MEDICARE PROVISIONS IN THE PRESIDENT'S BUDGET

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

FEBRUARY 23, 1995

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MEDICARE PROVISIONS IN THE PRESIDENT'S BUDGET

THURSDAY, FEBRUARY 23, 1995

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:33 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (chairman of the subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
February 16, 1995
No. HL-4

CONTACT: (202) 225-3943

THOMAS ANNOUNCES HEARINGS ON MEDICARE PROVISIONS IN THE PRESIDENT'S BUDGET

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on Medicare provisions contained in the President's fiscal year 1996 budget proposal. **The hearing will take place on Thursday, February 23, 1995, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 9:30 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be heard from invited witnesses only. Invited witnesses include representatives from the Administration, budget experts and actuaries, as well as other interested parties. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Medicare Part A pays for inpatient hospital care, certain inpatient care furnished in skilled nursing facilities, home health care and hospice care. Last year, the President submitted an ambitious health care plan which included significant savings in the Medicare program. This year, the President's budget does not contain proposals on Medicare-related budget issues. In addition, the budget does not address a pressing problem facing the Medicare program, the pending insolvency of the Medicare Part A trust fund. According to the Department of Health and Human Services summary of the President's budget, the fiscal year 1996 budget for Medicare benefits anticipates the enactment of legislation to extend certain current law policies that will otherwise expire. The summary states: "These are not new Medicare cuts; rather, these are policies that are currently part of the Medicare program." This hearing will review the Medicare provisions included in the President's Fiscal Year 1996 budget.

In announcing the hearing, Thomas said: "The Administration has chosen to ignore the fact that the Part A trust fund starts spending more money than it takes in during 1996 and will become insolvent in 2001. This Subcommittee will attempt to determine the Administration's rationale behind the limited provisions included in the President's budget in the face of this pending crisis for the beneficiaries and taxpayers."

FOCUS OF THE HEARING:

This hearing will focus on the Medicare proposals included in the President's fiscal year 1996 budget and their impact on the Part A trust fund.

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, Friday, March 10, 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 Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour 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'.

* * * * *

Chairman THOMAS. Good morning. Today's subcommittee hearing will focus on the Medicare provisions contained within the President's budget. We will examine the issues that were included in his budget and those which may have been omitted.

The President's budget includes three Medicare policies. First, it permanently sets part B premiums at 25 percent of program cost. Second, it maintains the freeze on home health and skilled nursing facility payments. The final policy extends Medicare secondary payer provisions, which expire in 1998.

Today, the subcommittee will discuss the part B premium and the Medicare secondary payer. The areas of home health and skilled nursing facility payment policies were covered in an earlier hearing.

It is important to note that the administration, in recommending these policy extensions, stressed that these proposals are "not new Medicare cuts." The President chose to take a hands-off, leave-it-as-it-is approach to Medicare. The President chose not to recognize, much less plan for, the deteriorating financial condition of the Medicare part A trust fund.

According to the most recent Medicare trustees report, as early as 1996, the part A trust fund will begin to pay out more for medical care than it receives from revenue. Furthermore, the trustees report that the trust fund will not only lack funds to cover its obligations for the Medicare beneficiaries by 2001, but it will be completely exhausted sometime later that year.

Now, some may scoff and say, this is not a crisis. They will cite the possibility that the trustees report, due April 1995, will predict that the bankruptcy of the trust fund will occur a year or so later than 2001 because of the recent decrease in the growth of medical costs. They may try to trivialize the issue by pointing to the experience of the last 15 years, where predictions of bankruptcy for the trust fund, they say, were premature.

I think the subcommittee, through testimony today, will learn, however, that the past is not prelude in this instance. Increases in taxes, reductions in the growth of Medicare payment to hospitals, and generally good economic conditions did prevent insolvency in the 1990s. But more than piecemeal fixes are needed now. Rising medical costs and the aging of the baby boomers is catching up with the trust fund. When the fund finally goes bust, it will be in the red by almost $50 billion in the first year alone.

It is unfortunate the President chose not to provide leadership on this issue. The year 1996 marks the start of the spend-down of the trust fund. This action sends off warning signals that this subcommittee will not ignore. If we don't act decisively, if we continue to mortgage the future, our children will be forced to bear a heavy burden. We must summon the courage to act, gentlemen, and protect the futures of our children, as well as ensure that promises made to the elderly are, in fact, kept.

The gentleman from California, Mr. Stark.

Mr. STARK. I hardly know what to say. Facing this list of right-wing lunacy that qualifies as a witness list, I am not sure whether to be amused or cry at the thought that these folks would talk to us about keeping the trust fund solvent.

We are supposed to focus on Medicare provisions in the President's budget, and if the experience of our hearing on February 10 is evidence, we will hear from the majority criticizing the President for not proposing more cuts and, as the chairman has done, pointing with alarm to the crisis in the part A trust fund.

Let us deal with the second issue first. The insolvency of the trust fund is a serious problem and we must pay attention to it, but the last people who have any right to say anything about it are my colleagues on the Republican side. As I have pointed out repeatedly, the Republicans are the only ones who have on the table a proposal which takes money out of the part A trust fund, through a reduction in the amount of Social Security benefits subject to taxation. Some $15 billion would be removed from the trust fund over 5 years, $48.2 billion over 10 years.

It is very disingenuous to complain that the President's proposal doesn't do enough when you have a proposal on the table that takes you in the wrong direction.

The other reason my Republican colleagues' newfound concern about the trust fund is ironic is that the last year they had the chance to help us enact the largest Medicare savings proposal ever proposed, it included, in the Ways and Means Committee reported version of health reform, that which would have done more than any proposal to improve the long-range fiscal health of the trust fund.

Nevertheless, during the full committee markup, the Republicans offered an amendment to remove all of the Medicare savings out of the proposal, and every Republican member voted for this specific proposal.

So I hope, Mr. Chairman, if I report to you that your newfound concern sounds a little phony to this side of the aisle, that we have good reason to be rather skeptical.

The last point is that we have been here before. As you mentioned, I am going to mention it, that the trustees in 1977 reported that the fund would become insolvent in 1987. By my calculation, that was about 8 years ago. By the time President Carter left office, the insolvency date was extended to 1994. Today, the insolvency date is 2001. I understand the next trustees' report will push the insolvency date out a few years further, not through anything we have done.

So years of reform in Medicare, through the creation of the DRG system for hospitals, through the resource-based relative value system for physicians, has kept the trust fund solvent far longer than expected. In maintaining the program solvency, there were absolutely no magic bullets. It has been hard work, something the Republicans don't seem to know much about.

We have been successful in strengthening the Medicare program and have done so without merely shifting costs to beneficiaries. Democrats have done this for one reason. We made a contract, a contract with Americans, not a contract with people who contribute to Newt Gingrich's GOPAC, not a contract with the big insurance companies who put their hired guns on Republican staffs and who buy out elected officials to bring big profits to for-profit hospitals and insurance companies while withholding needed care to the poor and to the seniors. Over the past 30 years, we have maintained a

commitment to the American people and we plan to keep that commitment.

I would offer a word of caution, and that is, don't rely on quick fixes. You can send the beneficiaries a check. You can call it a medicheck or anything else, but that would not be in the long-term interests of the seniors nor of average Americans in this country.

I look forward to listening to a witness list that is probably picked by the CATO Institute and other right-wing think tanks. I must say, it appears to be me to be a waste of time, but I will listen.

Chairman THOMAS. I thank the gentleman for his comments. Perhaps the record should show that we asked the Director of the Office of Management and Budget if she would appear before this subcommittee of the Ways and Means Committee and her answer was, basically, she doesn't "do" subcommittees. We asked; she did not come. We asked the AARP if they would like to testify. They declined to testify.

I would tell the gentleman, in terms of bragging about his efforts in terms of health care reform last year, that a jury-rigged plan to try to salvage the President's ill-conceived proposal passed this committee. I don't recall voting for it on the floor when you controlled the Rules Committee, the floor, and both houses.

So when you talk about honesty and sincerity, let us examine who was asked and who didn't come to appear before this particular subcommittee.

The first panel consists of two individuals who formerly were in the operation of the Office of Management and Budget and, frankly, I believe, have extremely impressive credentials. Deborah Steelman is the former Director, Human Resources, Veterans and Labor, Office of Management and Budget, and she chaired the 1991 Advisory Council on Social Security. Tom Scully is the former Deputy Assistant to the President for Domestic Policy and former Associate Director of the Office of Management and Budget.

We are very pleased to have both of you in front of us. Any written testimony that you might have will be made a part of the record, without objection. You may proceed as you see fit.

Mr. Scully, why don't you begin?

STATEMENT OF THOMAS A. SCULLY, PRESIDENT AND CHIEF EXECUTIVE OFFICER, FEDERATION OF AMERICAN HEALTH SYSTEMS; AND FORMER DEPUTY ASSISTANT TO THE PRESIDENT FOR DOMESTIC POLICY AND FORMER ASSOCIATE DIRECTOR, OFFICE OF MANAGEMENT AND BUDGET

Mr. SCULLY. Thank you, Mr. Chairman, and members of the subcommittee for having us here today.

Obviously, I think, as my testimony states in the beginning, I am in a little bit of a strange position. I spent a lot of time working with many of you on both sides of the aisle over the years, proposing four different budgets that President Bush sent up, many of which proposed just about every way to take money out of Medicare that anybody can imagine.

I have gone from the position of being on the slash proposing side to working for the hospitals now, in which, obviously, we are usu-

ally the number one targets of Medicare cuts. So the biggest chunk and the biggest portion of Medicare is Medicare part A, which is mostly hospital payments. Obviously, any time Medicare is on the table, we are the ones who generally get operated on.

It is a little bit of an unusual position. However, I do think that, realistically, there are ways to take money out of Medicare, and I think there are ways, if it is done constructively, that we can all win, that Congress can get the savings it needs, that seniors can have a much better, much improved Medicare system, and that hospitals, which is what our hospitals are interested in, can get a rational, gradual transition to more of a market-based system that gets rid of some of the perverse incentives that are in the Medicare system right now.

The first problem which the chairman asked us to come talk about today, which is pretty obvious, is the fact that the Medicare trust fund is going broke, again, and, I think, depending on what Guy King and others will testify on this morning, the trust fund will go broke somewhere between 2001 and 2004.

Obviously, we could sit around and complain about the administration's budget not taking enough cuts out of Medicare. Clearly, hospitals would love it if you took nothing out of Medicare. I am sure my members would all be thrilled if there was nothing done to Medicare this year.

But given the public demand for deficit reduction and given the demand for straightening out the public programs in health care, I think that is fairly unrealistic, and my view is and my organization's view is that there are going to be changes in Medicare, that there are going to be cuts in the program, and that we should probably deal with that and find a way to work with you to come up with rational solutions.

I don't think the administration, obviously, did—it is not, I don't think, a particularly partisan view. Senator Exon, the Senate Budget Committee, Time Magazine, and everybody else, said the administration essentially punted on Medicare policies in their budget. I can't say that I blame them. If I had been in their shoes, politically, I might have done the same thing.

But the fact is, they have pretty much left it to the Ways and Means, and Finance Committee, obviously, to come up with major changes in the Medicare program this year. My organization, at least, has chosen, instead of saying, let us just oppose all Medicare cuts, to hopefully sit down with you and try to work out some rational ways to restructure Medicare and to save some money.

I don't think it is going to be easy. Can you take money out of Medicare? You definitely can. It is not easy; it never has been. It is not fun. It is not pleasant when you go home to your districts. It is not going to be pleasant for anybody—hospitals, physicians, labs, anybody. Is it a lot tougher than it was in the past? I think it is.

I think the fact is that cost shifting, which was pretty apparent a few years ago, has largely disappeared. In any major metropolitan area, if you go out and look at hospitals or physicians, in the past, when Medicare cut its reimbursement rate, providers essentially shifted money over to the private side and charged the private payers more. With the advent and explosive growth of man-

aged care, that cost shifting is rapidly disappearing. There is not much opportunity to do it anymore.

I think if you go and ask your physicians or hospitals what their various rates are on Medicare versus private payers, the private payer side has been pretty significantly squeezed the last few years and there just isn't any cost shifting or is not much cost shifting left to do.

So can you save? Yes, I think you probably can save some money. Can you save the $100 to $150 billion over 5 years that many on the Republican leadership have said you can save? You can try, but I think you are going to have a massive meltdown all across the health care system if you try to take that kind of money out of it.

As I mentioned in my written testimony, I think if you get that kind of level of cuts, you are going to have the same kind of reaction that we had in the catastrophic in 1989. You can take money out of the system, but if you want your seniors, your hospital administrators, your patients, and your physicians meeting you at the airport every Friday, very unhappy because the health care system is melting down, at that level of cut, I think that is what you are going to get.

I think, realistically and objectively, if you look at the last two big budget deals we had, the 1990 budget deal, which I was very involved in negotiating, along with Mr. Stark and others on the committee, that budget deal, the original conference report came out of the conference with $56 billion in cuts over 5 years. The major reason that failed was because now-Speaker Gingrich, along with a number of other members, thought the Medicare cuts were too big, and they were scaled back to $43 billion.

That bill very barely passed, and the single most controversial issue in that bill in the 1990 budget agreement, other than the tax increases, was Medicare cuts. So it wasn't pleasant to cut $43 billion out then.

In 1993, the level of cuts in President Clinton's budget package was $56 billion, and that was highly controversial. There wasn't a single Republican vote for that package. Those votes were largely against taxes, but I think the second most controversial issue in that package was Medicare cuts, $56 billion. They were perceived as being rather large and rather painful.

So when you look at taking much bigger numbers out this year, Medicare inflation, health care inflation is much, much lower. The baseline is lower. The pot is smaller. You are talking about taking somewhere between three and five times as much money out of the system as anyone has ever tried before, from a system that is growing more slowly, the baseline is not as fat, and the cuts are much more painful.

Obviously, if you are going to take money out of the system, can you find ways that reasonable budget targets and reasonable health care policy can meet and we can all find results that we can live with? I think there probably are. I happen to believe there are a lot of different ways to do it. I am sure we will discuss them this morning in medicheck or privatizing or voucherizing the system. I happen to believe, and our hospitals happen to believe, that privatizing the system can save a lot of money and get rid of a lot of the perverse incentives that exist in Medicare now.

General Motors, 3M, and any other large company you will find, basically goes out and buys in the private system and private plans. The Federal Employees Health Benefits Plan goes out and uses private contractors to efficiently buy health care. It works in the private sector and, I think, it can work for the public programs.

Medicare is a great program, but I think that you will find that it is a dinosaur as far as payment systems go. We have been trying to reform it for 15 years. There have been a lot of problems anytime you touch Medicare, but, if you look at the private delivery system, there are an awful lot of very rational, easy fixes you can make in Medicare that will make hospitals, physicians, and other providers perform a lot more rationally.

If you privatize, can you restrain growth? I think the answer to that is, yes. Can you get budget savings? I think the answer to that is, yes. Can you get CBO to score it, which, I assume, we will get into a little bit today? I don't think there is any question, if you do it right, CBO has no choice but to score it.

Can you get lower prices through quality and competition between private payers? I believe the answer to that is, yes, and, I think, from our hospital standpoint, we would much rather deal with the private sector and competition squeezing us, and the issue here is definitely squeezing, than having the government continue to regulate us with perverse incentives and having a squeeze that is not fair across the board.

It looks like my time is up.

Chairman THOMAS. The gentleman's time is expired.

Mr. SCULLY. The issue, I guess, for us is it is not always how you cut or how much you cut; it is how you do it. I think that, basically, we prefer to have private sector cuts.

The thing that concerns us is that if you treat Medicare as a bank for tax cuts and for deficit reduction for the next 5 years, you are going to drive terrible health care policy. If you look at Medicare as a resource to solve part of the problem, to get some of the money to solve the problems that you have, then, I think, we can work together, and we would like to work together, to get reasonable amounts of money out of a restructured system.

But if Medicare policy and health care policy is driven solely by budget policy this year, I think Congress is going to have a problem, I think you are going to have a big problem with your hospitals and your people in your home districts, and I think we could have a very ugly year with a lot of screaming and yelling.

We would like to avoid that and we would like to work with you to get reasonable budget policy, reasonable health policy, and help you meet your goals, but I personally don't think Medicare and Medicaid alone are a big enough pot or a big enough bank to pay for all the things you want to do, and I think you will find that, as well.

Thank you, Mr. Chairman.

[The prepared statement and attachments follow:]

Federation of American Health Systems

Thomas A. Scully, President and CEO
Federation of American Health Systems
Testimony on Medicare Provisions Contained in
The President's Fiscal Year 1996 Budget Proposal
Before The Subcommittee on Health
Committee on Ways and Means
February 23, 1995

Mr. Chairman and Members of the Subcommittee, thank you for inviting me to testify today. I am in an admittedly awkward -- but interesting -- position. As a former Medicare budget slasher (as Deputy Assistant to President Bush and Associate Director of OMB), some of you know me as something of an expert on proposing big Medicare cuts. But now, as President of an association of the nation's 1,700 investor-owned and managed hospitals, I'm leading the charge for the #1 "slashees" -- hospitals. Seems like something of a dilemma?

Maybe. But maybe there is a way that we can all win: Congress and the nation get needed savings; seniors get more and better choices and incentives to pick more cost effective health plans; and hospitals and other providers get a gradual transition to a more rational system that rewards them for providing quality, cost effective care.

But First, The Problem: Medicare Is Going Broke.

Even without the need to reduce the deficit, the Medicare program's growth is unsustainable. The Medicare actuaries project that, at current rates, the fund will be insolvent by the year 2001 -- maybe 2003 or 2004 with more optimistic assumptions. **Doing nothing is not a rational policy option.**

Would hospitals love it if there were no Medicare cuts this year? Absolutely! Is that likely to happen given the drive for deficit reduction, the growth of Medicare and the pending insolvency of the trust fund? No.

So what are the options? Can you control spending and help solve the Medicare trust fund problem without ruining the system? Yes-- if you're careful.

Can You Save Money In Medicare? -- Yep, But It's Not Fun

Traditional provider cuts of the past won't do it. Hospitals and facilities used to shift costs to private payers to make up for reduced Medicare payments -- but that can't happen much any more. Managed care and stronger employers have squeezed private payment rates so there is no place left to shift. The health care market is beginning to work, but Congress must recognize those implications -- cost shifting is dying.

Can you save some money without huge tremors in the provider system, and its senior patients? Yes -- but not the $100 to $150 billion over five years that some have claimed could be cut.

Can you try? Sure, but former Chairman Rostenkowski's 1989 hood ornaments could soon be yours. Seniors and health providers will rebel at cuts far beyond anything before attempted -- much less accomplished.

In the 1990 Budget deal, the Conference originally approved $56 billion in Medicare cuts over five years. That proposal went down to defeat largely because of the key defection of now Speaker Gingrich who thought the cuts were too big. The eventual cut was $43 billion over five years.

In the 1993 Budget deal, the Medicare cut was $56 billion over five years. This was enough to cause significant political pain, and was one of the most controversial parts of the package. Not a single Republican voted for the plan -- largely because of new taxes, but Medicare cuts were an oft-cited reason as well.

And these cuts were done when health inflation was higher, the baseline was much fatter, and each dollar cut had less of an impact. So how do you do it without a war with seniors and providers?

Reasonable Budget Goals Can Mesh With Good Health Policy - Restructuring Medicare

Reasonable budget savings can be had through Medicare restructuring. In fact, the budget pressures may provide an incentive to push through much-needed programmatic reforms that might otherwise never happen. Congress can gradually privatize the Medicare system, providing seniors with options/incentives to join more cost effective plans.

The federal government can pay per capita rates to private plans -- just like GM or 3M, or another large purchasing group that efficiently uses private plans, the Federal Employees Health Benefit Plan. Medicare is a wonderful system for seniors, but it is a payment dinosaur. All hospitals and other providers receive roughly the same payment -- regardless of actual price or quality. The incentives and pressures to operate efficiently are far less than they are under private payment schemes. It's no one's fault, but you get what you ask for -- good quality with a lot of wasted dollars.

By privatizing the system you can restrain the growth of payments.

> You can get significant budget savings.
>
> You can get CBO to score it.
>
> And you can create a better system without destroying the one we have.

You can get much of the savings you need, but through a private payment/voucher/certificate system, the market will adjust gradually to the payment squeeze -- with providers competing on price and quality for Medicare business. Instead of making arbitrary cuts in the physicians' Medicare Volume Performance Standard (MVPS), or the Hospital Market Basket, Medicare would slow cost growth the same way private employers have -- through competition over price and quality.

It's Not Always How Much You Cut -- It's How You Do It

If Congress tries to take $100 to $150 billion out of the system over five years, our hospitals will be leading the charge against you. That's simply too much money to take without major damage to hospitals, patients, communities and lots of would-be former employees. I'll be driving patients to the demonstrations.

But, if the cuts are in a reasonable range, we'll roll up our sleeves to work with you to find creative ways to restructure the system. We can work to change behavior -- both individual and provider behavior -- to save money.

The Options Before Policymakers And Constituents Are:

1) Punt, and scream about "protecting Medicare;"

2) Work creatively to restructure and improve Medicare, and capture the resultant cost savings; or

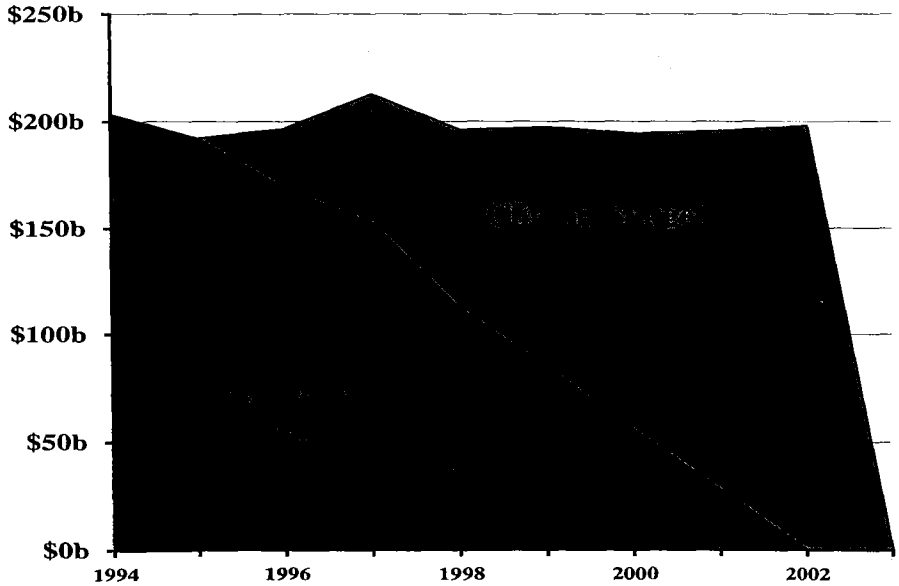
3) Treat Medicare as the "Bank" for tax cuts and deficit reduction and cut too far based on budget driven (not health care driven) policy.

Option 2 seems to be the rational course. We'd like to work with Congress to get there. If the 3rd option prevails, I'll have laryngitis -- as will lots of hospital administrators, doctors and patients -- long before September.

Attachments

The Steep Cost of Balancing the Budget

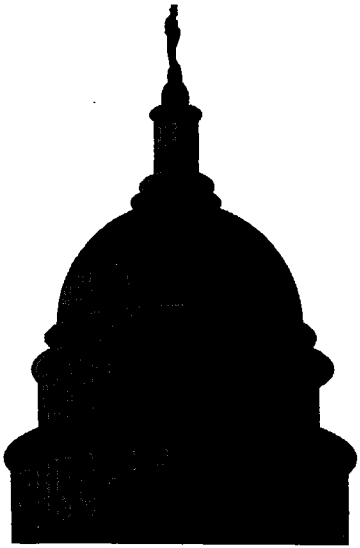
$800 Billion Must be Cut by 2002; $435 Billion in 5 Years



Federation of American Health Systems

Where's the Dough?

or How to Balance the Budget without Touching Social Security or Defense.

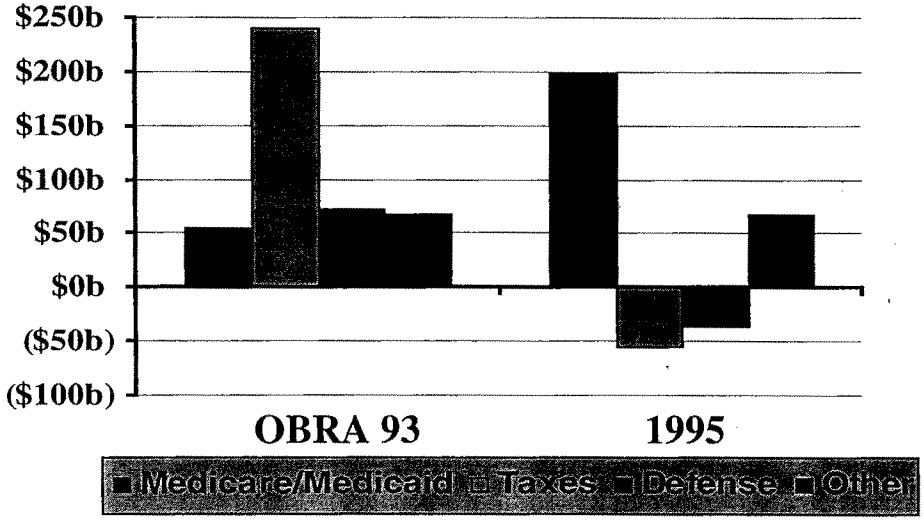


- **Cut Medicare by $100-$150 billion over 5 years.**
- **Cut Medicaid by $100 billion over 5 years.**
- **Cut Medicare again.**
- **Pray**

Federation of American Health Systems

Where Will It Come From?

Taxes Cuts and Higher Defense Spending Make Health Spending the Target*



* Even here, the numbers total only about $200 billion over 5 years— less than half the amount needed for the balanced budget glide path.

Federation of American Health Systems

Chairman THOMAS. I thank the gentleman.

Ms. Steelman.

STATEMENT OF DEBORAH STEELMAN, WASHINGTON, D.C.; FORMER ASSOCIATE DIRECTOR, HUMAN RESOURCES, VETERANS AND LABOR, OFFICE OF MANAGEMENT AND BUDGET; AND CHAIR, 1991 ADVISORY COUNCIL ON SOCIAL SECURITY

Ms. STEELMAN. Thank you, Mr. Chairman.

It is really a privilege to come here today to talk about Medicare, because Medicare reform is a thinking person's debate and has been for a long time. Presidents in both parties have previously sent up a number of proposals to try to deal with the unacceptable growth in the program. Members of Congress in both parties have long accepted the fact that this program needs to be reformed.

We have tried a number of different mechanisms over the last 10 years. I think this year is a very important year to continue what the Congress has worked on for the last decade, to try to get the program's cost down and to try to improve it for the beneficiaries and to try to stabilize its financing. This year is no different than any in the last decade, regardless of what this President's budget contains.

I think there are three reasons to talk about Medicare reform. All have budget relationships, but they are not all relationships to the Federal budget. A lot of them are relationships to beneficiaries' budgets.

For example, current beneficiaries today pay a part B premium and a part A deductible. If we don't do something to constrain the growth in the program, those costs will go up for beneficiaries, as those costs are tied to the costs of the program. In a brief 5 years the part A deductible will go from $716 to $872. In that same timeframe, the part B premium will go from $552 per year to over $700 per year.

If you take a look at just extending that out to, for example, the year 2020, the year in which I turn 65, you end up at a part B premium that is obviously beyond the means of any beneficiary. In the Advisory Council on Social Security, which I chaired a couple of years ago, we did a calculation that if the part B premium remains fixed at 25 percent of program costs, it will no longer consume about 6 percent of the beneficiary's check, which is what it consumes today. Right now, the part B premium, of course, is deducted from the Social Security check. It will consume over 13 percent, over twice as much a portion of the beneficiary's check.

The part B premium in the year 2020, unless this Congress acts, will be $310.50 a month. This isn't doable. So there are many reasons to take a look at Medicare's budget that have a lot to do with the way the program functions in people's lives, and for that reason, we owe the reform debate a serious effort this year.

Of course, there are also future beneficiaries involved. The trustees, as the chairman quoted earlier, were very clear in their instructions to the Congress last year on both part A and part B, specifically, the trustees, Secretaries Shalala, Reich, then-Secretary Bentsen, and Administrator Vladeck urged the Congress to take additional actions designed to control HI program costs through

specific program legislation. The trustees believe that prompt, effective, decisive action is necessary.

Again, I refer you to the trustees' report on SMI costs:

> Given the past and projected costs of the program, the trustees urge Congress to promptly take additional actions designed to control SMI costs through specific program legislation. The trustees believe that prompt, effective, and decisive action is necessary.

The President's current budget is the most recent policy proposal of the administration that follows this trustees' report. This trustees' report was issued in April. This budget document should have responded to the trustees' urgings. It didn't. It is, therefore, up to the Congress to do so.

Clearly, part A and part B matter to beneficiaries, not always in ways that are obvious in our inside-the-Beltway discussions. Another piece of pressure that is on the part B premium is how much of the program now goes through part B versus how much goes through part A. Part A, as you know, is paid for through a payroll tax. Part B is paid for by general revenues and by the part B premium.

When this program was enacted, part A was about 80 percent of the program. Part B only was about 20 percent of the program. Today, that ratio is more like 60:40. So when you say that you are limiting the part B premium to 25 percent of program costs, obviously, it really matters what program costs are. If part A is shifting into part B, beneficiaries' costs, general revenue costs, taxpayer costs are going up. That is why we have to have this discussion as a part of the budget.

Why is it that we keep avoiding the question of Medicare reform? Why is it? Why is it we keep going back to price slashes? Why is it we don't talk about the structural reform that is necessary to reduce the volume, that is necessary to reduce the program cost growth for current beneficiaries, for future beneficiaries, for trust fund balances, for allowing government to spend its resources more wisely and, therefore, spend within its means?

I think it is because we have been scared to face, all the unpleasant town meetings. In fact, reform can be more a matter of common sense if thinking people will engage in it.

If, for example, we were able to reduce Medicare simply to the rate of inflation in the private sector, we could save all the budget targets you need to save and we could make a part B and a part A deductible that was more in keeping with private sector levels. You can't do it by just going to old fashioned proposals. We know that after 15 years. You know how ineffective these proposals have been. They have been stop-gap, budget-driven measures.

Can we build on those to really try to stabilize the program at an inflation rate more akin to the private sector? I think, yes, if you do four things.

Number one, try to get prices to more clearly mirror private sector.

Number two, try to open up HMOs to try to give more beneficiaries the availability of purchasing managed care, if they prefer it.

Number three, open up interim steps like Medicare Select or the current risk contract law to try to create benefit packages that make more economic and rational sense to the beneficiary.

And number four, really try to restructure the program in some sort of certificate-based or voucher-based context to allow beneficiaries to use their market power to compensate for the obvious inabilities of government. Government pricing will always be countercyclical to the private sector. If we allow beneficiaries and their power in the private sector, we will be successful in getting Medicare's growth rate closer to that of the private sector. We will help beneficiaries, we will help the budget, and it won't be the kinds of screaming and pain that Tom has articulated, if we just step up to the plate now.

Thank you, Mr. Chairman.

[The prepared statement and attachments follow:]

TESTIMONY OF DEBORAH STEELMAN, ESQ.
WASHINGTON, D.C.

Thank you for the opportunity to appear before you today. Since my years in the Executive Branch, I have had the opportunity to work in the private sector as it revolutionizes beneficiary participation and health care delivery. I believe Medicare needs to be improved, and can best be improved by incorporating the type of approaches that have been innovated by the private sector.

TODAY'S MEDICARE BENEFICIARIES DESERVE A BETTER PROGRAM

Put plainly, Medicare needs to be a better program. It has failed to keep pace with the needs of beneficiaries and its financing is no longer stable. On these two issues, the President and Members of Congress in both parties agree. Yet the weaknesses persist.

Without reform, Medicare beneficiaries face a future of rising costs, and no ability to reduce their Part B premium or other costs.

- Today, the Part B premium costs $552 per year; by 2000, beneficiaries will have to pay over $700 per year for Part B coverage. Current premium costs equal a little over 6% of an average beneficiaries' Social Security check. According to technical work done by the 1991 ACSS, the Part B premium would rise to $310.50 per month, or over 13% of the average beneficiaries Social Security check. See **Chart 1**.

- The Part A deductible will rise from $716 this year to $872 by the year 2000. See **Chart 1.**

- The typical beneficiary will also incur coinsurance liabilities for physician services as well, raising the potential out-of-pocket liability to well over $2,000.

- Add these amounts to other out-of-pocket expenses typically paid by a beneficiary -- expenses for non-covered services, Medigap protection, and other routine costs -- and beneficiaries pay mightily for the crazy quilt system built on and around the inflexible and outdated Medicare program.

Without reform, Medicare beneficiaries will have only limited or no opportunity to improve their coverage.

- The ability of a beneficiary to choose a health care plan is severely limited by the rigidity of Medicare's statutory and regulatory structure and by HCFA's failure to make information about choices available. Allowing Medicare to continue as currently designed does a disservice to both current and future senior citizens.

- Some beneficiaries seek to lower their out-of-pocket burdens through managed care arrangements, but HCFA does little to provide them with a choice of health plans or information about their options.

- The only way most beneficiaries can improve their coverage is to purchase Medigap coverage that is rigid and rarely as cost-effective as a more integrated policy would be.

Unless Congress acts, beneficiaries have little ability to change this pattern of escalating expenses and inadequate coverage. The ability of beneficiaries to lower their out-of-pocket burdens through managed care -- an option afforded millions of people in the private sector -- will continue to be limited.

Absent reform, beneficiaries will have to contend with an increasingly anachronistic, fractured Medicare program falling further and further behind the private sector with each passing year. Eventually, the discrepancy between private care and Medicare will produce a two-tier system: the high-quality, cost-effective private tier, and the low-quality, high-cost Medicare tier.

It is time to provide Medicare beneficiaries with some options. At a field hearing held by the 1991 Advisory Council on Social Security, one person suggested the need for a different future: **"I think that it is time that we started looking at choices in Medicare. Medicare has gone on a single program and although there have been many reforms that have looked at reforming the payment methods to providers, there have not been reforms that have looked at making choices available and also traditional Medicare that is available today. We might well find that the business of managing the delivery of health care to the elderly is as susceptible to some cost-savings as we think the management of that care in the employment setting is. That has not been explored sufficiently in our opinion, and we believe that a choice product in the Medicare arena is something that we should look into as well."**

TOMORROW'S MEDICARE BENEFICIARIES DESERVE A MEDICARE PROGRAM THAT'S "ALWAYS THERE."

The problems experienced by current beneficiaries are not the only reason for reform. Current estimates suggest that by 2002, the Hospital Insurance Trust Fund will be broke. This year may vary by one or two, but the bottom line remains: the financing of the program is unstable, the costs are escalating too quickly, and future beneficiaries are at risk.

Absent reform of the program, Medicare's Part A Trust Fund will no longer be able to pay the bills. The time to reform the program is not when a crisis is upon us, forcing a choice between driving up already high tax rates, depriving the nation's elderly of their primary source of health care coverage, or forcing the Federal government to assume massive deficits to provide for their coverage.

The need to avoid this future has long been acknowledged by people in both parties in the Congress and the Administration. Yet the current Administration proposes no Medicare reforms in its 1996 Budget. This is especially curious given the fact that no fewer than three Cabinet Secretaries recommended prompt action in last year's Social Security Trustees Report, and the President himself has supported Medicare reforms.

Current Administration officials have said that the Medicare program is growing at an unsustainable rate, and in particular, that the Hospital Insurance program (Part A), requires decisive action in the short-term to prevent bankruptcy.

In April of 1994, less than a year ago, Secretaries Shalala and Reich, then-Secretary Bentsen, and HCFA Administrator Vladeck all signed the Social Security Trustees' Report that concluded:

> *"... the present financing (of Medicare Part A) is sufficient to ensure the payment of benefits only over the next 7 years."*
>
> *"...the HI program is severely out of financial balance and is unsustainable in its present form."*

"...the Trustees urge the Congress to take additional actions designed to control HI program costs through specific program legislation.... The Trustees believe that prompt, effective, and decisive action is necessary."

Similarly, Part B, the Supplementary Medical Insurance program, has been a constant drain on Federal revenues. As **Chart 2** shows, the burden is expected to accelerate in the years to come. I would again refer to the most recent report by Secretaries Shalala, Reich, and then-Secretary Bentsen:

"Given the past and projected cost of the program, the Trustees urge the Congress to promptly take additional actions designed to control SMI costs through specific program legislation.... The Trustees believe that prompt, effective, and decisive action is necessary."

Although few were effective, proposals to rectify the inflation problem in Medicare have been proposed by both parties throughout the last decade, in both the Congress and the Executive Branch.

In fact, in September of 1992, then-Governor Clinton noted that government health care costs were rising at nearly three times the rate of inflation, a refrain he continued to echo throughout the health care reform debate. His proposal to reduce health care inflation was to institute "fallback" price controls in the private sector, and his proposal to reduce Medicare inflation was to lower Medicare reimbursement schedules and payments to the tune of $118 billion in Medicare cuts over five years.

President Clinton's $118 billion cut focused, like many past efforts, almost exclusively on the price of Medicare services. The primary method of delivering care to Medicare enrollees has not changed substantially since 1967, the year of Medicare's implementation. Care is largely uncoordinated fee-for-service, free from appropriate utilization and quality reviews. Had the President's cuts been enacted, they probably would have suffered the fate of its predecessors: evaporation as volume increases overwhelmed any reduction in prices.

- As shown in **Chart 3,** increases in utilization and intensity accounts for most of Medicare's spending growth. Price reductions only increase the incentive for over-utilization.

- Roughly 64% of the increase in Medicare spending between 1995-1999 stems from greater and greater intensity and service utilization.

So, after over a decade of "slash prices" proposals, the lesson should be clear: such methods can achieve very short-term reductions in cost, at best, and if no reform that includes beneficiary choice and utilization is enacted, Medicare costs will return to levels much higher than those incurred by the private sector where such tools have become routine.

Mammoth price cuts to Medicare payment rates such as those President Clinton proposed last year are not "reforms." True Medicare reform addresses beneficiary choice, price, and volume.

HCFA's sole exception in the "only slash prices" method of reducing Medicare costs was a proposal in the Bush Administration to create a volume performance standard (VPS) for physicians.

- However, even the VPS, while successful in restraining the growth in physician fees, has allowed spending to rise at rates beyond inflation. **Chart 4** shows that spending on physician services is projected to rise at 10% per year between now and 2000 -- and it is the slowest growing component of Part B.

HCFA has made little real effort to incorporate modern cost-reducing technology into the Medicare program. (**Chart 5**). The agency has made no effort to adapt the success stories of the private sector. We must.

We know what works in the private sector to contain costs and ensure quality. We are not reinventing the wheel. The private sector has turned toward managed care to contain costs because managed care arrangements do a better job of giving the beneficiary something in return for organizational structure: a lower premium.

- Over 50% of private sector, insured employees were enrolled in managed care arrangements in 1993 *(see **Chart 5**)*; preliminary 1994 figures indicate that private sector managed care enrollment will exceed 60%.

- The consulting firm Foster Higgins reports that for the first time in a decade, private employers have actually lowered the costs of employee insurance. The apparent relationship between increased managed care enrollment and lower health inflation is striking *(see **Chart 6**)*.

- **Chart 7** displays per capita rates of growth in Federal health care spending; per capita Medicare spending is rising *31% faster* than private sector costs.

FOR GOVERNMENT TO SPEND WITHIN ITS MEANS, MEDICARE'S RESOURCES MUST BE SPENT MORE WISELY.

Entitlement spending consumes two-thirds of the Federal budget.

- Medicare alone takes one of every ten dollars the Federal government spends, and Medicare and Medicaid will eat up 16% of the Federal budget in 1995. See **Chart 8.**

- By 2002, the two major health programs will consume nearly one-quarter of Federal outlays, with Medicare alone costing over $325 billion. See **Chart 9.**

By 2003, Medicare will be the second largest Federal program, behind Social Security, greater than Defense and exceeding the combined total of all domestic discretionary programs (**Chart 10**).

In other words, if Medicare doesn't spend its resources more wisely, its appetite will consume more money than the combined total of every education, transportation, environmental, arts grant, occupational training, and public health program in the Federal budget.

IF MEDICARE REFORM IS SUCH COMMON SENSE, WHY DOES EVERYONE WANT TO AVOID IT?

The road to a better Medicare program is clear and there is nothing very dramatic about it except the results and satisfaction real reform will produce over time.

- Bring Medicare per capita inflation in line with that recently experienced in the private sector (**Chart 11**).

  •Reduce prices to mirror private sector prices.

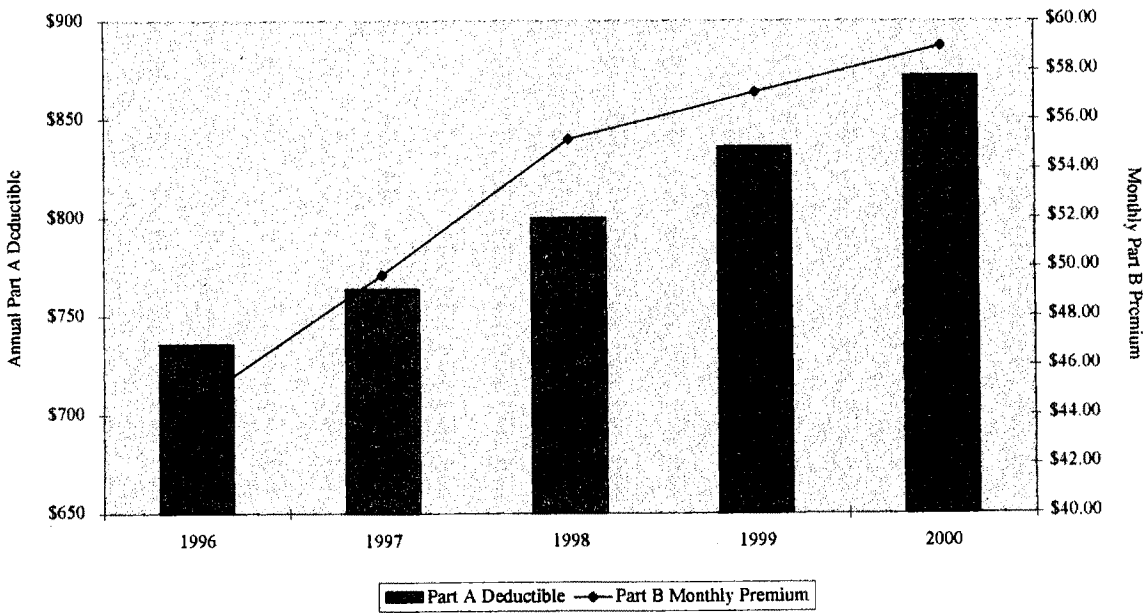
- Increase managed care enrollments by changing antiquated Medicare law and regulations to increase the availability of managed care to all beneficiaries who would prefer it.

- Increase beneficiary participation and lower utilization by opening the Medicare program to the variety of private sector innovations in health care financing and delivery, giving beneficiaries the ability to customize their benefit package and decide how best to improve their coverage.

This cannot be accomplished overnight, and will in fact will probably require the entire seven years now suggested by the Medicare Trust Fund's impending bankruptcy. Beneficiaries -- current and future -- would prefer the job finally get done right. A Congress that does not pave the way for a modern and secure Medicare program will have much to regret.

CHART 1

Rising Medicare Costs Will Require Beneficiaries to Pay More Out-of-Pocket



(Source: CBO)

CHART 2

Increasing Part B Costs Require Ever-Greater Contributions from the General Taxpayer
($ in billions)

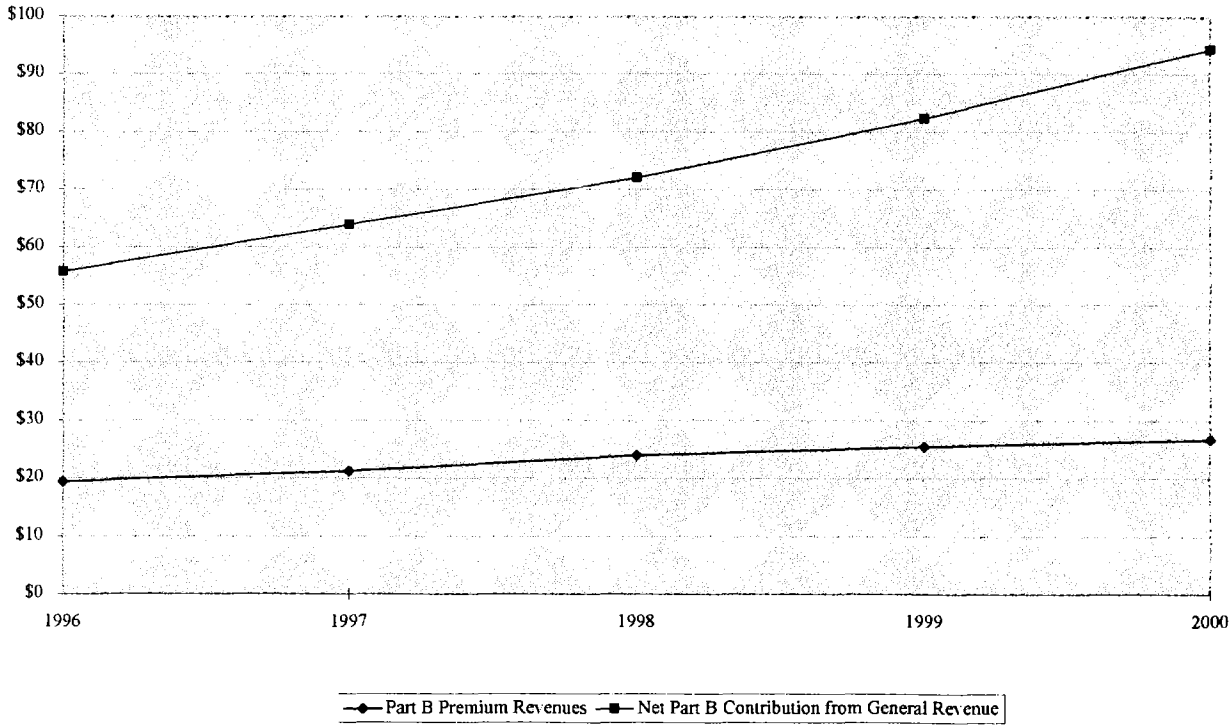
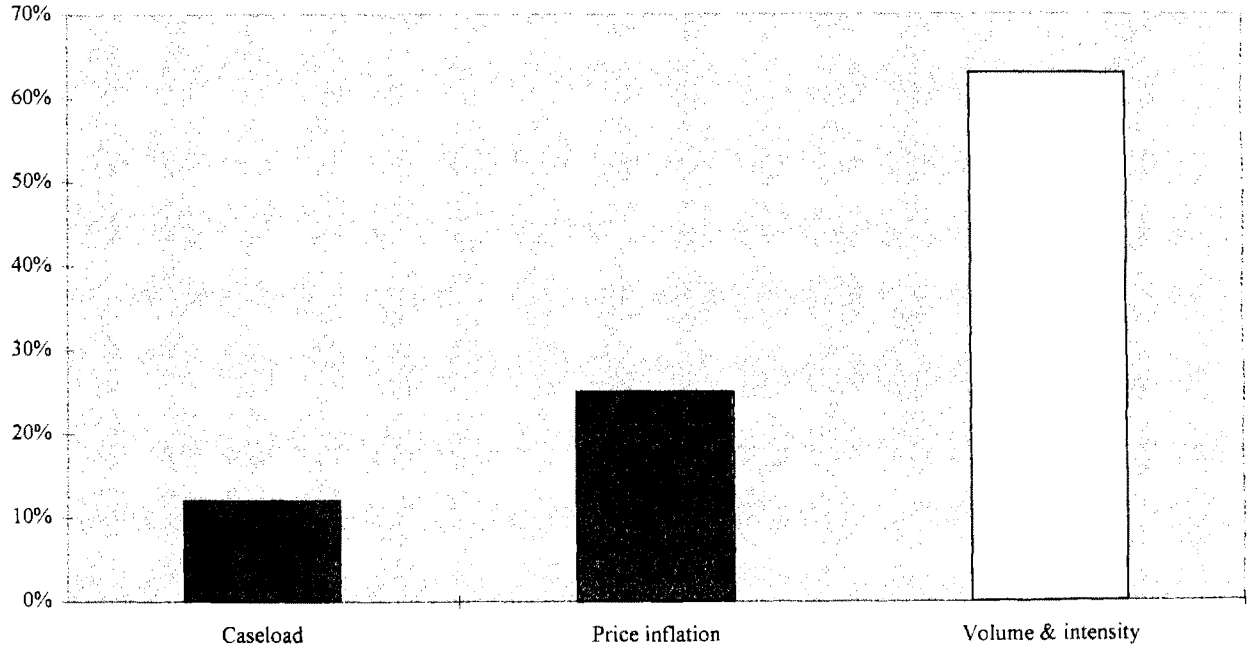


CHART 3

Baseline Projections Are Far in Excess of Current Services. Nearly 64% of Spending Growth Is Attributable to Greater Services

(Sources of growth in Medicare spending, 1995-1999)



(Source: CBO preliminary baseline estimates, January 1995.)

CHART 4

Rates of Growth for Respective Elements of Part B
(avg. annual growth rate, 1994-2000)

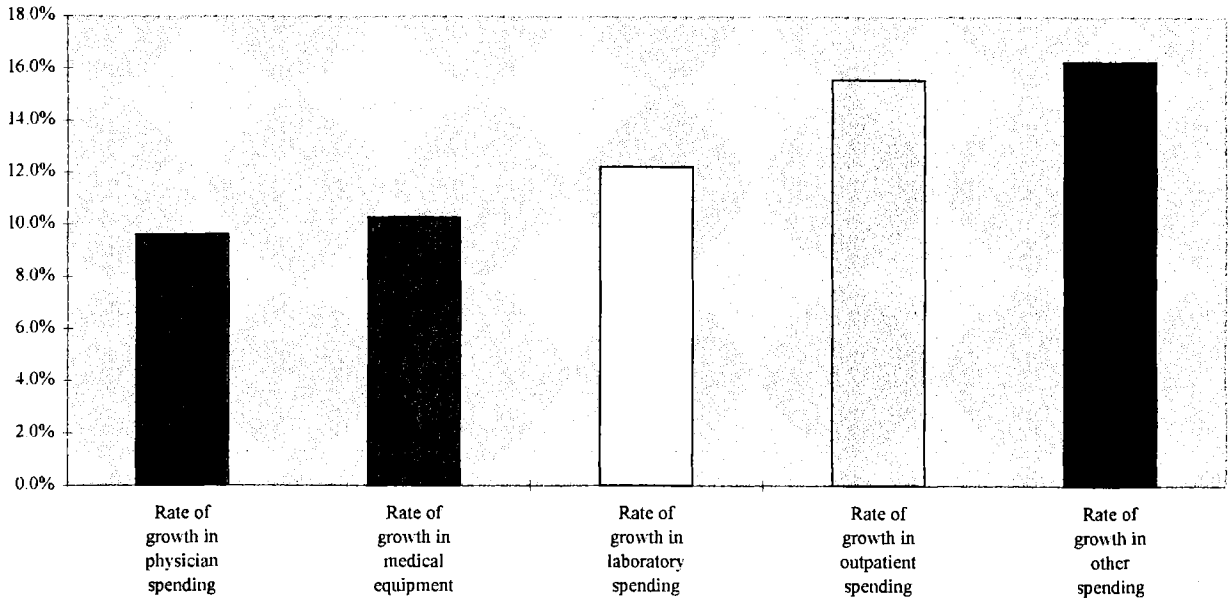
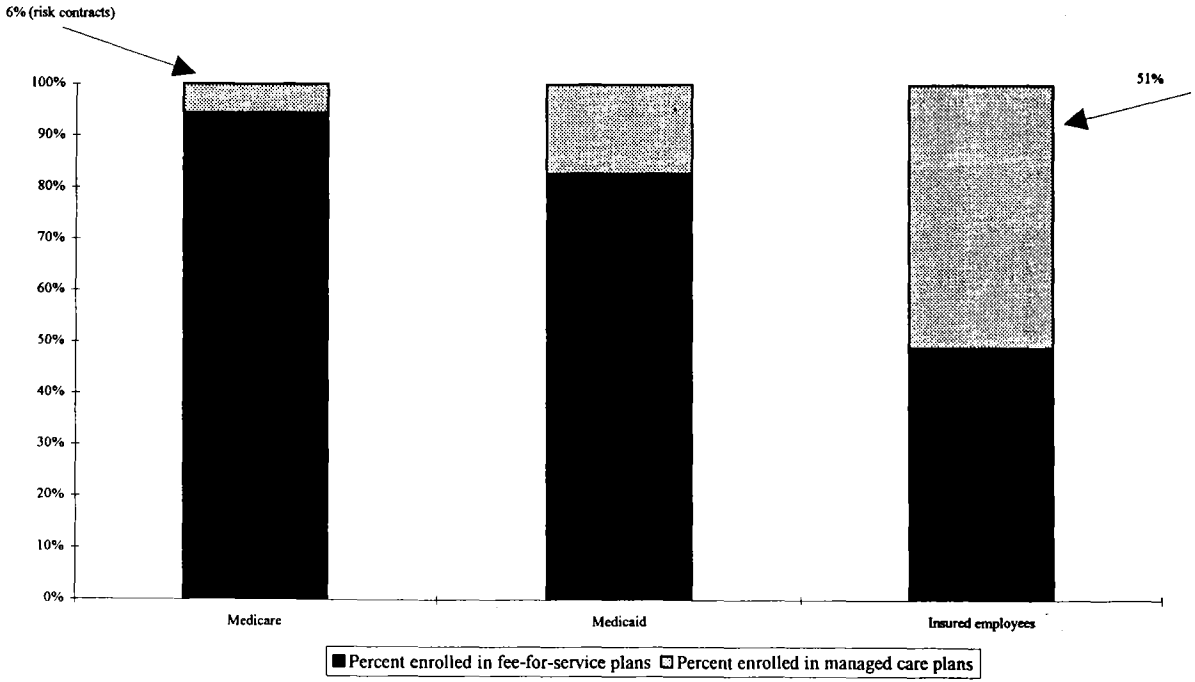


CHART 5

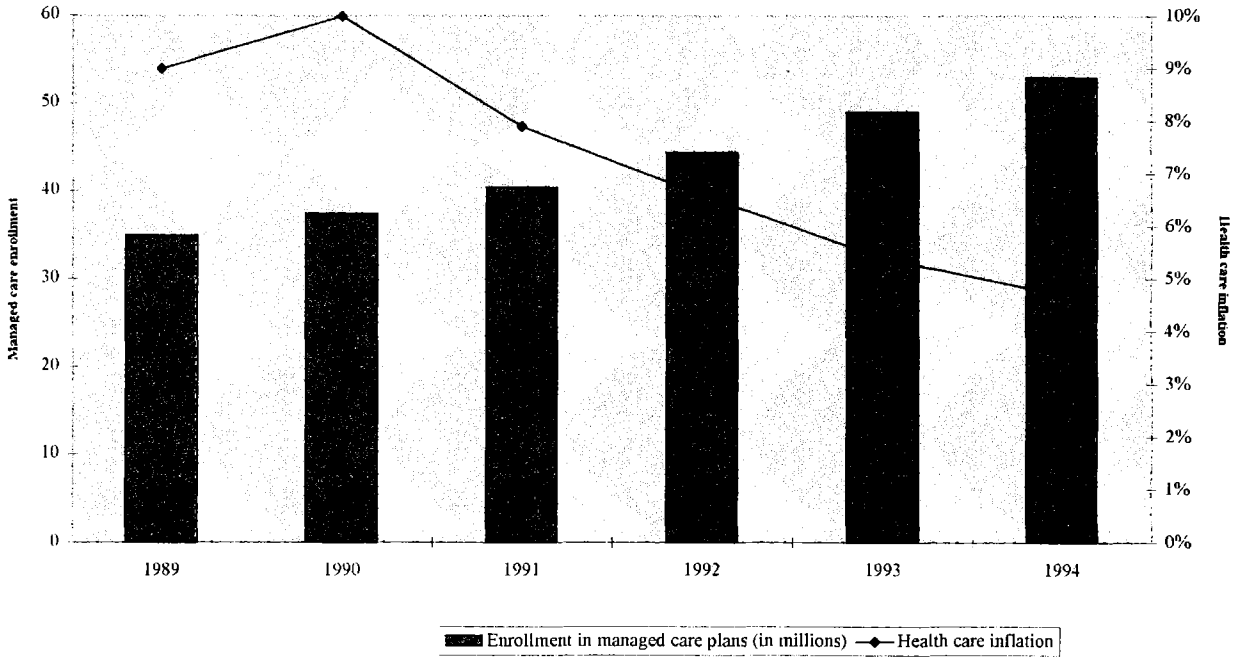
Medicare Does Not Use Modern Health Care Delivery Techniques



(Source: Aetna Health Plans, HCFA data. Managed care includes HMO, PPO, and POS plans. Data for 1993.)

CHART 6

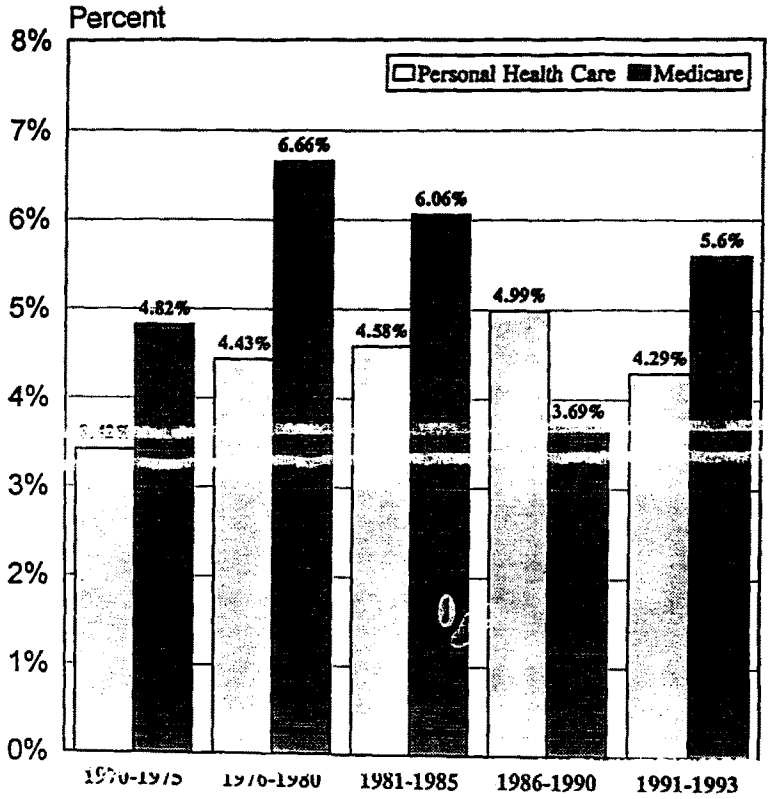
As Managed Care Enrollment Rose by 50%, Health Care Inflation Has Declined by Half



(Source: Marion Merril Dow for managed care enrollees. 1994 Economic Report of the Pres. for inflation. 1994 figures are esimates.)

CHART 7

Figure 4. Average Annual Growth Rate of Real Per Capita Medicare and Personal Health Care Spending, 1970-1993



Source: Figure prepared by CRS, based on National Health Expenditure data, Office of the Actuary, Health Care Financing Administration
NOTE: All real expenditures calculated using implicit price deflator for GDP

CHART 8

Entitlement Spending Consumes 2/3rds of the Federal Budget (Federal Spending 1995)

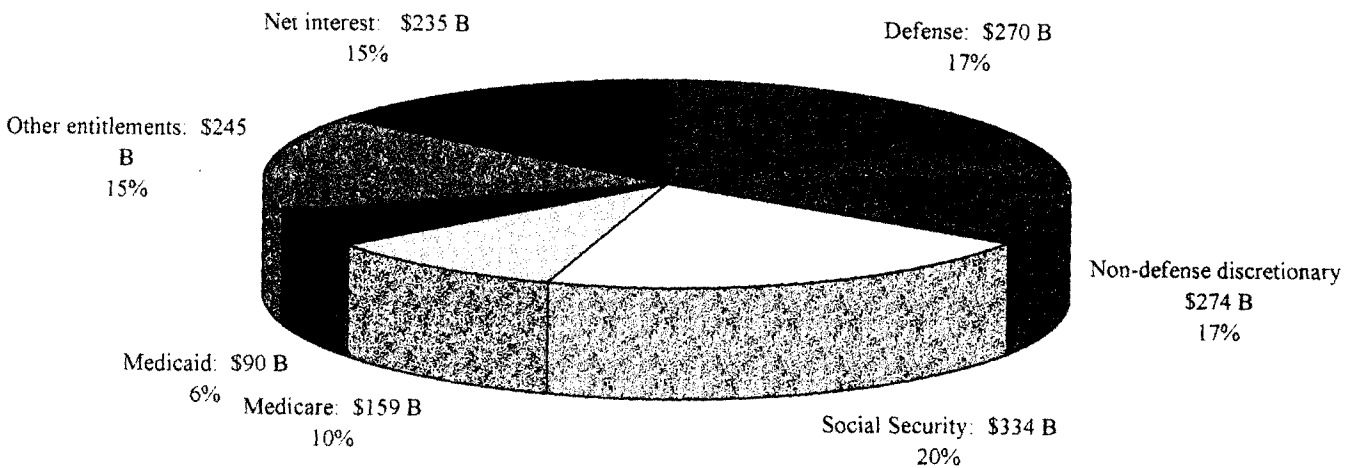
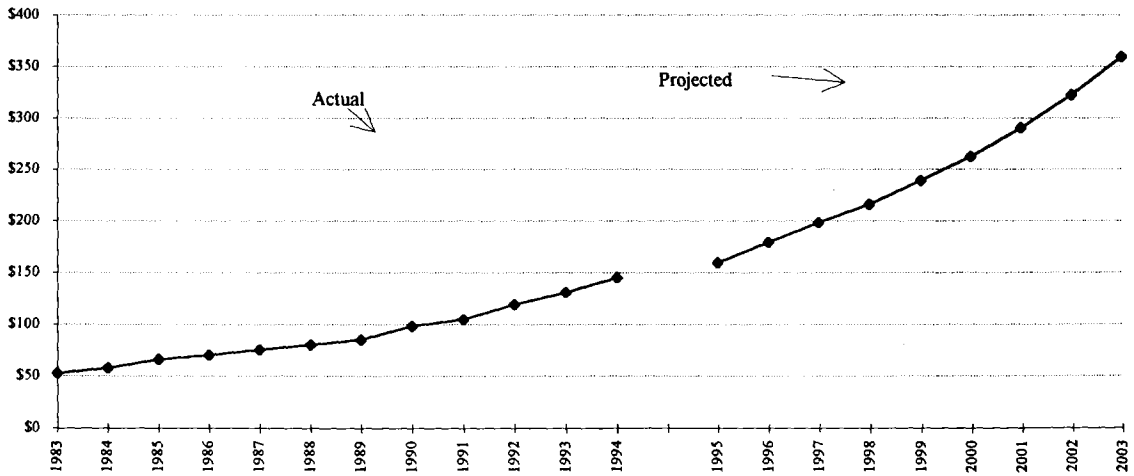


CHART 9

Medicare Will Double in Size over the Next Seven Years Unless Congress Reforms the Program

($ in billions)



(Source: Preliminary CBO baseline estimates, January 1995.)

CHART 10

Medicare is Growing Two-and-a-Half Times as Fast as Family Support or Domestic Discretionary Spending ($ in billions)

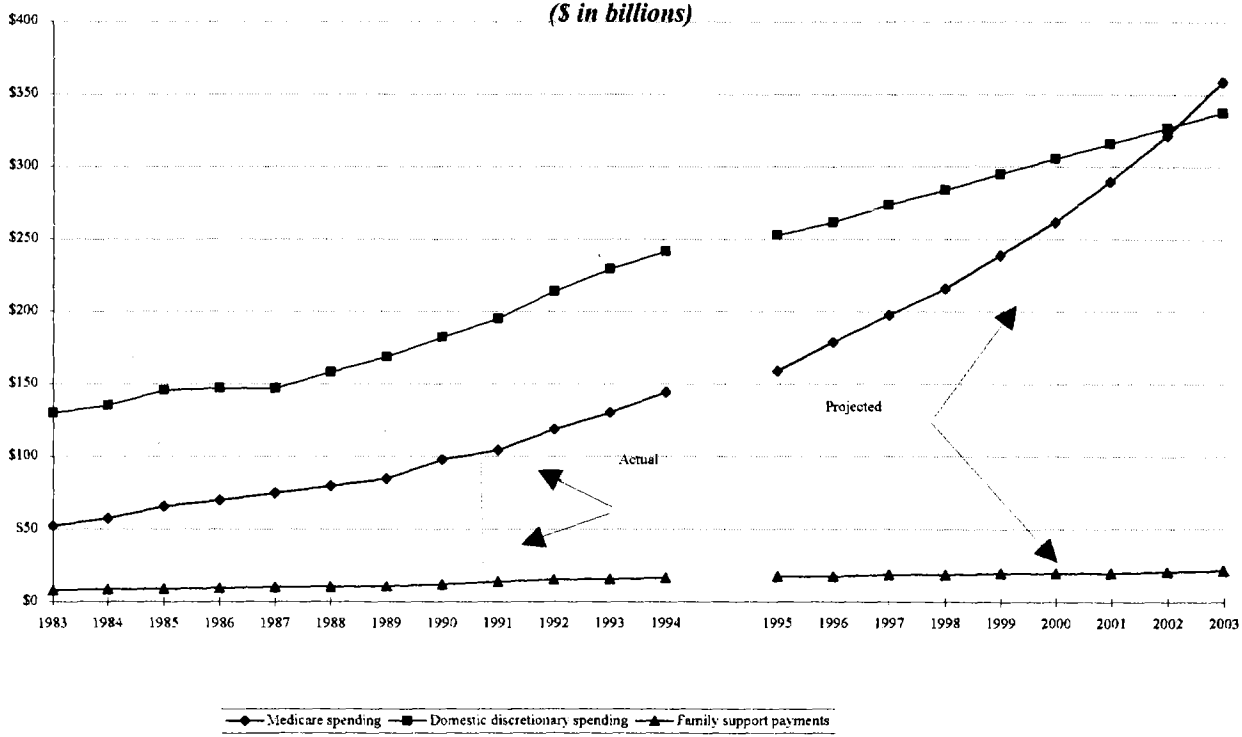
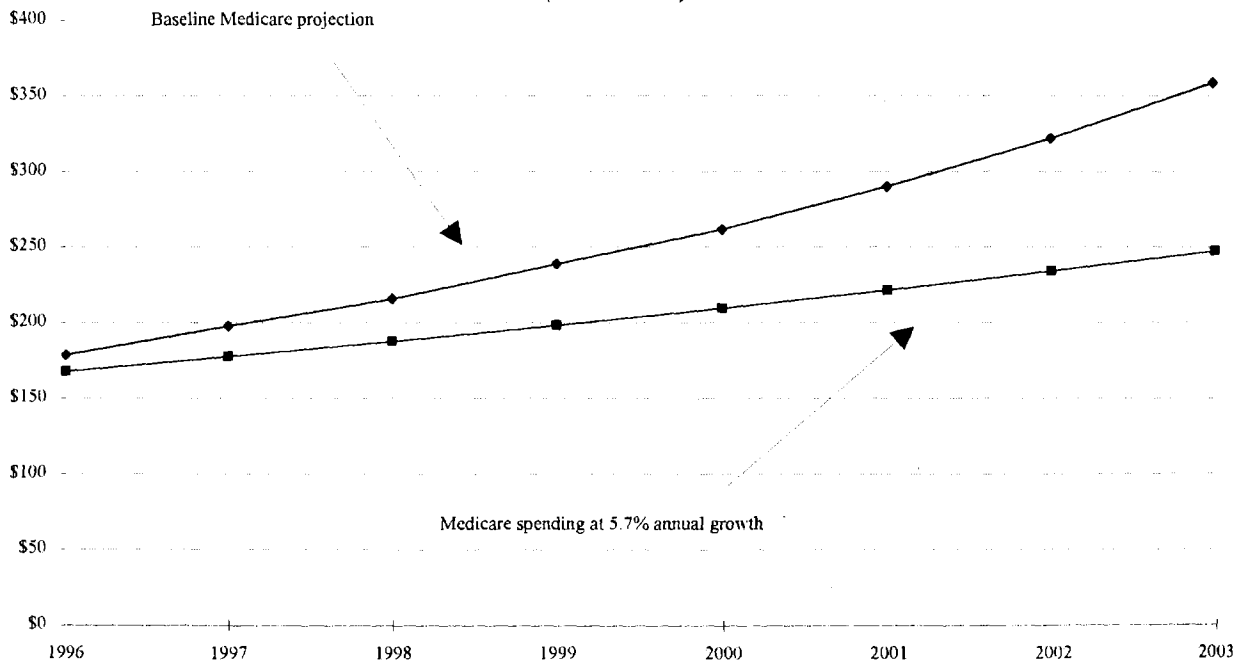


CHART 11

Holding the Rate of Increase in Medicare Spending to Private Sector Health Care Inflation Would Result in Significant Savings

($ in billions)



Preliminary 5-Year Savings from Holding Medicare to 5.7% Annual Growth: $152 BILLION

Chairman THOMAS. I thank both of you very much for a discourse in which you have obviously spent a lot of time and you have a lot of knowledge.

Mr. Ensign will inquire.

Mr. ENSIGN. Thank you, Mr. Chairman.

Ms. Steelman, people say that Medicare has worked well for the last 25 years. Why won't it work well for the next 25 years?

Ms. STEELMAN. I am not sure Medicare has worked well for the last 25 years. Obviously, the program was designed with a need in mind and on a stable financing structure. Over time, over the last 25 years, nothing in this country has stayed the same, especially not in the delivery of health care in the private sector.

The next 25 years for Medicare aren't so much a matter of making it stay the same as making it work well, and to do that, we have to get away from the kind of proposals that we have addressed here over the last 15 years, which are purely price cuts, and we have to talk about what is really going on in Medicare and how to make Medicare work better, how to make it secure for people, how to make sure it is there for all beneficiaries.

The obvious thing is, the place we are not controlling Medicare costs is in volume. The cost of Medicare goes up in three ways, the number of people in the program, the price of the services, and the utilization of the services. Utilization has gone through the roof in the last 15 years, unlike in the private sector, where tools are now routine to get that under control. Those are the kinds of things, I think, we need to do to make sure the program is there for the next 25 years and continues to work well, even though the guts of the program, obviously, have to work differently.

Mr. ENSIGN. When you are talking about the increase in volume, a lot of people say that we are talking about rationing in cutting down the amount of volume. If, in fact, we are talking about trying to decrease the volume, how do we allow the patient to make those choices instead of the government?

Ms. STEELMAN. Volume is not the same thing as rationing at all. Rationing gives the connotation that a needed service will not be provided. In health care, we have learned a lot over the last decade in the private sector on how to make sure needed services are provided and unneeded services are not provided. That is the basic lesson Medicare has not accommodated.

Mr. ENSIGN. Mr. Scully, if we move all these seniors into the private plans and managed care, how do you avoid the cherry picking or risk selection in these plans?

Mr. SCULLY. I would anticipate that Mr. Stark and others would bring that up. I think if you go to a more private sector-driven, privatized Medicare system, where people choose private plans, the single biggest problem you are going to have is risk selection.

We have been looking at that for 4 or 5 years. We did a very large study on that in the Bush administration. I know that the Ways and Means staff has looked at it. I know HCFA has looked at it. There is no perfect answer for risk selection and that is one of the problems in HMO risk contracts now.

I personally believe there are ways to get at it. If you are going to look at a structured system that is a model for it, either FEHBP or a privatized Medicare system where the Federal Government

has a relatively small group of carriers that it selects, that it basically has control over the rate payment to, is probably a good model to figure out how to avoid risk selection.

But there is no doubt that you are going to have risk selection problems in any kind of system that you move to in a privatized system and there is a danger there. My view is that HCFA has the tools to find a way to adjust the capitated payments of Medicare now to make sure that that is limited. My view is that there are a lot of ways to adjust the structure of the payments to private plans in Medicare that can improve on the current—I don't know if you are familiar with the AAPCC in Medicare now—that can improve on the current payment system to make sure that that doesn't happen.

I think the dangers of risk selection, which are clearly there, are nowhere big enough to justify not moving forward to a more efficient privatized system. Clearly, you need to experiment, and clearly, you have to be careful, but I have been looking at it for 5 years and I am convinced that there are ways around it, especially in Medicare. If you are going to experiment with these kinds of systems, Medicare is the place to do it.

Mr. ENSIGN. Thank you, Mr. Chairman.

Chairman THOMAS. Mr. Stark, do you wish to inquire?

Mr. STARK. Yes. I have just a couple of questions.

One of the things, I suppose, we could do, and we are not sure yet how much it would save, but if we required hospitals to charge Medicare no higher than their lowest price in town, we would save a lot of money.

Would your group support that, Mr. Scully? There is some anecdotal evidence that some hospitals, particularly in some States, are giving discounts about 30 percent below Medicare rates to groups to get managed care plans in. It has been an old approach, to say, look, you are a hospital. You can't charge Medicare any higher than you charge your lowest rate. We would save a lot of money that way. The hospitals, of course, have fought it, but maybe that is one of the things they would accept.

Mr. SCULLY. I personally don't think that would work. In my experience, the closest thing we have to that is the Medicaid drug rebate language that I, unfortunately, helped through——

Mr. STARK. Why should I pay more than some insurance company for the same procedure? Why should the taxpayers do that?

Mr. SCULLY. I am not sure what you mean. I guess my view is the market system delivers the most efficient care, eventually. The problem you have is if you, as an individual, are out there buying——

Mr. STARK. I mean the government. I am sorry. Why should the Federal Government pay more than Prudential at the Sisters of Mercy Hospital? If they are giving a 30-percent discount—Ms. Steelman has the answer, but you may figure it out. Go ahead.

Mr. SCULLY. My suggestion is basically that——

Mr. STARK. No, why wouldn't the hospitals accept that? Why isn't that fair? That is all I want to know.

Mr. SCULLY. Because, I think, what the Federal Government should be doing, more likely, is to take 33 million beneficiaries, or,

let us say, in Baltimore, why shouldn't the Federal Government go with Prudential in Baltimore with 100,000 beneficiaries——

Mr. STARK. They can. Seventy percent of the beneficiaries have an HMO available to them. I am talking about us spending Uncle Sam's money. Why should I pay a hospital more than what they are willing to take from other payers? In Maryland, they don't do that. You get one price for everybody, and they are doing a lot better job than any other place in the country.

What is wrong, as an attempt to save the taxpayers money, to say, look, we will pay the Medicare price or the lowest price you charge for a procedure. Why is that unfair to the government? We would save some money, wouldn't we?

Mr. SCULLY. The government, for many years, was the lowest payer, and in many places, still is.

Mr. STARK. But we aren't now.

Mr. SCULLY. It depends on the area, but it is a fundamental belief in whether you prefer markets or regulation. I, as we have discussed for years, do not think fee-for-service rate regulation works.

Mr. STARK. Suppose I prefer markets. What if we go out and bid, which we are about to do, for procedures?

Mr. SCULLY. I think that is great. If the Federal Government goes out in a private payment plan and uses Prudential or uses Kaiser——

Mr. STARK. Why can't I bid directly? We do it when we build airplanes. Why can't Medicare bid in a market to set a rate?

Mr. SCULLY. If Medicare is operating as an actual market player, for instance, in centers of excellence where Medicare goes out and says, we will pay *x* number of dollars to a center of excellence for certain types of procedures, I think that is fine.

Mr. STARK. But you don't think it is fine for me just to bid in the market in a particular area and say, we will take the lowest price in town?

Mr. SCULLY. If you say, we will take the lowest price in town and providers are willing to do that with you and they can operate economically that way, then you are, in fact, operating in the market, and that is fine with me. But for the Federal Government to go out and say, as we did in Medicaid rebates, we will pay the lowest drug price or we will pay the lowest—when you look at the Medicaid rebate, it was a disaster, because——

Mr. STARK. Why should we pay a higher price than Prudential in the market?

Mr. SCULLY. You shouldn't, but just again to use Medicaid as an example——

Mr. STARK. Then what is wrong with my passing a law that says we won't? We will pay whatever a hospital is willing to charge somebody else.

Mr. SCULLY. Because what will happen is exactly what happened in the Medicaid rebate. There will be no more low price, because what will happen is you will go into the market and say, we will pay the lowest price that everybody charges. Guess what? They won't charge that low price anymore.

Mr. STARK. So you are saying you want to let your crowd shift costs onto Medicare and we should pick up the slack. That is what you are saying.

Mr. SCULLY. No, I am——

Mr. STARK. I think the honeymoon is over. You can't have it both ways. If we are expected to be cautious with the public's money, there is no reason on God's green Earth that I should pay Humana any more than they are willing to take from Prudential for the same procedure. It would be, in my mind, absolutely a dereliction of duty and there is no good reason.

Mr. SCULLY. I would agree with you, and in 1990, I helped put the Medicaid rebate law in place on the same theory, and it turned out to be a disaster because what happened was everybody dropped their best price and it hasn't worked.

Mr. STARK. Medicaid is run by a series of States. It has no relationship to Medicare. What you did in 1990 has nothing to do with what we are going to do in 1995 or 1996. I am just suggesting that where hospitals are commonly charging other people less than they are charging Medicare, we kind of look like patsies if we don't get that same low rate.

None of your clients would allow any of their purchasing agents to buy ambulances at a higher price than they could get if they walked down the street and got a bid from the other ambulance company. Why, in the best sense of private enterprise, which none of the witnesses have ever been connected with, I might add, shouldn't we get the lowest price that is being offered in the market?

Mr. SCULLY. I think you should, and I think the way to do it is through private carriers. I think the way the market has worked is for you not to go out and set rates through government regulation, but——

Mr. STARK. Why shouldn't we get it any way we can?

Mr. SCULLY [continuing]. In a market driven system, I am all for it. I think it is great.

Mr. STARK. But you are not for it under the current system? You would just as soon see Medicare waste money if we are in the current system?

Mr. SCULLY. I am very anxious to see Medicare save money, to restructure the system. I just think that going out and, essentially, having Federal Government rate regulation and price setting is very negative for the market. You have a market that is beginning to work and beginning to squeeze. We don't like the squeeze; nobody likes the squeeze. But we would rather be squeezed by the market than by an inefficient fee-for-service system that sets perverse incentives.

Chairman THOMAS. The subcommittee will recess until we get this vote and then come back.

[Recess.]

Chairman THOMAS. The subcommittee will reconvene.

Mr. Christensen may inquire.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Ms. Steelman, earlier, my colleague from California, Mr. Stark, asked a question about pricing and shouldn't the Medicare pricing be similar or the same as others in terms of the private market. He took a couple of jabs at you, and I would like to hear what your response to that question would be.

Ms. STEELMAN. Clearly, Medicare ought to try to get to a price level, inflation level, more like the private sector. That is how I concluded my opening testimony. I think there is a way you can do that, and it is called an open integrated bidding system, or a voucher-type system. That is how you get to that price.

In the private sector, one of the things that has helped the cost crash that has occurred over the last 5 years is fully integrated systems. You used to have this fee-for-service, unsupervised, things happening all over the place. Now you have an integrated system, where a hospital bid for a bed day is part of an integrated bid.

In Medicare, of course, Medicare is an extremely fractured program. What you do in part A pushes out into part B, as we talked about earlier in terms of the premium and the dollars and the flow. What you price for an inpatient bed is different than what you price for an outpatient bed is different than what you price for this or that or the other.

For Medicare to succeed in getting the same prices that the private sector gives, Medicare has to adopt the tactics and the techniques of the private sector, and that means an integrated bid. Clearly, if you gave beneficiaries a voucher or a certificate, however you want to do it, and said to the beneficiaries, here is an amount of money. Go out into the private sector and see what kind of a bid you can get, or if HCFA conducted a bid process, there is no question that prices would fall and bids would fall and that Medicare beds would cost the same as private sector beds.

But you can't simply march in and say, let us have an all-payer system for the whole United States that isn't just as countercyclical and just as regulatory and just as confusing as the current Medicare system.

To get that kind of price, you have to move away from the way Medicare prices today and go into a new structure, and I think it can be done fairly easily.

Mr. CHRISTENSEN. In subcommittee, a couple weeks ago, we heard, Mr. Vladeck never did really give us a very good reason why Medicare Select should not been extended.

It is my opinion that Medicare Select, in one of your points, talking about trying to open up HMOs, expanding it further, might be the direction to go. You have had some experience in this area. Fifteen States currently offer Medicare Select. I think only one has pulled out of that.

What is your feeling as far as extending it permanently and offering it throughout the whole country?

Ms. STEELMAN. There is no question Medicare Select is a great idea and a way for a beneficiary to rationalize their economies in their retirement years. Right now, as we have already talked about, the beneficiary has to pay about $520 on a part B premium, at least $700-plus on a part A deductible, probably $700 to $1,200 for a Medigap plan. We ought to be able to give the beneficiary a way to rationalize and reduce those expenditures.

That is what Medicare Select does. Medicare Select allows the beneficiary to buy one product, get everything covered at an integrated, discounted rate, and save some money and get some extra benefits. That is a step on the road directly to the kind of program that Medicare to has become. The HMO risk contract law is one

step. Medicare Select is another step. There are some things that we ought to do to expand Medicare Select and HMO risk contracts, but we also need to recognize that those are steps on the path.

The ultimate goal is to try to make sure Medicare can operate like the private sector in an integrated product that has all the benefits people need, including pharmaceutical and others, at an integrated price that is going to be a lot lower than buying this stuff piecemeal.

Mr. CHRISTENSEN. Mr. Scully, do you want to comment on that?

Mr. SCULLY. Yes. I spent a lot of time on Medicare. I personally think Medicare Select is great, but it is a baby step. It is a small step. Medicare Select is a very limited, very structured managed care Medigap plan, and, basically, it is a sliver of what you really could do. If you look at what people below 65 have a choice of, all kinds of hybrids, of PPOs, point-of-service contracts, managed care plans, indemnity plans. If you are under 65, you can go out and buy any kind of hybrid contract you want. If you are over 65, you either get an HMO risk contract, a very structured Medicare Select contract.

It is a step in the right direction, but you can do an awful lot more. I think that seniors have nowhere near the ability to choose between different hybrids of plans and types of plans that people under 65 do, and I think what we are talking about, really, with more of an FEHBP-like system is to give you a lot more choice than just Medicare Select.

Medicare Select is a good start, but I think it doesn't go anywhere near far enough, personally.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Chairman THOMAS. Mrs. Johnson.

Mrs. JOHNSON. Thank you very much for your testimony this morning.

To get from where we are today to where we clearly need to go, if we are going to both control costs and expand benefits, because the current Medicare benefit package is really tragically out of touch with good medical practice, what are some of the things that we could do immediately?

This year, there are money problems, but there are also some proposals in the President's budget, the kind of things we have traditionally done that won't impose any new costs but will be scored nicely and so on and so forth, so there are some manageable aspects to this year's program. But there are a number of barriers in the law that we could eliminate.

Would either of you like to talk about a few of those barriers that we could eliminate right now to begin making change and moving in the direction we need to go, and then some of the bigger issues that we might have to face as we reform Medicare?

Ms. STEELMAN. On Medicare Select, one of the main barriers is the fact that it is not renewed for any appreciable length of time so that nobody knows whether they can count on it or not or whether the product will exist. So obviously, we need to do things that beneficiaries can plan on.

Mrs. JOHNSON. That is right.

Ms. STEELMAN. Retirement is not a short-term, 6-month type of deal for Medicare retirees. They want to plan on products that are

going to be there, so that is point on. Reauthorize some of these innovative things in a long-term format that can make a difference to people, so they know it is going to be there.

Second, obviously, one of the problems in the HMO risk contracts are the 50:50 rule and the construction of the average area per capita costs. The 50:50 rule uses a relatively arbitrary share of Medicare beneficiaries to commercial beneficiaries as some sort of a surrogate for a quality determination. I think there are a lot of quality determinations that could be made much more easily and much more productively that the private sector is actively engaged in, in terms of ranking HMOs and patient satisfaction, access to technology, and the like.

So if you open up HMOs to allow HMOs to specialize in Medicare beneficiaries and services, to bring in, perhaps, some of the social services that Medicare beneficiaries need more often, some of the sort of discharge services, after-hospitalization help with things around the house and that sort of thing, then you would have HMOs that cater much better and a much higher quality of medicine and much more likely to Medicare beneficiaries.

You also, of course, have the county-by-county problems and the rate determination. The AAPCC rate fluctuates wildly across the country because it is pegged to Medicare. It shadow-prices Medicare, so you don't really get the savings that you ought to. It overpays in some areas. It underpays in other areas. The AAPCC simply needs a fundamental reassessment to try to make it a better payment mechanism.

Of course, over time, I think any government payment mechanism is going to be countercyclical and probably off the point, so you need to get to a bid process of some kind to make sure that Medicare can match the private market.

Mrs. JOHNSON. I am not sure that trying to reform the AAPCC is worth it. It may be just flipping ourselves around it.

Ms. STEELMAN. I think there are some short-term things that could be assessed, but there is no question, your assessment of the difficulty is correct.

Mr. SCULLY. Debbie covered an awful lot. One thing I personally think would drive people much more—I think if you are going to go to more managed care, more capitation, more networks, whatever you want to call them, which, I think, is where the system is moving, you have to find incentives to do that.

The one incentive that I have always thought was missing in Medicare is the fact that most seniors, the vast bulk of them, are relatively low-income or modest-income people. If you want to give somebody a $5,000 AAPCC in Hartford, if they want to go out and limit their choice—Senator Gramm says he doesn't want anybody to limit his mama's choice. If she could get some money back for choosing to go to a more limited network, she is much more likely to go in it.

Right now, the way the Medicare risk contracts work is if you get a $5,000 capitated payment, you have to spend every dollar of it on a plan, which means more drug benefits, and more eyeglasses. Frequently, a lot of seniors would much rather say, if I saved the government $700, $800, $1,000 a year by choosing a tighter network or a more structured plan, they would just as soon get some

of the money back in savings, and I think that is the real missing ingredient that has kept seniors, in my opinion, from voluntarily choosing managed care a lot more aggressively.

Mrs. JOHNSON. Is there any problem in your mind, since we are only at the yellow light, between allowing seniors to get a discount back and still being able to have the oversight capability to assure that they do get the full bundle of Medicare benefits? Is that going to be difficult?

Mr. SCULLY. I don't think there is a problem there. I think if you went to a pure voucher system, which I, personally, do not think is a good idea, right off the bat, where you gave every senior a voucher to go out and buy whatever they want, you might have that problem. But if you have an FEHBP-like system where, say, in Hartford, you went out and had 10 or 11 or 12 HCFA-certified contractors initially going in, obviously, you would have fairly tight oversight over what they offer and an ability to make sure you have a range of products offered to seniors that gave them a choice of everything that you have as a Federal employee.

Mrs. JOHNSON. Thank you.

Ms. STEELMAN. But even today, I think it would be fairly easy to structure a rebate to a beneficiary in their Social Security check right off the HMO risk contract system. Right now, the part B premium is, of course, deducted from your Social Security check. It shows up, $46.10. Right now, the HMO only has the opportunity to build on benefits. If we structure a way that the HMO can route that money back through the government to a rebate in the Social Security check, you haven't changed anything about current law in terms of oversight or quality or anything else. You have simply given the beneficiary a tool that they can use to make sense.

Chairman THOMAS. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman.

I thank both of you for joining us today. I don't really have any more questions that I want to ask right now, because I am afraid of what you will say, but I do look forward to both of you contributing to our discussions. We are just starting this, as you know, and it is going to be a while before we reach any conclusions, so we will have more opportunities to get together and talk.

Again, thanks for coming today.

Chairman THOMAS. Thank you.

Let me ask you a question. In looking at Medicare as a nationwide structure and looking at the way in which managed care has caught on, that is, it tends to be coastal and in particular areas, it is clear that if we try to move Medicare into a managed care structure, in some areas, it will be a "follower." In other areas, it will be a "leader," in the Midwest, in certain areas.

Does that cause us some concern in trying to create a national program, or should we begin looking at ways in which we can regionalize it or create opportunities to let it follow more of the lead of whatever the health care direction is going in a particular area? Is it old fashioned to talk about a fundamental national program?

Mr. SCULLY. No. For instance, it will probably surprise you, most of the hospitals I work with are not wild about managed care. I don't necessarily look at this as moving to managed care. I look at it as moving to privatization. Up in Bakersfield, I am sure that

managed care is limited, but I don't see why HCFA, for instance, should be the only carrier in Bakersfield. I think you could let Aetna or CIGNA or Blue Cross of whatever offer an indemnity package.

I think what you are really talking about is how the Federal Government now runs Medicare as a cost-plus contract, where they pay the Blue Cross plans, mainly, around the country to administer a federally run insurance program. I think, aside from looking at it as managed care, it is moving toward a risk-based situation where you pay a private contractor to deliver services more efficiently, where it becomes a risk contract instead of a cost-plus contract.

Outside of areas where managed care isn't strong, that doesn't mean that you can't get better services at lower prices out of privately delivered indemnity plans. I don't think it necessarily has to be managed care.

Chairman THOMAS. Just let me respond. You quite rightly gave the answer that you were required to give, in part. The reason that I did not raise it that way is that I am just amazed at the growth in managed care. In California, every time I turn around, the statistic is another 5 percent higher than I thought it was. It literally is reaching 65, 70 percent.

So I was not correct in the way in which I phrased the question, in terms of focusing narrowly on managed care, but, frankly, in some areas of the country, the debate is already over. You were correct in terms of your response. I was simply reflecting the knowledge of the local changes that I have been familiar with.

Ms. Steelman, do you want to respond?

Ms. STEELMAN. Just to suggest that there are a number of innovative products in the health care delivery system. Very often, we end up focusing on managed care because it has made the most difference in the private sector. As managed care enrollees have gone up, health care inflation has gone down.

But, there are other innovative products, such as high-deductible plans. Clearly, medical IRAs have been an idea talked about for some time. High-deductible plans are being experimented with in a variety of Fortune 500 settings and have reached a great deal of success.

Can we use those kinds of ideas in a Medicare reform? I think it is up to us to allow the market to decide and to open the range of choices to the market and to the beneficiaries.

In an area like where I am from, Southern Missouri, where there is practically no penetration of managed care in my rural home town of 3,000 people, we need to make available the whole range of innovative products and see which one takes off and see which one the local area citizenship seems to sign on to.

Having said that, there may also be some ways to increase the tools of managed care in some of those areas. Clearly, the hospital in Springfield, which is the hospital closest to my home town, which is 2 hours away, has already made some inroads in terms of bundling tertiary care services and that sort of thing.

So I think the market is slowly but surely moving in directions that that regional area supports, and all of the movement should

be supported, whether or not it is specifically and only managed care.

Chairman THOMAS. You are correct, and my concern is that we do not lock the government into a particular profile of programs. Had we done that 25 years ago, which we did in terms of the fee-for-service, you would not have taken advantage of the innovations in the private sector. I want to make sure that that synergism is always available, that we don't make the same mistake twice in terms of locking into a time structure which, over time, will clearly change because of the dynamics of the private sector.

Mr. MCCRERY. If the gentleman will yield, since Ms. Steelman mentioned it, I will get into the concept of medical savings accounts or medical IRAs. It relates to what Mr. Scully was saying about some kind of rebate—some way to rebate savings.

In Mr. Scully's comments, though, I gather that he thought it would best work in some kind of up-front savings like in an FEHBP-style or cafeteria plan—in which you choose a lower priced plan and you get some rebate from purchasing a lower priced plan, as opposed to what Ms. Steelman brought up with the medical IRA concept—where you don't know what your rebate is going to be until the end of the year. You create your rebate by lowering your utilization.

Did I misread you, Mr. Scully? Do you think that it has to be some kind of up-front, guaranteed, agreed to savings, or can it be a more wide-open medical IRA-type setting?

Mr. SCULLY. I think you can do it both ways. I think if you went out and you give the senior, a 67-year-old, the opportunity to pick a Medisave account with a $2,000 deductible and they get to put the money in an account and save it to lower the utilization, I think you could do it that way and I think you could structure it that way, as long as there is a clear option.

I guess what I was referring to is if you wanted to go out and give somebody the choice of a tight point-of-service contract so they were going to lower the cost of the plan by 25 percent, the more effective way to draw them into that is to say, you are going to save the Federal Government $1,000 out of the trust funds but we will give you $700 of that back in a rebate. That is more likely than additional eyeglass benefits or drug benefits or something else, in many cases, to draw them into the plan.

I think you can structure it in a number of different ways, if you give people 10 or 12 choices.

My bigger concern about Medisave accounts, since you brought it up, is I think Medisave accounts are great. I also think Medisave accounts are going to bring out the purest, rawest form of risk selection there are. So if you are a fan of Medisave accounts, which I am, I think it is naive to think Medisave accounts are a good idea unless you are willing to look at and take head-on the issue of risk selection, because it is very obvious that healthier people are going to pick the lower cost plan.

Mr. MCCRERY. That is why I didn't bring it up a few minutes ago.

Mr. SCULLY. I am sorry.

Mr. MCCRERY. But I am hopeful that we can talk and maybe discover some way to harness that energy in individuals, as far as

trimming their own utilization, and yet find some mechanism to adjust so that government or insurance companies, don't get stuck with all the bad risks.

Ms. STEELMAN. I should say, I don't even think managed care has finished evolving and that managed care will find a connection with higher deductibles or Medisave-type ideas.

In managed care, one of their chief problems, obviously, with first-dollar coverage, is utilization for unnecessary cuts and bruises or things that you should have stayed home to take care of. So I think we will see a marriage over time. I don't think the market is anywhere close to being fully evolved. As the chairman indicated, we have to make sure that none of these options are prejudiced until we see how beneficiaries direct things.

Mr. MCCRERY. Thank you, Mr. Chairman.

Chairman THOMAS. To conclude the second round, the gentleman from New York, Mr. Houghton.

Mr. HOUGHTON. No questions, Mr. Chairman.

Chairman THOMAS. Mr. Stark, for a second bite of the apple?

Mr. STARK. Thank you, Mr. Chairman.

I just want to make a few attempts to straighten out the spin, at least, on the record. In the last decade——

Chairman THOMAS. The gentleman's time has expired. [Laughter.]

Mr. STARK [continuing]. From 1984 to 1993, the growth in hospital and physician expenditures per enrollee were lower for Medicare than they were with private health insurance, both for hospitals and physicians.

Second, I know that both the witnesses know this and even the Higgins analyst for the recent study that has been touted for the lower costs have warned us, don't get too optimistic, because what they basically know is that a shift to managed care or HMOs gives you a one-time savings, and that as far as we know and any evidence points out, there is no follow on and that costs after the one-time savings continue to increase as rapidly as the average.

Third, I have nothing against Medicare Select except that we have found that the growth of managed care plans in the unregulated atmosphere of Medicare have led to a lot of gouging and deaths in low-quality care.

Prudential, for example, has stolen $3 billion from its customers and has been indicted and convicted of felonies and fined over $300 million. I would say, are those the people you want to run your health care program?

Humana, in a recent HCFA study, is shown to have four or five times the number of reverse complaints, where people have asked for medical care, Humana has denied it, and it has been reversed by HCFA.

Most recently, in December 1994 in the Sun Sentinel, they have run their third exposé of the HMO systems. The national search for a workable, efficient health care system looked to Florida's HMO system as a role model, and something was wrong, terribly wrong. They have had a five-part series. They say the basic idea was sound, but the fact is that they found enrollment fraud, inadequate medical services, rampant profiteering by promoters who took advantage of the dearth of legislative regulation.

The bottom line, the HMO reform effort in Florida has evolved into a separate and dangerously unequal care system. The fraud system cost taxpayers $650 million a year. Florida's booming HMO industry is fraught with problems. Earlier projects led State and Federal officials to order corrections in HMO plans. Sadly, the latest investigation found even worse abuses, and it goes on.

The problem is that you cannot allow these people to steal, deny care, and go unregulated. I am not suggesting that the Federal Government ought to necessarily be the regulator, but what HCFA has proposed and what many of us have proposed is standards, then, if the States do not have regulations to protect patients who are not capable of making a market-based decision because they are inadequately trained and it is very confusing and the insurance salesmen are generally not very honest people.

Without adequate protection, we would be putting at risk the most fragile of our citizens, whether they are rich or poor, Republican or Democrat. You cannot do this, experience has shown us, in an unregulated manner.

So as soon as we can agree that there will be reasonable standards and regulations to protect the patients from underutilization, to protect unscrupulous operators who are rampant in the HMO industry today from stealing money and escaping to Spain or wherever they are now hiding out, until we can get some sense that there is a stewardship of the health of the seniors and the government's money, we should not trust this industry. Their record is fraught with fraud, abuse, and no one, in good conscience, can accept the responsibility for the obscene treatment in which this profit-dominated enterprise has used the sickness of elderly Americans for obscene profits.

Once we realize that we have a responsibility, not only to them to make profits but to the people who we represent, we can proceed to expand the coverage available to the seniors.

Mr. McCrery. Would the gentleman yield?

Chairman Thomas. The gentleman's time has expired. The Chair is in doubt. Is that a question?

Mr. McCrery. I was going to ask a question.

Mr. Stark. It was a major question about the efficacy of the HMO industry, as it exists today. I would be happy for them to respond.

Chairman Thomas. It is going to have to be on somebody else's time.

The gentlewoman from Connecticut.

Mrs. Johnson. I think it is very instructive that the article you are quoting, Mr. Stark, is about Medicaid HMOs and touches on some experience with Medicare HMOs. Both government-run systems, and we have no analogous degree of fraud in the privately run HMO systems. Furthermore, HCFA knew about the fraud problems in the Medicare HMO system in Florida in 1990 and did nothing. So this is hardly an advertisement for how we are going to save seniors from the dangers of the system. In fact, the big advances in quality oversight and quality monitoring have come in recent years from the private sector, not from the public sector.

But my question goes to two things and goes back to the issue of risk assessment that was raised earlier, because I think we have

to do that. If you want to get into this issue of quality and who does quality better and why the quality problems have been so big in the publicly run programs, that certainly is a good topic for us to discuss and it would be worth a whole hearing itself.

I did want to point out that these articles are all about government-run HMOs and government has known about the problems and has been completely incompetent to solve them over a number of years.

Mr. STARK. Would the gentlelady yield?

Mrs. JOHNSON. In just a moment. Let me ask my question.

My question goes to the issue of risk selection as we move Medicare into a system in which the individual has more choice. We had testimony 2 weeks ago to the effect that where 25 to 30 percent of the people in an area are in managed care, there is no problem of risk selection and companies that can medically underwrite don't, even for the senior population.

This says to me that medical savings accounts are a perfectly comfortable option for the private sector, as long as we have reached some critical mass of participation in integrated system care.

Would you agree or disagree? Are we reaching an era where medical underwriting isn't going to be a problem, anyway, and we can accelerate that through action that we might take, particularly as we look at bringing seniors into this system? We certainly can't allow seniors to be discriminated against.

Ms. STEELMAN. I agree very much with your observation, that as the market evolves, risk selection issues diminish. Much of the discussion about risk selection reminds me, unfortunately, a lot of the debate we had last year, on trying to anticipate every single problem associated with some massive restructuring, down to the 100th degree, and if we can't solve that, then we can't do anything.

I think we do need to turn this over to the market, where these problems are diminishing, and, step by step, watch it very carefully. Do we have a spiral that is out of control? We have a policy process here every year, of which this hearing is simply the beginning, in which we can go back and address those issues.

We cannot, sitting in Washington, anticipate how the market will behave or how beneficiaries will choose to use their dollars. We can only know that it cannot possibly be worse than what we have done the last 15 years, trying to run it from government.

So I think these things should not be barriers to action but should be carefully watched, try to track the private sector, try to make sure that the incentives are such that the integration of these plans does move up at some predictable simultaneous kind of level, so you don't have a massive insurgence into one kind and no availability in another area. But I think these problems are doable and we just have to do it over time.

Mr. SCULLY. If I could throw in for one brief second, I think, in a situation where we have guaranteed issue, guaranteed renewability, every plan that accepts seniors would have to take everybody, the opportunities for medical underwriting are a lot less.

Nevertheless, I think the one serious risk of going to an FEHBP-like program in Medicare, and I don't think there are any risks except this, are risk selection. I think the options for it are limited.

I think the risks are lower than most people think. I think HCFA could do a lot better job than most people think of trying to figure out a way to do a risk adjustment process, but I think you have to go in with your eyes open.

I remember in 1989 when RBRVS came up, and everybody said the same thing about the Hsiao schedule—we can't possibly figure out what we should pay at different rates. It wasn't perfect then and it is not perfect now, but they did a pretty good job of balancing off the payment scale. I think they could do a pretty good job of balancing off the payment scale as far as an amended AAPCC or some kind of a risk-adjusted payment system goes. It may not be perfect, but I think it would be a great improvement over the current system.

Mrs. JOHNSON. Thank you.

Chairman THOMAS. Mr. Ensign.

Mr. ENSIGN. Thank you, Mr. Chairman.

Ms. Steelman, we have talked some in the past about the Medisave accounts, and I just wanted to get into it a little more. Some of the benefits, I think, of the Medisave accounts aren't brought up a lot of times in discussion.

As you know, with my background in veterinary medicine, one of the aspects of that is that people actually have something at stake because they are paying out of their own pocket. But also, what comes of that is that the veterinarian has to explain to the client when they come in exactly what they are paying for, why they are paying for it, why they should choose plan A or plan B, get an x ray, get a blood test, or whatever it is, and has to justify it to the client. Because of that, you have a very good doctor-client relationship there.

One of the problems we have in our health care delivery system today is the deterioration of that doctor-patient relationship. So I see one of the side benefits with the Medisave accounts is that you are getting the patient back into more of the mode where they are accountable, and also, you would put the doctor into a mode to become more of the patient advocate and say, hey, you should go over here and get an MRI for $1,800 or over here for $300 and help them justify why that person should shop in the marketplace.

I think that that is the key to the Medisave accounts, not only the benefits that it can bring to the patient by having them use less services—I don't even see that as the benefit as much as I see them actually shopping at that point, and, therefore, bringing the market forces back into the health care field.

As a veterinarian, if you look at the whole field of veterinary medicine, we have held our costs way below inflation for a long, long time, as far back as, I think, there are probably statistics held on veterinary medicine. We offer a lot more services, and yet we have the same education, we have a lot of the same drugs, the same technology and everything, we just don't have a lot of the government involvement that they have in the human health care field.

Ms. STEELMAN. In restructuring Medicare, I think we do have to take advantage of those same incentives. It is completely unclear to me how we technically incorporate a Medisave idea into a privatization and a voucher across the whole range of services. The idea

behind a voucher would be to give people the ability to make choices for themselves. Some people would rather have an HMO. Some people might want a high-deductible policy. I am not sure they would necessarily make that decision on their health status. I think there are a lot of other factors involved.

But how do we make sure that works? For example, if the Medisave or medical IRA is a tax-advantaged product, how do we make sure it works with a voucher? Do you lower the voucher level to compensate for the tax advantages this product gets? I think there is a lot of work that needs to be done to refine this idea, and I would urge you, when talking to the various proponents of medical IRAs, to try to get some of that work underway, because, to my knowledge, it isn't.

Mr. ENSIGN. Thank you, Mr. Chairman.

Chairman THOMAS. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I am not sure I want my father's health care determined on the basis of what we do in veterinary medicine, but I would like to ask a question. As I know of it, there are only two studies——

Mr. ENSIGN. Would the gentleman yield for a second?

Mr. MCDERMOTT. Mathematica and GAO have done the only studies on the effectiveness of managed care in Medicare. They say when you control for risk assessment that there is no savings in managed care, both studies.

Can you give me any study, not anecdotes—I don't want to hear one case at a time, I want to hear a study, that there has been any real study of this issue?

Mr. SCULLY. I am not sure that—not to disagree with you, but you can draw the conclusions. I am familiar with the studies. I can't think of an additional one, but what those studies basically say is that 95 percent of the AAPCC, because of the fact that HMOs, given the current structure, happen to draw younger, healthier patients, for the most part, that, in fact, the government does not save money under that current structure at 95 percent of the AAPCC. I wouldn't necessarily disagree with that.

I would strongly disagree with the fact that you can't save money under a capitated network system, the changes and the incentives of the system. I just think that there is no doubt in my mind, and I used to look at it in the past, that 95 percent of the AAPCC—is the government saving money on that? Probably not. Is it costing them something? I think you can have a good debate about that.

But I think that is a fundamental flaw in the structure of the way we do Medicare risk contracts now. It doesn't mean that managed care doesn't work.

Mr. MCDERMOTT. Now that we have talked generally that there is no study that suggests there is a savings, at least, you haven't given me a name of one——

Mr. SCULLY. I am not sure there is one that suggests there aren't, either, but——

Mr. MCDERMOTT. Until you produce one, we will stipulate to the fact there isn't one. Let us go to the individual case. My father is 89 and my mother is 85. My father had an endarterectomy about 10 years ago. He had a stroke about 4 years ago. He has had chron-

ic heart disease since he was 72 years old. He has skin cancer and several other problems.

What HMO is going to want to give my father a policy and charge him the same as a 65-year-old who is playing golf everyday at some nice place and in good shape and has no problems at all?

Mr. SCULLY. First of all, under the current system, they don't have any choice. They would have to cover him.

Second, the AAPCC is geographically and age adjusted, so if he is 89, he would get a payment based on the fact that he is 89 and not 65. So it is not all that disadvantageous for them to take him, and, in fact, they do get a capitated rate based on the fact that he is 89 and where he lives.

Mr. MCDERMOTT. That is with government regulation. Remember, we are getting rid of big government. This proposal for vouchers is just to hand my father $2,000 or $3,000 and send him out into the market.

Ms. STEELMAN. No.

Mr. SCULLY. That is certainly not what I understand it to be and not what I would——

Mr. MCDERMOTT. What kind of consumer protection would you put in?

Ms. STEELMAN. There is no question that the rate and age adjustments would have to be maintained under any system that we are discussing. The voucher is not something like food stamps. The voucher is where——

Mr. MCDERMOTT. Oh. This is not community rating? You are going to allow underwriting on the basis of age even inside the——

Mr. SCULLY. No.

Ms. STEELMAN. No.

Mr. SCULLY. It is community rated on the basis of age. What you are saying is——

Ms. STEELMAN. The voucher, the value of the voucher, is linked to the individual qualities of the individual, just like in the AAPCC today. That could not change. It wouldn't work if you changed it.

Mr. MCDERMOTT. So you are saying that it won't be any problem. My father is going to get, with his voucher, enough so that he doesn't wind up coming to me and my brothers and sister for his out-of-pocket costs?

Ms. STEELMAN. I think we need to make this clear. A voucher is not a specified amount for every individual in the country. A voucher is a mechanism into a system. The individual can enroll anyplace, and the government's payment will have the same kinds of factors engaged as you do in the AAPCC.

Mr. MCDERMOTT. Can't they do that under Medicare now?

Mr. SCULLY. No.

Mr. MCDERMOTT. Why? What prevents them?

Ms. STEELMAN. How would a PPO qualify under Medicare now?

Mr. SCULLY. If the plan qualifies, in most areas of the country, there are very few and they are pure HMO risk contracts.

Mr. MCDERMOTT. If they have a qualified plan, Medicare has more choice than any plan in the country. If the plan is so bad it can't qualify, you probably don't want people in it, anyway.

Mr. SCULLY. I think it would be virtually impossible to find——

Mr. MCDERMOTT. These would just be the scumbags of the delivery system. But if they can live up to minimal Federal standards, there is absolute choice under Medicare.

Mr. SCULLY. I think it would be virtually impossible to find a city in this country where Medicare beneficiaries have the choice of as many polices as anybody in the Federal Employees Health Benefits Program.

Mr. MCDERMOTT. Seventy percent of the Medicare beneficiaries live in an area with HMO service availability. Seventy percent of the Medicare beneficiaries live in an area that has available to the Medicare beneficiary a managed care or HMO.

Mr. SCULLY. Maybe one, and it is probably a risk contract, and I will bet if you looked in those areas, the Federal Employees plan would probably have 10 or 12 choices, if not more.

Chairman THOMAS. The gentleman's time has expired.

Ms. STEELMAN. There are a number of questions that have been raised here, though, that are worth pursuing, because this is a thinking person's debate. How you structure this so that Medicare can work over the next 25 years, can be secure, is a thinking person's debate.

Chairman THOMAS. Absolutely, and I just want to ask the gentleman——

Mr. MCDERMOTT. It can't be done on a galloping horse in the next 35 days. Do you agree with that?

Ms. STEELMAN. I don't know that anyone is suggesting that.

Mr. MCDERMOTT. OK, as long as that doesn't happen.

Chairman THOMAS. The gentleman from Washington should seriously consider the idea of a sitcom based upon a psychiatrist in Seattle whose father has an interesting lifestyle that he is trying to determine what he ought to do.

Also, this afternoon, the gentleman from Washington has an opportunity, as we mark up Medicare Select, to provide us with more data as we move the Medicare Select program to a national program, so that we can better determine what is going on.

The gentlewoman from Connecticut does want just a moment.

Mrs. JOHNSON. I think it is important, because I do think that, in the end, what we are involved in here is a thinking person's debate. If we don't come out with the right answer, we are going to do great harm to our seniors.

I think it is important to clarify what choices seniors currently have. Seniors currently have primarily a fee-for-service choice. The only HMO choice they have is where an HMO has a risk contract with the government. So the fact that 70 percent of people live in an area where there is an HMO option in the market doesn't mean they have access to it, and I think that we have to be very clear about that.

Mr. STARK. Why don't they?

Mrs. JOHNSON. Because those managed care plans do not have a risk contract with the government. One of the reasons——

Mr. STARK. I said, 70 percent of them have risk contracts or other Medicare-approved contracts available to them in their area. Seventy percent of Medicare beneficiaries have it available and only less than 10 percent take it.

Chairman THOMAS. The chairman is going to exercise his prerogative and thank this panel.

Mr. SCULLY. Thank you, Mr. Chairman.

Ms. STEELMAN. Thank you.

Chairman THOMAS. One of the things that I do want to underscore is that this is a thinking person's game. We do need to look at options available to, and that only underscores, I think, the failure of the President's budget to participate in this debate at all.

I thank the panel very much.

The second panel will be Roland E. "Guy" King, who was former Chief Actuary with the Health Care Financing Administration; and Robert Myers, who was the former Chief Actuary of the Social Security Administration.

I am anxious to get these actuaries in front of us so that we can discuss trust funds, pay ins, pay outs, and that sort of thing.

Mr. Myers, why don't you begin? Without objection, all of the written statements will be made a part of the record and you may proceed as you see fit to inform us, Mr. Myers. Thank you.

STATEMENT OF ROBERT J. MYERS, SILVER SPRING, MD., FORMER CHIEF ACTUARY, SOCIAL SECURITY ADMINISTRATION

Mr. MYERS. Thank you, Mr. Chairman. It is always a pleasure and a privilege to testify before the Committee on Ways and Means.

Before getting into the matter of the Medicare provisions in the President's budget, what they are and what I believe they should have been, I would like to discuss, briefly, three other matters.

First, what should be done about health care costs? We all know that, over the years, health care costs have been rising rapidly for a number of reasons—namely, the greater presence of insurance, so there was less out-of-pocket cost—although in the last few years, that, perhaps, has slackened off—the increasing utilization and the better analytical procedures and techniques that have been made available for health care generally.

There are three ways that this problem can be handled. First, costs can be contained by reducing the remuneration of providers. Second, costs can be reduced by limiting the services available, and third, the rising costs can be met by additional financing, either directly or indirectly.

In my view, although the remuneration of the providers of services can be subject to some control, this can be overdone. I think that this is well evidenced by what happened when the DRGs were instituted by the 1983 amendments. What resulted, primarily, was reduced cost for the Medicare program, but cost shifting to the private sector. Now, there appears to be some reversal going on in this area. But these procedures to me, is not the real solution.

Similarly, I do not believe that services should be limited. I believe that people should, in general, be provided good medical care and should have it readily available. Again, there are some instances where completely unnecessary services should be controlled.

Currently, there is the buzzword, "managed care." This means many different things to different people. Managed care is just fine,

in my opinion, if it is managed for the sake of the beneficiary or the patient. However, if health care is managed primarily for the sake of the insurer, so as to cut out services that really are necessary but maybe are not so clearly necessary, I think that is not a good idea. That is more like controlled care.

I come down to the fact that the real solution to the problem is to provide adequate financing. I know that it is unpopular to say that we should have higher premiums or higher taxes, but I think that people, particularly when they need medical care, do not consider the cost as the primary element.

The second thing that I want to mention is in connection with the accuracy of some past actuarial estimates for Medicare. Often, in the debate about what should be done about health care in this country, the actuarial estimates are denigrated, and the estimates are always said to be too optimistic.

This is not necessarily the case, and I refer to the original estimates for Medicare, where the comparisons that are made show that the costs were 10 times understated, that is just not correct.

I also discuss in my testimony the relationship between Medicare and Social Security programs and the general budget.

Getting now to the major subject, the future operations of the hospital insurance program, as you well know, the trust fund is going to run out of money in about 5 or 6 years. It should be noted that, when the trust fund runs out of money, the program does not come to a halt. What happens is that the payments to the providers of services are delayed more and more, and the program does not just stop.

The President's 1996 budget proposal, unfortunately, did nothing in this long-term area. It merely extended several temporary provisions, such as that the part B premium rate for the enrollees should never be more than 25 percent of the average per capita cost.

For some years, I have been saying that something ought to be done about the long-range financing problem of the hospital insurance program. If nothing else, a tax rate schedule should be put in the law, horrendous as it might seem, that will make the program self-supporting over the next 75 years and will, thus, draw real attention to the problem.

I think that something should be done about this immediately. Five years off is not far away, and it is much better to plan in advance and take action carefully than to have a last-minute crisis solution.

Any changes should be made primarily for the sake of the program, rather than for the general budget, other than as to part B, where the general budget really is paying some of the costs. As to part A, changes should be made one way or the other, and they do not affect the budget. I develop that further in my prepared testimony.

Finally, as to the recommended changes for part A, I would do it by the traditional method, a little on the financing side and a little on the benefits side. In other words, I believe that the payroll tax rate for HI could well be raised, gradually, over the years, beyond its present level of 2.9 percent for employer and employee combined. At the same time, I would put some of the pain on the

beneficiaries by introducing daily cost sharing for all days, and not wait until the 61st day.

For part B of Medicare, I believe that certain changes should be made to make the program less costly as a governmental program and shift some of the cost back to individuals. I would raise the initial deductible from $100 per year up to about $250, so as to make it comparable with what $50, the original amount, was in 1965 when the program was enacted.

Also, I think that the enrollee premium should bear somewhat more than 25 percent of the cost. It is not possible to move it back to the original 50 percent, but it certainly should be moved up that way, but, again, slowly.

I believe that these changes are feasible and affordable, especially if done gradually.

Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT BY ROBERT J. MYERS PRESENTED TO THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON WAYS AND MEANS, HOUSE OF REPRESENTATIVES, FEBRUARY 23, 1995, WITH REGARD TO THE MEDICARE PROVISIONS IN THE PRESIDENT'S BUDGET

Mr. Chairman and Members of the Subcommittee: My name is Robert J. Myers. I served in various actuarial capacities with the Social Security Administration and its predecessor agencies during 1934-70, being Chief Actuary for the last 23 of those years. In 1981-82, I was Deputy Commissioner of Social Security, and in 1982-83, I was Executive Director of the National Commission on Social Security Reform. In 1994, I was a member of the Commission on the Social Security "Notch" Issue. I am currently a member of the Prospective Payment Assessment Commission.

Before discussing the Medicare provisions in the President's 1996 budget proposal, I should like to deal with three other matters. The first one is the all-important subject of what should be done about the continually-rising health-care costs. The second relates to the accuracy of actuarial estimates for the Medicare program, particularly those made in 1965, when it was initiated. The third is the relationship between the Medicare and Social Security programs and the General Budget.

What Should Be Done About Health-Care Costs

For many years, health-care costs have been rising more rapidly than the general price level. This has been due to a number of factors, such as increasing utilization as more and more people, until recently, have had less out-of-pocket cost due to insurance (including Medicare) and such as the availability of new, although costly, techniques and medicines.

If costs are to be contained -- i.e., lowered, at least in relative terms -- this can be accomplished by either limiting the services available or reducing relatively the remuneration of the suppliers of services. Services can be limited by rationing, requiring long waits, or so-called managed care (however that may be defined and practiced). As to managed care, this may be beneficial to the individual if it is done primarily for her or his interests, but the reverse is the case if it is done primarily for the insurer's sake. Certainly, the procedure under managed care should not be that the managing physician requires the individual to use more generic drugs, have fewer lab tests, and less frequent physician and specialist visits than he or she would want for his or her own family under similar circumstances.

I believe that the problem of rising health-care costs should not be handled by reducing services, except when it is completely clear that unnecessary ones are being rendered. Nor do I believe that legislative limits should be imposed on the providers of services unless it is clear that excessive charges are being made. Certainly, as to the Medicare program, the type of cost-shifting that has occurred as a result of legislative action was most unfair and was not in accordance with the intent of the original law. No more of such cost-shifting should occur, and it would even be desirable if the present degree thereof were lessened.

Thus, I have no solution to the problem of rising health-care costs. There should be great cost-effectiveness without reducing or unduly limiting services, as well as increased cooperation among patients, insurers, and suppliers of services -- and not head-on adversarial and antagonistic relationships. So, in the end, it comes down to the matter of increased financing, rather than reduction of services.

Quite naturally, nobody likes paying more for things like health services that are not necessarily enjoyable at the moment. However, I believe that people should, and will, do this rather than spend the money on creature comforts, such as more luxurious homes, more cars, and more entertainment. And, because of the uneven incidence of health-care costs, the risk must be spread around by some insurance mechanism.

Accuracy of Actuarial Estimates for Medicare

Some critics of health care reform have cited the variation of the actual experience under the Medicare program from the estimates for it which were made in 1965 as evidence that any estimates for new proposals may be far too low. In particular, some point out that the estimate for Medicare costs in 1990 which was made in 1965 was $9 billion, whereas the actual experience was $111 billion, or over 12 times higher. Such comparisons are invalid for a number of reasons, including the changing value of the dollar and new benefit provisions being added. For details on this matter, see my article, "How bad were the original actuarial estimates for Medicare's hospital insurance program?", The Actuary (Society of Actuaries), February 1994.

Relationship Between Medicare and Social Security Programs and the General Budget

Perhaps the greatest hoax -- even fraud -- that has been imposed on the American public is the information that the federal government has given about the relationship between the General Budget and the various trust-fund programs, such as Medicare and Social Security.

Under the so-called Unified Budget procedure, the operations of these programs are included within the general operations of the federal government. Thus, any excess of income from sources outside of the federal government are shown as reducing the General Budget deficit, which does not really happen because such excesses are invested in government bonds and other obligations which are part of the National Debt. If the trust funds had not had such excesses to invest in government obligations, the general public would have had to have purchased obligations of similar amount, and the National Debt would have been exactly the same size. Thus in fiscal year 1994, the real General Budget deficit was $293 billion, or $90 billion higher than the deficit shown under the Unified Budget procedure.

Further, under the Unified Budget procedure, the interest paid to the trust funds on their investments is not counted as interest, but rather merely as an intergovernmental transaction. However, such interest is real interest and adds to the General Budget deficit and the National Debt in just the same manner as any other interest paid on obligations of the federal government. Thus, the interest on the National Debt is now running at about $300 billion per year, rather than the horrendous $200 billion quoted under the Unified Budget procedure.

The operations of the Social Security trust funds and the Hospital Insurance Trust Fund, which are with respect to self-supporting payroll-tax-financed programs, should not be considered in connection with the great deficit problems of the General Budget. The operations of the Supplementary Medical Insurance Trust Fund do, however, affect the General Budget, because about 75% of the contribution income comes from the General Fund of the Treasury and is thus a true expenditure of the federal government.

In summary then, changes in the Hospital Insurance program, as well as the Social Security program, should be made solely for the sake of such programs, and not at all for the sake of the General Budget deficit.

Estimated Future Operations of the Medicare Program

In fiscal year 1994, the Hospital Insurance Trust Fund increased by about $3.4 billion, to $129.6 billion at the end of the year. However, under the Unified Budget concept, these operations contributed about $10 billion to the budget deficit, because receipts from the general public fell short of disbursements.

In the next year or two, the balance of the Hospital Insurance Trust Fund will peak and will then decrease rapidly until becoming exhausted, likely at some time in 2001. During this period, the operations of this trust fund will result in increasing amounts being added to the budget deficit under the Unified Budget concept, but nothing at all under the real budget deficit basis, because the bonds being redeemed by the trust fund will, most likely, be purchased by the general public indirectly through new public issues.

It should be noted that, if the trust-fund balance is ever exhausted, the program does not come to a halt and go out of existence. Rather, payments to the suppliers of services are delayed, and increasingly so as time goes by.

In fiscal year 1994, the Supplementary Medical Insurance Trust Fund decreased by about $2.4 billion, to $20.9 billion at the end of the year. In subsequent years, the fund balance will fluctuate around this level (or perhaps somewhat lower), but is unlikely that it will ever be exhausted, because the premium rate is determined annually so as to maintain the solvency of the program. Both the real budget deficit and the deficit under the Unified Budget concept are significantly affected by the operations of this trust fund, because about 75% of the cost of the program is borne by the General Fund of the Treasury.

The President's Budget as a Solution to the Financing Problems of Medicare

Unfortunately, the President's 1996 budget proposal does not address the financing problems of the Medicare program -- the impending exhaustion of the Hospital Insurance Trust Fund, which will very likely occur in about 5 years, and the high, ever-rising cost of the Supplementary Medical Insurance program. Instead, the budget proposal merely extends certain financing and reimbursement provisions which were of a temporary nature.

Changes should be made in the near future to solve these problems before we get any closer to the brink of disaster. Such changes as to the Hospital Insurance program should be solely for the sake of the program's solvency, and not for the sake of the deficit under the Unified Budget concept. However, changes in the Supplementary Medical Insurance program that are made for the sake of the program will also significantly reduce the real budget deficit (and also the deficit under the Unified Budget concept).

As to the Hospital Insurance program, I believe that no changes should be made in either the reimbursement-of-suppliers provisions or in the quantity or quality of health-care services furnished to the beneficiaries, but rather additional financing should be provided. This can be done either by increasing the payroll tax rate or by payments from the beneficiaries. The latter can be done through increased cost-sharing amounts or, for middle- and high-income beneficiaries, by income taxation on the value of the benefit protection which was not "purchased" by their own after-tax payroll contributions during their working years. Also, the minimum eligibility age for non-disabled beneficiaries should be increased from age 65 when the corresponding age for unreduced Social Security benefits is so raised (i.e., beginning in 2003, on a gradual basis). Preferably, a combination of several of these alternatives should be used.

Increased payments from the beneficiaries through increased cost-sharing amounts could be accomplished by instituting relatively small daily co-payments for the first 60 days of hospitalization. Income taxation of the benefit protection could be done by the inclusion of, say, 75% of the average value of the protection for the entire covered population in taxable income; the 75% factor amply allows for the amount "purchased" by the beneficiary's own payroll taxes. Note that making the benefit protection be subject to income taxation does not mean that income tax would be payable (because low-income persons do not have any income-tax liability now, and would not have any even with the value of the protection included).

As to the Supplementary Medical Insurance program, again I believe that no changes should be make in either the reimbursement-of-suppliers provisions or in the quantity or quality of services. The overall cost of the program could properly be reduced by increasing the initial deductible from $100 to $250 per year, so as to make it be much more comparable in real terms to the $50 which it was when the program began operations in 1966. Further, this amount should be automatically changed in the future as per capita program costs rise. Also, the minimum eligibility age for non-disabled beneficiaries could be increased in the same way as was suggested for the Hospital Insurance program.

Further, the proportion of the program's cost paid by the beneficiary should be gradually increased from the present 25% to, say, 35%; this is still far below the 50% proportion which was present when the program began. Also, the Part B enrollee premiums could vary with the income of the beneficiary, so that high-income ones would pay 75% of the program's cost; however, the transition should be developed so that no sharp breaks or notches occur as the income rises. Alternatively, for each covered person, the amount contributed on her or his behalf by the General Fund of the Treasury could be made subject to income taxation.

Conclusion

The choices to be made in solving the financing problems of the Medicare program are not at all easy. However, I believe that they should be make as soon as possible, no matter how painful they may be. To postpone any longer will make matters much more difficult later. I strongly believe that no reductions in quantity or quality of health-care services should be made, either directly or indirectly, or in the reimbursement bases for providers of services. Any changes made should be in the financing area or in the benefit cost-sharing or coverage provisions.

Chairman THOMAS. Thank you, Mr. Myers.
Mr. King.

STATEMENT OF ROLAND E. "GUY" KING, CONSULTING ACTUARY, ERNST & YOUNG, WASHINGTON, D.C.; AND FORMER CHIEF ACTUARY, HEALTH CARE FINANCING ADMINISTRATION

Mr. KING. Thank you, Mr. Chairman.

I would like to give you a little bit of perspective on my 15 years as Chief Actuary of HCFA and how the program has grown during that time. I just recently left to become a consulting actuary with the firm of Ernst & Young, so I have had an opportunity to observe the rate of growth in this program for a long time.

Back in 1978, the hospital insurance trust fund was projected to be bankrupt by the year 1990. Today, it is projected to be bankrupt by 2001, and the reason for the change, of course, is that there have been two tax rate increases, there has been additional revenue injected into the program by raising the wage base, and there have been some price cuts in part A. But with the possible exception of the DRG reform, there has really been no reforms in the hospital insurance program.

The coming bankruptcy of the program, though, is really just the tip of the iceberg. After the date when the trust fund is depleted, the hole is just going to get deeper and deeper and it is going to continue to get deeper and it is going to accelerate for many years.

I know that there are people who have said that these projections are a red herring, and they have suggested that we should just sit back and wait and see whether these dire projections really materialize before we decide to do anything.

But the financial problems that are being projected now in the hospital insurance program aren't the result of very pessimistic assumptions about the growth in health care costs. I actually consider the economic assumptions underlying the projections in the HI trustees' report to be very optimistic.

The real problem now is the coming post-World War II baby boom. When 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, of course, the growth in the number of beneficiaries is going to accelerate. Currently, about four taxpayers support each HI beneficiary, but by the middle of the next century, only two taxpayers will support each HI beneficiary.

This problem has gotten so large that it is not going to be possible to solve it painlessly at this point. To place income and expenditures in balance, even over the next 25 years, is going to require either a 34-percent immediate reduction in benefits or an immediate 52-percent increase in the HI tax rate, or some combination of the two. Even then, that only solves the problems through the next 25 years, and the years beyond that, which are even tougher to deal with, will still remain.

Some people have suggested that the recent apparently slowdown in growth in the rate of health care costs would suggest that there is going to be favorable experience in the HI program and that we ought to wait and see if this continues. This isn't going to happen, in my opinion. My observations over the years is that

whenever the threat of government intervention in the health care delivery system was there, that health care costs behaved very well. Then, when the threat is gone, health care costs increase again.

This happened during the early 1970s with wage price controls. It happened during the late 1970s with the threatened enactment of hospital cost containment legislation. And it happened once again in 1993 and 1994 with the debate over health care reform.

The SMI program, even though it is not in financial danger, because of the way it is funded, is still growing at an unsustainable rate. The cost of the program as a percent of GDP in 1994 was 0.89 percent, and it is projected to increase to 3.27 percent of GDP by the year 2020, when the post-World War II baby boom begins to retire. It will grow further to 4.5 percent of GDP by the middle of the next century, when the baby boom is fully retired. These are in the 1994 trustees' report.

The sad thing is, if some changes, seemingly minor changes, had been made in the SMI program many years ago, this problem wouldn't be nearly as large as it is. If the deductible, for example, for the SMI program had been indexed to the per capita costs for the program, then the SMI premium—first of all, outlays of the program would be 25 percent lower than they are today. The SMI premium could have been held at $4 instead of the $42.80 that it is today, and the government contributions to the program could still be $5 billion less than they are today.

In my opinion, there are two reasons why the outlays of the Medicare program are excessive today, and these are the same two reasons why they are excessive in the private health care system. That is the combination of two factors. One is third-party payments and the other is the fee-for-service system.

Of course, third-party payments, when patients and providers are spending other people's money, they don't worry as much about either the price or the quantity of the services provided. Our research in the Office of the Actuary in HCFA showed that even the modest cost-sharing provisions which remain today in the Medicare program, when they are allowed to work, have a substantial disincentive to overutilization.

When the health expenditures of people who faced even the modest cost sharing of today's Medicare program was compared with those who had Medigap policies that filled in that cost sharing so that their services were essentially free, then the utilization was substantially lower for those people who just faced today's modest cost sharing.

More importantly, not only is the level of health expenditures related to third-party payments, but also the rate of growth in health expenditures is related to third-party payments. In a research paper which will be published in "Health Affairs" coauthored by Mark Freeland and Al Pedon, they show that not only is the health care cost higher, but the rate of increase in health care costs is higher as the Nation has shifted from out-of-pocket payments to third-party payments.

Their research shows that, roughly, as a rule of thumb, for every 10 percentage-point shift from out-of-pocket payments to third-party payments, there is an increase in the rate of increase in

health care costs of 2 percentage points. This 2-percentage-point rate of increase in health care costs persists for about 8 to 10 years.

As I mentioned, the second factor is fee-for-service medicine. It interacts with the third factor to allow unlimited increases in the volume and intensity of services. We all know that the primary driving force behind increases in Medicare expenditures are not price increases—we can control those—but it is volume and intensity.

For example, during the 10-year period ending in 1992, over three-fourths of the increases in payments to physicians rose because of increases in volume and intensity, not because of price increases.

The cost of health care can theoretically be controlled by either one of these, by eliminating either one of these. Of course, introducing cost sharing is the way to control it by affecting third-party payments, and managed care is the way to remove the factor of fee-for-service medicine.

I am not so sure—you have heard testimony earlier about the implications of the TEFRA Medicare risk sharing program, and I am not so sure that that has as great a promise as some people think it has for controlling costs, and the reason is because of the difficulty of balancing the need for allowing a higher payment level in order to get plans and beneficiaries to participate against the need for lower payments so that Medicare can save on it.

Thank you.

[The prepared statement follows:]

TESTIMONY BY
Guy King
Former Chief Actuary for HCFA
before the
Subcommittee on Health
of the
House Committee on Ways and Means

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 1994 Trustees Report projects that the HI fund will be bankrupt by 2001. 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 middle of the next century. Even by the year 2020 the tax rate necessary to support the cost of the program will have more than doubled.

I know that many 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 34 percent reduction in expenditures or an immediate 52 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.

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 .89 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 59 percent in the aggregate and 45 percent per enrollee. According to the 1994 SMI Trustees report, SMI expenditures will be 3.27 percent of GDP by 2020 when the Post World War II Baby Boom has begun to reach age 65 and will be 4.05 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 $42.80 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 more than 80 percent of SMI enrollees who buy Medicare supplemental policies. 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 <u>most</u> 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, I'm not optimistic that managed care is a viable option for controlling costs in the Medicare program.

This concludes my formal remarks and I'll be pleased to answer any questions you may have.

Chairman THOMAS. Thank you.

I mentioned earlier that the President's budget contains three provisions which are extenders in terms of a kind of cost containment, at least, a modest cost containment. In your opinion, Mr. King, does this have any impact on the budgetary concerns? Do we buy 1 year? Do we buy 2 years? Do we buy anything with the President's proposal?

Mr. KING. The proposals that are in the President's budget will, at most, increase the life of the trust fund by several months.

Chairman THOMAS. Several months?

Mr. KING. That is right.

Chairman THOMAS. Mr. Myers, you commented about the fundamental difference between part A and part B, and, of course, part B is general revenues, approximately 75 cents of every dollar. Why do we rely so heavily on the general fund of the Treasury for this particular program? Was there a historical reason?

Mr. MYERS. Yes, there was, Mr. Chairman, and it occurred in this very room. When part B, which had not been proposed by the Johnson administration, was adopted, as a result of Congressman John Byrnes pushing for something like this to the program out, it was thought that it should be on a voluntary, individual basis. The question then arose, could you charge a uniform premium rate and could it be paid all by the enrollee? The answer was, "no," because the good risks, the low-cost risks would not participate, and the high-cost ones would, so there had to be some other source of financing.

I was asked by the committee about this, and it was my opinion that roughly 50:50 cost sharing would do the job. In other words, if the general fund paid 50 percent, it would be a good buy for even the healthiest person aged 65 and over. Therefore, there would be no anti-selection against the program. Everybody would have an incentive to come in it.

That 50:50 basis worked for a while, but then the premium rates started rising faster than the cash benefits did, which only went up at the rate of the consumer price index, roughly. It was decided that the premium rate for the enrollees should not rise more rapidly than the CPI, and as a result, the share of the general fund increased steadily until it approached 75 percent.

At that point, it seeMedicare ato Congress that that level is about as far as it should go, so we have had these artificial limits—not meaning this in a bad sense of the term—that the enrollees should pay at least 25 percent of the cost. That is one of the extenders in the President's budget proposal.

So it was purely an accident of history that we went to this 25-percent figure from the original 50-percent basis.

Chairman THOMAS. So as the cost went up, instead of trying to change the program or relationships, you just began to dip into the general fund to make sure that the individual recipient didn't pay more than whatever a "fair share" amount should have been?

Mr. MYERS. Yes.

Chairman THOMAS. And when it began, it was a 50:50 fair share?

Mr. MYERS. Yes, Mr. Chairman. There was a good reason for the 50:50 basis, so that everybody at least got their money's worth.

But the deterioration to 25 percent was, unfortunately, at least in hindsight, the easy way out. That is always, I think, the difficulty with general revenue financing. People think there is an unlimited amount there, whereas we know what there really is, is mammoth deficits.

Chairman THOMAS. I appreciate the gentleman's statement because it appears that we have always taken the easy way out. In taking a look at where we need to be in 5 to 6 years, in looking at the President's budget and the responses that he has offered to where we are, at least from an actuarial point of view, 5 or 6 years out, it looks like those folks are still taking the easy way out.

Mr. Stark, do you wish to inquire?

Mr. STARK. Thank you, Mr. Chairman.

Mr. Myers, it was your testimony, or included in your testimony, that changes in the hospital insurance program as well as the Social Security program should be made solely for the sake of those programs and not at all for the sake of the general budget deficit. Is that correct?

Mr. MYERS. That is correct, Mr. Stark. I think that, these days, there is really a great hoax being perpetrated on the American public by counting excesses of income over outgo of the Social Security and hospital insurance programs as reducing the general budget deficit.

Mr. STARK. So in the sense that if the President's budget falls short of moving toward the solvency of the trust fund that should be enough, or this committee should look to keeping the Medicare trust fund solvent rather than looking to pay for Star Wars or paving roads or something like that. That would be your testimony?

Mr. MYERS. Absolutely, Mr. Stark.

Mr. STARK. Further, would it be your testimony that an individual entering the work force today and paying into the Medicare trust funds through his tax contributions, on average, will those people pay in more or less than they are anticipated to draw out in their retirement years?

Mr. MYERS. To answer your question, Mr. Stark, first of all, I think we should consider whether we are talking about the combined employer-employee tax rate or just the tax rate that the employee pays.

Mr. STARK. I have a hunch the answer is the same. I have a hunch that taxes into the trust funds for a person entering today are not enough to cover the anticipated cost of that person's medical care 45 years hence.

Mr. MYERS. It is quite likely that that is the case, although it is very difficult to predict that matter—unlike, say, the cash-benefits program of Social Security.

Mr. STARK. Given the trend lines you are talking about, if they were, it wouldn't go bankrupt, it seems to me. So if you are suggesting that, at some point beyond that.

Mr. King, I heard you say that without cost sharing, utilization goes up significantly. You get far higher utilization when you do not have cost sharing. Was that your testimony?

Mr. KING. Yes.

Mr. STARK. So, then, if I said to you, under these Medicare Select plans, which have no cost sharing, we can anticipate far higher utilization, would that not be the case?

Mr. KING. With any Medigap policy filling in the coinsurance and deductibles of the Medicare program, the utilization is going to be higher when the beneficiary doesn't face any cost sharing.

Mr. STARK. Significantly higher?

Mr. KING. Yes.

Mr. STARK. Thank you.

Chairman THOMAS. Thank you, Mr. Stark.

It is also obvious that, since Medicare Select is a Medigap program, the argument you just made applies to the entire Medigap area in terms of cost sharing.

Mr. STARK. Yes.

Chairman THOMAS. In addition to that——

Mr. STARK. Would the gentleman yield?

Chairman THOMAS. Certainly.

Mr. STARK. But Medigap is purchased by 90 percent and most of the Medicare Select either are free or at much lower, so the tend is to make the copayments less there.

Chairman THOMAS. I understand.

I would enter into the record, and we are going to need to revisit this issue time and time again, a chart which talks about the lifetime Medicare benefits, taxes, premiums, and transfers. For example, for a person turning 65 in 1995, and these are constant 1993 dollars, a single male gets benefits of about $75,000, pays taxes and premiums of about $34,700, and gets a net transfer of $40,000. When you look at a two-earner couple in terms of the benefits of about $185,000, taxes and premiums of $68,000, the net transfer is about $117,000.

[The chart follows:]

TABLE 5. LIFETIME MEDICARE BENEFITS, TAXES, PREMIUMS, AND TRANSFERS
(in thousands of constant 1993 dollars)

	PERSONS TURNING 65 IN 1995			
	Single Male	Single Female	One-earner couple	Two-earner couple
BENEFITS	75.0	110.7	185.7	185.7
TAXES & PREMIUMS	34.7	45.6	59.0	68.5
NET TRANSFER	40.3	65.1	126.7	117.2

NOTE: All amounts are discounted to present value at age 65 using a 2 % real interest rate. Adjusts for chance of death in all years after age 21. "Taxes and premiums" include the actuarial value of all employer and employee HI payroll taxes, all SMI premiums, and estimated portion of federal income tax burden devoted to financing SMI. Projections are based on HCFA 1993 intermediate assumptions, adjusted for the estimated impact of 1993 enactments. SMI premiums are assumed to remain tied to 25% of program costs after 1995. Recipients are assumed to receive Medicare insurance protection, in each year after age 65, which equals in value the average Medicare outlay per enrollee in that year. Individuals are assumed to earn average wages for their cohort.

Source: Based on Steuerle, E.C. and J.M. Bakija. *Retooling Social Security for the 21st Century: Right and Wrong Approaches to Reform.* Urban Institute Press, 1994.

Chairman THOMAS. So when you deal with what is going into the system versus, currently, what people are getting out of the system, Mr. King, as you indicate, from a 4-to-1 pay-in to a 2-to-1 pay-in, and, of course, this is not projecting the increased lifespan. I went through a fight here in 1983 in which we extended the retirement age 2 years in 2027, which was certainly shorter than it should have been, based upon the battle that was a difficult one to fight.

It is just very easy to look at the time line and get into a discussion of a couple of months or even a couple of years. That isn't the point, I think, that you folks are trying to stress. You've got to fundamentally change the system, because if you continue the way we are, regardless of the changes in the private sector, regardless of anything else that may intervene, wish, hope, or otherwise, if we don't change the system, is it inevitable? Is that what you are saying?

Mr. KING. I would say it is inevitable, Mr. Chairman, yes.

Chairman THOMAS. So we can't avoid it? We have to do something about it?

Mr. MYERS. Yes.

Mr. KING. It is a system that is so far out of balance in the long run, between the revenues and the outlays of the program, that a fundamental restructuring of the hospital insurance program is going to be necessary. You can't just cut the costs of the program by 34 percent by cutting prices. You have to make fundamental restructuring of the program in order to do that.

Mr. MYERS. Yes, Mr. Chairman, I agree that it is inevitable, but I think that the changes can be made on the financing side because I think that costs are going to be there anyhow. People are going to have the health care costs. They are going to have hospitalization costs. It is a question of how these are going to be met. Should they be met out of pocket, or through an insurance system, or how much in each way?

Chairman THOMAS. And from an actuarial point of view, since you folks have been dealing with these societal concepts, how much time is 5 or 7 years to make these kind of adjustments that we need to make? Is that a short timeframe, from your perspective? Is that a reasonable timeframe?

Mr. MYERS. I think it is barely reasonable. Changes should have been made sooner. But the sooner we get to it now, the better it is.

Chairman THOMAS. But, clearly, if we don't do anything this year or next year, we are outside of the reasonable frame for adjustment?

Mr. MYERS. I believe so.

Mr. KING. Yes. Mr. Chairman, if I could be allowed to, I am always reluctant to disagree with Mr. Myers, because we agree on so many things, but I don't believe it is feasible to make the changes on the financing side for the hospital insurance program. By the middle of the next century, the tax rate of the hospital insurance program would have to triple if we didn't make changes in the outlays. The tax rate would have to triple.

What essentially is happening with the hospital insurance program now is that we are shifting an enormous burden for the over-

payments and the overpromises that we are making now onto future generations. Unless we triple the taxes on them, those promises that we are making now are not going to be kept.

Chairman THOMAS. If there are no further questions—that was going to be a perfect segue into the next panel.

Mrs. Johnson.

Mrs. JOHNSON. Mr. King, and Mr. Myers, your testimony is simply astounding. I mean, that Medicare is in as bad shape as it is and that this Congress knew that and has received these reports every year and paid no attention is truly tragic.

I want to quote from your testimony and ask you to look back. You say, I know that many people view these projections as a red herring. Clearly, we did, because we haven't done anything. But if you look back at your projections in the past, 20 years ago, 15 years ago, have your projections on the whole materialized, or have, in the past, your projections turned out to be red herrings? In other words, by projecting problems, we addressed them and so they didn't come true.

What is the history here? How accurate have your projections been?

Mr. KING. No, the history of the projections is that they have, in fact, materialized when adjustments are made for legislation that occurred subsequent to the initial projections that either increased the revenue or decreased the outlays by making price cuts. Yes, these projections have been basically accurate.

Mrs. JOHNSON. So you feel quite confident that when you tell us Medicare is on the absolute brink of bankruptcy and that in order to provide the benefits promised by the year 2020, we will have to triple the tax rate, you believe that will absolutely happen unless we take steps to prevent it?

Mr. KING. Yes.

Mrs. JOHNSON. Thank you.

Chairman THOMAS. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Mr. King, I want to ask a question. The two factors you raise make some sense, the third-party payments and the fee-for-service system. But how do you separate the parts caused by the growth in technology and the aging of the population. You don't even mention them, and I am sure you have thought about them.

Mr. KING. Yes, I have thought about them, sir. The aging of the population on a year-to-year basis has very little effect on the growth in costs in Medicare, either in the Medicare program or in private sector programs. The aging of the population only adds a few tenths of 1 percent to the costs.

Mr. MCDERMOTT. How about technology?

Mr. KING. Technology is really a symptom of the problem rather than a cause of the problem. In other words, because of this combination of third-party payments and fee-for-service medicine, where we will pay for anything as long as it is effective—it doesn't have to be cost effective, it doesn't even have to be medically effective, really. We will pay for anything.

That has a tendency to literally suck technology into health care, because it will be paid for in health care. So technology that might be directed in other directions where it might be more productive

is actually directed into the health care delivery system because of the third-party payments and the fee-for-service medicine.

Mr. McDERMOTT. You are not suggesting that technology has not extended lifespan, or caused people to seek procedures, are you?

Mr. KING. No, I am not suggesting that at all. The technology growth——

Mr. McDERMOTT. When I look at my own professional career, I graduated from medical school about 2 years before Medicare came in. The things that they do now compared to what I was trained to do are now totally out of my realm. I feel uneasy going in to a coronary care unit. I don't know how to perform these new procedures. All of that has happened in the last 30 years, during the life of Medicare, and it is hard for me to see how you can say that it is just a factor that gets kind of sucked in. An industry was created. How can a doctor not use it?

Mr. KING. I am not suggesting that—I think you are misunderstanding me. I am not suggesting that this growth in technology is bad, nor am I suggesting that it wouldn't have occurred. It wouldn't have occurred as rapidly, and the technology wouldn't have been as expensive if it hadn't been for the fact that we had this combination of factors that would pay for virtually anything.

Mr. McDERMOTT. So basically, what you are suggesting is that we ought to set up a system where we limit access to technology only to those people who have the money to buy the high-cost health care. The rest of the people ought to be relegated, as people fear, to what the British have, where they decide when they can have a kidney transplant or whatever. Is that what you are saying, a two-tiered system?

Mr. KING. No, actually, not at all. The kind of deductibles and copayments that would act as a deterrent to excess utilization are the kind of deductibles and copayments that most people can afford to pay today. Of course, there are safety nets for poor people. The Medicaid program would still fill in the deductible and copayments for people who couldn't afford to pay those.

Mr. McDERMOTT. Let me ask one other question in the time remaining and that is, is it your understanding that the managed care plan that people are talking about would put people into a plan where they would then be under the rules of the insurance company and out from under the Federal rules? In other words, the senior citizens would go with their voucher and buy into some private HMO. They would then be under the HMO's rules, not the Federal Government's rules, right?

Mr. KING. That is basically what a managed care plan is, yes.

Mr. McDERMOTT. In your view of that, would that mean that the patients, then, would no longer have the protection from balance billing?

Mr. KING. Actually, in most managed care plans, the copayments are lower.

Mr. McDERMOTT. There are a lot of different kinds of managed care plans.

Mr. KING. They use a different mechanism in order to control utilization. In most managed care plans, the copayments are lower than they are in Medicare fee-for-service.

Mr. McDERMOTT. But balance billing, if a patient does something in a managed care plan where the physician is paid a certain amount for a procedure, then the doctor can bill the patient for the balance? There is no prohibition in the private sector on that?

Mr. KING. No, but under a managed care plan, the doctor doesn't bill the patient on a fee-for-service basis.

Mr. McDERMOTT. Yet.

Mr. KING. In the closed panel HMO, he is on a salaried basis and he doesn't charge fee-for-service.

Mr. McDERMOTT. I would suggest that that is a "yet."

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

There is just one point I want to make. The characterization of technology that was just presented is the first time I have really heard it explained that way, not as an outside driver but as partially driven by the system. The only analogy that came immediately to mind was the situation in the space race between the Soviet Union and the United States, and the fact that we did not have high-thrust rockets and the Soviets did.

The high-thrust rockets of the Soviets didn't require miniaturization. The low-thrust of the United States drove the miniaturization, the technology. That is not to say that miniaturization was bad and not to say that technology is not good. It is good, but it was driven by something else, that is, our inability to lift large objects, so it forced the miniaturization.

The ability to bill for anything is driving the technology, to a certain extent. I had not heard it put quite that way. There is clearly a two-way street there, and I have only seen it one way. I appreciate the gentleman's clarification on that point.

Mr. McDERMOTT. If the gentleman will yield, I went through this when I was in the State legislature with the University of Washington saying they wanted to have a heart transplant unit. I argued, as a State legislator, we shouldn't waste our money on that. They should send all the patients down to Stanford. The argument was, oh, no, but to be a first-class university, we must have it here at the University of Washington. Our under-used capacity then was sold to the Canadians, because we didn't have enough patients. The British Columbians bought from us the capacity to do heart transplants. That is how the system has operated.

Chairman THOMAS. I thank the gentleman.

Mr. McCrery.

Mr. McCRERY. Thank you, Mr. Chairman.

Mr. King and Mr. Myers, both, you had excellent testimony, I particularly liked Mr. King's because I think he has put his finger on the problem in our system, which started back around World War II with the growth of health insurance. This problem is government getting involved in putting wage and price controls on the private sector and allowing them to increase benefits, thereby expanding the third-party payment system in this country, until we have our system today, where almost nobody pays for their health care. Some third party pays the bill.

You are exactly right. We cannot expect people to control their consumption of anything if somebody else is paying for the items to be consumed. I don't care if it is health care or automobiles. The

fact is, we cannot afford, as a society, to provide everybody a BMW, nor can we afford, as a society, to provide everybody everything they might want or think they need in health care. Yet, that is what we are trying to do.

I really appreciate your driving this point home, Mr. King. Unfortunately, we can't get very many people to listen. So I think what is going to happen, unless we make some drastic changes in how we pay for health care in this country, is that we are going to end up with Mr. McDermott's system, which is a single-payer system. He thinks that system is going to do the same thing, provide everything to everybody, when, in fact, what we are going to end up with is a single-payer system that provides the lowest common denominator to everybody.

I hope that you will continue, Mr. King, to sing that song and to tell people the underlying, fundamental reasons why we can't control costs, either in the Medicare system or in the private health care system. Maybe, if you do, you will get enough people to listen so we can turn this boat around before it is too late, but I am not very optimistic.

Mr. McDERMOTT. Will the gentleman yield?

Mr. McCRERY. I will be glad to yield.

Mr. McDERMOTT. I would admit that Congress made one serious mistake in setting up Medicare. It was almost the last amendment they accepted, was allowing the fee-for-service system in the Medicare system at the end, to get the doctors to back off their opposition. That was a serious mistake. That gave away the store, and they have been chasing it ever since. We really have never—it didn't make any difference whether we had a Democratic President or a Republican President, nobody wanted to take on the American Medical Association. Therefore, that part has just run wild.

Mr. McCRERY. But it goes back even further than that, Mr. McDermott, to when the government got in bed with insurance companies and said, we are going to give employers a break and encourage them to provide Cadillac benefits for their employees of first-dollar-coverage insurance. That is where the fundamental problem is in our health care system. Yes, the government compounded that by creating Medicare and Medicaid and just running right along with the same kind of system.

So, Mr. King, thank you very much for your testimony. It is very enlightened, in my opinion, and I hope you will continue to tell people about it.

Chairman THOMAS. Mr. Christensen.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

I just have a quick question for Mr. Myers. I wanted to find out the underlying reason for the general fund of the Treasury. Why should the general fund of the Treasury finance such a large part of the cost of part B Medicare?

Mr. MYERS. As you know, initially, the general fund financed half of the cost of part B, so that the enrollee premium met 50 percent of the cost and the general fund met the other 50 percent. The reason for this was that it was decided that every enrollee should pay the same premium rate, in dollars. If that were done and if there were no other source of financing than the enrollee premiums and the program is on an individual, voluntary basis, the low-cost peo-

ple, those who are near 65 and are healthy, would not have joined the plan. They would have said, "We will wait until later," so there would have been antiselection, and the cost would have been much higher than if everybody were in the plan, either compulsorily or if all elected to come in.

So some proportion of the cost had to come from somewhere else if you were going to attract the vast majority of the people to participate. The only place that could come from was the general fund. Unfortunately, over the years, that 50 percent has deteriorated to the present 25 percent because of a provision that was put in the law to say that the premium rate per enrollee should not rise more than the consumer price index.

So, that was the basis for it. In other words, if you had a voluntary program, you had to make the rate attractive for everybody, including the most healthy people.

Mr. CHRISTENSEN. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. Mr. Crane.

Mr. CRANE. I have no questions.

Chairman THOMAS. Mr. Houghton.

Mr. HOUGHTON. Very specifically, you have indicated that in order to keep this fund solvent, and with no dramatic differences in usage and cost, that you would have to have about a 52-percent increase as far as your rate is concerned. What would that mean? We now have a 15-percent shared rate as far as our FICA taxes. What would that do to the FICA taxes over the next 25 years?

Also, if you could take it another step beyond that, because you said there are going to be even greater problems. What are we talking about? What is the range?

Mr. KING. The FICA tax is currently 2.9 percent——

Mr. HOUGHTON. So you are increasing that by half?

Mr. KING. Yes, so that would be an additional 1.45 percent of taxable payroll.

Mr. HOUGHTON. So you are getting up to around 20 percent as far as your FICA taxes, then, is that right? Then what about beyond that?

Mr. KING. By the middle of the next century, the tax rate would have to triple, so that instead of being——

Mr. HOUGHTON. In addition to the 52 percent, you are saying——

Mr. KING. No. This is——

Mr. HOUGHTON. Including that 52 percent?

Mr. KING. Yes. So instead of being the 2.9 percent combined that it is now, it would have to be around 8.7 percent.

Mr. HOUGHTON. Thank you very much.

Thank you, Mr. Chairman.

Mr. MYERS. If I might say, just looking at it on the surface, if this were done all of a sudden, it would be unbearable. But I think that it can be done if the increases in the tax rate is graded in slowly over the decades.

I think one thing that must be kept in mind is these costs are going to be there anyhow. I think it is better to meet them through a directly visible payroll tax than to have them come out of general revenues for Medicaid.

Mr. HOUGHTON. It is too bad we can't devise a system that would threaten the Federal Government the way the private system is threatened and keep costs down that way. Maybe you can devise something like that.

Thank you.

Chairman THOMAS. Thank you, Mr. Houghton.

I would say that even if you phased it in gradually, the impact on employment in the rest of an 8.5-percent employment tax, just for a portion of the health care costs, frankly, is unacceptable to me. To say that the costs are going to be there anyway is also unacceptable to me, so I am going to try to attack it from both ends. I may not be successful, but I am sure going to try.

I thank this panel very much. Your testimony was enlightening. Actuaries are some of those folks that you don't want to sit down and talk with oftentimes because they tell you what you don't want to hear, but I believe that this particular subcommittee and this Congress needs to hear what we don't want to hear more often rather than less often.

Thank you very much.

Will the next panel come forward, please? From the Seniors Coalition, Jay Hopkins; from the Third Millennium, Heather Lamm; and from the National Taxpayers Union, Paul Hewitt.

I would say to all of you, if you have any written testimony for the record, it will be submitted, without objection. You may begin and, for 5 minutes, inform, instruct, and enlighten the subcommittee in any way you see fit.

Mr. Hopkins, we will start with you.

STATEMENT OF JAY HOPKINS, SENIOR ANALYST, SENIORS COALITION, ON BEHALF OF JAKE HANSEN, DIRECTOR OF GOVERNMENT AFFAIRS

Mr. HOPKINS. Thank you.

The Seniors Coalition is the Nation's third largest senior citizens advocacy organization, with over 1 million members across America. As a seniors organization that strongly supports the Medicare program, the Seniors Coalition must take the responsible step of recognizing that the program is broken and badly needs fixing.

Our Medicare system was designed in the 1960s, a time when America had fewer seniors, health care costs were relatively low, and many expensive medical wonders simply did not exist.

The very nature of our society has changed over the past 30 years, yet, Medicare has not changed with the times. In its current form, Medicare's costs are increasing too rapidly for the government and its citizens to bear. Medicare must be reformed now, or it will certainly perish.

The crisis cannot be exaggerated. Today, more than 32 million seniors depend on the protection provided by Medicare part A. By the turn of the century, that number will have increased dramatically. Without bold and immediate action, the health of America's seniors will be at grave risk.

Reforming Medicare will be a daunting, yet not insurmountable task. When people of good will come together, joined in a common cause, mountains can truly be moved. Such a monumental task

must be undertaken in an atmosphere of good faith and cooperation.

The Seniors Coalition was profoundly disappointed that President Clinton did not provide any measure of leadership or direction regarding the Medicare crisis in his budget for fiscal year 1996. While extending a few provisions that were scheduled to expire in 1998, the President's budget does nothing to change the Medicare system, as it stands now. In taking a dive on the issue, the President is shortchanging Medicare of the bipartisan attention it so desperately needs.

The Seniors Coalition urges President Clinton to join those who are actively looking for positive solutions to ensure Medicare's continued survival. In this time of crisis, neither party should use Medicare as a football to score political points.

The Seniors Coalition intends to take an active role in developing Medicare solutions and bringing them to the attention of America and America's seniors. Change can be an uncomfortable process, fraught with potential hazards. But in this case, change is both inevitable and necessary.

Mr. Chairman, we encourage all the other seniors organizations to roll up their sleeves and join us in the process. In tackling Medicare's problems, we must be careful to avoid the wrong solutions.

The recent national health care debate was a good example of good intentions run amuck. President Clinton was right in his attempt to focus national attention on health care reform, but his legitimate concern over serious medical problems that face the Nation did not justify his dramatic proposal for social engineering on a massive scale. Indeed, his plan would have created the sort of health care crisis, particularly for Medicare, that he said he wanted to forestall. Under any one-size-fits-all government plan, seniors would end up with less choice and poorer care.

Some policymakers favor making deep cuts in Medicare as a simple solution. The Seniors Coalition will not accept any cutbacks in Medicare without implementation of systems that would allow seniors improved access and choice in their health care.

Amidst all this peril, we find opportunities for seniors. Real Medicare reform must involve financially honest mechanisms that promote choice and market competition. Medicare reform is more than a theoretical notion. Right now, several intriguing proposals currently are in circulation and are well worth consideration.

Medicare Select right now is before Congress. We think it should be extended to all 50 States and made permanent. Medicare HMOs, given the proper funding formula, have the have the potential to shave health care costs. Voucher plans should be considered. In certain geographical areas, they can be very effective.

Without any doubt, many more alternatives will be proposed in the coming months. We can agree to disagree on what the best approaches might be, but we cannot afford to ignore this issue another day.

Mr. Chairman, thank you for bringing this matter of such importance to seniors before the American public.

[The prepared statement follows:]

The Seniors Coalition

Protecting the Future You Have Earned

TESTIMONY OF JAKE HANSEN
DIRECTOR OF GOVERNMENT AFFAIRS,
THE SENIORS COALITION

PRESENTED TO THE
U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

It's time to reform Medicare

The Seniors Coalition is the nation's third largest senior citizen advocacy organization with over one million members across America. As a seniors organization that strongly supports the Medicare program, The Seniors Coalition must take the responsible step of recognizing that the program is broken and badly needs fixing.

According to last year's report by the Health Insurance Trust Fund's Board of Trustees, funding for Medicare Part A will completely dry up sometime between 2000 and 2004, depending on various sets of economic assumptions.

Right now, it takes the payroll taxes of four working Americans to support Medicare coverage for just one Medicare beneficiary. Before the end of this decade, fewer working Americans will be expected to provide Medicare coverage to even more beneficiaries. The ratio of Medicare beneficiaries to workers is expected to grow so dramatically that by the end of the century, beneficiaries will be spending between $2 to $5 for every dollar workers put into the system. By the middle of the century, only two workers will be available to support each beneficiary. But the Trustees tell us that Medicare's trust fund will be long empty before the major changes even occur.

Our Medicare system was designed in the 1960s, a time when America had fewer seniors, health care costs were relatively low and many expensive medical wonders simply did not exist. The very nature of our society has changed over the past 35 years, yet Medicare has not changed with the times. In its current form, Medicare's costs are increasing too rapidly for the government and its citizens to bear. It does not take the wisdom of Solomon to recognize that Medicare must be reformed now or it will certainly perish.

The crisis cannot be exaggerated. Today, more than 32 million seniors depend on the protection provided by Medicare Part A. By the turn of the century, that number will have increased dramatically. Without bold and immediate action, the health of America's seniors will be at grave risk.

Washington DC Metro Office: 11166 Main Street, Suite 302 • Fairfax, Virginia 22030 • Phone (703) 591-0663

Reforming Medicare will be a daunting, yet not insurmountable task. When people of good will come together, joined in a common cause, mountains can truly be moved. But such a monumental task must be undertaken in an atmosphere of good faith cooperation. The Seniors Coalition was profoundly disappointed that President Clinton did not provide any measure of leadership or direction regarding the Medicare crisis in his budget for fiscal year 1996. While extending a few provisions that were scheduled to expire in 1998, the President's budget does nothing to change Medicare as it stands now. In taking a dive on the issue, the President is shortchanging Medicare of the bipartisan attention it so desperately needs. The Seniors Coalition urges President Clinton to join those who are actively looking for positive solutions to ensure Medicare's continued survival. In this time of crisis, neither party should use Medicare as a football to score political points.

The Seniors Coalition intends to take an active roll in developing Medicare solutions and bringing them to the attention of America's seniors. Change can be an uncomfortable process, fraught with potential hazards. But in this case change is both inevitable and necessary. That's why, Mr. Chairman, we encourage all the other seniors organizations to roll up their sleeves and join us in the process.

In tackling Medicare's problems, we must be careful to avoid the wrong solutions. The recent national health care debate was a good example of good intentions run amok. President Clinton was right in his attempt to focus national attention on health care reform. But his legitimate concern over the serious medical problems that face the nation did not justify his dramatic proposal for social engineering on a massive scale. Indeed, his plan would have created the sort of health care crisis, particularly for Medicare, that he said he wanted to forestall. Under any one-size-fits-all government plan, seniors would end up with less personal choice, higher bills, and poorer care.

In recent years, Medicare has turned to cost-shifting as a means of controlling the escalating cost of the program. While the results were partially successful on the surface, overall medical costs accelerated. The American public and Medicare beneficiaries suffered alike as a result.

Some policymakers may favor making deep cuts in Medicare as a simple solution. The Seniors Coalition will not accept any cutbacks in Medicare without the implementation of systems that would allow seniors improved access and choice in their health care. Others favor simply boosting the level of payroll taxes to the HI trust fund. In order to fill the gap, such an increase would need to be substantial. Such an increase, however, would harm our economy and ultimately push health care costs further out of reach for seniors.

Amidst all the peril, we find important opportunities for seniors. Real Medicare reform must include financially honest mechanisms that promote choice and market competition. A system can be designed to give seniors more choice in determining how their health care dollars are spent. As a result, seniors will receive better health care at a lower cost.

Medicare reform is more than a theoretical notion. Several intriguing proposals currently in circulation are well worth consideration:

- Medicare Select is an experimental Medicare supplement plan that has helped seniors realize considerable savings while increasing their health care choices. A bill to make Medicare Select permanent and extend it to all 50 states is now under consideration by Congress.

- Medicare HMOs, given the proper funding formula, has the potential to shave health care costs in areas with higher density populations of seniors. With only eight percent of the nation's seniors enrolled in managed health care plans, the potential for growth is considerable.

- A voucher plan would give seniors credits equivalent to the average cost of annual medical expenses in their geographical area. Seniors would be free to choose their own provider from the private sector.

Without a doubt, many more alternatives will be proposed in the coming months. We can agree to disagree on what the best approaches might be, but we cannot afford to ignore this issue another day. Mr. Chairman, thank you for bringing this matter of such importance to seniors before the American public.

Chairman THOMAS. Thank you, Mr. Hopkins.
Ms. Lamm.

STATEMENT OF HEATHER LAMM, NATIONAL POLICY COORDINATOR, THIRD MILLENNIUM

Ms. LAMM. Thank you, Mr. Chairman and members of the subcommittee for inviting Third Millennium to participate on this distinguished panel.

As we have heard already this morning, Mr. Chairman, the question before us is not whether or not the Medicare program will become insolvent. The facts speak for themselves. From Alan Greenspan to the Congressional Budget Office to the public trustees of Medicare, the experts agree that Medicare is on a 6-year collision course with bankruptcy.

By 2001, the Medicare part A trust fund is projected to simply run out of money. As one of the Nation's fastest-growing Federal programs, we are already feeling the impact of Medicare's deficits. The actual point of bankruptcy for the program may be 6 years off, but it is draining our country's resources today.

Thus, the question before us is when and how we act to change the course of Medicare. If this Congress acts soon, the changes can be relatively incremental and minor, but if the Congress waits, the solutions, out of necessity, will be draconian.

I come before you as a member of a group of people born after 1960 who are concerned about the future of America. Third Millennium's mission is to convince our Nation and its leaders to begin looking beyond the next election cycle and toward the next generational cycle.

The issue before us today is not about what size piece of the American entitlement pie one generation gets compared to the next, and it is not about generational warfare. The issue before us is about looking toward the future and realizing the severity of the problems out there. It is about dealing with those facts and those problems now before they deal with us.

Every year we wait, the problem compounds. As we have heard already this morning, unfortunately, in his 1996 budget, President Clinton and the administration punted on Medicare. It is imperative that this Congress not do the same thing. The pending insolvency of Medicare cannot be pushed off the table. The year 2001 is no longer a futuristic fantasy. To my generation, it is a reality that is literally just around the corner.

Imagine, for a moment, that we are in the year 2001. The Denver International Airport has just opened and the baseball strike has finally ended. For 6 years, Congress and the President have tossed the idea of Medicare reform back and forth. The President offered insubstantial reforms year after year, and Congress, while condemning such weak-kneed approaches, also ultimately became bogged down by special interests and partisan bickering.

Medicare is now 1 month away from running out of money. The Nation is faced with a horrendous decision. We must raise payroll taxes on young people by nearly 4.5 percent immediately to balance the program, or we must slash all benefit checks dramatically, leaving many needy seniors unprepared and without vital health care.

The Nation is, of course, outraged. Why must a country as great and wealthy as America have to choose between burdening its workers with unbearable tax rates and denying poor senior citizens health care?

Mr. Chairman, we will not have to make that drastic decision if we act soon. We can ensure that Medicare continues to provide benefits for those who need them and we can maintain reasonable tax rates if we have the courage to face the situation today rather than tomorrow.

Third Millennium's suggestions for reforming Medicare follow the approach advanced by Senator Bob Kerrey and Senator Jack Danforth of the Bipartisan Commission on Entitlement and Tax Reform. My written testimony outlines those proposals and I won't go into them further, but I will say that there are many ways to substantially reform Medicare and our solutions are just a few common sense approaches.

What is important, Mr. Chairman, is that something be done. This Congress must realize the problem and act in a bipartisan way to solve it. Congress must ensure Medicare's long-term solvency and not just slap a Band-Aid over it to get us through the next 2 years.

Congress must also begin to address the similar insolvency problems facing Social Security. Last year, Third Millennium commissioned a national survey that found that nearly twice as many young adults believe in the existence of UFOs as believe that Social Security will exist by the time they retire.

The crisis of confidence in Federal retirement programs among young people is astounding. With this in mind, we will be watching to see how the Nation's leaders confront the Medicare dilemma, with an eye to how they will confront the much larger problem of Social Security. From my generation's perspective, inaction on either of these fronts is not a justifiable alterative. Not to act now is public policy malpractice.

Young people are willing to sacrifice because we know the consequences to our generation and to future generations if we do not. In 1998, people born in the 1960s and the 1970s will represent the largest potential voting block in the country. So the good news is that doing the right thing, averting disaster in Medicare and Social Security quickly will become the politically rewarding thing to do, as well.

I believe the ultimate challenge of this Congress is one of farsightedness. Would a private business, knowing that financial disaster is pending, wait until tomorrow to deal with the situation? Would an individual family, realizing it is running into financial troubles, wait until tomorrow to change course? Why, then, should the Federal Government be held to any lower standard?

I realize I am out of time, so I will conclude simply by saying that every generation of Americans has its own assets and liabilities, and I truly don't believe that people in my generation are whining about the future we are inhering. But, we can no longer sit idly by as politicians compromise our economic future, and more importantly, the future of our children to pacify powerful special interest groups.

Mr. Chairman, no generation in American history has been left with the tail-end of so many dysfunctional systems as the generation currently graduating from college and entering the workplace. My generation and those after me will pay large amounts of our paychecks into programs that the experts tell us will be bankrupt when we retire. We are on the verge of inheriting a world of crumbling entitlement programs, a burgeoning national debt, decreased national savings, and an increasing number of retirees who expect to be generously supported.

As a generation, we cannot face this tremendous fiscal burden and still lead this Nation into greatness. Thank you.

[The prepared statement follows:]

Testimony of Heather Lamm, National Policy Coordinator for Third Millennium, before the Subcommittee on Health of the Committee on Ways and Means

Thursday, February 23, 1995
1100 Longworth House Office Building

Thank you Mr. Chairman and members of the Committee for inviting Third Millennium to participate on this distinguished panel. My name is Heather Lamm. I am the National Policy Coordinator for Third Millennium. Mr. Chairman, the question before us this morning is not whether or not the Medicare program will become insolvent. The facts speak for themselves. From Alan Greenspan to the Congressional Budget Office to the Public Trustees of Medicare -- the experts agree that Medicare is on a six year collision course with bankruptcy. By 2001, the Medicare Part A Trust Fund is projected to simply run out of money. As one of the nation's fastest growing Federal program, we are already feeling the impact of Medicare's deficits. The actual point of bankruptcy for the program may be six years off, but it is draining our country's resources today.

Thus the question before us is *when* and *how* we act to change the course of Medicare. If this Congress acts soon, the changes can be relatively incremental and minor. But if Congress waits, the solutions, out of necessity, will be Draconian.

I come before you as a member of a group of people born after 1960 who are concerned about the future of America. Third Millennium's mission is to convince our nation and its leaders to begin looking beyond the next election cycle, and toward the next generational cycle. The issue before us today is not about what size piece of the American entitlement pie one generation gets compared to the next. It is not about

generational warfare. The issue before us is about looking toward the future and realizing the severity of the problems out there. It is about dealing with those facts and those problems now, before they deal with us.

Every year we wait, the problem compounds. Unfortunately, in his 1996 budget, President Clinton and the administration punted on Medicare. It is imperative, Mr. Chairman, that this Congress not do the same thing. The pending insolvency of Medicare cannot be pushed "off the table". The year 2001 is no longer a futuristic fantasy. To my generation it is a reality that is literally just around the corner.

Imagine for a moment that we are in the year 2001. The Denver International Airport has just opened and the baseball strike has finally ended. For six years Congress and the President have tossed the idea of Medicare reform back and forth. The President offered insubstantial reforms year after year, and Congress, while condemning such weak-kneed approaches, also ultimately became bogged down by special interests and partisan bickering. Medicare is now one month away from running out of money. The nation is faced with a horrendous decision. We must raise payroll taxes on young people by nearly 4.5% immediately to balance the program, or, we must slash all benefit checks dramatically, leaving many needy seniors unprepared and without vital health care. The nation is of course outraged. Why must a country as great and wealthy as America have to choose between burdening its workers with unbearable tax rates, and denying poor senior citizens health care?

Mr. Chairman, we will not have to make that drastic decision if we act soon. We can ensure that Medicare continues to provide benefits to those who need them *and* we can maintain reasonable tax rates if we have the courage to face the situation today, rather than tomorrow.

Third Millennium's suggestions for reforming Medicare follow the approach advanced by Senator Bob Kerrey and former Senator Jack Danforth of the Bipartisan

Commission on Entitlement and Tax Reform.

When Medicare Part A was enacted, it was a self-supporting system, financed solely by payroll tax contributions. Today, the average enrollee pays only about 32% of the cost. As a result, the average enrollee collects benefits equaling approximately three times the amount contributed during his or her working life. The Medicare Part B program has undergone similar changes. When Medicare Part B began, the enrollee and the Federal government each paid 50% of costs. Today, the Federal government pays 70% of Part B costs, and that share is projected to increase to 92% by 2030. To address these inequities, Third Millennium advocates the following:

- Comprehensive means-testing of Medicare
- Adding a graduated Part A premium for beneficiaries with incomes above 150% of poverty.
- Indexing the Part B premium to program costs to maintain the 30% share of the costs currently paid by enrollees.
- Raising the Part B deductible from $100 to $300 and indexing it.
- Adding a 20% coinsurance payment for clinical lab services and home health care services costing in excess of $10.
- Reducing Medicare Provider Payments

In addition, to adapt to changing demographics caused by longer life expectancies and the aging of the Baby Boom generation we suggest raising the Medicare eligibility age to 70. Seniors would still have the option to enroll at age 62 with a charge for early retirement.

There are many ways to substantially reform Medicare. The above solutions are just a few common sense approaches. What is important, Mr. Chairman, is that *something* be done. This Congress must realize the problem and act in a bipartisan way to solve it. Congress must ensure Medicare's long term solvency, and not just slap a Band-Aid over it to get us through the next two years.

Congress must also begin to address the similar insolvency problems facing Social Security. Last year Third Millennium commissioned a national survey that found that nearly twice as many young adults believe in the existence of UFOs as believe Social Security will exist by the time they retire. The crisis of confidence in Federal retirement programs among young people is astounding. With this in mind, we will be watching to see how the nation's leaders confront the Medicare dilemma, with an eye to how they will confront the much larger problem of Social Security. From my generation's perspective, inaction on either of these fronts is not a justifiable alternative. Not to act now is public policy malpractice.

Young people are willing to sacrifice because we know the consequences to our generation and to future generations if we do not. In 1998, people born in the 1960s and 1970s will represent the largest potential voting block in the country. They will remain that way until well after the Medicare and Social Security systems are in the red. So the good news is that doing the right thing -- averting disaster in Medicare and Social Security -- quickly will become the politically rewarding thing to do as well.

I believe the ultimate challenge of this Congress is one of farsightedness. Would a private business, knowing that financial disaster is pending, wait until tomorrow to deal with the situation? Would an individual family, realizing it is running into financial troubles, wait until tomorrow to change course? Why, then, should the federal government be held to any lower standard?

Every generation of Americans has its own assets and liabilities and I truly don't

believe that most people in my generation are whining about the future we are inheriting. But we can no longer sit idly by as politicians compromise our economic future and, more importantly, the future of our children, to pacify powerful special interest groups. Young people have an obligation, both as citizens and as the parents of the next generation, to offer solutions, to have a voice, to be prepared to sacrifice, and to demand action.

Mr. Chairman, no generation in American history has been left with the tail end of so many dysfunctional systems as the generation currently graduating from college and entering the workplace. My generation and those after me will pay large amounts of our paychecks into programs that the experts tells us will be bankrupt by the time we retire. We are on the verge of inheriting a world of crumbling entitlement programs, a burgeoning national debt, decreased national savings, and an increasing number of retirees who expect to be generously supported. As a generation, we cannot face this tremendous fiscal burden and still lead this nation into greatness. Thank you.

Chairman THOMAS. Thank you very much, Ms. Lamm.
Mr. Hewitt.

STATEMENT OF PAUL S. HEWITT, EXECUTIVE DIRECTOR, NATIONAL TAXPAYERS UNION FOUNDATION

Mr. HEWITT. Thank you, Mr. Chairman.

The National Taxpayers Union Foundation and our sister organization, the National Taxpayers Union, have been trying for years to draw attention to the need to stem the runaway cost of the Medicare program. We appreciate, at long last, that some policymakers are listening, but we note that President Clinton is not among them. His budget seems to suggest that the hospital insurance program can continue running on autopilot. And that, clearly, is wrong.

The system's problems are extraordinary. Exploding costs threaten to impose unthinkable debt and tax burdens on our children. Past efforts to contain costs through capitated payment schemes are creating a two-tiered health system in which some providers no longer accept Medicare patients. These same measures are shifting enormous costs onto private payers, which, in turn, provide fuel for the administration's misguided efforts to enact national price controls, and to nationalize the health insurance system.

Mr. Chairman, we believe that Medicare's problems are solvable without higher taxes and without bigger government. But to achieve these ends, Congress will have to bite the bullet. You will have to tell today's elders that Medicare, in its current form, cannot be saved. You will have to insist that some beneficiaries, mainly the well-off, get less. And to those of us who are not yet retired, you must make it clear that, if we expect to have the very best medical care money can buy, we will have to save more toward that cost ourselves.

In their most recent actuarial report, the Hospital Insurance Trustees painted a very bleak picture. They predicted that the system's trust fund would go bankrupt at the turn of the century, provided that we can avoid a recession in the meantime. HI already costs more than its 2.9-percent payroll tax brings in, and, in this way, is adding billions to this year's budget deficit.

As a percentage of the wage base, HI surpassed 3 percent of payroll in 1992. By the year 2000, it will be close to 4 percent. By 2040, as my grandchildren enter the labor force, HI is projected to claim somewhere between 9.6 and 18.5 percent of payroll—and I would refer you to Mr. King's testimony in which, he said that 9.6 percent was very optimistic.

Together with Social Security and other health entitlements, HI will create enormous pressure for higher taxes. By 2040, the Social Security and Medicare programs alone are projected to cost between 35 and 55 percent of taxable payroll—35 percent is the optimistic number—up to four times their current combined tax burden. If it is the latter, the take-home pay of the average American worker will decline by 59 percent from today's levels. Even if economic and demographic circumstances turn out to be very favorable, the living standard for the average working family in 45 years will be no better than it is today.

I would note with dismay, Mr. Chairman, that some members of this subcommittee have argued, in light of these problems, that we dare not pass a balanced budget amendment. They say that we must keep open the option of deficit financing some or all of the spending growth.

Yet, Office of Management and Budget Director Alice Rivlin's infamous leaked budget memo from last October belies this hope. Her missive to President Clinton points out that under current taxing and spending policies, the budget deficit could soar to $4.1 trillion per year by 2030. Clearly, we cannot incur debt, or, for that matter, incur taxes on this scale. By risking such a course, we would ruin the American dream for generations to come.

If taxes and deficits are not the solution, then it follows that Congress must take decisive steps, and the sooner the better, to reign in the growth of the hospital insurance program.

The task is not as lonely as some of the interest groups who come before you would have you believe. You will have surprisingly strong support from the public.

In a September 1994 survey of working-aged Americans, we found that 94 percent agreed that the impending bankruptcy of the HI trust fund is a "serious" or "very serious" problem. There were 74 percent that said they would think more favorably of elected representatives who addressed the need for reform. Also, 69 percent favored reducing benefits to the affluent, and 88 percent favored shielding retirement savings from taxation.

We urge you to draw on this good will to fundamentally redesign the program. We recommend that you merge HI with the SMI subsidy and convert them into a single voucher that can be used to purchase private insurance. We recommend that these vouchers be means tested, based on the recipient's household wealth and income. We further recommend that you significantly expand the concept of the individual retirement account, so that working Americans who want to save and avoid dependency on the government can do so.

Let me say, in conclusion, that we at the National Taxpayers Union recognize the terrible, desperate dependency that has been created by social insurance. Many Americans have failed to prepare adequately for their old age, precisely because the government has told them: Don't save, we will fund these costs by taxing your children and grandchildren.

We must follow through on our obligations to the truly dependent. But at the same time, we must take immediate steps to improve the efficiency of our health benefit programs, and to cut their costs. And over time, we must convert these subsidies into true insurance systems that minimize dependency on government and increase national savings. Thank you.

[The prepared statement follows:]

Statement of
Paul S. Hewitt
Executive Director
National Taxpayers Union Foundation
before the
Committee on Ways and Means, Subcommittee on Health

February 22, 1995

Mr. Chairman, members of the Committee, thank you for inviting me to testify on behalf of the National Taxpayers Union Foundation concerning the Medicare provisions of the President's fiscal 1996 budget proposal.

NTUF and its 300,000 member sister organization, the National Taxpayers Union, have been trying for years to draw public attention to the need for fundamental reforms to the Medicare program. We very much appreciate that, at long last, some policy makers appear to be listening. But we are sad that the President still is not among them. From what we can see, his budget seems to suggest that the system can continue running on auto-pilot. And that clearly is wrong.

Medicare's problems are extraordinary. Exploding costs -- under both the Hospital Insurance and Supplementary Medical Insurance systems -- threaten to impose unthinkable debt and tax burdens on our children. Past efforts to contain costs through capitated payment schemes are creating a two-tier health system, in which some providers no longer accept Medicare patients. These same measures are shifting enormous costs onto private payers, which, in turn, fuels the administration's misguided initiative to institute national price controls.

Mr. Chairman, we believe that Medicare's problems are solvable without higher taxes or bigger government. But to achieve these ends, Congress will have to bite the bullet. You will have to tell today's elders that Medicare, in its current form, cannot be saved. You will have to insist that some beneficiaries, mainly the well-off, get less. And to those of us who are not yet retired, you must make it clear that, if we expect to have the best medical care money can buy, we will have to save more toward the inevitable costs of our own old age.

Hospital Insurance

In their most recent actuarial report, the HI trustees painted a bleak picture, indeed. They predicted that the system's trust fund will go bankrupt at the turn of the century -- provided, of course, that we can avoid another recession in the meantime. HI already costs more than its 2.7 percent payroll tax brings in -- and in this way it contributes to this year's unified budget deficit. As a percentage of the wage base, HI surpassed 3 percent of payroll in 1992. By the year 2000, its cost will be close to 4 percent. By 2040, as my grandchildren enter the labor force, HI is projected to claim somewhere between 9.6 percent and 18.5 percent of payroll.

Together with Social Security and Part B of Medicare, the program will create enormous pressures for higher taxes. By 2040, these three programs are projected to cost between 34.5 percent and 55.1 percent of total taxable payroll -- or between 2.3 and 3.7 times their current combined tax burden. If it is the latter, the take-home pay of the average American worker will decline by 59 percent from today's levels. Even if economic and demographic circumstances are highly favorable, the standard of living for the average working family will be no better in 45 years than it is today.

I would note, with dismay, that some members of Congress have argued that, in light of these problems, we dare not pass the balanced budget amendment. They say that we must keep open the option of deficit financing some, or all, of this spending growth. Yet, OMB Director Alice Rivlin's infamous leaked budget memo of last October belies this hope. Her missive to President Clinton points out that, under current taxing and spending policies, the budget deficit could soar to $4.1 trillion per year by 2030. Clearly, we cannot incur debt -- or, for that matter, taxes -- on this scale. By risking such a course, we would ruin the American dream for many generations to come.

Reform Recommendations

If taxes and deficits are not the solution, then it follows that Congress must take decisive steps -- and do so soon -- to rein in the future cost growth of the Hospital Insurance program. The task is not as lonely as the special interest groups who come before this Committee would have you believe.

You will have surprisingly strong support from the public. In a September 1994 survey of working aged Americans, 94 percent agreed that the impending bankruptcy of the HI trust fund is a "serious" or "very serious" problem. Seventy-four percent said they would think more favorably of elected representatives who discussed the need for reform. Sixty-nine percent favored reducing benefits to affluent households. Eighty-eight percent favored shielding retirement savings from taxation.

The National Taxpayers Union Foundation urges Congress to listen to the American people. We recommend that you merge the HI with the SMI subsidy, and convert them into a single voucher that can be used to purchase private health insurance. We recommend that these vouchers be means-tested, based on the recipient's household wealth and income. We further recommend that you significantly expand the Individual Retirement Account, so that working aged Americans who want to save, and avoid dependency on government, can do so.

This approach has important advantages. It would cut federal spending, and pressure on deficits and taxes. It would harness the market forces of consumer choice to contain costs. It would dispense with the Byzantine price controls and claims processing systems that currently plague HI. It would raise our national savings rate -- and thereby help America to retain its share of global markets in the next century. And it would remove much of Medicare's regressivity. It is beyond me, Mr. Chairman, how Congress can levy taxes on low income workers, for a program that has no future, to subsidize retired doctors and accountants.

Mr. Chairman, let me say, in conclusion, that we recognize the terrible dependency created by social insurance. Many people have failed to prepare adequately for their old age precisely because government promised to fund these costs by taxing their children and grandchildren. We must follow through on our obligations to the truly dependent. But at the same time, we must take immediate steps to improve the efficiency of our health benefit programs, and to cut their costs. Over time we must convert them into systems that minimize dependency on government.

Thank you for soliciting our views. I will be pleased to answer your questions.

Chairman THOMAS. Thank you very much, Mr. Hewitt, and I want to thank the panel.

We have a vote on now, so we are going to recess to go over and vote. If the panel will be kind enough to wait, we will come back and then we will continue our inquiry.

Thank you very much.

[Recess.]

Mrs. JOHNSON [presiding]. Mr. Thomas has asked me to resume the hearing. While I was waiting for some of my colleagues to return, I think that, given the hour and the work ahead of us, I am going to resume the hearing without them. I am sure that they will be joining me shortly.

First of all, I want to thank this panel for their input. I am very disappointed that neither AARP nor the Committee to Preserve Social Security came today. I think that is extremely unfortunate, that they chose not to come. I do not know why, but there could be no greater threat to either the seniors of America or the younger generation than the impending bankruptcy of the system on which they depend for medical care. It is not just seniors who depend on that system, it is their children and offspring, it is the larger family. I do regret their not being here.

I very much regret the administration's decision not to allow Alice Rivlin to be here, because, while, in fact, we are only a subcommittee and often the administration doesn't send people of that rank to subcommittees, and I appreciate that general policy, nonetheless, we are the only subcommittee dealing with one of the most explosive, difficult, dangerous problems that we face. If we don't fix Medicare, it could rend the very fabric of families and communities.

I just appreciate your testimony very much.

Mr. Hopkins, you recognize in your testimony the challenge of educating seniors. What plans has your group made to begin dealing with this? In my experience among members of the public, when I speak to seniors at senior centers, they are among the most rational of my constituents and also amongst the best informed. But you are right. The seniors need to understand what is at stake and how many very positive options there are.

What work has the Seniors Coalition done, or what work are you planning to do? What kind of broader coalitions can you build? Have you talked to RSVP about this? What is happening out there to help seniors understand what is at stake?

Mr. HOPKINS. Right now, we are in the process of coalition building, as you suggested, because it is going to take a lot of work from a lot of people. We don't have all the answers. We are looking at a lot of ideas out there. Your idea with expanding Medicare Select is an absolutely wonderful, necessary step, and we are supporting that actively.

But beyond that, we are exploring the idea of Medicare savings accounts. We are giving that some very serious looks. We are looking at reforming Medicare HMOs to actually make them work a little bit better and actually save some money while retaining choice and the ability to opt out. Certainly, we don't want seniors herded into one plan in which they are stuck.

We are in the building process right now. Again, we recognize that we won't have all the answers. We want to talk to as many

people as we can. The important part is recognizing that there is a problem so that everybody can work on it together.

Mrs. JOHNSON. Thank you. I appreciate that, and I appreciate your support of Medicare Select. It is a useful move. It is a very teeny, tiny action in the face of the enormity of this problem, but I do hope that we will be able to get that bill out of subcommittee and through the House in fairly rapid order, because it will, for the first time, make permanent a more flexible preferred provider option for seniors.

There is nothing mandatory about it. As you say, nobody on this side of the aisle, and, I dare say, no one on the other side of the aisle has any interest at all in forcing seniors into any plan they don't elect or in keeping them in any plan that they aren't happy in.

With that clear, I do look forward to working with you on reforms of HMO risk contracts and those kinds of vehicles to help seniors have greater choice. It is going to be their primary avenue to expanded benefits.

Ms. Lamm, I was very pleased to see in your testimony that you have picked up on some of the tougher recommendations made by some of my colleagues in the other body. The House Republicans have now, in two budgets, introduced and voted on means testing Medicare premiums. We have not gone through in the detail that you have, and I appreciate your putting on the record and talking through a little bit the specific recommendations that you are making to make Medicare more sensitive to the extraordinary variation in economic power that is typical in our seniors community.

Ms. LAMM. I will go ahead and do that, but I will start by saying, again, the recommendations that we make, and we realize, are just a few of many out there. We also realize that, after all is said and done, they might not be the best ones that could be made. Again, I say that it is most important that this body get together and act to solve the problem.

We believe, again, in the means testing of Medicare, simply because, as a group, Third Millennium believes that the elderly have gone from among the poorest in the country to the most wealthy in the country. It is important, when I say that, to begin by saying, the elderly are a very diverse group. Obviously, there are very many senior citizens who rely on Medicare and who need it, and that should not be taken away from them. But there are also very many wealthy seniors who, we believe, could pay a greater share of the Medicare costs.

That is followed by the second proposal that we had here, adding a graduated part A premium for beneficiaries with incomes above 150 percent of poverty. Again, I forward this by saying that the average enrollee only pays about 32 percent of the cost today. We feel that it would be a good move to add that premium.

The part B proposals that we recommend are, again, on similar lines, because when Medicare part B began, the share was really 50:50 and that has shifted significantly since the program began. We feel that it is only fair to make sure that we maintain the 30-percent share paid by enrollees today and that that is not decreased even further to 25 or 20 or even 15 percent.

Mrs. JOHNSON. The interesting thing about these kinds of proposals is that they could be done immediately. These are not mysterious. In my experience, actually, I have never met a senior in America who wasn't willing, in the upper-income brackets, to pay more of their Medicare premium and didn't understand how fair and reasonable it was.

I think, it is my hope, at least, that as we look at this crisis short term, we at least do some of those things that are fair and that are relatively easy to do right now. Medicare Select is among them. There are some other things that we can do, but means testing premiums is certainly one of them.

Mr. Hewitt, I thought that your laying out the costs in 2040 was very helpful, that payroll taxes could go as high as 18.5 percent, that we would be well into more than $4 trillion deficit spending per year. It is simply extraordinary.

So it is imperative that we come to grips with the significance of the problems we face in Medicare, and then, ultimately, in Social Security.

I thank you for your testimony, and I yield to my colleague, Mr. Cardin.

Mr. CARDIN. Thank you, Mrs. Johnson.

Let me apologize for not being here to listen to your testimony. I have tried to read, quickly, the summary of your statements. I was speaking downtown on health care on what is likely to be the type of health care bills to come out of this session of Congress, from the Democratic point of view. There was a Republican also there.

I know that we all share a commitment to deal with the Medicare system, to reduce the Federal cost, but, more importantly, to reduce the cost of health care growth in this country and to make it more available to all of our people.

Reading your statements, there is little to quarrel with from the point of view of trying to get a fairer financing structure for those who benefit from Medicare, and we need to take a look at that. But we also need to reduce the costs of health care and the costs of the Medicare system itself.

The problem that we confront, and I would appreciate your response to, at least, my assessment of how the problem has developed and what we can do about it, is the problem that we usually look simply to cutting provider fees. I notice in one of the statements here, from Ms. Lamm, you have reducing Medicare provider payments. When we reduced Medicare provider payments in the past, we have just seen it has been cost-shifted over to the private sector without really any reduction of the overall medical cost growth in this country.

The anomaly of it, though, is that on total, Medicare pays less than its fair share on the per-unit cost, but that if you could have a better organization for the delivery of health care, you could save money in the managing of the health care cost per beneficiary.

My State of Maryland has an all-payer rate system, where hospital rates are set for all payers to pay the same amount. So if you go to a hospital in Maryland, they really don't care whether you are a Medicare person or a Medicaid person or Blue Cross/Blue Shield or Prudential, or for that matter, a self-insured plan, be-

cause the hospital is going to get basically the same reimbursement rate. There is no difference. We have no cost shifting from one segment to the other.

When Maryland started this system in the 1970s, our costs were 25 percent above the national average on a per-admission basis. We are now about 15 percent below the national average, so we have brought our costs down considerably. We have been able to save Medicare money, save our companies money, and save costs for taxpayers generally.

I guess my point is that we are able to do that through developing a rational system for hospital reimbursement, a fair system. What concerns me in some of the testimony we have heard today is that there is at least the thought that, perhaps, Medicare could just pay less and that will mean we save money. That is not the case in my State. There is no discounting in Maryland. HMOs pay the same as a fee-for-service plan, as far as their hospital costs are concerned.

So I would hope that we would look for innovative ways to bring down Medicare costs rather than just slashing budgets and slashing provider fees. Yes, we should look at beneficiaries paying in a more rational way for what they receive, but we also should be looking at ways of delivering the product in a more cost-effective environment.

I would appreciate if anyone would like to make a comment about that in the moment or two that is left.

Ms. LAMM. I think that the concern over cost shifting is very valid, indeed. In what Third Millennium advocates, we must realize that it is part of an entire package. I would certainly not suggest that we simply reduce Medicare provider payments and that that would solve the problem. I think that, in the context of this package, it is one proposal that balances out some of the other proposals and that it must be taken as part of that package. But I certainly understand the cost shifting concern.

Mr. CARDIN. Thank you.

Thank you, Madam Chairman.

Mrs. JOHNSON. I thank the panel for your participation today and for your patience during our voting period.

Mrs. JOHNSON. I would like to call now the representative from the GAO, Sarah Jaggar, our last witness.

Welcome, Ms. Jaggar.

STATEMENT OF SARAH F. JAGGAR, DIRECTOR, HEALTH FINANCING AND POLICY ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY FRANK PASQUIER, ASSISTANT DIRECTOR, AND CRAIG WINSLOW, OFFICE OF THE GENERAL COUNSEL

Ms. JAGGAR. Thank you. Madam Chairman and members of the subcommittee, we are very pleased to be here today to highlight a recent development specifically related to the Medicare secondary payer (MSP) program. This is a narrow focus compared to the broad focus that you have had this morning, but it is something that we feel needs to be brought to your attention right away.

With me today is Frank Pasquier, who has been responsible for much of our Medicare secondary payer, or MSP, work over the years. We would like to have our full statement put into the record and I would like to present a summary.

First, a bit of background on the MSP program. By law, Medicare is to be the secondary payer for certain covered beneficiaries when they have other private health insurance coverage. To be the secondary payer, Medicare must know about a beneficiary's other coverages so its claims processing systems can assure that other insurers pay claims before Medicare. This enables Medicare to avoid incurring unnecessary costs.

A second part of MSP is when Medicare retrospectively recovers mistaken payments that should have been paid by other health insurers. This is called recovery of mistaken payments. This is a difficult and costly process.

MSP is a major Medicare cost containment measure. HCFA, the Health Care Financing Administration, estimates that it saved taxpayers about $3 billion in fiscal year 1994. Today, I would like to focus on two areas that affect the ability of the MSP program to realize savings. These are the HCFA data match and the Medicare/Medicaid data bank.

First, the HCFA data match. The HCFA data match allows Medicare to match data contained in IRS and Social Security Administration files to identify beneficiaries that have health insurance coverage through their own or a spouse's employer. To date, the data match program has been cost effective. The data match for the 1987 through 1990 time period has resulted in $1.6 billion in demand notices to insurers for payment to Medicare, of which about $400 million has been collected. In seeking these recoveries, Medicare contractors have incurred about $94 million in administrative costs through fiscal year 1994.

However, a May 1994 Federal court ruling invalidated two MSP regulations that HCFA officials view as critical to continuing this program. The first deals with the timeframe for recovering MSP mistaken payments. The court ruled that Medicare must adhere to insurers' timely filing requirements in seeking recoveries from insurers, generally meaning that claims must be filed within 1 year after the date of service.

However, the data match process, because it uses IRS and SSA data, does not permit HCFA to meet these timeframes. Medicare claims are usually at least 2 years old before recovery actions can be initiated. This limitation would basically eliminate HCFA's ability to recover mistaken payments, at the loss to Medicare of hundreds of millions of dollars annually.

The second ruling invalidates a HCFA regulation that allows Medicare to make recoveries from third-party administrators, which typically adjudicate claims and write benefit checks for employers that self-insure. Because one third-party administrator may serve hundreds of employers, HCFA officials told us they will face serious administrative complications if they must pursue recovery from each employer.

This week, the Supreme Court declined to hear the Federal Government's appeal of this case, leaving the appeals court's decision intact. Without legislative intervention to reinstate these regula-

tions, HCFA will be unable to recover on previously paid Medicare claims, resulting in an estimated lost savings of at least $600 million over the next 5 years.

Further, according to HCFA officials, there is now an open question as to whether Medicare will have to refund to insurers amounts already recovered under the data match program. As you can see, this court ruling has serious implications for the cost of and funding for the Medicare program.

In conclusion, Mr. Chairman, our work suggests that several actions are needed to protect the savings available under the MSP program. First, the MSP program's recovery efforts for previously paid Medicare claims have been shown to be cost effective, resulting in $400 million in recoveries thus far. However, this effort has, in effect, been negated by the recent appeals court ruling, and as a result, at least $600 million of expected recoveries over the next 5 years will be lost. Legislation is needed to prevent this. We would be happy to work with your staff to develop suggested language to remedy this problem.

Second, we have earlier made a recommendation that funding for what is known as the Medicare and Medicaid data bank be delayed until its potential value and benefits can be demonstrated, and we continue to support that recommendation.

This concludes my statement. We will be happy to answer any questions you may have.

[The prepared statement follows:]

TESTIMONY OF SARAH F. JAGGAR, DIRECTOR
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Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to highlight recent developments related to the Medicare Secondary Payer (MSP) program that could cost the Medicare trust fund hundreds of millions of dollars. Your Subcommittee recently held several hearings on the Medicare program to identify ways to avoid excessive or unnecessary spending. As you are aware, there are a number of legislative initiatives that are intended to improve the MSP program, which is administered by the Health Care Financing Administration (HCFA), an agency within the Department of Health and Human Services (HHS).

The MSP program helps assure that other health and accident insurers pay medical costs for certain covered beneficiaries before Medicare. To do so, Medicare must obtain data on a beneficiary's private health insurance coverage so that its claims processing systems can assure that other insurers, whose coverage is primary, pay claims before Medicare. This enables Medicare to avoid incurring unnecessary costs. In addition, Medicare retrospectively recovers mistaken payments that should have been paid by other health insurers. Thus, MSP is a major Medicare cost containment measure, saving about $3 billion in fiscal year 1994.

Historically, Medicare has faced many obstacles in carrying out the MSP provisions. When Medicare pays claims that other insurers should have paid, Medicare must recover its costs from the liable insurers. This is difficult. For the past decade, our reports (see Appendix I) and those issued by HHS's Inspector General have shown problems with efforts to identify and collect from insurers that are responsible for paying ahead of Medicare.

I now would like to focus on three specific legislative initiatives intended to improve Medicare's MSP program that I will discuss are the following:

-- The HCFA data match which relies on Internal Revenue Service (IRS), Social Security Administration (SSA), and Medicare records. The anticipated recovery of hundreds of millions of dollars of mistaken payments has been negated by a recent appeals court ruling that invalidates two HCFA regulations that are critical to MSP recoveries.

-- The Medicare/Medicaid data bank. As we previously testified and reported, we believe that the data bank will be expensive and add an unnecessary administrative burden to the nation's employers while achieving little or no savings because there is no assurance that the increased record-keeping requirements would provide needed or additional information on beneficiaries' health insurance coverage.

-- A beneficiary enrollment questionnaire. While this initiative has strong potential for identifying Medicare beneficiaries with other health insurance coverage, it will be some time before HCFA can assess its overall effectiveness.

BACKGROUND

Medicare provides health insurance coverage for over 36 million elderly and disabled Americans. Its coverage is quite extensive, including physician, hospital, home health, skilled nursing home, and various other services.

In enacting the Medicare program in 1965, the Congress made Medicare the secondary payer for expenses also covered by workers' compensation programs. Concerned about escalating costs in the Medicare program, the Congress made several statutory changes during the 1980s that also made Medicare the secondary payer to certain employer-sponsored group health insurance plans and to automobile and other liability insurance plans.

The MSP provisions are intended to assure that Medicare is the secondary payer, that is, other insurers pay claims before Medicare. As a result, Medicare claims processing contractors have two interrelated responsibilities: (1) to identify beneficiaries with other insurance coverage and thus avoid paying claims that other insurers should pay and (2) to identify and recover mistaken payments that were made before it was determined that the beneficiary had other insurance coverage.

The MSP provisions apply to a relatively small portion of the total number of Medicare-eligible persons. Last year, we estimated that no more than 3 million Medicare beneficiaries have other insurance that is primary to Medicare. Nevertheless, because of the size of the Medicare program, the dollar value of Medicare claims subject to the MSP provisions is substantial.

The majority of beneficiaries who are covered by the MSP provisions are the working aged and their spouses. Contractors often must rely on health care providers to identify beneficiaries with other insurance coverage and thus may experience difficulties in screening medical claims when such information is missing. Even more arduous and costly are the contractors' attempts to recover Medicare payments after a claim has been paid. Contractors must search their records, often dating back several years, to determine whether Medicare paid claims for which another insurer was the primary payer and, if so, seek recovery.

FUTURE RECOVERIES THROUGH THE DATA MATCH PROGRAM WILL NOT BE REALIZED

To help Medicare identify and also recover costs that other insurers are responsible for paying, the Congress provided for HCFA to establish a data match process. The data match process, originally authorized under the Omnibus Budget Reconciliation Act of 1989, allows HCFA to match data contained in several federal information systems--including IRS and SSA files--to identify beneficiaries that have the potential for health insurance coverage through their own or a spouse's employer. Section 13561 of Omnibus Budget Reconciliation Act of 1993 (OBRA-93) extended HHS's authority to conduct data match activities through September 30, 1998. The President's fiscal year 1996 budget proposes legislation that would permanently extend the provision.

To date, the data match program has been cost effective. HCFA records show that an initial data match of IRS/SSA records for the 1987-90 time period has resulted in $1.6 billion in demand notices to insurers for payment to Medicare, of which about $400 million has been collected. In seeking these recoveries, Medicare contractors have incurred about $94 million in administrative costs through fiscal year 1994. However, a May 1994 a federal court ruling invalidated two MSP regulations that HCFA officials view as critical to their continued recovery of MSP mistaken payments.[1]

The first regulation deals with the time frame for recovering MSP mistaken payments. HCFA regulations (42 C.F.R. 411.24(f)) provide that Medicare contractors may recover such payments without regard to any insurer imposed requirements to file a claim within a certain time period. The court ruled that in seeking recoveries from insurers, Medicare must adhere to insurers' "timely filing" requirements that are imposed on other claimants. Generally, this means that claims for reimbursement of health care services must be filed within 1 year after the date of service. However, the data match process does not permit HCFA to meet these time filing requirements. IRS data are for prior tax years and must be matched against SSA wage information. Thus, the data by nature are over a year old before HCFA can begin processing them to identify MSP

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[1]Health Ins. Ass'n of Am. v. Shalala, 23 F.3d 412 (D.C. Cir. 1994) *cert. denied*, 63 U.S.L.W. 3439 (U.S. Feb. 21, 1995) (No. 94-919).

situations. HCFA's process involves mailing questionnaires to employers, searching Medicare paid claims data, and providing contractors with lists of mistaken payments that must be researched. As a result, Medicare claims are at least 2 years old before HCFA can initiate recovery actions. For example, HCFA has just recently initiated efforts to recover mistaken payments that were identified by the 1991-92 data match. HCFA estimates that these claims could result in additional recoveries of about $200 million.

The second regulation deals with Medicare recoveries from third party administrators (TPA). The court ruling invalidated a HCFA regulation (42 C.F.R.411.24(e)) that allows Medicare contractors to recover from TPAs. TPAs typically adjudicate claims and write benefit checks for employers that self-insure. Most self-insured health plans operated by medium and large employers use TPAs. Because one TPA may serve hundreds of employers, they often represent the most efficient entity from which to seek recoveries. Because of the ruling, HCFA will now have to identify the specific employer that provides coverage and separately pursue recovery from each employer. HCFA officials told us that they will face serious administrative complications in recovering Medicare mistaken payments if they are prohibited from recovering directly from TPAs.

The Federal government appealed the court's decision to the Supreme Court, but this week the Court declined to hear the case, leaving the appeals court decision intact. Therefore, without legislative intervention to reinstate these MSP regulations, continued and effective recovery of Medicare mistaken payments from the data match process is not possible. Not being able to effectively recover on previously paid Medicare claims will result in estimated lost savings of at least $600 million over the next five years. Specifically, in regard to the fiscal 1996 budget, HHS estimated that the matches performed in fiscal 1996 could yield $400 million in MSP savings and projected savings of $430 million if the data match is extended beyond 1998. About half of these savings represent recoveries of previously paid claims that will not be collected because of the appeals court decision. In addition, according to HCFA officials, there is now an open question as to whether Medicare will have to refund to insurers amounts already recovered under the data match program since 1993.

LEGISLATION NEEDED TO DELAY
DATA BANK IMPLEMENTATION

Another MSP initiative that could have a significant impact on HHS fiscal year 1996 administrative costs for Medicare is the Medicare/Medicaid data bank. Section 13581 of OBRA-93 directed HHS to establish a data bank, beginning in February 1995, that would contain information on about 160 million workers, spouses, and dependents covered by employer group plans. Its purpose is to save millions by (1) identifying the approximately 7 million Medicare and Medicaid beneficiaries who have other health insurance coverage that should pay medical bills ahead of the Medicare and Medicaid programs and (2) ensuring that this insurance is appropriately applied to reduce Medicare and Medicaid costs. This information would then be used to recover mistaken payments.

In May 1994 we issued a report and testified that the proposed data bank would create an avalanche of unnecessary paperwork for both HCFA and employers and will likely achieve little or no savings while costing millions. The cost to HCFA of establishing and maintaining the data bank over 5 years was estimated by the agency at over $100 million. As a result, we recommended that the data bank be delayed until its potential benefit could be clearly demonstrated.[2]

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[2] Medicare/Medicaid: Data Bank Unlikely to Increase Collections From Other Insurers (GAO/HEHS-94-147), May 6, 1994.

While the Congress did prevent HCFA from using fiscal year 1995 appropriated funds for implementing the data bank, this restriction expires at the beginning of fiscal year 1996. At that time, the OBRA-93 provision would apply, and HCFA would be required to implement the data bank with fiscal year 1996 funds. We believe our 1994 recommendation is still appropriate and that the Congress should continue to delay the implementation of the data bank until its potential value and benefit can be clearly shown.

ENROLLMENT QUESTIONNAIRE
HAS POTENTIAL TO STRENGTHEN
MSP PROCESSES

MSP works best when Medicare has accurate, up-to-date information that enables it to keep from paying claims for which other insurers are responsible for paying. To enhance this ability, section 151(a) of the Social Security Act Amendments of 1994 directed HCFA to develop and mail questionnaires to Medicare beneficiaries upon enrollment. The questionnaires are to obtain information on whether the individual is covered by a health plan that should pay claims ahead of Medicare. HCFA anticipates mailing about 200,000 questionnaires a month. As of February 2, 1995, the first mailing was in process. In fiscal year 1996, HHS has budgeted $3.6 million to continue this activity.

While the questionnaire has strong potential to strengthen the MSP process and improve savings, it also has several built-in limitations. First, consistent with the statute, completing the questionnaire is essentially voluntary, so the extent to which beneficiaries will return it is not yet known. Second, because the questionnaire is administered only once, the information is accurate only as long as there is no change in the beneficiaries' health insurance coverage.

As a result, more experience with the questionnaire will be needed before HCFA can assess whether the questionnaire's results will provide sufficient information that will result in additional MSP savings.

CONCLUSIONS

Mr. Chairman, our work suggests that several actions are needed to maximize the savings available under the MSP program. First, because MSP recovery efforts of previously paid Medicare claims have, in effect, been negated by a recent appeals court ruling, legislation is needed to assure effective recovery of MSP mistaken payments. We would be happy to work with your staff to develop suggested language to remedy this problem. Second, we continue to support our earlier recommendation that funding for the Medicare/Medicaid data bank be delayed until its potential value and benefits can be demonstrated.

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This concludes my prepared remarks. We will be happy to answer any questions you may have.

For more information on this testimony, please call Frank Pasquier, Assistant Director, at (206) 287-4861. Other major contributors included Alfred Schnupp and Craig Winslow, Office of the General Counsel.

RELATED GAO PRODUCTS

Medicare: More Hospital Costs Should Be Paid by Other Insurers (GAO/HRD-87-43, Jan. 29, 1987).

Medicare: Incentives Needed to Assure Private Insurers Pay Before Medicare (GAO/HRD-89-19, Nov. 29, 1988).

Medicare: Millions in Potential Recoveries Not Being Sought by Maryland Contractor (GAO/HRD-91-32, Jan. 25, 1991).

Medicare: Millions in Potential Recoveries Not Being Sought by Contractors (GAO/T-HRD-91-8, Feb. 26, 1991).

Medicare: Over $1 Billion Should Be Recovered From Primary Health Insurers (GAO/HRD-92-52, Feb. 21, 1992).

Medicare/Medicaid: Data Bank Unlikely to Increase Collections From Other Insurers (GAO/HEHS-94-147, May 6, 1994).

Medicare/Medicaid: Data Bank Unlikely to Increase Collections From Other Insurers (GAO/T-HEHS-94-162, May 6, 1994).

Mrs. JOHNSON. Ms. Jaggar, what was the logic of the committee's ruling in regard to Medicare's right to collect from third-party administrators?

Ms. JAGGAR. Madam Chairman, when Medicare was put in place in 1965, the early program decided that for Workers' Compensation claims, Medicare would be the secondary payer. In the early 1980s, there was an expansion of the Medicare secondary payer coverage to include other individuals who met certain selected conditions, so this has been in place for a number of years and is not a new decision.

Mrs. JOHNSON. It is not a new decision, but now it is interfering with your ability to collect?

Ms. JAGGAR. What is at question now is a court ruling which essentially says that Medicare—it doesn't say that Medicare can't make the collection for these mistaken payments. It says that Medicare must do it within a year's timeframe, or within the timeframe that the insurance companies have set. The insurance companies have wanted that timeframe—it is normally within a 6-month to 1-year timeframe that insurance companies close out——

Mrs. JOHNSON. I understand the time problem.

Ms. JAGGAR. OK.

Mrs. JOHNSON. It is the second one that you bring up, the court ruling that invalidated the HCFA regulation that allowed Medicare contractors to recover from TPAs. What was their logic in denying your right to recover in that court decision?

Ms. JAGGAR. I have with me a gentleman from our Office of the General Counsel.

Mrs. JOHNSON. We would be happy to hear from him.

Ms. JAGGAR. His name is Craig Winslow.

Mrs. JOHNSON. Mr. Winslow, welcome, and thank you.

Mr. WINSLOW. Thank you. It was based on interpretation of the statutory language. The language says, basically, they can recover from those who are required to or have a responsibility to pay. The court accepted the argument that TPAs, although they are paying claims on behalf of insurers and others, because they don't have ultimate financial responsibility, that they are not required or responsible to pay, in the context of this language.

Mrs. JOHNSON. So you believe a clarification of the law would restore your right to deal with the TPAs?

Mr. WINSLOW. Exactly, yes, ma'am.

Mrs. JOHNSON. Thank you.

Mr. Cardin.

Mr. CARDIN. Could you elaborate a little bit more specifically as to what type of legislation you would like us to consider?

Ms. JAGGAR. Mr. Cardin, the Supreme Court's decision not to hear the case occurred on Tuesday of this week. As you can imagine, the people at the Health Care Financing Administration who are responsible for conducting the MSP and have been involved in the litigation over the years are working on legislation.

Our understanding is that the changes that would be required basically go to clarifying the timeframes and the responsibility, and that what we would like to do for the subcommittee, if the subcommittee would find it helpful, is work with the lawyers at the

Health Care Financing Administration. It would be a matter of language change.

Mr. CARDIN. I would assume, on the first point, you would want to extend the period to greater than 1 year. Is that what you would be seeking, a longer time period?

Mr. WINSLOW. The court ruling didn't say 1 year. It just said that they were bound by the filing deadlines in the contract. We would want to clarify that the Federal Government shouldn't be bound by those.

Mr. CARDIN. Would not be bound at all?

Mr. WINSLOW. Would not be bound by them.

Mr. CARDIN. You don't want any of the contractual limitations to apply? You don't want to put a limit on what those contractual limitations could be?

Mr. WINSLOW. Right, because, for example, the data match takes, I think my colleagues were saying, 2 years.

Mr. CARDIN. What are your limitations now? If you don't have contractual limitations, what would the limitations be?

Mr. WINSLOW. I really can't say for sure. I am sure there is a statute of limitations, perhaps, but I don't know what it is.

Mr. CARDIN. I think it would be useful if we knew what that limitation was. If you are asking us to eliminate any contractual restrictions, we should know what the limits are.

Mr. WINSLOW. I will be glad to get back to you.

Mr. CARDIN. I can understand that this just occurred and you don't have a specific bill before us.

On the second point, you would want the ability to go against the organization rather than against each employer, is that what you are basically asking?

Ms. JAGGAR. The third party administrators pay claims for a number of individuals, for a number of employers. For HCFA to go to each individual employer to try to get those recoveries would be extremely costly and time consuming and be a big burden on it.

Mr. CARDIN. I would think that your point there is very well taken, and we would like to see the specifics there, also.

The chairperson is not only chairing today's hearing, but she also chairs our Oversight Subcommittee, and this question may be better suited for that subcommittee. I can appreciate the importance of the match program. It does bring in moneys to the Federal Treasury.

You brought in, I think, $400 million, you indicated, over a period of time, and it cost $100 million to recover. That seems like a large overhead cost, $100 million for $400 million. We don't want to lose $300 million, but it seems to me that it is an expensive collection process.

Ms. JAGGAR. Perhaps I could clarify that. In fact, $1.6 billion in repayment demands have been made and $400 million has been returned, but because of this court case or for any number of other reasons, it may well be that insurance companies were, in fact, waiting to see whether they would have to return that money.

So I don't believe that it is possible yet to say exactly what the administrative costs are. In addition, those administrative costs cover the activity that allows for cost avoidance. That is the identification of individuals who have this insurance coverage. Essen-

tially, a flag is set in the computer and then you don't have to recover because you don't make the mistaken payments from the outset. That is estimated at approximately $3 billion for 1994. So the $94 million against the $400 million is not quite the full story.

Mr. CARDIN. I appreciate that clarification. Thank you.

Mrs. JOHNSON. As you come back to us with specific recommendations, and clearly, we are all interested in that, I think open-ended legislation is really not a good idea. We have timely filing requirements for good reason. But I think we could have, in this case, the timely filing period start from the availability of the data that you need to match and that you would have 1 year from the time that the information was available, rather than an open-ended opportunity to collect.

Ms. JAGGAR. It certainly would be possible to narrow it to a reasonable timeframe. The process is an arduous one. Once the data are obtained from IRS and SSA, it is matched, and then letters are sent to the employers to find out whether it was accurate. So it takes a while, but I do agree that it wouldn't need to be open-ended indefinitely.

Mr. CARDIN. Would the gentlelady yield on that point?

Mrs. JOHNSON. Yes.

Mr. CARDIN. I think it is important that we nail down a specific time period. That is why I would like to know what the general limits would be.

It is clear that contractual time limits make very little sense for the work that you are doing. That is a contractual limit between the policyholder and the company and it relates to what the policyholder should know. You don't know that until you get the information. So, clearly, the interpretation of the court is not acceptable for purposes of what we are trying to do and collect under Medicare.

But I do think it is important to come up with a limitation that is reasonable and not to keep it open-ended, so that we are fair to the agency but also fair to the company.

Ms. JAGGAR. We thought it was important to bring to your attention because it is so much money. Of course, there is a question, ultimately, of whether past collections would have to be returned, and there is some issue associated with that. So it is a significant amount of money.

Mrs. JOHNSON. We certainly would want to clarify all those things, but recognizing the pressure which we would be under regardless who is in control, these are the kinds of things that you can do in fairness to all, the taxpayers, the beneficiaries, and the government. We do need to clean up this act, and it is a legitimate thing to try to do in the very near future. Any help you can give us and send that word back, between GAO and HCFA, we ought to be able to fix this.

Mr. CARDIN. We could have a problem on retroactivity, so you probably would want to get something to us as quickly as possible.

Ms. JAGGAR. Yes, sir.

Mrs. JOHNSON. Thank you. We look forward to working with you.

Ms. JAGGAR. Thank you.

Mrs. JOHNSON. The hearing is adjourned.

[Whereupon, at 1:07 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF
NATIONAL ASSOCIATION OF MEDICARE DEPENDENT HOSPITALS
BEFORE THE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH
HOUSE OF REPRESENTATIVES
FEBRUARY 23, 1995

Introduction

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE: I am John Forsman, Chief Financial Officer of the Community/Kimball Health Care System of Ocean County, New Jersey, and Chairman of the National Association of Medicare Dependent Hospitals, a national trade association representing hospitals with unusually high Medicare patient loads. I am also a past member of the Health Care Financial Management Association's National Board Matrix.

We appreciate this opportunity to submit testimony on the Medicare program. The stated purpose of this hearing is proposals for Medicare changes in the President's FY 1996 budget, and proposals for Medicare that were **not** included in that budget. Our comments address the latter area, recommendations for change **not** proposed by the Administration, but that we believe would significantly improve the performance of the Medicare program for hospitals.

Medicare Reimbursement and Medicare Dependent Hospitals

My remarks will focus on flaws in the Medicare hospital prospective payment system ("PPS"). I recognize that, eventually, Medicare may need a broad and perhaps radical transformation toward a system based on managed care rather than fee-for-service. Frankly, I will welcome the change, because, as a Medicare-dependent health system, I have already been forced to become very efficient and am well-positioned to compete in the new world. In the short term, however, Medicare's fee-for-service sector, and the hospital PPS, will continue to exist. While the new Medicare system of the future is being built, the current structure should undergo some minor, but much-needed, repairs.

Let me preface my suggestions with a bit of context concerning the PPS and its evolution. Until 1983, Medicare reimbursed hospitals on the basis of the "reasonable cost" of providing services. In 1983-1988, Congress phased in the PPS to give hospitals incentives for efficiency by establishing fair payments at predetermined levels. Under the PPS, the unit of payment is the "diagnostic related group" ("DRG"). Payment is based on each patient's diagnosis, and the amount of payment, or DRG rate, varies with the complexity of the case.

The DRG rates are national, but vary around the country according to a geographical wage index. The DRG rates are also subject to two major adjustments: medical education ("GME" and "IME") and "disproportionate share" ("DSH"). GME and IME are intended to recognize additional costs incurred by teaching hospitals in training physicians. DSH is intended to compensate for additional costs incurred by hospitals that serve an unusually high proportion of low-income patients. Together, these add-ons cost $7.5 billion ($5 billion for GME and IME, $2.5 billion for DSH) (Att. A). As the Prospective Payment Assessment Commission ("ProPAC") has reported, these adjustments have been implemented "budget neutrally" -- shifting funds **away** from basic care for the elderly toward more specialized policy goals such as training doctors and caring for the indigent. See ProPAC, March 1993 Report to Congress at 20. Over time, the combination of these adjustments and the wage index has produced some dramatic variations in PPS payments, causing the PPS to move away from its original purpose to establish fair payments with incentives for efficiency, and causing the Medicare system to move away from its original purpose to provide hospital care for the elderly.

Using the same hospital cost report database that the Health Care Financing Administration ("HCFA") uses, we have conducted an extensive analysis of profits and losses. We discovered from this analysis that, on the whole, Medicare is not as poor a payer as the annual ratcheting down of PPS payments might suggest. On average, in fact, hospitals do reasonably well under the PPS. Our analysis of the 1992 database shows that, on average, hospital Medicare margins were -3% (a 3% loss); ProPAC has recently reported that in 1993,

hospitals' Medicare margins averaged +0.3%. But there is great variation among hospitals and groups of hospitals. The 1992 cost report database shows that hospitals' profits and losses on Medicare can range from profits as great as 12% to losses as great as 17%. Medicare dependent hospitals, those with unusually large Medicare loads, incur losses well beyond the average. In effect, these hospitals pay a penalty for their service to the elderly.

Medicare Dependent Hospitals

Who are the Medicare dependent hospitals? Our group defines them as those with **Medicare patient loads of 60% or more** on a regular basis. Often, these high Medicare patient populations are a creature of demographics, as in my own area, Ocean County, New Jersey. There, a large community of senior citizens began developing about 30 years ago. Senior citizens are generally not mobile in a demographic sense; in other words, they tend to age in place. This has been true of my county and my health system's patient population, which once consisted of a large population of fairly healthy 65-year olds, and now has a very large group in their 80's -- no longer generally healthy, but plagued with the chronic problems that very old age inevitably brings.

A visit to my hospital would reveal to you what Medicare dependent hospitals know well. Very, very old people need help with many basic activities that younger ones do not, such as bathing, eating, going back and forth to the bathroom, dressing, personal grooming, taking medication, even, in some cases, simply turning in bed. They have longer hospital stays, on average, because they heal more slowly than younger people, and are more susceptible to incurring secondary conditions in the hospital, such as pressure sores, respiratory infections, and others. In other words, a very old patient needs extra help with a lot of little things, most of which are not medical in nature, and none of which results in extra reimbursement under the PPS. But this essential extra help for my very old patients requires extra labor for my staff, and thus extra costs on our expense statement. Because Medicare dependent hospitals have a greater share of Medicare patients than others, they also have a correspondingly greater share of these very old Medicare patients that are more costly to serve, but without any additional reimbursement.

There are approximately 1400 Medicare dependent hospitals nationwide. Of these 1400, more than 900, or 65%, treat a Medicare patient mix greater than 65% (Att. B), with some approaching 80% Medicare. Approximately 600 of the 1400 Medicare dependent hospitals in the nation have **never** received any adjustment for IME, DME, DSH, or anything else. The rest are small rural hospitals that previously received a small rural adjustment which expired in September 1994. Thus, today, the overwhelming majority of Medicare dependent hospitals receive **no** adjustments under the PPS.

As ProPAC has observed, PPS payments have dropped much more steeply than other payors' in the last decade, so that hospitals **on average** lost 3% from Medicare in 1992. Consequently, "hospitals that cannot generate revenue from private payors are increasingly disadvantaged." ProPAC, id. at 24-25; see also, ProPAC, March 1994 Report to Congress at 5; March 1995 Report to Congress at 5 ("Medicare's payments...continue to be below those of most private payers."). Moreover, ProPAC has noted, the medical education and DSH adjustments have "substantially affected PPS margins," so that hospitals **without** these adjustments have been "disadvantaged...relative to others." ProPAC, June 1993 Report to Congress at 55. With no Medicare adjustments, and a much smaller pool of private pay patients to rely on for cost-shifting, Medicare dependent hospitals have suffered more than others during the last decade.

The reimbursement squeeze from their major payor, Medicare, has forced Medicare dependent hospitals to become more efficient. But, notwithstanding efficiency, Medicare dependent hospitals, with much less ability to make up Medicare losses from other payors, lose much more than others on Medicare and have lower overall margins. 1992 cost report data show that on Medicare alone, Medicare-dependent hospitals **lost** about 5%, while non-Medicare-dependent hospitals that qualify for GME/IME and/or DSH had about a 4% Medicare **profit**. **Overall** margins for **non**-Medicare dependent hospitals averaged nearly 5%, but for most Medicare dependent hospitals, overall margins averaged barely more than 2%. (Atts. C and D.)

With such low margins, and payments from all payors ratcheting down, Medicare dependent hospitals face two choices now: either close or reduce service. In either case, who **really** loses? The ultimate losers will be the Medicare beneficiaries these hospitals serve. When their community hospital closes, elderly persons must find another -- one which will certainly be less familiar and will almost certainly be farther away, a serious problem for elderly persons who are not as mobile as younger people. When hospitals are forced to reduce services, the first to go will be those programs that maintain the dignity of the elderly -- but represent costs not reimbursed by Medicare: transportation and feeding assistance, community outreach centers, and social services. Next on the chopping block will be labor costs -- reducing the hospital staff on whom the elderly depend for the special care they need, such as monitoring medication, preventing falls, and help with dressing, feeding, and other basic activities. All of these service reductions cause elderly patients to suffer and require family members to step in and provide the labor-intensive service that the hospital can no longer furnish.

Such results make no sense for Medicare, a program that was designed to serve the **elderly**. Such results also make no sense at a time in the nation's history when middle-class families are already shouldering more burdens to hold down jobs, raise children, and care for elderly relatives than ever before. Both the "Contract with America" and the Clinton Administration have pledged tax relief for the middle class and senior citizens. In light of these goals, the Medicare system should **not** be distorted by reimbursement inequities that unnecessarily compromise health care for the elderly and complicate life for their families.

A Modest Solution That Meets ProPAC's Goals

We fully recognize that the projected insolvency of the Medicare hospital trust fund and the prospect of a balanced budget amendment will result in even further PPS cuts. It is **not** our objective to stem that tide. What we recommend, instead, is a small correction **within** the system. A minor, **budget-neutral** adjustment in the PPS would resolve the inequity that handicaps Medicare dependent hospitals and threatens their patients. In order to **approach** a level playing field with the rest of the hospital industry, Medicare dependent hospitals seek a modest correction in the PPS update system. This correction would recognize Medicare dependent hospitals as a class and adjust PPS updates so that the update for this class annually was sufficient to bring their average Medicare margins to the level of the average for all hospitals. We would leave it to the experts at ProPAC to recommend the specific annual updates based on their data.

This modest shift to restore Medicare equity would cost the U.S. Treasury **nothing**. It would follow the pattern of update differentials used by Medicare in the past, and currently, to equalize margins between rural hospitals and others, and to create reimbursement equity for primary care physicians. Restoring some equity for Medicare dependent hospitals is also consistent with ProPAC's recent recommendations that Congress

> continue to modify PPS payment policies to ensure the equitable distribution of payments among hospitals. Payment adjustments are necessary to recognize appropriate variations in costs across hospitals...and reflect the broader responsibilities of the Medicare program to maintain access to quality care.

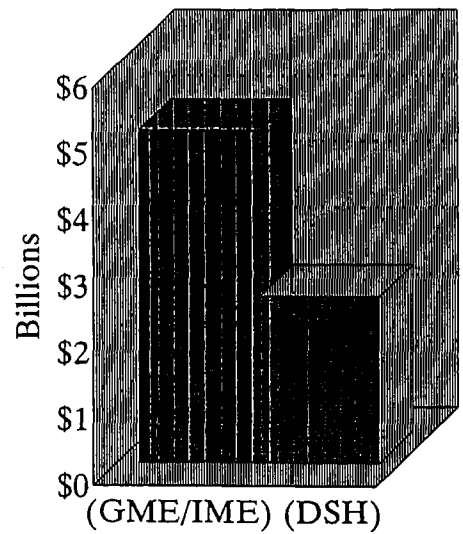
ProPAC, March 1993 Report to Congress, Recommendation #2 at 9.

We thank you for the opportunity to present our views to the Subcommittee.

3/10/95
Doc. 23818

Medicare Dependent Hospitals

Cost of Current "Special Add-Ons"



Teaching Hosp. Pymts	$5 Billion
Disprop. Share Hosp.	$2.5 Billion

Attachment A

Attachment B

MEDICARE DEPENDENT HOSPITALS
Based on 1992 Medicare Cost Reports

o Medicare Percent of Total Patients	60 - 65%	65% and over	Total
Number of Hospitals	512	918	1430
Rural Hospitals with 0-99 beds[1]	206	555	761
Urban Hospitals and Rurals with over 100 beds[2]	306	363	669

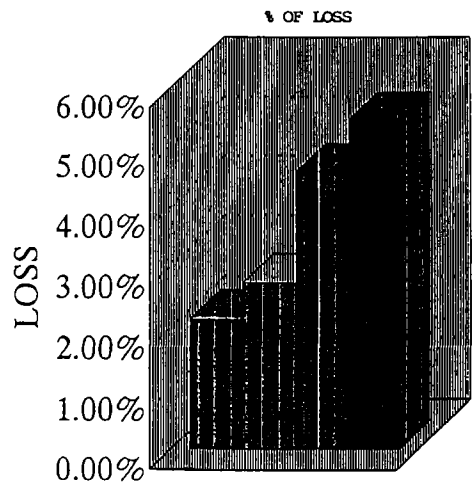
1/ The rural hospitals with 0 to 99 beds have previously qualified for a special adjustment, based on their dependence on Medicare, if they had a minimum of 60% Medicare patient days or inpatient revenues. This adjustment expired in September 1994.

2/ This group has never received any adjustment in recognition of their Medicare dependent status. The former small/rural adjustment was based on these hospitals showing lower Medicare margins. Most recent reports from HCFA and ProPAC now show performance for rural and urban hospitals to be basically equal.

2/1/95
Doc. #20866

Medicare Dependent Hospitals

Performance Under Medicare's PPS Based on 1992 Data



- < 60% Medicare Pop.
- Avg for all 5,300 Hosp
- 60%-64% Medicare Pop.
- 65% + Medicare Pop.

< 60% Medicare Pop.	2.13%
Avg for all 5,300 Hosp	2.73%
60%-64% Medicare Pop.	4.57%
65% + Medicare Pop.	5.45%

Attachment C

	TOTAL	MEDICARE % 65 % TO 100 %	MEDICARE % 60 % TO 64 %	MEDICARE % 0 % TO 59 %
TOTAL MARGINS	4.44%	2.91%	6.34%	4.41
DSH & TEACHING	3.84%	2.69%	2.34%	3.80
TEACHING	4.88%	5.20%	12.80%	3.94
DSH	3.41%	3.13%	6.52%	5.46
NON DSH & TEACHING	4.39%	2.35%	4.13%	4.99
MEDICARE MARGINS	-2.73%	-5.45%	-4.57%	-2.13
DSH & TEACHING	4.00%	-7.05%	-0.59%	4.33
TEACHING	-5.35%	-4.19%	-4.71%	-5.58
DSH	-3.02%	-6.09%	-1.73%	-2.86
NON DSH & TEACHING	-8.07%	-5.52%	-6.71%	-9.36

Attachment D

STATEMENT OF THE
NATIONAL ASSOCIATION OF PORTABLE X-RAY PROVIDERS
BEFORE THE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH
HOUSE OF REPRESENTATIVES
FEBRUARY 23, 1995

Introduction

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE: I am Jeffrey Burgess, President of Burgess Health Associates of Middletown, Connecticut and President of the National Association of Portable X-Ray Providers ("NAPXP"), a national trade association representing suppliers of portable x-ray and portable electrocardiogram ("EKG") services.

We appreciate this opportunity to submit testimony on the Medicare program. The stated purpose of the hearing was proposals for Medicare changes in the President's FY 1996 budget, and proposals for Medicare that were **not** included in that budget. Our comments address the latter area, recommendations for change **not** proposed by the Administration, but that we believe would significantly improve the performance of the program and especially its **cost-effectiveness**.

Portable X-Ray Suppliers: Who We Are and What We Do

I would like to preface these comments with some background about the service our members provide to elderly Americans. The portable x-ray is a relatively little-known service, although Americans should become more familiar with it in the coming years as the population continues to age and long-term care coverage expands. Portable x-ray suppliers are companies that bring x-rays and EKGs to the bedsides of elderly patients in homes or nursing homes. Historically, these suppliers have been small, local, literally "Mom-and-Pop" firms run by former x-ray technicians, but during the 1990s some consolidation has occurred, adding larger, multi-state firms that have been able to achieve economies of scale and introduce technological improvements to enhance the quality of our industry. Portable x-rays are performed entirely by x-ray technologists, with no physician involvement in the taking of the x-ray or the transportation of portable x-ray equipment to patients. Thus, portable x-rays are **not** physicians' services. (After portable x-rays are taken, the films are transported to outside, unrelated radiologists for interpretation only.)

Ninety percent or more of portable x-ray procedures are covered by Medicare. As a result, the structure of the Medicare reimbursement system has dramatic impact on the portable x-ray industry. Indeed, the way in which the incentives created by the Medicare system have affected the portable x-ray industry -- a point I will discuss later -- illustrates the enormous effect of health care reimbursement systems on market incentives.

Portable x-rays are functionally different from physicians' office x-rays and much costlier to provide. This is largely because portable x-rays entail special difficulties associated with a geriatric, infirm clientele. The technologist must position the patient in his/her bed for the x-ray and in the process, often deal with senility, orthopedic frailty, deafness, incontinence or uncooperativeness. (Sometimes these problems produce motion during the x-ray and, consequently, a flawed film. In these cases, we repeat the procedure without any additional reimbursement.) The technologist must also transport the x-ray equipment to the home or nursing home and then assemble, dismantle, and reassemble it for each patient who is x-rayed.

Taken together, these circumstances mean that, whereas a stationary x-ray technician can take about 40 x-rays per day, a competent portable x-ray technologist can take about six to seven x-rays per day. These circumstances also require special training for the technologists who perform portable x-rays and make the job relatively unattractive by comparison to x-ray technician jobs in hospitals or physicians' offices. Additionally, Medicare's Conditions for Coverage of Portable X-Ray Services require portable x-ray technologists to satisfy training and experience requirements that technicians in hospitals and doctors' offices do not have to meet. Consequently, it is NAPXP members' experience that portable x-ray suppliers must pay their

technologists higher salaries than those paid to hospital or physicians' office technicians to compensate for the higher level of training and the disadvantageous working conditions.

Portable X-Rays and Cost-Effectiveness

There are two aspects of the portable x-ray service that are critical to the principle of cost-effective health care spending. The first is that the portable x-ray service provides a highly cost-effective alternative to the other method of providing x-rays for nursing home patients: transporting the patient in an ambulance to a hospital emergency room. We estimate conservatively that the portable x-ray service generally costs Medicare one-third to one-fifth as much as this hospital/ambulance delivery method. Attachment 1 to this testimony provides a specific cost comparison for selected states.

And, in this case, what is cost-effective is also quality-effective. When very old, very frail persons are moved out of their beds and into and out of ambulances or other vehicles, they often sustain fractures. If the weather is harsh -- as it is for many months in my home state of Connecticut -- patients can get respiratory illnesses. And the many elderly patients who suffer from depression, Alzheimer's disease, or both, can become disoriented and traumatized when they are moved. Portable x-rays, by allowing patients to stay in their own beds, spare patients the physical injury and mental trauma that can occur when they are sent to the hospital. Additionally, the portable x-ray service also provides a faster turnaround of films to the attending physician than the ambulance alternative, thus speeding diagnosis and treatment of injuries. We do not believe that saving costs necessarily requires sacrificing quality, and our service illustrates that point very well.

The second aspect of the portable x-ray service that is critical to the principle of cost-effective health spending has to do with treatment settings. Many of the conditions that portable x-rays identify, such as pneumonia, chronic obstructive pulmonary disease and simple fractures, can be treated entirely in the nursing home. In contrast, when the same nursing home patient is taken to the hospital for an x-ray and the same condition appears, the patient will likely be admitted to the hospital for treatment. Generally, the hospital is the more expensive treatment setting. Thus, wherever portable x-rays identify simple conditions, patients receive treatment in the nursing home setting, the one that is least costly for the payor. That payor, in most cases, is Medicare.

Ineffective Medicare Treatment of Portable X-Rays: Fixing A System That Wasn't Broke

The legislators and regulators who shape Medicare have worked throughout the 1980s and 1990s to restrain the growth of expenditures in the Medicare system. Mr. Vladeck, in his testimony before this Subcommittee, pointed out that Medicare has pioneered the use of payment mechanisms that stress cost-effectiveness and feature incentives for efficiency, and Medicare has led other payors in establishing measures to combat the waste, fraud, and abuse that so unconscionably increase our nation's health care costs. The architects and administrators of the Medicare program are to be complimented for those successes. Other witnesses before this Subcommittee, however, have pointed out that Medicare lags behind the private-sector health care marketplace in significant respects, and that some of Medicare's payment mechanisms are ill-suited to the goals of cost-effective service and choice that the nation's leading health care insurer should achieve. The treatment of portable x-rays under the Medicare fee schedule for "physicians' services" illustrates the problem.

We do not quarrel with the concept of fee schedule payment. Indeed, portable x-rays were addressed under a portable x-ray fee schedule in 1989-1991 **before** the implementation of the physicians' fee schedule -- and neither Medicare administrators, Medicare carriers, Members of Congress, nor our industry ever found this system overgenerous, unworkable, or otherwise seriously flawed. In other words, the system wasn't broke. Nonetheless, the Health Care Financing Administration ("HCFA"), in the interest of uniformity, "fixed" it by rolling **non-physician** portable x-rays into the **physicians'** fee schedule beginning in 1992. And now the system, for portable x-ray services, does **not** work. It does not serve the goals of cost-effectiveness and appropriateness of care.

The physicians' fee schedule paints portable x-ray services with a broad governmental brush. The system includes non-physician services, such as portable x-rays, in a payment methodology designed almost solely for physicians' services and based solely on data concerning physicians' services. Currently, the system pays too little attention to the distinction between portable x-rays and physicians' services, and, most critically, the distinction between the different patient populations they serve.

As I mentioned earlier, the inherent difficulties entailed in dealing with the nation's growing population of very old, home-bound persons make it much more costly on a unit basis to provide a portable x-ray than to provide an x-ray to an ambulatory patient in a hospital or physician's office. HCFA at the urging of our industry has recognized this difference, in principle at least. Although reimbursement for the technical component of the portable x-ray service, or the taking of the x-ray itself, is exactly the same for portable x-rays as for physicians' office x-rays, HCFA has established a unique code that is billed with every portable x-ray technical component and attempts to capture the cost difference between the two types of service. However, the level of payment for this "set-up" code has not kept pace with the severe drop in technical component payment levels that portable x-ray suppliers will experience by full implementation in 1996, even with annual updates in 1992-1996.

The payment levels that portable x-ray suppliers will confront in 1996 will, very simply, be insufficient to cover the costs of providing services in many instances. In anticipation of this reality, portable x-ray suppliers are scrambling to make whatever changes they can, simply to remain in business. Many portable x-ray suppliers have already reached their limits in terms of squeezing economies out of their operations. Consequently, the choices that remain are to cut back on services so that Medicare revenues stretch the farthest. In some cases, cutting back means cutting out services on nights and weekends, when technologists must be paid overtime to work and interpreting physicians are harder to contact. Sometimes, cutting back may mean coming to nursing homes only according to a specified schedule to maximize the number of patients that can be seen at any given time. In some cases, cutting back may mean eliminating services altogether in certain localities -- such as the most rural, where driving distances and times between nursing homes are the greatest, or the most highly concentrated urban areas, where traffic waiting time is longest and the risks of vehicle damage and theft are highest. In some cases, cutting back means going out of business entirely in an area of the country where the business simply is no longer profitable -- or foregoing expansion to new geographic areas because the projected reimbursement is insufficient to justify the investment required.

At our 1994 Annual Meeting, we tried to assess the extent of these changes. A survey of just those NAPXP members present revealed the following. Companies had **eliminated** service in:

- Lompoc, CA
- Lompol, CA
- Clewiston, FL
- Maryland's Eastern Shore
- Corpus Christi, TX
- Rio Grande, TX
- Blackstone, VA and
- Irvington, VA,

affecting approximately 1700 nursing home beds. Companies had **reduced** service (e.g., from five days per week to two, or through the elimination of "after hours" work) in:

- Mt. Shasta, CA
- Red Bluff, CA

- Weed, CA
- Yreka, CA
- Hilliard, FL
- Miami, FL
- Atlanta, GA
- Atchison, KS
- Southfield, MI
- Hamilton, MO
- Maryville, MO
- Mound City, MO
- Cleveland, OH
- Columbus, OH
- Dayton, OH
- Toledo, OH and
- Houston, TX,

affecting approximately 67,000 nursing home beds. The net result of all this is a decline in the availability of portable x-ray services, even though demographics would predict exactly the opposite.

There will also be an offsetting increase in the number of hospital x-rays of nursing home and homebound patients that Medicare must pay for. The bottom line on cost will be a greater net outflow of Medicare dollars to provide necessary diagnostic radiology services to nursing home and homebound patients, plus more costly hospital admissions to treat the conditions these radiology services identify. The bottom line on quality and access will be an increase in potential injuries for patients who have to be moved to get x-rays and increased mental anguish for patients and their families when these patients have to be shifted in and out of hospitals instead of staying in the familiar environment of the home or nursing home.

Data from the Physician Payment Review Commission ("PPRC") suggests that there may be an access problem already. Data in the PPRC's 1993 report to Congress on access to care demonstrate that portable x-rays and other "routine diagnostic radiology" services are among only two categories of physicians' services that did **not** increase in volume after the imposition of the physicians' fee schedule. The average across all services for quantity of care per beneficiary increased 5.2% from 1991 to 1992. In contrast, "routine diagnostic radiology," including portable x-rays, **dropped** 6.6% in quantity of care per beneficiary during that period. PPRC, Report No. 93-2, Monitoring Access of Medicare Beneficiaries (June 4, 1993) at 15, Table 2-1. Notably, the time period addressed in this report was one when portable x-ray payments from Medicare were **higher** than they are now, since payments in most localities have fallen as the physicians' fee schedule moves toward full implementation.

Significantly, PPRC research also reveals "cause for concern" about reductions in access to care for that population group most typically served by portable x-ray providers: the "oldest old (those over 85)." Id. at 23. The PPRC's June 4, 1993 Report states:

> The Oldest Old. Patterns of service use by the oldest old (those over age 85) may also generate some cause for concern. The differentials between the oldest old and the remainder of the beneficiary population show a series of new lows for total use of

> services, primary care services, and selected other categories of services, including high-tech services, electrocardiograms (EKGs), cataract surgery, and radiology. (Emphasis added.)

Id. The "oldest old" are portable x-ray suppliers' major clients for both EKGs and radiology procedures.

Returning to the point made by other witnesses before this Subcommittee, that the Medicare program needs to be more closely aligned with the private health care marketplace, I cannot help observing that the problems of declining access to portable x-ray services and stagnation in this industry would not exist if our services were offered in an open, competitive marketplace, rather than to a single, government payor. For example, a buyer of x-ray services for nursing home and homebound patients in the private market would look at the alternatives available: purchase the services from a portable x-ray supplier, or send patients back and forth to the hospital in ambulances for their x-rays. On the issue of cost, the choice would be clear: even in those areas of the United States where reimbursement is the highest, the portable x-ray service is far cheaper. On the issue of quality, the choice is also clear: our x-rays provide physicians with the same accuracy of diagnostic information as hospital or physician's office x-rays, and give patients and their families far greater comfort and lower physical risk. Given such strong cost and quality incentives to use portable x-ray services, in a marketplace consisting of private-sector buyers, one would expect that most nursing homes would use portable x-ray services, as would most organizations supplying services to homebound patients. Purchasers would negotiate payment rates with portable x-ray suppliers that would create sufficient incentives for suppliers to provide the service, while maintaining the buyer's cost advantage of portable x-rays over the hospital/ambulance alternative.

But in the world of Medicare, as I have explained, this situation does not exist. Medicare has no policy requiring a nursing home administrator to use the cheaper portable x-ray service where it is available. And since Medicare is paying for the x-ray, it makes no difference to the physician ordering the x-ray or the nursing home administrator making arrangements for the service whether it is provided by a hospital or by a portable x-ray supplier. (And, if low reimbursement has kept a portable x-ray supplier from entering a locality or staying in it, then the alternative is simply not available at all.)

Additionally, in a private marketplace, purchasers of portable x-ray services and suppliers of those services would negotiate payment rates that fit the circumstances of the service and its cost. Our costs are significantly greater to provide service on nights, weekends and holidays, because federal wage and hour laws require us to pay technologists time and a half, or the equivalent, for service at those times. Yet Medicare payment rates make no allowance for the difference. Similarly, our costs are higher in the home care setting, where we typically have to use two technologists instead of one in the nursing home, since in the home, there are no nursing staff to assist us in dealing with frail or difficult patients, and there are often stairs (and never elevators), requiring two people to haul portable equipment. Yet again, Medicare's payment rates do not address this difference either -- whereas, in the private marketplace, the supplier and purchaser of portable x-ray service would negotiate a payment rate more sensitive to both the supplier's costs and the demands made by the buyer.

The unfortunate irony is that, if Medicare reimbursement were better attuned to the costs and circumstances of the portable x-ray service, portable x-rays would be available to more of the nursing homes and homes that need them, and Medicare would save significant sums on its costs for providing diagnostic x-rays to homebound and nursing home patients.

Small Changes for Big Benefits

In the long term, we recognize, Medicare may undergo a complete transformation. But in the short term, i.e., as long as the program maintains a fee-for-service component, there is an urgent need for some fine-tuning. Minor changes, consistent with the resource-based payment principle of the physicians' fee schedule, could solve the problems I have described and consequently allow the Medicare system to reap the full benefits in cost-effectiveness and quality care that the portable x-ray service offers.

The simplest solution would be to remove portable x-rays from the physicians' fee schedule, where they never belonged, and return them to the portable x-ray fee schedule, which, as I have said, was not "broke" and worked quite well for all concerned. That fee schedule could be simplified to make it easier and more streamlined for Medicare to administer.

Alternatively, changes could be made within the physicians' fee schedule to address portable x-rays more sensibly. When the physicians' fee schedule moves to a resource-based practice expense system in 1997, the unique practice expenses of portable x-ray suppliers **must** be taken into account. More specifically, consistent with the concept of a fully resource-based system, Medicare could establish a payment level for the portable x-ray "set-up" code that is more truly commensurate with the difference in cost involved in providing this service versus a physician's office x-ray. Similarly, the Medicare system could restore the "after-hours" code to recognize the higher costs of operating at nights and on weekends, when a substantial demand for emergency portable x-rays occurs. Medicare could also easily recognize the fact that doing a portable x-ray in a patient's home is more costly because of the nature of the treatment setting. This problem could be solved through the simple addition of a home-care code. Such changes would conform to the resource-based principle of the fee schedule and provide the same fine-tuning that is provided for physicians' services, for example, through existing codes that recognize unusual complications in surgical services and extra time required for anesthesia.

The changes I am suggesting are relatively minor. Such changes represent very small expenditures, since portable x-rays, by HCFA's estimate, are less than 2% even of Medicare **radiology** services -- a tiny, tiny fraction of Part B as a whole. Moreover, the net effect of such changes to maintain or increase the availability of portable x-rays would be **better than budget neutral**: it would produce substantial savings on ambulance and hospital services. Refining the Medicare payment system so that the distinct nature of the portable x-ray service is adequately recognized and there are adequate incentives to permit suppliers to remain in business will not alter the fact that the portable x-ray service is extremely cost-effective with respect to the alternative. Making changes along these lines would simply be an outcome-oriented way of seeing that the Medicare system gets the biggest bang for the taxpayers' buck.

We thank you for the opportunity to present our views to the Subcommittee.

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Attachment 1

COMPARISON OF MEDICARE PORTABLE X-RAY
PAYMENTS & AMBULANCE/HOSPITAL X-RAY CHARGES
SELECTED LOCALITIES
1990

LOCALITY	ROUNDTRIP AMBULANCE[c]	EMERG. ROOM	RAD. DEPT. (X-RAY)	PHYS.FEES (RAD.AND/OR EMERG.RM.)	TOTAL HOSP.	PORTABLE X-RAY	PORT. X-RAY INTERP.	TOTAL PORT. X-RAY	AMB. PORT. X-RA
Torzana, CA	302.00	135.00	66.50[a]	150.00	673.50	104.16[a],[g]	N/A	104.16	6.47
Plantation, FL	400.00	59.00	90.00[a]	50.00	599.00	90.25[a]	13.74	103.99	5.76
Tamarac, Davie, Plantation, Coral Springs, Hollywood, Margate, Sunrise, Hallandale, Cooper City and Lauder Hill, FL (2 hospitals)	306.00	59.50	120.00[b]	65.00	550.50	90.25[b]	13.74	103.99	5.29
	306.00	102.65	115.00[b]	115.00	638.65	90.25[b]	13.74	103.99	6.14
Clearwater, FL	270.00	96.50	80.15[a]	83.15	529.80	85.99[a]	13.14	99.13	5.34
St. Petersburg/ Tampa, FL	314.40	31.07[d]	98.72[a],[d]	N/A	444.19	98.09[a]	N/A	98.09	4.53
Miami, FL	352.00	156.67[d]	99.00[a],[d]	N/A	607.67	98.09[a]	N/A	98.09	6.19
Boston, MA	299.00	100.00	127.00[a]	13.64	539.64	163.64[a]	11.18	174.82	3.09
Quincy, MA	318.12	84.00	61.75[a]	13.74	477.61	163.64[a]	11.18	174.82	2.73
Lima, OH	318.00	75.00[d]	64.85[a],[d]	N/A	457.85	97.46[a]	N/A	97.46	4.70
Cleveland, OH	268.00	93.80[d]	68.28[a],[d]	N/A	430.08	97.01[a]	N/A	97.01	4.4[illegible]
Central OH	226.00	54.95[d]	65.50[a],[d]	N/A	346.45	95.28[a]	N/A	95.28	3.64
Dayton, OH	238.00	32.18	55.63[a],[d]	N/A	325.81	98.04[a]	N/A	98.04	3.3[illegible]
Newport, RI	176.58	69.00	13.09[a]	12.44	271.11	99.44[a],[g]	N/A	99.44	2.7[illegible]

[a] Chest x-ray
[b] Hip x-ray
[c] Excludes oxygen fee; assumes 6-mi. round trip
[d] Average of area hospitals
[g] Global billing

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POLICY PAPER NO. 10 December 30, 1994

Why the Graying of the Welfare State Threatens to Flatten the American Dream -- or Worse

by Neil Howe

Despite overwhelming evidence that the cost of major senior benefit programs is due to explode over the next half-century, the notion persists that they are sustainable without major cost-cutting reform. Although tax rates may rise, this argument runs, a growing economy will still allow workers to enjoy steady gains in real after-tax earnings. However, an examination of the likely future fiscal and tax impact of three major senior programs -- Social Security, Medicare, and Medicaid for persons age 65 and over -- demonstrates that this argument is clearly wrong. Projections based on a model that incorporates all of the official (scenario II and III) assumptions used by the Social Security and Health Care Financing Administrations in calculating the growth of three programs, show that, absent major reform, *the graying of the welfare state is likely to have catastrophic consequences for the after-tax living standards of most working-age Americans.* In particular:

- **Under the official scenario II (the so-called "best-estimate" case), after-tax earnings per U.S. worker in 1993 dollars will remain unchanged over the 45 years between 1995 and 2040.** In 1995, real after-tax earnings will amount to $19,221. By 2040, they will reach $19,346 -- *less than one percent total growth over nearly half a century.* At an annual rate, this growth is negligible by any statistical standard.

- **Under the official scenario III (whose less optimistic assumptions are closer to recent experience), after-tax earnings per U.S. worker in 1993 dollars will decline steeply and steadily between 1995 and 2040.** In 1995, they will amount to $19,000. By 2040, they will fall to $7,821 -- *a devastating 59 percent fall in real terms.* Incredibly, this would be a much faster annual rate of decline than the annual rate at which after-tax earnings rose between 1951 and 1970.

- **Under both scenarios, total government spending will grow steadily as a percent of GDP.** From 34.4 percent of GDP in 1995, it will grow to 43.9 percent in 2040

under scenario II or to 54.5 percent under scenario III. **Likewise, the total tax rate on worker compensation will climb steadily.** From 41 percent in 1994, it will climb to 57 percent by 2040 under scenario II or to 69 percent under scenario III.

The practical bottom line of this analysis speaks for itself. America's political leaders cannot continue in good faith to advocate balanced budgets, tax cuts, and leaner government -- to say nothing of defending the long-term viability of the American Dream -- without also talking about major, structural reforms in "untouchable" senior entitlements. Everything must be on the table.

I. THE UNPLEASANT FACTS

In 1994, the American public was bombarded by a spate of official warnings about the crushing public cost that will accompany the rapid aging of the U.S. population early in the next century.

- In February, the Office of Management and Budget included in its FY 1995 Budget a "special analysis" suggesting that baseline budget policies will crush younger generations beneath prohibitive tax-and-transfer rates.[1]

- In April, the Social Security trustees issued an annual report announcing that their combined cash-benefit trust funds would all go belly up in 2029 -- 7 years earlier than they had reported in 1993 and 19 years earlier than they had reported in 1988.[2]

- In August, a bipartisan presidential commission agreed by a 30-to-1 vote that "the government must act now" to prevent just five benefit programs (Social Security, Medicare, Medicaid, and federal civilian and military pensions) from consuming total federal revenues by the year 2030.[3]

- In September, the Congressional Budget Office confirmed that over the next decade entitlements will grow from roughly half to two-thirds of all federal spending. "The aging of the baby-boom generation," added the CBO, "will continue to drive that share higher over succeeding decades."[4]

- And in October, Office of Management and Budget Director Alice Rivlin's leaked budget options memo illustrated how annual budget deficits would soar above $4.1 trillion by 2030 under current tax and spending policies.

By now, the public has little problem comprehending the overall arithmetic of the situation. It is widely understood that retirement, disability, and (especially) health benefits outlays are already among the fastest-growing categories of government spending.

Asked about the growing numerical imbalance of retirees to workers in the Social

Security system, 64 percent of American adults say it's a "very serious" problem; 29 percent say it's "somewhat serious." Asked the same question about the impact of runaway health costs on the survival of Medicare, 78 percent say it's "very serious"; 19 percent say it's "somewhat serious." To either question, only about 5 percent say "not too serious," "not at all a problem," or "don't know."[5] Fifty-eight percent of adults now think that "the next generation's future will be worse than life today"; only 18 percent think it will be better.[6] What's more, Boomers realize they are in line to take the hit: 85 percent of Boomers agree that "government has made financial promises to my generation that it will not be able to keep."[7]

Many say they're ready to face up. Although Americans are understandably ambivalent about cutting benefits that flow to just over half of all U.S. households, neither have they become irredeemable entitlement addicts. Asked about "the financial problems of the Social Security and Medicare systems," 78 percent of all adults (83 percent of everyone under age 50) agree that the problems are "so severe that major reforms are needed now" in both programs.[8] A large and growing majority favors imposing a strict means test on major federal entitlements programs.[9]

Why Politicians Don't Act

But if voters are rousing themselves, most of our national political leaders are still running for cover. Even in the wake of November's stunning anti-big-government message from voters, members of Congress in both parties quickly lined up to declare that the vast senior share of the federal budget remains undiscussable. Many remain convinced that the "age wave" forecasts are overblown, that the public talks bolder than it walks, and that America in the end will be able to muddle through without "tough choices" or "major reforms." Hence their claim that economizers need only cut domestic discretionary programs -- and that the political risks of attempting surgery on senior benefits far outweigh the risks of doing nothing.

To the extent there is a rational justification for this position, the logic tends to gravitate around three propositions. First, it is said that the assumptions underlying the official benefit forecasts are too pessimistic. Second, it is said that the cost explosion in health-care benefits will recede due to relatively painless "comprehensive" reforms. And third -- if one and two don't explain things away -- it is said that a tolerable tax hike can be levied on future workers to fund whatever health and cash benefit growth remains.

The first proposition, alas, is not an argument at all -- but an attitude. Many legislators chafe at the political inexpedience of rules that force them to take long-term costs into account. But no one presses a comprehensive case that the official "intermediate cost" economic and demographic scenario -- offered by the Social Security trustees as their "best estimate" -- is overly pessimistic.[10] The reason is simple: *For most of the important variables, these assumptions are decidedly more optimistic than actual U.S. experience over the past quarter century.* Yes, one does hear the occasional "eureka" remark about recent

trends in immigration or the birthrate. But all this is small potatoes at best,[11] especially since there has been no actuarially favorable change in trends in labor productivity or longevity -- the two assumptions which totally dominate the cost outcome well past the year 2040.[12] So that means the "intermediate cost" projection had better be taken seriously.

Indeed, Americans should also pay close attention to the official "high cost" scenario -- whose critical assumptions are closer to (but still more optimistic than) recent experience if for no other reason than to avoid the absurdity of regarding a continuation of current trends as unthinkably dismal. Accordingly, in this report, all findings for the "intermediate cost" scenario are followed by findings for the "high cost" scenario. While both scenarios are perfectly plausible, the former may be regarded as a best-case -- rather than most likely - outcome, the latter as a worst-case outcome. (See below, "Appendix I: Official Economic and Demographic Assumptions.")

What about health care? Everyone agrees that health-care benefits are a major part of the projection equation, constituting much of the expected growth in total benefits. Almost everyone agrees that policy changes could do something to control that growth. What's doubtful, however, is whether either political party is likely to champion any change that might make a real difference. On the left, there is much talk tough about draconian "cost containment" -- but few members have ever identified a single benefit, service, or subsidy in Medicare or Medicaid that ought to be cut. To the contrary, health reforms offered by liberals point toward *vast cost increases beyond current projections* -- including a wider safety net for low-income families and new senior citizen benefits covering prescription drugs, at-home, and long-term care. Conservatives are not as tied to benefit expansion. But neither have they shown much interest in means-testing or rationing publicly funded health services.

The outlook for health-care spending is made even bleaker by another little-known fact: The official long-term projections for Medicare and Medicaid *already assume that a vigorous program of cost control will commence early in the next century*. Specifically, they all assume that the "extraordinary" rate of real cost growth per beneficiary *will decline by three-quarters between 2000 and 2020.*[13] Partly for this reason, many experts doubt that any now-discussable reform option is likely to bring health-care benefits down much beneath their currently projected trajectory. And even if they could, the savings are likely to be offset by the extra cost of better or additional public coverage (either at the state or federal level). Bottom line: Until the political standard of "touchability" changes dramatically, Americans should consider themselves lucky if public health costs do not rise faster than currently projected. (See below, "Appendix II: Official Health Care Benefit Assumptions.")

Given the weakness of the first and second propositions, a lot rides on the third: Just raise future taxes and pray that they don't have to be raised too much. At the very least, the prevailing inertia on entitlement reform makes this possibility of serious interest to all Americans. What happens to taxes if we leave all currently-legislated benefit provisions on auto-pilot? Specifically, how high will taxes rise on future workers?

Table 1 offers a suggestive, if partial answer to this question. It shows the projected future cost of Social Security and Medicare as a percent of the FICA-taxable wages of all U.S. workers covered by the programs. Two official projections (intermediate cost and high cost) are tabulated here.[14]

Table 1:
Annual Cost of Social Security and Medicare
(Parts A and B) as a Percent of Workers' Taxable Payroll

Calendar Year	Intermediate-Cost Projection	High-Cost Projection
1993	16.5 %	16.5 %
2010	21.4 %	26.7 %
2025	30.5 %	43.0 %
2040	34.5 %	55.1 %

Strictly speaking, not *all* of the costs tabulated in Table 1 will be borne by workers. A relatively small portion will be financed by taxation of benefits and by general taxation (which is borne by capital as well as labor income). But the worker share is so dominant -- well over 90 percent of the total in 2040 under any scenario -- that this is a distinction without a difference. Moreover, this table does not include all of the public costs (e.g., long-term care covered by Medicaid) associated with the age wave. Even so, the numbers point to a breath-taking climb in the effective tax rate required to fund these two major programs over the next 30 to 45 years: a *doubling* under the intermediate-cost scenario and a *tripling* under the high-cost scenario. By 2040, the spread between these two projections implies a likely "tax load" equivalent to somewhere between one-third to one-half of the typical worker's taxable wages.

II. WHAT HAPPENS TO AFTER-TAX EARNINGS?

Few politicians actually advocate burdening future workers with costs of this magnitude. When forced to confront the issue, most voters' first inclination is to declare that such tax hikes would be unfair if not unthinkable. Defenders of the entitlement status quo, however, have long labored to change the terms of the debate and to make the unthinkable seem really pretty decent after all. Even if the tax rate on future worker earnings must ultimately climb, they argue, real pretax earnings will still grow swiftly enough to allow future workers to enjoy a steady rise in real after-tax pay. In other words, they claim,

tomorrow's workers will be so well-off that they can afford to fork over a larger share of their income to government and still be a lot better off than today's workers.

The importance of this claim to the case against cost-cutting can hardly be overemphasized. If true, it means that the current policy drift is less alarming than portrayed by the reformers. Even if the official projections are right on the mark, in the end our kids can easily afford to take up the slack. If true, it also strengthens other arguments that tend to legitimize today's institutional arrangements. For example, the often-cited "lifecycle" defense of Social Security and Medicare (which reassures the rising generation that even if they now feel fleeced by the old, they'll someday be able to fleece a new rising generation in their turn) depends critically on the programs' permanence. Most people would probably doubt this permanence if the programs did not allow workers to enjoy a significant growth rate in after-tax living standards.

Small wonder that the claim about how our kids will be better off anyway (so why worry) crops up so often.

- "Don't shed too many tears for generations who will be working and retiring in the 21st century," says Nobel-Prize winning economist James Tobin. "They will be living higher than we did and do..."[15]

- According to former Social Security Administration Commissioner Robert Ball, the extra taxes necessary to fund Social Security in the next century are "not trivial, but easily supportable" by future workers -- and "not really a big deal." He then goes on to calculate that the extra taxes needed by 2025 would only "offset about 8 percent of the growth in earnings projected between now and then."[16]

- National columnist Michael Kinsley echoes the same line in reference to Social Security: "Even if it amounts to a large transfer from today's workers to today's retirees, and an even larger transfer from future workers to future retirees, so what? ...[T]he younger generation will still be richer than the older one, even after the transfer takes place."[17]

- Brookings Economic Studies Director Henry Aaron makes the same point even more succinctly: "Even if we do nothing to change present policies, modest economic growth will produce increases in consumption that dwarf the added cost of caring for the Baby Boom Generation in retirement."[18]

- In its blanket apologia on behalf of all federal entitlements, the American Association of Retired Persons notes that Social Security, Medicare, and related senior programs "are affordable" in the year 2065 because "[f]uture growth of the aging population does not necessarily impose an unsustainable burden on future generations if the economy grows at a moderate rate."[19]

One might expect that a claim so often repeated would be carefully researched. Surprisingly, this not the case.[20] Most often, the claim comes with no supporting evidence; when it does, the calculations are out of date, look only at cash benefits, or fail to account for the total tax burden on earnings.[21]

So is the claim, in fact, true? A computerized study of the government's own long-term projections reveals that it almost certainly is not. An analysis of the official intermediate- and high-cost scenarios shows that raising taxes to cover the cost growth of three major programs -- Social Security, Medicare, and Medicaid benefits to seniors -- will have a devastating impact on future after-tax wage growth. These scenarios indicate that over the next 45 years, real after-tax earnings will stagnate at best. Quite possibly (again, assuming no major reform), they will plunge steeply.

Incomes Model

These conclusions are derived from a computer model of future after-tax earnings that are consistent with the official Social Security Administration (SSA) and Health Care Financing Administration (HCFA) scenarios II and III, as calculated for the 1994 annual reports of the Old-Age, Survivors, and Disability Insurance (OASDI) Trustees, the Hospital Insurance (HI) Trustees, and the Supplementary Medical Insurance (SMI) Trustees.[22] The model isolates the historical and projected future growth of three programs: Social Security, Medicare, and Medicaid benefits received by persons over age 65. These data, in turn, were used to generate historical values for every year from 1951 to 1993, and two sets of future values for every fifth year from 1995 to 2070[23] -- which is the scenario horizon of the 1994 annual reports.

A few definitions help explain the scope and purpose of this model.

EARNINGS refers to annual cash paid for productive labor services throughout the market economy. *AVERAGE EARNINGS* is the annual cash paid per person engaged in production. Earnings is broader than *WAGES* (or *SALARIES*), since it includes self-employed persons. It is also different from *COMPENSATION*, which includes employer-paid payroll taxes and noncash fringe benefits as well as cash wages paid to employees.

AFTER-TAX EARNINGS refers to the earnings left over after subtracting all taxes imposed on earners by all levels of government. This includes not only payroll, income, and property taxes that are directly payable by the earner, but also the fees, excise taxes, and retail taxes that are indirectly payable when something is bought or sold.

SCENARIO II refers to the official "intermediate cost" (or "best estimate") scenario. *SCENARIO III* refers to the official "high cost" scenario.

Average real after-tax earnings is intended as a measure of the average "privately consumable" purchasing power of worker earnings. It does not include everything that contributes to every worker's living standard. Some contributions -- such as dividends and interest, government benefits and services, and employer-paid fringes -- are left out.[24] It does, however, encompass all of the "earned" resources over which most Americans can exercise personal control. As such, it constitutes a time-honored political and cultural standard by which most Americans have always judged whether they are "doing better" or achieving the "American Dream."

Assumptions

Wherever possible, the model relies strictly on the SSA and HCFA scenarios for all of our quantitative assumptions.[25] These include future economic data, such as GDP, inflation, labor productivity, total compensation, and earnings. They include future demographic data, such as future employment and hours worked. And they include all future dollar outlays for the two of the three of the major programs in question: Social Security (OASDI) and Medicare (HI and SMI).

To derive after-tax earnings continuously into the future, certain assumptions were necessary in addition to those provided by SSA and HCFA. Most of them are not only plausible but even conservative:

1. **When the OASDI or HI trust fund goes bust,[26] it immediately switches over to pure "pay-as-you-go" financing.** In other words, the model assumes that Congress -- during the year in which OASDI or HI reaches its projected bankruptcy date -- will immediately raise the program's earmarked payroll tax so that total revenues equal total outlays for that program. Each year thereafter, payroll taxes will be readjusted so that program balance is exactly maintained (and the trust funds remain empty). Given the historical "self-funding" tradition of OASDI and HI -- and absent any changes in benefit policy -- this appears to be what is intended by current law.

2. **Any increase in any payroll tax rate on employers will come at the expense of worker earnings.** According to standard economic analysis, the only other place it could come from would be employer-paid benefits. But these benefits are too small to absorb more than a tiny fraction of the increase. Moreover, since they are generally tax-exempt, they will tend to grow, not shrink, in an environment of steady payroll and income tax hikes. Our modest compromise: To assume that projected employer-paid benefits remain unchanged in both scenarios -- and thus to require that the full payroll tax hike be borne by earnings.

3. **SMI will continue indefinitely to receive premium income from beneficiaries equal to 25 percent of gross SMI outlays.** OBRA 1993 specifies that SMI premiums be pegged at roughly 25 percent of gross outlays through 1998; the model assumes that ratio remains unchanged. (Note that SMI outlays refer to *net* outlays,

that is, gross outlays net of premiums.)

4. **SMI outlays, under scenario III, will exceed their scenario II path by the same multiple by which HI under III exceeds HI under II.** As it turns out, the SMI trustees do not calculate a projection III for their program. Since the influence of demographic and medical trends on SMI are essentially similar to their influence on HI, this seems like a plausible assumption.

5. **Medicaid outlays for persons age 65 and over will grow, under both scenarios, at a rate determined strictly by demographic change and the Medicare inflation rate.** That is, the age-specific utilization of Medicaid is assumed (quite optimistically) to remain constant over time. The Medicaid inflation factor is assumed to be the combined factor for both parts of Medicare.[27]

6. **All other government spending (federal, state, and local) besides Social Security, Medicare, and Medicaid for seniors will continue to rise each year at the same rate as GDP.** Since our object is to calculate total after-tax earnings, we need to make some assumption about the rest of government. GDP neutrality is a conservative hypothesis -- even if it does reflect a gradual growth in real government spending per capita. Many government services are resistant to productivity growth and thus tend to require a constant share of GDP just to maintain their current delivery ("Baumol's Law"[28]). More importantly, the same demographic forces pushing up the cost of Social Security, Medicare, and Medicaid for seniors after the year 2010 will be pushing up the cost of many other government programs.

7. **Between the years 1995 and 2010, the net consolidated public-sector budget will move to balance; every year after 2010 revenues will be adjusted so that they will continue to equal outlays; all types of general revenues (i.e., all revenues excluding payroll taxes) will be adjusted proportionally.** Any realistic projection of the tax burden has to put some limit on the public sector's ability to borrow. Either that, or it would have to reflect the negative feedbacks of rising public-sector deficits on savings, investment, productivity growth, interest rates, and budgetary debt-service charges. Our model avoids this set of issues (which clearly cannot be handled within the framework of the fixed SSA scenarios) by assuming that the public sector moves linearly to budget balance between 1995 and 2010. While this "budget-balance" assumption may seem heroic in light of recent experience, it's worth noting that the prospect of a constitutional amendment requiring a balancing of the consolidated federal budget are becoming increasingly favorable. Moreover, the future productivity growth rates projected under both SSA scenarios exceed our historical record over the last twenty years. The extra national savings generated by a balanced budget may be necessary to achieve this performance. As for timing, the 1995-2010 demographic window before the Baby Boom generations' retirement seems ideal. In any case, a more lenient assumption (e.g., keeping public indebtedness constant as a share of GDP) would not significantly change the results.[29]

8. **The incidence of taxation is distributed in a standard fashion.** Specifically, the model assumes that payroll taxes are entirely borne by workers; that corporate taxes are entirely borne by capital; and that all other direct and indirect taxation is distributed among three groups -- recipients of labor income, capital income, and benefit income -- according to each group's share of the relevant total. In deference to the prevailing consensus of economists (about the supply elasticity of capital and labor to taxation), the model then shifts three-quarters of the tax on capital to workers. To incorporate the shift, the model "grosses up" the historical and scenario values for pre-tax worker earnings and compensation. This assumption seems appropriate given the very long-term equilibrium under consideration.[30] (See below, "Appendix III: Calculating the Tax Burden.")

9. **The tax increases required to finance the growth of elderly benefits will have no adverse impacts on economic growth.** Remarkably, both scenarios envision that the rate of pre-tax income growth will actually increase relative to recent experience, despite a dramatic rise in the total tax rate on worker compensation. It is at least equally plausable that economic growth would suffer under such crushing tax burdens.

Findings

The major findings of our model are the following. All per-worker figures are translated into constant 1993 dollars.

1. **Under the "best estimate" scenario II, real after-tax earnings per U.S. worker will remain virtually unchanged over the 45 years between 1995 and 2040.** In 1995, after-tax earnings will amount to $19,221. By 2040, they will reach $19,346 -- less than one percent *total* growth over nearly half a century. At an annual rate, this growth is negligible by any statistical standard. (See Charts 1 and 2.)

2. **Under the "high cost" scenario III, real after-tax earnings per U.S. worker will decline steeply and steadily between 1995 and 2040.** In 1995, they will amount to $19,000. By 2040, they will fall to $7,821 -- a devastating 59 percent fall in real terms. Incredibly, this would be a much faster annual rate of *decline* than the annual rate at which after-tax earnings *rose* between 1951 and 1970. (See Charts 3 and 4.)

3. **Runaway health-care benefits are clearly not the only force behind the rising tax take on worker pay.** Under scenario II, fully 62 percent of the pre-tax earnings growth between 1995 and 2040 will be wiped out by general government, Social Security, and budget balance. (Medicare will take another 27 percent; and Medicaid for seniors, 10 percent.) Under scenario III, remarkably, 95 percent of pre-tax earnings growth will be wiped out by general government, Social Security, and budget balance alone. Under scenario III, in other words, after-tax earnings would stagnate *even if all levels of government could immediately and permanently restrain real health-benefit outlay growth to the growth rate of employment* (which would

require truly Draconian real cuts per beneficiary in order to compensate for the adverse demographics).

4. **The grim after-tax earnings trends are clearly not the result of pessimistic economic assumptions.** Quite the opposite: The optimism of the most important economic assumption -- pre-tax earnings -- is very visible in Charts 1 and 3. From the early 1970s to the early 1990s, pre-tax earnings hardly grew at all -- in fact, by no more than 0.2 percent annually, no matter which end year you choose. Even during the much-vaunted 1979-1989 decade, pre-tax earnings only grew by 0.4 percent annually. (See Chart 12.) *Yet from 1995 to 2040, pre-tax earnings are expected to accelerate to an average of 1.0 percent annually under scenario II or 0.5 percent annually under scenario III.* Little of this turnabout is expected to come from changes in the various linkages between real National Income per worker hour -- worker productivity -- and real earnings per worker year. (See Charts 13 through 16.) Instead, it is expected to come from an underlying improvement in worker productivity itself. Everyone agrees that such improvement is possible. The question, of course, is whether it constitutes the prudent foundation for public promises on which people base their lives.

5. **Trust-fund financing mechanisms make little difference in the magnitude or timing of the cost burden on workers.** Under scenario II, Social Security is expected to run ever-larger operating deficits from 2012 until 2029 -- at which time the trust funds go bankrupt and the program switches over to pay-as-you-go. What's the impact of this switchover on workers? As Chart 1 indicates, very little. Between 2025 and 2030, the bite from general revenues narrows and the bite from Social Security payroll taxes widens. The total bite also widens, since workers are assumed to bear the full incidence of payroll taxes, but only slightly -- since the burden of general revenues also falls mainly on workers. The same is true for the other bankruptcies scheduled in the two scenarios.

6. **Under scenario II, total government benefit spending will rise by nearly 10 percentage points of GDP by 2040.** In 1995, benefits will amount to 14.0 percent of GDP; by 2040, 23.5 percent of GDP, nearly what the entire *federal* government spends today. Meanwhile, total government spending will rise from 34.4 to 43.9 percent of GDP. In order to balance the budget, total tax revenue will rise even faster. In fact, it will rise more than *twice as much* between today and 2040 (13 percent of GDP) as it did between 1955 and today. (See Charts 5, 6, and 7.)[31]

7. **Under scenario III, total government benefit spending will rise by nearly 20 percentage points of GDP by 2040.** In 1995, benefits will amount to 14.0 percent of GDP; by 2040, 34.1 percent of GDP, roughly what *all levels of government* spend today. Meanwhile, total government spending will rise from 34.4 to 54.5 percent of GDP. Again, in order to balance the budget, total tax revenue will rise even faster. It will rise more than *four times as much* between today and 2040 (24 percent of

GDP) as it did between 1955 and today. (See Charts 5, 8, and 9.)

8. **Under both scenarios, the total tax rate on worker compensation grows steadily.** From 41 percent in 1994, it climbs to 57 percent by 2040 under scenario II and to 69 percent by 2040 under scenario III. Tax rates on return to capital and benefits also rise, but not as sharply. Under both scenarios, taxes on worker compensation comprise just under 80 percent of total tax revenue throughout the projection period. Of the remainder, the capital share gradually declines over time and the benefit share gradually rises. (See Charts 10 and 11.)

III. DISCUSSION

The foregoing analysis suggests that, absent major reform, the graying of the welfare state is likely to have catastrophic consequences for the after-tax living standards of most working-age Americans.

It has long been known that current-law spending from major entitlement programs is projected to grow considerably faster than our economy under all of the official scenarios. If budgets must be balanced at some point in the future, these scenarios imply an even steeper growth in total tax revenues as a share of GDP and in total tax rates on most definitions of income. Some observers have maintained, however, that higher cost as a share of GDP or payroll does not rule out a comfortable growth rate in real after-tax earnings. We have shown that it does. According to the official "best estimate" scenario of the Social Security and Medicare trustees, real after-tax earnings will remain entirely stagnant over the next half century. According to a more prudent scenario that better reflects recent history, after-tax earnings will decline drastically over the next half century.

Few Americans would willingly or knowingly embrace either of these visions of the future. For defenders of the entitlement status quo, then, the challenge is not so much to defend the results described here as to question the assumptions that lead to them.

But there really isn't much opening for direct rebuttal. The most critical assumptions, after all, are embodied in the official economic and demographic scenarios. And while it is easy to *imagine* a brighter future than scenarios II or III, it would be difficult to argue that we should *count on* such a brighter future on the basis of past experience. Another key set of assumptions are the official "health-care cost multipliers" -- and these too are demonstrably optimistic relative to past experience. Remember: The age wave is going to generate a huge rise in health-care benefit costs even in the absence of a significant health-care multiplier. To illustrate, let's assume (implausibly, of course) that future Medicare spending per age-adjusted beneficiary were to grow no faster than GDP per worker from now on. This is on the order of about one percent per year under scenario II. The result? Medicare spending would still *more than double* as a share of taxable payroll by the year 2040 -- as opposed to tripling under the official scenario.

As for the additional assumptions needed to complete analysis presented here, these are either uncontroversial, have limited impact on the quantitative result, or both. Yes, economists can quarrel over the "true" incidence of taxation on labor and capital. But few economists would contest the basic thrust of our approach -- that, in a long-term equilibrium framework, most taxes are borne by workers. True, the "balanced budget" proviso may seem heroic. But even if one rejects the argument that a balanced budget is necessary to achieve the projected productivity performance, the goal remains so universally popular that few political leaders would want to plan a long-term future without it.

Some conservatives may object to the assumption that discretionary spending stays constant as a share of GDP. But in the realm of what's likely, three stubborn facts remain. First, no lawmaker (Democrat or Republican) has yet devised a plan that balances the budget for even a single year through discretionary spending reductions alone.[32] Second, conservatives themselves remain profoundly conflicted about long-term spending priorities. In some well-known areas of the budget, they want to cut; but in others (from military preparedness to immigration control to crime fighting) many look forward to spending more. Third, much "rest of government" spending is going to be enlarged by the same demographic and health-care multipliers that are projected to hit the three largest senior programs. Lives are getting longer for public-sector pensioners as well as Social Security retirees. A low-income Alzheimer victim typically needs special social services as well as Medicaid. Health costs are rising at VA and military hospitals as well as among patients with Medicare cards. It is reasonable to assume that the same political consensus that sustains the major entitlement programs will also support continuance of other health and aging services.

Meanwhile, of special concern to conservatives should be the virtual certainty, in the absense of serious entitlement reform, that the total tax rate on worker compensation will have to rise sharply early in the next century. It is a basic tenet of "supply side" economics that lower tax rates boost economic growth -- and likewise, that higher tax rates suppress economic growth. It follows, therefore, that scenario II is internally inconsistent: How can our economy possibly improve its productivity growth performance (with or without a balanced budget) while raising taxes? Indeed, if the large tax increases envisioned in scenario II depress economic growth to the level envisioned in scenario III, the result will be even higher tax rates, which may make even scenario III unattainable -- and so on.

The practical bottom line of our analysis speaks for itself. America's political leaders cannot continue in good faith to advocate balanced budgets, tax cuts, and leaner government -- to say nothing of defending the long-term viability of the American Dream -- without also talking about major, structural reforms in "untouchable" senior entitlements. Everything must be on the table.

Yes, touching the untouchables is politically dangerous. Any leader who brings up the subject of Social Security or health-care for the elderly had better be ready to discuss such gut-level issues as early retirement, "spending down" for Medicaid, the function of the extended family, second liver transplants versus student loans, Lee Iacocca's Social Security check, who

should care for other people's wayward children, and how to balance the rightful claims of the young and the old on our public fisc. These are issues that force most Americans to rethink their own ideals and institutions.

On the other hand, leaving the untouchables alone is also dangerous. Much of the American electorate is convinced that government has played some enormous scam with their future that no one is willing to talk about. And if the leaders in power do not solve this problem by the time the bills come due, the electorate will surely engage in some heavy retribution -- not against who did speak up, but against who didn't. Indeed, the willingness of either party to pay attention to these issues is probably an excellent indicator of whether that party has any serious intention of governing the nation for long.

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APPENDIX I: OFFICIAL ECONOMIC AND DEMOGRAPHIC ASSUMPTIONS

Every spring, the Trustees of the OASDI (Social Security) Trust Funds publish an annual report which includes an actuarial analysis of future projected expenses and revenues. These projections are computed by SSA on the basis of long-term economic and demographic assumptions that are approved yearly by the Trustees. The same assumptions are used by the Trustees of the HI (Medicare Part A) and SMI (Medicare Part B) Trust Funds in the expense and revenue projections included in their reports. Currently, the OASDI Trustees produce three sets of assumptions, or "scenarios": low cost (I), intermediate cost (II), and high cost (III) -- of which the second is considered the Trustees' "best estimate" and is used to report the official actuarial balances to Congress as required by law.

Each scenario consists of future projections for at least two dozen separate economic and demographic variables, including inflation, unemployment, labor force participation, real earnings growth, fertility, longevity, immigration, disability rates, and so on. Just two assumptions, however, dominate the cost projections early in the next century: real earnings growth and longevity. By the year 2020, these two assumptions account for 63 percent of the cost difference between scenarios II and III. Further into the future, fertility assumptions begin to play a significant role. By 2040, when fertility alone accounts for 18 percent of the cost difference, all three assumptions together account for 72 percent of the cost difference. Any effort to assess the plausibility of the official scenarios, then, can usefully focus on the plausibility of these three assumptions. Table 2 shows their ultimate long-term values, along with a 1973-93 historical average to provide a standard of comparison. Scenario I is omitted here because its assumptions are so optimistic as to put it out of the running as a prudent forecast.

As Table 2 indicates, what is most striking about the two most dominant assumptions -- real earnings growth and longevity -- *is that recent historical experience is more "pessimistic" than even the highest-cost projection assumption.* Scenario III, for instance, posits a higher long-term growth rate of real earnings than we experienced according to any fair trend analysis of the last 10 years, 20 years, or 30 years. Likewise, both scenarios assume that gains in longevity will slow down sharply in future decades, perhaps on the supposition that there are strict natural limits on the human lifespan. Recent research is casting doubt on this assumption. In fact, the demographers on the technical panel of the current Quadrennial Commission of Social Security may suggest that the official "best estimate" for longevity at age 65 be greatly accelerated, perhaps by as much as one year by 2000 and five years by 2060. As for fertility, though the long-term trend has been downward (for over two centuries in the United States), a plausible case can be made for scenario II. Since the late 1980s, the total fertility rate has risen just above 2.0. It is likely, however, that this spurt reflects nothing more than changes in birth timing. Surveys of expected lifetime births per woman have changed very little over the past two decades and are entirely consistent with the scenario II value of 1.9.[33]

Table 2:
Official 1994 SSA Scenarios Versus Actual Historical Experience

	Assumed Long-Term Trends (After 2010) Under Scenarios II and III		Actual Historical Experience:
	Scenario II	Scenario III	1973-1993
Average Annual Rate of Real Wage Growth (in percent)	+0.98%	+0.52%	+0.11%
Average Annual Growth in Longevity at Age 65 (in years per decade)	+0.43	+0.83	+0.98
Average Total Fertility Rate (in lifetime births per female)	+1.90	+1.60	+1.87

APPENDIX II: OFFICIAL HEALTH CARE BENEFIT ASSUMPTIONS

The cost and revenue projections for Medicare depend, to a large extent, on the three economic and demographic scenarios prepared by the Social Security Trustees. These scenarios specify the real tax base from which Hospital Insurance will derive most of its revenue as well as the total number and age composition of all of the HI and SMI beneficiaries who will be receiving benefits. Yet the cost projections for Medicare clearly require something more -- some extra set of assumptions about how fast health benefit costs will rise even if general inflation, beneficiary numbers, and beneficiary age are held constant. HCFA calculates these extra assumptions according to a complex and interacting array of variables, including "labor forces," "nonlabor forces," "input intensity," and "volume of services." None of these variables are very helpful in trying to understand the plausibility of the underlying assumptions.

A conceptually simpler approach is to take the future cost projections for Medicare and to disaggregate their annual growth into four separate components: first, the cost growth due to a greater number of beneficiaries; second, the cost growth due to the higher age composition of beneficiaries; third, the cost growth due to economy-wide inflation; and fourth, the cost rate due to "extraordinary" causes. The first three of these assumptions are all determined by the Social Security scenarios. Together, they answer the question: How much must Medicare spend each year to give the same amount of inflation-adjusted care to each beneficiary at each age? What they leave unanswered is the extent to which Medicare spending may rise above and beyond any consideration of inflation, population, or age. This is the "extraordinary" cost growth. Its past history and future projected values are shown in Table 3.

Ever since Medicare got started in the mid-1960s, this extraordinary cost growth has always been a very important (and explosive) component of total cost growth. From 1970 through 1993, for instance, it has averaged over 5.0 percent annually. Yet what's especially interesting is the projected future trend in extraordinary cost growth. Until the year 2005, it stays close to its recent rate. It begins to slow down, however, over the following decade -- just when the Boomers are beginning to retire. *Past the year 2015, it recedes to roughly one-quarter of its average historical rate.* In other words, the explosive historical cost trend is supposed to cool off just when a very large generation (with a notorious habit of bidding up the prices of whatever they need throughout their collective lifecycle) begins to exert unprecedented pressure on the demand for every variety of health care. Curiously, the cost difference between the two scenarios narrows over time. Past 2030, the extraordinary growth rate under the "pessimistic" scenario III is actually less than under scenario II.

What accounts for these anomalies is, basically, an ad-hoc projection methodology that pays little attention to underlying assumptions. To generate scenario II, HCFA simply assumes that, after the year 2018 (25 years from now), extraordinary program cost growth will slow all the way down to real hourly earnings growth (for Medicare Part A) or real GDP per capita growth (for Medicare Part B). In small print, the Trustees do at one point concede the optimism of this assumption: "Given the historical experience of SMI costs per enrollee increasing faster

than GDP per capita, the assumption of the increases in costs per enrollee declining to the same rate as GDP per capita may be considered optimistic...." This sanguine methodology also explains why the extraordinary cost growth rate in scenario III ultimately falls beneath the growth rate in scenario II: the former scenario has a slower ultimate rate of real GDP growth per capita than the latter. It's as though the Trustees have already determined that if we become a less affluent country than otherwise we will be stingier in what we offer to Medicare patients than otherwise. Enormous policy choices have been built right into the "current-law" projections.

Table 3:
Official 1994 HCFA Assumptions Versus Actual Historical Experience

	Assumed Extraordinary Annual Real Growth in Medicare (Parts A and B)		Actual Historical Experience
	Scenario II	Scenario III	
1970-75			4.6 %
1975-80			5.9 %
1980-85			6.3 %
1985-90			3.0 %
1990-95			5.0 %
1995-00	5.2 %	4.9 %	
2000-05	5.0 %	5.9 %	
2005-10	4.2 %	4.9 %	
2010-15	2.9 %	3.9 %	
2015-20	1.4 %	2.5 %	
2020-25	1.0 %	1.9 %	
2025-30	1.1 %	1.5 %	
2030-35	1.2 %	0.9 %	
2035-40	1.1 %	0.4 %	

APPENDIX III: CALCULATING THE TAX BURDEN

Our model determines the distribution of taxation according to a few simple formulas. The goal is to approximate the attribution of total taxation to worker earnings and compensation -- while avoiding the complexity of simultaneous equations or inappropriate attempts at precision. Given the fixed "scenario" framework, any dynamic assumptions are of course out of the question.

Following the familiar NIPA categories, our model identifies five types of taxation for all levels of government. To each, we add here our shorthand label in parentheses: (1) personal tax and nontax receipts, exclusive of federal taxation of Social Security benefits (INCOMETAX); (2) federal taxation of Social Security (SSTAX); (3) indirect business tax and nontax accruals (SALESTAX); (4) corporate earnings taxation (BUSTAX); and (5) contributions for social insurance (PAYTAX). GENREV equals the sum of the above, minus all payroll tax revenue to the Social Security and Medicare trust funds (PAYOASDHI) and minus the employer-paid share of all remaining PAYTAX. Future values for SSTAX are determined by the scenario. Otherwise, the model assumes that GENREV (both the total and each type) remains constant as a share of 1993 GDP in all future years, except to the extent that GENREV must increase to meet the budget-balance condition (which must be met through a linear reduction of the nominal deficit between 1995 and 2010 and through a continuous balance thereafter). If GENREV increases, the model assumes that each type within GENREV increases proportionally. The model assumes that all PAYOASDHI follows the official scenarios until trust fund bankruptcy, when (for each trust fund) pay-as-you-go financing requires that PAYOASDHI be raised to cover the current trust fund deficit. The model assumes that any PAYTAX not included in GENREV or PAYOASDHI remains constant at its 1993 GDP share; in order to avoid a trivial complexity, the model assumes that increases in SSTAX above the scenario values are not credited to the Social Security trust funds.

The above account describes how the amount of each type of taxation is determined for all years. Now we move on to the incidence of taxation. To begin with, we identify four potential bearers of the tax burden. Again, we add here our shorthand label in parentheses: worker earnings (EARNINGS); employer-paid compensation minus earnings (FRINGE); return on capital (CAPITAL); and total government transfer payments (BENEFITS). the model assumes taxes on EARNINGS and FRINGE are both borne by workers, but we separate the two in order to isolate the tax reduction in earnings alone. While taxes on BENEFITS may be borne by anyone, including workers or capital owners, it makes sense to treat them as a separate category -- since they usually aren't regarded as a tax on market activity, but more as a government clawback of its own outlays. A useful subset of BENEFITS is taxable benefits (TAXBENEFITS), which consists of the major benefits other than Social Security (i.e., all local, state, and federal employee pension programs) on which many or most recipients have to pay income taxes. In all future years, BENEFITS (excluding Social Security, Medicare, and Medicaid for seniors) and TAXBENEFITS are assumed to remain constant at its 1993 GDP share.

For each type of taxation, the incidence is attributed to different bearers as follows.

- One-quarter of BUSTAX is attributed to CAPITAL; the rest is attributed to EARNINGS.
- SSTAX is attributed all to BENEFITS.
- PAYTAX is attributed to FRINGE to the extent that it lies within (a) the employer-paid OASDHI according to the scenario, plus (b) the 1993 value of PAYTAX minus OASDHI as a share of GDP. All PAYTAX in excess of this amount is attributed to EARNINGS.
- INCOMETAX is attributed to EARNINGS, CAPITAL, and TAXBENEFITS according to the proportional share of each item in the sum of all three items. Three-quarters of the CAPITAL share is then transferred to EARNINGS.
- SALESTAX is attributed to EARNINGS, CAPITAL, and BENEFITS according to the proportional share of each item in the sum of all three items. Three-quarters of the CAPITAL share is then transferred to EARNINGS.

Note that the shift of capital taxes to labor requires us to gross up the scenario definition of "earnings." Historical EARNINGS in our model equals scenario "earnings" plus the total shift of capital taxes to labor. Future EARNINGS in our model equals the historical value for 1993 EARNINGS times the scenario growth rate for "earnings" thereafter. Thus historical EARNINGS exceeds "earnings" by the historical tax shift; future EARNINGS exceed "earnings" by a fixed multiple -- reflecting the implicit SSA assumption that the relative magnitude of such a tax shift would not change in future years. For all years, our measure of "worker compensation" is grossed up by the same dollar figure.

As mentioned earlier, the share of total taxes attributed to both EARNINGS and FRINGE (i.e., to total worker compensation) by these formulas is just under 80 percent throughout the projection period; of the remainder, the BENEFITS share rises and the CAPITAL share declines over time.

The total tax rate figures displayed in Charts 10 and 11 are derived by taking the total tax attributed to each bearer and dividing it by the total "income" in question. The total tax rate on worker compensation equals the tax on EARNINGS plus the tax on FRINGE, all divided by EARNINGS plus FRINGE. The total tax rate on capital equals the tax on CAPITAL divided by CAPITAL. The total tax rate on benefits equals the tax on BENEFITS divided by BENEFITS.

ENDNOTES

1. "Generational Perspectives" in U.S. Office of Management and Budget, *Budget of the United States Government, Fiscal Year 1995: Analytical Perspectives* (1994), pp. 21-31.

2. Board of Trustees, Federal Old-Age and Survivors Insurance and Disability Trust Funds, *1994 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Trust Funds* (1994), p. 124. See also the *1988 Annual Report* (1988), p. 84.

3. Bipartisan Commission on Entitlement and Tax Reform, *Interim Report to the President* (1994), p. 6.

4. Congressional Budget Office, *Reducing Entitlement Spending* (1994), p. ix.

5. See results to survey questions 24 and 25 in Matthew Greenwald & Associates, Inc., *Entitlement Survey*, commissioned by the Congressional Institute for the Future and the National Taxpayers Union Foundation (1994).

6. Results of New York Times/CBS News Poll, as reported in *New York Times* (November 6, 1994).

7. Merrill Lynch & Co., Inc. *Saving the American Dream: An Economic and Public Opinion Study* (1994).

8. See results to survey question 26 (and unpublished cross-tabulations) in Matthew Greenwald & Associates, Inc., *op. cit.*

9. See results to survey questions 14, 15, and 27a in Matthew Greenwald & Associates, Inc., *op. cit.* See also the *Survey on Retirement Confidence*, conducted by the Employee Benefits Research Institute and Matthew Greenwald & Associates, Inc. (1994), p. 39; its summary of four years (1990-1994) of answers to this question shows growing support for benefits means-testing.

10. Interestingly, amid all the negative or hedging remarks that have been made about the "interim findings" of the Bipartisan Commission on Entitlement and Tax Reform, virtually nothing has been said to contest the official "intermediate cost" scenario upon which nearly all of the Commission's quantitative projections are based. One exception is the claim of Commission member Richard Trumka that the SSA official labor force projections are too low. Trumka prefers the more buoyant BLS projections--a dubious point for him to raise since the BLS optimism about the future labor force is more than compensated by the (possibly related) BLS pessimism about productivity growth. The future growth rates for real GDP and real covered wages are actually lower in the BLS scenario than in the intermediate-cost SSA scenario!

11. Even by the year 2030, immigration and fertility combined only explain 16 percent of the difference between scenarios II and III. That same year, real wage growth and longevity explain 59 percent of the difference.

12. See discussion in Appendix I. When applied to longevity, the phrase "actuarially favorable" means tending to lower cost--and is "unfavorable" in any broader sense. Most people consider longer lifespans to be very good news indeed. Although the "root-canal" crowd who raise the issue of long-term benefit costs are sometimes labeled "pessimists," many of the trends they point to (such as longer lifespans or earlier retirements) are unambiguously positive--so long as America can afford them.

13. See discussion in Appendix II.

14. Both parts of Medicare (HI and SMI) are included here. SMI outlays are net of premiums paid by beneficiaries. Although the payroll tax denominator for HI is slightly larger than the denominator for OASDI, the SSA actuaries have traditionally ignored this discrepancy when adding the two together. In the same spirit, this calculation for SMI uses the OASDI denominator and adds it on to the other two without adjustment. The "intermediate cost" and "high cost" projections are equivalent to the official "scenario II" and "scenario III." Since there is no official long term scenario III projection for SMI, we calculate this projection (as in the model described below) by assuming that SMI outlays will exceed their scenario II path by the same multiple by which HI under III exceeds HI under II.

15. James Tobin, in "An Exchange on Social Security," *The New Republic* (May 18, 1987), p. 22.

16. Robert Ball (with Henry Aaron), "Social Security: It Is Affordable," *Washington Post* (February 15, 1994).

17. Michael Kinsley, "Back From the Future," *The New Republic* (March 21, 1994), p. 6.

18. Henry Aaron, *Proceedings of "Children at Risk: Who Will Support Our Aging Society?"* (Conference sponsored by Americans for Generational Equity and Center for Public Policy and Contemporary Issues; Denver, Colorado; May 13, 1988.)

19. American Association of Retired Persons, *Entitlements and the Federal Budget Deficit: Setting the Record Straight* (1994), pp. 2, 15.

20. Henry J. Aaron, Barry P. Bosworth, and Gary Burtless, *Can America Afford to Grow Old?* (1989), with its long-term macro model based on SSA assumptions, promises to be an exception. Unfortunately, neither SMI nor Medicaid are modeled, and (even for just OASDHI) the authors' extensive discussion of the tax burden always skirts any direct presentation of real after-tax earnings numbers. In any event, their overall tone is far from optimistic: "These [programs'] burdens will be manageable if productivity growth recovers to the pre-1973 rate, but they will be very heavy if the improvement in general living standards continues at the recent dismal pace." (p. 97).

21. Using out-of-date trustees' reports improves the outlook because the official assumptions have changed in a pessimistic direction in recent years. Looking only at Social Security cash benefits obviously improves the outlook even though several other programs transfer resources between generally the same two populations (from working age adults to retirees), are subject to the same demographic pressures (the Boomer-led age wave), and are even more resistant to cost control. We include two of the these programs, Medicare and senior benefits under Medicaid, in our analysis. As for failing to account for the total tax burden on earnings (say, by just looking at earnings after deductions for payroll taxes), this misses the basic political issue that matters to most Americans: Where do I stand personally after all of my transactions with government are complete?

22. HI is financed mostly by an earmarked payroll tax, SMI by general federal revenues; together they are known as Parts A and B of Medicare.

23. Although we generated numbers to 2070, we limit our discussions to the pre-2040 period for the purpose of brevity and policy relevance. None of the conclusions reached here would be materially altered by including the 2040-2070 period.

24. Also left out is the historical and projected trend toward fewer average hours of work per week (see Charts 15 and 16), which may be regarded as yet another component of a higher living standard to the extent it reflects less "effort" required from each worker to obtain the same market basket of real goods and services.

25. Although the data used in our model are always consistent with the official scenarios, a few terms had to be redefined. Our treatment of capital taxation (see below), for instance, requires us to gross up the official pre-tax worker "earnings" and "compensation" measures by the amount of the tax shift. Some of the official scenario numbers are published in the OASDI, HI, and SMI annual reports. Most of the annual figures are unpublished and are available from the SSA and HCFA actuarial offices.

25. OASI and DI are separate trust funds. But to simplify the analysis (and given that the two trust funds have historically borrowed from each other), we will regard them here as one. According to scenario II in the 1994 trustees' annual reports, OASDI is expected to become insolvent in 2029; HI in 2001. According to scenario III, OASDI is expected to become insolvent in 2014; HI in 2000.

27. That is, annual Medicaid cost growth is determined as a product of: (a) the Medicaid demographic multiplier, (b) the GDP deflator, and (c) the extraordinary cost multiplier for Medicare (see Appendix II). The Medicaid demographic multiplier is calculated, each five years into the future, by multiplying the population in each age bracket (over age 65) in the future with the per-capita Medicaid cost of that age-bracket in 1992. It is optimistic to assume unchanged utilization rates because such a large share (roughly two-thirds) of Medicaid benefits to the elderly consists of long-term care. Unlike acute care, the utilization of long-term care is very sensitive to the share of eligibles living alone or without family nearby (which we know will rise among the future elderly population) and to broader definitions of disability (which are already factored into Disability Insurance cost projections).

27. "The cost disease of the personal services" is the term William J. Baumol originally used for his analysis of how many personal services resist productivity improvement. It has since become known as "Baumol's Law" and has been often been observed to work with great stubbornness in the public sector. For a provocative essay on the issue, see Daniel P. Moynihan, "Don't Blame Democracy: The Socialization of Slow-Growth Jobs," *Washington Post* (June 6, 1993).

28. It is true that a balanced budget would lead to a steady reduction of public debt-service charges as a share of GDP. But it is assumed that this reduction would be approximately compensated by per-GDP spending growth in other government functions.

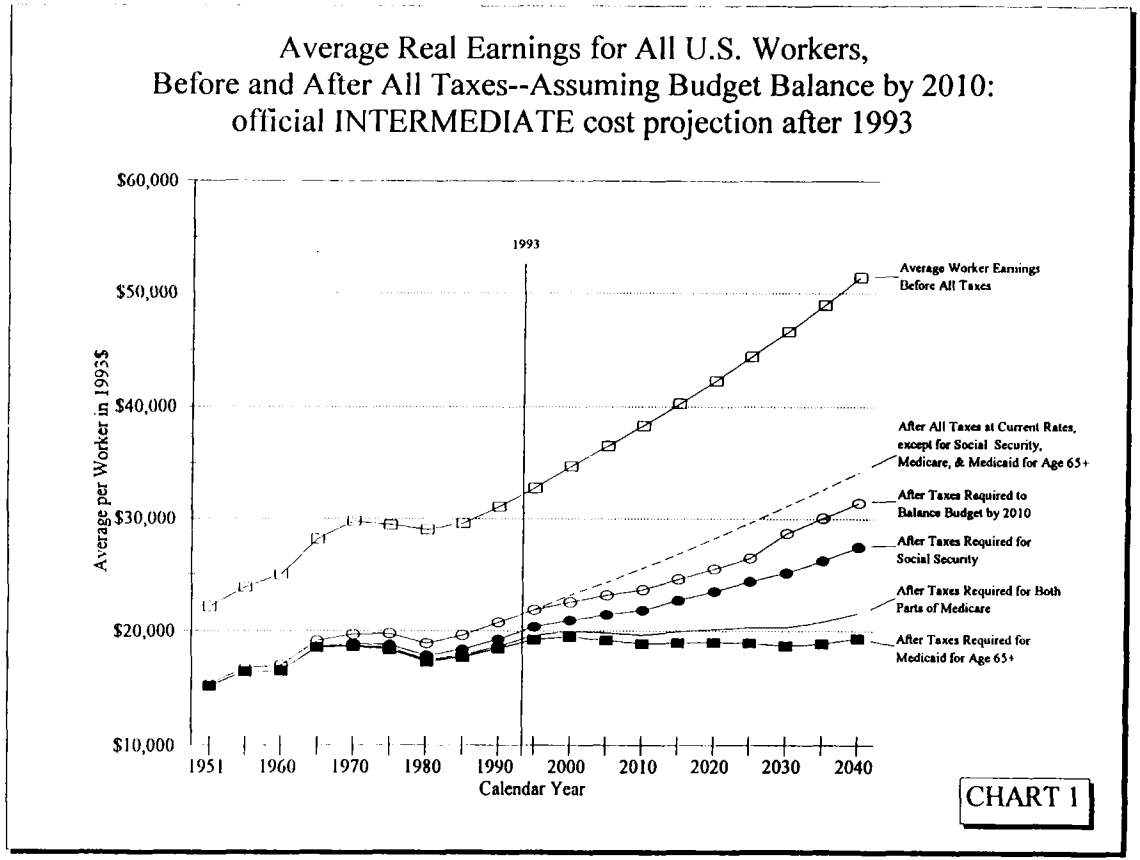
30. There is of course no consensus among economists on the incidence of taxes on the return to capital. Some analysts (e.g., the Congressional Budget Office) split the difference by presenting the results both ways--shifting the burden all to capital and then all to labor. For a long-term equilibrium framework (especially one that anticipates the expected future trend toward integrated global capital markets), we think that most economists would agree that most capital taxes are shifted to labor. Hence our choice of the three-quarters fraction. Although capital can also shed its tax burden by passing it on to consumers in the form of higher prices, it is generally believed that this shift is less important--since product markets are more competitive and integrated than labor markets. In our model, in any event, switching the assumption from shifting through wages to shifting through prices would hardly make any difference in the quantitative result for real after-tax earnings.

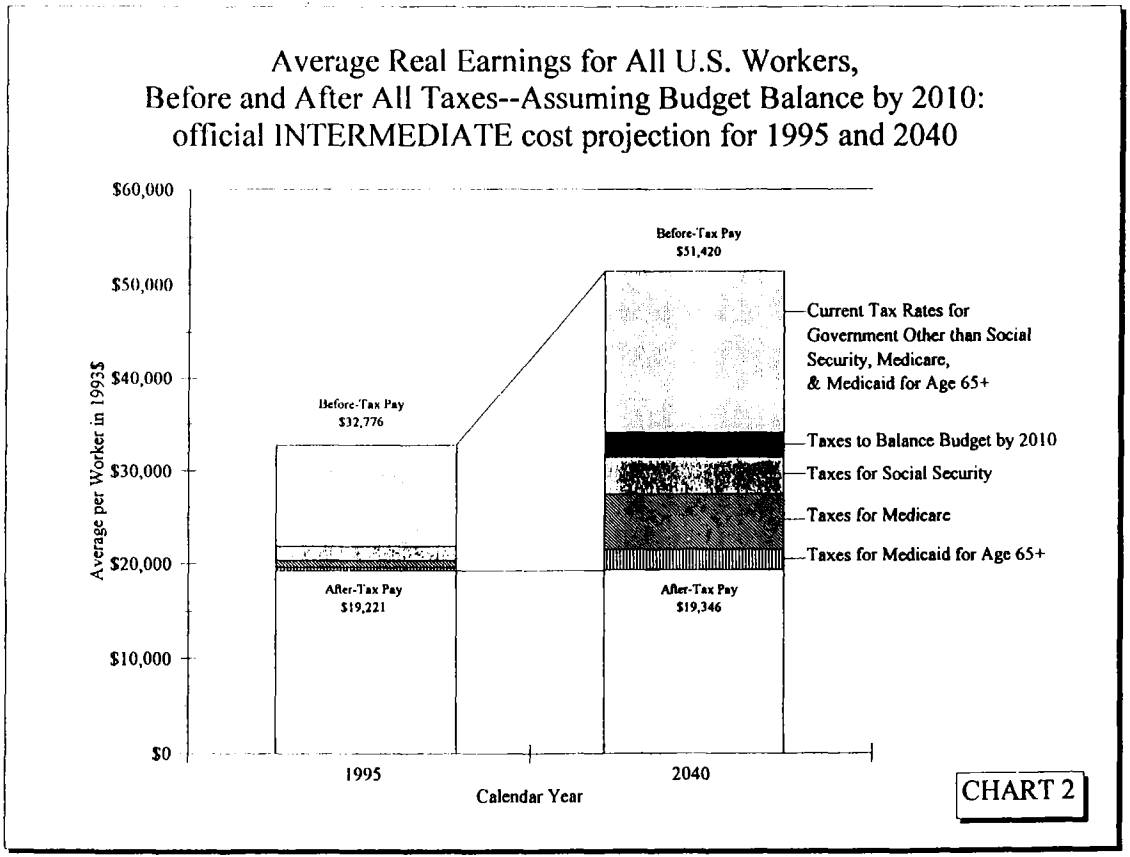
30. Here "benefit payments" refer to "transfer payments" as defined in the National Income and Product Accounts for all levels of government. At the federal level, this term is somewhat more restrictive than "federal entitlements" as defined by the Congressional Budget Office or "benefit payments for individuals" as defined by the Office of Management and Budget.

32. The plan proposed by Rep. Jerry Solomon, Chairman of the Balanced Budget Task Force, is one of the very few plans (if not the only extant plan) that meets the first two criteria--i.e., balancing the budget without raising taxes. But it does not meet the third. Even after including every line item anyone can think of, Solomon is still compelled to seek out massive reductions ($154 billion, or 22 percent of the cumulative five-year savings) in Medicare and Medicaid. If the goal is to keep the budget balanced over time, not merely to balance it once, then the need to reduce the growth in senior benefits is even more compelling; otherwise, Congress will ultimately run

out of other budget functions to cut.

33. For an up-to-date survey of these issues, see Richard Jackson, "An Analysis of Social Security and Medicare Long-Term Cost Projections," an unpublished submission to the Bipartisan Commission on Entitlement and Tax Reform at the request of Peter G. Peterson.


Average Real Earnings for All U.S. Workers,
Before and After All Taxes--Assuming Budget Balance by 2010:
official INTERMEDIATE cost projection after 1993
$60,000
$50,000
$40,000
$30,000
$20,000
$10,000
Average per Worker in 1993$
1993
1951
1960
1970
1980
1990
2000
2010
2020
2030
2040
Calendar Year
Average Worker Earnings Before All Taxes
After All Taxes at Current Rates, except for Social Security, Medicare, & Medicaid for Age 65+
After Taxes Required to Balance Budget by 2010
After Taxes Required for Social Security
After Taxes Required for Both Parts of Medicare
After Taxes Required for Medicaid for Age 65+
CHART 1


Average Real Earnings for All U.S. Workers,
Before and After All Taxes--Assuming Budget Balance by 2010:
official INTERMEDIATE cost projection for 1995 and 2040
$60,000
$50,000
$40,000
$30,000
$20,000
$10,000
$0
Average per Worker in 1993$
Before-Tax Pay
$32,776
After-Tax Pay
$19,221
Before-Tax Pay
$51,420
After-Tax Pay
$19,346
Current Tax Rates for
Government Other than Social
Security, Medicare,
& Medicaid for Age 65+
Taxes to Balance Budget by 2010
Taxes for Social Security
Taxes for Medicare
Taxes for Medicaid for Age 65+
1995
2040
Calendar Year
CHART 2

Average Real Earnings for All U.S. Workers, Before and After All Taxes--Assuming Budget Balance by 2010: official HIGH cost projection after 1993

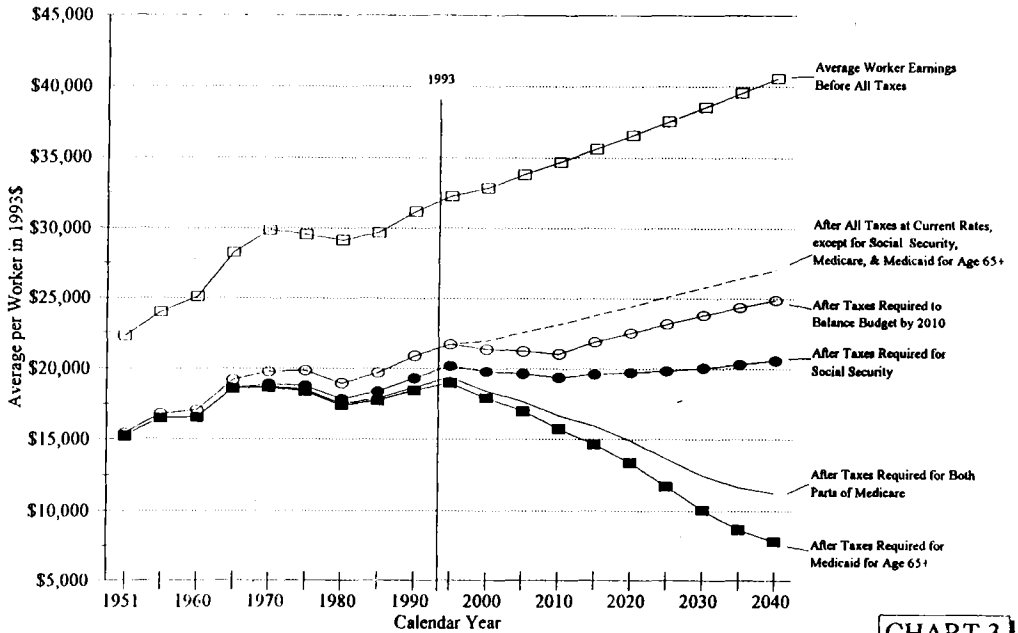


CHART 3

Average Real Earnings for All U.S. Workers, Before and After All Taxes--Assuming Budget Balance by 2010: official HIGH cost projection for 1995 and 2040

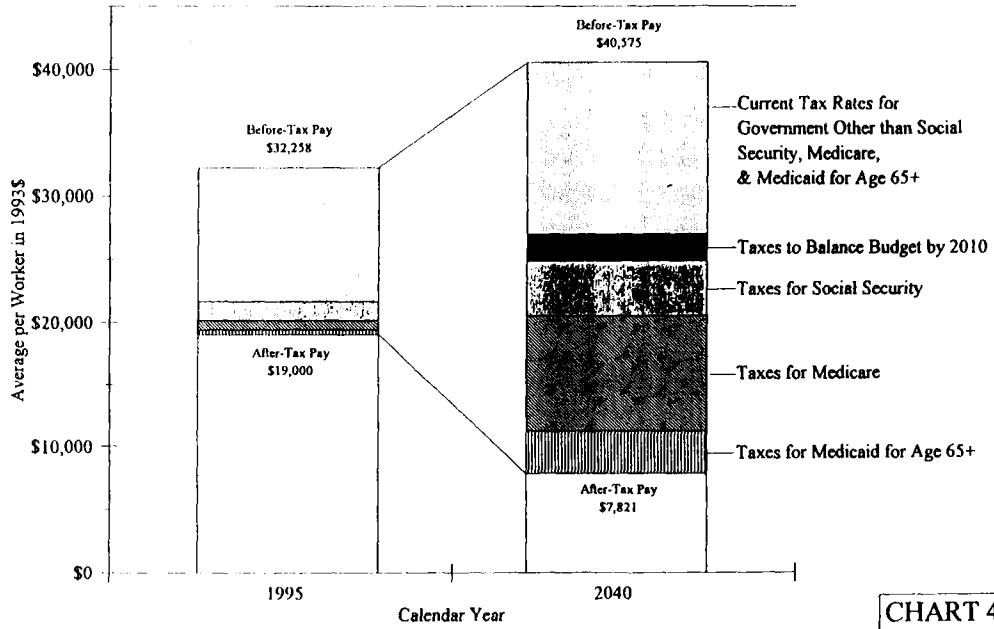


CHART 4

The Historical Record: Government Outlays as a Percent of Gross Domestic Product: Yearly, from 1951 to 1993

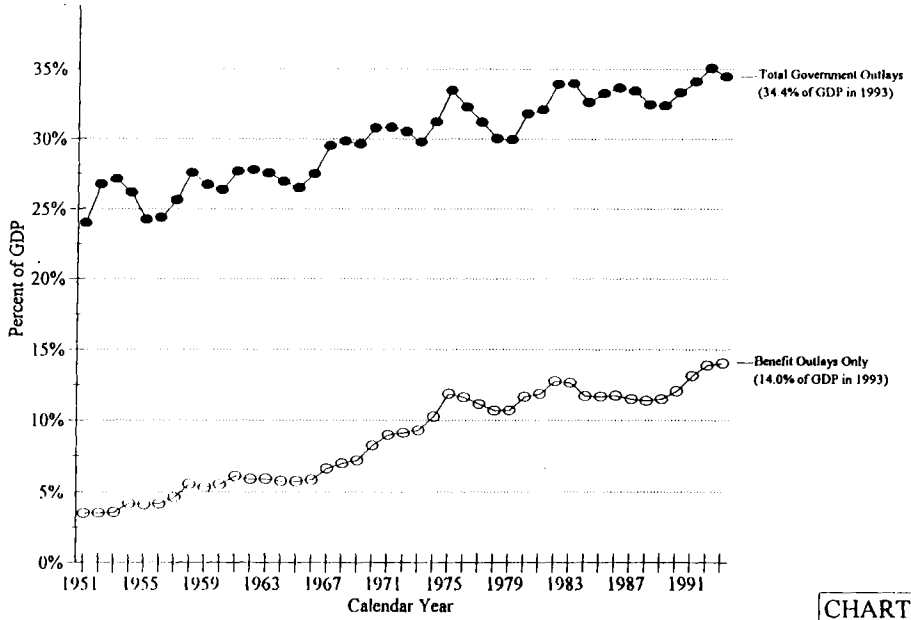


CHART 5

Total Government Benefit Outlays
as a Percent of Gross Domestic Product:
official INTERMEDIATE cost projection after 1993

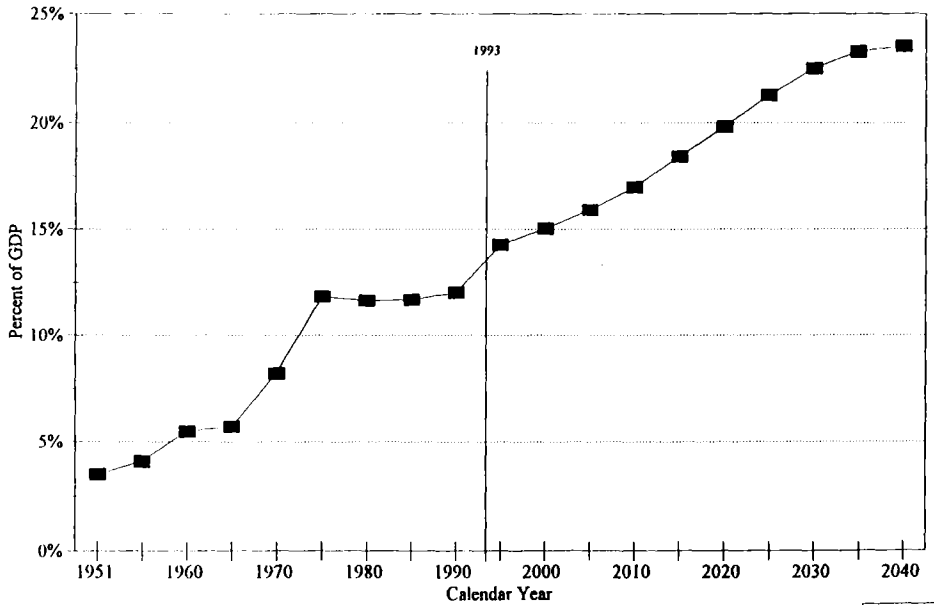


CHART 6

Total Government Outlays and Revenues as a Percent of GDP
--Assuming Budget Balance by 2010:
official INTERMEDIATE cost projection after 1993

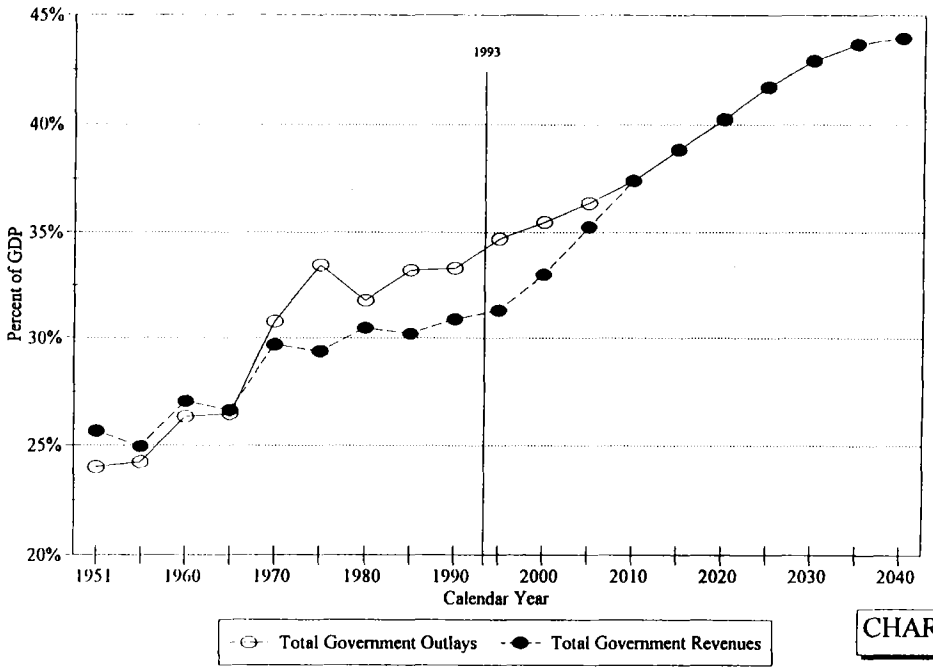


CHART 7

Total Government Benefit Outlays
as a Percent of Gross Domestic Product:
official HIGH cost projection after 1993

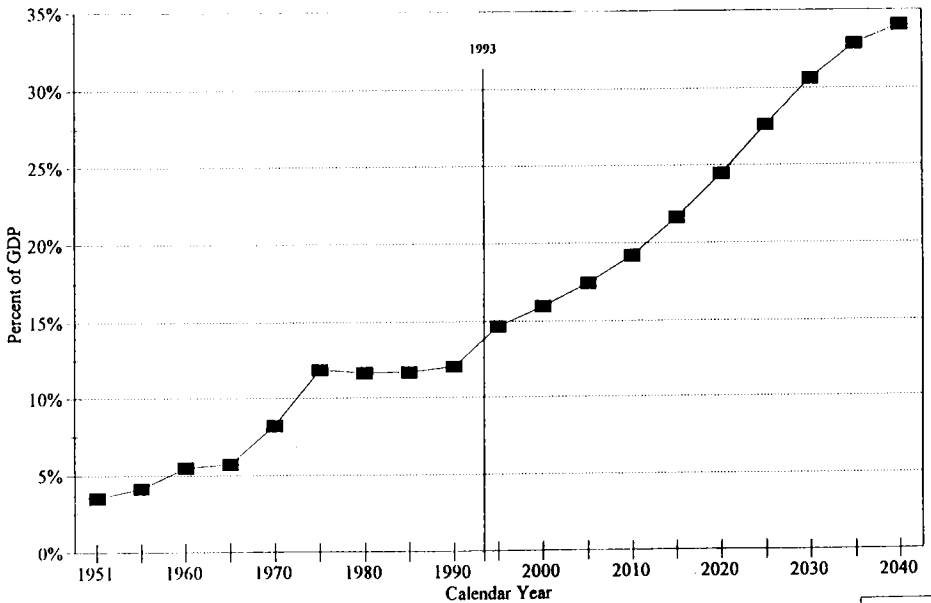
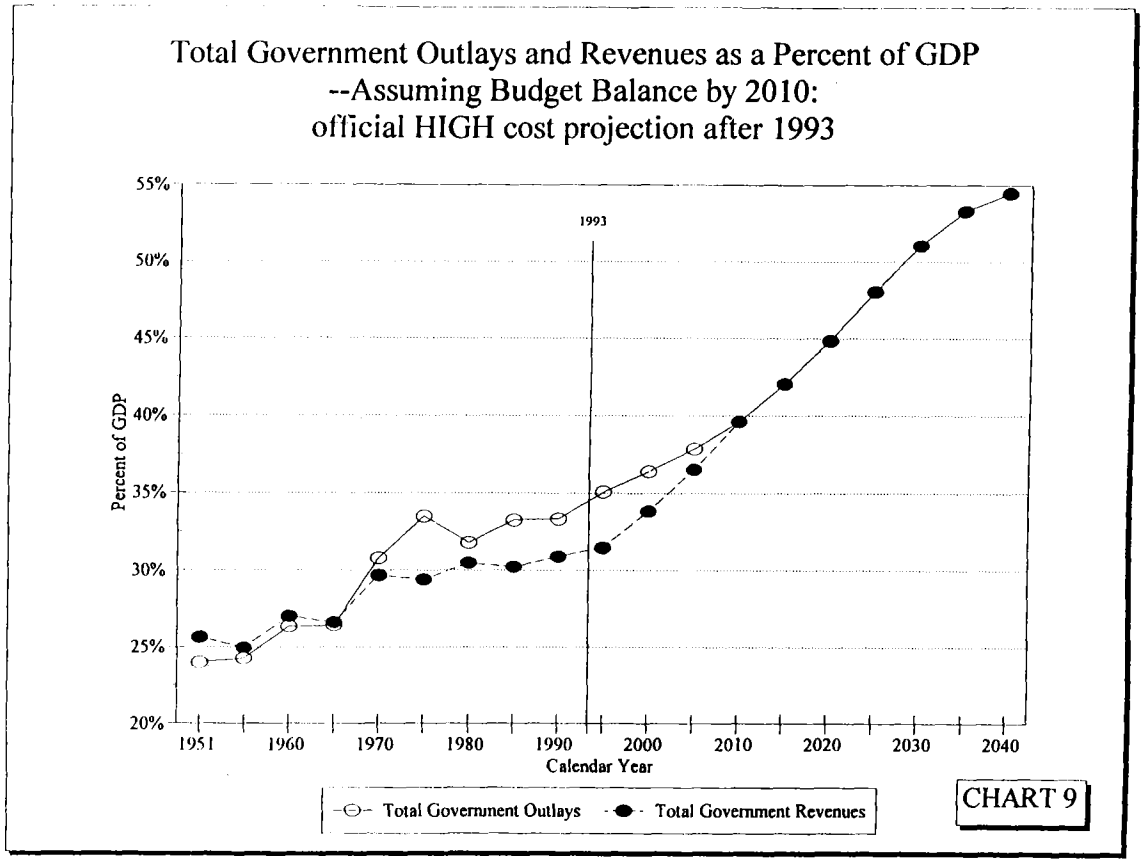


CHART 8


Total Government Outlays and Revenues as a Percent of GDP
--Assuming Budget Balance by 2010:
official HIGH cost projection after 1993
55%
50%
45%
40%
35%
30%
25%
20%
Percent of GDP
1993
1951
1960
1970
1980
1990
2000
2010
2020
2030
2040
Calendar Year
Total Government Outlays
Total Government Revenues
CHART 9

Total Tax Rate on Worker Compensation, Return to Capital, and Benefits
--Assuming Budget Balance by 2010:
official INTERMEDIATE cost projection after 1993

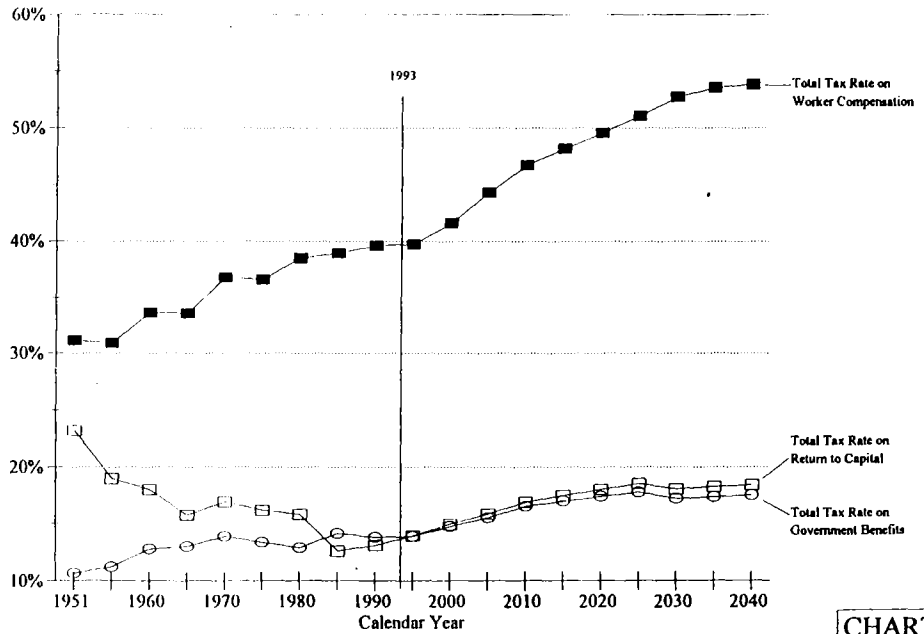


CHART 10

Total Tax Rate on Worker Compensation, Return to Capital, and Benefits
--Assuming Budget Balance by 2010:
official HIGH cost projection after 1993

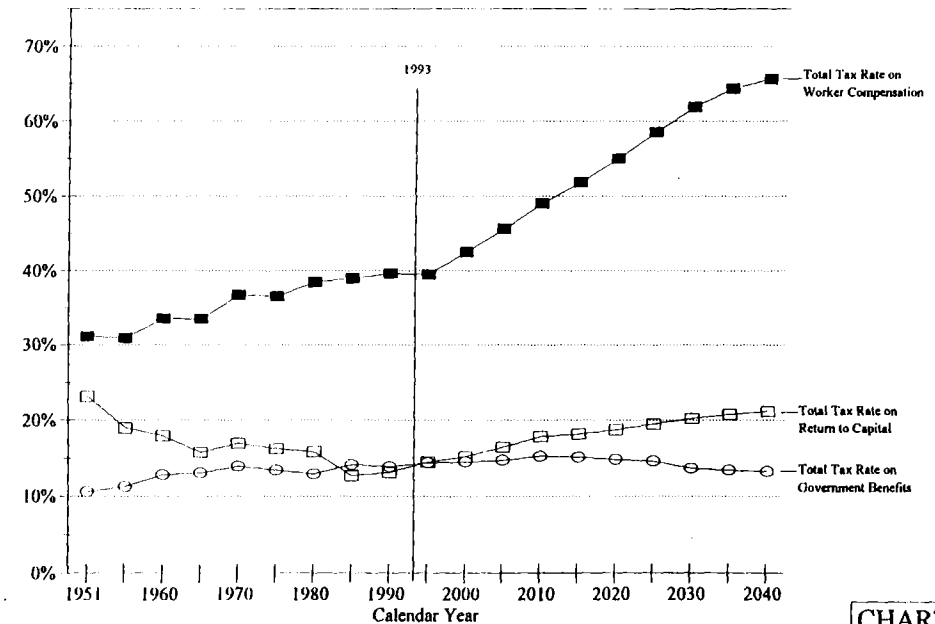


CHART 11

The Historical Record:
From National Income per Worker to After-Tax Earnings per Worker:
Yearly, from 1951 to 1993

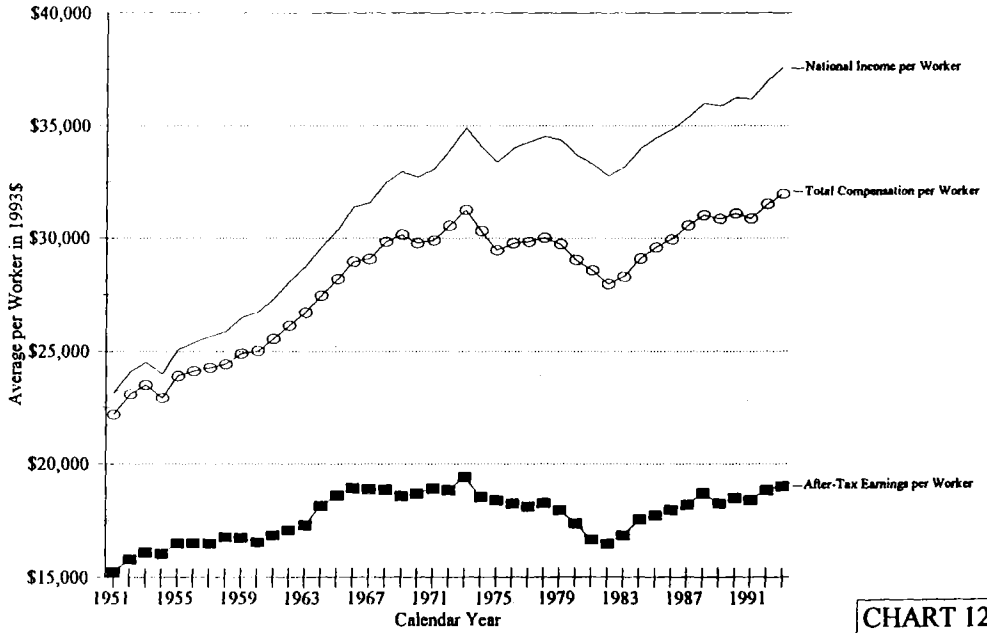
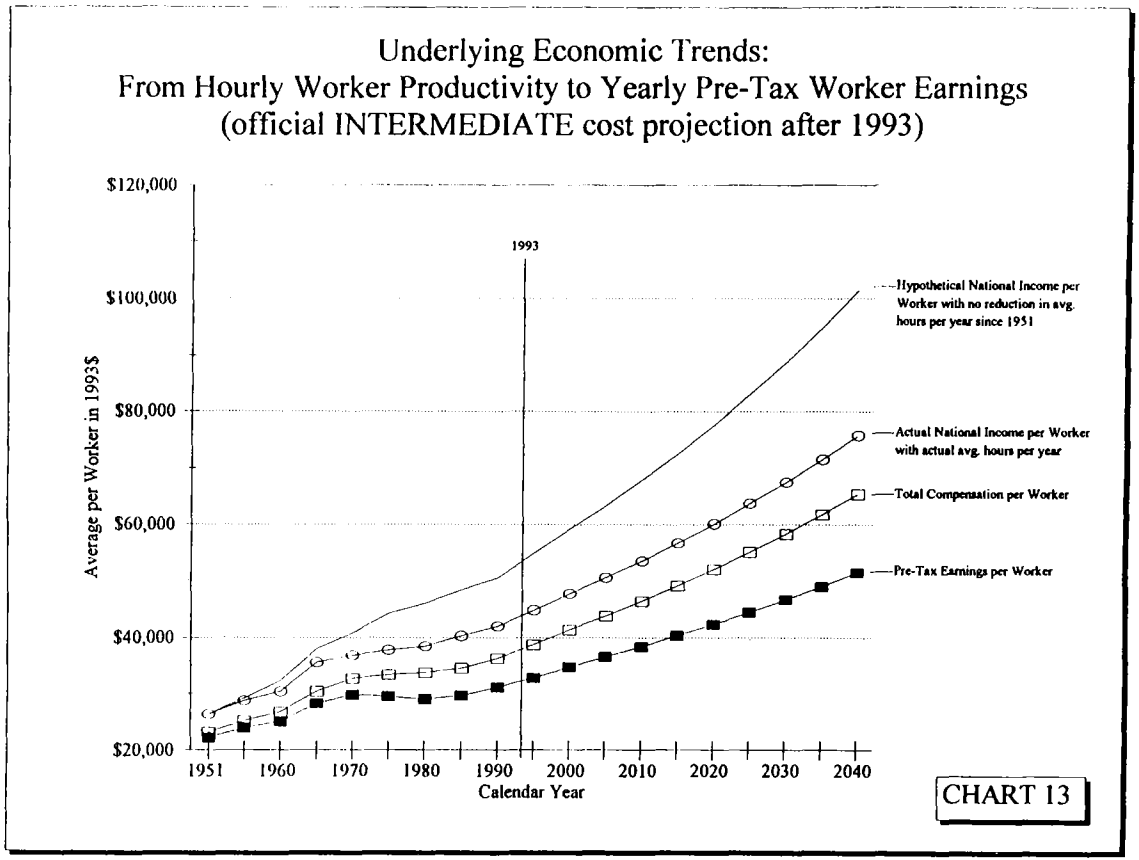


CHART 12


Underlying Economic Trends:
From Hourly Worker Productivity to Yearly Pre-Tax Worker Earnings
(official INTERMEDIATE cost projection after 1993)
$120,000
$100,000
$80,000
$60,000
$40,000
$20,000
Average per Worker in 1993$
1993
1951
1960
1970
1980
1990
2000
2010
2020
2030
2040
Calendar Year
Hypothetical National Income per Worker with no reduction in avg. hours per year since 1951
Actual National Income per Worker with actual avg. hours per year
Total Compensation per Worker
Pre-Tax Earnings per Worker
CHART 13

Underlying Economic Trends:
From Hourly Worker Productivity to Yearly Pre-Tax Worker Earnings
(official HIGH cost projection after 1993)

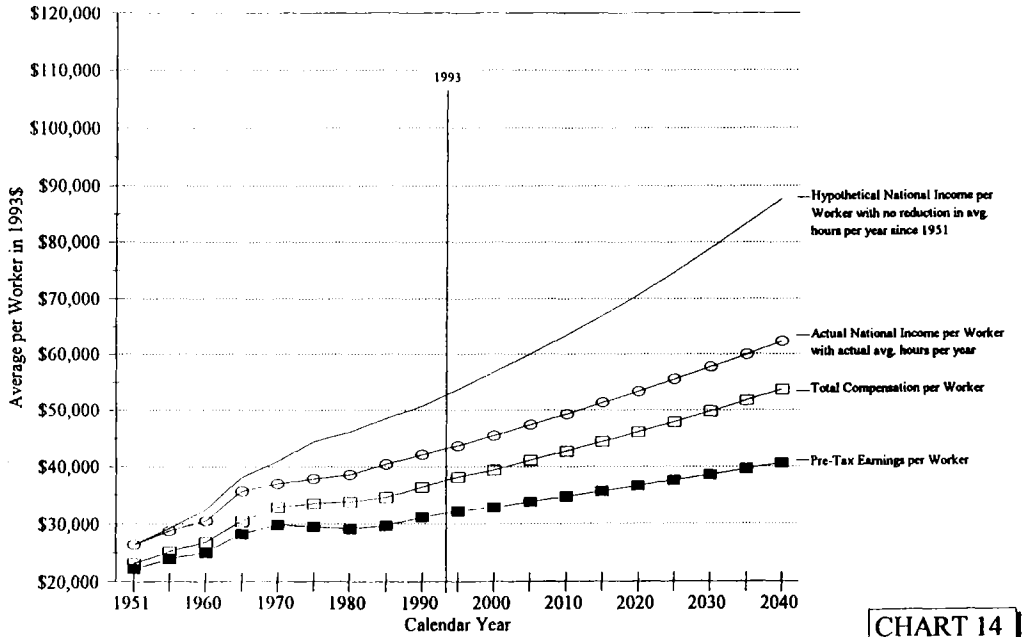
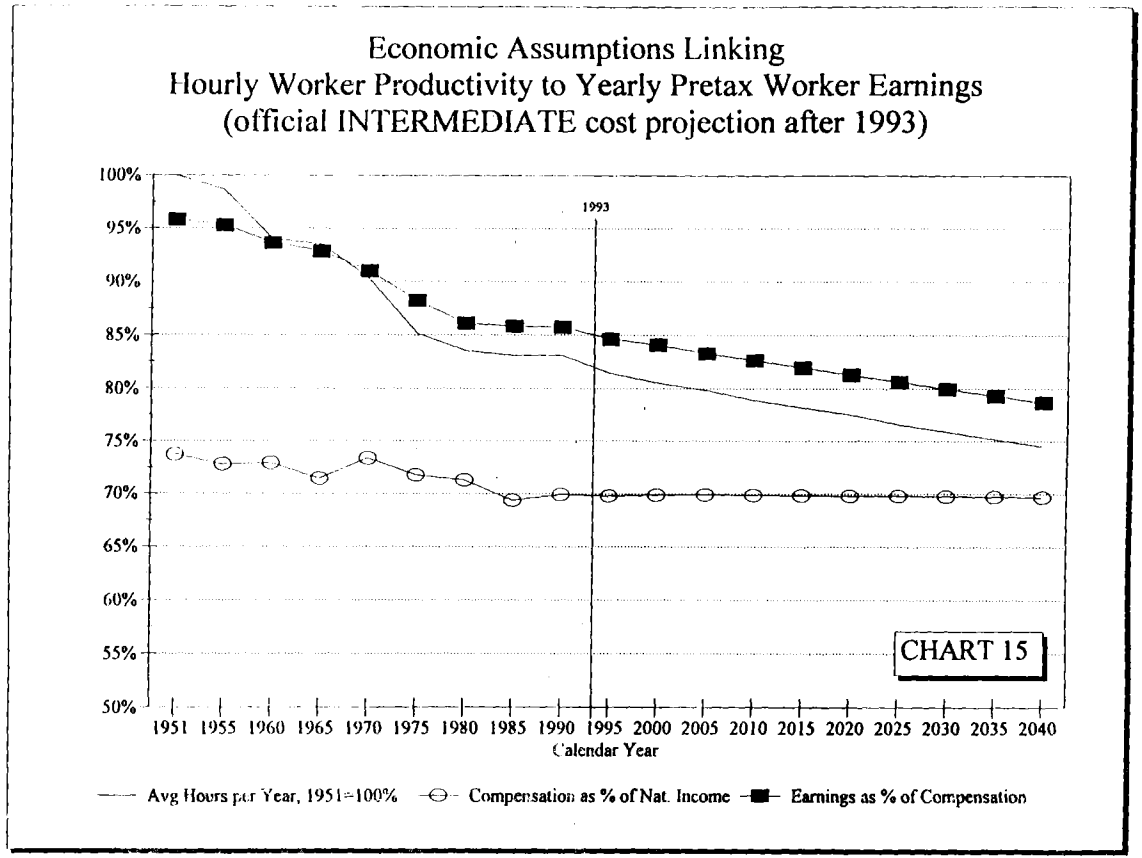
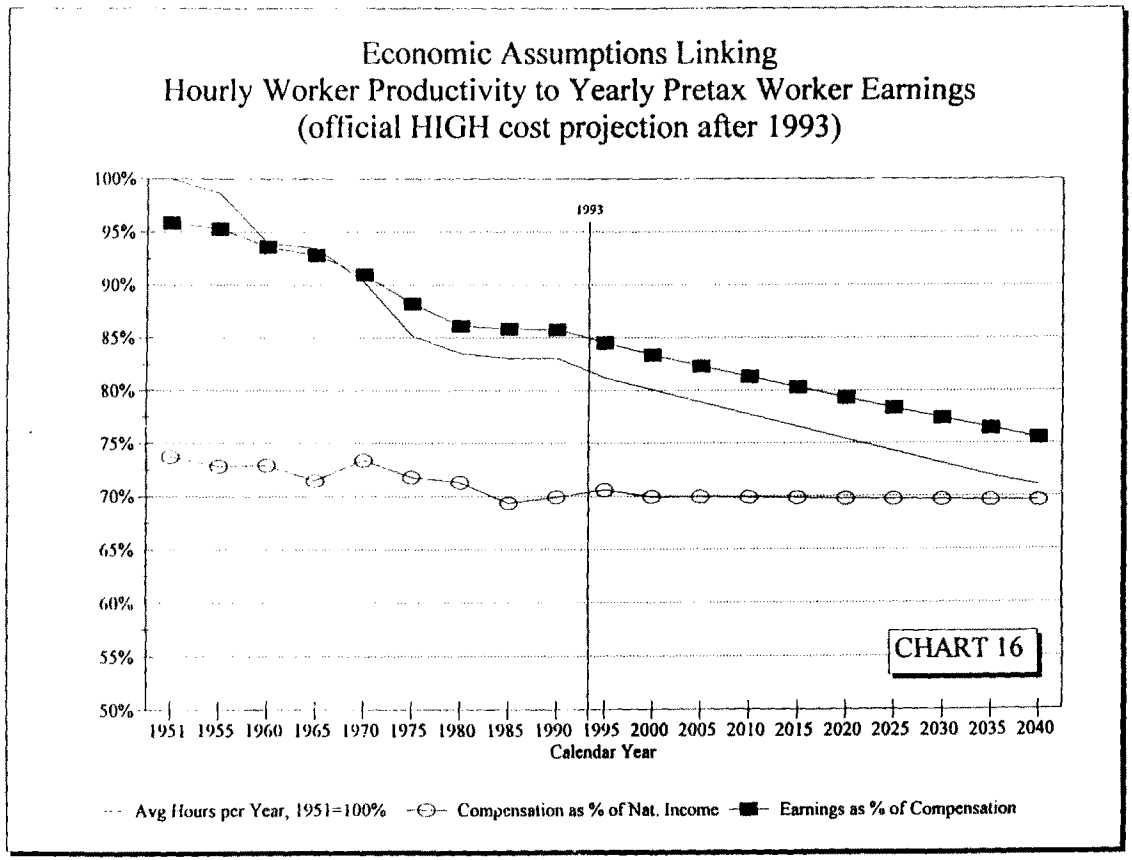


CHART 14


Economic Assumptions Linking
Hourly Worker Productivity to Yearly Pretax Worker Earnings
(official INTERMEDIATE cost projection after 1993)
100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%
1993
1951 1955 1960 1965 1970 1975 1980 1985 1990 1995 2000 2005 2010 2015 2020 2025 2030 2035 2040
Calendar Year
CHART 15
Avg Hours per Year, 1951=100%
Compensation as % of Nat. Income
Earnings as % of Compensation


Economic Assumptions Linking
Hourly Worker Productivity to Yearly Pretax Worker Earnings
(official HIGH cost projection after 1993)
100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%
1993
1951 1955 1960 1965 1970 1975 1980 1985 1990 1995 2000 2005 2010 2015 2020 2025 2030 2035 2040
Calendar Year
CHART 16
Avg Hours per Year, 1951=100%
Compensation as % of Nat. Income
Earnings as % of Compensation

STATEMENT TO THE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

Subject: Hearing held on February 23, 1995 on the failure of the President's fiscal year 1996 budget proposals to address the pending insolvency of the Medicare trust fund.

Person submitting statement
Gerald S. Parker
11 Shore Acre Drive
Old Greenwich, CT 06870

Capacity
Retired citizen, age 78, with 30 years experience in health insurance management with The Guardian Life Insurance Company of America

Representing
Himself only

With respect to Part A, the hospital deductible and co-payments are already indexed annually. I see no benefit pattern modification that would be helpful in saving money and practical to administer. The hospitals have been subject for years to price controls that ensure that they will care for Medicare patients at a loss which is then shifted on to other patients and their insurers. There is no profit in further squeezing the hospitals and their patients. That leaves means testing.

The professional advocates for the elderly keep trumpeting the fallacy that " You paid for these benefits and earned them. Don't let the Congress take them away from you." To be fair, much of the blame for that misunderstanding lies at the door of Congress, which made that sort of assertion for years in its determination to capture the elderly vote. But it was never true, never intended to be true, and is now a complete falsehood of which the organized advocates should be ashamed. I am sure they know the truth!

Nevertheless, regardless of how many advocates for the elderly descend on the hearings bearing petitions and pleas to Congress to "save medicare" or "save Social Security," action must be taken soon, and the longer it is delayed, the worse will be the pain when the problem is finally faced.

The working population can no longer be expected to pay all the cost of Medicare for those of us who are beneficiaries. Those of us who can must also accept our share. And Congress should keep in mind that there are many more of them than there are of us!

It seems to me that a reasonable approach would be to make a charge, deductible from Social Security monthly pension benefits like the charge for Part B, to people who can afford it. It could be levied on taxable incomes of, for example, $40,000 or $50,000 or more and perhaps graded up somewhat for those with taxable incomes exceeding $100,000, $150,000 and $200,000.

Charges could be made for Part A, and perhaps higher charges for Part B also if they are needed. And at that level, the impoverished elderly and the lower income half of the "middle class" would escape most of it. If taxable incomes would be too difficult to keep track of, adjusted gross incomes could be used, beginning at somewhat higher levels. Consideration could be given to higher income floors for couples.

○