STRENGTHENING HEALTH AND RETIREMENT SECURITY

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STRENGTHENING HEALTH AND RETIREMENT SECURITY

TUESDAY, FEBRUARY 28, 2012

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

The Committee met, pursuant to call, at 10:00 a.m., in room 210, Cannon House Office Building, Hon. Paul Ryan, [Chairman of the Committee] presiding.

Present: Representatives Ryan, Garrett, Calvert, Price, McClintock, Stutzman, Lankford, Black, Ribble, Flores, Mulvaney, Huelskamp, Young, Guinta, Woodall, Van Hollen, Schwartz, Doggett, Blumenauer, Yarmuth, Pascrell, Wasserman Schultz, Bass, Bonamici.

Chairman RYAN. The committee will come to order. Before we get started I want to yield to Mr. Van Hollen for the purposes of introducing our newest member to the committee, Suzanne Bonamici. Mr. Van Hollen.

Mr. VAN HOLLEN. Thank you very much Mr. Chairman, I just wanted to add my word of welcome to our newest member who signed up to do duty on the Budget Committee, Suzanne Bonamici, a new member from Oregon who served in the state legislature and focused on a lot of these issues at the state level, to the extent they related to the state budget, but obviously has an understanding of how the state budget interacts with the federal budget. You have signed up at a time when you have to fasten your seat belt; we are in the middle of budget season here and it is great to have you on board the committee, so thank you Mr. Chairman.

Chairman RYAN. Welcome. As a Wisconsin Badger fan, I will pause for a second here. You hit us pretty good in the Rose Bowl, but it is nice to have you, nevertheless.

Let's get started. Welcome to today's important hearing examining the structural challenges facing the federal government's major health and retirement security programs. This is a hearing we have every year and, unfortunately, it is a hearing where the news just gets worse.

We welcome back to the committee the two foremost experts on the financial crunch facing Medicare and Social Security, the chief actuaries of each of the two programs. Rick Foster, the chief actuary of the Center for Medicare and Medicaid Services. Rick's nonpartisan analysis is second to none in illuminating the challenges in health care and the consequences of trying to squeeze savings from the rather blunt instrument of price controls.

We also welcome Stephen Goss. We have known Steve a long time; he is the chief actuary at the Social Security Administration. Steven's analysis should be required reading for policy makers. We thank you for taking the time out of your busy schedule again to unpack the facts and to share your insights with us today.

For too long, politicians in Washington have not been honest with the American people, and seniors in particular, about Medicare and Social Security. Instead of engaging in an honest debate about the path forward to strengthen these programs, too many have offered little more than false political attacks and trillions of dollars in empty promises. Today's hearing is an effort to honestly assess the challenges facing these two critical programs, providing the clarity to Congress as we work to advance sensible reforms and to ensure that these critical 20th century programs can fulfill their important mission into the 21st century.

There is a very clear choice of two futures for both programs. For Medicare, we can follow the path set by the president's health care law, and the additional Medicare cuts called for in his most recent budget request. On this path, Medicare is rated to the tune of about $500 billion to fund a new, open-ended entitlement and the fate of senior's care is left in the hands of 15 unelected, unaccountable bureaucrats in Washington. These bureaucrats are in power to cut Medicare in ways that will result in restricted access and denied care for current seniors. Meanwhile, this path leaves Medicare bankrupt for future generations.

We can chart a brighter future for Medicare. There is a growing bipartisan consensus for reforms that ensure no disruptions for those in, or near, retirement, while offering the next generation a patient-centered Medicare program that offers more choices and more security.

For Social Security, we can follow the path set by President Obama's most recent budget request, failing to meet the test for leadership that he himself established, the president has hedged and dodged, but has yet to advance credible solutions to shore up Social Security's fiscal imbalance. As the trustees have warned, the president's unserious approach to Social Security will result in serious consequences for seniors, an across-the-board 23 percent benefit cut when the trust fund is exhausted, which is scheduled to hit when those entering the system today are in the heart of their retirement, or we can chart a brighter future for Social Security.

Similar to Medicare, I believe that there is a growing bipartisan consensus for sensible, gradual reforms that ensure no disruptions for those in, and near, retirement for offering the next generation a program that reflects demographic reality, a more progressive benefit structure, and a solvent future. I thank my colleagues here at the Budget Committee for engaging in this spirited debate with mutual respect for one another, and a shared commitment to make good on the promises of these critical programs. The decisions we make in the next few years will amplify throughout this century, and will affect every single human being we represent.

We look forward to the testimony of our two esteemed witnesses, but before I do I would like to yield to the ranking member Mr. Van Hollen for his opening statement.

[The prepared statement of Chairman Paul Ryan follows:]

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

Welcome to today's important hearing examining the structural challenges facing the federal government's major health and retirement security programs.

We welcome back to the Committee the two foremost experts on the financial crunch facing Medicare and Social Security: the chief actuaries of each program.

We welcome Rick Foster, the chief actuary at the Centers for Medicare and Medicaid Services. Rick's nonpartisan analysis is second-to-none in illuminating the challenges in health care and the consequences of trying to squeeze savings from the rather blunt instrument of price controls.

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• We can follow the path set by the President's health-care law and the additional Medicare cuts called for in his most recent budget request. On this path, Medicare is raided to the tune of $500 billion to fund a new open-ended entitlement, and the fate of seniors' care is left in the hands of 15 unelected, unaccountable bureaucrats in Washington. These bureaucrats are empowered to cut Medicare in ways that will result in restricted access and denied care for current seniors. Meanwhile, this path leaves Medicare bankrupt for future generations.

• OR we can chart a brighter future for Medicare. There is a growing bipartisan consensus for reforms that ensure no disruptions for those in or near retirement, while offering the next generation a patient-centered Medicare program that offers more choices and more security.

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We look forward to the testimony of our two esteemed witnesses, but before we do, I would like to yield to Ranking Member Van Hollen for his opening statement.

Mr. VAN HOLLEN. Thank you Mr. Chairman. I want to join the chairman in welcoming our two witnesses today. Thank you for your years of dedicated public service as federal employees, and I look forward to your testimony on the very important subjects we are focusing on today.

This committee has done a lot of work over the years to investigate the significant, long-term budgetary challenges stemming from the growing costs of Social Security, Medicare, and Medicaid.

We know that the aging population plays a role in driving up those costs, as do the rising costs of health care.

I think we can all agree that more needs to be done to restrain the rate of health care cost growth, not only to put the federal budget on a sustainable path, but also to make quality health care more affordable for all Americans, and to improve out economic competitiveness. The question is not whether to address these issues and the surrounding budget issues, but how. The long-term budgetary challenges of our health and retirement security programs do not exist in a vacuum. They are part of a larger debate that gets to some fundamental questions for our society.

Which mix of revenue and spending policies will best fulfill our twin goals of economic vitality and meeting the health and retirement security needs of an aging population? When it comes to deficit reduction and putting the federal budget on a sustainable path, who should bear the burden? I believe strongly that we must address these issues using a responsible and balanced approach. We need to have shared responsibility as we move forward.

The president's budget gets us off to a good start. Under that budget, the deficit declines as a share of the economy and the debt stabilizes as a percentage of the economy over the next decade. He reaches those targets with policies and choices that balance the need for wise investments to spur job growth and with other measures to put the budget on a fiscally sustainable path. It adopts cuts to discretionary spending that were included in the Budget Control Act. It saves over $600 billion in mandatory spending, including changes aimed at improving the efficiency of Medicare and Medicaid, but it also eliminates many special interest tax breaks for corporations and for the wealthiest Americans. It asks our highest income earners to return to the same tax rate that was in place during the Clinton Administration, a period when the economy was booming.

In short, the president takes a balanced approach. It is that balance that a lot of our Republican colleagues continue to object to. The overwhelming number of our colleagues on the Republican side have signed a pledge saying they will not close one special interest tax loophole for the purpose of deficit reduction, or ask millionaires to pay one cent more for the purpose of deficit reduction. Because they do not want to ask higher income earners to share more of the burden, it will mean greater cuts in education, greater cuts in investments in infrastructure and other drivers of economic growth, and it will mean that seniors have to bear more of the costs and burdens than under a balanced plan. I would remind my colleagues that the median income of seniors on Medicare is under $22,000.

Now, there is a key difference in the approach that Republicans and Democrats have outlined when it comes to Medicare. The Republican approach would end the Medicare guarantee of a package of benefits specified in law, and place it with the equivalent of a voucher for the purpose of private insurance that would fail to keep pace with the rising costs of health care over a period of time. As a result, future beneficiaries would either have to pay thousands more out of their pockets, or settle for a plan that does not meet their health care needs. I believe that is the wrong direction; I believe that instead we should focus on some of the steps we began

to take under the Affordable Care Act to try and improve the coordination of care, to try and eliminate a lot of the misaligned incentives within the Medicare program, and I think there is more work that can be done in that area.

For example, 37 percent of the individuals on Medicare and Medicaid are what we call dual eligibles. In other words, of all the people who are part of Medicaid and Medicare, 37 are part of both programs. Excuse me, 1 in 10 are members of both programs, but they represent 37 percent of the costs of those programs. It seems to me Mr. Chairman, there are additional things we can do to improve the coordination of care in that area without sacrificing the quality of care. That is just one example of the many ideas that we can pursue going forward that results in a reduction of costs without sacrificing quality of care rather than simply a transfer of costs onto seniors.

So I hope, as we move forward, we will focus on that approach to modernizing Medicare and Medicaid, an approach that improves the quality of care while we reduce the cost of care, rather than simply offloading those costs onto seniors. Thank you, Mr. Chairman.

[The prepared statement of Chris Van Hollen follows:]

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

Thank you, Mr. Chairman. I especially want to thank our two witnesses for their many years of dedicated public service as federal employees. Thank you for joining us today. I look forward to your testimony on the important topic of how best to strengthen our health and retirement security programs.

This Committee has done a lot of work over the years to investigate the significant long-term budgetary challenges stemming from the growing costs of Social Security, Medicare, and Medicaid. We know that the aging of the population plays a role, as do fast-growing health care costs. I think we can all agree that more needs to be done to restrain the rate of health care cost growth—not only to put the federal budget on a sustainable path, but also to make quality health care more affordable for all Americans and to improve our economic competitiveness.

The question is not whether to address these issues, but how? The long-term budgetary challenges of our health and retirement security programs do not exist in a vacuum. They are part of a larger debate that gets to some fundamental questions for our society: Which mix of revenue and spending policies will best fulfill our twin goals of economic vitality and meeting the health and retirement security needs of an aging population? When it comes to deficit reduction and putting the federal budget on a sustainable path, who should bear the burden?

I believe strongly that we must address these challenges using a responsible, balanced approach. We need to have shared responsibility as we move forward.

President Obama's budget gets us off to a good start. Under the President's budget, the deficit declines as a share of the economy and the debt stabilizes as a percentage of the economy over the next decade. The President reaches these targets with policy choices that balance the need to make wise investments to spur job growth in the near term and provide security for the middle class with the need to put the budget on a fiscally sustainable path. The President's plan adopts the cuts to discretionary spending included in the Budget Control Act. It saves over $600 billion in mandatory spending, including changes aimed at improving the efficiency of Medicare and Medicaid spending. But it also eliminates special interest tax breaks for corporations and the wealthiest Americans. It asks our highest earners to return to the same tax rate that was in place during the Clinton Administration, when the economy was booming. In short, the President's budget takes a balanced approach.

It is this balance that our Republican colleagues object to. The overwhelming majority of our Republican colleagues have signed a pledge saying they won't close one special interest tax loophole or ask millionaires to pay a cent more for deficit reduction. And because they don't want millionaires to pay more, they put the entire burden of reducing short-term deficits as well as long-term debt on the backs of middle-

income taxpayers and seniors. Indeed, if last year's budget is any indication, the Republican plan will slash our investments in education, science and research, and infrastructure—key drivers of innovation and economic growth. And it will force seniors on Medicare to absorb the rapidly rising costs of health care, while slashing Medicaid assistance to low-income and disabled individuals by over $700 billion. I would remind my colleagues that the median income of seniors on Medicare is under $22,000.

There is a key difference between the Republican and Democratic approaches to Medicare. The Republican approach would end the Medicare guarantee of a package of benefits specified in law, and replace it with a voucher for the purchase of private insurance that would fail to keep pace with health care costs over time. Future beneficiaries would either have to pay thousands more dollars out of their own pockets on premiums for a plan that provides the current Medicare benefit package, or else buy plans that may leave them significantly underinsured.

We have no reason to believe that unfettered market competition will result in affordable, acceptable coverage for seniors. Prior to the creation of Medicare in 1965, almost half of all American senior citizens had no health insurance. And health costs were rising steadily back then. And yet, the market didn't respond to the cost constraints faced by seniors and develop an affordable insurance product that provided them adequate protection. Insurers didn't rush to cover individuals over 65 years old. Since 1965, we have had several experiments with private competition within Medicare, through the Medicare Advantage program and its predecessors. And what we found is that in many areas of the country, private plans simply could not compete with traditional Medicare unless we paid them more than traditional Medicare.

I firmly believe that converting Medicare into a voucher system that doesn't keep pace with health care costs is a huge mistake for our seniors. We cannot solve our budget challenge simply by unloading the costs and financial risk associated with health care onto elderly and disabled individuals. The goal of reform should be to reduce cost growth within the health system, while protecting the essential benefits that Medicare covers. The Affordable Care Act laid a solid foundation, through measures such as more bundling of payments, penalizing unnecessary hospital admissions, and giving physicians and other health care providers incentives to organize themselves differently so they can provide high quality, coordinated, efficient care. These kinds of reforms change Medicare to reward value and quality of care instead of quantity of care. But there is plenty more that can be done.

For example, we need to improve the coordination of care for individuals who are eligible for both Medicare and Medicaid. These individuals account for 37 percent of combined Medicare and Medicaid costs, even though they represent only roughly 1 in 10 of the combined Medicare and Medicaid beneficiary population. They are more likely to live with multiple chronic conditions, and are three times more likely to be disabled.

It is no surprise that these individuals make up a large share of Medicare and Medicaid spending, because they are, in general, sicker. However, some of these extra costs result from misaligned incentives between Medicare and Medicaid and a lack of coordination between the two. For example, nursing homes often can benefit financially by offloading certain costs onto hospitals. This is bad for the budget and it undermines the well-being of a vulnerable population. The Affordable Care Act begins to address these problems, but there may be further actions that Congress can take to give a boost to these reform efforts.

We are open to other ideas that address specific sources of wasteful spending. What we are not open to is simply transferring all of those costs to seniors on Medicare without dealing with the underlying costs driving the entire health care system, of which Medicare is a very important part.

Social Security's financial outlook also deserves our attention. It is not a major factor in our current deficit, but it does have a long-term shortfall that will need to be addressed. I believe we ought to address it well before we face a crisis and we ought to do so in a bipartisan and balanced manner.

I would also like to take a moment to clarify incorrect claims that were continually made by my colleagues on the other side of the aisle about the extension of the payroll tax cut to 160 million working Americans. In their opposition to this tax cut, they claimed it would reduce the amount in the Social Security Trust Fund. That is simply not true. As Mr. Goss has said before, the law is set up to make sure the Social Security Trust Fund is held completely harmless.

So thank you again, Mr. Foster and Mr. Goss, for your testimony today. As we work to put our house in fiscal order over the long-term, we must ensure that our social safety nets are not shredded in the process. Your insight into these programs is key as we debate these important issues.

Chairman RYAN. Thank you. Mr. Foster, why do we not start with you and then go with Mr. Goss. Floor is yours.

STATEMENTS OF RICHARD S. FOSTER, CHIEF ACTUARY, CENTER FOR MEDICARE AND MEDICAID SERVICES, STEPHEN C. GOSS, CHIEF ACTUARY, SOCIAL SECURITY ADMINISTRATION

STATEMENT OF RICHARD S. FOSTER

Mr. FOSTER. Thank you. Chairman Ryan, Representative Van Hollen, and other distinguished members of the committee, thank you for inviting me here to testify today. I am appearing in my role as an independent, technical adviser to Congress and my statements may not necessarily reflect positions of the Department of Health and Human Services where I work. I am accompanied today by three people: Chris Truffer, who is a fellow at the Society of Actuaries, Aaron Catlin, who has a master's of science in management, specializing in health care, and my special assistant Catherine Curtis, Ph.D.

My written testimony has probably far too much detail about the financial outlook for Medicare, Medicaid, and total national health expenditures. For now, I will concentrate primarily on one aspect. In particular, if we can get the first chart up, this will show a comparison of the factors underlying growth in personal health care in the U.S. compared to economic growth or the GDP.

This is a long-term average set of growth rates over the period of 1960 to 2010. I will start on the left with personal health care, and work our way up from the bottom. Personal health care grows because we have more population growth, and that is averaged about 1 percent per year; so 1 percent out of our growth in health care expenditures is due to population. General economic inflation contributes another 4 percent on average during this period.

Now, medical prices tend to be higher than general economic prices for a variety of reasons, and that so-called excess medical price inflation has added another 1.4 percent to this long-term average. Demographic changes in the population, or the age and gender mix, has not had a big impact over this period, this is about .4 percent, but then we come to growth in the volume and the intensity, or the average complexity of health care services per person, and that has contributed on average 2.9 percent, mostly as a result of more and better medical technology over time. Those add up to a total of 9.6 percent per year on average over the last 50 years.

Now, for comparison, let's look at GDP. You get a stronger or bigger economy if you have more employees; and employment over this period has contributed 1.7 percent to the overall growth in the economy. General inflation contributes the same 4 percent that we saw before to nominal GDP growth; and then you have real GDP, inflation adjusted GDP, per worker, which is a measure of productivity, which has been about 1.2 percent. Collectively, those add up to 6.9 percent, which is quite a bit less than we saw for the personal health care expenditures.

This differential has been somewhat smaller in recent years, but is likely to continue, and in particular, economic productivity is not likely to be enough to cover the health care costs associated with

the excess medical price inflation, and volume and intensity of services.

If I can have the second chart please.

The second chart just shows the past and projected total national health expenditures as a percentage of GDP, that is the top curve, and we also show the Medicare and Medicaid components of that. Back in 1960, national health expenditures were about 5.2 percent of the total economy. In 2010, that has increased to just under 18 percent, and we project by 2020, the cost will be just under 20 percent.

Medicare and Medicaid have grown similarly during this period and have actually come to represent a somewhat greater share of the total over time. So, what can you do about slowing down the rate of health care cost growth? Is it hopeless, or can something actually be done? Well, a lot of things have been tried. In particular, over the years we have had prospective payment systems and other forms of bundled payments. We have had managed care plans introduced and become widespread like HMOs and PPOs. There has been an attempt to get more prudent use of health care on the part of patients and individuals through consumer-driven health care plans and medical savings accounts. We have also seen lean production techniques in facilities like hospitals and skilled nursing facilities. Most recently, there has been a raft of ideas, including accountable care organizations, medical homes, and disease management. All of these have had some success in reducing the level of costs, but in terms of their impact on cost growth, they have not had a large effect.

One of the key drivers of health care costs that I mention is new technology, and most new technology, medical technology to date has been so-called cost increasing. It comes in, and it costs a lot more than what we used to do. The importance of efforts to refocus the nation's research and development community into looking at new technology that would reduce costs, while providing the same or better care, those efforts cannot be under emphasized.

There are other things going on like new innovations just starting in the works and delivery systems and payment methods. There is a lot of potential here for these to improve quality for the payments we make already, and there is some potential for reducing cost growth rate.

Well, that is the brief summary of the 18 pages in my written testimony. I hope it is helpful. As you all, and your colleagues, tackle the financial challenges posed to the U.S. by health care cost growth, I pledge the Office of the Actuary's continuing assistance in these efforts, and in a minute I will be happy to answer any questions you have. Thank you.

[The prepared statement of Richard S. Foster follows:]

PREPARED STATEMENT OF RICHARD S. FOSTER, FSA, MAAA, 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 outlook for health spending in the U.S., including the Medicare and Medicaid programs. I welcome the opportunity to assist you in your efforts to ensure the future financial viability of Medicare (the nation's second largest social insurance program) and Medicaid (the largest government health program in terms of the number of people covered). To-

gether, these programs are a critical factor in the income security of our aged, disabled, and low-income 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 (CMS). 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.

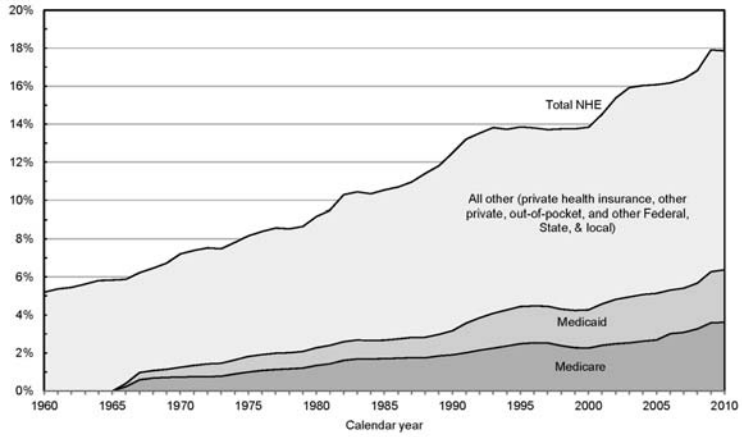
I am appearing before your Committee today in my role as an independent technical advisor to Congress. My factual statements, estimates, and other information provided in this testimony are drawn from the 2011 Medicare Trustees Report, the forthcoming 2011 Actuarial Report on the Financial Outlook for Medicaid, and our most recent historical and projected National Health Expenditure accounts; any opinions offered are my own and do not represent an official position of the Department of Health & Human Services or the Administration.

In view of your Committee's interest in budgetary impacts, and the Office of the Actuary's traditional role in assessing the financial outlook for health programs, my testimony will focus on the cost of Medicare and Medicaid, both in the past and as projected for the future. This focus, however, should not obscure the value of these programs. The health insurance coverage available to Medicare beneficiaries is obviously very valuable to them as individuals, with an estimated average benefit this year of more than $12,000 per person. Similarly, low-income individuals and families under Medicaid receive benefits worth, on average, $2,900 per child, $17,300 per disabled enrollee, $15,700 per aged enrollee, and $4,700 for other covered adults. There is also substantial value to society from the orderly provision of health care for the nation's older, sicker, and poorer populations.

I would also like to caution the Committee about the uncertainty of financial projections for health insurance programs. Certain aspects of projections, such as the demographic characteristics of the population, are relatively predictable.[1] Projections of health cost trends, however, are much more uncertain and depend critically on future economic developments, advances in medical technology, and other factors. Medicaid cost growth, in particular, has been more volatile than most other forms of health coverage, due to the impact of economic cycles on the number of enrollees, frequent legislative changes, and the efforts by the individual States to expand coverage or control costs. For these reasons, it is important to recognize that actual future Medicare, Medicaid, and total national health expenditures can—and generally do—differ from any specific projection. The projections are not intended as firm predictions of future costs, since this is clearly impossible; rather, they illustrate how these programs would operate under a range of conditions that can reasonably be expected to occur and thus serve a useful role in providing guidance to policy makers.

It is helpful to consider Medicare and Medicaid in the context of overall national health expenditures, since many of the factors affecting expenditure growth are common to all forms of health insurance. Chart 1 shows total health expenditures in the U.S. as a percentage of gross domestic product (GDP) from 1960 through 2010, the latest year for which we have complete historical data. The portions of total spending attributable to Medicare and Medicaid are also shown.

Chart 1—Medicare, Medicaid, and total national health expenditures as a percentage of GDP



Health spending in the U.S. has generally increased at a significantly faster pace than the economy, rising from 5.2 percent of GDP in 1960 to 17.9 percent in 2010. The upward trend has fluctuated somewhat, depending on the business cycle (which affects GDP growth) and on faster or slower periods of health cost growth. For example, national health expenditures represented about 13.8 percent of GDP for much of the 1990s, reflecting stronger-than-average real economic growth during much of this period and the widespread adoption of managed care health plans. Conversely, the share of GDP devoted to health care accelerated sharply in the early 2000s in part as a result of the public backlash against health care utilization controls and the economic recession that began in 2001.

From their enactment in 1965, Medicare and Medicaid costs have also grown faster in most years than the economy. Medicare expenditures represented 0.6 percent of GDP in 1967 and 3.6 percent in 2010. The corresponding percentages for Medicaid are 0.4 percent, increasing to 2.8 percent. The "all other" category in chart 1 is composed primarily of expenditures by private health insurance and individuals' direct out-of-pocket payments for health services.

Chart 2 shows the proportion of total U.S. health expenditures by source of payment for 1976 compared to 2010.[2] Medicare and Medicaid have been growing as a share of total expenditures. Over this period, Medicare increased from 13 percent of all U.S. health spending to 20 percent currently, and Medicaid grew from 10 percent to 15 percent. Payments by private health insurance have also increased as a share of the total, reaching 33 percent in 2010, although this level is a little lower than the maximum of 35 percent experienced in 2003 through 2005.

Out-of-pocket costs for health care services have declined substantially, from 27 percent of total expenditures in 1976 to 12 percent in 2010, reflecting private health insurance and Medicaid coverage expansions during this period.

CHART 2.—DISTRIBUTION OF NATIONAL HEALTH EXPENDITURES

[By source of payment, 1976 and 2010]

Source of payment	1976	2010
Individual's out-of-pocket costs	27%	12%
Private health insurance	24%	33%
Medicare	13%	20%
Medicaid (Federal, State, and local)	10%	15%
Veterans Admin., Dept. of Defense, and CHIP	4%	4%
Other third-party payers and programs	11%	7%
Public health	2%	3%
Investment	9%	6%

Medicare and Medicaid spending has increased as a share of total expenditures for several reasons:

• The Medicare benefit package has expanded since 1976 through such factors as a Part B deductible that was increased only twice during 1976 through 2004 and the introduction of the Part D prescription drug benefit in 2006. Eligibility for Medicaid was expanded by higher income thresholds for child and adult enrollees and the States' use of waivers to extend eligibility to other populations. In addition, the Medicaid proportion in 2010 reflects the impact of the 2008-2009 economic recession, which led to a significant increase in the number of enrollees.

• Expenditures by private health insurance plans grew at a somewhat slower rate as a result of the widespread adoption of managed care plans, including health maintenance organizations and preferred provider organizations. In addition, many employers sought to reduce cost growth by taking advantage of competition among insurers and through more frequent adjustments in employee cost-sharing requirements. Also, the proportion of the population with employer-sponsored insurance has declined over time.

• Contrary to popular conceptions, the aging of the post-World War II "baby boom" generation did not have a large impact on the increase in Medicare or Medicaid costs during this period. It will do so in the future, however, since the first members of this generation began reaching age 65 in 2011.

Chart 3 helps to explain why health care costs tend to increase at a faster rate than the overall economy. As indicated, health care cost growth averaged 9.6 percent per year from 1965 to 2010. About 1.0 percentage point is attributable to the growing population (more people, more health expenditures, all else equal). General, economy-wide inflation contributes to higher medical prices, adding about 4.0 percentage points on average over this period.

In addition, medical prices tend to grow at a somewhat faster pace than general economic inflation, since (i) a greater proportion of health care is produced by human capital than in the economy at large, and (ii) productivity improvement is lower for health care providers, reflecting their higher labor share and the individualized nature of many health services. Together, these factors have increased medical prices by about 1.4 percent annually above the level of economy-wide price growth, as measured by the GDP implicit price deflator.

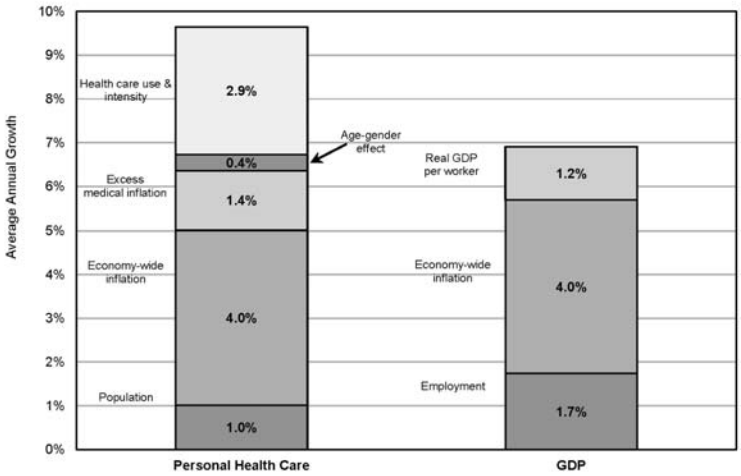
Over time, people tend to use more health care services, and the services tend to be more complex and expensive as new technology is developed. The "volume and intensity" of services per person has added about 2.9 percentage points per year to personal health care expenditure growth. Together, the increases in population, general prices, excess medical-specific prices, and volume and intensity, plus a small contribution from changes in the age and gender distribution of the population, have resulted in an overall average growth rate for personal health care expenditures of 9.6 percent over the last 45 years.

Similarly, growth in the economy can be decomposed into several roughly corresponding factors. The first of these is the increase in the number of workers, which has averaged 1.7 percent during 1965 to 2010—aided in part by the entry of the baby boom generation into the labor force.

The impact of general economic inflation, at 4.0 percent, is the same for both health expenditures and nominal economic growth. The increase in real (inflation-adjusted) GDP per worker occurs primarily as a result of productivity gains and has averaged 1.2 percent over this period.

Collectively, these economic growth factors add up to 6.9 percent, which has been well below the 9.6-percent growth in health expenditures. (As suggested by the trend variations shown in chart 1, the differential between health cost growth and economic growth has not been constant over time.) Going forward, employment growth is likely to be somewhat slower than overall population growth as the baby boom generation leaves the work force. The effect of general inflation is the same for both categories, but, based on past trends, labor productivity growth is unlikely to keep pace with continuing increases in excess medical prices plus the volume and intensity of services per person.

Chart 3—Factors accounting for growth
in Personal Health Care spending and the economy, 1965-2010



Another way to assess the causes of rapid health care expenditure growth is through an economic analysis of the key factors leading to increased demand for services and higher costs. Chart 4 summarizes the most recent research in this area, as published by Sheila Smith and Mark Freeland from the Office of the Actuary together with Joseph Newhouse of Harvard University.[3]

CHART 4.—CAUSAL FACTORS FOR GROWTH IN HEALTH CARE SPENDING, 1960–2010

Factor	Contribution to growth (percent)
Income effects	28–41
Relative medical price inflation	8–21
Demographic effects	7
Change in insurance coverage	10
Technology	26–45

Income growth has long been identified as a primary contributor to higher health spending. As individuals, or nations, become "richer," they tend to spend an increasing amount on health care. Smith et al. estimate that real per capita income growth during 1960 to 2010 was responsible for between 28 and 41 percent of the increase in real per capita health expenditures.

Relative medical price inflation (above and beyond economy-wide inflation) was found to have contributed between 8 and 21 percent. Demographic effects were not substantial over this period, but they explain about 7 percent of total health cost growth, while broader availability and higher levels of health insurance account for another 10 percent.

The impact of technology on health cost growth is usually measured as the residual, after all of the factors above have been estimated. In the Smith et al. analysis, technology is estimated to account for between 26 and 45 percent of historical real health expenditure growth per person. (In practice, other factors that are not separately estimated will also be included in the residual category. Such factors are believed to have only a small effect.) Technological advances contribute to expenditure growth both through the adoption of new treatments, devices, and drugs, such as implantable defibrillators, and through the ability of the health sector to apply existing services to a broader group of people, for example heart bypass and hip replacement operations to older patients. Although some new technologies enable the provision of existing services at lower costs, historically most technology has been cost-increasing. Growing incomes and the widespread availability of health insurance facilitate a ready market for new developments, even if their cost is much higher than existing treatments.

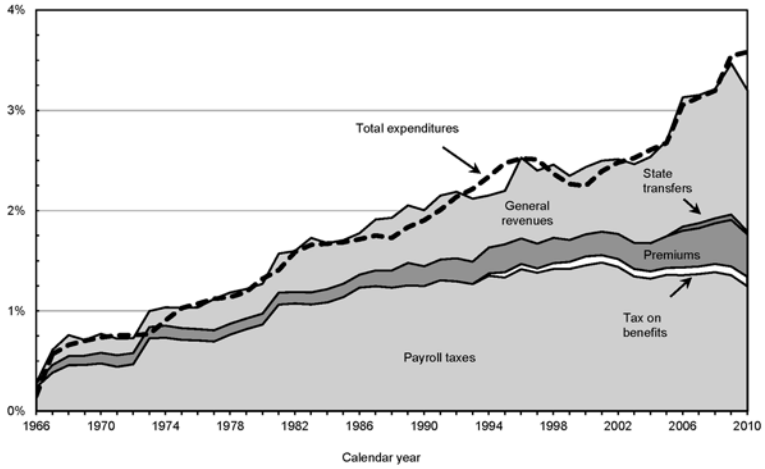
MEDICARE

Medicare expenditures are projected under current law to increase at a much lower rate than usual during 2012 through 2020, due to the combined effects of (i) continuing slow general inflation, (ii) a sharp reduction in physician payment rates required under the sustainable growth rate (SGR) formula, and (iii) the impact of the savings provisions in the Affordable Care Act. Most of these latter savings will occur as a result of the slower provider payment rate updates for most non-physician providers[4] and a downward adjustment in Medicare Advantage payment benchmarks and rebate percentages. Collectively, these factors contribute to a projected average annual cost growth rate of 5.9 percent during 2012 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 8.6 percent, with enrollment growth contributing 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 SGR payment reduction and the savings provisions in the Affordable Care Act.

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 2013. 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 in all future years by about 1.1 percentage point per year more slowly than the increase in input 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 for 2003 through 2012 to prevent the reductions in physician payment rates otherwise required by the SGR formula in current law.

Medicare has been financed by a somewhat eclectic set of dedicated and general revenues. The amounts of these financing sources are shown in chart 5, together with total expenditures, all expressed as a percentage of GDP. In total, Medicare revenues have been relatively close to expenditures, illustrating the "pay-as-you-go" nature of Medicare financing. (Most other forms of health insurance are also financed on a pay-as-you-go basis.)

Chart 5—Medicare sources of non-interest income and expenditures



The primary sources of financing for the Medicare program are as follows:

• Payroll taxes—Part A of Medicare is financed primarily through a portion of the FICA and SECA payroll taxes.[5] Employees and employers each pay 1.45 percent of covered earnings, while self-employed workers pay the combined total of 2.90 percent. Following the Omnibus Budget Reconciliation Act of 1993, Part A payroll taxes are paid on total earnings in covered employment, without limit. The Affordable Care Act introduced an additional 0.9-percent Part A payroll tax on individuals and couples with earnings above $200,000 or $250,000, respectively, starting in 2013.[6] Because these earnings thresholds are not indexed, over time a growing proportion of all workers will be subject to this additional tax rate. By 2085, for example, an estimated 80 percent of workers would be subject to the additional 0.9-percent HI payroll tax. 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. Until recently, payroll taxes were the largest source of financing for Medicare.

• Income taxes on Social Security benefits—Up to 85 percent of an individual's or married couple's Social Security benefits may be countable as taxable income for Federal income taxes. Any taxes payable on the taxable portion of benefits between 50 and 85 percent are allocated to the Part A trust fund. Because the income thresholds are not indexed, a growing percentage of Social Security beneficiaries are becoming subject to such taxes.

• Beneficiary premiums—Parts B and D of Medicare are financed in part by beneficiary premiums, which currently represent about 25 percent of Part B financing and 13 percent of Part D. These amounts are adjusted each year to keep pace with the cost of benefits; as a result, premiums have been a growing share of total financing for Medicare. In addition, premiums for higher-income beneficiaries are adjusted to cover a greater proportion of the average cost of Part B and Part D coverage.

• Payments by States—With the transfer of prescription drug costs for dual Medicare-Medicaid beneficiaries to Part D of Medicare, States are required to pay a portion of their forgone Medicaid costs to the Part D trust fund account. These payments currently cover about 10 percent of Part D financing and serve to reduce the amount of general revenues otherwise required.

• Fees on prescription drugs—Starting in 2011, manufacturers and importers of brand-name prescription drugs are required to pay annual fees, with the payments credited to the Part B trust fund account. These payments reduce the premiums and general revenues otherwise required to finance Part B.

• Federal general revenues—Roughly three-fourths of Part B and Part D costs are met by the general fund of the Treasury. As with beneficiary premiums, general revenues for these programs are reset annually and increase at the same rate as program expenditures. Consequently, income for Parts B and D automatically matches expenditures without the need for legislative adjustments. As a result of this financ-

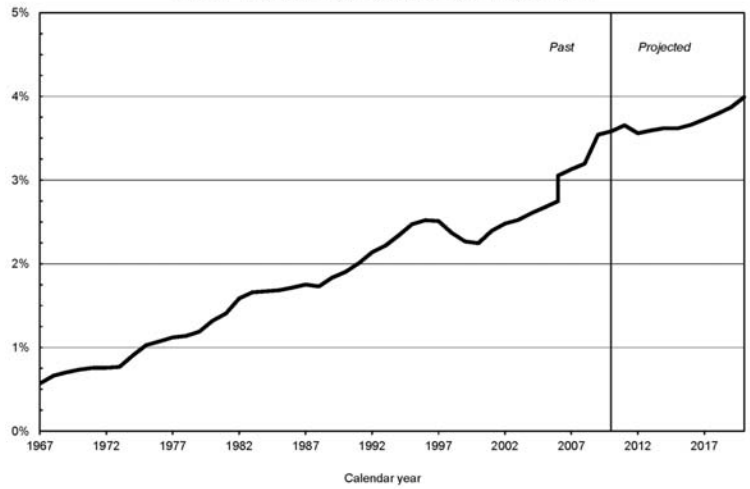
ing basis, and the slowdown in payroll tax receipts due to the 2008-2009 recession, general revenues recently became the largest source of Medicare financing.

• Interest—Any Medicare revenues that are not needed for the immediate payment of benefits and other costs are invested in Treasury securities. Interest earnings on these assets are credited to the associated trust fund account and may be used to pay program costs. Currently, interest represents about 4 percent of Part A income, 1 percent for Part B, and a negligible share of Part D revenues. (Interest is not shown in chart 5, since it is not a significant source of financing.)

In the early years of Medicare, beneficiary out-of-pocket costs for Part B premiums and cost-sharing requirements represented about 6 percent of an average Social Security benefit. Currently, Part B and Part D out-of-pocket costs for an average beneficiary are about 26 percent of an average Social Security benefit. Similarly, general revenue transfers to Medicare have increased from about 0.8 percent of total Federal personal and corporate income tax receipts in 1970 to about 18 percent currently. As Part B expenditures increase faster than the GDP or people's incomes, financing these costs represents an increasing share of available resources for both beneficiaries and the Federal government.

Chart 6 shows past and projected Medicare expenditures as a percentage of GDP. The past trend has been generally increasing, with the exception of the first 3 years following the Balanced Budget Act of 1997. The subsequent Balanced Budget Refinement Act of 1999 and the Benefits Improvement and Protection Act of 2000 eased certain of the BBA provisions, and cost growth continued to exceed economic growth. The addition of Part D prescription drug coverage in 2006 increased Medicare costs by about 12 percent. With the economic recession of 2008-2009, GDP declined and Medicare costs increased rapidly as a share of GDP, from 3.1 percent in 2007 to 3.6 percent in 2011.

Chart 6—Medicare expenditures as a percentage of GDP



Medicare expenditures are projected to remain fairly level at about 3.6 percent of GDP from 2011 through 2015.[7] This pattern reflects both faster assumed growth in GDP and slower Medicare cost growth as a result of the savings provisions in the Affordable Care Act and the large reduction in physician payment rates required under the statutory SGR formula. Expenditures are projected to increase as a share of GDP thereafter, but at a slower rate than historically as noted previously.

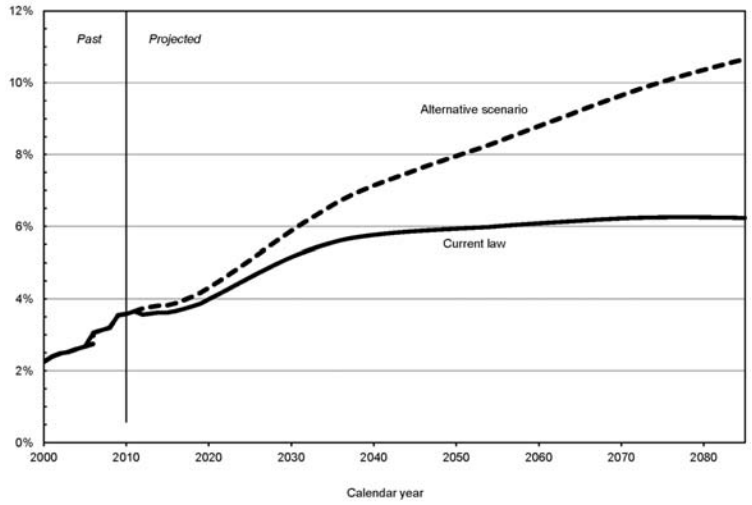
Together, the SGR formula and the reduced payment updates under the Affordable Care Act are estimated to permanently reduce Medicare expenditure growth rates by over 1.1 percentage points annually. In practice, however, Congress has overridden the physician payment reductions otherwise required by the SGR for every year 2003 through 2012, and further legislative action to prevent substantial payment reductions is probable. Also, as I and others have cautioned, the cumulative effect of the payment update reductions for other providers may lead to inadequate payment rates in the long range. In discussing strategies for reducing health care costs, former Office of Management and Budget (OMB) Director Peter Orszag wrote the following:

The first approach is to simply reduce payments to providers—hospitals, doctors, and pharmaceutical companies. This blunt strategy can work, often quite well, in the short run. It is inherently limited over the medium and long term, however, unless accompanied by other measures to reduce the underlying quantity of services provided. If only Medicare and Medicaid payments were reduced, for example, providers would shift the costs to other patients and also accept fewer Medicare and Medicaid patients. This would make the approach politically nonviable.[8]

If the SGR provision continued to be overridden and the productivity adjustments to other provider payment updates became unworkable, then future Medicare costs would be substantially higher than those projected under current law.[9]

Chart 7 shows the long-range projection of Medicare expenditures from the 2011 Medicare Trustees Report, together with the projected cost under an illustrative alternative to current law.[10] In 2010, total Medicare expenditures were $523 billion or about 3.6 percent of GDP. Under current law and based on the Trustees' intermediate set of economic and demographic assumptions, costs are initially projected to level off and decline slightly as a percentage of GDP as the economy recovers and unemployment returns to more normal levels. Costs will increase as the baby boom generation becomes eligible for HI benefits in 2011-2030 but are projected to largely level off thereafter at roughly 6 percent of GDP. This pattern results primarily from the accumulating effect of the productivity adjustments.

Chart 7—Medicare expenditures as a percentage of GDP



For comparison, costs under the illustrative alternative projections increase rapidly throughout the long-range period, reaching 10.7 percent of taxable payroll in 2085, compared to 6.2 percent under current law. Thus, depending on the long-range feasibility of the SGR provision and the slower payment updates for other providers, Medicare expenditures could be about three-fourths higher than projected under 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.

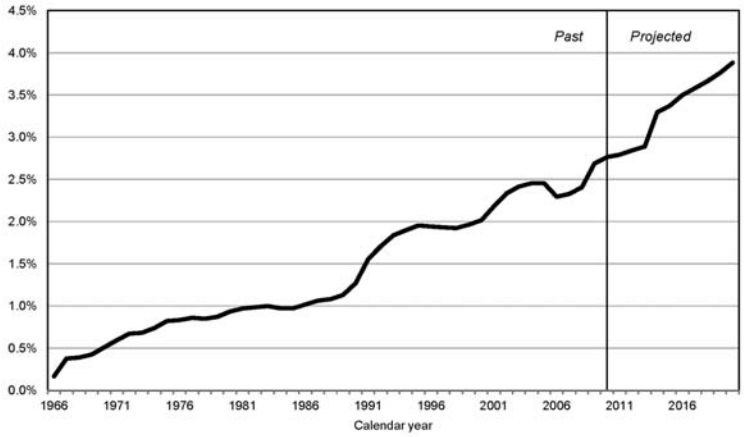
The effect of the baby boom generation on Medicare and Social Security is relatively well known, having been discussed by actuaries and others for almost 40 years. In brief, by 2030 when the baby boom cohorts have enrolled in Medicare, there will be about 65 percent more Medicare beneficiaries than there are today, but the number of covered workers will have increased by only about 15 percent. 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.

MEDICAID

Historically, total (Federal plus State) expenditures on behalf of Medicaid enrollees have increased faster than the U.S. economy in most years, as shown in chart 8. Costs as a percentage of GDP have fluctuated with the business cycles, since higher unemployment both adds to the number of Medicaid enrollees and decreases GDP, with economic recoveries having the opposite effects. Medicaid expenditures increased dramatically between 1988 and 1995, doubling as a share of GDP from 1 percent to 2 percent, in part as a result of eligibility expansions for children but more so from the enactment of "tax and donation" schemes by States to increase the Federal share of Medicaid financing. Medicaid costs decreased in 2006 with the implementation of the Medicare Part D prescription drug benefit, which transferred drug costs for dual beneficiaries from Medicaid to Medicare. Most recently, costs increased significantly as a result of the recent economic recession. These trends also reflect States' recent efforts to constrain cost growth through limits on provider payment rates, tighter eligibility standards, and increasing use of managed care plans.

Chart 8—Medicaid benefit outlays as a percentage of GDP



Medicaid cost growth should decelerate somewhat over the next several years as the economy recovers and many enrollees regain jobs and employer-sponsored private health insurance. Beginning in 2014, the number of enrollees is expected to increase substantially as a result of the Affordable Care Act provisions to (i) increase the income threshold to (effectively) 138 percent of the Federal poverty limits, (ii) eliminate asset limits, and (iii) expand eligibility to all low-income adults regardless of family or disability status. We estimate that enrollment in 2014 will increase by about 14.9 million, or 26 percent, but Medicaid expenditures are expected to increase by a much lower amount—7 percent—since most of the new enrollees will be non-disabled adults, with relatively low health care costs compared to the average for current enrollees.

Chart 9 shows Federal, State, and total Medicaid outlays in fiscal year 2010, by category of payment. Acute-care benefits remain the largest category of outlays, although payments made under capitated arrangements have been an increasing share of the total. Outlays for long term care services have increased more slowly than the historical average in recent years.[11]

CHART 9.—MEDICAID OUTLAYS FOR FISCAL YEAR 2010 BY TYPE OF PAYMENT

[In billions]

Title XIX outlays—2010[1]	Federal share	State share	Total
Medical assistance payments (MAP):			
Acute care benefits[2]	$98.5	$44.2	$142.7
Long-term care benefits[2]	76.3	36.7	113.0
Capitation payments[2]	71.5	32.4	103.9
DSH payments[2]	8.7	6.5	15.2
Adjustments[3]	4.7	3.6	8.3
Subtotal MAP	259.7	123.4	383.1
Administration payments	10.1	8.0	18.1
Vaccines For Children program	3.8	0.0	3.8
Gross outlays	273.5	131.4	404.9
Collections	−0.8	−0.1	−0.9
Net outlays	272.8	131.3	404.1

Source: 2011 Actuarial Report on the Financial Outlook for Medicaid (forthcoming).

[1] Outlays do not include Title XIX share of State Children's Health Insurance Program.

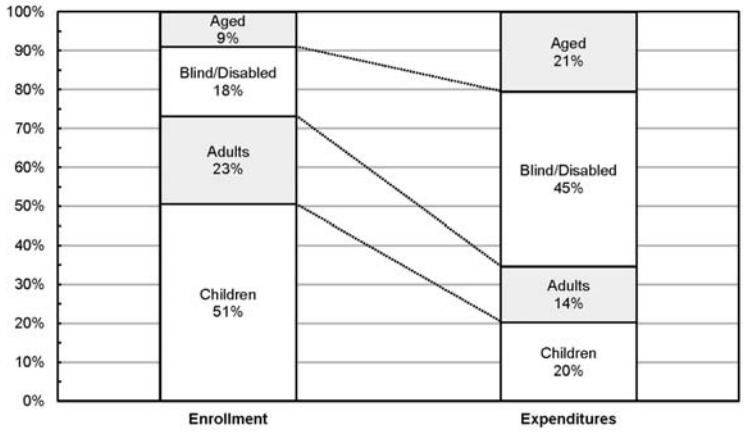
[2] Benefit expenditures by category from CMS-64.

[3] Adjustments include collections, prior period adjustments, and difference between expenditures and outlays.

Medicaid costs are met primarily by Federal and State general revenues, on an as-needed basis; the States may also rely on local government revenues to finance a portion of their share of Medicaid costs. Other than a very small amount of premium revenue from enrollees and certain other sources of State revenue (such as provider taxes), there are no dedicated revenue sources comparable to the Medicare Part A payroll tax. Federal financing for Medicaid is authorized through an annual appropriation by Congress. These funds are then spent through daily draws from the general fund of the Treasury in the amounts required to pay that day's Federal matching amounts on the State program expenditures. As a result, Federal Medicaid outlays and revenues are automatically in financial balance.

Chart 10 presents the distribution of Medicaid enrollees and costs by enrollee category as of 2010. About half of all enrollees were children; due to their relatively low level of per capita health care costs, Medicaid expenditures on behalf of children represented only about 20 percent of the total. Conversely, aged and disabled Medicaid enrollees were only about one-fourth of the total number, but their per capita Medicaid costs were about two-thirds of total costs, despite the fact that most of the aged enrollees, and many of the disabled, are also eligible for Medicare, which is the primary payer for dual beneficiaries.

Chart 10—Medicaid enrollment and expenditures by eligibility group, as a share of total



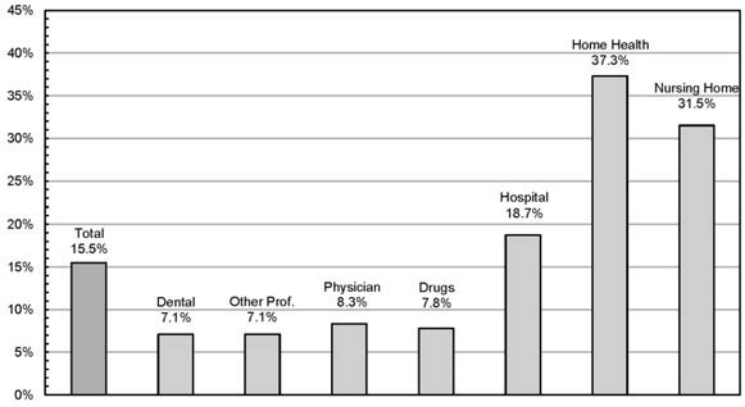
Source: *2011 Actuarial Report on the Financial Outlook for Medicaid* (forthcoming).

Total Medicaid enrollment in 2010 averaged about 54 million, representing 17.4 percent of the total U.S. population. As shown previously, Medicaid paid about 15 percent of all health care costs in 2010, or somewhat less than might be expected based on the percentage of the population covered by the program. The difference occurs primarily because Medicaid provider payment rates are much lower than average, and the proportion of children enrolled in Medicaid is significantly higher than the overall enrollment percentage. In addition, as noted above, Medicare pays a majority of health care costs for most aged Medicaid enrollees and for many of the disabled.

As indicated in chart 11, Medicaid's share of total U.S. health expenditures varies significantly depending on the type of service. In particular, Medicaid is the largest payer of the costs of nursing home care. Other categories, such as physician, other professional, and prescription drugs have lower percentages for the reasons given above.

States have taken many steps in recent years to try to reduce Medicaid costs, which have become one of the largest categories of State expenditures. The primary means has been to limit or reduce payment rates to physicians, hospitals, and other fee-for-service health care providers. Although such steps have been effective at holding down per person cost growth, an increasing number of enrollees report that they have difficulty in finding physicians (specialists in particular) who are willing to see new patients with Medicaid.

Chart 11—Percentage of total U.S. health expenditures paid by Medicaid, by type of service, 2010

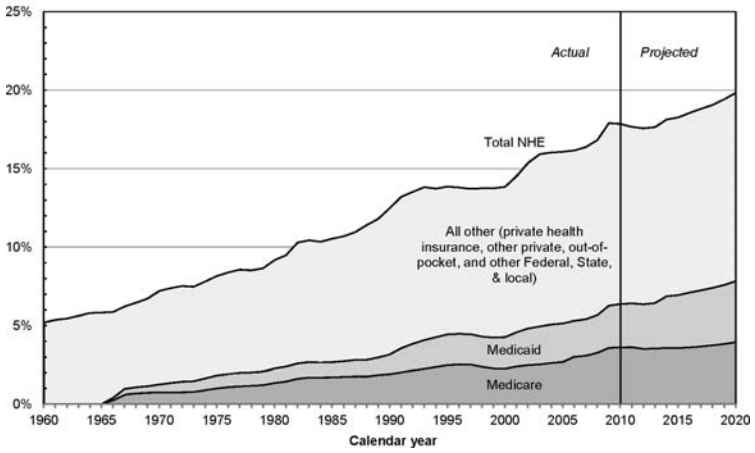


Source: National Health Expenditure accounts, Office of the Actuary.

CONCLUSION

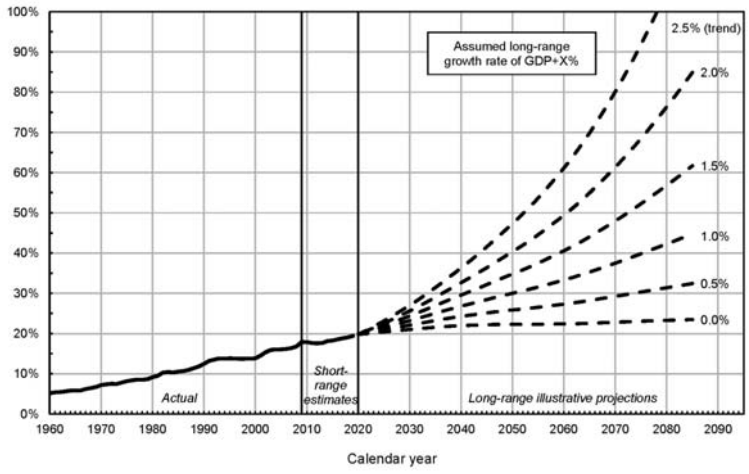
Chart 12 shows projected Medicare, Medicaid, and other health expenditures for the next 10 years.[12] Total national health expenditures are estimated to increase from their 2010 level of 17.9 percent of GDP to 19.8 percent in 2020, reflecting an average annual growth rate in health expenditures of 6.0 percent and average growth in nominal GDP of 4.8 percent.

Chart 12—Past and projected Medicare, Medicaid, and total NHE as a percentage of GDP



My final graph (chart 13) illustrates the level of national health expenditures as a percentage of GDP under several hypothetical cost growth rates in the long-range future. On average during 1960 through 2010, per capita health care spending increased at the rate of growth in per capita GDP plus another 2.6 percentage points. If that long-range past trend continued in the long-range future, national health expenditures would represent more than 100 percent of GDP—an obviously impossible situation. The pursuit of better health will continue to be extremely important, but it cannot crowd out food, clothing, housing, and all other necessities and desires of life.

Chart 13–Illustrative long-range NHE projections under alternative health cost growth assumptions



Note: Projections through 2020 are based on current law; after 2020, projections are illustrative only.

Over the last 20 years, health spending has increased at the rate of GDP plus 1.9 percent. Even if this rate continued into the indefinite future, health care would represent an untenable proportion of total economic production. As the late economist Herb Stein once quipped, "If something cannot go on forever, it will stop." Accordingly, something will occur and cause slower growth in health care in the future.

Most people would agree that certain developments, which could reduce the rate of health spending growth, would be very undesirable. For example, if individuals' premiums and cost-sharing liabilities were to increase significantly faster than their incomes for a sustained period, then many might find these costs unaffordable and have to drop out of their insurance plans and forgo needed services. Health expenditure growth would slow—but only because an increasing amount of appropriate care would be forgone. A similar situation could occur if employers continue to face cost increases for their group health insurance plans that outstrip their revenue increases, forcing them to scale back or drop their employee coverage to remain financially viable. Alternatively, if payment rates to health care providers were reduced or slowed too much, as may have already occurred for some State Medicaid plans and as may be the case in the future for Medicare physician and other provider payments, providers could become unable or unwilling to continue treating patients in these programs.

Many ideas have been developed and tried over the years in an effort to reduce health care cost growth. Examples include the development of prospective payment systems and other bundled-payment mechanisms; the widespread adoption of managed care plans; efforts to facilitate more prudent use of health care services through consumer-driven health plans and medical savings accounts; use of "lean production" techniques by hospitals and other facilities; and, most recently, the development of accountable care organizations, medical homes, disease management, and other efforts to better integrate the delivery of care. Most of these efforts have had some positive impact on lowering the level of health care costs, but there is relatively little evidence that they have succeeded in reducing cost growth rates.

As indicated by the Smith, Newhouse, and Freeland analysis of the causal factors underlying health care cost growth, the two largest contributors have been rising incomes and new medical technology. It is not surprising that increasing incomes prompt both individuals and nations alike to seek better health care. This trend could persist for many years, although demand for continually more and better health care services would presumably slow if meeting that demand could be accomplished only by reduced consumption of other necessities or high-priority goods and services.

The development and adoption of new medical technology may prove to be pivotal in future efforts to slow health care cost growth. Numerous studies have found that most new health technology has been cost-increasing, encouraged by comprehensive insurance coverage that shields individuals from most of the additional direct costs

of using the new technology. Over time, as all payers continue to seek ways to reduce costs and as providers can no longer be assured of revenue flows that will automatically adjust to their higher cost levels, the medical research and development community may direct their efforts more toward new treatments, devices, and drugs that can provide health outcomes that are equal to or better than those provided by existing technology but at a lower cost.

Signs of such a change in focus are already apparent. For example, efforts are underway to produce a one-time-use implantable defibrillator, which would be just as effective in an emergency as the existing multiple-use devices but would cost far less. In overseas health markets, most developing nations cannot afford the expensive health technology produced in the U.S., and a market is developing for somewhat less effective—but far less expensive—technology, such as fewer-slice/lower-field-strength MRI machines. As this market grows, U.S. providers, payers, and developers may join in.

A related area of policy consideration is "comparative effectiveness research." While controversial, the potential benefits of these efforts are significant. There have been many examples of new drugs and devices that have offered only a limited improvement (if any) over existing treatments but that cost substantially more. The introduction of the proton pump inhibitor drug Nexium, when the nearly identical drug Prilosec was about to lose patent protection, is a well-known example.[13] It is reasonable to expect that science can be applied to assess whether a new technology's minor gains justify what might be a major increase in expenditure.

Finally, public and private efforts to research alternative health care delivery systems and payment methods could lead to innovative new approaches with the ability to improve the quality of care and/or reduce the cost of care. The program authorized by the Affordable Care Act, through the new Center for Medicare and Medicaid Innovation at CMS, is a comprehensive example of innovations research and testing, with the potential to identify effective ways of achieving these twin goals.

Thank you for this opportunity to meet with your Committee. I applaud your efforts to strengthen Medicare and Medicaid and to find ways to help ensure the financial viability of these important health care programs. And as you work to determine effective means by which to ensure the availability of high-quality health care in the U.S., at a cost the nation can afford, I pledge the Office of the Actuary's continuing assistance. I would be happy to answer any questions you might have.

ENDNOTES

[1] For example, in 1957 noted actuary and demographer T.N.E. Greville projected that the "Social Security area" population in 2000 would be 302 million; the actual number, 43 years later, was 288 million or less than 5 percent lower than the estimate. More importantly for purposes of social insurance financial analysis, he projected that there would be 5.2 working-age people for every person at age 65 and over; the actual ratio was 4.8 to 1.

[2] The National Health Expenditure accounts also track health care spending by type of service (such as hospital care, physician services, and prescription drugs) and by source of financing (governments, businesses, and households). The historical and projected NHE accounts are available at *http://www.cms.gov/NationalHealthExpendData/01—Overview.asp* .

[3] See Smith, S., Newhouse, J., and Freeland, M., "Income, Insurance, and Technology: Why Does Health Spending Outpace Economic Growth?" Health Affairs, September/October 2009. The estimates shown in chart 4 have been updated through 2010 using the authors' methodology; the results are very similar to those shown in the article for 1960-2007.

[4] For hospitals, skilled nursing facilities, home health agencies, diagnostic laboratories, and most other providers of health services, Medicare payment updates will be set at the increase in provider input prices (or the CPI, in certain cases) less the increase in private, non-farm business multifactor productivity in the economy overall. In addition, the Affordable Care Act requires additional payment update reductions in 2010-2019 for specified provider categories. For hospitals, these additional reductions total 3.6 percent.

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

[6] The Affordable Care Act also specifies that individuals with incomes greater than $200,000 per year and couples above $250,000 will pay an additional "Medicare contribution" of 3.8 percent on some or all of their non-work income (such as investment earnings). However, the revenues from this tax are not allocated to the Medicare trust funds.

[7] These projections are drawn from the 2011 Medicare Trustees Report and thus do not reflect the Budget Control Act of 2011, the Temporary Payroll Tax Cut Continuation Act of 2011, or the Middle Class Tax Relief and Job Creation Act of 2012. The forthcoming 2012 Trustees Report will incorporate these impacts.

[8] Orszag, Peter R., "How Health Care Can Save or Sink America," Foreign Affairs Vol. 90, No. 4, July/August 2011.

[9] As described in my July 13, 2011 testimony before the House Committee on the Budget, Medicare payment rates for inpatient hospital care in 2009 were about 67 percent of those paid by private health insurance for their commercial plans. Under current law, Medicare payment rates are projected to decline 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). By the end of the long-range projection period, Medicare payment rates for inpatient hospital services would represent roughly 33 percent of the average level for private health insurance and about one-half of the current relative level for Medicaid.

Somewhat similarly, Medicare physician payment levels in 2009 were about 80 percent of private health insurance payment rates. Medicare physician payment rates would decline to about 57 percent of private health insurance payment levels due to the mandated reduction in the Medicare physician fee schedule of roughly 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 2012.) Under current law, the Medicare rates would eventually fall to 27 percent of private health insurance levels by 2085, which would be less than half of the current relative level of Medicaid physician payment 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 real per capita GDP increase factor specified by the SGR formula.

[10] 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 to 2035. No endorsement of such changes by the Office of the Actuary or the Board of Trustees should be inferred. The illustrative alternative projections are available at *http://www.cms.gov/ReportsTrustFunds/Downloads/2011TRAlternativeScenario.pdf.*

[11] The forthcoming 2011 Actuarial Report on the Financial Outlook for Medicaid will have a comprehensive discussion of past and projected trends in Medicaid spending.

[12] "National Health Spending Projections Through 2020: Economic Recovery and Reform Drive Faster Spending Growth," Health Affairs Vol. 30, No 8 (2011). *http://www.cms.gov/NationalHealthExpendData/01—Overview.asp* .

[13] See, for example, Dr. Marcia Angel, The Truth About Drug Companies: How They Deceive Us and What To Do About It, Random House, 2007.

Chairman RYAN. Thank you. For an actuary that was remarkably brief. Mr. Goss.

STATEMENT OF STEPHEN C. GOSS

Mr. GOSS. Chairman Ryan, ranking member Van Hollen, thank you very much. I will try to be as brief. Last July you asked Rick and me to come and talk to you, and we talked about the fiscal facts of Social Security and Medicare. The title for today's hearing I took very much to heart: Strengthening Health and Retirement Security. If I may, I would like to be a little bit broader in the discussion rather than just Social Security and Medicare.

If we can flip to the next slide please.

I would suggest there are two really fundamental issues that are facing us as a nation going forward into the medium and long-term future. One is one that I think we are all familiar with, and we talked about much last July, the demographic population aging issue, which is to a great extent due to the fact that birth rates have dropped from three children per woman down to two children per woman. To see, very simply, what that means, imagine that we were all being taken care of by our kids; if you had three kids there is a lot more sharing going on in what they have to do for you than if you have two kids, and fundamentally, that is what is going on in our society. The only good news here is that we are not alone. Every other economically developed nation in the world is facing this or worse situation in terms of the demographics.

There is another fundamental challenge that we are facing in this country, and if we flip to the second chart, still channeling on the idea of the lower birth rates and the changing age distribution, of course what that means is that we have a drop not only in the number of children, but in the number of works available for each beneficiary. That is also dropping over the next 20 years from three workers per beneficiary down to two workers per beneficiary. So whatever we choose to provide for retirees and for beneficiaries in

general, whether it is Social Security or Medicare, that burden is going to have to be shared amongst fewer workers to pay for it.

You go to the next slide, the other fundamental challenge I want to suggest is something we are all very familiar with, and I think Mr. Van Hollen alluded to this also, is the shrinking world and the competitiveness around the world, which is a great thing.

Every economist will tell us over and over, that having better trade, better opportunities all around the world is good for everybody, but the particular position that the United States has been in with its highly competitive situation will be under stress in the future. In order to retain the kinds of jobs, the kinds of high-paying jobs, and the level of productivity in our economy that our projections from our trustees, OMB, and CBO, are assuming for the future is going to require that we do things in the future to meet these global challenges, and that we make sure that we have the best trained, educated, and skilled work force, and that we invest appropriately in this country to make sure that jobs on our shores are high paid, highly productive because after all GDP, gross domestic product, is what counts, and that is the source of getting all the revenue we have for, not only everything that the government does, but everything that we do for people in our economy in their retirement. Go to the next slide.

So, those are the two fundamental challenges, how does this play into what we want for the future: again, this idea of strengthening health and retirement income security into the future. Well, we can see on this little chart something that you have seen before about the past and the projected future cost of Social Security and Medicare under the most recent 2011 trustee's report, and Social Security is averaged at about 4.5 percent of GDP cost over the past 20 years or so. Medicare has been rising, and was most recently around 3.5 percent of GDP. Both are projected, over the next 25 years, to go up to about 6 percent of GDP. That is a big increase. That is almost double for Medicare, and for Social Security it is an increase of about one-third, in terms of the cost of the programs.

The real question is, how are we going to meet these costs? If we want to strengthen, or even maintain the level of security, and the level of benefits provided under these programs, we would have to find a way to be able to fund that level.

Now, in terms of retirement security, if we can flip to the next chart.

The old saw that I am sure you all have heard too many times about the three-legged stool, Social Security and Medicare are not the only sources of retirement income and health coverage. There is also personal savings and there are private pensions. Dallas Salisbury over at EBRI, and others, have shared with us the kind of graph that you see here, which shows that over the last 25, 30 years we have had a dramatic drop in the number of defined benefit pensions, which typically, historically had provided lifetime annuities to folks, which is a pretty good definition of retirement income security where we have been moving more towards defined contribution plans. There is all kinds of reasons for that, obviously, but more and more, people have been taking just lump sum distributions and not getting annuities out of defined contributions. So the ability of the other two legs of the stool to really provide life-

time income retirement security has really been called into question and has been diminishing over time.

So if we look on the next slide at what Social Security actually has provided and what it is projected to provide under scheduled benefits for the future, which are not fully financed of course, for 65-year-old retirees, we show on this little chart what we call these replacement rates; it is just the level of benefit that a person would be expecting to get, as compared to the lifetime earnings level that they were used to having in the past.

For relatively low earners, retiring at 65, who had earned about $20,000 per year throughout their lifetime, and that is at about the 25th percentile of our career average earners, they would get a little bit less than half of what they had been earning throughout their career from Social Security, which means probably people would like to live on more than that, so we really do need the other legs of the stool. People with higher earnings obviously get a lower percentage of their lifetime earnings replaced by Social Security.

If we flip to the next slide, you can see if we look now at a little bit more of a reality, which is that most people who are not disabled actually take the benefits earlier than 65.

In fact, about half who are eligible take the benefits right at 62; and at 62 the benefit levels are about 20 percent less than are available at 65 for a retiree under Social Security, and so these replacement rates are about 20 percent less. The 50 percent drops to 40 percent for that $20,000 a year worker. All of this just indicating that Social Security provides what it provides under scheduled benefits now, we have pay attention to the future to how much it is going to provide, but also the other two legs of the stool, what they will provide in terms of retirement income security.

On the next slide is a picture now of how are doing so far.

How we are doing so far on Social Security is not as well as we would like, obviously as Chairman Ryan and ranking member Van Hollen indicated we need reforms, and we need changes for Social Security. We are projecting by 2036 for the trust fund reserves for Social Security to become exhausted. The DI, disability insurance, program alone is on a faster trajectory, by 2018 actually because of the large cost-of-living adjustment we had last year, which is almost 3 percentage points higher than we had estimated because of things that had happened over in the Middle East last spring, that we are all familiar with, ran up the cost of oil, and ran up the cost-of-living adjustments, and increased the cost of our program; and therefore, we expect the DI program actually will end up running out its reserves before the beginning of 2018; 2017 is likely, and maybe even 2016. So time is not on our side in terms of making these changes.

On the next slide, this shows on a sort of a year-by-year cash flow basis, that we are now running into the period because of this demographic change of having our costs on the blue line rise up above the tax income to the program, and as a result of that, we are using up those trust fund reserves.

By 2036 when they are gone, we will have to live off, as I think Chairman Ryan indicated, something like 77 cents worth of tax income still coming in for every dollar of scheduled benefits; so if we

do not do something, that is what is going to hit, and hit very directly at that point in time.

On the next slide, just a very brief look at what we are facing in the relatively near-term, which I know you all on the Budget Committee have to pay attention to, in addition to the long-term issues which are so important.

The little blue bars here indicate what is really happening with the Social Security trust fund with all sources of income. We still have more income coming in than we have outgo, so the dollar level of the trust fund is still rising through 2020. However, looked at from a different point of view, or looked at from a cash flow where we exclude interest, which of course balances out in the overall unified budget, we see the sort of pink lines here that we are running negative already as of 2010, and project those negatives to continue.

The darker pink, or red lines, in 2011 and 2012 show a little bit bigger drop by simply reflecting the impact of the payroll tax holidays that we had, while the trust funds were immune from any effect from that, obviously, as you all know so well the unified budget backfilled it, reimbursed the trust funds for that money, and so the general fund had to put that money on the table. That is what fiscal stimulus, I guess, looks like to run deficits on the near-term.

On the last little slide I have got, and if we get into some discussion of this, which I hope, is really looking forward in the positive sense of some of the kinds of things that you all, other members of Congress, and other policy makers, have considered for possible changes.

The first several items here under Strengthening Retirement Income are things that many people have considered: bringing more revenue to the table, ways of promoting better use of people's savings, and other accumulations in pensions to try to bolster the strength of retirement income.

Finally, at the bottom is another possibility also, which is even if we do not have more revenue, we can shift and reorient the money we have and how it would be spent. Many proposals have come to floor that would suggest that we should reduce the benefit levels to higher-income folks, so that we can be in a better position to make good on as much as possible of the commitments to the lower-income folks.

Thank you very much for the opportunity to come and talk to you today, and I look forward to any questions you might have.

[The prepared statement of Stephen C. Goss follows:]

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

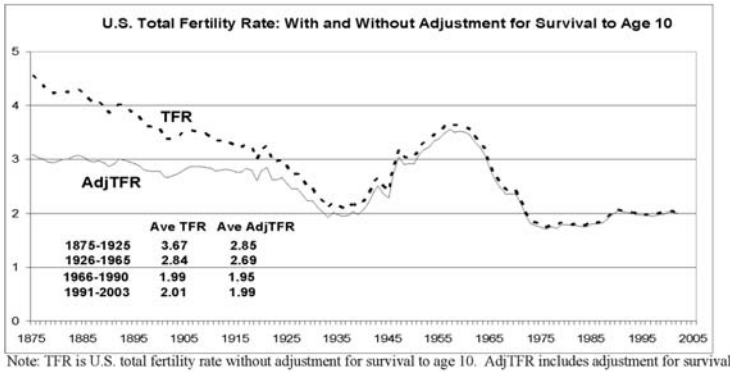
Chairman Ryan, Ranking Member Van Hollen, members of the committee: thank you for the opportunity to discuss with you today how we can strengthen the health and retirement systems that provide security for the population of the United States. In July of last year, we talked about the "Fiscal Facts" specifically for Social Security and Medicare. However, today's topic is broader than just those two programs. If we are to succeed in providing a secure future for retirees, and for all Americans, we need to: (1) understand the challenges we are facing; (2) decide on what we want for future retirees; (3) assess how we are doing so far; and (4) determine what changes we need to make.

(1) TWO FUNDAMENTAL CHALLENGES WE FACE AS A NATION

The near term fiscal challenges of the Federal budget must be considered in the context of the two longer-term challenges we face as a nation. First, our population is aging due largely to the drop in birth rates that began over 40 years ago and continues today. Second, the world has shrunk and we now compete for jobs directly with other populations around the globe.

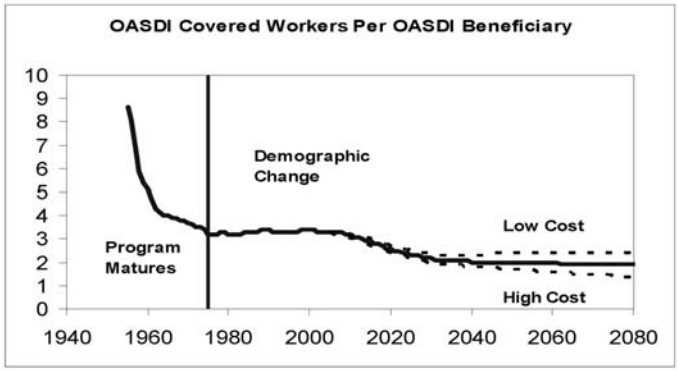
Our Aging Population

Prior to 1970, women in the US had about three children who survived to adulthood. Since 1970, our birth rate has dropped to a new level of two children per woman.



Note: TFR is U.S. total fertility rate without adjustment for survival to age 10. AdjTFR includes adjustment for survival.

This decline in birth rate affects the age composition of the population. All else equal, we will have one-third fewer working age people for every elder in the future. This shift started around 2010 and will be complete around 2030. Even with projected increases in employment of our older population, the number of workers for each Social Security and Medicare beneficiary will drop from three to two over the next 20 years.



Virtually all other economically developed countries are facing a similar or worse aging of the population. Therefore, we are not alone in this challenge. What this aging means, however, is that retirees will be a larger portion of the population, and so will consume a larger portion of the economic output of our economy. Whether through government programs or other means, a greater share of GDP will go to elders for food, shelter, and services, including health services, if we are to maintain the same relative standard of living in retirement in the future as in the past.

Shrinking World and Competitiveness

Capital and technology, and products and services, flow across borders more readily than ever before. Yet we support our population, and particularly our retirees, mainly from the earnings of workers within our borders.

Our projections for Social Security and Medicare assume real increases in output per hour worked of 1.7 percent per year, and real increases in average earnings of

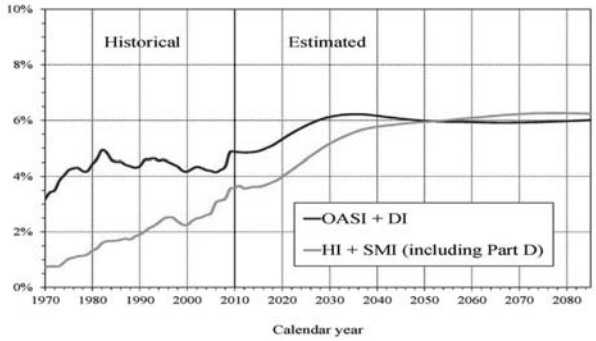
1.2 percent per year in the future. OMB and CBO make similar, if not more optimistic, assumptions. If we are to achieve these gains, we need a highly skilled, highly educated workforce in the future and must invest accordingly.

(2) RETIREMENT INCOME AND HEALTH SERVICES WE WANT

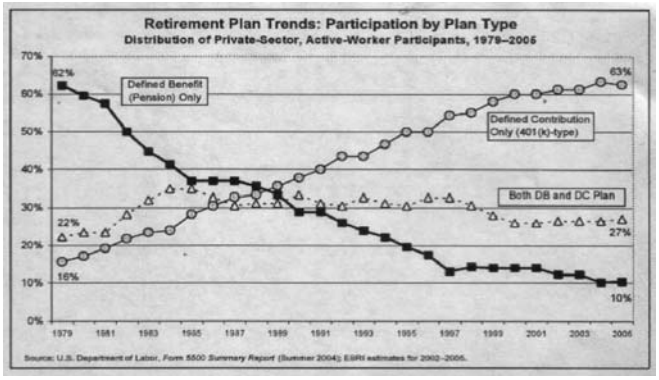
Retirement income provides for the most basic needs of food and shelter. These are essential. We have become sufficiently productive to afford many other things, such as the most extensive health care system in the world. Maintaining this level of retirement security in the future will require a greater share of gross domestic product (GDP) than in the past, simply because of the aging of the population. Social Security and Medicare are only two of many components of this security, but the projected trend in their cost parallels the trend in cost for all other sources of retirement security.

Over the next 20 to 30 years, the Social Security and Medicare Boards of Trustees project that the cost of Social Security will increase by about one-third, from 4.5 percent of GDP to 6 percent of GDP, and that the cost of Medicare will nearly double from 3.5 percent of GDP to 6 percent of GDP. If we desire to maintain the same relative retirement income and health care, these increased costs as a share of GDP will have to be met. The alternative is reduced relative retirement income and health care.

Projected Cost of Social Security and Medicare as Percent of GDP



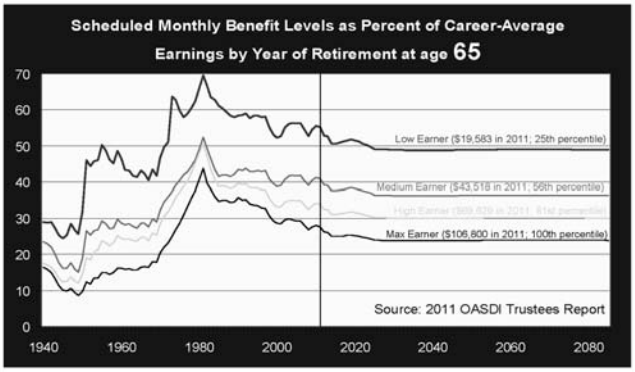
Social Security benefits were never intended to provide all we need in retirement. Employer-sponsored pensions and personal savings are the other two legs of the "three-legged stool." Pensions and savings have not kept up with retirement needs. Roughly one-half of workers retire with pension accumulations; however, these pensions have increasingly been "defined contribution" plans, where most retirees take lump-sum distributions instead of annuities. Annuities, like Social Security benefits, provide guaranteed monthly income for the rest of retirees' lives. Even many traditional "defined benefit" plans have begun offering lump-sum options.



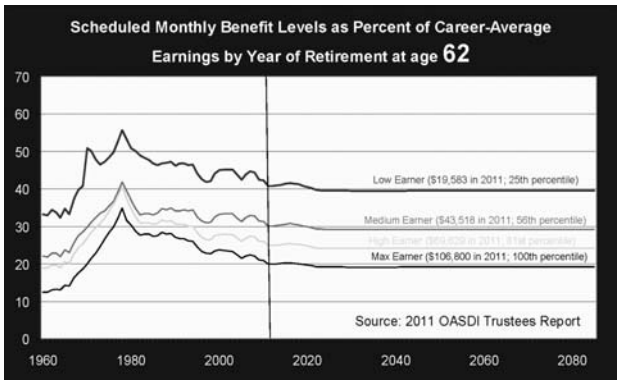
Efforts to encourage and promote purchase of annuities with private savings and pension accumulations could help. However, we have succeeded so well in empha-

sizing the importance of accumulating a "nest egg," few are willing to part with their accumulation to purchase an annuity. The "floor of protection" provided by Social Security is more needed than ever.

In this context, Social Security benefit levels require careful consideration. Even assuming retirement at age 65, Social Security monthly benefits will replace less than 50 percent of career-average earnings for those who made about $20,000 per year, and only about 30 percent for those who made $70,000 per year.

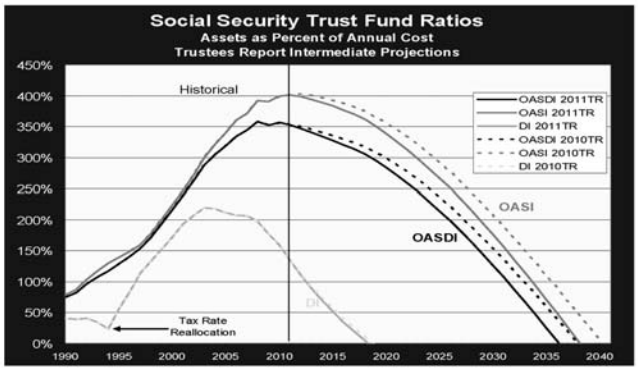


For those retiring at 62, as over half do, the percent of career-average earnings is even lower, at less than 40 percent for the $20,000 earner, and less than 25 percent for the $70,000 earner.



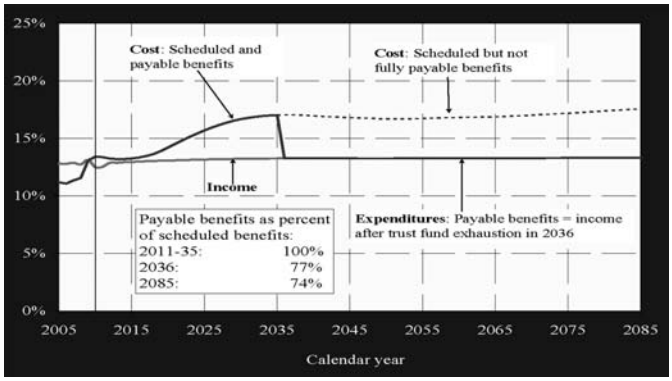
(3) HOW ARE WE DOING SO FAR?

Scheduled payroll tax and benefit taxation revenue for Social Security amount to about 4.5 percent of GDP. However, the cost of scheduled benefits will rise to 6 percent of GDP over the next 20 years. This growing shortfall will, over the next 25 years, gradually use up the $2.7 trillion in reserves now held in the Social Security Trust Funds.

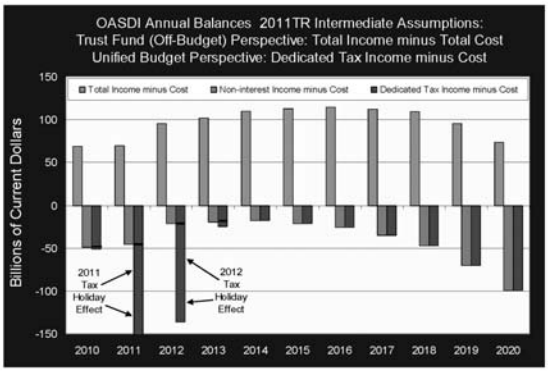


If no action is taken, the Disability Insurance (DI) Trust Fund reserves will be depleted soon. For the 2011 Trustees Report issued last May, we projected DI reserves would be exhausted early in 2018. With the surge in oil prices due to Middle East issues since last spring, the COLA for December 2011 was 3.6 percent, almost 3 percentage points higher than projected. As a result, the DI reserves will more likely be depleted early in 2017 or late in 2016. The immediate DI problem can be fixed with a tax-rate reallocation between the OASI and DI programs, as was done in 1994. However, exhaustion of combined OASDI Trust Fund reserves will still face us by 2036, or sooner. If we do not act, benefit levels will be reduced automatically by about 25 percent by 2036.

OASDI COST, INCOME, AND EXPENDITURES AS PERCENT OF TAXABLE PAYROLL



In the very near term, the dollar level of combined OASDI Trust Fund reserves is still rising. Total income, including interest, is projected to exceed program cost through 2020.



However, cost began to exceed non-interest income in 2010 due to the economic downturn and is projected to remain higher than non-interest income in the future.

In addition, payroll tax rates have been used as a mechanism for fiscal stimulus with the HIRE Act for 2010, and with 2-percent payroll-tax holidays for 2011 and 2012. None of these temporary stimulus measures has had a negative effect on the actuarial status of Social Security, because the General Fund of the Treasury has reimbursed the Trust Funds for every dollar of reduced payroll tax. The temporary payroll-tax rate reductions have, however, added to unified budget deficits, as a part of the fiscal stimulus measures to promote more consumer demand and economic growth.

(4) WHAT CHANGES DO WE NEED TO MAKE?

With Social Security scheduled benefits replacing less than half of earnings for workers earning $20,000, and replacing even less for higher earners, and the prospect of even these levels being cut by 25 percent automatically by 2036, we need to consider the following options:

(a) Provide added revenue to maintain Social Security benefits at currently scheduled levels;

(b) Provide even more revenue to increase scheduled benefits;

(c) Provide universal alternative means for guaranteed lifetime retirement income to supplement Social Security;

(d) Promote purchase of life annuities with a larger share of savings and pension accumulations at retirement; or

(e) All of the above.

Several proposals have recommended substantial increases in revenue to help pay for scheduled Social Security benefits.

(i) Both the Simpson-Bowles Commission and the Rivlin-Domenici Plan recommended increasing the maximum level of annual earnings subject to payroll tax by enough to eliminate about 25 percent of the long-range actuarial deficit.

(ii) Representative Deutch proposed to eliminate the limit on earnings taxed, as was done for Medicare, in order to completely eliminate the 75-year actuarial deficit.

(iii) Chairman Ryan and the Rivlin-Domenici Plan proposed to eliminate the exclusion of premiums for employer-sponsored group health plans from earnings subject to payroll tax. This change would eliminate about 50 percent of the long-range actuarial deficit.

Several proposals would increase the level of benefits for at least some beneficiaries.

(i) Both the Simpson-Bowles Commission and the Rivlin-Domenici Plan recommended enhancements to the current minimum benefit provisions of Social Security

(ii) Representative Deutch proposed using the Consumer Price Index designed for the elderly to determine COLAs, rather than the index designed for urban workers. This change would provide increased benefit adequacy at the oldest ages where poverty is greater. (Census 2009 Poverty: 8% for 65-74, 10% for 75 and over.)

Several proposals would provide workers with an option to redirect a portion of their payroll tax to personal accounts in return for lower benefits from Social Security.

(i) Chairman Ryan has recommended a plan for a voluntary personal account with a minimum guaranteed rate of return.

(ii) Representative Landry has proposed that workers have an option to reduce their payroll tax rate by 2 percent for any year in return for an increase in their normal retirement age by 1 month.

Several proposals would alter the structure of Social Security benefits in order to encourage workers to work longer and start benefits later.

(i) Representatives Kolbe and Stenholm, and others, have recommended increasing the size of reductions for taking benefits early, thus encouraging later benefit claiming.

(ii) The Simpson-Bowles Commission recommended an increase in the earliest age at which benefits could be started in order to keep monthly benefit levels as high as possible, even if payable for fewer years. This proposal also offered a waiver of the increased retirement age for low-paid, long career workers.

Many proposals have recommended targeted reductions in scheduled benefits, particularly for higher earners, so that currently scheduled revenue will be able to pay for more of the benefits now scheduled for lower earners.

Finally, we could promote the purchase of life annuities or "longevity insurance" with personal savings and pension accumulations. For example, a sum of $100,000 at 65 could provide inflation-indexed retirement income in several different ways, including:

(i) Without purchasing an annuity, spend $324 per month to make sure the $100,000 will last until age 110.

(ii) Buy a life annuity at 65 paying $544 per month for life.

(iii) Buy a 20-year deferred annuity and spend the remainder of the $100,000 until age 85, for $475 per month.

CONCLUSION

We are at the beginning of a substantial and permanent shift in the age distribution of our population. This shift was caused by the drop in birth rates from the long-time average level of about three children per woman through 1965, to just two children per woman since 1975. By 2040, there will be only two workers for every OASDI beneficiary, down from three workers per beneficiary throughout the period 1975 through 2008. As a result, the cost of Social Security will shift from about 4.5 percent of GDP to a stable level of 6 percent of GDP by 2040. Currently scheduled tax revenue will remain at about 4.5 percent of GDP. Making Social Security solvency sustainable 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 Fund reserves are projected to become exhausted in 2036, with only 75 percent of presently scheduled benefits payable thereafter through 2085.

In addition, we are facing a global challenge for the best high-paying jobs. It is critical that we invest in the workers of the future to assure that they will have the highest possible level of skill, training, and education. Without this investment, we will not achieve the level of real productivity and earnings growth needed to pay for retirement income and health costs in the future.

Members of Congress and various Commissions have laid out a wide range of possible approaches for financing and altering currently scheduled Social Security benefits to meet the challenges of the future. However, Social Security cannot achieve these goals alone. We also need personal savings and private pensions to contribute more to lifetime guaranteed retirement income.

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 and strengthen the retirement and health security of our population.

Chairman RYAN. Thank you Steve. Since we ended with Social Security, why do I not pick up on Social Security. If you could bring up Mr. Goss's second-to-last chart: OASDI costs, income, and expenditures as a percent of the taxable payroll. I want to ask you about the cliff that occurs in 2036. We have heard people advance, here in Congress, that the trust fund is fine until 2036, and we do not have to do anything until then, so why worry about it now? I want to get at the nature of that. Correct me if I am wrong, but

if we do that then we have an across-the-board cut of about 23 percent that occurs in benefits, is that correct?

Mr. GOSS. Exactly.

Chairman RYAN. And does that hit everybody equally? Meaning, does the 23 percent cut hit a low-income worker just as much as it hits a high-income individual?

Mr. GOSS. Well, as we understand it, our general counsel at Social Security across several administrations, has indicated that the law actually does not speak explicitly to this. The commissioner, standing at that time, would simply have 77 cents available for every dollar of scheduled benefits, and would not be permitted to spend more than that. We do not have borrowing authority, so a decision would have to be made about who would get the money. We could have an across-the-board 23 percent cut immediately, or a commissioner could say, well we are not going to pay the March benefits in March, we will wait until April, or wait until more revenue has come in to allow full payment a month late. After a few months we would, perhaps, and then have to start paying benefits two months late, so this would be a way that it could be handled; of course, if people have to pay rent on time, that would be a difficulty. So there is no easy way out on this. One could channel this towards having bigger reductions for people with higher benefits.

Chairman RYAN. That would be up to Congress at the time, right?

Mr. GOSS. We hope, and pray, that Congress would indeed act well before we ever hit the trust fund reserve exhaustion.

Chairman RYAN. Let me get to that. So given that we have this abrupt 23 percent cut that occurs in law, that is current law, is it not wise to start reforming now, sooner, so that the distribution of the change is spread more broadly and evenly across income cohorts. Let me ask it this way, does that abrupt 23 percent cut hit current senior cohorts, like a person who is turning 62 or 65 today, that affects them as well, correct?

Mr. GOSS. It certainly would. They would be at older age at that time, but clearly it would affect them. That is assuming that we wait and do absolutely nothing until that point.

Chairman RYAN. Right, so if one provides reform soon, could you not prevent these kinds of effects from hitting those current cohorts, or could you not phase reforms in gradually that prevent that 23 percent cut from happening so it does not affect people who are currently in or near retirement? Could you structure reforms that prevent that from happening if you act sooner?

Mr. GOSS. Absolutely. We have a number of proposals, including yours Chairman Ryan, and many other proposals that would take exactly that approach. Our trustees, and everybody who speaks on this, has opined extensively about the value of acting sooner rather than later, so that we can have gradual changes phased in, and we have more options if we act relatively soon.

Chairman RYAN. What was life expectancy when Social Security was created?

Mr. GOSS. Life expectancy when Social Security was created, where it is about 20 years at age 65 now, it was substantially less than that, I believe. I would have to get back to you with the precise numbers.

Chairman RYAN. You are an actuary, I thought you guys had this stuff off the cuff.

Mr. GOSS. Well, some stuff. It was probably somewhere on the order, I believe, over the last 30 years or so, life expectancy in general has increased by about five years, life expectancy at birth. The more important life expectancy probably is life expectancy at something like 65 because that is the point at which you start to get benefits, and it has increased significantly. We are projecting that it will increase somewhat slower in the future, but continue to increase. The real factor we believe, though, the big shift, what we see on this cost curve over the next 20 years, that is not because of life expectancy.

Chairman RYAN. It is demographics.

Mr. GOSS. It is demographics, but it is demographics, really, switching from having two kids paying the bills instead of having three kids.

Now, we have some continuing increase in the cost thereafter because of increasing life expectancy. We are hopeful, as all of you I know, that with increasing life expectancy that will be coupled with increasing health at any given age, and people will be able to work longer, and our estimates for revenues for both Social Security and Medicare do incorporate that aspect; but it is the shift to having only two kids instead of three kids that really is the fundamental demographic shift facing us.

Chairman RYAN. Okay, so Mr. Foster, let's introduce these points into the Medicare conversation. In your written testimony, you address the need for Medicare reforms that lower cost growth rather than just levels of spending. To that end you suggest delivery system reforms that could be effective. You have testified previously that as a general rule, a system set up along the lines of premium support for providers to compete against each other for patients' business, where society is most vulnerable, the poor and the sick receive more assistance while the wealthy receive less, would achieve savings in Medicare while continuing to provide a basic Medicare benefit. Do you still believe that that is the case, that that kind of a system can be designed?

Mr. FOSTER. Yes, many people have talked about premium support in different varieties of form for many years now, and it does have the potential to introduce competition among insurers for the Medicare business, and it does have the potential to lower the level of cost as well. There is some potential to lower the growth rate, but that is harder to do. Competition, itself, generally gets you the bottom dollar cost consistent with good quality, but then the growth rate beyond that bottom dollar cost may have to be addressed through other items in addition to the competition.

Chairman RYAN. Right, so in and of itself, cost-growth reform, and growth rate reform in Medicare is not enough, you had to deal with health care reform, itself, that goes to the broader issues of the root cause of health inflation. Is that, more or less, what you are saying? It is not enough just to reform Medicare; you have to have profound health care reforms that get at root cause of health inflation?

Mr. FOSTER. Yes, I would agree with that because if you think about it, the same reasons that cause Medicare costs to grow fairly

quickly, same thing for Medicaid, same thing for other private health insurance, and if you tried to fix these underlying factors in just one sector of the health economy, it probably would not work. You really need to attack all of them.

Chairman RYAN. So I want to get into competitive bidding. As you may know, that I have been working across the aisle with a member of the Oregon delegation from the Senate on a premium support plan that uses competitive bidding to help determine the contribution. Competitive bidding, we have seen, has worked well in Part D in Medicare Advantage. I would like to get your thoughts on choice and competition as it relates to these previous successful reform plans. Given what we have seen in these aspects of Medicare, do you believe that competitive bidding is a process that can be successfully applied Medicare wide?

Mr. FOSTER. Yes, I think it can. Obviously it would represent a large change from the status quo, but I think it could work. We have seen signs of this. You mentioned the Part D prescription drug program, for example, where the different drug plans compete against each other on the quality of their benefit package and the premium level, and we have seen every year since Part D started, migration of beneficiaries to more efficient plans with lower premiums, so that can help. We have also seen for durable medical equipment, when we had the demonstration, that competitive bidding in this particular area of fee-for-service Medicare reduced prices that we had to pay by 40 percent.

Chairman RYAN. By 40 percent?

Mr. FOSTER. 40 percent, that is right.

Chairman RYAN. Those are the kinds of cost savings we are going to have to achieve if we want to continue to make good on the promise of the Medicare guarantee. This is what I am trying to get at, which is this should not be a partisan issue. Competitive bidding is something that Alice Rivlin has been a champion of, Ron Wyden's been talking about, the bipartisan policy center; there is a lot of data out there that competitive bidding, when applied Medicare wide, can achieve the benefit of keeping these benefits going while attacking root cause of cost growth. What I am trying to get at is we have had CBO in here that says they cannot analyze it. They do not have the tools in the toolbox, I think is the word they use, to quantify competitive bidding. Do you feel more comfortable now that we have had about a decade's worth of history on how competitive bidding has worked in aspects of Medicare, like you just suggested, which if applied throughout the Medicare system could actually replicate those kinds of cost-growth improvements.

Mr. FOSTER. We have done a lot of work over the years estimating the financial effects of premium support proposals and other proposals. A good place to start is the current Medicare Advantage program because we have data for every single plan in the country, and what their costs are for the standard Medicare benefit package, and we can compare that to, say, corresponding fee-for-service costs in the area. So we have a pretty good idea of the cost levels, and if the premiums reflect that difference in cost, then it is not hard to model with some uncertainty, obviously, how people would make decisions to go with this package or stay in a fee-for-

service or do something else; in some cases fee-for-service would be the least expensive plan in parts of the country. So we can estimate those, we have done it, and there is potential for savings there.

Chairman RYAN. That is helpful to know because we do not see this as a big stretch, and we are applying finite dollars because of pending bankruptcy, we believe that those dollars ought to go the people who need it the most, the poor, the sick, middle-income individuals, and less toward higher-income individuals, and if applying this you can preserve the Medicare guarantee while also expanding patient choice and competition to try and get at excess cost growth. It is encouraging that this data exists. I would just simply say that we need to improve our ability to get this kind of analysis going because we do not have it here in Congress, we do not have it at CBO, and it would be fantastic to see if your office could work with CBO so that they, too, could glean the kind of analysis that you are providing.

Mr. FOSTER. We provide a lot of technical assistance to them, and they provide some to us; we would be happy to work with them. Let me just mention one other thing, Chairman Ryan. You mentioned two things that are almost two separable issues. One is the competitive bidding, the premium support. You can apply that to everybody, regardless of their income. If beyond that you want to do other things to increase coverage for low income and decrease it for high income, you can do that to, and in fact several such steps have been done in recent years. The two are almost different issues entirely.

Chairman RYAN. Sure. I totally agree with that. Thank you very much. Mr. Van Hollen.

Mr. VAN HOLLEN. Thank you, Mr. Chairman, and thank you both for your testimony this morning. I am just going to start with you Mr. Goss on the Social Security. First of all, thank you for your good advice on many issues relating to Social Security, and let me just say in response to the chairman, I think count me among those who think that we should tackle this issue sooner rather than later. In fact, I think we should get to it right away, and I think we should take a balanced approach. I think President Reagan and Tip O'Neill outlined the way forward in dealing with that question on a bipartisan basis.

Let me just go back to the letter that you wrote on February 17th, I think, which was reinforced by your testimony this morning because there has been some misinformation with respect to the impact of the payroll tax cut legislation that was just passed on the Social Security trust funds. I am just reading from your letter of February 17th saying, "the trust funds would be unaffected by enactment of this provision. Future benefit levels would be unaffected because the reduced payroll tax rate would not affect the amount of covered earnings that is credited for benefit purposes."

I take it you stand by your letter, and if you could just elaborate for a moment on that issue, just to put that issue to rest once and for all.

Mr. GOSS. Thank you, Mr. Van Hollen. That is exactly correct, and the good news is that is not opinion; that is the law. That is what was enacted and the president signed. In fact, the law is very explicit and it says, "Any of the payroll tax reductions are reim-

bursed immediately exactly as though the payroll taxes were not reduced." In fact, our office actually generates the numbers that the Department of Treasury then transfers to the trust funds, and we simply indicate to Treasury for this transfer that the money should be transferred to the trust funds exactly as though this had never gone into effect.

Mr. VAN HOLLEN. Thank you, thank you Mr. Goss. I hope we will not be hearing any more of that misinformation going forward now that you have laid it out very clearly.

Mr. GOSS. And you were also exactly correct on the fact that people's benefits are not affected.

Mr. VAN HOLLEN. Thank you, Mr. Goss. Mr. Foster, I want to pick up where the chairman left off in your testimony, with respect to the difference between reducing the base level of health care costs, whether it is in Medicare or in the private system, and addressing the rate of growth, the increase in health care costs, and I just want to read from a MedPAC report from 2009:

"While private and public programs differ in their coverage and financing, over the long term their rates of per-capita growth have been similar when comparing spending for benefits that private insurance and Medicare have in common, Medicare spending per enrollee grew at a rate about 1 percentage point per year lower than that for private insurance from 1970 to 2006."

And in your own 2011 trustees report on Page 87, you state, "over long historical periods average, demographically adjusted per-capita growth rates for common benefits had been somewhat lower for Medicare than for private health insurance. That was in 2011, do you stand by that statement today?

Mr. FOSTER. Yes, the trustees report and the MedPAC statements are correct.

Mr. VAN HOLLEN. Okay, because this gets to the fundamental question of how we address the rising costs of Medicare and health care in general. If you are simply transferring a Medicare beneficiary from the Medicare system into the private health market, and the growth in costs in the private health market is the same or higher than Medicare, they are not going to be paying any less, are they?

Mr. FOSTER. Other things being equal, that is correct. Now, one important thing to understand is that over the historical period Medicare payment rates came down quite a lot legislatively from being, essentially, much too high and today perhaps to being too low, or getting to that direction. So that 1 percent differential is at least partly attributable to the slower payment updates for Medicare compared to what private health plans could negotiate.

Mr. VAN HOLLEN. Right, and we got into this at the hearing last time and I will put it in the record again, surveys from individuals who are in the private health care system compared to surveys who are on the Medicare system, with regard to their current access to doctors and providers, and across the board, my colleagues may remember the Medicare surveys turned out to have higher levels of confidence support than in the private market. So this gets to the fundamental question because sometimes I think people forget that back in 1965, when we created Medicare, we had the experiment of private health care insurance for people over 65. They were

older, they were sicker. About 45 percent of older Americans had no health insurance. We had a free market system for those seniors at that time, and it just turns out that health insurers did not see a big market in making a profit on providing health care to seniors, which is why the pooling benefits of Medicare help drive down those costs, as we just discussed.

Now, I want to talk about the one experiment we have had with respect to the private insurance within the Medicare system. You mentioned Medicare Advantage, and you specifically mentioned that in some markets fee-for-service is less expensive. That is true today, is it not still?

Mr. FOSTER. That is correct.

Mr. VAN HOLLEN. Okay, and in fact, before the Affordable Care Act, we were subsidizing those private plans in some cases up to about 140 percent of fee-for-service, were we not?

Mr. FOSTER. Correct.

Mr. VAN HOLLEN. Just so everyone understands, that means for those enrollees in the private plans, we were paying $1.45 per enrollee compared to $1 in the fee-for-service plan. Even today, after the Affordable Care Act, we are still subsidizing some of those private plans up to 115 percent, is that not right?

Mr. FOSTER. Yes, once it is fully phased in.

Mr. VAN HOLLEN. So once it is fully phased in, and the chairman mentioned reductions in the Medicare. So some of the savings we achieved, a significant amount of savings we achieved, were in reducing these overpayments, these huge subsidies, to the private Medicare Advantage plans. That is one of the things that was done in the Affordable Care Act, right?

Mr. FOSTER. I would word it a little bit differently, but your basic point is correct. Because of the prior law Medicare could pay more than a typical fee-for-service cost to most Medicare Advantage plans per person, and that enabled the plans to offer extra benefits and lower premiums and so forth.

Mr. VAN HOLLEN. That is right, and the impact of that is that, not only tax payers, but other Medicare beneficiaries who are paying premiums in the fee-for-service program are actually cross-subsidizing the seniors on Medicare in the Medicare Advantage plans, is that not true too?

Mr. FOSTER. Yes, Part B premiums were higher because of the higher payments to Medicare Advantage plans, and that was true for all beneficiaries, including those in fee-for-service.

Mr. VAN HOLLEN. Okay, now I also want to get at a fundamental distinction between a pure, market-based premium support system, and one where you have a voucher, or some equivalent of a voucher, that is linked to some other artificial measure because those have very different impacts. For example, the federal employee health benefit system, which every member of Congress is on, is targeted to the market price, but members of Congress are guaranteed a certain share of their premiums will be paid for the federal government, is that not right?

Mr. FOSTER. That is correct.

Mr. VAN HOLLEN. Okay, and there is a big difference between that, in terms of economic security, between that and a system where the amount of the voucher, or premium support, or whatever

you want to call it, is not linked to the market price, but could be linked to an indice that actually does not rise at the same rate, cost wise, as the market, right?

Mr. FOSTER. Yes, this is one of the fundamental design principles when you are considering a competitive bidding or premium support approach. In the traditional premium support, you set the premium support itself as a function of the average bid of all the competing plans, including fee-for-service. Over time, as the cost of health care goes up, that average bid tends to go up with it. Now, people migrate to the cheaper plans, the more efficient plans with lower premiums, so this benchmark bid, or average bid, would not increase as fast as health care costs generally over a transition period.

Other versions would impose, also, in addition to the bidding aspect, an overall or global amount of increase that is allowed for the funding, and several of the more recent plans have included that feature.

Mr. VAN HOLLEN. And in fact, just to close out, Mr. Chairman, in your testimony you point out that in those cases where your support, the amount of your voucher does not keep pace with the market costs of health care, you may have to choose to either pay a lot more out of pocket, or not get a health care plan that covers all your needs, is that not correct?

Mr. FOSTER. That is certainly a risk, and it is a pretty important risk. The real question is by initiating such a system that is so different where there is a limited growth rate, does that send a signal to the people who develop the new medical technology, and will they act in such a way as to come up with devices and treatments and drugs that are just as good as the existing ones, but they are cheaper? Now, that would be a good thing for the country if it could apply the same techniques that you see every day in manufacturing and other sectors to health care, but it is not easy to do, and as I said, it is a risk.

Mr. VAN HOLLEN. Okay, and that of course was the world we were in before 1965.

Mr. FOSTER. There is one other difference too, let me just add because you are entirely correct, there is no meaningful private health insurance market for people over 65 before Medicare. Now, the difference between then and today is back then there were no federal subsidies in support of it. If there were no subsidies for Part D of Medicare, it would not be working nearly so well, because there are subsidies, a viable market is not only possible, it is thriving.

Mr. VAN HOLLEN. Right, and I will close out Mr. Chairman, but the question is whether the market will respond to provide the health care at below the current market price because individuals are income constrained; and in 1965 they were income constrained with vouchers, and the fact is you did not see the market adjust to take care of people over 65.

Chairman RYAN. This is fantastic. I think that was one of the best explanations of competitive bidding and how to structure this so we get at cost growth, and our point is subsidize the people who need it the most, people who are low income, people who are sicker, than people who are higher income. That is the smartest way to

go, and it puts on a virtuous cycle of trying to attack the root cause of health inflation, medical device cost growth. Get us on that virtuous cycle, like in manufacturing where new technologies actually served to reduce costs, not escalate costs, like we have seen in health care.

So to us it is about getting the right incentive structures in place so that we can have a program of genuine security for health care for people in old age. While we do that we want to make sure that those who had the least ability to take care of themselves, the sick and the poor, are totally taken care of, and not people who have extra disposable income, so that they can absorb the greater cost if that is going to be a result of these kinds of processes. So this is a fantastic conversation, I could go on and on, but we have got a lot of members here. Mr. Garrett.

Mr. GARRETT. So there is some perception by some that there is not a big problem, either with Social Security or with Medicare, but I think the consensus of this panel is that there is a need for reform in both of these entities. I see you are shaking your head at that. The reform should come sooner rather than later, and I guess both panelists would agree with that as well. When I say "some" because I have seen reports that Senator Reid has indicated that he is willing to tackle these issues as well on a bipartisan matter, but he is one that wants to wait the 20 years before we actually get to it. Again, does either panelist think either Social Security or Medicare that would it would be appropriate management plan to wait 20 years to make any reforms to these systems?

Mr. FOSTER. I would just comment that I just had my 39th anniversary in the federal government, and Steve yours is coming up in a few months, I believe. Over that time we have both seen an awful lot of proposals, and crises, and plans that give a lot of advance notice, and plans that gave no advance notice. I know I would vote every time for earlier action, which not only can be less disturbing to whatever market we are dealing with, but you have more options at that point because it is earlier in the process, and also to the extent you have to change something. You give more notice to whoever it might be, whether it is beneficiaries or health care providers, tax payers, or whoever is involved.

Mr. GARRETT. Right, and Mr. Goss, I thought I heard in your testimony, and on one of the charts to this point, that it is not 30 years down the road, or 20 years down the road, but when it comes to SSDI, the disability insurance, that it could be as early as 2016, did I hear that is when that program could potentially, I will use the term, bankrupt?

Mr. GOSS. Exactly. Certainly not bankrupt, but that is the point at which the reserves might be exhausted, and at that point we estimate about 86 cents for every dollar.

Mr. GARRETT. What does that mean to my constituent in 2016 or 2017, if nothing is done to that program and he is currently on it, how does his benefits change?

Mr. GOSS. That could mean that failure of this body to act could leave us in a position where the Social Security commissioner only has 86 cents for every dollar of scheduled benefits for the disability insurance program with no ability to borrow, so we would have a serious problem. Fortunately, the good news is this body has never

failed to act under such circumstances, and we have always made it through.

If I could just add one thing to Rick's comment, I just would like to make a distinction between enactment of changes and the implementation, or effective date, of changes. One of the really amazing successes, I think, of the 1983 Social Security amendments was that a change in the increase in the normal retirement age was enacted in 1983. It did not begin to become implemented until 17 years later in 2000. Here is a perfect example of how we can enact a change, put it on the books so people have the opportunity to see what is coming, and to be able to plan for it, and get plenty of advance notice for that purpose. This, I think, is the real positive of enacting changes relatively soon. Even if they do not actually become implemented and start to have effect until some years later.

Mr. GARRETT. That is interesting. One of the areas that this Congress did pass a law, where you might say where they enacted something and had an effective date, was with the Medicare program and the proverbial Medicare trigger to say that when spending versus revenue became more than 45 percent, there would be a trigger, so there we might say we enacted something so that something would occur in the future, right?

Now, under that trigger that is in place, since this administration has been in office, that trigger has been triggered, or pulled, approximately six times, I believe. What have we seen from the administration as far as their proposals or their requirements under that trigger? Have they submitted any legislation?

Mr. FOSTER. In the first year, yes. Since then, I believe, there has been a more general statement that the budget proposals from the president would be sufficient to address the so-called funding warning.

Mr. GARRETT. Well, let's take a look at those funding proposals and what have you. Last year's Medicare trustees report shows that Medicare, the Part A program for hospitals, would be exhausted in 2029, right?

Mr. FOSTER. That was the 2010 report, that is correct.

Mr. GARRETT. Okay, and this year it has shortened down to 2024?

Mr. FOSTER. Right.

Mr. GARRETT. So as far as the administration's proposal, if they are doing anything, they are going in the wrong direction, we would say. It is shortening the amount of time as far as the life projections of Medicare.

Mr. FOSTER. I would not say that any proposals had an effect on the earlier year of exhaustion projected for the hospital insurance trust fund from 2029 to 2024. That was mostly economic developments.

Mr. GARRETT. Thanks.

Chairman RYAN. Mr. Blumenauer.

Mr. BLUMENAUER. Thank you very much. Some context here, I really appreciate, Mr. Goss, your pointing out, first of all, that Social Security will be severely stressed, benefits will be reduced, and it will not go bankrupt. Nothing compared to what is happening with many private pension programs that get thrown into the pension guarantee board and give a fraction. I mean, there are lots of

people who would take the 74 percent solution. I do think it might be fun to explore, a little bit, because the notion about Senator Reid and 20 years, I think is in the context of what you said about the last reform. With Democrats in Congress and President Reagan, that was 17 years before the revenues started kicking in, before the benefits were modified, and I think that is a model for what we should be doing.

I do not know anybody and I will defer to my good friend the chairman later, about the people who are saying we do not have a problem and let it run out. I do not know anybody in Congress, and there are some goofy people around here, but I do not know anybody that says we are going to be on automatic pilot, wait 20 or 30 years, or wait until 2036. I think there is a big distinction about people who want to have something that is bipartisan and balanced and phased in over time in a thoughtful fashion, as opposed to people who want to precipitate an artificial crisis and not do it in a careful and managed fashion. I think that is a big divide. I think we ought to be careful and deliberate, and do it right because you point out how people depend on it, and the more that people are playing politics with this, the less likely we are going to have something that is balanced, thoughtful, bipartisan, and within that timeframe.

I continue to believe that this is something that we could do around this table with this committee if we wanted to get serious and generate some proposals, and move forward, rather than the talking points and stuff that occupies our time, but I appreciate you establishing the context.

Mr. Foster, I posed a series of questions to you when you were last here requesting some information you said you would get back to me on the differential in terms of the payments. To my knowledge I have not received that, I do not know that the committee has; I am very serious your assessment of those questions and being able to do a deeper dive into the difference between private insurance and what happened with Medicare.

I would like to zero in on one specific item that you mentioned in interacting with my friend, Mr. Van Hollen, about the cross-subsidization that is taking place right now for Medicare Advantage that is imposing higher costs on the 80 percent of the people who do not have Medicare Advantage. My friend Mr. Ryan has a proposal that will, theoretically, hold harmless everybody 55 and over? What happens to their premiums? They will be paying this under the existing Medicare system; they will have the right to do this for 10 years, 20 years, 40 years, some of them may be well beyond that. What happens to their premiums as a result of this shift to a smaller and smaller, and older and older, and sicker and sicker base? What is going to happen to what they pay each month?

Mr. FOSTER. Yes, sir. There are two issues here. The first one is the differential, the higher Part B premium that people have to pay currently because Medicare pays a greater than fee-for-service amount on behalf of Medicare Advantage enrollees. That differential is going to go away on its own because of the Affordable Care Act, which reduces the payment rates to the Medicare Advantage plans, so that is one issue.

Mr. BLUMENAUER. That is not what I am talking about. I am talking about what would be the cost.

Mr. FOSTER. No, I understand the second issue, which I am getting to; and that is a different question entirely, which is how is it structured so that you do not end up with a closed group of older and older people whose premium is at 25 percent of their cost, would skyrocket as their cost skyrocket. Chairman Ryan, you may wish to comment on the nature of your proposal, for example, of how that would be addressed.

Chairman RYAN. Yeah, so CBO's analysis, because of the reforms we have put in the plans, there would not be any added burden to those remaining seniors. So there are ways of making sure that those who are staying in the current system do not see that sticker shock that you are talking about, and we included those reforms in our plan and CBO suggested as much. Dr. Price.

Mr. PRICE. Thank you. Thank you, Mr. Chairman, and welcome. As a physician I can tell you that, regardless of what the ranking member says, the access care is in fact being compromised out there. Anybody who holds any town halls with seniors and asks if anybody is having trouble finding a physician to take new Medicare patients with 10,000 Americans reaching Medicare age every single day; the answer is yes. So access is already compromised.

Mr. Foster, on your chart that is on Page 5 in your written testimony, this differential of cost in health care, the rising cost in health care, and there is a 2.7 percent difference between gross domestic product increase and health costs. You said in your testimony that that was innovation and intensity use of the system, which is access, right? I mean, it is basically access to a higher quality of care.

Mr. FOSTER. That is correct. It also includes the excess medical price component.

Mr. PRICE. Now, the president's law that was passed, one of the major goals was to decrease costs in the health care arena, and was to get that delta down, get that difference down, and one of the major entities charged with doing that is the independent payment advisory board, correct?

Mr. FOSTER. Yes, sir.

Mr. PRICE. And that independent payment advisory board would be comprised of 15 members, unelected folks paid by the federal government, none of which have to be actively practicing physicians, is that not correct?

Mr. FOSTER. That provision I do not remember. I am sure you are right.

Mr. PRICE. That is correct, none of them have to be actively practicing physicians. Last year I asked you before this committee what the effect was decreasing payments to physicians in terms of access, which is the way that the independent payment advisory board will gain the savings that they are charged with gaining. You said the potential access problem could be very serious. Do you still believe that?

Mr. FOSTER. Yes, sir. Under current law, with everybody's favorite sustainable growth rate formula, a reduction in physician payment rates for Medicare of about 30 percent will be required in about a year. Now, you just narrowly avoided one at the end of this

month. If that sort of payment reduction were actually to occur, then I think there would be very serious consequences for access to physicians.

Mr. PRICE. Even if the sustainable growth rate, or that cliff does not occur, the independent payment advisory board has the power in current law, correct, if it is fully implemented, to decrease payments to physicians for services rendered, in fact that is how they are charged with decreasing the cost of health care, right?

Mr. FOSTER. Yes, within limits.

Mr. PRICE. And that limit, at this point, is 1 percent of gross domestic product, as opposed to 2.7 which is the current difference, correct?

Mr. FOSTER. Not exactly. They do not have to address a growth rate differential to the tune of more, I believe, it is 1 percent initially, then 1.5 percent. In the longer term, the target rate for growth rate is gross domestic product plus 1 percent.

Mr. PRICE. Plus 1 percent, that is correct. Has anything changed since you were here last year in the president's recommendations regarding that? Are you aware?

Mr. FOSTER. One of the president's budget proposals would lower that to make it GDP plus .5 percent.

Mr. PRICE. So that would be a lower potential payment to providers?

Mr. FOSTER. If the IPAB, the Independent Payment Advisory Board, chose to address the excess growth by further reductions in provider payment rates.

Mr. PRICE. And if they were to do that, the president has recommended that more money be saved in the health care arena. If they were to do that by decreasing payment to providers then, in fact, that would compromise access even more, would it not?

Mr. FOSTER. It has the potential. As you know, I have been worried under current law, with the changes in the long term of the payment rates, the effect that could have on access and quality of care.

Mr. PRICE. As my former colleagues, and physician colleagues, who are having real problems currently taking care of seniors. I want to revisit in my few short seconds remaining, what you said about the difference between now and pre-1965, and that is that there is a subsidy, there is a federal subsidy for health care. You said, quote, "There is a viable market currently present, and it is not only present, but thriving." That is the kind of subsidy that we have been recommending on our side of the aisle for saving Medicare, is that not correct?

Mr. FOSTER. Well, yes, there have been many Republican proposals to emphasize more private health plans, such as the Part D prescription drug plans.

Mr. PRICE. And the subsidy changes the whole dynamic, does it not?

Mr. FOSTER. Yes, if it is voluntary, you cannot make it work without a subsidy.

Mr. PRICE. Thank you.

Chairman RYAN. Thank you. Mr. Yarmuth.

Mr. YARMUTH. Thank you Mr. Chairman. Thank you both for your testimony. By the way, for the record I checked life expect-

ancy in 1965 was right at 70 years old, just for the record. Mr. Foster, have you calculated how much money would be saved by Medicare with the death panel?

Mr. FOSTER. With the death panel.

Mr. YARMUTH. I am just kidding. I am just kidding of course. He was asking about the IPAB, so I thought I would throw that in. Mr. Goss, just some informational questions. What is the impact on both the cash flow of Social Security and the potential impact on the longevity of the early retirement system we now allow people to take partial benefits starting at 62 and a half?

Mr. GOSS. Thank you, excellent question. If I might just add per chairman's earlier question, life expectancy at 65 in 1940 for people 65 in that year was 14 years. By the year 2010, life expectancy for 65 year olds is now 20 years, and we estimate that by the year 2085 that will grow to 24 years.

Currently the Social Security program has, what we call, the full retirement age or normal retirement age where you get your full standard benefit paid to you on a monthly basis from that point forward for life; right now that full age is 66. People are allowed to begin receiving their benefits, and start receiving as early as 62. If they do that, then the benefit they receive is 75 percent of what they could get on a monthly basis if they waited the extra four years. That 25 percent reduction, and for every age in between, and even up to 70 we have such increments, are calculated on a quote unquote actuarial basis, so the trust funds are essentially held harmless regardless of the age at which people select.

Mr. YARMUTH. Okay, and it does not matter on cash flow either?

Mr. GOSS. Well, cash flow does matter. If people were, for example, right now, the roughly half of individuals who start receiving benefits at age 62, if next year nobody started at 62 and they all waited until 66, we would have a four year period in which we would not have any new beneficiaries, so we would have a cash flow positive effect during that period, but over the longer term, throughout the totality of their lifetimes, the trust funds would be affected, exactly.

Mr. YARMUTH. The projections that we see out to the longevity of the trust fund and so forth, up to 2036 and so forth, what kind of GDP growth rate are those based on, and what would, say, an additional percent of growth in GDP mean to the longevity of the trust fund?

Mr. GOSS. Very good question. We do not really project GDP per se, all by itself. We really project the amount of output per hour worked, and the reason that that is so important is because the growth rate in our population, the growth rate in our working age, the growth rate in our workers changes over time, and has decelerated quite substantially. Back in the time the Baby Boomers were entering the work force, we had the work force rising at 3 percent a year and that could allow us to sustain gross domestic product rates at very high rates if you add on another percent and a half for output per hour worked. We are now moving into a period where the growth rate in the labor force is about a percent now, and will be dropping down towards much less than a percent in the future. So as we go on to the future we project a gross domestic product, even maintaining the same level of productivity in-

crease per hour worked by our workers, will drop down to less than 2 percent per year on average, and that is not a bad result; that is just what happens from having a slower growth rate in the number of workers in our workforce.

Mr. YARMUTH. Okay, Mr. Foster, quick question on Medicare Advantage. Do you have figures on the actual expenditures per beneficiary in Medicare Advantage versus standard Medicare, or conventional Medicare? It is 12,000 I know, I assume in conventional Medicare that is the number we are dealing with. What is the Medicare Advantage number?

Mr. FOSTER. Prior to the changes in the Affordable Care Act, as I believe Representative Van Hollen mentioned, the differentials could be as high as 40 percent, even higher in Puerto Rico, but anywhere between 100 and 140 percent would be the Medicare Advantage payment rates, and it varied around the country by particular area.

Mr. YARMUTH. Is there any evidence of cherry-picking as a cause of some of that, or all of that differential?

Mr. FOSTER. Back in the days before there was risk adjustment, that was a major problem, that plans could attract healthier than average beneficiaries, but get paid for average ones. With risk adjustment, that reduces, substantially, that ability. Now, there is still some ability, and we have to work hard at CMS to prevent benefit formulas that would tend to steer people away from that plan, if for example, they have a high likelihood of developing cancer or having cancer. So we have to make sure that these are not discriminatory benefit formulas, but the problem is greatly reduced compared to what it had been.

Mr. YARMUTH. Thank you Mr. Chairman.

Chairman RYAN. Mrs. Black.

Mrs. BLACK. Thank you Mr. Chairman. Mr. Goss, I want to turn to the subject that has not been discussed very much, but your testimony on disability insurance because that program, and, obviously, the other programs are out there to be concerned about, but this program is going to be affected much sooner than the others. I think it is interesting to note that it was created back in 1956 when physical labor was greater, and we now have more technology, and so you would anticipate that maybe those rolls would have shrunk a little bit; however, we have seen the opposite occur. As a matter of fact, I see here that since 1990, which is 21 years, spending on disability insurance outlays have grown by 420 percent, which is just remarkable, faster than Social Security as a whole. Can you give me any idea about why this program has grown so much?

Mr. FOSTER. Absolutely. This is a topic that we actually explored with the House Ways and Means Committee a couple of months ago and looked at quite carefully. It is really quite a remarkable story, and thank you for raising it. Over the last 25 years, two things have fundamentally happened that are quite dramatic. The probability of women in our workforce working, and working consistently, has expanded tremendously, and with that the percentage of women in our country who are insured to potentially receive disability insurance benefits, should they become impaired, has increased to a level of virtual parity with men. In addition, at the

same time, the probability for an insured woman to become disabled and start to receive our benefits, which used to be much lower than the probability for men who are insured, has also moved up to virtual parity with men. The combination of these two has resulted over the last 25 years, if you look at the curve, of the cost of the disability insurance program, it has risen quite dramatically.

The good news on this, though, is now that women are virtually at parity in terms of both insured status, and probability of becoming disabled with men, that we have realized that that massive increase in cost for disability and we do not expect women to continue up above men; we expect that they will remain at about the levels they are at in the future.

The other really important factor about disability is that exactly what we talked about regarding the effect of the drop in the birth rates making the baby boom loom so large for retirement over the next 20 years, and that has already happened. Because the Baby Boomers now are centered between about ages 45 to 65, which is the prime disability beneficiary age. So right now we are kind of at the peak of the disability program regarding the effects from the demographics going forward.

Mrs. BLACK. So given that, and we are looking at it going bankrupt in 2016, can you give me some idea of what we can expect there, are the beneficiaries just going to get less? What is your recommendation for the future?

Mr. GOSS. Well, the Congress has had a very interesting approach, and we do have separately the OASI, Old Age Survivors Insurance Fund, and the Disability Insurance Trust Fund, and that was set up specifically to make sure that you all would be monitoring what is happening in the disability insurance program, and that is really important. Back in 1994 we were approaching a point where the disability insurance programs reserves were about to run out. Exactly the same situation we are now facing, somewhere between 2016 and 2018. At that time, the Congress said, well, let's not let that happen because the OASI insurance trust fund was in much better shape, so they simply passed a very simple reallocation of some of our tax rates between the two funds that brought the financial status of the two funds back into closer parity. That same option certainly will be on the table as we approach 2016, 2017, 2018 to potentially do that, in effect buy us time until 2030 to have major reforms really impact the system as a whole. If that is not done we will face, in a very short period of time, the situation where we could be in a position of not having the reserves, taxes only accounting for about 86 percent of the cost of the program.

Mrs. BLACK. And it seems again, what we are doing is robbing Peter to pay Paul, which I do not have time because I know I am going to run out here, but looking at the payroll tax bill that was just passed, you said that by law the money had to be moved from the general fund, but then what happens to the general fund? Where does that money come from? Is that put on the bottom line of, again, a debt?

Mr. GOSS. Well in a current year where, on the margin, we are running a substantial general fund, unified budget deficit because

the payroll tax holidays are worth something slightly in excess of $100 billion per year, that simply adds to the unified budget deficit, and it requires that much more of borrowing, but that is, I guess, what fiscal stimulus looks like in a down economy.

Mrs. BLACK. Yeah, and I say again, we move one to the other, robbing Peter to pay Paul. Thank you.

Chairman RYAN. Thank you. Ms. Bonamici.

Ms. BONAMICI. Thank you Mr. Chairman. Mr. Foster, thank you for your testimony today. I think that we all can agree that the more we can contain costs, the more we can preserve benefits. I wanted to ask you about Part D and prescription drug benefits. We have seen the Department of Veterans Affairs, for example, successfully negotiate drug prices with some estimates showing that the VA's drug prices are up to 48 percent lower than Part D prices. So as Congress looks for ways to address cost containment while preserving the Medicare guarantee for seniors current and future, should we be looking at providing the Medicare program disability to negotiate drug prices, and if so how much can we save?

Mr. FOSTER. The Department of Veterans Affairs has a special deal where for their programs they get the lowest drug prices of any that is out there by law. So they may negotiate pretty well in addition, but they also get the benefit of the statutory provision. It is tough for Part D, which is a straight negotiation, to match that kind of level.

Now, the Part D plans do negotiate very effectively, but it is not the same thing as an administratively price set, for example, for most of fee-for-service Medicare services. Now, there could be ways to do this. For example, the law expressly prohibits negotiation by the part of the government for Part D drug prices. If we had that authority to negotiate with manufacturers directly, then you have to ask, okay, what can we offer the manufacturers? Can we, at the federal level, offer them a drug formulary that will include this company's drugs at a preferred tier? Now, that happens that all the times with the individual Part D plans, but for us to do it, we would essentially have to pull the rug out from underneath the individual plans. Not to say it could not be done, but it would be challenging. Without that option, to include the formulary, the promise of what do you get in for return, our negotiation probably would not accomplish much.

Ms. BONAMICI. But if we could replicate what the VA is doing, we could see significant savings, is that correct?

Mr. FOSTER. Maybe. That is a tough one, too, because for a small slice of the market, the drug companies have to provide their best price of anywhere in the country to the VA. If they now have to do the same thing on behalf of another 30, 40 million Medicare beneficiaries, can they still afford to offer that best price wherever it is going, or would they have to raise it? We would probably get some savings out of it, but maybe not as much as might be apparent at first glance.

Ms. BONAMICI. Thank you, and Mr. Goss, in your testimony you referenced various options for addressing Social Security's long-term funding challenges, and it is critical that we make the point here that there are responsible ways to address these challenges that truly protect Social Security without putting our seniors at

risk, but I wanted to focus on the issue of the payroll tax cut for a moment. Now, over the past year there has been a lot of discussion throughout our many communities about the growing income gap, and the stagnant, or in some cases, even shrinking wages seen by the lower and middle-income levels, while at the same time we have seen our top wage earners take home larger paychecks. So in light of the fact that currently about 85 percent, rather than the traditional 90 percent, of earnings is covered, how is this growing wage inequality impacting our Social Security revenues?

Mr. GOSS. Well, there is no question, but that has had a negative effect and it was back around 1983, 1984 where, indeed, as you indicated, roughly 90 percent of all the covered earnings of our workers were in fact under the taxable maximum. What is interesting is that since that time the taxable maximum has been indexed to rise with the average wage, but exactly, as you indicate, there has been a growing, sometimes referred to as dispersion of earnings, so that we are now back to a level of about 83 percent of all the earnings that are covered by Social Security actually falling below the taxable maximum.

A number of proposals have been put forth, including the Simpson-Bowles Commission, the Rivlin-Domenici, bipartisan policy center plan, and many others have put forth proposals to raise the taxable maximum, and those cases both to raise it very gradually up to get back to the 90 percent of covered earnings being taxable, and that would alleviate approximately one-fourth of the long-term, 75 year problem that Social Security is facing.

Ms. BONAMICI. Just to clarify, if we went up to 90 percent.

Mr. GOSS. If we went up to 90 percent, actually over very gradual period that would be between now and about 2050.

Ms. BONAMICI. Thank you. I yield back my time, Mr. Chairman.

Chairman RYAN. Thank you. Mr. Flores.

Mr. FLORES. Thank you Mr. Chairman. Gentlemen, thank you for joining us today. I have a macro question I would like each of you to answer, if you could, before we get into some of the weeds. The assumptions that have come out in each of your reports assume a virtually unlimited ability of the federal government to finance the unified deficits. In other words, that we are going to have to take, in order to call on trust funds, we have got to be able to issue more debt to be held by the public. I think each of your reports assume that, but you are not charged with any sort of qualitative analysis as to whether or not that can actually be done, is that correct?

Mr. FOSTER. That is essentially correct. The law provides for considerable general revenue financing for Medicare, and we assume that the law will be followed.

Mr. FLORES. Right.

Mr. FOSTER. We do not do a separate analysis, generally, of the implications for the economy at large.

Mr. FLORES. Okay, Mr. Goss?

Mr. GOSS. I would want to add that for the entirety of the Social Security trust funds, and for Part A of Medicare, in fact the law is explicit that if we reach the point where the trust fund reserves exhaust, then unlike budget scoring convention, which is held by CBO and by OMB, the excess cost over the revenue coming in would simply not be met.

Mr. FLORES. So the bottom line is the law says that they will be financed, the federal law, but we have not taken into account the laws of economics, which says that there is a natural limit above which a country, just like a family or business, can no longer finance itself.

Mr. GOSS. But if I may, in the case of Social Security trust funds and Medicare Part A, actually the law says that it would not be financed. If we reached the point in 2036 where the reserves are exhausted and we only have 77 cents coming for each dollar, that is all we will be able to spend. We do not have the borrowing authority to get the other 23 cents.

Mr. FLORES. Okay, so with respect to part of the trust funds, we could be violating the laws of economics even though the federal law says we are going to behave in a certain way. Let me go on, Mr. Foster, you were thoughtful enough to provide an alternative scenario to tell us what our actuarial liabilities would be in 2010. Do you have that number of the infinite time frame? What is the most updated number that you have for 2011? $34.8 trillion in 2010, what is that number today?

Mr. FOSTER. I can get that for you, I do not have it at the top of my head.

Mr. FLORES. Okay.

Mr. FOSTER. Let me tell you a different number that is at least similar.

Mr. FLORES. Okay.

Mr. FOSTER. Which I do have.

Mr. FLORES. Equally scary, I assume.

Mr. FOSTER. Well, it goes not in the happy direction, let's just put it that way.

Mr. FLORES. Okay.

Mr. FOSTER. Currently, in the long range we project that Medicare costs would rise to about 6.2 percent of GDP and largely level off there under current law. If current law turns out not to be viable in the long range, under the illustrative alternative to current law, the cost of the program would rise to 10.7 percent of GDP.

Mr. FLORES. Thank you. If we could bring up chart three from Mr. Foster's testimony on Page 5.

I will go ahead and start my question. I think the implication, and may have been explicitly said, but the problem we have with Medicare is the health care use and intensity part of the total health care inflation. Continuing the line of questioning from Mr. Van Hollen, let me give you some background. Our access and quality of health care is due to a continued investment in technology, drugs, medical schools, people, hospitals, equipment. You had expressed the view that there could be some uncertainty in the continuing desire of the private sector to invest in those resources under a premium support plan. Let's talk about the alternative that has been proposed in the Affordable Care Act; and that is you are going to have this unelected, unaccountable board called IPAB that is going to artificially determine what providers get paid. What does that do to the uncertainty of the private sector, wanting to invest in those? Think about it this way: What would it cause an 18-year-old to decide when they have graduated from high school who wanted to go to medical school when, at the end of the

day, their compensation is going to be set by this unelected board? So tell me what uncertainty you see coming in to the investment cycle and to access quality of health care with an IPAB scenario?

Mr. FOSTER. Well, that is a good question. I do not think anybody has a good answer to it.

Mr. FLORES. Well, let's ask it this way. Would it be better or worse than the premium support alternative?

Mr. FOSTER. The IPAB, by its nature, does not give you a certain outcome. Now, under current law, with the existing productivity adjustments and other provisions, we project that the IPAB will not have a big effect because everything else already lowers the cost rate so much. That may end up not being sustainable, and if it does end up being unsustainable, then the IPAB would have to take effect, and then you have the uncertainty you talk about.

The big question you have for premium support or under the IPAB, or under the current law payment update reductions, all of which sends a fairly clotty signal to the world out there: What is the future of health care going to be like? Nobody knows the answer to that. That certainly increases the uncertainty associated with what should we be doing? If I am a developer of new medical devices, do I want to assume I will have a guaranteed market no matter how expensive my new device is going to be, or should I think differently and think the pressure is going to be on, I need to develop something that is really pretty good and costs a lot less than what is currently being done. That remains to be played out.

Mr. FLORES. I think the logic of the American people would suggest that private sector solution will be much better than a government-imposed solution. Thank you, I yield back.

Chairman RYAN. Thank you. Mr. Pascrell.

Mr. PASCRELL. Thank you for having the hearing Mr. Chairman. Thank you two gentlemen for your great service. Let me start by saying this. Projected Medicare costs over the next 75 years, I do not know how reliable that is, by the way, when we see what happened in the last 10 years, but those projected costs are about 25 percent lower because of provisions in the Patient Protection and the Affordable Care Act; that was the purpose.

So I made this point several times that changing the entitlement was part of one-third of the whole health care act; so we have addressed it, and the argument that we have not started that process is absolutely erroneous. We have to come down to this: Are entitlements essentially good? Do they need changes? Well, we have done that. We have changed Social Security, we have changed Medicare, but we did not throw out the essential part of guaranteed benefits. Now, I am hearing that apparently the only way we can sustain Social Security and Medicare, although, the dates we can argue over, but dates will be coming in the future, is to change the essential parts. This is what this argument is all about, and I would say to you that this is all in an effort to change how we look at these guaranteed benefits, so that we can sustain both of those programs.

When I talk to the seniors in my district, they appreciate the way Medicare and Social Security work, and as a member of the Ways and Means Committee, I take what they say into account when we reform Medicare and Medicaid. I cannot reiterate this enough: health care reform was entitlement reform. Not only was

it good for the Medicare program and saving money, but it also reduced costs for beneficiaries. The only action this majority has taken on entitlement reform was to vote to repeal health care reform. That is it. Case closed.

On the other hand, the other side has a plan to turn Medicare into a voucher program which would hurt beneficiaries, in every report that I have seen would increase the cost of out-of-pocket money needed.

Here is my question, Mr. Foster. Health care reform, which is fully paid for, very different than what happened back in 2003 with your prescription drug bill, which was not paid for, well you did not pay for anything back in those days, is not to blame for Medicare's solvency issues, and that it actually extended the life of Medicare for eight years. In stark contrast to the savings in the Affordable Care Act, the other side's Medicare bill in 2003 cost $400 billion, and that was not paid for.

So let's be clear, while we may disagree on many issues, we can all agree that the status quo is not sustainable. That is why health care reform started to give Medicare new tools, tools like delivery system reforms, some of which have been outlined by the ranking member, and payment reforms are going to be tested by Medicare, and not only will the best tools be used by Medicare, but the private sector will likely adopt these same strategies. Mr. Foster, can you tell me how health care reform is already helping Medicare to test new strategies like the accountable care organization in order to change the incentives built into the current system?

Mr. FOSTER. Sure, I would be glad too. Let me first say that I am a great believer in the activities and the actions, and the debates, of men and women of good will working together, despite different philosophies, to achieve solutions for the different problems that face the country. Anybody would only have to look at the example of Senator Bob Dole and Senator Pat Moynihan to see one of the very best such practices. I will get off my soapbox now and answer your question. Under the Affordable Care Act, of course, there are a lot of provisions designed to set up, encourage the design, the testing, the evaluation of innovations and delivery systems and payment methods. A number of these are just getting underway. For example, the Medicare Shared Savings program for accountable care organizations, and the medical homes. In the new center for Medicare and Medicaid innovation, almost anything is potentially triable. It cannot continue if it is not working, but you can try different innovations, different techniques, and see if they might have some hope of reducing the cost of Medicare or increasing the quality of care or both. That is at the early stages, and I think it is a good thing; but the country needs to figure out how we can achieve these goals, even though so many things we have tried to date have not worked in the past.

Chairman RYAN. Thank you. Mr. Huelskamp.

Mr. HUELSKAMP. Thank you, Mr. Chairman. A couple questions, I guess, first for Mr. Foster. I had a follow-up question from last year, we discussed a little bit, I am sure you do not recall, but a number of providers that would likely disappear in the next few years because of the president's health care system. Can you re-

mind us what those figures are and have they changed since your testimony last year?

Mr. FOSTER. Yes, I would be happy to do that. No, the projection has not changed. We simulated, taking all existing hospitals, home health agencies, and skilled nursing facilities in the country, what would happen to their total facility margin, that is basically their profit margin for the entire organization, not just off their Medicare revenues. We simulated what would happen as a consequence of the slower payment updates for Medicare under the Affordable Care Act. What we found was that by 2019 another 15 percent of all of these facilities would end up with total facility margins below zero, other things being equal, solely as a result of the slower payment updates. We extended the projection and by 2050 the answer was 40 percent, and would go to a negative margin. Now, they can do some other things, they can try to clean up inefficiencies, they can try to be more productive, but if nothing else changed, that is what would happen.

Mr. HUELSKAMP. And those are nationwide figures.

Mr. FOSTER. Yes.

Mr. HUELSKAMP. I asked you last year a little bit. Do you have that data to extrapolate that to rural areas where we actually lack providers and are losing providers already? Do you have the data to provide that in a future response to me?

Mr. FOSTER. Yes, if your staff could get together with us so we could do that.

Mr. HUELSKAMP. Okay, well I appreciate that. Second line of questions would be in reference to the funding warning from the board of trustees. They issued a funding warning last year again, is that correct?

Mr. FOSTER. That is correct.

Mr. HUELSKAMP. Okay, and under federal law it is a requirement that presidents should submit suggested corrections within 15 days after submitting his budget. Did he do that?

Mr. FOSTER. Not to my knowledge. That is not to say it did not happen, but not to my knowledge.

Mr. HUELSKAMP. Okay, well not to my knowledge either. I do not know if you participate or listen in, but are you present at the board of trustees meetings?

Mr. FOSTER. I am present, yes.

Mr. HUELSKAMP. Okay, and that would include Secretary Geithner, Secretary Sebelius, Secretary Solis, and four others. Have they expressed any concern why the president has failed to lead and provide what is required under the law which is give us some solutions. What has been the discussion amongst those members of the board of Medicare trustees?

Mr. FOSTER. To the best of my recollection, the discussion has not involved the statutory requirement on the reaction to a Medicare funding warning. It is much more focused on the financial status of the Medicare and Social Security trust funds.

Mr. HUELSKAMP. So they have expressed no concern, at least in those meetings, as far as the failure of the rest of the administration for not meeting the requirements of the law and giving some direction on how to solve this serious funding warning?

Mr. FOSTER. That is correct.

Mr. HUELSKAMP. That is pretty disappointing to me. Again, we have seven members of this board of trustees, Secretary of the Treasury, who has been before our committee, Secretary Sebelius as well, Secretary of Labor and four others, and we still fail to have any solutions being provided by them, which is a very serious warning. I know others in the committee have mentioned that there have been few, if any people, that are concerned about the future and are not recognizing the problem. Well, apparently the administration is not. Not only not recognizing the problem, but refusing to follow the law and provide some corrective suggestions, corrective legislation. Do we anticipate, Mr. Foster, or have you heard anything within the Medicare board of trustees whether they might provide a solution this year from the administration?

Mr. FOSTER. The board of trustees traditionally has not acted in policy matters to come up with recommendations to specific things to change. They call attention to the financial status, they call attention to the need for change, but they do not make recommendations. Now, others in the administration, of course, the president's budget that was just released has a number of Medicare proposals in it, but these tend to stem more from OMB, and from CMS, and from HHS, and not from the board of trustees.

Mr. HUELSKAMP. Okay, but again, you recognize the board of trustees, obviously, are folks that, like Secretary Sebelius, who have a responsibility for overseeing these programs and are presenting no solutions. I am just frustrated by that, and I am just curious if that came up in a board of trustees. The folks that are supposed to oversee that for millions and millions of elderly retirees, and we know we have a problem, but we just do not see a solution come out of the administration. I appreciate the testimony. I will get back to you on the loss of providers, particularly in rural areas, and I look forward to the research. Thank you.

Chairman RYAN. Thank you. Ms. Schwartz.

Ms. SCHWARTZ. Thank you, Mr. Chairman, and I appreciate the testimony. Mr. Foster, I just wanted to follow up on some of the discussion we have already had about Medicare and about some of the potential cost savings. You certainly did point out, as did Mr. Goss, the demographic challenges we have with so many Baby Boomers coming online. It is a challenge for us to meet our commitment to our seniors, both on Social Security and on Medicare, but the real question seems to me, as we look at the demographic challenges, and the cost challenges, particularly under Medicare, I believe that we start with the principle that we are going to meet our commitments to our seniors and to our future seniors to provide health care coverage which is called Medicare. It has been one of the most successful programs we have ever had in this country, and keeping seniors out of poverty and able to access health coverage, so that is the beginning. The work is how do we actually contain the rate of growth in costs, and meet this obligation? How do we get better value for our dollars?

So, Mr. Foster, you actually have pointed out that there is good work being done already under the Affordable Care Act, and that these important steps in advancing payment structures, different models, that give providers really incentives to provide greater quality for less cost; well, many of them are out there, they are

working, and they are being evaluated in a way that potentially was not true, nor did we have that data, a year, two, or three years ago. I know that you have said it is difficult sometimes to assess the actual cost savings, but I wanted to just point out a few that you have pointed out yourself.

We see innovative payment and delivery service models in the accountable care organizations, in patients that are in medical homes, and there are models all across the country there, in improved care coordination for individuals, particularly with multiple chronic health conditions, the cost savings there, and the highest cost cohort of patients, if we are going to call it that, is significant. Improvements of coordination post acute care is one of the areas that we know is extremely ripe, if you want to say, for cost savings, bundling of payments, and pay for performance. You have made comments, and I have seen in the press about the Partnership for Patients, reducing the hospital-acquired infections and improving transitions of care, again, post acute care, and assisting individuals in making informed health choices.

I did want to point out one particular program that has shown such strong cost savings as to be a model for us to move on. This is part of the innovation models; it is called Independence at Home. It is a program that reduces spending by providing coordinated care in patients' homes. The model for this initiative comes out of the veteran's home-based primary care program that operates in 200 locations in every state, including the District of Columbia. We have seen 11,000 patients show, and these are veterans, after they have been moved to this Independence at Home model, the hospital days dropped by 62 percent. This is not a cost saving on the margins. This is substantial, this is 62 percent. Nursing home days went down by 88 percent. Again, this is not on the margins, this is really substantial savings. The overall costs fell by 24 percent.

So it are these kind of initiatives, and actually, a research at the University of Pennsylvania said if we could implement this model across Medicare you could save $30 billion annually. So this is just one, and I have not even given the numbers for some of the other models.

So as we look at this commitment that we have made to seniors in this country, and the alternative model that was presented in the Ryan budget last year, we do not know yet exactly what is going to be presented in this year's budget, that basically said we cannot do this, we cannot achieve the kind of savings, instead we are going to have to shift costs to our seniors to take many of the burden on increase in cost. Could you just speak to our ability, or the capacity, for us to move some of these innovative homes, to scale them up, to make them more universal under Medicare and save tens of billions of dollars and meet our commitment to our seniors?

Mr. FOSTER. As you ran down your list, it is a good reminder of how many different initiatives are out there, and how many promising efforts there are, many of which may turn out to be successful. I remain optimistic, and hope that turns out to be the case.

Under current law, if these initiatives either improve the quality of care without raising costs, or reduce costs without harming the

quality of care, then Secretary Sebelius can move them to the national scale without any further legislation.

Mr. SCHWARTZ. And moving to the national scale could be huge cost savings. Thank you.

Chairman RYAN. Thank you. Mr. Stutzman.

Mr. STUTZMAN. Thank you Mr. Chairman, and thank you to both of you for being here. I think this is probably one of the most important issues that we can discuss, as far as the federal budget, because of the size of both of these programs, including Medicaid. So I appreciate your input today, it has been very helpful.

I guess I would like to start on the Social Security side. Mr. Goss, if you could talk a little bit about how the payroll tax cut has affected Social Security in the short-term, and the outlook, if that particular rate would stay the same. Then also if you could touch on what was the largest general fund reimbursement the Social Security trust fund had received, and then also what is the combined amount for the past two years?

Mr. GOSS. Thank you. As discussed earlier, the nature of the laws that have been enacted, both for the 2011 payroll tax holiday, and now the one that was been extended through the full calendar year of 2012, do require that all of the reductions on the payroll taxes get reimbursed fully from the general fund of the Treasury, so Social Security's financial status and the trust funds are indeed unaffected by it. The unified budget, the overall budget of the country, however, is clearly not unaffected, and this is to the tune of between $100 and $110 billion is the extent to which the payroll taxes were reduced for 2011, and will also be for 2012. Again, those reductions in payroll tax rates will not cause the trust funds to get a penny less because they will be reimbursed from the general fund of the Treasury and that does, on the margin, mean that there will be that much more borrowing from the public in this period, as would be true for any fiscal stimulus approach that we might use to take.

Mr. STUTZMAN. It is a squeeze either way. It squeezes the general federal budget because of the reimbursement back to the Social Security trust fund, is that correct?

Mr. GOSS. It certainly does, I mean, presuming that the intent of the payroll tax holiday was not really to just cut money going to Social Security, which it did not do, quite explicitly, but rather to have the general fund of the Treasury provide money into the pockets of the 150 million workers in the United States. It has succeeded in doing that last year, and is succeeding in doing it this year, too.

Mr. STUTZMAN. In your analysis of the middle-class tax relief and Job Creation Act, states that it would have been a negligible effect on the long-range actuarial balance. It says this because of the general fund transfer to the Social Security trust fund makes up for the lost revenue. Could the federal government just issue bonds to the Social Security trust fund and eliminate the long-term actuarial deficit?

Mr. GOSS. In theory, it certainly could, and I am sure Rick would agree with me on this, basically what that would do is in effect put the Social Security OASI and DI trust funds in essentially the same position as we now have for the Medicare SMI funds, which

are guaranteed to receive general revenues on an as-needed basis to pay the bills. Social Security, the OASI and DI trust funds and the Medicare Part A trust funds are really special and different in that they do not have that kind of authority now, which does create extra pressure for members of Congress and every president to really pay even closer attention to the cost of those programs in the future.

Mr. STUTZMAN. Thank you. Mr. Foster, I appreciate your testimony and a couple of the examples that you had illustrated. I have heard from doctors back home that they are going to just not take Medicare, Medicaid patients, and go to just self paid, whether it is self-insured or cash patients. Could you talk a little bit about that? I know it is in your testimony, but what does that do long term? I understand that Medicare has to keep its costs down, but that cost does get passed on to someone else. I was interested in your chart, and I will go back and look at it later, but the increase in those who are self-insured and self-pay is going up faster, is that because of the cost of Medicare and Medicaid is staying lower because the government can control that, so that cost gets transferred to the upper side.

Mr. FOSTER. I am sorry, tell me again the self-insured you were talking about?

Mr. STUTZMAN. Doctors who are not taking Medicare and Medicaid patients are now going to be taking just self-insured, they are seeing that as a benefit to their particular practice. My question is are we driving more cost to those physicians who are still taking Medicare and Medicaid patients to those who are self-insured and those who self pay because we are keeping costs down? That cost is getting transferred to those other patients.

Mr. FOSTER. That is very hard to measure, but it is almost certainly happening in hospitals and other providers, including physicians, and to the extent that if Medicare rates become inadequate over time you would expect to see more of that. We have already seen that to a much greater degree for the Medicaid program where there is a lot of evidence that individual enrollees can have trouble finding doctors in particular, specialists in particular.

Mr. STUTZMAN. Thank you.

Chairman RYAN. Thanks. Ms. Wasserman Schultz.

Ms. WASSERMAN SCHULTZ. Thank you Mr. Chairman, and it is good to be with both of you, thank you so much for joining us. Mr. Foster, I want to focus on the out-of-pocket costs for Medicare beneficiaries related to the Affordable Care Act and the effect that it has on those out-of-pocket costs. Our colleagues on the other side of the aisle talk about how they want to reduce costs for seniors, but it is hard to see how they really mean that when we know that the Affordable Care Act, at least by your projections, will actually bring costs down in terms of seniors out-of-pocket costs. Can you describe, in Medicare fee for service, whether and how the Affordable Care Act reduced out-of-pocket costs for seniors over the next few years?

Mr. FOSTER. Sure, I would be happy to. Under the Affordable Care Act, of course, payment rates to almost all fee-for-service provider categories are reduced, and what beneficiaries have to pay for deductibles and co-insurance are tied to the prices that Medicare

pays for the service, so if that price is lower, then the co-insurance or the cost-sharing requirements are also lower. For beneficiaries in fee-for-service Medicare, that makes a pretty big difference over time. I have the numbers but not with me, but we have a memo on this subject if you would like to see it, and the reductions are in the hundreds of dollars per year, so it is not trivial.

It is only fair to add that for Medicare Advantage beneficiaries the opposite is true, because the payment rates are coming down, that means the extra benefits that plans have been able to offer are also going to come down, and that means that the beneficiaries or the enrollees will have to pay more out of pocket, and that could also be in the hundreds.

Ms. WASSERMAN SCHULTZ. But right now, all Medicare beneficiaries are paying for those benefits that Medicare Advantage beneficiaries are receiving, and so with the costs for non-Medicare Advantage beneficiaries would be reduced as a result of that shift?

Mr. FOSTER. Yes, the Part B premium, in particular, is roughly $4 a month higher than it would otherwise have been because of the higher cost associated with the law for Medicare Advantage plans prior to the Affordable Care Act.

Ms. WASSERMAN SCHULTZ. So in Medicare Advantage, you have Medicare beneficiaries who may well be benefiting from extra programs, and benefits, but you have people who are not getting those benefits paying for it?

Mr. FOSTER. Yes, although there are different numbers of people, so the extra benefits are typically worth far more than the $4 a month that everybody has to pay in addition. Now, that is a policy issue, what you do about that, the law has already been decided. That will change over time, but your main point was that for fee-for-service beneficiaries, their out-of-pocket costs for premiums and cost-sharing requirements are coming down. For Medicare Advantage enrollees, they are going up.

Ms. WASSERMAN SCHULTZ. The numbers that I have seen, and if you remember these, or if you can confirm their accuracy, Part B premiums would decline by more than $200 per beneficiary by 2019, co-insurance declines by more than $200 per beneficiary on average by 2019, and while Part D, the prescription drug beneficiaries will see a slight increase in premiums, those are substantially offset by the closure of the doughnut hole, which saves the average senior, I know in my district, more than $3,000. Is that about right?

Mr. FOSTER. For people affected by the doughnut hole, that is right.

Ms. WASSERMAN SCHULTZ. Right, okay.

Mr. FOSTER. And I would just want to emphasize, those are annual figures.

Ms. WASSERMAN SCHULTZ. Yes.

Mr. FOSTER. Not monthly.

Ms. WASSERMAN SCHULTZ. Oh, yes, right, of course, but when you are living on a fixed income, several hundred dollars a year is a big deal. Women in my district who are seniors are living on about $12,000 on average a year, total, which a few hundred dollars matters a lot.

Mr. Goss, just really quickly, I only have a minute to ask you this question, but the Ryan Republican road map released last year that would have proposed setting up private accounts by diverting Social Security payroll taxes, what was your estimate of the cost of diverting those payroll tax contributions and also how would that have impacted benefits?

Mr. GOSS. The design of the plan that Chairman Ryan put forth was to offer an option to individuals to accept a scaled amount of money going into personal accounts, and the offset to that was that they would be giving up on a portion of the benefits going forward, so it would be an option for individuals.

Ms. WASSERMAN SCHULTZ. It would have been a reduction in benefits?

Mr. GOSS. Well, in the design of the plan there would be a reduction in the general scheduled level of benefits overall under Social Security by altering the primary insurance formula, especially for higher income folks.

Ms. WASSERMAN SCHULTZ. As I said, as my time expires, when you only have about $12,000 available to you all year, any benefit cut is a serious impact on your life, and another example of how privatization of Social Security would be irresponsible. Thank you Mr. Chairman.

Chairman RYAN. Thank you. Since I was invoked I will simply say the plan that I personally authored, it was not in a budget, increases the minimum benefit to make sure that no senior citizen falls beneath the poverty line, so those people at $12,000 a year would actually have an increased minimum benefit. More to the point, for a dollar that comes out of person's personal account, that was voluntary, that is made up for. Meaning if they lose a scheduled benefit, they get it on the upside for the money they get in their personal account, and at the end of the day they will end up with better benefits if they exceed the rate of return that they would otherwise have gotten in Social Security. The whole purpose of this idea is to improve and enhance people's benefits and to improve the floor of benefits so that no senior citizen falls below the poverty line, which is unlike current law.

Ms. WASSERMAN SCHULTZ. But Mr. Chairman, it may not have been in your budget. It was offered by your leadership as legislation, Mr. Sessions has introduced that legislation, so it certainly still on the table.

Chairman RYAN. It improves and saves Social Security. Mr. Young.

Mr. YOUNG. Thank you Mr. Chairman. Thank you very much Mr. Foster and Goss for being here today, I have to say last year this was one of my favorite hearings, and same thing has applied this year, a lot of fact-based conversation and testimony. I thank you for your service to our president, to the Congress, and to the American people.

First, I want to associate myself with the comments of some of my colleagues related to this trigger under the Medicare Modernization Act of 2003. Current law definitely indicates that when that 45 percent threshold is breached, meaning 45 percent of financing for Medicare is no longer coming out of the dedicated Medicare funding stream and instead coming out of general reve-

nues, then it is the president's duty under the law to provide some sort of corrective legislation. Did I fairly represent that from the expert here, Mr. Foster?

Mr. FOSTER. Yes, sir.

Mr. YOUNG. Okay, and I also want to indicate that that deadline is in fact today, 15 days after submission of the president's budget, so that would be February 28th, which is today, correct?

Mr. FOSTER. I will assume your calendar math is just fine.

Mr. YOUNG. So that is disappointing to me, and we need the president to lead on this area as much as any other area with costs going up 6 percent per year, and the Part A program scheduled to go bankrupt by 2024.

Moving on to Social Security, Mr. Goss, I read an article not too long ago, the Senate majority leader indicated that within a couple of decades, 20 years he said, he would take a look at reforming this program. I know that other members of Congress have expressed that belief that they could wait until 2036 before any action would be necessary. I want to be fair here, our ranking member earlier today indicated that we do need to embark upon reform in this area, make Social Security sustainable so that it is around for current and future generations. Could you indicate the cost of waiting, please? Just articulate what would happen if we waited until 2036 and its impact on all seniors, but also speak to specific cohorts please.

Mr. GOSS. First of all, we simply cannot wait until 2036, specifically because of the disability insurance program. We have to have something to address that issue in the much nearer term, over the next three or four years. Looking at the Social Security OASI and DI programs on a combined basis, if we were to do nothing, we would hit this rather substantial and enormous problem in the year of 2036 as we now project it, where we would have this sudden 23 percent reduction in benefits, which I do not think anybody would be interested in doing. If we wait a substantial amount of time before we enact changes that can be graded in over some period of time, then we would clearly and severely limit the options that would be available at that time. I think many people have suggested if we were to wait, literally, until the last minute it would be difficult to raise enough revenue instantly at that point, or to lower benefits instantly at that point in order to make the financing and Social Security work on an appropriate basis. It would be a very dramatic and drastic situation to put ourselves into, to wait that long. I personally would doubt that anybody has an interest in doing that, and appreciate both Chairman Ryan and Ranking Member Van Hollen both indicating a strong interest in getting to this sooner rather than later.

Mr. YOUNG. I appreciate that as well, and thank you so much for your comments, and I yield back.

Chairman RYAN. Mr. Ribble.

Mr. RIBBLE. Thank you Mr. Chairman. Thank you both for being here, and I know it has been a long morning already. Mr. Foster, I would like to, first of all, thank you for a statement in your testimony. I would like to read it back to you so you would know how much I appreciate it.

"I applaud your efforts to strengthen Medicare and Medicaid and to find ways to insure the financial viabilities of these important health care programs." You know, we are kind of entering silly season in the political world where there are all these conversations about ending Medicare as we know it, and how everybody in Congress hates seniors, and they want to use it for political gain, and your very unbiased statement is particularly rewarding to me because we want to find solutions here.

Following up a little bit what my colleague from Florida was talking about regarding the costs of Medicare and costs to seniors. We know that there are going to be changes in an effort to control costs by paying providers differently, a reduction in payment to providers. What effect do you think the payment cuts to providers contained in current law will have on access to care?

Mr. FOSTER. It is a serious issue and one I have spoken about before. Over a long period of time the lower payment rate updates for most categories of providers accumulate, and they do not end up just being 5 percent or 10 percent lower, they end up being 30 percent, 40 percent, 50 percent lower. It strikes me as unlikely that that is viable in the long term, and that these payment rates would be so far below provider costs for providing the services that it just would not work. The providers would either have to stop providing services for Medicare beneficiaries or shift costs to somebody else with better paying coverage, or possible go out of business, or possibly merge with other companies. More likely, I think you all would step in and say this is not what Medicare is all about, we would have to adjust those payment rates to make them more adequate.

Mr. RIBBLE. Which is what Congress has done over and over again, has it not?

Mr. FOSTER. Well, certainly for physicians, every year 2003 through this year.

Mr. RIBBLE. Ultimately if care goes away we have not really benefited seniors at all if we are not careful. I also want to ask you about something in your testimony that struck me. Reading on Page 17, "The two largest contributors have been rising income" it is talking about factors that have caused health care costs to go up, "The two largest contributors have been rising incomes and new medical technology." I am struck by that, then later you go on to say, "Numerous studies have found that most new health technology has been cost increasing," and then you follow up by saying, "Encouraged by comprehensive insurance coverage that shields individuals from most of the additional direct costs from using the new technology." Could you talk to us a little bit about rising incomes, why technology has not driven costs down like it has almost every other place, and then this idea about shielding individuals from the real costs?

Mr. FOSTER. Right, because of the prevalence of health insurance, and this is true for Medicare and pretty much everything else too, a typical beneficiary or an individual does not see the full cost of the service they are getting. They have to pay a copayment or a co-insurance rate, so if a new device or procedure comes along that might be quite expensive, they are only going to see a portion of that new, more expensive cost. Deciding well, yes, I would really

like to get this procedure as opposed to something else that does not sound quite as nice and I only have to pay this much, and the procedure seems to be worth far more, it is a no brainer and we all go for it. In some cases, I mentioned in the testimony the classic case of Nexium replacing Prilosec. Even if the benefit is not even better, if it is almost exactly the same drug or other technology, we tend to go for it anyway.

Mr. RIBBLE. Well, is not the way that Medicare currently operates, almost the ultimate shield, where seniors really do not feel the cost at all and there is not a lot of incentive for them to help drive costs down?

Mr. FOSTER. In many cases I guess I would have to agree with that. First of all, let me say that Medicare does not have catastrophic protection. Most beneficiaries, the great majority, 90 percent of them have other supplemental coverage of one form or another, either Medigap supplemental policies, or Medicare Advantage, or Medicaid, and as a result, especially with people with Medigap, like, coverages C and F, I think they are; they cover first dollar. Then at the point of service the Medicare beneficiaries sees no cost at all for the service. Now the premiums that they have to pay, sooner or later, will go up, but at the point of service they see no cost-sharing requirement.

Mr. RIBBLE. Thank you very much. Mr. Chairman, I yield back.

Chairman RYAN. Mr. Woodall.

Mr. WOODALL. Thank you Mr. Chairman. Thank you gentlemen for sticking with us until the bitter end. I also appreciate your service. As I was doing the math in my head Mr. Foster, what is that, a combined 70 years, or more than 70 years between the two of you. I want to call on some of that experience because I go back to the letter that you sent, Mr. Goss, to Secretary Geithner last fall that said the level of the trust funds would be unaffected by payroll tax holiday legislation. I certainly defer to your actuarial expertise. I am worried about the integrity of the trust fund. In your 70-plus years of collective experience, is it your testimony that funding sources that come out of general revenues are equally secure as funding sources that come out of trust fund deposits, or have you seen over your years of service differences in the stability of those two revenue streams, Mr. Goss?

Mr. GOSS. Well, certainly we have seen that there seems to be an absolute sense that money once in the trust funds, putting aside arguments about economic impact and meaningfulness of trust funds, once money is in the trust funds that does represent a liability on the general fund of the Treasury, and that money will be produced and will be provided to that program.

Mr. WOODALL. A distinction without a difference then, that it is coming from the general revenues instead out of payroll taxes?

Mr. GOSS. Well, once the money has been generated in a given year and put into the trust funds, it is not easy, and it is not really possible to just determine how much of that money came from taxes in the past, from general revenue contributions in the past, from interest in the past. The money is just there and it is owed. On an ongoing basis in the future, though, I believe perhaps your distinction is there has always been the concept of Social Security as the earned right to benefits, and having payroll taxes on people's

individual earnings provides the sense of the earned right which gives the American people the strong hold that they have on the fact that the Social Security is owed. If there were a very long sustained period of time in which, for reasons other than just temporary fiscal stimulus, we were to have a substantial portion of the program paid for, rather than by payroll taxes, instead by general fund, then people would undoubtedly begin to view the program somewhat different.

Mr. WOODALL. It was just one year, now it is two years. We are heading down that road towards that long period of time. What about you Mr. Foster, do you feel that same sense that payments into trust funds from individuals give a sense of ownership that transfers from general revenues do not?

Mr. FOSTER. I think that is correct, and I would agree with what Steve said just now. As a practical matter, over the years we have seen that in a budgetary context, as opposed to a trust fund context, that the payroll tax revenues for both Social Security and hospital insurance, Part A of Medicare, are sort of off limits. It is a dedicated source of revenue; nobody is talking about let's take a portion of these payroll taxes and use them for some other purpose. That just is not considered. Whereas, for the general revenues, you all have to fight and worry about that every day that you are here, pretty much, because of all the competing requirements.

Mr. WOODALL. I think that is exactly right. No, that is what one of our Social Security trustees, Dr. Charles Blahous, was talking about. I want to quote him directly because I do not want to misstate his point. He says, "Social Security was not established to be a source of temporary stimulus funds. The idea that its payroll tax rates should be moved up and down with economic events is highly dangerous to the program's financial future." I mean, folks have been citing the letter that you wrote, Mr. Goss, to say that the trust fund levels would be unaffected, that is true, but the integrity of the program, at least so says one of your trustees is highly affected.

As a fellow who came here to solve problems rather than point fingers and blame, I am actually struck by the fact that you refer to this major piece of legislation dealing with Social Security and its trust fund as leaving the trust fund levels unaffected because I would tell you that is a failure, that we have all sat here around the table all morning talking about the challenges that are facing us, and we pass a major piece of legislation that does not one thing to solve the problem. Are you familiar with my freshman colleague Jeff Landry's Spice Act, it is HR3551, that would have said if we need this holiday for stimulus, let's do it, but let's establish personal choice on the backside that you will delay your personal receipt so that you can collect your trust fund rebate today, as it were. My understanding is that bill would have actually affected trust fund levels by reducing liability some $2 trillion over the three generational window. Can you speak briefly to that Mr. Goss?

Mr. GOSS. That is correct. Mr. Landry's proposal, and I believe he has some cosponsors, would make voluntary on a permanent basis the 2 percent payroll tax reduction that workers could choose to have, and in any one year in which a person chose to take that, they would have their normal retirement age, or their basic retire-

ment age for benefits, increased by one month. If they did it for 10 years, their basic retirement age would increase by 10 months. That change in the retirement age for the people who chose this option would accrue to a positive to improving the financial status of Social Security, but most particularly that would occur because the cost of the reduced payroll taxes would be reimbursed from the general fund of the Treasury on an ongoing basis in the future, as it has been for 2011 and 2012.

Mr. WOODALL. Thank you very much. Thank you both.

Chairman RYAN. Mr. McClintock.

Mr. MCCLINTOCK. To follow up on that point then, by linking the cost with the benefits we would be giving every American family the choice of whether the year's worth of tax relief is worth the actual cost of that to the system one month delay in retiring, and they could make that every year depending upon their own circumstances, desires, wishes, and needs, is that correct?

Mr. GOSS. That is exactly correct. In fact, we calculated, in working with Mr. Landry and his staff, one month for each year as being approximately an average neutral effect for the trust funds. If you keep 2 percent of your payroll taxes in one year, and have your normal retirement age go up by one month, the trust funds over the very long haul, would be about neutral, but the trust funds actually turn out to be better because the cost of the tax reduction then is reimbursed by the general public.

Mr. MCCLINTOCK. So we are reducing the payroll taxes coming into the system, at the same time, we are reducing the obligations of the system going out. Now, when we do not do that, we end up, as you pointed out now in response to questions from Mr. Van Hollen, Mr. Stutzman, and Mr. Woodall, we end up reimbursing the Social Security fund from the general Treasury. The general Treasury, of course, has basically one source of income, and that is the taxpayers, is that correct? Either through their taxes or to the extent that government has to borrow through their future taxes, but one way or another, it comes out of their taxes, is that correct?

Mr. GOSS. That is absolutely correct. That was true in the 2011 and 2012, but that is also true for the tax reductions.

Mr. MCCLINTOCK. So would it be fair to say that cutting the payroll tax without reducing the obligations that the payroll tax pays for is simply playing a shell game over which taxes are going to pay for those obligations?

Mr. GOSS. I certainly would not use the word shell game, but I think there is no question, but if, indeed, the intent of the reduced payroll taxes was simply to put more dollars in people's hands as a stimulus measure, the payroll tax undoubtedly was utilized just because it was a readily available.

Mr. MCCLINTOCK. Certainly general taxes will have to make up for the difference either now or in the future, is that correct?

Mr. GOSS. Absolutely.

Mr. MCCLINTOCK. I would call that a shell game. Mr. Foster, wanted a little bit more about the IPAB. How would you compare that with the U.K.'s National Institute for Health and Clinical Excellence; I believe that the smarmy acronym is NICE?

Mr. FOSTER. There are potentially some similarities with the NICE group in the U.K. Much of what they are doing is what we

refer to as comparative effectiveness, and that has been a controversial topic, I am sorry that is the case because I think there actually is potential there.

Mr. MCCLINTOCK. The IPAB has that same authority?

Mr. FOSTER. Somewhat. The IPAB can look into different approaches. They do not have to just reduce provider payment rates.

Mr. MCCLINTOCK. Can they said we will provide this service, but not that. We will provide this service, but only under certain circumstances?

Mr. FOSTER. They cannot fundamentally change the benefit structure and the coverage for Medicare. It is a little bit of a gray area; could they get into issues of this new procedure that is now available and which costs 10 times as much as the old procedure, it is not really any more effective.

Mr. MCCLINTOCK. But, for example, in the U.K. there is a drug, called Ipilimumab. Essentially it doubles the one and two year survival rates for malignant melanoma. NICE said at 80,000 pounds per year that is just too expensive. Could the IPAB issue a similar decree?

Mr. FOSTER. That I do not know. I think the intention is not to do that.

Mr. MCCLINTOCK. The intention, but do they have the authority?

Mr. FOSTER. Not having studied the law carefully enough for that question, I will give you an answer later on. I think the intention is that they not do that kind of thing.

Mr. MCCLINTOCK. Well, again, the intention and the authority are two different things. I am sure they intend only good. NICE intends only good, but through that single decree, that that is just too expensive for a new procedure, and you just said that the IPAB has the authority to say it is a new procedure, it is too expensive, we just do not want to deal with it, that has been called a death sentence for those with malignant melanoma, particularly those of younger age in the U.K.

Mr. FOSTER. Well, and that is why I believe that the IPAB does not have the authority. The analysis and the support for comparative effectiveness under the Affordable Care Act is also very limited because of concerns of that type.

Mr. MCCLINTOCK. Well, NICE has also said with respect to Lucentis, which is a drug that has been cited for an unprecedented ability to reverse macular degeneration. NICE said, well, that is pretty expensive. We will allow the treatment, but only after the patient has already lost sight in one eye. Is that something conceivably the IPAB could decree?

Mr. FOSTER. I do not think so.

Mr. MCCLINTOCK. Okay, thank you.

Chairman RYAN. Okay, gentlemen, thank you for coming again. Thank you for spending your time, this has been very enlightening. This hearing is adjourned.

[Question submitted for the record from Mrs. Black follows:]

QUESTIONS SUBMITTED FOR THE RECORD BY HON. DIANE BLACK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

During the hearing, I asked Mr. Goss about the sharp increase in the costs of the Social Security Disability Insurance (SSDI) program in the past fifteen years. He explained that this was largely the result of two changes. First, the baby boomer

generation entered the prime years (ages 45-65) for submitting applications to the SSDI program. Second, the gap in application rates between males and females normalized.

Mr. Goss, can you elaborate in more detail on the changes in female application rates to the SSDI program and how this affected the SSDI trust fund in the past fifteen years?

[The response from Mr. Goss follows:]

SOCIAL SECURITY,
OFFICE OF THE CHIEF ACTUARY,
Washington, DC, March 15, 2012.

Hon. DIANE BLACK,
House of Representatives, Washington, DC 20515.

DEAR MRS. BLACK: On March 9, I received your question related to our discussion at the Committee on the Budget Hearing on February 28, 2012. Thank you very much for the question. The cost of the Social Security Disability Insurance program has increased significantly over the past 15 to 20 years and it is important that we all understand why this increase occurred, and what is likely to happen in the future.

Question: During the hearing, I asked Mr. Goss about the sharp increase in the costs of the Social Security Disability Insurance (SSDI) program in the past fifteen years. He explained that this was largely the result of two changes. First, the baby boomer generation entered the prime years (ages 45-65) for submitting applications to the SSDI program. Second, the gap in application rates between males and females normalized.

Mr. Goss, can you elaborate in more detail on the changes in female application rates to the SSDI program and how this affected the SSDI trust fund in the past fifteen years?

The drivers of the cost of the Disability Insurance program was the topic of a hearing on December 2, 2011 before the House Ways and Means Subcommittee on Social Security. I have attached my written testimony from that hearing, where I testified specifically on the increase in the cost of the program. There are two very significant changes for women that have contributed to increased disability benefits, and thus to cost.

Figure 6 (on page 4 of the written Ways and Means testimony) shows a very substantial increase in the percentage of women who are insured for potential receipt of Social Security disabled worker benefits. Disability insured status requires both: (1) earning at least one quarter of coverage for each year elapsed since attaining age 22; and (2) earning at least 20 quarters of coverage during the most recent 10 years. In 1970, the percentage of women at working ages who met these requirements was only half as high as the percentage for men. Today, the percentage of working-age women who are disability insured is nearly as high as for men, having roughly doubled since 1970.

Figure 7 (on page 5 of the written Ways and Means testimony) shows a very substantial increase in the percentage of disability-insured women who become disabled and file for benefits. This "disability incidence rate" for women rose from 3.5 new benefit awards per thousand exposed population (those insured for disabled worker benefits but not already receiving benefits) in the early 1980s to about 6 per thousand now. After the recovery from the recent recession is complete, we expect the disability incidence rate for women will settle at around 5 per thousand, just below the level for men, but far above the level of the 1980s for women. Over this same period, disability incidence rates for men have fluctuated around a relatively stable base level of just over 5 per thousand exposed population.

These very substantial increases in both the percentage of working age women who are disability insured, and the percentage of those insured women who become disabled and apply for Disability Insurance benefits, have contributed to the rapid rise in the cost of the Disability Insurance program over the past 15 to 20 years. Just as important, however, is that both of these increases for women have moved their rates close to those for men, who have had fairly stable rates of disability insured status and disability incidence for several decades. For this reason, we assume that disability insured and disability incidence rates by age will remain close to recent levels for both men and women in the future. With this stabilization of these rates, and the movement of the baby-boom generations from disability ages to retirement ages, we project that the cost of the Disability Insurance program as a percentage of gross domestic product will not only stabilize, but will actually decline slightly in the future (see Figure 3 on page 3 of the written Ways and Means testimony).

I hope this analysis and the attached testimony will be helpful. Please let me know if we can be helpful in any other way.

Sincerely,

STEPHEN C. GOSS,
Chief Actuary.

Enclosure.

SECURING THE FUTURE OF THE SOCIAL SECURITY DISABILITY INSURANCE PROGRAM

Testimony by Steve Goss, Chief Actuary, Social Security Administration

House Committee on Ways and Means, Subcommittee on Social Security, December 2, 2011

Chairman Johnson, Ranking Member Becerra, and members of the subcommittee, thank you very much for the opportunity to speak to you today about the Social Security Disability Insurance program. I would like to share thoughts on three topics: (1) the nature of disability insurance; (2) the financial status of the Disability Insurance program; and (3) the "drivers" of the cost of the Disability Insurance program.

(1) THE NATURE OF DISABILITY INSURANCE

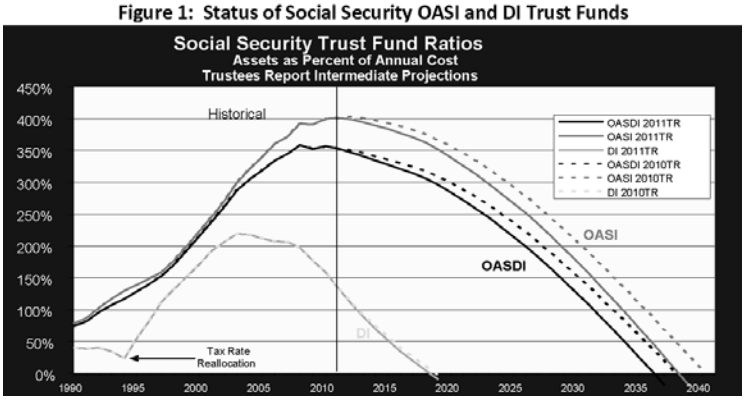
Disability insurance is arguably the most difficult form of insurance to administer. It is easy to determine whether an insured person has reached retirement age or has died. It is also easy to determine whether a car is wrecked or a house destroyed. It is even relatively easy to determine if health insurance should cover doctor and hospital bills. However, disability is by nature a very subjective concept. Whether a "medically determinable impairment" eliminates the ability to engage in any "substantial gainful activity" depends on a myriad of issues related to a person's residual functional capacity, past job experience, desire to work, and availability of suitable jobs. All of these issues differ among individuals, across geographic regions, and over time.

The determination of whether a person is disabled is a highly complex process subject to human judgment by the claimant, their representative, the claim examiner, and the medical consultant. Becoming disabled can be a gradual process. A person may not qualify when they initially apply, but may "cross the threshold" of disability during the appellate process or at a subsequent age resulting in reapplication. Initial disability determinations and periodic continuing disability reviews make administration of the Disability Insurance program an enormous challenge. The Social Security Administration meets this challenge effectively and efficiently. Accuracy rates in determinations are high, and multiple appeal steps are available to claimants. Yet, less than 2.5 percent of program expenditures are for administrative expense.

(2) THE FINANCIAL STATUS OF THE DISABILITY INSURANCE PROGRAM

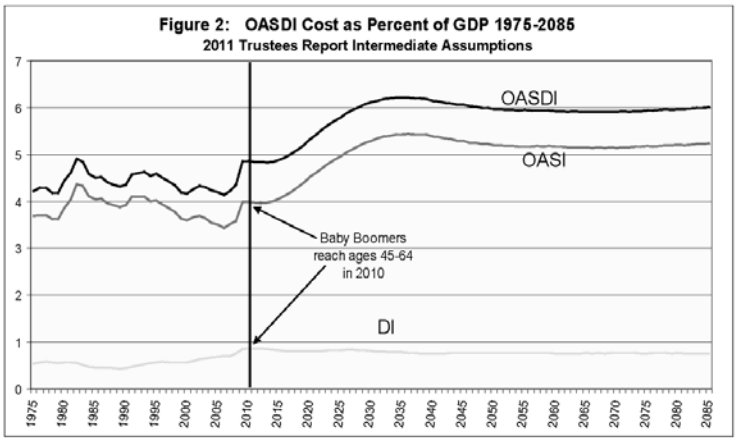
The Disability Insurance Trust Fund assets expressed as a percent of annual program cost peaked in 2003. The 2011 Trustees Report projects assets to become exhausted in 2018, with continuing tax revenue sufficient to pay 86 percent of scheduled benefits thereafter. The unexpectedly large COLA for December 2011 and a lower-than-expected increase in average earnings for 2010 may exhaust trust fund reserves even earlier. For 2085, the Trustees Report projects continuing tax revenue will be sufficient to pay 83 percent of scheduled benefits.

Figure 1: Status of Social Security OASI and DI Trust Funds



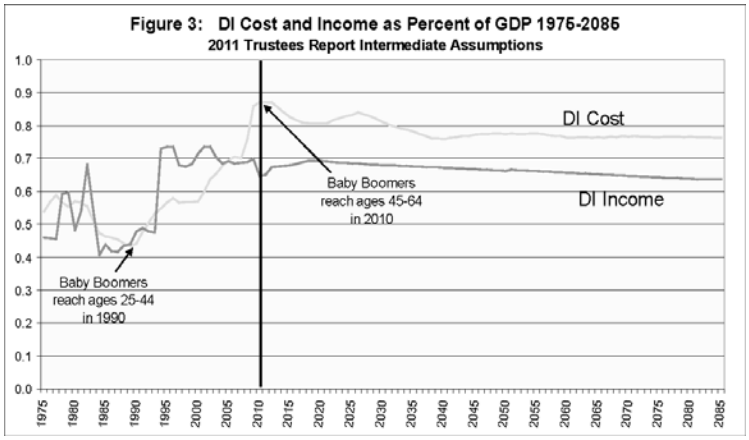
Sustainable solvency can be restored for the Disability Insurance program with a 16-percent reduction in benefits, a 20-percent increase in revenue, or some combination of these changes. Even in the absence of such change, a simple tax-rate reallocation between OASI and DI, as was done in 1994, could equalize the financial prospects of the trust funds. We estimate that temporarily raising the Disability Insurance program's share of the 12.4-percent OASDI payroll tax rate from 1.8 to 2.2 percent for 2012 through 2024 and to 2.0 percent for 2025 through 2029 would make scheduled benefits payable for both OASI and DI beneficiaries until 2036.

Overall OASDI cost will rise over the next 20 years as the baby boomers retire and are replaced in the working ages with lower-birth-rate generations born after 1965. The drop in birth rates after 1965 will cause a permanent shift in the age distribution of the population with fewer workers to support more elderly retirees.

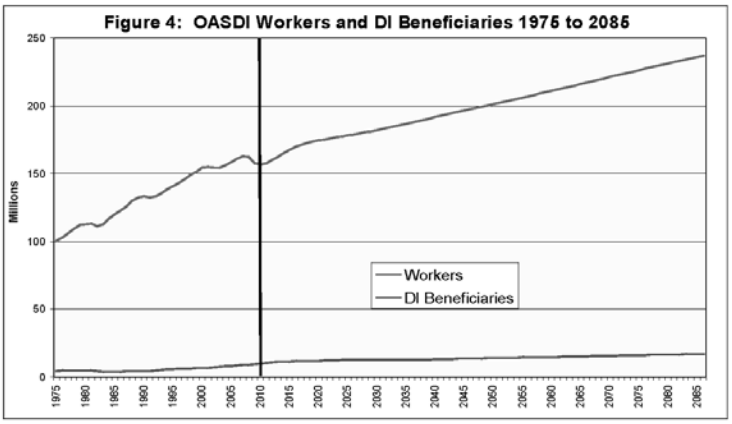


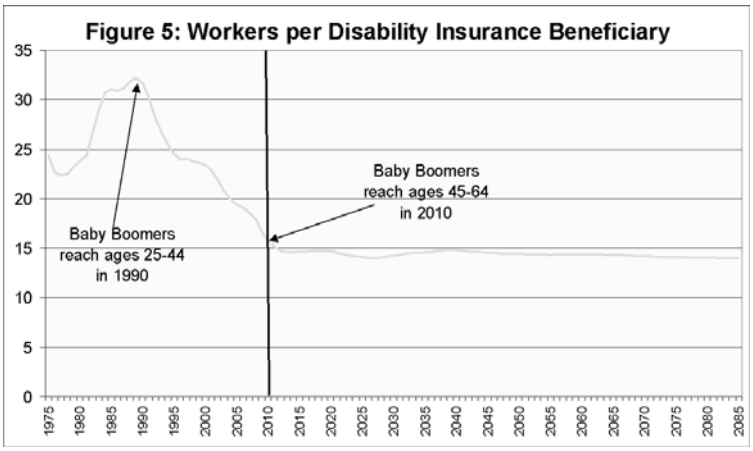
However, the baby boomers already moved from young ages (25-44) in 1990, where few were disabled, to older ages (45-64) in 2010, where many more are disabled. Thus, the 20-year demographic shift in the age-distribution of the population has already occurred for DI.

Lower birth rates slow population growth at all ages. We project similar but slower growth rates in both the workforce and DI beneficiaries for the future.



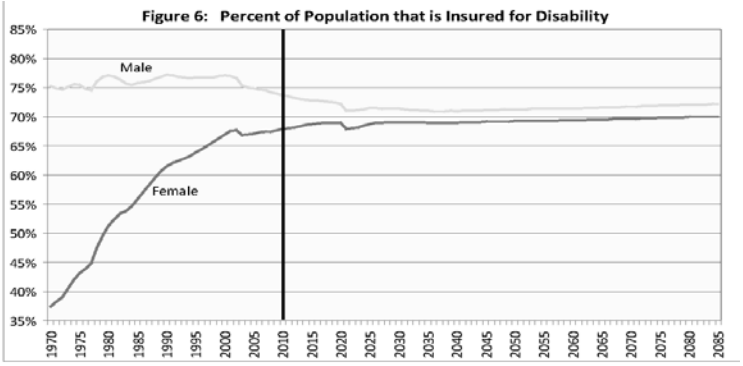
As a result, the number of workers per DI beneficiary is expected to be relatively stable in the future. This means that restoring sustainable solvency for the DI program will not require continually greater benefit cuts or revenue increases. A one-time change to offset the drop in birth rate is all that is needed to sustain the DI program for the foreseeable future.





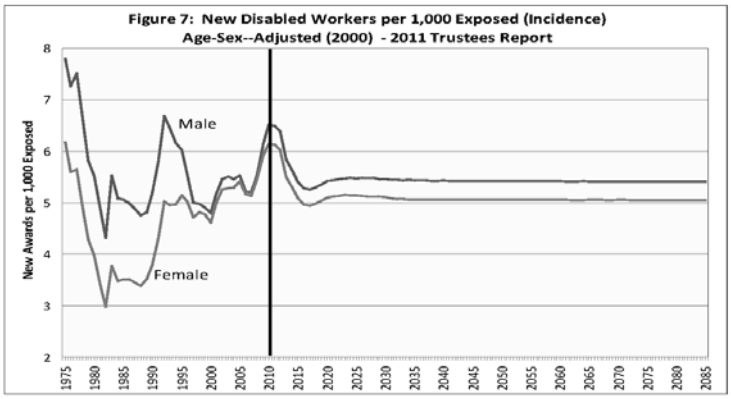
(3) THE "DRIVERS" OF THE COST OF THE DISABILITY INSURANCE PROGRAM

Several drivers specific to DI program cost will be changing in the future. The first important driver is the size of the disability-insured population. Since 1970, this population grew explosively as increasing numbers of women worked consistently and stayed insured.



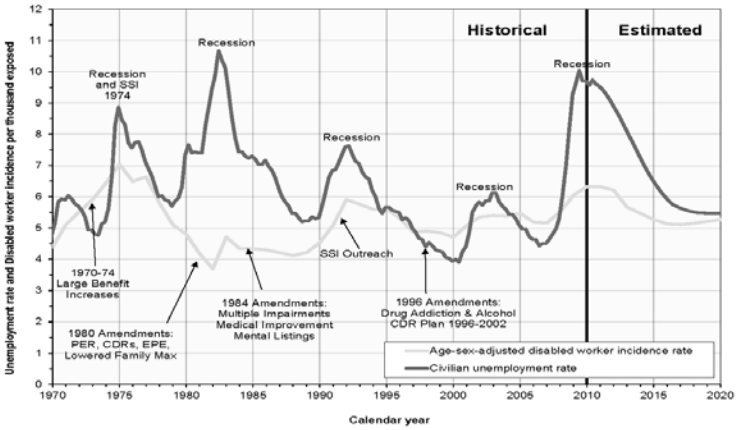
In the future, we project that men will be less likely to be insured, reflecting increased restrictions on undocumented aliens after 2001, and insured rates for women will stabilize close to men. This change will substantially slow the growth in the cost of the DI program.

The second important driver of DI cost is rate at which insured workers become newly disabled. Changes in the rate of disability incidence are best seen by excluding the effects of any change in the age-distribution of the general population. For men, this age-adjusted incidence rate has averaged somewhat over five new disability awards per thousand exposed (insured but not already disabled) workers and has seldom been below this level. Since 1980, the age-adjusted incidence rate for women has been moving up to a level much closer to men. We expect that male and female age-adjusted disability incidence rates will be fairly stable in the future.



A more careful look at past fluctuations in the overall age-sex-adjusted disability incidence rate reveals a number of specific economic and policy drivers that have influenced disability cost. Periodic economic recessions, as illustrated by the civilian unemployment rate in bright orange in the figure below, have been associated with temporary increases in disability incidence.

Figure 8: Effects of Economic Cycles and Policy Changes on DI Incidence Rates

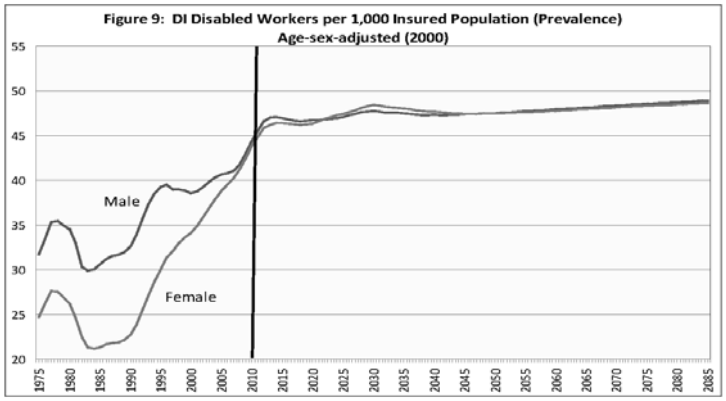


The very recent recession of 2008-2009 resulted in an increase in disability incidence that was exceeded only by the incidence rate in 1975. One apparent exception to the relationship between disability incidence and economic recessions is the strong recession of 1981-1982. Here the effect of the recession appears to have been offset by the net effects of the 1980 Amendments, which: (1) sharply increased the levels of pre-effectuation review of disability allowances and continuing disability re-

views of current beneficiaries; (2) introduced the extended period of disability to encourage work; and (3) lowered the maximum family benefit for DI beneficiaries.

Additional policy changes over the years had significant effects on disability incidence. Double-digit ad-hoc benefit increases in 1970 through 1974 made disability benefits more attractive. The 1984 Amendments may have countered the effects of a strong economic recovery with increased emphasis on multiple impairments and mental listings, and requirement to show medical improvement for benefit cessation. The SSI outreach to disabled adults likely added to the effects of the 1990-1991 recession. Also, the 1996 Amendments may have partially counteracted the effects of a strong economic recovery with elimination of drug addiction and alcoholism as disabling impairments, and effecting a 7-year plan to eliminate a backlog of continuing disability reviews. Future policy changes and economic cycles will undoubtedly continue to cause fluctuations in disability incidence rates.

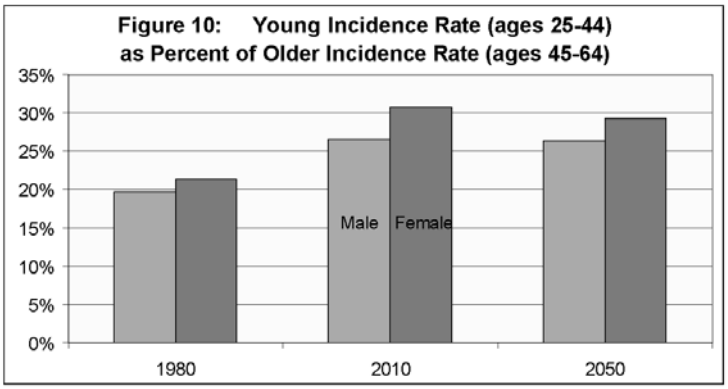
Disability incidence rates tell us the rate at which healthy workers become newly disabled. The cost of providing benefits to disabled workers also depends on how long their disability lasts. Disability incidence and length of the period of disability can be combined by considering the number of insured workers who are currently disabled at each age, regardless of how long ago they became newly disables. Disability prevalence rates are simply the percent of the insured population at a given age that is currently receiving disabled worker benefits, regardless of when benefits started. Age-sex-adjusted disability prevalence rates eliminate the effects of changing population age distribution and isolate the effects of disability-specific drivers.



The figure above shows that the age-sex adjusted disability prevalence rate for men increased by about a third between 1990 and 2010, even though age-sex-adjusted incidence rates were fairly stable over the observed period 1970-2010. Female prevalence rates increased even more because their age-sex-adjusted incidence rates did increase over the observed period.

The reason for the rise in male age-sex-adjusted disability prevalence between 1990 and 2010 lies in the age distribution of disability incidence rates. While the overall age-sex-adjusted incidence rate was fairly stable for men, a relative shift toward new disabled-worker awards at younger ages explains the prevalence increase. All else being equal, shifting new disability incidence from ages 45-64 to ages 25-44 will increase the total number of beneficiaries, or prevalence, because the younger awardees may remain disabled for many more years.

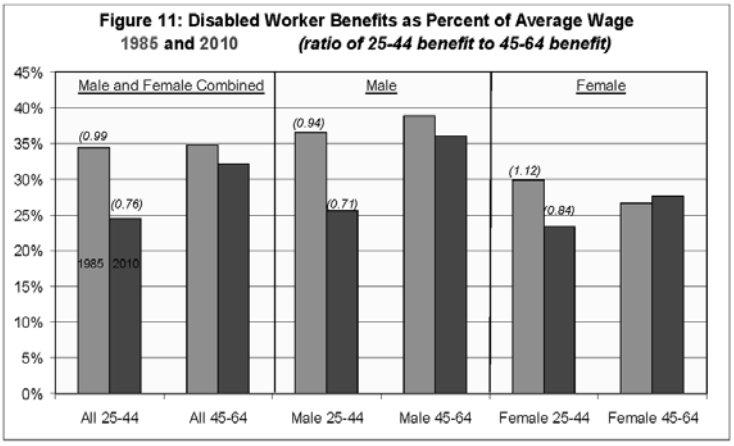
The figure below illustrates the degree to which disability incidence rates at ages 25-44 grew relative to incidence rates at ages 45-64, both for men and women, between 1980 and 2010. The shift toward relatively lower ages of disability incidence was even stronger for women than for men. This, combined with the age-sex-adjusted increase in disability incidence for women, largely explains the historical increase in prevalence rates for women.



The shift toward relatively lower ages in disability incidence rates stabilized after 2000. We expect that the relative incidence rates by age will continue to be stable in the future. This, combined with stable age-sex-adjusted overall incidence rates, explains our relatively stable projection of future age-sex-adjusted disability prevalence rates.

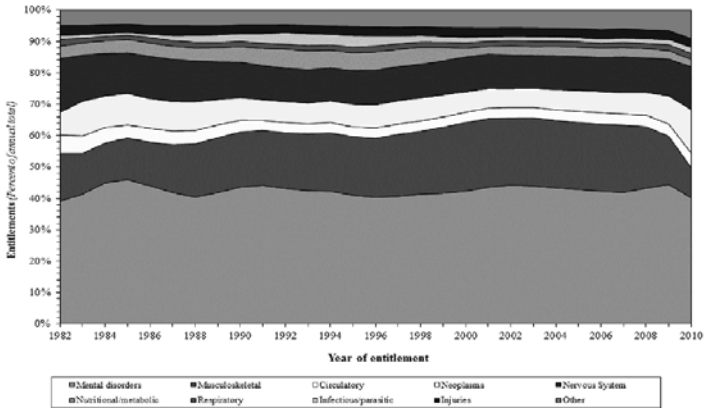
While we feel fairly confident about projections for the future, two questions remain about the past: (1) why did disability incidence grow at younger ages relative to older ages; and (2) are there any special characteristics of the additional, younger disabled worker awards?

Due to the complexity of the disability criteria and determination process, and the nature of disability, it is very difficult to determine why incidence rates at younger ages rose from the levels in 1975-1985 to the levels in 2000-2010. However, we can gain some insight into both questions by considering the characteristics of younger versus older disability beneficiaries over time. For example, we can consider (a) relative benefit levels across ages and (b) the distribution of primary diagnosis for younger versus older disabled worker awards.



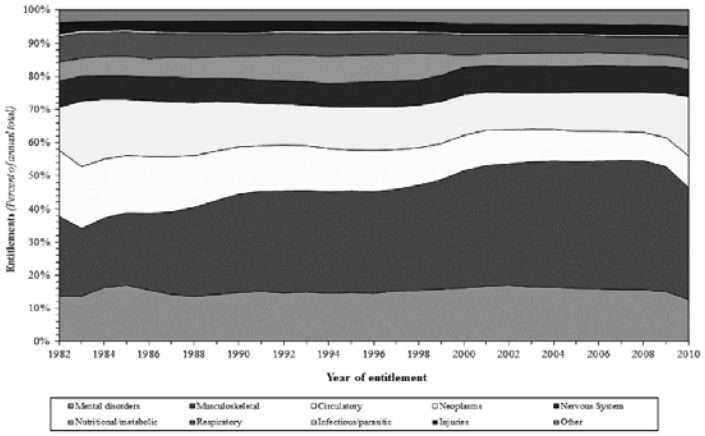
The chart below provides an interesting comparison of benefit levels for younger versus older disabled worker beneficiaries in 1985 and 2010. For each group, the average benefit level is expressed as a percentage of the national average wage index (AWI) for the year.

Figure 12: Distribution of New Female Disabled Workers at Ages 30-39 by Primary Diagnosis



In 1985, the average benefit level for all younger beneficiaries (age 25-44) was very close to the average benefit level of older beneficiaries (45-64). By 2010, the average benefit level for younger beneficiaries was 24 percent lower than that for older beneficiaries. The change is similar for men and women considered separately. This suggests that the increase in younger disabled worker awards between 1985 and 2010 came from insured workers with low career-average earnings levels, either because they were low paid workers or because they had intermittent employment. The implication for future average benefit levels is also interesting. As the recent younger beneficiaries with low benefit levels age, they will gradually restrain the growth in the average benefit level for older beneficiaries in 2030 and later. Thus, the increase in disability prevalence from younger disabled worker awards will be partly mitigated by lower future benefit levels.

Figure 13: Distribution of New Female Disabled Workers at Ages 50-59 by Primary Diagnosis



A second characteristic we can consider regarding younger versus older disabled worker beneficiaries is any change in awards by category of medically determinable impairment (primary diagnosis code). The figure below shows that even though the number of female disabled worker awards at younger ages has risen rapidly, the distribution by diagnosis has remained very stable. The pattern for younger men is very similar.

At higher ages, female disabled worker awards show increases in musculoskeletal diagnoses and decreases in circulatory diagnoses. The patterns for males are also similar at these older ages. These effects do not appear to explain the increase in young awards.

CONCLUSION

Disability insurance is highly complex and challenging to administer. General demographic changes have increased the cost of the DI program over the past 20 years in much the same way that demographics will raise OASI and Medicare costs over the next 20 years. Disability insured rates have increased substantially for women, as have age-sex-adjusted incidence rates for younger insured women, further contributing to higher DI cost. However, all of these trends have stabilized or are expected to do so in the future.

We project that the number of DI beneficiaries will continue to increase in the future, but only at about the rate of increase in workers. Thus, the current shortfall in tax income compared to DI program cost is projected to be stable in the future. Restoring sustainable solvency for the DI program requires about a 16-percent reduction in benefits, a 20-percent increase in revenue, or some combination of these changes. Even if such changes are not effected soon, a modest reallocation of the total OASDI payroll tax can be enacted prior to 2018 that would equalize the actuarial status of the OASI and DI programs, allowing both to pay full scheduled benefits until 2036.

[Whereupon, at 12:21 p.m., the Committee was adjourned.]