2011 MEDICARE TRUSTEE REPORT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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

ONE HUNDRED TWELFTH CONGRESS

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MEDPAC MARCH 2011 REPORT TO CONGRESS

WEDNESDAY, JUNE 22, 2011

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

The subcommittee met, pursuant to call, at 9:35 a.m., in Room 1100, Longworth House Office Building, Honorable Wally Herger [chairman of the subcommittee] presiding.

[The advisory of the hearing follows:]

HEARING ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

Chairman Herger Announces Hearing on the 2011 Medicare Trustees Report

June 22, 2011

House Ways and Means Health Subcommittee Chairman Wally Herger (R–CA) today announced that the Subcommittee on Health will hold a hearing on the recently released 2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. In what will be the first in a series of hearings on Medicare's future, the Subcommittee will focus specifically on the Medicare program's financial status. The Subcommittee will hear testimony from Medicare's two public trustees. **The hearing will take place on Wednesday, June 22, 2011, in 1100 Longworth House Office Building, beginning at 9:30 A.M.**

In view of the limited time available to hear from witnesses, oral testimony at this hearing will be from invited witnesses 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 Medicare Hospital Insurance (HI) and the Supplementary Medical Insurance (SMI) trust funds. The trustees, who are designated in statute, are the Secretary of the Treasury, the Secretary of Health and Human Services, the Secretary of Labor, the Administrator of the Centers for Medicare and Medicaid Services (CMS), and the Commissioner of Social Security. Additionally, the statute requires that there be two public trustees, from different political parties, who are appointed by the President and confirmed by the Senate for four-year terms. The CMS Office of the Actuary is responsible for preparing the report. The 2011 report was released on May 13, 2011, and can be found at *https://www.cms.gov/ReportsTrustFunds/downloads/tr2011.pdf.* The Medicare actuaries subsequently released an alternative scenario memorandum, based on what actions they expect Congress to take (such as preventing cuts to Medicare physician payment rates) to "present an alternative scenario to help illustrate and quantify the potential magnitude of the cost understatement under current law." That memo can be found at *http://www.cms.gov/ReportsTrustFunds/Downloads/2011TRAlternativeScenario.pdf.*

Ensuring the financial viability of Social Security and Medicare is one of Congress' most important responsibilities. The annual release of the trustees' reports provides Congress with a valuable update on the programs' fiscal status and important information with respect to projections of future expenditures.

The trustees currently predict the Medicare HI trust fund will go bankrupt in 2024, five years earlier than they estimated in last year's report. Additionally, this was the sixth consecutive report in which the Medicare trustees issued a "Medicare funding warning" because they project "excess general revenue Medicare funding," as defined by a provision contained in Public Law 108–173.

The trustees project Medicare spending to grow from 3.6 percent of Gross Domestic Product (GDP) in 2010 to 6.2 percent of GDP in 2085, or to 10.7 percent of GDP in 2085 under their alternative scenario.

In announcing the hearing, Chairman Herger stated, **"The findings of the Medicare trustees are alarming. Medicare's Hospital Insurance trust fund**

is expected to go bankrupt five years sooner than last year and was forced to redeem $32.3 billion in bonds last year so that it could pay medical claims. It is critical that the American people understand just how dire Medicare's finances are."

FOCUS OF THE HEARING*:*

The hearing will focus on Medicare's financial situation as detailed by the 2011 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 "Hearings." 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, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Wednesday, July 6, 2011**. 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 or (202) 225–3625.

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 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.

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.

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

Chairman HERGER. We are meeting today to hear from the two public members of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

It is important to understand the financial health of the Medicare program if we are to ensure that the program is solvent and available to future generations of Americans. The 2011 trustees' report makes it clear that Medicare's financial outlook is bleak. The Medicare trustees estimate that the Medicare Hospital Insurance Trust Fund will be bankrupt in 2024, 5 years earlier than estimated in last year's report. Even though the report paints a very troubling financial picture, the reality is likely much worse.

The independent actuaries at the Centers for Medicare and Medicaid Services felt the need to publish an alternative scenario because of the high likelihood that the trustees report, which is based on current law, understates future Medicare spending. The Medicare actuaries' alternative scenario assumes that Congress will prevent scheduled cuts in provider payments such that Medicare spending as a percentage of gross domestic product will be nearly twice as high as the spending called for under current law.

The trustees report and the alternative scenario reinforce the need for prompt attention to Medicare's severe financial problems.

Republicans recognize the seriousness of this situation, and have demonstrated their commitment to addressing Medicare's financial demise. We put forth a plan to save Medicare. Congressional Democrats and President Obama have not. My hope is that this hearing will help the Nation come to grips with the extent of the financial problems facing Medicare. We cannot wish it away or ignore it, as some have chosen to do, or demagogue it away. Medicare is fast going broke, and no amount of speechmaking or positioning for political gain is going to change that fact. Some may not like the plan we have offered, but the critics have the responsibility of proposing solutions.

I also call on the President to step forward and play a leading role. While the 2011 trustees report issued a funding warning that the general revenue contribution to Medicare's financing is excessive, the President has failed to recommend improvements in response to this trigger.

There will always be a next election and a temptation to put politics above responsibility and problem solving, but as Medicare trustees warn, the time to act is short and growing shorter. Ensuring the financial viability of Medicare is one of Congress' most important responsibilities. Today's witnesses will inform us of the extent of Medicare's financial difficulties as we execute this responsibility.

Chairman HERGER. Before I recognize Ranking Member Stark 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 Stark for 5 minutes for the purpose of his opening statement.

Mr. STARK. Well, thank you, Chairman Herger, for holding this hearing today. Monitoring Medicare's solvency is an important responsibility for our committee, and we welcome the opportunity to discuss this with our public trustees today.

The trustees report shows a Medicare program which has been significantly improved by the enactment of the Affordable Care Act. Beneficiaries are also enjoying new benefits as a result of the law.

And without the health reform law, insolvency would be projected at only 5 years, a full 8 years less than the 2024 date reported by the trustees.

It is important to look at the trustees report in historical context. Since we have been projecting Medicare's solvency, those projections have varied widely. In 1970 and 1971, just before I got here, the program was expected to only last 2 years. At the end of the Clinton administration, it had a robust 25 years of solvency. In the past 45 years, whether solvency projections have been 2 years or 25, we have never allowed Medicare to become insolvent. And why? Because Congress has always acted to make changes to the program to avoid that outcome. That is our job, and I think we have done it pretty well.

I would also note that no private health insurance company, and we know our colleagues on the other side of the aisle would prefer that Medicare be handed over to them, none of those companies are measured with regard to their projected solvency over the next 75 years, or even 1 year. They move quarter by quarter with the market.

My Republican colleagues will focus on the solvency date having slipped 5 years from last year's projection of 2029. We know that this slip is primarily due to the economic recovery being so slow, which directly affects Medicare's financial standing. I am not sure why the Republicans are focused on the issue of Medicare solvency at all. They have already voted to end Medicare several times. The Republican position is clear: Republicans don't believe it is the role of the Federal Government to guarantee health benefits to senior citizens and people with disabilities. Republicans would prefer to repeal the health reform law and end the delivery system reforms, reforms that the trustees' report highlight as showing real promise for controlling Medicare's spending growth even more in the future. Republicans instead want to provide Medicare beneficiaries with a voucher to purchase more expensive private insurance that may or may not be affordable or cover the benefits they need. There is no doubt that an underfunded voucher would save the government money. Medicare becomes a lot cheaper when you destroy the program.

The message to take from this year's trustees report is that the Affordable Care Act significantly improved Medicare's financial standing. There is always more to be done, and we must work together to protect and improve Medicare, not end its guaranteed benefits for senior citizens today and tomorrow.

With that, I yield back to my friend from California and look forward to the testimony and discussion to come.

Chairman HERGER. Thank you.

Today, we are joined by two witnesses, both of whom serve as public trustees for the Medicare program. The witnesses will both report on the dire financial status of the Medicare program as outlined in the most recent trustees' report.

In addition to serving as public trustees, both of our witnesses are nationally recognized experts in the fields of Federal fiscal policy and the Federal budget.

Our witnesses are Charles Blahous, a research fellow at the Hoover Institution and former Deputy Director of the National Eco-

nomic Council; and Robert Reischauer, president of the Urban Institute and former Director of the Congressional Budget Office.

Mr. Blahous, you are now recognized for 5 minutes.

STATEMENT OF CHARLES P. BLAHOUS, PH.D., SOCIAL SECURITY AND MEDICARE BOARDS OF TRUSTEES, WASHINGTON, D.C.

Mr. BLAHOUS. Thank you, Chairman Herger, Ranking Member Stark, and Members of the Subcommittee. It is a great honor to appear before you today to discuss the findings of the 2011 Medicare trustees' report.

By mutual agreement with my fellow public trustee Dr. Reischauer, I will present the primary findings of the report with respect to projected Medicare finances, and leave other important issues, such as the reasons for change in the projections and the degree of uncertainty in the projections, for him to discuss.

Medicare has two trust funds. There is a Hospital Insurance Trust Fund, colloquially known as Part A; and a Supplementary Medical Insurance Trust Fund, which includes Part B, which is basically physician services, outpatient hospital, home health services; and Part D, the prescription drug program. Every year there is a great amount of interest in the trustees' projections for the solvency of the Part A fund and its projected date of trust fund depletion. That attention is appropriate.

It is important to remember, however, this is just one component of overall Medicare financing. On the SMI side, basically general revenue contributions, premiums, these factors are reestablished each year so as to match expected costs on that side of the program. So when there are financial strains on the SMI side, which there definitely are, they are manifested in a different way. We don't show a projected date of trust fund depletion; instead, we show rising general revenue pressures and rising enrollee premiums.

Let me first review the HI projections. Currently we project that every year going forward annual hospital expenditures under HI will exceed program income in all future years. And the consequences of that would be a continuing diminution of the assets in the HI Trust Fund to the point where it is exhausted in 2024. As has been noted here, that 2024 date is 5 years earlier than was projected in the previous trustees' report.

At that point of depletion, projected revenues would be roughly sufficient to fund about 90 percent of expenditures, and that percentage would gradually decline from that point forward till by midcentury it would be about three-quarters of expected expenditures. That would be a low point. Afterwards, it would begin to drift up a little bit.

Over 75 years, the so-called long-range valuation period over which HI actuarial balance is measured, that is traditionally done as a percentage of the program's tax base, taxable payroll, and we show a projected deficit of 0.79 percent of taxable payroll over 75 years. Last year's report showed 0.66 percent.

Now, as I have noted, this is just one component of Medicare financing. On the SMI side, we see the financial strains arising in the form of rising costs. SMI costs were roughly 1.9 percent of GDP

in 2010. We show them rising fairly rapidly and going to 3.4 percent of GDP in 2035. And, indeed, Medicare costs as a whole are projected to rise fairly rapidly to reach about 5.6 percent of GDP in 2035 and to increase gradually thereafter to more than 6 percent of GDP.

Now, I have a couple of caveats about those numbers, but before I get to those, just one additional point. This year's report also issues a Medicare funding warning. There is a provision of law that requires us to state when we project that at any time over the next 7 years there will be a year where the gap between program outlays and dedicated revenues is more than 45 percent of program outlays, and that is the case for fiscal year 2011, and that funding warning has been issued in this report for the sixth consecutive year.

Now, the caveat about the numbers. There are a number of places in the trustees' report where it is stated pretty explicitly that actual costs in practice are likely to be substantially higher than what we show, and the reasons for this are various. The most obvious of them is the fact that under current law there would be roughly a 29 percent reduction in physician payments in early 2012. Historically, Congress and the administration have worked together to override those reductions that have been called for by the sustainable growth rate formula over the years. Obviously if that continued to be the case, then actual costs in practice would be higher than we show.

As members of this subcommittee know better than anyone, there is a vigorous ongoing debate as to whether or not the cost-savings provisions of the Affordable Care Act will be sustainably implemented other the long term. We as trustees are obviously not in a position to arbitrate on that and to predict the political economy of the Affordable Care Act over the long term. All we can do is show literal current law as it is written.

Now, what the Medicare actuary does is he publishes an illustrative alternative scenario in which it is shown that the consequences of physician payment reductions being overridden and the productivity adjustments from the Affordable Care Act being gradually phased out over time. Under that scenario total costs are substantially higher than in the main report, 10.7 percent of GDP in 2085 rather than 6.2 percent.

I know I am out of time, so I will wrap up. Just one final point. That all speaks to political uncertainty, but it is important for the subcommittee to know that Medicare projections are highly uncertain even if the politics are certain. There is a tremendous amount of variation in the projections over the long term according to different assumptions for health care cost inflation. It is a very difficult variable to predict over the long term.

The bottom line is that the Medicare programs faces real and substantial financial challenges. We will best serve the interests of the public if these financial corrections are made at the earliest possible time.

Thank you, Mr. Chairman.

Chairman HERGER. Thank you.

[The prepared statement of Mr. Blahous follows:]

THIS TESTIMONY IS EMBARGOED UNTIL 9:30 AM ON JUNE 22, 2011

Statement of Charles P. Blahous

Research Fellow, Hoover Institution and Public Trustee for Social Security and Medicare

Before the Subcommittee on Health

of the U.S. House of Representatives Committee on Ways and Means

June 22, 2011

Thank you, Chairman Herger, Ranking Member Stark, and all of the members of the subcommittee. It is an honor to appear before you today to discuss the latest Trustees' report. By mutual agreement with my fellow Public Trustee, Dr. Robert Reischauer, I will present the primary findings of the Trustees' report with respect to projected Medicare finances. Other important aspects of the topic, such as the reasons for change since last year's report as well as the magnitude of and reasons for continued uncertainty in the projections, I will touch upon only briefly with the understanding that they will be covered in Dr. Reischauer's testimony.

Medicare Trust Funds, Income and Expenditures

Trust Funds: Medicare has two trust funds, the Hospital Insurance (HI) Trust Fund (sometimes known as Part A) and the Supplementary Medical Insurance (SMI) Trust Fund (which includes both Part B, a voluntary enrollment program of physician, outpatient hospital and home health services, and Part D, another voluntary program that provides prescription drug benefits). Medicare also has a Part C, the "Medicare Advantage" program, whose costs are paid from both the HI Part A and SMI Part B Trust Fund accounts. As is the case with Social Security, the HI and SMI Trust Funds contain special-issue Treasury bonds, which earn interest and provide a financing reserve that can be drawn upon whenever incoming dedicated revenues fall short of outgoing expenditures.

Although the income sources for Medicare as a whole are more varied than they are for Social Security, in significant respects the Trustees' projections specifically for the HI Trust Fund are analogous to those made for the Social Security program. For each of these, the majority of program revenues are provided by a payroll tax imposed upon worker wages and self-employment earnings. Also with each of these Funds, the Trustees determine whether there is an aggregate imbalance between projected program income and expenditures, as well as the date (if any) by which Trust Fund assets are projected to be exhausted.

By contrast, the finances of Medicare's SMI Trust Fund operate somewhat differently. Part B and Part D premiums and contributions from general revenues are re-established annually to match expected costs. SMI is thus kept solvent essentially by statutory construction. Financial strains on the SMI side, therefore, are manifested not in a projected actuarial imbalance or a date of trust fund depletion, but in rising requirements of general government revenues and enrollee premiums.

Income: For Part A, the largest source of income is a 2.9% tax upon wage earnings nominally split between employer and employee, though economists generally agree that both ends of the tax are paid from covered wages. Unlike the Social Security payroll tax, the application of the Medicare tax is not capped by wage income level. Starting in 2013, single taxpayers with earnings above $200,000 and married couples over $250,000 will pay an additional 0.9% tax to the HI Trust Fund. Medicare also receives income from the taxation of Social Security benefits (up to 85% of such benefits are subject to the income tax, with taxation on 50% dedicated to Social Security and the remaining 35% to Medicare HI).

In Parts B and D, general revenues provide the vast majority of financing (74% of total revenues for Part B, 83% for Part D). Another significant portion of Part B revenues comes from beneficiary premiums. The basic Part B monthly premium for 2011 is $115.40, but about three-quarters of beneficiaries are as of now continuing to pay a $96.40 premium, having been held harmless from recent premium increases under a provision of law triggered by the last two "zero COLA (cost-of-living-adjustment)" years in Social Security. Higher-income beneficiaries ($85,000 for individuals, $170,000 for married couples) pay higher Part B premiums. For Part D, individual monthly premium payments are averaging about $31 in 2011, and another smaller portion of revenues is provided via payments by States, these latter revenues representing a partial payment of foregone drug costs for dual beneficiaries as such costs were transferred from Medicaid to Part D.

Medicare Income Sources, 2010 ($ Billions)

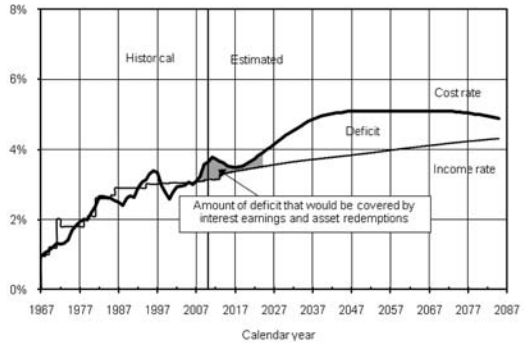
	Part A	**Part B**	**Part D**	**Total**
Payroll taxes	182.0	0.0	0.0	182.0
Taxation of benefits	13.8	0.0	0.0	13.8
Premiums	3.3	52.0	6.5	61.8
Transfers from States	0.0	0.0	4.0	4.0
General revenue	0.1	153.5	51.1	204.7
Interest	13.8	3.1	0.0	16.9
Other	2.7	0.2	0.0	2.9
Total	**215.6**	**208.8**	**61.7**	**486.0**

Expenditures: Total Medicare expenditures in calendar year 2010 were roughly $523 billion, of which roughly $516 billion were benefit payments and the remaining $7 billion administrative expenses. Categories of expenditures included $168 billion in hospital benefits (most of which were paid from Part A), $116 billion in Part C payments, $65 billion for physician fee schedule services (Part B), $62 billion in prescription drug payments (Part D), $27 billion for skilled nursing facilities (Part A), and $19 billion for home health care (Parts A and B), among other payments.

Findings for Medicare Finances

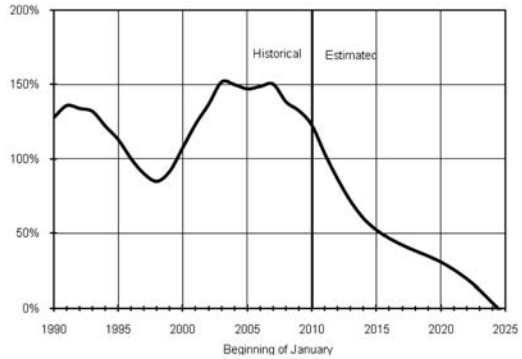
In this year's Trustees' report, Medicare's HI Trust Fund is projected to pay out more in hospital benefits than it receives in income in all future years, as shown on the following graph.

Projected Annual HI Income and Cost as a Percentage of Taxable Payroll



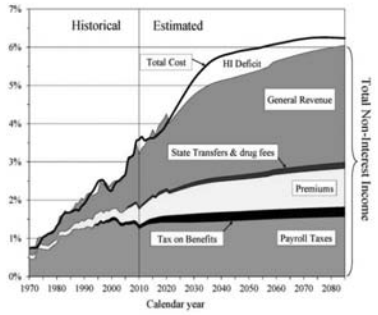
These flows are projected to result in a continuing diminution of the assets of the HI Trust Fund until it is exhausted in 2024. This 2024 Trust Fund depletion date is five years earlier than projected in the previous Trustees' report. At the point of HI Trust Fund depletion, dedicated revenues would be sufficient to pay 90 percent of HI costs. This share of expenditures that can be financed with HI dedicated revenues is projected to decline slowly afterward until it reaches 75 percent in 2045, after which it is projected to gradually rise again for reasons that I will later touch upon. Averaged over 75 years, under Trustees' assumptions, the actuarial imbalance of Medicare HI equals 0.79% of taxable payroll, up from 0.66% in the prior year's report.

Projected HI Trust Fund Balance at Beginning of Year as a Percentage of Annual Expenditures ("Trust Fund Ratio")



As noted earlier in my testimony, projections for the HI Trust Fund represent but one component of Medicare financing, as financial strains on the SMI side are instead manifested by rising pressures on general revenues and premiums rather than Trust Fund depletion. SMI costs equaled roughly 1.9 percent of GDP in 2010 and are projected to rise sharply to 3.4 percent of GDP in 2035. Costs for Medicare as a whole are projected to rise rapidly from 3.6 percent of GDP in 2010 to about 5.6 percent of GDP by 2035, and to increase gradually thereafter to about 6.2 percent of GDP by 2085.

Medicare Costs and Non-interest Income by Source as a % of GDP



As is the case with Social Security, the rapid cost growth in Medicare through 2035 predominantly reflects population aging, as the large Baby Boom generation is leaving the ranks of the workforce and entering the ranks of retirees, causing a sharp decline in the ratio of workers to beneficiaries. Unlike Social Security, Medicare costs under current assumptions would continue to rise relative to GDP in the years after 2035 largely because of continued health care cost inflation.

The Medicare Modernization Act of 2003 requires that the Board of Trustees determine each year whether the annual difference between program outlays and dedicated revenues exceeds 45 percent of total Medicare outlays in any of the first seven fiscal years of the projection period. When that determination is made in two consecutive reports, a "Medicare funding warning" is triggered. This year's report projects the difference between outlays and dedicated financing revenues to exceed 45 percent of total Medicare outlays during fiscal year 2011, prompting a determination of "excess general revenue Medicare funding" for the sixth consecutive report, triggering another "Medicare funding warning."

As the Trustees' report notes in several places, there are several reasons to believe that actual costs in practice will be higher than the figures I have just cited. I will say more about this issue at the end of my statement.

Methodology and Assumptions

The Trustees rely upon the same fundamental demographic and economic assumptions for the Medicare report as are used for the Social Security report. These assumptions are developed based on the recommendations of the Social Security Administration Office of the Chief Actuary, subject to review, possible alteration, and approval by the Trustees as a group. The CMS Office of the Actuary in turn develops the recommendations for the assumptions with respect to future health care cost growth, again subject to review, possible alteration, and approval by the Trustees. These variables are extremely difficult to predict with precision, and they have a very large impact upon Medicare cost projections over the long run.

The methodology used for the 2011 Medicare report is very similar to that employed in the 2010 report and reflects the evolving recommendations of a series of Technical Panels over the years. Over the next 75 years on average, and before consideration of the Affordable Care Act,[1] health care costs are projected to grow at a per-capita rate that is equal to the growth in per-capita GDP plus 1 percentage point. That, however, is an average figure, and the rate of assumed growth is higher earlier in the valuation period than toward the end. The growth rate, for example, is 1.28 percentage points above GDP in 2035, 0.8 above in 2055, and only 0.3 percent above in 2085. This reflects an expected slowing of the rate of health care cost growth as these costs absorb a greater and greater share of the economy as a whole.

From these growth rates are subtracted certain cost-saving provisions of the Affordable Care Act. Critical such provisions permanently reduce payment updates to all Part A providers and most non-physician Part B providers by the 10-year moving average increase in private, nonfarm business multi-factor productivity growth, which is projected to be 1.1 percent annually. Under our assumptions, therefore, per-capita growth in these payments would exceed per-capita GDP growth in the near-term but would increase more slowly than per-capita GDP in the long term. This, along with the flattening of demographic trends after 2035, is one of the reasons why our projections show dedicated HI revenues and expenditures coming much closer together after 2045, after having grown considerably further apart prior to that time. The difference also narrows because the additional 0.9% HI payroll tax on higher-earning workers affects a growing proportion of all workers over time, since the earnings thresholds are not indexed.

A Brief Note Concerning Projection Changes and Uncertainty

I understand that Dr. Reischauer's testimony will review in some detail the various sources of uncertainty in these projections, as well as the reasons for changes in the results since last year's report. I will touch on these subjects just long enough to clarify some of the information that I have just presented.

In a nutshell, Medicare cost projections are highly uncertain and there are significant reasons to believe that actual costs will be higher in practice than projected in the 2011 report, as the report itself notes in several places. Just as the Congressional Budget Office must do, the Trustees must

[1] The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.

project forward current law as written, even when there are precedential reasons to be skeptical that it will be implemented without alteration. Early next year, for example, physician payments would be reduced by about 29% under the current-law Sustainable Growth Rate formula, which Congress and the Administration have repeatedly acted together to override. If these reductions continue to be overridden, Medicare Part B costs will be considerably higher than the report shows. A similar set of concerns is expressed about cost-saving provisions on the Part A side, most especially the annual downward payment adjustments for multi-factor productivity growth; under our current assumptions (again, a critical specification) these adjustments would result in Medicare payment rates falling further behind private health insurance over time (and even substantially below the current relative level for Medicaid), threatening the profitability of institutions providing services under Medicare (again, under our existing assumptions).

I will leave matters of behavioral responses to current law to be addressed in greater detail by Dr. Reischauer, but I would simply summarize the effects on our projections by noting that Medicare cost projections are uncertain on the one hand because we don't know how future Congresses (and private health care providers) will deal with these issues, but also that projections would be uncertain *even if* current law were implemented exactly as written. The CMS Medicare Actuary publishes an "illustrative alternative scenario" in which the SGR payment adjustments are overridden, and the ACA productivity adjustments phased out over 2020-2035. This alternative scenario shows total program costs of 10.7% of GDP in 2085, rather than the 6.2% shown in the main report. But even under the political assumption that holds current law in place, long-term cost projections vary significantly as we employ different assumptions for health cost growth and economic factors. Toward the end of refining these projections, we look forward to receiving later this summer the report of a Technical Panel of experts currently reviewing these issues.

I understand that Dr. Reischauer will be explaining the five-year deterioration in the projected depletion date for Medicare HI (from 2029 in last year's report to 2024 in this one). Here I will simply relate this shift to the theme of overall uncertainty in the Medicare projections. It may exaggerate—but not by much—to note that the HI Trust Fund projects to be on a razor's edge for several years, starting by the latter part of this decade. This was true not only in the 2010 report but is also true in this year's report. By mid-2015, for example, we only project enough assets in the HI Trust Fund to cover less than half a year of benefit payments in the absence of incoming dedicated revenues. This financing reserve is thus very low for several years before running out altogether in 2024. It thus does not take a great deal of creativity to imagine a 2012 report in which the HI Fund exhaustion date moves again by several years, in *either* direction, even if there are relatively subtle changes in projections of annual program operations.

Conclusion

The essential message conveyed by the Trustees' report is clear and will not change absent legislation: that Medicare faces real and substantial challenges, and that elected officials will best serve the interests of the public if financial corrections are enacted at the earliest practicable time.

Chairman HERGER. Now Mr. Reischauer is recognized for 5 minutes.

STATEMENT OF ROBERT REISCHAUER, PH.D., PUBLIC TRUSTEE, SOCIAL SECURITY AND MEDICARE BOARDS OF TRUSTEES, WASHINGTON, D.C.

Mr. REISCHAUER. Thank you, Chairman Herger, Ranking Member Stark, and Members of the Subcommittee. I appreciate the opportunity to appear before you to discuss the 2011 Medicare trustees' report.

I will focus my comments on changes that have occurred between the 2010 and 2011 reports and on the inherent uncertainty that surrounds projections of health care costs, both in the public and the private sectors.

As you all know, the trustees' projections of the financial health of the Medicare program change each year for a variety of reasons. There might be legislation that affects them. There is almost always a failure of the base year actual amounts to equal what was projected the previous year for that year. There are changes in economic and demographic assumptions, and there are continual refinements and improvements in the methodologies used by the actuaries to make the projections.

The media and the public, as my colleague pointed out, look largely at the date at which the HI trust fund becomes exhausted to make a judgment about whether the changes have been significant or not from one year to the next. As has been mentioned, the 2011 trustees' report projects that the Medicare HI Trust Fund will be depleted in 2024, which is 5 years earlier than projected in 2010. But it is worth noting that that is still 7 years later than was projected in the 2009 report, which was the last one issued before the Affordable Care Act was enacted, and 8 years longer than the actuaries' latest estimates for the date of depletion were the Affordable Care Act not the law of the land.

The 5-year deterioration in the date of the trust fund exhaustion might suggest that some major changes have occurred in policy or in assumptions. That is not the case. Instead, rather small deviations of actual from projected performance in 2010, and a few small changes in assumptions about the future, were enough to move the estimated date of exhaustion 5 years earlier.

The second figure in my prepared statement shows that Medicare expenditures have exceeded income since 2008. Last year's trustees' reports projected that as the economy recovered, this would turn around, and we would experience small surpluses in that trust fund in the period between 2014 and 2022. But under the new projections, Medicare spending is expected to exceed income for the indefinite future.

A more comprehensive measure of the HI Trust Fund's fiscal situation is the actuarial balance, which is the difference between the program's annual income and costs rates averaged over a 75-year period and expressed as a fraction of taxable payroll. The actuarial balance has deteriorated from minus 0.69 to minus 0.79 between the 2010 and 2011 report. The primary factor responsible for this decline is that expenditures were higher and payroll taxes were lower in the base year 2010 than was anticipated in the previous year.

Let me just say a few words about the inherent uncertainty of projecting Medicare's expenditures. We all realize that there is a lot of change going on in health care, both in the public and the private sectors, and how that will play out over the next several decades is quite uncertain. As the chairman has mentioned, the trustees' report projects expenditures and income based on current law, and because current law assumes the implementation of a 29.4 percent reduction in the physician fee schedule payments in 2012, some have viewed this as a relatively optimistic scenario.

The actuaries have provided an alternative estimate, which, as my colleague explained, assumes that the physician fee schedule is increased each year by the Medicare Economic Index, and also that the productivity-related reduction in payment for other providers is phased out. Some have suggested that this is the right or appropriate alternative projection. I think one can argue that, in fact, just as the trustees' report might be a little optimistic, this is a little pessimistic, because over the last 9 years, the update in the physician fee schedule has not kept pace with the Medicare Economic Index, and at times we have seen a reduction from full updates for other providers.

I think the message that we leave you with is that further legislative changes have to be considered by the Congress. The sooner those are enacted, the less disruption there will be for taxpayers, for beneficiaries, and for providers. And so it is essential that this is on the front burner of the Congress.

Thank you.

Chairman HERGER. Thank you very much.

[The prepared statement of Mr. Reischauer follows:]

Statement of Robert D. Reischauer

President, Urban Institute[1] and Public Trustee for Medicare and Social Security

Health Subcommittee, Committee on Ways and Means

U.S. House of Representatives

June 22, 2011

Chairman Herger, Ranking Member Stark, and members of the subcommittee, I appreciate this opportunity to discuss the 2011 Medicare Trustees Report with you. In his testimony, my fellow Public Trustee Dr. Charles P. Blahous described the basic financial structure of the Medicare program and summarized the major findings of the 2011 Trustees Report. I, accordingly, will confine my statement to the changes that have occurred in the program's financial outlook since the 2010 report and the challenges inherent in any estimate of future Medicare or health care spending.

The Trustees' projections of the financial health of the Medicare program change each year, sometimes by small amounts, sometimes by moderate amounts, and sometimes by large amounts. The media and the public tend to focus on the change in the date at which a trust fund is projected to be exhausted as an indicator of how significant the year-to-year change is. In the Medicare program, this makes sense only for the HI trust fund which, like the OASDI trust funds, obtains the preponderance of its income from a dedicated payroll tax, income taxes on a portion of Social Security benefits, and interest on trust fund assets and is precluded from spending more than is available from annual income and accumulated trust fund assets.

The 2011 Trustees Report projects that the Medicare HI trust fund will be depleted in 2024, five years earlier than was projected in the 2010 report (Figure 1). It is worth noting that the date of exhaustion is seven years later than was projected in the 2009 report, the last report prepared before the Affordable Care Act was enacted.

While the five-year deterioration in the date of trust fund exhaustion might suggest that some major changes occurred in policy or in assumptions, that is not the case. Instead, rather small deviations of actual from projected performance in 2010 and small changes in assumptions about the future were enough to move the estimated date of exhaustion five years earlier. Actual HI taxable earnings in 2010 were considerably lower than projected in last year's report. Although real earnings are now assumed to grow somewhat faster over the 2011 to 2019 period, projected real HI payroll tax revenues for the 2011-2024 period are projected to be 1.3 percent lower than in last year's report. While actual HI expenditures in 2010 were fairly close to the previous estimate, faster real earnings growth leads to larger increases in projected real provider payment rates during this period and is the primary reason why real HI expenditures for the 2011-2024 period are some 3.6 percent higher than they were in last year's report.

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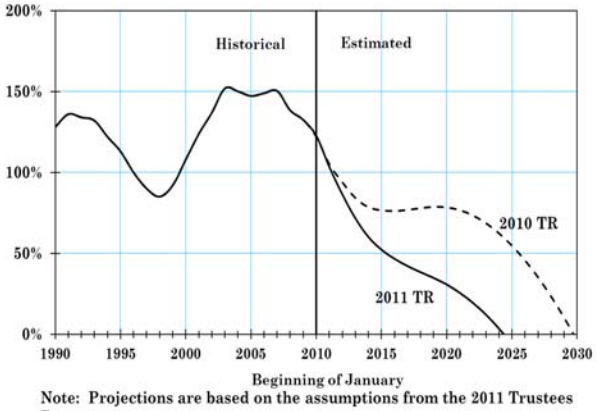
[1] The views expressed in this statement should not be attributed to the Urban Institute, its sponsors, staff, or trustees.

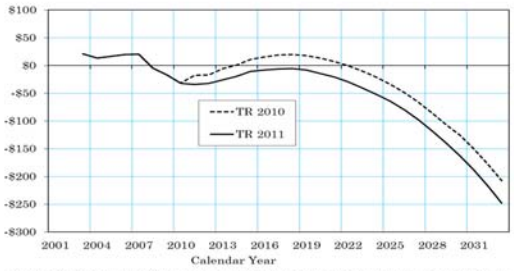
Figure 1—HI Trust Fund Balance at Beginning of Year as a Percentage of Annual Expenditures, 2010 and 2011 Trustee



Note: Projections are based on the assumptions from the 2011 Trustees Report.

Medicare HI expenditures have exceeded income since 2008. Last year's Trustees report projected that this situation would turn around as the economy recovered and small surpluses would be realized between 2014 and 2022 (Figure 2). Under the new projections, Medicare HI spending is expected to exceed income for the indefinite future.

Figure 2—Annual HI Trust Fund Surpluses(+) or Deficits(-) (in billions)



Note: Projections are based on the intermediate assumptions from the 2011 Trustees Report.

The change in the HI Trust Fund's actuarial balance is a more comprehensive indicator of the change from report to report in Medicare's financial situation. The actuarial balance is the difference between the program's annual income and cost rates averaged over the 75-year projection period.[2] The cost rates reported in the 2011 Trustees Report are slightly higher than those projected last year while the income rates have changed little (Figure III.B6). As a result, the actuarial balance has deteriorated to -0.79 percent from the -0.66 percent estimated in last year's report. The primary factor responsible for this decline is that expenditures were higher and payroll tax revenues lower in the base year, 2010, than was anticipated (Table III.B12) .

Figure III.B6.—Comparison of HI Cost and Income Rate Projections: Current versus Prior Year's Reports

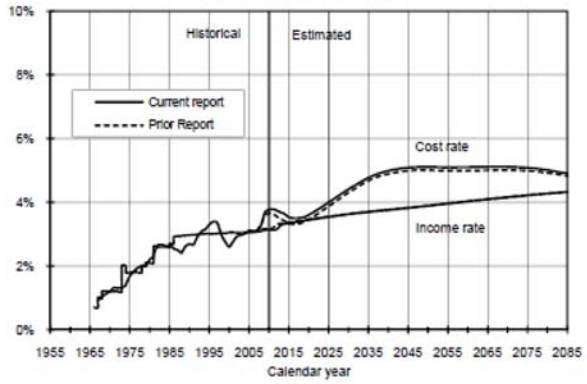


Table III.B12.—Change in the 75-Year Actuarial Balance since the 2010 Report

1. Actuarial balance, intermediate assumptions, 2010 report	−0.66%
2. Changes:	
a. Valuation period	−0.01
b. Base estimate	−0.17
c. Private health plan assumptions	0.04
d. Hospital assumptions	0.03
e. Other provider assumptions	−0.02
f. Economic and demographic assumptions	0.00
Net effect, above changes	−0.13
3. Actuarial balance, intermediate assumptions, 2011 report	−0.79

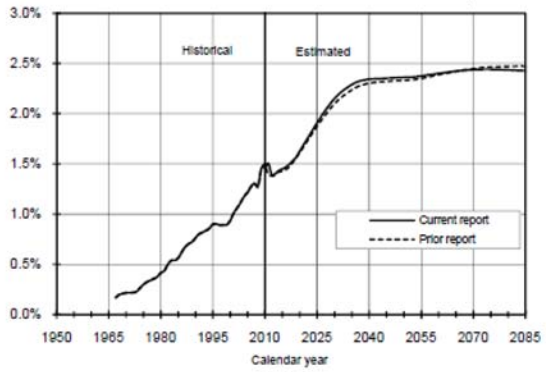
[2] The income rate is the ratio of incurred income from payroll taxes and the taxation of OASDI benefits to HI taxable payroll for the year. The cost rate is the ratio of incurred HI expenditures (excluding those for premium-paying voluntary enrollees and those whose expenditures are reimbursed out of the general fund) to HI taxable payroll for the year.

Whereas the 2010 report estimated that a 23 percent tax increase or a 15 percent reduction in expenditures would be needed to restore actuarial balance over the 75 year projection period, the comparable estimates in the 2011 report are a 24 percent tax increase or 17 percent reduction in expenditures.

By construct, neither of the two SMI trust funds can become depleted, so the changes in the date of trust fund exhaustion and actuarial balances are not relevant indicators with respect to the Part B (SMI) or Part D trust funds. General revenue transfers to the Part B trust fund are set each year to ensure that, together with beneficiary premiums, the program can meet expected costs and maintain an adequate contingency reserve. Part D has indefinite budget authority to draw on general revenues to cover costs not covered by beneficiary premiums and state transfers. For SMI, the relevant measure to focus on is the change from year to year in SMI spending, including premium payments, as a fraction of GDP.

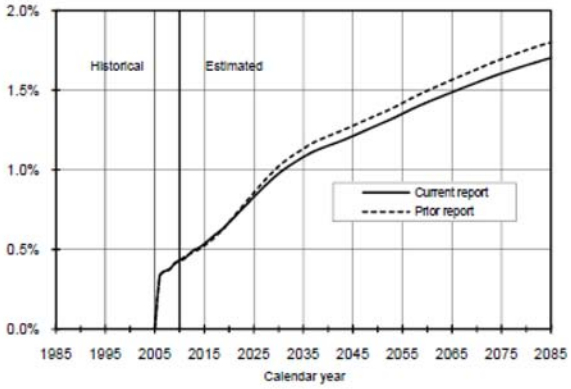
Figures III.C5 and III.C6, which are labeled with their identifiers from the 2011 Trustees Report, and the summary table show that the projections of SMI expenditures relative to GDP changed little between the 2010 and 2011 reports. Relative to GDP, Part B spending is projected to be slightly higher initially but to gradually become slightly lower than the projections in the 2010 report. This pattern reflects lower projected Part B expenditures starting in 2010, relatively lower GDP projections, and a slight refinement in the application of the ACA multifactor productivity adjustments in the long run.

Figure III.C5.—Comparison of Part B Projections as a Percentage of the Gross Domestic Product: Current versus Prior Year's Reports



In contrast, the 2011 report projects slightly lower Part D spending relative to GDP than was projected in the previous report. The primary explanation for the improved Part D outlook is an assumption that the growth rate for prescription drug expenditures in the U.S. as a whole will be somewhat lower than was assumed in the 2010 report.

Figure III.C6.—Comparison of Part D Projections as a Percentage of the Gross Domestic Product: Current versus Prior Year's Reports



While the changes between the 2010 and 2011 Trustee reports are relatively small and relate largely to updated economic and other assumptions, differences between projected and actual performance in the base year (which are not unusual), and small refinements in estimating methodologies, the projections remain highly uncertain. This is particularly true over the longer run.

Unlike Social Security, which provides a fairly straightforward and easily defined benefit (retirement income), Medicare provides access to an ever-changing and improving product--health care. It is impossible to predict with any confidence what might be considered adequate health care or its cost a decade or two in the future. New interventions, devices, procedures, therapies, and pharmaceuticals are being introduced every day. New payment systems are being developed, and delivery systems are evolving. It is widely accepted that past cost trends cannot be sustained long unless we are willing to devote the lion's share of our new private and public resources to health care.

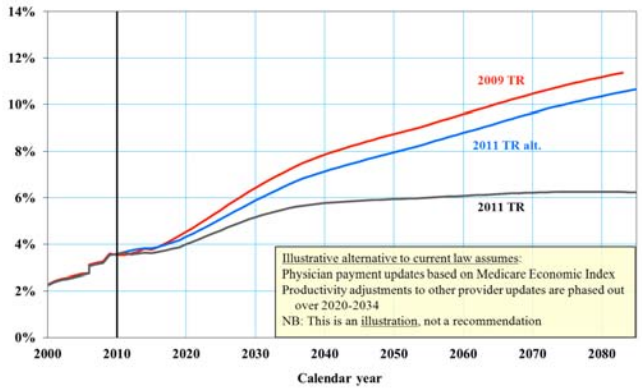
Many promising private initiatives are under way to curb the growth of health costs and improve the quality of care. Through the Affordable Care Act and other measures, the federal government is pursuing the same objectives. To the extent that federal efforts are reflected in law, their estimated impacts on costs are incorporated in the Trustees' projections. In some cases considerable experience suggest that the law will be modified to reduce or eliminate the adverse impacts of cost reduction measures on beneficiaries, providers, and taxpayers. The prime example is the Sustainable Growth Rate (SGR) mechanism that has been fully or partially

overridden in each of the last nine years. Notwithstanding this experience, the projections in this year's Report assume that the 29.4 percent reductions in the physician fee schedule called for by the SGR will go into effect in January 2012, even though Congress and the President are likely to waive the reduction. Were Congress and the President to substitute a MEI update for cuts called for by the SGR, Part B expenditures would be some 12.6 percent higher in 2012 than is estimated in the Report.

For this reason, the estimates in the Trustees Report might be viewed as a relatively optimistic set of projections. To provide a less optimistic picture, the CMS Office of the Actuary has produced an illustrative alternative set of projections for each of the past two years. This scenario significantly changes two assumptions underlying the Trustees Report. First, the SGR system is abandoned and in its place the physician fee schedule is updated each year by the Medicare Economic Index (MEI), which is an index of practice costs inflation minus an adjustment for the growth of economy-wide multifactor productivity. Second, the reduction the Affordable Care Act made to the updates for most other providers to account for economy-wide multifactor productivity is phased out starting in 2020 and ending in 2035.

Figure 3 shows total Medicare expenditures as a percentage of GDP as projected in the 2009 Trustees Report, which was issued before passage of the Affordable Care Act, and as estimated using the assumptions of the 2011 Report and the 2011 Alternative Scenario. Were the Alternative Scenario assumptions to prevail, 81 percent of the improvement anticipated in the 2011 Report from the Affordable Care Act would be lost by 2070.

Figure 3—Total Medicare expenditures as a percentage of GDP, 2009 and 2011 Trustees Reports, and Illustrative Alternative Scenario



Note: Projections are based on the intermediate assumptions from the 2011 Trustees Report.

Just as the assumptions underlying the 2011 Trustees Report might be considered relatively optimistic, the Alternative Scenario might be considered relatively pessimistic. While Congress and the President have not adhered to the discipline called for by the SGR, the updates that they have approved have averaged well below the MEI. Similarly, many provider types have not received full updates in every year. With considerable budgetary pressure on policymakers, average updates could be well below those assumed in the Alternative Scenario if the productivity adjustment were to be abandoned.

Furthermore, innovations being undertaken in the private sector and those stimulated by various provisions of the Affordable Care Act could prove more successful than have been assumed. With the private and public sectors working on the same problem and the provider communities more fully engaged, some optimism may be warranted.

Notwithstanding these possibilities, it is clear from the 2011 Trustees Report that further significant legislative action will be needed to put Medicare on a sustainable, long-run path. The sooner such actions are taken, the more gradual the change can be and the less disruptive it will be for beneficiaries, providers and the taxpayer.

Chairman HERGER. I thank our witnesses for their testimonies.

Before I get to my questions, I would like to welcome the newest member of the Health Subcommittee, Vern Buchanan. As Mr. Buchanan has many Medicare beneficiaries in his district, we especially look forward to his insights.

Mr. Blahous, I would like to get a few things on the record. When do the Medicare trustees expect the Medicare Hospital Insurance Trust Fund to go bankrupt?

Mr. BLAHOUS. We project depletion of the trust fund in 2024.

Chairman HERGER. What was the bankruptcy date in last year's trustee report?

Mr. BLAHOUS. It was 2029.

Chairman HERGER. So in the course of 1 year, the Medicare HI Trust Fund lost 5 years in solvency? Is this something Congress should be concerned about?

Mr. BLAHOUS. Well, I would state we should definitely be concerned about the hastening insolvency of the trust fund. As I note in my testimony, because trust fund balances are so low for several years going forward, changes of several years in the insolvency date are quite possible even without qualitative changes in the annual operations of Medicare.

Chairman HERGER. Mr. Blahous, I can tell you that it is certainly alarming to me that during the course of just 1 year, the Medicare Hospital Insurance Trust Fund lost 5 years of solvency and is now expected to go bankrupt, as you stated, in 2024. You state in your testimony that "it does not take a great deal of creativity to imagine a 2012 Medicare trustees' report in which the Hospital Insurance Trust Fund and solvency date moves again by several years in either direction."

Are you suggesting that it is possible that we could see a Medicare bankruptcy date within the next 10 years?

Mr. BLAHOUS. Well, it is certainly very possible. The trust fund ratio, that is basically the measure of the relationship of assets in the trust fund to annual expenditures, that is projected to drop below 50 in 2015. So less than half a year's worth of benefit payments could be accounted for by assets in the trust fund. Once you are down at that level, you run the risk of trust fund depletion. That is certainly very possible. It is also quite possible it could move the other way.

Chairman HERGER. The trustees' report estimates that the Medicare Hospital Insurance Trust Fund is projected to spend more money paying claims this year than it will collect via the payroll tax; is that correct?

Mr. BLAHOUS. Yes.

Chairman HERGER. How long has that been the case?

Mr. BLAHOUS. 2008 was the first year.

Chairman HERGER. Do you expect this trend of the Medicare Hospital Insurance Trust Fund spending more than it is collecting to continue?

Mr. BLAHOUS. Yes, we do.

Chairman HERGER. Are you aware of any program that will be financially sustainable if it spends more money than it has, or is this a recipe for bankruptcy?

Mr. BLAHOUS. Well, certainly our current projections would exhaust the trust fund because of these annual operating deficits, yes.

Chairman HERGER. I thank you.

Mr. Stark is recognized for 5 minutes.

Mr. STARK. Thank you, Mr. Chairman.

Mr. Reischauer, if you would just help me for a minute with a personal matter. I have a 9-year-old who hates math and science, but he wants to be the batboy for the Democrats' ball team. I have

to go home and explain to him how somebody with a Ph.D., like yourself, in computational quantum chemistry gets published in the Baseball Research Journal. Can you help me a little bit? That is a personal matter, and if you want to take time later, I would certainly appreciate the help at home to get this little bugger to study his math and science, and let him know that he could have something to do with baseball. It would be deeply appreciated.

The shortened solvency date, Dr. Reischauer, I believe has been caused by sluggish economic recovery, and it is due to a drop in revenues and an increase in spending, both factors caused by the general state of our economy; am I close?

Mr. REISCHAUER. You are right on the money. This is a program that is sensitive to the strength of the economy, both in direct and quite indirect ways. When economic growth picks up, wages of providers goes up, expenditures go up as a result of that. When the economy weakens, we see both induced enrollment of those who lose their jobs but were working when they were over 65, and a fall-off in payroll tax revenues.

Mr. STARK. Some have suggested that we could save a good bit of money by allowing Medicare private contracting. The Republicans seem to think that this would allow Medicare to continue paying doctors, but then allow doctors to charge whatever they want on top of the Medicare payment. Do you have any concerns about the effects of private contracting on, say, access to care and quality of care?

Mr. REISCHAUER. As a public trustee, I don't. As an analyst, it is an area that concerns me in that if private contracting were permitted and were not regulated, we could see access by individuals who are in tight markets, tight provider markets, begin to create some problems.

Mr. STARK. The Affordable Care Act is going to expire in 2016, and the report issued today shows that the reforms in the Affordable Care Act would add 8 years to the solvency. Before I ask if you think that is about right, I do notice that since I have been here, and perhaps since Mr. Rangel has been here, we have been going to go broke just about every year, and the reason, of course, we don't is that Congress acts in one way or another to protect Medicare. But going back, the question of the shortened solvency date caused by the economy in general, is there any one area that you suggest to us that we might move to extend the solvency of Medicare?

Mr. REISCHAUER. You know, there are a tremendous variety of measures that could strengthen the Medicare program's financial position, and some basic decisions have to be made by the Congress on the extent to which we should look to beneficiaries, taxpayers, or providers to contribute to that effort. Some of them involve changes in the current structure. Others involve incentives that might lead to a reformed delivery system, and we could talk for several weeks, probably, on the pros and cons of the various alternatives.

Mr. STARK. Thank you.

I thank you, Mr. Chairman.

Chairman HERGER. The gentleman from Texas Mr. Johnson is recognized for 5 minutes.

Mr. JOHNSON. Thank you, Mr. Chairman.

Good morning. You know, 5 years. Last Congress, the Democratically controlled Congress, passed a health care overhaul and a stimulus bill that were supposed to control health care costs and extend the life of the trust fund. From your report I would say these bills failed. Do you think those efforts are enough to solve this crisis?

Mr. PASCRELL. Would the gentleman yield, Mr. Johnson?

Mr. JOHNSON. Why?

Mr. PASCRELL. I wanted to ask you a question.

Mr. JOHNSON. Ask me a question? I don't yield.

I want to know if you think that those efforts are enough to solve the Medicare problem, or did we not get into it deep enough?

Mr. BLAHOUS. Clearly under our projections, we have a deficit in Medicare, even if we assume the current law is sustainably implemented. And as I indicated, actual costs are probably likely to be somewhat higher than what we show. So we clearly have a remaining problem left to solve.

Mr. REISCHAUER. Notwithstanding that, the best estimates, our estimates and CBO's estimates of the Affordable Care Act are that they extended the life of the trust fund, and were the Affordable Care Act to be repealed, the date at which the trust fund would become depleted would move from 2024 to 2016.

Mr. JOHNSON. I recognize you all are Ph.D.s, do you consult with medical doctors when you look at this kind of thing? Do you have them in front of you talking to you and telling you what their problems are; yes or no?

Mr. REISCHAUER. You mean when we do the iterations for the trustees' report?

Mr. JOHNSON. Yes.

Mr. REISCHAUER. No.

Mr. BLAHOUS. No.

Mr. JOHNSON. So you are not consulting the medical community at all. And, you know, docs, I think, play the system. They are going to ask for more than it really costs them because they know it isn't going to get paid. You are probably aware of that. That is why I ask you if you ever consult with the doctors themselves. The paperwork is atrocious. I don't know if you are aware of that or not. But it seems to me that the doc costs are part of our problem. I don't know that you all have really considered it.

Clearly we need to do more to save Medicare for future generations. I would just ask both of you: Do you have solutions for this problem? You know, you talk about the problem. What are the solutions?

Mr. BLAHOUS. Again, I would be very careful to say as trustees, we have to be very careful about not having a view. Personally, I think there are only so many levers you can pull. The things that drive the problem are the growth of the beneficiary population, so you have to look at eligibility criteria and eligibility ages. You have to look at the growth of the per capita benefits paid by the Federal Government. That is always dicey, and you get attacked for, quote, "cutting benefits" when you do that. But no matter how you do that, whether you are talking about the Affordable Care Act or alternative visions for Medicare, we are all in the game of having to

cap the growth of the per capita benefits the Federal Government is paying and controlling that rate of growth in some way. That has to be a component of the solution. In fact, we need additional cost constraint beyond what is in current law if Medicare is going to be maintained in terms of its solvency.

Mr. JOHNSON. Do you have a comment on that, Dr. Reischauer?

Mr. REISCHAUER. Well, I would agree with my colleague that there are a handful of areas that you can look to. Changing the number of folks who are eligible for this program, the definition of covered benefits, the payment to providers, the contribution from beneficiaries—in other words, premiums—and the contribution from the taxpayer, those are easy ones to estimate the savings that might result from them. A much harder one is to figure out what a change, a significant change, in the structure of the delivery system might do to lower the growth of costs over the long run.

Mr. JOHNSON. Thank you both for your comments. I appreciate it.

Thank you, Mr. Chairman.

Chairman HERGER. Thank you.

The gentleman from Wisconsin Mr. Ryan, the chairman of the Budget Committee.

Mr. RYAN. Thank you gentlemen for coming here. Five minutes isn't enough time to get into all of this.

A couple of things. It has been said that we want it to go away, or something like that. We all represent around 700,000 people. Our relatives are on Medicare. It is probably one of the most important programs the Federal Government has or has ever had. We want it to work; we want to save it.

Here is our problem. We have 10,000 baby boomers retiring every day with fewer workers coming into the workforce to pay for it. We have health care costs going up a lot faster than inflation. You are telling us that the HI Trust Fund is going bankrupt in 2024; CBO is telling us faster than that. So something has got to be done.

I want to ask you a couple of premise questions. A, do you both agree that you cannot say the savings in Medicare is going to pay for the Affordable Care Act and extend the solvency of Medicare? Do you agree that that is counting a dollar twice? Just a quick yes or no.

Mr. BLAHOUS. I agree with that.

Mr. RYAN. Bob, I assume you do?

Mr. REISCHAUER. From a unified budget standpoint, the answer is yes.

Mr. RYAN. Right. So we had the trustees giving us these alternative scenarios for 2 years now, which I find pretty amazing. So under more realistic assumptions, we find that you can't fund one other government program on the one hand and then extend the solvency on the other hand. That is double counting. We are not suggesting that CBO is doing the double counting, we are saying Congress is doing the double counting.

Point number two, Mr. Stark is right, we have faced insolvency before. Congress has always done something to deal with it; but the problem is the cliff is getting that much steeper. If we keep kicking the can down the road and waiting until insolvency is on the door-

step, then the solutions will be that much more dire, that much more bitter, and people will be that much more affected.

How many providers do you think are going to stay providing Medicare benefits if they are getting 66 cents on the dollar for every Medicare patient they have coming in the door? If you are telling us, as you do in your trustees' report, that they are going to pay 66 cents on the dollar down to 33 cents on the dollar, we might have a Medicare program, but it is not going to work for people on Medicare if nobody takes Medicare as a provider.

So we have got to be realistic about what is necessary to save Medicare. I would just simply say that the lessons we learned from the previous Medicare fixes are lessons we should take into the future. 1997 was an important budget agreement. It was bipartisan. It was a Republican Congress and a Democrat President doing a budget agreement to extend Medicare solvency and get the economy growing, produce budget surpluses.

But here is the lesson we got out of that exercise: Price controls and Medicare don't work. What happened, Congress did two successive bills, BIPA and BBRA, giving back the money to prevent Medicare providers from just dropping Medicare. What I think our friends on the other side of the aisle got out of that, as evidenced by the Affordable Care Act, is not that price controls don't work, it is that price controls are not politically sustainable, because Congress, seeing and knowing that access is being denied to Medicare beneficiaries, that providers are leaving providing the benefit, that we should just take it out of the hands of politicians. We should just take it out of the hands of Congress. Let us form an IPAB, an independent payment advisory board, of 15 political appointees and have them do the price controlling that goes right into law, circumventing Congress.

To us, what this simply means is we are going to do hard-core price controlling, which leads to rationing, which will lead to Medicare providers dropping Medicare, and that means future seniors will not have access.

We want to get rid of that. If we are going to save money to extend solvency, it should go to Medicare, not to pay for some other program. We shouldn't be raiding one government program to pay for another one. How many times have we heard that about Social Security?

Second, price controls, or rationing, or whatever you want to call it, it just doesn't work. So we believe at the end of the day, there is going to have to be a bipartisan solution. This is why we proposed premium support. The sooner you do it, you don't have to affect benefits for anyone above the age of 55. So the way we look at this, people who already retired on this program, don't change their benefits, because they have been made promises that government should keep to them. And if we do this soon, we can keep the promise also to the people who are within 10 years away from retirement.

So it is very negotiable. It is very reasonable to debate the contours of how to fix it with the new system, growth rates and design features. That is what this committee is trying to do.

But I simply want to ask you: Do you think providers of Medicare are going to keep taking Medicare if they are going to get paid 66 to 33 cents on the dollar?

Mr. BLAHOUS. I think you have highlighted a fundamental problem that we also highlight in the report, which is under our current assumptions, reimbursement rates under Medicare will lag very far behind what they are in the private sector, and we say that this could lead to substantial withdrawals of access to care under Medicare. So the answer is yes, I agree that is a fundamental problem.

Mr. REISCHAUER. I think you put your finger on a very important point, which is that the same providers offer services to the elderly and disabled through Medicare, the low-income population through Medicaid, and the working population and their dependents through employer-sponsored insurance or individually purchased insurance. And I for one think that efforts to restrain Medicare or Medicaid significantly are doomed to failure unless we provide incentives for dampening the growth of health care costs in the private sector as well. You can't have these huge differentials in reimbursements.

On the other hand, I would argue that the fixation we have with comparing Medicare's reimbursement rates to those in the private sector are a comparison of average payments or average costs, and most economists would argue that service is provided, a good is produced, as long as the provider can meet marginal costs. And so we can have some differentials here without destroying the market. They obviously can't get too large, and that is what you are concerned about, rightly.

Chairman HERGER. The time of the gentleman has expired.

The gentleman from California Mr. Thompson is recognized for 5 minutes.

Mr. THOMPSON. Thank you, Mr. Chairman.

Mr. Reischauer, isn't it true that whenever a new law results in a savings to Medicare Part A, that those savings improve the Hospital Insurance Trust Fund finances regardless of whether the savings are used elsewhere in the budget?

Mr. REISCHAUER. Yes, that is true.

Mr. THOMPSON. I just wanted to bring that up. My friend from Wisconsin raised that issue in questioning the double counting, but that is how the accounting system works.

Mr. REISCHAUER. And how it has been treated in many omnibus budget bills in the past, and other corrections by the Congress.

Mr. THOMPSON. My friend also used the Balanced Budget Act of 1997, which was passed under the Republican-controlled House, as an example. That included $994 billion in Medicare savings, and $292 billion of that was used for a tax cut. So it is the same practice; it is just depending on who is trying to do what. I guess the other guys are the critics.

Also, I have a sheet here. It was prepared by our side's staff, but you are the trustees' report starting in 1970, running through 2011, and years of solvency of the program, and I think—I would like to get you to look at it and let us know if this is accurate, but based on this, it has always been projected to reach insolvency at some point. And as Mr. Stark had mentioned earlier, Congress has

always addressed this issue by making changes. As a matter of fact, of the 40 years on this chart, 18 of those years, the solvency date is less than it is today in 2011. As you recognize, it is a problem because of the downturn in the economy. So I would like to have someone give you this and get your analysis of it.

And then also, the Affordable Care Act that was mentioned was an attempt to put in place provisions that would, in fact, improve the quality and reduce the cost of health care. Everything from bundling around a hospital admission to reducing hospital readmissions to expanding fraud-fighting efforts, and your trustees' report recognized that. Can you tell us your assessment of the delivery system reforms in the ACA?

Mr. REISCHAUER. Once again, I am going to have to take off my trustee's hat for this.

Mr. THOMPSON. Did you take these policies into consideration when you did this?

Mr. REISCHAUER. Yes. These follow the estimates by the actuary of the impact of those reforms on cost. There are many that both the CMS actuary and the Congressional Budget Office didn't provide savings for, or provided quite modest savings; that if all the planets come into alignment, and things work out well, and some of the initiatives that I discussed in my prepared statement come to pass, we could see, you know, significantly more in the way of savings.

On the other hand, some of them may prove to be ones that Congress reconsiders or ones that don't work out as well as the CBO and CMS have estimated. So we are in a period of huge uncertainty, I think, right now. But those base numbers are in our projections.

Mr. THOMPSON. I think the language on page 2 of the report says that "major program of research and development for alternative provider payment mechanisms, health care delivery systems, and other changes intended to improve the quality of health care and reduce the cost of Medicare." And this improves the cost and quality of health care outside of Medicare as well. I think that is important to note.

CMS did a press release on your report, and in it they say: Without the reforms in the Affordable Care Act, the Medicare HI Trust Fund would expire in just 5 years, in 2016. The report issued today shows these reforms added 8 years of solvency.

I would like to ask unanimous consent to submit this to the record.

Chairman HERGER. Without objection.

Mr. THOMPSON. Thank you.

Chairman HERGER. The gentleman from California Mr. Nunes is recognized for 5 minutes.

Mr. NUNES. Thank you, Mr. Chairman.

I would like to ask the two witnesses this question of insolvency. I apologize, I don't know how long you have been trustees, but when we look back throughout time, 10 years, 15, 20 years ago, we always knew we had an insolvency issue. I don't think anyone disagrees with that, and there has always been a need to save Medicare and save Social Security.

When you analyze the problem today, and you know here in this body we are locked into this budget debt limit increase and budget fight where it doesn't appear like there is any fix in sight, and basically one of the major holdups is are we going to deal with these entitlement programs to solve the insolvency problem. I don't believe we have ever defaulted on our debt. We are getting very close to that if we don't have an agreement soon. So my question to you is: Is the situation more serious and more urgent today than what it was when you looked back to 10 years ago and 20 years ago?

Mr. REISCHAUER. I think the answer to that is yes, both because the Medicare problem is embedded in a larger fiscal problem; and because, as opposed to 5, 10, 20 years ago, the baby boomers are retiring. They are beginning to apply for Medicare benefits. And so the acceleration of the burden that we talked about as a future problem 10 years, 15 years ago is now upon us. And this makes some solutions more difficult because the numbers of individuals who are receiving benefits is rising rapidly.

Mr. NUNES. Mr. Blahous.

Mr. BLAHOUS. I have a two-part answer, and Dr. Reischauer anticipated both parts. One, we have a much more serious overall fiscal situation. Deficits, unified deficits, are much larger than they previously were.

Secondly, we have an urgency that arises from demographics. Each year that passes, we have more baby boomers going onto the benefit rolls, and there is a great reluctance, a bipartisan reluctance, to withdraw benefits from people who are already dependent upon them. So the costs of dealing with these problems grows enormously with every passing year.

Mr. REISCHAUER. I would just like to add a third issue, to differentiate myself from my colleague here, and that is we have enacted major changes already in the Medicare program. So in some sense the cupboard is fairly bare. We can't go to that cupboard and open it up and say, well, let us cut provider payments even more. We are worried about can we sustain the ones we have already adopted.

Mr. NUNES. There is no question that every day in my office, people are coming in. Health care providers are coming in, either to my district office or here in Washington, and complaining about the status of the health care system as it relates to the Affordable Care Act, Medicare and Medicaid. There are problems throughout all of these programs.

Would it be good policy if somehow this Congress could move legislation that would take anyone that is 55 years of age and older and keep them on traditional Medicare; would that be a good goal for this Congress to partake in?

Mr. BLAHOUS. Are we basically saying anyone over 55, keep them in traditional Medicare and sort of hold them harmless for any future changes at all?

Mr. NUNES. If we could accomplish that?

Mr. BLAHOUS. I mean, I think it is good policy to try to hold people who are near retirement or in retirement, hold harmless as much as possible from any future changes. Having said that, with every passing year, it gets harder and harder to hold harmless people older than even 55. In 5 or 10 years from now, if you asked me

the same question, I might look at you and say, I don't think you are going to be able to do that.

Mr. NUNES. Mr. Reischauer.

Mr. REISCHAUER. I guess I am a believer that even old dogs can learn new tricks. And, you know, when we make a statement as you have made and Congressman Ryan also made about we will let people 55 and older stay in the system that they are in now, it implies that you want to keep that system unchanged.

Quite frankly, I don't think that is appropriate policy. I think Medicare should evolve in a gradual way. We have in the Affordable Care Act an innovation center. We have some changes in payment mechanisms and things like that that would gradually change Medicare. I think pushing those forward as fast as we possibly——

Mr. NUNES. I think we agree that there should be gradual change, and that is why in Mr. Ryan's plan he has put forward 55 and older, because that gives people time for retirement planning and such to deal with the changes. However, I think where we disagree is where this problem just seems to be bigger than what—as you both said earlier, this problem appears to be bigger than what it was 10, 20 years ago, and so I think we have to act quickly in order to save Medicare for everyone.

Chairman HERGER. The time of the gentleman has expired.

The gentleman from Oregon Mr. Blumenauer is recognized for 5 minutes.

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

I would just pose questions to our panelists not to answer now, because I have some others I want to get to, but if you would reflect, because I appreciated, Mr. Blahous, you talking about whether or not this is sustainable over time, that we are going to take, what is it, 79 million Americans and freeze them in Medicare as it is now, although my friend from Wisconsin takes the reviled savings from the Affordable Care Act and counts them, assumes them, in trying to make his plan pensile. But we will be having a situation where there is a huge population that will grow smaller over time, but still millions of people 30 years from now, an ever-sicker, smaller population that my friend, when he asked it to be scored, just assumed that the general fund would pick up the gap. I really would appreciate it if you two experts might reflect and maybe share with the committee what that impact is going to be over time.

Mr. RYAN. Would the gentleman yield just briefly?

Mr. BLUMENAUER. If I have time at the end, Paul, I am happy to do it.

I would like to be able to lock in what this means, because we haven't been able to get a good figure. It wasn't scored in terms of what that extra cost would be for an older, sicker population. Although declining, it would still be millions of people.

And I would take modest exception to my friend's characterization that IPAB takes the control out of Congress and puts it inevitably towards rationing and price control. As I think he knows that the recommendations from IPAB are just that, and they will come to Congress and have to be voted up or down. I think that is really good that we have a mechanism because we have seen political fail-

ure on both sides of the aisle on things like base closing and repeated failure with Medicare.

We are already seeing some people trying to walk back IPAB'S ability. And I have heard my Republican friends decry the fact that providers right now aren't getting enough money, and yet we can't afford what we are giving them, and they don't want a control mechanism.

I am wondering, is there any reason why, with the help of IPAB to maybe stiffen the spine of Congress, that we couldn't mimic the best practices that are going on right now with Medicare in my community, my colleague Mr. Kind's, Mr. Ryan's State of Wisconsin, where costs are dramatically lower than other parts of the country, and performance is better? Is there any inherent reason that we can't mimic that behavior, Mr. Reischauer?

Mr. REISCHAUER. It is certainly a goal that we should strive to achieve. But it is very difficult to figure out how to get from here to there, how to get from Miami to Wisconsin.

Mr. BLUMENAUER. But some people have figured it out, haven't they? Some people have figured it out. We are not all Miami; we are not all McAllen, Texas.

Mr. REISCHAUER. And we don't really know how to convince Miami to mimic the behaviors of Wisconsin, Minnesota, some of the more parsimonious practice pattern States.

Mr. BLUMENAUER. That are more effective?

Mr. REISCHAUER. In many cases, that are more effective.

Mr. BLUMENAUER. Well, I am troubled a little bit with this, because I think we do know what works. I think there is bipartisan agreement, at least there has been until recent years, of some of the experiments in the Affordable Care Act, the ACOs, of dealing with unnecessary hospital readmissions, being able to have more attention to primary care, dealing with freight with waste, fraud and abuse.

I mean, there is a litany of bipartisan actions that can be taken to squeeze far more out of the existing Medicare system. But people haven't been incented to do it. And Congress in both parties has wobbled, at least until we are starting to move back with the Affordable Care Act.

And I just, I think we are setting our sights too low. I think we ought to be accelerating the reforms that were talked about. And yes, there is a little discipline. There are some price signals. I don't think that is control. But we are not just going to open the spigot and then pay people for procedure after procedure after procedure, which is why doctors are getting more money, even though the reimbursement rates are more parsimonious.

And I think we ought to be more optimistic about this. And I think there is a bipartisan consensus about how it could be done once we get out of this whirl we are in right now. Thank you.

Chairman HERGER. The gentleman's time has expired.

The gentleman from Washington, Mr. Reichert, is recognized for 5 minutes.

Mr. REICHERT. Thank you, Mr. Chairman.

And thank you, gentlemen, for appearing this morning.

I agree with Mr. Blumenauer, we must find a bipartisan solution to this, and I think we need to be more optimistic that there is one. I think many of the members have expressed that this morning.

However, there have been some comments that have been made that sort of puzzle me just a little bit. Like the question was asked earlier, why are we even paying attention to this issue? Well, I think it is obvious from your testimony there are some major themes that you are expressing this morning to all of us, to all Americans, as some may be watching C–Span and don't have a life. Medicare is going bankrupt. You both agree with that, and it is accelerating, true, yes?

Mr. BLAHOUS. Yes.

Mr. REICHERT. Medicare's dire financial status is actually drastically understated, would you agree with that, yes?

Mr. BLAHOUS. I would say it is very likely to be significantly understated.

Mr. REICHERT. Sir?

Mr. REISCHAUER. I am unsure of that. I think if we don't take full advantage of the initiatives in the Affordable Care Act, if we don't encourage all of the innovation that is going on in the private sector and in the nonprofit sector, that is true.

Mr. REICHERT. Sir, wasn't it understated just a year ago?

Mr. REISCHAUER. Excuse me?

Mr. REICHERT. Wasn't it understated just a year ago in a report and here we are today, we are accelerating the——

Mr. REISCHAUER. You know, I think the——

Mr. REICHERT. Is that a yes?

Mr. REISCHAUER. No. I am not sure what your question is. Were you referring to the 2010 report?

Mr. REICHERT. Yes.

Mr. REISCHAUER. And this report also has warnings which say——

Mr. REICHERT. But it has been accelerated, is that not true?

Mr. REISCHAUER. Yes, it has.

Mr. REICHERT. By 5 years?

Mr. REISCHAUER. There are changes largely in the economic——

Mr. REICHERT. And you would not expect that to continue?

Mr. REISCHAUER. I hope the economy is going to rebound.

Mr. REICHERT. You are not sure, okay. Massive tax increases, do you see that on the horizon, or benefit cuts? If we don't do something now, isn't that sort of the scenario, if we don't act now? I mean, we must do something now; would you both agree with that?

Mr. BLAHOUS. I would say that the, on the HI side, the implication of trust fund exhaustion would be a benefit reduction in the absence of legislation. On the SMI side, the implication would be greater general revenue requirements, which implicitly would lead to higher tax burdens.

Mr. REISCHAUER. Yes.

Mr. REICHERT. Okay. Thank you. The thing that I guess is really confusing to a lot of Americans, they see this health care bill out there that has been passed, and it has been implemented by some degree or another and still more laws to take effect. But there is a $600 billion tax pay in this bill, $600 billion worth of taxes ap-

plied to small businesses and people to pay for this. How can we get the economy going if we continue to tax small businesses? $523 billion in cuts to Medicare. So no wonder people are expecting higher premiums and fewer benefits in Medicare.

I wanted to ask a specific question though regarding the alternative scenario. It states that overall Medicare spending is expected to grow to 10.36 percent of GDP, a 3.6 percent increase over the trustees report. Growth of this magnitude would substantially increase the strain on the Nation's workers, the economy, Medicare beneficiaries and the Federal budget. Could you elaborate on what the strain may look like related to these important areas in other national priorities, like education and medical research.

Mr. BLAHOUS. Well, I would just say, first of all, I agree with Dr. Reischauer that the main projected trustees' report is probably the best-case scenario, and then this would be sort of the pessimistic scenario. The reality is probably somewhere in the middle. But if we take that worst-case scenario, I mean, that is an unprecedented level of strain, fiscal strain, for the Federal Government. I mean, if you consider over 10 percent of GDP is for one Federal program alone, that is roughly twice as much as any Federal program to this point has ever absorbed. That would be over half, relative to GDP, over half of the size of the entire Federal Government relative to the economy as recently as 2008. So to have over half of our historic norms in terms of the Federal size of government devoted to one program would be an unprecedented strain.

Mr. REISCHAUER. My comment on this is long before those numbers would come to be realized, this nation is going have to address its deficit and debt problem. And in my view, Medicare will be one contributor to a solution. And so those numbers are horrific. But long before we face them, we are going to have to make some much more fundamental changes in our revenues and expenditures across the board.

Chairman HERGER. The gentleman's time has expired.

The gentleman from New Jersey Mr. Pascrell is recognized for 5 minutes.

Mr. PASCRELL. Thank you, Mr. Chairman.

How are you today? What is logical, we learn in logic 101, may not be true. It is our premises that determine those things. I want to enter into the record, Mr. Chairman, the S&P indices concerning the health care costs, and to bring to your attention, Mr. Chairman, that in 2010, Medicare claim costs associated with hospital and professional services for patients covered under Medicare increased at a more modest 3.2 percent rate, much lower than the private sector, much lower than the private sector. And I would like to ask to begin with and very briefly your response, I would appreciate that, what do you think attributed to the slowdown to the more moderate pace of increase in Medicare, as well as the private sector going down, too, but not to the degree of Medicare? Why do you think that happened? Both of you, either of you.

Mr. REISCHAUER. My response to that would be that one factor is certainly the turndown in the economy, which has left some seniors and others with less income to pay their co-insurance and their co-payments and so on. It is conceivable that some even had to drop their Medigap policies.

But I think of more importance here is the attention that CMS and the providers have begun to pay to overuse of services. And many practitioners are looking anew at their practice patterns.

Mr. PASCRELL. Which is a major target of the health care act, right?

Mr. REISCHAUER. Yes. And it is a major change in attitude and behavior, and I think that is going on throughout the society, and it is a good development.

Mr. PASCRELL. Mr. Blahous. Thank you.

Mr. BLAHOUS. I generally would agree with that. I think certainly the overall state of the economy played a role, and the factors Dr. Reischauer just spoke of also played a role.

But I would be candid and add a heavy dose of "I don't know" to the answer. Short-term fluctuations in these cost levels are very difficult not only to predict but also to explain after the fact, so my level of uncertainty as to what to attribute that to is very high.

Mr. PASCRELL. I would contend that even before it is only 20 percent in effect that the health care act has had an effect on the very costs that we are trying to reduce because we are never going to have a Medicare program that is able to keep up with inflation and the rising costs of health care until we control in some manner, shape, or form under a capitalistic system the rise of health care costs. We need to do something about that, and we are trying to do something about that.

One-third of the entire health care act dealt with Medicare and Medicaid and how we should save money in the process. Much of it was not scored in the final analysis.

Now, we had a major change. In the report of 1997, the report of the trustees in 1997, brought about some very interesting things. The beginning of Medicare Advantage, the beginning of the process to start to privatize the system. Now, we pay 12 percent more to these private plans, and seniors are going to pay much more if we move, obviously, to privatize the whole process under the guise of trying to straighten out Medicare. Look, all of these reports from 1970, as the gentleman from California pointed out before to now, talk about the dire position in which Medicare is in. Every one of those reports, that the world is coming to an end as far as Medicare is concerned. That did not happen.

As for my friend from Wisconsin that talks about double accounting, this is what a bank account is all about. You take money out of the account as you need it; you don't take it all out. It is, I believe, very analogous to those funds that are in a bank account. When moneys are deposited, the dollars are used for other purposes until they are withdrawn. What is so different about what we do in terms of how we are calculating savings in the future?

So we need to take a look, Mr. Chairman, at not only the logic of what we say, but if there is any resemblance to the truth. This is not reality TV. Thank you.

Chairman HERGER. The gentleman's time has expired.

The gentleman from Georgia, Dr. Price, is recognized for 5 minutes.

Mr. PRICE. I thank the chair and I thank our witnesses for coming to help us understand what are the financial operations of Medicare. We are talking about the financial operations. That is

the role of the trustees, right? Look at the financial, not the clinical side of health care. So, as a physician, we are talking about money today; we are not talking about quality of health care, those kinds of things, that are so important to patients across this country.

Our friends on the other side of the aisle have a penchant for mischaracterizing our positive solution, I think. And I want to touch on a couple of the things that Mr. Stark mentioned. He said that our proposal, our positive solution, was a voucher plan for Medicare. Well, it isn't a voucher plan; you know that. Both of you know that, correct?

Mr. Reischauer, you understand that our program is not a voucher program; it is a premium support program.

Mr. REISCHAUER. The difference between premium support and vouchers has been explained by some as the payment not relating to the cost of the underlying enterprise. That is a distinction that I am not——

Mr. PRICE. Well, you supported a premium support program in the mid to late 1990s.

Mr. REISCHAUER. I did. I still support it.

Mr. PRICE. You wouldn't have called it a voucher program, would you? In fact, you didn't call it a voucher program at that time, did you?

Mr. REISCHAUER. No, we didn't call it——

Mr. PRICE. No, you called it a premium support program, and that is important to know.

Mr. STARK. also said that our positive solution ends guaranteed benefits for seniors. Well, that is not true. You know that. In fact, we save Medicare for future generations. In fact, in our proposal, it actually stipulates that the program must be guaranteed. Isn't that true, Mr. Reischauer, when you read our program.

Mr. REISCHAUER. To the extent that I know the details of the program, yes.

Mr. PRICE. It is a guaranteed program; that is correct. Mr. Stark also mentioned the issue of private contracting and said that if private contracting were allowed in the Medicare program, which many of us believe is the kind of pressure valve that needs to be put in place to relieve the incredible access pressure that currently exists in Medicare, in response to his question, wouldn't that cause access problems?

Mr. Reischauer, you said, "if not regulated," is your quote, "if not regulated" it might cause—have access problems. Are you aware of any proposal that would put in place private contracting without regulation?

Mr. REISCHAUER. Well, I think this is a matter of degree as well as existence.

Mr. PRICE. Are you aware of any, though, that don't?

Mr. REISCHAUER. No, I am not.

Mr. PRICE. And in fact, isn't it possible that an appropriately regulated and structured private contracting program would in fact increase access for Medicare for seniors in this country, isn't that possible?

Mr. REISCHAUER. It is possible, but not probable, I would say.

Mr. PRICE. Well, I would beg to differ with you on that. And there are certainly individuals who understand the huge challenges

with access right now that seniors have. And that one of the ways to solve it, as you have identified in your list of solutions, is something that allows for increasing access.

I want to touch on the Medicare trigger, for this is now the sixth year in a row that the trustees have said that the board of trustees are required to issue determination projected excess general revenue for Medicare funding, this is the sixth consecutive such funding. When that trigger occurs, then, it is the obligation of the President, is it not, to then propose to Congress a solution to fix that problem. Is that correct?

Mr. REISCHAUER. Yes.

Mr. PRICE. And have you seen any solution that this administration has offered for having had this trigger be punched through for the past 3 years under his watch?

Mr. BLAHOUS. No.

Mr. PRICE. Have you, Mr. Reischauer, have you seen that solution?

Mr. REISCHAUER. No. I think the Congress has waived the requirement.

Mr. PRICE. Under the Democrat control in the past, yes, they said, oh, no, don't worry about that. Isn't that what they did, said don't worry about the money?

Mr. REISCHAUER. Yes.

Mr. PRICE. I want to touch on this whole issue of Medicare changing. In fact, Mr. Reischauer, you said that there are significant changes to Medicare through the PPACA, which is the reform bill that they put through. So, in fact, what has already been adopted ends Medicare as we know it. Would you agree with that statement?

Mr. REISCHAUER. It transforms the program as all legislation in the past——

Mr. PRICE. So Medicare as we know it right now in this colloquial term that is used out there in the marketplace, Medicare as we know doesn't exist under the Democrat's plan already, is that correct?

Mr. REISCHAUER. Well, the question is, what are we referring to as Medicare? If we are saying——

Mr. PRICE. Medicare as we know it is basically is what we have right now.

Mr. REISCHAUER.—a fee-for-service unmanaged care program, you know, it exists after the Affordable Care Act as it did before the Affordable Care Act.

Mr. PRICE. But Medicare as we know it, the program that exists right now, has been changed significantly under PPACA, would you agree with that statement?

Mr. REISCHAUER. There have been significant changes.

Mr. PRICE. But Medicare as we know it is already gone and done so by the reform bill that was put in place before.

Mr. Chairman, my time has expired, but I look forward to submitting further questions for the panel.

Chairman HERGER. I thank the chairman.

The gentleman from New York, Mr. Rangel, is recognized for 5 minutes.

Mr. RANGEL. Thank you, Mr. Chairman, for calling this meeting.

And I think it is helpful just to clear the air to have experts that are objective that will have their reputations to protect long after the election is over.

I think you have to agree that whatever decisions that we make that is going to cause any dissatisfaction with our constituents, it is much easier when the parties are talking together. They may not be happy with Democrats Or Republicans, but at least they would not be nearly as angry if the parties themselves have taken different positions.

The fact that so many Republicans got elected attacking so-called ObamaCare forced Democrats to get reelected in attacking the RyanCare. And now the facts are not nearly as important, it appears to me, as the parties getting reelected.

So, unlike Mr. Blumenauer, I just can't believe that a nation that owes so much to our aging population can spend trillions of dollars rebuilding the economy of Afghanistan and Iraq and able to say that we can't provide decent care. And that means that we are going to have to have reform, and that means it is going to be painful to a lot, but it also means that as long as we fight each other, then the parties don't want, the beneficiaries don't want to make decisions.

Let me ask this: As relates to Medicare and solvency, do you believe that the Affordable Care Act goes in the direction of dealing with the question of solvency?

Mr. BLAHOUS. Certainly the Affordable Care Act extended the duration of Medicare HI solvency.

Mr. RANGEL. And does it constantly request that we review what changes have to be made from the Congress and the administration in order to protect that solvency? I mean, do you believe that we are not dealing with the problem at all and that we need a dramatically different approach? I don't have a problem changing the approach if it is bipartisan and we agree that this is best. I believe that an old dog can use new tricks. I believe that if the Republicans come in and they say ObamaCare is moving in the right direction, not fast enough, and we think these changes have to be made that is not going to happen until, if it happens at all, until after the election.

So my question to you as being objective professionals, are you satisfied that the affordable act bill allows itself to deal with solvency if certain changes are made? I mean, do you believe that we just are hanging it out there and ignoring the problem? We know that this great country has the ability working together to deal with that problem.

Mr. BLAHOUS. I would say there are three things that come to mind in response to your question. One is the primary engine under the Affordable Care Act for extending solvency of the HI trust fund is these annual adjustments in the reimbursement rates for growth and economy-wide multifactor productivity. And in the last trustees' report, that engine was powerful enough to account for basically the overall contours of the cost projections over the long term.

Now, this year's trustees' report relies a little bit more on the payment advisory board. But basically, in order to hit the savings targets in the Affordable Care Act, the productivity adjustments themselves won't be completely sufficient.

Mr. RANGEL. Really—I am going get the answer, but my time is so restricted. Really what I want to do is understand the premium support position more clearly. And whether you call it a voucher or premium support, one, does anyone contradict that the insurance companies'—the health insurance companies' major obligation is to make a profit? No. That is their job. Two, if you are trying to make a profit, does anyone challenge the fact that the selection of people to be insured are based on the risk involved? Answer, no. If, indeed, a person is more vulnerable when they are older, are they less inclined to get a fair strike, less inclined to get benefits without higher costs? Answer, no.

So the premium support idea guarantees that you get something, but you can only get what you are able to afford to get, is that true? That is true. And so I don't care what you call it; the fact is that we are making major adjustments and putting the entire ability of people to get health care in the hands of those people that really don't want you as a client, and I got a—not a voucher, I got support. But you are not guaranteeing that I have enough support to get the health care that I have for my kids that I get, right.

Chairman HERGER. The gentleman's time has expired.

And our witness can respond in written letter to the committee on the question.

The gentleman from Florida, our new member to the subcommittee, Mr. Buchanan, is recognized for 5 minutes.

Mr. BUCHANAN. Thank you, Mr. Chairman, for holding such an important hearing.

I also look forward to working with you as chairman and the rest of the members on the subcommittee.

I also would like to thank our witnesses for being here today.

It got touched on a little bit. I want to go over a couple of points. Medicare trustee, which you projected, we touched on this a little earlier, would become insolvent in 2024 instead of 2010. In my district, I have 170,000 seniors, and we are in Florida, so, obviously, it is a big issue now all over the country, but percentage wise much bigger in Florida. When we are looking at projecting to 2024, one thing I don't believe that was taken into account is the reduction or the doc fix or the SGR that was taken into effect in terms of looking at insolvency.

When we project this out and look at it down the road talking with doctors in our community, I am very concerned a lot of them will have to go out of businesses, a lot of the big practices. We have got another 30 percent cut that we are looking at, but doesn't take any impact in terms of the viability of Medicare long term. So I guess, wouldn't you agree that these cuts if they go into a place would drive the insolvency date, because we are looking at a $300 billion problem a lot quicker? And I would like to have both gentlemen respond.

Mr. REISCHAUER. The solvency issue relates to the HI or hospital insurance fund. And the doc fix is Part B, part of SMI, and that is not affected by solvency issues. Because of the way the Part

B trust fund is constructed, it can never be exhausted. General revenues are automatically given to the trust fund to make up the difference between projected costs and premium payments and State transfers, so it doesn't affect the date of exhaustion of the HI trust fund.

Mr. BUCHANAN. My point is I have been here a little over 4 years, and we have had a doc fix once or twice a year. I don't know how anybody runs a business or any business, especially a lot of these medical practices, and have to look at a 15 or 30 percent cut every year. But I don't know how this isn't considered as a part of the overall Medicare, the viability of the medical community.

The other gentleman——

Mr. BLAHOUS. I would say I think the principal effect of the anticipated doc fix overrides would be in the overall cost of Part B. And under our projections, where we assume those huge cuts happen, we show Part B costs of a little over 2 and a quarter percent of GDP by the 2030s. But if you assume we override them, we are up over 3 percent of GDP. So there is a substantial increased cost on the SMI side if you assume the payment reductions are overridden.

Mr. BUCHANAN. Mr. Blahous, let me ask you another question. Last year a Harvard study found that malpractice costs in terms of our health care system at about—we could save as much as $55 billion a year. Do you think that we should have medical malpractice reform, especially as we are looking to try to drive down costs?

Mr. BLAHOUS. Well, certainly speaking as a trustee, everything we can do to hold down the growth of cost is going to make our overall financial projections better for Medicare. So, yes, if we can produce that level of savings for Medicare through malpractice reform, obviously, that would improve the financial outlook that we would show.

Mr. BUCHANAN. Is that something that you personally have looked at as a trustee of med mal costs in terms of Medicare? Because, obviously, I can just tell you doctors about defensive medicine, running a lot more tests than they feel that they need to just to make sure they are covered in case 1 in 1,000 or 10,000 cases of someone has a tumor and it doesn't end of being something more substantial. Is this something you have looked at in terms of tort legal reform?

Mr. BLAHOUS. Not so much, because the trustees' process generally focuses on scoring current law. It is somewhat different from say the Congressional Budget Office where they produce these menus of policy alternatives. Generally, in the trustees' process, we don't tend to evaluate alternative policies to current law. But obviously, it would certainly draw heavily from the input of everyone from CBO to the Medicare technical panels to others in scoring such a provision if it were enacted into law.

Mr. BUCHANAN. Mr. Reischauer, do you have any thought on legal tort reform, the impact that would have either as a trustee or your own personal opinion in terms of driving down costs, because I mean, obviously this is something—and again, I meet with a lot of doctors. I have a neurosurgeon who says his medical malpractice is $200,000 a year; he has got to see $1,000 worth of reve-

nues to pay the $200,000 in insurance, and they are practicing a lot of defensive medicine, and I think it is a big area we can make a big change in, but what are your thoughts?

Mr. REISCHAUER. My thought is that there are a number of studies trying to estimate the impact of malpractice reform on overall health care costs. By and large they come out saying that this isn't a huge contributor to the rapid growth of costs, of health care costs, but reform certainly would be a significant contributor to lowering the growth by reducing the level, really a one-time level shift. So I would align myself with Dr. Blahous' comments that I think some change would be a good thing.

Chairman HERGER. The gentleman's time has expired.

Mr. BUCHANAN. I yield back.

Chairman HERGER. The gentleman from Wisconsin, Mr. Kind, is recognized for 5 minutes.

Mr. KIND. Thank you, Mr. Chairman. I want to thank our witnesses for your update today. What strikes me—and Mr. Reischauer, maybe I can start with you—I am looking at this charge here showing the trustee reports dating back to 1970 in regards to years of solvency. And what jumps out is how much this really does track economic performance, whether we are in a growth state or a declining state, and how that influences the ultimate solvency of this trust fund. Is that something that is consistent with what the trustees are finding, too, what the strength of our economy is and the payroll revenue that is being generated and also the number of entrants entering Medicare?

Mr. REISCHAUER. Certainly that is a very important contributor, as is legislation. And at various times in this list, the Congress has enacted significant legislative changes that have prolonged the life of the HI trust fund.

Mr. KIND. I am looking particularly at the late 1990s, 2000 or so, when we had period of robust economic growth, and there the trustee were showing 25, 28 years of solvency. Unlike the great recession that we are coming through right now, we have had a drop off of the number of years of solvency. So I think one of the best things we can do as a nation to increase the solvency of the trust fund is to get this economy back on track creating good-paying jobs, would you agree with that?

Mr. REISCHAUER. I would agree.

Mr. KIND. And in regards to my friend's comment regarding med mal reform and the impact that is going to have, you know, and I think the President is there as well, that if we are going to be asking doctors through the Affordable Care Act to practice more best-evidence medicine or protocols of care, knowing what works and what doesn't work, there should be greater safe havens of protection for that type of practice system. But this is where you lose me on that; 37 States have already enacted med mal reform, including the State of Wisconsin. So, unless those 13 States that haven't taken action yet on med mal reform are driving all this additional cost in the health care system, I don't see it.

In fact, studies show that the utilization practice of doctors in States that have med mal reform in it is very little different than in States that don't have med mal reform. Is that what you found in your analysis?

Mr. REISCHAUER. I haven't done any independent analysis, but I am aware of studies that have come to that conclusion.

Mr. KIND. Well, this is what I think will also help, and a lot of this is already built in, baked into the Affordable Care Act; is we need to continue to move forward on delivery system reform, expecting better outcomes and better value at a better price. And there are models of care in various regions of the country that do work and work well. They are highly integrated, coordinated, patient-focused, that are producing some of the best results and for a better bang for the buck. And a lot of what is incented in the Affordable Care Act is driving that type of delivery system reform to a more efficient and better outcome-based system but at a better price. And the fact that studies have shown over and over again that a large part of the health care dollars is going to tests and procedures and things that aren't working, they are not improving patient care. In fact, some estimates range as high as $800 billion a year in a $2.4 trillion system are going to various procedures and tests that we are not getting a good bang for the buck. And therefore, I think the ultimate verdict in how successful we are in driving costs down is changing the way we pay for health care, to reward outcome in value as opposed to the volume-based payments that occur in Medicare. Would you agree with that analysis?

Mr. REISCHAUER. I would.

Mr. KIND. And there are things that are on track right now to lead us to that hopefully promised land of payment reform, whether it is the IPAP commission—I know that was brought up for criticism today—or the work that the Institute of Medicine is doing right now in changing the fee-for-service system to a fee-for-value-reimbursement system. And we also know that what happens in Medicare is going to also drive the private health insurance market in how they reimburse with health care expenses.

So the concern I have with the Ryan plan, the Republican plan that was just passed—that was just passed is that they would do away with all these reforms and instead create a voucher plan that virtually ends Medicare but without addressing the really systemic problem we have in the health care system, which is the rising costs and what we can do to bend that cost curve. And if we are moving forward on the reforms in the Affordable Care Act, especially in the payment area, so we are rewarding good quality outcomes, is an important thing that we need to do to shore up the trust fund and ultimately the long-term sustainability of the Medicare program, would you agree with that?

Mr. REISCHAUER. You know, I am not sure with my trustee hat on, I should be opining on these issues, but I think the Affordable Care Act incorporates——

Mr. KIND. Well, I think even in the trustees' report, they do acknowledge some of the reforms that are contained in the Affordable Care Act that can lead to——

Mr. REISCHAUER. That have the potential to move in the direction of providing better care at a reduced cost, yes.

Mr. KIND. And as a former head of CBO yourself, you realize that it is awfully tough to get a score from CBO on health care savings. You all seem to come from Missouri, and that is the show-me state; you got to show us the reforms and how it is actually re-

sulting in its cost savings before it gets scored. So a lot of this we need to move forward on, but we are not going to be certain what type of cost savings until they occur, is that right?

Mr. REISCHAUER. That is right. And I was criticized in this very room many times for that fact.

Mr. KIND. I know you were, as others have been and probably will be. But thank you for your testimony.

Chairman HERGER. The gentleman's time has expired.

The gentleman from Illinois, Mr. Roskam is recognized for 5 minutes.

Mr. ROSKAM. Thank you, Mr. Chairman.

Your report shows that Medicare will now be bankrupt in 2024. Americans would then be forced to either endure a massive tax hike or an immediate 17 percent reduction in expenditures. In other words, an immediate 17 percent Medicare cut. Can you explain what you mean by "immediate"?

Mr. BLAHOUS. Well, the way that the trust funds work, both on the Social Security side and on the Medicare HI side, is that the amount of expenditures the program can put out there is limited by what is in the trust funds. Now, on the SMI side, it is not really an issue because we just give the trust fund each year whatever is required to keep pace with costs. But once that trust fund runs out, the program lacks the authority to make benefit payments.

Now, there have been a lot of legal analyses that have been done of what happens when the trust fund runs out, and they don't all agree. But a fairly common one is that payments would simply have to be suspended or delayed until the requisite financing came into the trust fund, which would have the effect of reducing payments simply by virtue of delay.

Mr. ROSKAM. And that immediate is the common understanding of immediate? In other words, this present moment in time, in other words, when insolvency happens, then you immediately are prohibited based on the law and based on your understanding as a trustee from paying anything further out. And your estimation is that it would be a 17 percent cut in a benefit, is that correct?

Mr. BLAHOUS. Well, it is 17 percent on average over 75 years. Now, it varies according to year. I think in 2024, specifically, it is about 10 percent, but then that increases, and then it becomes about 25 percent by the mid-2040s.

Mr. ROSKAM. So it is averaged—go ahead.

Mr. REISCHAUER. What I think my colleague was describing is when the trust fund became insolvent, money would still be flowing in from tax receipts and Medicare would delay paying bills. And so a hospital would send its bill in and, rather than being paid in 24 days, might have to wait 5 months. And the CMS, the intermediaries and other payors would be writing out the checks, transferring the resources to the hospital, to the hospice, whatever, on a much delayed basis.

Mr. ROSKAM. So that cut, just so I am clear, is not a hypothetical cut. It is not a hypothetical delay. It is an actual delay in payment to the point of reaching the 17 percent number based on your own projection, is that right?

Mr. BLAHOUS. That is right. I mean, the Social Security Act which deals with these trust fund issues is very explicit that payments can only be made from the trust funds.

Mr. ROSKAM. So there is no other flexibility? If the revenues aren't there, if an insolvency is declared, you have no other remedy but to move forward and make those cuts, is that right?

Mr. BLAHOUS. Right. The programs don't have the authority to borrow in excess of the resources provided by the trust funds.

Mr. ROSKAM. And absent some change in the program, your prediction is that that is where our Nation will be in 2024, that is right?

Mr. BLAHOUS. That is right.

Mr. REISCHAUER. With respect to the hospital insurance system.

Mr. ROSKAM. I understand. So when the gentleman from Wisconsin said that there is a proposal that is out there by the majority on this committee that ends Medicare, in fact, Medicare as we know it will end in 2024 absent some change in policy or some change in moving forward, that is right, isn't it?

Mr. BLAHOUS. Yes.

Mr. ROSKAM. I yield back.

Chairman HERGER. The gentleman yields back.

The gentleman from Washington is recognized, Mr. McDermott, for 5 minutes.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

And I appreciate your allowing me to ask questions.

I have a report from the CMS actuary who says that—we were talking just now about a 17 percent reduction in expenditures if nothing is done. They suggest that if the Affordable Care Act were repealed, as the majority is trying to do, it would require a 53 percent reduction in benefits or 134 percent increase in the payroll tax to cover the deficit. So what we have seen here proposed by Mr. Ryan it seems to me is something that would make things much worse, at least according to the—if you believe in actuary.

Now, I want to ask you a question that I have sat here thinking about this whole time listening to. I came into medicine in 1963. I graduated from medical school just before Medicare started, so I have seen the whole history. I heard it was going to be socialism and the end of medicine as it was going to exist in this country, and I have watched it. And it is clear to me that the decision to give doctors the right to set their own fees was a crucial error made in 1964. When they wrote that they could have their usual and customary fees, they really set in motion an awful lot of what we are looking at today.

And you know about the RUC, the update committee, most people don't know what that is, but you know about it, and they set the rates. Now, why is there no discussion in your report about reform of the RUC committee or the rate setting that is done? We don't have a fee schedule set by the government. We have the RUC committee recommending to us what we should pay and that is what we pay.

Now, how can we have control of costs if we don't have the medical profession in some kind of direct negotiation with the government about what is going to be paid? This SGR was a simplistic

idea that never was going to be—never worked because it only controlled one thing and it left all the ability to raise rates or raise amounts of money by doing more of the same procedure.

I see in the Washington Post this week, many hospitals overuse double CT scans. There are a thousand examples of overuse of procedures in the medical care, but the RUC says, you get this amount a month for doing that, and boy, they do them and do them and do them, and the SGR has had no control whatsoever on it. How do we get there if we don't get the doctors at the table someplace to negotiate about their part in this game? It is not just between the government and the Medicare beneficiaries. There is a third-party here that we are ignoring, and that is the physicians and the health care system.

Mr. REISCHAUER. Are you looking at me?

Mr. MCDERMOTT. Yes, sir. I have looked at you many times.

Mr. REISCHAUER. I believe that the RUC is an advisory committee that gives its recommendations to CMS, and CMS is the ultimate decider.

Mr. MCDERMOTT. And they accept 85 to 90 percent——

Mr. REISCHAUER. What the RUC does is it looks at the relative values and decides which procedures, interventions, might be overpaid in a relative sense and which might be underpaid. And needless to say, there are few volunteers for being overpaid, and many claimants for being underpaid.

When they balance out what would happen if these changes were made? If on the whole, it saves resources, then those resources are thrown back into the overall pool, and the whole pool is raised. So it is designed to be, in a sense budget-neutral, which I don't think personally is an appropriate thing. And I believe the administration has made a suggestion that the overpayment amounts for procedures that we believe are overpaid should be used to reduce overall costs.

And I think we need a more robust review procedure like the RUC, one that reviews these amounts more frequently than is now the case and aggressively looks at what is happening in the balance of the market, the private sector, with respect to fees for these various procedures, and we could improve the accuracy of payments much more and probably save some money.

Chairman HERGER. The gentleman's time has expired.

Mr. MCDERMOTT. Thank you. I hope you put that in the report next year.

Mr. REISCHAUER. Well, the Medicare Payment Advisory Commission on which I served for 9 years has made recommendations and analyzed this issue quite frequently in its reports.

Chairman HERGER. The gentleman's time has expired.

The gentleman from Louisiana, Dr. Boustany, is recognized for 5 minutes.

Mr. BOUSTANY. Thank you, Mr. Chairman.

As a heart surgeon, I had the tremendous privilege of operating on thousands of Medicare beneficiaries, and I can tell you patient by patient perhaps better than anybody in this room, I understand the value of the Medicare program and the importance it plays in the lives of seniors, especially seniors back home in Louisiana,

many of whom have very limited means and depend on this truly for their life.

And I could go on and on about the quality and what we need to do to establish and maintain and strengthen a good patient-doctor relationship based on high quality medicine while managing costs, but that is not the purpose of the hearing. We are here to talk about the financial solvency of this program and some of the things that we need to do.

You know, the Medicare actuary has been quoted as saying that the improved hospital trust fund financing cannot be simultaneously used to finance other Federal outlays, such as coverage expansions, and to the extent the trust fund, despite the appearance of this result from the respective accounting conventions, meaning we can't double count; this is a real problem. And I will tell you as a physician who worked with many, many Medicare patients, this is a huge disservice to Medicare beneficiaries across this country.

We have an obligation to fix this program and to get it right. And when I see this double counting and the fact that we are playing games with the SGR and the reimbursement structure, this is literally legislative malpractice. And then if you go on with the IPAB, this is another example of where you are going to try to keep the lid on a boiling pot of liquid. It is not really going to be in the best interest of maintaining high quality patient care between a doctor and a patient.

My question is this: We know with current law, we are headed toward 2024 with the insolvency of the hospital trust fund, which means Medicare as we know it, at least that part, the hospital care, ends; is that correct?

Mr. BLAHOUS. Certainly it does not have the resources sufficient to discharge its obligations.

Mr. BOUSTANY. So if we don't correct this problem, then there will not be a payment mechanism for hospital care for our seniors?

Mr. BLAHOUS. Well, I would say there will still be a payment mechanism, but it would not be able to——

Mr. BOUSTANY. To pay.

Mr. BLAHOUS [continuing]. To pay, and get it on a delayed basis, reduced basis.

Mr. BOUSTANY. And before we get to that point, clearly it is not a just simple situation where we get to the point and then it stops. Would you suggest that there will probably be other forms of rationing for our seniors before we get to that point under current law with regard to hospital care?

Mr. REISCHAUER. In fact, it is a situation where you get to that point and fall off the cliff. You know, participants will be, even after the date of insolvency, entitled to the benefits that are laid out in the program. Providers may choose not to provide as much care because they will have to wait a long time or a longer time to get paid for it. But it is a situation that up to that point, everything seems fine.

Mr. BOUSTANY. And that gets us to the access problem because that is the other side of this equation, whereby the further we go, and it seems year after year we are seeing more and more prob-

lems with access for our seniors, so in effect, if you don't have access or limited access, delayed access, is that rationing?

Mr. BLAHOUS. Well, I would say, I mean, there are two elements of this issue. One is the sudden withdrawal of benefits that would occur in 2024. But then there is the other question of as we constrain our reimbursement rates under current law and prior to 2024, does that have the effect of causing providers to withdraw from Medicare or go out of business? And this is obviously something we are wrestling with as trustees and the actuaries are wrestling with analytically.

Mr. BOUSTANY. I think the answer is clearly yes based on my experience in visiting with many, many physicians across this country. And we are seeing worsening access problems. I saw them back in the 1990s in my own practice where as a heart surgeon, treating a patient who came into the emergency room needing emergency open-heart surgery, between the cardiologist and I, we were unable to find primary care providers to help these patients with their other medical problems, and that has only gotten worse.

And so we have an obligation to deal with this. And the problem I have is on the other side of the aisle, we see these characterizations that Republicans want to end Medicare. Well, the point is Medicare is ending under current law which they put in place, and we need to take our heads out of the sand, and I ask our colleagues on the other side of the aisle to take their heads out of the sand, as well as the President, who has deliberately ignored this trigger. We have to be honest with the American people, and we have to be honest with seniors who depend on this very valuable Medicare program and get this right. It is critically important.

I see my time has expired, Mr. Chairman. Thank you.

Chairman HERGER. I thank the gentleman.

The gentlelady from Tennessee, Ms. Black is recognized for 5 minutes.

Mrs. BLACK. Thank you, Mr. Chairman.

And first, I would like to begin by thanking you for allowing me to sit on this subcommittee hearing even though I am not an assigned member, I appreciate that.

Mr. Blahous, I would like to discuss the graph that you have on page 5 of your written testimony, and it is up on the screen, showing Medicare costs and non-interest income by source as a percentage of GDP. Medicare SMI trust fund spending is expected to make up a rapidly increasing percent of GDP, as you did talk about in your testimony, over the upcoming decade. And the trustees' report states that it will rise from 1.9 percent of GDP in 2010 to 3.4 percent in 2035. The trustees' report projects that $21.3 trillion in general revenue funding will be needed to pay the benefits financed by the Medicare SMI trust fund in the next 75 years. Can the country afford to fund the SMI trust fund at this level?

Mr. BLAHOUS. Well, I would say two things: One is that would be, under current law, it would be an enormous expansion of fiscal pressure on the Federal budget, far beyond any burdens we have carried in the past to finance Medicare SMI, the vast majority of which is funded from general government revenues. But even this probably understates the case, because as I indicated before, this is the best-case scenario, in which, for instance, the physician pay-

ment rates are suddenly reduced by 29 percent next year. So, in practice, we are likely to be significantly higher than this.

Mrs. BLACK. And given that information, and you are referencing that that money would have to come from the general fund because obviously it is not coming in, we don't get enough money in on the beneficiary side, would you agree that this is also going to impact some of the other national priorities, maybe such as education or roads or some of those areas?

Mr. BLAHOUS. Absolutely. I would say the growth of Medicare spending and the growth of our health care spending generally is probably the single greatest threat to discretionary spending throughout the Federal budget.

Mrs. BLACK. And given that, even if the Medicare SMI trust fund is not technically going bankrupt, like the hospital insurance fund, is it fair to say that it is bankrupting our Federal budget or could bankrupt our federal budget if not changed?

Mr. BLAHOUS. The way I would put it is there is no single cause of our overall fiscal problems, but under an untenable current law scenario that CBO and everyone else projects over the long term, this is about as big a contributor to it as anything.

Mrs. BLACK. Well, obviously, when it starts taking up that great percentage of our GDP, then we are going to have to in some way make some decisions about what it is that we are going to fund or not fund.

Let me also ask you this: Do you think that if Congress enacted policies that reduce Medicare spending by $15 billion over the next 10 years, would that be sufficient to address Medicare's financial crisis?

Mr. BLAHOUS. No.

Mrs. BLACK. No. Okay. I agree with you. And unfortunately, there is a growing chorus from our Congressional Democrats to simply do nothing and wait for the so-called delivery reforms from their health care overhaul to take effect. But CBO estimates those policies save just $14.7 billion over the next 10 years. So, given that, it seems to me that we have got to find other fixes other than what they recommend in the affordability act. Would you agree with that?

Mr. BLAHOUS. I agree with that.

Mrs. BLACK. Okay. Thank you. I yield back my time.

Chairman HERGER. The gentlelady yields back.

With that, I would like to thank our witnesses for your testimony and insight. From the trustees report and the expert testimony that we heard today, it has become abundantly clear that Medicare faces real and substantial challenges. We can and must meet these challenges in order to preserve Medicare for future generations.

It is also evident that Congress must act sooner, not later, to tackle this growing problem, as delay only makes the difficult choices we must make even harder and further threatens Medicare's bankruptcy.

I am confident that we can meet the challenge that lies before us. While it may seem like an insurmountable challenge, America's current and future seniors rightly expect us to work together to find a solution to preserve the Medicare program for generations to come.

As a reminder, any member wishing to submit a question for the record will have 14 days to do so. If any questions are submitted, I ask the witnesses to respond in writing in a timely manner. With that, the subcommittee is adjourned.

[Whereupon, at 11:30 a.m., the subcommittee was adjourned.]

[Submissions for the Record follow:]

Comments for the Record

House Committee on Ways and Means

Subcommittee on Health

Hearing: 2011 Medicare Trustees Report

June 22, 2011, 9:30 AM

by Michael G. Bindner
The Center for Fiscal Equity

Chairman Herger and Ranking Member Stark, thank you for the opportunity to submit my comments on this topic. The Trustees are quite correct in providing an alternative scenario, where they estimate the impact of what Congress is likely to do. In our opinion, they are still overly optimistic. The Center offers two scenarios to consider – one which relies on tax reform and a second which reforms how premiums and COLAs are calculated.

Option 1 – Tax Reform

While the trustees must offer their projections under law, the real story on what will happen cannot be determined. The entire debate on cost cutting is premature until the impact of pre-existing condition reforms on the market is known. The issue with the pre-existing condition reforms, which no one is talking about, is that the mandates under the *Affordable Care Act* (ACA) may be inadequate to keep people from dropping insurance - and will certainly not work if the mandate is rejected altogether (which is now Dogma in the GOP).

If people start dropping insurance until they get sick – which is rational given the weakness of mandates – then private health insurance will require a bailout into an effective single payer system. The only way to stop this from happening is to enact a subsidized public option for those with pre-existing conditions while repealing mandates and pre-existing condition reforms.

In the event that Congress does nothing and private sector health insurance is lost, the prospects for premium support to replace the current Medicare program is lost as well. Premium support also will not work if the ACA is repealed, since without the ACA, pre-existing condition protections and insurance exchanges eliminate the guarantee to seniors necessary for reform to succeed. Meanwhile, under a public option without pre-existing condition reforms, because seniors would be in the group of those who could not normally get insurance in the private market, the premium support solution would ultimately do nothing to fix Medicare's funding problem.

Ultimately, fixing health care reform will require more funding, probably some kind of employer payroll or net business receipts tax – which would also fund the shortfall in Medicare and Medicaid (and take over most of their public revenue funding).

The committee well understands the ins and outs of increasing the payroll tax, so I will confine my remarks to a fuller explanation of Net Business Receipts Taxes (NBRT). Its base is similar to a Value Added Tax (VAT), but not identical. Unlike a VAT, and NBRT would not be visible on receipts and should not be zero rated at the border – nor should it be applied to imports. While both collect from consumers, the unit of analysis for the NBRT should be the business rather than the transaction. As such, its application should be universal – covering both public companies who currently file business income taxes and private companies who currently file their business expenses on individual returns.

The key difference between the two taxes is that the NBRT should be the vehicle for distributing tax benefits for families, particularly the Child Tax Credit, the Dependent Care Credit and the Health Insurance Exclusion, as well as any recently enacted credits or subsidies under the ACA. In the event the ACA is reformed, any additional subsidies or taxes should be taken against this tax (to pay for a public option or provide for catastrophic care and Health Savings Accounts and/or Flexible Spending Accounts).

The Child Tax Credit should be made fully refundable and should be expanded to include revenue now collected under the dependent exemption, the home mortgage interest deduction and the property tax deduction. Transitioning these deductions will allow a $500 per month per child distribution with payroll. It will likely increase incentives to expand affordable housing and may not decrease housing for the wealthy, who are less likely to forgo vacation housing or purchase of luxury housing for wont of a tax cut, as the richest families likely pay the alternative minimum tax anyway, so that they do not fully use this tax benefit now.

This tax should fund services to families, including education at all levels, mental health care, disability benefits, Temporary Aid to Needy Families, Supplemental Nutrition Assistance, Medicare and Medicaid. If society acts compassionately to prisoners and shifts from punishment to treatment for mentally ill and addicted offenders, funding for these services would be from the NBRT rather than the VAT.

This tax could also be used to shift governmental spending from public agencies to private providers without any involvement by the government – especially if the several states adopted an identical tax structure. Either employers as donors or workers as recipients could designate that revenues that would otherwise be collected for public schools would instead fund the public or private school of their choice. Private mental health providers could be preferred on the same basis over public mental health institutions.

If cost savings under and NBRT, allow companies to offer services privately to both employees and retirees in exchange for a substantial tax benefit. Employers who fund catastrophic care would get an even higher benefit, with the proviso that any care so provided be superior to the care available through Medicaid. Making employers responsible for most costs and for all cost savings allows them to use some market power to get lower rates, but no so much that the free market is destroyed.

This proposal is probably the most promising way to decrease health care costs from their current upward spiral – as employers who would be financially responsible for this care through taxes would have a real incentive to limit spending in a way that individual taxpayers simply do not have the means or incentive to exercise. While not all employers would participate, those who do would dramatically alter the market. In addition, a kind of beneficiary exchange could be established so that participating employers might trade credits for the funding of former employees who retired

elsewhere, so that no one must pay unduly for the medical costs of workers who spent the majority of their careers in the service of other employers.

Conceivably, NBRT offsets could exceed revenue. In this case, employers would receive a VAT credit.

The NBRT would replace disability insurance, hospital insurance, the corporate income tax, business income taxation through the personal income tax and the mid range of personal income tax collection, effectively lowering personal income taxes by 25% in most brackets. Note that collection of this tax would lead to a reduction of gross wages, but not necessarily net wages – although larger families would receive a large wage bump, while wealthier families and childless families would likely receive a somewhat lower net wage due to loss of some tax subsidies and because reductions in income to make up for an increased tax benefit for families will likely be skewed to higher incomes. For this reason, a higher minimum wage is necessary so that lower wage workers are compensated with more than just their child tax benefits.

The Center calculates an NBRT rate of 27% before offsets for the Child Tax Credit and Health Insurance Exclusion, or 33% after the exclusions are included. This is a "balanced budget" rate. It could be set lower if the spending categories funded receive a supplement from income taxes.

If less radical reform is desired, the Committee should consider premium increases.

Option 2 – Premium and COLA Reform

Bruce Bartlett wrote in the New York Times Economix Blog on May 17 on the nature of the Medicare financial problem and how to fix it. The information he imparted is invaluable, however I disagree with his solution, which is to stop doing the Doc Fix. He relates that the ACA expansion of funding brought the Hospital Insurance Trust Fund (Part A) into balance, with parts B (doctor visits) and D (Drug coverage) responsible for most of the unsustainable cost growth, as patient premiums have declined from 50% of spending to 25% and with Drug coverage not at all close to covering program costs. (The CBPP states that premiums were always 25%, though if true, they are inadequate to control cost).

Stopping doctor bills from going up on the demand side will not work. We know that because it did not work for Medicaid - since restricting payments have stopped most doctors from taking Medicaid). This finding has a great deal of impact on what is possible in preventing the doctor fix.

The problem with Medicare Part B is that increases cannot keep up with costs, like they do in the private market, because doing so violates the commitment to not cut Social Security benefit checks. The cost of living adjustment must be high enough to cover the premium increase each year - although for many that is all it does. Further cuts bring up the specter of seniors eating cat foot to make ends meet, hence the reason that the Fiscal Commission was called the Cat Food Commission by progressives.

Premium support and not patching doctor fees are attempts to make doctors restrict their costs - both to seniors and overall. Prices naturally rise more quickly than inflation because these services are subsidized, so any co-pay must be increased to slow demand from users in exactly the same way the market would without subsidies or insurance. The desire to make doctors pay more is a recognition that the main impact of both insurance and subsidies (and subsidies for insurance) is

higher income for doctors and a larger medical care sector than would otherwise occur in a free market.

Our hybrid system is the most expensive option - either going to much less comprehensive insurance for everyone or an entirely governmental system would be cheaper, but is politically untenable (at least until private insurance collapses or is eventually supplanted by an ever expanding public option).

Going after doctors still won't work, however, as the Medicaid experience clearly shows. Premium support is a way to have insurance companies go after doctors instead, but that will likely yield the same result. Shifting the financial obligation to employers and past employers as part of a Net Business Receipts Tax would likely control doctor fees, although such a proposal will face resistance from both the medical and insurance sectors, even though it is the most likely to save money. Even if such a program is adopted, some employers are too small to support a medical staff or support retiree health care, so some kind of public program is still necessary, with reform all the more crucial.

Making patients more conscious of their care might do the trick, both with more realistic premiums for Part B and Part D, with both rising to absorb half the cost - although premiums could be lowered by increasing co-pays and providing seniors with Flexible Spending and/or health savings accounts. The problem is that this is untenable when dealing with a population with largely fixed incomes. That problem, however, is not unsolvable.

The obvious solution, which no one has yet suggested, is to change how COLAs are calculated, moving from the wage index to an index based on what seniors actually buy - especially health care. If premiums were increased quickly, COLA changes would have to be as rapid.

Such a proposal would hasten the date that the Old Age and Survivors Insurance fund needs rescue. It also impacts lower income seniors to a greater extent than higher income seniors, since they have less left over after any mandatory co-pay. Either bend points would have to be reset or the entire complicated system of bend points would have to be replaced a new method of crediting contributions, where employer contributions are credited equally rather than as a match to the employee contribution - thus moving redistribution from the benefits side to the revenue side.

An average employer contribution would provide even more incentive for increasing the amount of income subject to benefits - or even eliminating the cap altogether. Of course, if you do the latter, we might as well simply use a Net Business Receipts Tax or a VAT to replace the employer contribution (which captures all income with the latter burdening imports as well)

Thank you for the opportunity to address the committee.

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AMERICAN ACADEMY *of* ACTUARIES

Committee on Ways and Means
Subcommittee on Health
U.S. House of Representatives

Hearing on
2011 Medicare Trustees Report

June 22, 2011

Statement of
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The American Academy of Actuaries is a 17,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

On behalf of the American Academy of Actuaries' Health Practice Council, we appreciate the opportunity to comment on the 2011 Medicare Trustees Report. We first discuss the trustees' findings and then provide insights on several Medicare-related provisions included in various debt- and deficit-reduction proposals.[1] We will highlight the following key points:

- The Medicare program has three fundamental long-range financing challenges:
  - ⇒ Income to Medicare's Hospital Insurance (HI) Trust Fund is not adequate to fund the HI portion of Medicare benefits;
  - ⇒ Increases in Medicare's Supplementary Medical Insurance (SMI) costs increase pressure on beneficiary household budgets and the federal budget; and
  - ⇒ Increases in total Medicare spending threaten the program's sustainability.

- We strongly recommend that policymakers implement changes to improve Medicare's financial outlook. The sooner such corrective measures are enacted, the more flexible the approach and the more gradual the implementation can be. Failure to act now will necessitate far more drastic actions later.

- When evaluating proposals to improve Medicare's financial condition, it is important to recognize that improving the sustainability of the health system as a whole requires slowing the growth in overall health spending rather than shifting costs from one payer to another.

MEDICARE'S FINANCIAL CONDITION

Each year, the Boards of Trustees of the Federal Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) Trust Funds report to Congress on the Medicare program's financial condition. The Medicare program provides health coverage for the aged and for certain individuals with disabilities.

The trustees' report is the primary source of information on the status of the Medicare program, and the Academy proudly recognizes the contribution that members of the actuarial profession have made in preparing the report and educating the public about this important issue.

The projected financial condition of Medicare in the 2011 Medicare trustees' report has deteriorated compared with the projections in the 2010 report. According to this year's report, the HI trust fund will be depleted in 2024, five years earlier than was projected a year ago. HI expenditures are expected to exceed HI revenues for every year in the projection period. Medicare expenditures will consume an increasing share of federal outlays and the gross domestic product (GDP).

According to statutory requirements, the trustees' projections of Medicare's financial outlook must be based on benefits and revenues scheduled under current law. The trustees acknowledge, however, that these estimates likely understate the seriousness of Medicare's financial condition. In the Statement of Actuarial Opinion that is required by law, Richard Foster, the chief actuary of the Centers for Medicare & Medicaid Services (CMS), specifically notes that actual Medicare expenses are likely to exceed the current-law projections. He states, "the financial projections

[1] This testimony is based on two Academy issue briefs, *Medicare's Financial Condition: Beyond Actuarial Balance* and *An Actuarial Perspective on Proposals to Improve Medicare's Financial Condition.*

shown in [the] report for Medicare do not represent a reasonable expectation for actual program operations in either the short range…or the long range…" In particular, the trustees and the chief actuary point to scheduled reductions in provider payments that are unlikely to occur. Current law requires downward adjustments in provider payment updates to reflect productivity improvements; these adjustments might not be sustainable in the long term. In addition, currently scheduled physician payment reductions in accordance with the sustainable growth rate (SGR) mechanism are considered likely to be overridden by Congress.

At the request of the trustees, the CMS Office of the Actuary developed an alternative analysis that provides an illustration of the potential understatement of current-law Medicare cost projections if the productivity adjustments are phased out and the physician payment reductions are overridden. Although the illustrative alternative projections are not intended to be interpreted as the official best estimates of future Medicare costs, they do, as noted in the alternative analysis, "help to quantify and underscore the likely understatement of the current-law projections shown in the 2011 trustees' report." This statement presents projections based on both the current law and the illustrative alternative projections.[2]

The trustees conclude: "The projections in this year's [trustees'] report continue to demonstrate the need for timely and effective action to address Medicare's remaining financial challenges—including the projected exhaustion of the HI trust fund, this fund's long-range financial imbalance, and the issue of rapid growth in Medicare expenditures. Furthermore, if the lower prices payable for health services under Medicare are overridden, the financial challenges in the long range would be much more severe."

Because Medicare plays a critically important role in ensuring that older and disabled Americans have access to health care, the American Academy of Actuaries' Health Practice Council urges action to restore the long-term solvency and financial sustainability of the program. The sooner such corrective measures are enacted, the more flexible the approach and the more gradual the implementation can be. Failure to act now will necessitate far more drastic actions later.

Medicare Financing Problems

The Medicare program has three fundamental long-range financing challenges:

1. Income to the HI trust fund is not adequate to fund the HI portion of Medicare benefits;
2. Increases in SMI costs increase pressure on beneficiary household budgets and the federal budget; and
3. Increases in total Medicare spending threaten the program's sustainability.

Each of these problems is discussed in more detail below.

Medicare HI Trust Fund Income Falls Short of the Amount Needed To Fund HI Benefits
Like the Social Security program, Medicare relies on trust funds to account for all income and expenditures. The HI and SMI programs operate separate trust funds with different financing

[2] Both the 2011 Medicare Trustees Report and the CMS Office of the Actuary's illustrative alternative scenario analysis are available at: http://www.cms.gov/ReportsTrustFunds/.

mechanisms. General revenues, payroll taxes, premiums, and other income are credited to the trust funds, which are used to pay benefits and administrative costs. Any unused income is required by law to be invested in U.S. government securities for use in future years. In effect, the trust fund assets represent loans to the U.S. Treasury's general fund. The HI trust fund (Part A), which pays for hospital services, is funded primarily through earmarked payroll taxes.

The trustees' report's projections of Medicare's financial outlook must be based on current law. Under these current-law projections, the financial condition of the HI trust fund has deteriorated since the 2010 trustees' report. This deterioration results from lower real (inflation-adjusted) payroll tax revenues due to a slower assumed economic recovery, and from higher real expenditures due to higher assumed near-term wage growth. The projected trust fund exhaustion date is five years earlier than in last year's report, and the 75-year HI deficit increased from 0.66 percent of taxable payroll to 0.79 percent.

- HI expenditures currently exceed HI revenues. Although the gap is projected to narrow over the next few years, HI expenditures are expected to exceed revenues, including interest income, throughout the 75-year projection period. The HI trust fund assets, therefore, will need to be redeemed. If the federal government is experiencing unified budget deficits, funding the redemptions will require that additional money be borrowed from the public, thereby increasing the federal debt.

- The HI trust fund is projected to be depleted in 2024. At that time, payroll tax revenues are projected to cover only 90 percent of program costs, with the share declining to 76 percent in 2050 but then increasing to 88 percent by 2085. There is no current provision for general fund transfers to cover HI expenditures in excess of dedicated revenues.

- The projected HI deficit over the next 75 years is 0.79 percent of taxable payroll. Eliminating this deficit would require an immediate 24 percent increase in payroll taxes or a 17 percent reduction in benefits—or some combination of the two. Delaying action would require more drastic changes in the future.

Current-law projections, however, likely understate the fiscal challenges to the Medicare HI trust fund. In particular, the scheduled reductions in provider payment rate updates to reflect productivity adjustments may not be sustainable in the long term. At the request of the trustees, the CMS Office of the Actuary provided an illustrative alternative analysis that phases out the productivity adjustments gradually over 16 years, beginning in 2020.

Under the illustrative alternative scenario, the HI trust fund also would be depleted in 2024, but the projected deficit over the next 75 years would be 2.15 percent of taxable payroll—nearly triple that under current-law projections. Eliminating this deficit would require an immediate 74 percent increase in payroll taxes or a 36 percent reduction in benefits—or some combination of the two.

Increases in SMI Costs Increase Pressure on Beneficiary Household Budgets and the Federal Budget

The SMI trust fund includes accounts for the Part B program, which covers physician and outpatient hospital services, and the Part D program, which covers the prescription drug

program. Approximately one-quarter of SMI spending is financed through beneficiary premiums, with federal general tax revenues covering the remaining three-quarters.[3]

The SMI trust fund is expected to remain solvent because its financing is reset each year to meet projected future costs. As a result, increases in SMI costs will require increases in beneficiary premiums and general revenue contributions. Increases in general revenue contributions will put more pressure on the federal budget.

Similarly, premium increases will place pressure on beneficiaries, particularly in conjunction with increasing beneficiary cost-sharing expenses. The average beneficiary expenses (premiums and cost sharing) for Parts B and D combined currently are 27 percent of the average Social Security benefit. These expenses are projected to increase to 46 percent of the average Social Security benefit by 2085. These expenses do not include cost sharing under Part A.

The 2011 trustees' report projects that under current law, SMI spending will continue to grow faster than GDP, increasing from 1.9 percent of GDP in 2010 to 3.1 percent of GDP in 2030, and to 4.1 percent of GDP in 2085.

The current-law projections likely understate the increases in Part B spending. Given that SGR-related physician payment reductions have been overridden every year since 2003, it is considered unlikely that future scheduled reductions will take effect in full.[4] In addition, the scheduled reductions in non-physician provider payment rate updates to reflect productivity adjustments might not be sustainable in the long term. The CMS Office of the Actuary's illustrative alternative analysis sets physician payment updates according to the increase in the Medicare Economic Index, which averages approximately 2 percent per year—rather than assuming that the SGR-related reductions take effect. In addition, the alternative analysis assumes a phasing out of the productivity adjustments gradually over 16 years, beginning in 2020. The alternative scenario projections assume no changes to the current-law Part D projections.

Under the illustrative alternative scenario projections, SMI spending would increase from 1.9 percent of GDP in 2010 to 3.7 percent of GDP in 2030, and to 6.6 percent of GDP in 2085.

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[3] Part B beneficiaries pay monthly premiums covering approximately 25 percent of program costs; general revenues cover the remaining 75 percent of costs. Part D premiums are set at approximately 25 percent of Part D costs. Because of low-income premium subsidies, however, beneficiary premiums will cover only approximately 11 percent of total Part D costs in 2011. State payments on behalf of certain beneficiaries will cover approximately 11 percent of costs and general revenues will cover the remaining 78 percent of costs.

[4] The sustainable growth rate (SGR) system was enacted as part of the Balanced Budget Act of 1997 to limit the growth in spending for physician services. The system compares actual cumulative spending to a specified spending target. If actual spending exceeds the target, then physician payment updates are adjusted downward. A cumulative reduction of 30 percent is estimated over the next two years.

Table 1: SMI Expenditures as a Percent of GDP

Calendar Year	2011 Report (current law)	2011 Alternative Projection
2010	1.9	1.9
2020	2.3	2.6
2030	3.1	3.7
2040	3.5	4.5
2050	3.6	5.0
2060	3.8	5.5
2070	4.0	6.0
2080	4.1	6.4
2085	4.1	6.6

Sources: 2011 Medicare Trustees' Report, CMS Office of the Actuary

Increases in Total Medicare Spending Threaten the Program's Sustainability
A broader issue related to Medicare's financial condition is whether the economy can sustain Medicare spending in the long run. To help gauge the future sustainability of the Medicare program, we point to the share of GDP that will be consumed by Medicare. Because Medicare spending is expected to continue growing faster than GDP, greater shares of the economy will be devoted to Medicare over time, meaning smaller shares of the economy will be available for other priorities.

According to the current-law projections, Medicare expenditures as a percentage of GDP will grow from 3.6 percent of GDP in 2010 to 6.2 percent of GDP in 2085. Under the CMS Office of the Actuary alternative scenario, however, total Medicare expenditures would nearly triple to 10.7 percent of GDP in 2080.

Table 2: Total Medicare Expenditures as a Percent of GDP

Calendar Year	2011 Report (current law)	2011 Alternative Projection
2010	3.6	3.6
2020	4.0	4.3
2030	5.2	5.9
2040	5.8	7.1
2050	5.9	8.0
2060	6.1	8.8
2070	6.2	9.6
2080	6.3	10.4
2085	6.2	10.7

Sources: 2011 Medicare Trustees' Report, CMS Office of the Actuary

Action Is Needed to Improve Medicare Solvency and Sustainability
The Affordable Care Act (ACA) contains numerous provisions designed to reduce Medicare costs, increase Medicare revenues, and develop new health care delivery systems and payment models that improve health care quality and cost efficiency. Additional steps need to be taken, however, to address the long-term financial challenges to Medicare.

The HI trust fund is projected to be depleted in 2024, and Medicare spending will continue to grow faster than the economy—increasing the pressure on beneficiary household budgets and the federal budget and threatening the program's sustainability. If Medicare projections are calculated using assumptions that productivity adjustments are phased out and physician payment reductions are overridden, Medicare's financial condition is shown to be even worse than under current-law projections.

Even under the current-law projections, there are still significant concerns about Medicare's sustainability. As such, it is important for policymakers to implement changes to improve Medicare's financial outlook.

We agree with the 2011 trustees when they say:

> *We believe that solutions can and must be found to ensure the financial integrity of HI in the short and long term and to reduce the rate of growth in Medicare costs through viable means, building on the measures enacted as part of the Affordable Care Act. Consideration of such further reforms should occur in the near future. The sooner the solutions are enacted, the more flexible and gradual they can be. Moreover, the early introduction of reforms increases the time available for affected individuals and organizations—including health care providers, beneficiaries, and taxpayers—to adjust their expectations. We believe that prompt action is necessary to address these challenges.*

And we wish to underscore this call for action.

OPTIONS TO REFORM MEDICARE

Improving Medicare's financial condition requires efforts beyond those already enacted in the ACA. Slowing the growth in health spending is needed not only to improve the program's solvency and sustainability, but also to help put the country on a more sustainable fiscal path. To this end, debt- and deficit-reduction proposals put forward by various groups, such as the National Commission on Fiscal Responsibility and Reform, include provisions to control health spending.[5] Some of the Medicare-related provisions in these proposals are outlined below, including a summary of key cost, access, and quality issues from an actuarial perspective.

When evaluating proposals to improve Medicare's financial condition, it is important to recognize that improving the sustainability of the health system as a whole requires slowing the growth in overall health spending rather than shifting costs from one payer to another. So unless

[5] See The Henry J. Kaiser Family Foundation, "Comparison of Medicare Provisions in Deficit-Reduction Proposals," (last modified April 4, 2011) for a side-by-side comparison of key Medicare changes recommended by various debt and deficit reduction proposals.

system-wide spending is addressed, implementing options to control Medicare spending will have limited long-term effectiveness.

Limit the Growth in Medicare Spending

Some recent proposals would set spending targets, either for Medicare in particular, or for federal health spending in total. Exceeding those targets could trigger specific actions, such as automatically reducing benefits or increasing revenues. The trigger, alternatively, could be structured to require the president or a commission to submit proposals that would be considered by Congress on an expedited basis.[6] One approach, for instance, would set target spending for all federal health expenditures at the growth in gross domestic product (GDP) plus 1 percent. If the target is exceeded, the president would be required to submit proposals to reduce spending. Another approach automatically would reduce fee-for-service provider payments by 1 percent if general revenue contributions to Medicare exceed 45 percent of Medicare funding. (As discussed below, the ACA created the Independent Payment Advisory Board, or IPAB, which focuses on reducing Medicare spending if it exceeds a targeted growth rate. As currently structured, the IPAB is somewhat restricted on what options it can recommend.)

Cost: Medicare savings would depend on how aggressively the spending targets are set. Savings to the health system overall, however, would be offset to the extent that costs are instead shifted to Medicare beneficiaries or other payers.

Access/Quality: The impact on the access to and quality of care would depend on the specific recommendations made. Depending on how the reductions are structured, reducing provider payment rates could reduce beneficiary access to care and/or the quality of care. Other specific options for reducing benefit costs or increasing revenues are examined in other sections of this testimony.

Transition to a Premium Support or Voucher Program

Some proposals would transition Medicare to a premium support or voucher program, while others offer such an approach as an option if certain measures to reduce Medicare spending growth are not deemed adequate. These approaches would change the Medicare program from a defined benefit plan to a defined contribution plan.

Under a premium support approach, the federal government would limit the amount it contributes toward Medicare coverage, with beneficiaries paying additional premiums to cover any difference between plan premiums and the government contribution. The growth in government contributions would be indexed by inflation or some other factor. Under a voucher-type approach, individuals would receive a voucher to purchase private health insurance. The voucher could be adjusted by various beneficiary characteristics—such as age, health status, geographic location, and/or income—and would be indexed by inflation or some other factor.

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[6] The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established one type of trigger. If in two consecutive trustees' reports general funding sources are projected to account for more than 45 percent of Medicare spending within the next seven years, the administration would be required to recommend ways to reduce this percentage. Congress is required to consider the legislation on an expedited basis. There is no requirement, however, that any legislation be enacted. The 2011 trustees' report finds that for the sixth consecutive year, the funding warning was triggered.

Cost: Moving to a defined contribution approach would shift the risk of health spending growth away from the federal government and toward beneficiaries. Depending on how the government contribution is set, federal Medicare spending could be lower than currently projected. To the extent that health spending growth exceeds the increase in the government contribution, costs would be shifted to beneficiaries through higher premiums and/or higher cost sharing. As discussed below, increased cost-sharing requirements could lower spending growth due to reduced utilization. The impact of such an approach on overall health spending would also depend on how utilization management, administrative costs, and provider payment rates under private plans would compare to those under traditional Medicare.

Access/Quality: Access to Medicare or private insurance would depend on the difference between the government contribution and the premium. The greater the share of costs that are shifted from the government to beneficiary premiums, the more likely that beneficiaries will opt for less generous plans. Although this could encourage beneficiaries to seek more cost-effective care, some may forgo needed care. In addition, to bring costs down, care quality might be compromised. Such a system, for instance, might lead to a less-expensive second tier delivery system, which may be much more limited in the types of providers available.

Expand the Authority of the Independent Payment Advisory Board (IPAB)
The ACA created the IPAB, which is similar to the Medicare Payment Advisory Commission (MedPAC).[7] The IPAB is charged with preparing recommendations to reduce the growth in Medicare per capita expenditures if spending exceeds a targeted growth rate. The targets are based on inflation until 2019, and on GDP plus 1 percent thereafter. Unlike MedPAC recommendations, IPAB recommendations would be implemented automatically unless the Congress passes legislation producing comparable reductions. The board is somewhat restricted in its recommendations--it cannot propose to ration health care, raise revenues, increase beneficiary premiums or cost sharing, or otherwise restrict benefits or modify eligibility criteria.[8] In addition, until 2020 most hospital services are excluded from the scope of payment changes that can be recommended.

Provisions included in various fiscal proposals would expand the scope of the IPAB, by eliminating the temporary carve-outs for hospital services, allowing options related to cost sharing and benefit design, and giving it authority over all federal health spending. The expansion of scope could be tied to directing IPAB to meet more ambitious spending growth targets.

Cost: To the extent that the spending growth targets are tightened, additional Medicare cost savings could be achieved, compared to current law. However, total savings would be offset to the extent that costs are shifted to beneficiaries.

Access/Quality: The impact on the access to and quality of care would depend on the specific recommendations made. Options to revise Medicare's plan design are examined in more detail below.

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[7] MedPAC would continue its role as advisor to Congress on issues affecting the Medicare program and would review any IPAB proposals.
[8] Section 3403 of the Affordable Care Act: http://docs.house.gov/energycommerce/ppacacon.pdf.

Reform the Sustainable Growth Rate System
The sustainable growth rate (SGR) system was enacted as part of the Balanced Budget Act of 1997 to limit the growth in spending for Medicare physician services. The system compares actual cumulative spending for Medicare physician services to a specified spending target. If actual spending exceeds the target, then physician payment updates are adjusted downward. With the exception of 2002, the first year that physician fee cuts were called for under the SGR formula, the fee cuts have been temporarily overridden each year (i.e., the "doc fix"). As a result of the cumulative shortfall, physician payment rates will be reduced by nearly 30 percent in 2012, barring another override.

By putting pressure on physician payment updates, the SGR system might have resulted in slower growth in physician payment updates than would have occurred otherwise. There are calls, nevertheless, to reform or eliminate the SGR system due to concerns regarding beneficiary access to care under large fee cuts, provider frustration regarding the short-term nature of payment fixes, the growing budgetary costs of further overrides, and the way the system's across-the-board fee cuts poorly target those providers with the highest volume increases.[9,10] One approach would eliminate the SGR, temporarily freeze physician payments, and develop a new physician payment system. The proposal would pay for the elimination of the SGR by other reductions in Medicare and Medicaid spending.

Cost: Officially eliminating the SGR would increase Medicare spending over baseline projections including the SGR, unless offset by other spending reductions.

Access/Quality: Eliminating the SGR could help maintain beneficiaries' access to care. Depending on how a new physician payment system would be developed, it could better align payments with the provision of high-value care.

Reduce Spending for Prescription Drugs
Provisions included in various proposals would reduce payments for prescription drugs. One option would be to increase drug rebates by requiring Medicare to use its bargaining power to negotiate drug prices under the Part D program. Another option would extend drug rebates to those eligible for both Medicare and Medicaid.

Another approach would establish a federal government-run Part D option that would be offered alongside Part D private plans. The Centers for Medicare and Medicaid (CMS) would negotiate prices with prescription drug companies. However, as with Medicare Parts A and B, this ultimately could lead to CMS setting prescription drug prices.

Cost: By reducing the prices paid for prescription drugs, these options would lower Part D spending and reduce its rate of spending growth. To the extent that prescription drug companies can respond by increasing their prices in the private sector, costs would be shifted from Medicare to the private sector.

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[9] Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare Payment Policy* (Chapter 4), March 2011.
[10] The Congressional Budget Office (CBO) estimates that replacing the SGR with a 10-year physician payment freeze would cost about $250 billion; if payments were increased over time, the cost would be even greater. (*The Budget and Economic Outlook: Fiscal Years 2011 to 2021*, January 2011.)

Lowering Part D spending would also reduce beneficiary premiums for Part D plans. In some cases the copayments for some prescription drugs could also be reduced.

Access/Quality: Reducing the prices paid for prescription drugs potentially could reduce research and development in the pharmaceutical industry. Introducing a government-run Part D option could lead to some current Part D providers leaving the market, especially if the government-run plan sets drug prices—thereby reducing the choices available to enrollees.

Revise Medicare's Fee-For-Service (FFS) Benefit Design and Cost-Sharing Requirements
Medicare, like most other health insurance plans, uses patient cost-sharing requirements (e.g., deductibles, copayments, coinsurance) to help balance plan affordability with the comprehensiveness of coverage. Patient cost sharing directly lowers Medicare spending by shifting a share of medical costs to the beneficiary. In addition, cost sharing can lower spending overall by reducing utilization. Patient cost-sharing requirements ideally align beneficiary incentives with program goals to provide quality and cost-effective care. However, Medicare's FFS cost-sharing requirements are not currently structured to meet these goals. In particular:

- The FFS cost-sharing requirements are skewed more toward less discretionary services, with high deductibles for Part A inpatient services and lower deductibles for Part B physician and outpatient services;
- Most beneficiaries have supplemental policies to fill in most or all FFS cost-sharing requirements, thereby reducing the incentives for beneficiaries to seek cost-effective care;[11] and
- The lack of an out-of-pocket maximum under FFS leaves beneficiaries unprotected against catastrophic health costs.

Provisions in various proposals would increase and/or restructure Medicare's cost-sharing requirements. A number of proposals would combine or restructure the Part A and Part B cost-sharing requirements and add a new maximum out-of-pocket limit. (Medicare Advantage plans have some flexibility on how to structure cost-sharing requirements, but as of 2011, are required to cap out-of-pocket spending.) Some of these proposals would also eliminate first-dollar coverage in Medigap plans and/or prohibit supplemental insurance from covering any new or increased cost-sharing amounts. Taken together, these changes could help encourage Medicare beneficiaries to seek cost-effective care. A value-based insurance design (VBID) also could encourage the use of cost-effective care. A VBID approach would lower the cost sharing for high-value services and increase the cost sharing for low-value services. The ACA moved Medicare in this direction by covering certain preventive services with no cost sharing. Comparative effectiveness research can facilitate the identification of low- and high-value services.

Cost: Increasing Medicare's cost-sharing requirements would reduce Medicare spending by shifting more of the costs to beneficiaries. Savings could also result by lowering utilization, especially if supplemental plans are prohibited from covering the difference. Adding an out-of-

[11] MedPAC reports that 89 percent of FFS beneficiaries in 2005 had supplemental coverage: 33 percent had individually purchased Medigap coverage, 37 percent had employer-sponsored coverage, 17 percent had Medicaid, and 2 percent had other public coverage. See *Report to the Congress: Improving Incentives in the Medicare Program* (Chapter 6), June 2009.

pocket cap would offset cost savings. Adjusting cost sharing to align incentives with effective use of services has shown promise in reducing spending in the non-Medicare market—most often for prescription drugs.[12]

Access/Quality: A restructuring of Medicare's cost-sharing requirements could better align beneficiary incentives for high-quality and cost-effective care. In addition, incorporating a maximum out-of-pocket limit would provide the catastrophic protection that the FFS program currently lacks. Such a restructuring would increase out-of-pocket spending for many beneficiaries, but decrease it for those with the greatest health care needs.

Broad increases in cost sharing, rather than targeted increases, have been shown to reduce not only unnecessary care, but also necessary care, especially among the low income and chronically ill. For this reason, some proposals would exempt lower-income beneficiaries from cost sharing increases. In addition, a VBID approach could incorporate lower cost-sharing requirements for chronic treatments.

Raise the Medicare Eligibility Age

Since the program began in 1965, beneficiaries have been eligible for full Medicare benefits at age 65, consistent with Social Security's normal retirement age at that time. Since that time, the normal retirement age for Social Security has been increased to age 67 and there are currently proposals to increase it beyond 67. Similarly, there are proposals to gradually increase the Medicare eligibility age (e.g., to age 67 or 69), and some also would index the eligibility age for increased longevity.

Cost: Raising the Medicare eligibility age would reduce the cost of the Medicare program and could increase payroll tax revenues by encouraging individuals to work beyond age 65. However, the increased revenues would be offset by increased federal spending to the extent that individuals between age 65 and the new eligibility age receive premium subsidies through the health insurance exchanges or coverage through Medicaid. In addition, some costs would be shifted to employers, states, and individuals.

Access/Quality: People between age 65 and the new eligibility age would have to find a new source of health insurance—through employer coverage, the individual market or health insurance exchanges, or other public coverage such as Medicaid—or go uninsured. Provisions in the ACA increase the availability of other coverage sources. In particular, beginning in 2014, the ACA requires that private health insurance coverage be offered on a guaranteed-issue basis, prohibits preexisting condition exclusions, and limits premium variations by age. Low- and moderate-income individuals may be eligible for premium and cost-sharing subsidies or Medicaid coverage.

Shifting individuals between age 65 and the new eligibility age into private plans would increase average premiums for private plans. This could potentially reduce insurance coverage among younger individuals if their premiums increase as a result.

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[12] See for instance, "Evidence That Value-Based Insurance Can Be Effective," Michael E. Chernew, et al. Health Affairs 29(3): 530-536, March 2010.

Increase Medicare Part B Premiums
Medicare Part B premiums, initially set at 50 percent of Part B costs, currently are set at 25 percent of costs. Beginning in 2007, premiums for higher-income beneficiaries were raised to between 35 and 80 percent of costs, depending on income. The ACA temporarily freezes the index on income thresholds used to determine the premiums, which means more beneficiaries will be subject to higher premiums over time. Some proposals would increase the Part B premiums for those not already subject to higher premiums or raise them higher for those already subject to higher premiums.

Cost: Increasing Medicare premiums would increase program revenues by shifting costs to beneficiaries. But it would not reduce Medicare spending (unless some beneficiaries decide to opt out of Medicare Part B due to the higher premiums).

Access/Quality: Beneficiaries who are unwilling or unable to pay higher Part B premiums may face reduced access to care.

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The American Academy of Actuaries' Health Practice Council welcomes the opportunity to serve as an ongoing resource to policymakers and the public as solutions to Medicare's financing challenges are considered.

Statement for the Record

of the American Federation of State, County and Municipal Employees (AFSCME)

For the

For the Hearing on
The 2011 Medicare Trustees Report

Before the

Subcommittee on Health
Committee on Ways and Means

U.S. House of Representatives

June 22, 2011

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By the
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This statement is submitted on behalf of the 1.6 million workers and retiree members of the American Federation of State, County and Municipal Employees (AFSCME) for the hearing held June 22, 2011 on the 2011 Medicare Trustee Report.

AFSCME and its members are proud of labor's historic role in the creation of Medicare, an indispensable federal social insurance program. Medicare was established and expanded to provide what the private insurance market did not, would not and could not: Affordable, adequate health insurance for America's elderly population and individuals with permanent disabilities. We remain strong defenders of the Medicare program from those who either would directly, or under the general guise of deficit reduction, undermine its foundations by gutting guaranteed benefits or shifting more costs onto beneficiaries.

When President Johnson signed Medicare into law on July 30, 1965, he spoke of the profound promise of Medicare to our nation and its citizens:

> "No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents, and to their uncles, and their aunts.
>
> And no longer will this Nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this progressive country."

For today's 47.5 million Medicare beneficiaries and the millions who will depend on this program in the future, the need for Medicare to remain a refuge against financial ruin caused by the caprice of illness and disability rings as true in 2011 as it did more than four decades ago.

Slower than Expected Economic Recovery Undermines Medicare Solvency

Medicare's Hospital Insurance Trust Fund (Medicare Trust Fund) covers inpatient care in hospitals, skilled nursing facilities, hospices and home health care.

The dedicated major source of funding for this trust is payroll contributions paid by workers and employers, interest from the Trust Fund reserves, and income taxes on part of Social Security benefits of upper income beneficiaries.[i] The Trustees project that in 2024 the Medicare Trust Fund will be able to make 90% of payments to doctors and hospitals based on current payroll contributions. Congress could make up the remaining gap through direct appropriations. Last year the Trustees projected a slightly more distant date when the Trust Funds would not be able to pay 100% of the payments. The shortened solvency period for the Medicare Trust Fund is driven in large part by a weak economy that has led to reduced payroll receipts.

The surefire way to fortify the solvency of the Medicare Trust Fund and address the deficit is to improve the economy by creating jobs, closing corporate tax loopholes and requiring the wealthiest Americans to pay their fair share. The fundamental promise of guaranteed benefits in Medicare is not the problem. Myopic proposals for deficit reduction that focus on balancing the budget on seniors and working families are not the solution.

The Affordable Care Act Improves the Fiscal Health of Medicare

Without the Affordable Care Act, signed into law by President Obama, Medicare's solvency would be far worse. The Medicare Trust Fund's reserves would be exhausted in 2016 without the Affordable Care Act. As Medicare's Trustees concluded in their overview in this year's report: "The Financial Outlook for the Medicare Program is substantially improved as a result of the changes in the Affordable Care Act." [ii] Moreover, the improvements to the financial future of Medicare because of the Affordable Care Act were accomplished without shifting costs to seniors or reducing medical benefits.

Significantly, the Affordable Care Act achieves savings in Medicare through a series of payment reforms, service delivery innovations and enhanced efforts to reduce fraud, waste and abuse. It is important to highlight that none of the payment reforms affect Medicare's guaranteed benefit packages. In fact, section 3602 of the Affordable Health Care Act specifically states that the guaranteed benefits in Medicare Part A and Part B will not be reduced or eliminated as a result of changes to the Medicare program.

About $117 billion in Medicare savings from 2010 through 2019 is achieved by halting the growth in wasteful overpayments to private Medicare Advantage plans. However, even under the new health care reform law, in 2011 the Medicare program will on average still pay private plans $1.10 for what it would pay $1.00 for the same beneficiaries under traditional Medicare. This additional spending on Medicare Advantage plans is paid for by the nation's taxpayers and Medicare beneficiaries and threatens the solvency of the Medicare Trust Fund.

Restoring financial neutrality between the rates of reimbursement for traditional Medicare and for insurance companies that offer a private alternative to Medicare, as the independent Medicare Payment Advisory Commission (MedPAC) has proposed for years, would bolster the solvency of the Medicare Trust Fund and control taxpayer costs.

The Affordable Care Act gives federal law enforcement agencies and the Centers for Medicare and Medicaid Services new tools to ratchet up efforts to prevent, detect, fight and punish Medicare fraud and abuse. These programs will bring down costs and improve the solvency of the Medicare program while protecting Medicare's vital guaranteed benefits. According to the Department of Justice, for every dollar we spend combating health care fraud we return four dollars to American taxpayers.

The Affordable Care Act also includes new initiatives and models for reform to control overall rising health care costs that adversely impact Medicare. The nonpartisan Congressional Budget Office (CBO) estimates that repealing or defunding the Affordable Care Act would add $230 billion to the deficit.

Allowing the Affordable Care Act to do its job will improve care, strengthen the fiscal health of Medicare, hold accountable those who perpetuate Medicare fraud and hold down costs for taxpayers.

Eliminating Medicare's Guaranteed Benefits is Not the Way to Reduce the Deficit or Improve the Solvency of the Medicare Trust Fund

The House-passed budget would eliminate the guaranteed benefits available to all beneficiaries under Medicare and that are protected by the Affordable Care Act. Medicare would be radically transformed from a secure defined benefit into an underfunded defined contribution plan. In 2022, the government would offer a 65-year-old $8,000 to purchase a private insurance plan, if available. The federal contribution to Medicare beneficiaries under the new program is designed so that it will not keep pace with rising health care costs. It will lose purchasing power over time, shifting more and more costs onto seniors and people with disabilities each year. According to the nonpartisan CBO, the federal savings associated with this breach in our nation's promise of Medicare would be achieved only because beneficiaries would pay more, not because Medicare coverage would cost less than under current law. CBO estimates that in the first year, premiums and out-of-pocket costs for the affected beneficiaries would double, when compared to traditional Medicare. It is a fundamental distortion of Medicare's to call ending Medicare's guaranteed benefit and shifting costs from the federal government to beneficiaries and their families a way to protect and preserve the Medicare program.

Allow Medicare to Negotiate Drug Prices with Pharmaceutical Companies

The 2003 Medicare prescription drug law explicitly prohibits the federal government from negotiating directly with pharmaceutical companies to lower prescription drug costs for Medicare beneficiaries and save taxpayers money. The cost for prescription drugs has outpaced other health care spending and is expected to exceed spending on hospital care and other medical services in 2010 through 2019. Directing the Secretary to negotiate better drug prices puts the federal government on the side of our nation's taxpayers, seniors and persons with disabilities, leveraging the power of 47 million Medicare beneficiaries to negotiate deep discounts on prescription drug prices. The success of federal bulk purchasing of prescription drugs is well established. The federal government is currently allowed to bargain with the pharmaceutical industry for bulk prices to cover prescriptions provided in a range of federally supported settings (e.g., federal and military prisons, state veterans' homes, public health disaster mobile units and health services for Native Americans) but not for Medicare. Making the Medicare prescription drug benefit more efficient through bulk purchasing and having a single designated administrator of the program, instead of insurance companies, could potentially save taxpayers $200 billion over ten years. These savings could be used to improve the solvency of the Medicare Trust Fund, reduce growth in needed financing for the Supplementary Medicare Insurance Trust Fund and reduce the payments required from states to fund the Medicare prescription drug program.

Extend Medicaid Drug Rebates to Medicare Beneficiaries who are Eligible for Both Medicaid and Medicare

Prior to the creation of the 2003 Medicare Prescription Drug Program, brand-name drug manufacturers paid a rebate for beneficiaries who were eligible for both Medicaid and Medicare. However, when the new Medicare drug program was established, the drug companies no longer had to provide the rebates and got windfall profits as a result. The Medicare Drug Savings Act of 2011 (H.R. 2190) introduced by Representative Henry Waxman with Representatives Sander Levin and Pete Stark as original co-sponsors, would eliminate this special deal that allows drug companies to charge Medicare higher prices for lower income beneficiaries. This legislation could yield $112 billion in savings over ten years. These savings could be used to augment the solvency of the Medicare Trust Fund, reduce growth in needed financing for the Supplementary Medicare Insurance Trust Fund and reduce payments required from states to fund the Medicare prescription drug program.

Allow People between Ages 55 and 65 to Enroll in Traditional Medicare

As Americans near the end of their working lives, they often face uncertainty and significant challenges in securing or maintaining health insurance coverage and, therefore, access to needed care. Medicare is not an option for nondisabled persons until they reach age 65. Studies show that those who are uninsured in the decade before they are eligible for Medicare often need to access more costly health care services and treatments when they finally are eligible for Medicare.

The Affordable Care Act included several options to help these early retirees and pre-Medicare individuals access coverage. While there are a number of policy questions that would need to be addressed to ensure that workers between ages 55 and 65 continue to have access to affordable coverage through their employer, allowing the population that is near eligibility for Medicare to buy into traditional Medicare could add revenue and ensure a better transition into Medicare coverage.

Raising the Age of Medicare Eligibility from 65 to 67 Is Not Sound Policy

The House-approved budget plan would raise the age at which seniors are eligible to receive Medicare benefits. Starting in 2022 until 2033, the budget plan would increase the Medicare eligibility age by two months per year until it hits 67. A recent study by the Kaiser Family Foundation shows that such a proposal could hit beneficiaries, employers and states with higher costs. While the study looked at proposals to raise the age of Medicare eligibility in 2014, the added costs to other stakeholders is illustrative of the harm that would be caused by changing the law to implement the House-approved budget. For example, the study found that changing the age of Medicare eligibility would raise premiums by 3% for those who remain on Medicare and for those who obtain coverage through the health care reform's new health insurance exchanges. In addition, health care costs for employers would increase by an estimated $4.5 billion in the first year as employer plans become the primary payer for 65- and 66-year-olds who would no longer be eligible for Medicare, rather than provide supplemental coverage that wraps around Medicare. Also, costs to states would increase by nearly an estimated $0.7 billion, because 65- and 66-year-olds who would be otherwise eligible for both Medicare and Medicaid would depend on state Medicaid programs.

Raising the eligibility age is not a fix, but will create more harm to our health care system.

Conclusion

The 2011 Trustees Report confirms that Medicare is an amazing success story – providing health security to millions of Americans, even during the remaining economic shockwaves of the worst economic crisis of a generation. Some in Congress are calling for radical changes in the promise of Medicare in order to "save" the program. But they ignore the reality that health care reform has extended the solvency of the Medicare Trust Fund and that the economic recession and high health care costs continue to be stressors on this vital social insurance program. We must let the Affordable Care Act do its job to help control costs and protect Medicare's guaranteed benefits. There are ways to address the deficit and improve the solvency of Medicare's Trust Funds without doing it on the back of beneficiaries or working families.

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i The Supplementary Medicare Insurance (SMI) Trust Fund covers physician visits, outpatient services, lab tests, medical supplies, home health and outpatient prescription drugs. Because premium payments from beneficiaries and general federal revenues contributions are set annually to cover the expected cost of Part B and Part D Medicare benefits the Trustees stated that Part B and Part D accounts of the SMI trust fund is adequately financed. States are required to make unprecedented payments to finance the Part D Prescription Drug Program; AFSCME supports reducing or eliminating these state payments.

ii 2011 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS at page 6.