THE 2007 MEDICARE TRUSTEES REPORT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

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THE 2007 MEDICARE TRUSTEES REPORT

WEDNESDAY, APRIL 25, 2007

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:08 p.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (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
April 18, 2007
HL–8

CONTACT: (202) 225–3943

Health Subcommittee Chairman Stark Announces a Hearing on the 2007 Medicare Trustees Report

House Ways and Means Health Subcommittee Chairman Pete Stark (D–CA) announced today that the Subcommittee on Health will hold a hearing on the 2007 Medicare Trustees report. **The hearing will take place at 2:00 p.m. on Wednesday, April 25, 2007, in Room 1100, Longworth House Office Building.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from the invited witness only. 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:

The Social Security Act requires the Board of Trustees for the Medicare program to report annually to the Congress on the current and projected financial condition of the Hospital Insurance (HI) and the Supplementary Medical Insurance (SMI) trust funds. The Trustees, who are designated in statute, include the Secretary of the Treasury (who is the Managing Trustee), the Secretary of Labor, the Secretary of Health and Human Services, the Commissioner of Social Security and the Administrator of the Centers for Medicare and Medicaid Services (CMS). In addition, the statute requires that there be two public trustees, both of whom cannot be from the same political party, who are appointed by the President and confirmed by the Senate for 4-year terms. The CMS Office of the Actuary, led by Chief Actuary Richard Foster, is responsible for preparing the report. The *2007 Annual Report* is scheduled to be released on Monday, April 23.

Ensuring the sound management of Medicare is one of Congress' most important responsibilities. This annual report provides a valuable update on the program's status and important information with respect to projections of future expenditures, enrollment and other trends.

In addition, the 2003 Medicare legislation (P.L. 108–173) created a new mechanism based on a designated threshold to cap Medicare's funding. Accordingly, when the Trustees project that at least 45 percent of Medicare's funding will come from general revenues within seven years, a warning is issued. The 2006 report contained the first official warning that the projection is in sight. If the 2007 report contains the second consecutive warning, President Bush will be required in 2008 to send Congress legislation with Medicare payment reductions to keep general revenue spending below the threshold. This legislation is given expedited consideration in the Congress.

In announcing the hearing, Chairman Stark stated, **"Medicare is a vital program that serves 44 million beneficiaries and provides peace of mind for them and their family members. While the program faces fiscal challenges due to changing demographics and special interest payments, there is no reason we can't work on a bipartisan basis to protect and strengthen this important social compact with America's families, just as Congress has done since Medicare's creation in 1965."**

FOCUS OF THE HEARING:

The hearing will focus on the 2007 Medicare Trustees Report.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "*110th Congress*" from the menu entitled, "*Committee Hearings*" (*http://waysandmeans.house.gov/Hearings.asp?congress=18*). Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record*." Once you have followed the online instructions, completing all informational forms and clicking "submit" on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You ***MUST REPLY*** to the email and ***ATTACH*** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business **Wednesday, May 9, 2007**. **Finally**, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item 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 submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

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. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov*.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman STARK. If our guests would find a comfortable seat, we will commence the hearing on the 2007 Trustees' Report on the financial condition of the Medicare Program.

We have with us Mr. Richard S. Foster, Rick Foster, the chief actuary of the Centers for Medicare and Medicaid Services, from Baltimore. He is not a stranger to our Committee. He has been helping us for many years.

Thank you, Mr. Foster, for being here.

The Trustees' Report is a tool that helps us try and decide what to do about the Medicare Program, and we haven't done much adjusting in recent years. As we review your report this year, we will begin to oversee Medicare and try to ensure its continued viability for the future.

I would like to start by paraphrasing Mark Twain, saying that the report of Medicare's demise has been greatly exaggerated, but despite some gloom and doom forecasts, the report of the trustees doesn't show any disasters and perhaps can give us some ideas to keep it solvent and sustain it. While we face undeniable demographic challenges, increased cost challenges, the 45 percent trigger warning we keep hearing is, I think, little more than an attempt to both get us to turn away from Medicare as an entitlement.

Since Medicare's creation, we have regularly modernized the program to accommodate advances in medicine. For a growing population, one that is growing older and, in many cases in the last years, sicker—and we are going to return to that process—the private plans don't have their own fund, and those payments for Medicare Advantage are drawn from the regular trust funds, and there are some major implications there.

Overpayments are directly negatively affecting the solvency in the general revenues for Medicare, and it is something we will have to look at.

The report does highlight a large migration in the coming years from the traditional fee-for-service plans, and we can see how the plans have overtaken physician spending, for example, and are now second only to hospitals in terms of the provider costs.

The report also highlights that part B spending is artificially understated because the trustees are forced to assume continuation of the current law under which the physicians are scheduled to get a 10 percent cut next year and nearly a 5 percent cut each of the following 8 years. I think it is pretty clear that the political climate won't allow that to happen to such an extent.

So, we have our work cut out for us. I think most of us agree that all payments and all providers are going to have to be reviewed, and I look forward to working with my colleagues on both sides of the aisle and the administration to see if we can balance the competing priorities and enact a Medicare policy that is good for the beneficiaries, the taxpayers, and fair to the providers.

A big job ahead of us, and I look forward to the assistance of my Ranking Member, Mr. Camp, and I look forward to his comments.

Mr. CAMP. Thank you very much, Mr. Chairman, for holding today's hearing. I also want to welcome CMS Chief Actuary Rick Foster, who will testify about the 2007 Medicare trustees Report.

Having seen the report, which was released on Monday, the long-term solvency of Medicare isn't getting any better. The Health Insurance Trust Fund, which finances Medicare part A, is now projected to be exhausted by 2019. The Supplementary Medical Insurance Trust Fund, which finances both part B and Part D, continues to grow at a rate that is greater than both the rate of growth in private insurance and total national health expenditures.

Unlike part A, part B of Medicare does not face insolvency, but that is only because the program gets its funding from beneficiaries' premiums and general revenue. Because of the rapid growth in part B spending, beneficiary premiums have significantly increased over the last 4 years. Further growth in part B spending can only mean dramatically greater costs for both Medicare beneficiaries and taxpayers.

I also want to briefly discuss what I believe will be a topic during today's hearing, the 45 percent trigger. This is the second year Medicare trustees have signaled that program outlays will be comprised of at least 45 percent of general revenue funds, and under statute both the President and Congress must respond to this warning next year.

I think it is important that Congress not pass on an opportunity to bring real reform to Medicare. We can't afford to wait any longer because financial pressures threatening Medicare only grow greater with each passing year.

One positive item in the Trustees' Report highlights how we can potentially strengthen and improve the Medicare Program. Program costs for Part D are 30 percent lower than what was projected when the Medicare Modernization Act was passed in 2003, and in 2007 alone plan bids came in 10 percent lower than the previous year. To me, this is evidence that competition is working.

Participating plans have successfully negotiated with drug companies and pharmacies to offer plans to seniors at lower cost. Part D is the only part of Medicare that has a lower rate of growth than expected.

Some commentators have suggested that with different parties controlling the legislative and executive branches of government it is unlikely that we will enact any serious health care legislation this year. I still recall, however, a divided Federal Government came together to make difficult choices in the past, and this resulted in 1997 in the Balanced Budget Act, which ultimately led to major reforms strengthening and improving the Medicare Program and extended the solvency of the HI Trust Fund.

I certainly hope, Mr. Chairman, that we can work together again to address this new challenge, and I look forward to working with my colleagues as well on both sides of the aisle as well on this issue. I thank you for the opportunity to address this. Thank you.

Chairman STARK. I want to announce that during this period General Petraeus is enlightening the Members on problems in Iraq, and the Chair is one of the few Members in Congress who hasn't signed the secrecy pledge, so I can't go. But my colleagues may be interested, and should be, in hearing what he has to tell us. So, you may notice that they are coming and going.

I have suggested to the minority staff that if they have some written questions that you would like to have on the record, I would be glad to present them to Mr. Foster for you. The same would hold for Mr. Doggett, who I know has constituents who are interested in getting a report on General Petraeus' comments. So, I will try and see that if there are any questions that my colleagues want to have directed to Mr. Foster, we can.

I am again pleased to have you, Rick. I would like you to take as much time as you desire. Normally we talk about 5 minutes, but

you have got a rather major report. So, why don't you just proceed to enlighten us in any way that you feel comfortable.

STATEMENT OF RICHARD S. FOSTER, CHIEF ACTUARY, CENTERS FOR MEDICARE & MEDICAID SERVICES

Mr. FOSTER. Thank you, Mr. Chairman.

Chairman STARK. Pull the mike as close as you can to you.

Mr. FOSTER. Yes, I remember these microphones well.

Chairman Stark and other distinguished Members of the Committee, I really want to thank you for inviting me here to testify today about the financial outlook for the Medicare Program. I will briefly summarize the key points from the new Trustees' Report that just came out this past Monday.

By way of background, let me start off by reminding you that the purpose of the Trustees' Report is to assess the ability, the adequacy of the income of a trust fund and its assets, to ensure that benefits can be paid on time. In particular, while this may be somewhat of a narrow question, it turns out to be a fundamentally important question because unless we have a positive asset balance in a trust fund, then we don't have the statutory authority to make benefit payments.

So, the two are tied together. As I said, it is a narrow, but it is an important one.

It is not the only kind of question that can be asked. For example, we frequently hear questions having to do with, is Medicare sustainable in the long run? Or what is the impact of Medicare on the Federal budget? These are important questions, but they are fundamentally different questions than whether the trust funds are technically solvent or not. Unfortunately, you can't use one answer for the other question because they are just independent of each other.

So, what I will be talking about and what the Trustees' Report is all about is the assessment of the financial status and the ability of a trust fund to pay benefits when they are due.

Medicare has three trust fund accounts. There is one, the Hospital Insurance Trust Fund is well known; and then for the part B and Part D components of supplementary medical insurance, there is a separate account for each part of the program within the Supplementary Medical Insurance Trust Fund.

Of course, there is a Part C of Medicare or Medicare Advantage, but its payments or the payments to those plans are made from the part A and the part B accounts for Medicare. It doesn't have its own separate account.

By law, each trust fund account is separate. In other words, there is no provision that allows shifting revenues or assets from one trust fund account to another. There is no such provision. Consequently, to evaluate the financial status of Medicare, you have to look at each separate account individually and assess the adequacy of its income and assets.

I might add that the trustees make projections under current law; they don't assume any change in the laws regulating the program, and the projections are necessarily uncertain.

If you think about it, health care costs and their rate of increase from one year to the next can be somewhat volatile and, therefore,

hard to project. In addition, they are even more uncertain than normal because of the drug benefit, which is a relatively new program yet. We are starting to get actual experience on it, but it still is quite new. We don't have decades of a track record like we do for Parts A and B. So, the projections, while uncertain, can still provide useful policy information and can be useful in the development of the Medicare Program itself.

I will talk now about the individual accounts and their financial status as shown in the Trustees' Report, starting with the Hospital Insurance Trust Fund.

Most of the financing for this fund, as you know, comes from the HI payroll tax which is part of the FICA and SECA payroll taxes. These rates are set in law and they can't change to accommodate higher or lower spending levels unless the Congress acts to change them.

The hospital insurance financial status has improved slightly since last years Trustees' Report, but it remains fairly poor, I have to say. Costs for hospital insurance are expected to exceed the tax revenues to the trust fund in this year, 2007, and all future years. The difference, the shortfall, can be met for a while by using the interest earnings on the invested assets and also by redeeming those assets themselves, but in 2019, as you mentioned, Mr. Chairman, the assets would be totally depleted, and at that point, if there is no corrective action, we could not pay all the benefits that are owed on time. The 2019 depletion date, incidentally, is estimated at 1 year later than the estimate from a year ago.

At the end of the trustees' long-range 75-year protection period the schedule tax revenues for hospital insurance are expected to be sufficient to cover only less than one-third of the projected HI expenditures, so that signifies a very large actuarial deficit, which we are seeing just the beginning tip of, currently, but it would grow steadily worse.

For supplementary medical insurance and the part B account, here the financing is about 25 percent from beneficiary premiums, with the other 75 percent met by general revenues. Every year we reset or redetermine the premium and general revenue financing for part B, and as a result, income will keep pace with program expenditures and the part B accounts in the trust fund will never go broke.

A concern has been raised, however, about the rate of part B expenditure growth. For example, over the last 6 years, on average, part B expenditures went up by about 11 percent per year. In addition, for part B, as you know, there is a major problem with the mechanism for paying physicians under Medicare—the sustainable growth rate mechanism.

Under current law it would require us to reduce physician fees under Medicare by 10 percent at the start of 2008; and then at the start of 2009, we would have to reduce them another 5 percent; and at the start of 2010 another 5 percent beyond that, et cetera, for about another 8 or 9 years. Collectively, that would result in a reduction in physician fees of 41 percent in 2016, compared to today's level, so not only no increases, but a 41 percent reduction.

That situation is clearly implausible, and the Congress has overridden scheduled reductions for each of the last 5 years; and frank-

ly, I think you all are pretty likely to continue doing so in the future. What that means, however, is that the actual part B expenditures are quite likely to exceed the projected amounts shown in the Trustees' Report, which are based on current law, including all those reductions in physician payments, and in the longer run, the understatement in the Trustees' Report might well be in the range of 25 to 40 percent, so a fairly serious understatement.

Turning to the Part D account in the Supplementary Medical Insurance Trust Fund, Part D financing is similar to part B in that it comes from enrollee premiums, which currently cover about 7 percent of program costs; but that percentage will increase somewhat over time. General revenues provide the lion's share of the financing, currently about 82 percent, and then the payments, special payments by the States on behalf of the dual Medicare-Medicaid beneficiaries, those currently account for about 11 percent of total program costs. But that share will decline somewhat over the next 10 years.

The good news about Part D is that the cost estimates have come down significantly, and over the first 10 years of the projection, they are now 13 percent lower, or about $127 billion, than what we estimated for the same period a year ago. I can describe for you the reasons for this difference in the estimates once we get to the questions and answers.

Part D will also be an automatic financial balance, like part B, because we have this annual redetermination of the beneficiary premiums and the general revenue financing, so we won't have this trust fund going broke either. But it is important to note that we do project costs to grow fairly quickly in Part D over the next 10 years, averaging about 12.6 percent per year, with a bit over a third of that due to more enrollment and the balance due to increases in the per capita cost.

There is a basic challenge in financing Medicare or health insurance plans of just about any kind. It is not unique to Medicare, but that is, if you think about how the expenditures increase, health care costs grow if you have more people who are eligible for the coverage, for the benefits. They also grow based on increases in the price per medical service performed, and that typically reflects wages and price increases. But beyond that, as well, beneficiaries tend to use more services over time. The utilization goes up, and moreover, the intensity of those services or the average complexity goes up also. That is a function largely of technology.

Every year smart people invent new services, new techniques, new drugs, whatever, and we as the consumers of them want those because they make us in better health.

So, for all of those reasons, health care costs tend to increase at a faster rate, say, than our incomes or the national economy, and that causes a financing pressure. It makes it harder and harder over time to pay for the health insurance programs.

On top of that, of course, we have the demographic problems that are fairly well known at this point. With the retirement of the baby boom population, the number of beneficiaries will increase much faster than the number of workers, and in addition, as the baby boom generation ages, they will move into the higher ages where

health care costs grow the fastest or are the highest. That will contribute also.

For Medicare, in total, currently the expenditures represent about 3.1 percent of gross domestic product, or the total size of the economy; but by the end of the trustees' long-range projection period that cost level has grown to 11 percent under their intermediate assumptions.

Let me say just a couple words about the 45 percent trigger that has gotten so much attention this year. This was enacted as part of the Medicare Modernization Act in section 801, and the next couple sections as well, and it works as follows:

If the difference between Medicare expenditures and what is referred to as the "dedicated revenue sources"—and by that, I mean the payroll taxes, the premiums, the State payments, and the small amount of revenue we get from income taxes on Social Security benefits—so if those four dedicated revenue sources fall short of total expenditures to the extent of 45 percent, if the difference is at least 45 percent and is projected to get there within the first 7 years of the projection, then that prompts a determination by the trustees of excess general revenue Medicare funding.

Now if that determination is made in two consecutive Trustees' Reports, as it was—for example, the 2006 report had such a determination of excess general revenue Medicare funding, and we have now had a second consecutive determination in the 2007 report. When that happens, it triggers a, quote, "Medicare funding warning." So, this funding warning is now met or triggered for the first time with this report.

The Medicare funding warning requires that the President submit legislation designed to respond to the warning, and he has 15 days after the next budget submission to do that. In this case, that would be the fiscal year 2009 budget that comes out in early February 2008. So, either as a part of that budget or within 15 days afterward the President must submit the legislation, and then Congress is required to consider the legislation on an expedited basis under special rules.

The test itself is a little more complicated, perhaps, than I might prefer, but I would characterize it as a useful measure, useful indication of the magnitude of the general revenue financing that is provided under current law for Medicare.

For many years, hospital insurance always got the attention because the HI Trust Fund was always going broke or threatening to go broke. The Parts B and D of Medicare, which were, in fact, increasing at a faster rate than part A, got relatively little attention.

So, I think the intent of this new test, this new funding warning, was to call more attention to the magnitude of the general revenue financing and to the impact on the Federal budget; and I think it useful in that regard.

We have to be careful, however, because a Medicare funding warning, despite its title, should not be interpreted as an indication that trust fund financing is inadequate. It is not that kind of measure. That sort of assessment can only be made, as I mentioned, by looking at each account individually and assessing the adequacy of its financing and assets.

Let me finish up by saying that based on the projections in the 2007 Trustees' Report, the Medicare board of trustees recommends prompt attention to the financial challenges facing Medicare.

Chairman Stark, as you well know, for many, many years, really, many decades, the Office of the Actuary at CMS has helped Congress and the administration in analyzing the financial situation and what might be done about it; and I would just like to pledge the Office of the Actuary's continuing assistance to Congress as you continue to strive to solve these challenges.

I would happy to answer any questions that you might have.

[The prepared statement of Mr. Foster follows:]

The Financial Outlook for Medicare

Testimony before the
House Committee on Ways and Means, Subcommittee on Health
April 25, 2007

by

Richard S. Foster, F.S.A.
Chief Actuary
Centers for Medicare & Medicaid Services

Chairman Stark, Representative Camp, distinguished Subcommittee members, thank you for inviting me to testify today about the financial outlook for the Medicare program as shown in the newly released 2007 annual report of the Medicare Board of Trustees. I welcome the opportunity to assist you in your efforts to ensure the future financial viability of the nation's second largest social insurance program—one that is a critical factor in the income security of our aged and disabled populations.

The financial outlook for the Medicare program, as shown in the new Trustees Report, is not markedly different from the findings in last year's report. Overall, the outlook is slightly better, with actual costs in calendar year 2006 of $408 billion, which was 5.6 percent lower than previously estimated. Most of this difference is attributable to lower actual costs for the new prescription drug benefit under Part D, together with a decline in the number of inpatient hospital admissions during the year.

The financial status of the Medicare trust funds must be evaluated separately for each fund and for each account within the funds. I will first summarize the Trustees' findings for the separate accounts and subsequently address the overall cost of Medicare and the "Medicare funding warning" that is triggered this year.

The Hospital Insurance (HI) trust fund does not meet the Trustees' formal test for short-range financial adequacy for the fourth year in a row. The depletion of the HI trust fund, which had been projected for 2018 in last year's Trustees Report, is now projected to occur in 2019. HI tax revenues are projected to fall increasingly short of program expenditures in 2007 and later, eventually covering less than one-third of estimated costs by the end of the Trustees' 75-year projection period.

The Medicare Modernization Act (MMA) created two separate accounts within the Supplementary Medical Insurance (SMI) trust fund—one for Part B, which continues to cover the traditional SMI services, and one for the new Part D, which provides subsidized access to prescription drug coverage. Because of the annual redetermination of financing for both Parts B and D, each account will remain in financial balance indefinitely under current law. SMI costs, however, are projected to continue increasing at a faster rate than the national economy and beneficiaries' incomes, raising concerns about the long-range affordability of scheduled financing.

Background

Over 43 million people were eligible for Medicare benefits in 2006. HI, or Part A of Medicare, provides partial protection against the costs of inpatient hospital services, skilled nursing care, post-institutional home health care, and hospice care. Part B of SMI covers most physician services, outpatient hospital care, home health care not covered by HI, and a variety of other medical services such as diagnostic tests, durable medical equipment, and so forth. SMI Part D provides subsidized access to prescription drug insurance coverage as well as additional drug premium and cost-sharing subsidies for low-income enrollees. A Part D subsidy is also payable to employers who provide qualifying drug coverage to their Medicare-eligible retirees.

Only about 22 percent of Part A enrollees receive some reimbursable covered services in a given year, since hospital stays and related care tend to be infrequent events even for the aged and disabled. In contrast, the vast majority of enrollees incurred reimbursable Part B costs because the covered services are more routine and the annual deductible for SMI was only $124 in 2006. We don't yet have data indicating the proportion of Part D enrollees with reimbursable costs, but the percentage is expected to be high, given the prevalence of prescription drug use by aged and disabled beneficiaries and the preponderance of zero-deductible plans.

The HI and SMI components of Medicare are financed on totally different bases. HI costs are met primarily through a portion of the FICA and SECA payroll taxes.[1] Of the total FICA tax rate of 7.65 percent of covered earnings, payable by employees and employers, each, HI receives 1.45 percent. Self-employed workers pay the combined total of 2.90 percent. Following the Omnibus Budget Reconciliation Act of 1993, HI taxes are paid on total earnings in covered employment, without limit. Other HI income includes a portion of the income taxes levied on Social Security benefits, interest income on invested assets, and other minor sources.

SMI enrollees pay monthly premiums ($93.50 for the standard Part B premium in 2007, and an average base premium level of $27.35 for Part D in 2007). For Part B, the monthly premiums cover a little more than 25 percent of program costs with the balance paid by general revenue of the Federal government and a small amount of interest income. Beginning in 2007, there is a higher "income-related" Part B premium for those individuals and couples whose modified adjusted gross incomes exceed specified thresholds. When the income-related premium is fully phased in (in 2009), beneficiaries exceeding the threshold will pay premiums covering 35, 50, 65, or 80 percent of the average program cost for aged beneficiaries, depending on their income level, compared to the standard premium covering 25 percent. Part D costs are met through monthly premiums, which on average will cover 25.5 percent of the cost of the basic coverage, with the balance paid by Federal general revenues and certain State transfer payments.

The Part A tax rate is specified in the Social Security Act and is not scheduled to change at any time in the future under present law. Thus, program financing cannot be modified to match variations in program costs except through new legislation. In contrast, the premiums and general revenue financing for both Parts B and D of SMI are reestablished each year to match

[1] Federal Insurance Contributions Act and Self-Employment Contributions Act, respectively.

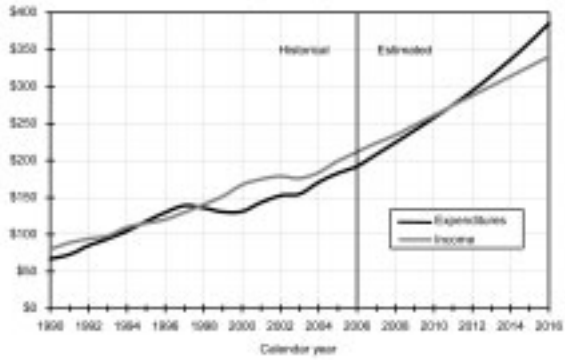
estimated program costs for the following year. As a result, SMI income automatically matches expenditures without the need for legislative adjustments.

Each component of Medicare has its own trust fund, with financial oversight provided by the Board of Trustees. My discussion of Medicare's financial status is based on the actuarial projections contained in the Board's 2007 report to Congress. Such projections are made under three alternative sets of economic and demographic assumptions, to illustrate the uncertainty and possible range of variation of future costs, and cover both a "short range" period (the next 10 years) and a "long range" period (the next 75 years). The projections are not intended as firm predictions of future costs, since this is clearly impossible; rather, they illustrate how the Medicare program would operate under a range of conditions that can reasonably be expected to occur. It is important to note that the results shown in this year's report are significantly more uncertain than those in past reports prior to enactment of the MMA. In particular, the Part D projections are estimated with only limited actual program experience. In addition, the Part B cost projections almost certainly understate the actual future cost of this component, due to the impact of the "sustainable growth rate" payment mechanism for physician services under current law. The projections shown in this testimony are based on the Trustees' "intermediate" set of assumptions.

Short-range financial outlook for Hospital Insurance

Chart 1 shows HI expenditures versus income since 1990 and projections through 2016. For most of the program's history, income and expenditures have been very close together, illustrating the pay-as-you-go nature of HI financing. The taxes collected each year have been roughly sufficient to cover that year's costs. Surplus revenues are invested in special Treasury securities—in effect, lending the cash to the rest of the Federal government, to be repaid with interest at a specified future date or when needed to meet expenditures.

Chart 1—HI expenditures and income
(in billions)



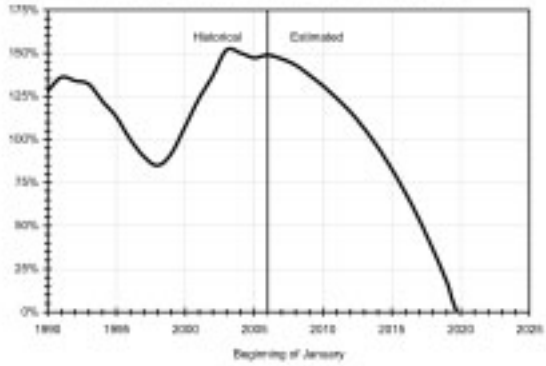
During 1990-97, HI costs increased at a faster rate than HI income. Expenditures exceeded income by a total of $17.2 billion in 1995-97. The Medicare provisions in the Balanced Budget Act of 1997 were designed to help address this situation. As indicated in chart 1, these changes—together with subsequent low general and medical inflation and increased efforts to address fraud and abuse in the Medicare program—resulted in a decline in Part A expenditures during 1998-2000 and trust fund surpluses totaling $61.8 billion over this period. After 2000, Part A expenditures and income converged slightly, as the Balanced Budget Refinement Act and the Benefit Improvement and Protection Act increased Part A expenditures and the 2001 economic recession resulted in lower payroll tax income for Part A.

Starting in 2004, the Medicare Modernization Act increased Part A expenditures, through higher payments to rural hospitals and to private Medicare Advantage health plans. Moreover, the growth rate of expenditures is expected to continue to exceed growth in revenues.[2] Total HI income, including interest earnings, is expected to be less than expenditures in 2011 and all years thereafter. (HI tax revenues alone are estimated to fall short of total expenditures beginning this year.) Note that even relatively small changes in growth trends for either income or expenditures could have a very significant impact on the projected difference between these cash flows. In particular, the onset of deficits in the HI trust fund could easily occur several years earlier or later than this intermediate projection.

Chart 2 shows the past and projected assets of the HI trust fund as a percentage of annual expenditures. The Board of Trustees has recommended maintaining HI assets equal to at least 1 year's expenditures as a contingency reserve.

Chart 2—HI trust fund assets

(assets at beginning of year as percentage of annual expenditures)



[2] Health care costs, including those for Medicare, increase in proportion to the number of beneficiaries, the increase in the average price per service, the number of services performed ("utilization"), and the average complexity of services ("intensity"). In contrast, HI payroll tax revenues increase only as a function of the number of workers and the increase in average earnings.

As indicated in chart 2, HI assets at the beginning of 2007 represented 147 percent of estimated expenditures for the year. Future asset growth, reflecting the diminishing difference between income and expenditures described above, is projected to be significantly slower than expenditure growth in 2007 and later. After 2010, as assets are drawn down to cover the annual deficits, the trust fund balance would decline and would be exhausted in 2019 under the Trustees' intermediate assumptions.

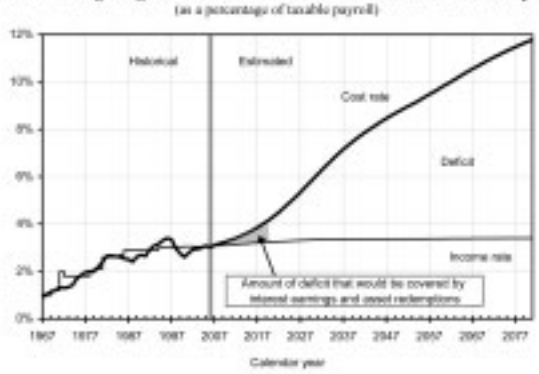
The projected exhaustion date for the HI trust fund is 1 year later than in last year's report, due to slightly higher projected payroll tax income and slightly lower projected benefits than previously estimated.

Long-range financial outlook for Hospital Insurance

The interpretation of dollar amounts through time is very difficult over extremely long periods like the 75-year projection period used in the Trustees Reports. For this reason, long-range tax income and expenditures are expressed as a percentage of the total amount of wages and self-employment income subject to the HI payroll tax (referred to as "taxable payroll"). The results are termed the "income rate" and "cost rate," respectively. Projected long-range income and cost rates are shown in chart 3 for the HI program.

Past income rates have generally followed program costs closely, rising in a step-wise fashion as the payroll tax rates were adjusted by Congress. Income rate growth in the future is minimal, due to the fixed tax rates specified in current law. Trust fund revenue from the taxation of Social Security benefits increases gradually, because the income thresholds specified in the Internal Revenue Code are not indexed. Over time, an increasing proportion of Social Security beneficiaries will incur income taxes on their benefit payments.

Chart 3—Long-range HI income and costs under intermediate assumptions
(as a percentage of taxable payroll)



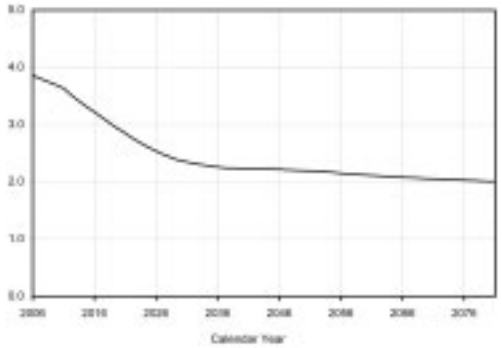
Past HI cost rates have generally increased over time but have periodically declined abruptly as the result of legislation to expand HI coverage to additional categories of workers, raise (or eliminate) the maximum taxable wage base, introduce new payment systems such as the inpatient prospective payment system, etc. Cost rates decreased significantly in 1998-2000 as a result of the Balanced Budget Act provisions together with strong economic growth. After 2000, however, cost rates increased, partly as a result of the Balanced Budget Refinement Act and the Benefit Improvement and Protection Act. After 2007, cost rates are expected to continue increasing and to accelerate significantly as the baby boom generation enrolls in Medicare, beginning in about 2010. By the end of the 75-year period, scheduled tax income would cover only 29 percent of projected expenditures.

The average value of the financing shortfall over the next 75 years—known as the actuarial deficit—is 3.55 percent of taxable payroll. For illustration, this deficit could be closed by an immediate increase of 1.78 percentage points in the HI payroll tax rate, payable by employees and employers, each. If, instead, no changes were made until the year of asset exhaustion, then the HI payroll tax rate would require an increase of about 2.30 percent (employees and employers, each). Note, however, that such changes would correct the deficit only "on average." Initially, HI revenue would be significantly in excess of expenditures, but by the end of the period, only about one-third of the projected annual deficit would be eliminated. The long-range deficit could also be eliminated by many other approaches involving revenue increases and/or expenditure reductions, but its magnitude poses a very daunting challenge to policy makers.

Per-person HI costs are expected to increase faster than per-worker tax revenues due to the health care price inflation and increases in the utilization and intensity of services. Collectively, these factors generally exceed the growth in average earnings per worker, on which HI taxes are based. Important demographic factors contribute further to this growth differential. The effect of the baby boom generation on Medicare and Social Security is relatively well known, having been discussed by actuaries and others for more than 30 years. Basically, by the time the baby boom cohorts have enrolled in Medicare, there will be nearly twice as many HI beneficiaries as there are today, but the number of covered workers will have increased by only about 20 percent. When the HI program began, there were 4.5 workers in covered employment for every HI beneficiary. As shown in chart 4, this ratio was about 3.9 workers per beneficiary in 2006. When the baby boom joins Medicare, the number of beneficiaries will increase more rapidly than the labor force, resulting in a decline in this ratio to about 2.4 in 2030 and 2.0 by 2080 under the intermediate projections. Other things being equal, there would be a corresponding increase in HI costs as a percentage of taxable payroll.

There are other demographic effects beyond those attributable to the varying number of births in past years. In particular, life expectancy has improved substantially in the U.S. over time and is projected to continue doing so. The average remaining life expectancy for 65-year-olds increased from 12.4 years in 1935 to 17.8 years currently, with an estimated further increase to about 22 years at the end of the long-range projection period. Medicare costs are sensitive to the age distribution of beneficiaries. Older persons incur substantially larger costs for medical care, on average, than younger persons. Thus, as the beneficiary population ages over time they will move into higher-utilization age groups, thereby adding to the financial pressures on the Medicare program.

Chart 4—Workers per HI beneficiary



Financial outlook for Supplementary Medical Insurance Part B

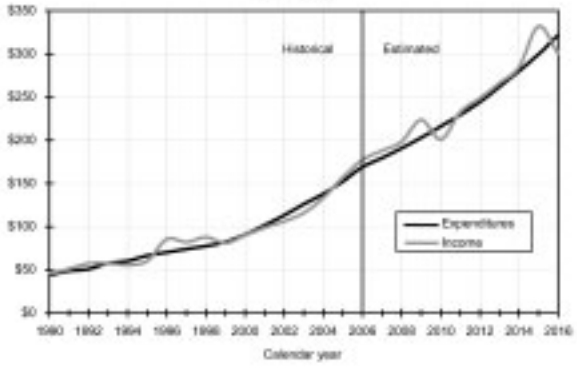
The financial status of the SMI trust fund is very different than for HI, although rapid expenditure growth is a serious issue for both components of Medicare. The Medicare Modernization Act established a separate account within the SMI trust fund to handle transactions for the new Medicare drug benefit. Because there is no authority to transfer assets between the new Part D account and the existing Part B account, it is necessary to evaluate each account's financial adequacy separately.

Chart 5 presents estimates of the short-range outlook for Part B. In contrast to the HI program, the income and expenditure curves for Part B remain closely related in the future. As noted previously, Part B premiums and general revenue income are reestablished annually to match expected program costs for the following year. Thus, the program will automatically be in financial balance, regardless of future program cost trends.[3]

As shown in chart 5, however, Part B expenditures exceeded income during 1999-2004. These deficits resulted in part from greater-than-expected increases in physician, outpatient hospital, and certain other Part B costs. They also occurred as a result of a series of legislative acts that overrode scheduled reductions in Medicare physician fees after the financing rates had already been set for a year. In particular, the Consolidated Appropriations Resolution of 2003 (CAR), the Medicare Modernization Act of 2003, the Deficit Reduction Act of 2005 (DRA), and the Tax Relief and Health Care Act of 2006 all raised Part B costs above the prior-law levels used to establish beneficiary premiums and general revenue financing.

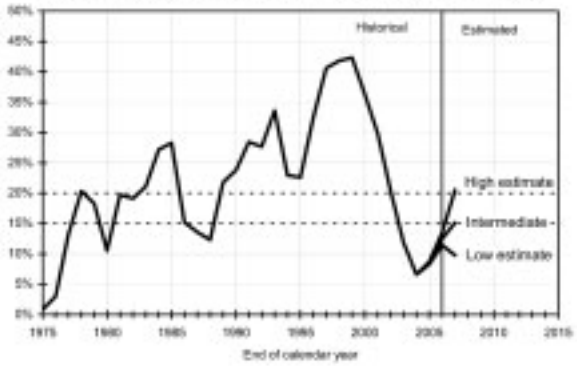
[3] The occasional odd patterns in the projected revenues occur when the normal January 3rd payment date for Social Security benefits falls on a Saturday, Sunday, or holiday. In such cases, payment is advanced to the next earlier business day—which, in certain cases, is December 31 of the prior year.

Chart 5—SMI Part B expenditures and income
(in billions)



The resulting deficits in the Part B account drew down account assets to a level that was well below the range needed for contingency purposes, as shown by the dotted lines in chart 6. Consequently, beneficiary premiums and matching general revenue financing were increased substantially for 2004, 2005, 2006, and 2007.[4] As a result of the legislation listed above, however, progress in restoring Part B assets to an adequate level has been slow, and the contingency reserve is estimated to only just reach the lower end of the desired range at the end of 2007, under current law.

Chart 6—Actuarial status of the Part B account in the SMI trust fund
(assets minus liabilities as percent of following year's expenditures)



4 The increases were 13.4 percent, 17.4 percent, 13.2 percent, and 5.6 percent, respectively, for these 4 years.

The Part B projections for 2008 are based on an estimated physician payment update of –9.9 percent, as would be required under current law, and a 3.1-percent increase in the beneficiary premium and general revenue transfer rate. Accordingly, the account is projected to increase to $48.2 billion by the end of 2008, which would restore contingency reserves to the preferred level. After 2008, the financing margins are set in such a way that the account assets would increase with the estimated expenditures plus a margin, so that the preferred contingency level would be maintained. In the likely event that Congress continues to override the reductions in physician fees that would be required under current law, a greater increase in premium and general revenue financing will be required to match program costs and restore assets to the necessary level.

As suggested by the preceding discussion, the projected Part B expenditures shown in the 2007 Trustees Report are unrealistically low, due to the structure of physician payments under current law. Future physician payment increases must be adjusted downward if cumulative past actual physician spending exceeds a statutory target. By the start of 2003, actual spending was already above the target level. CAR, MMA, and DRA raised physician payments for 2004 through 2006 without raising the allowable target spending to match. The Tax Relief and Health Care Act raised the physician fee schedule update for 2007 and increased the target for 1 year, but specified that the 2008 physician fee update be computed as if the 2007 update had not been changed. Together, these factors yield projected physician updates of –9.9 percent for 2008 and about –5 percent for at least 8 consecutive years, from 2009 through 2016. Because an aggregate 41-percent reduction in physician fees from current levels is implausible, the projected Part B expenditures shown in the 2007 Trustees Report must be considered substantially understated. By extension, costs shown for SMI, and for Medicare in total, are also understated.

Financial outlook for Supplementary Medical Insurance Part D

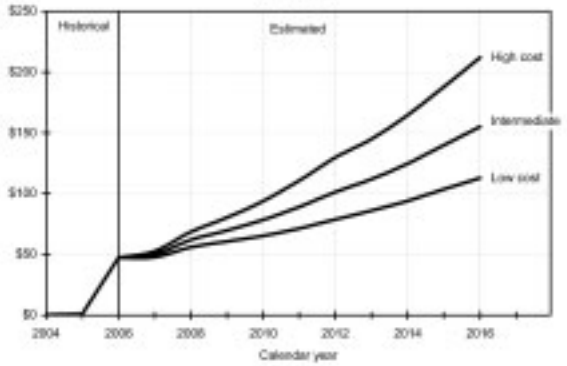
The Medicare Modernization Act introduced the most significant changes to the program since its enactment in 1965. The new prescription drug benefit brings Medicare more in line with modern insurance coverage and medical practice, while providing a valuable new benefit for all beneficiaries who choose to enroll, especially those with low incomes. At the same time, of course, the new drug benefit adds substantially to the overall cost of Medicare.

Beneficiaries obtain Part D drug coverage by voluntarily purchasing insurance policies from stand-alone prescription drug plans or through Medicare Advantage health plans. The costs of these plans are heavily subsidized by Medicare through a combination of direct premium subsidies and reinsurance payments. Medicare provides further support on behalf of low-income beneficiaries and a special subsidy to employers who provide qualifying drug coverage to their Medicare-eligible retirees. The financial risk associated with the private drug plans is shared between each plan and Medicare. Medicare's cost for the various drug subsidies is financed primarily from general revenues. A declining portion of the costs associated with beneficiaries who also qualify for full Medicaid benefits is financed through special payments from State governments.

Chart 7 shows actual Part D costs in 2004-2006 and estimates through 2016. For the Part D program, the financial operations in 2004 and 2005 related only to the prescription drug discount

card and low-income transitional assistance. The general revenue subsidies for this benefit are drawn daily, under a flexible appropriation arrangement. Part D income and outgo are expected to remain in balance automatically, as a result of annual adjustments of premium and general revenue income to match costs.

Chart 7—SMI Part D expenditures and income under alternative assumptions
(in billions)



The Part D expenditure projections shown in the 2007 Trustees Report are significantly lower than those in the 2006 report and substantially lower than the original projections from 2003. The lower actual cost in 2006 and projections for later years arise primarily from the following factors:

- Growth in national per-capita drug costs slowed abruptly in 2004-2006, to about 5 to 6 percent annually or less than half of the prevailing growth rates during the prior decade.

- Plan savings in 2006-2007 from retail price discounts, manufacturer rebates, and utilization management are significantly greater than originally assumed. (The actual savings to date are in line with our prior assumptions for 2010 and later.)

- Plan bids for 2007 were 10 percent lower, on average, than those for 2006. This dramatic change reflects (i) plans' expectations of increasing the proportion of drugs provided through low-cost generic equivalents, and (ii) the intense level of competition among Part D plans.

- Actual Part D enrollment is somewhat lower than original expectations. In addition, many enrollees waited until May 15, 2006 to enroll (the statutory deadline for the first open-enrollment period), making 2006 a partial year of cost experience.

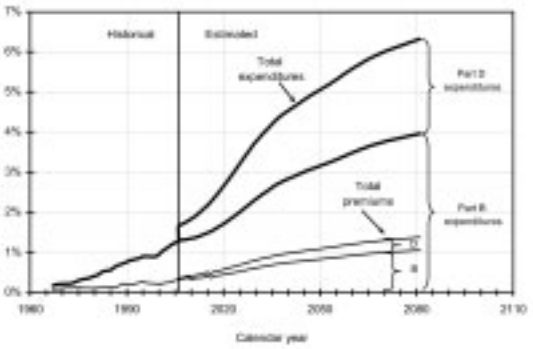
As a result of these factors, the current projections of Part D expenditures are roughly similar to the lower end of the Trustees' original range of projected costs, as shown in the 2004 annual report. The actual future cost of Part D remains uncertain, however, as illustrated by the

projection range shown in chart 7, because only limited data are available to date on the actual operations and cost of the program.[5]

Long-range outlook for Supplementary Medical Insurance overall

Chart 8 shows projected long-range SMI expenditures and premium income as a percentage of GDP. SMI expenditures are projected to increase at a significantly faster rate than GDP, for largely the same reasons underlying HI cost growth. Under current law, Part B beneficiary premiums will cover slightly more than 25 percent of total Part B costs, with the balance drawn from general revenues. Similarly, Part D beneficiary premiums are designed to cover 25.5 percent of the basic Part D benefit, on average, or about 14 percent of total Part D costs; the balance is paid by general revenues and State transfers.

Chart 8—SMI expenditures and premiums as a percentage of GDP



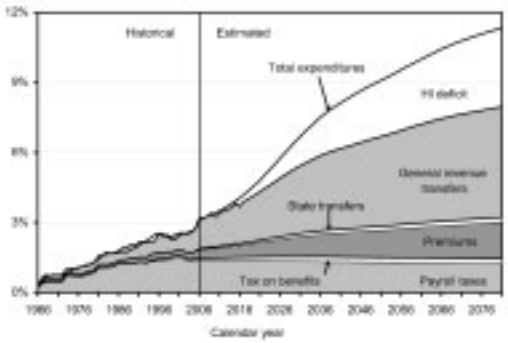
Although SMI is automatically in financial balance, the program's continuing rapid growth in expenditures places an increasing burden on beneficiaries and the Federal budget. In 2010, for example, a representative beneficiary's Part B and D premiums would require an estimated 12 percent of his or her Social Security benefit, and another 18 percent would be needed to cover average deductible and coinsurance expenditures for the year. By 2080, about 28 percent of a typical Social Security benefit would be needed to cover Part B and Part D premiums, and about 44 percent would be required for copayment costs. Similarly, Part B and D general revenues in fiscal year 2010 are estimated to equal over 12 percent of the personal and corporate Federal income taxes that would be collected in that year, if such taxes are set at their long-term, past average level, relative to the national economy. Under the same assumption, projected Part B and D general revenue financing in 2080 would represent over 41 percent of total income taxes.

[5] Actual enrollment data are available, as are the plan bids for 2006 and 2007. These bids are estimates, however, representing the plans' expectations of prescription drug cost and use in the following year. Actual claims experience could differ, and final claims data for 2006 will not be available until later this year.

Combined HI and SMI expenditures

The financial status of the Medicare program is appropriately evaluated for each trust fund account separately, as summarized in the preceding sections. By law, each fund is a distinct financial entity, and the nature and sources of financing are very different between the two funds. This distinction, however, frequently causes greater attention to be paid to the HI trust fund—and especially its projected year of asset depletion—and less to SMI, which does not face the prospect of depletion. It is important to consider the total cost of the Medicare program and its overall sources of financing, as shown in chart 9. Interest income is excluded since, under present law, it would not be a significant part of program financing in the long range.

Chart 9—Medicare expenditures and sources of income as a percentage of GDP

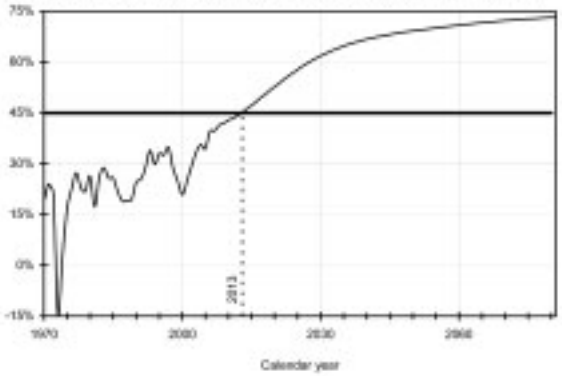


Combined HI and SMI expenditures are projected to increase from 3.1 percent of GDP in 2006 to about 11.3 percent in 2081, based on the Trustees' intermediate set of assumptions. The addition of Part D increased total Medicare costs by about 13 percent in 2006, and this increment is expected to ultimately grow to more than 25 percent. In past years, total income from HI payroll taxes, income taxes on Social Security benefits, HI and SMI beneficiary premiums, and SMI general revenues was very close to total expenditures. Beginning in 2007, overall expenditures are expected to exceed aggregate non-interest revenues, with the growing difference arising from the projected imbalance between HI tax income and expenditures. Throughout the long-range projection period, SMI revenues would continue to approximately match SMI expenditures.

Over time, SMI premiums and general revenues would continue to grow rapidly, since they would keep pace with SMI expenditure growth under current law. HI payroll taxes are not projected to increase as a share of GDP, primarily because no further increases in the tax rates are scheduled under current law. Thus, as HI sources of revenue become increasingly inadequate to cover HI costs, SMI premiums and general revenues would represent a growing share of total Medicare income.

Chart 10 shows the past and projected difference between Medicare's total outlays and its "dedicated financing sources" as a percentage of total outlays. This ratio is estimated to reach 45 percent of outlays in fiscal year 2013, the seventh year of the projection.[6] As a result, under section 801 of the Medicare Modernization Act, the Board of Trustees is issuing a determination of projected "excess general revenue Medicare funding" in this report. Since this is the second consecutive such finding, a "Medicare funding warning" is triggered, which will require the President to submit to Congress, within 15 days after the release of the *Fiscal Year 2009 Budget*, proposed legislation to respond to the warning. Congress is then required to consider the legislation on an expedited basis.

Chart 10—Projected difference between total Medicare outlays and dedicated financing sources, as a percentage of total outlays



Currently, most of the difference between Medicare expenditures and dedicated revenues is financed by the Part B and Part D general revenue transfers provided by law. The remainder of this difference equals the amount by which HI expenditures exceed HI tax income; this gap can be met by using a portion of the interest earnings on the assets of the HI trust fund, which are paid from general revenues.

Over time, the difference between expenditures and revenues is projected to continue to increase under current law—reflecting further growth in statutory general revenue transfers to Medicare, as costs for Parts B and D continue to increase, and also the widening shortfall of HI tax income compared to expenditures. Although the statute labels the total difference as "general revenue Medicare funding," it is important to note that there is no provision in current law to address the projected HI trust fund deficits, once the fund's assets are depleted. In particular, it would not be possible to transfer general revenues to HI to make up the difference.

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[6] The dedicated financing sources are principally HI payroll taxes, the portion of income taxes on Social Security benefits that is allocated to the HI trust fund, beneficiary premiums, and the special State payments to Part D. These sources of dedicated revenues are depicted in the bottom four layers in chart 9.

The comparison of expenditures versus dedicated revenues, as called for by section 801 of the MMA, is a useful measure of the magnitude of general revenue financing for Medicare plus the HI trust fund deficit. Similarly, the test underlying a "Medicare funding warning" can help call attention to the impact on the Federal Budget associated with the general revenue transfers to Medicare. The "Medicare funding warning," however, should not be interpreted as an indication that trust fund financing is inadequate. That assessment can only be made by comparing each trust fund and account's expenditures with all sources of income provided under current law, including the statutory general fund transfers and interest payments.

Conclusions

In their 2007 report to Congress, the Board of Trustees emphasizes the continuing financial pressures facing Medicare and urges the nation's policy makers to take steps to address these concerns. They also argue that consideration of further reforms should occur in the relatively near future, since the earlier solutions are enacted, the more flexible and gradual they can be. Finally, the Trustees note that early action increases the time available for affected individuals and organizations—including health care providers, beneficiaries, and taxpayers—to adjust their expectations.

I concur with the Trustees' assessment and pledge the Office of the Actuary's continuing assistance to the joint effort by the Administration and Congress to determine effective solutions to the financial problems facing the Medicare program. I would be happy to answer any questions you might have on Medicare's financial status.

Chairman STARK. Rick, thank you very much. My staff deeply appreciates your offer of helping us, because as we try and reconcile whatever savings we will have to find in the Medicare Program this year, we are going to need a lot of help estimating a figure that, whatever changes we make, will create in the overall.

I have got a couple of questions that I would like to get through and then a couple on your testimony.

A chart on page 148 shows that growing enrollment and expenditures; that we are getting growing enrollment and expenditure in Medicare Advantage. It seems to me we are spending more, not less, on these private plans than we would spend in the traditional program. Is that a correct assumption?

Mr. FOSTER. Yes, sir. Under the current payment mechanism for Medicare Advantage plans, except in rare circumstances, we end up paying more for those enrollees than we would for the traditional fee-for-service enrollee in the same area.

Chairman STARK. That would be the case during the whole 75-year window? You don't see any way of growing out of this?

Mr. FOSTER. We don't see any change under current law in that regard. The degree of the higher payments would change somewhat, but they would remain higher than the fee-for-service cost.

Chairman STARK. So, in your opinion, if we followed MedPAC's recommendations with respect to the Medicare Advantage plans, the financial condition or outlook for Medicare would be improved?

Mr. FOSTER. Yes. If you mean, by that, their discussion of setting the Medicare Advantage benchmarks equal to the fee-for-service cost in the area, yes, that would reduce costs.

Chairman STARK. Because the part B premiums are based on total part B expenditures, which include payments to the Medicare

Advantage plans, isn't it true that the part B premiums are raised for all beneficiaries even though 80 percent of the beneficiaries aren't in Medicare Advantage plans? In other words, we have to raise the part B premiums on all Medicare beneficiaries to pay for the slightly less than 20 percent who are in Medicare Advantage plans; is that a correct assumption?

Mr. FOSTER. Yes, sir, it is. There is a standard premium for all beneficiaries; and as you know, of course, starting this year, there is also an income-related premium for certain high-income beneficiaries. But the premium is the same for each income category regardless of whether you are in a Medicare Advantage plan or not; and we have estimated that the additional payments to Medicare Advantage plans above and beyond what the fee-for-service cost would have been adds about $2 per month to the standard part B premium.

Chairman STARK. If the Advantage rates had been equalized, do you know whether or not we would have hit the 45 percent trigger in the past 2 years?

Mr. FOSTER. Well, we wouldn't have hit the trigger in the past 2 years because if you had lower expenditures, then the ratio would go down and that would extend when you hit the trigger.

I misunderstood your question. You are saying, would we in fact have

Chairman STARK. Been under the 45 percent?

Mr. FOSTER [continuing]. Been under 45 percent within the 7 years? We might not have. In other words, we might have stayed below the 45 percent.

We could figure that out for you, but we have not actually done the calculation.

Chairman STARK. If it is easy to figure out, I would be curious to know it, but I am not sure that it is a bit of information that will sway a lot of votes.

[The information follows:]

WAYS & MEANS HEALTH SUBCOMMITTEE HEARING
on
THE 2007 MEDICARE TRUSTEES REPORT
APRIL 25, 2007

These are the answers for the record to be inserted into the transcript for this hearing:

MR. STARK – If the Advantage rates had been equalized, do you know whether or not we would have hit the 45 percent trigger in the past 2 years? [been under the 45 percent within the 7 years?]

INSERT: Page 21, line 469

MR. FOSTER – We estimate that if the Medicare Advantage payment benchmarks were set equal to the average fee-for-service cost in each area, then the difference between Medicare expenditures and dedicated revenues would reach 45 percent of expenditures 1 year later than under current law. In this scenario, the threshold would be crossed in 2014, rather than in 2013 as currently projected. Because this would be the eighth year of the Trustees' projection, then a finding of "excess general revenue Medicare funding" would not be made.

A similar result would have occurred with last year's Trustees Report under this scenario. The lower MA payments would have reduced overall Medicare costs without reducing dedicated revenues proportionately (since the largest source of such revenues, HI payroll taxes, would not have been affected). Thus, these changes would have somewhat reduced the portion of costs met through general revenues, thereby delaying when the 45-percentthreshold would be reached by about 1 year.

MR. STARK – You mentioned in the Part D that the costs were about 13 percent below the estimate. Can you tell me what—how much of that reduction, or cost savings, maybe it is figured in, would come because there was lower enrollment than was anticipated?

INSERT: Page 23, line 493

MR. FOSTER – In the 2007 Trustees Report, total incurred Part D expenditures for calendar years 2006 through 2015 are estimated to be 12.8 percent lower than the corresponding amount from last year's report. Of this total reduction, 4.6 percentage points are attributable to lower actual enrollment. The remainder of the total reduction, 8.6 percentage points, is due to other, non-enrollment factors—principally the actual 2007 plan bids that came in at 10 percent below the 2006 bids, on average. Please note that these factors are multiplicative, rather than additive, that is, $(1 - 0.128) = (1 - 0.046) \times (1 - 0.086)$.

Subsequent to the development of the Part D estimates for last year's Trustees Report, we obtained improved data on the number of Medicare beneficiaries with drug coverage through other sources. The principal reason for the lower-than-expected Part D enrollment was that

significantly more beneficiaries had existing drug coverage through Federal employers (for example, the Federal Employees Health Benefit Program) than we had previously thought.

MR. DOGGETT – [Context--As far as the group that is not automatically enrolled, but entitled to extra help, people that are not in Medicaid, are the number that have participated—how do they compare with the number that you estimated in your actuarial estimates originally?] Of the 13 million, did you estimate originally how many you thought would take advantage of the program, would actually be enrolled?

INSERT: Page 33, line 724

MR. FOSTER – In our original estimates for Part D, we had projected that roughly 14.4 million beneficiaries would be eligible for the low-income subsidy in 2006. Of those eligible, we estimated that 10.9 million would be auto- or self-enrolled for the extra assistance. Actual LIS enrollment during 2006 grew from about 9.2 million at the end of the open enrollment period to 9.5 million by the end of the year.

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Mr. FOSTER. I would tend to think that—because in 2013, in the projection currently, we are only slightly above the 45 percent

threshold, it is my guess that the lower payments, if the law were changed in that way, would reduce us below that threshold for 2013—maybe for not a lot longer.

Chairman STARK. If we had lowered the Advantage payments to equalize the fee-for-service rates, what would have been the effect on the solvency projections? Do you know that?

Mr. FOSTER. Yes, sir. If we set the benchmarks at the fee-for-service level, that would reduce part A payments to Medicare Advantage plans, just like part B payments; and we have estimated that would extend the insolvency date for about 2 years.

Chairman STARK. You mentioned in the Part D that the costs were about 13 percent below the estimate. Can you tell me what—how much of that reduction, or cost savings, maybe it is figured in, would come because there was lower enrollment than was anticipated?

Mr. FOSTER. I can provide the specific answer for you for the record. I can tell you less quantitatively that is one of the factors behind the lower estimated cost, but it is also one of the smaller factors.

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Chairman STARK. Are generic drugs one of the factors, higher utilization of generics?

Mr. FOSTER. That is one of the factors actually in two different respects.

If I may elaborate on that, the biggest factor underlying the lower cost estimates that we have today, compared to our original ones from 2003, far and away the biggest factor is that in 2004, 2005 and 2006 the cost growth for prescription drugs per capita in the country at large, not just Medicare, but that cost growth was suddenly only about 5 to 6 percent per year; and that is really only about half, less than half of what it had been for more than a decade prior to that.

So, that was a dramatic slowdown in the rate of cost growth for prescription drugs, and that affected the Part D program as well. So, that is the biggest factor.

Part of that is that the private sector plans—in fact, all drug plans—had a big push to increase the use of inexpensive generic equivalents and to cut back on the use of more expensive brand-name drugs. So, that contributed to this slower growth rate, along with other factors.

In addition to that, another one of the significant differences between the cost estimates had to do with the savings that Part D plans could generate by negotiating favorable retail price discounts, also manufacturer rebates. Through utilization management, we had originally expected such savings could represent 25 percent savings off of a retail level, but we thought it would take competition among plans a few years to reach that ultimate 25 percent. We were pleasantly surprised to find that the plans anticipated about 27 percent in the very first year and again in 2007. So, their savings from the retail discounts, the rebates, and the utilization management were bigger than we thought they would be initially, and similar thereafter.

The last factor has to do with the 10 percent reduction in the bids that you mentioned, Mr. Chairman. This was, again, a welcome surprise and somewhat startling. Drug plan costs generally increase over time, and so when we discovered that the bids, on average, had actually gone down 10 percent in 2007 compared to 2006, it was, as I said, quite a surprise.

Now many of the plans are continuing to push the generic use as a way to keep their costs as low as possible and to be competitive. In addition, we saw many plans in 2006 that had not bid terribly competitively, and as a result, they had relatively high premiums and they weren't competitive. They didn't get much enrollment. Most of those plans came in trying a lot harder in 2007, and in fact, they mostly were able to reduce their bids to a more competitive level.

Chairman STARK. Along that line, however, isn't it correct that the government, if they are overly aggressive in lowering their bids, then Health and Human Services comes in and gives them a subsidy to cover some of the costs so that, in effect, if I am running a drug plan, if I understand this system, if I do a low-ball bid, then I will get extra money from Health and Human Services to cover some of the costs that may result from my bidding too low.

Is that not the way the system works?

Mr. FOSTER. That is pretty close to the way it works.

Chairman STARK. How much would you guess that we are going to end up spending on these so-called risk sharing payments?

Mr. FOSTER. Well, we have had to think about exactly that issue, Mr. Chairman. Because the bids for 2007 were so low, you have to ask yourself, are they overly aggressive, can the plans actually fulfill this level of cost that they are expecting? We decided that at least for some of the plans, on average, they probably cannot for the 2007 bids.

Now, we estimate—based on what are frankly some relatively crude assumptions about how many plans and by how much, we estimate that for the next couple of years, based on the 2007 and 2008 experience, that we will have to pay back to the plans about $1 billion per year, roughly $1 billion.

Chairman STARK. For how long?

Mr. FOSTER. Well, for the experience coming out of 2007 and, again, for the experience coming out of 2008.

For 2006, we actually expect to get money back from the plans because the risk sharing works both ways. If they do better than their bids, they have to share with us on the same terms their extra profits. So, in the first year, for 2006, we expect to receive a modest amount of returned amounts from the plans, but thereafter, about—a little over a billion dollars for 2 years. There is a table in the Trustees' Report that shows these estimates.

Chairman STARK. How about over a longer period of time?

Mr. FOSTER. We expect it to gradually decrease.

It is reasonable to think that there will continue to be a very heavy degree of competition among plans, intense competition, as we have seen so far; and there might continue then to be some degree of either excess optimism, or over aggression or whatever you might want to call it, such that, on average, they might continue bidding a little lower than they can actually achieve in practice.

Now, starting in 2008, the risk-sharing arrangements, the risk corridors, are no longer as favorable from the plan standpoint, so if they lose money from bidding too aggressively, they have to retain more of the loss than they do for 2006 and 2007.

Chairman STARK. Do you want to give me an aggregate figure guess for 10 years?

Mr. FOSTER. We can add it up for you, but it starts off at a little over a billion a year and then quickly goes down to about 0.4 billion. Hang on a second; we will look up the year-by-year figures for you.

Chairman STARK. I have one more question, and I will let my colleagues jump in here.

Mr. FOSTER. Let me go ahead and answer this one for you.

On page 158 of this year's Trustees' Report, we have a table that shows, in the next-to-the-last column, the net amount of risk-sharing payments made by Medicare. For 2007, we expect to pay on behalf—I am sorry, to receive on behalf of—plans experienced in 2006 about $1.2 billion that they have to pay us back.

Within the next year, we estimate having to pay them another 1.2 billion as loss sharing; then 1.1 billion; then 0.9, 0.8, et cetera, and in the tenth year, about 0.7 billion.

Chairman STARK. For a total of——

Mr. FOSTER. I can add it up.

Chairman STARK. Around 7 billion, I am willing to bet you. I can't do that with my shoes and socks on.

Mr. FOSTER. 6.9 billion.

I should introduce who is behind me. This is Paul Patalnek, who is the director of our Part C and D actuarial group, a position created by the MMA.

This is Clare McFarland, the deputy director of our Medicare and Medicaid cost estimates group.

Chairman STARK. Welcome.

Mr. FOSTER. Elizabeth Hall, who I am sure you know.

Chairman STARK. I hope we can see more of you.

Let me just do something on part B, because as I mentioned, we are going do have to deal with the physician reimbursement. But you mentioned that physicians, under current law, which is what you used to base your estimate of the 11 percent per year growth, that their income would have to drop 10 percent.

Now, my guess is that you don't mean income, but you mean their rates per procedure would drop 10 percent.

Mr. FOSTER. Yes. If I said income, I should have said rates per procedure.

Chairman STARK. Therefore, if we are going to have an 11 percent per year growth, unless you assume you are going to get a 10 percent a year increase in the number of docs, is it fair to assume that even in the face of a per-procedure cut, that the physicians may be receiving at least as much or more gross payments or income from the Medicare part B system under fee-for-service?

Mr. FOSTER. It is certainly true that a physician's revenue from Medicare reflects not only the payment per service, but how many services they perform. It also depends on the type of service they perform.

So, for example—and let me mention, 11 percent is the actual historical growth rate on average over the last 6 years—under current law we project—and that was for part B in total, not just physicians, but part B—we project for total part B spending over the next 10 years an average growth rate of 6.6 percent, but that reflects the current law reductions in physician payments.

If Congress continues to override the payment reductions for physicians, then the growth rate would probably be more like 8 to 9 percent.

Chairman STARK. Thank you. Thank you very much.

I am going to recognize, with Mr. English's concurrence, Mr. Doggett, and then Mr. English.

Mr. DOGGETT. Thank you very much. I am glad you are here under less contentious circumstances than your last testimony to the Committee.

If I understand your testimony and the way this 45 percent trigger works, next February we should be receiving a report from the President outlining the steps that he recommends we take, perhaps the cuts in Medicare he had in his budget this time. Or he could propose changing the eligibility age of people, any number of things that would reduce the likelihood of the general revenue needs exceeding this amount.

Mr. FOSTER. That is correct.

Mr. DOGGETT. As to that 45 percent number, my recollection is that we never had a hearing in the House or the Senate to establish it, we never had anyone discuss it, that it was snuck in in the dead of night, or the light of day behind closed doors, in a conference Committee.

Isn't it a rather arbitrary number? Have there been any studies or expert testimony to say that 45 percent is an appropriate trigger figure?

Mr. FOSTER. I, too, was not part of the development of that particular threshold, so I am not in a good position to comment. I will say that it clearly must be judgmental; there is no scientific——

Mr. DOGGETT. Just as the 2 consecutive years is arbitrary and judgmental.

Mr. FOSTER. Yes.

I wouldn't say any of it is unreasonable. I think it is for a worthwhile purpose, but clearly it is judgmental.

Mr. DOGGETT. You discussed this a little with the Chairman about the lower enrollment and the impact that it had on lower-than-expected costs in Part D. Do you have data available on how many of those, as far as the decrease in enrollment, are the low-income, subsidy-eligible or extra-help-eligible individuals?

Mr. FOSTER. Relatively few out of the total difference that has come about between what we originally thought and the actual enrollees, relatively few of those people are in the low-income-subsidy category. We knew, of course, going into it that all of the Medicare-Medicaid dual beneficiaries would be auto-enrolled or facilitated into the program, and we had a pretty good idea about the additional number who would come in. So, that is not a large number.

Mr. DOGGETT. As far as the group that is not automatically enrolled, but entitled to extra help, people that are not in Medicaid, are the number that have participated—how do they compare with the number that you estimated in your actuarial estimates originally?

Mr. FOSTER. Currently, the total number of Part D enrollees who qualify for the low-income assistance is about 9.5 million, and we have estimated at one time or another that the total universe of people who we think would be eligible is about 13 million.

I always have to caution everybody that estimates like that are very hard to do.

Mr. DOGGETT. Of the 13 million, did you estimate originally how many you thought would take advantage of the program, would actually be enrolled?

Mr. FOSTER. Yes, we did; and I don't remember the figure off the top of my head.

Mr. DOGGETT. Is that something you could forward to our staff, because we have a hearing next week that relates to this subject, and I would appreciate getting the number by then.

[The information follows:]

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Mr. DOGGETT. Then on the question of the efficiency of Medicare in fee-for-service, have Medicare's administrative costs remained low?

Mr. FOSTER. Yes, sir. If you look at the total administrative costs for Medicare, including everything that we incur at CMS, as well as what we pay for our intermediaries and carriers and other contractors to help process the claims and all, that total cost is a bit under 2 percent of total expenditures.

Mr. DOGGETT. Is there any private plan in Medicare that comes close to that level of administrative costs?

Mr. FOSTER. No. Virtually no health insurance plan would be that low. We have a giant economy of scale, which helps a lot. We don't have to earn a profit as a government entity, which helps some.

But the other part of it is, we are probably not spending enough. I don't want this to sound like a blatant appeal for more funding, it is not that, but if you look at the private health insurance plans, they put a lot of resources behind tracking their claims experience monthly, or even weekly in some cases, to see how it develops. If they spot something funny involving potential fraud, for example, they are able to act on it very quickly.

CMS is doing a much better job than, say, 5 or 10 years ago, but I would argue we are not doing enough in that regard.

Mr. DOGGETT. Do you have an estimate of what additional amount would be cost productive to expend there?

Mr. FOSTER. No. We don't have such an estimate, but past exercises have indicated you generally get a multiple return on your administrative dollars in this respect.

Mr. DOGGETT. Mainly in looking for fraud?

Mr. FOSTER. Fraud, but also what I would consider abuse.

Let me give you an example. In my office a few years ago we were trying to understand why durable medical equipment costs were going up so quickly. That was the unit that we measured for that category of expenditures, durable medical equipment, and it was increasing much more rapidly than it had been.

So, we looked at the subcategories, and in the process, we discovered that powered wheelchairs, the expenditures on such devices were increasing at about 40 to 50 percent per year for 4 years. So, we called this to the attention of other folks at CMS, and everybody dug into it a bit to see what was happening, and they revised the rules and so forth.

Ideally, somebody—we or somebody else—would have discovered that problem in the first year, not the fifth year, before we had already spent a billion dollars, perhaps excessively, on the devices.

Mr. DOGGETT. Well, could we enlist the assistance of your office in talking to the Congressional Budget Office and working to get some scoreable services on antifraud and abuse investments?

Mr. FOSTER. We would be happy to talk with them and show them some examples of specific initiatives that have worked well.

Mr. DOGGETT. I think that would be helpful. We are trying to find all the savings that we can in order to address some of the needs here.

Then just, finally—and thank you for your consideration on this, Mr. Chairman—we don't have anything in your report, understand-

ably, on the efficiency and administrative expenses of Medicare Advantage plans. Are there any estimates on what their administrative costs are?

Mr. FOSTER. Yes. In fact, I do have some data here for Medicare Advantage plans, and these are broad averages of the plans participating in Medicare, the overall administrative cost, including profits, averages out about 13 percent.

Mr. DOGGETT. So, we probably afford all of the antifraud, antiabuse changes that you could ever conceive of with Medicare's less than 2 percent expense and still have substantial savings over those Medicare Advantage plans.

Mr. FOSTER. Substantial savings?

Mr. DOGGETT. In terms of the administrative costs.

Mr. FOSTER. But there are other components that go into it.

In fact, if it is all right, I will mention just briefly, the private plans have the potential to have a lower cost for the Medicare covered services than fee-for-service if they can do the following:

If they can negotiate more favorable prices for the services they get from their own providers than the Medicare payment rates, or if they can manage care so you avoid some of the unnecessary or harmful services, they can reduce money compared to Medicare fee-for-service. But they have to reduce it enough to offset their disadvantage on the administrative cost, because they have to make a profit and they don't have the economy of scale.

Mr. DOGGETT. Thank you so much for your testimony and your service.

Mr. FOSTER. You are welcome, sir.

Chairman STARK. Mr. English, would you like to inquire?

Mr. ENGLISH. Thank you, Mr. Chairman.

Mr. Foster, thank you for the opportunity to examine a program that obviously has been challenged as long as I have been in the House of Representatives, but with some wrinkles.

Mr. Foster, this year the Trustees' Report significantly lowered their expenditure projections for Part D. I think you have testified that they are 13 percent lower than last year.

How much lower is the 2008 estimate of Part D cost as compared to the original estimate in 2003?

Mr. FOSTER. That I can provide for you for the record. I don't have the figures with me. It would be roughly on the order of 30 percent.

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MR. FOSTER – In our original estimates for Part D, we had projected that roughly 14.4 million beneficiaries would be eligible for the low-income subsidy in 2006. Of those eligible, we estimated that 10.9 million would be auto- or self-enrolled for the extra assistance. Actual LIS enrollment during 2006 grew from about 9.2 million at the end of the open enrollment period to 9.5 million by the end of the year.

With the availability of improved data on beneficiary assets, we revised our estimate of the number of beneficiaries eligible for the low-income subsidy to 13.2 million. It should be noted that the estimate of the number of LIS-eligible beneficiaries continues to be based on survey data and remains fairly rough. (Survey respondents often understate their income and asset levels. While adjustments have been made to compensate for such understatement, they are necessarily imprecise.) Thus, the actual number of individuals eligible for the extra Part D assistance may be somewhat different than our estimate.

MR. ENGLISH – Mr. Foster, this year, the trustees report significantly lowered their expenditure projections for Part D. I think you have testified that they are 13 percent lower than last year. How much lower is the 2008 estimate of Part D cost as compared to the original estimate in 2003?

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MR. FOSTER – Our original estimate for the net total Medicare cost for Part D was $634 billion in fiscal years 2004 through 2013. Our current estimate, based on the 2007 Trustees Report, is $465 billion for the same period, or 27 percent lower. (These figures represent the net cost to Medicare and do not reflect the related Federal savings from reduced Medicaid expenditures, which we no longer estimate.)

MR. THOMPSON – What portion of the decrease in Part D expenditures is due to a lower-than-expected enrollment? And if that is the case, how many of those are low-income, subsidy-eligible individuals, your lack of data notwithstanding?

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MR. FOSTER – About 4.6 percent of the reduction in projected Part D expenditures during calendar years 2006-2015, from the 2006 Trustees Report to the 2007 Trustees Report, was due

to lower actual enrollment by Medicare beneficiaries. A little over half of this impact (2.5 percentage points) was attributable to lower actual enrollment by beneficiaries qualifying for the low-income subsidy. The remainder, (2.1 percentage points) was attributable to lower non-LIS enrollment. As noted previously, the principal reason for the lower-than-expected enrollment was that significantly more Medicare beneficiaries had existing drug coverage through Federal employers (for example, the Federal Employees Health Benefit Program) than we had previously thought.

Mr. ENGLISH. Maybe more.

As you see it, what was the most significant factor for the trustees in their consistently lowering their cost projections for this part of the program?

Mr. FOSTER. The biggest factor is actual data over time.

When you go back to 2003—the latest survey data we had on drug use by Medicare beneficiaries dated back to either 1998 or 1999, so we had to project forward from the late nineties to 2006 as to how the cost would increase over that time.

I think we did a good job of that at the time, but then, as I mentioned earlier, starting in 2004, the annual cost increase per capita dropped abruptly, taking us and virtually everybody else by surprise.

Mr. ENGLISH. I understand your analysis, but isn't it also true that Part D plans were able to actually negotiate deeper discounts from drug manufacturers than the trustees had originally anticipated?

Mr. FOSTER. Yes, sir, that is correct.

Mr. ENGLISH. By what dimension?

Mr. FOSTER. We originally estimated—really, it was an assumption—that ultimately the pharmacy benefit managers, working on behalf of the drug plans, would be able to achieve savings off of retail level of about 25 percent. That represented, roughly, the best experience in PBMs that occurred at the time.

We thought, initially, plans would not get there immediately. We thought the competition would take a few years to develop. So, we had an assumed savings of about 15 percent in the first year, building up to the 25 percent level over a few years.

In real life, when we got the bids for 2006, the actual savings for retail discounts, utilization management, and manufacturer rebates came in at 27 percent, so a little higher than our ultimate assumption was.

Mr. ENGLISH. Mr. Foster, on a different point, the Trustees' Report estimates part B premiums, and it appears to me at least that the estimates are unrealistically low on the strength of the fact that built in is a assumption that current law will not be overridden. That would require Medicare payments to physicians to, in effect, be cut by 10 percent in 2008 and 5 percent for the next 8 years.

I don't think that is going to happen. If Congress modifies these changes, beneficiary premiums necessarily will have to increase.

If Congress were to provide a 1-year fix for physicians, what would the impact be on part B premiums for next year? Looking beyond that, if the SGR were to be eliminated altogether, what would be the consequences for part B premiums paid by seniors to participate in this program?

Mr. FOSTER. Yes, let me give you a specific example to answer your question.

The premium this year, 2007, the standard part B premium is $93.50 per month. We anticipate under current law in the Trustees' Report, as you suggested, that if nothing is done about the physician payments, the premium would have to increase modestly to $96.40 per month for next year. That is about a 3 percent increase.

Now, if instead Congress acts to avoid the 10 percent reduction in physician fees that would occur otherwise under current law and

if you avoid that by providing a zero percent update—in other words, freezing the payment rates at current levels—then the premium would have to increase to $100.50, so about a $4 increase compared to current law.

If instead of the zero percent update, if the update were, say, equal to the Medicare economic index, which is a measure of input costs for physicians, then the premium—and it would be about a 2 or 2.5-percent increase for physicians in that scenario—then the premium would be $101.40. In other words, about a $5 increase.

Mr. ENGLISH. I think that is extremely useful information, because undoubtedly we are going to be under pressure to consider precisely those sorts of changes.

I yield back my time. Thank you, Mr. Chairman.

[3:09 p.m.]

Chairman STARK. Thank you, Mr. English.

Ms. Tubbs Jones, would you like to inquire?

Ms. TUBBS JONES. Thank you, Mr. Chairman. Yes. I would.

Good afternoon, Mr. Foster. How are you?

Mr. FOSTER. Good.

Ms. TUBBS JONES. I want to go back to an area that my colleague from Pennsylvania asked you about earlier with regard to claims information on the Medicare prescription drug program, Medicare Part D. We implemented Medicare Part D. Some of us like it, some of us don't, some of us say it is doing a great job. But your job is to do projections moving forward to help us understand what type of shape the fund is going to be in, right?

Mr. FOSTER. Yes, ma'am.

Ms. TUBBS JONES. So, do you have any numbers at all with regard to Medicare Part D, claims numbers?

Mr. FOSTER. We are only—we being the Office of the Actuaries——

Ms. TUBBS JONES. I understand.

Mr. FOSTER [continuing]. We are now only starting to get the individual claims itself, the individual drug-by-drug claim data. We now have access to it, and we are now starting to look at it and assess its quality. We have other data. We have actual data on enrollments.

Ms. TUBBS JONES. Actual data on what? I am sorry, sir.

Mr. FOSTER. Enrollments. How many people have signed up, what type of people, et cetera. We also have the data from the bids that the Part D plan submit.

Ms. TUBBS JONES. The bids?

Mr. FOSTER. Yes, the bids. As part of the process for the competition, they have to submit a bid by the first Monday or whatever it is in June, and that is the bid. They can't go back and change it. They live or die by how good a bid that is competitively against the other plans.

Now, the bids themselves are their expectations. They are still estimates. They give us a bid in early June, which is their estimate for the following calendar year's cost, but they have a pretty good idea of what those costs ought to be.

So, we have that kind of data, but insofar as what is happening in 2006 so far, we are only now really getting the data we have been wanting.

Ms. TUBBS JONES. Then back when this whole discussion about Medicare Part D began and there were projections, there was a big deal about what the real cost of Medicare Part D was really going to be. Back then it was—I guess the administration had some amount, and somebody else within the administration had a bigger amount, and supposedly that guy ended up losing his job because he said that amount was different than what the administration had originally planned.

I say all that to say that actuaries are pretty—you are pretty—what is the word? You do projections, but you are pretty accurate with those projections. That is why we use actuaries, right?

Mr. FOSTER. Sort of.

Ms. TUBBS JONES. Sort of. Now, wait a minute. If I had you on a witness stand in a case, I wouldn't want you to answer "sort of." What kind of expert would you be, sort of?

Mr. FOSTER. I would be glad to elaborate, ma'am.

Ms. TUBBS JONES. I am saying that to say that the job of actuaries and the reason that we as a nation and a world have come to rely on you is because of the ability you have to take numbers and make some projections.

Mr. FOSTER. It is partly that. It is partly perhaps our foolhardy willingness to undertake such projects. The reality is, of course, the future is uncertain, the future is unknowable. We do the best job we can to try to figure out what costs will be, what trends will be, and in some cases it is easy. If you ask us what would the savings be if we reduced a particular provider of market basket update by 1 percentage point, we can tell you the answer to that quite precisely. On the other hand, if you ask us something like Part D, a new drug benefit, no past experience because the program hasn't existed, it is voluntary, not everybody will sign up, and we don't know how many plans we will get, with all those behavioral questions, that is really hard to estimate.

Ms. TUBBS JONES. So, then you would be better—or we would be better spent, then, to have a section of the report say, well, we are unable to really give you any good projections about Part D right now. Let us—give us another year when we have some real numbers and some real expectations then to be able to make the projections of what kind of shape Medicare or Medicaid is in based on Part D versus all the hoopla we are getting about this is the best program in the world, you know, seniors are real happy, they are getting drug treatment—not drug treatment, maybe they need that, too—but prescription drug coverage and the like.

I am just trying to understand as I try and swallow or understand the report that there are factors such as I am relating to you with regard to Medicare Part D that you really can't tell us what is going on.

Mr. FOSTER. We certainly can't tell you with certainty. The best we can do or the best any actuary can do is to give you an idea, a reasonable idea, of what the cost might be under normal kinds of circumstances. That is a good thing for policymakers like yourself to know about as opposed to saying it is hopeless, let's not even try.

Ms. TUBBS JONES. If you could just give me 1 more second, Mr. Chairman. I know my time is up.

Is there anything else that I should be, as a policymaker, be concerned about that you can't put your arm around on a number, other than Medicare Part D? What else is there that I need to be concerned about?

Mr. FOSTER. The farther we go out with the projections, the less certain they become. We can predict maybe the next 5 years pretty nicely in most cases, but the further out you go, the more opportunity there is for health care costs, health care service and delivery, and the nature of medical practice to change in ways that we can't anticipate now.

Ms. TUBBS JONES. So, you are saying there could be included in this other group of some uncertainty the cost of equipment, the doctors' fees, I don't know what.

Mr. FOSTER. There are literally dozens and dozens of such factors we have to take into account to make these projections. Again, I think they are reasonable to help you in policymaking, but you don't want to bet the farm on our projections being exactly right in 5, 10 years or let alone 50 or 75.

Ms. TUBBS JONES. Mr. Foster, I am a former judge, and I had a lot of experts. You are the most honest actuary I have ever heard from in my life. Thank you very, very much for your testimony.

Mr. FOSTER. Thank you very much, ma'am.

Chairman STARK. Mr. Thompson, would like to inquire?

Mr. THOMPSON. Thank you, Mr. Chairman. I would.

I have a couple of questions for the honest actuary. Thank you for being here.

In your testimony you mentioned that the Part D plans, bids were 10 percent lower in 2007 than in 2006. Are you suggesting that this decrease could be attributed to the plans underbidding their actual cost in an attempt to gain market share?

Mr. FOSTER. It is possible. In other words, it is conceivable that one or more plans would figure out the best they could do and possibly bid a little lower than that in an effort to get the lowest possible premium and to get market share, and knowing that they can rely on the risk-sharing arrangement to keep from losing too much money.

However, they can't get too carried away with this because my staff and I review these bids to make sure that they are plausible, to make sure that they are reasonable. If we spot what looks like a low-ball bid, we go back to them and we give them a hard time, we make them explain it, and often we don't accept it.

Mr. THOMPSON. Given that follow-up or that review, what are your assumptions on future plan bid increases or decreases?

Mr. FOSTER. We expect starting in 2008—and this is more of an assumption than a solid fact of any kind—but we expect starting in 2008 that we will see a more normal kind of increase in the bids.

Mr. THOMPSON. A more normal what?

Mr. FOSTER. Sort of increase in the bids. It would be startling to have another decrease in the bids; not inconceivable, but startling.

When they first went into this in 2006, of course, the plans themselves did not know for a fact what their costs would be. This was a new program for them as well. They might have been a little on

the conservative side to make sure they didn't lose too much money. But now that they are getting some amount of experience in their first year, they had a better idea of where their costs would be in the second and later years, and they will get better with their bidding over time and dial it in.

Mr. THOMPSON. Thank you.

What portion of the decrease in Part D expenditures is due to a lower-than-expected enrollment? If that is the case, how many of those are low-income, subsidy-eligible individuals, your lack of data notwithstanding?

Mr. FOSTER. Right. I will provide a detailed answer for the record, sir. I will give you more of a qualitative answer right now.

Out of the three or four major factors explaining the difference in the cost estimates, the difference in enrollment is the smallest contributing factor. Within that, the low-income subsidy figures on the number of enrollees are not a big factor. But we will provide a more specific answer for you.

[The information follows:]

WAYS & MEANS HEALTH SUBCOMMITTEE HEARING
on
THE 2007 MEDICARE TRUSTEES REPORT
APRIL 25, 2007

These are the answers for the record to be inserted into the transcript for this hearing:

MR. STARK – If the Advantage rates had been equalized, do you know whether or not we would have hit the 45 percent trigger in the past 2 years? [been under the 45 percent within the 7 years?]

INSERT: Page 21, line 469

MR. FOSTER – We estimate that if the Medicare Advantage payment benchmarks were set equal to the average fee-for-service cost in each area, then the difference between Medicare expenditures and dedicated revenues would reach 45 percent of expenditures 1 year later than under current law. In this scenario, the threshold would be crossed in 2014, rather than in 2013 as currently projected. Because this would be the eighth year of the Trustees' projection, then a finding of "excess general revenue Medicare funding" would not be made.

A similar result would have occurred with last year's Trustees Report under this scenario. The lower MA payments would have reduced overall Medicare costs without reducing dedicated revenues proportionately (since the largest source of such revenues, HI payroll taxes, would not have been affected). Thus, these changes would have somewhat reduced the portion of costs met through general revenues, thereby delaying when the 45-percentthreshold would be reached by about 1 year.

MR. STARK – You mentioned in the Part D that the costs were about 13 percent below the estimate. Can you tell me what—how much of that reduction, or cost savings, maybe it is figured in, would come because there was lower enrollment than was anticipated?

INSERT: Page 23, line 493

MR. FOSTER – In the 2007 Trustees Report, total incurred Part D expenditures for calendar years 2006 through 2015 are estimated to be 12.8 percent lower than the corresponding amount from last year's report. Of this total reduction, 4.6 percentage points are attributable to lower actual enrollment. The remainder of the total reduction, 8.6 percentage points, is due to other, non-enrollment factors—principally the actual 2007 plan bids that came in at 10 percent below the 2006 bids, on average. Please note that these factors are multiplicative, rather than additive, that is, $(1 - 0.128) = (1 - 0.046) \times (1 - 0.086)$.

Subsequent to the development of the Part D estimates for last year's Trustees Report, we obtained improved data on the number of Medicare beneficiaries with drug coverage through other sources. The principal reason for the lower-than-expected Part D enrollment was that

significantly more beneficiaries had existing drug coverage through Federal employers (for example, the Federal Employees Health Benefit Program) than we had previously thought.

MR. DOGGETT – [Context--As far as the group that is not automatically enrolled, but entitled to extra help, people that are not in Medicaid, are the number that have participated—how do they compare with the number that you estimated in your actuarial estimates originally?] Of the 13 million, did you estimate originally how many you thought would take advantage of the program, would actually be enrolled?

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MR. THOMPSON – What portion of the decrease in Part D expenditures is due to a lower-than-expected enrollment? And if that is the case, how many of those are low-income, subsidy-eligible individuals, your lack of data notwithstanding?

INSERT: Page 49, line 1092

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to lower actual enrollment by Medicare beneficiaries. A little over half of this impact (2.5 percentage points) was attributable to lower actual enrollment by beneficiaries qualifying for the low-income subsidy. The remainder, (2.1 percentage points) was attributable to lower non-LIS enrollment. As noted previously, the principal reason for the lower-than-expected enrollment was that significantly more Medicare beneficiaries had existing drug coverage through Federal employers (for example, the Federal Employees Health Benefit Program) than we had previously thought.

Mr. THOMPSON. Okay. Thank you.

Then in regard to Medicare Advantage plans, should you expand your work to include more information about—I am talking about the Trustees' Reports, future Trustees' Reports. Should those be expanded to try to capture more information about the Medicare Advantage plans and their impact on the trust funds?

Mr. FOSTER. Yes. I think that would be helpful.

Mr. THOMPSON. How do we do that? Could you just do that? Do I have to ask Mr. Stark to tell you to do that? What do we do?

Mr. FOSTER. Sooner or later we have to ask the Board of trustees just because we write the words for them, just because we make the projections, we draw the graphs and print the report.

Mr. THOMPSON. So, should we send a Subcommittee letter to the Board or something?

Mr. FOSTER. You certainly could.

Mr. THOMPSON. What is the most effective way to get that? Put it in a bill someplace or——

Mr. FOSTER. Well, ultimately if you put it in the bill and it became law, of course, we would follow exactly that. But I think the easiest and best thing to do would be if you would like to send a letter to the Board of trustees asking for specific kinds of information, I am sure the Board would consider it. An even easier way is you just tell me. Have your staff send me a note about the kinds of things you would like to see in there.

Mr. THOMPSON. Could you consider my questioning, then, you being told?

Mr. FOSTER. I beg your pardon?

Mr. THOMPSON. You said tell you. Would you consider my questioning as me telling you?

Mr. FOSTER. Works for me, sir.

Mr. THOMPSON. Thank you. Thank you very much.

I have no further questions, Mr. Stark.

Chairman STARK. Thank you.

I would add to Mr. Thompson's request in that as it—I guess it is now our second largest expenditure group. It is going to become more important for us to know how those expenditures are broken down and what is comprised in them.

I wanted to ask just one other thing that I missed again. We have just started to income-relate the premiums. For the record, it is something to which I objected only because I think the system is already as progressive as it can be. You pay the tax on your income without limit. So, if you make $10 million a year, you pay a huge tax, and you get the same benefit as somebody making $10,000 a year. I don't know why we should make it superprogressive.

But relative to the part B premium change, a couple of questions. Could you tell me how many beneficiaries are being charged higher premium amounts? Do you have any idea of whether or not people are dropping out of Medicare because of the higher premiums? Then just other consequences to the plan that I am not aware of. So, I mean, relative to this kind of new procedure, do we know how many are getting charged? Is there any indication that they are dropping out because of this? Is it behavioral? What does it mean for—I don't suppose it adds much to the part B—it doesn't

change—or will it change what other people will pay? I don't know. Could you enlighten me on that?

Mr. FOSTER. Yes, sir, to an extent. We don't have actual data yet on the number of people paying the higher premium. We will down the road a ways. What we have right now are our estimates of the number of people who would be affected by the income-related premium. Also we do estimate that some people would drop out or have dropped out either because they don't think financially it is a good deal for them, or they are just irritated.

For 2007, the first year of operation for income-related premium, we are estimating that about 2.2 million beneficiaries are subject to the higher premium rate, and that is a little over 5 percent of all the beneficiaries. We further estimate that figure would grow over time, such that in 2016 it would be about 3.2 million, and that is about a little over 6 percent of beneficiaries for that year.

We don't anticipate a large-scale dropout of people from part B as a result of this for many reasons, but we have estimated that initially for 2007 about 11,000 beneficiaries would drop out, and that would increase over time, reaching about 46,000 in 2016.

Chairman STARK. Total or per year?

Mr. FOSTER. That is total, total that would have dropped out.

Chairman STARK. Well, I gather, then, that just the philosophical effect probably would be more than the financial effect on the system.

I want to thank you for most generously offering to be involved in helping us wind our way through. I was talking to Mr. Camp earlier, and I don't know that any of my colleagues on this Subcommittee have gone through the production of a reconciliation bill, and I would have a few senior moments remembering the last time I did. So, we are going to have a learning process here as we try to come to grips with whatever the budget will require us to save, and your staff could be most helpful to us in helping us come to grips with how we gather these numbers.

We, of course, are going to have to sit after some kind of a budget target for our Subcommittee and find those areas that we can dial up or dial down. Let's say we are going to change hospital payments. Then within that, as you recall, we have to deal with rural hospitals a disproportionate share, and teaching. All of those adjustments in kind of a zero-sum game are politically difficult, but they are somewhat easier if we have some idea, particularly in those areas where it is linear, we just have a market basket minus or plus, does it just go up and down in the straight line, or do we have to watch out for unintended consequences on the rest of the closed system.

So, we will take you up on your offer. It was very gracious of you to do that, and we have been having some seminars for the Members and staff, and I think we might—if you and some of your staff would be willing to have you come by and be our instructors for an hour or two when we meet again to get some idea of what we are faced with as we try to make this budget come into balance.

Thank you. Thank your staff. Look forward to working with you the rest of the year. Thanks very much.

Mr. FOSTER. Thank you, Mr. Chairman.

Chairman STARK. The hearing is adjourned.

[Whereupon, at 3:25 p.m., the hearing was adjourned.]
[Submission for the Record follows:]

Statement of AARP

On behalf of AARP's 38 million members we thank you for holding this hearing on the 2007 Medicare Trustees' Report. The annual Report of the Trustees offers an important opportunity for members of Congress to closely examine the financial health of the Medicare program.

Hospital Insurance (HI) Trust Fund

The new insolvency date for the Hospital Insurance (HI) Trust Fund is one year later than projected in last year's report, which means that Medicare beneficiaries' coverage is not in immediate jeopardy. It is important to note that predicting solvency over the long term is very difficult since it depends on estimates of both payroll tax income and health care spending. Part A solvency has averaged 12 years since the program began 36 years ago. In the past, Congress has stepped in to either increase Trust Fund income or decrease spending from the Trust Fund so that the reserves are not depleted.

The Trustees' findings are not unusual for Medicare Part A which has averaged a 12 year solvency projection since the program began 36 years ago (see Chart 1, p. 52).

The HI Trustees' report can be viewed as an early warning system—providing Congress with ample opportunity to act judiciously to strengthen and improve the Medicare program for current and future beneficiaries. This report is no different, but it does highlight the urgent need to control rising costs across the entire health care system—not just within Medicare.

Supplementary Medical Insurance (SMI) Trust Fund

Because the SMI or Medicare Part B Trust Fund is funded by premiums and general tax revenues, it faces cost pressure, but not insolvency. As in the private sector, Part B growth still outpaces the growth in the Gross Domestic Product (GDP) due in large part to growth in physician and hospital outpatient spending. Estimating conventions require the Trustees' baseline to reflect current law, which include significant cuts in physician payments scheduled to take effect as a result of the Sustainable Growth Rate (SGR) formula. Congress has consistently voted to override these mandated reductions since 2003. CMS actuaries have estimated that continuous overrides of the SGR would result in $300-$400 billion in aggregate expenditures in the Part B program over ten years.

Each time Congress overrides the SGR there is a direct cost for Medicare beneficiaries. That's because by law, the monthly Part B premium is set at 25 percent of Part B spending. The Part B premium has doubled since 2000—due in large part to increases in physician spending. The Trustees estimate that premium increases could be as much as 20 percent higher over 10 years if Congress prevents projected reductions in physician payments. Medicare beneficiaries would also pay higher copayments for physician care as payments to physicians increase.

Congress must address the physician payment issue in order to control Part B expenditures and protect Medicare beneficiaries from burdensome out-of-pocket costs. Short-term fixes simply exacerbate spending growth and only delay needed discussions about how to slow rising expenditures. A new Medicare physician payment system should be designed with the beneficiary in mind by holding cost-sharing and premium increases down and improving the care beneficiaries receive. AARP believes Medicare's physician payment system should be changed from one that rewards quantity to one that rewards quality.

Medicare Advantage

Because Medicare Advantage (Part C) plans are required to offer all Part A and Part B benefits, they are paid for from both the HI and SMI trust funds.

The Medicare Trustees note that in 2006 there was a substantial increase in MA enrollment due to higher payments for MA plans provided under the Medicare Modernization Act (MMA). Ultimately, the solvency of the Medicare Trust Funds is negatively affected by current excess payment policies to MA plans.

AARP believes Medicare payments should be neutral with respect to coverage options. Therefore, AARP urges Congress to more closely align MA plan payments with payments for traditional Medicare.

Currently, Medicare payments clearly favor the MA program over traditional Medicare, which is unfair to the majority of beneficiaries who participate in the traditional program. All taxpayers and all Medicare beneficiaries—not just the 18 per-

cent of Medicare beneficiaries enrolled in private MA plans—are funding these excess payments.

When private plans were introduced to Medicare, they were expected to provide extra benefits to beneficiaries by achieving greater efficiencies at a lower cost to the program than traditional Medicare through the use of care coordination, negotiated prices, provider networks and other strategies. Given the fact that MA plans have control over hospital and physician services, as well as the opportunity to manage and coordinate care, it is reasonable for Congress to hold MA plans to payment levels that are no more than those for the fee-for-service program.

In order to minimize the disruption to beneficiaries who rely on MA plans for their health care, AARP believes Congress should phase out MA plan payments that exceed fee-for-service costs over a period of time. Because geographic variations in spending continue to be a problem in the Medicare program, including within in the MA program, AARP believes it is important that Congress address the payment areas with the largest discrepancies first. It is important that those areas of the country that provide care most efficiently are not penalized.

Medicare Funding Warning

The Trustees' report includes the second "funding warning" in this year's annual report. The Medicare Modernization Act requires the Trustees to issue this warning if general revenues account for 45 percent of combined HI and SMI expenditures at any period during a seven-year window.

AARP believes the 45 percent trigger is an arbitrary limit and provides a false alarm about Medicare's funding situation. General revenues have always financed a significant portion of Medicare Part B.

Moreover, because of the way the trigger is designed, policy options to avoid the trigger are limited and may do little to help long-run cost growth. For example, while researchers have documented worrisome trends in obesity rates and chronic conditions for current and future Medicare beneficiaries, efforts to improve preventive services may reduce Part A costs, but increase Part B costs, thereby setting off the trigger. Similarly, shifting services from inpatient to outpatient settings has the same effect.

AARP believes the 45 percent trigger should ultimately be repealed so that Congress is not distracted from the real issue—runaway health costs in the entire health care system. Runaway costs burden not only Medicare and other federal health care programs, but negatively impact state and local governments, employers, and individuals. Congress must begin to address the problem of system wide health care cost growth—it is not just a Medicare problem, and it cannot be addressed in Medicare alone.

Medicare Part D

Because Part D is financed similarly to Part B, it too faces cost pressure, but not insolvency. The Trustees' Part D cost estimates are substantially lower than those reported last year, primarily due to lower prescription drug plan bid submissions. However, the Trustees are projecting the average annual increases in spending to be nearly 13 percent—due mainly to increases in per capita drug costs (about ⅔) and enrollment (about ⅓).

The projected increase in Part D spending is clear evidence of the need for Congress to enact policies to further help lower drug costs.

AARP supports legislation to:

- Remove the prohibition on the Secretary of HHS from negotiating with pharmaceutical manufacturers on behalf of Medicare beneficiaries (H.R. 4, S. 3);
- Allow for a pathway for the approval of lower cost, safe, comparable, and interchangeable versions of biologic drugs (H.R. 1038, S. 623);
- Legalize personal and wholesale importation of prescription drugs, starting with Canada (H.R. 380, S. 242);
- Prevent abuses in patent settlements between generic and brand name prescription drug manufacturers (S.316); and
- Provide full funding for comparative effectiveness research authorized in the MMA.

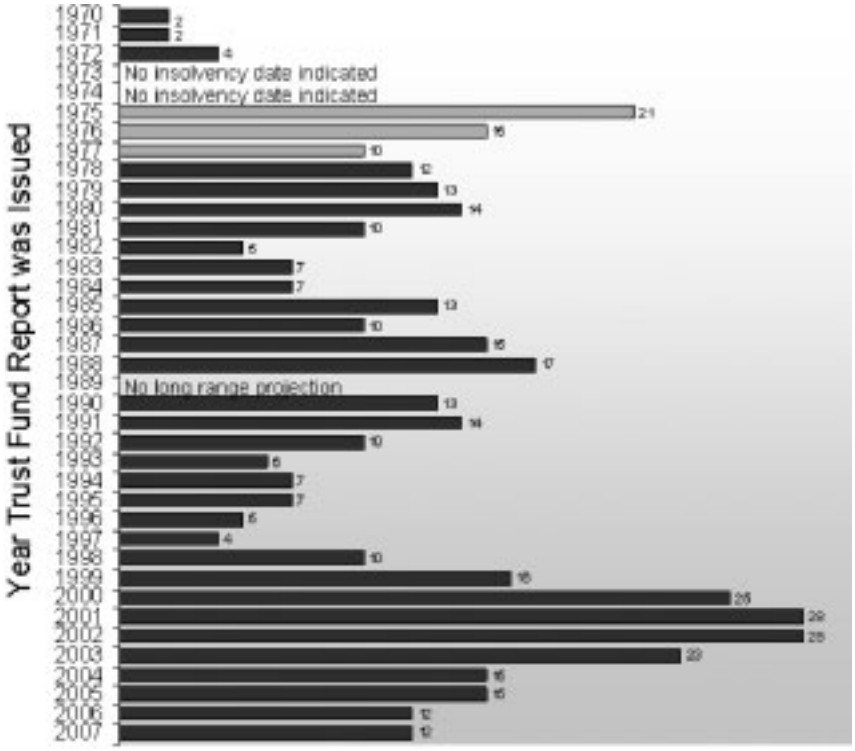
Conclusion

The Medicare program is vitally important to tens of millions of Americans and their families. Each year, the Trustees' Report presents the challenges faced by the program and offers the opportunity to make some improvements for the future.

AARP believes Congress must make changes to the way Medicare pays physicians and Medicare Advantage plans to keep the program strong for the future. In addition, Congress can take important steps to help reduce the price of prescription

drugs for all Americans. Ultimately, however, it must address the underlying rate of growth of health care costs in the entire health system—not just Medicare—if we are truly to achieve meaningful reform.

Chart 1. Projections of Part A Solvency Have Varied Widely
Average number of years until insolvency is 12 (1970–2007)



Source: Derived from CRS, April 1995, and the Annual Reports of the Board of Trustees of the Hospital Insurance Trust Fund, 1996–2007.

Notes:

- No insolvency dates indicated in 1973 and 1974.
- No long-range projection in 1989.
- Range reported, as indicated by the white bars: 1975 Report—late 1990s; 1976 Report—early 1990s; 1977 Report—late 1980s.

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