CBO TESTIMONY

Statement of
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on
Baseline Projections for Medicare and Medicaid

before the
Subcommittee on Health and Environment
Committee on Commerce
U.S. House of Representatives

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NOTICE

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Mr. Chairman and Members of the Committee, thank you for inviting me to discuss the status of the Medicare and Medicaid programs. Although the Congressional Budget Office (CBO) has recently reduced its projections of spending for Medicare and Medicaid, those two programs are still the most rapidly growing of the major entitlements, and they are the major source of upward pressure on the deficit. CBO projects that federal spending for both Medicare and Medicaid will increase at an average annual rate of more than 8 percent over the next 10 years (see Table 1). By contrast, CBO projects that federal revenues will grow by only 5 percent a year—about the same rate as the economy.

WHAT DOES THE BASELINE REPRESENT?

CBO's baseline projections of Medicare and Medicaid outlays are not forecasts of future outcomes but benchmarks against which to measure the effects of proposed legislation affecting the programs. The baseline is a projection of the spending on Medicare and Medicaid beneficiaries that would occur under current law—that is, without federal legislative action. The Medicare and Medicaid baselines include the effects of any future updates in reimbursement rates or changes in coverage already enacted into law. They also take into

TABLE 1. PROJECTIONS OF MEDICARE AND MEDICAID OUTLAYS (By fiscal year, in billions of dollars)

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Average Annual Percentage Rate of Growth, 1996-2007
Hospital Insurance[a]	125	137	149	161	176	184	202	218	235	259	275	290	7.9
Supplementary Medical Insurance[a]	69	75	82	90	100	105	116	126	138	155	167	179	9.1
Gross Medicare Outlays[a]	194	212	230	251	276	289	317	343	372	414	442	469	8.3
Premium Receipts	-20	-20	-21	-22	-23	-24	-26	-27	-28	-29	-31	-32	4.4
Net Medicare Outlays[a]	174	192	209	229	253	265	292	316	344	385	411	436	8.7
Medicaid	92	99	105	114	123	133	144	156	169	183	199	216	8.1

SOURCE: Congressional Budget Office.

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

a. Includes benefit payments and mandatory and discretionary administrative expenses.

account projected actions by federal administrators, state governments, health care providers, and beneficiaries.

In preparing its projections for both Medicare and Medicaid, CBO looks at growth in the number of people covered by each program and in the amount of spending per enrollee. Changes in payments per enrollee in turn reflect changes in payments for each unit of health care service as well as changes in the number and complexity of such services provided to each enrollee.

Enrollment

For Medicare, CBO bases its estimates of enrollment primarily on demographic trends that affect the size of the aged and disabled populations. We also take into account other factors, such as administrative decisions that might affect the number of people awarded disability benefits.

Projecting enrollment in Medicaid is more complicated, both because the eligibility rules are more complicated and because of recent legislative

changes. CBO generally assumes that enrollment of children and adults in low-income families will increase at the same rate as overall population growth. The figures are adjusted to reflect the continued phase-in of the expansions enacted in Omnibus Reconciliation Act of 1990 and the impact of welfare reform. Projections of enrollment for the aged and disabled are based on the growth of the Medicare and Supplemental Security Income programs and on the population over age 85.

Payments per Enrollee

For Medicare, CBO projects increases in payment rates to providers according to the formulas and reimbursement limits specified in law. For example, hospitals are paid a set fee for each inpatient admission, and the amount depends on the beneficiary's diagnosis. Under current law, the amount of the payment is raised each year by the increase in the hospital market basket—a price index intended to measure hospitals' costs.

CBO's projections of increases in the use of services by fee-for-service beneficiaries vary for different classes of services. For example, CBO projects

that the number of home health visits will increase by 6 percent a year over the 1996-2002 period, even though the number of fee-for-service beneficiaries will decline by 1.5 percent annually. The difference between the two numbers represents projected growth in use—a higher proportion of beneficiaries receiving home health services as well as an increase in the number of visits per user.

Distinguishing between increases in payment rates and increases in the use of services for the Medicaid program is considerably more difficult. First, Medicaid has no specific payment formulas at the federal level. Instead, states have a wide degree of latitude in determining how much to pay providers. CBO employs several health care price indexes as proxies for the amount by which states will increase payment rates. Those proxies are not intended to measure actual increases, but to provide some measure of the pressures that states face in setting reimbursement rates.

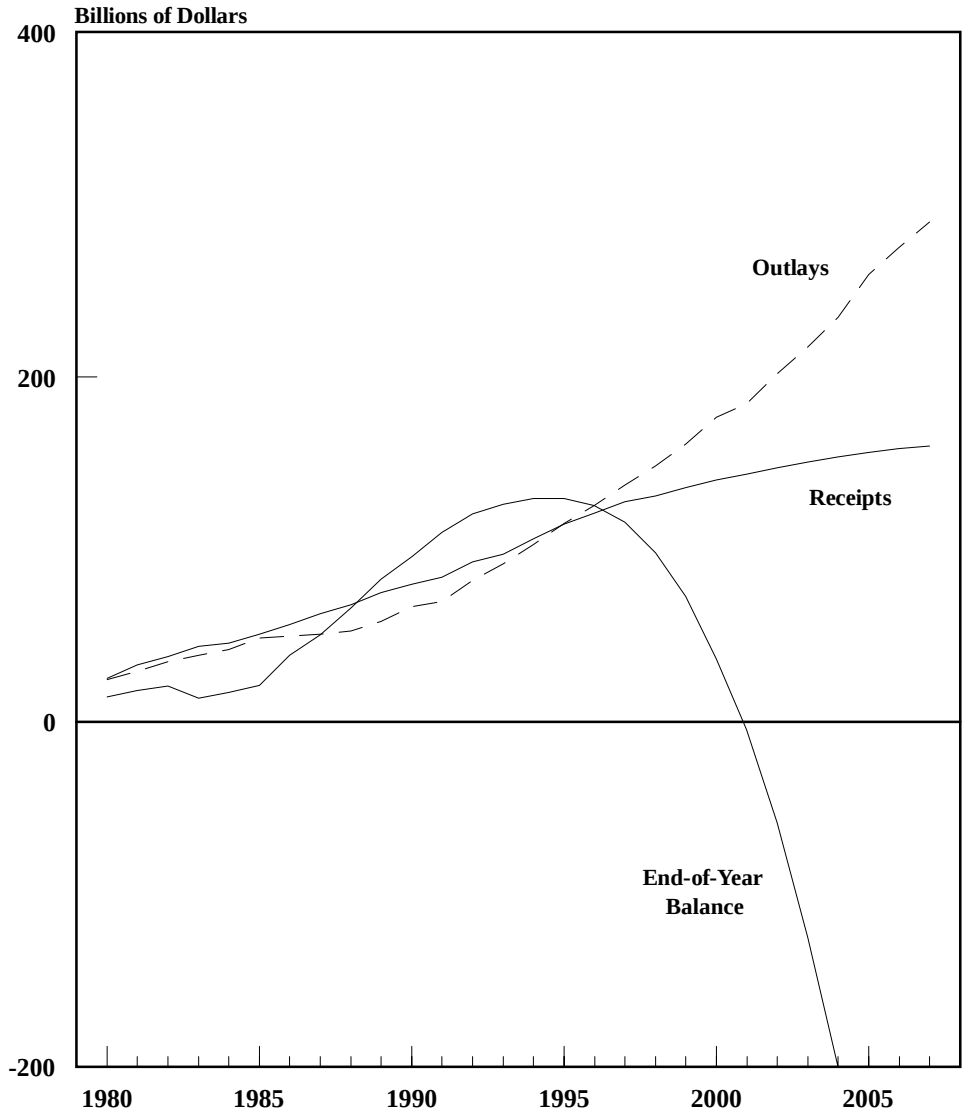
Second, Medicaid benefits vary among states and over time, making it difficult to disentangle growth in prices from changes in benefits. Consequently, changes in use reflect not only the increased number and complexity of services per enrollee, but also whether individual states have

reduced or expanded services. CBO assigns utilization factors to different categories based on its analysis of historical trends. This year's baseline projects continued increases in utilization for both long-term and acute care services provided outside the usual settings. Spending for those services has been increasing rapidly in the past few years.

PROJECTIONS OF MEDICARE SPENDING

CBO projects that spending for Medicare—primarily for medical benefits—will increase from $194 billion in 1996 to $317 billion in 2002 and $469 billion by 2007, an average annual increase of 8.3 percent. Although the growth in Medicare spending has slowed since the late 1980s and early 1990s, it will continue to outpace the growth in resources that finance the programs. Outlays for Hospital Insurance (HI) benefits will increase more rapidly than payroll tax revenues, depleting the HI trust fund by the end of 2001 (see Figure 1). Because premiums for the Supplementary Medical Insurance (SMI) program may increase by no more than the Social Security cost-of-living adjustment, the share of costs covered by premiums will continue to shrink.

FIGURE 1. RECEIPTS, OUTLAYS, AND END-OF-YEAR BALANCE OF MEDICARE'S HOSPITAL INSURANCE TRUST FUND
(By fiscal year)



SOURCE: Congressional Budget Office.

CBO's new projections of Medicare spending are lower than our May 1996 projections for two reasons. First, outlays in 1996 for both HI and SMI were lower than we anticipated, meaning that the growth in future spending starts from a lower level. Second, we have reduced the projected growth of SMI spending from 10 percent to 9 percent a year over the 1996-2002 period, primarily reflecting slower growth in spending for physician and laboratory services in the past few years. For HI benefits, CBO projects average increases in spending of about 8 percent, a rate that is essentially unchanged from our May 1996 projections.

Because the noninterest income of the HI trust fund is growing at only 5 percent a year, the balance of the fund will decline steadily unless legislative action is taken. By 2007, annual outlays will exceed receipts by $130 billion, and the trust fund will have a negative balance of $556 billion (see Table 2). Avoiding depletion of the HI trust fund before the end of 2007 will require cumulative reductions in spending or increases in receipts totaling about $450 billion over the 1998-2007 period. If achieved solely on the spending side, reducing the rate of growth in HI outlays from 7.7 percent to 3.4 percent between now and 2007 would reach that goal.

TABLE 2. BASELINE PROJECTIONS OF THE MEDICARE HOSPITAL INSURANCE TRUST FUND
(By fiscal year, in billions of dollars)

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Outgo	125	137	149	161	177	184	202	217	235	259	275	290
Income												
Payroll taxes[a]	111	118	122	129	135	142	148	156	163	171	180	189
Interest	10	10	9	7	5	2	-1	-5	-9	-15	-21	-29
Total	121	128	131	136	140	144	147	151	154	156	158	160
Deficit	-4	-10	-18	-25	-36	-41	-54	-67	-81	-103	-117	-130
Fund Balance[b]	125	116	98	73	36	-4	-59	-126	-207	-310	-426	-556

SOURCE: Congressional Budget Office.

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

a. Includes a small amount of premiums and other noninterest income.
b. At the end of the fiscal year.

CBO's new projections assume that the number of Medicare beneficiaries enrolled in health maintenance organizations (HMOs) will continue to grow rapidly. CBO now projects that the fraction of beneficiaries in such plans will approach 25 percent by 2002 (and 35 percent by 2007) from about 12 percent now. With growth in overall enrollment rising very slowly over that period, the number of beneficiaries in Medicare's traditional fee-for-service sector will decline in absolute terms.

As a direct result of the rapid increase in HMO enrollment, payments to managed care plans are the fastest growing element of Medicare spending. CBO projects that such payments will increase from $18 billion in 1996 to $73 billion in 2002—an annual rate of growth of 26 percent. Payments for each HMO enrollee will rise at about the same rate as fee-for-service spending because payments to risk-based HMOs are directly linked to fee-for-service spending under current law.

Despite the shrinkage in fee-for-service enrollment, spending for that sector will continue to balloon. CBO projects that spending for each

fee-for-service enrollee will increase by an average of 7.2 percent a year over the 1996-2002 period and that total fee-for-service spending will rise 5.6 percent a year.

CBO continues to project relatively rapid growth in Medicare because current reimbursement rules give neither beneficiaries nor providers much incentive to control costs. The vast majority of beneficiaries have supplementary insurance that covers deductibles, coinsurance, or both.

On the provider side, efforts to contain costs have generally focused on restricting growth in the price per unit of service by limiting the automatic fee increases or the growth in costs eligible for reimbursement. At the same time, those efforts placed few or no limitations on the number of services provided. Efforts to control the growth of both prices and volume of services furnished by a type of provider have in fact had some success in slowing the growth in payments to those providers. Yet they have also created incentives to channel patients into alternative settings that have no restrictions. In CBO's projections, therefore, spending for services with no form of control on volume

(home health services, for example) grow much faster than those with some control on volume, such as the prospective payment system, which pays for hospital inpatient services.

PROJECTIONS OF MEDICAID SPENDING

CBO projects that federal outlays for Medicaid will grow from $92 billion in 1996 to $216 billion in 2007. The largest component, spending for medical assistance payments, is projected to rise from about $79 billion to $186 billion, and spending for payments to disproportionate share hospitals—so-called DSH payments—is estimated to rise from about $9 billion in 1996 to almost $20 billion in 2007. Administrative expenses account for the rest of the program's spending. About 50 percent of Medicaid's growth over the 1996-2007 period stems from increases in payment rates, 15 percent from rising enrollment, and 35 percent from other factors, such as increases in DSH payments, administrative costs, and utilization of health care services.

CBO's current projection of federal Medicaid spending in 2002 is $23 billion below its May 1996 projection (see Table 3). Part of that reduction

TABLE 3. CHANGES IN CBO BASELINE PROJECTIONS (By fiscal year, in billions of dollars)

January 1997 Baseline							
Medicare	174	192	209	229	253	265	292
Medicaid	92	99	105	114	123	133	144
May 1996 Baseline							
Medicare	179	198	217	237	258	281	305
Medicaid	96	105	115	126	138	152	167
Changes in CBO Projections							
Medicare	-5	-6	-8	-8	-5	-16	-13
Medicaid	-4	-6	-10	-13	-15	-19	-23

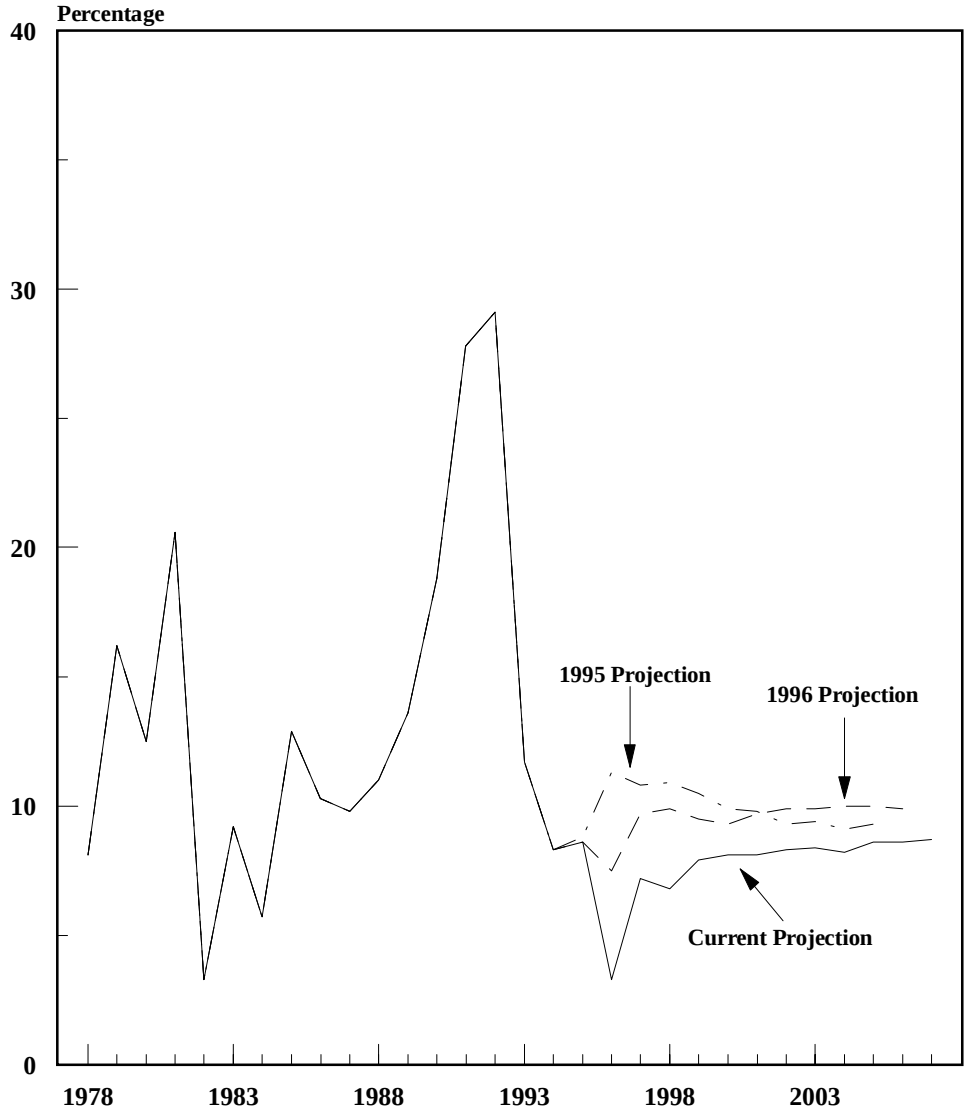
SOURCE: Congressional Budget Office.

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

is the result of a lower starting point because 1996 outlays were almost $4 billion less than we anticipated. In addition, CBO has lowered its projection of the average annual rate of growth in spending over the 1996-2002 period from 9.6 percent to 7.7 percent because of slower projected growth of enrollment, smaller expected increases in inflation, and lower projected use of services. The reduction also includes the savings resulting from enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

Growth in Medicaid has subsided from the sky-high rates of the early 1990s. Spending for the Medicaid program jumped between 20 percent and 30 percent a year from 1990 through 1992, but its growth decelerated to an average of about 10 percent from 1993 through 1995 and to just 3.3 percent in 1996 (see Figure 2). Two factors fueled the surge in spending: the states' use of provider donations and taxes, and intergovernmental transfers that generated federal matching funds to disproportionate share hospitals. States also shifted services that they alone had previously funded to the Medicaid program. That activity is commonly referred to as "Medicaid maximization." As a result, states could obtain additional federal matching funds without committing any new state resources. Other factors that contributed to Medicaid growth in the

FIGURE 2. GROWTH IN FEDERAL OUTLAYS FOR MEDICAID (By fiscal year)



SOURCE: Congressional Budget Office.

NOTE: The current projection begins in 1997.

early 1990s were expansions in coverage (especially for poor children and low-income Medicare beneficiaries), the recession of 1990-1991, and increased payment rates for providers.

Last year's low growth rate—one of the smallest annual increases since Medicaid started in 1965—may be attributed in part to general uncertainty about the outcome of proposals to reform the program as well as to efforts by the states to maximize their share of any new system. (In proposals for a Medicaid block grant, a state could have increased the base on which its future federal funding would have been computed by shifting some spending from 1996 to 1995). That uncertainty contributed to an erratic spending pattern: federal expenditures did not increase at all during the first half of 1996, but grew at an annual rate of more than 6 percent during the second half of the year.

CBO's Medicaid projection reflects a continuation of relatively low rates of growth in the near term and somewhat higher rates thereafter, as pressures for higher spending reemerge. Those pressures are likely to come from several sources.

First, CBO believes that savings from expanding enrollment in managed care are not likely to be large in the long run. Current fee-for-service reimbursement rates are already low, and the beneficiaries being moved into managed care account for a relatively small share of Medicaid spending. Developing appropriate and cost-saving models of managed care for elderly and disabled beneficiaries (particularly those in long-term care) will be difficult. Those beneficiaries account for the bulk of Medicaid expenditures. Second, states still have the ability to secure additional federal funds at no expense to themselves by using Medicaid maximization or intergovernmental transfers. Finally, pressures for increased use of services continue in a number of areas, including noninstitutional long-term care, prescription drugs, and other acute care services.

THE ADMINISTRATION'S BUDGET

Last week the Administration submitted its budget proposal for fiscal year 1998. CBO's analysis of the budget is currently under way and will be completed by the end of the month. In the meantime, I can make a few general comments.

Overall, CBO and the Administration have similar baseline projections for Medicare and Medicaid (see Table 4). CBO's Medicare baseline is slightly lower, our Medicaid baseline is slightly higher, and the sum of the two is virtually identical. The similarity in baselines will tend to minimize the estimating differences that have arisen in the past. If history is a guide, however, CBO may still conclude that some of the proposed reductions in spending save less and some of the proposed new benefits cost more than the Administration estimates.

The budget proposes to save $121 billion in mandatory programs over the next five years. By the Administration's own estimates, Medicare and Medicaid account for 90 percent of the net mandatory savings in the budget.

In Medicare, the Administration projects a net deficit reduction of $100 billion—$115 billion in gross savings less $15 billion in expanded benefits. Three-quarters of the savings—$78 billion—would occur in the HI program, and only one-quarter in SMI. In addition, the Administration is proposing to shift responsibility for a substantial portion of home health

TABLE 4. COMPARISON OF CBO AND ADMINISTRATION BASELINES (By fiscal year, in billions of dollars)

	1997	1998	1999	2000	2001	2002
CBO Baseline						
Medicare[a]	192	209	229	253	265	292
Medicaid	99	105	114	123	133	144
Administration Baseline						
Medicare[a]	194	211	231	252	274	298
Medicaid	99	104	111	120	129	139
Difference						
Medicare[a]	-3	-3	-2	1	-9	-6
Medicaid	b	1	2	3	4	5

SOURCE: Congressional Budget Office.

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

a. Includes benefit payments and mandatory and discretionary administrative expenses.
b. Less than $500 million.

spending from HI to SMI. Although the shift of home health costs would have no effect on total Medicare spending, it would help to extend the solvency of the HI trust fund for a number of years.

In Medicaid, the Administration proposes reductions of $22 billion and new initiatives of $13 billion, for a net savings of $9 billion. Two-thirds of the savings would stem from limiting Medicaid payments to disproportionate share hospitals. In addition, the Administration proposes to cap the rate of increase in federal payments per beneficiary. The new initiatives include measures to enhance coverage for children who are eligible for Medicaid and to restore coverage for certain immigrants and disabled children affected by welfare reform.

CONCLUSION

More important than making short-run savings, however, is restructuring Medicare and Medicaid to prepare for the retirement of the baby-boom

generation. If the growth of those programs is not slowed, federal deficits and debt could grow to unsustainable levels, with severe consequences for the U.S. economy.

How much budgetary stringency is needed—and of what kind—is a matter for debate. What is clear, however, is that both Medicare and Medicare must be prepared for the unprecedented demands that will be placed on them in a relatively few years. Policies put in place soon could provide both needed deficit reduction in the short term and start the restructuring needed for the long run.