# CBO TESTIMONY

Statement of
Dan L. Crippen
Director
Congressional Budget Office

on
Medicare for Future Generations

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

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This statement is not available for public release until it is delivered at 2:00 p.m. (EDT), Wednesday, September 22, 1999.

**CONGRESSIONAL BUDGET OFFICE**
**SECOND AND D STREETS, S.W.**
**WASHINGTON, D.C. 20515**

Mr. Chairman and Members of the Committee, I am pleased to be here today to discuss reforming Medicare for the long term. Growth in Medicare spending has slowed remarkably in 1998 and 1999, partly because of provisions in the Balanced Budget Act of 1997 (BBA). Nonetheless, without reform, the program is expected to face mounting pressures in coming years, arising from rapid growth in the number of eligible people and increases in the cost of care per patient.

## PROJECTIONS OF MEDICARE COSTS UNDER CURRENT LAW

Spending for Medicare is expected to exceed $200 billion this year, providing benefits to 39 million elderly or disabled people. Despite the recent slowdown in the growth of spending, outlays for benefits are expected to more than double in the next decade.

At that rate, Medicare spending will account for almost 20 percent of the federal budget by 2009, up from about 12 percent this year. Under current law, Medicare's share of the budget will continue to increase rapidly thereafter, partly because of the influx of the baby-boom population. According to the intermediate assumptions of the Social Security trustees, the elderly population will increase by about 1 percent a year between 2000 and 2010 but by almost 3 percent a year between 2010 and 2030—rising from 39 million to 69 million people. And, as in the past, Medicare's costs will probably grow faster than its enrollment, reflecting

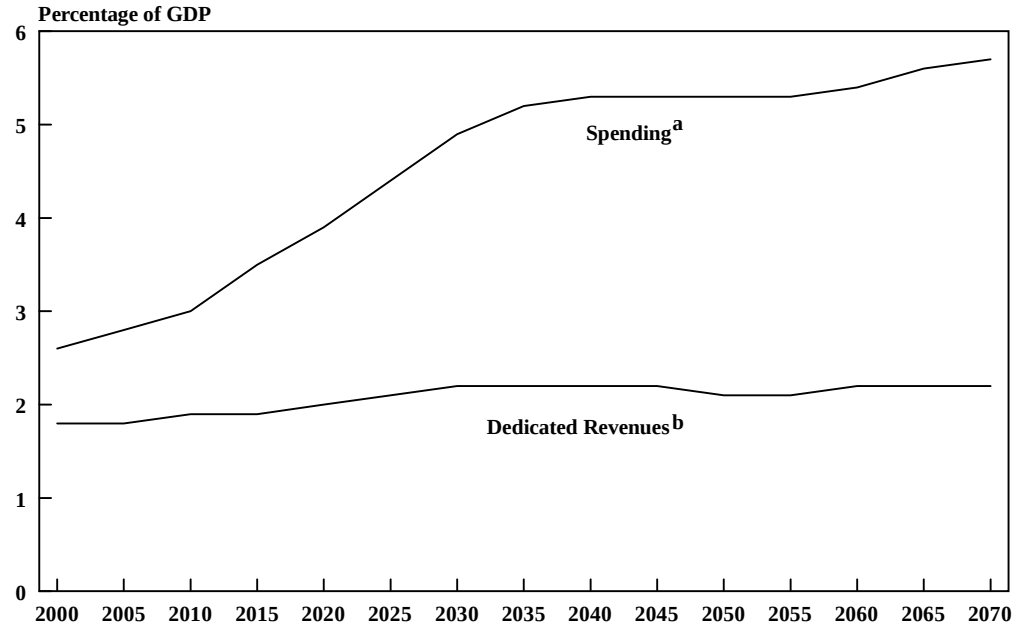
continuing advances in medical technology and increases in the use of services by enrollees.

Although such projections involve much uncertainty, Medicare has to prepare for the unprecedented demands that the baby-boom population will soon impose on it. Assuming no change in policy, the Medicare trustees estimate that program spending will grow from about 2.5 percent of gross domestic product (GDP) this year to 4.9 percent of GDP in 2030, as the last of the baby boomers enroll in the program. By 2070, spending is projected to grow to 5.7 percent of GDP. Meanwhile, the ratio of active workers to retirees will fall, making the current system of financing difficult to maintain without tax increases or substantial cost reductions.

There is a widening gap between spending for Medicare and the revenues that are specifically dedicated to the program (see Figure 1). The Congressional Budget Office (CBO) estimates that revenues dedicated to Medicare equal about 1.8 percent of GDP this year, substantially less than program spending.[1] The gap largely reflects the infusion of general funds into Supplementary Medical Insurance (SMI), which accounts for 75 percent of the cost of that program. The gap between

1. Dedicated revenues include payroll taxes and income taxes on Social Security benefits, which are paid into the Hospital Insurance Trust Fund, plus premiums for Supplementary Medical Insurance (estimated as 25 percent of the costs of that insurance).

FIGURE 1. PROJECTED FINANCIAL STATUS OF THE HOSPITAL INSURANCE AND SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS, 2000-2070




SOURCE: Congressional Budget Office based on the 1999 annual reports of the Medicare trustees.

a. The sum of disbursements for benefit payments and administrative expenses from the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) Trust Funds under the intermediate assumptions of the trustees.

b. The sum of income from payroll taxes and the taxation of Social Security benefits, which is paid into the HI trust fund, plus SMI premiums (estimated as 25 percent of SMI costs) under the intermediate assumptions of the trustees.

spending and dedicated revenues is projected to increase over time, as the Hospital Insurance (HI) Trust Fund goes into deficit. By 2030, dedicated revenues will be about 2.2 percent of GDP while spending will be about 4.9 percent of GDP. The financial imbalance will continue to grow after 2030.

Restoring actuarial balance to the HI trust fund for the next 75 years would require significantly increasing revenues or decreasing spending. According to the latest report of the Medicare trustees, balance would be restored in the HI trust fund if the payroll tax was immediately increased by about 50 percent—from 2.9 percent of wages to 4.36 percent—or spending was reduced by an equivalent amount. Such policies would not address the growth of SMI, which is already largely funded by general revenues.

Moreover, those projections assume that growth in spending per beneficiary will gradually decline to be more in line with growth in hourly earnings, even without a significant policy change. That assumption is probably unrealistic; if spending per beneficiary does not slow, the financial status of the HI trust fund will be considerably worse. For example, if the long-term growth in HI spending per beneficiary increased by 1 percentage point, the payroll tax increase needed to restore actuarial balance in the trust fund would more than double. Under that circumstance, the Medicare trustees estimate that the HI payroll tax would immediately increase from 2.9 percent of wages to 6.52 percent.

The nation will most likely devote more of its income to health care in the coming decades, and since the elderly will become an increasingly dominant part of the population, public acceptance of larger federal health spending may grow. Furthermore, the ability to pay for goods and services, including health care ser-

vices, grows as the economy grows. Thus, policies that enhance economic growth will make it easier to meet the needs of the elderly population. But the trade-off between health care and other goods and services would be less marked if Medicare was more efficient, meeting enrollees' needs in the least costly way. Improving Medicare's efficiency may involve restructuring the program more fundamentally than has been done so far.

## BBA POLICIES TO PROMOTE COMPETITION AMONG HEALTH PLANS

In establishing the Medicare+Choice system under the Balanced Budget Act, the Congress wanted to make Medicare's risk-based sector more competitive by expanding the range of available plans—both the kinds of plans offered and the areas in which they were offered. The Congress also mandated a coordinated open-enrollment process intended to better inform beneficiaries about their options.

But the BBA left in place the administered pricing system, which sets Medicare's payments to plans. Consequently, the program has no meaningful price competition among plans for the basic benefit package. Instead, plans have incentives to increase optional benefits rather than to reduce costs, just as they did before the BBA. Changing to a premium-support or bidding system could expand competition to include price as well as benefits and quality of service, so that Medicare

could capture some of the savings from plans' more efficient health care management. Many issues would have to be resolved, however, before Medicare could carry out such an approach nationwide. The competitive-bidding demonstrations mandated by the BBA, if successfully implemented, could provide some answers.

## OPTIONS FOR RESTRUCTURING MEDICARE

Recent policy debate has centered around two broad approaches to restructuring the Medicare program: shifting from pay-as-you-go financing to prefunding and shifting from open-ended federal payments to a defined contribution. Both of those approaches would attempt to make beneficiaries more aware of the costs and benefits of seeking additional care and would depend on vigorous competition among health plans to ensure efficiency and maintain high standards of quality.

### Prefunding

Proposals to prefund Medicare would require people to save during their working years to finance health insurance after they retire. Ironically, that approach would put into place a self-financing mechanism that many people believe already exists with the Medicare trust funds. When fully implemented, prefunding would largely

eliminate the current flow of subsidies from workers to retirees. Those subsidies will become increasingly burdensome as the number of workers for each retiree falls from 3.8 today to 2.2 by 2030. Because each generation would pay for its own Medicare costs, prefunding would avoid the prospect of generations with relatively few workers having to finance the health expenditures of larger generations—a problem inherent in Medicare's current financing system.

Any switch from a pay-as-you-go system to prefunding faces a potentially long, complex, and costly transition period. Current Medicare enrollees and older workers, who have insufficient working years left to save enough to cover their health spending in retirement, will continue to depend on pay-as-you-go financing. Younger workers could face significant mandatory contributions to finance their own future insurance needs while paying additional taxes to fund the transition.

Defined Contribution

Under a defined contribution (or voucher) plan, Medicare would make a fixed payment to beneficiaries, who would choose from a range of health plans —including the traditional fee-for-service program. If their chosen plan's premium exceeded Medicare's payment, they would pay the extra amount. In principle, with beneficiaries required to pay the additional costs of more expensive plans, health

plans would have an incentive to compete on the basis of price and become more efficient, thereby lowering costs and reducing the future fiscal burden on workers.

The design most frequently discussed in current debates—the premium-support model—would retain a basic benefit package that all plans would offer. The government's payment would ensure that at least one plan could be purchased with no more than a modest additional premium paid by beneficiaries. Plans could offer additional services and would be free to set higher premiums.

Accurate risk-adjustment methods are necessary if plans are to compete on the basis of benefits, quality of service, and premium cost. Plans that attracted higher percentages of high-cost enrollees would find it difficult to compete if the payments they could expect for those people did not reflect their probable costs. Instead of focusing on ways to improve efficiency, plans in those circumstances might focus on attracting healthier enrollees (a situation known as favorable selection).

Eliminating all of the risks associated with high-cost enrollees would be undesirable since financial risk promotes more efficient practices. Nonetheless, undue vulnerability to financial risk could be reduced in the following ways:

- *Payment adjusters*. The Health Care Financing Administration (HCFA) currently uses demographic factors for age, sex, Medicaid receipt, and institutionalization to adjust payments to plans for the expected costs of their enrollees. Beginning in 2000, HCFA will add an adjuster based on prior inpatient admissions to better account for health status. However, a payment adjustment based on prior inpatient admissions creates an obvious way for plans to increase their Medicare payments by hospitalizing enrollees unnecessarily—a problem that HCFA is well aware of. Consequently, HCFA intends to develop a more comprehensive health status adjuster as soon as possible.

- *Partial capitation*. Because even the best payment adjuster can account for only a modest amount of variation in health spending at the plan level, the Medicare Payment Advisory Commission and others have suggested that some kind of partial capitation may be necessary to ensure that plans do not skimp on the services provided to their enrollees. Partial capitation could be introduced by blending a capitated rate and a fee-for-service rate, supplementing payments for unusually costly cases, providing stop-loss protection on total costs at the plan level, or carving out selected high-cost services. All of those approaches would reduce the capitation rate across the

board, imposing a kind of premium on plans in return for insurance against excessive risk.

Other strategies for controlling adverse selection could reduce the demands on risk adjustment. Such strategies include coordinated open-enrollment periods, controls on the marketing of plans, and a requirement that plans offer a standardized benefit package.

## REFORMING FEE-FOR-SERVICE MEDICARE

About 85 percent of Medicare enrollees remain in the program's traditional fee-for-service sector. According to current CBO projections, that share will fall to 70 percent by 2009. Thus, Medicare's fee-for-service sector should remain dominant, especially in less populated areas, at least through the next decade. Consequently, efforts at cost control must include the fee-for-service sector. Previous efforts have focused almost entirely on providers. Although some additional policy changes affecting providers could be made, changes affecting enrollees could also be considered.

Policies Affecting Providers

Paying separately for each service a patient receives encourages the provision of unnecessary services. One alternative to separate payments is a single payment, determined prospectively, for all services deemed appropriate to treat a given condition. Prospective payment encourages providers to treat the patient with the fewest services possible to adequately address the condition. Medicare has had a prospective payment system for hospital inpatient services since 1983. The BBA mandates new prospective payment systems for hospital outpatient, skilled nursing, and home health services.

Prospective payment could be expanded. One way is to bundle together payments for acute and postacute hospital services. Another way is to combine payments for physician and facility services during a hospital stay. However, developing viable prospective payment systems is difficult. Having more comprehensive bundles of services reduces providers' opportunity to shift services to sites or times not included in the prospective payment, increasing their incentive to reduce costs; but such bundling also imposes greater financial risk on providers. One way to reduce excessive risk and the resulting incentive to avoid difficult cases is to include severity adjustments in the payment system, similar to the risk adjusters applied to capitation rates for paying Medicare+Choice plans. Another

option is to expand the current hospital outlier policy to compensate providers for unusually expensive cases.

An alternative approach could use competitive bidding to establish prices for individual services in the fee-for-service program. HCFA is conducting a demonstration of competitive bidding for certain categories of durable medical equipment, which Medicare currently pays for according to a fee schedule. The demonstration, in Polk County, Florida, covers hospital beds and four other categories of supplies. The agency received bids from 30 suppliers and plans to contract with 16 of them. Price reductions range from 13 percent for surgical dressings to 31 percent for enteral nutrition products. HCFA plans to begin paying suppliers under the new pricing system on October 1, although legal challenges could delay that. The animosity of suppliers toward the demonstration illustrates the general problem that HCFA faces in testing competitive bidding as an alternative to administrative price setting.

Policies Affecting Enrollees

Enrollees in Medicare's fee-for-service sector currently have to pay some of the costs of their covered services and all of the costs of outpatient prescription drugs, which are not typically covered by Medicare. In principle, cost sharing gives

patients an incentive to use services more prudently. For several reasons, however, Medicare's cost-sharing requirements are not as effective in that regard as they might be. First, the requirements are too varied and complex to be well understood by patients. Second, some services (such as home health care) have no cost-sharing requirements. Instituting such requirements could help reduce inappropriate utilization. Third, some circumstances (such as long hospital inpatient stays for severely ill patients) require high cost sharing, even though there is little possibility of reducing the use of services. Fourth, because Medicare does not limit enrollees' cost-sharing liabilities, most enrollees seek some kind of supplementary (or medigap) coverage to limit their financial risk. Such supplementary coverage often eliminates the incentives for prudent use of services that cost sharing is intended to create.

In its recent volume on maintaining budgetary discipline, CBO discussed one policy option that could better protect enrollees from catastrophic expenses and improve the effectiveness of Medicare's cost-sharing requirements. That option would change those requirements to more accurately reflect the costs of the services used and make the requirements easier for enrollees to understand. It would also cap each enrollee's annual liability for cost-sharing expenses. Medicare could implement the option for no net cost by raising cost-sharing requirements somewhat for the majority of enrollees, who use relatively few services during the year, and using those savings to finance the cost-sharing cap for the minority of patients with

more serious health problems that year. One option would replace the current complicated mix of cost-sharing requirements with a single $750 deductible, a uniform coinsurance rate of 20 percent for amounts above the deductible, and a cap of $2,000 on each beneficiary's total cost-sharing expenses. That would yield $8 billion in federal savings over the next 10 years.

A complementary option, which would further increase the effect of Medicare's cost-sharing requirements, would restrict the kind of coverage that medigap plans could provide. Under one approach, those plans might be prohibited from covering Medicare's deductible amounts. Alternatively, they might be permitted to offer coverage only for a cost-sharing cap that was lower than the one provided under Medicare—such as one set at $1,000 a year when Medicare's cap was set at $2,000. Restricting medigap coverage could generate considerable savings for Medicare, which pays most of the costs of the additional services that medigap policyholders use. If, for example, medigap plans were prohibited from covering any part of Medicare's new deductible under the cost-sharing option discussed above, program savings would be about $46 billion over 10 years. Those savings could be used to improve Medicare's benefits—for example, by financing the costs of a prescription drug benefit.

The President's recent proposal to reform Medicare provides a framework for making significant changes to the program. It is intended to modernize Medicare's benefits, enable the federal government to become a more prudent purchaser of health services, and encourage price competition among health plans to slow the growth of Medicare spending in the longer term. CBO estimates that the President's Medicare reform plan would increase federal outlays by $111 billion over the 2000-2009 period (see Table 1). By comparison, the Administration estimates the 10-year cost of the proposal at $46 billion.

TABLE 1. TEN-YEAR ESTIMATES OF THE PRESIDENT'S MEDICARE PROPOSAL (In billions of dollars)

| | Administration | CBO |
|---|---|---|
| Benefit Payments (Increase)[a] | | |
| Prescription drug benefit | 118.8 | 168.2 |
| Changes to fee-for-service Medicare | -64.2 | -48.2 |
| Competitive defined benefit[b] | -8.9 | -8.9 |
| Subtotal | 45.7 | 111.1 |
| Transfers from the General Fund | 327.7 | 327.7 |
| Total | 373.4 | 438.8 |

SOURCES: Congressional Budget Office (based on the July 1999 baseline) and Office of Management and Budget.

a. Includes effect on Medicaid.

b. Administration's estimate.

The President proposes a new prescription drug benefit that would provide first-dollar coverage, with an annual limit of $2,500 in 2008, when the benefit was fully phased in. Although most Medicare enrollees would receive some benefit, the proposal would not substantially protect those in poor health who incurred very large out-of-pocket expenses for prescription drugs.

Under the President's proposal, the federal share of the prescription drug benefit would be paid through transfers from the Treasury's general fund. Those transfers are simply promises to pay future benefits with future tax dollars. How burdensome that commitment might become depends on both the growth of future spending for prescription drugs and the growth of the economy over the coming decades.

The Balanced Budget Act includes provisions that limit updates, and the President proposes to extend some of them beyond their 2002 expiration date. The President would also provide a small amount of additional funds to reduce the impact of the act's payment reductions through as-yet-unspecified legislation. On balance, payments to providers would be lower than baseline levels, but only after 2002.

Reducing payment rates for fee-for-service providers would yield Medicare savings without contributing to the program's efficiency. But improving the

efficiency of the fee-for-service sector is key to achieving short-term cost savings and longer-term reform. Successful adoption of the contracting and payment methods that private health plans use to manage their costs could establish the basis for a competitive fee-for-service sector. But recent efforts to test such methods have not found much acceptance among providers, and the President's proposal treads lightly on that issue.

The President's provisions for rationalizing cost-sharing requirements would modestly increase some of those requirements and lower others, without reducing their complexity. A more thorough reform might subject all Medicare-covered services to a single deductible and uniform coinsurance rates, at the same time placing an annual limit on the amount that enrollees paid in cost sharing for all covered services (including drugs if that benefit was added to the program).

The President's proposal for a competitive defined benefit would provide new opportunities for Medicare's managed care plans to compete on the basis of price as well as the generosity of benefits and the quality of service. Although the proposal would introduce elements of competition among health plans that could help slow the growth of Medicare spending in the longer term, it would fall short of a fully competitive program. By establishing the fee-for-service sector as the benchmark for defining Medicare benefits and setting premiums for health plans, it would blunt the incentives for efficiency.

## CONCLUSION

The Balanced Budget Act of 1997 attempted to improve the efficiency of Medicare's fee-for-service system through payment reforms and laid the groundwork for a more competitive system through the creation of Medicare+Choice. The resulting changes to Medicare's risk-based and fee-for-service sectors have slowed the growth in costs. But the BBA reforms still do not promote the best health outcomes at the lowest cost to taxpayers and beneficiaries.

The Congress could consider raising Medicare revenues by increasing the payroll tax, allocating more revenues to the program from the general fund, or increasing the costs imposed on enrollees. Options to raise revenues for the program, however, are likely to succeed only temporarily in shoring up Medicare's financing as health care costs continue to escalate. The Congress could also consider reducing Medicare benefits, but that would impose greater financial burdens on the elderly and disabled that could eventually prove unacceptable.

A third approach would address the inefficient use of medical resources in Medicare. Treatment patterns vary greatly nationwide, with consequences for both health outcomes and program costs. For example, patients are more likely to be hospitalized in areas with high bed-to-population ratios than in other areas, even though they have identical medical conditions. Patients in fee-for-service settings

rely more on specialist and hospital care than patients in managed care. In addition, managed care settings emphasize disease prevention and primary care more than fee-for-service settings do.

Medicare could be restructured to allow health plans to compete on the basis of price as well as benefits and quality. Premium-support approaches, such as recent proposals from the President and the National Bipartisan Commission on the Future of Medicare, are potentially promising strategies. Enrollees could be given better information about their health plan choices, including a report card that could help them assess the quality of care that plans provide. Payment systems and cost-sharing requirements could be revamped to provide plans with clear financial incentives to improve both the quality of care and the efficient use of resources. Those changes could also provide beneficiaries with better incentives to enroll in efficient, high-quality health plans. But those types of changes are possible only through fundamental reform. Making marginal changes to the current program while adding significant benefits would only hasten the day of reckoning.