REPORT OF THE TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE TRUST FUND

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

May 2, 1995

Serial 104–53

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

26–820 CC WASHINGTON : 1996

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-053720-7

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CONTENTS

	Page
Advisory of April 18, 1995, announcing the hearing	2

WITNESSES

U.S. Department of Health and Human Services, Donna E. Shalala, Secretary	7
Congressional Budget Office, June E. O'Neill, Director	53
Ernst & Young, Roland E. "Guy" King	87
Federal Hospital Insurance Trust Fund:	
Standard G. Ross	76
David M. Walker	78

REPORT OF THE TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE TRUST FUND

TUESDAY, MAY 2, 1995

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The Committee met, pursuant to call, at 10:08 a.m., in room 1100, Longworth House Office Building, Hon. Bill Archer (Chairman of the Committee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
April 18, 1995
No. FC-6

CONTACT: (202) 225-1721

ARCHER ANNOUNCES HEARING ON MEDICARE HOSPITAL INSURANCE TRUST FUND

-Report Shows Trust Fund Will Start Going Broke In 1996-

Congressman Bill Archer (R-TX), Chairman of the Committee on Ways and Means, today announced that the Committee will hold hearings to review the Report of the Trustees of the Federal Hospital Insurance Trust Fund and the recommendations of the Trustees. **The hearing will take place on Tuesday, May 2, 1995, in the main committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.**

The Committee will receive testimony from Federal Hospital Insurance Trust Fund Trustees and expert witnesses.

BACKGROUND:

The payroll taxes paid by working Americans and employers into the Federal Hospital Trust Fund (HI Trust Fund) pay for about sixty percent of the medical care for Medicare beneficiaries. The Hospital Insurance program (Medicare Part A) is obligated to cover the costs of inpatient hospital care and other related services for those Americans who are entitled to insurance coverage under Medicare Part A.

The 1995 report of the Trustees of the HI Trust Fund indicates that the fund is in financial imbalance for both its short and long range projections. Beginning in 1996, the HI Trust Fund will for the first time, spend more in outlays than it receives in income. According to the Trustees report, if payroll taxes alone were raised to ensure fund balance into the future, those taxes would have to be nearly tripled from current levels.

Currently, payroll taxes from about four workers cover the Medicare Part A costs on average for each beneficiary. This ratio worsens over time, and drops precipitously when the baby boomers become eligible for Medicare after the year 2010. It is noteworthy, however, that the financial imbalance in the HI Trust Fund occurs prior to the eligibility of baby boomers. As the Trustees report states: "Not only are the anticipated reserves and finances of the HI program inadequate to offset the demographic change, but under all of the sets of assumptions the HI Trust Fund is projected to become exhausted before the demographic shift has even begun to occur."

"The report on the HI Trust Fund is an early warning signal that cries out for immediate Congressional attention. Despite the fact that President Clinton ignored the precarious state of the Trust Fund in his budget, it is now time for him to join with the Congress and face this issue squarely. We need to work together to keep the promises of the past while meeting the needs of the current and future Medicare beneficiaries," Archer said.

FOCUS:

This hearing will review the Report of the Trustees of the Federal Hospital Insurance Trust Fund and the recommendations of the Trustees.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement, with their address and date of hearing noted, by the close of business, Tuesday, May 16, 1995, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Committee office, room 1102 Longworth House Office Building, at least two hours before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are now available over the Internet at GOPHER.HOUSE.GOV, under 'HOUSE COMMITTEE INFORMATION'.

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Chairman ARCHER. The Committee will come to order.

Will guests and staff please take their seats? The Committee will commence just as soon as everybody is seated and audible conversation ceases. Surely everyone can find a seat and not continue to walk around in the middle of the Committee room.

Today, the Ways and Means Committee conducts one of its most important hearings of the year because we will examine the financial condition of the Federal Hospital Insurance Trust Fund Medicare Part A. The report we will examine today is essentially a Clinton administration document.

Three trustees are Cabinet secretaries. Their very own report shows that the trust fund will begin to go broke next year and will be bankrupt by 2002. Their report provides a wake-up call that this Committee and the Congress must not ignore.

Madam Secretary, welcome again to the Committee and I hope the administration also will not ignore its own report. Thirty-seven million Americans depend upon the trust fund for hospital care and the other part A benefits covered under Medicare.

At the same time, working Americans are paying hard-earned dollars in payroll taxes to finance Medicare and they rightfully expect that Medicare will be there for them when they retire or become disabled. It is essential that we begin today a conversation with the American people about the condition of their Medicare and the dire necessity to work together to make it solvent.

Frankly, it will not be easy to bring Medicare finances in line. The trustees' report tells us that simply to ensure solvency for the next 25 years, Congress would have to immediately increase payroll taxes by 44 percent or reduce growth in expected spending by nearly one-half. For the trust fund to remain solvent through the retirement years for the baby boom generation, the trustees' report indicates taxes would have to be tripled; that is, if restraint in spending increases does not occur.

Raising taxes would only postpone the need to curb medical cost growth and would simply pour fuel on the fire of medical cost inflation. Besides, it is bad economics and plain wrong to raise taxes further on this generation of working Americans.

It is our responsibility to begin the task of tempering growth in Medicare costs to preserve the program for current and future beneficiaries. I know the American people expect us to meet this challenge in a bipartisan manner. Medicare solvency is neither a Republican issue nor a Democrat issue and I will work to seek solutions for the full participation of Democrats on the Committee and with the administration, along with our Republican Members.

We begin today a two-part process to save Medicare. The first part is a careful examination of the causes behind Medicare's looming insolvency. Only after we understand the problem can we begin to advance solutions, and that will be the second part of the process.

Madam Secretary, I am growing increasingly concerned about the administration's lack of an approach to saving Medicare. The administration's public pronouncements appear to say that since the American people rejected a big government solution to health care reform last year, the administration will refuse to talk about

the unique problems of Medicare this year. I hope I am wrong in my understanding of those pronouncements.

This morning, I call upon the administration to join us in saving Medicare. I hope the mistakes of last year will not be compounded by an even bigger mistake this year. Let's not hold America's seniors hostage to an administration-failed, big government health care program.

Today, at the start of the 1995 White House Conference on Aging, I hope the administration will advance proposals so we can seek a consensus with the elderly and all Americans on positive solutions. We are ready to work with you.

I will now yield to Mr. Gibbons for an opening statement.

Mr. GIBBONS. Thank you, Chairman Archer, and I will yield my time to Mr. Stark, former Chairman of the Health Subcommittee and now Ranking Member on the Health Subcommittee.

Mr. STARK. Thank you, Mr. Gibbons and Mr. Chairman. You know, the Republicans holding this hearing to save Medicare reminds me of the man who murdered his parents and begged for mercy as an orphan. The hearing really is a blatant attempt to distract the public from a Republican tax bill that takes $87 billion out of the Medicare Part A Trust Fund over the next 10 years and gives it to the rich. Republicans are crying crocodile tears about the trust fund being in danger. Talk about wake-up calls. I would say, "hello, Earth to the Committee." The Republican hypocrisy is showing.

I urge the Committee Republicans to reread their minority views on H.R. 3600, last year's health reform bill. In that bill, Democrats saved the Medicare Trust Fund by getting all health spending under control. The billions we saved in Medicare helped the uninsured, expanded Medicare benefits, and provided a prescription drug benefit for everyone. Democrats used Medicare savings to improve the entire health care system.

Where were the Republicans? Every one of you on this Committee voted against any and all Medicare savings. In your dissent 10 months ago, Mr. Chairman, you said reimbursement levels had reached potentially disastrous levels and additional massive cuts in reimbursement to providers will reduce the quality of care for the Nation's elderly.

Now the radical right wants to cut three or four times more than we did. How can they now say it will not hurt quality? I'm sorry, folks, but massive cuts in Medicare without expanding coverage, will shift cost onto younger workers and destroy the quality of medical care.

Speaker Newt talks about reforming the system with more managed care and vouchers. I must say, I resent the Republicans suggesting that my mother and the Nation's seniors are either senile or so stupid they cannot see through that double-talk. Mother knows that managed care costs more and it means less choice of doctors and hospitals. She also knows that the vouchers being suggested by Republicans to buy private insurance will not ever be worth enough to pay for reasonable health care.

The Republican plan to push American seniors into plans with less choice saying it would give them more choice is a dog who just will not hunt. Republicans intend to disrupt people's health plans

and push them into managed care, and they know it will save little or nothing. Last week, the CBO, Congressional Budget Office, told the Committee that under the current laws, quote, "it is believed that Medicare spends more for managed care enrollees than it would have spent on them had they remained in the fee-for-service sector, about 5.7 percent more."

Until we know more about how to pay for seniors in managed care, you are just whistling in the dark and playing fast and loose with the sacred trust of Medicare. We Democrats have always worked with responsible Republicans to improve Medicare and reform the entire health care system. But $300 billion in cuts for the sake of tax cuts for the rich not only destroys Medicare, but harms the entire system.

We are about to hear from Secretary Shalala. I expect, she will ask to work with all of us to reform the U.S. health care system. We must not only preserve Medicare, but we must provide coverage to 42 million Americans who are today without coverage. Nobody is thinking about them on the Republican side of the aisle.

You proved your political dominance over the House in the past 4 months. Why not show us you stand for something besides insurance company profits and tax cuts for the very rich? You are in complete control of this Committee and you will be judged by your ability to legislate fairly for all Americans.

Thank you, Mr. Chairman.

[The opening statement of Mr. Christensen follows:]

OPENING STATEMENT OF HON. JON CHRISTENSEN

Medicare is going broke. It is on a crash course with reality and we've got to turn it around. We must have the courage to transform it.

It is a little-reported fact that Medicare's roaring growth has left a 1960s program on the verge of disaster in the 1990s. Medicare grew by almost 11 percent last year, more than twice as fast as private-sector health care spending. That gap alone is proof that something is dreadfully wrong with the program.

That is not the worst news. According to the Trustees of the Medicare Program, including three Clinton cabinet secretaries, the Medicare Program will spend more than it takes in next year—and by 2002 the Federal Hospital Insurance Trust Fund established to secure Medicare's future will be bankrupt. Worse still, by law, no disbursements may be made for Medicare if that fund is emptied. President Clinton's own officers admit that Medicare is going bankrupt—and will cease to exist when it collapses. To make sure our nation's seniors have access to adequate health care, we simply must save Medicare.

How much do we have to cut? Not a dime. The way to save Medicare is to allow the program to continue to grow, just at a slower rate. After we reform it, Medicare will still be growing faster than any other program in the Federal Government. Many groups, including tax-and-spend liberals seeking to relive the school lunch debate and score political points, will argue that Medicare is being "cut." Only in Washington can letting a program growing faster than any other government program be called a cut.

The Clinton administration's lack of any plan to salvage the broken program is unacceptable to our seniors. In his disastrous attempted government take-over of the Nation's health care system, Bill Clinton called for $118 billion in changes to Medicare, knowing that the program was headed for fiscal disaster. However, since his proposal was rejected the president has been silent on how to save Medicare. His marathon State of the Union Address did not even mention the Medicare crisis. His budget also ignores the problem altogether. Seeing the program was about to crash, he has taken his hands off the controls, forcing Republicans to take the leadership role once more.

I care deeply about our seniors, and so I will fight to defend Medicare. We need to work together in a bipartisan fashion to transform Medicare from an inefficient,

waste-ridden program to a secure, strong program for today's seniors and those of tomorrow.

Chairman ARCHER. Madam Secretary, welcome again to the Committee. We will be pleased to receive your presentation. Should you wish to restrict it in your oral comments, your entire printed statement will be entered into the record.

You may proceed.

STATEMENT OF DONNA E. SHALALA, SECRETARY, HEALTH AND HUMAN SERVICES

Secretary SHALALA. Thank you, Chairman Archer.

Let me say, Mr. Chairman, Members of the Committee, I will put my complete statement in the record with your permission and read a much briefer statement.

Thank you for the opportunity to testify this morning on the HI, Hospital Insurance, Trust Fund. I would like to begin by quoting the words of Franklin Delano Roosevelt who gave voice and vision to America's desire to provide income and health security to older Americans. Roosevelt said, "We always hope there is a better life, a better world beyond the horizon." It is reaching that horizon and protecting our older Americans that brings us here today.

As you know, my fellow Medicare trustees and I recently reported that the HI Trust Fund will be depleted in 2002. The Clinton administration believes that this is a major problem that deserves serious bipartisan attention. Let me begin by describing the HI Trust Fund and the services it supports for older Americans.

The HI Trust Fund primarily pays for inpatient hospital care. It also covers expenditures for home health services, for skilled nursing care, and for hospice care. In 1994, it paid for $104.5 billion in services for 32 million aged and 4 million disabled beneficiaries. The trust fund is financed primarily by payroll taxes.

Employees contribute 1.5 percent and there is a matching contribution by employers. However, in the years to come, trust fund expenditures are projected to rise more rapidly than trust fund revenues. This is because of a current and anticipated future increase in the number and complexity of medical services. Driving the expected imbalance between expenditures and revenues is the demographic shift that will occur with the aging of the baby boom generation. As that shift occurs, a larger percentage of our population will be eligible for Medicare and a correspondingly smaller percentage will pay the taxes that support the trust fund.

What does all of this mean? The 1995 HI trustees' report projects roughly another 7 years of solvency; the fund is exhausted in 2002. These are well understood trends. Over the past 15 years, the trustees have projected the date of insolvency to be anywhere from 1987 to 2005, and each year they recommended that Congress take action to protect the fund.

When the President took office on January 20, 1993, he inherited an escalating deficit and a Medicare Trust Fund that was projected to be insolvent in 1999. Twenty-seven days later, he proposed and then helped to pass a historic deficit reduction plan, the Omnibus Budget Reconciliation Act of 1993.

That included several strong policies to strengthen the economy and the trust fund. Indeed, these proposals pushed out the insol-

vency date by three full years. Unfortunately, the only proposal in the Contract With America that specifically addresses the Medicare Trust Fund would weaken it and undo some of the progress made in OBRA 1993. It is ironic that those who are suddenly interested in the plight of the Medicare Trust Fund have advocated policies that exacerbated the insolvency of the fund.

The fact is, any significant changes in Medicare, whether in the financing eligibility, in the benefit provisions or in payment rates, will affect the entire health care system. Therefore, this administration believes that strong action to avoid depletion of the HI Trust Fund should not be undertaken by looking at Medicare alone. Instead, we must consider the issue of the larger context of health reform as the trustees recommend.

We need an approach to protecting Medicare that is both bold and balanced. The President has repeatedly called for a meaningful bipartisan action on health reform, but so far, the reply from the Republicans has been only silence. Let there be no mistake. Solutions focused solely on Medicare could cause great harm. Let me give you a few examples.

Reductions in payments to health professionals would have significant effects on their overall financial condition. This is particularly true for care givers whose patients are predominantly Medicare beneficiaries or uninsured persons, whether located in inner cities or in rural America. In fact, large reductions in Medicare payments would have a devastating effect on urban public hospitals that already are providing a disproportionate share of uncompensated care.

In the 1994 special report of the National Association of Public Hospitals, it was reported that in 1991, Medicare accounted for a bigger share of net operating revenues than private payers for these hospitals. The Association further reported that while Medicare was the payer for only 11 percent of discharges in these institutions, it accounted for almost 20 percent of the net operating revenues.

Large reductions in Medicare payments should—could also endanger rural hospitals. Nearly 10 million Medicare beneficiaries, 25 percent of the total, live in rural America where there is often only a single hospital in their county. These rural hospitals tend to be small and serve primarily Medicare patients. Significant reductions in Medicare revenues will cause many of these hospitals, which already are in financial distress, to close or to turn to local taxpayers to increase what are often substantial local subsidies.

Rural residents are more likely than urban residents to be uninsured, so the practice of offsetting the effects of Medicare cuts by shifting costs to private payers is much more difficult for small rural hospitals. Moreover, rural hospitals are often the largest employer in their communities. Closing them will result in job loss and physicians leaving these communities.

Other providers may shift their costs on to payers who do not have the market power to negotiate advantageous rates. This means that ultimately many small businesses and individuals, those Americans who are already paying the highest health insurance premiums, will shoulder even larger shares of health care costs. Large cuts in Medicare could also hurt beneficiaries. About

75 percent of homes have incomes below $25,000. Let me repeat that. About 75 percent of Medicare beneficiaries have incomes below $25,000.

For the typical Medicare beneficiary, out-of-pocket health costs represent 21 percent of income. Increasing out-of-pocket costs would be the equivalent of reducing their Social Security. Attempts to restore the solvency of the trust fund cannot undermine our commitment to providing health security for older Americans right now and in the future.

The administration takes seriously its responsibility to current and future Medicare beneficiaries to insure the solvency of the trust fund. The Health Care Financing Administration continues to make many program changes to improve the efficiency of the Medicare system. As a result, on a per enrollee basis, Medicare grew at a slower rate than the private sector between 1994 and 1991; 7.7 percent compared to the private sector's 9.8 percent.

As we address these issues, we must remember that Medicare does not stand alone. It is an integral part of a larger health care system, a public/private health care system, as well as the Federal budget.

For this reason, if the Republicans are truly serious about strengthening the Medicare Trust Fund, they must first pass a budget resolution that specifies how they plan to balance the budget and pay for their proposed tax cuts. They must decide whether they want to pursue the reported $300 billion in Medicare cuts over 7 years, the largest cut in Medicare in American history to pay for a 7 year, $345 billion tax cut that goes predominantly to the well to do Americans, and they must acknowledge that the only way to resolve the problem surrounding Medicare is within the context of health care reform.

The administration looks forward to working with the Congress to develop lasting solutions to Medicare's fiscal problems, to reaching for a horizon in which all Americans enjoy long term health security.

Thank you and I would be happy to answer any questions you may have.

[The prepared statement follows:]

STATEMENT OF DONNA E. SHALALA
SECRETARY OF HEALTH AND HUMAN SERVICES

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

Thank you for the opportunity to testify before you on the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds.

As you know, my fellow Medicare trustees and I recently reported that the HI trust fund will be depleted in 2002. While the HI trust fund financial balance is a significant problem and deserves our serious attention, let me also remind you that (1) this is not a new problem and (2) the projected life of the trust fund has been extended for three years since 1993.

Due to the actions taken in the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) and a stronger-than-expected economy in 1994, Trust Fund depletion has been delayed from 1999 to 2002. Even with these improvements, however, the Trustees continue to foresee financial problems in the future for the HI Trust Fund.

As I noted, the Trustee's trends and projections have occurred before and are not surprising. In the course of the past 15 years, the Trustees have predicted near-term financial problems for the trust funds and recommended that Congress take action to slow the growth of Medicare spending to assure trust fund solvency. While we have worked with Congress to improve the outlook of the trust fund, broader issues of health care cost and access limit how much more we can accomplish through Medicare reductions in growth alone.

We are concerned solutions focused solely on Medicare would severely strain many of our fragile health care delivery systems in rural and inner-city communities and could result in cost shifting to small businesses and individuals. We must therefore consider this issue in the context of health reform.

Today, I will focus primarily on the solvency of the HI trust fund. Although the Trustees Report addresses cost growth in both the HI and the SMI trust funds, the issue of greatest concern is the HI trust fund's solvency. I look forward to working with Congress to strengthen the Medicare program in the context of broader reforms to assure that Medicare remains stable now and in the future.

Description and Background Information on the Trust Funds.

Let me begin by describing the HI trust fund and the services it supports for Medicare beneficiaries. The HI Trust Fund primarily pays for inpatient hospital care, but it also covers expenditures for home health services, skilled nursing care, and hospice care. In 1994, the HI Trust Fund paid for $104.5 billion in services for 32 million aged and 4 million disabled beneficiaries.

The HI Trust Fund is financed primarily by payroll taxes. Employees contribute 1.45 percent of wages, and there is a matching contribution by employers. Self-employed individuals contribute 2.9 percent of self employment income. OBRA 93 removed the ceiling on the amount of earnings that are taxable; consequently, this tax applies to all earnings. The Trust Fund also receives income from interest earnings on its assets, revenue from taxation of Social Security benefits, and from miscellaneous sources.

Trust Fund expenditures are projected to rise more rapidly than Trust Fund revenues. Anticipated increases in the number and complexity of medical services are expected to continue to increase expenditure growth rates. Driving the expected

imbalance between expenditures and revenues is the demographic shift that will occur with the aging of the baby boom generation. A larger percentage of our population will be eligible for Medicare, and a correspondingly smaller percentage will be paying the taxes that support the Trust Fund.

What does this mean? The 1995 HI Trustees Report projects roughly another 7 years of solvency. The fund is exhausted in 2002. Over the 75 year long-range projection period, the income as a percent of taxable payroll remains relatively level while the cost rate rises steadily.

These are well-understood trends; there is nothing new in this most recent Trustees Report. Over the past 15 years, the Trustees have projected the date of insolvency to be anywhere from 1987 to 2005, and each year they recommend that Congress take action to protect the fund. As I noted earlier, in part due to provisions in OBRA 93, Trust Fund depletion has been delayed to 2002.

OBRA 93 eliminated the maximum earnings cap for the HI program, so that the HI tax now applies to all earnings. It also achieved $55 billion in savings from the Medicare program, about $30 billion of which came from providers who are paid through the HI Trust Fund. In addition, OBRA 93 increased the maximum proportion of Old-Age, Survivors, and Disability Insurance (OASDI) benefits subject to Federal income taxes from 50 percent to 85 percent, for only those beneficiaries with the highest incomes. Revenues generated by this provision are dedicated solely to the HI Trust Fund. Unfortunately, as part of its Contract with America, the House has voted to repeal the change in the taxation of OASDI benefits. It is ironic that those who are suddenly interested in the plight of the Medicare trust fund have advocated policies that exacerbate the insolvency of the Medicare trust fund.

Effective Solutions Require Broader Health Care Reform

Any significant changes in the Medicare program, whether in the financing, eligibility, benefit provisions or payment rates, will effect the entire health care system. Therefore, this administration believes that strong action to avoid depletion of the Hospital Insurance Trust Fund should not be undertaken by looking at Medicare alone.

Reductions in payments to providers would have significant effects on providers' overall financial condition. This is especially true for providers whose patients are predominantly Medicare beneficiaries or providers who also treat uninsured persons, whether located in inner cities or rural areas.

- Large reductions in Medicare payments would have a devastating effect on a significant number of urban safety-net hospitals. These hospitals already are bearing a disproportionate share of the nation's growing burden of uncompensated care.

  - For large urban public hospitals, which are heavily used by Medicaid and self-pay patients, Medicare is an important source of adequate payment. According to the 1994 Special Report of the National Association of Public Hospitals, while Medicare in 1991 was the payer for only 11 percent of discharges in these institutions, it accounted for almost 20 percent of net operating revenues.

  - For these hospitals on average, in 1991 Medicare accounted for a bigger share of net operating revenues than private payers.

- Large reductions in Medicare payments could also endanger rural hospitals.

  - Nearly 10 million Medicare beneficiaries (25 percent of the total) live in rural America where there is often only a single hospital in their county. These rural hospitals tend to be small and to serve primarily Medicare patients.

  - Significant reductions in Medicare revenues will cause many of these hospitals, which already are in financial distress, to close or to turn to local taxpayers to increase what are often substantial local subsidies.

  - Rural residents are more likely than urban residents to be uninsured. As a result, offsetting the effects of Medicare cuts by shifting costs to private payers is more difficult for small rural hospitals.

  - Rural hospitals are often the largest employer in their communities; closing these hospitals will result in job loss and physicians leaving these communities.

Other providers may shift their costs onto payers who do not have the market power to negotiate advantageous rates. This means that ultimately many small businesses and individuals -- those Americans who are already paying the highest health insurance premiums in the nation -- will shoulder an even larger share of health care costs.

Large reductions in Medicare reimbursements to providers could also hurt beneficiaries. Significantly cutting payment rates to providers might restrict access for beneficiaries as providers would be less willing to provide services to them. Further, low income beneficiaries would be the hardest hit. According to AARP, out-of-pocket health costs represent 21 percent of income for those over 65 years. In addition, over 75 percent of Medicare beneficiaries have incomes below $25,000. Medicare reductions could increase the cost burden of the nation's most vulnerable elderly -- the low-income. Such increases become the equivalent of reducing their Social Security.

Attempts to restore the solvency of the trust fund cannot undermine Medicare's commitment to access to care for elderly persons. We should take care that any efforts to extend the solvency of the trust fund do not put Medicare beneficiaries at undue risk, but at the same time protect the program for them in the future.

Only through focusing on the entire health system will we be able to address issues within Medicare and preserve access for Medicare beneficiaries and underserved populations.

The Administration takes seriously its responsibility to current and future Medicare beneficiaries to insure the solvency of the trust fund. The Health Care Financing Administration (HCFA) continues to make many program changes to improve the efficiency of the Medicare system. For example, hospital prospective payment has contributed to slowing the increase in Medicare expenditures for hospital services. As a result, on a per enrollee basis, Medicare grew at a slower rate than the private sector between 1984 and 1991 -- 7.7 percent compared to the private sector's 9.8 percent.

As we address these issues, we must remember that Medicare does not stand alone. It is an integral part of a larger health care system, and its solvency should be addressed only in the context of that larger system. Broader health care reform will occur only if we work on a bipartisan basis. The Administration looks forward to working with the Congress to develop lasting solutions to Medicare's fiscal problems.

Chairman ARCHER. Thank you, Madam Secretary. And I must say, I am not surprised at your presentation. It has the tone of a very appealing political ring to it. We could go into a long debate about comprehensive health reform, which you mention is the answer to Medicare problems, but the American people turned thumbs down on your plan for the Federal Government to take over the entire health care system in this country in the last Congress.

I think it should be clear to you and to the President that, that is not going to occur again in this Congress. Therefore, we are confronted directly with the problems of the Medicare Trust Fund, which will begin to run short of money next year and according to your trustees' report, will go broke in 2002.

Isn't that your interpretation of your actuary's same conclusion to the trustees' 1995 report where he states, "although the assumptions used are reasonable, much of the available evidence suggests that they may not be optimal. In particular, the likelihood of a future result that is more adverse than the intermediate projection may exceed the likelihood of a more favorable result. Similarly, an outcome more adverse than the high cost projection may be more probable than one that is better than the low cost projection."

In other words, you are more likely to err on the losing side rather than on the gain side. The crisis we face could happen before 7 years are up, and that is very troubling to me. It tells me that we need to act soon to respond to this threat, to the insurance coverage retired Americans and the disabled now depend on, and workers paying payroll taxes rightfully expect that they will get the benefits when they retire. Clearly, we must assure the American people a solvent Medicare now.

What solvency test do you think the HI Trust Fund should meet in 10, 25, or 75 years, and what approach do you think we should take to insure solvency? Should taxes be raised or should spending growth be curbed?

Secretary SHALALA. Mr. Chairman, we have made it very clear that we believe that, number one, the problems of the Medicare Trust Fund cannot be solved by simply looking at the Medicare Trust Fund, because anything we do to the current Medicare Program has implications for the rest of the American health care system, because the public part is such an important part of that system.

Second, the President in his letter to the Speaker, has made it very clear that we believe that you ought to put a detailed budget on the table to tell us how you intend to keep your promise to balance the budget and to provide a large tax cut for the well-off and to explain to the American people that you are not slashing Medicare to pay for those tax cuts.

Obviously, we are prepared to sit down in a bipartisan manner, but only after we have seen the budget proposals of the current majority, and only in the context of larger health care reform because we do not believe that the Medicare problem can be solved by simply narrowly looking at Medicare.

Chairman ARCHER. You, in effect, are telling this Committee that you will have no proposal to solve the Medicare Trust Fund shortage, which will bankrupt the system by 2002 or earlier according

to your own actuary and your trustees' report, short of the Federal Government taking over the entire health care system of this country, which you know is not going to happen, and you are holding Medicare and the payment of Medicare bills hostage to a Federal takeover comprehensively of the entire health care system in this country.

That is what I hear you saying, Madam Secretary.

Secretary SHALALA. Mr. Chairman, I am saying exactly the opposite. I am saying that any sophisticated understanding of the American health care system recognizes that it is heavily a private system with a strong public participation, and that it is not possible to squeeze down on the public part of that system without spilling over into the private part, and therefore, we have to look at the entire system, not a takeover. The President made clear in his letter to the Congress in December, and he has said it repeatedly, that it is necessary for us to talk about a whole set of health care reforms, the first steps, incremental approaches, but that we cannot simply expect the Medicare beneficiaries and the providers to absorb radical cuts in the system without it having an effect on the private sector, and that must be part of the discussion.

Chairman ARCHER. Well, Madam Secretary, you and our colleague, Mr. Stark, continue to want to talk about the budget. We are here today to talk about saving the Medicare Part A Trust Fund and what it will take to do that. Now, that is what we are talking about. That is the focus of this Committee today, and you can obfuscate it with political sort of comments, but the reality is that we have got to do something about this. We are prepared to do it. We would like the President, as leader of this country, to give us a specific proposal that we can look at. We would like for Mr. Stark to give us a specific proposal that we can look at.

I am curious inasmuch as you think that the overall comprehensive dictated reform of the health care system by the Federal Government is the only way we can answer Medicare, whether or not you supported the Stark bill that was before this Committee and voted out by the Democrats last year.

Is it fair to say that the administration supported that bill?

Secretary SHALALA. The administration supported its own health care reform bill, and the point that I am making, if I might repeat it, is that it is not possible, as we learned last year and the year before, to squeeze down on the public system without it having enormous implications on the private system, and that independent recommendations to strengthen the Medicare Trust Fund can only have marginal impact.

This administration, since OBRA 1993, has actually extended the number of years to improve the solvency of the Medicare Trust Fund and our whole approach has been to protect and to improve the HI Trust Fund in a series of actions related to the deficit, investments in the trust fund, and our own strong innovative approaches to improve the quality of the Medicare Program. To reduce the baseline of the Medicare Program, and to see this independently of the private health care system would be wrong and dangerous in our judgment.

Chairman ARCHER. Yes, ma'am. You have repeated that now three times and I am sure we will hear it many, many more times

by members of the administration and by our Democrat colleagues up here, but the reality is that irrespective of what has happened in the past, we have a big problem today. Your trustees' report shows that.

It is probably bigger, based on the actuarial statement that I just read, than the trustees' report even admits. We have the responsibility to do something about that, not talk about what we did in the past or the budget, but to talk about Medicare, and I, for the life of me, do not understand how reducing payments to the medical profession in the area that is not under Medicare is going to help you save money under Medicare. If you reduce the income flow on this comprehensive program that you proposed last year, then you certainly are going to off-load more responsibilities if you are going to keep hospitals open and doctors functioning from the Medicare standpoint.

The reality is that the bill that was presented to our Committee and voted out of our Committee in the last Congress, which was primarily conceived by our colleague, Mr. Stark, was supported by your administration, people who sat right at that desk, and that bill took $490 billion in the next 5 years out of Medicare and Medicaid, $490 billion of cuts out of Medicare and Medicaid endorsed by your administration.

Clearly comprehensive reform, as you see it, is not going to remove the slashing of Medicare and Medicaid, as evidenced by the bill you endorsed.

We need to focus on the fact that the HI Part A Trust Fund is going to go broke by 2002 or earlier and do something about it to assure the senior citizens and working Americans that we have measured up to our responsibility.

I yield to the minority ranking member, Mr. Gibbons, for questions.

Mr. GIBBONS. Well, thank you, Mr. Chairman. First of all, let me say that if anybody can make any suggestions as to how to improve Medicare, its services and its cost, I am willing to listen. I do not get panicky about any trustees' report. I think I have heard every trustees' report brought before this Committee since 1965 and I was here on—in Congress in 1965 and I think I am the only Member here who voted for the program in 1965.

There has been a constant stream of people appearing on this Committee and before this Committee predicting that Medicare was going out of existence, never would work, and I just am not impressed by that. I know there is a profession of people that make a good living around Washington telling you that everything is going busted and going broke, but as I look at the Medicare Trust Fund, it is about as sound as it has ever been and I believe it will remain sound and I believe that any changes that must be made are minor changes. I just do not hit the panic button when we begin to talk about this.

I want to say that when I first came on the Committee, there were some changes we had to make in the Medicare Trust Fund. We simply did not change the overall rate of taxation for Medicare and Medicaid; we simply shifted some of the Medicare money into the Medicaid system and it made the system completely sound and it did not disrupt the Social Security system. All those options are

available today and I think if anybody has any proposals, I would be glad to listen to them and thoughtfully try to think them out.

Chairman Archer, as I recall, the health care reform program that we presented last year would have reduced Medicare expenditures over a 7-year period by the tune of $168 billion. That is a large amount of money, but not real large when you compare it to the overall size of the program.

I do not think we want to get Medicare and Medicaid mixed up in this discussion today. Medicaid, as everyone knows, is a low-income program, it is a charity program. Of course, if the health care proposal that we put forward last year had been enacted, we would have saved a lot of money in Medicaid because there would not have been any Medicaid Program left, just about. All of it would have been subsumed in the program we put forward last year. The figure that Democrats proposed to cut out of Medicare last year for the aged was the $168 billion, not $410 billion, as was said here.

Madam Secretary, I looked over your report and I notice you had a chart in the back of it tracing the solvency of the trust fund, and it seemed to me that the solvency of the trust fund and the length of the solvency of the trust fund to a certain extent tracked the U.S. economy. As unemployment goes up, the solvency of the trust fund tends to go down, and vice versa in this picture.

It also seems to me that the solvency of the trust fund tends to follow the projected line of what medical costs, particularly hospital costs, will be in the future. All of us know that the number of days of stay in a hospital paid by Medicaid—Medicare patients, and all patients today, is much less than it was just a few years ago. In fact, as I recall, the average daily residency in hospitals 15 years ago was about 1.3 million a day, and the average daily residency in hospitals today is down to about 750,000 people per day. There has been a substantial drop in the use of hospitals. There has not been the concomitant drop in hospital costs, unfortunately, despite the fact that residencies in hospitals are much shorter than they used to be, even for Medicare patients.

I say again, if anyone has got a proposal about how to improve this program and how to make it more secure, I am open, willing to listen. I do not think the program is in dire danger. I do not think the trustees' report is anything that I haven't heard on this Committee numerous times as trustees have come before us to testify about the condition of the Medicare Trust Fund. I am really mystified by all this scare talk, unless they are just trying to carve more money out of programs for old folks and give it away in tax breaks for people who I do not think particularly deserve it.

If anybody has got a suggestion, I am here to listen and thank you very much, Madam Secretary.

Chairman ARCHER. Mr. Crane.

Mr. CRANE. Thank you, Mr. Chairman.

Madam Secretary, last year you agreed that program expenditures should be slowed and you proposed to reduce the rate of growth by about $118 billion. Do you continue to support those proposals?

Secretary SHALALA. We do. I think the point I was making earlier is that the President believes, when we are talking about looking at the Medicare Program and our need to slow the growth of

the Medicare Program, that it ought to be part of an incremental health care reform discussion because of its implications on the private sector, and continuing the extenders was part of the current budget. We do think that there are things that we can do within the system, but we do not think that these big numbers that have been talked about and asking the Medicare recipients and the providers to take $300 billion in cuts is anything more than a very dangerous approach to this country's commitment to its elderly and disabled.

Mr. CRANE. Madam Secretary, you are talking about the President's proposal, and my question was about that $118 billion recommendation you made last year; Do you especially as a trustee, continue to support that proposition?

Secretary SHALALA. I'm sorry. You are referring to last year's health care reform budget. Let me simply say that we made those proposals within the context of health care reform. What the President has said is that any proposals to slow down the growth of Medicare, such as those that we recommended as part of his own health care reform proposal, ought to be discussed this year within the context of incremental health care reform, some steps that we can take to both slow down the growth, but simultaneously make sure that we have looked at issues like coverage and affordability and quality and choice. While I can't speak specifically to those recommendations, we certainly would consider them as part of a broader discussion of how to strengthen both the trust fund as well as make certain that we maintain a quality health care system, both in the private sector as well as the public sector in this country.

But again, the President this year has made very clear in his letter, we are talking about incremental reforms, taking steps toward what we hope will be a goal of every American having affordable health care available to them.

Mr. CRANE. Madam Secretary, since you as a trustee perhaps know better than anyone the compelling nature of the bankruptcy problem with the Medicare Trust Fund and the real effect of delayed action, can you, first of all, explain why you haven't sent us a plan to address this problem; and second, when might you be sending us a proposal to save the Medicare Program?

Secretary SHALALA. Mr. Crane, what we have said is—and what the chief of staff said very clearly in his letter, is that when your party puts a detailed budget on the table, when you tell us how you intend to keep your promise to balance the budget and to provide a large tax cut for the well-off, when you explain to all of us how you are not slashing Medicare to do that, we are anxious to sit down in a bipartisan way, as long as the context is real health care reform. the first steps toward health care reform, that we want to do it in that context because of the implications for the private sector health care system of making changes in the public health care system.

Mr. CRANE. Well, we have been waiting patiently for specific proposals to address the pending bankruptcy of that program, and we would hope and pray that you as one of the trustees might give us some guidelines since you have a specialized form of expertise. It hasn't been forthcoming to date and I think——

Secretary SHALALA. Congressman Crane, we have waited patiently, expecting on April 15, for the budget resolution to be passed. The President has committed himself to a bipartisan approach to health care reform in this country, to taking the first incremental steps. We expect the HI Trust Fund issue to be part of that discussion, and—but it has to be part of a broader discussion, because of our clear understanding, and this Congress', too, that if you do something on the public side of the system, it has implications for the health care infrastructure, for beneficiaries, for how much they actually get in their Social Security check, and it must be part of a larger discussion.

Mr. CRANE. Well, Madam Secretary, one final point, and this is a quote out of the Hospital Insurance Trustees' Report; "The fact that exhaustion would occur under a broad range of future economic conditions and is expected to occur in the relatively near future indicates the urgency of addressing the health insurance trust fund's financial imbalance." We are counting on input heavily from you and the other experts on the Hospital Insurance Trust Fund.

Thank you.

Secretary SHALALA. I appreciate that, Mr. Crane, and just let me repeat that when we inherited this government in 1990—the date of the trust fund bankruptcy was scheduled for 1991—1999, and everything we have done since then has added years on to protect the solvency of the trust fund. We are committed to that but it must be part of a larger discussion.

Chairman ARCHER. Mr. Thomas will inquire.

Mr. THOMAS. Thank you, Mr. Chairman. You have used the term incremental, Madam Secretary, twice now, in referring to health care reform, and that is real progress. The Ranking Member of the Health Subcommittee talked about our positions in the 103d Congress. The administration's position in the 103d Congress on their comprehensive health care plan basically had three problems with it; I think you will agree. A majority of Republicans were opposed to it. A majority of Democrats were opposed to it, and a majority of the American people were opposed to it.

We can now set aside the 103d Congress. I think we are all in agreement that the American people did not want a government takeover of their health care system and that we are committed to incremental reform.

When I look at the Board of Trustees of the Federal Hospital Insurance Trust Fund, I see six names. Four of them are members appointed by the President; in fact, three of them are secretaries of Cabinet positions. Four of the six trustees are Clinton's leadership team, similarly on the OASI, Old-Age and Survivors Insurance, same Board of Trustees.

In your initial statement, Madam Secretary, you indicated that there were demographic factors which were shaping the trust fund. Isn't it true that the same demographic factors are shaping the OASI Trust Fund, and if both are subject to the demographic factors, why is the insurance fund running out in 2002 and the Social Security Fund seems to be secure to 2030? Is there anything that was done in the Social Security Trust Fund structure that hasn't been done in the, HITF, Health Insurance Trust Fund, structure?

Secretary SHALALA. I am not sure that I shouldn't provide a more comprehensive answer for the record. When we are talking about——

Mr. THOMAS. If you will do that in writing. I have 5 minutes and I have several more questions, but I guess my question was pretty particular. Is there anything that was done in the OASI Trust Fund on demographic factors that hasn't been done in the HITF?

Secretary SHALALA. Let me simply say that the HITF and what we are paying for is the growth of health costs in this country. I made the point that private sector health costs per capita——

Mr. THOMAS. Madam Secretary, what age triggers the HI Trust Fund eligibility?

Secretary SHALALA. Oh, you mean you are talking about the difference between——

Mr. THOMAS. In the HI Trust Fund, when are you eligible to receive benefits from the trust fund?

Secretary SHALALA. At 65.

Mr. THOMAS. Sixty-five. In the OASI Trust Fund, through the year 2030, what is the eligibility?

Secretary SHALALA. We are—I believe, if I remember correctly, that it is a graduated age base, that Congress changed the dates.

Mr. THOMAS. What is the age by 2030 that people are eligible?

Secretary SHALALA. It is 67.

Mr. THOMAS. Sixty-seven. So, there is a different age eligibility in the Social Security Trust Fund as opposed to the Health Insurance Trust Fund. Would you, as a trustee of these trust funds, perhaps recommend that the Health Insurance Fund in the OASI fund be conformed in that regard?

Would that be a suggestion of the trustee?

Secretary SHALALA. It has not been a suggestion of the trustees and let me give you some concerns that we would have about that, and that is that——

Mr. THOMAS. So, that would not be something that you would support?

Secretary SHALALA [continuing]. What that may well do is add to the number of uninsured in this country. As you well know, the number of people, because of the reorganization of companies, that are being pushed out of the insurance market because of what is happening to their jobs is increasing among people 55 and older and we would have some concern that we would add to the number of people who are uninsured in this country.

Mr. THOMAS. Madam Secretary, on page four, you indicate that the trust fund actually increased at a slower rate than the private sector. Interestingly enough, the years you chose were 1984–91. Does this mean then that you have no figures available to you between the years 1992 and today, or was this merely an example of picking a timeframe in which you appeared pretty good? Do you have any 1992–94 figures?

Secretary SHALALA. I do not think we have—what has happened after that, if I remember the numbers correctly, what happens after that is the fundamental point that we are making that public health care per capita growth is not out of line with private health care per capita growth.

Mr. THOMAS. I think you will find if you had used, Madam Secretary, 1992–94 numbers, you would have found an accelerating reduction in the private sector and that, in fact, the public sector was significantly higher percentagewise. I believe you were trying to make your point. The problem is, you stopped in 1991.

Last question.

Secretary SHALALA. Let me, if I might respond to that, Mr. Thomas, let me point out that the longer the period of time, the more accurate the statistics are, and that no one that I know is projecting the down trend in private sector health costs as rapidly as it has been over the last couple of years. I think the general point of private and public sector per capita growth rates being about the same holds.

Mr. THOMAS. Just let me say, in conclusion, Mr. Chairman, that I would take your argument that you are not making partisan statements more seriously if you didn't carefully select years to make your points and have them, in fact, leave the 1992–95 period out. I think that weakens your argument that you are not making partisan statements frankly.

Chairman ARCHER. Mr. Rangel will inquire.

Mr. RANGEL. Thank you, Mr. Chairman.

Madam Secretary, I do not know whether you understand what my Republican friends are saying. They are here waiting for direction from the President of the United States to tell them what to do about repairing the solvency of the Medicare Trust Fund, and they are now frozen like deer in the headlights of cars. They can't move. They are immobilized. I do not know why you are just not getting that.

It is true that they have the votes to do anything they want to do, but they do not want to move now because—well, like the Chairman said, do not we have a plan to give them?

Now, as I recall, the President did have a plan in the last session, but they did not have the majority and I am not going to attribute statements to any of my Republican friends because I am flexible, too, depending on whether I am in the majority. I certainly recall that one of our major leaders on this Committee said, one thing you can depend on is that we are not going to use Medicare to fund any tax cuts. As a matter of fact, he said that "I would prefer to wait to do that in thinking about reform."

Now, I do not think that it is any big surprise that Medicare is just a part of a big health system. In my community, it is the Cadillac of reimbursement for the number of poor people we have. You take a car in and you tell them just to fix the water pump and they will tell you that the water pump is connected with this and connected with that and you know what mechanics do. That is the same thing the hospitals do.

If they want to reduce this massive $780 billion tax cut over 10 years, just reduce it so that our old folks can rely on the trust fund. Is that one vehicle that they might consider? I am not suggesting that the President will tell them how to do everything, but could they not do this on their own?

Secretary SHALALA. They obviously could.

Mr. RANGEL. Let's try another thing.

In the last Congress, when we were the majority, didn't we increase taxes on a lot of folks that were out there in the work market so that we could have this fund at least in better shape than it was before?

Secretary SHALALA. We did, sir, and it was repealed under the Contract With America, which added—which reduced the trust fund by at least 1 year in terms of its solvency.

Mr. RANGEL. Whatever we did in increasing taxes to make the fund more solvent, they decided that they would reduce the taxes and to put it in even more serious jeopardy.

Anything that we have done and they have complained about, it seems like they are doing it and making it worse. Now comes the question as to where do we go from here. If I understood the contract correctly, they told me, and I did believe them then, that they would not even suggest a tax cut to this Committee until they showed us where the savings were going to come from.

I know that a lot of savings came from the poor folks on welfare, because they targeted them even before the campaign. Poor folks have made more than their contribution toward balancing the budget.

They say they have $100 billion that they are going to cut but they won't say what they are going to cut. Could not some of these cuts be related to the same health delivery system that we have to look at the whole picture of when we are talking about health care?

Secretary SHALALA. Yes, sir.

Mr. RANGEL. How the devil can the President give them direction as to how they can repair this part of the health delivery system when they are hiding in the back rooms what they intend to do with the entire health system?

I hope the President has given them a lot of direction in other areas and I hope that they will respond with the enthusiasm that they are waiting now to see how we are going to do this. The way I looked at it is that they raked the increases we have had and deleted that with the contract and then all of a sudden, after 100 days when they cannot perform the contract because it is impossible to do with all the promises they make, now on the 101st day they come to the President of the United States and say, please get us out of this. Give us direction because, after all, you are the President.

I think this is a good beginning for the next hundred days and I hope that they come back to the President of the United States and ask exactly how they are going to pay for the tax cut, how they are going to pay for the nutrition programs, how they are going to cut all of these things that they are cutting and at the same time be able to say that it is a better America.

I really appreciate the humbleness of my colleagues on this Committee because I never thought that they thought the President had any ideas about this. They didn't like what the President presented before, and obviously they read the American people correct because they are hearing the numbers. You got a mandate on that side. I remember when we were talking about——

Chairman ARCHER. The gentleman's time is expired.

Mr. RANGEL. Oh, it has?

Chairman ARCHER. Long time. Long time expired.

Mr. RANGEL. Let me congratulate my majority for recognizing that there is a White House and we will give you something to work on.

Chairman ARCHER. Mr. Shaw.

Mr. SHAW. Thank you. Thank you, Mr. Chairman.

The gentleman from New York always tries to kill us with his levity, and I always enjoy listening to him. I think when you look at something as potentially disastrous as the collapse of Medicare, you have to at some time take a little bit of a break to try to find something that is amusing in what is said.

I would like to take his example of having a water pump broken on the car, and we have invited the administration in to give us their position, and their position is, unless you change the whole engine, we are not going to play. It seems to be that this hearing is rapidly becoming a total waste of time. If we did not ask the administration here to give us their direction, then we would have been severely and justifiably criticized because the President is the leader of this country and the President should definitely be a player.

What you have told us, Madam Secretary, is that unless we take some significant steps forward toward a comprehensive health care plan, you have nothing to tell us. Am I misinterpreting something here, or is that exactly what you have told us?

Secretary SHALALA. It is not what I have said at all, Mr. Shaw, and I have not used the word comprehensive. The point I have made about Medicare——

Mr. SHAW. Incremental. Let's define incremental steps toward health care reform. Would you, in about 30 seconds, just tick off a couple of incremental steps that you feel are necessary in order for you to be a player in this whole thing of trying to salvage Medicare?

Secretary SHALALA. The President has made very clear in his letter in December and in his subsequent comments, and most recently Mr. Panetta made clear in his letter to the Speaker, that we clearly believe that there continues to be a health care crisis in this country, that it is a crisis both of coverage, of affordability——

Mr. SHAW. Excuse me for interrupting. I only have 5 minutes. Would you tell us specifically what incremental steps? I took that out of your testimony on questioning by one of the Members here. You said incremental steps for health care reform. What is your minimum standard of incremental steps that are necessary in order for you to come in and be a player and join with us, as the Chairman has suggested, in a bipartisan way of trying to solve Medicaid?

Secretary SHALALA. We have talked about the necessity to look at insurance reforms, to look at coverage issues, particularly for children. As you well know, the difficulty of moving people from welfare into the work force without health care coverage, we have talked about our concerns about simply taking sharp cuts, the biggest Medicare cuts in American history out of the Medicare system to finance tax cuts is not an adequate way for dealing with the health care crisis in this country.

Mr. SHAW. Can I assume that you do not have an answer to my question? You know, in the last Congress, we had the Democrats controlling the House, the Democrats controlling the White House, the Democrats controlling the Senate. You did not get a vote on your health care plan. It never came up. It was changed in the Subcommittee. It was not even voted on, as I recall, in the Full Committee.

It was never brought to the House floor. In fact, nothing was ever brought to the House floor. When we tried to move welfare reform, we were told that we couldn't do that unless we had comprehensive health care. What in the world do you people do down there? Just waiting on health care? You have got to come forward and give this country some leadership.

I have got a great deal of respect for you, but you are getting some marching orders which are very inconsistent with the talent that you could bring to this Committee.

Secretary SHALALA. Congressman Shaw, we have provided extensive leadership, from OBRA 1993 when we made the major proposals to cut the deficit in this country, to the President's own health care debate when he made it very clear that we could not fix the problems in the public sector health care system without simultaneously talking about some of the needs in the private sector system, particularly those needs for coverage and affordability.

Mr. SHAW. Let me ask you a question. Do you still believe that welfare reform is dependent upon health care reform, that we cannot have welfare reform unless we have health care reform, as the President said last year?

Secretary SHALALA. We still believe that it is difficult to move young mothers from welfare to the workplace without child care and without addressing the health care needs of their children, whether it is through public sector changes or through the private sector reaching out and providing affordable health care to low income folks.

Mr. SHAW. Mr. Chairman, I am absolutely amazed that we are not getting any answers from this particular witness. I had looked forward, as you said in your very nonpartisan opening statement, in reaching out to the Democrats, and then you were answered in a very partisan manner by Mr. Stark, and then the statement of the Secretary in saying that the administration was not going to play ball unless they had comprehensive health care. I think that is an affront to the senior citizens of this country who are depending so vitally on Medicare.

Chairman ARCHER. The gentleman's time has expired.

Mr. Stark.

Mr. STARK. Well, Mr. Chairman, thank you. I guess in the few minutes it would be difficult to educate the Republicans, Madam Secretary, to the complexities of this system which obviously they have been ignoring for 40 years. They didn't need any help when it came to figuring out a tax system, which is arguably pretty complex. They figured out how to give hundreds of billions of dollars to rich people in the first 100 days. They didn't need any help figuring out how to destroy school lunches and lead to more abortions and destroy the welfare system. That they could do in 100 days.

They never asked the White House, I do not think they have asked you for any assistance, did they, Madam Secretary, when they reformed welfare? I do not know as they have needed any assistance, they haven't asked the White House for any help on a budget. All of a sudden they are stumped. They just can't figure Medicare out. That is the problem. I think maybe we ought to send them off to school and we could teach them a few things.

Medicare has been running right well I think for the last 30 years. I think they are in a box, and they won't face up to it. They do not know what to do. They have been lying to the American public about the idea that they can pay for these tax cuts to the rich without hurting anybody, and they want us to do the dirty work. I do not think you should, Madam Secretary. I think you should do just what you are doing and let them stew in their own juice and figure out how this contract will not balance, and will not work. It is going to do nothing but harm seniors the way they have already harmed children in this country. I can understand why the President doesn't want to have any part of it. I would like to yield the balance of my time to Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Stark.

Obviously, it has eluded the attention of the Republican leadership that tax measures start in the House of Representatives, according to the Constitution, and they start in the Ways and Means Committee, and they are supposed to, by law, pass a budget resolution by April 15. We have never come this far into the session without even a proposal laid on the table. All of this weeping and wailing here is a little bit hard to take.

I would like to ask Secretary Shalala, I think you rightly hit the point again and again about universal coverage, you can't control costs, the President made a proposal, but I would like to ask you a specific question.

If Medicare is cut by $250 billion over the next 7 years—let's just take that as an example because I read in the newspaper they are going to take $300 or $400 billion. I do not know. I do not know what they are going to do because they won't put out a resolution and commit themselves. They want the President to run out and throw himself in the street. They trashed him 2 years ago, and now they won't put anything on the table.

But let's say $250 billion are cut. What is the estimate by HCFA, the Health Care Financing Administration, as to the estimated increase in out-of-pocket costs to the American senior citizens by that kind of a cut?

Secretary SHALALA. Well, the best way to translate it would be probably in terms of its impact on people's Social Security check and what it would do is cut the COLA, cost-of-living adjustment, in half between now and 2002. That gives you some impact. For the senior citizens, the thousands that are coming to town this week, an increase in their part B payments, a cut in Medicare that is passed on to them, is, in fact, a cut in their Social Security check, and HCFA has estimated that if that was applied, we were basically talking about them getting half the COLA that they would normally get during that period of time. That is a tremendous impact for millions of Americans.

Mr. McDERMOTT. You are saying that my parents who are living on an $880 a month check, 89 years old and 85, when they get that 3-percent increase, this cut in Medicare is going to cut their COLA in half?

Secretary SHALALA. Yes.

Mr. McDERMOTT. That is basically what is going to happen to every senior citizen in this country?

Secretary SHALALA. Let me—if Medicare was cut by $250 billion over a 7-year period, we are talking about the estimated increase out-of-pocket expenses from about $3,000 to about $3,500.

Mr. McDERMOTT. My parents, who are living on $880 a month, around $10,000, they are going to have an extra $3,000 coming out of their pocket?

Secretary SHALALA. Over a 7-year period.

Mr. McDERMOTT. Oh, I see. It is about $300 a year. If they can't come up with it, where does it come from?

Secretary SHALALA. I do not know. For the senior citizen, it is one pot of money. If they have to pay more for their Medicare, it essentially comes out of their Social Security, and they understand that and that is why, when you talk to senior citizens and to the disabled in this country, they understand the very close relationship between the Medicare Program and the Social Security Program. That is, in fact for them—the part B premium, as you well know, is actually deducted from the Social Security check. So any effort to increase the part B premium as a way of financing the HI Trust Fund would, in fact, actually lower the check that people get.

Mr. McDERMOTT. If we take——

Chairman ARCHER. The gentleman's time has expired.

Mr. McDERMOTT. Thank you.

Chairman ARCHER. Mr. Bunning.

Mr. BUNNING. Ms. Shalala, the President's budget for 1996 that he has presented to the Congress, and your trustees' report, which was written first?

Secretary SHALALA. The President's budget.

Mr. BUNNING. The President's budget was written first and then the trustees' report. There is nothing in the President's budget that addresses this problem that you all reported relating to the shortfall in the Medicare Trust Fund. Is that correct?

Secretary SHALALA. There is nothing in his budget that directly addresses that, though, in OBRA 1993——

Mr. BUNNING. No. Just answer my question.

Secretary SHALALA. No. The President actually wrote a letter saying that, as we were in the process of preparing his budget, we were making it very clear that he expected to deal with the health care issues, including the issues of Medicare and Medicaid, as part of a larger bipartisan discussion with Congress this year.

Mr. BUNNING. He said that in his budget?

Secretary SHALALA. He said that in a letter to Congress.

Mr. BUNNING. Letter to Congress; right.

Secretary SHALALA. In December.

Mr. BUNNING. Did OBRA 1993 not increase taxes by $240-plus billion?

Secretary SHALALA. What OBRA 1993 did was combine cuts in existing programs and some taxes to reduce the deficit over time,

and that had an impact on the HI Trust Fund of increasing the solvency for three more years.

Mr. BUNNING. That is according to the trustees' account. What did the trustees' report say last year, relating to the expected termination or exhaustion of the trust fund?

Secretary SHALALA. We have added a year in the last year.

Mr. BUNNING. One year. That is what I thought, OK.

Do you recommend fixing the Part A Trust Fund solvency problem by increasing payroll taxes?

Secretary SHALALA. We do not.

Mr. BUNNING. You do not. Can you give us an indication of the extent of the cost growth reductions necessary to achieve a 10-year solvency, 15, 20, or just like we did in Social Security, a solvency for 75 years?

Secretary SHALALA. Let me, if you will give me one moment, see whether I have got it with me. I do not believe that I have it with me, but I would be happy to provide it for the record.

I think, Mr. Bunning, the point I want to make back to you is that we are not putting anything specific on the table at this point in time. What we have said very clearly is that we would like to see the detailed Republican budget, see the budget resolution, and that we are committed to dealing with Medicare in the context of a bipartisan discussion about health care reform.

Mr. BUNNING. I have heard that about four times now. We do not need to repeat that since we only have 5 minutes.

Since the Congress, under your control, rejected a comprehensive reform of health care, and since our side of the aisle always was for incremental change in the health care system, there ought to be some mutual ground that we can agree on to achieve that. I would suspect that the President and the administration would come forth with an incremental suggestion. They have not.

Secretary SHALALA. Congressman Bunning, what we have said is to put forward an incremental approach——

Mr. BUNNING. Well, we have attempted to address the problem, too, for 2 years, but we didn't get any cooperation from the administration. They said, you are going to take this or leave it. That is exactly what you said, Ms. Shalala.

Secretary SHALALA. In December, the President sent a letter to Congress, to the congressional leadership, and made it very clear——

Mr. BUNNING. This year. Only after the defeat of the one that was going to be stuffed down our throats.

Secretary SHALALA. Mr. Bunning, the President has committed himself, both in that letter and in his State of the Union Address and his subsequent statements, to sitting down——

Mr. BUNNING. We are not going to hold our seniors hostage to the fact that you failed in passing your health care plan when we have a Medicare problem and we have got to save it. If you do not want to suggest anything, then we are going to do it ourselves without your assistance, and I am not like some of my other colleagues. I think we are very capable of doing it without your assistance. We have asked you to participate. You are refusing to participate.

Secretary SHALALA. We are not refusing to participate, Mr. Bunning.

Mr. BUNNING. You absolutely have refused to participate in your answers to the previous five Members on our side of the aisle.

Secretary SHALALA. Congressman Bunning, we have not refused to participate. We have simply said, put your detailed budget on the table.

Mr. BUNNING. We will do that.

Secretary SHALALA. Get to dealing with the Medicare Trust Fund issue in the context of talking about incremental health care reform and we are prepared to sit down.

Mr. BUNNING. We have heard that four times. We do not need to hear it again.

Chairman ARCHER. The gentleman's time has expired.

Madam Secretary, where in your budget is there a provision to take care of this Medicare crisis?

Secretary SHALALA. Chairman Archer, as you well know, we did not deal with the HI Trust Fund issue in our budget. What the President did say in December in his State of the Union Message and what Chairman—what Chief of Staff Panetta has repeated is after the budget resolution is passed, we are committed to dealing with the HI Trust Fund issue in a bipartisan manner within the context of talking also about the——

Chairman ARCHER. I remember that, but you keep telling this Committee that we have to put a budget forward before you will do anything, but you——

Secretary SHALALA. Mr. Chairman, the law requires that you put a budget forward.

Chairman ARCHER. You put a budget forward yourself that has something to do with saving the HI Trust Fund. Your budget has zero attention to that.

Secretary SHALALA. Our budget was submitted before the trustees' report.

Chairman ARCHER. No. Madam Secretary, we all knew last year, because we had documentation, that the HI Trust Fund was going to go negative in 1996 and was going to go bankrupt in 2002 by the most optimistic actuarial projections. You knew that and we knew it. There was nothing in your budget. You sit here before this Committee today and say you are not going to do anything unless it is in our budget.

Secretary SHALALA. Mr. Chairman, I didn't say that at all. What we said was that we are prepared to sit down in a bipartisan manner after we see the Republican budget that was due, after all, on April 15. We are prepared to deal with the HI issue and to sit down in a bipartisan manner and work through these issues after the budget resolution has been passed.

Chairman ARCHER. Yes, ma'am. You are suggesting then that nothing in our budget resolution should have anything to do with the dire straits of the HI Trust Fund as yours did. Mr. Herger may inquire.

Secretary SHALALA. Mr. Chairman, I am not giving you any advice on your own budget resolution. I am simply saying that once the budget resolution has passed and we see it, we are prepared

to sit down in a bipartisan manner and to discuss the Medicare Trust Fund within the context of incremental health care reform.

Chairman ARCHER. Ms. Secretary, I agree with one of my colleagues. I have a great deal of respect for you, but your marching orders merely become a broken record in response to every question that is being asked.

Mr. Herger may inquire.

Mr. HERGER. Thank you very much, Mr. Chairman.

Madam Secretary, the trustees' report, this report which I have in my hand, the 1995 annual report of the Board of Trustees of the Federal Hospital Insurance Fund, is a Clinton administration document and as a matter of fact, three of the trustees who have signed it are Cabinet secretaries.

Secretary SHALALA. In the same way that in 1992, three of the trustees would have been Bush administration Cabinet secretaries. There is nothing different about trustee reports. They all have Cabinet secretaries as trustees of the system.

Mr. HERGER. That is correct. Let me just continue.

In this report, on which we are meeting here today, the trustees say that Medicare will be broke by 2002. As a matter of fact, by that date, there will be no more money for seniors to receive their health benefits.

Now, even if the budget was in surplus and if health care was perfect, Medicare would still go broke by this report, of which, again, you are a signatory. The issue cannot be ignored, and I guess I have to ask the question, does the administration feel a responsibility to be involved in this process, and if you do, can you come forward now and help us out with some of what your thoughts and what you feel the direction should be.

Secretary SHALALA. Congressman, I have said very clearly that we are prepared to sit down in a bipartisan manner after we see the budget resolution, but let me remind you of what the trustees said about the context in which the HI Trust Fund ought to be reviewed.

They said, "With the magnitude of the projected actuarial deficit in the HI Program and the high probability that the HI Trust Fund will be exhausted in less than 11 years, the trustees urge the Congress to take additional actions designed to control the HI Program costs and to address the projected financial imbalance in both the short range and the long range through specific program legislation as part of broad-based health care reform. The trustees believe that prompt, effective and decisive action is necessary."

Those are both the public, as well as the administration trustees saying that. That is what we are committed to, and all the administration has said is put your detailed budget on the table, commit to dealing with Medicare in the context of health care reform as the trustees recommend, and that we will sit down in a bipartisan manner and work through these issues.

Mr. HERGER. OK. In essence, you are saying to me, as you have said to many of the questioners before, that we are not going to see anything prior to that time. Now, we will have our plan out. I guess what I am asking, is that we would like to also see some leadership, some involvement at this time on an issue which is clearly and certainly, I would say you accept as being the case, one

of the most crucial challenges that we have before the American public today.

Let me now go to your testimony——

Secretary SHALALA. Mr. Herger, this is leadership. This is making it very clear to Congress and to the administration from administrative members as well as public members that the HI Trust Fund must be dealt with both in a short run strategy as well as a long run strategy and pointing out——

Mr. HERGER. But no specifics. No specifics. We are talking in generalities.

Secretary SHALALA. A bipartisan approach to the specifics, and we would like to sit down and do that. We fully expected the budget resolution to be passed by now, as is required by law. As soon as that is done, we are prepared to deal and to discuss the questions of the Medicare Trust Fund within the context of the kind of incremental health care reform that the President has talked about.

Mr. HERGER. Well, again, we will have specifics. As Republicans, we will. It would be nice if during this process, that the President, who is the chief administrator of our Nation, could be involved more so than just generalities, and if we could get some—at least some direction, some specific direction from him.

Thank you, Mr. Chairman.

Mr. THOMAS [presiding]. Mr. Matsui will inquire.

Mr. MATSUI. Thank you very much, Mr. Chairman.

I want to thank you, Madam Secretary, for your testimony today, and I think you are absolutely correct in not suggesting a specific proposal on how to deal with this Medicare problem until the Republicans come up with a budget. Actually, who we should have here today really is Speaker Newt Gingrich, the Republican Leader, mainly because on Friday, he made the observation that any savings from Medicare should be plowed back into the system. I thought, well, then that makes some sense, if you want to plow it back in, you can keep it separate from the budget.

Today I read in Congress Daily A.M. that a Gingrich aide says the Medicare savings won't be put in a lockbox, in other words, kept separate, but it will be made to reduce the deficit. Essentially they are saying that whatever savings we have in the Medicare system will then be used to reduce the deficit, which in turn will pay for the tax cut that goes to basically the very wealthy in America, and other unidentified spending cuts.

Essentially, we need to make sure we see their budget and a budget resolution passed before we fool around with the Medicare system, because we have got a lot of seniors out there who are dependent upon Medicare, and to use their money, their savings, the money they put into the HI Trust over the years to pay for tax cuts for the wealthy would be criminal for the Congress to pursue. Your approach is the right approach.

Second, what you have said in terms of the comprehensive approach—I talk to hospital administrators and my physicians in California all the time and they have said over the last decade, when we made 10 billion dollars' worth of cuts 1 year out of the Medicare system with tinkering—and I understand Mr. Stark had no choice, because that is what the budget resolution always re-

quired, we then put the situation on the private sector through cost shifts. Anybody elementary can figure that out if they understood the health care system.

All we will be doing is cost shifting $50 billion a year onto the private sector, thereby increasing premiums. You need a comprehensive approach. You can't do this piecemeal. We are not talking about little tubes that go into engines. We are talking about the engine itself.

Let me just make another observation. I think it is very important. I noticed panic on the other side of the aisle. I have never seen quite the panic the first hundred days. We are seeing it now.

I do not think the panic is because of the Medicare Trust Fund. I think it is because all of a sudden, with those individual bills they passed over the last hundred days, they can't balance the budget. They got a $640 billion tax cut. They, at the same time, won't make cuts in domestic programs, even though the Budget Committee chair almost every week comes up with another illustration of where he is going to cut $100 billion out of discretionary programs, but we know he is not going to be able to do it because they won't do it.

They won't do it on agriculture subsidies, they won't do it on anything that they want to protect in their own program. They are going to have to use Medicare in order to balance the Federal budget, and we are not going to let them do that without the American public knowing it.

Let me make this observation in terms of all this. If, in fact, we make these cuts and we do this, whatever amount of money they are looking at here, you indicated that we are basically going to be cutting back on the overall lifestyle of the average senior citizen. Now, what did you say that was, $3,500 over 10 years or do you have the actual statistics?

Secretary SHALALA. No. The actual numbers, $250 billion over 7 years would increase out-of-pocket costs 30—about $3,000 to $3,500 over 7 years.

Mr. MATSUI. OK. Now, let me also make one final comment because my time is running out here. Under this report, and I do not think this has been brought up yet, under this report, you are basically saying that the Medicare Trust Fund has an extra year, right? An extra year before it goes insolvent. Instead of 2001, it is 2002?

Secretary SHALALA. Right.

Mr. MATSUI. Now, I do not understand why the Members on the other side of the aisle, when it was 2001, didn't panic out then. Why didn't you panic out last year when we were trying to do comprehensive health care reform? That is what I can't understand. You are sure of that? In other words, we have gained an extra year on solvency through this report and through what we have done over the last year; is that correct?

Secretary SHALALA. Yes, but that would be lost if the tax cuts that the Republicans have proposed takes effect.

Mr. MATSUI. Exactly. But the panic should have been last year, because we gained some time; is that correct?

Secretary SHALALA. Well, that is correct, and as I pointed out, the year was 1999 when we came into the administration, which

means the previous administration, the previous trustees had some serious problems with the trust fund then.

Mr. MATSUI. I think we are seeing panic now because they can't balance the Federal budget with these tax cuts and they want to take it out on the backs of seniors.

Thank you.

Mr. THOMAS. The gentleman's time has expired.

Mr. Hancock.

Mr. HANCOCK. Thank you, Mr. Chairman.

You know, I do not know that what we are asking for is impossible from the President and from our Democrat colleagues. For 40 years, their solution to every problem was to raise taxes. Now, they are in a situation where they can't raise taxes and they do not know what to do. They cannot come up with any ideas about how we can live within the existing budgets.

I just wonder, they talk about us being in a panic. We are not in a panic. We are trying to do what the American people said they wanted done. They said we want to get government under control and we do not want any tax increases.

Now, the mentality of the Democratic party cuts them completely out of the circle because the only way they know how to solve any problem is to raise taxes, and I think we are asking the Democrats, including the President, for an impossible task. It is totally foreign to their thinking to try to solve any problem without spending more government money and raising taxes on the American people.

Now, would it be improper for me to suggest that the administration put itself in the frame of mind that we need to come up with suggestions to live within the present income as ways to solve the problem? It would appear to me that you are positioning yourself to ask for another tax increase, and the only thing you know to suggest is another tax increase.

Now, surely, surely there is enough brain power in this country that we can address this problem without going back to the Democrats' old tried and true method, we have got to have more money, we have got to start and create class warfare. We are going to give money to the rich and take it away from the poor. I mean, let's try to do like everybody in their own budget—that every businessman has to do when you have got a limited income, then you start trying to address the solutions other than saying, well, I am just going to go out and borrow more money and I am going to raise taxes. Is that impossible to ask you all to think in that vein a little bit?

Secretary SHALALA. Congressman Hancock, as far as I know, none of us have recommended additional tax cuts.

Mr. HANCOCK. I am aware of that. But, your refusal to try to solve it within the present tax structure is sure putting us on the road to saying, we have got to raise taxes. That is what you did in 1993.

Secretary SHALALA. All we have suggested is a tax cut for the well-off on the backs of the elderly and the disabled. This is not what is acceptable to this administration. The biggest Medicare cut in American history as a way to finance a huge tax cut for the well-off is not a way of keeping our contract with the elderly in this country.

Mr. HANCOCK. Would you recommend some tax increases on the well-off then?

Secretary SHALALA. I have not suggested that. I have simply said, let's see your detailed budget. Tell us how you intend to keep your promise to balance the budget, and to pay for tax cuts for the wealthy.

Mr. HANCOCK. We are going to balance the budget and we will do it without the administration, if necessary. We would like to ask them to cooperate. We would like to ask them to get this idea out of their head that you have got to have more money.

That is the only thing they can think about. In fact, let's go back to Harry Truman of the State of Missouri. He talked about the "do nothing" Congress. Well, I think we ought to be talking about the "do nothing" presidency. The only thing that Bill Clinton can do is attempt to put us in a position where we are going to have to raise taxes, and that is exactly opposite of what the American public, including the senior citizens of this country, want done. They know that those methods have gotten us into this position in the first place and it is time we address it based on the existing tax that we have got set up now and we can do it if, in fact, we get some cooperation.

Mr. THOMAS. Gentleman's time has expired.

Madam Secretary, a number has been repeated a couple of times and I just want to make sure, as we go through this, that we try to at least remain as accurate as possible in terms of numbers. The repeal of the phase-in on taking Social Security taxes and funding HI unprecedentedly, according to Joint Tax, was $15.6 billion over 5 years. Is that a figure that the administration agrees with?

Secretary SHALALA. I simply will have to provide that for the record, which I will, sir.

[The information was not available at the time of printing.]

Mr. THOMAS. Well, it is in relation to the statement the Secretary has made several times, that removing this unprecedented tax shift would reduce the solvency of the fund by 1 year, and Joint Tax has indicated that the cost of this will be a $15.6 billion cost over 5 years. When in 2000, the shortfall in the HI Fund alone, in just that 1 year, will be more than $35 billion.

The funding of this over 5 years is less than one-half of the cost of the shortfall in even just 1 year. I am concerned that the Secretary, in continuing to repeat the statement that it shortfalls for 1 year, perhaps is not accurate according to the numbers.

Secretary SHALALA. We are probably—I have to determine whether you are using CBO numbers versus Joint Tax.

Mr. THOMAS. Using the Joint Tax number.

Secretary SHALALA. Which we will review, sir, and provide for the record.

Mr. THOMAS. Although it seems a little ludicrous to the American people, I am sure our arguing over several months shifting into another fiscal year as to whether or not any change saved is 1 year or not, they are looking at ultimate solvency, but I do want us to be accurate.

Secretary SHALALA. The CBO numbers that we were using is 26 over 5 and 87 over 10.

Mr. THOMAS. Over five, that still is equal to less than the shortfall in 1 year of that 5-year period. Once again, it is a little incredulous that the dollar amount would extend it 1 year when, in fact, in 1 year the shortfall is $35 billion.

Gentlewoman from Connecticut's time is available.

Mrs. KENNELLY. Thank you, Mr. Chairman.

Thank you, Madam Secretary, for being with us this morning and I understand this is tedious, this testimony, because we are talking about a very difficult subject. I have been hearing all morning that this task is impossible, that the administration finds it impossible to go forward with addressing this program. That is not true. It is also not true that this Committee has found it impossible.

You, in your testimony, highlight very definitely what happened in OBRA 1993, the Budget Act, where in fact a very difficult vote was taken by this Committee to, in fact, help us get an additional 3 years in the HI Medicare Fund. That did happen. That is a fact. It was voted on in this Committee and a number of these Members, myself included, made that tough vote. It is not impossible, but it will be difficult.

I would like to go on to the next year, 1994, which again illustrates why this is not going to be easy. All of us know it is not going to be easy because we have been there.

In 1994, this very Committee voted on comprehensive health care reform. Once again, a very difficult vote, and in that vote, for those that voted for those changes and those improvements, everyone didn't agree on everything, there was a lot of angst to try to get there, but the majority of the Committee felt the status quo in the health care world is unacceptable.

In that comprehensive health care legislation that we addressed in this Committee, which is history, $168 billion in Medicare cuts were voted on. I just want to say to this Committee, we have always had a history of being able to take the hard choices and do something about it, and I certainly would hope at the end of the day, that this Committee can once again address the needs of the elderly citizens and future elderly in this country, that the Medicare Program has worked and it is up to us to do something about protecting it for the future. Let the facts stand that difficult decisions have been made in the past and only difficult decisions that are very unpopular will have to be made in the future.

What we are trying to do this morning is try to make sure that the difficult decisions we make do not go for tax cuts; that they go to help the Medicare Program. That is what all this talk is about. We are going to have to put up with each other until that is made very clear. Where the changes will come from and where they will go, to pay for what. That is what we are talking about.

Let's talk about a couple of those changes that were in fact made, Madam Secretary. In 1993, you came here and presented the idea that we do change the tax on Social Security for some people who had an income of a certain amount, and that change would go in the trust fund.

History was made again, just recently, when we passed a tax bill on the floor of the House that changed that back to 1993 and those dollars will not go into the trust fund and therefore we won't have

that money to bankruptcy that year off. Madam Secretary, as you just mentioned yourself, this passed the House. It is now before the Senate.

Is it the intention of the administration to try to convince the Senators that in their wisdom they should not have this tax cut—or excuse me, that they should not renege on this change and that they should leave it the way it is now so at least we will have a little more breathing room before we get to that horrible year of bankruptcy?

Secretary SHALALA. It is, Congresswoman. It is our intention.

Mrs. KENNELLY. I hope you are successful because I think the people I have talked to at home would much prefer that the program remain solvent rather than some get a better deal, though they found it hard, and every one of us heard from our constituents about that change.

Let me ask you about another possible change so we are not just at each other. In the report, your group, the trustees, recommended that the quadrennial advisory council be reinstated. Now, we have been hearing talk about the possibility of a commission, as happened in 1983 for the reform of Social Security. Would this commission—would this quadrennial advisory council be like a commission, or would you—any possibility you would want a commission to look at this as they did in 1983 for Social Security?

Secretary SHALALA. The trustees recognize that in the creation of the new independent Social Security Agency, we did not put in language to keep a quadrennial advisory Committee for the Medicare Trust Fund. In fact, it moved over to Social Security and became the advisory Committee to Social Security. We were simply asking for the reinstatement as another vehicle.

We believe that that advisory Committee, within the context of what the trustees have recommended, and that is we look at some health care reform as we discuss the HI Trust Fund issues, that that certainly would be important. It is a reinstatement, though, is the point that I should make, as opposed to something new that has not been there before.

Mrs. KENNELLY. Thank you——

Mr. THOMAS. The gentlewoman's time has expired.

Mrs. KENNELLY. Thank you. You will be back here and we will be here, and when the initial dancing is over, we are all going to have to come together to figure out how to save this program and I look forward to working with you.

Secretary SHALALA. Thank you.

Mr. THOMAS. In using terms like the biggest cut in history to balance it on the backs of seniors and disabled, isn't it true, Madam Secretary, that the 1993 budget made the largest program cut in the history of the trust fund? Is that true?

Secretary SHALALA. I am certain that there is no comparison between those steps and the kinds of steps that are being talked about in terms of the Medicare Program.

Mr. THOMAS. The largest program cut in the history of Medicare was made in the 1993 Budget Act. President Clinton attempted to balance the budget on the backs of seniors and the disabled, if we use your phraseology, Madam Secretary.

The gentleman from Wisconsin, Mr. Ramstad.

Mr. RAMSTAD. Thank you, Mr. Chairman.

Mr. Chairman, I think your point is well taken. I wish we could get away from this hyperbolic rhetoric and roll up our sleeves and work together in a bipartisan, pragmatic way to deal with this Medicare crisis, and it is a crisis, as your own trustees have pointed out to us.

Madam Secretary, in that spirit, I would like to ask you a series of questions for which I believe there is a yes or no answer. I am just trying to get at what, if anything, the administration has considered in terms of solving this crisis.

My first question, has the administration considered means testing higher income seniors as a way to reduce Medicare costs?

Secretary SHALALA. Congressman, I am not prepared to discuss what would be part of a broader discussion in terms of how we would reinforce the HI Trust Fund, make changes that would improve affordability and coverage and quality and choice as part of our discussions of insurance reforms, and I am not prepared to answer yes or no questions about very specific narrow changes that some may well want to consider as an indication of what we would put on the table.

Mr. RAMSTAD. Madam Secretary, what point in time will you be willing to discuss the administration's proposal?

Secretary SHALALA. Put your detailed budget on the table, sit down with us in a bipartisan manner, and right after that——

Mr. RAMSTAD. I think I am asking a very legitimate, straightforward question. Has the administration considered, as a way to solve this Medicare crisis, means testing?

Secretary SHALALA. The administration is not going to answer specific questions, and we have repeated that 75 percent of all of the Medicare recipients in this country have incomes under $25,000 a year. Eighty-three percent of our expenditures for Medicare recipients are for those with incomes under $25,000 a year. I do not know what we are talking about.

Mr. RAMSTAD. Madam Secretary, if I may, I only——

Secretary SHALALA. We are not talking about means testing because we are talking about a poverty population. To be old in America is not to have very much money, and I think that to have a reasonable discussion in a bipartisan manner, put your budget on the table and we are prepared to sit down and to talk about the Medicare Program, insurance reforms, what kinds of implications that has for the private sector. We obviously want to reduce the amount of cost shifting that goes to individuals who pay for private health insurance, but I will not answer detailed questions about what will be part of that discussion.

Mr. RAMSTAD. Madam Secretary, I thought that was the purpose of this hearing, to air not only the problem—we all know the problem. We know Medicare is going to be bankrupt by 2002. You, as the trustee, told us that previously. We want to try to deal with some solutions. Again, in a bipartisan, pragmatic spirit, may I ask the question, has the administration considered giving Medicare recipients incentives to participate in managed care plans? That is a very straightforward question. Have they considered that?

Secretary SHALALA. This administration has expanded access to managed care more than any previous administration, and both in

Medicaid and in Medicare, people are moving rapidly to managed care. In Medicare alone, at a rate of 1.5 percent a month. Individual plans are offering incentives for people to move in. In some cases, they are being taken. In other cases, they are not.

We are preserving choice. We are committed to choice, but simultaneously, we believe that the choices that Medicare recipients have ought to be expanded. We have already announced that we are discussing, in addition to the HMO range that are available—and 75 percent of all Medicare recipients now have access to HMOs, point of service options, PPOs.

Mr. RAMSTAD. Madam Secretary, is it your plan to deal with this problem with increased incentives?

Secretary SHALALA. There is—let me simply say this. It could be——

Mr. RAMSTAD. My time is almost up. I have two more important questions.

Does the administration support vouchers for seniors to purchase private health care insurance, again, as a way to move more seniors into private health care plans to avert the Medicare bankruptcy?

Secretary SHALALA. Mr. Ramstad, I am not sure I can answer that question as quickly as you would like. We have deep concerns about proposals that we have seen for vouchers.

Essentially what you are saying is that 37 million people, most of whom have preexisting conditions by the nature of their age, be tossed into the individual insurance market in this country to sink or swim, and I think that most of us, including the market itself, would have some deep concerns about whether they could be absorbed as such. We have made a commitment to a benefit package, to a series of benefits.

Mr. RAMSTAD. Madam Secretary, we have heard that, please. I'm sorry. I do not mean to be rude at all, but the time is obviously waning.

Mr. THOMAS. The gentleman's time has expired.

Mr. Zimmer.

Mr. RAMSTAD. I would have asked about medical savings accounts, but we will save that for another day.

Thank you.

Secretary SHALALA. I think I am on the record about that one, too, Mr. Ramstad.

Mr. ZIMMER. Thank you, Mr. Chairman.

Whether we like it or not, for the next—for the better part of the next 2 years, this country is going to be governed by a Republican Congress and a Democratic President, and we really have to try to figure out how we can try to work together. This relationship is beginning to remind me of a bad marriage. As with a lot of bad marriages, the problem is one of communication.

Secretary SHALALA. Where do I get a divorce?

Go ahead, Congressman Zimmer. I apologize.

Mr. ZIMMER. The administration says it is asking for a bipartisan dialog, but it won't start the dialog, and you are saying that you will talk to us when we do certain things first, and I just do not understand why we can't talk about the trust fund before you see the final Republican budget, and I do not understand why we can't

talk about the trust fund without a discussion of some unspecified health care reform, that you won't get into. The administration has punted on the issue of the budget. It has not fulfilled its own promise to half the deficit, let alone eliminating the deficit and in the budget, it doesn't deal at all with the HI problem, and the administration has punted at least in this session on the issue of health care reform, incremental or comprehensive, by not proposing specific ideas.

If, as somebody said on the other side of the aisle, the intent is to have Republicans stew in our own juices, that may be a politically desirable objective from your point of view, but it certainly doesn't help deal with what is a major and pressing problem.

I just want to express my dismay at this situation and I won't try to ask the same questions that have been asked over and over again because I would anticipate getting the same canned response, but let me just ask you, Madam Secretary, whether you agree with a couple of the statements that were made by some of the Democratic Members of this Committee.

The Ranking Democrat, Mr. Gibbons, said that the cuts that were proposed as part of the administration's health care reform program last year, $168 billion, "were not real large in the context of the entire program." Do you agree that 168 billion dollars' worth of cuts aren't real large?

Secretary SHALALA. Only if you continue the sentence in the context of the program.

Mr. ZIMMER. I did.

Secretary SHALALA. That was a comprehensive health care reform proposal which balanced off some of the cuts, or slowing down the growth of the Medicare Program with slowing down the growth in the private sector at the same time. All we have said is that the context for dealing with the HI Trust Fund, with Medicare and Medicaid, must be the broader context of the entire health care system, because what we do not want to do is to create terrible problems for the private health care system because of what we do with the public health system.

Mr. ZIMMER. Then that leads me to something that Mr. McDermott said. He said, without universal coverage, you can't control costs. Do you agree with that statement?

Secretary SHALALA. Yes. The point that Dr. McDermott was making is that large numbers of people without insurance are both putting off health care, which means that when they do finally go to the doctor, they are sicker, or using the most expensive parts of the health care system, the emergency rooms. Until we can get everybody into some kind of insurance, it will be very difficult for us to control overall spending in this country.

It means that we cost shift to cover some of that, as we—and one of the difficulties that rural hospitals have in America is they are very dependent upon Medicare because they are the payer and that Medicare money helps them to pay for the uninsured at the same time. The large public hospitals have the same kind of problem. That coverage is important as part of the equation.

The President has made it very clear that he fully understands that we are not going to again take on a comprehensive approach, but incremental discussions that include coverage as one of the

things on the table is absolutely critical to trying to control health care costs in this country.

Mr. ZIMMER. You do not think we can control costs even within Medicare without making major—without starting on the way to universal coverage with the anticipated objective of getting to universal coverage.

Secretary SHALALA. What we have said is that taking large cuts in the Medicare Program will simply cost shift and put at risk both the rural health infrastructure in this country——

Mr. ZIMMER. Could you answer my question yes or no? Can you make Medicare cuts without starting off on the way to universal coverage?

Secretary SHALALA. The point that we have made is that because we believe that coverage is critical to cost, that making Medicare costs—Medicare cuts or slowing down the growth of Medicare without understanding the implications for the rest of the health care system, the last thing you want to do is increase the number of people without health insurance or adequate health care coverage, and therefore we have argued that there is a—as most health economists have, that there is a relationship between coverage and the large number of uninsured and what happens in the public system.

Mr. THOMAS. Gentleman's time has expired.

Madam Secretary, despite the rhetoric, some of us are trying to look at solutions and I would like to ask of the resources that you have if it is possible, within a reasonable timeframe, next week or whenever it is reasonable, if you could give us what your department actuaries believe would be a growth rate that would ensure solvency for a 10- 15- 25- and 75-year period.

Secretary SHALALA. I will—whatever requests that you have, we have in a bipartisan manner tried to fill those requests. Anything specific the Committee wants to ask us, we will see whether the actuaries are able to do it, but we would be happy to respond.

That would be the request, because clearly it is an actuarial problem and not a political one.

[The information was not available at time of printing.]

Mr. THOMAS. Mr. Levin will inquire.

Mr. LEVIN. Thank you, Mr. Chairman.

Mr. Zimmer, I think you asked some good questions and I think the Secretary gave you good answers and I would like to just briefly respond to them. Who goes first?

You can simplify this issue. There is a political dimension. I think there is also a public policy dimension. People who make promises should tell the public what they mean. You made promises. You should tell the public what you mean, period. Do it.

The budget resolution in previous years had already been passed by the time we convened here this morning by many days. The broken record here is the broken record of your promises when you were going to come forth with a budget. Now it is said you will separate that. I mean, you go back and forth. One day it is part of the budget; the next day the Speaker says it will be taken separately. This morning, a senior member of the panel, Mr. Walker, said you have to include Medicare savings in the budget. We will provide a number and an overall level of confidence.

Say what you mean. That is good public policy, and it is bad public policy for you to say the other party will say what you mean when you run into some promise you may not be able to keep. That is why we are waiting. There is a political dimension, but there is also a public policy dimension.

People in the district I represent are disillusioned by people in public life who have made promises and then do not say how they will keep them. Say it. Tell us specifically, what you plan to do. Then, just do it. do not wait for anybody else. I think that is what the Secretary is saying. That is what the President is saying, and then you try to change the subject. You talked about $158 billion in Medicare cuts last time. I voted for those, and it wasn't an easy vote, but the vote for Medicare cuts were for cuts that plowed money back into the health system. That was what it was, and we took some money out of the Medicare system, for example, indirect medical education, or direct medical education, and we put it back so that hospitals would be compensated for uncompensated care.

Just do it. Do not look to the other person or blame the other person or look to the White House when you want to be bipartisan only when it suits your needs. You were not the first hundred days. Some of us tried, for example, on welfare reform.

Let me ask the Secretary a question about the testimony of June O'Neill about one possible response to this problem, and I think there is a problem with the Medicare Fund. There is no use disguising it. At least there is potential.

She says on page 15 about major restructuring, "major restructuring, however, would take time to develop and could not therefore address the short-term financing issues." You want to comment on this statement? Because, there is a lot of discussion about managed care, I think we are going to have to take a look at it. Some people look there and see a magic bullet. You have less than a minute. I am sorry, but if you would.

Secretary SHALALA. OK, thank you. I have great respect for Dr. O'Neill. The point she is making is that one of the alternatives that is being looked at, certainly by the administration as well, is a competitive system, and the point she makes is that the competitive redesign of Medicare is a major restructuring. It is not something that could be done quickly. It would have to be phased in, perhaps as demonstrations, and it is not something that someone could count on for potential savings in the short run, but it is something that ought to be looked at.

We have said publicly that we would like to look at it. It has to do, for those of you who have not followed this detailed discussion, with the pricing of HMOs in parts of the country, to go to a more competitive design as opposed to what we have been doing, and that is using fee for service as the base. It requires a great deal of conceptualization. We have done a lot of it already in the Department, but it is not a short run solution.

Mr. THOMAS. The gentleman's time has expired. Ms. Dunn.

Ms. DUNN. Thank you, Mr. Chairman. Madam Secretary, I am very troubled by the hearing that we are participating in today. I hoped, as a newcomer to this Committee, we could gather together and discuss really solid ideas on how we could solve this major problem. I see a huge crisis in leadership by the executive branch,

and I should think that you personally would feel very, very concerned coming to this Committee without a proposal for how to solve this crisis. I would think you would find that your plan to wait until we propose our budget-balancing plan is very reactive. I think it brings in the question of relevancy of the Presidency.

We are dealing with real reasons and good reasons, and I would simply like to know the real reason the President and the administration have not come forth with a plan to solve this crisis. For example, you and Secretary Rubin have been here with some ideas that were considered during our debate, proposals and our passage of that bill on the House side. This dearth of leadership is very sad. It is certainly not what the people I represent want to see out of the executive branch, and I would like to know the real reason you are not coming forth with some ideas.

Secretary SHALALA. Congresswoman Dunn, I think your comments are unfair. All I have said here is that we fully expect to see a detailed budget. The credibility issue, given what the law says, is not on our side. We fully expected a detailed budget because we were told that within that budget you would keep your promise to balance the budget, to provide a tax cut for the well off, and that——

Ms. DUNN. Madam Secretary, if you will excuse me, the budget is not the question. Your proposed ideas for reform of the health care system and reform of this system that we are talking about, Medicare, is the topic of today's debate. Where are the answers? Where are you going to provide some solution that we can put together in a bipartisan way and solve this crisis?

We know what your trustees have said. I know what I am hearing in the communities around my district where I just spent 2 weeks holding 13 townhalls in 13 different communities. They want us working together to solve this problem. They do not want this sort of rhetoric that we have heard during this debate and—excuse me, Madam Secretary, I would like to know when you are going to come up with this proposal. I would like to have it disconnected from the budget because we have got to work on this now. It was the number one priority in all my townhall meetings. They want us to solve this problem. They do not want you or anybody from the executive branch giving an excuse that we will wait until you propose the plan. Leadership should rest with the President. Where is it?

Secretary SHALALA. Congresswoman Dunn, the leadership of Congress is now in the hands of your party and we are waiting to see your budget. We have said——

Ms. DUNN. Have you completely given up, then, on the fact that the executive branch should be offering leadership in this and every other major debate we are going through in the House of Representatives?

Secretary SHALALA. Absolutely not, but it is fully acceptable for us to wait to see the detailed budget in which you have promised to deal with these issues, and we have said as soon as we see that detailed budget, we are prepared to sit down and to deal in a bipartisan manner with the health care portion of that budget, specifically——

Ms. DUNN. I think at this point excuses are not good enough, Madam Secretary. I would expect more than that from the administration. Thank you, Mr. Chairman.

Mr. THOMAS. Mr. Collins will inquire.

Mr. COLLINS. Thank you, Mr. Chairman.

Ms. Shalala, thank you. Let's talk a minute about the budget and how the budget actually pertains to the benefits that are paid for by those who are covered under Medicare. The budget itself is actually a foundation whereby the appropriated funds are used to pay benefits, are debited against the Hospital Insurance Trust Fund; is that not true?

Secretary SHALALA. The budget affects both parts of the Medicare Program, but specifically part B of the Medicare Program. Any cuts in the budget would affect other parts of the budget.

Mr. COLLINS. Ms. Shalala, please, we are talking about part A, true? This is a report on part A. The appropriated funds that are based on the budget for benefits are debited against the Hospital Insurance Trust Fund; is that not true?

Secretary SHALALA. It is true and——

Mr. COLLINS. OK, that is enough.

Under the current law, there is no authorization to use any other funds for health insurance benefits other than trust funds, is that not true?

Secretary SHALALA. Under current law, that would require a change by Congress.

Mr. COLLINS. Is that not true, my statement, under current law that it is no authorization——

Secretary SHALALA. That is exactly what we are waiting to hear, your budget.

Mr. COLLINS [continuing]. To use any other funds than trust funds for benefits for Medicare, true?

Secretary SHALALA. That is precisely why we are waiting to see your budget, to see what you are doing.

Mr. COLLINS. Is that not true, Ms. Shalala? Please. I do not want to go into all that other rhetoric.

Secretary SHALALA. I think I answered the question. I think I said it would require a Congressional change.

Mr. COLLINS. You did. You said it was true. No funds in the trust fund can be used for anything other than Medicare benefit payments or the administration of Medicare; is that not true?

Secretary SHALALA. That is true.

Mr. COLLINS. OK. That really makes the budget kind of a moot issue; is that not true?

Secretary SHALALA. No, it doesn't.

Mr. COLLINS. If you are not authorized to use those funds for anything else other than Medicare and you can't use public or general funds for Medicare, then that makes the budget a moot issue; is that not true?

Secretary SHALALA. I think that the difficulty here is understanding the——

Mr. COLLINS. No. There is no difficulty. There is, but we won't get into the difficulty.

But based on that, the budget issue is a moot issue because any adjustments that are made in Medicare in any shape, form, or

fashion remain within the guidelines in the trust fund called Hospital Insurance; is that not true?

Secretary SHALALA. You are misunderstanding the unified budget concept which——

Mr. COLLINS. I think I am very well in tune with how this program works. Taxes are collected from every employee and employer and from those who actually opt to be covered under Medicare. They pay a premium, $261 a month. I believe that is the figure, based on your report.

Those funds, they go into the general fund, but they are credited to the Hospital Insurance Trust Funds. Any benefits that are paid out and the cost of administration of those benefits are debited against the trust fund.

Those trust funds, the surplus in those trust funds, can only be used to purchase government securities. Therefore, any changes in the Medicare Program in any shape, form, or fashion will remain within the realms of the Medicare Program itself or the Hospital Insurance Trust Fund; is that not true?

Secretary SHALALA. I think that——

Mr. COLLINS. Yes or no. Yes or no.

Secretary SHALALA [continuing]. We have a difference of opinion over the unified budget.

Mr. COLLINS. Yes or no. Yes or no. Yes or no. The circle you have been running in is just like when I used to rabbit hunt. You cannot delay a rabbit. He will run way out and come back. That's what you keep doing. You keep running in circles, but the truth of the matter is, any adjustments made within the Medicare Program or the Medicare Trust Fund, those funds will stay in that Medicare Trust Fund, Mr. Chairman, therefore, the budget itself is a moot issue. You are not even talking about the budget when you talk about the trust fund and the Medicare benefits.

Secretary SHALALA. It is not a moot issue.

Mr. COLLINS. I wish you would stop this debate of trying to divide people and to threaten our seniors. I just do not like it that you want to hold our seniors hostage to your rhetoric and your programs. It is just not fair to them. You are not being honest with the American people and I regret that, Ms. Shalala.

Thank you for your appearance here today.

Mr. THOMAS. Mr. Payne will inquire.

Mr. PAYNE. Thank you very much, Mr. Chairman, and thank you, Madam Secretary, for being here today.

I wanted to first, since we are discussing Medicare, an issue that is so important to all of our senior citizens in this country, to commend you and the administration for the work you have done in setting up the Conference on Aging, will be held this week. It was a conference on aging that really laid the foundation that gave us our Medicare system, perhaps the first conference back in the sixties, and so these are very important conferences.

As I have talked to many people back home in my district, they were very interested in this. Of course we all have someone who is representing us at this conference, and this is an opportunity to get a lot of input from our senior citizens from all over the country, and I think this is an important part of any reform of the Medicare system, certainly as we move forward, and I did want to comment

on that and commend you for your work and the administration for that.

Secretary SHALALA. Thank you very much, Congressman Payne.

Mr. PAYNE. I understand from your testimony and from what I am seeing here in terms of the tables that were presented to us that the reduction in income from the taxation of benefits to the trust fund, in other words, the tax cuts that were passed as part of the Contract With America, have not been considered in the report of the trustees, so that if, in fact, that was considered, that it would not be a 7-year period of time, but rather something less than seven, maybe as short as six or fewer years that we now have to act as a result of that action that was taken. Is that correct?

Secretary SHALALA. Yes. Something—six plus I think it is. I think it is closer to about 8 months that that would knock it out.

Mr. PAYNE. So that the one action that this Congress has taken generally regarding this issue has actually exacerbated that problem to the extent that there is some $31 billion less that will be flowing into the trust fund.

Secretary SHALALA. That is exactly right, Congressman Payne. The point we were making is that it is going exactly in the opposite direction, all the steps that the administration and the Democratic leadership took previous to that was to extend the number of years to protect the HI fund and the contract actually reversed that for a number of months.

Mr. PAYNE. Now, in trying to understand this and putting aside partisan politics, just to understand where this is and what needs to be done, as I understand it, there are two different trust funds associated with Medicare, one the Part A and the other, the Part B Trust Fund. Why do we have two different trust funds? What was the purpose of setting that up that way and has any consideration been given to or has there been talk about making that a single trust fund?

Secretary SHALALA. There have been some conversations about making it a single trust fund over the years. One was set up obviously with payroll financing and the other, which has some cost sharing and some premiums paid by individuals, and I think that there have been some very thoughtful people who believe very strongly they ought to be combined, particularly as we begin to go to other kinds of vehicles, HMOs and other kinds of choices for people, and I would think that a thoughtful discussion on that subject would be worthwhile.

Mr. PAYNE. But, there is not yet——

Secretary SHALALA. There is not a proposal any place, and one obviously has payroll taxes deposited directly and the other has out of pocket and discretionary money allocated for it.

Mr. PAYNE. I understand there has also, in the past, been some discussion about the need for a trust fund at all. Is that something that the trustees have discussed at all?

Secretary SHALALA. Not during my term as a trustee; we have not had a discussion about that.

Mr. PAYNE. So, that there is no recommendation that it be——

Secretary SHALALA. There is no discussion on that.

Mr. PAYNE [continuing]. That it be examined relative to the necessity of doing that. Thank you very much and I will yield back the balance of my time.

Mr. THOMAS. The gentleman's time has expired, and the Committee will stand in recess for not more than 10 minutes. We have a vote on the floor. The Chair will return as soon as possible for additional inquiries.

[Brief Recess.]

Chairman THOMAS [presiding]. The Committee will reconvene. Mr. Christensen will inquire.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Madam Secretary, I have listened and I have waited patiently for a long time. During, the last 2 1/2 hours you have been giving very difficult answers. It has been a very difficult situation for you, I am sure, because I know that you are very capable and a very smart lady and I think that you have been given some marching orders that are probably contrary to what you would normally be able to do in answering the questioning.

As a new guy on this Committee, I come from a business background, and the best thing that I could probably do is—in terms of comparing what I have heard today and what I have seen from the Medicare Board of Trustees, would be to try to compare it to a board of directors. If you were the board of directors and I was the stockholder, I would probably sue and win on dereliction of duties, because from what I have seen, the stock of Medicare has gone down drastically during your watch, and what I would like to do, and rather than just throw barbs back and forth, I would like to talk about a couple of ideas that—and I know you gave Congressman Ramstad, you wouldn't answer specifics, but if you would, just for the moment, talk about some constructive ideas that might work.

For example, in the Medicaid situation, you have allowed a lot of waivers to various States. I know that our State, Nebraska, was allowed to receive, a medical waiver.

Do you think the administration would be open to allowing a couple of States to look at this situation of Medicare, whether they could handle the problem better, more efficiently, get better use of dollars on their own as a trial basis to see if we could do the same with Medicare like we have tried with Medicaid? Would the administration—and maybe if you can't speak for the administration, speak specifically as the Secretary of HHS.

Secretary SHALALA. I am afraid they are one in the same. I am not even an individual.

Mr. CHRISTENSEN. Personally.

Secretary SHALALA. I can't even speak personally. Let me make a couple of comments here and try to be helpful to you.

First, I think that you would probably keep me as the chief executive officer because our stock has gone up. As I pointed out at the beginning, we inherited a system that was supposed to be bankrupt by 1999. At least we have added some years to the solvency of the system.

Second, the trustees of the system, while they are called the Medicare trustees, are in fact advisors to Congress and to the administration.

The Congress and the executive are the trustees of the system, and we have, in fact, done our job as advisors to all of you. We have come and said that the HI Trust Fund has only a few more years and we need to make some thoughtful proposals together. With the split between who are the new majority in the Congress and the executive, we have said that we should do it together, not that I should independently truck out some ideas.

As to your proposal about Medicare and whether we should try some things that we tried on Medicaid, I think that the programs have two different histories. Medicaid has always been a State-Federal partnership. Medicare has not. The general point, and that is, should we try some things, competitive bidding, for instance, is one, on a regional basis, should we try different kinds of demonstrations for delivering care?

I have not been in Nebraska recently but I have been in South Carolina recently where we are trying, with the State, some different ways of delivering adult day care, for example; that we are using the Medicare system and the Medicaid system, sometimes in combination to try different approaches to health care.

That is precisely what we ought to be doing in an innovative way, trying to fit these programs together with Governors, within regions sometimes, so that they work better and so that we get more bang for the buck in the business sense.

Mr. CHRISTENSEN. I guess, Ms. Shalala, that we are talking about here, the advisors, and I am not so much in disagreement that we are going to go ahead and put together a plan.

Now, we would like to have your input. We would like to have a dialog so that we can work on together in a bipartisan fashion, but thus far, from what I have heard from your answers, it has been quite a one-sided discussion. We pretty much know your pat answers. What we would like to do is work together as much as we can and that is why I threw out the idea of what ideas would you have to come to the table with, and I guess this is a start. Thank you for your testimony here today.

Mr. THOMAS. The gentleman's time has expired. Mr. Portman will inquire.

Mr. PORTMAN. I thank the Chairman. Isn't this nice? We are at the lower rung, everybody is gone, the cameras are turned off. Now we can roll up our sleeves and really get into it.

Mr. THOMAS. Have her whisper her answer.

Mr. PORTMAN. I won't tell anybody.

During your budget presentation, you and I had a dialog about Medicare. At the time, you indicated you were looking forward to working with those of us on this panel who thought that not addressing Medicare in the budget was irresponsible, that based on the magnitude of the program, its cost increases, it couldn't be ignored, and is probably the single largest budget buster. I am disappointed, as are many of my colleagues, that we do not have a more forthcoming dialog yet. I hope we will get to that point.

Just very briefly, one of my colleagues, I wish he were here, Mr. Stark, said that, he wants us to stew in our juices for awhile, that he thought the program, and I quote him, "has been running right well." You know the statistics very well, but I think we have a need to back up maybe for purposes of the bigger picture for a minute.

In 1975, Medicare was at $12 billion. Now, it is at about $178, $180 billion. This past month, CBO told us that the figure is going to be $345 billion in 7 short years, by 2002, which is a $167 billion increase. That is a huge budget issue.

In addition to that, of course, we have the HI Trust Fund solvency issue in 7 years, and no more money to pay the beneficiaries. Whether you deal with it as a budget issue—broad-based budget issue or as a trust fund issue, we have a crisis and we need to resolve it. I would hope that with the administration, we can at least set some targets.

You told us when you came forward on the budget, you thought Medicare was going to be increasing at 10, maybe up to 11 percent per year over the next 5 years. As we all know, that is unacceptable. Perhaps we should start with saying, let's get our Medicare funding within a reasonable range over that 5-year period or 7-year period, maybe it is 7 percent, maybe it is 6 percent, maybe it is 8 percent, but I would hope we could agree on some targets and then work together in a constructive way to address it.

I am at a loss on the logic of not sitting down with us until we do a budget. I do not know if that means you want us to do Medicare in the budget or you do not want us to do Medicare in the budget. We can go back and forth on that, but I am disappointed and I hope we can work on together.

Let me ask you a couple specific questions, if I could.

We started to get into some specifics. It is my view that you pretty much shot down the means testing idea, the HMO issue. As you indicated, there is sort of full HMO coverage now and there is fee for service now. Many of us have talked about something in between, a PPO, preferred provider organization, or some other kind of provider.

Secretary SHALALA. Come forward with one.

Mr. PORTMAN. If, you are continuing to be interested in that, this may be an area we can work together.

How would this notion of continued employer coverage, where you would have the employer providing managed care now and under some arrangement through the government would be able to continue that same managed care under Medicare? How do you feel about that idea?

Secretary SHALALA. I think, Congressman, all of the issues that you are talking about, the additional HMO ideas, PPOs, point-of-service options, are things that we have been working on for quite awhile and have introduced some new—have tried to get some better coverage. We are clearly interested in the competition idea. It is difficult to do. It has required a major conceptual effort within the Department. All of the above ought to be part of our discussions as we sit down on a bipartisan manner so we can fill you in on all of the things we are already doing.

What I wanted to do was send a clear message that we are not locked into the old Medicare fee-for-service plan. The President said from the moment we walked in that this program has to get some discipline, we have got to provide some other options, we have to preserve choice, we have got to look at more efficiencies. We have collapsed our computer system. We have done all sorts of things, so——

Mr. PORTMAN. Specifically, then, you are not discounting the notion of an employer link, sort of a continuous service from the employer in some way?

Secretary SHALALA. I am not discounting anything, and as we see what is happening to people moving into Medicare—into HMOs, for example, clearly those who are currently in HMOs are interested in staying in their HMOs and working out these transitions ought to be part of the discussions that we are having.

Mr. PORTMAN. One other question, if I could. I do not want to lose my time here. Again, I think you are right. The continuing on makes sense. More and more Americans are used to managed care now and I think it would be easier to have them adjust to that at the Medicare level.

Medical savings accounts, Congressman Ramstad wanted to ask you about that. How do you feel about that? How much impact is it going to have on the Medicare population? An idea, as an example, would be for people to save tax free over time, during their working life, and then have that available upon retirement to draw from. They would be required to have some sort of catastrophic plan as well. What is your reaction?

Secretary SHALALA. When I testified earlier on medical savings accounts, I raised questions about whether we were not, in fact, taking the healthier and wealthier folks out of the health care system and setting them up separately. There is some evidence that we may be paying too much in terms of what our contributions are, and I think that we have had some very deep concerns about medical savings accounts. Creaming off part of the population is not the way to solve the health care crisis in America, and that is why it has to be part of a broader discussion.

Mr. PORTMAN. I thank you.

Mr. THOMAS. The gentleman's time has expired.

Mr. PORTMAN. I wish we had another hour or so. I thank the Chairman.

Mr. THOMAS. The gentleman from Nevada will be the last inquirer, I would tell the Secretary.

Mr. ENSIGN. Thank you, Mr. Chairman. Just a couple of quick questions. What does the administration see as the fundamental underlying problem with the growth of Medicare spending?

Secretary SHALALA. Well, the problem with the growth of Medicare spending——

Mr. ENSIGN. Or the cost. The cost.

Secretary SHALALA [continuing]. Is similar to what is happening in the private sector. It is the introduction of new technology. It is——

Mr. ENSIGN. The volume of services?

Secretary SHALALA [continuing]. For the Medicare population in particular, it is health inflation. I mean, it is the growth of health care costs.

The point I was making is that the growth in health care costs in the private sector is similar to what is happening in the public sector for very vulnerable populations. It is also, as we get better treatment, it costs us more in health care. Unlike other parts of the economy, if you have a technological breakthrough, it doesn't necessarily save you money.

Mr. ENSIGN. You are talking volume of services basically; that is the fundamental underlying problem?

Secretary SHALALA. The increase in population, too, and we have talked about the demographics.

Mr. ENSIGN. That is going to get much worse obviously with the baby boomers.

Earlier you and Mr. Matsui were in an exchange about cost shifting to the private sector. I guess one of the things that I want to get straight here, and then we need to get past this rhetoric, is that the private sector, the last couple of years, has done better than the public sector.

You are asserting that the public sector over the last 10 to 15 years has done as well, if not better, than the private sector as far as controlling its costs or how fast they are increasing their services. The cost shifting that Mr. Matsui was talking about, has that contributed to the private sector's increase in cost in your statistics?

Secretary SHALALA. It has, to the extent—Medicaid, in particular, where we clearly do not pay as much as we should.

Mr. ENSIGN. Medicare is the cost shifting I am talking about.

Secretary SHALALA. In Medicare, there is some cost shifting that is going on. What we do not want to do is produce more cost shifting by slashing the budget.

Mr. ENSIGN. No. I agree with that. My point is that in your statistics, when you were trying to defend the public health care system, Medicare basically, you were saying that it did as well or not better than the private sector, but yet we have been shifting costs to the private sector because of some of the reforms that have been done in this Congress; is that not true? That contributes to those statistics. OK, I just wanted to establish that. You agree?

Secretary SHALALA. No, I can't agree with that.

Mr. ENSIGN. We have not shifted costs to the private sector from Medicare?

Secretary SHALALA. It is not clear at this moment that the—that—it is clear that the private sector has been squeezing down, there is no question about it.

Mr. ENSIGN. Wait a second. We are talking about shifts of costs to the private sector from Medicare.

Secretary SHALALA. Yes.

Mr. ENSIGN. You have said, you were exchanging with Mr. Matsui, that we had shifted the cost to the private sector from the public sector in terms of Medicare.

Secretary SHALALA. I think that——

Mr. ENSIGN. You disagree with that now?

Secretary SHALALA. My point was to Mr.—I thought Mr. Matsui was asking me about cuts in the—dramatic cuts in the Medicare system.

Mr. ENSIGN. Correct, which shifted costs to the private sector. I am saying, were those taken into account in your statistics the total spending in the private sector? Do you understand what I am saying?

Secretary SHALALA. Yes, I understand what you are saying.

Mr. ENSIGN. It skews the statistics is all I am trying to say.

Secretary SHALALA. Well, it could be going both ways, though, Mr. Ensign. There is some evidence now, and some of the hospitals have indicated this, that Medicare has become the better payer, so that there may be some cost shifting going back the other way. To give you a precise answer at this point in time is very difficult.

Mr. ENSIGN. OK. Let me get to this, to a further definition, and that is, if a company saves dollars in a particular program, they have efficiencies through management techniques, technologies, and the next year they actually spend less money on one particular program than they did on that previously, do you define that as a cut or savings?

Secretary SHALALA. True efficiency, I would count it as savings, not——

Mr. ENSIGN. OK. So in Medicare, if we are able through efficiencies, through management techniques, through whatever we are able to do, to save money, is that going to be defined by the administration as a cut or savings?

Secretary SHALALA. It depends on the impact it has on quality, whether we are cutting out benefits in the process.

Mr. ENSIGN. That is what I am saying. I am saying delivering the same quality, through more efficient means. That would be considered a savings?

Secretary SHALALA. That would be counted a savings, if we could maintain quality and benefit coverage.

Mr. ENSIGN. If that savings is applied to the deficit or whatever it is, is that calling a cut in Medicare to apply to the deficit? Is that the way the administration will define it?

Secretary SHALALA. I would hope that we would be very precise in what changes we thought we could make in whatever the public system was, and the difference between changes that will save us money and maintain quality and changes that actually will reduce benefits, reduce coverage and increase costs to other parts of the health care system.

Mr. ENSIGN. I agree with that. I just want to make sure that we are precise in our definition and credit goes to savings and not called a cut. We have to distinguish between cuts and savings, because in the past, there have actually been cuts in Medicare, where in the future, hopefully, some of the things we are going to be doing will be savings, like American business. American business has transformed itself so that it can save money in some of its programs.

Thank you, Mr. Chairman. Thank you for your testimony.

Mr. HOUGHTON [presiding]. Mr. Neal will inquire.

Mr. NEAL. Thank you very much, Mr. Chairman.

As always, I want to welcome you here, thank you today, Madam Chairperson. I thought one of the purposes of these hearings in the form of this setting was to allow the panelists to answer the questions. I know you haven't been given that opportunity this morning. Generally, as you have asserted yourself, somebody has interrupted you to state another opinion, but we do thank you and welcome you here in the true spirit of what these hearings are supposed to be about.

Secretary SHALALA. Thank you.

Mr. NEAL. I would like to offer you an opportunity for a constructive opinion as well. The panacea that is being suggested in the halls of the Congress today, is we simply herd everybody into HMOs or managed care, that at the end of the day, we will recognize and witness considerable cost savings in Medicare.

Is that your understanding of the program if it were to be initiated on that basis? Would you care to, at least from a conceptual view, offer a suggestion at this time?

Secretary SHALALA. We believe that choice is absolutely critical to the Medicare system that—and that we ought to continue choice and that people ought not to be shoved into HMOs. There is no evidence thus far that there would be huge savings from putting large numbers of people into HMOs.

While there have been some initial savings which have been identified, most people believe it is because of the first group that went into HMOs from Medicare actually were a healthier group. We have to be extremely careful as we add—as more people choose HMOs not to assume that there will be substantial cost savings in the short—in the short run, or even in the long run, and I think both the administration and the CBO and other health care experts are being very careful in their language not to promise something that we are not sure initially that we can deliver.

That does not mean in any way we do not think people ought to have choices of HMOs or that we shouldn't make reforms in the system to make it more efficient, to bring down unnecessary utilization, and to be very hard-nosed about our administration of the program. We simply do not wish to overstate the effect of moving millions of people into HMOs in this country.

Mr. NEAL. Just a quick followup to that. Would you suggest that if we were to proceed down that road, that it ought to be done on an experimental basis?

Secretary SHALALA. Well, we have, as you know, increased the number of options available to senior citizens. Seventy-five percent of the Medicare population now has access to HMOs. The ones that do not actually live in rural areas where there are no HMOs. We think in addition to what we already have, we ought to have point-of-service options and some PPOs, but there ought to be more choices out there, and that those choices ought to, if possible, improve the efficiency of the system.

Mr. NEAL. Thank you. I have a quick anecdote to share. Yesterday morning, I went along to get a cup of coffee and there were some booths, and in three successive booths three different couples said to me, do not let them touch Medicare, do not let them destroy our Medicare system; and, indeed, at the end of the day we are counting on folks like you if we have to make changes, make changes, but certainly we intend not to let them destroy the system. Thank you.

Secretary SHALALA. Thank you very much, Congressman.

Mr. HOUGHTON. Madam Secretary, you have been through a real wringer this morning. Do you have time for one more inquiry from Mr. McDermott?

Secretary SHALALA. I do indeed.

Mr. HOUGHTON. OK. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman. I just want to set the record straight, I think, for—the Secretary has talked about the need for the budget resolution and why it is there. The President produces a budget, and he has done that. He has presented it to us. Then the Congress, by law, is required by the April 15 to produce a budget.

Now, last year the House passed the budget resolution on March 11. The year before it was on March 18. On the year before, when Mr. Bush was President, he presented his budget, and then the House Democrats produced their budget resolution by March 5. That is almost a month-and-a-half, and then the year before that, it was April 17.

Now, it is clear that when we go to make major cuts, we have had the budget resolution before us so that we know what we are doing, and when one reads the Speaker's comments from yesterday where he was asked about the use of Medicare savings, he says, "I know nothing, go ask Tony Blankley."

Now, that simply suggests that you are in an impossible position to react to this, but I want to ask a question that really troubles me, and that is this: Senior citizens, 63 percent of them, live on—substantially on Social Security. That is the major source of their income.

Now, this seems like really a hidden tax on them, and I wonder, where do the additional costs get picked up if you have already cut Medicaid? It seems to me that it is going to come out of the pockets of their children or there is going to be an increased debt in the system. Is that a fair analysis of what is going to happen if we do not pay at the Medicare level?

Secretary SHALALA. Well, I think that in real life for so many of our senior citizens who lived on fixed incomes it means less money available for food, to pay for housing and to pay for other things. Already they spend 21 percent of their income on average for health care, and passing on to them additional health care costs puts them clearly in a very difficult situation. We do not want to do that.

Recognizing who the program serves is very important as we think through what can we do to make it better, to make it more efficient, to keep our promises at the same time, but simultaneously to understand the impact that these large public expenditures have on the budget.

Mr. MCDERMOTT. In the present situation, if they have additional out-of-pocket costs and they are of low income, it is picked up by the Medicaid Program.

Secretary SHALALA. It is picked up by Medicaid from there.

Mr. MCDERMOTT. Are you guaranteeing the Medicaid Program will still have the capacity to pick up this increased out-of-pocket costs?

Secretary SHALALA. I cannot do that because of the conversations that are going on about the Medicaid Program in this country and the discussions going on in terms of capping it or block granting it, so the States would struggle with more limited resources and would have great difficulty handling the shift of costs that would come from Medicare recipients.

Mr. McDERMOTT. The States could choose in that block grant not to cover the out-of-pocket costs for senior citizens in their Medicaid; is that correct?

Secretary SHALALA. As I understand the kinds of recommendations, talking about it would be up to the State unless Congress mandated they pick up those costs.

Mr. McDERMOTT. For my mother and father, my mother 85, my father 89, living on Social Security, if they have additional out-of-pocket costs, it either comes out of their Social Security check or they turn to my brothers and my sister and I to pay for it; is that the alternative?

Secretary SHALALA. That is essentially what happens in real life in the United States.

Mr. McDERMOTT. This will accelerate that process, in your view?

Secretary SHALALA. It will accelerate that process.

Mr. McDERMOTT. Thank you very much.

We appreciate your testimony today. You have done a very fine job.

Mr. THOMAS. Madam Secretary, we appreciate your testimony. Although we engage in debate, what may or may not happen in the interaction between Medicaid and Medicare is precisely what we were trying not to do, but rather deal with realities.

Thank you very much for your generous time.

Next, we will have June O'Neill, Director of the Congressional Budget Office.

Director O'Neill, any written testimony you have will be made a part of the record, and you may proceed as you see fit to inform this Committee about this question from the Congressional Budget Office perspective.

STATEMENT OF JUNE E. O'NEILL, DIRECTOR, CONGRESSIONAL BUDGET OFFICE

Ms. O'NEILL. Mr. Chairman and Members of the Committee, it is my pleasure to be here today to testify on the financial status of the Medicare Program. Unfortunately, the financial liability of Medicare is currently eroding, primarily because of continuing growth in the cost of providing coverage to each beneficiary.

If left unchecked, this trend will create a problem of major proportions when the baby-boom generation begins to reach retirement age in 2010.

The 1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund, released last month, indicates that under intermediate assumptions, the Hospital Insurance Trust Fund, that is, the HI Program, will be depleted in 2002 unless changes in policy are made.

Even under the trustees' most optimistic assumption, the HI Trust Fund will be exhausted by 2006, which is just 11 years from now.

CBO finds ample reason to agree with the broad conclusions of the trustees regarding the short-range adequacy of HI funding. These projections of HI insolvency address only part of Medicare's overall financial outlook. It is well to keep in mind that the, SMI, supplemental medical insurance, which pays for physician and out-

patient services for Medicare beneficiaries, is also experiencing rapid growth in costs.

The Medicare Program is absorbing a growing share of the Nation's resources, and is expected to constitute 3.5 percent of the gross domestic product by 2005. Moreover, as the baby-boom generation reaches retirement age, the number of workers available to support each HI enrollee is projected to drop.

Currently, about four covered workers support each HI enrollee, but this ratio will decline rapidly after the turn of the century. Only two covered workers will be available to support each enrollee by midcentury. That demographic change will cause a continuing deterioration in the financial situation confronting Medicare and the Social Security program.

The evidence strongly supports the conclusion of the trustees that prompt effective and decisive action is necessary by the Congress to avert a financial crisis in the Medicare Program.

CBO projects that under current law, Medicare expenditures in HI and SMI combined will increase from $181 billion in 1995 to $463 billion in 2005. That reflects an average rate of growth of 9.8 percent a year.

Consequently, under current law, outlays for Medicare's share of Federal outlays will increase from 11 percent in 1995 to 16 percent in 2005.

Most of the projected increase in Medicare spending over the next 10 years can be attributed to rising medical prices and increases in the use of services. Beneficiary growth, however, will be slow as the baby-bust generation retires. The elderly population is growing slowly now, much more slowly than that which will come later.

The financial instability of the HI Trust Fund has been evident since 1992 when HI outlays first began to exceed income from the payroll tax.

HI outlays will begin to exceed all sources of income to the program in 1996. As a result of a continuing annual deficit in the HI account, the balance of the HI Trust Fund will erode each year, and by 2002 it will be depleted. In that fiscal year, according to CBO's assumptions, total HI income would be $153 billion, and the total amount in the trust fund at the beginning of that year would be about $16 billion. But projected outlays for the full year equal $199 billion; that would leave a shortfall of $30 billion.

Thus, without congressional action to provide additional financial resources the HI Program would be unable to pay for all the services that Medicare beneficiaries are expected to receive in 2002.

The rate of growth in Medicare's costs has caused concern almost from the program's inception. The Congress has made repeated attempts to slow that growth, including developing a prospective payment system for hospitals, changing the physician payment system, and allowing beneficiaries to enroll in HMOs. Those efforts have met with limited success.

A key question is whether Medicare can take advantage of managed care savings. Since 1985, Medicare enrollment in risk-based HMOs has grown steadily, although at 7 percent it is still very low compared with the privately insured population.

In 1992, almost 20 percent of people with private insurance were in HMOs. Currently, Medicare beneficiaries pay no more to enroll in fee-for-service Medicare than they do to enroll in a HMO. They often receive supplementary benefits, such as reduction in cost-sharing or prescription drug coverage if they enroll in a HMO.

They would have to pay a substantial premium for Medigap coverage to receive these benefits in the fee-for-service sector. For some Medicare beneficiaries, the financial incentives appear to be outweighed by the desire to choose physicians outside the HMO network. Others may not enroll in managed care programs simply because they are unaware of all the options available to them.

In the future, however, both stronger financial incentives to beneficiaries and better information will be necessary to encourage more Medicare enrollees to sign on for managed care programs.

Despite apparent evidence that the overall cost of services used by Medicare beneficiaries falls when they move from the fee-for-service sector to a HMO, higher HMO enrollment does not reduce Medicare's costs, and it may even increase them under Medicare's current payment system.

This effect occurs—and it is complicated partly because HMOs are paid 95 percent of Medicare's fee-for-service cost to provide care to a beneficiary, regardless of the actual resource cost of the services provided to the HMO.

Many analysts attribute the recent slow down in the rate of growth of private health insurance spending to more aggressive price competition among health programs. Between 1990 and 1993, private health insurance spending grew at an average annual rate of 7.7 percent, compared with 11.2 percent for Medicare.

As it is currently structured, the Medicare Program cannot take advantage of the recent competitive developments in the private health care market. If nothing is done and Medicare continues to grow at its current rate, the program will consume an increasing share of the Nation's resources. In part, that outcome reflects improvements in health services for the elderly, but it also raises concern about efficient resource allocation.

If Medicare absorbed less of the Nation's output, more could be spent on investment to improve the productivity of current and future workers. Moreover, a growing economy could be more dependably counted on to pay for the benefits of current and future retirees.

Fixing Medicare's financing problems will not be easy. As the reports of the trustees make clear, the problems begin in the short term and will only escalate in the long term as the baby boomers start to retire.

Either taxes must be increased or expenditures reduced or both, and the orders of magnitude involved are large. The tax alternative taken in isolation would require an increase in the HI payroll tax of 1.3 percentage points. That is a more than 40-percent increase over the next 25 years to ensure that HI financing covers program costs.

However, while an increase in the HI payroll tax would secure the HI portion of Medicare outlays, it would do nothing to secure the funding of SMI or to improve the overall efficiency of the Medicare Program.

There are two broad approaches for achieving slower growth of Medicare outlays, budgetary reductions and program restructuring. The two approaches are not mutually exclusive. With or without a tax increase, a combination would probably be needed to achieve immediate savings and longer term goals.

Examples of budgetary reduction options are included in CBO's 1995 report, "Reducing the Deficit: Spending and Revenue Options." They represent a traditional approach to containing Medicare costs. Such options which typically reduce payments for providers or raise the amounts that beneficiaries must pay, can offer immediate short-term savings in the Medicare Program. They are not necessarily designed to improve the efficiency of the program or to address the underlying long-term structural problems of spending growth.

Slowing the long-term rate of growth of Medicare spending and ensuring the solvency of the HI Trust Fund will probably require a major restructuring of Medicare. Three basic tenets underlie most redesigned proposals. One is that Medicare beneficiaries would have meaningful choices among a range of health plans, including fee-for-service options.

Two, beneficiaries would also have financial incentives to select efficient health plans.

Three, health plans would have strong incentives to compete for Medicare beneficiaries.

Several possible models for structuring the Medicare Program along those lines have been proposed. Frequently, competitive market approaches offer participants more choices and clearer financial incentives to choose less costly options.

A key feature of these approaches is the notion of Medicare making a defined contribution on behalf of each beneficiary. Participants could then put those contributions toward the cost of a health plan of their choice.

Beneficiary choice and limits on the government's contribution, for example, are important elements of the design of the existing health insurance program for Federal employees.

A competitive redesign of Medicare is a possible strategy for addressing the fiscal problems of the program. Establishing a competitive system could be a major undertaking requiring time to develop. Moreover, full implementation all at one time could be difficult, a phased-in approach starting with younger Medicare beneficiaries might be more feasible.

For these reasons, a structural change could not be counted on to deliver substantial immediate savings, although considerable savings might well accrue as time goes on.

One thing is certain, postponing decisions on Medicare's financing will only make the necessary policy actions in the future more severe. Without a tax increase, ensuring that the HI Trust Fund remains solid will require immediate spending cuts as well as reductions in the underlying rate of growth of spending.

Any delay will require more dramatic cuts and program changes in the future.

Thank you.

I would be happy to take any questions you may have.

[The prepared statement follows:]

STATEMENT OF JUNE E. O'NEILL, DIRECTOR
CONGRESSIONAL BUDGET OFFICE

Mr. Chairman and Members of the Committee, it is my pleasure to be here today to discuss the financial status of the Medicare program. Continuing growth in the cost of providing Medicare coverage to each beneficiary, coupled with a steady increase in the number of beneficiaries, is eroding the financial viability of the program. If left unchecked, those trends will create a problem of major proportions when the baby-boom generation begins to reach retirement age in the year 2010. Addressing the short-term and long-term financing problems of the Medicare program presents a serious challenge for the nation.

The *1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*, released last month, indicates that under intermediate assumptions, the Hospital Insurance (HI) Trust Fund will be depleted in 2002. In other words, unless changes in policy are made, the HI program will only be able to pay fully for services provided to beneficiaries for about the next seven years. Indeed, even under the trustees' most optimistic assumptions, the HI trust fund will be exhausted by 2006--11 years from now.

Based on the Congressional Budget Office's (CBO's) analysis of the trustees' projections and our independent analysis of the Medicare program, we find ample reason to agree with the broad conclusions of the trustees regarding the short-range adequacy of HI funding. But those projections of HI insolvency address only part of Medicare's overall financial outlook. The Supplementary Medical Insurance (SMI) program, which pays for physician and outpatient services for Medicare beneficiaries, is also experiencing rapid growth in costs.

Moreover, the Medicare program is absorbing a growing share of the nation's resources. Combined spending for HI and SMI has increased from 0.8 percent of gross domestic product (GDP) in 1974 to 2.4 percent of GDP in 1994. It is expected to increase to about 3.5 percent of GDP by 2002. Program revenues, however, are not increasing nearly as rapidly. The evidence strongly supports the conclusion of the trustees that "prompt, effective, and decisive action is necessary" by the Congress to avert a financial crisis in the Medicare program.

My statement today covers four topics:

- An overview of the Medicare program,
- Trends in program spending and in the trust fund balance,
- Medicare's cost containment measures to date, and
- Options for responding to the fiscal crisis in the Medicare program.

OVERVIEW OF THE MEDICARE PROGRAM

Medicare is the nation's major program providing medical services to the elderly and disabled populations. It offers two different types of insurance coverage, which are financed and administered separately.

The Hospital Insurance program pays for inpatient hospital care and related care for people 65 and older and for the long-term disabled. Payroll taxes primarily finance the program, with the taxes being paid by current workers and their employers. Those tax receipts are mainly used to pay for benefits to current beneficiaries. Income not currently needed to pay for benefits and related expenses is credited to the HI trust fund. In 1994, the HI program covered about 32 million aged and about 4 million disabled enrollees at a cost of $103 billion.

The Supplementary Medical Insurance program pays for physician and outpatient services. Although it is optional, most individuals eligible for Medicare enroll in SMI. Currently, premiums paid by enrollees finance about 31 percent of SMI program costs. But that share is projected to decline significantly under current law--to 25 percent in 1996 and lower after 1998. General revenues finance the remaining costs. The SMI program is not intended to accumulate funds for the payment of future benefits. In 1994, the SMI program covered about 31 million aged and about 4 million disabled enrollees at a total cost of $60 billion.

Payroll tax rates for the HI program are set at 1.45 percent of taxable earnings each for workers and their employers. However, the consensus among economists is that most of the tax charged to employers is indirectly paid by workers, whose earnings are ultimately reduced by the amount of the employer's contribution. Self-employed workers pay 2.9 percent of taxable earnings. No cap is placed on taxable earnings subject to the HI payroll tax. In 1994, approximately 141 million workers (and their employers) paid $92 billion to the HI trust fund.

As the baby-boom generation reaches retirement age, the number of workers available to support each HI enrollee is projected to drop. Currently about four covered workers support each HI enrollee. The trustees project that this ratio will decline rapidly early in the next century. They expect that only two covered workers will be available to support each enrollee by mid-century.

TRENDS IN SPENDING AND THE TRUST FUND BALANCE

In 1994, the Medicare program spent $162 billion, including both HI and SMI. Between 1985 and 1994, Medicare expenditures increased at an average annual rate of 9.6 percent. Under current law, CBO projects that Medicare spending will continue to grow at a similar rate, rising from $181 billion in 1995 to $463 billion in 2005. That increase represents an average annual rate of growth of 9.8 percent. By contrast, cash benefits for Social Security recipients will increase at only about half that rate.

Inflation in medical prices and increases in use of services account for most of the projected rapid increase in Medicare spending. Medicare enrollment of the elderly and disabled combined is projected to increase at an average annual rate of only slightly more than 1 percent over the 1995-2005 period.

CBO projects that Medicare will absorb a growing share of the federal budget over the next 10 years. In fact, under current law, outlays for Medicare (net of SMI premiums) will increase from 11 percent of federal outlays in 1995 to 16 percent of outlays in 2005.[1] Medicare and Medicaid are the fastest growing of the major entitlement programs, and as such, they are major contributors to the escalating budget deficits that face the country.

The Medicare trustees report 75-year projections of the financial status of the HI trust fund. Projections made by the trustees of the adequacy of HI funding to support program costs in the future are based on three alternative sets of assumptions about future economic and demographic trends: low-, intermediate-, and high-cost. Under their intermediate-cost assumptions, the HI trust fund will be exhausted in 2002.

According to the trustees, HI outlays began to exceed income from the payroll tax in 1992. They project that HI outlays will begin to exceed all sources of

1. Those estimates assume that discretionary spending rises with inflation after 1998.

income to the program (including interest on the trust fund balance) in 1996. As a result of that annual deficit in the HI account, the balance in the HI trust fund will begin to erode, and by 2002 it will be depleted.

CBO's projections of the HI trust fund balance only cover the 1995-2005 period. Those projections support the trustees' estimates concerning the depletion of the HI trust fund in 2002. Moreover, CBO's analysis provides ample reason to agree with the broad conclusions of the trustees regarding the short-range adequacy of HI funding.

It is useful to consider what trust fund depletion in 2002 means for the operation of the HI program. Under current-law assumptions, HI payroll taxes would continue to be collected from all covered workers (and their employers) throughout the year. According to CBO's assumptions, total HI income in fiscal year 2002 would be $153 billion. The total amount in the trust fund at the beginning of that fiscal year would be about $16 billion. Projected disbursements for the full year equal $199 billion. Consequently, the HI program would have a shortfall of $30 billion in fiscal year 2002. Thus, without some Congressional action to provide it with additional financial resources, the HI program would be unable to pay for all of the services Medicare beneficiaries are expected to receive in that year.

MEDICARE'S COST CONTAINMENT MEASURES TO DATE

The rate of growth in Medicare's costs has caused concern almost from the program's inception. The Congress has made repeated attempts to slow that growth, but with limited success.

Early efforts, in the 1970s, relied on price controls and relatively weak utilization review programs. It became apparent, however, that much of the potential savings to Medicare from price controls was lost, offset by an increase in the volume or intensity of services provided despite utilization review. Subsequent cost control efforts sought to introduce mechanisms that focused not just on price but on spending--the product of service price and volume.

The prospective payment system (PPS) for hospital services was established in 1984 to replace retrospective cost-based reimbursement. Under the PPS, hospitals are paid a fixed amount for each inpatient case, based on the patient's diagnosis. Under that payment system, hospitals are given strong incentives to avoid unnecessary services during a patient's stay and to discharge patients as soon as possible, since extra services or days in the hospital would increase hospitals' costs but not their reimbursement from Medicare. By contrast, under the previous payment system, Medicare paid hospitals for the costs of whatever services they provided.

Changes in the physician payment system were implemented in 1992 to replace charge-based reimbursement for physicians' services. The new system includes an explicit fee schedule along with an updating mechanism intended to generate lower fee increases when growth in the volume of physicians' services is large. Unlike the earlier changes in the hospital payment system, these changes did little to alter incentives for physicians. The method of setting fees was changed, but it remains a fee-for-service system that rewards physicians for providing more services.

One can see some indication of the effects of those changes for hospital and physician payment in the fee-for-service sector by comparing the rates of growth in Medicare's spending by service category for different time periods. Between 1985 and 1990, the rate of growth in Medicare's total costs was nearly half the rate for the preceding decade--annual growth of 9.0 percent, down from 17.1 percent. That

slowdown was mostly the result of sharply lower growth for hospital inpatient costs over the five-year period immediately following implementation of the prospective payment system. The growth rate for hospital inpatient spending rose somewhat after 1990.

By contrast, the freezes on and cuts in physicians' fees that took place during the latter part of the 1980s had little effect on the growth rate in spending for physicians' services because those measures were largely offset by an increase in the volume of services. Although the rate of growth in physicians' costs was lower between 1990 and 1995 than it had been before the fee schedule and its volume-based update system were introduced, the slowdown may reflect the low level at which the initial rates under the fee schedule were set. Projections for the 1995-2000 period assume a return to pre-1990 rates of growth.

Another significant change to Medicare during the 1980s was development of a mechanism whereby health maintenance organizations (HMOs) could enroll Medicare beneficiaries on a risk basis--receiving a capitation payment from Medicare for each enrollee. Until then, HMOs were able to serve Medicare enrollees only on a cost basis--a payment system not consistent with the way HMOs operate. Since 1985, Medicare enrollment in risk-based HMOs has grown steadily, increasing more rapidly than private-sector HMO enrollment has since 1989. Nevertheless, Medicare's risk-based HMO enrollment rate is still low--at 7 percent--compared with the privately insured population. In 1992, almost 20 percent of people with private insurance were in HMOs.

Currently, Medicare beneficiaries pay no more to enroll in fee-for-service Medicare than to enroll in an HMO. They often, however, receive supplementary benefits--such as prescription drug coverage and waiver of cost-sharing requirements--for little or no extra premium if they enroll in an HMO, whereas they pay a substantial premium for medigap coverage to receive those benefits in the fee-for-service sector. For some Medicare beneficiaries, those financial incentives appear to be outweighed by the desire to be able to choose physicians outside the HMO's network. Others may not enroll in managed care plans simply because they are unaware of all the options that are available to them. In the future, both stronger financial incentives and better information would be necessary to encourage more Medicare beneficiaries to enroll in managed care plans.

The most effective HMOs share the insurance risk for enrollees with their providers, thereby reversing or counteracting the incentive providers have to provide unnecessary services that is characteristic of the fee-for-service sector. As a result, an HMO's cost of caring for a given patient is generally lower than the costs incurred by an indemnity plan in the fee-for-service sector.

Despite apparent evidence that the overall resource cost of services used by Medicare beneficiaries falls when they move from the fee-for-service sector to an effective HMO, higher HMO enrollment may have the perverse effect of increasing Medicare's costs--not lowering them--under Medicare's current payment system. That effect occurs for two reasons. First, risk-based HMOs are paid 95 percent of Medicare's fee-for-service cost to provide care to a beneficiary, as measured by the average adjusted per capita cost (AAPCC). That link to fee-for-service costs means that Medicare pays a fixed capitation amount for each Medicare beneficiary enrolled in an HMO, regardless of the actual resource cost of the services provided. Second, Medicare's capitation rates do not fully adjust for the generally healthier group of people who are likely to choose the HMO option compared with those who remain in fee-for-service, nor do they account for the greater efficiency of managed care. If the service costs are lower than the capitation amount, Medicare does not recover any of the savings. The fee-for-service link also means that Medicare payments to HMOs

would increase if per capita costs in the fee-for-service sector rose, even if HMO per capita costs fell.

Medicare's HMO enrollment could generate savings, however, if the method of setting capitation rates was changed. A number of possible alternatives exist. But significant savings would not be generated unless the payment link between fee-for-service and managed care was broken. One way to break the link would be to allow the capitation rates to be set by competitive bidding in areas with enough HMOs to make that approach viable. That market-based approach could encourage stronger price competition among Medicare risk-based HMOs in a market area. However, generating more savings for the Medicare program could reduce the additional benefits that HMOs currently offer to beneficiaries, blunting incentives to enroll in HMOs.

Many analysts attribute the recent slowdown in the rate of growth of private health insurance spending to more aggressive price competition among health plans. Between 1990 and 1993, private health insurance spending grew at an average annual rate of 7.7 percent compared with 11.2 percent for Medicare. As it is currently structured, the Medicare program cannot take advantage of the recent competitive developments in the private health care market.

OPTIONS FOR RESPONDING TO THE FISCAL CRISIS IN MEDICARE

If nothing is done and Medicare continues to grow at its current rate, the program will consume an increasing share of the nation's resources. It will also continue to be a major cause of the rising federal budget deficit and the increasingly burdensome federal debt. Those outcomes raise concern about the efficient allocation of the nation's scarce resources and about the long-run prosperity of the nation. If Medicare absorbed less of the nation's output, more could be spent on investment to improve the productivity of current and future workers. Moreover, a growing economy could be more dependably counted on to pay for the benefits of current and future retirees.

Fixing Medicare's financing problems will not be easy. As the reports of the trustees make clear, those problems are of both a short-term and a long-term nature. Either taxes must be increased, expenditures reduced, or both, and the orders of magnitude involved are large. (A third approach that is sometimes suggested to address shortfalls in the HI trust fund would be to transfer funds to it from the Old-Age and Survivors Insurance (OASI) trust fund. That strategy, however, would merely postpone rather than address the funding shortfall and would hasten the depletion of the OASI trust fund.)

The tax alternative, in isolation, would require an increase in the HI payroll tax of 1.3 percentage points--more than 40 percent--over the next 25 years to ensure that HI financing covered program costs. Although such an increase in the HI payroll tax would secure the HI portion of Medicare outlays, it would do nothing to improve the overall efficiency of the Medicare program.

Two broad approaches would achieve slower growth in Medicare outlays: budgetary reductions and program restructuring. Those approaches are not mutually exclusive. With or without a tax increase, a combination of them would probably be needed to address Medicare's immediate and longer-term financing problems.

Budgetary reductions--exemplified by the options included in CBO's 1995 report *Reducing the Deficit: Spending and Revenue Options*--represent the traditional approach to containing Medicare's costs. Such options, which typically lower payments for providers or raise the amounts that beneficiaries must pay, offer immediate short-term savings in the Medicare program. Although both types of

policies are likely to be part of a more thorough reform of Medicare, they are not necessarily designed to improve the efficiency of the program or to address the underlying long-term structural problems of spending growth.

Slowing the long-term rate of growth of overall Medicare spending and ensuring the solvency of the HI trust fund would probably require major restructuring of the Medicare program. Three basic tenets underlie most redesign proposals: Medicare beneficiaries would have meaningful choices among a range of health plans, including a fee-for-service option; beneficiaries would also have financial incentives to select efficient health plans; and health plans would have strong incentives to compete for Medicare beneficiaries.

Several possible models for restructuring the Medicare program along those lines have been proposed. Frequently, such competitive market approaches offer beneficiaries more choices and clear financial incentives to choose less costly options. A key feature of those approaches is the notion of Medicare making a defined contribution on behalf of each beneficiary. Beneficiaries could then put those contributions toward the cost of the health plan of their choice. Beneficiary choice and limits on the government's contribution are important elements of the design of the health insurance program for federal employees.

A competitive redesign of Medicare is a possible strategy for addressing the long-term fiscal problems of the program. Major restructuring, however, would take time to develop and could not therefore address the short-term financing issues. Establishing a competitive system could be a major undertaking. Moreover, full implementation all at one time would be difficult; a phased-in approach, starting with younger Medicare beneficiaries, might be more feasible. But potential savings would accrue more slowly under that approach.

One thing is certain: postponing decisions about Medicare's financing will only make the necessary policy actions in the future more severe. Without a tax increase, ensuring that the HI trust fund remains solvent will almost certainly require immediate spending cuts as well as reductions in the underlying rate of growth of spending. Any delay will require more dramatic cuts and program changes in the future.

Mr. THOMAS. Thank you very much, Director.

Ms. O'Neill, we have heard testimony from people who have said we have been there before and do not worry about it, things will somehow work themselves out.

In fact, in your testimony you indicated that at one time the outlays exceeded income, in 1992, and once again will reach the tip point in 1996.

I do not think anyone has really directly addressed the problem if we do nothing.

If, in fact, the Congress and the President do not agree on what you have described as what I would call relatively far reaching and fundamental changes to Medicare, what would happen in 2002 and into 2003, if we do nothing and we play out this funding scenario, what would actually occur?

Ms. O'NEILL. If no legislative action was taken at all, in that year—according to our projections, and we agree substantially with the trustees—the trust fund would be depleted, which means that there would not be enough financing to cover what expenditures are likely to be in that year.

Mr. THOMAS. But what would happen?

Ms. O'NEILL. What would happen? I guess either some emergency infusions would have to be made at that point or spending would be cut off. Some type of rationing would have to occur at that point.

Mr. THOMAS. Since we have a relatively short lead time, and I guess in these areas actuaries would tell us a 6- or 7-year lead time is a relatively short lead time, decisions postponed really do have a significant impact on our options, isn't that true?

Ms. O'NEILL. That is true. You know, as I mentioned, the longer we wait, the spending proceeds will increase at a much higher rate than one might wish, making the problem harder to deal with. The longer you wait, the deeper the cuts you all have to make when you get there.

Mr. THOMAS. All of us are aware that the baby boomers are coming into a retirement period. That is going to affect the Social Security, OASI, Old-Age and Survivors Insurance, Fund. It is going to clearly affect the Medicare Fund. My understanding is that the wave, that demographic structure really will not hit the HIF, Hospital Insurance Fund, in the timeframe that we have been discussing. Is that accurate?

Ms. O'NEILL. We are talking about the easy years. The deficit in the trust fund account is growing and will, therefore, be depleting the trust fund. This is occurring during a slow period when the Depression babies and World War II babies are coming to retirement age. The baby-bust cohort was a very small one.

Mr. THOMAS. We have several problems in front of us, not just a short-term funding problem but the long term problem of the demographic shift that we would have to deal with. Is it possible in terms of the models that you have been looking at to make adjustments in this short-term period that will also help us in that demographic longer term problem period?

Ms. O'NEILL. The kinds of budgetary changes that would lead to expenditure reductions in the programs outlined in our options book are things that could be done right away. Significant savings

could be obtained in the short run. One could think of that as something that you might use in a transition period.

If the Congress and the Nation were to move toward a restructuring, many of those provisions would not be needed. They would be eclipsed by more systemic changes that would result in more efficient behavior on the part of providers, as well as, individuals making choices about their own medical care.

Mr. THOMAS. A fundamental restructuring of Medicare, getting it more into what seems to be a model that is occurring in the private sector, will not only help us in the short run, but will help get us ready for that more significant funding problem in later years?

Ms. O'NEILL. I meant, that the fundamental restructuring would probably take time, but in the transition one could use some of these short-range changes and presumably the particular bundle of immediate cost savings that were selected would be ones that would be helpful in leading to a major restructuring.

Mr. THOMAS. In the past, most often adjustments have been in adjusting formulas for providers. If we continue to do that, would that offer us a solution to our current funding program problem?

Ms. O'NEILL. It really hasn't worked very well in the past. Usually past history gives you some idea of what you can expect in the future.

In the past, Medicare problems seemed to be able to be resolved fairly easily. That was done in the context of a period when the retirement of the baby-boom population was not looming on the horizon, and it was started when the initial HI tax rates seemed very low. One could raise that and increase the tax base. We have gone those routes so that now there is no cap on the taxable earnings for HI program.

Mr. THOMAS. In fact, we have gone further than the Social Security Trust Fund payroll tax which has a cap on it.

Ms. O'NEILL. That is right.

Mr. THOMAS. You are saying we have gone to that well so frequently that we have removed all caps on income and it is simply then a factor of increasing the percentage of payroll tax. Do you have any estimates of what increase might be required of the payroll tax?

Ms. O'NEILL. The increase would be about 40 percent, somewhat more than a 40-percent increase in the HI tax rate. That is a 1.3 percentage point increase.

Mr. THOMAS. Forty-percent increase would cover us for the foreseeable future?

Ms. O'NEILL. No. I believe that is for the coming 25 years.

Mr. THOMAS. Thank you very much.

Mr. English will inquire.

Mr. ENGLISH. Thank you, Ms. O'Neill.

Following up on the last question, reviewing the report of the trustees, is it not true that without fundamental reform, payroll tax rates would have to triple to sustain the current Medicare Program long term.

Ms. O'NEILL. Through what period of time?

Mr. ENGLISH. This would be going out to the middle of the next century.

Ms. O'NEILL. That could well be because the problem is explosive. I could supply that for the record, but more than a 40-percent increase is needed for the first 25-year period. It would be significantly greater later on when the rate of increase in the elderly population is extraordinarily large.

Mr. ENGLISH. Thank you, Ms. O'Neill.

Can the Medicare Program as it is currently structured take advantage of managed care savings, and if not, why?

Ms. O'NEILL. The problem here stems from a number of factors that are quite complicated.

From the beneficiary's side, the incentive to go into a HMO is not exactly the same as it would be for private persons who face an array of costs and choose among the plans on the basis of the real costs of providing those resources.

In Medicare, the cost to the beneficiary is the same. The main difference would come from provision of services that might be offered by a HMO. Presumably it costs the HMOs less to provide the care because the managed care system allows them to take advantage of factors that a fee-for-service plan cannot. Those cost savings can't really be passed on.

A big factor there is that HMOs are paid 95 percent of the cost of a fee-for-service plan. It is not based on the actual costs. Even if it were, that would not be revealed to the beneficiaries.

You really do have an odd system. You can offer HMOs. More of the elderly have been moving into HMOs, possibly because many retirees have been in a HMO before and are used to the concept. Also, because HMOs do not compete in price, and their lower costs makes it possible to provide supplementary benefits, such as prescription drugs, no copayments, no deductibles, things of that sort.

Mr. ENGLISH. Ms. O'Neill, if we do not restructure the Medicare Program and we reduce spending growth through traditional budgetary approaches, in your view, what will be the likely result?

Ms. O'NEILL. I am sorry, I didn't——

Mr. ENGLISH. If we do not restructure the program as it is now and we reduce spending growth through the traditional budgetary approaches like we did during the eighties, in your view, what will be the likely result?

Ms. O'NEILL. There are a couple of changes that may have produced some reductions in the rate of growth, for example, the prospective payment system that is now used for the payment of inpatient services in hospitals. Of course, some of those may be shifted every time you try to control provider charges in some way. That is probably a better way because it doesn't allow for inpatient services. If it were just charges—the daily charge that was controlled—there would always be the option of increasing services. That controls the whole bundle in a prospective way, and it does appear to be a slow down in patient services, but it led to more outpatient services which are not controlled, and increasing use of home health care and other services that may be covered.

That is the reason we do not get very big savings; because most of the kinds of things that you can think of within the current system are forms of price controls.

Mr. ENGLISH. Thank you, Ms. O'Neill. I find your testimony to be substantive and nonpartisan, and as such, an edifying contrast with our last witness.

Mr. THOMAS. Mr. Portman will inquire.

Mr. PORTMAN. Thank you, Mr. Chairman.

Thank you Ms. O'Neill for your being here.

Is this your first appearance before the Committee?

Ms. O'NEILL. Yes, and I am happy to be here.

Mr. PORTMAN. Welcome before the Committee. We are very pleased to have you at CBO, and be so knowledgeable about this program, which I said earlier is the budget buster because of the magnitude of it and escalating costs that you outlined so well in your statement.

I have just a couple of questions, can you give us a sense as to the relationship between taxes paid and benefits received?

Often in the debate on Social Security we get into this discussion with our constituents, at least I do, and I would like to get a sense of what current Medicare recipients have paid in, versus what they are projected to get out on an average basis, and if you could look down the road some period of time, if you have that information, 10 years, 20 years.

Ms. O'NEILL. Well, in the HI Program——

Mr. PORTMAN. I am talking about HI.

Ms. O'NEILL [continuing]. Essentially, taxes paid by current workers provide most of the funding for the program.

Mr. PORTMAN. Which is true with Social Security as well, but the beneficiaries have also paid in a certain amount over their working life and——

Ms. O'NEILL. Yes.

Mr. PORTMAN [continuing]. Benefits, can you give us a sense of that?

Ms. O'NEILL. Payroll taxes right now bring in about $100 billion. There is also income from the taxation of benefits. Income from the trust fund accounts for less than one-third of the total that is needed to pay outlays. Outlays in 1995 run about $114 billion. So, it is mostly coming from payroll taxes of current workers.

Mr. PORTMAN. If you could provide, in writing, to the Committee, information as to current beneficiaries, that would be most helpful. In other words, the average beneficiary today given that person's life expectancy, whether that person indeed will draw more in benefits, and if so, how much more as compared to how much that person would have paid in payroll taxes under the HI Program over that person's working life. That would be very interesting for me and I think for other Committee Members.

If you could do a comparison with Social Security, I think we have it from the Social Security Subcommittee, but that would be very interesting to see just to contrast those programs.

[The following was subsequently received:]

On average, people turning 65 this year will contribute about $32,000 (in present value terms) over their lifetime to the costs of their Medicare coverage through payroll taxes during their working years and supplementary medical insurance premiums. They will use about $95,00 in Medicare benefits.

My second question would be what do you view as the larger problem, the impending bankruptcy of the HI Trust Fund? I know

you address this in your statement, of sort of the baby boomer crossing of the demographic lines, which does not occur before 2002, but in fact would occur at some later point. Which of these two problems do you see as the most pressing? I ask that question because our approaches might be guided by that.

Ms. O'NEILL. I think the next 10 years is a pretty big problem, and if you do not resolve the problem now, one thing leads to another.

I think the longer one waits, the harder it is to do anything about it. It is a problem now, but will be a worse problem in the future.

Mr. PORTMAN. Given the kinds of solutions that we have been talking about, even here today, some of which are longer term solutions, it seems to me we should get started now to address that demographic shift, where instead of four workers per retiree, where you indicated possibly two within 40 or 50 years.

Ms. O'NEILL. That is right, there is that.

Mr. PORTMAN. Again, thank you very much for your statement again. We look forward to working with you on this and other issues.

Mr. THOMAS. Mr. Cardin will inquire.

Mr. CARDIN. Thank you, Mr. Chairman.

Ms. O'Neill, let me also welcome you. CBO has had a rich bipartisan tradition with this Committee, and we look forward to you building on that tradition with CBO.

If I might clarify a couple points that have been previously raised; if I understand your testimony based upon your projections, the HI Trust Fund would run into a shortfall in fiscal year 2002 of $30 billion?

Ms. O'NEILL. That is right.

Mr. CARDIN. That is based upon no changes in the current funding system relating to the revenues or expenditures.

Ms. O'NEILL. These estimates are made on the basis of current law, so that doesn't assume any legislative change.

Mr. CARDIN. You have not put into these calculations the impact of the Contract With America on repealing the tax that went into the HI Fund on the part of the Social Security income?

Ms. O'NEILL. Only legislation that has passed, so it includes the current tax on Social Security recipients' benefits.

Mr. CARDIN. Chairman Thomas asked Secretary Shalala when the trust fund would run into trouble if that particular change would have come into law. The information that we have, I believe from you—it could have been from Joint Tax—it was a $26 billion loss of revenue over 5 years.

Ms. O'NEILL. It accelerates the depletion of the trust fund by 1 year.

Mr. CARDIN. One year. The statement is correct that there would be a 1 year difference in which the fund would go into depletion, 2001 rather than 2002?

Ms. O'NEILL. That is correct.

Mr. CARDIN. Thank you for that clarification.

Let me also clarify the point Mr. Collins raised earlier, because I think it should be clarified in the record. It is true the HI is a trust fund. The funds can only be expended for Medicare purposes.

If, in fact, we were to change the law so that HI produced surpluses and did not go into deficits, what impact would that have on the budget of the country as far as the deficit of the overall budget?

Ms. O'NEILL. It depends on how that was done.

Mr. CARDIN. If we were to just increase the revenues, or reduce the spending in Medicare so that the HI Fund ran surpluses, what impact would that have on the overall budget?

Ms. O'NEILL. Literally anything that you do to reduce expenditures in any program would contribute toward deficit reduction.

Mr. CARDIN. Even though the moneys can only be spent in Medicare, the fact we reduce Medicare spending reduces the overall deficit of the country?

Ms. O'NEILL. The way we figure the budget deficit is that, we figure the net deficit, we do not count the surplus.

Mr. CARDIN. Unless there is an understanding that the Medicare savings will not be used for deficit reduction, the way the current bookkeeping of the Federal Treasury is managed, a Medicare savings would be used for overall deficit reduction.

Ms. O'NEILL. To the extent that they are blended. The way it is currently figured, that would be true; what is called the net budget.

Mr. CARDIN. I say that for Mr. Collins' benefit, because you can't separate under our current way that we budget, the Medicare HI Trust Fund from the overall budget considerations unless there is some understanding as to how the Medicare cuts are being handled.

I just wanted to underscore the point that on April 15, we were supposed to have the budget. Without having the budget before us, it is impossible to know how Medicare is being calculated within the overall budget situation by the Republican leadership. I just wanted to clarify this point for Mr. Collins, and maybe others. If we run surpluses in the trust fund, it impacts the deficit and could be used to help finance the tax cut.

That is what concerns many of us on this side of the aisle.

Thank you, Ms. O'Neill.

Mr. THOMAS. Thank you very much.

Apparently, this is a debating point that obviously is going to go back and forth.

When you said, "extend it by a year," does that mean 12 months, since all of us know 12 months is 1 year. Frankly, if you look at the total dollar amounts we are dealing with, it couldn't possibly extend it for 1 full year. It might tip it from one fiscal year into the next by several months, but my understanding, and the understanding of most people watching, is that 1 year is 12 months.

Are we prepared to say that the extension of this particular program, which you have estimated at $26 billion, which Joint Tax has estimated at $15.6 billion over a 5-year period, is really 1 year as was stated?

Ms. O'NEILL. No, it is not. It is probably not a full year. The tax, as you say, is small per year. It is raising something like three, four, maybe up to——

Mr. CARDIN. Would the Chairman yield to clarify?

Mr. THOMAS. I would say that near the end of the Secretary's testimony, the Secretary indicated it would shorten it by some

months. I believe the Secretary was accurate in her last statement in regard to this issue, that it would shorten it for some months.

Mr. CARDIN. Would the Chairman yield?

Mr. THOMAS. Certainly.

Mr. CARDIN. I appreciate that.

The 5 years under CBO's projections cost the HI Fund $26 billion. If after 7 years we are going to be insolvent at $30 billion, it seems to me we could easily project that by the seventh year the loss in the HI Trust Fund revenues would exceed a full year's deficit or at least fiscal year 2002's deficit. Therefore, the $30 billion that you had projected in 2002, in fact, would not be there.

Ms. O'NEILL. I haven't followed everything that you have said but——

Mr. THOMAS. The point is that there is quite possibly some projected capability to cross once again a fiscal year structure. It seems to me that this is exactly the thing that we shouldn't be arguing, whether it is 6 months, whether it is 9 months, whether it is a year. That is no solution.

The gentleman from Nevada.

Mr. ENSIGN. No questions.

Mr. THOMAS. Does the gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON. I am sorry I had to miss your testimony. I wanted to welcome you here, and I appreciate your comments, which I did skim.

I did want to inquire in a general sense, one of the things that has been a difficulty in the past has been that the reorganization of the delivery system in health care has been moving so rapidly that it is hard to get good numbers on which one can predict any reduction in costs; in other words, by the time you have numbers they are outdated in terms of the pace of change in today's world.

Are you going to be able to work with us on those issues, look at the pace of change and the pace of cost savings when a company has gone from nonmanaged care to managed care, where an area of the country has gone from nonmanaged care to managed care, to help us understand the impact of seniors moving into integrated care systems on Medicare costs?

Ms. O'NEILL. We certainly would be. What you say is quite true, that it is very difficult to get data, partly because the changes have really been happening very fast. For example, I do not think that we know for sure what proportion of people in private health plans are in HMOs. This year, 1995, we do not know that.

We have some idea based on particular insurers who have provided some information, but that is only partial, it doesn't cover the whole United States. It takes a number of years. Our firmest data are actually for 1992.

Mrs. JOHNSON. For instance, in California where now managed care is a larger proportion of the care structure than any other State, we are beginning to see evidence that the slowing of growth in the health care costs in the private sector has also affected health care cost growth in the public sector.

While those figures are in a sense theoretical, nonetheless, they may indicate a trend.

We are going to have to look at some of those kinds of things. The fact that some of the most efficient providers in the State of California, like Kaiser, are seventh or eighth on the efficiency list, have to be looked at, and we have to look at what the implications will be for the future if we achieve that kind of thing.

In other words, we may have to project out on the basis of a different level of experience or different kind of experience rather than the data we have collected that are always 2 years old.

Ms. O'NEILL. There is considerable uncertainty because of these changes, in constructing our projections. We have worried about these issues and we feel that for both Medicare and Medicaid there probably is a larger degree of uncertainty about what will actually happen, in part because changes have been rapid.

In the Medicare Program, the managed care situation is not really the same as that which exists in the private sector. In the private sector you could safely assume that the reason that people are moving rapidly into managed care plans is that the plans cost less and people believe they are getting more for their money.

How much that would translate into for an elderly population is truly not known. There is a presumption that that could be true, and there is some evidence that that is true, but we do not know for sure.

One of the benefits of a private situation is that you do not have to guess what will be provided and what people will do, because you know that the situation really establishes itself. People do what is to their best advantage. That is not the way the Medicare system is currently structured. That can't really happen.

Mrs. JOHNSON. It might be necessary to have a number of projections, if that percentage moved, that would be the outcome, if this percentage moved, this would be the outcome, and if this percentage made that choice, this would be the outcome. So that we at least understand a fiscal implication of various choices within the senior community in terms of choosing a more even integrated system of care.

Ms. O'NEILL. That is true.

Mrs. JOHNSON. Thank you.

Mr. THOMAS. Mr. McCrery will inquire.

Mr. MCCRERY. Thank you, Mr. Chairman.

Mrs. O'Neill, I have some questions about the budget and how Medicare fits into the budget, kind of following up on Mr. Cardin's questioning.

Let's skip to part B Medicare for a minute. As I understand it, part B Medicare is subsidized, if you will, by general revenues, to the tune of about 70 percent, 70 to 75 percent.

Ms. O'NEILL. Yes.

Mr. MCCRERY. What is the mechanism by which we divert general revenues to make up the difference in part B, is that not an annual appropriation?

Ms. O'NEILL. The program is an entitlement so that there is a kind of trust fund—not exactly in the same sense as HI, since it is not a trust fund that accumulates. There is a trust fund and it also is a mandatory program so that spending is not appropriated.

Mr. MCCRERY. Not appropriated annually, we just by law say we will spend whatever it takes to make good the Medicare Part B Trust Fund.

Ms. O'NEILL. Premiums cover about 30 percent and the rest comes from general revenues.

Mr. MCCRERY. What about part A? If we were to reach 2002 with no changes and suddenly the trust fund is insufficient to pay the dependents of part A, is there some automatic mechanism that would fall into place to mandate that general revenues be used to supplement the trust fund money to make good on part A?

Ms. O'NEILL. I do not believe there is. It would require legislation. Of course, legislation could also put in an infusion from general revenues. That would require a change in the law.

Mr. MCCRERY. Even though Medicare Part A is also an entitlement, there is nothing——

Ms. O'NEILL. It has the complicated structure of an accumulating trust fund. I could check that further. Maybe I shouldn't be so quick to speak.

Mr. MCCRERY. I do not know either——

Ms. O'NEILL. I do not believe there is any automatic authority to use general revenues to pay for the HI expenditures.

Mr. MCCRERY. If that were the case, then at such time as we reached a negative balance in the trust fund and do not have to pay obligations under part A, that providers would go without payment if no further action were taken by the Congress?

Ms. O'NEILL. Or services would be rationed in some fashion. It is hard to say.

Mr. MCCRERY. OK. Right now, we have a positive balance in the trust fund; is that correct?

Ms. O'NEILL. Yes, that is true.

Mr. MCCRERY. Isn't that trust fund balance covered in the unified budget calculation?

Ms. O'NEILL. The trust fund balance is counted in the sense that it offsets. Not the trust fund accumulation. It is the incoming tax dollars that are earmarked for the trust fund that is in fact merged with other revenues when we calculate the net budget deficit. Not the funds in the trust fund. Those are really parenthetical to the budget calculation.

Mr. MCCRERY. Any interest that the trust fund earns would be counted as income?

Ms. O'NEILL. It is counted as income.

Mr. MCCRERY. OK.

When you get right down to it, Mr. Cardin and the Majority last year, or 2 years ago, chose to shore up the, if you will, the Medicare Part A Trust Fund by increasing taxes on Social Security recipients; is that correct?

Ms. O'NEILL. That is correct.

Mr. MCCRERY. We are saying there ought to be a better way to shore up that trust fund and make Medicare Part A pay for itself and that we choose not to raise taxes on Social Security recipients to do that. We choose some other way—which might be cutting spending in some other program or making programmatic changes in Medicare, but certainly, in our view, it was not a wise thing to do to raise taxes on Social Security recipients. Really, when you get

down to it, we are all searching for ways to make this trust fund viable past 2002. We just may disagree on which particular method to use to do that.

Mr. THOMAS. The gentleman's time has expired.

Mr. Levin will inquire.

Mr. LEVIN. I hear you, and the challenge is to spell out a better way.

Remember that you are digging the hole deeper if you repeal the tax on benefits—there have been savings from proposals spelled out by Ms. O'Neill that were initiatives from Republican administrations, regulating both hospital and physician reimbursement.

Anyway, Ms. O'Neill, welcome. I thought your testimony was really candid.

As mentioned, you have a great tradition in which you follow. We have had your predecessors come here and they have rather successfully walked the line and not let partisanship twist their testimony. That is true of this testimony. I congratulate you on it.

Could I ask in that regard a couple of questions about your comments on managed care?

Before I do that, do you know offhand, if not, maybe you could supply us, what percentage of the projected increase in Medicare expenditures in the next years would come from increased numbers of beneficiaries, and which would come from projected increases in hospital/physician costs?

Ms. O'NEILL. About 80 percent of the increase comes from increases in expenditures per beneficiary, and about 20 percent from increases in the number of beneficiaries. It is approximately of those orders of magnitude.

Mr. LEVIN. If you want to just—as you do recheck figures, and if there is any basic change in that, let us know?

[The following was subsequently received:]

CBO estimates that increases in caseload—that is, the number of beneficiaries—will increase Medicare spending by about 10 percent between 1995 and 2002. That estimate does not take into account possible changes in the demographic composition or health status of the beneficiary population.

Mr. LEVIN. Let me ask you about your testimony on managed care, because clearly there is increased discussion about there being more managed care in Medicare, and I think it is worthy of discussion as long as nobody thinks we are just finding an easy answer there.

You talk about it in your prepared statement. You say in the future both stronger financial incentives and better information would be necessary to encourage more Medicare beneficiaries to enroll in managed care plans. You go on to say that higher HMO enrollment may have a perverse effect of increasing Medicare costs not lowering them under Medicare's current payment system.

Then you take that issue right on, and there you say, but significant savings would not be generated unless the payment link between fee-for-service and managed care was broken.

Give us a clue how we would break that? I know mechanically how we would do that, but how would we implement a breakage in that linkage?

Ms. O'NEILL. It is very difficult under the current system because it is not a market system. It is essentially a fee-for-service system. In terms of the beneficiaries the cost is the same.

On the other hand, there must be some mechanism whereby the Federal Government could benefit from cost savings that HMOs actually incur.

Mr. LEVIN. But how would we——

Ms. O'NEILL. It has been suggested that one thing we could do would be to have competitive bidding on the part of HMOs. That is a change that could be implemented, instead of pegging it to 95 percent of the cost of the fee-for-service plan. Operating regionally, HMOs could bid and presumably the ones that could provide the same quality service for less would be the ones that would be awarded the HMO contracts.

Mr. LEVIN. I think you point out on page 12, there is a potential catch-22 in that. Because you say, however, generating more savings, theoretically, the program could reduce the additional benefits that HMOs currently offer to beneficiaries, blunting incentives to enroll in HMOs.

Ms. O'NEILL. That is right. On one side, you have generated a way that the Federal Government Medicare Program could actually receive some of the savings. But you have not done anything on the other side, because there is no way for the beneficiary to benefit by going into the HMO.

Now, although the dollar amount is the same, there are fewer costs attached to a HMO because it has room to add such features as not charging deductibles or providing free drugs.

Mr. LEVIN. Thank you.

Mrs. JOHNSON [presiding]. Thank you, Mr. Levin.

Mr. Houghton, it is your opportunity.

Mr. HOUGHTON. Just a very quick question.

Mrs. JOHNSON. I think we will be able to finish this very quickly.

Mr. HOUGHTON. Ms. O'Neill, good to see you, thanks very much.

One specific thing the Secretary stressed over and over again this morning was that you cannot take Medicare in isolation from the other health plans of both the public and private sector. I want to sort of ask you how you feel about that, because if I remember correctly, during the seventies and eighties when there were all sorts of health care programs, DRGs and things like that, the government really through Medicare moved way ahead of the private sector. The private sector really floundered. Then in the late eighties and early nineties, it sort of flipped.

As I look at the figures here that came out of the Annual Report of the Federal Hospital Insurance Trust Fund, that—and comparing those to the private sector, really, the government expenditures after the growth rate is about two times what the private sector is. The whole thing changes. Since we are running out of money, this thing has happened. It is different from what happened to the last generation.

I just wonder whether this isn't something we have to fix now rather than worrying about the totality of the private and public health programs?

Ms. O'NEILL. I do not think there is any question that Medicare is posing a problem right now. It seems to us, technically, it really

does have to be fixed because something negative will happen if it is not.

In the past few years it is true that private-sector spending has grown more slowly than Federal programs.

Mr. HOUGHTON. In effect, in terms of prioritizing this, you would fix Medicare and then at a later time go on to some of the other programs?

Ms. O'NEILL. I can't really comment on that, you know.

Mr. HOUGHTON. All right, thanks very much.

Mrs. JOHNSON. However, I would ask you to clarify your response. What I hear my colleague from New York saying is that in the early eighties, we made big changes in Medicare with hopes that it would affect the private sector, which to some extent it did. I mean, the DRGs came to cover reimbursements in the private sector as well as the public sector and initially that system did cut costs.

That indicates that it is perfectly possible to reform Medicare without reforming all of health care and the private sector as well and have some good effect on the Medicare problem. Is it not so?

Ms. O'NEILL. I believe that is true. I haven't fully followed or seen an argument that spelled out what that linkage is perceived to be, so it is hard for me to comment on it.

Mrs. JOHNSON. I think it is relevant to this hearing that the linkage has never been clearly defined, and in fact, past practice has recognized that while there is a linkage, it still is possible to reform one section of the economy without reforming the whole economy, or one section of a sector without reforming every section of that sector. I think that the implications of my colleague's comment was really in harmony with history, and I hear you not contradicting—not dissenting from that.

Ms. O'NEILL. As best I can tell, it looks as if it should be possible to do something to improve Medicare.

Mrs. JOHNSON. We only have 5 minutes. We do have to adjourn to vote and the next panel will convene. I would just ask you all, so if you would get back to me in writing any work that CBO has done on analyzing the Medicare premium from the perspective of what portion of it pays for seniors' health care costs, what portion of it pays for medical education in terms of percentage, and what portion goes to uncompensated care.

The other piece is any analysis you have done on all the different components that support medical education in America, because I want to get a better handle on those things.

Ms. O'NEILL. We do have those numbers. I would be happy to provide them.

[The following was subsequently received:]

The SMI, supplementary medical insurance, premium pays for about 31 percent of average SMI costs for an elderly beneficiary in 1995. Those costs include only medical benefits (97 percent of SMI outlays) and administration (3 percent of SMI outlays). All of Medicare's payments for medical education an uncompensated care are part of hospital insurance outlays. Direct and indirect medical education payments together account for about 5 percent of HI outlays, and disproportionate share payments account for about 3 percent of HI outlays.

Mrs. JOHNSON. Thank you very much and thank you for your testimony.

Ms. O'NEILL. Nice to be here.

[Recess.]

Mrs. JOHNSON [presiding]. If the panel will be seated, some Members have returned and others will be along shortly and we will proceed.

Mr. Ross, senior partner, Arnold & Porter, and public trustee of the Federal Hospital Insurance Trust Fund, you are welcomed to be with us. We appreciate you being here and you will open. After you, David Walker, partner, worldwide managing director of compensation and benefits, Arthur Andersen, another public trustee of the Federal Hospital Insurance Trust Fund; and then Guy King, consulting actuary, Ernst & Young, chief actuary of the Health Care Financing Administration.

We appreciate the opportunity to share your thoughts about a problem that really affects people of all ages, not just the seniors, but all of their families as well.

Mr. Ross.

STATEMENT OF STANFORD G. ROSS, SENIOR PARTNER, ARNOLD & PORTER, WASHINGTON, DC; AND PUBLIC TRUSTEE, FEDERAL HOSPITAL INSURANCE TRUST FUND

Mr. ROSS. Thank you, Madam Chairman, and Members of the Committee. We appreciate the opportunity to appear before you to testify on the 1995 trust fund reports. Mr. Walker and I have provided you a statement as public trustees and in order to maximize the value of our limited time before the Committee, I would ask that you enter our statement into the record and then Mr. Walker and I would like to each make some remarks on our own behalf.

Mrs. JOHNSON. Without objection.

Mr. ROSS. The public trustees are a part-time position and we act to represent the public interest in the preparation of these reports; and although I was appointed to the Democratic seat and Mr. Walker to the Republican seat by President Bush, we have operated through both a Republican and Democratic administration on what we believe is a nonpartisan basis.

We have made all of our statements jointly and we have had total accord in what we have reported over the 5 years, and my desire today is to emphasize some historical aspects of the long-term effort to adapt the Social Security and Medicare Programs to changing economic and social conditions, drawing particularly on my experience as Commissioner of Social Security in the late seventies and as a public trustee the last 5 years.

When viewed in historical perspective, the long-term financing problems of these programs that are before us today are not recent occurrences and the solutions are likely to be complicated to conceive and difficult to enact.

The Social Security Program was first enacted by the Congress in 1935 in a limited form. The program expanded slowly over the next 37 years and, in fact, did not reach full maturation until the amendments of 1972.

The Medicare Program was enacted in 1965. Although a Federal health care program was considered in 1935, only after some 30 years did such a program get enacted and then only for the elderly and disabled as a logical expansion of the Social Security system.

The extraordinary prosperity of the postwar period from 1945 to, roughly, 1972 allowed benefits to be expanded and the elderly to share in the economic success of the immediate post war period. The result of the matured Social Security Program and the Medicare Program was to remove many elderly from poverty and generally to enhance the security and well-being of workers who were disabled or retired.

However, beginning shortly after 1972 with the oil shock, stagflations and the more unsettled circumstances of the seventies, the Social Security system reflected the economic and social stresses of the time. It became clear that changes were necessary to adapt the program to these changed circumstances and those projected for the future. Thus major retrenchments in the program came in the form of amendments in 1977 and 1983. On each occasion, the Congress on a bipartisan basis, in a complex package of structural changes, both raised payroll taxes and reduced benefits in the interest of providing long-term financial stability to the program.

The Medicare Program was subject to a series of cost containment enactments in the eighties and has repeatedly been the subject of congressional concerns over the past decade. Many changes were enacted with the cooperation of Democratic Congresses and the Republican administrations of Presidents Reagan and Bush.

I believe it is clear from even this briefly capsulized history that it is entirely possible, indeed absolutely necessary, to successfully adapt the Social Security and Medicare systems to changing circumstances, and in particular, to the social and economic conditions that are anticipated to prevail in the next century.

However, the key to accomplishing needed changes is to make programmatic changes, that is, changes in which the programs are reformed on their own terms to provide long-term financial stability for them. History shows that changes proposed essentially to achieve deficit reduction or as part of any kind of a legislative program that is not perceived to preserve and maintain these programs for the benefit of not just current beneficiaries, but workers who will become beneficiaries in the years ahead, do not fare well.

In my judgment, deficit reduction and Social Security and Medicare reforms, which are both vital priorities for the nation, can best be achieved when pursued independently of each other. Bipartisanship and developing a broad consensus for change is essential to successfully adapting the Social Security and Medicare systems. I firmly believe that the problems these programs presently face are serious and need to be addressed promptly.

Perhaps the most important step we can take right now is to find ways for people of all persuasions to work together to bring these programs into long-term financial stability, for looking at history almost assuredly tells us that a complex package of structural changes will be needed that involves both benefit reductions and revenue increases, and construction of this package will require a great deal of goodwill and trust on the part of many people in our country.

Finally, I would submit that despite the difficulties in the last 20 years in achieving needed adaptations, our present Social Security and Medicare Programs have continued to serve the country well.

It is my strong belief that the Social Security and Medicare Programs are fundamentally sound and it is vital to the welfare of the nation in the 21st century that they be adapted now in ways to keep them sound in changing circumstances. By making relatively small changes soon and gradually, more radical disruptive changes can be avoided.

I will be happy to answer any questions you may have about either our statement submitted for the record or my personal testimony today. I thank you once again for the opportunity to appear before you and commend you for your sincere commitment in holding these hearings and trying to provide leadership vital to achieving needed reforms.

Mrs. JOHNSON. Mr. Walker, do you have a separate statement?

Mr. WALKER. That is correct.

Mrs. JOHNSON. Thank you.

STATEMENT OF DAVID M. WALKER, PARTNER, WORLDWIDE MANAGING DIRECTOR OF COMPENSATION AND BENEFITS, ARTHUR ANDERSEN LLP, ATLANTA, GEORGIA; AND PUBLIC TRUSTEE, FEDERAL HOSPITAL INSURANCE TRUST FUND

Mr. WALKER. Madam Chairwoman, Members of the Committee, I understand that each of the Committee Members have been provided with a copy of our latest joint public trustees' statement, therefore, I will focus my remarks on certain matters which, for the most part, go beyond our joint statement and present and represent my personal views.

These remarks are my personal views as an informed and concerned private citizen who also happens to be a former public trustee of the Social Security and Medicare Trust Funds, a former Assistant Secretary of Labor of Pension, Health and Welfare Programs, and head of the Pension Benefit Guaranty Corporation

In my opinion, when viewed on a combined basis, our current Medicare and Social Security Programs promise significantly more than this Nation can reasonably be expected to deliver in the next century, given known demographic trends, projected health care costs, the current national debt, projected fiscal budget deficits, the projected financial imbalances in the Social Security and Medicare Programs and other factors.

At the same time, the nature, timing, and magnitude of the projected financial imbalances facing the Social Security—namely the OASI and DI—and the Medicare, the HI and SMI Programs, are distinctly different. Clearly the projected financial balance in the HI Program is our most serious and immediate concern, since the projected cost rate for this program far exceeds the projected income rate, and the HI Trust Fund is projected to become exhausted in 2002.

Furthermore, the HI Trust Fund will start to experience a negative cash flow in 1996 and, in fact, already passed its peak of financial ratios. In other words, the highest trust fund balance was achieved in 1992 and we have been going downhill since then.

In addition, the projected escalation in health care costs for both the HI and SMI Programs is both alarming and unsustainable. These escalating costs were caused by a variety of factors, includ-

ing certain uncontrollable factors, such as the increasing dependency ratio and longer lifespans.

As Mr. Ross and I have stated in our last several public trustee statements, in fact the last three, the Medicare Programs, in their present form, are clearly unsustainable. In my opinion, these programs are in need of fundamental and dramatic reform. This includes reviewing who is covered, what benefits are provided, how they are provided, and how the programs are financed.

There is little question in my mind that the incremental and cost shifting approaches of the past have about been played out. In addition, while additional long-term savings can and should be achieved by more aggressive use of managed care approaches and tougher enforcement, these initiatives may result in more cost than savings in the short term. In addition, these actions alone will not come close to solving the long-term financing problems of the current Medicare Programs.

In my opinion, while the current Medicare Programs may have been appropriate and affordable in 1965, they clearly will not be in the next century. This opinion is based upon a variety of factors, such as known demographic trends, escalating health care costs, existing health care coverage gaps, the current tax treatment of health care benefits, the projected financial condition of Medicare Programs, the relative financial well-being of the elderly as compared to other cohort groups, the current national debt and fiscal budget deficits.

As a result, the time has come to reengineer our Medicare Programs in a manner that is fair, fiscally responsible, and economically rational. We must also assure that the reengineered programs are financially sound and sustainable over the longer term. Even fundamental reexamination of the Medicare Programs should preferably—I underline the word "preferably"—be pursued within the context of more comprehensive health care reform.

Practically, given the significance of the reforms that will be needed, we will have to pursue incremental reforms, conducting a major education public campaign and then pursue more comprehensive and dramatic health care reform on a bipartisan basis. Any broader health care reform initiative should include reviewing and reconsidering appropriate roles of government, employers and individuals in the provision and financing of health care, including reconsidering all current health care tax preferences.

This broader reform initiative should also focus on what individuals need and what our Nation can afford, rather than on what benefits are currently being provided and what additional benefits individuals want. After all, there is no free lunch, and to the extent that these programs are not self-sustaining or otherwise affordable, they will only serve to further mortgage our children's future and increase existing expectation gaps.

Importantly, a failure to effectively address escalating health care costs and the financial imbalance in the Medicare Programs in a timely, effective manner will have serious long-term economic and intergenerational consequences. We must have the courage, the vision, and the commitment to deal with the fundamental imbalance in the Medicare Programs and our other health care related challenges in a timely, comprehensive, and most importantly,

nonpartisan manner. Delay will only serve to increase the difficulty and the severity of any related changes.

In addition, failure to effectively address the financial imbalance in the Medicare Programs will likely have long-term adverse implications for the Social Security Program as well since Congress has had a history of redirecting funds from the better financed programs in the short term to the less well financed programs.

The most recent example is the transferring of the tax revenues achieved from increasing the amount of Social Security benefits subject to income inclusion from 50 percent to 85 percent from the OASI Trust Fund to the HI Trust Fund. This served to help the HI Trust Fund and hurt the OASI Trust Fund. In my opinion, that type of action is inappropriate.

In summary, as an informed and concerned private citizen and a father of two, I am extremely concerned that this Nation faces a number of looming crises, including a retirement and intergenerational crisis. We must have the courage, the vision and the commitment to deal with these looming crises in a timely, effective, and nonpartisan manner. Doing so is critical to the long-term competitive posture and economic security of this Nation, the economic security of our children and grandchildren, and the retirement security of American workers and retirees. As such, I stand ready to assist the Congress and any other interested parties to address this important challenge in a reasoned, responsible, and nonpartisan manner.

Madam Chairwoman, that concludes my statement. I would be happy to answer any questions you might have.

Mrs. JOHNSON. Thank you very much.

[The prepared statement follows:]

STATEMENTS OF STANFORD G. ROSS AND DAVID M. WALKER, PUBLIC TRUSTEES, SOCIAL SECURITY AND MEDICARE BOARDS OF TRUSTEES

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

It is our privilege to testify regarding the financial status of the Medicare Hospital Insurance Trust Fund as shown in the 1995 Annual Report of the Board of Trustees of that fund. As you know, the Public Trustees are part-time officials appointed by the President and confirmed by the Senate to represent the public interest in this important process of public accountability. In our normal activities, Mr. Ross is a lawyer and consultant and Mr. Walker is a CPA and consultant, both with extensive public and private experience in tax, financial and retirement security matters. Pursuant to law, our terms as Public Trustees ended with issuance of the 1995 Trustees Reports on April 3, 1995. Our joint statement reflects the positions we took in those reports.

Role of the Public Trustees

As Public Trustees, our primary activities were directed at assuring that the Annual Trust Fund Reports fully and fairly present the current and projected financial condition of the trust funds. During preparation of the Annual Reports over the last 5 years, we participated in the review of the proposed short-range and long-range economic and demographic assumptions and in the decisions made on those assumptions. We attempted to test assumptions, question methodologies and work with the Offices of the Actuary of the Social Security Administration and the Health Care Financing Administration and others in and out of government to seek improvements in the projections. Specifically, we sponsored roundtable discussions with expert panels on key assumptions, including the rate of change in fertility, mortality and real wages. We also sponsored a symposium and publication of papers on how methods and assumptions might be improved to better estimate the future income and health care needs of the elderly and disabled. The goal of these efforts was to assure the American public of the integrity of the process and credibility of the information in these reports.

In addition to our efforts to ensure the integrity of the projections in the trust fund reports, we also worked to improve communications with the Congress and the public regarding these important programs. We are particularly pleased to have provided leadership in returning to one set of intermediate projections, or "best estimates," in the reports, and in conceiving and instituting the increasingly popular *Summary of the Annual Reports*, including an annual "Message From the Public Trustees," as an important part of the reporting process. We also testified before congressional committees and other governmental commissions, and gave speeches and briefings to congressional staffs and other interested parties. Our goal in these activities has been to enhance understanding of the current and projected financial condition of the Social Security and Medicare programs.

A key point we have stressed is that projections ultimately are only estimates and must necessarily reflect the uncertainties of the future. Nevertheless, the projections in the Trustees Reports are useful if understood as a guide to a plausible range of future results and if acted on in a timely and responsible manner. With this purpose in mind, we now turn to the projections in the 1995 report on the Hospital Insurance (HI) Trust Fund but will also mention the status of the Supplementary Medical Insurance (SMI) Trust Fund.

Medicare Program

The 1995 reports on both the HI Trust Fund and the SMI Trust Fund show alarming financial results. While the financial status of the HI program improved somewhat in 1994, the HI Trust Fund continues to be severely out of financial balance and is projected to be exhausted in about 7 years. The SMI Trust Fund, while in balance on an annual basis, shows a rate of growth of costs which is clearly unsustainable. Moreover, this fund is projected to be 75 percent or more financed by general revenues, so that given the general budget deficit problem, it is a major contributor to the larger fiscal problems of the nation.

Currently about four covered workers support each HI enrollee. This ratio will begin to decline rapidly early in the next century. By the middle of the next century, only about two covered workers will support each enrollee. Not only are the anticipated reserves and financing of the HI program inadequate to offset this demographic change, but under all the sets of assumptions, the trust fund is projected to become exhausted even before the major demographic shift begins to occur.

The Trustees note that some steps have been taken to reduce the rate of growth in payments to hospitals, including the implementation of the prospective payment system for most hospitals. Experience to date suggests that this reimbursement mechanism, together with payment limitation provisions enacted by the Congress, has helped to constrain the growth in hospital payments and has improved the efficiency of the hospital industry.

Extension of this payment system to other providers of HI services and further legislation to limit payment increases to all HI providers could postpone depletion of the HI trust fund for about another 5 to 10 years. Much more substantial steps would be required, however, to prevent trust fund depletion beyond 2010 as the baby boom generation begins to reach age 65.

We continue to believe, as we also emphasized in our 1993 and 1994 Public Trustees Messages, that the Medicare program is clearly unsustainable in its present form. We had hoped for several years that comprehensive health care reform would include meaningful Medicare reforms and that comprehensive health reform would eventually reduce the rate of growth of health care costs and thus the financing shortfall facing Medicare. However, with the results of the last Congress, it is now clear that Medicare reform needs to be addressed urgently as a distinct legislative initiative. We also believe strongly that Medicare reform should be included as an integral part of any broader health care reform initiative which may be considered in the future.

There are basic questions with the scale, structure and administration of the Medicare program that need to be addressed. For example, is it appropriate to have a Part A (Hospital Insurance) and Part B (Supplementary Medical Insurance) today, or should this legacy of the political process that enacted Medicare in the mid-1960s be revised to create a unified program? Is it appropriate to combine participants' social insurance tax contributions for Part A and premium payments for approximately one-quarter of Part B with general revenues? If so, what should be the proper combination of beneficiary premiums, taxpayer social insurance contributions, and general revenues? How are each of these kinds of revenue sources to be justified and what rights to benefits and responsibilities to pay benefits are thereby established? How can the program become more cost-effective? How can fraud, abuse and waste be better controlled?

We believe that comprehensive Medicare reforms should be undertaken to make this program financially sound now and over the long term. The idea that reductions in Medicare expenditures should be available for other purposes, including even other health care purposes, is mistaken. The focus should be on making Medicare itself sustainable, making it compatible with Social Security, and making both Social Security and Medicare financially sound in the long term. While Social Security is in far better financial health than Medicare and the changes that will be required in Social Security can be relatively small and gradual if they are begun in the near future, the magnitude of those changes grows each year that action is delayed. Thus, urgent attention to Medicare's financing is critical, but it is important to keep in mind the financing needs of both Social Security and Medicare when making any changes because the resources that are devoted to one area will not be available to the other.

We strongly recommend that the crisis presented by the financial condition of the Medicare Trust Funds be addressed on a comprehensive basis, including a review of the program's financing methods, benefit provisions, and delivery mechanisms. Various groups should be consulted and reform plans developed that will not be disruptive to beneficiaries, will be fair to current taxpayers who will in the future become beneficiaries, and will be compatible with government finances overall.

We have attached to our statement the four-page "Message From the Public Trustees" that is included in the *Summary of the 1995 Annual Reports*, as well as our biographical information. We thank you for the opportunity to present our views and will be pleased to answer any questions you may have.

The Public Trustees

Six people serve on the Social Security and Medicare Boards of Trustees: the Secretary of the Treasury, the Secretary of Labor, the Secretary of Health and Human Services, the Commissioner of Social Security and two members (of different political parties) appointed by the President and confirmed by the Senate to represent the public. The Boards are required by law to report to the Congress each year on the operation of the four Social Security and Medicare trust funds and the projected financial status of these funds for future years. The Public Trustee positions were created by the Social Security Amendments of 1983. Stanford G. Ross and David M. Walker began four-year terms as Public Trustees on October 2, 1990, and completed their terms with issuance of the 1995 reports on April 3, 1995. In addition to their duties overseeing the trust funds, they have worked to increase public understanding and public confidence regarding Social Security and Medicare.

STANFORD G. ROSS

Stanford G. Ross is a Senior Partner in the law firm of Arnold & Porter in Washington, D.C. Mr. Ross dealt extensively with public policy issues while serving in the U.S. Treasury Department, on the White House domestic policy staff, and as Commissioner of Social Security. He also served as Chair of an Advisory Council on Social Security.

Mr. Ross has taught law at the Georgetown, Harvard, New York University and Virginia Law Schools, and has been a Visiting Fellow at the Hoover Institution, Stanford University. Mr. Ross has served as Chairman of the American Bar Association Tax Section Committee on Social Security and Payroll Tax Problems. He has provided technical assistance to various foreign countries on Social Security and tax issues under the auspices of the International Monetary Fund, the World Bank, and the U.S. Treasury Department. Mr. Ross served as President of the National Academy of Social Insurance from January 1990-April 1992, and is a founding member and a member of its Board of Directors. He received a J.D. degree from Harvard Law School and a B.A. degree from Washington University (St. Louis). He is the author of many papers on federal taxation and income security and is a frequent participant in conferences on these subjects.

DAVID M. WALKER

David M. Walker is a partner and worldwide managing director of the compensation and benefits practice of Arthur Andersen LLP based in Atlanta, Georgia. Mr. Walker has held a variety of executive and policymaking positions in the Federal government, including serving as head of two of the three Federal agencies that administer the Employee Retirement Income Security Act of 1974 (ERISA). His most recent full-time government position was Assistant Secretary of Labor for Pension and Welfare Benefit Programs at the U.S. Department of Labor. Mr. Walker served at the Pension Benefit Guaranty Corporation (PBGC) before joining the Department of Labor.

Mr. Walker is a Certified Public Accountant and received his B.S. in accounting from Jacksonville University. He holds a number of leadership positions, including serving as a director of the Association of Private Pension and Welfare Plans (APPWP), chairman of the American Institute of Certified Public Accountants' (AICPAs) Employee Benefit Plans Committee, and vice-chairman of the Legislative Committee for the Southern Employee Benefits Conference. He is a member of a number of other organizations, including the National Academy of Social Insurance and the Editorial Advisory Board of *Journal of Accountancy* and *Journal of Taxation of Employee Benefits*. He is a frequent speaker, author and expert witness on a variety of compensation, benefits, investment, retirement and related issues.

A MESSAGE FROM THE PUBLIC TRUSTEES:

This is the fifth set of Trust Fund Reports on which we have reported as Public Trustees. It is also, under the terms of our appointment, our last report, and we use this occasion to summarize our views on some major aspects of the Social Security and Medicare programs. As representatives of the public, our efforts have been to assure the American public of the integrity of the process and the credibility of the information in these reports. We feel privileged and honored to have been able to take part in this important exercise in public accountability, and want to provide our best advice on directions for change of these important programs in the years ahead.

The Need For Action

During the past 5 years there has been a trend of deterioration in the long-range financial condition of the Social Security and Medicare programs and an acceleration in the projected dates of exhaustion in the related trust funds. To some extent, this has been predictable because when doing annual 75-year projections, an additional deficit year in the 2060s is being added with each new projection. But to some extent, the increasingly adverse projections have come from unforeseen events and from the absence of prompt action in response to clear warnings that changes are necessary. These adverse trends can be expected to continue and indicate the possibility of a future retirement crisis as the U.S. population begins to age rapidly. We urge that concerted action be taken promptly to address the critical public policy issues raised by the financing projections for these programs.

Projections As A Guide To Action

We believe it is important for the public and the Congress to understand more about what the projections in the Trust Fund Reports really mean and how they are intended to be used. These projections represent the best estimates the Trustees can make based on the best available information and methodologies. We have, during our period of service, attempted to test assumptions, question methodologies and work with the Offices of the Actuary of SSA and HCFA and others in and out of government to seek improvements in the projections. We have also stimulated thought through a symposium and publication of papers on how methods and assumptions might be improved to better estimate the future income and health care needs of the elderly and disabled. Action should be taken to continue and extend survey and other data development efforts and to improve modeling capability regarding the income and health circumstances of future retirees. Such information is critical to the legislative and regulatory activity that will be required for both public and private income security and health care programs in future years.

However, with even the best data and models, projections ultimately are only estimates and must necessarily reflect the uncertainties of the future. They are useful if understood as a guide to a plausible range of future results and if acted on in a timely and responsible manner. They are not helpful if ignored, or if used improperly, or if distorted. We hope that more policymakers will come to grips with the strengths and limitations of projections such as those in the Trust Fund Reports and how those projections can be used most productively.

Social Security Program

The Old-Age and Survivors Insurance Trust Fund shows a deficit of 1.87 percent of payroll in the long run. It is by far the best financed of the trust funds, and we believe strongly that the OASI program can and should be maintained over the long term. Yet even here reforms should be undertaken sooner rather than later to ease the transition to providing financial stability in the next century. We note the recent work of the Bipartisan Entitlement Commission and the current work of the Advisory Council on Social Security regarding the long-term financing of the OASI program. We hope that this kind of work will continue and that this problem will be addressed in a timely fashion.

The condition of the Disability Insurance Trust Fund is more troublesome. While the Congress acted this past year to restore its short-term financial balance, this necessary action should be viewed as only providing time and opportunity to design and implement substantive reforms that can lead to long-term financial stability. The research undertaken at the request of the Board of Trustees, and particularly of the Public Trustees, shows that there are serious design and administrative problems with the DI program. Changes in our society, the workforce and our economy suggest that adjustments in the program are needed to control long-range program costs. Also, incentives should be changed and the disability decision process improved in the interests of beneficiaries and taxpayers. We hope that this research will be completed promptly, fully presented to Congress and the public, and that the Congress will take action over the next few years to make this program financially stable over the long term.

Medicare Program

The most critical issues, however, relate to the Medicare program. Both the Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund show alarming financial results. While the financial status of the HI program improved somewhat in 1994, the HI Trust Fund continues to be severely out of financial balance and is projected to be exhausted in about 7 years. The SMI Trust Fund, while in balance on an annual basis, shows a rate of growth of costs which is clearly unsustainable. Moreover, this fund is projected to be 75 percent or more financed by general revenues, so that given the general budget deficit problem, it is a major contributor to the larger fiscal problems of the nation.

The Medicare program is clearly unsustainable in its present form. We had hoped for several years that comprehensive health care reform would include meaningful Medicare reforms. However, with the results of the last Congress, it is now clear that Medicare reform needs to be addressed urgently as a distinct legislative initiative. We also believe strongly that Medicare reform should be included as an integral part of any broader health care reform initiative which may be considered in the future.

There are basic questions with the scale, structure and administration of the Medicare program that need to be addressed. For example, is it appropriate to have a Part A and Part B today, or should this legacy of the political process that enacted Medicare in the mid-1960s be revised to create a unified program? Is it appropriate to combine participants' social insurance tax contributions for Part A and premium payments for approximately one-quarter of Part B with general revenues? If so, what should be the proper combination of beneficiary premiums, taxpayer social insurance contributions, and general revenues? How are each of these kinds of revenue sources to be justified and what rights to benefits and responsibilities to pay benefits are thereby established? How can the program become more cost-effective? How can fraud, abuse and waste be better controlled?

We feel strongly that comprehensive Medicare reforms should be undertaken to make this program financially sound now and over the long term. The idea that reductions in Medicare expenditures should be available for other purposes, including even other health care purposes, is mistaken. The focus should be on making Medicare itself sustainable, making it compatible with OASDI, and making both Social Security and Medicare financially sound in the long term.

We strongly recommend that the crisis presented by the financial condition of the Medicare Trust Funds be urgently addressed on a comprehensive basis, including a review of the program's financing methods, benefit provisions, and delivery mechanisms. Various groups should be consulted and reform plans developed that will not be disruptive to beneficiaries, will be fair to current taxpayers who will in the future become beneficiaries, and will be compatible with government finances overall.

Institutional Considerations

We have as Public Trustees tried over the past 5 years to provide continuity and improve the institutional framework surrounding the Social Security and Medicare programs. We have bridged two Administrations (one Republican and one Democratic), two Advisory Councils (one appointed by a Republican Administration and one by a Democratic Administration), and many changes in the ex officio Trustees. We have consulted with each of the Advisory Councils, as well as the working group of the prior Public Trustees, the Bipartisan Entitlement Commission, the Notch Commission and many other government entities. We have testified before both the House Ways and Means Committee and the Senate Finance Committee and held regular briefings for Congressional staff on the Trust Fund Reports. We know that with the advent of the new Social Security Administration as an independent agency, many of the institutional relationships in these areas will change. We hope that the Public Trustees in the future will continue to make a contribution towards a coherent institutional structure that serves the interests of the public.

Finally, we note that although the statute provides that one of the Public Trustees must be from each of the major political parties, we have operated as independent professionals on a nonpartisan basis. Every statement we have made over 5 years has been joint and consensual, and without partisan content or political dissonance. We believe these programs are too important to be politicized and urge that a highly professional, nonpartisan approach continue to be followed in future reports to the Congress and the public.

Stanford G. Ross
Trustee

David M. Walker
Trustee

Mrs. JOHNSON. We will hear from Mr. King.

STATEMENT OF ROLAND E. "GUY" KING, CONSULTING ACTUARY, ERNST & YOUNG, WASHINGTON, DC, FORMER CHIEF ACTUARY, HEALTH CARE FINANCE ADMINISTRATION

Mr. KING. Thank you, Madam Chairman. I have a statement for the record and I would like to make a brief statement summarizing that testimony with your permission.

We have heard today, there seems to be general agreement that the Hospital Insurance Trust Fund is going to be depleted or bankrupt in 2002, and there seems to be general agreement that the rate of growth after that period of time is going to be very high, high enough so that by 2025, the tax rate is going to double if nothing is done to control costs, and that by 2065, the tax rate will have had to have tripled in order to pay for the cost of the program.

But of course, these tax rate increases are not the result of some extremely pessimistic assumptions about the rate of increase in health care costs because we have heard testimony regarding the impact of the baby boomers on the future costs, so the problem is very real, very predictable. The baby boomers are alive today and we have a very good idea what their mortality rates are and how long it is going to be before they retire.

One of the things I would like to talk about is that the HI Program isn't just a budget problem. Solving the HI problem is a problem of solving the problem in a way that is fair to both current and future generations of beneficiaries. We can define generational equity by calculating and comparing each generation's contributions to the program with the benefits that they receive from the program. When we do that and then look at the cohort of beneficiaries retiring in 1994, 2014, and 2034, and then look at the timing and the way in which we solve the problem, we are led to two conclusions.

First of all, it is more fair to take action earlier rather than later in order to solve the problem because the current generation of retirees is going to receive back over $5 in benefits for each dollar they pay into the program. Second, it is more fair to solve the problem by reducing the rate of growth in the outlays of the HI Program than in taxing future generations to pay for current benefits today.

While we are talking about the financial problems of the HI Program, let's not forget about the SMI Program. It is not in immediate danger of becoming insolvent because of the way it is financed, but the rate of growth here is also unsustainable. The SMI Program as a percent of GDP in 1994 is 0.93 percent and that will triple as a percent of GDP by 2020, and then it will have quadrupled by the middle of the next century. We can't solve the problems in the HI Program merely by shifting costs to the SMI Program.

The outlays of both the HI and SMI programs are growing at excessive rates today because of two primary factors. The first factor is third-party payments and the second factor is fee-for-service medicine. Removing either one of these factors which interact with each other in order to produce the rate of growth we are seeing today is a way of dealing with the problem.

Removing—dealing with the first factor, third-party payments, is addressed by increasing coinsurance and deductibles, and a way for dealing with the fee-for-service medicine factor is the managed care approach, so I would characterize those two approaches as being complementary and what I would define as true reform in the Medicare Program as opposed to just reducing the payment rates to providers.

If some adjustments had just been made in the Medicare Program many years ago, we wouldn't be seeing the high rate of increase that we see today. For example, in the SMI Program, if the SMI deductible had just been indexed to inflation, then the SMI premium today could be only $4 a month, and yet the contributions of the government to the program could be $5 billion lower than they are today, and instead of—instead of the SMI premium being set at the rate of $46.10 per month that it is today, it could be reduced to the level of $4.

I can see that my time is up, so I will be glad to answer any questions.

[The prepared statement follows:]

TESTIMONY BY
Guy King
Former Chief Actuary for HCFA
before the
House Committee on Ways and Means
May 2, 1995

Mr. Chairman, my name is Guy King. I am a Consulting Actuary with the firm of Ernst & Young. I was the Chief Actuary for the Health Care Financing Administration from 1978 to 1994. During my time as Chief Actuary, the expenditures for both the HI and SMI programs grew at rates that are unsustainable in the long run, and they continue to grow at those unsustainable rates today and into the foreseeable future.

Hospital Insurance (HI) Trust Fund

The expenditures of the Hospital Insurance Trust Fund (Part A of Medicare) increased from $17.7 billion in 1978 to $107.2 billion in 1994. This is an average rate of increase of about 12 percent per year. In 1978, the Annual Report of the Board of Trustees projected that the HI trust fund would be bankrupt by 1990. Because of some minor price reduction changes in the program which have been legislated over the years, the date of bankruptcy has been pushed back by a few years, so that the 1995 Trustees Report projects that the HI fund will be bankrupt by 2002. Thus, during my 15 years as Chief Actuary, virtually nothing was done as the problem grew and the HI program moved closer to the bankruptcy. The impending bankruptcy of the fund is just the tip of the iceberg, though. The hole is just going to continue to continue to get deeper for many years, and the pace of decline is going to accelerate. The tax rate necessary to support the current program will have tripled by the year 2065. Even by the year 2025 the tax rate necessary to support the cost of the program will have more than doubled.

I know that some people view these projections as a red herring. I have often heard it suggested that we should just wait awhile to see if these problems really begin to materialize. That is apparently what lawmakers were thinking when they heard the same projections back in the mid-1970's. The financial problems of the HI program aren't just the result of some extremely pessimistic assumptions about the growth of health care costs. The assumptions regarding the rate of growth in health care costs and the growth in income to support the program are really very optimistic. These projections are being driven now by the coming demographic shift. The Baby Boomers who will retire and begin drawing benefits starting in 2010 are all alive today. As the Post World War II Baby Boom begins to reach age 65, the growth in the number of workers paying taxes is going to decline, and at the same time the growth in the number of people eligible for Medicare benefits is going to increase. Currently, about four taxpayers support each HI beneficiary. By the middle of the next century, when all of the baby boom will have retired, there will only be two covered workers supporting each HI beneficiary, so this problem is very real and very predictable.

The problem is so large that there isn't any painless way at this point to solve the problem. To place income and expenditures in balance even over the next 25 years, which is the easy part, is going to require either an immediate 30 percent reduction in expenditures or an immediate 44 percent increase in the HI tax rate, or some combination of both. And even then, the financial problems beyond 25 years would still remain unsolved.

Some have suggested that the apparent recent slowdown in the rate of growth in health care costs and the recent favorable experience in the Medicare program may be enough to save the government from having to make these decisions. That isn't going to happen. During my twenty years as a government actuary I observed that, when there was a threat of government action, health care costs always behaved very well. This occurred with the wage-price

controls of the early 1970's, the threat of hospital cost containment legislation during the late 1970's, and during the discussions of health care reform in 1993 and 1994. Once the perceived threat is past, the rate of increase in expenditures once again accelerates.

In deciding how and when to take action to make the HI Program solvent, one of the difficult questions that needs to be addressed is the issue of generational equity. Generational equity can be measured by comparing each generations' contributions to the program with the benefits they receive from the program. We measured generational equity under four combinations of the following policy options: 1) act immediately or delay action and 2) increase taxes or reduce benefits. Our studies show that the solutions resulting in the greatest generational equity involve taking immediate action rather than delaying action and reducing the growth in benefits rather than increasing taxes. The table below shows the impact of various policy options on generational equity for persons retiring in 1994, 2014, and 2034.

Ratio of Benefits to Contributions

		Person Retiring in:		
	Proposed Change in Financing	1994	2014	2034
1.	Do nothing until trust fund depleted, then increase taxes.	5.19	2.93	2.17
2.	Do nothing until trust fund depleted, then reduce benefits.	3.25	1.31	1.14
3.	Reduce benefits immediately.	2.10	1.36	1.54
4.	Increase taxes immediately.	5.19	2.20	1.68
5.	Reduce benefits immediately, then index tax rates.	2.10	1.61	1.94
6.	No changes (hypothetical)	5.19	3.45	3.90

Supplementary Medical Insurance (SMI) Trust Fund

Because of the way it is financed, through a combination of premium payments by individuals and debt financing by the Federal Government, the SMI program is not in immediate danger of insolvency. However, the growth rate in the cost of the program is so rapid that it is not sustainable in the long run. During my time as Chief Actuary the outlays for the Supplementary Medical Insurance Trust Fund (Part B of Medicare) increase from $7.8 billion in 1978 to $61.8 billion in 1994. This is an average rate of increase of about 14 percent per year. During that same 16 year period, benefits paid by the SMI Trust Fund increased from .32 percent of the U.S. Gross Domestic Product (GDP) to .93 percent of GDP. This occurred despite the fact that some of the costs of the program (such as for most home health benefits) were shifted to the HI program. Even during the last five years, which have been relatively favorable, expenditures by the program have increased 53 percent in the aggregate and 40 percent per enrollee. According to the 1995 SMI Trustees report, SMI expenditures will be 3.18 percent of GDP by 2020 when the Post World War II Baby Boom has begun to reach age 65 and will be 3.97 percent of GDP by the middle of the next century when the Baby Boom will have been fully retired. As with the HI Program, these projections are being driven now by the coming demographic shift and the Baby Boom rather than pessimistic health care cost projections.

If some adjustments had been made to the SMI program years ago, this problem would never have developed to the size it is today. For example, if the SMI deductible had been indexed to increases in per capita program costs, and steps had been taken to ensure that Medicare supplemental plans did not neutralize the cost-saving features of the SMI deductible, then the outlays of the SMI program would be more than 25 percent lower than they are today. This would have allowed maintaining the SMI premium at $4.00 instead of the $46.10 it is today. At the same time, the government contribution to the program could have been nearly $5 billion less than it is today.

The outlays of the SMI program are excessive today due to two design features of the program which interact with each other to result in significant waste and abuse. These are the same two factors that are driving up health care costs for private sector health care plans.

The first factor is third party payment. When patients and providers are spending other peoples money, they don't concern themselves with either the price or the quantity of services provided. Today, even the very modest cost sharing provisions of the original SMI Program have been eroded because they were not indexed to keep up with costs and because health care is, in effect, free for the 80 percent of SMI enrollees who buy Medicare supplemental policies or are eligible for Medicaid. Research conducted by HCFA's Office of the Actuary on the Medicare Current Beneficiary Survey found that, even when controlled for self-reported health status, Medicare beneficiaries who did not have Medigap plans, and who thus were subjected just to the (severely eroded) cost sharing provisions which exist in the Medicare program today, have significantly lower overall health expenditures. Moreover, an important research paper which will be published in Health Affairs, coauthored by Mark Freeland, Ph.D. and Al Pedon, Ph.D., shows that the acceleration in the rate of growth in health care expenditures in the United States has been highly correlated with the shift toward third party payments. Their research shows roughly that every ten percentage point shift from out-of-pocket payments to third party payments results in an increase in the rate of growth of health care costs of about two percent, and this accelerated rate of growth persists for about ten years. In my opinion, this is the most important research conducted yet on health care costs because it explains the reason for the rapid growth in health care costs in the United States.

The second factor contributing to rapid growth in health care costs is fee-for-service medicine. This factor interacts with third party payments to allow for unlimited increases in the volume and intensity of services provided to patients, without regard for the efficacy or cost effectiveness of those services. During the entire history of the SMI Program, most of the increase in per-capita costs have arisen from increases in the volume and intensity of services rather than price increases. During the ten year period ending in 1992, over three fourths of the increases in payments to physicians arose from volume and intensity increases.

The cost of health care can theoretically be controlled by removing either of the two offending factors---third party payments or fee-for-service medicine. Increasing coinsurance and deductibles is an example of dealing with the third party payment factor; introducing capitated services, as in the TEFRA Medicare Risk Program, is an example of dealing with the fee-for-service factor.

The problem that I have observed with the second approach is that the TEFRA risk sharing program is structured in such a way that, even if there were no risk segmentation, and with a 10 percent capitated penetration rate the most that could have been saved would have been 1/2 of one percent. However, because of risk segmentation, the TEFRA risk program has increased expenditures of the Medicare Program rather than reducing them.

If the costs of the Medicare Program were going to be controlled by using managed care, then the structure of the program would have to be changed so that savings accrue to Medicare. This would have to be done in a way that didn't discourage managed care plans from participation in the program. Because of the extreme difficulty of balancing these conflicting goals, managed care alone cannot be relied upon to control costs in the Medicare program.

This concludes my formal remarks and I'll be pleased to answer any questions you may have.

Mrs. JOHNSON. Thank you for your testimony. I want to recognize the Chairman of the Subcommittee, Mr. Thomas.

Mr. THOMAS. Thank you very much, Madam Chairman. First of all, I want to thank the three of you, and Guy, you do not mind if I focus on Mr. Ross and Mr. Walker for a minute.

I believe you sat through the entire hearing today, or certainly most of it. I was watching you sitting over there. First of all, on behalf of the American people, I want to thank you for the time that you put in serving as the public trustees. Second, I know that you have been involved with an attempt to create an environment for a solution to this problem for some time.

I have in front of me a softback called "Proceedings: Conference on the Future Income and Health Care Needs and Resources for the Abled," sponsored by the public trustees of the Social Security and Medicare Trust Fund. I believe it is a 1993 publication. This basically gives you the parameters by which you can begin to focus on solutions.

You heard, perhaps, then the dialog between the Health and Human Services Secretary and Members of this Committee on both sides.

The question I guess I would ask you is one that you can either choose to answer or at least ponder over. Mr. Walker, you repeated a number of times that the solution has to be bipartisan. I agree with you, since we have got a Republican Congress and a Democrat President, if it isn't perceived at least as minimally bipartisan, it isn't going to become law, and all of us should be ashamed if something doesn't become law, if not in this first session of the 104th Congress, certainly in the second.

You folks have probably been as close to this issue as anyone. You have looked at a number of options. Have either of you, or both of you, discussed the role of service that you could perform for the American people, for the Congress and the President in terms of offering options, a set of solutions from your perspective presented as both a Democrat and Republican?

It certainly hasn't functioned that way on the public trustee role on these trust funds, and provide an agenda for discussion rather than this Gadsden-Alphonse business of who goes first. Have you thought about that? Have either of you thought about offering a series of solutions? The old business of no pride of authorship, here are some things, and you should at least consider them and we would expect you to consider them. Either of you.

Mr. WALKER. I will go first, Mr. Chairman. There are two dimensions of the problem. One dimension is short term and what type of things can and should be done in the short term until we have had time to conduct the massive public education campaign to educate the American people as to the nature and need for the dramatic reform.

With regard to the more dramatic reforms, which is the second element, I think we need to do something similar to what was done in 1983. I think we need a Greenspan-type commission.

With regard to the short-term issues, Stan and I probably both have personal views as to some things that should be considered and are more than willing to answer questions in that regard. We have not specifically talked about whether we should come up with

a package on our own for formal or informal submission to the Congress as a basis for the Congress to begin debate on this issue. I think it is critical that something be done and I will let Stan respond, and I am open-minded to anything that is reasonable, quite frankly, to get this thing moving.

Mr. ROSS. I would point out, first of all, that our role as public trustees is to oversee the integrity of the reports and to make sure they were timely and accurate; and this year was not only difficult, but there have been difficulties in the past over issues like the disability program where our role was to require that studies be done before we would agree to recommend the reallocation that was done.

We have very little staff resources. These are part-time jobs in which we have spent limited time —I have spent about 40 days a year the past 5 years.

Frankly, these are political judgments that are involved and I think that unless a process can be set up, such as a 1983 Greenspan-type commission, where political leaders themselves can be brought together with experts like Mr. Walker and I in a framework in which everybody is going to try to exercise their skills and best judgments, I do not see a way out of the impasse that is presented.

I personally believe that it is more important to focus on the procedural vehicle than trying to get particular substantive ideas, because there are a lot of substantive ideas out there, but until you see how the public reacts to them, it is very hard to make the political judgments.

How will ordinary beneficiaries, workers, doctors, hospitals, pharmaceutical manufacturers, medical device manufacturers react? There are just a whole range of interests as we know from the comprehensive health care reform debate, and in order to make the right political judgments, I think the public needs to see proposals out there.

Something like a national commission might be the way to begin to let the public understand the dimensions of the problem; I think they will get some things out of this hearing, but not the difficulty of the solutions, it is necessary to begin to see which proposals seem to have some staying power and which ones would just be totally unacceptable.

Like Mr. Walker, this job was my fourth stint in government and I would do anything I personally could within the limits of my time and capacities to try to help end this impasse which I think is really not good for the program, not good for our political system, much less for the Nation.

Mr. THOMAS. Thank you very much. One of the more frustrating things that I have been engaged in is looking at the question of Medicare. Mr. Walker, you talked about educating the American people, especially seniors and others, including, to a certain extent, Members of Congress about just what this program is. There is a lot of confusion about it.

One of the more frustrating things, as I have said, is to look at the dollar amounts expended in the HI Trust Fund and part B, the Supplemental Medical Insurance Trust Fund, and the government contribution along with the individual contribution. Examine what

is expended most often by an individual for the medigap insurance policy and look at the total dollars expended in this area. The resources being expended are not in the wisest fashion.

From your perspective, in the relative short-term, is it something that we should look at in terms of a whole new approach rather than keeping it A, B with supplemental, or try to go to the drawing board with a clean sheet of paper. Or, is that really more of a long-term change?

Mr. WALKER. My personal opinion is, you need to make some incremental changes that can help with the short-term problem, and second, you need to put the process in place to be able to engage in more comprehensive and fundamental long-range reforms. It is more than Medicare. I do not think that we can just look at Medicare standing alone.

With regard to the broader range of reforms, we have to keep in mind that we have got some other social programs. Namely, Social Security, that is facing a long-range problem, and our health care arena, to be addressed as well. From a political standpoint, candidly, You are going to have to address a number of those simultaneously in order to come up with a more comprehensive long-term solution.

Mr. ROSS. I would say that it is important to get the process started as soon as possible. The problem is serious and it is going to get worse, not better. The things you can do short term will be incremental. There should be some kind of a Medicare reform package that both does some things and also sets in process larger restructuring initiatives.

We didn't get into this problem overnight and we are not going to get out of it overnight. Unless we start to really work at it concertedly over a continuous period, the problems will not be sufficiently addressed.

You need to focus on what you can do through a separate package. I do not think you can do it all, but you can do some things, and determine what things you could only do through a broader, more complete package down the line and you shouldn't lose sight of the second as you do the first and as you do the first, you should pave the way for the second. It may be a two-set process.

Mr. THOMAS. Mr. Ross, you said this was principally a political function. I have to tell you, I lived through the 1983 Social Security adjustments, and I agree with you, because ultimately it is all political. There are just enormous temptations, especially because of the political volatility in dealing with this area that cries out for a rational, long-term discussion that produces a general consensus.

For example, the discussion over moving the retirement age from 65 to 67, which was long overdue at the time we began the discussion, was then prolonged for another 20 years into the 21st century so that it probably has virtually no significant impact in actually adjusting retirement benefits to retirement age given the way in which retirement age is going to continue to change, one small example that almost broke our political back in trying to achieve some kind of a compromise of solution.

As we look at these options, it just seems to me that people such as yourselves who have spent some time reflecting on this, people who have no particular narrow interest to gain from one option or

another, need to help all of us, and a commission or an advisory group of some sort to—clearly blue ribbon, to present a solution which, if we are going to reject it, would require the unification of Democrats and Republicans for a positive alternative to reject it, which I guess is the best kind of rejection. Short of that, I frankly do not see us coming to either a short term, or depending upon what the future brings, a long term solution.

I am very, very concerned about our ability to fundamentally readjust a piece of the Federal budget which, as the Kerry-Danforth Commission clearly laid out, is a long—an increased path which cannot be tolerated. Frankly, I see the HI Trust Fund as a warning flag that allows us to begin to make these fundamental adjustments sooner than we would otherwise.

I would hope that you folks could think about what other kind of a structure that will help us in terms of a solution.

Guy, you have any comments at all about where we are going? Do you think the commission route, some kind of a blue ribbon, third-party professional option is something that will work once again?

Mr. KING. Yes. It is something that could work. It is very good that you are getting started 7 years in advance of the projected date of bankruptcy, because the problems relating to the HI Program are really much more complicated than those that related to Social Security in 1983 and they require a longer lead time.

Now, the other thing I might say is that, technically, it is not a difficult problem. I am a technician. I am not answerable to the voters, so I could probably think of 100 different ways to solve the problem, but it becomes much more difficult when you are trying to solve the problem and be answerable to the voters as well.

Mr. THOMAS. I do think though that there is perhaps some alternatives or some hierarchy, structuring of alternatives, that provide a better solution for certain problems that do not make it a fundamental political choice. Probably the ultimate mix in the package in terms of who gets impacted in the larger question is clearly a political one, but it seems to me that the changes, the fundamental restructuring in the system, those that give us more mileage for a given dollar do not necessarily have to be partisan.

You said you had 100 of them. I believe that late at night you know that one is better than the other and you can prioritize them along a return on investment, societal investment, in what is given to us in terms of benefits and the rest. That is the kind of help we need to get started in making choices, because without something between us to discuss, as you saw today, we didn't make a whole lot of progress, and that is very frustrating to me as someone who is charged with trying to solve what is a very real problem for a growing number of Americans, and I want to thank you for your past contributions and, hopefully, we can get some more mileage out of you.

Thank you very much.

Mrs. JOHNSON. Mr. McCrery.

Mr. MCCRERY. I thank the Chairlady for recognizing me, and I really enjoyed your testimony, however vague it was. Let me just ask you a few questions and then get into some more general discussion following Mr. Thomas. Let me begin by making a comment,

Mr. Walker, about making sure that what we do is actuarially sound and provides for an actuarially sound system.

If I am not mistaken, when Medicare was created in 1965, they fully expected it to be actuarially sound with the mechanism that was in place, and what has happened is the assumptions they made in declaring that system to be actuarially sound just simply didn't hold water. I am afraid any time the government creates a program or adjusts a program or comes up with a new approach that is actuarially sound, we have proven time and time again that it is almost impossible for us to come up with an actuarially sound program, particularly when it is something as open-ended as Medicare.

Social Security is another thing. We have defined benefits and we have a way to finance those. Medicare is not like Social Security. It is an open-ended benefit. I am not sure that although you are well intended, I am not sure we can create a Medicare system, a government health care system that is actuarially sound that will deliver open-ended benefits.

I am going to give you a chance to respond because I liked most of what you said. In fact, you are using what I call the honest approach, which is very seldom used in this place and is not being used now, in my opinion.

You said—and I do not want to put words in your mouth, you correct me if I am wrong—but you said, we simply cannot afford as a society to provide the current set of benefits or level of benefits in the manner that we provide now, and that, to me, says it all. You are exactly right, that we ought to be, as policymakers from the Speaker to the President on down, honest with the American people, honest with the AARP, with the elderly, and say what we have, and what we cannot afford. We couldn't afford it, I don't think, in 1965, and we darn sure can't afford it in 1995. Where do we go? What is our responsibility, as a public, to deliver to our elderly citizens?

If it is what we are delivering now, Lord help us. We are going to have to change our whole economy and our economic system. I appreciate your using the honest approach. We get further in this debate if we would start using that approach rather than, you know, trying to tiptoe around all these issues and placate the AARP and placate the Democratic Party and the Republican Party. I appreciate your testimony.

Did I mischaracterize your comment?

Mr. WALKER. The only thing I would say is, we have to reengineer the program to make it financially sustainable, and clearly the current program is not. I do not think we can throw enough money at it.

If you look at it in the broader context, we have to fundamentally restructure it, and we have to be candid with the American people and tell them that. In order to do it, we are going to have to ultimately do it within the broader context of more comprehensive reform, more comprehensive health care reform, but we need to get on with it because it is a major job.

Mr. MCCRERY. Well, I am intrigued by your two-step solution here, first do incremental reform and then do more broad-based reforms. You are speaking in codes here and I wish we could get out

of the codes and start speaking in specifics. Perhaps you can supply this Committee with some specific suggestions for incremental reforms, leading to more broad-based reforms and what those might be.

Frankly, I do not think we have time for incremental reforms. We have been incrementaling this thing to death throughout the eighties, chipping away here and there and squeezing providers here and there, and I just think we are about out—you said it yourself, we have about exhausted those. I do not know what you mean by incremental if it is not more of the same, which you said we are out of.

I wish you would get more specific and tell us what kind of incremental reforms you are talking about that could save—or that could buy us some more time to get these more broad-based reforms, and then tell us what the broad-based reforms ought to be.

In my opinion, Mr. King is closer to the solution than anybody else I have heard speak before this Committee. I do not know if you have had a chance to examine his testimony or listen. He did not get very far today in his oral presentation, but, you know, basically Mr. King says we offer something for nothing. Any time you do that, you are going to have a supply problem, and that is what we are doing with the Medicare system.

Mr. ROSS. Could I just add one point, though? One of the great complexities of dealing with this problem is that one of the things that has to be done, as the Congressional Budget Office witness, Ms. O'Neill, said, was to change the incentives, which by definition means that a lot of the public needs to understand what the changes are and how they are expected to react or not to react to a different set of incentives provided by the program.

Therefore, somehow a process has to be started where no matter how technically accurate some of these solutions would be in terms of producing the savings, they have to be shown to the people so that people can understand them.

I was on a panel with Mr. King at the AEI, American Enterprise Institute, recently and it was mainly experts in the field. They offered a great deal of information using phrases like, "risk adjusted vouchers." As I sat there, I said to myself, half of this audience is having trouble understanding all these highly technical ideas. What about the general public that is going to be asked to respond to these changes?

Somehow this process was not properly executed. You need some way of getting these proposed solutions, technical and nontechnical, more broadly exposed, so that people can understand the new regime that they will be asked to be a part of, and that process really needs to start just as soon as possible.

Mr. WALKER. It is important to note that the incentives have to be fundamentally changed, because you have got several things driving health care cost as relates to Medicare, not only the inflationary costs and the costs in excess of inflation; you have got utilization, utilization of procedures, intensity of care, the aging society, and longer lifespans. You have got a number of different factors and, frankly, right now most of the incentives in our system are to do more, in many cases where it is totally economically irrational, or not in the interest of the person receiving the care.

I mean, I can give you one example that is close to home. My grandfather had open heart surgery when he was 89, I believe it cost hundreds of thousands of dollars. The current incentives in the system were to say yes. Obviously, the family wanted to say yes. I mean, we love him and we obviously would like him to be with us for as long as he can.

The doctors obviously are going to say yes because they are going to get paid. The health care facility, even though we are funding it, you know, wanted to say yes because they wanted to keep him around a little bit longer, OK? The Medicare construct incentive was to say yes, but yet that procedure did not extend his lifespan very much, did not improve his quality of life, and after it happened, he wished it hadn't happened.

There are things we can do within the existing structure to be more economically rational and, frankly, more humane in some cases to the people involved.

Mrs. JOHNSON. Mr. Christensen.

Mr. CHRISTENSEN. Thank you, Madam Chairwoman.

I want to thank this panel. This panel has been worth waiting for. After this morning's testimony by the Secretary, I want to tell you how appreciative I am of your attendance and really sharing with us some very important points. I would like to spend a lot of time asking some questions, but I just have one brief question I would like to ask you.

We have heard from some of our friends on the other side of the aisle that there is not really a problem here, that why are we doing all this, why are we rushing to solutions, and I just want to know, if Congress fails to do anything to solve the Medicare situation, what will happen in 2002?

Mr. WALKER. You will not be able to pay benefits on a timely basis in 2002 because you can only, under the law, under present law, you have to use trust fund assets to pay benefits, and if you have a shortfall, you won't be able to pay benefits in a timely basis. It gets much worse every year after that.

One thing real quick if I may, Madam Chairwoman. See this chart? That is the roller coaster ride we are on. We started going downhill and it goes underground and it gets real deep real fast.

Mr. CHRISTENSEN. If payments are not rendered on timely action, what will happen in terms of the consumer?

Mr. WALKER. Coverage will have to be denied. Something will have to be done either—to put it in balance, either you will raise taxes, you cut benefits, or you do a combination thereof. You further mortgage the children's future. There are only so many options you have.

Mr. CHRISTENSEN. Mr. Ross, any further comments?

Mr. ROSS. Well, to me the great danger here is because that will not be allowed to happen. Just, for example, last year, the disability fund was reaching the point where if you did not take action, benefits couldn't be paid. What happened? You reallocated funds from the Old Age and Survivors Fund into disability, which hastens the day which we will run out of money in that fund.

These last minute sort of actions to sort of not allow Armageddon to happen simply deepen the long-term problems. That is why it is wise to begin now so that you are not faced with doing one of these

last-minute things in 2001 whenever you are looking over the precipice, which do not really solve anything but just put it off for a little bit longer.

The spirit of what I am hearing here today, which is that you want to get the process going to try to really address the problems, is absolutely the right thing. Obviously, in a country this size, and with millions and millions of beneficiaries, you are not simply going to say, we are going to stop paying benefits and people will have to start scurrying around with what resources they have. It just won't happen. You will do something last minute that may rob Peter to pay Paul and get you through another couple years.

Mr. CHRISTENSEN. I agree 100 percent, and the testimony I heard this morning did nothing but produce a lot of bickering and presented no positive alternatives. I am looking forward to working with my colleagues to try to come up with an answer. Congressman McCrery is right. We can't tinker with this. We have to have a real long-term solution, and coming up with suggestions like Secretary Shalala suggested to help keep the system alive for two more years is the wrong approach.

We need something that is going to secure the system for not only our senior citizens, but for those people who are going to be depending on the system in years to come, and I truly believe that the administration has abdicated responsibility and leadership in providing ideas. They do not have to lead if they do not want to, but they can produce some ideas so we can work together in a bipartisan fashion, because this is an area where the American people want a solution, and we are going to go ahead and figure out what we can do.

I am open for suggestions, Mr. Walker, Mr. Ross, and Mr. King. Send them our way, because I want to do the right thing, and if you can help, we would like to know what you think. Thank you very much for being here all day.

Mrs. JOHNSON. Thank you. I would like to note, Mr. King, that in your testimony, you do make very clear that to reach balance in 25 years—I mean, we are talking about trying to balance the Federal Government's budget in 7 years—to get this program balanced over 25 years, you would have to increase HI taxes 44 percent immediately or cut expenditures 30 percent immediately or some combination thereof; is that correct?

Mr. KING. Yes. That statement is contained in the Trustees' Report.

Mrs. JOHNSON. It just shows what a dramatic effort is needed. Every year we wait, those figures are going to go up. It will be a 40-percent cut or a 50-percent increase in taxes. We are really talking about decimating health care services for seniors or an extraordinary new burden on their grandchildren, and that is exactly where we are.

I was pleased that at the end of your testimony, Mr. King, you mentioned that if the costs of the Medicare Program are to be controlled by using managed care, then the structure of the program has to be changed so that savings accrue to Medicare.

Well, what we are really trying to do is just slow the growth of costs, and according to another study that was done, we are spending about $3,500 per capita per year now, and over the next 7

years, we could afford to spend $5,000 per capita per year. That takes into account the new numbers, but also allows almost a 50-percent increase. We just can't allow an increase to $6,000 per capita.

We are really talking about allowing a rational increase, actually more than the increase of the past 7 years. This is not draconian if we do it now. It can be done responsibly now. It can allow an increase that is still 50 percent of what we are spending on every individual senior now and still bring us to balance.

In this portion of your testimony, Mr. King, wouldn't it be possible if we were able to, for instance, dissect the amount of money that actually pays for senior care from both the hospital reimbursement and the physician portion, Medicare part B, and use that money to allow seniors to buy a plan in the private sector that would give them prescription drugs and other things if they chose that, if we did not allow that premium to grow nearly as rapidly as costs are growing now, couldn't that achieve our goal of reducing costs but assuring seniors current services and also some opportunity to get better coverage through managed care systems? Theoretically.

Mr. KING. Yes. There are different approaches to managed care. There is the approach where every Medicare beneficiary is given a voucher and then that certainly gives you the wherewithal to control the rate of increase in per capita cost in the Medicare Program.

The other approach, I am not—it could work also, the approach where Medicare beneficiaries are allowed to decide whether they want to go into a managed care program or stay in fee-for-service Medicare, has a difficult problem to overcome, and that is the problem of favorable selection where the healthier beneficiaries are induced to enroll in an HMO and the HMO is given the average payment for fee-for-service Medicare. Then we are paying too much.

Mrs. JOHNSON. Of course it depends on how you set that capitated reimbursement rate, and under the Medicare risk programs, that capitated rate has been set high because the companies have only been willing to participate in risk programs where the spread between cost and capitated rate is high.

Mr. KING. Yes, that is true. The capitated rate would have to be set lower in order to produce savings, and that produces a difficulty in the fact that the lower the payment rate to the capitated plans, then the less attractive those plans are, both to the beneficiaries and to the plans themselves, because the way it is right now with these generous payments, they are used to finance the extra benefits that are used as an inducement to the beneficiaries.

Mrs. JOHNSON. Correct. But couldn't you take, for instance, managed care plans in an area, because these will have to be geographically variable, and take an average of those plans that provide the general Medicare benefits and see what that premium is, and if that premium is affordable for Medicare, then that would be the choice of plans that the Medicare recipients would have.

I am trying to think of some shorter way to this than actually factoring down what we spend in Medicare to kind of identify what is cost related, drawing the premium from that and then moving that premium into the private sector. I do not know whether there is a way of looking at what is the average managed care plan in

the private sector and giving seniors the access to that, if when it is multiplied out, it meets our cost test.

In other words, I do not know quite how to get around the problem of giving seniors choices of integrated systems of care without absolutely forcing them to take capitated payments, though not all managed care plans are capitated now, and the noncapitated ones seem to work as well as the capitated ones. In my opinion, capitation has some problems. I wouldn't want to start from the position that we could only have capitated managed care plans participate, and in order to do that, you have to give seniors a premium value and a choice of managed care plans around them.

Mr. KING. Yes. The approach that you mentioned, which is more of a market-based competitive approach, could certainly result in savings for those people who choose to enroll in the plans, and the difficulty is in achieving a large enough penetration rate in order to produce significant savings for the entire Medicare Program.

The problem—the financial problems of the HI program are so large now that we can't just rely on the carrot approach with beneficiaries to induce them to enroll in managed care plans. It is going to require not only carrots but sticks as well.

Mrs. JOHNSON. Interesting.

Mr. Walker.

Mr. WALKER. With regard to the HMO or the managed care process we have now, competitive bidding clearly ought to be looked at as a way to try to get the market involved in determining what—you know, what they are willing to bid at. Right now they get reimbursed for 95 percent or whatever.

Mr. KING. Yes.

Mr. WALKER. Therefore, let the market determine what they would be willing to do.

Mrs. JOHNSON. Certainly competitive bidding would be appropriate if we followed the risk contract model. If we try to actually follow the model of opening up care options for seniors as the market opens them up for companies currently, employers now in the market, we wouldn't need to manufacture the competition through bidding and we, frankly, would get a healthier situation because it wouldn't be based on capitation. If you go into bidding, you are an entirely capitated system then with all the possible problems associated with mass capitation.

Mr. WALKER. Unfortunately, fee-for-service and capitation have both problems, but they are exactly the opposite. One of the problems that we have right now, quite frankly, is that our fee-for-service system, among other things, encourages additional utilization, additional intensity——

Mrs. JOHNSON. I do not disagree with that. I am looking at the midway that many managed care plans are using more the management controls volume that relies on a capitated payment structure. There is a midway there, at least.

Mr. Collins.

Mr. COLLINS. Thank you, Madam Chairman. I will be very brief.

Noticing—listening to the conversation and the questioning between you gentlemen and the Chairlady, it is very interesting and very different from the way this hearing started out earlier today. I assume that all three of you are from the private sector, and

based on the fact that other members of the trust, which I believe Mr. Ross and Mr. Walker are members of the Board of Trustees, but looking at the other members of the Board of Trustees for the Health Insurance Trust Fund, I see public officials or appointees of the President, no matter who the President is, whether it be Democrat or Republican, which puts politics right in the middle of the trust fund.

This gets right to the heart of politics, especially having, I believe, three members of the Cabinet serve on the Board of Trustees. My question to you, each of you, is this; Would you advise the Congress to look at changing the makeup of the board of trustees for this type of trust fund?

Mr. WALKER. You ought to consider an independent board. In 1983, the Congress took part of the step and it created two independent public trustees, one Democrat and one Republican. At that time you had three ex-officio trustees, now you have four. This is no reflection on current or past ex-officio trustees let me make that very clear. The fact is, if you want to try to depoliticize this, if you want to try to get professional bipartisan opinion that is separate and distinct with a separate trustee fiduciary hat on rather than dual hats, that is one way to do it.

Mr. COLLINS. Thank you, sir.

Mr. ROSS. When we testified before the Senate Finance Committee, Senator Kerry came and made that suggestion. Senator Simpson was chairing the Committee and they are working on a proposal for at least addressing the long-term problems of the Social Security system and perhaps the Medicare system too. I do not know.

The Committee suggested they were considering that, and my response was that in part, when the Congress created these public trustee positions in 1983, they could look at it as an experiment to see whether there were values added by having two private citizens, and you could look especially at the last 5 years of the things Mr. Walker and I have done to see whether there has been real value added.

We believe there has been and there is a track record that could be looked at to determine whether you would want to go to the next step and make it independent. You are thinking along the lines that I would be thinking, if I were in your position.

Mr. COLLINS. Thank you, sir. Mr. King, do you have a comment?

Mr. KING. I can remember joking when the—when I was chief actuary at HCFA and the positions of the two public trustees were created in 1983. They said that there was too much politics involved in the development of the trustees reports and they solved the problem by injecting two more politicians into their process, despite that, Mr. Walker and Mr. Ross have made significant contributions to getting rid of the politics in the report, but I do not think that an independently constituted Board of Trustees would go very far toward solving the financial problems in the Medicare Program without giving that Board of Trustees considerably more power to solve the problems than the current Board of Trustees does. All the Board of Trustees can do now is report on the problem. They have very little wherewithal in order to actually solve the problems of the program.

Mr. COLLINS. Well, that is very good. I appreciate each of you making those comments. There was quite a difference between the comments and responses you had when compared to those of Mrs. Shalala. We appreciate that very much and thank you, Madam Chairman.

Mrs. JOHNSON. I thank the panel for your comments, and urge you to provide follow-on information as requested by the Committee.

Thank you for being with us and for your patience.

[Whereupon, at 3:08 p.m., the hearing was adjourned.]