

An Introduction to the Medicare Financing Problem

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MEDICARE SERVES ELDERLY AND DISABLED individuals through two separate programs—Hospital Insurance (HI), which pays for inpatient hospital care, stays in skilled nursing facilities, and home health services, and Supplementary Medical Insurance (SMI), which pays for all other services covered by Medicare, principally physician and hospital outpatient services. The programs are financed through separate trust funds, with distinct sources of revenues.

Revenues for HI come for the most part from a portion of the Social Security payroll tax. Employers and employees covered by the program each contribute 1.3 percent of earnings up to a maximum level (in 1984, the first \$37,800 of earnings), with the rate scheduled to increase to 1.35 percent in 1985 and 1.45 percent in 1986. Under current law, general revenues cannot be used to make up any shortfall between outlays required to pay benefits and the balance in the trust fund.

In contrast, SMI revenues are obtained from premiums and general revenues. The premium amount (in 1984, \$14.60 per month) increases by law each year, with a contribution from general revenues making up the difference between premium income and outlays. In fiscal year

1983, general revenues required to meet this difference totaled about \$14 billion, or 77 percent of SMI funding.

The Medicare program faces serious financing problems for the foreseeable future. Under current policies, the HI trust fund will be depleted around the end of the decade, while required contributions from general revenues to support physician benefits will continue to grow at a rate that far exceeds the growth in general revenues. The basic problem is that spending on medical care is growing more rapidly than national income, with demographic trends explaining only a small part of the difference.

This introductory paper will assess the magnitude of the Medicare financing problem and discuss its sources. The range of options for dealing with the problem will then be sketched out. The papers that follow will explore the potential of some of the specific options in more detail.

The Problem

Projections over periods as long as ten or fifteen years are very imprecise. Nevertheless, the differences between growth in outlays and growth in revenues for both parts of Medicare are so large that errors in forecasting are relevant only to dates and amounts—not to the conclusion that the program will face severe financing problems under current policies.

The root of the financing problems in both trust funds is the wide gap between the projected rates of growth of payments to medical care providers and revenues from payroll taxes and premiums. The projected growth in outlays is attributable primarily to rising medical care costs, and to a lesser extent to the aging of the population. A large part of the increase in costs is attributable to expansion in the volume of services provided. Volume of services as used here refers both to intensity of care—that is, changes over time in treatment practices for specific medical problems—and to the number of courses of treatment provided to patients. For example, victims of heart attacks now receive a more complex range of services than in the past, including additional tests and monitoring activities, which increase the costs of treatment. Moreover, some procedures, such as hip replacement operations, have increased in frequency as their safety and effectiveness

have improved. Since Medicare is committed to financing medical care similar to that used by the bulk of the population for its beneficiaries, changes in the norms of medical care practice automatically are reflected in Medicare outlays.

The HI Problem

Under present policies, depletion of the HI trust fund is projected around the end of the decade, most likely in 1990 (see table 1). The year-end balances are projected to decline after 1987, as annual outlays exceed annual income by increasing amounts. By 1995 the annual deficit would be over \$60 billion, or more than one-third of the projected outlays for that year, and the negative trust fund balance would total more than \$250 billion.¹ These projections all assume continuation of present policies, and hence may be used as a baseline from which to measure the effects of alternative policies.

Two items cause an unusual degree of uncertainty in these projections. One is interfund borrowing. The Old Age and Survivors Insurance trust fund (OASI) has borrowed \$12.4 billion from HI. The projections here assume no further interfund borrowing, and repayment of this loan by 1987. If the loan were not repaid by 1989, depletion of HI would occur in that year instead of in 1990.

The second cause of uncertainty is the extensive discretion given to the secretary of Health and Human Services (HHS) to set payment rates to hospitals after 1985. At that point, hospital reimbursements are projected to be 9 percent lower than they would have been under the previous cost-reimbursement system. The projections here assume that the secretary will maintain the 9 percent reduction but not make further cuts. This level of stringency implies a rate of growth in payments per admission of approximately 3.5 percentage points more than the rate of increase of hospital input prices.

If the secretary decided to cut reimbursements further—for example, if payments per admission were increased by only one percentage point more than the rate of increase of hospital input prices—the projected depletion date would be later, in this case, 1992 (see table 2). The

¹By the time this article is published, these estimates are likely to have been revised. Those interested in the latest numbers should check with the Congressional Budget Office.

TABLE 1
 Baseline Projections of Hospital Insurance Trust Fund Outlays, Income,
 and Balances (by calendar year, in billions of dollars)

	Outlays	Income ^a	Annual surplus (excluding any negative interest)	Year-end balance
1981	30.7	35.7	5.0	18.8
1982	36.1	25.6	- 10.6	8.2
1983	40.6	43.8	3.1	11.3
1984	46.5	46.3	- 0.2	11.1
1985	51.2	53.4	2.2	13.3
1986	57.3	66.4	9.1	22.4
1987	64.5	66.7	2.2	24.6
1988	72.5	66.8	- 5.7	18.9
1989	81.5	70.7	- 10.8	8.1
1990	91.7	74.5	- 17.2	- 9.1
1991	103.1	77.9	- 23.8	- 34.3
1992	115.8	81.1	- 31.1	- 69.0
1993	130.1	83.9	- 39.7	- 115.1
1994	146.2	86.3	- 49.5	- 175.1
1995	164.5	87.7	- 60.9	- 251.8

Source: Congressional Budget Office estimates based on February 1983 budget and economic assumptions, but updated to reflect the Social Security amendments of 1983 (P.L. 98-21).

^a Income to the trust funds is budget authority. It includes payroll tax receipts, interest on balances, and certain general fund transfers. In years when balances are negative, income includes negative interest, which is the amount that would be paid by the trust fund on hypothetical borrowing required to continue benefit payments. Income in 1982 reflects \$12.4 billion in interfund transfers from the HI trust fund to the OASI trust fund. Income in 1984, 1985, 1986, and 1987 includes repayments of this loan according to a schedule projected by the Social Security Administration. The estimates assume that the interfund transfer will be repaid in full by 1987.

projected deficits would still grow larger each year, even under this further restricted growth in outlays. By 1995 the annual deficit would be about \$30 billion and the negative balance over \$90 billion. The longer the projection period, the more important is the assumption concerning the rates set by the HHS secretary. The more stringent assumption described in the text implies a 27 percent reduction from the cost-reimbursement baseline in 1995. Many would dispute the categorization of such a reduction as a continuation of current policies.

TABLE 2
 Projections of Hospital Insurance Trust Fund Outlays, Income, and
 Balances under Assumption of More Stringent DRG Rates after
 1985^a (by calendar year, in billions of dollars)

	Outlays	Income ^b	Annual surplus (excluding any negative interest)	Year-end balance
1986	57.3	66.4	9.1	22.4
1987	62.1	66.9	4.8	27.2
1988	68.3	67.1	-1.2	26.0
1989	75.1	71.5	-3.6	22.4
1990	82.6	75.9	-6.8	15.7
1991	90.9	80.1	-10.7	4.9
1992	99.9	84.6	-15.2	-10.4
1993	109.8	89.1	-19.4	-31.2
1994	120.8	93.6	-24.1	-58.4
1995	133.0	98.0	-29.5	-93.4

Source: Congressional Budget Office estimates based on February 1983 assumptions, but updated to reflect the Social Security amendments of 1983 (P.L. 98-21).

^a Assumes diagnosis-related group (DRG) rates are increased one percentage point per year faster than the increase in the hospital market basket.

^b Income to the trust funds is budget authority. It includes payroll tax receipts, interest on balances, and certain general fund transfers. In years when balances are negative, income includes negative interest, which is the amount that would be paid by the trust fund on hypothetical borrowing required to continue benefit payments. Income in 1982 reflects \$12.4 billion in interfund transfers from the HI trust fund to the OASI trust fund. Income in 1984, 1985, 1986, and 1987 includes repayments of this loan according to a schedule projected by the Social Security Administration. The estimates assume that the interfund transfer will be repaid in full by 1987.

Projections for the subperiod beginning in 1985, at which point most of the recent legislative changes will have been implemented, indicate in more detail the nature of the problem. Over the 1985 to 1995 period, outlays are projected to grow at a 12.4 percent annual rate, while revenues are projected to increase at a 7.9 percent rate.

This 12.4 percent annual growth in Medicare outlays reflects the influences of general inflation, growth in the eligible population and its aging, and changes in the nature of hospital care. General inflation accounts for a significant portion of the increase in hospital costs, but does not itself contribute to the financing problem since it is also reflected in growth in revenues. Over the 1985 to 1995 period, the gross national product (GNP) deflator is projected to increase at a

3.8 percent annual rate. The “market basket,” which is an index of prices paid by hospitals for labor, supplies, and capital goods, is projected to increase somewhat faster, at an annual rate of 5.7 percent.

Changes in the age composition of the population are projected to account for 2.2 percentage points of the growth in HI outlays. Of this, 1.9 percentage points capture growth in the number of enrollees, while 0.25 percentage points reflect outlay implications of the expected aging of that population. While HI claims increase with age, the aging of the Medicare population is not rapid enough to be a major contributor to outlay growth during this period.

The remaining cause of growth of outlays—changes in the nature of medical care that affect the elderly—is the most difficult to project, partly because it, in itself, is influenced by the nature of the reimbursement system. Extrapolating from Medicare’s experience under cost-reimbursement, and removing the effects of the aging of the Medicare population that were discussed above, real outlays per enrollee are projected to grow at slightly more than 4 percent per year after 1985. This includes both the impact of a higher admissions rate per Medicare enrollee and more resources applied per hospital stay.

The projection of the revenue growth rate for covered earnings reflects a forecast of the near-term performance of the economy and assumptions of moderate growth thereafter. The estimates for 1983 and 1984 were developed using the Congressional Budget Office (CBO) economic forecast published in February 1983 (updated to reflect the economy’s performance to date), which reflects the current cyclical upswing; those for later years assume moderate noncyclical growth with gradually declining inflation. Whether the projected growth path is attainable with tax and spending policies now in place is, however, uncertain. If the economy’s performance is worse than projected, HI balances will decline more quickly.

The SMI Problem

Problems raised by the rapid growth expected in SMI are closely related to concern over the size of the federal budget deficit. Since, by law, appropriations from general revenues to SMI must be sufficient to guarantee solvency of the trust fund, SMI does not face a financing crisis per se. Rather, concern arises over this part of Medicare because the projected growth of SMI is so much higher than the growth of

general revenues—that is, federal tax revenues not earmarked for specific purposes—from which it draws support.

Like HI, outlays under SMI are projected to increase rapidly, by almost 16 percent per year through 1988. To finance this increase, general revenue contributions will have to rise even faster—averaging about 17 percent per year. (The difference occurs because SMI premiums are scheduled to grow at a slower rate after 1985 when, under current law, their growth will again be limited by the rate of growth in the Social Security cost-of-living increase.) Consequently, the share of general revenues necessary to finance the SMI trust fund will rise from 3.7 percent to 5.7 percent between 1982 and 1988. If the share of general revenues contributed to the SMI trust fund were not allowed to rise, outlays would have to be reduced or premiums increased by almost \$27 billion over the 1984 to 1988 period, an amount representing about 19 percent of all SMI expenditures for the period.

Projections of SMI growth beyond 1988 are difficult, but two possible scenarios are outlined to indicate the demands that SMI could place on federal revenues. If both revenues and SMI outlays were to continue growing at the same annual rates now projected through 1988, SMI would require a transfer of more than 11 percent of general revenues not earmarked for other use in 1995. Alternatively, even if the growth of SMI outlays decelerated to an annual rate of 12 percent and general revenues rose by 8 percent annually, the share of such revenues necessary to fund SMI would still rise to over 7 percent in 1995.

Projections of the expected growth in SMI expenditures are based on past experience that indicates growth to be a product of an increase in the number of persons covered by Medicare, higher prices for services rendered, and rising use of services per beneficiary—both in number of services used and in their composition. For example, between 1978 and 1982, total SMI benefits grew at an annual average rate of 21 percent. About one-tenth of this growth was attributable to expansion in the enrolled population, and the remainder to a combination of increases in prices and in the use of services.

Although it is difficult to separate the price and volume factors, changes in the latter are particularly important in SMI, accounting for almost half of total per capita growth in outlays. For example, total per capita physicians' services—which constitute over 72 percent of SMI benefits—grew at an annual rate of 18 percent. Over the 1978

to 1982 period, the physician services component of the Consumer Price Index grew at an average annual rate of just over 10 percent. This figure is likely to be an overstatement of increases in prices paid by Medicare, however, for two reasons. First, some of the increase reflects changes in the nature of physician services over time rather than pure price increases. Second, Medicare uses an economic index that is intended to restrict the growth of the prevailing charge to the same rate as increases in operating expenses of physicians and in general earnings levels. Thus, the rate is more likely to have been about 9 percent on average. The residual—representing just over an 8 percent annual growth rate—can be attributed to increases in the number of services and to a changing mix of services, which includes a shift toward specialists.

Options for Solving the Financing Problem

Given the magnitude of the problem facing Medicare in the next decade, incremental approaches are unlikely to provide solutions. Moreover, simultaneous pursuit of disparate incremental options might create inconsistencies and conflicts that would ultimately limit any reduction in Medicare outlays.

Given the likelihood of major changes facing Medicare, the House Committee on Ways and Means conceived the need for a conference to stimulate discussion of options more ambitious than those currently under consideration, and asked the Congressional Budget Office and the Congressional Research Service to organize it in conjunction with the committee staff. A call for papers was publicized, urging the potential authors to be bold in developing options and to advocate rather than present a balanced analysis. The authors were also urged to concentrate on one area of reform, rather than to develop a comprehensive plan. The sponsors selected authors on the basis of the quality of the proposals and a desire to get a broad range of options, each of which would contribute to the solution of Medicare's financing problem.

This introductory paper will not describe options in detail or evaluate them—which is the job of the papers that follow. Rather, it will provide an overview of the range of general approaches, an indication

of how they are supposed to work, and a discussion of their potential interrelationships. Since a likely strategy would be to combine several options rather than to focus on just one, it is important to consider which approaches are complementary and how they might be structured to be most effective.

As described above, the problems facing Medicare are essentially threefold: the number of beneficiaries is rising, the volume of services per beneficiary is increasing, and the unit costs of those services to the federal government are going up. Unless options for change address these underlying problems, Medicare likely will continue to face financial pressures.

Possible options for attacking Medicare's financial problems can generally be classified into four broad categories:

- Reduce the number of beneficiaries;
- Pay for fewer services;
- Pay less for each service; and
- Shift responsibility to beneficiaries or taxpayers.

Reduce the Number of Beneficiaries

Since its inception, Medicare has provided almost universal coverage for persons aged 65 and over (in 1972, coverage was extended to the disabled and to those suffering from end-stage renal disease). Outlays could be reduced by either raising the initial age of eligibility or by retrenching somewhat from the program's universality of coverage.

The major argument for raising the age of eligibility is that 65-year-olds are healthier today than at the inception of the program. On the other hand, older persons continue to retire earlier, so many might not be covered if the age of eligibility were increased. Moreover, for those continuing to work past age 65, Medicare already pays little, since recent legislation has made Medicare secondary to employer-provided coverage. This option might have to await changes in Social Security to raise the retirement age.

More controversial are options to exclude some groups of persons—for example, those with relatively high incomes—from eligibility. While such means testing would permit higher benefits or lower taxes for others, this would reflect a major philosophical shift for the program. Many of those who consider varying the level of premiums or the

degree of cost-sharing by income of the beneficiaries to be acceptable, balk at such a departure from universal eligibility (see, for example, the remarks of former Secretary of Health, Education, and Welfare Wilbur Cohen (U.S. House of Representatives. Committee on Ways and Means 1984, 336–40).

Pay for Fewer Services

One of the criticisms often leveled at Medicare has been its limited control over what medical care services are delivered. Payment schemes that reimburse on a fee-for-service basis provide few incentives to providers or beneficiaries either to limit the number of medical services or to use a lower cost mix of services.

The number of services paid for could be reduced either through direct controls or through incentives to beneficiaries and/or providers. Direct controls would involve decisions not to pay for services on the basis of lack of efficacy or lack of cost-effectiveness. Currently, rules on the coverage of procedures are made by Medicare or its intermediaries. For example, reimbursements may be restricted on the basis of location of treatment or applicability to the particular diagnosis. Further restrictions on coverage could be established by introducing costs into the criteria used or by limiting the use of difficult procedures to designated providers. Peer Review Organizations (PRO) can refuse payment for courses of treatment that depart from local medical norms, although the stringency with which these controls will be exercised remains to be seen.

Indirect incentives to control volume now in use by Medicare include cost-sharing, and, more recently, the new hospital prospective payment system based on diagnosis-related groups (DRGs). Medicare assesses cost-sharing on beneficiaries—particularly through SMI. While this may limit use of services, the degree of effective cost-sharing is relatively low due to the extensive use of supplemental insurance. About 70 percent of beneficiaries are covered either by Medicaid or by a private supplemental insurance policy.

The new DRG hospital payment system also gives hospitals the incentive to be more efficient in the treatment of each case, and will probably result in limiting the number of services associated with each hospital stay. On the other hand, it will also encourage additional admissions, and it does not improve incentives to provide only the

most efficacious forms of care. For example, the DRG system provides no economic incentive to discourage choice of a more expensive surgical course of treatment rather than an alternative regimen with lower costs classified into a different DRG. Thus, even this major change in hospital reimbursement does not fully address the problem of volume of services.

The essence of an approach emphasizing incentives for providers would involve changing the unit of service that is reimbursed. This approach could be pursued further, by incorporating physician services delivered in the hospital into the prospective payment, or by still further broadening the unit of payment to encompass all medical services required by a patient over a year. Under the latter, providers would economize on the number of hospital admissions as well as on the services ordered during each admission and on outpatient services. The health maintenance organization (HMO) is the best-known provider organization that contracts to provide medical care on a per person (capitation) basis, and it has demonstrated substantial reductions in volume compared with fee-for-service medicine. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) authorizes Medicare to pay HMOs on a per enrollee basis. A Medicare voucher system has the potential of expanding the use of capitation to control volume by giving beneficiaries access to other organizations willing to provide care under capitation payment. Stimulating the development of alternative delivery systems that serve non-Medicare patients would, in turn, make Medicare voucher options more attractive.

In contrast to incentives for providers, additional cost-sharing could reduce the volume of services by emphasizing incentives to the patient. Although little research exists on the effects of cost-sharing on Medicare beneficiaries, work available on the aged under-65 population indicates that use of services falls as cost-sharing rises. Since extensive private supplemental coverage is in place, however, increased cost-sharing would largely shift costs to beneficiaries and others paying the premiums for supplemental coverage (for example, former employers), rather than reduce the volume of services.

Whether by direct controls or incentives, reducing the volume of services would require careful consideration of the efficacy and value of individual medical procedures. While some services might be readily discarded under closer scrutiny, significant reductions in volume would probably require foregoing some services that are efficacious but whose

medical benefits are judged to be small in comparison with their cost (Schwartz 1983).

Pay Less for Each Service

Although reducing reimbursements for each unit of service provided can produce considerable short-run federal savings, such approaches do not directly address the underlying problems leading to higher Medicare costs. Indeed, lower reimbursements might aggravate problems with volume of services, thereby offsetting some federal savings. Cuts in physician reimbursement appear to have increased billings (Rice and McCall 1982), and some have speculated that reducing hospital DRG rates too much could result in more attempts by providers to exploit the loopholes in the system—for example, by admitting low-cost patients that otherwise would have been treated on an outpatient basis—than would otherwise be the case.

Restricted access to services by Medicare beneficiaries is another concern if the level of reimbursements is severely restricted. When providers are required to accept Medicare reimbursements as payment in full, as in hospital care, some providers may find the rates too low to continue to serve the Medicare population, or providers continuing to serve Medicare beneficiaries may be forced to offer a very different style of care. When assignment is voluntary, as in physician services—that is, when providers may seek amounts above Medicare's rates from beneficiaries—the providers may pass on part of a reduction in federal reimbursements to beneficiaries, or they may refuse to treat those patients who could not afford additional cost-sharing.

Coordinating reductions in reimbursements with other payers (mostly insurance companies) could alleviate some of these problems, however. Under all-payer systems, providers would be more prone to increase efficiency and resist wage increases than if only Medicare were reducing payment rates. Many fear that providers have opportunities to make up for a portion of Medicare reimbursement reductions by raising charges to private patients (and, thus, their insurers), a phenomenon labeled "cost-shifting." Indeed, providers' greater efforts at cost reduction under an all-payer system might open possibilities for additional reimbursement reduction by Medicare in the future. On the other hand, all-payer systems tend to be more administratively cumbersome because

it is important that rates that govern a hospital's entire revenue be "reasonable." Some feel that such regulation of payment reduces the potential for increased use of competition between providers to control the volume of medical services delivered.

Shift Responsibility to Beneficiaries or Taxpayers

Unless medical care costs can be readily brought into line by changes in reimbursement practices, it is likely that additional burdens must be borne by beneficiaries, taxpayers, or both. Medicare beneficiaries could pay a greater share through across-the-board increases in premiums, premium increases restricted to higher-income beneficiaries, or greater sharing of costs by the users of such care. Revenues for Medicare could be increased from the payroll and general tax sources that now are used to finance the system or by moving to a different revenue scheme.

Beneficiary Cost-Sharing. The tradeoffs among the major options for shifting costs to beneficiaries are relatively straightforward: across-the-board increases would spread the burden among the greatest number of individuals, while tying cost-sharing to use of services would have a somewhat greater impact on beneficiaries' incentives for use of care. The same reductions in outlays could be obtained from either approach.

Using higher premiums for SMI or introducing an HI premium would be similar to tax increases—raising revenues to fund Medicare outlays, without necessarily changing the structure or nature of the program—although the burden would fall on a different group of persons. If equal premium increases were deemed too harsh for low- or moderate-income elderly and disabled individuals, they could be differentiated according to income.

Cost-sharing tied to the use of services would both shift costs onto beneficiaries and affect the use of services by some—thereby reducing the volume of services. The existence of private supplemental insurance for Medicare means, however, that some beneficiaries are able to insulate themselves from the incentive effects of any additional cost-sharing. These individuals would still pay a higher share of total costs—through higher insurance premiums—but would not be encouraged to use fewer services. Moreover, if some protection against

catastrophic expenses is desirable for beneficiaries, there are a number of practical constraints on the implementation of additional cost-sharing, especially since SMI already has a high degree of it.

Vouchers, discussed above as a tool to allow greater use of capitation incentives to reduce the volume of services, if mandatory, might alternatively be viewed as a mechanism to shift burdens to beneficiaries. By setting the voucher amount at a low level, Medicare outlays could be reduced. Beneficiaries might find this less burdensome than cost-sharing because of the range of choice available, especially if innovative capitation or preferred provider plans were offered.

Revenue Increases. The deficit could also be reduced through increased revenues. Increased revenues could be obtained by raising the payroll tax rate, levying a new tax and dedicating the revenues to the trust fund, or transferring general revenues to the trust fund. A number of considerations would be relevant to this choice. One is who should pay the additional taxes. Should it be the working population, the beneficiary population, or the broader population of all consumers? Another issue is the importance of maintaining the trust fund approach. Some would prefer the trust fund approach because it focuses attention on serious problems, although the fund could be brought into balance even if spending remained at the level projected under current policies. Finally, the overall budget outlook is relevant. With such large deficits projected for the foreseeable future, approaches depending heavily on transfers of general revenues would probably have to consider specific proposals for increasing general revenues.

Interactions among Approaches

As has already been suggested, some of the options for changing Medicare would resolve the financing problem through at least two of the three broad mechanisms. Cost-sharing, for example, would both affect use of services and shift costs onto beneficiaries. Moreover, some of the specific approaches might be combined to reduce disadvantages that would occur if only one were adopted.

In general, if two options seek to change the same behavior, they cannot be expected to achieve combined savings equal to the sum of savings from each alone. For example, hospital coinsurance directed at shortening lengthy stays probably would not generate savings as great as before the introduction of the DRG system, which is itself

likely to discourage such behavior. On the other hand, since the DRG system may encourage additional stays in hospitals, new cost-sharing might be implemented through higher or multiple deductible amounts to reduce incentives for hospital admissions. In this second case, the two options would serve as complements rather than substitutes.

Another area where careful coordination is needed is in designing ways to cut reimbursements to providers, while improving incentives for limiting use of care. For example, paying physicians less for each service performed would create incentives for increasing the volume of services provided. Consequently, simple reimbursement restrictions might need to be combined with constraints on use.

Since it might be necessary to employ a number of changes to achieve a sufficient reduction in costs and/or increase in revenues, another goal of coordinating options might be to ensure that the burden of various changes is spread across many individuals, rather than being concentrated only on one group such as providers or beneficiaries. For example, if cost-sharing were to be increased, any increase in tax revenues might be restricted to payroll taxes so as not to affect beneficiaries further. On the other hand, current beneficiaries, who paid little in taxes for HI, will draw out large amounts of benefits and it might be reasonable to ask greater sacrifices from this beneficiary group.

Conclusion

The Medicare financing problem is a manifestation of a broader societal problem—the vastly different growth rates between health care spending and incomes available to pay for it. While the present HI “crisis” exists because outlays in the program are currently supported only by payroll taxes, the projected high growth rates in Medicare outlays would be of concern even if other means of financing were used. While changing technology continually yields opportunities for additional medical services that may improve medical outcomes, such technology is often very costly. Moreover, current financing arrangements give only limited encouragement for weighing benefits of services against their costs. Changes in financing that would improve incentives on the use of services are likely to be an important part of solving the Medicare financing problem in particular and society’s problem in

general. Solutions to Medicare's problems are not, however, likely to result from a single change, but rather will require a combination of approaches, making it particularly important to keep in mind issues of coordination and interaction among the options to be considered at this conference.

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