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MAGNITUDE OF THE FINANCIAL CRISIS IN MEDICARE

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH CARE

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FIFTH CONGRESS

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MAGNITUDE OF THE FINANCIAL CRISIS IN MEDICARE

WEDNESDAY, FEBRUARY 12, 1997

U.S. SENATE,
SUBCOMMITTEE ON HEALTH CARE,
COMMITTEE ON FINANCE,
Wasnington, DC.

The hearing was convened, pursuant to notice, at 2:10 p.m., in room SD–215, Dirksen Senate Office Building, Hon. Phil Gramm, (chairman of the subcommittee) presiding.

Also present: Senators Chafee, Grassley, Rockefeller, and Kerrey.

OPENING STATEMENT OF HON. PHIL GRAMM, A U.S. SENATOR FROM TEXAS, CHAIRMAN, SUBCOMMITTEE ON HEALTH CARE

Senator GRAMM. Let me go ahead and begin the hearing. Let me apologize in advance for my voice, since I have a cold or flu, or something.

I wanted to begin with an opening statement. When Senator Rockefeller comes, I will recognize him to make his opening statement. To the degree that other members are here, we will give them an opportunity to make an opening statement.

We will then go to our witnesses. We will go through three panels today. Basically, we will take them in order and give them an opportunity to make their opening statements with regard to the long-term financial health of Medicare.

But let me go ahead with my opening statement, then we will turn to our first witness, if no one else arrives.

I believe that we have a very severe financial problem in Medicare. I think the problem is of much greater magnitude than is commonly recognized. You can center the problem on two distinct sources. No. 1, we have had an explosion in the per capita cost of Medicare. The cost of Medicare for the last 15 years has grown at over twice the rate of general medical inflation. It is the fastest-growing program of the Federal Government.

While taxes have increased very rapidly since the beginning of Medicare, Medicare spending has now outpaced the tax increases and premiums. We find ourselves in a position where Medicare is in the red, where the Medicare trust fund will be exhausted in 4 years, and where the cumulative debt in the Medicare trust fund will be approximately $600 billion within a decade.

This is not a problem which is going to come to fruition in the sweet by and by or at some far-off point in time. This is something that is happening right now.

Our first mission, it seems to me, in the subcommittee, the Finance Committee, and Congress, is to gain control of per capita costs. There is no hope for a long-term solution unless per capita costs can be brought under control.

To have any hope of preserving Medicare as we now know it, we have got to come up with a program that will bring incentives into Medicare that will induce the provider of Medicare to be cost-conscious, that will induce the consumer of Medicare to be efficient and cost-conscious. Today we do not have a program that promotes either one of those objectives.

I think we can be encouraged by the fact that the medical price index, for the first time since 1965, appears to be coming back in line with the general consumer price index. I think that should suggest to us that, when you allow competition to occur, competition tends to bring costs under control. I think that is the lesson of what is happening in the general medical market in the last decade.

The paradox, it seems to me, is that we are facing a financial crisis even while the number of people who are retiring annually and the number of people who will retire relative to the number of people in the labor market is still small when compared to what it is going to be in the future.

An analogy that I like to use is the Biblical story about Joseph. You may remember that Joseph, Jacob's son, the chosen child, technicolor coat, in modern rock opera fame, was kidnapped by his brothers and sold into slavery.

While in slavery in Egypt, Pharaoh had a dream. The dream was about seven fat cows and about seven skinny cows, and the seven skinny cows ate the seven fat cows. There was general inability in Egypt to interpret the Pharaoh's dream. Finally, Joseph read the dream to mean that there was going to be 7 years of plenty, followed by 7 years of drought.

Those who remember the Biblical story remember that the Pharaoh, under the control of Joseph, stored grain in the period of plenty to satisfy the needs of Egypt and its neighbors during the coming drought.

The incredible paradox is, we are on the verge of bankruptcy while we are still in the fat years. Only 200,000 people are going to retire this year and qualify for Medicare. Within 14 years, we will have 1.6 million people a year who will become eligible for Medicare. That number will remain roughly at that level for 20 years thereafter. We have a bankrupt system, and we have yet to get to the coming famine.

Medicare was started the year that the first baby boomer came into the labor market. In that year, 1965, we were looking at a massive growth in the number of labor force participants. The number of new people coming into the labor market was substantially higher than it had been in the modern era, and there were 20 years of people coming behind them.

It looked, at that point, as if we could fund Medicare as a transfer payment, where current workers would pay for benefits for current retirees, and then the next generation of workers would pay benefits to them.

The problem now is that this baby boom explosion is working its way through the system and we are reaching a point where the number of people who are going to be retiring is getting larger and larger, and no provision has been made to satisfy that need.

We are going from 4.4 workers per retiree in 1970 to about 3.9 workers per retiree today. We are, headed to 2.2 workers per retiree in the last year when the baby boomer generation will retire. Such a system is absolutely unsustainable.

In looking at numbers that have been provided from various estimating entities, from CBO to estimates that have been made by the trustees, we are looking, 5 years from today, we will have a roughly $121 billion debt in Medicare. Ten years from today it will stand at $603 billion, 20 from today, $2.8 trillion, and 30 years from today, $8.7 trillion.

The problem is, I only have one constituent who knows what a billion dollars is. His name is Ross Perot, and he is not here. Nobody knows what a trillion dollars is. But the point is, these are tremendous costs, they are not going to go away, and our charge is to do something about it.

Let me conclude with the following point then recognize Senator Rockefeller. Within 4 years, Medicare, under the current system, is going to be insolvent. Within 10 years, it is going to be very substantially in debt, without a change in current policy, $600 billion in the red.

Within 8 years, we are going to have a single year's shortfall of roughly $105 billion. Someone is going to have to explain, if they have served on this subcommittee, if they are in the Congress, where they were when the roof fell in on Medicare.

What I hope to do in these hearings is talk about the magnitude of the problem, to be absolutely sure that anyone who is concerned about this problem is aware of the magnitude of the problem we are dealing with.

I think, when we sit down as we ultimately must on a bipartisan basis, the only way we can hope to deal with this problem is for members of both parties to understand the cost of not acting. I do not want to, 8 years from now when we are running an annual deficit of $100 billion in Medicare, have to explain why I did not take any action.

There are a lot of things I am going to have to do in my life that I do not want to do, but calling my 83-year-old mother to tell her, Mom, Medicare went broke today because I did not have enough courage to do something about it, or because I could not work with Bill Clinton, is not something that I intend to do.

So I want to say to our representative of the administration here and to my two colleagues who have come, and I am grateful they are here, my goal is to try, this year, to do something about the Medicare problem, to do something that is worthy of being remembered as we deal with this major financial crisis in the making. I think we are going to have to work together to make this happen. I intend to do everything in my power to try to do that, and I want to thank my colleagues for coming.

I want to recognize the ranking member of this subcommittee, Senator Rockefeller.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Thank you, Senator Gramm. I like the way you ended that up. I will not have a chance to tell my mother that, because she has already gone. But I understand exactly what you are saying, and I do not think anybody wants to be in that position. I think you are doing a very wise thing.

First, I need to congratulate you on being where you are, chair of the new, consolidated Committee on Health, which is something I had hoped was going to happen for a long time, but, because of various problems, did not happen.

So now we have Medicare, Medicaid, long-term health insurance, the whole thing, everything under one committee. That is the way it ought to be. I like the idea of your taking on the big picture first, looking at the long-term solution, first, the short-term solution, second, but basically knowing what we are talking about, the magnitude of it. I think that is a wise decision.

I also want to say that I want to work together with you on this subcommittee. We do not necessarily have the same voting records, but we are confronted here with a very major problem, which is not very much blandished effectively by words, but it is by actions and by the principles behind those actions, and so the moral perspective with which one begins to take those actions. But, anyway, we will end up with actions, or else the problem does not get solved.

So I pledge my best to you, Chairman Gramm, to be open-minded, to be non-ideological, to be, in fact, unpartisan, which I am, in fact, very capable of being. I will say that I approach this with a couple of principles, and I will just give you three or four and that will be it.

I guess the first principal would be that you are presumed innocent until proven guilty in this country under our legal system, but I think that it is also probably fair to say that, unless we can prove otherwise, we need to make Medicare be viewed as sustainable into the next century, unless there is some reason by which we just cannot do that.

It has been an amazing program. It covers 97 percent of our elderly. We all know what the situation was prior to Medicare. It was not happy. Half of our people had no health care, virtually, at all, except what they could get.

Now, people are worried today about, what are they going to do when their parents get old, and how are they going to pay for long-term care, the cost of nursing homes. That is one side of the equation. What we are looking at today is the acute care side, and that is also terribly important. Families are worried just as much about that, because if Medicare goes broke, as you indicate, then they are going to be in the same pickle that they were before 1965.

My second principle has to do with what our country can or cannot afford. We are a great country. Here is kind of a moral principle that I think is interesting to put forward, that we have a system of national defense which keeps our people free, and that is free to be all kinds of things, to do what one wants to, to get educated, to be healthy, to grow old in peace.

In a sense, Medicare is a form of national security, too. It is called health care security, but it is involved with a very, sort of,

basic American principle and people just did not get it because they grew old, they did it because they worked hard, they paid taxes, and they pulled the cart. They earned their way. It is not something which is around to pick up a vegetable garden.

I think it is important to say, too, that not all Medicare patients are rich. In West Virginia, the average senior citizen, average Medicare patient, has an average annual income of $10,700 a year. I think the average annual 65-plus income in this country is closer to $18,000 or $19,000.

So, in Appalachia, as in parts of, I would guess, East Texas, you are dealing with income levels that are very, very difficult. Even as it is, whether seniors are rich or poor, they are spending, on average, about 21 percent of their income on health care costs which are not covered by Medicare at all, hence, into the Medigap market, and all the rest of that.

My third principle, is I think that the public needs to know about this. This is really a big issue. This is a B–52, or however we would craft it. Medicare may be the most popular government program ever passed by this Congress, and probably is.

It has a most unusual quality, and that is that it is administered with enormous efficiency, so much so that when you say that the administrative over-cost is about 2 percent, people do not believe you.

Then you explain to them the best you can. It does not make a difference, they still do not believe you. They do not believe anything could be administered at 2 percent that belongs to Washington, but that fact remains. That is quite extraordinary.

Medicare is so popular, in fact, that a lot of people do not even think it is a government program. They think this is just something that comes along with them and they start talking about taking their program away. But that is not because they are not alert, it is simply because it is so integral to their lives.

So let me close my principles on that. Let me just say that I take this as a serious work. It is a work which I am sure scares and throws some fear into all of us, but substantive fear, fear based upon not only going into the unknown and doing things which we have not done before, but also the fear to get it right.

We have people we need to protect and worry about who are here for good reason, who have grown older for good reason. We are living longer now for good reason, part of which is the work that Medicare does.

So my great-grandfather lived to be 98 years old, Senator Gramm, and I hope to do that, too. He did not depend on Medicare, they did not have it then. But Medicare, I hope, is going to live to be a ripe, old age for all three of us here who have bothered to show up.

Senator GRAMM. Let me thank my colleague. I think we have it within our power to ensure that Medicare does live to a ripe, old age. I look forward to working with you.

Let me recognize our colleague, Bob Kerrey. In recognizing him, let me say something I have not said before. That is, Bob Kerrey, probably more than anybody else, is responsible for the Entitlement Commission, which did not change any policy.

But I think one of the things it did do, is it started the long, difficult process of awakening the country to the threat that we face in programs like Social Security and Medicare that will require us to take action. For your leadership, Bob, on that, we are very fortunate to have you on this subcommittee.

OPENING STATEMENT OF HON. BOB KERREY, A U.S. SENATOR FROM NEBRASKA

Senator KERREY. Well, thank you very much, Mr. Chairman. I will try to get to the witness here in a hurry, but I would say a couple of things. One is that we are dealing with a Federal law which says that if you are over the age of 65, you are eligible to have hospital and physician bills paid for under very specific conditions. It was a law, enacted in 1965, which has worked to dramatically reduce the number of uninsured people over the age of 65 from about 50 percent to nearly zero, which is a pretty significant success story.

The problem is that it reimbursed providers at usual and customary rates until 1983, when the prospective payment went into play. The problem is, the costs of health care have continued to go up. I appreciate very much the administration's proposal; they propose $100 billion of additional savings out of the system and push the insolvency date back, I guess, 5 years or so. But it pushes it back just to 2007. The big problem for us, as you look out in the future and consider your mother, or anybody's mother out there, is 77 million baby boomers. I appreciate it when the President says, well, let us have a commission on this thing. I can give you all of the options, but none of the options are pretty. All the options are difficult when it comes to trying to figure out how to pay for 77 million baby boomers.

I would argue that the sooner we make those changes, the better, if for no other reason than it would put people on notice that the changes are going to be there for that generation. The longer we wait, the bigger the surprise will be. We are going to have to plan an alternative way to do this.

There is no question that managed care is going to be a big help, but the 77 million person baby boom generation—that starts, I guess, in 2008, 2009, somewhere in that range—threatens to swamp everything that we are doing in Washington.

The President's budget shows a growth in mandated programs, plus interest, from 64 percent of the budget to 70 percent of the budget, and it continues out to about 2013, or so, where it is 100 percent of the budget. It does not stop there, and it continues to grow.

So I hope that we can get a Republican and Democratic proposal that deals with this thing, and hope we can reduce some of the more inflammatory rhetoric, because we have a very serious problem that needs to be solved, not for us politically, but, as you said, Mr. Chairman, for the people out in the future who are going to rely on this program.

Senator GRAMM. Senator Grassley's is going to withhold from making an opening statement. So Bruce Vladeck, let me welcome you before the committee. Bruce is the administrator of HCFA. I promised him today that we will not probe too deeply into the de-

tails of the President's proposal. He wants to let the Secretary do that in the next couple of days.

So what I have asked Bruce to do, is to focus on this long-term problem in trying to define what the problem is and what they are doing that he would like us to know about.

STATEMENT OF HON. BRUCE VLADECK, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC

Mr. VLADECK. Thank you very much, Mr. Chairman. I very much appreciate the opportunity to be here today to talk with you about these issues. I must add that I very much appreciate your indulgence relative to the issues of scheduling for today's session, and the consequent late arrival of my testimony. I hope we will be under a little bit less pressure about these sorts of things in the future and in our subsequent conversations.

I especially want to take note of the spirit that I have felt all over this Hill in the last several weeks, the desire to really work together this year and to put some of the past conflicts aside to work together. Across party lines and across the historically more difficult divide between the Congress and the executive branch, we are trying to work together to address some common problems.

I very much appreciate the way in which this hearing fits into that effort and look forward to the opportunity to work on all of these issues this year.

As several of you have suggested, we need to move forward, to address simultaneously the shorter-term problems of the Medicare program and the longer-term problems of the Hospital Insurance Trust Fund.

The President has submitted a budget that extends the solvency of the trust fund for 10 years. We do not believe we need all 10 years to address the long-term problems. However, we do believe that getting some of the shorter-term problems off the table will give us the opportunity to look more systematically and more carefully at the long-term issues.

Now, let me make a very few comments in my role as Secretary to the Board of Trustees of the Medicare Trust Fund and a few more general observations.

In their last three reports, the Medicare trustees have been pretty consistent in their recommendations. In fact, over the last 15 years the trustees have projected the date of HI trust fund insolvency to be from 5 to 17 years in the future. The Congress and the executive branch have been able to meet short-term challenges to ensure continued Medicare protection for beneficiaries. But, as several of you noted, the fundamental demographic changes that we are expecting relatively early in the next century suggest that although our past practice of fixing things as we go is necessary in the short-run, it will not take us all the way through the baby boom period.

As you know, the fundamental problems of the HI trust fund come from two sources. The Chairman identified them both in his opening statement—exploding Medicare per capita cost and Medicare expenditures that are exceeding the growth of Medicare revenue. The Medicare trustees, in their report based on the work of

our actuaries, have made very explicit projections about the two parts of this program.

Since the inception of Medicare, except for a few years, medical expenditures have risen faster than the growth of the economy as a whole. And medical expenditures paid by the Hospital Insurance Trust Fund, have risen more quickly than Medicare revenue.

I do want to note for the record that, from the beginning of Medicare in 1965 through about 1993, the cost per enrollee in the Medicare program consistently grew more slowly than costs per enrollee in private health insurance plans. Over that period of time, on average, Medicare per capita costs grew at a compound rate of about 1 percent below the per capita cost in the private sector.

Since 1992 or 1993, as you know, there has been a very considerable slowing of the rate of growth of costs in the private sector. At the same time without any significant legislative change in the Medicare program, we have continued since the late 1980's on a kind of auto-pilot of expenditure growth. For the first time, we are looking at the third consecutive year in which Medicare costs will grow faster than private sector costs.

The President's budget for the period of 1998 through 2002 will actually bring per capita growth in the Medicare program up to the range of just over 5 percent per year. This is very close to current CBO, Department of Labor, and other projections of per capita growth for the private health insurance sector in the same period of time.

There has also been some attention given to the differences between the benefit package that Medicare covers and what most private health insurance plans cover. If you compare Medicare coverage to Federal employee (FEHBP) coverage, you can see that we have had a problem in the Medicare program since its inception.

It has been part of the problem of the rise of health care costs relative to the rest of the economy. Historically, Medicare has generally outperformed the private sector somewhat. We believe the President's budget proposals, for the short-run, will bring us back in line with the rate of growth in the private sector.

But in the period prior to the year 2010, the major problems of financing the HI trust fund are driven by the fact that our health care costs are still projected to grow more quickly than the economy as a whole.

In their 75-year projections, our actuaries project no differential in growth rate between health care costs, per capita, and the wage base after about 2020. All of the problems of the trust fund over the long-term are driven by the demographics, as several of you have appropriately pointed out.

In about 2010, we have a sort of discontinuous shift in the number of retired persons and the ratio of retired persons to workers. While this kind of shift will be experienced in a somewhat analogous way by some other industrialized countries in Western Europe, it is a phenomenon that is entirely without precedent in human history. In the year 2030, a quarter of all living Americans will be 65 years old or older. We have never had a society like that in human history.

I would suggest that the implications of such a dramatic shift in the age distribution of our population do not stop at just the financ-

ing of public programs, or even at the macroeconomic effects that such a change in the age distribution in the population suggests. Every aspect of our society and culture will change as a result.

Now, I like to give the example that some private sector entities seem to be much further along the road than the government in figuring out the implications of these changes.

I tell people that I think this is where the Arch Deluxe comes from. McDonald's has invested a fortune in trying to figure out the implications, for its business, of the significant and permanent change in the age distribution of our population. McDonald's has probably given the broader socio-economic impacts of this set of changes more systematic and careful thought than the entire apparatus of the Federal Government together.

I certainly am not aware of any public analysis of the effects on the distribution of consumption in society more generally that comes about from aging of our population.

Similarly, when we began looking at these issues this year, I asked our actuaries to talk about their expectations about the age composition in the labor force, given the change in the age distribution of the population as a whole, and the relative shortage of younger workers that we would be experiencing in the years after 2010.

They told me that the amount of hard research on that subject was very limited, by exactly the fact that we were going to be confronting an historically unprecedented situation. That is the underlying problem that is facing us, as you all have correctly identified. We have to begin working together to figure out just what that means and how we are going to address it as a society.

Let me say in that regard that the most solid numbers we have are the demographic projections. Everyone who is going to be a Medicare beneficiary in the year 2020, for example, has already been born. We can count them pretty reliably.

We are relatively good at predicting mortality rates. We are much better at predicting how many folks there will be than what will happen with health care costs, what will happen with economic growth, and what will happen in other areas of the economy.

In my view, the fundamental problem that we face in 2010 and beyond is that, regardless of the proportion of their health services that are financed by the Medicare program and regardless of the other mechanisms that we might develop to finance those services, all 77 million of those baby boomers are going to be there needing health care services.

If Medicare is not available to pay for those services, some other financing source will need to be found or people will go without needed services. Now, we might get 10, 15, or even 20 percent more efficient in the delivery of health services, but those of you who have looked at the numbers know that even such enormous and unprecedented gains, would be overwhelmed by just the fundamental demographic change.

So, apart from the narrow issue of maintaining the solvency of one particular trust fund, we have to figure out how we, as a very different kind of society some years in the future, are going to finance health services, not to mention retirement income, for this extraordinarily large number of retired people.

In doing so, I would just recall a couple of other facts that several of you have already noted. One is that when we think about how we are going to finance medical care for all of us baby boomers in our retirement years, whether it is Medicare or supplemental mechanism, we need to remember that, at the moment, Medicare is paying for less than 60 percent of the total health care expenditures of its current beneficiaries.

The limitations of the benefit package, the relatively substantial co-insurance and deductibles compared to most private policies, and particularly the absence of coverage for prescription drugs, already create very substantial out-of-pocket liabilities for many beneficiaries.

There are also very substantial liabilities for the States, and the Federal Government through the Medicaid program. The Medicaid program provides supplemental insurance, an additional insurance to pay the out-of-pocket medical expenses, for about 15 percent of all current Medicare beneficiaries.

The other point I would make very quickly, just to further complicate this discussion, is that for the last decade the fastest-growing category of Medicare beneficiaries, and the category that our actuaries project will grow most quickly over the next decade is disabled beneficiaries. Disabled beneficiaries currently account for about 13 percent of the Medicare population, but their numbers have been growing three or four times as fast as those of retirees over the last decade.

I said earlier that our capacity to project age distribution in the future is pretty good. However, our capacity to project a change in the number of folks who will qualify for Medicare coverage as disabled is extremely limited. You can get into quite a debate as to whether change in the number of disabled persons is going to continue, diminish, or even accelerate further.

Where does that leave us? We at HCFA, recognize and do not for a second underestimate the difficulty and the magnitude of the task that we all have before us and that this subcommittee has undertaken and to begin to address. However, I think we need to attend first to our short-term issues because they are tied to the very important imperative of balancing the Federal budget over the next 5 years and because I think doing so will make some structural and organizational changes in the nature of the program that will be of some help in dealing with the longer-term problems of financing the Medicare program.

But, in order to address the longer-term solutions, we are going to need not only some degree of cooperation, but a way to engage all sorts of folks in discussions of what our society should be 20–30 years from now. As several of you have suggested, we must involve especially those outside this Beltway, and outside this city, in thinking with us about the kind of society we would want to have and what we will need to do to move toward the expectations we have about that society.

I would suggest that, even with the excellent work of Senator Kerrey's commission, and others, we are really just at the very early stages of thinking through all of the implications of those changes. We think it is very important that we start the process of thinking through them right away, and we very much look for-

ward to the opportunity to think through them with you in the months ahead.

Again, I appreciate the opportunity to be here. I appreciate your consideration about scheduling issues, and I am happy to respond to any questions or comments you might have.

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

Senator GRAMM. Thank you, Bruce. Let me just make a couple of points. I will be brief, then yield to my colleagues.

First of all, the one point you made, I think very clearly, is there is no doubt about the fact that the people are going to be here, that actuarially this is a certainty that we have this crisis, and that we have two different problems.

One, we have got a problem in that revenues coming in to Medicare are determined by the average wage rate times the number of people that are actually employed, and that figure has to equal a per capita cost times the number of people that we have who are qualified for Medicare.

So to have any kind of even short-term stability when you have got real wages growing around 1, 1.2, 1.3 percent in real terms, and when you have got the labor force growing in the 1.2–1.5 percent range, that even in the short-term we are a long way from dealing with the short-term cost problem where we are sitting.

I assume that you would agree that, if you reduce reimbursement rates, that there is a one-time effect but does not change anything in this formula. It simply shifts the line-up, so to speak. Or if you raise premiums or taxes, that also has a one-time effect, unless it is done in a way that affects behavior. So would you agree that, ultimately, we have got to change the behavior of those buying and selling Medicare services if we are going to have any hope of dealing with this problem, even in the short term?

Mr. VLADECK. Well, Senator, I am not sure we have seen the middle level and the end of all the changes that have gone on in the health care sector in this country in the last five or 6 years.

But I would argue that most of the savings that we have attributed to managed care in the last decade have, in fact, come about as a result of more effective negotiations about price and redistribution of incomes in the system rather from dramatic changes in behavior on the part of either consumers or providers of service.

I think the underlying analysis is absolutely correct. As long as health care costs are growing faster than the wage base on which the revenue is applied, depending on the rate at which people are coming into and out of the program, you have a structural problem.

Whether we are going to be more effective in controlling health care costs in the short-run by changing behavior or more effective by controlling price by changing the nature of the way that purchasers behave and competition among sellers, I think is an interesting theoretical argument. We probably cannot come to a conclusion on that anytime soon.

But the point is, we have to bring the rate of medical costs growth down to some reasonable relationship to the revenues supporting those medical costs. I think we could all agree on that. But, again, that works only so long as the number of folks supplying the revenue is in some balance with the number of folks receiving ben-

efits from the revenue. Once the demographics start to shift dramatically, you have got to do additional things as well.

Senator GRAMM. Well, I do not want to get too much into the President's proposal, but I think the President, clearly, from my point of view, is moving in the right direction by expanding the number of options that Medicare beneficiaries could exercise in choosing the mode that they consume their medical services. I think that is going to be a very fruitful area for us.

But let me ask you a question about the fundamental Medicare program. I know you know more about it than anybody here, because I have read a lot of your stuff to try and understand it. But, as I look at it—and I was not here when the Medicare program was written—but, to save my life, I cannot figure out any logic in a system that, for example, just to take one part, on hospital benefits you have got no co-payment for the first 60 days, and then on the 61st day you have a $184, roughly, co-payment per day. Then on the 90th day, that goes up to over $360 per day. Then on the 150th day, somebody is thrown out on the street. It seems to me that any kind of rational system would have had a co-payment, and would have had co-payments up front. But nobody who has been in the hospital for 60 days could respond to a co-payment.

The threat of being thrown out on the street at 150 days has led my mother, and most other people's parents, to buy a Medigap policy that fills up all of those gaps, but at the same time, eliminates the necessity of having to pay co-payments and deductibles. So, except for pharmaceuticals, she faces no cost at all in consuming health care.

Now, I do not want to put you on the spot, but just let me ask you, theoretically, if you were going to start Medicare again, would you have structured costs the way they are, or would you have put the deductibles and the co-payments up front?

Mr. VLADECK. Well, let me, if I may, Senator, remind you that inpatient hospital benefit has a $760 deductible. Having said that, I do not think anyone would seek to justify the current structure of co-insurance and deductibles on the Part A side. I would argue that the Part B side looks pretty sensible in comparison to a lot of private plans.

We think it would make a lot of sense to modernize that structure in a variety of ways. Again, for the services that we are talking about, the evidence about the behavioral effects of varying out-of-pocket expenditures is much less dramatic than it is for the more "discretionary" services like those under Part B. And under Part B, we already have a more rational structure.

So what the economic implication of that would be, I think you will have some honest-to-goodness, board certified economists here in the subsequent panels and they may have opinions on that. But we would be all for making the structure of co-insurance and deductibles more rational. I just do not know how far it would get you in terms of addressing the financial problems of the program.

Senator GRAMM. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Bruce, it is interesting, when you look at CBO projections of private health insurance from 1996 to 2007, they are saying it will come down from the present, let us say, 6.8 percent projected

growth to 5.1 percent. Then Medicare will come down from 10 percent, down to 8.6 percent, again, taking us to the year 2007.

Part of the reason that the Medicare cost is coming down, I take it, is that you now have about 25 percent of Medicare recipients in HMOs, is that correct?

Mr. VLADECK. No, Senator. We now have about 13 percent of Medicare beneficiaries in HMOs.

Senator ROCKEFELLER. Well, I am talking about your projections. You are projecting up to 25 percent.

Mr. VLADECK. But under current law, both our actuaries and CBO's actuaries score increments in HMO enrollment in the Medicare program as a net increase in costs to the program.

Senator ROCKEFELLER. All right. Now, if you can explain private health insurance going from 8.9 percent of 1992 projections to 5.1, that is a fairly dramatic leap. I have to assume that competition with an HMO's managed care has something to do with that.

Mr. VLADECK. Well, I think there are three things going on. I think it is somewhat more valid to look at per enrollee or per capita numbers rather than aggregate numbers. Over the last 3 years, using CBO or using OMB numbers, the private sector has outperformed Medicare. Under current law, the private sector still will.

I think it is clear that the total change in the health care marketplace, of which managed care is one manifestation, has generated substantial savings for payors that have not been taken advantage of by the Medicare program. There is no question about that.

I also think there has been some documented shift in the private sector from employers to individual households. Where that fits in terms of the magnitude of the CBO numbers, I am not entirely certain, but for completeness in looking at the numbers, you have to remember that piece of the puzzle as well.

Senator ROCKEFELLER. That skirts a question which I will not ask now, but I will simply raise for future reference, about rural areas where seniors would not have a choice, let us say, of HMOs. I mean, if they had one they would be lucky and they would have to go ahead and take that, no matter what. That distribution is one that is out there.

Let me go on to another part. I do not know the figures on this, or the facts on this, but I have to think that the way technology is coming along, and now you are talking about miniaturization in medical technology, as in manufacturing technology, which sort of our minds cannot even begin to take in what those implications might be.

Therefore, the whole cost to Medicare of people who are over 84 years old, that being for some time already the fastest-growing population within Medicare, what do you project in trying to look at this sort of larger picture for the longer-term, the implications of, simply, medical advances which are going to be tremendously expensive, particularly at the beginning, and which are going to be taken advantage of, with or without an HMO gatekeeper concept, which would then be an important consideration, and its affect on Medicare budgets, regardless of what we do with it, just the raw numbers?

Mr. VLADECK. Again, it is very interesting. A lot of it has to do with the amount of uncertainty that we are talking about. If you look retrospectively, or if you look over the next decade or so, our actuaries attribute a significant amount of the growth in Medicare costs and other health care costs to the adoption of new technologies, new treatments, and new interventions, and so forth. I think CBO would have a very similar analysis.

I would say that we get this all the time on a case-by-case basis, and I am not sure, if one looks at the treatment of coronary disease, for example, that over the life of a beneficiary the use of an advanced stent as part of angioplasty costs us more money net than an older technique, but it sure keeps the beneficiary alive longer. After about 2010, they pull those out of the model, in part, I guess, because of their perception that just the sheer numbers of folks outweigh everything else.

Senator ROCKEFELLER. I understand where you are going, and I need to get my last question in. How do you look upon Medicare as social insurance as compared to health insurance; how do you mix those two philosophically?

Mr. VLADECK. Well, I think there are three issues there. The first is, of course, that health expenses are such a large proportion of the total expenses of elderly persons that Medicare, in and of itself, is an income maintenance program.

It is a barrier against poverty for seniors who, if they had to pay a larger share of their health care expenses out of pocket, would fall below the poverty level. This is the part of the population that is most vulnerable to health care costs.

Second, clearly, Medicare has some of the attributes of a social insurance program in that everyone pays proportionately the same amount during their working lives, and everybody pays a flat premium for Part B when they retire. But the benefits are not distributed according to contributions, according to past earnings, or anything. They are distributed according to actual consumption of health care services.

Third, the universality of the Medicare program also turns it from health insurance into social insurance, I think, in a variety of important ways, and with some important economic consequences as well.

Senator ROCKEFELLER. Thank you.

Senator GRAMM. Senator Kerrey.

Senator KERREY. Mr. Vladeck, this is probably going to be too long a question with a very simple point. I am trying to discover whether or not, in your quiet, private moments, you have any thoughts sort of outside of the box of the traditional solutions to Medicare. Again, referencing this Presidential Entitlement Commission Senator Danforth and I chaired, Social Security, in many ways, is an easier problem, because that is just a transfer payment to individuals. It does not involve all of the detailed internal calculations of what produces what kind of behavior, and analyses. It is easier to figure out.

But, again, you get quickly to some very ugly solutions. When you are dealing with 77 million people, the baby boom generation, one of the things that you face is, if you are just looking at it from an actuarial, not a political, standpoint, you say, well, what we

need to do is move the eligibility age back. But, coming in the other direction, the market, the individuals, the citizens, are saying they want to retire earlier, or they are feeling health care insecurity earlier as a result of down-sizing, if you are talking about Medicare. So you find yourself with a problem.

Again, secular humanists did not cause 77 million baby boomers. That is not Ronald Reagan's fault. You have got a big number there, and you have got to solve it. As I said, the universe of options are not very great if you are looking at it only as a budget issue. So, as I said, Social Security, in some ways, is an easier one to address than Medicare.

Medicare, for all of our talk—and I appreciate very much your answer to Senator Rockefeller's question about the equities of it as a social insurance—under the law, what it really is, is a legal claim on somebody's income to pay somebody else's bills. That is what it is. We have got 41 million Americans out there without health insurance, most of whom are working, who have no legal claim on anybody else's income.

Now, you are hearing a question from somebody who has got a legal claim on theirs. I am a service-connected disabled veteran. I have talked to a lot of families in Nebraska whose children are amputees from various accidents, and so forth, and they are out there begging for charity because their insurance is either absent a requirement to pay, or they do not have insurance.

I have got a claim on their income. Colin Powell has got a claim on their income. A lot of people who are wealthy on Medicare, they have a claim on their income. Every State and Federal employee has a claim on their income. These folks are out there begging.

Moreover, you have got a real question of inter-generational equity here. In Nebraska, I have got 330,000 school children, public and private. We spend $1.6 billion on them. We spend $3.2 billion on 200,000 people over the age of 65.

If you look at the President's budget, he is out there courageously asking for a big increase in education, most of which goes to higher education, as Senator Grassley was honing in on earlier. My guess is, and I did not bring the budget numbers, it is probably a $35–36 billion increase in Social Security and Medicare together, with almost no debate.

I am wondering if, in the process of thinking about this, after you have heard all the passionate arguments about what good the program does, have you thought outside the box? For example, it is counter-intuitive, I will admit, but one of the counter-intuitive thoughts that I have had, is maybe we should just start from scratch and take Medicare, Medicaid, and VA income tax deduction and say we are going to change the way you are eligible.

If you are an American or legal resident you are in. Everybody pays according to the capacity to pay. One of the most effective arguments against the President's health care plan in 1993 was that bumper sticker that said, "If you think health care is expensive now, wait until it is free."

I mean, I do not think you can ignore that you have an offer on the table right now that basically says, even though I am only paying 55 or 60 percent, you still basically got a promise that says, do not worry, once you get to be 65 somebody else is going to pay the

bills, somebody else is going to at least pick up 55 to 60 percent of the bills. And, lest it go unnoticed, we are asking researchers to keep us alive longer and keep us healthier while we are alive.

So I am wondering if you have thought, sort of outside of the box rather than just taking one of the ugly budget options that are available under Medicare, about any kind of health care reform that might help us solve other problems that we have got in our system, too?

Mr. VLADECK. Let me just say a few things, if I may, Senator. I do not know how good a response to your question this is, if this is a response at all. I think it is important to remember that, even though the numbers do not work—and they do not work in Social Security either—Medicare is a contributory program. What that means is not that every Social Security beneficiary or every Medicare beneficiary is drawing on an account in which they, themselves, put the money, because we know that in neither program has that ever worked entirely. There has always been a considerable pay-as-you-go element in both Social Security and Medicare.

But, what the contributory social insurance programs have been since their inception, I do believe, is a kind of social and intergenerational contract as much as anything else.

Senator KERREY. To allow wages to be taxed at a fixed percentage and transferred to another group.

Mr. VLADECK. No. 1 I think what the contract has been, the way I understood it at a younger age and the way my kids understand it, is that we pay a part of our income to provide certain kinds of support for certain needs of our parents' generation.

When we get to be our parents' age, our children and grandchildren will pay a certain part of their income to support our generation. The equation works or does not work only partly as a matter of demographics. The other pieces of the equation, as the Chairman pointed out in the beginning, are economic growth and the growth in expenses to maintain retired people. But I think we have to think about this inter-generational contract. I think when we talk honestly to members of the next generation of taxpayers, they give us a somewhat different answer than we, ourselves, would give in terms of their greater willingness to support older people and to do a lot of other things for which they might pay taxes. So, I think that is the conversation we need to have that we have not had in a very effective way.

Senator KERREY. Well, you used a very key word there, when we talk to them honestly. Very often, we do not. Very often we do not disclose all of the facts about how the income is being transferred and distributed now. As I said, you have described the program as you understand it. I understand it in a very similar way. It is a contributory program, but, nonetheless, under law it is a legal claim on somebody's income to pay somebody else's bills. That is what it is.

So long as I am putting a legal claim and transferring it to somebody who has an urgent need, I have no trouble with that. But I see lots of claims out there being transferred to people that do not have the need. Again, you are talking to one right now, under current law.

We had the big VFW convention here last night, and I suspect all kinds of great speeches were given. I am glad I was not there, because it probably would have made me nervous as hell that somebody might be able to dig up my income tax return and figure out that I did not need what they were giving me.

Senator GRAMM. Senator Grassley.

Senator GRASSLEY. Yes. While we are discussing the long-term viability of Medicare, and not only you, Mr. Vladeck, but also the committee, I hope that we can, all the time we are talking about the long-term viability, discuss the inequities between rural and urban areas that come as a result of the program the way it is now. If we do not do anything about it, the difference is going to be dramatically different as years go on.

That is the issue of the AAPCC, and what your thoughts are about doing something about that right now, as well as in the future. We have situations in my State where the average per month, per beneficiary is $288; in Miami, it is just a little under $700; in the Bronx, just a little over $700.

In some of these areas where the money is used to buy into HMOs, people get with their program, pharmaceuticals, lower copays, eyeglasses, wellness, so I raise a question about that. Not that it is bad that they have it, but that the situation is not such in rural areas of America, where we practice more inexpensive medicine—although I am sure Iowans in hospitals today would think I am crazy for saying that, but on a relative basis, relatively inexpensive medicine. Considering the fact also that Medicare is a national program, we ought to be able to get into some of those programs and have this be a national program rather than some people having a lot of fringe benefits that others do not have.

From the standpoint of it being a national program, I would like to have your feeling whether or not, in rural areas where we do not have these fringes that HMOs would have in Miami, your comment on that, and the possibilities of moving toward correcting that situation.

Mr. VLADECK. Senator, the President's budget calls for two mechanisms to address those problems. One, in a manner similar to our proposal last year or to the Majority bill of 1995 or the coalition bill of 1995, a movement toward reduction in the differential between high-rate and low-rate counties in the AAPCC through some blending of the national and local rates. At the same time we were proposing, as has been proposed in the past by a number of folks, a floor of $350 per enrollee per month in the capitation rate in the lowest cost counties in the United States.

Between them these two proposals would substantially shift the relative capitation rates very much in the direction of rural and other low-cost counties. Those are both part of the budget proposal.

Senator GRASSLEY. Now, am I right that $350 would kick-in in 3 years?

Mr. VLADECK. No, sir. That $350 would be effective at the start of the fiscal year, except that most HMO contracts with Medicare are on a calendar year basis, so presumably it would be generally available on January 1, 1998.

Senator GRASSLEY. Now, considering the fact that $350, as a threshold, was what was in our bill 2 years ago, it seems to me like

that is considerable progress where we are, but we would have been there January 1, 1998. So this would trigger in January 1 of——

Mr. VLADECK. 1998.

Senator GRASSLEY. No. We would have been at $350 on January 1, 1997, in the bill that the President vetoed. You are proposing $350 for January 1, 1998.

Mr. VLADECK. Yes, sir.

Senator GRASSLEY. Then is it your study of it that, if we were able to have that level of a threshold, that we would be able to then provide some of these programs, like eyeglasses, lower co-pays, wellness programs that they have presently in Miami, the Bronx, and places like that?

Mr. VLADECK. Sir, given what we know about the cost structure of the provision of services in those communities, my belief is that the availability of supplemental benefits at no premiums would be very, very extensive. This, of course, depends upon what plans are available in those communities.

Senator GRASSLEY. Would be very expensive?

Mr. VLADECK. Extensive.

Senator GRASSLEY. Extensive.

Mr. VLADECK. Yes, sir.

Senator GRASSLEY. So then you are saying, at $350, you would expect in rural areas we could do that.

Mr. VLADECK. Absolutely.

Senator GRASSLEY. Thank you, Mr. Chairman.

Senator GRAMM. Thank you, Senator Grassley.

Bruce, thank you for coming before the committee. I would like to ask you for one thing in writing. I have started to receive from people that have held positions in government ball park estimates of the new additional benefits in Medicare that the administration asked for in its budget, which will be presented by the Secretary later this week. Basically, they are questioning the cost beyond the 5-year period, of these add-ons such as the Alzheimer addition, and specifically the addition where you take outpatient care and reduce the co-payment.

If you could get someone to give me a ball park estimate on how much those new programs cost, not just over the 5 years, but over 10, 20, or 30 years, it would be very helpful to us.

Mr. VLADECK. We can do that, Senator. It is Wednesday afternoon. I will not promise it before Monday, but we will have it to you as soon as we can.

Senator GRAMM. No, that is fine. I think if you can give it to us Monday, a week, it would be good.

Mr. VLADECK. You have got a deal.

Senator GRAMM. Thank you very much.

Mr. VLADECK. Thank you, sir.

Senator GRAMM. Let me call our witnesses from the Congressional Budget Office. Joe Antos, Linda Bilheimer, Sandra Christensen.

Let me say to my colleagues that, in the last 3 or 4 months as I have tried to read everything I could find on Medicare, that while I am not saying I always agree with what the CBO writes, I think

their material is of consistently high quality and some of the best work that I have read.

It is my understanding that, Joe, you will make the presentation, then everybody else will participate with you in the questions. So, let me go ahead and recognize you.

STATEMENT OF JOSEPH R. ANTOS, PH.D., ASSISTANT DIRECTOR FOR HEALTH AND HUMAN RESOURCES, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC; ACCOMPANIED BY LINDA BILHEIMER, PH.D., DEPUTY ASSISTANT DIRECTOR FOR HEALTH, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC; AND SANDRA CHRISTENSEN, PH.D., PRINCIPAL ANALYST, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC

Dr. ANTOS. Thank you, Mr. Chairman. You are most kind. Thank you, Mr. Chairman and members of the committee for this opportunity to discuss with you today the outlook for Medicare spending and options for slowing its long-term growth.

With your permission, I would like to submit my statement for the record and I will briefly summarize my remarks.

Senator GRAMM. It will be printed in the record.

Dr. ANTOS. Thank you.

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

Dr. ANTOS. I have four points to make today, Mr. Chairman. First, Medicare spending in the near-term will continue to grow faster than our ability to pay for it. Second, incentives built into the current Medicare program are driving that rapid growth in spending.

Third, as challenging as Medicare's near-term financing problems are, those problems will be dwarfed by the crisis that will occur as the baby-boom generation reaches age 65. Fourth, restructuring is needed to put Medicare on a sustainable spending path for the long term.

CBO projects that Medicare spending over the next 10 years will continue to grow faster than the resources available to pay for the program. Medicare outlays under current law will increase from $212 billion this year to $469 billion in 2007. That represents an increase in spending of 8.3 percent a year. Over the same period, CBO projects that GDP will grow by only 4.7 percent a year.

Both parts of the Medicare program, HI and SMI, are growing rapidly. The HI, or Hospital Insurance program, also known as Part A of Medicare, covers inpatient hospital care and post-acute services provided by hospitals, skilled nursing facilities, home health agencies, and hospices. Spending for HI is expected to increase by 7.7 percent a year over the next decade, as shown in the first table of the prepared statement.

HI outlays have been greater than receipts over the past 2 years. At current rates, the HI trust fund will be depleted during the year 2001.

The SMI, or Supplementary Medicare Insurance program, also known as Part B, covers services provided by physicians and other outpatient providers. Spending for SMI is expected to grow by 9.1 percent a year through 2007, which is even faster than the growth of HI spending.

Unlike HI, which is financed primarily by a payroll tax, three-quarters of SMI's financing comes directly from general revenues. Because this call on general revenues is not limited under current law, the SMI trust fund cannot be depleted, but spending growth in SMI is very much a part of Medicare's financial crisis.

The high rates of growth in Medicare spending reflect the rapid rise in medical costs per beneficiary. Medicare spending per beneficiary is projected to grow by about 6.9 percent a year over the next decade, and much of that growth is due to an increase in the use of services.

My second point is that incentives built into the current Medicare program are driving that rapid growth in program spending. Although most beneficiaries have a choice of traditional fee-for-service Medicare or an HMO, nearly 90 percent choose the traditional system.

That system provides little incentive, either to beneficiaries or providers, to limit their costs. Moreover, Medicare does not realize savings possible for managed care because Federal payments to HMOs are linked to costs in the fee-for-service sector.

Third, the already high rates of growth in Medicare spending will accelerate sharply after 2010 as the baby-boom generation reaches age 65. Enrollment will rise rapidly after 2010, as the baby boomers become eligible for Medicare. Between 2010 and 2030, for example, enrollment is projected to grow by 2.4 percent a year compared with the 1.4 percent annual growth that we project through 2007.

By 2030, as Bruce and others have indicated, Medicare enrollment will double from what it is today to over 75 million people. At the same time, Medicare's costs per beneficiary could continue to spiral upward, placing an enormous burden on the Federal budget and the economy.

How big a problem might this become? Medicare trustees assume that growth in spending for beneficiaries will gradually slow between 2005 and 2020 to be more in line with growth in national income per capita. But the trustees' assumption may be optimistic, since no policies designed to slow spending per beneficiary are currently in place. Moreover, even with the trustees' assumption, Federal spending on Medicare is projected to overtake spending on Social Security within 30 years.

Clearly, staying on Medicare's current spending path is not sustainable in the long term. Although we might decide to devote a larger share of the budget and of national income to Medicare in the near term, no program can indefinitely grow faster than the economy.

Fourth, restructuring is needed to put Medicare on a sustainable spending path for the long term. In a recent analysis that we are updating next month, CBO looked at three widely discussed options for slowing Medicare spending in the long term. We use the ratio of Medicare spending to GDP as a yardstick for assessing how successful alternative policies might be in limiting spending.

Let me move quickly through this.

Senator GRAMM. Go ahead and finish your statement.

Dr. ANTOS. All right. Delaying the age of eligibility from 65 to 70 would ultimately reduce Federal spending for Medicare by 15

percent, compared with current law, but net spending would continue to grow as a percentage of GDP after 2010.

Increasing Medicare premiums would also reduce Federal spending, but those premiums might reach unreasonable levels. We looked at an example. Premiums that would cover 50 percent of Medicare's costs—that is total Medicare costs, not just SMI costs—would be sufficient to keep net Medicare spending as a share of GDP fairly constant over the next 75 years. Such high premiums would, however, consume a large and ever-growing share of enrollees' income.

Senator GRAMM. How high are those premiums?

Dr. ANTOS. Excuse me?

Senator GRAMM. How high are those premiums, do you have the numbers there?

Dr. ANTOS. We probably do not.

Dr. CHRISTENSEN. They would represent about 50 percent of Medicare's total costs or $3,000 at today's costs.

Dr. ANTOS. Restructuring the program could broaden competition among health plans, provide incentives for enrollees to choose lower-cost plans, and limit the growth of Medicare's contribution toward premiums.

Competition among plans and providers could spur efficiency and increase real health benefits per dollar spent, but Medicare would shift the risk of excessive cost growth to health plans and enrollees, in effect, transforming the program into a defined contribution plan.

The impact of the restructuring option on the total costs of a basic benefit package, and therefore on the costs beneficiaries would face, are uncertain. Some plans would probably keep their costs low enough to avoid charging supplemental premiums, possibly jeopardizing access and quality. Other plans might do a better job with access and quality, but at a higher cost to enrollees.

To conclude, exactly how much budget stringency is needed in Medicare and how to achieve it are open to debate. What is clear is that Medicare must prepare for the unprecedented demands that the baby-boom generation will soon place on it. Policies put in place over the next several years could provide necessary deficit reduction in the short term and start the restructuring needed for the longer term.

Thank you.

Senator GRAMM. Thank you, Dr. Antos. Let me begin by going back to a point that you made, and I want to be sure that it did not escape anybody's attention. Currently, the trustees have an estimate that, at the end of 5 years, we are going to have $106 billion deficit.

At the end of 5 years, the trustees say it will be $106 billion a year, at the end of 10 years, $193 billion a year, at the end of 20 years, $564 billion a year. At the end of 30 years, it will be $1.2 trillion a year.

The debt accumulated in the Part A trust fund in 5 years would be $121 billion; in 10 years, $603 billion; in 20 years, $2.8 trillion; and in 30 years, $8.7 trillion.

But there is actually a trick built into those estimates. That is, the trustees assume that early in the next century there is going

to be a change in policy that will bring the costs of Medicare in line with medical prices in general. But nowhere do they explain that policy, nowhere are they making a proposal that would do it.

I guess the implicit assumption is that, economically, we will have to make that change. Since the numbers are so big anyway, they go ahead and build what is tantamount to sort of a solution to the per capita cost into the equation. Is that your reading?

Dr. ANTOS. Mr. Chairman, I think the trustees' assumption is based on the reasonable principle that, if something cannot happen, it probably will not. The thing that cannot happen, ultimately, is that we cannot have Medicare, or any other program, grow large enough to consume all of the Federal budget.

The trustees' assumption, more specifically, for HI, is to slow the growth in spending down to the rate of growth of average hourly earnings after 2020. In SMI, it is to slow the rate of growth in spending to the growth in GDP per capita.

Senator GRAMM. Well, let me stop you there and let me just get a ball park kind of answer. Have you ever seen a proposal from any administration or any Congress that would achieve that goal, if implemented?

Dr. ANTOS. Well, Senator, the budget process generally speaks in 4- to 7-year terms. So one reason why one has not heard of such a proposal is that we are talking about a very long-term issue.

It will arrive if we do not take steps between now and then, but there is no opportunity in the policy process to make that recommendation.

Senator GRAMM. I guess the point I want to make, is that even in these incredible numbers for the trustees, there is the built-in assumption that there is going to be a dramatic policy change which no one has yet proposed, and neither Congress nor the President has yet to implement. I think it ought to give us real pause as we look at these numbers.

The second issue I want to address, is the issue of incentives. You talked a little bit about allowing people to choose alternative modes of consuming health care. The President has made a proposal now to move in that direction. As you know, 2 years ago Congress made a proposal to move further in that direction.

But let me go back to the standard Medicare policy, where you have a split deductible, where the deductible for Part B is $100, and the deductible for Part A is $760, and when Part A has no copayments until you become a very substantial user. Do you believe that the current structure really leads in part to the explosion in costs that we are seeing? How long have you been at CBO?

Dr. ANTOS. A full 2 years, sir. But my colleagues have been there much longer.

Dr. CHRISTENSEN. Longer.

Senator GRAMM. Give us your ideas in the short-term problem of cost control, of what you think we need to do that could achieve this goal that the trustees assume will be achieved, and that is, bringing down the growth of Medicare costs to a level of growth that the economy could pay for.

Dr. ANTOS. Let me see. You have asked a number of interesting questions. On the question of the structure of Medicare's cost-shar-

ing requirements, I think most analysts today would agree that structure is not very well designed.

However, because so many people have Medigap coverage, which is required to fill in those gaps—to fill in not only the high-end expenses that Medicare does not cover, but also the first-dollar expenses—the incentives that could be there through cost sharing to make beneficiaries more sensitive to those costs and more prudent purchasers of health care are largely vitiated.

Now, there are ways to deal with that problem. Medigap coverage, in effect, induces more utilization in health care than would be expected otherwise.

If Medicare were reconfigured placing a maximum limit on out-of-pocket costs as well as other kinds of adjustments in the cost-sharing structure, then perhaps it could be improved without increasing Federal costs.

Senator GRAMM. Would any of our other panelists want to respond to the question about restructuring, having studied this, in your case, for a substantially longer time, the basic Medicare system in a way would promote greater cost sensitivity and efficiency?

Dr. CHRISTENSEN. Well, it is the case that Medicare's cost-sharing requirements are perverse given the evidence that exists. The evidence that exists on the effects of cost sharing is that those effects are largest at the time that a patient initiates an episode of care, and that they are largely ineffective once the episode of care has begun. At that point, the patient is largely under the control of the doctor, who does not necessarily respond to the cost sharing that the patient might pay.

So it would make more sense to have higher cost-sharing requirements in the SMI program at the point at which a patient first decides whether or not to go to the doctor. It is really not necessary to have the rather substantial cost-sharing requirements that we have on the HI side. As you point out, there is no co-insurance, per se, on the initial 60 days of the hospital stay, but there is a first-day deductible, which is hefty.

Probably none of the incentives on the hospital side are necessary because people do not go to the hospital for frivolous reasons. Once they are in the hospital, the PPS system ensures that patients are discharged as quickly as quickly as they can be.

So within Medicare you could certainly restructure cost sharing such that you had a higher SMI deductible, probably some co-insurance on home health, which is another instance in which the patient can initiate care and lower cost-sharing requirements on inpatient stays.

That, perhaps, would reduce the very great desire that Medicare enrollees have to purchase Medigap policies. What would reduce that desire still further would be to have a cap on copayment costs in Medicare. CBO has in the past done options of that sort. Adding a cap on copayments in Medicare, along with restructuring some of its other co-insurance parameters, could be done at no additional Federal cost if, along with that, you eliminated the possibility of Medigap coverage for the cost-sharing that remains in Medicare. By eliminating Medigap, you could save from 8 percent to 10 percent of Medicare's costs.

Senator GRAMM. Would you like to add to that?

Dr. BILHEIMER. No, nothing further to add, Senator.

Senator GRAMM. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

On page 5 of the testimony, Dr. Antos, you have a phrase there, the third sentence from the top, "Give neither beneficiaries, nor providers, much incentive to limit costs." You are referring to Medicare's current reimbursement fee-for-service system.

I just want to kind of keep some perspective on this discussion, because if I am to take, literally, what I have heard from my colleagues, there really is not a solution for Medicare after the year 2020, but for the one, Dr. Antos, that I am convinced that you yearn for, which is the cap voucher.

I have some problems that I want to discuss with you about that. But is the DRG hospital system not a form of incentive? That accounted for about $84 billion, which is a very large part. Does that not qualify as being an incentive?

Dr. ANTOS. I would agree that any system that brings together in one payment more of the services delivered in an episode of care clearly reduces the incentives that previously existed in the hospital sector to unbundle, to subdivide the services, and to get——

Senator ROCKEFELLER. Because that is basically saying that, no matter what it is that you have to do to this patient, no matter what exigencies arise during the term of the patient, this is what you will be paid for that DRG group.

That was really the first of the major interventions in trying to get Medicare under control, and I think it has been effective. $84 billion is not the savings, obviously. That is the amount of hospital payments as a part of Medicare, and that is a great deal. Good. I wanted to get that.

Now, going back to this inflation thing, you say that private health insurance is going to be, from 1996 to 2007, 5.1 percent; Medicare is going to be 8.6 percent. Nevertheless, therefore, is it not possible to say that the private health insurance sector is still going up at twice the rate of inflation in this country?

Dr. ANTOS. Those figures suggest that it would be growing faster than inflation. I cannot remember what our projection of inflation is. It is probably around 3 percent.

Senator ROCKEFELLER. Roughly.

Dr. ANTOS. So it is almost twice, yes.

Senator ROCKEFELLER. Roughly. Yes. So that, in a sense, it is not just Medicare costs that become "increasingly burdensome to the country," as you have stated, but also that the private health system is increasingly burdensome to the economy, to the country, to the future hope of America, right?

Dr. ANTOS. Absolutely. Any single component of the economy that is growing faster than the rest of the economy will eventually consume it.

Senator ROCKEFELLER. Yes. Therefore, when we are talking about the sort of intrinsic future, we have to deal in both areas, Medicare, Medicaid, private sector, all of them, and we will all have our hopes for HMOs. But that takes me to my next question.

That is, assuming, as I do—and tell me, wrongly—that your referred restructuring of Medicare, on a per beneficiary basis, would be giving seniors cap vouchers.

Dr. ANTOS. I would not want to characterize that as CBO's recommendation. That happened to be one of three or four long-term options that we estimated in a report that we did last year.

Senator ROCKEFELLER. All right. Let me then just speculate.

Dr. ANTOS. All right.

Senator ROCKEFELLER. Then I want you to help me to understand how that works in East Texas or in West Virginia. First, there is not now—and I do not know about East Texas—a single, risk-based Medicare HMO operating in West Virginia, not one.

Yesterday, the insurance commissioner of the State said that the few HMOs that are operating in West Virginia are no longer profitable, i.e., they are losing money. None of them, incidentally, are federally certified to serve Medicare beneficiaries. So the so-called supply of Medicare HMOs in West Virginia is one that we cannot even talk about. Now, you have 55 counties, you have lots of problems there.

The Chairman will forgive me if I digress here, but let us say Dr. Smith signs up with managed care plan A in Tyler County, WV. There is not one provider available to sign up with managed care B, because it does not exist.

If a senior living in Tyler County wants to continue receiving care from their lifelong doctor, which is a mantra that I have heard over the last several years, what choice do they have but to sign up with HMO A; do they have any other choice?

Dr. ANTOS. I am not really familiar with the circumstance that you are describing.

Senator ROCKEFELLER. Yes, you are.

Dr. ANTOS. I am very familiar with the problems that rural people have in getting the choice of health plans that people in urban areas in large markets might have. Linda, you might take that one.

Dr. BILHEIMER. Yes. I think, Senator, some of the things that are being considered now by the administration and by HCFA are new options for offering managed care that would particularly help rural areas, and one in particular is to allow Medicare to contract with provider-sponsored networks.

Senator ROCKEFELLER. I know. That is what they keep saying.

Dr. BILHEIMER. Well, if provider-sponsored networks became eligible for Medicare reimbursement, then local medical societies are very likely to form such networks. So a person living in a rural county in West Virginia might very well be able to continue to receive care from their lifelong physician in a plan that was formed by the physicians in that community.

Senator ROCKEFELLER. In a bill which was sponsored by Bill Frist and myself.

Dr. BILHEIMER. Yes, sir.

Senator ROCKEFELLER. And adopted by the administration.

In any event, I want to put that problem before you—my time is out—as well as the one that I earlier referred to you, and that is the problem of the average income annually of $10,700, and what that causes and what that brings upon a senior.

This is not simply to make a classic "don't touch Medicare" argument, this is simply that we have to not only deal with the horror of the figures out there in the future, but we also have to deal, in looking at the big picture, which these hearings are about, at the

real people who live, just now and for the next several years, under current circumstances, whatever they might be. Thank you.

Senator GRAMM. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman.

I appreciate the work you have done here. This is really a definitive effort on this, and I look forward to having an opportunity to study it some more.

I am going to ask you a couple of questions. First, when we talk about Medicare going broke, what we are really talking about is the hospital insurance fund going broke, because the Part B is an open-ended program. As long as you pay your premiums, your doctor gets paid.

Second, so even though you might be taking an ever-increasing portion of the Federal budget, there are no restraints on that so far, in Medicare. The program can spend all it wants out of the Federal Treasury under Part B.

So Part A is where they talk about it being broke, and there is no reference to what is happening to the Federal Government under Part B when they say the program is going broke.

Now, let me ask you this here. There are five steps that we dealt with last year in our centrist budget, and would they make a significant difference? Now, you have got to take some things for granted, and I will tell you which ones they are. All right. Ready? The first step would be to increase the eligibility age to the Social Security age. Now, that gets up to age 67, I am not sure when, 2012, 2018, something like that.

Second, means test Part B. Now, you are going to say, at what levels? I do not know what levels. We had a figure, and I must say I cannot remember it. It might have been $70,000. But take a reasonable level.

Third, reduce payments to the providers under Part A. Fourth, increase inducements for individuals to join HMOs. Fifth, to retain the premium at 31.5 percent under the Part B.

Now, I know there is some guesswork in there in the means test levels, and reduce payments to providers, but you have just got to guess at some of those. My question to you is, is this just putting your finger in the dike, or will these things have some long-range benefits, as you look at it?

Dr. ANTOS. Well, certainly I think that these ideas and the other ideas that were proposed in the major proposals of the last 2 years——

Senator CHAFEE. Well, could you name a couple of those other proposals?

Dr. ANTOS. The general idea that I think everyone has discussed is to provide more choice of plans to Medicare enrollees, for example, and other ideas to try to address Medicare's payment to those HMOs.

Those are steps in the direction of the kind of restructuring that might lead to a rosier financial long-term future for Medicare.

Increasing the eligibility age is certainly something that would save Medicare some money. I think our particular analysis looked at increasing the eligibility age from age 65 to age 70, but probably over a longer period of time than——

Senator CHAFEE. Well, I think you would have trouble with that. I think you can make such a logical argument in going to the Social Security age, it gets pretty tough beyond that. I am not saying it cannot be done, but ours seems to follow along.

Dr. ANTOS. Going to age 67 would ultimately save 5 percent of Medicare spending. Means testing Part B. We did an estimate that involved a means-tested premium last year, and I think, over 6 years, it might have saved $6 billion, or $8 billion, at the kind of income levels you were thinking about.

Reducing provider payments. Without restructuring the program, that is still a reasonable short-term idea. However, simply reducing payment levels will not change any of the incentives working to increase the volume of services.

Increasing inducements to join HMOs. As Administrator Vladeck pointed out, under the current payment system for HMOs and Medicare we would score that as a coster.

Senator CHAFEE. You mean, all your healthy people rush out and join the HMOs?

Dr. ANTOS. There is an element of selection; that is right. I think HCFA recently estimated that HMOs are over-paid, on the average, by about 8 percent, under the current system.

Then, finally, retaining the flat premium at some fixed level. We are now at 25 percent, and the proposal to maintain that level would certainly save some money.

Senator CHAFEE. Well, we were above that, because that is what we were. That is what it actually worked out to for the prior years, 31.5 percent.

Thank you. Thanks a lot for what you did here. We can all spend a lot of time on this, I think.

Thanks, Mr. Chairman, for holding these hearings.

Senator GRAMM. Let me thank you, Senator Chafee.

Let me thank our people from CBO. Again, I hope that the members, the people who are here who are interested, will read the CBO testimony, because I think it is about as clear and concise a statement as we have of the problem.

Let me call our final panel. I do not know if Marilyn Moon is here or not. Well, let me say, I have heard many good things about you, Ms. Moon, in terms of how smart you are. I am very appreciative that you have come to help enlighten us today.

And Gail Wilensky. I know Gail very well. I have a very, very high opinion of her. We are very fortunate to have a chance to listen to two people who clearly are experts in this area, and they have a lot to say that should be heard.

I am indifferent as to who goes first.

Dr. WILENSKY. Well, why don't you let me go first, because, as a W, I usually get to go last, alphabetically.

Senator GRAMM. All right. That is fine.

STATEMENT OF HON. GAIL R. WILENSKY, PH.D., SENIOR FELLOW, PROJECT HOPE, WASHINGTON, DC

Dr. WILENSKY. Thank you, Mr. Chairman, and members of the subcommittee for inviting me. I would like to have my written statement submitted for the record.

Senator GRAMM. Both written statements will be printed in full in the record.

Dr. WILENSKY. Thank you.

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

Dr. WILENSKY. I am currently a senior fellow at Project HOPE, and chair of the Physician Payment Review Commission, but I am here today to talk about the issues of Medicare purely from my own view.

I am concerned, and therefore appreciative that you are holding this hearing, that the public does not understand adequately the magnitude of the problem that we are facing in Medicare, but I believe hearings of this nature may help to inform the public.

There are at least three ways to look at the difficulties we are facing in Medicare, the short term, the intermediate term, and the long term. By that, I mean that the period between now and 2002, where we are looking at Medicare frequently in terms of helping to resolve the budget and bring us to a balanced budget bill, the intermediate period being between then and 2010, when the first of the baby boomers start to retire, and finally the period after the baby boomers are retiring, from 2010 to 2030.

When we look at Medicare, it appears to be growing at unsustainable rates relative to the rest of the budget, relative to revenues coming in to the trust fund, and also relative to the private sector.

In the 1980's, the private sector actually was doing worse than Medicare, but, since 1991, Medicare has been growing substantially faster. Right now, there is actually quite a widespread—about a 3.2 percent growth rate from 1996, the latest number that was available—versus 8.5 percent in Medicare.

As has been pointed out, that differential is projected to be not as great in the future because there is concern that the private sector might not be as aggressive as it has been in the last two or 3 years. I hope those projections are wrong.

When you look at the CBO numbers that we just heard described, basically it is what we have known about Medicare's problem for the last several years: the HI trust fund bankrupt in 2001, huge accumulated deficits in the next several years, by 2007, well over half a trillion dollars in the hole for the trust fund. It is clearly something that we cannot allow to happen.

If we only try to extend the trust fund by reducing spending, as a letter that CBO submitted indicated, you would have to make some very startling reductions either to reduce spending in the trust fund down to 3.4 percent per year if you started in 1998, even more drastically if you did not do it as soon as 1998, or you could have an increase of a substantial amount in the wage tax as another way out.

Or, alternatively, one of the things that is being considered that was part of the President's proposal is to transfer some current obligation of the trust fund into Part B, in this case, $80 billion of home care.

While you can make some argument as to why that might be justified on policy grounds, it is an issue that I find very troubling be-

cause of the precedent in terms of how it is being designed, at least, in the proposal.

That is, it is not really putting it into Part B. There are a lot of reasons you can say that our current split between A and B are archaic and arbitrary, that it really is not the way to redesign Medicare, but at the moment we have very few constraints in Medicare.

We have the wage tax feeding into the revenue of the trust fund with a big deductible, and then some very end expenses, after someone has been in the hospital for 61 days, of co-insurance.

In Part B, you have 25 percent paid by the premium, and the 20 percent co-pay and a small deductible. And, while you could make lots of arguments about why those are not wonderful constraints, it is very troubling to me to get rid of the constraints before you have reformed the program.

So if there is any consideration about moving parts out of the trust fund, it ought to be in the program as we now know it, which means subject to the usual constraints of Part B.

In terms of the long-term, the implications of these changes are stunning in terms of the fiscal impact. We are talking about going to 22 percent of our population being on Medicare, three times the current share of the GDP going for Medicare, up to 7.5 percent. But it is not really a surprise that we have all this problem.

We have some very perverse incentives, as I think you have heard, in the years before. There are not a lot of rewards for either the people providing services to the elderly to be cost effective or careful, and there are not a lot of rewards for the elderly, or the physicians, or many of the other providers, a little less true for the hospitals because of DRGs.

To my mind, we need to restructure Medicare. I am a fan of looking to the Federal Employees' Health Care Plan as a model. It basically has a fixed payment adjusted for age and some other components, hopefully health risk, that would allow people greater——

Senator GRAMM. Go ahead with your statement. You do not have to abide by the clock.

Dr. WILENSKY. Thank you.

Greater choices with the Federal Government making basically the same payment if someone takes an expensive plan, or a not-so-expensive plan, or traditional Medicare.

It ought not to be the government's business whether someone goes into managed care, indemnity insurance, or traditional Medicare, but it ought not to pay more—aside from the adjustments it makes—because someone chooses a more expensive or less expensive plan.

If we do not begin to do some serious restructuring that I think we will find ways to buy us a few more years, we will not solve this very significant social problem.

Medicare is a very important part of our current environment, and I think we owe it not only to the existing seniors, but to all of us who are going to be looking to that program at some point in the future to make these reforms and restructurings.

Thank you.

Senator GRAMM. Dr. Moon.

STATEMENT OF HON. MARILYN MOON, PH.D., SENIOR FELLOW, HEALTH POLICY CENTER, THE URBAN INSTITUTE, WASHINGTON, DC

Dr. MOON. Thank you. I appreciate very much the opportunity to be here today to address the subcommittee. It is difficult to be the last person testifying today, because many of the things that I wanted to say have already been said. So, I will try to keep my remarks very brief.

The problem has been well laid out by a number of other people today, but I would like to stress several additional issues. One of the two main drivers of the problem that we are facing today is the rapidly rising health care costs that have grown much faster than wages or other sources of revenue into the Medicare program. Like the problem of increases in the population eligible for Medicare, this is not a problem that is necessarily a government problem, or a Medicare problem. It is a problem that has arisen outside of the Medicare program as well.

You have heard different statistics about the rates of growth of the private sector versus Medicare. I would stress, as Bruce Vladeck did, that you should always look at these in per capita terms, because the growth of Medicare beneficiaries has been faster than the number of people covered by private insurance for many years. As a consequence, higher aggregate rates of growth of Medicare sometimes simply indicate that more people are being covered.

It is true that since 1993 costs in the private sector have grown more slowly than costs of Medicare, and Medicare does have a number of things to do to catch up with the private sector, adopting some of the lessons to be learned from the private sector.

The growth in the number of beneficiaries is an interesting problem; we talk about it as a crisis. It is a crisis that we all hope we are around to enjoy in later years. So, from that standpoint, I think of it as a challenge and not a crisis.

But we will have to recognize that if we are going to move from covering one in every eight Americans to one in every four Americans, that there are going to be financing issues to be faced for this program.

In my testimony, I also talk about the fact that I think there are a number of issues that need attention before we lock into any long-run solutions for the Medicare program.

The fee-for-service part of the program has a number of problems that need to be addressed. We need to be much more prudent purchasers, to the extent that that is possible in Medicare.

We need to reform the payment mechanisms and build on some of the improvements that Medicare has enjoyed from the hospital payment reforms in the 1980's and the physician payment reforms that Gail was involved in earlier. That is, we need to do the same types of reforms for home health and skilled nursing care, which are in great need of attention.

Even if we think we are going to restructure the program and eventually move to a system in which a lot of private plans cover the bulk of beneficiaries, fee-for-service will be around for a long time and it deserves attention.

Although my testimony does not address your earlier questions about restructuring cost-sharing, I think we have done some work

in this area. Some restructuring would be helpful. The current cost-sharing structure does not make a lot of sense. Some parts of the cost sharing are already very high, however, so restructuring may not save the program very much.

I am not as much of a believer in some of the evidence that people point to about savings from higher cost sharing. Lower-income individuals are the ones who are most sensitive to cost sharing changes and we can, and should, protect them from any increases in cost-sharing burdens if we make changes in that area.

Changes in the private choice options under Medicare will require a lot of attention to get it right. There are a number of problems that need change before much expansion. Plans are now paid based on costs in the fee-for-service sector. This makes little sense, and there is a commitment by a lot of people to change this, but the difficulty comes from knowing exactly how to do that.

Consider risk adjustment. No one believes we have the answer yet, but increasing people believe we should just get on with it and do what adjustments are possible, but be vigilant that vulnerable groups need some particular protection. The problem is that in Medicare the vulnerable groups are a great chunk of the population.

Approximately 15–20 percent of all Medicare beneficiaries are disabled or chronically ill, and 40 percent of all beneficiaries have incomes under 200 percent of poverty, which means that they have incomes, if they are single individuals, of less than $15,000 a year. These are the people who need protection to be sure that private plans meet their needs well. That is not going to be an easy task.

Further, in this interim period, before we get to the long-run, we should worry about whether the fee-for-service side of Medicare can get to be a more efficient and more prudent purchaser, to do things well so that it can be a viable option in a range of private plans. Successful survival of Medicare's traditional fee-for-service benefit is one of the big, open questions. We have to be careful about how we proceed in this area.

It is also important to stress that we need to figure out how to provide information, support, guidance, protection, and oversight—that is, the things that employers often provide under arrangements like the FEHBP program. If Medicare moved directly to offering lots of private choices to beneficiaries, none of the mechanisms to help people make choices would be there.

But no matter how well we do with efficiency, the big problem is going to be who will pay. In my testimony, I talk about a number of options looking at who will pay. I would simply stress that protections for beneficiaries who are particularly vulnerable need to be present in any such option.

In one of the earlier questions that came up in this hearing was, what would happen if you set the premiums at half of the Medicare costs. Right now, setting the Medicare premiums for 1997 at 100 percent would turn out to be a little less than $5,800. So if beneficiaries were required to pay half, that would be $2,900.

The median beneficiary right now has an income in the range of $12,000, so that would be a pretty large amount to ask those individuals to pay. That share of income, if health care spending grows over time, will get worse and not better because the incomes of

older persons are growing, but not nearly as fast as projected costs of health care.

I have some concerns in particular about vouchers as a long run option. They are likely to be good for higher income beneficiaries over time and not so good for lower income beneficiaries. The number of choices for those with incomes would be severely constrained creating problems. In addition, the risks of higher health care costs get shifted off onto beneficiaries under those options.

There are some other options that ought to be looked at carefully. Taxation of Medicare benefits, for example, is an area that has not been explored very much. This may be a way of improving some of the progressiveness of the program without moving to something as severe as means testing.

I think I should stop there and let people ask questions.

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

Senator GRAMM. Let me thank both of you very much for presenting excellent testimony.

Let me try to be fairly precise in my questions. We all know, and I think there is a good consensus, that if you were going to set up Medicare today we would never structure the basic Medicare policy the way it was done, with big gaps in coverage and huge co-payments at high levels of usage.

This induces moderate-income people to go out and spend tremendous amounts of money for Medigap. I think the average is now about $1,100 in annual premiums that people are paying to fill these gaps up. When they have done it, they also generally get first dollar coverage on many of the deductibles, so whatever incentives there are to be cost-conscious are eliminated.

If we could sit down with CBO, OMB, with HCFA, and with outside experts such as yourselves and come up with a new Medicare structure we might merge Part A and Part B premiums and fill up all the coverage gaps that we have in the system now. I do not think I could ever support prohibiting people from buying Medigap policies. My mother has a big Medigap policy to avoid being thrown out on the street after 150 days in a hospital. She faces huge co-payments at the end of 60 and 90 days.

If we could restructure Medicare so that, for people in West Virginia and people in Texas, the net out-of-pocket costs would be unchanged for the average profile and we could fill up all of those gaps and have deductibles and co-payments up front, would you view that as being a step in the right direction, as a positive thing? If we could do it, should we do it?

Dr. WILENSKY. I think it would be movement in the right direction. Actually, if you want to go back, I think there were a number of proposals in the 1980's that had been prepared making budget-neutral swaps for back-end coverage, which insurance normally covers, in place of the first-dollar coverage that Medicare has more of. You could look at what those distributions look like.

You could, for example, also, rather than ban Medigap, require any insurance be a full replacement for Medicare, if you wished. That would be a way to try to get away from the tiering effect that reduces cost-sharing, but that would probably have some political difficulties associated with it.

But I do not think it would be enough, although I would not want to discourage you from doing it because it would be a more sensible insurance plan. Right now, we have come up with Medicare——

Senator GRAMM. Oh, I am not implying in any way that this is a solution to the problem. The question is, would this be a logical step to take, among many?

Dr. WILENSKY. It would be an improvement over what we have now. It is very peculiar insurance because it has the gaping holes once people have spent large numbers of days in the hospital.

The notion that your co-insurance rate goes up starting at day 61 in the hospital, and then ultimately you have this 150-day reserve and after that you are on your own for hospital care, makes no sense at all.

Having no limits to co-insurance for Part B, where you can pay 20 percent as long as you are using physician services, is very peculiar insurance. So you certainly can redesign a budget-neutral swap that would make the program more sensible.

Senator GRAMM. Dr. Moon.

Dr. MOON. I agree. I think that there clearly are a number of ways to make the fee-for-service side of the program a more attractive and a more rational option for people. Particularly if it is going to stay in as an option in a choice package, it makes sense to make it as good and reasonable a system as possible.

However, since so much of the spending on Medicare really occurs for the very few number of folks who are very high users, the tradeoff that you think you might get between upfront deductibles and protections for high users is not ever as nice as you hope. The stop-loss, the back-end coverage, is actually quite expensive, and so you might have to raise the deductibles considerably.

We have looked at a combined Part A/Part B deductible, for example, as one option. One of the interesting results, which is going to be problematic, is that you create winners and losers in such changes.

Anybody who is in the hospital is a big winner in a combined deductible. Anyone with no hospital stay is a loser. So, as a consequence, there will be concern by people who look at these calculations.

Let me add another caution. A number of years ago, I looked at Blue Cross/Blue Shield Medigap plans in Illinois. This was before limits were placed on exactly what kinds of plans people could have. They had two options, one that covered the $75 deductible under Part B, and one that did not. Both covered everything else. The cost of the first plan was $75 higher, and almost everybody took the $75 add-on. This is a population that is risk-averse.

Senator GRAMM. Yes.

Let me go ahead and yield to Senator Rockefeller, and then I may come back and ask some other questions.

Senator ROCKEFELLER. Senator Gramm, I want to say that I think this has been a very useful hearing, I think for a couple of reasons. I do have a question. Incidentally, do you remember when we did catastrophic health care, which I stoutly defended, getting, I think, 73 votes not to repeal in the Senate, but the House would not yield.

One of our problems on that was that people said, why would I want catastrophic, which I think was, what, 37 bucks a month, something of that sort. They were saying, I already have Medigap. So, there was this problem.

But one of the things that I think is interesting and important, for people on my side of the aisle and on both sides of the aisle, is that this is a huge problem. There is a difficulty, a huge financial problem.

I think it is one of the services of Chairman Gramm sort of taking this out to 2020, et cetera, is to force us not to look just at short-term, or even interim, solutions, or single solutions which might appear to have long-term consequences. There has to be a series of things that will be in effect. Then that, in turn, is fair, intellectually honest, financially honest, and honest to the American people.

That, in turn, runs directly into what you mentioned, Marilyn, and that is the problem of the person that, let us say, has $10,700 annual income and no more, and it is not rising as fast as anybody else because they are not allowed to add on to wages, or do not, or whatever, so it goes up slowly.

Therein is an enormous dilemma because, on the one hand, you could say that the U.S. Government has an absolute responsibility to be accountable, fiscally responsible, and things have to work out in the long run then, that you have to see in the long run, plan, and legislate in the long run as well as the short run.

The other, is that you have to take care of people. Whatever their condition may be, you have to do it. You have to do it with whatever means you can. So, it is really hard.

Marilyn, I might ask you, are there any kind of cost incentive reductions, or incentives of any sort, that you can think of, for example, that would help people on Medicare be more prudent in their purchase of costs of services?

Dr. MOON. One of the things that we are going to need to do when we see private plans, expand—and I think they will on their own, even if there were no desire to encourage them to do so—is to think about what mechanisms people need to have to be assured that they are making good choices, and what kinds of protections they need when they do not make good choices.

In particular, a lot of people are concerned about moving into plans when it represents a big change. It means you are going to change your physician, it means you are going to change, in some cases, three or four physicians. You are making a major commitment.

I would raise two cautions. First, if we are going to clamp down on what we are going to pay private plans we should do it sooner and not later, because it is not a good idea to get lots of people excited about extra benefits, like prescription drugs and no co-pays. If they move into these plans, and then next year we clamp way down on what we pay, many problems will arise. We need to make clear to people what we are going to do.

Second, we need to provide additional services to them, perhaps through outside contracting, to provide good information about the quality of plans so that when they make these decisions that are going to be hard to undo, they do them well.

Senator ROCKEFELLER. Gail, one point to you. I, like you, favor FEHBP very much. I think it is a terrific model. It is not, of course, a model for Medicare at this point, but it is one that has worked and continues to work very, very well, and is run by 200–300 people somewhere downtown, and is efficient, offers all kinds of services, 29 different brochures to pick from.

There would even be some who would say that a certain legislative initiative that was taken a few years ago contemplated being very much like FEHPB. In any event, it does not cover Medicare. So the problem there is, what do you say to the $10,700 person? In some States—at least, in my State—I think, that Medicare person is inevitably going to have to go to the only, or the cheapest, or both, plan.

Dr. WILENSKY. Well, when I say that FEHB is a model, what I mean, is offering a range of plans as they may be available in an area, and having the Federal Government take an active oversight to make sure plans are not cheating, they deliver the benefits that they say, information is provided to people who are making choices. That is very important.

I think if we are a little more reasonable than Medicare has been in the past we can offer a little more variety to seniors in East Texas or West Virginia. The PSNs in the bill that you have introduced with Senator Frist, is a way to allow the people already taking care of seniors—the physicians and their hospitals—to band together and go at-risk, and you can also have preferred provider organizations, networks that are easier to form than the more rigid HMOs. One of the reasons it is so hard to get these options to rural areas or less densely populated areas is the rules that we have put in place.

But the way to help people like the low-income people of West Virginia, or wherever they are, in my mind raises a question that will be a difficult one for this country, which goes to the whole nature of social insurance.

It would be an improvement, in my mind, to let the amount that the government pays be fixed with regard to the more expensive or less expensive plan that an individual chooses, but to provide a greater supplement to those who are lower-income, and a positive amount, but not as large, for higher income seniors. I do not believe that would make it a welfare program. But I worry not just that we are spending money on some of the high-income seniors that we do not need to, but that we are not doing enough for some of the very needy as we should.

If you think of a fixed payment that is made, on average, to seniors but one that could be larger for low-income people and smaller for high-income people, it would let us merge what we now have in terms of Medicare and Medicaid, trying to come together and make a more rational program. But it goes at a very serious issue, and I understand that, for many people, this might be more of a change to Medicare than they are willing to contemplate.

It is something that I think we will be more pressed to think of as the baby boomers start to retire; the whole inter-generational transfer from the currently working to the currently not working population becomes much more difficult.

That is even if you allow that you are probably going to need more revenue when the boomers retire. You still may be forced to look at these issues. So, I would like to reward people for making cost-effective choices. I would like to see the government providing more support to low-income people and, conversely, less support directly to higher income people, but I recognize that will be a difficult decision.

Senator ROCKEFELLER. Thank you.

Senator GRAMM. Well, let me thank both of you for coming. Let me say that I do not personally foresee, though I am obviously open to anything and suggestions from anybody, us eliminating the fee-for-service component from Medicare now.

I think that whatever we can do to make it rational, however, puts us in a position to make changes in the future that make sense. If you gave people, no matter where they live, alternatives through a system similar to, or virtually identical to, the Federal Employee Health Benefits Plan, where people could pick alternatives or stay in the current system, and if we gave them the ability to come back to the current system, we could raise their level of confidence so that they can experiment with something else. For people who simply say I do not want to touch this program, and I do not want to know how big the problem is, these may represent substantial changes.

But for somebody who is looking disaster in the face, these are fairly modest, but important, changes. We are going to have to address all of these other things like reimbursement. Ms. Moon, let me say I totally agree with you that if we are going to be reforming the system so that HMOs are not going to be able to give all these expansive services to attract people, the sooner we make that clear, the more honest we are being.

Obviously, we are going to have a discussion of the whole Part B premium issue. There is no doubt that we will look at, whatever the final decision is, the retirement age.

But it seems to me that the attractiveness of the simple things, like rationalizing the traditional Medicare policy and giving people options without taking away the option that they know best, represent rational changes.

While we do not know how big the savings are going to be, they represent our only real hope to begin to change behavior which, in some form, is absolutely indispensable in dealing with this problem.

I have suggested to Senator Rockefeller that, as we continue our hearings, it would be my proposal that I would pick, together with the Republicans, one individual or group to testify, that Senator Rockefeller, working with Democrats and getting input from them would pick an individual or group, so that we would present a broad range of ideas, a broad range of perspectives.

I think we have seen in this panel today the product of that, and I think it is a good thing. I do not think there is any doubt about the fact that, as we get into looking at specific proposals, that we are going to want to have both of you back before the subcommittee.

So, Senator Rockefeller, if you have any final words, we will hear it, and then we will go. If you are through, we will quit.

Senator ROCKEFELLER. Nothing further.
Senator GRAMM. Thank you very much for coming.
[Whereupon, at 4:21 p.m., the hearing was recessed.]

MAGNITUDE OF THE FINANCIAL CRISIS IN MEDICARE

THURSDAY, FEBRUARY 27, 1997

U.S. SENATE,
SUBCOMMITTEE ON HEALTH CARE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 2:12 p.m., in room SD–215, Dirksen Senate Office Building, Hon. Phil Gramm, (chairman of the subcommittee) presiding.

Present: Senators Chafee and Rockefeller.

Also present: Senator Frist.

OPENING STATEMENT OF HON. PHIL GRAMM, A U.S. SENATOR FROM TEXAS, CHAIRMAN, SUBCOMMITTEE ON HEALTH CARE

Senator GRAMM. Let me call the committee to order. Senator Rockefeller is on his way. I know we are going to have several members here today. They will be coming in and out.

I am very honored that Bill First, an outstanding member of the Senate from Tennessee, a renowned heart surgeon and expert in the area of medical care—in fact, in the Senate, the expert—and am very happy that he is here today.

We have today two witness panels. I will introduce the first panel in a moment, but I want to go ahead while we are waiting on Senator Rockefeller and make an opening statement.

I am very proud of the hearing that we had as our first hearing in this subcommittee, because our focus in that hearing was on the crisis. Basically, in that hearing we talked about the problem we face in maintaining Medicare. We talked about our dual problem of exploding cost and the actuarial problem arising from the baby boomer generation which is now working its way through the system.

The focus of our attention in that hearing, this hearing, and the others that we will have over the next month and a half was defining the problem. To the degree that people have suggestions for a long-term solution to that problem, we want to begin to listen to those suggestions.

I think it probably is advisable and to our advantage to begin with the basic premise that I believe we all agree with, and that is, Medicare is an important program. It has been a godsend to millions of Americans. Everybody wants to save Medicare; the question is, how can we do it?

I think it is always very tempting, when someone is saying the house is on fire and smoke is escaping from the roof, to say, well,

boy, it is a wonderful house. It is a great house. But the point is, smoke is escaping from the roof. Medicare is in the red. Medicare will be bankrupt in 4 years.

Medicare will have an accumulative deficit of over a half a trillion dollars in 10 years. The financial prospects for Medicare under the status quo are, clearly, unsustainable.

So the question that this subcommittee, first, and then the whole Congress and, in a sense, in the decisionmaking process the American people have to answer is, how can we preserve what we love about Medicare and at the same time pay for it?

That is the focus of our attention today, and will be for the remaining month and a half of these initial hearings. What is the long-term problem, how big is it, what do we need to know about as we begin the process of trying to deal with it, and what suggestions do each of you have as to where we begin to look for those solutions?

So having started with that opening statement, let me recognize Senator Rockefeller, if he has an opening statement.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Mr. Chairman, first of all, I need to apologize for being late. I was absolutely mortified when I was told that you were actually holding the hearing up. That put terrible pressure on me. So, I apologize to you.

Senator GRAMM. So my message got through.

Senator ROCKEFELLER. Yes, your message got through and I came over here on the dead run. Fortunately, I am in reasonable enough shape that I am not going to need the services of the good doctor over there. But I apologize to you. I have a little statement. I always have a little statement. I do not just speak it out articulately, like you do.

Again, I am very pleased that we are having this hearing. I am very pleased that you asked folks from the Budget Committee to come, and I am very pleased that my friend and colleague, Senator and Dr. Frist is here.

We talked about Medicare, as you did. I went through a hearing on Medicare this morning in this same room at the full committee level, and it is mind-numbing in its complexity. We have to make major changes when there are not all that many people who really understand the program as we ought.

At our last meeting, Senator Gramm, you mentioned the crazy cost-sharing requirements of the current Medicare program. The Medicare program has a huge hospital deductible, followed by daily co-payments once a person has been hospitalized for more than 60 days. I could not agree with you more, that simplifying the cost sharing structure would make a lot of sense and it is something that we should be taking a very close look at.

Having, in fact, a Medicare Part A and a Medicare Part B is also, in some ways, outdated. As more Medicare beneficiaries move into managed care, it seems to me maybe it does not make sense to segregate health care services in the artificial way that we did back in 1965. That is worth a look.

I would like to add one more issue to the hopper. That is, since Medicare was enacted in 1965, state-of-the-art medical care in this country has changed overwhelmingly.

A couple of examples. In 1965, surgery for a hip fracture was dangerous and it was not done very much. Hip replacements were rare, mortality rates were high due to pulmonary complications from something as simple as bed rest. Now hip replacements are routine, mortality rates are low. A change.

In 1965, patients with chronic obstructive lung disease were hospitalized and provided with oxygen. Antibiotics available for their care were, at that time, limited. Now people are able to receive oxygen at home and newer and more expensive antibiotics are available. Some patients are receiving lung transplants. Big change.

In 1965, about the best thing that could be done for heart attack victims was to try to relieve their pain. Now doctors have new drugs to dissolve clots, new treatment options such as acute cardiac catheterizations and mechanical techniques to assist heart function.

So medicine has changed a lot since 1965 and, as a result, the health care needs of Medicare beneficiaries have also changed significantly. Yet the Medicare benefit package is essentially unchanged from when the Medicare program was first enacted over 30 years ago.

A few new services have been added, and I have been a part of some of them: hospice care, drug coverage for immuno-suppressive drugs, outpatient chemotherapy, coverage of certain oral anti-cancer drugs. That is the one I was involved in. We added some other limited preventive services. But not covered, to name just a few, are insulin, cholesterol-lowering drugs, or even pain medication for cancer patients.

I was interested, Dr. Frist, to read the other day, or was it this morning, that exercise does not do it all. You can be in great shape, eating the right things, but maybe still it is medicine that helps.

As recently as 1987, hip fractures and strokes were the two most frequently reported diagnoses for patients admitted to skilled nursing homes. These two diagnoses then accounted for almost 25 percent of all Medicare SNF admissions in 1987, today, it is 14 percent. So, changes there.

On home health care, while we want to take measures that curb spending in this area, we also want to make sure we do not eliminate coverage for necessary care that keeps patients at home and out of the hospital or nursing home.

The most frequently reported diagnosis for home health patients is something called diabetes. This condition accounted for 7.6 percent of all persons using home health care services, and 11 percent of all spending. The second and third leading diagnoses for home health patients were heart failure and hypertension.

So, now the President has proposed adding some new benefits, such as limited respite benefit for Alzheimer's patients and their families, and improved coverage for preventive services.

These new benefits should not be viewed as just new add-ons. These benefits reflect positive changes in our country's health care system and ought to be made available to our country's seniors, if we can make that happen.

So I hope that we can take a look at all of these three issues that I have raised. I know we will. I thank you, Mr. Chairman.

Senator GRAMM. Thank you, Senator Rockefeller.

Let me explain to my colleagues that I asked those on the Budget Committee who might be interested to join us. The reason is the Budget Committee is going to set the target for what we are going to be required to do in reconciliation, and I think the better job we do communicating early, the better job we will do when we try to reform Medicare.

Let me say at the outset, I am not interested in getting into a debate with the President about a dollar figure. I want to reform Medicare in the long run to deal with this long-term problem and preserve its solvency. I do not think we serve any great purpose by getting into a big debate about 5 years of savings. What I am interested in is preserving Medicare for eternity. I asked Bill Frist, who is a member of the Budget Committee, to come and sit in on this hearing. I am very glad he is here.

Bill, did you have an opening statement you wanted to make?

Senator FRIST. No thanks, Mr. Chairman. It is a pleasure to be here. Again, we have a unique opportunity in this Congress to address, in a very fundamental way, the long-term, not just solvency of a trust fund, but the overall integrity of a system that has meant life or death and quality of life to millions and millions of Americans.

The hat I wear is simply that of one who has spent well over 50,000 hours in a hospital, and have taken care of well over 10,000 Medicare patients, somebody who wants to preserve that value, but also recognizes that we have this demographic brick wall about to hit us. I really appreciate the chance, as a member of the Budget Committee, to participate.

Senator GRAMM. Thank you, Dr. Frist.

John Chafee.

Senator CHAFEE. No, Mr. Chairman. I just want to say that I think this discussion is worthwhile. I commend you for exploring this. Whether this is the right solution or not, we do not know, but I do know we have got a terrible problem on our hands.

I think it behooves all of us to acknowledge the problem. Not only are the costs escalating in Medicare, but, as Senator Frist said, we have got looming ahead of us the baby boomers who are going to be coming on this program. This presents a great challenge to all of us, and I am sure we can attack this in a bipartisan fashion and try to find a solution. Thank you.

Senator GRAMM. Let me introduce our first panel. Dr. Thomas R. Saving, professor of economics at Texas A&M Private Enterprise Research Center, and Dr. Andrew Rettenmaier, who is a research associate with the center. I taught with Dr. Saving for 12 years at Texas A&M, and I will just relate, in introducing him, one small incident.

I remember as a young assistant professor, I was writing an article, that ultimately was published, on banking theory and the optimum real quantity of money, something that seemed awfully important then, yet seems irrelevant to me today. But it did get me tenured and make me a full professor, in part.

I went to see Dr. Saving to get his suggestion as to which statistical test I needed to use. And so he started out with the fundamental probability formula and then mathematically worked out a test around which to build this paper. And I can remember going back down and saying to one of my fellow junior colleagues that I did not know anybody in the world was as smart as Tom Saving is.

So, in any case, I am very glad to have you here today, and I want to thank you for coming to Washington to share your views with us.

Senator CHAFEE. And there is nothing you have done in the Senate that has caused you to change your mind about him being the smartest man you ever met?

Senator GRAMM. Well, at that moment, I had not yet met you, Senator Chafee.

STATEMENT OF THOMAS R. SAVING, PH.D., DIRECTOR, PRIVATE ENTERPRISE RESEARCH CENTER, TEXAS A&M UNIVERSITY, COLLEGE STATION, TX, ACCOMPANIED BY ANDREW J. RETTENMAIER, PH.D., RESEARCH ASSOCIATE, PRIVATE ENTERPRISE RESEARCH CENTER, TEXAS A&M, COLLEGE STATION, TX

Dr. SAVING. Well, thank you, Senator Gramm. I do not know if I can live up to that introduction. But we are here today because Medicare expenditures have outstripped current revenue sources and, if left unchecked, the problem is going to continue to worsen.

The solution to this problem can only come from effective cost containment or revenue growth, or some combination of both. But this current problem is a problem of the aged, of whom I will soon be a member.

And, while the Medicare crisis of the aged must be solved soon, we are not here to advise you on that solution. Rather, we are here to discuss the Medicare crisis of the young.

We are proposing a complete change in the way Medicare is financed that will restore the young workers' faith in Medicare. We propose that the current pay-as-you-go financing of Medicare that pits one generation against another be replaced with cohort-based financing, where each generation pays for its own Medicare.

Our solution addresses the more enduring problems associated with pay-as-you-go financing by suggesting a financing method that is immune to birth rate variations and gives both retirees and insurers an incentive to care about the price of medical care.

Two things to keep in mind at the outset are: one, the risk associated with paying for medical care needs of current and future retirees exists regardless of whether the financing plan that we now have is tweaked or fundamentally changed; two, that saving for retirement is not a radical idea.

Medicare's current problems simply bring into focus the need to reexamine how, as a society, we ensure against and save for each member's retirement medical expenses. We are offering a plan that produces the right incentives and secures individuals' ownership of their retirement medical insurance and, thus, ultimately makes Medicare a sustainable program.

On July 30, 1965, President Lyndon B. Johnson signed a bill that established the Medicare program, and several trends converged during the early 1960's that helped facilitate that passage.

First, from 1946 to 1965, the average real manufacturing wages were rising at 2.3 percent a year, much faster than the current rate. Second, the post-World War II baby boom produced a record number of bodies, soon to enter the labor force and become taxpayers.

In 1965, there were almost 77 million individuals between zero and 19 years of age, and only 19 million retirees. Thus, the medical costs of a relatively small number of retirees, the top of the pyramid, so to speak, could be paid with small tax payments by an ever-growing number of workers, the bottom of the pyramid. Growing wages and a blossoming future work force were the ideal conditions for a social insurance program that relied on pay-as-you-go financing.

The baby boomers' entry into the labor force can be likened to the 7 years of plenty in the Biblical story of Joseph and the Pharaoh. The passage of the baby boomers through their life cycles provided a large lump of taxable earnings for provision of government services, including Medicare for the aged. But, just as in the story of Joseph and the Pharaoh, however, there was good news and bad news. For the Pharaoh, the good news was 7 years of plenty, and the bad news was 7 years of famine.

In our case, the baby boomers are both the good news and the bad news. They are good news when they arrived and while they are in the system, and the bad news is when they retire.

So the coming retirement of the baby boomers, starting a mere 15 years from now, will mean a reduction in Medicare revenues as the boomers stop paying taxes, and an increase in Medicare costs as the boomers start consuming benefits.

The coming surge in the number of retirees, and in the first chart here it is quite evident, you can see, what that chart represents is the annual percentage change in the population of above-65 people. It is really the difference between the people who are leaving the system, that is, dying, of course, and the people who are entering, births into the system.

Senator CHAFEE. Doctor, is that chart in your statement?

Dr. SAVING. No, I'm sorry, Senator. Everything else we are going to put up there is, but that one is not.

Senator CHAFEE. All right.

Dr. SAVING. But I can make it available to you, because I think it is very instructive. You can see this surge that the baby boomers are going to present as they begin retiring.

Senator FRIST. Dr. Saving, can you just give us where that peak is, what year is that?

Senator CHAFEE. What year is that peak?

Dr. RETTENMAIER. The 1946 birth cohort. So, that is 2011.

Dr. SAVING. 2011. Now, remember, these are rates of change so they are not actually the size of the population. The size of the population is going to continue to grow throughout this period, it is just going to grow most rapidly in that early part.

Senator GRAMM. To give you an idea of the absolute size we are talking about, about 200,000 people are going to turn 65 this year, 1.6 million are going to turn 65 14 years from now.

Dr. SAVING. As I say, talking about our Biblical kind of analogy, for the Pharaoh the coming famine was not a problem. The reason for that was simple, because Joseph convinced the Pharaoh to put grain away during the years of plenty so that when the famine came the grain silos were full. Unfortunately, our silos are empty.

In a future world we might have been able to cryogenically freeze some of these baby boomers as they were coming along, but we are not living in the future world so we allowed them to come into the system and now we are going to have to deal with them.

What we did, however, was set up a Medicare system which assured the baby boomers that they did not have to put anything away for their retirement medical care because we were going to take care of it for them. So now the problem is, how are we going to provide that retirement medical care?

This was addressed by the Joint Economic Committee, actually, in 1965. They argued, what the aged need is a plan that would permit them to acquire insurance protection against the high medical costs of old age for modest premiums paid during their long working lives without the need to pay heavy premiums after retirement. Such insurance is now virtually unknown among private carriers, which is the argument that was made just before the Medicare bill was passed.

As the 1965 Joint Economic Committee's report indicates, the original proponents of Medicare believed that the market had failed in some way, and the committee saw a government insurance provision for virtually all elderly Americans at the best solution.

Now, without asking why private insurers were not offering such insurance to be purchased with benefits during their work in the labor force, we established a demand for retirement health insurance and then we chose to finance that by using the working population as the source of that financing.

Now, that is not necessarily bad, as we will see later on, but, as it turned out, we never actually put enough away in the system. What we established was a system that any aspiring new business would envy.

The program has grown in all dimensions. The number of enrollees has grown from 19 million in 1966 to 37 million in 1995. The average Part A benefits per retiree have grown at 11 percent a year since 1967. The per retiree Part B benefits have increased 12 percent a year over that same period. These growth rates compare to a 5.6 percent annual growth in the Consumer Price Index, and a 7.6 percent annual growth in the medical care component of that price index.

I would probably argue that the medical care component of the price index probably overstates the real changes in medical care prices, but that is a different project.

So as we now know, with this growth Medicare has exhausted any reserves. The fact that nothing is in our silo means that, as we look at Medicare, it is apparent that the current enrollees are being paid for by younger workers.

These same younger workers believe that their children and grandchildren are not going to be as generous as we have been to current retirees, and, since I will be one of those people soon, as maybe the younger people here are being to me, perhaps because they will see, as we are seeing right now, how costly this program really is.

In effect, the current pay-as-you-go financing is the equivalent of signing contracts for as-yet unborn—no, as yet-unconceived—children. While states have enacted laws concerning the age of consent in signing contracts to protect young children, these same children and their as yet not conceived children, have their names on the dotted line of this Medicare contract.

The current and future status of the Medicare program is well-documented by the Medicare trustees. Since 1992, the trustees of Medicare's hospital insurance trust fund have reported the fund does not meet the trustees' short-range test of financial adequacy. You had your last hearing on this.

In their 1996 report, the trustees warned, without corrective legislation soon, the fund would be exhausted shortly after the turn of the century, initially producing payment delays, but very quickly leading to a containment of health care services to the beneficiaries. Well, we know that is really not going to happen.

They go on to state that to bring the health insurance program into actuarial balance over a 75-year horizon would require an immediate tax rate of 7.42 percent. The trustees also report that, under their intermediate assumptions, the Part B expenditures, as a percent of gross domestic product, are expected to grow from the current level of less than 1 percent to 3.5 percent by the year 2030.

Concerning the Part B program the trustees note, "As in past years we note with great concern that the program costs have been growing faster than Gross Domestic Product, and this trend is expected to continue under present law."

Of additional concern is the fact that the premium income after 1998 is projected to cover a progressively smaller fraction of SMI expenditures, shifting a greater share of the program financing and beneficiaries to the general public. They really are calling on Congress to do prompt, effective, and decisive action on this thing. But what can we do? What would a social insurance program designed to take care of the health care needs of the elderly look like if we started with a clean slate? The Medicare system put in place in 1966 allowed retirees who put nothing into the system to begin receiving benefits.

From 1965 to the present, the current Medicare trust fund crisis essentially implies that no savings have been put away. We have used them all up by this time. We reached the point where each year's payroll taxes and general revenues finance each year's expenditures under Medicare.

Taxpayers are required to pay into this system, but whether they receive retirement medical care is contingent on their children's willingness to tax themselves at a high enough rate.

Current and future Medicare obligations represent an unfunded potential government liability whose size depends on whether or not we make good on our promises, something young people believe we will not do.

We can, and should, change all this. We can permanently make ourselves immune to the impact of variations in cohort size. We can be in a boat and ride up on the top of large waves instead of being on the shore and getting swamped by large waves.

We propose a cohort-based solution where each age cohort, defined as all individuals born between January 1 and December 31 in any given year, insures itself against retirement medical expenses. Each worker within an age cohort pays a premium that ensures against the medical expenses that arise during retirement.

As the cohort ages, the required premium is adjusted as more information about the cohort's future medical care needs is revealed. So this would occur, perhaps, every 5 years. You would have to actuarially adjust what was being put into the system.

This kind of finance establishes a link between the purchasers and the consumers of medical care that is absent in a pay-as-you-go financing system. Another benefit of cohort financing is that it eliminates cohort size risk of the form we are now facing with the pending retirement of the baby boom generation.

The population age distribution experiences a bulge because of larger than normal fertility or immigration. The contribution to retirement medical insurance of these cohorts will rise, maintaining the same per capita value as smaller cohorts. This automatic adjustment, again, is similar to a boat rising and falling with sea level, no matter what happens to sea level.

Our proposed retirement medical insurance naturally raises numerous questions, some of which I will turn to right now. One of them is mandatory participation. For various reasons, all individuals are required to participate in the insurance program we are proposing.

The primary reason for mandatory participation is a result of individual's incentives to under-insure themselves against medical care expenses that arise during retirement because we are going to take care of them, and they know that.

In the past, family units, through implicit intergenerational contracts, provided this insurance function. But with today's increased mobility, changing dynamics of family units, a new means of insurance is required. Cohort-based insurance in which, at the minimum, all working individuals in a cohort pay into the system, ensures that a sufficient level of assets will be set aside as the cohort ages.

Mandatory participation also solves the problem of what the insurance company refers to as adverse selection, that is, trying to join the insurance scheme when you know you're about to have some expensive medical procedure.

Additionally, during the transition to the new system, all individuals will continue to pay the taxes required to finance the current and future retired population who remain in the current system. Obviously, any system that you move to has to be able to do that. You have to take care of the current aged and you have to take care of the young people that are coming into the system.

The insurance we propose, in its simplest form, is a catastrophic retirement health insurance coverage. That is, high deductible, then 100-percent coverage after that, purchased during a worker's

years in the labor force. It is comparable to these high-deductible policies.

Our plan calls for universal retirement health coverage. Any universal program must address redistribution. Under the current Medicare system, redistribution occurs across generations. Workers are expected to pay for the medical care of retirees, and receive medical care upon retirement from the next generation.

This system functions well when the number of workers per retiree is high, but poorly, as we are finding out right now, when the number of workers per retiree is low. Since birth rates have been steadily declining in America, life expectancy has been steadily lengthening, the current Medicare system relies upon an ever-shrinking pool of workers to fund an ever-growing pool of retirees. This is both unfair to younger workers, and unsustainable.

A cohort-based Medicare system can address both these problems by redistributing income within, rather than across, generations. Workers in a particular cohort would subsidize non-workers in their cohort, and high-wage earners would subsidize low-wage earners in their cohort. If the cohort is small it will have fewer workers, but it will need fewer dollars.

If a cohort is large it will have more workers and it will, of course, need more dollars. Thus, the cohort-based system protects both Medicare recipients from a lack of funding and younger workers from high taxes in a way that the current Medicare system cannot do.

We suggest that all future generations provide their own retirement health care by cohort-specific contributions. The advantage of such a system is the complete elimination of cohort-sized risk. Had cohort-based financing been in place since the inception of Medicare we would not be concerned about the coming retirement of the baby boomers. We would, in effect, be riding in the boat instead of standing on the beach.

There are some other positive effects of this change. One of them is, if we act soon we can capture many of the baby boomers, perhaps all of them, before they retire and put them in the new system when there is still time to put some grain in the silo.

The second one is, since we are actually putting resources away, the national saving rate will rise. And, as we know, the United States has the lowest saving rate among any developed country in the world, significantly lower than any other developed country in the world. So, we would actually be putting real things away that will increase the real output of the country.

Third, a high deductible, 100-percent coverage policy will make retirees care about medical care costs and will actually give us some of the benefits of competition, which is important to solving the problem of the level of Medicare expenditures.

The required contribution rate for our system is really calculated——

Senator GRAMM. Professor Saving, how much longer do you have? Let me ask to go ahead and summarize the rest of your testimony, and basically we will take it from there.

Dr. SAVING. No problem. I will summarize it. We have placed ourselves in a position of allowing a surge in the population, generally referred to as the baby boom, to lull us into a sense of secu-

rity that the pay-as-you-go system of financing would work. As a result, nothing has been set aside to provide the extra resources that will be required to fund the medical care costs of this surge in population.

Now, we can move—and our estimates indicate that using as a base the current 2.9 percent tax rate—cohorts of age 39 or younger into our proposed cohort financing. Older cohorts remain in whatever the amended Medicare system that comes out of this Congress is.

Their expenditures are financed by the excess of contributions from the switched population, that is, those individuals who are younger than the switch age who will be paying more into the system than their insurance is going to cost, and from those who remain in the old system, all of their taxes go into the old system, and from general revenues.

We estimate the total cost of this transition is going to be $970 billion, to be paid over a period of 50 years. Once the last of this group that does not get switched has left the system, all the future generations are self-funded. We will never be caught in a population bind again.

One of the great benefits of moving to cohort-based financing is that the reputation of the system can be restored. Even before the reductions in benefits that must be enacted to keep the current system solvent are enacted, young people believe the system will not be there for them.

The distrust of the government will be exacerbated when this year's changes in the Medicare system are enacted. If the changes that must be made in the system are coupled with a movement to cohort-based financing, a clear message will be sent to the young.

The message is that, while we have changed the existing system, we have simultaneously taken steps to ensure that the system will be there for you. We have restored their confidence in government by giving them a property right in their Medicare.

Thank you.

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

Senator GRAMM. Let me begin the questioning. Considering the average 22-year-old in America today, if you were going to set up a program where they were going to put money into an actual trust fund, say they did it through the government and the government would give them a menu like we do for Federal employees' medical care, in this case it would be a menu of annuities, and they got to pick one and the money went into that fund, what do you estimate that the average 22-year-old would have to put into such an annuity to be able to fund their medical care in retirement?

Dr. SAVING. Well, as you are aware, Senator Gramm, that depends on a lot of assumptions you are going to make about life cycle earnings, and things. I will give you the estimates for rates of return of 3.5 percent real.

Assuming that you actually get control of medical care expenditures so that per capita expenditures stayed the same, but also assuming no growth in income, which I think is too small a number, we are looking at 1.36 percent.

Senator GRAMM. In other words, by your estimates with the 3.5 percent real rate of return, someone could put 1.35 percent of their

wages into an annuity, and that would be real. If inflation went up they would put more in, if their wages went up, obviously, it would be that percentage of the new wage level. That is less than half of what they are currently paying for Medicare.

Dr. SAVING. That is correct. But I think the other important thing about this that did not get mentioned because we shortened things up a bit, is that we are replacing both Part A and Part B.

So if you added to the 2.9 percent, the implied 1.35 percent for Part B subsidies that you are currently making, because the taxpayers are paying those also, then you are looking at this costing about one-third of what they are currently paying.

Senator GRAMM. So your proposal, at least initially in this transition, is that you would let young people, as a group, or age cohort, through the government, choose among annuity plans, and then invest 1.3—what was it?

Dr. SAVING. 1.36.

Senator GRAMM. 1.36 percent. And then the difference between that and 2.9 percent, under your proposed transition, would go to help pay off the cost of people who are already retired and who are in the current system.

Dr. SAVING. That's correct, the current people in the system.

Senator GRAMM. Now, at what age, under your initial model, could people still go into self-funding and have a chance of doing that before they retired?

Dr. SAVING. Under those set of assumptions, it is 39 years old. So we can take 39-year-old people and younger, and 40-year-olds would be still in the current system.

Senator GRAMM. So basically what you are saying is, is that 22-year-olds today, depending on how you structure the model and counting what we are paying in Part B, are paying about three times as much for the current system as they would have to pay to build up an annuity which would fund their health care in retirement. And people as late as the age of 39 years of age could convert to this new system and, in the remaining working years of their life, could fund their own health care as a cohort, not just each individual, but everybody in that age cohort, including people who are not working.

Dr. SAVING. That is correct. If I were to add something to that, that is at the 2.9 percent. If you were to assume that they also have to pay for the current Part B subsidy, their share of that, then at 4.0-something percent you can actually move all the way up to 45 years old. So if you were to take what people are really currently paying for Medicare, you can go all the way up to 45 years old and you can capture almost all of the baby boomers under that scenario.

Senator GRAMM. Whatever the difference is between what you have to pay for your guaranteed benefit and the 2.9, or whatever the number is if you are counting the subsidy to Part B, that then would go to pay for the health care of people who were already retired or about to retire. What would be the hole that would be left?

In other words, how much money would we be talking about if we made the transition you are proposing, secured the health care retirement for younger people, and took the difference between what they are paying now? What would they have to pay for retir-

ees and people who are approaching retirement? How big a hole would we still have left that would have to be filled up financially?

Dr. SAVING. The present value of that hole is $970 billion. If you paid it off over 50 years, if you really decided that is what you were going to do, that means you would build up debt over the first part of the years and then pay it off. It is a $41 billion a year expenditure.

Senator GRAMM. Now, what if we did nothing for 10 years, just maintain the status quo, the inflation rate, the current system of financing, what would it cost then?

Dr. SAVING. What happens is, the unfunded liability gets to 2.4 billion——

Senator GRAMM. Trillion.

Dr. SAVING. Trillion. I do not think in these kind of numbers. And the annual payment would have to be $101 billion, almost $102 billion.

Senator GRAMM. Do you have a figure if we waited 20 years?

Dr. SAVING. And that is $4 trillion, almost $4.5 trillion, and near $190 billion a year if you wait. Waiting is expensive, and you know why. Waiting is expensive because of the baby boomers. You let them retire, this is going to cost an awful lot more money. You have to do something soon, before the baby boomers retire, and get them into the system.

Senator GRAMM. Let me make one more point, then I will recognize Senator Rockefeller. All of these numbers are based on the assumption that we have dealt with the short-term problem of exploding per capita costs of Medicare.

In other words, the problem you are talking about is only the problem with the distribution of the population and this baby boomer bulge going through the system. The costs you are talking about are costs that would still be there, even after we deal with spiraling per capita costs, which obviously is our first mission because, if we do not deal with that, none of these other things work.

Dr. SAVING. That is correct. No doubt about it. This assumes that you have, indeed, dealt with that problem.

Senator GRAMM. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Dr. Saving, I welcome creative thinking. We do not get enough of it around here and we tend to try and tinker with what we are already doing and sometimes, therefore, do not look at larger solutions that might seem radical in the short-term, but which could be sensible in the longer term. I am not passing judgment one way or another on what you propose, but I like the idea that it is different, it is massive, and it is highly invigorating.

A large part of what your proposal would rely on though is a high deductible to control health care costs by, as you say, making consumers more cost sensitive. That is an argument we have had around here for quite a while, do consumers become cost sensitive, under what conditions do they become cost sensitive, under what conditions do they stop being cost sensitive. So, that is important.

There is a lot of research that suggests that cost sharing requirements can, in fact, discourage the use of health care services, both when those services might be medically necessary or when they

might be medically unnecessary, when a person is initially deciding in the first instance whether or not to enter the health care system.

But once a person gets into that system and is under health care, cost sharing research shows—and we can discuss this, and I want your views on this—does not reduce the amount of level of services that a person receives.

Now, let me explain. The majority of health care spending, obviously, is concentrated on those who are sick. Ten percent of Medicare beneficiaries account for about 75 percent of Medicare spending. Research—again, we can argue that—says that sick people are not really that cost sensitive because they are sick.

So I have a question about your proposal. Would it, in fact, lower the bulk of Medicare spending after all, since most of it—Medicare spending, that is—is concentrated on very sick people and sick people are not that cost sensitive? They do not ask the same questions.

Dr. SAVING. Let me respond to that sort of in two ways. Some of the evidence would suggest, and you are certainly right, that for people who are ill, once you get beyond the high deductible and you are at 100 percent coverage, everything is free, in one sense.

But, on the other hand, most medical expenditures are not trauma care. Trauma care is where you do not have time to care about what it costs. Most medical expenses are not trauma care. They may be expensive, but they are not trauma situations.

The second thing is, we are suggesting, perhaps, real insurance, meaning that someone is providing the insurance and is at risk, and the insurer is going to care what it costs. Right now, that is not the case. Well, in the sense that Medicare cares what it costs, but they have limited abilities to do much about that, other than at a very broad sense, whereas private insurers—and that is the system we would really suggest—would provide this insurance for the above-65 population and they would care what it costs, and you get that kind of shopping.

The thing that you notice most about medical care, if you have just opened your newspaper and you see grocery store ads, they are all about prices. When you see hospital ads, because hospitals now compete to get patients, they are never about prices. Nobody cares. The hospitals certainly do not care what they are charging, and the patients do not care. Unless somebody cares, we cannot get competition to work.

Senator ROCKEFELLER. All right. Now, I am struggling here to understand this better. A series of short questions. Would your plan provide every retiree, when they turn 65, with a catastrophic policy with a $2,500 deductible?

Dr. SAVING. Yes.

Senator ROCKEFELLER. Would there be any sort of medical savings account at the front end to help seniors pay their high deductibles?

Dr. SAVING. There would be if people wanted it, or if the government decided to provide it. In the way we are doing it, of course, it would have to be a medical savings account, but there is no reason not to have that. It could easily be done. We have not costed that. This is now looking strictly at a $2,500 deductible policy. But we discuss here that a medical savings account would be a way to take care of the $2,500.

Senator ROCKEFELLER. Let me stop, because I have a yellow light here.

Senator GRAMM. That is all right. You can go ahead.

Senator ROCKEFELLER. All right. What, in effect, would workers be saving for during their lives, would it be a catastrophic insurance policy; what would they teli themselves they are saving for?

Dr. SAVING. What they are saving for is this policy that, when they are 65, they pay no more premiums. That is the way we have addressed this, because if we were to adopt the $42 a month current Part B premium, this whole system becomes a lot cheaper. But our system is, you buy at 65 a lifetime medical insurance, actuarially priced, and it takes care of you the rest of your life. You pay no more premiums once you reach 65.

Moving to 67, for example, which is one of the suggestions you might consider in some of this, of course, makes this again a lot cheaper, because it has 2 more years that you are paying into it and 2 fewer years in which you are going to be collecting. But every individual gets this policy.

It is uniformly priced because at age 22, when someone enters the labor force, in a sense they are "tabula rasa." They do not know who is going to be rich or poor, who is going to be healthy or sick, who is going to live to 65, and who is not.

So we all agree to have the same tax rate then that is going to be adjusted, perhaps, every 5 years to account for what is happening to medical technology, demographics, length of life, for example. When you get to 65, everyone has the same price. We have agreed that sick people will have the same premium as well people because we agreed to that back at age 22.

Now that we are 65 and we know that someone is sick, they would have much higher premiums, but we have already agreed we are all going to pay the same premium. So the healthy ones are going to be subsidizing the sick ones.

Senator ROCKEFELLER. Then that may make the answer to my final question easier for you. The average income, as I have said many times in this committee, in West Virginia for those who are 65 and older is about $10,700 a year.

If I understand you correctly, they would, in order to get their catastrophic policy, have to pay $2,500. That would represent about 25 percent of their income. How does this become affordable?

Dr. SAVING. Now, they have already bought the policy. What they have, is if they are going to spend the first $2,500, then that comes out of their own money. Or put in an income level, say it's $20,000, and anyone under $20,000, the government general revenues are going to provide for them a medical savings account. That is an alternate way of handling this, which is fine.

I consider that issue, though, a welfare kind of an issue that has to do with income and the poor, and not an issue of trying to finance the aged medical care. I think that that is an important distinction that we have made throughout this.

We are trying to find a sustainable system that will allow young people to do this and pay for this insurance, and at the end we can decide that we can add to the premium that you are going to pay so that everyone has a $2,500 medical savings account.

That is something we could do. It would certainly make this percentage, this 1.36 percent, slightly larger, and I do not know how much larger, because you still get all the good incentive effects with the medical savings account. So we could very easily, perhaps, make that 1.45 percent and provide everyone with a medical savings accounts for the first $2,500.

Senator ROCKEFELLER. All right. Well, you have given me something to digest here. Thank you, sir.

Senator GRAMM. Let me just say that currently the deductibles under the current system are $870, and the average person is paying for a Medigap policy $1,100. So your deductible is not a whole lot different than what people are paying today. They are just paying it in a different form.

Dr. SAVING. Well, actually, that even understates the real deductible, because by the time you were to pay all the co-pays and everything, if you were seriously ill, that comes to—what is the number, Andy?

Dr. RETTENMAIER. $1,400.

Dr. SAVING. $1,400. So basically someone currently on Medicare who got really ill is going to be facing a paying out of their own pocket $1,400. This is not that much different from that, except that it is not first-dollar coverage at all, which is important. So it is not as much different as it appears.

Senator ROCKEFELLER. That is a fair point.

Senator GRAMM. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman.

Regrettably, I have a commitment at 3:00 that I have got to go attend to for a while. Dr. Altman will be coming after you, Dr. Saving. I have cribbed from his material for some questions, because I thought they were good questions.

First, I want to join in the commendations you have received from Senator Rockefeller and Senator Gramm for an original proposal. We need these things. I hope we get a lot more. We have got a terrible problem, as I mentioned previously.

Now, these questions come from Dr. Altman, but I will claim they are mine. Have I got license to do that, Doctor?

Dr. ALTMAN. Sure.

Senator CHAFEE. The predictions of the payroll tax rate in 1965 proved to be wrong. What makes you think yours are more accurate now?

Dr. SAVING. Well, what we would do, is we intend to adjust these every 5 years, actuarially. So we are moving through time and these tax rates that we are talking about we expect to adjust, depending on what is going to happen.

Senator CHAFEE. So they might, indeed, require a larger contribution, or less.

Dr. SAVING. Exactly. We are putting away the right amount, as long as individuals know that is what they are doing. Under the current system, you raise their taxes, they do not believe they are still going to get Medicare.

I think that is what we are trying to do, is to ensure that when you raise the taxes, because they know it is actuarially sound to do so, they recognize that, in the end, they are actually going to get their retirement insurance.

Senator CHAFEE. Now, one of the points you made I think is very valid. You pick up a newspaper and look at the Giant advertisements, and you see that little time is spent on quality, it is all price. Now, your advertisements on the radio for that marvelous hospital is always about quality, never about price, as you mentioned. How, under your program, are we going to get more attention to price?

Dr. SAVING. I think because we are going to have a high deductible. What that means is, for first-dollar, individuals are going to shop and the medical industry will respond by competing by price. That is how they are going to get the customers in.

Senator CHAFEE. But, as Senator Gramm mentioned, the difference between the deductible, when all is said and done, is relatively modest. Yours is $1,200, I think Senator Gramm said it was $850 now. The deductible has not done the trick. I mean, I share the concern that no one pays any attention to costs or trying to get costs down.

Dr. SAVING. Well, what we have in Part B are, of course, very small deductibles and co-pays.

Senator CHAFEE. Under the system now.

Dr. SAVING. Exactly. This is going to be a pure full deductible of a high number, $2,500. That is going to make people care at the beginning about costs, and if you do it as a medical savings account, either way, they are going to get the money they do not spend back. That is going to have, I think, a significant reduction.

The second aspect is, we are envisioning private provision of this medical insurance, so it is real insurance. That is, the insurer is at risk. That is not the case now with medical insurance. Typical medical insurance in this country is really prepaid medical expenses run by a large group. The insurance company has no risk. They are simply paper-shufflers for the group.

Senator CHAFEE. So you think under this system the insurer would be active in trying to hold down the costs, sort of like an HMO.

Dr. SAVING. That is right. I think both the insurer and the patients at the beginning. But once the patient gets beyond $2,500, it is all free to them, so they do not care what it costs. They're going to want the Rolls-Royce of medical care once they get beyond the deductible, and someone else then has to carry it.

This is a very difficult question. I do not pretend to have all the answers for how to make competition work in this industry. It is a tough question that a lot of people have worked on, and we are continuing to work on it now.

Senator CHAFEE. Good. Now, currently, as you know, Medicare pays for some things that have nothing to do with the individual. Examples are the disproportionate share payments and supplemental payments to teaching hospitals and rural hospitals. Have you thought about how these things would be covered?

Dr. SAVING. Well, I have not thought about that because, myself, I believe that those should come from general revenues. It is really wrong to strap a system that is designed for retirement of the aged with all these other programs. I mean, it is wrong to do that.

It is misleading to the public, who believe that they are paying for their retirement and their money is being used for other things.

I think those things are valuable and ought to be done, but we should not be taking them out of this system. They ought to come out of general revenues. If we believe that rural areas need subsidies, the aged should not have to pay for them.

Senator CHAFEE. All right. Then, of course, as you know, currently we are covering the disabled before they get to age 65. Would they be covered under your plan, too?

Dr. SAVING. No. This is a plan, as we are careful in our report in saying, where we have taken all of those expenditures out and we have also taken any revenues out that might be attached to that, because that is, again, something that is not related to retiring, it is related to something else. You might want to insure people against becoming disabled, but, again, we should not confuse that with the idea that we want to provide for old age. Those are separate events and should be insured separately.

Senator CHAFEE. Yes. All right. They are expensive.

Dr. SAVING. Oh, no question about it. We know they are expensive.

Senator CHAFEE. For people under 65, if you are going to cover them from general revenues, plus the disproportionate share, plus the rural, plus the—what have I left out of the three?

Senator ROCKEFELLER. GME.

Senator CHAFEE. What?

Senator ROCKEFELLER. GME.

Senator CHAFEE. Yes. Graduate medical education. You have got quite a significant amount. Well, having completely stolen Dr. Altman's presentation, I will now depart.

Dr. SAVING. I think I have one thing to say. These expenses are there, no matter how you choose to finance things. That is the point. These are not going to go away. We are not pretending that this is cheap and we are not trying to hide any other expenses. These expenses are there, no matter what you do.

We are trying to say, there is a way to restore people's faith in the Medicare system. What most people mean by the Medicare system is their retirement Medicare. We can do that. That is all we are trying to do. Other things ought to be done, but they are a different question.

Senator CHAFEE. Thank you, Doctor.

Thank you, Mr. Chairman. If I can come back, I will.

Senator GRAMM. Thank you.

Well, let me thank both of you for coming. Yes?

Senator ROCKEFELLER. It is interesting, because you do raise some rational and logical points. I am going to be very interested in what Stuart Altman and Len Nichols have to say. When I heard that you did not include the disabled, that was deeply troubling to me. I was saying, how is he going to answer that? Your answer is, logically, very defensible.

You say, that is not a part of getting old and getting sick, that is a permanent condition and one which needs to be taken care of, and which is expensive, and which should be done separately. You would do the same thing with indirect medical expenses, with graduate medical education, training of foreign doctors, and all the rest of it.

You would say, that does not have to do with being old and being sick, that is something that needs to be done in our society but should be done on an earmark system of revenues that are separate because you are trying to say, people, if they are going to have trust in Medicare, they have to know that what is going to come in is going to come back to them. So you do raise some interesting points.

I was just having a little debate with my two staff health care experts behind me on this. It is incumbent, Senator Gramm, on us to look at what it is that we are accustomed to doing. If we change what we are accustomed to doing, then people automatically say, that is a bad thing to do. It may not be. On the other hand, we do have an obligation to make sure the disabled get taken care of.

We do have an obligation to make sure that our teaching hospitals are given the money, 50 percent of the Medicare expenses, for teaching, as well as the indirect expenses. All of that that is paid for by Medicare in this case is going to have to be paid for by some other mechanism if we go with your system.

So I am just raising the fact, in your praise, that you are being literally, incisively literal about what Medicare is and what it ought to be. Then you are sort of banishing other parts and saying, well, that has to be taken care of separately. I think that is interesting.I think that is very complicated and it could be potentially dangerous in a Congress and in a society where people do not adjust to change easily. But I respect you for bringing it up, Dr. Saving, and for being very straightforward about it. You have been very honest.

Senator GRAMM. Well, let me say that President Clinton has proposed that we change the method of funding medical education out of Medicare. I mean, that is a proposal that they have originated. We are moving in that direction because, in essence, we are hiding cost. Would it be a fairly simple thing to try to get actuarial figures on disability and have a disability premium added to this if you decided to do it? It seems to me the principle would be exactly the same.

Dr. SAVING. That is right, the principles are the same. You could decide that this medical insurance that you were paying for was going to also be insurance that you would not become disabled sometime between zero and 65, because once you become 65, of course, you are covered by this other thing.

So it would be very similar to the kind of insurance that people get for mortgages, for example, in case they become disabled and somebody else pays the mortgage. So you are going to do exactly the same kind of thing. Someone is going to pay your premiums if you become disabled and, more than that, they are also going to pay you for being disabled.

Senator GRAMM. Well, I like the concept and I think it is pretty novel that if you do it by age group, that at 22 you do not know who is going to get rich and who is not, you do not know who will end up disabled and who will not, you do not know who is going to live to be 65 and who is not. Basically that age cohort is entering into a contract with everybody else who is 22, which says they will pay in a certain amount for these purposes and, in essence, insuring your retirement health care coverage. You could do the same

thing for disability, so that whatever else happens, you are going to be covered for this particular need.

It does not guarantee you are going to get a nice wife, or that you are going to own a nice house. But I think that is a very interesting concept, and it means that that group, as with every other group under your plan, would be self-sustaining, no matter what happened to the population growth of the country in the future, or what has happened in the past.

Well, again, let me thank both of you for coming very much.

Let me now call Dr. Stuart Altman. Stuart Altman, of Brandeis University, is one of our Nation's leading academics interested in health care, and Len Nichols, who is at the Urban Institute.

STATEMENT OF STUART H. ALTMAN, PH.D., SOL C. CHAIKIN PROFESSOR OF NATIONAL HEALTH POLICY, THE FLORENCE HELLER GRADUATE SCHOOL FOR SOCIAL POLICY, BRANDEIS UNIVERSITY, WALTHAM, MA

Dr. ALTMAN. Well, Mr. Chairman, thank you very much for letting me come back to this subcommittee. This is, for me, a true pleasure. I have had the privilege over the last 26 years of coming before you many times, and I consider this one of the highlights of my professional life, the ability to work with the Congress.

I particularly had a very fine experience as chairman of ProPAC for 12 years, and so worked very closely with your staffs, and I thank you for this.

I found myself absolutely fascinated by the previous testimony. As Senator Rockefeller said, I think if you take it the way it is established it is a clear statement. Let me just make a few comments; I know we want to keep it limited.

First of all, I realize, too, this problem is overwhelming. I mean, you do not need to be a rocket scientist to see that the growth in Medicare spending is going through the roof. I really appreciate, Mr. Chairman, your starting the debate on how to handle this problem. I think it is very important that as we think about the short-term problems we do not lose sight of the long-term problem. So, I really want to thank you for doing that.

I also share with Senator Rockefeller the idea that maybe some of us have been around too long and we keep saying the same things, and it is good that we hear new ideas. And, as I was listening to Professor Saving, I thought back to my youth. I, too, was trained, in my case, out of a farm school from the University of Chicago, called UCLA, and I remember fondly my economics training from that discipline.

But I do have concerns, and I want to put them in the form of questions. Now, I appreciate Senator Chafee having raised a few of them, but I need to say something about my testimony, first.

I was writing from the vantage point of previous writings of Professor Saving and your Wall Street Journal piece, and so many of the questions I discuss in my testimony are about his original thinking. As I understand it from Professor Saving, his idea was that this would be an individual policy. So, a number of my questions deal with concerns about an individual policy.

I want to say first off, I am really fascinated by this age cohort idea. But I think, in the spirit in which you have introduced these

hearings, I need to go further about my concerns and at least lay them on the table. They relate much to what Senator Rockefeller summarized very briefly.

If we had clearly established in 1965 an insurance policy which was applicable only to individuals who paid into the Medicare fund the full amount over their lifetime, I do not think we would have had the Medicare financial problems of today. On the other hand, millions of people were added to the rolls late in life. What we did as a society, maybe naively, is we added millions of Americans who did not have the earning experience during their lifetime to justify the level of benefits they received. That jacked up the cost without adding sufficient revenue.

Second, we terribly underestimated, I am glad to say, longevity. As Senator Rockefeller said in his introductory remarks, we did not anticipate—nobody anticipated in 1965—that we were going to be living 10, 15, and 20 years longer.

Third, I do agree that the Medicare program, private insurance and first-dollar coverage allowed our health care system to grow the way it did. A lot of that may be viewed negatively, but, on the other hand, we do have an incredibly good health care system and I do not think we would have had the same health care system if we had not done that. So, I think we need to look at the positive as well as the negative aspects of Medicare.

My concerns, though, deal with what I consider to be the unfairness of comparing an approach like Dr. Saving's to the current Medicare program. I liked the simplicity of his plan. But then we need to be fair, and I am sure you will be, Mr. Chairman. I think we need to recognize that Medicare includes many additional social benefits. If we do not do that, we are going to have chaos in our country.

Included in Medicare are the disabled, and patients with end-stage renal disease. There are extensive home benefits and skilled nursing benefits that a catastrophic plan might not pay for. There are $6 billion from graduate medical education (GME).

While I can see real value in taking some of these GME funds out of Medicare, I definitely think GME should be supported.

I came before this committee several years ago in my role as chairman of ProPAC, and we were criticized because the DRG system was not doing an appropriate job for our rural hospitals. As a matter of fact, I was brought up on Good Morning, America and blamed for Texas rural hospitals closing and people having to drive long distances. I did not have that power, but, anyway, I was the front person for it.

The Congress made substantial changes in the DRG system, in part, because they recognized that sole community hospitals and many rural referral centers were critical to this country. If you go to a catastrophic-only type plan, such funding will not be there.

Therefore you have got to add all the social benefits together. You start adding up the $25 billion in spending for the disabled and renal patients; the $6 billion for graduate medical education; the $3 billion in disproportionate share, the $3–$4 billion in rural, we are getting up to real money.

Then the comparison between the existing program and the new one begins to change. I say that, not because I do not like the ap-

proach, but we do need to deal with it and we need to deal with it head-on.

In support of their plan, I do believe we need to get the individual more involved. I like the idea of more competition. I like the idea that we would have more choice for our seniors.

I do believe we are moving in that direction, by the way. I think the President's plan does do a little of that. I think the previous plan that was supported by the Congress in the last session did a lot of that. So I support that as a change, but I am very fearful that if we totally focus on a private insurance model, important components of the existing Medicare program could get lost and I think it could do serious harm to the health care system.

As you move forward, I would hope you would not lose sight of these areas. But I will tell you this, I was intrigued and I appreciate the opportunity to have read this proposal. We at Brandeis are working on a Medicare reform plan, and much of the thinking of Professors Saving and Rettenmaier will be considered in our plan as well. Thank you very much.

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

Senator GRAMM. Dr. Nichols.

STATEMENT OF LEN M. NICHOLS, PH.D., PRINCIPAL RESEARCH ASSOCIATE, HEALTH POLICY CENTER, THE URBAN INSTITUTE, WASHINGTON, DC

Dr. NICHOLS. Thank you, sir. The views I will express today are my own, and not those of The Urban Institute, its sponsors, or its trustees.

Medicare is our most sacred social contract precisely because it binds generations of Americans together. It has achieved much success, helping to lengthen and to improve the quality of life for our senior citizens since 1965. But now, as is clear, it needs serious structural repair.

Now, this entire discussion of restructuring Medicare is really a question about how to make the market work well for Medicare beneficiaries and for taxpayers. Sadly, it is not as simple as just setting the market absolutely free, for completely unregulated health insurance markets have not performed well for the elderly in the past, as our Medigap experience has shown, and there are good reasons to believe they will need structure in the future.

At the same time, the tremendous power of a well-structured market needs to be harnessed for the good of Medicare beneficiaries, for this is, in my view, the only way to accomplish our long-run goals of quality, choice, and an affordable price tag.

The most important variable, as the Chairman pointed out earlier, for Medicare to control is the real rate of growth of costs per beneficiary. As you know, it has been growing at 5 percent a year for 20 years, on average. That is clearly unsustainable, whether you have cohort-based financing or intergenerational financing.

What is surprising for many people to learn, is that Medicare's real rate of growth of cost per beneficiary has actually been lower than the private sector's for 25 of those 27 years.

Lately, the private sector has done better, mostly by taking advantage of the current excess capacity in hospital beds and special-

ist physician services. But, of course, private sector rates started out higher than Medicare's.

While welcome, this kind of cost reduction is essentially a one-time adjustment and may do little to affect the underlying long-run rate of growth of health care costs which appear to be driven by our collective appetite for better and more expensive health technology.

Now, Medicare prices have not fallen commensurately lately, partly because its formulae are too rigid. That is one of the many reasons it needs to be restructured. But, as we think about restructuring Medicare, I believe Medicare can learn a lot from a number of private sector initiatives that are under way all across the country. More than 100 business coalitions have sprung up, and I and my colleagues at The Urban Institute have been studying health insurance purchasing cooperatives in four different states.

Now, as you both know, the key to making any market work is accountability. Buyers need to be able to evaluate what they are getting, and sellers need to be forced by competition to produce quality products sufficiently and to provide enough information to evaluate the product itself. Some, but not many, health insurance markets out there are working that way today.

All of the successful ones I know of across both the private and public sectors are practicing rather similar variants of the principles of managed competition, to demand and to get health plan and provider accountability.

A major problem with health plan innovation in the Medicare program today is that plans and provider groups are not held accountable, and they are not forced to provide enough information so that HCFA could evaluate how its beneficiaries and its payment rates are doing.

Now, I believe the evidence, while necessarily preliminary at this point, nevertheless supports the contention that there are really seven keys to the value-based purchasing of health insurance and health care: defined benefit packages, defined enrollment and marketing rules, specified plan reporting requirements, negotiate competitive bids with plans, give consumers incentives to choose efficient plans, publish enough information so that enrollees can be informed about quality measures, and risk-adjust plan payments.

In the written statement I have provided I describe some concrete premium growth evidence that demonstrates the effectiveness of these principles in action. I believe Medicare could restructure itself along these general lines and serve our Nation's elders and taxpayers very well.

Now, while the cohort-based proposal outlined by Professors Saving and Rettenmaier has some features I like a lot—more responsibility borne by seniors for financing their own health care and cross subsidization of the low-income by the high—I think it would be a serious mistake to sever the intergenerational nature of our social contract.

First, the risks to any single cohort of unanticipated cost increases are great, and I believe the pain they would suffer is greater than that which would be imposed if we keep the funding stream broader and more intergenerational. My written testimony, again, lays out some examples I would be glad to discuss.

In addition, medical advances might come along that we would want all seniors to benefit from at some time in the future, but cohorts at or near retirement would be unable to augment their intra-cohort funding stream in time.

But, even more importantly, erasing the explicitly intergenerational nature of the Medicare program would sever our social contract and loosen the bonds between generations.

Now, we Americans require individuals to take a great deal of personal responsibility to enjoy the full fruits of our society, but we also take care of our elders. We do not forget those who end up unlucky, or the victims of the inexactitudes of actuarial, economic, or medical science. The strongest and most prudent safety net is the promise of unconditional acceptance in a larger community. We abandon such a promise, I believe, at our individual and collective peril.

Now, would restructuring Medicare along the lines that I have suggested be all that Medicare needs? No. I am not a fan of this silver bullet theory, that there is one magic solution to Medicare's financing problem that we just have not been smart enough here inside the Beltway to figure out.

Any serious Medicare restructuring effort, as Senator Dole wrote the other day in the Washington Post, will require a little bit of sacrifice and change from all parts of the program and from all parts of our society.

Yes, this will probably entail some tax increases down the road, but with competitive bidding and a defined benefit package we could decide collectively exactly what we are willing to pay for, as promised medical value and current opportunity costs change over time and are weighed against each other right here in Congress each year into the future, as it should be.

Though we may end up with tax increases if we decide collectively we actually want to pay for this high technology, we need not start there. Where we should start, is with a serious effort at restructuring Medicare along workable market lines, not ideologically pure free market lines, but structured market lines.

A competitive health plan market can be the Medicare program's best long-run friend, but only if we structure the relationship carefully. This structured relationship would be stronger, I believe, if the overall program remains intergenerational. Those are our elders out there looking for medical care after a lifetime of work and sacrifice. They are us. Thank you very much.

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

Senator GRAMM. Thank you, Dr. Nichols. Let me, first, say that I appreciate your testimony very much. I had sort of envisioned that we were going to hear your ideas concerning the long-term problem, but I think getting your reflections on the ideas of Dr. Saving and Dr. Rettenmaier is positive, and I appreciate it.

Let me say, Dr. Altman, I appreciate your comments. Let me say this, and I think it is especially a problem here on Capitol Hill. But I am very encouraged that, wherever the left and right are in the intellectual community on these issues, there is an increasing commitment to competition and choice and cost sensitivity.

When you have CATO and The Urban Institute basically agree on how we ought to deal with exploding per capita cost, there is

obviously something wrong with Senator Rockefeller and me if we cannot figure out how to work together to try to make these things happen.

The plain truth is, the intellectual community that works with these problems every day has long ago concluded that there are a series of changes that need to be made to rationalize the current system, to make people more cost-conscious in their behavior, and to give them a much greater range of choice.

I think, in listening to a broad cross-section of people, that clearly is the message that is coming through. I think, hopefully, we are going to get over this partisan chasm that divides us and make a step in that direction. I would say one thing, Dr. Altman.

It is very important that we do not set up the sort of straw man where we accuse anybody who says there is anything wrong with Medicare and says that the problem is significant and that it requires dramatic change, of attacking the elderly or in some way, understating the great benefits we have had in longevity or what we have gotten out of the program.

There is no doubt about the fact that, by making the program operative immediately, something we did not do with Social Security, that there were beneficiaries—my mother was one of those beneficiaries, and is still a very substantial beneficiary.

Dr. ALTMAN. So is mine.

Senator GRAMM. But that does not change the problem we are facing now. That does not change the fact that we are looking at the present value of the unfunded liability of the current system, growing to $8 trillion in 20 years if we do not do anything.

So I just would like to caution that we cannot get ourselves in a position of accusing anybody who is saying that something is profoundly with the current system financially and that we cannot preserve the status quo of somehow assaulting the elderly.

In fact, I think one of the appealing things of the Saving proposal is, up front they are saying it is going to cost you almost $1 trillion in benefits that you have guaranteed, but nobody has ever paid for.

Whether we are all in this together generationally, I am not sure, Dr. Nichols, that I agree with you on that. My tie, generationally, is that my mother tells me what to do, and from the time I first was aware, more often than not she is right, even though I am 55 years old. That is my intergenerational tie.

But the point is, we are going to have to make some dramatic changes. Now, what those changes are, I think, clearly is open to debate. But there is no possibility that we are going to be able to sustain the status quo, because when you look at these numbers, even if you are willing to triple or quadruple the tax rate, we have got to get costs under control, and everybody, left, right, and center agrees with that.

Then we are going to have to find a way to get through this intergenerational problem with this baby boom crisis and at least try to look at it, because Senator Rockefeller and I, 15 years from now, I think will both be alive and healthy. We could both be here. I do not know whether that would be a good or a dismal prospect.

But the point is, somebody is going to say to Senator Rockefeller or to me, where were you when the roof fell in. I think what we are trying to do is get as much input as we can as to what we can

do so we can say, well, we were there and we helped sustain it. That is really the objective we are looking at. Let me stop and let both of you all respond, then I will recognize Senator Rockefeller.

Dr. ALTMAN. Let me both agree and apologize, to the extent that I did not want to necessarily blame and say you are not thinking clearly. On the other hand, in defense, I do think it is a little unfair to blame the structure of Medicare for the totality of the size of the problem.

When you look and you separate out why it is that we are running into this problem, part of it is this idea that there has been this substantial growth in longevity. Part of it is medical inflation.

As Len talked about, the medical inflation has been actually higher on the private side than on the Medicare side. Part of it is the fact that my mother, your mother, and my father did not put enough in, because they were caught mid-stream, so we put them in. Part of it is the extent to which we have taken on these extra social benefits.

So where I was critical, or I tried to be critical, was not to lambast. As I said, I found Professor Saving's comments quite interesting, and what I liked about them was that they were clean and they made sense. But I would hope that when we go forward we focus on the issues that need to go forward.

For example, what is the best way to control medical inflation? Is it better to put every individual totally at risk? I am sympathetic to getting many more individuals in. I do not think it ought to be done only by the government.

On the other hand, as Senator Rockefeller pointed out, 50–80 percent of our spending is among the 5 percent and 10 percent of the sickest, which means most of the spending will be in the catastrophic plan. So, that is something we need to work on.

I am also concerned, as I said, about our health care system. For better or for worse, a big chunk of our health care system is now dependent on Medicare. I like this 50 years that you talk about; maybe we can wean them off Medicare. But we sure need to recognize that Medicare is not—and I like what Professor Saving said—only an insurance policy for our elderly. It has not been, it has never been.

Maybe we, collectively, have sold a bill of goods, but the truth of the matter is, it is one complicated infrastructure that is holding up a big, substantial chunk of our existing health care system, as well as providing these subsidies.

If we are going to move away from that, as I tried to say, we need to either accept that and let the system fall where it may, or put in place a whole series of new general revenue supports. That was what I was trying to do. To the extent I did not do it, I apologize.

Senator GRAMM. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman. I have had some sort of comparable thoughts as I have just been listening to this debate. I agree, for example, with the statement that you just concluded with, Stuart, that we have decided, either knowingly or unknowingly, over a period of years that Medicare, in order to work, is not just the reimbursement for medical services, but it is

a system which allows all of that to happen within some form of a rational health care policy.

I also agree, and if I know Phil Gramm the way I think I know him, one of the reasons he is doing this is to prod us, who like to think that we know about health care policy, to be more imaginative, more creative.

In your own testimony you say that you want to come back and talk about solutions for the long-term. On the other hand, I think that Senator Gramm's very oblique and very gentlemanly criticism was that you did not have it, or might not have given it if you did have it because you wanted to respond to Dr. Saving is met on Dr. Saving's side by the fact that, two weeks ago, his proposal was not the same as it is today.

Dr. ALTMAN. That is right.

Senator ROCKEFELLER. So, everybody is in flux. I think it is fair to raise the very interesting philosophical question about, is something of a better social compact if it is intragenerational as opposed to if it is intergenerational? That 20-year-olds and 30-year-olds bonding together for a purpose brings back trust in Medicare and somehow, through Medicare trust in the government or some part of the government, at least. That, to me, is interesting.

I keep coming back, as somebody who went to West Virginia as a VISTA volunteer and still has a lot of that thinking in my mind, that when people get older they tend to get real sick. I have seen some real, real sick people in West Virginia, and that is true, of course, everywhere all over the world. I do not want to really take a chance with their not getting the care they need.

Then you see, as soon as I say that, that means I have got to stay with the present program because I know what that is, even if it is getting too expensive and it is going to blow us off the face of the Earth financially.

But then I turn around and I come back and I say, well, look at what happened when they did catastrophic health care, which, in fact, for $37 a month, as I recall, was probably one of the finest health care programs this Congress ever passed, to save Medicare and Medicaid. What happened?

It was a spectacular opportunity for seniors in which we at that time, and the administration at that time, did a spectacularly bad job in explaining to the American people what it was all about. As a result, a lot of people chased Danny Rostenkowski down the street in his car. That became a symbol.

The thing was shot down in the House. I led the fight in the Senate not to have it shot down, and three times we got 73 votes to keep catastrophic health care, Senator Gramm. But, nevertheless, the House would not receive, and so we gave up and it was gone.

And what happened, interestingly, after that—and I think this is pertinent—is that people really withdrew. It had a tremendous effect on people like Pete Stark and Bill Gradison and others who had been integral to the creation of that program.

It sort of pulled them back from health care policy altogether, made them timid, or angry and had a bad effect, generally, on health care consideration. Health care is a very difficult subject to begin with. Those who are in it have to be in it and have to constantly be in it.

So let me just end with that. Somebody is going to pay for GME, somebody is going to pay for end-stage renal disease, and somebody has got to pay for the disproportionate share hospitals, somebody has got to pay for the extra amount of money which is now put out to rural hospitals through Medicare.

We have no guarantees in a budget-closing climate that that is going to happen. In fact, one of the things I always kind of liked about GME was the fact that it was hidden, that all kinds of people were getting trained. I thought they were getting trained to do the wrong things, but the money was hidden, in a sense, from the public because it was under something called Medicare.

And nobody would have ever guessed that doctors at Columbia Presbyterian or some other place were getting paid 50 percent of their training costs for graduate students by something called Medicare, which had nothing to do with caring for the sick, which would some day, but did not then.

So, I think very interesting philosophical approaches have been raised here. I am not sure they are compelling, I am not sure they are practical, I am not sure they are doable. But they are valuable to drag us through intellectually a process that we have not ventured on before, I think, is indisputable.

Senator GRAMM. Thank you, Senator Rockefeller.

Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman.

Dr. Altman, as I recall reading your testimony over, you indicated whereas you did not have any solutions now, that you would like to come back sometime.

Dr. ALTMAN. I would very much, sir.

Senator CHAFEE. We have seen you frequently here.

Dr. ALTMAN. A few times.

Senator CHAFEE. We look forward to seeing you again.

Dr. ALTMAN. Thank you.

Senator CHAFEE. This is really a fascinating problem. People say, well, how do you like being in the Senate? I think one of the things about being in the Senate is that you deal with some pretty important matters. Few things are more important than this. It is really a difficult problem. I am certainly going to do everything I can to try and find a solution to it.

I am not sure we can, but we can certainly try. We need to because of all of the problems that have been mentioned here of what we are facing in the future. We had an interesting hearing yesterday before the Environment and Public Works Committee dealing with the so-called ISTEA Measure, which deals with surface transportation.

The Secretary said we should look at these not with the eyes of adults, but with the eyes of children. In other words, it is through the eyes of children we will be looking to see what is going to happen in the future. I feel that the same applies to this issue. We have got to be thinking about the future of this program.

We can skid through 5 years, maybe, with just a little tinkering here and there, but when we finish that things are still going to be worse off. If we are going to tackle these programs, the best thing to do is to tackle them now. That applies to a lot of programs, Social Security, too.

So I want to thank everybody. I did not hear you, Dr. Nichols. I apologize for that. I would say, Mr. Chairman, I look forward to seeing Dr. Altman again. Thank you.

Senator GRAMM. Well, thank you, Senator Chafee. I think, as we get further into this, maybe it would be a good thing to do in several months to have our two panels back, maybe together next time, to talk about this long-term problem. I understand Dr. Altman is having a seminar this week, bringing people together, talking about the problem.

Let me just conclude on a point that Senator Chafee made. That is, I think there is this belief that somehow there is a short-term problem and a long-term problem out there, and that never the two are going to meet.

I think the thing that is different between what we are talking about in Medicare and what, as members of the Finance Committee, we are all worried about in Social Security, is that the long-term problem in Medicare is here.

The long-term problem in Social Security is 27, 28 years away. Given the magnitude of the problem that is not a very long time, but, given the makeup of politics, that is an eternity. But I do not think we have the luxury of just approaching this over the 5-year savings approach.

Obviously we are going to write a budget and it's either going to do what I would like to see us do or not, but I do not think we benefit by getting into this debate that we have been in for several years over the level of savings we are supposed to achieve in 5 years.

I am much more concerned about how we are changing the program and how what we are doing now is going to have long-term effects on behavior and the costs 10 and 20 years from now than I am about what costs are going to be 5 years from now.

So I am hoping that one of the partisan pitfalls we can avoid, which has just really consumed our energy for the last 2 years, is this whole debate about whether we should save $100 billion in the next 5 years, or whether we should save $140 billion, or whether we should save $180 billion.

The truth is, none of those savings has any substantial impact on the long-term problem. Twenty years from now, $100 billion or $180 billion, if all we do is reduce reimbursement rates, will not make any difference whatsoever.

So what I am hoping we can do is to build a bipartisan consensus to begin to look at these long-term problems, and I think everybody who has been here today has contributed to that. Let me thank each of you. Thank you very much.

[Whereupon, at 3:51 p.m., the hearing was recessed.]

MAGNITUDE OF THE FINANCIAL CRISIS IN MEDICARE

THURSDAY, MARCH 6, 1997

U.S. SENATE,
SUBCOMMITTEE ON HEALTH CARE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 2:05 p.m., in room SD–215, Dirksen Senate Office Building, Hon. Phil Gramm (chairman of the subcommittee) presiding.

Also present: Senator Rockefeller.

OPENING STATEMENT OF HON. PHIL GRAMM, A U.S. SENATOR FROM TEXAS, CHAIRMAN, SUBCOMMITTEE ON HEALTH

Senator GRAMM. Let me call the hearing to order. I want to thank our panelists today for being here. I think we have an excellent panel. As has been true of everything else we have tried to do, we are trying to hear from a broad cross-section of people.

We are focusing in these early hearings on the long-term problems we have in Medicare and the options we have in dealing with those problems. The logic of where we are and what we need to do came to mind a minute ago when I said hello to the members of our panel. When you get ready to start a race—which is basically what we are going to do when we start the process of writing the Medicare component of whatever budget is ultimately either negotiated or adopted—it is important to know whether you are running the 100-yard dash, the two-mile race, or the marathon.

One of the things that is very important about what we are doing, instead of getting immediately into the debate about how we are going to score the various savings and how we are going to negotiate out these differences, is to look at the long-term problem, getting it into perspective, and understanding the size of the job we have to do.

We do have a good cross-section of people here today, and I am very grateful that each of you have come and that the institutions you represent have decided to participate in what we are doing.

Let me now yield to Senator Rockefeller.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Who will have a little bit longer comment, as usual. I also thank the witnesses very much, and you, Mr. Chairman. Actually, the article I just gave you disturbed me because it did not have the statement in it which I made at the end

of the last hearing, in which I said I thought it was a very provocative and helpful process that you were doing, in sort of forcing us to look way out into the future. I think that is good, but it is not in the article.

Senator GRAMM. I have said many good things that did not end up in the paper.

Senator ROCKEFELLER. But I think it has been a good process, and is a good process because the numbers are frightening and we have to do something. It is possible that part of the reason the numbers are so frightening also is because Medicare has been an enormous success.

I mean, if it had been a failure, people had not responded to it or it had not worked well—but people are living longer. That is a blessing and it is a cost factor. They are living longer because of more complex medicines. That is a blessing and it is a cost factor. Technology, all the rest of it.

Lynn Etheredge is going to testify a little later on the importance of making sure that Medicare beneficiaries receive appropriate end-of-life care. That is a subject that I care about enormously.

There have been some very interesting articles on that recently in the New York Times and the Washington Post, and it is a huge, huge subject, ethically, morally, financially, who makes decisions in society, how do Americans come to make judgments. I had to go through that with my mother, when she was dying of Alzheimer's. It is a very, very important issue.

Medicare offers hospice benefit for patients whose life expectancy is projected to be 6 months or less. There are a large number of individuals with chronic, debilitating, and often fatal diseases whose death cannot be predicted with that amount of certainty, and we need to offer better, or think about offering better, options for compassionate, supportive, and not necessarily more costly care for patients near the end of their lives.

So we take care of one group, we do not look at another group. Everything involves cost, everything involves ethics. It is tremendously complicated. It is also true, I think, if we can avert unnecessary hospitalizations, we should be able to figure out a way to rechannel those savings, if there are some, to provide a more appropriate mix of services for patients at the end of their lives.

I am going to be introducing legislation on this that builds a little bit upon what Jack Danforth and I did back in 1990, which seems now really rather pale, in fact, because that was when we thought that a living will might have something to do with advanced directive or durable power of attorney, and they do not. But at least we got into every hospital and in every institution that receives public help notification about the possibility of doing these things. So, I will be doing that.

The improvement in technology, I think, as I said, is another important area to further explore when talking about how to revamp Medicare for the 21st century, for rural beneficiaries.

I think a lot of money is going to be saved no matter what we do because of telemedicine services. They are going to offer a lot of promise. Medicare does not pay currently for telemedical consultations or other services available, or for major advances in telecommunications technology. That does not make a lot of sense, be-

cause that sounds to me like a real money saver. But we will see. For seniors with chronic health conditions in West Virginia, it would certainly be an enormous help.

The Veterans Administration does cardiac monitoring of 30,000 VA pacemakers each year to make sure that the pacemakers are operating correctly and to check on the status of the pacemaker's batteries.

Well, through a very simple technology, patients can hook up themselves to a special device, to an ordinary phone that transmits their EKG readings to their doctor's office. Again, technology reducing costs, not inflaming costs.

At the same time, patients are able to talk to a nurse about their health status. The nurse can check on whether the patient is complying with his or her treatment protocol, all helpful.

There are literally thousands of examples of how Medicare programs lagged behind, in fact, the private sector and even other government health programs when it comes to the array of benefits that are covered. So benefit design is a key reform. It does not necessarily have to make things more expensive, but it is something we do have to think about. That is my statement.

Senator GRAMM. Thank you, Senator Rockefeller.

Let me introduce our panel members, and I will start from my left with Stuart Butler, who is the vice president for Domestic Research of The Heritage Foundation; Karen Davis, who is the president of The Commonwealth Fund in New York; Lynn Etheredge, who is a consultant with the Health Insurance Reform Project at George Washington University; Robert Helms, who is director of Health Policy Studies at AEI.

Dr. HELMS. Robert.

Senator GRAMM. Excuse me?

Dr. HELMS. I am not related to Richard. He was formerly of the CIA, so it is Robert Helms.

Senator GRAMM. Did I say Richard?

Dr. HELMS. Yes, you did.

Senator GRAMM. Well, I do not know whether I should apologize or not.

Dr. HELMS. Well, I get that a lot of times.

Senator GRAMM. Let me just say, Robert Helms, who is the director of Health Policy Studies at the American Enterprise Institute in Washington; and Michael Tanner who is the director of Health and Welfare Studies at The Cato Institute in Washington.

What I would like to do is begin with Stuart and try to, if we could, stay as close to 5 minutes as you can. If you have to run over, do not worry about it. What we want to do is hear from everybody, and then get an opportunity to ask questions.

Since we just have the two of us here, during my questioning, if you want to chime in, let me know because, again, we are here to listen to you.

So, Stuart, you are our first witness, and thank you for coming.

STATEMENT OF STUART M. BUTLER, PH.D., VICE PRESIDENT FOR DOMESTIC RESEARCH, THE HERITAGE FOUNDATION, WASHINGTON, DC

Dr. BUTLER. Thank you, Mr. Chairman. I think it is very important to hold these hearings with a very broad look at the problem and the range of solutions. I think everybody on the panel would probably agree that the Medicare program is hopelessly out of balance.

As we know, that is partly due to the demographics of the system. It is partly because of the technology driving costs. But, as many have said, it is also due to the design of the program itself, and many people have pointed out that the benefit structure of Medicare is in what one might call a time warp. It is not a particularly modern set of benefits.

It is also important that we recognize that the problem is really the whole program, not just the HI trust fund. Also, the next few years are really just the tip of the iceberg. We are not just trying to survive until 2005. If you look at the figures beyond that, it gets worse and worse. So we really do have to look at fundamental reform of the system.

The scale of the problem is enormous. Net of premiums, Medicare spent about 2.3 percent of GDP in 1995. The CBO projects it to spend 7.1 percent by 2030.

Also, if you look at the options we have within the current structure, simply shifting money from Part A to Part B may please the accountants, but it does not solve the underlying problem. It is a little bit like paying off your overdue credit card with a check on your overdrawn account—it does not really get you very far.

Also, taxes can hardly be the solution to the problem. Just to continue hospital services to 2005 would cost the average household about $4,000 in new taxes, if we were simply to bail out the system.

If you add in the projected costs of the Part B deficit, i.e. the part that has to be covered by the taxpayers, the total cost for the average household in 2005 would rise to $14,000 in taxes that would have to be paid to cover that program. That is a staggering amount of money.

Similarly, if one tried to deal with the problem by squeezing down on the providers, you are talking about a similar scale of action. So to try and simply just force the current system to fit into a straightjacket would mean enormous costs, either to the taxpayer or to beneficiaries. Thus it is very important to think, as you appreciate, Mr. Chairman, very differently about the program. There were several broad ideas for such long-term reform, and many of them are compatible with each other. They are the kinds of things the committee and Congress should be considering.

The first is to move to some form of defined contribution system. There are many such proposals. The term "defined contribution" actually is like the term "managed care," in that there are many, many versions of it. It does not have to mean an arbitrary budget where the taxpayer is protected against all risk in some way, and the beneficiary just has to carry all risk. It does not necessarily mean that.

But it does mean creating a very different set of incentives to limit the degree of support that the taxpayer provides and to encourage beneficiaries to begin to look for greater value for money in competing plans.

A defined contribution can be a blend of a cash limit, or total cash amount of assistance, with some proportion of the premium being paid. The FEHBP is structured like that, in that a certain percentage is covered of a premium, up to a limit. Federal workers and members of Congress thus have a strong incentive to look for value for money in the system, and yet are protected against out of pocket costs.

In addition, Congress can look at a contribution that is linked to the average cost of some basic benefits package. So what the government would assure that the contribution is based on the cost of a certain package.

If a beneficiary wanted to go beyond that or slightly change the package, they could but would have the incentive to shop around.

We at Heritage have suggested something along those lines. Bob Reischauer and Henry Aaron at Brookings have also supported something along those lines.

So, when you look at a defined contribution idea the essential issue is to encourage a different set of incentives and to ensure that the beneficiaries are at least protected to a certain degree against the costs of coverage.

The second broad type of approach which is also compatible with this, is to look at really restructuring the whole combination we have today of social insurance and general taxpayer financing system.

As you well know, the current arrangement is very much an historical accident of the politics of the 1960's. We have a combination of social insurance which is heavily out of balance, with general taxpayer financing much of it.

I think it might be possible to look at limiting that social insurance to a core benefit package with a much higher degree of beneficiary support than today, but covering a wider range of services. In addition, there would be a second element in the form of a strictly means-tested, tax-supported subsidy for those who need extra help to afford the out-of-pocket costs that are not met with social insurance.

So, in other words, we should say explicitly that if we are going to give help above the social insurance element, it should be strictly means tested.

Let me end by looking very quickly at some shorter term steps that would begin to move you, I think, in the kind of direction that these longer term approaches would suggest.

First, I think it is very important that Congress change the statutory standards for the Medigap policies. Right now, essentially, in order to get help to cover the out-of-pocket costs, an elderly or disabled person must buy first-dollar coverage in Medigap. The law essentially requires that, if they want to get a drug benefit or catastrophic coverage.

It is time to change that to make it much leaner and to make it much more designed to cover catastrophic costs. That would save money for the elderly immediately and it would protect the Medi-

care system from the spill-over effect of people being covered for first-dollar coverage.

Second, I think it is very important to consider raising the Part B deductible and introducing some means testing for the Part B premium.

There are a number of proposals that have been put forward to do this. Guy King, the former Chief Actuary of HCFA, suggested even raising the deductible to $1,000, thereby being able to bring down the premium to as little as $4 a month. Maybe some combination in between that and today's level may be the way to go, but that would certainly introduce a greater cost consciousness while allowing Congress to reduce the premium costs for low-income people.

Third, it is important to delink the payment for HMOs from the fee-for-service system. Right now, we have artificial linkage. Many HMOs are overpaid, some are underpaid. But I think it is time to start looking at paying HMOs in line with what the market conditions are in those areas. That is essentially what the FEHBP does through negotiation.

The PPRC has suggested a similar approach based on the weighted average of costs of plans in a certain area. But delinking it would be doing what the private sector and corporations discovered many years ago, that once you have that artificial link you are, in fact, overpaying, in many cases, for HMO.

Finally, I would suggest that we look right now at separating the running of the traditional fee-for-service program from the overall management of the Medicare program itself.

In other words, set up a separate, independent board to run the actual medical care in the traditional fee for service system and then have HCFA remaining as the over-arching body to examine the general dimensions of the program and to run the finances.

That would give much greater independence to the traditional program to slowly change over time and improve its benefits and look for options. It would allow it to be ready to compete if one allows competing plans in the future. I think it is an idea that really ought to be examined very carefully.

Recently, CBO Director June O'Neill suggested something along the lines of the Federal Reserve Board for running the traditional system. I am not sure that I think having an Alan Greenspan of health care makes a lot of sense. But something more answerable to Congress would be a very important step.

So, just in conclusion, I think that it is very important, as you have suggested, to really take a blue skies approach to Medicare. We cannot continue in the way we are going. Nobody's proposal to make small changes will solve the problem, and it certainly is essential to look at these very different alternatives.

Thank you, Mr. Chairman.

Senator GRAMM. Thank you, Dr. Butler.

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

Senator GRAMM. Dr. Davis.

STATEMENT OF KAREN DAVIS, PH.D., PRESIDENT, THE COMMONWEALTH FUND, NEW YORK, NY

Dr. DAVIS. Thank you, Mr. Chairman, for this invitation to appear before the subcommittee. I would like to just enter my statement into the record and then abstract from the charts in my statement.

Senator GRAMM. And let me say that everybody's statement will be put in the record in full.

Dr. DAVIS. There is a set of charts at the back of my statement. Chart 1, I think, tries to put the dimensions of the problem, both in the short-term and the long-term, into context.

Medicare is growing faster than the economy, the Federal budget, and tax revenues that are coming in from payroll taxes, premiums, and general tax revenues. Certainly none of the proposals now before Congress would assure the adequacy of Medicare financing over 30 years.

But what you see in Chart 1 is that tightening payments to providers and managed care plans such as those suggested in the President's budget would improve the situation by bringing Medicare spending more in line with economic and budgetary growth, and these are using CBOs numbers from just a couple of days ago, where they project baseline Medicare growing at 8.4 percent a year, the President's budget's 6.7, but the Federal budget between now and the year 2002 and the gross domestic product growing at about 4.7.

So there is about a 3.5 to 4 percentage point a year gap between where Medicare is growing under baseline and the economy. The President's budget would narrow that gap, but you still have a 2 percentage point difference.

When you turn to Chart 2, you see that we really have basically the same situation in front of us for the foreseeable future. Between now and the year 2020, Medicare is growing by 9 percent a year. Payroll taxes and the economy are growing 5 percent a year. So there is a 4 percentage point gap.

That is why these numbers add up, or why one long-term trend line shoots way up quickly and the other looks pretty flat. But I think it would be a mistake to lock in long-term changes in Medicare now. We have a health system that is in enormous flux. I think it is going to take time for hospitals and other health institutions to adapt to the changes going on in the market.

I think we really need time to develop sound policies and put some building blocks in place, such as better ways of paying managed care plans and instituting quality standards so that we are really sure that we are guaranteeing Medicare's basic promise of assuring access to quality health services for elderly and disabled beneficiaries.

I think we need to do more research on these different choices and have demonstrations and really learn what we are getting into before we are locked into it. As Senator Rockefeller said, with technology we really do not know 30 years from now how long people will be living and what will be possible, and what will reduce costs and what will increase costs.

So I think, in fact, it is good to look at these options. I think it would be a mistake to settle on a fixed course at this point in time.

This 4 percentage point gap between what Medicare is growing and the economy and the Federal budget are growing really is a function of rising health care spending in the economy as a whole.

If you look at Chart 3, historically health expenditures have simply gone up faster than the gross domestic product. For Medicare to grow at 5 percent a year, what is really implied is that real Medicare spending per beneficiary would have to go down, because 5 percent covers about 4 percent for inflation, but you have got about 1.5–2 percent for population growth.

So you actually have nothing left over for any real increase in Medicare outlays. So this curve for the Nation as a whole, for health industry as a whole, would have to go down to really bring Medicare down to a 5 percent rate of increase.

I think if you look at Chart 4, you see in the last 35 years there were only four times that health expenditures ever went up slower than the gross domestic product, and that was in the early 1970's under the Nixon wage and price controls, the late 1970's when President Carter proposed his hospital cost containment bill, and in the mid-1980's when Medicare instituted DRG payments for prospective payments for hospitals.

Then very recently in 1994, there was also a year where health spending went up slower than the economy. Chart 5 just translates those trends into inflation-adjusted expenditures on a per person basis.

If you look at this period over the last 45 years, real health spending per person in the economy as a whole has gone up about 4.5 percent. In the last 3 years, it is about 2.7 percent. So I think we are all pleased to see this slow-down in health spending. But I do not think we really understand what is accounting for it.

There is a very recent study by the National Bureau of Economic Research that I reference in my statement that says it actually cannot be attributed to managed care because the premiums are very similar at this point. It could have been the threat of the Clinton health reform plan, where the industry thought big controls were coming so they were prudent in their decisions.

But we also do not know whether it is temporary or permanent, and I think it is really hard to believe that it is permanent. What little we know from the research is that managed care has, at best, one-time savings. The Washington Post yesterday had a very interesting article where experts in the field are estimating private spending will start shooting back up at 8 or 10 percent, which in real per capita terms that is 4 to 6 percent. So, it is reverting back to this historical trend.

But even if you think we are going to be growing at two, 3 percent a year, to close this gap you would have to have Medicare spending per beneficiary decline in real terms. It is unrealistic to think that private spending and health spending in the industry as a whole is going to decline. As a result, we are going to have to look at other options.

Those options basically are for beneficiaries to pay more, to cover fewer people, for example, raising the age of eligibility, or even means testing eligibility for Medicare. But those have down sides. It increases the number of people who would be uninsured. There is not much savings from income-conditioning eligibility, since so

many elderly, as you see in Chart 6, are both already on fairly modest incomes and already paying a lot out of pocket. The elderly, as a whole, pay 21 percent of income for health care, low income elderly 30 percent.

Chart 7 shows how much the deductibles have actually gone up in real terms since Medicare started in 1966. The hospital deductible in 1996 was $736. In inflation-adjusted dollars, its original deductible would have been only $190. The premium is also higher in real terms today.

It is also the case, as Senator Rockefeller mentioned, that Medicare's benefits are less generous than employer benefits. These are high deductibles, compared with private plans, and Medicare does not cover prescription drugs.

Chart 8 shows that one of the consequences is that the elderly spend $2,600 per person on health care out-of-pocket. Chart 9 reminds us that Medicare expenditures are very skewed for the 10 percent who are the sickest. Medicare is paying $37,000 a person. For the 20 percent who are the healthiest, Medicare incurs no costs.

It is one of the reasons that vouchers or managed care defined contribution, without tools for adjusting for the health risk of the population, can lead to major problems. Obviously, for the healthiest 50–70 percent paying the average of $4,700 is more than adequate. In fact, if you pay the average, Medicare will lose money. It also then is covering the sickest 10 or 20 percent under a traditional Medicare fee-for-service alternative.

Chart 10 shows the beneficiary flip side of this. For that 10 percent who are the sickest, they are paying now $8,800 per person. So those who are the sickest, some of them are dying, but others who are chronically ill with very serious chronic problems are paying a lot already.

If you were to say, put co-payments on home health care, it would really fall on this population that already have very substantial out-of-pocket costs.

We do have Medicaid to supplement Medicare, but Chart 11 points out that only two-thirds of the poor actually are finding out about and getting enrolled in that Medicaid supplemental coverage. There is a little bit of premium subsidy for those just above the poverty level, but only 10 percent of those who are eligible are getting enrolled.

But I would just remind you, the poverty level for a single elderly person is $7,500, so we are only doing subsidies up to, at most, $9,000. So anybody above that is paying these out of pocket costs, which are quite substantial.

Chart 12 really looks at whether there is room for Medicare to improve relative to private insurance. It has done better from the period from the mid-1980's until the early 1990's. Then private spending has been going up a little bit slower.

But Medicare, over that decade from the mid-1980's to the mid-1990's, was already getting price discounts from physicians and hospitals, and today Medicare pays 69 percent of what private insurers, even with managed care, are paying physicians.

So I think there is some question about how much more one can squeeze provider payments to hospitals and physicians. On the

other hand, we could extend prospective payment to home health, skilled nursing, and hospital outpatient departments.

Chart 13 turns to the issue of managed care and whether to expand enrollment in managed care plans. Even without any changes in law, the Congressional Budget Office estimates that managed care enrollment will double between now and the year 2000 as a percent of the total population.

But I think the main thing to know is, first of all, Medicare loses money on everybody who enrolls in a managed care plan, about 6 percent, because of the way we set the payment method. We need to adjust the way Medicare pays HMOs for the health status of beneficiaries, but the methods out there are still inadequate. The research shows that the very best methods available today only explain 9 percent of this variation in health expenditures.

That is better than our current method that only explains 1 percent, but is far from being a minimally adequate system and we may have to look at other alternatives, such as lowering the HMO payment rate to 90 percent of the fee-for-service level, or trying some blended composition of capitation and fee-for-service prospective payment.

There has been a reference to the geographic variation in managed care premiums. We need to solve that problem. There has been a reference to finding a better way of increasing it over time. We need to solve that problem.

We really have no effective quality standards in place, and I think that is particularly troubling because there are studies showing that the elderly in managed care plans have their health deteriorate relative to those in fee-for-service. So we do have some quality problems out there, and we need to have high quality standards and have a way of monitoring what is happening.

Chart 14 raises some of the concerns I have with extending choices to insurance products, medical savings accounts, independent indemnity fee-for-service plans, and just capping a governmental outlay in the form of a defined contribution.

Obviously, if costs are going up at 9 percent and you cap a voucher at 5 percent, it is the elderly who will be financially at risk for the difference. It is unlikely, I think, that any given voucher would keep up with growth in health care costs. Also, if you have a voluntary voucher system, it will cause adverse risk selection and cost the government money.

People who are healthy will take the voucher, people who are sick will stay with Medicare. I think we have seen problems in the private sector in terms of marketing abuses, and certainly high private insurance administrative costs, Medigap is 30–50 percent of costs, and such approaches undermine the social insurance nature of Medicare.

To just conclude, I think we are talking about a 4 percent gap that we need to find ways of closing. Certainly some of that could come out of prospective payment methods for all Medicare services, perhaps expenditure targets applied to more of Medicare's fee-for-service benefits. But I think we do need, as Senator Rockefeller said, to improve Medicare's benefits. Perhaps better benefits can be financed, in part, with higher premiums.

But we are going to have to provide better subsidies to low-income beneficiaries. It is these low-income, very old and very disabled beneficiaries that are growing in numbers particularly rapidly over the next 5–10 years for whom we need to improve Medicaid's protections.

I think we can do a lot to put in the building blocks with managed care with better payment methods, quality standards, information for beneficiaries on choices.

But I really think over the long term we are going to have to look at refinancing Medicare, merging A and B, looking at different revenue sources than just the payroll tax.

The payroll tax will always lead to a crisis, because revenues are just going to go up slower than the number of elderly and health care costs. We really need to look at some other options for making this fiscally sound.

To go back to the Chairman's fine analogy at the beginning of the hearing, we have got Medicare the train going at 9 percent a year, we have got revenues, the runner, going at 5 percent a year. If we cannot slow the train down, we are going to have to speed up the runner a little bit if we are going to narrow that difference. Thank you.

Senator GRAMM. Thank you.

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

Senator GRAMM. Lynn Etheredge.

STATEMENT OF LYNN ETHEREDGE, CONSULTANT, HEALTH INSURANCE REFORM PROJECT, GEORGE WASHINGTON UNIVERSITY, CHEVY CHASE, MD

Mr. ETHEREDGE. Thank you, Mr. Chairman. There has been a lot of discussion lately about restructuring the Medicare program and about more choices for Medicare beneficiaries. My testimony this afternoon is going to be concerned with the question: What are the new choices that would help beneficiaries to get better medical care?

Today, Medicare beneficiaries basically have two choices: stay with fee-for-service or join an HMO. Those are analogous to the choices between a huge buffet table with a very large number of a lá carte dishes or a chef's fixed-price meal.

But there could be a lot of new options, better packages of services, better tailored to meet needs of special populations in Medicare. Medicare has a lot of different populations, with 37 million elderly and disabled individuals.

With those choices, the kinds of choices that are being developed in the private market system now for the under-65 to choose, we could get benefits of greater competition in quality, in service, and in economy.

In my written statement, I provide an inventory of a number of those ideas that Medicare analysts and patient-oriented groups have been suggesting and trying to develop, ideas of how to structure new choices for patients and to use markets so that beneficiaries can get better care and save money, and so that the providers who do a better job are going to prosper.

This will be particularly important, Mr. Chairman, for that 75 percent of Medicare patients who are going to be in fee-for-service

medicine in 2002. Many of those in managed care will have some of these benefits, but most Medicare beneficiaries for the foreseeable future are going to be in fee-for-service. We need to change fee-for-service so there are better options there.

Let me summarize some of these ideas for you, generally organized by how many benefits they would package. For example, single-service preferred provider options would be useful for areas where we have fairly standardized products, where Medicare's regulated prices are well above what would be there in an effective market, or where there are big problems of quality, poor service, or abuse.

For example, in durable medical equipment, DME, Medicare could select a number of DME suppliers to serve an area based on those that offered the best discounts and the best service. Medicare enrollees could go to other DME suppliers, but they would have to pay more if they did it. That would be a preferred provider option. This preserves choice, and it creates a market where those who do a better job get rewarded, get the business, and the beneficiaries get those benefits. Among the candidates for single-service kinds of contracting are lab testing, outpatient surgery, home health, and diagnostic imaging.

Multiple service packages are best exemplified by the Centers of Excellence concept that Medicare has already developed to help its patients who need heart bypass surgery get access to the best centers in the country, with additional benefits as well as lower costs. Transplants are another area for Centers of Excellence contracting.

Candidates for Centers for Excellence contracting are really pretty broad. Hip replacements, a major problem for the elderly, are a leading idea. A lot of surgical procedures have large differences in mortality based on volume. So, the ideas can be developed beyond those I just mentioned.

Chronic care programs are a particularly important area for Medicare patients to have new options. Chronic care is a huge problem in Medicare. For the under-65 population often a hospital stay is a single time-limited episode. For the elderly, a hospitalization is more often an episode in a long duration, chronic illness that can be better managed.

So we need to focus on programs that can help patients with congestive heart failure, focus on their needs, provide the education they need, the support they need. Patients with chronic obstructive pulmonary disease, cancer care programs for cancer patients, these are also ideas, for example, that are being contracted now by HMOs for their patients. We need to be able to make these kinds of choices directly available for those who are fee-for-service.

Then, finally, there are some very broad, very creative, and important options for serving special needs populations. One of these is the Medicaring idea that Senator Rockefeller mentioned a few minutes ago, for helping people with terminal illness. We do not talk about it much, but everyone who is in the Medicare program is going to die. A lot of them will die of terminal illnesses.

We do not know when they will die, they do not know when they will die, their doctors do not know. But we do know that, once you are diagnosed with certain kinds of cancer, with chronic obstructive

pulmonary disease in an advanced state, and so on, there is a disease process at work which will be life-limiting.

The Medicaring idea is to develop programs specially designed for people with those kinds of illnesses to avoid the acute episodes that add so much to the patient's distress and Medicare's costs, and to use the savings to provide better home care. That is one area that I think has a great deal of benefit, potential benefit, for Medicare beneficiaries.

Then there are other broad options to allow a comprehensive Medicare PPO. I believe the administration has even proposed an idea along these lines. This would integrate Medicare and Medigap coverage, giving administrative efficiencies, adding prescription drugs and catastrophic coverage to Medicare. That kind of PPO could use many of these other options.

In summary then, Mr. Chairman, there are many good ideas for how to make Medicare a better program when we take the longer view and try to develop this over several decades.

With its $200 billion of purchasing power, Medicare could be a ferociously effective buyer in the marketplace. Congress could probably follow the maxim, come and they will build it. You bring your money to the table, the market will respond. Your job is to figure out what it is you want to buy, what is it that Medicare beneficiaries should be allowed to buy. That, I think, will need a sustained period of field trials and evaluation to identify the most promising of the ideas and to make them available as new choices. Thank you.

Senator GRAMM. Thank you.

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

Senator GRAMM. Michael Tanner.

STATEMENT OF MICHAEL D. TANNER, DIRECTOR OF HEALTH AND WELFARE STUDIES, THE CATO INSTITUTE, WASHINGTON, DC

Mr. TANNER. Mr. Chairman, I also want to express my thanks for you to be holding this hearing. I think that Medicare is going to be a crucial issue, not just this year but for many years to come. It is an issue that, perhaps if we had faced up to it a few years ago, we would have avoided many of the problems we are seeing now.

I recognize that both you, Mr. Chairman, and Senator Rockefeller, both have been long-time advocates for health care reform, in somewhat different directions, but very willing to entertain ideas on this. I thank you.

Medicare, I think, is facing a fundamental problem for three reasons. First, is demographics, second, technology, and the third, is the fundamental flaws of any third-party health care payment system.

The first of these we can do almost nothing about. The second, I do not want to do anything about in terms of limiting the technology and lifesaving advantages that are available to today's elderly. The third, we may be able to have some impact on.

But ultimately we are going to have to face up to the fact that we may simply have over-promised on Medicare. We may simply

have promised benefits that are not sustainable into the future and we may have to be willing to admit that mistake and to admit that, in the future, beneficiaries may not be able to claim all the benefits that have been promised in the past.

Let me start, if I can, and suggest some things that Congress should not do in fixing the Medicare program. The first is essentially under the broad heading of accounting gimmicks. That is basically shifting costs from Part A to Part B. They do nothing to alter the structural problems of the system or to do anything about the long-term costs within the system.

Medicare Part B is adding tremendously to the deficit and will be just shifting costs from one group of American taxpayers to another group of over-burdened American taxpayers, so it is nothing to fix the system and is simple gimmickry.

The second, is Congress should resist any increase in the payroll tax. The payroll tax increase necessary to keep the trust fund in balance will be significant. It is going to have to be somewhere over 3.5 percent, at least, perhaps more. That would be a significant burden on working America, with the payroll tax being a terribly regressive tax and a job-destroying tax.

I should just mention that the last set of payroll taxes increases, for example, according to the Congressional Budget Office, between 1979 and 1982 destroyed over 500,000 jobs per year and resulted in a $25 billion a year loss to the gross domestic product. I do not think that is where we want to go.

Likewise, I do not think we should increase Part B premiums. I know that was a big part of many of the plans last year, but I believe that is the functional equivalent of a tax increase and it is simply funneling more money into a system without making any structural changes.

It is, in essence, especially on a program in which 97 percent of the elderly pay, a tax increase on the elderly, who would then have to pay more money for a system that has not been fundamentally reformed. Absent any structural reforms, I would be opposed to any increase in the Part B premium.

Finally, I think we need to be very cautious in two other areas. One, is in reducing reimbursement rates. The history has been that, despite whatever projections have been made for reimbursement rates, they have actually had little impact on total spending within the Medicare program, that physicians and others find a way around them.

It is sort of like trying to catch mercury in your hands. You find it one place, and it squirts out someplace else. People unbundle services, charge for different diagnoses, run patients through faster. So it does not do anything to really restrain costs, but it can have an impact on care. There is at least some evidence that the quality of care deteriorates when you cut back reimbursement rates.

Likewise, managed care needs to be approached very carefully. It should not be seen as a magic bullet. The evidence to whether managed care will actually reduce costs in the long run is not there.

We see one-time cost reductions when people shift to managed care, but year-to-year increases appear to be comparable, at least

premiums in the private sector, to those in the fee-for-service health insurance market. So, we need to be very careful of that.

We are seeing some quality problems cropping up in the managed care Medicare market already, people reporting difficulties in seeing their physician, access to care, and other quality problems.

What would I suggest we should do? I suggest that we should make changes that fundamentally restructure the program, beginning with raising the deductibles, particularly under Part B. The $100 Part B deductible is absurdly low, amounting to almost first-dollar coverage and exacerbating all the problems of third party payment and encouraging over-consumption and over-utilization.

I would suggest that that needs to be increased. If you were going to keep it just constant with inflation, you would have to raise it to about $400, and I can see raising it even further.

You should allow the elderly who wish to do so to opt out of the Medicare program by taking a flat dollar amount voucher and using that for whatever private insurance they prefer to purchase, whether it is managed care, whether it is private fee-for-service insurance, or, yes, even medical savings accounts. They should be able to have that option.

We should raise the eligibility age for Medicare in line with the increases in Medicare with the eligibility age for Social Security and link them permanently in the future. If you make any future changes to the eligibility age for Social Security, Medicare eligibility age should rise along with it.

You are going to have to face one of two options, I think, however. I think that you are going to either have to decide that you are going to say that Medicare will not provide first-dollar health insurance coverage for the elderly any further, in which case I would suggest the best way to do that would be to continue raising the deductible levels gradually each year until Medicare is transformed into a back-up catastrophic insurance plan that essentially protects individuals so they will not lose their home if they come down with cancer, or something of that nature, while the young worker will begin to have to save now for the future for when he retires, recognizing that he will have to pay most of his own health care costs at his retirement.

Last, I would consider very seriously that we need to look at the work of Thomas Saving and others who have suggested that we can allow young people to take the portion of the payroll tax currently being devoted to the Medicare Part A system and essentially opt out with that, allowing them to purchase a private annuity with that that would kick in at age 65 and purchase them a health insurance plan. I think there is a great deal of work still to be done in that.

Senator ROCKEFELLER. To allow them or require them?

Mr. TANNER. I think I would allow them. I do not think I would make it a mandatory system.

In conclusion, let me just suggest that I think that there are fundamental problems in the Medicare system that are structural, that cannot be fixed by tinkering around the edges. We simply cannot sustain all the promises we made in 1965. It was a nice idea. It cannot be done without seriously over-burdening the economy

and the American taxpayer. We are going to have to face up to making some significant changes in the future.

Thank you, Mr. Chairman.

Senator GRAMM. Thank you, Mr. Tanner.

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

Senator GRAMM. Robert Helms.

STATEMENT OF ROBERT B. HELMS, PH.D., DIRECTOR OF HEALTH POLICY STUDIES, AMERICAN ENTERPRISE INSTITUTE, WASHINGTON, DC

Dr. HELMS. Thank you, Mr. Chairman. As the last person on the panel, many of the points that I made in my written testimony have already been made. Let me say that I agree that the magnitude of Medicare's long-term financial problem is a serious one. It is large.

I think the financial imbalance is large by almost any standard we want to use to evaluate it. I was impressed by the amount of the unfunded liability in the present value figures Tom Saving presented to you last week. Those are astounding numbers.

I do not think Medicare's fundamental situation is well understood by the general public, or most members of Congress. But after listening last week to 14 papers at a Medicare conference at Princeton and reading through the testimony that was presented to you last week, I do not think there are very many health policy experts that are being realistic about the implications for Medicare's future.

So I want to second all of the appeals that I have heard from the other panel members here today about how serious this problem is. We need to get into a more fundamental debate, and sooner rather than later.

We have about 14 years before the baby boom generation starts to turn 65 and becomes eligible for Medicare under current law. Many people that will be retiring in future years will have been in various kinds of managed care plans or employee benefit plans where they are accustomed to making choices among plans and being subject to cost-control strategies. They will be more acceptable to change than many of those currently on Medicare.

I would like to make some quick remarks about some of the options that were presented to you last week. I have testified a number of times over the last several years about the effects of using a regulatory approach in the health care sector.

It is far better to have reform based on market or competitive principles where you get the incentives right than it is to continue to think you can just ratchet down on rates. Price controls create situations of excess demand where consumers and providers have very strong incentives to avoid the controls. I think we know enough about the economics of health care to devise a better system.

There were three options that were discussed last week. One presented by Lynn Nichols from The Urban Institute was called structured competition. This term refers to a class of proposals somewhat similar to managed competition. Proposals of this type try to make the market work by legislatively prescribing the benefits to be offered and other details about how competition should work.

The advantage is to make comparisons easier for consumers, but if you have the government defining the benefits, you get yourself into a very difficult political situation.

I think we could look at the history of Medicare and say that when the Congress gets to defining benefits it is going to be subject to a lot of political pressure, and the outcome is probably going to be expensive and not necessarily what consumers would choose on their own.

The second approach is called a defined contribution plan and has already been discussed. I think there is an advantage to a defined contribution plan where, for each eligible Medicare beneficiary, you establish a fixed amount of payment per year. As Stuart Butler had said, there are various ways that you could determine the defined contribution. One of the advantages is that it would force the Congress to decide about how much to pay for Medicare compared to all the other things in the budget.

At present, we have a system of open-ended entitlements where all kinds of things such as the social functions of Medicare that Stuart Butler discussed and graduate medical education are hidden in the budget so that the total burden of Medicare is less than obvious. I think there is an advantage to making this budget decision "transparent," as the Europeans say.

If you have a defined contribution, you create a greater role for the price system. Competing plans would have to design a health plan that they think consumers want. They would also have to set the prices for that plan. If they do it wrong, consumers would punish them. That, to me, is how a market could work.

There are special problems in health care markets, as Karen Davis keeps reminding us. I think it is better if we are explicit about how much we want to subsidize the poor. I do think there is a case for helping some of the poor, but we should not hold the rest of the system hostage because of our concerns about the poor.

The third approach is the Tom Saving/Andy Rittenmaier proposal that was presented last week. I think it is called PRIME, Personal Retirement Insurance for Medical Expense. I view this as a very welcome addition to the debate. It is the only proposal I have seen that tackles the difficult, long-term problem of reforming the financing of Medicare.

This is a work in progress. So far, they have devoted most of their attention in this elaborate study to trying to show that you can restructure the financing and make it work. They assume that there will be catastrophic coverage provided by Medicare, but there is very little discussion at this point about the details.

I see their research as an ambitious effort. I think it is easy to predict that the kinds of assumptions they are making are the types of things that are going to draw a great deal of attention from economists, because they love to debate these kinds of things. But I have known Tom Saving for a long time and he is certainly up to defending himself in that debate.

Let me close with this one observation, Mr. Chairman. Maybe sometime in the next century the Chairman will have a grandchild that will continue the Gramm family tradition by writing an article in the Wall Street Journal comparing all of us here today talking about the future of Medicare to those alarmists back in 1867 who

were predicting doom and gloom when the supply of whale oil was to be depleted.

You might remember, Mr. Chairman, you did write a Wall Street Journal article about this in the middle of the energy crisis.

Maybe those of us here are in the same boat in our predictions about Medicare. We could turn out to be wrong, but right now I sort of doubt it. But I think the main lessons that we should learn from history is that we should try to create a health care system that can respond to unpredictable future conditions.

The longer we stay with current Medicare policies, with its known faults, I think the less chance we will have to save Medicare—or, that is, to save it in a way that will actually improve the health and well-being of the elderly. Thank you.

Senator GRAMM. Thank you.

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

Senator GRAMM. Let me just say two things in following on to what you said, Robert. First of all, Tom Saving's work is not only work in progress, it is really work that is just beginning. They are sort of in the stage of getting their financing and expanding their thought process on it. I do believe that it is the only new, innovative work that I have seen in this area in a decade, and I think, therefore, it is very important.

I would say, second, in responding to you that this is an area where we have got to think big.

I think anybody who is defending the status quo in anyway other than our commitment to helping people get access to quality care, I think, either does not understand the magnitude of the problem or does not want to understand the magnitude of the problem.

I hope that there will be a grandchild writing in the Wall Street Journal about how these new ideas came about to solve this problem. I want to be sure they do not think their old grandpa was defending the status quo when the roof fell in. If they listen or watch, they will know that that is not the case.

I want to begin my first round of questioning, and we may have a couple of rounds. One of the things that one of you mentioned—maybe it was you, Robert—was disproportionate share and graduate medical education subsidies. Medicare is substantially funded by seniors. It is also funded by a payroll tax, which does not tax rents, interest, and profits.

Yet, we clearly have in this program general subsidies. I think if we are looking at extending the life of Medicare, one of the things we need to look at is whether we should be funding disproportionate share, which is a welfare program, in a health program that is in the red, on the verge of insolvency, and that has a short-term financial crisis like no other program in existence in the country.

Should we be subsidizing those things out of the "Medicare Trust Fund," or should they be taken out, made transparent, put in the appropriation process, and debated. Shouldn't we have a real debate on graduate medical education, where we know how much money we are spending on graduate education? Shouldn't we have a real debate on disproportionate share? Should we make those changes?

Let me just start with Stuart, and we will just go down the line and get everybody to respond to it.

Dr. BUTLER. Well, I think we certainly should make them transparent and decide what they should be and how they should be allocated. But I think, as you would agree, Mr. Chairman, that in itself is not a structural reform.

Senator GRAMM. Oh, I understand that.

Dr. BUTLER. It is similar to shifting. But I think it is very important to do that and I think that, as we have seen health care become much more competitive, we see marginal revenue gravitating toward actual marginal cost. So it makes these additional costs a big problem for specific hospitals. Therefore, it is very important to take this out, talk about it explicitly, fund it directly, and decide what we are going to do and to what purpose.

Senator GRAMM. Dr. Davis.

Dr. DAVIS. Mr. Chairman, I would first of all would like to say that I, along with you, agree that graduate medical education and support for hospitals serving low-income populations is very important, and I think Medicare has contributed to improved technology and life expectancy because it has supported, indirectly through Medicare, academic health centers for their research and translating innovation and technology in the medical practice. So I think those are important to preserve in some form, and I think debating the appropriate level and mechanism is also worthwhile.

Last weekend, I did the math and was a little bit surprised to find that if you moved DSH and graduate medical education out of A into, let's say, B or into an appropriation, it actually has the same magnitude as the President's proposal to move part of home health out of A and into B.

So you are talking about graduate medical education of about $6 billion a year now with Medicare, DSH about $4 billion. You are really at about $10 billion a year, and that is basically what the President's proposal is talking about.

So it kind of clicked when I saw the numbers were the same, and whichever one you are talking about, shifting part of home health or DSH and graduate medical education out of A, what it does is to bring revenues and outlays more in line immediately in Part A and make achieving a rate of increase that is a little more sustainable a lot easier to do.

If you do not move something out of A, you really are talking about absolute negative declines in Medicare Part A spending, which you really cannot pull off. So, because of that, just calculating the math, it struck me that thinking about moving graduate medical education into B or moving it into a mandated appropriation, whatever the term of art Congress used last time, is something worth thinking about.

Senator GRAMM. Well, before I go on, let me say in response to that, I am not talking about moving it into B.

Dr. DAVIS. I meant B with general revenue financing, but without a premium contribution from beneficiaries for a general societal good of graduate medical education.

Senator GRAMM. I think it is important. There is an element of reform here, going back to what Stuart was talking about. What you are saying is, Medicare is Medicare. If we are going to ask a

specific group to pay for substantial parts of it, it ought to be about them. They ought to be the beneficiaries.

Medicare was like a huge train with lots of empty compartments and massive amounts of money. Over time, everybody got their hand in it. Now, nobody is saying these programs are not wonderful things. Graduate medical education is critical to my State.

I am a firm believer in science. Education is critically important. But the question is, should some congressional panel somewhere be debating this rather than it being a residual on Medicare? I think the answer is, clearly, yes.

Should some other committee be debating disproportionate share as a welfare program rather than asking seniors to subsidize poor people in a hidden way through Medicare?

If you are going to achieve real reform, I am becoming convinced you need to take those elements out of Medicare and really begin to focus on what is the true financing.

I do not think you are getting a fair financial picture of Medicare—even though it does not change the big numbers—when you have it subsidizing welfare programs and subsidizing graduate medical education.

I mean, those are big-dollar items, and they are critically important. I support both of them in some form, but they are not Medicare. What is really your evaluation of that? Go ahead, Mr. Etheredge.

Mr. ETHEREDGE. Well, I agree with you completely on both of those counts.

Mr. TANNER. I also agree completely. It causes two problems. One, as you say, it is sort of distorting what Medicare is. Second, it also manages to just sort of disguise these appropriations in a way that you do not have the debates necessary over policy, over these.

I think there are some serious debates coming up over medical education and what should be subsidized, what should not, what types of physicians, what should and should not, all of those sort of issues that I think get swept under the rug when it is part of an entitlement process rather than as an appropriations process. So I think for the benefit of both programs, it should be out in the open.

Dr. HELMS. Given what I said before, I certainly support what you have said. Graduate medical education is a valuable part of the medical system, but so is training engineers to build safe bridges.

I do not see the justification for continuing GME as an entitlement program which automatically goes up in a hidden way. So, I support having a more explicit discussion about what we want to buy with the taxpayer's Medicare funds.

Senator GRAMM. I have felt for a long time, in listening to different members of what I would call the academic intellectual community or university-centered think tanks around the country, that there is a growing consensus in favor of giving Medicare beneficiaries more choice.

We all know Senator Rockefeller has introduced a bill that would move in that direction. Senator Widen is now a leader in that process and has introduced a bill that would expand choice. So this is

something that both parties are now talking about, and I find across a broad political spectrum people are talking about it.

Let me just be sure I have got everybody's opinion. The question is, do you believe that rather than just having the choice between conventional Medicare and an HMO, we ought to have at least a substantial expansion in choices, and perhaps a dramatic expansion in choices?

Dr. BUTLER. Yes.

Dr. DAVIS. I believe in choice, trained as an economist, as I know you are, and believe that people should have opportunities. But I do not believe that seniors should be exposed to inferior products or poor buys. So my first interest in expanding choice is to make sure that every plan offered to Medicare beneficiaries meets high quality standards.

Currently, Medicare does not require accreditation of managed care plans. There is an accreditation process in the private sector through the National Committee for Quality Assurance.

If you were to say to me, as long as you guarantee accreditation by NCQA, as long as we get adequate quality data on these plans and monitor their performance in meeting quality standards, make that information available to beneficiaries in a uniform way, then I am with you on the quality part.

On the price side, I want to make sure that what we are offering to beneficiaries is a good buy. I do not think that the performance of private indemnity meets that test. I think what we have seen with Medigap is unacceptably high administrative costs. Even in the managed care field, you have got 15–20 percent administrative costs. I would want some standards there.

Basically, I would not expand it beyond health care delivery systems to insurance products until we can solve the way we paid for this, the way we set a voucher, the way we set a capitation rate.

So, certainly managed care that meets quality standards should be available choices for beneficiaries, but let us not open Medicare up to everything under the Sun until we have those quality standards in place and until we have a way of paying managed care plans that Medicare does not lose 6 percent for every beneficiary that enrolls in it.

Senator GRAMM. Well, do you consider the Federal system that Senator Rockefeller and I choose from, where companies have to go through an evaluation to get on that list, a system where the government is assuring quality?

Dr. DAVIS. I like a platter of choices, so I do not have any problem with that. There is a lot of myth about the Federal Employees Health Plan, though. The Commonwealth Fund supported a study of the Federal Employees Health Plan.

If you look historically, the premiums in the Federal Employees Health Plan have really gone up at the same rate as health spending in the economy as a whole. There is no real evidence that it is cheaper. You get problems of adverse risk selection because there is not a uniform benefit package in the Federal Employees plan.

Federal Employees has actually not been very aggressive about negotiating the premiums. They have been pretty much a price-taker over the years. They have not really negotiated.

They have not used the purchasing clout that Medicare has on behalf of 38 million beneficiaries to get a good price out of managed care plans, and they really do not have a system of quality standards that ensure that there is quality care in the plans.

So, I like the idea of a platter of choices, I like opening up choices to Medicare beneficiaries, having a formal annual enrollment process, informing them of the choices that are available to them. But I think we overstate how wonderful the Federal Employees plan is. It opens up choice, but if you really look at the trends over time it is not a lot better than anything else that has gone on.

Senator GRAMM. Let me get everybody else to quickly address this, then I will recognize Senator Rockefeller.

Mr. ETHEREDGE. Senator, obviously I like more choice. That is what I testified on. But having worked at OMB in four administrations on Medicare, I worry about it because every time Medicare has added more choices in the past it has expanded the costs.

In fact, if you look at most of our runaway costs today, they come from past attempts to add choice. We started with hospitals, and that was going up 17 percent a year, so we added nursing homes.

Senator GRAMM. Well, those are not choices, those are benefits.

Mr. ETHEREDGE. They are different kinds of providers that were allowed into the program. We added home health, we added outpatient surgery. If you look at the uncontrolled parts of the program—we added HMOs, and I helped do all of these, I must say, and we wound up overpaying their costs. So I agree with many of the things Karen has said but we are going to have to make sure that we structure competition this time.

The two big mistakes we made over the last 20 years, in my view, were allowing anyone in regardless of whether they were a better value or lower price, and whether we could control the quality and deal with fraud and abuse. So I think we need to be selective and make sure. That is why I talk about preferred provider arrangements, where we know we can control the fraud and abuse and have quality providers.

Second, we need to use markets to set prices for these new choices; because of the regulatory prices we have always wound up getting taken to the cleaners.

Mr. TANNER. I would strongly support increased choice, as much choice and diverse a choice as possible. I would just suggest that I am very confident that individuals can decide for themselves what is quality and what is cost effective.

In fact, on something as personal as health care, I want to make those choices for myself. I really do not want the government telling me what they think is quality care for me.

Dr. HELMS. Well, certainly I support more choice. I think Karen and Lynn both have made very good statements on what may be called structured competition, that is, competition with rules.

I would agree with them that neither the choice part of Medicare nor the FEHBP program are the best models for a competitive payment system. They have some good features, but they could be improved by the use of a fixed payment that is not based on FFS payments.

Senator GRAMM. In recognizing Senator Rockefeller, let me say, Mr. Etheredge, that I am in total agreement with you. I am not

aware of a single case where we have added a benefit, as I would call it, and that benefit displaced cost in another area that paid for it.

Each and every one of those added benefits that I am aware of has been a failure, if the objective was to control costs. Adding home health care clearly did not send people to the hospital less, and I do not see any evidence that hospital costs were reduced enough to pay for expanding home health care benefits, which is now the exploding, runaway, renegade part of the budget. I think your point is a very, very good point.

Senator Rockefeller.

Senator ROCKEFELLER. I think this discussion is interesting in one respect, because I think it shows that, although all are valiantly trying, all are slightly missing the point. I say this, obviously, to be provocative, but also because I believe it.

What Mr. Tanner said, for example, I do not want government telling me what to do because I can choose quality for myself, with all due respect, sir, I do not think you can, particularly if you become very sick. You just do not know enough about it.

Mr. TANNER. It is the fundamental, philosophical difference between us, Senator.

Senator ROCKEFELLER. I know it is a philosophical difference. But when it gets down to your life and death, it may be a philosophy that you regret having adopted. In any event, it is like the question where I think we are also at cross-purposes here on the savings plan which you talked about very much, where he was saying that intragenerational competition could be eliminated and intragenerational decision-making made better by having 20- and 30-year-olds pay for themselves, and 35- and 40-year-olds pay for themselves, et cetera, so each one takes care of itself, you do not have the working supporting the old.

I come from a State which is right now experiencing a great deal of flooding, and you have got some in your State, too. Always the fascinating thing, if there is anything you really can predict in Appalachia, it is a flood. I mean, you cannot predict cancer in life, you cannot predict coronary disease in life. You can have genetic predispositions, but you cannot predict it.

You can predict floods in Appalachia, where 4 percent of the land is flat and the rest goes up or down. Nevertheless, about 4 percent of the people have flood insurance who live along the streams and rivers.

Every year, there is an effort made to try and get them to change their ways. It does not work. It just does not work. People do not always do what is in their best interests because of competing economic realities in their life, competing economic needs that require attention on their part.

So I really question whether that will work. The whole discussion about GME not covering the disabled, which we have not mentioned today but which was mentioned at our last hearing, and DSH. I think the point was well-made, I think by Karen—I think you have all made it in a way—you do all of that, but you do not really change the numbers very much. There is certainly a philosophical change. Therefore, let us strip Medicare clean of every-

thing that does not have directly to do with reimbursing Medicare costs.

But then as you wander through testimony, and I will admit, Karen, in yours in this case, let us not lose sight of Medicare's goals, to provide health and economic security to older Americans, maintain improved access to care, provide longer and healthier lives, at the same time as you are saying that we are losing, what is it, 6 percent on every Medicare patient.

So at some point, one is faced with a larger philosophical question, which I know how I want to answer, but I do not know how I am able to answer at this point. That is, can the program be afforded? I am not really sure any of you have made the case for making changes that will, in fact, call for the type of savings that Senator Gramm introduced this whole discussion with. You have peeled off GME, you have peeled off the disabled, you have peeled off DSH, and it is minimal.

Actually, when Phil Gramm opened all of this he said, we can cut $100 billion, $150 billion, $200 billion out of Medicare over the next 5 years, 10 years, 7 years, whatever. It will not make any difference. It makes no difference for the long term whatsoever.

So I think the challenge that I would put to you is, do you really feel that any of you in your testimony, other than on the more liberal side, that we are in perilous times, we have to do some very different things?

We certainly have to look at GME. But, on the other hand, we cannot compromise on quality of care. We have to insist that the government—and I happen to agree with you on that—monitors and establishes quality, because I think that is a necessary factor. We have to wait until the market system adjusts, the way I see the market system adjusting and health care calming down or settling in 15 or 20 years. But we cannot wait that long, by definition.

So on that side, yes, we have to do some things, but let us remember the purposes of Medicare, and we cannot compromise on those purposes, which, in a sense, to me says no real change. Then I would invite your argument.

On the other side, saying things like medical savings accounts, or let people who are spending money make the choices themselves. OTA did a study in 1994 which summarized a lot of research on the whole area of cost sharing.

What they basically came out with, and you can agree or not agree with them, they said that cost sharing is cost saving, but principally because it deters individuals from seeking health care services, potentially beneficial treatments, as well as necessary care.

No evidence exists that people make better choices and decisions about their health care when they bear some of the cost. Once a patient is in the pipeline, the amount and the cost of their care was largely unaffected by cost sharing and determined principally by their physician, which I think is probably a fairly fair assessment, in view of the fact that people sort of give themselves over to their physicians.

I want to use my physician, I do not want my physician taken away from me. That is an expression of trust and confidence, a

bond, which implies a relationship, almost Confucian; you accept the mandate of the ruler.

But, in any event, I am struck almost, not by hypocrisy, but by the fact that we are talking around all of this. I think I worry about that because I share Phil Gramm's sense of real fear about the future of Medicare and having it sustained financially. I also feel that all five of you, in some ways, have kind of nibbled. I invite response.

Mr. TANNER. Senator, I think I actually specifically said, Medicare cannot be sustained with the promises that were made in 1965, and said we have to face up to that fact. I suggested that we increase deductibles gradually and transform Medicare into a back-up catastrophic policy rather than any attempt to provide first-dollar health care coverage for all of the elderly.

So I would suggest that we do need much more radical changes than just tinkering around the edges, just doing a few billion dollars here, a few billion dollars there.

Beyond that, I guess, again it comes down to our fundamentalist agreement, that I do believe people make rational decisions, that people are not pawns at the hands of their doctors, that people are capable of thinking for themselves, even when faced with their doctors.

I can tell you, there is a wide variety, I believe, of literature out there on that from the Rand health insurance experiment and several others that indicate that. But I can just give you my own case on that, Senator.

I suffer from very severe sinus headaches, and I can treat them either with Advil or I can get an Empirin with codeine prescription for them. Codeine works a little bit faster and knocks it down a little bit better, and it is about $65 a prescription, versus about $5 for the Advil. But I have a prescription drug card, so I can get that codeine for $5, and I get it every time. If I were paying for it out of my own pocket, I would be looking for Advil.

So, I do think people are capable of making rational decisions when it comes to cost in their lives. Only about 14 percent of care is emergency care. The rest of care, people can and do make decisions around the margins.

Senator ROCKEFELLER. Yes. Although I would respond to that, that a good deal of the cost of the care comes in the latter stages of people's lives, when their whole attitude about sustaining and choosing between Advil and something else is a little bit different.

Dr. BUTLER. Let me try to answer your provocative challenge in a slightly different way. When you are looking at a program, or really anything, where the cost is outstripping the ability to pay for it, you really have several kinds of ways of dealing with that situation.

You can try to just pay less and hope you will still get the same, and approaches we have tried in Medicare try to cut costs by reducing the amount we pay or reducing the rise in the amount we pay to physicians and to hospitals. Or you can say, let us see if there are ways in which we can actually get a higher level of care for the same dollar, in other words, improve efficiency. I think a lot of the things that we are talking about on this panel attempt to say, let us look and see if there are different ways that we can organize

Medicare so that it is more likely that we will begin to get a higher level of efficiency in the system. Moving to a competitive system of competing plans is one element of doing that.

Changing the way you pay is one way to help do this. If you pay as we do in Medicare today, with a certain fraction of what we provide to one set of type of providers is paid to HMOs, the chances are we will not get a very efficient outcome. Lo and behold, that is exactly the case.

Senator ROCKEFELLER. Stuart, let us use the telemedicine as an example. Let us say telemedicine just eliminates all kinds of hospital visits and all kinds of costs. It is just in the infancy stage, but if a kid from McDowell County, WV, can learn Japanese language in a classroom being taught by a professor at the University of Nebraska, surely there is hope for telemedicine in medical care.

But even as you do that, a point that Phil brought out at the first hearing, if 200,000 more people are getting onto Medicare per year, I think you said in recent years, it is going to be 1.5 million per year starting fairly soon, for the next 20 years. So that saving is obliterated 55 times over by the sheer numbers of what is upcoming. So this whole question of making Medicare more efficient so that you can deliver services at less cost or whatever, I even question that.

Dr. BUTLER. But the reverse is clearly not the case. You do not say, well, let us not try to make efficiency improvements.

Senator ROCKEFELLER. That is true.

Dr. BUTLER. That gets you then to the second element, which is to decide, well, we do have to make some priority decisions as a country in terms of what is to be provided, under what kind of circumstances. Those of us who argue for any kind of defined contribution in any form or explicitly saying how much are we going to pay for this program are at least facing up to the fact that a decision has to be made.

As long as we are in a program that says, we just promise you this and we will keep our fingers crossed that somehow, somewhere, somebody will figure out how to pay for it, that is what we have got to get away from. I think that those of us who argue that we have to face that now are doing exactly what you are challenging us to do.

Yes, it is going to mean some tough decisions. It may well be that more affluent elderly, or maybe even some poor elderly, end up getting exactly the same level as today, hopefully a more efficient system than today. But that is a kind of decision that we have got to make, and I think that is very clear. I think we are facing up to that.

Dr. DAVIS. If I could answer in just a little different way, that Medicare is projected to go up 9 percent over the long run and tax revenues and the GDP, the economy, are projected to go up 5 percent, it is a judgment call.

But my view is, if you did telemedicine, if you did preventive care for diabetics, if you used prospective payment for all Medicare services, if you tried expenditure targets, if you opened up all the choices, then Medicare can maybe grow at 7 percent, because that is basically what we are expecting for private health expenditures. So you could get 2 percentage points of that difference by trying all

of the good ideas that you have heard here today, but you are still going to have a gap. I think what you heard is some personal preferences across the panel about how to deal with the rest of that gap, but there are really only two basic options. That is having beneficiaries pay more, such as a $2,500 deductible, or catastrophic coverage, or defined contribution, or vouchers, basically shifting it to the beneficiaries, or you can look at taxes and say that it is going to take a bigger share of the economy, it is going to take a bigger share of the Federal budget to really guarantee Medicare's goal of assuring access to quality services for Medicare beneficiaries.

Now, is that affordable? It is a public policy decision. But we have an economy that is growing, so even if you were to increase that revenue flow from 5 percent to a 6 percent or 6.5 percent rate of increase, you could achieve solvency and still have more of the economic pie left over for everything else. So I think that there is a way to do a combination of these things.

The $100 billion is significant for our first 5 years' savings by tightening provider payment rates and tightening up what we are paying for managed care plans. That is an important contribution, brings down growth in spending by 1.5 to 2 percentage points.

So, I think it is not an either/or. It is not that we have got to do all of this by squeezing Medicare down so it absolutely declines. It is not giving up on benefits. It is not a generous benefit package. Beneficiaries have high cost-sharing already.

I think if we really look at who a beneficiary is today, we see most of these expenditures are concentrated in 10 percent of beneficiaries that include the dying, they include people with Alzheimer's, they include people with pulmonary disease, they include people in nursing homes.

These are people who are not making cost-conscious choices every day. There are people who are already spending $8,800 a person out of pocket, so to increase cost sharing, increase contributions, is not realistic once you look at who the beneficiaries are, their health status, their income, and what they are now paying.

There is not a lot more to come out of beneficiaries, maybe some high-income beneficiaries, some healthy beneficiaries. But for lower income or the modest income, which are the bulk of the elderly, for those who are very frail, I think we are beyond the limit now of what we are asking them to pay.

Mr. ETHEREDGE. Let me try to get some variety here too and to give a provocative answer to your provocative question. Much of the discussion I hear here in Washington and on this panel, I think, kind of reflects regulatory capture by the industry of the whole political process.

What you hear are pure examples of regulatory capture, where the industry gets policy makers convinced that their revenues ought to go up, that their real incomes ought to keep growing, and that we should just presume that the value is there already and will continue to grow at those rates, although there is almost a virtual absence of evidence for much of that.

You can look at particular things like the profit rates that academic health centers have, the 18 percent margins they have now,

the GME, and other things built into the Medicare program. So that is sort of a provocative answer.

If you looked at health in inflation as an economist, you could say what we have is an industry with 30 or 40 percent excess capacity and the buyers with $1 trillion of purchasing power, including Medicare with $200 billion of purchasing power, have barely begun to use that power in the marketplace.

You could look to people like Uwe Reinhart, who make very good points that people in other countries get many of the same services, and sometimes even a higher volume of services, than in this country. Largely, what we are doing is transferring more income per provider from payors to providers.

So that is a major caveat I would put to Medicare projections. I do not know how much we can get from beginning to use a market, but I think we really have got to try and give a market a chance to work. I do not see the evidence that the industry has ever put forward to show that they can justify the trillion dollars that they are spending now, let alone the rates of increase built in in the future.

I say that about the Medicare program, too. We do not have good measures of the value of the $200 billion we are spending a year now.

Let me mention one example. As managed care companies have begun to look at where you can save money in Medicare, they are finding new ways to serve the dual eligibles. There are about six million of them who are qualified for Medicare and Medicaid.

Bruce Vladick has testified that those six million people are about 50 percent of Medicaid costs, and 25–33 percent of Medicare. Those six million people who are dual eligibles, roughly 50 percent of Medicaid and 25–30 percent of Medicare. That is how concentrated that expense is.

When the managed care companies begin to look at that population, they are finding major ways to reduce the hospitalization rates of people in nursing homes—and that is mostly where this expense is—by 40 percent.

How? Very simply, by putting better primary care in nursing homes. Those people with Alzheimer's, for example, in nursing homes do not get much primary care. We have a very hard time getting a physician to see them every 60 days, and you have to beat up the nursing home through the regulatory process to do that.

By giving them influenza and pneumonia vaccinations, for example, where the rates have been as low as 5 percent in some nursing homes, by getting them taken care of in the nursing home so they do not get sent to the hospital, you are giving them better medical care and are saving a lot of money in the process.

This is part of the ping pong between the States and the Federal Government. If the nursing home sends someone to the hospital, the Medicare cash register rings for $10,000, so States have no incentive to provide basic primary care in the nursing home.

It is just an example of where, when you begin to look explicitly where the Medicare costs are and the management opportunities, we are finding ways that you can reduce costs quite substantially with fairly easy interventions.

Congestive heart failure is another example where managed care companies are having a nurse practitioner and volunteers call people with congestive heart failure every day or two and ask just two questions, what is your weight this morning, because that build-up of fluid is an early indicator of a potential crisis, and how are you feeling.

Just those two questions are early warning enough that they are reducing hospitalization rates by 30 percent more. So I agree with everything you have said about questioning the Medicare projections. I have worked on Medicare for 20 years, and the lines have always gone like that.

I do not think we have begun to put in the kind of sustained effort to find savings, to find ways to provide better medical care that Medicare needs to to be sure that we need to pay those projected costs in the future. Maybe we do, but I just want to add into the conversation that Medicare needs to do a lot more effective purchasing of care and effective management of the program than in the past.

Senator ROCKEFELLER. If I could give the other two a chance to respond, if they want to. I think you did, Mr. Tanner. Incidentally, I think I made a mistake. I think I said that the government knows better about your health care than you do. I meant the doctor, if I did say that. I am sure that I did. But I want that very clear.

Mr. TANNER. I just caution the ability or the attitude that says that we can sit here in Washington and develop the equivalent of a 5-year plan that is going to reach into every hospital in the country and sort of devise the micro-incentives that are going to improve the quality of health care or the cost effectiveness of health care.

We simply do not have the knowledge or the ability to do that from Washington. That needs to be done on an individual, case by case basis, hospital-hospital, and in essence it needs to be done between the doctor or the other provider and the patient responding to the market forces of that situation.

I think that if we sat down and tried, in the classic example of how to devise to get the egg from the hen all the way to the omelet in the morning, we would have 5,000 pages of Federal regulations and 20 commissions, and we would never get an egg there.

I think we have to avoid that sort of attitude in devising these cost-reducing incentives in the future. They will happen. They are happening now and various things are on the market, but they are not something that can be imposed from above.

Dr. HELMS. In my testimony, I tried to say that the financial situation for Medicare is a serious problem and that it is not well understood by the public, by the Congress, or even the health policy community that I am a part of. I am sorry you interpret that as nibbling around the edge.

In my testimony, I do not think I ever said that the Congress would necessarily reduce Medicare payments.

The baby boom generation is going to gain in political power.

In the future, Congress may very well decide that they want to spend more on the elderly, and that would be their explicit choice.

In today's system of open-ended entitlements, nobody has control of the budget. Members of Congress continue to go to appropriations committee meetings and every year they are told there are less funds to do the other things that they want to do, things like education, infrastructure, and even defense.

So I think the voters and Congress have to make those choices. Whether they will actually choose to spend less on Medicare, I am not sure. But I do think if we can work to improve the efficiency of the system we have a better chance of actually improving health care.

One more small point about quality. I think the process of quality competition is generally misunderstood, and we economists are to blame.

It is easier to teach elementary economics if you abstract from quality competition. In every non-medical market, quality competition in terms of the product, the service convenience, and so on, is a very important part of what we mean by competition. In the world that I see for competition, I think you would get that kind of quality competition in health care also.

Mr. DAVIS. I wanted to comment on Mr. Etheredge's point about putting Medicare/Medicaid dual beneficiaries into managed care. I am very alarmed by that.

Half of Medicaid/Medicare dual beneficiaries have very poor health, 39 percent are limited in activities of daily living. The studies that have found that health status goes down in managed care have been particularly true for low-income populations.

The studies that have been done on managed care and long-term care show they are not providing home health services. It is also the case that, if you put somebody in a nursing home, you can actually lower their Medicare costs.

So, an HMO that has a patient at home getting home care is going to make a lot of money if they just put that patient in a nursing home. So I think we have to be very careful about putting the most vulnerable beneficiaries, the dual Medicare/Medicaid beneficiaries, in managed care.

Senator GRAMM. Let me conclude. Having listened to a very important discussion, I want to, after I am through saying just a few words, let Senator Rockefeller also make a closing statement, then we will both go back to work and let you go back to work.

I want to end the hearing on what I see as a positive note. First of all, the recent article in the Washington Post, with all due respect, suggesting that after 8 years of standing on the seashore looking at potential competition, we have somehow realized all the savings to be had from competition is absolutely absurd.

Second, the system is as it is today because of the incentives we built into it. If we change the incentives we are going to change the system dramatically. We now sit and spend endless hours worrying about the cost of new technology.

The only market in the history of mankind where we have ever worried about the cost of new technology is health care, under collectivized medical systems. In every other market in history, new technology comes in when it is cheaper.

Going back to my Wall Street Journal article, whale oil was used as a principal source of lighting and of quality lubricants. The price

of it started to rise on a secular basis and there was tremendous hand-wringing about what was going to happen.

But what happened was, as costs started to rise on a secular basis, an effort was kicked off to find a substitute. We have here the heir of a great man who helped identify and develop that substitute. But you know something, the substitute was cheaper than whale oil.

Senator ROCKEFELLER. Those were my closing remarks. [Laughter.]

Senator GRAMM. When the substitute came on the market, it made everything cheaper, not more expensive. Why? Well, like the first Churchill, the first Rockefeller did not have an incentive to find a more expensive way to do it, he had an incentive to find a cheaper way to do it. He found a cheaper, more plentiful product, and that product was crude oil, and millions of uses for it were found.

We have not yet lived a day in the modern era where technology in the area of medicine was aimed at cost-saving. Medical technology has, in the whole modern era, been aimed at doing it better, no matter how much it cost.

A final couple of points. There are ways of changing behavior by simply changing the way, not the amount, we pay for services. Part B premiums are a perfect example. Part B premiums have no impact on behavior because you have to pay them, and once you have paid them the marginal costs are the same. But if you simply converted that Part B premium into a deductible, you would change behavior instantaneously.

So I think there are many avenues. We have fallen into a pattern of thinking where you have got the providers and the beneficiaries, and you have to take it from one or both of them. Not so.

Of course, we have wanted to take it from the providers because there are fewer of them and they are richer. But what we have to figure out is how to reorganize the system and bring these competitive forces to bear. It is going to be done. Ultimately, we are going to solve this problem. The question is, are we going to do it sooner rather than later? We can improve the quality of life for a lot of people if we can do it, which is why we are here.

This is a tremendous problem, but, gosh, it is a great opportunity to really do something worthy. Did you ever serve in the House?

Senator ROCKEFELLER. No.

Senator GRAMM. Well, there is in the House, over the Speaker's chair, a charge to its members attributed to Daniel Webster. Sometime when we are listening to some dull State of the Union speech, take a minute to read it. It says "Let us develop the resources of our land, call forth its powers, build up its institutions, promote all its great interests, and see whether we also in our day and generation may not perform something worthy to be remembered."

If you save Medicare, it will be remembered. Now, you may well be out of office back in West Virginia somewhere or back in Texas, but if you do that, people will remember.

I think that is what makes this exciting. I mean, this is one little subcommittee that is dealing with a great big problem that is going to affect every living person in America.

We have an opportunity to do something about it. We have people debating today how to fund investigating the President and the Congress. Those are important things, but they just do not happen to excite me. This excites me. I want to thank each of you for coming.

If Senator Rockefeller wants to make a statement, we will end with that.

Senator ROCKEFELLER. No, I sign on to what you said. I think it is good. I think it is made complicated by the fact that, number one, the opportunity is extraordinary. Here we are, of course, surrounded by all of our fellow subcommittee members and legions of the media.

But the fact is, this is a subcommittee which controls Medicare, controls Medicaid, it controls the uninsured, which is 40 million people that we have to worry about, and 10.5 million children, which is more cost to somebody. It does, what else?

Senator GRAMM. All of the medical programs.

Senator ROCKEFELLER. Long-term care, uninsured, Medicare, Medicaid, those four. It is a gigantic opportunity. What I hope is, as we proceed on this—and, Phil, I think you have done a terrific job in getting us off the mark on it by being provocative and by being intelligent and driving hard—is that we can understand that, on the one hand, we have to deal with the average senior in West Virginia whose retirement income is $10,700 a year.

If you say we have got to increase something on that individual and they are already spending an enormous amount of their income, will, in fact, they do it, or will they bring about their own demise more quickly by having the philosophical free choice to so do, and then ignoring health care and being in trouble?

Then on the other hand we have the world of the totally unknown and the unexplored, and that is, and I agree with Phil, the extraordinary things that technology can do.

And it is true about my great-grandfather. He did see something that was not working, and it was not just whale oil, it was everything from kerosine, to crude oil, to barrel staves all over the world. He made it efficient, he made it cheaper, he made it more plentiful. If there was any model between what he did, minus the Sherman Antitrust Act and what could be done to health care, it is worth looking at.

Senator GRAMM. Thank you all for coming. We are adjourned.

[Whereupon, at 3:55 p.m., the hearing was recessed.]

MAGNITUDE OF THE FINANCIAL CRISIS IN MEDICARE

THURSDAY, MARCH 13, 1997

U.S. SENATE,
SUBCOMMITTEE ON HEALTH CARE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 2:07 p.m., in room SD–215, Dirksen Senate Office Building, Hon. Phil Gramm (chairman of the subcommittee) presiding.

Also present: Senators Grassley and Rockefeller.

OPENING STATEMENT OF HON. PHIL GRAMM, A U.S. SENATOR FROM TEXAS, CHAIRMAN, SUBCOMMITTEE ON HEALTH CARE

Senator GRAMM. Let me begin by thanking our colleagues for coming to the hearing. I want to thank members, and both our first and second panel. I want to be very brief in my opening statements today and focus my attention on the charge that I would give those who are testifying before the subcommittee on this issue.

Our charge in these hearings is to define the long-term problem that we face in Medicare, to understand the magnitude and the timing of this problem, and to seek input and ideas. Hopefully, new ideas, which we can consider when trying to deal with this problem.

From the hearings we have already had, and from the study that we have all undertaken, every member of this subcommittee and the full committee is acutely aware that Medicare is in the red for the first time ever, and that at the end of 3 years the trust fund of Part A will be insolvent.

In a technical and real sense, to the extent there ever was a Part B trust fund, it has been insolvent for some time. The cumulative deficit over the next 10 years under the status quo will be $600 billion, and we are still in a period where we have relatively few people who are retiring every year.

This year, our population will have 200,000 more people who are age 65 and over. In 14 years, that annual increase will be 1.6 million people. That number will hold up, more or less, for the next 20 years. We have had estimates in testimony before this committee and evidence that no one has disputed that the unfunded liability of the Medicare system is at a minimum $2.5 trillion. That is about 50 percent of the existing national debt.

So what we are seeking to do in this set of subcommittee hearings is, No. 1, be absolutely sure that we understand as much as we can understand about the problem.

No. 2, that we seek out and try to get ideas from people as to what we can do, either about exploding costs or how we can address the underlying actuarial problem of the system.

The final point. I know many people—Mr. King, you being one—who have studied this problem for many years. One of the things that I have always tried to do in talking to CBO or any other group is to say to people, given all the studies you have made of this problem, if there is something you could do unilaterally to deal with this problem, what would it be? Is there a pet peeve you have always had that no one would look at? We are not afraid here to discuss this problem.

The kind of courage we will have when it comes time to deal with it obviously has to be proven. But there is not any subject that cannot be brought up here, no matter how sensitive, frightening or politically hot it is. We want to hear about it if you believe that it is relevant to the problem.

Before I recognize and introduce the panel, let me recognize our distinguished Ranking Democrat member of the committee, Senator Rockefeller.

Senator ROCKEFELLER. Mr. Chairman, thank you. Actually, today for a change, I have no opening statement.

Senator GRAMM. Senator Grassley.

Senator GRASSLEY. I have no opening statement, Mr. Chairman.

Senator GRAMM. Well, let me recognize our panel members. We, first, have John C. Goodman, who is president of the National Center for Policy Analysis in Dallas, TX. We have David B. Kendall, who is senior analyst for Health Policy at the Progressive Policy Institute in Washington.

We have Guy King, who is the former chief actuary of the Health Care Financing Administration. He now lives in Maryland. I want to thank each of you for coming today. And I do not have any particular order, so why do we not begin on my left, Mr. King, with you.

Let me say one other thing. We will print everybody's statement in the record. If you could, try to keep your comments to about 5 minutes so we have plenty of time for questions. But, if you are in the middle of explaining something or if there is just something we have got to hear, within limits, I am not going to cut you off.

STATEMENT OF GUY KING, F.F.A., FORMER CHIEF ACTUARY, HEALTH CARE FINANCING ADMINISTRATION, ELLICOTT CITY, MD

Mr. KING. Thank you, Mr. Chairman. There has been much discussion of the financial condition of the Medicare program during the last 2 years, and this discussion has focused primarily on the imminent depletion of the HI trust fund and on ways to move that date back for a few years.

In my opinion, this focus on merely delaying the depletion of the trust fund is actually a distraction from the much larger long-run financial problems of the program.

The existence of the long-run financial imbalance in the HI program has been known for over 20 years, and the failure to address these problems, I believe, has been far more destructive to the program than taking action that some may deem to be too much.

Concentrating on stop-gap measures to temporarily stave off the depletion of the fund is the moral equivalent of making a molehill out of a mountain, in my opinion.

The huge long-term financial imbalance and the generational equity or inequities that are associated with that financial imbalance, I believe, is the single largest threat to the long-term viability of the Medicare program as a social insurance program.

Let me give you a few examples of just how large the deficit in the HI program is. The tax rate necessary to support the current program if nothing is done, according to the 1996 trustees' report, will have more than tripled by the year 2050, and even by the year 2020 the tax rate necessary to support the program will have more than doubled.

Even when we are discussing just the short-range financial adequacy of the trust fund, that is, the molehill, even then the magnitude of the problem is understated. For the HI program to meet the minimum requirements established by the board of trustees, it would require savings of $300 billion over the next 7 years, and that is to meet the minimum requirements.

To preserve the HI program for the post World War II baby boom, that is, to put the fund in balance for 75 years, would require an immediate 59 percent reduction in expenditures or an immediate 141 percent increase in the HI tax rate, or some combination of the two.

To preserve the program just for 25 years would require either an immediate 39 percent reduction in expenditures or an immediate 63 percent increase in the HI tax rate, or some combination of the two.

One of the critical problems in correcting the financial imbalance in the HI trust fund is generational equity. How do we do it in a manner that preserves generational equity? When I say generational equity I am talking about a comparison of a what a person pays in over their lifetime with what they receive in benefits over their lifetime.

Our studies that were done at HCFA show that the greatest generational equity involves taking action immediately rather than later, and reducing the growth in benefits rather than increasing taxes. So opposition to increasing taxes and taking immediate action stems, in my case, from a scientific study of the program rather than just political dogma.

With regard to the SMI program, we do not hear much about that. Because of the way it is financed it is not in immediate danger of insolvency. However, the growth in the cost of the program is so rapid that it is not sustainable in the long run.

According to the 1996 trustees' report, expenditures which are currently less than 1 percent of GDP will be nearly 3 percent of GDP by 2020, and 3.5 percent of GDP by the middle of the next century.

The outlays of the SMI program are growing at excessive rates due to two design features of the program which interact with each other to result in significant waste and abuse. These two factors combine to drive up health care costs in the private sector as well.

The first factor is third party payments. When patients and providers are spending other people's money, they do not concern

themselves with either the price or the quantity of services that they receive.

A good example of research that demonstrates just how powerful third party payments is, is that Medicare beneficiaries who do not have Medigap plans that fill in their co-payments and deductible have significantly lower Medicare costs than those who do have Medigap plans, even when we control for health selection.

Research shows that not only are health care costs higher, but they also increase faster because of third party payments. This research that shows that, I would say, is the most important research giving us a clue as to how to solve the rate of growth in health care costs, because it is the only one that explains why health care costs are growing so rapidly in the United States.

The second factor contributing to rapid growth is fee-for-service medicine. Fee-for-service medicine allows providers to defeat price controls by increasing volume and intensity to make up for a potential loss of income.

Medicare is projected to grow by $260 billion over the next decade. Over $140 billion of this growth results from increases in the volume and intensity of services, so even if the government froze prices for the next decade, Medicare would grow by over $200 billion if providers responded to price controls as they have in the past.

So if price controls do not work, what is the answer? Well, they can theoretically be controlled by moving either of the two factors, third party payments or fee-for-service medicine. Increase in co-insurance and deductibles is an example of dealing with third party payments, and introducing capitated services, as in the TEFRA Medicare risk program, is an example of dealing with the fee-for-service factor.

Because of the design limitations in the TEFRA risk program and because of the limitations on the ability to adjust for risk selection, I do not believe that managed care can be relied upon to control costs in the Medicare program, particularly since enrollment is voluntary.

Finally, I would like to suggest that whatever reforms are adopted, some kind of a fail-safe mechanism is adopted that would prevent the program from growing more rapidly than the taxes which support it. This concludes my formal remarks. Thank you.

Senator GRAMM. Thank you, Mr. King.

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

Senator GRAMM. Mr. John Goodman.

STATEMENT OF JOHN C. GOODMAN, PRESIDENT, NATIONAL CENTER FOR POLICY ANALYSIS, DALLAS, TX

Mr. GOODMAN. Thank you, Mr. Chairman and members of the committee. For as long as I have been interested in Medicare and Social Security and other government entitlement programs, I have been morbidly curious about just how bad things can get for future generations.

It is not all that easy to find out. If one goes to the reports of the trustees of the various trust funds, you find that they are obsessively focused on what they call the actuarial balance of the system.

This treats the bonds in the trust funds as assets the way you would if you did a private audit of a private pension fund. It overlooks the fact that an asset of the pension fund is exactly offset by a liability of the Treasury. For the government as a whole they net out to zero.

Adding more bonds to the trust funds does not in any way increase the capacity of the government to pay benefits in future years. So what we really want to know, is what kind of tax burden are we going to have to impose on future generations in order to pay benefits currently promised into law?

Now, I have appended to my testimony the Social Security trustees' own projection going out 75 years, and this is for Social Security plus Medicare Part A. But what they leave out is Medicare Part B, and also they leave out all of the other ways in which we pay health care bills of the elderly through, for example, Medicaid and the Veteran's Administration, and so forth.

We think it is important to recognize all of these different ways of paying health care costs because otherwise the temptation will be to push spending out of one program and into another, to pretend that something has been done when in fact the total burden has not changed.

The other problem with the trustees' reports is it is very difficult to tell how sensitive those final tax burdens will be to the assumptions that are being made. For example, over the last decade health care costs have been rising at least twice as fast as wages. Were that trend to continue into the next century, health care would consume the entirety of the gross national product by about the middle of the next century.

Now, the actuaries recognize that this is impossible, so what they do in their forecast is arbitrarily limit, in the year 2020, health costs to rise no faster than wages. When you get out to the year 2045, both the pessimistic and optimistic projections are squeezed together and they are made to match the intermediate projection. These are very arbitrary assumptions. They have no basis in reality. But they are made just so you will not see the curves go literally off the chart.

If this were a private audit of a private pension, there would be on the top of it a letter to management in bold letters and all of this would be brought out. But I find that, in order to get it out of the Social Security trustees' report, I have got to go to the fine print and search around a lot.

Nonetheless, the bottom line numbers are these. Going out to the year 2040, which is about the time when today's college graduates will be reaching the retirement age, we will need a payroll tax of about one out of every $10 that workers are earning in order to pay Part A benefits, on the intermediate assumptions. On the pessimistic assumptions, we will need 18 percent, almost one out of every $5.

If you take Part B costs and express them as a percent of the same taxable wage that applies for Part A, on the intermediate assumptions you will need 6 percent in the year 2040 to pay Part B benefits and you will need 11 percent, more than one out of every $10, on the pessimistic assumptions.

Adding the two parts of Medicare together out in the year 2040, to honor both Part A and Part B obligations, we will need about $1 out of every $7 that workers earn under the intermediate assumptions, and we will need $1 out of every $3, they earn under the pessimistic assumptions.

The other ways that we pay for health care for the elderly have been estimated here. On the intermediate assumptions, if we add them all up, we are going to need $1 out of every $4 to pay obligations already created as part of current law. These are already part of entitlements programs that are there now, without any expansion.

That is a rather amazing fact. This is the intermediate, midstream projection. We are talking about $1 out of every $4 taken off the top before any road or bridge is built, before any teacher's salary is paid. or police officer's salary, before any food is put on the table for a family is paying the taxes. That is quite an amazing burden.

And if things are as bad as the pessimistic assumptions forecast, we are going to need $1 out of every $2. We have not even gotten to Social Security. If we add Social Security in, the intermediate burden is 41 percent of taxable payroll, and the pessimistic burden is $2 out of every $3.

These forecasts are not only frightening, but they are impossible tax burdens. They, by the way, assume that it is just as easy to collect a dollar of tax when the tax rate is low as it is when the tax rate is high.

Yet we know that is not true. When you have substantial tax hikes you have more tax evasion, tax avoidance, less economic activity. So, in fact, to really get that kind of money you would need a much higher tax rate than these burdens would suggest.

So I would say the bottom line conclusion is, we are on an unsustainable path, that we must move quickly and radically to a new system. We have got to get rid of the idea that each generation can look to the next generation to pay its benefits. We must move quickly to a system under which each generation pays its own way. Thank you, Mr. Chairman.

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

Senator GRAMM. Mr. Kendall.

STATEMENT OF DAVID B. KENDALL, SENIOR ANALYST FOR HEALTH POLICY, PROGRESSIVE POLICY INSTITUTE, WASHINGTON, DC

Mr. KENDALL. Mr. Chairman, Senator Rockefeller and Senator Grassley, thank you for holding this series of hearings and for the opportunity to testify today.

Let me summarize my written testimony by essentially trying to address the magnitude of the financial crisis by describing the magnitude of a solution.

The goal I believe we should pursue is to keep Medicare's promise, that older Americans and the disabled always have the health care that they need and deserve. Fulfilling that promise has become increasingly difficult and will become even more so, but it is by no means impossible.

According to CBO projections, Medicare costs will triple by the year 2030. At that time, the combined costs of Medicare and Medicaid will consume about the same share of the economy that we spend today for all American's health care.

The Nation faces three basic choices: Either we increase taxes or the deficit, we reduce benefits across the board, or we ask those who can take responsibility for their health care to do so.

I believe we must choose the third option, and keep Medicare's promise. But, however, we have to return to Medicare's original principles and use those original principles to assess whether Medicare's current laws and regulations are actually consistent with those principles.

The first principle is that Medicare's health care delivery system should be a modern health care delivery system, just as it was when it was enacted. In 1965, fee-for-service health care was the dominant form of coverage. Today, it is managed care.

The Nation's large employers have dropped their employer-pay-all benefit package and instead offer a defined contribution for basic coverage. They offer a menu of choices for each employee, which includes both managed care and fee-for-service plans.

Medicare should do the same by providing greater choices and a contribution that is large enough to pay for a high-quality care plan but does not decline in value over time. This type of plan, whether it is fee-for-service or managed care, should set a benchmark for Medicare spending for all time in the future.

The main obstacle to consumer choice in today's marketplace, however, is clear and reliable information about the quality of care provided by managed care plans. Medicare beneficiaries and all Americans need to know how well their health plans promote and restore our health. The government has a critical role to play in providing this information to consumers.

The second principle is consistent and geographically uniform benefits. Even though Medicare benefits are fixed in law, the value of the benefits grow larger every year. For example, the $100 Part B deductible would have to be more than doubled to compensate for the effects of inflation since 1966. The Part B deductible should simply be doubled and indexed to inflation.

In a similar way, the fixed age of eligibility has driven up costs as life expectancy increases. Medicare's age of eligibility should be gradually increased to at least at 67, just as it is increasing for full benefits under Social Security.

The principle of geographic uniformity is also eroding. For HMO enrolles in Southern California and Florida, Medicare pays for health spa memberships and for dental benefits, whereas somebody, like my grandmother, who used to live in rural Ohio, does not receive those benefits. But older Americans should have equal coverage throughout the country.

To make these benefits uniform, Congress should link Medicare subsidies to a competitively priced, uniform standard benefit package. This approach, however, does not mean that beneficiaries could choose alternative benefit packages, it simply means that there would be a national standard that is affordable.

The third principle is that we should have equal access to care for the rich and the poor. For high-income elderly, Medicare's bene-

fits are too generous to produce equal access. Let me explain why. A $100 deductible for somebody who is wealthy is more of an excuse to pay $100 so that Medicare will pay for whatever they might demand. Upper income older Americans should receive a Medicare subsidy that is limited no more than a catastrophic policy.

Obviously, the reforms I have described here would have significant political obstacles, but the alternatives are worse. Cutting benefits across the board is unacceptable because the most vulnerable and the well-off beneficiaries would be hurt equally. We could raise payroll taxes to support Medicare, but that would be a tax on work which would simply make it harder to fund social programs.

Moreover, raising taxes in support of Medicare faces two significant moral hurdles. The first, is how can we ask low-income workers, who often today lack coverage for their own health insurance, to pay more for the benefits of wealthy retirees? The second hurdle, is how can we ask the Generation X'ers to cover more of the cost of the baby boomers when we have already saddled the Generation X'ers with significant public debt?

Medicare was enacted in the spirit of mutual responsibility. As a society, we were not going to let the older Americans die in poverty because of sickness or deny them the miracles of modern medicine. The young would support the old, so that generation after generation would have support in their old age.

Today, however, the principle of mutual responsibility is not working. As Guy King just pointed out, future retirees will receive more in Medicare benefits than they will contribute in taxes.

A social program where most people take out more than they put in is unsustainable. But acknowledging this problem does not mean that we should forsake the basic principles of Medicare and the great achievements. Instead, the Nation must find the political will to face this problem head on, as you are today. Thank you.

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

Senator GRAMM. Well, first of all, Mr. Kendall, let me thank you for your testimony. I tell you one thing that encourages me, and maybe I am trying to find reason to be encouraged. When it comes down to the reforms to deal with the explosion in per capita costs and you look at the broad cross-section of what I would call the academic intellectual thought community, you have a few people who say, well, it is outrageous to suggest the house is on fire, because it is a wonderful house. But they are in such a minority as to be irrelevant.

That is what I am encouraged about. Whether we are talking about think tanks or facets of the intellectual community who come at this from our sacred commitment to those who are beneficiaries, or we have testimony from those who come at it promoting less government and more freedom, the policy prescription for the short-term is virtually identical.

If we can simply have Congress ratify the conclusion that has been reached independently by a broad cross-section of people who have really given intellectual thought to this problem, we can make a substantial change in Medicare policy. No matter who you are listening to, there are many dangers. But there is no danger that we will do too much. That is not a danger.

I want to touch on a couple of things within my time. Mr. Goodman, you mentioned it, but it is something that I have been concerned about and have been trying to come up with a mechanism to correct.

As alarming as the trustee report is, the plain truth is that right in the middle of the projection, the year 2020, they simply arbitrarily assume away half the problem.

They assume without telling how that something is going to magically and dramatically change the picture in Medicare, yet they do not tell us what that policy would be.

So, as alarming as their numbers are, the plain truth is that they are grossly understated. Would you agree with that?

Mr. GOODMAN. I would agree totally. They spend very few words on it. They allude to the fact that if they do not make these arbitrary assumptions we will be on an unsustainable course, and there we have it.

The assumption is that health care costs will grow no faster than wages, and then for the optimistic assumptions it is 2 percentage points below the rate of growth of wages, and for pessimistic it is 2 percentage points above. But even those converge on wages by the year 2045.

It is very arbitrary and, as far as I can tell, there is no purpose in doing that other than just to keep the numbers from going off the page.

Senator GRAMM. Now, I want to thank you, Mr. King, for your testimony. Obviously, what you have to say here carries a great weight because you principally were charged with generating these numbers for the government. But I want to go through and simply raise some potential policy changes, and I would like to get each of you to tell me whether you think we ought to do it.

No. 1, we have got a Medicare system where you have, for all practical purposes, no co-payment on Part B. It has declined by 50 percent since the program started. You have a separate deductible for Part A. Should we combine the two deductibles and raise them to something approaching the real level they were when the program started? Let me just go starting left to right.

Mr. KING. I would say the important thing is not combining the two deductibles. The important thing is to raise the deductibles to the real levels that they were when the program started.

There are some mechanical problems associated with a combining of the deductibles because there are still people who have only Part A coverage, and also people who have only Part B coverage, although I realize that that is a pretty small percentage lately.

Mr. GOODMAN. What I would do, is I would plug all the holes in Medicare and create one uniform deductible across all services. I am not exactly sure what that deductible would be, and you would want to get it as low as possible. But one deductible, and everything above it is covered and everything below it is the beneficiaries' responsibility.

Senator GRAMM. Mr. Kendall.

Mr. KENDALL. I think on a limited basis, yes, we should update the beneficiaries' deductibles and co-payments for inflation. However, I think if you simply did it across the board you would hurt low-income beneficiaries as well as upper income beneficiaries.

So I think that it is important to find ways in which lower income beneficiaries can have health benefits without high deductibles and co-payments. That way is, frankly, managed care. So I think you have to have a two-prong strategy.

Senator GRAMM. One of the things that there is a growing consensus on, is that we ought to open up a broad range of options for Medicare beneficiaries so that they can opt out of the conventional program regardless of how we might change it. I personally believe that it has got to be modernized, no matter what other choices we give.

But at least there is a growing bipartisan consensus that between fee-for-service and the HMO, that we need to fill in with a large number, or a larger number, of other options that would be available. Do you agree with that?

Mr. KING. Yes, sir. I do. I believe that more options would help cost containment in the Medicare program. However, I might point out that in the process of doing that you have to find a way to make the capitation rate that you are paying for these other options save money for the Medicare program.

Right now, the current AAPCC capitation rate does not save money for the Medicare program. If it was geographically redistributed, that would not save money for the Medicare program. In fact, it would probably cost money. But the basic idea of expanding the number of options, I think, is a good one.

Mr. GOODMAN. I think beneficiaries should have access to the full range of options that are available to the under-65 population in the private sector.

Mr. KENDALL. Yes, certainly you should expand choices. But just to address Guy's problem, risk adjustment is a fine solution, and we need to do a better job of it, but the short answer to that problem is simply have the government set a fixed amount and let the problems fall where they may. In other words, risk selection will not be a problem if everyone is under the same cap.

Senator GRAMM. I want to get one yes or no real quickly, then recognize Senator Rockefeller. If you were sitting where we are sitting and you were looking at this financial time bomb where the fuse is very short, would you phase in an increase in the retirement age for Medicare to conform to what we have done for Social Security. We have already raised the retirement age for Social Security to 67, beginning the phase-in after the turn of the century.

Mr. KING. I would not actually place a great deal of emphasis on that as a problem because I think the real problem in Medicare is that health care costs are growing so rapidly. If that problem were solved, then I think the demographic shift could be solved much more easily. But I would not suggest that it should not be done, it is just that I do not think that is the one that is going to save a lot of money.

Senator GRAMM. I am not suggesting it is a magic bullet, I just threw it out there to see what you think.

Mr. GOODMAN. It should be done, but I would be troubled if it were done by itself. It needs to be combined with a general movement toward a fully funded system.

Mr. KENDALL. Yes, I agree that we should move it to 67, and maybe beyond because that is the best way to get the baby boomers to pay for more of their own benefits.

Senator GRAMM. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I think when you get a problem with programs like Medicare and Social Security, which obviously has very deep and long dimensions and long history, there is a tendency to try to fix it all at once. Now, I am not sure that is a bad idea, but I want to posit something to you three gentlemen on an entirely unrelated subject just to get your sort of frame of mind.

I think it is probably safe to say that most Americans who graduate from high school are not really, in fact, graduating from high school, they are graduating from the ninth grade in terms of the equivalent skills that they bring to the work place.

As a result, American business has to spend untold billions of dollars trying to get them to be able to read manuals and do all kinds of things. As we go on, obviously, the need for not just literacy, but technological literacy, is going to grow enormously and the problem is going to compound.

Now, you look at any European or Asian school system and kids go to school 220 days a year. In our country, they go to school 180 days a year. Parents and teachers are part of the problem, because they want their vacations. Would each of you gentlemen answer me that we ought to move fairly rapidly to a 220-day school year for our children in order to be competitive in a modern economy?

Mr. GOODMAN. I would not.

Mr. KING. That is not my area of expertise.

Senator ROCKEFELLER. No, that is not a fair answer. You are a citizen. You can have an opinion on that, even a wrong one. No answer?

Mr. KING. If we knew for sure that that is what it took.

Senator ROCKEFELLER. Well, we know for sure it is going to take at least that. At least that.

Mr. KING. Then I would suggest that we ought to do it.

Senator ROCKEFELLER. All right. And you, sir?

Mr. KENDALL. I do not know if managing the process of educating children is the right way to regulate the business of education. The Progressive Policy Institute has recently proposed national standards for the performance of our education system and I think a similar model would work for our health care system. We do not really care how educators do it, we should just make sure they perform and we can measure that.

Senator ROCKEFELLER. All right. It just interests me, because Guy King, as the Chairman pointed out, you have been at this now for 20 years and I have never heard this testimony from you before, or these views. So problems have a way of accumulating, and then one enters another phase of life and one wants to cure. I want to cure, but I do not want to do anything that is wrong.

For example, Mr. Goodman, I think you start out by saying, "A fully funded retirement system under which each generation pays its own way, generation, age group, whatever it might be." By which, I would suppose that 18-year-olds would pay for 18-year-olds and they would buy health insurance for that age group, and

20–30 for that age group, or they would for Medicare. But they would not be getting their health insurance, they would be buying for future Medicare.

Now, if you do that and the, let's say, 20–30 age group puts aside money for future Medicare costs, how, at a time when their earning potential is particularly low, and in many cases in our modern American economy very low, do they buy health insurance? In other words, you have answered one problem by talking about making a solution like Mr. Hasting——

Senator GRAMM. Saving.

Senator ROCKEFELLER [continuing]. Saving did the last time. Cohorts. Be responsible for your own generation, not for others. But then for the younger ones, how do they have health insurance since they say now by the year 2000 that maybe 50 percent of businesses that employ people will not offer health insurance?

Mr. GOODMAN. Well, if I can just use the analogy of Social Security, the vast majority of all Social Security systems in the world today are just like ours, they are pay-as-you-go. People pay taxes to support the elderly.

But about 21 former British colonies, of which I guess Singapore is the most notable, decided instead to force people to pay for their own retirement, so they had to sock savings aside each year and when they retire, they have a fully funded pension of their own.

Now, what has happened with the passage of time is that more and more countries have realized, they have made a mistake. If there is a way to fund this, it is better to fund it than to try to get each generation to pay the next generation's benefits. So now we have Chile and a half a dozen Latin American countries and Hong Kong are going to a funded system. But what you have to do, is you require each generation to put aside savings to pay for their own retirement benefits.

Senator ROCKEFELLER. I understood you to say that, which is the reason I asked you the question that I did. How do they then also at the same time take care and provide for their health insurance requirements that they have at that time in their 20's, in their 30's?

Mr. GOODMAN. On top of their health insurance requirements at that time, they must put away savings for the future.

Senator ROCKEFELLER. I see. All right. Fair enough. Mr. Kendall?

Mr. KENDALL. Can I add just one third thing they would have to do, which is they would also have to pay for the people who are currently supported in the pay-as-you-go system, so they would have three burdens.

Senator GRAMM. And there is nothing that can undo that. We know that is true.

Mr. KENDALL. That is what was wanted.

Senator ROCKEFELLER. Thank you.

Senator GRAMM. Senator Grassley.

Senator GRASSLEY. Before I ask my question, Mr. King, in your statement you had something about a track record of less costs to Medicare for those who do not have Medigap insurance. Did you tell us how much less usage there was, or did you just say it as a general statement?

Mr. KING. I just said in my spoken testimony that they had less.

Senator GRASSLEY. Have you studied how much that is?

Mr. KING. Yes. We looked at the Medicare current beneficiary survey which accumulates health care costs for Medicare beneficiaries and it asks questions about their health status so that we can be sure that we are not just looking at healthier beneficiaries, we are looking at everybody.

When we compared those people who have Medicare only with those people who also have employer-sponsored Medigap, we found that the Medicare expenditures for those who had Medigap policies so that they did not have to face even the modest co-payments and deductibles in Medicare now, it ranged from a minimum of 131 percent for those in poor health, to a maximum of 173 percent for those who were in excellent health, in other words, those who did not face the co-insurance and deductibles of the Medicare program as they exist now.

Senator GRASSLEY. So if you have Medigap insurance you are less discriminating in going to a doctor or not, more apt to go.

Mr. KING. Much less discriminating.

Senator GRASSLEY. All right.

I want to ask any or all panelists about the fact that by the year 2010, we are only going to have about 2.2 workers paying in for every one drawing out of Medicare.

The extent to which we make changes now to save Medicare over the short-term on the expenditure side is not going to solve the problem. I think you all said that, the extent to which that is the case.

So then the problem becomes something on the funding side. I am not an advocate for increasing taxes, although I suppose that could be one of your answers. How are we going to solve this problem on the funding side, then, of making sure that we meet these needs when you can only do about so much more on the expenditure side?

Mr. KING. I would suggest, based on the studies that we did at the Health Care Financing Administration, that in the interest of generational equity, all of the changes be on the expenditure side and none of them be on the funding side.

In other words, if you increased the funding in order to preserve the financial integrity of the program, what you will be doing, in fact, all other things being equal, is increasing the inequity among different generations of beneficiaries. The currently retired generation is already receiving a huge windfall and the future retired generations will have paid far more into the system than they will receive in benefits.

Senator GRASSLEY. All right. See, I started with a premise of not increasing taxes, what alternatives do we have. But I guess you are saying the alternative is, we can do everything on the expenditure side.

Mr. KING. Yes.

Senator GRASSLEY. All right. Do you other two agree with that or do you think that we need to do something on the funding side?

Mr. KENDALL. I believe not until we have exhausted all the possibilities on the expenditure side. But we do not know how far, for instance, competition can save money. PPI did an analysis of our plan last year and it showed that the plan would save $80–$100

billion, which was without any price controls. That is from a kind of econometric perspective, which often underestimates the dynamic qualities of a marketplace. So I think there is huge potential for saving on the expenditure side.

Senator GRASSLEY. All right. I will move on to the fact that if we were to set up a Medicare savings account and have people throughout their lifetime pay into that, for people that are always in the work force, establishing a record of work, being able to save, they would presumably have the resources. What do we do for those that are in and out of the work force in a lifetime, having some unemployment, how do we take care of their needs?

Presently under Medicare, as long as you qualify for Medicare, if you are in short-term or long-term, you have that coverage. But presumably if you had an individual account, even with forced savings, there would be some people who would have more and some would have less, right?

Mr. GOODMAN. Well, I think you always have to have a safety net. Some people will not be able to pay their own way. Some people will not be able to earn enough to provide themselves with a pension and with health care in retirement.

But what we find in looking at these countries that have forced savings programs is that that is a very small percent of the population. That is a problem that is very easy to deal with relative to the problem you have when you have a chain letter approach to funding retirement benefits.

Senator GRASSLEY. So it is a very small problem, it is not a big problem.

Mr. GOODMAN. It is very small relative to the kinds of problems that we are talking about here.

Senator GRASSLEY. Including women who are now in the work force more than before but are in and out a lot more than men and do not have the continuity of employment?

Mr. GOODMAN. Well, there are various ways to devise a safety net. The way I would devise a safety net, is you guarantee people a minimum set of benefits during their retirement years. Women can move in and out of the labor market. They might get married and divorced. You only need to look at their assets and their income at the time they reach the point of retirement. Most such women are not going to find it necessary to rely on the safety net.

Senator GRASSLEY. Thank you, Mr. Chairman.

Senator GRAMM. Thank you. Well, let me thank each of you for your testimony. I think this has been a very, very good discussion, and I want to thank you.

Let me call our second panel. Our second panel is Richard J. Davidson, who is president of the American Hospital Association, and Daniel H. Johnson, Jr., M.D., who is president of the American Medical Association. I want to thank both of you for coming.

Again, let me first say that we will put your testimony in the record. It will be printed in full. What I would like to ask you to attempt to do is to try, in about 5 minutes, to give your statement. If what you have got to say is something we need to hear, I am not going to cut you off.

Second, let me say that I would really like your focus to be on two things. No. 1, your perception of this long-term problem, but,

more importantly, from your point of view in being the leaders of the two parts of the medical care community that are the most important components and the most costly components, what can we do to try to deal with this exploding cost? What proposals do you have?

One of my frustrations in public policy is the people who have the information by and large are not the people making the decisions. The people who are making the decisions are not the people who have the practical experience. Now, maybe it is the same way in industry. Maybe the guy down on the assembly line really knows what is not working. But management seems to do a better job of listening to that person than we do.

So I thought, as we move to sort of the end of one phase of our hearing, that it would make sense to listen to the presidents of the two great medical associations who are really the leaders in providing the greatest medical care in history. You are the people that we want to hear from. We want to get feedback from you as we move forward to be sure that when we are trying to fix one problem, we do not create greater problems.

So, Dr. Davidson, since you are sitting immediately on my left, why do you not go first?

STATEMENT OF RICHARD J. DAVIDSON, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC

Mr. DAVIDSON. I am Dick Davidson, president of the American Hospital Association. The AHA represents some 5,000 hospitals, health systems, and other care-givers throughout the entire Nation, and for us Medicare plays a major part in our ability to ultimately take care of people that live and work and are treated in our communities.

It is kind of interesting to look back over the last year in 1996. Democrats, Republicans, and special interests, including us, aired thousands of ads, spent millions of dollars sending pieces of mail around. We spent a lot of money fighting all of the issues around Medicare.

And what did we get at the end? The program still headed toward bankruptcy, with billions of dollars going out the door. So a lot did not happen. But there was a lot of talk and a lot of smoke, and no action. So we need to get to some action.

It seems to us there are a series of myths that seem to paralyze us from taking actions—that are really barriers to action. What I would like to do, Mr. Chairman, is to share six key myths that we think are in the way of getting some decisions made.

Myth No. 1: Medicare will not be around for future generations. We have all heard that. Our guess is, and if you begin to ask young people whether they think it is going to be around, people under 40 say it will not be there. We think that it will be there, that the American public will demand it. If you talked about abolishing Medicare in this country, we would have a revolution. So, we think it is going to be there.

Myth No. 2: Medicare is a trust fund. People think their payroll taxes go into a bank account from which they will be provided Medicare benefits when they retire. Of course, the fact of the matter is, as we have heard here today, today's taxes are used to care for

today's beneficiaries, and there are very few people in America that know that fact. They do not really understand the way the program works.

Myth No. 3: Medicare can be saved by reducing provider payments. You know this is our favorite. You know and I know that the gap between the trust fund spending and revenues is becoming enormous and cannot be remedied through provider cuts alone. That string has run out, and I think you have heard that. There would be no way to save this program just by cutting providers.

Myth No. 4: Hospitals do so well on Medicare that we can give them big cuts, they can afford it. Of course, recent ProPAC data may encourage this kind of thinking. But remember, in ProPAC's information, what you did not hear about was that ProPAC also estimated that 40 percent of America's hospitals lose money taking care of Medicare inpatients.

Myth No. 5: Medicare can be saved by eliminating fraud and abuse. A lot of people are starting to believe that. Now, we support the whole notion of ridding the system of fraud and abuse, but let us not kid ourselves. This alone will not solve Medicare's crisis.

Just to make a point, look at the President's budget. He has got a proposal in there that calls for saving less than $2 billion over 5 years by targeting fraud and abuse. That is certainly not a long-term strategy, but something we need to deal with.

Myth No. 6: Solve the short-term problem and somehow the long-term problem will seem to take care of itself. All of us seem to think that. Just look at the things that have been on the table. You have heard here today, in the year 2011, 77 million baby boomers start to come on line for this program, and I think you know the rest of the story. At that time, we are only going to have two workers to pay for each Medicare beneficiaries, and this thing just does not work out.

So from our view, these myths kind of get in the way of really dealing with the tough choices that you will be confronted with. From our perspective, the longer we talk about it and not take action, the more serious the problem is going to be.

In our view, we need to restructure the program and we need to create a new, independent, permanent commission for Medicare. Let us look at restructuring. We can start immediately by creating provider-sponsored organizations, another kind of delivery system to provide services to Medicare beneficiaries.

Today, most seniors have two options, the traditional fee-for-service option, or an HMO option if, in fact, there is an HMO in their community. In lots and lots of communities across America, they do not have that option.

So, we think it is essential to put together a new kind of delivery system that really brings local doctors and hospitals together to do direct contracting to take care of Medicare beneficiaries.

If we can get action on this front, we think that we would be pleased to move quickly and you would see a lot of things. We urge this committee to support the Rockefeller-Frist bill, S. 146. It has bipartisan support and it would create Medicare-qualified PSOs. There is a lot of agreement in the Congress about this whole notion.

Now, let me share five other restructuring ideas, and I will just deal with them briefly. Restructure Idea No. 1: Make Medicare managed care payments, the AAPCC, more equitable across the country. You heard these gentlemen talk about that earlier.

Restructure Idea No. 2: Make sure that Medicare, whether it is a defined benefit or a defined contribution approach, which is part of the debate we are going to have, guarantees a minimum set of benefits for all beneficiaries. That is essential.

Restructure Idea No. 3: Ask high-income seniors to pay a bigger share of their benefit costs so dollars go to those that are most in need. That is a problem we are going to have to work out here.

Restructure Idea No. 4: Let us not forget malpractice reform. That has some effect on the cost of the system. Let us have malpractice reform.

Restructure Idea No. 5: We think this is a very important recommendation. Offer workers tax-deferred savings accounts to help them defray health costs when they retire. We had a little bit of that conversation here today, too.

Now, in our view, Medicare reform requires tough choices. But the tough choices are not getting made, and I would like to close with this particular recommendation. We need a new long-term approach, an independent commission. The independent commission would be a permanent process.

It is not a solution, but a process to get to the solution. In our view, that is the problem we suffer. We have a paralysis over the politics of all of this and we are not getting the answers, and we need a permanent process to deal with this approach.

Now, we applaud Senators Roth and Moynihan for S. 341 to create a commission, but we would like to kind of build on their whole idea of a commission.

This new permanent independent commission each year would help Congress set a Medicare spending target. The commission would hold public hearings and it would recommend how much can be spent, what that money will buy in benefits, and for whom, and how to ensure quality. Then Congress would be asked to look at the entire package and vote it up or vote it down.

If Congress voted it down or did not vote, a default mechanism would kick in and provider payments and beneficiary cost sharing would be aligned with the spending target, in essence, cuts. Knowing that cuts could not be avoided in looking at this whole strategy, we think it would be a powerful incentive for Congress to pass the package of tough choices.

There is legislation, Mr. Chairman, to create this very commission. It is H.R. 406. It was introduced in the House by Representative Phil English from Pennsylvania. From our perspective, we are certain when we call for this kind of an independent, permanent commission for tough choices that we know that the hospitals of America may not necessarily like all the things that get recommended by this commission, but we think it is a process to get to some of these solutions and we are willing to run the risk of being in disagreement because we think it is essential to get on with the set of decisions that are on the table and make some tough choices.

We are very happy to work with you. In fact, we are appreciative of your leadership in raising these kinds of questions, and we are anxious to get a process where we can work together with you. We will be happy to be supportive of further discussion and debate around these issues. We think, again, America will demand that there be a Medicare program, and we have got to find a way to make that happen. Thank you.

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

Senator GRAMM. Dr. Johnson.

STATEMENT OF DANIEL H. JOHNSON, JR., M.D., PRESIDENT, AMERICAN MEDICAL ASSOCIATION, METAIRIE, LA

Dr. JOHNSON. Thank you, Mr. Chairman. Mr. Chairman, Senator Rockefeller, my name is Daniel H. Johnson, Jr., M.D. I am a diagnostic radiologist from Metairie, LA, and president of the American Medical Association.

On behalf of our 300,000 physician and medical student members, I would like to express appreciation for the opportunity to testify on behalf of our proposal for transforming Medicare, the most significant issue.

We believe that Congress and the administration need to move now to fix Medicare in order to save it for future generations. The long-term problems will only grow larger if we postpone structural reform and only tackle the short-term trust fund problem.

Our American Medical Association proposal to transform Medicare can best be summed up in one word: choice. Our proposal offers seniors the choice of staying in the traditional Medicare program or switching to a supermarket of competing health plans that we would call MediChoice.

We are extremely pleased that the basic elements of our proposal were endorsed by the American public in a nationwide survey that was released just last month. I want to emphasize that our proposal puts Medicare's fiscal house in order, while preserving the bond of trust between a patient and physician that makes medicine unique.

We believe that we have a plan that makes sense, and that the public likes. We think that now is the time to act to protect Medicare for our seniors, and also to save it for our children.

First, we would modernize traditional Medicare. The traditional Medicare program should continue as an option for seniors, but it needs to be updated from 1965 gas-guzzler to a 1997 fuel-efficient model. Our proposal modernizes traditional Medicare by eliminating the need for Medigap and replaces government price controls that we have heard discussed earlier with a competitive pricing system.

Most beneficiaries, as has already been discussed, convert Medicare into first-dollar coverage by purchasing Medigap, avoiding the cost sharing that exists in the current program.

Our AMA proposal would do away with the need for Medigap by eliminating all cost sharing except for a refundable deductible placed in an escrow account. In addition to simplifying the program, shifting to a single deductible would lead enrollees to be

more price-conscious without leaving them vulnerable to expensive episodes of illness.

A transformed Medicare also requires doctors and hospitals to compete on price and for beneficiaries to be rewarded for seeking the best health care value. Under our AMA proposal, beneficiaries would receive a rebate if they choose a physician who charges less than the government rate of reimbursement.

Our plan also maintains important safeguards for low-income seniors by providing the equivalent financial support they currently receive from Medicare and Medicaid. It is important to note that Medicare savings need not come from reducing physician payments or hospital payments such as those found in the President's budget proposal.

Our proposal achieves savings while minimizing reductions that will push many physicians to reduce, or even eliminate, their ability to care for Medicare patients. Those savings would be shared both by the program and by the beneficiaries.

Next, Mr. Chairman, is the notion of enhancing beneficiary choice. We believe that most beneficiaries will opt into our MediChoice option, which might be modeled after the Federal Employee Health Benefit Plan, the FEHBP.

This option gives seniors a defined contribution which they would then use to purchase a private health plan. MediChoice plans would include traditional insurance, benefit payment schedules, PPOs, provider-sponsored organizations, HMOs, and medical savings accounts.

In order to level the playing field for the MediChoice option, regulatory reforms are needed which will give the private market the flexibility to develop various products that meet the needs of those who use them, not the preconceived notions of central planners.

For example, Federal standards are needed for PSOs because regulations that are appropriate for traditional insurers are not appropriate for PSOs, whose primary business is health care delivery. Under our proposal, Federal PSO solvency standards would be based on the amount of risk assumed by the organization.

Medicare reform should also encompass professional liability reform, as has been mentioned by Mr. Davidson, including a $250,000 cap on non-economic damages. In 1995, CBO scored $200 million in Federal Government savings over 7 years in physician malpractice premium costs alone, without considering similar hospital, HMO, and medical supplier liability costs. These are millions of dollars that should go to patient care and to extending the life of the HI trust fund instead of going to attorney's fees and insurance premiums.

Then, third, Mr. Chairman and Senator Rockefeller, in preparing for future generations and in response to the concerns you raised, Mr. Chairman, society must honor its obligations to those on Medicare, but we should also move to preserve the program for future generations.

Our AMA believes that Medicare funding must be shifted from a pay-as-you-go system to an investment-based system in which beneficiaries begin to provide for their own retirement health care during their working years.

As part of this approach, medical savings accounts should therefore be made available to the entire working population so that individuals who choose them can accumulate earnings for use in retirement for medical care.

We understand that the transition from the pay-as-you-go system to a fully funded system will take time. In the interim, we recommend increasing the age of eligibility to match that schedule for Social Security. That would be our answer to the question you posed earlier. I am just about done, Mr. Chairman.

We also are recommending a reduction in the subsidy for high-income beneficiaries, so that minimum wage workers are not subsidizing the Medicare premiums of millionaires.

In conclusion, Mr. Chairman, we believe that Congress can no longer delay making the fundamental reforms that we have suggested to the Medicare program. Americans who depend on Medicare now, as well as those who rely on it for the future, should not have to worry whether it will be there. They should not have to be concerned about the myth that Mr. Davidson mentioned.

Our AMA proposal can best be distilled into four points: expand the choices; have Medicare make the same defined contribution to the beneficiary no matter what choice he or she makes; give beneficiaries both the opportunity and the responsibility to select a physician and a health plan, but with a periodic reasonable opportunity to change if dissatisfied with the previous choice; and finally, establish some mechanism, perhaps modeled on the FEHPB, to make it all work.

Our AMA looks forward to working with you and the rest of the committee and the Congress in developing legislation to protect Medicare for our seniors and save it for our children, and we thank you for the opportunity to present, Mr. Chairman.

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

Senator GRAMM. Thank you, Dr. Johnson, and Mr. Davidson, I want to thank both of you for very, very constructive, well-thought out, well-reasoned testimony. Let me just say a couple of things, and then I want to ask a few questions. Then I will recognize Senator Rockefeller.

I want to just give you my response on the idea of a commission. I am not encouraged by the results we have produced with recent commissions. We had an Entitlement Commission which generated a lot of good data, which I use every day, but it produced no change in entitlements.

We had a Social Security Commission which came up with many recommendations, but none of which they could agree on because, in fact, when you look back at the structure of the commission, it was never going to reach an agreement.

So I would just like to say, Mr. Davidson, that I see a commission and greater independence and a decision-forcing mechanism as being part of the implementation for the solution, but I do not see it as being part of the source of the solution.

I think we are going to have to make those decisions right here. I think there will be a great temptation simply to have a commission and put off making choices. I am not going to participate in that, and I do not know whether my view would be in the majority

or the minority. But I think we have an obligation to do something this year.

Let me also say that there is one thing I am convinced of, and that is there is no way to divide this problem into the short-term and the long-term problem. In reality, the long-term problem is here right now. All of the things that we talk about being a problem in Social Security occurring way off in the future are occurring at this moment in Medicare.

So, I think there will be those who say, well, you have got the exploding per capita costs. That is the short-term problem. Then you have got longer-term problems with an actuarial imbalance of the system. But I do not think we are doing our job unless we really begin to deal with both of these problems.

Having said that, let me just pose a couple of questions to both of you. First of all, in listening to your testimony I think it is clear that both of you believe that we need to look at the 1965 traditional Medicare policy and attempt to dramatically modernize that policy.

One way of doing that would be simply to make the changes cost-neutral to beneficiaries, but fill up all the gaps at the end and put the co-payments and deductibles up front, dramatically reducing the attractiveness of Medigap insurance.

I personally favor that change. I am sure there are a lot of other ways of modernizing Medicare, maybe better ways, but I would like to ask each of you, as spokesmen for your associations, whether you would support that type change, and how you would do it if you were going to do it?

Mr. DAVIDSON. Mr. Chairman, I think you have to think of this in the context of starting with a clean sheet, and that really puts you in a position of making some tough choices.

If Medicare did not exist and this was a hearing about creating a new mechanism to ultimately provide health care services to senior citizens, would we do it differently than we did in 1965? I think the answer to that is yes. In other words, we modeled a set of benefits around an insurance mechanism that was driven, in essence, by the Blue Cross plans.

It seems to me that is what we took, and ultimately created a Federal program built around that. And if you look at that model and then how the world has changed, we live in a very different era in terms of how we provide medical services, in terms of them being organized.

The whole question of whether there ought to be a Part A and a Part B is something that really ought to be considered. Why do we need two parts? I mean, we really ought to begin to think.

If we are ultimately contracting and making arrangements with organized delivery systems of doctors, hospitals and other providers, we might want to think about how you structure that. It seems to me we would also need to consider how we would structure the financing mechanism.

We certainly would be in favor of creating some trust in the trust fund to ultimately find a way to separate and protect dollars and have them grow so that we are not paying today's beneficiaries with today's workers, and truly have a trust fund that begins to accumulate things.

I think we clearly start out saying that we need to have a different delivery system where there is much better coordination of care, and where people really help patients make decisions about their care. The history of the program is, we have given people cards and we have said, just kind of go where you want to go, see whom you want to see, and kind of work it out.

It seems to me we could do much better than that in terms of efficiencies and effectiveness, with better medical outcomes. So I think there are a lot of strategies that could be employed to make the program be a current era program, and I think the whole question of indexing co-pays, deductibles and all of the rest around income is a part of what we have got to consider. It has got to have some income-related test to it.

Senator GRAMM. Dr. Johnson.

Dr. JOHNSON. Mr. Chairman, earlier for the previous panel you asked if there was a frustration that each person sensed, and you have hit right on a major one for us. In the last Congress, we had made a very similar proposal to the one I have outlined to you this afternoon. But a big part of that did not get adopted by the Congress, and that was the modernization of the traditional program.

You will, perhaps, recall that I suggested that we would like to see the Medicare beneficiaries have a choice of either staying in the traditional program, but modernize it, or move to MediChoice.

With respect to the traditional program in the previous Congress and the game today, we are proposing a radical change in that that does consolidate the various cost-sharing requirements in the following fashion. The individual today pays a Part B premium of $525.60 for this coming year.

We estimate, we believe, that the average person who buys Medigap insurance, which is 75 percent of the Medicare population, will pay an average premium of $1,092. It comes out, rounding it off, to $1,618. We have suggested two scenarios, which we have shared with your offices respectively, and would be glad to do so again. But two scenarios around the concept of a refundable deductible.

What we have said, is that to have that person who has Medigap coverage who is currently paying that premium and paying that Medigap coverage, who is currently paying that $1,618, put up that same amount of money now, but hold $500 of that in a beneficiaries escrow account. That money is potentially refundable back to the individual if the individual does not spend all that money.

In other words, rewarding the person for using the new, modernized traditional Medicare in a more cost-effective way. Some 20 percent of beneficiaries currently incur no cost sharing in any given year, 70 percent incur a cost-sharing liability of less than $500.

So a significant percentage of the current beneficiaries would have the opportunity, if they use the system in a cost-effective way, to be rewarded for doing so. We believe it is a very positive initiative that protects the interests of the Medicare beneficiaries, but puts them in a situation where the Medigap coverage, which has converted their coverage to first-dollar coverage, is eliminated. They are linked back to the cost of the services they are consuming and are rewarded for doing so in a cost-effective way.

Senator GRAMM. Let me just add one factual point, then recognize Senator Rockefeller. Over 90 percent of our seniors have supplemental insurance. So the point is, when you are talking about deductibles, people think of that as a new cost.

But if, in fact, you filled up all these gaps that induce my mother to pay $1,100 for her Medigap policy she would not have to buy that policy. My guess is she would be just as happy, if not happier, spending that money on health care rather than spending it on insurance in an effort to correct the crazy structure we have in the current Medicare program. Now she is worried that at the end of 60 days, she will face a co-payment she cannot pay, and at the end of 90 days it doubles, and at the end of 150 days she would be technically thrown out in the street. At that point, her Medicare would no longer cover her hospital care.

So she has no choice but to buy this insurance policy. Yet when she buys it, it changes all of her incentives about being cost-conscious.

But I just wanted to correct the fact, or add to it, that when you say 75 percent you are not really counting those who are getting Medicaid-funded supplemental coverage.

So really you are up pretty close to 95 percent of all Medicare beneficiaries who are not getting Medicaid supplemental coverage, who are already paying vast amounts of money for insurance to try to fill up these gaps that exist out there.

Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman. Let me just make a comment, too, a little bit in response to what I am gathering the pace is here. I would say, and I think Dr. Goodman mentioned this at some point, it is very hard to sort of take somebody else's system and impose it on our own. I agree with that.

The American people have a right, it seems to me, and the American Medicare population has a right, to understand what is happening to them or on their behalf. There is a great sense of urgency here to act, as though we have discovered that, although it has been interesting to me in today's testimony there has been enormous emphasis on that, and I think a very constructive one, Senator Gramm, because I think it is one of the things that you want to see brought out to show us the magnitude of the problem, a large emphasis on that, that we are in desperate trouble, and we are.

I find some of the reactions, answers or solutions to that either wanting or inappropriate, at least from my point of view. But, in any event, it seems to me that it is very important for the American people to understand what it is that we in Congress, or in a commission, or whatever, are considering. Particularly the Medicare population, where we know we have an enormous amount of the costs coming from a very small percentage of the people who are the most sick and nearest the end of their lives and for whom the question of choice and all of these things becomes much less relevant.

So I would suggest a very careful understanding of what we are about here. You suggested a commission. I happen to agree with your approach, Dick. Senator Gramm does not feel that way, that we should not be bound by its inaction. We should be able to act,

perhaps, ourselves with or without it. I may be speaking for him, or I may not.

But the sense of urgency that automatically arises, coming from a State where the average income, as I have said a thousand times, for seniors is about $10,700 a year. We cannot afford to make mistakes as we solve this problem. We have to solve it in a way which is American, which is understandable to Americans. It is really quite remarkable, I think, that often when you take the time to explain something to people, they will understand it. They will say, fine, we will go along with that.

It was a little bit like what I spoke about the other day, back during the Clinton health care debate the American people, 72 percent, were saying, we want to make sure that every single American has health insurance, including the 37 million who do not, and we will pay more taxes if that is what is required to do that.

Seventy-two percent said they would do that. But they did not mean it. They said it, but they did not mean it. I mean, they answered the question in sort of a nice way, but they did not mean it. What they were concerned about, was they were scared as the dickens about their own health insurance, what was going to happen to it, what was going to happen to their own quality of health care.

So what gets through, what is understood, I think, often has a lot to do with how people receive, and therefore perhaps accept, an idea which comes down from on high, whether it is a commission, a Congress, or a county commission.

So I would put that cautionary note, Mr. Chairman in, that I think that we have heard more so far about the dimensions of the problem than at least this Senator has found in terms of the solutions for the problem. I think the solution for the problem is where you get into really affecting the American senior population in some very fundamental ways.

In that, I think all are going to have to sacrifice. Liberals are going to have to sacrifice, conservatives are going to have to sacrifice, everybody is going to have to sacrifice. Seniors are going to have to sacrifice. Rich seniors are going to have to sacrifice. Hopefully poor seniors will not have to sacrifice much, but maybe they will, too.

All of which leads me, Dr. Johnson, to wonder what it was that caused you, in the middle of your otherwise, I thought, very interesting testimony, to sort of make a most unusual comment when you said, "It will not be necessary for doctors' fees to be reduced at all."

Dr. JOHNSON. First of all, Senator, with respect to that and to shared sacrifice, I never did like sacrifice very much, and I certainly do not like pain. So we have tried to construct a proposal that is positive, that does not look to pain, that does not look to sacrifice, it looks to rewarding people for using the system in a more cost-effective way. We have tried to figure out how to reward Medicare beneficiaries—we have a similar proposal in the private sector—for using the system in a cost-effective way.

Now, I have to inject, if I may, with all due respect, we are very frustrated about this. We first put a formal proposal to look at Medicare on the table back in 1986, and I cannot tell you how de-

lighted we are to have some conversation about it now. But please forgive us if we are getting more pushy with each passing year, because we foresaw a dilemma then, and we still do.

Senator ROCKEFELLER. It is not that question which I asked, though.

Dr. JOHNSON. I understand. But if——

Senator ROCKEFELLER. Why is it that a radiologist, for example, should expect us to reform Medicare, with all of the super-abundant dimensions of that, and then to have the head of the American Medical Association say, but we will not yield a dime on our salaries. That just baffles me.

Dr. JOHNSON. There is something intrinsically wrong with our system today. I want to make clear that I am not a defender of the status quo, and never have been. There is something intrinsically wrong with our system, where people who are cost effective are not rewarded for being cost effective. What causes that, in my judgment, is the insulation of the person consuming the services from the cost. That has a direct effect on the providers of services, as well as all the other players.

What we seek to do is to use the same kind of forces that make the economy work in all other sectors of our economy, which is to say market forces, bring about cost effectiveness by making providers of services like physicians and like hospitals accountable to the people who count, and that is the patients who consume our services. But we cannot do that unless we can figure out a way to link them to the cost.

Now, they do not want to be linked to the cost. But if we could then figure out a way to reward them for being linked to the cost, I think we could accomplish a more cost-effective delivery of services.

People like myself who pay a lot of attention to trying to do it better at less cost would be rewarded instead of punished by the system, the whole thing would work better, we would take the burden away from the younger people who now have an almost insurmountable burden and have more resources to pay for their own future needs, to speak to an earlier question you had. I believe our proposal is positive, Senator. It is intended to get to the right price for the right service at the right time and the needs of the patient.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Senator GRAMM. Well, let me conclude the hearing by thanking both of you for coming. I would like to say that this is really the beginning of the process. As we get closer to a formal proposal to be considered by the Finance Committee, we want to give you and every other element of the health-providing and the health-consuming community an opportunity to have an input. I would say that I think that there are more problems today in Medicare than there are solutions, but I think if we are going to find a solution, that we have got to recognize how severe the problem is. I see it like being in an athletic contest in doing what is called "putting your game face on."

I think that part of our problem in trying to face up to this problem in the past, is we have all started with our petty little political positions, claiming that this is what I am going to do as a Republican, or this is what I am going to do as a Democrat.

I think that one advantage of really getting people to understand the magnitude of the problem is that by getting people to look at it you reach the conclusion that this problem is huge, and that political considerations are a luxury that we just simply do not have.

It is like when banks were going broke left in right in my State and we were desperately trying to find new capital to invest in the banks, and of course people from all over the world were coming to buy up banks in Texas. We ended up with not a single locally-owned major bank.

I had a group of citizens come to see me in the midst of all this to say, well, what are you going to do to keep these people from New York, Chicago, and Los Angeles from buying our banks? I said, we already turned that corner 6 or 7 miles ago.

The alternative to having people come in, despite our State pride, and buy these banks is an economic calamity. I think basically what we have got to understand if we are going to find solutions, that there are a lot of good ideas out there, and we have got to sort through them.

We are not going to fix the whole problem in 1 year, but what we have got to do is get in the frame of mind different from our old positions which have been staked out by Democrats and staked out by Republicans, and recognize that this is where we are and this is where we are going to be. The problem is big enough that partisan thinking has got to go out the window. We are going to have to do some dramatic things at some point, and the longer we wait the more difficult it is going to be.

I think you have helped us in that. I want to thank both of you for your testimony. Thank you very much. We are adjourned.

[Whereupon, at 3:34 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF STUART H. ALTMAN, PH.D.

Thank you, Mr. Chairman, for the opportunity to testify before this committee on the critically important issue of the future of Medicare. My name is Stuart Altman, and I am the Sol C. Chaikin Professor of National Health Policy at the Heller Graduate School, Brandeis University. During the past 26 years I have had the privilege of working for the government in various capacities and I especially enjoyed my frequent involvement with this committee. Often, as Chair of the Prospective Payment Assessment Commission, a position I held for 12 years, I worked closely with the Congress on proposed changes to the Medicare program.

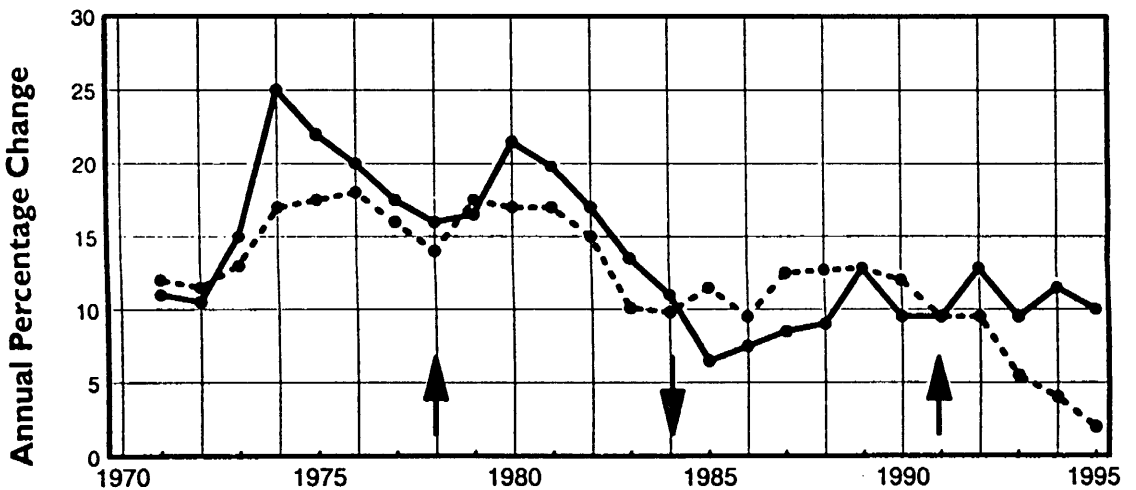
As I understand the focus of the hearing today, it is to look into possible long-run changes in Medicare to insure that in the future all Americans can access the appropriate health care they need when they retire. In particular, I was asked for my comments on a proposal submitted by Thomas Saving and Andrew Rettenmaier to create, "A Plan to Privatize Medicare."

First, let me state, that I do not share the negative assessment of the authors about the value that Medicare has been to this country. The beneficiaries of Medicare include, not only the millions of Americans who have received services paid by the program, but also their families who have been freed from the worry of potential bankruptcy following a costly illness of their parents or grandparents. In addition, Medicare has supported important components of the health system which provide a broader based social good such as biomedical research or the sole community rural hospital.

I also believe the views of the authors of why Medicare spending has grown so much is unfairly negative to the program. I do share their assessment, that without the open ending spending of third party payers, much of the high cost expansion of the health care system would not have been possible. But, such third party payers included private insurance as well as Medicare. In fact, between 1984 and 1991, total Medicare spending was below that of private insurance (see Chart 1). I also believe, a liberal payment policy was what most American's wanted of their health insurance. Nevertheless, the authors are correct. We cannot go forward with the same types of open ended coverage or payment systems. We already see some changes being made, lead by private managed care plans, to increase competition and consumer choice. But, Medicare too needs to change.

The budget submitted by President Clinton, includes several structural changes of the Medicare program which, I believe, begins this process. Medicare needs to become a more aggressive purchaser of services even within its traditional program. In the President's budget plan there are a number of proposals to do just that. But, much more comprehensive or radical changes are needed to help solve the longer term problems of the program. The Saving, Rettenmaier proposal attempts to deal with this problem by establishing a long term (50 years) plan to end the current Medicare program, and to substitute a Personal Retirement Insurance for Medical Expense (PRIME) account, to pay for the care of retirees.

Growth in Total Payments for Medicare and Private Health Insurance



Source: Congressional Budget Office, 1996 data from the Health Care Financing Administration, Office of the Actuary

CHART 1

I realize, Mr. Chairman, it is often easier to criticize than to develop an acceptable alternative. Unfortunately, I find myself in that situation today. While I have many questions about the PRIME plan and several serious concerns, I am not in a position, today, to offer an alternative plan which will provide the necessary protection and be fiscally sound. This is a project, we at Brandeis have begun to work on, and I hope you will have me back at some future time when I am better prepared to offer such an alternative. I would say, however, that I believe the long-term fiscal problems of Medicare are so serious that all options must be considered, including restructuring its benefits, changing the age of eligibility, and reallocating how much is paid by taxes and how much by beneficiaries. I also believe, we can not rule out the need for an increase in the funding mechanism, including increasing the payroll tax, if that is the preferred option.

With respect to the PRIME plan, let me indicate my concerns under two headings, first technical questions about the proposal itself and second, issues related to Medicare's funding for social goals.

TECHNICAL QUESTIONS

To prepare for this testimony, Mr. Chairman, I reviewed the article you wrote in the Wall Street Journal and several presentations of Thomas Saving and Andrew Rettenmaier which summarize the main aspects of their PRIME plan. The PRIME plan calls for the creation of a private Medical Savings Account system to replace the current Medicare social insurance system. Each eligible individual would be assessed a payroll tax to be remitted to a qualified private insurance company. In return, the insured would be provided, at a predetermined age, with both a catastrophic health plan (e.g. $2500 deductible) and a limited voucher which could be used to pay for all medical services not covered by the catastrophic plan. Any funds not spent at the end of the year from the voucher would be the property of the participant. What seems to be most important to the authors is that at some point in the future, "any payer's contribution into the system should belong to that payer to be used for medical expenses after age 65. Further, each payer's contribution MUST BE INVESTED IN THE ECONOMY AND NOT USED BY THE GOVERNMENT TO PAY THE EXPENSES OF CURRENT MEDICARE RECIPIENTS." (Bold added)

In your article, Mr. Chairman, you would gradually implement this plan over 50 years so that the payroll contributions of current workers would continue to support those currently eligible or becoming eligible in the next 25 years. Workers under 40 would contributed the current payroll tax contribution into their PRIME account which would provide them with a private insurance plan upon reaching age 65, since they will not be eligible for Medicare.

I have serious concerns about substituting a private insurance approach for the current Medicare social insurance system, but the long-term financial problems are so serious that I do not believe we should dismiss such a plan without a careful review. In that spirit, I have a number of questions concerning the Saving, Rettenmaier proposal. In my questions listed below I have accepted the authors statement that the existing tax rate would provide an acceptable insurance plan for younger workers when they retire. Even if this is true the following issues need to be addressed.

1. The authors strongly criticize the original Medicare planners for their underestimates of the cost of the program. But, how can we have confidence that the selected payroll tax rate for the PRIME system would be any more accurate than the one selected in 1965? For example, suppose medical science improves so that life expectancy grows by another 10 years? Would the plan cut back on benefits or require greater payments from beneficiaries?

2. How can we have confidence that non-employer based individual insurance would be even as successful as Medicare in controlling health care spending? Most analysts have little faith that a individual Medical Savings Account approach would be superior to Medicare? At best it is an untested concept which, hopeful, we will learn more about as a result of the recently passed demonstration program. Even if most beneficiaries join managed care plans, suppose private medical insurance inflation rates return to pre-1992 levels?

3. Even if the selected payroll tax rate is accurate for the average wage worker, what happens to those whose wages are below the average, or who have extensive periods of unemployment? Also, what would happen to spouses who choose to remain out of the labor force for long periods of time to raise a family?

4. If the PRIME fund is inadequate to meet the health needs of some (or many) participants, would we continue to require all private medical providers to supply them with needed services or will it be necessary to expand the public health care delivery system?

5. Both private health insurance coverage and Medicare have undergone significant benefit changes in the last 35 years, would the PRIME benefits, particularly those covered in the catastrophic plan, be allowed to change in the future? If these changes add to the outlays of the plan, would it be acceptable to increase the tax rate? If so, what happens to those currently receiving or about to receive benefits?

Let me now turn to concerns about funding for social goals.

FUNDING FOR SOCIAL GOALS

The current Medicare program includes substantial extra payments to certain types of institutions to help pay the costs of providing services that are considered social or public goods. As you know, Mr. Chairman, public goods are those where individuals can benefit even if they don't pay for them directly. A generally recognized public good is national defense. Since all inhabitants benefit, we should expect all to contribute and so it is paid for through the countries general tax revenue system.

In a similar way, we currently provide extra Medicare funds to three types of hospitals; teaching, disproportionate share, and rural, which Congress has judged to warrant special consideration because of the social benefits they provide. Medicare also pays more than is necessary in an open market sense for a variety of other services such as outpatient hospital care. With respect to teaching hospitals, Medicare currently provides an extra $6.3 billion annually to help compensate these institutions for the cost of graduate medical training. Private payers, in the past, also helped pay for these costs by paying higher rates to teaching hospitals than for similar patients in community institutions. In the current more price competitive environment, these higher private payments have fallen considerably.

Of concern in the PRIME proposals, what will happen to those institutions that currently receive these extensive Medicare social good subsidies? Since it is unlikely that private insurance companies will make up the difference or even continue to pay what they had in the past, will Congress consider creating a series of programs supported by general revenue for these institutions?

Medicare, and its payroll tax financing, has also been used as a mechanism to pay for the health care needs of several non-elderly populations such as those suffering from end-state renal disease, or those judged to be permanently disabled. In 1994, Medicare payments for end-state renal disease and the disabled was about $25 billion. What will happen to their coverage in a PRIME system? Clearly no private policy, which is paid for using an average tax rate, would be adequate to meet these added expenses unless an added rate is applied to each plan.

In essence, Medicare is currently a social insurance system which provides far more than individual coverage for its beneficiaries. If we replace the current Medicare system with a private insurance system, what happens to the social aspects of the system?

SUMMARY

I want to commend you, Mr. Chairman, for beginning the debate on how to solve the long-term financial problems of the Medicare program. Much as I question replacing the existing social insurance aspect of Medicare with a private insurance approach, there may be aspects of such a proposal which should be included in a revised Medicare structure. I also agree with the goals you stated in the Wall St. Journal, Mr. Chairman, that we should give beneficiaries a choice between competing health delivery systems including introducing the kind of competition that has already reduced private sector health care costs. But I think we can accomplish these goals and still retain many of the existing social insurance aspect of Medicare.

We are aware from recent political experience that the current system is valued highly by most Americans. They value the security of knowing they will receive health care in their elder years regardless of their circumstance. A private insurance approach does have the potential to deliver more services for lower tax payments. But like any investment, the chance for a higher return also entails increased risk that the reverse will occur. It is these risks, particularly to individual beneficiaries, that we should be careful about incurring.

If we adopt a private insurance approach we also will limit the funding for several important components of our health system which, in the past, have been judged to be socially deserving of subsidization. It is quite possible that, in the future, we may choose to end such social subsidies or create new funding mechanisms for their continuation. In the meantime, we cannot ignore the present needs of these programs for support. Nor, can we simply compare the cost of maintaining the existing Medicare system with one that excludes such expenses.

Thank you, Mr. Chairman, and members of the committee for allowing me to testify before you today on this most important public policy issue. I hope my comments will be of some assistance in your deliberations.

PREPARED STATEMENT OF JOSEPH R. ANTOS

Mr. Chairman and Members of the Committee, I appreciate the opportunity to discuss with you the outlook for Medicare spending and options for slowing its growth. Continued rapid growth in spending for Medicare means continued pressure on the budget in the short term, with the problem getting much worse when the baby-boom generation retires. In my remarks today, I will briefly summarize projections by the Congressional Budget Office (CBO) for the next decade and then focus on options for the long term.

CBO'S PROJECTIONS THROUGH 2007

Although the growth in Medicare spending has slowed since the late 1980s and early 1990s, CBO projects that it will continue to outpace the growth in resources that finance it (see Table 1). Total outlays for Medicare under current law will increase from $212 billion in 1997 to $317 billion in 2002, an average annual increase of 8.4 percent. By 2007, outlays will reach $469 billion, an average annual increase of 8.3 percent over the 1997-2007 period. Spending for Medicare will grow nearly twice as fast as gross domestic product (GDP) over the next decade.

TABLE 1. CBO's PROJECTIONS OF MEDICARE OUTLAYS AND GROSS DOMESTIC PRODUCT (By fiscal year in billions of dollars)

				Annual Growth Rates (In percent)	
	1997	2002	2007	1997-2002	1997-2007
Medicare Total	212	317	469	8.4	8.3
Hospital Insurance	137	202	290	8.0	7.7
Supplementary Medical Insurance	75	116	179	9.2	9.1
Gross Domestic Product	7,829	9,870	12,379	4.7	4.7

SOURCE: Congressional Budget Office.

Spending for the Hospital Insurance (HI) program is expected to increase at an average annual rate of 7.7 percent between 1997 and 2007. By contrast, HI noninterest receipts (primarily payroll taxes from current workers) will grow by 4.8 percent over that period. CBO expects the imbalance between outlays and receipts for HI to deplete the HI trust fund during 2001 (see Table 2). By 2007, outlays will exceed receipts by $130 billion, and the trust fund will have a negative balance of $556 billion. Postponing depletion of the HI trust fund through 2007 will require a cumulative combination of spending and receipt changes of more than $450 billion over the 1998-2007 period.

Spending for the Supplementary Medical Insurance (SMI) program is expected to increase at an annual rate of 9.1 percent between 1997 and 2007, whereas SMI premium receipts will grow by only 4.5 percent a year. The SMI program is funded primarily by general revenues, with enrollees' premiums currently covering about 25 percent of the costs. The percentage of costs paid from general revenues will steadily increase after 1998 when, under current law, the cost-of-living adjustment to Social

Security benefits will limit future premium increases. The SMI program is no more financially sound than the HI program, in the sense that both components of Medicare are growing more rapidly than the economy's capacity to finance them.

TABLE 2. STATUS OF THE HOSPITAL INSURANCE TRUST FUND
(By fiscal year in billions of dollars)

	1997	2002	2007
Income[a]	128	147	160
Outlays	137	202	290
Surplus (Income minus outlays)	-10	-54	-130
Trust Fund Balance (End of year)	116	-59	-556
Memorandum:			
Noninterest Receipts	118	148	189
Interest	10	-1	-29

SOURCE: Congressional Budget Office.

a. Income includes noninterest receipts (primarily payroll taxes) plus interest received on positive balances or paid on negative balances in the trust fund.

CBO continues to project relatively rapid growth in spending because Medicare's current reimbursement rules in the fee-for service sector which covers nearly 90 percent of beneficiaries give neither beneficiaries nor providers much incentive to limit costs. Further, Medicare's payments to health maintenance organizations (HMOs) that enroll beneficiaries are directly linked to its costs in the fee-for-service sector, thereby preventing the program from realizing savings from managed care. A variety of well-known policy options could be used in the short term to slow the growth in Medicare spending by enough to postpone depletion of the HI trust fund. However, if the options adopted leave Medicare's current structure intact, they are likely to prove insufficient for the long term, when Medicare will face unprecedented demands from the aging baby-boom generation.

THE LONG-TERM OUTLOOK

My remarks about the long-term outlook are based on Chapter 7 in CBO's August 1996 report, *Reducing the Deficit: Spending and Revenue Options*, which examined a range of approaches for reducing future spending commitments for Social Security and Medicare. Next month, CBO will publish a revision of that analysis, incorporating the latest projections from the programs' trustees. The estimates I will be presenting today use the new projections.

Although the federal deficit as a share of GDP has fallen to a 22-year low, that good budgetary news should not make us complacent because the retirement of the large baby-boom generation looms just over the horizon. Their retirement will greatly increase the costs of two government programs that are already large Social Security and Medicare unless changes in the programs are made.

In 1996, federal spending for Social Security and Medicare exceeded $500 billion, which was about 7 percent of GDP. By 2030, when most baby boomers will have retired, those two programs will consume nearly twice as large a portion of national income as they do today almost 14 percent. Nearly all of the increase in Social Security's share of GDP between now and 2030, and almost two-thirds of the increase in Medicare's share, will occur after 2010 as baby boomers become eligible for those programs.

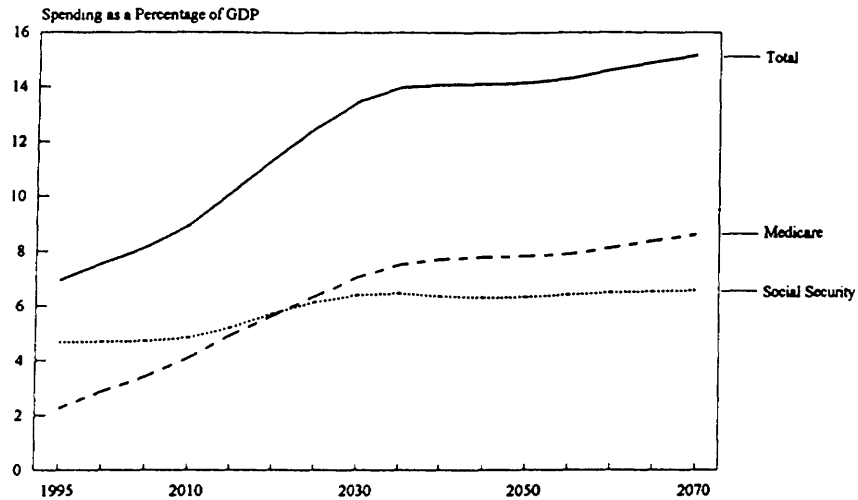
The projected increase in spending for Social Security is entirely the result of the expected surge in the number of people eligible for benefits. Spending on Medicare, however, is already growing much more rapidly than national income because of steep increases in costs per enrollee. Unless ways are found to reduce the growth

in Medicare's per capita costs, the addition of the baby boomers to the Medicare rolls will place an enormous burden on the federal budget and the economy. Indeed, federal spending on Medicare is projected to overtake spending on Social Security within 30 years (see Figure 1).

My remarks today deal only with approaches that might slow the growth of Medicare spending. Options that would reduce growth in spending for Social Security, however, are substitutes in the sense that a dollar saved in either program reduces the federal deficit by a dollar. The two programs have essentially the same beneficiaries, but there is an important difference between the two. Although federal savings from a change in the Social Security program translate directly into lower benefits paid to recipients, that is not necessarily so for federal savings achieved by changes in the Medicare program. In particular, changes that would reduce payments to health care providers would not necessarily reduce health care benefits for enrollees if those payments were used to deliver health care more efficiently.

If federal spending for Medicare could be kept from growing more rapidly than the economy when the baby boomers become eligible, the long-term outlook for the federal deficit and for the economy would improve dramatically. The illustrative goal used to develop the options that I will discuss today was to prevent net federal spending for Medicare as a percentage of GDP from exceeding 4.1 percent its projected level in 2010 under current law. Stabilizing the ratio of spending to GDP provides a convenient yardstick. Yet, in view of the magnitude of the demographic shift that will take place, it is not necessarily an appropriate goal. Reasonable people may differ about what proportion of GDP is appropriately spent on health care for the Medicare population. To achieve similar effects on the deficit, smaller reductions in Medicare spending than those discussed here could be combined with reduced spending in other government programs or with tax increases.

Figure 1. Projected Growth in Spending for Social Security and Medicare, Calendar Years 1995-2070



SOURCE: Congressional Budget Office based on intermediate assumptions from the 1996 reports of the boards of trustees of the Social Security and Medicare trust funds.

NOTES: GDP = gross domestic product.

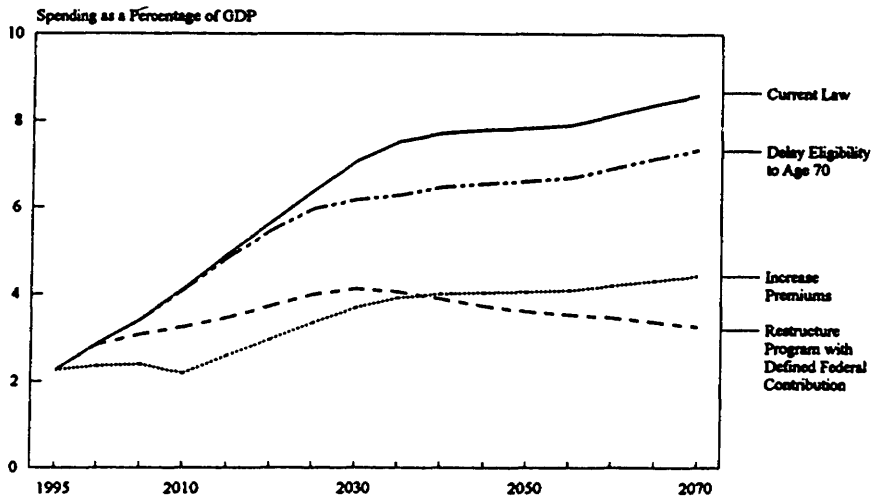
Data are plotted at five-year intervals. Medicare spending is shown net of premium receipts.

Medicare has been highly successful in achieving its original objective ensuring access to mainstream medical care for the aged and (later) the disabled. Unfortunately, though, Medicare's costs have become increasingly burdensome to the economy. In 1996, Medicare's spending net of premiums paid by enrollees was 2.4 percent of GDP. If no changes are made in current law, net spending would reach 8.6 percent of GDP by 2070, according to projections made by Medicare's trustees. Underlying those projections is an assumption that growth in Medicare's spending per beneficiary will gradually slow between 2005 and 2020 to be more in line with growth in national income per capita. That assumption may be optimistic, though, since no policies designed to achieve that result are currently in place.

Three fundamental approaches exist for slowing the long-term growth in federal spending for Medicare. The Congress could reduce the number of people eligible for benefits, collect more of the costs from beneficiaries without changing Medicare's structure, or restructure Medicare to reduce total health care costs per beneficiary (see Figure 2 for the estimated effects on net Medicare spending under a specific example for each of those approaches). One way to reduce the number of people eligible for benefits would be to increase the age of eligibility from 65 to 70. That approach would ultimately reduce federal spending for Medicare by about 15 percent compared with current law. Despite those considerable savings, net spending would continue to grow after 2010 as a percentage of GDP, reaching 7.3 percent of GDP by 2070. Further, that approach would do little to lower total health care costs, and it would lengthen the period of time in which people who opted for early retirement under Social Security might have difficulty getting private insurance coverage.

Under the second approach, premiums collected from beneficiaries could be increased to cover 50 percent of Medicare's costs (for both Parts A and B). Nearly all of those collections would represent federal savings because enrollees' premiums cover only about 10 percent of costs now, and that share will fall steadily after 1998 under current law. Using that approach would keep net Medicare spending as a share of GDP from rising above the target level until 2060. However, increasing premiums would shift costs to beneficiaries rather than constrain the growth in total health care costs. Without any changes to improve the efficiency of the Medicare program, FIGURE 2premiums would consume an ever larger share of enrollees' income. Indeed, Medicare premiums would equal nearly 30 percent of enrollees' income by 2070, compared with 3.4 percent in 1995.

Figure 2. Net Medicare Spending as a Percentage of GDP Under Alternative Options



SOURCE: Congressional Budget Office based on the Medicare trustees' reports for 1996.

NOTES: GDP = gross domestic product.

Data are plotted at five-year intervals.

A third approach to slow the growth of federal Medicare spending would be to restructure the program, giving patients and providers greater incentives to make cost-effective choices. One way to do that would be to set up a system of competing health care plans and limit growth in the amount that Medicare would contribute toward the premiums charged by the various plans. In such a restructured system, Medicare's fee-for-service sector could be one of the plans, competing for enrollees on the same basis as all other plans. Because enrollees would be responsible for any excess premium amounts (and would receive rebates for plans costing less than Medicare's contribution), they would have financial incentives to be prudent purchasers of health plans. Also, because plans would be at risk for any costs above their predetermined premium collections, they would have financial incentives to operate efficiently. Control of federal Medicare spending would be assured because the financial risks from higher growth in health care costs would be shifted to health plans and enrollees. Although the federal subsidy per enrollee would be smaller than it is under current law, competition among plans and providers could spur efficiency and increase real health benefits per dollar spent.

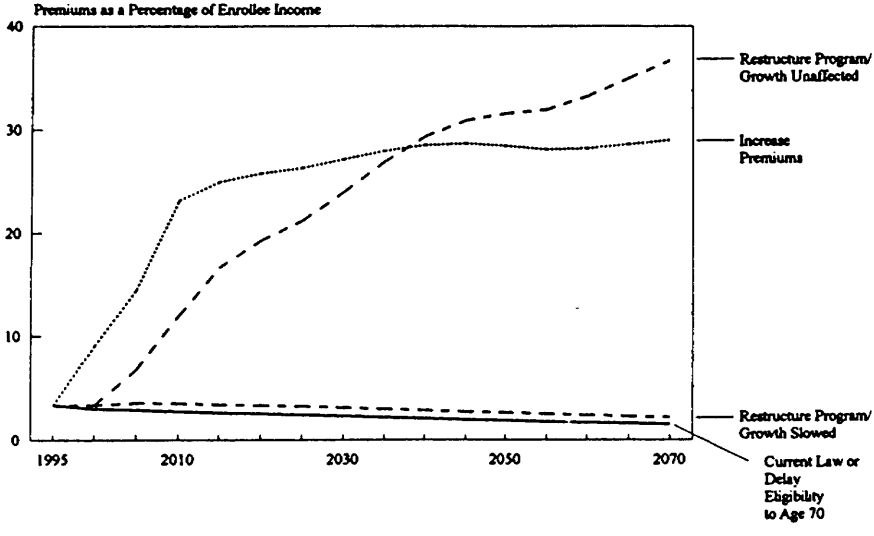
For example, Medicare's defined contribution could be set to equal net spending per enrollee in 2000, increased by 6 percent a year through 2005, 5 percent a year through 2010, and 4.2 percent a year thereafter. Under that option, federal savings would amount to 42 percent of currently projected spending by 2030 and 62 percent by 2070. That approach would keep federal spending from exceeding the target through 2030, and would keep it below the target in later years. Consequently, growth in the federal contribution might be increased (up to 4.9 percent a year) once the baby-boom generation had been fully absorbed.

However, the effects of that approach on total costs for a basic benefit package and therefore on the costs that beneficiaries would face are uncertain. If the incentives that would be generated for more cost-conscious behavior reduced annual growth in total costs per enrollee only to the rate assumed by Medicare's trustees

under current law, premiums paid by enrollees would steadily increase reaching 37 percent of their average income by 2070 (see Figure 3). If, instead, growth in costs per enrollee was slowed to match the annual growth in the federal defined contribution, premiums would represent only 2.2 percent of the average income of enrollees in 2070.

In practice, the effects would probably differ among various enrollee groups. Some basic plans would keep their costs low enough to avoid having to charge supplemental premiums, but access to providers and quality of services available in those plans might limit their appeal primarily to low-income enrollees. Higher-income enrollees might gravitate instead to plans that charged supplemental premiums and provided better access and quality.

Figure 3. Premiums as a Percentage of Enrollee Income Under Alternative Options



SOURCE: Congressional Budget Office based on the Medicare trustees' reports for 1996.

NOTE: Data are plotted at five-year intervals.

Costs must be reduced substantially if net federal spending for Medicare is to be limited as a percentage of GDP (see Table 3). To keep net spending at or below 4.1 percent of GDP, savings equal to about 50 percent of currently projected spending must be generated annually from 2010 onward. By contrast, the maximum savings expected from the Balanced Budget Act of 1995 were only about 20 percent of projected Medicare spending for the 1996-2002 period.

CONCLUSION

Exactly how much budgetary stringency is needed and how to achieve it are open to debate. What is clear is that Medicare must prepare for the unprecedented demands that the baby-boom generation will soon impose on it. Policies put in place over the next several years could provide necessary deficit reduction in the short term and start the restructuring needed for the longer term.

TABLE 3. EFFECTS OF THREE ILLUSTRATIVE OPTIONS FOR REDUCING GROWTH IN NET SPENDING FOR MEDICARE (In percent)

Option	2010	2030	2050	2070
Net Federal Spending as a Percentage of GDP				
Continue Current Law	4.1	7.1	7.8	8.6
Delay Eligibility to Age 70[a]	4.1	6.2	6.6	7.3
Collect 50 Percent of Costs from Premiums[b]	2.2	3.7	4.1	4.4
Restructure the Program and Limit Growth in Defined Contribution to 4.2 Percent a Year[c]	3.3	4.1	3.6	3.2
Savings as a Percentage of Projected Spending				
Delay Eligibility to Age 70[a]	1	13	16	15
Collect 50 Percent of Costs from Premiums[b]	47	48	48	49
Restructure the Program and Limit Growth in Defined Contribution to 4.2 Percent a Year[c]	21	42	54	62

SOURCE: Congressional Budget Office based on the Medicare trustees' reports for 1996.

a. The age of eligibility for Medicare would be increased to 70 by 2032, phased in from 2003.

b. Premiums for Medicare enrollees would be increased to cover 50 percent of total Medicare (HI and SMI) costs by 2010.

c. Medicare's per-enrollee contribution in 2000 would be set at total per capita costs less 25 percent of Part B costs. That amount would be increased by 6 percent a year through 2005, 5 percent a year through 2010, and 4.2 percent a year thereafter.

Although federal spending for Medicare could be reduced by increasing the premiums or cost-sharing requirements imposed on beneficiaries, that approach by itself, without changing the options available, could threaten access to medical care for some enrollees. It would reduce federal costs by shifting them to beneficiaries (or to Medicaid, for dually-eligible beneficiaries) with little improvement in the mechanisms that might limit growth in the total costs of care.

Broader policy goals would be served by putting policies in place that would slow the growth in total (not just federal) costs of services used by Medicare beneficiaries. Such policies would encourage both beneficiaries and health care providers to make more cost-effective choices than many do now. If successful, that approach would reduce the resources used for health care while ensuring that enrollees would have continued access to medical care. Whether such efficiencies would be achieved, however, is uncertain and would depend on the policies adopted. The one certainty is

that Medicare will come to consume an enormous share of national income unless significant changes are made in the program.

PREPARED STATEMENT OF STUART BUTLER

My name is Stuart Butler. I am Vice President for Domestic Policy Studies at The Heritage Foundation. I am also a member of the steering committee of the National Academy of Social Insurance's project on long term Medicare reform. I must stress, however, that the views I express are entirely my own, and should not be construed as representing the position of either organization.

I can summarize my testimony in three points:

(1) The finances of Medicare are hopelessly and permanently out of balance. Without structural reforms the program will in the future provide increasingly inferior care at staggering cost to taxpayers.

(2) It is time to think "outside the box" about structural reforms, and to consider now the implications of radical changes.

(3) Within the current system, there are important structural changes that should be put in place as soon as possible. And there are a number of short term steps that can and should be taken now that will begin to institute new incentives and new arrangements. These will prepare the program for change and enhance the effectiveness of structural reforms.

MEDICARE'S FINANCIAL PLIGHT

I have provided the subcommittee with several charts assembled from the most recent Medicare Trustees' report. These are attached to my testimony. They indicate unambiguously two very unpleasant truths.

The first is that the Medicare HI trust fund not only is headed into structural insolvency, but the deficit in that part of the program is not a temporary problem—the picture becomes bleaker the further into the next century the trustees' project (using even the most favorable projections).

The second is that while some temporary accounting respite can be achieved by shifting obligations, such as home health care, from the HI trust fund into the SMI program, that would simply add to the taxpayer financed deficit in Part B. Such a shift is like paying off your overdue credit card balance with a check on your overdrawn personal checking account—it just shifts the problem around but solves nothing.

As the trustees and the CBO have pointed out, the Medicare program as a whole will place enormous strains on the economy and taxpayers in future years. The CBO noted recently, for instance, that the share of GDP devoted to Medicare (net of premium income) will rise from 2.3 percent in 1996 to 4.1 percent in 2010, and to 8.6 percent by 2070.

When one considers what would have to be done to maintain the program under its current design, the scale of the task becomes all the more daunting. Absent any reform, and using the trustees' 1996 projections, Medicare HI can continue after 2001 only if Congress drastically cuts services or tries to keep the HI program afloat with tax increases. But the level of new taxes needed (either payroll taxes or general revenue) would be staggering. The 1996 report indicates that the cumulative deficit in the trust fund (that is, the extra money needed to maintain services) would be over $400 billion by 2005. In that year alone outlays would exceed income by over $100 billion, and the annual red ink would be accelerating.

Just to continue hospital services until 2005, the bailout cost to the average American household would be about $4,000 in new taxes.

But that is just Part A. The taxpayer-funded element of Part B is already rising sharply. Under current law, say the trustees, taxpayers will have to cover 84 per cent of Part B costs by 2005 and an increasing proportion thereafter. According to the trustees' figures, the cumulative taxpayer subsidy between 1996 and 2005 alone will be $950 billion, or roughly $10,000 in taxes for the average American household. The figures for succeeding decades will be even larger.

Taking the two parts of Medicare together, to keep the program afloat just until 2005, without reforms, will take about $14,000 per household in taxes—covering the projected Part B deficit and the taxes needed to maintain balance in the HI fund. Moreover, the rate at which the projected shortfall progresses would increase sharply after 2005, making the cost much higher in later decades.

Trying to bridge the fiscal chasm by squeezing costs appears to be a hopeless task. Trying to rein in Medicare spending to levels in line with the growth of GDP would impose draconian reductions in the quality and availability of care.

THINKING DIFFERENTLY ABOUT MEDICARE

Given this financial picture, I believe Congress has two tasks. The most important is to reassess the entire Medicare program, considering entirely new ways to provide for the health care of the elderly and disabled. This task involves not only an evaluation of very different designs for Medicare, but also a rethinking of the basic "social contract" implicit in Medicare.

A number of blue-sky proposals have been advanced for the reform of Medicare. One intriguing idea is to permit working Americans to place their Medicare tax payments into a personal account, which could be used during retirement to purchase care and insurance. Among the advantages of this proposal is that it would actually create the personal accounts that many Americans—erroneously—believe actually exist today. It would also discourage elderly Americans in the future from viewing Medicare as an unlimited obligation on their neighbors. It would encourage working Americans to consider lifestyle choices (such as preventative care and refraining from smoking) that would reduce the likely costs of their retirement care. And it would allow and encourage retirees to seek the most cost effective care for their needs.

Like any radical change in the current system the proposal raises questions for Congress to consider. Among these would be the issue of how would this individualized savings/insurance approach square with the objective of ensuring that all retired and disabled Americans could afford at least a basic level of care? Of course the current system increasingly faces this same problem, given the financial pressures it is encountering. The proposal merely forces discussion of an issue which needs to be addressed in any case.

Today's Medicare consists of a social insurance element (since the income-related payroll tax entitles Medicare beneficiaries to a range of services regardless of the contributions made) and an element that is subsidized without regard to income (Part B). Moving to individualized savings/insurance would require a more explicit, separate subsidy of social objectives. That explicit subsidy would address low-income workers who could not accumulate sufficient funds for reasonable retirement care. It would also have to address objectives currently "hidden" within the social insurance framework of Medicare, such as the subsidization of medical education and the needs of high-cost hospitals serving poor neighborhoods.

Another approach to this issue of social versus individual insurance, which could help shape more immediate reforms, would be to redefine the elements of Medicare in a different way.

- A financially-sound social insurance element (call it Part A) that covers a modern set of core services (including drug benefits and physician services), but with higher out-of-pocket beneficiary costs than today.
- A strictly means-tested tax-supported element (call it Part B) that simply provides financial assistance to offset some Part A costs and part of the cost of health services not included in Part A. Congress would set a fixed multi-year budget for Part B. This would mean ending the non-income related subsidy under the current Part B.

A second major issue would of course be how to deal with the cash-flow problems of the current system if some Medicare payroll tax payment were instead diverted to individual accounts.

To be sure, the immediate effect of this would be to add to the financial stress in the program. But the long-term obligations of the program also would be significantly reduced, which must be one of the most important goals of any reform. Moreover, covering the next several years of Medicare obligations is something that working Americans will in any case have to face. Doing so in the context of structural reform is surely more attractive that doing so without taking significant steps to make the program more sound for their retirement years.

IMMEDIATE ACTION

Whatever long term changes are contemplated by Congress, actions are also needed to change the incentive system in the current program, to move away from the unlimited Part B subsidy without regard to income, and to begin to create the framework needed for structural change. Over the medium term, the changes I propose are compatible with a shift to a more individualized savings/insurance, as well as alternative structural reforms.

The immediate changes I propose are designed to accommodate two structural objectives:

(a) A sounder social insurance element, with general revenue subsidies based on need.

(b) An FEHBP-style system of competing plans available to beneficiaries. In this system, HCFA would manage the finances of Medicare, provide quality and other information on plans, and set standards of operation for plans. Like the Office of Personnel management in the FEHBP system, HCFA would not have a detailed regulatory and fee-setting role. A separate government-appointed board, answerable to Congress, would operate and fine-tune the "traditional" Medicare in all areas. In this arrangement, Medicare would provide a defined financial contribution (a combination of Part A and Part B benefits) to the plan chosen by the enrollee.

With these objectives in mind, Congress should take a number of steps this year. Among them:

1) Change the statutory standards for Medigap policies.

The combination of a unduly small deductible for Part B and Medigap requirements that virtually require first dollar coverage drive up the cost of Medicare and the price of Medigap plans. Congress should maintain the idea of categories of Medigap plans, to reduce confusion among the elderly and exploitation by insurers. But Congress should change the rules applying to those categories. Among the most important changes, no plans should be required to cover the Part B copayment or deductible, or the Part A deductible.

2) Raise the Part B deductible to at least $300 per year, using some of the savings to reduce the Part B premium for lower-income beneficiaries, and introduce means-testing for upper-income beneficiaries.

The $100 deductible for Part B is expensive for the program—and hence taxpayers—and increases the incentive to overutilize services. It also requires Medicare to maintain a relatively high premium, which in turn makes it politically difficult for Congress to introduce means-testing of this tax-supported, voluntary component of Medicare.

In addition, there is no means-testing in Part B. This is indefensible, as well as costly, because Part B is not a social insurance program but a subsidized, voluntary insurance program unconnected to the payroll tax. And while Part B escapes an income adjustment, both Part A (through the income related payroll tax) and Social Security (through the taxation of benefits as well as the flat payroll tax) have some element of means-testing.

A reasonable increase in the Part B deductible not only would save money: it would also be one of the first steps needed for a restructuring of Part B. Former HCFA actuary Guy King has testified that, based on 1996 Medicare spending, the Part B premium could be reduced to $4 per month if the deductible were raised to just over $1,000 annually. King maintains that the combined deductible/premium change would mean little or no increase in the average out-of-pocket cost of Part B and would have saved $4.8 billion in outlays in 1996 due to reduced utilization.

It is unlikely that beneficiaries would accept the increase in deductibles King proposes, even with a sharp reduction in premiums. But raising the deductible to around $300, while reducing premiums for lower-income beneficiaries, might be accomplished. Even without immediately raising other premiums, the step would introduce the principle of means testing while achieving savings in net Part B outlays.

3) Introduce a budget for net Part B outlays, in place of the formula for establishing premiums, and vary premiums accordingly

Under current law, the Part B premium increases will soon be based on the cost-of-living adjustment for Social Security payments. Thus unless the annual cost increases of Part B services fall below increases in the general cost of living, and the per capita volume of services does not rise, taxpayers will pay an ever-larger share of Part B costs. Indeed, the 1996 trustees Report estimates that taxpayers will pick up and average of 84 per cent of costs by 2005 and a higher percentage thereafter—without regard to the income of the beneficiary.

The original Medicare program split the cost of Part B equally between the beneficiary and the taxpayer. The current arrangement not only means an unlimited financial exposure for taxpayers, but it also means beneficiaries have no incentive to accept any limits in their benefits—and every incentive to push for even higher benefits—because programs costs will have no effect on their premiums. This premium formula must be altered immediately if Part B costs are to be constrained in the near term and the program ultimately reformed. The longer the formula is left in place, the greater will be the beneficiary opposition to reform.

The case has been made often for returning to the original principle of beneficiaries and taxpayers sharing the cost of the program. Even if warranted, there is little chance that Congress would consider such a change today. But the goal should be to place in the hands of Congress the power to decide how much the tax-

payer will contribute to Part B. Congress should decide what the net subsidy shall be and set a budget accordingly, as well as the corresponding premium.

4) No longer base HMO payments on local fee-for-service costs. Instead base the capitation payment on the local managed care market.

Medicare is discovering today what private corporations discovered and corrected almost twenty years: setting capitation payments to HMOs at 95 percent of the average fee-for-service costs typically costs money rather than saving it. Private corporations abandoned formula payments of this kind and instead shop around in the managed care market, agreeing to market-price contracts to save money. By contrast, the strict formula in Medicare not only invites cherry-picking by HMOs, but in some markets means HMO are universally overpaid, and in others underpaid (meaning quality suffers or modest potential savings from managed care are not obtained).

Simply reducing the capitation rate to 90 percent is a crude reform that would cut losses in some markets but reduce the potential for long-run savings from adjusting Medicare payments to actual market conditions. Moreover, cutting all payments to HMOs invites the opposition of all HMOs. Adjusting more closely to local HMO markets would avoid united opposition. And while it would save money by allowing capitation rates to be reduced blow 95 percent in some markets, it would also permit savings by adjusting payments upward in others (particularly in markets where HMO penetration is low and raising capitation amounts would stimulate money-saving switching to HMOs).

5) Introduce an annual or biennial "open season" for switching between the traditional fee-for-service program and HMO coverage—or any other type of plan permitted by Congress

Under current law, beneficiaries may switch in and out of risk contract HMO coverage within a month. This allows beneficiaries to game the system and adds to costs. Introducing an annual or biennial period in which binding annual coverage decisions are made would reduce this problem and would establish the necessary procedures for a more comprehensive later reform to permit enrollees to choose from a variety of plans. The open enrollment period could be at a fixed time in the calendar year (the FEHBP model) or during a period related to each beneficiary's birthday.

6) Introduce a 20 percent copayment for home health services

Home health care services are now one of the fastest-growing components of the Medicare program, rising at an annual growth rate between 1983 and 1995 of over 20 percent. Worse still, being in mind our experience with the overall Medicare program during the last three decades, the design of the benefit is virtually guaranteed to explode future costs. Benefit are paid on a "reasonable" charge basis, which means the government is essentially a "price-taker." Moreover, volume is encouraged by the rather subjective assessment of need—many Medicare-paid home visits, for instance, may simply be a substitute for what many Americans would consider the normal responsibility of adult children.

To be sure, home-based services can be sensible, and money-saving feature of good health care. Thus any long term reform of Medicare must include careful reforms that will allow home-based services to be an integral part of the overall program without the current incentives for questionable and heavy use. Introducing a copayment to discourage excessive demand would be a first step to structural reform.

7) Separate the management of the overall Medicare program from the management of traditional fee-for-service Medicare, and create a semi-independent board for the latter.

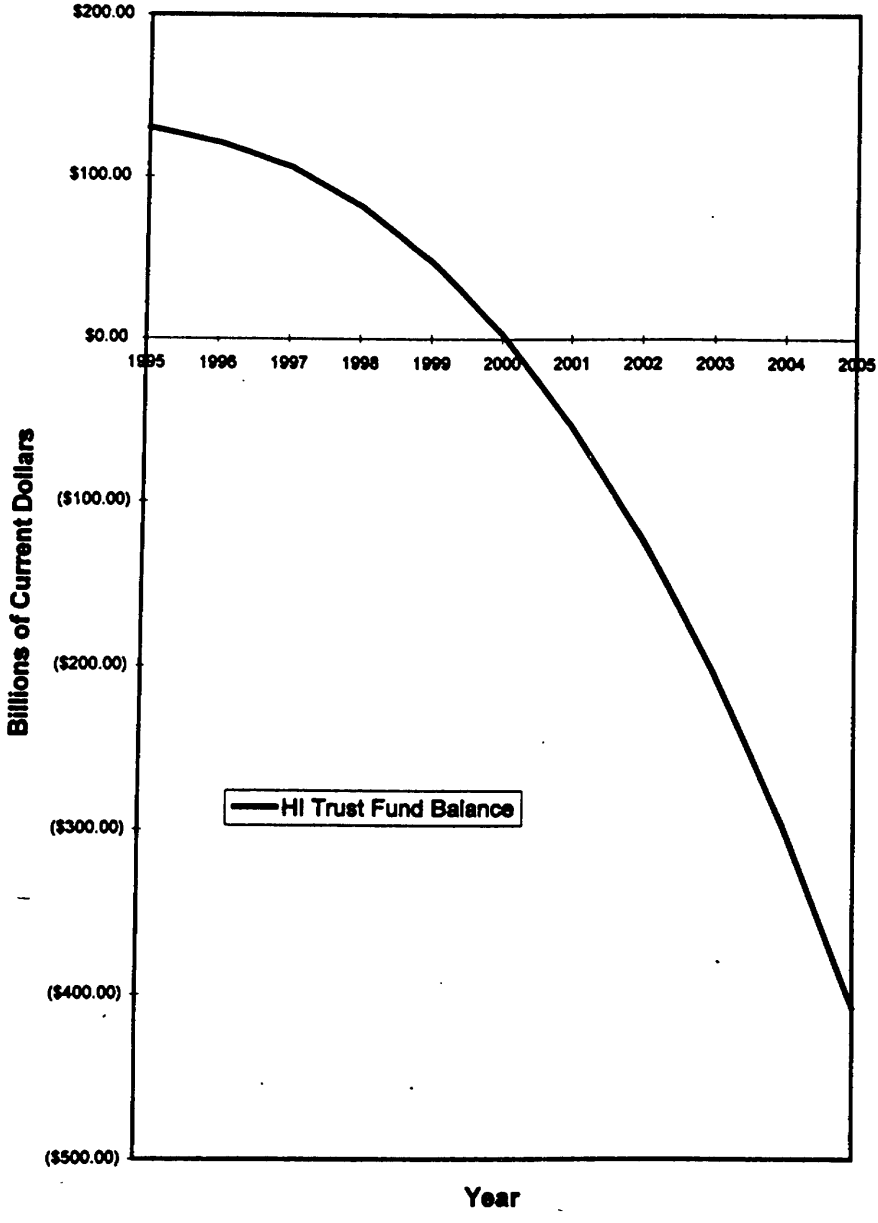
If an ultimate goal is a system in which beneficiaries can choose from a range of competing plans, it would seem unwise to maintain the current blending of HCFA's role as manger of the entire system with its role of running one of the plans (the traditional fee-for-service plan). Allowing that dual role to continue would make fair competition less likely: it would be like a baseball umpire owning one of the teams. Moreover, with all details of the traditional program run directly by a cabinet department and Congress, even the most minor changes and decisions become politicized.

Splitting HCFA's general management and oversight of the entire program from the management of the traditional program would allow two different cultures to develop. One culture, remaining firmly within HHS, would focus on the overall functioning of Medicare, its finances, and on steps to improve all services from any provider—such as developing usable quality measures. This would be roughly the role the office of Personnel Management plays within the FEHBP. The other culture

would focus on how to make the traditional program a better service for the elderly and disabled—in other words, customer service.

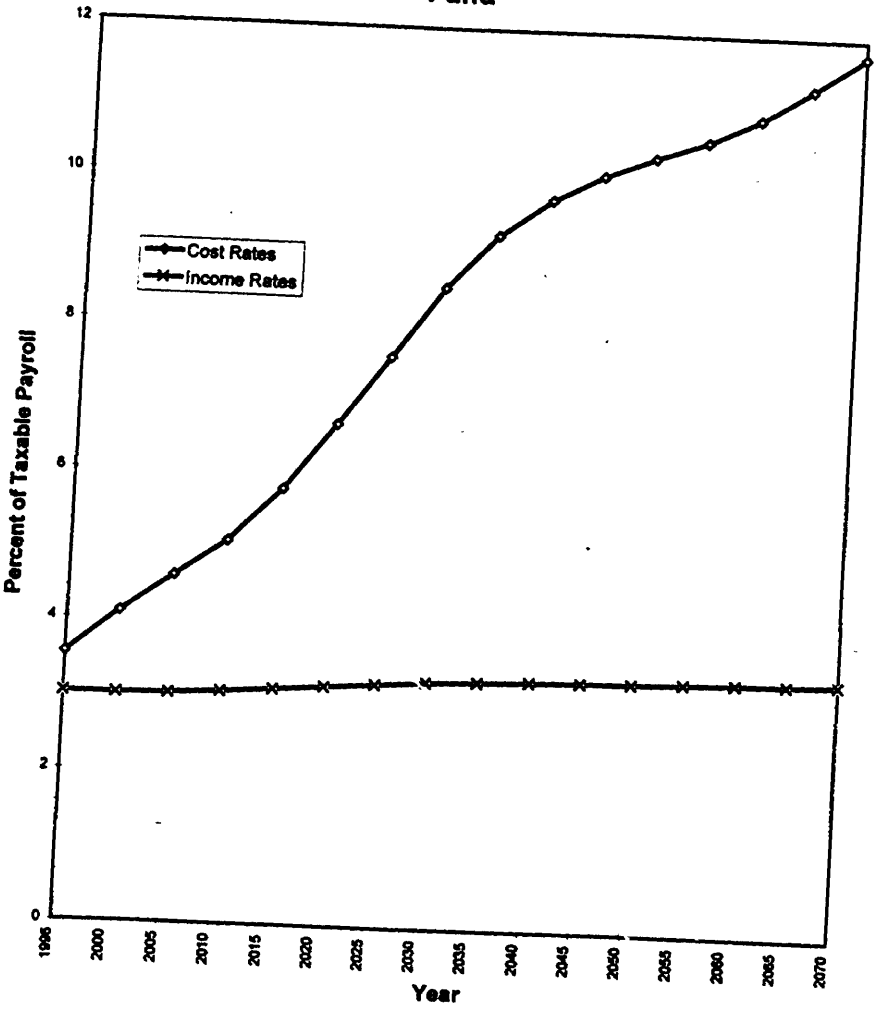
In combination with this separation of responsibilities, the management of the traditional program should be vested in a board that is independent of HHS, chosen by Congress and answerable to it, and with limited powers to adjust benefits and payments.

Estimated Operations of the HI Trust Fund

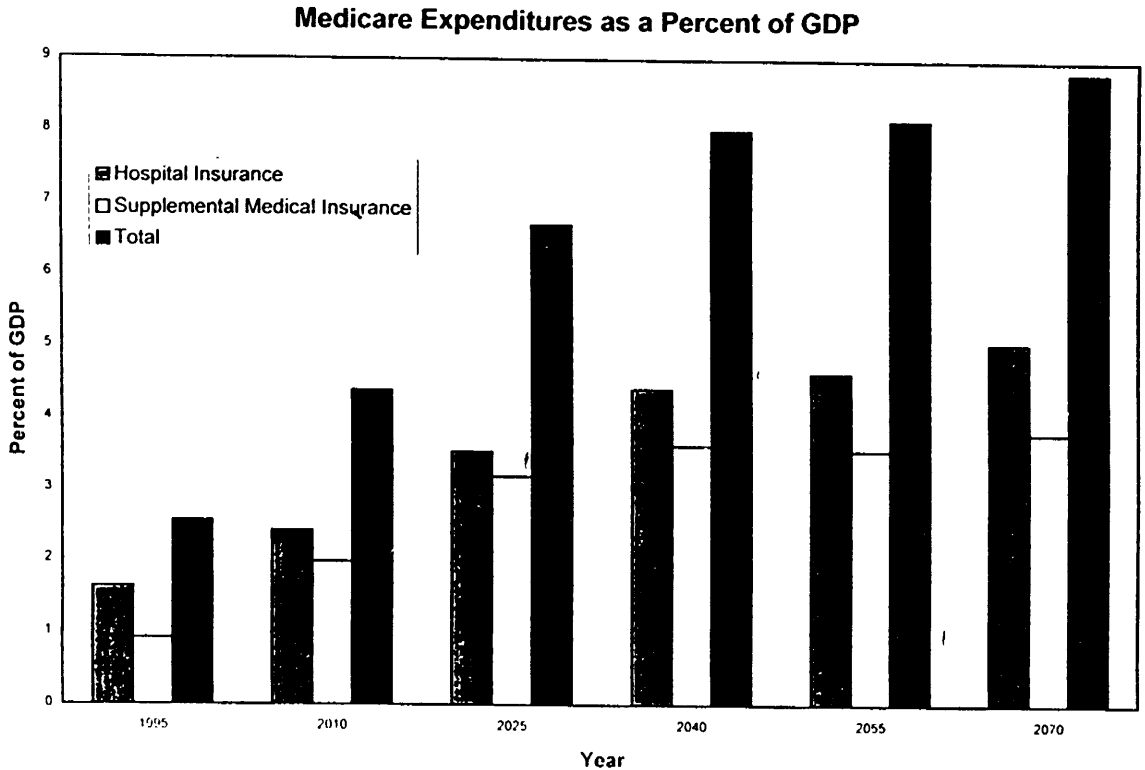


Source: 1996 Trustees' Report

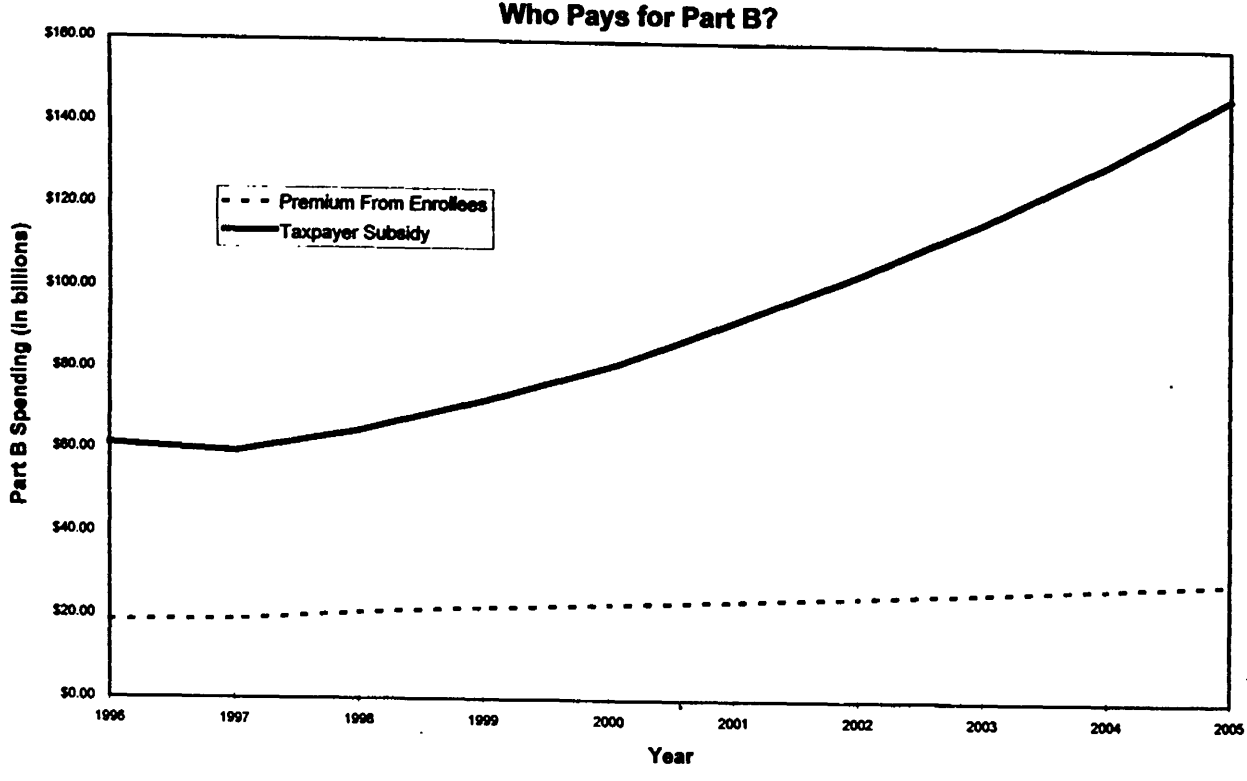
Projected Cost and Income Rates of the HI Trust Fund



Source: 1996 Trustees' Report, Intermediate Assumptions



Source: 1996 Trustees' Report



Source: 1996 Trustees' Report

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PREPARED STATEMENT OF DICK DAVIDSON

Mr. Chairman, I am Dick Davidson, president of the American Hospital Association. The AHA represents nearly 5,000 hospitals, health systems, networks, and other providers of care. Medicare plays a major role in the everyday efforts of our members to deliver care in their communities, and we appreciate this opportunity to present our views on the long-term financing of the program.

The impending financial collapse of Medicare has been topic number one in a lot of places for much of the 1990s. It has been the subject of news stories and of congressional hearings. In 1996, Democrats, Republicans and special interests—including the AHA—aired thousands of television and radio ads, dropped millions of pieces of mail, and spent tens of millions of dollars fighting about Medicare. And what do we have to show for it? During that time, the Medicare trust fund continued to lose billions of dollars. Maybe it's time for a different approach. Why?

Because Medicare is an issue surrounded by myths. Until we destroy those myths, the same confusion will continue to reign over Medicare. And the program will continue its slide into bankruptcy.

I would like to begin by exploding a few myths about Medicare that reflect the problems we face. Then I will offer two key solutions that can keep Medicare strong for generations to come: restructuring of the program; and an independent commission to help Congress make the tough choices that lie ahead.

EXPLODING THE MYTH: MEDICARE IS NOT GOING TO BE AROUND FOR FUTURE GENERATIONS.

Three-quarters of voters under the age of 40 believe that Medicare is unlikely to be around when it comes time for them to collect benefits. The fact is that Medicare will continue to serve our nation's seniors, because the American people will demand it. For more than 30 years, Medicare has been one of our nation's most successful health care initiatives. It has helped keep millions of elderly Americans healthy and has dramatically lowered the number of elderly who live in poverty. Medicare is good for America, and Americans know it. The question is what form will it take in the future?

EXPLODING THE MYTH: MEDICARE IS A TRUST FUND.

Many Americans believe the payroll taxes that are taken out of their paychecks and earmarked for Medicare are placed in a trust fund—a bank account, of sorts, from which they themselves will be provided Medicare benefits when they retire. Of course, the fact is that today's workers pay taxes that are used to care for today's Medicare beneficiaries. Currently, it takes the payroll taxes of four workers to support one Medicare beneficiary.

The Hospital Insurance Trust Fund, which is used to pay Part A benefits, is financed by an earmarked payroll tax. But the taxes going into that trust fund are already insufficient to cover the benefits being paid out. To make up the difference,

the reserves that have been built up in the Part A Trust Fund are being depleted. By the year 2001, they will be gone.

EXPLODING THE MYTH: MEDICARE CAN BE SAVED BY REDUCING PAYMENTS TO PROVIDERS.

This simply doesn't add up. For instance, the President's current budget proposal, which relies almost entirely on cuts in provider payments, would reduce payments to hospitals by $38 billion over five years. This reduction, when combined with all of the President's proposals, would still only extend the life of the Hospital Trust Fund for a short period—until the year 2007. Further arbitrary reductions in provider payments would do more harm than good. They would postpone the Trust Fund crisis for a short time, but at the same time threaten the ability of providers to maintain the very programs and services that Medicare beneficiaries—and others—rely on.

The enormous gap that will continue to widen over the years between Trust Fund spending and revenues simply cannot be remedied through provider cuts alone. A continued reliance on provider cuts will not solve the problem, and could do serious harm to the delivery system.

EXPLODING THE MYTH: PROVIDERS ARE DOING WELL ON MEDICARE AND CAN AFFORD SUBSTANTIAL PAYMENT CUTBACKS.

Recent ProPAC hospital financial performance data may encourage this belief. Unfortunately, it is not true. Many hospitals are struggling financially—so reductions in Medicare payments to hospitals will hurt. First, it's important to note that ProPAC's findings apply solely to Medicare inpatient services. Second, at the same time ProPAC reported these Medicare PPS inpatient margins, it also estimated that approximately forty percent of the nation's hospitals lose money when they treat Medicare inpatients.

More important, 20 percent of hospitals have negative total margins, meaning that, overall, they are losing money on all patients served. Government payment sources pay less than the cost of providing care. In the aggregate (including both inpatient and outpatient services), Medicare pays only 97 cents on the dollar, according to ProPAC, and Medicaid pays less—a critical difference for those hospitals that do not have enough privately-paying patients to make up the difference.

For roughly 1,000 hospitals, representing one in five of the nation's community hospitals, Medicare and Medicaid combined represent more than two-thirds of total revenue. Many are already in weakened financial positions, with roughly 10 percent of these hospitals experiencing bottom-line losses for three years in a row, considering all sources of revenue. These hospitals are vital resources in their communities; many serve a large number of elderly citizens.

While it's true we need to rationally reduce our excess hospital capacity, placing at risk many hospitals in rural and inner-city areas with high Medicare and Medicaid populations does not qualify as a rational approach.

EXPLODING THE MYTH: MEDICARE CAN BE SAVED BY ELIMINATING FRAUD AND ABUSE.

Nearly 30 percent of Americans believe that, by cracking down on fraud and abuse, we can prevent the bankruptcy of Medicare. Again, this just does not add up. America's hospitals and health systems wholeheartedly support efforts to rid our health care system of abuses. In 1992, the General Accounting Office (GAO) estimated that 10 percent of health care costs are attributable to fraud and abuse. Other studies dispute this, saying the cost is less than half of that. Nevertheless, such costs should be eliminated. But doing so is not a long-term solution. And, to illustrate how difficult solving this problem could be, the President's budget proposal claims savings of less than $2 billion over five years by targeting fraud.

EXPLODING THE MYTH: SOLVE MEDICARE'S SHORT-TERM FUNDING PROBLEM, AND THE LONG-TERM WILL TEND TO ITSELF.

This is perhaps the most damaging myth of all. It has led to budget proposals from Congress and the Administration that would shore up Medicare funding for a few years—at the most—when the real crisis lies down the road. The real crisis: In the year 2011, the first of the nation's 77 million baby boomers will turn 65. And, not too long after that, there will be only two workers supporting each enrollee, instead of the four workers supporting each enrollee today. Will those two workers be expected to carry the same burden that four are carrying today? Something will have to be done, because, as the Medicare program is currently structured, beneficiaries do not cover their own costs. For instance, an individual retiring in 1995,

after earning average wages, has spent much of his working life contributing payroll taxes into the trust fund. Still, CBO estimates that his total contribution of payroll taxes and Part B premiums will add up to only 38 percent of his expected lifetime Medicare benefits. For someone retiring in 2005—who has contributed payroll taxes to Medicare since age 26—the contribution of taxes and Part B premiums still adds up to only 42 percent of total benefits.

It is clear that, in order to maintain the solvency of the Medicare program, we need long-term solutions, and that those solutions will demand that we make tough choices. Therefore, we need to restructure the Medicare program, and we need to create a permanent, independent commission.

RESTRUCTURING MEDICARE

We would like to applaud those members of Congress and of this subcommittee who are seeking real restructuring of the Medicare program. We believe there is a need to begin to restructure the Medicare program in three specific areas: expanding beneficiary options by allowing them to choose PSOs; making payments to health plans more equitable; and moving toward a defined contribution that guarantees a minimum benefit package.

PSOs—We can expand the coordinated care options that Medicare beneficiaries have by allowing provider sponsored organizations (PSOs) to contract directly with Medicare.

PSOs are community-based, formal affiliations of hospitals, doctors and other health care providers who come together to provide high-quality health care to the people and communities they serve.

PSOs can expand the choices Medicare beneficiaries have, putting medical decisions in the hands of local providers who know best how to balance efficiency and patient care, and giving Medicare the same tools the private sector uses to increase efficiency.

PSOs hold special promise for rural and underserved areas of the nation, areas where HMOs won't go because there simply aren't enough patients. Allowing health care providers who are already part of the community to build local networks in such areas could literally save access to care for the citizens of those communities.

Bipartisan PSO legislation has been introduced in the Senate (S.146) by Senators Jay Rockefeller (D-WV) and Bill Frist (R-TN), and in the House (H.R.475) by Reps. Jim Greenwood (R-PA) and Charles Stenholm (D-TX). We strongly urge this committee to support this legislation.

Payments to health plans—When Medicare beneficiaries join managed care plans, Medicare pays an up-front, monthly, per-person amount based on the adjusted average per capita cost (AAPCC). The AAPCC is a formula by which Medicare determines the average cost of providing care to beneficiaries in a particular area. Given the wide variations in historic fee-for-service utilization patterns, there is a resulting wide variation in health plan payments—more than 300 percent among counties across the United States. We believe these payments should be made more equitable across the United States in a way that will allow more communities to establish coordinated care networks like PSOs.

We also support proposals to remove, or "carve-out," graduate medical education and disproportionate share hospital payments from Medicare payments to managed care plans. This would ensure that the payments go directly to the entities that incur the costs of those programs.

Defined benefit vs. defined contribution—This topic has sparked much controversy. It almost explodes another myth: that Medicare must always remain a defined benefit program as it is today. Those in the defined benefit camp call for a range of services to be provided by Medicare, regardless of cost. Those in the defined contribution camp call for a bottom line amount to be spent per beneficiary, with services limited to what can be purchased for that amount.

In the current era of managed care, we fall somewhere in the middle. We believe there is nothing inherently flawed with the concept of a defined contribution—as long as the amount is sufficient to guarantee a minimum set of services. In other words, let's not let the emerging world of coordinated care take Medicare away from its historic mission: to provide basic health care for all senior Americans who need it, regardless of their ability to pay.

"Means-testing" Medicare—As health care costs continue to rise and baby boomers begin to retire, the dollars available to fund Medicare will become even more constrained than today. To better allocate Medicare dollars, Medicare's share of the cost of coverage should be income-related. Medicare would pay for the full costs of coverage—excluding required copayments and deductibles—for lower-income seniors and would pay a very limited amount for upper-income seniors. This could

be achieved in a number of ways, but the effect would be the same—to ensure that limited Medicare dollars can continue to provide care for those most in need.

A new savings opportunity for workers—If Medicare's share of the cost of coverage becomes income-related, people should have the opportunity to save during their working years and set aside funds that could defray medical expenses during their retirement. They can be encouraged, through tax-deferred vehicles, to save these funds. These vehicles should not be confused with Medicare medical savings accounts (MSAs), which are designed to allow already-retired seniors to purchase only a high-deductible, catastrophic coverage plan and accumulate tax-preferred savings to defray non-covered health care costs. The tax-deferred vehicles we are talking about allow working people to save for post-retirement health care coverage and could be combined with any type of health coverage plan.

A NEW PROCESS

We are also proposing a commission that explodes another myth—the myth that all commissions are alike. The commission that we are proposing is different from any other. How?

- It would have "teeth," by facilitating congressional action.
- It offers a permanent process—not a single solution.
- Many in Congress already support the concept, in one form or another.

Mr. Chairman, at no time during any budget discussion or Medicare debate has any proposal been brought to the table that would take Medicare into the next 30 years and beyond. And that is what is needed—something that will so radically change the decision-making process about Medicare that it guarantees the program's strength well into the next century.

First, we applaud Senators Roth (R-DE) and Moynihan (D-NY) for their legislation (S. 341) that would create a bipartisan commission on the long-term future of Medicare. Their commission would make recommendations to the President and Congress within a year of enactment.

However, we would like to build upon that concept, and believe that a permanent commission is required. The commission we are talking about would, each year, provide information and advice to help Congress set a Medicare spending target. Under that target, the commission would hold public hearings, recommend how much can be spent, what that money will buy in benefits and for whom, and how to ensure quality. Then, the whole package would be voted on, up-or-down, by Congress.

And if Congress voted it down? Or didn't vote at all? A default mechanism would kick in to automatically align provider payments and beneficiary cost-sharing with the Medicare spending target. The knowledge that cuts could not be avoided would be a powerful incentive for Congress to pass the commission's comprehensive and carefully considered package.

The commission would be made up of seven experts in all areas of the health care field, appointed by the president and confirmed by the Senate. Being on the commission would be a full-time position. Legislation (H.R.406) to create such a commission has been introduced in the House by Rep. Phil English (R-PA) and enjoys bipartisan support. Moreover, a provision included in the budget proposal of the House Democratic "Blue Dogs" is similar to our vision of the kind of commission Medicare needs.

This commission itself would not be a solution to Medicare's problems, but a process—a public process—that can help us make the tough choices that need to be made to solve those problems.

It is important that the commission be a permanent one, because the problems that Medicare faces will continue to change as time moves on. A lot of the proposals to "save" Medicare that exist today may have little or no relevance in the year 2011, for example.

And let me make this very clear. The AHA supports this mechanism, even though we are fully aware that we may disagree with some of the recommendations the commission may make. We are willing to take that risk, because maintaining the status quo by doing nothing, or by stopping at short-term solutions, is a bigger risk. We need to put this new process into place immediately. Time is, quite literally, running out.

Mr. Chairman, Medicare has, in some way, touched the lives of every American. It was a good idea 30 years ago, when it was created, and it is a good idea today. But, in order for Medicare to continue its mission of caring for America's seniors for another 30 years, it has to be brought up to date. It has to be restructured, just as America's health care system has restructured itself. And decisions about its funding must be made in a more open, less political process so that tough decisions—decisions that would not get made in the heat of politics—can be made.

We look forward to working with you to ensure that hospitals and health systems can continue serving America's seniors for generations to come.

PREPARED STATEMENT OF KAREN DAVIS

Thank you, Mr. Chairman, for this invitation to address options for assuring that Medicare provides health and economic security for elderly and disabled Americans as the baby boom generation enters retirement. None of the proposals currently under consideration by the Congress would assure the adequacy of Medicare financing over the next 15-30 years. However, slowing the growth in Medicare outlays through such provisions as tightening provider payment rates represents important short-term action to bring Medicare spending closer to rates of economic and budgetary growth.

Short-term steps to achieve budgetary savings now provide some leeway for more careful consideration and debate about desired long-term directions for Medicare. There is a strong argument for postponing action to lock in place long-term policies now. The health system is in a state of enormous flux. It takes time for important health institutions to adapt to these changes. It takes time to understand the changes underway and their implications for the projected growth in Medicare outlays or trends in private sector health care outlays. Very little solid evidence is available on the long-term success of new forms of managed care in controlling the rate of increase in health care costs while assuring access to quality care for elderly and disabled patients. What works for a relatively healthy working population will not necessarily work the same way for a chronically ill, frail elderly population. Time to test new approaches to Medicare and conduct more in-depth analysis of recent private sector initiatives is important before locking in decisions that affect the health care of some of our nation's frailest and most vulnerable citizens.

Both short-term steps and long-term changes should be designed with a clear focus on Medicare's fundamental goals. Medicare has brought health and economic security to elderly Americans for over 30 years. Before it was enacted half of older Americans were uninsured, leaving them and their families at risk of financial catastrophe in the face of major illness. Nor should we lose sight of the fact that growth in health care spending nationally and in Medicare have brought improvements in life expectancy and quality of life. Life expectancy at age 65 has increased by three years since Medicare was enacted, and the U.S. is a world-leader in life expectancy of older adults. Technological innovations such as cataract surgery, joint replacements, and advanced methods of treating coronary artery disease have prolonged life and improved functioning for millions of Americans. Medicare, in particular, has contributed to technological advances not only by directly financing health care for older Americans but through payments to academic health centers which are on the forefront of developing and testing new advances in medicine. Medicare has improved access to health care, contributed to better health for millions of elderly Americans, and protected against the financial hardship of medical expenses. These fundamental goals should be preserved.

THE CHALLENGE

Understanding Medicare's long-term challenge requires an examination of projected growth in Medicare outlays as well as economic and fiscal trends. Medicare is projected to grow more rapidly over the next 30 years than the economy, the federal budget, and tax revenues from payroll taxes, premiums, and general revenues that support Medicare. As a result, as currently structured Medicare will consume an increasing share of the Gross Domestic Product and the federal budget.

This is true both in the intermediate turn as well as after the retirement of the baby boom generation beginning in 2010. The Congressional Budget Office estimates that Medicare net outlays will grow at 8.7 percent annually over the period 1997-2002.[1] Over this period the Gross Domestic Product (GDP) is projected to grow at an annual rate of approximately 5 percent, and the federal budget is projected to grow at an annual rate of 5 percent. Payroll tax revenues which are used to finance Part A of Medicare are projected to grow at approximately 5 percent. The President's Medicare budget proposals would slow the growth in Medicare outlays to 6.3 percent annually. With the shift of part of home health benefits from Part A to Part B, Part A would grow at 5.4 percent annually while Medicare Part B would grow at 7.8 percent annually—but both parts of Medicare are slowed significantly by an array of proposals primarily aimed at restraining provider payment rates. While it still leaves a gap between Medicare revenues and outlays, it makes a substantial contribution toward narrowing this gap.

The Medicare trustees intermediate projections assume that over the long-term, average annual wages will grow at 5 percent, the consumer price index will increase at 4 percent annually, real wages will grow at 1 percent annually, and real GDP will grow at 1.4 percent (in 2030). Under baseline projections, Medicare will increase from 2.1 percent of GDP today to 7.4 percent in 2030. Over this period, the older population eligible for Medicare will grow faster than the entire population. For Medicare not to grow as a percent of GDP, real Medicare expenditures per beneficiary (adjusted for inflation) would have to stay constant or decline slightly given the growth in the beneficiary population.

Such a decline would be historically unprecedented. Nor is it likely to be consistent with Medicare's fundamental goal of providing health and economic security to older Americans. To assure access to quality services for Medicare beneficiaries, it is reasonable to expect that over the long term Medicare outlays will need to increase at the same rate as health spending per capita in the private sector. The critical projection, therefore, is what can be expected in terms of the overall growth in health care expenditures. Historically, health care expenses per capita have grown about 9 percent, or in real terms about 4.5 percent (from 1950-1995). There have been only four major occasions where real rates of health spending have been markedly lower: the Nixon wage and price controls of 1972-1974; the period when the Carter hospital cost containment proposal was under consideration by the Congress (1978-1980); when Medicare prospective payment for hospitals was introduced (1984-1987); and the most recent period for which national health expenditure data are available (1993-1995).[2] It is only briefly in these periods that national health expenditures have grown more slowly than GDP. During this most recent three year period, national health expenditures per capita rose at 5.5 percent, or 2.7 percent in real terms, and only in 1994 did national health expenditures grow more slowly than GDP. Private health expenditures per capita grew at 3.5 percent or less than 1.0 percent in real terms. [3]

It is hard to know at this point what is responsible for the recent slowdown in private health outlays or whether it is permanent or temporary. The major reason attributed to the slowdown is the growth of managed care, and certainly surveys of employer health benefits by Foster Higgins and KPMG Peat Marwick[4] have found a shifting of employees into managed care plans, and a moderation of employer health premium growth. Private sector managed care could have generated savings by achieving price discounts from providers, and there is some evidence that physician incomes have declined on average. Savings may also have been achieved in other ways—such as reduced hospitalization or shortened hospital stays, appropriate or inappropriate barriers to care, reduced benefits or more denied claims, shifting costs to employees, and/or improved efficiency. However, it is not clear whether managed care in fact deserves the credit for the recent slowdown. A recent National Bureau of Economic Research study finds that the shift to managed care does not appear to be directly responsible for significant cost savings because managed care premiums are almost as high as those for fee-for-service plans, on average.[5]

There are other factors at play. The Clinton health plan generated considerable uncertainty in the health sector in 1993-1994, and may have had a restraining effect, for example, on decisions to hire hospital employees, raise wages, and replace capital plant and equipment. Pharmaceutical companies and other health suppliers may have held down price increases to reduce political support for price controls as part of a comprehensive health plan. Proposals to achieve substantial savings in Medicare from provider payment restraints added another element of uncertainty in the 1995-1996 period. Some of the slowdown may actually be a result of an increase in the number of uninsured people or their increasing difficulty in obtaining free or subsidized care.

But the most immediate issue relevant to Medicare's long term future is discerning whether the slowdown is permanent or temporary. The few studies that have examined the impact of managed care have found that its savings are one-time savings, such as reduced utilization or price discounts, but do not affect rates of increase over time. Other explanations such as the threat of government controls under the Clinton health plan can at best have been a short-term factor and no longer expected to have a deterrent effect.

One can hope that this time is different, that managed care or the threat of political action is working, that health technology is no longer driving up costs but rather generating improved efficiency and productivity, that the stabilization of wages is having an effect on a labor-intensive industry and will continue to do so, or simply that the health sector is so large that it simply can not grow faster than the rest of the economy. But it's hard to feel confident that 45 years of history are history, and that three years of data are the new reality for the future.

The safest guess is that real health expenditures per capita will grow somewhere between the historical rate of 4.5 percent and the more recent three-year experience of 2.7 percent, but that they will not stay constant or decline slightly in real terms. Bringing real Medicare outlay growth per beneficiary down to between 2.5 and 4.5 percent requires substantial tightening but is achievable. For example, the President's budget represents total growth in Medicare of 6.3 percent, or 5.1 percent growth in Medicare outlays per beneficiary, and about 2.1 percent in real expenditures per beneficiary (6.3 percent less 1.2 percent for beneficiary growth and 3.0 percent for inflation). To lower this further runs the risk of real deterioration in the quality of care available to Medicare beneficiaries relative to care provided to working families.

But this still leaves outlays growing more rapidly than revenues. The fundamental dilemma is whether assuring quality health care for the nation's elderly and disabled population is really achievable without increasing the fiscal and economic resources committed to this national objective. If not, how much give should there be and in which direction, and what combination of policies are available to balance these objectives. In the end it will be a public policy decision which can be best informed by better delineation of the choices and better information on the benefits, costs, and consequences of different options.

THE CHOICES

What are the real choices for altering the future growth of Medicare outlays and revenues? The principal candidates are:

- Eligibility—raising the age of Medicare eligibility (e.g. to age 67 or 70) or means-testing eligibility (e.g. phasing out benefits for those over $50,000 income)
- Benefits—reducing effective benefits through increased cost-sharing (e.g. a catastrophic deductible of $2500 per person annually)
- Provider payment restraints (e.g. introducing prospective payment methods for all health care providers and holding growth in Medicare prices to CPI or CPI-medical prices, or basing increases on performance in meeting per capita expenditure targets based on GDP per capita or private sector health expenditure per capita growth)
- Managed care (e.g. developing a new method of paying managed care plans and holding increases to CPI, private sector managed care premium growth, or Medicare fee-for-service expenditure per capita growth adjusted for health status of those staying in traditional Medicare; other reforms such as quality standards, eligible managed care plans, beneficiary information and enrollment procedures, beneficiary incentives)
- Defined contribution (e.g. establishing a voucher that grows with GDP per capita or private sector health expenditures per capita and making beneficiaries financially at risk for the difference between the value of the voucher and premiums charged by private health plans; medical savings accounts)
- Financial contributions from beneficiaries (e.g. increase premiums or institute income-related premium).
- Other financing (e.g. increase payroll taxes, merge Part A and B trust funds and increase general revenue share of total, replace some or all of payroll taxes by value-added tax, other tax changes).

MEDICARE ELIGIBILITY AND BENEFITS

Medicare could be changed to cover fewer people or fewer benefits. These are one-time savings, but when phased gradually over a long period of time would affect the actual annual rate of change. Obviously, they run counter to the basic purpose of Medicare, but by scaling back commitments they do reduce the draw on fiscal resources. If, as expected, elderly people in the future are economically more secure, they may not require as extensive governmental support as earlier generations.

Raising the age of eligibility for Medicare runs the risk of adding to the numbers of uninsured. Employer retiree health benefits have been dropping precipitously in the last decade. Today only about one-third of retirees have such coverage. Early retirees between the ages of 55 and 64 are already at risk, and those with major health problems find it difficult to obtain affordable coverage.[6] Whether the age of eligibility is increased or not, consideration should be given to permitting those under age 65 to purchase Medicare coverage. Subsidies may be required for low and modest income retirees to make such coverage affordable. These costs would undoubtedly more than offset any savings from raising the age of Medicare eligibility.

Means-testing eligibility for Medicare also has considerable downside. The starting point is one where incomes of the elderly are quite modest and personal respon-

sibility for health care expenses is already quite high. About three-fourths of all Medicare beneficiaries have incomes below $25,000.[7] On average Medicare beneficiaries already spend 21 percent of their income on health care. For those with incomes below the poverty level, elderly beneficiaries spend 30 percent of income on health care.[8]

These high costs come in large part because the Medicare benefit package has deteriorated rather than improved over the last 30 years. The structure of benefits is fundamentally the same today as it was when it was implemented, but cost-sharing is considerably higher. In 1966 the hospital deductible was $40 ($190 in 1996 dollars); in 1996 it was $736. The deductible for Part B (Supplementary Medical Insurance) services is $100, also up from $50 in 1966, but lower in current dollars than it was in 1966 ($238 in 1996 dollars). The Part B premium was originally set at $36 ($171 in 1996 dollars), representing 50% of SMI outlays; in 1996 it was $510 a year representing 25% of program outlays. These premiums and cost-sharing are also higher than faced by most workers. In addition most employer plans include a ceiling on out-of-pocket expenses; Medicare does not.

The Medicare benefit package is essentially unchanged over the last 30 years. The only major new services include hospice care, rural health clinics, drug coverage for immunosuppressive drugs, erythropoietin for persons with chronic kidney failure, outpatient chemotherapy, and some limited preventive services (subject to the Part B deductible and 20% coinsurance).

The application of cost-sharing to preventive services such as mammograms has restricted access to this service, especially for those without supplemental coverage to Medicare. A recent study supported by The Commonwealth Fund found that elderly women without Medicaid or supplemental private health insurance were much less likely to get mammograms.[9] The financial barriers posed by deductibles and coinsurance for cancer screening contribute to failure to detect cancer in an early stage when recovery chances are higher.

Medicare does not cover prescription drugs (covered by 95 percent of employer plans). Not covered, for example, are insulin, cholesterol-lowering drugs, hormone replacement therapy medication, and pain medication for cancer patients. Medicare also has limited long-term care benefits (only 16 percent of nursing home and home health care is paid by Medicare; another 38 percent is paid by Medicaid[10]).

The high cost-sharing and limited benefits expose seriously ill Medicare beneficiaries to high out-of-pocket costs. In 1996 Medicare beneficiaries paid $2,605 per person for their own health care costs.[11] Medicare expenditures and out-of-pocket costs, however, are highly skewed. The sickest 10 percent account for 75 percent of Medicare outlays. In 1996 the sickest 10 percent of Medicare beneficiaries averaged $37,000 in Medicare outlays; the healthiest 20 percent incur no Medicare expenses.[12] But the sickest beneficiaries also spent the most themselves. Their out-of-pocket costs for Medicare covered services was $5,600, and their out-of-pocket costs for all health services was $8,800. Any increase in cost-sharing would fall disproportionately on these beneficiaries and add to this considerable financial burden.

Since a major purpose of Medicare is to provide financial protection for beneficiaries, a good case could be made for improving benefits, lowering cost-sharing, and raising premiums in the long-term. This would improve financial protection, especially for the 10 percent of Medicare beneficiaries who have no supplemental retiree or Medigap coverage and for those chronically ill Medicare beneficiaries with major health care expenses.

One possibility would be giving Medicare beneficiaries the choice of a comprehensive benefit package with little or no cost-sharing and a commensurately higher premium so that beneficiaries would not be forced to purchase costly private MediGap coverage. With some important exceptions, MediGap plans often deny coverage to elderly people with pre-existing conditions. MediGap plans are required by federal law to limit administrative costs to 40 percent for individual plans and 25 percent for groups plans; yet in 1993, 38 percent of plans did not comply with minimum loss ratio standards.[13] Combining supplemental coverage with Medicare into a single comprehensive Medicare benefit package would lower administrative costs, reduce paperwork burdens, and the necessity of coordinating Medicare and MediGap payment. At a minimum MediGap plans should be required to accept all Medicare beneficiaries without underwriting, excluding bad risks, or charging higher premiums to sick or very old beneficiaries.

Low-income elderly and disabled beneficiaries have increasingly relied on the Medicaid program to supplement their Medicare benefits. The Qualified Medicare Beneficiary (QMB) program entitles all poor Medicare beneficiaries to supplemental Medicaid coverage to pick up cost-sharing and premiums. Beneficiaries with incomes up to 120 percent of the poverty level are eligible for Medicare Part B premium subsidies from Medicaid (Specified Low-Income Medicare Beneficiary [SLMB] program).

These provisions are quite modest. The poverty level for a single elderly person in 1996 was $7,525 and $9,484 for a couple.

Only about two-thirds of those eligible for QMB coverage, however, participate, and only about 10 percent of those eligible for SLMB do so.[14] A Commonwealth Fund study found that the most common reasons why elderly poor are not covered by public benefit programs are that they are unfamiliar with the programs or do not think they are eligible.[15] Better outreach to those who are qualified for Medicaid supplementation to Medicare is important.

Poor and near-poor elderly are more likely to be experiencing health problems that require medical services than elderly people who are economically better off. Yet, they are less able to afford needed care because of their lower incomes. For those who do get care, large out-of-pocket medical expenses can lead to impoverishment.

Medicaid could be improved to assure better benefits and financial protection for low-income Medicare beneficiaries. Federalizing this portion of Medicaid, improving supplemental coverage (including prescription drugs), and increasing eligibility to, say, 150 percent of poverty are options worthy of exploration. Federalization of the QMB and SLMB programs would permit better coordination with Medicare and likely increase participation of those eligible.

PROVIDER PAYMENT

The extent to which Medicare can tighten payments to providers without jeopardizing access to quality services for beneficiaries and introducing serious financial instability in the health sector is a judgment that is difficult to make with any precision. As a general principle Medicare can not depart too fundamentally from payment rates in the private sector without risking the deterioration of its fee-for-service coverage.

Because Medicare is a major source of revenues to health care providers, nearly all qualified health care providers and increasingly nearly all HMOs have opted to participate —despite the fact that payment rates have historically been set by Medicare below private sector rates. In the last few years managed care plans have followed Medicare's practice of using significant purchasing power to obtain "price discounts" from providers.

Medicare has been an innovator in provider payment. Its system of physician payment has been increasingly accepted by physicians as payment in full. Its innovations in physician payment in fact have contributed to the growth of managed care plans who use it as a basis for establishing fee schedules for physicians participating in discounted fee-for-service managed care plans. A survey of managed care plans finds that Medicare still obtains the best "discounts" from physicians—with most managed care plans paying physicians in excess of Medicare rates.[16] On average Medicare pays physicians about 69 percent of the fees paid by private plans.

A good comparison of the performance of Medicare and private coverage for the working population is difficult because of the age differences in those it covers. Prior to the mid-1980s both Medicare and private health expenditures grew rapidly, with Medicare growing slightly faster. Starting with the introduction of prospective payment for hospitals, Medicare grew more slowly than private health expenditures in the mid-1980s to early 1990s.[17] Employers complained regularly that Medicare was "cost-shifting" to the private sector because it achieved price "discounts" from hospitals and physicians. From 1993 to 1995 private sector spending per person for similar services has been the same or slightly below Medicare spending growth.

Rather than continue the somewhat unproductive charges and countercharges about the comparative performance of Medicare and private plans, it is important that the innovations of prospective payment for hospitals and physicians be extended to other Medicare services. Growth in Medicare hospital and physician expenditures have moderated considerably. The major areas where Medicare is now growing rapidly are for those services not covered by prospective payment approaches—particularly home health, skilled nursing facilities services, sub-acute hospital care, and hospital outpatient care. Developing new methods of prospective payment for these services should be a top priority, and the President's budget recommends steps in this direction. Other techniques such as profiling patterns of utilization of different physicians, appropriateness guidelines, and high cost case management may also generate further savings.

MEDICARE'S MANAGED CARE CHOICES

The President's budget also proposes to achieve savings under its managed care options. This is to be achieved by: tightening fee-for-service provider payments, which lowers the managed care capitation rate ($18 billion); a proposal to lower the

capitation rate from 95 percent to 90 percent of the fee-for-service cost ($6 billion); removing the allowance for teaching and disproportionate share from the managed care capitation rate ($10 billion); and reducing the wide geographic disparities in the payment rates (budget neutral). In addition, the proposal would expand the kinds of managed care plans eligible to participate in Medicare.

Managed care plans are aggressively marketing to Medicare beneficiaries. Medicare permits qualified health maintenance organizations, including point of service plans, to participate in the program. Seventy percent of HMOs offer coverage to Medicare beneficiaries. Currently 10 percent of Medicare beneficiaries enroll in HMOs, but this number is growing rapidly. The Congressional Budget Office estimates that by the year 2000, 20 percent of Medicare beneficiaries will belong to HMOs.[18]

Genuine choices between quality managed care and fee-for-service care for Medicare beneficiaries are important to preserve over the long-term. Fee-for-service care has the disadvantage of creating incentives for too much care at too high cost; managed care has the disadvantage of creating incentives for too little care at substandard quality. Providing a genuine informed choice for beneficiaries of both options may counter the harmful consequences of either extreme. If either part of the program deteriorates in the quality and level of service available, neither beneficiaries nor the government will be well served. Careful attention, however, will need to be paid to issues of risk selection since sicker beneficiaries are more likely to opt for fee-for-service coverage while healthier beneficiaries are more likely to enroll in managed care plans.

While most Medicare beneficiaries have managed care options available to them, familiarity with this option is not widespread. Medicare could systematically make information available to beneficiaries about choices in their geographic area, and conduct a formal annual enrollment process.

It is important, however, that managed care plans be held to high quality standards. A recent study finding that health outcomes of elderly patients worsen under managed care compared to fee-for-service care is particularly troubling.[19] There may also be a significant downside to managed care enrollment that requires beneficiaries to change physicians. A study supported by The Commonwealth Fund found that continuity of care from retaining the same physician for a long period of time has benefits. Medicare beneficiaries who had seen the same physician for ten or more years had fewer hospitalizations and lower Medicare costs.[20]

Starting slowly is important. Expanding coverage to loosely organized managed care plans such as preferred provider organizations does not seem warranted, until many of the problems with current capitation payment are resolved and adequate quality standards established and an enforcement mechanism instituted. The Health Care Financing Administration is taking important steps to require that participating managed care plans provide standardized information on quality indicators, but an effective quality information and assurance system is a long way from realization. Nor does the program as yet require accreditation of HMOs. One protection for beneficiaries is the right to disenroll from a managed care plan on a monthly basis. This ability to "vote with their feet" is an important protection until better quality standards are in place.

Even if enrollment in managed care plans were to expand more rapidly, it would not yield savings to the program. The best study on the issue finds that the actual cost of serving Medicare beneficiaries who opt for HMO enrollment is 5.7 percent more than Medicare would have paid for these same beneficiaries had they been covered under fee-for-service Medicare coverage.[21] Instead of saving Medicare money, the program loses almost 6 percent for every Medicare managed care enrollee.

Nor is there compelling evidence that managed care generates health system savings over the long term. Most savings such as price discounts or reduced hospitalization are one-time savings and do not offset the rate of increase over time. Managed care administration costs, furthermore, average 15 to 20 percent, compared with Medicare's 2 percent administration costs.

To the extent that private sector managed care savings have come from price discounts, this may not be replicable for Medicare. Medicare physician fees average 69 percent of private sector fees, and are already well below those of managed care plans.[22]

Medicare loses money on managed care to the extent that plans enroll and retain healthier than average beneficiaries. Given the extreme variability in health outlays among beneficiaries, there is great leeway for plans to select relatively healthier beneficiaries for whom capitated rates exceed true costs. If managed care plans succeed in attracting and retaining relatively healthier Medicare beneficiaries (which they have very strong incentives to do), Medicare will be overpaying for those under

managed care, and yet paying the full cost of the sickest Medicare beneficiaries who are unattractive to managed care plans. Managed care plans have the option of switching out of the risk contract program if they experience adverse selection.

The current method of paying managed care plans for Medicare patients is seriously flawed. Its primary weakness is that it does not adequately adjust for differences in the health status of beneficiaries. Unfortunately, a good method of setting capitation rates to adjust for differences in beneficiary health status still seems years away.

Tying Medicare HMO payment rates to local fee-for-service experience is neither equitable nor tenable in the long-term. A national rate with appropriate geographic adjustment for differences in the cost of practice would be preferable. However, rates are currently so widely variable across geographic areas that a long transition period will be required.

The current method of Medicare HMO payment includes allowances for the direct and indirect costs of medical education, even though managed care plans do not incur these costs; The payment rate also includes an allowance for disproportionate share payments even though managed care plans do not cover the uninsured, and in general are open only to those who can afford the premium or have employers or public programs that pay the premium on their behalf.

It makes little sense to overpay HMOs and encourage Medicare beneficiaries to enroll, yet have the program lose money on each beneficiary who enrolls. If adequate measures to adjust for health status can not be developed in the short run, serious consideration should be given to lowering the Medicare HMO payment rate. It is currently set at 95 percent of Medicare projected expenditures for beneficiaries with average health status. Given the favorable selection that occurs, reducing this to 85 to 90 percent could be considered. Managed care payment rates over time should also be linked to trends in private sector health expenditures per capita—not Medicare's fee-for-service experience—which is likely to grow more rapidly as sicker beneficiaries are more likely to remain in traditional Medicare.

The extent of managed care abuses could be curbed by lowering capitation payment rates and imposing penalties on plans for high disenrollment rates, but the basic underlying incentives are unlikely to be substantially altered. Nor has the long-term success of managed care in controlling costs while providing quality care to seriously ill patients yet been demonstrated. Proceeding cautiously and slowly is in order.

DEFINED CONTRIBUTION: VOUCHERS, MEDICAL SAVINGS ACCOUNTS, CATASTROPHIC COVERAGE

Another approach is to convert Medicare from a defined benefit program to a defined contribution program. Currently, Medicare sets payments to hospitals and HMOs; this payment is payment in full. Hospitals and HMOs may not charge beneficiaries on top of what Medicare pays. Physicians have strict limits on balance billing over the fee schedule (no more than 15 percent above the fee schedule); and about 90 percent of all claims are now assigned. Most defined contribution approaches would eliminate this feature and permit managed care plans and health care providers to set their own charges, with beneficiaries financially at risk for the difference between a fixed voucher and what providers and health plans charge.

In a difficult federal budgetary climate, capping the federal budget obligation for Medicare on first examination has appeal as a policy option. Vouchers or giving beneficiaries the actuarial value of Medicare to purchase private coverage permits the government to control its expenditures regardless of the trend in health care costs. However, this approach shifts financial risks to beneficiaries, and undermines the financial security that Medicare is intended to provide. By freeing managed care plans, hospitals, and physicians to charge whatever they choose in the marketplace, the benefit of the large purchasing power that Medicare has, as well as the governmental authority it represents, no longer would be available to help beneficiaries obtain care at lower cost.

Proposals to change Medicare into catastrophic coverage with, for example, a $2,500 combined deductible could pose major barriers to care for low- and modest-income beneficiaries. Most elderly have quite modest incomes. Three-fourths have incomes under $25,000. They already pay $2605 per person for their own health care expenses, half of which is for noncovered services and Medicare cost-sharing and half is for Medicare premiums and private Medigap premiums. Increasing deductibles falls most heavily on the sickest beneficiaries who exceed the deductible, but has little effect on the 20 percent who are healthiest and do not exceed Medicare's current deductibles.

Vouchers to purchase catastrophic health coverage with the balance invested in medical savings accounts raise particular concerns. Such provisions are likely to be costly to the Medicare program. While a mandatory voucher system could be designed to guarantee savings, a voluntary voucher program is almost certain to be attractive only to relatively healthier beneficiaries. Setting the voucher at an average level could result in very substantial overpayments. Medicare currently spends very little on the healthiest 50 percent of Medicare beneficiaries. If they were to take vouchers, the cost to the program could be extraordinary. Skimming off the healthiest Medicare beneficiaries undermines the advantages of risk pooling that Medicare as a universal program now achieves.

The most serious potential problem with vouchers is that the market would begin to divide beneficiaries in ways that put the most vulnerable beneficiaries--those in poor health and with modest incomes—at particular risk. If vouchers or other types of specialized plans like medical savings accounts skim off the healthier, wealthier beneficiaries, many Medicare enrollees who now have reasonable coverage for acute care costs, but who are the less desirable risks, would face much higher costs due to the market segmentation. A two-tier system of care could result in which modest income families are forced to choose less desirable plans.

Coverage is unlikely to be attractive to many beneficiaries. After all, 90 percent of Medicare beneficiaries now obtain supplemental coverage to avoid the $736 Part A deductible and $100 Part B deductible. Few beneficiaries who truly understand that a plan has a $5,000 or $6,000 annual deductible are likely to find it attractive. Many of the chronically ill would be required to pay this deductible not just once, but year after year. Nor is it affordable for the three-fourths of Medicare beneficiaries with incomes below $25,000. If beneficiaries were to experience a serious illness, they could face financial bankruptcy and bad debts to providers. Providing financial protection for beneficiaries was the major rationale for creating Medicare. It should not be abandoned now.

Further, the experience with sale of private MediGap coverage to beneficiaries is that without stringent safeguards, marketing abuses are likely. Confused or scared, some beneficiaries could take options which are not in their best interests—nor genuinely preferred by them.

On balance, vouchers offer little in the way of guarantees for continued protection under Medicare. Further, the federal government's role in influencing the course of our health care system would be substantially diminished. For some, this is a major positive advantage of such reforms. But the history of Medicare is one in which the public sector has often played a positive role as well, first insuring those largely rejected by the private sector and then leading the way in many cost containment efforts. But most troubling is the likelihood that the principle of offering a universal benefit afforded by social insurance would be seriously undermined.

FINANCING MEDICARE IN THE 21ST CENTURY

Most of the immediate concern regarding Medicare revolves around the Part A Trust Fund. Pragmatically, the short-term options for preventing the looming exhaustion of the Part A Trust Fund come down to: increasing beneficiary cost-sharing for hospital and other Part A services, tightening provider payments substantially further than those contained in the President's budget, increasing payroll taxes, or moving some expenses from Part A to Part B. The deductible for Part A services is already exorbitant ($736 in 1996) and cost-sharing already falls heavily on those who are seriously ill enough to incur a hospitalization or need post-acute services such as home health or skilled nursing facility services. There is a limit to how rapidly the health sector can adjust to tighter provider payment rates, and how sharply Medicare can curtail provider payment rates relative to the private sector.

The fiscal problem of the Hospital Insurance Trust Fund is directly related to the fact that hospital, home health, and skilled nursing facility care are financed by a payroll tax, while general tax revenues and beneficiary premiums are used to finance ambulatory care. The payroll tax will always fall short of covering Medicare hospital and post-acute care outlays--for the simple reason that the number of older people is growing faster than the number of workers and health care costs historically go up faster than earnings. According to the Congressional Budget Office, the Hospital Insurance Trust Fund could be solvent for an additional 25 years if the payroll tax were increased by an additional 0.65 percent on both employers and workers (from 1.45 percent now).[23] More modest increases of, for example, 0.15 percent on both employers and workers, would generate about $10 billion annually and extend the solvency of the Trust Fund for an additional 15 years.

Shifting costs out of Part A would also make achieving solvency in the Part A trust fund easier. The President has proposed moving part of home health from part

A to Part B and their is a rationale to this. It makes little sense that visits by a nurse to the home should be paid for by a payroll tax while visits to the home by a physician should be paid for by general revenues and premiums.

The real issue is the rapid growth of home health spending in recent years, and what changes in the Medicare program would help assure that appropriate services are being provided efficiently. Changing from cost reimbursement to prospective payment is an important improvement. But the levels of service vary widely across geographic areas and by type of home health agency. For-profit agencies provide twice as many home health visits per beneficiary as nonprofit agencies.[24] Home health visits annually range from over 24,000 per 1000 enrollees in Louisiana to less than 3,000 in Wisconsin.[25] Setting guidelines for numbers of services based on patient health or functional status, and perhaps establishing an overall expenditure target such as the Volume Performance Standard incorporated in the prospective payment system for physicians are worthy of exploration.

Another alternative would be to move all of Medicare's payments for graduate medical education and disproportionate share payments for hospitals into a trust fund with general revenue financing. There is no particular rationale for financing these social benefits with a payroll tax instead of general tax revenues. This would reduce Part A spending by about $10 billion a year, or slightly more than the proposed shift of partial home health benefits.

In the long-term it will be imperative to make changes in the way Medicare is financed. Division into two parts is a historical artifact. In part the division arose from the fact that it was modeled on Blue Cross (BC)/Blue Shield (BS) plans which separately covered hospital and physician services; subsequently most BC and BS plans have merged, but Medicare has not. Another reason that Medicare has two parts is that Part B was tacked on late in the legislative process as a political compromise. Whatever its origins, it is fair to say that the dual structure serves little useful purpose today and is even counterproductive.

How we choose to finance Medicare benefits is a policy choice, not a given dictated by history. Merging Part A and Part B into a single Trust Fund would improve the rational operation of the program, especially as managed care grows. With managed care providing both hospital and physician services, a combined benefit makes more sense. A single ceiling on out-of-pocket expenses is also facilitated by a single benefit.

In the long-run, payroll taxes may not be the best source of financing Medicare. It would be useful to have a revenue source that grows automatically as the population ages—whether that is greater reliance on general revenues, new taxes such as consumption taxes or value added taxes, a health sector tax, or greater taxes on the elderly (e.g., taxing the actuarial value of Medicare or an income-related Medicare premium). Payroll taxes can continue to be a portion of financing, but will always generate periodic crises as Medicare expenditures outstrip payroll tax revenues.

BUILDING ON MEDICARE'S STRENGTHS

At present, too little attention is being focused on how to improve the functioning of the Medicare program, rather than departing radically from its basic structure. The goal should be preserving genuine choice for all Medicare beneficiaries to be cared for by physicians or a health system of their choice while guaranteeing quality care at a reasonable cost to beneficiaries and to taxpayers. Steps can be taken in the short-term to: 1) improve benefits and financial protection for beneficiaries; 2) institute prospective payment methods for all Medicare services; 3) improve Medicare's payment system for managed care plans, set and enforce quality standards, provide standardized information to beneficiaries, and manage an annual enrollment process with genuine choices for beneficiaries; and 4) extend the solvency of the Part A Trust Fund while beginning an indepth examination of the merits of alternative sources of financing Medicare over the long term.

What should be preserved is the essential role that Medicare plays in guaranteeing access to health care services and protecting from the financial hardship that inadequate insurance can generate for our nation's most vulnerable elderly and disabled people. No American should become destitute because of uncovered medical bills nor be denied access to essential health care services. Medicare is a model of success. It should be strengthened and improved, and any fundamental restructuring should occur only after a full array of options is carefully analyzed, critiqued, and debated.

ENDNOTES

[1]: Congressional Budget Office, *CBO January 1997 Baseline: Medicare/Medicaid,* January 18, 1997.

[2]: For more detailed analysis of the 1950-1987 period, see Karen Davis, Gerard F. Anderson, Diane Rowland, and Earl P. Steinberg, *Health Care Cost Containment,* Baltimore, Md.: Johns Hopkins Press, 1990.

[3]: Katharine R. Levit et al., "National Health Expenditures, 1995," *Health Care Financing Review,* Fall 1996, pp. 175-214.

[4]: KPMG Peat Marwick, *Health Benefits in 1996,* October 1996.

[5]: Alan B. Krueger and Helen Levy, "Accounting for the Slowdown in Employer Health Care Costs," National Bureau of Economic Research Working Paper 5891, January 1997.

[6]: Pamela Loprest and Cori Uccello, *Uninsured Older Adults: Implications for Changing Medicare Eligibility,* The Commonwealth Fund, January 1997.

[7]: Health Care Financing Administration, *Profiles of Medicare,* May 1996.

[8]: Marilyn Moon, Crystal Kuntz, and Laurie Pounder, *Protecting Low-Income Medicare Beneficiaries,* The Commonwealth Fund, December 1996.

[9]: Janice Blustein, "Medicare Coverage, Supplemental Insurance, and the Use of Mammography by Older Women," *New England Journal of Medicine* 332:1138-1143, April 27, 1995.

[10]: Harriet L. Komisar, Jeanne M. Lambrew, and Judith Feder, *Long-Term Care for the Elderly,* The Commonwealth Fund, December 1996.

[11]: Marilyn Moon, *Restructuring Medicare's Cost-Sharing,* The Commonwealth Fund, December 1996.

[12]: Marilyn Moon, *Restructuring Medicare's Cost-Sharing,* The Commonwealth Fund, December 1996.

[13]: General Accounting Office, *MediGap Insurance: Insurers' Compliance with Federal Minimum Loss Ratio Standards, 1988-1993,* August 1995.

[14]: Marilyn Moon, Crystal Kuntz, and Laurie Pounder, *Protecting Low-Income Medicare Beneficiaries,* The Commonwealth Fund, December 1996.

[15]: The Commonwealth Fund Commission on Elderly People Living Alone, *Old, Alone, and Poor,* April 1987.

[16]: Physician Payment Review Commission, *Annual Report to Congress 1995,* p. 83.

[17]: Marilyn Moon and Stephen Zuckerman, *Are Private Insurers Really Controlling Spending Better than Medicare?* The Urban Institute, July 1995.

[18]: Congressional Budget Office, *January 1997 Baseline: Medicare/Medicaid,* January 18, 1997.

[19]: John E. Ware, Jr., Martha S. Bayliss, William H. Rogers, Mark Kosinski, and Alvin R. Tarlov, "Differences in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems: Results From the Medical Outcomes Study," *Journal of the American Medical Association* 276:1039-1047, October 2, 1996.

[20]: Linda J. Weiss and Jan Blustein, "Faithful Patients: The Effect of Long-Term Physician-Patient Relationships on the Costs and Use of Health Care by Older Americans," *American Journal of Public Health,* December 1996.

[21]: R. Brown et al., *The Medicare Risk Program for HMOs: Final Summary Report on Findings from the Evaluation,* Mathematica Policy Research, February 18, 1993.

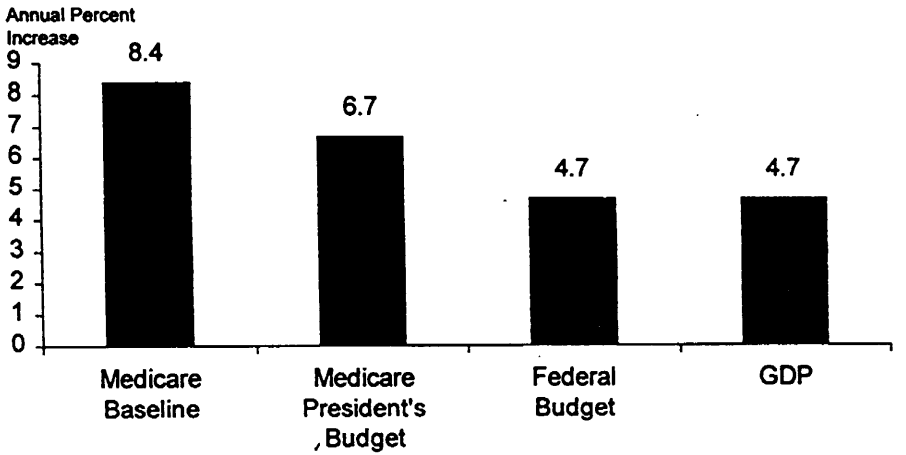
[22]: Physician Payment Review Commission, *Annual Report to Congress 1995,* p. 83.

[23]: June E. O'Neil, "The Financial Status of the Medicare Program," testimony before the Committee on Ways and Means, U.S. House of Representatives, May 2, 1995.

[24]: General Accounting Office, Medicare: Home Health Expands While Program Controls Deteriorate, March 27, 1996.

[25]: Genevieve Kenney and Marilyn Moon, "Reining in the Growth in Home Health Services under Medicare," draft report to The Commonwealth Fund, February 1997.

Annual Projected Growth in Medicare, the Federal Budget and Economy, 1997-2002

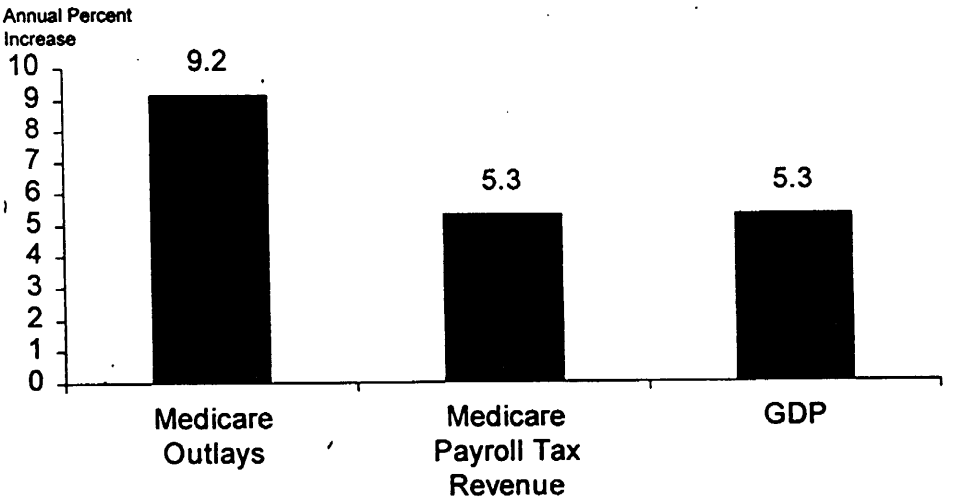


Source: CBO, 1997.

Chart 1

THE COMMONWEALTH FUND

Annual Projected Growth in Medicare, Medicare Payroll Tax Revenue, and the Economy, 1997-2020

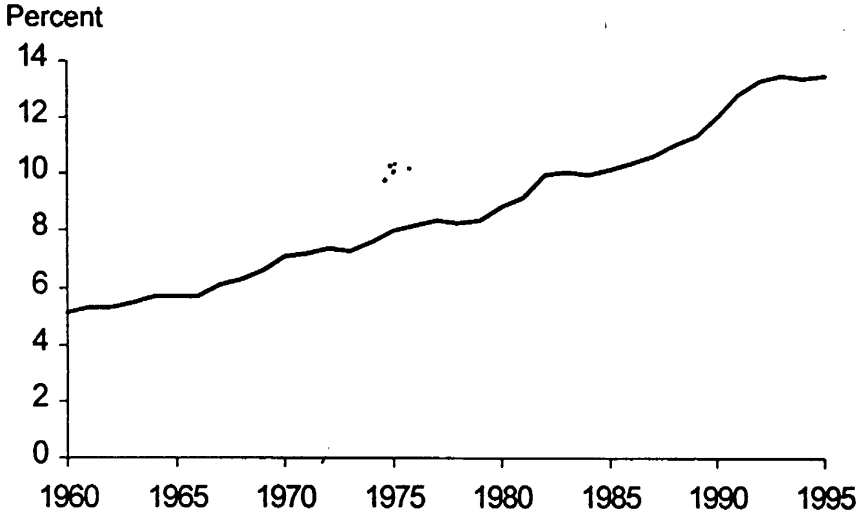


Source: Moon, 1997.

Chart 2

THE COMMONWEALTH FUND

National Health Expenditures as a Percent of Gross Domestic Product, 1960-1995

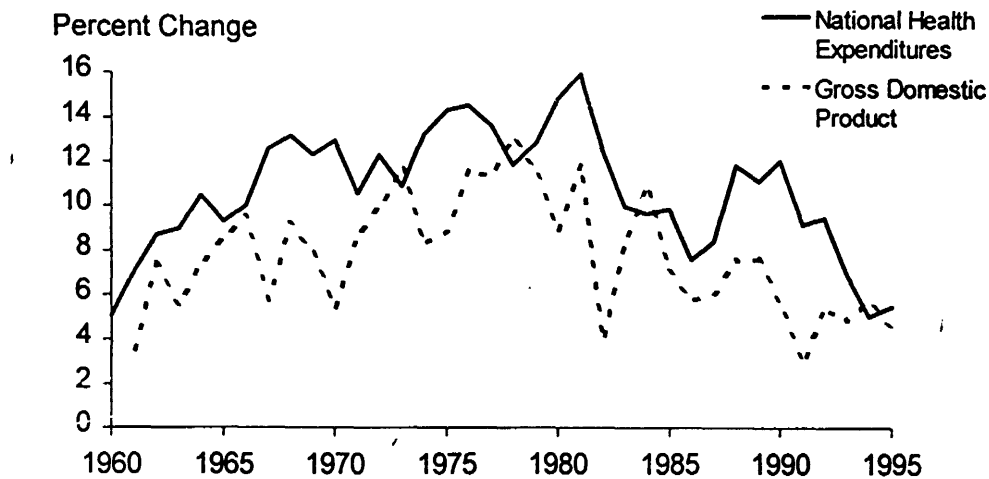


Source: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics, Fall 1996

Chart 3

THE COMMONWEALTH FUND

Percent Growth in National Health Expenditures and Gross Domestic Product, 1960-1995

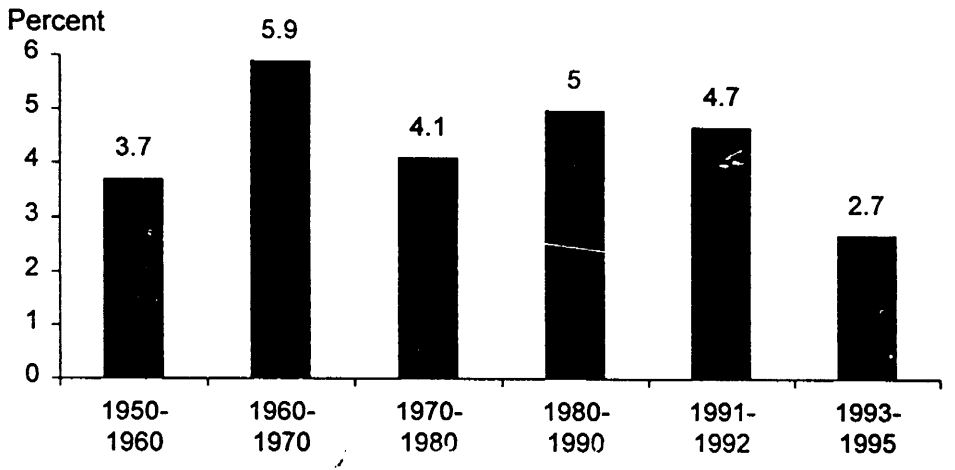


Source: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics, Fall 1996

Chart 4

THE COMMONWEALTH FUND

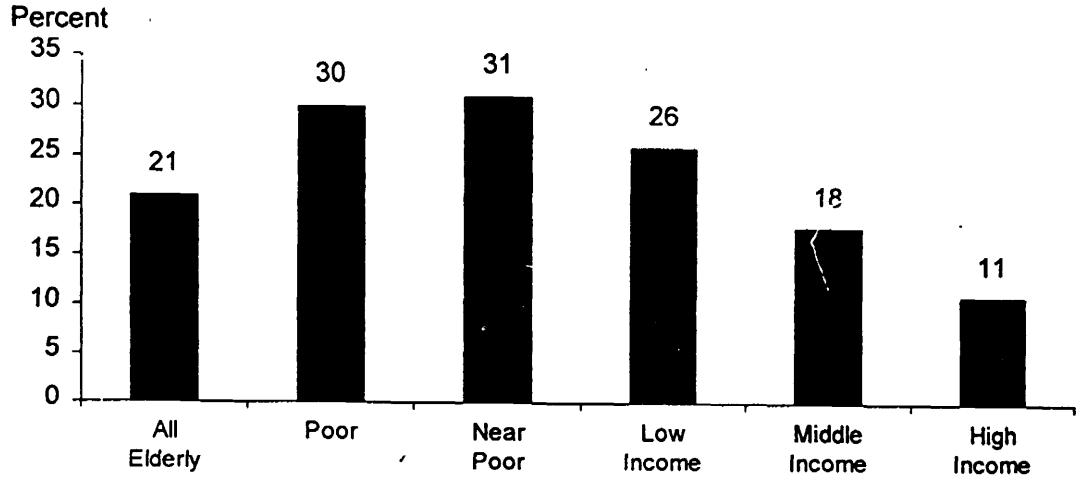
Annual Growth in Real* National Health Expenditures Per Capita, 1950-1995



* Deflated by GDP Price Deflator

Source: Newhouse, 1996; Levit et al., 1996.

Out-of-Pocket Health Spending by the Noninstitutionalized Elderly as a Percent of Family Income, 1996



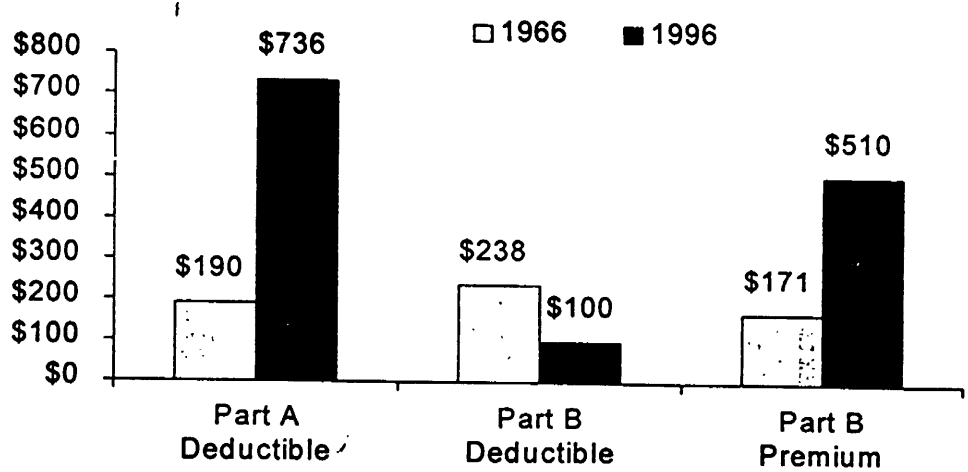
Poverty status definitions: poor=<100% of poverty; near poor=100-125%; low income=125-200%; middle income=200-400%; and high income=400%+

Source: Marilyn Moon et al., *Protecting Low-Income Medicare Beneficiaries*, The Commonwealth Fund, December 1996.

Chart 6

THE COMMONWEALTH FUND

Medicare Cost Sharing, 1966 and 1996 (in 1996 dollars)



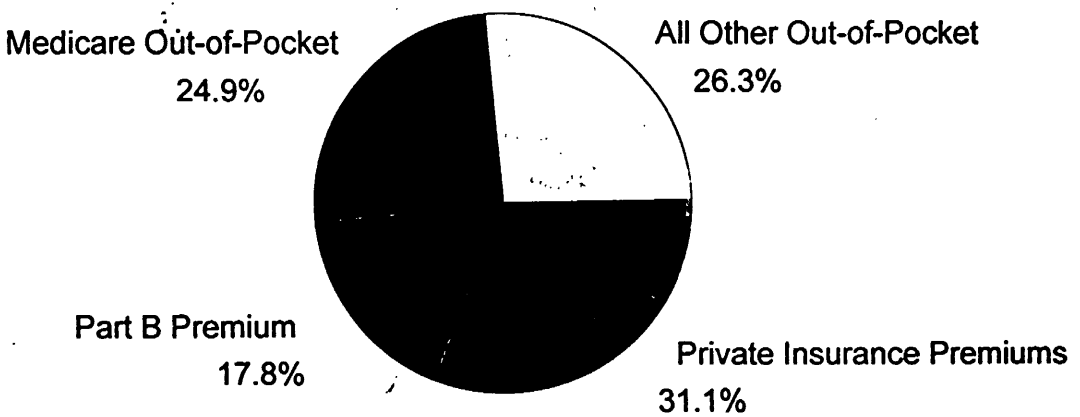
Source: Calculated by Karen Davis, based on U.S. House of Representatives, Committee on Ways and Means, 1996 Green Book.

Chart 7

THE COMMONWEALTH FUND

Out-of-Pocket Health Expenditures for the Noninstitutionalized Elderly, 1996

$2,605 per Beneficiary

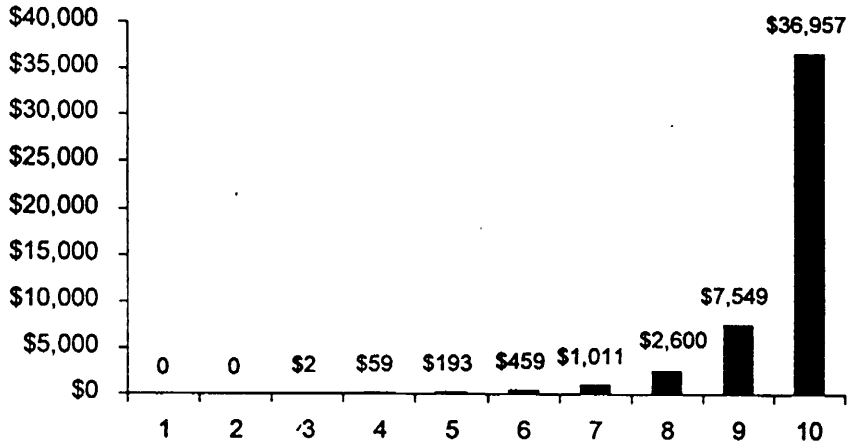


Source: Marilyn Moon et al., *Protecting Low-Income Medicare Beneficiaries*, The Commonwealth Fund, December 1996.

Chart 8

THE COMMONWEALTH FUND

Medicare Expenditures per Beneficiary by Decile of Least Costly to Most Costly, 1996
($4,753 mean)

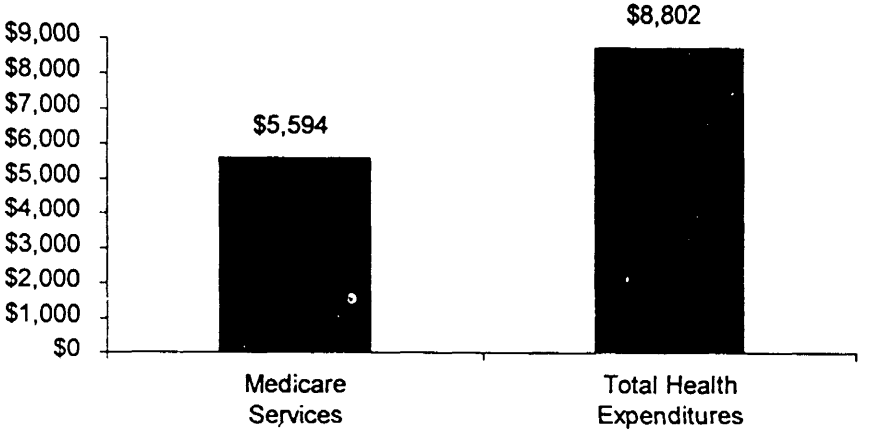


Source: Marilyn Moon, *Restructuring Medicare's Cost-Sharing*, The Commonwealth Fund, December 1996.

Chart 9

THE COMMONWEALTH FUND

Out-of-Pocket Expenditures per Beneficiary for 10 Percent Most Costly Beneficiaries, 1996

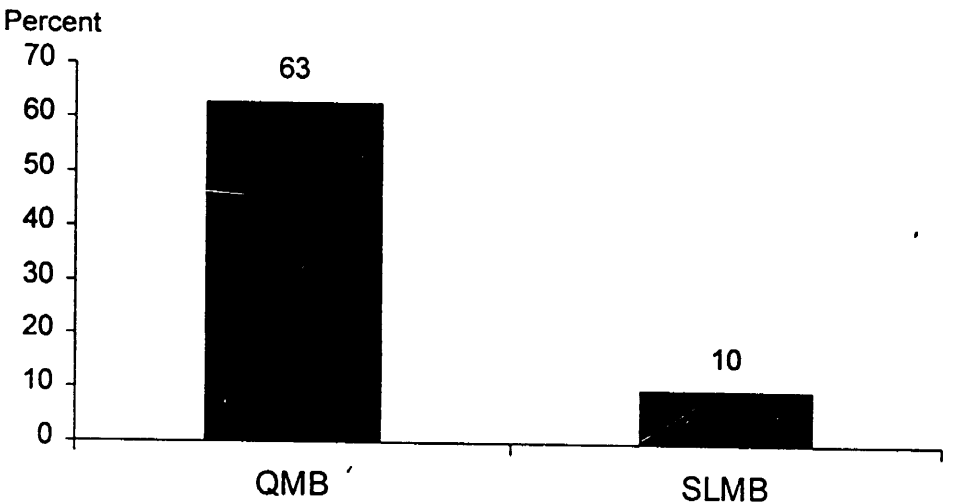


Source: Marilyn Moon, *Restructuring Medicare's Cost-Sharing*, The Commonwealth Fund, December 1996.

Chart 10

THE COMMONWEALTH FUND

Participation in Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) Programs, 1990

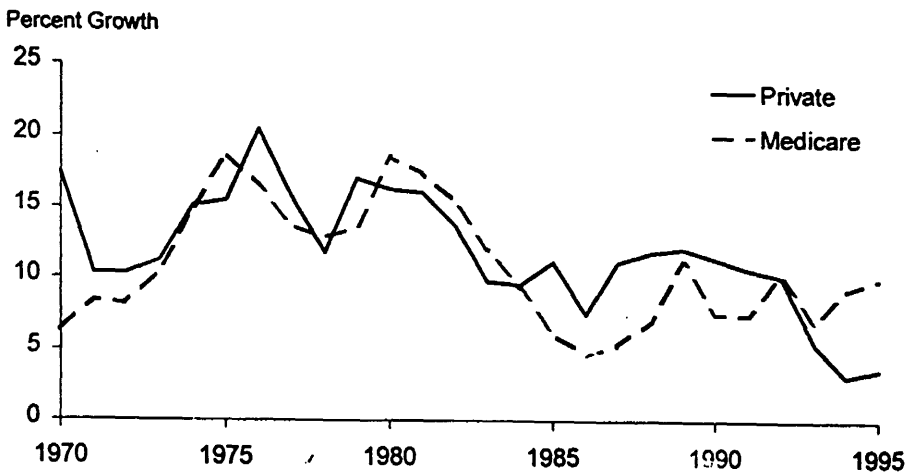


Source: Marilyn Moon, *Restructuring Medicare's Cost-Sharing*, The Commonwealth Fund, December 1996.

Chart 11

THE COMMONWEALTH FUND

Growth in Medicare and Private Health Insurance Benefits Per Enrollee, Calendar Years 1970-1995

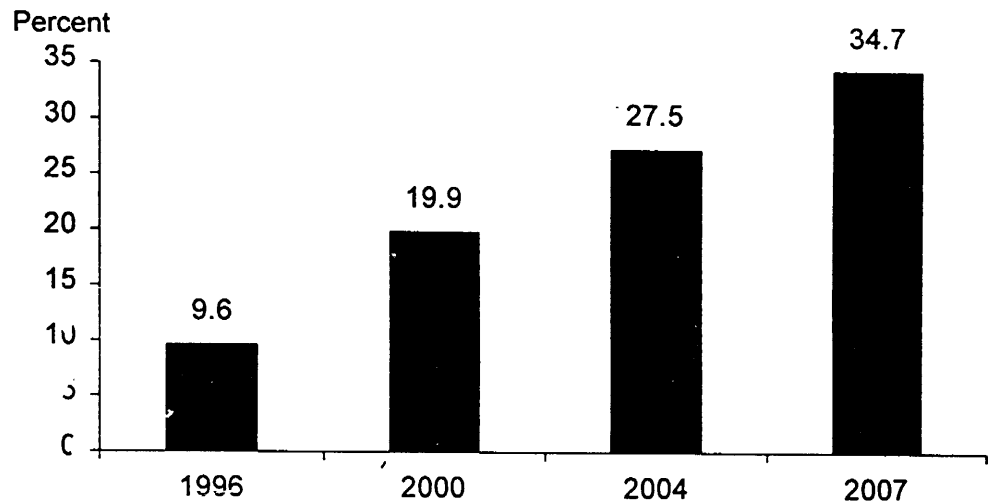


Source: Health Care Financing Administration, Office of the Actuary, data from the Office of National Health Statistics.

Chart 12

THE COMMONWEALTH FUND

Percent of Medicare Beneficiaries Enrolled in HMOs, 1996-2007



Source: Congressional Budget Office, January 1997 Baseline: Medicare/Medicaid, January 18, 1997

Chart 13

THE COMMONWEALTH FUND

Vouchers, Medical Savings Accounts, Catastrophic Coverage

- Put financial risk on beneficiaries
- Unlikely to keep up with growth in health care costs
- Cost to the Medicare program from favorable risk selection
- Marketing abuses and high private insurance administrative costs
- Undermines social insurance nature of Medicare

Building on Medicare's Strengths

- Improve and restructure benefits
- Expand Medicaid protection for poor and near-poor Medicare beneficiaries
- Institute prospective payment methods for all Medicare services
- Improve Medicare's managed care option
  - Reform payment method
  - Set and enforce quality standards
  - Provide information to beneficiaries and manage enrollment process
- Analyze alternative sources of long-term financing

PREPARED STATEMENT OF LYNN ETHEREDGE

Mr. Chairman, Thank you for the invitation to testify this afternoon. My name is Lynn Etheredge. I am a health policy consultant working mostly with foundation-sponsored programs on health insurance reform. My experience related to Medicare includes having served as head of OMB's professional health staff, where I worked on Medicare issues during four administrations. I also serve on the PPRC panel on Medicare beneficiaries. My recent research has been concerned with the Medicare program's future.

Since Medicare's enactment, the national health policy debate has mostly been dominated by two competing visions—fee-for-service insurance and capitated HMOs. From today's perspective, these concepts appear as points on a continuum; the private sector is evolving many intermediate delivery and financing options.

Medicare consumers have been offered a choice between fee-for-service benefits and HMOs. As Congress considers Medicare's future, it is timely to take a broad look at the possibilities for new consumer-purchase and provider-offer options. What is this program going to be, on which Congress will be spending so many hundreds of billions of taxpayers dollars? What are the choices that beneficiaries will have to best meet their needs? to make a competitive market work for them? Such consideration is long overdue. One could argue that the traditional fee-for-service system made providers' interests paramount, while the emerging system of capitated health plans best serves payers' interests. While both systems have advantages for consumers, they also have drawbacks. Medicare reforms should address the question of how to design a menu of program choices that best serves beneficiaries and puts their interests first.

The choices now available to Medicare beneficiaries are analogous to the choices between a huge buffet table, with a very large number of 'a la carte dishes, and a chef's fixed price meal. New options could offer better service packages for individual patient needs, and stronger competition for both fragmented fee-for-service medicine and comprehensive health plans.

My purpose in this testimony, Mr. Chairman, is to provide an inventory of such proposals and to discuss some implementation issues.

DISCUSSION OF OPTIONS

The ideas for Medicare consumer choices span a wide range, from improved individual service delivery arrangements (e.g. durable medical equipment (DME)) to comprehensive service package options (e.g. a new Medicare plan (PPO) benefit, Medicaring for the terminally ill). Mostly, these ideas are preferred-provider variants the government would allow and encourage new provider products that offer better quality, services and economy (with improved benefits and/or lower patient copays), but Medicare enrollees would always have the option to elect fee-for-service or to choose fully capitated health plans. Frequently, a key feature of these new proposals is to foster specialization—development of new beneficiary-focused products that aim to do one or more things better, or to serve a special-needs population better. than fee-for service medicine. These new delivery arrangements could be financed by a variety of payment methods such as mixed fee-for-service/capita/ion, risk-sharing and performance incentives.

The following discussion arrays the new consumer-choice ideas by how many Medicare benefits would be packaged into the new option.

SINGLE SERVICE OPTIONS

Under this approach, Medicare would contract, on a preferred provider basis, for fairly standardized outpatient goods and service. Patients who used non-network providers would face higher co-pays than if they used in-network providers. Among the candidates for such contracts are durable medical equipment (DME), laboratory services, outpatient surgical procedures, diagnostic imaging, and home health services. Such preferred provider contracts might be a particularly useful tool for dealing with areas of quality problems, inefficiencies, fraud and abuse.

MULTI-SERVICE PACKAGES

A second set of new products for Medicare beneficiaries would extend Medicare's centers of excellence concept, e.g. heart bypass and transplants, to other inpatient procedures. These centers would be chosen on the basis of offering better outcomes, lower beneficiary costs, and improved benefits (e g. needed outpatient drugs). Hip replacements are one such area for HCFA's new centers of excellence initiative. More generally, multi-service packages can also be considered for other DRGs as well, particularly for major surgical procedures with demonstrated outcome dif-

ferences among providers. In principle, most DRGs could be competitively bid as service packages. Indeed, DRGs were initially designed to be diagnosis/procedure packages that could be managed—for cost and quality—and competitively marketed/purchased.

The concept of bundling services related to inpatient procedures can also be extended to integrated DRGs that make all Medicare A & B payments for inpatient care to a hospital-staff organization. The integrated DRG concept could bring perhaps 75% or more of Medicare's acute care expenses within a prospective payment system and would be a building block toward PSO (provider service organization) arrangements. The DRG payment system might also be extended by packaging acute care DRGs + rehabilitation services (rehabilitation facility, SNF, and home health) within an expanded DRG payment concept.

Another broad packaging concept is to pay physician group practices (and, possibly, physician practice management companies) on an incentive basis. The incentives, recognizing that physicians have a key role as care managers, would provide additional income for meeting certain preventive targets and for reducing hospital care through improved case management for chronic care populations and other efforts.

CHRONIC CARE PROGRAMS

Chronic care appears to be a fruitful area for new service products, targeted to specific groups, that would improve the Medicare program. Indeed, many chronic care patient groups have long been dissatisfied with fee-for-service arrangements that put money into provider "silos" and perpetuate a fragmented, uncoordinated delivery system focused on acute care episodes, rather than building on-going care programs with secondary and tertiary prevention needed by chronically ill patients. There is substantial research evidence to document the problems of fee-for-service arrangements in treating chronically ill patients and better alternatives.[1] At the same time, managed care plans now have no incentives to seek out, or to gain a reputation for excellence in serving, high-needs Medicare patients on whom they will predictably lose money under the AAPCC payment system. Chronic illness is particularly prevalent in the Medicare population; while acute care episodes for the under 65 population tend to be isolated events, acute care episodes for the Medicare population are more likely to be incidents in an on-going chronic disease process.

Among the promising kinds of management modules for chronic care patients that could be available for Medicare consumer choice are programs for patients with congestive hears failure that involve teams of nurse practitioner, protocols, and volunteers who call daily to check on a patient's weight, medication problems and well-being. Diabetes, asthma and chronic obstructive pulmonary disease programs are other examples of special preventive/management arrangements that could be adopted for Medicare's basic program. A large number of entrepreneurs are seeking to get into specialized disease management of high-cost, chronic ill patients, trying to sort out what approaches to incorporate into Medicare's choices. Comprehensive cancer care programs are another multi-service delivery option that are being contracted with by managed care plans for their cancer patients and could also be made available directly to Medicare program enrollees. Alzheimers patients are also among those who need services on a long-term basis in a number of settings, as are ESRD patients and others among Medicare's 5 million disabled. A broader concept is for chronic care networks that would provide comprehensive services for patients with a number of chronic conditions and service needs.

There are also possibilities for general case management entities that could be useful for special Medicare populations. The leading edge of managed care practice is to assess new Medicare entrants and put high-risk patients into case management programs. The "dual eligible" Medicare/Medicaid populations appear to be prime candidates for such management initiatives. Managed care companies are finding that providing primary care in nursing homes is less expensive than hospitalization of such patients, and a number of states are also interested in state government management of funds for the dual eligibles.

Finally, the range of services for Medicare's chronically ill beneficiaries could also include arrangements with pharmacy benefit management (PBM) companies to provide seniors with a "buying card" for pharmaceutical discounts, plus quality management. Particularly important for patients with chronic illness, this option would

[1] An recent overview of research on treatment for the chronically ill in both fee-for-service and other settings is Edward Wagner, et al. "Organizing Care for Patients with Chronic Illness" in Milbank Quarterly No. 4 1996. Chronic care "best practices by managed care companies are discussed in Peter Fox and Teresa Fama *Managed Care and Chronic Illness,* Aspen Publishers 1996.

save seniors (and Medicare's disabled) money on their pharmacy benefits and help to prevent mix-prescribing and drug-drug interactions. The pharmacy discount card in the Blue Cross/Blue Shield Federal Employees Plan is an example of such a benefit already widely enjoyed by members of Congress and government workers.

PATIENTS WITH TERMINAL ILLNESS

Major advances could also be made in offering better options for terminally ill patients. Since all Medicare enrollees will die in the program this is a potentially important area. Preliminary estimates show that roughly 40% of Medicare's spending for patients who die in a year are for patients with clinically-identifiable terminal illnesses, e.g. some forms of cancer, congestive heart failure, and chronic obstructive pulmonary disease. While individuals may live with these conditions for a number of years, they become predictably progressive and life-limiting. Improved programs, e.g. Medicating, are intended to avert predictable crises and unnecessary hospitalizations for such patients and to use savings for enhanced services. Nearer the end of life, wider availability of Respire services could also be part of Medicare's future.

COMPREHENSIVE OPTIONS

Medicare could also allow offer of comprehensive Medicare PPOs. This is an approach that could incorporate many of the individual options above and accelerate their development; it responds to concerns that it would be prohibitively difficult, contentious, and time consuming for HCFA to develop, contract, and administer individual-service and service-package PPO options throughout the country. In most versions, such a PPO would integrate current Medigap coverage as well. Thus beneficiaries would gain from the addition of Medigap benefits (prescription drugs and catastrophic protection), and there would be savings from eliminating the inefficiencies of Medigap policies as well as from provider rate discounts. An important variant on the Medicare PPO idea is to allow comprehensive Medicare PPOs for special needs populations, e.g. individuals with congestive heart failure, cancer patients, terminally ill patients, ESRO patients, etc. Such PPOs could be easier to organize and manage than HMOs that had to take on all Medicare population groups; they would actively compete for patients who are not now receiving the best care from Medicare fee-for-service and/or health plans.

There are also possibilities for expanding the current managed care options to include SHMOs (social HMOs) that offer comprehensive management of health care and long term care benefits. The proposed separation of the Medicare home health benefit into post-acute (Part A) and longer-term (Part B) components, as well as a new Alzheimer's respite benefit, will open up the possibilities for using the longer-term home health and respite benefits as the core for building new long-term care options into future service choices for Medicare enrollees, perhaps supplemented, in the longer term, by expanded private and public long term care benefits.

IMPLEMENTATION ISSUES

Three basic implementation issues for such initiatives are: priorities, fair payments, and feasibility.

(1) Priorities

Over the long haul, initiatives for the chronic care and high expense populations merit a top priority. One major reason is because so many of these population groups are still in fee-for-service Medicare, and under CBO options over 75% of the Medicare population will still be in fee-for-service in 2002. There need to be ways to act more of the benefits of better managed care and market competition for this group on a faster time schedule. PPO options, which employers introduced as an interim step between fee-for-service and capitated HMOs, offer an attractive way to retain the benefits of broad choice, while also providing ways for patients to benefit from "managed care light" options. A second major reason is that the HMO industry, with the AAPCC methods (and other risk adjusters now available), is simply not interested in competing for enrolling many of these Medicare high-need groups. Have you ever seen a billboard that says "If you have cancer, we're the health plan for you?" ? Medicare beneficiaries (and taxpayers) deserve a health system that is actively competing to give them excellent care regardless of their diagnosis.

(2) Fair payments

The current Medicare HMO option, with its fully capitated AAPCC payment, overpays, as do other Medicare prices, e.g. DME. Can these new PPO options be paid by better payment methods?

The problems of regulatory pricing can be dealt with by using market competition to set payment rates. In general, PPO payment rates would best be set by a combination of discounted fee-for-service and capitation (as proposed by Joseph Newhouse), plus performance incentives. There should also be learning over time about how to set rates, e.g. the AAPCC is akin to an insurer's "book rate"—the rate applied when there is very little information about the group being insured—while cumulating experience by the Medicare program and groups serving specific Medicare populations should produce much more useful "experience rate" bases.

(3) Feasibility

The concept of developing more Medicare consumer- choice products is consistent with recent market trends to fill in the continuum between fee-for-service and integrated HMOs. The various service packages or "management modules" described above are also consistent with market trends away from vertically integrated HMOs and toward health plans that contract with provider groups and networks. In such arrangements, one provider group will contracted to do orthopedics and hip replacements, another entity will be the cancer care network, a cardiology group will be selected to do the heart procedures, etc. The arrangements often have explicit selection criteria and performance measures, with providers are paid on a mixture of capitation, fee-for-service and incentives.The Medicare program would be adopting such leading edge business practices for its beneficiaries.

To carry out these market-oriented reforms, there will need to be both increased administrative discretion and Congressional oversight. Perhaps a Medicare advisory commission analogous to PROPAC's and PPRC's roles in evolving Medicare price regulations should be established for Medicare market-oriented reforms.

FROM HERE TO WHERE?

Medicare's greatest difficult in devising more consumer choices arises from its extraordinary dominance as a purchaser for its 37 million beneficiaries. If Medicare does not offer the kinds of new options described above, the private market is unlikely to develop them for the elderly. HCFA's development planning can probably operate on the maxim "Come and they will build it," i.e. with $200 billion of purchasing power and market-responsive providers, Medicare could evolve a wide range of new delivery system options for its enrollees.

One of the key tasks to develop such a menu is to generate even more good ideas, assess them, and select the best ones for further evolution. Three approaches may prove useful: (1) health services research that identifies the "best practices" of managed care plans; (2) discussions with patients, providers, and health plans about their preferences; and, (3) "invitational RFPs" that identify particular areas where Medicare would like to have more offerings, e.g. chronic care programs, and invites proposals for HCFA's consideration. A second major task ahead will be to move from demonstrations and prototypes toward broad scale implementation of the most promising ideas. This will require both a time-disciplined R&D strategy for such development, as well as an overall management strategy that offers these new consumer choices to the populations and areas that will most benefit from them. Both efforts will need bi-partisan support for a sustained period of field-trials, learning, and building administrative capabilities in which to evaluate such ideas and to make the most promising ones increasingly available as new Medicare beneficiary choices.

PREPARED STATEMENT OF JOHN C. GOODMAN

THE FUTURE OF MEDICARE

The federal government's own forecasts show that the Medicare program is on a collision course with reality. The taxes that will be needed to pay benefits in the future are far in excess of what taxpayers realistically will be willing to pay. Moreover, we cannot avert disaster by relying on quick fixes and minor changes. The only real solution is to move soon to a fully funded retirement system under which each generation pays its own way.

FORECASTS OF THE TRUSTEES

The key to understanding elderly retirement programs is to recognize that they are all based on pay-as-you-go finance. Social Security and Medicare benefits for today's retirees are paid with taxes collected from today's workers. When today's workers retire, their Social Security and Medicare benefits will have to be paid with taxes collected from future workers. The Medicare and Social Security Trustees

make three forecasts, based on different economic and demographic assumptions--"high cost," "intermediate" and "low cost" forecasts. For ease of discussion, I will term these "pessimistic," "intermediate" and "optimistic." People are encouraged to believe that the intermediate forecast is the most likely. But many students of Medicare and Social Security believe that the pessimistic projection more closely reflects our recent experience. (See Table I.)

The analysis that follows is based on the assumptions and forecasts published in the trustees' 1996 reports. For reasons discussed below, these reports are focused on actuarial balance, rather than on future tax burdens. Nonetheless, a presentation of some of the projected tax burdens can be found in the reports and is reproduced as an appendix to this testimony.

Medicare Part A. In 1995, Medicare Part A (the Hospital Insurance Trust Fund which pays primarily for inpatient hospital services) spent $2.6 billion more than it took in. The deficit is projected to grow each year for as far into the future as we care to look. Under the intermediate assumptions, Medicare Part A is forecast to require 9.74 percent—almost one out of every ten dollars—of the taxable payroll by 2040, when today's 22-year-olds retire. (See Table II.) Based on the pessimistic forecast, Medicare Part A will cost 18.4 percent of taxable payroll by 2040. (See Table III.)

These results are highly sensitive to increases in health care costs. In recent years, health care costs have been increasing at twice the rate of real wages. Were this trend to continue, health care spending would consume the entire gross domestic product by the middle of the next century. The Trustees understand that this is impossible, so they have arbitrarily assumed that health care costs will rise at the same rate as hourly wages in their intermediate forecast. The optimistic forecast assumes an annual increase 2 percentage points less and the pessimistic forecast assumes an annual increase 2 percentage points more. But even the optimistic and pessimistic forecasts assume convergence with the intermediate assumptions in the year 2045.

Medicare Part B. Medicare Part B (which primarily pays doctor bills and other outpatient expenses) is financed in part by monthly premiums that currently equal about 25 percent of the cost. General revenue pays the remainder. The Trustees project the government's share as a percentage of GDP. To give a clearer picture of the impact on workers, we have converted the projection to a percentage of Part A's taxable payroll. Under intermediate assumptions, the government's share of Medicare Part B will climb to 5.99 percent of taxable payroll in 2040, assuming that the elderly continue to pay one-fourth of the cost. (This is a conservative assumption; since premiums are restricted to grow no faster than Social Security payments, the elderly's share of Part B costs will fall to about 6 percent by the year 2070 under current law.) According to the pessimistic forecast, Part B cost will reach 11.32 percent in 2040. The government's combined spending on Parts A and B ranges from one out of every seven dollars (intermediate) to almost one out of three dollars (pessimistic).

As with Medicare Part A, the Trustees have arbitrarily restricted the growth rate of medical costs for Part B. In this case, health care costs are assumed for the intermediate forecast to grow at the same rate as GDP per capita. The optimistic and pessimistic forecasts assume growth rates 2 percentage points lower and 2 percentage points higher, respectively.

Other Government Health Care. Medicare is not the only way we pay for the medical bills of the elderly. We also pay through Medicaid for the poor, the Veterans Administration system and other programs. These expenditures are funded by general revenues. Health economists at the National Center for Policy Analysis have calculated this spending at 40.4 percent of Medicare spending, based on findings reported in the Health Care Financing Review. Based on the intermediate assumption, this burden will rise to 9.16 percent of taxable payroll in 2040. Based on the pessimistic assumption the burden will reach 17.3 percent in 2040.

When all health care costs paid by government are combined, the burden ranges from almost one of every three payroll tax dollars (intermediate) to more than one out of every two (pessimistic). In other words, to pay the medical bills of the elderly about the time today's college students retire, government may need to claim more than half the income of workers at that time. (See Tables IV and V.)

All Elderly Entitlements. Spending on Social Security benefits currently takes about 11.5 percent of taxable payroll. When total Medicare benefits are added in, the figure rises to more than 16 percent of taxable payroll. With other government health care, about 19 percent of the nation's taxable payroll is being spent on elderly entitlements today. By the year 2040, we have effectively pledged between 41 percent (intermediate) and two-thirds (pessimistic) of the income of future workers.

Figures I and II show elderly entitlement spending as a percent of taxable payroll under both the intermediate and pessimistic assumptions. Bear in mind that these forecasts assume that taxable payroll in the future will be the same, whether the tax rate is 15 percent or 80 percent. Experience shows otherwise. In the face of higher tax rates, people work less and avoid or evade taxes more. A good rule of thumb is: you will lose about one-third of the revenue you plan to receive from a significant tax hike.

We have had little experience with tax rates in excess of 35 percent to 45 percent for middle-income taxpayers. But we have had a lot of experience with tax rates above the range for the highest income earners. In general, whenever we have increased the rate for the highest income earners, their total tax payments have gone down, not up. In other words, beyond a certain point, higher tax rates do not collect additional revenue. Although the highest income earners have greatest discretion over how they receive income and the greatest skill at avoiding taxes in the face of high marginal rates, this is a skill that other taxpayers can learn.

THE ILLUSORY TRUST FUNDS

Most countries with pay-as-you-go retirement systems don't even have trust funds. We would probably be wise to follow their example. The funds not only mislead people—who think their taxes are actually being invested in something—they distract attention from the real funding problem.

Every payroll tax check sent to Washington is written to the U.S. Treasury. Every Social Security benefit check and medical reimbursement check is written on the U.S. Treasury. The trust funds are merely an accounting system—totally unessential to any real activity.

Technically, the trust funds hold interest-bearing U.S. government bonds, representing the accounting surplus of payroll taxes collected minus benefits paid. But these are very special bonds. The trustees cannot sell them on Wall Street, or to any foreign investor. They can only hand them back to the Treasury. In this sense, these bonds are IOUs the government has written to itself.

On paper, the Social Security trust funds have enough IOUs to "pay" Social Security benefits for about 17 months on any given day; the Medicare trust fund can "pay" benefits for about one year. In reality, they cannot pay anything. Handing IOUs back to the Treasury does not increase the size of Uncle Sam's bank account one iota. In order for the Treasury to write a check, it must first tax or borrow.

The existence of the trust funds has merely served to mask the unsustainability of our Social Security and Medicare systems in their current form. For example, the annual report of the Trustees of the Social Security trust funds tends to focus almost exclusively on the concept of actuarial balance. This treats bonds in the trust funds as assets (the way accountants would do if they were auditing a private pension fund) and ignores the fact that every asset of the trust funds is a liability of the Treasury. For the government as a whole these assets and liabilities net out to zero. If the trust funds were simply abolished, there would be no effect on real economic activity. No private bondholders would be affected. The government would not be relieved of any of its existing obligations or commitments.

Economist Robert Eisner has suggested that we abolish the trust funds or, with the stroke of a pen, double or triple the number of IOUs they hold. Either option would allow us to dispense with artificial crises and get on to the real problem: how is the Treasury going to pay the government's bills?

SOLUTIONS

The alternative to funding retirement benefits by income transfer is to fund benefits by saving. The alternative to creating escalating burdens for each successive generation of workers is for each generation to save for its own retirement benefits and pay its own way. While these ideas may appear radical, they are not without international precedent. Although the vast majority of countries have pay-as-you-go retirement benefits, a number of countries have avoided, or at least limited, the chain-letter approach to retirement income that characterizes our elderly entitlements programs.

If the United States is to move from pay-as-you-go systems to fully funded private systems, we must find a way to make the transition. All serious proposals made to date have involved giving individuals tax deductions or tax credits for deposits to private investment accounts. In return for the right to make such deposits, individuals (roughly speaking) would give up the right to draw a dollar in benefits for each dollar deposited in their private accounts. After a number of years, the private account balances would grow to a point at which the account holders' claims against government programs would be zero. Through such a mechanism, individuals could opt out of Medicare, Social Security and the survivors and disability system as well.

In this way, the U.S. could move quickly toward a private savings alternative to pay-as-you-go social insurance and avoid the financial crisis that looms in our future. The experience of other countries demonstrates that this is an option well worth considering.

FIGURE I

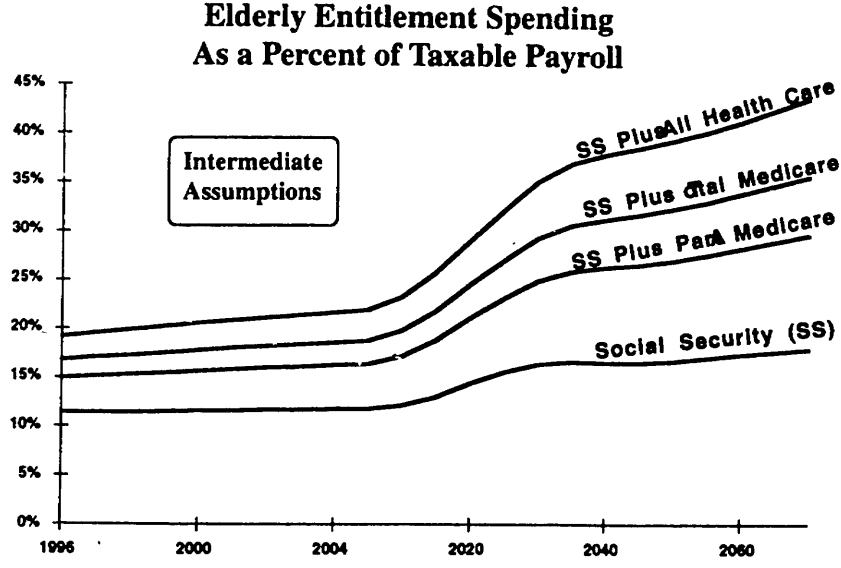


FIGURE II

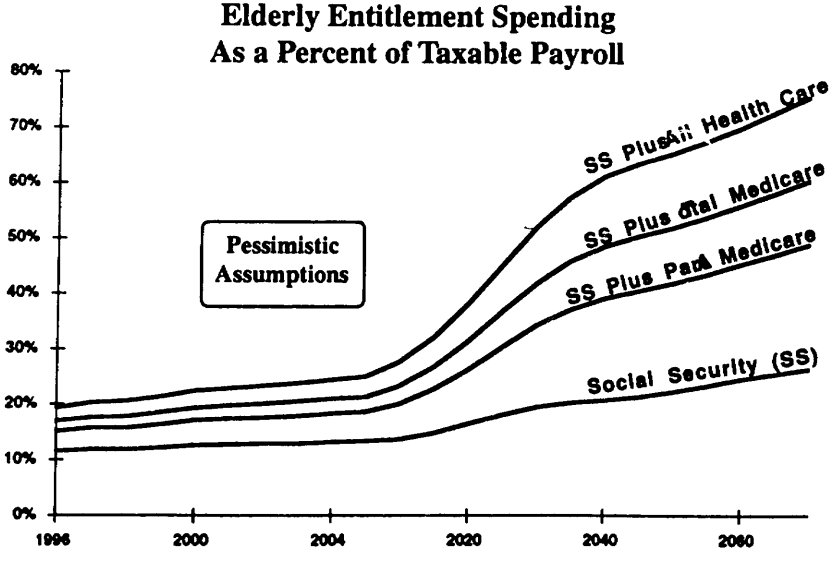


TABLE I

Key Economic and Demographic Assumptions for the Year 2020

Assumption	Recent Experience	Optimistic Projection[1]	Intermediate Projection[2]	Pessimistic Projection[3]
Total fertility rate	1.93[4]	2.2	1.9	1.6
Annual increase in real wages (%)	0.5[5]	1.5	1.0	0.5
Annual increase in consumer price index (%)	4.6[6]	3.0	4.0	5.0
Annual decrease in mortality rate (%)	0.9[7]	0.2	0.5	0.9
Annual increase in hospital costs (%)	12.8[8]	6.3	8.9	11.4

[1]Based on the Social Security Administration's Alternative I assumptions.

[2]Based on the Social Security Administration's Alternative II assumptions.

[3]Based on the Social Security Administration's Alternative III assumptions.

[4]Average number of children per woman of childbearing age for years 1980 to 1995.

[5]Average annual real wage rate for the years 1980 to 1995.

[6]Average annual increase for the period 1980 to 1995.

[7]Average annual decrease in the age/sex-adjusted death rate for the years 1980 to 1995.

[8]Measured as the annual rate of increase in Medicare inpatient hospital insurance payments for the years 1980 to 1995.

Source: *The 1996 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and the Federal Disability Trust Funds* Tables II.D.1 and II.D.2 and *The 1996 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund* Tables II.F.1 and II.F.3.

TABLE II

Elderly Entitlement Spending As a Percent of Taxable Payroll

Intermediate Assumptions

Calendar Year	Part A Medicare	Part B Medicare	Other Government Health Care for the Elderly	Social Security
2000	4.10%	1.83%	3.25%	11.59%
2005	4.59%	2.33%	3.89%	11.80%
2010	5.07%	3.11%	4.76%	12.12%
2015	5.78%	3.92%	5.75%	13.06%
2020	6.67%	4.51%	6.63%	14.41%
2025	7.58%	5.12%	7.53%	15.57%
2030	8.52%	5.66%	8.38%	16.38%
2035	9.25%	5.93%	8.91%	16.63%
2040	9.74%	5.99%	9.16%	16.52%
2045	10.08%	5.94%	9.25%	16.52%
2050	10.34%	5.93%	9.35%	16.70%
2055	10.58%	6.08%	9.58%	17.07%
2060	10.90%	6.26%	9.86%	17.43%
2065	11.32%	6.49%	10.23%	17.69%
2070	11.78%	6.64%	10.55%	17.91%

See footnotes to Tables IV and V.

TABLE III

Elderly Entitlement Spending As a Percent of Taxable Payroll

Pessimistic Assumptions

Calendar Year	Part A Medicare	Part B Medicare	Other Government Health Care for the Elderly	Social Security
2000	4.46%	1.99%	3.45%	12.73%
2005	5.34%	2.71%	4.52%	13.41%
2010	6.37%	3.91%	5.98%	13.87%
2015	7.88%	5.35%	7.85%	14.91%
2020	9.90%	6.69%	9.83%	16.59%
2025	12.33%	8.33%	12.25%	18.18%
2030	14.86%	9.87%	14.61%	19.50%
2035	16.94%	10.87%	16.32%	20.31%
2040	18.40%	11.32%	17.30%	20.84%
2045	19.20%	11.31%	17.62%	21.49%
2050	19.66%	11.28%	17.78%	22.36%
2055	20.12%	11.56%	18.21%	23.51%
2060	20.75%	11.93%	18.79%	24.68%
2065	21.55%	12.36%	19.48%	25.71%
2070	22.43%	12.65%	19.67%	26.64%

See footnotes to Tables IV and V.

TABLE IV

Elderly Entitlement Spending As a Percent of Taxable Payroll[1]

Intermediate Assumptions

Calendar Year	Part A Medicare	Total Medicare[2]	All Government Health Care for the Elderly[3]	All Government Health Care Plus S.S.
2000	4.10%	5.93%	9.18%	20.77%
2005	4.59%	6.92%	10.81%	22.61%
2010	5.07%	8.18%	12.94%	25.06%
2015	5.78%	9.70%	15.45%	28.51%
2020	6.67%	11.18%	17.81%	32.22%
2025	7.58%	12.70%	20.23%	35.80%
2030	8.52%	14.18%	22.56%	38.94%
2035	9.25%	15.18%	24.09%	40.72%
2040[4]	9.74%	15.73%	24.89%	41.41%
2045	10.08%	16.02%	25.27%	41.79%
2050	10.34%	16.27%	25.62%	42.32%
2055	10.58%	16.66%	26.24%	43.31%
2060	10.90%	17.16%	27.02%	44.45%
2065	11.32%	17.81%	28.04%	45.73%
2070	11.78%	18.42%	28.97%	46.88%

TABLE V

Elderly Entitlement Spending As a Percent of Taxable Payroll[1]

Pessimistic Assumptions

Calendar Year	Part A Medicare	Total Medicare[2]	All Government Health Care for the Elderly[3]	All Government Health Care Plus S.S.
2000	4.46%	6.45%	9.99%	22.72%
2005	5.34%	8.05%	12.57%	25.98%
2010	6.37%	10.28%	16.26%	30.13%
2015	7.88%	13.23%	21.08%	35.99%
2020	9.90%	16.59%	26.42%	43.01%
2025	12.33%	20.66%	32.91%	51.09%
2030	14.86%	24.73%	39.34%	58.84%
2035	16.94%	27.81%	44.13%	64.44%
2040[4]	18.40%	29.72%	47.02%	67.86%
2045	19.20%	30.51%	48.13%	69.62%
2050	19.66%	30.94%	48.72%	71.08%
2055	20.12%	31.68%	49.89%	73.40%
2060	20.75%	32.68%	51.47%	76.15%
2065	21.55%	33.91%	53.39%	79.10%
2070	22.43%	35.08%	54.75%	81.39%

Tables IV & V Footnotes

[1] Taxable payroll used to compute all the tax rates in this table is the tax base for the Old-Age, Survivors and Disability Insurance program (referred to as Social Security). It consists of wages and salaries of workers in employment covered by Social Security up to a maximum of $62,700 in 1996 for any worker. Actual taxable payroll for Medicare Part A is larger than that for Social Security because there is no maximum and more workers are covered. See 1996 *Board of Trustees Report*, Table III.A.2. Spending is net of the income tax revenues collected on Social Security benefits. Taxation of benefits is projected to amount to 0.25 percent of taxable payroll under intermediate assumptions and 0.30 percent under the pessimistic assumptions in 2000, increasing to 0.92 percent of taxable payroll under intermediate assumptions and 1.38 percent of taxable payroll under the pessimistic assumptions by the year 2070. See *Board of Trustees Report*, Table II.F.17.

[2] The Part B calculations are based on the Trustees' intermediate projections of the ratio of Part B to Part A as a percent of gross domestic product, and assume that Part B participants will continue to pay 25 percent of this amount through premiums. See 1996 *Report of the Board of Trustees of the Federal Supplemental Medical Insurance Fund*, Table III.A.1.

[3] Includes spending for the elderly under all government health programs. In 1987, per capita spending by people age 65 and over from Medicaid and other government health programs was 40.4 percent of Medicare spending. This study assumes the same relationship over the 75-year projection period. See Daniel R. Waldo, Sally T. Sonnefeld, David R. McKusick, and Ross H. Arnett, III, "Health Expenditures by Age, Group, 1977 and 1987." *Health Care Financing Review*, Vol. 10, No. 4, Summer 1989, Table 4.

[4] Year when today's 22-year-olds will reach age 65.

III. APPENDICES

Table III.A2. - Comparison of Estimated Income Rates and Cost Rates 1/ for OASDI and HI by Alternative, Calendar Years 1996-2070
[As a percentage of taxable payroll 1/]

Calendar year	OASDI Income rate	OASDI Cost rate	OASDI Balance	HI Income rate	HI Cost rate	HI Balance	Combined Income rate	Combined Cost rate	Combined Balance
Intermediate:									
1996.....	12.63	11.64	0.98	3.02	3.54	-0.52	15.64	15.18	0.46
1997.....	12.63	11.69	.94	3.02	3.68	-.67	15.65	15.38	.27
1998.....	12.63	11.72	.92	3.02	3.83	-.81	15.65	15.55	.11
1999.....	12.64	11.77	.87	3.02	3.97	-.95	15.66	15.74	-.08
2000.....	12.65	11.84	.81	3.02	4.10	-1.07	15.67	15.93	-.26
2001.....	12.65	11.89	.76	3.03	4.21	-1.19	15.68	16.10	-.43
2002.....	12.66	11.93	.72	3.03	4.31	-1.29	15.68	16.25	-.57
2003.....	12.66	11.97	.69	3.03	4.41	-1.38	15.69	16.38	-.69
2004.....	12.67	12.03	.64	3.03	4.50	-1.47	15.70	16.53	-.83
2005.....	12.67	12.07	.61	3.03	4.59	-1.56	15.71	16.66	-.95
2010.....	12.74	12.46	.29	3.07	5.07	-2.01	15.81	17.53	-1.72
2015.....	12.84	13.50	-.66	3.12	5.78	-2.66	15.96	19.27	-3.32
2020.....	12.94	14.95	-2.02	3.17	6.67	-3.49	16.11	21.62	-5.51
2025.....	13.03	16.20	-3.17	3.22	7.58	-4.35	16.25	23.78	-7.53
2030.....	13.10	17.08	-3.98	3.27	8.52	-5.25	16.37	25.60	-9.23
2035.....	13.15	17.38	-4.23	3.29	9.25	-5.95	16.45	26.62	-10.18
2040.....	13.17	17.29	-4.12	3.31	9.74	-6.43	16.48	27.03	-10.55
2045.....	13.19	17.31	-4.12	3.32	10.08	-6.76	16.51	27.39	-10.88
2050.....	13.21	17.51	-4.30	3.33	10.34	-7.01	16.55	27.85	-11.31
2055.....	13.25	17.92	-4.67	3.35	10.58	-7.23	16.60	28.50	-11.90
2060.....	13.28	18.31	-5.03	3.37	10.90	-7.53	16.65	29.21	-12.56
2065.....	13.30	18.59	-5.29	3.38	11.32	-7.94	16.69	29.92	-13.23
2070.....	13.32	18.83	-5.51	3.40	11.78	-8.38	16.72	30.61	-13.89
Low Cost:									
1996.....	12.62	11.52	1.10	3.01	3.51	-.50	15.64	15.03	.61
1997.....	12.62	11.36	1.26	3.01	3.59	-.58	15.64	14.96	.68
1998.....	12.62	11.20	1.42	3.01	3.67	-.66	15.64	14.88	.76
1999.....	12.63	11.06	1.56	3.01	3.74	-.73	15.64	14.80	.84
2000.....	12.61	10.94	1.67	3.01	3.80	-.78	15.63	14.74	.89
2001.....	12.63	10.85	1.78	3.01	3.85	-.83	15.64	14.70	.95
2002.....	12.63	10.76	1.88	3.02	3.88	-.87	15.65	14.64	1.01
2003.....	12.64	10.69	1.94	3.02	3.92	-.90	15.65	14.61	1.04
2004.....	12.64	10.63	2.01	3.02	3.95	-.93	15.66	14.58	1.08
2005.....	12.64	10.58	2.06	3.02	3.96	-.95	15.66	14.54	1.12
2010.....	12.70	10.79	1.91	3.05	4.08	-1.03	15.75	14.87	.87
2015.....	12.78	11.67	1.11	3.09	4.30	-1.21	15.87	15.98	-.11
2020.....	12.86	12.84	.02	3.14	4.60	-1.46	15.99	17.44	-1.44
2025.....	12.93	13.75	-.82	3.18	4.76	-1.58	16.11	18.51	-2.40
2030.....	12.98	14.23	-1.25	3.21	4.98	-1.77	16.19	19.21	-3.02
2035.....	13.00	14.15	-1.15	3.22	5.14	-1.92	16.23	19.30	-3.07

2040.....	13.01	13.73	-.73	3.23	5.26	-2.04	16.23	18.99	-2.76
2045.....	13.01	13.41	-.40	3.23	5.40	-2.17	16.23	18.81	-2.57
2050.....	13.01	13.27	-.25	3.23	5.53	-2.30	16.24	18.79	-2.55
2055.....	13.02	13.27	-.25	3.24	5.66	-2.42	16.26	18.93	-2.67
2060.....	13.03	13.26	-.22	3.24	5.83	-2.59	16.28	19.09	-2.81
2065.....	13.04	13.18	-.14	3.25	6.06	-2.81	16.28	19.24	-2.95
2070.....	13.04	13.12	-.08	3.25	6.30	-3.06	16.29	19.42	-3.13
High Cost:									
1996.....	12.63	11.85	.78	3.02	3.59	-.57	15.65	15.44	.21
1997.....	12.64	12.18	.46	3.02	3.84	-.81	15.66	16.02	-.36
1998.....	12.64	12.09	.55	3.03	4.00	-.97	15.67	16.09	-.43
1999.....	12.65	12.52	.14	3.03	4.21	-1.18	15.69	16.73	-1.04
2000.....	12.70	13.03	-.32	3.04	4.46	-1.42	15.74	17.48	-1.74
2001.....	12.68	13.12	-.44	3.04	4.63	-1.59	15.72	17.75	-2.03
2002.....	12.68	13.24	-.56	3.04	4.80	-1.75	15.73	18.04	-2.31
2003.....	12.69	13.38	-.69	3.05	4.98	-1.93	15.74	18.36	-2.62
2004.....	12.70	13.56	-.86	3.05	5.16	-2.11	15.75	18.72	-2.97
2005.....	12.71	13.72	-1.02	3.05	5.34	-2.28	15.76	19.06	-3.30
2010.....	12.80	14.27	-1.47	3.10	6.37	-3.28	15.89	20.64	-4.75
2015.....	12.91	15.42	-2.51	3.15	7.88	-4.73	16.06	23.30	-7.24
2020.....	13.03	17.22	-4.19	3.22	9.90	-6.69	16.25	27.12	-10.88
2025.....	13.15	18.93	-5.78	3.29	12.33	-9.04	16.43	31.26	-14.83
2030.....	13.25	20.35	-7.09	3.35	14.86	-11.51	16.60	35.20	-18.61
2035.....	13.33	21.24	-7.92	3.39	16.94	-13.55	16.72	38.19	-21.46
2040.....	13.38	21.82	-8.44	3.43	18.40	-14.97	16.81	40.21	-23.40
2045.....	13.44	22.53	-9.09	3.46	19.20	-15.74	16.89	41.73	-24.83
2050.....	13.50	23.46	-9.97	3.49	19.66	-16.17	16.99	43.13	-26.14
2055.....	13.57	24.68	-11.11	3.54	20.12	-16.58	17.11	44.80	-27.69
2060.....	13.65	25.93	-12.28	3.58	20.75	-17.17	17.23	46.68	-29.45
2065.....	13.72	27.03	-13.31	3.62	21.55	-17.93	17.34	48.59	-31.24
2070.....	13.78	28.02	-14.24	3.66	22.43	-18.77	17.44	50.45	-33.01

1/ The taxable payroll for HI is significantly larger than the taxable payroll for OASDI because the HI taxable maximum amount was eliminated beginning 1994, and because HI covers all Federal civilian employees, including those hired before 1984, all State and local government employees hired after April 1, 1986, and railroad employees. Combined OASDI and HI rates as a percent of taxable payroll are computed as the sum of the rates for the separate programs.

Notes:
1. The income rate excludes interest income and certain transfers from the general fund of the Treasury.
2. Totals do not necessarily equal the sums of rounded components.

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PREPARED STATEMENT OF ROBERT B. HELMS

Last week was a busy time for policy makers and policy analysts concerned with the future of the Medicare program. This committee heard a presentation by Tom Saving and Andrew Rettenmaier of a major new proposal to save Medicare along with several serious critiques of their proposal.[1] In addition, approximately 14 presentations by the country's leading policy experts, three of which are on this panel, were presented at a two-day conference on Medicare reform at Princeton University.[2] After listening to and reading this expert analysis, I came to the following three conclusions about the current state of the Medicare debate within the health policy community. First, there seems to be rather strong agreement that the Medicare program is in serious financial trouble in both the short run and the long run—the short run because of expected depletion of the Part A trust fund by 2001, and in the long run because of the aging of the baby boom generation in the next century. Despite this agreement, my second conclusion is that there is substantial disagreement within this sample of the policy community about what policies should be adopted to reform Medicare. There is disagreement about the magnitude of the problem, about what we should do this year, and about what we should do to solve Medicare's longer term problems.

My third observation is that there seems to be a sense of extreme pessimism among health policy analysts about the ability of our political system to come to an agreement on an efficient and effective reform strategy. After more than 20 years in Washington, I share that pessimism, not because I think there is something wrong with our political system, but because of the difficult and complicated situation we have created for ourselves with Medicare. It was easy to establish and expand Medicare when the population of tax-paying Americans was growing relative to those receiving benefits. Popular benefits could be given to the elderly and disabled without requiring them to pay much of the cost, the cost of these benefits could be spread over a large and growing population of workers, and no one had to worry very much about either the costs or the future.

But today the tables are beginning to turn and it does not come easy for most politicians, excluding yourself, Mr. Chairman, to stand up and tell the American people that either we are going to have to pay more taxes or we are going to have to reduce benefits. Improvements in the competitive performance of medical markets can go a long way to ease the pain, but the magnitude of Medicare's problems is so great that we cannot avoid all pain. That is why hearings of this nature are so important to start educating the American voter about the real choices we face to save Medicare for future generations.

But what are the real choices we have for Medicare reform? I would like to comment on two aspects of the policy choices we face—the magnitude of Medicare's financial problem and three policy approaches that I think should be the central focus of both the policy and the political debate.

THE MAGNITUDE OF MEDICARE'S FINANCIAL CRISIS

There are numerous predictions of Medicare's future financial plight, but in my view, nothing is more alarming than the last report of the HI trustees, a document typically known for its dry and technical language. Some examples follow:

> The HI program remains severely out of financial balance. As we have said since 1992, we must report that the HI trust fund does not meet even our short-range test of financial adequacy.
>
> The long-range outlook also remains extremely unfavorable. The trust fund fails by a wide margin to meet our long-range test of close actuarial balance. . . . To bring the HI program into actuarial balance, over just the next 25 years under the intermediate assumptions, would require either that outlays be reduced by 39 percent or that income be increased by 63 percent (or some combination of the two) throughout this 25-year period.
>
> . . . substantially stronger steps will be needed to prevent trust fund depletion after 2010 as the baby boom generation reaches age 65 and starts receiving benefits. At that time, the ratio of workers to HI beneficiaries, currently about 4 to 1, is projected to begin declining rapidly to a ratio of about 2 to 1.[3]

My own way of illustrating the magnitude of Medicare's problem is to convert the trust fund reports' income and cost figures as a percent of payroll into actual dollar amounts and look at the annual difference between Medicare's projected revenues and expenses. Based on the latest Trustees' Report, these annual differences, as illustrated by Chart 1, are $48 billion in the year 2000, and $154 billion in 2010. After 2010, as the baby boom generation begins to become eligible for Medicare, these differences between current law expenditures and receipts increase to $268 billion in 2015 and $456 billion in 2020.[4]

By whatever standard you want to use, these are large numbers. But they are not without their critics, mostly people who think that the actuaries' assumptions about the rate of growth of per unit of service is too optimistic given past experience.[5] But arguing about economic assumptions seems somewhat equivalent to rearranging the deck chairs on the *Titanic*—these forecasts are driven by demographic projections that, barring a major war or new disease, we can accept with a high degree of confidence. For example, in the year 2030 when the last baby boomer turns 65, on the basis of people alive today, we know there will be approximately 78 million people on Medicare (compared to 37 million today) and approximately 170 million people employed and paying taxes (compared to 144 million today).[6] The iceberg is there and, like the *Titanic*, the longer we wait to turn the rudder, the more difficult it will be avoid a political disaster.[7]

The magnitude of Medicare's financial situation will always be controversial. Whether the methodology is Greek Delphic or modern actuarial, no one has developed a sure-fire way to predict the future. But my impression is that few in the policy community are being realistic about the size of the problem we face. Stuart Altman[8] and Karen Davis [9] have recently reminded us that there are broader social functions and financial assistance for the poor elderly that are now an important part of the Medicare program. Keeping the elderly's out-of-pocket payments and premiums low and supporting various good causes are popular parts of Medicare, but these functions cannot be continued unless we find a way to substantially restructure Medicare. In my view, it is not realistic to keep talking about maintaining an open-ended entitlement program that is known to have very weak incentives for both providers and beneficiaries to make careful and cost-effective medical decisions. Like the Titanic, the Medicare ship is not well designed for the number of passengers it is carrying.

THREE PREFERRED POLICY CHOICES

There are several different policy approaches that involve the use of regulatory and competitive strategies that will likely be the focus of the debate about Medicare reform. In previous testimony, I have tried to point out why I think policies that attempt to change consumer and provider incentives are superior to policies relying on direct government controls.[10] Today I would like to briefly discuss three approaches that would be superior to any policy based on direct controls of prices or utilization. All three approaches attempt to achieve structural reform of Medicare by relying on the incentives of beneficiaries and providers to make the kind of decisions that we associate with most non-medical markets. Actual reform using any of these three approaches would be a vast improvement over our present program, but the kind of reform we achieve with each may be different.

1. Structured Competition. This term refers to a set of policies that could be adopted by Medicare to try to achieve the type of competitive market reform that is currently developing in private health insurance and health delivery markets. These policies were recently presented to this committee by Len Nichols of the Urban Institute in his testimony last week.[11] To "make market competition work for Medicare," Nichols discusses a number of requirements that Medicare could impose to assist beneficiaries to make informed choices among competing plans. These would include defining the benefits that Medicare plans would have to offer, regulating enrollment and marketing practices, and publishing information about the plans. In addition, Medicare would become a more aggressive purchaser of health care services by negotiating competitive bids with plans and risk adjusting plan payments to reduce selection bias.

This approach has much to commend it, especially when compared with the perverse incentives in Medicare's present fee-for-service sector and the distorted form of competition created by the way we pay for managed care. Structured competition is based on the concept of creating competition among plans to satisfy beneficiaries demands for both quality care and cost effective choices. The evidence Nichols presents about the effects of competition in the private sector is encouraging, both in showing consumers' ability to make choices when they are given the incentive to do so, and the ability of providers to offer quality care.

The disadvantage of this approach is that it involves the government in the highly prescriptive exercise of defining benefit packages and allowing only those market prices determined through the competitive bidding process. Competition will occur in this environment, but it is more likely to be the kind of competition we get in regulated industries than the competition we get in markets where firms are more free to compete on the basis of quality and price. In addition, a key factor in evaluating a structured competition approach is what will happen to the existing fee-for-service sector. Efficient competition and new benefits in Medicare choice plans

might cause a more rapid decline in the fee-for-service sector than is presently occurring, but this depends to a large extent on the payment levels in the fee-for-service sector and what action these providers take to attract beneficiaries back from the qualified plans. Fee-for-service Medicare is still the dominant part of Medicare, so we have to envision a relatively large shift to capitated plans or stringent payment controls to be able to predict a major change in the growth of Medicare expenditures. I agree with Nichols when he doubts that such an approach can "save Medicare."[12]

2. A Defined Contribution Plan. In its purest form, a defined contribution approach to Medicare reform would make available to each person eligible for Medicare a fixed payment that could be used by that person to purchase a health plan of their choosing. Each plan would be free to set its own price and determine the features of the plan it wished to offer. Each individual would be free to spend more or less than the fixed amount allowed by Medicare. It is based somewhat on the model of the health plan for federal employees , although the determination of the amount to be paid in that program is determined by the performance of the largest plans rather than by the Congress.[13]

The theory behind this approach is that Medicare beneficiaries would have strong incentives to choose plans that satisfied their own preferences and competing plans would have strong incentives to satisfy consumers by providing them with the combination of quality, service convenience, and price that they wanted. The result would be economically efficient performance with a minimum of government regulation and direction. Most proponents of this approach, including myself, envision that Medicare would have to adjust the fixed payment on the basis of age, health status, and maybe geography to minimize incentives to serve only the healthiest beneficiaries.

There are two basic criticisms of a defined contribution approach, one economic and one political. In my view, the political criticism is more serious than the economic.

The economic criticism has been expressed by Karen Davis in previous testimony and I imagine will be expressed again in this hearing.[14] Briefly, the criticism is that Medicare will not provide a fixed payment sufficient to maintain the benefits that the elderly enjoy under the present system. Wealthier elderly will be able to pay for more elaborate benefits while the poor elderly would be able to afford only a bare-bones plan or a catastrophic plan with high deductibles and copayments. The result would be a two-tiered system of health care leaving the poorest elderly with reduced access to care and increase financial risk.[15]

There are two answers to this criticism. The first is that it is an extremely pessimistic view of the effects of market competition among plans. While some competing plans could be expected to move away from inefficient first-dollar coverage, it is unlikely that the market (consumers and other health plans) would allow them to put all these savings into profits. As we now see in some Medicare choice markets, plans can be expected to compete for enrollees by offering them expanded benefits such as prescription drugs. In all economic markets, consumers value the ability to match their specific wants to actual products and services, so I see no reason why they would not be better off with this kind of choice in health markets.

The second answer is that we need to distinguish between our desire to create an efficient health care market and our desire to subsidize the poor. While a more efficient health care system would give the poor more options, they may be exposed to more first-dollar financial risk unless we adopt an explicit policy to give additional financial assistance to the poor elderly. This could be done through the welfare system, through the tax system, or directly through Medicare by adjusting the fixed dollar payment on the basis of income. Whatever this subsidy turns out to be, it will buy more for the recipients if they have a more efficient health care market in which to shop.

The second basic criticism of a defined contribution approach is a political one. This criticism is based on political science and public choice theories explaining how politicians obtain political advantage by passing and maintaining programs with hidden taxes and hidden subsidies. If the art of politics is obtaining votes by convincing people that you can provide benefits to them at little or no cost, then Medicare is an efficient political machine that fools most of the people most of the time. As the Saving and Rettenmaier history of Medicare clearly shows, most of the present beneficiaries pay little of the costs of their present benefits and those paying for the program are under the illusion that they are investing in a trust fund to pay for their future benefits. Most Members of Congress like the fact that they do not have to make difficult budget decisions because the federal government is obligated to pay for entitlements. The criticism of the defined contribution plan is that it is not politically realistic because it forces the Congress and the Administration

to make an explicit annual decision about how much it is willing to pay for this program. Making Medicare funding transparent, as the Europeans say, goes against every known theory of political behavior so that fundamental reform of the kind we are discussing today is unlikely to be addressed.

Maybe this admittedly cynical theory of political behavior is wrong and the public will learn to award those politicians who are honest about Medicare. We have some evidence that the political reward system has changed in the areas of transportation and environmental regulation. As the aging of the baby boom pushes Medicare funding into public view, we will be presented with a grand opportunity to test which theory of political behavior will dominate.

3. Personal Retirement Insurance for Medical Expense (PRIME). Last week Tom Saving and Andrew Rettenmaier presented the rough outline of a plan they are developing to redesign Medicare.[16] Their plan is equivalent to putting the ship in dry dock and making sure the rudder, the engine, and the navigation system will do the job. Unlike most reform proposals that concentrate on reforms in the delivery of health care, the parts of the proposal they have developed so far concentrate on the long term financing, especially the transition from the current pay-as-you-go system to their new system based on age-related cohorts of Medicare beneficiaries. This is a welcome addition to the reform debate because it tackles the problem of how to restore the long term financial solvency of Medicare as well as how to improve the efficiency of the health market.

It is easy to get lost in the trees, so let me step back and try to describe their forest. Starting with the delivery side first, which is only briefly described at this point, Saving and Rittenmaier propose that Parts A and B of Medicare be combined and offered in the form of a catastrophic plan with a relatively high annual deductible (they use $2,500 in their estimates). By keeping the payroll tax at its present level of 2.9 percent, the savings from the lower cost of the catastrophic plan are used to fund Medicare for the older cohorts of beneficiaries, both those already on Medicare and those above some cutoff age (39 in their example) who would expect to stay with traditional Medicare. Each of the younger workers, those below the cutoff age, would begin paying the amount of their payroll taxes into a fund designed to provide Medicare coverage for all of the people of the same age. Since the younger cohorts would pay into the system for a longer period, there would be enough time to accumulate a fund to pay for their care after retirement at age 65. Each of these cohort funds would be real savings and invested to earn market rates of return. By the time the older of the working people retire, the system would have accumulated enough funds to cover the cost of providing catastrophic coverage for the older workers as well as the new cohorts of workers retiring each year. The result is a gradual conversion of our present pay-as-you-go system to a system funded by a dedicated fund, a trust fund in the original sense of that word.

The easiest prediction to make is that this is a plan that economists will love to criticize. The authors' attempt to illustrate how such a system might work utilizes numerous assumptions about economic and financial behavior that are exactly the kinds of issues economists like to question and debate. These two authors are well qualified to participate in that debate, so it will be interesting to see further work on this proposal and what competing plans others may come up with to solve the here-to-fore unsolvable problem of how to correct an unfortunate series of past policy decisions that got us into this mess.

Meanwhile, this proposal can be expected to be criticized along the same lines as the other two market proposals discussed above. Concerns will be expressed about the financial risks that catastrophic plans may put on the poor and middle-income elderly who have to use the medical system. Pessimistic predictions of the harmful effects of competition will continue to be expressed since, like all market-based plans, the PRIME proposal envisions the use of competitive incentives to induce plans to control costs and maintain quality. Still, in my view, this is a welcome addition to the Medicare reform debate which, regardless of what happens in this year's myopic budget debate, will heat up in the coming years.

ENDNOTES

[1]: Thomas R. Saving and Andrew J. Rettenmaier, "Medicare Policy for Future Generations: A Search for a Permanent Solution," Statement before the Subcommittee on Health Care, Committee on Finance, United States Senate, February 27, 1997; Statements by Len M. Nichols and Stuart H. Altman at the same hearing.

[2]: The Princeton conference, held on February 27—March 1, 1997, was organized by the Council on the Economic Impact of Health System Change at Brandeis University.

[3]: All three quotes taken from the *1996 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund,* p. 15.

[4]: Intermediate projections of the *1996 HI Trustees' Report,* Table II.E2; Payroll figures from the Office of the Actuary, HCFA. It is worth remembering, as former HCFA Chief Actuary Guy King has reminded us, these Part A deficits cannot happen under current law. Therefore, these differences in projected receipts and expenditures should be looked on as an indicator of the size of the problem we have to correct. Part B projections are a different matter since that so-called trust fund has an unlimited claim on general revenues.

[5]: Robert D. Reischauer, "Medicare: 2002 and Beyond," Testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, February 13, 1997, p. 2. See also HCFA Chief Actuary Guy King's repeated warnings about over-optimistic assumptions in the HI Trustees' Reports for the years 1988-1994.

[6]: *1996 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund,* p. 13.

[7]: For an intriguing account of why the design of the Titanic's rudders prevented it from avoiding the iceberg, see George W. Hilton, Eastland: *Legacy of the Titanic.* Stanford University Press, 1995, pp. 1-3.

[8]: Stuart A. Altman, "Should Medicare Pay Social Benefits?" Paper presented to the Princeton Conference on Medicare Reform, February 28, 1997.

[9]: Karen Davis, "Medicare Budget Savings: Are We On the Right Course for the Long-Term? Testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, February 13, 1997.

[10]: Robert B. Helms, testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, February 10, 1994, and February 13, 1997.

[11]: Len M. Nichols, "Restructuring Medicare," testimony before the Subcommittee on Health Care, Committee on Finance, United States Senate, February 27, 1997.

[12]: Nichols, p. 8.

[13]: For a history and analysis of the FEHBP, see Walton Francis, "The Political Economy of the Federal Employees Health Benefit Program," in Robert B. Helms, ed., *Health Policy Reform: Competition and Controls.* Washington, D.C.: The AEI Press, 1993, pp. 269-307.

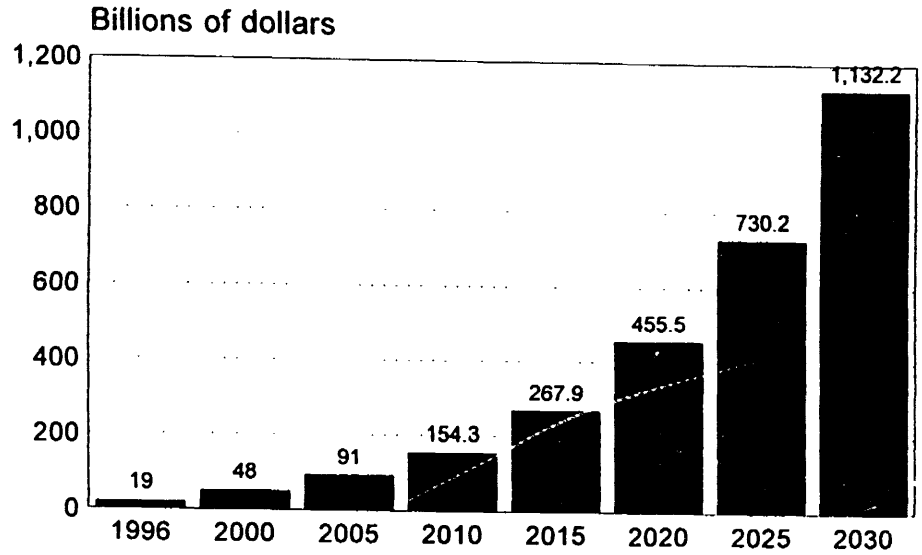
[14]: Karen Davis, Ways & Means testimony, pp. 10-12.

[15]: A variation of this criticism is that in the long run Medicare is in such financial trouble that the Congress would not be able to afford to maintain a fixed payment sufficient to assure the present level of benefits. That is true, but we will face the same problem under current law, so I do not see that as a criticism of a defined contribution approach.

[16]: Thomas R. Saving and Andrew J. Rettenmaier, "Medicare Policy for Future Generations: A Search for a Permanent Solution," testimony before the Subcommittee on Health Care, Committee on Finance, United States Senate, February 27, 1997.

Chart 1

Annual Cash Flow Deficits of the HI Trust Fund 1996-2030



Sources: Intermediate Projections of the 1996 HI Trustees' Report, Table II.E2; and Office of the Actuary, HCFA.

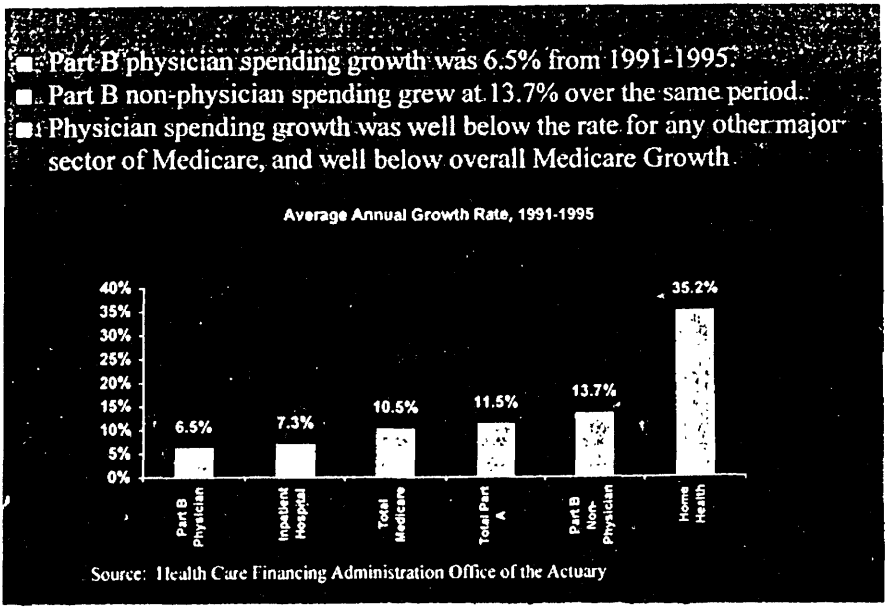
PREPARED STATEMENT OF DANIEL H. JOHNSON, JR., MD

Mr. Chairman, my name is Daniel H. Johnson, Jr., MD. I am a radiologist from Metairie, Louisiana, and President of the American Medical Association (AMA). On behalf of the 300,000 physician and medical student members of the AMA, I thank you for the opportunity to present testimony to the Subcommittee today regarding the AMA's proposal to transform Medicare. We are pleased to share our thoughts with you as the Congress considers how to protect Medicare for our seniors and save it for our children.

A wide range of experts have independently concluded that, despite Medicare's clear success in improving the health status of our elderly and disabled citizens, the program cannot be sustained without fundamental restructuring. The Hospital Insurance Trust Fund faces bankruptcy in five years or less. The program contains almost no incentives for providers of services—or patients—to be efficient in providing or using medical care. There is no competition among providers in price, no effective cost sharing among beneficiaries, and very little choice in health plans available for seniors. In short, the Medicare program is structurally flawed and the time has passed for tinkering and minor modifications.

PROBLEMS WITH MEDICARE

It is clear that Medicare's current expenditure growth cannot be sustained. The high growth rates for many of the services are due to a combination of factors, including increased beneficiary demand for new services, slow program response to known flaws in payment rules which encourage high volume growth in some categories of service, insulation of most beneficiaries from cost considerations, and ineffective approaches to cost control. However, as the chart below indicates, spending on physician services is not the problem in Medicare's growth. The AMA is pleased that the President's 1998 budget proposal explicitly recognizes this fact.



In addition, Medicare faces a daunting longer-term problem: the number of workers contributing payroll taxes to finance the hospital trust fund is declining. In 1965 when Medicare was enacted, there were 5.5 working-age Americans for every individual over 65. Today, there are only 3.9. In the coming decades, as the "baby boom" generation continues to age, the number will fall more rapidly. By the year 2030 there will be only 2.2 working-age Americans for each individual over age 65. By that time, 20% of the population will be covered by Medicare, compared with 12.8% now.

I would like to emphasize our belief that Congress and the Administration should enact fundamental reforms now in order to save Medicare for future generations.

If this Congress only addresses the short-term problems with the Hospital Insurance Trust Fund by reducing payments and making minor modifications to the program, while postponing the major restructuring needed for the long-term, the long-term problems will only grow larger, requiring more draconian and expensive solutions. The AMA has a plan which addresses both the short and long-term problems with Medicare.

AMA'S PROPOSAL FOR MEDICARE TRANSFORMATION

The AMA's *Transforming Medicare* proposal is based on 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 and the disabled. We must give patients both the opportunity and the responsibility to make wise prospective choices of their physician and health plan, with the reasonable opportunity to change either if they prove unsatisfactory. An effective health care marketplace is only achievable if we rid ourselves of the current program's distortions that have had the perverse effect of aggravating, rather than easing, the government's burden in keeping Medicare's promise. As long as Medicare insulates patients from the true cost of the services they are consuming, a competitive Medicare marketplace will never flourish and costs will continue to escalate.

The AMA has synthesized ten years of policy development into our proposal which has been distributed to every Member of the Congress. Our plan can be distilled to three main points:

1. Modernize traditional Medicare, eliminating the need for Medigap, while preserving the security and quality of care beneficiaries now receive;
2. Create a broad menu of health plan choices for Medicare beneficiaries to choose from, including Medical Savings Accounts (MSAs) and Provider Sponsored Organizations (PSOs);
3. Ensure that a healthy Medicare is available for future generations.

We are very pleased that the basic elements of the AMA's proposal to transform Medicare received the healthy endorsement of the American public in a nationwide survey released this month. The *AMA Nationwide Survey on Medicare Issues,* conducted by the independent Global Strategy Group, Inc., found that sixty percent of those surveyed believed Congress and the President should completely redesign or make major changes to the current Medicare program. Sixty-nine percent support allowing Medicare beneficiaries the choice of staying in the traditional program or choosing from competing health plans. Sixty-eight percent support eliminating the need for a separate private supplemental policy by folding Medigap into Medicare coverage. All of these positive design features are central to the AMA's *Transforming Medicare* plan.

I. MODERNIZE TRADITIONAL MEDICARE

We believe the traditional Medicare program should continue to be an option for Medicare beneficiaries. Because most beneficiaries are likely to remain in the traditional program for many years, it is necessary to restructure the program to make it more efficient. Our proposal calls for modernizing the insurance plan that is offered by eliminating the need for Medigap, and replacing over time the antiquated and failing system of price controls with a structured competitive pricing and reimbursement system.

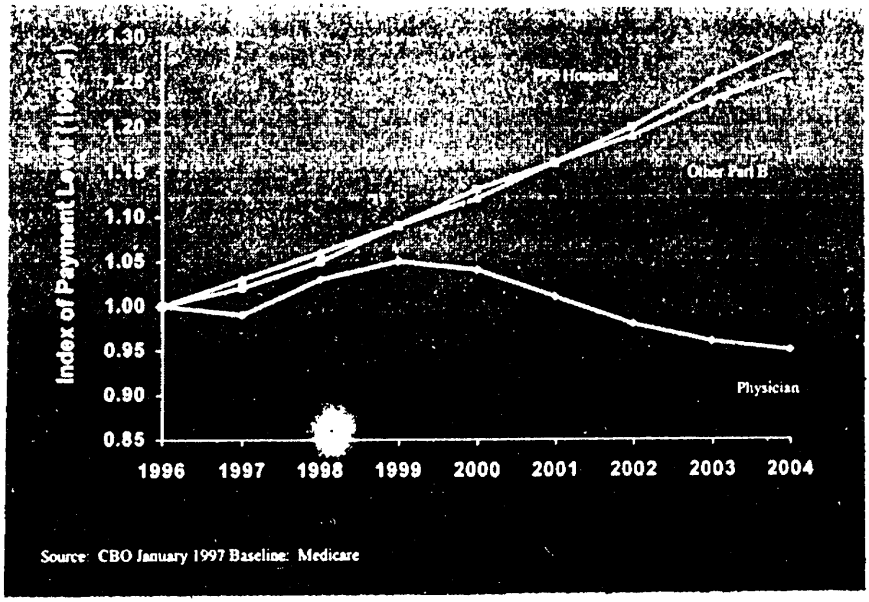
The current Medicare system relies on separate deductibles for Parts A and B, as well as a confusing variety of copayments based on everything from the number of hospital days covered down to the amount of blood received. However, most beneficiaries effectively convert Medicare into first-dollar coverage by purchasing private supplemental insurance coverage or Medigap. The AMA proposal would do away with the need for Medigap by eliminating all cost-sharing except for a refundable deductible that would be collected and placed in an escrow account in the beneficiary's name.

The AMA's improved traditional health plan would have the same coverage as three separate policies contain today (Part A, Part B, and Medigap Plan C). In addition to simplifying the program, shifting to a single deductible in lieu of existing copayments would lead enrollees to be more price conscious about acquiring routine medical care, while not leaving them vulnerable to non-routine, expensive episodes of illness. The savings produced under this improved arrangement would be shared by both the program and beneficiaries.

Our proposal achieves savings while minimizing further reductions that will push many physicians over their own budgetary red line, reducing or eliminating entirely their ability to continue caring for Medicare patients. I want to emphasize that these savings do not have to come from a continuation of past failed policies repeat-

edly reducing physician payments, such as those provided in the President's budget proposal. Physicians have, year after year, contributed more than their fair share to the budget deficit effort. Physicians, who accounted for 32% of combined physician and hospital Medicare spending from 1987 to 1993, have absorbed 43% of Medicare provider cuts over the same time.

Unless the current physician update formula is changed, the projected Medicare payment level for physicians is a steep actual decline, while hospital and other provider payment rates go up, as the chart below indicates. In addition, many physicians face additional extreme payment reductions due to the implementation of the resource-based practice expense in 1998. We look forward to working with the subcommittee to address these important issues.



Under the present systems of price controls in the Medicare program, prices do not perform a market function of facilitating competition. Competition requires that prices be decontrolled and that beneficiaries be rewarded for seeking lower prices in the market. Our proposal for physician services builds on the current RBRVS-based system. Beneficiaries would be rewarded for seeking value by receiving rebates if they choose providers whose charges are lower than the government rate of reimbursement. The current DRG-based hospital payment system would provide a comparable basis for a competitive hospital price system.

We believe competitive pricing, combined with adequate program funding, will ensure that patient access to services will not be endangered by faulty reimbursement schemes. The government rate of reimbursement should be set to maintain certain guaranteed levels of access to services. In addition, under the AMA proposal low-income seniors would continue to receive the equivalent financial support they currently receive under the traditional Medicare program as individuals dually eligible for Medicaid and Medicare and Qualified Medicare Beneficiaries (QMBs).

II. ENHANCE BENEFICIARY CHOICE

Medicare's open-ended entitlement, a major contributor to its budgetary instability, must be contained for budgetary control. A fair way to do this is to permit beneficiaries to voluntarily opt out of the traditional program with a defined contribution toward the purchase of a private health plan. We would establish a structured private health insurance program, called MediChoice, modeled on the Federal Employees Health Benefits Program (FEHBP).

In the first year, the value of the subsidy provided to purchase a private health insurance plans would be the actuarial equivalent of the amount that would be spent by Medicare on the enrollee=s behalf if the person had remained in the traditional Medicare program. In subsequent years, growth in Medicare expenditures

would be limited to the increase in the market price of a privately offered health plan providing comparable benefits as the traditional Medicare program in the market area.

A wide variety of plans would be able to participate in the MediChoice program, including:

- fee-for-service and benefit payment schedule plans;
- prepaid comprehensive medical plans such as health maintenance organizations, and preferred provider organizations;
- plans offered by provider sponsored organizations (PSOs); and
- Medical savings account (MSA) plans that offer high deductible medical expense insurance in combination with establishing an MSA.

The structure of the health system in the United States has changed significantly since the passage of Medicare in 1965, but unfortunately, Medicare has not changed with the times. The Medicare program needs regulatory reforms to allow the private market to develop and offer products and systems to meet the needs of those who use them, not the preconceived notions of central planners. Federal standards and procedures will be necessary to make competition work, to make it fair and balanced, and to assure patients that quality of care can be maintained at a high level in a market driven system with a focus on costs. Patients must also be assured that plans and practitioners within the plans meet high levels and standards of competence in the quality of care provided and the way it is delivered. To provide these assurances, our proposal for enhancing beneficiary choice includes a set of standards that plans must meet.

PROVIDER SPONSORED ORGANIZATIONS

In general, MediChoice plans would be organized and licensed under State law, but the AMA believes that federal standards are needed for PSOs. Regulations that are appropriate for traditional insurers, whose primary business is acting as a financial intermediary, are not appropriate for PSOs whose primary business is health care delivery. Under the AMA's proposal, federal PSO solvency standards would be based on the amount of risk assumed by the organization and would recognize the value of assets normally used in health care delivery, such as facilities and equipment, but which historically have been excluded by insurance commissioners for purposes of meeting solvency standards. In addition, regulatory changes are needed in order for PSOs to be viable competitor to HMOs, which include changes to federal and state securities regulations, and federal regulation of tax exempt organizations.

FRAUD AND ABUSE IN THE MEDICARE PROGRAM

The Medicare fraud and abuse laws also need to be updated to address the realities of a competitive marketplace in order to allow innovative, cost-effective PSOs and other networks to compete in the MediChoice program. Fraud and abuse has no place in medical practice and the AMA is committed to leading the profession's opposition to health care fraud and abuse. However, the current fraud and abuse laws—which were designed for the fee-for-service world in which providers had an incentive to increase volume—can create problems in establishing PSOs and other networks because many contractual arrangements may fall within a technical violation, even if the intent is to reduce costs.

For those who wish to comply with the law, the incidence of misconduct can be greatly reduced by setting standards of appropriate behavior, disseminating this information widely, and designing and implementing programs to facilitate compliance. To accomplish this goal, the AMA recommends the creation of a public-private program to develop standards that clearly define abusive practices and to implement compliance programs for providers and others. We also believe health care plans should be held accountable for establishing a structure that permits participating physicians to provide quality health care to their patients, and should implement review mechanisms to assure that reimbursement policies do not give physicians incentives to limit care inappropriately.

The AMA strongly opposes the Administration's efforts to repeal the fraud and abuse safeguards included in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which would reduce the government's burden of proof for civil monetary penalties, eliminate the obligation of the Departments of Justice and Health and Human Services to issue advisory opinions on the anti-kickback statute, and repeal the risk sharing exception to the anti-kickback statute.

PROFESSIONAL LIABILITY

Medicare reform should also include the professional liability reforms that have been so successful in California. Health care liability costs are built into the Medicare system in the form of physicians' and hospitals' liability premiums, defensive medicine, and coverage for distributors of medicines, blood services, and medical devices. In 1995, CBO scored $200 million in federal government savings over 7 years in physician malpractice premium costs alone, without considering similar hospital, HMO and medical supplier liability costs. These are millions of dollars that could go to patient care and extending the life of the HI Trust fund, instead of paying attorney fees and insurance premiums.

National reform should include provisions that have been tried and proven effective in 20 years of state-based reform, including:

- A limit on non-economic damages of $250,000;
- A sliding scale limit on attorney contingency fees, which decreases at designated intervals as the award increases, thereby permitting the most injured claimants to keep more of the award they receive;
- Modification of the "collateral source" rule to permit evidence of compensation from health insurance or disability insurance to be introduced when these items are claimed as damages;
- Mandatory periodic payment of future damages in excess of $50,000; and
- Limits on the time period for filing claims to no more than two years after the injury is discovered but in no event more than five years after the initial injury occurred.

III. PREPARING FOR FUTURE GENERATIONS

While our obligations to those who are and will be dependent on Medicare in the future must clearly be honored, continuing the pay-as-you-go system of financing Medicare will impose an ever increasing burden on working U.S. citizens with the prospect of ever-increasing taxes and eroding benefits. We believe that in order to restore the viability of the program's promise to future generations, Medicare funding must be shifted from the "pay-as-you-go" transfer payment system to an investment-based system in which beneficiaries have a larger responsibility to provide the funding for their own retirement health care during their working years.

We support increasing the age of eligibility to match that scheduled to occur for Social Security. We support reducing the subsidy for high income beneficiaries by using income-related premiums. We also believe that private savings during working years for health care in retirement should be part of the solution to Medicare's financial health over the long-term. As part of this approach, Medical Savings Accounts should be made available to the entire working population as a means of allowing individuals to accumulate earnings tax-free for use at retirement age in paying for medical care.

The AMA believes that shifting out of a government-managed system to a system of private ownership is the preferred approach to assuring that all working Americans have access to health care in retirement. This does not mean that government would not have a major role to play. The government would continue to make a substantial contribution toward the purchase of insurance for the elderly and it would enforce requirements for individual savings. The government should have a larger responsibility in assuring that the economically disadvantaged of all ages have access to quality health care.

Assuring the Future of Graduate Medical Education Funding

The transition from the pay-as-you-go system to a fully funded system will take a number of decades. Meanwhile, the current system of benefits, delivery of services, and government regulation requires immediate modernization and cost-savings. We believe some of the needed Medicare savings can be achieved by making the funding of our graduate medical education (GME) system more rational. While all patients benefit from the GME system, Medicare is the primary source of support for the training of future physicians. At the same time, recent studies of the physician workforce have produced compelling evidence that the United States is on the verge of a serious oversupply of physicians.

Just last month, the AMA along with five other major medical organizations released a *Consensus Statement on the Physician Workforce.* In this statement, we proposed that the number of entry level positions in the country's GME system should be aligned more closely with the number of graduates of accredited U.S. medical schools by limiting federal funding of GME positions. In addition, Medicare's contribution to GME should be reduced over time and the private sector should play a stronger role in both work force planning and funding of GME through the devel-

opment of an "all payer" fund. Non-U.S. medical graduates would still be allowed to train in the U.S. but would not receive funding from Medicare or the all-payer fund, and would also be expected to return to their country of origin after completing GME in the U.S.

In addition, the consensus statement calls for funds to be paid directly to the entity that incurs the costs of training, whether that entity is a medical school, hospital, nursing home, or ambulatory clinic. Federal incentives should be provided to encourage students to pursue careers as generalists and to establish practices in medically underserved urban and rural communities. Federal support should continue to be provided to teaching hospitals which incur higher costs than non-teaching hospitals in providing patient care. Finally, a national physician workforce advisory body should be established to monitor and periodically assess the adequacy of the size and specialty composition of the physician workforce in the context of the changing needs of the evolving health care delivery system and evolving patterns of professional practice by non-physician health professionals.

CONCLUSION

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, as well as those working Americans who are called upon to help finance it. Continuation of past stop-gap measures, such as chopping away at rates paid to physicians 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. Simplistic budget-cutting has not resulted in cost-control over recent years; on the contrary, price controls have had the perverse effect of exacerbating Medicare's fiscal crisis and severely threatening the promised access of beneficiaries to medical care.

However the change in Medicare is accomplished, it will be our overriding goal to ensure that the change not damage the essential elements of the patient-physician relationship. Above all, reform should not break the bond of trust between a patient and physician that makes medicine unique. By that we mean:

- All patients must remain free to choose the physician they feel is best qualified to treat them or individually elect any restrictions on choice;
- All patients, including those with chronic conditions and special health or financial needs, must have access to any needed service covered by Medicare;
- No restrictions on information about treatment options and no financial incentive program can be allowed to interfere with the physicians' role as patient advocate;
- Both patients and physicians must have complete, easily understood information about the Medicare program, and a right to raise questions, voice grievances, and to have them responded to in a fair, effective process; and
- Patients must be protected from unscrupulous or inept health plans, physicians, and other providers.

Americans who depend on the Medicare program for their medical and 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. We are extremely pleased that Chairman Gramm and the Subcommittee have taken the lead in the Senate in protecting Medicare for our seniors and saving it for our children. The AMA looks forward to working with you and the 105th Congress in achieving this vital goal.

PREPARED STATEMENT OF DAVID B. KENDALL

Mr. Chairman, thank you for holding this series of hearings on the magnitude of the financial crisis in Medicare. These hearings send a clear signal that the nation needs to debate and resolve Medicare's future.

The goal of the debate should be to keep Medicare's promise that older Americans and the disabled will always have the health care they need and deserve. Today, that promise is threatened by soaring costs.

According to the Congressional Budget Office's projections, Medicare costs will triple by 2030. By that year, the combined costs of caring for Medicare and Medicaid beneficiaries will consume about the same share of the economy as what we spend today caring for all Americans.

In the near term, the increases will be primarily due to medical inflation that drives up costs for each beneficiary. Eight years from now, Medicare's financing will deteriorate further because the number of workers whose taxes support each retiree will begin to decline. This demographic trend will accelerate as baby boomers begin

reaching age 65 in 2011. Moreover, the actual costs will likely be higher than currently projected, because the estimators make the bold assumption that medical inflation will disappear as the baby boomers retire.

The nation faces a basic choice: increase taxes or the deficit, reduce Medicare benefits across the board, or ask those who can take more responsibility for their health care to do so. The Progressive Policy Institute (PPI) supports the third course: The government should equip retirees to share more of the responsibility for their own health care.

But how can we ask Medicare beneficiaries to share more responsibility and keep Medicare's promise? The answer may be found in Medicare's founding principles: 1) Medicare's health care delivery system should be based on modern practices; 2) Medicare's benefits should be constant and geographically uniform; and 3) the rich and poor should have equal access to care. By returning to Medicare's origins, we can reassess Medicare's current laws and regulations that are no longer consistent with these principles, and establish the basis for reforms.

Such reforms can solve Medicare's long-term problems and create a dynamic Medicare policy that permits continuous improvements. PPI has previously described such reforms in its book, *Building the Bridge: 10 Big Ideas to Transform America, and in the report, A New Deal for Medicare and Medicaid: Building a Buyer's Market for Health Care.* We believe that Medicare reform is critical not only for its own sake, but also for the larger effort of creating a universal health care system.

PRINCIPLE #1: A MODERN HEALTH CARE DELIVERY SYSTEM

Medicare's health care delivery system should be consistent with the rest of the health care marketplace just as it was when the program was enacted. In 1965, fee-for-service health care was the dominant form of coverage. Today, less than 30 percent of insured workers and their families have fee-for-service coverage, while 89 percent of Medicare beneficiaries still have this more expensive form of care.

Instead of a single, employer-pays-all health benefits plan, large employers provide a defined contribution for basic coverage and a menu of choices for each employee, which usually includes both managed care and fee-for-service plans. Once a year, after the employer has negotiated prices with a variety of provider groups for the next twelve months, each worker selects a plan based on his or her own budget and priorities.

Rather than entitle people to coverage regardless of the cost or quality of care, Medicare should provide a subsidy large enough to pay for a private health plan offering high-quality care. High-quality, low-cost health plans regardless of type (fee-for-service or managed care) would set the benchmark for Medicare spending.

It is time to dispel the myth that high quality medical care must cost more. The world-famous Mayo Clinic in Rochester, Minnesota practices cost-effective medicine by following the precept, "do it right the first time." Mayo clinicians commit substantial resources "up front" to diagnose a patient s symptoms correctly. They do not waste time and money fixing the wrong problem. The cost of patient care in Rochester, which is served almost exclusively by the Mayo Clinic, is 22 percent below the national average.

Skeptics often argue that consumers cannot effectively shop for health care because no one chooses when to become sick or injured. While this may be true in an emergency, the experience of millions of workers at large employers proves that consumers can make responsible choices about their coverage. Moreover, older Americans have proven their ability to shop effectively for many other services, why not health care coverage, too?

The main obstacle to effective consumer choice in health care is clear and reliable information about the quality of care. Leading health care experts, such as Paul Ellwood, MD, have proposed quality measures, or health plan "report cards," as the key tool for reforming health policy and driving marketplace change.

Health plan report cards may soon become a familiar feature of insurance purchasing. The Foundation for Accountability, a coalition of the nation s largest private and public purchasers of care (representing more than 80 million Americans, including Medicare and Medicaid beneficiaries), recently created a common checklist of quality indicators. Beginning in 1998, these reports will provide consumers with the information they need to choose among health plans based on the plans' actual track records in treating such diseases as breast cancer, diabetes, and severe depression.

Medicare beneficiaries, who suffer more chronic conditions than the general population, would benefit most from the widespread adoption of these report cards. A recent study published in The Journal of the American Medical Association (Oct. 2, 1996), showed that in the early 1990s, managed care health plans produced the

same health outcomes for average patients with acute conditions as did fee-for-service arrangements, but had worse outcomes for patients with chronic conditions. Timely and reliable report cards would help government set appropriate standards of care, if necessary. Moreover, the government must make sure that payments to private health plans with chronically-ill patients reflect the higher costs of treating chronic conditions.

PPI's proposal contrasts directly with both the status quo and Republican Medicare proposals of last year. Rather than politically determined budgets either through price controls or overall budget caps budgeting would be performance-based. Medicare spending would be tied to market prices and quality indicators, thereby avoiding the problem that government payments would either be too high or too low. Medicare's fee-for-service system would operate as a competitive enterprise and permit the kind of innovative practices recently described for this committee by health policy expert, Lynn Etheredge. For example, the fee-for-service system could competitively select medical equipment suppliers based on the best price and service; beneficiaries could choose other suppliers, but would pay the additional costs themselves. A competitive, fee-for-service plan would have to find the right balance between charging higher premiums at the risk of losing patients, or lowering provider payments at the risk of losing providers.

In the short run, the bulk of the savings from Medicare reform, as President Clinton has proposed, will likely come from price controls, which can stifle innovation and erode quality and access. However, the President's Medicaid proposal may work for Medicare, too. Right now, the federal government matches state Medicaid spending without limit, tempting many states to squander federal funds even as they restrain their own spending. The President proposes to cap federal spending for each person with Medicaid coverage and give states flexibility to administer Medicaid more effectively. A per person cap on Medicaid is the same concept as a defined contribution for Medicare.

The potential of a modern health care delivery system is clear: higher quality care at lower costs. The United States is on the cusp of a health system that is unique in the world: one that combines the best features of American medicine and capitalism. The role of the federal government should not be to inhibit these changes in Medicare and other health programs, but rather to make sure these innovations work for Medicare beneficiaries and all Americans.

PRINCIPLE #2: CONSTANT AND GEOGRAPHICALLY UNIFORM BENEFITS

Even though Medicare benefits are fixed in law, the value of the benefits has grown larger every year. For example, some of Medicare's benefits are not adjusted for inflation. Congress seldom changes the Medicare Part B deductible, yet inflation has lowered the amount of the deductible in real terms, thereby also lowering beneficiaries share of overall Medicare costs. The $100 deductible would have to be more than doubled to compensate for the effects of inflation since 1966. The original Part B premium was 50 percent of Part B costs. Today, it is 25 percent. At the very least, the premium should be substantially increased for upper-income beneficiaries.

The problem of expanding benefits is compounded by increases in life expectancy. Since 1965, the life expectancy of 65 year-olds has increased by two-and-one-half years, but the age of eligibility for Medicare has not changed. As a result, the amount of lifetime benefits for retirees continuously expands. Instead, Medicare's age of eligibility should be gradually increased to at least age 67, just as it is increasing for full benefits under Social Security.

Medicare's benefit structure also has an equity problem: geographical uniformity has been undermined by Medicare's health maintenance organization (HMO) program. For older Americans who live in Southern California or Florida, Medicare pays HMOs to provide dental services and health club memberships, benefits which are not included in Medicare's fee-for-service coverage. But older Americans in rural Ohio, for instance, receive no such extra benefits. The cause of these discrepancies is the wide variation in local health care practices, which determine the financial basis of payments to HMOs. (HMOs are currently paid 95 percent of average area per-capita costs of insurance in Medicare's fee-for-service plan.) These discrepancies will become more commonplace as more older Americans enroll in HMOs.

To make Medicare benefits geographically uniform, there are two options: Limit the existing HMO program or establish a new basis for uniformity. President Clinton is effectively choosing the former approach when he proposes to lower payments to HMOs from 95 percent of fee-for-service costs to 90 percent. His proposal would reduce the variation in benefits by simply making the HMO program less attractive overall. If HMOs cannot offer key benefits such as prescription drug coverage, which

are not included in fee-for-service coverage, then older Americans would have very little incentive to switch from fee-for-service coverage to an HMO.

The President's proposal is inconsistent with the notion of updating Medicare's delivery system to reflect today's use of managed care. Instead, Congress should link a Medicare subsidy for every beneficiary to a competitively priced package of uniform benefits. This approach does not, however, rule out the possibility that beneficiaries could choose alternative benefit packages; it simply guarantees a national standard.

PRINCIPLE #3: EQUAL ACCESS TO CARE FOR RICH AND POOR

In Medicare's original form, the poor had significantly less access to care because Medicare's deductibles and copayments created a substantial obstacle to care. Supplemental benefits for poor elderly under Medicaid had to be added.

For high-income elderly, Medicare's benefits are too generous. A $100 deductible for a lower-income older American may be enough to curb some unnecessary demand for care, but for a wealthy older American, it is more of an excuse to spend $100 so that Medicare will pay for their future demands. As health care economist Mark Pauly has said, in order to make health care consumption equal among different income levels, the level of insurance coverage needs to be unequal.

To create equal access to health care among the rich and poor, upper-income older Americans should receive a subsidy that is limited to no more than the cost of a catastrophic policy, and we should fortify Medicaid's supplemental benefits for low-income elderly to make sure that their lower purchasing power does not again become a source of inequitable access to coverage.

CONCLUSION

The reforms I have described face significant political obstacles. But the alternatives are worse. Cutting benefits across the board is unacceptable because the most vulnerable and well-off beneficiaries would be hurt equally.

We could raise payroll taxes to support Medicare. But that would be a tax on work which would exacerbate the overall economic problem: slower economic growth makes it more difficult for our nation to meet its social needs.

Moreover, raising taxes in support of Medicare faces two significant moral hurdles. First, how can we ask low-income workers who often lack coverage themselves to pay more for the benefits of the wealthy elderly? Second, how can we ask Generation X to cover more of the cost of the baby boomers' retirement when the boomers have already saddled the X's with substantial public debt?

Medicare was enacted in the spirit of mutual responsibility. As a society, we were not going to let older Americans die in poverty because of sickness or deny them the miracles of modern medicine. The young would support the old so that generation after generation would have support in their old age.

But instead of mutual responsibility, Medicare is suffering from the politics of entitlement. Political pressures to expand benefits and protect the status quo create obstacles for appropriate adjustments to Medicare's delivery system and benefits.

The principle of mutual responsibility has been violated because older Americans will receive more in Medicare benefits than they will contribute in taxes. Of course, the question of mutual responsibility should be evaluated only by examining those beneficiaries who have spent their working lives contributing taxes to support Medicare. No one expected the first Medicare beneficiaries to pay their "fair share" because they had already reached retirement age when Medicare was enacted; their benefits were essentially a windfall. But now, according to economists C. Eugene Steuerle and Jon M. Bakija, individuals with average incomes retiring in 2010 who will have spent their entire working life with the obligation to support Medicare, will receive at least 60 percent more in benefits than they will contribute in taxes.

Such a scheme will work as long as the economy expands faster than the burdens society places on it. I believe the impending retirement of the baby boomers will expose this inequity and fundamentally change the political and economic equations that determine Medicare and Social Security policies. But acknowledging these problems should not lead us to forsake the basic principles and great achievements of Medicare.

Unfortunately, Medicare's long term problems are not at the center of the public debate today. By failing to debate decisive action, we risk letting today's excessive costs compound in the future and give current and future Medicare beneficiaries less time to prepare for needed changes. That is why the work of this committee and others is critical to Medicare's future.

PREPARED STATEMENT OF GUY KING

Mr. Chairman, my name is Guy King. I am a self-employed Consulting Actuary. I was the Chief Actuary for the Health Care Financing Administration from 1978 to 1994.

There has been much discussion of the financial condition of the Medicare Program during the last two years. This discussion has focused primarily on the imminent depletion of the Hospital Insurance (HI) Trust Fund. In my opinion, the focus on merely delaying the depletion date of the trust fund for a few years is a distraction from the much larger long run financial problems of the program. The existence of the long run financial imbalance in the HI program has been known for over twenty years. The failure to address these problems is far more destructive to the program then taking action that some may deem too ambitious. Concentrating on stop-gap measures to temporarily stave off the depletion of the fund is the moral equivalent of making a mole hill out of a mountain.

The huge long term financial imbalance, and the generational inequities associated with this financial imbalance, is the largest single threat to the viability of Medicare as a social insurance program.

HOSPITAL INSURANCE (HI) TRUST FUND

The impending bankruptcy of the fund is, as I said earlier, just the tip of the iceberg. According to the 1996 Trustees Report, the deficit is going 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 more than tripled by the year 2050. Even by the year 2020 the tax rate necessary to support the cost of the program will have more than doubled.

Even when discussing the short-range financial adequacy of the HI Trust Fund, the magnitude of the problem is seriously understated. The HI Board of Trustees has established an explicit test of short-range financial adequacy. For the HI Trust Fund to meet this minimum requirement would require savings of $300 billion over the next seven years. Yet I don't hear discussions of savings that are adequate even to meet this minimum requirement.

I know that it is difficult for lawmakers to act immediately on problems projected to occur far into the future, no matter how large. But 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 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 preserve the HI Program for the Post World War II Baby Boom would require either an immediate 59 percent reduction in expenditures or an immediate 141 percent increase in the HI tax rate, or some combination of both. To preserve the program just for 25 years would require either an immediate 39 percent reduction in expenditures or an immediate 63 percent increase in the HI tax rate, or some combination of both.

In deciding how and when to take action to place the HI Program in financial balance, the critical question is the issue of generational equity. Generational equity can be measured by comparing each generation's contributions to the program with the benefits they receive from the program. In a recent study, 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. According to the lg96 SMI Trustees report, SMI expenditures are currently less than one percent of GDP. They will be nearly three percent of GDP by 2020 when the Post World War II Baby Boom has begun to reach age 65 and will be over 3.5 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.

The outlays of the SMI program are growing at excessive rates 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 combine to drive 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%
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,* co-authored 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. Fee-for-service medicine allows providers to defeat price controls by increasing the volume and intensity of services to make up for the potential loss of income.

Medicare is projected to grow by $260 billion over the next decade. Over $140 billion of this growth results from increases in the volume and intensity of services. Only $40 billion results from population growth and only $80 billion from price increases. Even if the government freezes the price of Medicare services for the next decade, Medicare will grow by over $200 billion, assuming providers respond to price controls as they have previously by increasing the volume of services. This is an indication of why price controls are so ineffective in controlling the growth in the cost of the Medicare Program.

Since price controls don't work, what is the answer? 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, because of risk segmentation, the TEFRA risk program has increased expenditures of the Medicare Program rather than reducing them. In addition, 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.

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 virtual impossibility of balancing these conflicting goals, managed care 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 "failsafe" 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 to 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.

PREPARED STATEMENT OF SENATOR CONNIE MACK

(FEBRUARY 12, 1997)

Welcome Secretary Rubin. I appreciate having the Secretary of Treasury with us today to discuss the President's new budget and tax policies. Bipartisan support is essential for balancing the budget in a way that focuses on reducing *both* federal spending and the tax burden on American families.

I'm concerned that despite slow and steady economic growth, total taxes (federal, state and local) as a percentage of our economic output is at record highs. As outlined in the President's budget, *federal receipts alone* represented 19.4 percent of our Nation's total output in 1996. You would have to go back 15 years (to before the Reagan tax cuts) to see a tax burden that high.

I have to admit, I am disappointed with the level of tax relief put forth in the President's budget. I'm also concerned about the proposed $76 billion in new and increased taxes on American businesses. If the "era of big government" is over then the era of big taxes should be over as well!

Overall, the President's proposed net tax relief during the next *five* years is only $22 billion. That's less than $4.5 billion per year when receipts will run more than $1.5 TRILLION a year! The President's 1993 tax hike is estimated to cost $60 billion in higher taxes this year alone. I sincerely believe there is more room to lighten the tax burden on hard working American families.

While the President has proposed $76 billion in *permanent tax increases,* it is my understanding that all of the family tax relief is temporary. Simply stated, the

President's budget could result in some *$20 billion in net new taxes* if the family tax relief is triggered off. I'm very concerned about these "triggers" particularly since the Congressional Budget Office assumptions would show the President's budget some $50 billion short of balance in 2002. This makes it very likely that the tax cut "triggers" will take effect.

One of my principles of good tax policy is *certainty*. Taxpayers must have confidence in the tax laws when planning their future and entering into financial transactions. Proposing *permanent* tax hikes but *temporary tax* relief is simply bad tax policy. What would you tell the family that was depending on that tax cut to put into retirement savings or into a college fund when it is triggered away?

Cutting taxes is important not only to give families needed tax relief. I believe tax relief is essential for economic growth. One of the most destructive elements of the current tax system is that it punishes saving and investing with high marginal tax rates and double taxation. While the economy has shown slow and steady growth over recent years, one of my main concerns is the complacency that seems to exist over current growth rates. I believe with the right tax policy changes, our economy can and should grow faster.

We certainly should include broad capital gains tax relief if we are serious about boosting long-term growth. Mr. Rubin, the Treasury has recently issued "inflation indexed bonds" to help protect investors from inflation. Ironically, capital gains are not indexed for inflation. Investors are forced to pay taxes on the illusory gains due to inflation. I hope you will have an opportunity to address this policy contradiction in your testimony today.

Genuine economic growth comes from hard work, creative ideas, improved productivity, and capital formation. Therefore, the President and Congress have a tremendous responsibility to make sure our tax policies foster and reward saving, investing, and risk-taking.

For most of this century, American families have enjoyed the benefits of stronger economic growth—with each generation leaving the next better off. But recently, we have seen our economic growth rate fall from a robust 4.4 percent annual average during the last five expansions to about 2.5 percent since 1992.

In recent years, major tax hikes, increased government spending and growing regulations have taken their toll on the economy and the American family. Conversely, the periods of our nation's strongest economic growth were marked by lower taxes, less spending and fewer federal regulations. However, I am optimistic to see our current budget debate focused on bipartisan support for balancing the budget through less spending and lower taxes.

I am anxious to hear Secretary Rubin's views on any additional pro-growth tax changes he would suggest to the President that would raise our potential economic growth level. Given the record tax burden on the American family, cutting taxes while balancing the budget is simply the right thing to do. I'm glad it's a goal on which we can all agree.

PREPARED STATEMENT OF MARILYN MOON*

After the turn of the century when baby boomers begin to retire, Medicare will face daunting challenges. However, Medicare also faces challenges in the short run and needs to begin to explore reforms that will position it better for the long run changes ahead. My testimony today stresses both the broad choices we will face in the future and the learning process necessary to be ready for the next century.

I am pleased to be here today to testify on some of these broader issues. My name is Marilyn Moon and I am a senior fellow at the Urban Institute and Program Director of the Commonwealth Fund's Program on Medicare's Future. I am also a public trustee of the Medicare trust funds, but I am here today to express my own views and not those of any of these institutions.

THE NATURE OF THE LONG RUN PROBLEM

Two factors are driving up the costs of Medicare. First, for many years, health care spending has been rising more rapidly than either spending on other goods and services, or wages and other sources of income. As a society, we have signaled how much we value such goods and services, consuming ever more each year. This is not just a Medicare problem, nor is it just a problem associated with a government program. But while in recent years, many employers have contributed larger and larger

* Senior Fellow, The Urban Institute. This statement represents the views of the author and not of the Urban Institute, its sponsors or trustees.

shares of compensation to pay for insurance in the private sector, Medicare's tax base has increased only modestly over time. For example, although the base subject to tax has gone up, the payroll tax rate for Part A (Hospital Insurance) has not risen since 1987. Over this same period, Part A spending per capita in Medicare rose by 111 percent and the number of beneficiaries increased from 32 to 38 million. It should come as no surprise then that the program now faces a financing shortfall.

Further, Medicare's history since 1980, when serious attention shifted to cost containment, is generally one of considerable success as compared to private insurance spending. In the last several years, Medicare has grown faster than the private sector, but this is a relatively new phenomenon. Without legislative changes to allow it to incorporate innovations from the private insurance sector, Medicare has fallen behind in terms of rates of growth. But the private sector started from a higher base of provider payments, enabling it to reduce costs substantially in the last few years, and in many cases employers have also cut benefits offered as a way of slowing growth. Thus, Medicare's experience is certainly not out of line with the rest of the health care system.

The second reason for higher costs is the expansion in the number of beneficiaries covered by Medicare. Although much higher rates of growth will occur in 2010 and beyond, the number of persons served has also grown at a faster rate than the general population since its inception in 1966. This disproportionate growth over the last thirty years largely reflects the increased life expectancy of the covered population—surely a sign of success and not failure. Both the current increases in the number of beneficiaries thus far and the large rise expected in the future mean that we will have to meet the expenses of an aging population either through a public program like Medicare or privately. Again, this is not just a problem that arises for the public sector. The fact that about one in every four Americans will be either over the age of 65 or disabled in the year 2030 poses challenges throughout our economy and society.

But we should not treat these as insurmountable challenges, however. For example, one statistic often used to discuss the magnitude of the problems facing Medicare is the ratio of workers to retirees—that is, the number of people contributing to the system compared to the number receiving benefits. In 1995, there were about 3.9 workers for every beneficiary using Medicare. That number will fall steadily as the baby boom begins to retire, to 2.2 workers per beneficiary in 2030. Appropriately, many analysts point out that this substantial decline will place higher burdens on workers over time.

But there are also other less dramatic ways to view these numbers. In 1995, 37 million people received Medicare as compared to about 144 million workers paying into the system. This means that, on average, each 100 workers must support 126 workers and Medicare beneficiaries. By 2030, 100 workers will need to support 146 workers and beneficiaries. That constitutes about a 16 percent increase in the burden on workers.

Going even further, if we add in the number of children who are also dependent on working age adults and then consider how many additional people each worker will be required to support in the future, the increase in burden is even smaller. By this measure, there will be only a 6 percent increase in how many people each worker must help support between now and 2030.

DISTINGUISHING SHORT RUN FROM LONG RUN OPTIONS

Delivery of health care in the United States is undergoing enormous changes at an unprecedented pace. The private insurance market has gone from a period of rapidly increasing costs and little effort to slow that growth, to a fixation on holding the line in health care spending. Indeed, between 1983 and 1993, Medicare was more innovative and successful in reducing spending and slowing growth than was the private sector. The last three years have shown that the private insurance industry and employers can make a difference, but the jury is still out concerning whether all the changes have been positive and whether the trend will continue on its slower pace. A number of analysts of private insurance are beginning to warn that prices of insurance may again begin to rise in the near future. And concern in both state legislatures and at the federal level about excesses in managed care cost cutting have raised legitimate fears about how to achieve a balance between cost containment and maintaining the quality of health care in the United States.

To this picture, we are now contemplating adding Medicare reforms. In the short run, Medicare could undoubtedly benefit by adopting some of the innovations in the private sector to help improve its operations and achieve savings. More prudent purchasing of supplies, more profiling of the practice patterns of its providers of care, reforms of its payments to both providers of services that are now paid on a cost-

basis, and revamping of payments to the private plans that serve Medicare patients, and more attention to excess use of benefits can and should be adopted. These should help to transform Medicare into a more efficient program given its current structure and to reduce the rate of growth of spending on the program by one or two percentage points. These would be important achievements and the sooner the work begins on them the better. For example, just adopting the prospective payment systems proposed for home health and skilled nursing services would save about $10 billion over five years. Further, the ability to permanently slow the growth in spending by just a percentage point or two helps take considerable pressure off the long run as well.

Expansions of the enrollment of beneficiaries into managed care plans can also help to control costs. But, it is important to distinguish Medicare's likely gains from what is happening in the private sector. To date, managed care plans—especially the newest ones—have achieved much of their savings through the discounts they receive from providers of care. Rates of payments to hospitals, doctors and other providers for traditional private indemnity plans are quite high, so these discounts can immediately result in lower premiums. Medicare, however, has already obtained discounts in the form of administered prices that are usually well below what private insurers pay, and even below what some managed care plans now pay.

One area where managed care may be able to improve upon Medicare is in truly managing services received by patients, although this is still more true in theory than in practice. Private plans not only can provide closer oversight, they can also be more prescriptive than a national public program like Medicare. This means that particularly in some areas like home health service use and hospital outpatient services, private plans could provide more controls on use of services than Medicare is currently doing. And while Medicare could certainly improve under its current structure, private plans may be better able to deal with providers who abuse the system, for example, by ordering too many tests. Private plans can simply exclude problematic providers or place restrictions on their behavior in ways that Medicare would not likely be able to do. But, it is important to keep a caveat in mind in this regard. While Medicare can be limited by the requirements for due process and other legal restrictions, these restraints are not all bad. They help to guarantee access to all patients and providers to the system and it is important not to give up all such protections in enthusiasm over managing care.

Thus, Medicare could benefit from accelerating its expansion of enrollment in private plan options. But taking on the bigger questions about the desirability of changing the structure of the program is premature. Until some of the short run changes play out and until information about the quality of care delivered as a result of the changes going on in the overall delivery of health services and private insurance arrangements is understood, it is difficult to know what further steps are appropriate for Medicare. Moreover, Medicare's situation is not always synonymous with the employment-based insurance market to which it is often contrasted. A number of protections and structures need to be established if Medicare is to function well over time.

Consider, for example, the issue of expanding the offering of choice of private plan under Medicare. This would be a vastly different arrangement as compared to what most families who have private insurance now face. Increasingly, employers are offering their employees no choice among plans in order to more carefully control costs and to avoid problems that choice creates such as the unequal enrollment in plans by people with different needs and health status. This is not to say that Medicare should not offer choice, but rather that, as the market is now recognizing, allowing individuals to choose among a variety of plans creates issues that must be addressed.

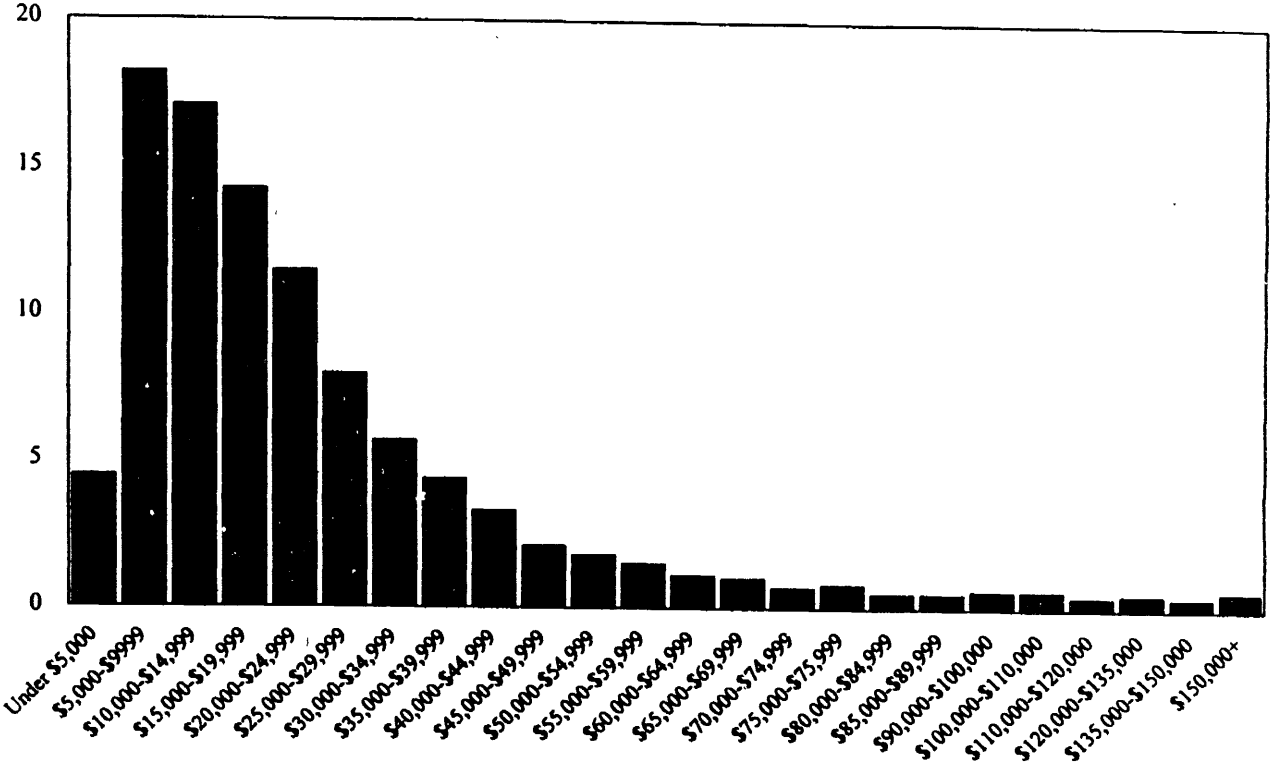
One model where choice is available to families is the Federal Employee Health Benefits (FEHB) system and it is likely to be a model that Medicare could use. But FEHB also poses challenges. For example, in order to reduce risk selection, plans over time have become less willing to differentiate their offerings such as in the area of mental health benefits. And even still, there are substantial differences in costs among plans reflecting uneven risk distributions. The federal government absorbs some, but not all of these differences.

Further, Medicare offers coverage to a much larger number of people than are covered by FEHB, and beneficiaries do not have the same avenues of information available to them through personnel representatives who assist federal employees in making choices and resolving problems. What type of infrastructure would be needed to assist Medicare's beneficiaries? Moving in the direction of an FEHB model is consistent with several different long run strategies and is likely desirable, but it will take time to establish a reasonable infrastructure.

Medicare could be a leader in developing a system of private choices, but it will take time to get it right. Several very large issues remain on the table. Should the traditional Medicare fee-for-service program remain as one of the choices? The answer here depends upon whether the short run improvements discussed above can make it a more efficient and effective program. If so, the benefit structure ought to be re-evaluated and redesigned to be brought up to current standards. Second, Medicare's vulnerable populations—particularly the very frail and disabled and those with limited incomes—need special attention so that they are not left behind. This requires either risk adjustment mechanisms to establish reasonable premiums or after-the-fact adjustors to compensate plans that treat sicker-than-average patients, and special attention to the costs of private plans to insure that even those with low incomes have choices. These are not small issues since a majority of Medicare beneficiaries would fall into one or both of these vulnerable categories. For example, as the enclosed chart illustrates, most Medicare beneficiaries are concentrated at the low end of the income scale.

Thus, it is important to allow Medicare more time to assess the impacts of the changing marketplace before locking in structural changes. Of necessity, a public program is likely to be less flexible than private companies, so before making substantial changes, it will be critical to follow how much the private insurance market changes in the next few years. Not all of those changes will be for the better and Medicare should proceed cautiously in this regard. Changes to bring the per capita costs of care into a more reasonable balance should begin as short run changes, with a commitment to continued vigilance over time and reassessments as needed concerning how much structural change will best serve the program.

Income Distribution of the Elderly: 1994



Source: U.S. Bureau of the Census, 1995

Even a very successful program to control the costs of Medicare by making the delivery of services more efficient will not be enough to put the program on a path to long term financial stability. By 2010, when the first of the baby boom generation reaches the age of eligibility for Medicare, the number of beneficiaries will begin growing at a substantially faster pace than at present. Thus, to resolve the financing issue by improving the efficiency of the program would require that health care spending per capita indefinitely grow more slowly than wages—a feat not readily achieved in health care.

Consequently, finding savings to keep the current Medicare program healthy into the future will require tough choices. Aside from reforms that increase the efficiency of the delivery of services, all of the options to keep Medicare sound effectively raise the question of who will pay and when. A wide range of options will need to be considered, including revenue increases.

Expansions of existing cost sharing and premium contributions are obviously options that essentially shift the problem to individuals and families and some of these changes are likely to be part of any solution. A number of additional options that are often promoted would indirectly pass the costs onto beneficiaries as well. These include vouchers and increases in the age of eligibility. Privatization options to forward fund the program have recently been added to the mix. Ultimately it will also be important to consider an increase in the contribution from payroll or other broad-based taxes to finance health care for an increasing share of the population as one piece of the solution. The sections below raise a few of the many issues that need to be considered in weighing various options.

Vouchers and Privatization

Advocates of a private approach to financing health care for Medicare enrollees argue for a system of vouchers in which eligible persons would be allowed to choose their own health care plan from among an array of private options. For example, individuals might be able to opt for larger deductibles or coinsurance in return for coverage of other services such as drugs or long term care. In addition, this approach would allow beneficiaries to combine the voucher with their own funds and buy one comprehensive plan. Moreover, persons with employer-provided supplemental coverage could remain in the health care plans they had as employees.

While competition among plans to attract enrollees might help to lower prices, the only certain way for Medicare to reduce costs under a voucher scheme would be to fix the payment level and its rate of growth over time (presumably with appropriate adjustments for risk factors). Vouchers are not a necessary element of offering choice to beneficiaries, but they are a means of ensuring predictable savings. And even more important, by placing a cap on the rate of growth of the benefit, vouchers effectively shift the risk to the private insurer and/or to the enrollee. If a plan is not successful in holding down costs and Medicare's contribution is fixed, the most likely response is to raise the premium contribution required of enrollees. This is effectively an indirect premium increase on beneficiaries.

The most serious potential problem with vouchers is that the market would begin to divide beneficiaries in ways that put the most vulnerable beneficiaries—those in low health and with modest incomes at particular risk. If vouchers result in high cost, Cadillac plans or if other types of specialized plans like medical savings accounts skim off the healthier, wealthier beneficiaries, many Medicare enrollees who now have reasonable coverage for acute care costs but who are the less desirable risks, would face much higher costs due to market segmentation. A two tier system of care could result in which modest income families are forced to choose plans that offer fewer benefits or substantially more restrictions.

On balance, vouchers offer less in the way of guarantees for continued protection under Medicare. The problems of making tough choices and the financial risks would be borne by beneficiaries. Further, the federal government's role in influencing the course of our health care system would be substantially diminished. For some, this is a major positive advantage of such reforms. But the history of Medicare is one in which the public sector has often played a positive role as well, first insuring those who could not find insurance coverage in the private sector and then leading the way in many cost containment efforts. But most troubling is the likelihood that the principle of offering a standard benefit would be seriously undermined, dividing up the market into ever smaller risk pools.

If privatization is carried to its ultimate extreme, Medicare could cease to be social insurance and instead become simply a publicly-mandated private insurance plan. Social insurance implies that those with more resources over their lifetimes help to fund the program for those with less. For example, requiring individuals to

make contributions into medical savings accounts that would then be turned into private health insurance plans during retirement could essentially eliminate the redistributive function of social insurance. Such an approach would not only achieve privatization, but also "individualization" of the program, reflecting an "every woman for herself" approach. It is possible to achieve a balanced privatization approach somewhere along the continuum without fully giving up the redistribution and other characteristics of social insurance that many observers of these programs feel are essential.

Changing the Age of Eligibility

Another major option now being mentioned would increase the initial age of eligibility for Medicare. One of the justifications for such a change—aside from the primary one of saving the system money—is that as the life expectancy of the population has moved upward, the normal age of retirement should also increase. Since Medicare was introduced in 1966, life expectancy for persons aged 65 has grown by a little less than three years. And, as people live longer, they now receive Medicare benefits for a greater share of their lifetimes. Thus, increasing the age of eligibility could bring this proportion back closer to the 1965 level. In fact, such an approach has already been adopted under the Social Security amendments of 1983 which established a schedule by which the age of eligibility for full Social Security cash benefits would increase from age 65 to age 67 by the year 2022.

For Medicare, the transition might need to be somewhat more rapid since the financial crisis for the Part A trust funds will come sooner than the trust fund problems for Social Security. But moving too rapidly also creates problems for people near retirement age or who have recently retired and who have made their financial plans based on assumptions about the availability of Medicare coverage.

Further, a number of those in the age 65 to 68 age group would likely remain eligible or would require special treatment in some other way. Those who were previously eligible because of disability would be unlikely to be dropped from the roles. And some additional persons who qualify for disability but turn 65 before receiving Medicare would also undoubtedly still be eligible for Medicare. The costs of the dually eligible who also receive Medicaid would be fully shifted to that program, with important consequences for federal spending. The needs of these special groups suggest that savings from raising the eligibility age would be less than many people expect.

Further, raising the age of eligibility for Medicare would create problems. Not all Americans are equally healthy at age 65. And while some Americans remain in the labor force or have generous retiree benefits at age 65, others struggle to make it to that age to qualify for Medicare. As yet, increasing life expectancy has not been translated into later retirement by workers. To make this option less burdensome on individuals who are out of the labor force, private insurance reform to assure access to the purchase of affordable insurance would be critical—reforms that have proven difficult to establish for the under 65 population.

Alternatively, Medicare could allow individuals between age 60 or 62 and age 68 to buy into Medicare. This would be analogous to the early retirement option under Social Security available at age 62—an option that will be retained even after the Social Security retirement age rises. Medicare would be available for those who must retire early. If this were combined with some low income protections and phased in slowly, the objections of critics could be effectively addressed. But such options would be expensive.

Means-Testing Medicare

Another possible dramatic change would be to fully means test Medicare, that is, making it available only to persons whose resources are below some prescribed limit. Higher income elderly and disabled persons could be offered the option of buying into the system at a nonsubsidized rate or precluded from participating altogether.

But, while the financing for Medicare is not progressive, the combination of benefits and taxes does result in a program where higher income beneficiaries already pay a greater share of the costs through payroll taxes assessed over their working lives. For example, contributions from a salaried individual making $100,000 per year total $2,900, as compared to the $20,000 per year worker whose combined employee-employer contribution will be $580—both for the same benefit package. Thus, it is not hard to conclude that eliminating high income persons from eligibility would likely undermine some of the strong support that has traditionally gone to Medicare. It would eliminate the image of Medicare as a program where everyone pays, but where everyone also benefits. It would constitute a major shift in philosophy from a universal to a "welfare" based program.

A major practical concern with such an option is where the cutoff for eliminating the federal subsidy should be set. At what income is an elderly person capable of footing the bill for the full costs of Medicare? The Medicare premium for both Parts A and B would total $5754 in 1997. Other out-of-pocket spending and premiums for private insurance would average over $1500. Together this total of over $7200 would consume a substantial share of the income of most enrollees. Median per capita income—that is, the income level for the average elderly person—stands at about $12,000. Certainly, at least half of the elderly and likely many more would thus not be good candidates for paying for all their own care.

If policy were set so that the average expenditures on health care should not total more than 15 percent of an individual's income, the cutoff for eligibility for Medicare would be set at over $48,000. These levels would mean that very few elderly persons would be excluded from Medicare. In 1995, only 3.4 percent of Medicare beneficiaries had per capita incomes in excess of $50,000. To get a higher share of the population (and hence generate more savings) from means testing, the cutoff would need to begin at much lower incomes.

Taxing the Value of Medicare Benefits

An alternative to raising premiums would be to treat Medicare benefits—all or in part—as income and subject to the federal personal income tax. If, for example, half of the average value of benefits were added to the incomes of the elderly and disabled, these benefits would be subject to tax rates that would vary according to other income received. This would naturally result in a progressive tax on Medicare benefits. This is analogous to taxing Social Security, although more complicated because these benefits are received "in-kind" and are not traditionally viewed as income by the beneficiaries.

It would not only raise revenue to help fund the current program (or expansions in Medicare), but it would also make beneficiaries more acutely aware of the "value" of Medicare benefits and their rate of growth over time. If a portion of benefits were taxed, but only for those whose incomes are above some threshold (as is now the case with Social Security), mostly high income beneficiaries would be affected. This could satisfy many who are now concerned with providing universal benefits to elderly and disabled persons regardless of their economic circumstances, while not removing them from eligibility.

This option results in a substantial change in policy, and one that would add considerably to the complexity of the program while raising relatively small amounts for Medicare. Critics of this approach also argue that it is unfair to tax some in-kind benefits and not others. Consistency would imply that we should tax health benefits provided by employers to their workers as well—also a very controversial policy. Nonetheless, this would be perhaps the most equitable way to require higher income beneficiaries to pay more towards the cost of their care.

Revenue Increases

In addition to asking beneficiaries to bear more of the costs of their care, new revenues affecting all taxpayers will likely be needed to finance the Medicare program over time. It is not reasonable to require that a program that doubles the share of the population it serves do so with the same tax base. In fact, we ought to consider efforts to hold the line on Medicare spending very successful if real per capita spending could be stabilized through a combination of delivery reforms and higher beneficiary contributions. That will still leave the need to expand the tax base that supports the program as the baby boom generation begins to retire.

Legitimately, many policy makers have raised concerns about the level of the payroll tax. But that does not mean that Medicare could not be supported with other revenues. The balance depends upon how, as a society, we decide to share these burdens. Moreover, the proper balance of beneficiary burdens and taxpayer burdens needs to be weighed in the context of combined Social Security and Medicare reform. If changes in Social Security can be done within the existing tax framework, that leaves more room for modest increases in revenues to support Medicare.

CONCLUSION

The formidable long run financing problem facing Medicare will required difficult choices and a frequent revisiting of policy issues. It is not too soon to begin planning for the aging of the baby boom, but we also need time to determine the best strategies to deal with moderating growth in the costs of health care. And all of the options described above would require either substantial sacrifices from beneficiaries and/or new revenues from a broader set of taxpayers. To meet the difficult challenges ahead, no viable tools to solve the problem should be overlooked. Consider-

able public education and debate will be needed before choices among such options can be made.

PREPARED STATEMENT OF LEN M. NICHOLS*

My name is Len Nichols and I am a Principal Research Associate at the Urban Institute. The views I will express today are my own and not those of the Urban Institute, its sponsors, or its trustees.

Medicare is our most sacred social contract precisely because it binds generations of Americans together. It has achieved much success, helping to lengthen and to improve the quality of life for our senior citizens since 1965, when it was implemented over the objections of some of the program's most vocal supporters today. While accomplishing these impressive feats, Medicare has become both our most popular public program and a program that is in need of serious structural repair. Without this repair, it cannot continue to serve us well in the 21st century. I am pleased to come before you today to offer some thougths on how we might perform the repair without reducing our fundmental commitment to quality health care for all our seniors, a commitment that I know we all share.

The discussion of "Restructuring Medicare" is really a question about how to make the market work well for Medicare beneficiaries and for taxpayers. Sadly, it is not as simple as setting the market absolutely free, for completely unregulated health insurance markets have not performed well for the elderly in the past and there are good reasons to believe they will need some structure in the future. At the same time, the tremendous power of a well-structured market needs to be harnessed for the good of Medicare benficiaries, for this is the only way to accomplish our long run goals of quality, choice, and an affordable price tag. Happily, it is my belief that a reasonable and mutually beneficial set of market rules and profitable incentives can be implemented in time to head off the coming financial challenges. When coupled with reasonable financing and program flexibility over time, I am confident that Medicare can continue to be a bedrock commitment upon which all Americans depend.

LONG RUN PROBLEMS AND RECENT PERFORMANCE

By now, at least to this audience, Medicare's two long run problems are well known: (1) the cost per beneficiary is growing at an unsustainable rate; and (2) the number of beneficiaries per worker will increase precipitously as the baby boomers begin to retire after 2010. The baby boomer problem cannot be properly addressed until the cost growth problem is solved. All palatable solutions to Medicare reform require reductions in the real rate of growth of cost per beneficiary.

The feasibility of cohort-based financing, for example, the proposal advanced by Profs. Saving and Rettenmaier in their testimony today, depends vitally on reducing the real rate of growth of cost per beneficiary down to 1% per annum. Now their proposal has much to recommend it, in my view. I like the emphasis on having relatively more responsibility placed on beneficiaries to pay for themselves, and I like the fact that that responsibility is applied in a straightforward and fair way. As I understand it, there would be one payroll tax rate for all in a cohort, and thus the highest earning members of a cohort would pay for more than the cost of their care, while the lower earning members of a cohort would get their Medicare coverage subsidized. These are principles which I would welcome as cornerstones of a restructured Medicare program.

However, adopting cohort-based financing in its entirety is not the path that I would recommend. The risks of the assumptions not working out as calculated are just too great for any one cohort to bear alone. For example, Figure 1 shows the tradeoff between Medicare cost growth per beneficiary and the number of years that cohort-based financing could support the expected Medicare needs of today's 22 year olds. At a 1% real rate of growth of cost per beneficiary, as the cohort-based financing model assumes, a 4.22% overall tax rate will pay for 18 years of today's Medicare benefit package for all of today's 22 years olds who will retire in 2041. This would be enough to fully fund the proposal.[1] However, if the growth in cost per beneficiary turns out to be 3% in real terms, the same tax rate will pay for only

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*This statement represents the views of the author alone and not of the Urban Institute, its sponsors or its trustees. Adam Badawi and Laurie Pounder of the Urban Institute provided outstanding research assistance for this testimony, and I am grateful for helpful comments from my colleagues Marilyn Moon and Tim Waidman. I would also like to thank Andy Rettenmaier of Texas A&M University for explaining the details of the model used to estimate the cohort-based Medicare funding proposal on the phone.

6 years of Medicare. And if the real growth in cost per beneficiary remains lodged near its 20 year average of 5% per year, that same tax rate will buy fewer than 3 years of Medicare coverage.

There are different ways to compensate for higher cost growth, but no single one is likely to be feasible. Figure 2 shows that if the real rate of return on savings turns out to be 6% for the next 70 years, then this cohort could afford 3% annual growth in cost per beneficiary between now and their retirement. That kind of investment performance can hardly be guaranteed over the long haul, however. Figure 3 shows that the generosity of the Medicare benefit package could be reduced to compensate for faster cost growth, but even a growth rate as low as 2% would require a 40% reduction in Medicare's generosity for the younger generation. Finally, Figure 4 presents payroll tax rate tradeoffs. It shows that a real growth rate of cost per beneficiary of 3% would require a medicare payroll tax rate of over 12% throughout their working lifetime to finance today's Medicare benefit package for the length of time expected to be necessary for today's 22 year olds.

Obviously, if real growth in cost per beneficiary is actually higher than 1%, a combination of all the policy options mentioned above will likely prove necessary. But ultimately, under the cohort-based financing proposal, the risk of faster than anticipated cost growth, i.e., the risk of erroneous projections, is borne completely by each cohort alone. This is the one great disadvantage of cohort-based financing, in my view. If optimistic assumptions turn out not to hold, then each cohort will face the abyss alone. The 22-year old cohort's payroll tax rate, for example, as shown in Figure 4, would have to increase almost threefold throughout their working lifetime to accommodate 2% higher real growth in cost per beneficiary. Intergenerational funding, by contrast, lowers the severity of the required reaction to unanticipated cost growth experience because the funding base is so much larger and more elastic. For example, in the Medicare Trustees Report, the "High Cost" scenario is that costs increase 2% faster in real terms than in the baseline. This 2% increase in cost growth would raise the required payroll tax rate to fully fund all of Medicare in 2020 by about 50%.[2]

But more importantly, erasing the explicitly intergenerational nature of the Medicare program would sever our social contract and loosen the bonds between generations. We Americans require individuals to take a great deal of personal responsibility to fully enjoy the fruits of our society, but we also take care of our elders. We do not forget those who end up unlucky or the victims of the inexactitudes of actuarial, economic, or medical science. The strongest and most prudent safety net is the promise of unconditional acceptance in a larger community. We abandon such a promise at our individual and collective peril.

Still, as the Professors' and my discussion of cohort-based financing's financing tradeoffs have made clear, the future rate of growth of Medicare's cost per beneficiary is a key variable. While we focus on cost, however, it is useful to keep Medicare's cost growth problem in perspective. Private health plans that serve the under-65 working population have done better lately, but Medicare actually outperformed the private sector for most of the last 25 years. From 1969 to 1994, Medicare cost per beneficiary grew slower than the private sector analogue each year (slightly less than 11% compared to just over 12% per year). This is not to say that either's performance was good, just that Medicare has not lagged the private sector, on average, very long. In the last two years, the private sector has done very well, and it is important to understand why and to draw the proper lessons about what this does and does not imply for restructuring Medicare.

First, private prices relative to Medicare prices have fallen largely as the result of hard bargaining from employers and managed care health plans in the face of substantial excess capacity in hospital beds and specialist physicians. This excess capacity has manifested itself rather suddenly as a result of a veritable revolution in health care delivery patterns, epitomized by the rise in outpatient surgery, reductions in hospital admissions and shorter lengths of stay for many conditions and treatments. (This revolution in delivery patterns, by the way, was jump-started by the Medicare hospital payment reforms (PPS) in 1983.) Relative private prices have fallen so far lately because they were much higher than Medicare prices to start with, and because Medicare's current pricing formulae are insufficiently flexible to take advantage of competitive market fluidity. This "one-time adjustment" of private health service prices to new competitive realities has proceeded at different speeds across the country, and thus could continue to exert downward pressure on prices, on average, for a while. Still, there are limits to this source of cost reduction, namely, when the excess hospital and physician capacity is finally squeezed out of the system. This will happen, though perhaps not as quickly as in other markets which have experienced excess supply throughout our nation's history.

In addition, the frequently cited statistics on lower growth in private employer health insurance costs (per employee), which have looked promising lately in both Foster Higgins' and KPMG Peat Marwick's surveys, are also largely due to one time, and not structural, factors. The major explanation here is that much of the country is shifting to lower priced managed care plans from higher priced indemnity or fee-for-service arrangements. Employee switching to plans with lower premiums can lower the average cost per employee of health insurance, even if no underlying inflation rate has been affected at all. The example in Table 1 shows how this can happen. The premium for each hypothetical health plan increased by 10%, but enough employees switched from the high priced plan to the low priced plan that the *average* health insurance cost per employee increased by only 3.2%. This is partly why, in their latest report, Foster Higgins analysts predicted a rekindling of health insurance inflation in the next few years, despite the recent good news on this front. Eventually, most employees will be in the lowest priced plans available, but unless the underlying causes of health care cost inflation have been cured, i.e., our apparent taste for ever more expensive health technology, we'll be right back on a path toward higher and higher health insurance costs soon enough. This upward path will steepen as the excess capacity in hospitals and specialists begins to disappear.

In summary, the private sector has done better than Medicare lately by using market forces and excess capacity to negotiate lower prices. The private sector has found a way to make first generation managed care work for it, at least in the short run. Of course, as you know, first generation managed care does not work all that well for Medicare taxpayers at the moment, since Medicare's payment formula overpays HMOs 5-7%, on average, for the actual cost of care received by beneficiaries who choose managed care. That is why HMOs can afford to offer benefits more generous than the basic Medicare benefits package. This could possibly be fixed with adjustments to the formulae now, but this is a somewhat technical matter for another time.

MAKING 21ST CENTURY MARKET COMPETITION WORK FOR MEDICARE

The real goal of long term structural reform of Medicare is to make next generation managed care and health insurance plan competition work well. By "next generation managed care" I mean managed care that provides proof of high quality outcomes to beneficiaries who use that information to make informed choices about health plan and health provider arrangements. By "health insurance plan competition" I mean market competition among a variety of arrangements, including indemnity plans and preferred provider organizations. By "work well" I mean provide high quality care for all beneficiaries, a reasonable choice of plans and providers, and do so at acceptable social resource cost. Aligning Medicare with market forces is absolutely essential for all this to occur. But at the same time, abandoning Medicare enrollees with a dollar voucher in an unfettered market is unlikely to be judged a success in the short or long term.

The key to making any market work is accountability. Buyers need to be able to evaluate what they're getting, and sellers need to be forced by competition to produce quality products efficiently and to provide enough information to evaluate the product itself. Some, but not many, health insurance markets are working this way today. All the successful ones I know of, across both the private and the public sectors, are practicing rather similar variants of the principles of managed competition to demand and get health plan accountability. A major problem with health plan innovation in Medicare today is that plans and provider groups are not held accountable and forced to provide adequate information for HCFA to evaluate how its beneficiaries and its payment rates are doing.

Successful principles for health insurance purchasing systems today are being practiced by groups as diverse as the San Francisco-based Pacific Business Group on Health, the Minnesota Buyers Health Care Action Group, the Colorado Health Care Purchasing Alliance in Denver, The Employer Health Care Alliance Cooperative of Madison, Wisconsin, the California Health Insurance Purchasing Cooperative, and the Washington (state) Health Care Authority, to name a few. Over 100 business coalitions for purchasing health insurance have sprung up in recent years. "Value based purchasing" is more than a new buzzword. It means getting the most out of what you pay for. In my judgment, the real world experience of employers and state governments suggest seven important steps to value based purchasing.

Define benefit packages. Standard benefit packages help consumers comparison shop among plans, allow purchasers (employers and governments) to evaluate exactly what they're getting for their money, and help reduce risk selection by benefit design. There can and should be different cost-sharing options and perhaps different

add-ons (like dental or vision), but they, too, need to be defined to focus competition on the twin dimensions of price and quality.

Medicare beneficiaries' experience with Medigap regulations should be enough to demonstrate the merits of defined benefit packages. The Baucus Amendments of 1980 called for voluntary industry standards, but seniors still found literally hundreds of medigap policy configurations and found it quite difficult to compare the plans. There is little doubt that some insurers used seniors' confusion over all this to select good risks and to sell seniors duplicate coverages. OBRA 1990 addressed this shortcoming of the Baucus legislation by specifying 10 different types of medigap policies. A recent study published in the Health Care Financing Review by Fox, et al. found that the vast majority of market participants think the medigap market is now functioning much better than it did before the benefit standardization reforms.[3] States, by the way, administer these medigap regulations under broad HCFA guidelines and oversight.

We should always be mindful that the Medicare population is not just a slightly older version of the under-65 population that is largely insured through employer-sponsored health plans. Many elderly have severe and chronic health care needs, and thus the standard set of services guaranteed for Medicare beneficiaries must differ substantially from the typical insurance policy sold to thirty-somethings with two young children. Medicare must, e.g., include skilled nursing facility and home health care benefits, as well as age-appropriate preventive services. Fee-for-service medicine may very well be the only way to provide some of these services in the foreseeable future in some parts of the country, and thus that option must be preserved and integrated into the new competitive framework.

Define enrollment and marketing rules. Within business coalitions, this is simply an annual open enrollment process. In Medicare's case, this would entail open enrollment as Medicare risk contractors must provide today, as well as oversight over marketing materials and recruitment techniques. This oversight need not be heavy handed, at least no more heavy than many employers and employers' coalitions exercise on behalf of their workers today, but it does need to be effective so that all health plans are truly open to all Medicare beneficiaries.

Specify plan reporting requirements. Health plan reporting is a prerequisite for the evaluation of quality outcomes, a key component to next generation managed care and all health delivery systems of the 21st century. Without laying the foundation for quality reporting and assessment, no market-based purchasing strategy can ever succeed in delivering outstanding performance. Definitive case-mix adjusted outcomes measures, especially for ambulatory care, will likely never be perfect, so all participants should exercise due diligence and caution in making clinical judgments based upon the ones we have available today. Still, enough progress has been made in developing process measures that are likely to be correlated with true outcome quality that the case for "waiting" until better measures come along is getting weaker every day. At a minimum basic utilization statistics should be institutionalized as reportable as soon as possible, as many organized health care purchasers have learned recently.

Negotiate competitive bids with plans. Business coalitions have found they need about a 15% market share to exercise enough purchasing clout to get providers' attention and to demand accountability from their local health care systems. Medicare starts the game with easily enough clout to get everyone's attention in virtually every market in the country. HCFA is now starting a competitive bidding demonstration in Denver, after a false start in Baltimore. I think for the first time HCFA now wants to move to competitive bidding more than do Medicare vendors. That says good things about the learning curve at HCFA and not so good things about the current formulaic overpayment to risk contract HMOs. In any event, competitive bidding is a vastly superior way to contract for the guaranteed Medicare benefit package than any formulaic or fixed growth approach, for it allows the program to react to market trends, favorable and unfavorable, as time passes and our health delivery system evolves.

Give consumers incentives to choose efficient plans. This has proven to be particularly effective in state plans in Minnesota, Washington, California, and in various universities. Contrary to long held myth, if faced with price incentives, people will switch to lower cost plans, voting with their feet, which will force those plans that have more costly delivery styles to demonstrate their extra value or lose market share and ultimately disappear. While this is essential to letting consumer preference drive the market in the long run, Medicare must be careful not to rush through incentives into a two-tiered system with low income beneficiaries congregating in lower priced and ultimately lower quality health plans (in the very long run). Senator Gregg's Medicare reform proposal, I believe, deals with this issue adroitly by letting seniors share in the savings from choosing lower priced plans, but does

not require higher payments from seniors for choosing any plan that Medicare sponsors. Medicare does not have to sponsor every health plan in the world, but it must allow all Medicare beneficiaries equal access to the plans it does sponsor to preserve our traditional commitment to one-tier medicine for seniors. This can be done in a manner consistent with new incentives for efficiency.

Publish enough information to inform enrollees about quality measures and to facilitate plan switching. Effective consumer choice requires that objective information be readily available. Health care is a very complex commodity, and health insurance arrangements are not simple either. Still, organized buyers can generate sufficient high quality information that not every consumer need know every detail, for plans will try to attract knowledgeable consumers who are likely to drive the switching behavior in any market. Thus, good knowledge for some protects all consumers/patients. Employers often act in employees' behalf, as do state governments. There is a crucial role for HCFA to play here as the ultimate agent on behalf of seniors and their families, especially for older and more infirm beneficiaries.

Risk adjust plan payments. To engender true price-quality competition and avoid selection effects, good risk adjustment is necessary. This will ensure that premium dollars flow to plans that do a better job delivering high quality cost-effective health care and not just to those who do a good job of selecting healthy enrollees. Risk adjustment is being practiced by a few public or publicly organized purchasing coalitions, but no private business coalition to date is using this complex and as yet imperfect methodology. Medicare would have to, however, since its experience with the Medicare risk program indicates that selection effects are very likely. This is particularly important if we decide to permit MSAs as an option for Medicare beneficiaries, for it is possible that selection effects for MSAs would be extreme.

But the proof of all these experience-honed insurance market rules is in the pudding, as they say. For a study that my Urban Institute colleague Linda Blumberg and I are doing of purchasing cooperatives in four states, I have been granted access to (unidentified) plan specific pricing data by one of the purchasing cooperatives listed above. Table 2 shows the effects of their application of these market structuring principles over the last three years. Unlike Table 1, where hypothetical plan switching was used to explain the reported result that health insurance costs per enrollee has grown slowly in recent years, these premium inflation rates apply to specific types of plans with an unchanged benefit package (a package substantially richer than Medicare's, by the way). These inflation rates are not enrollment-weighted, to permit evaluation of the plans' performance independent of employee switching. The plan types are ordered from tightest to loosest forms of managed care and by generosity.

The salient lesson I draw from the table is that when consumers can compare apples to apples and weigh the benefits of more choice or lower copays vs. the demonstrable cost, many opt for lower priced alternatives. Competition thereby imparts greater pressure for all health plans to deliver even more value for dollar the next year. Enrollment in plan types 3 and 4 has fallen to less than 2% of the total over these three years, and yet intra-plan type competition is clearly keeping the performance of the most successful plan types well beyond that observed in less competitive markets. Structured competition works for enrollees and for payors, and for successful and effective providers and health plans as well.

Although these business coalition experiments are fairly new and all data are preliminary, I believe that organized purchasing experiences to date strongly suggest that defined benefit packages, reporting requirements, competitive bidding, and marketing rules all force accountability on health plans and can MAKE HEALTH INSURANCE MARKET COMPETITION WORK! This is exactly what Medicare needs for the 21st century.

A BALANCED APPROACH TO THE FUTURE

Would effective market competition of this type guarantee the 1% real rate of cost growth per beneficiary that so many "save Medicare" plans depend upon? Probably not, for there are no guarantees in the real world. I am not a fan of the silver bullet theory, that there is one magic solution to Medicare's financing problem that we just haven't been smart enough to discover yet. Any serious Medicare restructuring effort, as Senator Dole wrote the other day in the Washington Post, will require a little bit of sacrifice and change from all parts of the program and from all parts of our society. This entails some version of the usual list of suspects to address the short run Part A trust fund shortfall, and it probably entails some tax increases down the road in the longer run. But with competitive bidding and a defined benefit package, we could decide collectively exactly what we are willing to pay for as prom-

ised medical value and current opportunity cost are weighed right here in Congress each year into the future, as it should be.

Though we may end up with tax increases if we decide collectively we would actually like to pay for more health technology as it becomes available, we need not start there. Where we should start is with a serious effort at restructuring Medicare along workable market lines, not ideologically pure free market lines, but structured market lines. A competitive health plan market can be the Medicare program's best long run friend, but only if we structure the relationship carefully. This structured relationship would be stronger, I believe, if the overall program remains intergenerational. Those are our elders out there looking for medical care after a lifetime of work and sacrifice. They are us.

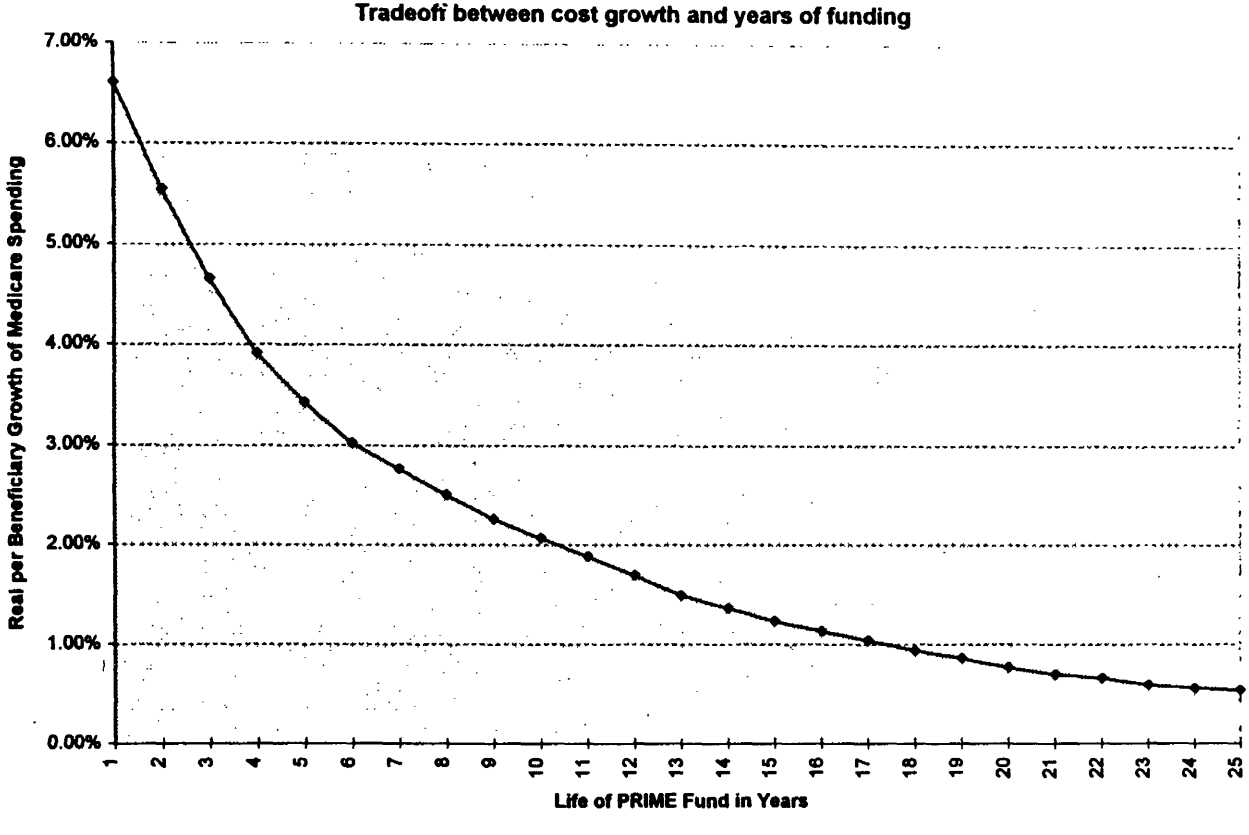
ENDNOTES

[1]: I am grateful to Tim Waidman for making the life expectancy calculation using Center for Disease Control's death rate projections for 65 year olds in 2039. The complete estimate in the text assumes a 3% real rate of return on savings during the cohort's working lifetime, 1% real wage productivity growth and returns to experience over a working lifetime similar to those that are observed today. 4.22% is the 1993 (the last year that Social Security Administration payroll data are publicly available) payroll tax rate required to fully fund Medicare, the ratio of Medicare expenditures to worker plus self-employed earnings.

[2]: From 12.7% in the baseline to 18.8%. These rates take into account the HI cost ratio and the estimated ratio of SMI to HI outgo in 2020, taken from the Trustee's report.

[3]: cite. This is not to say the medigap market is functioning perfectly, but that too is a topic for another day.

Figure 1


Tradeoff between cost growth and years of funding
Real per Beneficiary Growth of Medicare Spending
7.00%
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
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24
25
Life of PRIME Fund in Years

Figure 2

Tradeoff between real rate of cost growth and real rate of return on savings to finance PRIME Medicare

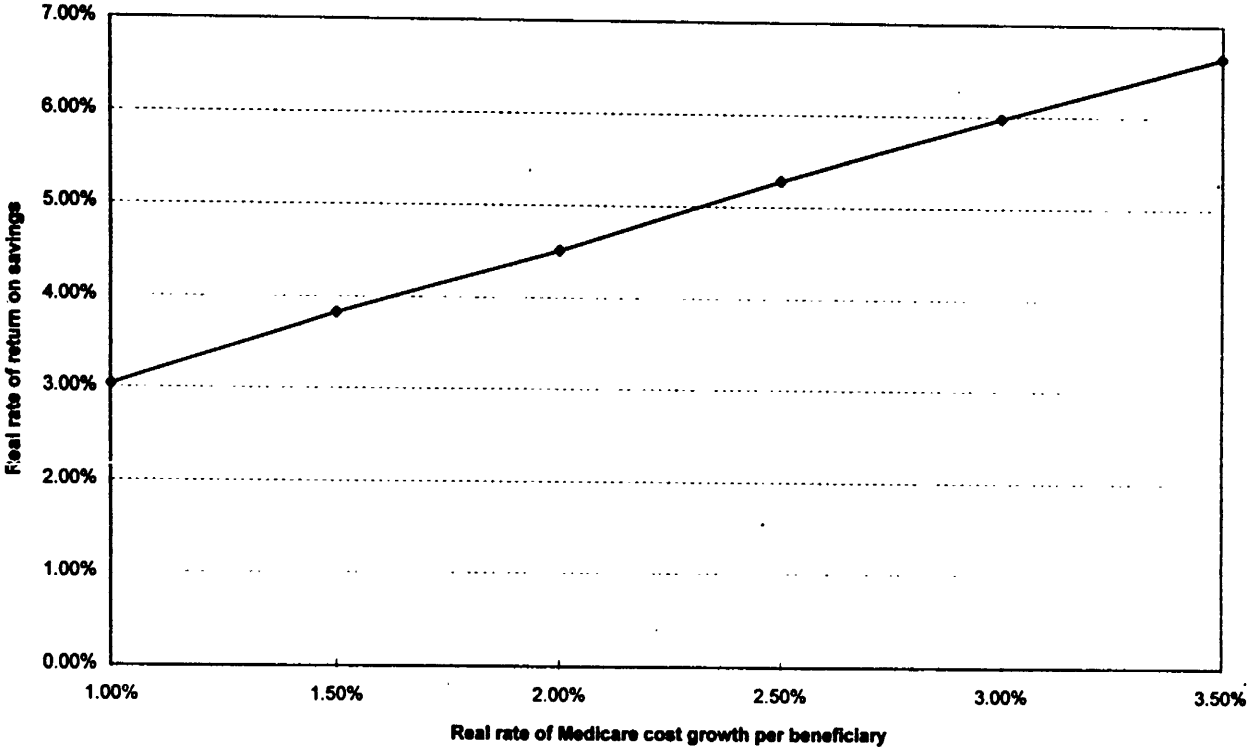

Figure 3

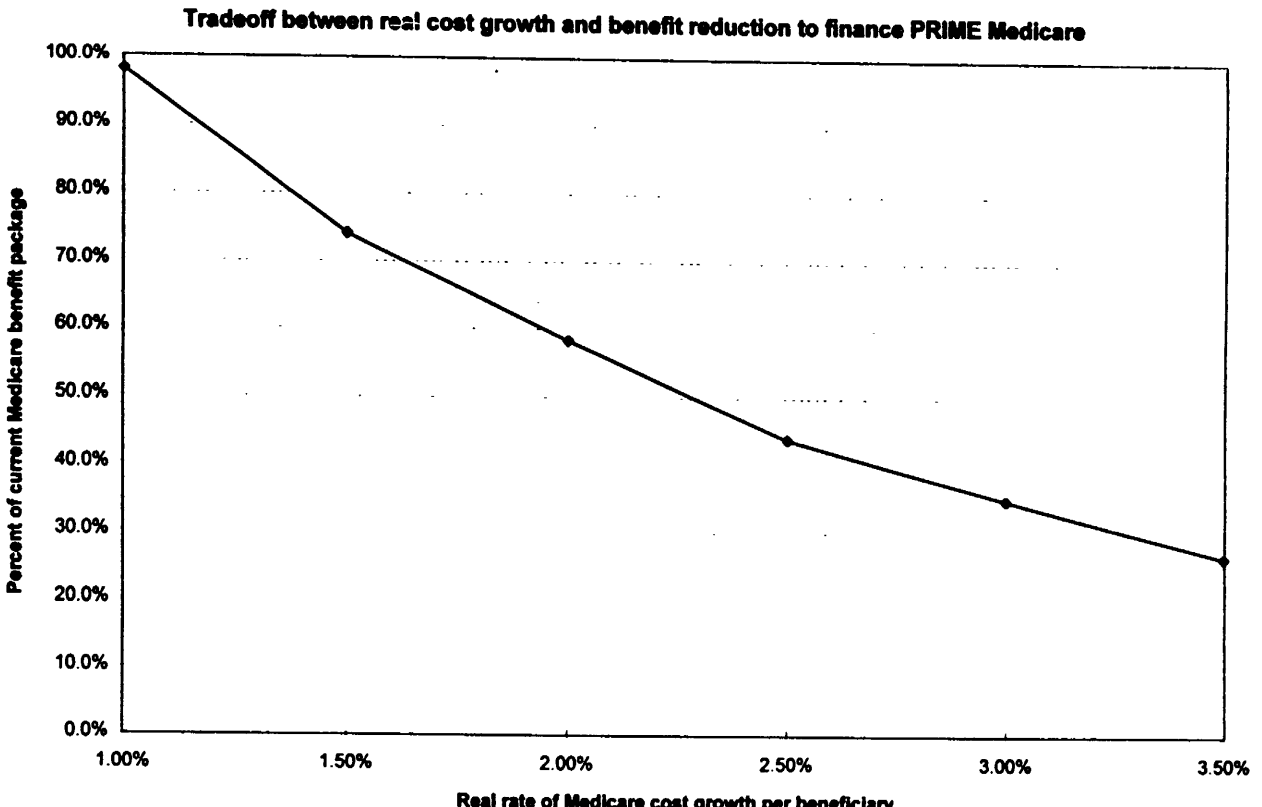
Tradeoff between real cost growth and benefit reduction to finance PRIME Medicare
Percent of current Medicare benefit package
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
1.00%
1.50%
2.00%
2.50%
3.00%
3.50%
Real rate of Medicare cost growth per beneficiary

Figure 4

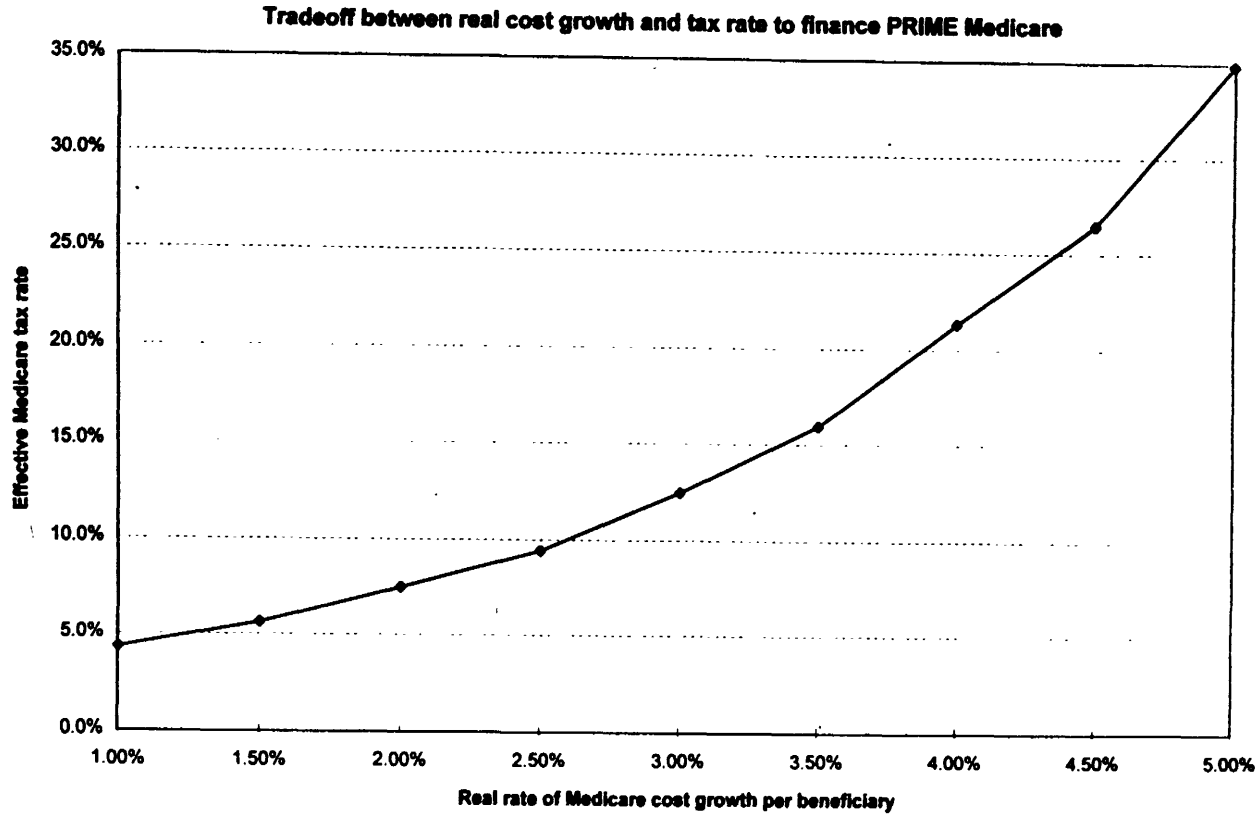
Tradeoff between real cost growth and tax rate to finance PRIME Medicare
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
Effective Medicare tax rate
1.00%
1.50%
2.00%
2.50%
3.00%
3.50%
4.00%
4.50%
5.00%
Real rate of Medicare cost growth per beneficiary

Table 1.

How Switching Among Health Plans Can Lower the "Growth" In Health Insurance Cost Per Worker

	1995	1996	growth
Indemnity			
premium	$ 400.00	$ 440.00	10%
enrollment	200	100	-50%
HMO			
premium	$ 330.00	$ 363.00	10%
enrollment	100	200	100%
Total Employees	300	300	0
HI cost per worker	$ 376.67	$ 388.67	**3.2%**

Source: Author's example.

Table 2.

Growth rates in premiums of specific health plan types

rates of change in a family policy bought by a 40-49 year old employee

	1994-95	1995-96	1996-97	cumulative
plan type 1	-7.0%	-7.9%	-3.6%	-17.4%
plan type 2	-6.5%	-7.4%	-1.9%	-15.1%
plan type 3	-4.3%	5.6%	16.2%	17.4%
plan type 4	-4.4%	7.4%	16.9%	20.0%

Source: Confidential data from an actual purchasing coalition.

Plan types are ordered from tightest to loosest form of managed care and by generosity.

PREPARED STATEMENT OF THOMAS R. SAVING *

EXECUTIVE SUMMARY

Medicare recently celebrated its thirtieth birthday. How many more birthdays it celebrates in its present form is currently one of the more controversial policy issues in America. The debate lies in the degree to which the system will be reformed. Will we settle for a minor tune-up now, of a 1965 model program, or will we re-engineer and redesign it for the future?

We believe that Medicare's original design is flawed in two fundamental ways. First, the current Medicare pay-as-you-go financing system has resulted in no one putting anything aside to pay for retirement medical care. Second, because Medicare recipients care little about the price of the medical services they consume, the level of Medicare expenditures have risen faster than Gross Domestic Product.

A Medicare reform plan that confronts pay-as-you-go financing's inherent problems and reestablishes prices as the mechanism that allocates health care can be accomplished if we act quickly and decisively. We suggest a retirement medical insurance program coupled with a financing method that is immune to birth rate variations and that gives both retirees and insurers an incentive to care about the price of medical care.

Two things to keep in mind from the outset are: (1) the risks associated with paying for the medical care needs of current and future retirees exist regardless of the financing plan that is ultimately adopted and (2) saving for retirement is not a radical idea. Medicare's current problems simply bring into focus the need to reexamine how, as a society, we insure against and save for each member's retirement medical expenses Our plan produces the right incentives and secures individuals' ownership of their retirement medical insurance, and thus ultimately makes Medicare a sustainable program.

We have placed ourselves in the position of allowing the surge in population, generally referred to as the baby boom, to lull us into a sense of security that a pay-as-you-go system of financing Medicare would work. How different the situation would be if the original planners of Medicare had recognized that the large group they foresaw entering the labor force was similar to the seven years of plenty Joseph predicted for Pharaoh. Joseph also predicted that these seven years of plenty would be followed by seven years of famine and he convinced Pharaoh to put grain aside during the years of plenty in order to feed his subjects during the seven years of famine.

In our case, the equivalent of the seven years of famine will begin when the baby boom population surge begins to leave the labor force. Have we put anything aside to prepare for these years? The answer is no. Thus, we are faced with the imminent famine without reserves in our grain silos.

But it is not too late. While we cannot turn back the clock, we can rescue the situation and insure that we are never again caught in a cohort or generation size caused crisis. Converting our current pay-as-you-go system of financing Medicare to a cohort based system can be accomplished if we act quickly. We can replace both Parts A and B of Medicare with fully funded cohort based real investment.

The approach we suggest is the conversion of the current Parts A and B of Medicare into health insurance consisting of a high deductible and then 100% coverage. This type of health coverage makes consumers care what health care costs and will play a major role in restoring competition to the industry

Our estimates indicate that using as a base the current 2.9% Medicare tax rate we can move cohorts of age 39 and younger into our proposed cohort financing. Older cohorts will remain in the to be amended Medicare system. Their expenditures financed by the excess of contributions from the switched population, the contributions of the yet to retire population, with the remaining coming from general tax revenues. We estimate the total cost of this transition at $970 billion to be paid for over a period of twenty years Once the last of the over 39 group has left the system all future generations are self funded.

One of the great benefits of moving to cohort based financing for Medicare is that the reputation of the system can be restored. Even before the reductions in benefits that must be enacted to keep the current system solvent are enacted, young people believe that the system will not be there for them. However, if the changes that must be made in the system are coupled with a movement to cohort based financing a clear message will be sent to the young the system will be there for them. We will have restored their confidence in government by giving them a property right in their Medicare.

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* This statement represents the views of the authors and not necessarily those of Texas A&M University.

INTRODUCTION

Medicare recently celebrated its thirtieth birthday. How many more birthdays it celebrates in its present form is currently one of the more controversial policy issues in America. Though the rhetoric is heated and the issues complicated, most serious observers would probably now agree that Medicare is due for an overhaul of some sort. The debate lies in the degree to which the system will be reformed. Will we settle for a minor tune-up now, of a 1965 model program, or will we re-engineer and redesign it for the future?

We believe that Medicare's original design is flawed in two fundamental ways. First, the current Medicare pay-as-you-go financing system has resulted in no one putting anything aside to pay for retirement medical care. Current Medicare recipients' medical expenditures are financed by taxes on current workers' wages. Social Security is financed in a similar manner. This kind of financing is problematic if there are peaks and valleys in birth rates or if workers' wages are stagnant. With the start of the baby-boom generation's retirement looming in fifteen years, the ratio of workers per retiree will dramatically drop. In addition, wages, primarily those of male workers, have been relatively stagnant in inflation adjusted dollars for the last twenty years. Both of these trends do not bode well for a financing system that requires growth in both workers and their wages for real growth in benefits to occur.

Second, because Medicare recipients care little about the price of the medical services they consume, the level of Medicare expenditures have risen faster than Gross Domestic Product (GDP). Medicare shares this problem with most prepaid medical "insurance" programs. When individuals do not face the full price of a service or product, they consume more than they would if they were to pay the full price. The growth rates in per beneficiary expenditures actually experienced over the life of the program have far outpaced Medicare's financing mechanism.

A Medicare reform plan that confronts pay-as-you-go financing's inherent problems and reestablishes prices as the mechanism that allocates health care is offered in the following sections. We propose a solution that addresses the more enduring problems associated with pay-as-you-go financing by suggesting a financing method that is immune to birth rate variations and that gives both retirees and insurers an incentive to care about the price of medical care. Two things to keep in mind from the outset are: (1) the risks associated with paying for the medical care needs of current and future retirees exist regardless of whether the financing plan is tweaked or fundamentally changed and (2) saving for retirement is not a radical idea. Medicare's current problems simply bring into focus the need to reexamine how, as a society, we insure against and save for each member's retirement medical expenses. We offer a plan that produces the right incentives and secures individuals' ownership of their retirement medical insurance, and thus ultimately makes Medicare a sustainable program.

MEDICARE TODAY

Medicare is the federally financed and administered program that covers the medical care expenses of the elderly and disabled population in the United States. Medicare has two components: Hospitalization Insurance (HI), Part A, financed through a 2.9% payroll tax with no limit on the level of earnings subject to the tax; and Supplemental Medical Insurance (SMI), Part B, 75% financed through general revenues with the remainder coming from retiree premium payments which are currently $42.50 per month.[1]

In 1996, 37.5 million individuals had Part A coverage. Of these, 32.8 million were 65 years of age or older and the remaining 4.7 million were disabled.[2] The 32.8 million over age 65 represented over 97% of the elderly population. Just over 32 million of the 65 and above population have Part B coverage. Approximately 4.3 million disabled workers have Part B coverage. Health care insurance under the Medicare program was extended to the disabled in 1972.[3] While providing health care insurance for the disabled is an important issue,

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[1] Health Care Financing Administration Document, p. 1.
[2] 1996 *Green Book*, p. 135.
[3] Social Security Bulletin, Vol.56, No. 4, Winter 1993, p. 42.

it is more appropriately handled as part of a general welfare program. For this reason, the remainder of our discussions will only address the health care needs of the elderly population.

In 1996, about 22% of the aged enrollees in Part A received reimbursable services. The average benefit received by an enrollee who had a reimbursable service was $15,095, producing an average benefit across all enrollees of $3,346. Medicare enrollees are much more likely to utilize their Part B than Part A coverage. Over 85% of Part B enrollees received reimbursable services and the average benefit across all Part B enrollees in 1996 was $1,864.[4]

A BRIEF HISTORY

Original Intent - On July 30, 1965, President Lyndon B. Johnson signed the bill that established the Medicare program. Several trends converged during the early 1960s that helped facilitate the passage of Medicare. From 1946 to 1965 the average real manufacturing wage rose 2.3% per year. Just as importantly, by 1965 there were almost 77 million children and teenagers between zero and 19 years of age. Growing wages and a blossoming future workforce were the ideal conditions for a social insurance program that relied on pay-as-you-go financing. These were heady times. Medicare was not the only government sponsored health insurance program passed during 1965, it shares its birth year with Medicaid. These two health insurance programs are Titles 18 and 19 of the Social Security Act, respectively.

The genesis of these programs also owe much to the wage and price controls that were in effect during World War II, some 20 years earlier. Prior to the war, employer provided health insurance was rare as was health insurance in general. But the combination of a wartime increase in the demand for labor and wage controls resulted in employers searching for other ways to raise workers' compensation. Paying workers in the form of health insurance was one way to raise workers' compensation without raising their wages. Employer-based health insurance purchases were also tax exempt. Because of their special tax status, employer-based health insurance plans became a fixture in the employment relationship. Between 1940 and 1965, health insurance premiums grew as a proportion of workers' compensation. During that same time period, the proportion of the population covered by a health insurance plan grew from 9% to 80%.[5] The preferential tax treatment enjoyed by health insurance changed the way in which health care was financed and viewed.

The following statements from the 1965 Joint Economic Committees' report summarize some of the reasoning behind Medicare's provision of immediate universal coverage.

> *This year the Congress faces another stage in one of the great unfinished tasks of our society--assuring an adequate hospital insurance program for the aged. Private insurance plans have failed to provide adequate protection at premiums that most of the aged can afford. The Committee concludes that Federal help is essential to an effective program. (p. 24)*
>
> *The question before our Nation is not whether our aged should have adequate medical care--all are agreed that they should--but in what manner that care should be financed. The facts on the income and savings levels of the aged population, and on the medical costs to which they are subject, indicate clearly that the aged simply lack the means to pay for adequate medical care from their retirement incomes and savings. Primary reliance should not be placed on welfare programs which give public assistance based on means tests If applied by all states at the requisite level of medical care, such programs would be inordinately expensive--both because of the medical costs involved and because of the high costs of administering means tests.*
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> *Moreover, the committee believes that the aged of modern America should not be forced to exhaust all savings and be reduced to a state of demonstrable poverty before they can qualify for help toward meeting medical costs. Public assistance can play an important role, but it must be to*

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[4] 1996 *Green Book*, p. 135-136.

[5] *Economic Report of the President 1966*, p. 106.

supplement a broad, national program for the aged which meets their health needs without detracting from their dignity and self-respect. After all, dignity, self-respect, and a feeling of economic security are just as important to the health of our elder citizens as is care for their physical ills.

The solution to the health needs of the aged lies in insurance. If private insurance could do the job there would be no need for a Federal program. But it is clear that adequate private insurance plans for aged are beyond the means of most. ...(p. 25)

***What the aged need is a plan which would permit them to acquire insurance protection against the high medical costs of old age for modest premiums paid during their long working lives, without the need to pay heavy premiums after retirement. Such insurance is now virtually unknown among private carriers.** (Emphasis added)*

Health insurance for aged under the Social Security System would seem to offer one effective and efficient response to the need. This system has proved its capacity to administer, at low cost, broadly based social insurance programs. It would provide uniform benefits for Americans, regardless of their location. And it would free private insurance companies from some of their present expense burdens and enable them to offer plans supplementing the basic coverage. (p. 26) (Report of the Joint Economic Committee, Congress of the United States, on the January 1965 Economic Report of the President)

As the 1965 Joint Economic Committee's report indicates, the original proponents of Medicare believed that the market had failed in some way to provide adequate insurance against the health expenses of old age. The Committee saw government insurance provision for virtually all elderly Americans as the best solution, without asking why private insurers were not offering retirement medical insurance that could be purchased during a worker's years in the labor force. The 89th Congress established a demand for retirement health insurance and chose to finance this program by using the working population as the source of payment for the retired population's medical expenses.

Medicare was intended to be a universal insurance program for the elderly, not one limited to the poor among the elderly. It was patterned after the Social Security Program in this regard. Medicare was also to be a program that provided uniform benefits. Little did the 89th Congress or President Johnson know that they set into motion a series of incentives that would produce a program representing over 10 percent of the federal budget shortly after its 30th birthday.

Medicare's Growth Chart - Any aspiring new business would envy Medicare's growth chart. The program has grown in all dimensions. The number of enrollees has grown from 19 million in 1966 to 37 million in 1995. The average Part A benefits per retiree grew at an annual rate of 11.34% from 1967 to 1995. Per retiree Part B benefits have increased 12.07% per year over the same period. These growth rates compare to 5.6% annual growth in the consumer price index and 7.6% annual growth in the medical care component. In 1972, disabled persons who meet Social Security's eligibility requirements and individuals with end-stage renal disease were added to the program.

To keep pace with Medicare growth, the payroll tax has been increased numerous times, starting at 0.7% in 1966 and reaching its current level of 2.9% in 1986. Besides the growth in the tax rate, the level of earnings subject to the tax rose from $6,600 in 1966 to its current unlimited level in 1994.[6]

Current and Future Status of the Medicare Program - Since 1992 the Trustees of Medicare's Hospital Insurance Trust Fund have reported that the fund does not meet the Trustees' short-range test of financial adequacy. In their 1996 report, the Trustees warned that, "*without corrective legislation soon, the fund would be exhausted shortly after the turn of the century - initially producing payment delays, but very quickly*

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[6] 1996 HI Trust Fund Report, p. 19.

leading to a curtailment of health care services to beneficiaries."[7] They go on to state that to bring the HI program into actuarial balance over the next 25 years would require an immediate 68% increase in the tax rate from 2.9% to 4.86%. To sufficiently fund Medicare's HI program under the intermediate assumptions over a 75-year horizon, the tax rate would have to be increased immediately to 7.42%.[8]

Because SMI is not financed by a dedicated payroll tax, the Trustees discuss it in a separate report. In 1995, premium payments represented 29.8% and general revenues represented 58.6% of SMI expenditures. The remaining 11.6% of expenditures, was primarily financed through drawing down the SMI trust fund.[9] Premium payments as a percent of total expenditures are expected to drop to 12% of SMI expenditures by 2010 and to 8.5% of expenditures by 2030.[10]

The Trustees report that under their intermediate assumptions, SMI expenditures as a percent of GDP are expected to grow from to 1.97% in 2010 and 3.47% in 2030 from their 1995 level of 0.92%.[11] Further, SMI expenditures, net of premiums paid, as a percent of taxable payroll are expected to rise from the 1995 level of 1.34% to 3.65% in 2010 and 6.90% in 2030. In their concluding comments on the future status of the SMI program, the Trustees note: *"As in past years, we note with great concern that the program costs have been growing faster than GDP and that this trend is expected to continue under present law."* The Trustees continue by stating, *"Of additional concern is the fact that the premium income after 1998 is projected to cover a progressively smaller fraction of SMI expenditures, shifting a greater share of the program financing from beneficiaries to the general public."* They call on Congress to address the increased costs of both SMI and HI associated with the baby boomers' retirement, and conclude by stating that *"prompt, effective and decisive action is necessary."*[12]

A CLEAN SLATE

What would a social insurance program, designed to take care of the health care needs of the elderly, look like if we started with a clean slate? The 89th Congress had a clean slate in 1965. The Congress and President opted for a fee-for-service insurance program that is primarily financed on a pay-as-you-go basis. In 1965, the insurance and its financing seemed reasonable enough, but as the program has expanded during the intervening years we now have good reasons to search for alternatives.

Our proposal harkens back to the 1965 Joint Economic Committee's (JEC) report that states, *"What the aged need is a plan which would permit them to acquire insurance protection against the high medical costs of old age for modest premiums paid during their long working lives, without the need to pay heavy premiums after retirement."* The 89th Congress' JEC basically suggested that individuals save for their retirement. There is nothing novel about saving for retirement. But the Committee went on to suggest that, *"Such insurance is now virtually unknown among private carriers."*

Public provision of such insurance was seen as the answer to what the JEC perceived as market failure. The Committee went on to suggest that public insurance be administered though the Social Security Administration. Public provision guaranteed that private carriers would not offer retirement medical insurance, and the pay-as-you-go financing system guaranteed that nothing would be set aside during worker's "long working lives."

Further, between 1946 and 1965 the general price index rose at an annual rate of 2.6% while the medical care index rose at a 3.8% annual rate. Medical care prices essentially doubled over this period while general prices rose 60%. With the perceived higher prices and heightened expectations, calls for retirement medical insurance were increasingly heard. It was argued by the proponents of Medicare that medical care

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[7] 1996 HI Trust Fund Report, p. 15.
[8] 1996 HI Trust Fund Report, pp. 14-15.
[9] 1996 SMI Trust Fund Report, p. 6.
[10] 1996 SMI Trust Fund Report, p. 13.
[11] 1996 SMI Trust Fund Report, p. 11.
[12] 1996 SMI Trust Fund Report, p. 14.

insurance for the elderly was prohibitively expensive, ranging from 15% to 20% of a retiree's annual income in 1965.[13] It may have been that the rising real costs of medical care caught retirees unaware, and what seemed adequate provision for retirement was now insufficient. Or, alternatively, the incentive to save less than needed for retirement given the expectation that "society" will take care of one's health care needs in old-age may have been a contributing factor in the perception that the elderly were receiving less than adequate medical care.

The Medicare system put in place in 1966 allowed retirees who had put nothing into the system to begin receiving benefits. From 1965 to the present, the current Medicare Trust Fund crisis essentially implies that no savings have been put away for contributing workers. We have reached the point where each year's payroll taxes and general revenues finance each year's expenditures under Medicare. Taxpayers are required to pay into this system, but whether they receive retirement medical care is contingent on their children's willingness to tax themselves at a high enough rate. Current and future Medicare obligations represent an unfunded potential government liability whose size depends on whether or not we make good on our promises, something that the young believe we will not do.

A Cohort Based Solution - We propose that each age cohort, defined as all individuals born between January 1 and December 31 in any given year, insure itself against retirement medical expenses. Each worker within an age cohort pays a premium that insures against the medical expenses that arise during retirement. If the insured event does not happen, the insurance does not pay. As a cohort ages, the required premium is adjusted as more information about the cohort's future medical care needs is revealed. This kind of financing establishes a link between the purchasers and the consumers of medical care that is absent with a pay-as-you-go financing system. Another benefit of cohort based financing is that it eliminates cohort size risk of the form we are now facing with the pending retirement of the baby boom generations. If the population age distribution experiences a bulge because of larger than normal fertility or immigration, the contribution to retirement medical insurance of these cohorts will rise maintaining the same per-capita value as smaller cohorts This automatic adjustment is similar to a boat rising and falling with sea level, no matter what happens to sea level. Our proposed retirement medical insurance naturally raises numerous questions, to which we now turn.

Is Participation Mandatory? - For various reasons, all individuals are required to participate in the insurance program we are proposing. The primary reason for mandatory participation is a result of individuals' incentives to under-insure themselves against medical care expenses that arise during retirement. Retirees reasonably expect "society" to take care of them should they fall ill.

In the past, family units, through implicit inter-generational contracts provided this insurance function. With today's increased mobility and the changing dynamics of family units, a new means of insurance is required. Cohort based insurance in which, at the minimum, all working individuals in a cohort pay into the system insures that a sufficient level of assets will be set aside as the cohort ages. Mandatory participation also solves the problem that arises when individuals choose to join the system only when they expect large medical expenses, adverse selection, by forming age cohort risk pools. Additionally, during the transition to the new system, all individuals will continue to pay the taxes required to finance the current and future retired population who remain in the current system.

How Does Increased Savings Provide Insurance? - Insurance that comes into play only if an individual reaches the age of 65 and has medical expenditures that exceed the policy's annual deductible requires smaller contributions than would a medical IRA. The insurance we are proposing pays no death benefits to survivors should an individual die before reaching 65 years of age. A medical IRA implies a transferable property right to a survivor and is thus more costly. Medicare is similar to this insurance in that it does not pay a death benefit.

What Kind of Insurance? - In its simplest form, catastrophic retirement health insurance coverage is purchased during a worker's years in the labor force. We are proposing insurance that is comparable to today's high deductible policies.

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[13] 1965 Joint Economic Report, p. 25.

Who Will Pay for the Poor? - Any universal program must address redistribution. Under the current Medicare system, redistribution occurs across generations — workers are expected to pay for the medical care of retirees and receive medical care (upon retirement) from the next generation of workers. This system functions well when the number of workers per retiree is high but poorly when the number of workers per retiree is low. Since birth rates have been steadily declining in America and life expectancy has been steadily lengthening, the current Medicare system relies upon an ever-shrinking pool of workers to fund an ever-growing pool of retirees. This is both unfair to younger workers and unsustainable for the health of the Medicare system.

Some of the more radical proposals to "privatize" Medicare would let each worker save for his or her own medical needs during retirement but provide nothing for those who do not have enough money to make such contributions. While simple privatization solves the issue of inter-generational redistribution, it does not ensure that the medical needs of the less fortunate will be met. A cohort based Medicare system can address both of these problems by redistributing income within rather than across generations — workers in a particular cohort would subsidize nonworkers in their cohort and high wage earners would subsidize low wage earners in their cohort. If a cohort is small, it will have fewer workers but it will also need fewer dollars to help the less fortunate in its cohort; if a cohort is large, a relatively high amount of money will be needed to help the less fortunate but a relatively high number of workers will be present to provide it. Thus, the cohort based system protects both Medicare recipients (from a lack of funding) and younger workers (from high taxes) in a way that the current Medicare system cannot do.

Will Insurers Enter this Market? - The level of retirement medical care that will be demanded by today's young workers is unknown. What medical care will look like in 40 years is also unknown. Because of this uncertainty are there no market-based insurance solutions? Can an insurer even estimate the future risks? Our approach does not specify when retirement medical insurance will be purchased. This answer depends on who bears the risks associated with the medical care purchases that will be made by today's young workers when they are old. These risks will exist regardless of who bears them.

For our purposes the insurance could be purchased as each age cohort reaches a specified age, currently 65. Thus, the timing of the purchase of retirement medical insurance is irrelevant. The real question is, will future retirees pay for their own retirement medical purchases or will they rely on their children and grandchildren to pay for their medical care? Pay-as-you-go financing shifts the risks from medical care consumers to taxpayers. Relying on future workers' willingness to tax themselves is the only security current workers have in the present system.

THE THEORETICAL CONTRIBUTION RATE

From the pay-as-you-go accounting identity we can derive the formula for a cohort based financing equation. The pay-as-you-go accounting identity can be written as

$$T \cdot N_w \cdot Y = N_b \cdot B \qquad (1)$$

where T is the tax rate, N_w is the number of workers, Y is the mean annual wage, N_b is the number of beneficiaries, and B is the average benefit. The left-hand side identifies tax revenues and the right-hand side identifies the gross benefits. If the tax rate is held constant then the gross benefits can grow at a rate that is equal to the tax base growth.[14]

Rearranging (1) we can also identify the relation of the pay-as-you-go tax rate to the relative sizes of benefits and income and the relative sizes of the retirement and working populations,

$$T = \frac{N_b}{N_w} \cdot \frac{B}{Y}. \qquad (2)$$

[14] Schieber and Shoven, *American Economic Review*, May 1996, p. 373.

The sensitivity of the required tax rate to the relative size of the retirement population and the benefit-income ratio are well known and form the basis of the current crisis. In 1995 the ratio of beneficiaries per retiree, N_b/N_w, was 0.256, but by 2030 the ratio is expected to rise to 0.454. The 1996 HI Trust Fund report also indicates that in 1995 the ratio of total benefits to available taxable income, $(N_b \cdot B)/(N_w \cdot Y)$, was 3.40% and that by 2030 it is expected to be 8.52% under the intermediate assumptions. Thus, average Part A benefits as a percent of an average worker's income are expected to rise from the 1995 level of 13.3% to 18.7% by 2030. Under the current pay-as-you-go financing system the effects of the pending retirement of the baby boomers and the expected rapid growth of average benefits relative to average earnings will require higher tax rates or a substantial reduction in benefits.

In contrast to pay-as-you-go financing, consider the problem of an age cohort entering the labor force where we want to provide for the cohort's retirement medical expenses upon reaching age 65. Thus, we have defined an age cohort as the relevant group for the provision of retirement medical care. We can simplify the problem by considering a representative individual in the cohort. For this case N_b and N_w are both equal to unity (the one representative individual) who at some point will be retired and the required "tax" rate is the ratio of the present value of future expected medical costs, B, to the present value of expected earned income, Y, all adjusted for the probability of survival, which yields

$$C_{a_0} = \frac{\sum_{t=65-a_0}^{119-a_0} \frac{p_{a_0,t} b_{a_0,t} (1+g_m)^t}{(1+r)^t}}{\sum_{t=0}^{64-a_0} \frac{p_{a_0,t} y_{a_0,t} (1+g_y)^t}{(1+r)^t}}, \tag{4}$$

where a_0 = age of cohort entering the program, C_{a_0} = percent of lifetime earnings that must be saved to purchase retirement medical insurance given entering age of a_0, $y_{a_0,t}$ = mean cohort a_0 income in year t, r = real interest rate, g_m = real medical expenditures growth rate, g_y = real income growth rate, $b_{a_0,t}$ = estimated retirement medical care cost in year t for cohort a_0, $p_{a_0,t}$ = probability of living to time period t for cohort a_0, and $p_{a_0,t} = \prod_{i=a_0}^{t} s_i$, (where s_i = probability of surviving to year i+1, given a_0). In effect, C_{a_0} is the tax rate that must be applied to mean cohort a_0 income in order to fund the retirement medical benefits of cohort a_0.

The numerator of (4) is the expected present value of the retirement medical insurance benefits for members of cohort a_0 and the denominator of (4) is the expected present value of cohort a_0 income. The ratio of the expected present value of benefits to the expected present value of income yields the appropriate tax rate to fund all members of cohort a_0. This simple idea represents a replacement for the current pay-as-you-go financing for Medicare.

We suggest that all future generations provide for their own retirement health care by cohort specific contributions. The advantage of such a system is the complete elimination of cohort size risk. Had cohort based financing been in place from the inception of Medicare, we would not be concerned about the coming retirement of the baby boomers. We would, in effect, be riding in a boat instead of standing on the beach. We will simply float on a larger than normal wave, in the form of a population surge such as the baby boomers, rather than be swamped by it.

DATA SOURCES

Earnings - Age cohort contribution rates depend on a cohort's future life-cycle earnings. One estimate of life-cycle earnings is the current cross-sectional age earnings profiles. However, current earnings profiles are not a good indication of the real earnings that today's 25 year old worker will have 25 years from now; especially for females because of the rise in female labor force participation, human capital investment, and length of labor force continuity.

As a result of the changes in women's labor market behavior, we assume that younger female cohorts' life cycle earnings will be higher than exist in a current cross-section. Specifically, we assume that female full-

time workers will have lifetime earnings that reach 84.5% of men's lifetime earnings by the time today's younger workers complete their careers.[15] We also assume that the women's ratio of the full-time profile to the profile for all individuals will approach the ratio that exists among men. Finally, the average earnings across all women at ages 50 to 64 drop dramatically. Women report quite similar rates of not working or working part-time due to retirement as males.

To account for changes in both the male and female life-cycle earnings, earnings across all men of a given age are averaged up to the age of 50. For ages 50 to 64 projected earnings that follow a profile estimated from the full-time cross section are used. We make a similar adjustment to the average earnings for all women 50 years of age and above. We also assume that as the younger female cohorts age, their earnings profile approaches the cross-sectional shape of the men's profile.

Retirement Medical Insurance Benefits - We use as our base retirement medical insurance the estimated price of a $2,500 deductible policy as currently issued by the Golden Rule Insurance Company. The policy we are pricing covers 100% of doctor visits, hospital stays, surgery, X-rays, lab work, and prescriptions, once the deductible is met. The maximum lifetime benefit is $2 million. Because almost all individuals over the age of 65 have Medicare coverage, we predicted the price of a policy of this type for ages 65 to 119. The out-of-sample estimates are based on a regression of premium prices on a cubic in age. The actual and predicted premiums are presented in Figure 1 along with a series tied to the 1997 Health Care Financing Administration (HCFA) Revised Demographic Cost Factors for the Aged. The cost factors are used to adjust HCFA's county by county per capita rates of payment to HMOs by age groups. As seen in the Figure 1, our projections are quite similar to the growth implied by Medicare's experience.

Using the estimated shape of the benefit profile beyond 64 as a guide, we can calculate the premium price by age under different assumptions about the price of a policy at age 64. The national weighted average price for a policy of this type is approximately $150 per month for a qualifying 64 year old as compared to an implied Medicare population age 65 premium of $200.[16] If the lower Golden Rule premium is the result of behavior changes that result from the lack of first dollar coverage, then the $150 premium is appropriate. On the other hand, if the lower Golden Rule premium is the result of the Medicare population being a higher risk population than the Golden Rule population, then the $200 premium is appropriate.[17] Indexing the $150 price for all ages beyond 64 and weighting by the 1996 population produces an average premium of $201 per month for the 65 and above population. Assuming the higher price of $200 at age 65 and again indexing by age and weighting by the 1996 population produces an average monthly premium of $268. In the estimates of the contribution rates that follow, we will use both premium series.

Mortality and Population Data - The mortality estimates are based on predicted life expectancies from the Census Bureau's middle series. The 1995, 2005, and 2050 life tables are used along with linear interpolations by age for the intervening years and for the years beyond 2050. The population estimates used in our discussion of the transition are from the Census Bureau's intermediate population projections for the years 1995 to 2050.

REQUIRED CONTRIBUTION RATE ESTIMATES

The contribution rate at age 22, presented in Table 1, is the tax rate that a new labor force entrant would face over his or her lifetime. We define the feasible switch age as that age at which the current Medicare contribution rate of 2.9% will fully fund the retirement medical care (including both Medicare Part A and Part

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[15] We assume that the younger cohorts' life-time earnings profile approaches that shape of the current cross-sectional profile for men. Though the shape of the profiles approach each other, the ratio of women's to men's life time earnings does not reach unity because we implicitly assume that the difference in the intercepts that exist at age 22 in the 1995 survey data persist into the future.

[16] Indexing a $200 premium at age 65 by the estimated benefit profile produces an annual premium of $3,208 in 1996.

[17] The estimation of the incentive effect of high deductible insurance is one of our current research projects.

B) of the cohort.[18] By definition then, cohorts younger than the feasible switch age can pay for their retirement medical accounts at rates that are less than 2.9% of their remaining life time earnings.

The contribution rates and feasible switch ages presented in Table 1 are based on three real rates of return, two real earnings growth rates, and two real medical price growth rates. The three real return assumptions of 3%, 3.5%, and 4.0% reflect conservative estimates of the rate of return a cohort could expect to receive over the years that it insures against future medical care expenses. These rates of return fall between the 2.3% rate assumed in the Trust Fund intermediate projections and the historical 6% to 7% real return on the S&P 500 (including dividend reinvestment since nothing is withdrawn until retirement age is reached).

The two real earnings growth rates of 0% and 1% also reflect conservative assumptions regarding real productivity growth. The Trust Fund's intermediate forecasts assume a 1% real earning growth rate.[19] The real medical expenditures growth rates used to calculate the contribution rates in Table 1 are also 0% and 1%. By way of comparison, the Medicare Trustees' report assumes that Medicare's cost per unit of service during the first 25 years of their 75 year projections will decline gradually from the current level to the same growth rate that is projected for average hourly earnings and then to continue at that rate for the following 50 years.[20]

As the estimates in Table 1 indicate, it is feasible for new labor force entrants to fund their retirement medical care at tax rates that are less than the current 2.9% rate. Alternative assumptions concerning income growth, rate of return, and health care expenditure growth produce new labor force entrant tax rate estimates that range from 1.14% to 2.34% for the lower premium estimate. The tax rate estimates range from 1.52% to 3.12% for the higher premium estimate. The feasible switch age under the implied tax rate assumption ranges from 27.37 to 41.29 years depending on growth rates and premium price estimates. In our discussion of the transition, we assume a real rate of return of 3.5%, real earnings growth rate of 0%, and real medical expenditures growth rate of 0%.

ESTIMATING THE TRANSITION COST

Since we are replacing both Parts A and B of the current system, the saving in Part B federal expenditures are the equivalent of a revenue to our system. As cohorts in the new system retire, the implied reduction in federal Part B expenditures are considered as a reduction in costs to the new system, where the cost reductions are valued for a fixed number of years (50 years in the calculations presented below).[21] In this method, the tax rate remains at the current 2.9% for 50 years after the cohort financing system is adopted, at which point the tax rate becomes C_{a_s}.

Revenues - We begin by choosing the switch age S, at which all individuals less than or equal to S will be in the new system. Each cohort less than the switch age contributes (2.9% - C_{a_s}%) of its aggregate earnings to fund the Medicare expenses of cohorts above the switch age. Members of cohorts above the switch age continue to pay the 2.9% tax. The savings that result from eliminating Part B expenditures are counted as revenues for 25 years after the first cohort in the new system retires.

Expenditures - Real expenditures during the transition are the annual cost per aged enrollee, adjusted for real growth, times the number of individuals who remain in Medicare. The aged Medicare population is equal to

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[18]Because men and women have different life-cycle earnings and life expectancy, the contribution rates for each sex are estimated separately. The single tax rate and switch age presented in Table 1 are averages weighted by life-time earnings and population. The 1996 HI Trust Fund Report indicates that HI costs as a percent of taxable payroll were expected to be 3.54% of taxable income in 1996. Including SMI costs, net of premium payments, produces an implied tax rate that is equal to 4.99% of taxable payroll. Aged beneficiaries' Part A and B expenditures, net of premium payments, were equal to 4.39% of taxable payroll in 1996.

[19]However, real wages for men have been relatively stagnant in recent years. Kevin Murphy and Finis Welch in Real Wages 1963-1990, (1992) Table 1c, p. 9, suggest that real productivity growth, measured at the hourly wage, has been closer to -0.09.

[20]1996 HI Trustee's Report, p. 8.

[21]The reduction in the current Part A subsidy, if it continues, could also be considered as a revenue to our system, however, for purposes of our calculations we have only considered the Part B subsidy reduction.

the number of individuals in any future year that are at least 65 years of age and who were older than the switch age in the first year of the transition. For example, if the switch age is calculated to be 39 in 1996, then all individuals 40 and above remain in the current Medicare system. Assuming a switch age of 39, Medicare's unfunded liability is eliminated as the last individual born in 1956 leaves the system. Because the switch age is defined in conjunction with the 2.9% payroll tax, Part A expenditures are identified and Part B expenditures continue to be funded through general revenues.

Transition Costs - Figure 2 presents the total tax revenues, Part B savings, and total Part A costs assuming a 3.5% real return, 0% real earnings growth, 0% real per capita growth in the cost of the medical care (both Medicare and the cohort based medical insurance), and the lower priced insurance policy. Under these assumptions the switch age is 39. As the upper series indicates, the real total Part A costs rise rapidly beginning in 2011 when the oldest of the baby boomers retire. Part A costs continue to increase until 2021, the year in which today's (1996) 40 year-old individuals retire. Part A costs, as well as Part B costs, then begin to decline in all future years as the individuals in the old system die. The middle series, total tax revenues, are relatively flat from 1996 to 2021 and then gradually rise.[22] The final line depicts the Part B savings which begin in the year that the first cohort in the new system retirees. For our transition cost estimates we only count these savings as revenues for 25 years after the first cohort in the new system retirees even though they are permanent savings.[23] We also assume in the following calculations that the 2.9% tax remains in effect for 50 years after the transition to the new system is made at which point the tax rate falls to the rate required to fund each cohorts retirement medical expenses.

Table 2 summarizes the simulation results under three different scenarios. The first column presents the results if the transition towards cohort-funded retirement medical insurance begins in 1996. As presented in Table 1, the tax rate that all new entrants would face is 1.36% and the feasible switch age is 39.25 years. The unfunded Medicare liability is equal to the present value of the difference between the total Part A costs and the sum of the three revenue sources. If the transition had started in 1996 this unfunded liability would have been $970 billion. Paying the debt off over the next 50 years would require annual payments of $41 billion. The last row presents the present value of the liability assuming that the only revenues used to offset the Part A debt are the taxes paid by the individuals above the switch age. That debt amounts to $2,398 billion.

The next two columns in Table 2 present the transition costs if 10 or 20 years pass before the transition to the new system is made. During the years between 1996 and the beginning of the transition, the real growth rate in per retiree benefits is assumed to grow at the real growth rate experienced over the last 10 years in per retiree expenditures. The present value of the unfunded Medicare Part A liability grows to $2,385 billion if 10 years pass and to $4,426 billion if 20 years pass before the transition is made. The annual payment that would be required to retire the unfunded liability grows in similar proportions. Finally, the Part A debt, assuming that tax revenues are only collected from individuals who remain in the old system, is equal to $3.6 trillion and $5.5 trillion under the 10 and 20 year wait scenarios.

SUMMARY

We have placed ourselves in the position of allowing the surge in population, generally referred to as the baby boom, to lull us into a sense of security that a pay-as-you-go system of financing Medicare would work. As a result, nothing has been set aside to provide the extra resources that will be required to fund the medical care costs of the surge in the retired population that is almost upon us.

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[22]Recall that the tax revenues are the sum of the 2.9% payroll taxes paid by people who stay in the old system and the difference between the 2.9% tax and a given cohort's required contribution rate. The tax revenues from the individuals who remain in the old system gradually approach zero over time as they retire. The tax revenues from the individuals who enter the new system gradually rise as more and more cohorts face the contribution rate for new labor market entrants.

[23]The Part B savings are calculated net of premium payments. The premium payment is assumed to remain in the range of 25% of average benefits.

How different the situation would be if the original planners of Medicare had recognized that the large group they foresaw entering the labor force was similar to the seven years of plenty Joseph predicted for Pharaoh. Joseph also predicted that these seven years of plenty would be followed by seven years of famine. Joseph convinced Pharaoh to put grain aside during the years of plenty in order to feed his subjects during the seven years of famine.

In our case, the equivalent of the seven years of famine will begin when the baby boom population surge begins to leave the labor force. Have we put anything aside to prepare for these years? The answer is no. We have lulled the population surge to sleep by promising them retirement medical care so that they did not put anything aside. Thus, we are faced with the imminent famine without reserves in our grain silos.

But it is not too late. While we cannot turn back the clock, we can rescue the situation and insure that we are never again caught in a cohort or generation size caused crisis. Converting our current pay-as-you-go system of financing Medicare to a cohort based system can be accomplished if we act quickly. We can replace both Parts A and B of Medicare with fully funded cohort based real investment. Such investment will increase the nation's capital stock and provide the resources necessary to fund the retirement medical care of the baby boomers while at the same time protecting the rights of older generations to retirement medical care.

The problem of the retirement population surge that will occur as the baby boomers leave the labor force is compounded by the fact that real per capita health care expenditures have been rising faster for the Medicare population than for the population as a whole. Our ability to cope with the unfunded medicare liability depends on our willingness to get control of these out of control health care expenditures by the Medicare-covered populations. The approach we have suggested is the conversion of the current Parts A and B of Medicare into health insurance consisting of a high deductible and then 100% coverage. This type of health coverage makes consumers care what health care costs and will play a major role in restoring competition to the industry.

Our estimates indicate that using as a base the current 2.9% Medicare tax rate we can move cohorts of age 39 and younger into our proposed cohort financing. Older cohorts will remain in the amended Medicare system. Their expenditures financed by the excess of contributions from the switched population, the contributions of the yet to retire population, with the remaining coming from general tax revenues. We estimate the total cost of this transition at $970 billion to be paid for over a period of fifty years. Once the last of the over 39 group has left the system all future generations are self funded. Thus, we will never be caught in a population surge bind again.

One of the great benefits of moving to cohort based financing for Medicare is that the reputation of the system can be restored. Even before the reductions in benefits that must be enacted to keep the current system solvent are enacted, young people believe that the system will not be there for them. This distrust of government will be exacerbated when this year's changes in the Medicare system are enacted. If the changes that must be made in the system are coupled with a movement to cohort based financing a clear message will be sent to the young. That message is that while we have changed the existing system we have simultaneously taken steps that insure that the system will be there for the young. We have restored their confidence in government by giving them a property right in their Medicare.

TABLES

Table 1
Contribution Rate and Switch Age Estimates

r, g_y, g_m	$150 Monthly Premium		$200 Monthly Premium	
	Tax at Age 22	2.9% Tax Switch Age	Tax at Age 22	2.9% Tax* Switch Age
3,0,0	1.63%	36.93	2.17%	31.05
3,1,1	2.34%	30.30	3.12%	N/A
3.5,0,0	1.36%	39.25	1.81%	34.16
3.5,1,1	1.96%	33.80	2.62%	27.37
4,0,0	1.14%	41.29	1.52%	36.74
4,1,1	1.64%	36.68	2.19%	30.86

r is the real rate of return, g_y is the real earnings growth rate, g_m is the real growth rate in medical prices. The tax at age 22 is the contribution rate that is necessary to fund the retirement medical benefits under each set of assumptions. The feasible switch age is the age at which the contribution rate is equal to the stated tax rate.

* Note that Medicare's Part A payments to HMOs are on average only $169 for each man and $143 for each women between the age of 65 and 69. A $200 premium at age 64 exceeds Medicare's HMO Part A reimbursement rate, and though for three of the four cases this policy could be funded for less than 2.9% the switch age at this tax rate is not applicable. Also note that the $150 and $200 monthly premium refer to the price at 64 years of age.

Table 2
Transition Cost Estimates

	Transition in 1996	Wait 10 years	Wait 20 years
Tax at age 22	1.36	1.36	1.36
Feasible switch age	39.25	40.95	42.50
PV of unfunded Medicare liability	$970.27 billion	$2,385.35 billion	$4,426.34 billion
Required 50 year annual payment	$41.36 billion	$101.70 billion	$188.71 billion
PV of total Medicare liability	$2,397.75 billion	$3,596.29 billion	$5,531.95 billion

Transition Cost Estimates if $r = 3.5$, $g_y = 0$, $g_m = 0$, the tax rate = 2.9, and the lower cost policy is used. Medicare per capita cost are assumed to grow at 0% in all years after the transition year. During the waiting period, real Medicare per capita costs are assumed to grow at the 10 year historical rate.

FIGURES

Figure 1
Predicted Monthly Premium Age 65 to 119

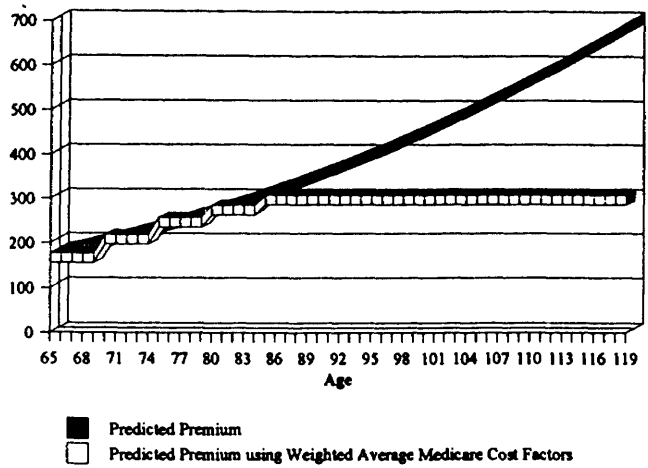
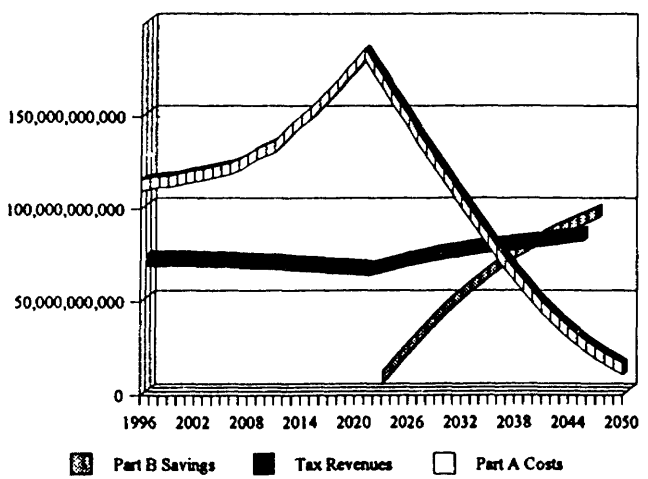


Figure 2
Tax Revenues, Part B Savings, and Part A Costs



BIBLIOGRAPHY

Blau, Francine D., "The Economic Well-Being of American Women, 1970-1990." Cornell University and *NBER*, April 1996.

Board of Trustees of the Federal Hospital Insurance Trust Fund. *1996 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund.* Washington, D.C., June 1996.

Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund. *1996 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund.* Washington, D.C., June 1996.

Economic Report of the President. Council of Economic Advisers, Washington, D.C.: U.S. Government Printing Office, 1965, 1966, 1967.

Furchtgott-Ruoth, Diana and Christine Stolba, "Women's Figures, The Economic Progress of Women," *Independent Women's Forum and American Enterprise Institute, 1996.*

Green Book, Washington, DC: U.S. Government Printing Office, 1996.

Health Care Financing Administration. (1996, November 21). Medicare Handbook: What is Medicare? [Online]. Available http://www.hcfa.gov/pubforms/mhbkc01. htm#Who's Eligible

Health Care Financing Administration. *Information on Availability of Medicare/Medicaid Manuals*, Publication No. HCFA-Pub 02192, August 1996.

Joint Economic Report, Report of the Joint Economic Committee Congress of the United States on the January 1965 Economic Report of the President with Minority and Additional Views, Washington D.C.: U. S. Government Printing Office, 1965.

MaCurdy, Thomas and Thomas Mroz, "Measuring Macroeconomic Shifts in Wages from Cohort Specifications," Working Paper, September 1995.

Murphy, Kevin and Finis Welch, "Real Wages 1993-1990," *Unicon Research Corporation*, Santa Monica, California, 1992.

National Association of Insurance Commissioners and Health Care Financing Administration of the U. S. Health and Human Services, "1996 Guide to Health Insurance for People with Medicare," Publication No. HCFA-02110, February 1996.

Peracchi, Franco and Finis Welch, "Trends in Labor Force Transitions of Older Men and Women," *Journal of Labor Economics*, Volume 12, Number 2, April 1994.

Schieber, Sylvester J. and John B. Shoven, "Social Security Reform: Around the World in 80 Days," *American Economic Review*, May 1996, 86(2), pp. 373-377.

Social Security Bulletin, Vol. 56, No. 4, Winter 1993.

PREPARED STATEMENT OF SENATOR JOHN D. ROCKEFELLER IV

[FEBRUARY 12, 1997]

Mr. Chairman, I congratulate the Secretary and his boss on their excellent job of stewardship of our economy over the last several years. The deficit has been reduced for four consecutive years and is lower than anyone projected. As promised. the President has laid out a five year plan to reduce the deficit *and* give middle class families meaningful tax relief to help raise their children, buy the next home, and face the costs of sending their children to college. The President has proposed a children's health package that would go a long way towards covering the more than 10 million children in America who are uninsured. The Administration's Medicare provisions tackle our short term solvency problem—protecting Medicare through the next decade, and show how to begin the adjustments needed to fulfill Medicare's promise into the next century. That's all good news and a good start for serious balanced budget negotiations.

With Congress determined to work together on the budget and other pressing issues, we can look more optimistically to the future. But I would like to note that we have our work cut out for us on some key aspects of the budget process that awaits us. What we can afford and, therefore, what we should responsibly promise the American people in terms of additional tax relief remains to be determined. Expanding tax breaks is no different than expanding entitlements—they both spend real dollars, and both can go out of control before you know it. We need to work out a budget where spending on programs and on tax cuts are both paid for fairly and realistically. I think we need a healthy and open debate about priorities, and who will benefit most from the many wishes now being uttered all over Washington.

Finally, I am eager for this Committee to hear from the Secretary about the consequences of the constitutional amendment to balance the budget—such as how Medicare is affected when something like a recession triggers arbitrary cuts to comply with a constitutional requirement.

The country is very fortunate to have someone helping to steer our economic ship with Secretary Rubin's immense talent and devotion to public service. Thank you.

PREPARED STATEMENT OF MICHAEL TANNER

Mr. Chairman, distinguished Members of the Committee:

The problem is not just that Medicare's funding will run short of promised benefits in a few years. Even worse, over the long run the program's financial gaps become truly enormous. By the time today's young workers retire, Medicare's current sources of funding will at best only be sufficient to finance one-third of the currently promised benefits. Consequently, without fundamental reform of the system, U.S. politics over the next 2 generations will be dominated by battles over draconian tax increases or draconian benefit cuts for Medicare.

Attempting to salvage the current system by raising taxes and cutting benefits will greatly harm both working people and the elderly. Quite simply, the program can't be saved through these means. The solution lies in a third way—reforming the system to take advantage of the efficiencies, incentives, competition and productivity of the private sector.

The government's own annual reports detail the catastrophic long term finances of Medicare. The latest annual report of the Medicare Board of Trustees shows that under intermediate projections the program's funding will be insufficient to pay promised benefits by 2001, just four years from now.[1] By that year, Medicare Part A alone will be running an annual deficit of $56 billion.[2] The general revenue contribution for Medicare Part B is projected to be $95 billion in that year.[3] So Medicare alone will be adding $150 billion to the total Federal deficit in that year, larger than the entire Federal deficit today.

Moreover, as indicated above, over the longer run the financial gap in Medicare becomes even larger. Under the intermediate projections in the Medicare trustees' reports, paying all promised Medicare Part A benefits to today's young workers when they retire would require more than tripling today's Medicare payroll tax rate of 2.9 percent to 10 percent or more. This would be in addition to the Social Security payroll tax, which is currently 12.4 percent and will have to increase to close to 20 percent or more to pay all of that program's promised benefits.

Even with that tax increase, the deficit in Medicare Part B would continue to soar. Assume that premiums paid by the elderly continue to cover 25 percent of Part B expenditures, leaving general revenues to cover the remaining deficit. By 2005, the Part B deficit alone would climb over $100 billion, in 1997 dollars. By 2015, it would be about $150 billion, larger than the entire Federal deficit today, and by

2025 it would be over $200 billion. By 2040, when those starting work today will be retiring, the Medicare Part B deficit alone would be $336 billion in today's dollars, more than twice the entire current Federal deficit.

In addition, the premiums covering just 25 percent of Part B expenses will have grown to an enormous burden on the elderly. Premiums in retirement for those entering the work force today will be more than three times current levels, to over $3,000 per year for each retired couple. Given the intermediate assumptions in the latest trustee's report concerning future wage growth, the incomes of retirees to pay these more than tripled premiums will be only 55 percent higher than today. This means the premiums will take more than twice as much of their income as today.

And this is not all, because the intermediate assumptions in the trustee's reports may be overoptimistic. As former Social Security chief actuary A. Haeworth Robertson has noted, in the past actual experience has more often been closer to the so-called pessimistic projections in the annual trustee's reports than to the others.[4]

Analysis of the key assumptions underlying the projections in the trustees' reports indicates that future experience may be closer to these pessimistic assumptions as well. For example, a key assumption for the future financial prospects of Medicare is the rate of growth of real wages. With Part A financed by a payroll tax, the growth of wages over time will determine how much Part A revenues will grow. The intermediate projections in the latest trustee's reports assume that real wages will grow at about 1 percent per year over the next 75 years. But real wages have in fact grown at only half this rate for the last 25 years, according to the SSA's own data.[5] The so-called pessimistic projections, however, assume that real wages will continue to grow at this 0.5 percent annual rate.

Another critical assumption is the rate of increase in life expectancy in retirement. The longer the elderly live in retirement, the higher Medicare expenditures will be. The so-called intermediate projections assume that the rate of increase in life expectancy will actually slow down over the next 75 years compared to experience over the last 50 years, again as shown by the SSA's own published data. The so-called pessimistic projections assume that life expectancy over the next 75 years will continue to grow at about the same rate as the average shown by the data for the past 50 years (though it assumes that the increase for men and women will be much closer than in the past). Indeed, these "pessimistic" projections may even understate the problem. Given high tech advances already developing in genetics, biotechnology, and other medical fields, the increase in life expectancy may well accelerate over the next 75 years rather than decline.

Finally, while health costs have increased faster than the general rate of inflation for the last 30 years, the intermediate projections assume that after the next 25 years this will stop and health costs will rise only at the general rate of inflation. The pessimistic projections assume that health costs will continue to rise faster than inflation, though at only a slightly higher rate slower than in recent years.

Under the pessimistic projections, Medicare's future financing problems are about twice as bad. Paying all promised Part A benefits to today's young workers when they retire would require increasing today's Medicare payroll tax more than 6 times, to 18 percent or more. This would be in addition to a needed Social Security payroll tax of about 25 percent under the pessimistic projections.

Moreover, even with that tax increase, the Medicare Part B deficit would soar to $109 billion in today's dollars in 2005, close to $200 billion by 2015, and about $300 billion by 2025. By 2040, this Part B deficit alone would be close to $500 billion in today's dollars.

And this assumes, of course, that premiums paid by the elderly continue to cover 25 percent of Part B expenditures. If that is so, then premiums in retirement for those entering the work force today will be more than four times current levels, to over $4,000 per year for each retired couple. With the "pessimistic" assumptions regarding future wage growth, incomes in retirement to pay these higher premiums will be only about 25 percent higher than today. This means the premiums will take more than three times as much of the income of retirees as today.

Clearly, the financial problems of Medicare cannot be solved in this way. On this course, the program would bankrupt taxpaying workers, the Federal government, and the elderly. Moreover, with current revenue sources financing only about one-third of projected expenditures under intermediate assumptions, or less than 70 percent of expenditures under "pessimistic" assumptions, cutting benefits to match these revenues would effectively end the program.

Finally, the Medicare crisis needs to be viewed in the context of the overall entitlement crisis facing America. The Bipartisan Commission on Entitlements and Tax Reform found that if no fundamental reforms are adopted, then just 15 years from now only 5 Federal programs will consume all available Federal revenues, including income taxes, payroll taxes, and everything else. The five programs are Medicare,

Medicaid, Social Security, Federal employee retirement, and interest on the national debt. There would be no money left for national defense, Federal law enforcement, welfare, or any other program. All of this would have to be financed out of deficit spending.

Medicare is fundamentally unsustainable because of three irresistible facts: demographics, technology, and third-party payment.

First, America is growing older, because of both the aging of the baby-boom generation and longer life expectancies. In 1965, when Medicare was established, the average American lived to just over 70 years of age. Today, that has risen to nearly 76. By 2025, Americans can expect to live over 78 years on average, even without any major new life-prolonging medical breakthroughs. Moreover, in 1965, a person who reached age 65 could expect to live an additional 14.6 years. That has now risen to 17.5 years and by 2025 will increase to 18.8 years. As a result, in the next 30 years, the number of Americans over the age of 65 will increase from 65 percent of the population today to more than 20 percent. The number of Americans over the age of 70 will double.[6] Indeed, Americans age 85 and older are now the fastest growing segment of the population.[7] With medical breakthroughs and new technology we can expect life expectancy to continue to increase, leading to even greater numbers of elderly.

The older people become, the more, and the more expensive, health care they consume.[8] Individuals over the age of 65 see physicians nearly twice as frequently as younger Americans and enter the hospital twice as often.[9] Average per capita health care spending is approximately four times higher for the elderly than the non elderly and is increasing at nearly three times the rate.[10] In general, half of a person's lifetime health care expenses are incurred after age 65.[11] Therefore, as the number of elderly continues to grow, Medicare expenses will continue to increase.

Second, medical treatments and technologies exist today that were not even dreamed of when Medicare was conceived. Those new treatments and technologies have saved lives and increased the quality of life, but they have also undeniably increased the cost of health care.[12]

Third, Medicare suffers from the problems inherent in any third-party payment system. Numerous studies have demonstrated that individuals will consume more, and more expensive, health care services if someone other than the consumer is bearing the cost.[13]

The deductible levels for Medicare are extremely low. Under Medicare Part B, for example, the deductible is an absurdly low $100. (Although there is a 20 percent copayment.) The deductible under Part A is higher, $716 on the first 60 days of hospital care for each spell of illness. There is also a copayment required for hospitalization of longer than 60 days. However, nearly 70 percent of the elderly have some form of "medigap" insurance which covers all or part of the deductibles and copayment.[14] Not only are the deductible levels low, but the value of those deductibles has been steadily declining relative to both beneficiaries' income and medical inflation.[15]

Thus, recipients pay very little out of their own pocket for Medicare services and have little incentive to be good consumers and avoid unnecessary expenses or seek the best deal for their dollar. Guy King, former chief actuary for the Health Care Financing Administration, says that third-party payment is one of the primary causes of the rapid growth in Medicare expenditures. As King explains, "When people, either patients or doctors, are spending other people's money, they do not worry about the cost or number of services consumed."[16]

Moreover, as Nobel Prize winning economist Milton Friedman has pointed out, not only has third-party payment driven up the cost of Medicare, but by dramatically increasing the portion of health care spending covered by a third-party payer, the system has driven up health care costs for all Americans. As Friedman notes, health care spending was rising only modestly in the years prior to 1965. But, since the enactment of Medicare (and Medicaid), health care spending has skyrocketed.[17]

Finally, Medicare Part A suffers from the same inherent problems of other pay-as-you-go systems, including Social Security. In theory, Medicare Part A is supposed to be funded through the Hospital Insurance (HI) portion of the payroll tax, currently 2.9 percent combined for employer and employee. In a pay-as-you-go system, today's benefits to the old are paid by today's taxes from the young. Tomorrow's benefits to today's young are to be paid by tomorrow's taxes from tomorrow's young. A pay-as-you-go structure is an intergenerational transfer from younger workers to older retirees.

If the benefits paid to each recipient approximated the amount that that worker had previously paid in taxes, there would be no problem. However, each Medicare Part A recipient currently receives $5.19 in benefits for every dollar contributed.[18]

Therefore, like a chain letter or pyramid scheme, the Health Insurance Trust Fund depends on having a large pool of workers paying into the system for each recipient taking out of the system. Unfortunately, the ratio of workers to recipients has been steadily declining. As noted above, the number of elderly Americans continues to grow. At the same time, the birth rate has steadily declined since the beginning of the century, meaning that ever fewer young workers are entering the labor force. The result: today there are almost five working-age persons for each person over 65. By the year 2030, when today's workers have retired and our children are in their prime working years, there will be fewer than three working-age person for each person over 65.[19]

Although reform of Medicare is inevitable, there is no guarantee that the method of reform will be a good one that will solve the system's problems and protect Medicare's recipients.

HOW NOT TO REFORM MEDICARE

Accounting Gimmicks

Congress should resist any "reforms" that do not alter the Medicare system but merely shift costs from one accounting ledger to another. While it may be tempting to preserve the Medicare Part A Trust Fund by shifting expenses to Medicare Part B, such accounting gimmicks do nothing to fix the program's fundamental problems. The American people will still have to pay for the program's failures. Moreover, as noted above, Medicare Part B is already adding substantially to the budget deficit.

Increasing Payroll Taxes

It is theoretically possible to keep the Health Insurance Trust Fund solvent by radically increasing the payroll tax. But the increase would have to be quite large, taking an enormous toll on the American economy and employment. According to the Health Insurance Trust Fund's trustees, if Congress acted immediately, an additional 1.3 percent tax would be required to keep the Trust Fund solvent for the next 25 years. To preserve the Trust fund beyond 2020 would require hiking the tax increase to 3.52 percent.[20] To give you a better idea of the magnitude of this increase, it would amount to a tax increase of $1,584 on a salary of $45,000.[21] If Congress delays action, even larger tax hikes would be required. By 1997, a 3.65 percent increase would be required; by 2002, the tax hike would have to be 3.9 percent. Some outside observers believe that the Trustees' assumptions are over optimistic and understate the size of the tax increase required to keep the fund solvent. For example, Michelle Davis, an economist formerly with the Joint Economic Committee estimates that a tax as high as 11 percent would be required.[22]

What impact would a payroll tax increase have on the American economy? Past payroll tax increases are illustrative. According to the Congressional Budget Office, payroll tax increases between 1979 and 1982 produced a loss of 500,000 jobs per year.[23] Likewise, a study by economist Aldona Robbins estimated that the payroll tax increases from 1985 to 1990 cost at least 900,000 jobs and reduced the U.S. gross national product by $25 billion per year.[24] A subsequent study of the 1988 and 1990 payroll tax hikes estimated job loss at 500,000 per year.[25]

Moreover, it is important to note that those payroll tax increases were much smaller than the ones proposed to keep the Health Insurance trust fund solvent.

Increasing Premiums

The Part B equivalent to increasing the payroll tax is to raise the premiums that the elderly pay for Part B services. This approach has been endorsed by several conservative organizations, including the Heritage Foundation.[26] However, premiums already represent a significant burden for many elderly Americans, $1,106.40 per year for an elderly couple. Any major increase in premiums, therefore, risks pushing large numbers of the elderly into poverty.

And, major increases in premiums would be required. Under the Trustee's intermediate assumptions, premiums would have to increase nearly ten fold in constant 1995 dollars by 2015 to keep pace with Medicare spending. Even allowing for expected higher incomes in the future, the premium burden would be four and half times as great for the average elderly recipient. Under the Trustees' pessimistic assumptions, premiums would have to increase 13 fold in constant 1995 dollars, a relative increase in the premium burden of 900 percent.[27]

Technically, groups such as the Heritage Foundation are correct when they argue that a premium increase would not be a tax increase. As Stuart Butler, Heritage's Director of Domestic Policy, explains, Medicare premiums are payments for a "commercial" service. Thus, increasing Medicare premiums would be no different than a private insurer increasing its prices.[28] This would be true if Medicare recipients realistically had the opportunity to go elsewhere for their medical care. But, despite

Medicare Part B's "voluntary" status, under today's market, Medicare is a government-run monopoly. Most elderly Americans have few alternatives to Medicare. Under today's conditions, mandating a premium increase would have the same practical impact on the elderly as would a tax increase.

Even more importantly, a premium increase would do nothing to fix the system's fundamental flaws. A premium increase would simply pour more money into a failing system. Unless costs are constrained, that will simply result in a never-ending chase, with ever-increasing revenues (from both premiums and general revenues) vainly attempting to catch ever-increasing spending.

Reduce Reimbursement Rates

Traditionally, the answer to rising Medicare costs has been to attempt to squeeze providers by enacting price controls and/or reducing reimbursement rates. Virtually the entire history of the Medicare program has been a litany of one form or another of price controls. From "cost-plus" to "DRGs" to the "Resource-Based Relative Value Scale," attempts at Medicare price controls have failed to reduce the program's skyrocketing cost.[29]

Such cost controls have managed to reduce provider reimbursements to the point where many providers now receive barely half the fee that private insurance pays. This has had two major results. First, much of the program's costs have been shifted to the private insurance market.[30]

Second, evidence is growing that Medicare price controls put at risk the quality of care. For example, a 1988 report of the Department of Health and Human Services warned that 540,000 Medicare patients were receiving poorer quality care and increasing numbers were being discharged before their conditions stabilized. The House Government Operations Committee figured the cost at 3,269 avoidable deaths, a high price to pay for uncertain budget savings.[31] In 1993, the Physician Payment Review Commission worried that declining Medicare reimbursement levels may "compromise access to care for Medicare beneficiaries."[32]

Other research confirms the deleterious impact of Medicare price controls on patient care. Economist Michele Davis warns, "hospitals respond to the [Prospective Payment System] the way all producers respond to fixed, below-market prices: they curtail the supply of service, thereby rationing care to Medicare beneficiaries."[33] Surveys of doctors have found that many feel they are being pressed to discharge patients too soon and that the quality of care has suffered as a result. Reviews of discharges for heart and hip fracture patients have found evidence of premature discharges.[34]

Another study, published in the federal government's own Health Care Financing Review, concluded that "the intensity of care" fell after implementation of PPS, though the impact on quality was harder to assess.[35] The authors found significant evidence that the conditions of patients when discharged were less stable than before.[36] Another review came to similar conclusions: though anecdotal evidence[37] of premature discharges was not backed by any firm statistical evidence of increased mortality, patients were in less stable condition when they were discharged.[38] Some more serious problems have apparently arisen at individual hospitals.[39]

Managed Care

Many politicians have fixed on managed care with an almost religious fervor. But their faith may be badly misplaced.

Managed care is not new to Medicare. For the last 10 years, Medicare recipients have been allowed to enroll in health maintenance organizations (HMOs), with Medicare paying a capitated amount per enrollee. Currently, about 2 million Medicare recipients are enrolled in one of 136 risk-based HMO plans.[40]

However, predicted cost savings have not materialized. In 1992, the Congressional Budget Office reported that shifting Medicare patients to HMOs "had little or no effect on hospital use and costs."[41] Indeed, an evaluation of the program by an outside consulting firm found that this policy actually raised government costs. Concluded the researchers: The "program does not save money for HCFA [Health Care Financing Administration]—in fact, costs are higher than they would have been had the enrollees not joined the HMOs."[42]

The experience of the private sector also suggests that managed care is unlikely to be a panacea for rising Medicare costs. For instance, a study by the General Accounting Office found "little empirical evidence" that managed care cut costs.[43] The best that can be said for managed care is that it appears to have lowered participants' cost baseline, though the amount is in dispute. Consider HMOs. Their expenses are somewhat lower, but this in part reflects patient self-selection—healthier people are more likely to join HMOs, a phenomenon noted by HCFA and GAO alike.

As a result, reports Stanley Wallack of Brandeis University's Bigel Institute for Health Policy, "HMOs seem to serve a healthier group of enrollees."[44] The consulting firm FosterHiggins reports that nearly six of ten employers believe that HMOs attract better health care risks from their employees.[45]

Moreover, while HMOs are, on average, cheaper than other plans, they are by no means uniformly less expensive. Two recent business surveys, one by KPMG Peat Marwick in 1992, the other a 1991 review published in Health Affairs, found little difference in premiums and premium growth rates between managed care and fee-for-service plans.[46] Moreover, warned the GAO, "Some firms have found that their total health care costs have increased after implementing network-based managed care."[47] FosterHiggins found that HMOs averaged 14.7 percent less expensive in 1991, yet 35 percent of corporations surveyed stated that their HMO rates were higher than those for traditional indemnity plans.[48]

To the extent that managed care has reduced costs, it is largely a limited, one-time phenomenon. While the expansion of managed care may have cut the costs of some individual plans immediately after implementation, it has done little to reduce system-wide costs and has not halted medical cost inflation. Stanley Wallack, for one, has commented on "The inability of managed care to control system costs, as health care expenditures have continued to rise rapidly with the widespread adoption of managed care."[49] A 1988 study found that managed care had "a one-time effect of reducing use and expenditures" that did not recur in future years, a conclusion reaffirmed by other researchers a year later.[50]

Managed care does not change the underlying incentive structure created by pervasive third-party payment. Observes Dr. Thomas Rice, at UCLA's School of Public Health, HMOs "record of accomplishment is no better than that of fee-for-service medicine, probably because HMOs are not insulated from any of the underlying causes of health care cost inflation."[51]

While managed care appears to have little impact on Medicare costs, it does have a significant impact on the quality of care delivered. Quality problems have already hit the government's attempt to shift Medicare recipients to managed care. A recent report by the Department of Health and Human Services' Inspector General found "pervasive" quality problems throughout managed care programs for Medicare, including difficulties for recipients in receiving access to care.[52]

Such quality problems are well known in the private sector. In general, HMOs are significantly less likely to use diagnostic tests, such as MRI and CAT scans, than fee-for-service plans.[53] Patient complaints about HMOs are common; some dissatisfied patients (and their families, where the patient has died) have sued over the denial of treatment. Doctors report that managed care organizations pressure them to save money even at the cost of quality.[54] One-third of doctors surveyed by the American Medical Association in 1988 stated that patients were harmed by delays or non-treatments as a result of managed care.[55]

Managed care's tradeoff between cost and quality is particularly threatening to the elderly. Observers have long noted that individuals incur the majority of health care costs in the last few months of life. Nearly 30 percent of medicare expenditures occur during a person's last year of life.[56] Indeed, on a per admission basis, Medicare spends four times as much money on patients who die as on those who live. It seems likely, therefore, that in cases presumed to be terminal, there would be a great deal of pressure to save money by simply denying treatment. However, health economist Anne Scitovsky found that the most money was spent caring for the patients in which the doctors' predictions—that the person would die or live—turned out to be wrong.[57] Similarly, elder-care specialists Dennis Jahnigen and Robert Binstock warn that age is an extremely poor predictor of clinical success, because of the diversity of seniors: "In fact, the elderly display greater heterogeneity than do younger adults in many measurable aspects of physiologic and psychological function."[58] So much for allowing administrators, bureaucrats, and politicians to decide which treatments are unneeded.

THE RIGHT WAY TO FIX MEDICARE

A successful reform of Medicare must addressthe program's fundamental structural flaws. The program simply cannot continue as a third-party first-dollar payer for the health care needs of a growing elderly population. Finding additional revenues will simply throw good money after bad. Reducing reimbursement rates or forcing the elderly into managed care will not yield significant savings, but could compromise the quality of care. There is no way to preserve Medicare as we know it.

Raise Deductibles

Accordingly, Congress should resist calls to increase Medicare premiums on the elderly or payroll taxes. General revenue contributions to Medicare Part B should also be limited to grow no faster than economic growth.

Medicare benefits in both Part A and Part B should then be subject to an increased deductible, adjusted each year to be large enough to keep Medicare expenditures no greater than Medicare revenues. If necessary, vouchers could be provided to low income elderly, sufficient to enable them to cover part or all of the added deductible.

Allow the Elderly to Opt Out

In addition, each retiree should have the right to opt out of the Medicare system by receiving a voucher equal to the average per capita expenditure under Medicare. That voucher could be used to purchase private insurance or HMO coverage or, better yet, to make contributions to a medical savings account. The elderly who chose that option would be protected from both catastrophic expenses and increasingly burdensome Medicare premiums. The vouchers would also allow them to escape the increased rationing and reduced quality of care under Medicare, and choose the private coverage and services they prefer.

Some question whether allowing such an opt-out provision would lead to adverse selection, with the healthiest recipients opting for private coverage, leaving the government to provide care for the sickest and most expensive. There is evidence that this phenomena has already occurred with Medicare's managed care option. Mathematica Policy Research reports that "beneficiaries with chronic health problems were less likely than healthy beneficiaries to enroll in HMOs."[59]

This is not surprising. In the private sector, HMOs have proven to be more popular among the young and the healthy.[60] Individuals with serious or chronic illnesses are more likely to be concerned about retaining their current physicians, seeing specialists on demand, and avoiding the rationing inherent in managed care. However, evidence from the private sector also indicates that adverse selection does not occur among individuals choosing medical savings accounts.[61]

There are several ways to minimize the adverse selection problem. For example, adverse selection is likely to be more pronounced when individuals are able to move freely between types of plan—selecting a medical savings account or managed care when healthy, for example, and shifting back to traditional Medicare when sick. Therefore, the decision to opt out of Medicare should be irrevocable.

Second, the amount of the voucher could be risk-adjusted to reflect the beneficiaries age, sex, geographic location, and health status. Thus older and sicker individuals would receive a larger voucher than younger and healthier beneficiaries, increasing their options.

Finally, it should be noted that if current trend toward the reduction of benefits and rationing of care under the Medicare program continue, private sector options will begin to look increasingly attractive to all Medicare beneficiaries, including those with chronic illnesses.

Raise the Eligibility Age

Finally, the age at which an individual becomes eligible for Medicare should be gradually increased. When Medicare began, its eligibility age was 65, the same as for social security. However, the retirement age for social security is currently scheduled to be gradually increased to age 67 by the year 2022. Many proposals for social security reform would increase the eligibility age to 70 and make the phase in more rapid.[62] However, the eligibility age for Medicare will remain 65.

Logically, the eligibility age for Medicare should be linked to that of social security and raised at the same rate. This will bring eligibility for Medicare in line with the increase in life expectancy since the program's inception.

These reforms will solve Medicare's short-term problems, but even more drastic changes are needed for the long-term.

Today's young workers should be allowed to choose to take their tax funds out of Medicare and save and invest them in personal investment accounts. These invested accounts would grow to huge amounts by retirement, providing the funds to finance the best private alternatives with no additional burden on retirees.

This component has such a powerful effect because Medicare currently operates on a pay-as-you-go basis. That means the funds paid into the program are not saved and invested for the future benefits of today's workers. Rather, these funds are immediately paid out to finance the current benefits of today's retirees. The future benefits of today's workers when they retire are then to be paid out of the taxes assessed on those working at the time.

Since essentially no investment is made through this pay-as-you-go system, essentially no investment returns are earned to help finance future benefits.[63] If we shifted to a fully funded private system instead, workers would be saving and investing their current tax payments in the private sector, and the investment returns would accumulate to huge amounts by retirement that can be used to finance health coverage.

Under this second reform component then, workers could choose to direct the full 2.9 percent of their Medicare tax, including both the employee and employer shares, into a personal investment account called a Health Bank IRA. The same rules, regulations and restrictions would apply to the private accounts as apply to IRAs today, except no withdrawals would be allowed before retirement.

Investment of the funds in each worker's Health Bank IRA would be conducted through a system of private professional investment management firms. Firms would apply to the government to be designated as recognized investment management firms eligible to handle investment of Health Bank funds. Workers would then choose among these designated firms to handle investment of their accounts. The firms would choose the investments for the workers' accounts. Workers could switch from one designated firm to another on short notice.

This system would make investment of the Health Bank funds easy for unsophisticated investors. They only need to choose an investment management firm. The firm would then choose the investments. This system would also protect workers from fraudulent operators, as only established firms that receive government designation could invest Health Bank funds.

At retirement, the Health Bank funds would finance an annuity that would pay a specified amount each year for the rest of the worker's life. These amounts can be adjusted so that they would increase with inflation over time. These annual annuity payments would then be used to pay for the private health coverage alternatives in place of Medicare under the system described above under the first component of the reform. The retiree could choose whatever private alternative he or she preferred, including MSAs, just as described above.

Workers already in the work force at the time of the reform will have already paid substantial taxes into the current Medicare system for all their working years. If they chose the private Health Bank option, the government would pay into their accounts recognition bonds compensating them for their past taxes. The amount of the bonds would be set so that with interest they would pay a proportion of future Medicare benefits equal to the proportion of lifetime Medicare taxes the worker and employers had paid. At retirement, Medicare would pay this proportion each year of what it would have otherwise paid for the private alternatives.

Studies calculating the benefits that could be paid by a private system in place of Social Security indicate how much benefit can be derived from such Health Banks.[64] Assume that over a worker's career the Health Bank investments earn a real rate of return of 4 percent, which is just over half the average return earned in the stock market over the last 70 years. A conservative reading of these studies suggests that at such a return, a private investment account like a Health Bank IRA would pay three times the benefits of a pay-as-you-go system like Medicare. Indeed, most of the recent studies suggest the private investment system can pay even more.[65]

Since the payroll tax funding Medicare Part A would be used for the Health Bank, at a 4 percent real return the funds accumulated in the Health Bank would pay about three times the benefits payable by Medicare Part A. In other words, the annual annuity amount payable through the Health Bank would be about three times what Medicare Part A could spend per beneficiary under the current payroll tax. If in retirement the worker chose the most efficient private alternatives such as Medical Savings Accounts, then our prior analysis indicates the costs for the benefits paid by both Part A and Part B would be reduced by 30 percent.

The combination of these effects from both components of the reform would roughly be sufficient to eliminate the Medicare financing gap under the intermediate projections, where our prior analysis showed that current revenue sources would finance only about one-third of promised benefits. In other words, with both components of the reform adopted, under the intermediate projections for Medicare, the funds payable through the Health Banks should be roughly sufficient to pay the costs of private MSAs providing retirement health benefits in place of Medicare as described above, with little or no additional cost burden to the retiree. These MSAs remember provide better benefits than Medicare, as also discussed above.

The combined effects of both components of the reform would be sufficient to close most of the long term financing gap under the pessimistic projections for Medicare as well. If retirees are going to be living substantially longer as assumed under those projections, then it would be reasonable to delay retirement for a few years

as well. In addition, the invested funds in the Health Banks would generate substantial additional tax revenues besides the returns earned directly by the investor. These revenues would come from taxes assessed at the business level on the full before tax return to capital, before the returns to the investor were paid. These additional revenues would offset the transition costs of the Health Bank proposal in less than 25 years and start to generate substantial surpluses which grow to huge amounts by the time today's young workers' retire. These eventual surpluses could be paid to retirees for the private health coverage to close any remaining gap under the pessimistic assumptions, perhaps on a means-tested basis focusing the funds on low and moderate income retirees.

These two sources would likely be sufficient to eliminate the remaining financing gap under the pessimistic assumptions. But there is an additional possible source of new funds that would more than close this remaining gap by itself. If the entire Social Security system were privatized, then the additional benefits paid from the private invested system would be more than enough to cover the remaining Medicare financial gap under the pessimistic assumptions.

Work by Professor Thomas B. Saving of Texas A&M University, who has recently endorsed similar reforms, also shows how the Medicare crisis would be resolved as a result.[66] Saving calculates the results under the new reform for a worker entering the work force at age 22. Under Saving's system, this worker in retirement would be covered by a private health insurance policy with an annual deductible of $2,500, but covering all health expenses over $2,500 each year. The worker would also pay no premiums in retirement for this policy, unlike the current Medicare system where again premiums are already $1,000 per year for a retired couple, and will likely grow to $3,000-$4,000 per year in today's dollars by the time today's young workers retire.

Saving calculates under the equivalent of intermediate assumptions, and with only a 3 percent real return on investment, that the private investment accounts would generate enough funds to finance the above described health insurance in retirement, *with only 1.15 percent of annual earnings invested in the account.* Even under pessimistic assumptions, the accounts would generate enough funds to finance the insurance policy described above with no more than the 2.9 percent of earnings taken by the current Medicare tax.

The government can assure all workers with Health Banks a guaranteed minimum benefit, supplementing what the Health Banks would pay with additional payments each year to the extent necessary to achieve the minimum. This minimum benefit would assure a basic level of support for retirement health expenses in any event. Yet, with the likely performance of the private investment system in providing much higher benefits than Medicare, as described above, government expenditures for this minimum benefit are likely to be minimal. The public can consequently be assured that no one will be left without essential assistance for retirement health spending, while still enabling workers and the nation to enjoy the freedom and better benefits offered by the private system.

During the transition to the new system, the government would lose the payroll tax revenues it currently uses to finance Medicare Part A benefits, to the extent workers chose the private Health Bank option. If about half of all workers exercised the option in the first year, this revenue loss would total about $50 billion. However, over time the government would receive an important new source of revenue to offset this loss. The new savings and investment in the Health Banks would generate the full before tax return to capital. Substantial taxes on this return would be paid by the business investing these funds before the interest, dividends or other returns were paid back to the original Health Bank investors. As the Health Bank funds grow, this new revenue would grow to huge amounts.

A recent study on the privatization of Social Security by this author, where the same effect would occur, indicates that such new revenues would completely offset the loss of payroll tax revenue in about 15 years.[67] Prior to that time, the revenue loss could be offset in part by cutting other government spending. During this period, the government could also use the savings it would receive from limiting the growth of Medicare spending as described in the first set of reforms proposed above. The government could also issue new bonds during this period to raise money to cover a part of the lost revenue.

ENDNOTES

[1]: *1996 Annual Report of the Board of Trustees of the Federal Hospital Insurance Program* (Washington, DC: Government Printing Office, 1996), Table II.D.2.

[2]: Ibid.

[3]: *1996 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Program* (Washington, DC: Government Printing Office, 1996), Table II.D.2.

[4]: TO COME

[5]: *1996 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds,* (Washington, DC: Government Printing Office, 1996), Table II.D.1.

[6]: Bipartisan Commission on Entitlement and Tax Reform, *Final Report to the President* (Washington: Government Printing Office, 1995), pp. 12-15.

[7]: Lynn Schneider and Robert Guralnik, "The Aging of America: Impact on Health Care Costs," *Journal of the American Medical Association* (May 2, 1990): 229.

[8]: David Waldo, Sally Sonnefeld, et. al., "Health Expenditures by Age Group, 1977-1987," *Health Care Financing Review* (Summer 1989): 118.

[9]: Robert Paul and Diane Disney, eds., *The Sourcebook on Post-Retirement Health Care Benefits* (Greenvale, NY: Panel, 1986), p. 296.

[10]: Deborah Chollet and Robert Friedland, "Employer-Paid Retiree Health Insurance: History and Prospects for Growth," ed. Frank McArdle, *The Changing Health Care Market* (Washington: Employee Benefit Research Institute, 1987), p. 206.

[11]: U.S. Department of Health and Human Services, *Catastrophic Illness Expenses: Department of Health and Human Services Report to the President* (Washington, November 1986). p 8.

[12]: William Schwartz, "The Inevitable Failure of Current Cost-Containment Strategies," *Journal of the American Medical Association* (January 9, 1987): 220-224.

[13]: See e.g., Joseph Newhouse, et al., "Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance," *New England Journal of Medicine* (December 17, 1981): 95-112; Willard G. Manning, et al., "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," *American Economic Review* (June 1987): 251-73; Martin Feldstein, "Econometric Studies of Health Economics," in *Frontiers of Quantitative Economics,* ed. David Kendrick and M. Intrilligator, (Amsterdam: North Holland Press, 1974); Richard Eichhorn and Lu Ann Aday, *The Utilization of Health Services: Indices and Correlates: A Research Bibliography,* NTIS No. PB-211 720 (1972); Adam Donabedian, *Benefits in Medical Care Programs* (Cambridge: Harvard University Press, 1974).

[14]: "Coming Up Short: Increasing Out-of-Pocket Health Spending by Older Americans," Urban Institute, April 19, 1994.

[15]: Michele Davis, "Medicare's Self-Destruction," Citizens for a Sound Economy Foundation Economic Perspective, January 22, 1993, pp. 12-14.

[16]: Guy King, remarks delivered to a conference on "The New Medicare Trust Fund Report: Have Things Really Changed?" American Enterprise Institute, Washington, DC, April 1995.

[17]: Milton Friedman, "Gammon's Law Points to Health Care Solution," *Wall Street Journal,* November 12, 1991.

[18]: Guy King, "Health Care Reform and the Medicare Program," *Health Affairs* (Winter 1994):39-43.

[19]: Bipartisan Commission on Entitlements and Tax Reform, p. 16.

[20]: Trustees Report. Table I.A.1.

[21]: Donald Lambro, "Swimming Upstream to Rescue Medicare," *Washington Times,* May 11, 1995. p. A17.

[22]: Michelle Davis, Medicare's Self-Destruction, p. 8.

[23]: Congressional Budget Office, "Aggregate Economic Effects of Changes in Social Security Taxes," August 1982.

[24]: Aldona Robbins, "Social Security: At What Price?" Fiscal Associates, Alexandria, Virginia, 1986.

[25]: Aldona Robbins and Gary Robbins, "The Effect of the 1988 and 1990 Social Security Tax Increases," Institute for the Research on the Economics of Taxation, Washington, DC, 1991.

[26]: Stuart Butler, "Medicare Part B Reform," Heritage Foundation Committee Brief no. 4, February 15, 1995.

[27]: Peter Ferrara, A Proposal for Reform, extrapolating from Trustees Report.

[28]: Stuart Butler, Medicare Part B Reform, p. 4.

[29]: See, for example, Gerald Kominski, Dena Pushkin, et. al., "The Impact of Medicare's Prospective Payment System on the Use of Hospital Inpatient Services," eds., Mark Pauly and William Kissick, *Lessons From the First Twenty Years of Medicare* (Philadelphia: University of Pennsylvania Press, 1988). pp 215-235; H. E. Frech, ed., *Regulating Doctors' Fees: Competition, Benefits, and Controls Under Med-*

icare (Washington: American Enterprise Institute, 1991); and Robert Helms, ed., *Health Policy Reform: Competition and Controls* (Washington: American Enterprise Institute, 1993).

[30]: See, Michael Morrissey, *Cost Shifting in Health Care* (Washington, American Enterprise Institute: 1993).

[31]: Kevin Hopkins, *Time to Die: The Coming Destruction of American Health Care* (forthcoming), pp. 96-97.

[32]: Robert Pear, "Medicare Paying Doctors 59% of Insurers' Rate, Panel Finds," *New York Times,* April 5, 1994, p. A16.

[33]: Michele Davis, "Medicare's Self-Destruction," Citizens for a Sound Economy foundation, January 22, 1993, p. 23.

[34]: M. Stanton Evens, et. al., "Denying Health Care tot he Elderly," *Consumers' Research,* July 1992, p. 11.

[35]: Robert Coulam and Gary Baumer, "Medicare's Prospective Payment System: A Critical Appraisal," *Health Care Financing Review,* 1991 Annual Supplement, pp. 56-57.

[36]: Ibid., pp. 68-69.

[37]: See, for example, *A Message from the American Public: A Hearings and Site Visits Report of the Advisory Council on Social Security,* December 1991, p. 173.

[38]: Lewin/ICF, "An Examination of Winners and Losers Under Medicare's Prospective Payment System: A Synthesis of the Evidence," Prospective Payment Assessment Commission, October 1991, pp. 29-30.

[39]: Louise Russell, *Medicare's New Hospital Payment System: Is It Working?* (Washington, D.C.: The Brookings Institution, 1989), p. 48.

[40]: *Medicare Managed Care Contract Report,* Office of Managed Care, Health Care Financing Administration, July 1, 1994.

[41]: Congressional Budget Office, *The Effects of Managed Care on Use and Costs of Health Services,* June 1992.

[42]: Randall Brown, et al., *Does Managed Care Work for Medicare? An Evaluation of the Medicare Risk Program for HMOs,* Mathematica Policy Research, Inc., December 1993, p. 1.

[43]: General Accounting Office, *Managed Health Care: Effect on Employers' Costs Difficult to Measure,* October 1993, GAO/HRD-94-3, p. 3.

[44]: Stanley Wallack, "Managed Care: Practice, Pitfalls, and Potential," *Health Care Financing Review,* 1991 Annual Supplement, p. 31.

[45]: FosterHiggins, *1991 Health Care Benefits Survey: Report 2, Managed Care Plans,* 1992, p. 13.

[46]: KPMG Peat Marwick, *Health Benefits in 1992: Executive Summary,* 1992; Howard Bailit and Cary Sennett, "Utilization Management as a Cost-Containment Strategy," *Health Care Financing Review,* 1991 Annual Supplement, pp. 87-93.

[47]: GAO, p. 15.

[48]: FosterHiggins, p. 4.

[49]: Wallack, p. 32.

[50]: Paul Feldstein, Thomas Wickizer, and John Wheeler, "Private Cost Containment: The Effects of Utilization Review Programs on Health Care Use and Expenditures," *New England Journal of Medicine,* Vol. 318, No. 20, May 19, 1988, p. 1313; Thomas Wickizer, John Wheeler, and Paul Feldstein, "Does Utilization Review Reduce Unnecessary Hospital Care and Contain Costs," *Medical Care,* Vol. 27, No. 6, June 1989, p. 643.

[51]: Thomas Rice, "Containing Health Care Costs in the United States," *Medical Care Review,* Vol. 49, no. 1, Spring 1992, p. 35.

[52]: Brown, J.G., *Medicare Risk HMOs: Beneficiary enrollment and Service Access Problems,* U.S. Department of Health and Human Services, Office of Inspector General, May 1995.

[53]: Steve Salemo, "High Price of Managed Care," *Wall Street Journal,* January 18, 1994.

[54]: John Goodman and Gerald Musgrave, *Patient Power:Solving America's Health Care Crisis* (Washington: Cato Institute, 1992), pp. 40-41.

[55]: Hopkins, p. 95.

[56]: Jack Meyer, Sharon Silow-Carroll, and Sean Sullivan, *Critical Choices: Confronting the Cost of American Health Care* (Washington: National Committee for Quality Health Care, 1990), p. 52.

[57]: Hopkins, pp. 74-75.

[58]: Dennis Jahnigen and Robert Binstock, "Economic and Clinical Realities: Health Care for Elderly People," in Robert Binstock and Stephen Post, ed. *Too Old for Health Care? Controversies in Medicine, Law, Economics, and Ethics* (Baltimore: The Johns Hopkins University Press, 1991), p. 25.

[59]: Brown, et. al, Does Managed Care Work for Medicare, p. 1.

[60]: See, for example, Alan Sorkin, *Health Economics: An Introduction* (New York: Lexington Books, 1992), pp. 215-218; Harold Luft, "Patient Selection in a Competitive Health care System," *Health Affairs* (Summer 1988): 106-109.

[61]: Peter Ferrara, "More Than a Theory: Medical Savings Accounts at Work," Cato Institute Policy Analysis no. 220, March 14, 1995.

[62]: See, for example, Bipartisan Commission on Entitlements.

[63]: A pay-as-you-go system would be able to pay a real return equal to the rate at which real tax revenues grow over time. This return would be equal to the rate of growth in the work force plus the rate of growth in real wages. Even this return would involve only a redistribution from others rather than net new income earned as in an invested, fully funded system. In any event, the real redistribution return from a pay-as-you-go system can be expected to be at best about 1 percent. The before tax real rate of return to capital, which would be generated by private investments in a fully funded system, is over 9 percent. See Martin Feldstein, "The Missing Piece in Policy Analysis: Social Security Reform," *American Economic Review* 86 (May 1996) p. 12.

[64]: See, for example, Peter J. Ferrara, Social Security Rates of Return for Today's Young Workers (Washington, D.C.: National Chamber Foundation, 1986); William G. Shipman, "Retiring with Dignity: Social Security v. Private Markets," Cato Institute Social Security Paper no. 2, August 14, 1995; Marshall N. Carter and William G. Shipman, *Promises to Keep: Saving Social Security's Dream* (Washington, D.C.: Regnery Publishing, 1996); Robert Genetski, A Nation of Millionaires (Chicago: Heartland Institute, 1996).

[65]: Ibid.

[66]: Thomas B. Saving and Andrew J. Rettenmaier, "Privatizing Medicare: The Permanent Solution to the Crisis," *Perspectives on Policy,* Private Enterprise Research Center, Texas A&M University, Fall, 1996.

[67]: Peter J. Ferrara, "A Plan for Privatizing Social Security," Cato InstituteSocial Security Paper no. 8, March 1997.

PREPARED STATEMENT OF BRUCE C. VLADECK, PH.D.

Mr. Chairman, Members of the Committee, thank you for the opportunity to address the Committee on the long-term future for the Medicare program.

There is time for us to act to ensure the long-term solvency of the Federal Hospital Insurance Trust Fund. We are hopeful that we can find common ground with the Congress on Medicare reforms that will strengthen the HI trust fund in the short-term, and provide us with sufficient time to carefully consider approaches to preserving the fund's long-term solvency. Accordingly, the President has submitted a budget that extends the solvency of the HI Trust Fund into 2007, allowing sufficient time to address the long-term financing issues of the HI Trust Fund.

Let me remind you that this past year's Trustees Report is consistent with the three previous reports. In fact, over the past 15 years, the Trustees have projected the date of insolvency to be anywhere from 5 to 17 years, and each year they recommended that Congress take action to protect the HI trust fund. Each time, the Congress and the Executive branch have been able to respond to short-term challenges, improve the short-term longevity of the HI trust fund, and ensure continued Medicare protection for beneficiaries. Addressing the long-term solvency will similarly require a collaborative effort.

In 1993, when the Clinton Administration first took office, the HI trust fund was projected to become insolvent in 1999. We immediately took action and proposed a package of Medicare savings. The resulting legislation extended the solvency of the HI trust fund for another three years. In each successive year, the President has proposed measures to further extend the solvency of the HI trust fund. I believe that this record reflects the President's unwavering commitment to ensuring that the trust fund remains solvent for both the short term and the long term.

SUMMARY OF THE 1996 TRUSTEES REPORT AND RECOMMENDATIONS

Let me begin by describing the HI trust fund and the services it supports for Medicare beneficiaries. The HI trust fund pays for inpatient hospital care, as well as expenditures for home health services, skilled nursing care, and hospice care. When Medicare was enacted it paid for hospital and post-hospital services only. Subsequent program expansions have added hospice and non-hospital related home health care. In 1995, the HI trust fund paid for $116.4 billion in services for 33 million aged and 4 million disabled beneficiaries.

The HI trust fund is financed primarily by payroll taxes. Employees contribute 1.45 percent of wages, and there is a matching contribution by employers. Self-employed individuals contribute 2.9 percent of net self-employment income. The trust fund also receives income from interest earnings on its assets, revenue from taxation of Social Security benefits, and income from miscellaneous sources.

Medicare expenditure increases are driven by increases in enrollment, the growing complexity of medical services, changes in the volume of health care services provided, and health care inflation generally. In the future, HI trust fund expenditures are projected to rise more rapidly than trust fund revenues. Anticipated increases in the number, cost, and complexity of medical services are

expected to continue to result in expenditure growth rates in excess of payroll growth. Beginning in 2010, the demographic shift that will occur with the retirement of the baby boom generation is projected to significantly exacerbate the expected imbalance between expenditures and revenues. After that point, a larger proportion of our population will be eligible for Medicare, and a correspondingly smaller percentage will be paying the taxes that support the HI trust fund. Over the 75-year long-range projection period, trust fund tax income as a percent of taxable payroll remains relatively level, while the expenditure rate rises steadily.

Supplemental Medical Insurance (SMI) or Part B covers physician services, along with outpatient hospital services, laboratory services, durable medical equipment and other miscellaneous services. The SMI trust fund is financed by general revenues and premiums paid by enrollees and it covers Part B services. Part B premiums are deducted directly out of the monthly checks of Social Security beneficiaries. In 1997, premiums are $ 43.80 per month, and currently cover 25 percent of Part B costs.

Unlike the HI trust fund, the SMI trust fund could never become insolvent. In the 1996 Trustees Report, the Medicare Trustees note that the financing established for the SMI program for calendar year 1996 is estimated to be sufficient to cover program expenditures and preserve an adequate contingency reserve. SMI Trust fund income is projected to equal expenditures for all future years -- but only because beneficiary premium and government general revenue contributions are automatically increased to meet expected costs each year.

The 1996 Trustees Report projects about 4 more years of HI trust fund solvency under present law. Unless the Congress acts, the HI trust fund will be exhausted in 2001 using the Trustees' intermediate assumptions. These intermediate assumptions represent the Trustees' best estimate of the expected future economic and demographic trends that will affect the financial status of the HI trust fund.

Based on the projections, the Trustees make two recommendations. First, they recommend prompt, decisive, effective action to ensure short-term HI trust fund solvency. Such action is required so that Medicare services continue smoothly, as beneficiaries expect. It also is required to ensure sufficient time for consideration of options to ensure long run trust fund solvency.

The second recommendation is related to Medicare's long-term financial concerns for both the HI and the SMI trust funds. The Trustees recommend the establishment of an advisory group to address long term solvency. The objective is to move toward the development and thoughtful consideration of policy options in response to this unprecedented demographic shift.

DEMOGRAPHIC CHANGES -- A FUNDAMENTAL CHALLENGE

The "baby boom" generation begins to age into Medicare coverage in large numbers starting in 2010. With a drop in the ratio of active workers to retirees, scheduled payroll tax revenues cannot keep pace with expected expenditure levels.

The focus to date has been on addressing the perceived problem that Medicare costs have been

increasing too rapidly and are projected to continue to do so in the future. Critics cite these projected cost increases as a deficiency of the program . In practice, however, the program is administered efficiently and we have experimented with and implemented innovative purchasing strategies where permitted by law. Administrative expenses for Medicare represent less than 2% of total program expenditures. The future cost increases associated with this program primarily reflect more beneficiaries, wage increases and inflation, and increases in the utilization and intensity of medical services. As such, a portion of the the cost increases are attributable to the cost of providing needed health care services. These increases should not automatically be considered a deficiency.

In addition, few analysts would suggest reducing the basic set of services covered by Medicare. In comparison to other health care plans, Medicare's coverage is already modest, and only pays for about 55 percent of the health care costs of the elderly. Furthermore, it should be noted that for most of Medicare's history, the growth in per-person benefit spending has been similar to or a little slower than that of the private sector. The average annual Medicare increase per person during 1969-1995, for example, was one percentage point lower than for the private sector.

Also, the high projected cost of entitlement programs reflects the growth in economic and health security needs that will arise as the population ages in the future. The demographic changes that will occur as the post-World War II "baby boom" generation ages are well known, having been discussed at great length over the last 20 years. Past variation in birth rates, together with steady improvement in life expectancy, starting in about 2010 will result in major increases in the number of older persons relative to those at working ages. Currently about four workers paying HI taxes support each HI enrollee. This ratio will begin to decline rapidly early in the next century. By the middle of that century, only about two workers will support each enrollee. Moreover, contrary to intuition, the ratio does not return to current levels once the subsequent "baby bust" generation reaches retirement age. As a result of continuing improvements in life expectancy, the ratio is expected to stay at the higher level and to gradually increase over time.

The major underlying problem facing us is that this country's future elderly will consume health care services that will need to be financed in some way. If Medicare is not available to pay for those services, some other financing source will need to be found, or people will go without needed services. Any Medicare "solution" must make economic and social sense in a society unlike any that has ever been encountered in human experience--a society with more old people, comparatively fewer children and adolescents, and with life expectancy at age 65 measured in decades.

The long-term solvency problems of the Hospital Insurance trust fund arise from profound demographic changes which will create needs that must be met whether or not they are met through Medicare.

Any effort to address the future of Medicare also needs to recognize that, as noted previously, Medicare currently pays only a little more than half of the health care costs of the elderly, with the remainder paid by individual beneficiaries, or their individual or employer-based insurers, or Medicaid. Any proposals to address Medicare solvency need to consider the impacts on those

other health care financing streams. For example, increasing the eligibility age for Medicare would likely increase employer liabilities for their retirees and state Medicaid expenditures for dual enrollees. We also need to assess the impact on broader economic security for the elderly and disabled -- of which entitlements are only one of three "legs," the other two being pensions and individual savings. We need to spell out how difficult it is to privatize the financing of health care for Medicare beneficiaries. It is very difficult to construct a private system that is able to address such issues as benefit adequacy for lower-income workers. In addition, it would be extremely burdensome on current workers to attempt to "forward fund" these obligations while covering current obligations.

The demographic trends that create a financing crisis in Medicare and Social Security will also have profound macroeconomic effects. The same demographic changes that increase Medicare outlays will produce enormous changes in the labor market, while reducing the social burden of caring for dependent children. Labor policy that increases the size of the labor force by promoting later retirement not only helps address the need for a skilled labor force supply when the rate of growth in the workforce will be shrinking, but also increases the income to the payroll-funded trust funds.

CONCLUSION

The upcoming policy debate should have as its starting point how to slow the growth in Medicare in the context of our aging of society.

Addressing the short range objective of postponing the HI fund exhaustion date to provide time to consider longer range solvency, as called for in the Trustees Report, will likely encompass the more traditional Medicare savings strategies, such as reductions in provider reimbursement, as well as structural reforms that provide beneficiaries greater choice and introduce innovative cost containment strategies, such as competitive bidding. The financial problems facing the Medicare program are well known. However, policy analysis to date may have focused too narrowly on the financial issues of Medicare and other Federal programs and paid too little attention to the overall implications of an aging society.

Perhaps we need to consider that the serious long-range financing issues facing society can be better evaluated through an expanded point of view, incorporating the overall health care and retirement income needs of an aging population and overall economic policy, rather than focusing solely on expenditure growth rates in Medicare and other Federal programs.

While many of the forces underlying Medicare growth are inexorable and outside the control of policy makers, responding to these forces is the responsibility of the policy process. Given the complexity of the issues, their interwoven nature, and the magnitude of the problem, the policy process must recognize that:

- The health care needs of the baby boom generation will exist and will need to be met—regardless of the question of private or public funding;

- Entitlement programs should not be considered deficient just because of the costs they incur as a result of meeting these needs;

- The magnitude of the needs, and the importance of ensuring that they are met, suggests the desirability of a balanced, diversified collection of social insurance programs, private group insurance and pension plans, and individual savings efforts; and

- Future demographic trends have significant implications for more than just entitlement programs and are intrinsically related to the nation's economic well being. Sufficiently robust economic growth can provide the resources to meet future retirement and health care needs while securing the living standard of the non-aged.

As the Trustees have recommended, action is needed in the short-run to gain sufficient time to make recommendations on approaches to long-term solvency. It would be irresponsible not to take action. It is time to set aside the controversial elements in the competing Medicare proposals to fashion a Medicare package of changes that can be enacted and that can extend the HI trust fund sufficiently in the short-term to enable us to face the challenges of the future.

The American people believe in Medicare, as does the Administration. We take seriously our responsibility to current and future Medicare beneficiaries to ensure the solvency of the HI trust fund. The Trustees Report is a call to action, but it should not be cause for unnecessary alarm to beneficiaries, present or future. We can and must move forward in a responsible, bipartisan manner to quickly enact reasonable Medicare reform that will address short-term solvency, providing us with sufficient time to carefully consider approaches to preserving Medicare for the long-term.

PREPARED STATEMENT OF GAIL R. WILENSKY, PH.D.

Mr. Chairman and members of the sub-committee, thank you for inviting me to appear before you. My name is Gail Wilensky. I am a John M. Olin Senior Fellow at Project HOPE, an international health education foundation, and Chair of the Physician Payment Review Commission. I am also a former Administrator of the Health Care Financing Administration. However, I am here today to present only my own views on Medicare, and my testimony should not be regarded as representing the position of Project HOPE or PPRC.

In my comments, I will discuss some of the short and long term implications of the financial crisis facing Medicare. My concern is that most of the reforms considered in the last session of Congress and those already being raised in this session do not resolve the long term problems of Medicare and in many cases, not even the intermediate financing needs of Medicare. The public needs to be more aware of the magnitude of the changes needed to keep the Hospital Insurance Trust Fund afloat until the baby boomers begin to retire, as well as the changes that will be needed to accommodate the baby boomers.

THE NEED FOR REFORM

Although Medicare has been one of our most popular social programs, it has some major weaknesses and is in serious need of reform. The most significant problems concern the financing of the program and the need to restructure Medicare so that the benefits that have been promised to our seniors can be delivered at a sustainable rate of spending.

Medicare's current financing problems pose short term, intermediate term and long term difficulties for the program. In the short term, Medicare Part B represents a major drain on the budget since three-quarters of its spending is financed from general revenu This spending exacerbates the deficit and makes it more difficult to reach a balanced budget. In the intermediate term, the Hospital Insurance (HI) Trust Fund will become bankrupt in the next four years and under current projections will accumulate enormous deficits over the next ten years. In the longer term, with the retirement of the baby boomers, Medicare is not financially viable and its future insolvency raises serious questions about the design of a program that will be sustainable in the 21st Century.

SPENDING RATES AND SOLVENCY ISSUES

At a time when spending in the private sector has slowed significantly, spending on Medicare continues at unsustainable rates. Although private sector growth rates exceeded Medicare rates in the 1980's, this trend has been reversed since 1991. In 1996, private sector spending increased at a rate of 3.2 percent, Medicare at a rate of 8.5 percent.

Using the recently released Congressional Budget Office January 1997 baseline estimates, Medicare is still projected to grow at a rate of almost 8½ percent per year over the next five year budget period. Comparatively, during this same period, total Federal Budget Outlays are only projected to grow at an average annual rate of 5.2 percent and the Gross Domestic Product is projected to only grow at an average annual rate of 4.8 percent.

The projections for the solvency of the HI Trust Fund remain alarming. Most of the lower spending growth (.5 percent per year) projected for Medicare from the 1997 baseline came from Part B reductions. The Trust Fund is still projected to be bankrupt in 2001, with accumulated deficits of more than half a trillion dollars by 2007.

In order for the Trust Fund not to be completely exhausted before the end of 2007, there needs to be $450 billion dollars of accumulated policy changes. As a CBO memo dated Jan. 29, 1997 indicates. there are a variety of ways this could be accomplished but all of them require a dramatic departure from present spending levels or a substantial infusion of new funds.

For example, if the growth rate in spending for the Trust Fund were reduced from the expected level of 7.7 percent to 3.4 percent for the entire period, 1998 to 2007' solvency would continue until 2007. Reductions in the growth rate could be postponed until 1999 or 2000 but the subsequent rates of growth would have to be reduced even further in order to maintain solvency through 2007. Alternatively, the combined employer-employee HI payroll tax could be increased by one-third, starting in 1998. All of these proposals involve a more radical change than any of the proposals of the last session had contemplated.

Yet another alternative is to transfer a portion of the current obligations of the Trust Fund to another source of funding, as has been proposed by the Clinton Ad-

ministration. The main appeal of the transfer is that it "buys time" by extending the life of the Trust Fund without having either to reduce spending or raising taxes to the degree otherwise needed. The transfer of a portion of the home health care benefit (sort of) into Part B has been justified at a policy level on the grounds that approximately half of home care is no longer associated with a hospital stay and is therefore no longer logically associated with Part A.

However, the terms of the transfer of $80 billion of home care should be considered carefully because of the precedent it sets in transferring an obligation into what effectively is the general revenue of the Treasury. Normally, when an expense is brought into Part B. a portion of the total spending becomes part of the premium paid by the elderly and the expense itself is subjected to a 20 percent coinsurance charge. This is not being done for the home health care transfer. While an argument can be made that the separation of Medicare into Parts A and B. with two separate streams of funding is an archaic holdover from Medicare's inception, removing the limited cost constraints that now exist without reforming the entire program is very risky.

The problems which have been receiving the most attention involve financing Medicare until 2002 and the implications of keeping the Trust Fund solvent for the next decade. Although the problems are less immediate, the implications of the impending retirement of the baby boomers are profound. In 1995, Medicare enrollees represented 13.6 percent of the population and Medicare spending as a percentage of GDP was 2.6 percent. In 2010, when the first of the boomers start to retire, Medicare enrollees will be 15.1 percent of the population and spending on Medicare is expected to be 4.5 percent of GDP. By 2030, when the last of the boomers will be retiring, Medicare enrollees are projected to represent 22 percent of the population and Medicare spending as a percentage of GDP is projected to be at 7.5 percent or almost three times what it was in 1995.

PRESENT STRUCTURE OF MEDICARE

There has been an enormous change in the organization and delivery of health services in the private sector. While not all of the changes have been regarded as desirable, there has also been a noticeable decline in spending growth for the private sector, at least to date.

Despite all of the changes occurring in the private sector, Medicare continues to remain primarily a fee-for-service program with limited availability of and participation in any form of managed care. The projections for 1997 indicate an expected enrollment of 4.4 million seniors in risk-based HMO's, representing 11.5% of all enrollees. While the enrollment in HMO's has grown rapidly over the last several years, and is expected to continue growing rapidly for the next decade, even by 2007, it is expected that two thirds of the Medicare population will still remain in the traditional program.

There are several reasons that explain the relatively small numbers of seniors in managed care, but one of the most important reasons is the limited types of non-HMO managed care options available to the Medicare population, the very population that most needs and probably most desires flexibility. Medicare Select, a PPO offering for Medigap, is finally available across the country and a heavily regulated type of point-of-service plan was made available in 1996 but is not yet available everywhere. A Medicare Choices demonstration is setting up a number of provider service network and partial capitation models of managed care, but it will be years before an evaluation of this limited set of options is likely to be available. Even promising demonstrations may not result in changed legislation.

In addition to the limited options that have been available and the lack of incentives for the elderly to be cost conscious, there are also some significant problems with the way payments are made to HMO's. These problems relate both to the geographic variations that occur across the country and the lack of adequate risk selection adjustments.

Payments to HMO's reflect the Medicare spending per capita that occurs within the geographic area. These payments, called the Adjusted Average Per Capita Cost (AAPCC), vary enormously from a high of more than $750 per person per month to a low of $220 per person per month.

Differences in the AAPCC primarily reflect very different practice styles and volumes of services used, although to a small extent, they also reflect differences in costs of living. Not surprisingly? HMO growth has been greatest in the areas where the capitation rate is very high and HMO's are able to offer many extra benefits at no additional cost to the senior.

By setting the capitation payment rate at 95% of the rate of spending that occurs under the traditional program and having the traditional program operate as an

open-ended entitlement, the government guarantees it cannot save money by having seniors choose an HMO, other than the 5% it would save assuming there was no favorable risk selection. The issue of risk selection, however, has raised the possibility that the capitation payment may actually cost the government money. This would happen if the elderly choosing HMO's are healthier than the elderly in their same age/sex categories and if they would spend less than 95% of the average were they to stay in traditional Medicare. While it appears that the elderly choosing an HMO use less services and are healthier the year before they enter an HMO, it is unclear whether favorable selection persists over time for the very large numbers of seniors who remain in HMO's.

In sum, the present structure of Medicare hardly makes it surprising that it is facing financing problems. The elderly have limited options in the health care plans available to them. Medicare pays most of the costs for the services it covers and almost all of the elderly have coverage that is supplemental to Medicare, either privately purchased Medigap or Medicaid. That means there is little reason for an elderly person to seek out cost-effective physicians or hospitals, or to use lower cost durable medical equipment, laboratories or outpatient hospitals. Hospitals and physicians also have little reason to provide cost-effective care if there is any medical gain to be had from providing more services and some reason to fear legal repercussions if they do less than they might have done and the patient has an adverse outcome. Payments to capitation plans follow payments in fee for service and to the extent risk selection occurs, may even cost the government money. Ultimately, we need to reward the elderly for choosing more cost-effective health care, to provide incentives for physicians and hospitals to order and prescribe cost-effective medicine, and be willing to share the savings which an aggressive reorganization of health care can produce.

RESTRUCTURING MEDICARE

The use of a better designed AAPCC, the payment currently used for HMO's, could become the basis for a voucher type payment which would encourage more cost-effective choices by seniors. In order to make this transformation, it would be necessary to redesign the determinants of the AAPCC to make it more stable than it is now and to take better account of risk selection than appears to occur. It also needs to be decoupled from spending in an open-ended entitlement, either being set by competitive bid or by administrative fiat. Government spending in the traditional Medicare program also needs to be limited to the same rate of increase as occurs in the capitated plans if seniors are to be encouraged to choose between traditional Medicare and capitated plans and among capitated plans on the basis of their cost-effectiveness and the seniors' own preferences.

The closest approximation of the structure I believe would be a better model for a reformed Medicare program is the Federal Employees Health Benefits Plan (FEHB) in which traditional Medicare would become one of the plan offerings and the premium payment by the government would be the same irrespective of the choice made. This model assumes many more choices available to seniors than is currently available, an annual enrollment process, more information available to seniors about the choices available. monitoring or control of the enrollment process and oversight of plan performance. The level of payment could be set by a weighted average of plans available, by a competitive bid of plans in an area or as a percentage increase over existing rates.

SOME SPECIFIC MEDICARE PROBLEMS

Aside from the more general issues of restructuring Medicare, there are some specific problems currently facing the Medicare program which need to be resolved.

The traditional Medicare program is expected to be the dominant program for at least the next decade. There are management strategies which are routinely used by the private sector to improve efficiency which could be used in Medicare. These include physician profiling, case management, practice guidelines and the bundling of payments. Several of these have or are currently being tried by HCFA as part of a demonstration but HCFA needs to be able to take the early results of demonstrations and move on them more rapidly than has seemed possible in the past.

There are several areas in Part A of Medicare that need to be addressed in the near term. These include strategies for slowing the growth in home health, hospice and other non-hospital services through prospective payment, co-payments or other policies, and reforming payment methodologies for hospital outpatient departments.

There are also several areas concerning physician payment under Part B that need to be addressed in the near term. These include the implementation of re-

source-based practice expense values and the move to a single conversion factor under the relative value system.

Finally, there are several areas concerning the AAPCC that need to be addressed, regardless of whether it becomes the basis for restructuring the entire Medicare program. These include limiting the extreme variations in the AAPCC and introducing better risk adjusters. Also both as part of the AAPCC and as a more general issue in Medicare, reforms need to be made in the payments that are being made for graduate medical education.

Much of the attention in the months ahead will be on ways to produce Medicare savings needed for a balanced budget bill. It will be very important that the Congress be selective about the types of short term savings that are pursued to be sure that they are consistent with a reformed Medicare structure.

It is possible to accommodate the need for short-term revenue increases and also set the stage for the more fundamental changes in the incentives, information and options that are needed to reform the Medicare program. Since it will take some time to restructure Medicare and to realize the gains from reforming Medicare, it is important that these reforms be started as soon as possible. This session of Congress is none too soon to start.