

Hearing on the 2013 Medicare Trustees Report

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SUBCOMMITTEE ON HEALTH
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C O N T E N T S

[Advisory of June 20, 2013 announcing the hearing](#)

WITNESSES

Mr. Charles P. Blahous Ph.D.
Public Trustee, Social Security and Medicare Boards of Trustees

Witness Statement [[PDF](#)]

Mr. Robert Reischauer Ph.D.
Public Trustee, Social Security and Medicare Boards of Trustees

Witness Statement [[PDF](#)]

Hearing on the 2013 Medicare Trustees Report

U.S. House of Representatives,
Committee on Ways and Means,
Washington, D.C.

The subcommittee met, pursuant to call, at 9:30 a.m., in Room 1100, Longworth House Office Building, Hon. Kevin Brady [chairman of the subcommittee] presiding. [Advisory](#)

Chairman Brady. The subcommittee will come to order. We are meeting today to hear from the public members from the Board of Trustees, the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds on their 2013 report analysis regarding the current dire status of the Medicare program. It is important to understand the financial health and viability of the Medicare program if we are to ensure that the program is solvent and available to our immediate seniors as well as future generations of Americans.

Author George R.R. Martin wrote, “most men would rather deny a hard truth than face it.” I worry that when it comes to Medicare that is true for too many in Washington today. If Medicare is just fine, as some claim, then why the Medicare trustees issue and Medicare funding warning for the seventh straight year? If there is no problem that needs action now, then why have the assets in the trust fund shrunk by 15 percent from the projections made just 5 years ago? And if sincere concerns about Medicare's financial condition are summarily dismissed as alarmist rhetoric by some Members of Congress, then why can't Medicare pay its medical bills for seniors in just 13 short years?

Today no Member of Congress can honestly look a 52-year-old American in the eye and assure them that Medicare will be there for them when they retire because the trustees report has just confirmed that. That is not just fine. For those who continue to stick their head in the sand, where hope is the denial of reality and who shirk from their responsibility to act to save Medicare now, here is yet another wakeup call. The 2013 trustees report continues to make it abundantly clear that Medicare's financial future is in trouble. Americans all over the country and across generations are paying into a program that we as a Congress cannot promise they will receive benefits for. But if we simply face reality and come together we can act now, this year, to take the first real steps to make

sure our citizens receive the medical care they deserve and have paid into when they need it the most.

If you somehow think a couple of years of reduced health care spending within a recession solves the problem, do the math. The number of people in Medicare doubled over the last 35 years and is going to double in size again. And no one credible has proven that reduced health care spending will last. Even the Medicare trustees didn't attempt to make that claim. And they are not alone, the independent actuaries at the Centers for Medicare and Medicaid Services again published what they call an alternative scenario. In their full scenario they assume that Congress will prevent, schedule cuts in physician providers payments, and repeal the heavy handed independent advisory board causing Medicare spending as a percentage of our economy to skyrocket. The trustees report and the alternative scenario reinforce the need for prompt attention to Medicare's severe financial problem.

As we will hear from our witnesses today, we should continue to push, now is the time to act as the sooner we make changes the better the program structure, the less dramatic these changes will have to be. My hope is that this hearing will help my colleagues on both sides of the aisle continue to understand the extent of the financial problem that pushes us to work toward a bipartisan common sense solution. We can't wish this problem away. Medicare is going broke too quickly, and no amount of positioning for political gain is going to change that fact. The Medicare Board of Trustees urged us as Congress to take prompt legislative action and recognize the projection in this year's report continue to demonstrate the need for timely and effective action to address Medicare's remaining financial challenges.

So if the trustees don't view the two added years of solvency as a significant reprieve, then why should Congress or the White House? Our witnesses here today will further explain to us the extent of Medicare's financial difficulties as we work to deliver on this promise. Medicare is important, it is in trouble, common sense dictates that we act now.

Before I recognize Ranking Member McDermott for the purposes of an opening statement I ask unanimous consent that all members' written statements be included in the record. Without objection so ordered. I now recognize Ranking Member McDermott for his opening statement.

Mr. McDermott. Thank you very much, Mr. Chairman. I want to welcome Dr. Reischauer. It seems like you have been a permanent fixture around here doing something every since I came 25 years ago. So it is good to see you here today as one the public witnesses. And Dr. Blahous, thank you for your service as being willing to sit on a commission like this. I believe it has been a couple of years since we have seen you before the committee, and I look forward to hearing your thoughts today about what is going on.

As in the past, as you listened to my colleague Mr. Brady, this hearing has usually been a hearing where there has been continual harping on Medicare supposed dire finances and

scaring the public into believing that Medicare is going bankrupt and it won't be there for you when you get to a certain age. Every generation has been subjected to that since I've been in Congress; it is not going to be here by the year X.

When I looked outside this morning as I got up, I can assure you the sky's not falling. The latest trustees report projects 2 initial years of solvency to 2026, and that is pretty healthy by historical standards. Additionally the Affordable Care Act is improving conditions across the Medicare program. Projected Medicare spending is down from where it was headed before the passage of ACA. Before ACA we were projected spending would reach 11.4 percent of GDP in 2082. I don't know who can believe we know anything about 2082, but people sit around and make those kind of projections. This year that number is down to 6.5 percent in 2087, so that is almost a 50 percent cut.

The long-term 75-year deficit has also improved, dropping from 3.88 percent in 2099 to 1.11 percent in 2013, that is a 72 percent decline. So you are seeing that things in fact are in the long term seem to be getting better. Now if you believe those predictions the guys who want them believe them I guess. I am one of those a little dubious about who will know what will happen in 75 years. But the ACA is also resulting in historically low health care spending rates. Per capita Medicare spending rate was only .4 percent in 2012, that is less than 1 half of 1 percent, and national expenditures grew only 3.9 percent in 2011, the third straight year of slower growth. But these rates are expected to remain low through the decade, it is not just a one-time occurrence. These are the result of the initiatives within the ACA and the initiatives it has catalyzed throughout the country. Providers and insurers have gotten the message loud and clear they need to transform into high value, efficient providers if they want to compete in the health care system of tomorrow.

While of all of this good news won't keep my Republican colleagues from playing Chicken Little, I would like to remind them that repealing the ACA, they tried it 37 times, their singular goal for the last 3 years, would actually put the program on a worse financial footing. The latest estimates of the actuaries say that repeal would shorten solvency by 8 years. It would also increase beneficiary costs and eliminate benefit improvements such as free preventive care and closure of the part D donut hole.

So rather than using this year's trustees record to invoke panic and fear, rather let's use it to justify shifting costs or justifying costs on to beneficiaries and undermining the program in the name of solvency, I challenge my colleagues to think bigger. Let's figure out how to ensure Medicare is an efficient program that provides a quality benefit to those who rely on it. While I support improvements to the Medicare program, no program designed in 1964 could possibly be adequate for today. There's just no way you can do that. And I reject calls to slash the program to save it, it wasn't made too big at the beginning. Let's give the ACA and the civil liberty system reforms the chance to work. After all the sky isn't going to fall anywhere tomorrow either. And I think that the committee has to look at what you present to us and decide how we actually implement the efficiency that is in the ACA because it will affect Medicare as it affects everything. The delivery of health care and the way we pay for it is going to change over the next few

years. It is changing in part by the fact that we have actually put ACA in motion. That made people start to think about it.

I yield back the balance of my time.

Chairman Brady. Today we will hear from two witnesses, Charles Blahous and Robert Reischauer, both Public Trustees on Social Security Medicare Boards of Trustees. Thank you both for being here today. I look forward to your testimony. You both will be recognized for 5 minutes for the purposes of providing your oral remarks.

Mr. Blahous, we will begin with you.

Mr. Blahous. Thank you, Mr. Chairman, Mr. Ranking member, all the members of the subcommittee. It is as always a great honor to appear before you today to discuss the findings of the Medicare Trustees Report. By mutual agreement with my fellow Public Trustee Dr. Reischauer I am going to present in my oral remarks the primary financial projections of the Medicare Trustees Report and leave it to his testimony to discuss some of the recent evolution of longer term outlook.

The first point I would make in my oral remarks is simply that Medicare finances are very complex, the program has two trust funds and they are financed in different ways. Each year there is naturally a high degree of public and press attention in our projections for the date of depletion of the Hospital Insurance Trust Fund, and that is very important to the data and it is appropriate there be such attention, but that is just one piece of a larger mosaic of Medicare program finances.

Medicare also has a Supplementary Medical Insurance Trust Fund which actually has larger expenditures, and that is constructed so that it can never go insolvent by design. It is basically given whatever general revenues it needs out of the general fund in order to maintain benefit payments. So when we have financing strains on that side of Medicare they are not manifested in the data's trust fund depletion but they are manifested in the form of rising enrollee premiums and rising pressure on the general budget. And in fact we are showing such rising pressure. Under our current projections -- well, in 2013 we are expecting about \$594 billion in total Medicare expenditures. That is about 3.6 percent of our Gross Domestic Product. We are projecting going forward that Medicare costs will rise substantially faster than our economic output to the point where in the 2030s, by mid 2035 we are expecting total program costs to be about 5.6 percent of GDP. Thereafter we are expecting continued increases relative to our economic output but moderating a little bit to hit about 6.5 percent of GDP by 2087.

Now the primary driver of this cost growth of course is demographics. We have a lot of Baby Boomers coming onto the benefit rolls. Health care cost inflation also plays an important role and is a relatively more important factor later in the evaluation period, although in the near term the demographics are the larger one.

Under our current projections as has been noted we are projecting that the Hospital Insurance Trust Fund will be depleted in 2026, that is 2 years later than we projected in last year's report. My colleague Dr. Reischauer will explain some of the reasons for recent changes in the outlook. Here in my remarks, I will just note that Medicare finances are really very much on a knife's edge over the next several years. We are starting this year with less than one year's worth of benefit payments in the Hospital Insurance Trust Fund and so our 2026 projection depends to a great degree on whether annual tax income and outgoing benefit expenditures will be almost exactly balanced over the next several years. If our projections are off a little bit and our long-term projections are subject to great uncertainty, that 2026 date could move a few years in either direction.

The last point I will make, Mr. Chairman, is simply that for various reasons total costs are likely to be higher in practice than what we are showing in the report. The most obvious of these is simply the sustainable growth rate formula for physician payments. We are obliged to project what happens under literal current law and under literal current law there will be a 25 percent reduction in physician payments at the beginning the next year. Historically Congress has tended to override these. If we assume that that pattern continues, then costs will be higher than we are currently projecting, by our estimates a little bit more than 10 percent higher over the long term.

Now there are some who argue that costs will be higher than our current projections for other reasons and those are rooted in some of the technicals of how we make our projections. I will try to explain these without getting too far into the weeds. But basically our projections for Medicare cost growth are very highly dependent on our projections for health care costs growth in the broader economy which determines the input costs that providers report to Medicare. What we do in our long-term projections is we assume a certain level of deceleration in national health care cost growth. The reason we assume that has to do with the historical elasticity of medical cost growth as a function of price growth. I think the layman's way of understanding it is that as health care takes up a larger and larger share of our economy and absorbs more of each of our pocketbooks the pressure in the direction of further increases is lessened a bit. If that weren't the case then ultimately we would get to the point where our economy would serve nothing other than health care. So we assume a certain level deceleration going forward in national health care expenditures. So when you overlay on top of that the ambitious cost constraints of current law in some areas we actually have projections that have per capita expenditures in Medicare more rapid than GDP growth in the near term, but actually less than GDP growth in the long term. And so there are some people that look at our projections and say, we don't think that is plausible, we don't think lawmakers would permit expenditures in Medicare to be less than a per capita basis and per capita GDP growth. We as trustees have to be agnostic about that. We can't predict the future actions of lawmakers, but what we do say is we show the main projections in the current law and we also provide some alternative scenarios in which it is assumed that some of these provisions are overridden.

In conclusion, Mr. Chairman -- I know I am out of time -- Medicare is a complex program in which finance strains have consequences that include projected depletion of the trust fund and raising pressure on the general budget. We are showing costs raising

markedly over the next couple of decades, primarily due to demographics, costs are likely to be at least as high as we currently project if the historical pattern of SGR overrides continues. In our report we say that under our current projections legislation will be needed to prevent financing shortfall in the Hospital Insurance Trust Fund and to address rising budgetary pressures arising from Medicare SMI. The sooner such legislation is enacted the more likely you can produce substantial long-term savings with less potential disruption for beneficiaries.

Thank you.

Chairman Brady. Thank you.

Chairman Brady. Mr. Reischauer.

Mr. Reischauer. Chairman Brady, Ranking Member McDermott and other members of the subcommittee, I appreciate the opportunity to appear before you today. My colleague Dr. Blahous has already covered the trustees' latest projections and the basic operations of Medicare. And I am going to stray a bit in part in response to the op-ed that was in last week's Washington Post about the credibility of Medicare's long-term projections.

What I was going to talk about is the implications of the slowdown in overall health care spending will have or could have on the Medicare program's future financial situation. As you know, both Medicare per beneficiary spending and private sector per capita spending has slowed considerably over the last few years. The latest trustees report projects that the year in which the HI Trust Fund will be depleted has been pushed out 2 years from 2024 to 2026. This is good news, but does it suggest that the cost curve has been bent in a sustainable way and we can relax? Even though I count myself among those who think that much of the spending slowdown is structural in nature, I believe that the fundamental financial challenge facing Medicare and the need for further costs restraint and reform remain largely unchanged from where they were a year or two ago.

The slow down in per capita in national spending has been going on in bits and starts for a better start of a decade. Probably the biggest single factor explaining the slowdown is the economic weakness of the past 5 years. This weakness has reduced the ability of many workers and their families to afford health care. What is less recognized is that it has also had an effect on Medicare beneficiaries who experienced sharp declines in the value of their IRAs and 401(k)s and reduced interest income from their CDs and bonds. In addition they went 2 years without a Social Security COLA.

The fact that relatively few major new technologies and blockbuster drugs have been introduced in the past few years is a second factor that has contributed to the slowdown. Policy changes, both at the Federal and the State level, also can take some credit for the spending slowdown and the final factor is the sea change that has taken place in the attitudes and focus of leaders in the health care sector. In contrast to the past there is now widespread appreciation among these leaders that health care cannot be provided without concern for its costs and the efficiency with which it is delivered. As a result of this

attitudinal shift hospitals, physician groups, insurers and employers have initiated innumerable projects designed to moderate cost growth and some have helped to dampen overall spending.

Whether the spending slowdown will continue is an open question. While there are reasons to be cautiously optimistic there are also reasons for concern. Prime among those reasons of course is the possibility that breakthroughs in genomic science, nanotechnology, stem cell research and other cutting edge technologies could lead to an explosion of new and expensive interventions.

The increased market power that providers may gain when they consolidate to provide integrated high quality care as it is envisioned under health reform is also a threat, potential threat to the continuation of the spending slow down.

Some might ask whether the future pace of growth of overall health care spending has much relevance for Medicare, because Medicare has administered, not market based praisers and does not negotiate with providers when it sets other cost related program parameters. Notwithstanding these differences, Medicare cannot set its own course with respect to future growth independent of what is happening in the rest of the health care marketplace. This has been illustrated clearly by the appropriate reluctance lawmakers have shown towards adhering to the sustainable growth rate formula. As you know, the projections in our report assume that the physician fee schedule will be reduced by 24.7 percent at the start of 2014. The report notes, however, that it is a virtual certainty that this reduction will be overridden. This judgment is based on experience since 2003 and an appreciation of the disruptive consequences that a sudden sharp reduction would have on Medicare payment rates leaving them far below those of other payers. In short, what happens in the private marketplace does constrain what Medicare can do to slow spending.

For several years the trustees reports have expressed caution with respect to the long run sustainability of the major cost reduction measures required by the Affordable Care Act. The most important of these are the productivity related reductions in annual payment rate updates for Medicare providers and the IPAB. While the trustees believe that these measures or alternative ones of similar impact can be sustained over the long run, they judge that this will occur only if the overall health care sector transitions to significantly more efficient models of care delivery. Such a transition will not happen unless private payers as well as Medicare continue to pursue cost saving innovations aggressively and providers respond to the incentives to moderate growth. In short Medicare's ability to moderate growth over the long run depends critically on the private sector's success and its efforts to slow spending and vice versa.

Thank you.

Chairman Brady. Thank you, Mr. Reischauer.

Chairman Brady. Mr. Blahous, you and six other trustees predicted in 13 years Medicare, will only be able to pay 87 percent of its benefits going forward. How can a cut that severe or a shortfall that severe what impact does it have on Medicare and its ability to provide medical assistance to seniors?

Mr. Blahous. Well, that shortfall is in the Hospital Insurance Trust Fund, and if it were allowed to simply play out without action the amount of benefits we could pay would be 87 percent of what is currently scheduled. Under law that side of Medicare cannot make payments in excess of the balance of its trust funds. So basically under most interpretations of the law Medicare would simply have to wait until there was incoming revenues before it could send out payments. This would mean in many instances denial or delay of care but certainly a reduction in the aggregate amount of the amount of care of seniors receive of 13 percent in that year.

Chairman Brady. You say your testimony that you project likely higher cost growth rates going forward, so in effect we ought not count on the low growth rates of the last 2 years. And you make the point that our finance "are on ice edge." The seven trustees said we need -- Congress needs to take prompt, timely and legislative action. So is that prompt and timely meaning in some time in the next 10 years, sometime in the next 5 years? Do we need to act sooner than that to address these issues?

Mr. Blahous. Well, certainly the sooner there is action I think the more prudent it would be, for a number of reasons. One is the sooner you act the more people you can involve in the solution. You can involve more cohorts of taxpayers, you can have a gentler impact if there's going to be an impact on beneficiaries you can spread it out over a longer period of time. The other point I'd make is that you have to remember the main factors driving the cost, one of them is demographics. It is hard to just change on a dime with respect to demographics. If we are going to change anything about eligibility ages or eligibility criteria you are going to want to phase that in.

Chairman Brady. A lot more people are coming into the program. Are higher costs over the long term continuing to drive the financial problems?

Mr. Blahous. That is right.

Chairman Brady. What is your recommendation to us? How soon should we act to address this? You have been there, you know the issues, and you know the challenges. How much longer do we delay taking some meaningful steps?

Mr. Blahous. And the difficulty of this of course is lawmakers always have to make a judgment as to what is the right environment or the best time to act from a number of perspectives. I can just tell you strictly from numerical perspective the earlier you act, the better. The more immediate action, the better.

Chairman Brady. Now, this session preferably.

Mr. Blahous. From a purely from a purely technical substantive perspective, yes.

Chairman Brady. Thank you. Mr. Reischauer, your testimony sounds like everything is just fine in Medicare. Is your thinking don't worry, be happy, it will all work out?

Mr. Reischauer. Well, I mean I think I said early in my oral remarks as well as my written remarks that although I am optimistic about the spending slowdown, I think that we still face a very significant problem. And like my colleague I think the sooner we adopt measures to address the long-term situation, the better. I am not one who spends sleepless nights worrying about 2087, but looking out at the next two decades there is cause for concern. And like Dr. Blahous, I believe the sooner decisions are made, the more gradually they can be implemented, and the more political viability they will have.

Chairman Brady. Is your thinking too rather than waiting 5 years or 10 years, would your recommendation as far as taking some meaningful steps to Congress be to do this session, to start those solutions or at least the steps of them now rather than continuing to delay?

Mr. Reischauer. We have adopted a lot of changes. We are going to learn a lot from the demonstration and pilot programs and from the implementation of various cost reducing measures in the Affordable Care Act. And I think in a few years we will be in a much better position to adopt in a sense the next generation of changes, informed by what we learn about how well some of these demonstrations are doing.

Chairman Brady. I didn't -- you spent a lot of time in your testimony talking about the benefits of the Affordable Care Act. I didn't see that. What section of the trustee's report was that in?

Mr. Reischauer. It wasn't. I said I was going to stray a bit from the trustees report because.

Chairman Brady. So it is your personal view, just looking ahead on these issues?

Mr. Reischauer. Yes. And it comes from the belief that the success of the efforts to hold down Medicare costs depends critically on what is happening in the rest of our health economy that Medicare can't go off --

Chairman Brady. Sure. No, no, I heard your testimony loud and clear.

Final point, is it accurate that the trust fund -- hospital part A trust fund this year started out only having enough to cover 81 percent of liabilities; is that accurate, in your trustees report?

Mr. Reischauer. The trust fund's assets amounted to 81 percent of 2013's expected expenditures. If there were no money coming into the trust fund that is --

Chairman Brady. Is that expected to get better or to decline?

Mr. Reischauer. It is expected to decline.

Chairman Brady. Get worse.

Mr. Reischauer. Over the next 13 years, yes.

Chairman Brady. Mr. McDermott?

Mr. McDermott. Since these hearings are basically educational for the public let me try and get clear in people's minds, when you are talking about a deficit, you are talking about a deficit in part A, that is what you are talking about? And part B, that is doctors and other incidental laboratory and so forth, will be paid in full. And part D will be paid in full. So those two programs are not what we are worried about here. We are worrying about the hospital is at 87 percent and there is going to be 87 percent of the value in whatever it is, 20, or whatever, out there.

If we do nothing, you are saying if we do nothing but what is here in the law. But in fact we have done, we put in place the ACA. So we now are putting in cost control mechanisms in the ACA that are affecting this or seem to be affecting it. I look at the Medical Advantage program and see that it is dropping and that there is really encouraging news that the bids are coming in lower on Medicare Advantage, which suggests to me that, the ACA is already having an effect. Is that a fair estimate to either one of you, Dr. Reischauer or Dr. Blahous?

Mr. Reischauer. The trustees report says that the initial estimates of the impact of the Affordable Care Act on Medicare Advantage plans were probably a bit high -- a bit low in terms of reductions and that behavior of these plans and the changes in the benchmarks that have occurred over the last 3 years have led the actuaries to believe that the savings will be larger in Medicare Advantage that they thought in 2010, and we have also seen an increase in the numbers of folks signing up for Medicare Advantage, higher than was predicted at the time the Affordable Care Act was enacted.

Mr. McDermott. The initial Medicare Advantage introduction was a little bit rocky, as I remember it.

Mr. Reischauer. Well, I mean let's start with recalling that Medicare Advantage in a sense cost the government more money than fee for service.

Mr. McDermott. Because --

Mr. Reischauer. Because we were overpaying these plans relative to the cost that the individuals who participated in the plans would have cost had they been in fee-for-service medicine. And so the Affordable Care Act took a number of steps to try and reduce that situation and those have been quite successful.

Mr. McDermott. So to sum that up, what you have just said is that the Congress took actions that have reduced costs already. And it looks like there is no reason to believe that that won't continue out into the future if people, more people get into managed care and Medicare Advantage and the bids keep coming down we will save money in the future?

Mr. Reischauer. Well, but to take this to the next step, the bids really have to come down well below what the costs would be in fee for service, which means that these plans have to become ever more efficient, which I think they are on the way to doing. But to go back to my original testimony, these are plans that by in large are run by companies that also run managed care plans in the commercial market. And so this is all one big ball of wax here and we want to keep pushing on all aspects of it.

Mr. McDermott. It seems to me that what you are really saying is that some of the things that are being put in place and have been put in place both in the ACA and in Medicare Advantage in the past are you can't expect them to go in and instantly have a major change, that it is like trying to take a super tanker and turn it on a dime, it takes 20 miles to bend it 4 degrees in its direction and that is really what we are doing here with a big program. Is that your view, that we are getting the benefits from the ACA?

Mr. Reischauer. We are I think. And I think -- I hope we would get more, and I think you are right on the money when you say this is a big, complex sector of our economy and needs time to evolve to change, to move in the right directions and that is why the chairman's suggestion that making decisions sooner rather than later, giving instructions on what direction to go is very timely.

Mr. McDermott. I would be glad to help with the cost control. Thank you.

I yield back the balance of my time.

Chairman Brady. I am going to recognize Mr. Johnson for questioning. We have a vote series of 15, I know members want to take a look at those before we begin and we are going to recess until 5 minutes after the vote series concludes. We will reconvene at that point. Mr. Johnson.

Mr. Johnson. Mr. Blahous, the trustees report estimates that Medicare Hospital Insurance Trust Fund is projected to spend more money paying claims this year than it will collect from the payroll tax; is that correct?

Mr. Blahous. That is correct.

Mr. Johnson. How long has this been the case?

Mr. Blahous. 2008 was when expenditures began to exceed tax income.

Mr. Johnson. Okay. Are you aware of any program that is financially sustainable if it spends more money than it has or is this a recipe for bankruptcy?

Mr. Blahous. Obviously we can't continue on that path forever. In our current projections over the next decade we are projecting almost an exact symmetry between income and outgo, and there actually is a brief blip later in this decade when we are projecting tax incomes for one year exceed expenditures, but then after that the lines pull apart and expenditures exceed income on a permanent base and that is what leads to depletion of that trust fund.

Mr. Johnson. Well, I don't know how you come up with that decision.

Mr. Blahous, in your testimony you say that current Medicare cost growth projection shows there will be increased pressure on the general Federal budget highlighting the increase in general revenues that will be needed to prop up the SMI Trust Fund. What does this mean for Federal finances as a whole and won't this further pressure the Federal budget never to pay down our debt?

Mr. Blahous. The answer is yes, it does mean much increased pressure on the general budget. And there is only three outcomes, one is you have to have higher taxes, one is you have to have higher indebtedness or you have to have reduced expenditures elsewhere in the Federal budget.

Mr. Johnson. Okay. And which of those do you favor?

Mr. Blahous. Well, I mean this is my personal view. I am not excited about the idea of steadily rising taxes or steadily rising debt, but I am also not excited about seeing the rest of the budget squeezed either. So I think we have do something to get the rising cost of Medicare under control.

Mr. Johnson. Maybe you could pay for the whole cost out of your salary, what do you think?

Mr. Blahous. I would not want to do that.

Mr. Johnson. Mr. Reischauer, in your testimony you say policies included in the Affordable Care Act, ObamaCare, will reduce costs and create more efficiencies in the system. You specifically mention cost conscience insurance products that will be offered within the exchanges but many States have also released numbers showing that premiums will be increasing 10 percent, some 20 to 50 percent, and some as much as 150 percent.

Your assumption doesn't sound right to me, how does this help us control costs in Medicare, which is facing the problems right now?

Mr. Reischauer. Well, first of all those numbers that you suggested I don't think account for the differences in generosity between the plans that are being offered now and the plans that will be offered in the exchange because there are minimum benefit requirements for plans offered in the exchange. But what I really am referring to is the situation that we will have once the exchange starts, which is the individual consumer

having a choice of which plan he or she decides to sign up for. And as you know, there will be plans at different levels of generosity. And we might find that very significant fractions of the American public are quite comfortable with plans that are not as generous as those that we see offered in the usual employer/employee situation and that will change and start a competition that heretofore really hasn't existed both because fewer employers offer a range of plans, and those that do usually make their contributions to those different flavors of plans such that true market responses by their employees are not exhibited.

Mr. Johnson. Well, my impression is people don't want to spend more money on health care than they already are and that is what I am afraid is going to happen. Thank you.

Mr. Reischauer. No, I think you are right, I agree with that.

Mr. Johnson. Thank you for your testimony.

Chairman Brady. We have a vote series of 15 votes, but each of them are 2 minutes long. So we will -- this subcommittee will reconvene promptly 5 minutes after the last vote series. So grab a cup of coffee but be back here ready to work.

[Recess.]

Chairman Brady. The subcommittee will reconvene.

Thank you for being patient during the vote series. We have another one coming up, but I would like to recognize Mr. Pascrell for 5 minutes.

Mr. Pascrell. Thank you, Chairman Brady. Dr. Reischauer, do you think that Medicare can hit the spending projections in the trustees report under current law? Do you think that we will hit those spending projections that you mentioned?

Mr. Reischauer. Well, one aspect of current law is the assumption that the SGR will be implemented and that physician payment rates will go down by almost 25 percent, and in that respect I don't think we will hit the projections, and I think the impact that that has on Medicare's overall spending is about 2 percent, but abstracting from that, you know, I think it is perfectly plausible that over the course of the next 10 and 20 years that we will hit the projected numbers that are in the report, but as I said in my testimony, this presumes that there will be a significant transformation of our delivery system, not just the delivery system from Medicare's perspective, but from the private sector as well, but I think that we are on our way to that in large measure because of the pressure that the Congress has been exerting on health care providers.

Mr. Pascrell. Well, correct me if I am wrong on this, that the alternative scenario projects spending at 9.8 percent of GDP compared to a projection of 11.4 percent prior to health care reform. Is that accurate?

Mr. Reischauer. Yes, that is. I mean, if you look at the --

Mr. Pascrell. That is pretty important, isn't it?

Mr. Reischauer. If you look at the 2009 report, the 75-year projections were considerably more pessimistic than either the current law projections in the 2013 report or the alternative scenario contained in that report. Some of that is, of course, the Affordable Care Act, but that is taken out by the alternative scenario, and some of it is the different projections of the economy and inflation, and, you know, some of it is the slowdown in spending that we have experienced, so there is a lot of factors that are going on, but your basic observation is correct.

Mr. Pascrell. You would agree with that?

Mr. Reischauer. Yes.

Mr. Pascrell. Now, we have slowed down the rising cost of drugs, yes or no?

Mr. Reischauer. We have --

Mr. Pascrell. Prescription drugs.

Mr. Reischauer. -- slowed down prescription drug costs in large measure because there has been a very substantial shift from branded drugs to generic drugs, much more than experts had predicted a few years ago, in part because of the pressures that PBMs have exerted through the Medicare part D program.

Mr. Pascrell. Now, the projects that we are into right now in terms of Medicare and health care, for that matter, the rest of health care are designed to moderate costs.

Mr. Reischauer. Uh-huh.

Mr. Pascrell. If we don't touch that, we cannot catch up, we cannot raise enough money to do, so if we continue to go on the past process, we are out of business. But let me add this: I don't want to be morbid about it, but there is really, as I see it, and correct me, please, there is no real hope of a real reduction of the costs of health care, and indeed Medicare, unless folks take control of their health choices and learn to read their bills.

I have looked at the reports from both sides of the aisle. Neither of the sides of the aisle are stressing those choices, and I would say both sides of our aisle are going in the wrong direction and that the major emphasis, if I had a chance to finish the question, Mr. Chairman, and maybe just a short answer if it is possible?

Chairman Brady. If I could -- I want to give plenty of time --

Mr. Pascrell. I mean, we have got 45 minutes.

Chairman Brady. Mr. Pascrell, I will probably ask the witnesses to respond.

Mr. Pascrell. Okay. But the point I was concluding the question is this: If we can't raise enough money to do the things that we want to do, then we need to deal with the person who seeks care, whether he is in control of his health. You can't pass a bill to say you are in control of your health, this is what you will do, but that is the side that we are not discussing. We are not emphasizing this, and I fear, Mr. Chairman, with all your good intentions and the great intentions of our ranking member, that we are not going to deal with this cost and deal with the lowering of that cost unless we deal with those two things, the bill that you get and taking control of your own health. That is not in the books here. I don't know why we are not discussing it. Thank you.

Chairman Brady. Thank you, Mr. Pascrell.

Dr. Price.

Mr. Price. Thank you, Mr. Chairman, and I appreciate Mr. Pascrell's observation. I would just call his attention to a bill H.R. 2300 that we have introduced that actually responds to those things, and I will be glad to sit down and chat with you about them.

I want to thank our witnesses and the expertise that you bring and the contributions that you have made to trying to move us in the right direction. Dr. Blahous, I am struck by your testimony and much of the graphics within your testimony. We hear some of our friends on the other side sound relatively sanguine about the situation, that it is not a big deal, that we don't have to worry about it too much, but you cite that the demographics are driving the challenge. We have 10,000 folks reaching retirement age every single day and will continue to do that until we get the 78 million folks of my generation, the boomers, through this process, and that is a huge, huge economic challenge. My sense is that things aren't as rosy as some would like them, like us to believe they are, and in fact they may not even be as rosy as the trustees report. Would you care to comment on that?

Mr. Blahous. Sure. I think with respect to the observation that costs may be higher than we are currently projecting, I would return to Dr. Reischauer's point, we are assuming in our projections an almost 25 percent reduction in physician payments early next year. Historically there is very little basis for assuming that is going to happen, so if you assume that those payment reductions continue to be overridden, costs would be at least to that extent higher than we are currently projecting.

Beyond that, I think an important part of the message I would offer is that we still have work to do to sustain the finances of Medicare. There has been an awful lot written and said about the recent slowdown in health care cost growth, and obviously we are very hopeful that that will continue, and we are hopeful that it will render the aggressive cost containment mechanisms in current law more plausible over the long run, but I think it would go too far to assume that things are going to turn out significantly better than we are currently projecting.

Mr. Price. And likely not as good?

Mr. Blahous. And probably not as much, not as good because we are basically assuming that is going to work, assuming it is going to work.

Mr. Price. Let me turn to the issue of cost control that has been stipulated by the ACA for Medicare, which is through the Independent Payment Advisory Board. Something that many of us oppose vehemently because we believe it removes those choices for patients and families and doctors for the kind of care that they desire.

The projections right now are that the Independent Payment Advisory Board, IPAB, will come into play when they have to make a decision about reducing services or reducing compensation, reimbursement to physicians in 4 or 5 years. What is the interplay between that and the projection that the trustees have made already?

Mr. Blahous. It is a little tricky. Basically the IPAB comes into play whenever total Medicare expenditures exceed a target rate of growth, basically GDP plus 1 percent.

Mr. Price. Right.

Mr. Blahous. Now, that renders it a little difficult to run out some of our sort of illustrative alternative scenarios because, for example, if you assume that the cost containment provisions in the Affordable Care Act are overridden, then unless the IPAB is also overridden, IPAB would basically just have to come in to fill in the gap. They would have to provide the savings that those cost containment mechanisms did not provide, so there is a strong interplay between the two. That is why in our illustrative alternative scenario we show the consequences of those cost containment provisions being overridden and the assumption that IPAB's recommendations are overridden. It is not because we are making a policy recommendation or prediction, it is just that you can't really show the effects of one unless you assume the other is turned off because the IPAB would basically just come in to fill the gap if those cost containment mechanisms were overridden.

Mr. Price. And if the SGR reduction doesn't occur, which virtually all of us believe it ought not, and that we, Congress will act, does the IPAB come into play from decreasing reimbursement to physicians sooner or later?

Mr. Blahous. I think the short answer is I am not certain, but I will tell you what I think the answer is. I think the answer is that the main interplay is with the so-called productivity adjustments in the Affordable Care Act, and the reason I believe that is that the SGR override that we are assuming, basically most of that effect is in early 2014. We are assuming 25 percent higher physician payments in 2014, whereas the years that we are projecting IPAB coming into play based on the targets they have to hit, those are more in the outyears, it is subsequent to 2018.

Mr. Price. But they could be much sooner?

Mr. Blahous. It could be sooner, but I think a bigger factor is whether the other cost containment provisions of the ACA are overridden, and I am looking to my cotrustee to correct me if he thinks I have that wrong, but I think that is the case.

Mr. Price. Thank you. Thank you, Mr. Chairman.

Chairman Brady. Thank you very much. Mr. Smith, for the final questions?

Mr. Smith. Thank you, Mr. Chairman, and thank you to our witnesses for being here today and sharing your insight and expertise. Dr. Reischauer, in your testimony you suggest spending on health care may actually decrease in the future in part because of the creation of IPAB, and what part of IPAB is it that you think can lead to that? I know many folks are concerned that it is a form of rationing of care.

Mr. Reischauer. First of all, I don't believe that spending will decline. I think the rate of spending will continue at a relatively slow rate increase, so I am not here predicting nirvana, so to speak.

Mr. Smith. Okay.

Mr. Reischauer. You know, the IPAB effect is a relatively modest one in our projections. As Dr. Blahous mentioned, the significant impact comes from the productivity adjustment in the payment updates for most types of providers. You know, the IPAB, if it is created and if it is put into effect, as you know, will be charged with bringing up suggestions that don't necessarily have to be a cut in physician payments or other payments, it can be some other things as well, to bring spending down below a threshold, and if Congress disagrees with those measures, it can enact a substitute way of damping down the growth of costs, but some of the materials that we have suggest that looking out over the next 20 or 30 years, the IPAB is really a relatively minor part of the story of holding down cost growth.

Mr. Smith. Would you say it is minor but important? The reason -- a little bit of context.

Mr. Reischauer. I think its importance really comes -- I mean, if I were making a prediction, its importance would not come from its actions so much as its threat of actions. I mean, it focuses the minds of policymakers that, hey, we have to do some more, you know. We have done a modest amount so far, but we have to do some more or else, you know, this is, could be viewed in a way as something like sequestration, you know, it is nobody's first or tenth, you know, idea of what a good solution to the problem is, so let's, as legislators, come up with an alternative.

Mr. Smith. Okay. So just to follow up, Dr. Blahous, if creating the IPAB perhaps is considered by many to be good policy -- I have my concerns -- why is its elimination assumed, then, in the supplemental report?

Mr. Blahous. Basically it pertains to -- what we are trying to show in the illustrative alternative scenario, we are basically trying to acquaint lawmakers with the potential expenditures that could arise if certain cost containment mechanisms of current law are turned off, and IPAB is very important in that demonstration because if you left IPAB continue to operate and if Congress came in and overrode those cost containment mechanisms in current law, then under other aspects of current law, IPAB would come in and just have more savings to facilitate. So in order to show the magnitude of the additional expenditures, if you assume certain elements of current law are overridden, you also have to assume that IPAB is basically overridden as well because otherwise IPAB would just come in and fill in the gap for that savings. Is that clear?

Mr. Smith. Somewhat. But my fear is perhaps that SGR will just be replaced by IPAB, you know, under a little different acronym. Is that conceivable?

Mr. Blahous. Well, I would say, I think there is different levels of skepticism within the trustees process as to which elements of current law are likely to be sustained. I think the trustees as a body, based on history, are very, very skeptical that anything approaching the SGR is going to happen because historically we have overridden that. I think with respect to something like IPAB, with respect to other cost containment provisions in current law, I think you have a greater diversity of views and greater agnosticism. You certainly have some players in that process who think it is possible that they could be sustained, you have others who are more skeptical. We had a technical panel look at this over the last couple of years, and they basically came back with a recommendation that in our illustrative alternative scenario we assume that these cost containment mechanisms operate in full up through 2020, and then are partially phased out from 2020 to 2034. Again, it is not a prediction, it is not a policy recommendation, but basically that reflects an alternative assumption that basically these cost containment mechanisms will be overridden to the extent that would be necessary under our methodology, which people can argue with, but under our methodology to prevent a growing wedge between Medicare reimbursement rates and private sector ones, but there is a great diversity of views on that, especially since we haven't seen whether these are going to be effective yet.

Mr. Smith. Thank you, Mr. Chairman.

Chairman Brady. I want to thank both witnesses for your testimony today. Clearly, I hope we heed your warning to act sooner rather than later to take the meaningful steps to save and extend the life of Medicare.

As a reminder, any member may submit questions for 14 days for the record. I would ask the witnesses to respond in a timely manner, as I know you will. With that, the subcommittee is adjourned.

[Whereupon, at 11:45 a.m., the subcommittee was adjourned.]

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