# CBO TESTIMONY

Statement of
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# Projections of Medicare Spending Under Current Law

before the
Committee on the Budget
U.S. House of Representatives

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Chairman Nussle, Congressman Spratt, and Members of the Committee, I am pleased to be here today to discuss projections of Medicare spending under current law.

As part of the Congressional Budget Office's (CBO's) analysis of the President's budgetary proposals, we have just completed updating our projections of Medicare spending. My testimony today will summarize those projections, which are part of our forthcoming March baseline, and discuss how they have changed since January. I will then compare CBO's baseline projections of Medicare spending with the Administration's baseline projections. I will focus my discussion on projections of mandatory spending for Medicare benefits and on the premiums paid by Medicare beneficiaries.

## CBO'S PROJECTIONS OF MEDICARE SPENDING UNDER CURRENT LAW

CBO projects that gross mandatory outlays by Medicare will total $248 billion in 2002. Benefits account for over 99 percent of that total, with spending for peer review organizations, efforts to control fraud and abuse, and other administrative activities making up the rest.

In 2002, beneficiaries who are enrolled in Part B of Medicare (the Supplementary Medical Insurance program) will pay a monthly premium of $54.00. Premiums in the Part B program are set to cover about 25 percent of spending for its benefits. A small number of beneficiaries who are not entitled to Part A benefits (through the Hospital Insurance program) on the basis of their work history (or that of a spouse) also pay a premium to enroll in Part A. CBO estimates that premium payments by beneficiaries will total $26 billion in 2002, resulting in net mandatory spending of $223 billion this year. In addition, the costs of administering the program, which are funded by appropriations, will amount to an estimated $3.6 billion in 2002.

CBO projects that gross mandatory outlays for Medicare will total $3.6 trillion over the 2003-2012 period, with beneficiaries paying about $400 billion in premiums (see the table on the next page). Therefore, if current law remains unchanged, net mandatory spending is estimated at $3.2 trillion over the next 10 years.

Net mandatory spending for Medicare as a share of the nation's gross domestic product will be 2.2 percent this year, CBO estimates. That share will remain relatively constant through 2007; it will then begin to rise, reaching 2.5 percent by 2012, driven both by the large increase in enrollment as the baby-boom generation turns 65 and by the ever-expanding demand for health care.

SUMMARY OF CBO'S MARCH 2002 BASELINE PROJECTIONS
OF MANDATORY MEDICARE OUTLAYS (By fiscal year)

| | Billions of Dollars | | Average Annual Rate of Growth (Percent) |
|---|---|---|---|
| | 2002 | 2003-2012 | |
| Gross Mandatory Outlays | 248 | 3,590 | 6.9 |
| Premiums | -26 | -413 | 8.4 |
| Net Mandatory Outlays | | | |
| Unadjusted | 223 | 3,177 | 6.7 |
| Adjusted for timing shifts[a] | 226 | 3,177 | 6.6 |

SOURCE: Congressional Budget Office.

a. Outlays adjusted to eliminate the effect of accelerating payments to group plans from October to September in some years.

## Spending Growth Has Varied in Recent Years

Net mandatory spending for Medicare grew by 10.3 percent in 2001. However, that rate of growth was inflated by a provision of the Balanced Budget Act of 1997 (BBA) that accelerated $3 billion in payments to group plans from October to September 2001—or from fiscal year 2002 to fiscal year 2001. When spending is adjusted for that accelerated capitation payment, the underlying rate of growth in 2001 was 8.7 percent—a substantially larger increase than the changes in annual spending during the 1997-2000 period, which averaged 1.2 percent. Significant growth resumed in 2001, after Medicare absorbed the substantial changes in the program's payment rules enacted in the BBA in 1997. That growth also reflected increases in payment rates and other changes enacted in the Balanced Budget Refinement Act of 1999 and the Benefits Improvement and Protection Act of 2000. CBO projects that net mandatory spending in 2002 will be 7.1 percent higher than such spending in 2001, after adjusting for the accelerated capitation payment.

## Components of Spending Growth in the Coming Decade

Over the next 10 years, net mandatory spending for Medicare is projected to grow at an average annual rate of 6.6 percent—again, after adjusting for shifts in the timing of payments to group plans. About 1.7 percentage points of that growth rate stem from increases in enrollment in the Medicare program, and about 3 percentage points are attributable to automatic hikes in payment rates in the fee-for-service sector to adjust

rates for changes in the prices of inputs. Another 3 percentage points are due to changes in the use of services above those accounted for by changes in enrollment. The increased use reflects boosts in the number of services furnished per enrollee and a shift in the mix of services toward higher-priced and often more technologically advanced services. Those increases are offset in part by a decrease of about 1 percentage point as a result of updates in the rates paid to Medicare+Choice plans, which will be lower than updates to payment rates in the fee-for-service sector.

Projected rates of growth in net mandatory spending are relatively low through 2006 (averaging 5.7 percent a year) because updates to payment rates for many services will be held below the increase in the prices of inputs in the next few years and because enrollment in Medicare is projected to grow by only about 1 percent a year. Rates of spending growth are higher after 2006 (averaging 7.7 percent a year) because updates to payment rates for many services will be fully adjusted for changes in input prices and because enrollment will grow at an average rate of about 2 percent a year (see Table 1).

**Projections of Spending by Type of Provider**

Payments to hospitals for inpatient services and payments to physicians are the largest components of Medicare spending, accounting for about two-thirds of the program's outlays. They are also the slowest-growing components of spending in the fee-for-service sector. Payments to hospitals will grow at an average rate of 6.3 percent a year through 2012, CBO projects, and payments to physicians will grow at an average rate of 5.4 percent a year. By contrast, payments are projected to grow at rates that average 9 percent to 16 percent a year for services furnished by home health agencies; hospital outpatient departments and other facilities covered under Part B; and nonphysician professionals and other providers of ancillary services. CBO estimates that payments to Medicare+Choice plans and other group plans will decline through 2006 and then grow slowly, returning to their 2001 level by 2012.

**Changes from January to March in CBO's Baseline**

CBO's March baseline projection of $3.2 trillion in net mandatory spending for Medicare over the 2003-2012 period is about $80 billion—or 2.5 percent—lower than its projection in January. Three factors account for that revision:

- Reduction in projections of payments to Medicare+Choice plans—about $30 billion over the period. That change reflects the Administration's January

announcement of preliminary payment rates for Medicare+Choice in 2003, as well as updates to CBO's projections of enrollment in those plans.

- Reduction in projections of payments for hospital outpatient services—about $35 billion over the 10-year span. That change reflects the Administration's announcement of an implementation date for a final rule concerning pass-through payments and an analysis of updated data on the cost of "buying down" (contributing more to) coinsurance paid by beneficiaries for hospital outpatient services.

- Reduction in projected spending—another $15 billion over 10 years to reflect an updated analysis of the effect on spending of the changing age distribution of Medicare beneficiaries; an improved method of converting the price indexes that the Administration uses to update payment rates to price indexes based on CBO's economic projections; and the effects of revised projections of outlays on premiums collected from beneficiaries.

The change in CBO's projections of payments to Medicare+Choice plans reflects a significant revision in CBO's methods. Under the rules established in the Balanced Budget Act and modified in subsequent legislation, the rates paid to Medicare+Choice plans are supposed to move gradually to the higher of a floor amount or a 50:50 blend of rates based on local per capita spending in the fee-for-service sector and the national average amount of spending per capita, adjusted for variation in local prices. When the payment rate is at either the floor amount or the 50:50 blend, it will be increased each year at the same rate as the increase in spending per capita in the fee-for-service sector. The transition to the floor amounts took effect immediately with the legislation's enactment. The transition to the 50:50 blend is subject to a minimum update that is generally 2 percent and to a budget-neutrality provision requiring that payment rates, on average and overall, grow from their pre-BBA levels at the same rate as the increase in per capita spending in the fee-for-service sector.

In CBO's January baseline, as in previous baselines, rates paid to Medicare+Choice plans were assumed to grow, on average, at the same rate as per capita spending in the fee-for-service sector.

In January, the Administration issued a preliminary notice of the rates that Medicare would pay to Medicare+Choice plans in 2003. The notice stated that because of revisions to estimates of growth in per capita spending in the fee-for-service sector, payment rates would be reduced to comply with the budget-neutrality provision in the

BBA. However, the notice also stated that because of the minimum-update provision, all payment rates—including rates at the floor amounts—would be increased by 2 percent in 2003. The Administration did not announce its projections of updates to payment rates for 2004 and later years.

CBO drew several conclusions from the Administration's announcement:

- Medicare+Choice payment rates, on average, are above the budget-neutral amount and under current law will remain permanently above it. Overall, therefore, Medicare pays more for enrollees in Medicare+Choice plans than it would pay if those beneficiaries were in the fee-for-service sector.

- All payment rates will increase again by 2 percent (the minimum update) in 2004.

- Floor amounts will increase by more than 2 percent in 2005 and will grow with fee-for-service spending in subsequent years, but all other rates will increase by 2 percent each year until they reach the level of the floor or the 50:50 blend. (CBO estimates that the proportion of payments made at floor rates or at 50:50-blend rates will increase from about 40 percent in 2005 to 95 percent by 2012.)

CBO has also revised its projections of enrollment in Medicare+Choice plans on the basis of the program's recent experience and projected payment rates. The percentage of Medicare enrollees in Medicare+Choice plans is now estimated to decline from 15 percent in 2001 to 8 percent in 2012. By contrast, CBO last year projected that the percentage of Medicare beneficiaries enrolled in Medicare+Choice plans would remain relatively stable throughout the 10-year budget window.

## COMPARISON OF CBO'S AND THE ADMINISTRATION'S BASELINES

The Administration projects that net mandatory spending for Medicare will grow at an average rate of 5.4 percent a year through 2012. It also projects that growth will tend to be lower than that 10-year average rate through 2006 (averaging 4.0 percent annually) and higher after 2006 (averaging 6.4 percent). The Administration also estimates that net mandatory spending for Medicare will total $3.0 trillion over the 2003-2012 period, which is about $225 billion, or 7 percent, lower than CBO's projection for the same period (see Table 2 and Figure 1).

## Differences Arising from Economic Assumptions

About $40 billion of the 10-year difference between CBO's and the Administration's estimates is due to differing economic projections. Payment rates for most services are adjusted, or updated, each year to reflect changes in the prices of inputs. In general, CBO projects that those updates to payment rates will be one or two tenths of a percentage point higher than the Administration's projected updates.

## Differences Resulting from Assumptions About Administrative Actions

Another $10 billion to $20 billion of the 10-year difference stems from possible administrative actions that the Administration's baseline assumes but that CBO's does not. The Administration's baseline assumes that the payment method for outpatient prescription drugs covered under the program will be changed in 2003. However, the Administration has not yet announced any specific proposal for changing the payment rules. As a result, CBO's projections incorporate the assumption that Medicare continues to use the existing payment method.

## Differences Stemming from Technical Assumptions

The remaining difference of about $175 billion over 10 years reflects different technical assumptions about participation in Medicare+Choice plans and in the rate of increase in the volume and mix of services furnished to beneficiaries in the fee-for-service sector. A clear comparison of CBO's and the Administration's baselines by payment category is difficult, because the two groups of estimates reflect very different assumptions about the proportion of beneficiaries who will participate in Medicare+Choice plans.

**Medicare+Choice.** The Administration projects that the proportion of beneficiaries enrolled in Medicare+Choice plans will remain fairly stable—in the range of 14 percent to 15 percent—over the coming decade, whereas CBO projects a sharp decline in that share—to 8 percent—by 2012. The Administration's assumption that a relatively large share of Medicare enrollees will remain in those plans while their payment rates are growing much more slowly than rates in the fee-for-service sector may contribute significantly to the differences between CBO's and the Administration's baseline projections.

**Growth Stemming from the Volume and Mix of Services in the Fee-for-Service Sector.** Both CBO and the Administration assume that spending per capita on services in the fee-for-service sector will grow at a faster rate than will the adjustments to payment rates for changes in input prices. In general, however, CBO assumes larger increases in per capita spending as a result of changes in the volume and mix of services than does the Administration.

The biggest differences between those assumptions about increases in spending are in the areas of skilled nursing services, hospital outpatient services, and home health services. The payment systems in all three settings have been changed substantially in the past few years, and how the volume and mix of services will change under the new systems is uncertain. Both CBO and the Administration assume that increases in the volume and mix of those services will contribute less to growth in spending under current law than they contributed under the payment systems that existed before the BBA. CBO estimates that those effects will steadily decline over the coming decade as follows:

- From about 7 percentage points a year in the next few years to 4.5 percentage points by 2012 for skilled nursing services;
- From about 5.3 percentage points to 3.8 percentage points a year for hospital outpatient services and other payments to facilities for services covered under Part B of Medicare; and
- From 12.5 percentage points to 7 percentage points a year for home health services.

The Administration appears to make a similar assumption about the steadily lessening effect of changes in the volume and mix of services—although it projects a more rapid weakening than does CBO—for skilled nursing services and hospital outpatient services. Compared with CBO's assumption about volume and mix changes for home health services, however, the Administration's assumption seems to reflect more-rapid increases in the volume and mix of home health services through 2005 or 2006, and a more rapid decline in the volume and mix in subsequent years.

CBO and the Administration make very similar assumptions about the effect of volume and mix changes in relation to the sustainable growth rate (SGR) system of payment for services on the physician fee schedule and in relation to payments to hospitals for inpatient services.

The SGR system automatically adjusts payment rates for services on the physician fee schedule to compensate for changes in the volume and mix of services. Therefore, the differences between CBO's projections of payments under the physician fee schedule and the Administration's projections are almost entirely attributable to economic factors and to differences in the projected number of beneficiaries in the fee-for-service sector. Likewise, both CBO and the Administration assume that changes in the mix and volume of services contribute about 1 percentage point to annual increases in payments to hospitals for inpatient services—1 percentage point, that is, above the growth resulting from increases in enrollment and adjustments for inflation.

In the near term, CBO's baseline and the Administration's projections are similar, differing by only 4 percent over the 2003-2007 period. The differences between the estimates over the 2003-2012 period broaden, amounting to about 7 percent cumulatively. That difference is not very large in view of the uncertainty that is always associated with a 10-year budget window and, in particular, in view of the new payment systems that Medicare has recently instituted in a number of areas.

TABLE 1. CBO'S MARCH 2002 BASELINE PROJECTIONS OF MANDATORY OUTLAYS FOR MEDICARE, 2002-2012 (By fiscal year, in billions of dollars)

| | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Part A: Hospital Insurance | | | | | | | | | | | |
| Fee-for-service program | | | | | | | | | | | |
| Hospital inpatient care | 102 | 108 | 115 | 122 | 130 | 138 | 147 | 156 | 166 | 176 | 188 |
| Hospice | 4 | 4 | 4 | 5 | 5 | 6 | 6 | 6 | 7 | 7 | 8 |
| Skilled nursing facilities | 14 | 14 | 15 | 17 | 19 | 21 | 23 | 25 | 27 | 30 | 33 |
| Home health services | 6 | 6 | 6 | 7 | 9 | 10 | 12 | 13 | 15 | 17 | 19 |
| Subtotal | 126 | 132 | 141 | 151 | 162 | 174 | 187 | 201 | 215 | 231 | 248 |
| Group plans[a] | 18 | 18 | 17 | 18 | 15 | 17 | 17 | 18 | 18 | 21 | 19 |
| Total, Part A Benefits | 144 | 150 | 158 | 169 | 177 | 191 | 204 | 218 | 234 | 252 | 267 |
| Part B: Supplementary Medical Insurance | | | | | | | | | | | |
| Fee-for-service program | | | | | | | | | | | |
| Physician fee schedule | 43 | 44 | 44 | 46 | 49 | 52 | 56 | 60 | 64 | 68 | 72 |
| Other professional and outpatient ancillary services[b] | 19 | 21 | 23 | 26 | 29 | 32 | 35 | 38 | 42 | 46 | 50 |
| Other facilities[c] | 21 | 22 | 24 | 27 | 29 | 32 | 36 | 39 | 43 | 46 | 51 |
| Home health services | 6 | 7 | 8 | 10 | 11 | 13 | 15 | 17 | 20 | 23 | 26 |
| Subtotal | 88 | 94 | 100 | 108 | 118 | 129 | 142 | 155 | 168 | 183 | 199 |
| Group plans[a] | 15 | 16 | 15 | 16 | 13 | 15 | 15 | 16 | 17 | 19 | 17 |
| Total, Part B Benefits | 103 | 109 | 115 | 124 | 131 | 144 | 157 | 171 | 185 | 202 | 216 |
| All Medicare Benefits | 247 | 259 | 273 | 293 | 309 | 335 | 361 | 389 | 419 | 454 | 483 |
| Other Mandatory Outlays | 2 | 2 | 2 | 1 | 2 | 2 | 1 | 2 | 2 | 1 | 2 |
| Gross Mandatory Outlays | 248 | 261 | 274 | 294 | 310 | 336 | 363 | 391 | 420 | 456 | 484 |
| Premiums | -26 | -28 | -30 | -32 | -35 | -39 | -42 | -46 | -50 | -54 | -58 |
| Net Mandatory Outlays | 223 | 233 | 245 | 262 | 275 | 298 | 321 | 345 | 371 | 402 | 426 |
| **Memorandum:** | | | | | | | | | | | |
| All Home Health Agencies | 11 | 12 | 14 | 17 | 20 | 23 | 27 | 31 | 35 | 40 | 45 |
| All Group Plans | 33 | 34 | 31 | 33 | 28 | 32 | 32 | 34 | 35 | 41 | 36 |
| All Fee-for Service Programs | 214 | 225 | 241 | 260 | 280 | 303 | 329 | 355 | 384 | 414 | 447 |
| Outlays as a Percentage of GDP | 2.2 | 2.1 | 2.1 | 2.2 | 2.1 | 2.2 | 2.3 | 2.3 | 2.4 | 2.4 | 2.5 |

SOURCE: Congressional Budget Office.

a. Group plans include Medicare+Choice plans, plans paid on a cost basis, health care prepayment plans, and some demonstrations. Nearly all enrollment and spending is in Medicare+Choice plans.

b. Includes durable medical equipment, independent and physician in-office laboratory services, ambulance services, and other services paid by carriers.

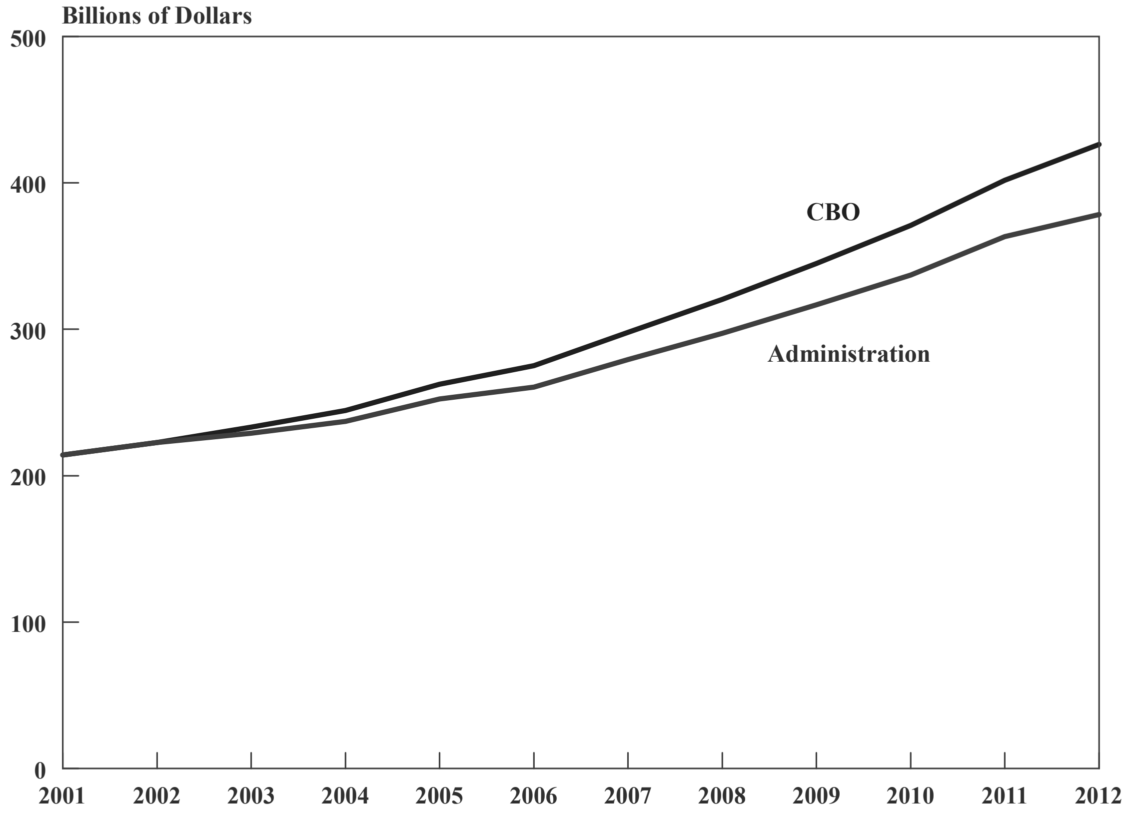
c. Includes hospital outpatient services, laboratory services in hospital outpatient departments, rural health clinic services, outpatient dialysis, and other services paid by fiscal intermediaries. Also includes payments to skilled nursing facilities for services covered under Part B.

TABLE 2. COMPARISON OF CBO'S AND THE ADMINISTRATION'S BASELINE PROJECTIONS OF NET MANDATORY OUTLAYS FOR MEDICARE, 2002-2012

| | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Net Mandatory Outlays (Billions of dollars) | | | | | | | | | | | |
| CBO | 223 | 233 | 245 | 262 | 275 | 298 | 321 | 345 | 371 | 402 | 426 |
| Administration | 223 | 229 | 237 | 252 | 260 | 279 | 297 | 317 | 337 | 363 | 378 |
| Difference (CBO minus Administration) | 0 | 4 | 7 | 10 | 15 | 19 | 23 | 28 | 34 | 39 | 48 |
| Annual Percentage Change in Spending | | | | | | | | | | | |
| CBO | 4.0 | 4.7 | 4.9 | 7.3 | 4.8 | 8.3 | 7.6 | 7.6 | 7.5 | 8.3 | 6.1 |
| Administration | 4.0 | 2.8 | 3.6 | 6.4 | 3.2 | 7.3 | 6.4 | 6.6 | 6.4 | 7.8 | 4.2 |

SOURCE: Congressional Budget Office.

FIGURE 1. CBO AND ADMINISTRATION PROJECTIONS OF NET MANDATORY OUTLAYS FOR MEDICARE




SOURCE: Congressional Budget Office.