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before the

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Mr. Chairman, I am pleased to appear before the Committee today to discuss the Hospital Insurance Trust Fund. The fund faces two distinct but related financial pressures. First, hospital insurance expenditures represent a rising proportion of total federal spending and contribute to federal budget deficits, which the Congressional Budget Office (CBO) projects will rise dramatically over the next five years. Second, the Hospital Insurance Trust Fund itself faces potential financial insolvency in the coming decade.

Since you asked me to address specifically the trust fund issue, my testimony today will focus on CBO's recent projections of outlays, income, and balances in the Hospital Insurance Trust Fund. It will concentrate on the following:

- Our recently completed August baseline projections of Medicare's Hospital Insurance Trust Fund from 1985 to 1995; and

- Various uncertainties in making projections of program growth and the sensitivity to alternative assumptions.

Projecting trust fund balances is very difficult to do with any certainty. The outlay projections are particularly difficult because a new hospital reimbursement system has recently been established, and its effects are not yet fully understood. Nevertheless, since outlays are projected to

grow considerably faster than revenues, we anticipate that the balances in the Hospital Insurance Trust Fund will fall to zero sometime in the mid-1990s.

CBO BASELINE ESTIMATES

The Hospital Insurance (HI) portion of Medicare covers hospital, home health, and skilled nursing care for 30 million aged and disabled persons. CBO estimates that the HI trust fund will spend $48 billion in fiscal year 1985, while receiving $52 billion in income. This $52 billion includes $47 billion in payroll taxes, with the remaining income being primarily interest. Because revenues are estimated to grow more rapidly in the beginning of the projection period than at the end, the trust fund balance is expected to increase through 1989 and then begin to decline. Under CBO's baseline assumptions, outlays are projected to be $146 billion by 1995--some 36 percent above revenues in that year. These baseline projections are displayed in Table 1.

Outlays

The projected annual growth in spending of 11.8 percent incorporates projected increases in basic hospital costs, enrollment, and utilization, as well as other factors.

TABLE 1. BASELINE BUDGET PROJECTIONS OF HOSPITAL INSURANCE TRUST FUND OUTLAYS, INCOME, AND BALANCES (By fiscal year, in billions of dollars)

Years	Total Outlays	Income	Year-End Balance
1985	48	52	20
1986	53	61	29
1987	59	73	43
1988	66	72	49
1989	74	75	51
1990	82	79	48
1991	92	85	41
1992	103	91	28
1993	116	97	9
1994	130	102	-18
1995	146	107	-56

SOURCE: Congressional Budget Office, August 1984 estimates.

The basic cost of providing hospital care is estimated from the cost of a market basket of goods and services purchased by hospitals. Labor costs, which account for almost two-thirds of the total market basket, are assumed to grow at an average rate of more than 6 percent per year. The costs of capital goods and supplies--the remaining items in the market basket--are assumed to grow at the same rate as consumer prices in general. Under CBO's baseline economic assumptions, the total market basket for hospital costs is projected to increase by about 6 percent annually.

Beginning in October of 1983, hospital reimbursement under Medicare underwent a major change from a cost-based system to a system of prospective payments based on Diagnosis Related Groups (DRGs). This system was designed for gradual implementation and is expected to be fully in place by 1986. Under the new system, hospitals are reimbursed according to a fixed payment for each of 468 different diagnoses.

Outlays will be directly related to these DRG rates. Under existing law, the DRG rates are set to be budget-neutral through 1985, meaning that they should have no cost or savings impact on Medicare hospital reimbursement relative to law prior to enactment of the Social Security Amendment of 1983. CBO's baseline estimates for 1985 are based on preliminary regulations issued by the Secretary of Health and Human Services on July 3, 1984, which specify a budget-neutral rate of increase in 1985. 1/ In 1986, the increase in the DRG rate cannot exceed the market basket increase plus 0.25 percent, as specified by the Deficit Reduction Act. After 1986, the Secretary will determine increases in the DRG rates in consultation with the Prospective Payment Commission. CBO's projected HI increases beyond 1986 assume a growth rate equal to the market basket rate plus 1 percent, following the convention used by the HI actuaries. The

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1/ The final regulations were released by the Secretary of Health and Human Services on August 31, 1984. These regulations will result in slightly higher projected HI outlays than estimated in baseline, but will have only a marginal impact on the trust fund's financial problem.

additional 1 percent is designed to allow for improvements in medical technology. These estimated increases in the DRG rate can be thought of as the increases in the unit costs of covered hospital activities.

HI outlays will grow more rapidly than these unit costs, however. Additional annual increases in HI outlay growth stem from increases in program enrollment and in hospital admission rates. These are projected to be 2 percent and 1 percent per year, respectively. Finally, CBO's projections include another cost increase of 1.5 percent per year to allow for other growth in Medicare hospital reimbursement not specifically limited by the Secretary. This growth, for example, could be the result of changes in hospital admitting practices that change the mix of procedures performed, thereby increasing the average cost per admission. In response to the implementation of the DRG system, this residual growth is projected to be slightly lower than in past experience. Combined, these yield an average total outlay growth of 11.8 percent per year.

Revenues

On the income side, revenues flow into the trust fund mainly through payroll taxes, although some income is derived from interest earned on balances and from general revenue transfers. Payroll tax receipts depend on wages and salaries and on employment. Increases in wages and salaries determine the per-person increases in revenues to the trust fund, while the level of employment determines the pool of individuals to be taxed.

The 7.5 percent average annual growth in revenues over the entire period is best explained in two time frames--pre- and post-1989. Between 1985 and 1989, a very special set of circumstances will increase income to the HI trust fund, and after 1989 income growth will average only 6 percent. Two factors dominate the early period: first, the Old Age and Survivors Insurance (OASI) Trust Fund is expected to repay a loan of $12.4 billion to the HI trust fund; second, the HI payroll tax rate is scheduled to increase from 1.3 percent to 1.35 percent in 1985 and to 1.45 percent in 1986--an overall increase of 12 percent. No tax increases are scheduled after 1986.

Thus, while spending is projected to continue to increase by over 11 percent a year, income growth is expected to keep pace only through 1989. After 1989, when the loan to the OASI trust fund is fully repaid and all scheduled HI payroll tax increases are in place, the trust fund balance is projected to decline steadily.

UNCERTAINTIES IN PROJECTING PROGRAM GROWTH

Estimates of the financial status of the trust fund are very sensitive to the projected growth rate of outlays. Unfortunately, recent reimbursement patterns to hospitals have heightened our uncertainty about such projections.

Since August 1983, spending for HI has been much lower than previously predicted. Based on actual HI outlay data for the first 10 months of fiscal year 1984, CBO now estimates that 1984 outlays will be only 10 percent greater than those in 1983. This is considerably below historical growth rates. Part of this change simply reflects the low overall inflation rate for wages and other inputs during 1984, but part undoubtedly reflects the introduction of the new DRG reimbursement system.

For projection purposes, the problem is to separate out temporary adjustment factors from long-term improvements in the hospital cost picture. Because the prospective payment system is new, hospitals can be expected to go through some temporary adjustments that involve learning the mechanics of the system, understanding where the rate structure is most binding, and so forth. These factors, which might initially hold down HI outlays, should lessen over time and would therefore not affect the long-run performance of the system.

On the other hand, many changes have been occurring in the hospital industry that might have more enduring effects on cost growth. For example, in partial response to consumer, business, and government concerns over rising health care costs, many new health organizations are being formed. Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and state and local government cost control

plans are growing in size and importance. These groups could affect both hospital admissions rates and hospital costs. Simultaneously, during the last year there has been an unexpected dip in the rate of increase of hospital admissions for those age 65 and older. This decline in the rate of growth of admissions is the opposite of what many observers thought would result from DRG pricing--namely, that hospitals would increase admissions to compensate for lower per-admission reimbursements. All of these factors make forecasting the growth in health-care costs over the next decade a very uncertain task.

While the exact path of HI fund balances is highly uncertain, severe financial problems are ultimately very likely even with more optimistic assumptions about lower outlay growth. Table 2 shows CBO baseline projections modified by a one percentage-point increase or decrease in the rate of change for Medicare hospital reimbursement. For example, if the growth rate in Medicare hospital reimbursement is one percentage point lower than assumed in the baseline, the trust fund balance will be $0.4 billion higher for the first year. The amount accumulates over time, so that by 1989 the balance would be $9 billion higher than the baseline estimates. By 1995, the difference would total $77 billion. While the financial status of the trust fund under this lower growth path of outlays is obviously improved, the trust fund would ultimately be depleted because growth in outlays still exceeds growth in trust fund income. Conversely, if the increase in hospital

reimbursement were one percentage point higher than assumed in the baseline, the trust fund would be depleted in 1992 and by 1995 the deficit would grow to $138 billion, $82 billion more than the baseline estimate.

Several examples of uncertainty in the forecasts can be cited--namely, that arising from DRG rate increases, that arising from how the system and other factors affect hospital use, and, to a lesser extent, that arising from the underlying macroeconomic forecasts.

DRG Rate Increases

While rate increases for 1985 are now known, those for 1986 and beyond remain uncertain. The Deficit Reduction Act caps the 1986 growth on the DRG rate at that of the market basket plus 0.25 percent, and the CBO baseline assumes that the actual increase will equal this cap. After 1986, no limits are specified by law, and the Secretary of Health and Human Services must specify the annual changes. The Secretary thus has discretionary power over future increases, although payments will almost certainly reflect movements in aggregate hospital costs. The baseline estimates, as described above, assume that the DRG rate increases at 1 percent above the increases in the cost of the market basket.

TABLE 2. PROJECTIONS OF HOSPITAL INSURANCE TRUST FUND OUTLAYS, INCOME, AND BALANCES UNDER ALTERNATIVE RATES OF INCREASE IN HOSPITAL COSTS (By fiscal year, in billions of dollars)

	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Baseline Path											
Total Outlays	48	53	59	66	74	82	92	103	116	130	146
Income	52	61	73	72	75	79	85	91	97	102	107
Year-end Balance	20	29	43	49	51	48	41	28	9	-18	-56
Baseline Path--Assuming 1 Percent Less Increase											
Total Outlays	48	52	57	64	70	78	87	97	107	119	132
Income	52	61	73	73	75	81	87	93	100	107	113
Year-End Balance	21	30	46	55	60	62	63	59	52	40	21
Baseline Path--Assuming 1 Percent More Increase											
Total Outlays	49	54	60	68	77	87	98	111	125	141	160
Income	52	61	73	72	74	78	84	88	93	98	101
Year-End Balance	20	27	40	44	41	33	19	-4	-35	-79	-138

SOURCE: Congressional Budget Office, August 1984 estimates.

Effect of DRGs and Other Factors on Hospital Use

Perhaps the greatest uncertainty, however, revolves around how hospitals react to the DRG system and other pressures in terms of hospital utilization, admitting practices, and pattern of admissions. For example, hospitals could switch certain diagnoses from out-patient to in-patient care, or vice versa. Hospitals could also continue a movement toward a more complex caseload mix, a trend that has already been observed. With the system not yet fully in place, however, it is still too early to determine the effect of DRGs on hospital behavior.

Economic Assumptions

Our projections of trust fund finances depend to a large extent on projections of wages and prices for the economy as a whole. Because inflation and growth affect both outlays and revenues, however, our projections of the financial status of the trust fund are not very sensitive to changes in our macroeconomic assumptions. Barring some unexpected change in real wage growth, the trust fund's long-run financial stability will depend most on hospital behavior and DRG rate policy. The exact timing of the depletion of the fund, however, could be sensitive to possible economic fluctuations.

CONCLUSION

The alternatives I have discussed demonstrate that the projections of HI spending are sensitive to many factors. As the DRG system is fully implemented, some of this uncertainty should dissipate. Nevertheless, growth in spending is projected to outpace the growth in revenues so that the trust fund is likely to be either in critical condition or depleted in the 1990s.

The financial status of the HI trust fund does not suggest an urgent need to take action immediately. Two things, however, should be pointed out. First, since action will ultimately be required, beginning adjustments early generally allows for the most options in dealing with the situation and helps mitigate any disruptions caused by large and sudden policy changes. Second, any action taken to improve the financial status of the trust fund has the added advantage of improving the overall deficit in the unified budget.