Statement of
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before the
Senate Finance Committee
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NOTICE

This statement is not available for public release until it is delivered at 9:30 a.m. (EDT), Thursday, June 1, 1989.

Mr. Chairman, I am pleased to have the opportunity to testify before this Committee about Congressional Budget Office (CBO) estimates of the costs of expanding coverage provided by the Medicare Catastrophic Coverage Act of 1988 (MCCA). My statement today will cover three main areas:

- CBO's February 1989 estimates of the outlays and receipts from the Medicare provisions of MCCA;
- CBO's estimates of the trust fund balances; and
- The degree of uncertainty inherent in these estimates and possible changes to them.

CBO FEBRUARY ESTIMATES

The Medicare Catastrophic Coverage Act of 1988 established two financing mechanisms--a flat premium to be paid by each Part B enrollee and an income-related premium to be paid by those eligible for Part A whose federal income tax liabilities exceed $150. In February, CBO estimated for its baseline projections that over the

1989-1993 period the flat premium would generate $13.5 billion and the income-related premium would raise $25.9 billion (see Table 1).

Two categories of new Medicare spending will arise from the MCCA: additional outlays from expanding the existing Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) programs, and outlays arising from a new program to cover expenditures on prescription drugs that exceed a certain level. In February, CBO

TABLE 1. CBO FEBRUARY 1989 ESTIMATES OF MEDICARE CATASTROPHIC HEALTH INSURANCE
(By fiscal year, in billions of dollars)

	1989	1990	1991	1992	1993	Five-Year Total
Financing Provisions (Revenues or Receipts)						
Income-Related Premium	-0.4	-5.4	-6.1	-6.7	-7.3	-25.9
Flat Premium Receipts	-1.2	-1.8	-2.7	-3.6	-4.1	-13.5
Spending Provisions (Outlays)						
HI/SMI Catastrophic Outlays	1.3	4.1	5.8	6.7	7.6	25.5
Catastrophic Drug Benefits	0.0	0.0	0.8	1.6	2.4	4.8
Drug Administration	0.0	0.1	0.2	0.3	0.4	1.1
Net Deficit Effect	-0.3	-3.1	-2.0	-1.6	-1.0	-8.0

SOURCE: Congressional Budget Office.

NOTE: Details may not add to totals because of rounding.

estimated that the added HI/SMI costs would total $25.5 billion over the 1989-1993 period, while the cost of the drug benefits would be $4.8 billion. Estimated administrative costs for the drug benefit program are expected to add another $1.1 billion in outlays (see Table 1). We did not include these estimated administrative expenses in our February baseline projections because of the convention to limit the projections for discretionary spending to programs funded in the base year (1989). Nevertheless, these expenses must be included in any assessment of the trust fund balances in future years.

CBO's February estimates show total receipts attributable to the MCCA to be $39.4 billion over the 1989-1993 period, with outlays of $31.4 billion, including estimated administrative expenses. These amounts result in a surplus of $8.0 billion.[1] When the MCCA was enacted, the CBO/JCT estimate of the five-year cumulative difference between receipts and expenditures (including administrative expenses) was $4.2 billion, or $3.8 billion lower than CBO's $8.0 billion February estimate. The primary reason for the higher surplus estimate in February is a revised estimate of likely receipts from the income-related premiums.

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1. Adding in the administrative expenses for drug benefits that were excluded in baseline projections implies a higher surplus--$9.1 billion.

TRUST FUND BALANCES

The Congress planned for a surplus of receipts over expenditures for the MCCA during the 1989-1993 period to assure the timely payment of benefits, to protect against unexpected contingencies, and to account for the uncertainty in estimates of how much the program would cost. To provide these safeguards, contingency margins were included in the financing provisions of the program.

The amount of money available to make payments in a given year for the MCCA program depends not only on that year's income, but also on the balances left over from previous years. To reflect this concept, the contingency margins for the catastrophic account and the drug trust fund are calculated by determining how large the projected end-of-year balance for a given calendar year in the trust fund is when compared with the expected spending for that same calendar year. The projected end-of-year balance then reflects the amount of money left over after all payments in a given year are made, or the amount of money that would be available to pay higher-than-projected costs or to make up for lower-than-projected receipts. Because it is important to know how much will be left over relative to anticipated spending, contingency margins are discussed in terms of percentages rather than in absolute dollars.

The Congress legislated specific goals for contingency margins at the time it developed catastrophic financing provisions. For the new HI/SMI account, it set the contingency margin at 20 percent in 1992 and in subsequent years. Obviously, the Congress wanted to ensure that sufficient funds would be available in the trust funds to pay for benefits in that year even if actual costs were as much as 20 percent higher than projected at the time the premiums were set. Because of greater uncertainty about the prescription drug costs, the margins for the drug trust fund were set at 75 percent in 1992 and 50 percent in 1993. By 1996, the goal for this margin falls to 20 percent to recognize the greater certainty that will develop as experience with the new benefit accumulates.

As Table 2 shows, CBO's February estimates generate contingency margins considerably larger than those planned when the MCCA passed. These estimates show 1993 margins of 72 percent and 77 percent, respectively, for the HI/SMI account and for the drug trust fund. Whether these margins are too large or not depends on the accuracy of our estimates of receipts and spending. Because of the considerable uncertainty inherent in these estimates, especially for the prescription drug program, the scheduled contingency margins could prove to be inadequate. Even if this is not the case and projected excess reserves occur, a mechanism exists for their eventual depletion. These margins would decline after 1993 because actual program

experience will determine future flat and income-related premium rates. Premium rates could be adjusted downward sooner to eliminate the excess above the original goals for contingency margins.

TABLE 2. CBO FEBRUARY 1989 ESTIMATES OF CATASTROPHIC RESERVES (By calendar year, in billions of dollars)

	1990	1991	1992	1993
HI/SMI/Catastrophic				
End-of-Year Balance	2.5	3.3	4.6	5.7
HI/SMI Catastrophic Outlays	4.9	6.1	6.9	7.9
Estimated Contingency Margin (Percent)	51	54	67	72
Scheduled Contingency Margin (Percent)	n.a.	n.a.	20	20
Drug Trust Fund				
End-of-Year Balance a/	0.3	1.5	2.0	2.3
Drug Outlays	0.2	1.3	2.2	3.0
Estimated Contingency Margin (Percent)	174	118	92	77
Scheduled Contingency Margin (Percent)	n.a.	n.a.	75	50

SOURCE: Congressional Budget Office.

NOTE: n.a. = not applicable.

a. Category includes estimated administrative expenses.

UNCERTAINTY OF THE ESTIMATES

While CBO provides the Congress with point estimates of the effects of legislation on the budget, these estimates have a margin of error surrounding them. The inherent uncertainty surrounding CBO's receipts and spending estimates declines when the estimates can be based on experience drawn from similar programs and policies, when relevant data is available that is both current and accurate, and when the new program or policy is not likely to induce significant changes in behavior.

Not surprisingly, the uncertainty inherent in CBO's estimates for the different provisions of the MCCA varies considerably. For example, on the receipt side, our estimate for the flat premium should be fairly reliable because the premium is similar to the SMI premium, which is currently applied to all participants in Part B of the Medicare program. CBO's estimates of the income-related premium are a bit more uncertain, both because incomes are more volatile and because we have no experience with an income tax surcharge applied to a demographic subset of the population. On the spending side, CBO's estimates of the added HI/SMI benefits are likely to be more reliable than those for the prescription drug program. This greater reliability occurs because the bulk of the added HI/SMI costs will result from the

types of services that Medicare has historically covered, while the drug coverage will move us into uncharted territory.

The differences between CBO's February baseline estimates and the Reagan Administration's budget estimates for the several broad components of the MCCA illustrate the degree of uncertainty that exists. For the 1989-1993 period, the Administration and CBO have virtually identical estimates of the receipts associated with the flat premium (see Table 3).

There is a $2.4 billion or 9 percent gap between the Administration's and CBO's February baseline estimates of the revenues that the income-related premium is likely to generate. This difference is not as significant as it appears. CBO and the Administration are within 1 percent of each other in their estimates of the underlying tax liabilities associated with the MCCA for the 1989-1993 period. The difference largely represents different assumptions about the timing of tax payments. Specifically, CBO and the Administration have employed different assumptions regarding the relative portions of this tax liability that will be withheld from paychecks or paid in quarterly estimated tax payments, as opposed to being paid at the time tax returns are filed. CBO assumed a smaller portion of payments would be made through withholding and quarterly estimated payments than did the Administration. The

Department of the Treasury recently provided information explaining the Administration's fiscal year timing assumptions for the 1990 budget. On the basis of this information, CBO has concluded that a strong case exists for adopting these assumptions in CBO's next baseline. Except for any possible change in the current baseline

TABLE 3. FIVE-YEAR ESTIMATES OF MEDICARE CATASTROPHIC COVERAGE BY CBO AND THE ADMINISTRATION
(In billions of dollars, fiscal years 1989 through 1993)

	CBO	Administration	Difference (Admin.-CBO)	Percentage Difference (Admin.-CBO)
Financing Provisions				
Income-Related Premium	-25.9	-28.3	-2.4	9.2
Flat Premium Receipts	-13.5	-13.4	0.1	-0.5
Subtotal	-39.4	-41.7	-2.3	5.9
Spending Provisions a/				
HI/SMI Catastrophic Outlays	25.5	26.6	1.1	4.3
Catastrophic Drug Outlays	5.9	8.9	3.0	51.7
Subtotal	31.4	35.5	4.1	13.2
Net Budget Effect b/	-8.0	-6.2	1.8	-22.7

SOURCE: Congressional Budget Office.

NOTES: Details may not add to totals because of rounding.

CBO estimates from February 1989. Administration estimates included in the Reagan Budget, January 1989.

a. This category includes estimated administrative expenses.

b. The effect for some years after 1993 will be positive as excess reserves are reduced by holding premium rates constant.

estimate of liability, this new timing assumption will increase CBO's estimate of baseline supplemental premium receipts by roughly $3 billion over the 1989-1993 period, with most of the increase in receipts coming in 1990 and 1991.

In the case of the prescription drug benefit, however, CBO and the Administration differ markedly in their estimates. The Administration's estimates exceed CBO's by $3 billion over the five years, but this figure understates the true difference. Inadequate balances in the drug trust fund constrain the Administration's estimated outlay for the drug program in fiscal years 1992 and 1993. If these constraints were removed, the Administration's estimate of outlays for the prescription drug benefit would total $10 billion through 1993, or $4.1 billion above CBO's estimate for the five-year period.

Differences of this magnitude occur for two reasons: the lack of recent data on the drug expenditures of Medicare recipients, and our lack of knowledge about how beneficiaries and providers might respond to the new prescription drug benefit. Let me say a few words here about both problems.

The cost of the outpatient prescription drug benefit depends on how rapidly drug expenses are likely to rise each year and on the distribution of spending for drugs by participants (that is, how many

people will spend more than $600 a year and hence will exceed the deductible for 1991). Lacking any current data, CBO developed its estimates from a variety of surveys done between 1977 and 1984. While these data were the best we could find to use in estimating the costs of the prescription drug benefit, the age and quality of this information introduces a good deal of uncertainty into the February 1989 estimates of the costs of the prescription drug provisions.

As to how beneficiaries and providers might respond to Medicare coverage of prescription drugs, we face a somewhat different problem. In general, after meeting their deductible, beneficiaries will have lower net costs for prescription drugs than they would if they had no prescription drug benefit. Normally, one would expect people to acquire more of an item when the cost is reduced. However, CBO's estimate of the expected response in terms of the volume of prescriptions is quite small. This small response is the result in part of the high deductible set in the law. It also occurs because the use of prescription drugs appears to be only weakly related to having insurance coverage for prescription drugs but is significantly related to the number of visits to physicians. Since physician visits were already fairly well insured under Medicare, Medicaid, and Medigap policies before passage of the MCCA, much of the effect of health insurance on drug spending is already incorporated in the baseline

spending estimates. Therefore, CBO does not expect the volume of prescriptions to increase significantly.

It is also difficult to predict how drug companies and health care providers will respond to Medicare's prescription drug coverage. Drug companies may attempt to stimulate demand for drugs by advertising to Medicare enrollees. In addition, they may be more willing to develop new drugs that they previously would have considered too expensive to market. Furthermore, physicians may be less price conscious when they prescribe drugs for beneficiaries who have met the deductible. These responses could lead to higher than anticipated drug costs. CBO's estimates do not include any adjustments for these intangible factors.

The analysis of new data should soon reduce somewhat the uncertainty of our estimates of the actual cost of the drug program. The Administration has recently issued its report to the Congress entitled, "Expenses Incurred by Medicare Beneficiaries for Prescription Drugs." In this report, the Administration provides an updated estimate of the expected costs of providing prescription drug coverage. This recent estimate is only marginally below previous Administration estimates.

On May 9th, CBO received the prescription drug data from the 1987 National Medical Expenditures Survey (NMES), conducted by the National Center for Health Services Research and Health Care Technology Assessment. In accordance with Public Law 100-360, we will report to the Congress in early July on how these new data will affect our estimates of the costs of providing Medicare recipients with prescription drug coverage.

While we have not completed our analysis, initial tabulations of the NMES data indicate that we will be revising our estimates upward. At the moment, we expect to increase our five-year estimate by $0.5 billion to $1.5 billion. This revision will narrow somewhat the difference between the CBO and the Administration's estimates, and offset some of the expected increase in projected receipts. The net effect of the two largest potential CBO revisions--the timing of income-related receipts and the costs of prescription drug coverage--would be to increase the $8 billion surplus estimated in February to around $10 billion.

CONCLUSION

I have focused my remarks thus far on the 1989-1993 period. If our estimates prove to be correct, the projected surpluses will generate

contingency margins above targeted levels for the first few years. In the out-years, CBO expects the surpluses and the differences between the CBO and the Administration estimates to decline. First, our ability to estimate future receipts and spending will improve with program experience. Second, mechanisms in the law are designed to adjust future premiums to assure that adequate, but not excessive, funds are available. Third, there will be more agreement over the prescription drug costs because the number of beneficiaries will, by law, be fixed at 16.8 percent of enrollees.