

# MEDICARE SOLVENCY

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HEARING  
BEFORE THE  
COMMITTEE ON WAYS AND MEANS  
HOUSE OF REPRESENTATIVES  
ONE HUNDRED SEVENTH CONGRESS  
FIRST SESSION

MARCH 20, 2001

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## CONTENTS

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Advisory of March 13, 2001, announcing the hearing .....	Page 2
WITNESSES	
Health Care Financing Administration, Richard S. Foster, Chief Actuary, Office of the Actuary .....	4
Congressional Budget Office, Dan L. Crippen, Director .....	14
SUBMISSION FOR THE RECORD	
Advanced Medical Technology Association, statement .....	42



## HEARING ON MEDICARE SOLVENCY

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TUESDAY, MARCH 20, 2001

HOUSE OF REPRESENTATIVES,  
COMMITTEE ON WAYS AND MEANS,  
*Washington, DC.*

The Committee met, pursuant to notice, at 12:30 p.m., in room 1100 Longworth House Office Building, Hon. William M. Thomas [Chairman of the Committee] presiding.

[The advisory announcing the hearing follows:]

# ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE,  
March 13, 2001  
FC-5

CONTACT: (202) 225-1721

## Thomas Announces Hearing on Medicare Solvency

Congressman Bill Thomas (R-CA), Chairman of the Committee on Ways and Means, today announced that the Committee will hold a hearing on Medicare solvency. **The hearing will take place on Tuesday, March 20, 2001, in the main Committee hearing room, 1100 Longworth House Office Building, directly following the joint Committee on Ways and Means and Senate Committee on Finance hearing on solvency.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. The sole witness at this hearing will be Rick Foster, Chief Actuary, Office of the Actuary, Health Care Financing Administration. 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:

Although growth in Medicare expenditures has been flat the last several years, costs are expected to rise substantially in the near- and long-term. For example, the Congressional Budget Office estimates that Medicare expenditures will rise by 10.5 percent in fiscal year 2001 and more than double over the next 10 years, from \$219 billion in 2000 to \$497 billion in 2011. At that time, 77 million baby boomers begin to retire and the ratio of workers per beneficiary will decline from about 4:1 today to 2:1 in 2030. The Medicare Trustees will release their updated 30-year projections of Medicare expenditures and revenues, on Monday, March 19, 2001.

In announcing the hearing, Chairman Thomas stated: "Members of Congress must have a thorough understanding of the fiscal challenges that confront the Medicare program before we embark on any policies to modernize the program. The Chief Actuary will provide insight and analysis regarding the factors driving the Trustees' projections."

### FOCUS OF THE HEARING:

The House Committee on Ways and Means and the Senate Committee on Finance will hold a joint hearing on the Medicare and Social Security Trustees' report earlier in the day. The purpose of this hearing is to explore in more depth the fiscal challenges confronting the Medicare program and current measures of Medicare solvency.

### DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should *submit six (6) single-spaced copies of their statement, along with an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, with their name, address, and hearing date noted on a label*, by the close of business, Tuesday, April 3, 2001, to Allison Giles, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may de-

liver 200 additional copies for this purpose to the Committee office, room 1102 Longworth House Office Building, by close of business the day before the hearing.

**FORMATTING REQUIREMENTS:**

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be submitted on an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, typed in single space and may not exceed a total of 10 pages including attachments. **Witnesses are advised that the Committee will rely 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. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers where the witness or the designated representative may be reached. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press, and the public during the course of a public hearing may be submitted in other forms.

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

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Chairman THOMAS. The Committee will come to order. The Chair was interested in having a Ways and Means hearing following the joint hearing with the Senate Finance Committee on the Medicare and Social Security reports for principally one reason. There may be other reasons that members wish to focus on. But when there is a change in the estimating procedure, especially when it is a change which increases the concerns about the solvency of the program, the Chair believes that it is useful to spend a few minutes talking about the background, the history of, the intention of the decision to make the change. There is so much in this process which is not political or partisan that we do not focus on that the Chair thought that if we would bring the Medicare Actuary before us, Mr. Foster, who has been very helpful to us in the past, and I do want to personally say, Mr. Foster, thank you for the contributions you made to the bipartisan Commission on the Reform of Medicare at the time we were grappling with what does the future look like and how do you predict it, to shed light on why we changed the way we estimate the cost of Medicare.

With us also is Mr. Crippen of the Congressional Budget Office (CBO) because they had adopted the methodology prior to that. I would say that without objection we would move directly to any

comments they might have and then throw it open to questions by members, hopefully focusing on the rationale for, the reason for and the consequences of the change of the estimating procedure for the Medicare Trust Fund. And first I would recognize the Chief Actuary of the Medicare Trust Fund, Mr. Foster.

**STATEMENT OF RICHARD S. FOSTER, CHIEF ACTUARY, OFFICE OF THE ACTUARY, HEALTH CARE FINANCING ADMINISTRATION**

Mr. FOSTER. Thank you, Chairman Thomas. Chairman Thomas, distinguished members of the Committee, thank you for inviting me here today to testify about the financial outlook of the Medicare program. I welcome the opportunity to assist you in your efforts to ensure the future financial viability of the Nation's second largest social insurance program. I will briefly mention the most important findings of the 2001 trustees reports that were introduced yesterday. My written testimony as well as the reports themselves contain substantial additional detail.

I would like to note I am not much of a historian, but I do know the history of Medicare a little bit. I think legislative historians recognize that Medicare was enacted as a combination of competing proposals that were artfully assembled by your predecessor, Mr. Thomas, Wilbur Mills, in order to consolidate political support. As a result, there are substantial differences between hospital insurance, or Part A of Medicare, and supplementary medical insurance, or Part B of Medicare. These involve differences in coverage, eligibility requirements, benefit structures, and in particular the financing provisions.

Hospital insurance is financed primarily by payroll taxes, and the tax rate is fixed in the law. It cannot change without further legislation. In contrast, supplementary medical insurance, or Part B, is financed about 25 percent by beneficiary premiums and the balance, 75 percent, by general revenues. These financing amounts for Part B are adjusted annually to match the following year's expected cost.

I would argue that because by law these two trust funds are distinct financial entities, each with its own specified financing and benefits, that it is necessary to do a separate analysis of the financial status of each Part because they are so different. Accordingly, in the Trustees reports and in evaluating the financial status of Medicare, we look separately at the two trust funds. That is consistent with actuarial standards of practice and also the statutory requirements. That is a different issue of course, (and we may get into this in the discussion) than focusing on Medicare overall in terms of its financial requirements on society and on the economy.

We heard a lot this morning about the mixed financial picture presented by the new Medicare Trustees reports. We have seen a moderate improvement in the short range financial outlook for the Part A trust fund over the next 25 to 30 years, and that is welcome. On the other hand, based on more realistic assumptions adopted for use in this year's Trustees reports, the long-range expenditure growth for Medicare, both Part A and Part B, is substantially greater than previously assumed. This revision in assumptions was recommended by an independent expert panel of actu-



aries and economists that was convened by the prior Board of Trustees in 2000 to review these assumptions.

I concurred with these recommendations, as did the Board of Trustees, and I would note that in both the Part A and Part B Trustees reports, as in prior Trustees reports, the Board of Trustees urges prompt attention to the remaining financial issues facing Medicare.

I would conclude these introductory comments by again thanking you for the opportunity to testify and I pledge the Office of the Actuary's continuing assistance with the efforts by the Congress and by the administration to determine effective solutions to the remaining financial problems facing Medicare. I would be happy to answer any questions that you have.

[The prepared statement of Mr. Foster follows:]

**Statement of Richard S. Foster, Chief Actuary, Office of the Actuary,  
Health Care Financing Administration**

Chairman Thomas, Congressman Rangel, distinguished Committee members, thank you for inviting me to testify today about the financial outlook for the Medicare program as shown in the recently released 2001 annual reports of the Medicare Board of Trustees. I welcome the opportunity to assist you in your efforts to ensure the future financial viability of the nation's second largest social insurance program—one that is a critical factor in the income security of the our aged and disabled populations.

The financial outlook for the Medicare program presents a mixed picture. Over the next 10 years, the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds are adequately financed and meet the Trustees' formal tests for short-range financial adequacy. The depletion of the HI trust fund, which had been projected for 2025 in last year's Trustees Report, has been postponed to 2029 in the new estimates.

Over the long range, in contrast, HI and SMI expenditures are projected to grow more rapidly than in previous reports as a result of revised long-range Medicare cost growth assumptions. The assumption change was recommended by the 2000 Medicare Technical Review Panel, an independent, expert group of actuaries and economists convened by the Board of Trustees to review the Medicare financial projections. HI tax revenues are projected after 2015 to fall increasingly short of program expenditures, eventually covering only one-third of estimated costs by the end of the Trustees' 75-year projection period. For SMI, continuing rapid expenditure growth would place growing financial burdens both on beneficiaries and on the Federal budget. The SMI trust fund would remain in financial balance indefinitely, however, due to the annual redetermination of program financing.

*Background*

Roughly 39 million people were eligible for Medicare benefits in 2000. HI, or "Part A" of Medicare, provides partial protection against the costs of inpatient hospital services, skilled nursing care, post-institutional home health care, and hospice care. SMI covers most physician services, outpatient hospital care, home health care not covered by HI, and a variety of other medical services such as diagnostic tests, durable medical equipment, and so forth.

Only about 22 percent of HI enrollees received some reimbursable covered services during 2000, since hospital stays and related care tend to be infrequent events even for the aged and disabled. In contrast, the vast majority of enrollees incur reimbursable SMI costs because the covered services are more routine and the annual deductible for SMI is only \$100.

The two parts of Medicare are financed on totally different bases. HI costs are met primarily through a portion of the FICA and SECA payroll taxes.<sup>1</sup> Of the total FICA tax rate of 7.65 percent of covered earnings, payable by employees and employers, each, HI receives 1.45 percent. Self-employed workers pay the combined total of 2.90 percent. Following the Omnibus Budget Reconciliation Act of 1993, HI taxes are paid on total earnings in covered employment, without limit. Other HI in-

<sup>1</sup>Federal Insurance Contributions Act and Self-Employment Contributions Act, respectively.

come includes a portion of the income taxes levied on Social Security benefits, interest income on invested assets, and other minor sources.

SMI enrollees pay monthly premiums (\$50.00 in 2001) that cover about 25 percent of program costs. The balance is paid by general revenue of the Federal government and a small amount of interest income.

The HI tax rate is specified in the Social Security Act and is not scheduled to change at any time in the future under present law. Thus, program financing cannot be modified to match variations in program costs except through new legislation. In contrast, SMI premiums and general revenue payments are reestablished each year to match estimated program costs for the following year. As a result, SMI income automatically matches expenditures without the need for legislative adjustments.

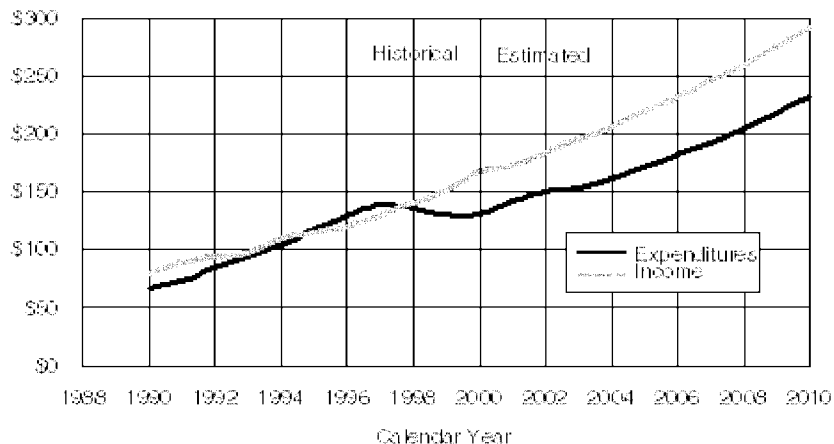
Each part of Medicare has its own trust fund, with financial oversight provided by the Board of Trustees. My discussion of Medicare's financial status is based on the actuarial projections contained in the Board's 2001 reports to Congress. Such projections are made under three alternative sets of economic and demographic assumptions, to illustrate the uncertainty and possible range of variation of future costs, and cover both a "short range" period (the next 10 years) and a "long range" (the next 75 years). The projections are not intended as firm predictions of future costs, since this is clearly impossible; rather, they illustrate how the Medicare program would operate under a range of conditions that can reasonably be expected to occur. The projections shown in this testimony are based on the Trustees' "intermediate" set of assumptions.

#### *Short-range financial outlook for Hospital Insurance*

Chart 1 shows HI expenditures versus income over the last 10 years and projections through 2010. For most of the program's history, income and expenditures have been very close together, illustrating the pay-as-you-go nature of HI financing. The taxes collected each year are intended to be roughly sufficient to cover that year's costs. Surplus revenues are invested in special Treasury securities.

**Chart 1—HI expenditures and income**

(In billions)



During 1990–97, HI costs increased at a faster rate than HI income. Expenditures exceeded income by a total of \$17.2 billion in 1995–97. Prior to the Balanced Budget Act of 1997, this trend was expected to continue, with costs growing at about 8 percent annually, against revenue growth of only 5 to 6 percent. The 1995–97 shortfalls were met by redeeming trust fund assets, but in the absence of corrective legislation assets would have been depleted in about 2001. The Medicare provisions in the Balanced Budget Act were designed to help address this situation. As indicated in chart 1, these changes—together with subsequent low general and medical inflation and increased efforts to address fraud and abuse in the Medicare program—resulted in

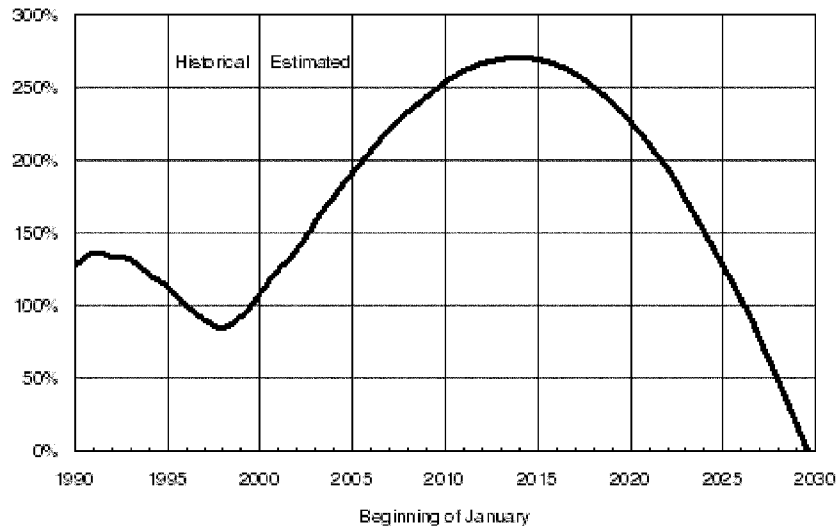
a decline in HI expenditures during 1998–2000 and trust fund surpluses totaling \$61.8 billion over this period.

The Board of Trustees has recommended maintaining HI assets equal to at least one year's expenditures as a contingency reserve. As indicated in chart 2, HI assets at the beginning of 2001 represented about 125 percent of estimated expenditures for the year. The HI trust fund is estimated to continue to experience significant surpluses for about the next 15 years. After 2020, however, expenditures are projected to again exceed income. As shown in chart 2, assets would initially accumulate rapidly but then be drawn down to cover the resulting shortfalls. The trust fund would be exhausted in 2029 under the Trustees' intermediate assumptions.

The depletion date estimated in the 2001 Trustees Report represents a significant improvement compared to the estimate in last year's report (2025). The improvement arises from higher payroll tax revenues and income taxes on Social Security benefits in 2000 than had been estimated, together with assumed faster economic growth over the next 10 years. In addition, benefit expenditures in 2000 were lower than estimated, and adjustments have been made to projected expenditure growth for the future based on this experience. The higher payroll taxes in 2000 resulted from robust economic growth, particularly the rapid growth in productivity and wages. Lower-than-expected HI expenditures reflected a reduction in the utilization of skilled nursing facility services, low increases in health care costs generally, and continuing efforts to combat fraud and abuse in the Medicare program.

**Chart 2—HI trust fund assets**

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



#### *2000 Medicare Technical Review Panel*

The projections in the new Trustees Reports also reflect a number of recommendations made by the 2000 Medicare Technical Review Panel. The impact of these recommendations on the HI projections for the first 25 years were largely offsetting and had a minimal impact on the estimated year of asset depletion.

The Technical Panel was convened by the Board of Trustees in 2000 to review the financial projections in the Medicare Trustees Reports. It was made up of seven independent health actuaries and health economists, who were nominated by the prior public members of the Board of Trustees. The panel met from June through November 2000 and issued its final recommendations in December 2000.

The panel unanimously found that the projection work of the Office of the Actuary at the Health Care Financing Administration was of excellent quality and was performed in a highly competent and completely professional manner. Overall, the members concluded that the methods and assumptions used to project the status of the Medicare program were reasonable, with the exception of the long-range ex-

penditure growth assumption, which they believed to be too low. In addition to their recommendation to increase this growth rate assumption, the panel issued 37 other findings and recommendations.

For the 2001 Trustees Reports, the Medicare Board of Trustees adopted all of the panel's recommendations that could realistically be incorporated within the short time available following the panel's report. These included the recommended long-range growth assumptions, corresponding adjustments to short-range "case-mix" growth assumptions, an improvement in certain assumptions relating to the costs for beneficiaries who switch from fee-for-service coverage to Medicare+Choice plans, and several recommendations regarding the content of the Trustees Reports. The Board will consider the panel's remaining recommendations for possible inclusion in future reports, as time and available health research knowledge permit.

In past Trustees Reports, increases in the average HI cost per unit of service were assumed to gradually decline after the first 15 years and to equal growth in average hourly earnings during the final 50 years of the projection. The last expert review panel, in 1991, concluded that the assumption was "not unreasonable" but recommended that it be monitored carefully in subsequent years. The 2000 Technical Panel recommended that average HI and SMI expenditures per beneficiary be assumed to increase at the rate of per capita GDP plus one percentage point. They based this recommendation primarily on the historical impact of advances in medical technology on health care cost increases, which they expected to continue indefinitely. They also considered other factors contributing to health care cost growth, the assumptions of other forecasters, and the "sustainability" of such cost increases in the very long range. Although they acknowledged the remaining (and considerable) uncertainty regarding health expenditure growth rates over very extended periods, the panel concluded that there is substantially greater evidence in favor of the faster growth assumption than there is in support of the prior HI and SMI Trustees Report assumptions. I concur with their conclusion, as does the Board of Trustees.

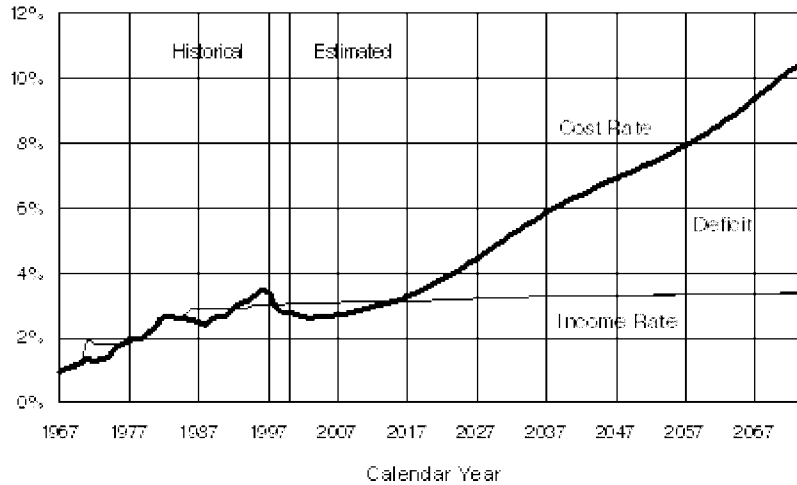
#### *Long-range financial outlook for Hospital Insurance*

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

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

**Chart 3—Long-range HI income and costs under intermediate assumptions**

(as a percentage of taxable payroll)

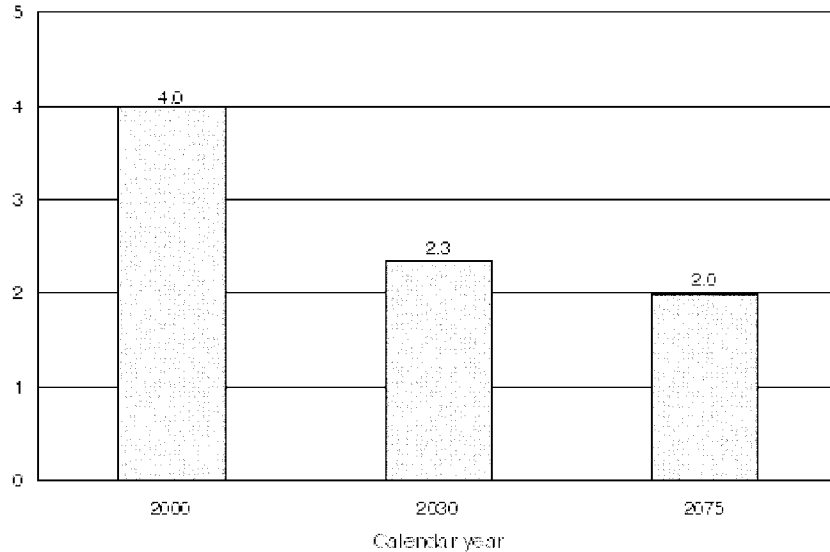


Past HI cost rates have generally increased over time but have periodically declined abruptly as the result of legislation to expand HI coverage to additional categories of workers, raise (or eliminate) the maximum taxable wage base, introduce new payment systems such as the inpatient prospective payment system, etc. Cost rates decreased significantly in 1998–2000 as a result of the Balanced Budget Act provisions together with strong economic growth. After 2002, however, cost rates are projected to increase steadily and accelerate significantly with the retirement of the baby boom, beginning in about 2010. As a result of the revised long-range expenditure growth assumption, projected cost rates after 2030 are substantially greater than the corresponding estimates in last year's Trustees Report. In particular, by the end of the 75-year period, scheduled tax income would cover only one-third of projected expenditures.

The average value of the financing shortfall over the next 75 years—known as the actuarial deficit—is 1.97 percent of taxable payroll. This deficit could be closed by an immediate increase of 1 percentage point in the HI payroll tax rate, payable by employees and employers, each. (The projected deficit could also be eliminated by many other revenue increases and/or expenditure reductions.) Note, however, that such a change would only correct the deficit “on average.” Initially, HI revenue would be significantly in excess of expenditures, but by the end of the period, only about one-fourth of the projected deficit would be eliminated.

The effect of the baby boom's retirement on Social Security and Medicare is relatively well known, having been discussed at length for more than 25 years. Basically, by the time the baby boom cohorts have retired, there will be nearly twice as many HI beneficiaries as there are today. When the HI program began, there were 4.5 workers in covered employment for every HI beneficiary. As shown in chart 5, this ratio is currently 4.0 workers per beneficiary. With the advent of the baby boom's retirement, the number of beneficiaries will increase more rapidly than the labor force, resulting in a decline in this ratio to 2.3 in 2030 and 2.0 in 2075 under the intermediate projections. Other things being equal, there would be a corresponding increase in HI costs as a percentage of taxable payroll.

Chart 4—Workers per HI beneficiary



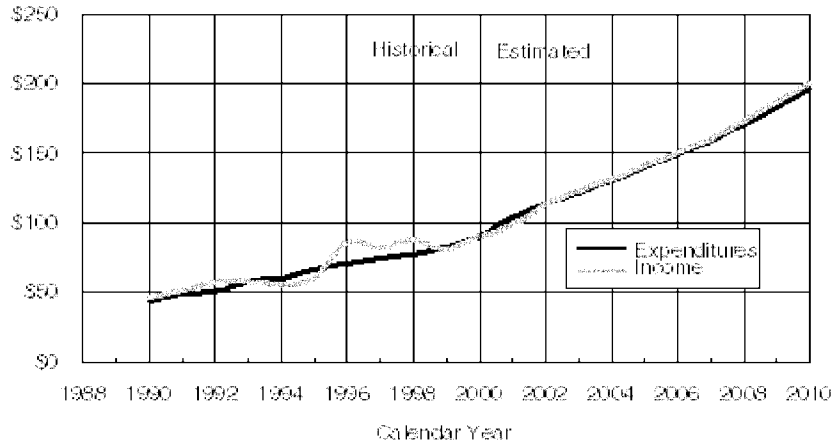
There are other demographic effects beyond those attributable to the varying number of births in past years. In particular, life expectancy has improved substantially in the U.S. over time and is projected to continue doing so. The average remaining life expectancy for 65-year-olds increased from 12.4 years in 1935 to 17.4 years currently, with an estimated further increase to about 21 years at the end of the long-range projection period. Medicare costs are also sensitive to the age distribution of beneficiaries. Older persons incur substantially larger costs for medical care, on average, than younger persons. Thus, as the beneficiary population ages over time they will move into higher-utilization age groups, thereby adding to the financial pressures on the Medicare program.

*Financial outlook for Supplementary Medical Insurance*

Chart 5 presents estimates of the short-range outlook for SMI and is generally similar to the information presented in chart 1 for the HI program. Two key differences stand out: First, the income and expenditure curves for SMI are nearly indistinguishable in the future. As noted previously, SMI premiums and general revenue income are reestablished annually to match expected program costs for the following year. Thus, the program will automatically be in financial balance, regardless of future program cost trends. The second difference is—in contrast to the decline in HI expenditures during 1998–2000—SMI expenditures increased at an average rate of 6.9 percent over this period.

Chart 5—SMI expenditures and income

(In billions)

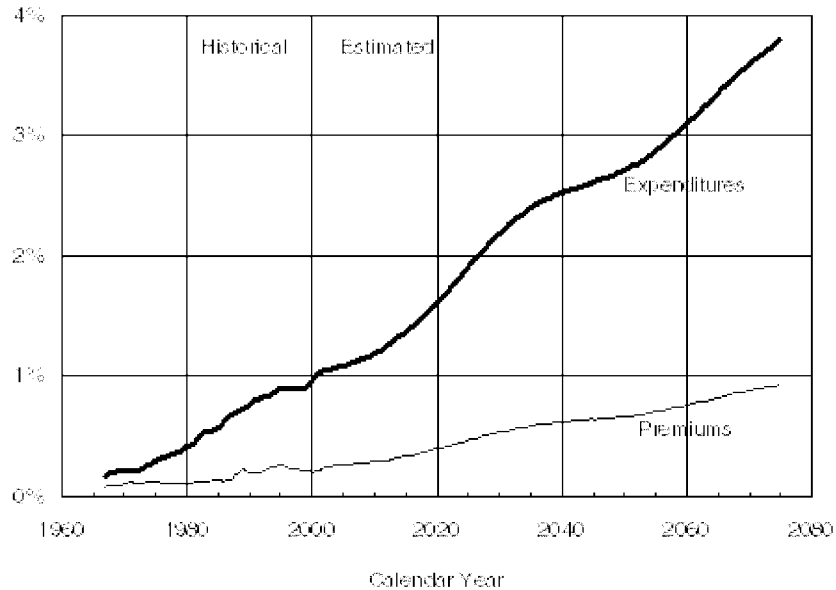


Although the Balanced Budget Act contained a number of provisions designed to reduce the rate of growth in SMI expenditures, their impact was more than offset by other factors. First, the Act specified that home health services not associated with a prior stay in an institution were to be converted to Part B benefits and paid for by the SMI trust fund (phased in over several years). In addition, the Act provides for several significant new preventive or “screening” benefits, such as colorectal examinations, not previously covered by Medicare, and it gradually corrects an excessive level of beneficiary coinsurance for outpatient hospital services. As a result, SMI costs are estimated to increase somewhat as a result of the Balanced Budget Act. Further cost increases have resulted under the Balanced Budget Refinement Act of 1999 and the Benefit Improvement and Protection Act of 2000.

Chart 6 shows projected long-range SMI expenditures and premium income as a percentage of GDP. Under present law, beneficiary premiums will continue to cover approximately 25 percent of total SMI costs, with the balance drawn from general revenues. Expenditures are projected to increase at a significantly faster rate than GDP, for largely the same reasons underlying HI cost growth. After about 2030, the SMI costs projected in the 2001 Trustees Report are substantially higher than those in the 2000 report, again primarily as a result of the revised long-range growth rate assumption recommended by the Medicare Technical Review Panel.

Although SMI is automatically in financial balance, the program’s continuing rapid growth in expenditures places an increasing burden on beneficiaries and the Federal budget. In 2000, for example, about 6 percent of a typical 65-year-old’s Social Security benefit was withheld to pay the monthly SMI premium of \$45.50, and another 8 percent was required to cover average deductible and coinsurance expenditures for the year. Twenty years later, under the intermediate assumptions, the same beneficiary’s premium and copayment costs would average 21 percent of his or her benefit.<sup>2</sup> Similarly, SMI general revenues in fiscal year 2000 were equivalent to 5.4 percent of the personal and corporate Federal income taxes collected in that year. If such taxes remain at their current level, relative to the national economy, then SMI general revenue financing in 2075 would represent 22 percent of total income taxes.

<sup>2</sup>The growth in average copayment costs over this period is reduced significantly by (i) the fixed \$100 deductible applicable to SMI services, and (ii) the gradual correction of an excessive level of beneficiary coinsurance on outpatient hospital services, as provided for in the Balanced Budget Act of 1997 and subsequent legislation.

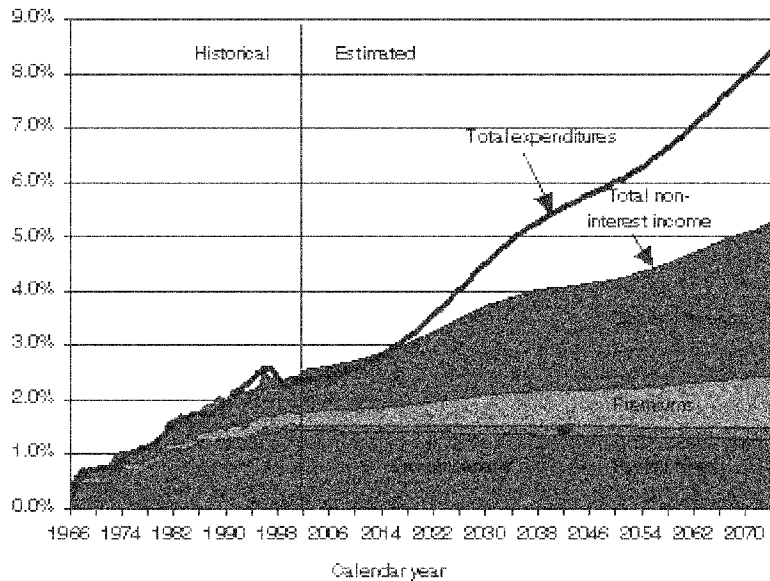
**Chart 6—SMI expenditures and premiums as a percentage of GDP***Combined HI and SMI expenditures*

The financial status of the Medicare program is appropriately evaluated for each trust fund separately, as summarized in the preceding sections. By law, each fund is a distinct financial entity, and the nature and sources of financing are very different between the two funds. This distinction, however, frequently causes greater attention to the HI trust fund—its projected year of asset depletion in particular—and less attention to SMI, which does not face the prospect of depletion. It is important to consider the total cost of the Medicare program and its overall sources of financing, as shown in chart 7. Interest income is excluded since, under present law, it would not be a significant part of program financing in the long range.

Combined HI and SMI expenditures are projected to increase from 2.2 percent of GDP to about 8.5 percent in 2075, based on the Trustees' intermediate set of assumptions. In past years, total income from HI payroll taxes, income taxes on Social Security benefits, HI and SMI beneficiary premiums, and SMI general revenues was very close to total expenditures. Over the next 15 years, such Medicare revenues are estimated to slightly exceed program expenditures, reflecting the expected excess of HI tax income over expenditures. Thereafter, however, overall expenditures are expected to exceed aggregate revenues. Again, the growing difference arises from the projected imbalance between HI tax income and expenditures—throughout this period, SMI revenues would continue to approximately match SMI expenditures.



**Chart 7—Medicare expenditures and sources of income as a percentage of GDP**



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

#### *Conclusions*

In their 2001 reports to Congress, the Board of Trustees notes the significant improvement in the financial outlook for Medicare that has come about as a result of legislation, strong economic growth, relatively slow growth in health costs generally, and efforts to combat fraud and abuse. But they emphasize the continuing financial pressures facing Medicare and urge the nation's policy makers to take further steps to address these concerns. They also argue that consideration of further reforms should occur in the relatively near future. Today's relatively favorable conditions could change, accelerating the expected return to deficits in the HI trust fund. Moreover, the earlier solutions are enacted, the more flexible and gradual they can be. Finally, the Trustees note that early action increases the time available for affected individuals and organizations—including health care providers, beneficiaries, and taxpayers—to adjust their expectations.

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

Chairman THOMAS. Thank you very much. Mr. Crippen.

**STATEMENT OF DAN L. CRIPPEN, DIRECTOR,  
CONGRESSIONAL BUDGET OFFICE**

Mr. CRIPPEN. Mr. Chairman. We have—

Chairman THOMAS. Turn the microphone on and it is unidirectional.

Mr. CRIPPEN. Mr. Chairman, we have effectively, although not through any conspiracy, split our duties today. Rick has talked to you about the trust funds, about changes. As you know, the trustees assumptions on cost growth are roughly the same as ours now. We went up a little earlier, not because we were any better but frankly because we had more current information at the time than the actuaries had for their last report. So we were able to make this change last July in contrast to the actuaries who were not able to make it in time, did not have the data in time for the earlier reports.

We are now pretty much in accord, certainly on the long-run cost assumptions. So instead of dwelling on that aspect, at least until you get to your questions, I thought I would spend a couple of minutes talking about different ways of analyzing these trust funds.

I think part of the discussion at the earlier hearing today showed some confusion about the concepts behind the approaches. There are any number of ways of analyzing governmental programs, especially those that span many years and multiple generations. We need to be very careful about the questions we are attempting to answer and which analyses to apply. We also need to be careful not to mix the analyses and their respective concepts.

In the case of Social Security and Medicare, we pay the benefits of our parents and grandparents through our taxes, both payroll and income taxes. When we retire, both programs will take much more from our children to fund our benefits. This year, Social Security and Medicare will account for 6.5 percent of gross domestic product (GDP). By 2030, those programs will grow to 11 percent of GDP. Moreover, the number of beneficiaries will grow much faster than the number of workers paying taxes to support those programs.

How we analyze these spending commitments and demographic changes is vitally important. One approach, the one you have been dealing with thus far today, is to use actuarial techniques to project costs and income and focus on the revenue specifically dedicated to the program. That approach can help us ascertain whether a program—when isolated from the rest of the budget and the program's effect on the economy—is stable on its face, over long periods of time.

One measure of actuarial long-run viability is solvency—that is, when expected revenues and expenditures are roughly equal over prescribed but long periods. Another measure is the comparison of the present value of total expected revenues and total expected obligations, or whether the program is “funded” in some sense. Within each of those measures are variations on the concepts that could actually give you some fairly disparate results.

In the end, actuarial analysis is limited to a relatively narrow analysis of one program at a time without consideration of the rest of the Federal budget or the economy. It can reveal whether a program, as designed, appears to be stable over time, but it cannot tell

you if the program is sustainable over time—whether the Federal budget or the U.S. economy will support the program’s level of transfer of resources from the working population to the retired population.

A second approach to the analysis involves the program’s interaction with the rest of the budget. In the case of Medicare the interactions are direct because it is on-budget along with the rest of the non-Social Security programs. Even Social Security, although technically off-budget, can have striking on-budget effects. But whether a program is on- or off-budget, it is the combined effects of all taxes and spending that determine the Federal Government’s impact on the economy—for example on whether public debt is increasing or declining.

Mr. Chairman, a quick example of difference between actuarial and budgetary accounting might help. If you choose to transfer general revenues, say, from the on-budget surplus to the Medicare part A trust fund, the two analyses—that is, budgetary versus actuarial, would yield very different conclusions. Under an actuarial approach, the trust fund balance, and therefore its projected solvency and unfunded liability, would all be improved. If the transfer is large enough, the trust fund could remain solvent forever. The trust fund looks better because there would be more official Committee debt credited to it. That debt and any interest on it, however, would have to be redeemed in the future by raising taxes, cutting spending elsewhere in the budget, or borrowing from the public, effects that are much the same as those that would occur if there had been no transfer at all.

Another obvious example is the construction of the part B trust fund. It is actuarially sound, or adequately financed, in the words of the trustees, but only because it has an unlimited draw on the general funds of the Treasury. Again, the trust fund appears sound, but the growth in part B spending will have direct and potentially dramatic effects on the rest of the budget and the economy.

Last, Mr. Chairman, these programs are susceptible to economic analysis—that is, the interaction of the programs and the economy. Let me give you one important example. The chart, which the Committee has seen before, represents our best current projection of the amount of resources we baby boomers will consume after we retire. We will consume in just these three programs almost as much of the economic output in 2030 as does the entire Federal Government today. That result is driven by the well-known fact that we will double the number of retirees while the number of workers barely increases.

This measure depends on only two factors, the size of the economy and the amount of resources obligated for retirees. It has nothing to do with the existence of a trust fund or of any balances within the fund. It does not matter if the program is solvent or if it has unfunded liabilities, and the only way to alter this in the future is to alter one of the two factors—that is, change the size of the economy or the amount of benefits.

By way of summary, let’s compare the actuarial budgetary and economic effects at the time when dedicated revenues to either of these trust funds no longer cover expenditures. The reports that

Rick has presented to you today show that it happens for both programs in the year 2016. In both cases, the actuaries estimate that there will still be positive and, I believe, growing trust fund balances in 2016. Therefore, the actuarial analysis would suggest ample resources to meet obligations.

The budgetary analysis, however, would denote the transfer of general revenues to the trust funds, as interest paid on trust fund balances. Those general revenues could not be used for other spending or debt reduction. Indeed, the transfers would have to be funded again by the usual tax increase, reductions in spending, or the Treasury's issuance of debt.

Similarly, the economic analysis would pose the question, that you heard this morning as well. Where is the cash? The Treasury will have to have the cash to honor the checks sent to retirees and medical providers. The Committee can get the cash in only three ways: cut other spending, raise taxes, or borrow from the public. The economic analysis also suggests that it doesn't matter if there are balances in the trust fund or, indeed, if there is a trust fund at all. The cash still has to be generated to cover the shortfall in current revenues.

Mr. Chairman, until now we have been discussing how to finance the promises made to retirees, but a clearer picture may emerge if we think of these long-term programs in terms of consumption, or how the elderly ultimately spend the money that is transferred through these programs. After all, facilitating the consumption of goods and services—including medical services—is the purpose of the transfers. When I retire, I will use Social Security funds to buy groceries, clothes, and transportation, most of which will be produced about the time I use it. In other words, I will be competing with my children and grandchildren for the goods they are producing. What I eat, what I wear, what I drive, they cannot. That is why measures such as program spending as a percentage of GDP may be more relevant and real than trust fund or actuarial balances.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Crippen follows:]

**Statement of Dan L. Crippen, Director, Congressional Budget Office**

Mr. Chairman, members of the Committee:

There are a number of ways of analyzing governmental programs, especially those that span many years and multiple generations. We need to be careful about the question we are attempting to answer and which analyses to apply. We further need to be careful not to mix the analyses and their respective concepts.

In the case of Social Security and Medicare, we pay the benefits of our parents and grandparents through taxes on current workers, on us—both payroll and income taxes—and both programs will take much more from our children to fund them when we retire.

This year, Social Security and Medicare will account for 6.5 percent of GDP. By 2030, those programs will grow to 11.0 percent of GDP. Moreover, the number of beneficiaries will grow much faster than the number of workers paying taxes to support those programs. The ratio of covered workers to beneficiaries will drop from about 3.4 this year to about 2.3 by 2030.

How we analyze these spending commitments and demographic changes is vitally important.

One approach, the one you've been dealing with thus far today, is to use actuarial techniques to project costs and income, and focus on the revenues specifically dedicated to the program. That approach can help us ascertain whether a program, ab-

stracted from the rest of the budget and the program's effect on the economy, is stable on its face-usually over long periods of time.

One measure of actuarial long-run viability is "solvency"-are expected revenues and expenditures roughly equal over proscripted but long periods? Another measure is the comparison of the present value of total expected revenues and total expected obligations-whether the program is "funded" in some sense. Within each of these measures are variations on the concepts that can give fairly disparate results.

In the end, actuarial analysis is limited, however, to a relatively narrow analysis of one program at-a-time, without consideration of the rest of the federal budget or the economy.

It can reveal whether a program as designed appears to be stable over time. It cannot tell you, however, if the program is sustainable over time-whether the federal budget or the U.S. economy will support the level of transfer of resources from the working population to the retired population.

A second approach to the analysis involves the programs' interaction with the rest of the budget. In the case of Medicare, the interactions are direct because it is "on-budget" with the rest of the non-Social Security programs. Even Social Security, although technically off-budget, can have striking on-budget effects. But whether on- or off-, it is the combined effects of all taxes and spending that determine the federal government's impact on the economy-on whether public debt is increasing or decreasing, for example.

Mr. Chairman, a quick example of the difference between actuarial and budgetary accounting might be helpful.

If you chose to transfer general revenues, say from the on-budget surplus, to the Medicare Part A Trust Fund, the two analyses would yield very different conclusions. The Trust Fund balance, and therefore its' projected solvency and unfunded liability, would all be improved-if the transfer is large enough, the Trust Fund could be made "solvent" forever. However, the rest of the budget would be unchanged and unaffected and the effect of the transfer on the economy would be nil.

The Trust Fund looks better because there would be more official government debt credited to it. That debt and any interest on it, however, would have to be redeemed in the future by raising taxes, cutting spending elsewhere in the budget, or borrowing from the public-effects much the same as if there had been no transfer at all.

Another obvious example is the construction of the Part B Trust Fund. It is actuarially sound or "adequately financed", but only because it has an unlimited draw on the general funds of the Treasury. Again, the trust fund appears sound, but the growth in Part B spending has direct and potentially dramatic effects on the rest of the budget and the economy.

Last, Mr. Chairman, these programs are susceptible to economic analysis-the interaction of the programs and the economy.

Let me give one important example. This chart, which the Committee has seen before, represents our current best projection of the amount of resources we baby-boomers will consume after we retire. We will consume in just these three programs almost as much of the economic output in 2030 as does the entire federal government today. This result is driven by the fact we will almost double the number of retirees while the number of workers barely increases.

This measure depends on only two factors: the size of the economy and the amount of resources obligated for retirees. It has nothing to do with the existence of a trust fund or any balances within it. It does not matter if the program is solvent or has incurred unfunded liabilities. And, the only way to alter this future is to alter one of the two factors-change the size of the economy or the amount of benefits.

By way of summary, let's compare the actuarial, the budgetary, and the economic effects of the time when dedicated revenues to either of these trust funds no longer covers expenditures for that year-in yesterday's reports that year for both programs happens to be 2016.

In both cases, the actuaries estimate there will still be positive and growing trust fund balances in 2016. Therefore, the actuarial analysis would suggest ample resources to meet obligations.

The budgetary analysis would denote the transfer of general revenues to the trust funds as an intergovernmental interest payment. Those general revenues could not be used for other spending or debt reduction-indeed, the transfers would have to be funded by a tax increase, reductions in other spending, or the Treasury issuance of debt.

Similarly, the economic analysis would pose the question: where's the cash? Treasury will have to have the cash to honor the checks sent to retirees and medical providers. It can get the cash in only three ways: cut other spending, raise taxes, or borrow from the public. This analysis also suggests that it doesn't matter if there

are balances in a trust fund or, indeed, if there is a trust fund at all—the cash has to be generated by the Treasury to cover any shortfall of revenues.

Mr. Chairman, until now, we've been discussing how to finance the promises made to retirees, but a clearer picture emerges if we think of these long-tailed programs in terms of consumption—how the elderly spend the money. After all, facilitating consumption is the purpose of the transfers.

When I retire, I will use Social Security funds to buy groceries, clothes, transportation—most of which will be produced about the time I use it. In other words, I will be competing with my children and grandchildren for the goods they are producing. What I eat, what I wear, what I drive, they cannot. That is why measures such as program spending as a percent of GDP may be more relevant and real than trust fund or actuarial balances.

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Chairman THOMAS. Thank you very much. I want to ask a question and I don't expect an answer today. But I would like one as we begin to look at this. This is difficult enough in a nonpolitical environment to make decisions about resources and clearly who gets what, when and how, oftentimes, given the longevity question, immediately competing with those who are paying in versus those who are receiving the benefits. To what extent does the terminology that we use; i.e., a trust fund, with what people would normally read into the concept of a trust fund, a fiduciary responsibility, people who are, quote -unquote, managing the funds, to what extent does a term like "supplemental medical insurance" create an impression that there is again a relationship there if you use the term "insurance" when in fact if we examine what is actually going on, and neither the HI or the Social Security Trust Fund is a trust fund in that sense, nor is the supplemental insurance an insurance fund in that sense. Would it help us in your opinion—and here is where I need your help—what would be the terms that actuaries would use or people who have an apolitical interest in dealing with this issue? Would you perhaps give us choices of names we might begin to use so that we could deal with this issue away from what people read into the terms so that they take political positions that don't truly reflect the decision that is in front of us in terms of how we deal with the accounting problem of the Medicare and the Social Security Trust Funds along with the so-called part B or the supplemental medical insurance funds?

And I would request that you think about that and give us some options. I know it is popular for large corporations now to rename themselves. This some way has some response out of the society. I just want to see what it would be that we would be talking about if we had actuaries and others give us the titles of the program rather than politicians, Mr. Foster, trying to put together a deal to produce a majority of votes to pass the House and the Nation to make something that was desirable law. It may have been useful at that time to create an appearance for purposes of creating it. I am not so sure that it is really helping us solve our problem today, if you sat through any of the earlier hearing, in trying to understand what it is that we are doing.

That would be the Chair's request that you can take your time and respond back to.

[The following was subsequently received:]

There has been a long and honorable debate over proper terminology for social insurance programs like Medicare and Social Security and whether or not such pro-

grams constitute "insurance." As former chief actuary Robert J. Myers has written, "The [Social Security Administration] very definitely overstressed the insurance concept in the early days of the program. This was done primarily to buildup and maintain public support for the Social Security program—by drawing on the good name and reputation of private insurance."

Similarly, former chief actuary A. Haeworth Robertson blames some of the public's lack of understanding of Social Security and Medicare on government rhetoric. He notes that "The use of words and phrases such as 'insurance,' 'trust fund,' 'account,' 'contributions,' and 'earned right,' while not necessarily wrong, has sometimes conveyed the wrong impression."

Most experts conclude that these programs constitute "insurance" in the formal sense. As insurance professor George E. Rejda has pointed out, Social Security involves the classic insurance characteristics of risk pooling, fortuitous loss, risk transfer, and indemnification against loss. Medicare also contains these elements. The problem is more that relatively few people understand the important differences between social insurance and private insurance.

On balance, the current statutory designations of "Hospital Insurance" and "Supplementary Medical Insurance" seem reasonable to me so long as the underlying nature of the Medicare program and its financing are clearly explained. It is interesting to note, however, that prior to the 1937 Supreme Court decision upholding the constitutionality of the Social Security program, the trust fund was called the "Old-Age Reserve Account," rather than the "Old-Age and Survivors Insurance Trust Fund." In fact, the original name does a nice job of capturing two of the most important characteristics of the trust funds—namely, their role as contingency reserves, and the fact that they exist as accounts within the U.S. Treasury. The "reserve account" terminology thus helps to explain the nature of the funds, rather than tending to confuse their purpose, as can occur with the "trust fund" terminology.

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Chairman THOMAS. Does the gentleman from New York have any questions or inquiries?

Mr. RANGEL. Mr. Chairman, in connection with your request, I assume when you come back with this language that the Chairman is suggesting it would be because you would know we would have to change the law in order to use different language than we are using now for the trust fund. Suggestions as to how could we improve the way we deliver services and the way we pay for it are always helpful. However, the Medicare Part A Trust Fund is in better shape now no matter what system you use than it has ever been. That is correct, Mr. Crippen?

Mr. CRIPPEN. In terms of surpluses?

Mr. RANGEL. Yes.

Mr. CRIPPEN. I believe that is correct.

Mr. FOSTER. I would clarify slightly, Mr. Rangel.

Mr. RANGEL. I don't care. Just—whatever.

Mr. FOSTER. If you go back to the beginning of Medicare—

Mr. RANGEL. No, no, we do not do that.

Mr. FOSTER. Certainly in recent years, that is correct.

Chairman THOMAS. Well, not so fast okay. Go ahead.

Mr. RANGEL. It is not crippled, okay. It is in pretty good shape, Part A. Now some people will have us to believe, and some of them are pretty close to me physically, that we should really take Part A and Part B and just merge this thing together. And then of course we are dealing with a different situation in terms of income and payment. I am asking you that if Part B is paid for out of the general funds, at least 75 percent of it, is it possible that you can call that part having a deficit at all? With your understanding of Committee spending and trust funds, is it possible to say that you have a deficit in Part B under existing law?

Mr. FOSTER. Mr. Crippen gave a nice summary of the different perspectives.

Mr. RANGEL. I know that, but if he could help me, if either one of you could just help me understand existing law for the purpose of getting where we have to change it. With all of your expertise, can you assume any way that you could say that we have a deficit in Part B as long as it is being funded the way it is funded today?

Mr. FOSTER. Under present law and focusing on the financial status of the Part B trust fund, I would not refer to it having a deficit, no, sir

Mr. CRIPPEN. No, sir. It runs fairly close to zero—a little above or a little below, depending on whether we misestimate the premiums, but it essentially runs at zero.

Chairman THOMAS. On that, if in fact Part B continues to grow in the portion of the general funds that it assumes since it is an entitlement program and if you would extrapolate it out to the future in which it goes from 20 percent to 50 percent to 70 percent to 90 percent, and that were projected to take the entire general funds, which is not beyond the realm of possibility, and have it to be expended on the Part B entitlement program, you would then be forced to do what? In essence, it would be in deficit because you didn't have enough money to pay for it, given the current revenue stream; is that correct?

Mr. FOSTER. I would differentiate between revenues that under present law are owed to the Part B Trust Fund and the means by which you come up with these revenues. Both are important questions. We haven't seen any current scenarios where in fact the revenues would get anywhere near that high

Chairman THOMAS. What percentage of the general fund have you looked at would be eaten up by Part B with the current structure?

Mr. FOSTER. We have some examples in the current Trustees report. Let me give you one of them. In the year 2000 if you look at the Part B general revenues they represented 5.4 percent of the total Federal income taxes, both personal and corporate, that were collected that year. Now if those income taxes maintain the same share in the future of GDP that they are currently, and SMI or Part B continues to grow as rapidly as it has and we project, then at the end of our long-range projection period the general revenues would require 22 percent of the total income taxes.

Chairman THOMAS. So one out of every five dollars of the entire Federal budget would be dedicated to the Part B entitlement program. At some point people would be concerned about the total amount consumed by this program. Whether or not the term deficit might be used, the crowding out of other programs that might be funded certainly ought to be a discussion matter. Without looking at changing the program, 22 percent of the Federal budget is consumed by this one program.

Mr. RANGEL. Mr. Chairman, I think we have come a long way in being together. If you want me to understand the use of language like a crisis in terms of Part B because of the larger proportion of the general revenues, we can find that language. The problem is that you are using deficit-type language which is making it difficult to explain your position. And the main reason is that we



don't have the same interpretation of the same word. So if what you are saying and agreeing with them that you can't have a deficit if you intend to pay for the programs out of the general revenue, but you can have a crisis in terms of the percentage, then I think we can understand each other a lot clearer if that is what you are saying.

Chairman THOMAS. What I am saying is that taking a piece of the Medicare program that funds up to 50 percent of it and never examining it, but simply paying for it because of the way it was originally constructed 35 years ago, is probably not a good way to husband the current resources or future resources of the taxpayers of the United States.

Mr. RANGEL. We were not debating that. I am just asking whether or not you are prepared to say that you can't say Part B is in deficit.

Chairman THOMAS. No, because it is an entitlement program and it is funded out of the general funds.

Mr. RANGEL. Well, I think we have come a long way. This has been a good discussion.

Chairman THOMAS. I thank the gentleman. Does the gentleman from Connecticut, the Chairman of the Health Subcommittee, wish to inquire?

Mrs. JOHNSON OF CONNECTICUT. Yes, thank you. Mr. Foster or either one of you, could you just highlight for us briefly what were the differences in assumptions that made such a difference in cost projections?

Mr. FOSTER. I would be glad to. By way of background let me say that periodically it is a good idea to convene an independent group of experts to review the financial projections made in the Trustees reports. It is not that I think we are doing a bad job, but it is a good idea to reassure the public and reassure us that we are using the best methods and the best assumptions.

Just about a year ago, the Board of Trustees convened a Medicare Technical Review Panel, with seven of best known health actuaries and health economists in the country. They issued their report in December 2000 with a total of 38 findings and recommendations for us. In general they found the methods and assumptions used by the Trustees were reasonable, but they noted the exception of the long-range Medicare growth rate assumption, which they thought was too low. In the past, and this is an assumption that goes back for many, many years, we have always assumed that over a long period of time it would not be sustainable for Medicare growth rates to continue at their worst level because eventually the entire economy would be Medicare. As I like to joke, we would all be either doctors or patients; there wouldn't be anything else. So we purposely slowed down the assumption over the next 25 years to about the growth rate in per capita GDP, and we have used that for some time.

The last technical panel that reviewed this assumption was back in 1991 prior to the current one, and they concluded that the assumption was not unreasonable but they suggested we keep an eye on it and consider for the future any possible changes. The new panel was specifically asked to look at this key assumption, which they did. They have looked at long-range historical, past experi-

ence. They have considered the determinants of health care growth, including demographic impacts, insurance availability, income growth, excess medical inflation, all the normal factors considered for why health care costs increase, and in particular the role of technology and improvements in medical technology. They also considered other forecasts of long-range growth for health spending, including the CBO projections. They also considered the long-term sustainability, how high can health spending go in the U.S. before something has to give. Based on all of these considerations and after a lot of hard work on their part, they unanimously recommended that the Trustees increase the assumed long-range growth rate for average per person spending from about per capita GDP (what it used to be) to per capita GDP plus one percentage point. I concurred with their recommendation. We passed the recommendation on to the Board of Trustees and they adopted it, and that is what is in the new reports.

Mrs. JOHNSON OF CONNECTICUT. So the key thing was moving after the 25-year mark from per capita GDP to per capita GDP plus 1 percent.

Mr. FOSTER. That is correct.

Mrs. JOHNSON OF CONNECTICUT. And, Mr. Crippen, in light of past performance, is this a realistic assumption?

Mr. CRIPPEN. Well, it is certainly closer to what we have seen historically. As Rick said, we have both tried to come to a middle economic ground where economists are keen on saying, this can't go on forever. It can't go on forever, but it can go on for a long time. So GDP-plus-1 percent growth is certainly closer to what we have seen than just GDP growth would be. But we aren't assuming that policy changes will eventually drive it down to where, ultimately, it has to be, which is stable relative to the growth rate of the economy.

Mrs. JOHNSON OF CONNECTICUT. Also in making estimates for us in Part A or Part B, which you do regularly throughout the process, does a change that we make in Part B often affect spending in Part A?

Mr. CRIPPEN. It would depend upon the change you made.

Mrs. JOHNSON OF CONNECTICUT. Right, but does that situation come up of interactions between the two programs in terms of cost?

Mr. CRIPPEN. Only to a relatively small extent. It is only when you make programmatic changes like moving home health care that it dramatically changes that outlook.

Mrs. JOHNSON OF CONNECTICUT. When we shortened the length of stay to control costs in Part A, did not we expect that it would increase costs in Part B?

Mr. CRIPPEN. It would.

Mrs. JOHNSON OF CONNECTICUT. So while a policy change is not as blatant a corruption of the process, it is simply moving home health services from A to B, it really did shift costs from A to B?

Mr. CRIPPEN. Yes, ma'am, it did, because of the way we account for those two programs. As you know, it was a conscious effort to move people out of hospitals and into skilled nursing facilities and home health services.

Mrs. JOHNSON OF CONNECTICUT. So while it was good public policy, it didn't in any way provide any greater solvency for the Medicare problem as a whole?

Mr. CRIPPEN. No, not as a whole.

Mrs. JOHNSON OF CONNECTICUT. So one of the things that worries me in this debate about the HI Trust Fund, and that worries me a lot when I look at my colleagues from across the aisle's approach to this issue—it seems to be focused on primarily budget issues in the immediate present—is that unless we begin looking at both funds, A and B, and all of these things we are talking about and it is fair to say all the numbers in the Trustees reports are without prescription drugs, without reforming the way technology is incorporated into Medicare, which is 4 or 5 years behind the private sector. It is a totally inadequate process, particularly as we move into the modern era. It is without annual physicals. We will cover a flu vaccine, but we don't cover the visit to get it. Truly the program is a bizarre health care plan, but none of these estimates in any way take into account any of the reforms that we have to make that might increase the spending levels.

Let me conclude by saying I appreciate your comment, Dr. Crippen, that we will consume in just Social Security, Medicare, Medicaid almost as much of the economic output of 2030, that is 29 years from now, as does the entire Federal Government today. When you think of a year ago the U.S. General Accounting Office's (GAO) report that we would consume three-quarters of the revenues, you can see how much your more realistic assumptions and your experience has altered the picture in just a single year. I don't care whether you use the word "deficit" or not, but I consider this a crisis, and I hope that people on both sides of the aisle in both bodies will appreciate the significance of our responsibility this year to try to impact these trend lines in such a way that we can make good on your promise to provide seniors with a more modern health care plan that is affordable to their children.

Mr. CRIPPEN. Mr. Chairman, I want to make one quick clarification. Our assumption, which matches that of the Trustees, of GDP-plus-1-percent is a long-term assumption. Most of the cost estimates we do for you cover 10 years, because that is the baseline we have. In that baseline, we assume more than GDP-plus-1-percent. We assume for example, in that next year it will be higher than that.

Mrs. JOHNSON OF CONNECTICUT. Frankly, I thought it was quite shocking that the Trustees all this time have allowed themselves to drop back to GDP after 25 years, because we have not been able to stay within GDP or GDP-plus-1 for I do not know how long now. So thank you.

Chairman THOMAS. In that regard when was the last time there was an adjustment in the Actuary's estimates of this magnitude for the Medicare trust funds.

Mr. FOSTER. For the long-range actuarial deficit for Part A this is one of the bigger changes. Of course when the Balanced Budget Act was enacted—

Chairman THOMAS. Of course not.

Mr. FOSTER. That was a bigger impact. I would have to stop and think beyond that. I can't think of one as big as this in recent years.

Chairman THOMAS. I thank the gentleman. The gentleman from California, the ranking member on the Health Subcommittee, wish to inquire?

Mr. STARK. Yes, thank you. I hate to talk to actuaries with my shoes and socks on because I have trouble with all these numbers, Mr. Foster, but I will try. Due to the more rapid growth of health care in general, and I assume that is for Medicare and non-Medicare, the cost of everybody's health care will go up. So it isn't just Medicare. The concerns are the adequacy of long-term financing for the program. And as far as I remember, we have got three ways to address the concerns you raise. We can cut benefits or increase the beneficiaries' payments, which are, I will submit, the same thing. We can reduce payments to providers, or we can increase revenue through increased taxes.

I think that pretty much represents our options. The President's budget obviously prohibits tax increases. It is silent on cuts in benefits or provider payments, so we must assume that if we are going to do anything we have to make deep cuts to beneficiaries and providers. Preliminarily, that is uncomfortable for many of us. Could you please tell us, Rick, what would the 2.9 percent Medicare tax have to go up to to just accommodate for the 1 percent cost increase? Do you know, or can you estimate it?

Mr. FOSTER. Sure.

Mr. STARK. Okay.

Mr. FOSTER. The HI deficit that we had before this change was about 1.2 percent of taxable payroll. The deficit after this change is not quite 2 percent of taxable payroll. There were other changes in addition, but this of course was the primary one. So I think you could argue that the increase from 1.2 to 2.0 roughly is the gap that you are looking to address through your question by a higher payroll tax.

Mr. STARK. So saying it another way, if we raise the payroll tax from 2.9 to approximately 3.7, or 1.85 percent for employers and 1.85 percent for employees, we would offset the change that your cost calculations have brought us right?

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

Mr. STARK. Okay. I just wanted to get some idea of the order of magnitude that we are talking about. Let's say we went to 3.7 percent. How long does that solve our problems? Can we do that once? Are we home free for the next 20 years, or does that just push the soap a little farther ahead in the bathtub?

Mr. FOSTER. It probably comes as no surprise to this group to know that the projections are quite uncertain and real life has a bad habit of surprising us. If the projections came true and if we immediately raised the HI payroll tax by the .4 percent for employers and employees each and held it at that throughout the 75 years, that would balance the system on average. It is important to understand though that that would give us a higher tax now than we need but eventually a much lower tax than we would need at that point. On average it would be about right, but it wouldn't

cover a very large percentage of the ultimate deficit in the long term.

Mr. STARK. So put it another way, when I am accused of being a tax-and-spend Democrat, if I said I want to use taxes to solve our future Medicare problems right now, I would be talking about .8 percent payroll tax, right? That is about as bad as it can get, if raising taxes is bad. Is that another way to say it?

Mr. FOSTER. If you did it immediately, sir—

Mr. STARK. We are changing taxes around here pretty fast.

Mr. FOSTER. Then on average that would do it. On the other hand, suppose you decided to raise the tax rate year by year as much as necessary to cover this higher projection.

Mr. STARK. You are saying we would build up a little surplus in the outyears.

Mr. FOSTER. Yes, much like Social Security. If you did it year by year—it is important to note that in the new projections the scheduled tax income under present law for Part A is only one-third of the total expenditures at the end of the period. If you did it year by year, you would have to pretty much triple the current tax rate.

Chairman THOMAS. Is that triple the current tax rate?

Mr. FOSTER. Triple.

Mrs. JOHNSON OF CONNECTICUT. Would the gentleman yield? I think you need to clarify that point. That is an extremely significant point. Could you go through that again?

Mr. MCCRERY. May I ask a question for clarification?

Chairman THOMAS. As soon as he finishes you will get your time.

Mr. MCCRERY. I don't think you responded. Maybe I am missing something, but I thought Mr. Stark was asking you to estimate the payroll taxes needed to solve just the 1 percent additional growth.

Mr. STARK. That is right.

Mr. FOSTER. That is correct.

Mr. MCCRERY. Okay. And that is .8 percent, but you responded to his last question by saying that to solve the whole Medicare problem all we needed to do was .8-percent increase in the payroll tax, and I don't think that is correct.

Mr. STARK. I would defer to my distinguished colleague from New Orleans, as I suspect he is correct as well.

Mr. FOSTER. I fully agree that what I gave you just now with the tripling was to solve the entire deficit rather than just the incremental part due to the 1 percent. If I were a little faster mentally, I could figure that out here for you. But it would be on the order, we used to have a ratio that was on—one-half the scheduled taxes were one-half of the ultimate at the end of the period and now it is about one-third. So if you want to go on the difference there, that is what? A sixth, if I did that right, of the difference, which would put us more in the order of about a 1 percentage point each for employers and employees at the end of the period rather than the .4. I would be happy to check that arithmetic at some point and let you know if I made any errors.

[The following was subsequently received:]

After the hearing, as I offered to do, I checked my arithmetic and provide the following clarification: The latter would be on the order of about 2 percentage points each for employers and employees at the end of the period rather than the .4.

Chairman THOMAS. And rather than a third party assessing whether it is too much we ought to ask the people who are paying it. The gentleman has one more question.

Mr. STARK. If I may, Mr. Chairman. Again, to Mr. Foster in terms of reform, in both last year's report and this year's report you indicated, though in somewhat different ways, that Medicare+Choice is costly or does not save money for the Medicare system. In fairness, you have also indicated that we are losing less currently but you did not tell me how much less. We were still losing money but how much less this year than last year, half as much?

Mr. FOSTER. You are correct, Mr. Stark, that we estimate that—under present law with the way we pay managed care plans under Medicare—that on average (not necessarily plan by plan but on average) we pay on behalf of these beneficiaries amounts more than they would cost us under fee-for-service. There is a well-known selection impact that has occurred. The Balanced Budget Act requires risk adjustment in order to help us adjust this, and we believe in fact that once full risk adjustment can be implemented that can help a lot. Risk adjustment would reduce payments compared to where they are now on the order of 7, 8 or 9 percent. But it wouldn't eliminate the entire difference.

Mr. STARK. So it would be fair to say that encouraging people to join managed care-plus-choice is not going to save Medicare any money?

Mr. FOSTER. That is our expectation under present law because what we pay the managed care plans—the capitation rate is determined off of what was originally an average fee-for-service cost with fee-for-service growth thereafter. If we change the reimbursement mechanism, I think there is the potential for savings.

Mr. STARK. How would you change it?

Mr. FOSTER. If we went to something that reflected the plan's actual cost more so than what happens now, perhaps in the context of competitive bidding, I think the potential is there.

Mr. STARK. Thank you.

Chairman THOMAS. Thank you. My assumption is it wasn't a rhetorical question that he asked at the beginning because if you look at some of the recent changes we have made in the area of prevention and wellness, that in fact if some of these managed programs were moving forward on prevention and wellness, notwithstanding the fact you would not count the savings, we probably could see a benefit which might accrue to savings, productivity, technology, error rate reduction, fraud and abuse reduction. All of these are ways in which we can continue to get, if you will, more bang for your buck; i.e., savings in the program, which by the way would probably produce a healthier America.

The gentleman from Louisiana wish to inquire?

Mr. MCCREERY. Yes, thank you, Mr. Chairman. Mr. Crippen, on your graph over here, in the year 2030 it appears that Social Security expenditures and Medicare expenditures are roughly equal in that year. But you do not show beyond 2030. Isn't it true that beyond 2030 the Social Security expenditures level off as a percent

of GDP and the Medicare expenditures continue to rise at a fairly sharp rate?

Mr. CRIPPEN. Yes.

Mr. MCCREERY. So if you extend the graph out to 2075, which is the end of the window that the trustees have to look at, those colors would be in different proportions, in fact dramatically different proportions, wouldn't they?

Mr. CRIPPEN. They would. We assume, just as the trustees do, that Medicare will continue to grow faster than the economy in the long run, even if you have a steady number of people in the program. That is not the case with Social Security. So Medicare grows faster than Social Security, and after the lines cross, it continues to grow faster.

Mr. MCCREERY. And correct me if I am wrong, but I believe that your graph and the extension of that graph, it would show Medicare expenditures rising at a much faster rate than Social Security, that does not include prescription drug expenditures, does it?

Mr. CRIPPEN. It does not. This is our attempt to look at current law.

Mr. MCCREERY. So if we were to add a new entitlement component to Medicare, prescription drugs, that red section of your graph would be even larger than it is today?

Mr. CRIPPEN. Yes.

Mr. MCCREERY. I don't know exactly what the Ranking Member of the Committee is getting at with his line of questioning about the deficit and whether part B is in a technical deficit or not, but I assume he is trying to tell us that there is really no hurry here, that there is no crisis and we do not need to do much with Medicare right now because gosh, everything is OK. We have a surplus in Part A, Part B has a surplus, so no problem.

Well, if that is the case I would refer my good friend from New York to the Trustees report, this little summary. It is in the back message from the Trustees and they say, quote, Thus, rather than providing net revenue to the Treasury, after 2016 the combined trust funds will require rapidly growing infusions from revenues from the Treasury to pay benefits projected under current law. It is at this point and not at later dates when trust fund assets are technically exhausted, that Social Security and Medicare will begin to be in direct competition with other Federal programs for resources of the Treasury, requiring either growing tax increases or debt financing to pay the benefits promised under current Federal law. And again that is not even counting prescription drugs.

And they go on to say, It is important that changes in Social Security and Medicare be initiated sooner rather than later that address the rapidly growing annual deficits these programs are projected to incur beginning with the retirement of the baby boom population.

Mr. Crippen, Mr. Foster, do you concur in the assessment of the trustees as I just read it?

Mr. CRIPPEN. I do, yes.

Mr. FOSTER. I think it is important to address these longer range issues. I might note that the current Board of trustees made these statements regarding the need for action sooner rather than later.

If you look at prior reports you will find that language is the same language used by the prior trustees as well.

Mr. MCCRERY. Yes, their language hasn't changed. It appears to me at least in the reading of this trustees report that the years in the immediacy of years past is still there regardless of the fact that we can say some trust fund has been extended by 4 years or another one is still in technical surplus. Isn't that right? Isn't that a correct reading of this year's report? It is still an immediate concern?

Mr. FOSTER. Yes, the trustees I think are pretty clear that the need remains.

Mr. MCCRERY. To sum up, the sooner that we put in place changes that over time will give us positive results in terms of expenditures or revenues or whichever approach we take, then the easier it will be to solve this problem. The longer we wait the more drastic the solutions that we will have to put in place. Is that accurate? Is that in keeping with the trustees' words?

Mr. FOSTER. Yes, it is. Part of the message is that if you act sooner rather than later you have more options and the changes can be introduced more gradually and give greater warning time to affected parties, whether it is beneficiaries or taxpayers or health care providers.

Mr. MCCRERY. To use a historical analogy, the longer we fiddle the more Rome is going to burn, and I think we are burning right now and we are fiddling and we ought to be acting. Thank you.

Chairman THOMAS. Does the gentleman from Michigan wish to inquire?

Mr. LEVIN. Let me, if I might, pick up that theme, because, you know, I think all of us tend to use optimism or pessimism, I said we tend to, to drive a policy result, and so we can put on our optimistic or our pessimistic hat depending on the conclusion we want to reach. And I want to pick up that issue because the Secretary of Treasury touched on this kind of issue earlier today.

Mr. CRIPPEN, I am not sure if I understood what you said here and I am sorry the page number is not here but you say at the bottom of, it is quite far back, and the only way to alter this future is to alter one of two factors, change the size of the economy or the amounts of benefits. I am not sure the context is clear. What is not included there are program changes.

Mr. CRIPPEN. What I was trying to say, Mr. Levin, is that to change the outlook on this chart—which is based on how large these programs are as a percentage of the economy—you only really have two moving parts: one is how big the economy which you are dividing by is and the other is how many benefits you are dedicating to the retirees.

Mr. LEVIN. Well, I think it has been suggested another way to do it is not to change the benefits or the size of economy but the content and the quality of the program. And I didn't get a chance to ask the Secretary this. I was struck by his statements about the defects in the present system and the need for systemic reform and how—and then you talked about the error of the medical error rate and said something about we could cut costs 30 to 50 percent and our system would be wonderfully better. And I didn't really understand that at all. I mean, and he talked about his experience with



Alcoa, but—and this somewhat relates to Mr. Stark's question about how we handle care in managed care and fee for service. But if there are these savings, these efficiency savings that are just right here to pick up off the tree, we do not need this kind of dramatic reform, whether you favor it or not, whatever it is.

Now, do you in your work, either of you, have you come up with any information that would give you optimism that we can dramatically change the cost of health care through these efficiency reforms? I don't mean to pit you against the Secretary of the Treasury and I am sorry I didn't ask him that. But in your testimony you do not seem to give any substantial weight to a dramatic reduction in costs through such changes. Am I wrong?

Mr. FOSTER. I like your analogy, sir, of the low hanging fruit or the easy picking fruit. But in fact I think the potential is there, but I think it is a lot further up that tree and it is hiding behind some pretty big branches. There was a RAND study from a few years ago that suggested roughly 30 percent of medical services are unnecessary, that they don't accomplish anything. So the potential is there if we could find a magical way of avoiding doing those.

Mr. LEVIN. Is there a magical way?

Mr. FOSTER. That is the thing because the RAND study also showed after the fact you can often identify unnecessary services. But you can almost never identify them before the fact.

Mr. LEVIN. If we could just legislate after the fact around here, we might even have some bipartisanship.

Chairman THOMAS. Actually I thought we do that more often than not.

Mr. LEVIN. But seriously, I mean, to talk about something wonderfully better and it wouldn't take 40 years, 50 years to do this, right? I mean if the potential is there, I assume it is there not next year but over a decade, we ought to be able to squeeze that kind of excess, if it is real, but—

Mr. CRIPPEN. I don't know, Mr. Levin, who the Secretary was directly referring to. There are probably some subsets of the Medicare population among whom you could, through case management or some other innovation that we know about today, save substantial amounts of money and maybe have better health care outcomes. But at this point, the subset that we could think about applying that to is probably small. If we could expand those techniques, then maybe there would be systemic savings, but my guess is that what he was referring to was some unusual techniques applied to a very small number of people.

Chairman THOMAS. I will tell the gentleman, it also, as I have had discussions with the Secretary, deals in the way we could reduce error. The problem is it is easy to talk about it, but when you say it is something we should be able to pick up immediately what we are dealing with is the fundamental shift in the mindset of those who deliver health care. And you look at someone in a white coat with a stethoscope around their neck, there is a conspiracy of silence to discuss what is going on. If you put them in a blue uniform with epaulets, they are anxious to get on the stand to talk about all of the errors that were made in the crash they are examining. It is a fundamental way that health care has been delivered in the relationship between health care providers that if we could

change it to create a punishment free assessment of decisions that are made and how they are made from a systemic point of view rather from the heroic artist healing, a physician point of view—I don't mean that in a pejorative sense, but that is the way the system is structured today—you could get significant reductions in errors and in unnecessary operations. But to say that and then to do it means you fundamentally have to change the culture and the character of those who participate in the delivery of health care today, and that is the problem.

Does the gentlewoman from Florida wish to be inquire?

Mrs. THURMAN. Thank you, Mr. Chairman. Mr. Foster, I need to get some clarification here because I know there has been a lot of conversation about the GDP-plus-1, and in reference to the chairlady of the Health Care Subcommittee, and rightfully so, there is a concern about what is going to happen with medical technology and our seniors being able to participate in any technology that comes. Is that not a part though of your assumptions, your growth assumptions, did you not use medical technology as one of the components?

Mr. FOSTER. Yes, ma'am. In fact, it is the primary component of the recommendation from the technical panel. They have measured the historical contribution of medical technology improvement to health care cost increases and they assumed that that level of impact would continue indefinitely.

Mrs. THURMAN. So the technology issue is really already in here; it is just how do we implement it as being part of the issue. What it doesn't have is the prescription drug benefit. That is not a part of the technology then, and change and new medicine, or anything of that nature.

Mr. FOSTER. In a sense it is part of it because what has happened with prescription drugs has an impact on Medicare beneficiaries and their Medicare costs because we do not pay—

Mrs. THURMAN. Because of the in-hospital drug—

Mr. FOSTER. Hospitalization rates, other issues.

Mrs. THURMAN. Okay.

Mrs. THURMAN. Okay. One of the areas that—and this goes to the Medicare reform issue because we are hearing an awful lot of that. I mean, I am not even sure I know what a reform is anymore because it keeps changing on me, and I think it kind of fits whoever wants to make it fit.

But, you know, we hear about how this is a 35-year-old program and we need to make changes. But some of the changes that we have made in the past were specifically on the managed care program and for Medicare+Choice. And in your report, you actually make an assumption that reductions in the projected levels of managed care enrollment resulted actually in a positive 30 percent change in the actuarial balance because of people pulling out of these plans, suggesting to them fee-for-service is a lesser cost.

So then let me take a step further: When you talked about—you thought that potentially those numbers would switch if we had something that was more—get active, I think is what you said. Let me ask this question, then, if that is true; and then I need to find out, do you think that the Federal Employees Health Benefits Plan (FEHBP) is a competitive program? Do you think private pay is a

competitive program, and if so, what I have understood to believe is that over the last 20 years the costs have been about the same in all of those programs, including Medicare?

Mr. FOSTER. There is competition in private health insurance, for example, starting back when, about the early 1990's, employers got fed up with the rising cost of health care for their employees, and they started shopping around for better premiums. And this did lead to a degree of competition that I think did help get to a lower cost than would otherwise have occurred.

Mrs. THURMAN. But in saying that, we have seen Medicare and all of these others maintain about the same cost over the last 20 years, so no real significant savings.

Mr. FOSTER. That is correct. If you look over a long time period, say the last 30 years perhaps, and you look at the average cost increase over that whole period per person insured or per beneficiary for Medicare, if you make the comparison between Medicare and private health insurance, the average increases are pretty similar. Medicare is actually a little bit lower, but overall over the whole period they are pretty similar.

Within subperiods, you can find some fairly large differences. For example, when the inpatient prospective payment system was introduced for Medicare back in 1984, the Medicare growth rates were quite a bit lower than private health insurance for some period. More recently, with the managed care revolution, it was the other way around; the private health insurance rates were much lower. Most recently, with the Balanced Budget Act and the strong economy, et cetera, Medicare has been doing a lot better.

On a long-term average, they are similar.

Mrs. THURMAN. So then if we look at this report and based on the conversations that we are going to have over the next couple of years of solvency, nonsolvency, whatever, and the guess the President has taken off, which, quite frankly, I probably rightfully think so, on the payroll taxes, what does that leave us? If we have got a similar program other than we now talk about Breaux-Frist, which seems to be the competitive mode, but yet based on your answer that really doesn't give us much savings in the long run.

I think there might be some things that could happen. But other than decreasing benefits, Mr. Crippen, what do we do?

Mr. FOSTER. I will let Mr. Crippen answer that one.

Mr. CRIPPEN. Fortunately, we don't deal in policy. But I will suggest one approach that you might think about, and this is not a math solution either. Since the outset of these programs we have been thinking about a set of benefits that we provide to the elderly population and the financing of them as the problem we have to worry about, and rightly so. But one could also think about the issue as an insurance pool. I mean that in the generic sense—not private or public, but just an insurance pool with 39 million people. In that pool, there is a significant amount of risk, both health risk and financial risk.

You can think about apportioning that risk perhaps differently than we do now, so that there is some risk borne by the recipients, the providers, and by the taxpayers. And in the division of that risk you may create a set of incentives that produces a much more efficient, better health care system. But it is just a different way

of thinking about it rather than considering it as a set of benefits that we have to finance for a given population.

Mrs. THURMAN. However, Mr. Crippen, back to the Trust Fund report, it actually uses an implementation of an improved risk in it. That is part of the statement that I just pulled out on the point 30, so I am not sure.

On the benefit issue when you talk to me then about managed—management of a person's health and those kinds of things, those are also benefits that actually increase other than decrease. So then we have a trade-off of what do we give to a beneficiary based on some of those assumptions as well.

Mr. CRIPPEN. This is an example I have used before, so the numbers are no longer right because they are now 2 years old. But if you were going to get a liver transplant and you were a Medicare recipient in the New York City area, you would probably go to the nearest hospital that would perform that operation for you and that Medicare would reimburse for that surgery. If, however, you wanted to get the best liver transplant available, the one that would let you live the longest or not be rehospitalized—the most successful—you would go to the Mayo Clinic.

It turns out that Mayo charges about half of what the hospital in Manhattan would charge. What we are talking about here is \$150,000 versus \$300,000—those are the kinds of numbers. So, clearly, you could afford to pay for a plane ticket to send somebody to the Mayo Clinic.

In that kind of a system hospitals would compete against each other on not only price but outcomes. Because we can measure outcomes on some of these things pretty clearly: Does the patient survive?

On that basis, you have a better outcome in quality, and you have a lower price. So you could allow people to take advantage of the lower price and the better outcome. They could still go to the hospital next door to them if they wanted to, but they would pay a higher price.

What you are doing is changing the nature of the risk in the overall pool by taking out some of these very big payments.

And if you think about the nature of that risk, you may be able to restructure the pools in a way that we haven't thought of thus far. I don't know if that makes any sense.

Mrs. THURMAN. But that wouldn't mean just necessarily going to some kind of managed care program. That would actually work within the Medicare program as we know it today.

Mr. CRIPPEN. You could take solid-organ transplants out of any payment system, whether it be managed care or fee-for-service, and do what we were just talking about.

Chairman THOMAS. I tell the gentlelady, though, a couple of points with that colloquy. One is, to be able to measure outcomes and have the taxpayers' dollars spent for the highest and best result will require the ability to collect data. We don't have a patient confidentiality statistical structure available to us, and to the degree it is done on a State basis, it becomes a crazy quilt. That is a thing that we have tried to work on here.

Also, in terms of prescription drugs, remember the Part A Trust Fund is the part A Trust Fund; and the only really significant por-

tion of prescription drugs in that would be in the in-hospital, diagnostic-related group provision. Your party, your President's proposal, was a part B which was outside of Part A. And the successes of using higher technology on drugs where the associated costs really are largely going to be influencing the General Fund portion of Medicare, rather than the hospital Part A. So their adjustment, from a technology point of view on drugs, is in that area of the hospitalization portion.

Mrs. THURMAN. And I would agree with you. I was trying to get to that point, though, that—you know, that the technology with that GDP-plus-1 was—there were some purposes in that. And so we can't just say that that has not been included in this growth that is being looked at as we look at changes in Medicare.

Chairman THOMAS. Right, to the extent that drugs are in the Part A program. But the idea of getting to outcomes so that we could compare costs and quality is something I think that would advance the debate far beyond where we are now in making sure that we can get the best product for the dollar spent. It won't necessarily reduce costs, of course, but it can reduce the amount of the increase, which is, after all, one of the things we are looking for.

Does the gentleman from Texas wish to inquire?

Mr. DOGGETT. Thank you, Mr. Chairman.

Gentlemen, frankly I have to tell you that I was planning my questions today for Secretary Thompson, who I had been advised would be back here. I gather that after some of his answers last week, he is in reeducation camp today.

So I am going to try to focus my questions—since there is no one here from the administration to discuss policy—just on the numbers since Mr. Crippen said that your focus is on the numbers.

If I understand correctly, if by law, as Secretary Thompson told the Committee last week, all of Part A must be used for Part A, and that the commitment of the administration, according to what you might call the "Thompson oral lockbox" on Part A, is to use it only for that purpose, then is it not true that it is not available for the contingency fund for other purposes that the President proposed in his budget?

Mr. CRIPPEN. The answer depends on how you analyze the program.

Legally, you may be absolutely correct that if you look just at Part A, that analysis can tell you what kind of financial shape the program is in. What I was suggesting is that to look at Part A alone, outside the rest of the Federal budget or the economy, could be misleading.

You may want to change Part A, even if it looks all right, simply because you have other budgetary constraints. The extreme example is that you could either increase spending or cut taxes by \$5.6 trillion over the next 10 years, and the actuarial analysis in the trustees' report, would not change.

So if you think of the issue as Part A, then yes, in an actuarial sense, your statement is absolutely right. If you think of it in the context of a larger budget or of the economy, you may get a different answer.

Mr. DOGGETT. If it is by law for Part A only, it can't be used for the Contingency Fund for something else, can it?

Mr. CRIPPEN. It depends on what you mean by “used.” For years we’ve used the Social Security Trust Fund for other things.

Mr. DOGGETT. Fortunately, we are not doing that. You are not proposing that we do that again, are you?

Mr. CRIPPEN. No, I am not. All I am saying is that because of the way the Federal budget works and the way the program’s financing works, the money that flows through the Part A trust fund leaves behind Committee debt but also provides cash out the other side, which can—

Mr. DOGGETT. So unless we want to use it in the way the Social Security surplus was once used, then Part A is for Part A, and it is not an available for the Contingency Fund for other things.

Mr. CRIPPEN. Again, in the actuarial and legal senses, I am sure that the words you are using are right. In a budgetary sense, it doesn’t matter.

Mr. DOGGETT. Let me ask you about prescription drugs then.

Your CBO came out with a new estimate that seniors, I believe, will be paying about a third more for prescription drugs over the next 10 years than had been previously estimated. That is a total, I believe, of about \$1.5 trillion, which is the best estimate your number crunchers have been able to come up with on that.

Mr. CRIPPEN. Right.

Mr. DOGGETT. The President has proposed in his budget that we allocate \$105 billion over 10 years to meeting the prescription drug needs of seniors; isn’t that correct?

Mr. CRIPPEN. I believe that is right, yes.

Mr. DOGGETT. So American seniors need to know that while they were promised a kind of “we can have it all” budget in the President’s speech, in fact, what the President is proposing in his budget is to give seniors a little less than a dime on the dollar—I think it works out to about 7.5 percent—to meet their prescription drug cost over the next 10 years if your numbers are accurate and the sticks with his budget figure of \$105 billion.

Mr. CRIPPEN. Certainly, what you have just said is true. I would add, however, that a portion of the \$1.5 trillion is currently being paid by employers, by other insurance. We are using—

Mr. DOGGETT. There are a few seniors that are fortunate to have their prescription drugs met. Maybe instead of 7.5 percent, they will get a dime. But it is clearly not a dollar of their prescription drug needs. It is not anywhere close to meeting the prescription drug expenses that you think seniors will have over the next 10 years, is it?

Mr. CRIPPEN. It would depend upon how you spent the money. We don’t know exactly what the gap is, what the need is. For seniors without insurance, you have to define how many more pharmaceuticals they need than they are getting now and what that would cost. We don’t know, so we can’t tell you whether the input you mentioned meets the need.

I can’t disagree with the numbers you use, but if you targeted the money, presumably you could provide more than a dime to those who don’t have prescription drug coverage.

Mr. DOGGETT. So you could give nothing to other people or you could give it all to some. Their helping-hand program seems to be more like a helping-little-finger program than a helping-hand.

But if you look at it just in terms of your numbers and the President's number, he is proposing to give about 7.5 percent on their dollar of prescription drug costs over the next 10 years. Thank you very much.

Chairman THOMAS. Does the gentleman from North Dakota wish to inquire?

Mr. POMEROY. Yes. Thank you.

Mr. Foster, you are the Health Care Financing Administration (HCFA) actuary?

Mr. FOSTER. That is correct.

Mr. POMEROY. Mr. Crippen, we know you.

Mr. CRIPPEN. For good or ill.

Mr. POMEROY. I think the North Dakota basketball teams whopped South Dakota again this year.

Mr. CRIPPEN. Are you sure?

Mr. POMEROY. I am a little—I am heartened by the discussion today, because I think it is extraordinarily important to talk about the entitlement programs and their long-term consequence. And I think that sometimes the 10-year focus ignores what is going to happen to us in the next decade, and the decade I call the “troublesome teens.”

GAO Comptroller General David Walker has said that even on a unified budget basis the Social Security program, entitlement program, and the Medicare program, the General Fund program, we are in a deficit position by the year 2019 without a dime of tax cuts.

Mr. Crippen, do you have any knowledge of whether that is accurate?

Mr. CRIPPEN. I know that on the spending side GAO uses our numbers, so presumably that is pretty close. The question is what level you assume for revenues—that is, whether you change the tax laws or not. Historically revenues have been 18 or 19 percent of GDP; today, we are at 21 percent of output.

If you assumed that revenues would remain at 21 percent of GDP for a long period, you might not be in deficit then. If you assumed the historical average of 18 percent or 18 percent-plus, then you might be. The conclusion you draw depends on what you assume revenues are going to do even under current law.

Mr. POMEROY. Actually I think that there is no debate about the exploding costs of entitlements as baby boomers move into retirement years; is that correct?

Mr. CRIPPEN. It is. We boomers start retiring in 2010, so between 2010 and 2030, you get the most demographic impact.

Mr. POMEROY. I suppose from time to time there have been demographic changes, substantially demographic changes across cohorts within the American population.

Mr. Foster, do you know?

Mr. FOSTER. Well, the statistics going back for very long periods are not too good, as you can imagine.

Mr. POMEROY. We know what we are dealing with now. We have three workers per retiree today, and we are going to have two workers per retiree by the year 2030, a very substantial shift and a very rapidly aging population if you look at the total picture. Is that correct from an actuarial standpoint?

Mr. FOSTER. That is correct. What really happens is not only the retirement of the baby boomers, but you also have the low-birth cohorts during the Depression years; and then you have, subsequent to the baby boom, the relatively low-birth cohorts. There has been a long downward trend in U.S. fertility for the last two centuries.

Mr. POMEROY. Because my time is limited, I completely agree with you. You and I are agreeing on the same point; that is, we have a rapidly aging population, a significantly greater proportion of our population moving into entitlement program eligibility, the over-65 age group.

This will be the first time in the history of our country—irrespective of whether this has happened before or not, it will be the first time that it has happened when you have those seniors, each one of those 65-year-olds and over, with an absolute right to entitlement program support, Social Security and Medicare. Is that correct?

Mr. FOSTER. It is the first time we have had this sort of demographic change, an adverse change in that sense. In the past we have had a favorable situation.

Mr. POMEROY. You have an aging population, but this time an aging population with Medicare and Social Security, which means the next decade is going to be something like we have never seen before. That would tell me that this decade we ought to be doing everything we can to prepare for the next decade.

The President has said this surplus is the American people's surplus, but a good chunk of that surplus is also essentially the prefunding of the entitlement programs that has been written into the program. The FICA taxes collect more today than is paid out today, and that difference has all piled into calculation of the surplus; is that correct, Mr. Foster?

Mr. FOSTER. It is essentially correct. Let me caution you that it was not so much by design as by accident.

Mr. POMEROY. I would say on the Social Security side it was very deliberately by design.

Mr. FOSTER. I would disagree with you respectfully, sir.

Mr. POMEROY. I think the heart of the 1983 reforms was to bring a dimension of prefunding in. I used to be an insurance commissioner; whenever I argued with actuaries, I lost. But I do think that the demographic was anticipated. It is not a surprise that suddenly the population is as it is by age cohort, and therefore, prefunding was built into the program.

When we talk about the dramatically expanding obligations and we talk about basically trying to stabilize them through reform, reform essentially is cutting benefits, increasing the tax burden to pay for the benefits, or laying off a significantly greater cost than is presently laid off on the beneficiaries. In other words, higher Medicare premiums, something of that nature, is that basically the range of alternatives?

Mr. CRIPPEN. Again, it depends on which of the analyses you are using. If it is an actuarial analysis, then you are right. If it is one, however, that includes or, rather, looks at the effect on the economy, there are only two moving parts in the macroeconomic analysis: you can reduce benefits—that is, the promises made to the



baby boomers, not the current retirees—or you can grow the economy faster, then you will get a different result.

Mr. POMEROY. I subject there is a third. Can I make my suggestion?

Chairman THOMAS. Move to the third.

Mr. POMEROY. If this country moves into the next decade having made the most rapid advance in debt retirement possible, bringing us to—literally to the point without debt, we have as Secretary Summers used to say, “recharged the fiscal cannon of the United States of America.” We have bequeathed to—the next generation has got to pay for our entitlement costs, virtually the entire borrowing capacity of the United States; and in the event there are some deficits encountered in some future Congresses, God forbid, we have got a lot of borrowing capacity to deal with that.

Would you agree with that from a budgetary standpoint?

Mr. CRIPPEN. Yes, but I would argue that paying down the debt might actually grow the economy faster and is thus even more important.

Mr. POMEROY. It is a two-fer. Win-win. Thank you.

Chairman THOMAS. I thank the gentleman.

Without objection, the Chair will place in the record a letter addressed today—dated today from the Secretary of Health and Human Services.

[The information follows:]

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
WASHINGTON, DC 20201  
March 20, 2001

Hon. BILL THOMAS,  
Chairman, Committee on House Ways and Means  
Rayburn House Office Building  
Room 2208  
Washington, DC 20515.

DEAR MR. CHAIRMAN:

Thank you for the invitation to testify before the Committee on Ways and Means last week. It was a great honor to present the President’s Budget blueprint for the Department of Health and Human Services to you and the Members of your Committee.

As Secretary of Health and Human Services, I was encouraged to be reminded of your strong support and leadership in reforming the Medicare Program by improving the current benefits package and adding a prescription drug benefit for Medicare beneficiaries. As you know, I share your commitment to true Medicare modernization. A 21st Century Medicare program must catch up to the rest of health care by recognizing that all modes of treatment—hospitalization, outpatient care, home care and prescription medications—must be integrated if patients are to receive quality care.

Modernizing and improving Medicare must rank among our most urgent priorities. Reform, however, must not be limited to improving the benefit package but must also establish an accurate measure of solvency to ensure the program is financially stable for generations to come. To this end, we must ensure that all Medicare money must be used for Medicare and Medicare reform. I know that you share this goal.

I look forward to working with you in the coming months to address these important issues. Your knowledge of the Medicare Program and your history of leadership in reform is essential to our success.

Sincerely,

TOMMY G. THOMPSON,  
*Secretary.*

Chairman THOMAS. Does the gentleman from Wisconsin wish to inquire?

Mr. RYAN. Yes, thank you, Mr. Chairman.

Gentlemen, I just wanted to bring up some key timing points. Is it not true—and I will ask each of you—that the first year the outgo exceeds income, excluding interest, in the HI Trust Fund in the year 2016? Correct?

Mr. FOSTER. That is correct.

Mr. RYAN. Payroll taxes will not meet the demand of the time?

Mr. FOSTER. Payroll and other taxes.

Mr. RYAN. So the problem is not in the year 2029, as some would say; the problem really begins in the year 2016, correct?

Mr. FOSTER. Well, there are lots of problems out there. That is one of them.

Mr. RYAN. In looking at your spend-out rates—and I think it is very exciting and interesting to see this—you are using current-law assumptions in determining your spend-out rates, correct?

Mr. FOSTER. That is correct.

Mr. RYAN. Based on the fee-for-service program exclusively?

Mr. FOSTER. Well, fee-for-service and Medicare+Choice.

Mr. RYAN. Which is based on fee-for-service.

It is pegged to the fee-for-service rate, correct?

Mr. FOSTER. The payments, that is correct.

Mr. RYAN. Mr. Crippen, is it not the case that the Congressional Budget Office has estimated the premium support commission plan as saving more money in the long run when you switch your estimates from not just exclusively fee-for-service, but fee-for-service plus private rates as well?

So it is my understanding that CBO's projections of Medicare spending under the premium support system would grow more slowly than Medicare spending under current law based on the current fee-for-service spending modeling; is that correct?

Mr. CRIPPEN. I think you are right. I can't say for sure. I think that is right.

Mr. RYAN. That is my recollection. And Mr. Foster—

Mr. CRIPPEN. That is correct.

Mr. RYAN. Mr. Foster, that is not the case with HCFA, though, as well, correct?

Mr. FOSTER. Referring to the premium support estimates?

Mr. RYAN. That is right. Yes.

Mr. FOSTER. We have had different versions of this proposal going back to the bipartisan Medicare Commission and also the last administration's proposal. And what we have found is that there is the potential for savings. It tends not to be dramatic, not of the same order of magnitude as the long-range costs that we project, for example.

Mr. RYAN. I find that there is a decent-size discrepancy between HCFA modeling and CBO modeling, and that the important qualifying difference here is that the Congressional Budget Office has looked at the price competition issue and has concluded that it does exist and that savings can be accrued so that when you apply the

price competition model to your spend-out rates, you can actually save a considerable amount of money in the end.

So the point I am trying to get around to is, it has often been said here in the Committee that the only way to reform or fix Medicare, to address that chart, is to either raise taxes or cut benefits. My colleague, who just left, said, “or draw down debts so that we can raise debt later.”

I just don’t see it that way.

The third way is, reform Medicare. And reform Medicare doesn’t necessarily mean cut taxes or raise benefits. Reform Medicare can necessarily mean inject price competition into the system as has been measured by the Congressional Budget Office, which ends up saving more money in the long run; and it does a great deal of good toward limiting that liability that we see on these charts in the outyears. Is that not correct, Mr. Crippen?

Mr. CRIPPEN. Yes, but we would not say it as generally as you have; that is, the details of these things make a dramatic amount of difference.

Rick hasn’t had the opportunity to look at all of the plans that we have—not that he would change HCFA’s estimating methods, as the differences in our methods aren’t the major issue. An economic proposition, I think we agree that if you can introduce competition, as Rick said earlier, you have the prospect of having some savings.

Mr. RYAN. So what you are saying is that that is the possibility, that in addressing this issue there is a third way other than raising taxes and cutting benefits, and that is to enact Medicare reforms that inject price competition into the system—the devil is in the details—but there is a possibility of doing that whereby Medicare expenditures would slow relative to current law; is that correct?

Mr. FOSTER. I would argue that price competition can get you to your bottom-dollar cost, and more effectively than price administration that we currently do or other methods. I tend to believe—and Dan and I might differ just a little bit on this; I tend to believe that once you are at the bottom-dollar price, through competition or whatever means, that the factors affecting health care growth, including technology, higher incomes, insurance availability, et cetera—that the factors affecting this growth tend to be the same.

So what a premium support proposal can do for you is get you to a lower cost, but then the growth of the future won’t be a lot different than fee-for-service. It is just you are down here instead of up here, but growing at similar rates.

Mr. RYAN. Growing at similar rates.

But it is my opinion from reading the CBO analysis that you would actually incur some savings; that, yes, costs will incur, new technologies will be hopefully evolving, and that those new expenditures will occur, but that under current law those expenditures growth rates would be higher than under the price competition premium support model if constructed properly? Correct?

Mr. CRIPPEN. I think that is right, yes.

Mr. RYAN. Thank you.

Chairman THOMAS. I thank the gentleman.

You might recall that the last Congress, in putting out prescription drug programs, the way in which the President's plan was constructed and the way in which the plan that passed the House of Representatives was constructed, there was literally twice as much savings in a particular area because of the way the competition was structured.

So I think the gentleman is correct that you can get, based upon the plan, a reduction in the cost; but another way of saying that is, you simply slow the growth curve. Eventually you wind up having to talk about increased costs. But after all, what we are doing is trying to make sure that we get out into the future the best possible quality at the lowest possible price. All of those factors would contribute to that.

If there are no further questions—the gentleman from Louisiana.

Mr. MCCRERY. I would just like to clear up something, because there may be some people watching, maybe even some press listening, that are confused about the part A Trust Fund and the Contingency Fund in the budget. And I am not accusing any of our colleagues of trying to mislead the public on this, but just to make it crystal clear:

The Part A—Medicare Part A Trust Fund, under current law, will be spent on Medicare. Regardless of what we do with the cash flow excess, at this time or next year or the year after, the Part A Trust Fund is dedicated to Medicare. And when those bills, those IOUs become due, the general Treasury has an obligation, the full faith and credit of the United States is behind that obligation to pay those IOUs. Regardless of what kind of budget you set up for a tax cut or a contingency fund or funding education or defense, that trust fund is dedicated under current law and nobody is suggesting changing the current law on Medicare, end of discussion. Not the administration, not this Committee, nobody has suggested changing current law so that the Part A Trust Fund is spent on anything other than Medicare.

Does anybody on the panel disagree with that?

Mr. FOSTER. I would agree with you. You said “under present law,” which is the critical factor here. Under present law, not only is it spent only on Medicare, but it is only spent on Part A Medicare.

Mr. MCCRERY. That is correct, only on Part A Medicare. That is current law.

Mr. CRIPPEN. I would say, as I said once before, that even if you utilize for tax cuts or other spending, what we estimate to be the entire surplus over the next 10 years that would not change the actuarial reporting in this report at all. It would still be reported as a surplus in the Medicare Part A trust fund.

Mr. MCCRERY. That is correct. I just wanted to clear that up, Mr. Chairman

Chairman THOMAS. Or perhaps another way of saying it, do we anticipate a Part A Trust Fund surplus beyond the 10-year—Mr. Foster, as the actuary—beyond the 10-year window, Mr. Crippen, that we require for our budgetary purposes?

Mr. FOSTER. Yes, we do.

Chairman THOMAS. So if the surplus that has to be due and payable when it is due and payable is outside the 10-year window, we

basically can deal with that surplus in any way we want prior to being obligated to have to spend it. So if we create a fund for 10 years or less, which is called a contingency fund, travel fund, a help-mate fund, whatever we call that, that money is not due and payable until we are required to pay it. And if it is outside the 10-year window, no one should be concerned about where or how it is structured within that 10-year window, so long as it is not spent.

Mr. STARK. Would the Chairman yield?

Chairman THOMAS. Sure.

Mr. STARK. I think what you are saying, or maybe not, is that the Contingency Fund for other than Medicare purposes is then really only approximately 300, instead of 800.

Chairman THOMAS. Actually, it is more than 40 different trust funds that are currently in surplus. So that it is a number of trust funds, again because of the description as to what the trust fund really is, from an actuarial point of view, comprising the Contingency Fund. It is not just the Part A Trust Fund.

Mr. STARK. If in 1 year you tried to spend \$800 billion out of the Trust Fund on defense, that would be spending Part A Trust Fund money on something other than Medicare, right?

Mr. MCCRERY. That is incorrect.

Chairman THOMAS. We have enough surplus to pay the bills due and payable on Medicare Part A, clear through, outside the 10-year window. We are not spending that money.

Mr. STARK. My understanding, all you could do with that Trust Fund money is buy certain Committee notes.

Mr. MCCRERY. No. No. No. No. No.

Initially that is correct. The Treasury Department is obligated to put into the Trust Fund IOUs just so that everybody out there will understand IOU—paper IOUs, go into the Trust Fund and they stack up. No money. No cash.

That would be stupid, wouldn't it, to put the cash under the mattress? But the Treasury Department has to do something with the cash that it gets from the trustees.

What did we do with the cash? When you guys were in control of Congress, we spent it on everything from defense to education to anything else you can think of. We spent every penny of it, plus some. We went out to the markets and borrowed even more money.

Now, thankfully, we have reversed that and we are not spending it; we are using it to buy down debt. The Treasury Department takes that cash from the Trustees and buys down debt.

Some of us would like to give it back in the form of a tax cut to let the economy grow more so these trust funds may get in even better shape.

Mr. STARK. The same thing is true with the Social Security Trust Fund? Could you do the same with Social Security?

Mr. MCCRERY. We could. Just as you all spend it for years and years, we could give a tax cut.

But the gentleman's statement that we are spending the Medicare Trust Fund on defense, or anything else, was incorrect. You are not spending the Trust Fund. You are spending the excess in cash flow that comes into the Trustees.

And we have to spend that somewhere. You can't stuff it under a mattress. So you can pay down debt, you can spend it, or you can cut taxes. We are going to do probably some of each.

Chairman THOMAS. Actually, this entire discussion is an accounting discussion since there is no Trust Fund; it is merely an entry. And hopefully we have made accounting far more exciting than most people think it is, and we await our friend's return visit to us.

I do think these discussions are important because frankly perceptions govern; and some people's perception of what we are doing hopefully is misguided. Because if they understand exactly what we are doing, but make the accusations that they are, it makes it much more difficult to resolve the problems that already are extremely difficult to resolve for this society. But we are going to resolve them.

I want to thank both of you for your time and more importantly for your devotion and expertise in working with us to make sure that the Social Security, the Medicare Trust Funds are sound and will be sounder.

This hearing is adjourned.

[Whereupon, at 2:05 p.m., the hearing was adjourned.]

[Submission for the record follows:]

#### **Statement of Advanced Medical Technology Association**

AdvaMed, is pleased to present this testimony on behalf of the world's leading medical technology innovators and the patients we serve. As the largest medical technology trade association in the world, AdvaMed is committed to ensuring that patients have timely access to the advanced medical technologies that can save and improve their lives and help reduce health care costs.

AdvaMed represents more than 800 medical device, diagnostic products, and health information systems manufacturers of all sizes, from small start-ups to global leaders. AdvaMed member firms provide nearly 90 percent of the \$68 billion of health care technology products purchased annually in the U.S. and nearly 50 percent of the \$159 billion purchased annually around the world.

AdvaMed shares the concerns of the Members of Congress, the Administration and seniors across the country about the financial state of the Medicare program. It is critically important to take steps to make sure this program remains strong for today's seniors and people with disabilities and future generations as well.

The annual Medicare Trustees' Report released yesterday offers important insights to Congress as it addresses this issue. However, the long-term cost increases projected in this report tell only part of the story and must not be used by Medicare as a pretense for delaying or denying patients' access to lifesaving and life-improving advances in medicine.

In fact, AdvaMed believes that medical technology offers the solution to rising health care costs. As such, ensuring timely adoption of medical advances by Medicare is crucial not only for the health of America's seniors and people with disabilities covered by the program, but for the fiscal health of the program itself.

America is on the cusp of a revolution in medical technology. Through advances in technology we can detect diseases earlier when they are easier and less costly to treat, provide more effective and less invasive treatment options, reduce recovery times and enable people to return to work much more quickly.

The Trustees' Report does not account for this revolution in medical technology. As a result, it overlooks a paradigm shift that is already taking place to a New Health Economy. Medical technology has advanced to the point where it is fundamentally transforming our health care system in ways that improve quality and reduce costs.

For example:

- Angioplasty and other minimally invasive heart procedures, for example, have greatly reduced the need for riskier, more expensive heart bypass procedures. An angioplasty procedure costs \$20,960 on average, compared to \$49,160 for open-heart surgery. Surgeons can complete an angioplasty procedure in 90 minutes compared to 2–4 hours for open bypass surgery. Patients can leave the hospital in one day

instead of 5–6 days, and recovery only takes one week rather than 4–6 weeks for bypass.

- Total knee replacement produces an average one-time health care cost savings of \$50,000 per patient; a savings of \$11.5 billion in 1994 alone, according to the American Academy of Orthopedic Surgeons (AAOS).
- Three types of laparoscopic surgery have generated approximately \$1.9 billion annually in increased productivity by enabling people to return to work more quickly, according to a study by DRI-McGraw Hill.

A story in Sunday's *Washington Post* highlights another of the many advances transforming health care delivery: a health care information system that alerts doctors at Brigham and Women's hospital to potentially dangerous medical decisions. The system has cut the medication error rate at Brigham by 86% compared to 10 years ago.

Information systems like these can dramatically improve the safety and efficiency of health care delivery and help reduce health care costs. Automation in the insurance industry alone could save an estimated \$20 billion. That is why both the President's Information Technology Advisory Committee and the Institute of Medicine in its recent report on health care quality have stressed the need for a new health information infrastructure.

Steady declines in mortality rates, medical procedure times, hospital stays and patient recovery times all illustrate the emergence of the New Health Economy. Gains in workforce productivity and accelerating declines in disability rates point to this shift as well.

In order to reap these benefits, advanced medical technologies must be rapidly assimilated into the health care system. The Institute of Medicine's recent report, "Crossing the Quality Chasm," underscored this point, stating: "Narrowing the quality chasm will make it possible to bring the benefits of medical science and technology to all Americans in every community . . . and this in turn will mean less pain and suffering, less disability, greater longevity, and a more productive workforce."

In a statement yesterday on the Trustees' Report, Treasury Secretary and Medicare Trustee Paul O'Neill cited this IOM report in highlighting "tremendous potential for improvements in the health care sector." AdvaMed shares this concern, as well as Secretary O'Neill's understanding of the importance of adopting new technologies and medical practices that can transform the health care sector by improving quality and reducing costs. As Chairman of Alcoa, O'Neill championed the adoption of so-called "disruptive" technologies as the solution to rising health care costs. In a recent *Forbes* article, O'Neill stated: "It is possible to improve the health and medical care value equation by as much as 50%."

AdvaMed also applauds HHS Secretary Thompson for pointing out the need to improve health care quality, stating in March 7 testimony that his department's goal is "to build a healthier America by improving the quality of health care, the quality of life for all Americans and reduce health care costs." Secretary Thompson recognized during his confirmation hearings that "Medicare is failing to meet the needs of our seniors and is not allowing them to reap the benefits of the tremendous advances in medicine and technology we are witnessing today." AdvaMed looks forward to working with the Secretary to achieve his department's goal. One important step towards improved health care quality is reducing Medicare delays in the adoption of advanced medical technology.

The steps Congress took in the Balanced Budget Refinement Act of 1999 (BBRA) and the Benefits Improvement and Protection Act (BIPA) of 2000 will help ensure that advanced medical technologies are adopted by Medicare in a timely manner. The technology access provisions in these bills help move us into the New Health Economy of higher quality and lower costs.

These bills made important changes to streamline HCFA's coverage, coding and payment procedures, including: requiring HCFA to report annually to Congress on the timeliness of its coverage, coding and payment decisions; streamlining the Medicare Coverage Advisory Committee process; establishing transitional payment mechanisms to support adoption of breakthrough technologies used in the hospital inpatient and outpatient settings; and reducing delays in establishing codes and reimbursement rates for new diagnostic tests.

HCFA should rapidly and fully implement these important measures to improve health care quality by eliminating roadblocks to patient access to innovative medical technologies. The agency and Congress should examine additional steps that should be taken to ensure that Medicare patients have access to 21st century medicine.

The BBRA and BIPA legislation enacted by Congress help move HCFA toward a leadership role in supporting timely patient access to quality-enhancing innovations.

AdvaMed believes it is critically important for the agency to take the lead in this area, and can do so by achieving the following goals:

- Eliminate delays in coverage coding and payment for new technologies. BBRA and BIPA legislation will help accomplish this goal. HCFA and Congress should take additional steps to reduce access delays, such as issuing codes on quarterly basis and establishing coverage requirements that recognize broad range of reliable data that can support coverage decisions.
- Establish payment incentives that support quality health care. BBRA and BIPA help eliminate payment policies that discriminate against advances in care by systematically under-reimbursing for them for two to three years after they are introduced.
- Support creation of an integrated health care information infrastructure.
- Give patients more control over health care decisions. HCFA should set coverage policies that give doctors and patients flexibility to make their own medical decisions.
- Develop policies and methodologies that recognize the full benefits of medical technology.

Again, AdvaMed applauds Congress for recognizing the value of technology in improving the quality and efficiency of the health care system, and taking steps to reduce the barriers patients face to accessing these innovations. Recent reforms continue to improve the system and AdvaMed encourages additional changes to make coverage, coding and payment decisions more predictable, transparent and timely.

