MEDICARE AND SOCIAL SECURITY: THE FISCAL FACTS

HEARING

BEFORE THE

COMMITTEE ON THE BUDGET
HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

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MEDICARE AND SOCIAL SECURITY: THE FISCAL FACTS

WEDNESDAY, JULY 13, 2011

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
Washington, DC.

The committee met, pursuant to call, at 10:08 a.m. in room 210, Cannon House Office Building, Hon. Paul Ryan [chairman of the committee] presiding.

Present: Representatives Ryan, Campbell, Price, Lankford, Black, Huelskamp, Young, Guinta, Van Hollen, Schwartz, Doggett, Blumenauer, Pascrell, Wasserman Schultz, Castor, Tonko and Bass.

Chairman RYAN. Hearing will come to order. I didn't mean to scare you there. We are ready to get started now.

We thank the witnesses for coming. I will open with a brief comment and then turn it over to my partner here Mr. Van Hollen.

Welcome to today's hearing focused on our critical health and retirement security programs, specifically Medicare and Social Security. Today we welcome Rick Foster, chief actuary at the Centers for Medicare & Medicaid Services. Rick remains among the Nation's foremost experts on health care policy, and we remain grateful for his nonpartisan analysis and for his returning to testify before this committee.

It is good to see you again, Rick.

We are also very fortunate to be joined by Stephen Goss, chief actuary for the Social Security Administration. Like Rick, Steve's analysis provides policymakers with an indispensable guide to the structural need for reforms.

Steve, I've known you a long, long time. It is great to have you back. We appreciate your taking time out of your day to come and testify today.

The failure of Washington to be honest about Medicare and Social Security and the Federal budget threatens the economic security of Americans. For too long policymakers have avoided the critical question on how the social insurance strategies of the 20th century can deliver on their promise of 21st century. It is just that simple.

The House Budget Committee has devoted considerable energy to changing Washington's culture of irresponsibility. The American people deserve better than empty promises with respect to these important programs.

Earlier this year we proposed, debated and advanced a plan that helps fulfill the mission of health and retirement security for all

Americans. Our budget charts a path to lift the crushing burden of debt, to spur economic growth and job creation, and to fix these problems. It has been a source of urgently needed debate along with an occasional distortion or two.

Both sides have engaged in the unfortunate weaponization of entitlement politics. It is bad for our political discourse, it hinders efforts at bipartisan solutions, and, most importantly, it actually threatens the health and well-being of society's most vulnerable who rely most importantly on these programs.

We need a clean break from the politics of the past, and that begins with a shared consensus on the facts. So today's hearing is an effort to unpack the fiscal facts on Medicare and Social Security, two critical programs that represent a solemn commitment to America's seniors. This is a commitment that cannot be kept unless reforms are made. To help us get our arms around the magnitude of these two programs' financial health, I can think of no better witnesses than the ones we have today.

It is just this simple: These are the most important program of the Federal Government right here, these two. Millions of people rely on them. They are going bankrupt. They have to be reformed in order to be saved. And it is crystal clear to anybody who looks at these numbers that the sooner we act to shore these programs up, the better off everybody is going to be, the less disruption that occurs in the lives of the people who rely on them the most.

You can't help but turn on the TV and see what is happening in Italy, in Greece, in Portugal, you name it. A debt crisis is on our horizon, and a debt crisis is driven in large part because of these programs. So it is so much better for us as leaders to act like leaders, and to fix this problem, and do it under our own terms and our own timeline before it gets out of our control. And it is just that simple. And so hopefully we can begin a conversation with the recitation of the fiscal facts as the nonpartisan trustees and actuaries display them.

And with that I would like to turn it over to my colleague Mr. Van Hollen.

[The prepared statement of Mr. Ryan follows:]

PREPARED STATEMENT OF HON. PAUL RYAN, CHAIRMAN, HOUSE COMMITTEE ON THE BUDGET

Welcome to today's hearing focused on our critical health and retirement security programs—specifically Medicare and Social Security.

We welcome Rick Foster, Chief Actuary at the Centers for Medicare and Medicaid Services. Rick remains among the nation's foremost experts on health care policy, and we remain grateful for his nonpartisan analysis and for his returning to testify before this committee. We are also fortunate to be joined by Stephen Goss, Chief Actuary for the Social Security Administration. Like Rick, Stephen's analysis provides policymakers with an indispensible guide to the structural need for reforms. I thank you both for taking time out of your schedules to join us today.

The failure of Washington to be honest about Medicare, Social Security, and the federal budget threatens the economic security of America's seniors. For too long, policymakers have avoided the critical question on how the social insurance strategies of the 20th century can deliver on their promise in the 21st century.

The House Budget Committee has devoted considerable energy to changing Washington's culture of irresponsibility. The American people deserve better than empty promises with respect to these important programs. Earlier this year, we proposed, debated and advanced a plan that helps fulfill the mission of health and retirement security for all Americans. Our budget charts a path to lift the crushing burden of

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To help us get our arms around the magnitude of these two programs' financial health, I can think of no better witnesses than the two nonpartisan experts testifying before this committee today.

Again, I thank you both for joining us today and look forward to your testimony. With that, I'd like to yield to Ranking Member Van Hollen for his opening statement.

Mr. VAN HOLLEN. I thank you, Mr. Chairman.

I want to join the chairman in welcoming our witnesses today. I look forward to your testimony on what is a very important subject. I would note, Mr. Chairman, that this will be, I believe, the fourth hearing devoted to either Medicare or Social Security solvency, including yesterday's hearing where we had an extensive discussion of this issue with Secretary Sebelius and other witnesses, and I think that is entirely appropriate. But I want to note that we have not yet had a single hearing devoted to the issue of tax expenditures and revenue. And we all know that the President's bipartisan fiscal commission on which you serve, Mr. Chairman, said that you can look at the tax expenditures in the Tax Code and find about $1 trillion every year.

Chairman RYAN. We are working on scheduling that hearing.

Mr. VAN HOLLEN. Okay. We have had four on this issue, and, again, we should have many more this issue, but we have not yet had one on a hugely important part of our budget.

There is no doubt that we need to make reforms in Medicare and Social Security to ensure the long-term strength and viability of those programs. We have very different views on how to do.

But, Mr. Chairman, if we are talking about the facts, let us also be clear about this point. The Congressional Budget Office analysis shows that the primary recent policy decision driving the need to raise the debt ceiling was the decisions in 2001 and 2003 to provide tax breaks that disproportionately benefited the very wealthy. That is what driving the current debt ceiling. We are talking about bills, past bills due and our ability to pay for those past bill dues.

And as we all know, we have a very important conversation going on as to whether and how we take a balanced approach to that decision, one that includes important and difficult cuts in discretionary spending, one that looks at mandatory programs, one that looks at some of the things we can do to strengthen Medicare. Again, we have different views on how to do that. But one that we would urge also includes closing corporate tax loopholes and dealing with tax preferences for the folks at the very top.

So again, I am glad we are having what by our account is the fourth hearing on this subject, but if we are going to take a balanced approach to the long-term challenges, let us include that conversation about tax expenditures.

Now, with respect to Medicare and Social Security, again, we heard a lot of testimony yesterday from Secretary Sebelius and oth-

ers. We believe we have to make very important reforms to Medicare. We believe we have to change the incentive structure so that we reward value of care and quality of care over volume of care and quantity of care. And Secretary Sebelius talked about some of the important initiatives she is taking with respect to improved coordination of care for dual-eligibles, people on Medicare and Medicaid, people with a lot of chronic diseases where we spend a whole lot on the Medicare program. We need to look at those sorts of things. We are open to other ideas.

What we are not open to is transferring all those costs simply to seniors on Medicare without dealing with the underlying costs driving the entire health care system; not just Medicare, but the entire health care system of which Medicare is a very important part.

And so, yes, we do object to the approach that was taken in the Republican budget, which the CBO says will not decrease health care costs nationally, but actually increase total health care costs, and we push a lot bigger part of that burden onto Medicare beneficiaries.

With respect to Social Security, we believe that reforms need to be made to make sure that we strength the solvency of Social Security beyond the year 2036, 2037. We all know that if we do nothing to act now, Social Security beneficiaries would get 78 cents approximately on the dollar, 75, 78 cents. Yes, we need to act sooner rather than later to address those issues. Again, we have differences of opinion on how best to do that, but no difference on the fact that we need to make sure we strengthen those programs.

So we are in fundamental agreement that Medicare and Social Security require some reforms to be strengthened. We are in very big disagreement as to how to do it. And apparently we continue to be in a big disagreement over taking a balanced approach to the overall budget that says let us not make the kind of mistakes that we made that are actually driving the budget deficits at the particular moment. Let us deal with tax expenditures, let us close some of those corporate loopholes whether it is for the jets or for oil and gas companies, and let us look at the tax preferences for folks at the very high end of the income scale on tax rates.

So, Mr. Chairman, again, I would like to have a lot more hearings on this particular issue, but I would like us also to address the very important issues of tax expenditures as part of an overall budget discussion.

[The prepared statement of Mr. Van Hollen follows:]

PREPARED STATEMENT OF HON. CHRIS VAN HOLLEN, RANKING MINORITY MEMBER, HOUSE COMMITTEE ON THE BUDGET

Thank you Mr. Chairman, and I want to thank our witnesses for joining us today, and I look forward to your testimony on what is a very important subject. I would note, Mr. Chairman, that this will be what I believe is the fourth hearing devoted to either Medicare or Social Security solvency, including yesterday's hearing where we had an extensive discussion on this issue with Secretary Sebelius and the other witnesses. And I think that's entirely appropriate. But I want to note that we have not yet had a single hearing devoted to the issue of tax expenditures and revenue. And we all know that the President's bipartisan fiscal commission, on which you served Mr. Chairman, said that you can look at the tax expenditures in the tax code and find about $1 trillion every year in savings. We have had four hearings on this issue, and we should have many more on this issue, but again—we have not yet had one on a hugely important part of our budget.

There is no doubt that we need to make reforms in Medicare and Social Security to ensure the long term strength and viability of those programs, and we have very different views on how to do it. But, Mr. Chairman, if we're talking about the facts, let's also be clear about this point: the Congressional Budget Office (CBO) analysis shows the primary recent policy decision that is driving the need to raise the debt ceiling were the decisions in 2001 and 2003 to provide tax breaks that disproportionately benefit the very wealthy. That is what is driving the current debt ceiling debate. We're talking about bills—past bills due—and our ability to pay them. And as we all know, we have a very important conversation going on as to whether and how we take a balanced approach to that decision. One that includes important and difficult cuts in discretionary spending. One that looks at mandatory programs. One that looks at things we can do to strengthen Medicare, and again we have different views on how to do that. But one, that we would urge, also looks at closing corporate tax loopholes and dealing with tax preferences for the folks at the very top. So, again I'm glad we're having, by what our account is the fourth hearing on this subject, but if we're going to take a balanced approach to the long-term challenges let's include that conversation about tax expenditures.

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With respect to Social Security we believe that reforms need to be made to make sure that we strengthen the solvency of Social Security beyond the year 2036. We all know that if we do nothing to act now then Social Security beneficiaries would get 77 cents on the dollar that they were expecting to receive. Yes, we need to act sooner rather than later to address those issues. And again, we have differences of opinion on how best to do that, but we have no difference in opinion regarding the fact that we do indeed need to strengthen those programs.

We are in fundamental agreement that Medicare and Social Security require some reforms so that we can strengthen them, but we have some very big differences as to how to do it. And apparently we continue to be in significant disagreement over taking a balanced approach to the overall budget, one that says 'Let's not make the same kind of mistakes that we made which are now driving the budget deficits at this particular moment. Let's deal with tax expenditures. Let's close some of those corporate loopholes—whether it's for the jets or for the oil and gas companies. Let's look at the tax preferences for the folks at the very top of the income scale.' So, Mr. Chairman, again I'd like to have a lot more hearings on this particular issue, but I'd like also for us also to address the very important issue of tax expenditures as part of the overall budget discussion. Thank you.

Chairman RYAN. The gentleman made his point very clearly. Why don't we begin with you, Steve, and then go to Rick. The floor is yours. Please turn your mic on.

STATEMENTS OF STEPHEN C. GOSS, CHIEF ACTUARY, SOCIAL SECURITY ADMINISTRATION; AND RICHARD S. FOSTER, F.S.A., CHIEF ACTUARY, CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF STEPHEN C. GOSS

Mr. GOSS. Thank you very much, Chairman Ryan.

Chairman RYAN. Turn your mic on.

Mr. GOSS. There we go.

Chairman Ryan, ranking member Van Hollen, members of the committee, thank you very much for the opportunity to discuss with you today the fiscal status of these programs.

The 2011 annual reports issued by the Board of Trustees on May 13 have clearly laid out the projected future costs and financing of these programs under current law and our best assessment of future economic and demographic conditions.

We are at the beginning of a substantial and permanent shift in age distribution of our population. The drop in birth rates from the longtime average level of three children per woman through 1965 to just two children per woman since 1975 is, in fact, responsible. By 2040, there will be only two workers for every Social Security beneficiary, down from three workers per beneficiary throughout the period 1975 to 2008. As a result the cost of Social Security will shift from 4.3 percent of GDP in the period 1975 through 2008 to a stable level of 6 percent of GDP for 2040 and later. Scheduled tax revenue will remain at about 4.5 percent of GDP in the future. Program sustainability for Social Security, therefore, will depend on making a choice to either increase revenue by 33 percent after 2035, reduce benefits by 25 percent after 2035, or some combination of these two changes.

In the absence of legislation, the combined Social Security OASI and DI Trust Funds are projected to be exhausted in 2036 in our latest reports, with only about 75 percent of presently scheduled benefits being payable thereafter through 2085. It is actually 77 percent right away in 2036. Projected trust fund exhaustion is now 1 year earlier than in the 2010 report largely because of lower mortality and net immigration and a slightly slower expected economic recovery since the prior report.

Social Security total income, however, will continue to exceed expenditures, causing the trust fund assets to grow until 2023. But Social Security noninterest income is now expected to be permanently below cost starting 2010. This is 5 years earlier than expected a year ago. Positive net cash flow that hadn't been projected at less than $10 billion for each year 2012 through 2014 in the 2010 trustees report has been replaced with projected negative cash flow of less than 20 billion for each of these years in the current report, largely because of the economic recession having a slower recovery in our assumptions. While GDP grew 0.4 percent less in 2010 than expected a year ago, the average real earnings level of workers grew by 3.1 percent less for 2010.

Social Security and other trust fund programs are subject to special constraints that do not exist for other Federal programs. The trust funds have no borrowing authority in and of themselves, so these programs must always maintain a positive cumulative net cash flow, a positive asset level.

If trust fund assets were ever to become exhausted, payable benefits limited to the continuing revenue of the program. In the case of Social Security, only about 75 percent of scheduled benefits would be payable after 2035. Congress has always taken action in the past in order to prevent the precipitous drop in benefits that would be required if there were ever the exhaustion of a trust fund.

Budget scoring convention presumes that Social Security shortfalls after any trust fund exhaustion that might occur would be

made up with revenue from the general fund of the Treasury, requiring extensive borrowing from the public. In fact, the law would not permit this. If currently scheduled benefits are to be paid after 2035 for Social Security, the Congress will need to pass legislation providing more revenue. Graphs of the theoretical growth in the publicly held debt after trust fund exhaustion based on the presumption that full benefits would continue with additional revenue from the general fund of the Treasury may be impressive; however, the reality of a precipitous drop in benefits at trust fund exhaustion has actually proven historically to be a more certain motivation for congressional action.

The total Federal debt subject to ceiling includes the amounts the Treasury has borrowed from and owes both directly to the public and indirectly to the public through the trust funds. In the absence of asset accumulation by the trust funds in the past, the Treasury would simply have to have needed to have borrowed that much more directly from the public. The total debt subject to ceiling, therefore, depends entirely on the net cash flows of all the Federal programs that do not have trust funds. Changes in Social Security income and spending do not and will not have a direct effect on the total debt subject to ceiling, but they certainly do on the publicly held debt.

Again, thank you for the opportunity to come and talk to you today, and I will be happy to answer any questions.

[The prepared statement of Mr. Goss follows:]

PREPARED STATEMENT OF STEPHEN C. GOSS, CHIEF ACTUARY, SOCIAL SECURITY ADMINISTRATION

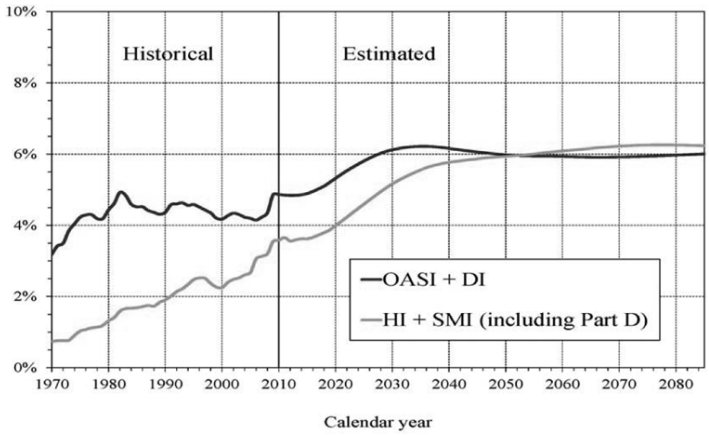
Chairman Ryan, Ranking Member Van Hollen, members of the committee: thank you for the opportunity to discuss with you today the fiscal status of these programs. The 2011 Annual Reports issued by the Boards of Trustees on May 13 have clearly laid out the projected future cost and financing for these programs under current law and our best assessment of future economic and demographic conditions.

We must consider two fundamental questions in developing any future changes for the Social Security and Medicare programs.

- The first relates to the level of cost for these programs in the national economy. This is simply a question of what we want from these programs and how much are we willing to pay. "Program sustainability" depends on our addressing both what we want and what we are willing to pay—and finding the balance that the American people desire.
- The second is whether scheduled financing is sufficient to pay the scheduled cost of these programs in the future. This is the "Trust Fund solvency" perspective and is the central focus of the annual reporting of the Trustees. The law requires that the Trustees report on the actuarial status of the Trust Funds.

Let me first address Program Sustainability, which may best be considered by looking at the cost of these programs expressed as a percentage of Gross Domestic Product (GDP).

Projected Cost of Social Security and Medicare as Percent of GDP



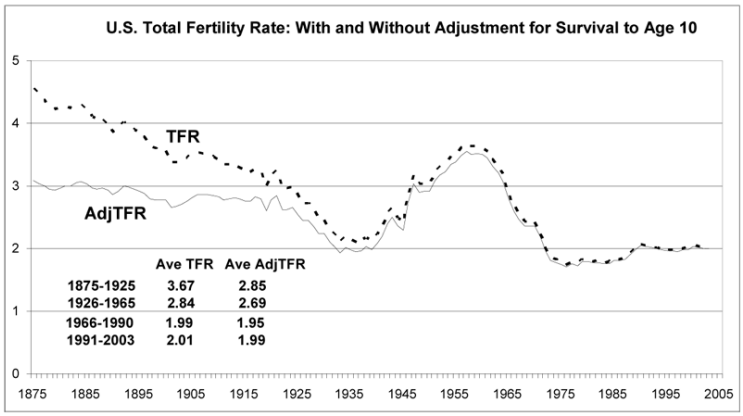
In 2008, prior to the effects of the recent economic recession, Social Security expenditures were 4.3 percent of GDP and Medicare expenditures were 3.2 percent of GDP. Social Security expenditures were essentially stable at about 4.3 percent of GDP from 1975 through 2008. Medicare expenditures rose from 1 percent of GDP in 1975 to 3.2 percent in 2008. The cost of both programs as a percent of GDP rose temporarily in 2009 due to the economic recession.

The fundamental Program Sustainability issue for these programs is illustrated by the projected future growth in cost as percent of GDP under the Trustees' intermediate assumptions. The cost of providing benefits scheduled in current law is projected to rise to about 6 percent of GDP for each of these programs by 2040. Social Security cost increases by about one-third and Medicare cost nearly doubles. The Congress, on behalf of the American people you represent, will need to decide whether (a) we are willing to pay 12 percent of GDP to maintain currently scheduled benefits, or (b) we will accept lower benefits at lower cost.

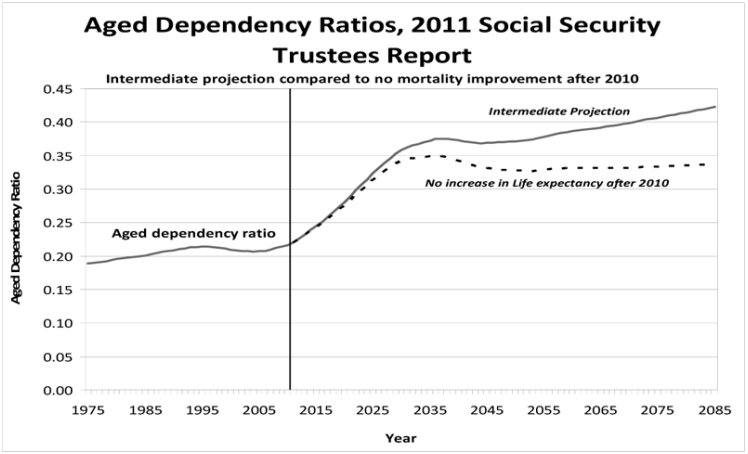
WHY IS PROGRAM COST PROJECTED TO SHIFT TO A NEW LEVEL BY 2040?

The projected shift up in cost by 2040 for both programs is largely due to the aging of our population. The "baby boomers" born in 1946 through 1965 will be moving from working age to retirement age during this period. However, the reason the population as a whole is aging is that birth rates dropped after 1965, leaving relatively fewer people entering the workforce just as the boomers are retiring. Lower birth rates are the cause of this substantial and permanent shift in the cost of Social Security as a percent of GDP from 2008 to 2040. Lower birth rates are also a large part of the cause for the increase in Medicare cost as a percent of GDP over the same period.

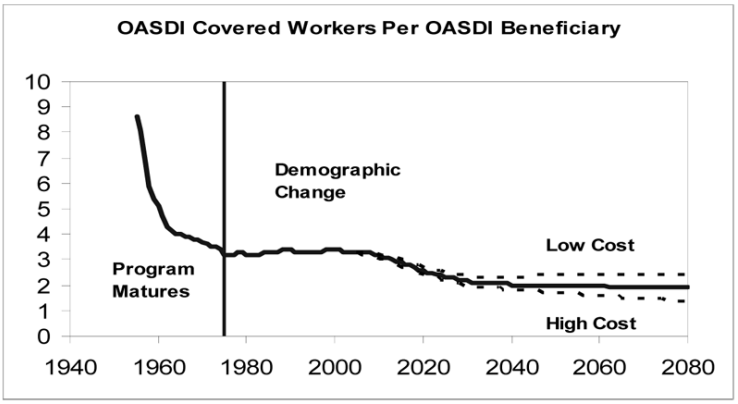
The adjusted total fertility rate (TFR) dropped from a long-term historical average level of about 3 children per woman surviving to age 10 to just 2 children per woman by 1975, and is expected to remain at this lower level. If birth rates had remained at around 3 children per woman after 1965, the cost of Social Security would not be shifting up in the future.



This drop in birth rates fundamentally changes the age distribution of our population for the future, meaning more people at age 65 and over compared to the number at working age, 20-64. (The ratio of population age 65 and over to that aged 20-64 is referred to as the aged dependency ratio.) Improving life expectancy has a much more gradual effect on this ratio.



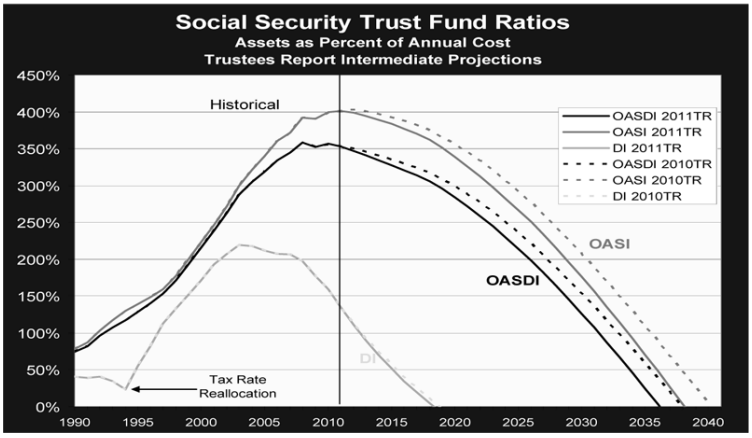
The changing age distribution of the population directly affects the numbers of workers we will have for each beneficiary in the future.



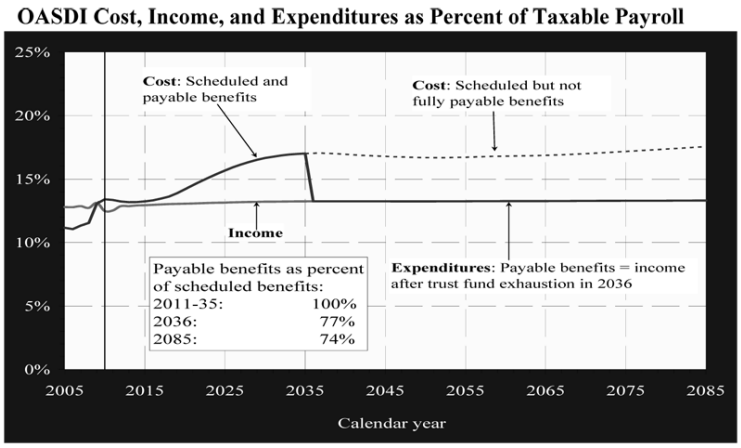
The timing of the level shift in the cost of these programs as percent of GDP and the timing of the increase in the ratio of aged to working age population is no coincidence.

TRUST FUND SOLVENCY

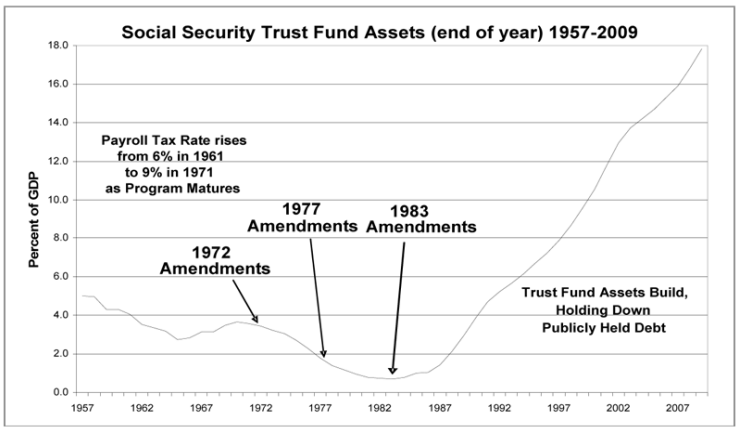
Solvency requires a positive level of assets in order to pay scheduled benefits. Unlike most other Federal programs, the "trust fund" programs have NO borrowing authority.



If a trust fund becomes exhausted, expenditures are limited to current revenue. For the Social Security OASI and DI Trust Funds this is critical. Should the combined OASI and DI Trust Funds become exhausted in 2036, only ¾ths of scheduled benefits will be payable.



This inability to borrow for the trust funds has forced congressional action in the past so that aggregate trust fund assets have always remained positive.



OASDI Trust Fund assets that were about 5 percent of GDP in 1957 declined to less than 1 percent of GDP by 1983, when the second of two major reforms was enacted to preserve solvency for the trust funds. Trust fund assets for OASI and DI have now risen to over 16 percent of GDP but will decline until exhaustion in 2036. Congressional action is needed again, before 2036, to maintain solvency for the OASDI Trust Funds.

For years after 2036, we need to either (1) increase OASDI income by one-third, (2) reduce scheduled benefit cost by one-fourth, or (3) enact some combination of these changes. Enacting changes relatively soon, even if the changes were not implemented for some years into the future, would provide advance notice for those who will be affected, and would remove uncertainty about the solvency of the program for the future. The 1983 Social Security Amendments provide a good example. These amendments included an increase in the normal retirement age that did not begin to be implemented until 17 years after enactment.

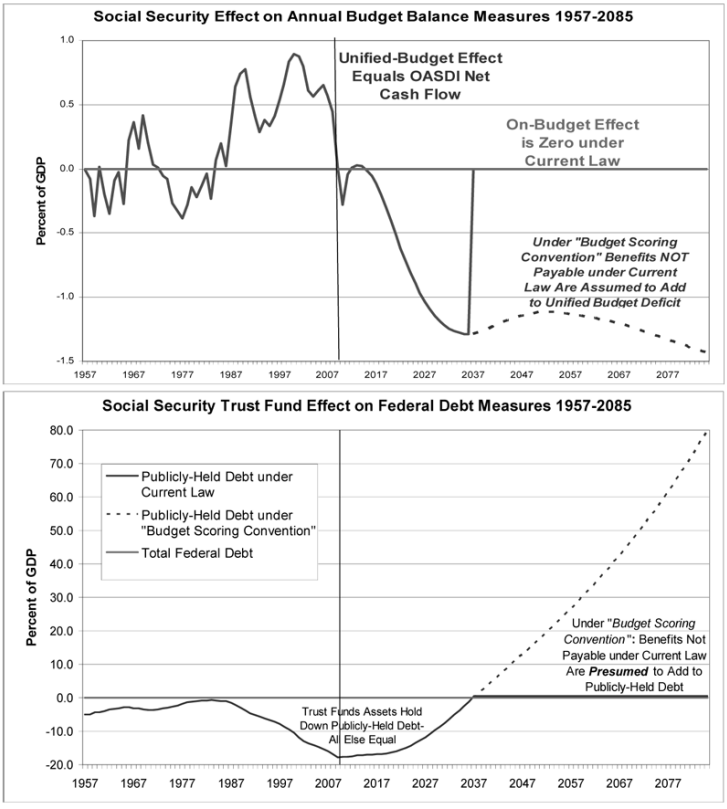
EFFECTS OF SOCIAL SECURITY ON THE FEDERAL BUDGET AND FEDERAL DEBT

There are two important facts to note about budget accounting for these trust-fund programs.

• First, assets in the trust funds have been borrowed by the rest of the government in lieu of additional borrowing directly from the public. Publicly held debt, currently about $10 trillion, is lower than the total Federal debt of about $14 trillion solely due to the borrowing from the trust funds. If the trust funds had not run cumulative surpluses, loaning $4 trillion to the Treasury, then the General Fund

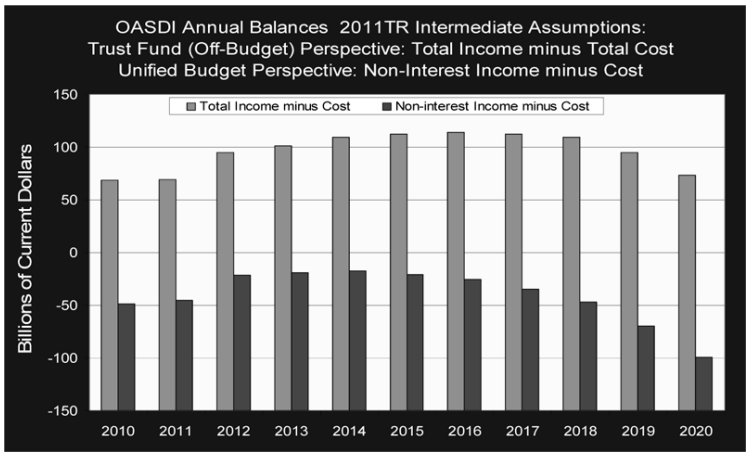
would now have $14 trillion in publicly held debt. Social Security financial operations and assets thus have no direct effect on either on-budget operations or total Federal debt subject to the ceiling.

• Second, the budget scoring convention that reflects shortfalls in Social Security financing after the trust funds are exhausted is inconsistent with the law. Because the trust funds have no borrowing authority, financial shortfalls after trust fund exhaustion would not be met. Such shortfalls would not cause either the increase in unified budget expenditures or the increase in publicly held debt that are presumed under budget scoring convention.

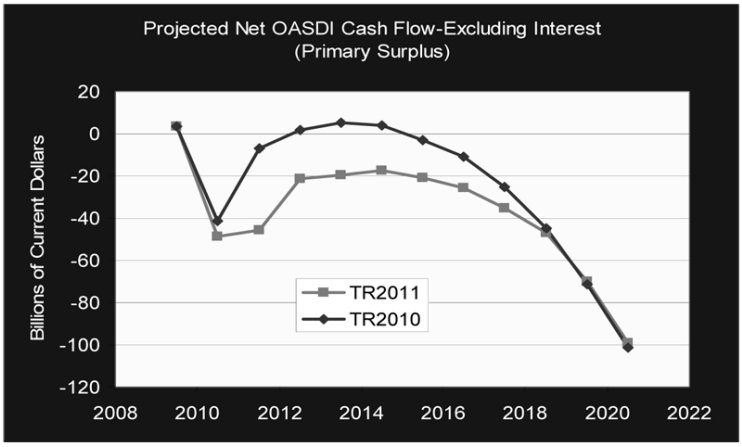


SOCIAL SECURITY FINANCIAL OPERATIONS IN THE 2011 TRUSTEES REPORT

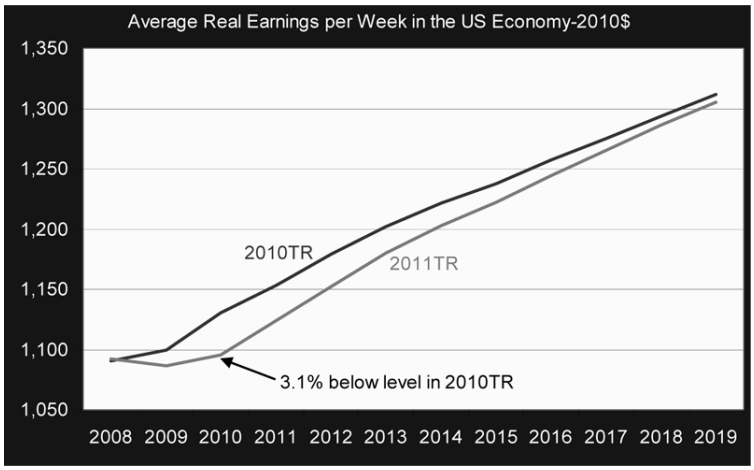
Total income for the combined OASI and DI Trust Funds, including interest, is projected to exceed program cost until 2023. Thereafter, the combined assets are projected to decline and become exhausted in 2036. OASDI net cash flow—excluding interest, consistent with a unified budget perspective—turned negative in 2010 due to the recent recession and slow recovery.



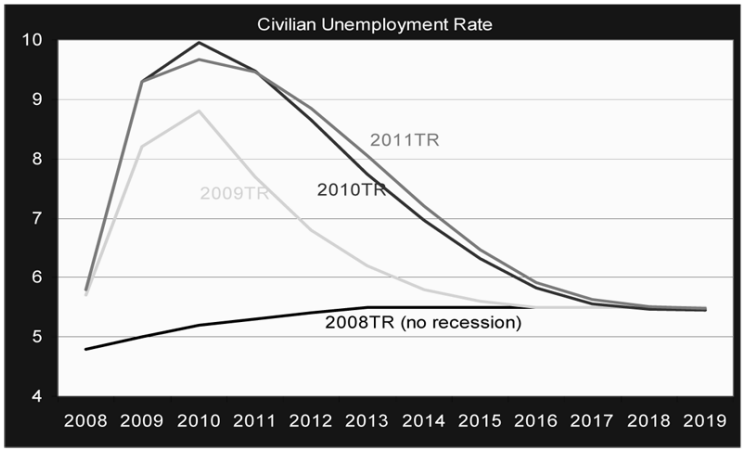
In the 2010 Trustees Report, a small positive net cash flow was projected for OASDI for 2012-14. Net cash flow in the 2011 report is projected at about $20 billion lower for each of these years due to slower economic recovery, principally due to lower levels of average real earnings for workers.



While real GDP for 2010 was 0.4 percent below the projection in the 2010 report, average real earnings turned out to be 3.1 percent lower than expected. For 2013, the 2011 report projects real GDP to be 1.6 percent lower and average real earnings to be 1.9 percent lower than in the prior report.

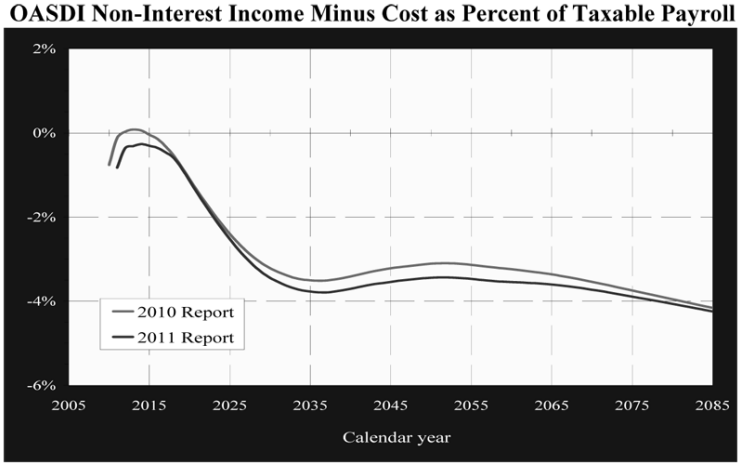


For the 2011 report, the Trustees assumed a slightly slower decline in the civilian unemployment rate, reaching the assumed ultimate average level of 5.5 percent by 2018.



Beyond 2020, OASDI annual balances (non-interest income minus cost as a percent of taxable payroll) are projected to be slightly lower for the 2011 report reflecting (1) lower than expected recent death rates for those age 65 and over and (2) lower than expected net immigration. Changes in life expectancy and net immigration explain most of the increase in the long-range OASDI actuarial deficit from 1.92 percent of payroll in the 2010 report to 2.22 percent of payroll in the 2011 report. These changes, along with the slower than expected economic recovery, resulted in projected trust fund exhaustion for 2036, one year earlier than was projected last year for the combined OASDI Trust Funds. The exhaustion date for the OASI Trust Fund is projected to be 2 years earlier, in 2038. The projected exhaustion date for the DI Trust Fund is unchanged at 2018.

OASDI Non-Interest Income Minus Cost as Percent of Taxable Payroll



CONCLUSION

We are at the beginning of a substantial and permanent shift in the age distribution of our population. The drop in birth rates from the long-time average level of about 3 children per woman through 1965, to just 2 children per woman since 1975, is responsible. By 2040, there will be only 2 workers for every OASDI beneficiary, down from 3 workers per beneficiary throughout the period 1975 through 2008. As a result, the cost of Social Security will shift from 4.3 percent of GDP in the period 1975 through 2008 to a stable level of 6 percent of GDP by 2040. Currently scheduled tax revenue will remain at about 4.5 percent of GDP. Program Sustainability will therefore require a choice to:

- Increase revenue by 33 percent after 2035,
- Reduce benefits by 25 percent after 2035, or
- Enact some combination of these changes

In the absence of legislation, the combined OASDI Trust Funds are projected to become exhausted in 2036, with only 75 percent of presently scheduled benefits being payable thereafter through 2085. Projected trust fund exhaustion is now 1 year earlier than in the 2010 report largely because of lower recent mortality and net immigration, and a slower than expected economic recovery.

Social Security total income will continue to exceed expenditures, causing the trust fund assets to grow, until 2023. Social Security non-interest income is now expected to be permanently below program cost starting in 2010, 5 years earlier than expected a year ago. Positive net cash flow of less than $10 billion for each year 2012–2014 projected in the 2010 Trustees Report has been replaced with projected negative net cash flow of less than $20 billion for each of these years. While real GDP grew 0.4 percent less in 2010 than expected a year ago, the average real earnings of workers grew by 3.1 percent less.

Social Security and other trust fund programs are subject to a special constraint that does not exist for other Federal programs. The Trust Funds have no borrowing authority, so these programs must always maintain a positive cumulative net cash flow—a positive asset level.

If trust fund assets were ever to become exhausted, payable benefits would be limited to the continuing revenue of the program. In the case of Social Security, only about 75 percent of scheduled benefits would be payable after 2035. Congress has always taken action in order to prevent the precipitous drop in benefits that would be required at exhaustion of a trust fund.

Budget scoring convention presumes that Social Security shortfalls after trust fund exhaustion would be made up with revenue from the General Fund of the Treasury, requiring extensive borrowing from the public. In fact, the law would not permit this. If currently scheduled benefits are to be paid after 2035, the Congress will need to pass legislation providing more revenue. Graphs of the theoretical growth in publicly held debt after trust fund exhaustion based on the presumption that full benefits would continue with additional revenue from the General Fund of the Treasury may be impressive. However, the reality of a precipitous drop in bene-

fits at trust fund exhaustion has actually proven to be a more certain motivation for Congressional action.

The total Federal debt subject to ceiling includes the amounts the Treasury has borrowed and owes both directly to the public and indirectly to the public through the trust funds. In the absence of the actual asset accumulation by the trust funds, the Treasury would simply have needed to borrow that much more directly from the public. The total debt subject to ceiling therefore depends entirely on the net past cash flows of all of the Federal programs that do not have trust funds. Changes in Social Security income and spending do not and will not have a direct effect on the total debt subject to ceiling.

Chairman Ryan, Ranking Member Van Hollen, and members of the committee, all in my office look forward to continued work with you and all members of the Congress in the development of legislation that will restore long-range sustainable solvency for the Social Security Trust Funds.

Chairman RYAN. Mr. Foster.

STATEMENT OF RICHARD S. FOSTER

Mr. FOSTER. Good morning, Chairman Ryan, Representative Van Hollen and distinguished committee members. Thank you all for inviting me to testify today about the financial outlook for the Medicare program. I am accompanied by Clare McFarland sitting behind me, who is the Deputy Director for Medicare and Medicaid——

Chairman RYAN. Pull the mic a little closer.

Mr. FOSTER. Sure. Clare McFarland, who is the Deputy Director for Medicare and Medicaid Cost Estimates in the Office of the Actuary.

Now, as you know, the health care cost growth generally exceeds that for the economy at large. This happens because health care costs grow in proportion to the number of people who are covered; the general inflation in the economy, in addition excess medical-specific inflation above and beyond general; as well as increases in the volume and the intensity or the average complexity of services that are provided. In contrast, the gross domestic product increases with the number of workers, with general inflation again, and also roughly with productivity gains in the economy.

Now, over the last 10 or 20 years, per capita health care cost growth has run about 1 to 2 percent faster than growth in the per capita GDP. As we look at Medicare specifically, over the last 10 years, the average annual increase in cost for Parts A and B combined of Medicare has been 7.6 percent, and that is a little less than 2 percent of that is due to growth in enrollment; in other words, the number of beneficiaries. That is a lot faster than the economy grew.

Over the next 10 years, however, we expect a much slower growth rate than we have seen in the last 10 years, in part because come January 1st, 2012, under current law we have to reduce payments to physicians by almost 30 percent. In addition, there are the Affordable Care Act savings provisions, notably the productivity adjustments to payment rate updates for most other kinds of health care providers, as well as the reductions in the Medicare Advantage payment benchmarks. Together these factors result in a slower rate of projected growth for combined A and B costs to about 5.3 percent on average over the next 10 years, and 3 percentage points of that is just in growth and enrollment as the baby boom retires.

In the longer range under current law, we now have Medicare costs in total that represent about 3.6 percent of GDP, and that is projected under current law to be about 6.2 percent at the end of the trustees' long-range 75-year projection period. Now, that is far lower than the level that was projected prior to the Affordable Care Act. On the other hand, it is still a 70 percent relative increase compared to today.

So if the current law payment provisions for Medicare are sustainable in the long run, then we are looking at a substantial improvement in the financial outlook for Medicare. But there is a lot of evidence that suggests some of these payment provisions will not be sustainable in the long range.

For example, Congress has overridden the physician payment reductions required in every year, in 2003 through 2011. And I will guess that you will be likely to continue doing that for some time to come.

Also, as I testified before your committee in January, the productivity adjustments under the Affordable Care Act could well lead to a situation where Medicare payment rates are just inadequate so that they may not be viable in the long range. If, in fact, these features do not prove to be viable, then the actual cost for Medicare will be much higher than projected under current law.

We have an alternative to current law, an illustrative alternative that the Board of Trustees asked to us to prepare to illustrate the extent to which costs could be understated under current law. Under this illustrative alternative, costs are projected in the long run to grow from their current level of about 3.6 percent of GDP to 10.7 percent by the end of the period, so that is about three times the current level.

So, in conclusion, the current-law Medicare projections do serve as a valuable indicator of the potential improvement in the financial outlook that could be achieved if the growth rates in health care costs can be slowed down as current law attempts to do. Moreover, the Affordable Care Act puts in place a very aggressive program of research and development to help find innovations in the delivery of health care and how we pay for health care through bundling of payments, through more integrated care, all with the goal of improving the quality of care and the cost-effectiveness of care. This is a great opportunity to design and test and implement meaningful, long-lasting reforms. They offer the potential for lower cost levels, without question, and some potential for lower growth rates. Now, until these are tested, however, we can't really have a good sense for what will actually happen, but research is a good idea.

I hope this information has been helpful to you all, and I look forward to continuing to work with all of you as you struggle with the financial challenges for beneficiaries and the budget from the Medicare program. Thank you.

Chairman RYAN. Thank you.

[The prepared statement of Mr. Foster follows:]

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

Chairman Ryan, Representative Van Hollen, distinguished Committee members, thank you for inviting me to testify today about the financial outlook for the Medi-

care program as shown in the 2011 annual report of the Medicare Board of Trustees. I welcome the opportunity to assist you in your efforts to ensure the future financial viability of the nation's second largest social insurance program—one that is a critical factor in the income security of our aged and disabled populations.

I would like to begin by saying a little about the role of the Office of the Actuary at the Centers for Medicare & Medicaid Services. We have the responsibility to provide actuarial, economic, and other technical assistance to policy makers in the Administration and Congress on an independent, objective, and nonpartisan basis. Our highest priority is to help ensure that policy makers have the most reliable technical information possible as they work to sustain and improve Medicare, Medicaid, and health care in the U.S. overall. The Office of the Actuary has performed this role on behalf of Congress and the Administration since the enactment of these programs over 45 years ago.

I am appearing before your Committee today in my role as an independent technical advisor to Congress. My factual statements, estimates, and other information provided in this testimony are drawn from the 2011 Medicare Trustees Report; any opinions offered are my own and do not represent an official position of the Department of Health & Human Services or the Administration.

The financial outlook for the Medicare program, as shown in the new Trustees Report, continues to raise serious concerns, in both the short range and the long range. Although the actuarial projections are much more favorable than those in the 2009 and earlier reports, as a result of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, a significant financial imbalance still remains for the Hospital Insurance (Part A) trust fund. In addition, key elements of current law are probably not sustainable—specifically, the "sustainable growth rate" formula for setting physician payment updates and the downward adjustments to payment rate updates for most other categories of health providers, based on economy-wide productivity growth. Should Congress find it necessary to override these factors in the future, as it has for 2003 through 2011 in the case of the physician payment rates, then actual Medicare costs would be substantially greater than projected in the Trustees Report under current law.

The purpose of the annual Trustees Report is first and foremost to evaluate the financial status of the Medicare trust funds, which must be done separately for each trust fund account since there is no provision for sharing financing or assets among these accounts. I recognize, however, that the Budget Committee's interest is primarily the overall cost of Medicare. I will first summarize the Trustees' findings for the separate accounts and subsequently address the overall cost of Medicare.

The Hospital Insurance (HI) trust fund once again does not meet the Trustees' formal test for short-range financial adequacy. The exhaustion of the HI trust fund is projected to occur in 2024, 5 years earlier than was projected in last year's Trustees Report, reflecting lower projected payroll tax income as a result of the 2008-2009 economic recession and higher levels of real (inflation-adjusted) expenditures. During 2008 through 2010, HI income fell short of program expenditures by a total of $54 billion, and these shortfalls are expected to continue in all future years under current law. Over the Trustees' long-range 75-year projection period, HI expenditures exceed scheduled tax revenues by an average of 0.79 percent of taxable payroll, primarily as a result of the retirement of the post-World War II "baby boom" generation. As described in more detail below, this actuarial deficit would be substantially larger if the productivity adjustments in current law could not be sustained.

There are two separate accounts within the Supplementary Medical Insurance (SMI) trust fund—one for Part B, which covers physician, outpatient hospital, and other ambulatory care, and one for Part D, which provides subsidized access to prescription drug coverage. Because of the annual redetermination of financing for both Parts B and D, each account will remain in financial balance indefinitely under current law. Expenditures from these trust fund accounts, however, are projected to generally continue increasing at a faster rate than the national economy and beneficiaries' incomes, raising concerns about the long-range affordability of scheduled financing.

In 2010, total Medicare expenditures were $523 billion or about 3.6 percent of gross domestic product (GDP). Under current law and based on the Trustees' intermediate set of economic and demographic assumptions, costs in 2020 would be $932 billion or 4.0 percent of GDP. Total Medicare expenditures would continue to increase somewhat faster than GDP in the long range, reaching 6.2 percent at the end of the 75-year projection period. If the scheduled reductions in physician payment rates were not implemented and if the productivity adjustments to payment updates

for most other provider categories were gradually phased out after the first 10 years, then Medicare costs would represent 10.7 percent of GDP in 2085.

BACKGROUND

Over 47 million people were eligible for Medicare benefits in 2010. HI, or Part A of Medicare, provides partial protection against the costs of inpatient hospital services, skilled nursing care, post-institutional home health care, and hospice care. Part B of SMI covers most physician services, outpatient hospital care, home health care not covered by HI, and a variety of other medical services such as diagnostic tests, durable medical equipment, and so forth. SMI Part D provides subsidized access to prescription drug insurance coverage as well as additional drug premium and cost-sharing subsidies for low-income enrollees. A Part D subsidy is also payable to employers who provide qualifying drug coverage to their Medicare-eligible retirees.

Only about 22 percent of Part A enrollees receive some reimbursable covered services in a given year, since hospital stays and related care tend to be infrequent events even for the aged and disabled. In contrast, the vast majority of enrollees incur reimbursable Part B costs because the covered services are more routine and the annual deductible was only $155 in 2010. Similarly, a large proportion of Part D enrollees have reimbursable prescription drug costs, given the common occurrence of prescriptions, the preponderance of zero-deductible plans, and the significant proportion of low-income enrollees, for whom the deductible does not apply.

The HI and SMI components of Medicare are financed on totally different bases. HI costs are met primarily through a portion of the FICA and SECA payroll taxes.[1] Of the total FICA tax rate of 7.65 percent of covered earnings, payable by employees and employers, each, HI receives 1.45 percent. Self-employed workers pay the combined total of 2.90 percent. Following the Omnibus Budget Reconciliation Act of 1993, HI taxes are paid on total earnings in covered employment, without limit. The Affordable Care Act introduced an additional 0.9-percent HI payroll tax on individuals and couples with earnings above $200,000 or $250,000, respectively, starting in 2013. Other HI income includes a portion of the income taxes levied on Social Security benefits, interest income on invested assets, and other minor sources.

SMI enrollees pay monthly premiums: $115.40 for the standard Part B premium in 2011 (although, under a "hold harmless" provision, most enrollees pay the same $96.40 premium that was effective in 2008) and an average premium level of about $30 for Part D standard coverage in 2011. For Part B, the standard monthly premium is designed to cover about 25 percent of program costs, with the balance paid by general revenue of the Federal government and a small amount of interest income. Starting this year, the Affordable Care Act requires fees on manufacturers and importers of brand-name prescription drugs, and these fees are allocated to the Part B trust fund account, reducing the need for premium and general revenue financing. Beginning in 2007, there is a higher "income-related" Part B premium for those individuals and couples whose modified adjusted gross incomes exceed specified thresholds. Beneficiaries exceeding the specified income thresholds pay premiums covering 35, 50, 65, or 80 percent of the average program cost for aged beneficiaries, depending on their income level, compared to the standard premium covering 25 percent. The resulting premiums in 2011 range from $161.50 to $369.10 per month. Part D costs are met through monthly premiums, which are designed to cover 25.5 percent of the cost of the basic benefit for an individual, with the balance paid by Federal general revenues and certain State transfer payments. The Affordable Care Act introduced income-related additional Part D premiums, ranging from $12.00 to $69.10 per month in 2011, which are paid by high-income enrollees in addition to their regular plan premiums.

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

Each component of Medicare has its own trust fund, with financial oversight provided by the Board of Trustees. My discussion of Medicare's financial status is based on the actuarial projections contained in the Board's 2011 report to Congress. Such projections are made for current law under three alternative sets of economic and demographic assumptions, to illustrate the uncertainty and possible range of vari-

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

ation of future costs, and cover both a "short-range" period (the next 10 years) and a "long-range" period (the next 75 years). The projections shown in this testimony are based on the Trustees' "intermediate" set of assumptions. 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.

As the Trustees and I have cautioned, it is important to note that the actual future costs for Medicare are likely to exceed those shown by the current-law projections. Congress is almost certain to override the approximately 30-percent reduction in Medicare payment rates to physicians that is scheduled to take place in 2012. In addition, it is doubtful that other providers will be able to improve their efficiency and productivity sufficiently to match the downward adjustments to Medicare payment updates based on economy-wide productivity. Since the provision of health services tends to be labor-intensive and is often customized to match individuals' specific needs, most categories of health providers have not been able to improve their productivity to the same extent as the economy at large. Over time, the productivity adjustments mean that the prices paid for health services by Medicare will grow about 1.1 percent per year more slowly than the increase in prices that providers must pay to purchase the goods and services they use to furnish health care to beneficiaries. Unless providers could reduce their cost per service correspondingly, through productivity improvements or other steps, they would eventually become unwilling or unable to treat Medicare beneficiaries. In this event, Congress would likely override the adjustments, much as they have done to prevent the reductions in physician payment rates otherwise required by the sustainable growth rate formula in current law.

It is possible that providers can improve their productivity, reduce wasteful expenditures, and take other steps to keep their cost growth within the bounds imposed by the Medicare price limitations. The implementation of payment and delivery system reforms, facilitated by the aggressive research and development program implemented by the Affordable Care Act, could help constrain cost growth to a level consistent with the lower Medicare payments. These outcomes are far from certain, however. As specific reforms have not yet been designed, tested, or evaluated, their ability to reduce costs cannot be estimated at this time, and thus no specific savings have been reflected in the Trustees Report projections for the initiative.

To help illustrate the degree to which the current-law projections potentially understate actual future costs, the Board of Trustees asked the Office of the Actuary to prepare short- and long-range projections under an illustrative alternative to current law that assumes (i) all future physician payment updates are based on the increase in the Medicare Economic Index, and (ii) the productivity adjustments for most other categories of providers are gradually phased out during 2020-2035.[2] My testimony includes the key results of these alternative projections.

FINANCIAL OUTLOOK FOR HOSPITAL INSURANCE (PART A)

Chart 1 shows HI expenditures versus income since 1990 and projections through 2020. For most of the program's history, income and expenditures have been very close together, illustrating the pay-as-you-go nature of HI financing. The taxes collected each year have been roughly sufficient to cover that year's costs. Surplus revenues are invested in special Treasury securities—in effect, lending the cash to the rest of the Federal government, to be repaid with interest at a specified future date or when needed to meet expenditures.

During 1990-1997, HI costs increased at a faster rate than HI income. Expenditures exceeded income by a total of $17.2 billion in 1995-1997. The Medicare provisions in the Balanced Budget Act of 1997 were designed to help address this situation. As indicated in chart 1, these changes—together with subsequent low general and medical inflation and increased efforts to address fraud and abuse in the Medicare program—resulted in a decline in HI expenditures during 1998-2000 and trust fund surpluses totaling $61.8 billion over this period. (Part of this decrease was attributable to the shift of a substantial portion of home health care costs to Part B, which improved the financial status of the HI trust fund but did not reduce Medicare costs overall.) After 2000, Part A expenditures and income converged slightly, as the Balanced Budget Refinement Act and the Benefit Improvement and Protection Act increased HI expenditures and the 2001 economic recession resulted in lower payroll tax income.

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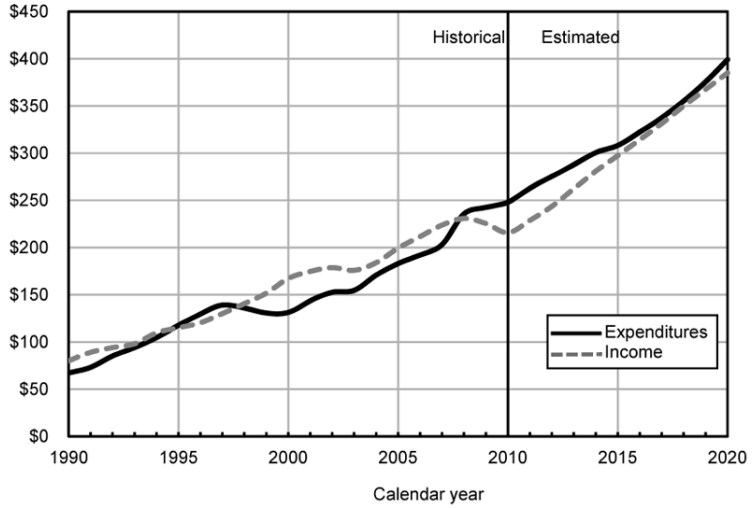
[2] The illustrative alternative projections are available at *http://www.cms.gov/ReportsTrustFunds/Downloads/2011TRAlternativeScenario.pdf*.

Chart 1—HI expenditures and income
(in billions)



Starting in 2004, the Medicare Modernization Act increased Part A expenditures through higher payments to rural hospitals and to private Medicare Advantage health plans. Costs continued to increase in 2008, reflecting a correction to an accounting system that had inadvertently resulted in the payment of some hospice benefits from Part B, rather than Part A, along with the increasing popularity of Medicare Advantage plans. The year 2008 also saw the start of a significant decline in payroll tax revenues, caused by higher unemployment and slow wage growth associated with the economic recession that began in late 2007.

HI expenditures are projected to increase at a much lower rate than usual during 2012-2020, due to the combined effects of continuing slow general inflation, the slower provider payment rate updates caused by the productivity adjustments, and a substantial downward adjustment in Medicare Advantage payment benchmarks and rebate percentages. Collectively, these factors contribute to a projected average annual cost growth rate of 4.9 percent through 2020, despite the advent of the baby boom generation reaching age 65 and qualifying for HI benefits during this period. About 3 percentage points of this increase are due to growth in the number of HI beneficiaries. For comparison, the average annual growth rate over the last 10 years was 6.6 percent, with enrollment growth contributing less than 2 percentage points to this average. Put another way, the per-beneficiary growth rate for the next 10 years is expected to be less than half of the rate over the last 10 years, principally as a result of the savings provisions in the Affordable Care Act.

At the same time, growth in HI revenues is projected to accelerate, in part as a result of an assumed economic recovery from the 2008-2009 recession (and subsequent weak economic growth) and in part because of the additional 0.9-percent payroll tax on high earners. Together, the slower expenditure growth and faster increase in HI tax revenues would significantly narrow the annual trust fund deficit over most of the short-range projection period.[3]

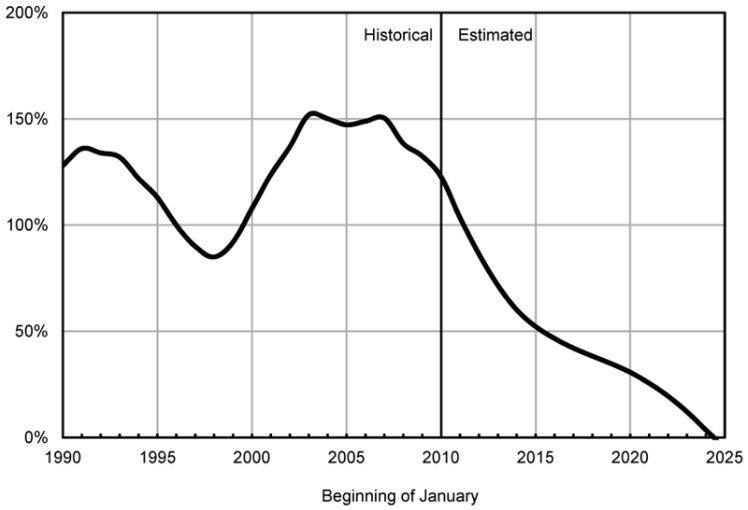
The Board of Trustees has recommended maintaining HI assets equal to at least one year's expenditures as a contingency reserve. As indicated in chart 2, HI assets at the beginning of 2011 represented 103 percent of estimated expenditures for the year, down significantly from the 150-percent level maintained in 2002-2007. Assets are projected to continue to decline steadily as a percentage of annual expenditures and to be exhausted in 2024. Redemption of trust fund assets, for use in covering annual deficits, requires a transfer of cash amounts from the general fund of the Treasury to the trust fund, thereby increasing the overall Federal Budget deficit.

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

Note also that while ongoing receipts from payroll taxes and income taxes on Social Security benefits would be sufficient to cover roughly 85 to 90 percent of HI expenditures after 2024, it is not clear that many health providers would be willing or able to continue furnishing services to beneficiaries under such circumstances. In any case, Congress has never allowed the HI trust fund to become exhausted.

Chart 2—HI trust fund assets

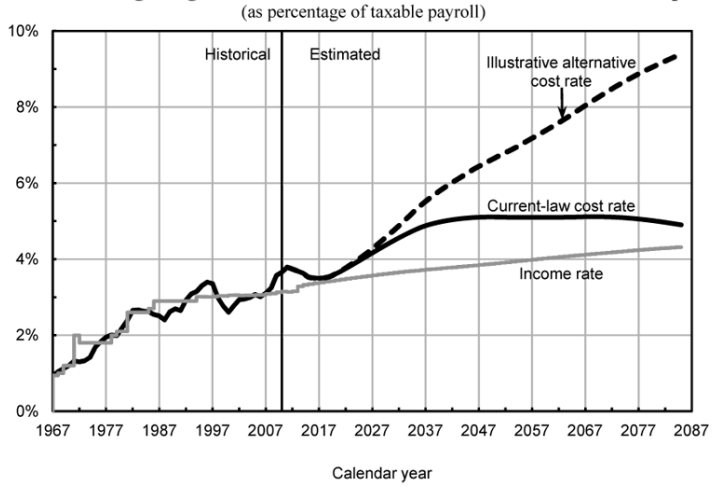
(assets at beginning of year as percentage of annual expenditures)



As noted, the projected exhaustion date for the HI trust fund is 5 years earlier than was shown in last year's report (2024 versus 2029). In the absence of the savings provisions of the Affordable Care Act, exhaustion would occur in 2016, or 8 years earlier. The projections under the illustrative alternative to current law, which assumes that the productivity adjustments are gradually phased out starting in 2020, are nearly identical to those shown in charts 1 and 2.

The interpretation of dollar amounts through time is very difficult over extremely long periods like the 75-year projection used in the Trustees Report. 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. Cost rates are shown for both current law and the illustrative alternative to current law. (The income rates are the same under both scenarios.)

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



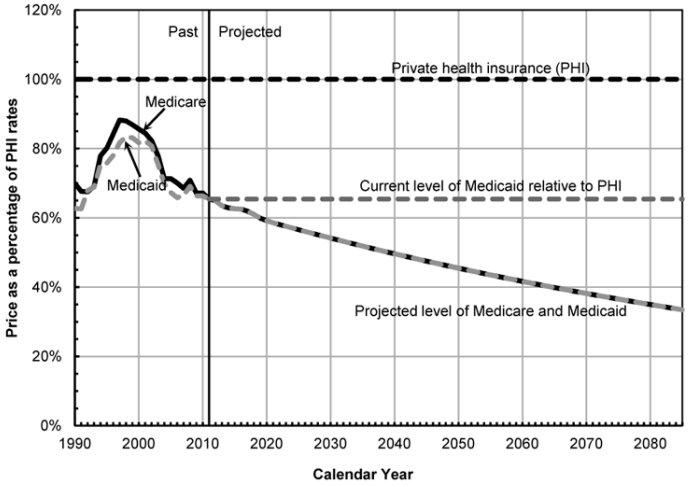
Past income rates have generally followed program costs closely, rising in a stepwise fashion as the payroll tax rates were adjusted by Congress. Although the HI payroll tax rates are fixed in law (at the standard total rate of 2.9 percent, plus the additional 0.9 percent for high earners), total income rates will increase because the income thresholds for taxes on Social Security benefits and for the 0.9-percent additional rate are not indexed. Over time, a growing proportion of Social Security beneficiaries have become subject to income taxes on their OASDI benefits. Similarly, an increasing proportion of workers in the future will have earnings above the $200,000/$250,000 thresholds established by the Affordable Care Act. By 2085, for example, an estimated 80 percent of workers would be subject to the additional 0.9-percent HI payroll tax.

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, and make other changes. Cost rates decreased significantly in 1998-2000 as a result of the Balanced Budget Act provisions together with strong economic growth. After 2000, however, cost rates increased, partly because of the Balanced Budget Refinement Act and the Benefit Improvement and Protection Act and especially in 2008-2010 as the recent economic recession and weak recovery reduced the level of taxable payroll.

Cost rates are initially projected to decline as the economy recovers and unemployment returns to more normal levels. Under current law, costs will increase as the baby boom generation becomes eligible for HI benefits in 2011-2030 but are projected to largely level off—and even decline somewhat—thereafter. This pattern results from the accumulating effect of the productivity offsets and other payment rate adjustments for Part A providers. For comparison, cost rates under the illustrative alternative projections increase rapidly throughout the long-range period, reaching 9.4 percent of taxable payroll in 2085, compared to only 4.9 percent under current law. Thus, depending on the long-range feasibility of the slower payment updates, scheduled tax revenues would be sufficient to cover about nine-tenths of HI expenditures (current law) or less than one-half (illustrative alternative).

This critical impact can be further assessed by comparing the relative level of HI payment rates to the corresponding prices paid by the Medicaid program and private health insurance plans. Chart 4 shows such a comparison for inpatient hospital services.

Chart 4—Illustrative comparison of relative Medicare, Medicaid, and PHI prices for inpatient hospital services under current law



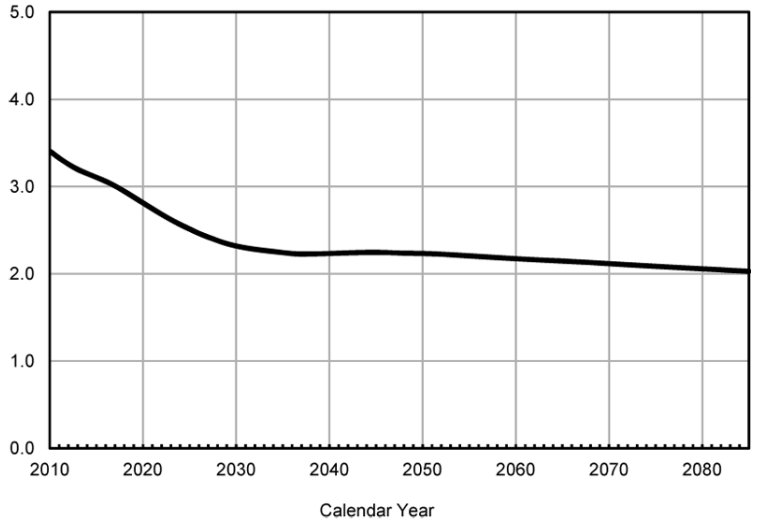
Medicare payment rates for inpatient hospital care in 2009 were about 67 percent, and Medicaid payment rates were about 66 percent, of those paid by private health insurance for their commercial plans. Under current law, Medicare and Medicaid payment rates are estimated to be approximately equal in 2011, and both are expected to decline in tandem relative to private health insurance payment rates over the next 75 years. The increasing differential between Medicare and private payment rates is due to the productivity adjustments in 2012 and later for the Medicare payment updates (and, to a lesser degree, to the other, smaller downward adjustments in 2010-2019 specified by the Affordable Care Act in addition to the productivity adjustments).[4] By the end of the long-range projection period, Medicare and Medicaid payment rates for inpatient hospital services would both represent roughly 33 percent of the average level for private health insurance. Medicare rates would be about one-half of the current relative level for Medicaid.

Per-beneficiary HI costs are normally expected to increase faster than per-worker tax revenues due to health care price inflation and increases in the utilization and intensity of services. Collectively, these factors generally exceed the growth in average earnings per worker, on which HI taxes are based. If the current-law productivity adjustments can be sustained, however, then per-beneficiary costs would likely increase more slowly than per-worker taxes.

Important demographic factors also contribute to the differential between HI income and expenditure growth rates. The effect of the baby boom generation on Medicare and Social Security is relatively well known, having been discussed by actuaries and others for almost 40 years. Basically, by 2030 when the baby boom cohorts have enrolled in Medicare, there will be about 65 percent more HI beneficiaries than there are today, but the number of covered workers will have increased by only about 15 percent. When the HI program began, there were 4.5 workers in covered employment for every HI beneficiary. As shown in chart 5, this ratio was about 3.4 workers per beneficiary in 2010. When the baby boom joins Medicare, the number of beneficiaries will increase more rapidly than the labor force, resulting in a decline in this ratio to about 2.3 in 2030 and 2.0 by 2085 under the intermediate projections. Other things being equal, there would be a corresponding increase in HI costs as a percentage of taxable payroll.

[4] For inpatient hospital services and some other categories of care, Medicaid payments are subject to certain upper payment limits (UPLs). For these services, total payments for all services in each category by a State Medicaid program cannot exceed what Medicare would have paid for the same care. The smaller UPL established by the Medicare rates forces a similar differential for Medicaid payments.

Chart 5—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. and is projected to continue doing so. The average remaining life expectancy for 65-year-olds increased from 12.4 years in 1935 to 19 years currently, with an estimated further increase to about 23 years at the end of the long-range projection period. Medicare costs are sensitive to the age distribution of beneficiaries. Older persons incur substantially larger costs for medical care, on average, than do younger persons. Thus, as the beneficiaries age, 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 PART B

Chart 6 presents estimates of the short-range outlook for the SMI Part B trust fund account. As noted previously, Part B premiums and general revenue income are reestablished annually to match expected program costs for the following year. Thus, barring exceptional circumstances, the program will automatically be in financial balance, regardless of future program cost trends.[5]

Historically, Part B expenditures have increased at a rapid pace in most years. The average annual growth rate over the last 10 years was 8.9 percent, for example, despite the modest increases in physician payment rates during this period.[6] (About 1.6 percentage points of this increase were attributable to growth in the number of enrollees.) In contrast, Part B expenditures are projected under current law to increase by 5.9 percent per year, on average, over the next 10 years. As noted in the Trustees Report, this projection is unrealistic in view of the very high probability that Congress will override the roughly 30-percent reduction in physician payment rates that is required on January 1, 2012 under the current SGR formula.

[5] The periodic odd patterns in projected revenues occur when the normal January 3rd payment date for Social Security benefits falls on a Saturday, Sunday, or holiday. In such cases, payment is advanced to the next earlier business day—which is generally December 31st of the prior year. This situation affected calendar-year Part B receipts in 2009-2010 and will do so again in 2015-2016.

[6] The increase in 2010, at 3.5 percent, was a notable exception to this trend. The reasons for this abrupt deceleration in Part B costs, which occurred across most types of services, are still being assessed.

Chart 6—SMI Part B expenditures and income

(in billions)

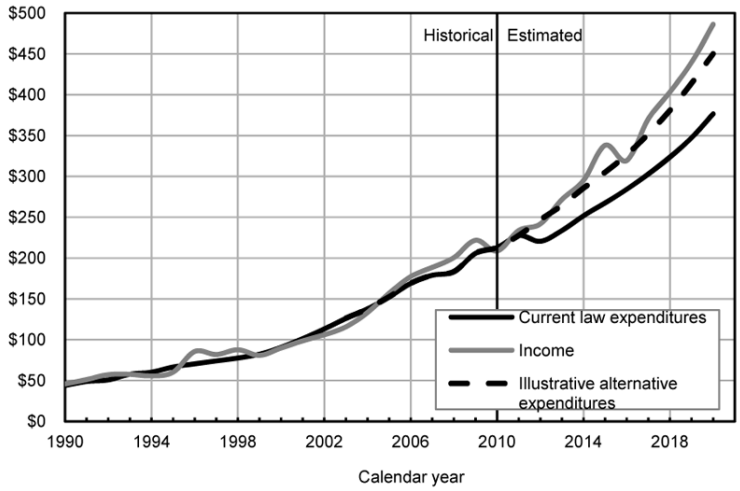
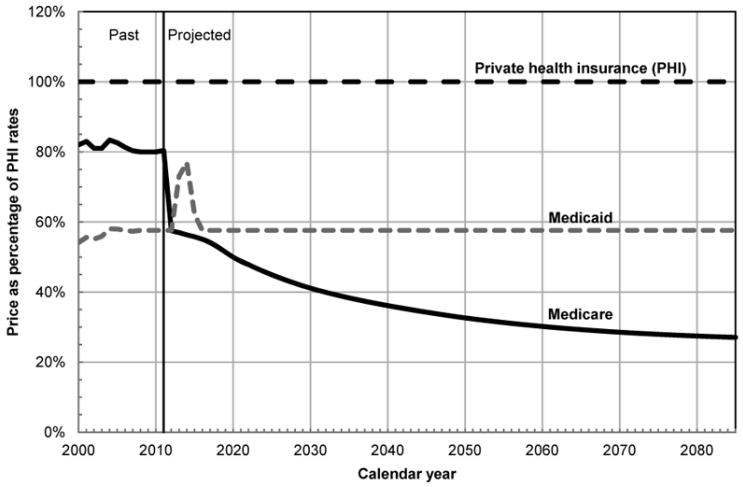


Chart 6 also shows projected expenditures under the illustrative alternative to current law, which would base physician payment updates on the Medicare Economic Index; the average annual growth rate in this scenario is 7.8 percent. (Both the current-law and illustrative alternative projections are affected by the productivity adjustments for other Part B providers and by the lower Medicare Advantage payment rates that are being phased in during 2012-2017.) As noted for HI, the retirement of the baby boom generation will increase the number of Part B enrollees by about 3 percent per year. Projected Part B income under the illustrative alternative scenario is very similar to the current-law levels shown below.

In past years, Part B income from premiums and general revenues has closely matched expenditures year by year, as would be expected given the annual financing basis for this part of Medicare. The projected future operations, however, show a sizable excess of income over current-law expenditures. In view of the near-certainty that Congress will act to prevent the 2012 reduction in physician expenditures, and will probably do so after financing is set for 2012, it is necessary to maintain a much higher contingency reserve than normal. In practice, if Congress continues to override the SGR formula, then actual Part B expenditures will more closely resemble the illustrative alternative projection, and the income-outgo relationship will be similar to that in past years.

Chart 7 compares projected future Medicare and Medicaid payment rates for physician services relative to private health insurance levels. Medicare payment levels in 2009 were about 80 percent of private health insurance payment rates, and Medicaid payment rates in 2008 were about 58 percent. In this illustration, Medicaid payment rates increase to 73 percent of private health insurance levels in 2013 and to 77 percent in 2014 and then return to 58 percent. Medicare physician payment rates decline to 57 percent of private health insurance payment rates in 2012, due to the scheduled reduction in the Medicare physician fee schedule of nearly 30 percent under the SGR formula in current law. (As noted, Congress is very likely to override this reduction, as it has consistently for 2003 through 2011.) Under current law, the Medicare rates would eventually fall to 27 percent of private health insurance levels by 2085 and to less than half of the projected Medicaid rates. The continuing slower growth would occur as a result of negative update adjustment factors caused by growth in the volume and intensity of physician services that exceeds the increase factor specified by the SGR formula.

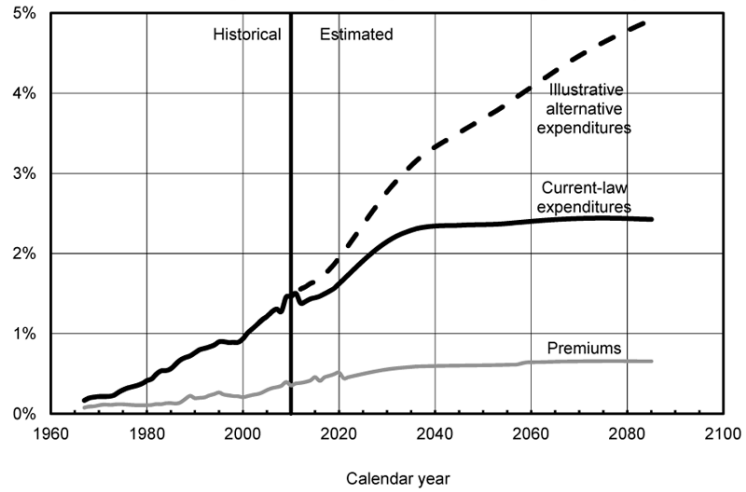
Chart 7—Illustrative comparison of relative Medicare, Medicaid, and PHI prices for physician services under current law



Although not shown, the relationship between Medicare, Medicaid, and private health insurance payment rates for outpatient hospital and most other non-physician Part B care would be similar to that shown in chart 4 for inpatient hospital services.

Chart 8 shows projected long-range SMI Part B expenditures and premium income as a percentage of GDP. Under present law, Part B beneficiary premiums will continue to cover about 25 percent of total Part B costs, with most of the balance drawn from general revenues. (Fees on manufacturers and importers of brand-name prescription drugs will provide up to $2.8 billion annually in 2019 and later, with varying amounts in 2011-2018. Over time, the fixed amount of Part B revenues from these fees will represent a declining share of GDP.)

Chart 8—Part B expenditures and premiums as a percentage of GDP



Under current law, SMI expenditures are projected to increase faster than the GDP as the baby boom generation becomes eligible for and enrolls in Part B. After 2030, however, costs as a percentage of GDP would be relatively level as a result of the statutory limits on physician payments and the compounding effects of the productivity adjustments for most other categories of Part B providers. As discussed

previously, the physician payment reductions are very unlikely to occur in practice, and there is considerable doubt about the long-range viability of the productivity adjustments. Under the illustrative alternative projection, Part B costs would continue increasing rapidly, reaching 4.9 percent of GDP in 2085 or a little over twice the level projected under current law.

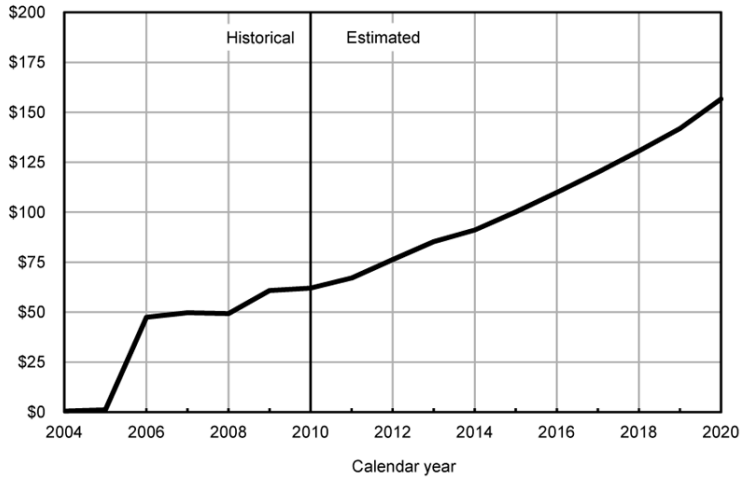
FINANCIAL OUTLOOK FOR SUPPLEMENTARY MEDICAL INSURANCE PART D

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

Chart 9 presents actual Part D costs in 2004-2010 and estimates through 2020.[7] Part D income and outgo have been, and will continue to be, in virtually exact balance automatically due to (i) annual adjustments of premium and general revenue income to match costs, and (ii) a flexible appropriation process under which general revenues are transferred to the trust fund account on a daily basis as needed to cover that day's outlays. As a result of this latter feature, there is no need to maintain a contingency reserve in the Part D account.[8] Because payments to Part D plans are established based on a competitive-bidding system, the program is not affected by the productivity adjustments; accordingly, projected costs for Part D are the same under both current law and the illustrative alternative.

Chart 9—SMI Part D expenditures and income

(in billions)



Over its short history to date (2006-2010), Part D expenditures have increased at an average annual rate of 6.9 percent (in part due to enrollment growth of 3.1 percent). A somewhat faster increase is projected over the next 10 years (9.7 percent, including enrollment growth of 3.0 percent), based principally on an expectation that the conversion from brand-name to generic prescription drugs cannot continue its very rapid pace for many more years. This change has contributed substantially to slower drug expenditure growth, for both Part D and other drug spending, but a sizable majority of Part D prescriptions is already filled by generic drugs.

[7] Part D financial operations in 2004 and 2005 related only to the prescription drug discount card and low-income transitional assistance. The full Medicare prescription drug coverage became available in 2006.

[8] Individual Part D plans maintain contingency reserves in case actual costs during the year exceed their expectations.

Actual Part D expenditure projections have been substantially lower to date than the original projections from 2003. This improvement has arisen primarily from three factors: First, starting in 2004, growth in total prescription drug expenditures in the U.S. slowed abruptly from what had been a decade and a half of double-digit increases to only a few percent per year. As noted, most of the slower growth in drug costs is believed to be attributable to the rapid expansion of tiered copayment arrangements in private health insurance plans, which provide a strong incentive for enrollees to switch to generic drugs. Part D plans also adopted these copayment arrangements, and the generic percentage for Part D is currently about 75 percent. This factor explains 54 percent of our overestimate of Part D costs. (The original estimates were made before this change in trend occurred.)

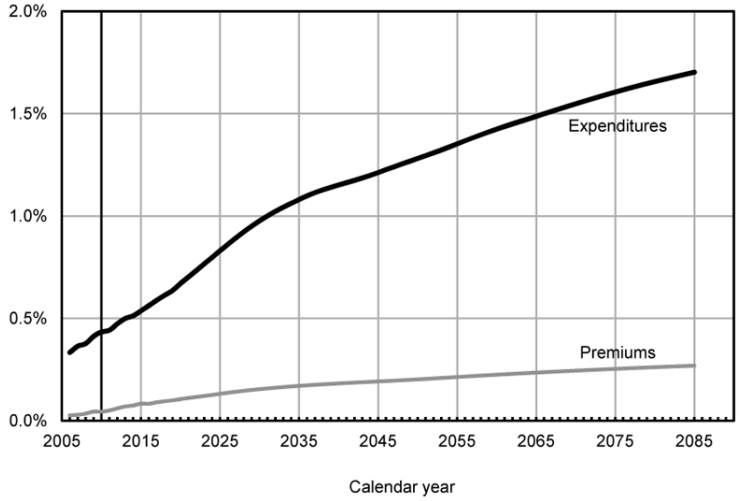
Next, in our original estimates, we expected strong competition among Part D plans, but we assumed it would take a few years for the competition to build up and reach its full level. In practice, the competition was strong from the very beginning, with negotiated retail discounts and manufacturer rebates achieving the best levels prevailing at that time almost immediately, rather than after a few years. This difference explains another 27 percent of the overestimate.

Third, in 2003 we anticipated that almost all Part D enrollees would enroll for coverage by January 1, 2006 so that they would have the insurance for the full year. Over a third of people did not sign up until well into the year, however, in part because of the extended first open enrollment period (which did not close until May 15). This factor had a relatively small impact on the overestimate since those beneficiaries who enrolled promptly in Part D tended to have higher-than-average drug expenditures. In addition, significantly more eligible individuals had credible coverage from other sources like the Veterans Administration or Indian Health Service than initially anticipated, based on the data available in 2003. Together, these enrollment factors explain 17 percent of the overestimate.

Finally, all other factors combined explain the last 2 percent of the difference between our original 2003 estimates for Part D and the subsequent actual experience.

Chart 10 shows projected long-range Part D expenditures and premium income as a percentage of GDP. As indicated, expenditures currently represent about 0.4 percent of GDP and are projected under the Trustees' intermediate set of economic and demographic assumptions to increase to 1.7 percent by the end of the long-range period. This increase reflects additional enrollees, as the baby boom generation reaches eligibility age, together with continuing growth in the prices, utilization, and intensity of prescription drugs.

Chart 10—Part D expenditures and premiums as a percentage of GDP



Part D beneficiary premiums are designed to cover 25.5 percent of the basic Part D benefit, on average. Because many enrollees qualify for the Part D low-income subsidy and do not have to pay full (or any) premiums, and because the low-income subsidy and retiree drug subsidy costs are not financed through premiums, total

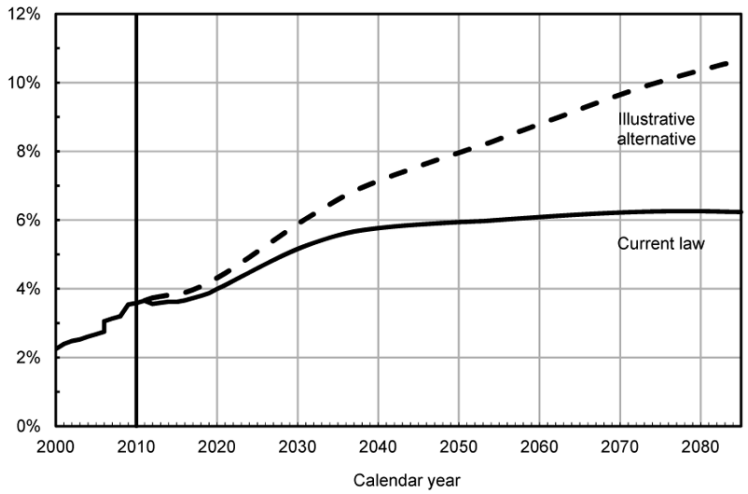
premium revenues currently represent about 11 percent of total Part D costs. The balance is paid by general revenues (79 percent) and State transfers (10 percent).[9]

Although the Part B and Part D accounts are automatically in financial balance, the rapid growth in combined SMI expenditures places an increasing burden on beneficiaries and the Federal budget. In 2010, for example, a representative beneficiary's Part B and Part D premiums required an estimated 13 percent of his or her Social Security benefit, and another 13 percent would be needed to cover average deductible and coinsurance expenditures for the year. In 2085, about 20 percent of a typical Social Security benefit would be needed to pay the Part B and Part D premiums, and about 26 percent would be required for copayment costs. Similarly, Part B and Part D general revenues in fiscal year 2010 equaled about 19 percent of the personal and corporate Federal income taxes that were collected in that year. If such taxes are set at their long-term, past average level, relative to the national economy, then projected Part B and Part D general revenue financing in 2080 would represent over 26 percent of total income taxes. Both the beneficiary and Federal burdens would be substantially greater in the future if the physician payment reductions were overridden and/or the productivity adjustments were phased out.

COMBINED HI AND SMI EXPENDITURES

The financial status of the Medicare program is appropriately evaluated for each trust fund account separately, as summarized in the preceding sections. By law, each account is a distinct financial entity, and the nature and sources of financing are very different between the trust funds. This distinction, however, frequently causes greater attention to be paid to the HI trust fund—and especially its projected year of asset depletion—and less to SMI, which does not face the prospect of depletion. It is also important to consider the total cost of the Medicare program, as shown in chart 11 under current law and the illustrative alternative to current law.

Chart 11—Medicare expenditures as a percentage of GDP



Under current law, combined HI and SMI expenditures are projected to increase relatively quickly from 3.6 percent of GDP in 2010 to 5.6 percent in 2035 and slowly thereafter to 6.2 percent in 2085. Absent the cost constraints imposed by the sustainable growth rate system for physician expenditures and the productivity adjustments to payment updates for most other categories of service, costs would continue to increase rapidly relative to the GDP. As indicated by the illustrative alternative projection, total Medicare expenditures would reach about 10.7 percent of GDP at the end of the long-range period.

[9] These percentages are estimates for 2011; the balance will shift somewhat over time as (i) the State requirement declines from 90 percent to 75 percent of the forgone cost of prescription drugs for full dual beneficiaries, and (ii) the majority of employer-sponsored retiree health plans transition from the Retiree Drug Subsidy (RDS) to Part D drug plans following the change in tax status of the RDS payments.

The Social Security Act requires a test of whether the difference between Medicare's total outlays and its "dedicated financing sources" is expected to exceed 45 percent of total outlays within the next 7 fiscal years.[10] As required under section 801 of the Medicare Modernization Act, the Board of Trustees has issued a determination of "excess general revenue Medicare funding" (the sixth such determination), since the ratio is estimated to exceed 45 percent in 2011 and 2012. These findings in the 2010 and 2011 reports trigger a fifth consecutive "Medicare funding warning." Section 802 of the MMA requires the President to submit to Congress, within 15 days after the release of the Fiscal Year 2013 Budget, proposed legislation to respond to the warning, and Congress is required to consider such legislation on an expedited basis.

Currently, most of the difference between Medicare expenditures and dedicated revenues is financed by the Part B and Part D general revenue transfers provided by law. The remainder of this difference equals the amount by which HI expenditures exceed HI tax income and premiums. This gap is currently being met by using the interest earnings on the assets of the HI trust fund and by redeeming a portion of these assets. The cash required for the payment of interest and the redemption of assets is drawn from the general fund of the Treasury. It is important to note, however, that there is no provision in current law to address the projected HI trust fund deficits once the fund's assets are depleted. In particular, it would not be possible to transfer general revenues to HI to make up the difference.

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

CONCLUSIONS

In their 2011 report to Congress, the Board of Trustees emphasizes the continuing financial pressures facing Medicare and urges the nation's policy makers to take steps to address these concerns. They also argue that consideration of further reforms should occur in the relatively near future, since the earlier that 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.

Although the current-law projections are poor indicators of the likely future financial status of Medicare, they serve the useful purpose of illustrating the exceptional improvement that would result if viable means could be found to permanently slow the growth in health care expenditures. The Affordable Care Act establishes a broad program of research into innovative new delivery and payment models in an effort to improve the quality and cost-effectiveness of health care for Medicare—and, by extension, for the nation as a whole. This process is in the early stages of development but offers an extraordinary opportunity to design and test alternatives with the potential to make quality health care much more affordable. Thus, the projections in this year's Medicare Trustees Report should provide an unequivocal incentive to vigorously pursue the development of effective and sustainable new approaches.

Thank you for this opportunity to meet with your Committee. I pledge the Office of the Actuary's continuing assistance to the joint effort by the Administration and Congress to determine effective solutions to the financial challenges facing the Medicare program. I would be happy to answer any questions you might have on Medicare's financial status.

Chairman RYAN. You know, Mr. Foster, when was the first year you did your appendix to the trustees report? Was last year the first year?

[10] The dedicated financing sources are principally HI payroll taxes, the portion of income taxes on Social Security benefits that is allocated to the HI trust fund, beneficiary premiums, the fees on manufacturers and importers of brand-name prescription drugs, and the special State payments to Part D.

Mr. FOSTER. I have been doing the appendices with my actuarial opinion statement since 1995 when I became chief actuary. The last 2 years they have had some extra language in there cautioning about the possible nonsustainability of current-law provisions.

Chairman RYAN. The way I read your appendix, at least in the last 2 years, and please correct me if I am wrong, it reads kind of like the way CBO describes their alternative fiscal scenario. CBO basically says that they think the alternative fiscal scenario is what is sort of more reality-based, what they think based on patterns in Congress, the SGR getting patched and things like this, but that is the more likely outcome of policy, and therefore they are projecting based on that.

Is that what you are attempting to do essentially with your appendix?

Mr. FOSTER. That is what we do with the illustrative alternative projection where we essentially assume what was perhaps a more sustainable approach for these provisions. In my appendix, in the certification statement, I have to certify that the projections are reasonable based on reasonable assumptions and methods. I say that they are for current law, but then I caution that current law may not be sustainable.

Chairman RYAN. Right.

Mr. FOSTER. And point people towards the illustrative alternative to current law.

Chairman RYAN. What is the 75-year unfunded liability under your alternative—you call it your alternative illustration?

Mr. FOSTER. Yes. The way you define it for budget purposes is not the same way we define it for trust fund solvency. But using your definition where you take the difference between hospital insurance income and expenditures in the long term—this is a long-range 75-year present value—and then you add to that the present value of the general revenues that are provided in current law to pay for Parts B and D, but for which there is no dedicated revenue source, if you take that definition, then the answer is $37 trillion as the present value over 75 years.

Chairman RYAN. What was that number last year in your appendix?

Mr. FOSTER. Similar, perhaps a little bit lower. I don't have it handy.

Chairman RYAN. Could you bring up chart 1? I see your chart number 4, which is your—in your testimony we have basically that chart. We just put it in color. Chart 4 and chart 7 in your testimony. Chart 1 here, which is chart 4 in your testimony, is the Medicare hospital reimbursement rates. You are showing us that Medicare and Medicaid hospital reimbursement rates are going from about 80 percent today down to 60 percent in 2020, and down to 33 percent at the end of the budget window.

Can you show us chart 2, please?

Then you are showing us physician payments are going down from 60 percent today to 33 percent, Medicare below Medicaid, starting in a few years.

Is this sustainable? I guess that sort of is the reason why you have this appendix. If Medicare is going to be paying providers at rates by which for every senior citizen walking in their door, walk-

ing into the hospital or the doctor's office, they lose money on each person, are they going to keep providing the benefit? And have you made calculations as to what that is going to do to the Medicare provider community with respect to whether they have negative margins, meaning bankruptcy, or not, and what are those projections as you carry these numbers out?

Mr. FOSTER. Yes, you had several questions in there.

Chairman RYAN. Yes. Feel free to take your time.

Mr. FOSTER. First, regarding these comparisons, we assume that private health insurance payment rates to their doctors and their hospitals and so forth would continue to be negotiated in an open market pretty much the way they are now. And then we compare the Medicare rates, payment rates, to those of private health insurance. Because of the productivity adjustments and some other reductions in growth rates within the Affordable Care Act for all the Part A providers, you get the pattern that you showed in the prior slide, and the figures you quoted were correct. And that assumes that, again, the private health insurance can't do something comparable to these mandated reductions in growth rates that are part of current law now for Medicare.

In looking at those, it is pretty hard to imagine that they could be sustainable, because when you think about it, the providers have to pay certain input cost increases. They have it to pay their workers somewhat more next year than they do this year. They have to pay higher energy costs. They have medical supplies. They have rent or leases that go up. And they don't get a break from the energy company just because Medicare is paying them a lower payment update. They still have to pay all of these input costs.

So what we are paying them in the future is the growth of their input cost—input price, excuse me—minus about 1.1 percent, representing the productivity gain in the economy overall. That accumulates, as we have seen in these charts, to quite a bit of a difference. That is why I have tried to raise concern about this and make sure that all of you are aware. You can monitor this and make sure that nothing bad happens, because as you pointed out, Mr. Chairman, if at some point our payment rates to providers become less or significantly less than their cost of providing services, they either will be unwilling or unable to continue providing services.

Now, before that happened, I think you all would have to act to override the productivity adjustments, much as you have had to do for the sustainable growth rate formula for physician payments. So I think that is the more likely scenario, but absence that, there could be very serious problems.

Chairman RYAN. What would your projection be on the amount of providers unwilling or unable as time goes on, say, 2030, 2050 as we go through this chart?

Mr. FOSTER. Well, we estimated—we did a simulation for hospitals, skilled nursing facilities and home health agencies looking at their actual cost report data and calculating that if everything else stays the same, just what would the impact of these slower provider payment updates have on their margins over time. I will confess I have forgotten the specific figures, but they are in our April 22nd memo that showed over even within 10 years a signifi-

cant proportion of these providers would go from positive margins to negative margins solely as a result of the slower payment updates. In the longer term in the trustees report it gets up to be over 40 percent of these providers would have to—would end up shifting to negative profit margins.

Chairman RYAN. Forty percent?

Mr. FOSTER. Yes, sir.

Chairman RYAN. Premium support is an idea that has been around for years. You have looked at lots of different plans. There is the 1999 Breaux-Thomas, there is Rivlin-Domenici, there is the Rivlin-Ryan, there is what we put in the House budget. I don't want to get into specifics of each plan because they all approach premium support in a slightly different way. And the design features of premium support are clearly something that is worth debating and negotiating and all of the rest. But each of these ideas share an underlying principle, and that is that a system requiring providers to compete against each other for a patient's business with more assistance for the poor and the sick and less for the wealthy can responsibly reform Medicare without compromising its role as a vital safety net program.

I want to get your basic framework thoughts on this. Do you think a system set up along these kinds of design features can achieve savings in Medicare while continuing to provide for a basic Medicare benefit?

Mr. FOSTER. As a general rule, certainly. These kinds of premium support approaches have been discussed now many times over many years. There have been different designs. Most the premium support proposals have used an approach not unlike Medicare Advantage where there is payment benchmark that plans are tested against. And if a plan can come through with more efficiency and a lower cost than that benchmark, then participants in that plan will get a cheaper premium, and the plan would benefit and Medicare would benefit from the lower cost.

On the other hand if a plan is less efficient and has a cost above the benchmark, then the beneficiary would have to pay most of the extra difference or all of it. Those plans would be less attractive.

So we have estimated for many years that the competition among plans in a premium support setting like this could have advantages and lead to somewhat lower costs for Medicare. It can get to you the lowest cost consistent with good quality of care. It may or may not help a lot with the cost growth. In other words, you might go from a starting point here down to a lower level because of the competition, but they both might grow at a similar level. It is much harder to attack the growth rates.

If you build into a plan like this, a different approach for pay in the support which has an index built in that is typically lower than the expected premium growth or the cost of health care, then you can address the cost growth issue, but then you get into all the issues of do the premium support payments remain adequate over time.

Chairman RYAN. So the secret then is, which has been vexing all of us from both sides of the aisle, how do you get at the root causes of cost inflation? So we shouldn't—what I am getting from you is we shouldn't delude ourselves that Medicare reform fixes every-

thing in health care. It can help fix Medicare problems, but unless you address the underlying root cause of health inflation, you really can't fix these problems at the end of day. Is that not the case?

Mr. FOSTER. Yes, I would agree with that. If you look at the causes, the underlying causes, of health care cost growth, income is a big part of it. The richer we are, the better health care we want, and the better health care we can afford. That problem kind of takes care of itself, because if costs are going up comparable to our incomes, then the overall cost is similar to growth in the GDP, and nothing gets harder to handle. But often, of course, is goes up faster than that.

Another of the major factors driving health care costs is technology.

Chairman RYAN. Yes.

Mr. FOSTER. We all want the best possible medical care, and the research and development community is more than willing to invent new techniques, and treatments, and drugs and so forth, and often they are pretty expensive.

Chairman RYAN. And on our fee-for-service model, that sets the incentive structure for them just to keep billing and keep billing and keep adding to the cost, because they just get reimbursed on a fee-for-service schedule.

Would you agree that perhaps a better lying incentive structure where the provider community on technology has a research and development incentive to provide better costs, cheaper devices that have more value? Do you believe that under the right incentive structure, you could put in place sort of a virtuous cycle, productivity improvement and innovation, working to bend the cost curve versus the status quo as we now know it today?

Mr. FOSTER. Yes, I think it is possible. To date there has been very little incentive to focus on cost-reducing technology. Most of it has been cost-increasing, with some exceptions.

To the extent that you send a signal to this research and development sector that things have changed, we can no longer afford to pay for every new thing that comes along, even if it is only marginally an improvement that costs 10 times as much, we can't afford to do that anymore. Hopefully they will get the message and turn their considerable abilities to cost-reducing techniques. So premium support can be consistent with that approach. Traditionally fee-for-service is typically not.

Mr. PASCRELL. Mr. Chairman, I have a question.

Chairman RYAN. When you have your time.

Mr. PASCRELL. You have time. Would you yield?

Chairman RYAN. No.

Mr. PASCRELL. Thank you, Mr. Chairman.

Chairman RYAN. You are welcome.

Mr. Goss, a quick one. Some have argued that because Social Security is able to pay full benefits until 2036, action now is not necessary. You hear this more and more these days, which is there is no problem, don't have to worry about it, not until 2036.

I think we know what happens then if nothing is done, but give us a sense of the cost of delaying and the sense of how gradual reforms would be if we do it now versus how severe they would be if we delay. And what is the growth in the unfunded liability on

average on a year-to-year basis?How much deeper of a hole are we digging ourselves every year we delay fixing this problem? Because it is a pay-as-you-go system, 10,000 boomers retiring every day with far fewer workers following them in the workforce. It is the same problem with Medicare. What kind of hole are we digging ourselves if we don't do anything, and how gradual versus how severe are we looking at based upon when we decide to do something?

Mr. GOSS. Thank you. Excellent question.

I think it is really the same for Medicare as it is for us. Our unfunded obligation, we project, over the next 75 years, which is for the shortfalls in the years 2036 through 2085, is about $6.5 trillion in present value as of 2011. In fact, if we waited 5 years to enact changes from now, the present value of that shortfall as of 2011 would still be $6.5 trillion. The shortfall is what it is over the period.

Indeed, the real advantage of enacting something soon—and I would emphasize enacting something soon as opposed to acting per se—is that it really gives people advance warning, allows you many more options to consider, and allows you the ability to phase things in more gradually over time. It is possible that we could just simply follow present law, wait until 2036, do nothing, and allow benefits to drop by 23 percent precipitously for everybody receiving benefits in Social Security. If we really did nothing, in 2018 very, very much sooner, our Disability Trust Fund will become exhausted, and we would have a 14 percent reduction in benefits.

Chairman RYAN. In 2018?

Mr. GOSS. In 2018. That is the date where we are projecting——

Chairman RYAN. Fourteen percent.

Mr. GOSS. A 14 percent reduction in disability insurance benefits would be what would be required because we would only have the continuing revenue coming into that fund. So that is actually our sort of "most soon date" that we are concerned about at this point.

There are many remedies for that to get OASI and DI back on track together, but our sense is, and we have always emphasized and our trustees have always emphasized, enacting relatively soon allows you, the Members of the Congress, more options to consider; allows you to give people advanced warnings of the changes that will be coming, whether it be more taxes or lower benefit levels; and also allows you to phase in the changes more gradually, which is really important.

Chairman RYAN. Thank you.

Mr. Van Hollen.

Mr. VAN HOLLEN. Thank you, Mr. Chairman, and thank you both for your testimony.

Let me just pick up on the Social Security questions here just so I understand this. With respect to the disability portion of Social Security, what you are saying is we would be required to make essentially a transfer of some of the trust fund revenues to that component of the program in the near future; is that right?

Mr. GOSS. Well, we could do that. Under the law we cannot do that at this point. We had a similar situation in 1994, where the DI Trust Fund, the split insurance was exhausting very quickly, and the OASI Trust Fund had plenty of money, and we simply had

a reallocation of tax rates without changing the total tax rate for OASI and DI combined. The same could be done in order to get the solvency of the DI Trust Fund and OASI Trust Fund back together.

Mr. VAN HOLLEN. And your testimony with regard to 2035 and 2036, that testimony involved all components of the trust fund, correct?

Mr. GOSS. That is assuming that we do not let the DI Trust Fund——

Mr. VAN HOLLEN. I just want to make it clear. We are not talking about adding to the problem; your numbers already assume we have addressed that issue.

Mr. GOSS. Exactly.

Mr. VAN HOLLEN. Which we can the way you said. Thank you.

Just with respect to Social Security, there has been a piece of legislation that was introduced recently by two Members of the Republican leadership to privatize Social Security. Have you had a chance to look at that?

Mr. GOSS. I believe you might be referring to the SAFE bill?

Mr. VAN HOLLEN. Yeah. This is legislation introduced by Congressmen Hensarling and Sessions.

Mr. GOSS. We took a quick look at that. We have not done a formal estimate on that, but our sense is that particular proposal as put forth is perhaps incomplete and not fully formed.

As it is described, it would give people the option to begin to have their portion, half of their payroll taxes, directed to an account, and after 15 years to have the entirety of their payroll taxes directed to an account, including the employer's share also. And the cost to them would be that they would never get any benefits, they or their dependents.

The problem in terms of the solvency of Social Security is that the reduction in payroll taxes for people who chose the option would occur right away; the reduction in benefits might occur with a 20- or 30-year delay. So this would put a considerable additional negative effect on the solvency of Social Security and would cause or trust fund exhaustion date to be earlier than 2036.

We have dealt with several other proposals that would have some of the features. All of them, including the proposal put forth by Chairman Ryan, have in the past dealt with this issue by coming up with additional sources of revenue.

Mr. VAN HOLLEN. I understand, but I am talking about this particular piece of legislation. Just so I understand your testimony, it would accelerate the insolvency of the Social Security Trust Fund, correct?

Mr. GOSS. It would absolutely, yes.

Mr. VAN HOLLEN. Just turning to the Medicare issue—and, Mr. Foster, thank you for your testimony and expertise on this issue. You recognized in your testimony that there are lots of features in the Affordable Care Act that allow us to experiment with new incentives for the provision of care to focus more on coordination of care rather than sort of the volume of care that is incentivized in some way in fee-for-service. And we had a lot of testimony yesterday from Secretary Sebelius, and I think everybody recognizes that those changes need to be made.

If you repeal the Affordable Care Act, you, of course, eliminate the authority to move forward with those changes; do you not?

Mr. FOSTER. Yes, sir.

Mr. VAN HOLLEN. Let me just ask you with respect to the Medicare Trust Fund, because clearly we need to make the kind of changes to address those issues. But I think there is also a lot of misunderstanding about the Medicare Trust Fund. So just so people understand, the Medicare Trust Fund relates just to Medicare Part A; does it not?

Mr. FOSTER. There is a separate Medicare Trust Fund for Part A. There is another trust fund for Parts B and D. Each have their own separate accounts within that trust fund.

Mr. VAN HOLLEN. Okay. But with respect to the payroll tax, your Medicare payroll tax, those revenues are directed for Part A; is that correct?

Mr. FOSTER. That is correct.

Mr. VAN HOLLEN. Okay. And when we talk about the year 2023, creating an issue with the solvency of a trust fund, that is what we are referring to, correct?

Mr. FOSTER. Yes, sir.

Mr. VAN HOLLEN. We are not referring to Parts B or D, correct?

Mr. FOSTER. That is right. Those by their design for financing, barring some extraordinary circumstance, should never go broke.

Mr. VAN HOLLEN. Right. And there was a deliberate decision by the Congress, correct, for example, with Part D prescription drugs, to fund it out of general revenue, either current revenues or through deficit spending, correct?

Mr. FOSTER. Yes. The primary form of financing for Part D is general revenues. There is also premiums paid by enrollees and special State payments, since the cost of drugs for dual-beneficiaries transferred from Medicaid to Medicare.

Mr. VAN HOLLEN. Right.

Now, we had a conversation, and you made the point and I think the chairman made the point we need to address some of the cost structures and incentives in the whole entire health care system. And if I could just put up a chart here that shows—these are the per enrollee increases in health care costs. And as you can see, the average increase in a cost for the Medicare per beneficiary has been lower than in the private market, where it has been considerably higher. So essentially if you were to say to someone who is enrolled in the Medicare program they had to go out and get their insurance in the private market, they would be facing substantial costs; would they not?

Mr. FOSTER. That question leads to a not straightforward comparison of the advantages and disadvantages of each form, private health care plans versus Medicare fee-for-service, and each one does have advantages and disadvantages. Comparisons of this type are a little difficult. You have done a couple things that are very good. First of all, it is per capita rather than just total aggregate expenditures.

Now, something else I would recommend, and this may or may not have been done here, is to do this for a similar package of benefits. For example, Medicare only gained drug coverage starting in

2006, so over some longer period of time, you end up counting drugs for Medicare some of the time and not the rest of the time.

The other thing is that if I read this correctly, this is based on 2002 to 2009.

Mr. VAN HOLLEN. Correct.

Mr. FOSTER. Over long periods of time, they tend to grow similarly, with Medicare at a slightly slower rate, as much as a percent slower on average, which is a good difference. But over subperiods it can be quite a bit either way.

Mr. VAN HOLLEN. Right. No, I understand. I mean, if you look at the 50-year cycle, as you said, Medicare outperforms the private market on the per enrollee cost structure by about 1 percent, but in recent history, in fact, you see the numbers here. And I think there is general agreement here that we should reduce—try and reduce health care costs throughout the private market.

Now, you raise some issues there as to what some of the potential negative consequences would be in doing that. One would be to provide less incentive for research and development into new treatments and technologies, and maybe focusing more resources on providing care with the existing treatments; is that correct?

Mr. FOSTER. Well, I mentioned that it would be nice to get the benefit of technology the way most other sectors of the economy have for computers and cars and televisions, and many other things have gotten relatively less expensive over time because of technology. For health care we tend to get more and better new things and much more expensive. If the same approach were applied to developing less expensive treatments, for example one-time-use implantable defibrillators rather than many-time-use defibrillators, that can be a good thing and help us save money.

Mr. VAN HOLLEN. Absolutely. Just on the point—I am going to finish with this because of the confusion. If we go to the next slide, and I want to make it very clear that we all know in this committee we face a big challenge on the future of Medicare. We have a very big difference of opinion on how to address it. But I think in our conversations about trust funds and payroll, we need to make clear a couple things.

This chart is taken from the data in your current report with respect to the shortfall. And when we are talking about the Part A Trust Fund, which is—you know, a lot of language we hear all relates to the solvency of that trust fund in 2023; does it not?

Mr. FOSTER. Yes, that is correct.

Mr. VAN HOLLEN. Okay. And so when you are looking at that specific component over the 75-year period, and you want to fully fund that, that is the—this represents the shortfall, does it not, in Part A?

Mr. FOSTER. That looks about right. I can't see the figures from here. But it is correct that under current law if all the provisions for the payment rates are sustainable in the long range, then the problem to solve is not nearly as big as it used to be. It is of that order of magnitude.

Mr. VAN HOLLEN. And just for illustrative purposes—and we did the calculation, and this is for illustrative purposes only—in order to close the shortfall in the Part A, in the trust fund, what we all refer to as the trust fund, you would have to increase the Medicare

payroll tax from 2.9 percent to 3.69 percent. Again, I am not recommending that proposal, but for illustrative purposes people need to understand that when we are talking about solvency of the Part A Trust Fund, which is what most of the conversation has been about, that is what we are talking about.

Now, everything in blue is funded out of general revenue, correct?

Mr. FOSTER. This is hospital insurance?

Mr. VAN HOLLEN. With the possible exception of some—let me correct that. Yes, it is. No. This is Medicare expenditures.

Mr. FOSTER. This is Medicare total. Okay. A lot of the blue then is general revenues, a lot of it is payroll taxes, a lot of it is premiums.

Mr. VAN HOLLEN. Premiums. And the premium component. And there is no doubt there is a challenge, so we address that challenge in two ways. One, we have to make the reforms in the system; again, big differences on how do you it. And then as part of the broader conversation, you have to discuss the revenue component, and no one should be—I don't think anybody should be kidded into thinking you can solve this problem realistically on the revenue side. You can't.

On the other hand, revenue, it should be part of this discussion, just like when you are talking about dealing with Social Security solvency, what—how much income is subject to payroll tax as part of the income. So I just wanted to use this chart for the purposes of people understanding that when we are talking about trust fund solvency, we are really talking about that red sliver up there with respect to the Medicare payroll taxes.

Thank you very much, Mr. Chairman.

Chairman RYAN. Mr. Campbell.

Mr. CAMPBELL. Thank you, Mr. Chairman.

I will yield to the chairman.

Chairman RYAN. Yeah. I just want to get in the Medicare cost—we have a chart from CBO, table 3, a long-term report that shows four time horizons. Three out of those four time horizons, Medicare's cost growth per capita grew faster than other health insurance. When you widen the time horizon, it doesn't make the case that Medicare always costs less per enrollee than other health care. The only point I would make also is, look, if you pay providers 80 cents on the dollar, of course it is going to cost less, but you are paying them 80 cents on the dollar.

I would also say if we just focus on the Part A Trust Fund which is going insolvent, we are ignoring the much larger liabilities. Part B and Part D, that is over 20 trillion in the trustees report of unfunded liability as well.

So it is important to look at the blue and the red because the entire system taken together, from the testimony we heard yesterday from the economists, 51 percent of Medicare is being cashflowed by the general fund, bonds, we are borrowing. And so I don't think anybody is arguing that that is a sustainable situation. I think it is very clear the sooner we deal with this problem, the better off everybody is. If you just underpay providers, yeah, it is going to cost less, but are providers going to keep providing the benefit, I think, is the question.

With that, thank you.

Mr. CAMPBELL. Thank you.

I am just going to focus in my reduced time here a couple of questions on understanding better just where we are and what the straight-line solutions are.

First, Mr. Goss, we have a positive cash flow if you put both trust funds together right now. When do you project that turns negative?

Mr. GOSS. In terms of cash flow where we do not include the interest that is credited to the trust funds in 2010, we turn to a negative cash flow for the combined OASI and DI Trust Funds. We actually were at a negative cash flow situation for the Disability Insurance Trust Fund starting in 1990—starting in 2005. But as of 2010, on a combined basis, they have going to negative cash flow. But the amount of interest that is credited the trust funds exceeds that cash flow shortfall and will continue to through 2022.

Mr. CAMPBELL. And if we were to continue, when you say the trust fund is exhausted in 2036, that, I presume, means in 2036 then, payments of—Social Security payments would have to be reduced to whatever the income was at that point?

Mr. GOSS. Precisely, solely because our trust funds under the law do not have the authority to do any borrowing. That would mean that at that point when we had 77 cents of tax revenue coming in for every dollar's worth of scheduled benefit, we would only have that much amount of money. We would have to—somebody would have to make a decision as to how we would pay benefits.

Mr. CAMPBELL. If you wanted to increase payroll taxes today just on a straight-line basis to make both trust funds solvent within your 75-year window, what percentage increase in taxes would that take?

Mr. GOSS. It would require an increase in the payroll tax rate from 12.4 by about a little over 2 percent of payroll. So that would be about a one-sixth increase in payroll taxes, from 12.4 up to 14.6, roughly.

Mr. CAMPBELL. Okay, all right. Thank you very much.

Mr. Foster, currently what percentage of total Medicare expenditures are covered by Medicare taxes?

Mr. FOSTER. I can calculate that for you. It is most of it.

Mr. CAMPBELL. It is more than 50——

Mr. FOSTER. Certainly. Well, if you count the payroll taxes, and if you are talking about Part A only, or are you talking about total——

Mr. CAMPBELL. The whole system.

Mr. FOSTER. Okay. The payroll taxes would be a smaller proportion, but it would be in the neighborhood of 35 or 40 percent of the total.

Mr. CAMPBELL. Okay. There is something in law that says that—that triggers that the President is supposed to issue some solution at a certain point. Are we at that point? What is that point? And has the President proposed something?

Mr. FOSTER. Yes. What you are referring to is a formal test instituted by the Medicare Modernization Act in 2003, which says if you take the difference between total Medicare outlays and total Medicare dedicated revenues, if that difference is expected to reach 45

percent of the total cost within 7 years, then the trustees have to issue a determination of excess general revenue Medicare funding. If you get two such determinations in two successive reports, that triggers a Medicare funding warning. Then—we issued the fifth such one with this current report. Then the President has the obligation to issue proposed legislation——

Mr. CAMPBELL. And final question, because I am—I just had to—have you done any projections that assume—you talk about current law, but that assume that we do not lower physician reimbursement rates and that the Medicare reductions that are in the ObamaCare law don't go into effect?

Mr. FOSTER. Yes, generally. That is the basis of our illustrative alternative to current law.

Mr. CAMPBELL. Thank you.

Chairman RYAN. Ms. Schwartz.

Ms. SCHWARTZ. Thank you.

I just want to get to Medicare, but just a couple things I did want to follow up on the Social Security.

First let me say I agree with and want to associate myself with the opening comments of the ranking member in terms of a balanced approach as we move forward, and that applies to our deficit reductional role, that we need to be able to look at tax expenditures as well; and to only look at spending, whether it is nondefense discretionary, whether it is Medicare—Social Security is its own piece—is really just not a balanced approach, and we really need to have everything on the table. So I appreciate his comments and want to echo them.

And I think the last few answers actually suggest that even when we are looking at Social Security and Medicare, that we need a balanced approach, and the balanced approach that allows to us look both at cost savings and potential for other revenues would be a way to approach it to really look at everything on the table.

I did want to, again just following up on the discussion about Social Security, there was some discussion about just for illustrative purposes what percentage you would need to increase the tax in order to get to solvency, and you did answer that question of having to go 2.9 to 3.69. Again, that is just illustrative purposes. I just want quickly if you just answer, because I do want to get to Medicare, if you could just answer that.

There are other options there as well. The cap on the payroll income that applies—that taxes are applied to. For example, have you looked at other opportunities for ways we might be able to bring in some additional revenues so maybe the cuts don't have to be so drastic or that we can increase the solvency of the trust fund?

Mr. GOSS. We certainly have. One other clarification Rick and I were just talking about is going from 2.9 to about 3.7. That is the Medicare Part A.

Ms. SCHWARTZ. I am sorry, and it was 12.4?

Mr. GOSS. Also it would be 12.4 up to about 14.6 would be an immediate tax rate increase on the payroll tax that would be sufficient to——

Ms. SCHWARTZ. But if we didn't want do a tax rate increase at all, there are other options.

Mr. GOSS. If we didn't want to do that, there have been several other possibilities that have been considered. One would be to instead of raising the tax rate on the earnings up to our current taxable maximum, which is 106,800, would be to, in fact, raise that taxable maximum itself. Now, that would be, in fact, an increase in the tax rate from nothing to 12.4 for the earnings above that.

One popular proposal that has been put forth in many places by both the fiscal commission, the President's fiscal commission, and by the Domenici-Rivlin Commission would be to gradually raise the payroll tax rate—but to raise the taxable maximum up to cover not ultimately about 83 percent, but about 90 percent.

Ms. SCHWARTZ. Which is where it started.

Mr. GOSS. Which is where we were back in 1983, 1984. That would solve about a third of our long-term problem. If we eliminated the taxable maximum entirely, as is the case for the Medicare 2.9 percent, that would basically eliminate our 75-year shortfall.

If I may, just one other item that I would want to mention, another revenue-enhancement proposal that has been put forth actually in Chairman Ryan's proposal and was picked up in the Domenici-Rivlin proposal for the Bipartisan Policy Center was to tax employer-sponsored group health insurance premiums, and that would cover about half of our long-term shortfall.

Ms. SCHWARTZ. Thank you. I appreciate the fact that there are other options for us to explore.

I don't have a lot of time left, but I really appreciate both of you adding really good information about why we are in some of these situations. We anticipated all the baby boomers in Social Security Trust Fund. Good, smart move. For some reason we did not in Medicare. It seems to be that those same seniors are surprised, to the Medicare Trust Fund. The additional—it is almost a doubling, not quite. So going from 40 million to almost 74 million seniors who will be covered under Medicare, and that demographic—simple demographic change is certainly a very significant burden particularly since we are seeing fewer workers.

I just want to know if you could in a little time do this: Speak to the Republican proposal to end Medicare as we know it and to create a voucher program at the same time we will have these 74 million seniors in the old—in the current system under Medicare, and particularly if the Republicans were successful at their second goal, which is to repeal the Accountable Care Act and take away all of the cost savings that are available potentially. You talked about, Mr. Foster, incentivizing payments that would reduce costs and improve quality. What does that do to our deficit? Does that not explode the deficit over the next 10 to 20 years?

Mr. FOSTER. On the latter question, the Affordable Care Act clearly had major savings provisions for Medicare in it. We estimated the first 10 years a total of $575 billion between lower expenditures and/or higher taxes. So if that were repealed, you would have to do something else.

Ms. SCHWARTZ. What about the notion of having this double group? I would be interested in knowing your answer to that. My time is up.

Chairman RYAN. Mr. Price.

Mr. PRICE. Thank you, Mr. Chairman. And I want to thank the witnesses as well for enlightening us today.

Our colleagues on the other side of the aisle and Ms. Schwartz just stated as well, talked about our desire to end Medicare. The fact of the matter is what our proposal does, as you all well know, is to save Medicare, and she categorizes it as a voucher program. As you also know, it is not a voucher program at all. It is program of premium support, which is remarkably different. In fact, it is something that was actually proposed toward the end of the Clinton administration by friends of folks on the other side of the aisle.

I want to ask a number of questions. First I want to follow up on Mr. Campbell's line, Mr. Foster, about the 5 straight years of this Medicare warning that has been issued, and at the end—when have you 2 of those years in a row, then it is the obligation, is it not, of the President to then make some kind of recommendation about how you get out of this situation of having Medicare in such dire financial straits, correct?

Mr. FOSTER. Yes, sir. Section 802 of the Medicare Modernization Act puts in a requirement for the President to recommend ways to address——

Mr. PRICE. And have you received any recommendations from this President on that?

Mr. FOSTER. Not to my knowledge.

Mr. PRICE. Thank you.

You also stated in your testimony that the Medicare payment—quote, "the Medicare payment may be inadequate," unquote, as it relates to physicians and other providers. As a physician we talk about numbers all day long, but what happens when Medicare payments are inadequate?

Mr. FOSTER. We would like not to find out. But as you can imagine, especially in your situation, but any of us, if we have a job, if we are paid a certain amount for the services or the goods we provide, and what we are paid ends up not being adequate to keep us in business, then we are going to go out of business or turn our business elsewhere. So the potential access problems could be very serious. I mean, we see with the Medicaid program, of course, in some States the payment rates particularly for physicians are quite low, and access to care is quite a problem.

Mr. PRICE. So the access that patients have to physicians may be markedly limited.

Mr. FOSTER. Well, if the 30 percent reduction went through, for example, come January 1st, I think there would be a noticeable reaction, very noticeable.

Mr. PRICE. We had Secretary Sebelius here yesterday to talk about, and other witnesses to talk about the Independent Payment Advisory Board, the IPAB, which I think I believe is a "denial of care" board to seniors. Isn't it true that the largest hammer that they have is to deny payment to physicians for services that are being proposed to be rendered or have already been rendered; is that correct?

Mr. FOSTER. They have the authority to make recommendations for payment rates, not just for physicians but for other providers as well. They can do some other things in addition, but the other ones are less clear as to their effect.

Mr. PRICE. But they have the authority—would have the authority to deny payment for a certain service or a certain procedure?

Mr. FOSTER. That I am not so clear about. In other words, there is language in the law that governs what kinds of recommendations they can make and not make. In terms of a specific procedure, for example, they clearly can't deny care for the treatment of heart disease. Could they deny care for a particular method of treating heart disease that they deem to be of little value? That I don't know.

Mr. PRICE. I think that is the case. So that patients and physicians would no longer be the ones making the decision about whether or not that occurs, it would be this Board. Now if in fact the Board denied payment for a service, then isn't that the same kind of thing that you referred to earlier, which is when the Medicare payment is inadequate?

Mr. FOSTER. Well, in this hypothetical you get the same result. The whole point of Medicare is to provide health care to older people and disabled people.

Mr. PRICE. In my few brief seconds left, I just want to touch on your report that you have offered here, currently assumes the effects of the health reform bill passed last year on Medicare, correct?

Mr. FOSTER. Yes. The current law projections assume all current elements in current law.

Mr. PRICE. And under these assumptions when the Medicare Part A Trust Fund be exhausted?

Mr. FOSTER. Under current law the Part A would be exhausted in year 2024.

Mr. PRICE. So the program itself right now is unsustainable under current law, and changes are necessary?

Mr. FOSTER. Yes. Certainly the Part A part, and you can argue and have a fun time with the other parts.

Mr. PRICE. Thank you.

Chairman RYAN. Mr. Blumenauer.

Mr. BLUMENAUER. Thank you. I'm just following up on what Dr. Price was talking about where there may be some decision about certain procedures for heart treatment that conceivably could be restricted or modified in some form. Isn't that what happens with private insurance right now? Doesn't private insurance set standards about what they will reimburse? They go over doctor billings, they don't cover every procedure that a patient or a doctor may want? Isn't that the case?

Mr. FOSTER. I would say that is correct, not only for Medicare but also Medicaid and for private health insurance.

Mr. BLUMENAUER. I want to clarify that that is not unique to government. Private insurance sets standards about they negotiate rates or they disallow some treatment if they don't think it is effective or it is not within the scope. Isn't that what happens every single day?

Mr. FOSTER. Every payer of health care has medical review boards that decide what things are covered and payable and what things are not. Very few things are denied, I might add. Yeah, I will stick with that.

Mr. BLUMENAUER. We will have some fun with that later.

Mr. FOSTER. Okay.

Mr. BLUMENAUER. Insurance companies do set rates, they allow some things, they deny others. But let's—I want to get to the notion here, you and I have talked before, you think that some of the things that is in the Affordable Care Act is not sustainable politically. I find it interesting that the cuts that would take—the burden that would be assumed from day one, where it is all of a sudden 60 percent of the premium liability increasing over time in terms of the dollar, out of dollar pocket, is equally unsustainable, maybe more so, but we have difficulty evaluating that.

I want to get to one area where I think your expertise should be undeniable, and that is looking at trend lines. Now, Mr. Ryan said that there were some periods that you could pick that showed that it might be higher or lower. My understanding is for the last 40 years private insurance premiums have been going up 9.3 percent, on average.

Mr. FOSTER. I can check that figure for you.

Mr. BLUMENAUER. Would you please?

Mr. FOSTER. I don't know the answer off the top of my head.

Mr. BLUMENAUER. My question is how is that sustainable? I would love to see a chart from you about what would happen if we are going to load all our senior citizens into the private insurance market. But we just take the trend line for the last 40 years where it is above inflation, it is significantly above the increase in productivity of what we have had in the past or anybody thinks we are going to have in the future, and I would like you to chart what that looks like in 2075. If we are going to put all our eggs in that basket, if we could just have one chart that shows, given a rate of the last 40 years of what private insurance premiums or health care costs are going to be in 2075 compared to inflation and compared to increase in national productivity.

Mr. Chairman, I am going to suggest that that chart is going to be very vivid. I mean, you throw things up over time about our entitlements aren't sustainable. No quarrel. But the path we are on now is worse. And if we are going to play that game, I think we ought to at least look at what it is going to be in 2075 if, absent the efforts in the Affordable Care Act, which used to be bipartisan to control cost—and I think ultimately we will do this when we get through the games over the next 2 or 4 years—but just model your plan, entire private sector based on 40 years' experience, compared to the increase in productivity. And I think that that is not on the charts that you give us, and I think it is going to be a very vivid portrayal of why wishing away the dynamic that we have all been wrestling with for 40 years, and politicians have blinked time and time again, and they will on SGR, that is why we have an iPod or whatever it is, to try and stiffen——

Chairman RYAN. This is an iPod.

Mr. BLUMENAUER. Excuse me. IPap, I guess it is, because I think this is an iPad. But I think that will be a very vivid illustration of why—my time is up. Okay.

Chairman RYAN. I was into this.

Mr. BLUMENAUER. So was I, so was I. I appreciate the correction of the terminology.

Chairman RYAN. Mr. Lankford.

Mr. LANKFORD. It would be interesting to note as well, how much of a cost shift there has been because of the lower reimbursement rates of Medicare, that they to pick up additional in the private insurance market, and how the private insurance market is not only paying their tax for Medicare but also paying as well an additional amount in their insurance rates to help cover the costs of Medicare. But we will be able to track that as well from there.

Let me ask you a question about Social Security. You made a very stark statement, Mr. Goss, about the disability. 2018 is very, very close. The stats I was looking at show that disability has grown, from 1990 to the present, by 420 percent with this very rapid rise in disability. Can you tell me why that we have this rapid rise?

Mr. GOSS. Well, in fact the disability insurance program is in a sense a preview of what is going to be happening to our retirement portion of the program. The baby-boom generation—and we talk about the baby-boom generation as the baby boom principally because the birth rates dropped so much after them. If birth rates had stayed higher they wouldn't look so much like the boom. But the fact that we have the baby-boom generation, born 1946 through 1965, they in fact are people who are I think today between ages 44 and 65. Those are precisely the ages at which we have the bulk of our people receiving disability insurance benefits now. So we are right now sort of at the apex or at the height of the point where the baby-boom generation is creating the surge, the highest level, arguably relatively speaking, for disability insurance costs. The rate of growth in disability insurance should be expected to be slower in the future and an aggregate level in percentage of GDP.

Mr. LANKFORD. Do you have an idea when that slows down?

Mr. GOSS. That should be slowing down just in the next couple of years. Actually our incidents rates of disability on an age/sex-specific basis has not been growing that much. It is largely that our population under 65 has been shifting, because of the baby boom, towards being many more in the ages that are prime disability.

Mr. LANKFORD. This is very helpful. Thank you.

Let me ask you a question, Mr. Foster. I am still trying to wrap my head around the estimates currently that we are facing with 2024 insolvency of Part A. That assumes, to get that number, we have to cut doctors' reimbursement 30 percent or just not fix it, basically, on this 30 percent amount.

Mr. FOSTER. If could I jump in?

Mr. LANKFORD. Sure, please do.

Mr. FOSTER. Slight correction. Physician payments come out of the Part B accounts.

Mr. LANKFORD. I'm sorry.

Mr. FOSTER. So it doesn't affect Part A.

Mr. LANKFORD. Okay. So then you said there is a reduction in payments in the Affordable Care Act. How does that involve the Part A?

Mr. FOSTER. It affects all Part A providers and will reduce their rate of growth in the payment updates each year by about 1.1 percent per year. So instead of an update of maybe 3.3 percent, it might be 2.2 percent.

Mr. LANKFORD. I was in a meeting in June with Secretary Geithner, and we were going through some of the specifics of the President's proposal to do savings in different areas. Obviously we have a major need for that. One of the proposals that he stated specifically was $100 billion in savings in the next 10 years in Medicaid through lowering the reimbursement rates, doctors and hospitals, and also some flexibility in the States. And then $250 billion in savings in Medicare in addition to what is being done by lowering the reimbursement rate to doctors, hospitals, and drug providers.

Now, that statement was fairly stark to me based on some of the statements that you just made, saying that you are not sure it is sustainable now, both for B and dropping reimbursements for physicians 30 percent in A, and lowering reimbursements in the payments that are happening, and then an additional $250 billion in reducing reimbursements. Do you think that is sustainable? What do you think the consequences of that would be?

Mr. FOSTER. On the physicians' side, I think it is quite clear. I mean I won't ask for any volunteers in here, but I am sure nobody would raise their hands and say, Let's cut the payment rates for physicians by 30 percent. So that will be changed, I think it goes without question. It is unsustainable immediately.

Now regarding the productivity adjustment, the slower payment updates for most other kinds of health care providers, that is much more gradual. It is a little over a percent per year. And over the long range, as we saw in the charts earlier, it accumulates to a very large difference, which is disconcerting at best. Over 10 years, it is not to say that couldn't work just fine. That remains to be seen. And of course, some providers on the margin right now.

Mr. LANKFORD. I am going back to your previous comment of informing us before something bad happens. I appreciate that. And my time has expired.

Ms. SCHWARTZ. Just a point of information that is true under the Accountable Care Act, that we also did increase reimbursement for primary care physicians, nurse practitioners and PAs, recognizing their lower reimbursement.

Chairman RYAN. I thank the gentlelady. Mr. Pascrell.

Mr. PASCRELL. I just wanted to follow up, Mr. Chairman, on what the gentleman from Oregon was mentioning before, and that is that the real cost shift that we are talking about here rests with the folks who have no coverage whatsoever and wind up in emergency rooms. That is the real cost shift; they wind up there. And if we don't recognize that—and Mr. Chairman, I tried to ask you a question earlier—I am going to ask it now.

Chairman RYAN. Your time.

Mr. PASCRELL. I tried to ask you a question earlier about your famous chart. You had it up yesterday.

Chairman RYAN. Chart number 1 or 2?

Mr. PASCRELL. That is the one, right up there.

About physician payments, if I could get that chart we got it up there right now, does this chart—or doesn't this chart assume a 30 percent cut to SGR, the sustainable growth rate, Mr. Chairman?

Chairman RYAN. Mr. Foster?

Mr. PASCRELL. Correct?

Chairman RYAN. Mr. Foster, this is chart 7 in your testimony. Do you want to provide him the answer?

Mr. FOSTER. Yes, sir, it does.

Mr. PASCRELL. Thank you. Well, don't you think, Mr. Chairman, that that is a bit pessimistic and not in line with the current reality since we as a Congress in fact——

Chairman RYAN. I agree.

Mr. PASCRELL [continuing]. I think we mentioned it before. We have averted that, these SGR cuts for the last 10 years, and are currently working in Ways and Means—you are a member there as well—on a long-term fix; isn't that true?

Chairman RYAN. I think that is right. And I think that is why it lends more credence to the appendix that Mr. Foster put in his report showing that the true unfunded liability on Medicare is more at 37 trillion than not.

Mr. PASCRELL. Well, let me ask you this question, Mr. Chairman. Does it take into account the payments that are made to doctors for health information technology, electronic medical records? Does it or does it not?

Chairman RYAN. Well, mind you, even if we plug that hole, doctors are still getting paid 80 cents on the dollar.

Mr. PASCRELL. What about quality—what about bonuses for quality reporting?

Chairman RYAN. So If you take a look at this chart you will see it is at 80 percent and then off the cliff. That cliff is the SGR. So let's assume we plug the SGR, the cliff doesn't occur, the slope still goes down, but starting at 80 percent. So that means instead of paying physicians next year 60 cents on the dollar, we plug the hole and pay them 80 cents on the dollar. And that still goes down to a lower amount and that means then we are moving more toward a $37 trillion unfunded liability than a——

Mr. PASCRELL. We are here today to address the problems in Medicare and Social Security, Mr. Chairman. I think what we need to do is have real detailed explanations about the charts that you put up there, we put up there, it doesn't matter who puts the charts up. You can't just slide those charts. "Given assumptions," what does that mean?

Chairman RYAN. So the next time we put up the actuary's chart, we will tell you we are putting up the actuary's chart.

Mr. PASCRELL. I didn't ask you that.

Chairman RYAN. See the source down there, actuary?

Mr. PASCRELL. Mr. Foster, at yesterday's hearing on the IPAB, one of my colleagues attributed Medicare's insolvency to the Democratic plan. I just want to make clear what creates solvency problems and what does not. Health care reform which is fully paid for is not to blame for Medicare's solvency.

Chairman RYAN. Would the gentleman yield on that point?

Mr. PASCRELL. Sure.

Chairman RYAN. So if we are to assume what you say, that these cuts will never occur, then your health care bill is not paid for.

Mr. PASCRELL. We know that the health care bill is paid for, we——

Chairman RYAN. Well, no, you are saying it is paid for.

Mr. PASCRELL. We painfully laid it out very clearly.

Chairman RYAN. Can't have it both ways.

Mr. PASCRELL. And very different from what——

Chairman RYAN. Either these cuts do not occur and it is not paid for, or the cuts do occur and is paid for.

Mr. PASCRELL. Reclaiming my time.

Mr. VAN HOLLEN. Would the gentleman, yield?

Mr. PASCRELL. Just making one point. Very different from what you did in your prescription drug plan of 8 years ago, we didn't pay for anything.

Chairman RYAN. May I ask you a question?

Mr. PASCRELL. Didn't pay for anything.

Chairman RYAN. Would you yield?

Mr. PASCRELL. Sure.

Chairman RYAN. If these cuts do not occur, then your bill is not paid for. If these cuts do occur, then on paper your bill was paid for and this happens.

Mr. PASCRELL. This is my point, this is my point. Look, we are trying to provide services to people, we are trying to provide those services for everybody. But you refer, you know, refer to tax cuts. Many of the gentlemen on the other side and ladies refer to tax cuts. We know that the deficit that we are addressing—and you are not going to respond to the deficit and you are not going to clear up the deficit by blaming Social Security or Medicare or the recipients of those benefits. Three-fifths of the deficit by 20——

Chairman RYAN. I will let you——

Mr. PASCRELL. Let me finish.

Chairman RYAN. Go ahead and finish. You are beyond your time. But since I took some of it go ahead and wrap it up.

Mr. PASCRELL. I appreciate it very much, Mr. Chairman. You are very kind to me today.

Chairman RYAN. Don't push it, come on.

Mr. PASCRELL. I said today.

The tax cuts of 2001 and 2003 are going to mean by 2019—and you like figures, Mr. Chairman.

Chairman RYAN. All right. I got where you are going.

Mr. PASCRELL. You dig figures. By 2019, three-fifths of the deficit will be as a result of the extended tax cuts that you supported, you voted for, and you think will bring us to the promised land.

Chairman RYAN. We can go on and on and on. Ms. Black.

Mr. PASCRELL. It is not going on and on; it is the truth.

Mrs. BLACK. Thank you, Mr. Chairman. And thank you, panelists, for being here today.

Mr. Foster, I would like to turn to the issue of how income is calculated for the Federal health programs. And I know that this issue was mentioned in the Energy and Commerce hearing where you testified. I hope that you might be able to help elaborate for this committee the implications for including the MAGI, or what they call the Modified Adjusted Gross Income, which was created by the Affordable Care Act, and specifically by requiring States to use the modified adjusted gross income as defined in the Internal Revenue Code.

Mr. FOSTER. Yes, ma'am. I would be glad to do that. This has to do with the expansion of the Medicaid program under the Affordable Care Act and the creation of the health insurance exchanges.

You need to have a consistent definition of income to determine eligibility for Medicaid and the level of your exchange Federal subsidies to avoid any gaps or overlaps.

So to handle that, Congress chose to use the definition of modified adjusted gross income for this purpose is readily available. The problem is that for many or most Social Security beneficiaries, little or none of their Social Security benefits are included in adjusted gross income, which is the first step in determining the modified version.

So as a result, if you have Social Security beneficiaries under 65 who don't qualify for Medicare yet, and that is a lot of them, then the income test for them is not up to 133 percent plus 5 percent of income, of all income. It leaves out their Social Security benefits in many cases, and in some examples we have done, the test can actually be more like 300 to 400 percent at the extreme, which is probably not intended.

Mrs. BLACK. And given that—and I know yesterday, or maybe Monday, was when the initial rulemaking for the State exchanges did come out. And so I know this may be a little bit difficult for you to answer, but I am interested to hear the effects on the State exchange premium, credits, and the cost sharing subsidies, and Medicaid. What do you think the effect of this is going to be on the States?

Mr. FOSTER. For the states you have the issue of their portion of the cost for Medicaid, of the expansion. Of course, for the first 3 years the Federal Government pays the entire cost for the expansion population, and then it grades down to 90 percent, if I remember correctly.

On the exchanges you still have an issue of the eligibility, in the following sense. If you have somebody and you include their Social Security benefits in their total income, and on that basis they would qualify, say, for a given level of premium assistance, in cost-sharing assistance, but now you don't count their Social Security benefits, they will qualify for a higher level because they look more low income, so it shifts people on that eligibility curve and puts them into brackets where they get a greater subsidy.

Mrs. BLACK. And I have heard this could be 3 to 5 million more individuals who could be added to Medicaid by 2014. I have estimates from CBO that closing this loophole that was created by the Affordable Care Act could save well over 10 billion over 10 years.

And that is why I have legislation that I am going to be introducing early next week to establish a formula in the revenue code that accurately reflects an individual's eligibility for certain healthcare-related programs and that is in line with the eligibility requirements for other government programs such as SSI, SNAP, TANF and unemployment insurance, to hopefully get at this loophole, to close it so that the States will not be terribly affected, and that it will be a more fair system, as I say, in those other programs.

And so the bill would ensure that health care programs are available to those who need it the most, rather than it going to people who may be outside of that because of this loophole. The bill also would be about ensuring fairness, as the health care law is now written, and some individuals would get a significant break on

their health care premiums, so making this a fairness issue is where I am hoping to go with this bill that we close this loophole.

Do you have any comments in my few, 8, 7 seconds left on this?

Mr. FOSTER. I try to stay out of policy issues, but this is one where I think the change is in order.

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

Chairman RYAN. Ms. Wasserman Schultz.

Ms. WASSERMAN SCHULTZ. Thank you, Mr. Chairman. My first question of Mr. Goss on the Social Security privatization in the Ryan plan. What the Ryan plan does is it proposes to set up private accounts by diverting Social Security payroll taxes. What was your estimate of the cost of diverting those payroll contributions?

Mr. GOSS. Thank you. We did—this is a year or 2 ago when we did the last version of the road map. And there were a number of changes in that that would actually lower the scheduled level of Social Security benefits. The amount of payroll tax contributions that would be redirected—we estimated over the 75-year period at 1.74 percent of payroll—would be redirected to the personal accounts.

Ms. WASSERMAN SCHULTZ. Now, the Ryan plan offset that increase cost to Social Security through its benefit cuts under progressive price indexing; is that right?

Mr. GOSS. In part. I think it might be a more appropriate—to look at the way the Ryan road map worked was first to effect a reform to the Social Security structural program itself in that three basic components.

Ms. WASSERMAN SCHULTZ. And that reform was a privatization of Social Security?

Mr. GOSS. Well, there were first of all just the basics of the Social Security program as we know it, without the privatization assets, set the progressive price indexing, a change in the normal retirement age, and the additional revenue from the taxation.

Ms. WASSERMAN SCHULTZ. Personal account is the equivalent of privatization.

Mr. GOSS. But personal accounts were also included and money was taken out of trust funds to fund the personal accounts, but then people who participated in that would have a reduction in the benefits they would subsequently receive.

Ms. WASSERMAN SCHULTZ. So there would be a reduction in benefits that individuals would personally receive under that plan?

Mr. GOSS. For those, absolutely, yes.

Ms. WASSERMAN SCHULTZ. Yes, okay.

Chairman RYAN. Would the gentlelady yield for a quick question?

Ms. WASSERMAN SCHULTZ. You are pretty rigid about holding to the 5 minutes, Mr. Chairman, so——

Chairman RYAN. Okay. There is a guarantee that you don't lose money if you put it in——

Ms. WASSERMAN SCHULTZ. Mr. Chairman, I didn't yield. If you give me time beyond the 5 minutes then I would be glad to yield. Thank you.

Chairman RYAN. All right.

Ms. WASSERMAN SCHULTZ. Moving on, it really deeply concerns me, your response deeply concerns me that there is a plan on the table that has been proposed by the chairman repeatedly, that an expert acknowledges would reduce benefits, would actually jeop-

ardize the long-term solvency, create an insolvent—does not address the long-term solvency problems we have with Social Security, and risk the safety net that is clearly in place now for Social Security beneficiaries.

I am particularly concerned about the impact on women, because—sorry to the men in the room, but women generally live longer than men so there is a greater need for Social Security benefits to be in place. The average Social Security benefit is about $12,000 a year to help an individual keep a roof over their head, pay for their prescriptions, and that is needed even longer for women. So at the end of the day, to me it is very troubling that there would be a plan on the table that would privatize Social Security.

Let me turn to Medicare in my final about minute-and-a-half. Mr. Foster, Republicans have said they want to reduce the costs for seniors, but I don't know how they can say that with a clear conscience when the Affordable Care Act does reduce costs for seniors, and the Ryan plan actually adds $6,000 or more in costs to Medicare beneficiaries.

Just to review what the Affordable Care Act does, it reduces the out-of-pocket costs for fee-for-service Medicare beneficiaries, Part B premiums declined by more than $200 per beneficiary by 2019, coinsurance declined by more than $200 per beneficiary by 2019. And although Part D beneficiaries see a slight increase in premiums, isn't it right that that is actually offset by the closing of the doughnut hole and the actual reduction in the amounts of the out-of-pocket costs for seniors?

Mr. FOSTER. For the Part D beneficiaries, that is correct.

Ms. WASSERMAN SCHULTZ. Thank you, Mr. Chairman, I yield back.

Chairman RYAN. Mr. Huelskamp, will you yield 30 seconds?

Mr. HUELSKAMP. Absolutely, Mr. Chairman.

Chairman RYAN. Mr. Goss, can you just quickly answer questions about the bill I sent you 2½ years ago? Number one, does it make Social Security solvent? Number two, does it raise the minimum benefits to keep every senior out of poverty? Number three, does it have a benefit guarantee for those people who elected to have those voluntary personal accounts?

Mr. GOSS. Yes, it does result in solvency. There is a minimum—a low-earner benefit enhancement, and as for the guarantee in the form we scored most recently, there is a guarantee that personal account would accumulate by retirement with a non-negative real return. It would not yield less than CPI.

Chairman RYAN. Thank you, Mr. Huelskamp.

Mr. HUELSKAMP. Thank you, Mr. Chairman.

Mr. VAN HOLLEN. If could just ask a question on that really quickly.

Chairman RYAN. It is Mr. Huelskamp's time.

Ms. WASSERMAN SCHULTZ. Mr. Chairman, I had 40 seconds left that I would be glad to yield to the ranking member.

Mr. VAN HOLLEN. Okay.

Mr. HUELSKAMP. Thank you, Mr. Chairman. And I believe I have a chart, if you would put up my chart from staff. Yes, the chart is up there.

Yesterday I was particularly disturbed as were many constituents by a statement the President of the United States made. And the question would be to Mr. Goss. And it said something to the effect from the President that "I cannot guarantee that those checks go out on August 3rd if we haven't resolved this issue. It is in reference to Social Security checks and it is in reference to the debt ceiling issue.

Looking at a chart that was "Source, U.S. Treasury, prepared by GS Global ECS Research." And I wonder if you can explain to me how the checks would not go out on August 3rd. Under what circumstances would Social Security checks be withheld?

Mr. GOSS. I wish I could give you a definitive answer to that. I think you would have to talk to people at the Department of Treasury, quite frankly. What we know and understand is that whenever we pay any money out of the Social Security Trust Funds, we must redeem bonds. When we redeem bonds, that actually lowers the amount of debt subject to the ceiling. However, in order to pay the benefits, the Treasury must at the same time then issue bonds to the public, which therefore increases the debt subject to the ceiling.

So there is in effect kind of an offset between the two. The exact mechanism by which that happens is very complicated, and it is the Department of Treasury, and for a public debt you have to speak to that issue.

Mr. HUELSKAMP. Thank you. I appreciate that. So you are not familiar with how the Department of Treasury manages their resources in terms of paying Social Security checks?

Mr. GOSS. We are to a degree, but there are many detailed intricacies about how exactly it is handled with respect to the timing of the redemption of the Social Security bonds, and then the issuance of debt to the public, and whether or not that process, if not done exactly simultaneously, would in fact breach the debt ceiling if we were already added is, I think, really the issue.

Mr. HUELSKAMP. I appreciate that. And for members of the committee, if we take a look at that chart—and this is cumulative cash flows—and the line is the receipts; and you see throughout the end of the month of August, that line of receipts exceeds our expenses, including essential defense, Medicare, Social Security interests, and then the receipts line.

I was trying to figure out, and I guess we will have to ask the Department of Treasury, which we are having difficulty getting answers from them. Buy I see under no circumstances, unless it was a political decision, that the administration would refuse or withhold Social Security checks because there are sufficient receipts. And I appreciate the opportunity to make that statement.

I wish we could have a little more information. Folks at the Social Security Administration—have they asked that question? You are going to be asked, When do you cut those checks and when are you told not to cut those checks?

Mr. GOSS. The responsibility of the Social Security Administration per se, my boss, Commissioner Astrue, is to in fact determine how much in the way of benefit payments people are supposed to receive. We send that information actually over to the Department of Treasury. They are the ones that actually send out the payments, electronic funds transfer or checks.

Mr. HUELSKAMP. Can I ask you to ask the Treasury Department, because the administration just really does not want to provide information. When you stand on the evening news and make a statement that 40-some million Americans are not going to receive their checks, could you ask the administration are they planning on withholding those checks, and is there a reason they wouldn't make those payments on August 3rd?

Mr. GOSS. I would be happy to join you in raising that question.

Mr. HUELSKAMP. Thank you. I yield back the balance of my time.

Mrs. BLACK [presiding]. Ms. Castor, you are recognized.

Ms. CASTOR. Thank you, Madam Chair. While Social Security is not a driver of the deficit and it is not an immediate crisis, I think hopefully we can all agree that it is vitally important to work together to strengthen the Social Security Trust Fund.

Mr. Goss, do you know when I talk to folks at home, you know what they are most surprised to learn when you are talking about the basics of Social Security? They are surprised to learn that Americans pay into Social Security, but only up to $106,000, 106,800 and anything higher than that is exempted. I think I heard you share with Ms. Schwartz earlier that that cap has been adjusted over time. Can you kind of lay out the changes in that taxable maximum over the past couple of decades?

Mr. GOSS. I believe it is since about 1978 to 1980 we have enacted into the law, you enacted into law, an automatic adjustment mechanism for this taxable maximum amount. And it grows with the average wage in the U.S. economy, which we project will be at about a 4 percent average annual rate in future. So the taxable maximum does grow at that rate. It has grown at that rate over the historical period.

There was a comment earlier, though, about the percentage of all earnings in the U.S. economy that are covered under Social Security and the percentage of those earnings that in fact are subject to our payroll tax—that is, the 106,800—that is currently around 84 percent. We expect by the year 2020 to be around 83 percent. It did reach a high water mark in recent history of about 90 percent back in 1983 and 1984.

Now, the fact it has drifted down is due to a widely known and understood phenomenon in our economy that there has been a dispersion of earnings, meaning that people at the highest income levels tend to have a faster rate of increase in earnings than at the lower income levels. That has caused a shift towards more of the total earnings in the economy being above our taxable maximum and that is what has pulled down our share of——

Ms. CASTOR. That is very interesting, because the other thing I hear from folks when you are just talking about the basics of Social Security, is that they—folks are very interested in making sure the trust fund is healthy and solvent and can—I think I am a little younger than a baby boomer, so my generation wants it to be around as this baby-boom bubble moves through. And they think that, gosh, if you can raise that cap, maybe even over time—and the Rivlin-Domenici Commission looked at it and others have studied—if you could raise that cap over time, is it true we could make the trust fund solvent without any change in the retirement age and without any change in benefits? Is that right?

Mr. GOSS. Well, the estimates we have done is if we were to, as is true with the 2.9 percent Part A Medicare tax, which has no limit whatever, it is charged on all earnings at any level; if we were to do the same for the 12.4 percent Social Security tax, that would generate revenue, in fact, in excess of the amount needed to fully finance Social Security benefits through the 75-year period, through 2085.

If, however, we were to give benefit credit for the additional earnings that would be subject to tax under our current benefit formula, it would fall somewhat short of being able to cover the whole 75-year period, but would cover an awful lot of the costs.

Ms. CASTOR. Thank you. I think that is a smart way to shore up the trust fund and strengthen Social Security and keep the promise to our older Americans that Social Security is going to be there for them.

On Medicare, Mr. Foster, thank you very much for being here. See, when the Medicare Part D was added and came on line in 2006, people are very surprised to learn that it wasn't paid for, that there was no dedicated funding, no offsets, no revenue raisers. And the CBO has estimated that that is going to cost us $1 trillion from 2012 to 2021. Do you agree with that CBO number?

Mr. FOSTER. I am sure it is in the right ball park. I could add it up from our own estimates for you.

Ms. CASTOR. It is very interesting, as we discuss all of the debt policy—the Affordable Care Act, remember, was paid for, 575 billion over 10 years; isn't that correct?

Mr. FOSTER. Yes, it was.

Ms. CASTOR. Yeah, so there's a difference when it comes to Medicare and who are the good fiscal stewards of the Medicare initiative. That Medicare Part D was added at a time the Bush administration was already projecting the largest debt in American history. I think that was very poor public policy and very poor fiscal policy.

But there is a proposal that has been introduced by Mr. Waxman and Mr. Dingell that could help us shore up, find additional savings for Medicare Part D. Are you familiar——

Mrs. BLACK. The gentlelady's time has expired.

Ms. CASTOR. Let me just highlight to everyone the Medicare Drug Savings Act of 2011, H.R. 2190. CBO estimates that we can bring in over $112 billion in Medicare Part D, so I highlight that to everyone. Thank you very much.

Mrs. BLACK. Thank you. The gentleman from Wisconsin, Mr. Ribble, is recognized.

Mr. RIBBLE. Thank you, Madam Chair. I just would make one quick response. You know, if we reduce physician payments from 80 cents on a dollar to 33 cents on a dollar and raise taxes by a trillion dollars, I suppose we could fund some things.

And so I would like to go back to Mr. Goss to try to clarify some of the questions and the follow-up on Mr. Huelskamp's line of questioning before. I am trying to get my hands around Social Security Trust Fund. Where does the money exist? Is it just on a balance sheet someplace, does it just show up on a ledger, or is there an account with money in it? Where is all this money?

Mr. GOSS. Well, when Social Security or any of the trust funds in the Federal sector have excess revenue coming in, excess dedi-

cated taxes, that money is in fact received by the general fund of the Treasury, and securities which are required by law to be interest-bearing securities backed by the full faith and credit of the U.S. Government, are then issued to the trust funds. The trust funds hold those securities, much as you might with a double E bond or a Treasury bond that you have in your own position, or folks overseas, for that matter, in terms of publicly held debt.

Actually, interestingly, the debt obligations issued to the trust funds are referred to by the Department of the Treasury as public debt obligations, but not publicly held debt obligations, obviously, but they are referred to as public debt obligations. So they are not a pile of dollar bills, obviously, anymore than if we go and put $100 in the savings and loan down the street, they will go out and invest it or put it to some use later.

What counts is our ability, when we need that money, to be able to come and get it back. So far in all of history, whenever the trust funds have needed money—and it has been ever since 2005 that the DI Trust Fund has needed to be pulling money out of the trust fund, it has been there and it has been made good.

Mr. RIBBLE. If I took and invested money in a bank, and they went and invested it someplace else, and I wanted to get it back, and they said to me, "Gee whiz, you can't have it back because I have to go borrow it," what would that do to your confidence about it?

Mr. GOSS. Well, if they said you could not have it back, that would be a problem. Actually, I think we had a situation like that fairly recently with some of the big banks, and they came to the government to bail them out. And in terms of the Social Security Trust Funds that is a concern. This is the reason that the trust funds are required to invest in interest-bearing securities backed by the full faith and credit of the government, so that in fact there is thought not to be that issue of concerns of being able to get the money when you need it. Really, for that to be undone, I think would require an act of Congress to say that the money would not be available.

Mr. RIBBLE. Okay. In your testimony you said, first, assets in a trust fund had been borrowed by the rest of the government in lieu of additional borrowing directly from the public—is what we are speaking about here, correct? Publicly held debt, currently about 10 trillion, is lower than the Federal debt of about 14 trillion, solely due to borrowing from the trust funds. That $4 trillion, is that just surplus or is that the total amount?

Mr. GOSS. Well, the $4 trillion is in fact the accumulated amount of excess revenues that have been brought in by the trust fund.

Mr. RIBBLE. Since the beginning of——

Mr. GOSS. Since the beginning of time in Social Security cases since the year 1937, Medicare since 1965. It is the excess of revenues that have been brought in with accumulated interest that are held in those funds. And in effect had they not been brought in that excess, and the rest of the government had spent what it spent and taxed what it has taxed, we would still have the rest of the government owing somebody $14.3 trillion. It is just that it would not have 4 trillion of that, in effect, borrowed from the trust funds, it would have to all be borrowed from the public.

Mr. RIBBLE. If that had been the case it would have been transparent to the American people, and the President wouldn't go on TV and say if we don't raise the debt limit, we can't send our Social Security checks out. Is that accurate? If that money had in been in—like Al Gore campaigned on a few years ago—in a lockbox.

Mr. GOSS. Well, the definition of what exactly a lockbox would be has never been clear to me, so I am not sure we can exactly answer exactly what would have happened under that circumstance.

Mr. RIBBLE. But your testimony would imply that it was borrowed—not implied, stated—was borrowed by the rest of the government in lieu of additional borrowing. So I am assuming that the Federal Government views it just to spend on its normal activities and basically continue to fund other things other than Social Security.

Mr. GOSS. Well, the fact that the non-trust fund programs have in fact had, cumulatively, spending of $14.3 trillion more than the revenue that they have taken in, does mean that total amount of $14.4 trillion has needed to be borrowed. Perhaps a convenience that the trust funds were running excesses and could shoulder part of that burden.

Mr. RIBBLE. Thank you very much and I yield back.

Chairman RYAN [presiding]. Mr. Tonko.

Mr. TONKO. Thank you, Mr. Chair.

Mr. Goss, I listened with interest to the exchange on the releasing of Social Security checks, and find it rather amazing that we would even entertain the idea of allowing that to happen. And it really calls for us to build this consensus and respond appropriately.

Given the barrage of calls for entitlement reform as negotiations on the debt ceiling continue, I would like to take a moment to return to your testimony, where you gave a very helpful explanation of how Social Security funds itself and what its impact on the deficit and debt are. We know the simple answer is that it has none. Social Security is self-funding and has not added one dime to the debt. However, in the face of repeated claims to the contrary and the policymaking that is now building upon those claims, I think this is an issue worth examining in greater detail.

So could you please indicate for us the total dollar amount on in the OASDI Trust Fund, the Social Security Trust Fund as you know it to be?

Mr. GOSS. At the beginning of this year the OASI and DI Trust Funds on a combined basis held about $2.6 trillion. We are right around that, approaching $2.7 trillion.

Mr. TONKO. So Social Security has about $2.7 trillion in the bank. Mr. Goss, you pointed out that Social Security ran a cash deficit last year that comes from discounting Social Security's interest income. However, given that Social Security has $2.5–$2.7 trillion in what was until recently the safest investment bank in the world, the program is earning pretty substantial interest, and if that interest income is included, Social Security income in 2010 totaled $781 billion, while outlays totaled 713 billion. Is that accurate?

Mr. GOSS. I believe those would be the correct numbers, yes. The total interest credited in trust funds in 2010 was in excess of $100 billion.

Mr. TONKO. Thank you. So if Social Security was a business, it would have netted about 70—just shy of $70 billion last year. Let me say that in a different way. If Social Security were a business, it would have earned well over twice the profits of the most profitable corporations in the world. It would have earned twice the profits of ExxonMobil who raked in about 30 billion in profits. Despite having one of the most successful companies on Earth, ExxonMobil gets government welfare and receives billions in oil subsidies, approved by this body and defended by my Republicans colleagues. It contributes more to Federal debt and deficit than Social Security ever has or, under current law, ever will.

And yet our Republican colleagues are demanding entitlement reform and pushing forward bills to privatize Social Security and cut benefits, while outrightly refusing to cut subsidies to big oil. That, I think is rather interesting.

Mr. Foster, an interesting point for me to examine is this line drawn in the sand by the Republican plan to end Medicare. At some point you are 55, and you can't climb into the program. And the legacy population continues to age without a new population entering in. As I see the actuarial world, it is that younger population that doesn't consume as much health care, that helps balance the pot and maintain the financial outcomes and stability of the insurance programs in this country, private sector, or Medicare program.

What is the impact of having this legacy population age without any new younger seniors entering into the mix?

Mr. FOSTER. On the one hand, if you measure the average cost per person under current law versus, as you deem it, the legacy population, obviously with a closed group of people who get older and older, a greater proportion of them die each year, et cetera, their costs per person are going to be much higher.

Mr. TONKO. Right. But what is the impact, then, on the program, on the finances of the program? There is no new group coming in from whom you are collecting premiums, and perhaps using much less in health care and absorbing and costing more?

Mr. FOSTER. I am not sure the impact is so different. In other words, either way. Current law or this kind of proposal for the 55-and-over group, Medicare is still going to pay the lion's share of their costs.

Mr. TONKO. Right. But premiums are held harmless.

Mr. FOSTER. That is right.

Mr. TONKO. So what is the impact if you have no younger senior group coming in to absorb some of that ebb and flow, what is the impact of a growing, ever-increasing age group?

Mr. FOSTER. That is the point I am working towards. For the older group, nothing really has changed. We are still paying them the same benefits. They are still paying the same premiums they would have.

Mr. TONKO. But who absorbs that cost, the added cost?

Mr. FOSTER. So far there there is no added cost.

Mr. TONKO. The premium is constant, the group is growing older, and you are saying per capita they are paying more.

Mr. FOSTER. The current law, proposed law, the same people, the same cost. It hasn't gone up.

Chairman RYAN. Thank you. Mr. Guinta.

Mr. GUINTA. Thank you, Mr. Chairman. Thank you both for being here.

Mr. Foster, are you familiar with the Trustee of Trusts report that was issued back in May relative to bankruptcy of Medicare?

Mr. FOSTER. The Medicare Trustees Report? Yes.

Mr. GUINTA. What did that say? If nothing is done, when does Medicare go bankrupt?

Mr. FOSTER. For trust fund financial status, you have to look at each account separately. The Part A Trust Fund is projected to run out of assets in 2024. The other two trust fund accounts are not projected to run out.

Mr. GUINTA. So 2024 is not that far off, about 12, 13 years. What we have heard from our friends on the other side of the aisle in terms of solutions is either A, that is just false information and it is not accurate, which I disagree with; B, raise taxes either on beneficiaries or on other folks in order to pay for it; or C, do nothing. And I say that because I have not seen a plan from the other side to preserve and protect Medicare.

I think we have a responsibility in Congress to preserve and protect it. There have been proposals put forward, most recently passed by the House of Representatives, that preserve and protect Medicare. It doesn't affect anyone who is 55 or older. It recognizes and acknowledges that if nothing is done, Part A will go bankrupt in about 12 years. It recognizes that 10,000 baby boomers per day are coming on to the rolls, and that doctors each and every day—less and less doctors are choosing to accept Medicare patients.

So there is a fundamental problem in this country with the solvency which Congress is charged with fixing. If we did it solely on raising the payroll tax—the tax is 2.9 percent today, correct? What would it have to go up to?

Mr. FOSTER. The tax is 2.9 percent split evenly between employers and employees. There is also an additional 0.9 percent for high-income workers. If you address the Part A long-range actuarial deficit just by raising taxes, then the tax rate would have to go up to 3.69 percent, starting immediately. That is a 24 percent increase.

Mr. GUINTA. So starting immediately, you would have to go from 2.9 to 3.69.

Mr. FOSTER. Right.

Mr. GUINTA. This is on top of the Affordable Care Act increasing taxes half a trillion dollars. This is on top of the President of the United States demanding tax hikes for some Americans that would exceed 50 percent of their income, 50 percent, between Federal, State and local. This is on top of the 9.2 percent unemployment rate and 18,000—abysmal 18,000 jobs created in June. That is 360 jobs per State in this country.

Central High School in Manchester graduated 500 people this past month. There is a serious problem in this country that is not being dealt with by this Congress and by this President. And people in this country are frustrated with that. And what I think we

need to be doing as members of Congress is not looking at raising taxes, but finding reasonable solutions to shore up Medicare, to shore up Social Security,

Medicare, right now, we spend in 2010, what, $520 billion roughly?

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

Mr. GUINTA. What is your estimation that that number will increase to in the next 10 years?

Mr. FOSTER. Hang on just one moment; 932 billion projected for the year 2020.

Mr. GUINTA. We are in that neighborhood. We have 47 million eligible Americans today. Do you have a projection of what that would go up to in 10 years?

Mr. FOSTER. Sure. We have got projections for just about everything. Sixty-four million.

Mr. GUINTA. Sixty-four million people. So from 47 to 64, but almost a doubling of the cost.

Mr. FOSTER. Yes.

Mr. GUINTA. These particular facts have to be acknowledged by Congress and real solutions have to be proposed. The House of Representatives has put a proposal forward. It came out of this committee, passed the House, nothing has been done in the Senate. Quite frankly, nothing has been offered on the other side. So I would like to hear from the other side some solutions and some fact-based positive ideas, rather than critique and criticism of the ideas we continue to bring to the table.

I yield back the balance of my time.

Chairman RYAN. Ms. Bass.

Mr. FOSTER. Before we hear from the other side. Let me just say we would be very happy to help all of you on both sides in your efforts to find solutions.

Chairman RYAN. You have been exceptionally helpful, we appreciate that. Ms. Bass.

Ms. BASS. I would like to thank the witnesses for taking their time out to speak to us today. And also to my colleague, Mr. Guinta, I don't want to mispronounce your name.

Mr. GUINTA. Close enough.

Ms. BASS. If you want to know the ideas from the other side of the aisle, the Democrats did offer an alternative budget proposal and a balanced approach, which is something that I think we could use, especially as we are getting very close, aside from the budget, talking about raising the debt ceiling as we are getting dangerously close to jeopardizing our Nation's credit standing.

I wanted to ask you a couple of questions. This question is for Mr. Foster. Yesterday Secretary Sebelius said that Medicare is on a solid fiscal footing because of the Affordable Care Act. And on page 6 of the 2011 Medicare Trustee Report it says the financial outlook for the Medicare program is substantially improved, certainly not without concerns, but improved as a result of the changes in the Affordable Care Act.

So Mr. Foster, I wanted to know how would repealing the Affordable Care Act impact Medicare's financial situation?

Mr. FOSTER. There were, of course, very many savings provisions in the Affordable Care Act for Medicare. We estimated a total sav-

ings of $575 billion through 2019. If the law were repealed outright and retroactively because some of these provisions have already taken effect, of course, then we would not have those savings.

Ms. BASS. Okay. Thank you. And I also wanted to associate my comments with Mr. Tonko's, who left a little earlier, about the—I think we both heard the President's comments yesterday in response to the question of if we didn't raise the debt ceiling, would we be able to make Social Security payments, as opposed to the President wanted to withhold those payments. I think when we do reach a balanced approach, we will be able to keep the Social Security payments on time.

Mr. Goss, while my colleagues on the other side of the aisle claim that the House-passed budget resolution did not cut Social Security, it does indeed cut the agency's funding by more than $10 billion over the next 10 years. And I realize that, you know, you are the actuary. But I wanted to know your opinion, if you could describe what those size cuts would mean for the agency as it looks to serve—and you have certainly given numerous examples of the growing number of new retirees over the same period.

Mr. GOSS. Very, very recently—in fact, my boss, Michael Astrue, Commissioner, testified before the Ways and Means Committee and indicated the necessity of maintaining sufficient administrative budget to be able to fully serve the American people. One of the charges that Social Security is working very, very hard at is to try to get the backlog for Social Security disability applications down, especially as they are waiting for administrative law judge determinations. A reduction in administrative revenue for the program would of course make it much more difficult to do this.

Ms. BASS. Thank you very much. And I know that those of us on both sides of the aisle recognize that we do have to deal with our deficit and that cuts are needed. But I think this is an example that sometimes you can have cuts that actually create more problems for people than solving the situation that we are in now.

Thank you very much for your time.

Chairman RYAN. That is it? You have plenty of time to spare.

Ms. BASS. I yield my time to Ranking Member Van Hollen.

Mr. VAN HOLLEN. I think it has been a very, very good hearing. Thank you, Ms. Bass. And I appreciate that windfall. I don't get many on the Budget Committee.

Let me just say I think this has again been a very important conversation. I just wanted to say what I have said in the past, and the chairman agreed. We will have a hearing to look at the tax expenditures and revenue. Just a couple of points in that regard. The median income of a Medicare beneficiary, median income, is $22,500. The median income of a Social Security beneficiary, someone over 65, $25,000. Both those median-income numbers include their Social Security benefit. My understanding is the average Social Security benefit is $14,000 a year. So when we talk about these issues, let's keep that in mind.

And that is why it is so important from our perspective to have balance and also look at some of the, you know, revenue pictures and look at some of the folks who did get big tax breaks not that long ago. And again, during the time when the Clinton administra-

tion—we saw the economy booming and jobs created. Thank you, Mr. Chairman.

Chairman RYAN. The gentlelady's time has expired.

I will just simply say, when we do entitlement reform we know there are limited resources. Those are the people who should get the most of the resources as we do this.

Gentlemen, thank you very much for coming and taking your time. We really appreciate it. This hearing is adjourned.

[Whereupon, at 12:12 p.m., the committee was adjourned.]

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