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MEDICARE AND THE FEDERAL BUDGET: PAST EXPERIENCE, CURRENT POLICY, FUTURE PROSPECTS

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EXECUTIVE SUMMARY

In an era of budget surpluses and after several years of slower spending growth, containing Medicare expenditures seems like less of an urgent policy consideration than it has perhaps at any time in the history of the program. Yet Medicare remains a major component of the Federal budget, accounting for almost one-seventh of all Federal spending, and seems inevitable to become even more important in the years ahead, as a result of both Baby Boom aging and especially continued cost-increasing technological progress. This paper presents a primer on Medicare budgeting. I review of Medicare financing and budgetary history, and use some alternative plausible forecasts of long-run spending growth to highlight the considerable uncertainty about forecasts of future program expenditures. In particular, it seems plausible that future Medicare spending will

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increase more rapidly than the most widely-cited recent forecasts have suggested. Using the alternative forecasts, I then discuss the possible short- and long-term budgetary effects of a range of "accounting" and "real" reforms in the Medicare program.

1. INTRODUCTION

The future of Medicare remains a difficult and contentious issue in domestic policy debates. In 2000, most of this debate has focused on reforming Medicare benefits, including steps to promote price and quality competition between the "traditional" government-run fee-for-service plan and private plans, and the addition of an outpatient drug benefit to the Medicare insurance package.¹ In an era of budget surpluses, the budgetary implications of Medicare reform have received somewhat less attention recently; no longer is containing Medicare costs the predominant policy consideration. Yet Medicare remains a major component of the Federal budget, accounting for almost one-seventh of all Federal spending, and it seems inevitable that it will become an even more important component in the years ahead, as a result of both baby-boom aging and continued cost-increasing technological progress. Medicare policy decisions now may thus have budgetary consequences in the years ahead that are far greater than their short-term consequences may suggest. Clearly, Medicare's budgetary implications are an important consideration in the Medicare debate.

In this paper, I present a primer on Medicare budgeting, and use this framework to discuss the accounting and real effects of recent proposed reforms in Medicare financing. I begin with a review of Medicare's current financing system, which (like Medicare benefits) includes two principal parts. This review also describes the past budgetary history of the program. I then discuss the very challenging problem, given this history, of forecasting Medicare's budgetary implications, in the context of a review of the most careful recent forecasts—those of the Office of the Actuary of the Health Care Financing Administration. I then review the key sources of uncertainty in these forecasts: future population demographics, changes in population health, and changes in the intensity of medical care for Medicare beneficiaries. Next, I present some alternative forecasts of Medicare spending that allow for more rapid growth in Medicare spending per beneficiary and that seem quite plausible given Medicare's historical record and continuing rapid technological innova-

¹ For a recent review of the Medicare policy debate, see the Symposium on Medicare Reform in the *Journal of Economic Perspectives*, Spring 2000.

tion in care for the elderly. These forecasts suggest quite different budgetary implications. Finally, based on this framework of budgetary analysis, I discuss the possible short- and long-term budgetary effects of a range of *accounting* and *real* reforms in the Medicare program.

2. AN OVERVIEW OF MEDICARE FINANCING AND BUDGETARY HISTORY

Medicare Part A, or Hospital Insurance (HI), includes not only payments for inpatient acute hospital services but also payments to the major covered alternatives to such hospitals: services provided by skilled-nursing and rehabilitation hospitals, hospice care, and much home health care. Medicare Part B, or Supplementary Medical Insurance (SMI) includes payments for hospital outpatient services, physician services (regardless of where they are provided), laboratory tests, durable medical equipment, and assorted other non-inpatient services and products.

Though both parts of the program were created at the same time, they were the result of a legislative compromise and so incorporate a Congressional debate about how Medicare should be financed. Like Social Security and Disability Insurance (Old Age Survivors and Disability Insurance, OASDI), Medicare Part A (HI) is financed largely by a dedicated payroll tax. The Medicare payroll tax differs in some respects from the OASDI payroll tax. First, the total (employer plus employee) HI tax rate of 2.9% is much lower than the OASDI rate of 12.4%. This rate, which is low by the standard of current and future expected relative expenditures in Medicare and OASDI, is a reflection of Medicare's historically lower spending. Second, for the past decade, the tax has been applied to all earnings; there is no ceiling as with Social Security payroll taxes. Like OASDI, Part A is also financed by a portion of the tax receipts from Social Security benefit taxation, and by interest payments from accrued balances of these dedicated funding streams in the Part A Trust Fund. Eligibility for Medicare Part A is essentially automatic and free at age 65, with coverage for all Social-Security-covered workers and their spouses as well as virtually all exempt workers and their spouses.² The only

² A large share (almost 90 percent) of beneficiaries in the traditional Medicare program have additional ("supplemental") insurance that pays for some or all of the out-of-pocket costs of services not fully covered by the traditional plan. Such costs include a deductible for each hospital admission (around \$800 in 2000), copayments for stays of 20 days or more in a non-acute hospital, and copayments that increase for catastrophic (extraordinarily long) stays in acute-care hospitals. For very low-income seniors, such coverage is provided by Medicaid; for most seniors, such coverage is provided by private "Medigap" insurance, which does require an additional premium (but may be financed by a former employer).

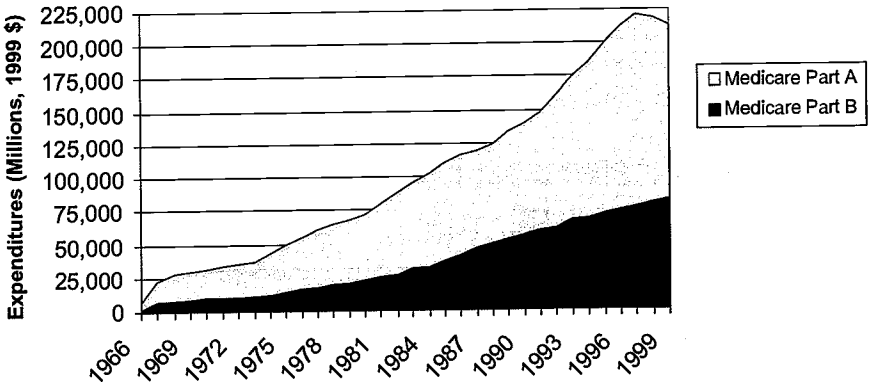


FIGURE 1. *Historical Medicare Expenditures (1999 \$)*

exception is recent immigrants who did not pay Medicare taxes. Americans under 65 who qualify for Disability Insurance are also eligible for Medicare after about two years. Of the approximately 39 million Medicare beneficiaries in the Part A program today, approximately 33 million are elderly and 6 million are under 65.

In contrast, Medicare Part B is financed from two sources: monthly beneficiary premiums, which account for about one-fourth of program costs, and general Federal revenues, which account for about three-fourths. Participation in Part B is voluntary. Undoubtedly because of the large subsidy, over 95% of beneficiaries choose to participate.³

Figure 1 shows Medicare's fiscal experience since its inception in 1966 through 1999, divided into Part A and Part B expenditures. (Note that the Part B expenditures are government payments net of beneficiary premiums.) Most notably, like medical expenditures more generally, Medicare expenditures have far outstripped GDP growth over the past 35 years. The reasons include population aging—between 1965 and 2000, the share of the U.S. population aged 65 and over has increased from 9.5 percent to over 13 percent. But the most prominent reason is undoubtedly cost-increasing changes in medical technology (e.g., Newhouse, 1992). Medicare has long regulated the prices it pays to hospitals, physicians, and all other health care providers. The rate of growth of these prices has generally been below the rate of medical price inflation; for example, between the mid-1980s and mid-1990s, Medicare payments for hospital services increased by over 1.5 percent less than the hospital

³ Medicare beneficiaries who are dually enrolled in Medicare, as well as those with somewhat higher incomes [Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs)], have their Part B premiums paid by the government.

"market basket" (Medicare Payment Advisory Commission, 1998). Thus, the main contributor to real growth in expenditures per beneficiary has been utilization—new treatments, and more widespread use of existing treatments.

Within this general pattern of increasing real expenditures, however, a number of marked changes in trends in expenditure growth occurred. For example, prior to 1983, acute hospital expenditures in Medicare Part A accounted for the bulk (around two-thirds) of Medicare spending. In 1983, Congress enacted the Prospective Payment System for hospitals, which changed hospital reimbursement from a regulated payment system based on services provided (e.g., including a per diem payment for each day in the hospital) to a regulated payment system based on diagnosis-related groups in which the hospital received a largely fixed amount per admission based on the diagnoses and procedures present. Because payment depends retrospectively on the treatment a patient actually receives as well as diagnoses (McClellan, 1997), and because of so-called "creep" in the reported severity of diagnoses (Carter, Newhouse, and Relles, 1990), this payment system was not entirely "prospective." But it did create substantial new incentives to limit hospital stays and move many treatments out of acute-care hospitals and into alternative settings, including hospital outpatient departments and physicians' offices, which are still reimbursed on a regulated fee-for-service basis. Thus, between 1983 and 1990, the share of Medicare expenditures on Part B services increased from about 32 to about 40 percent of spending.

Part A benefits were also changing in the late 1980s. Hospitals began to rely much more heavily on post-acute facilities, often affiliated with the hospital, to provide further treatments for inpatients who received acute treatments but no longer required the level of intensity of an acute hospital bed. For example, the share of patients with admissions for hip fractures who were discharged to Medicare-covered non-acute facilities (skilled nursing and rehabilitation beds) increased enormously between 1988 and 1997. Home health services, which had been included as a Part A benefit because they were viewed as a much cheaper alternative to hospitalization, also became a far more important component of Medicare expenditures. An administrative ruling in the late 1980s determined that Medicare home health services should not be limited to beneficiaries immediately after their hospitalization. Use of home health services subsequently grew at a phenomenal rate, over 20 percent per year between 1990 and 1995, to the point that this program alone accounted for around 10 percent of total Medicare expenditures by 1997. Thus, Medicare spending growth between around 1990 and 1997 was most importantly

related to increasing non-acute expenditures in Part A.⁴ Real Part A per-beneficiary expenditures increased by about 34 percent during this period (from around \$2,500 to around \$3,800 in 1999 dollars), compared to a real increase of 19 percent for Part B expenditures (from around \$1,700 to around \$2,100).

The pattern of expenditure growth changed dramatically again with the Balanced Budget Act of 1997. In many respects, the BBA can be viewed as a culmination of the traditional mechanisms for limiting spending growth in Medicare: reducing real growth in the regulated prices paid to providers and bundling together payments for more services. Though it did not cut any prices, the BBA tightly limited price increases through 2002, especially for hospital services. For example, the fees paid to acute-care hospitals, which would otherwise have risen from year to year along with increases in the hospital market-basket price index, were limited to an average of 1.7 percentage points below the market-basket rate. By 2003, the cumulative effect of the reduced updates would have been to limit payments for acute hospital services to about 10 percent less than they otherwise would have been. Such price growth limits are not too far out of line with those imposed previously; however, they came at a time when hospitals were also facing very strong pressure from private insurance plans to limit expenditures.

The BBA also dramatically altered payments for the non-hospital Part A services that had been so important in Medicare spending growth in the 1990s. For example, via a transitional payment system, payments for home health services were changed from a per-visit payment to a prospective payment for each 60-day episode of home health care. This change led to an actual decline in home health utilization, after almost a decade of extremely rapid growth.

The diverse patterns of growth in Medicare expenditures over the last several decades illustrate the enormous dependence of Medicare's financial obligations on specific legislative and regulatory changes in the program's benefits, as well as significant changes in medical treatment. Not surprisingly, historical expenditure growth has varied widely from year to year, and even over several years. Nonetheless, over longer time periods, Medicare spending had reflected the economy-wide fundamental of persistent real increases in medical spending. Over the past 30 years, this spending growth has averaged around 2.6 percent per year more than the real rate of growth of the overall economy, or well over 3 percent per year.

⁴ See Geppert and McClellan (2000a, 2000b) for a more detailed analysis of the importance of non-acute spending growth in Medicare between 1988 and 1997.

3. AN OVERVIEW OF RECENT MEDICARE BUDGET FORECASTS

In addition to documenting the budgetary costs of these programs since their inception, a range of actuarial reports and fiscal studies regularly present forecasts of Medicare's future fiscal implications. The most careful and detailed regular forecasts are the official annual reports of the Medicare Trustees, which are based on technical analyses conducted by the Office of the Actuary of the Health Care Financing Administration (HCFA). Based on the 2000 Trustees' Reports, Figure 2 combines Medicare's budgetary history through 1999 with the 75-year forecasts that the actuaries are required to provide by law. Figure 2a extends Figure 1, describing total real Medicare expenditures. The second panel of Figure 2b shows the same expenditures on a per capita basis, based on past enrollment and assumptions about the future size of the elderly population that are currently incorporated in the main ("intermediate") forecast of the HCFA actuaries and the Social Security Administration. The third panel of Figure 2c shows Medicare expenditures as a share of GDP, using assumptions about future GDP growth also contained in the 2000 reports.

Together with new limits on payment updates for the private managed-care plans that participate in Medicare, the BBA changes collectively had an enormous impact on current and projected Medicare spending, though other factors undoubtedly also contributed.⁵ Since 1997, Medicare Part A spending has been approximately flat in nominal terms. Because this recent unprecedented experience of real *declines* in Medicare spending reduces the expected base of future per-capita spending growth, the BBA has had major consequences for Medicare spending forecasts. For example, the 1999 forecast of Medicare expenditures for 2000–2007 by the Congressional Budget Office was over \$530 billion (18 percent) less than the forecast in 1997, and the 2000 forecast was over \$600 billion less. This unprecedented slowdown in spending growth, coupled with the increasingly favorable budget surplus projections associated with them, has formed the basis for intense lobbying by provider groups to "roll back" some of the BBA provisions. Such a modification was passed in late 1999, and another BBA rollback may well be the only Medicare reform legislation enacted in the 2000 session of Congress.

⁵ For example, the Clinton Administration has substantially increased enforcement of "waste, fraud, and abuse" provisions in billing, with the result that inappropriate and insufficiently-documented claims are much more likely to be reduced or denied than they were before 1996.

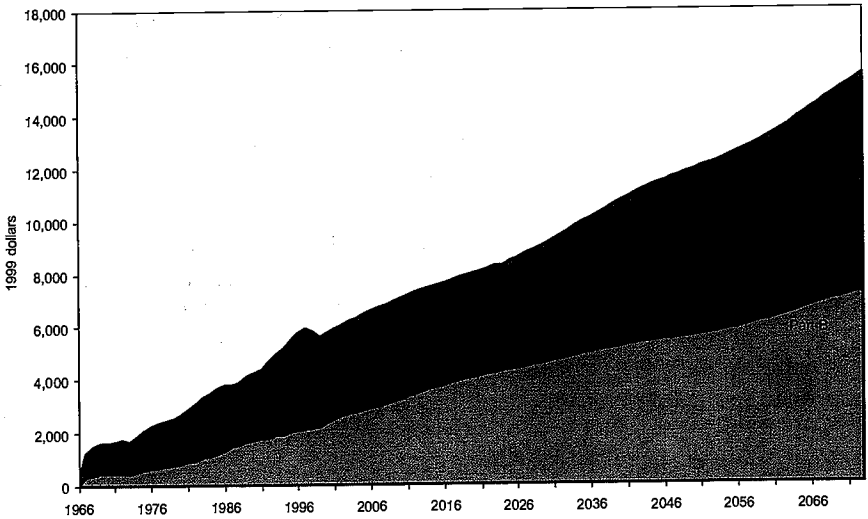
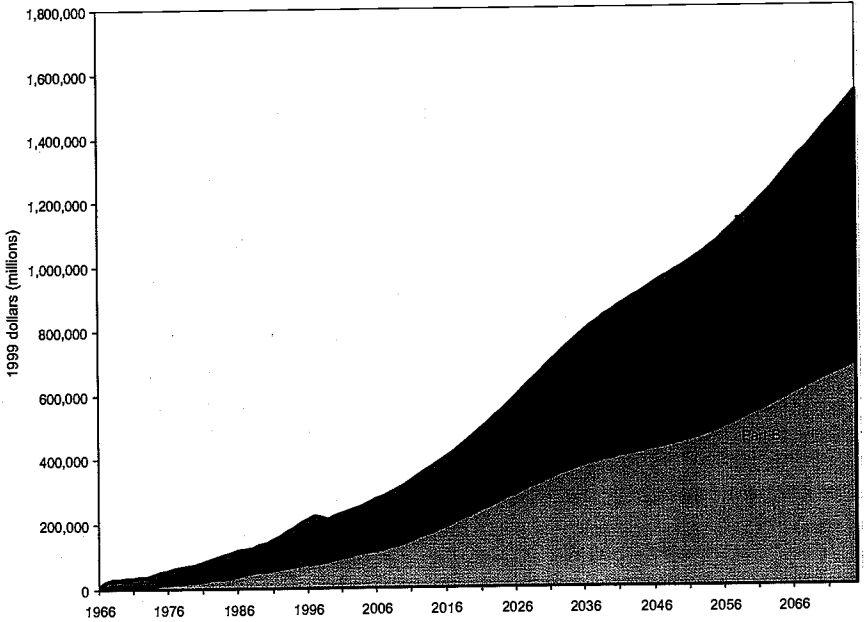


FIGURE 2. Medicare Expenditures, 1966–2075: Actual Experience and Actuaries' "Baseline" Projections: (a) Total; (b) Per Capita; (c) As Share of GDP

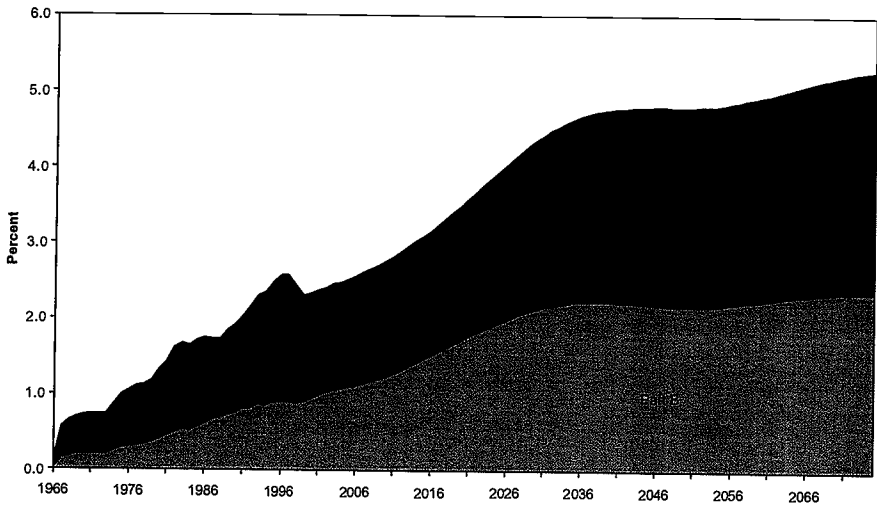


FIGURE 2. *Continued*

In addition to predicting the consequences of frequent Medicare policy changes, the HCFA Actuaries and other forecasters of Medicare spending face other daunting tasks. Like the Social Security Actuaries, the HCFA Actuaries face considerable uncertainty about such demographic features as future trends in survival and immigration. They also face uncertainty about the future health of the Medicare population, which would seem to be an important determinant of how much medical care they use. In addition, because Medicare's defined benefit covers a broad range of "appropriate" medical treatments, whatever those turn out to be, they also face uncertainty in per-beneficiary expenditures due to the difficulty of predicting future changes in medical technology.

The Actuaries' intermediate forecasts, as summarized in Figure 2, reflect their assumptions about these and other important determinants of future Medicare spending. As with Social Security, the retirement of the baby boom between approximately 2010 and 2030 is expected to lead to a massive increase in program enrollment, from around 40 million beneficiaries today to almost twice that many by 2030. The Actuaries' demographic assumptions are consistent with those used by the Social Security Actuaries for projecting OASDI costs. The more difficult and potentially more important assumptions relate to the rate of increase in expenditures per Medicare beneficiary. The Actuaries assume that the recent slowdown in real spending growth per beneficiary will increase somewhat back toward historical levels in the coming years. However, the growth in

TABLE 1
Average Past and Projected Growth in Expenditures per Beneficiary

Years	Average real growth in per-beneficiary expenditures (%)		
	Part A (HI)	Part B (SMI)	Total Expenditures
1980–1989	3.49	8.22	5.15
1990–1999	3.27	2.96	3.15
1990–1997	6.06	3.03	4.89
1997–1999	–5.91	2.71	–2.75
2000–2009 (projected)	1.31	3.04	2.06
2010–2030 (projected)	0.75	2.14	1.51
2030–2075 (projected)	1.42	1.05	1.24

Source: Projections from Trustees' Reports, 2000; historical data from Medicare Statistical Supplement, 2000, and U.S. HCFA, Office of the Actuary (2000a, 2000b).

Medicare spending per beneficiary only returns partially toward the real rate of growth observed in the past—around 2 percent per year in 2000–2009, compared to an average of over 3 percent per year in 1990–1999. Table 1 illustrates, showing the average past and projected growth rate in expenditures per beneficiary. It highlights the extent to which the last few years since the BBA have been atypical, compared to growth rates in per capita expenditures in all previous periods.

The assumptions of moderating expenditure growth in part reflect the influx of relatively young baby boomers, which will initially lower the average age of Medicare beneficiaries and will tend to reduce per-beneficiary expenditures.⁶ More important, however, appear to be assumptions that real price growth will continue to be modest (though somewhat higher after 2002, when the BBA limits on regulated price updates expire), and particularly that increases in per-beneficiary utilization of most types of covered services will moderate compared to Medicare's experience before the BBA was enacted. As a result, future growth in intensity per beneficiary is expected to be substantially lower than past experience, as well as lower than the Actuaries' own forecasts as recently as 1997. This appears to be especially true for services covered by Medicare Part A; the overall growth in intensity in Part B services is assumed to decline only modestly from its recent past experience. Thus, implicit in the Actuaries' recent forecasts is a guiding assumption that recent legislation (such as the adoption of more prospective payment

⁶ Medicare expenditures generally increase with age to around age 85, so that expenditures for a beneficiary aged 65–66 are only about two-thirds of average expenditures. (Source: author's calculation from Medicare expenditure data.)

systems for home health and hospital nonacute services) as well as other recent policy changes (such as a crackdown on insufficient documentation in claims) will have a substantial impact on growth in Medicare expenditures per beneficiary that lasts through the coming decades.

Finally, the Actuaries' forecasts have long been guided by an assumption that Medicare spending growth will moderate further toward the rate of growth of the program's financing sources in the long run—which is driven by the long-term growth rate of productivity per worker—by about 25 years from the date of the current forecast.⁷ This assumption does not reflect any specific anticipated efforts of current policies; rather, it reflects the fact that health care spending in general and thus Medicare spending in particular cannot grow forever at current rates. As of this writing, there was some evidence that the assumption that Medicare growth would fall fully into line with the rate of growth of the economy as a whole would soon be relaxed. A technical advisory panel for the Actuaries was considering a recommendation that the long-term growth rate be increased, and the Congressional Budget Office forecasters began to consider explicitly a "pessimistic" scenario in which Medicare spending would continue to exceed overall economic growth (U.S. CBO, 2000a). Over time, the assumption of even 1-percent-greater annual growth in Medicare expenditures can have major consequences for budgetary costs, as some of the alternative forecasts described below illustrate.

4. ARE RECENT PROJECTIONS IN LINE WITH THE FUNDAMENTALS OF MEDICARE EXPENDITURE GROWTH?

Because projecting Medicare expenditures is so difficult, key assumptions related to future expenditure growth inevitably have been questioned by a variety of experts. As Lee and Skinner (1999) have recently reviewed, many demographers believe that the assumptions about improvements in life expectancy used by the OASDI and HCFA actuaries assume too little improvement in the future. OASDI appears to emphasize quite recent slowdowns in mortality improvements, whereas other demographers emphasize international comparisons and the better

⁷ The so-called "high-cost" scenario assumes expenditure growth rates 2 percent higher than assumed in the intermediate case discussed in detail in the text. This leads to growth in per capita expenditures more in line with growth rates observed before 1997. Even in this scenario, Medicare expenditure growth is assumed to moderate toward the long-term growth rate of the economy by 2050.

long-term fit of demographic models that suggest larger long-term improvements. For example, under the current OASDI projections, life expectancy in the United States will not achieve the level observed today in Japan (about 80.5 years) until around 2050. Between now and 2070, OASDI projects an improvement in life expectancy only from 76 to 82. In contrast, one of the most widely cited demographic forecasts, by Lee and Carter (1992), projects an improvement to over 86.

Figure 3 illustrates the effect on Medicare expenditures of more extensive population aging than incorporated in the OASDI intermediate forecast. The figure relies on the beneficiary population projections of the OASDI "high-cost" scenario, which are similar to the Lee-Carter projections, but keeps all other forecast assumptions the same. Greater increases in longevity would lead to higher Medicare costs. However, the effect on Medicare spending as a share of GDP is rather modest until 2030 and beyond; the figure shows that the increase would amount to less than 1% of GDP even after 2050. Moreover, the budgetary effects of the higher survival rates at older ages are likely to be moderated by higher survival rates before age 65 as well, leading to a larger tax base to support Medicare and social security.

What about future growth in spending per beneficiary? One factor influencing spending per beneficiary is health status. Improvements in survival of the elderly over the past two decades do not seem to be associated with increasing time spent in a disabled state (e.g., Manton,

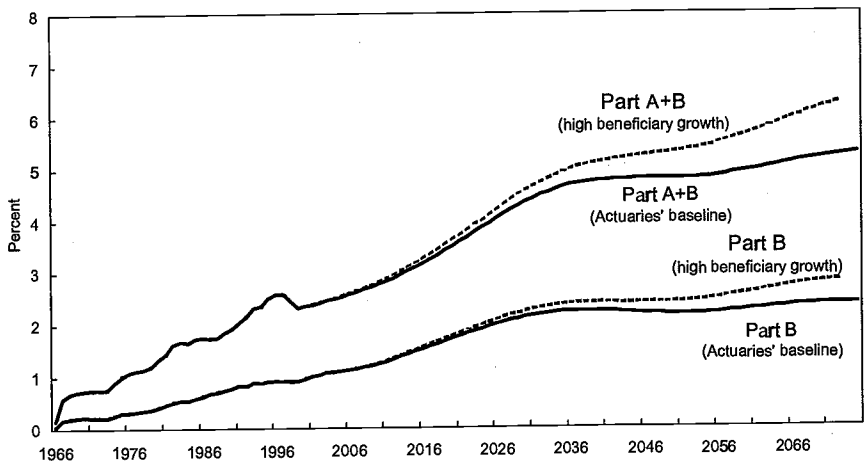


FIGURE 3. *Medicare Expenditures as a Share of GDP with Actuaries' "High"-Beneficiary-Growth Assumption*

Corder, and Stallard, 1997). Because poor health status is clearly associated with higher Medicare spending (Manton, Stallard, and Liu, 1993), the additional survival years may not be very costly for the Medicare program (see Miller, 2000, for a more detailed discussion of this view). Moreover, survival improvements in the elderly are likely to be correlated with improved health in the non-elderly, leading to greater labor-force participation and more contributions to Medicare financing (Lee and Tuljapurkar, 1997).

On the other hand, the favorable trends in health and survival do not appear to be associated with declining rates or intensity of treatment for illnesses (McClellan and Yan, 2000), and are associated with disproportionate increases in the use of intensive and costly procedures in the very old, such as joint replacements and bypass surgery (Fuchs, 2000). Consequently, it is possible that declining disability may be associated with increases in intensity of treatment and thus Medicare costs. These studies suggest that the increasing intensity of treatment that is associated with improving health may swamp any potential savings from greater longevity. Table 2, taken from Geppert and McClellan (2000a), illustrates this point. The table decomposes the growth in total Medicare expenditures on the elderly between 1988 and 1995 into two major components: growth in spending per beneficiary and growth in the number of beneficiaries. In turn, growth in spending per beneficiary can be decomposed into a *mortality effect* (that is, the savings resulting from postponing deaths until older ages, when spending is lower; this is the health effect) and an *intensity effect* (the increase due to higher spending per beneficiary, holding constant survival status).

As the table shows, the per-beneficiary increase in real spending of \$1135 (1995 dollars) during this period would have been about 5 percent (around \$51 per beneficiary) had survival not improved. The savings from greater survival were particularly notable for younger patients, who had relatively large reductions in mortality and who also had the highest end-of-life costs. However, increasing utilization given survival status had an effect on spending that was over 20 times larger than the mortality effect—close to \$1200 per beneficiary. In contrast, as the last column shows, the growing beneficiary population accounted for a relatively minor additional increase in Medicare spending during this period.

Using different datasets, Cutler and Sheiner (1999) and McClellan and Yan (2000) also conclude that improvements in disability rates have had non-trivial effects in reducing Medicare spending growth, but these effects were modest relative to increases in utilization given survival status. No studies have yet evaluated carefully the real declines in per-beneficiary spending since 1997, but it seems extremely likely that pay-

TABLE 2
Decomposition of Medicare Expenditure Growth, 1988-1995

Age group	Growth in real spending per beneficiary (\$)	Decomposition of growth in real spending per beneficiary (%)			Additional spending growth due to growth in beneficiary population (%)
		Mortality effect	Utilization effect	Interaction effect	
Overall	1,135	-4.5	105.5	-1.0	10.2
			Males		
Overall	922	-9.6	111.4	-1.8	10.6
65 to 69	665	-7.9	110.2	-2.2	1.5
70 to 74	660	-15.1	117.2	-2.1	14.2
75 to 79	1,022	-14.4	116.9	-2.5	13.4
80 to 84	1,604	-6.8	108.1	-1.3	21.0
85+	2,163	-1.4	101.7	-0.3	21.2
			Females		
Overall	1,269	-2.3	102.9	-0.6	9.9
65 to 69	746	-2.2	102.9	-0.7	0.0
70 to 74	990	-2.6	103.3	-0.7	12.4
75 to 79	1,397	-2.5	103.2	-0.6	9.8
80 to 84	1,924	-2.1	102.6	-0.6	16.8
85+	2,303	-2.2	102.6	-0.3	22.7

Source: Geppert and McClellan (2000).

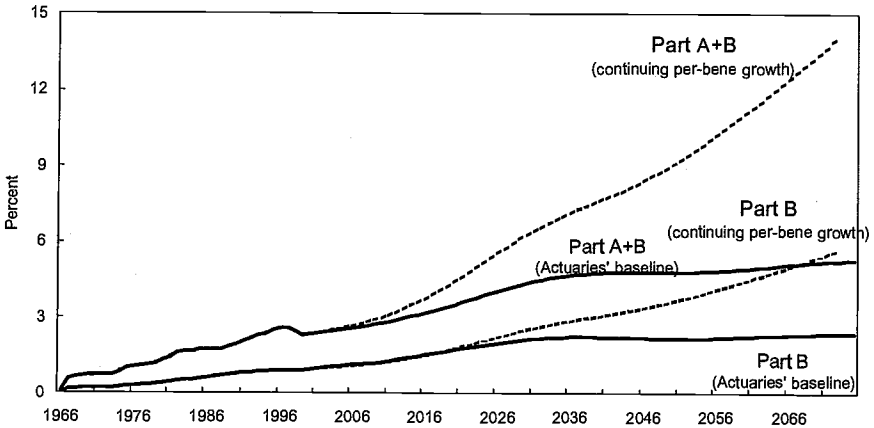


FIGURE 4. *Medicare Expenditures as a Share of GDP, with Expenditure Growth per Beneficiary Closer to Historical Rate (2.75 Percent)*

ment and utilization changes associated with policy changes and other environmental factors—leading to changes in utilization and expenditures given health status—are primarily responsible.

Medicare's fiscal history thus suggests that by far the most critical factor for forecasting future Medicare spending is the one that is most difficult to predict: the rate of spending growth for Medicare beneficiaries given their health status. To illustrate the sensitivity of Medicare expenditure forecasts to the growth in per-beneficiary spending, Figure 4 contrasts the Actuaries' intermediate forecasts with a forecast that assumes real growth in per-beneficiary spending will rise to a rate of 2.75 percent per year by 2003 (and remain there, i.e., no long-term slowdown in spending growth) while changing no other assumptions. As Table 1 showed, this rate is somewhat lower than the actual rate observed over the 1990s or any previous time period in Medicare's history. It is also more consistent with the recent growth rate of private-health-insurance premiums, which have again accelerated since 1998 to real growth rates of over 5 percent per year (Levit et al., 2000).

Figure 4 shows that, over time, the assumption of more rapid (but by historical standards relatively modest) per-beneficiary spending growth leads to much higher projected Medicare expenditures. In 2010, Medicare's share of GDP is projected to be around 3.0 percent in the alternative forecast, compared to about 2.8 percent under the Actuaries' intermediate forecast (translating to around \$30 billion in 2000 dollars). The differences grow more rapidly over time—about a full percentage point of GDP by as soon as 2020, and almost 3 percent of GDP by 2040.

This alternative forecasts of Medicare spending growth can also be compared with expected government revenues. Figure 5 focuses on implications of higher spending for the 10-year budget window. As Figure 4 suggested, these implications seem relatively modest during the budget window, especially in an era of budget surpluses. In 2010, under the assumption that per-beneficiary growth returns toward historical levels, Medicare spending as a share of federal revenues other than social security payroll taxes would be only about 10 percent higher (21.8 percent vs. 20.0 percent).⁸ This is only a little higher than Medicare spending as a share of non-social-security federal revenues in 1995.

Soon after the 10-year budget window, however, the fiscal implications become much weightier. Table 3 illustrates, showing forecasts of long-term GDP shares associated with different components of the federal budget. Projected shares of the other major components of the federal budget are taken from OMB's analysis of the long-term budget outlook (U.S. CBO, 2000b), which constructed GDP estimates using a somewhat different method and set of assumptions than the Actuaries.⁹ Thus, the GDP share estimates are not exactly comparable, though they are useful for illustrating the importance of future Medicare spending growth. In contrast to the baseline budget forecasts, the table assumes that real discretionary spending grows at the rate of population growth, so that real discretionary spending per capita remains constant. This assumption seems reasonable and, given recent experience and budget debates, may well be conservative (Auerbach and Gale, 1999).¹⁰

In the baseline projections, Social Security and Medicare expenditures account for a progressively larger share of GDP and federal expenditures, increasing from 6.5 percent today to 12.1 percent by 2075. The baseline projection incorporates the HCFA Actuaries' (2000) intermediate assumptions about Medicare spending growth: a lower real growth rate in per-beneficiary expenditures over the next two decades than historical rates, and a further slowing beyond 2025. As a result, the Medicare GDP share does not increase very rapidly. Table 3 also includes a Medicare scenario that resembles OMB (2000a), which presents an alternative "high growth"

⁸ Projected federal revenues in the figure are based on the CBO midsession review, July 2000 (U.S. Congressional Budget Office, 2000). OMB projections do not differ substantively.

⁹ OMB assumes that real productivity per hour continues to grow at the same rate assumed in their intermediate forecast, 1.7 percent per year, and that population grows according to the Social Security Actuaries' projections, which slow down relative to historical rates. Thus, real GDP grows by close to 3 percent per year in the earlier years, and gradually slows to around 2 percent per year in the outyears.

¹⁰ In any case, it does not lead to a dramatically greater share of GDP devoted to the budget by 2075 (e.g., 2.9 percent vs. 2.3 percent of GDP for discretionary spending in 2075).



FIGURE 5. Medicare Expenditures as Share of Total Federal Revenues Excluding Social Security Taxes

TABLE 3
Impact of Medicare Expenditure Growth on Long-Term Budget Outlook
(Major Budget Components as Shares of GDP)

Quantity	Value (% of GDP)				
	2000	2020	2040	2060	2075
Outlays:					
Social security ^a	4.2	5.7	6.7	6.7	6.8
Medicaid ^b	1.2	2.4	4.0	6.2	8.6
Other mandatory ^{b,d}	2.4	2.0	1.5	1.3	1.2
Discretionary ^{b,d}	6.5	4.7	4.0	3.3	2.9
Total non-Medicare outlays	14.3	14.8	16.2	17.5	19.7
Alternative Medicare assumptions:					
(1) actuaries' intermediate assumptions ^e	2.3	3.5	4.8	4.9	5.3
(2) 2% real growth in spending per beneficiary ^f	2.3	3.8	5.7	8.6	10.3
(3) 2.75% real growth in spending per beneficiary ^g	2.3	4.4	7.6	11.1	14.7
Receipts ^b	20.4	19.3	19.7	19.9	20.0

(a) *Source:* OASDI Trustees' Report (2000).

(b) *Source:* OMB (2000a), which is constructed by a somewhat different estimation procedure than the trustees' baselines.

(c) Not social security, Medicare, or Medicaid.

(d) Assumed to grow with inflation and population.

(e) *Source:* Medicare Trustees' Report (2000).

(f) *Source:* Author's analysis using per-beneficiary growth rate of 2%, with actuaries' assumptions about population, GDP, and other growth, as described in text. The analysis is somewhat similar to the OMB "high-cost" assumption about long-term growth in Medicare spending included in their budget analysis (OMB, 2000a), in which they assumed a 2.25% *per capita* rate. This corresponds to a lower growth rate in spending per beneficiary, especially during the years of the baby boom entry into the program.

(g) *Source:* Author's analysis using per-beneficiary growth rate of 2.75%, with actuaries' assumptions about population, GDP, and other growth, as described in text.

Medicare scenario in which real long-term Medicare expenditure growth is forecast to continue at 2 percent per beneficiary—a rate substantially lower than historical per-beneficiary growth rates.¹¹ The 2-percent per-beneficiary growth rate is also roughly consistent with the "pessimistic"

¹¹ The OMB scenario in the long-term budget forecast states that it uses a real growth rate of 2.25 percent per capita, and that this is about twice as high as the actuaries' assumptions. I interpret this to mean something like a 2 percent per-beneficiary growth rate, as per capita rates translate into lower per-beneficiary growth rates. In years where the actuaries' intermediate forecast involves higher per-beneficiary growth, the higher estimates are used.

assumptions about health care spending growth in CBO's long-term budget forecast (U.S. CBO, 2000b), which is 1.1 percent above the rate of growth of wages. This projection of Medicare expenditures steadily diverges from the actuaries' intermediate forecast, as the Medicare share increases to 10.3 percent of GDP by 2075 (vs. 5.3 percent).

Both of these estimates are considerably lower than the Medicare share that would result from a long-term per-beneficiary real growth rate of 2.75 percent. The modest differences in shares of federal revenues apparent in Figure 5 by 2010 become steadily larger thereafter, so that significant differences in the projected Medicare GDP share emerge before 2020. As a result, the projected unified budget surpluses would disappear far sooner than current baseline estimates project.¹²

The fact that such a broad range of assumptions is plausible indicates the enormous uncertainty about future growth in Medicare spending per beneficiary. Are any conclusions possible? On the one hand, a number of factors support long-term growth that is somewhat lower than historical rates, yet still substantially greater than overall GDP growth. The most important of these factors is continuing medical innovation: the development and diffusion of treatments for conditions that previously had been treated less intensively if at all. Though techniques ranging from minimally-invasive surgery to gene therapy and biomedical devices are all likely to lead to higher medical costs,¹³ innovation may not be quite as cost-increasing as in the past. The health of Medicare beneficiaries is likely to continue to improve, possibly at rates greater than have been observed in the recent past; at a minimum, the average age of beneficiaries will decline for a decade or so beginning around 2010. Managed care and other recent changes to encourage cost control in non-Medicare markets may also reduce Medicare spending growth through spillover effects (Baker, 1999). Indeed, at a macro level, it seems plausible that Medicare and non-Medicare technology and prices cannot diverge too much: Medicare's recent reforms may be allowing it to catch up with the spending slowdowns in the private sector that occurred in

¹² Interestingly, projected Medicare expenditure growth under this scenario is more comparable to OMB's long-term forecast of Medicare spending, which is projected to increase more than sevenfold as a share of GDP, from 1.2 percent in 2000 to 8.6 percent in 2075. In contrast, CBO forecasts only a tripling of Medicare spending as a share of GDP over the next 75 years, again illustrating the extreme uncertainty about per-beneficiary growth in public-health-insurance spending.

¹³ Even if these treatments seem like they would reduce costs on a per-case basis (e.g., gene therapy to treat diabetes), they may still lead to higher long-run costs because (1) more patients are likely to use the higher-quality treatment than use currently-available alternatives, and (2) averted costs for preventing some conditions may be replaced by (potentially higher) medical expenditures on other, more chronic conditions.

the mid-1990s.¹⁴ However, though many studies have documented large savings from managed care, many of these gains appear to be one-time occurrences due to price reductions (see, e.g., Cutler, McClellan, and Newhouse, 2000). The evidence on the lasting effects of recent health care market changes on expenditure growth is much more limited. There is some evidence that managed care has only a modest effect on technological change and longer-term expenditure growth rates (e.g., Cutler and Sheiner, 1998; Kessler and McClellan, 2000). Thus, the assumption of 2.75-percent real per-beneficiary expenditure growth, which is about four-fifths the average real growth observed in Medicare in the 1990s, may be more consistent with the view that cost-increasing technological change has moderated a bit, but still remains a fundamental long-term feature of the health care economy.

On the other hand, with continued rapid long-term growth, medical spending would steadily grow as a share of the overall economy; the 2.75-percent growth rate is consistent with overall medical spending rising to well over half of the overall economy in the second half of the twenty-first century. Thus, at some point, long-term medical spending growth and Medicare growth along with it must slow toward the rate of GDP growth. The question is when such a change will occur, and there is little evidence that it will occur anytime soon. Indeed, Fuchs (2000) estimates that about one-third of the total consumption by the elderly today, including that financed by both public and private sources, is medical consumption; for the elderly in the lowest third of the income distribution, the figure is already 50 percent.

Thus, if ongoing technological progress and the consequent growth in medical spending are anything like those of past decades, real growth in Medicare expenditures per beneficiary is likely to be considerably greater than most widely-cited forecasts would suggest. Such a scenario would clearly have very different medium- and long-term consequences for federal spending from the baseline forecast in Table 3.

Several other forces might prevent Medicare expenditure growth from continuing at a rate approaching historical levels. First, medical spending could become more efficient, so that valuable but costly new treatments could be adopted without substantially increasing Medicare expenditures. Even with the recent reforms in health care markets, enormous variations in Medicare spending across geographic areas persist (e.g., Skinner, Silverman, and Fisher, 2000), and within geographic

¹⁴ It is possible to view the "BBA giveback" legislation of 1999 and 2000, which restored or delayed some of the payment restrictions in the Balanced Budget Act, as incremental steps toward such longer-term balance.

areas, there is some evidence that many costly Medicare treatments have little measurable effect on patient outcomes (e.g., McClellan, McNeil, and Newhouse, 1994). Thus, at the margin, large efficiency gains seem possible. But they may be difficult to achieve. At present, Medicare beneficiaries have little incentive to obtain cost-effective care. Most have supplemental Medigap insurance that insulates them from any out-of-pocket payments, and competition among health plans in Medicare is not structured to encourage cost-conscious choices.¹⁵ In addition, only limited information on the quality of health plans, providers, and treatments is available to beneficiaries or purchasers acting on their behalf, making it difficult to identify and avoid care that is wasteful. As expenditures rise, support for initiative to encourage more efficient Medicare purchasing seems likely to grow. McClellan (2000) discusses such issues in more detail.

Second, Medicare budgetary considerations may provide a force for more substantial reform in the future. Medicare budgeting obviously reflects the underlying financial obligations of the program: as Medicare costs continue to rise, the competition between Medicare and other potential uses of federal revenues or private incomes will become more intense. But beyond these fundamental fiscal pressures, the Medicare budget has some distinctive accounting features that may also exert some influence on the Medicare reform process and on the economy's ability to absorb increasing health care costs in the future.

5. MEDICARE ACCOUNTING

Just as Medicare expenditures are divided into two major parts for budgetary purposes, so are Medicare's financing streams. Though both are essentially pay-as-you-go streams, they have some important accounting differences. Like the Social Security Trust Fund, the Part A Trust Fund may become technically insolvent if program outlays exceed its accumulated dedicated payroll tax revenues. However, unlike the Social Security Trust Fund, the income for the Medicare Part B Trust Fund comes from general revenue and beneficiary premium contributions that adjust year to year with its expected outlays. This section discusses the key features of this somewhat bifurcated budgetary accounting, and

¹⁵ Because beneficiaries pay a premium equal to only half of Part B costs, a \$1 across-the-board increase in Medicare spending translates into only about a 10-cent increase in premiums. Moreover, price competition among alternative Medicare plans is restricted. Reforms proposed by President Clinton and Senators Breaux and Frist would create strong new incentives for beneficiaries to choose lower-cost plans, but they seem unlikely to be enacted in the near future.

how they influence real debates about Medicare expenditures and overall government revenues.

The Medicare HI Part A Trust Fund accumulates the payroll taxes and other specific revenue streams dedicated to Medicare Part A and disburses Part A payments to providers and health plans. To the extent that dedicated revenues exceed outlays, the Trust Fund can accumulate interest on the balances through investment in special government bonds. As a result of legislation passed in the summer of 2000, it appears that Medicare Part A revenues, like Social Security revenues, are going to be treated as *off budget*, that is, as an account of payments and dedicated revenues that is separate from the rest of the federal budget expenses and revenues. Both the notion of Trust Fund solvency and on- and off-budget status are accounting concepts. The government could make the HI Trust Fund solvent indefinitely simply by transferring to it a sufficient volume of government bonds to meet all conceivable future obligations. Similarly, whether spending is defined as on-budget and off-budget simply affects the on- and off-budget surplus and deficits, not the government's overall fiscal position. Do these accounting constructions have any real economic policy consequences? The answer is yes, to the extent that they influence real policymaking behavior.

Technically, if the HI Trust Fund exhausts its assets, Medicare does not have the authority to meet its financial obligations without a change in law. This threat, along with the popular notion that the projected solvency of the HI Trust Fund is an indicator of the specific ability of the Medicare program to meet its obligations, is perhaps the explanation for the fact that every major cost-limiting reform in the history of Medicare Part A occurred with an insolvency date looming. Such reforms include the initial adoption of "prospective payment" for hospitals in 1984, the increase in the Medicare payroll tax rate in the early 1990s, and the extension of "prospective" reimbursement systems to other types of Part A-covered services (non-acute hospital admissions and home health visits) with the Balanced Budget Act of 1997.

Figure 6 shows the projected revenues and obligations of the Medicare HI Trust Fund, under both the Actuaries' baseline assumption and the alternative assumption of continuing real growth in per-beneficiary expenditures at near-historical rates. The Trust Fund historically has run modest surpluses; with a relatively low payroll tax rate, it has never had the revenue cushion to build up large balances as the Social Security Trust Fund has been doing for some time. Consequently, in the mid-1990s, when the Part A Trust Fund began to run a current-account deficit, insolvency was projected to be just a few years ahead. Following

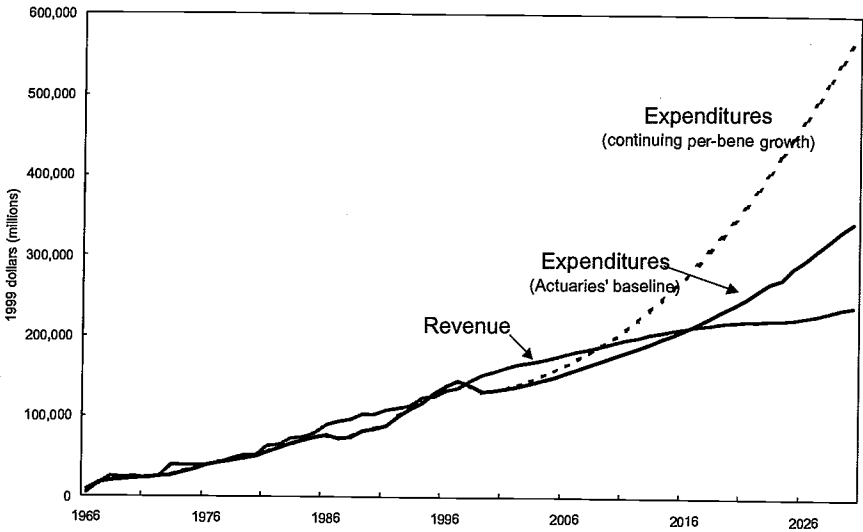


FIGURE 6. *Expenditures and Revenues of the Hospital Insurance (Part A) Trust Fund*

the real spending declines resulting from the BBA and other policy changes, along with the growth in payroll tax revenues from the ongoing economic expansion, the Trust Fund has been running a mild surplus. With real Medicare expenditures only projected to rise at a fraction of their historical growth rate, this mild positive balance is now projected to decline only gradually, so that the Trust Fund balance grows through 2016. As a result, in 2000, the HI Trust Fund was projected to remain solvent through 2025.

The alternative projection shows that the Trust Fund's outlook may be considerably worse if expenditure growth again approaches historical levels. In that case, Trust Fund outlays would exceed receipts fully seven years earlier, pushing forward the date of Trust Fund exhaustion by around a decade. As the Actuaries have noted, the impressive improvements in exhaustion dates in the 1999 and 2000 reports are something of a "knife-edge" phenomenon that could easily be undone by relatively modest changes in per-beneficiary expenditure growth in the not too distant future. And under all forecasts, the long-term status of the Trust Fund looks very unfavorable. In the last years before Trust Fund exhaustion under either scenario presented here, Trust Fund revenues are only four-fifths of expenditures or less, and decline rapidly as a share of expenditures thereafter.

This outlook for the HI Trust Fund bears some similarities to the Social Security Trust Fund, which has seen notable but considerably smaller improvements in its solvency prospects in the last few years but also faces dismal long-term prospects. However, dedicated Trust-Fund accounting in Medicare differs in a fundamental respect from Social Security: it does not apply to the increasing share of Medicare obligations in the Supplemental Insurance (Part B) program. As Part B expenditures rise from year to year, the government automatically adjusts beneficiary premiums and transfers additional general revenues in the Part B Trust Fund. Some critics of this bifurcated accounting structure have argued that it impedes pressure for overall cost containment in the program. Perhaps not coincidentally, payment for virtually all of the services covered by Part A has now been shifted to prospective, increasingly bundled payments; in contrast, the vast majority of services funded under Part B are still reimbursed using lower-powered payment schemes that still look very much like traditional fee-for-service payments.¹⁶ The vast majority of recent and projected Medicare "savings" have come from Part A, not Part B. Consequently, the share of Medicare expenditures outside of Trust Fund accounting is expected to continue to grow in the coming years (see the Actuaries' assumptions about spending growth for the next decades in Table 1, which are reflected in Figure 2). Finally, unlike Social Security, the bifurcated structure facilitates accounting responses to increases in Medicare costs that threaten Part A Trust Fund insolvency. One of the steps taken in the BBA to improve the Trust Fund's outlook was to transfer the majority of home health services from Part A to Part B.

The recent Congressional and Presidential proposals to "take Medicare off budget" also apply only to Part A. As with the dedicated-Trust-Fund concept, such an accounting change could have real political effects, at least for the current-account surpluses in the Part A Trust Fund. As Elmendorf and Liebman (2000) note in their analysis of similar issues involving Social Security, which has been off budget since 1983, the key question is how surpluses in off-budget accounts are treated in the budget policy process. Compared to on-budget accounting, does the Trust

¹⁶ This is not to imply that Part B payments have not been subject to important reforms. In part as a result of the growing importance of Part B services, reforms in Part B payments were enacted in the late 1980s, such as the enactment of a new "resource-based relative value scale" to match physician payments more closely to an "objective" analysis of physician effort costs. "Volume performance standards" are also now in place that are expected to offset automatically any increases in the utilization of services. Nonetheless, the payment schemes remain "lower-powered" in the language of incentive theory.

Fund affect policy decisions about Medicare and other government spending and revenues that have different consequences for national saving and hence capital accumulation,¹⁷ as well as the benefits and revenues of those programs? If off-budget surpluses are ignored in making decisions about new government spending or tax cuts, they can potentially lead to new net savings by the government. Recent public debate about "not touching the Trust Fund" suggests that, at least in an era of surpluses, off-budget status may really mean that these surpluses are not committed to new spending or tax cuts, and thus may result in new government savings. Prior to 1999, Social Security had, for all practical budget decisionmaking purposes, been grouped with other activities in a unified accounting framework. As of 2000, there is strong bipartisan support for counting only the on-budget surplus when considering new tax cuts or spending initiatives.

If the same approach to budget policy now applies to Medicare as well, it implies that the Trust Fund accounting surpluses projected for the coming years (Figure 6) might lead to a non-trivial amount of new savings. Medicare Part A ran a \$20-billion current-account surplus in 1999, and as of July 2000, Part A was projected to run a surplus of around \$350 to \$400 billion over the next 10 years. Thus, if on-budget surpluses matter for political decisionmaking, this change could have the effect of reducing the on-budget surplus available for initiatives other than paying down Federal debt over the period 2000–2010 from around \$2 trillion to around \$1.6 trillion (the other \$2.2 to 2.3 trillion of the projected unified surplus during this period comes from the Social Security Trust Fund). On the other hand, if the political decisionmakers tend to balance the unified budget surplus, then there is no effect of the accounting change to off-budget treatment. This seems like a better description of the budget process in deficit eras like the previous 30 years, when policymakers generally focused on the unified budget accounts.¹⁸ For example, if the response to deficits in the Social Security or Part A Trust Funds in the future is to transfer general revenues off budget to shore up the Trust Funds, in effect decisionmakers would be aiming to balance a unified budget.

¹⁷ Other things equal, greater capital accumulation will lead to higher productivity for future generations. Such capital might consist of technical knowledge (e.g., investment in research and development and education), though greater national savings would primarily lead to a larger stock of physical capital, at the cost of lower current consumption.

¹⁸ In 1967, around the time that Federal deficits became a regularity, the official budget process was changed in accordance with the recommendations of a government commission to adopt a "unified budget" perspective.

6. BUDGETARY IMPLICATIONS OF MEDICARE REFORM PROPOSALS

This section discusses some illustrative Medicare reforms with implications for the Part A and Part B budgets. It is useful to divide these reforms into accounting reforms, which could lead to real effects, and real reforms that affect program benefits and revenues directly. As with the recent move to take Part A off budget, a key fact in recent Medicare policy is the emergence of substantial projected budget surpluses; in 2000, the projected unified surplus was as large as 2.3 percent of GDP, and as noted above, unified surpluses were projected to continue through the middle of the twenty-first century (OMB, 2000b). Indeed, as noted above, the changes in Medicare benefits and other policies were undoubtedly important contributors to the improved surplus projections. As a result, in 2000, policymakers are reluctant to consider further Medicare tightening. Reforms that would lead to significant benefit reductions in Medicare in the years ahead are not on the table, and neither are reforms that would lead to significant new sources of Medicare revenues.

6.1 *Accounting Reforms*

Two major types of accounting reforms have been proposed for Medicare. The first involves the adoption of a more uniform accounting structure. As part of the Medicare Commission process in 1999,¹⁹ Senators Breaux and Thomas proposed to finance Medicare Part A and B through a new unified Medicare Trust Fund. This single government account for all Medicare spending would be accompanied by a harder long-term limit on general-revenue financing. In particular, general-revenue transfers to the account would be fixed at 40 percent of overall program expenditures, which is larger than the share of Part B in Medicare today but eventually is expected to become a more binding constraint. Alternatively, the share of general revenues that could be devoted to Medicare Part B could be capped or fixed. This would limit Part B revenues in a way analogous to that imposed by the restricted revenue stream allowed for Part A. Supporters argue that impending Trust Fund insolvency is more of a spur to action on potentially painful benefit or financing reforms than the gradually creeping share of Medicare expenditures in the

¹⁹ The Bipartisan Commission on the Future of Medicare was a mixed political-academic commission charged with laying out a long-term plan for assuring the financial soundness and quality of the Medicare program. Co-chaired by Senator Breaux (D-LA) and Representative Thomas (R-CA), it concluded its work in March 1999 without being able to get the required supermajority support for any specific proposal. See McClellan (2000) for more details on the recent Medicare reform debate.

unified budget, and at a minimum that such accounting reforms would refocus policymakers on a complete picture of Medicare's fiscal status, rather than the partial summary provided by the Part A Trust Fund.

President Clinton and congressional Democrats have proposed a different type of accounting reform: transferring part of the projected on-budget surplus to the Part A Trust Fund. The most recent proposal (OMB, 2000b) would transfer approximately \$115 billion by 2010, extending the solvency of the Trust Fund to around 2030. As noted above, to the extent that the transferred revenues are treated as off budget *and* the budget process focuses on the on-budget surplus, this change could lead to a real increase in net government savings.

Thus, although neither of these accounting changes has real effects directly, both could conceivably influence policy decisions about Medicare and other government programs in the budget process, with potential effects on net savings and net Medicare obligations and other government programs. A potential accounting compromise could involve setting up a unified Trust Fund in conjunction with more general-revenue transfers than currently envisioned in the Breaux-Frist proposal; this would achieve the goal of a unified Trust Fund, but would also push back the accounting insolvency date.

6.2 Real Reforms

As recently as 1999, in the Medicare Commission and the President's original Medicare reform proposal, notable reductions in benefits and increases in Medicare revenues were being seriously debated. Benefit reductions in Medicare have generally taken the form of tighter limits on provider payments, as in the BBA. Early versions of both the Breaux-Thomas proposal and the President's proposal included "payfors" that would have extended the BBA in moderated form, by continuing to restrict updates in payments for Medicare services below the rate of medical price inflation past 2002. However, the only Medicare reform legislation passed in 1999 and 2000 was legislation that moderated many of the current BBA provisions, and the discussion of "BBA extenders" has largely disappeared.

Similarly, discussions about raising more revenues for Medicare were not a major part of the policy debate in 2000. Increasing the share of Medicare paid for by beneficiaries themselves—which now stands at about 10% of program costs and is increasing very slowly—could be achieved by implementing an income-related Medicare premium. That is, premiums would not be raised for the lowest-income beneficiaries, but might be increased for those of moderate and higher incomes. Even if the political difficulty of enacting a new Medicare payment could be

overcome, the opportunity it would provide for substantial revenue raising is limited. Assuming that the Part B premium remains voluntary and that near-universal participation is desired, Medicare needs to retain a substantial subsidy for wealthier beneficiaries to prevent many of them from dropping out of the program (especially healthier ones with potentially good outside options, like tax-subsidized employer insurance). In addition, phasing in even a moderate additional Medicare premium over the \$25,000–45,000 income range could contribute to significant implicit tax rates over this range (due to the taxation of Social Security benefits), which could discourage future elderly from working or saving. And phasing in the additional premium payments at a higher income level would not raise much revenue. Although both the Medicare Commission and President Clinton seriously considered an income-related premium, neither ended up endorsing it. In addition, though there was some discussion in the Medicare Commission of increasing the Medicare eligibility age along with the scheduled increases in Social Security normal eligibility to 67 by 2025, support for this proposal diminished as the short-term budget outlook continued to improve.²⁰

Instead, most of the recent Medicare debate has focused on benefit expansions. Reflecting the difficulty of legislating significant and potentially costly change in the program, Medicare (in contrast to the vast majority of private plans) does not include coverage for outpatient prescription drugs. A number of drug-benefit reforms have been proposed, which differ in both comprehensiveness and administration.²¹ According to CBO, estimated costs of major drug-benefit proposals during the 2001–2010 budget window range from around \$150 billion (for the recent Rx2000 proposal by Rep. Thomas and others, which provides comprehensive coverage for beneficiaries with incomes up to 135 percent of poverty, plus 25-percent subsidies up to cap for all others for purchasing drug coverage with catastrophic protection) to much higher expenditure levels. To illustrate some budgetary issues that apply to all the plans, I focus on the President's most recent proposal. This proposal provides comprehensive coverage for low-income beneficiaries (as in the Rx2000 plan) and a 50-percent premium subsidy for all other beneficiaries to purchase drug coverage that provides 50 percent for all purchases plus

²⁰ Raising the eligibility age would also generate more modest savings for Medicare than for social security. Younger beneficiaries are relatively inexpensive, and the most costly 65–66-year-olds would probably continue to qualify for Medicare through disability insurance.

²¹ See McClellan, Spatz, and Carney (2000) and Merlis (2000) for more detailed discussions of issues surrounding the addition of a prescription-drug benefit to Medicare.

complete catastrophic coverage for drug expenditures over \$8,000 per year. By comparison, private plans generally provide more comprehensive benefits than this, though they may also impose tighter restrictions on drug choices.²² The estimated cost of this plan to Medicare over the 2002—2010 period was over \$300 billion according to CBO and slightly less according to administration estimates.²³

Several issues are important in considering the budgetary implications of the Medicare drug-benefit proposals. First, all proposals use general-revenue financing—that is, they would be on-budget programs that would not affect Part A Trust Fund solvency in any way. Thus, they would further limit the extent to which the Part A Trust Fund describes Medicare's overall fiscal status. Second, they are costly, especially for benefits that approach the level of coverage that private plans have adopted. Truly comprehensive coverage, similar to that provided by most private insurers for the non-elderly, would have considerably greater budgetary implications, probably in the neighborhood of \$1,000 per beneficiary or around \$40 billion in 2002. Second, drug costs are universally forecast to grow rapidly. In the last five years, drug expenditures have grown by over 10 percent per year in real terms (Levit et al., 2000). With continuing progress in human genetics and understanding the molecular bases of diseases, most analysts envision many years of innovative product development and thus rapid expenditure growth. Many of the resulting biotechnology products are likely to be particularly costly. Thus, not only is rapid drug expenditure growth likely to continue long after a Medicare drug benefit is enacted; a larger share of drug expenditures are likely to be accounted for by high-cost drugs that would lead to expenditures above the level at which catastrophic coverage would kick in. For all of these reasons, growth in the Medicare drug benefit is likely to be particularly rapid. After the President's plan is fully phased in in 2008, CBO projects per-beneficiary growth rates of around 6.5 percent per year.

Figure 7 modifies Figure 3 to show the forecasted budgetary impact through 2010 of a moderately generous benefit proposal like President

²² The President's plan would be managed by a private pharmaceutical benefits management (PBM) firm in each geographic region of the country. Such firms manage most private-insurance drug benefits. However, there is some debate about whether managers of the Medicare drug benefit would have the same flexibility and independence in negotiating drug prices and limiting drug costs as in private plans.

²³ CBO also "scored" some additional Medicaid and other governmental costs, but these were small relative to the Medicare costs. President Bush proposed a plan similar in cost and structure to the Rx2000 plan.

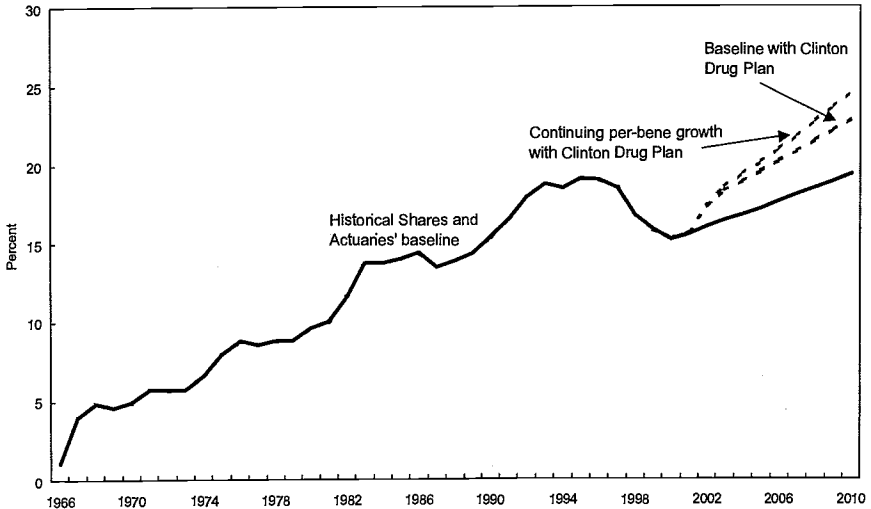


FIGURE 7. Medicare Expenditures as Share of Federal Revenues Exclusive of Social Security Taxes with President Clinton's Proposed Prescription-Drug Benefit Included

Clinton's, as well as the Actuaries' baseline forecast and the alternative forecast that assumes Medicare growth returns toward historical rates after several years. By 2010, according to the CBO analysis, the new drug benefit would amount to about one-sixth of all Medicare spending, raising Medicare expenditures as a share of Federal revenues other than Social Security taxes by about 3.5 percent (according to the administration's analysis, Medicare would require about 3.1 percent). The figure also shows that, if Medicare growth rises back toward its higher historical rate, Medicare would require financing equal to around one-fourth of Federal revenues other than Social Security taxes. Regardless of which drug benefit proposal is adopted, the rapid growth of drug costs will probably cause the overall rate of Medicare spending growth to increase significantly. The consequences of more rapid growth become steadily greater after 2010, as shown in Figure 8. This figure includes a forecast of Medicare expenditures as a share of GDP out to 2030, with the addition of a drug benefit whose expenditure growth per beneficiary is projected to slow to 5 percent per year—significantly less than the growth rate forecast by CBO and the Actuaries up to 2010. Even with this slower growth rate, the Medicare drug benefit would amount to around 1.6 percent of GDP by 2030.

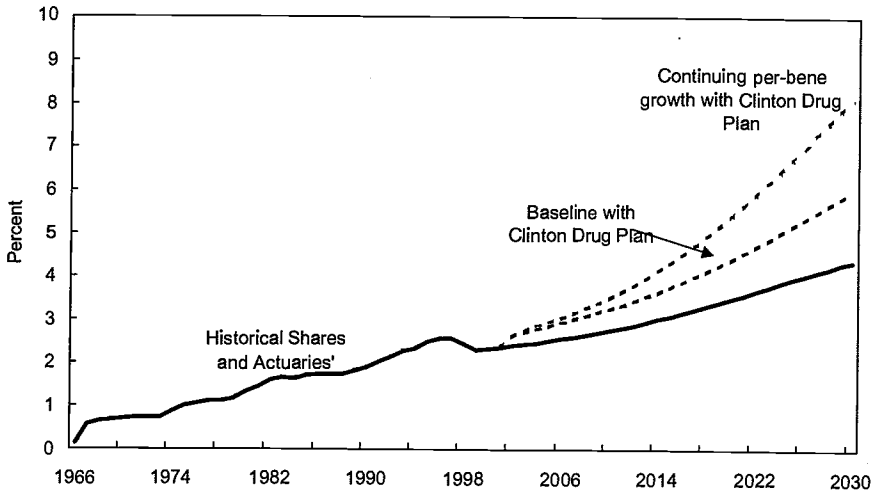


FIGURE 8. Medicare Expenditures as Share of GDP, 1966–2030

7. CONCLUSION

This overview of budgetary issues related to Medicare has highlighted several themes. First, although Medicare already is a major factor in the Federal budget, under any set of plausible assumptions it is likely to become even more important in the years ahead, especially after 2010. The budgetary uncertainty only involves a question of how much more important, and how quickly; and the answer to these questions depends critically on future growth in Medicare spending per beneficiary. Second, although the last several years have been unprecedentedly favorable ones for the Medicare program from a budgetary standpoint, it is possible and perhaps likely that such a favorable fiscal run will not continue for much longer. A slowdown in expenditure growth for private-health-insurance expenditures that began several years before the Medicare slowdown has not persisted, and Medicare has never sustained lower growth rates than the private sector for very long.

It is possible that Medicare—or at least Medicare Part A—has found a “solution” to the benefit reforms enacted in the BBA that may limit the growth in per-beneficiary utilization of Medicare services for the long run, even though such reductions in long-term growth are proving elusive in the private sector. But such a long-term change runs contrary the entire history of expenditure growth in Medicare and of the health care

economy more generally. If, through either changes in treatment or further giveback legislation, Medicare expenditure growth rises back toward its previous growth rates now being observed again in private insurance, then the budgetary outlook, at least in the medium and long term, will be much less favorable than projected in some of the most widely cited forecasts. The current Medicare reform debate, which is now focusing on the addition of a drug benefit rather than any new benefit limitations or new revenues, is unlikely to alter this outlook. Indeed, while the recent forecasts suggest that adding a new benefit to Medicare will not have burdensome fiscal consequences over the 10-year budget window, the longer-term budgetary implications of such a benefit addition will almost certainly be much greater.

Rapid expenditure growth and increasing importance in the Federal budget do not necessarily imply bad policy. There are many good reasons for the government to subsidize adequate health insurance for elderly and disabled Americans. These include most of the social-insurance justifications for Social Security as well as additional reasons related to the distinctive features of health care at older ages, such as the increasingly predictable differences in the risk of incurring significant medical expenditures. The high level of uninsurance and underinsurance for prescription-drug coverage among the elderly today, despite the rising value and increasing cost of prescription drugs for a range of illnesses, illustrates what can happen in the absence of significant federal intervention to support health insurance markets.

Yet as Medicare becomes an increasingly major component of Federal spending, it is increasingly important to know whether such spending is worthwhile. The fact that trends in Medicare utilization can swing as wildly as they have in the 1990s indicates not only that relatively obscure Medicare policy decisions can have enormous fiscal impacts—imagine the public debate that would surround benefit reforms in Social Security that reduced 10-year expenditures by over \$600 billion! It also indicates that we do not have a very clear idea about which utilization patterns involve worthwhile medical services, let alone which policies will help achieve these patterns. Medicare budgeting could be more effective, if not more predictable, if it were coupled with equally careful evaluations of the quality and value of Medicare services, and with program reforms to encourage more efficient purchasing and the provision of better information on quality of care. Even if it is not politically feasible to reform the program now to in ways that would improve its budgetary outlook, current reforms could take steps toward improving our confidence that we will be getting our money's worth in the years ahead.

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