S. HRG. 104-269

1995 BOARD OF TRUSTEES ANNUAL REPORT ON THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY INSURANCE TRUST FUNDS

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

JUNE 6, 1995

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

91-887—CC WASHINGTON : 1995

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-052112-2

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TUESDAY, JUNE 6, 1995

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 2:30 p.m. in room SD–215, Dirksen Senate Office Building, Hon. Bob Packwood (chairman of the committee) presiding.

Also present: Senators Chafee, Simpson, D'Amato, Murkowski, Moynihan, Baucus, and Graham.

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. Good afternoon, Mr. Secretaries. Thank you both for accommodating your schedule to ours. As you know, we have been having a series of hearings on Medicare; we are going to have even more now with Budget Reconciliation coming up.

I know last year the President was talking about Medicare in the context of mega health reform. As I have read his statements recently, he is talking about, the kind of modest health reform that I interpret as insurance reform and a variety of other things, that we might agree upon, but it is not mega in the sense that he meant last year.

In that case, I am curious about what you plan to suggest on Medicare bankruptcy, because this morning we had some economists on the issue of the Consumer Price Index; a good panel. I believe it was Dr. Norwood that talked about, it was not the word appearance, but acceptance, that we just must not do something legislatively on the Consumer Price Index that looked political because there would not be public acceptance. I commented to her, we do face the same problem on Medicare. Factually, it is going bankrupt. Everybody has said that.

Whether or not, if we just tried to cure it by fiat, if we have to cure it, there would be public acceptance of it, I do not know.

But it is going bankrupt. As of 1992, it was paying out more money than it was taking in in taxes. As of this year, or next year, it will pay out more money than it takes in altogether, and, apart from liquidating its modest supply of bonds—which run out in 2002—it has no money.

So, you are two of the six trustees. Two other secretaries are two more, and then we have had the two public trustees come and testify. I think of them as private trustees. They were both excellent I thought, Senator Moynihan. They knew the subject backwards and forwards, Republican and Democrat, and were excellent.

Senator MOYNIHAN. Yes.

The CHAIRMAN. Senator Moynihan.

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK

Senator MOYNIHAN. Mr. Chairman, I would just like to welcome our distinguished cabinet secretaries. While we are here to discuss the very important topic of the Medicare Trust Fund, I would hope, if the time allows, that we might hear from Secretary Rubin and Secretary Reich on the subject that is directly related to our resources in the trust funds, which is the counter-cyclical provisions that we have built into the American economy over the last 60 years, since the enactment of the Social Security legislation.

We have seen extraordinary success in maintaining economic stability for half a century now. We have not had a year in which there has been double digit unemployment. This after a century of wild swings up and down. Yet the House has proposed to eliminate extended unemployment insurance benefits.

There are proposals across the way to reduce benefits in the health care programs, food stamps, and in AFDC itself. These programs have a counter-cyclical provisions built in to them. So the whole question of the economy arises. I believe we are in the 50th month of an expansion at this point. That is the edge of the average expansion in the last half century, so some thoughts on that subject would be helpful to us, as this committee is responsible for all of the above, minus, food stamps.

Thank you, Mr. Chairman, for having this hearing.

The CHAIRMAN. Senator Baucus.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you, Mr. Chairman. I, too, welcome our Secretaries; very distinguished, very helpful, and very public-spirited.

Mr. Chairman, I have said this before but we can never hear it too often, here in Washington people often lose the forest for the trees. I am afraid that is what might be what is going on right here with Medicare.

We are looking at something like a $250 billion cut in Medicare. It will reduce Medicare services by nearly a quarter; 25 percent by the year 2002. What happens to these costs, do they just go away? Does health care somehow magically come cheaper for seniors? Of course not.

The consequences are very easy to predict. When you go bowling, for example, you hit the head pin and it will fall down, and the pins behind it are sure to fall, too. The same thing is coming up here. We will reduce Medicare services. That will hit senior citizens and their families. But behind them are rural hospitals, their em-

ployees, small business, agriculture, and the wages for working people.

To begin with, Montana Medicare beneficiaries would pay up to $900 more a year for health services. That will come out of their own savings and from their children, who are now scraping for money to send their children to college, make a down payment on a house, or pay property taxes.

We would see thousands of operations and hospital stays put off; thousands of people who decide to go without home health care. All that means, of course, is that they will suffer a more serious, more painful, more expensive illness later on that early health care could have prevented.

As the Federal Government cuts reimbursement, it would push rural hospitals to the brink. Several Montana hospitals get more than 60 percent of their revenue from Medicare. There is no doubt that some hospitals would close.

We will lose jobs. In many small prairie towns, losing a hospital means losing the biggest employer in a whole county. It is a shock to the whole economy. At the same time, it will reduce access to basic care and will force people who need care to make long winter drives to the cities.

Some hospitals will close. A few big for-profit hospitals in urban areas will be able to absorb the hit completely, but most fall in the middle. They will be strapped. They will have to start charging other patients more for services, so insurance costs will go up even more, and that is when the last pins fall.

Now, in rural areas about 75 percent of a hospital's patients are on Medicare or Medicaid; 5-10 percent have no insurance. Hospitals will have to start charging the 20 percent or so who have private insurance policies to make up for the lost reimbursement.

Who are they? Employees of the local hospital and country government, people at the USDA field station, self-insured farmers and ranchers, small business owners at agricultural supply stores, gas stations, roadside restaurants, and working people in risky areas like timber, mining, and construction. They are the last and biggest rank of pins. All of them will see premiums going up and wage growth slowing down.

We are going down a dangerous road. The leadership is cutting Medicare simply for the sake of cutting Medicare. There has been no effort at all, as far as I can see, to make changes that address the real problem, the rising cost of health care generally.

Perhaps some changes in Medicare are necessary, but if so, it should be done for one purpose: preserving essential health services for senior citizens and people with disabilities. We should have a commission take a look at it and do it right.

But some people around here are making Medicare into a piggy bank: Medicare is where we will get all the money to balance the budget; Medicare is how to pay for capital gains tax cuts; taking money out of Medicare will get the space station aloft and keep the TV Marquee Balloon beaming money out into the void. It is a big mistake, it is setting the wrong priorities, and I hope these hearings will make us turn back while we still can.

Thank you, Mr. Chairman.

The CHAIRMAN. I do not know what alley you go to, but when I hit the head pin straight on I leave the seven and 10 pin up all the time. [Laughter.]

Senator BAUCUS. A little bit to the right or the left.

The CHAIRMAN. Thank you. I will remember that. Is that it?

Senator BAUCUS. Yes.

The CHAIRMAN. All right.

Senator BAUCUS. In other words, you get a split.

The CHAIRMAN. Yes. Is that what you call it?

Senator BAUCUS. Yes.

The CHAIRMAN. Senator Chafee.

Senator CHAFEE. No. I have nothing. I want to greet the witnesses. I am glad you are here.

The CHAIRMAN. Gentlemen, as we revere the seniority system, we will follow that in the testimony and take Secretary Rubin first.

STATEMENT OF HON. ROBERT E. RUBIN, SECRETARY OF THE TREASURY, WASHINGTON, DC

Secretary RUBIN. Thank you, Mr. Chairman, members of the committee. I am pleased to appear before the Finance Committee today in my role as Managing Trustee and Chairman of the Medicare Board of Trustees.

The board, as you know, is required to report annually to the Congress on the Financial status of two separate Medicare trust funds, the Hospital Insurance, or HI trust fund, and the Supplementary Medical Insurance, or SMI trust fund.

As you know, this year's report shows that the HI trust fund will be exhausted by the year 2002, and the costs of the SMI program continue to rise rapidly. The board has notified Congress about the HI trust fund's short-term insolvency, a condition that has existed for many years. This administration clearly recognizes that the financial condition of the HI trust fund needs to be addressed.

The Medicare financing problem is a complex interaction of demographics and the rapidly rising costs that affect all parts of our health care system. We need to carefully reform Medicare, in the context of health care reform, in order to get the best possible solution for both the short-term, and the long-term.

Or, to put the same matter differently, the administration believes that the growth of Federal health care expenditures, including Medicare, needs to be reduced in order to continue the process of deficit reduction, but that reducing this growth must be done by careful reform of the Federal health care programs and by doing so in the context of health care reform.

The alternative is arbitrary, and while arbitrarily attempting to resolve the problem may restore solvency to the HI trust fund, it will create and intensify other problems. Specifically, we are concerned that deep reductions in Medicare may cause cost-shifting, which could raise health care costs in the private sector, reduce private insurance coverage, and reduce outlays for other government programs.

The trustees have provided the Congress with an early warning, and it is time to develop effective Medicare reforms, again, in the context of health care reform, an objective this administration has energetically pursued since it first took office in January of 1993.

We have enough time to fix Medicare and the HI trust fund properly, even if we have to do it in stages, so we can avoid a hasty, unworkable solution that may have to be undone in the future.

The Medicare program merits this type of careful consideration because it is critical to a large number of our citizens. One of the most important things our country has done over the past 30 years has been to work to reduce poverty and deprivation amongst senior citizens and disabled persons, and thereby also reduce the burden and the anxiety of their children. Medicare has effectively provided a reliable source of medical care coverage for aged and disabled Americans. There are few issues of greater concern to working families than the cost of retirement and the problem of providing health care to the elderly.

Changes to Medicare as part of health care reform can restore Medicare to financial soundness, while at the same time improving the health of elderly and disabled Americans.

As I mentioned a few moments ago, the Clinton Administration has sought to work with Congress since the administration first came to office to solve the current Medicare financing problem, and the Nation's more general health care issues.

As noted, the trustees reported in April that the HI trust fund would be exhausted in 2002, 1 year later than was projected last year. This slight improvement largely reflects the effects of the President's 1993 deficit reduction plan, a stronger-than-expected economy in 1994, and the lower-than-expected program cost increases.

Since this administration took office, the exhaustion date has been extended by 3 years. Over the long-term, the 75-year actuarial deficit was reduced from last year's estimate of 4.14 percent to 3.52 percent of payroll. The reduction is largely the result of lower-than-expected future increases in HI costs based on the recently observed slow-down in HI spending growth.

Despite the decline, the HI program remains substantially out of long-run actuarial balance, and that very important problem is not specifically addressed by either of the current Congressional budget resolutions.

The Trustees also continue to project rapid growth in Supplementary Medical Insurance program costs well into the future. Over the next 5 years, outlays are expected to increase 78 percent in the aggregate, 66 percent per enrollee.

Combined HI and SMI costs are expected to increase from 2.6 percent of GDP in 1995 to 8.8 percent in 2069, roughly tripling, due largely to anticipated demographic changes. Because of this rise in long-term program costs and the expected exhaustion of the HI fund in 2002, the Board of Trustees recommends effective Medicare reform, but, again, we believe this must be done with a careful weighing and balancing of all impacts and all considerations, and in the context of health care reform.

Let me comment for a moment on the history of Medicare costs. When the Hospital Insurance program has faced financing problems in the past, as it has since the very first year of its existence, Congress and the Executive Branch have been able to cooperate on making modest changes in the program that slowed the rate of cost increases.

Most recently, the President's 1993 deficit reduction plan, which included Medicare spending cuts, removal of the earnings limits for HI contributions, and increased taxation of OASDI benefits with the proceeds going to the HI trust fund, is partly responsible for the recent decline in growth rates and the increase in revenues which, together, as I mentioned a moment ago, extended the trust fund exhaustion date by 3 years.

Technically, the SMI trust fund is actuarily sound, but only because the majority of its funding is from general revenue. SMI and HI face similar near-term financial pressures and long-term issues. Over the long-term, demographic change will dominate as an aging population compounds the financing problem for both programs.

The fundamental reason for the rise in Medicare expenditures is the increase in health care costs, affecting all parts of the Nation's health care system. A dramatic attempt by government to contain Medicare spending in a vacuum—for example, through large reductions in payments to hospitals—will cause significant distortions and inefficiencies elsewhere in the health care system.

Medicare cuts of the magnitude proposed in the House and Senate budget resolutions will harm the most vulnerable in society, the elderly and the disabled, and may cause doctors, hospitals, and other health care providers to shift costs to everyone else.

In contrast, much more can be done to strengthen the Medicare program if we reform it thoughtfully and undertake health care reform. Taking steps to extend health insurance coverage to the uninsured population and developing a more competitive health care market will create a more efficient system. This increase in efficiency will slow the growth in overall health care spending and provide savings to the Medicare program.

In closing, Mr. Chairman, the administration believes it is possible to address the HI trust fund problem, the rising costs in the rest of the Medicare program, and broader health care reform objectives in a thoughtful manner and produce effective, acceptable solutions that will stand the test of time. We are ready, and we have been from the beginning of this administration, to work with Congress toward those ends.

I would be delighted, after Secretary Reich's testimony, to respond to any questions you may have.

The CHAIRMAN. Thank you.

[The prepared statement of Secretary Rubin appears in the appendix.]

The CHAIRMAN. Secretary Reich.

STATEMENT OF HON. ROBERT B. REICH, SECRETARY OF LABOR, WASHINGTON, DC

Secretary REICH. Thank you, Mr. Chairman, members of the committee. Thank you for the opportunity to appear before you today to discuss the future of the Medicare system. My fellow trustees and I recently submitted to Congress our annual report on the financial status of the two separate Medicare trust funds.

As my colleague, the Managing Trustee of the trust fund, has made clear, this year's report shows that the Hospital Insurance trust fund will be insolvent by the year 2002, and that the costs of the SMI program will continue to soar.

Now, these problems are not new, let me emphasize that. For the past 15 years, the trustees have called for reform and the Clinton Administration has already worked with Congress to address the problem, although there is still much to be done.

Prior to the Omnibus Reconciliation Act of 1993, the HI trust fund was expected to be depleted by 1999. But the reforms included in that OBRA 93, along with a strong economy—and the strong economy America has enjoyed since then—have delayed the trust fund's depletion until 2002.

These short-term remedies, let me be absolutely clear, do not solve the deeper problems with the Medicare system, nor do they exhaust the administration's commitment to reform, but they do buy us precious time in which to devise and implement a more comprehensive solution. It is now up to all of us to use this time well.

Now, we all agree that the Medicare system is in need of change. The President has repeatedly stated that he would like to sit down with Congress and produce a bipartisan blueprint for broad-based health care reform. The Clinton Administration believes that the financing problems that the Medicare system faces must be solved within the broader context of health care reform.

Now, as a trustee of the Medicare trust funds, I am very concerned about the impending insolvency of the HI trust fund, and am pleased that this Congress seems intent on addressing the issue.

I am deeply troubled by some of the approaches that are being discussed. Any attempt to quickly shrink Federal spending by greatly reducing Medicare benefits, in isolation from broader reform, will leave many Americans worse off without addressing the fundamental structural flaws in our health care system.

Large reductions in Medicare will increase health care costs to the elderly, they will also strain the finances of many health care providers, including some of America's most valuable and respected institutions of health care.

But the effects do not stop there. Providers may attempt to shift the costs to private insurance companies, and if costs are shifted, many working Americans who are privately insured and who may believe themselves to be insulated from the Medicare issue will, in fact, feel squeezed.

Now, while no specific bill has been put on the table, one prominent proposal, to take simply one example, would increase premiums, co-payments, and deductibles for elderly and disabled Medicare recipients. Under this one plan, deductibles would be doubled from their current levels, premiums would be hiked every year until 2002, and there would be dramatic increases in co-payments for home health care and other services.

These changes, to take this one example, taken together, would raise annual Medicare costs by over $2,000 per couple in the year 2002 alone. For the typical Medicare beneficiary, increased premium costs will come right off the top of their Social Security checks. Now, this is tantamount—in fact, the simple equivalent—of a Social Security benefit cut.

This is particularly grave when one considers that these deep Medicare cuts may potentially be used to offset tax cuts for some of the most comfortable of our citizens.

Now, some vulnerable health care providers will also feel the pain of these deep cuts when Medicare benefits are slashed outside of the context of the overall health care reform issue, and I want to emphasize this.

Some hospitals may shift costs to the privately insured. In the face of large Medicare cuts of this magnitude, hospitals whose patients are predominantly Medicare beneficiaries and the uninsured will have few other options except to reduce the quality of care to all patients or to close their doors.

Now, in particular we are concerned that large reductions of this magnitude in Medicare payments could endanger both rural and urban safety net hospitals, which are often teaching hospitals as well.

Hospitals in rural areas are often small. Some serve mostly Medicare recipients and often are the only health care provider within 50 miles or more. Since many of these hospitals are already in financial distress, large Medicare cuts in costs like this, in isolation from broader efficiency improvements, may cause rural hospitals to reduce the quality of care or to squeeze the wages of hospital workers.

In extreme cases, these hospitals will be forced to go out of business and workers will be laid off. Nearly 10 million Medicare beneficiaries live in rural areas. Such large cuts in Medicare outside the context of broad-based health care reform puts their health in great jeopardy.

Now, some urban hospitals, what might be called safety net hospitals, including many teaching hospitals, faced with a growing burden of uncompensated care, are equally limited in their capacity to shift the burden of dramatic reductions in Medicare benefits and will face similar pressures.

Now, some hospitals that can shift costs to insured patients may do so, but, you see, the analogy is very much like a balloon. Cost shifting, we all know how it operates. You squeeze at one place in that balloon and those costs are merely shifted to another place in the balloon.

Health care providers frequently charge insured patients more right now to cover the expenses of the 40 million Americans who do not have health insurance and, thus, frequently receive uncompensated care. In this context, slashing the Medicare program without broader health care reform may lead hospitals to increased costs to the privately insured in order to make up for the enormous losses from Medicare patients.

For any action, in other words, there is an equal and opposite reaction. This is an immutable law of physics, and it applies in comparable ways to health care policies; squeeze one side, the balloon expands elsewhere.

It stands to reason that deep Medicare cuts of the magnitude proposed by the Senate budget resolution, if they are undertaken without reforming the health care system itself and if they are taken without denying medical care to Medicare beneficiaries, will likely force 150 million privately-insured Americans to pay more.

The cost shifting that results from large Medicare cuts, outside the broader context of health care reform, would essentially impose a hidden tax on working Americans. As Henry Aaron, an expert on health care issues at the Brookings Institution, recently testified, "Large reductions in Medicare spending within the current program framework will impose taxes on private businesses and individuals."

There are many studies which clarify and underscore the problem of cost shifting and this hidden tax burden that could and would be imposed. But, even worse, we are concerned that cost shifting, triggered by Medicare cuts of the scale currently proposed, will have the ultimate effect of reducing health care coverage for many Americans.

Costs may be shifted to the privately insured and premiums will tend to rise to cover those costs. Obviously, as premiums rise, some workers and their families will not be able to afford health care even if they can afford it right now.

Traditionally, membership in the American middle class included not only a job with a steadily increasing income, but also a bundle of benefits that came with employment. Since 1978, 1979, we have seen a greater and greater wage dispersion in the United States. We are now surging toward inequality in wages, but we are also surging toward inequality in benefits, health care coverage, health care benefits.

We are seeing a divergence in health benefits, which is also related to education and skills. Employer-sponsored health coverage for workers with college degrees has declined only slightly, from 79 percent in 1979 to 76 percent in 1993. That is not a great loss of coverage for high-skilled workers in our society.

But rates for high school graduates who do not have advanced degrees have fallen from 68 percent to 60 percent over the same period, and for high school drop-outs, coverage has gone from 52 percent in 1979, plummeting to 36 percent today. Nearly 100,000 Americans are already losing health insurance every month. You can see the consequences of this shifting; it simply goes eventually to the most vulnerable institutions, the most vulnerable businesses, small businesses, and the most vulnerable members of our society.

One drawback in cutting Medicare in isolation from health care reform was recently summarized by The Economist. Although the Federal budget would benefit, the savings could be offset by higher costs in private health care.

Now, for that reason, in summary, let me just say that we need to sit down together in a bipartisan manner and produce a blueprint for broad-based health care reform. We must put the HI trust fund on a sound, sustainable footing. We have all known this for a very long time. But we have a responsibility to every American who works hard and plays by the rules to fix the problem of our health care system, not simply reshuffle from one group to another group the excess costs that the current flawed system produces.

Thank you.

The CHAIRMAN. Thank you, Mr. Secretaries.

[The prepared statement of Secretary Reich appears in the appendix.]

The CHAIRMAN. Let me start out, Secretary Rubin, with you.

Last year, when Dr. Reischauer was head of the Congressional Budget Office, he testified on the cost of the President's health plan and other health plans. He said if we adopted the President's health plan and it worked perfectly, that his estimated reduction in medical costs would be a full 1 percent.

I remember Senator Durenberger asking him what that would be, and he said from 20.5 percent to 19.5 percent, to which Senator Durenberger said, but they are only 14 percent now. He said, that is hardly restraining medical costs. I think that particular answer may have done more to hurt the President's plan than all of the Harry and Louise ads put together.

If that was not going to restrain costs, and that was if it worked perfectly, if the caps worked, and graduate medical school residencies, according to the Federal Government, and all of that, if it all worked perfectly, that is what you got.

If that was not going to work to restrain cost and if we are not going to have a mega health reform bill—and we are not—what do we do about this impending Medicare disaster that is on us?

Secretary RUBIN. Mr. Chairman, I think that if you look at the HSA, which was last year's health reform plan, as you said, the CBO—my recollection of the numbers are roughly the same as yours—estimated it would reduce growth by about 1 percent of GDP, or thereabouts.

It may well be that had we engaged in a Congressional process, because, as you may remember, there was a lot of reinvestment and there were a lot of programs, a lot of decisions may have been made differently in the final analysis; I do not know. But, unfortunately, that program never was seriously engaged with and, instead, its opponents determined not to have health care reform.

Our view today is that health care reform is as critical as it was ever discussed as being last year, but that the right way to go about it is in a more gradual way, since last year's enormous effort turned out not to be something that was politically doable.

I think the answer to your question, Mr. Chairman, will emerge when Congress and the administration engage in the kind of process that Secretary Reich mentioned at the end of his remarks.

The CHAIRMAN. Well, we are engaging right now, though.

Secretary RUBIN. No. Mr. Chairman, with all due respect, I really do not think so. I think that we have rhetoric on both sides, and what the President has done is to say that he spent a year and a half working his heart out to try to get the health reform process effectively through Congress, and, as you know, it did not work. The opponents, as I said, determined to defeat health care rather than come to the table and try to develop a health care reform program. The judgment that he has made now, I think rightly, is that for him to make that effort again is probably going to have a similar result and, therefore, what he should do is set a framework.

As you know, he has set a framework with various components that he thinks need to be satisfied if you are going to have successful health care reform: increased coverage, quality, cost, choice, cost control, and affordability.

His view is, Congress should come back, in the context of that framework, and then engage with him to develop more of a step-

by-step process to health care reform. That is the best way to move forward in the Nation's interest.

The CHAIRMAN. You indicated, or Secretary Reich did, that we extended from 1999 to 2002 the expected bankruptcy date.

Secretary RUBIN. Correct.

The CHAIRMAN. Two of those 3 years, however, were because of the tax increases, and 1 year was because of the economy.

Senator MOYNIHAN. Don't I know.

The CHAIRMAN. Are you suggesting any further tax increases to help rescue Medicare?

Secretary RUBIN. Well, we are where I just said a moment ago, Mr. Chairman. There is no question that the HI trust fund, both in the long-term and the short-term, needs to be dealt with. Health care costs to society as a whole need to be dealt with. We believe they need to be dealt with in the context of health care reform.

I really think that there is not a better idea than to have Congress come back in the context or the framework of the components that the President suggested and become engaged in a serious process, albeit a more incremental one that we undertook a year and a half ago. But I am certainly not suggesting tax increases, just for the record.

The CHAIRMAN. Would you care to give me a projection on the outcome of the rugby game between Brisbane and Canberra?

Secretary RUBIN. I would be happy to, if I knew what that was.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Well, we are grateful for this testimony. We think this might be the beginning of a process.

Mr. Rubin, may I just say gently that the health legislation in the last Congress was not defeated by its opponents. In the House of Representatives it never came to the floor for a vote. We could not find sufficient accord within the Majority in either House, which suggests that a bipartisan effort clearly is in order, and you obviously agree.

We are not going to have a major health proposal in this Congress, but we do have this specific problem. Would it not be possible to think of a bipartisan effort on this issue and get one thing done? We are going to have to do it anyway.

Secretary RUBIN. Senator, I do not think that we should address this issue out of context. I really do not.

Senator MOYNIHAN. Out of context?

Secretary RUBIN. I think we should do as Secretary Reich and I both suggested, and do so in the context of health care reform, even if that health care reform is incremental. We have also pushed the date back three years——

Senator MOYNIHAN. We might declare Medicare reform, the first in a series of incremental steps.

Secretary RUBIN. No, no, no. Even if we do so in the context of a health care reform program, that is, a set of steps rather than the very large effort that we made last year. As was evidenced by the 1993 Reconciliation Act, the Deficit Reduction Act——

Senator MOYNIHAN. Which we did do.

Secretary RUBIN. We did manage to push the exhaustion date back 3 years, partly as a result of that, partly as a result of an improved economy.

Senator MOYNIHAN. Could I make the point that, by exhaustion, it is not as if suddenly no money is coming in for health insurance. There will no longer be reserves, as there are today.

Secretary RUBIN. Yes. Well, under the current circumstances I think in the year 2003 you would actually have a shortfall of receipts relative to expenditures.

Senator MOYNIHAN. Yes.

Secretary RUBIN. So I agree with the Chairman, there is a problem that needs to be addressed. Fortunately, particularly by virtue of the 3 years that we bought through President Clinton's program in 1993, we have time to do it in a thoughtful fashion.

Senator MOYNIHAN. Secretary Reich, does the state of the economy concern you as we go about cutting this, cutting that, taking this out of the Social Security Act, and taking provisions out that have served the economy well, I would think, over the last 50–60 years? Let's see. We had 100,000 jobs lost in the May report last week.

Secretary REICH. 101,000.

Senator MOYNIHAN. 101,000.

Secretary REICH. Yes. But, again, I do caution people every time we have a monthly report not to make too much of one report, but undoubtedly it was a disappointing report. There is some evidence of an economic slow-down. I do not see any evidence that we are heading toward a recession, however.

Senator MOYNIHAN. But could the Congress push you in that direction if we contract Federal outlays too much?

Secretary REICH. As the Council of Economic Advisors has said, there is some higher risk, obviously, of an economic contraction if, in a short period of time, there is a great deal of deficit reduction simply because that much more money is coming out of the system. There is also a separate issue to which you alluded at the start, having to do with the built-in stabilizers in the system.

Senator MOYNIHAN. Yes.

Secretary REICH. That is, we have for the better part of the last 60 years had a series of stabilizers almost automatically going up when the economy starts going down: unemployment insurance, extended unemployment insurance, AFDC, food stamps, and a variety of other stabilizers. Obviously, to the extent that those were capped or terminated, what would otherwise would be an economic slow-down could be tipped into a recession.

Senator MOYNIHAN. We would unlearn an awful lot of hard-gained knowledge, would we not?

Secretary REICH. Well, one of the great successes, Senator, over the last 60 years has been the utilization of these stabilizers to automatically counterbalance to some extent, or at least cushion, what is otherwise some softening in the economy.

Senator MOYNIHAN. And you are now at the 50th month of the current expansion. You are at the edge of the average for expansions in the past half century.

Secretary REICH. Yes. We are in month 50. To the best of my knowledge, Senator, there have been 10 post-war recoveries. The average recovery has lasted 50 months, the median recovery has been 39 months, and only three recoveries have lasted longer than the current recovery.

But let me stress this, that many economists believe that the business cycle is less volatile than it used to be in the earlier part of the century when we did not have the automatic stabilizers. So, again, I do not see any sign right now that we are heading toward a recession.

Senator MOYNIHAN. But you would not want to encourage that.

Secretary REICH. Nobody wants to encourage it, obviously.

Senator MOYNIHAN. Thank you, Mr. Secretary.

The CHAIRMAN. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman.

Secretary Reich, on page two of your unnumbered pages you say that "increased premium costs are the simple equivalent of a Social Security benefit cut," at the bottom of the page there. I really think that is unfair. I suppose you can say an increase in gasoline prices is equivalent to a Social Security cut; is that right? I mean, I know when the premium goes up it is deducted from one's Social Security.

Secretary REICH. Yes. That Part B premium, for almost all people, is a deduction from Social Security.

Senator CHAFEE. That is right, it is a deduction. But, if we are going to feed that belief that anything we do in Medicare in connection with the Part B premium, for example, is a Social Security cut, we have got a lot of trouble around this place. Certainly people can believe that.

If we feed that view, it is going to come back to haunt us, I believe, and haunt not only us up here, but you in the administration likewise, because inevitably we are going to have to do something about, say, the Part B premium, to start with.

So I want to indicate to you my dismay at what you are saying there. It does cut one's Social Security check, but it comes about not because we are cutting Social Security but because we are increasing the costs of a benefit, namely Medicare.

Secretary REICH. Senator, I think I found the page you are referring to. They are unnumbered, so I am having a little bit of difficulty.

Let me just say, the point—and I think the critical point here—is certainly not to scare anyone. I want to emphasize that either those costs are going to be imposed upon the Medicare beneficiary in a way that reduces the benefits or they are going to be shifted.

If they are going to be imposed on a Medicare beneficiary, it is not simply a matter, as some people have said, of slowing down the increase in costs because, given population increases and given the increase in health care costs, the per capita, per person consequences will actually be a reduction in benefits, unless they are shifted elsewhere.

But, as I tried to suggest in my formal testimony, the shifting, as it has occurred without any reform of the health care system, tends to impose costs upon institutions, upon small businesses, upon people, middle class, working class people, who are least able to bear that kind of burden.

Senator CHAFEE. My plea here in dealing with this is, we are dealing with a highly volatile issue and I think we all have to be very careful with what we say. For example, on page three of your unnumbered pages is a dissertation on what could happen to rural

hospitals. Well, rural hospitals are closing now, city hospitals are closing now. Hospitals are closing all over the country. In my State, hospitals are closing.

The CHAIRMAN. John, mine have little numbers up on the right-hand corner.

Senator CHAFEE. Well, I am talking about Secretary Reich's testimony.

The CHAIRMAN. That is what I am looking at.

Senator CHAFEE. Well, see if we can find it. Page three.

Senator MOYNIHAN. Mine do not. That is a courtesy provided the Chairman. He explained to you about seniority when he came in. [Laughter.]

Senator MOYNIHAN. Well, he is a classical scholar. In mine they are Roman numerals.

Senator CHAFEE. In any event, I will tell you what it says. You do not even have to look it up. All I am urging here is, everybody has to be careful of the language we use and the way we approach this. This is going to be difficult enough, for you and for us, to do what is necessary in connection with Medicare and Social Security, likewise, as we go along.

Rural hospitals will close, Wal-Mart has caused the close of a lot of stores in rural areas and other areas, and bigger and more efficient hospitals will cause other hospitals to close in rural areas.

Here is the point I would like to ask both of you gentlemen. You have stressed and constantly used the term "broader health care reform." But where are you, where is your bill? I mean, you both talk about a bipartisan approach. Here is the committee that deals with it. I do not think you have approached us with anything. Either one. [Laughter.]

Secretary RUBIN. Let me take a first shot at it.

Senator CHAFEE. I was going to say go alphabetically, but that is too close a call.

Secretary RUBIN. I am not even sure we can figure that out.

Secretary REICH. I cannot number my pages, I cannot—— [Laughter.]

Secretary RUBIN. You are better off letting us do this arbitrarily.

Senator CHAFEE. All right. Even though the light has gone on, can we get an answer?

Secretary RUBIN. Senator, in a word, I think it is the same discussion that the Chairman and I were having before. As you know because you were a very, very constructive participant in the process, as were many of the other Senators in this committee, the President spent a year and a half trying to do this, through the end of the last Congress, and he was unsuccessful. I guess I would say that the opponents did defeat it. We could argue about how it got defeated, but be that as it may——

Senator CHAFEE. Well, let us not play that. That is water over the dam.

Secretary RUBIN. It was our view that the most constructive way to go forward and the way that was most likely to wind up with a productive outcome would be for the President to set a framework, which, as you know, he has done, and then have Congress come back to engage in the context of that framework. He is, as

he has said many times, very desirous of doing that from the very beginning.

Senator CHAFEE. Well, first, I acknowledge that the President certainly went all out with the health care bill in 1994 and it did not succeed, but it seems to me that it is incumbent upon you folks to exert continued leadership in this and to make greater efforts than have been made as far as achieving this bipartisan approach.

The CHAIRMAN. I want to correct just a bit of history if I can, Mr. Secretary. I wish this administration would listen more to Senator Moynihan than it appears to listen. He and I, in February of 1994, were at the White House and Senator Moynihan said to the President, Mr. President, this health bill is either going to pass with 70 votes or die with 40, but there is no 52-vote bill.

What he was saying is, this is not the same as the budget battle of the summer of 1993, when the administration did not deal with Republicans until it was too late. At that stage, it was too late. They did not listen to Senator Moynihan at the start.

Secretary RUBIN. Mr. Chairman, my comment did not relate so much to legislative strategy, and I would not choose to re-debate that, but I do think that there was a broad-based effort—and you mentioned the Harry and Louise ads—to defeat health care reform rather than to engage with it. That was really the gist of my comment.

Also, on your other question some time ago, I think on the HSA, it comes back to me now, when Bob Reischauer issued his CBO report I think there were some real scoring questions as well. I am not disagreeing with his scoring necessarily, but I think he said he could not effectively score the competitiveness advantages, and I think a lot of the cost savings, in our judgment, at least, would have come from the increased competitiveness of the system.

The CHAIRMAN. Well, of course, that has been a perpetual battle we have had with CBO because they did not score our cost savings either on any of the bills, and at least we were all treated equally.

Secretary RUBIN. That may be.

The CHAIRMAN. Senator Simpson.

Senator SIMPSON. Thank you, Mr. Chairman. Good afternoon. I have high regard for you both. I have come to know you both. You and I, Robert Reich, were able to do a little road show work together as fellow thespians. After that benefit performance, you and I were to go to Cleveland on the road.

Secretary REICH. I thought it was Pittsburgh.

Senator SIMPSON. Pittsburgh. Well, certainly we will never play in Peoria.

So, as I see you both there and know you both as able, bright people, I was just thinking that the political types in the White House must be praying for your success here, because what you have to do—and you have no choice—is to tell us that Medicare will somehow not go broke in the year 2002, that if we reform the health care program, all will be well. Just by doing a health care bill, all will be well. And be sure to tell them that payroll taxes will not go up. Now, that is the official line that has to be presented here.

I was always appalled at how the administration completely rejected the work of the Entitlements Commission, a commission ap-

pointed by the President of the United States to do the heavy lifting and give the cover, and not one word of it has ever been ascribed to. Not a word.

But there was a chart which is so clear that I want you to get a copy of the Entitlements Commission report, because 30 of the 32 of us agreed that these are the figures of what is going to happen in America. These are people like John Dingel, Carol Moseley-Braun, Al Simpson, Tom Downey, Dale Bumpers. Go look at the people who are on the Entitlements Commission.

And here is a chart that 30 of the 32 of us agreed on, that even if we controlled health care inflation, Federal health care spending doubles by the year 2030. You know that, I know that, we all know that.

It is very disappointing, because I know you, to hear that if we just do health care reform, that all will be solved. We all know what is happening here. In the last budget, tragically enough they left out every page of the section on generational accounting.

In the budget of this President to his citizens, fiscal year 1995, on page 21, 22, 23, 25–31, is an entire rational discussion on generational accounting. In this year's budget, nothing, not one single word. Not a word. You know that, I know that.

A table on page 23 of the President's budget, the President's budget 2 years ago, said that the lifetime net tax rates will go to future generations, will go to 35–36 percent for the generations born since 1970. Even if we did a perfect health care bill, that still leaves us paying 28 percent of our National payroll on Social Security and Medicare by the year 2030. You know that, we know that.

Now, there are only several places to go, and you know that and we know that. You either cut benefits and rile up the seniors, which no one desires to do, regardless of their net worth or their income, as Senator Chafee talked about what we were trying to do with Part B, and you people, in this budget, requested means testing and affluence testing, as I call it.

And now you talk of income testing, or anything, as if it were something from the outer spaces of the atmosphere. You said that first. Now we are saying it and you have rejected that and pressed it to your bosom, that we could never allow such a thing to happen.

Now, you either are going to cut the benefit of the seniors or you are going to raise the payroll taxes. You cannot get there any other way. So tell us, which way are you going to go?

Secretary REICH. Senator, let me just say a couple of things. First of all, there is also the question of potential efficiency gains in the system. This is the question that was raised in part last year, and as Treasury Secretary mentioned a moment ago, several members of this panel were actively engaged in improving the actual workings of the system—we repeatedly heard this last year again and a again—nobody looking at our health care system today would say that it is a model of efficiency.

The question we are addressing today is, whether it is possible to simply cut Medicare costs and expect that those costs are just going to go away. They are not going to go away, they are going to be shifted onto other parts of this system. I used the analogy before you walked in of a balloon that is just simply being squeezed

one place and it expands someplace else. That is why a systemic approach is necessary.

Now, the second question we are addressing and you are raising is, if a systemic approach is necessary, how do we get there? The President put forward a comprehensive bill last year. As Senator Chafee said, that is sort of water under the bridge, because we have dealt with that and we can describe what happened in slightly different ways.

But the point is, and our point today, is to stress that we need to look comprehensively, maybe step-by-step. Maybe you cannot do it all in one big swoop, but we need to look step-by-step at how to improve the system, looking ideally, Senator, for any efficiencies that we can get out of the system to just make this thing work better.

We have a few years. We all agree that 2002 is a deadline here with regard to Medicare, certainly, but we have got some additional years. As we move step by step we might be able to improve the efficiency of the system. I think it is fair to say the President is willing and eager to work with Congress step-by-step. He has put forward a bill, let us do it.

Senator SIMPSON. Well, Mr. Chairman, it is going to be difficult to do when you use phrases like "savaging Medicare" when we are going to let it go up 7.1 percent every year for 7 years. We are going to let the Republicans, the evil poops out here, let Medicare go up 7.1 percent per year for 7 years in a row instead of letting it go up 10.5 percent, or 11 percent, or 12 percent per year. And if we cannot get that done in this country, tell us about who is going to shift in the year 2002? You ain't seen nothing like shifting in 2002 when it goes broke.

Secretary RUBIN. Senator, if I could just add one comment, I do not think there is any question but that the President has focused with enormous seriousness on health care. He worked his heart out for the last year and a half to deal both with the HI trust fund, but much more broadly the health care system of this Nation.

And, just to identify with something the Secretary said, it certainly was my view coming away and attempting to participate in that process in a very serious fashion that there are enormous inefficiencies in our system, and that the right way to go at this was to start with the system and then, working within the context of the system, dealing with Medicare.

I also think, in terms of the generational accounting—I think you and I discussed this once before—if you had the numbers for this in the 1996 budget, and had they been in that book, they would have been considerably better than the 1995 budget.

The reason they were not put in is, that is only one of a number of approaches to looking at this and it was felt that it would be more misleading to put them in than helpful, but it certainly was not an effort to avoid focusing on the long-term, because this President focused on the long-term at the very beginning of the administration, particularly in the context of dealing with health care.

Senator SIMPSON. Well, it seems to me that if it was so vitally important to take up that many pages in the previous budget the President suggested, that it certainly should have been addressed again because it is the guts of the issue, and that is, the real shift-

ing is, there are not enough people paying in to get the money out and it is going to get worse, and worse, and worse because of demographics, age, and the baby boomers. You know that, and we know that, and that is why you left it out. The political types left that one out.

Secretary RUBIN. No, that is really not true, Senator. I was in the room when they were left out, even though the numbers were a lot better, they actually were shown to be a lot better.

Senator SIMPSON. Well, then why did you not put them in if they were better?

Secretary RUBIN. Because we really and truly felt that it would be misleading to people to put them in when there were so many approaches to looking at the same issue. We all agree, however, there are long-term problems that are driven by demographics and they have got to be dealt with in a sensible fashion.

Senator SIMPSON. Thank you, Mr. Chairman, for your indulgence.

The CHAIRMAN. Senator Murkowski.

Senator MURKOWSKI. Thank you, Mr. Chairman.

In your testimony, there was a reference to the reason for the rise in Medicare expenditures due to the increase in health care costs affecting all parts of the Nation's health care system. The Prospective Payment Assessment Commission report to Congress, states the rate of increase in private health insurance spending between 1990 and 1993 was only half that seen during the previous decade. Medicare spending rose more than 50 percent faster than total health care spending between 1990 and 1993, and Medicaid increased at almost 300 percent of the overall rate.

Now, I am curious to know how you reconcile your statement with the findings of the PROPAC. There seems to be some discrepancy.

Secretary RUBIN. Senator, there are a lot of different views as to what the rate of increase in the private sector has been. Some studies have looked at only large companies which, in fact, have accomplished, in many cases, considerable efficiencies, although by virtue of their leverage, which I do think has caused a shifting to other payors.

HCFA, the Health Care Financing Administration, put out numbers recently. They are projecting from 1995 to 2005 that, per enrollee, Medicare will increase at a rate of 7.7 percent, and the private sector will be 7.4 percent, which is, roughly speaking, comparable rates of increase.

If you look back over the history, what you will find, at least based on HCFA's numbers, is that the per enrollee rates of increase have been roughly the same except for, I think it is something like the last two or 3 years—or maybe it is 2 years either side of this year, I have forgotten exactly—but if you go back to the beginning of the program in 1967 you will see that the per capita rate of increase had been roughly the same through this whole period, and they project it will be the same, roughly speaking, forward going from 1995 to 2005.

Senator MURKOWSKI. Well, to follow up, the CBO scored President Clinton's health care proposal as not saving money but actu-

ally increasing health care costs. Is that a given; do we agree on that?

Secretary RUBIN. No. I think actually what it said was what the Chairman said earlier, I think, before you came in today. They scored it as decreasing health care costs as a percentage of GDP by, I think, roughly one percent.

It was our view that there were very substantial additional benefits to be had, but, as we discussed before, they were not scored, they were the benefits of competition. Then as you got into outer years beyond—and I apologize; I do not remember the years anymore—the way outer years, I think that percentage of percent of GDP actually started to come down again.

Senator MURKOWSKI. Well, then what overall health care proposal does the administration support that would reduce health care spending, specifically?

Secretary RUBIN. Secretary Reich and I both said, it is the view of this administration, and one that I think we all share, that, having spent a year and a half working our hearts out to accomplish health care reform—not necessarily with the HSA, because clearly there were a lot of reservations about the HSA, but that is a point from which we could have worked toward something—that the best way to proceed now, to have the highest likelihood of a successful end result for the American people was for the President to outline a framework, which he has done, and then for Congress to come back in the context of that framework, and then for all of us to work together on a bipartisan basis. That, at least in our view, is the way the most likely——

Senator MURKOWSKI. Yes. But that is very general. I mean, we have got a difference of opinion on the rate of growth. The private sector is reducing the rate of growth, but the rate of growth in Medicare is still greater than it was. You are disputing that proposal. We have got the reality that we are facing a substantial crisis if we do not address and get a hold of spending.

We have seen the President's budget come to the Senate. If it was not balanced it did not have any base of support. It seems to me that we are getting words here but we are not addressing realities. You can do one of two things: you either increase revenues or reduce spending. That is all there is, and there is nothing more.

Secretary RUBIN. Well, as Secretary Reich said a moment ago, it may well be that——

Senator MURKOWSKI. You cannot pick it all up on efficiency.

Secretary RUBIN. No. But you certainly can look at efficiency, number one. Number two, as you begin to have adverse impacts on people you can try, in your health care reform system, to compensate for that.

Senator MURKOWSKI. Well, you tell me then what percentage you expect to pick up on efficiency, how much you are going to offset.

Secretary RUBIN. I think, Senator, that is a question you will only know when we finally get engaged in the process that the President, as Secretary Reich said, is overwhelmingly anxious to get into, which is a real and serious discussion of health care reform.

Senator MURKOWSKI. Well, we had a real and serious discussion last year and found out we could not afford the program as proposed.

Secretary RUBIN. Well, I guess my view is, we could have moved from there to an effective health care program, but I agree with you, we did not.

Senator MURKOWSKI. We can watch what the Canadians are doing, which is pretty much the health care plan that was proposed by the President. Now the Canadians find that 24 percent of their budget is interest on their debt. They are trying to back away from a situation that is pretty much along the lines of what President Clinton proposed.

Secretary RUBIN. Well, I am not making a brief for the HSA, although I thought it had a lot of constructive elements in it. I guess the only brief I was making is, I think it is unfortunate for the Nation that we did not go from there to working out a health care program rather than simply having had it die as it did.

Senator MURKOWSKI. On the other hand, it may have been the most fortunate thing that could have happened to the Nation, so it depends on your point of view.

Secretary RUBIN. As is true of most things.

The CHAIRMAN. Senator D'Amato.

Senator D'AMATO. Thank you, Mr. Chairman. Mr. Secretary.

I have a difficult time understanding how it is when one reads, and has the opportunity, as both of you have had, to participate in the report, and this is a summary "Status of Social Security and Medicare Programs," and at the bottom of the first page, the message to the public, a summary of the report indicates that "we will be able to pay benefits for only about 7 years, and the fund is severely out of financial balance in the long range.

The trustees urge the Congress to take additional actions designed to control the Hospital Insurance program cost and address the projected financial imbalance in both the short-range and the long-range through specific program legislation, as part of broad-based health care reform. The trustees believe that prompt, effective, and decisive action is necessary."

It seems to me that what you are saying is that, unless you do it the way we tell you, and we recognize, by the way, that the program is going to be out of money in seven years, but the only way that we are willing to do anything is if you—you being the Congress—agree to health care reform.

Do we just ignore the precarious condition unless we accept the kind of health care program that was put forth and which was soundly rejected by the American people as well as the members of the Congress? They were not willing to go forward.

Now, I remember one member of the Congress who said, the American people are going to get health care whether they like it or not. Is that the administration's position? Do we just sit back and let this deteriorate? I would like your view on that.

Secretary REICH. Senator, let me just say, if I can refer back to the same sentence you quoted from, that is, the trustees recommended that this issue with regard to the Federal Hospital Insurance trust fund and its insolvency be dealt with specific pro-

gram legislation as part of broad-based health care reform. Let me explain——

Senator D'AMATO. But we are not going to do that, Mr. Reich. You understand that. Why duel? What you keep coming back with is something that there is no way, no hope, no opportunity that this Congress, certainly at this time this year or next year, is going to come up with this comprehensive legislative reform.

Now, recognizing the reality of the situation, do you suggest then that we just let nature take its course and expend those funds at the rate that we are expending, or do we begin to exercise some kind of cost containment in an attempt to reduce the rate of growth, instead of having it grow at 10 percent per annum and get to the bankruptcy stage within 7 years?

Do we not attempt to bring some cost control in, and will that not inevitably bring the market forces into play so that there will be different kinds of options that will be offered, some of them being medical plans and programs that your administration has suggested?

Secretary REICH. Senator, comprehensive health care reform does not necessarily mean that, all at once, in one fell swoop, we have got to do everything. What it does mean is, the problem has got to be looked at as a system problem. I want to emphasize that, because of the cost shifting that is already going on.

Senator D'AMATO. Some of it quite advantageous for the consumers in retarding that growth; is that not true?

Secretary REICH. But one of the pernicious aspects of cost shifting to which I alluded in my testimony is that costs are intended to be shifted to those institutions, those teaching hospitals, urban safety net hospitals, as Senator Chafee mentioned, some rural hospitals, and some working class people who can no longer afford health care, because their health care premiums go up because the costs have been shifted to them.

In other words, in this system costs are shifted to those institutions and those parties that have very little choice, or are particularly vulnerable, or who lack market power, like small businesses. It is not as if one can isolate one small piece of the system—call it Medicare—and simply control those costs without expecting some other part of the system to be affected.

Now, when we say comprehensive health care reform, again, the goal does not necessarily have to be in one large comprehensive, ambitious package, it can be a step-by-step approach.

And what the President has suggested repeatedly is that—particularly after our experience last year and the attempts that he and others made to deal with a very ambitious program that, for reasons we can debate why, was not accepted—let us go step by step, let us try to come up with a comprehensive approach that will give us a cushion, at least a cushion against that 2002 insolvency date, give us some more time, and then let us also look at the large demographic issues that are driving beyond 2002, some of the longer-term problems of this system. We can do it.

The problem is, if we fail to do it in that systemic way, I fear we have fooled ourselves into thinking we have actually solved a problem when we have just moved it off in a very regressive direction.

Senator D'AMATO. Well, I guess maybe what I am saying, and I know my time is over, is that I think we have to be careful in not attempting to frighten senior citizens in particular, and some of the rhetoric that I have heard—and I am not going to mention who—is frightening and is rather one-sided. If it is intended to instill fear in people, it has done that.

It is not bringing about a balance which says, we have a problem, we must work to solve it; just simply to say, I will not permit cuts that will affect and impact the elderly is rather, I think, unfair because certainly no one accuses the administration when attempting to deal with this problem of saying that you are going to leave the poor and the elderly out.

Reasonable people can disagree as to how to get there, but those who say we have a problem, we have got to restrain the growth in this, is to simply bring injury to seniors, and I believe does great harm to the process of governance.

The CHAIRMAN. Secretary Reich, as long as I have got you here, let me ask you two unrelated questions. We had our third hearing this morning on the Consumer Price Index issue.

So far, we have not had any witness that says it is understated. Only one or two have said below 0.5, one has said as high as 2.5, but if he had to pick a mean or an average, maybe I would say around 1 percent. Do you have any opinion on whether or not the Consumer Price Index is overstated?

Senator MOYNIHAN. For purposes of measuring changes in the cost of living.

The CHAIRMAN. Yes, that is correct.

Secretary REICH. Mr. Chairman, let me just say, the Bureau of Labor Statistics, as I know you know——

Senator CHAFEE. Could you just repeat that question? If it is what I thought it was, it is very important.

The CHAIRMAN. Yes. The Consumer Price Index, is it overstated from the standpoint of stating the cost of living?

Senator CHAFEE. Yes. Thank you.

Secretary REICH. Mr. Chairman, the Bureau of Labor Statistics is now undertaking an exercise, a quite technically complex exercise, it goes through once every 10 years to improve the quality of our data on which the CPI is based: the market basket, the assumptions underlying in the market basket. I frankly do not know how anyone can make a quite technical judgment about that without relying upon the work that the professionals are now undertaking.

The CHAIRMAN. Well, as a matter of fact, that is who we have had testifying. I think, and I think Senator Moynihan would probably agree with me, that there are 10 or 15 people in this country that go beyond the realm of expertise in this subject, and they have all been here and they all read each other's work. This is sort of a consensus of their opinion.

In fact, the one fellow today from Harvard, who is the guru that everybody else refers to, says, well, there are really only three or four major works on this, and he said, mine is one of them.

Secretary REICH. Well, I am not sure I would trust very many people from Harvard to begin with, sir. That is an inside joke.

Mr. Chairman, let me just say that I would go with the professional opinion of the BLS. That is, they represent to me the people who were not only officially charged with making that determination, but also a group of people that has the technical competence to make that determination.

They are on a regularized schedule. In fact, they are speeding up their schedule. They are under direction from me and from the administration. They are doing a quicker job than they normally do. They are doing what they can do as quickly as possible to make sure that those instruments on which they base their estimates are as good as possible.

I understand how much hangs in the balance in terms of their ultimate judgments, but, again, it seems to me that this is an area, because it is so fraught with potential political conflict and bias one way or the other, that we need to rely very much on the technical judgments of the experts. So I do defer to the Bureau of Labor Statistics.

The CHAIRMAN. Let me ask you a second question, totally unrelated. I read this in the paper someplace. Did you make a statement within the last week or so about private pension funds investing in socially worthwhile projects?

Secretary REICH. No.

The CHAIRMAN. You did not?

Secretary REICH. No.

The CHAIRMAN. What am I thinking of?

Secretary REICH. I absolutely did not. There has been some concern expressed in certain circles about an interpretive bulletin.

The CHAIRMAN. About what?

Secretary REICH. An interpretive bulletin, which is simply a codification of existing law and advice provided by the Pension and Welfare Benefits Administration on so called economically-targeted investments.

That interpretive bulletin was extremely explicit and precise. There should be no sacrifice whatsoever of a competitive rate of return with regard to pension fund investments. Fiduciaries have an obligation to maximize——

The CHAIRMAN. The prudent man rule.

Secretary REICH. Absolutely the prudent man rule. It codified what is also an understanding that has been provided in many letters to pensions over the last 12 years, and that is, if they can find a competitive rate of return in which there is absolutely no sacrifice with regard to fiduciary obligation, they may also consider ancillary social goods that come out of that, but this is not social investing. This is not in any way jeopardizing the prudent man rule. This is simply, again, a codification of existing understandings.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Mr. Chairman, just briefly, to restate your first question, and to ask if I can, and get agreement from the Secretaries.

There is no dispute in our committee with the competence, the professionalism of the Bureau of Labor Statistics in producing the Consumer Price Index. However, they put out a pamphlet that tells you "What is the Consumer Price Index?" and it says it is not a

cost of living index. They are the ones who so assert in a very professional way.

We have heard panel after panel of eminent economists telling us their estimate of the range to which the CPI overstates the cost of living. I guess our first witness in this regard was the distinguished Chairman of the Federal Reserve Board.

We have a problem of faithfully executing the laws here. The intent of the law is to adjust for changes in the cost of living, in respect to a whole range benefits and to taxation. It would be very helpful if 1 day we could hear from the administration privately, leave a note somewhere or something like that. [Laughter.]

Senator MOYNIHAN. Or the Chairman, I am sure, will hold a hearing.

The CHAIRMAN. Well, or they can leave a note and just move a flower pot.

Senator MOYNIHAN. Move a flower pot.

The CHAIRMAN. That is right. As a signal.

Senator MOYNIHAN. You know the distinction. Of course you do.

Secretary REICH. Senator, if you will allow me, if we are trying to make judgments about the cost of living as opposed to the Consumer Price Index, let me just say as clearly and loudly as I can that the CPI is the best technical information that we have.

The cost of living itself reflects a lot of value judgments, value judgments about what it takes to live a life relative to what it took to live a similar life a year before, 2 years before, or 5 years before. We use the CPI to inform those value judgments.

The CPI is a set of technical instruments that help us make those value judgments. But if you are asking should politicians ultimately make those value judgments, must politicians ultimately make those value judgments, my answer is a resounding yes. Based upon the technical expertise founded in the BLS and founded particularly in the CPI.

Senator MOYNIHAN. But there are also technical judgments as to what adjustment should be made. As the Chairman said, the range of professional judgments from persons who have been working on this for about 25 years is remarkably narrow.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Simpson.

Senator SIMPSON. Thank you, Mr. Chairman.

I just want to touch on this aspect again as to when we hear the horror stories you can imagine what we get on this committee about what is going to happen if we cut Medicare, if we do this, if we do this with Social Security, what about the poor people, and no one is talking about what happens to them when it goes broke, which to me is rather more dramatic than a cut of a 7.1 percent raise.

I just do not swallow that one, and anyone under 50 who is swallowing it is stupid. Now, that is what is happening to people between 18 and 50. They must be out to lunch if they cannot figure this out.

Now, last year the administration in the Health Care Reform bill proposed provider cuts—and that is what we shall call them, I guess; you liked that term—along with new co-payments for home health care. They also proposed income testing for Part B Medi-

care. That was $80,000 for single persons and $100,000 for couples, while we have to listen to the rhetoric about, who are the rich.

I would think that is pretty rich when somebody is up at $80,000 or $100,000. The reductions were to pay for the new prescription drug benefits, long-term care, and subsidies for the uninsured, and this year they are not proposing any of these reductions.

Now, I think that is really something. We act like we have never heard of income testing, it is some devious plot. I would like to know why you have not offered these reductions as recommendations to ensuring the solvency of the Medicare trust fund.

Finally, every 4 years this 12-member advisory council is to report to the commissioners about the various issues that affect Social Security, Disability, and Medicare. Last year's legislation eliminated—eliminated—this advisory council and mandated a seven-member advisory board charged with advising the commissioner on policies related to Social Security and the two disability programs, and then left off Medicare. Medicare was not included.

So when I see an administration that first starts in a very stable and attractive way in dealing with these issues, like talking about Medicare under the advisory committee, talking about generational accounting, and then wait till this year and find no reference to generational accounting and Medicare left off of the advisory committee's mission, can either of you tell me or give me insight into why the advisory council was rejected in favor of the advisory board if it was not for the purpose of just dropping Medicare, which is the greatest aberration I can fathom?

Secretary RUBIN. Senator, I do not think that the administration has anything but an enormous commitment to dealing with Medicare, I was just repeating what we said before, with Medicare and the entire health care system. I think the only disagreement we have probably is on what is the best way to move the process forward.

We spent 2 years, we have said now quite a number of times, working our hearts out for a program that may have had many deficiencies, but, nevertheless, was a basis on which the Nation could have had health care reform. The judgment we made this year, rightly or wrongly, was the best way to proceed was to set a framework and then get a response from Congress in the context of that framework.

Senator SIMPSON. Bob, the thing that disturbs me, and you have used it about 10 times, is that it is almost like the administration worked their poor little old hearts out, and nobody swallowed it. But that was not me doing that, that was the American people doing that, and they did not swallow it. But that is over. It did not work. It was not accepted. I think I hear this, gee, we worked so hard and nothing happened. You are right, nothing did happen and nothing like that will happen.

Secretary RUBIN. Well, no. The point I was making is a slightly different one, which is, having tried to go that route and having not been successful, I think that even if somebody disliked the HSA in its entirety, and I personally think there were many things in there that were valuable, it was a basis. And if in the public domain and elsewhere there had not been this enormous effort to defeat it, I

think it did provide a basis for developing health care reform. That did not work.

The judgment we have made—and you may disagree—is that the process that is most likely to affect the results this year is not for us to put forward another program, but rather do what we have already done, which is set a framework and work with Congress within the context of that framework.

Senator SIMPSON. Well, here is a place to start. Why do we not help put Medicare back into that advisory council so we can probe one of the big issues of our day, which is $162 billion worth of stuff, and headed for $250 billion. We could do that.

But what I sense in dealing with the administration on Social Security, Medicare, and all these aspects—and you are the trustees; I put great credence in you—is evasion. We get evasion from the Social Security Commissioner, we get evasion from the Secretaries. I do know enough about the game to know that, if I might just throw it in with my last breath here, it seems to be the policy with the political people—I do not know who all that is—to sit back, wait for the Republicans to make all the tough choices, seize the political advantage that comes from that, kind of putting your hands together, and now that health care that we have tried so hard for and suffered for is now dead, it is the Republicans' problem, let them stew in their own juice, boil in their own oil, and if they fail, then who cares, other than our children and our grandchildren? And I do not go along with that one.

So, Senator Kerrey and I are up to a bipartisan approach to restore solvency to the Social Security system, and we would certainly like to hear your views, if you could share them with us, about these tidy or untidy little items that we mess with here.

Secretary RUBIN. Senator, I think that after 15 or 20 years of increasing deficits and the quadrupling of the Federal debt, it was this administration in 1993 that made enormous numbers of very tough choices, and arguably paid a big political price, to truly reverse the direction of the deficit in this country. As you know, it came down from roughly 5 percent of GDP to 2.7. Now you know the numbers, 2.1 percent projected at the end of this decade.

Senator SIMPSON. Well, now it is going up 200, with 300 out there, under this budget of our President.

Secretary RUBIN. Well, we had this debate before, I think. I personally think, in an economic sense, it is much better if we look at it as a percent of GDP. Having said that, the President himself has said that the next major step is health care reform and reducing the rate of growth of Federal health care expenditures. I think we all agree on that. I do think the only real question or the only disagreement amongst us is what process is best going to lead to a fruitful result.

Senator SIMPSON. Well, I pledge to work with you. I would like to see something coming back other than just kind of, gosh, we tried and we failed.

Secretary RUBIN. I am sure we will all work together.

Secretary REICH. If I may also, Senator, it was not only the Health Security plan that we put forward, but, as you know, the Omnibus Reconciliation Act of 1993 was a step—and we might argue a small step—in the right direction. Before that, the HI trust

fund was expected to be depleted by 1999. Now, economics was on our side in terms of recovery, but also that particular piece of legislation—which, I might add, was not easy to enact, and we had a lot of resistance to that—did go some small way toward helping and pushing back that insolvency deadline. I really believe that there are two issues in front of us.

One, has to do with that short-term cushion. That is, what small-scale steps can we make and can we agree to pretty quickly to give us more of a cushion beyond 2002, and then we have the large demographic issues.

I have not heard anybody that has come up with a very good, fail-safe idea for dealing with the fact that, by the time that the early baby boomers are going to be well into their retirement, it looks like that each of them is going to be supported by, not four workers, but two workers. That changes dramatically the way in which we need to think about all of this.

So, the administration is eager to engage on both the short-term cushioning questions, but also the longer-term demographic issues.

Senator SIMPSON. Thank you, Mr. Chairman, and to our Ranking Member. You are very patient as we labor long here and do not get many great suggestions.

The CHAIRMAN. I think we have no more questions. I just checked with Senator Moynihan.

Mr. Secretaries, thank you very much.

[Whereupon, at 4:01 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF ROBERT B. REICH

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to appear before you today to discuss the future of the Medicare system. My fellow trustees and I recently submitted to Congress our annual report on the financial status of the two separate Medicare trust funds—the Hospital Insurance (HI) Trust Fund and the Supplementary Medical Insurance (SMI) Trust Fund. As you know, this year's report shows that the Hospital Insurance Trust Fund will be insolvent by the year 2002, and that the costs of the SMI program will continue to soar.

These problems are not new. Indeed, for the past 15 years, the trustees have called for reform. And the Clinton Administration has already worked with Congress to address the problem, although there is still much more to be done. Prior to the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), the HI Trust Fund was expected to be depleted by 1999. But the reforms included in OBRA 93, along with the strong economy America has enjoyed since then, have delayed the Trust Fund's depletion until 2002. These short-term remedies, let me be clear, do not solve the deeper problems with the Medicare system, nor do they exhaust the Administration's commitment to reform. But they do buy us precious time in which to devise and implement a more comprehensive solution. It is now up to all of us to use this time well.

We all agree that the Medicare system is in need of change. The President has repeatedly said that he would like to sit down with Congress to produce a bipartisan blueprint for broad-based health care reform. The Clinton Administration believes that the financing problems that the Medicare system faces must be solved within the broader context of health care reform. As a trustee of the Medicare trust funds, I am very concerned about the impending insolvency of the HI Trust Fund, and pleased that this Congress seems intent on addressing this issue. However, I am deeply troubled by some of the approaches that are being discussed.

Attempts to quickly shrink federal spending by greatly reducing Medicare benefits, in isolation from broader reform, will leave many Americans worse off without addressing the fundamental structural flaws of our health care system. Large reductions in Medicare will increase health care costs to the elderly. They will also strain the finances of many health care providers, including some of America's most valuable and vulnerable health-care institutions. But the effects don't stop there. Providers may attempt to shift costs to private health insurance companies. If costs are shifted, many working Americans who are privately insured, and who may believe themselves to be insulated from the Medicare issue, will in fact feel the squeeze.

Speaker Gingrich and others claim that reducing Medicare expenditures will be "painless." This simply is not plausible. Dramatically cutting spending for a program like Medicare—to the extent the Senate Budget resolution has proposed—without reforming the overall health care system requires either reducing services or shifting the costs of the services to somebody else.

THE ELDERLY

While no specific bill has been put on the table, one prominent proposal would increase premiums, co-payments, and deductibles for elderly and disabled Medicare recipients. Under this plan, deductibles would be doubled from their current levels, premiums would be hiked every year until 2002, and there would be a dramatic increase in co-payments for home health care and other services. These changes, taken together, would raise annual Medicare costs by over $2,000 per couple in 2002

alone. For the typical Medicare beneficiary, increased premium costs will come right off the top of their Social Security checks—the simple equivalent of a Social Security benefit cut. This is particularly grave when one considers that these deep Medicare cuts may potentially be used to offset tax cuts for some of the most comfortable of our citizens.

HEALTH CARE PROVIDERS

Some vulnerable health care providers will also feel the pain of these deep cuts. When Medicare benefits are slashed outside the context of the overall health care reform, some hospitals may shift costs to the privately-insured. In the face of large Medicare cuts, hospitals whose patients are predominately Medicare beneficiaries and the uninsured will have few other options except to reduce the quality of care to all patients, or to close their doors. In particular, we are concerned that large reductions in Medicare payments could endanger rural and urban safety-net hospitals.

Hospitals in rural areas are often small. Some serve mostly Medicare recipients, and often are the only health care provider within 50 or more miles. Since many of these hospitals are already in financial distress, large Medicare cuts in isolation from broader efficiency improvements may cause rural hospitals to reduce the quality of care or to squeeze the wages of hospital workers. In extreme cases, these hospitals will be forced to go out of business, and workers will be laid off. Nearly 10 million Medicare beneficiaries live in rural areas. Such large cuts in Medicare outside the context of overall health care reform puts their health care in greater jeopardy. Some urban "safety net" hospitals—which are also in many cases America's most important teaching hospitals—are equally limited in their ability to shift the burden of drastic reductions in Medicare benefits, and will face similar cost pressures.

PRIVATELY-INSURED WORKING AMERICANS

Some hospitals that can shift costs to insured patients may do so. Many of America's hospitals have used gains from some payers to cover losses from others. Health care providers frequently charge insured patients more to cover the expenses of the 40 million Americans who do not have health insurance and thus frequently receive uncompensated care. In this context, slashing the Medicare program without broader health care reform may lead hospitals to increase costs to the privately-insured to make up for the enormous losses from Medicare patients.

For example, the 1995 Prospective Payment Assessment Commission (ProPac) report to Congress stated that as payments for Medicare and Medicaid were reduced over the last decade, hospitals responded by increasing revenue from private payers. Indeed, in 1992, hospitals spent $26 billion more than they received for furnishing services to Medicare, Medicaid, and uninsured patients. In the same year, they took in $29 billion in revenue above their costs of providing care to privately-insured patients. For example, just a few miles away at Georgetown University Hospital they charge paying patients 95 cents for an Advil tablet—8 times the retail price at a nearby drug store—in order to help offset the costs of uncompensated care.

For any action there is an equal and opposite reaction. This is an immutable law of physics, and applies in comparable ways to health-care policy. Those who prefer concrete models to abstract theorems can think of it as squeezing a balloon. If you push on one side, the air is forced to the other side. It stands to reason that deep Medicare cuts of the magnitude proposed by the Senate Budget resolution—if they are undertaken without reforming the health care system itself and without denying medical care to Medicare beneficiaries—will likely force 150 million privately-insured Americans to pay more. The cost shifting that results from large Medicare cuts outside the broader context of health care reform would essentially impose a hidden tax on working Americans. As Henry Aaron, an expert on health care issues at the Brookings Institution, recently testified: "Large reductions in Medicare spending within the current program framework will impose . . . taxes on private businesses and individuals."

A Congressional Budget Office analysis of an earlier proposal concludes that some of the expenditure reductions to providers will simply be shifted—in the form of price increases—to private payers. Martin Feldstein, a Harvard professor and former chairman of the Council of Economic Advisers, agrees. He wrote last year that a "very large hidden tax would result from reducing government payments to hospitals and other providers of Medicare services without any reduction in the care that they are expected to give. As a result, the hospitals and other providers would just raise their prices to patients and insurance companies. In the end, it would be

the privately insured individuals who bear those costs in the form of higher insurance premiums and lower wages."

A hidden tax is serious enough. But even worse, we are concerned that cost-shifting—triggered by Medicare cuts of the scale currently proposed—will have the ultimate effect of reducing health-care coverage. Costs may be shifted to the privately-insured and premiums will tend to rise to cover those costs. And as premiums increase, some workers and their families will be priced out of the market, and will end up without coverage. Mark Pauly, a health care economist at the University of Pennsylvania, wrote in a survey of the relevant literature that "there is fairly consistent evidence that insurance coverage is sensitive to proxies for its price." A recent CBO report concurs with this assessment.

Traditionally, membership in the American middle class included not only a job with a steadily increasing income, but a bundle of benefits that came with employment. Since 1979, we have seen a divergence in health benefits, related to education and skills. Employer-sponsored health coverage for workers with college degrees has declined only slightly, from 79 percent in 1979 to 76 percent in 1993. But rates for high school graduates have fallen from 68 percent to 60 percent over the same period, and for high school dropouts, the 1979 rate—already low at 52 percent—has plummeted to 36 percent. Nearly 100,000 Americans are already losing health insurance each and every month. Medicare cuts unaccompanied by broader reforms can only exacerbate this crisis.

According to a recent study by David and June O'Neill, less-educated workers are more likely to lose coverage when confronted with higher premiums. This gives reason to believe that the hidden tax associated with cost shifting will disproportionately affect workers with less education—the very group that has suffered the sharpest drop in health-care coverage since 1979, and whose overall prospects have become bleaker and more unsettled in today's changing economy.

One drawback to cutting Medicare in isolation was recently summarized by *The Economist:* "Although the federal budget would benefit [from reduced Medicare expenditures], these savings could be offset by higher costs in private health care . . . Thus the best way to cut Medicare . . . would be to subsume them within broader health-care reforms." For that reason, we need to sit down together—in a bipartisan manner—and produce a blueprint for broad-based health care reform. We must put the HI Trust Fund on a sound, sustainable footing. We have all known this for a long time now. But we have a responsibility to every American who works hard and plays by the rules to fix the problem of our health-care system, not simply shuffle from one group to another the excess costs that the current flawed system produces.

PREPARED STATEMENT OF HON. ROBERT E. RUBIN, SECRETARY OF THE TREASURY

Mr. Chairman and Members of the Committee:

I am pleased to appear before the Finance Committee today in my role as Managing Trustee and Chairman of the Medicare Board of Trustees. The Board is required to report annually to the Congress on the financial status of two separate Medicare trust funds—the Hospital Insurance (or HI) Trust Fund and the Supplementary Medical Insurance (or SMI) Trust Fund.

As you know, this year's report shows that the HI Trust Fund will be exhausted by the year 2002 and that the costs of the SMI program continue to rise rapidly. The Board has repeatedly notified Congress about the HI Trust Fund's short-term insolvency. This Administration clearly recognizes that the projected Medicare shortfall needs to be addressed.

The Medicare financing problem is a complex interaction of demographics and the rapidly rising costs that affect all parts of our health care system. We need to carefully reform Medicare, in the context of health care reform, in order to get the best possible solution for both the short term and long term. Or, to put the same matter differently, the Administration believes that the growth of federal health care expenditures, including Medicare, needs to be reduced in order to control the budget. But reducing this growth must be done by carefully weighing trade-offs and reforming these programs in the context of health care reform. Only such a process will lead to an outcome that best meets the multiplicity of objectives that need to be considered.

The alternative is arbitrary attempts to resolve the financing crisis that may restore solvency to the HI Trust Fund, but will create and intensify other problems. Specifically, we are concerned that deep reductions in Medicare may cause cost shifting, which could raise health care costs in the private sector, reduce private insurance coverage, and increase outlays for other government programs.

The Trustees have provided the Congress with an early warning and it is time to develop effective Medicare reforms in the context of health care reform, an objective this Administration has energetically pursued since it first took office in January of 1993. But we do have enough time to fix it right, even if we have to do it in stages, so that we avoid a hasty, unworkable solution that may have to be undone in the future.

The Medicare program merits this type of careful consideration because it is crucial to a large number of our citizens. One of the most important things our country has done over the past 30 years has been to work to reduce poverty and deprivation among senior citizens and disabled persons, and thereby also reduce the burden on and the anxiety of their children. Medicare has effectively provided a reliable source of medical care coverage for aged and disabled Americans. There are few issues of greater concern to working families than the cost of retirement and the problem of providing health care to the elderly.

Changes to Medicare as part of health care reform can restore Medicare to financial soundness, while at the same time improving the health of elderly and disabled Americans. As I mentioned a few moments ago, the Clinton Administration has sought to work with Congress—since the Administration first came to office—to solve the current Medicare financing problem and the more general health care crisis.

FINANCIAL STATUS OF THE MEDICARE TRUST FUNDS

As noted, the Trustees reported in April that the HI Trust Fund will be exhausted in 2002, one year later than projected last year. This slight improvement largely reflects the effects of the President's 1993 deficit reduction plan, the stronger-than-expected economy in 1994, and lower-than-expected program cost increases. Since this Administration took office, the exhaustion date has been extended by three years.

Over the long term, the 75-year actuarial deficit (interpreted as the amount of payroll tax increase or benefit reduction needed now to balance the trust fund over the next 75 years) was reduced from last year's estimate of 4.14 percent to 3.52 percent of payroll. The reduction is largely the result of lower expected future increases in HI costs, based on the recently observed slowdown in HI spending growth. Despite the decline, the HI program remains substantially out of long-run actuarial balance, and that problem is not addressed by either of the current Congressional budget resolutions.

The Trustees also continue to project rapid growth in Supplementary Medical Insurance program costs well into the future. Over the next five years, outlays are expected to increase 78 percent in the aggregate and 66 percent per enrollee. During the same period, the program is expected to grow about 38 percent faster than the overall economy.

Combined HI and SMI costs are expected to increase from 2.6 percent of GDP in 1995 to 8.8 percent in 2069—roughly tripling—largely due to anticipated demographic changes. Because of this rise in long-term program costs and the expected exhaustion of the HI Fund in 2002, the Board of Trustees recommends effective Medicare reform, but again, we believe that this must be done with a careful weighing and balancing of all impacts and all considerations and in the context of health care reform.

HISTORY OF MEDICARE COSTS

When the Hospital Insurance program has faced financing problems in the past, Congress and the Executive Branch have been able to cooperate on making modest changes in the program that slowed the rate of cost increases.

The program has experienced financial difficulty since its inception in 1966 because of rapidly rising hospital costs, higher-than-expected utilization, and program expansion. The actuarial balance deteriorated between 1966 and 1972, leading to an increase in payroll taxes in 1972 and temporary control of hospital prices between 1972 and 1974. After 1974, annual hospital costs again increased rapidly until 1983 legislation changed the manner in which Medicare pays for hospital services (from a retrospective to a prospective basis). As a result, the annual growth of hospital costs was modest in the mid-1980s.

During the 1990s, program expenditure increases were below those of the previous decade, reflecting a comparatively moderate rise in overall health care inflation and utilization. The President's 1993 deficit reduction plan, which included Medicare spending cuts, removal of the earnings limit for HI contributions, and increased taxation of OASDI benefits (with the proceeds going to the HI Trust Fund),

is partly responsible for the recent decline in growth rates and the increase in revenues which, together, extended the trust fund exhaustion date by three years.

Technically the SMI Trust Fund is actuarially sound, but only because the majority of its funding is from general revenue. Spending for physician services has grown faster than spending for hospital services in recent years. This is due, in part, to the establishment, in 1983, of Medicare' prospective payment method for hospital services. This payment procedure, among other things, provided hospitals with an incentive to shift some services from an inpatient to an outpatient setting, where services were not reimbursed on a prospective basis. In 1992, the SMI program began to phase in a fee schedule based on the estimated cost of resources used to provide various physician services. Although this change should help restrain the future growth of SMI expenditures, SMI and HI face similar near-term financial pressures because of medical price inflation and rising utilization of services. Over the long term, demographic change will dominate, as an aging population compounds the financing problem for both programs.

MEDICARE FINANCING AND HEALTH CARE REFORM

The fundamental reason for the rise in Medicare expenditures is the increase in health care costs affecting all parts of the nation's health care system. A dramatic attempt by government to contain Medicare spending in a vacuum—for example, through large reductions in payments to hospitals—will cause significant distortions and inefficiencies elsewhere in the health care system, unless such a reduction is undertaken in the context of health care reform.

Medicare cuts of the magnitude proposed in the House and Senate budget resolutions, if not accompanied by health care reform, will harm the most vulnerable in society—the elderly and the disabled—and may cause doctors, hospitals, and other health care providers to shift costs to everyone else. That means that working families will face higher private insurance premiums or will lose their insurance coverage. In addition, Medicare cuts of this magnitude, without any other reforms, could lead to the closing of already scarce rural hospitals; real pressures on big, urban public hospitals and academic health centers; and reduced services to many vulnerable people through cutbacks in payments for uncompensated care.

In contrast much more can be done to strengthen the Medicare program if we undertake health care reform. Taking steps to extend health insurance coverage to the uninsured population, and developing, through insurance reform, a competitive health care market will create a more efficient system. This increased efficiency will slow the growth in overall health care spending and provide long-term savings to the Medicare program.

In closing, the Administration believes it is possible to address the HI Trust Fund problem, the rising costs in the rest of the Medicare program, and broader health care reform objectives in a thoughtful manner, and produce effective, acceptable solutions that will stand the test of time. We are ready, and we have been from the beginning of this Administration, to work with the Congress to achieve these goals.

I will be happy to answer any questions you may have.

PREPARED STATEMENT OF HON. ALAN K. SIMPSON

As a member of the President's Bipartisan Commission on Entitlement and Tax Reform, I became acutely aware of the problems we face if we do not address the issue of entitlement reform.

The total cost of entitlement programs, which include Social Security, Medicare, federal retirement programs, welfare, and farm subsidies, will grow by nearly 40 percent over the next five years unless their costs are contained.

Indeed spending on entitlements and interest on the national debt alone will consume all tax revenues collected by the federal government by the year 2013 under current law. That means that Congress will be forced to add to the national debt simply to fund necessary spending on national defense, highway repair and education.

As far as Medicare goes, I believe it is vitally necessary to place restrictions on the future growth of this spending. The 1995 Trustees Report states that the Medicare-HI trust fund (Part A) will be bankrupt by year 2002 if we don't place restrictions on the growth of this program. That is seven years from now. The Trustees have given us one year of reprieve—this is not exactly a major improvement!

The HI Trust Fund is severely out of financial balance and will be exhausted in just seven years. The fund will go bankrupt even before the baby boomers reach age 65 in 2020. A startling statistic that recently came out of a study completed by HCFA is that the baby boomers will cost Medicare an estimated $210 billion before

they die—almost double the expense of caring for persons who passed this milestone in 1990. The researchers concluded that "Total Medicare payments will be more substantially affected by the expected increase in the absolute number of elderly people, rather than the increased longevity beyond age 65." These increasing numbers are going to wipe out the Medicare program.

The Supplemental Medical Insurance (SMI) which pays doctor bills and other outpatient expenses, is financed on a year-to-year basis and is adequately financed at this time. However, the program has experienced rapid growth in costs with program growing 19 percent faster than the economy as a whole. We need to look at specific program legislation which is designed to more effectively control these Medicare costs. If we do not face these problems while we have the opportunity, there will be nothing left for our children and grandchildren.

We need to take the Trustees' advice and undertake comprehensive Medicare reforms to make this program financially sound now and in the long term.

We need to examine imposing a "cap" that allows Medicare spending to increase only at the rate of inflation and in a manner to accommodate the growth of the number of Medicare beneficiaries.

This would mean that future increases in Medicare spending would be limited to perhaps five or six percent annually—instead of ten or eleven percent.

I also believe that seniors who are more "well-off" should be required to pay a larger share of their premium if they personally choose to participate in Part B. Currently, the Part B premium paid by seniors covers just about 30 percent of the cost of their coverage. The other 70 percent is subsidized with general funds from the U.S. Treasury. This policy needs to be immediately reevaluated.

It just does not make sense for all seniors—including those with high incomes—to have their Medicare coverage subsidized when many of the taxpayers who pay for this generous subsidy can't even afford to purchase health insurance for themselves or their families.

We must honor our commitment to those who are "truly needy" and are counting on Social Security, Medicare, federal retirement and veterans benefits for their retirement needs, but we surely have to start getting serious with those who do not need to have their incomes subsidized by younger generations of working Americans.

COMMUNICATIONS

STATEMENT OF THE AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS

METHOD TO IMPROVE AND PRESERVE MEDICARE

The American Society of Plastic and Reconstructive Surgeons (ASPRS) represents 97% of the nearly 5,000 board certified plastic surgeons in the United States. Plastic surgeons provide highly skilled surgical services which improve both the functional capacity and quality of life of our patients. These services include the treatment of congenital deformities, burn injuries, traumatic injuries, and cancer.

I. Background

Enacted in 1965, Medicare has proven to be a great success in improving the health status of the elderly and disabled, keeping them in the mainstream of American medical care. However, Medicare suffers budgetarily due to its fundamentally flawed financing structure and erroneous budget projections.

According to an April 3, 1995 report by the Social Security and Medicare Boards of Trustees, Medicare's Hospital Insurance Trust Fund is projected to be insolvent by year 2002 and will pay out more than it takes in beginning in 1996. This warning comes after several years of severe cuts in Medicare's physician payments. Physicians account for 23% of Medicare outlays, yet have absorbed 32% of provider cuts over the last decade. Even with these levels of cuts, for years 1991-93, physicians have succeeded in actually holding down volume increases below projected levels, thus saving the program billions in projected dollars.

In response to the recent insolvency projection and in an attempt to reduce the federal budget deficit, Congress has begun to consider restructuring the Medicare program along with further proposed reductions of $250-300 billion over the next seven years. Some are projecting as much as $100 billion in savings to come from expanding managed care into Medicare program, although the Congressional Budget Office (CBO) is skeptical about managed care programs generating any significant amount of savings.

II. Expanding Managed Care to the Elderly Population Will Not Result in Savings for Medicare

A number of policy-makers and academics have cited the potential of managed care to generate significant savings from Medicare and slow the rate of growth of the program. Managed care is premised on the notion that effective case review can lower overall costs without affecting the quality of care provided. However, it is highly unlikely that managed care will be the panacea for Medicare's financial crisis nor does it adequately serve the program's bottom line.

In the private sector, managed care has produced one-time savings through provider discounts, but has not slowed the long-term rate of growth of health care expenses. As for serving an elderly population, studies have consistently shown that Medicare managed care programs do not save the government money and do little to address the long-term problems facing Medicare. Experience of the Medicare risk contract program confirms that the healthiest segment of Medicare beneficiaries tend to enroll in managed care, while the older and sicker beneficiaries do not appear willing to change doctors or give up their freedom to choose a particular specialist or hospital.

In testimony to the Senate in February, the CBO testified that HMOs attract healthier members of the Medicare population and "there may also be a tendency for HMO enrollees to switch to the fee-for-service alternative when severe health problems arise." When sicker beneficiaries return to the fee-for-service pool, the HMOs are relieved of the costs associated with providing the patient with advanced services and necessary equipment. This favorable selection holds down the managed care plans' expenses, but can result in major losses to the Medicare program overall.

A 1994 General Accounting Office report explains that "as more healthy beneficiaries join HMOs, the Medicare fee-for-service population on average becomes sicker, driving up Medicare's average costs of treating fee-for-service patients. When this average cost rises, so does the capitation rate HCFA pays to risk contract HMOs."

Favorable selection results in Medicare over-paying managed care to treat the healthy and then being forced to swallow the costs of the older and sicker who return to fee-for-service in the later stages of life.

There is no reason to believe that expanded enrollment in Medicare managed care programs will prevent favorable selection. The GAO concluded last year that "favorable selection is not likely to disappear once larger numbers of Medicare beneficiaries are enrolled in HMOs."

III. Managed Care Lacks Capacity to Serve Entire Nation

There are also limits to the ability of managed care programs to serve rural areas that do not contain sufficient population to sustain effective HMO competition. After all, nearly one in three Americans live in such rural areas. According to a study published in the New England Journal of Medicine, communities with less than 180,000 people may be too small to support effective competition among managed care providers.

HCFA Administrator Bruce Vladeck cautioned that "the movement toward managed care cannot outpace the capacity of managed care plans to serve large numbers of new enrollees, particularly those with expensive and special health needs of the Medicare population."

IV. Managed Care is Not Suited to Handle Unique Health Needs of Elderly

Cost is not the primary concern of the elderly. This reduces their sensitivity to pricing and their tolerance for slower, less tailored care. The special health needs of Medicare enrollees place them at higher risk for failure of managed care to provide timely access to needed care. The drive to hold down costs may threaten the health of senior citizens enrolled in the program. Numerous studies have cautioned about the adverse effects of HMO participation by the elderly. In responding to financial pressures to provide care at a low cost, HMOs may restrict care too much, leading to lower quality care. In recent years, seniors have expressed their dissatisfaction with Medicare managed care by disenrolling from the Medicare risk program in large numbers.

A study published in the May 1994 issue of the New England Journal of Medicine questions the ability of managed care to treat chronic conditions prevalent within the Medicare population. The study suggests that HMOs may be ill-suited to handle the needs of individuals with conditions that demand extended and repeated medical attention.

It is not realistic to assume that managed care delivery systems will effectively serve our seniors. As retirees grow older and sicker, they become increasingly dependent on ready access to specialists and treatment of their choice. Their expanded reliance on prescription drugs and advanced treatments will put them at odds with organizations that are under pressure to look squarely at the bottom line. An 1994 study of HMO performance warns that little evidence exists that the performance of prepaid care in relatively healthy populations can be replicated among sicker patients.

V. Medicare Changes Should Encourage Personal Responsibility in Health Care Spending

Further short-term reductions of expenditures and the expansion of managed care will not solve Medicare's budgetary problems. The Medicare program requires serious, long-term transformation if its promise is to be preserved for future and current generations.

Any formulation of a long-term solution should include the principles of enhancing inter-generational equity in financing, reducing regulatory and administrative complexity for patients and physicians, and facilitating price competition among physicians.

Moreover, we believe that a crucial component in reducing the rate of growth in the cost of Medicare and health care in general is encouraging personal responsibility and cost-consciousness at the point of service.

In restructuring Medicare, a possible solution for Congress is to provide the same tax incentives for Medical Savings Accounts (MSAs) as given traditional employer-paid health benefits. The enactment of MSAs, as proposed in various bills pending in Congress, would be an important step in moving away from the current system of first-dollar coverage provided by third parties, and toward returning control over health care spending to individuals and decreasing costs by lowering utilization.

VI. Medicare Patients Enrolled in Managed Care Should be Provided With Certain Protections

To the extent that managed care expands within the Medicare program, ASPRS strongly believes that beneficiaries should be provided with formal safeguards to ensure that the profit motive does not endanger patient care. Also, seniors should be fully informed about the coverage, restrictions and procedures of various plans.

To protect Medicare patients enrolled in managed care from potential abuses of managed care, ASPRS recommends that Congress adopt the following safeguards:

- Financial incentives should not be allowed to interfere with medical judgment. For instance, plans should be prohibited from establishing arrangements in which the gatekeeper has a financial incentive to not refer patients. The patient's first point of contact should be encouraged to make all needed medical referrals and should not feel constrained financially from doing the best job for the patient;
- Point of service options should be mandatory for all plans with limitations on out-of-pocket expenses to patients. Patients should be able to opt out of any closed system to seek the specialist of their choice. The financial penalties that accrue to such an opt out, or "point of service" should be capped. This option is the ultimate consumer protection against poorly managed health care plans, or those that unduly restrict access to necessary specialty treatment;
- Plans should be required to provide the full range of specialized care for enrollees with rare, unusual or highly complex conditions, and should provide all appropriate specialty services in accord with clinical practice guidelines established by recognized specialty societies. Direct access to specialty care is essential for patients in emergency and non-emergency situations, and for patients with chronic and temporary conditions, as well as those with unexpected acute care episodes. Specialty care must be available for the full duration of the occurrence, and not limited by time or number of visits;
- Beneficiaries should have the ability to disenroll from managed care programs at any time. This would provide an important incentive for plans to provide high quality care;
- All plans participating in the Medicare program should be evaluated in a consumer "report card" in part on the basis of the timeliness of access to specialty care and the quality of that care as established through the credentials of the physicians and the outcomes of their treatments; and
- Plans should provide potential enrollees with clear information about the services covered and excluded, and information on patient satisfaction with the particular plan.

VII. Conclusion

ASPRS is opposed to proposals to expand managed care to the Medicare population as such a move will not result in savings for the program, while risking the health of the elderly.

The Medicare program should be restructured to encourage personal responsibility in health care spending and decrease reliance on third-party payment. Enactment of MSAs is important to accomplishing this objective.

Medicare patients enrolled in managed care should be provided with safeguards protecting their quality of care, access to necessary specialty services, and ability to disenroll from a particular managed care plan.

ASPRS appreciates the opportunity to testify on the topic of Medicare before the Senate Committee on Finance, and is available as a resource on this issue as the Committee continues its work.

STATEMENT OF THE NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

(SUBMITTED BY MARTHA MCSTEEN, PRESIDENT)

The National Committee to Preserve Social Security and Medicare is a grassroots advocacy organization representing millions of Americans concerned about the future of Medicare.

A comprehensive, system-wide approach to health care cost-containment is necessary to control the growth of Medicare spending and to prevent the insolvency of the Medicare Part A trust fund. Unless real progress is made in controlling health care costs generally, Medicare and Medicaid costs will continue to grow significantly.

Proposals are being made to reduce Medicare spending $250 billion to $300 billion over seven years to reduce the deficit and to finance tax cuts. Reductions of this magnitude are unprecedented-several times larger than the $56 billion in reductions over five years enacted as recently as 1993 as part of the reconciliation bill. The Medicare program cannot sustain the level of cuts discussed recently by some Congressional leaders without significant hardship to seniors and the disabled.

The National Committee rejects significant increases in out-of-pocket costs for Medicare beneficiaries as the solution to Medicare's problems. Medicare beneficiaries should not be liable for health care inflation over which they have little control. Out-of-pocket health care costs are now a larger percentage of income than when Medicare first started.

The debate over Medicare costs is driven largely by the deficit problem. It is important to note that Medicare Part B has contributed a relatively small amount to the current deficit. (See attached chart) Medicare Part A has contributed nothing to the deficit. When spending on all general revenue fund programs is compared, Medicare Part B accounts for only 4 percent of overall deficit spending. The deficit was caused by tax cuts in the 1980s coupled with significant increases in defense spending. As a result, interest on the federal debt accounts for a staggering $1 out of every $4 general revenue dollars spent. *If it were not for interest on the debt, the federal budget would be in balance today.*

Medicare and Medicaid are being asked to shoulder an unfair proportion of deficit reduction. One reason for that is that Congress continues to structure the budget process so as to ignore the contribution tax expenditures make to the deficit. These "tax entitlements" provide substantial financial benefit to many individuals and corporations through the ax code and have the same effect on the budget and deficit as direct spending. In fact, tax entitlements now cost the government nearly as much as all discretionary spending programs totaled. Congress must subject these tax entitlements to the scrutiny of the budget process and identify equitable reductions. It is particularly unfair to shield tax entitlements from Congressional scrutiny since they primarily benefit upper income individuals and corporations while the direct spending programs primarily benefit low and middle income individuals.

COST CONTAINMENT

Medicare cost containment must be part of a comprehensive plan to control national health care costs. Without a comprehensive program of cost containment, Medicare reductions will result in higher costs to beneficiaries, reduced payments to providers, increased cost shifting and access problems for beneficiaries. The steep increase in Medicare costs is typical of health care costs in society in general.

Medicare is a far more efficient program than it is given credit for being.

- Over the past decade, Medicare outlays per enrollee have grown more slowly than outlays for private insurance patients.
- Medicare has an excellent record on administrative costs—averaging 2 percent of program outlays compared to 25 percent in the small group market of the private sector and 5.5 percent in the large group market.
- Medicare rates for hospitals and doctors are at deep discounts, approximately 70 percent of what private insurers pay. Medicare is already a large, nationwide preferred provider organization.
- The notion that cost increases are due to a lack of cost consciousness on the part of beneficiaries is false. Medicare pays less than half of senior health care costs, including long-term care, and many seniors face financial hardship as a result of health costs, despite Medicare and Medicaid.

CONTROLLING FRAUD

A major effort to prevent fraud and abuse is essential and appropriate. According to the General Accounting Office and the Inspector General of HHS, fraud and abuse in the Medicare and Medicaid programs are rampant. Current estimates are that Medicare and Medicaid lose up to $31 billion annually to fraud and abuse. The government must commit resources to fighting fraud and provide increased opportunities for beneficiaries to make confidential complaints about fraud, perhaps through designated personnel at local Social Security offices.

- A June 1994 report by Senator William Cohen, R-Maine, Chairman of the Special Committee on Aging, concluded that major patterns of fraud and abuse have infiltrated the following health sectors: ambulance and taxi services, clinical laboratories, durable medical equipment suppliers, home health care, nursing homes, physicians, psychiatric services and rehabilitative services in nursing homes.

- The HHS Inspector General reports $80 in savings for every dollar invested in efforts to control fraud. Yet, Congress has yet to make meaningful efforts to prevent fraud of taxpayer money in the Medicare and Medicaid programs.
- GAO conservatively estimates that Medicare could save $650 million a year just on Medicare Part B physician and supplier services by using state of the art commercial software to eliminate abusive and fraudulent billing practices. Commercial insurers using his software typically save 5 to 10 percent.

MANAGED CARE

Managed care options should be made available to Medicare beneficiaries on a voluntary basis as long as federal standards, safeguards and appeals rights are assured.

- Some seniors prefer managed care arrangements due to more comprehensive coverage and/or lower out of pocket costs. Beneficiaries should not be required to join managed care plans and should have the option to seek care outside the plan when special expertise is needed.
- Expectations that managed care will lower spending may be unrealistic. Adequate risk adjusters are not yet developed to insure that Medicare does not pay too much for healthier beneficiaries who choose managed care. An expansion of managed care options could actually increase overall costs if healthier, lower cost beneficiaries choose managed care and sicker beneficiaries remain in fee for service Medicare.
- Quality managed care plans coupled with consumer education about managed care could increase participation of Medicare beneficiaries and reduce costs over time.

ADDITIONAL SAVINGS

The National Committee can support careful and equitable efforts to restrain health care inflation necessary to secure Medicare's long-term stability. We recognize the need to look for reasonable savings to slow the growth of Medicare in the short-term. Some short-term and long-term proposals that the National Committee has endorsed or would consider as part of an equitable proposal are listed below. If all these proposal are adopted, it would save over $150 billion in the Medicare Part A trust fund and slow the growth in Medicare Part B spending.

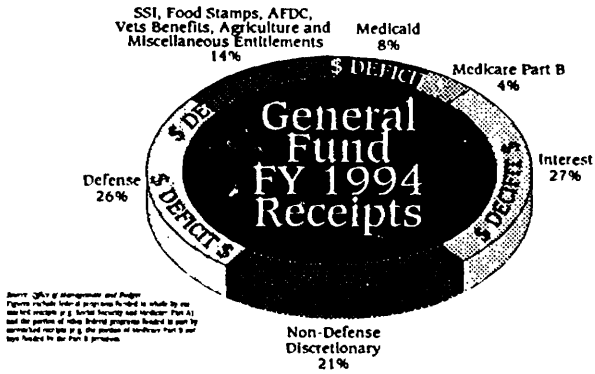
- In the recent budget, the President proposed to save $10 billion over five years by making permanent several temporary provisions in current law, including setting Part B program premiums at 25 percent. Other provisions included extending Medicare secondary payer provisions and permanently lowering payments to home health agencies and nursing homes. These "extenders" were adopted by the Ways and Means Committee but the revenue was not used for deficit reduction or to shore up the Part A Medicare trust fund. Instead, the savings were diverted to help pay for tax cuts. The National Committee believes that these savings should be used to strengthen Medicare.
- The National Committee supports the extension of Medicare coverage to include state and local government employees not now covered. This would not only raise $7 billion over five years, but it would also extend Medicare coverage and insure that all future Medicare beneficiaries contribute toward Medicare. Increasing the tobacco tax to $2 per pack could generate $15 billion a year for Medicare in addition to $1.5 billion for medical research. (H.R. 1455)
- A reevaluation of Medicare payments for hospital capital costs and professional education could reasonably save between $7 billion and $23 billion over five years.
- Formula driven overpayments to hospitals for outpatient surgery and radiology also can be reduced $20 billion over five years according to a recent HHS study, but these savings should be used to offset the cost of reducing beneficiary copayments, which averaged 43 percent of total payments rather than 20 percent in 1993.
- Stricter utilization review and streamlining of Medicare administrative costs, including combining Part A and Part B.
- Increasing the eligibility age for Medicare by tying it to eligibility for Social Security will create savings beginning in 2003.

CONCLUSION

Medicare provides valuable insurance protection to millions of seniors and disabled individuals, insurance that would be difficult for many to obtain in the private market. Medicare and the health care system of which it is a part face serious prob-

lems. The National Committee is committed to finding solutions which preserve Medicare.

FINAL ACTUAL FY '94 FEDERAL DEFICIT-GENERAL FUND



DEFICIT AMOUNTS BY CATEGORY (WITH INTEREST DEFICIT ALLOCATED) IN BILLIONS

DEFENSE	$108
DOMESTIC DISCRETIONARY	87
SSI AND OTHER MISCELLANEOUS	59
MEDICAID	33
MEDICARE PART B	17
MEDICARE PART A	0
SOCIAL SECURITY	0
TOTAL	$304

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ISBN 0-16-052112-2