

THE 2013 MEDICARE TRUSTEES REPORT

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED THIRTEENTH CONGRESS
FIRST SESSION

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THE 2013 MEDICARE TRUSTEES REPORT

THURSDAY, JUNE 20, 2013

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

The Subcommittee met, pursuant to call, at 9:30 a.m., in Room 1100, Longworth House Office Building, Hon. Kevin Brady [Chairman of the Subcommittee] presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
Thursday, June 13, 2013
No. HL-05

CONTACT: (202) 225-3625

Chairman Brady Announces Hearing on the 2013 Medicare Trustees Report

House Ways and Means Health Subcommittee Chairman Kevin Brady (R-TX) today announced that the Subcommittee on Health will hold a hearing on the recently released 2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. This hearing will allow the Subcommittee to focus specifically on the Medicare program's financial status and changes from the trustees previous reports. The Subcommittee will hear testimony from Medicare's two Public Trustees. **The hearing will take place on Thursday, June 20, 2013, 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 4-year terms. The CMS Office of the Actuary is responsible for preparing the report. The 2013 report was released on May 31, 2013, and can be found at <https://www.cms.gov/ReportsTrustFunds/downloads/tr2013.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, overriding productivity adjustments to Part A providers, and eliminating the Independent Payment Advisory Board) 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 Medicare trustees again issued a "Medicare funding warning" stating that the more than 45 percent of Medicare outlays in FY2013 will be comprised of general revenues. Additionally, the trustees report the Medicare Hospital Insurance (HI) Trust Fund is expected to go bankrupt by 2026, 2 years later than the 2012 estimate. However, under the high-cost assumptions, the HI Trust Fund is expected to go bankrupt by 2019.

The trustees state that the HI Trust Fund is not adequately financed through 2014 as its “expenditures have exceeded income each year since 2008” and will run a “deficit amounting to \$23.8 billion in 2012.” The trustees project Medicare spending to grow from 3.6 percent of Gross Domestic Product (GDP) in 2012 to 6.5 percent of GDP in 2087.

Under the alternative scenario, the trustees estimate that Medicare spending would increase to 9.8 percent of GDP in 2087. The trustees state that growth of this magnitude would “substantially increase the strain on Nation’s workers, the economy, Medicare beneficiaries, and the Federal budget.

In announcing the hearing, Chairman Brady stated, **“The conclusions of the Medicare trustees are deeply troubling and should serve as a call to action for those who want to save Medicare. While Medicare’s Hospital Insurance Trust Fund has been given a brief 2 year reprieve before going bankrupt, that doesn’t mean Congress has two more years to act. The simple truth is that Medicare remains in deep financial trouble and the time to act is now. It is critical that the American people, the President and Congress 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 2013 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 Friday, July 5, 2013.** 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 TDD/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 BRADY. The Subcommittee will come to order. We are meeting today to hear from the public members from the Board of Trustees, the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds on their 2013 report analysis regarding the current dire status of the Medicare program. It is important to understand the financial health and viability of the Medicare program if we are to ensure that the program is solvent and available to our immediate seniors as well as future generations of Americans.

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

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

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

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

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

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

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

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

As in the past, as you listened to my colleague Mr. Brady, this hearing has usually been a hearing where there has been continual harping on Medicare's supposed dire finances and scaring the public into believing that Medicare is going bankrupt and it won't be there for you when you get to a certain age. Every generation has been subjected to that since I've been in Congress; it is not going to be here by the year X.

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

The long-term 75-year deficit has also improved, dropping from 3.88 percent in 2009 to 1.11 percent in 2013, that is a 72 percent decline. So you are seeing that things in fact in the long term seem to be getting better. Now if you believe those predictions the guys who want them believe them I guess. I am one of those a little dubious about who will know what will happen in 75 years. But the ACA is also resulting in historically low healthcare spending rates. Per capita Medicare spending rate was only .4 percent in 2012, that is less than one-half of 1 percent, and national expenditures grew only 3.9 percent in 2011, the third straight year of slower growth. But these rates are expected to remain low through the decade, it is not just a one-time occurrence. These are the result of the initiatives within the ACA and the initiatives it has catalyzed throughout the country. Providers and insurers have gotten the message loud and clear they need to transform into high-value, efficient providers if they want to compete in the healthcare system of tomorrow.

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

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

I yield back the balance of my time.

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

Mr. Blahous, we will begin with you.

STATEMENT OF CHARLES P. BLAHOUS, PH.D., PUBLIC TRUSTEE, SOCIAL SECURITY AND MEDICARE BOARDS OF TRUSTEES

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

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

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

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

Under our current projections as has been noted we are projecting that the Hospital Insurance Trust Fund will be depleted in 2026, that is 2 years later than we projected in last year's report. My colleague Dr. Reischauer will explain some of the reasons for recent changes in the outlook. Here in my remarks, I will just note that Medicare finances are really very much on a knife's edge over the next several years. We are starting this year with less than 1 year's worth of benefit payments in the Hospital Insurance Trust Fund and so our 2026 projection depends to a great degree on whether annual tax income and outgoing benefit expenditures will be almost exactly balanced over the next several years. If our projections are off a little bit and our long-term projections are subject

to great uncertainty, that 2026 date could move a few years in either direction.

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

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

In conclusion, Mr. Chairman—I know I am out of time—Medicare is a complex program in which finance strains have consequences that include projected depletion of the Trust Fund and raising pressure on the general budget. We are showing costs rising markedly over the next couple of decades, primarily due to demographics, costs are likely to be at least as high as we currently project if the historical pattern of SGR overrides continues. In our report we say that under our current projections legislation will be needed to prevent financing shortfall in the Hospital Insurance Trust Fund and to address rising budgetary pressures arising from Medicare SMI. The sooner such legislation is enacted the more

likely you can produce substantial long-term savings with less potential disruption for beneficiaries.

Thank you.

[The prepared statement of Mr. Blahous follows:]

Statement of Charles P. Blahous
Public Trustee for the Medicare Trust Funds¹
Before the Subcommittee on Health
of the U.S. House of Representatives Committee on Ways and Means
June 20, 2013

Thank you, Mr. Chairman, Mr. Ranking Member, and all of the members of the subcommittee. It is as always a great honor to appear before you to discuss the findings of the 2013 annual report of the Boards of Trustees for the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, more commonly known as the Medicare trust funds. 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. I will be leaving other important aspects of this topic, such as the reasons for changes since last year's report as well as the implications for Medicare of broader health care trends, to be covered in his testimony.

Medicare Trust Fund Operations and 2012 Data

Trust Funds: Medicare has two trust funds. The Hospital Insurance (HI) Trust Fund (sometimes known as Part A) helps to pay for hospital, home health following hospital stays, skilled nursing facility, and hospice care for the aged and disabled. Medicare's other trust fund is 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 for the HI Trust Fund specifically are analogous to those made for the Social Security program. As with Social Security, the majority of HI Trust Fund revenues are provided by a payroll tax levied upon worker wages and self-employment earnings. Also with respect to HI, the Trustees make an annual determination of 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 depleted.

¹ I am also a research fellow with the Hoover Institution and a senior research fellow with the Mercatus Center.

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 cover 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 enrollee premiums and requirements of general government revenues.

Each year there is naturally public and press interest in our updated projection for the date of depletion of the Medicare HI Trust Fund. While this projection is important, it is but one piece of a much larger mosaic of Medicare program finances.

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 worker compensation. Unlike the Social Security payroll tax, the application of the Medicare tax is not capped by wage income level. Starting this year, single taxpayers with earnings over \$200,000 and married couples over \$250,000 are paying 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 for those above certain income levels, with taxation on 50% dedicated to Social Security and the remaining 35% to Medicare HI).

In Parts B and D, general revenues finance roughly 75 percent of total costs. Another significant portion of Part B revenues comes from beneficiary premiums. The standard Part B monthly premium for 2013 is \$104.90. Higher-income beneficiaries (over \$85,000 for individuals, \$170,000 for married couples) pay higher Part B premiums. For Part D, individual monthly premium payments depend on the specific plan selected but average about \$30 for standard coverage in 2013. As with Part B, higher-income beneficiaries in Part D are subject to higher income-related premiums. Part D also receives payments from States, covering about 12 percent of Part D costs in 2013.

Medicare Income Sources, Calendar Year 2012 (\$ Billions)

	Part A	Part B	Part D	Total
Payroll taxes	205.7	0.0	0.0	205.7
Taxation of Soc. Sec. benefits	18.6	0.0	0.0	18.6
Premiums	3.4	58.0	8.3	69.8
Transfers from States	0.0	0.0	8.4	8.4
General revenue	0.5	163.8	50.1	214.4

Interest	10.6	2.8	0.0	13.4
Other	4.1	2.4	0.0	6.5
Total	243.0	227.0	66.9	536.9

Expenditures: Total Medicare expenditures in calendar year 2012 were roughly \$574.2 billion, of which \$565.9 billion were benefit payments and the remaining \$8.3 billion administrative expenses. Categories of expenditures included \$178.8 billion in hospital benefits (most of which were paid from Part A), \$136.2 billion in Part C payments, \$69.6 billion for physician fee schedule services (Part B), \$66.5 billion in prescription drug payments (Part D), \$28.0 billion for skilled nursing facilities (Part A), and \$18.6 billion for home health care (Parts A and B), among other payments.

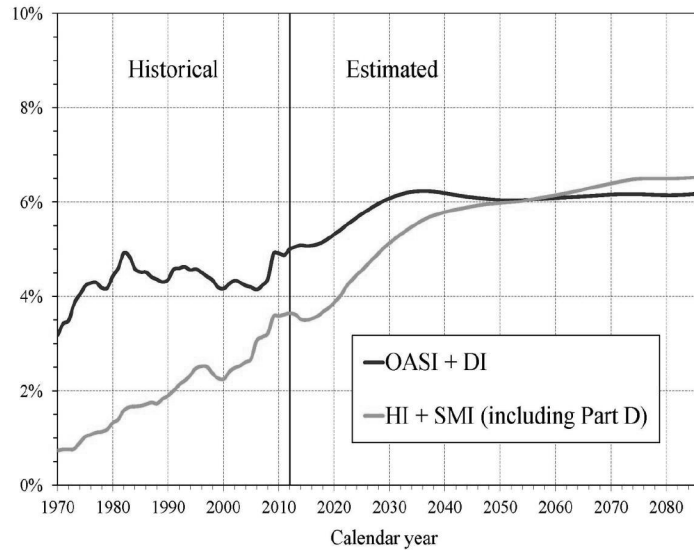
Because 2012 expenditures exceeded income in both the HI and SMI Trust Funds, total asset reserves in each fund declined. Holdings of the HI Trust Fund declined from \$244.2 billion at the end of 2011 to \$220.4 billion at the end of 2012. The SMI Trust Fund is smaller by statutory design because its financing is established annually to cover expected costs. Assets in the SMI Trust Fund declined from \$80.7 billion at the end of 2011 to \$67.2 billion at the end of 2012.

Medicare Financial Projections

Medicare costs are projected to rise substantially in future years relative to today's levels as shown on the following graph. The graph compares projected Medicare (HI + SMI) costs to Social Security (OASI + DI) costs as a percentage of GDP. In 2013 Medicare costs are estimated to be 3.62% of GDP. By 2035 they are projected to have risen substantially to 5.6% of GDP under current schedules and then to rise somewhat more slowly afterward to reach 6.5% of GDP in 2087.

In both Social Security and Medicare the vast majority of cost growth relative to GDP is projected to occur prior to the mid-2030s. The primary driver of this cost growth is demographic change. Under current-law eligibility criteria, the number of beneficiaries per taxpaying worker will rise markedly as the large baby boom generation leaves the workforce and joins the rolls of beneficiaries. The slope of cost growth is somewhat higher in Medicare than it is in Social Security because Medicare costs are also affected by medical cost inflation, which has tended to grow faster than general price inflation. For the next couple of decades, however, the primary driver of program cost growth will be the rise in the number of beneficiaries, with health cost inflation only becoming the relatively more important factor later in the long-range projection period.

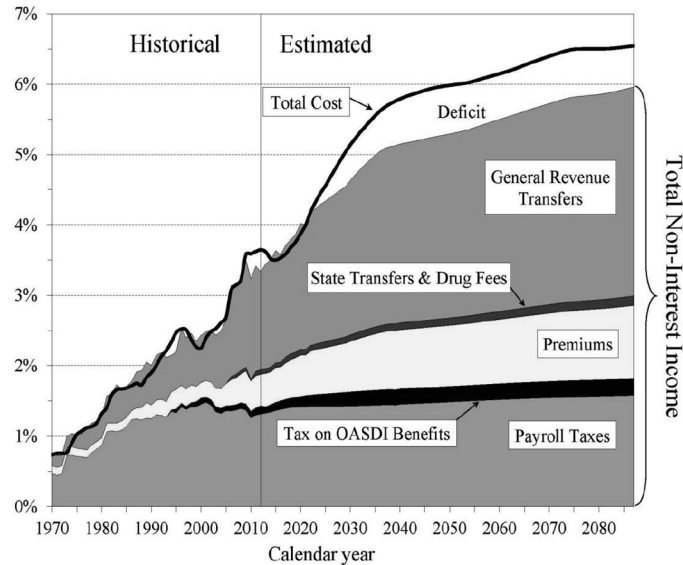
Social Security and Medicare Cost as a Percentage of GDP



Both of the aforementioned drivers of Medicare cost growth (population aging and general health care cost inflation) exemplify why it is generally preferable to enact program financing reforms sooner rather than later. Changes to health care expenditure growth are unlikely to be realized in the form of a sudden reduction in national health care costs, whereas earlier reforms that reduce the rate of cost growth can compound to produce substantial savings over the long term. Similarly, reforms to constrain the growth in the number of Medicare beneficiaries are better enacted sooner rather than later so as to give affected individuals more time to prepare for any legislated changes.

As Medicare costs grow over time, program financing resources are projected to change as shown in this graph reproduced from the summary of the annual reports.

Medicare Cost and Non-Interest Income by Source as a Percentage of GDP

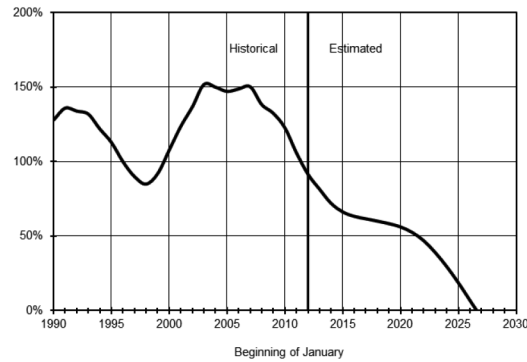


Under current projections this cost growth will exert substantially increased pressure on the general federal budget. General revenue transfers to support SMI payments, for example, would grow from 1.5 percent of GDP in 2013 to 2.9 percent in 2087. The share of total Medicare spending covered by dedicated taxes would fall from 39 percent in 2013 to 28 percent in 2087.

As mentioned earlier, the financing of Parts B and D of Medicare will be established annually to cover expected benefit payments irrespective of cost growth rates. The same is not true, however, with respect to Part A, Medicare's HI Trust Fund. There is no mechanism under current law for financing HI benefits in excess of HI Trust Fund resources. Such benefits can only be paid in full as long as the HI Trust Fund maintains a positive balance.

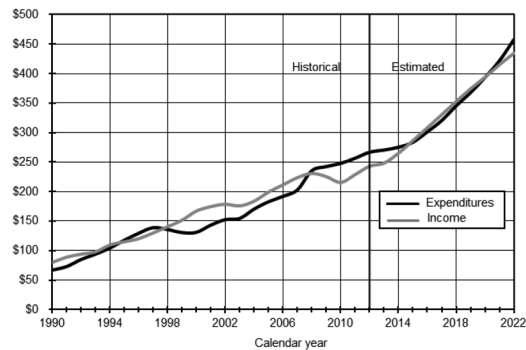
Under our current projections Medicare's HI Trust Fund would be depleted in 2026, at which point its income would be sufficient to finance 87 percent of program costs, a percentage that would decline to 73 percent by 2087. To date lawmakers have never allowed projections of HI Trust Fund depletion to be realized. Our current projection of 2026 is two years later than the projection made in last year's Trustees report.

Medicare HI Trust Fund Reserves as a Percentage of Expenditures



My colleague Dr. Reischauer will explain some of the reasons for the modest change in the projected HI Trust Fund depletion date. Here I will simply note that the pattern of trust fund financial flows is substantially different in Medicare HI than it is, for example, in Social Security. Social Security by contrast ran substantial surpluses in recent decades, amassing much larger trust fund reserves that it will draw upon, enabling the full payment of benefits during several years of substantial deficits of tax income relative to expenditures before its trust funds are depleted. Medicare HI instead has a comparatively smaller trust fund. Its balance at the start of this year represented the equivalent of only 0.81 years' worth of HI benefit payments. Thus the projection that its trust fund will continue to show a positive balance until 2026 depends on whether its tax and premium income will closely match outgoing benefit payments over the next several years as we currently project.

Past and Projected HI Income and Expenditures



Medicare finances are subject to greater projection uncertainty than are Social Security's because of the difficulty of projecting general health care cost inflation. Later in this testimony I will briefly describe our projection methods as well as some sources of projection uncertainty. Here I will simply note that modest inaccuracies in our projected growth rates could cause the projected HI depletion date to move by a few years. If, for example, our projections for annual HI cost growth are off by roughly half a percentage point per year, the projected depletion date could shift by two years. Under the Trustees' so-called "high-cost" scenario that assumes less favorable trends in economics, demographics and health cost inflation, the HI Trust Fund is depleted in 2019.

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. The provision is intended to measure the extent to which rising Medicare costs are placing pressure on the general federal budget. When the Trustees make such a determination 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 2013, prompting a "Medicare funding warning" for the seventh straight year.

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. As members of this subcommittee are well aware, health care experts often disagree on what to expect in health care cost inflation even over short-term periods, let alone over the 75-year valuation period over which the Trustees make projections. And while these variables are extremely difficult to predict with precision, they have a very large impact upon Medicare cost projections over the long run.

Our current projection methodology follows recommendations of the 2010-11 Medicare Technical Review Panel. The first step is essentially to estimate the rate of cost growth in the health sector overall. These projections are based on estimates of the elasticity of health care cost growth in response to changes in certain underlying factors that include medical prices, income levels, and levels of insurance coverage. Based on this methodology we project that total health care cost growth per capita will average 1 percent more than per-capita GDP growth annually over the 75-year valuation period. Importantly, this rate of growth is projected to decline over time. The rate is “GDP plus 1.15 percent” in 2037, and it gradually declines to “GDP plus 0.32 percent” by 2087. One technical explanation for the expected slowdown is that as medical prices rise and health care consumes a greater proportion of income, the demand for increased health care will lessen, which would exert downward pressure on future rates of health care spending growth. A layman’s translation of this phenomenon is that we do not expect medical care spending to grow to the point where our economy is devoted to nothing other than health care. As has sometimes been said, we should not expect that in the future we will all be homeless, naked and starving but with impeccable health care. An important point to understand is that a certain amount of health care cost growth deceleration is built into our projections irrespective of the effects of Medicare legislation.

Projecting Medicare cost growth requires us to translate these estimates of overall health spending to take account of Medicare reimbursement rates. Pursuant to a recommendation from the Technical Review Panel, we assume that the input costs facing health care providers would increase roughly 0.4 percentage points faster than medical output prices. This 0.4 percentage point difference reflects an estimate based on the historical level of annual provider productivity improvements. This estimate in turn underlies the aforementioned assumption of GDP plus 1.0 percent for the overall health sector. In other words, we estimate that the health care sector reflecting just input costs but not health sector productivity will increase at GDP plus 1.4 percent on average over 75 years. Certain cost-saving provisions of the 2010 Affordable Care Act (ACA) are important for translating this GDP plus 1.4 percent estimate into estimates of Medicare cost growth. These provisions 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. This by itself would reduce expected cost growth in these categories of Medicare services to GDP plus 0.3 percent annually, on average over 75 years. The Technical Panel further concluded that these provisions of the ACA would reduce health service volume and intensity growth by 0.1 percentage point annually, bringing our projection for total growth in these Medicare categories to GDP plus 0.2 percent over 75 years.

Again it is important to remain aware that this is an average growth rate over 75 years. Earlier in the valuation period we are projecting that per capita Medicare cost growth in these areas will be

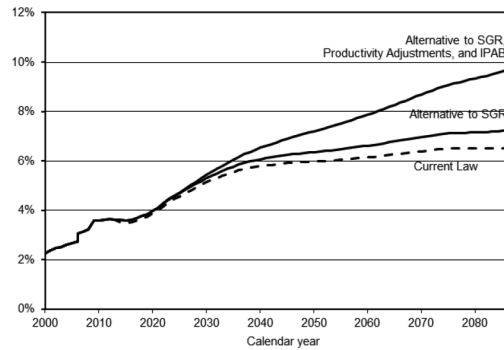
more rapid than per capita GDP growth, but less rapid later in the valuation period. Under our projections, costs for these HI and SMI Part B services will grow at a rate of “GDP plus 0.4 percent” in 2037 but slow to “GDP minus 0.5 percent” by 2087.

Total Medicare Costs Likely to be Higher than Projected Under Current Law

The contours of our long-term Medicare projections subsequent to the passage of the 2010 ACA have caused some to speculate that certain cost-saving provisions of the ACA may prove unsustainable over the long term and are likely to be overridden by future lawmakers. This concern is rooted in part in the observation that our projections show Medicare cost growth declining relative to private health care cost growth, and even relative to per-capita GDP growth, over the long term. As Trustees we are not in a position to predict the future actions of lawmakers, and most of the Trustees’ report is devoted to projecting the course of future program finances under current law as written.

That said, the Trustees’ report does note that under current law, Medicare physician payments would be cut by roughly 25% at the start of 2014 under the Sustainable Growth Rate (SGR) payment formula, and that lawmakers have overridden the SGR in each year since 2003. While our primary projection assumes that current law will be maintained and that the physician payment will take effect, we also show an illustrative alternative scenario in which scheduled SGR reductions are overridden so that future payment increases reflect the average physician fee payment updates that occurred from 2004 to 2013. Under this scenario total Medicare costs are more than 10% higher over the long term, reaching 7.2 percent of GDP in 2087 as opposed to 6.5 percent under current law. We also show a second illustrative alternative scenario in which, in addition to overriding the SGR, certain cost-saving provisions of the ACA are phased partially out over the years 2020-2034. Under this second alternative scenario total Medicare costs would reach 9.8 percent of GDP by 2087.

Total Medicare Costs as a % of GDP, Current Law and Illustrative Alternative Scenarios



The inclusion of these illustrative alternative scenarios should not be interpreted as a prediction or a policy recommendation by the Trustees. The historical pattern of SGR overrides, however, is by itself an indication that actual Medicare costs are likely to be higher than we are currently projecting.

Conclusion

Medicare is a complex program in which financing strains are manifested in phenomena ranging from the projected date of depletion of its HI Trust Fund to the rising pressure that growth in SMI expenditures will exert upon the general federal budget. Over the next few decades costs are projected to rise at rates significantly faster than GDP growth primarily due to the rising number of program beneficiaries. Thereafter the rate of program cost growth will be influenced to a significant extent by general health cost inflation. Projections of Medicare cost growth are subject to considerable uncertainty especially over the long term, but costs are likely to be higher than under current projections if lawmakers continue the historical pattern of overriding current-law physician payment reductions under the SGR formula. Under our current projections legislation will be needed to prevent a financing shortfall in Medicare HI and to address rising budgetary pressures arising from Medicare SMI. The sooner such legislation is enacted, the more gradual can be its effects and the greater the potential for long-term savings.

Chairman BRADY. Thank you.
Mr. Reischauer.

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

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

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

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

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

Whether the spending slowdown will continue is an open question. While there are reasons to be cautiously optimistic there are also reasons for concern. Prime among those reasons of course is the possibility that breakthroughs in genomic science, nanotechnol-

ogy, stem cell research and other cutting-edge technologies could lead to an explosion of new and expensive interventions.

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

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

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

Thank you.

[The prepared statement of Mr. Reischauer follows:]

***TESTIMONY IS EMBARGOED UNTIL THE START OF THE HEARING ON
THURSDAY, JUNE 20 2013 AT 9:30 AM***

Statement of Robert D. Reischauer¹

Subcommittee on Health of the Committee on Ways and Means

U.S. House of Representatives

June 20, 2013

Chairman Brady, Ranking Member McDermott, and members of the subcommittee, I appreciate this opportunity to discuss with you issues related to the 2013 Annual Trustees Report of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. In his statement, my fellow Public Trustee Dr. Charles P. Blahous covered the basic operations of Medicare and the Trustees' current law projections of the program's financial situation over the next 75 years. My statement focuses on a related topic, one not examined in any depth in the Trustees Report. It is the implications the apparent slowdown in per capita national health spending might have for the financial challenge facing the Medicare program.

My statement first reviews the slowdown and its possible causes. Next it speculates a bit about whether the slowdown will continue or whether spending growth will bounce back. Finally it discusses what this may mean for Medicare's future financial situation.

The slowdown: As has been widely reported, the growth of per capita health spending has slowed in recent years. This slowdown appears to have started around the middle of the last decade and therefore predates the advent of the Great Recession. While the slowdown has not proceeded in a monotonic fashion, it has been evident across all of the major types of coverage—employer/union sponsored plans, Medicare, Medicaid and individual policies.

The following table shows the CMS Office of the Actuary's most recent estimates of the annual rates of growth of per capita health consumption expenditures during the last three plus decades.

1980-1990	1990-2000	2000-2007	2008	2009	2010	2011
10.1%	5.6%	6.7%	3.7%	3.6%	3.3%	3.2%

Private analysts have suggested that the spending growth in 2012 remained subdued. The growth rates of the past few years are the lowest recorded in over half a century.

¹ Distinguished Institute Fellow and President Emeritus of the Urban Institute and Public Trustee of the Social Security and Medicare Trust Funds. The views expressed in this statement should not be attributed to the Urban Institute, its sponsors, staff, or trustees or the other Trustees of the Medicare Trust Funds.

As the table on the next page reports, fiscal year 2012 per beneficiary spending in Medicare grew by less than half a percent and all of the program's components contributed to this outcome. Over the three year period 2009 to 2012, the annual growth rate of per beneficiary spending was a modest 1.9 percent. Notwithstanding these slow growth rates and the 2013 Trustees Report's projections which push out by two years—from 2024 to 2026—the date at which the HI Trust Fund is expected to be depleted, the fundamental financial challenge facing the program and the imperative for further cost restraint and reform remain largely unchanged.

Medicare Results for FY 2012

Total Medicare		Parts C (Medicare Advantage)	
Spending	4.1%	Spending	7.8%
Number of Beneficiaries	3.6	Number of Beneficiaries	7.8
Per beneficiary spending	0.4	Per beneficiary spending	0.0
Parts A + B (Fee for Service)		Parts D (Prescription Drugs)	
Spending	3.0%	Spending	3.6%
Number of Beneficiaries	2.0	Number of Beneficiaries	3.9
Per beneficiary spending	1.0	Per beneficiary spending	-0.4
(Payment rates)	0.1)		
(Volume and intensity)	0.9)		

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Possible explanations for the slowdown: Analysts have pointed to a number of factors that have contributed to the slowdown in health care spending. Some have had a broad impact across the entire sector while the effect of others was more narrowly concentrated in one area like Medicaid.

First and foremost among the explanations for the spending slowdown is the Great Recession and financial collapse of 2008-9 and the slow subsequent recovery. Analysts have estimated that somewhere between 37 percent and 77 percent of the slowdown is attributable to the weak economy. Many workers lost their jobs and, with their jobs, their employer sponsored health insurance. Finding themselves uninsured or covered by individual policies with higher cost sharing and more restricted benefits or on Medicaid with more limited access to providers, these

workers and their families reduced their use of health care services. Economic uncertainty, anemic wage growth, and the collapse of house values caused even those who were not directly affected by job loss to be more cautious about their discretionary health expenditures.

While some think that the recent economic problems shouldn't have had a large impact on Medicare spending, it is worth remembering that Medicare beneficiaries were strained as well. They received no Social Security COLAs for two years. The collapse of equity values decimated the value of many retirees' IRAs and 401K plans. And historically low interest rates reduced their income from CDs, bonds and other savings vehicles.

Employers, facing weak demand for their products and workers, constrained by slow wage growth and feeling financially insecure, sought ways to reduce their health premium costs. An increasing fraction of workers were offered, often as their only option, high deductible insurance plans or experienced a reduction in the generosity of their traditional plans. Between 2006 and 2012 the fraction of employees with high deductible plans grew from 4 percent to 19 percent and the fraction with plans that had general deductibles of \$1,000 or more grew from 10 percent to 34 percent. With more "skin in the game" it is not surprising that the growth of utilization moderated.

A second factor that has contributed to the recent spending slowdown relates to technology. Compared to past periods, the last few years have been a period during which relatively few major new technologies—drugs, devices, procedures, and other interventions—have been introduced. Furthermore, the diffusions of newer technologies, like advanced imaging, seem to have run their courses. Nowhere is this more evident than in the pharmaceutical arena where fewer new blockbuster drugs have been introduced while significant numbers of widely used branded drugs have come off patent and have been faced with competition from low cost generics.

Changes in policy are a third factor that explains a portion of the recent spending slowdown. The fiscal challenges facing most states caused them to adopt policies that moderated the per beneficiary growth of their Medicaid spending. Whereas per beneficiary Medicaid spending rose at just under 3 percent a year from 2005 to 2007, the growth rate averaged only 1.1 percent between 2007 and 2011 even as the rolls swelled.

While the Affordable Care Act enriched some Medicare benefits thus boosting costs, it also cut the payment rates of some providers and reduced the annual updates most categories of providers received thereby helping to dampen the growth of program spending. Probably of more significance was the signal that the Act gave to the broader health care sector about the emphasis policy was going to place on cost growth moderation in the future. The various demonstrations and pilot programs, the IPAB, the Cadillac tax and other measures made providers and insurers aware that business as usual—cost unconscious care—would not be acceptable going forward.

While the direct impacts of many of the Act's cost restraining measures may not be felt for several years, employers, providers and insurers have begun to prepare by taking anticipatory actions that undoubtedly have already dampened spending growth somewhat.

While less amenable to measurement, changes in the views of the provider community, particularly its leaders, have probably been an important contributor to the slowdown in per capita health spending. In contrast to the past, there is now widespread appreciation among leaders that health care cannot be provided without concern for its costs and the efficiency with which it is delivered. Similarly, there is little dispute now that a significant fraction of care is of marginal or no value. There is even a growing acceptance of the notion that care quality can and should be measured and the results should be disseminated and factor in to payment rates. It is also widely understood that the cost of equivalent care varies widely from provider to provider and little of this variation is attributable to input cost differences or differential outcomes or quality. Finally, leaders in the provider community have realized that, if they don't come up with mechanisms that incentivize high quality, cost effective care, others will impose change on them. All of this amounts to a sea change in attitudes which has spurred hospitals, physician groups, insurers, employers, and others to undertake innumerable efforts designed to moderate cost growth and improve care quality. Some of these initiatives have already helped to dampen cost growth.

Finally and most speculatively, consumer attitudes about health care seem to have begun to shift in ways that may have begun to reduce cost growth. Consumers have become more informed and more sophisticated decision makers thanks to the proliferation of information available through the Internet and the increased attention devoted to health in the traditional media (newspapers, TV, and radio). There is a growing awareness that more health care and more expensive and newer intervention do not always lead to improved outcomes.

Will the slowdown continue? There are too many uncertainties to predict with any confidence whether the spending slowdown will continue. Some of the factors that have contributed to the moderation of cost growth should abate while the impact of others could strengthen.

On balance, there are reasons to be cautiously optimistic about the future course of health care spending but also reasons not to be complacent or to think that whatever bend might have been put in the cost curve will be sustained without further actions.

The economy is recovering, albeit slowly. This will boost wages and incomes which, in turn, will increase the demand for health care services. But no one is predicting tight labor markets or rapidly rising incomes. It is unlikely, therefore, that workers will want to devote a significant portion of any modest future increases in compensation they may receive to reacquire the less restrictive and more costly health insurance policies they enjoyed in the past. Many have probably adjusted to more restrictive networks, higher cost sharing, generic drugs and lower

levels of utilization. Even if this is not the case, employers cognizant of future costs they may face, will be reluctant to move in the direction of enriching the health insurance they offer.

While one hopes that there will be significant advances in medical technology, scientists, entrepreneurs and venture capitalists realize that the bar is being raised, although very gradually. To gain widespread utilization in the future, expensive new technologies will increasingly have to demonstrate that they are significantly more effective or patient friendly than existing, cheaper interventions or be subject to step therapy regimes which will reduce their market potential.

Over the next decade, policy, if adhered to, should exert an ever stronger moderating impact on cost growth as many of the measures contained in or induced by the Accountable Care Act and other recent legislation are fully implemented. Where successful, the insurance exchanges could offer a variety of innovative, cost conscious insurance products in a competitive marketplace. For the first time significant numbers of individuals will be able to trade off their preferences for bearing risk, accepting narrow provider networks, and foregoing cutting edge therapies as well as amenities against their willingness to pay higher premiums. What we learn from the exchange experiences could significantly affect the forms of insurance offered by employers. The Cadillac tax should encourage many employers and their employees to start discussing how much each is willing to pay for generous coverage. Over the long run, this could lead to a significant scaling back of some employer sponsored policies and put more pressure on providers to contain costs.

There is every reason to believe that increasing numbers of providers and other stakeholders will focus their attention on costs and quality as more find themselves facing new payment arrangements that incentivize them to coordinate care, provide care more efficiently and bear some of the financial risk associated with excessive cost growth.

The gradual demographic transition that is taking place in the provider community is a final reason to be guardedly optimistic about the possibility that the recent spending slowdown can be sustained over the next decade or so. The skills and interests of younger cohorts of health professionals are more congruous with the institutional structures that will be required by a reformed health system. They are more digitally proficient and more comfortable working as members of teams of health professionals. Seeking a better work-life balance, younger health professionals, especially those in two career families, are more willing to work in organizations large enough to support the complex informational and financial infrastructure required by modern medicine and to provide more flexible work schedules.

To balance this optimism, it is worth pointing to a few of the risks that could cause spending growth to rebound. Prime among these is the possibility that breakthroughs in genomic science, nanotechnology, stem cell research and other cutting edge technologies could lead to an explosion of new expensive interventions. On the other hand, the mining of big data could lead to a better understanding of which specific interventions are most effective for which patients

and under what circumstances. That could result in better targeting of care and lower overall utilization.

A second development that might boost the pace of future spending growth is the increased provider market power that could develop from the consolidation and integration that will probably take place as the health care system undergoes reform. The complexity and cost of modern medicine requires operations of a minimum scale to be efficient. The Affordable Care Act seeks to encourage integrated or coordinated care and the use of information technology to manage that care which small and fragmented providers find challenging. Operations of a significant size are also presumed by new payment arrangements that require providers to share risk when quality falls below or costs rise above certain thresholds, a burden that small organizations are ill equipped to bear. While provider consolidation and integration may be required for improved care quality and efficiency, in some areas this may give these organizations more power to set prices. Some metropolitan areas will be large enough to support robust health markets where a number of large providers compete aggressively. But in many smaller metropolitan areas and in non-metropolitan regions of the country one or a few providers may have an inordinate influence over prices and spending growth.

The increase in the demand for health services that will occur with the implementation of the Affordable Care Act could be a third threat to the continuation of the spending slowdown. In some areas where many are uninsured or under-insured temporary shortages of providers might develop. This could cause prices and spending to rise. On the other hand, the increased demand could be spur an expansion of new, more efficient delivery organizations like “minute clinics,” the more intensive use of expensive equipment that could bring down unit prices and an expanded reliance on nurse practitioners, physician assistants and other non MD health professionals where their contributions have proven to be effective.

The implications of a continued slowdown for Medicare: Some might ask whether the future pace of growth of overall health care spending has much relevance for Medicare’s future fiscal situation. After all, unlike employer sponsored insurance, individual insurance or even the policies that will be offered on the exchanges, Medicare is a system with administered prices whose course is set by legislation not market forces. Legislation and regulation, not market place negotiations with providers, also define the other program parameters and cost saving measures that determine Medicare’s overall and per capita spending. Because Medicare makes up such a large fraction of the overall health care market and because its enrollees constitute such a well-regarded component of American society, few providers can afford or would want to forego their Medicare business under any circumstances.

Doesn’t this suggest that Medicare is free to set its own course with respect to future cost growth independent of whatever is happening in the rest of the health care marketplace? The answer to this question is a resounding “No.” Nowhere is this illustrated more clearly than in the

appropriate reluctance Congresses and Presidents have shown toward adhering to the discipline required by the Sustainable Growth Rate (SGR) formula. Notwithstanding the fact that the projections in the Trustees Report assume, as they must following current law, that the SGR will impose a 24.7 percent reduction in the physician fee schedule on January 1, 2014, the Report notes that it is a “virtual certainty” that this reduction will be overridden. This judgment is based on the experience since 2003 and an appreciation of the disruptive consequences that a sudden, sharp reduction that would leave Medicare payment rates far below those of other payers would have. In short, what happens in the private market place constrains what Medicare can do.

For several years, the Trustees Reports have expressed caution with respect to the long run sustainability of the major cost-reduction measures required by the Affordable Care Act. The most important of these are the reductions in the annual payment rate updates for most categories of Medicare providers by the growth in economy-wide multifactor productivity and the IPAB. While the Trustees believe that these measures can be sustained, this will occur only if the health sector can transition to more efficient models of care delivery. Such a transition will not happen unless private payers as well as Medicare continue to pursue cost saving innovations aggressively and providers respond to incentives to moderate cost growth and improve quality.

In conclusion, Medicare’s ability to moderate the growth of its costs over the long run depends critically on the private sector’s success in its efforts to slow its spending and vice versa.

Chairman BRADY. Thank you, Mr. Reischauer.

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

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

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

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

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

Mr. BLAHOUS. That is right.

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

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

Chairman BRADY. Now, this session preferably.

Mr. BLAHOUS. From a purely technical substantive perspective, yes.

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

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

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

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

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

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

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

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

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

Final point, is it accurate that the Trust Fund—hospital Part A Trust Fund this year started out only having enough to cover 81 percent of liabilities; is that accurate, in your trustees report?

Mr. REISCHAUER. The Trust Fund's assets amounted to 81 percent of 2013's expected expenditures. If there were no money coming into the Trust Fund that is—

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

Mr. REISCHAUER. It is expected to decline.

Chairman BRADY. Get worse.

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

Chairman BRADY. Mr. McDermott.

Mr. MCDERMOTT. Since these hearings are basically educational for the public let me try and get clear in people's minds, when you are talking about a deficit, you are talking about a deficit in Part A, that is what you are talking about? And Part B, that is doctors and other incidental laboratory and so forth, will be paid

in full. And Part D will be paid in full. So those two programs are not what we are worried about here. We are worrying about the hospital is at 87 percent and there is going to be 87 percent of the value in whatever it is, 20, or whatever, out there.

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

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

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

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

Mr. MCDERMOTT. Because—

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

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

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

Mr. MCDERMOTT. It seems to me that what you are really saying is that some of the things that are being put in place and have been put in place both in the ACA and in Medicare Advantage in the past are you can't expect them to go in and instantly have a major change, that it is like trying to take a super tanker and turn it on a dime, it takes 20 miles to bend it 4 degrees in its direction

and that is really what we are doing here with a big program. Is that your view, that we are getting the benefits from the ACA?

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

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

I yield back the balance of my time.

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

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

Mr. BLAHOUS. That is correct.

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

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

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

Mr. BLAHOUS. Obviously we can't continue on that path forever. In our current projections over the next decade we are projecting almost an exact symmetry between income and outgo, and there actually is a brief blip later in this decade when we are projecting tax incomes for 1 year exceed expenditures, but then after that the lines pull apart and expenditures exceed income on a permanent basis and that is what leads to depletion of that Trust Fund.

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

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

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

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

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

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

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

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

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

Mr. REISCHAUER. Well, first of all those numbers that you suggested I don't think account for the differences in generosity between the plans that are being offered now and the plans that will be offered in the exchange because there are minimum benefit requirements for plans offered in the exchange. But what I really am referring to is the situation that we will have once the exchange starts, which is the individual consumer having a choice of which plan he or she decides to sign up for. And as you know, there will be plans at different levels of generosity. And we might find that very significant fractions of the American public are quite comfortable with plans that are not as generous as those that we see offered in the usual employer/employee situation and that will change and start a competition that heretofore really hasn't existed both because fewer employers offer a range of plans, and those that do usually make their contributions to those different flavors of plans such that true market responses by their employees are not exhibited.

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

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

Mr. JOHNSON. Thank you for your testimony.

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

[Recess.]

Chairman BRADY. The Subcommittee will reconvene.

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

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

Mr. REISCHAUER. Well, one aspect of current law is the assumption that the SGR will be implemented and that physician payment rates will go down by almost 25 percent, and in that respect I don't think we will hit the projections, and I think the impact that that has on Medicare's overall spending is about 2 percent, but abstracting from that, you know, I think it is perfectly

plausible that over the course of the next 10 and 20 years that we will hit the projected numbers that are in the report. But as I said in my testimony, this presumes that there will be a significant transformation of our delivery system, not just the delivery system from Medicare's perspective, but from the private sector as well, but I think that we are on our way to that in large measure because of the pressure that the Congress has been exerting on healthcare providers.

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

Mr. REISCHAUER. Yes, that is. I mean, if you look at the—

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

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

Mr. PASCRELL. You would agree with that?

Mr. REISCHAUER. Yes.

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

Mr. REISCHAUER. We have—

Mr. PASCRELL. Prescription drugs.

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

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

Mr. REISCHAUER. Uh-huh.

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

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

Chairman BRADY. If I could—I want to give plenty of time—

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

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

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

Chairman BRADY. Thank you, Mr. Pascrell.

Dr. Price.

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

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

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

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

Mr. PRICE. And likely not as good?

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

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

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

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

Mr. PRICE. Right.

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

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

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

Mr. PRICE. But they could be much sooner?

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

Mr. PRICE. Thank you. Thank you, Mr. Chairman.

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

Mr. SMITH. Thank you, Mr. Chairman, and thank you to our witnesses for being here today and sharing your insight and expertise. Dr. Reischauer, in your testimony you suggest spending on

health care may actually decrease in the future in part because of the creation of IPAB, and what part of IPAB is it that you think can lead to that? I know many folks are concerned that it is a form of rationing of care.

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

Mr. SMITH. Okay.

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

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

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

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

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

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

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

Mr. SMITH. Thank you, Mr. Chairman.

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

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

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

[Submissions for the Record follow:]



AMERICAN ACADEMY *of* ACTUARIES

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

**Hearing on
2013 Medicare Trustees Report**

June 20, 2013

Statement of
Thomas F. Wildsmith, MAAA, FSA
Chairperson, Medicare Steering Committee
American Academy of Actuaries

and

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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' Medicare Steering Committee, we appreciate the opportunity to provide written testimony on the 2013 Medicare Trustees Report. Our comments focus on the findings of the report with respect to the program's solvency and sustainability. 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. Medicare plays a critically important role in ensuring access to health care among Americans age 65 and older and certain younger adults with permanent disabilities. The program is operated through two trust funds. The HI trust fund (Medicare Part A) pays primarily for hospital services. The SMI trust fund includes accounts for the Medicare Part B program, which covers physician and outpatient hospital services, and the Medicare Part D program, which covers the prescription drug program.

The trustees' report is the primary source of information on the financial status of the Medicare program, and the American Academy of Actuaries proudly recognizes the important contribution that members of the actuarial profession have made in preparing the report and educating the public about the important issues surrounding the program's solvency and sustainability.

The projected financial condition of Medicare as identified in the 2013 Medicare trustees' report has improved compared with the projections from the 2012 report. The year in which the HI trust fund is projected to be depleted is now 2026, two years later than projected last year. The 75-year HI deficit decreased from 1.35 percent of taxable payroll in last year's report to 1.11 percent of taxable payroll in the 2013 report. This improvement is due to more recent data and technical changes in projection methods. Nevertheless, HI expenditures are projected to exceed HI revenues in most years of the 75-year projection period. And total Medicare expenditures will make up an increasing share of federal outlays and the gross domestic product (GDP).

As required by statute, the trustees' projections of Medicare's financial outlook are 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 accompanies the trustees' report, Paul Spitalnic, the acting 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 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 acting chief actuary point to scheduled reductions in provider payments that are unlikely to occur. Currently scheduled physician payment reductions in accordance with the sustainable growth rate (SGR) mechanism are considered likely to be overridden by Congress (i.e., the Medicare "doc fix"). In addition, current law requires downward adjustments in payment updates for most non-physician providers to reflect productivity improvements; these adjustments might not be sustainable in the long term.

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 physician payment reductions are overridden, the productivity adjustments are phased down, and there are no savings from the Independent Payment Advisory Board (IPAB). 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 illustrate and quantify the potential magnitude of the cost understatement under current law.” This testimony presents projections based on both current law and the illustrative alternative projections.¹

The trustees conclude: “The projections in this year’s report continue to demonstrate the need for timely and effective action to address Medicare’s remaining financial challenges—including the projected depletion 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 cannot be sustained, then these further policy reforms will have to address much larger financial challenges than implied by the current-law projections.”

The American Academy of Actuaries’ Medicare Steering Committee concurs that the Medicare program faces serious financing problems. As highlighted in the 2013 Medicare trustees’ report and its accompanying illustrative alternative analysis:

- The HI trust fund is projected to be depleted in 2026, two years later than projected in last year’s report.
- The HI trust fund faces serious long-term funding challenges. HI expenditures are expected to exceed HI revenues in most future years. In the year that the trust fund is projected to be depleted—2026—tax revenues would cover only 87 percent of program costs.
- The projected HI deficit over the next 75 years is 1.11 percent of taxable payroll.² Eliminating this deficit would require an immediate 38 percent increase in standard payroll taxes or an immediate 22 percent reduction in benefits—or some combination of the two. Delaying action would require more drastic tax increases or benefit reductions in the future.
- Under the illustrative alternative scenario, the HI trust fund would be depleted a few months earlier in 2026 and the 75-year HI deficit would be 2.17 percent of taxable payroll.
- The SMI trust fund is expected to remain solvent because its financing is reset each year to meet projected future costs. Projected increases in SMI expenditures will require significant increases over time in beneficiary premiums and general revenue contributions. Under current-law projections, SMI spending is expected to grow from 2.0 percent of GDP in 2012 to 4.0 percent of GDP in 2085. Under the illustrative alternative scenario, SMI spending is expected to reach 5.6 percent of GDP in 2085.

¹ Both the 2013 Medicare Trustees Report and the CMS Office of the Actuary’s illustrative alternative scenario analysis are available at: <http://www.cms.gov/ReportsTrustFunds/>.

² The current HI payroll tax rate is 1.45 percent of taxable earnings, payable by both employees and their employers for a total of 2.90 percent. Self-employed individuals pay both shares. Beginning in 2013, earnings exceeding \$200,000 for individuals and \$250,000 for married couples filing jointly are subject to an additional HI tax of 0.9 percent.

- Total Medicare expenditures also are projected to increase as a share of GDP, thereby threatening Medicare's long-term sustainability. Under current-law projections, total Medicare spending as a share of GDP is expected to grow from 3.6 percent in 2012 to 6.5 percent in 2085. Under the illustrative alternative scenario, total Medicare spending is projected to reach 9.6 percent of GDP in 2085.

These findings are discussed in more detail below.

Because Medicare plays a critically important role in ensuring that older and certain disabled Americans have access to health care, the American Academy of Actuaries' Medicare Steering Committee 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;
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 Social Security, Medicare relies on trust funds to account for all income and expenditures. The HI and SMI programs operate separate trust funds with different financing 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, which pays for hospital services, is funded primarily through earmarked payroll taxes.

The projections of Medicare's financial outlook in the trustees' report must be based on current law. Under these current-law projections, the financial condition of the HI trust fund has improved since the 2012 trustees' report. This improvement results from more recent data and technical changes in projection methods. The projected trust fund exhaustion date is two years later than in last year's report, and the 75-year HI deficit decreased from 1.35 percent of taxable payroll to 1.11 percent.

- HI expenditures currently exceed HI revenues. The gap is projected to narrow over the next few years, becoming a surplus for a few years before HI expenditures are expected to exceed

revenues, including interest income, for the remainder of 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 deficit and debt.

- The HI trust fund is projected to be depleted in 2026. At that time, tax revenues are projected to cover only 87 percent of program costs, with the share declining to 71 percent in 2050. In 2085, payroll tax revenues are projected to cover 73 percent of program costs. 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 1.11 percent of taxable payroll. Eliminating this deficit would require an immediate 38 percent increase in standard payroll taxes or a 22 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 down the productivity adjustments gradually over 15 years, beginning in 2020, from about 1.1 percent to 0.4 percent and assumes no savings from IPAB.

Under the illustrative alternative scenario, the HI trust fund also would be depleted in 2026, but the projected deficit over the next 75 years would be 2.17 percent of taxable payroll—compared to 1.11 percent under current-law projections. Eliminating this deficit would require an immediate 75 percent increase in standard 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 Medicare Part B program, which covers physician and outpatient hospital services, and the Medicare 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.

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 14 percent of total Part D costs in 2013. State payments on behalf of certain beneficiaries will cover approximately 12 percent of costs and general revenues will cover the remaining 74 percent of costs.

Premium increases similarly will place pressure on beneficiaries, especially when considered in conjunction with increasing beneficiary cost-sharing expenses. The average beneficiary expenses (premiums and cost sharing) for Parts B and D combined currently are 23 percent of the average Social Security benefit. These expenses will increase to 40 percent of the average Social Security benefit by 2085. These expenses do not include cost sharing under Part A.

The 2013 trustees' report projects that under current law, SMI spending will continue to grow faster than GDP, increasing from 2.0 percent of GDP in 2012 to 3.1 percent of GDP in 2030, and to 4.0 percent of GDP in 2085.

As acknowledged by the Trustees, 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 to 0.7 percent per year throughout the short range projection period (the average update for the last 10 years), thereafter phasing down to the growth in per capita national health expenditures. In addition, the alternative analysis phases down the productivity adjustments gradually over 15 years, beginning in 2020, from about 1.1 percent to 0.4 percent, and assumes no savings from IPAB. 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 2.0 percent of GDP in 2012 to 3.3 percent of GDP in 2030, and to 5.6 percent of GDP in 2085.

Table 1: SMI Expenditures as a Percent of GDP

Calendar Year	2013 Report (current law)	2013 Alternative Projection
2012	2.0	2.0
2020	2.2	2.3
2030	3.1	3.3
2040	3.4	3.9
2050	3.5	4.2
2060	3.7	4.7
2070	3.9	5.1
2080	3.9	5.5
2085	4.0	5.6

Sources: 2013 Medicare Trustees' Report, CMS Office of the Actuary

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 25 percent is estimated for next year.

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 examine 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 2012 to 6.5 percent of GDP in 2085. Under the CMS Office of the Actuary alternative scenario, however, total Medicare expenditures would increase to 9.6 percent of GDP in 2085.

Table 2: Total Medicare Expenditures as a Percent of GDP

Calendar Year	2013 Report (current law)	2013 Alternative Projection
2012	3.6	3.6
2020	3.9	4.0
2030	5.1	5.4
2040	5.8	6.5
2050	6.0	7.2
2060	6.1	7.9
2070	6.4	8.7
2080	6.5	9.3
2085	6.5	9.6

Sources: 2013 Medicare Trustees' Report, CMS Office of the Actuary

CONCLUSION

The Affordable Care Act (ACA), enacted in 2010, 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 solve the long-term financial challenges to Medicare.

The HI trust fund is projected to be depleted in 2026, 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.

In addition, Medicare's financial challenges are likely to be much more severe than projected in the trustees' report. The report's Medicare spending projections are considered understated to the extent that currently scheduled reductions in physician payments are expected to be overridden by Congress, as they have been every year since 2003, and the ACA's provisions for downward adjustments in provider payment updates to reflect productivity improvements are unsustainable

in the long term. If Medicare projections are calculated using assumptions that the physician payment reductions are overridden and the productivity adjustments are phased down, Medicare's financial condition is shown to be even worse than under current-law projections.

The American Academy of Actuaries' Medicare Steering Committee continues to have significant concerns about Medicare's financing problems, even under the current-law projections, and strongly recommends that policymakers implement changes to improve Medicare's financial outlook.

The committee concurs with the 2013 trustees when they say:

The Board of Trustees believes 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. Consideration of such 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. Congress and the executive branch must work closely together with a sense of urgency to address these challenges.

And committee wishes to underscore this call for action.



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United States House of Representatives
 Committee on Ways & Means, Subcommittee on Health
 Hearing on the 2013 Medicare Trustees Report
 June 20, 2013

Chairman Brady, Ranking Member McDermott, and distinguished members of the Subcommittee on Health, I am Joe Baker, President of the Medicare Rights Center. The Medicare Rights Center is a national, non-profit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives.

We know firsthand the economic and health challenges facing people with Medicare. We provide answers to 15,000 Medicare questions annually on our national helpline, serving older adults, people with disabilities, family caregivers and professionals. Through our educational initiatives, we touch the lives of another 65,000 beneficiaries and their families each year.

We appreciate the opportunity to submit a written statement on the 2013 Medicare Trustees Report. Each year, the trustees offer projections on the fiscal health of the Medicare program. The trustees' recent findings confirm what we already know to be true: Medicare is *not* in crisis.

The trustees conclude that the Medicare Hospital Insurance (HI) trust fund is solvent through 2026—two years later than reported last year—and the Supplemental Medical Insurance (SMI) trust fund remains on firm financial footing, ensuring full payment for outpatient care and certain prescription drug needs.¹ After 2026, the HI trust fund will be able to pay 87% of inpatient claims, gradually declining to 71% in 2047 and then rising to 73% in 2087.² Insolvency is not a concern for the SMI trust fund, and the trustees presume that Medicare will be able to cover outpatient costs for the foreseeable future.³

¹ The Board of Trustees, "2013 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Supplemental Medicare Insurance Trust Fund" (May 2013), available at: <http://downloads.cms.gov/files/TR2013.pdf>.

² P. Van de Water, "Medicare is Not Bankrupt, Health Reform Has Improved Program's Financing" (Center on Budget and Policy Priorities: June 2013), available at: <http://www.cbpp.org/cms/?fa=view&id=3532>.

³ The Board of Trustees, "2013 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Supplemental Medicare Insurance Trust Fund" (May 2013), available at: <http://downloads.cms.gov/files/TR2013.pdf>; P. Van de Water, "Medicare is Not Bankrupt, Health Reform Has Improved Program's Financing" (Center on Budget and Policy Priorities: June 2013), available at: <http://www.cbpp.org/cms/?fa=view&id=3532>.

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According to the U.S. Department of Health and Human Services, Medicare cost growth slowed dramatically in recent years to levels “unprecedented in the history of the Medicare program.”⁴ Additional analysis by the S&P Dow Jones Indices illustrates that “...health care costs have decelerated over the past few years, and Medicare costs have decelerated more than other health costs.”⁵ While some of this slowdown is attributable to the continued effects of the economic downturn, research shows that much of this change is structural.⁶

Debate continues as to whether or not the recent slowdown in health care cost growth will persist, underscoring the difficulty of adequately projecting future Medicare spending, particularly over the long-term.⁷ According to the trustees, due to unforeseeable advancements in medical technology and uncertainty surrounding the implementation of current law, “Projections of Medicare costs are highly uncertain, especially when looking out more than several decades.”⁸

Despite these facts, some members of Congress firmly assert that Medicare is going bankrupt. This false claim contributes to the misguided belief that Medicare benefits must be cut to sustain the program for future generations. Towards this end, some policy makers propose shifting added costs to people with Medicare, such as by further means-testing Medicare premiums, increasing deductibles, copayments or coinsurance, or scaling back supplemental Medigap insurance coverage.

Adopted separately or in combination, each of these proposals would achieve savings for the federal government while also worsening the already fragile economic and health status of many people with Medicare. Added health care costs impose financial hardship, particularly for those living on low- and moderate-incomes, and increased cost sharing leaves many beneficiaries with no choice but to self-ration care. Faced with higher upfront costs, beneficiaries living on fixed-incomes are likely to forgo doctors’ visits altogether—a decision made on the basis of affordability as opposed to need.⁹

Based in part on the findings of the 2013 Medicare Trustees Report, we believe that there is no justification for policy interventions that would shift added costs to people with Medicare. Most people with Medicare cannot afford to pay more. Half of all beneficiaries—25 million older adults and people

⁴ Office of the Assistant Secretary for Planning and Evaluation, “Growth In Medicare Spending Per Beneficiary Continues To Hit Historic Lows” (DHHS: January 2013), available at: <http://aspe.hhs.gov/health/reports/2013/medicarependinggrowth/ib.cfm>.

⁵ S&P Dow Jones Indices, “Press Release: Deceleration in Annual Growth Rate for All Nine Indices in June 2012, According to the S&P Healthcare Economic Indices” (January 2012); J. Weisenthal, “Peter Orszag’s Chart Of The Year Could Change Everything You Think About Healthcare And The Federal Budget” (*Business Insider*: December 2012), available at: <http://www.businessinsider.com/peter-orszag-chartshows-medicare-costs-slowng-2012-12>.

⁶ A. Ryu, T. Gibson, McKeller, M.R., and M.E. Cherner, “The Slowdown in Health Care Spending in 2009-11 Reflected Factors Other Than the Weak Economy and Thus May Persist” (*Health Affairs*: May 2013); D. Cutler and N.R. Sahni, “If Slow Rate of Health Care Spending Growth Persists, Projections May Be Off \$770 Billion” (*Health Affairs*: May 2013).

⁷ L. McGinley, “Are slower-growing health care costs temporary or permanent?” (*Washington Post*: June 2013), available at: <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/06/18/are-slower-growing-health-care-costs-temporary-or-permanent/>.

⁸ The Board of Trustees, “2013 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Supplemental Medicare Insurance Trust Fund” (May 2013), available at: <http://downloads.cms.gov/files/TR2013.pdf>.

⁹ For a more detailed analysis on the harms of added cost sharing, see: J. Baker, “Testimony Prepared for the United States House Committee on Ways & Means, Subcommittee on Health on ‘The President’s and Other Bipartisan Proposals to Reform Medicare’” (May 2013), available at: http://waysandmeans.house.gov/uploadedfiles/baker_testimony_final_hl_052113.pdf.

with disabilities—live on annual incomes of \$22,500 or less. And people with Medicare already spend a significant amount on health care. The average Medicare household spends 15% of their annual income on out-of-pocket health care costs—three times that of non-Medicare households.¹⁰

Rather than shifting added costs to people with Medicare, we urge members of Congress to advance value-driven delivery system and payment reforms designed to improve health care quality while simultaneously driving down the cost of health care. The Affordable Care Act (ACA) offers a blueprint for these reforms, and testing of many promising solutions is underway. Already a proven leader in cost-control, Medicare is the incubator for these innovations.

The 2013 Medicare Trustees Report confirms that cost-control mechanisms in the ACA, such as scheduled payment adjustments to Medicare private health plans and efforts to combat fraud and abuse, significantly improved the fiscal outlook for the Medicare program. In addition to testing and expanding promising delivery system reforms, these provisions must be implemented to the full extent.

More can be done to put the Medicare program on strong financial footing. Towards this end, we ask members of Congress to support prudent cost containment that neither harms nor shifts costs to people with Medicare. Examples of these solutions include reducing wasteful spending on Medicare pharmaceutical drugs and medical equipment and further equalizing payments to private Medicare health plans.¹¹

Short-sighted approaches that shift costs to people with Medicare will not only harm older adults and people with disabilities, but will also achieve only short-term savings. Instead, policymakers must focus on the long-term challenges facing our health care system overall. Transforming how we pay for health care services and eliminating wasteful spending is the right path forward.

Thank you for the opportunity to provide comment.

Sincerely,



Joe Baker
President

¹⁰ J. Cubanski, "An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Service Use" (Kaiser Family Foundation: February, 2013), available at: <http://kaiserfamilyfoundation.files.wordpress.com/2013/02/an-overview-of-the-medicare-program-and-medicarebeneficiaries-costs-and-service-use-testimony.pdf>.

¹¹ Medicare Rights Center, "Build on What Works: Medicare Cost Savers" (June 2013), available at: <http://www.medicarerights.org/pdf/Medicare-Cost-Savers.pdf>.

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Statement of

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and

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Senior Fellow

National Center for Policy Analysis

2013 Medicare Trustees Report

Ways and Means Committee
Health Subcommittee Subcommittee
United States House of Representatives

June 20, 2013

Chairman Brady and members of the Subcommittee, I am John Goodman, President and CEO of the National Center for Policy Analysis (NCPA). My co-author, Laurence Kotlikoff, is a senior fellow at the NCPA. We are a nonprofit, nonpartisan public policy research organization dedicated to developing and promoting private alternatives to government regulation and control, solving problems by relying on the strength of the competitive, entrepreneurial private sector. We welcome the opportunity to share our views about the recent 2013 Medicare Trustees Report.

Even before the public saw the latest report of the [Medicare trustees report](#), the White House had already crafted a carefully orchestrated story. Medicare's finances have improved, they told us. The trust fund will last longer. The unfunded liability is lower. One of the reasons is ObamaCare. The core of the new health reform law doesn't kick in until next year, but already it's improving things for seniors. The president's new budget carries much the same message. But is any of this really true?

Here is the rest of the story. The Trustees report is based on assumptions that even the Medicare actuaries are calling "[clearly unrealistic](#)." Ditto for the president's budget. Even with these unrealistic assumptions, the future looks bleak. The unfunded liability in Medicare, the Trustees tell us, is \$34 trillion over the next 75 years. Looking indefinitely into the future, the unfunded liability is \$43 trillion – almost three times the size of the economy. Based on more plausible assumptions, such as the ones reflected in the "[alternative](#)" scenario produced by the Congressional Budget Office, the long term shortfall is **over three times** that size.

To take one example of rosy optimism in the latest administration report, the Trustees assume that next January 1, there will be a 25% decrease in the fees Medicare pays doctors. Beginning next year, every doctor in America who participates in Medicare will take a 25% pay cut. The reason has nothing to do with ObamaCare. In the Balanced Budget Act of 1997 Congress declared that Medicare physician fees would grow no faster than the economy as a whole. But Congress has [on 14 occasions](#) postponed the cuts and not allowed them to take place.

A second problem actually does stem from ObamaCare. In order to pay for the expansion of health insurance for the young, the health reform law calls for steep cuts in spending on the elderly. Whereas Medicare spending per person in real terms has been growing at about the rate of growth of real GDP per person plus 2 percentage points, the ObamaCare law calls for a growth rate of GDP plus 0.04 percent. Over the next ten years that slower growth rate produces about \$716 billion in savings. But it doesn't stop there. The health reform law mandates slower growth forever!

How is this possible? There are a number of demonstration projects that were supposed to find more efficient ways of delivering care. But [three separate CBO reports](#) have found that these programs are not working. As a result, Medicare will have to resort to a fall back mechanism: more cuts in provider fees.

Were these cuts actually to be implemented, the problem of Medicare would be basically solved. If Medicare grows no faster than the economy as a whole, we can keep on doing what we have been doing without the need for any fundamental change. Yet two graphs produced by the Medicare actuaries report show how draconian the suppression of provider fees will be. Medicare fees fall below Medicaid next year and then fall further and further behind Medicaid and the private sector as the years pass by.

From a financial point of view, senior patients will become less desirable than welfare mothers. On the hospital side, the actuaries office is predicting that one in seven hospitals will completely leave the Medicare system because of these pay cuts.

This is not a newly discovered problem. At the time the Affordable Care Act was passed, Medicare's Chief Actuary, Rick Foster, said the cuts envisioned would damage access to care. Harvard health economist Joe Newhouse predicted that seniors may have to seek health care at the same places frequented by Medicaid patients today – at community health centers and the emergency rooms of safety net hospitals.

Of course if Congress caves to political pressure and restores the cuts in provider fees (as it has done consistently for the past 16 years) the unfunded liability in Medicare will be much greater -- on the order of twice what the Trustees are now showing. Meanwhile, it's not as though other areas of government can't be easily cut to accommodate health care. We've made promises we can't keep in Social Security, disability insurance and elsewhere.

All told, the fiscal gap separating the present value of all future projected federal expenditures – Social Security, Medicare, Medicaid, Obamacare, defense, gassing up Air Force 1, servicing existing debt, you name it – and all future federal taxes and other receipts is a staggering \$222 trillion.

Anyone in Washington who thinks there is no need to rush into a grand bargain on the budget any time soon should think about that number. Then think again. And again and again....

We appreciate the opportunity to submit our views on this important question and we offer any assistance we might give to help solve this significant public policy problem.





United States House of Representatives
Committee on Ways and Means, Subcommittee on Health
Hearing on the 2013 Medicare Trustees Report
Thursday, June 20, 2013

Mr. Chairman and Members of the Subcommittee:

I am Max Richtman, President and Chief Executive Officer of the National Committee to Preserve Social Security and Medicare (NCPSSM), a grassroots advocacy and education organization devoted to preserving and promoting Social Security, Medicare, and Medicaid – programs that are the foundation of financial and health security for older Americans. On behalf of the National Committee’s millions of members and supporters across America, I appreciate this opportunity to submit our analysis of the 2013 Medicare Trustees Report.

The 2013 Medicare Trustees Report shows that enactment of the *Affordable Care Act* has improved Medicare’s financial situation and extended the solvency of the Part A trust fund by two additional years. Provisions in the health care reform law are reducing spending while improving the quality of care for Medicare beneficiaries. This is being accomplished through new coordinated care models and incentives that reduced the rate of hospital readmissions in 2012. At the same time, millions of Medicare beneficiaries are receiving preventive screenings and wellness visits without copayments and increased help with their prescription drug costs.

The Trustees Report also points out the need to further reform our health care system so that Medicare’s long-term costs, which will grow due to the retirement of the baby boom generation and the increase in overall health spending, are affordable for both the federal government and beneficiaries.

In addition, Medicare cost projections do not take into account the likelihood that Congress will act, as it has many times in the past, to prevent a nearly 25 percent reduction in physician fees on January 1, 2014 as required by the sustainable growth rate (SGR) enacted by the Balanced Budget Act of 1997. Moreover, some question whether the reductions in reimbursements to providers mandated by the *Affordable Care Act* will be sustained if the control of their growth causes access problems for beneficiaries.

Background

Each year the Medicare Trustees release a report on the current status and projected condition of the funds over the next 75 years. The Trustees report on both of Medicare’s Trust Funds - the Hospital Insurance (HI) Trust Fund and the Supplementary Medical Insurance (SMI) Trust Fund. The HI Trust Fund finances Part A which covers inpatient hospital and related care. The SMI Trust Fund finances Part B physician and outpatient care, as well as Part D which pays for prescription drugs.

Medicare Part A (HI Trust Fund) is primarily financed by payroll taxes on earnings that are paid by employees, employers and the self-employed. Employees and employers each pay 1.45 percent in taxes on all earnings. The self-employed contribute 2.9 percent, the equivalent of the combined employer and employee tax rates.

Medicare Parts B and D (SMI Trust Fund) are financed by payments from federal general fund revenues (about 75 percent) and by monthly premiums charged to beneficiaries (about 25 percent). Because Medicare Part B and Part D are automatically financed through general revenues and beneficiary premiums to meet estimated program costs each year, the SMI Trust Fund is adequately financed in both the short and long term.

Financial Outlook of the Medicare Program

The Medicare Part A (HI) Trust Fund will be solvent until 2026, which is two years longer than was projected last year. In 2026, payroll taxes alone are estimated to be sufficient to cover 87 percent of HI costs.

Solvency has improved by nine years from the date that was projected before enactment of the *Affordable Care Act*. This legislation improved Medicare's financing by reducing the rate of increase in provider payments, phasing out overpayments to Medicare Advantage plans, and increasing Medicare payroll taxes for high-income individuals and couples.

Medicare's actuarial shortfall decreased from last year. The HI Trust Fund now has a projected 75-year actuarial deficit equal to 1.11 percent of payroll compared with last year's estimate of 1.35 percent. This is much less than the 3.88 percent of payroll that the trustees estimated before the *Affordable Care Act* became law. In other words, the HI Trust Fund's fiscal imbalance could be solved by increasing payroll taxes by 1.11 percent, by reducing the program's spending by a corresponding amount, or by some combination of the two.

Medicare spending decreased slightly as a share of the economy. The Trustees project that Medicare's costs (for both the HI and SMI Trust Funds), which were 3.6 percent of gross domestic product (GDP) in 2012, down from 3.7 percent in 2011, will grow substantially to 5.6 percent of GDP in 2035, down from last year's estimate of 5.7 percent. This increase is because the number of people receiving benefits will grow as the baby boom generation retires. Thereafter, Medicare's costs are projected to grow more slowly, to 6.7 percent of GDP in 2087. Again, these increases are lower than what was projected before enactment of health care reform when Medicare's costs were projected to grow from 3.5 percent of GDP in 2009 to 11.3 percent of GDP in 2083.

Costs for Part B (SMI Trust Fund) are growing due to the aging population and rising health care costs. Part B spending, which was 2.0 percent of GDP in 2011, is projected to increase to 3.4 percent within 25 years and to 4.0 percent in 2087. Although costs are projected to rise, the increases are lower than those projected before enactment of the *Affordable Care Act* – i.e. that costs would rise to 4.5 percent of GDP in 75 years.

Medicare Part B Premium and Deductible

The standard Part B monthly premium for 2014 is projected to remain the same as the current \$104.90 premium because of a slowdown in the growth of Medicare spending due to reforms in the *Affordable Care Act*. Part B enrollees with incomes exceeding \$85,000 for an individual and \$170,000 for a couple must pay higher income-related monthly premiums, which are estimated to range from \$146.90 to \$335.70 in 2014 (the same as the 2013 amounts). The annual deductible is projected to remain at \$147.00.

Medicare Part D

Medicare Part D spending estimates are lower than projected last year. The projections are a result of lower-than-anticipated drug spending in 2012 due to patent expirations for some high costs drugs and greater use of lower-cost generic drugs.

Part D expenditures as a percent of GDP are expected to increase from 0.45 percent in 2012 to 0.92 percent in 2035 and to 1.42 percent in 2085. The average Part D monthly premium is \$31.17 in 2013, and is estimated to be \$33.93 in 2014. In 2013, Part D enrollees with incomes exceeding the threshold of \$85,000 for an individual and \$170,000 for a couple are paying an income-related monthly adjustment amount in addition to their normal plan premium, ranging from \$11.60 to \$66.60 per month. The Part D annual deductible, which is \$325 in 2013, will decrease to \$310 in 2014.

NATIONAL COMMITTEE POSITION

Medicare spending per beneficiary is projected to continue growing more slowly than private sector spending. However, Medicare faces a long-term financial challenge due to the large increase in the number of beneficiaries, as baby boomers reach age 65, and overall health care inflation.

It is critical that we successfully implement reforms in the *Affordable Care Act* that are containing costs and promoting access to quality health care. This includes supporting coordinated care through Accountable Care Organizations, bundled payments, and reducing hospital readmissions and hospital-acquired infections, as well as efforts to further reduce spending due to waste, fraud and abuse. These provisions, along with requirements in the law to slow the rate of increase in provider payments and reduce overpayments to Medicare Advantage plans, are necessary to prevent Medicare costs from becoming unsustainable for both beneficiaries and the federal government.

The National Committee supports strengthening Medicare's financing without shifting costs to beneficiaries by requiring Part D drug rebates for dual eligible Medicare beneficiaries and allowing the federal government to negotiate prescription drug prices. The Congressional Budget Office (CBO) has estimated savings of \$141 billion over 10 years if drug manufacturers were required to provide rebates for drugs used by low-income Medicare beneficiaries, as they were required to do before passage of the Medicare Modernization Act.

