CBO TESTIMONY

Statement of
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Medicare's Long-Term Financial Condition

before the
Joint Economic Committee
Congress of the United States

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Mr. Chairman and Members of the Committee, I appreciate the opportunity to discuss the future of the Medicare program with you. Medicare is the federal government's largest health care financing program and, with projected outlays of $277 billion this year, the second largest federal program overall after Social Security. It is the principal payer of medical bills for some 40 million elderly and disabled people, with payments per enrollee currently averaging $7,000 a year.

Because the issues that the Medicare program will soon face are not exclusive to it, they are best understood when evaluated in the context of society's aging, the rising costs of health care generally, and the long-range financial strains that in coming decades will affect the federal government as a whole. If the program continues to operate as it is currently structured, its costs will rise significantly—even in the absence of program expansions such as a prescription drug benefit. As a consequence, Medicare will necessarily compete with other spending priorities for a much greater share of the federal budget or with private-sector spending for a bigger share of the national economy—or with both.

In light of that outlook, any approach to Medicare should incorporate two features: a recognition of the larger economic and budgetary trade-offs, and consideration of the program structure that would best support Medicare's overall objective of providing financing for high-quality medical care for the elderly and disabled. With regard to economic and budgetary trade-offs, two issues stand out. First, to the extent that the U.S. economy grows at a healthy pace, it will be better able to meet the Medicare population's demands for health care. Put differently, the overall level of national income available in the future constitutes the reservoir from which the resources for both private needs and public programs will be drawn, and the nation must endeavor to enlarge that reservoir to the greatest degree possible in making public policy. Second, the potential pressures on the federal budget from Medicare and other sources will necessitate trade-offs with other spending priorities if federal programs are to absorb no more than their historical fraction of national income.

Alternatively, public policy may steer a course toward devoting a larger fraction of the federal budget and the economy as a whole to Medicare. Even if that is so, it will be desirable to utilize those Medicare funds as efficiently as possible—to purchase the highest-value care with each dollar. Medicare beneficiaries (or their families), together with their providers, are best positioned to guide the use of additional dollars and to choose services that meet therapeutic demands and match individual tastes. Providing those parties with a broader range of choices and improved information, and ensuring their sensitivity to the cost of those services, should facilitate better decisionmaking. At the same time, an appropriate balance must be struck between

providing stronger financial signals to beneficiaries about the cost of their care and providing protection against greater financial exposure.

Improved decisionmaking offers the potential for dynamic consequences as well. Technological advances have historically been a big driver of cost growth in health care services. Subjecting health care innovation to the test of whether a new service, device, or procedure is "worth it" in the view of beneficiaries and their doctors may bring improved discipline to the innovation process.

Finally, as a matter of perspective, I would note that Medicare spending constitutes 17 percent of national expenditures for health care. Accordingly, any effort to ensure that Medicare emphasizes obtaining the highest quality of care per dollar of spending will be more effective if it is undertaken in the context of comparable efforts in the health care sector as a whole.

DEMOGRAPHIC TRENDS

The trustees of the Medicare and Social Security programs estimate that the number of people ages 65 and older could more than double over the coming decades, rising from 37 million today to 70 million in 2030 and 82 million in 2050. That increase is part of a great change in the structure of the U.S. population. Looking at the 20-year period ending in 2010, if the current projections hold, the number of workers in the economy will have grown by more than 33 million; yet the number of people ages 65 and older will have grown by only 8.3 million, or roughly one-quarter as much. In contrast, for the subsequent period, 2010 to 2030—when the baby-boom generation will retire—the number of workers is projected to grow by 14.4 million, whereas the population ages 65 and older is expected to grow by 30 million, or about twice as much.

The consequence of those diverging patterns is that the ratio of the population ages 65 and older to the population in its prime working years—people ages 20 to 64—is projected to grow from 21 percent today to 35 percent in 2030 and 42 percent in 2075. In other words, although the shift to an older society starts with the baby boomers, it persists after they have retired, making the changes more than just a temporary bulge.

That projected demographic shift rests heavily on assumptions about longevity, birth rates, immigration, retirement patterns, and other factors. Although based on past trends and recent experience, all of those assumptions are subject to varying degrees

of uncertainty. Major breakthroughs in medical science could further extend life expectancy, immigration could continue its upward track or be curbed by security concerns, and people could choose to work longer or spend more of their advanced years in partial employment. Without question, considerable uncertainty surrounds any 75-year projection.

Nonetheless, a substantial portion of the coming demographic shift is already in place. The post-World War II baby boom and the 1970s "baby trough" are historical events; the subsequent uptick in birth rates has not been substantial and may now have leveled off; and life expectancy continues to increase. Indeed, the Medicare trustees project that life expectancy for the Medicare population will rise by one year for every 15 years in their 75-year projection period.

HEALTH CARE TRENDS

Nationally, health care expenditures as a percentage of gross domestic product (GDP) have more than doubled over the past several decades, growing from 7.0 percent in 1970 to 14.8 percent in 2002. At the federal level, with Medicare and Medicaid in the forefront, health care expenditures have risen from 1.7 percent of GDP in 1970 to 4.7 percent in 2002, and their share of federal outlays has risen from 9 percent to 24 percent.

On a per capita basis, national spending on health care has increased from $1,321 in 1970 (in 2002 dollars) to $5,366 in 2002, or an average of about 4.5 percent per year. The major factor contributing to the growth of real (inflation-adjusted) per capita health care spending has been the development and diffusion of new medical technology. Other factors include expansions in insurance coverage, rising income, medical price inflation in excess of general inflation, and the aging of the population.

In recent years, spending for prescription drugs has grown more rapidly than other health care spending. In real terms, from 1990 to 2002, per capita spending for prescription drugs increased at an average annual rate of about 9 percent, compared with about 3 percent for all other health expenditures. (In contrast, during the 1970-1990 period, spending for prescription drugs grew more slowly than all other health expenditures.) Despite the recent rapid increase in prescription drug spending, it currently accounts for only about 10 percent of all national health expenditures.

In general, new technology changes the pattern of use of medical services, leading to increases in utilization for some services and decreases for others. In other sectors of

the economy, technological advances have often served to reduce costs. On balance, however, research has found that medical innovation has led both to increases in health care expenditures and, frequently, to improvements in the treatment of medical conditions.

With respect to pharmaceuticals, Congressional Budget Office (CBO) analysts continue to monitor the available evidence on the extent to which spending for prescription drugs might be offset by savings in other categories of health care costs (such as hospitals, physicians, and nursing homes). Existing research provides little insight into the overall effect of changes in prescription drug coverage. Several studies have suggested that giving specific drugs to particular classes of patients will reduce their spending for other health services, but it is unclear whether those results can be applied to the general population. More broadly, determining what health care spending would have been in the absence of increased drug use presents substantial methodological challenges.

Whether measured in total or on a per capita basis, both government-financed and private-sector health care costs have grown rapidly over the past 30 years, outpacing the economy's growth rate. Comparing cost growth in the private sector and in the Medicare program can be difficult because of the differences in the populations covered and the benefits provided—particularly as those components change over time; as a result, even well-structured comparisons have shown differing rates of growth for periods of several years. Over the longer term, however, the data show roughly comparable growth rates for total health care costs for Medicare and the private sector (reflecting, in part, past legislative action aimed at bringing Medicare payments in line with market-based rates).

MEDICARE TRENDS

From 1970 to 2002, Medicare costs after adjusting for inflation increased more than eightfold. As a share of GDP, they rose from 0.7 percent in 1970 to 2.5 percent in 2002 (based on CBO's revised estimates). Although cost growth on a per-enrollee basis was volatile, it, too, generally rose by much more than the economy. Over the 1970-2002 period, real costs per enrollee grew at approximately the rate of per capita GDP plus 2.8 percentage points—or more than twice the economy's growth rate.

The major elements in the Medicare program's overall rise in costs have been increased enrollment (from 20 million beneficiaries in 1970 to 40 million this year) and the same factors that have led to increases in health care spending in the nation as a

whole—most notably, the development and diffusion of new medical technology. Other contributors to cost growth have been program expansions as a result of legislative and administrative changes.

In dollar terms, inpatient hospital care accounts for the largest portion of the Medicare program's growth. Expenditures for skilled nursing care and home health services, though constituting only 5 percent each of current program spending, have grown particularly rapidly. Real spending for those services increased at an average annual rate of about 12 percent from 1975 to 2001, compared with an average annual rate of about 7 percent for total Medicare spending.

HOW BIG IS THE PROBLEM?

The convergence of an aging society and rapidly rising health care costs portends a very large long-term escalation of Medicare spending. For more than two decades, the program's trustees have consistently projected long-range financing shortfalls and eventual insolvency of the larger of the two parts of Medicare, the Hospital Insurance (HI) trust fund. In the trustees' latest report, the HI trust fund is projected to be depleted by 2026; over the next 75 years as a whole, the program would need 71 percent more resources than those provided under current law. In the 75th year, it would need over 200 percent more—under current law, its receipts would equal 3.4 percent of taxable payroll while its expenditures would equal 11.2 percent.

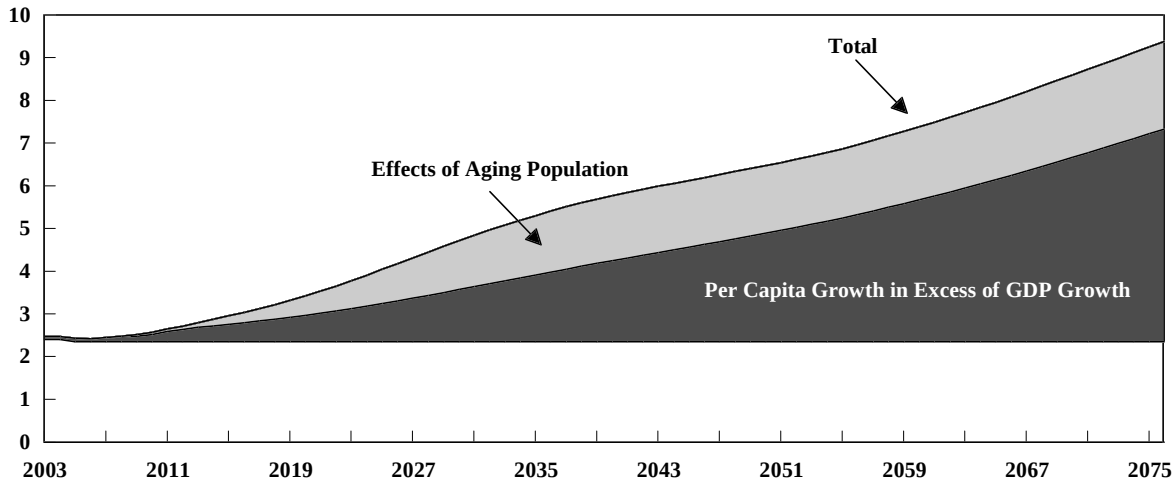
The impact of the demographic shift is clearly illustrated by the trustees' projection of a decreasing number of workers per HI beneficiary. In 1970, there were 4.6 workers for every recipient; today, there are 3.7. The trustees project that in 2030 and 2075, there will be 2.4 and 2.0 workers, respectively, per beneficiary.

Important as these reports are, the trustees' projections and "trust fund accounting" tell only part of the story of the program's impact on federal budgetary resources and the economy in general. Trust funds are bookkeeping devices. As such, the Medicare trust funds provide spending authority for the Treasury Department to make payments, but they do not generate the actual resources needed to make those payments. Much of what is credited to trust fund accounts comes from payments or contributions from the government's general fund—transactions that are simply internal bookkeeping entries by the Treasury.

More important, the trustees' traditional measures of insolvency are not measures of the program's impact on the economy. The best example of that is reflected in the

Figure 1.
Projected Long-Term Growth of Medicare Spending

(As a percentage of GDP)



Source: Congressional Budget Office.

financing of the Supplementary Medical Insurance (SMI) part of Medicare, three-quarters of which comprises general fund contributions that are intended to cover costs not met by enrollees' premiums. Under those financing provisions, it is technically infeasible for SMI to be projected insolvent, despite the fact that its costs are projected to rise from 1 percent of GDP today to 4.2 percent in 2075, a faster rate of growth than that projected for HI.

To put the long-term outlook in a broader economic framework, CBO has projected the cost of Medicare as a share of GDP to show how much of the nation's production of goods and services it estimates will be used to pay for the program. Using its recent baseline budget assumptions for the next 10 years and those of the Medicare trustees for the subsequent long-range period (to 2075) as a base case, CBO estimates that Medicare's costs will rise from 2.5 percent of GDP in 2002 to 9.2 percent in 2075 (see Figure 1). Approximately 30 percent of that growth is due to society's aging; the remaining 70 percent is attributable to general growth in health care costs in excess of the rate of GDP growth.

Another way of looking at that growth is to consider it in today's context. If the Medicare program's costs *today* accounted for 9.2 percent of GDP, they would equal

half of what is now spent under the entire federal budget. If the program's higher costs were added to what is now expended, total federal receipts (which currently absorb about 18 percent of GDP) would have to be one-third larger. And if those increased costs were paid for entirely through a payroll-based tax, the rate now set at 15.3 percent on the earnings of most workers would have to more than double—a rise equal to roughly $6,000 per worker (that is, $3,000 each for the worker and his or her employer).

RISKS TO THE OUTLOOK

The most significant aspect of those projections is that annual growth of per capita Medicare spending is expected to increase faster than GDP but less quickly than in the past. CBO's base-case projection assumes that per capita Medicare spending will eventually rise 1 percentage point faster than the growth of GDP—a rate substantially slower than the 2.8 percentage-point "excess cost" rate that the program has experienced over the past 32 years. CBO's assumption of an eventual deceleration in the relative rise of health care costs is consistent with that of the Medicare trustees (as well as others). But that assumption might be too optimistic, and even small variances from it could have significant economic implications when costs are projected over long periods.

For example, if CBO's long-range projection had incorporated an excess-cost rate for Medicare that was 0.5 percentage points faster than was assumed in the base case, Medicare expenditures would be projected to grow to 5.4 percent of GDP in 2030 and 13.2 percent in 2075, compared with the base-case projections of 4.7 percent and 9.2 percent. Alternatively, if the growth rate was pegged to rise by 0.5 percent less than in the base case, Medicare spending would still reach 6.4 percent of GDP in 2075, or more than two and a half times its current share. Both assumptions imply much higher relative costs than those Medicare incurs today, but the spread of nearly 7 percent (of GDP) between the two estimates provides some perspective on the uncertainty surrounding the program's eventual share of the economy.

Adding to that uncertainty is the potential for program expansions. Enacting a new prescription drug benefit, easing existing limits on payments to providers, and possibly expanding long-term care coverage would exacerbate both the rising long-range spending trajectory and the risks associated with the long-term outlook.

A FRAMEWORK FOR POLICY ANALYSIS

Ultimately, the costs of Medicare, other forms of future retirement income and services, and consumption for the working-age population will be drawn from the economy. The larger it is, the more easily retirement-related costs can be covered without cramping the lifestyles of workers. In that light, it would be beneficial to structure policies, to the extent possible, to minimize incentives for people to consume more at the expense of resources for investment. Medicare and related federal entitlement programs are heavily oriented toward consumption, and as their costs rise, they generate pressures at odds with the savings and investment that constitute the core of economic growth. Program expansions by themselves would only increase the extent to which those pressures impinged on faster economic growth. If major changes to Medicare's benefits are to be undertaken, both their value to program recipients and the strains they will place on the economy must be considered.

The most effective approaches to constraining Medicare costs in the future—and to getting the greatest improvement in health for the money that is spent—are likely to be those that give beneficiaries and health care providers appropriate incentives to spend federal funds wisely. In particular, beneficiaries should have as many choices among providers and health plans as are feasible, but they should also be aware of and be sensitive to the consequences of those choices. Because Medicare—for all its massive size—constitutes only about 17 percent of national outlays for health care, efforts to improve its efficiency would stand a greater chance of success if they were generally consistent with the directions being taken in the larger health care system.

POLICY OPTIONS: THE FUNDAMENTAL CHOICES ARE DIFFICULT

Medicare is a popular program, so options to relieve these long-term fiscal pressures require difficult choices. Garnering public support to cut or constrain the program's growth is difficult. Even in the face of the long-term fiscal strains described here, the momentum of late has been for program expansion. Taxes could be boosted, but doing so could impair economic growth, and if taxes were the sole means used to pay for Medicare, the resulting increase would be large.

CBO has estimated the long-term impact of two measures to constrain the program's growth (see Table 1). Gradually raising Medicare's eligibility age from 65 to 70 would adjust the program to reflect past and projected increases in longevity. On the basis of average longevity at the time, new retirees in 1970 could expect 16 years of

Table 1.
Effects of Illustrative Options for Reducing Growth of Net Medicare Spending

(As a percentage of GDP)	2002	2030	2050	2075
Raise the Eligibility Age to 70	n.a.	-0.2	-0.6	-0.7
Collect 50 Percent of SMI Costs from Enrollees	n.a.	-0.6	-0.7	-1.0
Memorandum:				
Projected Gross Medicare Spending Under Current Policies	2.5	4.7	6.5	9.2
Less: SMI Premiums	0.3	0.6	0.7	1.0
Projected Net Medicare Spending Under Current Policies	2.2	4.2	5.8	8.2

Source: Congressional Budget Office based on its January 2003 baseline budget projections and the 2002 report of the Medicare trustees.

Notes: SMI = Supplementary Medical Insurance (Part B of Medicare); n.a. = not applicable.

The effects of each illustrative option are considered in isolation; if implemented together, the options would interact in ways that would reduce the combined savings.

Medicare coverage. Today, new enrollees can expect 18 years of coverage. On the basis of current projections, those enrolling in 2030 will be able to expect nearly 20 years. Such a change in the age of eligibility would constrain the program's long-term spending trajectory and produce savings equal to 0.7 percent of GDP in 2075. Medicare's overall costs would nevertheless climb from 2.5 percent of GDP in 2002 to 8.5 percent of GDP in 2075.

Doubling the SMI premium would similarly recognize and adjust for the increase in lifetime benefits as well as return the enrollee's responsibility for that program's financing to its original 50/50 split with the federal government. (Today, enrollees' premiums cover only 25 percent of SMI's costs.) This change would produce program savings equal to 1 percent of GDP in 2075.

Although the options noted above seemingly constitute major reforms of Medicare, they would merely temper the rising program costs now projected. Even if measures were enacted that cut in half the projected rate of excess cost growth in Medicare, the program's eventual share of GDP would still more than double, rising to 6.4 percent in 2075.

Other approaches would raise beneficiaries' cost sharing for services, reduce providers' payments, employ disease management and case management, and introduce greater competition to the Medicare market. For example, one alternative would limit what Medicare contributes toward health care expenses. A defined contribution could strengthen consumers' and providers' incentives to seek efficient modes of

care. Depending on the level of the benefit and the response of consumers, providers, and health plans, such an approach might (but would not necessarily) increase the costs borne by beneficiaries. A related approach would be to stimulate private health plans to compete through premiums to a greater degree than they do under current policies. Such an approach might reduce costs to the extent that it gave beneficiaries suitable encouragement to join efficient health plans and provided structured incentives to induce private plans to negotiate rates with providers that grew more slowly than Medicare's current-law payment rates. However, there is little experience on which to base long-range estimates of the cost savings from introducing competitive approaches to Medicare or to assess their effects on beneficiaries.[1]

CONCLUSION: BETTER TO ACT SOONER RATHER THAN LATER

Without changes to Medicare—and to other federal programs—the aging of the baby-boom generation will cause a substantial deterioration in the fiscal position of the U.S. government. The sooner we begin to address that problem, the better off we will be. Implementing gradual action today avoids the need for precipitous and disruptive action later—which could take the form of either sudden large constraints on benefits or large increases in taxes that depress marginal work effort and incentives to invest. Phasing in program changes allows for gradual accommodation and time to promote alternatives for the recipient population. And it gives time for the public to modify its expectations and for people to adjust their work and saving behavior.

Most important, taking action now to moderate the long-range spending pressures would lessen the risks of large tax increases or unsustainable borrowing and thus enhance the economic prospects of future generations. Of course, reducing the growth of benefits means lower future payments than those currently scheduled. However, the alternative of doing nothing now could also mean lower future benefits. The potential strain on overall budgetary resources—resources for all other government activities—when the baby boomers start to reach age 65 eight years from now, and Medicare expenditures begin their rapid ascent, may cause lawmakers to curb Medicare spending. Taxes and premiums for Medicare are already lower than the program's expenditures (for HI and SMI combined). That gap—now about $89 billion—is projected to grow to $191 billion by 2013.

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1. Chapter 4 of CBO's recent publication *Budget Options* (March 2003) discusses in more detail approaches to slow the growth of both Social Security and Medicare.

Looking more broadly, spending for Medicare, Medicaid, and Social Security—the three federal entitlement programs most directly affected by the looming population trends—now absorbs 8 percent of GDP. If CBO's projections hold, that figure will rise to 14 percent of GDP by 2030. Beyond that year, spending pressures will intensify, with longevity continuing to increase and health costs continuing to grow. Simply weathering the demographic surge of the baby-boom generation will not be enough to restore the federal government's fiscal posture to its recent norms. By 2075, CBO projects, the cost of the three programs could climb to 21 percent of GDP, the largest portion of which would be attributable to Medicare. To accommodate the increase in spending, either taxes would need to be raised dramatically, spending on other federal programs would have to be curtailed severely, or federal borrowing would soar.

Economic growth is the principal engine to ensure that future retirement needs can be met. However, there is no free lunch. Effective measures will not necessarily be popular measures, and the longer they are deferred, the harder they will be to enact, as those affected grow as a share of the population.