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SOLVENCY OF THE MEDICARE PROGRAM

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UNITED STATES SENATE

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SOLVENCY OF THE MEDICARE PROGRAM

THURSDAY, MAY 11, 1995

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

The hearing was convened, pursuant to notice, at 9:30 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Bob Packwood (chairman of the committee) presiding.

Also present: Senators Hatch, Simpson, D'Amato, Pryor, Rockefeller, Breaux, Graham, and Moseley-Braun.

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

The CHAIRMAN. The committee will come to order, please.

This is the second in a series of hearings we have had on Medicare. I have read Director O'Neill's testimony, and I have read Dr. Steuerle's testimony, there are some modest variances—but, frankly, not very serious variances—between what you say, Dr. O'Neill, and what Dr. Steuerle says, and what the trustees say, and what everybody else says in terms of bankruptcy of Medicare.

Whether you phrase it that the average worker pays in $25,000 and gets back $100,000 in benefits, or $125,000 in benefits, or maybe it is stated as a couple and, therefore, the figures are slightly higher, but they are variances that are modest.

Everybody says the same thing, given these plus or minus margins of error; we are bankrupt. Medicare is 30 years old. If we do not do anything, it is going to die before most of the people who are currently living will be eligible for Medicare.

I understand the politics of this. I understand that nobody wants to step up to the plate; they all want to get hit by a pitched ball and get to first base without saying anything.

Either we raise taxes—and I have not heard anybody who is seriously talking about that—or we somehow reform all health care, including Medicare, in such a way that it works to reduce the increase in costs.

I well remember when your predecessor was here last year testifying about the President's health care plan, Dr. Reischauer, and if ever there was practically a single paragraph, and maybe a single sentence, that sunk that bill, it was his testimony when he said, if everything worked right with the President's health reform bill, all the cost containments, and everything, why, we could expect to reduce our health cost as a percentage of our Gross Domestic Product by a full percent.

Somebody said, what is that? He said, from 20.5 percent to 19.5 percent in 10 years, to which Senator Durenberger said, but they are only 14 percent now. That is the wrong direction. And he said, well, that was his estimate. I think at that stage the committee just stopped, and the Congress stopped, and said, no, that is not what we want to do.

So even health reform, as proposed by President Clinton, was not going to solve the cost problem. Even health reform, as proposed by President Clinton last year, would not have solved the Medicare bankruptcy problem. And, of course, what he has proposed this year is even significantly less; it does not solve the problem at all.

There are those who say, well, maybe we can solve it by merging Part A and Part B. That does not solve any problems. They suggest having it all be payroll tax. In that case, you are looking, in 10–15 years, at a payroll tax for health alone of around, as best I can tell, of fourto 5 percent, assuming that the beneficiaries continue to pay their 31 percent of the Part B premium and the rest of it is payroll tax.

So are those solutions? No, those are not solutions. It is frustrating. I understand the partisan politics of this on both sides. The partisan politics on both sides is not going to solve the problem.

Whether we do not solve it until these two locomotives run into each other or not, I do not know, but if we do not do anything else, they are going to run into each other. And not in the distant future, it is not even the near future, it is practically around the corner in terms of our budget planning.

So, Doctor, we are delighted to have you here. I know over the next few years we are going to have you here frequently on any number of occasions. Go right ahead.

STATEMENT OF JUNE E. O'NEILL, PH.D., DIRECTOR, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC

Dr. O'NEILL. Well, it is my pleasure to be here. I will summarize my prepared statement, which I will submit for the record.

As you know, the report of the trustees of the Hospital Insurance (HI) Trust Fund released last month indicates that, under intermediate assumptions, the HI trust fund will be depleted in the year 2002 unless changes in policy are made. Even under the trustees' most optimistic assumptions, the HI trust fund will be exhausted by the year 2006, which is just 11 years from now.

The Congressional Budget Office (CBO) finds ample reason to agree with the broad conclusions of the trustees regarding the short-range adequacy of HI funding, but those projections of HI insolvency address only part of Medicare's overall financial outlook. The Supplementary Medicare Insurance program, that is, SMI, which pays for physician and outpatient services for Medicare beneficiaries, is also experiencing rapid growth in costs.

The Medicare program is absorbing a growing share of the Nation's resources that will reach 3.5 percent of gross domestic product (GDP) by the year 2005. Moreover, as the baby-boom generation reaches retirement age, the number of workers available to support each HI enrollee is projected to drop. Currently, about four workers support each HI enrollee, but that ratio will decline rap-

idly after the turn of the century. Only two covered workers will be available to support each enrollee by midcentury.

That demographic change will cause a continuing deterioration in the financial situation confronting Medicare as well as Social Security. The evidence strongly supports the conclusion of the trustees that prompt, effective, and decisive action is necessary by the Congress to avert a financial crisis in the Medicare program.

Under current law, CBO projects that Medicare expenditures in the HI and SMI programs combined will increase from $181 billion in 1995 to $463 billion in 2005, reflecting a rate of growth of 9.8 percent a year, on average.

Consequently, under current law, Medicare's share of total Federal outlays will increase from 11 percent in 1995 to 16 percent in 2005. Most of the projected increase in Medicare spending over the next 10 years is attributable to rising medical prices and to increases in utilization of services.

Demographic factors over the coming decade will play a minor role because beneficiary growth will be slow as the baby-bust generation retires. This is the generation born in the low-birth years of the Depression and World War II.

The current financial instability of the HI trust fund has been evident since 1992, when HI outlays first began to exceed income from the payroll tax. HI outlays will begin to exceed all sources of income to the program in 1996.

The CHAIRMAN. Say that again. That is very important. We have already, in 1992, outstripped the payroll tax.

Dr. O'NEILL. That is exactly right.

The CHAIRMAN. We had some other modest sources of income that kept our head above water until 1996.

Dr. O'NEILL. And one source that, in a way, is a paper transaction, which is the interest on the trust fund balances. In 1996, HI outlays will outstrip all income sources, even when you include the interest on the trust fund balances.

As a result of a continuing annual deficit in the HI account, the balance in the HI trust fund will erode each year and by 2002 will be depleted. In that fiscal year, according to CBO's assumptions, total HI income would be $153 billion, and the total amount in the trust fund at the beginning of the year would be about $16 billion.

The CHAIRMAN. $60 billion or $16 billion?

Dr. O'NEILL. Sixteen billion—just $16 billion, as we go into the year 2002. We would have income of $153 billion and an initial trust fund balance of $16 billion. But the expenditures projected for that year would be $199 billion, which would leave a shortfall of $30 billion in the year 2002.

The actual deficit on current accounts is larger than $30 billion because that figure includes the $16 billion from the trust fund balances. The deficit just counts income and outgo.

Thus, without Congressional action to provide additional financial resources, the HI program would be unable to pay for all the services that Medicare beneficiaries are projected to receive in the year 2002.

The rate of growth in Medicare's costs has caused concern almost from the program's inception. The Congress has made repeated attempts to slow that growth, including developing a prospective pay-

ment system for hospitals, changing the physician payment system, and allowing beneficiaries to enroll in health maintenance organizations (HMOs). Those efforts have met with limited success.

A key question is whether Medicare can take advantage of managed care savings. Since 1985, Medicare enrollment in HMOs has grown steadily, although at 7 percent for risk-based, or true, HMOs, it is still low compared with the privately insured population. In 1992, almost 20 percent of people with private insurance were in HMOs, and the proportion is probably higher today.

The lower HMO enrollment of the Medicare population is likely influenced by the incentive structure in the Medicare program—the incentives for users as well as providers.

Currently, Medicare beneficiaries do not pay any more to enroll in fee-for-service Medicare than they do to enroll in an HMO. However, the HMO may provide extra benefits, such as a reduction in cost sharing or prescription drug coverage. Beneficiaries would have to pay a substantial premium for medigap coverage to receive such extra benefits in the fee-for-service sector.

Perhaps for some beneficiaries, these financial incentives to enroll in an HMO are outweighed by the desire to be able to choose physicians outside the HMO's network. Others may not enroll in managed care simply because they are unaware of the available options. In the future, both stronger financial incentives and better information will be necessary to encourage more Medicare beneficiaries to enroll in managed care plans.

Despite the apparent evidence that the overall cost of services used by Medicare beneficiaries falls when they move from the fee-for-service sector to an HMO, higher HMO enrollment does not reduce Medicare's costs and may even increase them under Medicare's current payment and incentive system. That effect occurs, in part, because HMOs are paid 95 percent of Medicare's fee-for-service cost to provide care to a beneficiary, regardless of the actual cost of the resources or the services provided.

Many analysts attribute the recent slowdown in the rate of growth of private health insurance spending to more aggressive price competition among health plans. Between 1990 and 1993, private health insurance spending grew at an average annual rate of 7.7 percent compared with 11.2 percent for the Medicare program. As it is currently structured, the Medicare program cannot take advantage of the recent competitive developments in the private health care market.

If nothing is done and Medicare continues to grow at its current rate, the program will consume an increasing share of the Nation's resources. In part, that outcome reflects improvements in health services for the elderly, but it also raises concern about efficient resource allocation.

If Medicare absorbed less of the Nation's output, more could be spent on investment to improve the productivity of current and future workers. Moreover, a growing economy could be more dependably counted on to pay for the benefits of current and future retirees.

Fixing Medicare's financing problems will not be easy. As the reports of the trustees make clear, the problems begin in the short term and will only escalate in the long term as the baby boomers

start to retire. Either taxes must be increased, expenditures reduced, or both, and the orders of magnitude involved are necessarily large.

The tax alternative, taken in isolation, would require an increase in the HI payroll tax of 1.3 percentage points; that is more than a 40 percent increase over the next 25 years to ensure that HI financing covers program costs.

However, while an increase in the HI payroll tax would secure the HI portion of Medicare outlays, it would do nothing to secure the funding of SMI or to improve the overall efficiency of the Medicare program.

There are two broad approaches for achieving slower growth in Medicare outlays. One is budgetary reductions, and the other is program restructuring. The two approaches are not mutually exclusive. With or without a tax increase, a combination of the two would probably be needed to achieve immediate savings and longer-term goals.

Budgetary reductions, examples of which are included in CBO's report "Reducing the Deficit: Spending and Revenue Options," represent the traditional approach to containing Medicare's costs. Such options, which typically reduce payments for providers or raise the amounts that beneficiaries must pay, can offer immediate short-term savings in the Medicare program.

However, they are not necessarily designed to improve the efficiency of the program or to address the underlying long-term structural problems of spending growth. Slowing the long-term rate of growth of overall Medicare spending and ensuring the solvency of the HI trust fund will probably require a major restructuring of Medicare.

Three basic tenets underlie most redesign proposals. First, Medicare beneficiaries would have meaningful choices among a range of plans, including a fee-for-service option; second, beneficiaries would also have financial incentives to select efficient health plans; and third, health plans would have strong incentives to compete for Medicare beneficiaries.

Several possible models for restructuring the Medicare program along those lines have been proposed. Frequently, competitive market approaches offer beneficiaries more choices and clear financial incentives to choose less costly options.

A key feature of those approaches is the notion of Medicare's making a defined contribution on behalf of each beneficiary. Beneficiaries could then put those contributions toward the cost of the health plan of their choice. Beneficiary choice and limits on the government's contribution, for example, are important elements of the design of the health insurance program for Federal employees.

A competitive redesign of Medicare is a possible strategy for addressing the fiscal problems of the program, but establishing a competitive system could be a major undertaking, requiring time to develop.

Moreover, full implementation all at once of such a redesign would be difficult. A phased-in approach, starting with younger Medicare beneficiaries, might be more feasible. For these reasons, a structural change in the program could not be counted on to de-

liver substantial near-term savings, although considerable savings might well accrue in the long term.

One thing is certain: postponing decisions on Medicare's financing will only make the necessary policy actions in the future more severe. Without a tax increase, ensuring that the HI trust fund remains solvent will require immediate spending cuts, as well as reductions in the underlying rate of growth of spending. Any delay will require more dramatic cuts and program changes in the future.

Thank you. I would be happy to answer any questions.

[The prepared statement of Dr. O'Neill appears in the appendix.]

The CHAIRMAN. Doctor, let me read that last sentence of yours again, because it says it all. "One thing is certain: postponing decisions on Medicare's financing will only make the necessary policy actions in the future more severe.

"Without a tax increase, ensuring that the HI trust fund remains solvent will require immediate spending cuts, as well as reductions in the underlying rate of growth of spending. Any delay will require more dramatic cuts and program changes in the future."

Very few people are talking about tax increases. That appears to leave only your other alternative of spending restraints, as the Republicans call them, rather than cuts, as well as reductions in the underlying rate of growth.

Is there any other alternative?

Dr. O'NEILL. I do not believe that there is a real alternative. There are temporary expedients, like shuffling funds from one part of the Social Security system to another, but that approach would only accelerate the problems for the Old-Age, Survivors, and Disability Insurance (OASDI) trust fund.

The CHAIRMAN. Well, when we had our hearing on Tuesday I said, that is my greatest fear. I can see neither party wanting to approach this without the other party for fear of being blackjacked and being in a losing political situation.

So we get to about October or November and nothing has been done, and you have been back here testifying three more times, in essence saying exactly what you said today, and all the other experts will say the same thing, and we will say, well, let us move $200 billion of the Old Age trust fund to Medicare, that solves the problem, thereby, of course, probably drawing Social Security down from 2029 to 2020, or something like that, when it runs out of money. And we will have "solved" the problem for the next 5 years, and we will have done nothing. We just will have postponed it by shifting the pea around under the shell.

Let me ask you this. Is $147–165 billion roughly the reasonable range? HCFA says $147, you say $165 billion. That is a reasonable estimate, is it not?

Dr. O'NEILL. Yes. That figure is for the HI program.

The CHAIRMAN. For the HI program. That is the short-term fix. That is what we have to do over the next 7 years to have just a 10-year solvency test.

Dr. O'NEILL. To meet the test of adequacy—that is right.

The CHAIRMAN. Yes. Of adequacy. Test of adequacy for 10 years; not for 25 years, just for 10.

Dr. O'NEILL. The reason, incidentally, for the difference between our figure and that of the Health Care Financing Administration

(HCFA) is that we have a somewhat different baseline. The HCFA growth rate is slightly lower, but both estimates are in the same ball park.

The CHAIRMAN. Well, but that is why I say I would regard your testimony, Dr. Steuerle's testimony, and others that we have had, as all within roughly the same range, $147 billion versus $165 billion over the next few years is not a mega difference in estimates, and all pointing to the same thing. So we are $150 billion short versus $165 billion short; if we do not do anything, both of them lead to the train wreck.

In the President's budget proposal this year, did he have any proposals of any significance or consequence that would have solved this short-term problem?

Dr. O'NEILL. Small changes were proposed. Including those changes, the trust fund would still become insolvent in the year 2002.

The CHAIRMAN. His proposals do not even save it for an additional year.

Dr. O'NEILL. That seems to be the case.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. Well, that is a good place to start. I was reading the Contract for American with regard to what they propose for Medicare. As I understand it, they propose to cut the increase that we provided the Medicare Trust Fund in the Reconciliation Bill last year.

The CHAIRMAN. To reduce the rate of growth.

Senator BREAUX. Do you understand what they were proposing with regard to Medicare?

Dr. O'NEILL. I do not know the specifics of what was proposed.

Senator BREAUX. In their tax cut.

Dr. O'NEILL. Oh, in the tax cut.

Senator BREAUX. Yes.

The CHAIRMAN. Now, I am confused about the question.

Senator BREAUX. The House, in their Contract for America, called for repealing what we did in the Budget Reconciliation bill, where we increased the amount of Social Security Retirement funds that would be counted as income that the wealthiest people in this country would have to pay taxes on and that money was put into the Medicare trust fund to try and help it out.

Would you comment on that for me?

Dr. O'NEILL. That is the tax that Social Security recipients pay. It increases the tax on their income.

Senator BREAUX. What did we do with that?

Dr. O'NEILL. That amounts to——

Senator BREAUX. $27 billion.

Dr. O'NEILL. We have taken that into account. The tax now is bringing in about $3 billion a year; it goes up to about $7 billion a year.

Senator BREAUX. It's $27 billion.

Dr. O'NEILL. That tax increase, I think, buys you about a year in terms of solvency.

Senator BREAUX. It's $27 billion over 7 years, is it not?

Dr. O'NEILL. Not having it loses you——

The CHAIRMAN. Loses about a year.

Dr. O'NEILL. Right, Senator.

Senator BREAUX. It is $27 billion over the 7-year period, is it not?

Dr. O'NEILL. No.

[The following was subsequently supplied for the record:]

The additional tax on Social Security benefits that was enacted in the Omnibus Budget Reconciliation Act of 1993 is currently bringing in about $2 billion. That amount will rise to about $7 billion in 2002. The tax will bring in about $37 billion over the 1996–2002 period.

Senator BREAUX. All right. So their proposal is to take that amount of money out of the Medicare trust fund, is it not?

Dr. O'NEILL. Yes; that is right.

Senator BREAUX. Does that help the trust fund, or hurt it?

Dr. O'NEILL. Well, obviously, if you are removing a source of funds from the trust fund, as I initially said, you lose a year of solvency. The trust fund would become insolvent a year earlier than otherwise would be the case.

Senator BREAUX. Is there any other proposal in the contract that affects Social Security that you are aware of?

Dr. O'NEILL. To tell you the truth, I cannot recall whether there is. But I would be happy to provide that information in writing.

Senator BREAUX. It is a real simple thing to provide, since there is nothing in there that does it.

[The following was subsequently supplied for the record:]

In addition to repealing the tax increase on Social Security benefits that was part of the Omnibus Budget Reconciliation Act of 1993, the Contract with America proposed to raise the earnings limit threshold for Social Security. Under the bill passed by the House, the limit on exempt earnings would be raised to $30,000 by the year 2000.

Senator BREAUX. The only thing in the Contract for America that deals with Social Security was a tax proposal which hurts Medicare by reducing by $27 billion the amount of money that is going into the Medicare trust fund.

I notice that the Chairman's budget mark calls for a 7-year reduction in Medicare. I think it is $256 billion. In order to reduce Medicare by $256 billion over 7 years, or $141 billion over 5 years, do you have any idea what would have to be done to Medicare to do that?

Dr. O'NEILL. Well, over the 7-year period, that would be a reduction in what is projected for Medicare expenditures of about 15 percent. That reduction would be in the total program—in HI and SMI combined.

Senator BREAUX. I am trying to figure out what the figure of $256 billion in cuts in Medicare over 7 years would mean from two perspectives: number one, the type of cuts you would have to have in the program to reach that number; and second, is that more than you would have to cut in order to help solve the problem of not having enough money for the current programs?

Dr. O'NEILL. It is difficult to answer those questions because we do not know how much of the proposed cut would be in HI as opposed to a cut in——

Senator BREAUX. What is the shortfall in Medicare over the next 7 years, approximately?

Dr. O'NEILL. To remain solvent, the HI trust fund would need $165 billion, according to CBO's numbers.

Senator BREAUX. $165?

Dr. O'NEILL. Billion. Right. It is hard to tell, out of that $256 billion, how much would be cut from the HI portion and how much from the SMI program. We have not seen the details of a specific proposal, so I cannot really answer that question.

Senator BREAUX. Is this cut more than you need to bring it into solvency, or less?

Dr. O'NEILL. I cannot tell you. I do not know how the cut is allocated between the SMI and HI programs. The SMI program is growing quite rapidly; it is growing more rapidly than the HI program, but the cut is to be applied to the two of them combined.

Senator BREAUX. Just combine the two. If you had to combine the two, how much is needed to make them both solvent over the next 7 years?

Dr. O'NEILL. Well, the SMI portion of Medicare does not have a trust fund in the same sense that the HI program does.

Senator BREAUX. So you cannot answer that question.

Dr. O'NEILL. The SMI program is funded, essentially, by general revenues.

Senator BREAUX. You see, the number we have is $256 billion reduction in Medicare over the next 7 years. I am trying to figure out, is that more than we need?

Dr. O'NEILL. If all of that reduction was applied to the HI program, it would be more than what was needed for solvency, but the cut applies to both programs. And SMI is a very big program. I cannot tell you how the reduction would be split between the two programs because we have not been told. Once details emerge, it is really this committee that would be, I believe——

Senator BREAUX. I am supposed to vote on this on Monday; I have not seen the details either.

Dr. O'NEILL. You can get some idea of the kinds of cuts that could be put together to get you to that number from CBO's deficit reduction book, which contains many suggestions for possible short-run changes that can be made. By combining options from that volume, you can get totals that go up to more than $256 billion. There are different permutations and combinations of those approaches that we have worked with in doing work for various committees.

Senator BREAUX. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Is that big hospital, John, that Huey Long built still in existence?

Senator BREAUX. Yes.

The CHAIRMAN. Is it?

Senator BREAUX. Yes.

The CHAIRMAN. Does it get a lot of Medicare money?

Senator BREAUX. They are all going broke.

The CHAIRMAN. Senator Simpson.

Senator SIMPSON. All going broke. That is where Medicare is going, but we do not seem to pay a bit of attention. Now, we are going to go into the most extraordinary 6 months that this body has ever been in, because there will be those babbling on the other side—I do not mean the other side of the aisle, the other side of the issue—that we did not need a Balanced Budget Amendment because we would do this all by ourselves.

Now the poison is laying there. The House has laid the poison and the Senate has laid the poison. You are going to find a lot of Republicans on our side who go right into it and do it, regardless of the political consequences, while others—none in this room—have said, just give us a chance to do that with a lot of good, tough votes. That is the greatest laugh of the century, that we need good, tough votes. I agree totally with Senator Breaux; I think it was a serious mistake, and is a serious mistake, to expose now only 50 percent of Social Security benefits to tax.

You will hear guys say, well, I cannot stand a 50 percent tax on Social Security. We said, you are not getting a 50 percent tax, you are exposing 50 percent of your Social Security benefits to tax if you are up there in the heavy-hitter bracket, and your tax is probably 12–17 percent, or somewhere down in there.

That was a mistake, because it is going to come directly out of the trust fund. We raised that percentage to 85 percent. Eighty-five percent of a person's Social Security income was to be taxed and the proceeds were to go to the Health Insurance fund. I do not understand that, but it will not be the first part.

But I can tell you one thing I do understand. I understand the definition of the word "cut." When Medicare, in the eyes of the AARP, a lovely group of people, bound together, as I have said, with a common love of airline discounts, and auto discounts, and pharmacy discounts, who really must not care a whit about their grandchildren. That is the best I can figure. At least, I have asked them. They kind of smile and do not seem to indicate that they care about their grandchildren.

So here we are with this situation, where people who have worked the issue are saying, we cannot allow Medicare to grow at 10.5 percent per year, or 12 percent, or it will implode. So we are going to say, we are going to let it go up 7.2 percent a year for the next 7 years. And if the people in America cannot understand that, they deserve exactly what they are going to get. 7.2 percent per year we are going to allow Medicare to go up, under this savage, savage budget and there is not a cut in the car load, we are reducing, and if we do not the evidence is clear.

The evidence is not coming from some vapors left over from the Reagan Administration, or someone else, the vapors are coming from the trustees of the Social Security program who are Donna Shalala, Robert Rubin, Robert Reisch, and two public citizens, one Republican and one Democrat, telling us that Social Security's Medicare insurance fund will be broke in the year 2002, that Disability Insurance will be broke in the year 2016, and that Social Security itself will be broke in the year 2031 and head in its swandive decline in the year 2013. That is not a cut.

I would like you to define to me what you see must be done if we do not do one of two things. We either increase the payroll taxes, and that will not hit the aged very hard, it will hit the young that people always talk about around this place.

Who do you think pays the payroll tax if we raise it? The young, the people who will get nothing out of Social Security; the people, still smiling as they are paying more in Social Security than they are paying in income tax.

So if we do neither; increase the payroll tax or cut the benefit, where the seniors will be swamped over the steps out here if we were to cut the benefit 10 percent, 20 percent, 30 percent, where do we go?

Dr. O'NEILL. I am sorry. Would you repeat the specific question?

Senator SIMPSON. If we do not raise the payroll tax or reduce the benefit on the other end, where do we go to do something about a system that is swallowing itself at an increase of 10.5–12 percent per year without restriction?

Dr. O'NEILL. As I said in my remarks, it is important to do something to improve the efficiency of the program. In cutting Medicare, you are not cutting a program in which every dollar spent is really leading to desired results.

Medicare is not like other kinds of insurance situations in which people are making the choices themselves. In the private sector when you choose a health plan, you choose it because you think you are going to get more for your dollars than you would in another plan.

But the average Medicare beneficiary is not in that situation. Medicare is a very old-fashioned kind of plan that almost nobody else has. It is a more or less unlimited entitlement, and similar to what at one time, I guess, was more the mode of all private fee-for-service health insurance. But in the case of Medicare, there is very little link between the actual services that beneficiaries receive and spending that any beneficiary sees. That leads to a basic problem that affects providers as well.

Providers are certainly not evil in any way, or even greedy. But if they see that the government is the payer and a person comes in with a problem, in a system without limits, providers do not perceive any restrictions on what they should do to help that person.

As a result, you get growth in expenditures because nobody is really asking, is the next dollar spent going to get something we really want, or would we prefer to have that dollar spent in some other way?

Senator SIMPSON. Mr. Chairman, I thank you. I have to go Chair a hearing on the Veteran's Affairs Committee. So, be sure to release Senator Rockefeller soon so he can come over and labor with me as my Ranking Member.

But, Mr. Chairman, in lieu of my absence, would you leave a little question with all of the witnesses and say, what is best, taking a little cut off of people now, or taking the whole thing in 2022.

Thank you very much. Good day.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Dr. O'Neill, I do not know where to start here. About half of the hospitals in West Virginia are small and they are rural. They have a large number of Medicare patients. We are talking here about what happens to the health insurance trust fund.

We are talking about budgets, but we are also talking about people, about hospitals and communities—that is called jobs—health care, rural States, big cities.

I think six or eight emergency rooms have closed down in the City of Chicago in the last 3 or 4 years; only two remain. There

is a lot at stake here. Budget is part of it, people are part of it. There is a lot of drama involved.

Now, about half of our hospitals, as I indicated, are rural. Most of them will average between 68–75 percent of their costs being paid for directly by either Medicare or Medicaid. Then there will be an average of another five percent of uncompensated care, and then the rest will be private pay.

Necessarily, I think it is fair for me to ask you, what would be the economic consequences, which, in turn, have budget consequences, if we made $256 billion in cuts over 7 years? What do you think would happen to these hospitals?

Dr. O'NEILL. Without knowing the actual composition of the cuts, it is really impossible to answer that question. For example, you bring up the issue of rural areas. Well, rural areas have always been a problem within our entire medical structure——

Senator ROCKEFELLER. It has been a problem?

Dr. O'NEILL [continuing]. In terms of providing adequate care. It is difficult to provide adequate care in rural areas, simply because of the sparseness of the population. The contribution of rural areas to overall costs is low because the populations are really not large in total. I think that exemptions have been made for rural areas. So, I really could not speak to that issue without——

Senator ROCKEFELLER. But I can.

Dr. O'NEILL [continuing]. Knowing exactly what the cuts were, what the suggested changes were.

Senator ROCKEFELLER. Yes.

Dr. O'NEILL. For example, if we were to phase in a major restructuring, that might very well start with only large urban centers. Suppose somebody was actually to try one of these competitive approaches in which you have a defined benefit and put Medicare beneficiaries in a similar mode.

Senator ROCKEFELLER. You have the right to answer questions; I also have the right to ask questions. So far, you are outdoing me.

Dr. O'NEILL. I am sorry.

Senator ROCKEFELLER. Sooner or later, this Congress is going to discover that graduate medical education is paid for 50 percent by Medicare. Then you talked about, we will make the cut in the large urban hospitals.

Many of those are teaching hospitals. Last year, we graduated about 18,000 medical students and that was 50 percent paid for by Medicare, and we took in 6,000 foreign medical school graduates. Would we stop taking in foreign medical school graduates?

Dr. O'NEILL. There is no way I can answer that question because I do not know what the proposals on the table would be. CBO, as you know, can make suggestions and offer options, but we do not make any of those choices.

Senator ROCKEFELLER. It is a possibility, though, is it not?

Dr. O'NEILL. Anything is a possibility.

Senator ROCKEFELLER. Yes.

Dr. O'NEILL. It is really up to this committee to decide, to make those awful decisions. I am glad I am not you.

Senator ROCKEFELLER. Your predecessor, Dr. Reischauer, said earlier this year what would happen if the Medicaid program was capped. He said that, under a Medicaid cap, three things would

happen: States would be forced to pick up the extra cost, it would come out of the skins of the providers, or beneficiaries would get fewer benefits.

Do you agree with his assessment?

Dr. O'NEILL. Anything that reduces the rate of growth of expenditures has to affect providers. When we had a winding down of expenditures in defense, people who worked in the defense industry had to make radical changes in their lives, and it was unpleasant.

The same thing is bound to be true for the providers of medical services. Of course, when we are talking about 7 years down the road, there is time for people to change what they were going to do—for example, not go to medical school if they were planning to, things of that sort.

Senator ROCKEFELLER. It was a quality question, though.

Dr. O'NEILL. A structural change. Yes.

Senator ROCKEFELLER. Yes. I talked to a physician the other day in Morgantown, West Virginia, who is a family physician, who said that he was seeing 65 patients a day in order to keep his income level—for family doctors that is not very high in West Virginia—at the same level that he had before cuts.

Reimbursement cuts had already affected his life so that he was doing 65 patients a day to keep up with his income compared to the 35 or 40 he had been doing before. I really questioned him. I said, does not quality, does not time, the investigating, the probing that family doctors have to do, get compromised? He said, yes, it does.

So, that is a concern, quality, rural hospitals, closings. You talk about bases being closed, you talk about hospitals being closed. There is a human equation, long-term and short-term, to all of this, which is, I think, quite dramatic, do you not think?

Dr. O'NEILL. It is always true that there are costs. As they say, no pain, no gain. It is certainly true, and it applies in this case.

Senator ROCKEFELLER. No pain, no gain. Yes. All right.

Mr. Chairman, I apologize. I did not hear the bell. One of my hearing aids must not have been working.

Dr. O'NEILL. There are pluses and minuses, is what I was trying to say.

The CHAIRMAN. Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman. I would like to explore some areas in which the Medicare cuts might be affected. It has been stated that the principle source of increase in Medicare has been in the increase in the volume and intensity of utilization, that is, as distinguished from the number of persons being served or the price of individual services rendered, that it is the volume and intensity of the services consumed which has been the greatest contributor to the increase in Medicare costs. Does that comply with your assessment?

Dr. O'NEILL. Beneficiary growth has contributed a little to the increase, but the major factor has been the volume and intensity of services, as you say. That same pattern is certainly going to be maintained over the next decade when beneficiary growth is going to be unusually low.

Senator GRAHAM. If that is the case, what would be your recommendations as to steps that could be taken that would most ef-

fectively deal with the issue of volume and intensity of services rendered, minimizing the adverse effects in terms of the necessary medical services and health of the beneficiaries?

Dr. O'NEILL. There are a number of possibilities. One would be to impose higher deductibles and coinsurance within the current Medicare system—that is, in both Part A and Part B. That would be one possible way.

Another would be to try and do something so that Medicare——

Senator GRAHAM. But do you think that suggestion would actually reduce the volume and intensity, or shift the cost of the volume and intensity?

Dr. O'NEILL. Studies have shown that higher deductibles and coinsurance make people more cost conscious and encourage providers, who know that patients are going to bear more of the costs, to think more carefully about what they recommend. So increasing deductibles and coinsurance would, in principle, lead to more cost-consciousness.

Another approach would be, as I mentioned, to increase enrollment of Medicare beneficiaries in HMOs. The private sector has used HMOs—that is, managed care—as the way to provide care more efficiently, and we know there is some oversight over a person's total health care.

I think that in many cases, managed care offers an improvement in the quality of care for the same price, or a lower price for the same quality of care. Obviously, the private sector sees advantages in this approach because people have been rapidly moving into managed care arrangements.

This has not happened in Medicare for a number of reasons. Because of the way the program is structured, even if Medicare beneficiaries were to move more rapidly into HMOs, there would be no benefit to the Medicare program. The reimbursement to an HMO for a beneficiary's care is pegged at 95 percent of the fee-for-service amount within the county in which the HMO is located. So there is really no way for the Medicare program to capture savings from managed care. An HMO's costs are significantly lower than the 95 percent, that is known. In part, they are lower because of the managed care approach, and in part they are lower because those beneficiaries who tend to choose HMOs are the younger, and presumably healthier, people within the Medicare population.

Senator ROCKEFELLER. And costs Medicare, therefore, more money.

Dr. O'NEILL. When the healthier people in the Medicare population choose HMO's, it leads to adverse selection, which has the perverse effect of driving up the costs in the fee-for-service sector. Since the reimbursement rates for HMOs are pegged at 95 percent of the average fee-for-service amounts higher reimbursements for HMOs result.

When HMO's have been pressed by HCFA to give back some of their excess reimbursement, they typically give it back in the form of a better benefit package. Nevertheless, the current system is a good deal for participating HMOs.

Senator GRAHAM. Could I ask a couple of questions about the use of managed care? The 95 percent is not a statutory requirement;

it is not something that is Biblical. We do not have to stay with that particular form of reimbursement, do we?

Dr. O'NEILL. I am not sure that the rate is legislated, but it is imbedded in the program. Somebody at some point thought that that was about the difference between HMO and fee-for-service costs, but they concluded incorrectly——

Senator GRAHAM. But we are not wedded to that irrationality forever, are we?

Dr. O'NEILL. No, it could be changed. If the 95 percent rate is legislated, it is certainly something that could be changed.

Senator GRAHAM. Is there an example, a role model, of managed care for an elderly population that you think we might look to to gain some wisdom as to, what are the practical necessities for making that a more utilized option for the Medicare population?

Dr. O'NEILL. Although the level of participation in HMOs among the Medicare population is still very low—only 7 percent in the true HMOs—it has been growing very rapidly. So I think providers themselves have been figuring out ways to appeal to the elderly population.

Now, the problem is that Medicare beneficiaries do not see any difference in the cost to them, whether they enroll in an HMO or use the fee-for-service sector. They get more services in an HMO, so in that way they are getting more for their money. But their decision to enroll is not based, as it would be for other people who are purchasing insurance in the private market, on a difference in the cost of a premium.

So one way to restructure Medicare in the long run is to move the program to more of a defined contribution basis.

Currently, the expenditures per Medicare beneficiary are about $5,000 per year.

Let us say that that sum was applied toward a plan of your choice that fulfilled certain requirements, and you could choose among an HMO package, or more than one HMO package, and some kind of fee-for-service plan. Then the beneficiaries would evaluate the plans. They would be able to see the true costs of the various plans—because the total costs would be more than the government contribution—and they would make a choice based on the true costs of the services they would be receiving.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. Thank you, Mr. Chairman, for letting me ask another question.

Dr. O'Neill, I am trying to find some information because I am going to have to vote next week, in all probability, on the budget that has come out of the Senate Budget Committee. The House is voting on that budget today.

My question to you, as head of the Congressional Budget Office, whom I have to turn to to answer these questions, is pretty simple. It may not have a simple answer, but the question is very simple, and I, as a member of Congress, I think, need to know the answer in order to justify how I vote.

The House budget proposes $282.3 billion in cuts in Medicare over the next 7 years. The Senate Budget Committee proposes $256 billion of cuts in Medicare over the next 7 years.

Now, my question to you, as head of CBO, is, how much more, if any, does that cut reflect than is needed to take care of the Medicare system?

You have told me this morning that you cannot answer that because you do not know how that cut is applied under the HI program or the SMI program, hospitals versus doctors.

Now, my question to you, knowing that you cannot answer the question because you do not have all the facts, is this: what facts do you need to know in order to be able to answer that question, and can you get the answer to that question before I, as a member of the Senate, have to vote next Monday?

Dr. O'NEILL. I admit that it is really a tricky process now. It is sort of which comes first, the chicken or the egg.

Senator BREAUX. A tricky process. I cannot vote on tricks.

Dr. O'NEILL. No.

Senator BREAUX. And if you think it is a tricky process, I think that is pretty frightening to me as a person who has to vote on what you have just labeled a "tricky process."

Dr. O'NEILL. I did not mean in terms of a deceitful process. What I mean is the order in which things come—that you have to vote on the budget without knowing the details. Then again, when the spending committees do their work, they have to know what their budget allocation is. So you have to envision some kind of package that would be acceptable and still make that kind of a cut in spending growth. It is difficult.

Senator BREAUX. Now, the answer to my question is what?

Dr. O'NEILL. I cannot literally answer the question. I cannot tell you.

Senator BREAUX. I know that. I got that message pretty clearly. My question to you at this point is, what do you need to know which will enable you to answer that question so that I can receive a response, and my colleagues, so that we can make an informed decision on whether we are voting for more Medicare cuts than is needed to take care of the Medicare system, or is this the right number that is needed.

Dr. O'NEILL. What you need to know is how much of the cut would apply to the HI program. Just that, really—how much of it is for HI.

Senator BREAUX. All right. Let me try this question then. How much is needed to ensure, over the period, that the HI system would be in good shape, and how much is needed to ensure that the SMI system would be in good shape?

And I would assume that if you add those two up and it is more than $256 billion, well, then this is not enough of a cut. If, in fact, it is less than that, then this is too much of a cut and there is some money out there that is out there for some other purpose.

Dr. O'NEILL. One hundred sixty-five billion dollars is needed to meet the trustees' definition of solvency for the HI trust fund.

Senator BREAUX. $165 billion.

Dr. O'NEILL. Yes.

Senator BREAUX. And the cut we have proposed by the House is $282 billion, and the cut proposed by the Senate Budget Committee is $256 billion, and the trustees tell us we need $165 billion. Where is the rest of the money?

Dr. O'NEILL. That would come from the SMI program. The SMI program is funded by premiums and by general revenues.

Senator BREAUX. But your statement is that they need $165 billion for HI.

Dr. O'NEILL. Just for the HI trust fund.

Senator BREAUX. For HI. And this is $282 billion in the House, and $256 billion in the Senate. So, boy, we must be putting a heck of a lot of money in SMI.

Dr. O'NEILL. SMI is projected to grow by more than 11 percent a year over the next 7 years.

Senator BREAUX. All right. Is it possible for you and your office there, all the Congressional Budget analysts people that are there, top-notch professionals, can you find for me and this committee the answer, get the information you need as to how much is allocated to HI, and how much is allocated to SMI, to be able to give me an answer so that I can make an informed decision by the time we have to vote on the budget this coming week?

Dr. O'NEILL. I do not know whether the budget committees have really separated out the amounts for the two programs. The information that I have does not say what the exact proposals would be. That information may be available, but it has not been made available publicly.

Senator BREAUX. Is there any way I can vote on that and know the answer to that?

The CHAIRMAN. I can give you, partially, an answer.

Senator BREAUX. All right.

The CHAIRMAN. You have got the $165 billion for HI that is needed, or everybody is pretty close to that assessment. On Part B, it is really hard to say bankrupt or not bankrupt because it is kind of an open-ended entitlement and we pay a percentage of the money out of the general funds to make sure that there is the money there. It is a trust fund, but it is open-ended as to what we pay.

At the moment, beneficiaries are paying about 31 percent of the premiums, we are paying about 69 percent. As I recall, Dr. O'Neill, that is $40–50 billion a year that we are paying on the Part B side.

This is not a cut, by anybody's definition. Initially, the Part B premium was to be 50 percent beneficiary, 50 percent government. That gradually fell down to 25 percent over the years, and it is our failing at not keeping it at 50 percent.

Several years ago we set a dollar figure on Part B, thinking that was 25 percent. We did not say 25 percent, we said a dollar figure. The dollar figure turned out to be 31 percent, and that is what beneficiaries are paying now. That percentage is due to fall to 25 if we do not do anything.

If we do nothing but extend the current law on Part B, that raises $61 billion, just extending where we are now. Not raising it to 35 percent, or 40 percent, or 45 percent, just keeping it where it is at 31 percent.

So if you take the $165 billion on Part A and you add the $61 billion by just keeping the law where it is on Part B, why then you are approaching within $20 billion, as I recall, of what Senator Domenici is suggesting in the Medicare figure.

Senator BREAUX. About $30 billion.

The CHAIRMAN. All right.
Senator BREAUX. $30 billion, right on the nose.
The CHAIRMAN. All right.
Senator BREAUX. Thank you.
The CHAIRMAN. Senator Rockefeller.
Senator ROCKEFELLER. Thank you, Mr. Chairman.

Again, on the theory that, if we are arguing about the word "cuts" and budget problems, this country has a lot of problems. Oklahoma City had some problems. There are those who think that when you cut so deeply into programs that affect urban areas, or whatever, that you create racial tensions which could explode with devastating, not just human consequences, but, less importantly, economic consequences for revenues which have to do with what you worry about.

So that only talking about a budget, whether it is a cut or not, I think, is sort of amoral, because you have to look at the consequence of what you are doing. Whether or not you consider it a cut or whether you just consider it a reduction in the rate of growth, if it has a human consequence, it seems to me that a representative of the people has a right to talk about something like that and that you have a right to worry about something like that, even if it is only on a personal basis.

CBO projected that Medicare spending will increase by 10 percent over the next 5 years.

Dr. O'NEILL. It will increase 10 percent a year.

Senator ROCKEFELLER. Yes. 10 percent a year over the next 5 years. And that is based upon medical technology and enrollment growth. You are not going to stop either of those, are you, with a budget cut?

Dr. O'NEILL. Enrollment growth is projected to be slow over the next 5 years.

Senator ROCKEFELLER. I mean, you are not going to stop medical technology and innovation. A budget cut does not stop that, that just keeps going on. I mean, believe me, it just does.

Dr. O'NEILL. That is true. But how it is used is affected by behavior.

Senator ROCKEFELLER. But I am just telling you, there is a long history of people saying that people will change their habits so they do not have to use all of the new medical technology. Not true. People use new medical technology. That is part of the 10 percent. Enrollment growth is part of the 10 percent. Can you stop that with budget cuts?

Dr. O'NEILL. You are not going to stop technology, but you can encourage the prudent use of what is out there.

Senator ROCKEFELLER. I am on the second point, now. I am on enrollment growth.

Dr. O'NEILL. Enrollment growth is slow. That is a minor contributor to what is happening.

Senator ROCKEFELLER. It is a contributor, though, is it not?

Dr. O'NEILL. It is actually the lull before the storm. The next 10 years is a period of low beneficiary growth. When you get to the year 2010, however, growth is going to be more than double the rate it is now.

Senator ROCKEFELLER. So you cannot stop that. You cannot say, well, let us take in only 50 percent of that enrollment growth. I mean, when people get to Medicare, they get to Medicare. That is going to be true now, it is going to be true 10 years from now. So you cannot stop that.

Dr. O'NEILL. Right.

Senator ROCKEFELLER. You cannot stop the general health inflation, which usually is two or three times the rate of health care.

Dr. O'NEILL. That need not be the case. In the private sector——

Senator ROCKEFELLER. Well, yes, you can, actually, if you do comprehensive health care reform.

Dr. O'NEILL. A slowdown in the rate of growth has happened in the private sector by itself. There have been dramatic changes going on since 1990 in the private sector, so the rate of growth in private spending——

Senator ROCKEFELLER. Since 1994.

Dr. O'NEILL. Actually, the dates I am referring to are 1990 through 1993.

Senator ROCKEFELLER. Well, let me just try to simplify that. If you have technology growth, enrollment growth, health inflation—and you can argue how big a factor they are, but they are factors, substantial factors—do you think that beneficiaries will be getting the same quality of health care services that they are today if you have a 7 percent cap on Medicare?

Dr. O'NEILL. That is hard to say because, in part, people may still be obtaining services of a similar quality. They may be paying more for them, but they could certainly be obtaining ones of similar quality.

Senator ROCKEFELLER. So probably under Medicaid——

Dr. O'NEILL. I think that most people who are working on various kinds of restructuring for Medicare see a considerable amount of inefficiency in the system.

It is not that quality has not improved; if you spend a great deal, here is probably going to be an improvement in quality. But we have not really gotten the quality per dollar spent that might have been achieved if Medicare had been a more efficient program.

Senator ROCKEFELLER. Dr. O'Neill, in trying to listen through your words, I do not think I detected the answer, no, there will not be a decrease in quality.

Dr. O'NEILL. As I said, I cannot answer that question. It is possible that the elderly population will——

Senator ROCKEFELLER. By paying higher premiums.

Dr. O'NEILL [continuing]. Spend more. They will pay more for services.

Senator ROCKEFELLER. Yes.

Dr. O'NEILL. The services provided by the government within this amount are not likely to be of the same level of quality as what is provided today.

Senator ROCKEFELLER. All right. Now, let us suppose they go to vouchers, which has been suggested by some of those on the other side of the aisle. That would let seniors buy private insurance. Now, Medicare is about two percent administrative costs, right?

Dr. O'NEILL. Yes.

Senator ROCKEFELLER. Pretty efficient, administrative-wise.

Dr. O'NEILL. They do not have any marketing costs for the plan——

Senator ROCKEFELLER. I know. I know.

Dr. O'NEILL [continuing]. That is true.

Senator ROCKEFELLER. I know. I know.

Now, people get vouchers. Of course, one of the reasons we did Medicare in the first place was because the private insurance market was such an absolute disaster.

Now, you give somebody a voucher, you give an 84-year-old woman a voucher and say, you just head right on out there to that private market.

That is a pretty terrible thing to do to an individual, to put him or her up against the private insurance market. What is the average today of the administrative overhead cost of a private insurance policy? And then I will not say another word.

Dr. O'NEILL. I do not know the answer to that question, but I would be happy to provide it in writing.

Senator ROCKEFELLER. But you would agree it would range between 25 and 40 percent.

Dr. O'NEILL. I do not know, because it depends on what is included in administrative overhead costs. There are HMOs in the private sector that certainly come in at low rates. So I do not know.

[The following was subsequently supplied for the record:]

Administrative costs for private health insurance plans range from 5 percent to 40 percent of premiums, depending on the size of the covered population. Administrative costs for health maintenance organizations average about 11 percent.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Moseley-Braun.

Senator MOSELEY-BRAUN. Thank you very much, Mr. Chairman.

Dr. O'Neill, I have a question. In your testimony you advocated several approaches to reduce the growth in Medicare. The Budget Committee, just yesterday, suggested that we come up with some $256 billion in cuts over the next 7 years. They say they are going to set up a commission, or there will be a commission that will come up with the magic answers in a couple of months. Your testimony seems to suggest that that is overly optimistic.

I would like to pick up where Senator Rockefeller left off. That is, the whole notion of the relationship between the major restructuring in health care generally and its relationship or its interaction with the restructuring and savings that we are trying to accomplish with regard to the Medicare system.

It kind of becomes a chicken and an egg question, which comes first? Can you really expect to affect major savings in Medicare in the absence of health care reform for the system as a whole? I would like your specific response, do you believe that we can restructure Medicare and exact $250 billion in savings in the context of our failure to address health care reform generally?

Dr. O'NEILL. The Medicare program itself is a very large program. If nothing is done, the rate of growth in its expenditures will be very large. That growth is not only a problem for the trust fund; it is a problem in terms of general resource allocation in the economy. The private health insurance sector, as I mentioned, has been dramatically restructuring itself so that the rate of increase in private spending has slowed to 7.7 percent. That seems to be not

merely a passing dip in the rate but a reflection of actual things that are going on.

Every day when you open the paper you can read more about the really dramatic restructuring that is going on in the private sector. That restructuring has led to the closing of hospitals, for instance, and many other changes in the private health sector that are, I am sure, painful—for the providers, for people who run hospitals that are facing closing, for specialists whose services are not needed or who will not receive the same reimbursement as they used to because managed care does not use them as much as is the case under fee-for-service plans.

So the private sector seems to have managed to reduce its rate of growth. Medicare is now the outlier. Its spending is growing at a much more rapid rate than that of the private sector. So it does not seem as though things that are going on in the private sector are causing the increase in growth in Medicare. The private sector is doing a lot better than Medicare.

Another issue that is sometimes raised is the cost-shifting issue—that if Medicare tightens the reins, costs will be shifted onto the private sector.

During the 1980's, that would have been true, but the private sector is now much more organized. There are now many large insurance providers who are not going to have costs shifted onto them.

Senator ROCKEFELLER. Would the Senator from Illinois yield?

Senator MOSELEY-BRAUN. Absolutely.

Senator ROCKEFELLER. I am just sitting here going quietly berserk. I mean, what the good Doctor is getting away with is absolutely unbelievable. I mean, this cost saving. Nobody testifies that managed care saves money for more than a year, year and a half, or, if you are really lucky, 2 years, number one.

Second, the cost savings are obviously because of what went on over the last 2 years. Maybe they will continue, and we hope they do. But to sort of make this as a prognosis for the future is absolutely irresponsible, Dr. O'Neill, and you certainly ought to know that.

Dr. O'NEILL. As far as we can tell, the rate of growth of spending in the private health insurance sector has slowed. Whether it stays literally at the 7.7 percent mark or comes up a bit, which is certainly possible, it still looks to us——

Senator ROCKEFELLER. But that is important to say.

Dr. O'NEILL [continuing]. As if the rates are not going to go back to the 11 percent or 12 percent a year growth rates that were true of the past.

Senator MOSELEY-BRAUN. Doctor, in fact, I have a chart here from the Health Care Financing Administration and their actuarial numbers, which indicate that the annual percentage increase in expenditures projected past 1995 are not that different, which would seem to underscore and support Senator Rockefeller's reading of the difference. But I kind of lost a little bit of my time. Mr. Chairman, if I could just ask the last question.

The CHAIRMAN. We will take it out of Senator Rockefeller's on the next round.

Senator MOSELEY-BRAUN. The point is, Medicare specifically addresses the health needs of the population that has been least impacted by changes in the private sector, that is to say, the elderly and the very ill. These are the Medicare patient populations. The demographics that affect those populations have not changed that much or been affected that much by changes in the private sector. You used the term that Medicare is the outlier. That is almost ironic, under the circumstances.

We are faced with a situation in which government is addressing the health needs of the elderly and the sickest Americans, while the private sector is kind of going off and, if you will, skimming the cream of the crop, as it were, in terms of the costs of health care.

Certainly the lower cost patient populations are being dealt with by the private sector. We are still left with an obligation to the elderly, to seniors, and to the very ill. That suggests a dynamic that is not going to show any real decreases in cost.

So, I come back to my first question to you, which was, how do we just lop away at Medicare and not deal with health care reform in the generic sense for the entire system?

Dr. O'NEILL. Again, the answer, I think, is that the private sector appears to be reforming itself along many of the lines that have been suggested for Medicare because there has been a considerable infusion of competition into the private health insurance sector. At one time, the only insurer, really, was Blue Cross, which got its start in the 1930's.

Hospitals promoted the development of Blue Cross so that they could get their bills paid, and Blue Cross got a discount at those hospitals. But for many years, the private insurance market was essentially composed of Blue Cross, and then later, when we started getting comprehensive plans, Blue Cross/Blue Shield.

It took a long time before there was very much competition at all, but in the past decade or so, many large insurers have entered the market, providing different modes of insurance that were not available before.

The HMO form of health insurance has been around for awhile, but its modern versions display many different modes of providing health care and health insurance. The private sector has been quite dynamic and creative in seeking solutions.

A lot of that dynamism was probably precipitated by rising costs. When everybody was in a fee-for-service plan, there were no questions asked, especially with workers getting a discount through the tax system for their health insurance. But once costs started rising very rapidly, employers and workers began taking a hard look at what they were getting.

The private sector seems to have found—and one hopes that this situation lasts—a way to reduce the rate of growth of health expenditures by choice, without being forced to do so. The Medicare system is really an anachronism. It is an uncapped entitlement. People see something like a blank check.

Senator MOSELEY-BRAUN. But, Doctor, just in conclusion, the private sector has the choice not to take the elderly and the very sick; Medicare does not have that choice.

Dr. O'NEILL. Many of the same efficiencies that have helped the private sector would be possible for Medicare, but obviously, ex-

penditures will always be larger for the elderly than for the younger population. Under any of the projected growth rates, expenditures per beneficiary would remain considerably higher for elderly people than they are for the younger population. Nobody is proposing that the amount spent for the elderly go below what a young, healthy population spends.

The CHAIRMAN. Senator Hatch and Senator D'Amato, do you want to ask questions?

Senator HATCH. I think that would be a good idea. Welcome. We are so happy to have you here. Congratulations on being appointed the head of CBO. We appreciate having you work with us. I have read your written statement; it is an excellent statement.

Dr. O'NEILL. Thank you.

Senator HATCH. You have taken a very complex program and a complex series of problems, and have laid out an explanation that is very concise and understandable, so I am pleased at your presentation.

I just have a few general questions that are designed to help us understand some of the trends in Medicare spending.

You state on page five that "Medicare expenditures increased at an average annual rate of 9.6 percent between 1985 and 1994," and that "Medicare spending will continue to grow at a similar rate, rising from $181 billion in 1995, to $463 billion in the year 2005, just 10 years away."

Now, it is almost incomprehensible that this program could expand from $181 billion to $463 billion in just 10 years. Could you explain to us, exactly what were the details about this, and how did you arrive at that number?

Dr. O'NEILL. These figures are projections. They are based on our study of past trends and the components of trends and how we expect them to change over the next 10 years.

The easiest part of those projections is beneficiary growth, because we have a pretty good idea of how rapid it is going to be. Beneficiary growth is really a minor component in the growth of Medicare spending because it is low. The other factors are the increase in the overall level of medical inflation—that is, changes in the cost of the same-quality service—and the change in utilization. It is really utilization that drives the costs, to a large extent.

Senator HATCH. All right.

Another aspect, and one about which many of my senior constituents have expressed concern to me, is the impact of Medicare changes on current beneficiaries. You state on page 15 that "full implementation of Medicare structural reforms would be difficult if done all at one time, and a phased-in approach is desirable, starting with younger Medicare beneficiaries."

Now, do you mean younger beneficiaries, that is, those individuals currently on Medicare, or do you mean future beneficiaries, those perhaps under age 55 or some other age limit? In other words, when do we begin to phase in changes and how do you do it; is there an age threshold that we should consider here?

Dr. O'NEILL. We could not say what the exact threshold would be, but roughly speaking, the population age 65–69 would be the younger Medicare beneficiaries, as well as those who are coming up for retirement in the next few years.

Senator HATCH. I see. So you are using that age.

Dr. O'NEILL. Yes—because you do not expect an 85-year-old person, for example to move all at once from the set of doctors he or she is now using to another mode of care. It would be difficult to do that.

Senator HATCH. Yes.

I am concerned also about the desire to move people into managed care or HMOs. There is considerable interest in moving Medicare beneficiaries into managed care programs, and you focus on that in your testimony quite well, if I read it correctly.

You state on page 11 that, "Higher HMO enrollment may have the perverse effect of increasing Medicare's costs, not lowering them, under Medicare's current payment system." These circumstances may be attributed to Medicare's capitation rates that do not fully adjust for generally healthier groups of people who are likely to choose the HMO option.

Could you elaborate on this point? I think it is critical. We are hearing more and more about moving beneficiaries into managed care, and I think this is fine as long as they have a choice between managed care or traditional fee-for-service as options.

Educate me on this point, because I am particularly concerned about the potential obstacles and difficulties of managed care. Ultimately what I am concerned about is if we move into a one-size-fits-all managed care program, that we will reach a point where the bottom line is more important in delivering good health care services. That is something I think everybody is worried about.

Dr. O'NEILL. We did not mean to suggest that managed care per se, is a solution or that anybody should be compelled to go into managed care. The key is that there be competition among insurance plans and choices given to Medicare beneficiaries so that they can see the difference in the costs of providing services and make choices accordingly. They can evaluate the different plans and decide which one they think would give them the most for the money.

Based on what we see going on in the private sector, managed care does appear to generate savings. If that is true, then, under a restructured system, a managed care plan would be the choice, that would be the one that wins out. But under the current system, that cannot happen, and we do not have much of a way of finding out.

We do, however, have some inkling that the cost of providing health care through HMOs would be lower, based on the experience of HMOs that are already serving the elderly population and seem eager to serve the Medicare population. They have been trying to enroll Medicare recipients in their plans, probably because it is lucrative, given that the reimbursement rates are pegged at 95 percent of the fee-for-service reimbursement in the area.

Yet that is why we get into a situation that is a paradox. Managed care saves money, but in the Medicare system, the people who enroll in HMOs could end up costing Medicare money for two reasons. One is the 95 percent peg to the fee-for-service reimbursement level, and the other is that selection operates among the elderly population.

It tends to be younger people—who probably have had experience in HMOs before they retired—who select the HMOs under Medi-

care. Because those people are younger and healthier, they would generate lower costs. The older, less healthy people who go into fee-for-service arrangements put some upward pressure on the fee-for-service reimbursement rate, which raises—because of the 95 percent peg of the HMO—the reimbursement level of the HMO.

The HMOs have been pressed by the government to return some of this additional money, and they have been doing that in many cases by offering prescription drugs and lower or no cost sharing and deductibles. HMOs appear to be able to offer more services for the same amount that a fee-for-service plan charges, so presumably that means that they are able to provide the services at a lower cost.

Exactly how much of those lower costs occur because the people in their program are healthier and how much of it is because HMOs are more efficient is not known, but that is something that could be found out.

Senator HATCH. Thank you.

The CHAIRMAN. Senator D'Amato.

Senator D'AMATO. Thank you, Mr. Chairman. I guess there are many of us who, when looking at the trustees report on Medicare and the dire consequences that they predict unless we do something, particularly as it relates to Part A and the problem that will take place within the next 7 years, are asking, what are some of the solutions?

Now, I notice that on page four the commissioners suggest that by extending the current inpatient hospital payment system—which pays hospitals on a prospective basis regardless of the actual cost—to other providers, that we might be able to postpone the depletion of Part A for an additional 5–10 years.

Have you had an opportunity to study that proposal, and do you agree or not?

Dr. O'NEILL. I cannot say that we have actually studied it, but we have discussed it. It is more difficult to use that, so it has led to increases. Some health problems that are not being taken care of in hospitals are now being taken care of on an outpatient basis and in home health care. So those two sectors have been growing rapidly.

Senator D'AMATO. So it might be an over-simplification then to say, apply——

Dr. O'NEILL. Yes. I think it would be difficult. Maybe something could be done along those lines, but I do not think that you could expect to see the same kind of results as with prospective payment of hospitals. But, again, we have not studied this.

Senator D'AMATO. Let me ask you, what kind of innovations do you believe have the best hope—again, if you have had an opportunity to look at this—for dealing with this shortfall?

Clearly, if we continue doing business in the same modality, it is obvious that the system is going to run out of money. Can we, by some innovations, reduce costs, maintain a high level of services, and be more effective and more efficient?

Dr. O'NEILL. We could start right now by planning a restructuring of the program that would bring more cost-consciousness into the system, on the part of providers as well as beneficiaries. Beneficiaries would be making choices knowing how those choices would

affect their own costs at least. With more competition, HMOs could truly compete among themselves and with other modes—perhaps mixed modes that are part fee-for-service with preferred-provider arrangements.

It is hard to guess what might be out there. Providers are very creative and may think of other kinds of arrangements that none of us have thought of but that would open up the Medicare system.

When I talk about competition, I do not mean by sending everybody forth into the private market but allowing much more competition among providers within a structured government program that would have different insurers bidding for the services of the Medicare population. We could start designing it now. I think, though, that you could not realistically expect that it would be implemented next year or the year after.

You might be able to begin to phase it in in 3 years in large urban areas or places where there is already a considerable HMO provider group serving the population. But in the short-run, there are some things that can be done along the lines of prospective payment for hospitals or to bring more cost consciousness into the system generally.

Some proposed changes would increase deductibles and coinsurance payments for beneficiaries so that they would be more sensitive to the cost of the services they receive. Their doctors would also know what sort of costs were being imposed rather than always believing that the government would pick up the check. We have suggestions in our deficit reduction book—many little changes that together add up to a great deal that could be done right now that would, in one way or another, curb increases in costs.

Senator D'AMATO. That is without affecting the quality of the care?

Dr. O'NEILL. It is always very hard to say how quality will be affected. In cutting costs, you hope that you are going to improve efficiency and not harm quality, but cuts would impose more costs on Medicare beneficiaries themselves. They would also be likely to reduce the reimbursements that doctors and hospitals and the rest of the health establishment would be receiving, so cuts would be hard on them as well. But it is not a question of quality being reduced below what it is today; it is that quality of care would not improve as much as it might if the changes had not occurred. It is very hard to say whether that would happen or how much of that would happen.

Senator D'AMATO. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Yes. I would hope that we do not have too many more questions of Dr. O'Neill; we have got another panel. But I see David Pryor has arrived.

Senator PRYOR. I have no questions.

The CHAIRMAN. No questions.

Any other questions?

Doctor, thank you very much for coming.

Dr. O'NEILL. Well, thank you.

The CHAIRMAN. We appreciate it.

We will now move to a panel of Dr. Arthur Flemming, former Secretary of what was then called Health, Education and Welfare,

and C. Eugene Steuerle, who is a Senior Fellow at the Urban Institute.

Dr. Flemming and I are old friends. Thirty or more years ago when I was in the Legislature he was president of the University of Oregon. I was thinking about political correctness and how things change. Do you remember the debate about whether Gus Hall, the executive secretary of the Communist Party of the United States, could be allowed to speak on the campus or not? There was a big flap.

I cannot remember if the Legislature actually passed a resolution saying he should not be allowed to speak or not. I had gone to law school in the mid-1950's in New York and had heard Gus Hall speak many times. Not many, but two or three times. I thought, the best thing we could do to convince students about the merits of capitalism was to let them hear Gus Hall speak about the merits of Communism.

But, in any event, I cannot remember what the outcome of it was. But I thought, how political correctness changed. Today, my hunch is, if there is still an executive secretary of the Communist Party of the United States, we would be happy to let him speak anyplace. Now, if Rush Limbaugh were invited to speak, I am sure there would be an outcry from the opposite side of those who objected to Gus Hall speaking. So, as much as things change, I bet you they are the same.

Doctor, it is good to have you with us. We will start with Dr. Flemming today.

STATEMENT OF HON. ARTHUR S. FLEMMING, J.D., CHAIRMAN, SAVE OUR SECURITY COALITION, WASHINGTON, DC

Dr. FLEMMING. Mr. Chairman, I am very happy to be with you. I might say, Gus Hall did speak.

The CHAIRMAN. Good.

Dr. FLEMMING. That was a very interesting issue at that time.

I appreciate very much the opportunity of appearing before this committee on an issue that is very important to the older persons and disabled people of this country. I do feel that, as we consider these various issues, we should keep them in mind.

In February 1963, President Kennedy included in a special message on aging in the Congress a plea for the enactment of Medicare legislation. In doing so he said, "They, older persons, have to either ask their children or grandchildren to undergo financial hardship or accept poverty or charity themselves, or suffer their illness in silence. I think this Nation can do better than that. Social Security has shown, for 28 years, that is a logical first-line of defense in this field."

I was thrilled when I became aware of that message to the Congress of the United States. I had responsibilities as Secretary of Health, Education and Welfare for the first White House Conference on Aging in January 1961. The delegates to that conference had supported enthusiastically the concept of Medicare.

They believed that this was a logical addition to the great concept that Franklin Roosevelt had provided us—a national community, where both the private and public sectors recognize a responsibility, along with State and local communities, for programs that

would make it possible for Americans to help one another deal with the hazards and vicissitudes of life.

President Kennedy had some difficulty in persuading a majority of the United States Senate to agree with his vision. At the suggestion of Senators Javits, Anderson, and with President Kennedy's concurrence, a committee to review the situation was set up in the private sector. I was asked to Chair that committee.

We submitted a report to the President just one week before his assassination. He liked it. In conversation with him as I was leaving the Oval Office, he shared with me his feelings of frustration, not over having one of his plans blocked, but over the fact that older persons who face premature death and unnecessary suffering were being denied assistance. Soon after the late President's assassination, the Congress quickly enacted his proposal into law.

Medicare has had a great history. It has helped millions of older persons. I was delighted when persons with disabilities were added under President Eisenhower. It has shown us what universal coverage can do for two major segments of our population. It is a prelude, in my judgment, to universal coverage of our entire population.

Personally, I believe this is no time for us to retreat. We must build on Medicare as it is and move forward. I am confident that the President of the United States, backed by a group of outstanding public servants who have had in-depth experience in this field, and the Congress, can and will work out a solution to the trust fund problem. Solutions to problems in the past have been worked out so that the system has never missed a month in the payment of benefits. This record can and will be maintained.

One of the reasons why we have to periodically confront this problem is the spiraling cost of health care. This will continue to confront us until we achieve the goal of universal coverage.

The delegates to the fourth White House Conference on Aging, of which I was one and which has just adjourned, expressed their overwhelming support for Medicare and Medicaid as programs that have developed a real place for themselves in the life of our National community and that should be strengthened, not weakened.

I feel I speak for many of them when I say that we are determined to do everything possible to hand this program down to our children and grandchildren. It is an essential part of the challenge that Franklin Roosevelt gave us 60 years ago.

I have had the privilege of working with Presidents since Franklin Roosevelt. I have worked with them and I have seen them embrace his concept and add to it. This is the first time in my life that I have seen a real threat to that challenge to the national community.

Thank you.

The CHAIRMAN. Dr. Flemming, thank you.

[The prepared statement of Dr. Flemming appears in the appendix.]

The CHAIRMAN. Dr. Steuerle, I know you are a Senior Fellow at the Urban Institute. I understand you are speaking on your behalf today, not necessarily on their behalf. Is that correct?

Dr. STEUERLE. That is correct, Mr. Chairman.

The CHAIRMAN. Thank you, Doctor. Go ahead.

STATEMENT OF C. EUGENE STEUERLE, PH.D., SENIOR FELLOW, THE URBAN INSTITUTE, WASHINGTON, DC

Dr. STEUERLE. If it please the committee, I would just like to summarize the remarks in my testimony. But I would like to present some of the reasons why I think we, as a society, have to face up to these problems created by the high rate of growth in consumption of health expenditures, including Medicare.

However, my discussion is really not about cutting Medicare. The Medicare health package offered tomorrow will be much more valuable than the one offered today, which, in turn, is much more valuable than the one that was offered yesterday.

When I retire, and the members of this committee retire in the future, we will be receiving a better Medicare package than the Medicare package received by people today, and that is simply because of the more advanced medical services that will be available.

The issue confronting us, it seems to me, is not whether we maintain Medicare, or even whether we maintain a Medicare system that has a growth in benefits, but whether the relatively high rate of increase in growth in those benefits and health care consumption is worth the cost being imposed on all parts of society.

Let me take, as an example, the Clinton 1995 budget projections to demonstrate the growth for different items in the budget as a percentage of Gross National Product—that is, the share of our National pie that we devote to different items.

The story is quite simple: health goes up, Medicare goes up, and everything else, for the most part, goes down as a share of what we would spend.

Lest one think that this is an attack upon the Democrats or the Clinton Administration, I should say that the same story held during the Bush Administration, and the same story held during the second term of the Reagan Administration; health goes up, most other things go down.

These budgets then choose health care over educating our youth, over helping children who now have the highest poverty rates in the population, over preventing crime, over restoring promise in some of our central cities, and, if you want, over simply allowing individuals to keep more of their tax dollars.

Now, I do not mean to imply that making these other budget choices, by any means, would be easy or that we would all agree on what these other budget choices would be. However, I do believe we are on a path that almost no one would choose, not even as a compromise.

Medicare expenditures for elderly persons have been rising quite rapidly, from less than $1,500 per recipient in 1970 to about $5,000 today, and they are scheduled to rise to above $10,000 per person just after the baby boom generation begins to retire. This adds enormous additional pressure upon the system.

For a couple retiring in 1970, the lifetime value of benefits would be about $65,000. For one retiring today, the lifetime value of benefits is approaching a quarter of a million dollars, at least under current projections, and for one retiring in 2010, over one-third of a million dollars.

Partly because these Medicare costs are growing so fast, almost no past or current retirees, even the richest members of society,

have been asked to pay for their benefits. For a one-earner couple with a high-wage worker retiring in 1995, for instance, the net transfers—that is, the benefits received over and above taxes—are projected to be over $100,000.

Of course, these net transfers to everyone, including the rich, cannot continue, and the projections of future cost reflect an impossibility scenario. Nonetheless, they still represent and demonstrate the substantial size of Medicare benefits from a lifetime perspective.

Now, in addition to worrying about the size of the transfers, government also has to pay attention to whether it is getting value out of each dollar it pays. As an example, in 1993 total Medicare expending was estimated to equal about $154 billion.

Had medical prices since 1965 only risen as fast as the price index for all other goods and services, that is, if there had been no excess medical inflation, the same amount of medical services could have been purchased for about $86 billion, that is, for less than 60 percent of the amount now paid.

The budget problems with Medicare are glaring and immediate. The Medicare trust funds are scheduled to run out of money just after the turn of the century, and the trustees of Medicare have continually warned us about the shortfall.

Once the baby boomers begin to retire, moreover, Medicare outlays could increase by more than five percentage points of GDP and more than triple—more than triple—relative to the size of the economy.

Many researchers, including one of my colleagues at the Urban Institute, John Sablehouse, believes that the growth in Medicare and other government health spending is now partly responsible for the decline in the Nation's savings rate.

Before I conclude, Mr. Chairman, I would like to make one last remark. In the environment of reinventing and redesigning government, it is often dangerous to place different government programs into different compartments. Such fragmentation often puts off the table some of the broad trade-offs that might offer more, and efficient, and fair government and might be acceptable to all sides. Narrowing of options may also be a major obstacle to the reform of Medicare.

In my view, it is a mistake to treat Medicare Part A separately from Medicare Part B, from Medicaid long-term care, and, if you want, even from Social Security cash benefits.

That is, there are some reasonable compromises we can make among these benefits, and we would make a mistake in trying to think of each of them as belonging in their own separate compartment. If you would like, we can discuss this further in the questions and answers.

In conclusion, the health care package we offer tomorrow will be much more generous and rich than the one we offer today. There is almost universal agreement, however, that the current system, with its extraordinary demands on the trust funds and general revenues, simply cannot be sustained.

Thank you.

[The prepared statement of Dr. Steuerle appears in the appendix.]

The CHAIRMAN. I am curious. Are you suggesting Part A, Part B, Medicaid, and Social Security should all be folded into a payroll tax of some kind?

Dr. STEUERLE. I would not go so far as to say they should all be folded into a payroll tax. But let me suggest, for instance, that when we look at Part A separately from Part B, as we heard in the previous testimony, we often make transfers that only increase the cost of one versus the other.

If we do not address Medicaid long-term care, we are ignoring a very important part of the total health benefit package given to elderly Americans and we may cut back on Medicare without addressing the Medicaid long-term care package.

Finally, the reason I bring the Social Security issue into this can be shown through an example. If we are going to cut back on Medicare, for instance, by upping the Part B premium, a way could be found to adjust the cash benefits for the lower income among the elderly so they did not really take a hit when this occurred. So those types of trade-offs are possible if we deal with all these issues together in the same package.

The CHAIRMAN. I am intrigued that we often use the word transfer, or reallocation, or taxes, when they are, in essence, the same thing. We take that tax above 50 for Social Security and instead of putting it in the Social Security trust fund, which we had always done, we put it in the Medicare trust fund. But we really do not call that a transfer.

In essence, it is a transfer. We have taken money that would have otherwise gone to Social Security and put it in to Medicare. It has the same effect as if it went into Social Security and then we just transferred funds from the Social Security trust fund, but people regard it as different.

Dr. Flemming, let me ask you a question. In your statement—and I know you are a supporter of universal coverage—you say, "One of the reasons we have to periodically confront this problem is the spiraling cost of health care will continue to exist until we achieve the goal of universal coverage."

President Clinton's bill last year was a universal coverage bill. Yet Dr. Reischauer said, if it all works right the percentage of our Gross Domestic Product devoted to health would go from 14 to 19.5 percent.

If we were to reach a philosophical conclusion that that is too much to spend on health, that we want to hold it at 14 percent, or get it to 11 or 12 percent, which would be more in line with other industrialized countries, how should we go about it? It does not appear that universal coverage, per se, does it. How should we go about it?

Dr. FLEMMING. Mr. Chairman, I did favor the proposal that the President made last year for universal health coverage. I do not feel that we lost ground in 1994, I feel that we had one of the most in-depth debates on a national health plan that we have ever had in the history of our country.

I feel that we reached a pretty general consensus on the fact that the health delivery system was broken down and was improper. Then every poll taken for a period of a year showed that 75–80 percent of our people favored national health care.

I believe we laid a foundation last year. If we build on that foundation, we, as a Nation, can achieve the goal of national health care. Now, I respect Dr. Reischauer's point of view and the point of view that you have just expressed. But it seems to me, if we have a risk pool made up virtually of all the people of this Nation, that that is bound to have an effect on the price structure as far as our health system is concerned.

I cannot help but believe that if we, as a national community, decide that we are going to have this kind of universal coverage, providing a risk pool of that kind, whether you are talking about social insurance, or private insurance, it is bound to drive down cost.

The CHAIRMAN. Well, he thought it would. He thought it would drive it down from 14.5 percent of our Gross Domestic Product to 19.5 of our Gross Domestic Product.

Dr. FLEMMING. As I say, I am not in a position to argue about those particular percentages. But it stands to reason, to me, that if we included virtually all the people of this country in our risk pool, then we can carry on the health care system for less than we are carrying it on today.

The CHAIRMAN. I would hope you are right. Although, in addition to Dr. Reischauer, we did not have any other testimony that indicated that costs would go down, mainly because part of it was demographics, part of it was more expensive equipment, part of it was the normal things that exist whether or not we have universal coverage.

But I guess this is a philosophical question I am asking. Last night I was at a small dinner party and there were two career government people there, involved basically in basic research. They were quite disturbed about the budget proposals in the House and Senate, and, in essence, said, surely we do understand that, while there must be immense savings, that basic research is really an investment in the future. I understand that. I bet if I were to talk to a commuter from here to New York he would regard Amtrak as an investment in the future.

At some stage, is it our job as a Congress, or the President and the Congress, to say, look, we do not want to spend more than 35 percent of our Gross National Product in government programs, total. We reached that conclusion. Then we say, in order to do that, we think 15 percent is all we can justify spending on health.

Do we then attempt to work toward that goal? This does not mean government, this means total spending: public, private insurance companies which you pay. Or is it that percentage ought to be exempt and we ought to spend as much on health as is humanly possible because that is the decent thing to do, regardless of the costs?

Dr. FLEMMING. My judgment is, we are one of the richest Nations in the world. We are in a situation where upper brackets are getting wealthier, and the middle and lower brackets are getting poorer. If we embrace universal health coverage such as you suggest, I do not think we should fix any arbitrary percentage of our total expenditures.

I think we should face reality and face the situation that individuals in this country confront. I agree with you. I think when we

talk about the national community we talk about both the private sector and the public sector.

Incidentally, I found out that when you say private sector some people think you are only talking about the business community. That is a very important part of the private sector. But we also are talking about all the congregations of this country, community service organizations, and so on. So, I agree with you that I think we should approach it as a national community proposition.

Now, I would like to address division of responsibilities that develops between the Federal Government, State and local governments, and between the private sector and the public sector. I do not think these divisions should be determined by our picking out of the air, possibly, or agreeing on an arbitrary figure and trying to fit the needs of human beings into that particular figure. It seems to me that responding to health needs of our country should be paramount.

After all, we are here, as I indicated, for the purpose of helping one another through this journey through life. What is a greater problem for us than health? What is a greater problem than facing premature death, facing unnecessary suffering?

Now, I am not saying that you do not finally end up with a percentage that is reasonable, but I would not set a figure and then try to fit the program into that figure because it seems to me that taking the national community into consideration, all of it, the private and public sector, we should try to determine what the needs of our people are and then, as the richest country in the world, do our best to respond to those needs.

I listened to the discussion this morning. So often it is a question of going back, can we afford this. I believe firmly that, as a national community, we can afford an adequate health service for the people of this country, whether it comes from the private or public sectors.

I have watched the national community develop for 60 years. I have watched it get started. Franklin Roosevelt proposed it when he was in the middle of the worst Depression we have ever had. Then I have watched every President since then, Republican and Democrat, up until the start of the 80's—Presidents I have worked with and served, add to the responsibilities of the national community.

That concept of the national community and the national community having responsibility along with the State and local communities to deal with a problem as important as health care, is a very important responsibility. I certainly feel we can do it. That is my conviction, growing out of my own experiences over 60 years.

The CHAIRMAN. Maybe a year ago—and then I will turn to Senator Moseley-Braun—I had back-to-back-to-back, within 3 weeks, people in my office. In fact, I did not know some of these organizations existed. The National Association of Hospital Boards of Directors; not their principle administrative officers, their boards of directors.

In most areas, those are the town's 400, the elite, they are good citizens; they raise money for charity, they are business people, they are successful, and they are on the hospital boards and they help raise money. Most of them, except maybe for some of the larg-

er, larger hospitals in major areas, are Republicans, most of them conservative. Most of them would probably support balancing our budget, but they would explain to me how different health was from other priorities.

The following week they were succeeded by the National Association of School Board Directors. Again, in most of the towns, those are Republicans, members of the establishment, good citizens. And they would explain that the priority of this Nation is the education of our youth, and that is the top priority, and if there is not enough money, we could take it from health.

And the following week was the National Association of Police Chiefs, usually conservative people, reasonably convinced that the way we are educating our youth does nothing to reduce crime, and that they knew how to reduce crime, and if we did not have enough money we could take it from education.

I understand the needs of this country, but everybody sees the needs through their own eyes. There is not an unlimited supply of money to fulfill all of the needs, so we have to have priorities.

If health and retirement are going to take increasing portions of our whole, then other needs are going to have to give, or we are just going to increase the taxes, and increase the taxes, and increase the taxes until we have a taxpayer revolt.

Before we get to that, I wonder if we have to say, either some things are not needs at all, we are just going to eliminate them and fund others as best we can, or we are going to say, we cannot satisfy everybody's needs as they see them and we simply have to have limits.

Dr. FLEMMING. I appreciate, Mr. Chairman, the problems you and every member of the Congress is up against along that particular line. I appreciate the point of view of the groups that were talking to you, in addition to the health groups.

I also appreciate the importance, for example, of a high rating as far as education is concerned—we have been in it for a considerable period of time—knowing how much we depend on education for the development of our human resources.

But I still maintain that, for each one of those groups, the people in those groups, health is the most important thing for them to confront. It is an integral part of the field of education. We all carry on a lot of activities along that particular line.

So, I know that somebody could come up with a higher priority than health, but I cannot quite comprehend a higher priority. Last year, I went to about 20 or 25 communities and I had the opportunity of listening to real people discuss their problems in the health care field.

I tell you, I was really impressed with that because, for example, on the older person's side, I heard person after person tell me that when they woke up in the morning they had to decide whether they were going to spend money for food and clothing or prescription drugs. Most of them, of course, would decide against prescription drugs. I feel that is a condition that exists now.

Some of the discussion here today has been on the assumption that Medicare, as it is now, is a perfect program. Well, it is far from a perfect program. We deal with acute care but we do not deal

adequately with long-term care and we do not deal, for example, with prescription drugs.

It seems to me that the challenge to this country is not to figure out how we are going to cut Medicare, but how we are going to develop resources that will make it possible for us to build on the program we have. We have made mistakes; we should correct those mistakes.

But we also know that it is an inadequate program and we should be desperately trying to find resources that will make it possible for us to build on Medicare. Again, I come back to the fact that it seems to me that that is the highest priority.

When I hear figures like cutting $260 or $270 billion out of Medicare, and another $160 billion out of Medicaid, I try to think of what this is going to do for millions of our people in this country. It means that those who are now faced with the problem, deciding whether they are going to spend their limited income for food, clothing, or drugs, are going to be added to. We are going to add millions of people to that particular group.

I believe that this National community can afford to respond to this particular need, if we think of it in terms of the public and the private sector, and if we think of pooling our resources.

That was one of Franklin Roosevelt's great ideas, to pool our resources so that we could help one another deal with, as he put it, the hazards and vicissitudes of life. It seems we have a wonderful opportunity. We can create a risk pool of tremendous size. I feel that that would help us deal with some of the problems confronting us at the present time.

The CHAIRMAN. Thank you.

Dr. Steuerle, you want to comment, and then we will go to Senator Moseley-Braun.

Dr. STEUERLE. I was just going to offer, perhaps, a means of mediating this discussion. I think there is a difference between deciding whether health is the most important item we need to spend money on and whether the next dollar we spend should be spent on health versus education, versus police, versus other items.

One test might be, what areas of our life are getting better as we go along, and in what areas do we really see that we are not making the progress we think we can make? It seems to me, in health care, partly due to the efforts of people like Dr. Flemming and others, we have actually made great strides and success in terms of improved health care, improved health services we could receive.

In some areas, like education, we do not seem to be making quite the progress that we want to make. In still other areas like crime, things are certainly worse today than they were, say, 30 years ago.

That is a test not of whether health is more important or less important than these other items, but it is kind of a test of to what do we want to devote our next dollars of resource?

The difference, I think, in terms of the budget, is that the health care packages, as we have in the budget, in both Medicare and Medicaid, have automatic growth built into them that compete unfairly with some of the other items in the budget that do not have automatic growth.

Now, the automatic growth was not badly intended. It was because health was basically indexed to a technology frontier at a zero price for individuals. Retirement has been indexed for longevity so, as we have lived longer, we have not adjusted for the fact we might have to work a little longer. So health and retirement go up quite rapidly by the way they are indexed, but compete, it seems to me, unfairly with these other needs.

The concern that Dr. Flemming raises about addressing the needs of our society is a very profound one, and that is what government mainly does today. Most of the government's budget is a social welfare budget and we have to decide which of those needs are most important today and which could be best addressed by the next dollar of expenditures. I think that can only be addressed by putting them on a fair and equal footing on a budgetary basis.

The CHAIRMAN. Senator Moseley-Braun.

Senator MOSELEY-BRAUN. Thank you very much, Mr. Chairman.

This has been a fascinating discussion. I am reminded of a friend of mine who once admonished me that the legislature's role was to be the CDLS, and that is the Committee to Draw the Line Somewhere. That is our job today. I thank you.

I am delighted to listen to you, Dr. Flemming, and am delighted to have a chance to hear your testimony. I, frankly, could not agree more that this really is a challenge to our National community, and, frankly, defining how that national community is going to respond to this next generation and into this next century.

Since we are asking theoretical kinds of questions, I have not a philosophical one, but a theoretical question for Dr. Steuerle. Is that how you pronounce your name, Steuerle?

Dr. STEUERLE. Actually, I pronounce it Steuerle.

Senator MOSELEY-BRAUN. Steuerle.

Dr. STEUERLE. It is Americanized.

Senator MOSELEY-BRAUN. Steuerle. All right. Dr. Steuerle.

I have a question for you. Again, this is kind of big picture theoretical, in the sense of, our entire health care system, particularly the private sector system, is dependent on third party payment. It is a third party pay system.

To what extent—and I do not know if your research has covered this—does the third party payment aspect of the system account for increase in health care costs? You referenced in your statement the notion of people being acquainted with what they are paying for. Has any measurement been made of the extent to which third party payment, as opposed to direct payment, accounts for the increase in health care costs?

Dr. STEUERLE. There are numbers on the extent to which payments come from third parties versus others. You raise, I think, a very important question. Not just the public health care system, but the private health care system, initially was designed upon the notion that we would provide insurance and that, when you and I went to our doctors, we would not worry about the price at all of what we received.

So, it really put us in a situation of bargaining to spend other people's money. But this was not just an issue with the public health care system, it was an issue with the private health care system. There are some who argue that, well, what we need to do

is put more prices into our choices so that when you and I go to the doctor we have to face up to a price, and we recognize the resource cost we would be imposing on others when we buy health care.

But there is another level at which we could also make that decision, and that is where I think a lot of the reform efforts will be going, including national health care reform, including the Medicare reforms that you will be addressing in the next few years, and including the reforms that I think a lot of the private sector is taking.

That is, well, let people make a decision a little earlier, as opposed to having people decide when they are actually buying their health care. It is hard for us to decide when we are in the hospital, you know, what we can pay the doctor. Let us decide a little bit ahead of time.

Let us decide how much money we are going to put into an insurance package and have competition among sellers of that insurance package so that the doctors or a group of providers have to come in and say, all right, here are the benefits I will provide you for this amount of money, or I am only going to give you $100,000-a-year surgeons, but I am not going to give you these $300,000-a-year surgeons.

Now, if you take my package, you will probably get a little bit less surgery, but I can save you this amount of money for other purposes. I can save you in terms of wages you might spend for other needs of your family, or I can save you in terms of other needs you might need as a government.

So, there are two places at which you can make people price conscious. One, is at the actual point of service, the other, is at the point you buy health insurance. Traditionally, we have not asked individuals—whether they are Medicare recipients or wage earners in the private sector—we have not asked them to make choices at either level. I think that, as much as anything, is a major driver of the cost of health care.

And what you see now in HMOs, managed care options, and other options that the private employers are trying to put on their employees, is that they are trying to push more on to employees the notion that, when you make these choices, this is affecting your wage and your total compensation package in a way that you can choose; you can choose to put slightly less into health care and let the rate of growth be slightly less. That will have a cost in terms of health care, but there will be offsetting advantages elsewhere. It is those types of choices that we are grappling with, I think, both in the public sector and the private sector.

Senator MOSELEY-BRAUN. But, again, I guess my point is, we still impose—and this is very theoretical and I am just trying to see if there is any research in this area—a third party payor in the system.

The question becomes, to what extent would savings be achieved by having reimbursement directly to the individual who pays for health care as opposed to dealing with the direct transfer of payments as the system now exists? If you just kind of turn that model around, has any research been done to look at what would transpire there?

Dr. STEUERLE. Most money does come through third party payors.

Senator MOSELEY-BRAUN. Right.

Dr. STEUERLE. In fact, most individuals in the United States have very little idea of the cost of health care. The cost of health care, per average household, is approaching $10,000 per household. We have to come up with that money somehow. We come up with it through taxes, we come up with it through deficits, we come up with it through State and local taxes, we come up with it through reduced wages. So we are trying to grapple with this $10,000 per household we are spending on health care. It is coming from somewhere.

Senator MOSELEY-BRAUN. Right.

Dr. STEUERLE. Now, what you may be suggesting is, well, maybe if we saw a little bit more of it, maybe we get a third party payor pay us and we pay the doctor. I think the difficulty of that transition is, administratively, most of us do not want to handle all of the paper work.

I think we do have to get involved in the process, but I think a better place to get us involved in the process is at the point we buy health insurance, so that we know the cost of health insurance rather than always getting involved at the actual point at which we have to pay the doctor.

Senator MOSELEY-BRAUN. I am just trying to see if anybody has looked at quantifying this, putting aside the paper work costs, assuming that is a part. Has there been any investigation of the extent to which costs would be reduced by having that one-on-one payment for health services?

Dr. STEUERLE. If it is nothing more than I just transfer the money to the doctor, I do not think there is too much evidence because I am not sure how much we actually do that. Very few systems would set up the money that way.

Senator MOSELEY-BRAUN. We do that very little. I am just examining, in terms of the fundamentals of the way the system works——

Dr. STEUERLE. There is evidence, if we have to pay ourselves, if this cost us to pay, that, yes, we would reduce some of our demand for health care.

Senator MOSELEY-BRAUN. Thank you, Mr. Chairman.

The CHAIRMAN. Go ahead.

Senator MOSELEY-BRAUN. Well, again, if you would provide that I would be very interested to see that, because it seems to me that a major part of what we are looking at is, again, there are assumptions going to how the system is construction that I think need to be examined as we approach this whole issue.

[The following was subsequently supplied for the record:]

Table 1 HOW HOUSEHOLDS PAY FOR HEALTH CARE - WITHOUT RECOGNIZING COSTS
(Estimated Total Health Care Spending in the U S , FY 1995)

	Average Per Household (1)	Percent of GDP	Percent of Personal Income	Percent of Money Income	Total spending in billions
PAID INDIRECTLY:					
TAXES – Federal Hospital Insurance Payroll Tax	$965	1.5%	1.6%	2.1%	$96.7
TAXES – Other Federal, State, & Local (2)	$4,282	6.6%	7.1%	9.5%	$428.9
REDUCED WAGES – (Paid by Employers) (3)	$1,751	2.7%	2.9%	3.9%	$175.4
OTHER (4)	$487	0.8%	0.8%	1.1%	$48.8
PAID DIRECTLY:					
PERSONAL CONTRIBUTIONS – To Private Health Insurance (5)	$775	1.2%	1.3%	1.7%	$77.7
OUT OF POCKET PAYMENTS	$1,663	2.6%	2.8%	3.7%	$166.5
PREMIUMS – Medicare	$201	0.3%	0.3%	0.4%	$20.1
TOTAL	$10,124	15.6%	16.8%	22.4%	$1,014.1
Addendum					
Mean GDP Per Household	$64,743				
Mean Personal Income Per Household	$60,161				
Mean Money Income Per Household	$45,151				

SOURCE Author's calculations based on data from CBO (1995), OMB (1995), and the Joint Committee on Taxation (1994) C Eugene Steuerle and Gordon Mermin, THE URBAN INSTITUTE

NOTES

(1) Average household size in the U S was 2 63 persons in 1993, and there will be approximately 100 2 million households in 1995

(2) Includes taxes needed to finance direct government health spending out of general revenues, plus the amount general taxes must be raised in order to compensate for revenue lost due to special tax treatment of certain health related income (about 23% of the total)

(3) Employer contributions for health insurance less government tax subsidies

(4) Non patient revenue for the health care industry, including charitable donations interest income, hospital parking and gift shops etc

(5) Includes both employee contributions to private group health insurance plans, plus individual policy premiums

Senator MOSELEY-BRAUN. The second issue is—and this was kind of raised by Dr. Flemming and it makes absolute sense to me and goes to the notion of the risk pool—it seems to me that the notion of universal coverage is intricately tied into the notion of cost containment. You cannot really have cost containment without having universal coverage because otherwise you wind up with the kind of cost shifting we have in the system now.

So, Dr. Flemming, if either of you would like to elaborate on the importance of universal coverage in terms of achieving some kind of rationality to the system, I would be delighted to hear your comments.

Dr. FLEMMING. Personally, I feel that we will not get a rationale for the system unless we have universal coverage. For example, I listened to the discussion here today about the growth of HMOs and their involvement as far as Medicare, and so on, is concerned. I have watched that growth with real interest, and so on. I again think of the older person, particularly middle class and lower class people, and I think of HMOs. I read an article just the other day that the average salary of the four principle HMOs was $7 million.

I began to think of that in terms of what that was doing as far as the consumer was concerned. It seems to me that issues of that kind can be under a system of universal coverage and that we can

tie the public and private sector together in a much more effective way under universal coverage.

I know there are a number of ideas and plans along that particular line, but I do not care particularly about which plans we adopt. If we accept the concept of universal coverage it seems to me we can develop through the private and public sector a system that makes sense. I think we are all in agreement—or not all of us, but many of us—on the fact that our present delivery system could be improved through universal coverage. I personally do not think we are too far away from that, in spite of the difficulties we are having today.

I could be very discouraged and very pessimistic along that particular line, but I have the feeling that we are close, and I have the feeling that the focus is now being placed on Medicare and Medicaid and their relationship to our total health care system, particularly the focus on Medicare, with that providing universal coverage for the elderly and disabled is all to the good.

It seems to me that maybe our next step is going to be to suggest that pregnant women and children be included under the Medicare tab and that will be the next step toward universal coverage. I guess we have to take it in steps based on our experience last year, but I think we can take it in that way.

Senator MOSELEY-BRAUN. Dr. Steuerle?

Dr. STEUERLE. I do not think there is a debate over whether, as a society, we would like to have universal coverage. I think the issue is, how do we get there? In my own view, we have a lot better chance at compromising in moving in that direction by worrying about minimum benefits that we provide to people.

I do not mean to be hard-nosed about it, but by minimum benefits, I personally have proposed things like a credit for children. In fact, I have even suggested this for the tax credit that is now in a number of the tax packages—that if we offer this type of tax credit that we only make it available to families who buy health insurance.

I think we ought to be viewing very closely things like the clinics we make available. I have been an advisor in my high school for some time now and talk to the people who run the clinic nearby, and they tell me that often these children have the health insurance but they are not coming to the doctor. The more important issue, at least for the people in this clinic, is to get the health services closer to the people. So, I think there are a lot of approaches we need to make in terms of improving health care.

I think, unfortunately, the notion of just a universal health care system is available to all, say a universal Medicare system, or the type of thing that was tried in the Clinton package, tries to go too far, too fast, in a way that dodges some very important issues. And one of the important issues is the trade-off between equity and efficiency.

If government mandates something for everybody in a totally equal way, it can create equity at one level. But then, by making it so equal, it denies to society the ability to decide, well, how do I want to change it over time?

I have never been afraid that a mandated universal care system would make health care worse in the first year, or two, or three.

What I worry about is, 20 years down the road, how do you decide where you really want to go as a society? What technology do you want to adopt? What goods and services do people want to trade off, and what do we want to trade off even between health care and something else? Well, if you mandate it the entire package comes through a regulation system, it seems to me you lose that flexibility.

You could control cost. You could control cost by simply denying technological improvements. My guess is, if you had a totally regulated system by the government, you would also end up with established doctors pretty much trying to prevent new doctors from coming in the system to offer their own services. So there is an efficiency cost to trying to go to this totally regulated system.

So my suggestion is, if you want to think about universal, think about working on the minimum, think about working on pregnant mothers, think about children, for whom I think we could have made substantial progress last year if there had been more willingness to compromise.

I think that is the way you get toward more universal care. But think about what we want. We could debate what is the minimum package we want for those people, recognizing we are never going to be able to cover everything for all people in an equal manner. I think that is how we get the improvement.

Senator MOSELEY-BRAUN. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Gentlemen, thank you both very much. It has been most helpful. I appreciate your long wait this morning while we questioned Dr. O'Neill.

We are adjourned.

[Whereupon, at 11:54 a.m., the hearing was recessed, to reconvene at 9:30 a.m. on Tuesday, May 16, 1995.]

SOLVENCY OF THE MEDICARE PROGRAM

TUESDAY, MAY 16, 1995

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

The hearing was convened, pursuant to recess, at 9:35 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Bob Packwood (chairman of the committee) presiding.

Also present: Senators Grassley, Hatch, Pressler, D'Amato, Nickles, Moynihan, Bradley, Rockefeller, and Graham.

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

The CHAIRMAN. Gentlemen, let us come to order.

This is the third of our hearings on Medicare. We had 10 on welfare, we have more scheduled on Medicare. I am not sure we can have a more distinguished panel than we have today, or people who know more about this subject than the four of you that we have here.

I must confess that I am not sure I know the answer. Although, from our last hearings we have discovered this: Most people now say that, in terms of "bankruptcy," Medicare, to even begin to solve what HCFA or anybody else would call short-term solvency problems, needs about $145–165 billion to narrow the gap; whether that is tax increases, or whether that is a restraint in the growth of services. I did not find much difference of opinion about that. I do not find overwhelming support for raising taxes.

I realize it has budget implications. No one is trying to say, well, this is being done solely for the purpose of saving Medicare, but we are now paying out more money than we are taking in in revenues and we are living off a bit of the income and living off the bonds as we are redeeming them. But, by the year 2002 the bonds are gone, the interest is gone, and everything is gone and we are down to money in and money out and there is not as much money coming in as there is going out.

Of course, that is just Part A. Part B, the Federal Government is picking up about 69 percent of the total cost of that, in any event. It was intended to be 50 percent when we started and it gradually has dwindled down to 25 percent. It was down lower than that for awhile, and then we set a dollar amount rather than a percentage amount and it turns out the dollar amount is 31 percent rather than 25 percent.

But we need help, we need your advice, because we genuinely want to keep Medicare solvent. We also genuinely want to see if we can produce a balanced budget. If you can do both at the same time, that is fine, but we have to solve both problems. If we do not solve them both, we have to solve the Medicare problem, in any event.

So, with that, let us start. We will start with Stuart Butler, who is the vice president and director of Domestic and Economic Policy for The Heritage Foundation, which has produced reams and reams of good material for this Congress.

Dr. Butler?

STATEMENT OF STUART M. BUTLER, PH.D., VICE PRESIDENT AND DIRECTOR, DOMESTIC AND ECONOMIC POLICY STUDIES, THE HERITAGE FOUNDATION, WASHINGTON, DC

Dr. BUTLER. Thank you, Mr. Chairman, for the opportunity to testify before the committee on the problems facing the Medicare program.

Others on this panel will no doubt focus more on the scope of the financing problems as such, so I will not concentrate on that. I will instead discuss the root causes, in my view, of why the program is out of balance, and the structural changes I believe are needed.

There are three underlying reasons why we face persistent problems in Medicare. Only by addressing these can Congress hope to assure the long-term viability of the program at a reasonable cost.

The first problem is that Medicare uses price controls and other tools of central planning in its efforts to control costs and improve efficiency. Most economists agree that these tools always work poorly and their record in Medicare is no different.

Besides failing to curb costs, price controls in Medicare have led to exactly the same distortions and evasions as we see when they are employed elsewhere, and to the same heavy-handed government regulation in response to these side effects.

The second problem, which is linked to the first, is that Medicare consistently lags behind the private sector, and even behind some other governmental health programs, in the pace at which efficiency-improving innovations are incorporated. I indicate several examples of this in my written testimony, such as the painfully slow introduction of managed care options and flexible benefit options.

This slow pace of innovation is not a coincidence, it is the direct result of the program's design where innovative ideas have to trickle up centralized bureaucratic decision making systems.

By contrast, in the decentralized insurance market for corporate benefit dollars, strong competition generates rapid innovations in the organization and delivery of services.

The third problem concerns one particular element of the program that you have identified, Mr. Chairman, namely Part B. Part B is a voluntary program. Unlike Part A, Americans do not make explicit contributions to the program during their working life.

When Medicare was established in 1965, the Part B monthly premium was set at a level to finance 50 percent of the Part B program costs. This premium has now fallen to around 31 percent, irrespective of the income of the beneficiary.

As the trustees noted, the amount of this general subsidy is already high and will rise sharply in the future. It is difficult to see why this subsidy should continue, but around 75 cents on the dollar, at least without regard to income.

Large savings and efficiency improvements are possible in the Medicare program only by changing fundamentally the way the program functions. That structural reform should move Medicare away from the current highly regulated system towards a system based on consumer choice among competing health plans.

This change would not just save money. In this reformed Medicare system, retirees would have the widest possible freedom to enroll in plans of their own choosing with the benefits that they want.

The way to achieve this reform, in my opinion, is to convert Medicare from a defined benefit program to a defined contribution program, in effect, a voucher program. In this arrangement, the Medicare program would make a contribution to the health plan of the retiree's choice. A Medicare enrollee would have the option of using the voucher to stay in the current government designed benefits in reimbursement.

The CHAIRMAN. As long as it is just me, let me ask you a question as you are going. Would you have, however, a minimum standard benefit package which any of the programs would have to meet?

Dr. BUTLER. Yes. I believe that there should be at least a basic core of benefits. Now, there can be a lot of discussion about how extensive that core should be. One could say it should simply be a catastrophic base, or it should be a limited number of basic services. But, beyond that, I think there should be a wide range of options for the elderly, say, to substitute a drug benefit for less coverage for other items.

The CHAIRMAN. The reason I ask that is because last year, when we were considering President Clinton's plan, the proposal of a minimum benefit package met fierce opposition, usually conservative opposition.

Dr. BUTLER. Yes. But even among conservatives, Mr. Chairman, there is a big distinction between requiring only very basic, very limited benefits aimed at catastrophic protection—Senator Nickles' bill, for example, had only a catastrophic requirement—and requiring a very comprehensive set of benefits, say the current services and structure in the Medicare system. I think that is the issue that should be under discussion.

The CHAIRMAN. But you do have to have some kind of minimum benefit package so that people can compare policies and they can buy more if they want. They cannot buy less than the minimum, but they can buy more if they want.

Dr. BUTLER. That is correct. But I would certainly advise a basic benefits package that is much leaner than the current Medicare system, to allow people to make substitutions.

The CHAIRMAN. All right.

Dr. BUTLER. Just to end, Mr. Chairman, I would argue that the voucher amount available towards this benefits package should be such that, if the elderly pick a plan that is lower in total cost to that value, they should be able to reap the savings or a part of the

savings. If they chose something which is more elaborate, then they would be responsible for the difference.

An alternative to a voucher program would be an agreement by Medicare to cover a certain percentage of the premium and out-of-pocket costs associated with a selected plan.

In order to reflect the likely cost of the retiree's health care needs, the voucher amount would be adjusted based upon the beneficiary's age, gender, and geographic location, but not their health condition. To be eligible to market to the Medicare population, plans would have to use the same underwriting principles that are used to set the value of the voucher.

They would have to include catastrophic protection and perhaps a limited core of benefits, as I mentioned, but could offer alternative packages of benefits beyond that, such as a drug benefit, and they would have to meet certain financial viability requirements and guidelines in stating their benefits.

This reformed Medicare program would be much like the Federal Employee Health Benefits program. As you know, this is a defined contribution program which covers Congress and approximately 10 million other Federal employees and their families, as well as Federal retirees.

Mr. Chairman, Congress has only two choices regarding Medicare. You can let the flawed program continue unreformed, in which case you will have to divert huge amounts of money from other programs to keep the program afloat or impose heavy new taxes on the non-elderly. Or you can make fundamental changes in the design of the program to introduce incentives for consumer choice and delivery innovations and thereby trim future costs, while maintaining or improving the quality of care for the elderly.

Thank you, Mr. Chairman.

The CHAIRMAN. Dr. Butler, thank you.

[The prepared statement of Dr. Butler appears in the appendix.]

The CHAIRMAN. Next, we will take Roland King, who currently is the national director of Government Insurance Programs and Actuarial Services for Ernst & Young, but for 16 years—it was 16, was it not—was the Chief Actuary for HCFA, which gives you more than enough background and experience to address this subject.

STATEMENT OF ROLAND KING, NATIONAL DIRECTOR OF GOVERNMENT INSURANCE PROGRAMS, ACTUARIAL SERVICES GROUP, ERNST & YOUNG, L.L.P., WASHINGTON, DC

Mr. KING. Thank you, Mr. Chairman.

There has been much discussion of the 1995 Trustees' Report since the Trustees' Report has been issued. It shows that the Hospital Insurance program is going to be bankrupt by 2002, and that if nothing is done to control the costs of the program, then the tax rates that support the program will have to double by 2025, and triple by 2065.

Rather than go into more detail discussing the 1995 Trustees' Report, I would like to discuss some of the solutions to the problems as well.

The CHAIRMAN. Let me ask you a quick question, and I will interrupt as we go.

Do you agree that figure of roughly $145–165 billion is a pretty good approximation of what would be necessary to meet the trustees' 10-year solvency test?

Mr. KING. Yes.

The CHAIRMAN. All right.

Mr. KING. The problems of the Hospital Insurance program are not just budget problems, and they are not just problems of program growth. What we really want to do is to preserve this program for future generations of beneficiaries and that is why it is necessary to curb program growth.

One of the things that concerns us about the way in which we go about curbing program growth is the issue of generational equity. We can quantify generational equity—actuaries always like to quantify things—and we can quantify it by comparing a beneficiary's present value of their benefits from the program compared to the accumulated value of their contributions to the program.

For example, when we do this for someone retiring in 1994 we find that a person retiring in 1994 gets $5.19 back for every dollar they paid into the program. When we quantify inter-generational equity and then look at the various options for fixing the program, there is really only two ways that the timing can go.

You can either do something immediately, or you can wait until the last minute. There are basically only two ways you can go with regard to putting the program in balance, and that is either raising taxes or reducing the rate of growth and benefits.

When we look at the four combinations of those two ways of going, what we see is that the fairest way, the one that results in the most equalization of generational contributions and benefits from the program, is the one that involves taking action immediately and doing it through reducing the rate of growth in the program rather than raising taxes.

And while we are dealing with the problems of the Medicare program, let us not forget about the SMI program. The projections in the Trustees' Report show that the cost of the SMI program is going to triple as a percent of GDP by the year 2020, and will quadruple as a percent of GDP by the middle of the next century. So the SMI program is going at rates that, in the long-term, will endanger its financial viability also.

The outlays of the SMI program are excessive today and growing at excessive rates primarily because of two factors of the program. The first, is fee-for-service medicine, and the second one that I would really like to dwell on is, third party payments. Third party payments result in patients and providers not concerning themselves with the price and quantity of services they consume.

Today, even the very most cost-sharing provisions of the SMI program are not really being affected because 80 percent of SMI enrollees either have supplementary Medigap policies, or else Medicaid, that fills in the deductibles and co-payments.

A study that was done by the Office of the Actuary and HCFA shows just how powerful even these modest co-payments are in restraining the rate of growth and resulting in more prudent purchase of health care.

Even when we control for health care status, the people who subject themselves or who are subjected to the modest co-payments of

the current Medicare program have a minimum of 31 percent lower utilization than those who do not face those co-payments because of Medigap policies.

The CHAIRMAN. Say that again.

Mr. KING. The Medicare beneficiaries who do not have Medigap policies and so, therefore, they have to pay the co-insurance of the SMI and HI program out-of-pocket, compared with those who do have Medigap policies and, therefore, essentially their care is free, those who have Medigap policies have 31 percent lower utilization rates than those who do have Medigap policies, according to a study developed by the Office of the Actuary and HCFA.

The CHAIRMAN. Well, tell me about this study by Drs. Freeland and Pedon and the 2 percent.

Mr. KING. That study is another important study. It is going to be published in Health Affairs. What they did was do regression analysis of the rate of growth in health care costs compared to the shift that we have had over the last 30 years in health care from out-of-pocket payments to third party payments. And what they discovered is, not only do third party payments result in higher health care costs, but they also result in a more rapid rate of growth in health care costs.

Roughly speaking, as a rule of thumb, what they found is that, for every 10 percentage point shift from out-of-pocket to third party payments in the Nation, the rate of increase in health care costs increases by 2 percentage points and it persists for about——

The CHAIRMAN. Two percentage points greater than it would otherwise increase.

Mr. KING. That is right.

The CHAIRMAN. I want to understand that figure. Let us say you have a 50/50 split for the moment. I am paying $50 of the doctor's bill, the third party is paying $50. If that goes to the third party paying $60, 10 percent more, we can expect the cost of health to increase about two percent faster than it would otherwise increase, and then that compounds as you go into the out years. Have I got that right?

Mr. KING. That is right, it compounds. It would be about 2 percent faster, and that more rapid rate of growth would persist for about the next 8–10 years.

The CHAIRMAN. Well, the key here is, 2 percent faster than it would otherwise go for every 10 percent shift in third party payments versus personal payments. So, to the extent that it is 70 percent, or 80 percent, or in some of these plans, it used to be from dollar one, although some of them are getting away from it, the increase is immense.

Mr. KING. That is right.

The CHAIRMAN. All right.

Mr. KING. Let me give you an example of the way that this might work in the Medicare program. The Part B premium could be reduced from $46.10 that it is now to $4.00 a month; the extra $505 a year could go back into the pockets of Medicare beneficiaries in their Social Security checks.

If we then took back that increase in the premium, the actuarial value of that increase in premium through an increase in the deductible, then that would still allow the government to have a sav-

ings of $5 billion in 1996. That is how powerful the effects of third party payments are.

My last recommendation, Mr. Chairman, is that I would suggest that, after the Congress has done all of the reforms that it finds necessary in order to get the costs of these programs under control, that it put in some kind of fail-safe mechanism so that these programs are never again in danger of financing insolvency the way they are now.

That could take the form of a deductible that is increased as program costs increase: in the case of HI, as a percent of taxable payroll; or in the case of SMI, as a percent of GDP.

IF the reforms worked, then this indexation of the deductible would never result in an increase in the deductibles for the HI and SMI programs. If they did not work, then this indexation would keep the program solvent.

The CHAIRMAN. Thank you.

[The prepared statement of Mr. King appears in the appendix.]

The CHAIRMAN. Next we will take Dr. Bob Reischauer. I cannot get used, yet, to calling him a Senior Fellow at the Brookings Institution. He was, of course, for six years, the Director of the Congressional Budget Office, and I think did a sensational job there.

Bob?

STATEMENT OF ROBERT D. REISCHAUER, PH.D., SENIOR FELLOW, THE BROOKINGS INSTITUTION, WASHINGTON, DC

Dr. REISCHAUER. Mr. Chairman, Senator Nickles, I appreciate the opportunity to discuss the future of the Medicare program with you.

Let me summarize the five simple and straightforward points that are made in my prepared statement. The first, is that in this era when bashing the government is quite popular, we should keep in mind that the Medicare program is a program that has worked, and has worked well. Whatever changes we make in this program, we must be sure not to erode its impressive accomplishments.

My second point is, the short-run budget situation facing the Nation and the long-run demographic problem that will hit when the baby boom generation begins to retire render the program unsustainable in its current form. It is going to have to be changed, and it is going to have to be changed in fundamental ways.

The third point that I would like to make is, the budgetary and demographic pressures are so large that we will have to turn to both the tried-and-true mechanisms that we have employed in the past to restrain the growth of Medicare costs, and to more fundamental structural changes, ones that encourage efficient, low-cost health care delivery systems.

If we are going to balance the budget over the next 7 years and make the adjustment entirely on the spending side of the ledger, Medicare will have to be a major contributor to the effort. There is no way around that, because Medicare looms so large in the budget and it is a major contributor to projected spending growth.

The necessary savings will have to come largely from the traditional policy measures employed to slow Medicare's budgetary costs in the past, and providers and beneficiaries are going to have to sacrifice. They are going to feel the changes that are made.

The fourth point that I would like to make is, to keep the Medicare program viable over the longer run we will have to adopt more fundamental structural reforms. Reforms such as these are complicated and difficult undertakings. Many complex design and implementation issues will have to be resolved.

New institutions will have to be created, new administrative capabilities will have to be developed, and tools and mechanisms that do not now exist will have to be devised. All of this will take time, but the sooner we begin to make these changes the less disruptive they need be.

As we begin to consider the structural reforms, it is important to keep in mind not only what we do know, but also what we do not know. One thing that we do not know is the magnitude of the savings that might be generated by structural reforms that encourage managed care and create a more competitive marketplace.

These savings probably would not constitute significant amounts over the next five, or even 10, years and, therefore, they should not be expected to contribute significantly to the effort to balance the budget by the year 2002.

My final point is, if we adopt fundamental structural reforms in Medicare, this program could lead the Nation as we evolve a new and more equitable and affordable system for providing health insurance.

The institutional and administrative capabilities, risk adjustment mechanisms, quality evaluation systems, and other elements that will be required for the smooth functions of a more competitive and efficient health insurance market, can be developed and tested by the Medicare program.

Ironically, this is a total reversal of the order of reform that was embodied in the various health reform proposals which this committee considered last year.

I will be happy, after the panel finishes, to answer any questions.

The CHAIRMAN. Let me ask you one. Don, feel free to ask, too, because it is just the two of us here and I think we can ask as we go.

You have four possibilities. You have payroll taxes, Part B co-insurance, and deductibles, and structural. It is only the structural that is really back-loaded. If we go from 31 to 35 percent on Part B, that raises an immense amount of money right away, or just go to $200 on the deductible or co-insurance. It is quick money.

Dr. REISCHAUER. Certainly those changes are the changes that we have used in the past to bail out the system. They leave the fundamental structure of the Medicare program unchanged, and I think all of the previous witnesses—myself included—have suggested that that structure really has to be changed.

The CHAIRMAN. Yes.

[The prepared statement of Dr. Reischauer appears in the appendix.]

The CHAIRMAN. We will conclude with Dr. John Rowe, who is the president of the Mt. Sinai School of Medicine and president of the Mt. Sinai Hospital and Health System, and formerly a director of the Division of Aging at the Harvard Medical School.

Doctor?

STATEMENT OF JOHN W. ROWE, M.D., PRESIDENT, THE MOUNT SINAI HOSPITAL AND THE MOUNT SINAI SCHOOL OF MEDICINE, NEW YORK, NEW YORK

Dr. ROWE. Thank you, Mr. Chairman, Senator Nickles, for the opportunity to testify on the mission of Medicare.

I am a geriatrician. I have dedicated my career to the care of the elderly. I am not an economist. I will direct my comments to those aspects of Medicare reform that I think relate to the care of the beneficiaries.

It is important that Medicare be considered not just another insurance program, it has a broader mission, including assuring the quality of and the access to health care through training of physicians and maintenance of hospitals that serve a disproportionate share of poor patients.

Its beneficiaries have substantially greater health care needs than their younger counterparts, and one area of concern is that the discourse regarding Medicare suggests, Senator, that all Medicare beneficiaries are the same.

This is a tremendously heterogeneous population of beneficiaries. The health care needs of 66-year-olds are very different than the health care needs of 86-year-olds, and those individuals over age 85 are the most rapidly growing portion of the population.

Congress, and more particularly this committee, has recognized from the outset of the Medicare program that graduate medical education programs improve the quality of care and enhance the development of clinical research, and provide access to a high level of care for populations that would not normally access this care.

Physicians in training provide a substantial amount of care in supervised settings to the elderly, and training of physicians in the care of the elderly must be a cornerstone of any strategy to achieve Medicare's goal of accessible, cost-effective, high-quality health care for older Americans. The elderly are not just old adults, any more than children are young adults; care of them requires specialized experience and education.

The Institute of Medicine has concluded that current recruitment and training efforts will fall far short of producing enough skilled physicians in geriatrics to form a core of teachers for the next generation of physicians.

A primary goal of the Medicare trust fund should be to assure that American medicine provides all physicians during their training with the knowledge, the skills, the attitudes, and the values to provide high-quality care for older individuals.

Let me turn to the issue of support for hospitals. Medicare provides supplementary support for hospitals that provide care to disproportionate numbers of indigent patients. It does so to guarantee access to care for these needy Medicare beneficiaries. Despite this, recent studies of access by HCFA demonstrate persistence of substantial pockets of vulnerable populations, with very limited access to care.

These populations, which include the urban poor, have limited access to comprehensive and continuous ambulatory care, preventive services, and the newer procedures performed in hospitals.

For many of these elderly Medicare beneficiaries, the sole or dominant source of care is a large, busy, private, not-for-profit hos-

pital under fiscal stress. There are approximately 250 of these hospitals in the United States, and crippling these at-risk hospitals that serve the inner city poor will dramatically reduce the access to, and the quality of care, for a large number of older Americans.

It will place them in the absurd position of being eligible for Medicare services and not having access to these health care services. Such a scenario would represent a failure of Medicare and a violation of the basic tenet of medicine "primum non-nocere, above all, do no harm."

In New York City, Senator, there are three of the five largest hospital beneficiaries of Medicare payments for graduate medical education: Montefiore Hospital, Presbyterian Hospital, and Mt. Sinai, three out of the five largest in the country. Those three hospitals surround one population.

Crippling those hospitals' ability to provide care to that population would have a summative effect of dramatically reducing access to care for that population. They have nowhere else to go. Far too few physicians are practicing in the community, and the hospital is the source of that care.

Clearly, Medicare cannot be expected to shoulder the entire private and public responsibility for medical education and disproportionate share payments. But, given the erosion of support from other payors, as reviewed in The New York Times editorial yesterday, teaching programs are already downsizing and Medicare must at least maintain its traditional commitment so that these hospitals can maintain their commitment to physician training and caring for the urban poor.

As a geriatrician, I feel compelled to talk about one specific aspect of care for older people that I think is overlooked. I know it seems absurd to talk about additional things that should be done in Medicare, but I have this opportunity and I have worked on this for 20 years, and I cannot resist.

A major factor limiting access to and quality of clinical services provided to the elderly is a tremendous deficiency in this country in palliative care, which is humane, comforting, medically appropriate care of the physical and psychological needs of dying individuals.

Only one-fourth of the residency programs in the United States include any required instruction in terminal care. In the United States, every day in our hospitals we substitute painful, cruel treatments that demean personal dignity, such as urinary catheters, feeding tubes, physical restraints, invasive diagnostic and therapeutic maneuvers, and sedating medicines which are pharmacological straightjackets. We substitute those technologies for the close personal attention that would represent the highest quality care for dying patients in American hospitals.

Reimbursement policies under Medicare act to decrease palliative care. Hospital survival depends on the shortest possible length of stay. There is no DRG for terminal care; the emphasis is getting the patient out of the hospital quickly. How do you do that when a patient is dying?

Medicare must assure that quality care is extended to those patients who die, as well as those who survive. Since the majority of medical students and residents in the United States receive most

of their training in hospitals, and over two-thirds of Americans who die, die in hospitals, it would seem appropriate that hospital-based physicians be supported by Medicare to provide palliative care.

Thank you very much.

[The prepared statement of Dr. Rowe appears in the appendix.]

The CHAIRMAN. Doctor, on page two of your statement.

Dr. ROWE. You read it. They promised me you would not read it.

The CHAIRMAN. "Any analysis of the Medicare program, or other health programs, for that matter, must consider three aspects: cost, quality, and access." As cost is receiving more than its share of attention, you focus on something else. I understand. Should cost be a consideration?

Dr. ROWE. Yes.

The CHAIRMAN. It almost sounds like your testimony is that cost—I mean, do no harm, take care of dying patients. If we are going to attempt to restrain the growth, where does cost come into this in the particular aspect of medicine that you practice?

Dr. ROWE. Senator, I believe that cost is exceptionally important, it is as important as quality and as important as access. And I do not mean to eliminate it, it is just that it seems to me that everyone else is talking about it and I try to put a bit of a human face onto the Medicare beneficiaries rather than their being cost centers.

I am fiscally responsible. I am the CEO of a $1.3 billion a year academic health science center. That is revenues; expenses are a little above that. I think cost is——

The CHAIRMAN. So is the Federal Government.

Dr. ROWE. Yes. I think cost is essential and I think we have to reduce cost. I am just concerned that, as we do it, we pay attention to why we started this in the first place. I recognize that cost must be contained and I would like to make sure that when we are done doing that we do not look back and say, oh, but we overlooked this central mission, or that central mission. I am concerned that some of the debate that I have heard suggests some approaches that would, in fact, do that.

The CHAIRMAN. Give me some mega suggestions as to how we reduce this cost.

Dr. ROWE. Well, I think that managed Medicare, in a revised format so that it does not reward managed care entities that skim off patients by enrolling them in the fourth floor of a walk-up at 2:00 in the morning, or something. Managed Medicare promises to save some funds. I think the suggestions about putting balance back in Part B are responsible to the original mission. As you pointed out in your comments, the original mission——

The CHAIRMAN. Back to 50 percent?

Dr. ROWE. Well, I would think back closer to 50 percent than it is. As you point out, let us go back to the original intent, what the promises were to the American people. That slid a bit, and there are lots of resources there.

I think that my concern is that the easy fixes are going to result in hospitals restricting—and if we have time I can tell you what it would cost my hospital—access to care, particularly ambulatory care, high-risk neonatal care, pediatric care. And we know, we have

learned a lesson, that that results in greater costs later on with greater hospitalization for these ambulatory care-sensitive issues.

So I think that we have to reform it, not only from an economic point of view, but from a point of view that is informed by what we know about health care for the elderly. But I am strongly supportive of your intention and the other members of Congress' intention to fix this, because it is broke.

The CHAIRMAN. Well, I am intrigued with your Part B suggestion. If we go to 50 percent and hold harmless everybody so that their Social Security would not go down, that produces, in 7 years, $173 billion. It may have the added effect that Mr. King might say people are paying a larger share of their medical expenses, and they might not utilize them as much also.

But are you suggesting we go to a 50 percent on Part B, which was the intention?

Dr. ROWE. No, I think you are. I am suggesting that we get this program back in balance and get closer to the original intent. It seems to me, I do not want the elderly to pay any more than they are paying and I do not want them to get any less care.

But, as I look at it as a non-economist, it seems to me that that is the area in which there are substantial opportunities and which, if it were sculpted correctly, the urban poor would not disproportionately be affected, they could be protected.

I also want to emphasize to you, Senator, that the number of hospitals that we are talking about that are these large, busy, intercity hospitals that provide this care to these large numbers of poor elderly, is not in the thousands, it is a relatively small number of institutions that are completely dependent upon the Federal Government for their survival.

Dr. REISCHAUER. Mr. Chairman.

The CHAIRMAN. Dr. Reischauer.

Dr. REISCHAUER. Raising the Part B premium so it covered 50 percent of the elderly's cost would do nothing to utilization directly. Indirectly it might reduce utilization marginally because some folks would not have the resources left to buy a Medigap policy, and that would have an effect on utilization.

Not wanting to use this word, an increase in the Part B premium is the functional equivalent of a tax increase. We are asking ourselves, who should it be imposed on, and we are saying here it should be imposed on the beneficiaries.

I see Dr. Butler is getting very exercised. I have no problem with this. The Medicare program is providing very large subsidies to current beneficiaries now, but it is a way of raising more revenue rather than lowering the spending of the program.

The CHAIRMAN. Dr. Butler, do you want to comment? Then we will move to Senator Nickles.

Dr. BUTLER. I disagree fundamentally that raising the Part B premium is a tax. As we all know, the Part B system is a voluntary program which people can make a decision as to whether they want to enroll in. It is a very attractive option because it is roughly 75 percent subsidized, whether you earn $1 million a year or zero.

To reduce a subsidy and call that a tax, I think, is an Alice in Wonderland view of budgets, where any reduction of any subsidy is a tax. If that is the case, then if you reduce subsidies to large

corporations, and reduce subsidies to all sorts of people in this country, you are going to be hearing everybody describing it as a tax.

Dr. REISCHAUER. It is a receipt. It is not compulsory in the sense that a tax is. But, as you say, when you put something that is an unbelievably good deal in front of people, and it will be a good deal still if they only have to pay 50 percent of the costs, it is not really a free choice situation.

Dr. BUTLER. Well, I do not agree with that. It is, of course, a free choice situation. One can either choose it, or not choose it. The choice right now is between a heavily subsidized, very inefficient option, where the actual price to the beneficiary is very low, versus a change in that subsidy which would encourage people to look for more efficient options that would bring savings to the taxpayer, as well as reduced cost in outlays. I think that is the issue we are dealing with. And to call that a tax increase, I think, is absurd.

The CHAIRMAN. Senator Nickles.

Senator NICKLES. Mr. Chairman, first, I would like to ask all four of our panelists a question. All of you agree that we need to do something. Congress should make some action, and I guess our options are limited to reducing the rate of growth or increasing the amount of money coming in, either through payroll taxes or increases in Part B premiums, or something.

Would you all agree that Congress needs to do that and should do it earlier rather than later?

Dr. ROWE. As a non-economist, I would keep to my medical theme. I would agree with that, but I think that some of the suggestions in the discourse here and elsewhere indicate that this patient is in the intensive care unit, and I do not think the patient is. This is a chronic illness for Medicare, not an acute illness. It can be brought into solvency with reasonable, early, I agree, adjustments, but some of the suggestions go beyond that.

Senator NICKLES. Let me put a little more sense of urgency. Most people have mentioned the year 2002 as being the time when the trust fund is bankrupt. But am I not correct—and Mr. King, you are a former actuary, maybe you can handle this, or Dr. Reischauer—it is going to actually start spending more than it is taking in in 1997.

Maybe that is the way to describe it; the fund has to borrow money. Correct me if I am wrong, but, theoretically it is a surplus, but the Federal Government is going to have to borrow money in 1997 to keep Medicare solvent. Is that not correct?

Mr. KING. Basically, the reserves of the fund are beginning to decline next year and the Federal Government will have to borrow from sources other than the trust fund.

The CHAIRMAN. We are liquidating the bonds, so we have to borrow to pay off the bonds.

Senator NICKLES. But, in reality, there is not even a bond.

Mr. KING. Right.

Senator NICKLES. In reality, we are borrowing that money. There is a paper entry that says that there is a trust fund of $125 billion, but in reality the government is going to have to issue T bills to pay for this, beginning in 1997, not the year 2002. I just make that point.

Mr. KING. Senator, I would agree fundamentally with what you said, with one caveat. That is, that if you are going to use revenues to solve the problem, then it is not just a question of increasing the revenues, you have to increase the rate of growth in revenues, too, if you do not do anything to address the rate of growth in the outlays.

Senator NICKLES. Well, Mr. King, let me just touch on that then. We have two or three different options. If we relied solely on the payroll tax to keep Medicare solvent, right now the payroll tax is what, 2.9 percent of payroll?

Mr. KING. Yes, sir.

Senator NICKLES. How much would we have to increase the payroll tax, or do you have those figures, in a certain number of years to keep Medicare solvent?

Mr. KING. To keep the program solvent on a pay-as-you-go basis, by the year 2025 the payroll tax would have to double, and by the year 2065, it would have to triple, roughly.

Senator NICKLES. All right. I appreciate that. In the year what it would have to triple?

Mr. KING. 2065.

Senator NICKLES. All right.

Now, I want to get into this question that Chairman Packwood brought up in a little discussion with our panelist on subsidies on Part B. Mr. Chairman, I will confess, I have an interest. I have two children in their 20s that are taxpayers that are subsidizing Part B.

So, I heard Mr. Butler, I heard Mr. King, and then Dr. Reischauer. I was looking at all of the recommendations, and part of your recommendations were increasing co-payments, or I am going to say Part B premiums. I was reading into, I think, all three of your statements that that would be income-related. In other words, we would end the subsidy at some point for upper income people. Is that a correct summation?

Dr. BUTLER. I think there are several options. One is just to make it a flat 50 percent or some flat amount, or to have an income-related change. I think that, in reality, that would be a better way and that would mean that people in very high incomes would be paying a much higher proportion than 50 percent of the premium.

The CHAIRMAN. Except the problem with that is—and I support it—there are not enough rich in this country. It does not produce an overwhelming amount of money. I do not know if Dr. Reischauer has got the figures.

Dr. BUTLER. No. I am not really suggesting that it necessarily will change the amount of money that is saved by doing that, I just think, as a matter of principle, the original intent of Part B was——

Senator NICKLES. But, Mr. Chairman, you said if we went to 50 percent it would raise——

The CHAIRMAN. Well, that is if you go to 50 percent for everybody, $173 billion.

Senator NICKLES. But what if you went to 100 percent? In other words, saying for people who had incomes above $100,000, we are not going to subsidize it.

The CHAIRMAN. I am going to pull this from memory if I can, and we may have it here. As I recall, when we were talking about a $100,000 threshold and they would pay 75 percent, we were talking about $5–7 billion, I think, over 5 years. At 100 percent, I am going to take a guess, maybe $10 billion; I am not sure. So is it big money? Yes. Does it solve our problem? It does not come close to solving our problem.

Senator NICKLES. Would all of you agree that raising payroll taxes is not a solution and, therefore, Congress is going to have to take some measures, maybe, Mr. King, as you suggested, having the participants contribute more as a percentage, but making some changes, some reforms, to reduce the rate of growth in the Medicare fund to keep it solvent, and that needs to be done soon? Is there agreement with that?

In other words, reducing the rate of growth, as proposed by some, from 10.5 percent to 7.1 percent, or somewhere in that neighborhood, to try and keep the fund solvent? I have not heard anyone beating the drums saying, we want to have a payroll tax increase, or that would solve the problem.

Therefore, if the payroll taxes are out as a solution, which I think probably should be out, then we are going to have to reduce the rate of growth in the program. Is there consensus amongst the panel on that?

Dr. BUTLER. Well, I certainly take that view. I think that, as Mr. King will point out, and has done, the amount you would have to raise in payroll taxes if you took that route simply to keep the current system functioning as it functions today would be staggering in size.

So I do think that we have got to recognize that the way the program functions today leads to the rapid rate of growth of outlays and that, therefore, we should be looking at the way the system functions and changing that.

I am not talking about cuts in benefits or cuts in prices paid, but you have a system which functions very differently from the way other health systems function, even those run by the Federal Government. That is the root cause of the problem that has got to be identified and dealt with.

Dr. REISCHAUER. My view on this is, increased payroll taxes are the least desirable of the alternatives that you have before you. But, as you begin plowing through the other alternatives—raising Part B premiums and looking at how much can you get from that, reducing provider reimbursements by lowering the update formulas, reducing indirect teaching payments or disproportionate share payments—you are going to realize that those have very detrimental impacts on things you care about as well.

It might end up that we have to rely on all of these possibilities over the short-run while we wait for the structural reforms to kick in. That may be unavoidable.

Senator NICKLES. Thank you.

Mr. KING. Senator, I agree with the other panelists, because raising the payroll tax is a fundamentally unfair way to attempt to solve the problem. First of all, it does not solve the problem, and what it does is shift the burden onto future generations who are

not going to get the same Medicare program that current beneficiaries get.

Senator NICKLES. Thank you. I thank the panel.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Grassley.

Senator GRASSLEY. I was very much interested in the last question that Senator Nickles just asked, and so that answered one of my questions. Anybody on the panel could answer my first question, but I guess I would feel particularly favorable to having Dr. Butler and Dr. Reischauer respond.

Many of us still believe that health care reform is necessary, but one of the questions in the current debate is whether we should wait to address the Medicare program problems until we are ready to advance on a broader health care reform. That is the position entirely of the White House, as I see it. They are shaping their whole debate around not solving this Medicare problem unless we do it in the context of broad health care reform.

In your view, is there any reason why we should not go forward trying to fix the Medicare program problems, even if we are not ready to deal with broader health care reform?

Dr. REISCHAUER. My view is, no. Medicare is lagging the private marketplace rather considerably. It has a long way to go to catch up. I believe, as I said in my prepared statement, that structural reforms could be made in Medicare that, in fact, could lead—not just catch up, but lead—the changes that are taking place in the private sector as well.

I think it is unreasonable to expect the systems to get too divergent from one another. It would be undesirable if we had one structure that was providing insurance and care for the elderly and a rather different one for the non-elderly, non-disabled populations, because then providers would be faced with conflicting sets of incentives which would be, I think, detrimental to health care and to the financial stability of institutions. I think that we can move forward with reforms in Medicare, and should, without necessarily considering broader reforms in the entire health care marketplace.

Dr. BUTLER. I agree completely with Dr. Reischauer on that. Medicare is really almost an example of a time warp; in its design and functioning, it is 20 years out of date compared with what is happening elsewhere in the health care economy.

As I stressed in my testimony, I do not think this is just a coincidence. I do think a program that is centrally designed in Washington cannot be expected to function the same way in mid-town Manhattan as in the north slope of Alaska. It is not likely to work efficiently and prudently. So I think that that fundamental design needs to be overhauled, but I agree that we have a situation of Medicare being well behind everything else that is going on.

So, the first step is to bring it up to date along the lines we have discussed. I also feel that structural reform of the entire health care system is necessary, but I think that should wait until Medicare catches up, at the very least.

Senator GRASSLEY. Now, neither one of you mentioned the term cost shifting. I assume, although I have not heard the Vice President or the President use that term either, that that is what they

are talking about. If you reform Medicare to too great of an extent, then you are going to enhance cost shifting.

To what extent has the potential for cost shifting changed recently; has it decreased? Are you able to give us any concrete sense of the extent to which it might have changed? Are there still any victims of cost shifting, if it has decreased?

Dr. BUTLER. I will leave it to others, to some extent, to argue about whether it has increased or decreased. Maybe Dr. Rowe is best placed, on the front line, for answering that.

But let me just say that, if you try to curb the general growth in costs of Medicare, as we have been doing, by trying to tighten up on fees and prices in the system, then what we see here as in any system, whether it be in health care or anywhere else where you use a price control method, is that the costs are shifted to the less regulated or the unregulated area.

That is what happens everywhere price controls are used, whether it be in the housing market or the health care market. So the more you try to control costs by squeezing prices, the more cost shifting you will get.

Now, as you change prices—and there have been adjustments in the fee schedules—that has all kinds of effects at the margin on what happens. But the general pattern of trying to use price controls is that it will lead to cost shifting.

That is why I argue that, if we are talking about restraining the rate of growth, what we have got to do is to look at giving incentives for innovative ways to deliver services, to put together packages of services, all these kinds of things, where prices may be very different for the same procedure in different places depending on how plans feel they are best able to produce the product and the services that we want in Medicare.

Mr. KING. Senator, I am not fundamentally disagreeing with Dr. Butler about what could happen if the payments to providers under the Medicare program were tightened up, however, I might add to that that, up to this point, there certainly is no credible evidence, in my opinion, that Medicare has succeeded in shifting cost to the private sector.

I think the private sector has been one step ahead of the Medicare program in making sure that when Medicare tightened up, the private sector reacted in such a way that the costs were not shifted to private sector payors.

Dr. ROWE. I would just say that, from the front lines, I am in New York where cost shifting is severely limited by regulation and tying together of the various payment schedules.

But the major change that we see is that, with increasing penetration of managed care in the non-Medicare market and the lack of recognition of those payors for some of the costs associated with large urban teaching hospitals, that there is decreased, rather than increased, opportunity now and in the future for cost shifting, so that the opportunities, even outside of New York, that did exist for hospitals such as ours are decreasing rather quickly as managed care increases its penetration.

Senator GRASSLEY. Thank you.

The CHAIRMAN. Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman. I would like to pick up on that last discussion on managed care and direct some questions to Dr. Reischauer.

Dr. Reischauer, what do you think is the reasonable, attainable percentage of Medicare beneficiaries in a managed care system? I understand, today, about seven percent of the beneficiaries are in managed care. What do you think?

Dr. REISCHAUER. Seven percent are in a risk-managed care environment. An additional 2 percent are in managed care that is cost reimbursed. The CBO baseline has the fraction of Medicare recipients in managed care rising to about 20 percent by 2005.

A lot of this increase will, of course, depend on how the private market evolves and also on whether Medicare advertises or lets its participants know about the HMO alternatives that are available. The program does not do a very good job of this now.

So, the future HMO share is open to a good deal of uncertainty under the current circumstances. The potential over the long run, depends very much on what kind of incentives, what kinds of carrots and sticks we provide to encourage people into more efficient delivery systems.

The larger the stick, the juicier the carrot, the more people will take advantage of this option. I would not doubt that, if you went to the maximum, you could get over half of the population in HMOs.

There is a certain fraction, maybe a quarter or so, who live in less densely populated regions of the country where it is unrealistic to expect managed care delivery systems and competitive markets to develop.

There also will be a group of people who, if given the alternative of staying in a fee reimbursement system, even if they are asked to contribute substantially more, will choose that option.

So, I do not think it is reasonable to suggest that over the next couple of decades we are going to get 100 percent, or even 75 percent of the population in strict managed care delivery systems.

Senator GRAHAM. Currently, the Federal Government prices managed care at 95 percent of the average fee-for-service within that community. Could you comment as to whether that is an appropriate method of managed care reimbursement, and if not, what do you think would be an appropriate method?

Dr. REISCHAUER. Well, the studies that have been done suggest that this is a generous payment level because those selecting the managed care or the HMO option tend to have lower health risks than those remaining in the traditional system. So, this is a mechanism that has not been fine-tuned even for the current system.

In the long-run, I would agree with Dr. Butler's suggestion, that what we should be moving towards is some system in which participants are given a fixed amount of money, adjusted for cost and other factors that vary across market areas. Participants would be asked to pay the marginal cost if they choose plans that are more expensive than the Federal contribution.

The level of the Federal contribution is a judgment that policy makers will have to decide. How much savings do you want? How much do you want to spend on health care for the aged and the disabled? You can set these levels anywhere you want; health care

will be provided. The amenities associated with that health care, the quality of that health care, et cetera, will vary depending on where that level is set.

Dr. ROWE. Senator Graham, if I could comment also on that. Your question is whether or not the average annual per capita cost is a fair way of reimbursing or paying under managed Medicare. I would like to make two comments.

One, is I think the trouble that HCFA has had in the Medicare program with respect to managed Medicare grows out of this myth that it is a homogeneous population with equal risk and equal utilization. It is a tremendously heterogeneous population, and obviously what has happened is there has been a certain amount of skimming and there has been profit in that 95 percent. So, we have to keep the heterogeneity in mind.

The other point I would make is, the experience in several HMOs in managed Medicare is that, while they have been provided graduate medical education and disproportionate share payments or its equivalent in their payments on a per capita basis, those have not been passed through to the intended beneficiary institutions.

So, the teaching hospitals would feel that it would be fair to carve those payments out of the AAPCC rather than have that go to the HMO as an additional source of profit for the HMO. This would more reflect the needs of the population that does not have access through the managed care plan.

Senator GRAHAM. Thank you.

The CHAIRMAN. Senator Hatch.

Senator HATCH. Thank you, Mr. Chairman.

Stuart, I was particularly interested in your comments on pages three and four of your statement regarding the problem of providing innovative new therapies to Medicare beneficiaries. You state that "the current price control system of Medicare fails to control costs because its bureaucratic nature reduces the pace at which efficiency and improving innovations are introduced."

You further state—and I agree with you—that "it is the bureaucracy within the Health Care Financing Administration which is to blame for the denial of state of the art medical technology to our Nation's seniors in the Medicare program."

You refer to the fact that Medicare denies reimbursements to hospitals which conduct clinical studies on Medicare patients. This is an issue we have not heard much about, but which I strongly believe presents a real problem for not only Medicare patients, but for the introduction of new and innovative technologies.

In effect, what is happening is that Medicare patients are being denied some of the most promising and latest technology that is already available to the non-Medicare population.

So I guess what I am saying is, would you elaborate on this issue? Again, this is not something we have heard much about, and which I believe, in the context of structural reform of Medicare, may be something that we desperately need to correct. But I would like to just hear what you have to say.

Dr. BUTLER. I think that it is important to understand the process that occurs in the Medicare system, as opposed to say the provision of benefits through corporate plans, or individual plans, or whatever.

In the Medicare system you essentially have a situation where approval for every innovation, both in the structure and payment of the system, such as the percentage that you are going to set for, say, managed care, or the provision of specific services, has to trickle up through an entire system, a bureaucracy, and in some cases major political decisions have to be made before any of these things can be introduced.

In the rest of the health care market, you find a continuous innovation. This is driven by the incentives within that system and it is driven by the demands of the patient, or the corporate buyer in some cases.

So, the reason why this occurs, as I say, is not an accident. We are bound to have a slower rate of innovation, both of procedures and the way in which service is delivered in Medicare the way it is designed today, than we will see in the rest of the health care system.

That is why I argue that we ought to be moving towards more of a defined contribution system to encourage competing plans and competing providers to offer services that are more cost effective and better medical care for the elderly.

Until we move in that direction, all we are going to do is try and catch up and continually try to break down bureaucracy. It will always be there because of the nature of decision making in the Medicare system.

Dr. ROWE. But, Stuart, I think it goes beyond that. I think Senator Hatch is really right on. Mt. Sinai Medical Center, where I work, has discontinued clinical research on investigational devices for Medicare beneficiaries because of a ruling——

Senator MOYNIHAN. On what, sir?

Dr. ROWE. For Medicare beneficiaries.

Senator MOYNIHAN. What is that, devices?

Dr. ROWE. Yes. let me explain, Senator. The Inspector General of HHS has indicated that if a patient is given an investigational device—that is something that is not approved by the Food and Drug Administration for general use—during their experience in the hospital—let me be clear on this—then the entire reimbursement or payment for that admission to the hospital is not allowed and the hospital is liable for treble damages.

An example: a 70-year-old patient in New York City, former U.S. Senator or Congressman, gets admitted, has a heart attack.

Senator MOYNIHAN. That is a good age.

Dr. ROWE. Has heart surgery, does well with that, and has a heart rhythm problem on day 20 and gets a pacemaker. But the pacemaker is included in a clinical study because the leads for the pacemaker have been changed. It is an innovation, a new pacemaker.

Therefore, that is clinical research, not health care, and the entire admission can disallowed under certain circumstances, the treatment for the heart attack, the treatment for the surgery, and we are exposed to potential treble damages. There are cases now being considered by the IG of HCFA. This is called "time out" on clinical research for Medicare beneficiaries.

We recognize that Medicare does not want to pay for research, and maybe NIH should do that, et cetera. But there are differences

between real research and marginal refinements of innovations of things that you would want to have for you or your parents.

So this is one area where the academic medical centers in the United States have really called time out, and we are very, very concerned about the impact of this. And the investigation by the IG has taken a very long time; this may go on for a couple of years.

Senator HATCH. This is important. My time is up, but I would just like to say that we have to do something about this because hospitals are spending a lot of money and time.

They are refusing to do things for seniors that could really be very beneficial to them because of the liability concerns. I might also mention that Senators Gregg, Frist, and I are going to try to come up with a legislative solution; we are working on it and will try and resolve these problems for you.

You have got to be concerned that you cannot help seniors who need the help that you know would be beneficial to them, but you just cannot do it because of the liability concerns.

Dr. ROWE. The hardest part is when my faculty come to me and say, I am in an academic medical center to try to improve care and develop new approaches, and you are telling me there is a policy preventing this research? "I thought we had a physician at the helm of this place." You are telling me there is a policy I cannot do this research because of what the government will do to us?

Senator HATCH. Thank you.

Senator MOYNIHAN. That is a persuasive point, if I can say, Senator.

Senator Bradley?

Senator BRADLEY. Thank you very much.

Mr. King, the Senate Budget Committee suggests cutting Medicare by $256 billion over 7 years. Is that enough to keep the Medicare trust fund solvent?

Mr. KING. My belief is that that applied to both Part A and Part B. Those were both Part A and Part B savings, and depending on how much of that is used in Part B and Part A, that would be enough to keep it solvent.

Senator MOYNIHAN. Could I interrupt to tell Senators that there is a vote on? We will continue this round. You go right ahead.

Senator BRADLEY. I did not quite get your answer. How much money is needed to prevent it from being insolvent?

Mr. KING. Well, it depends on how long you want to keep it from being insolvent. To put it on a path to 25-year solvency, just the HI program alone would require somewhere in the vicinity, depending on the path, say $140–150 billion in savings over 7 years to be on a path towards continued solvency over 25 years.

Senator BRADLEY. And $256 billion is more than that.

Mr. KING. $256 billion, I believe, includes savings in Part B as well. Part B, although it is not in danger of insolvency because of the way it is financed, it is in danger of insolvency because its long-term growth rate is gobbling up more and more of the GDP.

Senator BRADLEY. Right.

Mr. KING. In order to preserve that program for future generations, it will be necessary to get the cost of that program under control as well.

Senator BRADLEY. Dr. Butler, will vouchers limit seniors' choice of providers?

Dr. BUTLER. On the contrary, vouchers would allow seniors to pick plans with different forms, different physicians within them, much as seniors who are former Federal employees can make those decisions. So I think, in fact, it enhances it.

The danger we have right now is, by continuing to tighten prices paid and fees paid to physicians, you are going to find the real danger is fewer and fewer physicians willing to take Medicare patients at all. That is, I think, the real concern, which will mean much less choice under the current system, even though it is a fee-for-service system.

Senator BRADLEY. What about the low-income individual who can only afford the health care plan that the voucher will fully cover? In other words, if they cannot supplement it at all, if they do not have the income to do that, won't their choice of plans be less.

Dr. BUTLER. Their choice of plans will certainly be more than it is today, so I do not know why it would lead to less choice. They would be able to get certain benefits that they do not get today.

Senator BRADLEY. But would it be less than other people who would, of course, be able to supplement the cost of the voucher with their own private resources?

Dr. BUTLER. That is true today.

Senator BRADLEY. But that would be true under the plan?

Dr. BUTLER. That is true under Medicare today; there is no difference. But a voucher program would mean that, let us say, a lower income senior who has a particular problem, which might need maintenance drugs or other kinds of services, could, in fact, get that under a plan within Medicare rather than having to go out and buy an additional plan, as they would have to do today.

Senator BRADLEY. Right. But it would be true under the voucher as well.

Dr. BUTLER. What would be true?

Senator BRADLEY. That a low-income individual would not have the same range of opportunities as the individual who can supplement the program.

Dr. BUTLER. That is true under a voucher program——

Senator BRADLEY. I understand.

Dr. BUTLER [continuing]. Or any other design of Medicare.

Senator BRADLEY. Is it not true under the voucher program as well?

Dr. BUTLER. As it is true under any other design of Medicare.

Senator BRADLEY. Right. All right.

Let me ask this. Will vouchers really solve the Medicare cost problem, in your opinion?

Dr. BUTLER. I think they are a major step towards doing so because, irrespective of how they are designed, they move towards a defined contribution system, which means that the elderly have two different situations facing them.

One, is they can pick a plan that is right for them and, therefore, they can pick benefits that are right for them, and second, it does encourage them to look for the best value for money in the system, as retired Federal workers do. I think that will help to trim the

general growth in cost. I can think of no other method that we can employ in the system to bring about that effect.

Senator BRADLEY. Do you think sicker patients would opt for voucher versus fee-for-service?

Dr. BUTLER. Well, depending on how you design a voucher, I think a sicker patient will be able to pick a plan with the benefits in that plan that actually deals with their sickness.

Senator BRADLEY. All right.

Dr. Rowe, what is your view? I mean, it seems to me that sicker patients would stay with fee-for-service and voucher would go to healthier patients.

Dr. ROWE. As I mentioned before you joined us, Senator, I am at the relative disadvantage in this debate of not being an economist, I am a geriatrician. The old patients that I have been taking care of through my career, if they were sick and vulnerable, they would not change. They would not buy a new government program with a voucher. I bet 90 percent of them could not define what exactly that was.

Senator BRADLEY. Right.

Dr. ROWE. They would stay with what they had rather than take any risk of going into a new program, particularly when it was generated out of a discourse of budget reduction. So, I find it a little unbelievable that they would go out of a fee-for-service system.

Senator BRADLEY. Right.

Dr. Reischauer, could I ask you, please, how long would it take to establish a voucher system, in your opinion?

Dr. REISCHAUER. I think it would probably take five years to set up the institutions that are necessary and there would be parts of the country where it would even take longer.

Senator BRADLEY. All right.

So we have got a system. It is an interesting thought. I mean, it is an interesting debating point. I am glad we are having a hearing on the voucher system.

Dr. REISCHAUER. Just to interject on where beneficiaries would end up. Dr. Rowe was really talking about the transitional issue, which is that people who are already sick and in the system would be very unlikely to shift. But presumably we would have a system that would change over time.

The question is, would people drop out of a managed care environment and go into a fee-for-service system after they have been in managed care most of their working life, and let us say, their first 5 years in retirement. I doubt that that would be the case.

Dr. ROWE. I agree.

Dr. REISCHAUER. But a lot would depend on what kind of cost sharing was required in the residual or traditional form of Medicare. You have to remember that sick people right now can pay very, very large amounts out of pocket because of the co-insurance requirements that we have. Presumably those in a managed care setting would be at risk for much lower payments.

Senator MOYNIHAN. We are going to stand in recess for just a few moments, during which I would like to ask you three gentlemen to consult among yourselves as to just how good an economist Dr. Rowe would have made. [Laughter.]

Dr. ROWE. That is the one thing they will agree on, Senator.

Dr. REISCHAUER. He does not realize that he ruins his credibility every time he says, I wish I were an economist. [Laughter.]

Dr. ROWE. No, I never said I wished I were an economist.

Dr. BUTLER. Well, on the one hand——

Dr. ROWE. But it is safe, because you guys never agree on anything, right?

[BRIEF RECESS]

The CHAIRMAN. The committee will come back to order, please.

I apologize if I ask some questions that others may have asked while I was gone. I am not sure who is coming back, but I do have a few more. Then if I finish and they have not come back, we will wait just a few moments to see if some of the others are. We have another vote coming sometime before lunch, I am not sure when.

Mr. Butler, you suggest the voucher system and some kind of basic benefit package, a modest one, catastrophic and I am not quite sure what else. But do you think the sooner we go to that system there are many near-term savings, or are those going to be gradual?

Dr. BUTLER. I think what Congress has got to look at is a combination of changes. Some would lead to savings right now, and we have discussed some of them in terms of Part B, changes in deductibles, and so forth. But, at the same time, Congress should put into place more structural reforms that will not tend to lead to significant savings until the out years.

The CHAIRMAN. They do not?

Dr. BUTLER. Well, I am saying that one should look at the two-part strategy. One is a structural change which, generally speaking, for all the reasons that Dr. Reischauer has mentioned, you are not likely to see any big savings quickly.

I think you might actually see additional outlays in some cases because you have to set up new systems. But if that can begin to trim down the general trend in costs, and that is cumulative over a period, you can achieve major savings. I think obviously there has got to be a debate over what are the short-term changes.

As I have said over and over again, I think that short-term changes that focus primarily on, say, cutting fees and so forth, will not lead to a better program. But there are other things that you can do, and certainly some of the cost sharing of the some of the elderly at least should be increased.

The CHAIRMAN. I do not want to give you the impression I do not like vouchers, I rather do. Senator Moynihan and I have been involved in tuition tax credits for the better part of 20 years, which is sort of a voucher. It is not quite the same thing, but it has the same effect.

But you do not expect, from just changing to a voucher and a minimum benefit plan, immediate big savings.

Dr. BUTLER. No, because what you are trying to do is change the dynamic of the program and the incentives for people in the program, in order to lead to a gradual process of the elderly beginning to pick plans that reflect quality and price more than they can do today, and which encourages delivery innovations.

I think that if you look at the corporate sector over the last 15 years you have seen an evolution from the early days that has been

dealing with the concerns that Dr. Reischauer mentioned. Corporations learned that giving 95 percent of the average cost if you enroll in an HMO, in some cases, actually costs extra money, for all of the reasons that he mentioned.

Setting payments has gradually been refined over time, and now we are beginning to see the private sector getting costs under control. I suspect that that is the process we would see in Medicare if we moved down that direction.

I do not see any alternative to that, but it is not, of itself, going to lead to big, up-front savings. So you must combine that with other changes that are designed to deal with some of the immediate problems and to get some up-front savings.

The CHAIRMAN. We have actually had some experience in Oregon with Medicare in the market system. We have slightly over 50 percent of the Medicare beneficiaries in Portland in HMOs now, and it is on a voluntary basis. Some of them are paying a bit more for expanded programs, some of them are not. It, by and large, is working out without any rancor.

I think part of it is the history of Kaiser having been in the area since World War II. At one time during World War II, Kaiser employed 30 percent of all the adult labor force; it had three big shipyards. I assume County Independence probably, therefore, had insured half the people in the metropolitan area.

And, after the war, the people liked it and Kaiser continued in the business, although the shipyards are gone. I assume if you have been in managed care all of your life and you get to retirement age and you like your managed care, you think nothing of staying on it.

Dr. BUTLER. I think that is exactly right. I think that is also why you want to have a reform in the system which allows a lot of flexibility in different parts of the country.

It may be that there are more opportunities for certain innovations of delivery in some areas than others, because of the experience individuals have had in the workplace. You do not want to have a reform that tries to lock us into one specific approach, say managed care, or some other type of system. You want to have flexibility. Moving towards a defined contribution system allows you to do that.

A voucher is a very general concept. All it really means is moving to the government giving you a specific degree of help, which could be designed in all kinds of ways, and then allowing the elderly much greater opportunity to pick the plan that is right for them, and the one that they think is best value for money for them.

The CHAIRMAN. It is interesting. In the late 1950s I was in a large law firm. I was low man on the totem pole in their labor law department. But, even then, a number of the collective bargaining contracts had Kaiser as the principle carrier. Health insurance was then $30–40 a month at the outside and you could opt out if you wanted and go to a fee-for-service. I was intrigued with how few people opted out.

Give Kaiser credit; even in those days they would bring some primitive van over and try to do physical exams in this primitive van, and do what preventive medicine they could at a time when others were not doing it.

I remember their testifying in the legislature in the mid-1960s that their hospital—they had a hospital even then of their own—costs were not a great deal cheaper, they just did not hospitalize as many people; they caught more things quicker and did not have to hospitalize so many. It was big employers, usually not small employers, that were involved in that. But the system seemed to work and seemed to satisfy most of the people that were involved in it.

Mr. King, let me ask you a question on your two percent, 10 percent, and the fact that, if you have a Medigap policy, you pay almost nothing and you do not know what your fees are.

Even if we were to go up on Part B, or co-insurance, or deductibles, what difference would it make in behavior if people continued to buy Medigap policies so they still did not know, roughly, what they were paying?

Mr. KING. Yes. If they continued to buy Medigap policies so that they had no idea of what they were paying, then there would not be a behavioral change that would result from it.

The CHAIRMAN. All right.

Bob, do you agree with that?

Dr. REISCHAUER. Yes. Absolutely no behavioral change.

Senator Rockefeller, did you get a chance to ask any questions?

Senator ROCKEFELLER. No.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman, very much.

For Dr. Rowe, I am looking at the House Budget Committee recommendations. The question I am going to ask is, are managed care plans willing to help finance the cost of medical education? In DME, the budget plan would cut $6 billion over 7 years, and in IME it would cut $21 billion over seven years, which is $27 billion total over 7 years.

I have often said, I think there are relatively few in the country, and maybe even fewer in the Congress, that know that Medicare is responsible for 50 percent of graduate medical education at all levels.

If our medical education Medicare numbers are cut, will managed care pick that up?

Dr. ROWE. The short answer is, no, Senator. To give you an example of the impact on an institution, in my institution, Mt. Sinai Medical Center and Hospital, the Medicare component of IME and DME per year is approximately $40 million. This is not disproportionate share; that is another $20 million. This is just the IME and DME to my institution from Medicare, $40 million.

Our experience across the country in Medicare managed care, as I mentioned in a prior discussion with Senator Graham here, is that managed care entities have two sources of profit.

One, is they enroll individuals whose average utilization is less than reflected in the fee that they get, which is 95 percent of that region's average utilization.

And the second is, they retain that component of the fee designed for graduate medical education and disproportionate share so that they have not passed that through to the provider or the institution.

I think my colleague, Dr. Reischauer, agrees with me, or indicated he did, that that is just not only a bonus for the managed

care entity, but a disadvantage to the institution that is providing care. That should be carved out and just given separately. I am all for managed care for elderly individuals. I think it is inherently, potentially, very good.

And I am particularly interested in Senator Packwood's point about prevention. Medicare only pays for four preventive services right now: mammograms, flu shots, pneumococcal vaccine, and Pap smears.

Well, as a geriatrician, if you brought a 70-year-old individual to me, there is a lot of prevention that I would do beyond those four specific tests. And managed care entities, knowing that in the long-run this saves them, are more aggressively involved in preventive geriatrics. I think that is the positive part, Senator.

Senator ROCKEFELLER. Thank you very much for that. To ask Dr. Reischauer, if Medicare Part A is cut by $165 billion, the Part B premium is set at 31 percent of program costs and another $30 billion is made up through other beneficiary cost sharing increases, all of which is now contemplated. I have this question.

Will seniors see a big reduction or a reduction in their monthly Social Security checks since Part B premiums are automatically deducted from their checks?

Dr. REISCHAUER. I do not know the exact numbers; maybe Mr. King does.

The CHAIRMAN. Well, but the present law is a hold harmless law, so that there are no reductions.

Dr. REISCHAUER. You cannot reduce a person's Social Security check. But, under current law, the Part B premium is actually projected to fall in nominal terms in 1996 because it will go from its current fixed level of $46.10, I believe, down to 25 percent of program costs.

The CHAIRMAN. Well, what happened is, when we set it at a dollar figure, we thought we were getting 25 percent, and the dollar figure turns out to be significantly higher than 25 percent. The law falls back to 25 percent unless we change it, unless we just hold it harmless at 31 percent.

Senator ROCKEFELLER. Are you waiting for the next question?

Dr. REISCHAUER. Yes.

Senator ROCKEFELLER. All right. That is all I want to ask.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. On that subject, Mr. Chairman, last week Stanford Ross appeared before us, one of our public trustees of the Social Security and Medicare Trust Funds. He suggested that consideration be given to combining Part A and Part B of Medicare, and he pointed out that the present arrangement, is the result of political accommodations made in the mid-1960's.

I asked Dr. Podoff here, as the institutional memory—not that he is that ancient, he is just learned—and, sure enough, it comes out of the Ways and Means Committee and the Committee on Interstate and Foreign Commerce. For jurisdictional reasons, Ways and Means wanted just a straight Social Security payroll tax arrangement, while Interstate and Foreign Commerce wanted a program funded out of general revenues.

That has given us our present arrangement with separate jurisdictions in the House.

But what does the panel think about combining Medicare Parts A and B? I'd like to give Dr. Butler the first chance to offer is oft always helpful views.

Dr. BUTLER. Well, I once studied that period. But I must admit, my memory is a bit vague on it. But you are absolutely right. We have a Medicare system of two parts, which is a product of political compromise rather than the best design.

We also have two parts of a program run on slightly different principles. Funding principles, one could or should argue, in terms of services to the elderly ought to be more integrated. We also have in Part B a voluntary program where virtually all of the eligible elderly actually choose it.

So, I think that combining the two parts, with other reforms, would help to make sure that services are provided efficiently and effectively in a holistic way to the elderly, and I think it is one element in the reform. Refining the general financing of the system, moving towards a different structure of financing, would also be sensible in that regard.

Senator MOYNIHAN. Thank you.

Mr. King?

Mr. KING. Yes. I think that, fundamentally, the program, both Part A and Part B, are administered consistently by the Health Care Financing Administration now through carriers and intermediaries, so with regard to the administration, there is no fundamental need to combine the two programs.

But combining the two programs creates a very sticky issue with regard to financing because people earn their eligibility for their benefits for Part A while they are working, and then they never pay anything more other than their deductibles and co-insurance for their benefits that they get under Part A, whereas, under Part B, they do not get any benefits unless they enroll.

So you have to deal with the problem, which is, are you going to create a single program where now you are going to tell people who earn their eligibility for Part A, you are going to have to pay the Part B premium to earn eligibility for Part A and Part B combined, or are you going to say that the people in the combined program earned their eligibility by earning their eligibility for Part A and, therefore, nobody has to pay a premium? So it does create a very sticky problem that you have to deal with.

Senator MOYNIHAN. There are some doctrinal issues there, yes.

Dr. Reischauer?

Dr. REISCHAUER. That is a very important issue. There is also another one, and that is that the Part A system has a fiscal discipline that is imposed on it by the fact that the trust fund cannot run out of money and we have to do something. Some people who have suggested merging the two have viewed this as basically a way of solving the Part A problem by tapping into the Treasury. That would be a big mistake.

On the other hand, I think if we are going to move towards a world in which many Medicare participants are receiving their care through managed care plans, having these two separate entities really does not make a lot of sense. So, as we moved toward more fundamental structural reforms——

Senator MOYNIHAN. And we expect that will happen as HMOs become the normal experience.

Dr. REISCHAUER. Well, that will happen in that way, but I would hope that the Congress would adopt some reforms to spur that movement along.

Senator MOYNIHAN. Does the non-economist have a view?

Dr. ROWE. Yes, Senator. I think this runs the risk of being a major step forward.

Senator MOYNIHAN. Uh-oh.

Dr. ROWE. Because what it does is, it gets us out of the mind set of thinking that all this is about hospitals and doctors. This is about health care of older individuals and the health status of the older population. For the indigent poor, many of whom are in our cities, but others in rural areas, in fact, it does not matter because the hospital and the individual providers of care are one and the same.

The hospital and the doctors it employs and trains are the ones that provide the care, be it inpatient or outpatient, physician fee or hospital fee. So, in fact, it also runs the risk of simplifying things for the beneficiaries.

I wish I had a nickel for every one of my patients who comes to me with these confusing bills about Part A and Part B, and I thought I paid this, and aren't I covered, and why did I get two bills, et cetera, or two reports?

So I think that, fiscal issues aside, there are substantial benefits and I agree that the changes in the delivery system are such that it would make those transitions easier rather than harder in the future.

Senator MOYNIHAN. Thank you, Dr. Rowe.

Mr. Chairman, Dr. Rowe said that such a merger runs the risk of being a major step forward.

The CHAIRMAN. Well, we cannot do that.

Senator MOYNIHAN. Well, I thought you had to hear that. I would like to strike it from the record. [Laughter.]

The CHAIRMAN. I would not want us to change our practices.

Senator Graham?

Senator GRAHAM. Thank you, Mr. Chairman.

We are going to be faced, in the next few days, with the question of, can we reduce the projected level of Medicare outflows by approximately $256 billion over the next 7 years without adversely affecting the services to the beneficiaries, or increasing the cost to the beneficiaries. Do you think that is possible, Dr. Reischauer?

Dr. REISCHAUER. No.

Senator GRAHAM. How much change can you make in the system that could be legitimately defined as increased efficiencies without either shifting costs to the beneficiaries, to some other sector of the health care system, or reducing services? Do you think that could be attained within the next 7 years?

Dr. REISCHAUER. These savings can come from a variety of sources and we really do not know how they would be apportioned. Much would depend on exactly which measures you adopted and then you would have to let markets work themselves out.

The hope, of course, is that the first place the reduced spending would come out of would be fraud and waste, but that is difficult

to bring about. Second, one would hope that unneeded services would be reduced. There certainly are some of those, but it is hard, also, to ferret those out.

Savings from lower provider incomes and profits, to the extent that they represent rent—that is an economic term which means more income or more profit than needed to remain competitive in that business—would not affect the beneficiaries. The quality of the providers and institutions would remain the same.

Another source of savings could be greater efficiencies. The resources could be put together in such a way that the same output could be achieved with fewer inputs or less costly inputs. Maybe some amenities—amenities that American people like but are not essential to health outcomes—could be reduced.

But, when all is said and done, there is still going to be a huge chunk of this that will have to come out of fewer services or a slowdown in the improvement in the quality of care. I do not want to say a reduction in the level of the quality of care, but a slow-down in the improvement in the quality.

These conclusions apply mostly to the savings that we are trying to extract from the system over the next 5–7 years. In the longer run, a changed market structure and changed delivery systems could cut spending but leave the quantity and quality of service minimally affected. More savings would come out of efficiency. But I think it is unrealistic to expect that this is not going to hurt; it is.

Senator GRAHAM. Yes. Dr. Butler?

Dr. BUTLER. I just look at this in a slightly different way. I think one way of looking at the situation that you face with Medicare and the budget, is that if no reforms are put into place, Medicare is going to impose itself increasingly on the rest of the Federal budget, both in terms of meeting the short-term financial outflow and inflow gap in the next couple of years, and then, of course, to restore the viability of the program itself. Therefore, it seems to me you have got to try to do two things.

You have got to look at a way of changing fundamentally the way the program functions, to get as many savings as you can by improving efficiency and maybe the selections of services and so forth. But, at the same time, you have got to make some decisions about the continuing shortfall in terms of who pays for that.

That is where I think the bottom line is, and there is a need to make some decisions in that regard. That is where the debate should take place with regard to savings of a more immediate nature; who is going to pay for this?

Senator GRAHAM. What do you think of the $256 billion in cuts over the next 7 years? Dr. Reischauer listed a number of areas, from fraud suppression, reduction of unneeded services, the provider's rent, greater efficiency, elimination of non-essential amenities. What portion of the $256 billion do you think can be found in those categories?

Dr. BUTLER. I think it is very hard to say. I think our experience in health care—indeed, in budgeting, generally but certainly in health care areas—is that it is very difficult to envision exactly what cost impacts and what savings are going to occur.

All I would say, and I think this is the only thing you can say in setting a budget, is that you must do as much as you can to put into place fundamental changes that begin to bring about these savings and efficiencies.

To the extent there is a shortfall, then you have got to make some decisions about whether, in terms of Part B, more affluent elderly should have to pay more towards that program, whether deductibles are changed, and so forth.

I think that is the way you have got to look at it, rather than saying, let us just get a specific target, which I know you have to do for the budget process, and then trying to figure out how much is going to come from this, that, and the other.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Dr. Butler, I guess I would ask this of you. If it is true that 84 percent of elderly women have incomes less than $25,000 a year—which breaks down, interestingly, into 26 percent of 65- to 69-year olds have incomes of less than $10,000, and 55 percent of all 85-year-olds also have incomes of less than $10,000 a year—what kind of choices are they really going to have under a system that causes them to pay a lot more to keep their lifelong doctor?

Dr. BUTLER. I am not quite sure what system you are talking about that would make them pay more.

Senator ROCKEFELLER. Well, if you are going to have to pay more to stay in Medicare.

Dr. BUTLER. Well, I would challenge your premise for that group. If you do nothing, then something is going to have to change. Fees are going to be cut, in which case those elderly are going to discover that their physician is either going to spend less time with them, or is not going to take assignment for them. So they are going to be faced with that situation if you do nothing.

The issue, I think, is how you reform. If you try to make a change that, as far as possible, keeps that group of the elderly, the low-income people, as immune as possible from the financial impact but gives them some alternative choices of getting their health care, then it would mean that that person might be able to pick a plan that has certain procedures in it, including preventive care, as Dr. Rowe mentioned, that is very limited under the current Medicare system. such a reform would allow them to get those services under Medicare rather than, as today, having to pay extra for those services. It would allow that.

So that is why I challenge the premise that a reform of the kind I have been talking about means that individuals in these income brackets are going to "pay more." In fact, what it means is they will be able to get services that they do not get today under the Medicare system and not have to go out of the system.

Senator ROCKEFELLER. If you assume that Medicare's administrative costs are about 2 percent.

Dr. BUTLER. In Washington, yes. Then there are administrative costs that Dr. Rowe and others have to shoulder as well.

Senator ROCKEFELLER. All right. But, still, if you make that assumption.

Then if you say, well, what we will do is give seniors vouchers and we will let them go out and work the private market, what

part of that gets eaten up, or what would you say would be the average administrative overhead cost of the average private health insurance plan or policy that those seniors would be attempting to purchase?

Dr. BUTLER. It is very hard to make a determination because you have got three elements of overhead cost. You have the direct costs that Medicare itself pays, you have got the indirect costs that Dr. Rowe pays in the hospital. And then you have got, to the extent you are running an insurance system, a cost there.

Overhead costs are involved not only in just the simple delivery of a service, but in making decisions about how to effectively deliver services. As you, I am sure, appreciate, there are many very efficient companies in the competitive marketplace outside of health care that may have high "overhead" costs, but part of that overhead is figuring out how to deliver services more effectively.

I think if you want to look at a comparison you might want to look at the FEHBP program that serves the retired Federal workers, many of whom decide to take FEHBP coverage rather than Medicare, and look at the costs associated with that. I think that program is very competitive, as a system, with the way Medicare functions.

Senator ROCKEFELLER. Well, I agree. I agree.

Dr. BUTLER. That is really what we are talking about. A voucher is a very loose term, as I said to the Chairman. What we are really talking about is some method where the Federal Government says to the elderly, we will cover a portion of the plan that you pick.

That could be a voucher. It could be a sliding scale degree of support, so that your lower income person gets far more than they actually get today. There are all kinds of variants. But I think the overhead issue is a bit of a red herring when it comes to how this would actually function, because an elderly person would only pick an alternative with that voucher as opposed to the current system if they felt——

Senator ROCKEFELLER. Dr. Reischauer, do you think that it is a red herring issue? I mean, I make the assumption that those premiums go up 10, 15 percent a year and that the overhead is a very big part of that.

Dr. REISCHAUER. It is not a red herring, but it is a very complex issue. Administrative costs in managed care plans tend to be relatively high, but that is because that is an internalization of the type of overhead that is taking place in the doctor's office, and in the hospital system as well.

What the high administrative costs tend to do is try and delivery services efficiently and weed out unnecessary services. It costs money to save money, in a sense. With respect to other administrative costs, marketing costs, they tend to be high in the private sector.

But, if you structured a managed competition market where Medicare was providing the information largely and the options to its participants, they need not be as high as one finds in, let us say, the small group market, or even the large group markets.

Senator ROCKEFELLER. All right. That was interesting. I appreciate it.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Thank you, Mr. Chairman. I think Senator D'Amato has arrived.

The CHAIRMAN. Oh, I am sorry. Senator D'Amato. I apologize.

Senator D'AMATO. Well, thank you very much, Mr. Chairman. Since I came late and know that many, many questions have been asked, I am going to just read the testimony of the witnesses and yield back to Senator Moynihan so I can attempt to learn more about how we can get innovation into the system.

I will say this. I really do hope that we can come up with the number of changes that will allow competition and attempt to reduce cost. I know this is easier said than done. I certainly think we need to get the medical community involved in the various aspects of how that is possible, if it is possible, and the best methods.

So, I want to commend the Chairman for calling these hearings. This is an important issue and one that needs us working together in a cooperative effort. I yield my time.

Senator MOYNIHAN. Well, if I could just ask one last question of the panel. Mr. Chairman, Senator D'Amato and I are particularly interested in the subject of teaching hospitals.

I spent 1994 studying medicine. Senator Rockefeller has been doing it for most of his life, but I had to catch up fast. I recall the first time I met with a group of physicians from medical schools, in New York as it happened. The first thing I learned I had previously assumed to be impossible. Namely, in a progressive State on the northern tier, someone remarked that the teaching hospitals, such as this particular university, might have to close. I said, what? They never close, things like that, in that State.

Well, they might, indeed they may have had to, because HMOs had advanced to the point where they were covering a large portion of the population. HMOs do not send patients to teaching hospitals because they are more expensive. They are more expensive because they are teaching hospitals, as Dr. Rowe knows, economist or not. I see him nodding.

We, in the last Congress, provided a small tax on medical premiums to provide for teaching hospitals and research. Senators Hatfield and Harkin had wanted the latter. We had broad support in this committee for this tax.

Is this something we should be looking at again this year? I would ask Dr. Rowe to start.

Dr. ROWE. Well, I remember that luncheon, Senator Moynihan. I put in the title of my testimony the term "primum nonnocere, above all, do no harm," because I pointed that out to you as the first tenet of medicine at that luncheon, and you used it in this committee without attributing it to me on 25 occasions thereafter. [Laughter.]

Dr. ROWE. I wanted to just set the record straight.

Senator MOYNIHAN. Well, I do believe it is Hippocrates. [Laughter.]

Dr. ROWE. I do not think Hippocrates spoke Latin, Senator.

Senator MOYNIHAN. A Hellenistic version. [Laughter.]

Dr. ROWE. I would agree with you, and I thank you for your question. The basic point is, of course, that with managed care, ap-

propriately so in many ways, there is a very significant focus on cost.

In the competitive health care marketplace, managed care entities have not chosen to provide to payors, institutions, funds to support the academic mission, training, or clinical research, or to recognize the extra costs associated with a disproportionate share of poor individuals who use more care, as you know.

The teaching hospitals, as was pointed out in yesterday's editorial in The New York Times, rely, therefore, upon the government for these supports. Our institution has 40 percent Medicare and 25 percent Medicaid; 65 percent. I believe Presbyterian Hospital in New York has 44 percent Medicare.

The CHAIRMAN. Of your total revenues?

Dr. ROWE. Of our total clinical revenues, 25 percent Medicaid and 40 percent Medicare.

The CHAIRMAN. What does clinical revenues mean?

Dr. ROWE. It means, not counting our medical school grants from NIH, and things like that.

Senator MOYNIHAN. For care.

Dr. ROWE. That is right. We are not-for-profit, but for the hospital revenues.

Therefore, our concern is that, with increasing focus on cost, no payor will provide the payment to recognize the investment in training the next generation or generating the next generation of knowledge.

Senators Harkin and Hatfield proposed a mechanism by which such funds would be made available outside of this competitive environment. Another approach would be to have HMOs pay some recognized share of that rather than have all the burden be on Medicare and Medicaid.

Senator MOYNIHAN. As you know, sir, we did adopt such an approach in the Finance Committee. In the end nothing happened, but we have a record here.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Pressler.

Senator PRESSLER. Thank you very much, Mr. Chairman.

A concern in my State is that some of my rural hospitals get as much as 80–90 percent of their revenue from Medicare; perhaps this is also true in some urban areas.

The South Dakota Hospital Association estimates that as many as one-fourth of the hospitals may close their doors if the changes in Medicare are too severe. What safeguards can be taken to protect these hospitals from unfair cuts? And I would guess the same problem exists in inner city hospitals; is that a correct assumption?

Senator ROCKEFELLER. I think you mean Medicare and Medicaid, do you not, Senator?

Senator PRESSLER. Yes, that is correct.

Senator ROCKEFELLER. Both. Yes.

Senator PRESSLER. Medicare and Medicaid.

Dr. BUTLER. If I may answer that, I think that if savings in the Medicare system are achieved by simply reducing the amount of money paid to those hospitals to provide the same services to the same people, then the scenario you lay out is exactly what is going

to happen. That is the pattern that we have seen over the last several years in the way Medicare is structured.

I think obviously if savings are achieved through a different approach, by encouraging innovations and ways of delivering care that are different, then these hospitals will be affected much less; indeed, some may gain from that reform because they will be looking at different ways of delivering services with much greater flexibility than they are currently allowed to under Medicare. So, I think those are the choices.

Senator PRESSLER. Does the same problem exist in inner cities?

Dr. BUTLER. Oh, absolutely.

Senator PRESSLER. What are the percentages that the inner city hospitals rely upon Medicare and Medicaid for their operations?

Dr. ROWE. There are approximately 250 hospitals in this country which have the following characteristics: they are large, they are busy, they are urban. They serve a very substantial proportion of Medicare and Medicaid beneficiaries, and have over 55 percent of their revenues from those programs. So, that would be the percentage, over 55 percent. There would be about 250 of those hospitals.

And, as I mentioned earlier, Senator, they are, in some instances, grouped; Senators D'Amato and Moynihan are familiar with this, being from New York. Three of the five largest teaching hospitals in the country—Montefiore, Presbyterian, and Mt. Sinai—are all in the same town, grouped around the same large indigent population. So, the summative impact on that population would be dramatic if all three of those institutions, who are depend on these Federal funds, were crippled.

Senator PRESSLER. Now, as I understand it, the various budgets that are floating around—especially the Domenici budget and perhaps the President's proposed budget—really do not cut basic Medicare/Medicaid, they cut the rate of increase.

Now, one set of numbers I saw said we are cutting the rate of increase from 10 percent to 7 percent. Assuming inflation is less than 7 percent in that area of the economy, then we would are basically looking at a freeze rather than a cut. Is that not correct?

Dr. ROWE. My colleagues can answer this more specifically, but I think the concern is, Senator, with the Medicare population, the rate of growth of the number of beneficiaries in Medicare is greater. That would be fine if there were the same number of beneficiaries and if the cost in that sector of the economy went up four percent, and we are holding it to four or 5 percent, then we should be all right.

The problem is, with the aging of America, the number of individuals in the 65 or greater cohort who are eligible is rapidly rising, and that increase in the number of people is what is driving the basic economic problem, from my understanding.

Senator PRESSLER. So in what years will the biggest upswing in that group occur? I know the World War II baby boom is not yet there.

Dr. REISCHAUER. Actually, we are going through a bit of a demographic holiday right now, the fractions——

Senator PRESSLER. A little bit of a demographic——

Dr. REISCHAUER. Holiday.

Senator PRESSLER. All right.

Dr. REISCHAUER. In the sense that the growth of the 65 and older population is slower than it has been, and will be over the next 10 years. So this is not really what is driving——

Senator MOYNIHAN. We are in the generation of the Depression.

Senator PRESSLER. The Depression, right. The Depression and war years is what we are into.

Dr. REISCHAUER. Yes; so, for the next 10 years, we have a window of opportunity to make reforms before a deluge hits about 2010.

Now, it is true that the composition of the aged is changing in the sense that there are more older folks on Medicare, and they are much more expensive. But what is going on here is what is going on in the rest of the health care world, that we have increased utilization, in other words, the number of procedures that are performed, and the quality, complexity, and sophistication of the treatments we are giving cost more.

And if the rest of the world, the non-Medicare world, is increasing at seven or so percent per capita, it is hard to make the Medicare population survive on a lower rate of growth. I think what Stuart Butler has been pointing out is, we have a system in place in Medicare that does not restrain utilization, does not restrain these cost increases, and it is difficult to wave a wand and say, let us bring the growth rate from 10 down to 7 percent without doing something to restructure the underlying system.

Senator PRESSLER. All right. A final, concluding question. If we take it from 10 percent down to seven percent, inflation is four percent, the rate of increase of people qualifying goes up 3 percent, then we have got a freeze. Is that not about what the percent goes up, about 3 percent?

Dr. REISCHAUER. No, I think it is closer to one percent, actually.

Senator PRESSLER. One percent.

Mr. KING. It is about 1.5 percent.

Senator PRESSLER. Then we are actually increasing. Under the Domenici budget we are actually increasing Medicare by 1–1.5 percent then, if we have four percent of inflation.

Dr. REISCHAUER. In constant dollars you might be. But if the average non-elderly person is receiving health care treatments that are four percent more expensive—I am just making that number up—because they are more sophisticated and more tests are being done, then if you do not provide that four percent for Medicare, Dr. Rowe is not going to be able to provide those services or he is going to have to borrow resources from some other source to provide them to Medicare patients.

Senator PRESSLER. Thank you very much.

The CHAIRMAN. Dr. Rowe, hold old is Mt. Sinai?

Dr. ROWE. We were established in 1852.

The CHAIRMAN. What about Columbia Presbyterian?

Dr. ROWE. I think it was established a substantial period before that. New York Hospital was established by the Charles the something.

Senator MOYNIHAN. George the II.

Dr. ROWE. George the II. Thank you, Senator.

Senator MOYNIHAN. And the College of Physicians and Surgeons at Columbia Presbyterian was George the III.

Dr. ROWE. The major academic health science centers are linked in some very close way with universities and medical schools.

The CHAIRMAN. Is this true of Montefiore also?

Dr. ROWE. Yes.

The CHAIRMAN. And these have been great teaching hospitals for the better part of a century or so.

Dr. ROWE. We like to think so.

The CHAIRMAN. And teaching hospitals, these 250 that you mentioned, simply have disproportionate expenses to other normal hospitals.

Dr. ROWE. Yes. I believe that there are very clear data from numerous sources here and in the United Kingdom that lower the socioeconomic status, the higher your health care utilization, and that goes for elderly people as well as non-elderly, and if you are treating an indigent population, there is greater utilization.

In addition, there are real costs associated with teaching, and those teaching costs and the support of some clinical research costs represent additional costs when you compare those institutions to others.

The CHAIRMAN. How did these great institutions make ends meet before Medicare and Medicaid?

Dr. ROWE. Well, I think that we have made ends meet, in large part, with the assistance of Medicare.

The CHAIRMAN. What did you do for the 70, 80, 90, or 200 years before that when they were great teaching institutions and serving the poor?

Dr. ROWE. Well, I think that we relied substantially on a different health care system and private philanthropy to support the charity care, as well as, in many cases, resources from local governments which are no longer provided to these institutions.

Cities had a major role in providing for the care of indigent members of that city, which I believe they no longer do, with the advent of Medicare and Medicaid but my history may not be as good; perhaps Senator Moynihan remember.

The CHAIRMAN. Why do they no longer do it?

Dr. ROWE. I think it varies, but I think that one of the major driving forces is that mayors, for instance, see an era coming of excess hospital capacity, hospital utilization is declining, there are too many beds.

In an era of excess hospital capacity, why should they run hospitals and provide care when it can be provided in the voluntary not-for-profit sector? So, that is one of the factors which is driving away from the standard of having city-run hospitals.

The CHAIRMAN. Why would that same reasoning not apply to Federal support, if we had excess hospital beds and declining need for beds?

Dr. ROWE. I think that if we focus on the fact that we need to provide care for the individuals, I think that the focus is, how do we provide the care that is needed for those individuals, regardless of where the bed is.

But, as I said in the beginning of my testimony, Senator, I think that payment of the care for individuals who arrive seeking care is one of the missions of the Medicare program.

The other traditional constituentive missions are training of physicians for the next generation of health care and support for institutions that bear the burden of care to the indigent. I think that those have to be taken into account.

The CHAIRMAN. We all go back to earlier days. Again, when I was in the legislature, one of the expenses we had was what we then called the University of Oregon Medical School. It is now the Health Sciences Center.

Dr. ROWE. Yes.

The CHAIRMAN. But the legislature attempted to take care of it, realizing it was a teaching hospital. Are legislatures less inclined to do that now?

Dr. ROWE. Very significantly so. One of the reasons is that many of the States now no longer have the substantial deficiency in number of physicians.

The CHAIRMAN. No longer have what?

Dr. ROWE. Deficiency or deficit in the number of physicians. Many of those medical schools in those States were developed in order to develop a cadre of physicians for Oregon, Kansas, Nebraska, et cetera, and the legislatures, in tighter fiscal times, see less reason to support those institutions.

The CHAIRMAN. Well, then what is the argument for the Federal Government supporting them? If the purpose was physicians, and if we have an excess of physicians, why should we be supporting them?

Dr. ROWE. Well, I think that we do not have an excess of physicians overall, we have a maldistribution of physicians. But I think that the argument for the Medicare program supporting physicians' training is excellent, because if what we are talking about is care of the elderly, that aspect of health care is a very important part of training of physicians, which many physicians have not received previously which is now currently available. It would seem to me that a proper use of the Medicare trust funds is to assure that the next generation of physicians are expert in caring for the Medicare beneficiaries.

The CHAIRMAN. Not having been in the legislature for 30 years, I would just make a top of the head guess, and not getting into an argument about the pie growing, and supply-side economics, and whether we can all have more.

Dr. ROWE. Sure.

The CHAIRMAN. My intuition tells me that the legislatures got out of this or declined in this because they knew the Federal Government was picking up the cost, and they had limited resources and had to balance their budget and we did not. So, they let us take it over because we had the money, or we thought we had the money.

Dr. ROWE. I think that is probably right. I think that, in many cases, they were eased in that because of less pressure locally with respect to the physician manpower issue.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Well, I am going to do something which you are taught in law school not to do. But I did not go to law school. I am going to ask a question to which I do not know the answer.

The CHAIRMAN. This is the first time this has ever happened.

Senator MOYNIHAN. Well, I think I know the answer, but Dr. Rowe certainly knows the answer.

Dr. Rowe, Mt. Sinai has been in place for almost a century and a half. In what decade of which century would you say that the random patient with the random disease encountering the random doctor at Mt. Sinai was better off with the treatment that was received, not just comforted and counseled, but actually, in some sense, treated in an efficacious way.

Dr. ROWE. There was some benefit in the average encounter of the average patient with the average physician.

Senator MOYNIHAN. Yes.

Dr. ROWE. Somewhere in the late 1930's, early 1940's.

Senator MOYNIHAN. There you are, sir. I rest my case. They could not do anything more than comfort until the late 1930's, early 1940's.

Dr. ROWE. The antibiotic era.

Senator MOYNIHAN. Yes. They did not have anything. They could set bones; so could Hippocrates. But he also directed physicians, do not cut for the stone. That is from the Hippocratic oath. "Primum nonnocere" is from the volume "Of the Epidemics" which survived in Latin after having been taken from the Library of Alexandria.

Dr. ROWE. I knew I was in trouble when you left the room for a minute. [Laughter.]

Senator MOYNIHAN. Did you hear Dr. Rowe say, in the late 1930's, early 1940's? Of course expenses rise when you can do something. It took a long 19th century to learn not to harm patients, did it not? By the turn of the century you were not harming anybody. You had to learn not to do that.

The CHAIRMAN. I understand the expenses rise. We have not got any more money than the States. It all comes from the same source.

Senator MOYNIHAN. But you have got a lot more health.

The CHAIRMAN. I understand we have more health. We do not have any more money collectively in this country than you have by adding all of the government taxes and revenues together. The only way we make it is running $200–300 billion deficits a year, and so long as people will loan us money, I guess we can do it. At some stage, that game runs out, I think.

Senator MOYNIHAN. But, Mr. Chairman, I just want to make the point which I thought Dr. Rowe was wonderfully candid about, if you find medical costs rising it is because medicine has changed.

At King's County Hospital, that wonderful hospital out in Brooklyn which the city built, most of the patients probably at one point had pneumonia.

The doctors who sent them there knew that they had pneumonia. They put them in a well-lighted room with a bed, and a nurse looked after them, and they waited for the crisis to come. When the crisis came, either the next day the patient went home or he went out to Greenwood Cemetery. They could not do anything about it. But they did not do any harm, and they comforted the patient.

The CHAIRMAN. But then one of two things is going to happen. If this trend is going to continue, then health is not going to be 14 percent of our GDP, or 19 percent, it is going to be 25, or 30, or 35. If we get better and better at it and it gets progressively more

and more expensive, do we ever reach an end to how much of the Gross Domestic Product we spend on health? I do not mean just the Federal Government, I mean all of us.

Senator MOYNIHAN. A great mistake was made when we stopped discussing these matters in Latin. [Laughter.]

Senator MOYNIHAN. But I rest my case.

Dr. ROWE. That is why I was invited, actually.

The CHAIRMAN. Senator D'Amato, Senator Pressler, either of you have any more questions?

Senator D'AMATO. Doctor, one of the methodologies which has been suggested over a period of time, and I share with my distinguished senior Senator, Senator Moynihan, was to reduce or eliminate a special payments adjustment, such as in graduate schools. Obviously, this would be a disaster for teaching institutions.

Can you think of alternative ways of containing the growth in provider payments that would be more equitable and less damaging to the teaching institutions?

Dr. ROWE. Well, it is always difficult to sort of point to someone else whose ox should be gored.

Senator D'AMATO. Well, we have got to begin to think about that.

Dr. ROWE. Right. I thought it was appropriate to mention that.

I would say, the one thing I would suggest in your question that we might phrase differently is, it would be a disaster, not just for the teaching hospitals, but for the poor, indigent people, particularly in the urban areas, who rely on those institutions.

If we lose, at Mt. Sinai, our direct and indirect payments and our disproportionate share payments, and that is $50–55 million a year, that is $55 million less of care or services we are going to provide in obstetrics, geriatrics, or pediatrics, or something. So I think the services will continue to be provided, but the institutions will be hurt. I think that is really important.

We have spoken earlier here about options with respect to Part B, options with respect to means tests. My concerns are at the center. What will I defend amongst all else? I will defend the fact that I think we need to provide care for poor people and to recognize that they have less capability to participate in the payment of it, and I think we need to provide training for the next generation of doctors. It is a risky strategy societally not to do that. Those are the two core things I need to support.

And, not being an economist, I do not know whether changing the age from 65, to 66, to 67 would do it, or changing Part B would do it, or putting Part A and Part B together would do it, but I do believe that these things, these teaching hospitals, are at the core mission of this. This is not an insurance plan that was started in 1965, it is a very different kind of plan.

The CHAIRMAN. Doctor, you said $50–55 million?

Dr. ROWE. It would be. We have $20 million in disproportionate share, $20 million of IME, and somewhere between $17–20 million of DME Medicare share in one institution.

The CHAIRMAN. This is out of a budget of $1.2 billion?

Dr. ROWE. No. $1.2 billion includes our medical school and our contracts with City Hospital, so the hospital budget is in the high $700 millions.

The CHAIRMAN. All right.

Senator D'AMATO. Well, that would be quite a whack if you were going to take, out of $700 million, $55 million. You are talking about almost 8 percent.

Dr. ROWE. It is about $40,000 a job. For every $20 million, it is 500 jobs.

Senator D'AMATO. Well, I think, Mr. Chairman, that it would come as no surprise to you to know that Senator Moynihan and I share a very, very real interest in seeing to it that, in whatever particular formulas that we arrive as it relates to Medicare, and I certainly believe that we cannot continue beyond the growth rate, we have to do something to check that, or contain it, or bring about more efficiencies. It may be a number of variations in terms of those who have substantial means, contributing more, managed competition, et cetera.

Having said that, there is no doubt in my mind that I will be working with Senator Moynihan very closely to see to it that the institutions do provide the training for our physicians that we need. And I might add that the medical care that is given today is superior to any that was available in any measurable time, whether a decade ago, or 20 years ago.

You can see the progress, whether it is in the treatment of heart failure or whether it is putting together people who are badly smashed up. I have a son today who is in Lennox Hill and he is going to be moved to another facility with a heel that is smashed. It is incredible, the kinds of things they are looking to.

They know that 50 percent of this kind of injury, unless treated in a particular way, will develop, with assurity, an arthritic condition later, so you had better make sure that you are treated. These things were not available, and they are available today.

I had a little experience, a stress test, that gave a false positive. They had me up at a facility and did an angiogram that same night. Incredible. People were not getting angiograms 10 years ago regularly. So, we are paying more, but we are getting more, and life is being extended, I think, proportionately as it relates to these incredible scientific advancements that come, and teaching hospitals play a major, major, critical role. Indispensable.

So, I would hope, Mr. Chairman, who is without peer as it relates to the cost and the consequences of doing nothing, in how they escalate and how they move, also understands that we are going to have to be very sensitive to preserving the opportunities to continue to provide the best in medical care and research that is ongoing.

Again, the Doctor touched on this. I do not want him to think that we do not listen. As it relates to meeting the needs of the poor, there is a very special relationship as it relates to these young, very vigorous medical students and doctors who are in doing their residency in the various specialties, et cetera. We have got great creativity, great training.

The fact is they are administering at a cost ratio that you could never, never achieve. I mean, if they were not there doing this work, they are getting paid probably minimum wage, given the hours, that so many of them put in, tremendous, tremendous hours. So it is something that is of special concern to this Senator, and I just wanted to share it with the Chairman.

I look forward to working with Senator Moynihan as it relates to protecting this very important area in medical care and training.

The CHAIRMAN. Senator Pressler.

Senator PRESSLER. Let me ask one final question after that fine statement by my colleague.

Many doctors and medical providers tell me they spend more time processing a Medicare claim than a non-Medicare claim. Now, it seems to me that Medicare is much more bureaucratic. Do you agree? Is that because of requirements we are placing on the all the forms; how is it that the non-Medicare claims are much less time consuming?

Mr. KING. I can speak anecdotally. A physician that I know has told me that Medicare is not the most bureaucratic of the payors, that there are others who are more bureaucratic.

Senator PRESSLER. Is that right?

Mr. KING. Yes.

Dr. ROWE. Certainly for institutions, our charges to Medicare are electronic, in the large, as they are across the country. HCFA was one of the first, Senator Pressler, to really introduce electronic billing and payments and the central administrative charges in Medicare are down around two percent. That is related, I guess, in part, to the size of the system, but I do not believe it is significantly less efficient.

I think one of the areas where physicians have a lot of problems, Senator, is when they get into disagreements with Medicare about what is covered and what is not. That is often a lengthy and bureaucratic interaction. Maybe my colleagues know more about the system. I do not think it is that bureaucratic. Bob, do you know?

Dr. REISCHAUER. My understanding is that it is not, that there are plenty of private payors that are equally onerous or more onerous.

Senator PRESSLER. All right. Thank you very much.

The CHAIRMAN. Gentlemen, thank you very much.

[Whereupon, at 12:00 noon the hearing was recessed, to reconvene at 9:30 a.m. on Wednesday, May 17, 1995.]

SOLVENCY OF THE MEDICARE PROGRAM

WEDNESDAY, MAY 17, 1995

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

The hearing was convened, pursuant to recess, at 9:35 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Bob Packwood (chairman of the committee) presiding.

Also present: Senators Chafee, Grassley, Hatch, Simpson, Moynihan, Baucus, Breaux, Conrad, Graham, and Moseley-Braun.

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

The CHAIRMAN. The Committee will come to order, please.

This is another in our continuing series of hearings on Medicare. Every economist who has studied this, including Dr. Reischauer who was here, has indicated that Medicare is someplace between $145 and $165 billion short.

And by the trustees' report, it is insolvent, will be insolvent, it takes that much money to get it solvent. And that is short-term solvency. That is not 25 years; that is 10 years.

So we are asking witnesses if they have suggestions as to how we might pick up some money. Obviously, if we can pick up more money elsewhere, you do not have to pick up so much money in Medicare. But how do we slow the growth from where it is at 7 percent? Do you ask beneficiaries to pay more? Do you ask providers to take less? Do you ask for tax increases?

I do not think we can now avoid the understanding that we are $145 to $165 billion short, and that for the last number of years, taxes have been less than the money paid out.

The only way we have been able to pay the bills in Medicare is that Medicare has had some interest income on the Government bonds that they hold, and some other modest income of people that can sign up for Medicare who were not otherwise eligible. Frankly, they are now redeeming the bonds. They return the bonds, the Treasury gives them some money, and in the year 2002 all the bonds are gone. So all the interest is gone, the bonds are gone, everything is gone, and the system is bankrupt.

Our first witness today has been an extraordinary leader in the effort to balance the budget for as long as he was in the Senate. He has been as strong a voice after he left the Senate as he was before. He is one of the co-founders of the Concord Coalition, one of the co-authors of the Gramm-Rudman-Hollings bill, a statutory effort that we made to balance the budget. There is no man who

has done more for a longer period of time to try to effectively staunch the flow of red ink than Senator Warren Rudman.

Warren, we are delighted to have you with us this morning.

STATEMENT OF HON. WARREN B. RUDMAN, CO-CHAIR, THE CONCORD COALITION, WASHINGTON, DC

Mr. RUDMAN. Senator Packwood, Mr. Chairman, thank you very much.

Senator Chafee, my fellow-New Englander, I must say that as I have watched events unfold before this Congress, I am more and more delighted that I sit here, and you sit there. [Laughter.]

I want to just make a correction. As the Concord Coalition staff put these numbers together, I would like to make a correction in the numbers on page 5 of the prepared statement, because the numbers themselves were for a shorter time period. For the time period we are talking about, it should be 7 years. In the last paragraph, it begins, "These reforms to the Part B program," and so forth.

The CHAIRMAN. Which page are you on, Warren?

Mr. RUDMAN. It is page 5, I believe, of your statement.

The CHAIRMAN. All right.

Mr. RUDMAN. I have an enlarged copy.

Senator CHAFEE. That is right. The bottom of page 5.

Mr. RUDMAN. That $85 billion should be $110 billion; the $25 billion should be $40 billion; and the $110 billion should be $150 billion. So would you please make those changes.

The CHAIRMAN. Thank you.

Mr. RUDMAN. Mr. Chairman, I want to point out that I do not represent myself here this morning, but the Concord Coalition.

We have chapters in all 50 States, in almost every Congressional district, several hundred thousand members, and building. We have retired people, young people, college students, working people. This really represents a consensus of what we have done over the last 2 years across this country.

So, if you would permit me, I am going to do the statement itself.

Mr. Chairman, last month the public trustees of Medicare released their annual report on the status of the Medicare trust fund. Their message was clear and unmistakable. Medicare Part A is on a 7-year collision course with bankruptcy.

The report went on to stress that, even if we do not address the larger issue of national health care reform this year, we must act promptly to correct the unsustainable course of the Medicare system.

By ignoring Medicare's obvious difficulties, we put the program, the well-being of older citizens, and our nations' economic future at risk. Every year we wait, the problem compounds, and the necessary reforms become more drastic. Thus, we must act now, and act decisively, to assure Medicare's immediate and long-term solvency.

Earlier this month, the Concord Coalition released its updated Zero Deficit Plan to eliminate the entire Federal budget deficit by the end of 2002. A key component of the plan is a comprehensive entitlement means test. Under the Concord Coalition plan, Medicare and all other entitlement benefits would be reduced using a

sliding scale starting at a beneficiary annual family income of either $40,000 or $50,000. For every $10,000 of income above the starting point, beneficiaries' entitlements would be trimmed by an additional 10 percent.

Therefore, if a retired couple had $40,000 of income and $15,000 of Medicare and Social Security benefits under the current system—and, parenthetically, let me say that would include the value of the health insurance, not the benefits they might have received in that year—benefits would be reduced by $2,000 a year under the Concord plan.

Thus, the couple's total income would be $53,000 instead of $55,000. Under our plan, families with incomes of $120,000 or more would still be permitted to receive payments equal to 15 percent of their total entitlement. And I would again add parenthetically, Mr. Chairman, under the calculation done by Data Resources for us, they would get back everything they put in.

The CHAIRMAN. Can we interrupt you?

Mr. RUDMAN. Oh, absolutely.

The CHAIRMAN. I want to make sure I understand this. You are not talking about a means-tested premium—you are talking about a means-tested benefit?

Mr. RUDMAN. Yes. For instance, if you had an income of $50,000, of which $10,000 was Social Security and $5,000 was the cost the Government estimates of the value of Medicare coverage, we would count that.

You could not do it the other way because someone who had an enormous amount of medical expenses would essentially get wiped out in that year.

The CHAIRMAN. All right. That is what I wanted to be sure about, that it is the premiums that were tested.

Mr. RUDMAN. Whatever that premium cost is.

Senator CHAFEE. Let me follow through on that, if I might. We are not talking strictly Part B here. We are talking about Part A.

Mr. RUDMAN. This is Part A I am talking about right now.

Senator CHAFEE. As you know, under Part A, there is currently no premium.

Mr. RUDMAN. That is correct.

Senator CHAFEE. So what you are talking about is that somehow we would arrive at the premium cost.

Mr. RUDMAN. What it would cost to have that type of insurance. It is easy to do; we have already done it.

Senator CHAFEE. So if it comes out $10,000——

Mr. RUDMAN. It would probably come out closer to $7,000, probably less.

Senator CHAFEE. All right. Let us say it is $7,000. Would you then add that to the Social Security benefit?

Mr. RUDMAN. Correct.

Senator CHAFEE. Let us say your Social Security benefit is $10,000.

Mr. RUDMAN. Right. If you add that to the $7,000, it is $17,000.

Senator CHAFEE. All right, $17,000. And take 10 percent of it. If you start with income of $40,000, then it would be 10 percent. If you started at $50,000, it would be 10 percent for each $10,000 above $40,000 or $50,000, whichever you wanted to pick. Obvi-

ously, you could save more money starting at $40,000. Many people think that is too low.

The CHAIRMAN. You basically would subtract that from Social Security because you are not actually paying a premium for Part A.

Mr. RUDMAN. Only those in extraordinarily high income brackets would pay anything. I will get into that later.

The CHAIRMAN. All right. We will hear about that later in the statement.

Mr. RUDMAN. The administrative mechanisms of means-testing Medicare could be dealt with in various ways. For example, most Medicare beneficiaries in the 10, 20 or 30 percent brackets of the comprehensive means test—meaning people earning $50,000, $60,000 or $70,000; that is where I get the 10, 20 and 30 because it is 10 percent for each additional increment of $10,000 above let us say $50,000—would be able to handle means-testing of Medicare by having more deducted from Social Security or other entitlements they are eligible to receive, as the Chairman stated. High-income Medicare beneficiaries probably would have to pay in an insurance premium to cover their means-test requirements.

Now I do remember what happened when we did catastrophic here a few years ago. And you face that kind of a problem. But I want to develop that a bit further because it seems to me that there was a lot more understanding of the problem in the country today than there was then.

Mr. Chairman, means-testing is one of the fairest ways to reform Medicare. Many of today's retirees are doing far better economically than their younger neighbors who are paying for their Medicare benefits.

In addition, the average retiree today collects many, many times more than the amount contributed during his or her working life. It is unreasonable to ask the well-off to give up a portion of that return?

Is it fair for workers earning far less than $40,000 a year, a number of whom cannot afford health insurance for themselves, to continue to support all of these well-off retirees indefinitely? We say unequivocally no.

So do most Americans, contrary to some of the slanted public opinion polls that have come out recently. In fact, when asked, most people approve of affluence testing in principle.

In fact, opinion surveys show that this approach vastly and consistently outscores any other type of structural entitlement reform. It is preferred, for example, over even such reasonable alternatives as higher retirement ages (which I also support) or so-called "diet COLA's."

Under the current Medicare system, Medicare benefits for the well-to-do are financed in part by payroll and income taxes paid by workers who meet the official definition of poverty or near poverty; single mothers doing their best to raise children on barely more than a minimum wage; students working their way through college; or couples who are both working, paying child care and double commuting costs, and still not earning enough to afford a home of their own.

It is both unjust and bad economic policy to require these individuals to turn over a large portion of their hard-earned wages to

buy health insurance for retirees who live far more comfortably and securely than they do.

Although reducing benefits for wealthier retirees is commonly thought to be politically difficult, we contend that such a measure would actually strengthen support for Medicare, especially when compared to options that demand dramatic tax hikes on young workers or draconian cuts across the board.

A sure recipe for generational war and political revolt is to ask struggling young workers and families to finance an increasing number of wealthy retirees.

At the Concord Coalition, we frequently hear from many of these fortunate retirees who themselves are appalled at the thought that they are living off the sweat of those who are economically far worse off than themselves.

Many retirees today feel the current entitlement system is a moral and economic assault on future generations. And many of them would be more than willing to accept lower benefits if they were convinced that by doing so they would be contributing to the long-term growth and prosperity of this Nation.

Until some way can be found to restrain the double-digit growth in our Nation's health care costs, the entitlement means test remains a fair and equitable solution, especially compared to other options.

Some analysts suggest, for example, that we reform Medicare by raising payroll taxes even further. Raising taxes is clearly an unacceptable alternative. Payroll taxes are already too high.

This will not come as news to this Committee, but it comes as news to most of the American people. Nearly three-quarters of the population has more taken out of their paychecks for combined employer-employee FICA than for income taxes. For young people, this is true for 9 in 10.

Relying on a tax increase alone to balance Medicare Part A would require a 4.5 percent payroll tax hike in 2001 on employers and employees combined. Our nation's workers and our economy cannot afford such a burden.

Others advocate further restrictions on payments to health care providers. We have gone this route many times already, Mr. Chairman. And I suspect that we are getting near the outer limits of this strategy.

Health care providers have already become adept in adjusting the volume of services provided to compensate for reimbursement reductions.

Furthermore, at some point, providers will simply decline to provide services at reduced levels of Medicare reimbursement.

Tightening up on Medicare waste, fraud and inefficient administration are very attractive options that obviously should be pursued. However, they do not promise anywhere the near the level of savings required to put Medicare on a healthy footing.

We believe that a managed care model, applied to the Medicare population across the board, with appropriate financial disincentives for those who do not enroll in managed care, could produce substantial savings. However, estimating the precise level of those savings is, as you well know Mr. Chairman, more an art than a science.

In addition to imposing a comprehensive entitlement means test, the Concord Coalition recommends several changes in Medicare Part B.

The share of Medicare Part B costs paid by enrollees was originally established in the 1960's at 50 percent. This declined to less than 25 percent by the early 1980's. Currently, it is set as 30 percent of benefits, but will decline again under current law. By 2030, if left unchecked, the premium would cover only 8 percent of program costs, and general revenues would have to pick up the remaining 92 percent.

The Concord Coalition recommends that Part B premiums be maintained at the present 30 percent of program costs. This provision would not affect enrollees with income below 120 percent of the Federal poverty threshold because they, of course, are eligible to have Medicaid pay their Medicare premiums.

Alternatively, Part B premiums could be related to retirees' incomes. However, the Concord Coalition's Zero Deficit Plan did not recommend this because it overlaps with the comprehensive entitlement means test.

As the Part B premium is considered, it should be remembered that program costs not covered by premiums are paid from general revenues. The payroll taxes cover Part A. But when it comes to the Part B supplementary medical insurance, the "I earned it" objection simply does not wash.

In 1966, the amount enrollees had to pay out of pocket each year, before the Government shared responsibility, was set at $50, an amount equal to $225 today if it had been adjusted for inflation. The deductible has been increased only 3 times since then, and now stands at $100.

The Concord Coalition recommends raising the annual deductible to $150, and indexing it to the rate of growth in Part B.

Currently, no copayment is required for home health and clinical laboratory services. We believe that enrollees should pay the same 20 percent of the cost of other covered services.

These reforms to the Part B program, along with the means-testing proposal, constitute a fair and gradual start toward reforming Medicare and reducing the Federal deficit.

Under the Concord Coalition plan, the total 7-year savings from Medicare comes to $110 billion, plus another $40 billion from means-testing, for a total of about $150 billion over 7 years. And we would be pleased to supply the Committee with all of the backup and number crunching that produces these figures.

A lot of our work was done by Data Resources up in Boston, who volunteered to the Coalition that they would crunch the numbers for us.

The reason the Concord Coalition's Zero Deficit Plan requires so much less from Medicare than either the House or Senate budget resolution is that our budget leaves no part of the Federal budget untouched.

Of course, Mr. Chairman, we would subject Social Security to the comprehensive entitlement cuts, along with other entitlements, Congressional pensions and so forth. And we would begin to gradually shift to a retirement age of 68 over a period of years. We would

also cut a couple of billion dollars below the current path of defense spending.

Mr. Chairman, the Medicare programmatic and means-testing recommendation proposed by the Concord Coalition and its Zero Deficit Plan unfortunately represent only a short-term fix that will save the trust fund from bankruptcy and Federal budget deficits for a few more years.

We will not be able to say the job is complete until national health care costs have been brought under control and our entitlement programs have been recalibrated to prepare for the demographic tidal wave that will crash down upon us in about 15 years.

The benefit of all the short-term painful budget choices required to balance the Federal budget by 2002 will be in vain if we do not use the next few years to address the inevitable long-term health reforms that must be made.

In short, when it comes to Federal health care entitlements and the underlying cost drivers that push them relentlessly upward, doing nothing is no longer an option. The current system, Mr. Chairman, is unsustainable.

[The prepared statement of Mr. Rudman appears in the appendix.]

The CHAIRMAN. Warren, thank you very much.

Let me make sure I understand. You are basically combining means-testing Part A and Social Security. You are adding the benefits, figuring the income, and subtracting whatever you want to subtract from the benefits. Have I got it right?

Mr. RUDMAN. Essentially, from the total benefit package. Of course we would not duplicate. There would have to be an adjustment on what is currently a means test on Social Security, as the Chairman knows.

The CHAIRMAN. Yes.

Mr. RUDMAN. So we would not duplicate that.

The CHAIRMAN. So the $150 billion that you talk about includes a combined means-testing of Social Security and Part A Medicare, plus some change in Part B.

Mr. RUDMAN. Mr. Chairman, that is incorrect.

The CHAIRMAN. All right. I am confused.

Mr. RUDMAN. I have not included Social Security in these savings numbers. However, the plan——

Senator CHAFEE. No, no. He did not ask you the numbers of the savings.

Mr. RUDMAN. In the savings, you were asking the method, were you not?

The CHAIRMAN. No. I was asking the total savings. In other words, what do you do? I know you and I want to raise the retirement age. Is that part of Concord Coalition's recommendations also?

Mr. RUDMAN. Yes, it is.

The CHAIRMAN. All right. How much do you figure on saving in Social Security, if you know? Do you have it in front of you?

Mr. RUDMAN. I do not have it in front of me. It is in the plan, which I will leave with the staff.

The CHAIRMAN. All right.

Mr. RUDMAN. However, to answer your question precisely, the numbers that I corrected at the start of the hearing, which are on page 5 of your statement, the $110 billion, the $40 billion, for a total of $150 billion, are strictly Medicare.

The CHAIRMAN. And they are Part A and Part B?

Mr. RUDMAN. Correct.

The CHAIRMAN. All right. Now let me ask you this. We are about $155 billion short on Part A. I guess, in theory, Part B never runs short because the Government just pours in general funds revenues to keep it solvent, if you can call it that.

Would you recommend doing anything more to try to keep Part A separate and solvent?

Mr. RUDMAN. Well, Mr. Chairman, I will tell you that the Coalition has been asked for the last year to come forth with whatever it would recommend in the national health care reform. We have not done that.

But let me simply give you my own view. Having now traveled this country, I guess in 48 of the 50 States, holding Coalition meetings, talking to literally thousands of people, including seniors, doctors, people who run facilities, I am absolutely convinced—and I think there is great evidence out there—that the managed care model could save enormous amounts of money. But, of course, a lot of seniors do not like that because they want to "go to their own doctor."

Of course, in many of these cases their own doctor ends up within the managed care model, as is being set up all over the country. Some of them are huge.

Although we are not going to venture a number, because it is too difficult to estimate, I have been told by people I respect—medical economists and people who practice and run these programs—when you look at what has been happening in the decline of the cost of delivery of services under managed care models, compared to what happens under the way we run Medicare, there are substantial savings there. I would hope that the Committee would look at that very closely.

The CHAIRMAN. Senator Chafee?

Senator CHAFEE. Thank you Mr. Chairman.

It seems to me that one of the arguments that should be used against increasing the payroll tax is not only the very valid point you made, and I did not realize this. You say three-quarters of Americans pay more in withholding tax than they pay in income tax.

Mr. RUDMAN. That is the combined FICA, employer/employee.

Senator CHAFEE. That is correct.

Mr. RUDMAN. That is the combined. It is about half if you do not combine it.

Senator CHAFEE. All right. In other words, you are saying that they are paying it because the employer's share is going for a tax instead of a benefit to the individual?

Mr. RUDMAN. Exactly right.

Senator CHAFEE. All right. The other point I would make to reinforce that is if you raise the payroll tax, which is a designated tax for Social Security and Medicare, you are absorbing from the total tax potential of the nation another big chunk that is not then avail-

able for education, for environmental reasons, or for defense. In other words, there is only so much that the taxpayer can carry. And the more you take off, designed for a particular area, the less there is available for other things that we want to do as a nation, whether it is a better FBI, school lunches, or whatever it is. Do you agree with that?

Mr. RUDMAN. One of the things I noticed while I was here on the Appropriations and Budget committees—and I notice even more this year—is the increasing squeeze on discretionary spending.

With all due respect to the current mood in Congress, there are some things the Government has to do, and it ought to do well. We need a strong FBI. We need a strong FAA. We need research in certain areas. There are things we have to do for education. There are things we must do for the environment.

We are totally squeezing that discretionary budget so that it is now down to 15 percent. It will be down to 13 percent by 1997. And according to our numbers, which are from the CBO, if you go on current services, and have an economy that is going as it is going, 100 percent of your Federal budget will go for entitlements and interest by the year 2012.

Now that is clearly unacceptable, and this is driving it.

Senator CHAFEE. Well, I could not agree with you more.

I have long been an advocate of means-testing the Part B premium. The public says it is there, we put the money into it. But you point out that this is not true.

Mr. RUDMAN. It is absolutely untrue.

Senator CHAFEE. The person who is working in a jewelry factory in Providence, Rhode Island, making the minimum wage: his or her income tax is helping to pay the doctors' bills for Jack Kent Cooke.

Mr. RUDMAN. Exactly right.

Senator CHAFEE. And, if that is fair, there is something wrong.

Mr. RUDMAN. Mr. Chairman, Members of the Committee, the thing that we hear most often across this country from seniors, from young people, when they fully understand it, is the following. They simply say this. How is it fair that a young couple living in Providence, both working, maybe one full time one part time, earning let us say $30,000 a year, with two young children, are paying about $2,200 in FICA?

In this case, that is going to pay the Part A premium, or contribute to Part B, for somebody living in, shall we say Newport, Senator Chafee? This is someone who has a retirement income of——

Senator CHAFEE. Let us take Palm Springs.

Mr. RUDMAN. Palm Springs. That is better. [Laughter.]

This person has a retirement income of $85,000 a year. And we have these retirees come up to us in Palm Springs, in St. Petersburg, in California, where we have gone and spoken to these groups and said, listen, there is no reason I should not be paying a better part of my own.

Now the problem is, as soon as you start talking this way, the person living in Woonsocket or Nashua, who has an income of $21,000 a year and hardly making it retired, thinks you are talking about them.

We have got to make it very clear that we are talking about people whose median income is well above that of the people who are paying these bills.

Senator CHAFEE. Well, I could not agree with you more. I commend you for what you are doing here, not only in connection with Medicare, the subject before us today, but the whole Social Security system.

I must say that when you point out that, even with these rather stern measures, this only represents a short-term fix. We have to recalibrate to prepare for the demographic tidal wave that will crash down upon us in about 15 years. I think that is what we are hired for, to look to the future and try to prepare for those things.

There are plenty of people who say do not worry. They have moaned and groaned about the Medicare situation continually, and nothing has happened. Well, each day the final drop dead date comes closer and closer.

I appreciate what you have done.

Mr. RUDMAN. Thank you, Senator Chafee.

The CHAIRMAN. Senator Simpson?

Senator SIMPSON. Well, Mr. Rudman, how are you my friend?

Mr. RUDMAN. I am fine.

Senator SIMPSON. It is always good to see you. You were never faint hearted when you were here. Perhaps that is the fact that you were the light heavyweight NCA boxing champion at Syracuse. Would you not say that?

Mr. RUDMAN. That was a long time ago, Senator Simpson.

Senator SIMPSON. But you still have a pretty good left—and right.

And that good attribute of being a scrapper is what you need. I admire Paul Tsongas too. When I served with you, I always had the deepest respect for you, and that has not changed a whit. Please give him my highest regard.

Mr. RUDMAN. I will. And he is doing well. He is in great health, and he is traveling all over the country with me for this Coalition. He is just first-rate.

Senator CHAFEE. His health is all right?

Mr. RUDMAN. Perfect.

Senator CHAFEE. Good. Great.

Senator SIMPSON. Well, since you left me here and went on, I had a curse visited upon me. I was placed on the Entitlements Commission, and I learned too much. And, in learning too much, along with Bob Kerry and Jack Danforth, whom you know and respect as well as I, we are here and there is nowhere to run.

When you see Time magazine finally doing something that says the numbers are real, then I think we are going to get there.

I have heard all the debate I can stomach about the fact that we do not need a balanced budget amendment. We are here, and we should do the hard votes. Oh, here they are, and you watch these guys run for the exits. It is fascinating business.

It is so absurd that people cannot understand that the burger flipper at McDonalds is paying 69 percent of the premium for the richest people in society, while the senior groups tell us wait a minute, that was part of the contract. That is a lie. That was never

part of the contract. It is a voluntary program. It is welfare in one sense.

So I just want to ask you about another part where the senior groups describe it as welfare when you talk about means-testing any kind of benefit or COLA, the Concord Coalition, as I understand it, is talking about means-testing or affluence testing benefits.

Mr. RUDMAN. The cost of those benefits, if they are not actual. So in the case of Social Security, it would be the actual amount. In the case of Medicare, it would be what the insurance premium is worth.

Senator SIMPSON. At least I have always been talking about means testing of COLA's.

Mr. RUDMAN. Right. We think either works, although there is a great deal more here.

One of the problems with COLA freezes that I always had a problem with in the Senate, as you remember, is that it applied to everyone the way we proposed it. So if the lady living by herself with a total income of $9,000 a year, all Social Security, got her COLA frozen, that was a lot more serious to her than someone who had an income of $60,000, of which $12,000 was Social Security. The COLA differential did not mean as much to that individual.

Means testing has to be fair, and recognize that there are many people in this country who are poor. There are many elderly who do have problems. We are concerned about them, and this does not touch them at all.

Senator SIMPSON. Well, how does your group refute the ancient argument of some of the senior groups, which is if you are thinking of doing such a hideous thing as affluence testing COLA's—even COLA's, much less benefits—that somehow places them in a position where it looks like they are on welfare.

Mr. RUDMAN. Well, of course, it is an absurd argument because the entire United States Tax Code is based on means testing. The more you have, the more you pay. We are saying that the more you have, the less you get under this particular situation.

Except for those people who would never accept it, this country has always recognized the idea of a graduated income tax. This country has accepted as dogma that the better off you are, the higher the obligations you had to society, and you express that in your tax payments. Some of us do not like that, but that is the way it is.

Senator SIMPSON. Let me just add a final note. It seems to me that in listening to the testimony of all the senior groups during the Entitlements Commission hearings, and here too, that they do have a solution for us. When you finally corner them, they will say raise the payroll taxes.

If that is not the most selfish act I have ever heard, because they are at an age now where they will not be paying much of it. The people who will be paying it are the same people who are bearing this three-quarter burden on combined employer/employee FICA. What is your thought about that?

Mr. RUDMAN. Well, let me say this to you, Senator Simpson. There is a wonderful book, written by a professor named Laurence Kotlikoff, who maybe will appear before this Committee at some

point. He is known here in this city. He has written a book about generational accounting and inequities, and it really is talking about generational warfare.

We have never had that in this country. There has been a close bond between parents and children. But it is not just 4 or 5 percent I am talking about. If you look at your own CBO numbers, you are talking about boosting FICA up to 15 percent, certainly 12 percent per employer and per employee, to sustain this program.

The people who are in the greatest jeopardy right now are those who are presently on Medicare and Social Security, and those who are in their late 40's and 50's today, who are going to come into the program. They are in the greatest jeopardy. If I understand politics at all, the working people of this country are not going to accept those kinds of tax increases. And then the cutting will have to be extraordinary.

So what we say to the AARP and other groups is, let us get together in a reasonable way, and let those who are affluent in this society at least pay more of their fair share. Because otherwise we are heading for generational warfare, and we are heading for class warfare and strife.

And I will say this. Unless the two political parties get together in finding a joint solution on this, the two parties themselves will become irrelevant. Because this is where the rubber is going to meet the road, when you see the cost of these programs 7 to 10 years out.

Senator SIMPSON. What does the AARP do in response?

Mr. RUDMAN. Well, we have had some meetings with them, and some reasonable meetings with many of their members. I have debated some of their leadership in various parts of the country. I think they recognize that to simply increase the payroll tax is hardly a suggestion which is politically palatable at this time.

Senator SIMPSON. Good. Thank you, Mr. Chairman.

The CHAIRMAN. I am going to call on Senator Graham in just a minute.

I tried to run the same figures you have. Assume we do nothing on Social Security, do nothing on Medicare Part A. Probably we would very soon take off the earnings limit on Social Security, as we have on Medicare. So that would raise the taxes. And I estimate that in about the year 2012, 2013 or 2014, you are looking at—roughly the same figures you have—a minimum of 10 percent each on the employer and the employee.

If you are self-employed, it is all yours. It will be a maximum of 12.5 to 15 percent. So round it off, call it 12 percent. You are self-employed, making $100,000 a year. There is $24,000 in payroll taxes, because you pay both ends of it. And we have not even got to your Federal income tax, State income tax or other taxes you pay.

And you are absolutely right as to what is going to happen. One day a son is going to say to dad, "Dad, I love you and I want to support you but, as between the two, you get my love, not my support." And you are going to have a generational battle with those on retirement who think they have been promised this and deserve it, and a younger group that says they never promised this.

I suppose you and I, and Alan, and most of the people at this table can put it off in our careers if we want, but that battle is coming as sure as we sit here, and every day, every week we delay makes it that much tougher to solve the problem.

Senator Graham?

Senator GRAHAM. Thank you, Mr. Chairman. I too wish to welcome my good friend, Senator Rudman. He always stimulated your thinking and strengthens your resolve to deal with this issue.

Warren, you stated in your paper four steps to bring the Medicare budget into line, the principal one being means testing. You also recommend raising Part B premiums, raising Part B deductible, and requiring 20 percent copayments for home health care and clinical laboratory services.

What do those four items cumulative result in, in terms of reduction in Medicare spending?

Mr. RUDMAN. If you will look at page 5 of my statement, in the last paragraph, we had done it for a shorter period, so we combined it with the 7 years in here. If you look at those numbers in the last paragraph, if you will cross out the $85 billion and put in $110 billion; take the next item, which says $25 billion, make that $40 billion. Thus, the answer to your question is the third figure on there, which is currently $110 billion, should be $150 billion. That is your answer.

Senator GRAHAM. The proposals that we have before us are for $256 billion in cuts over the next 7 years in the Senate plan, and a somewhat higher number in the House.

What is the assessment of the Concord Coalition as to the implications of numbers which are roughly $100 billion greater than the ones you have recommended?

Mr. RUDMAN. The reason is we include Social Security in our means test, which I understand most people here think is politically unacceptable.

Of course, they are means-testing it now by taxing at 85 percent for those above a certain level. But the means test we propose would not be any more harsh than that. It would be a substitute for it.

But this plan you all have received in your offices, which has been developed by our Coalition. I might point out that Pete Peterson was on the Entitlements Commission. He is the president of the Concord Coalition. Paul Volcker serves on our board. So we have some pretty savvy folks. These are not my numbers; these are numbers of people who have been working on this for a long time.

We essentially do some other kinds of cutting. And we do not take as much out of Medicare and Medicaid as the House and Senate budget proposals.

Now what I said in my statement was simply this. If you take those proposals that are currently before you—or will be in some form—if you believe that a managed care model can reduce those costs by that much, then maybe you could cap that amount and still give all the service.

We think this is a more balanced, equitable way to do it. We are certainly not the lobby for the providers. We are neutral and detached from that issue, but if you start trying to cut back more on providers, you are going to cause some other problems as well.

Even if you decide you are afraid of a means test starting at $40,000 or $50,000; start at $60,000 if you want to. That is still $30,000 above in average income of the people who are currently paying the bills.

Senator GRAHAM. So you are essentially saying that you are as committed to a balanced budget as any of the members of Congress, but there is a different road to achieve that objective?

Mr. RUDMAN. Exactly. And this lays it all out. It has been developed on a consensus with our members all over this country.

The interesting thing about this is that there is not a lot of pain in this budget. Let me give you an example of what I am talking about.

Let us take the entitlement means test. I am retired up in the White Mountains of New Hampshire. I have been very fortunate. I was in the U.S. military for a while, I was here. I was fairly careful, and I have Social Security. So let us assume that my retirement income is $60,000 a year, which in New Hampshire is a fair amount of money to be retired on. There are a lot of folks in that category.

Let us assume that of that, $10,000 is Social Security and $6,000 will be estimated by this Committee to be the value of my Medicare Part A premium if I had to go out and buy it from a company. That is $16,000. Under our plan, $3,200 of my benefits would be reduced. Thus my income, rather than being $60,000, would be around $56,000 or $57,000.

Now with all due respect, if you are retired, and you do not have to worry about educating children and the other things that young people have to worry about today, and your medical care is totally taken care of, I do not see that as painful.

Unfortunately, when you talk about this, it is the person with the low income who thinks you are talking about them. And we are not talking about them.

You all know Paul Tsongas, what he stands for. And I certainly agree with him. We protect the people in this country who truly need protection.

Senator GRAHAM. Senator, did you make any other recommendations in your overall program that related to the health care costs in other sectors—for instance, in Medicaid or the issue of the deductibility of premiums?

Mr. RUDMAN. We have not recommended Medicaid changes as of now. And the reason we have not is that the Coalition has tried to do a very good and credible job, and be believable on everything we do. So far, we have succeeded. People look at these numbers and say that they are right.

The health care thing requires a lot more staff than we have, a lot more expertise than we have. The only thing we have said is that the managed care model appears to us to be something that would yield substantial savings. I am afraid that there is so much pressure on us that we will probably move in that direction at some point. But we have not come up with a plan on Medicaid or the others. We show assumptions of some savings, but they are assumptions in many cases for work already done by the Congress.

I want to point out that we do also recommend that the portion of employer-provided health insurance benefits that exceed the av-

erage cost of all such employer-provided benefits should be included in employees' income for Federal income tax purposes.

The CHAIRMAN. Senator Moseley-Braun?

Senator MOSELEY-BRAUN. Thank you very much, Mr. Chairman. Welcome, Senator Rudman. I am delighted to have a chance to talk with you. I was not in the Senate when you served, but I have watched your work from afar, and admire it.

I had occasion to serve on the same Entitlements Commission with Senator Simpson, and learned too much.

I just want to applaud you and the Concord Coalition for what you are doing. If nothing else, talking about the issue in a non-partisan, bipartisan way, speaking truth to power, if you will, is probably the single most important element of this entire debate.

As a member of the Entitlements Commission, I was convinced that the biggest problem we had was that there was not yet the climate of opinion in the country as to how to go about deficit reduction, how to go about reaching a balance in the budget. And creating that climate of opinion in the country is what you have done so wonderfully with the Concord Coalition. And I would like to thank you for your efforts in that regard.

Mr. RUDMAN. Thank you very much, Senator Moseley-Braun.

If you look at our charter, the intent of this organization is to educate and inform the American people of the perils of the deficit, and what can be done to solve it.

Senator MOSELEY-BRAUN. Right. Well, I have some specific questions for you about numbers, but I have an observation that came out of my service on the Entitlements Commission. Maybe one of the things we are looking at, in terms of creating a climate of opinion and educating people really is not just a matter of a generation gap, but an experiential gap.

A lot of the people who are relying on Social Security, and who rely on Medicare, are children of the depression. And they know what this country was like before we had a social safety net, and know what happened to seniors that could not get health care and seniors that did not have retirement.

So any discussion about these issues raises tremors of fear for them in terms of what their experience base has been. To what extent do you think that the experience of the depression, what it did to an entire generation of Americans, affects this current debate?

Mr. RUDMAN. Well, Senator, let me simply answer it this way. I believe that what you say is true. That generation certainly had deep concerns about their future, and whether or not they could make it, and what would happen when they got old. They saw what happened to the people in the 1930's and 1940's, some of their own parents.

I am not going to point fingers here, I am just going to make a statement, and you can all interpret it as you wish. There have been members of both political parties in this country who have used this issue in such a way as to demagogue it to death, and to scare the living daylights out of the American people.

They make them really believe that we are "after your Social Security" or "after your Medicare". The average American is not who we are talking about when we talk about means-testing. We are

talking about people in a much higher income bracket than the income of working people.

But as I watched television the other night, I thought some of the responses to the budget proposal were really far off the mark. Now I understand politics. I have played it soft, and I have played it hard. But there comes a time in this country when the two political parties are going to have to come together or they will destroy themselves. There is no way you can sustain this program on the course it is on today. There is no way you can sustain it without having an uprising from working people who say they have had enough.

So you were right. There is an age problem; there is an environmental problem of what they grew up in. But neither political party deserves bouquets for trying to be honest about this until very recently, when members of both parties have talked about this issue.

I was fascinated when President Clinton submitted his first budget. It is very interesting to look at that document because there is a large section in that document called "generational accounting," which had its derivation from a book I spoke about just before you arrived, written by Dr. Laurence Kotlikoff of Boston University, who I think has testified before some committees.

It is fascinating what we are saying to this young generation growing up today. We are saying to our kids and our grandchildren, we are going to have it, we are going to enjoy it. We will get there, you worry about it. We are going to hand them $6 or $7 trillion worth of debt. With all due respect, we are going to have an upheaval before that happens. So that is the best way I can answer that question.

Senator MOSELEY-BRAUN. If anything, that generational accounting was left out of the budget this time around. That is a real concern to many of us who believe that is an appropriate way to frame the issue, for everyone to see it and understand what is going on.

Mr. RUDMAN. It is a legitimate concern, Senator.

Senator MOSELEY-BRAUN. Specifically, one of the plans that we are looking at calls for $256 billion worth of reductions in this program over 7 years. The Concord Coalition is about $110 billion. So you have about a $171 billion gap between the budget plan and what you have come up with.

Mr. RUDMAN. Ours is $150 billion, I might add.

Senator MOSELEY-BRAUN. One hundred fifty billion.

Mr. RUDMAN. Yes. It is $110 billion plus $40 billion, for a total of $150 billion.

Senator MOSELEY-BRAUN. All right. Yes, you are right. But there is still a $120 billion gap.

Mr. RUDMAN. Right.

Senator MOSELEY-BRAUN. And yours assumes affluence testing and assumes some changes in the program. Based on your response to Senator Graham, what I heard was that you thought additional savings could be achieved through the managed care approach.

However, yesterday former Budget Director Reischauer testified that, "We do not know the magnitude of the savings that could be generated to expanding managed care. And, in any event, it should

not be expected to contribute significantly to efforts to balance the budget."

Mr. RUDMAN. I said almost the exact same thing a few moments ago.

Senator MOSELEY-BRAUN. All right. So you do not know either. You just think that you might be able to find it there. Are there any other proposals that you have come up with as part of the Concord Coalition?

Mr. RUDMAN. Yes, we have. They are in your office. I will make sure you have a copy.

We have comprehensive plan. However, understand that we do not take Social Security off the table because, quite frankly, you can keep it off the table for as long as you want. But at some point in the near future, it is coming back on the table along with everything else. There is no way out of that.

I am not talking about you personally, I am talking about collectively, but if you want to tell people that there is, quite frankly, the fact is that you are just going to get reelected, have a good time and get out of town. Because the light at the end of the tunnel is an oncoming train.

Senator MOSELEY-BRAUN. Well, we hope to give that train some direction.

Thank you, Senator.

The CHAIRMAN. Senator Breaux?

Senator BREAUX. Thank you, Mr. Chairman. Thank you, Senator Rudman. We are glad to have you back, Warren.

Mr. RUDMAN. Thank you.

Senator BREAUX. I think that Senators are able to speak differently after they are not in the Senate. However, I think you were speaking pretty much the same when you were here.

Mr. RUDMAN. I gave a speech on the floor in 1987 that is not much different from what I said today.

Senator BREAUX. Well, we congratulate you for your continued work in a very difficult area. It is very, very important that you continue your effort.

I remember during the middle of our debate on health care reform in the last Congress, I was going through the airport in New Orleans on my way back home. A senior citizen lady came up to me and said, "Senator, you all are working on health care reform. Whatever you do, do not let the Federal Government take over my Medicare."

So I told her Medicare is a Federal program. Congress wrote it, the President signed it, it is run by Federal bureaucrats. But she was very happy with it. She did not want the Federal Government to do anything with it, which I thought was pretty surprising. I did not spend a lot of time debating with her, but I said, "Yes, ma'am. Do not worry, we are not going to do that." That sort of solved that problem right there. [Laughter.]

I think the recommendations in your testimony, Senator, certainly bear serious consideration. The concept of means testing is not something that I think is too far off the mark. It deserves serious consideration by all of us.

As I look through the testimony, it seems to me that most of it is talking in terms of how we are going to pay for Medicare, rather than how do we reform the health care system that it pays for?

And I think that, while your suggestions are very valuable, we should consider that, while we are talking about means-testing it, that says who pays for it. And the other suggestions are to raise Part B premiums by 30 percent, raise Part B deductibles to $150, require 20 percent copayments for home health and clinical laboratory services. All those suggestions are aimed at how we pay for what we have, rather than how do we change what we have to make it cost less?

I guess my question is, have you moved in the direction of trying to determine how do we fundamentally change the system that we are paying for, which I think is probably the most inefficient way of delivering health care services? Unless we address that, we will never have enough money to pay for what is very inefficient.

Mr. RUDMAN. Senator, you are absolutely right. If you look at the last paragraph of my statement, I say exactly what you just said. I agree with you totally. This is a short-term fix. There has to be a national solution. The Coalition, thus far, has not considered itself to have sufficient expertise to make that kind of recommendation. There are certainly people available to this Committee who could.

We do intend to look at it more closely, but we certainly believe—as I say here in the beginning of my statement—that there probably should be a move toward more of a managed care model for Medicare, with some disincentives for those people who say I do not want to do that. We will say, fine, if you do not want to do it, you have that privilege. It will also cost you a little more.

Senator BREAUX. I am pleased to hear you say that. Yours is sort of an emergency fix to take care of it, and make some adjustments in how it is paid for. And the real long-term question is how do we make what we get more efficient, and get more competition in the system? Right now there is none of that. That is one of the reasons why it is increasing by 10 percent a year. And I appreciate your comments.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman. Senator, it is good to see you again.

Mr. RUDMAN. It is nice to see you.

Senator BAUCUS. You may have mentioned this in your testimony. I apologize for my absence.

If your proposals alone were adopted, how much further down the road would that step insure the viability of the Medicare trust fund?

Mr. RUDMAN. Well, that depends on some assumptions you are making. Certainly you will avoid the bankruptcy of the fund. You will start accumulating money at a higher rate of retention than you are know. I cannot give you the precise number. We have it, but I did not bring it with me this morning. But I will send it to you, and I will show you the balances we show under our proposal for each of the 8 years, up to 2010, following the 2002 that we balance the budget.

Senator BAUCUS. All right. But you give us 5 or 6 years?

Mr. RUDMAN. It is probably solvent up until about 2010, before other major reforms, such as Senator Breaux was talking about, would have to be adopted.

Senator BAUCUS. Often when we talk about reforming Medicare, not only do we discuss the points raised by Senator Breaux, but senior citizens say well, you start going down the road of means testing, then it takes on the nature of welfare. And a lot of people do not feel very good about that.

A lot of people pay the payroll tax during their working years. And it is true that the general rise in health care costs is the main reason why the Medicare hospital insurance trust fund is in such bad shape now. People still feel that they are paying into the trust fund, and it is going to be there when they get to 65. The closer they get to 65, the more they think it is going to be there. As we all know, the further they are from 65, the less they think it is going to be there.

Mr. RUDMAN. Exactly right.

Senator BAUCUS. But, nevertheless, just as in Social Security, there is a certain comfort in knowing that if you are paying in and it is not means tested very much, that base is going to be there when you retire.

Perhaps if it is means tested, then it gets more in the nature of a welfare payment, because it is more of a lower-income payment. That is philosophically bothersome to a lot of people. And it may ultimately lead to less political interest, or support in the Congress and the country, for the program because it is more in the nature of a welfare program.

We all know that welfare programs do not have a lot of support in a certain sense, but they do not bubble up to the top all the time.

So what is your reaction to that? What do you say to people who are concerned that this turns it into the nature of a welfare system?

Mr. RUDMAN. I say two things to them. First, as I stated earlier to the Chairman, the entire tax system of the United States is a graduated tax system. And we have accepted that. And we always thought in this country that people who had a great deal should contribute more to the running of this society.

What we are saying now is that the same thing is going to have to apply because we are running out of resources. If you are very well off, you should be able to do more yourself. And if you are moderately well off, you should be able to do slightly more than the average person.

And the means testing here, for the great bulk of the people we are talking about, is really minor. It is not a major amount of means-testing if you want to look at the incomes involved. And we have all the examples and the plan here as to how it works.

Sure there are people who are going to say that. But, quite frankly, we have run all the numbers, and unless you are willing to really boost payroll taxes or cut benefits savagely, even with a new national health care system, means-testing is going to have to be part of it.

I would bet the farm on this. Within 10 years, there will be substantial means-testing on all of these programs, including Congressional pensions and everything else because the Federal Government is just not in a position to pay it. It is going to happen, so we might just as well start talking about it now. It is going to happen. It is surely going to happen.

People may think it is welfare, Senator Baucus, and they may have a basis for feeling that, but it will not make any difference because the working people in this country are not going to pay the kind of taxes that are going to be called on. They just will not pay them.

Senator BAUCUS. And if your suggestions are not approved, would the Coalition not support the recommended budget cuts that are in the House and Senate budget resolutions?

Mr. RUDMAN. The Coalition has put forth its own program. Many of those suggestions are similar; some are different. We have not taken a specific position on the Medicare and Medicaid deductions within those two budget proposals. However, we probably will.

We believe that Medicare does not have to be cut as much as the House or Senate plans do if all the other budget elements are also on the table.

Unfortunately, the political realities are that you would have to start means-testing Social Security as well, and start it next year, as we would under our plan, which I do not think will happen.

Senator BAUCUS. Thank you very much. You have performed a very useful, provocative, and constructive service here. Who knows how it is all going to work out? But certainly these proposals have merit.

Mr. RUDMAN. It is totally bipartisan, totally conservative, liberal, Democrat, Republican.

Senator BAUCUS. Thank you.

The CHAIRMAN. Senator Grassley?

Mr. RUDMAN. Well, this is a situation Senator Grassley has wanted to be in for a long time, to ask me some questions. [Laughter.]

Senator GRASSLEY. Well, just remember, you always exhibited deference.

The CHAIRMAN. Normal deference to all Senators. That is what you always did.

Senator GRASSLEY. Normally, 100 percent of the corn is planted in the Midwest by now. And only 35 percent is planted. So if you do not find food in the supermarket next fall, you will know why. [Laughter.]

Mr. RUDMAN. My annual lecture on agriculture.

Senator CHAFEE. That ties in with the Part B premium.

Mr. RUDMAN. Right.

Senator GRASSLEY. Well, first of all, I appreciate your coming here and your bringing attention to the impending problems that are coming because of the retirement of the baby boom generation. If there is any benefit from the discussion of the Medicare financing problems, and the bankruptcy of Medicare, it is that we are concentrating on the baby boomers' retirement. Experts have been talking about it for a long time, but Congressmen have not really been talking about it.

I hope that we are able to use this opportunity to educate the public. And I know you have done a very good job, and your organization has done a very good job of doing that. But even with the tremendous effort you put into it, and the tremendous resources of Congress, there is still not an understanding out there of the serious problems that lie 10 or 15 years down the road, let alone where we are now.

So I just want to start out by that sort of compliment.

Now, beyond that, I would like to ask you just one question, and it would be the very same question that I asked the panel yesterday. That is that many of us still believe that health care reforms are necessary.

One of the questions in the current debate is whether we should wait to address the Medicare problems until we are ready to advance on a broader health care reform. I believe that is what I hear from the White House, that we should not be talking about this unless in the context of health care reform.

So what is your view? Is there any reason why we should not go forward in trying to fix the Medicare program's problems, even if we are not ready with broader health care reform?

Mr. RUDMAN. There is no question in the Coalition's mind that you must proceed post haste with Medicare reform because, to use the expression, the rubber is finally meeting the road. And you are just heading down a path of bankruptcy.

Now I certainly do not disagree with the administration at all that the sooner the Congress can get on to a comprehensive discussion with the administration that is truly bipartisan, and you can work out a new approach to national health care, you ought to do it. But I do not think you can afford to wait.

Senator GRASSLEY. Have you studied approaches to Medicare reform to know if we are going to run into the problems we have had before, that when you try to do something to doctor Medicare, you end up with cost shifting? Do you think that is still a problem?

Mr. RUDMAN. We do.

Senator GRASSLEY. We do. Some people are saying that we might be running out, that there might be less cost shifting because there just is not so much to cost shift to any more.

Mr. RUDMAN. I have not had a chance to read the Senate Budget Committee's document in full, but my understanding is that they are going to allow it to grow at a slower rate. It is going to grow at 7 percent instead of 7.5 percent. And people say well, with new enrollees, how are you going to do that? And the answer I get back is that we are going to hope that there are some managed care requirements placed on the system.

I do not think you can grow within that range unless you do something affirmatively to reduce the growth. I think most agree with that. And I expect there is going to be something come out of the Congress this year that will do that.

To simply limit the growth will probably by itself result in some cost shifting. How much, I am not an expert on, Senator Grassley.

Senator GRASSLEY. All right. Your question on requiring managed care, do you want us to actually require that? Or is the approach of your Coalition to have economic incentives so that people would maybe make greater use of managed care?

Mr. RUDMAN. Absolutely.

Senator GRASSLEY. The latter?

Mr. RUDMAN. Absolutely.

Senator GRASSLEY. Thank you, Mr. Chairman. Thank you for your service too.

The CHAIRMAN. I would hope that the panel would have no more questions because we have a long panel coming next.

Any others? If not, Warren, thank you very much.

Senator MOSELEY-BRAUN. Mr. Chairman?

The CHAIRMAN. I am sorry. Go ahead.

Senator MOSELEY-BRAUN. I am sorry. I just have one little question.

The CHAIRMAN. One little question? It is the little ones I worry about. Go ahead.

Senator MOSELEY-BRAUN. It is very specific. And it is on recommendation number 3. You talk about requiring a 20 percent copayment for home health and clinical laboratory services.

Mr. RUDMAN. Yes. Right.

Senator MOSELEY-BRAUN. I am trying to get the numbers. But it is my understanding that home health care, particularly for elderly seniors, is really a more cost-efficient way than the nursing home/hospital care to provide for their care.

And if you require a copayment for those services that are the most cost-efficient, you create a disincentive to use them.

So my question is, have you not considered that you may put in place a 20 percent copay, which is different than in other parts of Medicare, and thereby create a disincentive for a most cost-efficient way to provide services in the home?

Mr. RUDMAN. And excellent point. We understand that point. However, the one thing you have to pay some attention to is the fact that because of some of the new technology, and the very fact it costs less, there is increasingly an amount of shifting out of a normal hospital or nursing home environment to the home for the very reason that the Senator cites.

And we say, as a larger and larger portion of health care is done there, unless you have that copayment, you lose a lot of revenue. This is what we are saying.

Senator MOSELEY-BRAUN. Thank you very much.

The CHAIRMAN. Thank you.

Senator MOSELEY-BRAUN. A little question. No more questions.

The CHAIRMAN. Warren, thank you.

Mr. RUDMAN. Well, Senator Packwood, Mr. Chairman and Members of the Committee, I want to just thank the Committee for giving the Concord Coalition an opportunity. I sit here this morning representing several hundred thousand people, young and old, who really care about this issue. I represent them, and I am delighted you invited us to be here.

Thank you.

The CHAIRMAN. I have a feeling we will be calling you back again when we get to some other issues.

Mr. RUDMAN. Well, I appreciate it.

The CHAIRMAN. Thank you.

Mr. RUDMAN. Thank you.

The CHAIRMAN. Now we will move to a panel of Richard Davidson, who is the president of the American Hospital Association; Nancy Dickey, who is member of the board of trustees of the American Medical Association; and Eugene Lehrmann, who is the president of the American Association of Retired Persons.

Senator CHAFEE. I would point out to Senator Moseley-Braun that that 20 percent copayment for home health care was included in the President's package last year.

Senator MOSELEY-BRAUN. I was not taking issue. I just think it is important for us to not lose slight of the fact that, particularly for many seniors and disabled, the home health care option really is a better option than nursing home or hospital inpatient care, and a more cost-efficient one. Any time you are talking about copayments there that do not match the copayments for the other venues of service, it seems to me that you are setting up a disincentive. I just wanted to raise that question with Senator Rudman.

Thank you.

The CHAIRMAN. Mr. Davidson? You are first on the list, if you want to go ahead.

STATEMENT OF RICHARD J. DAVIDSON, ED.D., PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC

Mr. DAVIDSON. Thank you, Mr. Chairman, and good morning. And good morning to the Members of the Committee.

The American Hospital Association supports fiscal responsibility in the Federal budget. We feel very strongly about that. And we feel strongly about putting trust back in the Medicare hospital insurance trust fund. It surely needs that.

Our perspective can be summed up very simply. First, hospitals are strong supporters of change in the Medicare program.

Second, spending reductions alone do not bring about the right kind of change in Medicare, and they do not save the trust fund.

Third, the budget reduction proposals under consideration will severely damage America's hospitals, and endanger the ability of hospitals to serve not only seniors, but all of the citizens in their communities.

Fourth, in our opinion, we need a new public policy process to enable Congress to make the tough choices you have just been discussing in a fair and equitable manner for Medicare, and to create public confidence that a trust fund means just that—public trust.

Back to the first point. Hospitals support change. We testified before this Committee last year, saying that we have got to change the way we deliver health care to senior citizens, as well as everyone else in America. We feel very strongly about that. And it means moving people to coordinated care systems. Medicare needs the right incentives and beneficiaries need the right incentives to make that happen.

Second, spending reductions alone do not address the real needs of Medicare, and they do not serve the long-term problems. You have been hearing that. It just makes no sense to debate whether the budget proposals extend the life of the fund for 3 years, 4 years, 5 years.

The fact of the matter is, that is not the issue. I think we need to recognize that this is the 30th anniversary of Medicare program, probably one of the most successful programs in the history of this Government in serving the American public and its elderly. We need to be thinking about the next 30 years, not the next 2, 3 or 4 years. That is what we have got to do to assure that the program is going to be there in some form. The real issue is long-term solvency, which you have heard Mr. Rudman talk about.

We call this chart the "jaws" chart. If you take a look at it, what you see is a balance of expenditures and income leaping out into a position of jaws, which is going to gobble up the Federal budget, which means we have got to have significant change. This is a chart which was developed by the hospital insurance trustees in looking at the long-term issue. I believe you have a copy of that at your desks.

Third—there is a lot of debate over whether what we are talking about is "reductions in growth" or "cuts". The proposed reductions threaten hospitals, health services and systems that people rely on. Maybe technically, on paper, these look like reductions on growth, but let us be clear. To the people who rely on Medicare, and the people who provide the care, the proposals are likely to translate into cuts—cuts in services, cuts in personnel and, for many institutions across America, closure. There is no question that the modeling of that turns out to be that result.

A Lewin-VHI analysis shows the impact of $250 billion in overall Medicare reductions over 7 years. We have some information in your packets that shows you the effect on your States. These results are not predictors of the future, but they are illustrations of the kinds of pressures that hospitals face if such Medicare spending reductions are enacted.

Based on historical patterns of previous reductions, the analysis assumes that a $250 billion reduction could translate into hospital PPS reductions of some $94 billion over 7 years.

Under this scenario, every type of hospital loses—urban hospitals, rural hospitals, large hospitals, small hospitals, teaching hospitals and non-teaching hospitals. By the year 2000, only 5 years away, this analysis shows that Medicare PPS inpatient operating margins could fall to a negative 20.6 percent. And hospitals could lose $1,300 in PPS payments for every Medicare inpatient that they take care of.

Over the years, we have enabled hospitals to survive Government payment reductions. You reduce the payment, and we shift the costs. That is what we have been doing. And that day is gone, as you have heard. Managed care contracts have fixed payments for us, for all the other payors, and there is nowhere else to turn in terms of cost shifting. So that day is gone for us. We can no longer shift for Government underpayment. There is no place to turn.

And please note—I think it is very important—one out of four hospitals in America is in serious financial trouble. So when you look at averages in terms of margins, and all of the rest, one out of four are in serious financial trouble. And the payment shortfalls that are part of this budget are of such magnitude that they will hasten the closure of many institutions. They will not close over-

night, but they will start bleeding very rapidly, and they will go out of business. That means loss of service to millions of Americans in small communities, as well as in the inner city.

Our view of the answer for the long term is this—everything must be on the table. We must look at program structure, we must look at benefit levels. We must look at spending targets, and we must look at revenue requirements when you look at that jaws chart. Otherwise, you ultimately do not have a program.

And we think that we need a new process to deal with these critical issues. To build on the past 30 years, and to somehow insure something for America's senior citizens for the next 30 years, we are calling for the creation of an independent national commission—not a one-time body for the emergency, not a quadrennial body looking at it from time to time, but an independent, permanent body that looks at this issue year after year, to work to ensure the next 30 years.

Mr. Chairman, we could talk a lot about this. We think it is essential that there be some new independent body to raise all of the tough questions that Senator Rudman said need to be dealt with, and to give you some advice on what the options are so we can get on with that.

We support tough choices. And we need a mechanism out of the political environment and the heat of back rooms in the reconciliation process to really come to grips with the kinds of decisions that will have to be made. We are not here to say that we oppose cuts. We are here to say that we have to do this rationally, and find the right solution for the next 30 years.

Thank you.

The CHAIRMAN. Thank you.

[The prepared statement of Dr. Davidson appears in the appendix.]

The CHAIRMAN. Dr. Dickey?

STATEMENT OF NANCY W. DICKEY, M.D., MEMBER OF THE BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, RICHMOND, TX

Dr. DICKEY. Mr. Chairman, thank you for the opportunity to testify today. My name is Nancy Dickey, and I am a practicing family physician in Richmond, Texas. And I am vice-chair of the AMA board of trustees.

You have asked the AMA to participate in this panel to address the solvency of the Medicare program. We welcome the invitation to help explore options before the Committee, in seeking long-term financial stability for Medicare.

In the 30 years of Medicare's existence, physicians are proud of our success in meeting Medicare's primary goal, that of improving the health status of elderly Americans.

The failure of the program to be properly financed over time now threatens the health and future of the very people Medicare was designed to protect. Repeated shortsighted efforts to prop up a fundamentally flawed financing system have only served to erode the contract that Medicare represents to millions of Americans.

Simply stated, Mr. Chairman, budget-based program reductions will not work any more. A transformation of Medicare is required

if we are to keep our pledge to Americans. A balanced budget cannot be balanced on the back of a single program and those who provide the program's services.

Serious, and perhaps irreversible consequences to patient access, to quality care could flow from yet another series of ill-considered reductions. I especially worry about the magnified effect on patients in rural, inner-city and other underserved areas.

Physicians have contributed their fair share to recent deficit reduction efforts. Part B has been an attractive and repeated target of the Budget Reconciliation Acts. Physicians, who account for 23 percent of Medicare outlays, have absorbed 32 percent of Medicare provider payment reductions over the past decade. Between 1981 and 1993, Medicare-projected physician payments were decreased by $39 billion.OBRA 93 imposed an additional $47 billion in provider reductions over 5 years.

Yet even with these levels of reductions, physicians have succeeded in actually holding down the volume of increases below the level predicted for 1991, 1992 and 1993. These have saved the program billions in projected dollars.

The major factors that have brought us to this perilous point are demographics, new technology, increased demand for a wide range of health care services, and health provider fraud and abuse. They are detailed in our written statement.

But intensifying the effect of this volume growth is a financing system that requires a major overhaul if the program is to survive. The AMA believes that a meaningful transformation of Medicare must adhere to five basic principles.

First, beneficiaries must be encouraged to be cost-conscious. Medicare's deductibles and copayments only cover 25 percent of costs. The rest is subsidized with tax dollars. The availability of Medigap further diffuses individual responsibility for costs by providing first-dollar coverage. We need to give beneficiaries the tools to participate knowledgeably in their own health decisions on the basis of service, quality and price.

Second, providers must be allowed to compete on costs. For Part A, hospitals should be able to set competitive DRG's. For Part B, physicians and other suppliers of services should be allowed to determine and disclose to beneficiaries their own conversion factor in a competitive marketplace.

Third, we must be generationally fair, something we have heard from other speakers this morning. The working population is growing smaller each day in relation to the burgeoning over-65 group, and cannot be expected to pay higher and higher taxes. The AMA supports a modest, sliding-scale reduction of the Medicare subsidy, based on beneficiaries' ability to pay.

Fourth, we need to think about ways to reduce the number of citizens who will be dependent on Medicare in the future. Congress should allow individuals to invest in medical savings accounts. We should restore the right of patients to contract for services outside of Medicare. Privatization has been suggested by some.

Fifth, we need to reduce regulatory and administrative complexity. Physicians now spend over 25 percent of their time processing the blizzard of paperwork necessary to comply with Medicare's

technical requirements. This is time that could be far better spent by our physicians taking care of patients, not paper.

These five basic principles should guide the design of any approach to transforming Medicare. The variables of premium, deductible, copayment, beneficiary income level, tax rates and eligibility age must all be subject to evaluation as we pursue such a transformation.

But we urge your caution. Manipulation of these elements alone will not address the structural factors, such as benefit plans and the demographics that likewise contribute to the increasing program costs.

At the same time, those whose personal resources are inadequate must to be helped to assure that their needs are met.

In conclusion, the need for farsighted transformation of Medicare requires us to look beyond the demand for a quick or convenient political fix. Failure to recognize and accept the need for transformation, responding with business-as-usual program reductions, will insure two things: One, that access to and quality of care of senior citizens will deteriorate; and two, Congress will have to keep coming back, budget cycle after budget cycle, to deal with the same problems.

Millions of Americans expect to be able to rely on Medicare in the future. Thirty years ago, Congress enacted a pledge for America's future by passing Medicare. That pledge was founded on three explicit and fundamental promises: That patient choice of provider would be guaranteed; that professional autonomy would be respected; and that individual responsibility would be preserved. Our approach honors these original promises, while recognizing a new commitment to fiscal responsibility.

Mr. Chairman, the AMA hopes to continue to work with the Committee, the Congress and other organizations to keep the Medicare promise to our elderly in the future.

The CHAIRMAN. Doctor, thank you.

[The prepared statement of Dr. Dickey appears in the appendix.]

The CHAIRMAN. Mr. Lehrmann?

STATEMENT OF EUGENE I. LEHRMANN, PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS, WASHINGTON, DC

Mr. LEHRMANN. Mr. Chairman, and Members of the Committee, I am Gene Lehrmann from Madison, Wisconsin, and I am the president of AARP. I appreciate the opportunity to appear before the Committee to discuss the future of the Medicare program.

AARP and its members know the value of Medicare, and we want to make sure that it remains a viable health insurance program, not only for current beneficiaries, but also for future generations.

Several challenges face Medicare, including assuring solvency of the trust fund for the next decade, and making changes in the program to meet the needs of the next generation of retirees, the baby boom generation. Meeting these challenges will not be easy, but it can be achieved.

While some Medicare spending reductions are needed to shore up the Part A trust fund for the short term, the current budget pro-

posals to reduce Medicare spending go too far, too fast. These proposals could actually make it more difficult to achieve longer-term reform that will serve future beneficiaries.

AARP believes that Medicare should be a part of a responsible deficit reduction strategy. In fact, Medicare has steadily contributed to deficit reduction since the early 1980's, and AARP has supported almost all of these deficit reduction measures. We believe that we need to continue on a steady path of deficit reduction, rather than letting arbitrary deadlines and budget targets force hastily and ill-considered policy decisions.

The 36 million older and disabled Americans who rely on the Medicare program will find it hard to accept the inside-the-beltway semantics of simply cutting the rate of the growth in Medicare spending.

The level of reductions being proposed translates into higher out-of-pocket costs, reduced access to providers, real coverage limitations and serious quality problems. To these individuals, it is my Medicare you are talking about.

That is why AARP believes that deficit reduction should be fair and balanced, equitably distributing the burden of spending reductions across all programs and populations. And we can no longer ignore the fact that successful deficit reduction also depends on controlling costs throughout our health care system.

The CHAIRMAN. Out of curiosity, do you include Social Security in that across-the-board restraint?

Mr. LEHRMANN. Right now we are talking about Medicare because Social Security does not contribute to the deficit, Senator.

The CHAIRMAN. I thought you said to extend to all programs.

Mr. LEHRMANN. Well, we are talking about reductions to all of the program that add to the deficit.

Singling out Medicare is not fair, and would mean significantly higher out-of-pocket costs for beneficiaries. The average older person spends about $2,700 out of pocket for health care, not including the cost of nursing home care.

Older Americans also pay about three times as much out of pocket for their health care as the non-elderly, but their income is only half of that of those under 65. AARP estimates that, under the Senate budget proposal, the average beneficiary could pay over $3,200 more out of pocket in the next 7 years.

Changes in Medicare will be necessary, but we are concerned that much of the current rhetoric about Medicare reform may mask an intent to cut the program severely, or even dismantle it, leaving beneficiaries vulnerable to high cost, low-quality health care coverage. This is unacceptable.

It is one thing to strengthen the Medicare program by filling in the gaps in coverage, or broadening coverage options. It is quite another to send older persons into the private market to purchase insurance coverage with a voucher that does not cover the cost of care.

The Association believes that a reformed Medicare system should achieve several outcomes. For instance, it should continue to provide the basic package of Medicare benefits, it should offer incentives, not punishments, to encourage the use of fewer and less expensive services, but it should not make fee-for-service care

unaffordable for current beneficiaries who choose to have that option.

We have included many more examples in our written statement. We firmly believe that any changes must also be made slowly, deliberately, and with substantial input from Medicare beneficiaries.

One of the most valuable lessons of last year's health care reform debate is the need to move incrementally at a pace that is comfortable for older Americans. Before Congress makes major changes in Medicare, the public must be engaged in this dialogue. Congress has the responsibility to answer specific questions about how changes would affect the future of Medicare.

AARP is prepared to work with you and Members of the Committee on identifying ways to assure a strong future for America and a healthy future for Americans of all ages.

Thank you very much.

[The prepared statement of Mr. Lehrmann appears in the appendix.]

The CHAIRMAN. Mr. Lehrmann, thank you.

Let me ask you this. The Congressional Budget Office indicates that we are $165 billion short of solvency, on Part A their definition of solvency.

How does AARP suggest we achieve that level of savings?

Mr. LEHRMANN. AARP believes that the trust fund balance should remain roughly where it is today. That is; we should delay the annual spend-down of reserves that starts in 1996.

The CHAIRMAN. Say that again. The annual spend-down of which reserves?

Mr. LEHRMANN. Of the reserves that now exist in Part A.

The CHAIRMAN. Well, I understand that. You mean the reserves of the bonds that they hold?

Mr. LEHRMANN. Yes.

The CHAIRMAN. All right. So we are not going to redeem those?

Mr. LEHRMANN. Yes. And to keep current, we will have to make adjustments to put more into the fund.

The CHAIRMAN. Well, how do we do that?

Mr. LEHRMANN. By reducing the costs, or in some way making those adjustments.

The CHAIRMAN. All right, but what do we do?

Mr. LEHRMANN. What specifically do we do? We look at what is required to get it done, as reported in the trustees' report, and then we make adjustments accordingly. And we will be glad to work with you.

The CHAIRMAN. But I would like to hear now.

Mr. LEHRMANN. This is a complicated problem Senator. But we will be happy to work with the Committee.

The CHAIRMAN. So your basic answer is that the only thing we are doing to keep our heads above water now is gradually redeeming the bonds, which run out in 2002?

Mr. LEHRMANN. No, no. We have to make adjustments in the program. We have to use some of the things that have been suggested, like using HMO's, giving people incentives to use those, reducing the cost of the program as much as we can, so that we do not have to draw on those reserves.

The CHAIRMAN. I have got to be fair with you. It looks like you have come out in opposition to almost every suggested reform, reduction—call it what you want—that has been suggested. We need some help as to what AARP will accept.

Mr. LEHRMANN. Well, at this point, we want to work with you to consider what is on the table. AARP will do all that we can to preserve and protect Medicare for the current and future generations.

The CHAIRMAN. Well, you know what is on the table—20 percent copayments for home health and laboratories, Part B is on the table. If you do not like those, what do you have?

Mr. LEHRMANN. Well, we will look at all the options and make a decision as to which direction we believe the program should take. That is what I am saying. We want to make sure that what we are telling our members will slow down the rate growth in Medicare but, at the same time, not shift all the burden onto older people. That is what we are looking at, and that is what we will be working toward.

The CHAIRMAN. Let me ask you a specific question on Part B. Of course, when the program was founded, Part B was to pay 50 percent. Should we be moving back toward that goal?

Mr. LEHRMANN. We certainly should not be moving toward 50 percent. But we certainly will be willing to sit down with Members of Congress and look at what adjustments are appropriate.

The CHAIRMAN. Why should we not be moving back to what was the original intent of the program?

Mr. LEHRMANN. Congress, I do not remember how many years ago, decided that a 50 percent premium was unaffordable for most older Americans. Since then, the premium has been approximately 25 percent. And we believe that continues to be appropriate because it would be very difficult for people—most of the people—to pay at the 50 percent level.

The CHAIRMAN. All right. It is currently at 31 percent. Is AARP opposed to leaving it there? The law sunsets; it will be back at 25 percent very quickly unless we extend the law. Is AARP opposed to extending the 31 percent?

Mr. LEHRMANN. We would certainly look at that as an option in trying to resolve all of these issues. We will look at the whole package of Medicare and deficit reduction strategies that the House and Senate will propose. We will evaluate the fairness of the package as a whole.

The CHAIRMAN. How soon do you think AARP might look at all these options?

Mr. LEHRMANN. We are in the process of doing it right now, as we talk.

The CHAIRMAN. As we talk?

Mr. LEHRMANN. As we talk.

The CHAIRMAN. All right.

Mr. Davidson, let me ask you this, and I am quoting that you said, "In order to fully address the long-term problems of the Medicare program, all ingredients must be on the table—the program structure, the level of benefits, the program revenues, as well as spending." And we have an immediate shortfall.

Are you suggesting we wait, in terms of addressing the problem of the shortfall, until all of these other ingredients not only are considered, but put into a package, passed and signed by the President?

Mr. DAVIDSON. No, we are not. We are recommending that consideration be given to some immediate steps and some dramatic incentives to try to move more seniors into coordinated care systems. I think everyone tends to agree with that.

One of the problems is that we have raised expectations so high, thinking that will somehow produce enormous savings. That is going to take a lot of time, and no one can even quantify it.

We started early on, working with the leadership here, to talk about some reasonable levels of reductions in payments. We talked with Senator Judd Gregg about his proposal with in excess of $100 billion in cuts, with a look-back arrangement and all of the rest.

So what we are saying, Senator, is that there needs to be some reasonable level of reduction in payments. And we understand that. Our posture is that the size of the payment cuts at this point are so enormous that they will cause tremendous disruption. And they do not do much for that short-term objective of dealing with the trust fund.

Our concern is that we can have such serious disruptions that it will ultimately impair the ability of the very institutions you are going to want to be there to take care of senior citizens.

So we need to move on all fronts. We need to move on the whole question of participation by beneficiaries. We need to restructure the program as quickly as we can. There are short-term and long-term strategies for that as well. There should be reasonable levels of spending reductions, and we ought to try to work on those together.

We would be very happy to work with the Committee to come up with some resolutions. What we are saying is that it is the size of the number, and the ambitious timetable, that is going to cause serious disruptions, disruptions that we do not think will serve communities very well. That is the part that concerns us most.

The CHAIRMAN. Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman.

I would like to ask each of the members of the panel the following question. Do you all agree that an emergency exists in Medicare? Dr. Dickey?

Dr. DICKEY. Yes, Senator. I think we would have to agree.

Senator CHAFEE. As far as the funding goes. Mr. Davidson?

Mr. DAVIDSON. It is a continuous problem that has reached near emergency proportions.

Senator CHAFEE. Mr. Lehrmann?

Mr. LEHRMANN. We see it as a continuing problem, and it is something that has to be dealt with.

Senator CHAFEE. All right. We all agree. Either it is an emergency, or it is something that has to be dealt with.

First I want to thank you, Mr. Davidson, for the help you gave us when we were dealing with the health care reform proposals. You came to our conference at Annapolis, and did an excellent job. I appreciate that.

Mr. Davidson, did I miss something in your testimony? It seemed to me that you explored the Medicare funding problem, and then said that the answer is to have an independent commission look at it.

Mr. DAVIDSON. Well, there is a lot in between that idea, Senator Chafee. There are a whole series of recommendations that we make, beginning on page 9. But we feel that the long-term issues are so difficult to deal with in the political environment that we really need a body that devotes all of its time and energy to looking at what the options are, analyzing how much money we have got to spend, and then bringing back to you ways to come up with the solutions and to make tough choices.

Senator CHAFEE. Well, I think that one of the virtues of a commission—and certainly no one has had more experience on it than our distinguished former chairman, who served on the Greenspan Commission—is that it gives a bipartisan solution to a problem. Inevitably, that would be the make-up of a commission.

Second, by coming from a commission, it gives the impression that this is something we can all latch onto without getting caught politically.

But all those things take time. How long do you think it would take a commission to report?

Mr. DAVIDSON. I think, if you could appoint a commission effective on July 1, by the next budget year you would have a significant set of balanced recommendations for you to make determinations on. The question is, how do you get from here to next year, with the goal of a balanced budget by 2002? I think that is what is driving the immediacy of somehow hitting that magical year of 2002.

Senator CHAFEE. Well, I believe in the 2002 deadline. I have heard arguments on the floor, what is magic about 2002? Why not 2003 or 2005? Well, pretty soon, you say how about 2050?

If we are going to do this, we had better get to it. We are in peacetime. We are not at war. The inflation rate is relatively low. The unemployment rate is relatively low. Times are pretty good in the country. If we cannot do it now in 7 years, there is something wrong with us. That is my judgment anyway.

Mr. Lehrmann, you touched on inducing seniors into managed care. I think all of you said that you cannot mandate it. Why not? Why not mandate it if we agree that managed care is a big step forward in savings?

I personally think we are in a jam here. The prior witness talked about the deluge that is coming when the so-called baby boomers retire. I believe Senator Rudman said it was 12 years. In my judgment, we had better do something and get on with it.

What do you say to that, Mr. Lehrmann? Just mandate it that every senior, except where it is not available, would have to be under managed care.

Mr. LEHRMANN. Well, you are talking to someone who has been in managed care for 12 years as an older person.

Senator CHAFEE. And you look very well. [Laughter.]

Mr. LEHRMANN. I am doing very well. The program is doing very well for me too, Senator.

Senator CHAFEE. Good.

Mr. LEHRMANN. So I understand what you are saying. However, as you indicated, there will be many places where managed care is not available.

Senator CHAFEE. Well, let us set that aside.

Mr. LEHRMANN. I think mandating older persons, which might require them to change doctors and the like, would be a real challenge.

What I would like to put forth is the notion of creating an incentive for more people to get involved. I think that is the direction we ought to go.

Senator CHAFEE. Well, I agree with that. But, you know, any incentive obviously is something that is going to cost money. Otherwise it would be out there now. The incentive we frequently talk about is prescription drugs. That is a good inducement, and I am all for it. The plan we had in the Mainstream Coalition last year involved the incentive of prescription drugs for those who went into managed care. But that is an added cost. I am not sure if we can afford that.

Mr. LEHRMANN. It is an added cost, but it also could reduce costs because, if prescription drugs are used properly—and they very often are not because older people right now cannot afford prescription drugs that can help to prevent serious and costly conditions. With an incentive like that, it would certainly encourage many people to get into managed care. I certainly believe that managed care could, in effect, offset some of that cost.

Senator CHAFEE. That is good. One final quick question. Dr. Dickey, you seem to argue against Medigap policies. You say that removes the cost consciousness. That would be a little unusual. Do you say we should ban the use of Medigap policies?

Dr. DICKEY. Well, we have not suggested that they be banned. We have suggested that we try to look at ways to be sure the beneficiaries continue to have some individual responsibility. That is not just the Medicare age group, but anyone who has first-dollar coverage has a tendency to use more. In fact, if you look at those in Medicare who have Medigap policies that give them first-dollar coverage, data suggests that they use up to 25 percent more health care than those who do not have first-dollar coverage.

We simply want to be sure that the individual stays in that loop of caring how much care and how much cost they incur.

Senator CHAFEE. Well, that would be a little difficult. I agree with you. I think the facts are clear that first-dollar coverage means increased usage. But can you say that somebody cannot take the precaution of buying a Medigap policy that does give first-dollar coverage?

Dr. DICKEY. Well, we have suggested in our written testimony a couple of ways that you can discourage the use of that by variable taxation on such a Medigap policy, or by using incentives, lower costs for those who continue to be responsible for their own deductibles.

The data is so overwhelming about the cost to the program of individuals having first-dollar coverage that it is something we need to give consideration to, even as we talk about other variations in the program for the purpose of cost-saving.

Senator CHAFEE. Thank you. That is an interesting point. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Simpson?

Senator SIMPSON. Thank you, Mr. Chairman.

Mr. Davidson, the American Hospital Association's recent newspaper ad has this headline, "What will you tell your voters if you take $250 billion out of their Medicare?" shrieks this ad.

Claiming that Congress is doing a "cut," I guess everybody else uses that, at least among the senior groups. Instead of slowing the growth, it is called a cut.

The reality of this Senate budget proposal is that the budget authority for Medicare will increase $162.6 billion in the current fiscal year, until it reaches $258.9 billion in fiscal year 2002, with steady increases in each of the intervening years. Now this may be a smaller increase than you would like it to be, but it is surely not a cut.

Instead of misleading and confusing the public with this fallacious claim of the $258 billion cut, why not just come out and say that the proposed increases may not be sufficient to continue to meet the costs of providing services as you would like to provide them under the current system? Then we could at least have an honest debate about how to change this system, instead of having to spend so much time on the eternal game of numbers.

Would you at least acknowledge that Medicare spending would increase by about 7 percent annually under the current budget proposal, and tell your good people that? And then possibly commit yourself to working with this Committee and this Congress to advance the structural reforms that are needed to sustain the program over the long haul—not the short haul—at a 7 percent annual growth rate. And when we are all through with that, after 20 years it will still suck us up.

Mr. DAVIDSON. Senator, I do not believe the ad said to "cut." I think it said to "take out of."

Senator SIMPSON. Yes, well——

Mr. DAVIDSON. And we got into the debate of whether something is a reduction in growth versus a cut. I think the point that we wanted to make—and specifically for your hospitals in Wyoming—is that the reductions in growth will become honest and real cuts, that, in essence, it is likely to put several of the hospitals in the State of Wyoming out of business by dramatic underpayment.

We have been on the record here pretty clearly time and time again, of being a constructive participant in new ways to do all of the things you would like to. We are fully supportive, but we do have an obligation. You know, a trade association is in the business of protecting its members. And, in some cases, members deserve protection.

If we are a special interest, we think we are a very special interest because the institutions we represent are there as the safety net for tens of millions of Americans who you expect us to have there, taking care of senior citizens at the time of their illness.

So it is a matter of perspective. These things become real cuts for us, Senator. And they really jeopardize the future of a lot of institutions, not only in your State, but in many parts of America.

I think I said earlier that we had open discussions with Senator Gregg about an excess of $100 billion in reductions with strategies of looking back. We have been responsible players, but we are also responsible to the nation's hospitals, to seek to protect them if we think these actions here are going to do harm to them.

Senator SIMPSON. Well, I have the silly opinion that something is out there that will really do harm to them, and that is bankruptcy of the Medicare system in 7 years. That is my personal opinion, a rather overriding one.

By the way, your ad does say "reduce Medicare." So reduce or cut, we will get together and pull out the Reader's Digest word game and mess around with it together.

Mr. Lehrmann, let me ask you this. In the March, 1995 issue of The AARP Bulletin, which was the one where you whomped up on the balanced budget amendment, you said, "Medicare beneficiaries will be required to pay $5,175 more in premiums and other out-of-pocket health costs between 1996 and 2002." This was the terrible danger of the balanced budget amendment.

That is what you told your members, that it would require Medicare cuts of $404 billion over 7 years, thus requiring this figure of $5,175.

Yet in the testimony you submitted this morning, you state that the Senate Budget Committee proposal, which does achieve a balanced budget in 7 years, would require beneficiaries to pay $3,200 more in out-of-pocket costs over the next 7 years. Now that is a rather significant difference. You went from $5,175 to $3,200. Could you explain that? Did you misfire again, or overshoot the mark back in March? And, if so, will you inform your Members that the situation is less dire than you originally reported in March?

Mr. LEHRMANN. We have constantly been reviewing various approaches to deciding how these impacts are going to affect older people, Senator.

The most recent we have is the one I reported to you at $3,200. In the original calculations, we made some different assumptions, I presume. We have now made this adjusted report, and that is the figure we are using right now.

Senator SIMPSON. So, in the thick of the balanced budget amendment, it was a good strong figure of the loss of $5.175. Now it is down to $3,200 in just a few weeks. So is this the way you crunch the numbers at AARP? How do you miss by that far?

Mr. LEHRMANN. Senator, we used different as[illegible]ptions.

Senator SIMPSON. I believe that.

Finally, could you go on record today as supp[illegible] a policy that requires wealthy Medicare beneficiaries to pay t[illegible] cost of their coverage under Part B, which was never a part [illegible] original contract of Social Security? They are paying $46.10 a month, and we would like to affluence test that, so that they would pay $184.40 a month if they earn over $50,000 or $60,000 in retirement, and therefore still have a premium which is less than some guy or gal who are earning $30,000 a year.

Mr. LEHRMANN. Senator, AARP believes that if income relating premiums is a good idea for older Americans and the disabled, then it is at least as good an idea for the rest of the country.

In 1995 alone, the Federal Government is estimated to spend $61 billion by providing tax breaks for employer-provided health care premiums. This is one of the fastest growing expenditures in the country.

What we are saying, Senator, if it is good for wealthy older persons to pay, then it should be dealt with across the board, not targeted just on the older Medicare beneficiaries.

Senator SIMPSON. Mr. Chairman, maybe we should get rid of tax expenditures then. That could be employer deductions, and it might be home mortgage interest. We might get rid of both of those.

Senator MOYNIHAN. Be careful, Alan. Careful.

Mr. LEHRMANN. Well, to be fair, we are looking at this on the broadest perspective, so that it applies equitably.

The CHAIRMAN. Thank you.

Senator SIMPSON. I will have more to say in a week.

The CHAIRMAN. Senator Graham?

Senator GRAHAM. Thank you, Mr. Chairman.

In Senator Rudman's comments, and running through the comments of this panel, the use of some form of managed care as a fundamental part of restraining the growth in Medicare has been a constant.

Mr. Davidson, you used the term "coordinated care." Could you define that, and how is that different from what is normally referred to as "managed care?"

Mr. DAVIDSON. Senator Graham, I think the term "managed care" means different things to different people. Most of the managed care in America today is point-of-service cost control. I want to repeat that—point-of-service cost control. When you go to get a service, they make a decision about the appropriateness of it. Or then, when you do find that you need a service, you move to the lowest-cost provider, and arrangements are made to make that happen.

Our notion is that that does not necessarily effectively coordinate the care of America's citizens, where the focus would be more on prevention and improving health status than just worrying about how to deal with you at the time of an incident of illness.

We think the delivery system has to change to where the focus is on improving your health and keeping you out of the system, which is very different than point-of-service managed care cost controls. And that is the difference from our perspective. We think the community-based organizations should serve as collaborative bodies to move you to the right levels of care, to focus on your needs.

For instance, for senior citizens in coordinated care networks, in our view, one of the first things you do when you enroll a senior citizen, you send someone out to visit then in their home. Think how many insurance companies do that. Find out what their home life is like. Find out if their carpets are tacked down. Find out if their railings are sturdy. Look in their medicine cabinet. Know something about them. Because a lot of admissions to hospitals are related to simple little things like falls at home, the loose railing, prescription medication problems.

Senator GRAHAM. If I could, I am very interested in pursuing some of the practicalities of the managed care, as applied to the older population.

I was interested in your recommendation about modeling the Medicare program after the Federal Employees Health Benefit Programs, in which the Federal Government puts up a set amount and allows the employee to select from a cafeteria of options.

One of the differences between the Federal employee population and the Medicare population is the greater degree of homogeneity. There is certainly a range within Federal employees of their health care needs, but it is a narrower range than you have in the population of Medicare. How would you adapt the Federal health care benefit analogy to the Medicare population?

Mr. DAVIDSON. Senator, it seems to me that what we are trying to point out is that there is no single answer to any of these things. We have to be innovative and try a whole variety of things to see what is most effective in getting some cost containment in the program.

I think the problem is that we are all searching for this magic answer.

Senator GRAHAM. But the practicality is that within Medicare there are extreme differences in utilization.

Mr. DAVIDSON. Well, sure.

Senator GRAHAM. The statistics that we have had would show that some 70 to 80 percent of the Medicare population uses less than half of the average. Ten percent use 5 to 10 times the average.

How would you adapt the Federal Employees' Health Benefit Plan model to those differences in the health care needs of the Medicare population?

Mr. DAVIDSON. Each of the plans would have to be certified by the Federal Government to assure it would take all comers over age 65. Obviously, they could not be selective in taking patients.

Once they were certified by the Government, they would be obligated to provide services to all patients, regardless of preexisting conditions. I think that is the issue that you ultimately get to here. And the ones that will be attractive to senior citizens are going to be the ones that have an array of services and benefits that seem to meet their needs.

But the protection is a Federal qualification and an accountability on the performance of those plans.

Senator GRAHAM. Mr. Lehrmann, how do you feel the AARP members would react to a proposal to use the Federal Health Benefit Program model, where the Federal Government would pay a stipulated amount, and then the beneficiary would choose from a range of health care plan options, with those options having different impacts in terms of how much additional responsibility beyond the Federal payment would be borne by the beneficiary?

Mr. LEHRMANN. I believe, Senator, that would take a lot of educating on our part, and on everybody's part, to acquaint our membership with such a proposal.

I would not be prepared to tell you at this time how our membership would react to that because we have not tested that with them.

Senator GRAHAM. Could I ask one follow-up question?

The CHAIRMAN. Yes, sure.

Senator GRAHAM. Would AARP recognize a distinction between applying that type of a program, or some other similarly strategically different plan, to persons coming into Medicare, that is, those persons who are just entering the system, as distinct from applying it to persons who are already in the system?

Mr. LEHRMANN. We certainly would look at it in a much different light then because persons coming into the program at age 65 are familiar in many cases with that type of program, and the adjustment would be much easier.

In that regard, we would take a good look at it, and certainly be willing to consider it as an adjustment.

Senator GRAHAM. Thank you.

The CHAIRMAN. Senator Breaux?

Senator BREAUX. Thank you, Mr. Chairman. I thank the panel members for being with us this morning.

I do not think Medicare is the problem. Medicare is just a system that pays for health care. The problem is the cost of health care. And I do not think we are ever going to solve this problem merely by plugging numbers in and out of the Medicare program, without doing fundamental changes on what it is paying for.

Medicare pays for health care. The problem that we are facing is that we do not have enough money. We do not have enough money not because Medicare was not structured properly. It is a problem because health care costs too much.

A few years ago, we argued about whether we had a health care crisis in this country. And a lot of my colleagues said there was no problem. We have the finest health care system in the world. We should not be doing health care reform. We do not need to do that. Do not worry, be happy.

Well, I think today we are looking at the problems we talked about in the last Congress when some of us said let us get together and do health care reform because it is going to help alleviate the cost of treating people in this country, whether it is senior citizens or middle-income families, or rich people. The problem is that it is increasing at 10 percent a year. We cannot afford it, and we are not going to fix it just by plugging numbers in and out.

We have $256 billion in reductions, cuts, less of an increase—whatever you want to call it—in the budget in the Senate. They have $282 billion reduction, cuts, reductions in the rate of increase over on the House side. I think it is larger over there because they want to pay for tax cuts.

But I do not think that resolves any problems. Does anybody on this panel think that reforms health care, just to cut the money? Do we not have to have fundamental health care reform in order to get a handle on the cost of Medicare or any other program that pays for health care?

Mr. DAVIDSON. You cannot look at these programs in isolation, Senator. It seems to me that whatever it is that you do in tinkering with Medicare has an ultimate effect on the rest of the delivery system. We had that debate last year, and there does not seem to be an enormous willingness to raise that one again.

Senator BREAUX. Is that why you are suggesting a commission?

Mr. DAVIDSON. No. We are suggesting a commission that really deals with this aspect of the Medicare program. We think that we

are kidding ourselves if we are going to go through this budget exercise, take these enormous amounts of dollars out, and think that we did something to assure the long-term solvency of the trust fund.

Senator BREAUX. Well, I agree with you. We are not going to fix a single darn thing by just cutting money.

Mr. DAVIDSON. Not at all. It will not change a thing.

Senator BREAUX. Unless we fundamentally address the system by which people are treated, you are not going to have a fixed Medicare, which is just a means to pay for it, in my opinion.

What is wrong with Congress being the commission? Why not challenge us and say look, get the Majority Leader and the Democratic Leader to designate a commission consisting of the Finance Committee and the Labor Committee, and anybody else. Give us a timetable to come back with a recommendation. That is why we make the big bucks.

Mr. DAVIDSON. I understand that. I understand Senator Packwood and Senator Moynihan were going to go up to the farm over the weekend. And we were impressed with that. [Laughter.]

We were impressed with that notion that you would sit down and made the tough choices.

But we have not been able to do that. What happens here? Let us be real honest? You have every vested interest in God's creation coming to the table and fighting for their interests, including us. And there is a point where you do not get the most balanced decision.

Our view is that you need a balanced decision with shared pain for everyone. The only way you are going to achieve that is by some independent body that will do the setup for the tough choices, and you decide up or down.

That is being critical of the political process we have, but we have also recognized that in the past with regard to Social Security, that is a path we went down. And this is too important not to go in that direction.

The CHAIRMAN. I wonder if I might add a note here. I have a delightful note from Liz Moynihan, as follows: "I appreciate the advance notice. All will be ready. We will have a bonfire by the pond at Derrymore for the retreat (crossed off), event (crossed off), seminar, summit. Just let me know when you are coming." [Laughter.]

So all is in readiness.

Senator BREAUX. I will supply the beer. [Laughter.]

They may need it.

Mr. DAVIDSON. We will send you some health food.

Senator BREAUX. Well, I think the problem is very obvious, and all of us should realize that it is not just plugging numbers.

Mr. DAVIDSON. Right.

Senator BREAUX. The bulk of Senator Rudman's recommendations involve shifting who pays, and how it is paid. But the problem is not how it is paid for. It is what we are paying for, and how it is delivered. What we are talking about is fundamentally reforming health care. Health care reform is essential to ever get a handle on Medicare spending, Medicaid spending, and everything else, as well as the budget. And that is the real challenge.

I thank the panel for their recommendations.

The CHAIRMAN. Senator Moynihan?

Senator MOYNIHAN. Mr. Chairman, with Senator Breaux's generous offer, I do not know how we can resist.

Senator GRASSLEY. Those of us who are Baptist should stay home. Is that right?

Senator MOYNIHAN. Well, there is a church down the road for you. [Laughter.]

The Chairman has been very patient in his effort to assure a certain rigor in these discussions.

There is talk about the point in time at which the reserves of the Medicare Trust Fund will be exhausted. It is a literal fact—and I think you would agree, Mr. Davidson—it is not a matter of agreeing.

In 1992, Medicare entered a negative cash flow. There are still some interest payments from bonds held by the Trust Fund. These bonds, however, are not like warehouses filled with Campbell's soup that you can go in and bring out. They are just debt of the Federal Government. So our situation has been with us now for 4 years, 3 years at the very least.

And I would like to thank you, sir, for saying that a particular solution what Senator Breaux called a plugged number, is not going to deal with this year's budget problem. We are dealing with a change in medicine.

Yesterday, we had a wonderful exchange with the dean of Mt. Sinai Hospital in New York. We asked him, at what point in the 20th century did the random patient with the random disease, encountering the random doctor, become better off for his care in a hospital? Without hesitation, he said toward the end of the fourth decade of this century. That is how new medicine is.

Later, one of our witnesses, a very distinguished British gentleman said that it was not until 1900 in Britain that the average person entering a hospital died of the thing he came in with rather than the thing he got when he arrived. [Laughter.]

Mr. DAVIDSON. We have come a long way.

Senator MOYNIHAN. We have come a long way.

Trying to be rigorous is important. I have to say to our friend from the AMA, Dr. Dickey, you say here, "It has been estimated that physicians now spend over 25 percent of their time processing paperwork and complying with the technical requirements of an unending blizzard of Medicare regulations." What is your data?

Dr. DICKEY. That comes from the AMA's center on health policy.

Senator MOYNIHAN. Do you have that data?

Dr. DICKEY. I do not have it with me, but I can provide it for you.

Senator MOYNIHAN. And this is medical doctors?

Dr. DICKEY. Yes, sir.

Senator MOYNIHAN. I am standing here saying to you, I do not believe that.

Dr. DICKEY. I would welcome you to come and spend the day with me.

Senator MOYNIHAN. Doctors spend a quarter of their time on paperwork?

Dr. DICKEY. Yes, sir.

Senator MOYNIHAN. We will invite you back.

Mr. Lehrmann, you did say, as the Chairman asked, "The AARP believes that deficit reduction should be fair and balanced, equitably distributing the burden of spending reductions across all programs and populations."

Now, sir, that does not refer to Medicare; you said deficit reduction. Surely that must mean Social Security and disability insurance as well, and the Defense Department as well.

Mr. LEHRMANN. Since Social Security does not add to the deficit, it was our understanding that it is not part of the current deficit reduction debate. I did not quite understand what the direction of the earlier question was, but we will certainly will take a look at all of those.

Senator MOYNIHAN. Your position is that everything is open?

Mr. LEHRMANN. Well, at this point——

Senator MOYNIHAN. We are having a discussion. You do not have to agree to specifics.

Mr. LEHRMANN. At this point, we have not made a decision on that because, as I said earlier, I did not come prepared in terms of discussing Social Security this morning. However, as you know, Social Security does not contribute to the deficit.

Senator MOYNIHAN. Well, we can talk farm programs too, or urban welfare.

Mr. LEHRMANN. Well, we will certainly take a look at all of them.

Senator MOYNIHAN. Come back and let us know more. Would you answer the Chairman's question in writing? I know he would appreciate it.

Mr. LEHRMANN. Yes. We will write the Senator a letter.

Senator MOYNIHAN. Good.

And, Mr. Davidson, particular thanks to you for making clear to us that we do not have a problem with next year's budget. We have an institutional problem that has to be resolved in institutional terms, and it has mostly to do with the wonders of modern medicine. It is a good problem to have because people get better health care, live longer, live better.

This is very new in the human experience? Would you not agree?

Mr. DAVIDSON. Absolutely.

Senator MOYNIHAN. Thank you. That is my kind of answer, Mr. Chairman.

The CHAIRMAN. I just want to quiz Mr. Lehrmann once more. Do you mean that AARP is willing to let Social Security be on the table for discussion as one of the possible programs we might consider in deficit reduction?

Mr. LEHRMANN. At this point, we have not made a decision on that. That is what I was trying to say.

The CHAIRMAN. You mean you have not even made a decision whether we can discuss it?

Mr. LEHRMANN. At this point, that is where we stand. But we will certainly respond to your question in writing when we have a chance to look at it.

Senator MOYNIHAN. That is fair enough.

The CHAIRMAN. Senator Grassley?

Senator GRASSLEY. Mr. Lehrmann, where Senator Simpson would try to provoke you, I would try to plead with you. Your organization is probably one of the biggest organizations in our country.

And mostly you are a very responsible organization, not only on a question of public policy, but on a question of just doing good for your members.

You have to be very much a player in this effort, and you cannot and have not denied the statistics of the bankruptcy of the Part A hospital fund by the year 2002.

You are also an organization that supported the Medicare catastrophic reform when you thought you were representing your members. Then a year later, when you felt that you had misread your membership, you reluctantly accepted repeal of it.

This all demonstrates to me that you are an organization that is flexible. And I suppose now is a real opportunity to show flexibility and to work with us to solve this problem, both short-term and long-term. I suppose we would all say that the most responsible thing is to do it long-term.

But I suppose, if you do something for the short-term problem, that gives us a little more leeway to solve the long-term problem.

Now that is just a pleading on my part. I do have a specific point that I would like to make with you. And that is that a number of witnesses we have heard over several days of hearings so far seem to believe that we can and, in fact, that we should try to restrain Medicare spending even if we do not do broader health care system cost containment.

These would include the public trustees who testified last week. They would include people like Dr. Reischauer, who is very respected, and probably even more respected now that he is not in Government.

Some of these people argue that the private side of health care seems to be containing health care costs with new approaches to organizing health care. In fact, here on this very panel, Mr. Davidson has argued that the cost shift phenomena is becoming less pronounced. Medicare, some of our witnesses argue, seems to be out of control and needs thorough reform.

So I guess I do not follow, or maybe I just do not agree with your argument that Medicare cannot be reformed separately from the rest of the health care system. That is a comment, or that is a question. I guess you still feel that they have got to be tied together. Those of us that see the White House saying the same thing think this is an excuse the White House is using not to really deal with a tough issue.

How do you see it, not in reaction to the White House? Your position is very similar.

Mr. LEHRMANN. Our position is that we need to do something to reform health care on a broad basis. When you are asking the question, why has Medicare not come down in comparison to the private sector?

There are two things that I can think of right offhand that account for it. First, people are living longer. More people are reaching the age of 65, and the number that are being treated is growing. So there is an increased number of people that have to be cared for. So those are important reasons.

Second, in the private sector at this point there is a lot of negotiating going on by very skilled negotiators with respect to prices, particularly, in HMO's, cafeteria or employer plans and the like.

On the other hand, in Medicare we do not have many people enrolled in HMO's. That is why we are taking a look at what incentives we can provide to get people involved.

Senator GRASSLEY. All right. But your argument still is that we should not deal even with the short-term problem?

Mr. LEHRMANN. No. I was trying to indicate at the beginning that we have to do something with the short-term problem right now. We cannot resolve it without doing something right now.

Senator GRASSLEY. Could I please ask one last question? It will be short.

The CHAIRMAN. Go ahead.

Senator GRASSLEY. Dr. Dickey, you gave a very helpful statement, but there is something a little unclear about how the AMA thinks we should deal with short-term funding of the Medicare program.

It is evident to most of the witnesses we have had before this Committee, and even the Budget Committee I serve on, that this issue of Medicare financial solvency involves a need to reform the system over the longer term. But we really have to do something about reducing spending in the program, not just Part A, but Part B spending has also increased to a point that we cannot tolerate it.

What should we do for the short term?

Dr. DICKEY. Well, I think that, as in the past, Part B—the physicians' part of Part B at least—is willing to absorb a reasonable change in the rate of rise. However, as has been said this morning, if it happens too quickly, it threatens the very program that it is supposed to be served, the access of the elderly and the quality of care.

Our other concern is that if we allow ourselves to constantly answer just the short-term question, as has happened in the past, and do not insist that we also look at the transformation of the entire program, we will simply be back a year or 2 years from now, addressing the same issue again, in terms of what to do for the short term.

Senator GRASSLEY. So your fear is that we will just solve the short-term problem, and not the long-term problem.

Dr. DICKEY. Yes, sir. It is very important that we look at the long term, or we will simply be addressing the short-term problem until the day of bankruptcy. Then I presume we will have to create a new program.

Senator GRASSLEY. And I suppose you see, as we have cut reimbursement over the last decade and have not solved the long-term problem—probably have not even solved the short-term problem—you see us repeating that mistake. That is your admonition, right?

Dr. DICKEY. I think our concern would be to say that we would like to work with you to solve the long-term problem. As we do that, you will find a willingness on our part to work as well on the short-term problem.

Senator GRASSLEY. All right. Thank you very much.

The CHAIRMAN. Mr. Davidson, you suggest the possibility of the equivalent of a base closing commission, where we give the commission a number and say, now you come up with a recommenda-

tion on whatever you want to come up with, and we vote it up or down?

Mr. DAVIDSON. Well, something would precede that. That would be that the independent national commission would give you a body of knowledge to make a determination of the condition of the program, and so forth, and then give the commission back a mark that you would like to spend.

The commission in turn would then tell you what you could get with that mark, in terms of changes in conditions for beneficiaries, payment to providers, innovative ways to change the program. Then yes, a vote up or down.

The CHAIRMAN. So in this current Part A bankruptcy, it would work as follows. We would say to the commission, the best economics we have is that we are $165 billion short. Ladies and gentlemen of the commission, we ask you to make recommendations—not just suggestions—as to how we do that, present them to us, and we vote it up or down, no amendments?

Mr. DAVIDSON. No amendments. That is the view long-term. We do not think you can do that in the immediate term, in terms of having enough time to analyze information.

The CHAIRMAN. All right. I think you are probably right.

Mr. DAVIDSON. That is how we feel about this long term. That gets to the issue. We are never going to get there if we do not try it that way.

The CHAIRMAN. Then let me ask you the last question. Are you saying that this problem has become so sensitive that we are unable to face it directly as a Congress, and need to buck it to a commission to take the load off of our shoulders. And then we say they made us do it.

Mr. DAVIDSON. Well, I would hate to be the one that talked about the imperfections of the political process.

I guess it was Mr. Madison, in the Federalist Paper No. 10, who talked about factions voicing their concerns and interest. And that has become very sophisticated. And I guess I would have to observe that the level of sophistication has on many occasions brought this Congress to gridlock.

It seems to me that we have to be honest about it. The issues have become so serious that we need to get beyond the gridlock. The interest groups have in fact been an impediment to the process of democracy. And it seems to me that we have to help you make the tough choices. And we are willing to suffer our pain as part of that process.

The CHAIRMAN. I know the factions of which you speak. Pat, we are having a flat tax hearing tomorrow. And in the headline of the National Realtor News about a month ago, on the subject of the flat tax, was "It's War." I have not seen headlines as big since Pearl Harbor.

That is just another faction on another issue, but it is all the same problem.

Folks, thank you very much for coming. We are adjourned.

[Whereupon, at 11:50 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF STUART M. BUTLER, PH.D.

Thank you, Mr. Chairman, for the opportunity to testify before the committee today on the problems facing the Medicare program. My name is Stuart Butler. I am Vice-President for Domestic and Economic Policy Studies at The Heritage Foundation. I must emphasize, however, that the views I express are entirely my own, and should not be construed as representing any official position of The Heritage Foundation.

Others have testified before this committee on the chronic financing problems facing the Medicare program, and so I will not dwell on the need for Congress to take, in the words of the Medicare Trustees, "prompt, effective and decisive action."[1] I will instead discuss the reasons why the program is so out of balance, and the shape of reform suggested by these root causes.

There are three principal causes of the Medicare predicament. They are structural problems and they need structural solutions. Implementing these solutions will permit the quality of medical services to be improved while the trend in the cost of providing these services is moderated. This the key to restoring financial soundness and thus assuring future generations that Medicare will be able to serve them without draining resources from other parts of the budget. The structural problems are:

(1) Medicare attempts to moderate costs through the use of ineffective price controls.

(2) Medicare's price control and central planning philosophy necessarily resists service delivery innovations.

(3) Part B of Medicare heavily subsidizes Americans who do not require taxpayer support.

(1) THE FAILURE OF PRICE CONTROLS

Any student of economics looking at Medicare would recognize immediately that it is a classic example of the failures of price controls and that it exhibits all the chronic distortions and inefficiencies that typically accompany a price control system.[2] It is ironic that when countries around the world are abandoning price control and central planning, America tries to use these tools to deliver health care to the elderly. And it is rather astonishing that some lawmakers are surprised that these tools do not work.

Price controls in Medicare take the form of such things as the DRG system for hospital payments and the RBRVS system for physician services—the latter explicitly designed according to the labor theory of value, which is the basis of socialist economics. Besides the failure of these control to hold down the rate of growth of expenditures to a degree comparable with the private sector, they have led to distortions and inefficiencies familiar to any student of price controls. For example, squeezing prices in Medicare has led to significant cost shifting (or more accurately "price shifting") to non-Medicare services and to providers seeking to increase volume (with the typical government response of attempting to control volume). Diagnoses are widely modified to qualify for better payments. Or in an attempt to improve profit margins under price controls, costs are moved to other places in a hospital's accounts—such as capital expenditures—which might qualify for separate payments.

The history of price controls in Medicare exemplifies the games that naturally occur in any price control system. Providers, and sometimes patients, react to each control by seeking ways to evade it, with a loss of general efficiency; then government introduces a new, more elaborate control in an attempt to address the defi-

ciencies of the first control. Then the cycle continues as the providers find a way around that control. Meanwhile efficiency suffers and expenditure targets are exceeded.

This chronic problem cannot be solved with tighter controls and new rules. The system of price controls itself is flawed as a method of controlling expenditures. Needed instead is a switch in policy towards a system in which expenditures are held in check in a Medicare program based on consumer choice among competing plans.

(2) RESISTANCE TO EFFICIENCY-IMPROVING INNOVATIONS

In addition to the distortions and evasions implicit in a price control system, such a system also fails to control costs because its bureaucratic nature reduces the pace at which efficiency-improving innovations are introduced. In a competitive market-based system, choice and competition lead to a decentralized, continuous and rapid introduction of ideas to improve the ratio of quality to price. These are accepted or rejected in the system to the degree that buyers and sellers agree that they are an improvement. In a centrally-planned system, like Medicare, the process is entirely different. Ideas must "trickle up" to senior officials responsible for the program. Typically they must then be evaluated by officials and boards, proposed to politicians and subjected to the pressures of competing interests before they take effect. The result is both slow and likely to result in politically-influenced decisions.

While Congress is responsible for creating the Medicare laws, it is the bureaucracy within the Health Care Financing Administration which is to blame for the denial of "state of the art" medical technology to our nation's seniors in the Medicare program. For example, by denying reimbursements to hospitals conducting clinical studies on Medicare patients, seniors are adversely affected by being denied access to medical innovations invented in the United States. As highlighted in the cover story of USA Today on May 10, 1995, "Faced with possible federal charges and potentially millions of dollars in fines, hospitals slammed on the brakes . . . shutting down all device studies or excluding Medicare patients from them. Doctors were no longer able to provide what they considered the latest treatments to many older patients."[3]

This happens not only because HCFA must formulate guidelines for every category of medical equipment, but because it also must decide whether each new medical device or treatment meets the criteria for coverage under Medicare Part B. This highly regulatory process has proven to be extremely expensive for taxpayers and dangerous for patients.

It is thus no surprise that tools to control costs efficiently that are widespread in the private sector are not used, or used only sparingly, in the Medicare program. Some examples:

- Medicare is essentially only a "fee-for-service" program. It has made little progress in allowing, as an option to the elderly, managed care plans such as health maintenance organizations (HMO's) or competitive medical plans (CMP's). Moreover, with the rigid guidelines established by the Health Care Financing Administration (HCFA), Medicare's payment scheme to HMO's is crude. For example, Medicare should not be using local fee-for-service Medicare costs as the means of setting HMO payment rates.[4] As a result, former HCFA administrator Gail Wilensky has recently testified before the House Ways and Means Committee that inadequate adjustments appears to have produced overpayments to many HMO's, and underpayments for other HMO's.
- Unlike typical insurance plans available to working Americans, Medicare places no limit on insurance copayments. As a result, most Medicare enrollees purchase "Medigap" policies to cover Medicare's 20 percent coinsurance requirement. Under current Medicare law, Medigap policies are required to cover all coinsurance costs under Medicare and the typical plan also covers the HI deductible, and some even cover the SMI deductible. But because 80 percent of Medicare beneficiaries are covered by additional insurance policies, they face little or no out-of-pocket costs for Medicare covered services and thus little incentive to question costs or the need for services. According to the Congressional Budget Office, the use of medical services by those with additional private insurance coverage is 24 percent higher than those with only Medicare coverage.[5]
- While the Medicare Part B program appears to be a comprehensive benefit package at a superficial glance, closer scrutiny reveals that it is nothing more than a standardized and quite limited benefit package locking our nation's elderly into a one-size fits all health plan. Such a standardized benefit package

does not take into account the different needs and desires of individuals, and lacks, for example, catastrophic coverage or a drug benefit.

This problem of slow service design innovation is endemic to Medicare's price control/central planning system. While conceivably the process could be speeded up, it cannot even theoretically match the pace of innovation in a competitive marketplace. The solution to this problem thus is the same as the solution to the first problem: change the underlying economic dynamic of the Medicare system.

(3) PART B HEAVILY SUBSIDIZES MANY UNDESERVING AMERICANS

The first two problems discussed are generic features of the Medicare program that contribute to unnecessarily rapid increases in expenditures. But in addition, net Medicare outlays are higher than they need be because Part B (SMI) is so heavily subsidized.

Medicare Part B is a voluntary program. Unlike Part A, Americans do not make explicit contributions to the program during their working life and there is no obligation whatsoever for citizens 65 or over to participate in this part of Medicare. It is merely a heavily subsidized, federally-run physician-care "insurance" plan available at a community-rated price to older Americans without regard to income.

When Medicare was established in 1965, the Part B monthly premium was originally set at a level to finance 50 percent of the Part B program costs, irrespective of the income of the beneficiary.[6] However, when the Part B costs began to increase at a faster rate than inflation, the Congress decided to limit the percentage increase in the premium to the same percentage as Social Security benefits were made for cost of living adjustments. Under this new formula, revenues from Medicare Part B premiums decreased from 50 percent to roughly 25 percent of the Part B expenditures. This is because the Part B costs increased at a faster rate than inflation as measured by the Consumer Price Index. Beginning in the early 1980's, Congress has consistently voted to set the part B premiums at a level which would cover about 25 percent of the program's costs. Thus enrollees in the Part B program thus enjoy a very generous 75 percent subsidy paid by taxpayers—irrespective of the beneficiary's income. Unlike the Part A program, which is primarily financed through the taxation of wages, general revenues in order to pay for it.

There is little justification for a flat 75 percent subsidy without regard to income. Congress should reduce or eliminate this subsidy for upper-income Americans.

ACHIEVING TRUE MEDICARE REFORM

Large savings and efficiency improvements are possible in the Medicare program only by changing fundamentally the way the program functions. That structural reform must move Medicare away from the current highly-regulated system towards a system based on consumer choice among competing health plans. This change would not just save money. In this reformed Medicare system, retirees would have the widest possible discretion to enroll in plans of their own choosing, with the benefits they and their doctors feel are right for the retiree, and with the government making an appropriate contribution towards the cost of the chosen plan.

The way to achieve this reform is to convert Medicare from a defined benefit program to a defined contribution program—in effect a voucher program. In this arrangement, the Medicare program would make a contribution to the health plan of the elderly but retirees would be given a very wide range of plans in which to enroll and keeping part of the savings if they choose a less costly way of obtaining their care. A Medicare enrollee would have the option of using the voucher to stay in the current government-designed benefits and reimbursement system or applying the voucher towards the cost of any Medicare-approved private health insurance plan on the market. If the private plan cost more than the worth of the voucher, the enrollee would be responsible for the difference. However, if the plan cost less than the value of the voucher, all or part of the savings would go to the enrollee. An alternative to a voucher program would be the agreement by Medicare to cover a certain percentage of the premium and out-of-pocket costs in the selected plan.

In order to reflect the true value of the retiree's health care needs, the voucher amount would be adjusted based upon the beneficiaries' age, gender, and geographic location (but not health condition). To be eligible to market to the Medicare population, plans would have to meet certain criteria. They would have to use the underwriting principles that mirror those use to set the value of the voucher. They would have to include catastrophic protection (and perhaps a limited, core set of benefits). And they would have to meet certain financial viability requirements and perhaps guidelines in stating their benefits and cost (to make comparisons easier for the elderly). Plans could offer an insurance/medical savings account option and be eligible for receiving the Medicare voucher.

The new program offering more choices thus would be structured much like the Federal Employee Health Benefits Program (FEHBP) which covers approximately 10 million federal employees, their families—and retirees. To be sure, the proposed Medicare reform would not incorporate the rigid community-rating in the FEHBP, but it would function much like the FEHBP does for retired federal employees. And just as many FEHBP plans are organized by associations, such as the Mailhandlers union, it is likely that organizations with a strong link to the elderly, such as AARP or certain churches and unions, would have an interest in designing a health plan to market to the elderly. Even if such organizations did not actually market plans, they could play a valuable role in providing consumer information to the elderly, to assist them in making choices.

Congress in reality only has two choices when considering the future of Medicare:

Choice #1

Make no change in the way in which Medicare is run by the government, and pay for future trust fund shortfalls by raising new revenues through higher payroll and other taxes, or by diverting money from other programs. This means Medicare survives only by draining money away from the rest of the budget or by raising taxes.

Choice #2

Change the way Medicare is run, so that benefits are delivered more efficiently, avoiding future tax increases or a diversion of money from other programs. Making the program more efficient would improve the quality of benefits and the choices available to retirees while reducing the double-digit rate of outlay increases. This would slow the depletion of the trust fund and stabilize the program.

I believe, Mr. Chairman, that you and the committee agree that the second choice is the only responsible one. That means Congress must address the chronic design flaws of the Medicare program.

FOOTNOTES

[1]: *1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund,* p.4.

[2]: See Stuart M. Butler, "The Fatal Attraction of Price Control," in Robert B. Helms, *Health Policy Reform: Competition and Controls* (Washington D.C.: The AEI Press, 1993).

[3]: Tim Friend, "Clinical Trials in U.S. called endangered," USA Today, May 10, 1995, p.2A.

[4]: General Accounting Office, "Medicare, Health Maintenance Organization Rate-Setting Issues," GAO Report to Congressional Committees, January 1989, GAO/HRD-89-46, p.4.

[5]: Congressional Budget Office, "Restructuring Health Insurance for Medicare Enrollees," CBO Report, August 1991.

[6]: Congressional Research Service, "Medicare: 1994 Budget," Mark Merlis and Richard Price, June 28, 1993, p. 6.

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A Special Report to the House Ways and Means Committee

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MEDICARE PART B REFORM

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The American people sent the powerful message last November that they want Congress to undertake a radical overhaul of government. They want Congress to review the activities of the federal government to determine how to move functions closer to the people. They want Congress to curb the growth of government and its intrusion into their lives. And they want Congress to look at how to reform those programs within the domain of the federal government so that they can better achieve their stated purposes.

Congress has an unprecedented opportunity to undertake such a fundamental reform of the Medicare program. It must do so in the context of the immediate need to take steps to balance the books of the federal government and to rein in the huge growth in federal spending over the last several years, which has pushed the country into debt while raising the burden of taxes on Americans. More specifically, Congress must consider Medicare reform in the context of a general reform of entitlement spending. None of the entitlement programs can be considered "off the table" as Congress grapples with the deficit—especially programs that provide large subsidies to one generation by passing the tab to the next.

The Medicare system thus should come under careful review to see whether sensible savings can be achieved while reforms are undertaken. As I will point out in this testimony, among the many possible reforms to achieve a reduction in the growth of net outlays of Medicare, Congress should consider an increase in the heavily subsidized Medicare Part B premium. As I will explain, this can be justified whether or not the objective of the reform is to reduce net outlays.

Still, any changes in the Medicare Part B premium should be taken in tandem with steps toward structural reform of the entire Medicare program. That structural reform should move Medicare away from the current highly regulated system, characterized by complex price and volume controls and Washington-specified services, toward a system which seeks to protect the health of eligible Americans as economically as possible. In this latter, reformed Medicare system, retirees would have the widest possible discretion to enroll in plans of their own choosing, with the benefits they and their doctors feel are right for the retiree, and with the government making an appropriate contribution toward the cost of the chosen plan.

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1 Substantial portions of this were delivered in testimony before the Health Subcommittee, House Committee on Ways and Means, on February 7, 1995.

Note: Nothing written here is to be construed as necessarily reflecting the views of The Heritage Foundation or as an attempt to aid or hinder the passage of any bill before Congress.

With the government making a fixed contribution for each retiree, Medicare beneficiaries not only would have the freedom to choose the benefits and type of plan they preferred (such as fee-for-service or managed care), but also would have the incentive to seek out the best value for money among plans. This reform would give retirees in Part B choices and incentives very similar to those applying to Members of Congress under the Federal Employee Health Benefits Program. It is no coincidence that the FEHBP has managed to keep increases in enrollee costs well below those of Medicare and, more significantly, those of corporate health plans while maintaining a high level of satisfaction.

The possible changes in the Part B premium I will review are compatible with this structural reform.

THE CASE FOR RAISING PART B PREMIUMS

The Medicare Supplementary Medical Insurance (SMI) program, known as Part B, pays for physician services, outpatient hospital services, and other medical expenses for Americans aged 65 and over and for the long-term disabled. Unlike the hospital portion of Medicare (HI, or Part A), enrollment in Part B is voluntary. And unlike the HI program, Part B services are paid for through a system of premiums (supplemented with general revenues) rather than payroll taxes. According to the most recent report of the Board of Trustees, SMI disbursements in 1993 were $57.8 billion ($54.0 in benefits). The program received $41.5 billion in general revenue contributions in 1993 (71.9 percent of income).[2]

This subsidized, voluntary program is very popular. At the time of its enactment on July 1, 1966, 17.7 million aged persons enrolled in Medicare Part B. This population has steadily increased over time. In 1990, 32.6 million aged persons were enrolled in Medicare Part B. In 1995, 35.7 million persons are enrolled in Part B, or 97 percent of the total Medicare population. In 1990, 3.2 million enrollees were covered under both the Medicare and Medicaid programs (the state paid for premiums and required cost-sharing expenses).

There are several reasons for making changes in the Part B program, and in particular for requiring some beneficiaries to shoulder a higher proportion of program costs. Among them:

- **Part B is a heavily subsidized entitlement without regard to income or any past contributions.**

  Unlike the HI program (Part A), the benefits available from Part B are not even in theory based on contributions made by recipients during their working years. Instead, it is a government-sponsored health insurance program that is heavily subsidized by taxpayers (including many elderly Americans who have chosen not to enroll).

  The subsidy is roughly three dollars for every dollar of premium paid. More precisely, beneficiaries in 1993 contributed just 24.6 percent of program income.[3]

  When Part B was established, it was Congress's intention to provide a subsidy, but at a much lower rate than today. Until 1973, SMI premiums were set by law to finance one half the benefit and administrative costs of the program plus a small contingency amount to go into a separate trust fund. However, in 1972, Congress amended the Social Security Act and drastically altered that arrangement. Beginning in July 1973, SMI premiums could be increased only if monthly Social Security cash benefits were increased. Premiums are permitted to rise no more than the percentage increase in cash benefits. Since the 1972 amendments, the proportion of Part B income contributed by

2 Board of Trustees, Federal Supplementary Medical Insurance Trust Fund. *1994 Annual Report of The Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund* (Washington D.C.: U.S. Government Printing Office, April 1994), p. 1.

3 *1994 Annual Report*, p. 1.

enrollees has declined, and so the degree of subsidy has increased. Enrollees in 1995 pay a premium of just $46.10 for insurance that covers 80 percent of allowable charges with a deductible of only $100. Had the original deductible been allowed to rise in line with outlays, it would be over $1,000 today. With such inexpensive and generous coverage, subsidized by the taxpayer, it is little wonder that almost all eligible Americans decide to enroll in Part B.

When working Americans are facing up to the need to tighten their belts and accept reductions in federal programs, it is hard to see why, at the very least, more affluent retirees should not contribute a larger share of the cost of Part B. While Medicare Part B requires the payment of premiums, it is actually an income transfer program, taking away income from one segment of the population and redirecting it to another without regard to the latter's income.[4]

❷ Part B costs are growing at an alarming rate.

In the 1994 trustees' report to the Congress, the financial outlook for Medicare Part B is not encouraging. While the trustees believe the SMI program currently is actuarially sound, they "[n]ote with great concern the past and projected rapid growth in the cost of the program....Growth rates have been so rapid that outlays of the program have increased 59 percent in aggregate and 45 percent per enrollee in the last five years. For the same time period, the program grew 23 percent faster than the economy despite recent efforts to control the cost of the program."[5] While the trustees do not make any long-range projections as they do in the HI (Part A) program, they point out that the SMI program will be affected by many of the same factors that are projected to increase Part A's costs (medical inflation, a rapidly aging society, etc.).

Part B outlays are growing at such a rapid rate that they are consuming an ever-larger share of the gross domestic product (GDP), as are HI expenditures. In 1993, Part B spending constituted 0.88 percent of GDP. This year the proportion is projected to be 0.99 percent, and in just 10 years' time the proportion is projected to be 1.17 percent.[6]

Such an alarming rate of increase in a program, particularly a voluntary enrollment program, demands congressional action to curb the growth of future outlays by benefit reductions and/or by requiring at least some beneficiaries to shoulder a greater share of costs.

❸ The generosity of Part B subsidies is a barrier to finding more economical and efficient ways of providing health care services to the elderly.

Since enrollees pay only 25 percent of the costs of Medicare Part B, insurance alternatives to the program generally are very unattractive even if they are actually much more efficient in delivering services—unless the proportion of the premium paid by the private sector enrollee is close to 25 percent. Some corporate retiree plans require low cost sharing from beneficiaries, and so are competitive with Part B. But if, say, a retiree had to pay the full cost of equivalent insurance coverage, Part B could be almost three times as costly in delivering services (including overhead) and would still be more attractive to the retiree. There are good reasons to believe that because of this wide price differential made possible by the heavy subsidy, Part B is under less pressure to realize true efficiencies. Its payment schedule is a highly complex price control system, for instance, and is very inflexible, and only nine percent of enrollees are in managed care. In the competitive private sector,

4 David Koitz, *Medicare Taxes, Premiums, and Government Contributions for 1995*, CRS Report for Congress, December 20, 1994, p. 2.

5 *1994 Annual Report*, p. 3.

6 Guy King, "Health Care Reform and the Medicare Program," *Health Affairs*, Vol. 13, No. 5 (Winter 1994), p. 41. Projections based on Trustees Report.

by contrast, there is continuous adjustment of pricing and benefit levels as plans seek greater efficiency, and there has been a quite dramatic shift in recent years to managed care.

Reducing the subsidy level in Part B would encourage many retirees to compare the costs and benefits of private alternatives with those of the Part B program. The further the subsidy was reduced, and hence the more level the playing field, the greater would be the inducement to pick more efficient private plans. That would lead to a reduction in the outlays of the program.

Whether or not the subsidy level is reduced, the desire to introduce greater incentives for efficiency has led many analysts to favor reforms that would reconstitute Medicare Part B (and Part A) into the equivalent of a voucher program to give the elderly the opportunity and incentive to choose plans and benefits that are very different from Part B. This reform would not, in itself, change the government's contribution to retirees, but it would give them far more freedom of choice and a strong incentive to seek the best value for their money among private-sector plans competing on an equal footing with the Part B program.

OPTIONS FOR RAISING PART B PREMIUMS

Not a Tax Increase. If this subcommittee gives serious consideration to reducing the level of subsidy by raising the Part B premium, members no doubt will be accused by some critics of favoring a tax increase.

An increase in the Part B premium is *not* a tax increase.

Members of this subcommittee can feel very confident that as a senior official of The Heritage Foundation, I would not come before you and advocate a tax increase. On the other hand, while opposing tax increases, we at Heritage have argued consistently that individuals or corporations receiving an explicit service from government—especially one which also could be provided by the private sector—should pay the full cost of that service unless there is some pressing reason for a subsidy (such as poverty). And such a subsidy should be explicit, rather than hidden in the price of the service. This is why scholars from The Heritage Foundation have testified before various committees and published studies advocating full-cost user fees for commercial services available from the federal government.

Part B is a "commercial" service provided by the federal government. If there is to be a subsidy for enrollees in the program, it should be restricted to those whom Congress has determined cannot reasonably afford an acceptable level of physician services and other services available under Part B. There is a strong case for ending the subsidy available to other Americans.

While a case can be made for greater cost sharing in Part A, the case is much stronger for Part B. Americans contribute to their Part A benefits throughout their working life. Those contributions are mandatory and are income-related. Thus, there is reasonable argument against means-testing Part A or reducing benefits if they fall below the equivalent value of payroll contributions. No such argument applies to Part B. Part B is voluntary—retirees and the long-term disabled examine the cost of coverage under the subsidized Part B program and under private alternatives and choose whether or not to enroll.

Under current law, according to the Congressional Budget Office, the federal government is projected to spend $485.9 billion over the next five years in Part B payments (of which premium payments cover just 25 percent).[7]

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7 Congressional Budget Office, "CBO December 1994 Baseline, Outlays by fiscal year, in billions of dollars," January 9, 1995.

OUTLAYS
(In billions of dollars)

1996	1997	1998	1999	2000
75.3	85.3	96.1	108.0	121.2

There are several options available for raising Part B premiums.

OPTION 1: Raise the beneficiary premium to 100 percent of costs.

While obviously the most difficult option politically, this change could achieve net savings to the program of as much as $364 billion over five years, depending on the assumptions made.[8] Even if this sharp increase had applied in 1995, beneficiaries still would pay just $184.40 per month for good coverage.

But, needless to say, this change would be a great hardship for many lower-income Americans. It would also be a new burden to states unless states chose to maintain their current level of financial support for individuals also on Medicaid—in which case these low-income Americans would face relatively large premium costs.

OPTION 2: Raise the premium contribution level to 50 percent of costs.

Congress originally set the premium for Part B at 50 percent of costs, so this option would merely reinstate that premium percentage. This would still retain a heavy subsidy to enrollees, regardless of income. Had this change been in effect in 1995, premiums would be $92.20 per month. The net savings to the government from this change would be as much as $121.5 billion over five years.

While lower-income enrollees would not be affected by this change as much as under option 1, many would still face hardship—while upper-income enrollees would continue to be heavily subsidized.

OPTION 3: Means-test premiums for upper-income beneficiaries.

A compromise change would be to reduce the subsidy as income rises. The savings achievable from such a change would vary widely, depending on what method of means-testing was introduced.

A general concern about any means-testing system is that it has the equivalent effect of raising marginal tax rates for individuals enrolled in the program, since premiums rise with income. Still, this effect could be kept quite small. Consider the following change:

> Gradually reduce the Medicare Part B premium subsidy for "high retirement income" beneficiaries. The threshold begins at $65,000 in adjusted gross income for individuals and $85,000 for couples. The subsidy is phased out in increments of 3 percent per $1,000 of income above the threshold. The full premium would be paid by individuals above $98,000 in AGI and couples above $118,000 in AGI.

The increase in the equivalent effective marginal tax rate in this case would be approximately 5 percentage points.

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While these reductions in the subsidies in Part B would yield savings to taxpayers, I must emphasize again, in conclusion, that such changes should be instituted in tandem with initial steps toward a restructuring of the Medicare program. The aim of the structural changes should be a Medicare system in which retirees receive a contribution toward the cost of coverage (perhaps inversely related to income) which they may use to enroll in a plan of their choice. Such a system would have to be introduced gradually and would require certain changes in insurance rules for plans serving the Medicare population. But if the long-run expenditures of Medicare are to be brought under control while assuring the widest choice and value-for-money for retirees, structural reform is essential.

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8 A change of this magnitude would have large behavioral effects which are beyond the scope of this analysis. Clearly one effect would be that the number of persons enrolled in Part B would decline as individuals comparing premium costs chose more competitive private plans. That would reduce outlays and the net savings to the deficit.

PREPARED STATEMENT OF DICK DAVIDSON

Mr. Chairman, I am Dick Davidson, president of the American Hospital Association. I am pleased to testify today on behalf of AHA's 4,600 institutional and 50,000 individual members.

The Medicare budget issues under consideration will touch the lives of almost all Americans: the 37 million people who rely on Medicare benefits for their health care; the families of those beneficiaries; the millions of baby boomers who are edging closer to retirement; and the young workers who are paying into the system and rightfully expect Medicare to be there for them when they grow older and retire.

America's hospitals and health systems are proud of the high-quality care they've provided for Medicare beneficiaries over the first 30 years of the program. It hasn't always been easy—Medicare on average pays hospitals just 89 cents for each dollar of care delivered, a figure that is certain to drop if the spending proposals being considered are adopted. But we've kept our promise to deliver high-quality health care to the millions of Americans covered by the Medicare program. We're here today because we want to be able to keep that promise well into the next century.

I'd like to present my testimony in three parts:

The crisis in Medicare Part A—the Hospital Insurance (HI) Trust Fund
The effects of further Medicare spending reductions
Some long-term answers to make the Medicare program stronger

The current crisis in the Hospital Insurance Trust Fund

The number of Medicare enrollees is increasing exponentially: When Medicare became law 30 years ago, 19.1 million people were covered; today's 37.5 million Medicare-insured Americans will swell to more than 40 million in five years. The average one-earner couple retiring in 1995 will use an estimated $126,700 more in Medicare benefits than they paid in taxes and premiums. In just 15 years, the nation's 77 million baby boomers will start turning 65. And not too long after that, there will be only two workers supporting each enrollee, instead of the four supporting each enrollee today.

All of these facts are contributing to the HI trust fund's financial fragility. The trust fund's board of trustees recently reported that the fund will be insolvent by 2002. They also reported that program costs are expected to far exceed revenues over a 75-year long-range period under any reasonable set of assumptions.

But Medicare is, like the rest of Social Security, a contract with America's seniors, and the HI trust fund is the centerpiece of that promise. The HI trust fund is the financial backing that keeps the Medicare contract from becoming just a bill of goods. Something must be done to fulfill the contract. But, contrary to current political rhetoric, the business-as-usual approach of simply cutting HI trust fund spending will do little or nothing to solve the problem.

That rhetoric has shifted in recent weeks. Many in Congress are now saying they want to cut Medicare to save Medicare. Unfortunately, no proposal currently on the table shores up the long-term viability of the trust fund. Behind all the rhetoric about shoring up the trust fund lurks the business-as-usual approach of more and more cuts to Medicare—this time in order to balance the budget.

It's clear why this shift in rhetoric occurred: National polls and focus groups conducted by the American Hospital Association and others suggest that Americans believe deeply that Medicare is Social Security—an earned annuity, paid for over a lifetime of payroll deductions. A member of Congress who votes to erode Medicare is seen as violating a promise not to touch Social Security. That sentiment cuts across all age, income, geographic, and gender boundaries.

And they are right. Medicare is part of the Social Security law. Medicare Part A is funded through payroll deductions; Medicare Part B premiums—which, with general revenues, fund physician, ambulatory, and other services—are deducted from beneficiaries' Social Security checks.

These proposed Medicare spending reductions may, in fact, be reductions in the rate of growth and not cuts in spending, but let's be clear: To people who rely on Medicare for their care and to people who provide their care, the spending proposals being considered are very likely to translate into cuts—cuts in services and cuts in personnel. To the people to whom we provide care, these slowdowns in the rate of spending translate into real cuts.

Even the fund's trustees acknowledge that further legislation to limit payment increases to providers or extend prospective payments to other providers would only postpone insolvency for five to 10 years. In fact, the $256 billion in overall Medicare savings over seven years proposed by the Senate Budget Committee would delay insolvency of the HI Trust Fund for only about four years. Adding four years to the solvency of the trust fund is not worth the price these reductions would extract from

the millions of Americans who rely on Medicare. And even if the drastic reductions in spending do delay insolvency, solvency is not the only issue. Even if solvent, the trust fund must contain enough dollars to provide quality care for seniors.

In order to fully address the long-term problems of the Medicare program, all ingredients must be on the table—the program structure, the level of benefits, and program revenues, as well as spending. Unfortunately, current proposals look only at slowing the rate of spending, a business-as-usual approach that ignores much of the problem.

The effects of Medicare spending cuts

There's no question that Medicare spending is growing. But it's important to take a closer look at why. The AHA commissioned a study by Price-Waterhouse that revealed some interesting things:

- Enrollment growth and medical and general inflation accounted for nearly 89 percent of Medicare spending growth since 1980.
- Growth in Medicare enrollment between 1980 and 1993 was double the rate of growth in the general population. At the same time, enrollees over 75 years old as a percentage of all elderly (over 65) grew to 43 percent in 1993 and are expected to reach nearly half by 2005.
- The proportion of Medicare spending on hospital care has declined from 70.2 percent in 1980 to 60.1 percent in 1993.
- Since 1980, Medicare hospital spending growth has been lower than growth in Medicare spending for other services.

Since the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) was enacted, Medicare hospital spending reductions of at least $48 billion have had significant impact on hospitals and health systems. So have Prospective Payment System (PPS) payment rates that haven't kept up with inflation. On Medicare inpatient and outpatient care combined, 1993 Prospective Payment Assessment Commission data show hospitals losing 11 cents on the dollar.

The effects of the Senate Budget Committee's proposed cuts of $256 billion over seven years can be illustrated by a new impact analysis AHA commissioned from Lewin-VHI, a health care consulting firm. We asked Lewin-VHI to model the impact on hospitals and health systems of overall Medicare spending reductions totalling $150 billion over five years and $250 billion over seven years.

Based on historical patterns of previous Medicare spending reductions, the Lewin-VHI analysis assumes that a $250 billion reduction could translate into hospital PPS reductions of $94 billion over seven years.

The Lewin-VHI findings show:

- Under this scenario, every type of hospital loses—rural, urban, large, small, teaching, and non-teaching.
- By the year 2000, Medicare PPS inpatient operating margins fall to negative 20.6 percent. Because most of the reductions are made in the first five years, margins rise for the last two years, but still remain negative—a negative 12.2 in the year 2002.
- By the year 2000, hospitals will lose $1,300 in PPS payments for every Medicare patient. Hospitals will be paid $900 less in the year 2002.
- Hospitals' PPS costs last year grew at 2.1 percent—the lowest rate ever. Lewin-VHI estimates use a very conservative number for hospital cost growth, based on last year's experience. If actual cost growth is higher than projected, hospitals could face substantially lower margins than those illustrated here.

In the past, hospitals have coped with Medicare spending reductions by shifting costs—by passing the difference on to other payers, like non-Medicare patients and their employers. But those days are fast disappearing—and these reductions are unprecedented. Simply put, the market is shutting down the cost-shift option. Managed care contracts and a growing number of private insurers who negotiate discounted prices are making cost-shifting a thing of the past. They're tired of shouldering the burden of government underfunding.

This leaves hospitals with unpalatable options: reduce the size of the work force; reduce services and programs; or both. Either action takes us farther from our mission of providing the highest-quality health care to all the people we serve, including America's elderly.

AHA's vision for the future of Medicare

To deal with the trust fund problem constructively, and for the long term, we need to make fundamental, structural changes in the Medicare program—like moving it toward coordinated care—and create an independent citizen's commission on Medicare.

For Medicare beneficiaries, coordinated care means greater ability to meet their needs and to deliver preventive care. More and more, coordinated care is covering all Medicare services, plus coverage for vision, dental, preventive services and even hearing aids—benefits that most "Medigap" policies don't provide. Many coordinated care plans eliminate the 20 percent co-payment seniors must pay for doctor visits,

and at the same time eliminate mountains of claim forms. These may be key reasons why a survey by the consulting firm of Frederick/Schneiders found that Medicare enrollees in coordinated care plans are as satisfied with their overall care as those in traditional fee-for-service.

Most importantly, coordinated care networks can bring Medicare beneficiaries closer to a better vision of health care for the future: a connected health system, with everyone who provides care—doctors, hospitals, nurses and others—linked together and communicating with each other at every stage of treatment and service.

Coordinated care works better than the old-fashioned, fragmented system we must pull away from. And it can bring better, more efficient care to older Americans who entrust their health to Medicare. There are a number of options Congress could consider that would help move Medicare into coordinated care. Here are a few:

- Fix the current methodology used to pay Medicare risk contractors—There is general agreement that the current payment system is flawed, and Congress has directed the Health Care Financing Administration (HCFA) to propose revisions by October. Current payment is based on the Adjusted Average Per Capita Cost (AAPCC) of care in a county. Medicare should eliminate geographic inequities in payment across counties, inequities due to variable health status of local populations, and inequities due to differential utilization of services in local area, which affects costs and the calculation of the AAPCC.
- Model the Medicare program after the Federal Employees Health Benefit Program—For federal employees, the government makes a fixed contribution and the employee chooses from a wide variety of plans. Medicare could do the same on behalf of its beneficiaries if they choose to enroll in a coordinated care plan in the private sector.
- Provide financial incentives for Medicare beneficiaries who choose coordinated care options that are available in their area. These plans, offering comprehensive services at lower than current fee-for-service prices, give seniors better value for their Medicare dollars.
- Explore new ways of paying coordinated care organizations that contract with Medicare—a new approach would allow plans in the same market area to bid competitively for Medicare contracts, for example. Bidding would have the effect of setting different market prices in local areas for Medicare coordinated care enrollees in a way that takes into account local costs and health care needs.
- Expand the types of plans that Medicare beneficiaries can choose—Currently, beneficiaries can choose care through some health maintenance organizations (HMO) or traditional fee-for-service providers. Medicare should also contract with the growing number of non-HMO networks of care that meet high standards for quality and public accountability, and offer a full continuum of services for a fixed premium. New types of contracts could be negotiated with these non-HMO networks in which the networks and the Medicare program would share risk.
- Provide seniors with more information on coordinated care plans—send a list of local coordinated care plans directly to beneficiaries and give them an annual report that compares coordinated care and fee-for-service plans on the basis of premiums, supplemental benefits, cost sharing, and quality ratings. This will make seniors more knowledgeable consumers and will highlight the benefits of coordinated care.
- Allow for an open enrollment period each year, during which Medicare beneficiaries can elect to receive services from a coordinated care plan—and make their choice of a managed care plan valid for one year instead of the current 30-day period, to enable the plan to better manage beneficiary needs and practice preventive care.

We are already seeing the beginnings of a transition to coordinated care for many seniors. In the longer-term, this can bring lower costs and more efficient health care to seniors, and ultimately restructure the Medicare program itself. But, what about the process under which Medicare budget decisions are made? That process has to change as well.

True restructuring of the program can only come by removing its funding process from the stifling politics of "business-as-usual." The American people have a right to know that what their nation spends on Medicare is buying the best benefits and the most efficient care. They should rest assured that federal budget pressures won't get in the way of providing good health services for older Americans. AHA urges Congress to create an independent citizens' commission to do this job—and put the "trust" back in the trust fund.

Senators Domenici and Dole, and Speaker Gingrich, have talked about a commission. But their idea is to have a commission on a short-term basis to address short-term budget questions. We believe a bipartisan, citizens' commission on Medicare should be permanent, with a life expectancy beyond the current crisis.

Unless an independent, national citizens' commission is formed to make the tough calls on Medicare, older Americans will continue to be caught in the political crossfire obscuring the real issue: how to provide quality, cost effective health care to a growing number of beneficiaries.

Those political pressures have led to congressional, back-room, middle-of-the-night Medicare cuts of $100 billion under the past two budget bills. And they could lead to cuts of nearly three times that amount if the current proposal is adopted.

An independent commission would get the process out of the political back rooms and into the sunshine. The commission would do an independent study on the spending needed to maintain current commitments. Then, Congress can set a target for how much it wants to spend on Medicare. The commission would hold public hearings, translate the congressional target into recommendations for a benefit package and provider payment rates, and present Congress with its recommendations—which would then be voted up or down as a package.

With an independent commission, we can have an open and honest discussion about how much we want to spend—and what we can buy for that money. The commission would also provide an annual report to Congress on the quality of care and access to care under the Medicare program.

Creating an independent commission to make recommendations on Medicare spending and benefits doesn't mean that we won't constrain growth. It does mean that we'll do it rationally, in the full light of day.

CONCLUSION

There is a responsible way and an irresponsible way to achieve reasonable reductions in Medicare and to shore up the Hospital Insurance Trust Fund. The irresponsible way is to do business as usual, letting short-sighted political pressures squeeze Medicare spending and weaken a program that needs to remain strong for our nation's seniors. The responsible way is to restructure the program by providing seniors more *choice* and encouragement to participate in a broader range of coordinated health plans.

And the responsible way is to establish an independent national commission to make the tough choices that will be needed to keep services and benefits in line with available money—and to keep Medicare from being a "cash cow" that continually finances other policy initiatives and legislative agendas.

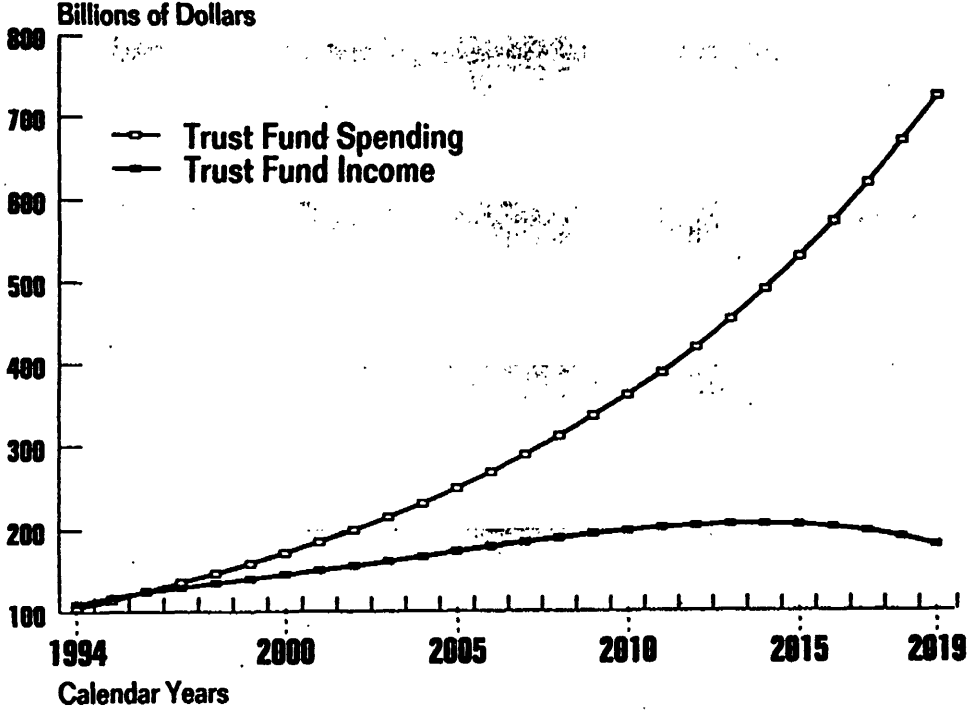
Mr. Chairman, America's hospitals and health systems understand the need to lower the federal deficit. We understand that to accomplish this monumental task, all federal programs will have to contribute their fair share. That's why we were willing to discuss a responsible alternative offered by Senator Judd Gregg (R-NH) that would have saved billions and reduced the rate of growth. Unfortunately, the budget committees have chosen a more extreme approach. It is an approach that hospitals simply cannot support if we are to keep our promise to the millions of Americans who rely on Medicare funding for their health care

We look forward to working with this panel to create constructive change in the Medicare program—and to protect a program that in some way touches almost every American life.

AHA

Spending Cuts Alone Won't Make Hospital Insurance Trust Fund Solvent

Hospital Insurance Trust Fund Income and Spending 1994-2019



SOURCE: 1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund

SEN. PACKWOOD

IMPACT OF MEDICARE AND MEDICAID SPENDING REDUCTIONS ON HOSPITALS

MEDICARE SPENDING

Oregon 61 Hospitals	**Baseline** **1993**	**Baseline** **2000**	**Illustrative Scenario ($150 B) Over 5 Years 2000**	**Illustrative Scenario ($250 B) Over 7 Years 2002**
Medicare PPS Operating Margins	10.5%	11.2%	-10.0%	-2.4%
Payments as a Percentage of Costs	111.7%	112.6%	90.9%	97.7%
Medicare Dollars per case Gain\(Loss)	$614	$852	($615)	($171)

MEDICAID FEDERAL SPENDING*

Oregon	**Current Projected Spending**	**Proposed Spending**	**Reduction**	**% Change**
1996-2002	8,927	7,423	(1,503)	-16.8%

* WITH 8, 7, 6, 5, 4 % CAP ON TOTAL EXPENDITURES IN MILLIONS

PREPARED STATEMENT OF NANCY W. DICKEY, MD

Mr. Chairman, on behalf of the 300,000 physician and medical student members of the American Medical Association (AMA), I thank you for the opportunity to present testimony to the Committee today. My name is Nancy W. Dickey, MD. I am a practicing family physician in Richmond, Texas, and Vice-Chair of the AMA Board of Trustees.

Thirty years ago, the Congress enacted a pledge for America's future: the Social Security Amendments of 1965 creating the Medicare program. Over time, the original underlying principles of Medicare—autonomy, choice and individual responsibility—have been eroded by inattention and miscalculation, exacerbated by repeated short-sighted efforts to prop up a fundamentally flawed financing system. The program began as an open-ended promise, not limited in financial amount or conditioned on financial need. Make no mistake, the program has achieved great success in meeting its objective of providing universal access to high quality medical care for elderly Americans. Today's Medicare patient is generally healthier, lives far longer and is more productive than his or her counterpart of thirty years ago. Physicians are proud of our key role in this record of success, and our goal is to build on these achievements.

Yet as all who study the program now know, Medicare spending has grown much more rapidly than initially projected, as services and populations have been added with an increased demand for the advances of modern health care technology. The growing financial burden of the program has led to increased taxes on working Americans and payment reductions imposed on physicians and other providers that threaten the access to health care of the very citizens the program is designed to benefit. Clearly, basic reform of Medicare is urgently needed. The time to renew the original vows of the Medicare program has arrived in any legislation you craft in Congress this year.

BUDGET-BASED PROGRAM REDUCTIONS WILL NOT WORK

A transformation of Medicare is required if we are to keep our pledge to Americans. The answer is not simply to throw more money at Medicare. Nor is the answer to continue slashing reimbursement levels. A balanced budget cannot be "balanced" on the back of one program and those who provide that program's services. Serious, and perhaps irreversible, consequences to patient care could flow from yet another series of ill-considered cuts.

Last summer, John Eisenberg, MD, outgoing Chairman of the Physician Payment Review Commission (PPRC) established by Congress, was quoted in the New York Times as saying:

> "The problems in access to physician services for Medicare beneficiaries are just below the surface. People in areas underserved by doctors, members of minority groups and poor people already have the beginning of a problem. This should be a red flag."

To put it simply, greater cuts could seriously harm Medicare patients. And the answer is not another round of huge Part B Medicare cuts; physicians have contributed their fair share to recent deficit reduction efforts. Physicians, who account for 23% of Medicare outlays, have absorbed 32% of Medicare provider cuts over the last decade. Between 1981 and 1993, budget reconciliation has been the vehicle for reducing Medicare baseline expenditures by some $98 billion. In this process, Medicare projected physician payments have been cut by $39 billion. Enactment of OBRA 93 alone imposed an additional $47.4 billion in provider cuts over five years for Medicare, including conversion factor cuts for 1994 and 1995. Even with these levels of cuts, physicians have succeeded in actually holding down the volume increases below that predicted for 1991, 1992 and 1993, thus saving the program billions in projected dollars.

We believe that Congress and the Administration should recognize physicians' recent success in moderating growth in Medicare expenditures for physician services. HCFA data indicates that Medicare expenditures for physician services increased by only 3% during FY93. In the two years preceding that, the average annual rates on Medicare physician spending was only 5.8%. Lower rates of growth in physician spending between 1989 and 1993 have reduced the Medicare baseline by $50 billion, nearly as much as the total 1992 outlays for physician spending. Physicians should be recognized for these savings and not be forced to shoulder inequitable burdens in another round of budget cuts.

Recent evidence from the PPRC and AMA's Center for Health Policy Research suggests that reimbursement rules set in place by OBRA 93 will cause a nosedive in physician payments later in this decade unless they are remedied now. While the trendline has increased during the first two years since enactment, by the end of

the century physicians will be paid less than they are today for treating Medicare patients. This downward slope is from figures calculated without any adjustment for inflation; measured in real dollars, the decline would be even steeper. Thus, even without further legislative modifications to Medicare, actual payment amounts for physician services will be further reduced below their already inadequate level of 64 percent of private payers' rates.

FACTORS DRIVING MEDICARE GROWTH

We can probably agree on the major factors that have brought us to this perilous point: demographics, new technology, and an increased demand for a wide range of health care services. Exacerbating the problems of unchecked growth is a fundamentally flawed financing system that has gone largely unrecognized until the last decade.

- From 1967 (the initial complete year of program operation) to 1992, the number of enrollees served by the program increased from 19.5 million to 35.2 million.
- From 1967 to 1992, program expenses grew from $4.7 billion to $135.8 billion.
- From 1967 to 1992, the number of claims paid grew from 31.5 million to 496.5 million.

Demographic change has contributed significantly to Medicare's growth. The U.S. population has grown 31 percent since the inception of the program, while the percent of the population aged 65 and older grew by more than 50 percent. Life expectancy of the Medicare population has also increased by more than 14 percent for both males and females. Finally, the age distribution of the elderly has shifted toward an older average age, with the group aged 85 and older growing by 68 percent.

Technological progress in medical care is generally acknowledged as having been a significant factor behind Medicare expenditure growth. Technological advances since 1966, when Medicare was first implemented, have expanded the scope of diseases and conditions that are treatable, increased the treatments available and improved their efficacy and safety, made the treatments less painful and unpleasant, and have often decreased the recovery time necessary for a patient to be able to return to productivity. In recent years, estimates for the impact of new technology on expenditure growth are generally in the 15-17% range (PPRC 1993 estimate; AMA's Center for Health Policy Research 1992 estimate).

Significant growth also has occurred in the rate of use of services, in that the number of enrollees who use more services paid for by the program has increased markedly. The number of persons actually receiving services increased 118 percent between 1966 and 1993. At the same time, the average amount of services consumed by each enrollee receiving services increased 6.5 times. This increased rate of use and more expensive consumption served to increase the amount paid per enrollee by 1340 percent.

Other beneficiary demand factors have been suggested as driving a portion of Medicare's growth. These include growth in beneficiary income and reductions in out-of-pocket liability by way of: (1) increased Medigap coverage; (2) increased assignment of claims, combined with limits on balance billing; and (3) real rate reductions in the deductible. It is well known that patient utilization of services is directly related to the degree of cost sharing for those services. CBO research estimates that beneficiaries with Medigap coverage consume 24% more physician and hospital services than those without such supplementary coverage. Since more than 70% of beneficiaries own such policies (which essentially convert Medicare into first-dollar coverage), program expenditures are significantly increased by defeating the cost-sharing requirements of Medicare.

Finally, health provider fraud and abuse is responsible for some portion of Medicare's growth. Allegations of "upcoding" by physicians, and charges that physicians inflate the number of necessary visits by a Medicare patient are undoubtedly true among a very small percentage of "outliers." Researchers disagree about the effect of these few practitioners; while some have discovered some evidence of upcoding, for instance, others have produced studies repudiating any significant effect from such fringe practices. For example, PPRC's initial investigation of physician coding for evaluation and management services between 1991 and 1992 suggested that no upcoding had occurred (PPRC 1994). A summary of relevant literature prepared by the PPRC suggests a wide variation in estimates of the rate of inappropriate care, with most falling in the 5-20% range. (PPRC 1993). Despite the relatively small number of aberrant or "outlier" practitioners, the damage they do is enormous; the AMA has a zero-tolerance policy in dealing with these physicians. For its part in the battle against inappropriate physician activity and fraud, the AMA is currently working in conjunction with both the Department of Justice and the FBI in stepping up its assault on fraud and abuse within Medicare.

While the Part B Trust Fund is technically considered "actuarially sound," this determination is based on the fact that the Part B side of this entitlement program is financed largely from general revenues. When Medicare was enacted in 1965, general revenues were to have covered 50% of Part B expenses; yet, in 1993, general revenue contributions to the Part B trust fund amounted to about $41.6 billion, accounting for 71.9% of total Part B program expenses ($57.8 billion in 1993). Premium payments accounted for approximately $14.2 billion, or about 24.6% of program revenue. Interest payments accounted for the remaining 3.5% of fund revenue.

In the twenty-five year period between 1967 and 1992, the program has increased in population by 80.3% (2.4% annual growth), program expenditures have increased by 2,767.7% (14.4% annual growth), and claims paid volume have increased by 1,477.7% (11.7% annual growth). This growth trend is certain to continue well into the future absent determined intervention. Last September, the Congressional Budget Office released figures projecting that Medicare spending will increase from $195 billion in 1994 to $434 billion by 2004.

PENDING BUDGET ACTION

The AMA supports the idea of a competitive market-driven system as the best option for the future of the Medicare program because it offers more choice to senior citizens.

Those who would reduce Medicare outlays to shore up the program must consider the consequences to professional autonomy, patient choice and individual responsibility—the three promises of Medicare when it was originally enacted—those same three promises that need so desperately to be reaffirmed today. This simplistic budget-cutting approach has not resulted in cost-control over recent years, and now severely threatens the promised access of beneficiaries to medical care. The truth is that the Congress could come back every term and, facing intense political pressure, cut and cut payments for physician provided health care under Medicare, and we would still not have resolved the underlying financing dysfunction of the program as whole.

THE LONG TERM: MEDICARE TRANSFORMATION

With the potential for patient harm implicit in yet another round of budget cuts and micromanagement in Medicare, the AMA believes that a far different course of action is needed. Budget-based actions simply do not address the fact that the Medicare program is at a crossroads and headed toward a destructive financial crisis early in the next decade. There simply will not be enough money in the Medicare fund to meet the health care needs of an aging population that is growing larger and larger and living longer and longer without fundamental reform.

In short, a major transformation of the Medicare program is required. This transformation cannot wait. Congress and the Administration should not settle for further short-term cuts at the margins or place an artificial cap on Medicare expenditures in the name of political expediency. The Medicare program urgently requires serious, lasting change if its promise is to be preserved for current and future generations of Americans.

The AMA is prepared to enter into a new partnership in which all parties—patients, physicians, business, and the government—work together to develop rational and effective long-term solutions to Medicare's financing problems. We support actions to reduce the expected growth of the program over time. In light of what is known about the program's structural flaws and its dismal prospects if basic reforms are not made, the AMA believes that efforts to formulate long-term reform must adhere to five basic principles:

Beneficiary cost-consciousness must be encouraged. Medicare has deductibles and co-insurance provisions to encourage cost-consciousness. However, 70% of beneficiaries insulate themselves from these provisions by purchasing private supplementary coverage ("Medigap") policies which transform Medicare into first dollar coverage. As a result, some beneficiaries consume more medical services than they otherwise would, costing the program substantially. The adverse impact of Medigap policies must be critically evaluated as they affect the long-term stability of the program. At the same time, we must be cautious about the burdens on the elderly.

Price competition among providers must be facilitated to increase economic efficiency. Medicare payments to physicians and providers are determined in a way that provides little incentive for price competition. Without price competition, beneficiaries have no incentive to be price-conscious in choosing among providers. As patient choice is a bedrock of AMA policy and part of the original Medicare promise, options for selecting coverage and the providers to deliver services

must be encouraged. Mechanisms that allow beneficiaries to participate knowledgeably in their own health decisions on the basis of service, quality and price should be used in the program.

Intergenerational inequity in financing must be reduced. Medicare is funded by pay-as-you-go financing: current workers support the medical expenses of current beneficiaries. Not only are the elderly better off financially as a group than the working population, but the number of workers supporting each beneficiary will begin falling rapidly from four at the present time to two in the middle of the next century. The working population cannot be expected to willingly pay higher and higher taxes over this period—especially if the long-term future of Medicare is in serious doubt.

Test ways of reducing dependency of future generations on Medicare. To reduce the burden of the program on future working generations and the federal Treasury, the number of beneficiaries should be minimized. Income-relating of the benefit subsidy has been suggested as one approach that is supported by the AMA; however, additional approaches also merit consideration. Incentives should be created for more people to work towards becoming financially independent of Medicare during retirement. Tax incentives to build Medical Savings Accounts (MSAs), tax-free accounts dedicated to medical expenses, including nursing home and long term care expenses, should be enacted. The availability of Medical Savings Accounts (MSAs) to be used for this first dollar coverage, in tandem with "catastrophic" coverage, would enhance patient choice and encourage individual responsibility, promoting two of the three foundations on which Medicare was originally established. Another idea is that of offering vouchers to beneficiaries to supplement their purchase of private insurance, which may be more desirable to some individuals than Medicare coverage.

Reduce regulatory and administrative complexity. It has been estimated that physicians now spend over 25 percent of their time processing paperwork and complying with the technical requirements of an unending blizzard of Medicare regulations. This is time that could be used more productively treating patients. Furthermore, it is one of several factors (including low rates of payment) that discourages physicians from seeing Medicare patients.

These five basic principles should guide the design of any approach to reforming Medicare to correct current structural problems and to reduce the dependency of future generations on subsidized government medical care.

OPTIONS FOR MEDICARE REFORM

A few broad categories of reform have been advocated by an array of interests, both public and private, participating in the public dialogue on Medicare. The first category of reform, reduced coverage and benefits, takes a short-term view. Two others, structural reforms to contain costs and privatization, take the long-term view of transforming the system.

Short-term Options Which Affect Benefits and Coverage

The Bipartisan Commission on Entitlement and Tax Reform staff report presented a short-term approach to reducing Medicare spending which would restructure benefits and/or coverage. The Commission staff did not consider implementing cost containment initiatives in their report, an approach suggested by others for many years. Another set of options aim to privatize the system over various lengths of time. These are discussed in more detail below.

Numerous suggestions for restructuring eligibility and benefits were contained in the Bipartisan Commission staff report and have also been suggested by the Congressional Budget Office (CBO) in past reports to Congress. Such approaches, if applied alone, will not solve the structural problems which must be addressed if program costs are to be contained. Moreover, any approach along these lines should be careful to differentiate between the elderly who have adequate resources and those who do not. For those whose resources are inadequate, such changes should be structured to assure that their needs are met.

Enhancing Intergenerational Equity in Financing

As indicated earlier in this testimony, the taxing of younger workers with modest incomes derived from employment to pay for the routine medical expenses of elderly beneficiaries with substantial assets is unfair as well as irrational. The working population, which is growing smaller in relation to the burgeoning "65 and older" group, cannot be expected to pay increasingly higher taxes when the long-term security of the Medicare program is in such jeopardy. A number of proposals to address this growing problem of intergenerational inequity have been advocated, including:

- income-relating of Part B premiums. The CBO has made a number of suggestions, such as to increase the Part B premium for individuals with an annual income greater than $100,000 and for couples with combined annual incomes greater than $125,000;
- revision of the eligibility age of 65. The arbitrary decision to select 65 as the age of eligibility when Medicare was created has even less justification today: it is a medical fact that the health status of the average 65 year old individual today is not comparable to that of a 65 year old in 1965; and
- reducing the dependency of future generations on Medicare and increase personal responsibility by encouraging the working population to accumulate savings in Medical Savings Accounts for medical care needs in retirement.

Long-term Structural Repairs Are Needed to Increase Efficiency

It is widely recognized that private Medigap insurance places a large financial burden on Medicare when beneficiaries with such coverage demand additional services because of reduced cost-sharing. The program should add insurance options for beneficiaries which ameliorate the effect of Medigap insurance on the Medicare program. Under this proposal, Medicare would combine the current Parts A and B by:

- offering two Federal insurance options to beneficiaries. Medicare Plan I would provide all current benefits without cost-sharing. Medicare Plan II would provide the same benefits, but would include reasonable deductible and coinsurance levels plus reasonable out-of-pocket annual caps on these amounts;
- setting the Plan I premium to be competitive with the current Medicare Part B premium plus the premium for a comparable Medicare supplemental insurance policy. The Plan II premium should be lower than the current Part B premium but the deductible should be higher by a compensating amount; and
- discouraging purchase of supplementary insurance covering Plan II services by requiring Medicare to be the secondary payor if a third party covers the Plan II cost-sharing provisions.

Another commonly proposed approach to dealing with the Medigap problem is to tax Medigap enough to recover the additional cost imposed on Medicare. One should note, though, that the CBO has estimated that a 100% or greater tax on Medigap premiums would have to be imposed to compensate the program for the additional cost, with the probable outcome of greatly increased medigap premium prices.

Privatization of Medicare

Many, including the AMA, have proposed privatization approaches to the Medicare problem. Such a proposal would provide vouchers for beneficiaries to purchase private health insurance and encourage individual savings for retirement medical care needs which would reduce dependency on Medicare over the long-term. Features include:

- giving Medicare beneficiaries vouchers to purchase either existing Medicare coverage or health insurance with some other minimum prescribed benefits (beneficiaries must have the option to purchase additional coverage using their own funds); and
- expanding IRAs to provide supplemental funds for health care expenses on retirement (as provided in "The Senior Citizens' Equity Act" of the Contract With America) and creating tax incentives for establishing tax-free Medical Savings Accounts (MSAs).

Others have suggested that Medicare immediately provide vouchers to beneficiaries to purchase private health insurance, which would result in immediate privatization of the system. These proposals would clearly necessitate some reforms of the private insurance system to assure that coverage is available to all beneficiaries.

CONCLUSION

In the process of advancing these systemic reforms, the AMA understands the demand to address the pressing needs of today. This is why we are undertaking two commitments to help reduce unnecessary spending in the Medicare program. We are stepping up efforts to reduce fraud and abuse and are working with the Department of Justice and the FBI. In addition, we recognize that physicians must take the lead in addressing "care at the margins" and "futile care" as death approaches; some of this care is wasteful and even unwanted. Physicians have an obligation to confront these unnecessary uses of Medicare resources. Part of the problem is educational, as patients, doctors, and health care institutions need to better understand the legal and ethical issues involved. The AMA is committed to clarifying these issues for physicians and patients.

Americans can no longer postpone tackling fundamental reform of the Medicare program. Failure to do so is certain to prove even more costly for the millions of

Americans who expect to be able to rely on this program in the future. Continuation of past stop-gap measures, such as chopping away at rates paid to providers in hopes of getting more services for less money, will ultimately divorce the Medicare system and its beneficiaries from the mainstream of American medical care. Americans who depend on the Medicare program for their health care, as well as those who will rely on it in the future, should not have to worry about whether benefits promised them will be forthcoming. In the weeks and months ahead, the AMA pledges to work with the Congress to convince the American people that long-term reform is necessary and in the nation's best interest in order to keep the Medicare promise.

Daniel Patrick Moynihan
New York

United States Senate
Washington, D. C.

July 13, 1995

Dear Dr. Dickey:

In the course of your testimony before the Senate Committee on Finance you were asked to provide data substantiating your claim that "physicians now spend over 25 percent of their time processing paperwork and complying with the technical requirements of an unending blizzard of Medicare regulations." Your response was that although you did not have the information with you, it did exist and you would be more than willing to provide it.

What was received constituted a collection of irrelevant anecdotes accompanied by data which not only failed to substantiated your testimony, but was in fact wholly contradictory.

Beyond the irrelevant, your letter attempted to restate the question. And while the assertion that: "**It is no exaggeration to say that a quarter of the time I spend serving Medicare patients is consumed by personal administrative responsibilities,**" (your emphasis) may be true, it was made abundantly clear that your testimony and the data requested was to the experience of all physicians.

Testimony before the Senate Committee on Finance is carefully considered with particular attention to research and data. Mistakes are acceptable, efforts to mislead are not. Members of this Committee rely on such testimony in the formulation of public policy; this cannot not be based on the experience of one doctor when there are more than half a million nationwide. You were asked for data, you responded with anecdotes.

Even the anecdotes themselves are highly suspect. No distinction is made between unnecessary Medicare administrative costs and administrative costs associated with quality patient care. For example, you state that you spend "five

minutes of 'chart time' for every 15-20 minutes spent with a Medicare patient." A complete patient chart, however, is an integral part of quality patient care. Do you regard recording a patient's temperature as a needless demand of the Medicare bureaucracy?

In addition, the only data you did provide, generated from the 1993 AMA survey of physicians, demonstrates that only 5% of the time spent by those physicians surveyed was consumed with utilization review, claims, and billing. The Senate Finance Committee is debating the future of Medicare; different parties may disagree on the most appropriate actions, but we must come to some agreement on the facts of the current situation. For this rigorous research is demanded. Your testimony did not meet this standard.

Failure to submit data supporting your claim, leads to the conclusion, with some reluctance, that the Committee was misled. If any data corroborating your testimony does exist, please send it immediately.

Sincerely,

PREPARED STATEMENT OF ARTHUR S. FLEMMING

I appreciate very much the opportunity of appearing before this committee on an issue that is very important to the older persons and disabled people of this country. I do feel that, as we consider these various issues, we should keep them in mind.

In February 1963, President Kennedy included in a special message on aging to the Congress a plea for the enactment of Medicare legislation. In doing so he said, "They, older persons, have to either ask their children or grandchildren to undergo financial hardship or accept poverty or charity themselves, or suffer their illness in silence. I think this Nation can do better than that. Social security has shown, for 28 years, that is a logical first-line of defense in this field."

I was thrilled when I became aware of that message to the Congress of the United States. I had responsibilities as Secretary of Health, Education and Welfare for the first White House Conference on Aging in January 1961. The delegates to that conference had supported enthusiastically the concept of Medicare.

They believed that this was a logical addition to the great concept that Franklin Roosevelt had provided us—a national community where both the private and public sectors recognize a responsibility, along with state and local communities, for programs that would make it possible for Americans to help one another deal with the hazards and vicissitudes of life.

President Kennedy had some difficulty in persuading a majority of the United States Senate to agree with his vision. At the suggestion of Senators Javits, Anderson, and with President Kennedy's concurrence, a committee to review the situation was set up in the private sector. I was asked to Chair that committee.

We submitted a report to the President just one week before his assassination. He liked it. In conversation with him as I was leaving the Oval Office, he shared with me his feelings of frustration, not over having one of his plans blocked, but over the fact that older persons who face premature death and unnecessary suffering were being denied assistance. Soon after the President's assassination, the Congress quickly enacted his proposal into law.

Medicare has had a great history. It has helped millions of older persons. I was delighted when persons with disabilities were added under President Eisenhower. It has shown us what universal coverage can do for two major segments of our population. It is a prelude, in my judgment, to universal coverage for our entire population.

Personally, I believe this is no time for us to retreat. We must build on Medicare as it is and move forward. I am confident that the President of the United States, backed by a group of outstanding public servants who have had in-depth experience in this field, and the Congress, can work out a solution to the trust fund problem. Solutions to problems in the past have been worked out so that the system has never missed a month in the payment of benefits. This record can and will be maintained.

One of the reasons why we have to periodically confront this problem is the spiralling cost of health care. This will continue to confront us until we achieve the goal of universal coverage.

The delegates to the fourth White House Conference on Aging, of which I was one and which has just adjourned, expressed their overwhelming support for Medicare and Medicaid as programs that have developed a real place for themselves in the life of our national community and that should be strengthened, not weakened.

I feel I speak for many of them when I say that we are determined to do everything possible to hand this program down to our children and grandchildren. It is an essential part of the challenge that Franklin Roosevelt gave us 60 years ago.

I have had the privilege of working with Presidents since Franklin Roosevelt. I have worked with them and I have seen them embrace his concept and add to it. This is the first time in my life that I have seen a real threat to that challenge to the national community.

PREPARED STATEMENT OF HON. ORRIN G. HATCH

Thank you Mr. Chairman. I just want to make a few observations regarding today's hearing.

First, I want to welcome our distinguished witnesses and thank them for appearing today and providing us with their expertise on the solvency of the Medicare program.

At our hearing on Tuesday, Mr. Stanford Ross, one of the Public Trustees put it succinctly. He said that the financial solvency problem of the Medicare program is "as serious as anything in our government."

I could not agree with him more.

The numbers speak for themselves. They clearly illustrate a profoundly important situation which is in need of immediate corrective action.

It is my hope that we can work together in a nonpartisan fashion and take the necessary steps to insure the financial solvency of the Medicare program for generations to come.

I don't think this should be a game of "who blinks first."

We owe the American people more than that.

We have heard a lot of numbers. We have heard a lot of potential solutions. None are immediately appealing.

I don't know what the ultimate solution is. I don't think anyone does.

Obviously, what we do know is that we have to restrain the rate of growth in the program. We know that we have an increasingly complicated mix of services and an increasingly aging population.

At the same time, I also know what my constituents in Utah are saying. They, and particularly the elderly, are understandably concerned.

There is no question, however, we will be faced with making some difficult and, I expect, some unpopular decisions. But, these tough decisions are necessary. We just can't pretend everything is hunky-dory anymore.

Accordingly, I welcome the Chairman's hearings on Medicare reform so that we can gain a better understanding of the problems and potential solutions.

The time for making those decisions is now. We can no longer afford to perpetuate a problem that is only getting worse.

I encourage the American people to listen and to learn as well. Their understanding of the complexity of these issues will help facilitate the development of meaningful reform. Thank you.

PREPARED STATEMENT OF GUY KING

Mr. Chairman, my name is Guy King. I am a Consulting Actuary with the firm of Ernst & Young. I was the Chief Actuary for the Health Care Financing Administration from 1978 to 1994. During my time as Chief Actuary, the expenditures for both the HI and SMI programs grew at rates that are unsustainable in the long run, and they continue to grow at those unsustainable rates today and into the foreseeable future.

HOSPITAL INSURANCE (HI) TRUST FUND

The expenditures of the Hospital Insurance Trust Fund (Part A of Medicare) increased from $17.7 billion in 1978 to $107.2 billion in 1994. This is an average rate of increase of about 12 percent per year. In 1978, the Annual Report of the Board of Trustees projected that the HI trust fund would be bankrupt by 1990. Because of some minor price reductions and tax increases which have been legislated over the years, the date of bankruptcy has been pushed back by a few years, so that the 1995 Trustees Report projects that the HI fund will be bankrupt by 2002. Thus, during my 15 years as Chief Actuary, virtually nothing was done as the problem grew and the HI program moved closer to the bankruptcy. The impending bankruptcy of the fund is just the tip of the iceberg, though. The hole is just going to continue to continue to get deeper for many years, and the pace of decline is going to accelerate. The tax rate necessary to support the current program will have tripled by the year 2065. Even by the year 2025 the tax rate necessary to support the cost of the program will have more than doubled.

I know that some people view these projections as a red herring. I have often heard it suggested that we should just wait awhile to see if these problems really begin to materialize. That is apparently what lawmakers were thinking when they heard the same projections back in the mid-1970's. The financial problems of the HI program aren't just the result of some extremely pessimistic assumptions about the growth of health care costs. The assumptions regarding the rate of growth in health care costs and the growth in income to support the program are really very optimistic. These projections are being driven now by the coming demographic shift. The Baby Boomers who will retire and begin drawing benefits starting in 2010 are all alive today. As the Post World War II Baby Boom begins to reach age 65, the growth in the number of workers paying taxes is going to decline, and at the same time the growth in the number of people eligible for Medicare benefits is going to increase. Currently, about four taxpayers support each HI beneficiary. By the middle of the next century, when all of the baby boom will have retired, there will only be two covered workers supporting each HI beneficiary, so this problem is very real and very predictable.

The problem is so large that there isn't any painless way at this point to solve the problem. To place income and expenditures in balance even over the next 25 years, which is the easy part, is going to require either an immediate 30 percent reduction in expenditures or an immediate 44 percent increase in the HI tax rate, or some combination of both. And even then, the financial problems beyond 25 years would still remain unsolved.

Some have suggested that the apparent recent slowdown in the rate of growth in health care costs and the recent favorable experience in the Medicare program may be enough to save the government from having to make these decisions. That isn't going to happen. During my twenty years as a government actuary I observed that, when there was a threat of government action, health care costs always behaved very well. This occurred with the wage-price controls of the early 1970's, the threat of hospital cost containment legislation during the late 1970's, and during the discussions of health care reform in 1993 and 1994. Once the perceived threat is past, the rate of increase in expenditures once again accelerates.

In deciding how and when to take action to make the HI Program solvent, one of the difficult questions that needs to be addressed is the issue of generational equity. Generational equity can be measured by comparing each generations' contributions to the program with the benefits they receive from the program. We measured generational equity under four combinations of the following policy options: 1) act immediately or delay action and 2) increase taxes or reduce benefits. Our studies show that the solutions resulting in the greatest generational equity involve taking immediate action rather than delaying action and reducing the growth in benefits rather than increasing taxes. The table below shows the impact of various policy options on generational equity for persons retiring in 1994, 2014, and 2034.

Ratio of Benefits to Contributions

Proposed Change in Financing	Person Retiring in:		
	1994	2014	2034
1. Do nothing until trust fund depleted, then increase taxes	5.19	2.93	2.17
2. Do nothing until trust fund depleted, then reduce benefits	3.25	1.31	1.14
3. Reduce benefits immediately	2.10	1.36	1.54
4. Increase taxes immediately	5.19	2.20	1.68
5. Reduce benefits immediately, then index tax rates	2.10	1.61	1.94
6. No changes (hypothetical)	5.19	3.45	3.90

SUPPLEMENTARY MEDICAL INSURANCE (SMI) TRUST FUND

Because of the way it is financed, through a combination of premium payments by individuals and debt financing by the Federal Government, the SMI program is not in immediate danger of insolvency. However, the growth rate in the cost of the program is so rapid that it is not sustainable in the long run. During my time as Chief Actuary the outlays for the Supplementary Medical Insurance Trust Fund (Part B of Medicare) increase from $7.8 billion in 1978 to $61.8 billion in 1994. This is an average rate of increase of about 14 percent per year. During that same 16 year period, benefits paid by the SMI Trust Fund increased from .32 percent of the U.S. Gross Domestic Product (GDP) to .93 percent of GDP. This occurred despite the fact that some of the costs of the program (such as for most home health benefits) were shifted to the HI program. Even during the last five years, which have been relatively favorable, expenditures by the program have increased 53 percent in the aggregate and 40 percent per enrollee. According to the 1995 SMI Trustees report, SMI expenditures will be 3.18 percent of GDP by 2020 when the Post World War II Baby Boom has begun to reach age 65 and will be 3.97 percent of GDP by the middle of the next century when the Baby Boom will have been fully retired. As with the HI Program, these projections are being driven now by the coming demographic shift and the Baby Boom rather than pessimistic health care cost projections.

If some adjustments had been made to the SMI program years ago, this problem would never have developed to the size it is today. For example, if the SMI deductible had been indexed to increases in per capita program costs, and steps had been taken to ensure that Medicare supplemental plans did not neutralize the cost-saving features of the SMI deductible, then the outlays of the SMI program would be more than 25 percent lower than they are today. This would have allowed maintaining the SMI premium at $4.00 instead of the $46.10 it is today. At the same time, the government contribution to the program could have been nearly $5 billion less than it is today.

The outlays of the SMI program are excessive today due to two design features of the program which interact with each other to result in significant waste and abuse. These are the same two factors that are driving up health care costs for private sector health care plans.

The first factor is third party payment. When patients and providers are spending other peoples money, they don't concern themselves with either the price or the quantity of services provided. Today, even the very modest cost sharing provisions of the original SMI Program have been eroded because they were not indexed to keep up with costs and because health care is, in effect, free for the 80 percent of SMI enrollees who buy Medicare supplemental policies or are eligible for Medicaid. Research conducted by HCFA's Office of the Actuary on the Medicare Current Beneficiary Survey found that, even when controlled for self-reported health status, Medicare beneficiaries who did not have Medigap plans, and who thus were subjected just to the very modest cost sharing provisions which exist in the Medicare program today, have significantly lower overall health expenditures. The table below indicates the differences in health care spending for those Medicare beneficiaries without Medigap plans and those with employer-sponsored Medigap plans.

Medicare Spending per Person for Age 65 and Over

Health Status	Medicare only	Employer Medigap	Ratio
Excellent	$705	$1217	172.6%

Medicare Spending per Person for Age 65 and Over—Continued

Health Status	Medicare only	Employer Medigap	Ratio
Very Good	$905	$1490	164.6%
Good	$1713	$2347	137.0%
Fair	$2462	$3236	131.4%
Poor	$4684	$6477	138.3%

Research shows that not only are health care costs higher because of third party payments, but health care costs increase faster because of third party payments. An important research paper which will be published in *Health Affairs,* coauthored by Mark Freeland, Ph.D. and Al Pedon, Ph.D., shows that the acceleration in the rate of growth in health care expenditures in the United States has been highly correlated with the shift toward third party payments. Their research shows roughly that every ten percentage point shift from out-of-pocket payments to third party payments results in an increase in the rate of growth of health care costs of about two percent, and this accelerated rate of growth persists for about ten years. In my opinion, this is the most important research conducted yet on health care costs because it is the only research that explains the reason for the rapid growth in health care costs in the United States. Thus, it is the only research that provides the key to reducing the rapid growth in health care costs in the United States.

The second factor contributing to rapid growth in health care costs is fee-for-service medicine. This factor interacts with third party payments to allow for unlimited increases in the volume and intensity of services provided to patients, without regard for the efficacy or cost effectiveness of those services. During the entire history of the SMI Program, most of the increase in per-capita costs have arisen from increases in the volume and intensity of services rather than price increases. During the ten year period ending in 1992, over three fourths of the increases in payments to physicians arose from volume and intensity increases. The cost of health care can theoretically be controlled by removing either of the two offending factors—third party payments or fee-for-service medicine. Increasing coinsurance and deductibles is an example of dealing with the third party payment factor; introducing capitated services, as in the TEFRA Medicare Risk Program, is an example of dealing with the fee-for-service factor.

The problem that I have observed with the second approach is that the TEFRA risk sharing program is structured in such a way that, even if there were no risk segmentation, and with a 10 percent capitated penetration rate the most that could have been saved would have been 1/2 of one percent. However, because of risk segmentation, the TEFRA risk program has increased expenditures of the Medicare Program rather than reducing them.

If the costs of the Medicare Program were going to be controlled by using managed care, then the structure of the program would have to be changed so that savings accrue to Medicare. This would have to be done in a way that didn't discourage managed care plans from participation in the program. Because of the extreme difficulty of balancing these conflicting goals, managed care alone cannot be relied upon to control costs in the Medicare program.

Finally, I would suggest that whatever reforms are adopted to control the growth rates of the HI and SMI programs, a "fail-safe" mechanism should be adopted that prevents the program from growing more rapidly than the taxes which support the program. Changes in health care costs are extremely difficult estimate, and a "fail-safe" mechanism would be the ultimate protection of the program against excessive cost growth. One example would be a mechanism providing for increasing the HI deductible if the cost of the program were projected to exceed a threshold percent of taxable payroll. A similar fail-safe mechanism would increase the SMI deductible if the cost of the SMI program were projected to exceed a threshold percent of the Gross Domestic Product.

This concludes my formal remarks and I'll be pleased to answer any questions you may have.

PREPARED STATEMENT OF EUGENE LEHRMANN

Mr. Chairman and members of the Committee. I am Gene Lehrmann from Madison, Wisconsin. I am President of the American Association of Retired Persons (AARP). I appreciate the opportunity to appear before the Finance Committee today to discuss the future of the Medicare program. AARP and its members are strong

advocates of Medicare and we want to make sure that it remains a viable health insurance program for current and future generations.

To this end, the Association believes that ensuring the solvency of the Part A Trust Fund should be a priority. The solvency of the Hospital Insurance (HI) Trust Fund was, in fact, one of the important reasons behind AARP's support for health care reform that included system-wide cost containment. In the absence of system-wide reform, however, we must now address the twin challenges that confront the Medicare program: 1) assuring the solvency of the Trust Fund for the next decade; and 2) over the course of the next several years, making the policy adjustments in the program that will be necessary to address the demands of the "baby boom" generation. This will not be easy, but neither is it an insurmountable challenge. What is clear, however, is that the current budget proposals to reduce Medicare spending go far beyond what is necessary for short-term Trust Fund solvency. Moreover, significant reductions in Medicare for deficit reduction could jeopardize our ability to make the realignments in the program that will be necessary to keep it strong for the next generation.

Medicare has contributed significantly to deficit reduction since the early 1980's and AARP has supported almost all of these deficit reduction measures. We continue to believe that deficit reduction is important. Our members want to contribute to this goal if their contribution is fair, and they want a strong economy for their children and grandchildren. But to do this, we need to continue on a steady path of deficit reduction rather than let arbitrary deadlines and budget targets force hasty and ill-considered policy decisions. Unfortunately, the level of Medicare spending reductions included in the Senate Budget Committee proposal is too much and too fast.

The 36 million older and disabled Americans who rely on the Medicare program will find it hard to accept the inside the beltway semantics of "simply cutting the rate of growth in Medicare spending." The level of reductions being proposed translates into higher out-of-pocket costs, reduced access to providers, real coverage limitations and serious quality problems. To these individuals "it's my Medicare you're talking about."

That is why AARP believes that deficit reduction should be fair and balanced, equitably distributing the burden of spending reductions across all programs and populations. We also believe that there needs to be a clearer understanding of the important role Medicare continues to play in our health care system and a clearer recognition of how arbitrary cuts—without cost controls throughout the system—would affect beneficiaries, their families and the long-term stability of the program.

THE NEED FOR MEDICARE

In the early 1960's, before Medicare was enacted, only about half of older Americans had any health insurance, compared to 75 percent of those under 65. Employer-provided health insurance was the exception, not the rule, and most people lost this coverage when they retired. Older persons trying to purchase coverage privately were frequently denied coverage on the basis of age or pre-existing condition. Others found that private coverage was unaffordable. The implementation of Medicare in 1966 provided long-overdue protection to older Americans against high health care costs.

The current Medicare program covers a wide range of health services: hospital, physician services, outpatient care, skilled nursing facility care, home health, hospice, diagnostic tests and durable medical equipment. One of the program's greatest attributes is that it does not discriminate—no beneficiary is excluded from Medicare coverage because he or she has a pre-existing condition—a guarantee that does not generally exist in the private sector today.

Another important element of Medicare is the protection of beneficiary choice. Medicare beneficiaries can choose their physicians or certain non-physician practitioners, through a standard fee-for-service plan. In addition, beneficiaries may be able to choose a managed care alternative. There are no penalties that force beneficiaries to choose one delivery system over another.

Contrary to the general public's view of government programs, Medicare is one of the most efficient federal programs returning, in benefits, between 97 and 99 cents on the dollar. By contrast, the administrative costs of private health insurance range from 18 percent of benefit costs for group plans of 100 to 40 percent of benefit costs for individual private insurance. This is because private insurers must pay marketing expenses, agent commissions and other administrative costs that Medicare does not.

Most importantly, Medicare enjoys strong public support. Poll after poll indicates strong support for Medicare *across all age groups*. While they may be many years

away from eligibility, those under the age of 65 recognize that Medicare lessens the burden on families who would otherwise end up paying the medical bills—often enormous—of their parents and grandparents. An April, 1995 national poll conducted for the American Hospital Association found that 81 percent of older Americans surveyed gave Medicare a favorable rating. A 1994 Kaiser Family Foundation Survey found that older Americans value the sense of security Medicare provides and believe that it serves as a necessary and important safety net. And a 1994 ICR survey on Medicare found that opposition to cutting Medicare ranged from 86 to 94 percent across all age groups.

THE FEDERAL BUDGET DEFICIT

Congressional leaders have set an arbitrary deadline to achieve a balanced federal budget. That deadline—the year 2002—is now driving policy decisions that have implications far beyond the current budget cycle. We believe that before attempting to remedy this current fiscal situation by singling out the Medicare program, it is appropriate to first consider the causes of the federal budget deficit.

In 1981, the last time the deficit was below $100 billion, the Economic Recovery Tax Act (ERTA) was enacted, thereby reducing income taxes by nearly 25% on a phased-in basis. According to subsequent budgets issued by the Office of Management and Budget, these tax cuts reduced revenues by over $1.75 trillion between 1982-90. Even after taking into account several tax increases (the Tax Equity and Fiscal Responsibility Act, the Deficit Reduction Act, the Consolidated Budget Reconciliation Act of 1985, and the Omnibus Budget Reconciliation Act of 1987, among others) enacted between 1982 and 1988, net revenues (excluding Social Security) still declined by nearly $1.2 trillion.

At the same time ERTA took effect, there was a substantial defense build-up and defense outlays went from $158 billion to $300 billion between 1981-90. These factors combined to create a massive build-up of federal debt precisely at the time when Treasury bills and longer-term bonds were yielding double-digit rates of interest. The Treasury was forced to finance over $2.2 trillion in public debt in this high interest rate period, causing net debt service costs to increase by 167% in the 1980's.

MEDICARE PROGRAM SPENDING

Advocates of reducing Medicare spending point to the projected rate of growth in the program—CBO projects a 10.2 percent growth rate per year for FY1996-2002—as the reason why cuts are necessary. But what is often overlooked is the fact that the growth in Medicare spending is not simply a problem with the Medicare program. The problem is system-wide. National health spending will approach one-fifth of our economy by 2003. And, many of the same factors that drive overall health care spending—general inflation, health care inflation, utilization and technology changes—drive Medicare spending as well. Medicare's costs are also obviously affected by the poorer health status of an older and disabled population.

The fact that private sector health spending has declined somewhat does not negate the need for system-wide cost controls. Cutting Medicare spending will only be a short term fix. Singling out Medicare for spending reductions without implementing cost controls throughout the rest of the system is like putting a bucket under the hole in the ceiling each time it rains rather than repairing the roof.

MEDICARE SPENDING CONTROLS

Beginning in the early 1980's, to help bring spending under control, Medicare instituted new payment systems for hospitals and later, in 1989, for physicians. These reimbursement systems—which were deliberately phased-in over several years—slowed the growth in Medicare spending. According to the March, 1995 Prospective Payment Assessment Commission (ProPAC) report, "overall hospital spending experienced the third lowest real increase since the beginning of the Medicare program, decelerating from an annual growth rate of 5.2 percent in 1992 to 3.6 percent in 1993." AARP believes that the key to keeping these growth rates down is by controlling growth throughout the rest of the health care system as well.

Those areas in which Medicare growth is currently the highest—mainly skilled nursing facility (SNF) and home health care—are not subject to the Part A prospective payment system or the Part B fee schedule. As we stated in our testimony before the Ways and Means Health Subcommittee on February 6, AARP believes that it will be important to examine the reasons for growth in these areas before adopting specific cost containment strategies. Cost containment mechanisms should address the reasons for growth and should not simply shift additional costs onto beneficiaries.

Growth in these programs is due, in large part, to clarifications of coverage rules in home health and SNF benefits in the late 1980s that previously had been very ambiguous and/or overly restrictive. These ambiguities had caused artificial, as well as illegal, constraints on the availability of these services for beneficiaries. For home health in particular, growth rates from 1984 to 1988 were flat and, in some years, actually declined.

Beginning in 1989, court-ordered coverage changes and the issuance of new intermediary coverage rules increased the number of meritorious claims submitted for Medicare coverage. Other factors contributing to growth rates include the introduction of new technologies and increases in provider participation in the programs. It is also important to note that growth in these benefits correspond with a 12.5% decrease in Medicare hospital length-of-stay from 1989 to 1994. That is, more beneficiaries were discharged sooner leading to greater need for SNF and home health services.

Estimates from a number of sources indicate that the unusually high growth rates in Medicare home health since 1989 will not continue, and that drastic measures are not needed to slow future rates of growth. According to ProPAC, "between 1995 and 1999, home health expenditure growth is projected to level off at an average annual rate of 9.8% per year." HCFA's Office of the Actuary has projected that, after 2002, annual growth in Medicare home health expenditures will level off at approximately 6.7% and annual growth in the number of visits received by beneficiaries will level off at approximately 1.5%. By comparison, CBO has estimated that Medicare home health expenditure growth rates will decline to 8.4% by the year 2000. These projected growth rates would bring home health spending into line with that for total Medicare spending over the same period.

There is no clear or convincing evidence to support the assertion that the growth rates in these two benefits are the result of inappropriate utilization by beneficiaries. Additional research is currently underway to investigate possible billing abuses by providers, the alarming variations in utilization patterns across geographic regions, and growth in the demand for so-called "subacute" care. We urge this Committee not simply impose shortsighted budget cuts in these programs as a way of complying with arbitrary targets to pay for tax and deficit reductions. If there is abuse of these benefits, then we must address it—but we should act on the basis of a sound diagnosis rather than on mere guesswork.

MEDICARE'S ROLE IN DEFICIT REDUCTION

Medicare has played a responsible role in deficit reduction. Over the past 15 years, a number of large deficit reduction packages have been enacted, all of which included Medicare cuts and other changes affecting older Americans. Lack of system-wide cost containment, however, has meant that much of these reductions have simply been shifted onto beneficiaries, businesses and individuals as providers attempt to recoup their "losses" on Medicare by shifting costs to beneficiaries or charging private patients more.

Cost-shifting onto employers and individuals also exacerbates the deficit since employers deduct their employee health care costs and individuals (including Members of Congress) exclude the benefits from income. As employers' costs go up, the amount of the deduction increase, thereby reducing federal tax revenues. Moreover, as health costs continue to crowd out wages, employees' compensation is increasingly made up of nontaxable benefits instead of taxable wages. Federal revenue—both general and payroll tax revenue—again is reduced. In addition, cost-shifting leads to higher health care premiums for businesses and individuals which, in turn, cause them to reduce or drop their insurance coverage. This leads to greater reliance on public health programs and increases the level of uncompensated care, leading to more cost-shifting. In short, without system-wide cost containment we will never escape from the vicious cycle of cost-shifting to a higher deficit.

WHAT ADDITIONAL SPENDING REDUCTIONS MEAN TO MEDICARE BENEFICIARIES

Singling out Medicare for deficit reduction would have serious implications for older Americans because it would probably mean significantly higher out-of-pocket costs. On average, older persons will spend roughly $2,750 out-of-pocket for health care services (including physician, hospital, home health, prescription drugs and most premiums) in 1995. This does not include the enormous cost of nursing home care, which is nearly $40,000 a year. By the year 2002, out-of-pocket costs for older Americans under current law are projected to increase to nearly $4,500. Even without any changes in Medicare, older beneficiaries are already projected to spend more than $25,500 out-of-pocket for health care costs over the next seven years (1996-2002). [1]

As a percent of household income, older persons already pay almost three times as much out-of-pocket for their health care as the non-elderly (see Chart 1). Yet, the median household income of the elderly—$17,160 in 1992—is only half that of those under 65—$35,639 in 1992. Increases in out-of-pocket spending would mean that an even greater proportion of beneficiary income would be eroded (see Chart 2).

POTENTIAL IMPACT OF SENATE BUDGET COMMITTEE PROPOSAL ON MEDICARE BENEFICIARIES

The Senate Budget Committee has proposed unprecedented reductions in Medicare spending as part of its FY96 Budget Resolution—reducing Medicare spending by $256 billion over seven years.

AARP is very concerned that this level of cuts is unsustainable. Assuming that 50 percent of these reductions would come from beneficiaries, the Association estimates that the average Medicare beneficiary would pay over $3,200 more out-of-pocket over the next seven years. While we recognize that the Senate Budget Committee's resolution does not spell out any specific policy changes, we are particularly concerned about some of the proposals now under discussion that would simply shift these greater costs to beneficiaries without any controls over system-wide spending, including:

A HIGHER PART B PREMIUM

Currently, the Part B premium is intended to approximate 25 percent of Part B costs. In 1995, the premium is $46.10 per month, $553.20 annually. It is estimated to grow to $60.80 per month, $729.60 annually, by 2002. The premium is deducted from most beneficiaries' Social Security checks. The remaining 75 percent of Part B costs are paid from general revenues. When Medicare was enacted in 1965, the Part B premium was set at 50 percent of program costs. In 1973, in an effort to keep health care costs from consuming more and more of beneficiaries' income, Congress limited the percentage growth in the Part B premium to the annual increase in the Social Security COLA; the share of costs paid by premiums declined thereafter until it reached roughly 23 percent in 1982. Since 1982, Congress has set the Part B premium to equal or approximate 25 percent of program costs.

The Senate Budget Committee proposed reductions could mean a substantial increase in the Part B premium paid by Medicare beneficiaries, thereby shifting higher health care costs to Medicare beneficiaries. For example, under the Senate plan, a premium equaling 31.5% of Part B program costs—an option under discussion—would increase the premium to $106.00 by the year 2002. Under this option, over the next 7 years, most Medicare beneficiaries would pay an estimated additional $2,042 under the Senate proposal for the Part B premium alone.

A NEW 20% HOME HEALTH COINSURANCE

For a beneficiary to qualify for Medicare home health coverage, a physician must certify that the care is medically necessary and that the client is homebound and in need of only intermittent or part-time skilled care (skilled nursing or therapy). In 1996, about 3.8 million Medicare beneficiaries will use home health benefits. Approximately two-thirds of Medicare home health users are women; almost two-thirds are over age 75. Under current law, there is no coinsurance for persons who use Medicare home health services. This is intended to encourage the use of more effective, less costly non-institutional services.

A new 20% coinsurance would require the average home health user to pay an additional $900 in 1996 and almost $1,200 out-of-pocket in 2002. The very frail individuals who need and use home health care the most, over 700,000 Medicare beneficiaries in 2002, would pay an annual coinsurance of over $3,800 in that year.

Almost 80% of all Medicare home health users have annual incomes of less than $15,000 in 1992. Approximately 24% have incomes between 100% and 150% of the federal poverty line (almost one million beneficiaries in 2002)—too high to qualify for current low-income protection under the Qualified Medicare Beneficiary (QMB) program, and too low to be able to afford a Medigap policy to cover these new out-of-pocket costs. As a result, many would lose access to these necessary services.

Since physicians are responsible for determining eligibility for Medicare home health coverage, a new beneficiary coinsurance is not an effective method for controlling potential inappropriate utilization.

Moreover, the 20% coinsurance proposal is "penny wise and pound foolish" because many beneficiaries who could not afford the coinsurance and, as a result, failed to receive needed services would be forced into nursing homes or hospitals. Those who could afford the new coinsurance would also spend down to Medicaid eli-

gibility levels more quickly. As a result, states and the federal government could end up having to spend more than they would without the new coinsurance.

AN INCREASE IN THE PART B DEDUCTIBLE—INDEXED TO PART B PROGRAM COSTS

Each year, all Part B enrollees pay the first $100 in approved charges for Part B services. This annual Part B deductible is not indexed. Of the 31 million aged Part B enrollees in 1993, approximately 78 percent met the Part B deductible.

One proposal under discussion would double the Part B deductible from $100 to $200. This would present a significant barrier to access for lower income beneficiaries. Moreover, indexing the deductible would increase out-of-pocket costs for the average Medicare beneficiary for each succeeding year. Even those beneficiaries with Medigap plans covering the Part B deductible would not be immune to the increased out-of-pocket costs since Medigap premiums would likely increase as well.

A NEW 20% COINSURANCE FOR SKILLED NURSING FACILITY (SNF) CARE

Under current law, beneficiaries are eligible to receive up to 100 days of Medicare-covered skilled nursing facility (SNF) services following at least three consecutive days in a hospital. Beneficiaries must need medically necessary skilled services to receive coverage. No coinsurance is imposed for the first 20 days of covered care. For days 21-100, beneficiaries must pay $89.50 per day (one-eighth of the Part A Hospital deductible). On average, Medicare beneficiaries who need SNF care receive about 30 days of coverage. Typical diagnoses for SNF users are hip fracture and stroke.

Imposing a 20% coinsurance amount for all covered days means that the vast majority of SNF users would have to pay more out-of-pocket to receive needed care.

A major concern is that lower income beneficiaries would not be able to afford the coinsurance and may be denied access to needed rehabilitative services in a SNF. This is particularly true if the proposal to cap and block grant the Medicaid program is enacted, because it would seriously jeopardize the only low-income protection available under current law—the Qualified Medicare Beneficiary (QMB) program. Without this help in paying for SNF coinsurance, many low-income stroke and hip fracture victims would not be able to get the rehabilitation they need, and could end up spending additional days in the hospital or needing to be readmitted to the hospital.

A NEW 20% COINSURANCE FOR LABORATORY SERVICES

Currently, Medicare beneficiaries do not pay a coinsurance for laboratory services. Labs are paid on the basis of a fee schedule and are required to accept Medicare payments as full payment.

Since physicians order laboratory tests—not beneficiaries—a 20 percent coinsurance could present a shift in costs for services over which beneficiaries have no control. Moreover, many lab tests are low cost—under $15.00 or $20.00. In some cases it probably will not be cost effective to collect a coinsurance.

A NEW INCOME-RELATED PREMIUM FOR HIGHER INCOME BENEFICIARIES

Currently the Part B premium is intended to approximate 25 percent of Part B costs; it is not adjusted to reflect individual beneficiaries' income.

Yet another option would impose a new, income-related premium for beneficiaries with higher incomes. At the highest income categories, beneficiaries would pay triple the amount they now pay for the Part B premium. If the income thresholds for the proposed high-income premium are not indexed, each year a greater percentage of

Medicare beneficiaries would be required to pay the new, higher premium. In the future, Congress could simply choose to lower the income threshold, thereby increasing revenues.

At the same time that an income-related premium would be imposed on Medicare beneficiaries, federal subsidies for health care costs for those under age 65 would continue, regardless of an individual's income. These subsidies come in the form of the tax deduction for employer-provided health insurance and the exclusion of health benefits from individual income taxes. This proposal would impose higher health costs on higher-income older Americans but would continue federal subsidies for corporate executives, middle-aged millionaires, and Members of Congress. A recent Price Waterhouse analysis estimated that reducing federal subsidies for higher-income individuals under age 65 in the same manner as for Medicare beneficiaries—using the income thresholds suggested in the February, 1995 Joint Committee on Taxation analysis ($50,000 for singles and $100,000 for couples)—would result in

federal budget savings that are three times as large as the Medicare income-related premium savings.

BENEFICIARY ACCESS TO CARE

In addition to a dramatic increase in the direct out-of-pocket burden, AARP also believes that continued reductions in Medicare spending without system-wide cost controls will jeopardize beneficiary access to care. Certain segments of the Medicare population—namely African-American beneficiaries, those in urban poverty areas as well as health personnel shortage area (HPSAs)—already have problems with access to physicians. In addition, we hear from Medicare beneficiaries who have moved into new communities and have had problems finding a doctor willing to accept Medicare patients. AARP believes that further cuts in Medicare could exacerbate this problem.

STRENGTHENING MEDICARE—TRUST FUND SOLVENCY

AARP believes that actions must be taken to ensure that the Part A Trust Fund remains solvent. While the 1995 Hospital Insurance (HI) Trustees Report projection of potential insolvency of the Part A Trust Fund by the year 2002 must not be taken lightly—it should be noted that this is not the first time the Trustees have reported a potential problem far enough in advance for reasonable corrections to be made. In 1970, the Trustees projected insolvency within two years and in 1985 the insolvency projection was 5 years. And in fact, the 1995 Trustees projections gives the Trust Fund 7 years before insolvency—exactly the same number of years the Trust Fund had in 1994 and one year more than projected in the 1993 report (see Chart 3).

The HI Trustees Report is a valuable tool for examining the long-term stability of the Medicare program far enough in advance to make appropriate mid-course corrections. What the Trustees projections should not be used as, however, is an excuse to make massive reductions in Medicare spending for deficit reduction in the guise of Trust Fund solvency.

Some Medicare spending reductions would significantly improve the short-term status of the Part A Trust Fund and extend solvency through 2005-2006. This would allow sufficient time to carefully examine what further changes will be necessary to address the projected enrollment increase beginning in 2010 when the baby-boom generation begins to retire. However, the level of spending reductions proposed in the Senate budget is too much and comes too fast. In short, it could jeopardize the program.

REFORMING MEDICARE

AARP believes that improvements can and should be made to strengthen the Medicare program. But unless adjustments are undertaken with great care, any changes could exacerbate beneficiaries' fear of losing the health insurance program on which they depend. This fear could outweigh their willingness to explore options for the future.

The Association believes that a reformed Medicare system should have several outcomes:

- it should continue to provide the basic package of Medicare benefits;
- it should allow for choice of providers, as well as a wider choice of plans, but in expanding the choice of plans it must not allow adverse selection to destabilize the Medicare risk pool;
- it should offer incentives—not punishments—to encourage the use of fewer and less expensive services, but it should not make fee-for-service care unaffordable for current beneficiaries who choose or have no option but to remain in it;
- it should aggressively employ strategies that minimize fraud and abuse throughout our entire health care system, enlisting the assistance of Medicare beneficiaries directly in this effort;
- it should expand Medicare to include coverage for prescription drugs, because it is foolish to pay for expensive hospitalizations, but not for the medications that could have avoided the treatment; and
- last but not least, it should lower the projected cost of the Medicare program, while preserving benefits, quality, choice and affordability. It should not simply transfer costs onto Medicare beneficiaries in the form of higher premiums, cost-sharing or balance billing.

While changes in the Medicare program will be necessary, AARP's greatest concern is that much of the current rhetoric describing Medicare reform may mask an intent to cut the program severely or even dismantle Medicare as we know it, leaving beneficiaries vulnerable to high cost, low-quality health care coverage. This is

unacceptable. It is one thing to strengthen the Medicare program by filling in the gaps in coverage, broadening coverage options or reducing fraud and abuse, it is quite another to send older persons into the private market to try to purchase insurance coverage with a voucher that does not cover the cost of their care.

Any changes must be made slowly, deliberately and with substantial input from Medicare beneficiaries. One of the most valuable lessens of last year's health care reform debate is the need to move incrementally, at a pace that is comfortable for older Americans. It is also essential to carefully examine all of the options to gauge which ones are in the best interest of beneficiaries and the Medicare program.

MANAGED CARE

AARP supports managed care as an option for Medicare beneficiaries. We also believe that the extent to which expanded managed care options can provide Medicare beneficiaries with more—not less—genuine choice is a positive step.

At the same time however, we would caution that managed care is not the answer for all Medicare beneficiaries. Currently, only about 9 percent of Medicare beneficiaries are enrolled in managed care. While this number is increasing, not all beneficiaries find managed care the best option for them. In fact, the 1994 Kaiser poll on Medicare found that beneficiaries not enrolled in HMOs were skeptical about the quality of care and concerned about the lack of choice of physician and the possibility of substandard care.

AARP believes that while incentives to encourage beneficiaries to enroll in managed care may be appropriate (e.g. prescription drug coverage), disincentives, such as penalties for remaining in fee-for-service, should not force Medicare beneficiaries into plans. Making the cost of fee-for-service unaffordable by levying penalties or additional premiums is not acceptable because it would force those beneficiaries who could not afford the additional amount into plans they may not want.

AARP also believes that changes to the current Medicare HMO payment formula—the AAPCC—are warranted. This payment system not only discourages more managed care plans from participating in the Medicare program, but it has resulted in government overpayment of some managed care plans.

MEDICARE VOUCHERS

Another proposal currently under discussion is a Medicare voucher plan. Under this approach, Medicare would provide a "voucher" directly to beneficiaries, who would, in turn, be expected to buy health insurance in the private market. AARP has a number of concerns with this type of proposal. First, assuming that the amount of the voucher would be tied to Medicare per-enrollee expenditures—around $4,700 in 1995—average Medicare beneficiaries could face considerable additional out-of-pocket expenses. For example, in 1995, the cost of purchasing Medicare-equivalent coverage in the private individual insurance market—assuming Medicare fee-for-service rates—would be between $6,400 and $8,500 for persons between the ages of 65 and 74. This means that the average beneficiary of this age would be left with a sizable out-of-pocket expense—between $1,600 and $3,700 for Medicare covered services alone—unless plans were required to offer the Medicare benefits package for the cost of the voucher.

The voucher proposal also assumes that private health insurance plans would be available to older beneficiaries and to those with pre-existing conditions—which is not the practice today. For a voucher system to be viable, insurance plans would have to be required to sell to all Medicare beneficiaries. In addition, the voucher amount would need to parallel the actual cost of insurance plans offering the Medicare benefits package. Without these assurances, Medicare beneficiaries could no longer be confident that the Medicare program would continue to provide the insurance protection that it has in the past.

WHERE WE GO FROM HERE

Before Congress makes major changes in Medicare, the public must be engaged in a dialogue about what the changes will mean to them. Congress has the responsibility to answer specific questions about how changes would affect the future of Medicare:

- Would Medicare "reform" protect and enhance the coverage of older Americans?
- Will the Medicare benefits package be a standard plan that all insurers are required to offer?
- Will government payments to health plans adequately cover the costs of benefits or will the "benefit" package be underfunded and additional costs shifted to beneficiaries?

- How will choice be protected? Will Medicare beneficiaries who remain in a fee-for-service plan be penalized?
- Will all competing plans be required to offer the kinds of protections—like balance billing limits—that Medicare currently provides?
- Will adequate risk adjusters be built into the payment system to discourage adverse selection and help maintain beneficiary choice and access to care?
- Would older, sicker beneficiaries be able to get the coverage they need? Would insurers be required to accept any beneficiary wishing to purchase coverage?
- Will there be a "level playing field"—standardization of current pricing and underwriting rules so that genuine comparison of plans is possible?
- How will an information and enrollment process be structured to help beneficiaries make informed choices?
- Will the transition to an improved Medicare program be phased-in incrementally so that corrections can be made as necessary?
- How will changes be communicated to beneficiaries so that they understand the changes being made in Medicare?

CONCLUSION

AARP believes that changes to the Medicare program must be made slowly, judiciously and with significant input from the beneficiary community. AARP also believes that Medicare should be part of a responsible deficit reduction strategy. But measures that place an unfair burden on the program—and the people who depend on them—are not acceptable. Deficit reduction measures must take into account the importance of Medicare to millions of Americans as well as the contributions that programs like Medicare have made to deficit reduction. And we can no longer ignore the fact that successful deficit reduction also depends on controlling costs throughout our health care system.

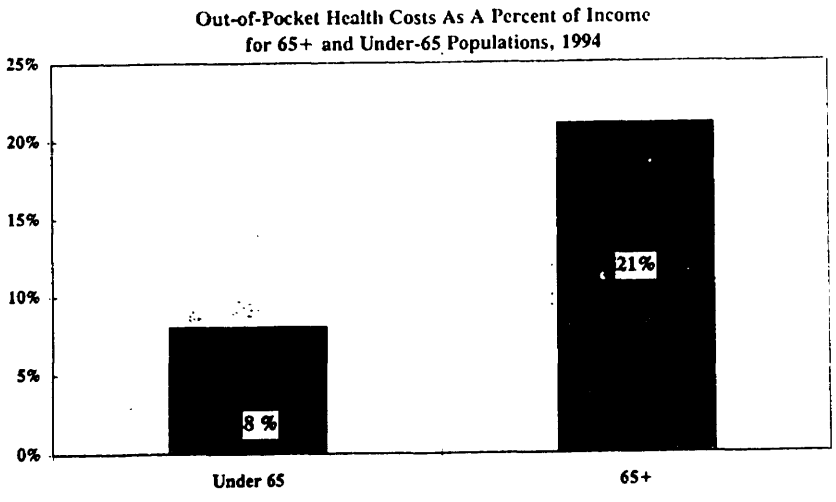
AARP is prepared to work with you and the members of the Committee on identifying ways to assure a strong future for Medicare and a healthy future for the Americans of all ages who depend on this program.

FOOTNOTES

[1]: Out-of-pocket health costs include all health care expenses of non-institutionalized older individuals except those paid by Medicare. Medicare and private premiums, and prescription drugs, for example, are considered out-of-pocket costs. Data are based on December, 1993 CBO projections of population subgroups and National Health Accounts data by type of service and payer.

Chart 1

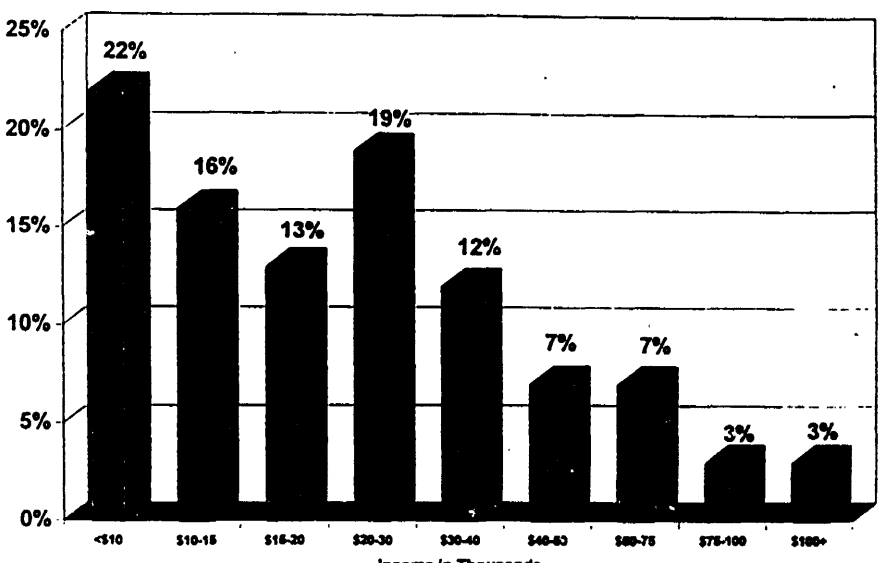
Older Americans Already Spend A Large Percent of Their Incomes On Out-of-Pocket Health Costs



Source: "Coming Up Short: Increasing Out-of-Pocket Health Spending By Older Americans," prepared by AARP Public Policy Institute and the Urban Institute, updated February 1995. Does not include long-term nursing home costs

Chart 2

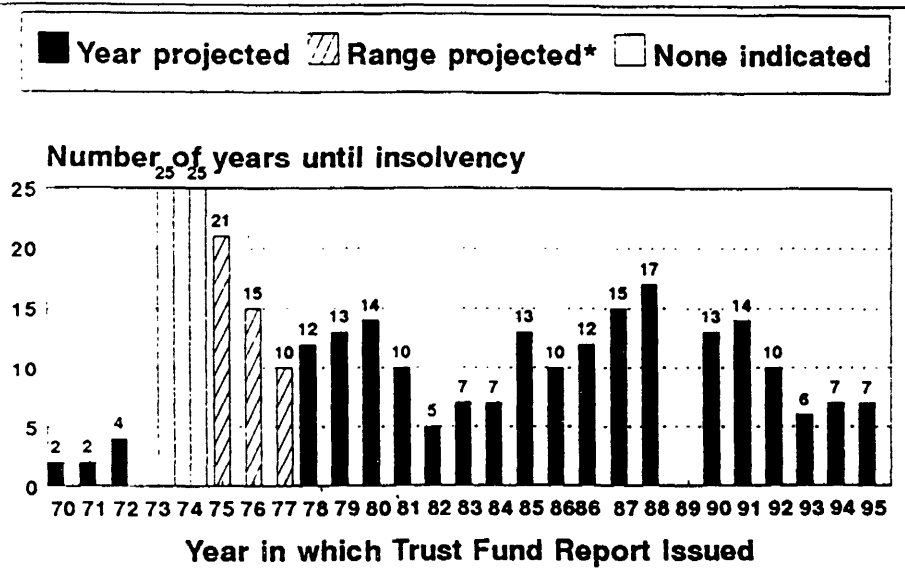
Income Distribution of Americans Aged 65 and Over



Source: Current Population Survey, March 1993

Chart 3

Projection of number of years until insolvency of Medicare HI Trust Fund by year of Trust Fund Report



Derived from CRS, April, 1995
No insolvency indicated (1973, 1974); no long-range projections (1989)
*Range - 1975 Report: late 1990s; 1976 Report: early 1990s; 1977 Report: late 1980s

AARP

Bringing lifetimes of experience and leadership to serve all generations.

July 14, 1995

The Honorable Robert Packwood, Chairman
Senate Finance Committee
205 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood:

Thank you for giving AARP the opportunity to testify at the Senate Finance Committee hearing on the future of Medicare. During the question and answer segment of the panel discussion, AARP was asked to respond in writing to questions raised by you and other members of the Committee. The purpose of this letter is to respond to that request.

Mr. Chairman, you asked whether AARP would accept reductions in Social Security as part of deficit reduction measures. As you know, Social Security is a self-financed program that does not contribute to the deficit. The program's trust funds at the end of 1994 held a reserve of $436 billion, which is projected to grow over the next decade. These reserves actually result in a lower overall federal deficit. Because Social Security takes in more revenue than is needed to pay benefits, Congress took it off budget to shield it from unwarranted reductions. AARP agrees that Social Security should not be part of any deficit reduction measure. Instead, Social Security issues should be addressed separately. AARP has testified before Congress and the Social Security Advisory Commission that the American public and Congress should begin debate over ways to improve the long-term solvency of Social Security.

The Social Security trustees, in their 1995 report, state that the program will be able to pay benefits for the next 35 years. While Social Security is in good financial shape for the near future, changes will be necessary in order to guarantee long-term solvency. However, any changes to Social Security should be made only to ensure the long-term solvency of the program. More details on AARP's position on long-term solvency for Social Security can be found in AARP's recent testimony before the Finance Subcommittee on Social Security and Family Policy. The testimony is attached.

With respect to Medicare, both you and Senator Moynihan asked how AARP would achieve the level of savings necessary to ensure Part A Trust Fund solvency. As we stated at the hearing, the Association wants to work with Members of Congress to determine the appropriate level of savings as well as a set of policy changes designed to achieve this goal. Few assume that the current rate of growth in Medicare is sustainable; but the $270 billion in Medicare spending reductions included in the Budget Resolution is too much, too fast.

American Association of Retired Persons 601 E Street, N.W., Washington, D.C. 20049 (202) 434-2277
Eugene L. Lehrmann *President* Horace B. Deets *Executive Director*

We believe that Congress should adopt a two-step approach The first step should be to place the program on a 10-year solvency track -- the historic average for Medicare in the Trustees' Reports. The second should be to determine the appropriate steps to keep Medicare strong for future generations.

The 1995 Part A Trustees report indicates that Medicare reductions -- in the ballpark of $60 billion over five years -- could improve the near-term status of Part A by delaying the "spend down" of reserves. This would ensure that the Trust Fund would remain solvent for the next 10 years. While extending the life of the Trust Fund through 2005 would require savings that exceed any previous budget bill, it is important for two reasons: 1) to maintain public confidence in Medicare's future, and 2) to provide sufficient time to carefully examine the best policy options for longer-term solvency to ensure the Trust Fund remains stable past 2010 when the baby-boom generation begins to retire.

It is clear that confronting the challenges of the next decades will require adjustments in the Medicare program. Controlling costs in health care, including Medicare, is a part of that challenge, but AARP believes that these adjustments must be guided by the ultimate goal of maintaining a strong and stable Medicare program. If we let arbitrary budget targets dictate policy decisions, the health care of millions of Americans and the economic well-being of their families will be seriously jeopardized.

Finally, we would like to respond to a question raised by Senator Simpson regarding the difference in calculations in beneficiary out-of-pocket expenses the Association has used in its analysis of both the Balanced Budget Amendment and the Senate Budget Resolution.

In the March, 1995 AARP Bulletin, the Association reported that Medicare beneficiaries would have to pay $5,175 more in out-of-pocket costs between 1996 and 2002 as a result of the Balanced Budget Amendment. Our analysis assumed that to achieve a balanced budget, across-the-board reductions would be imposed on all programs except Social Security and defense. It also assumed that tax cuts proposed in the "Contract With America" would reduce projected revenues. We distributed the savings needed to achieve a balanced budget proportionately across all the programs targeted for reductions. We did not assume that the balanced budget would produce a $170 billion "economic dividend." As a result, we projected that Medicare spending would be cut by about $400 billion between 1996 and 2002. We projected that beneficiaries would be responsible for half of these savings and that their out-of-pocket costs would increase by $5,175 over the next seven years.

In May, after the Senate Budget Committee proposal was publicly unveiled, AARP released an analysis of that proposal's effect on Medicare beneficiaries. Since the Senate Budget Resolution contained no explicit tax cuts and it assumed an "economic dividend" of $170 billion, the Medicare cuts were less than our initial analysis projected. The proposed Medicare cuts in the Senate Budget Resolution remained very large -- $256 billion between 1996 and 2002 (now $270 billion in the Budget Resolution conference agreement). To determine the potential impact on beneficiaries, we used the same approach as in February; that is, we projected that beneficiaries would be targeted directly for half of these savings. We found that the Senate Budget Resolution would increase beneficiaries' out-of-pocket costs by about $3,200 over the next seven years.

In each case, the out-of-pocket projections made by the Association are correct. The numbers differ because they are based on analyses of two different proposals. We used the same approach, the same methodology, in both analyses. And the results in terms of substantially higher out-of-pocket costs for older Americans are very troubling, however you choose to look at it.

Thank you again for giving the Associaiton the opportunity to testify before the Committee. It is our hope that we can work with the Committee over the next several months to find a way to assure the long-term integrity and solvency of the Medicare program and to protect the health care coverage of millions of older and disabled Americans, as well as to begin the process of building public understanding of the choices we face in Social Security over the longer term.

Sincerely,

Martin Corry
Director
Federal Affairs

cc: The Honorable Daniel Patrick Moynihan

Attachment

PREPARED STATEMENT OF JUNE E. O'NEILL

Mr. Chairman and Members of the Committee, it is my pleasure to be here today to discuss the financial status of the Medicare program. Continuing growth in the cost of providing Medicare coverage to each beneficiary, coupled with a steady increase in the number of beneficiaries, is eroding the financial viability of the program. If left unchecked, those trends will create a problem of major proportions when the baby-boom generation begins to reach retirement age in the year 2010. Addressing the short-term and long-term financing problems of the Medicare program presents a serious challenge for the nation.

The *1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund,* released last month, indicates that under intermediate assumptions, the Hospital Insurance (HI) Trust Fund will be depleted in 2002. In other words, unless changes in policy are made, the HI program will only be able to pay fully for services provided to beneficiaries for about the next seven years. Indeed, even under the trustees' most optimistic assumptions, the HI trust fund will be exhausted by 2006—11 years from now.

Based on the Congressional Budget Office's (CBO's) analysis of the trustees' projections and our independent analysis of the Medicare program, we find ample reason to agree with the broad conclusions of the trustees regarding the short-range adequacy of HI funding. But those projections of HI insolvency address only part of Medicare's overall financial outlook. The Supplementary Medical Insurance (SMI) program, which pays for physician and outpatient services for Medicare beneficiaries, is also experiencing rapid growth in costs.

Moreover, the Medicare program is absorbing a growing share of the nation's resources. Combined spending for HI and SMI has increased from 0.8 percent of gross domestic product (GDP) in 1974 to 2.4 percent of GDP in 1994. It is expected to increase to about 3.5 percent of GDP by 2002. Program revenues, however, are not increasing nearly as rapidly. The evidence strongly supports the conclusion of the trustees that "prompt, effective, and decisive action is necessary" by the Congress to avert a financial crisis in the Medicare program.

My statement today covers four topics:

- An overview of the Medicare program,
- Trends in program spending and in the trust fund balance,[1]
- Medicare's cost containment measures to date, and
- Options for responding to the fiscal crisis in the Medicare program.

OVERVIEW OF THE MEDICARE PROGRAM

Medicare is the nation's major program providing medical services to the elderly and disabled populations. It offers two different types of insurance coverage, which are financed and administered separately.

The Hospital Insurance program pays for inpatient hospital care and related care for people 65 and older and for the long-term disabled. Payroll taxes primarily finance the program, with the taxes being paid by current workers and their employers. Those tax receipts are mainly used to pay for benefits to current beneficiaries. Income not currently needed to pay for benefits and related expenses is credited to the HI trust fund. In 1994, the HI program covered about 32 million aged and about 4 million disabled enrollees at a cost of $103 billion.

The Supplementary Medical Insurance program pays for physician and outpatient services. Although it is optional, most individuals eligible for Medicare enroll in SMI. Currently, premiums paid by enrollees finance about 31 percent of SMI program costs. But that share is projected to decline significantly under current law—to 25 percent in 1996 and lower after 1998. General revenues finance the remaining costs. The SMI program is not intended to accumulate funds for the payment of future benefits. In 1994, the SMI program covered about 31 million aged and about 4 million disabled enrollees at a total cost of $60 billion.

Payroll tax rates for the HI program are set at 1.45 percent of taxable earnings each for workers and their employers. However, the consensus among economists is that most of the tax charged to employers is indirectly paid by workers, whose earnings are ultimately reduced by the amount of the employer's contribution. Self-employed workers pay 2.9 percent of taxable earnings. No cap is placed on taxable earnings subject to the HI payroll tax. In 1994, approximately 141 million workers (and their employers) paid $92 billion to the HI trust fund.

As the baby-boom generation reaches retirement age, the number of workers available to support each HI enrollee is projected to drop. Currently about four cov-

[1] See the appendix tables for detailed information on trends in Medicare spending.

ered workers support each HI enrollee. The trustees project that this ratio will decline rapidly early in the next century. They expect that only two covered workers will be available to support each enrollee by mid-century.

TRENDS IN SPENDING AND THE TRUST FUND BALANCE

In 1994, the Medicare program spent $162 billion, including both HI and SMI. Between 1985 and 1994, Medicare expenditures increased at an average annual rate of 9.6 percent. Under current law, CBO projects that Medicare spending will continue to grow at a similar rate, rising from $181 billion in 1995 to $463 billion in 2005. That increase represents an average annual rate of growth of 9.8 percent. By contrast, cash benefits for Social Security recipients will increase at only about half that rate.

Inflation in medical prices and increases in use of services account for most of the projected rapid increase in Medicare spending. Medicare enrollment of the elderly and disabled combined is projected to increase at an average annual rate of only slightly more than 1 percent over the 1995–2005 period.

CBO projects that Medicare will absorb a growing share of the federal budget over the next 10 years. In fact, under current law, outlays for Medicare (net of SMI premiums) will increase from 11 percent of federal outlays in 1995 to 16 percent of outlays in 2005. Medicare and Medicaid are the fastest growing of the major entitlement programs, and as such, they are major contributors to the escalating budget deficits that face the country.

The Medicare trustees report 75-year projections of the financial status of the HI trust fund. Projections made by the trustees of the adequacy of HI funding to support program costs in the future are based on three alternative sets of assumptions about future economic and demographic trends: low-, intermediate-, and high-cost. Under their intermediate-cost assumptions, the HI trust fund will be exhausted in 2002.

According to the trustees, HI outlays began to exceed income from the payroll tax in 1992. They project that HI outlays will begin to exceed all sources of income to the program (including interest on the trust fund balance) in 1996. As a result of that annual deficit in the HI account, the balance in the HI trust fund will begin to erode, and by 2002 it will be depleted.

CBO's projections of the HI trust fund balance only cover the 1995–2005 period. Those projections support the trustees' estimates concerning the depletion of the HI trust fund in 2002. Moreover, CBO's analysis provides ample reason to agree with the broad conclusions of the trustees regarding the short-range adequacy of HI funding.

It is useful to consider what trust fund depletion in 2002 means for the operation of the HI program. Under current-law assumptions, HI payroll taxes would continue to be collected from all covered workers (and their employers) throughout the year. According to CBO's assumptions, total HI income in fiscal year 2002 would be $153 billion. The total amount in the trust fund at the beginning of that fiscal year would be about $16 billion. Projected disbursements for the full year equal $199 billion. Consequently, the HI program would have a shortfall of $30 billion in fiscal year 2002. Thus, without some Congressional action to provide it with additional financial resources, the HI program would be unable to pay for all of the services Medicare beneficiaries are expected to receive in that year.

MEDICARE'S COST CONTAINMENT MEASURES TO DATE

The rate of growth in Medicare's costs has caused concern almost from the program's inception. The Congress has made repeated attempts to slow that growth, but with limited success.

Early efforts, in the 1970s, relied on price controls and relatively weak utilization review programs. It became apparent, however, that much of the potential savings to Medicare from price controls was lost, offset by an increase in the volume or intensity of services provided despite utilization review. Subsequent cost control efforts sought to introduce mechanisms that focused not just on price but on spending—the product of service price and volume.

The prospective payment system (PPS) for hospital services was established in 1984 to replace retrospective cost-based reimbursement. Under the PPS, hospitals are paid a fixed amount for each inpatient case, based on the patient's diagnosis. Under that payment system, hospitals are given strong incentives to avoid unnecessary services during a patient's stay and to discharge patients as soon as possible, since extra services or days in the hospital would increase hospitals' costs but not their reimbursement from Medicare. By contrast, under the previous payment system, Medicare paid hospitals for the costs of whatever services they provided.

Changes in the physician payment system were implemented in 1992 to replace charge-based reimbursement for physicians' services. The new system includes an explicit fee schedule along with an updating mechanism intended to generate lower fee increases when growth in the volume of physicians' services is large. Unlike the earlier changes in the hospital payment system, these changes did little to alter incentives for physicians. The method of setting fees was changed, but it remains a fee-for-service system that rewards physicians for providing more services.

One can see some indication of the effects of those changes for hospital and physician payment in the fee-for-service sector by comparing the rates of growth in Medicare's spending by service category for different time periods. Between 1985 and 1990, the rate of growth in Medicare's total costs was nearly half the rate for the preceding decade—annual growth of 9.0 percent, down from 17.1 percent. That slowdown was mostly the result of sharply lower growth for hospital inpatient costs over the five-year period immediately following implementation of the prospective payment system. The growth rate for hospital inpatient spending rose somewhat after 1990.

By contrast, the freezes on and cuts in physicians' fees that took place during the latter part of the 1980s had little effect on the growth rate in spending for physicians' services because those measures were largely offset by an increase in the volume of services. Although the rate of growth in physicians' costs was lower between 1990 and 1995 than it had been before the fee schedule and its volume-based update system were introduced, the slowdown may reflect the low level at which the initial rates under the fee schedule were set. Projections for the 1995-2000 period assume a return to pre-1990 rates of growth.

Another significant change to Medicare during the 1980s was development of a mechanism whereby health maintenance organizations (HMOs) could enroll Medicare beneficiaries on a risk basis—receiving a capitation payment from Medicare for each enrollee. Until then, HMOs were able to serve Medicare enrollees only on a cost basis—a payment system not consistent with the way HMOs operate. Since 1985, Medicare enrollment in risk-based HMOs has grown steadily, increasing more rapidly than private-sector HMO enrollment has since 1989. Nevertheless, Medicare's risk-based HMO enrollment rate is still low—at 7 percent—compared with the privately insured population. In 1992, almost 20 percent of people with private insurance were in HMOs.

Currently, Medicare beneficiaries pay no more to enroll in fee-for-service Medicare than to enroll in an HMO. They often, however, receive supplementary benefits—such as prescription drug coverage and waiver of cost-sharing requirements—for little or no extra premium if they enroll in an HMO, whereas they pay a substantial premium for medigap coverage to receive those benefits in the fee-for-service sector. For some Medicare beneficiaries, those financial incentives appear to be outweighed by the desire to be able to choose physicians outside the HMO's network. Others may not enroll in managed care plans simply because they are unaware of all the options that are available to them. In the future, both stronger financial incentives and better information would be necessary to encourage more Medicare beneficiaries to enroll in managed care plans.

The most effective HMOs share the insurance risk for enrollees with their providers, thereby reversing or counteracting the incentive providers have to provide unnecessary services that is characteristic of the fee-for-service sector. As a result, an HMO's cost of caring for a given patient is generally lower than the costs incurred by an indemnity plan in the fee-for-service sector.

Despite apparent evidence that the overall resource cost of services used by Medicare beneficiaries falls when they move from the fee-for-service sector to an effective HMO, higher HMO enrollment may have the perverse effect of increasing Medicare's costs—not lowering them—under Medicare's current payment system. That effect occurs for two reasons. First, risk-based HMOs are paid 95 percent of Medicare's fee-for-service cost to provide care to a beneficiary, as measured by the average adjusted per capita cost (AAPCC). That link to fee-for-service costs means that Medicare pays a fixed capitation amount for each Medicare beneficiary enrolled in an HMO, regardless of the actual resource cost of the services provided. Second, Medicare's capitation rates do not fully adjust for the generally healthier group of people who are likely to choose the HMO option compared with those who remain in fee-for-service, nor do they account for the greater efficiency of managed care. If the service costs are lower than the capitation amount, Medicare does not recover any of the savings. The fee-for-service link also means that Medicare payments to HMOs would increase if per capita costs in the fee-for-service sector rose, even if HMO per capita costs fell.

Medicare's HMO enrollment could generate savings, however, if the method of setting capitation rates was changed. A number of possible alternatives exist. But significant savings would not be generated unless the payment link between fee-for-service and managed care was broken. One way to break the link would be to allow the capitation rates to be set by competitive bidding in areas with enough HMOs to make that approach viable. That market-based approach could encourage stronger price competition among Medicare risk-based HMOs in a market area. However, generating more savings for the Medicare program could reduce the additional benefits that HMOs currently offer to beneficiaries, blunting incentives to enroll in HMOs.

Many analysts attribute the recent slowdown in the rate of growth of private health insurance spending to more aggressive price competition among health plans. Between 1990 and 1993, private health insurance spending grew at an average annual rate of 7.7 percent compared with 11.2 percent for Medicare. As it is currently structured, the Medicare program cannot take advantage of the recent competitive developments in the private health care market.

OPTIONS FOR RESPONDING TO THE FISCAL CRISIS IN MEDICARE

If nothing is done and Medicare continues to grow at its current rate, the program will consume an increasing share of the nation's resources. It will also continue to be a major cause of the rising federal budget deficit and the increasingly burdensome federal debt. Those outcomes raise concern about the efficient allocation of the nation's scarce resources and about the long-run prosperity of the nation. If Medicare absorbed less of the nation's output, more could be spent on investment to improve the productivity of current and future workers. Moreover, a growing economy could be more dependably counted on to pay for the benefits of current and future retirees.

Fixing Medicare's financing problems will not be easy. As the reports of the trustees make clear, those problems are of both a short-term and a long-term nature. Either taxes must be increased, expenditures reduced, or both, and the orders of magnitude involved are large. (A third approach that is sometimes suggested to address shortfalls in the HI trust fund would be to transfer funds to it from the Old-Age and Survivors Insurance (OASI) trust fund. That strategy, however, would merely postpone rather than address the funding shortfall and would hasten the depletion of the OASI trust fund.)

The tax alternative, in isolation, would require an increase in the HI payroll tax of 1.3 percentage points—more than 40 percent—over the next 25 years to ensure that HI financing covered program costs. Although such an increase in the HI payroll tax would secure the HI portion of Medicare outlays, it would do nothing to improve the overall efficiency of the Medicare program.

Two broad approaches would achieve slower growth in Medicare outlays: budgetary reductions and program restructuring. Those approaches are not mutually exclusive. With or without a tax increase, a combination of them would probably be needed to address Medicare's immediate and longer-term financing problems.

Budgetary reductions—exemplified by the options included in CBO's 1995 report Reducing the Deficit: Spending and Revenue Options—represent the traditional approach to containing Medicare's costs. Such options, which typically lower payments for providers or raise the amounts that beneficiaries must pay, offer immediate short-term savings in the Medicare program. Although both types of policies are likely to be part of a more thorough reform of Medicare, they are not necessarily designed to improve the efficiency of the program or to address the underlying long-term structural problems of spending growth.

Slowing the long-term rate of growth of overall Medicare spending and ensuring the solvency of the HI trust fund would probably require major restructuring of the Medicare program. Three basic tenets underlie most redesign proposals: Medicare beneficiaries would have meaningful choices among a range of health plans, including a fee-for-service option; beneficiaries would also have financial incentives to select efficient health plans; and health plans would have strong incentives to compete for Medicare beneficiaries.

Several possible models for restructuring the Medicare program along those lines have been proposed. Frequently, such competitive market approaches offer beneficiaries more choices and clear financial incentives to choose less costly options. A key feature of those approaches is the notion of Medicare making a defined contribution on behalf of each beneficiary. Beneficiaries could then put those contributions toward the cost of the health plan of their choice. Beneficiary choice and limits on the government's contribution are important elements of the design of the health insurance program for federal employees.

A competitive redesign of Medicare is a possible strategy for addressing the long-term fiscal problems of the program. Major restructuring, however, would take time to develop and could not therefore address the short-term financing issues. Establishing a competitive system could be a major undertaking. Moreover, full implementation all at one time would be difficult; a phased-in approach, starting with younger Medicare beneficiaries, might be more feasible. But potential savings would accrue more slowly under that approach.

One thing is certain: postponing decisions about Medicare's financing will only make the necessary policy actions in the future more severe. Without a tax increase, ensuring that the HI trust fund remains solvent will almost certainly require immediate spending cuts as well as reductions in the underlying rate of growth of spending. Any delay will require more dramatic cuts and program changes in the future.

TABLE A-1. OUTLAYS FOR MEDICARE BENEFITS, SELECTED FISCAL YEARS 1970-1993

—	1970	1975	1980	1985	1990	1993
			Billions of Dollars			
Total	6.8	14.1	33.9	69.6	107.4	143.1
Hospital Insurance	4.8	10.4	23.8	47.8	65.9	90.7
Inpatient	4.5	9.9	22.9	45.2	59.4	75.0
Skilled nursing facility	0.3	0.3	0.4	0.6	2.8	5.0
Home health	0.1	0.1	0.5	1.9	3.3	9.5
Other	0	0	a	0.2	0.5	1.2
Supplemental Medical Insurance	2.0	3.8	10.1	21.8	41.5	52.4
Physician	1.8	3.1	7.8	16.8	29.0	34.4
Outpatient	0.1	0.5	1.8	3.9	8.4	11.2
Group practice prepayment plans	a	0.1	0.2	0.6	2.6	4.7
Other	a	0.1	0.3	0.5	1.5	2.2
			Average Annual Rate of Growth from Previous Year Shown (In percent)			
Total	n.a.	15.8	19.2	15.5	9.1	10.0
Hospital Insurance	n.a.	16.6	18.1	15.0	6.6	11.2
Inpatient	n.a.	17.4	18.1	14.6	5.6	8.1
Skilled nursing facility	n.a.	-1.7	7.5	7.0	38.0	22.2
Home health	n.a.	19.8	31.6	29.5	11.6	42.5
Other	n.a.	n.a.	n.a.	63.8	25.3	31.6
Supplemental Medical Insurance	n.a.	13.7	21.9	16.5	13.7	8.1
Physician	n.a.	11.1	20.6	16.5	11.5	5.9
Outpatient	n.a.	39.5	27.8	16.8	16.4	10.1
Group practice prepayment plans	n.a.	19.0	25.1	24.6	35.9	20.8
Other	n.a.	22.4	25.9	9.5	23.3	12.5

SOURCE: Congressional Budget Office calculations based on data from the Health Care Financing Administration.

NOTE: n.a. = not applicable.

a Less than $50 million.

TABLE A-2. PROJECTIONS OF MEDICARE OUTLAYS, FISCAL YEARS 1995-2005 (In billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Average Annual Rate of Growth, 1995-2005 (In percent)
Total Outlays	181.1	202.2	222.7	243.9	267.0	291.9	319.2	349.5	383.3	421.1	463.2	9.8
Hospital Insurance	113.6	125.4	136.8	148.3	160.2	172.5	185.5	199.1	213.8	229.9	247.4	8.1
Supplementary Medical Insurance	67.6	76.8	85.9	95.6	106.8	119.4	133.8	150.4	169.5	191.2	215.8	12.3
Premium Receipts	-20.1	-20.3	-22.0	-24.5	-26.1	-27.3	-28.7	-30.1	-31.6	-33.2	-34.4	5.5
Net Outlays	161.1	181.9	200.7	219.4	241.0	264.6	290.6	319.4	351.7	387.9	428.8	10.3

SOURCE: Congressional Budget Office.

TABLE A-3. MEDICARE OUTLAYS PER ENROLLEE UNDER ALTERNATIVE GROWTH ASSUMPTIONS (By fiscal year)

Percentage Growth in Total Medicare Outlays	Medicare Outlays per Enrollee (In dollars)			Total Savings[a] (In billions of dollars)
	1995	1998	2002	
9.8 (Baseline)	4,833	6,214	8,456	n.a.
7.0	4,833	5,655	7,038	219.0
5.0	4,833	5,343	6,167	347.8

SOURCE: Congressional Budget Office.

NOTE: n.a. = not applicable.

a. Total savings are measured over the 1995-2002 period.

PREPARED STATEMENT OF HON. DAVID PRYOR

Mr. Chairman, thank you for holding this hearing on the solvency of the Medicare program. also want to thank our witnesses for coming forward to help us with this important subject.

Mr. Chairman, as you know, this year marks the 30th anniversary of the Medicare program. In these three decades, Medicare has brought health and economic security to some of the nation's most vulnerable citizens. And, as voiced by the delegates to the recent White House Conference on Aging, most beneficiaries are satisfied with their Medicare program and would like to see it preserved.

It is our mission as members of this panel and as U.S. Senators to ensure that the program remains fiscally sound so that we do not return to the days when most elderly were uninsured.

To meet this goal, we need to address the financial soundness of the program, which is being eroded by increasing per-beneficiary costs and a steady increase in the number of beneficiaries. As we all know, the *1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund* indicates that the Hospital Insurance Fund may be depleted by the year 2002.

Mr. Chairman, as we consider addressing this financial viability problem, there are two things that we need to keep in mind. First, we should not assume that the current Medicare system is beyond repair and that the program therefore must be drastically altered.

Current Medicare cost-control systems are actually doing a pretty good job. In fact, Medicare outlays for hospital and physician services per enrollee have grown more slowly than private health insurance outlays for these services in the last decade, according to Government statistics. The major areas where Medicare is now growing rapidly are for those services not covered by prospective payment approaches, such as home health and skilled nursing, and the Administration is now working to address these areas.

One drastic change to the Medicare program—one that I have grave concerns about—would be to institute a voucher system whereby beneficiaries would receive a voucher that would allow them to select a private insurance policy. Some of these proposals would give the beneficiary cash and allow them to use the money any way they wanted.

Mr. Chairman, these various Medicare voucher proposals would dismantle Medicare and replace it with something that cannot be called a program, and certainly cannot be called insurance. Under the best scenario, every beneficiary—including the sickest—would have to become insurance experts and evaluate whatever private insurance policies might be available in the market. Under the worst scenario, beneficiaries would have inadequate coverage or no coverage at all. We would be abdicating our responsibility for ensuring a basic level of health care coverage for some very vulnerable citizens.

The second point I want to make is that regardless of what changes are made, beneficiaries need to continue having access to an affordable fee-for-service option. This means a fee-for-service plan with reasonable beneficiary premiums and cost-sharing levels. Under the current Medicare system, out-of-pocket expenses for the poor and those with serious medical problems pose a serious financial burden. In general, the elderly are actually spending a higher percentage of their income on health care than they did prior to the enactment of Medicare. Increasing this burden would be unacceptable.

Beneficiaries who choose a risk-based HMOs should do so because that type of delivery system is right for them, not because they cannot afford the fee-for-service option.

In any case, now may not be the time to increase dramatically the number of beneficiaries in Medicare risk-contract plans. Beyond some findings which indicate we may actually pay more for HMO-covered Medicare beneficiaries than we do for the fee-for-service-covered population, there are a number of concerns about this program which need to be addressed if we are to expand its scope responsibly.

Mr. Chairman, I again commend you for holding this series of hearings on the Medicare program. As all of our witnesses will tell us today, now is the time to act.

PREPARED STATEMENT OF ROBERT D. REISCHAUER*

Mr. Chairman and members of the Committee, I appreciate this opportunity to discuss the future of the Medicare program with you. My statement elaborates on the following five points.

- Medicare, which will celebrate the 30th anniversary of its enactment this summer, has been a phenomenal success. It is a government program that has worked and worked well.
- Notwithstanding its past success, the short-run budget situation facing the nation and the long-run demographic problem that looms as the baby boom generation retires render the program unsustainable in its current form; it will have to be changed in fundamental ways.
- To respond to these budgetary and demographic pressures, policymakers will have to rely on both the mechanisms employed in the past to restrain the growth of Medicare's costs and on structural changes that encourage efficient, low-cost health-care delivery systems.
- Structural reforms such as these are complicated and difficult undertakings. Many complex design and implementation issues will have to be resolved which will take time. The magnitude of the budgetary savings which could be generated from structural reforms is uncertain and probably would not constitute significant amounts over the next five or ten years. Nevertheless, the sooner we begin to make these changes, the less disruptive they will be.
- Medicare has been left behind by the revolution sweeping through the health care market. Structural reforms could allow Medicare not just to catch up with the market but also to lead it.

MEDICARE IN PERSPECTIVE

Discussion of the rapid growth in Medicare spending and its contribution to the deficit problem has overshadowed the fact that Medicare has fulfilled its basic mission impressively. Before 1965 few elderly or disabled had the protection offered by health insurance. Of the few that had insurance, many lived with the uncertainty of the knowledge that their coverage could be canceled or their premiums raised to prohibitive levels if their health deteriorated. Today, thanks to Medicare, virtually all of the elderly and a substantial fraction of the disabled—37 million people in all—have affordable health insurance that cannot be taken from them. Medicare has given them access to the vast majority of health care providers and to the fruits of the technological revolution that has taken place in the health care over the past 30 years.

To be sure, Medicare's benefits are fairly basic when compared to those of employer-sponsored plans which cover most workers and their families or even to those of the Medicaid program which covers many with low incomes. Its coverage of preventive services is limited, it doesn't cover prescription drug or dental expenses, and it does not provide protection against catastrophic expenditures including long term care. Nevertheless, Medicare has provided its beneficiaries with a substantial amount of peace of mind and has relieved their children, relatives and friends of financial burdens which could be substantial.

AS CURRENTLY STRUCTURED, MEDICARE IS UNSUSTAINABLE

Over the past decade, Medicare spending has risen 9.7 percent a year; if the program is not modified, spending is projected to grow by 10.2 percent per year over the next decade. Because Medicare spending is growing much faster than the economy, an ever-increasing share of the nation's resources are being devoted it. As a percent of GDP, Medicare has increased from 1.80 in 1985 to 2.61 in 1995 and is projected to rise to 3.75 percent by 2005. When the baby boom generation begins to retire in the second decade of the next century, Medicare spending is projected to soar from 4.50 percent of GDP in 2010 to 6.01 percent in 2020 and to over 8 percent by 2040.

As a society, we could choose to devote a large and ever increasing share of our resources to government financed health care for the aged and disabled. Such a shift of priorities would not be unprecedented. Between 1948 and 1952 the fraction of GDP devoted to defense rose from 3.7 percent to 13.5 percent and, with the exception of two year, defense spending remained above 8 percent of GDP through 1970. But if we allow the unrestrained growth of Medicare we will have to accept one or

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a combination of three possible repercussions: the share of national resources available for other government programs will have to be reduced drastically, taxes will have to be increased significantly, and/or government deficits will have to increase thereby eroding the economy's long-run potential. None of these is acceptable.

In fact, for the past five years we have been struggling to reduce the size of the budget deficit. In this effort, Medicare has played an important role. Of the policy-related savings contained in the 1990 and 1993 deficit reduction packages, 10.1 percent and 14.4 percent respectively were contributed by Medicare. The fiscal year 1996 budget resolutions being considered by the Senate and the House this week, continue this policy. Under the resolution reported by the Senate Budget Committee, Medicare will contribute roughly 22 percent of the policy-related savings needed to bring the budget into balance by the year 2002.

The exact amount that Medicare should contribute to the effort to balance the budget is open to debate. Nevertheless, if balancing the budget is to be the top national priority, and if the job is to be done solely by paring spending, then Medicare must be a major contributor both because it looms large in the budget and because it is a major source of the projected growth in baseline spending. In fact, Medicare accounts for roughly 13 percent of all baseline spending and 20 percent of all non-interest, non-social security spending over the next seven years. Roughly 19 percent of the growth in baseline spending and 36 percent of the growth in spending on items other than interest and social security is due to Medicare. In short, the Medicare program will have to undergo substantial budgetary downsizing if we are to balance the budget and prepare for the retirement of the baby boom generation.

MEASURES TO REDUCE THE BUDGETARY BURDEN OF MEDICARE IN THE SHORT-RUN

There are four general approaches to reduce Medicare's budgetary burden over the short-run. Each has been used for deficit reduction purposes during the past decade; each affects different groups; and each has advantages and drawbacks. None changes the fundamental structure of Medicare. Even taken together, these approaches probably do not have the potential of meeting the financial challenge posed by the retirement of the baby boom generation.

The four approaches to reducing the short-term budgetary burden of Medicare are:

Raise payroll taxes. Hospital Insurance (HI) payroll tax rates could be raised as we have done 6 times since 1966 for non-self employed workers. This would strengthen the financial position of the HI trust fund but would do nothing to moderate the growth of spending or change the behavior of beneficiaries and providers. The burden of the tax increase would fall largely on workers, not current beneficiaries who receive substantial subsidies through the Medicare program. The growth of workers' cash compensation, which has been slow over the past two decades, would be dampened. There could be some small disemployment effects for low-skilled, minimum wage workers.

Raise Part B (SMI) Premiums. The monthly Supplementary Medical Insurance (SMI) or Part B premium, which is set at $46.10 for 1995, could be raised and indexed to program costs. This premium is estimated to cover 31.5 percent of the Part B costs incurred by the average elderly participant in 1995 and 21.8 percent of those incurred by disabled participants. Over Medicare's first 9 years, Part B premiums were set to cover 50 percent of the program's costs. Under current law, premiums will not keep pace with program costs and, therefore, the ratio of premiums to program costs will drift down to under 20 percent of costs by 2005. If the monthly premiums were increased, all participants except the poor, whose premiums are paid by the Medicaid program, would be affected. The burden would be heaviest on the near poor causing some small number to forego Part B coverage or to drop their Medigap policies if they were financially strapped. Medicaid expenditures would rise. An alternative approach would be to impose an income-related surcharge on the Part B premium through the income tax system. A majority of participants would be unaffected by such a policy. No matter how it is accomplished, increased Part B premiums would do nothing to alter provider or beneficiary behavior or slow spending growth.

Increase Deductibles and Coinsurance. The $100 SMI deductible and the 20 percent coinsurance rate could be increased to higher levels. In addition, coinsurance requirements could be imposed on clinical laboratory and home health services where none currently exist and those on skilled nursing facility services could be made similar to those applied to other services. The burden of such changes would fall most heavily on the 25 percent of participants who lack supplementary, Medigap type, coverage and have large medical expenditures. Some might be discouraged from seeking care; home health and SNF service utiliza-

tion among this group would fall. Others might face large increases in their out-of-pocket costs. Those who purchase supplementary coverage, which pays for deductibles and coinsurance, would see their premiums rise and a few might drop their supplementary policies. Medicaid costs would also increase because this program picks up those costs for Medicare participants who are poor. The administrative costs associated with laboratory, home health, and SNF services would increase because providers would have to bill both Medicare and the enrollees.

Reduce the Growth of Provider Payments. The growth in the payment rates for inpatient hospital and physicians' services could be slowed by modifying the formulas used to update payments each year. Alternatively, or in addition, some of the special adjustments or factors which Medicare takes into account in its hospital payment mechanisms could be reduced or eliminated. Among these are disproportionate share payments which are made to hospitals serving large numbers of low income patients, payments to cover direct and indirect teaching costs, payments to sole community hospitals, bad debt allowances, and payments for inpatient capital-related costs. Some of the impact of reduced provider payments would be reflected in lower provider incomes and greater efficiencies, but beneficiaries could be affected as well. Access could suffer if more distressed institutions were forced to close and others were to offer less charity care. Physicians might be less willing to serve Medicare patients if the gap between Medicare reimbursements and those offered by other third party payers became too large. The pace at which overall quality of care improved might slow. Finally, providers might attempt to offset their reduced Medicare payments by boosting charges to other payers although the spread of negotiated rates and managed care has made this more difficult.

None of these approaches to reducing Medicare costs in the short-run is painless. All would affect beneficiaries, at least indirectly. Given the size of the Medicare savings contained in the proposed budget resolution for fiscal year 1996, probably at least three of these approaches will be required. Yet large as the resolution's savings are, they are not enough to alleviate the fiscal pressures Medicare will feel when the baby boom generation retires.

MEASURES TO REDUCE THE LONG-RUN BUDGETARY BURDEN OF MEDICARE

Profound structural changes will be required to prepare Medicare for the population deluge that will hit after 2010. At this point, however, we must be frank and admit that a good deal of uncertainty surrounds the magnitude of the long-run savings that could result from the types of structural reforms that are being discussed. What we can say with more confidence is that such reforms are unlikely to make a significant contribution to balancing the budget over the next seven years.

Many of the structural reform proposals taking shape are based on the belief that Medicare must be transformed from a single-payer, fee-reimbursement system into one in which participants are given a choice of cost-effective managed care plans offered in a competitive, but managed, market place. Creating such a framework is a complex and difficult undertaking that would involve the following steps.

Establish Market Areas. HCFA would draw boundaries for the market areas within which plans would be offered to all program participants. Preferably these would be multi-county areas which correspond to existing health markets; if appropriate, they would cross state boundaries.

Set a Uniform Basic Benefit Package. To reduce confusion, facilitate comparison shopping, and protect against risk segmentation, HCFA should establish a uniform basic benefit package. To minimize administrative costs, this benefit package should, conform to the average package managed care plans offer to employer groups. To encourage participation, the benefit package should be more generous than the current Medicare package. For example, in addition to lower cost sharing, the package might include prescription drug coverage, more preventive care, and catastrophic stop-loss protection.

Organize the Market. HCFA would have to develop a system through which health plans could submit bids for covering Medicare participants. These bids would have to be evaluated by HCFA to ensure that the plans had the medical capability and financial strength to deliver the services they promised. Information on the price, performance, and consumer satisfaction of the various plans would have to be disseminated to Medicare participants within each market area. Significant consumer protection measures would have to be established because many Medicare participants are vulnerable and not sophisticated buyers able to resist high pressure marketing.

Set the Federal Contribution Rate for Managed Care Plans. The most difficult decision would involve establishing the appropriate level for the federal contribution. This decision will determine the long-run savings that might be generated from a competitive environment. Savings would be maximized if the federal contribution were set at the lowest bid received in each area from a plan of acceptable quality and significant capacity. Such a severe approach would probably be programmatically and politically undesirable. An alternative would be to set the federal contribution somewhere around the level of the average bid. Participants who chose plans costing more than the federal contribution would be required to pay the balance themselves. Those who select plans cheaper than the federal contribution amount could receive either cash rebates or additional services.

Set the Federal Contribution for the Residual Fee-for-Service Plan. Decisions concerning the amount the federal government should contribute for those who remain in the residual fee-for-service delivery system are equally difficult. It is not realistic to expect markets with competing managed care plans to develop in areas with low population densities. Furthermore, some participants in areas where competitive markets exist will have a strong preference to remain in a fee-for-service delivery system. Disproportionate numbers of such participants may be in poor health, heavy users of health care, institutionalized, or very old. It would probably be impossible to ask those remaining in the traditional program to bear the full excess costs of this delivery system even if adjustments were made for health status. Nevertheless, some financial disincentive would have to be imposed on those who had the option of joining a managed care plan but chose not to do so.

Create a Risk Adjustment Mechanism. In the long-run a competitive market for Medicare services can be viable and efficient only if plans compete on the basis of the quality and cost of their services and not on their ability to manipulate risk—that is, to attract healthier-than-average participants or those with a less-than-average propensity to seek care when they are sick. Inevitably, the risk pools of plans will differ and mechanisms will have to be developed to compensate those plans with concentrations of high risk participants for the excess burden they face. Such mechanisms do not yet exist and could take some time to develop.

The steps listed above should be familiar to anyone who followed the health reform debate of 1994 because every comprehensive reform proposal that was presented had to grapple with these same issues. The solutions inevitably involve establishing new institutions and developing new administrative capabilities, and that takes time. Moreover, they raise a number of practical considerations and questions of political viability, several of which are:

- Would it be politically acceptable to provide very different federal contributions in different market areas? Currently, per capita Medicare expenditures adjusted for health status vary a great deal from one region of the country to the next because costs, practice patterns, taste for medical treatment, and the availability of providers varies so tremendously. These differences, however, are not visible. Under the structure outlined above they would be starkly apparent; participants in Minneapolis area might question why, when they paid the same HI tax during their working years, their federal contribution is set at $350 per month while that offered to beneficiaries in the Miami area is over $600.
- Would the various plans become segregated by income? Low income elderly and disabled would enroll disproportionately in plans that charged premiums at or below the federal contribution rate. Middle and upper class participants who could afford to supplement the federal contribution would be more inclined to choose a more expensive plan with more amenities.
- How could the new structure and the Medicaid program be integrated?
- Would it make sense to continue separate Hospital Insurance and Supplementary Medical Insurance Trust Funds if most of the Medicare population was receiving services through capitated managed care plans?

While structural reforms have the potential to generate savings over the long-run, the magnitude of these savings is uncertain. We do not know how much more economical managed care plans might be than Medicare in part because Medicare currently utilizes some of the cost restraining mechanisms used by private plans. These plans have held down costs by demanding discounts, that is, by reducing payments made to providers for services. But Medicare, which pays almost one-third less than private plans for physician services and roughly 10 percent below costs for hospital services, has also relied heavily on discounting.

Another way managed care plans reduce costs is by limiting the number of times participants go for treatment to high-cost setting such as hospitals. In this respect,

there is considerable potential for savings if Medicare participants shift into group and staff model HMOs which have reduced hospital usage the most. Savings can also be realized by minimizing the number of procedures performed on an individual once the patient is admitted. On this score, Medicare's DRG payment system already provides hospitals with a strong incentive to provide no more care than is medically necessary and to shorten hospital stays.

MEDICARE'S ROLE IN FUTURE HEALTH REFORM

Medicare has been left behind by the revolution that is transforming the health plan market. More and more Americans are covered by plans with at least some managed care components. Meanwhile, Medicare remains largely a fee-for-service reimbursement system with price controls. As a matter of principle, it is probably best if the system of coverage for the elderly and disabled is similar to that which provides coverage to the balance of the population. This would reduce confusion and minimize the possibility that providers will face different incentives from two different systems. If incentives are not the same, differences in access or in the quality of care or hidden cross subsidization could become problems.

The time has come to gradually transform Medicare into an insurance plan and delivery system that more closely resembles the ones that are evolving in the market place for the non-Medicare population. If this is done, Medicare could lead the nation on its way to a new health care structure. The institutions, administrative capabilities, risk adjustment mechanisms, quality evaluation systems and other elements that will eventually be required to develop a more competitive and efficient health insurance market can be developed and tested by Medicare. Ironically, this is a total reversal of the order of reform embodied in the health proposals of 1994.

Thank you.

PREPARED STATEMENT OF JOHN W. ROWE, M.D.

Thank you for this opportunity to testify on the mission of the Medicare Program. I am a geriatrician not an economist and serve as President of the Mount Sinai School of Medicine and President of The Mount Sinai Hospital and Health System. Mount Sinai, one of the nation's largest academic health science centers, serves an urban population that includes a substantial proportion of disadvantaged individuals who are Medicare beneficiaries.

In its 30th anniversary year, substantial congressional scrutiny is being placed on Medicare as continued increases in health care expenditures for older persons threaten the solvency of the program. I am confident the system can be reformed to achieve the savings needed to maintain fiscal integrity. As has been pointed out by several analysts, the fiscal instability of the Medicare program is a chronic not an acute illness and relatively moderate modifications in the program can successfully avert its threatened solvency.

We are entering a period of risk in Medicare that goes beyond fiscal solvency. The current preoccupation on reductions in expenditures has blurred our view of the broad mission of the program. Medicare is not just another insurance program, it has a broader mission, has made greater promises and commitments and serves a group of Americans who have substantially greater health care needs than their younger counterparts. Fiscal modifications must be undertaken in the context of a thorough understanding of the missions of the program to avoid adverse effects on those the program is designed to serve. We should, in brief, honor the first principle of medicine, Primum Non-Nocere; above all, do no harm.

Any analysis of the Medicare program or any other health program for that matter, must consider three aspects—cost, quality and access. As cost is receiving more than its share of attention, I will focus my remarks on the neglected but essential areas of quality and access. In doing so, I will discuss quality and access as they relate to Medicare's recent quality-of-care initiatives, geriatric education, palliative care, and the health care institutions that serve as the dominant source of care for many elderly.

The quality of health care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes, consistent with current professional knowledge. In 1990, the Institute of Medicine, acting in response to the request of Congress, convened an expert panel which reviewed the quality assurance programs in Medicare and issued a broad-ranging widely-respected report calling for a number of new Medicare initiatives to assess and assure the quality of care. The Health Care Financing Administration has accepted this challenge and established Medicare's Health Care Quality Improvement Program, incorporating state- of-the-art principles and techniques of quality management into

Medicare. The program, includes efforts to measure quality, to foster continuous quality improvement, to assess and assure the effectiveness of clinical initiatives in the elderly and to assist consumer choice. One very significant change that occurred in the context of these quality initiatives was Medicare's broadening its concern from the individual patient to also include the older population. Medicare should assess and assure the quality of care and health status not only of older individuals who present for care, but of the entire older population. This is essential work which will assist the efforts of practitioners and institutions who are delivering preventive, as well as therapeutic services to older individuals.

I am concerned that these new, important programs which promise to reduce costs by reducing overuse and misuse of services in the elderly, as well as correcting underuse of services which permits progression of disease and ultimately greater expenditures, will be eliminated by the current focus on cost reductions. Too often, in budget cutting, a convenient approach is "last-in, first-out," with the most recent program additions often those most promptly unfunded. Any initiative to reduce the quality initiatives in Medicare would be a risky, short-sighted strategy with long and intermediate-term increases in costs.

A second aspect of quality of health care in the elderly regards the training of physicians in geriatrics—the area of medicine that deals with the diagnosis, treatment and management of health care in older persons and the older population. Proper care of older individuals requires special education and training. The elderly are not just old adults any more than children are just young adults. The physiologic changes that occur in organ systems with advancing age have a substantial influence on the presentation of disease late in life, its response to treatment and the complications that ensue. Similarly, proper diagnosis and treatment of many diseases common late in life, such as Alzheimer's Disease, incontinence, falling, osteoporosis, depression and the like, are often not included in the core of general medical education in this country. This is an extraordinarily important and often neglected area in which the United States is far behind other nations. One measure of the degree of neglect of geriatric medicine in the United States is that the Mount Sinai School of Medicine, where I serve as President, is the only medical school out of 127 in the United States of America that has a formal established department of geriatric medicine. In the United Kingdom every medical school has a department of geriatrics.

Education in the proper diagnosis and treatment of older persons, the body of information which is generally assumed under the term, "geriatrics," is a cornerstone of any strategy to achieve our goal of accessible, cost-effective high-quality health care for all older Americans. Far too few individuals adequately trained in geriatric medicine work in academic settings teaching the next generation of physicians the core principles of geriatrics. The Institute of Medicine has concluded that in addition to the major current deficits in the supply of faculty for teaching and conducting research in geriatrics, that recruitment and training efforts underway currently will fall far short of producing enough skilled geriatricians to form a "core" for improved geriatrics education. Studies by the Institute of Medicine, one of which I chaired, have identified a number of barriers to the development of geriatrics including inadequate payment for provision of the health care services of geriatricians by the Medicare program. This lack of support erodes the base of teaching programs in geriatrics and hinders the development of the substantial cohort of physicians sophisticated in this care. Despite the striking need for more geriatric trainers and geriatricians, one current proposal would discontinue the current Medicare policy of providing hospitals with support for physicians training in geriatrics! It would seem that a primary goal of the application of funds from the Medicare Trust Fund would be to assure that American medicine includes a cadre of individuals whose training imbues them with the knowledge, skills, attitudes and values to provide high quality care for older individuals, as well as a smaller cadre of expert geriatricians to teach the principle of geriatrics to the next generation of American physicians.

I believe that part of the resistance of the Congress to support adequately the development of geriatricians and geriatric programs lies in the myth that geriatricians, because they have advanced training, are specialists. We all know specialists are the center of the target and we need more primary care physicians. Geriatricians are primary care physicians for older individuals. Surveys show that 78% of the care provided by the internista/geriatricians are primary care services and that 90% of the care provided by family physician-geriatricians qualifies as primary care. There is a growing consensus that the medical care of elderly populations should remain primarily the responsibility of primary care physicians appropriately trained in geriatrics. While all these physicians need not have such extensive training to be certified as geriatricians they must be exposed to substantial education in geriatrics during their medical school and residency training. These educational pro-

grams can only be developed and implemented by a core faculty. Such a core group is currently missing in most academic medical centers in the United States and will never be developed if Congress discontinues support for training of geriatricians.

One major aspect of the clinical services of geriatricians that is inadequately supported by Medicare is palliative care—that is humane, comforting, medically- appropriate care of the physical and psychological needs of dying individuals. There is grossly inadequate palliative care in the United States. The principles of palliative care medicine while well-established, are rarely taught and very rarely practiced in American acute care hospitals. A study in 1993 found that only 26% of residency programs in the United States gave any required instruction in terminal care. Our medical culture is one of invasive treatment and we often consider death as failure. Too often we substitute invasive, painful, cruel treatments that demean personal dignity such as urinary catheters, feeding tubes, physical restraints, invasive diagnostic and therapeutic maneuvers and sedating medications (pharmacologic straight-jackets) for the close personal attention that would represent the highest quality care for dying patients. Several studies have shown that pain in those dying of cancer is generally undertreated in American hospitals.

Despite this glaring need, current reimbursement policies under Medicare act to decrease palliative care. Hospital fiscal survival depends on shortest possible length of stay. There is no DRG for terminal care as medical care utilization review has not yet deemed it to be an appropriate inpatient medical function, despite the fact that most Americans die in hospitals. As many terminally-ill patients may be in the hospital several weeks before dying, in many instances life-sustaining technologies are applied to the patients in order to "justify" the continued inpatient stay. This results in inevitable conflicts between proper care of the patient and utilization and review requirements.

Medicare must assure that quality care is extended to those patients who die, as well as those who survive. Real quality care for such patients is not more, less or quicker care, but the right care. Since the majority of medical students and residents in the United States continue to receive most of their training in hospitals, and most deaths occur in hospitals, it would seem appropriate that hospital-based physicians or teaching units be supported by Medicare to provide palliative care training. The Medicare program should move promptly to support initiatives of palliative care, which will provide students and residents with the attitudes, values, knowledge and skills so they can provide the same high quality care for patients who are dying as they do for all others.

The strength of our programs in care of the elderly which influence the training of all students and residents, will be enhanced by proper adjustment of the Medicare payment system such as establishing separate payment codes for the provision of palliative care. Provision of such payments, for services that are essential and are currently rendered by academic geriatricians, will bolster the geriatric programs and perhaps permit them to be sustained rather then having them dwindle under general reductions in Medicare payments.

Lastly, let me turn to the issue of access—an aspect of the mission of the Medicare program which is also often neglected in the ongoing discourse regarding reforming the program. Payments to support training of physicians particularly primary care physicians, partial reimbursement of capital expenditures and provision of support for hospitals that provide care to disproportionate numbers of indigent patients, all guarantee access to care for Medicare beneficiaries. Recent analysis of access by the Health Care Financing Administration demonstrates that there continues to exist very substantial pockets of underserved populations with very limited access to care. These populations are usually indigent and often urban. Few physicians practice medicine in offices based in poor communities in our major cities. For these indigent populations, many of whom are elderly Medicare beneficiaries, the sole or dominant source of care is hospitals. Some proposals currently being discussed to reduce Medicare benefits to hospitals will cripple these hospitals that serve the poor and will dramatically reduce the access to care of Medicare beneficiaries. This will place a large number of older Americans in the absurd position of being eligible for health care services under the Medicare program and not having access to these health care services. Emergence of such a scenario would represent a failure of the Medicare program and a violation of a basic tenet of medicine—Primum Non-Nocere—Above All, Do No Harm.

To assure establishment of proper policies to guide Medicare's future development, in regard to quality and access as well as cost, HCFA should establish Medicare Policy Institutes in academic medical centers where physicians involved in the care of older persons can work with health services researchers and policy analysts to enhance our understanding of policy issues related to the provision of care to older persons. Such clinically-based policy initiatives are much more likely, in my

view, to yield practical, clinically-relevant, non purely economically-based approaches to improve Medicare's achievement of its goals.

In summary the Medicare program can serve its authentic mission and enhance our capacity to provide care for the older population by: (1) continuation and enhancement of the present programs to fund training of geriatricians; (2) sustaining Medicare's Health Care Quality Improvement Program; (3) supporting initiatives in palliative care; (4) sustaining the functional capacity of hospitals which serve a disproportionate share of indigent elderly Medicare beneficiaries; and (5) establishing reality-based Medicare policy institutes.

I appreciate the opportunity to provide this perspective on the Medicare program, and especially those aspects relating to quality and access. I am very confident that attention to these issues and fidelity to the broad mission of Medicare can be achieved within the context of the "belt-tightening" reform and reorganization that will result from the current analysis of Medicare.

PREPARED STATEMENT OF HON. WARREN B. RUDMAN

Mr. Chairman, last month, the Public Trustees of Medicare released their annual report on the status of the Medicare trust fund. Their message was clear and unmistakable: Medicare Part A is on a seven year collision course with bankruptcy. The report went on to stress that even if we do not address the larger issue of national health care reform this year, we must act promptly to correct the unsustainable course of the Medicare system. By ignoring Medicare's obvious difficulties we put the program, the well-being of older citizens, and our nation's economic future at risk. Every year we wait, the problem compounds, and the necessary reforms become more drastic. Thus, we must act now, and we must act decisively, to ensure Medicare's immediate and long-term solvency.

Earlier this month, the Concord Coalition[1] released its updated *Zero Deficit Plan* to eliminate the federal budget deficit by the end of 2002. A key component of the plan is a comprehensive entitlement means test. Under the Concord Coalition plan, Medicare and other entitlement benefits would be reduced using a sliding scale starting at beneficiary annual family incomes of $40,000 or $50,000. For every $10,000 of income above the starting point, beneficiaries' entitlements would be trimmed by an additional 10 percent. Therefore, if a retired couple had $40,000 of income and $15,000 of Medicare and Social Security benefits under the current system, benefits would be reduced by $2,000 a year under Concord's plan. Thus the couple's total income would be $53,000 instead of $55,000. Under our plan, families with incomes of $120,000 or more would still be permitted to receive payments equal to 15 percent of their entitlement.

The administrative mechanisms of means testing Medicare could be dealt with in various ways. For example, most Medicare beneficiaries in the 10, 20 or 30 percent brackets of the comprehensive means test would be able to handle means testing of Medicare by having more deducted from Social Security or other entitlements they are eligible to receive. High income Medicare beneficiaries probably would have to pay in an insurance premium to cover their means test requirement.

Mr. Chairman, means testing is one of the fairest ways to reform Medicare. Many of today's retirees are doing far better economically than their younger neighbors who are paying for their Medicare benefits. In addition, the average retiree today collects many, many times more than the amount contributed during his or her working life. Is it unreasonable to ask the well-off to give up a portion of that return? Is it fair for workers earning far less than $40,000, a number of whom cannot afford health insurance for themselves, to continue to support all of these well-off retirees indefinitely? I say no.

So do most Americans. In fact, when asked, most people approve of "affluence testing" on principle. In fact, opinion surveys show that this approach vastly and consistently outscores any other type of structural entitlement reform. It is preferred, for example, over even such reasonable alternatives as higher retirement ages (which I also support) or so-called "diet COLAs."

Under the current Medicare system, Medicare benefits for the well-to-do are financed, in part, by payroll and income taxes of workers who meet the official definitions of poverty or near-poverty: single mothers doing their best to raise children on barely more than minimum wage; students working their way through college; or couples who are both working, paying child care and double commuting costs and

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[1]The Concord Coalition is a bipartisan grass roots organization with chapters in all 50 states and most congressional districts dedicated to eliminating the federal budget deficit and strengthening the American economy.

still not earning enough to afford a home of their own. It is both unjust and bad economic policy to require these individuals to turn over a large portion of their wages to buy health insurance for retirees who live far more comfortably and securely than they do.

Although reducing benefits for wealthier retirees is commonly thought to be politically difficult, I contend that such a measure would actually strengthen support for Medicare, especially when compared to options that demand dramatic tax hikes on young workers or draconian cuts across the board. A sure recipe for generational war and political revolt is to ask struggling young workers and families to finance an increasing number of wealthy retirees. At The Concord Coalition, we frequently hear from many of these fortunate retirees who themselves are appalled at the thought that they are living off the sweat of those who are economically far worse off than themselves. Many retirees today feel the current entitlement system is a moral and economic assault on future generations. And many of them would be more than willing to accept lower benefits if they were convinced that by doing so they would be contributing to the long term growth and prosperity of our nation.

Until some way can be found to restrain the double-digit growth in our nation's health care costs, the entitlement means test remains fair and equitable solution, especially compared to other options. Some analysts suggest, for example, that we reform Medicare by raising payroll tax rates even further. Raising taxes is clearly an unacceptable alternative. Payroll taxes are already too high. Nearly three-quarters of our population has more taken out of their paychecks for combined employer/employee FICA taxes than for income taxes. For young people, this is true for 9 in 10. Relying on tax increases alone to balance Medicare Part A would require a 4.5% payroll tax hike in 2001 (on employers/employees combined). Our nation's workers and our economy cannot afford such a burden.

Others advocate further restrictions on payments to health care providers. We have gone this route many times already, and I suspect that we are getting near the outer limits of this strategy. Health care providers have already become adept in adjusting the volume of services provided to compensate for reimbursement reductions. Furthermore, at some point providers will simply decline to provide services at reduced levels of Medicare reimbursement.

Tightening up on Medicare waste, fraud, and inefficient administration are attractive options that obviously should be pursued; however, they do not promise anywhere near the level of savings required to put Medicare on a healthy footing. We believe that a managed care model applied to the Medicare population across-the-board, with appropriate financial disincentives for those who do not enroll in managed care, could produce substantial savings. However, estimating the precise level of those savings is, at this point in time, more an art than a science.

In addition to imposing a comprehensive entitlements means test, The Concord Coalition recommended several changes in the Medicare Part B program:

1. Raise Part B premium to 30 percent: The share of Medicare Part B costs paid by enrollees was originally established in the 1960's at 50 percent. This declined to less than 25 percent by the early 1980's. Currently it is set at 30 percent of benefits but will decline again under current law. By 2030, if left unchecked, the premium would cover only 8 percent of program costs and general revenues would have to pick up the remaining 92 percent. The Concord Coalition recommends that Part B premiums be maintained at the present 30 percent of program costs. This provision would not affect enrollees with income below 120 percent of the federal poverty threshold because they are eligible to have Medicaid pay their Medicare premiums. Alternatively, Part B premiums could be related to retirees' incomes; however, the Concord Coalition's Zero Deficit Plan did not recommend this because it overlaps with the comprehensive entitlement means test. As the Part B premium is considered, it should be remembered that program costs not covered by premiums are paid from general revenues. The payroll taxes cover part A. But when it comes to the Part B Supplementary Medical Insurance, the "I-earned-it" objection simply doesn't wash.

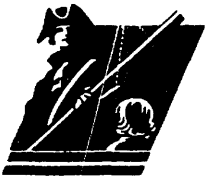
2. Raise Part B deductible to $150: In 1966, the amount enrollees must pay out-of-pocket each year before the government shares responsibility was set at $50, an amount equal to $225 today if it had been adjusted for inflation. The deductible has been increased only three times since then, and now stands at $100. The Concord Coalition recommends raising the annual deductible to $150 and indexing it to the rate of growth in Part B charges per enrollee.

3. Require 20 percent copayments for home health and clinical laboratory services: Currently no copayment is required for these services, whereas enrollees must pay 20 percent of the cost of other covered services.

These reforms to the Part B program, along with the means testing proposal, constitute a fair and gradual start toward reforming Medicare and reducing the federal

deficit Under the Concord Coalition plan, the total seven-year savings from Medicare comes to $85 billion, plus another $25 billion from means testing, for a total of about $110 billion over seven years. The reason Concord's Zero Deficit Plan requires so much less from Medicare than either the House or the Senate budget resolutions is that our budget plan leaves no part of the federal budget untouched. We would subject Social Security to the comprehensive entitlement means test along with the other entitlements and would begin to gradually shift gradually to a retirement age of 68. We would also a couple of billion dollars below the current path of defense spending.

Mr. Chairman, the Medicare programmatic and means testing recommendations proposed by The Concord Coalition in its Zero Deficit Plan unfortunately represent only a short term fix that will stave off trust fund bankruptcy and federal budget deficits for a few more years. However, we will not be able to say the job is complete until national health care costs have been brought under control and our entitlement programs have been recalibrated to prepare for the demographic tidal wave that will crash down upon us in about 15 years. The benefit of all the short term painful budget choices required to balance the federal budget by 2002 will be in vain if we don't use the next few years to address the inevitable long-term health reforms that must be made. In short, when it comes to federal health care entitlements and the underlying cost drivers that push them relentlessly upward, doing nothing is not an option. The current system is unsustainable.



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Additional Comments from the Hon. Warren B. Rudman
Co-Chair, The Concord Coalition[1]

Before the Senate Committee on Finance
Wednesday, May 17, 1995

During my testimony, a number of very important questions arose concerning the effects of means testing entitlement programs. A detailed explanation of The Concord Coalition's means test is given in the *Zero Deficit Plan*. our plan for eliminating the federal budget deficit by 2002. Contained here is an attempt to quantify some of our policies and to help focus the debate on restructuring Medicare.

The means test included in the *Zero Deficit Plan* would be phased in beginning at $40,000 of family income and save a total of $136 billion over seven years. Fifty-five percent of the savings would come from Social Security, saving $75 billion, and 29% would come from Medicare[2], saving $40 billion.

The means test, as it is described in the *Zero Deficit Plan,* does little to prolong the sustainability of the Hospital Insurance Trust Fund because it is phased in gradually so as not to impose abrupt changes on current beneficiaries. Currently the fund is projected to be bankrupt in 2002; under the *Zero Deficit Plan's* phased in means test, the fund's balance becomes negative in 2003. If means testing were implemented immediately, the fund's balance would remain positive until 2006.

The Concord Coalition is concerned with eliminating the federal budget deficit, not just in the year 2002, but indefinitely. This task not only involves bringing spending and revenues in line, it involves addressing entitlements and their growing commitments. If entitlements are not addressed. all of the hard work done to balance the budget will be meaningless. As Social Security and Medicare are presently structured, both are on collision courses with bankruptcy. We could balance the budget by 2002, just to be faced with mounting deficits all over again from

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[1] The Concord Coalition is a bipartisan grass roots organization with chapters in all 50 states and most congressional districts dedicated to eliminating the federal budget deficit and strengthening the American economy.

[2] Part of the Medicare savings from the means test would be attributable to Part A and part to the portion of Part B that is not financed by premiums. Though there is no available data on the precise break-out of these savings, most of the savings would be applied to Part A.

increases in spending in these two programs.

In the Medicare debate, much of the focus is on the date that the Hospital Insurance Trust Fund goes bankrupt -- when it no longer shows any balances remaining from excess taxes paid in previous years. As pointed out above, this year is 2002 if no changes are made to the program, 2003 if a means test is gradually phased in, and 2006 if the means test is implemented immediately.

But this point of focus arises from the misguided belief that there is a trust fund filled with government IOUs. Let's look at this problem realistically. The trust fund is already empty. The dollars were spent years ago. How is a government that is struggling to balance its budget going to find well over $100 billion dollars between now and 2002 to make good on the obligations to the trust fund?

The real day of reckoning is not the day the imaginary trust fund uses up its last remaining resources, it is the day that revenues to Medicare Part A fall below the program's level of spending. Payments will then have to come from general government revenue or borrowed money rather than payroll taxes. **This real day of reckoning will not occur in 2002, it will occur in fiscal year 1996.**

Immediately implementing the means test rather than phasing it in would postpone the time when Medicare outlays exceed revenues by three years. This policy would allow time for an extensive plan to overhaul the program to be developed, so that the onsetting crisis would not destroy all the work that is being done to balance the budget.

On the other hand, abrupt implementation of the means test would cause severe dislocation and perhaps hardship for retirees who have not planned for these changes. The six-year phase-in proposed by the Concord Coalition would allow retirees and those approaching retirement a few years to adjust their financial affairs. Although the Medicare Trust Fund turns negative sooner if the means test is phased in than it does if the means test is implemented "cold turkey", once the means test is fully in effect, in year 2002, it would provide substantial relief to the Trust Fund. The Trust Fund's annual shortfall of income compared to costs would by reduced by $15 billion in 2002, and by gradually increasing amounts in succeeding years. Thus, while the means test would not cure the Medicare solvency problem, whether implemented suddenly or gradually, it would provide substantial relief.

Chart 1
Outlays and Revenues of the Hospital Insurance Trust Fund, 1994 - 2002

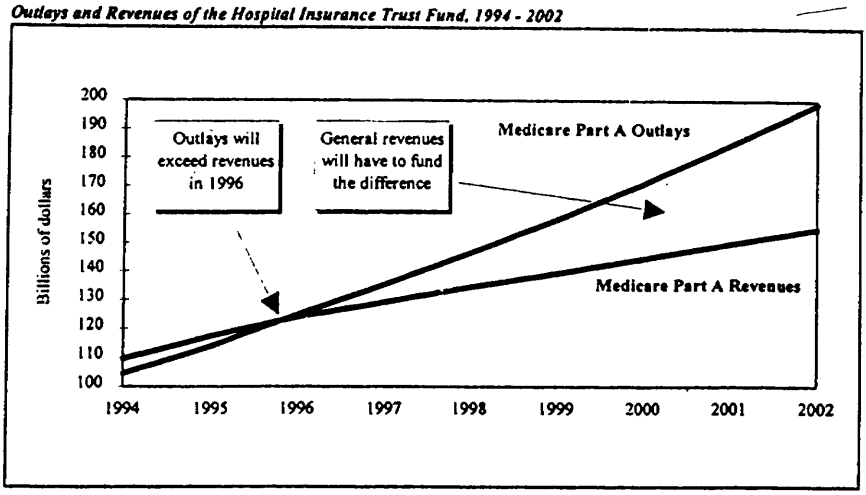
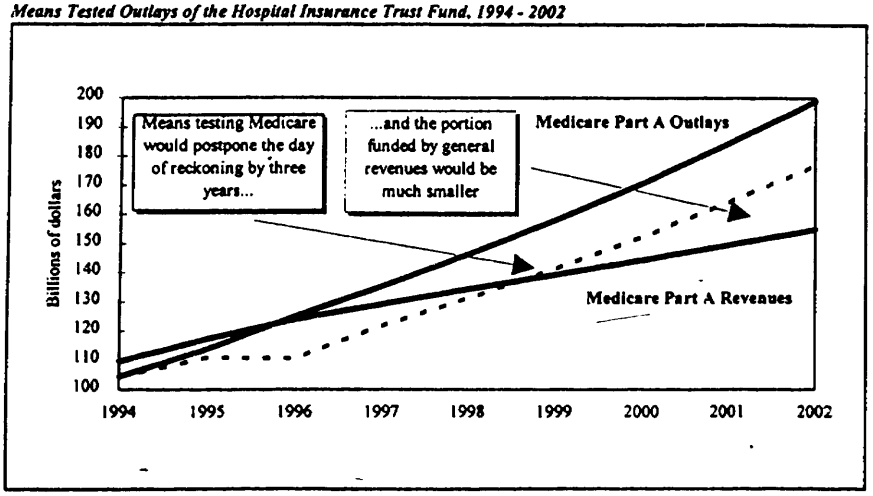


Chart 2
Means Tested Outlays of the Hospital Insurance Trust Fund, 1994 - 2002



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 don't address the issue of entitlement reform.

The total cost of entitlement programs, which include Social Security, Medicare, Medicaid, 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 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 chance, 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 per cent.

I also believe that seniors who are more "well-off" should be required to pay a larger share of their premium if they 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.

My proposal would phase in a reduction in the Part B premium subsidy for enrollees with incomes above $40,000 for couples and $30,000 for individuals, with income thresholds indexed for general price inflation.

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 have to start getting serious with those who don't need to have their incomes subsidized by younger generations of working Americans.

PREPARED STATEMENT OF C. EUGENE STEUERLE

Mr. Chairman and Members of the Committee:

In my testimony today, I would like to present some reasons why we, as a society, must face up to the problems created by the high rate of growth in government health expenditures, including Medicare. My discussion, however, is not about cutting Medicare. The Medicare health benefit package offered tomorrow will be much more valuable than the one granted today, which, in turn, is much more valuable than the one available yesterday. When the members of this panel and this commit-

tee retire on Medicare, for instance, we can expect to receive far better and more advanced medical services than current retirees.

The issue confronting us as a society is whether government continuance of a relatively high rate of increase in health care consumption—a rate that has its greatest impact on future retirees and future taxpayers, not today's retirees—is worth the costs being imposed on all parts of society. The current unsustainable rate of growth in health expenditures, in my view, is helping to support a disinvestment in our nation's and our children's future. A comprehensive approach to reform ideally would go beyond Medicare, take a broad view of our social needs, and then budgetarily allocate resources where needs and government ability to meet them were greatest.

MEDICARE AND HEALTH VERSUS EVERYTHING ELSE IN THE BUDGET

Many aspects of the growth in Medicare and other health expenses is automatic, determined almost accidentally by previous designers of government health insurance. If the health budget were forced to compete on equal terms with other items in the budget, I doubt seriously that any member of Congress or of the public would vote to put so many additional resources in health in preference to almost everything else.

Let us take the Clinton 1995 budget projections to demonstrate growth for different items of the budget (Figure 1). As a percentage of gross domestic product, the story is simple: Medicare and other health spending would continue to go up at rapid rates, almost everything else would go down. Put another way, a lower tax rate on total income would be required to support everything else; a higher tax rate would be required to support the Medicare and health budget.

Lest one attribute these trends only to President Clinton's budgets, the second term of President Reagan and the Presidency of George Bush show very similar characteristics. Is increasing spending on health care the most important need that government should be addressing? The federal government's budgets say so year after year. These budgets choose health care over educating our youth, helping children who now have the highest poverty rates in the population, preventing crime, restoring promise and order in some of our central cities, or simply allowing individuals to keep more of their tax dollars. I don't mean to imply that making other budget choices is easy. We are on a path, however, that almost no one would choose, not even as a compromise.

EXTENT OF INCREASE

Medicare expenditures per elderly person have been rising quite rapidly. In real terms (that is, after taking out the effect of general price inflation) Medicare expenditures per person rose from less than $1,500 per recipient in 1970 to about $5,000 today and are scheduled to rise above $10,000 just after the baby boom generation begins to retire. Even these figures understate federal support for the health care of the elderly, for they exclude such categories as long-term care under Medicaid and veterans assistance.

We can also examine these figures on a lifetime basis by measuring the approximate cost of purchasing Medicare health care benefits if they were paid for with an up-front deposit with a private insurer. For a couple retiring in 1970, the lifetime value of benefits would be about $65,000; for one retiring today, about $230,000; and for one retiring in 2010, over $350,000—again excluding general price inflation (Table 1). These increases are due not simply to cost increases but to more years of support as individuals live longer, but are not expected to work longer.

Partly because Medicare costs are growing so fast, almost no past or current retirees, even the richest members of society, have been asked to pay for their benefits. Instead, the costs have continually been shifted to their children. Take a two-earner couple, one spouse with high income, one spouse with average income, who retired in 1980. Their benefits are estimated at close to three times the value of their taxes and premiums; they are projected to receive about $57,000 more than they contributed to the system, counting interest on those contributions (Table 2).[1] For a one-earner couple with a high-wage worker retiring in 1995, net transfers—benefits over and above taxes—are projected to be over $100,000. Of course, these net transfers to everyone, including the rich, cannot continue. The costs of the system must eventually be covered and not simply by continual increases in rates of taxation on future generations. Indeed, Medicare is designed eventually to be fairly progressive,

[1] Note that the benefit in Table 1 is somewhat higher than that of Table 2. The former calculates value at age 65, whereas the latter takes into account the probability of death before age 65.

since a proportional tax over a broad range of income is used to pay for a benefit that does not vary by income.

While these projections of future costs reflect an impossibility scenario, they still demonstrate the substantial size of Medicare benefits from a lifetime perspective. When both Social Security and Medicare benefits are counted together, the lifetime value of benefits approaches $1/2 million for an average-wage couple retiring today. Excluding inflation, the total is scheduled to exceed $1 million for some high—income couples retiring a few decades into the future.

ARE WE GETTING OUR MONEY'S WORTH?

In addition to worrying about the size of these transfers, government should pay some attention to whether it's getting value out of each dollar it pays. One of the difficulties with government's current methods of purchasing in-kind benefits such as Medicare is that much of the transfer may not accrue to the benefit of the intended recipients. As an example, in 1993 total Medicare spending was estimated to equal $154 billion. Had medical prices since 1965 only risen as fast as the price index for other goods and services, however, the same amount of medical services could have been purchased in 1993 for $86 billion. Without this excess medical inflation, government could have purchased $68 billion more in goods and services without raising taxes or could have lowered taxes by $68 billion without reducing the amount of goods and services provided. Although measures of health price inflation must be viewed with much caution, these figures make fairly clear that a substantial share of higher government outlays for Medicare went to providers in the form of higher payments rather than to beneficiaries in more or higher quality health care.

Obviously, Medicare is not responsible alone for this excess inflation. The design of most insurance, private and public, has been faulty in a variety of respects. In my view, one of the principal problems has been the tendency of both government and employers to hide from individuals how much they are paying for health care even at the time of insurance purchase. In this way, the public is kept out of participation through informed choice of how to spend their wages and tax dollars and how to allocate their government benefits. Government programs, counting tax subsidies, provide more than one-half of the more than $10,000 per household per year that is being spent on average for health care in the United States. Therefore, while not fully responsible, these programs are hardly immune from responsibility for the growth in health care costs.

UPCOMING PROBLEMS: MEDICARE SHORTFALLS AND DECLINES IN WORKERS-TO-RETIREE RATIOS

The budget problems within Medicare are glaring and immediate. The Medicare trust funds are scheduled to run out of money just after the turn of the century. The trustees of Medicare have continually warned about this shortfall. To make matters worse, this depletion of the Medicare trust fund occurs during a period of reprieve—when the number of new elderly is relatively small, due to the retirement in this decade and the next of the baby bust population born during the Depression and World War II.

Once the baby boomers retire—and some hit age 62 in as little as 13 years—the worker-to-retiree ratio drops swiftly and dramatically. Even if health costs were almost totally under control and were rising no faster per person than real income in the economy, Medicare costs would still grow from a little more than 2 percent of gross domestic product today to a little less than 4 percent by 2030. Under intermediate Social Security assumptions that include higher levels of increase in health costs, Medicare outlays will increase by more than 5 percentage points of GDP and will more than triple relative to the size of the economy. The demographic shift, of course, hits Social Security, as well as Medicare. If taxes are kept constant relative to income, and all other expenditures are kept constant, projections performed by Jon Bakija and myself at the Urban Institute, then by the Bipartisan Commission on Entitlement and Tax Reform, show deficits rising to unsustainable rates like 10 percentage points of GDP.

THE SAVINGS ISSUE

Some researchers—including my Urban Institute colleague, John Sabelhaus, and Laurence Kotlikoff of Boston University—now believe that growth in Medicare and other government health spending is partly responsible for the decline in the nation's savings rate. One reason, of course, is that the federal deficit keeps rising along with these costs. The current design of Medicare, however, tends to reduce private saving as well. Remember that younger members of society are contributing

more and more for retirement and health programs, but those contributions for the most part are not being saved. In the case of health care, these taxes or contributions are transferred and spent almost immediately. Interestingly, while the decline in income transferred by younger workers is recognized by them, the significant increase in the value of Medicare—and, hence, real income transferred—is often ignored by the recipients. That is, since the costs of health care are seldom recognized individually, many view themselves as having health insurance today just like they had yesterday. In fact, a societal choice is being made to transfer significantly greater income every year in the form of health care benefits. Whereas the young have less income out of which to save, however, those receiving health care transfers simultaneously consume all of their health care transfer.

When the federal budget is examined as a whole, it, too, has become increasingly consumption-oriented—largely because of increases in the share of the budget devoted to health. This share has risen from 2.1 percent in 1962 to 11.1 percent in 1980 to 19.8 percent in 1995 and toward 23.3 percent by 2000. Retirement and health now comprise about half of the federal budget. Interest and defense comprise another 30 percent of the total, while less than 20 percent is devoted to everything else. The attempts of different policy makers, Republican and Democrat, to "invest" in education or research and development credits or similar items have been quite trivial in their impact relative to the vast amounts spent on health care. Reflecting this consumption/investment shift even further, President Clinton's current budget asks for substantial increases in health care consumption as a percentage of GDP, but cuts in health care research as a percentage of GDP.

DESIGNING PROGRAMS FOR THE ELDERLY IN A COMPREHENSIVE MANNER

In an environment of "reinventing" and redesigning government, it is often dangerous to place different government problems into separate compartments. While perhaps useful during a period of expansion, broad reform of government often cannot be achieved as well when choices are constrained compartment by compartment. Such fragmentation often puts off the table some of the broad trade-offs that might offer a fairer or more efficient government and, hence, be more acceptable to all sides.

Narrowing of options may also be a major obstacle to the reform of Medicare. In my view, for instance, it is a mistake to treat Medicare Part A separately from Medicare, Part B, from Medicaid, long-term care, and even from Social Security cash payments. A better approach, it seems to me, is to figure out the best package of benefits that can be given to the elderly at a given cost, and then to divide that package across functional areas in the most practical and administrable manner.

From a tax perspective, the cost of health care for the elderly—much less all programs for the elderly—are not covered by earmarked Social Security taxes. General revenues support Part B of Medicare, Medicaid long-term care, and even Part A through a fairly generous formula of attribution of income taxes on some Social Security benefits to the Medicare trust fund.

Partly because of the open-ended nature of Medicare, the entire package of programs for the aged has become increasingly health-dominated. Until the mid-1960s, all Social Security payments were in the form of cash. Even after the adoption of Medicare, cash payments were dominant: they comprised about 82 percent of total Social Security plus Medicare expenditures as late as 1970. Today, however, cash payments have fallen to about 68 percent of total Social Security plus Medicare expenditures, and they are expected to fall to about half of total expenditures by 2010.

The shift from cash to in-kind benefits dramatically changes the character of Social Security and threatens to distance it from its original purposes. Initially thought of as a means of providing the elderly with annuities that would give them freedom to choose how to live their last years with dignity, Social Security as a whole is being converted to one where a much greater portion of their benefits are not under the control of recipients. With Medicare, the government increasingly is directing what the elderly spend, how they spend it, at what price the spending can occur, and how producers must supply the goods and services they receive.

If Social Security and Medicare are considered as an integral whole, I believe that we would be less likely to continue the trend toward increasing real Medicare benefits even while we cut cash benefits. Some worthwhile trade-offs would become more apparent, including an increase in cash benefits for some, especially the poor elderly, in exchange for a more tightly controlled expenditures in Medicare. In this regard, note that despite vast improvements in the well-being of the elderly, the United States still has one of the highest poverty rates for the elderly in the industrialized world.

As I indicated above, I believe that we would also get better insurance choices if individuals were acquainted with just what they are paying for that insurance. Thus, we ought to be honest with Social Security recipients by indicating to them the real cost of their health insurance at the same time that we send them their Social Security checks. My guess is that they, too, would begin to question whether they are getting their money's worth out of Medicare and would be more willing to consider alternative packages of benefits.

The failure to treat Medicare and Social Security in a more comprehensive manner has resulted in some questionable policy shifts. For instance, there is now a scheduled increase in the normal age of retirement for Social Security, but not for Medicare. While whittling away at the earnings test applying to cash benefits, moreover, Congress has established a new and more powerful health earnings test—the requirement Medicare be a "secondary payor" relative to health insurance provided by employers of 20 or more workers. This latter requirement creates enormous pressure to retire—and for employers to encourage early retirement—even when individuals have much to contribute to the economy.

CONCLUSION

The health care package we offer tomorrow will be much more generous and rich than the one we offer today. There is almost universal agreement, however, that the current system, with its extraordinary demands on both trust funds and general revenues, cannot be sustained. Even if such levels of spending were possible, as a society we must ask ourselves whether it is in the best interest of all members of society to spend continually higher shares of our national income on health care consumption. I believe that if budget rules were really neutral toward all choices, we would identify other needs and investments—both for this and future generations—that deserve equal or greater attention.

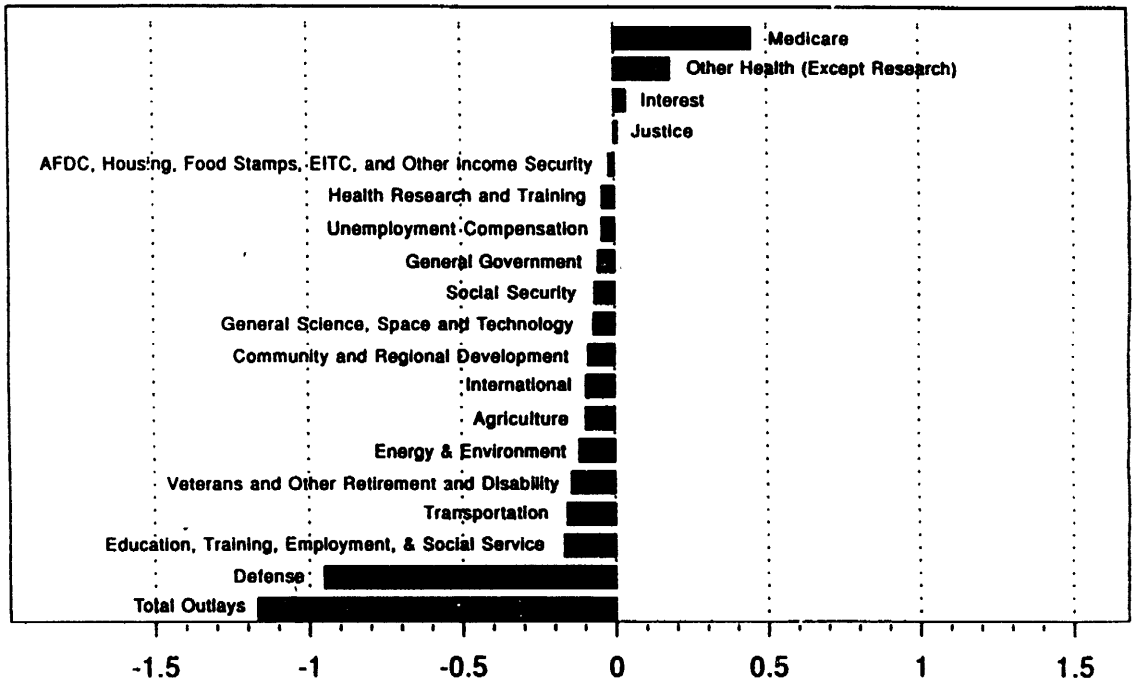
Table 1: Annual and Lifetime Medicare Benefits

(In Thousands of Constant 1993 Dollars)

Year Cohort turns 65	Avg. annual Medicare benefit per enrollee	Actuarial present value at age 65 of lifetime Medicare benefits for a couple
		(at age 65)
1970	1.4	66.3
1980	2.3	114.8
1990	3.7	186.1
1995	4.8	231.6
2000	6.4	278.6
2010	9.9	355.7
2020	11.5	428
2030	13.2	497.1

Notes: Data are discounted to present value at age 65 using a 2 percent real interest rate. Table assumes survival to age 65. Each recipient is assumed to receive Medicare insurance benefits, in every year after age 65, which equal the average Medicare outlay per enrollee in that year. Projections are based on the intermediate assumptions of the 1993 Social Security Board of Trustees reports, adjusted by the authors for estimated impacts of 1993 enactment's. Subtracting out Medicare premiums paid by retirees would reduce these figures slightly; they offset about 10 percent of total Medicare costs in 1990.

Figure 1: Projected Change in Federal Outlays, 1995-2000 (Percentage Points of GDP)



Mortgage Credit, Postal Service, Deposit Insurance, Other Advancement of Commerce, Undistributed Offsetting Receipts, and Allowances are not included in the categories but are included in Total Outlays

Gene Steuerle and Gordon Mermin, THE URBAN INSTITUTE

Based on data from the Budget of the United States Government FY 1996

Table 2: Lifetime Medicare Benefits, Taxes, Premiums, and Transfers

(In Thousands of Constant 1993 Dollars)

Year cohort turns 65		Single male			Single female			One-earner Couple			Two-earner couple		
		Low wage	Avg. wage	High wage	Low wage	Avg. wage	High wage	Low wage	Avg. wage	High wage	Low & low	Avg & low	High & low
1980	Benefits	32.7	32.7	32.7	53.8	53.8	53.8	86.5	86.5	86.5	86.5	86.5	86.5
	Taxes and premiums	7.6	10.5	13.2	13.0	16.1	19.2	18.2	21.1	23.8	20.7	23.5	29.5
	Net Transfer	25.1	22.2	19.5	40.8	37.7	34.6	68.3	65.4	62.7	65.8	63.0	57.0
1995	Benefits	75.0	75.0	75.0	110.7	110.7	110.7	185.7	185.7	185.7	185.7	185.7	185.7
	Taxes and premiums	23.3	34.7	57.6	33.5	45.6	70.2	47.5	59.0	81.7	57.1	68.5	104.6
	Net Transfer	51.7	40.3	17.4	77.2	65.1	40.5	138.2	126.7	104.0	128.6	117.2	81.1
2010	Benefits	124.7	124.7	124.7	171.4	171.4	171.4	296.1	296.1	296.1	296.1	296.1	296.1
	Taxes and premiums	47.3	78.1	154.7	61.0	93.3	173.8	83.0	113.8	187.6	106.4	139.4	252.1
	Net Transfer	77.4	46.6	-30.0	110.4	78.1	-2.4	213.1	182.3	108.5	187.7	156.7	44.0
2030	Benefits	179.8	179.8	179.8	242.9	242.9	242.9	422.7	422.7	422.7	422.7	422.7	422.7
	Taxes and premiums	87.2	160.8	383.0	106.6	183.7	416.6	131.4	204.6	414.8	197.0	276.2	599.8
	Net Transfer	92.6	19.0	-203.2	136.3	59.2	-173.7	291.3	218.1	7.9	225.7	146.5	-177.1

Notes: All amounts are discounted to present value at age 65 using a 2 percent real interest rate. Adjusts for chance of death in all years after "Taxes and premiums" include actuarial value of all employer and employee HI payroll taxes, all SMI premiums, and estimated portion of federal income tax burden devoted to financing SMI. Projections based on HCFA 1993 intermediate assumptions, adjusted by the authors for the estimated impacts of 1993 enactments. Assume HI payroll taxes are set at rates necessary to keep the system solvent on a pay-as-you-go basis after 1995. SMI premiums are assumed to remain tied to 25 percent of program costs after 1995. Recipients are assumed to receive Medicare insurance protection, in each year after age 65, which equals in value the average Medicare outlay per enrollee in that year.

COMMUNICATIONS

STATEMENT OF THE AIR FORCE SERGEANTS ASSOCIATION

(SUBMITTED BY CHIEF MASTER SERGEANT JAMES D. STATON, USAF (RET.) EXECUTIVE DIRECTOR)

Mr. Chairman and distinguished members of the committee, millions of senior citizens who are retired from the military, the majority of them enlisted (non-commissioned), are concerned about how Medicare reform will affect them. I am testifying on behalf of the Air Force Sergeants Association's 160,000-plus members. AFSA represents the millions of enlisted active duty and retired Air Force, Air National Guard and Air Force Reserve members, and their families. Many of our members have served their nation, have entered their retired years, and are now among those currently receiving care through the Medicare system. We appreciate this opportunity to include AFSA's views in your important deliberations.

We are well aware of the important challenge faced by this committee, greatly appreciate your focus on controlling costs and improving care, and are sensitive to the enormous growth in Medicare expenditures in recent years. The overall costs and fees for service become especially significant for our members because enlisted military retirees are among the lowest-paid annuitants. As such, significant medical bills can be devastating for this group of retirees. As you are looking at ways to control costs and improve care in the system, we would like to suggest an important money-saving possibility.

Our suggestion is that the committee support Medicare subvention: The transfer of funds from the Department of Health and Human Services (HHS) to reimburse the Department of Defense (DOD) for care received by Medicare-eligibles either in TRICARE or at Military Treatment Facilities (MTF) (on-base medical care facilities). The question is not spending HHS dollars versus DOD dollars; the real possibility is to save taxpayer dollars by the non-parochial transfer of funds.

As this committee looks at ways to incorporate managed care ideas into the Medicare system, great consideration should be given to allowing Medicare-eligible military retirees to remain in the Military Health Services System through the TRICARE program. This three-part system, DOD's health care plan of the future, is currently available only to under-65 military retirees and their dependents, and active duty family members. TRICARE includes an HMO option, TRICARE Prime. Prime's enrollment fee and cost-shares also provide lower-cost care than traditional "fee-for-service" care associated with Medicare Part B insurance.

The lower pension income of enlisted military retirees and their survivors magnifies the issue of health care costs. The TRICARE program promises to offer enrollees much lower costs than current fee-for-service insurance programs. Additionally, military retirees would be allowed to stay in the MHSS for life as they were promised when they served their nation. At the same time, costs for their care would be reduced.

Another advantage in cost-savings would be that HHS would spend fewer dollars for the care it buys at MTFs than it does from civilian providers. Savings on-base are derived through the military's "utilization management," which is preventive in nature. This DOD—(more) unique system gives the right treatment in the right place at the right time. This heads off more serious treatment problems and thereby holds down costs. Also, the cost of physicians is significantly tempered by the military rank structure. Finally, MTFs already have an infrastructure in place, so the basic care components are there. The results, when comparing MTFs to civilian providers, are savings in costs, overhead and mark-up fees.

However, on-base care opportunities are very limited for Medicare-eligibles. Whereas all military retirees are eligible to seek space-available care at MTFs, most are viewed differently after they are forced to transition from CHAMPUS (soon to

be TRICARE) to Medicare. In practice, MTF commanders are facing smaller and smaller budgets, and our older members tell us that space-available care has been increasingly denied for Medicare-eligibles because of a lack of treatment funds. Thus, AFSA feels that the practice of Medicare subvention would make on-base care more likely for our older retirees and, at the same time, save program costs by reducing the level of Medicare expenditures for military retirees.

To put the need for subvention in proper context, consider that for years, military members were told at every re-enlistment that when they retired, they and their family would have free health care for life. Enlisted retirees, especially, considered this a part of their deferred compensation package. Over the years, that promise has been broken. At age 65, they are abruptly prohibited from formally participating in military health care programs altogether. This practice must end, not just because it is discriminatory, but also because it shatters already-broken promises.

DOD leaders have repeatedly supported subvention for Medicare-eligible retirees. Now is the time to make it happen.

Mr. Chairman, again, thank you for this opportunity to express our ideas on ways to lower the costs associated with the Medicare system. As you are investigating the numerous facets of the problem, we would ask you to give serious consideration to AFSA's ideas on the matter. Approving ways to keep all retirees in the military health system is not only cost-effective, it also keeps a promise made to retirees, i.e., that they would have lifetime, affordable care as part of the military family.

The men and women of the Air Force Sergeants Association wish you well as you work to accomplish your important mission. As always, we are available to assist you in matters of mutual concern.

STATEMENT OF THE AMERICAN REHABILITATION ASSOCIATION

Mr. Chairman: This statement is submitted on behalf of the American Rehabilitation Association (formerly NARF) for inclusion in the record of your committee's hearings on the Solvency of the Medicare Trust Fund.

The American Rehabilitation Association (formerly NARF) is the largest not-for-profit organization serving vocational, residential and medical providers in the United States. The established leader in the field of rehabilitation for more than a quarter century, American Rehab serves its more than 800 member facilities by effecting changes in public policy, developing educational and training programs, and promoting research. In addition, it provides networking and communications opportunities, all of which help to ensure quality care and access to services to more than four million persons with disabilities each year.

There is a critical need for reform of the current Medicare payment policy for PPS exempt rehabilitation hospitals and units exempt from the prospective payment system (PPS). The present system is harmful to patients and providers alike and is wasteful for the Medicare program. No one—not HCFA, ProPAC, providers or consumers—defends the status quo. We urge reform of this payment system, that it be thorough and immediate, and that any proposals to include the services of rehabilitation hospitals and units, skilled nursing facilities and home health agencies with the DRG payments to acute hospitals be rejected.

DEFECTS OF THE PRESENT SYSTEM

When the Medicare PPS was enacted in 1983 rehabilitation hospitals and units were excluded because the data used to develop that system did not account for cases with longer lengths of stay, including rehabilitation cases. Such facilities continue to be paid through cost reimbursement, subject to per-discharge rate-of-increase limits imposed by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). TEFRA limits were intended to be a temporary means of controlling costs pending adoption of a PPS. They are still in place 12 years later and have produced serious, and unintended, distortions in the delivery of rehabilitation services for the following reasons:

- TEFRA limits do not adjust for change in case mix and/or increased acuity of patients. This means that any increase in intensity of services or length of stay is likely to cause a hospital or unit to exceed its TEFRA limit.
- TEFRA limits place pressure on rehabilitation hospitals and units to cut average length of stay as a means of reducing per-discharge cost. By treating all rehabilitation discharges as having the same value, the system provides a strong incentive to treat short stay, less complex cases and avoid more severely disabled patients. The government is telling hospitals to avoid severely disabled patients and not to develop programs to treat them.

- New hospitals and units can establish limits based on contemporary wage levels and other costs, thereby achieving much higher limits than older hospitals. Accordingly, hospitals in the same service area may have widely differing TEFRA limits and reimbursement for similar services. This encourages the development of new providers, which are reimbursed at much higher levels, and seriously distorts the positions of competitive providers.
- This system virtually prohibits the development of programs by existing providers, because any change in services that increases average length of stay or intensity of services will likely result in costs over a TEFRA limit, while encouraging the development of new rehabilitation hospitals and units. This adds unnecessary cost while eroding the service capacity of established institutions.
- The administrative process for adjustment of TEFRA limits does not provide a remedy because it does not produce timely decisions and does not recognize many legitimate costs.

How is the government hurt by these effects? First, because new hospitals are paid more, the system encourages capital spending. Second, the Medicare program is paying many new hospitals and units considerable amounts in incentive payments while not covering the cost of service to many older facilities. This is a disservice to beneficiaries. Any system that so seriously distorts the allocation of payment with no regard for patients needs or services delivered will distort quality and availability of services.

Data available from HCFA for Medicare reporting years ending between October 1, 1992 and August 31, 1993 contained cost report information for 128 rehabilitation hospitals. Of these 67 were under their limits, 23 were over their limits and 38 had no limits (because they were new). Those facilities over limits had and average cost per day of $562. Those under their limits had a cost per day of $559. Thus, presuming cost per day reflects intensity, there is no evidence of differing intensity of services. The average TEFRA limits for those with cost over their TEFRA limits was $11,122. The average for those under their limits was $15,267.

The difference in payment between these groups does not reflect a difference in services provided, but rather the vagaries of the Medicare system. The picture for rehabilitation units is similar.

1. Cost Reimbursement/TEFRA Should be Replaced by a PPS for Rehabilitation

Prudent use of scarce resources and the interests of patients dictate that this system be replaced with a prospective payment system (PPS) specific to rehabilitation as soon as possible. Marginal changes in the TEFRA system will not, at least as it affects providers of rehabilitation services, eliminate its basic defects.

It should be replaced with a PPS for PPS exempt rehabilitation hospital and rehabilitation unit services that makes payment based on patients' needs for services. By doing so Medicare payment will eliminate the bias in the present system against more disabled people and treat all providers equally, thus removing the preferential treatment and incentives for new facilities, and therefore unnecessary cost to the trust fund. Our association sponsored research to fashion such a system. A research team at the University of Pennsylvania developed a patient classification system based on Functional Related Groups (FRGs). This classification system includes age, diagnosis and functional ability on admission to rehabilitation. It predicts duration and intensity of rehabilitation services. The Health Care Financing Administration (HCFA) has issued a request for proposals to evaluate this system and design of a payment system based on it. We are encouraging and supporting this effort in every way possible.

The first law of governmental action is that research and analysis will expand to fill the time available. This is a major concern for us. The best evidence of this reality is the fact that in the Omnibus Budget Reconciliation Act of 1990 the Congress directed the Secretary of HHS to submit recommendations on reform or replacement of TEFRA by April 1, 1992. Almost three years after that deadline no such recommendations have been forthcoming. Hence, we believe that a statutory deadline for implementation of a PPS for rehabilitation is badly needed to force this matter to a conclusion.

Therefore, we recommend that any Medicare legislation considered this year include a provision setting such a deadline. We suggest that this be for cost reporting periods beginning on and after October 1, 1996.

2. Modification of Criteria for Definition of Rehabilitation Hospitals and Units

Rehabilitation hospitals and units must meeting certain criteria established by regulation for exclusion from the Medicare PPS. These are contained in 42 CFR 412.23. Among these is a requirement that not less than 75% of a provider's inpatients be in one or more of 10 diagnostic categories. These are:

- stroke;
- spinal cord injury;
- amputation;
- major multiple trauma;
- fracture of femur (hip fracture);
- brain injury;
- polyarthritis, including rheumatoid arthritis;
- neurological disorders, including multiple sclerosis; motor neuron disease, polyneuropathy, muscular dystrophy and Parkinson's disease; and
- burns.

This list was adopted from the practice of rehabilitation facilities in the 1970s. Over the past 20 years it has become increasingly common for rehabilitation hospitals and units to treat other patients with other diagnoses, including particularly those with pulmonary conditions, chronic pain, cancer and cardiac problems. The functional limitations of each of these, often post-surgery, can be improved through rehabilitation.

The present criteria for exclusion of rehabilitation hospitals and units from the Medicare PPS are established by regulations, not statute. For several years the rehabilitation community, through this association and otherwise, has urged HCFA to revise the pertinent regulations, to no avail. We recommend that this committee correct this problem by legislation by adding the above referenced four conditions to the criteria for exclusion.

We advocate this change for two reasons. First, it is important to a number of hospitals now excluded from PPS as long term care hospitals. Many of these function as rehabilitation hospitals, but are precluded from qualifying for exclusion from the PPS as such because they have significant numbers of patients in one or more of the four diagnostic categories we seek to have added to the exclusion criteria. The matter is increasingly critical for institutions that have reduced lengths of stay to try to mitigate financial damage from TEFRA limits.

ProPAC recently released figures showing that, on average, long term hospitals are reimbursed on about 75% of cost because of TEFRA limits. Enclosed is a schedule we prepared from HCFA data that indicates large TEFRA penalties for this group. As a practical matter the only way to reduce per discharge cost significantly is to reduce lengths of stay. But, long term hospitals have a floor of 25 days, beyond which is loss of exclusion. (The need for rebasing of TEFRA limits of long term hospitals is discussed below).

The logical course for such facilities is to be excluded from the PPS as rehabilitation hospitals, but the provision of significant services to pulmonary, cancer, pain and/or cardiac patients is a barrier to doing so.

The second reason these conditions are important is the effect of current rules on institutions now excluded as rehabilitation hospitals and units. Those that operate programs for patients in the four conditions must constantly monitor their admissions in these categories to avoid going over 25%. Admissions should reflect the needs of patients and the current practice of rehabilitation in the field rather than such artificial regulatory considerations.

3. Need for Oversight of TEFRA Adjustment Process

Section 1886(b) of the Medicare Act provides that a provider with operating cost over a TEFRA ceiling may seek administrative adjustment of its TEFRA limit by HCFA. The law requires that HCFA issue the provider a decision on a complete application within 180 days of its receipt and that a full explanation of the decision be provided to the applicant. The law also provides for assignment of a new base year for determination of TEFRA limits "which is more representative of the reasonable and necessary cost to a hospital of providing inpatient services."

While the authority vested in the Secretary is sufficient to permit proper adjustment of limits to recognize changes in services and inequities between new and old providers, the adjustment process is flawed in its implementation.

It is beyond the scope of this statement to critique the administration of these provisions by HCFA. However, we recommend that the committee examine this matter through oversight hearings, GAO inquiry or otherwise with respect to the following points:

- Timeliness of decisions. The statutory requirement for issuance of decisions within 180 days is routinely violated by HCFA, while filing requirements are strictly enforced against providers. Currently applications take a total of 14-16 months before a decision is received.
- Failure to use rebasing authority. HCFA has refused to use the authority to rebase providers, while acknowledging the disparity of treatment between newer and older providers.

- Inconsistency. Standards for adjustment are not applied uniformly, without explanation.
- Absence of explanations. While the law requires that a provider receive a "detailed explanation of the grounds" on which its application is approved or denied decisions often do not address issues raised and do not explain actions taken.

4. Interim Modifications of the TEFRA System Pending A PPS for Rehabilitation

We recommend enactment of legislation to set October 1, 1996 for implementation of a PPS for rehabilitation hospitals and units. If a later deadline is adopted we recommend certain modifications to the TEFRA system as it is applied to such providers.

First, we recommend that there be a floor on TEFRA limits, set at 70% of the national average. Presently there are some rehabilitation hospitals and units with limits as low as $3,000, while the national average is over $12,000. These providers are required by Medicare coverage guidelines to provide the same levels of nursing and therapy services as other hospitals and units. Because Medicare coverage guidelines require similar services there should be some comparability of payment. We suggest 70% of the national average TEFRA limit as a floor to provide relief for hospitals and units stuck with extremely low limits.

Second, we suggest that any new rehabilitation hospital or unit certified after date of enactment receive a TEFRA limit no greater than 150% of the national average. It is completely inequitable for the Medicare program to continue to reimburse new facilities at far higher rates than older ones—while both compete for staff and patients. The inequities presented by the widely varying limits of current providers will be eliminated only through adoption of a PPS. In the meantime, some small measure of sanity can be introduced into the system by capping limits for new facilities.

5. TEFRA Limits Should Be Recalculated Based on Contemporary Cost for Long Term Care Hospitals

The serious distortions and inequities of the TEFRA system for rehabilitation providers can and should be solved by the adoption of a PPS for rehabilitation hospitals and units. We believe that the patient classification system discussed above provides a sound basis for doing so at an early date. Well over 90% of patients treated in rehabilitation hospitals and units fall into the classification categories represented by FRGs and payment for the balance can be easily computed through averaging and/or provision for outliers.

A PPS for rehabilitation will not, however, remedy the impact of TEFRA limits on long term care hospitals, except for those facilities that are recognized by the Medicare program as rehabilitation facilities. The sole criterion for exclusion of a long term care hospital from the PPS is maintenance of an average length of stay of over 25 days. The types of patients treated in this group of facilities vary widely and the patient classification system developed for rehabilitation does not apply to most of them. The adverse effect of TEFRA on long term care hospitals has been profound. ProPAC reports that in fiscal years ending 1989 long term care hospitals as a class were reimbursed only 75% of cost by the Medicare program and in FY 1991 75% were over their TEFRA limits. This is because many such facilities were Medicare providers when the TEFRA system was adopted in 1982 and have limits based on base years that are not representative of current costs.

Exhibit A shows the position 75 long term care hospitals. These data are drawn from the HCFA PPS-IX Minimum Dataset and are the most current data so reported by HCFA. The cost reports contained in this data base are for fiscal reporting periods ending in the period 10/1/92-8/31/93.

In 1994 HCFA separately reported that there were 115 long term hospitals excluded from the PPS. This absence of 40 hospitals from the Minimum Dataset cannot be conclusively explained. It is likely that many are new facilities. To the extent that this is the case, they were not subject to TEFRA limits and would not be affected by rebasing of limits. Similarly, there would be no increased Medicare payment to these hospitals from rebasing.

These data show that the average TEFRA limit for facilities over limits was only $11,181. For those under limits the average was $21,740. This is a huge difference, for which there is no sound public policy.

Since a PPS is not a prospect for this group of facilities we recommend rebasing of TEFRA limits to current cost. In the process incentive payment of providers under their TEFRA limits should be protected.

6. Proposal to Bundle Post Acute Care into the DRG Hospital Payments

This proposal, which appeared in a Senate Budget Committee staff document, would require that post acute care services be brought under the diagnosis related group (DRG) based prospective payment system (PPS) used to pay acute care hospitals under Medicare. Post acute care includes the services of rehabilitation hospitals and units, skilled nursing facilities and home health agencies. We are concerned that it is an easy way to cut expenses without concern for patient care.

We are extremely concerned about this proposal and believe that it should not be considered during the reconciliation process. Instead the separate prospective payment system for rehabilitation referenced above should be adopted.

It would increase DRG payments and make the DRG provider responsible for rehabilitation services. Presently DRG payments cover only the acute stay. The rehabilitation provider, if it is a rehabilitation hospital or unit, is paid reasonable cost, subject to a limit known as a Tax Equity Fiscal Responsibility (TEFRA) limit.

We oppose post acute care bundling, as it is known, for a number of reasons. Acute care medicine addresses the immediate medical condition of patients, focusing on the pathology and chemistry of a given diagnosis. Rehabilitation is concerned with the patient's ability to function—to perform activities of daily living, work, and otherwise enjoy life. Thus, in the acute phase a physician attending a stroke patient is concerned with reducing cranial swelling and the potential for another Cardiovascular Accident (CVA) through drug therapy. Rehabilitation is concerned with restoring or improving patients' ability to walk, talk, use their arms and adapt to any residual limitations of these functions. This is done through the interdisciplinary provision of physical, occupational, speech and other therapies, as well as psychological counseling to deal with the depression that often accompanies newly experienced physical disability. Rehabilitation also involves working with families and others who are affected by the patient's condition, and whose response is likely to affect the patient's progress. While good medical practice calls for the coordination of these different types of services, in concept and philosophy they are quite different.

Several nationally known figures, such as violinist Itzak Perlman, baseball umpire Steve Palermo and actor and dancer Ben Vereen, as well as some members of Congress are dramatic proof of what rehabilitation can do in overcoming disabling conditions and assuring people can contribute to our society.

The fundamental problem with bundling rehabilitation into the DRGs is that it creates a conflict of interest for acute providers, who will have an incentive to deny or abridge rehabilitation services. And, many hospitals are simply ill prepared, nor have the desire to assume the responsibility or liability for, these services. Only 800 acute hospitals have rehabilitation units, and there are only 190 freestanding rehabilitation hospitals. If there are 5,000-6,000 hospitals in the country, this represents less than 20%. Both those with and without units have an incentive to shorten or eliminate rehabilitation services, but the incentive is particularly telling in the case of a hospital that must refer the patient to another provider for services.

Also, there is no basis for computing the additional DRG payments for rehabilitation (and/or other post acute services). Such costs vary widely depending on the patient's diagnosis, age, degree of impairment, family circumstances, medical condition, and other factors. Studies done by the American Rehabilitation Association (then NARF), and the RAND corporation and the Medical College of Wisconsin, after the DRGs were passed, confirmed that they did not predict nor cover the length of stay or cost of rehabilitation. And, use of aggregated post acute care Medicare data would penalize hospitals focusing on particularly old or severely involved patients, further creating incentives to limit services to those who need them most.

Furthermore, there is no way to monitor whether care is appropriately provided under such a system, in other words, to measure outcomes and thereby hold the hospital accountable. Rehabilitation providers are unique in the health care system in that they focus on outcomes—improved functional capabilities of patients. A decline in utilization of their services, which would accompany bundling, may result in a loss of such focus and in higher levels of residual impairment and dependency.

And, we believe there a series of additional mechanical, legal, policy and other questions that include, for example, the implications with respect to antitrust, self referral and state certificate of need laws. Finally, even HCFA's own researchers on this subject have cautioned about the serious design issues that arise with respect to the rates of payment and accountability for the delivery of care. They strongly urge that all the methodological issues be resolved and a demonstration be done before such a proposal is implemented.

For these reasons we believe that bundling rehabilitation into the DRGs is arbitrary and harmful to patients. Instead, the FRGs should be adopted for rehabilitation. We hope they will serve as the basis for a PPS for rehabilitation. FRGs do not, however, tie to DRGs. Rather, the primary element is the functional status of a pa-

tient upon admission to rehabilitation. Therefore, we believe this proposal to bundle services into the DRGs should not be considered by the Finance Committee.

7. Future Initiatives

The committee's announced intention to consider alternatives to the present structure of the Medicare program is to be applauded. We are particularly concerned with the fragmentation of rehabilitation services due to current institutional definitions, coverage guidelines and division of services between Part A and Part B. Our association has several committees working to fashion proposals to address these matters and hope to submit further recommendations to you in the near term.

Our guide in this undertaking is care for patients and provision of services in the least restrictive and most cost beneficial environment, subject to the ultimate goal of maximum recovery of function and ability to live independently and productively.

Thank you for your consideration of the recommendations set forth above.

Respectfully submitted,

AMERICAN REHABILITATION ASSOCIATION

Sy Schlossman
Interim President and CEO

Attachment.

ATTACHMENT
11/23/94

MEDICARE COSTS VS. TEFRA LIMITS
LONG TERM HOSPITALS

Total Hospitals Reporting	75
Under Limits	19
Over Limits	40
No Limits	16
Average Length of Stay (Total)	28.46
Average Length of Stay (Under)	27.68
Average Length of Stay (Over)	28.60
Average Length of Stay (No Limit)	30.18
Average No. Medicare Days (Total)	7,538
Average No. Medicare Days (Under)	11,813
Average No. Medicare Days (Over)	6,270
Average No. Medicare Days (No Limit)	5,631
Average No. Medicare Discharges (Total)	265
Average No. Medicare Discharges (Under)	427
Average No. Medicare Discharges (Over)	219
Average No. Medicare Discharges (No Limit)	187
Average Cost Per Discharge (Total)	$15,877
Average Cost Per Discharge (Under)	$13,004
Average Cost Per Discharge (Over)	$16,050
Average Cost Per Discharge (No Limit)	$23,176
Average TEFRA Limit - All Discharges (Under)	$16,308
Average TEFRA Limit - All Discharges (Over)	$11,831
Average TEFRA Limit - per Hospital (Under)	$21,740
Average TEFRA Limit - per Hospital (Over)	$11,181
Average Cost Per Day (Total)	$558
Average Cost Per Day (Under)	$470
Average Cost Per Day (Over)	$541
Average Cost Per Day (No Limit)	$768
Average Medicare Cost Under Limits	$1,410,101
Average Medicare Cost Over Limits	$925,145
Total Medicare Cost Under Limits	$26,791,922
Total Medicare Cost Over Limits	$37,005,813
Total Incentive Payments (Under Limits)	$4,740,793
Total Cost Sharing (Over Limits)	$6,388,328

Data Source: PPS-IX Minimum Dataset
For fiscal periods beginning on or after 10/01/91 and ending by 6/31/93

STATEMENT OF JONATHAN BARRY FORMAN,

PROFESSOR OF LAW, UNIVERSITY OF OKLAHOMA

Mr. Chairman: I am pleased to submit this statement for the record of your Committee's May 16th hearing on methods to preserve and improve the Medicare program. I am submitting this statement in my individual capacity as a Professor of Law at the University of Oklahoma where I teach courses on tax, pension, and Social Security law and research primarily on the relationship between the tax and social welfare systems. The purpose of this statement is to recommend that a portion of the insurance value of Medicare be taxed and the revenues earmarked for the Medicare trust funds.[1] This change would help preserve and improve the Medicare program.

IT'S TIME TO TAX MEDICARE BENEFITS

The Medicare program is in financial trouble. As noted in the notice for this series of hearings on Medicare, "Medicare is already paying out more money than it is taking in, and it will be completely bankrupt by 2002." One partial solution to this impending disaster would be to tax Medicare benefits and to dedicate the proceeds from that tax to the Federal Hospital Insurance Trust and the Supplementary Insurance Trust Funds.

Medicare benefits have never been expressly excluded from gross income by statute.[2] In 1970, however, soon after the enactment of Medicare, the Internal Revenue Service ruled that benefits under Medicare are not includable in gross income.[3] The ruling applies to Medicare benefits received both under Part A (hospital insurance) and Part B (supplementary medical insurance). The ruling excludes these benefits because they "are in the nature of disbursements made in furtherance of the social welfare objectives of the Federal government."

There are a number of reasons to consider taxing Medicare benefits. The costs of the Medicare program have been skyrocketing in recent years, yet the contributions made by current beneficiaries will cover only a small portion of the costs of their expected lifetime benefits. According to one recent study, the annual value of the subsidy to current beneficiaries is at least $2,100 a year.[4]

Moreover, as Medicare is not means-tested, many Medicare beneficiaries are relatively well-off. The overwhelming number of Medicare beneficiaries are elderly. Far from being in need of special tax preferences, the elderly tend to be better off and have a greater ability to pay tax than many other demographic groups. The elderly often have higher incomes and more wealth than younger individuals—especially than those younger individuals who are starting families. And the elderly are far less likely to be poor than other demographic groups.[5]

Moreover, the elderly tend to pay less taxes than their nonelderly counterparts. For example, an elderly couple with $20,000 of Social Security benefits, $12,000 of interest income, and valuable Medicare benefits owed no federal taxes at all in

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[1] This statement is drawn from the following articles: Jonathan B. Forman, *The Income Tax Treatment of Social Welfare Benefits*, 26 University of Michigan Journal of Law Reform 785, at 808-11 (1994); and Jonathan B. Forman, *Reconsidering the Tax Treatment of the Elderly: It's Time For the Elderly to Pay Their Fair Share*, 56 University of Pittsburgh Law Review ——— (forthcoming 1995).

[2] *See generally* Staff of the House Comm. on Ways and Means, 103d Cong., 2d Sess., Overview of Entitlement Programs: 1994 Green Book: Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means 696 (Comm. Print 1994) [hereinafter Green Book].

[3] Rev. Rul 70-341, 1970-2 C.B. 31.

[4] Sandra Christensen, *The Subsidy Provided Under Medicare to Current Enrollees*, 17 Journal of Health, Politics, Policy & Law 255 (1992); see also Robert J. Myers & Bruce D. Schobel, *An Updated Money's Worth Analysis of Social Security Retirement Benefits*, 44 Transactions (Society of Actuaries) 47, 68-69 (1993).

[5] For example, in 1992, when the overall poverty rate was 14.5 percent, only 12.9 percent of the elderly were poor. In contrast, almost 22 percent of children were poor that year. See Green Book, supra note 2, at 1158.

1994.[6] On the other hand, a young married couple with $32,000 of earned income in 1994 owed $3,112.50 in income tax and $2,448 in Social Security taxes.[7]

The couple's Social Security tax liability was $2,448 ($2,448 = $32,000 x 7.65 percent Social Security tax rate). Moreover, a matching amount of Social Security taxes will be paid by the couple's employer(s), and most economists believe that the burden of these Social Security taxes is also borne by the workers themselves.

In effect, the taxes collected from young taxpayers are being used to pay for health care benefits for well-off retirees. Yet many young taxpayers cannot afford health insurance for their own families. Taxing the insurance value of Medicare benefits could help fix this generational inequity.

Over the years, the exclusion of Medicare benefits has been routinely identified as a tax expenditure.[8] The federal government first began to seriously consider taxing Medicare benefits when it was looking for ways to finance the so-called Catastrophic Health Insurance Act,[9] and the Bush Administration also flirted with the idea of taxing Medicare benefits.[10] But neither effort came to fruition.

More recently, as one of its options for deficit reduction, the Congressional Budget Office has suggested taxing a portion of Medicare benefits.[11] In particular, the Congressional Budget Office outlined a proposal to tax up to 85 of the insurance value of Medicare Part A benefits and up to 75 percent of the insurance value of Medicare Part B benefits. The proposal would raise $78.8 billion over five years.

I believe that the Congressional Budget Office proposal deserves serious consideration by your Committee. Taxing Medicare benefits would make the system fairer, and taxing Medicare benefits could help raise the revenues needed to bolster the Medicare trust funds.[12] All in all, taxing Medicare benefits would help preserve and improve the Medicare program.

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[6] Because Social Security benefits are not taxed at all unless the couple has at least $32,000 of income and Medicare benefits are not taxed at all, only the $12,000 of interest would be included in gross income. But the couple's income tax threshold was $12,750, because the couple could claim a basic standard deduction for a married couple of $6,350, two additional standard deductions for the elderly of $750, and two personal exemptions of $2,450. As the couple's income tax threshold exceeds its gross income, the couple's taxable income was $0 and its tax was $0.

[7] The couple's taxable income was $20,750 ($32,000 less a $6,350 standard deduction and two $2,450 personal exemptions). The couple would owe $3,112.50 in income tax (15 percent x $20,750).

[8] See, e.g., Green Book, supra note 2, at 678-79.

[9] See, e.g., *Finance Committee Reviews Catastrophic Health Care Financing Options*, available on LEXIS, Fedtax Library, TNT File, 87 tnt 59-2 (March 27, 1987).

[10] See, e.g., David Wessel, *Bush Budget Chief Studies Ways to Raise Added Billions, Including Medicare Tax*, Wall Street Journal, August 24, 1989, at A2; Robert Pear, *Bush Weighs Health Benefits Tax and Cap on Medicaid Payments*, New York Times, Jan. 24, 1992, at A1.

[11] See, e.g., Congressional Budget Office, Reducing the Deficit: Spending and Revenue Options: A Report to the Senate and House Committees on the Budget 363-64 (1995) (Rev-17).

[12] For federal budget purposes, taxing Social Security benefits has previously been scored as a spending cut, rather than a tax increase. Similarly, taxing Medicare benefits should also be viewed as a means of cutting health care spending rather than as a means of increasing tax revenues.

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