reduces Medicare outlays for the fiscal year by 2.3 percent. But that reduction is only temporary because the delay merely moves outlays into the next fiscal year.

CBO assumes that longer claims-processing times and the effects of improved compliance with payment rules are short-term phenomena that will have little or no effect on Medicare spending in the longer run. Under baseline assumptions, payment lags will begin to return to more typical levels late in 2000, with a catch-up in spending and a resumption of normal spending growth in 2001 and 2002.

Total Medicare outlays will therefore grow at an average annual rate of about 7 percent through 2004, rising to slightly more than 8 percent over the 2004-2009 period. By 2009, total outlays will be almost $450 billion. Much of the increase over the next few years reflects rising expenditures per enrollee; enrollment itself will expand only modestly as the last of the "baby-bust" generation reaches age 65.

Medicare spending will grow substantially faster in the decades after 2009 as the baby boomers begin to turn 65. Between 2010 and 2030, the elderly population will grow at a rate three times faster than between 2000 and 2010. Medicare costs are likely to grow considerably faster than program enrollment, however. The cost per beneficiary of providing health care services, which has risen dramatically in the past, is likely to continue doing so. That anticipated growth reflects advances in medical technology that will raise health care costs and a continued increase in the use of services by beneficiaries.

Based on assumptions used by the Medicare trustees, CBO has calculated that Medicare spending will rise from about 2.5 percent of gross domestic product (GDP) this year to 6.3 percent in 2030 as the last of the baby boomers enroll in the program. But that projection is likely to be optimistic because it assumes a gradual slowdown in program spending, which would require a significant change in policy. If spending per beneficiary did not slow, Medicare's share of GDP would be higher.

THE MEDICARE+CHOICE PROGRAM

The BBA established the Medicare+Choice program to expand the range of health plans from which beneficiaries could choose and to lay the foundation for a more competitive Medicare system. Building on the existing Medicare risk market, in which all of the plans are health maintenance organizations (HMOs), the program allows a wide variety of health plans—including preferred provider organizations, point-of-service plans, and provider-sponsored organizations—to participate in Medicare.

The BBA also sought to constrain the growth of per capita spending in the Medicare risk sector and to reallocate payments from markets with high payment rates to those with lower rates. In addition, subsidies for medical education were "carved out" of the payments that risk plans receive. The act also required the Health

Care Financing Administration (HCFA) to establish a mechanism for adjusting payments to plans to account for variations in costs associated with differences in the health status of enrollees.

The overall growth of per capita payments to Medicare+Choice plans remains tied to spending growth in the fee-for-service sector, but it will be below the fee-for-service rate of increase through 2004. Moreover, the growth in payments will not be uniform among Medicare+Choice markets. In the short term, payments in markets that have above-average fee-for-service costs will grow more slowly than in markets where fee-for-service costs are lower. Markets like those in Florida, New York, and parts of California—which have both high fee-for-service costs and high penetration of managed care plans—will experience relatively slow growth in capitation rates under Medicare+Choice.

The transition to the Medicare+Choice system is proving to be quite rocky. Most plans have received an update of only 2 percent—the minimum increase specified in the BBA—for the past two years. Moreover, HCFA's "megareg" was issued in June 1998, after plans were required to inform HCFA of the additional benefits they would offer and the premiums they would charge in 1999.

Many plans reevaluated their Medicare participation in light of disappointing payment increases, new regulations, and a general retrenchment in the managed care

industry in response to rising cost pressures. Some plans dropped out of the program entirely in 1999, others cut back the markets that they served, and few new plans applied to participate. Only about 400,000 beneficiaries were affected by those withdrawals, however, and most of them had other plans in which they could enroll. Additional plans are threatening to leave Medicare in 2000, especially if the phase-in of the new risk-adjustment system begins in 2000 as scheduled. The approach to risk adjustment that HCFA is adopting will reduce overall payments to the Medicare+Choice sector.

The recent upheavals in the Medicare+Choice market have caused CBO to modify its projections of enrollment growth and spending in that market. The heightened awareness that plans can leave the market is likely to reduce the willingness of some Medicare beneficiaries to enroll in risk plans over the next few years. Moreover, the lower payments that will result from risk adjustment will make it difficult for plans to offer the additional benefits, such as prescription drugs, that were expected to drive enrollment growth.

Despite the possible dampening of enthusiasm for managed care, however, enrollment growth is still predicted to be strong. Consequently, payments to Medicare+Choice plans will soar from $37 billion in 1999 to $141 billion in 2009, which represents an annual growth rate of more than 14 percent. Enrollment growth

of almost 9 percent a year accounts for much of that increase, with the remainder coming from growth in payments per enrollee.

Because growth in per-enrollee payments to Medicare+Choice plans is tied to growth in fee-for-service spending, increasing enrollment in those plans does not necessarily curb the rise in Medicare spending. Although adjusting payments for risk will reduce the annual rate of growth of Medicare spending by 0.1 percentage point through 2004, CBO projects that per-enrollee payments to Medicare+Choice plans will increase in line with fee-for-service spending in subsequent years.

As a consequence of the growth of enrollment in risk plans, enrollment in Medicare's fee-for-service sector will actually drop by about 1.5 million people over the next decade. Yet, despite that decline and cuts in the growth of payment rates for many services, fee-for-service spending will still increase at a rate of more than 5 percent a year, reaching $302 billion in 2009.

MEDICARE PROPOSALS IN THE PRESIDENT'S BUDGET

The President's budget for fiscal year 2000 includes provisions to expand Medicare coverage to new populations and curb spending in the fee-for-service sector. Those

proposals would have only minor effects on Medicare spending.[1] In addition, the President proposes to use a transfer from the general fund to shore up the Hospital Insurance (Part A) Trust Fund.

Populations newly eligible for Medicare would include certain people between the ages of 55 and 64 and the working disabled. The costs of those expansions would be more than offset by fee-for-service savings, which would have spillover effects on spending in Medicare+Choice plans and also result in lower premiums for Part B (Supplementary Medical Insurance). The net effect would be mandatory savings of about $19 billion through 2009—a tiny fraction of total program spending.

Policies to Expand Medicare Coverage

The President's proposals to allow certain people under the age of 65 to buy into the Medicare program are similar to proposals that were in his budget last year. Two groups of people would be eligible: those ages 62 to 64 who do not have private health insurance, Medicaid, or other public coverage; and certain workers ages 55 to

1. The budget also includes a $750 million demonstration project to enable Medicare beneficiaries to participate in clinical trials, which would be paid for outside the Medicare trust funds.

61 who lose their health insurance because of a job loss. The terms of participation would differ for the two groups.

A third proposal, to expand Medicare coverage for the disabled, would be part of a broader initiative to allow disabled people to return to work and maintain their health insurance coverage. The initiative would use funding from both the Medicare and the Medicaid programs.

Buy-In for People Ages 62 to 64. Under the Administration's proposal, people ages 62 to 64 could enroll voluntarily in Medicare, provided they did so as soon as they were eligible. Events that would qualify people to enroll include turning 62 or losing employment-based health insurance under certain circumstances between the ages of 62 and 64.

Enrollees would pay premiums in two parts, both of which would be updated annually. Before age 65, they would pay a monthly premium, which would be about $324 in 2001 (the first year of the program). At age 65 and thereafter, they would pay a monthly premium surcharge (in addition to their regular Medicare premiums) to recapture for the government the extra costs that Medicare would pay because the program would attract enrollees who were less healthy than average.

Taking the premiums that enrollees would pay into account, the buy-in for people ages 62 to 64 would cause net Medicare outlays to rise by an estimated $3.3 billion through 2009. In that year, about 718,000 people would be enrolled through the buy-in program.

Buy-In for Displaced Workers Ages 55 to 61. The Administration also proposes to allow certain workers ages 55 to 61 who lose health insurance because of a job loss to buy into Medicare. The program would be available only to people who met several eligibility requirements, including having been previously insured and eligible for unemployment insurance benefits. Those restrictions plus high monthly premiums—almost $440 per person in 2001—would ensure that enrollment in the program would be low. CBO estimates that by 2009 only about 50,000 people would be enrolled in the program at any one point in time.

Premiums for the program would be insufficient to cover its costs because it would attract enrollees whose expected medical expenditures were high. But because of low participation, the costs to Medicare would be small. CBO projects that net Medicare outlays would rise by a total of about $300 million through 2009.

Medicare Coverage for the Working Disabled. The President's budget includes provisions under both the Medicare and the Medicaid programs to allow disabled people to return to work and maintain their health insurance coverage. The Medicare

proposal would entitle disabled people who returned to work—thereby losing their eligibility for Social Security benefits—to lifetime coverage under Medicare Part A. That entitlement would be available only to people who enrolled in the program during the first 10 years after enactment of the legislation.

CBO estimates that expanding the Medicare entitlement for the disabled would increase outlays by about $1.4 billion through 2009. About 59,000 people would be participating by then—the last year in which people could enroll, according to the proposal. Most likely, however, such an initiative would prove popular enough to be extended beyond 2009.

Policies to Reduce Fee-for-Service Spending

The President is proposing a variety of program changes to reduce fee-for-service spending. The most significant savings would come from direct reductions in payments for certain services. Additional savings would come from measures to improve compliance with Medicare's payment rules and to give hospitals incentives for more efficient performance.

Taken together, the proposals would lower fee-for-service spending by about $10 billion through 2004 and $21 billion through 2009. Because spending growth

in Medicare+Choice plans is linked to spending growth in the fee-for-service sector, the reductions in fee-for-service spending would also lower Medicare+Choice spending by about $6.5 billion through 2009. Some of those savings would be offset, however, by the lower Part B premiums that enrollees would pay.

Two of the proposed reductions in payments to providers would account for more than half of the fee-for-service savings. The largest savings would be generated by the proposal to freeze payment rates for inpatient hospital services in 2000, which would reduce payments to hospitals by about $600 million in 2000 and $8.7 billion through 2009. A second proposal would also generate considerable savings from hospitals and other providers. It would further reduce Medicare's payments to hospitals for the bad debts that they incur—those payments having already been lowered under the BBA—and extend the reduction in bad-debt payments to such providers as skilled nursing facilities, federally qualified health centers, and community mental health clinics. Total savings would be about $4.6 billion through 2009.

The President's Trust Fund Proposal

The President also proposes to augment Medicare's financing by transferring funds from the general fund to Medicare's trust fund for Hospital Insurance. Currently,

Medicare spending is drawn from two trust funds: the Hospital Insurance (HI) Trust Fund, which pays for Part A services, and the Supplementary Medical Insurance (SMI) Trust Fund, which pays for Part B services. The HI trust fund relies primarily on payroll taxes, which account for 88 percent of its receipts. By contrast, about 75 percent of SMI receipts are transfers from the general fund, with premiums from beneficiaries accounting for the other 25 percent.

HI outlays are growing faster than income, and CBO currently projects that outlays will exceed income by 2007. (If interest payments are excluded, outlays already exceed income.) The trust fund will become insolvent sometime after 2010.

The Administration would postpone the insolvency date for the HI trust fund by transferring $350 billion from the general fund to the trust fund during the next decade. That bookkeeping transaction would increase the balances held in the trust fund and delay the date of insolvency. But the transfer would do nothing to address the underlying problem: rapid growth in spending for Medicare, Social Security, and other federal programs will cause outlays to outstrip total anticipated revenues. Ways must eventually be found to slow the growth in program spending, which will require major restructuring of Medicare.

Unlike most employer-sponsored health plans, Medicare does not provide coverage for prescription drugs taken on an outpatient basis. The President supported the concept of a prescription drug benefit for Medicare in his State of the Union message, although that proposal was not formally included in the budget. Others, including the National Bipartisan Commission on the Future of Medicare, have also considered the possibility that Medicare might be expanded to cover outpatient drugs.

The Medicare population uses prescription drugs more extensively than the general population because of high rates of chronic illness. Although the elderly represent only about 12 percent of the population, they account for about one-third of spending on prescription drugs. An estimated 80 percent of retired people use at least one prescription drug every day.

In 1995, Medicare beneficiaries spent an average of $600 for prescription drugs, half of which they paid out of pocket. But average out-of-pocket expenditures varied considerably depending on whether beneficiaries had prescription drug coverage from some other source and, if so, the type of coverage they had.

More than 60 percent of Medicare beneficiaries have some form of drug coverage, although the generosity of coverage varies greatly. In 1995, for example, 95 percent of beneficiaries enrolled in HMOs had drug coverage compared with about half of the beneficiaries in fee for service, who may obtain drug coverage through supplementary insurance policies from their former employers, medigap policies that they purchase themselves, or Medicaid. But drug coverage obtained through medigap is costly, and the benefits are limited. Moreover, most HMOs now place an annual cap on prescription drug benefits, which can be as low as $600.

The availability of prescription drug coverage at little or no additional cost to the beneficiary has contributed to the growth of managed care enrollment. But many Medicare HMOs appear to be reducing the generosity of those benefits in response to their rising costs. Smaller-than-expected increases in Medicare capitation payments may also be contributing to that trend.

A new drug benefit in Medicare would be popular with beneficiaries, but the additional program costs would be large. Consider, for example, adding a drug benefit to Medicare Part B beginning in January 2000. In this example, beneficiaries would be responsible for a $250 annual deductible and 20 percent coinsurance, and Medicare would pay all pharmaceutical costs once the beneficiary had paid $1,000 for drugs covered under the benefit during a year. That cap would be reached once the beneficiary had incurred $4,000 in drug expenses.

Under such a proposal, total outlays would increase by about $30 billion in calendar year 2000, CBO estimates. That cost would be partially offset by an additional $7.5 billion in Part B premiums that would be collected.

Adding drug coverage would increase the growth rate as well as the level of Medicare expenditures since prescription drugs are the fastest-growing component of health expenditures. HCFA analysts project that national spending for prescription drugs will grow at an annual rate of almost 10 percent between 2001 and 2007. By comparison, total national health spending will grow by about 7.5 percent a year over the same period.

CONCLUSION

Despite the recent slowdown in spending, Medicare outlays will grow substantially faster than the economy in the foreseeable future. The program will continue to place financial pressures on the federal budget in the near term. Those pressures will intensify over the next decade and beyond as the baby boomers begin to qualify for Medicare and as health care costs per beneficiary rise. The Balanced Budget Act took some important steps to reduce the growth of Medicare spending and foster a more competitive market. The Medicare proposals included in the President's budget would do little to promote the efficient and effective use of health care resources. The long-term financial stability of the program would require additional steps.