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FINANCIAL STATUS OF MEDICARE

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BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED SIXTH CONGRESS

FIRST SESSION

MARCH 10 AND 18, 1999

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FINANCIAL STATUS OF MEDICARE

WEDNESDAY, MARCH 10, 1999

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

The hearing was convened, pursuant to notice, at 10:15 a.m., in room SD–215, Dirksen Senate Office Building, Hon. William V. Roth, Jr. (chairman of the committee) presiding.

Also present: Senators Chafee, Grassley, Murkowski, Nickles, Gramm, Moynihan, Baucus, Rockefeller, Breaux, Conrad, Kerrey, and Robb.

OPENING STATEMENT OF HON. WILLIAM V. ROTH, JR., A U.S. SENATOR FROM DELAWARE, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will please be in order today to hold our first Medicare program hearing in the 106th Congress. There are many important issues developing in Medicare, and I plan to explore them in the committee during this session.

In addition, I am following with great interest the work of a bipartisan commission on Medicare reform which is proceeding under the able leadership if Senator Breaux. And I look forward to providing opportunities for members to examine closely the ideas and issues being debated within the commission after their work is completed and formally submitted to the Congress.

Today, I would like to focus our attention on the arcane, but ever important matters of current Medicare spending trends and baselines. We are focusing primarily on our 5 and 10-year budget windows for legislation scoring purposes and recent updates in the Medicare baseline.

In particular, I think it is important for members of the Finance Committee to review the dramatic changes in spending brought about by the actions we took in the Balanced Budget Act of 1997.

The Balanced Budget Act of 1997 was the largest Medicare spending and policy change package since the inception of a program in 1965. And the budgetary and policy ramifications are still not fully understood.

For instance, I was advised recently by the Congressional Budget Office that the period of October-December, 1997 was the last quarter in which there was any spending growth. This is unprecedented.

For the first time in the 35-year history of the Medicare program, there has been a substantial period of no growth in Medicare

spending for health services. Since the number of beneficiaries continue to grow, this may even represent a real decline in spending, both in an aggregate and a beneficiary basis.

For instance, the monthly Treasury report indicated that the program spent $2.1 billion less in the last calendar quarter of 1998 than in the last calendar quarter of 1997. I must say I find this to be a very significant development.

Here, we are posed to undertake reform of the Medicare program. We are largely driven by a desire to keep the cost of the program under control. And we discover an unexpected decrease in program cost. It strikes me as very good news. Let us hope it has the additional value of being true. If it is true, what are the implications for our reform efforts?

You know, we have had a lot of surprises lately, Senator Moynihan. Our efforts at welfare reform brought about a decline in the role that surprised even its proponents. Our economy has surprised our economists. And now, Medicare is surprising our budget experts. These are, I have to say, very interesting days.

Separately, I am increasly concerned about the financing adequacy and stability of the Medicare+Choice program over time.

I view this program as a seed bed for future program reforms needed to sustain the promise and security of Medicare benefits for the demographic surge in retirees expected in a relatively short 12 years from now.

Payment stability and adequacy as well as reasonable regulatory requirements are crucial to simulate the entry and continued participation of private health plans in the Medicare program. All these matters speak to the fact that Medicare raises budget and design complexities that exceed even those that have risen in the other very important domestic program, Social Security.

Finally, I am pleased to take testimony from Jacob Lew, the OMB Director on the budgetary objectives of the President's 2000 budget submission as it relates to Medicare and the President's proposal to spend 15 percent of potential future surplus dollars on Medicare.

I suspect it is no secret that I am concerned about any proposed across the board increase in general revenue spending.

With that, I will turn to my friend and colleague, Senator Moynihan.

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

Senator MOYNIHAN. Well, sir, indeed, we are commenced on this enterprise. We have the chairman of the commission with us and two of the distinguished members are here already.

To your point about the decline in spending, on the zero spending in recent times, I think the Finance Committee was ahead of the Executive Branch and others in this regard. I remember in 1994, we were dealing with the administration's health bill. And we were hearing things that were new to this.

Sitting right over there was a Jesuit from Fordham, Monsignor Charles Fahey who said what you are seeing is the "commodification of medicine," which means that markets are developing in what had previously been a guild arrangement.

And from down that end of the table, a gentleman who was the head of the UCLA hospital in Los Angeles informed us that in southern California we now have a spot market for bone marrow transplants—a new concept? And it does not mean prices will stabilize indefinitely, but it suggests a market phenomenon.

At the same time, you had the scientific phenomenon. Where would we say gene therapy will be in 50 years' time? You can predict what the population of the United States will be but not the state of medical science.

So it is a wonderful conundrum. And thank goodness that Senators Breaux and Gramm and Kerrey are going to resolve it for us. Thank you, Mr. Chairman.

The CHAIRMAN. I will call on others for a brief statement. I would ask you to keep them under three minutes, please.

Senator Baucus.

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

Senator BAUCUS. Mr. Chairman, I will be much less than three minutes. I look forward to the hearings. It is very important. I do want to though mention one aspect. And that is as we move to reform Medicare, we be sure that the rural communities are treated fairly.

When I say rural, I mean, very rural. Many of us in the east, those who live in the east think that rural is maybe 20 miles away or something like that.

I can remember years ago, Doc Bowen, the HHS Secretary was testifying right where Mr. Lew is now sitting. He prided himself, Doc Bowen, as a rural doc and from Indiana. And I have made a calculation and pointed out to him that at least in my State Montana that Montana is 20 times more rural than Indiana because of the number of Congressional districts in Indiana compared with Montana.

When the first lady came to Montana several years ago, five or 6 years ago, she got off the plane, it was in Billings, and traveled Montana a bit. And suddenly, she just said, this is not rural. Montana is not rural. It is mega rural. It is hyper rural. And she internalized, you know. She got it that rural west is much, much more than the rural mid-west or the rural east or rural California. It is of great difference. There is no comparison.

And so when we write the rules for Medicare and when we figure out reimbursement under Medicare for hospitals and docs, I just want to remind all of us to make sure that we keep in mind the real rural parts of the United States, not the pseudo-rural parts of the United States. Thank you.

Senator MOYNIHAN. The wild west.

The CHAIRMAN. Senator Breaux.

OPENING STATEMENT OF HON. JOHN BREAUX, A U.S. SENATOR FROM LOUISIANA

Senator BREAUX. Thank you, Mr. Chairman. And thank you for having this meeting on Medicare and what we do with it. Medicare in 1965 when Congress passed it was a terrific, tremendous pro-

gram that a lot of people thought was extremely controversial. And some people said it would never work. It has worked very well.

But in 1999, as we move to the 21st century, it is not a modern, efficient, and effective program, not nearly as much as it should be. Medicare only covers about 53 percent of the average beneficiary's health cost.

That is far less than all private plans and employer-sponsored plans and the plans that we and you as a member of Congress have and every single Federal employee has. The average beneficiary has to pay over $2,000 out of pocket for costs of health care that is not covered by Medicare.

So by 21st century standards, Medicare is not nearly as good as it should be nor nearly as good as it can be made to be. In addition to the fact that it is not that good, it is going broke. So we have a program that does not address the needs of the beneficiaries, 40 million Americans who are on the program.

In addition to not addressing their needs, it is going insolvent and today pays out more than it takes in today. And by the year 2010, it will be insolvent in the truest sense of the word.

So the question is, what do we do? Some would advocate, well, we need to throw it all out the window and come up with a totally new system based on competition, much like we have in the Federal employees health plan.

Others say, no, that is not the answer. Keep it just like it is, but just put more money in it and that will solve it. The truth is that neither one of those solutions standing alone will get the job done. Neither one of them will work to make a 21st century, modern health care delivery system for America's seniors by itself.

So I would suggest it has to be some combination of more money, yes, because more money will be needed and more reform because we need a better delivery system than we currently have.

So I would think that what we hopefully will be able to do through the commission work that will be completed next week, we have I think a majority recommendation that could pass with a majority vote today, but we do not have a super, super majority which is what the commission is required to receive in order to make a recommendation.

We are still working on it. And I am always optimistic about reaching an agreement. But even if we do not get the super, super majority recommendation, Mr. Chairman, it is certainly my intent and the intent of many of the others on the committee to in fact take the recommendation that a majority has and present it in the form of legislation to this committee and to the committees in the House to move forward.

I happen to personally believe that there is a majority in the U.S. Congress for a recommendation that can combine the best features of both suggestions, additional revenues and a new delivery system for the 21st century.

The CHAIRMAN. I would say to the distinguished chairman of the commission that we congratulate and thank him for the leadership he has provided in that commission and that upon receiving the recommendations, whether that by the super majority or otherwise, we do intend to proceed with hearings.

I will now call on Senator Kerrey to be followed by Senator Nickles.

Senator Kerrey.

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

Senator KERREY. Mr. Chairman, I look forward to hearing the witnesses. And I look forward to having a chance to ask some questions.

The CHAIRMAN. Thank you. I hope others follow your example. [Laughter]

With that, Senator Nickles.

OPENING STATEMENT OF HON. DON NICKLES, A U.S. SENATOR FROM OKLAHOMA

Senator NICKLES. Mr. Chairman, thank you. And I want to compliment Senator Breaux for his comments and urge him to move forward and not to dilute the real promising possibilities that can come out of your commission.

I know there has been an effort to try and pick up that additional vote. It has been unfortunate in my opinion that the administration has failed in my opinion to really help and cooperate to make that happen. I think it has to happen. It needs to happen.

Regardless of what happens, if you cannot get the super majority, I hope that we come up with the really effective reforms that need to be done, that should be done, and that this committee and others in Congress will support the efforts and help really save Medicare.

I think the President's rhetoric about saving Medicare has been very misplaced. His rhetoric that says, well, we are going to put 15 percent of the surplus is actually saving Medicare does not.

I think that is false. I think it is misleading. I think it is deceptive. I think that by putting IOUs into Medicare, that does not save Medicare. And we should be honest. It does not save Social Security either. And I think honesty would help and very frank talk would help us come to some good solutions.

I do not think we saved Medicare last year by transferring home health into general revenue. I look at the numbers. And we just heard Senator Breaux say we are paying out more than we are taking in. You look at the report that we get from CBO that says, well, Medicare Part A trust fund has a surplus. And I think those surplus are more interest than they are. I think the actual outlays exceed the revenue coming in.

And so we have real problems. And we have those problems today. And for us not to address them I think would be irresponsible.

And so I would urge the commission to do what is right and make the recommendations to Congress. And I would hope that this Congress will work together in a bipartisan fashion, as many of the members of the commission have to come up with some positive, constructive solutions towards saving Medicare that will work. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Next on our list is Senator Grassley to be followed by Senator Chafee.

Senator Gramm, you were out.

Senator GRAMM. I am back.

The CHAIRMAN. You are back. You have to go to the bottom of the list. [Laughter]

That is for being absent.

Senator GRAMM. In that way, Mr. Chairman, I get to listen to everybody else like the wise old owl that lived in the oak. You know that story.

The CHAIRMAN. I ask everybody to be very brief because we do have three distinguished witnesses.

Senator Grassley.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. Mr. Chairman, first of all, I would suggest to you that it is your prerogative whether we have opening statements or not. My staff said we would not have opening statements for today's hearing. That is what we were notified. And whether you have them or not, does not make any difference to me, but I would like to know when we can have them and when we cannot have them, sir.

I would only point to the President. And I take off from where Senator Baucus left off about rural America and the special concerns there and the President's cut in hospital reimbursement presumably based on the proposition that hospitals are making tremendous profit.

There may be some hospitals in the United States that are making profit that would give the President a rationale for freezing Medicare reimbursement to hospitals for 1 year only, but the cumulative effect of that in my State over a 5-year period of time would be $600 million.

And for a State like mine, and I will bet it is true of Montana as well where we already deliver like in my State we are 48th out of the 50 States in cost of medical care delivery.

We already are relatively inexpensive. And you have that sort of an across-the-board cut in hospital reimbursements. And it is just going to be terribly detrimental to rural hospitals, maybe putting a lot of them out of business. And when we are trying to expand opportunities for the delivery of health care, a move like this does not help anything.

And I wanted to bring this to the attention of my colleagues when that budget issue comes before this committee and ask you to consider not freezing the reimbursement for at least rural hospitals. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Chafee.

OPENING STATEMENT OF HON. JOHN H. CHAFEE, A U.S. SENATOR FROM RHODE ISLAND

Senator CHAFEE. Mr. Chairman, I want to voice my deep concern over the suggestion that we are going to use money from the general fund of the United States to support and help with Medicare. I think that takes us down a very, very slippery path.

I think what it does it means that we will set aside the structural changes that have to take place in this program. And it is not as though these structural changes are unknown to us, not that these are going to save everything, but we have actually had votes.

Let me just call the committee's attention to June 24, 1997. That is less than 2 years ago. We voted 70 percent to support means testing on the Part B premium. We voted 60 to 40, 60 percent to have the $5 co-payment. And we voted 62 to 38 to increase the eligibility age from 65 to 67 to conform with Social Security.

Now, I do not know how far these will get us in making this program solvent once again, but they are certainly a step in the right direction.

And, again, I want to stress there are a lot of challenges in this whole program. In my State, we are insufficiently being reimbursed for home health visits, the professionals that do that. And we are lower than our neighbors. I just cannot understand it.

But I certainly think we ought to take these structural changes that have been mentioned here plus others that the commission probably came up with and not get into this business of using the general fund. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Murkowski and then Senator Gramm.

OPENING STATEMENT OF HON. FRANK H. MURKOWSKI, A U.S. SENATOR FROM ALASKA

Senator MURKOWSKI. Thank you. Good morning. It is my understanding, Mr. Chairman, that the hearing today is to ensure Medicare for the elderly in the future. And my problem in my State, a rural State is access. We are just absolutely, our physicians are dropping people. Access to health care is the overriding problem for the elderly in my State.

Nearly every week, I hear from a person in Alaska who writes me saying that his doctor can no longer treat a patient. And the reasons are what we are discussing. And I would hope that we would address them with some remedies.

Reimbursement is insufficient because I does not take in, I think the next year or wherever up in your rural area, the cost of travel, transportation costs. We just have higher costs.

And the new Medicare regulations very frankly are too complex for the small physicians. A larger clinic can handle it, figure it out. And they have people. But a small operation cannot do it.

And the tactics that the Health Care Finance Administration, the Department of Justice working together on this issue of fraud have gone into some of these smaller operations and just driven them crazy. It is unwarranted. It is abusive. And it is uncalled for.

Here is a letter from a patient saying "My doctor says he can no longer accept me as a patient. It came as a shock. I am 75 years old. I have to start looking for a new doctor."

Another woman writes "I was forced to be turned away as an elderly patient due to inadequate Medicare reimbursements and threats and fines for inadvertent billings from the doctor."

Another one "I have no personal doctor. I had one for 10 years, but he has advised me he can no longer basically take care of me."

I mean, this is a real problem out in rural America. And the thing that bothers me more than anything is the administrator,

Nancy Ann Mide-Peer of the Health Care Finance Administration said to this committee last year that access is not a problem for Medicare patients, but, Mr. Chairman, it is a problem. It has got to be addressed. Thank you.

The CHAIRMAN. Thank you.

Senator Gramm.

OPENING STATEMENT OF HON. PHIL GRAMM, A U.S. SENATOR FROM TEXAS

Senator GRAMM. Well, Mr. Chairman, let me first say if the President had simply proposed giving meaningless IOUs to Medicare and that had been the end of it, I think we could say that this was sort of phony budgeting. The bottom line is whether you have one IOU or a shoe box full of them, what is important is where do you get the money to make good the IOU?

But what turned this into a cruel hoax is that this was done at the very moment that we were on the verge of getting an agreement in the Medicare Commission to institute real reform. And in the process, it appears to me that the odds are quite high that the President has killed that commission report.

I remember vividly when the President called the new commission which I am honored to be a member of and honored to be a member with Senator Kerrey and Senator Breaux. And I want to congratulate Senator Breaux for his leadership and for his courage on this issue.

But I remember when the President called us all down to the cabinet room and charged each of us, do not let this commission fail because of your vote. And yet, it is on the verge of failing because every member appointed by Bill Clinton is opposed to doing something about this problem.

So I think what has happened is a phony budget proposal which I would be ashamed to propose is now being used to kill a legitimate bipartisan effort to save Medicare. And I think it is an outrage. And I appreciate getting a chance to say so.

The CHAIRMAN. Thank you, Senator Gramm.

And Senator Conrad.

OPENING STATEMENT OF HON. KENT CONRAD, A U.S. SENATOR FROM NORTH DAKOTA

Senator CONRAD. Thank you, Mr. Chairman. I want to add my voice to Senator Murkowski to indicate, I have just completed a series of community forums in my State. And other than the agricultural crisis, the number one subject was, what is happening to rural hospitals?

At everyone of those meetings, administrators and employees of rural hospitals appeared and told me that they just cannot take any more cuts and be viable. Hospital administrators came to a number of my meetings and told me that they are in preparation of doing the analysis for shutting down, that unless something is changed that the reimbursement system and the cuts that have already been imposed on top of those which are suggested this year mean they simply cannot survive.

So I think we have reached a crisis in rural America in terms of providing health care. I am certain Senator Baucus here has heard the same thing when he is going town to town in his State.

I think we all understand the demographic time bomb that is out there that is leading us to have to reform Medicaid and Medicare and Social Security. Those things simply must be done. But in doing it, we have got to ensure that we have a system that provides health care. I mean, that is the purpose of the exercise. I mean, if we just cut, cut, cut and at the end of the day people's health care is not provided for, we have failed.

So I am hopeful that we will hear today suggestions on how we proceed in a way that meets the fiscal requirements, but at the same time provides the health care that people so desperately need. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. We will now proceed to our first witness. It is indeed a pleasure to welcome you. We are looking forward to your testimony. Your full statement as all the statements of the witnesses today will be included as if read.

Mr. Lew.

STATEMENT OF HON. JACOB J. LEW, DIRECTOR, OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC

Mr. LEW. Thank you, Mr. Chairman, Senator Moynihan, and members of the committee. I appreciate the opportunity to appear today to present the President's framework for Social Security and Medicare reform and for long-term fiscal discipline.

I think I have to begin by saying that we need to marvel at the remarkable economic circumstances we find ourselves in. I am the first OMB director ever to sit here, looking at a $5 trillion surplus over 15 years, discussing what should we do with this opportunity? How should we allocate the surplus to take care of our fiscal problems, take care of our programmatic needs?

This is a very, very unique opportunity which gives us an historic opportunity to make some decisions that will really shape the economic future for the next decade and beyond. Using the surplus to reduce public debt, to finance benefits in Social Security and Medicare will enhance the economic performance that we are seeing today.

We are seeing an economy that has the longest, non-wartime growth in American history. We have seen 18 million new jobs created since 1993. Our goal is to continue with an economic program that will lead to this kind of performance.

A decision today to use the surplus, to set it aside for Social Security and Medicare, and to reduce public debt will enhance economic performance over the long run. However, a decision to use the surplus for tax cuts or for large new spending programs could have the opposite effect.

If I could, Mr. Chairman, I would like to just walk through a couple of charts to present our program and to make some comparisons with the alternative as we understand it to be developing on the Republican side.

Senator CHAFEE. Do we have some matching forms up here? Do we have a handout?

Mr. LEW. Yes, Senator, I believe we have circulated it.

Senator CHAFEE. That is his handout?
Mr. LEW. Yes.
Senator CHAFEE. All right. Thank you.
The CHAIRMAN. Yes, we have a marked one here.
Mr. LEW. The President's framework for Social Security reform and long-term economic growth——
Senator MOYNIHAN. Jack, would you hold on just a second?
The CHAIRMAN. Does everybody have a copy of this?
Senator CHAFEE. This is it, right?
Mr. LEW. Yes, Senator.
Senator CHAFEE. Thank you.
Mr. LEW. I think we have more copies if anyone needs more copies.

We have begun by saying that we should set aside the surplus for Social Security and Medicare. And if you look at the chart, on the colored chart in the green area, the 77 percent that is set aside for Social Security and Medicare is all reduction in publicly debt.

So we do get two very important uses. One, we set money aside for these programs where the benefits are already required to be paid under current law and we are reducing the debt held by the public which is a very important macroeconomic policy.

We have then proceeded to say the next step ought to be to take care of some critical discretionary requirements, both in defense and non-defense with 11 percent of the surplus; and then to set 12 percent aside for a tax cut. The President has proposed universal savings accounts which are a savings incentive to promote retirement savings.

Proceeding to the next chart: We have tried to compare on equal terms the President's framework and what we understand to be the alternative that is emerging in Congress. Obviously, these comparisons get complicated. The CBO does numbers for 10 years. We have done numbers for 15 years. We have extrapolated a 15-year comparison.

I would like to make two points. First, the discussion as we have heard it over the last week has focused on, do you spend on-budget or off-budget surpluses?

And the suggestion has been the Republican plan that is emerging is somehow more fiscally prudent because it limits the amount to be spent on a tax cut or other purposes to the on-budget, non-Social Security surplus.

As this chart shows, we think it has the opposite effect. What it does is to make more resources available for tax cuts or spending than would the President's framework; as opposed to putting $1 trillion into a combined investment in discretionary spending and tax cuts, the Republican alternative would put $1.7 trillion aside.

If I could turn to the next chart, if you compare our programs and see where the money is going, it becomes pretty clear that the choice that Congress will have to make will be fairly straightforward between how much of the surplus goes for a tax cut, how much of it is available for Medicare, defense, and for a tax cut as well.

We have proposed that after Social Security the next 15 percent should be set aside for Medicare. We think that it is critical that discretionary priorities also get a portion of the surplus because the

appropriations process will be impossible unless we in the long term look at relaxing the caps. And then, we propose a tax cut as well, but it is much smaller than the Republican plan.

If I could proceed to the next chart, the suggestions are made that somehow the alternative plan reduces the public debt more than the President's framework. We do not believe that is correct over 15 years.

And the reason we do not think it is correct is that the portion of the President's plan that is devoted to Medicare is reducing debt held by the public. We think over 15 years, the President's proposal would reduce debt held by the public by $600 billion more than the Republican alternative.

And if I can go to the next chart, it illustrates the point that I would use to respond to many of the comments made in the opening statements. By reducing the debt held by the public, we are reducing the amount of Federal dollars that are going to pay net interest. When we started in 1993, we were projecting that in 2014, the 15th year that we are now looking at, that 27 cents out of every Federal dollar would be devoted to paying interest on publicly-held debt.

As a result of the progress we have made to date and the proposals the President has put forward, we will reduce that 27 cents to 2 cents on a dollar. Now, 25 cents on a dollar creates a lot of room in the Federal budget. And we will be making decisions on how to allocate it.

We have the choice to allocate it towards a tax cut or towards making resources available for Social Security and Medicare. And we look forward to the policy debate about that choice.

If I could proceed to the next chart, the question of Social Security and Medicare solvency is critical. The President's plan would put resources aside. And as many of the Senators noted in their opening remarks, it does involve general revenues going into Medicare and Social Security.

The fact that we are putting resources into the trust funds is precisely the reason that we are able to extend trust fund solvency. A proposal which sets aside the surplus, but does not put the money back into the trust fund will not extend trust fund solvency for a day.

The plan as, we understand it, emerging on the Republican side would not extend the Social Security trust funds and would not dedicate anything to the Medicare trust fund.

In contrast, the President's plan would extend the Social Security trust fund until 2055 and the Medicare trust fund until 2020.

If I could proceed to the next chart, I think that this puts into perspective the nature of the choice that we have in terms of using an infusion of cash into Medicare as opposed to the other alternatives.

And they are very stark choices. The President's budget this year proposed $9 billion of savings over 5 years through traditional provider reductions. I think everyone on this committee has heard from providers concerned about those proposed savings.

We designed these proposals carefully. We think that we can respond to many of the concerns raised. But $9 billion of savings over

5 years has prompted more concern than probably any other single proposal in our budget.

In contrast, our transfer from the surplus amounts to $149 billion over 5 years and $713 billion over 15 years. If we do not make this transfer from the surplus; if we do not reserve any of the surplus for Medicare; I would argue that despite all of the efforts Senator Breaux and others are going through for reform, there simply would not be enough savings to substitute for the resources that we are looking to the surplus to provide.

The surplus is not the end. It is the beginning. And we need to extend the trust fund, using the surplus first for Medicare before we go through with a tax cut.

And, yes, we need to go through the reform process. The President has proposed that we need to have bipartisan reform in both Social Security and Medicare.

If I could just make one additional point and then I will conclude. I think in order to understand the President's framework, I need to spend just a moment on discretionary spending.

The alternative that we see developing now in terms of the budget, in terms of the Congressional budget resolution gives us grave concern in terms of discretionary spending.

Now, we support an increase in defense. We support increases in education, but we have to be mindful of the impact on all other spending if we do not provide for discretionary spending increases, particularly over the long-term from the surplus.

If you were to increase defense and education by the amounts that we have heard discussed over the last week, it would mean cutting all other discretionary spending by $24 billion. That is a 9.3 percent cut. It would mean dramatic reductions in programs across the board that I think are just not possible on a policy basis or on a political basis.

So as we go through this discussion of how to allocate unified budget surpluses, we would say that Social Security is first and Medicare comes second. Discretionary spending has to be right in there with tax cuts as we debate the use of the surplus.

I will conclude my remarks there and be happy to take any questions that the committee has.

The CHAIRMAN. Well, Mr. Lew, I have to say I'm very disappointed with your testimony. I am disappointed because the purpose of this hearing today is to discuss the problems with Medicare and what we need to do to correct them.

It is not to get into some kind of discussion of Medicare versus tax cuts or whatever. We are here as a follow-through on the excellent job that Senator Breaux is doing as chairman of the commission so that we are in a position to try to follow through on the recommendations that they hopefully will be making to us later this week. This is not a political exercise. And we do not intend to let it become such.

Again, what we are here for is for the purpose of trying to decide where we are on Medicare and what needs to be done to give the kind of care we think our senior citizens should receive. Now——

Mr. LEW. Senator, if I may just point out, I was asked to testify on the President's framework. And that is what I have tried to do. I would be happy to answer any questions you have on——

The CHAIRMAN. I think it was a political speech, and regretably a political budget.

Let me go on to the question period. As I mentioned in my opening comments, I was advised recently by the Congressional Budget Office that the period of October-December, 1997 was the last quarter in which there was any spending growth. That is the first time that program growth has declined, I think, in the 35 years this program has been in effect.

And if true, as I said, it is a very, very significant development. If it is not true, I would like to know why it is not true.

Would you please—well, let me say, for instance, the monthly Treasury reports indicated the program spent $2.1 billion less in the last calendar quarter in 1998 than in the last calendar quarter of 1997. Can you comment as to why this happened?

Mr. LEW. Mr. Chairman, it is difficult for me to explain month-to-month variations like that. I suspect it has something to do with the managed care providers and the timing of payments to them.

I would just say that over the next 5 years, we project that average growth in Medicare is projected to be 5.6 percent which is a more moderate rate of growth than we saw in the last decade, but it is a positive rate of growth.

The CHAIRMAN. I would just point out that in the various agencies, including your own, the economists have not been very good in their predictions.

It was not too long ago, Pat, that they were predicting continued deficits into the future. And now, we are predicting surpluses into the future. And here, we have a savings or no increase in spending. So I must confess, that does not give me a heck of a lot of confidence in these projections.

But are you saying that you think that this is just an aberration, that some of the providers are not seeking reimbursement rapidly enough?

Mr. LEW. Well, there are a lot of factors that influence month-to-month numbers like that. We see it on the tax side as well as on the spending side.

When we look overall at the annual rates of growth, we expect the pattern over the next few years to be fairly consistent, with the exception of certain anomalies that we know will occur. Some months have more payment periods than others just because of the way the calendar falls out.

I would be happy to go back and look at the monthly data that you are referring to. I do not typically review the month-to-month data.

I have tried over the years not to read too much into month-to-month data because when you look at it over a longer term, a lot of it tends to smooth out. And I would suspect that would be the case here as well.

The CHAIRMAN. Well, I would ask that you do so because I think it is important for us to know whether there is any significance in these.

Let me ask you this, what is your estimate of the total dollar amount of the general fund transfer under the President's surplus proposal? And does this proposal alter the current law trust fund structure? How does it affect the definition of solvency that we are

accustomed to working with under the hospital insurance trust fund?

Mr. LEW. Well, the structure of the payments, Senator, is that as we set funds aside for Medicare, we will be putting Treasury bonds into the Medicare trust fund. As those resources are needed to pay benefits, they would be redeemed. And as with all bonds in the trust fund, they are redeemed with general revenues.

So the structure of the transaction is only different in that this deposit of additional resources into the trust fund is coming from the surplus. When it is redeemed, it will come out of the general fund.

In terms of the amounts, over 15 years we propose putting $713 billion in Medicare. It is $149 billion over the first five years and $385 billion over the first 10. We have tried to conform our numbers to the new numbers that CBO has put out for the first 10 years. I am pretty confident that we have tracked CBO over the last five years. However, these numbers may be off by a little bit.

The CHAIRMAN. Now, under your budget submission, you propose a freeze on payments to hospitals. I think you heard a number of our panel object very strenuously to this. I must say my hospitals in Delaware are very concerned about what is occurring on both inpatient and outpatient services. What is your answer to what the panel asked?

Mr. LEW. Mr. Chairman, I have thought a lot about the questions raised at the hearings when the budget came out. Similar questions were raised. And I think they are very serious questions.

We have designed a policy that I believe nationwide works quite well. We are seeing rates of return for hospitals that are quite large nationwide. There are, however, pockets where that is not the case. And I think the challenge in doing any kind of provider savings will be to achieve the desired goal of a national policy that pays a fair amount without having regional inequities.

We are not as good as we should be at targeting payments based on regional differentials and risk differentials. That is work that we and this committee continue to focus on.

I would just point out, there is no real fourth choice. The three choices you have in Medicare are cutting benefits, raising payroll taxes, or finding resources that you can devote to Medicare.

The President's plan, by devoting a significant portion of projected surpluses to Medicare rather than to a tax cut has made a significant decision. And without taking that step, we will be forced to much, much more severe policy choices. So I think the framework as I presented in my opening remarks, as it is presented in the budget is a critical first step. It clearly is not a last step.

The CHAIRMAN. Why do you know the figure is $700 billion? Why is it not $500 billion or $1 trillion?

And then, I would ask you, what happens if the surplus does not materialize at the levels you now project?

Mr. LEW. Mr. Chairman, the proposed is, as we have said, that 15 percent of the surplus should be devoted to Medicare. And we are applying that 15 percent to what are the new CBO numbers as we have extended them for 15 years. Using our baseline they are slightly different.

In terms of what we do if the surplus does not appear, we have that problem today. The benefits that we would be paying for with these transfers are all benefits that are due under current law.

We would either need to restructure the program where we would have competition and other factors leading to savings. We might have to cut benefits. We might have to raise payroll taxes. The status quo already requires that these benefit payments be made. And our proposals have not added a penny to the burden.

I think the issue that I heard in the opening remarks and in your question, Senator, is that somehow we are making the problem worse by committing the surplus to Medicare. I really disagree with that.

I think if we look at the problem in Medicare, it is as complex a problem in terms of the policy options we have to review as any we are going to tackle. It is more complicated in terms of policy than is Social Security, where we know what the options are. They are difficult choices, but we understand them well.

Senator Breaux deserves a lot of credit for the work he and the commission have done in trying to work through these very complicated questions. And I think we would all agree that there is a lot of uncertainty in any of the plans that call for massive reform that would produce savings.

If we begin by saying that we are going to set aside 15 percent of the surplus, a large amount of money admittedly, that does not make the problem go away, but it certainly gives us the ability to tackle the problem with a very good head start.

It gives us the ability to look at the questions of reforming benefit structure to modernize the benefits. The President suggested we should look at prescription drugs as an additional benefit, but we are going to need substantial savings to do that. We are going to need reforms. And we need to get on with the process of that discussion. We agree with that.

The CHAIRMAN. Well, my time is up, but I want to again make the comment that upon the conclusion of the commission and its work, we intend to proceed with hearings and seek to develop a program that will assure the solvency and continuance of this most important program.

That can only be accomplished if we work in a bipartisan fashion. That is the practice of this committee. We will continue that practice. And we expect those representing the administration to do exactly the same thing.

Senator Moynihan.

Senator MOYNIHAN. Thank you, Mr. Chairman. And I would very much like to restate what you said—that this committee has been closely bipartisan in these matters. If somebody downtown had noticed this in 1994 when we reported out a health care bill—we would kill for it today—on a bipartisan basis. But it was not everything you wanted, so it was not enough. And so you got nothing in short order. And we are going to be united around the reports that come out of the majority of the Breaux commission—Breaux, Gramm, Kerrey, Rockefeller commission.

Just one larger comment if I can. I wonder if the structure of this analysis down in the OMB on health care costs is not stuck in an

earlier period. And not to say that we do not have financing costs, we do, but they are a different kind.

Back in the early 1980's, Richard Darmon, one of your successors, a distinguished man, projected that health care costs would reach 37 percent of GDP by the year 2030. When the health bill was sent up by this administration in 1993 or 1994, the proposal was 20 percent.

Paul Elwood came forth and said, no, it is never going to reach 20 percent. And Bob Packwood said, what did you say? He said, it is never going to reach 20 percent. And it is now running around maybe 14.3 percent. We are talking about billions and billions of dollars.

And one of the things that has happened is—you almost referred to it. You referred to rates of return on hospitals. That is like rates of return on a steel mill. You are seeing this commodification of medicine.

And in that setting, you get price restraints by competition, but the one institution that is left out is a singular new issue which are the teaching hospitals and the medical schools.

And we tried to address that. We specifically addressed that in 1994. We put a premium tax on all health care policies of 1.75 percent Well, Mark Hatfield wanted 1.5 for teaching hospitals and medical schools, and .25 for research because these institutions cannot survive in a price-driven environment. And if they do not survive in this great age of medical discovery—I see you nodding which is encouraging because you are not slow to follow things. But this is a new problem which we have not addressed as a government or so I believe.

Mr. LEW. I think that is a real problem. And there have been a number of solutions suggested that may or may not work and I think we have to grapple with. We have actually proposed in our budget——

Senator MOYNIHAN. Well, instead of saying solution, why don't you say response?

Mr. LEW. Response.

Senator MOYNIHAN. Yes.

Mr. LEW. A fair correction. For example, the suggestion has been made that the direct medical education costs should be shifted from Medicare to the appropriated part of the budget. That has to be looked in the context of overall resources that are available for discretionary spending.

Should that kind of a decision be made and no additional resources provided for discretionary spending, then it really would not have solved the problem. It might have relieved the Medicare program, but it would not necessarily provide the resources for the training of doctors as you very correctly point out is a need.

We, in our budget this year, propose that the cost of education, medical education related to children's hospitals be directly funded because it was not really appropriately funded out of programs for the elderly and——

Senator MOYNIHAN. Fine, but don't be too politically correct. Children's hospitals are better than hospitals for other people. You have a question of these nonprofit enterprises procuring the nurses,

the doctors, and the research. And they really need to be addressed because they are in distress right now, don't you agree?

Mr. LEW. Well, we certainly agree on the need to fund the teaching hospitals and to fund medical education generally. The dilemma that we have is right now the system that funds teaching hospitals for the most part comes out of Medicare payments.

Senator MOYNIHAN. Yes, yes.

Mr. LEW. Efforts to reduce Medicare spending often suggest reducing the payments for medical education.

Senator MOYNIHAN. Exactly.

Mr. LEW. And that is a problem. If you reduce medical education, then how are you going to pay for it?

All I am suggesting is that there is a problem on the other side. If you move it from Medicare to somewhere else, you still have to pay the bill.

Senator MOYNIHAN. Right.

Mr. LEW. The challenge is grappling with paying the bill.

Senator MOYNIHAN. But noting that the bill comes about because costs are being brought under control. We will leave it there. I do not want to use up more time. I think I have your attention. That is all I can hope for. Thank you.

The CHAIRMAN. Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman. I bet we would like to move from Manhattan, New York to Manhattan, Montana.

Senator MOYNIHAN. What about Mayo Clinic?

Senator BAUCUS. There is no hospital in Manhattan, Montana. Manhattan, Montana is a little town in Deerbosman.

I would just like to emphasize your recognition of the problem of the tyranny of averages. Senator Moynihan talked about teaching hospitals in Manhattan. In Montana, hospitals are not making money and on average in Montana lost, lost 1.7 percent in 1997 on average lost. And the rural hospitals lost 6.5 percent, lost. They did not make any money. They lost money.

So when you are talking about how hospitals have high rates of return, maybe generally in some parts of the hospitals, it is very, very important to recognize the point that Senator Moynihan made about teaching hospitals and also about the smaller rural hospitals where access as suggested by Senator Murkowski and to some degree by Senator Conrad is a real problem.

And we have to find a way to address the reimbursement rates when we are cutting $9 billion and if we do cut $9 billion, and overall how that with respect to certain parts of the country in certain special hospitals.

I know you recognize that, but I am asking you to think deeply about because we are going to have to find some solution. I is just not right that the smaller hospitals in more rural parts of the country get cut more when they are already losing money.

The second point I want to make is just the general concern I think all of us have with locking in the first claim apparently that Medicare, Social Security, I think Medicaid would have on future general revenue.

It is a question. And it is a disturbing question is whether and to the degree to which in future years, assuming that the budget projections are accurate that the certificates or the IOUs, whatever

they are, if I understand correctly will have a prior claim to reimburse the Social Security trust fund, the Medicare trust fund over other general revenue expenditures.

And that becomes particularly vexing to me if the projections are not accurate. And I think all of us in the room know that probably the projections are not accurate, probably not, that probably over the next 15 years we will not have the kind of economic prosperity that we have had in America in the last couple of years. I doubt that is going to happen.

I do not know if there is any 15-year projection ever in American history that was accurate because times have changed so much.

So as I see this, it seems like the administration has made a political calculation that it is better to try to reform Medicare when times are tough than when times are good. Times look good now so we are putting off the rainy day when we have to reform Medicare to when times are tough, that is when the projections do not turn out to be as accurate as we would like them to be right now.

And I do not know. Maybe, that is your calculation. I do not know, but that is what it looks like to me. And I ask again the question Senator Roth asked. And I must say, Mr. Director, you do a heck of a job, but when you did speak, I had some of the same feelings this is kind of a political statement. It came across to me a little that way, too.

But I am concerned about the surplus—I mean, about the projections here. And what happens if the projections just do not pan out? Then, what are we going to do?

Mr. LEW. Senator, if I may respond maybe starting in reverse order, I think there is a political decision that has to be made this year which is fundamental to the substance of Medicare which is why I testified as I did.

The political decision will be what to do with the surplus, whether to put it aside for Medicare or whether to have a tax cut. That is a political decision with enormous, enormous policy consequences. And I do not apologize for it being a political decision. This wonderful system of government we have makes it a political decision quite properly.

It is a choice. It is a policy choice. It is a choice that our budget is built having made one way. And there is a debate now to say make it the other way. So that is how we see the larger question.

Senator BAUCUS. I understand. But is it true though that these IOUs will, if enacted into law as recommended by the administration, have a prior claim over future general revenue?

Mr. LEW. If I could Senator Baucus, let me divide it into parts. First, the prior claim is there now. Medicare is currently an entitlement program where our long-term baseline, as well as CBO's long-term baseline assumes we will pay the bills as they come in.

Unless we enact reductions—and frankly the kinds of reductions that traditionally have resulted in lower reimbursement rates just exacerbate the kind of problem you are hearing about from providers—the alternatives to that are either a payroll tax increase or using some of the surplus.

We think it is a good choice in terms of Medicare to start with a commitment of general revenues from the surplus in order to finance the obligations that we now have.

No doubt it does squeeze out other choices. It squeezes either a tax cut or other spending, but we are showing right now that the surplus is there. And if the surplus does not materialize, we are no worse off. The most prudent place to be is not to spend the money. And if the surplus does not materialize, we are at least no worse off.

Senator BAUCUS. And that is your basic point is given the situation today, given all the choices that we have, this seems to be the most rational.

Mr. LEW. Correct.

Senator BAUCUS. Frankly, I tend to agree with that. And I guess the Congress will meet another day, 10 years from now, 5 years now, what not and it will address the situation as it seems to exist at that time. We are trying to do the very best job that we can.

My time is up. You do not have to respond. You do not have time to respond, but I do ask you to think very deeply about how we solve the hospital reimbursement. Thank you.

The CHAIRMAN. Senator Gramm.

Senator GRAMM. Mr. Lew, I have a couple of questions. And I will try to be brief if you will sort of give me crisp answers. As I understand right now in 1999, we have roughly a $111 billion surplus that we are looking at in the general budget. We have $127 billion as a surplus in Social Security.

So I assume that you would say that that money belongs to Social Security, the surplus belongs to Social Security. Is that right?

Mr. LEW. The money is in the Social Security Trust Funds in the form of bonds, but the cash is part of the unified surplus. And we think an appropriate debate is how to use the unified surplus. So we agree, we are not taking a penny from Social Security, but there is a separate decision: how do you allocate the unified surplus?

Senator GRAMM. Well, if you are not taking if from Social Security, where is it coming from if the surplus in Social Security is bigger than the budget surplus?

Mr. LEW. Social Security will not be spending more money than it needs to to pay its current bills under any circumstances.

Senator GRAMM. Well, are we going to buy down debt with that? Is that not the whole purpose of your plan?

Mr. LEW. The buying down of debt is what happens when we increase the number of bonds in the Social Security and Medicare trust funds and reduce the number of bonds sold to the public.

Senator GRAMM. Well, here is what I do not understand. The President stands up in front of the joint session of Congress and says put Social Security first. You send this budget saying you are going to take all this money and you are going to save it for Social Security, you are going to save it Medicare. And the Social Security surplus is bigger than the budget surplus in 1999. And yet, you have sent us an emergency supplemental appropriation to take $2 billion that is Social Security money and spend it in Central America.

Now, if we are putting Social Security first, how come we are spending this money in Central America? Are you not violating exactly the principle the President has set out? And that is you are taking Social Security money and as great the need is in Central

America, are you not raiding Social Security to fund that "emergency supplemental"?

Mr. LEW. No, Senator Gramm. I think we may disagree on emergency spending and how it has been and should be accounted for. But the Budget Enforcement Act, when it provided for emergency spending, envisioned exactly the kinds of circumstances that we are responding to. Nothing is more classic than a hurricane with the kind of human devastation which I think we all feel a need to respond to.

The calculation of the surplus is an ongoing calculation. Over the course of the year, certain things do come up to use the surplus.

Senator GRAMM. Well, listen, I understand that.

Mr. LEW. And emergency spending is one of them.

Senator GRAMM. The point I am making is it seems to me this money belongs to Social Security, except when you want to spend it. When we want to take the entire Social Security surplus and apply it to saving Social Security and then take the non-Social Security surplus and give it back in tax cuts, then suddenly that is bad because it is taking money away from Social Security and Medicare.

But yet, even though the Social Security surplus is bigger than the budget surplus, you are asking us to take $2 billion on an emergency basis away from Social Security to give it to Central America. And I think the American people would see a conflict between what you are saying and what you are doing, do you not?

Mr. LEW. I do not, Senator. I think that what we are discussing is how to allocate the unified surplus, and the choice of what you do once there is a dollar of unified surplus could not be more straightforward.

We are not taking a penny from Social Security in our plan. And over the long term, we are putting much more money into the Social Security. And the alternative——

Senator GRAMM. Let me try this again. The Social Security surplus this year is $127 billion. The budget surplus is $111 billion. You are getting ready to make that budget surplus $109 billion with this money in Central America.

Now, if every penny of the surplus is Social Security, why are you not buying down debt and earmarking it for Social Security? It seems to me that whether you want to say it or whether you do not want to say it, you are taking money from Social Security to give to Central America.

Mr. LEW. We are keeping all the commitments to pay Social Security in the future when it needs the money, redeeming the bonds as needed. And that is keeping the——

Senator GRAMM. The money is going to Central America.

Mr. LEW. No, no, it is not.

Senator GRAMM. Then, you are going to give it back to pay Social Security?

Mr. LEW. If Social Security needed the $2 billion this year, it would be spending the $2 billion this year. It is paying 100 percent of every benefit that is due this year. And under our plan, it will pay 100 percent of every benefit due until 2055. And the issue is how do you have the resources available when Social Security needs them? I think we are confusing time periods here.

Senator GRAMM. Well, let me just conclude with one question. So what you are really saying is there is $2 billion that is part of the Social Security which you are giving to Central America that they have an IOU for $2 billion and some day the general taxpayer is going to pay it. Is that right?

Mr. LEW. If we collectively pursue the fiscal policy that we propose, we will be very able to pay the bonds back when they are needed, yes.

Senator GRAMM. But the answer is, yes. In other words, it is raising taxes on people in the future that is going to pay them?

Mr. LEW. No, sir, it is not raising taxes. Right now, we are still in a surplus.

Senator GRAMM. But when we need the money for Social Security, we are not going to have the surplus which is why we need the money for Social Security, right?

Mr. LEW. No, Senator. We are projecting after paying back all of the bonds—you call them IOUs, but they are bonds; I am going to keep calling them bonds. When we pay back every bond, there is still a surplus. We will not have to raise taxes. If we cut taxes, we will not have the money. That is why the issue is so fundamental. We cannot cut taxes and have the revenue to pay——

Senator GRAMM. You are not telling me 20 years from now, we are going to have a surplus in the unified budget, are you?

Mr. LEW. Yes, I am, under our current projections.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. Thank you, Mr. Chairman, good morning. I thank my colleagues for the nice comments that many of them made about the work that we are trying to do on the Medicare Commission. I was kind of reminded of the nice comments they make about people when they are being lead off to the gallows. [Laughter]

But I do think that I know now where I can find a majority for our proposal. And it may be right here which is encouraging.

Jack, I have been reading the General Accounting Office paper on the administration's proposal in this area. And I think it is extremely helpful because this is I think truly a nonpartisan comment on this. I am very serious fear that once again the debate on Medicare is going to turn into a political debate as opposed to a debate on the merits.

And if that happens, for the next 2 years, nothing will get done. That will be a very unfortunate legacy for a President who I want to leave a legacy behind of addressing Medicare because nothing will happen, nothing.

And having said that, I want to ask you to comment on some of the comments that we have gotten from GAO. It says, number one, which I think is obvious that the proposal constitutes a new honoring claim on general funds for the Medicare program for really the first time. It is a marked break with current law.

But it says and it goes on "It has no effect on the current and projected cash flow deficits that have faced the program since 1992, deficits that taxpayers will continue to finance through higher taxes, lower spending elsewhere, lower pay-downs of publicly-held debt. And partly, the President's proposal would not provide any new money to pay for medical services. It does not include any

meaningful program reform that would slow spending in the Medicare program. In fact, the transfer of these new Treasury securities, IOUs to the program could very well serve to reduce the sense of urgency for reform. And at the same time, it could strengthen pressure to expand the Medicare benefits in a program that is fundamentally unsustainable in its present form."

It continues to say that this idea of putting money into the account, we should remember that under current law with no changes that this would happen without crediting additional securities to either Social Security or Medicare trust funds.

Finally, this says the President's proposal does nothing to alter the imbalance between the program's receipts and benefit payments. There has been a cash deficit since 1992 and remains in a cash deficit situation even with the new Treasury securities. Thus, the President's proposal to provide additional claims on the Treasury not additional cash to pay benefits.

Now, I mean, I think that is a pretty disturbing set of statements by an agency that is not Republican and not Democrat. And it goes right to the heart of my concern. I am willing to recognize that we need more money in Medicare, but I also will not recognize that and agree to it unless there is also fundamental reform.

So my question I guess if you can comment on these statements and then to ask you, where is the reform? It used to be, where is the beef, but now it is, where is the reform?

Putting more money in an old program is not reform. You have heard me say time and again it is like putting more gas in a 1965 car. It is still going to run like a 1965 car. So where is the reform?

Mr. LEW. Senator Breaux, the President's budget proposes a financing solution and calls for reform. And both need to happen.

Senator BREAUX. And what reform is being recommended?

Mr. LEW. The President's budget has modest changes in the first few years which——

Senator BREAUX. Like what?

Mr. LEW. Well, he has proposed the financed expansion of coverage to 62 to 65 year-olds.

Senator BREAUX. That saves money?

Mr. LEW. Well, we pay for it with Medicare savings, but the Medicare savings we have proposed have engendered some controversy. I think it is a debate that we will have to go through.

Senator BREAUX. Where is the reform, back to my initial question?

Mr. LEW. The proposals in the President's budget, like I said, are modest, traditional savings proposals.

Senator BREAUX. We call the SOS approach.

Mr. LEW. SOS.

Senator BREAUX. Have you figured that out?

Mr. LEW. The same old, same old. [Laughter]

The process of reform as you know better than anyone else is very difficult. And we——

Senator BREAUX. That is questionable, but go ahead.

Mr. LEW. Well, it is very difficult. I will assert it on my own. The President has put forth principles that he thinks should guide the discussion of reforms: that we need to guarantee a defined set of benefits without excessive new costs to beneficiaries, that we need

to modernize Medicare and make it more competitive, and that we need to use savings from reform to finance benefit improvement, such as prescription drugs.

Now, the idea that you have been pursuing in competition—at its core is something that we have talked about for years. We believe that competition has to be encouraged. It is very difficult to know exactly what the consequences would be in terms of burdens on individuals and what the savings would actually be.

We hope that by putting part of the unified surplus into Medicare, we are able to reduce the burden of the savings that have to come from other areas, so that maybe we can have the kind of bipartisan discussion that I know you want to have in terms of solving the structural Medicare problem.

I think leaving the problem to be solved solely from structural approaches is going to turn out to be very difficult and very frustrating.

The numbers that I referred to earlier I think are quite daunting. And the first thing we need to do is deal with the financing decision because we could easily make a decision this year that takes that decision off the table.

And I know that some Members of this committee, have viewed this as a partisan statement, but the choice is a stark one. If you enacted a tax cut this year that makes it impossible to put the money into Medicare, you have foreclosed that financing option.

We think it is critical to put 15 percent of the surplus into Medicare as a first step. And then, we can have the kind of discussion about other alternatives on a bipartisan basis, but we cannot do it the other way around. I think we will all regret it if we first do a tax cut and then come to the bipartisan discussion.

So we do not think one goes without the other. We need reform as well, but I do think you make it less likely if the 15 percent of the surplus decision is set aside. .

Senator BREAUX. I would just only comment that GAO totally disagrees with that. Thank you, Mr. Chairman.

Mr. LEW. But that is a political judgment more than it is a policy judgment. It is a question of what keeps pressure on the system.

The CHAIRMAN. Senator Grassley.

Senator GRASSLEY. I believe that Senator Breaux has made the point that I want to make, but if I could associate myself with his remarks and back them up with a point from 2 years ago with the Balanced Budget Act of 1997, I would like to do that because I think that the real message that you get from this committee is that we are looking at this very much in a bipartisan way with cooperation of our two parties in order to have a long-term solution to the Medicare problem.

And it ought to also be very telling to you that there are probably just as sharp remarks towards what the administration has done from the Democratic side of the aisle as there is from the Republican side of the aisle.And I think that also probably tells you that our expectations of the administration are not being met as much as they should.

But it has been referred to that this 15 percent is a painless way of helping Medicare, give it a little longer life. At the President's behest 2 years ago, we went along with a plan and maybe we

should be found guilty also of going along with a painless way of getting Medicare some additional life. And that was to take home health care out of Part A and put it into Part B. And that was generally understood at the time to be somewhat of a budgetary gimmick that would give Medicare trust funds some life for a period of time now up to 2008 or something like that.

We bought time. We set up the commission that Senator Breaux heads with the idea that we would bite the bullet and make the tough decisions now. And so I guess I see us still—or the White House still finding a painless solution to Social Security. I keep saying Social Security. I mean, Medicare in this instance.

Mr. LEW. You want to solve both problems.

Senator GRASSLEY. Do you consider just these painless approaches a very good long-term strategy? And do you in fact think that we can delay the day of reckoning for Medicare forever by simply buying time for a few years?

Mr. LEW. I do not think that any of us can be accused of having gone the painless route on Medicare. If you look at what we together did in 1997, that was the largest set of Medicare savings ever enacted at well over $100 billion. In 1993, we had very substantial savings in Medicare enacted.

In our budget this year, we proposed relatively modest savings, but I have heard from the most of the members of this committee concerns that those savings will put a burden on providers. I do not think that the question is whether we have put aside painful choices. We have been making painful choices since 1993.

We now have the opportunity to decide what to do about the surplus. And we think that it is part of the Medicare solution. It is not the whole Medicare solution, but it is a critical part of it.

And I think that the description of it as painless is perhaps a little bit incorrect because the choice is a very painful one. There are many members of this committee and many members of this Congress who would rather do other things with the surplus than put the money into Medicare. It is a choice that is obviously difficult or we would not be having a debate over what to do with the surplus.

We think that putting additional resources into Medicare is prudent and is the right thing to do. We think that a tax cut should come afterwards, but that is a difficult choice, a difficult policy choice, that we are going to have to work through together.

Senator GRASSLEY. One of your charts took my party apart for maybe not spending enough on discretionary spending. In a sense, is there not an intellectual dishonesty to taking money out of the surplus and putting it into the Medicare fund? And to that extent, are you not doing what you would consider an injustice to discretionary spending?

Mr. LEW. Well, I think if you were to ask me the question, are the resources that we have allocated to discretionary spending from the surplus enough, I think it is going to be tight. But we have put, for our proposal, $517 billion from the surplus into discretionary spending over 15 years. If we want to debate whether more should go into discretionary spending, we are open to that debate.

Senator GRASSLEY. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman.

You have talked about the pain that you have provided or was provided for I think it was in 1997, but that pain was all on the providers, none of it on the beneficiary side, as I recall.

Indeed, there was a reduction for the beneficiaries I think in some home health payments. Anyway, there is no pain inflicted on the beneficiaries, as I recall. Is that correct?

Mr. LEW. The bulk of the savings were provider savings.

Senator CHAFEE. This is the bulk, all of them.

Mr. LEW. There were small beneficiaries savings.

Senator CHAFEE. Name me one?

Mr. LEW. My memory is not good enough for me to go back, but——

Senator CHAFEE. That is a real challenge.

Mr. LEW. I can go back and check.

Senator CHAFEE. Because I do not think—now, in the course of your testimony here, you said we have got to get on the process of reform. What reform are you talking about?

Mr. LEW. I think that the discussion of reform, as Senator Breaux and the members of the commission have been involved in, is one that has to begin with determining what your goals are, and then seeing whether the mechanisms you have discussed meet the goals. And it is a difficult analytic process.

Senator CHAFEE. I do not understand a word you have said. [Laughter]

Mr. LEW. Let me try to say it another way. The idea of competition producing savings is one that we in the administration have supported from the very beginning.

Senator CHAFEE. Well, let us just get back to things we have voted on here. You want some pain. And we voted on pain. And I will bet every single member of this committee voted for the pain. It was back in 1997 which is 2 years, June 24th, the ones I ticked off. And I do not see what is the matter with the administration. Here are things that we voted on.

Senator MOYNIHAN. We did.

Senator CHAFEE. The House did not. That is true, but we did. Sixty percent of the Senate, in other words 60 Senators voted for a $5 co-payment. Sixty-two percent voted for the increase in eligibility from 65. Who can be against that? And that tracks exactly the Social Security increase in age.

Mr. LEW. All these proposals have real impact on people, as you know, Senator. And depending on how you design the proposals, the impacts vary. The income cutoff for any kind of an income-related premium has a very substantial impact on whether people at moderate incomes are affected.

These are difficult decisions. Designing the policy is difficult.

Senator CHAFEE. I know they are difficult decisions, but we have a whale of a problem here.

Mr. LEW. I agree.

Senator CHAFEE. And I cannot see that we are getting any help at all from you or from the administration.

Now, what do you think of my concerns that once you start dipping into the general fund that it is Katy by the door. Why should we make any tough votes? Just take it all from this marvelous sur-

plus. I mean, there is some pain in every single one of these votes that over 60 Senators—it was not one of them that got less than 60 Senators.

Mr. LEW. We were driving the debate in 1997 on the balanced budget amendment. We worked together on the policies in the 1997 balanced budget agreement. They were difficult decisions, the decisions that are having a large effect on the nature of the health care system that people have.

The choices that you are suggesting we make are choices that there was not a consensus on in 1997. There was a vote in the Senate, but there were very serious concerns about the effect on moderate income, elderly people of a premium, and the effect on people who would not have access to health care insurance from age 65 to 67. It does not mean that these problems cannot be discussed. We are open to discussion. I am sitting here today discussing them.

But you are asking me if we have concerns about them. Yes, we do have concerns about them. And what we have proposed does not rule out taking other actions. What we said though, is that it is not enough.

Senator CHAFEE. Let me ask you a question. You have outlined there is only three things in your estimation if I recall, increase the premiums, cut the benefits. And I have forgotten what the third one was.

Mr. LEW. Find more resources.

Senator CHAFEE. Find more resources. Out of curiosity if you went—as you know now, an individual pays for Medicare with no cap to it, 4.5 percent of his or her pay. That is Medicare. Now, I would be curious. You probably do not have a figure. But if you went from 1.45 to 1.50, how much more revenue would you get?

Mr. LEW. Well, I am not sure about that, Senator, but I can give you a number that I do have. If you were to back out the transfer from the surplus that we proposed and increase that payroll tax to make up the difference through 2020, it would require an 18 percent increase in the payroll tax.

Senator CHAFEE. Well, I cannot do 18 percent times 1.45 percent. Can you help me out?

Mr. LEW. Well, I can do the arithmetic.

Senator CHAFEE. Well, I can do that fast.

Mr. LEW. I do not have it in my head. If you do not want me to do the arithmetic, I have to——

Senator CHAFEE. Don't you have a calculator over at that place?

Mr. LEW. Someone will figure it out while we are talking.

Senator CHAFEE. Well, tell me—that is a tough one anyway, 18 percent of 1.45 percent.

Senator MOYNIHAN. It is 40 billion.

Senator CHAFEE. Well, let me just say this that as I have indicated here, I just think we are going down the wrong path. See if I understand. What you are saying is you are going to take 15 percent of the surplus every year going out and put it into Medicare. Is that what you are saying, 15 percent from the general revenue surplus?

Mr. LEW. Over 15 years.

Senator CHAFEE. Over 15 years.

Mr. LEW. Yes.

Senator CHAFEE. And that would not be the Social Security? That would be what we so call the off-budget?

Mr. LEW. Actually.

Senator CHAFEE. The on-budget.

Mr. LEW. Over 15 years, it is entirely on-budget because the amount that we are putting into Social Security over 15 years is a little more than the off-budget surplus.

Senator CHAFEE. I remain unconvinced. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Murkowski, he left.

Senator Conrad.

Senator CONRAD. Thank you, Mr. Chairman. Thank you, Jack. Thank you for being here. Actually, I think this has been a productive discussion in many ways. I thought your testimony was thoughtful. I know there is some who felt it is political, but these are political decisions. And they are difficult decisions.

And if you are just honest with each other about the fundamental questions involved, they relate to we have a $4.4 trillion projected surplus depending on one's estimates over the next 15 years.

The question is how we are going to use that. Are we going to use it for Social Security? Most of the money is generated by Social Security surpluses, 62 percent over the 15 years, as you have calculated. And you are suggesting another 15 percent be used to shore up Medicare, 12 percent for targeted tax cuts, 11 percent for high priority spending.

Others have a different view. And that is what this debate is all about, this discussion is all about. Some do not want to have any more money allocated to Medicare. Well, they are going to be presented with very difficult choices on how you extend the solvency of the fund if you do not put more money into Medicare.

Let me just say that in my State, we are faced already with enormous pressure. I just have completed, as I indicated in my opening statement, nine community forums across my State mostly in small rural towns. And if we look at kind of indicators of why there is more pressure in rural areas than urban areas, it is very simple.

An HMO reimbursement, the average in my State is $350 a month. That is the cost per beneficiary per month. In more urban areas, it is twice as much. Now, if you have an equal percentage cut for everybody, you can see what happens. Yes, they take a big dollar cut in the more urban areas. We are down to the knobs now in terms of rural areas.

On the wage index that is used with respect to Federal programs, in North Dakota, it is .79. That means we get 79 percent of what the national average is. If you take a further cut on that, you are under enormous pressure because there is not that much difference in delivering modern health care to a patient in a rural area versus an urban setting.

In more urban areas, it is not unusual for their wage index to be at 1.2 when ours is .79. That is nearly 50 percent more in terms of being able to deliver service to a patient in an urban area versus a rural area. I tell you, the cost of these high technology equipment is no different in an urban area than in a rural area.

And so we are faced with a cost squeeze that is putting health care at risk in rural areas. That is just the hard reality. And I am getting it from people who do not cry wolf. I am getting it from the most responsible health care administrators in my State, people who careful with a buck.

And in many ways, the traditional cost effectiveness of people in my State is being used against them. We certainly see it in the home health care where we are one of the lowest cost providers in the Nation. But other States that are high cost providers do not want to give up their favored position.

I would ask you what is your view of how this disparity can be dealt with and how we can preserve outside of the debate on where the money goes the basic health care network in these more rural parts of the country?

Mr. LEW. Senator Conrad, we have a number of mechanisms in current law that try to deal with it. And apparently, they do not deal with this issue as effectively as they might. This is an area that I am going to be spending more of my time looking at because I have heard enough comments to make it clear to me it is a matter of great concern to many in the Senate and the House as well. And we are concerned if in fact what we hearing is correct.

We have a disparity between national averages and what is being seen in some communities. If the programs are not adequately dealing with them, we have to look at other mechanisms, whether it is a risk factor or cost factor. I do not know that I can sit here today and give you the answer, but we have a dilemma.

If we want to save money overall in a program and we do not want the impact to be an unfair hardship in an area that deviates from the national average, we either have to figure out how to distinguish between areas that deviated from the national average or we cannot get any savings.

And our package of savings in comparison to what we did in 1993, and what we did in 1997, are actually quite modest. And the fact that we are hearing the extent of concern that we are hearing suggests that we need to go back and do a little bit more work and understand better what the differential impact is.

Senator CONRAD. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Conrad.

Senator Rockefeller.

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

Senator ROCKEFELLER. Thank you, Mr. Chairman. I just wanted to make a couple of comments. One is that I believe, Mr. Lew, that one of the reasons that there is not a full administration proposal out is because we have been waiting out in the commission which is chaired by John Breaux which Bob Kerrey and I are on. So that puts you in a little bit of a difficult situation.

I want to say to my colleagues that I worry a lot right now about Medicare. John Breaux said something very interesting a few moments ago. And I think he may be correct in what he said and that he usually is correct in what he says. And that is that the proposal which he comes forward with in the commission may indeed be attractive to the majority of this committee and indeed may be at-

tractive of the majority of this Congress. It will not attractive to this Senator. And therein lies a dilemma.

I remember the death of the ill fated Clinton health care bill. Pay Moynihan and I were waiting on the floor to have a monumental amendment debate on GME.

Senator MOYNIHAN. Graduate medical education.

Senator ROCKEFELLER. Graduate medical education. And since that time, I, of course, have moved over to his position. And I am really worried not just for the Charleston Area Medical Center, the Ruby Memorial Hospital which are the two major teaching centers in West Virginia, but for the 17 percent of all medical students I believe are medical residents in this country who practice in New York.

And most States have an academic health center. And there is not in the commission proposal so far a way to protect them. In other words, it is turned over to the appropriations process which means that you can sort of begin to say goodbye to doctors who come from other countries. The appropriation process is not kind to discrete and difficult issues like graduate medical education.

And there is all kinds of the things. I mean, the rural health center, there is the sole community hospitals, the extra bonus which is provided for doctors which practice in rural areas are left out.

And depending on who you talk to and what time you talk to them, there is always a question about where are the prescription drugs. Will it be 50-50? Will be for HMO, but not for FSS? If it is FSS, will it be the employer or the person paying the 50 percent or is there some other arrangement?

But it is not clear to me that it is there. It is not clear to me that there are benefits which people can look to. Nor is it clear to me that in 1965 that the needs in health care are the same as they will be in the year 2000 and beyond and particularly when we have this enormous 75 million Medicare recipients by the year 2025 I guess.

So I think my point to you or to my colleagues is that I think that is the importance of the using of the 15 percent. I do not think, at least it is my view, this cannot be done.

BVA, we do not know fully the implications of that. It has begun, but, heck, they have also said they do not have the money to fully implement that. So that is kind of swirling around as providers, hospitals, and physicians are extremely nervous about reimbursement levels.

So the question is, can we do, quote, not only the fiscal solvency of Medicare, but also the responsible policy for the future of appropriate medical care for seniors as it has changed from 65 until now and in the future as best as we can afford to without both doing fiscal restraints, but also dipping into money which the President has set aside which I favor?

I mean, I think his GDP estimates are reasonable. I think they are about, what, 2.3 percent, something of that sort?

Mr. LEW. In the near term. But in the long term, they have turned down a little bit as the——

Senator ROCKEFELLER. Well, that makes them more conservative.

Mr. LEW. That is right.

Senator ROCKEFELLER. I mean, so that is responsible so that I am inclined to believe that the 15 percent, the $675 billion or whatever it is is going to be there. And I do not think you can talk about prescription drugs. I do not think you can talk about sole community providers. I do not think you can talk about Max Baucus' rural hospitals.

You cannot talk about graduate medical education and making sure that we have not just the right number of specialists but the right kinds of specialists and general practitioners and people who are going out into the hard-to-serve areas in the cities and in the rural areas without both making it solvent and updating it which I think is going to require using that 15 percent.

And that was not a particularly good question, but I feel better. [Laughter]

Senator MOYNIHAN. Mr. Chairman, could I associate myself with Senator Rockefeller on the matter of graduate medical education. The commission has not resolved.

The CHAIRMAN. So recognized, Pat.

Next on the list is Senator Thompson.

OPENING STATEMENT OF HON. FRED THOMPSON, A U.S. SENATOR FROM TENNESSEE

Senator THOMPSON. I will read to you a portion of today's CBO testimony and see if there is any part of this that you disagree with:

"The administration would postpone the insolvency date of the hospital trust fund by transferring $350 billion from the general fund to the trust fund during the next decade. That bookkeeping transaction would increase the balances held in the trust fund and delay the date of insolvency, but the transfer would do nothing to address the underlying problem. Rapid growth in spending for Medicare, Social Security, and other Federal programs will outstrip total anticipated revenues. Ways must essentially be found to slow the growth in program spending which will require major restructuring of Medicare."

Is there anything in that that you disagree with?

Mr. LEW. The only thing I would take some issue with is that it does nothing to address the underlying problem because the underlying problem has two components. One is a financing component and the other is a program spending component.

Clearly, the financing solution that we have proposed does not alter the outlays for Medicare. And I agree with it in that regard. But insofar as the problem is a cash problem, there is not sufficient money to pay the benefits. And our proposal is very much a solution to the financing problem until 2020.

Senator THOMPSON. Well, I think we have a chance to answer. I think the answer to that is it addresses the problem, but not the underlying problem.

Mr. LEW. We are not disagreeing that there is a need for a long-term reform. So I do not think there is a disagreement.

Senator THOMPSON. Well, eventually, we are going to have to do something along the lines of the Breaux commission, price competition, the general approach that they seem to be taking. Is that right?

Mr. LEW. I am not ready today to say what we think the next step is. I think that there are serious questions that arise from the discussions of the Breaux commission. And we need to work together over the coming months on them.

Senator THOMPSON. Well, you know, it is obvious to everyone that looks at it that there is going to have to be structural changes. Your reform, as I understand from listening to you, constitutes or consists of actually expanding coverage, an additional $1.4 billion cost in the early retirement alone, expanding coverage, broadening it, continuing to squeeze providers assuming that surpluses will last forever.

I mean, if we make important decisions in this Congress on what we think the surpluses will be 15 or 20 years from now, you know, we all ought to be sued for malpractice. [Laughter]

Senator THOMPSON. But apparently, that is from the conversation. That is what we are doing. We are assuming in addition to that that the per capita expenditure for Medicare patients will actually go down. I think the trustees assume that it will only increase at 1 percent. And my understanding is they assume that because they assume Congress will surely do something structurally. And Congress—and the administration apparently thinks that we do not have to do anything structurally because of the rosy scenario the trustees paint.

So it looks to me like all this talk about tax cuts and how many IOUs we put into the trust fund or even additional spending is of political relevance, but it has to do very little with the underlying problem.

What we are doing is ensuring a gigantic dipping into general revenues of the future, a gigantic tax increase in the future if we by chance we happen to be a little bit off as we always are in terms of our projections, you know. When we run into a deficit, we predicted a deficit forever. Now, we are running a surplus, we are predicting surpluses forever.

But we are taking some huge chances it looks to me like if we continue on year by year by year of making peddling little changes here and there to get us by the next election when we all know that eventually that we are going to have to do something different. Is that not right?

Mr. LEW. Well, Senator Thompson, actually, I really disagree with the fundamental premise. If you were to take the idea that you just expressed and carry it to its I think logical conclusion, then the Republican plan was put out last week is very problematic. It calls for a tax cut nearly equal to the on-budget surplus. That is a much bigger risk than what we are proposing.

Senator THOMPSON. Well, not doing anything to structurally change or fundamentally change the system is the big risk. I mean, you are talking about a few dollars. We are talking in the margins here. What are you talking about a tax cut, expenses, additional IOUs into the trust fund which you propose, extending it a few more years. I mean, is that really what our obligation is to try to figure out every year how to get down, you know, another half step?

Mr. LEW. I do not disagree that we need to be taking a longer term view on reform. So I agree with the thrust of your question

that we cannot stop with the financing solution. But if one were to commit to on-budget surplus being dedicated to a tax cut, what you are doing is you are reducing the baseline. You are taking an action that would reduce the baseline.

Senator THOMPSON. I do not recall mentioning a tax cut.

Mr. LEW. No, I know you did not.

Senator THOMPSON. But if you want to talk about tax cuts, I mean, continue on.

Mr. LEW. I think that is the choice that we see this budget year, the defining decision. And that is why we have presented our budget framework the way we do. If we did nothing, then we at least would stay in a position of running a surplus. And when you get to a later year, you decide what to do with it, but we do not make anything worse in terms of spending.

Medicare expenses are all there. We are saying we should allocate the surplus to meet that. It does not add at all to the risk in terms of what the costs are.

Senator THOMPSON. The risk is that we get swamped by the demographics. Things change unexpectedly. We do not have these huge surpluses. And we have to pay all this out of the general revenue. That is the risk, but, of course, none of us will be around when that happens. Thank you, Mr. Chairman.

The CHAIRMAN. Time is moving on. And according to my recollection, we have three Senators who have not had a chance to ask questions.

Senator Nickles on our side, I believe you have not asked any?

Senator Robb and Senator Kerrey. People I know for good reason have had to come and go, but I have been going down the list. So if you were not here, you missed your earlier opportunity.

With that ruling, we call next on Senator Robb.

OPENING STATEMENT OF HON. CHARLES S. ROBB, A U.S. SENATOR FROM VIRGINIA

Senator ROBB. Thank you, Mr. Chairman. And I apologize. I have, as we all do, conflicting hearings, one of which I was ranking. And I was told I am due on the floor right now to make a speech. So I will be very brief.

Mr. Lew, I regret that I cannot offer you much relief because many of my questions were along the same line as just posed by Senator Thompson and many of my concerns.

I will say reflecting on Senator Chafee's comments earlier that he talked about pain. And one of the reasons I wanted to be on this committee and not on appropriations is because I much prefer to assist in the administration and the appropriate distribution of pain rather than providing the pleasures that might come from handing out goodies.

And with respect to Senator Conrad's question, he posed the question as how do we spend the surplus? I would like to suggest that we ought to think about when do we spend the surplus is the more relevant question. And it takes off directly on the questions from Senator Thompson about projections that may or may not materialize, but making decisions today that reflect that.

Now, let me just preface the question that I am going to ask by saying that I think the single most brilliant statement that was

made in terms of policy in the President's state of the union message not this year, but last year was to predict the surplus and then say let's save the surplus to save Social Security. It in effect was at least a rationale to keep our cotton picking hands off of a projected surplus that we would either spend or give back prematurely in tax cuts.

So I commend the fact that the President is putting 62 percent and another 15 percent into Medicare. And I commend the Breaux commission and others for working on it.

But we have been talking about saving Social Security and saving Medicare. And my question has to do with whether or not what we are doing in terms of putting dollars that are currently available mostly because of the Social Security into those accounts really does respond to the question Senator Thompson asked about structural reform. Are we really saving either one by simply scooping up some current projected savings and putting them into those accounts?

Mr. LEW. I think we are doing this. We are definitely doing this very substantially in terms of financing benefits and extending trust fund solvency.

Senator ROBB. I did not understand that and do not disagree with that. But the question is, are we——

Mr. LEW. I do not disagree with the thrust of many of the questions, but we need go beyond that. And we need to have real program reform. It is not an either-or.

I think the judgment that has lead some to criticize our proposal is the idea that we are putting out a proposal on allocating the surplus in order to stop the discussion. That is not our goal.

In the State of the Union, the President was very clear that he saw many positive reasons to go forward with Social Security——

Senator ROBB. We are looking for the immaculate conception, to use a term that has been frequently referred to in terms of how it comes together. Senator Breaux will not be able to keep his fingerprints off of the conception of whatever comes down on the Medicare. But with respect to Social Security, everybody wants the other side or the other person to go first. And I understand the politics of that particular equation.

Could we simply not postpone using the projected surplus until we have the surplus actually in hand is really the bottom line question I will ask you, both with respect to spending programs as well as with respect to tax cuts that might be desirable, if not it is also postponeable?

Mr. LEW. The effect of doing that would be basically to have the debt reduction that is in the baseline occur which would be a good thing for economic policy. However, it would not have the effect of enhancing the trust funds at all. We would argue that setting it aside for the trust funds is an appropriate first step. The difference between them, I think the difference——

Senator ROBB. I am entirely willing to pay it down, but I am saying if we put all of the money into paying down the debt at this point and used any of the programs both with respect to tax cuts, targeted or otherwise as well as additional spending to put those adds in the years when a legitimate, unified budget surplus would be available and with obvious emphasis on the need to save Medi-

care which has a shorter life expectancy than Social Security at this point?

Mr. LEW. The analytic problem is that we have the obligations now in the form of the program that is projected to spend more money than it is going to be receiving from 2008 to 2020.

What we propose is putting a financing plan against those obligations. If we were able to do both, that and address some of the structural issues at the same time, we would be in a very good policy place.

I do not personally see the benefit of deferring the judgment on putting the surplus dollars into the trust fund in large part because it has been very difficult for the last 18 months to maintain saving the surplus. At some point——

Senator ROBB. I am not arguing with that, let me say.

Mr. LEW. All right.

Senator ROBB. I am suggesting that we are taking the 15-year view and capturing one-fifteenth of it in each year in effect so that we can expedite some spending and tax cutting decisions in this year when we have not actually realized the savings that were generated.

All I am asking is could we postpone those until we have them safely in hand?

Mr. LEW. If you did, you would not end up with the kind of policy that would permit the actuaries to look ahead and expect to have trust fund solvency. So one could do it on a year-by-year basis, but one would be looking at an expiration date of the trust fund that was not changed until you made the transfer itself.

Senator ROBB. I expect we will have an opportunity to continue the conversation. Thank you, Mr. Chairman. And thank you, Mr. Lew.

The CHAIRMAN. We next have Senator Kerrey and then closing this panel will be Senator Nickles.

Senator KERREY. Jack, I presume you are going to have a very enjoyable lunch after appearing before the committee. [Laughter]

I think you have, and you and I have talked about this. But I think you have a policy conclusion that you all have reached that I am having difficulty getting you to disclose which is that you think both Social Security and Medicare should be funded with progressive taxes as opposed to payroll taxes.

You think that Congress did a good thing in 1983. I think we did not disclose it, that one of the things that we were doing in 1983 was we were committing substantial amounts of general fund of income tax money to pay Social Security beneficiaries out in the future.

I see that as a problem. You see it as a virtue. You see it as a good thing that was done in 1983. Not only do you think it is good, but you want to do even more.

And specifically, and the Social Security actuaries have said there are about $6.5 trillion worth of income taxes will have to be used in 2013 to 2032 to pay Social Security bills, to pay the monthly checks. And under your proposal according to the actuaries, over a 40-year period, it is going to be $39 trillion.

So there must be a policy belief that the President has that he wants to fund more of Social Security and of Medicare because

Medicare does the very same thing. I men, you are going to increase the amount of hospitalization bills. Today, no hospitalization are paid for with income taxes. And under the President's proposal, it will be funded both with the payroll and with an income tax.

Now, is that an underlying assumption that the President now wants to talk to the American people about?

Mr. LEW. Well, Senator Kerrey, I have tried to acknowledge over the course of today's testimony that the resources that we are putting into Medicare and Social Security are in fact going to come from general revenue. It is a little bit delayed because the actual cash from general revenue comes when the bonds are redeemed. But there is no doubt that that is the effect.

Senator KERREY. Has the President reached the conclusion that we should fund a larger share of Social Security and of Medicare with income tax?

Mr. LEW. Well, the President's proposal has precisely that effect.

Senator KERREY. No, no, no. We all understand it has that effect, Jack. The question is, has he reached that conclusion? Is he prepared to say to the American people that in 2032 when the largest generation in American history will be retired—and by the way, there is 37 million Americans today who are retired and they have a great deal of influence on Congress.

And though the President may not have intended it to be that way, I do think his message has made it more difficult to get a Social Security reform package passed and a Medicare package passed. Whether he intended that to be or not, I think the consequences of making it appear that there is an easy way to do that are that the more difficult ways are going to be a lot less attractive.

Mr. LEW. I have been trying to answer your question directly. Let me try once more.

Senator KERREY. I would disagree with that. I think you were trying to answer it indirectly. I am trying to ask you, does the President believe—this is yes or no. That is why I am frustrated with your answer.

Does the President believe that we should fund hospitalization with income taxes, that we should HI bills with income taxes? Does the President believe that we should pay more Social Security checks with income taxes, yes or no?

Mr. LEW. The reason it is difficult to say yes or no is that that is not exactly how the policy choice is presented. The President has said that we are reducing the amount that we are spending from the general fund on interest a substantial amount.

Senator KERREY. All right.

Mr. LEW. And that gives us the ability to spend the dollars that would have been spent on interest on Medicare. That is general revenue going into Medicare. We are not raising taxes. Obviously, revenues come in to the Federal Government from taxes.

Senator ROBB. Not according—according to the Social Security Administration, Jack, there will be a 1.5 percent of GDP of income taxes will be used to pay for Social Security in 2003. Now, you are not saying that is an income tax increase. I would define it as an income tax increase in terms of how Social Security is going to be funded.

That is his answer. In 2032, right now, we have a drop-off. We enough money to pay the bills. And the President's answer appears to be we are going to fund that with 1.5 percent of GDP coming from income taxes.

Mr. LEW. The reason we keep bringing the discussion back to the choices that you will have to make this year is that right now, without raising taxes, we are projecting surpluses adequate for those payments.

Senator KERREY. Jack, if Congress goes home right now and does nothing, we have reduced the debt more than your proposal.

Mr. LEW. That will be correct, yes.

Senator KERREY. That is correct. Have you read the GAO's evaluation of the President's proposal on Medicare? It is devastating. It is not——

Mr. LEW. It is——

Senator KERREY. It says if we do nothing we reduce more debt and that there is no structural reform in the President's proposal. And he does, in my judgment exactly the opposite of what we ought to be doing. He gives the baby-boomers in both Social Security and Medicare a larger claim.

This is not going to be a generation that is going to be less greedy than the current generation. This is going to be a generation with even greater demands. And if we pass the President's proposal, we give that generation a large claim on income tax, both for Medicare and Social Security.

Mr. LEW. But that generation has the claim on benefits now. And there is an implicit commitment which we are making explicit to pay for it out of the general fund.

Senator KERREY. No, sir. You say general fund. You are paying for it with income taxes. The general fund is an accounting term. We will tax people's incomes to pay for Social Security benefits and we will tax people's incomes to pay for hospitalization.

Mr. LEW. We have had this conversation before. And we obviously still disagree on how one analyzed it. I think that you are suggesting that it is a tax increase when compared to——

Senator KERREY. It is a tax increase.

Mr. LEW. No, it is not a tax increase compared to the current level of taxation.

Senator KERREY. Where do I get the money to pay the bills in 2000?

Mr. LEW. Right now, there would be a surplus. And the choices are these: do you say because there is a surplus, we will have a tax cut or do you say we are going to allocate that surplus and use it for Medicare. We think the right thing to do is to allocate it and use it for Medicare. It does not require a tax increase.

Senator KERREY. Jack, my red light is on or it is your red light, one of the two. You are not using it for Medicare. You are not using it for Social Security. You are buying an asset and you are transferring it over. Look at——

Mr. LEW. How are you going to pay that asset back?

Senator KERREY. Jack, GAO's evaluation says that you are not using it for expansion of benefits. You do not use it for benefits. You transfer an asset. In order for us to get the cash from that asset, we have to raise income taxes.

Mr. LEW. But GAO's analysis said that there is a financing solution because those bonds, those assets are going to be repaid. It is not a programmatic reform. And we are not arguing that it is a programmatic reform in the sense of changing the outlays of the program. But there is a first call on the benefits of debt reduction for Social Security and Medicare which is very real. And if we preserve the current law projections of revenue, we can pay the bills without raising taxes.

Senator KERREY. Thank you.

The CHAIRMAN. Senator Nickles.

Senator NICKLES. Mr. Chairman, I am concerned about our two witnesses because I want to hear from them and I do not know that we are going to have adequate.

The CHAIRMAN. Well, we are in process of——

Senator NICKLES. I appreciate that because I think it is very, very important.

Mr. Lew, let me just ask you a question. The President stated in his state of the union address last year, "Tonight I propose that we reserve 100 percent of the surplus, that is every penny of any surplus until we have taken all the necessary measures to strengthen the Social Security system for the 21st century." Does he still agree with that statement?

Mr. LEW. This year's budget is entirely consistent with that. He has proposed that we——

Senator NICKLES. No, for the year 2001, for the year 2002, is his budget consistent with that?

Mr. LEW. Yes, it is.

Senator NICKLES. Well, I do not think it is. I think you need to tell the truth. Maybe, we——

Mr. LEW. I can answer your question, Senator, because I can tell you why I think it is true and you may disagree, but I am happy to give you an answer as to why I think it is true.

Senator NICKLES. Well, let me just ask you, are you not you taking a lot of the Social Security surplus next year and spending it?

Mr. LEW. The quote you just read me had nothing to do with on-budget, off-budget surpluses. It had to do with Social Security reform.

Senator NICKLES. Social Security surplus. And is it not correct, and give me a correct answer, does not the President in the year 2001, the year 2002, does he not take some of the Social Security surplus and spend it?

Mr. LEW. The President's commitment last year was that we should fix Social Security first. That is what he said in the state of the union. The quote you read me says that before we spend the surplus, we should fix Social Security. He never said last year what percentage of the surplus should go to Social Security. And frankly——

Senator NICKLES. I am talking about the Social Security surplus.

Mr. LEW. No, that was—but I am not responding to your question about his statement last year versus his statement this year. You can ask me whether our policy was right or wrong last year, but they are entirely consistent.

Senator KERREY. Let me just give you your facts. In your budget, page 389, it says in the year 2001, the Social Security surplus, and

these are your figures, is $134 billion. It says the on-budget surplus is zero. And so the united budget surplus is 134. But yet, in your budget, you propose transferring $20 billion to Medicare. That is taking money out of Social Security.

You propose new spending initiatives of $26 billion. You have the universal savings account of $16 billion. So you were spending a total of $62 billion of that Social Security surplus because we do not have a united budget, on-budget surplus. You are taking money out of Social Security next year in your budget to spend on a lot of things. And that is totally inconsistent with what the President said in the state of the union message.

Mr. LEW. I do not believe that is a correct description of our budget. And I would be happy to——

Senator NICKLES. Well, it is on page 389. You ought to look it up.

Mr. LEW. I can tell you what the budget stands for, Senator Nickles. I can tell you what the policy is.

Senator NICKLES. Now, what you have done is say you have moved.

And I disagree with this, Mr. Chairman, strongly. They have come up with a new concept, well, over 15 years. And over 15 years, we are going to do such and such which is total hog wash. We pass—we are lucky if we do 2-year budgets I mean, frankly. And there is significant discussion if we are going to change 1997 budget.

And yet, you come up with this 15-year hog wash. And let me just go back to the year 2001 because I have stated in the Budget Committee you are double counting and I want to prove it. You have a Social Security surplus of 134. And then, you say, well, we are going to transfer back to Social Security 70, but you are already crediting. Correct me if I am wrong. You've credited the Social Security trust fund with that $134 billion as excess payroll tax and interest over expenditures. So you credit that to the Social Security trust fund and you add back another $70 billion in that year. Isn't that correct? It is on the same page.

Mr. LEW. Yes, that is correct.

Senator NICKLES. All right. So in 1 year, this shows you, Mr. Chairman, how the smoking mirrors of your shop—and you ought to be ashamed. Do not give me that disgusted look. I am the one who is disgusted.

Here is what you are doing. In the year 2001, Social Security has a surplus according to you of $134 billion and you credit the Social Security trust fund with $204 billion and are taking credit we saved Social Security when what you are doing is double counting. There is only a $134 billion surplus according to your figures total. Non-Social Security is zero. You credit the Social Security trust fund in that same year $204 billion and say, see, we saved Social Security when that extra 70 is just—where did it come from?

So you are double counting. And then, you spend 50 some billion dollars. You raid the Social Security trust fund in the early years and then you give it extra accounting and say, well, we catch up in the out years.

But this President is going to be President for a year and a half. And he is trying to raid the Social Security trust fund to spend a lot more money.

Let me ask you a couple of questions. The President stated in his state of the union address that he wanted prescription drugs. Is that in your budget?

Mr. LEW. The President stated in the State of the Union address that when we go forward with bipartisan Medicare discussions, one of the issues should be how we can spend for prescription drugs.

Senator NICKLES. Is it in your budget now?

Mr. LEW. It is not in the budget. It was not in the State of the Union as if it were in the budget. He did not say it was in the budget.

Senator NICKLES. You also proposed USA accounts. And you said here that that was a 12-percent tax cut or something. Are the USA accounts in your budget?

Mr. LEW. The budget describes the impact of USA accounts in the context of the allocation of the surplus, the discussion——

Senator NICKLES. I do not see a description.

Mr. LEW. Well, Senator, you know, you have not given me a chance to answer any of your questions. And there actually is an answer to almost all of your questions. It is the same answer. And I would be delighted at any time to give it.

Senator NICKLES. USA accounts, are those refundable tax credits?

Mr. LEW. Can I answer your first question first?

Senator NICKLES. No. Answer my last question. Are USA accounts refundable tax credits?

Mr. LEW. We will be presenting a detailed USA account proposal when it is completed.

Senator NICKLES. But you have not done so?

Mr. LEW. We will present it when it is completed.

Senator NICKLES. In other words, you have not done so. So the tax cuts you are talking about—and I saw a tax cuts. And I will close with this. But you have tax increases over and above the present amount I just mentioned because the Finance Committee is going have to wrestle with this. You have tax increases of 100—well, I like 5-year budgets, $79.9 billion.

And then, you use tax credits which I think are for the most spending of another $29.9 billion. And so you have that, but I do not have USA accounts. And as soon as you give me those figures, I will be happy to plug those in.

Mr. LEW. Senator, I will be delighted to respond to all of the questions whenever I am given the opportunity.

Senator NICKLES. All right. Thank you.

The CHAIRMAN. Do you want to make any further comment?

Mr. LEW. Mr. Chairman, if I may. I actually feel it is rather unfair to mischaracterize the President's budget. I believe that was not a correct characterization of the President's budget. I would be delighted to testify at length on the details of the President's budget in every regard. I have done it before every committee of Congress with the jurisdiction.

The President said last year in the state of union that his proposal was to save the surplus until we fix Social Security first. He

quite deliberately did not say that he wanted to put all the surplus into Social Security. And in fact, the criticisms that I have heard from members of this committee would only be more so if he put more of the surplus into Social Security.

Senator NICKLES. How do you justify—next year, the Social Security surplus is 134. How do you justify crediting Social Security with 204 and then spending another 50?

Mr. LEW. Senator, I cannot answer 15 questions at once. I am delighted——

Senator NICKLES. Just answer that one.

Mr. LEW. Well, I am getting nowhere trying to answer any of your questions because you are not letting me finish the answer.

Senator NICKLES. All right. Finish this one. How do you credit Social Security with $204 billion when only—when the surplus next year is 134?

Mr. LEW. I would be happy to describe how we have been using unified surpluses since the unified surplus has been in effect to have the consequence of producing a surplus on the unified budget after the initial bond is put in the Social Security trust fund.

In the past, those dollars have been spent. They have been spent on appropriations, on tax cuts, and other things. We said rather than spend them, we should make a commitment of an additional bond to the Social Security trust funds which is a full faith and credit obligation to be paid in the future. That is fiscally more prudent than spending the money today which is what Congress has done every time there has been a unified surplus.

Senator NICKLES. So you leave the regular 134 in. We credit that to Social Security. And then, you come with this immaculate conception $70 billion.

Mr. LEW. It is a very real transaction.

Senator NICKLES. Wait a minute. No, 100 percent of this is Social Security. We do not have an on-budget surplus. You only have a Social Security surplus next year.

Mr. LEW. Social Security does not need the cash this year. The reason there is a surplus is that the outlays are less than the receipts. The way Social Security keeps a trust fund balance is in the form of Treasury bonds.

What we are saying is the effect of the Treasury bonds has been to create a unified surplus. That unified surplus in the past has been spent, but it has not gone back into additional resources for Social Security. The President has proposed that we put additional resources into Social Security.

Senator NICKLES. So you transformed this $134 billion surplus into a credit for increasing the Social Security trust fund by $204 billion even though the surplus is only 134?

Mr. LEW. You know, Senator, you cannot have it both ways. I mean——

Senator NICKLES. Aren't I correct?

Mr. LEW. We are increasing the surplus, yes. We are definitely increasing. We are increasing the trust fund balance, but——

Senator NICKLES. By 200?

Mr. LEW. Depending on what period of time.

Senator NICKLES. It is a 134 next year, the year 2001. Is that not correct?

Mr. LEW. I do not remember the year-to-year numbers. I would have to check.

Senator NICKLES. Well, next year, let us worry about next year. Next year, you have Social Security surplus of $134 billion. You have a zero surplus other than that according to you figures. And you——

Mr. LEW. Well, I think the mistake in the way you are doing the arithmetic is the trust fund has, regardless of whether we do anything, it has the amount that is in there, the 134 that you describing. It is only the additional increment that requires action.

The CHAIRMAN. The time has come I think that we have to move on. We are not going to solve this today. You will be glad to know, Mr. Lew, there is not going to be a second round of questions.

Mr. LEW. I would be delighted to take any questions. I just get frustrated when I cannot answer them.

The CHAIRMAN. It is just answering them you have trouble with. Typing them, you have no trouble with.

Senator GRAMM. Mr. Chairman, could I make a 30-second statement?

The CHAIRMAN. Yes, but let me——

Senator GRAMM. All right.

The CHAIRMAN. Mr. Lew, we appreciate your being here. Let me emphasize once again, we want to proceed in a bipartisan way. And we want the White House to be part of that approach. And if we are going to do anything constructive this year, I think it is critically important that that be the case and not to turn this into a political debate.

Because of the lateness of the hour, I am going to postpone the next two speakers because I think the full panel, the full committee wants to be here to hear their discussion. We apologize to Dr. Crippen and to Comptroller General Mr. Walker, but we will have that next session with them on Thursday, March 18, 1999, 10:00 a.m. At least that is the tentative date.

And thank you, Mr. Lew, for being here today.

And I apologize again to you gentlemen, but I think in fairness as to the importance of what you have to say, we should save that for another day.

Senator GRAMM. Mr. Chairman.

The CHAIRMAN. Senator Gramm.

Senator GRAMM. Mr. Chairman, I just want to say I have sat in a lot of hearings in the 20 years I have been in Congress, but I have never heard a more deceptive witness in my 20 years in Congress. And it seems to me that one of the things that is clear is that the President's basic approach to refusing to give a straight answer is increasingly spilling over to people that are engaged in policy debate.

And I think this presentation was an insult to this committee. I think it was an insult to our intellect. And I think that we ought to let people know about it.

The CHAIRMAN. With that, we will call the session to a close. The committee is in recess.

[The charts prepared by Mr. Lew appear in the appendix.]

[Whereupon, at 12:25 p.m., the hearing was recessed.]

FINANCIAL STATUS OF MEDICARE

THURSDAY, MARCH 18, 1999

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

The hearing was convened, pursuant to notice, at 10:10 a.m., in room SD–215, Dirksen Senate Office Building, Hon. William V. Roth, Jr. (chairman of the committee) presiding.

Also present: Senators Grassley, Gramm, Mack, Thompson, Moynihan, Breaux, Graham, Bryan, and Robb.

OPENING STATEMENT OF HON. WILLIAM V. ROTH, JR., A U.S. SENATOR FROM DELAWARE, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will please come to order. We are very happy to welcome Mr. Crippen and Mr. Walker, two distinguished gentlemen. I apologize for the delay and appreciate your willingness to adjust your schedule to be here with us today.

We are here to consider the arcane, but important, matters of Medicare spending trends, baselines, and solvencies. Frankly, these issues have created some very real challenges for the program.

There is no easy answer to these challenges. To address them, I believe we have to put politics aside and roll up our sleeves together. A bipartisan Coalition of 10, and Senator Breaux's Medicare Commission, has given us a good start. Let me once more congratulate the chairman for his leadership.

I intend for this committee to hold hearings and mark up legislation based on their good work. So, again, let me welcome Dr. Crippen, the Director of the Congressional Budget Office, and Mr. David Walker, the Comptroller General of the United States.

Senator Moynihan?

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

Senator MOYNIHAN. Yes, indeed. And to thank them for their patience in coming back, and to restate your congratulations to Chairman Breaux. I have to say to you, sir, in a manner of some trepidation to me, that the editorial page of The Wall Street Journal this morning says, "Republicans should endorse Breaux's Medicare plan."

The CHAIRMAN. That is true bipartisanship. With that, I think we will proceed with our two witnesses.

Dan, do you want to start out?

STATEMENT OF HON. DAN L. CRIPPEN, DIRECTOR, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC

Mr. CRIPPEN. Thank you, Mr. Chairman. I think, since this is my first appearance before this committee, I need to say a couple of things in the interest of full disclosure.

First, and most important, is that I feel quite at home here. Most of you I have known for some time. I remember that you were selling St. Bernard pups, as I recall, when I first met you. I have worked with Senator Moynihan's colleagues—Howard Baker and Dick Nathan—when I started in Washington. I also shared that experience with Senator Thompson.

But, probably more to the point of any bias that I might have, I grew up north of Senators Kerrey and Grassley, east of Senator Baucus, and south of Senator Conrad, which, of course, puts me in the home state of the Democratic Leader.

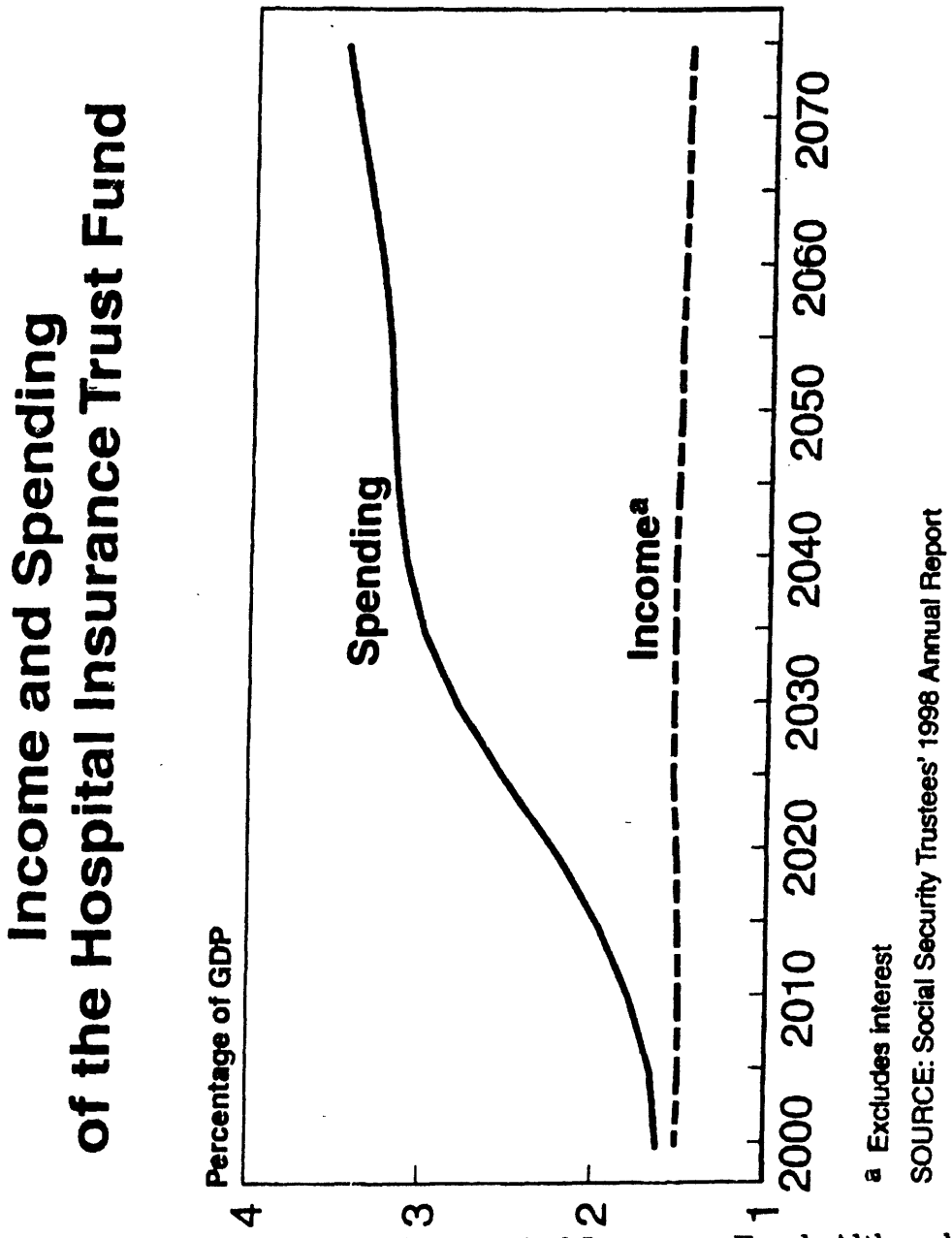
Given the diversity of views those folks represent, you would not be surprised to know that that is why I decided to study economics, because as a profession it lets me say, on the one hand, and then on the other hand. Having grown up in South Dakota may give me some views that are comfortable, too, in this committee.

Mr. Chairman, Senator Moynihan, members of the committee, I am pleased to be here today to discuss the financial status of Medicare.

This year, Medicare will pay for the health care of some 39 million elderly and disabled people at a cost of $216 billion, or about 13 percent of total federal outlays. Despite its high cost, Medicare's benefits are not as generous as those of most private health insurance plans. The program does not cover outpatient prescription drugs, routine physical exams, or dental care, nor does it cap the amount the beneficiaries pay out of pocket.

This first chart, Mr. Chairman, is reproduced from the Medicare trustees' 1998 report.

[The chart referred to follows:]



It deals only with Part A, the Hospital Insurance Fund. Although we are expecting this year's report soon, the underlying trends will certainly not be much different. The Balanced Budget Act of 1997 will push the spending line out a bit, but the conclusion will be the same: Spending will outstrip payroll taxes by ever-increasing amounts.

Medicare spending has grown substantially faster than the economy since the program was created in 1965. The primary factor driving recent spending growth has been the rise in costs per beneficiary; the eligible population has expanded only slowly. But, with the looming retirement of the baby-boom generation, Medicare faces a major demographic challenge that will add significantly to the expenditures. Even if spending per enrollee somehow sta-

bilized, Medicare outlays would still rise sharply after 2010. Without significant restructuring, therefore, the program is unlikely to achieve financial stability in the long term.

The patterns of growth for Medicare and private-sector health spending diverged in the 1990's after both types of spending had grown at double-digit rates in the 1980's. Private health insurance spending increased by less than 4 percent a year between 1993 and 1997, while Medicare spending continued to rise at an annual rate of almost 9 percent.

The growth of Medicare spending slowed sharply in 1998, however. Total outlays rose only 1.5 percent in 1998, and growth continues to be extremely slow in 1999. Part of that slowdown was anticipated; the Balanced Budget Act (BBA)lowered the projected growth of Medicare spending by 4 percentage points in 1998. The act reduced payment rates for many services and restrained the update factors for payments through 2002. Both fee-for-service providers and Medicare+Choice plans are experiencing lower payment increases as a result.

But actual spending growth has fallen considerably lower than the BBA provisions alone were expected to produce. Two other factors appear to have contributed to this sudden flattening of Medicare expenditures.

First, widely publicized efforts to clamp down on fraud and abuse in the program have resulted in greater compliance by providers with Medicare's payment rules.

Second, the average time for processing Medicare claims rose dramatically in 1998. Expanded compliance activities combined with major efforts to prepare computer systems for the year 2000 contributed to longer payment lags, which can have a substantial effect on Medicare outlays. For example, an increase of one week in the average time for processing claims reduces Medicare outlays for the fiscal year by 2.3 percent. But that reduction is only a temporary payment shift.

Until we have further evidence, CBO assumes that those factors are both short-term phenomena that will have little or no effect on Medicare spending in the longer run.

Much of the increase over the next few years still reflects rising expenditures per enrollee. Enrollment itself will expand only modestly as the last of the baby-bust generation reaches 65.

Medicare spending will grow substantially faster in the decades after 2009 as the baby boomers retire. Between 2010 and 2030, the elderly population will grow at a rate three times faster than between 2000 and 2010.

The Balanced Budget Act established the Medicare+Choice program to expand the range of health plans from which beneficiaries would choose and to lay the foundation for a more competitive Medicare system that will give the elderly more choices.

The BBA also sought to constrain the growth of per capita spending in Medicare's risk sector and to reallocate payments from markets with high payment rates to those with lower rates. In addition, subsidies for medical education were carved out of the payments that risk plans receive. The act also required the Health Care Financing Administration (HCFA) to establish a mechanism for adjusting payments to plans to account for variations in costs

associated with differences in the health status of the people they enrolled.

Mr. Chairman, I encourage you and the committee to examine in some detail the entirety of Medicare payments. In many ways, the BBA created a structure to allow more options for the elderly, but it may not have created a payment system that allows people to exercise those options.

Further, the transition to Medicare+Choice system is proving to be quite rocky. Most plans have received an update of only 2 percent—the minimum increase specified in the BBA—for the past 2 years. Moreover, HCFA's "megareg," which was issued in June 1998, said plans were required to inform HCFA of the additional benefits they would offer and the premiums they would charge in 1999.

Many plans reevaluated their Medicare participation in light of disappointing pay increases, new regulations, and a general retrenchment in the managed care industry because of rising cost pressures. Some plans dropped out of Medicare entirely in 1999. As the committee is well aware, others cut back the markets they served, and few new plans applied to participate. Additional plans are threatening to leave Medicare in 2000, especially if the phase-in of the new risk-adjustment system begins in 2000 as scheduled.

I should note here, Mr. Chairman, as you recall, that the Finance Committee endorsed a system of risk adjusters that were essentially neutral for average payments. HCFA's proposal to implement the BBA conference report will dramatically reduce the average payment by at least 7 percent and according to the Administration's estimates in its baseline, by perhaps as much as 15 percent.

I turn now, Mr. Chairman, to the proposals in the President's budget on Medicare. The President's budget for fiscal year 2000 includes provisions to expand Medicare coverage to new populations and curb spending in the fee-for-service sector. In addition, the President proposes to use a transfer from the general fund to shore up the Hospital Insurance (Part A) Trust Fund.

The President's proposal to allow certain people younger than 65 to buy into the Medicare program are similar to proposals that were in his 1999 budget. An additional proposal this year is to expand the coverage for the disabled. It would use funding from both Medicare and Medicaid to finance the program.

Because these proposals, especially the first two, were included in last year's budget as well, I will not dwell on them today. A more complete description is included my submitted statement. CBO estimates the total budgetary impact of these proposals to be $5 billion in additional spending between 2000 and 2009.

The President is also proposing a variety of program changes to reduce fee-for-service spending. The most significant savings would come from direct reductions in payments for certain services. Additional savings would come from measures to improve compliance with Medicare's payment rules and to give hospitals greater incentives to operate efficiently.

Taken together, the proposals would lower fee-for-service spending by about $10 billion through 2004 and $21 billion through 2009. Because spending growth in Medicare+Choice plans is linked to spending growth in the fee-for-service sector, the reductions in

fee-for-service spending would also lower Medicare+Choice spending by about another $6.5 billion through 2009. Some of those savings would be offset by lower Part B premiums for enrollees.

In total, Mr. Chairman, the President's proposed savings exceed the proposed expansions by $20 billion over 10 years. The President proposes to spend those savings, however, not on Medicare but on discretionary and other mandatory programs.

Finally, Mr. Chairman, unlike most employer-sponsored health plans, Medicare does not provide coverage for prescription drugs taken on an outpatient basis. Prescription drugs are the fastest-growing component of health care expenditures. The President supported the concept of a prescription drug benefit for Medicare in his State of the Union message, although that proposal was not formally included in the budget. We therefore cannot score it.

The President also proposes to augment Medicare's financing by transferring money from the general fund to Medicare's trust fund for Hospital Insurance. Currently, Medicare spending comes from two trust funds: the Hospital Insurance (HI) Trust Fund, which pays for Part A, and the Supplementary Medical Insurance (SMI) Trust Fund, which pays for Part B. The HI trust fund relies primarily on payroll taxes, which account for 88 percent of its receipts. By contrast, about 75 percent of SMI receipts are transfers from the general fund, with premiums from beneficiaries accounting for the other 25 percent.

As we saw in the first chart, HI outlays are growing faster than income, and CBO currently projects that outlays will exceed income by 2007. (If interest payments are excluded, outlays already exceed income). Payroll taxes now are not enough to make the payments. The trust fund will become insolvent sometime after 2010. Our baseline only goes to 2010. The trustees' report, which you will get in the next week or two, will extend the insolvency date.

The Administration would postpone the insolvency date for the HI trust fund by transferring $350 billion from the general fund to the trust fund in the next decade. That bookkeeping transaction would increase the balances held in the trust fund and delay the date of insolvency. But the transfer would do nothing to address the underlying problem: rapid growth in spending for Medicare, Social Security, and other Federal programs will cause outlays to outstrip total anticipated revenues. Ways must eventually be found to slow the growth in program spending, which will require major restructuring of Medicare.

This second chart, Mr. Chairman, attempts to address one of the issues that you and your colleagues raised last week about the impact of that transfer—mainly the effect of the President's budget on how much of the surplus is actually saved. We compared the estimates of the 10-year surpluses with and without the President's budget.

[The chart referred to follows:]

HOW MUCH OF THE SURPLUS IS SAVED? (2000-2009)

	OMB		CBO	
	Billions of Dollars	Percent	Billions of Dollars	Percent
1) Baseline Surplus	2,409	100	2,603	100
2) President's Budget Surplus	1,401	58	1,435	55
3) President's Budget Surplus Adjusted for Social Security Equities	1,681	70	1,715	66
4) Baseline Social Security Surplus	1,658	n.a.	1,777	n.a.
5) Baseline Social Security Plus Medicare Surplus	*	n.a.	1,807	n.a.

NOTES: n.a. = not applicable, * = not available

The difference between those numbers should equal how much of the surplus the President proposes to save.

If all of it was saved, for example, line two would be identical to line one. Obviously, it is not. According to the Office of Management and Budget's (OMB's) numbers, the President proposes to save 58 percent. Using our estimates, the amount is 55 percent.

The third line on this chart, Mr. Chairman, includes the amount of equities the President proposes to buy, because those equities could represent additional saving, depending on the source of the financing. Although our numbers and OMB's are slightly different,

it appears that even if you add in the equity purchases, the total saved is about equal to the baseline Social Security surpluses over the period. Compare line three with line four on this chart. The very last line suggests that the small, $30 billion Medicare surplus under current law is not saved at all. In addition, it would appear that none of the 15 percent that has been discussed is saved.

Despite the recent slowdown in spending, Medicare outlays will grow substantially faster than the economy in the foreseeable future. The program will continue to place financial pressures on the Federal budget in the near term. Those pressures will intensify over the next decade and beyond as the baby boomers begin to qualify for Medicare and as health care costs per beneficiary rise.

The Medicare proposals included in the President's budget would do little to ameliorate those problems and could ultimately make them worse. Ensuring the long-term financial stability of the program would require taking additional steps.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you Mr. Crippen.

Now it is a pleasure to call on our Comptroller General. Mr. Walker.

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

STATEMENT OF HON. DAVID M. WALKER, COMPTROLLER GENERAL OF THE U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON DC

Mr. WALKER. Thank you, Mr. Chairman, and Senators. It is a pleasure to reappear before this committee to discuss the President's recent proposal for addressing Medicare and the use of projected surpluses over the next 15 years.

As you know, Mr. Chairman, I was originally scheduled to testify on March 10th, and, while I did not testify, I did submit that testimony for the record. I would like it to be resubmitted as it was initially submitted.

It has been extensively quoted, but, in addition to that, there have been significant subsequent events and, as a result, I have a one-page appendix supplement to that statement that I would like to have incorporated into the record, Mr. Chairman.

The CHAIRMAN. Without objection.

[The prepared appendix supplement appears in the appendix.]

Mr. WALKER. Thank you.

Today I will summarize our views regarding the overall fiscal consequences of the President's initial proposal, discuss what it does and does not do for the Medicare program, and examine the importance of, and the difficulty in, making fundamental changes to this important, yet complex program.

Regarding the President's initial proposal, I'll get right to the bottom line with regard to our observations.

Specifically, the President's initial proposal would, first, significantly reduce debt held by the public from current levels, thereby reducing net interest costs, raising national savings and contributing to future economic growth. This element of the President's proposal will have positive short- and long-term effects on the economy.

The proposal would provide a grant, or in the President's own words, a gift- of a new set of Treasury securities for the Medical Hospital Insurance, or HI program, which would extend the life of the HI trust fund from 2008 to 2020.

It is important to note, however, that these new Treasury securities, would constitute a new unearned claim on the general funds for the HI program, a marked break from the payroll tax based financing structure of the program. This would be a significant change that could serve to undermine the remaining fiscal discipline associated with the self-financing trust concept.

The initial proposal would have no effect on the current and projected cash flow deficits that have faced the HI program since 1992. Deficits to the taxpayers will continue to finance through higher taxes, lower spending elsewhere, or higher public borrowing.

Importantly, the President's initial proposal would not provide any new cash or hard assets, such as marketable securities, to pay for medical services. It would not include any meaningful program reform that would slow the spending growth in the HI program.

In fact, the transfer of these new Treasury securities to the HI program, could serve to reduce the sense of urgency for reform. At the same time, it could strengthen pressure to expand Medicare benefits in a program that is fundamentally unsustainable in its present form.

Let me restate that. The current Medicare program is both economically and fiscally unsustainable in its present form. This is not a new message. The Medicare trustees noted in the 1990's, the early 1990's, that the program was unsustainable in its present form.

As you know, Mr. Chairman, I was a trustee of Social Security and Medicare from 1990 to 1995. I was one of those trustees, but you have the Secretary of Treasury, Labor, HHS, now the Social Security commissioner and two public trustees, who joined in that statement. They also noted the need for dramatic and fundamental reform in the program to ensure its solvency.

With regard to Medicare, the program's continued growth threatens to crowd out other spending and economic activity of value to our society. Even if we save the entire unified budget surplus, Medicare is expected to more than double its share of the economy by 2050.

Meaningful reform of this program is urgently needed and such reform would require hard choices. The program changes enacted in 1997 illustrate how difficult even incremental reform could be to adopt.

These major changes and other major changes require reshaping the Nation's perspective on health care consumption and drawing distinctions between what the Nation wants, needs, and can afford, both at a national and individual level.

To be effective and sustainable, reforms must begin soon and be comprehensive in nature. However, the history of entitlement reforms tells us to be enduring. Such reforms must be introduced gradually after widespread public education in order to garner sufficient support from the system's multiple stakeholders.

Mr. Chairman, let me now try to summarize the President's proposal, and I have a few charts that I will put up in a minute.

To go back to the President's proposal, with regard to debt reduction, the President's initial Medicare proposal would enhance the Nation's future economic capacity by significantly reducing debt held by the public from the current 44 percent of GDP to 7 percent, over a 15-year period.

Our latest simulations that have been done for the Senate Budget Committee are demonstrated here on the first chart. It will demonstrate, for example, that if you look at the dotted line which is on-budget balance, that with the on-budget balance, as well with saving the surplus, that's the unified surplus, during the period of time that it would occur, that per capita GDP in constant dollars, or stated differently, the standard of living for Americans, will continue to improve throughout the period 1998 to 2050.

However, if the surplus is not saved, if the surplus is spent, then the standard of living for Americans would start to decline in about 2013. About that time you would experience negative cash flow for Social Security, and will gradually decline at an accelerated rate beginning at about 2038.

Next, I would like to show the proposed impact of the President's proposed transfer to the Medicare program. The mechanics of this proposal are like his Social Security proposal, complex and somewhat difficult to follow. In form, they are similar. However, importantly, in Medicare, they would be somewhat different.

Unlike Social Security, Medicare's HI program has been experiencing a cash flow deficit annually since 1992. As we know, Social Security has been having a positive cash flow, and is expected to continue until 2013.

However, for the HI program of Medicare, it has already been experiencing a negative cash flow since 1992. And, as a result, if you look at the schematic here, the circle around the entire schematic represents the unified budget.

On the left-hand side represents the budget account, known as the HI trust fund. It is really a budget account. The right-hand side represents all the other accounts in the Federal budget.

Now, obviously, we have Social Security, which I depicted at the last hearing. What happens is, unlike Social Security, when you have excess cash going into the HI trust fund and securities coming back, for HI, on the top, in between the HI fund and general fund, you will see claims for interest earned on past surpluses.

They are submitting Treasury securities to the Treasury every year and getting cash back in order to pay benefits and be able to create additional Treasury securities for interest on past debts.

If we can show the next one. What the President is proposing is exactly the same, with one exception. That is, he proposes to take 15 percent of the unified budget surplus over the next 15-year period, and to transfer that to grant that, or in his own words, to gift that to the HI trust fund, which, again, represent future claims on future taxpayers.

It is not cash, it is not hard assets, to transfer that to the HI trust fund in the future, and that is what would end up extending the trust fund solvency to 2020.

However, it is important to understand the financial consequences of the transfer. It is important to know that, while the trust fund solvency would be extended from 2008 to 2020, the

President's initial proposal would do nothing to alter the cash flow position of the HI trust fund.

It has been in a deficit since 1992, and it remains in a cash deficit, and would remain so, even with the new Treasury securities. Thus, the President proposes to provide additional claims on the Treasury, not additional cash or hard assets to pay benefits.

Let me show you, Mr. Chairman and Senators, if you look at the bar graph, that represents the positive annual cash flows in the HI program. You will see that it turned negative in 1992, and you will see that those annual cash flows are projected to accelerate and to turn increasingly negative as we move forward.

If you look at the solid line, that will show you the projected trust fund balance in the HI trust fund and you will see that, under current law, it is supposed to be exhausted in about 2008. And you will see that, under the President's proposal, which is the dotted line, it would be exhausted in 2020.

Now, while the trust fund is extended, the underlying cash flows do not change at all and, therefore, the fundamental imbalance between program revenues under the existing financing model does not change.

The transfer would constitute an explicit general fund subsidy for the HI program, a subsidy whose magnitude is unprecedented for this program. This is a major change in the underlying theoretical design of the HI program.

In our view, the proposal carries some risk that should be carefully considered by the Congress. One of the risks is that the transfers to both the Medicare and Social Security trust funds would be made regardless of whether the expected budget surpluses are actually realized.

The way that it is being proposed, it is a flat dollar amount, not a percentage of the actual budget surplus. Therefore, these transfers could occur even though the budget surpluses may or may not materialize. And, as Dan Crippen knows, and his predecessors, projections sometimes do not prove to be reliable.

Of more significant potential risk of the initial proposal is that it would extend the trust fund solvency, but it could very well under-cut incentives to engage in meaningful and fundamental reform of the HI program, reforms that are vital to assuring sustainability of the HI program over the long term.

Absent any changes, the combined Medicare program, HI and SMI, Part A and Part B, are projected to more than double their share of the economy by 2050, from 2.5 percent now to 6.7 percent based upon the Medicare trustees' most recent best-estimate assumptions.

When coupled with Medicaid and other Federal health care costs, they will grow to over 10 percent of GDP by 2050, as depicted by this chart. Now, this does not cover other aspects of health care with regard to the private sector, and also individual personal consumption of health care.

This is part of the macroeconomic problem, is the mushrooming cost of health care and the ever-increasing percentage of our economy that it is projected to consume, absent meaningful fundamental structural reform. When viewed together with Social Secu-

rity, the financial burden of Medicare on the future economy takes on daunting proportions.

As this next chart shows, the cost of these programs combined would nearly double as a share of the payroll tax base over the long term. Assuming no other changes, these programs would constitute an unimaginable drain on the earnings of future workers.

This does not even include the financing challenges associated with the SMI program. This is a projected increase in the payroll tax rate for OASDI and HI alone. Absent meaningful program reform and absent other infusions of revenue—and, in fairness, the President is proposing general fund financing for Social Security and Medicare. That, in substance, is what he is proposing. That is a major policy issue which the Congress has to debate, but that, in substance, is what he is proposing.

Next, please. I think it is important to note that, from a macro perspective, what might happen here. If you look at the composition of Federal spending as a share of Gross Domestic Product under a save-the-surplus scenario, you will see that the bottom darkest is Social Security, the next level is Medicare and Medicaid, the next level is interest, and the top level, in white, is all other spending.

You will see that right now we have a small surplus, a small unified surplus. In 1998, we paid down $50 billion in debt held by the public in 1998.

You will see that if we save the surplus, and this is the unified surplus, that we have to haircut all other spending starting in 2030. And significantly haircut by 2050. Now it is important to note that——

Senator GRAMM. Scalping in 2050.

Mr. WALKER. Scalping in 2050. Senator, some of us have already been scalped. But the fact of the matter is that discretionary spending includes things like national defense, law enforcement, programs for children, the things that, clearly from a practical standpoint, are not acceptable.

Next please. And if we do not save the unified budget surplus, the picture is even more bleak. By the year 2030, the scalping occurs, Senator Gramm. And by the year 2050, we do not have enough money, under the current tax structure, to cover just Social Security and Medicare and Medicaid. These are the long-term challenges that we face, that we must come to grips with while we still have time and opportunity to do so.

While these financial questions loom, pressure is mounting to update Medicare's outdated benefit design. However, doing so carries with it the potential to exacerbate Medicare's spending trajectory and fiscal imbalance.

The kinds of reforms needed to put Medicare on a more sustainable footing for the future will require hard choices. Senator Breaux knows this. Senator Gramm and Senator Kerrey are on the commission with him.

Real changes in providers' income and services to beneficiaries will undoubtedly be necessary. Substantive reform, not simply financing shifts from funds within the budget, which have been all too frequent in the past and which only serve to delay the inevi-

table day of reckoning, will be required in order to effectively address this daunting challenge.

Mr. Chairman, I think it is important to note some of the subsequent events that have occurred since my initial statement. Just in the past week, several significant events have occurred that have an important bearing on Medicare reform.

The National Bipartisan Commission on the Future of Medicare has concluded its deliberations, and the President, on March 16, announced his intention to draft a substantive Medicare reform plan for submission to the Congress.

We are heartened by what seems to be an emerging consensus that substantive, programmatic, reform, are necessary to put the Medicare HI program on a sustainable footing.

As my full statement points out, the President's proposed transfer of new securities to the HI trust fund constitutes a significant financing change by pledging new general revenue funding for the program in the future.

However, the President's original proposal for the HI program did not include any meaningful program reforms, reforms which are vital to reducing the program's growth rates that threaten to absorb increasing shares of budgetary and economic resources.

Extending the solvency of the HI trust fund should be coupled with real programmatic reforms to strengthen the programs underlying sustainability. The debate on these issues has already begun, with the important work just completed by the National Bipartisan Commission on the Future of Medicare. The commission's work, indeed could be a starting point for the development of a package of programmatic reforms.

We should not kid ourselves: reforms will call for hard choices. Congress may want to consider providing new revenues as part of a comprehensive solution, but it may wish to consider making any new financing contingent upon substantive program reforms.

Stated differently, when I was growing up in the south, my mamma used to tell me that I had to eat my spinach before I could have my dessert. And I think that is one of the questions that we face: do we do it together, or do you do it in installments?

And, realistically, I think it is fair to say that the magnitude of the Medicare problem is much greater than Social Security. It is going to be much more difficult to deal with.

And, while one can probably craft, and should craft arguably, a solution to Social Security that would make it solvent and sustainable for 75 years and beyond, we are probably going to have to deal with Medicare in installments.

But it is important to recognize that programmatic reform needs to be an important part of that in order to not only extend solvency, but, importantly, to ensure sustainability of the program for future generations.

The Nation stands at an historic crossroad. The temporary budget surpluses present an historic opportunity to strengthen the long-term economy and the Federal budget for the challenges associated with our aging society.

Saving a good portion of today's surpluses through such actions as debt reduction can help future generations better afford the ballooning costs of future commitments, but we must also reform pro-

grams such as Medicare to make them more sustainable and affordable over the longer term.

We at the GAO, Mr. Chairman and Senators, stand ready to help the Congress develop effective, equitable and affordable approaches to Medicare reform.

Thank you, Mr. Chairman.

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

The CHAIRMAN. Thank you, Mr. Walker. I have to say, it is not a very happy picture that either one of you paint for us today. I am not sure whether I am happy I invited you back or not. [Laughter]

But, seriously, I thank you for your candidness and frankness. It underscores the critical nature, the importance of addressing the problem now, and doing it in a bipartisan way. That is the only way we are going to accomplish it.

Mr. Walker, I listened to what you said about the President's original surplus proposal, that it represents a great change in the underlying design of the Hospital Insurance program.

Let me ask you, are you saying that there is a danger that Medicare can become increasingly divorced from the Social Security model which has enjoyed such great public support?

Senator MOYNIHAN. Pay-as-you-go.

The CHAIRMAN. What is that?

Senator MOYNIHAN. The pay-as-you-go.

The CHAIRMAN. The pay-as-you-go, yes. But what are the implications? Well, you have outlined that, so I will not ask you to do it again.

Mr. WALKER. I would be happy to, Mr. Chairman.

The CHAIRMAN. Please proceed.

Mr. WALKER. The President, in essence, is proposing for the first time that the HI program would be funded, to a significant extent, by general revenues. That, in effect, is what is happening with this granting, or gifting of Treasury securities to the HI trust fund. That means that general revenues in the future, future taxpayers will be paying part of income taxes that will go to fund HI.

As you know, Mr. Chairman, that has been the case for SMI for quite some time, since the beginning. Initially, when the Part B program came in, 50 percent of the financing of that program was through general revenues, and 50 percent was through premiums paid by the individuals.

That has now changed such that 75 percent is general revenues and 25 percent are premiums. And one of the concerns that we have, is if you move away from the trust fund model and if you move away from the current financing structure, it could undercut the discipline associated with the signalling that you get through the trust fund structure, and it could create a slippery slope to greater and greater revenue financing of this program.

The CHAIRMAN. That is a real danger.

Mr. WALKER. It is a concern, yes.

The CHAIRMAN. Now, as you pointed out, Dan, in your testimony, there has been some slow-down in the increase across the Medicare which gave some people hope that maybe we had a partial answer. But the fact is, we do not know what caused that slow-down in cause, is that correct?

Mr. CRIPPEN. That is correct, Mr. Chairman. We do not have data from HCFA that are current enough to tell us very much about what is happening. We can only surmise a couple of things that are going on concurrently here. The slowdown in parts of Medicare started before the BBA, but the BBA certainly contributed to it. But we do not know for sure what is happening. We can only give you our best guess.

The CHAIRMAN. That concerns me. I mean, it is a significant slow-down. We do not know what caused it. I would ask you, Mr. Crippen, and you, Mr. Walker, can we undertake a study so that we know exactly what is happening? Because I think it is critically important that we have up-to-date information.

Mr. CRIPPEN. I think, Mr. Chairman, that we could start discerning some answers pretty quickly by talking with the contractors that actually process the payments. The number of people we could talk to is limite, but they could tell us whether those payments are stacking up or whether obligations are going on where there are processing delays. That may not be the whole answer, but I think they could give us a lot of insight as to what is happening.

The CHAIRMAN. Mr. Walker?

Mr. WALKER. I would be happy to work with you and the committee to try to craft some appropriate approach to getting some additional information here.

Mr. CRIPPEN. I would say, Mr. Chairman, the quicker we could do it—obviously, it is important for your budget considerations. We have a Mid-Session Review coming up, and the MEDPAC Commission has an interim report this summer. So to the extent that we could find anything out in the very near term, the better off we would be.

The CHAIRMAN. I would say that it is very critically important to this committee that we have information within the next 2 months, at least.

There has been a talk about adding new programs to Medicare. Mr. Walker, one of these proposals is to add a drug benefit. Is that doable? What tests should we try to meet or what principles should we try to follow if we decide to consider adding a drug benefit? What financial problems would that give us?

Mr. WALKER. Several things, Mr. Chairman.

First, near the end of my full statement, we outlined several factors that the Congress may wish to consider in any type of Medicare reform proposal.

Second, with regard to prescription drugs, that is obviously an issue where there is considerable interest in adding that benefit. That benefit exists in the private sector to a great degree.

However, I think it is important to note that, to the extent that you are going to look at adding prescription drugs, that ends up adding costs. That will exacerbate the financing imbalance and, therefore, to the extent that one would consider prescription drugs, the Congress may wish to consider that as part of a more comprehensive reform proposal, rather than that alone and, second, to look at the standards or the criteria that we lay out in our statement as something that you may want to consider in assessing the appropriateness of that reform.

The CHAIRMAN. Now, Dan, you indicated the proposed Medicare+Choice risk adjuster will further reduce payment. How is that the case? As I recall, in the BBA 1997, this was proposed and is scored as producing no savings. What has happened?

Mr. CRIPPEN. Precisely, Mr. Chairman. CBO scored, at that time, no savings from the risk adjuster. This committee and the Senate actually had language in your version of the BBA that said that this was to be implemented on a cost-neutral basis.

However, that language disappeared in conference, and HCFA has proposed a set of risk adjusters that would have a net reduction in the first phase of 7 percent. And, as I mentioned earlier, if you look at OMB's baseline numbers, the net reduction would appear to be 15 percent in the long run.

What happened, apparently, is that HCFA took the opportunity, in developing the risk adjusters, to further reduce the Medicare+Choice payments. As you said, this committee's intention was to have something that was cost neutral. That is not the way the adjusters turned out.

The CHAIRMAN. Now, let me ask you this. In your initial testimony, you indicated that there would be, in the President's budget, certain savings made, but those saving would not be used for Medicare, rather, they would be used for other purposes.

Could you elaborate on that?

Mr. CRIPPEN. Yes, sir. We are now reexamining the President's budget and will publish our usual annual report in the next week or so. In looking at the President's budget, it is pretty clear—and these are not just estimating differences—that the President proposes some pretty significant reductions in payments to current providers.

Last week, when Director Lew was here, there were a number of questions about reductions in hospital payments, for example. Those reductions are clearly proposed here, the net of which is about $25 billion in savings.

There are a few proposals in the budget for expansion of benefits, particularly for early buy-in for 62-year-olds, the disabled, and those who lost insurance because of unemployment. We estimate the cost of those proposals to be about $5 billion. So, over 10 years, there are savings of $25 billion and spending of $5 billion and, therefore, a net of $20 billion in savings. In the President's budget, that $20 billion is split between other mandatory spending and discretionary spending.

Part of the reason that we estimate that the Administration exceeds the discretionary spending caps in its budget is their proposal to use some mandatory offsets for that spending. The Medicare savings are part of the offsets for the discretionary spending. So, the President proposes to save more out of Medicare than he uses for those purposes and then uses it for other spending in the budget.

The CHAIRMAN. Let me ask you both to comment on this. It is my understanding that the Medicare Commission, a majority of them supported creating a unified trust fund with a budgetary trigger of 40 percent on the ratio of general revenues to total revenues.

The intent is to create a new type of budgetary benchmark for measuring programmatic solvency. Is this a good proposal? What do you think?

Mr. CRIPPEN. As you know from previous testimony, I am not a fan of a lot of reliance on trust fund accounting, but I have said and do believe that the trust funds are certainly an indicator of program health.

If you design a trust fund to have only specific revenues dedicated to it, as you have with the HI trust fund, you know that the program is unstable if projected expenditures exceed projected revenues. So the trust fund is useful for that purpose. But Part B receives substantial funding from general revenues. Thus, if we combined Parts A and B, we would have to devise another solvency measure. A new measure could indicate whether the program was performing as intended when it was created and as the Congress had intended when it reformed the program.

The CHAIRMAN. Mr. Walker?

Mr. WALKER. I think it is important to have some solvency standards, Mr. Chairman. Obviously, I understand, right now, I think, the current spending rate is about 37 percent, if I am not mistaken. And so I think it is important to have a solvency standard for that in order to try to help provide gifts from the program.

I also think it is important to look longer term in these types of programs, not just to look on an annual basis. SMI really just looks annually. I think it is important to look longer range for the reasons that these charts pointed out.

Because, when you look down the road a piece, you find out that things, through compounding, can provide some very difficult problems out in the future that we need to start looking at sooner rather than later. So I think having a solvency test is good, but we have also got to look long range, not just short range.

The CHAIRMAN. My time is up. It is my understanding there is to be a vote at 11:00. I will run down and vote early. If we could keep the questioning going on, I think that would be helpful.

Senator MOYNIHAN. Mr. Chairman and gentleman, I was struck by a comment that Mr. Walker made considering the perspectives on health care. And it occurs to me that we must not let this National debate become just a matter of the accounts and the revenue flows and such, but, keep focused on health care.

When we were considering the President's proposal in 1964, we had a very considerable input from Dr. Paul Ellwood, his group that had been thinking about health care out there in Jackson Hole, all these years.

He, incidentally, said to us that the projected rise in outlays in medical care costs that Mr. Crippen talked about was not going to happen, and it was nothing like that at all.

I went on, actually—it was their idea, not mine—to give the Cartwright lecture at the College of Physicians and Surgeons at Columbia on the commodification of medicine.

I am sorry that Senator Gramm is not here but I went back to Say's Law of 1803 that supply creates demand.

We see this enormous outbreak in supply. I would just make two comments and ask your response. It seems to me that the modern

hospital—we get our first medical schools about 1920, the modern medical school.

Yale probably did not have a decent school until the mid-1920's. Our hospitals begin to be the sort of institutions we know in the 1930's. Not much healing, but a lot of caring, and not just a place where you go to die.

That was what impressed the people who were putting together Social Security. They, in turn, had their time come around on a generational basis in 1965. And they were thinking of the hospitals they had learned about when they were in college and so forth in the 1930's, and the modern hospital was the answer.

In the interval, we have learned so much more about the care of the body, and, particularly, and this is something that Senator Breaux's group tried to address, the matter of prescription drugs. They were a form of medical treatment quite unknown. They appear—well let me see. Last year was the 100th anniversary of heroin.

A trademark for heroin was claimed by the Bayer Company in 1898—cough medicine that did not work out quite as well as they had hoped. The next year they got aspirin, which has been, on the whole, pretty good. But it was not until the sulpha drugs and penicillin came along in the 1930's that you had a prescription drug that made a difference. Now they make a great deal more difference.

So, obviously, prescription drugs are a larger component of health care than they previously had been. Should we not get a medical perspective, having doctors come in and providers tell you, this is not just a matter of costs; we are talking about care? How can we do that? I mean, you obviously are thinking about it.

Mr. WALKER. Senator, I think you are correct. The health financing area within the GAO is doing a lot of work in a variety of areas with regard to health care. It is not just a matter of cost, it is a matter of quality, and, frankly, there are some circumstances in which prescription drugs can actually save money, absolutely, and so it is a complex analysis that needs to be performed.

But, I think, based upon most of the numbers that I have seen so far, the assumption is, if you add a prescription drug benefit along the lines that it would have been talked about, that there will be a net incremental cost.

Senator MOYNIHAN. I think one pill reduced the number of operations in American hospitals by two-thirds on ulcers. [Laughter] And another pill will add to what you found.

Mr. WALKER. I would agree with you that you need to consider quality and costs and you also need to consider the fact that some prescription drugs, actually, will save costs, if you look at on a discounted present value basis. That is part of the problem that we have, our budgeting system in the Federal Government is based upon annual cash flows.

If the Congress made budget decisions based upon a discounted present value analysis, it might well make some very different decisions than what it has made in the past. But I think it is relevant to consider that, especially in times of unified budgetary surpluses, I do think it relevant consider.

Senator MOYNIHAN. And not stick simply to the hospital model of health care.

Mr. WALKER. Exactly.

Senator MOYNIHAN. Thank you, Mr. Chairman.

The CHAIRMAN. Next, we have Senator Breaux.

Senator BREAUX. Thank you, Mr. Chairman. We are certainly going to miss the wisdom and wit of Senator Moynihan, with all these little tidbits of great information that you toss out, it is always amazing and well appreciated, and we thank you for that.

I thank both of these professional economists and witnesses who have testified before us. It is very, very difficult in a political atmosphere which, probably Medicare is at the top of the list.

To decipher all of the information and all of the proposals in a non-partisan or bi-partisan fashion, even among the various groups that testified, OMB is generally thought to have a bias towards the administration. CBO is generally biased towards the Congress.

Hopefully the GAO will never have a bias in either direction. We desperately need individuals and organizations that can analyze these proposals in a nonpolitical fashion and give us the facts. If they are good for our cause, so be it, if they are bad, so be it, but they cannot be criticized because of politics. That is incredibly important or we will never get the job done, first point.

The second point. I would strongly say, as one Senator, that the issue of Medicare cannot, should not, and must not be a "wedge" issue. That is, old politics and the old way of looking at this problem.

Looking at it in that fashion has led us to never solve it with any serious reform since it was passed in 1965. The issue for the 1990's and the 21st century cannot be a tax cut versus saving Medicare. That is an improper statement of the problem facing this Congress.

I am for a tax cut, targeted where it can be most helpful, and I am dedicated to trying to save Medicare. Both of them are legitimate things that this Congress needs to address. It is not—not—an either/or situation and should not be made to be so. I think both of your statements address that, with good numbers, to show that that is not a legitimate so-called wedge issue.

I think, third, the American people are really sick and tired of the Congress playing with wedge issues and engaging in the blame game, and arguing about failure and whose fault it is.

They would much prefer us to work together and solve the problem and then have the legitimate political argument about who solved it. At least we would be arguing about success as opposed to arguing about failure and whose fault it is. There is no proposition that brings all these things into consideration more than the issue of Medicare. All right.

I have tried very hard, particularly, David, with your numbers and analysis, to really understand exactly where we have. I mean, I have read it, I have highlighted it, and I have underlined it in red, and I have marked it up in blue, and I am still trying very hard to figure this out correctly. Maybe I need a green. I have got a green, too. That is my next one.

But let me ask you a couple of questions about your statements. Page 1 of your earlier statement you say, "The President's proposal has no effect on the current and projected cash flow deficits that

have faced Medicare since 1992." Partly, the President's proposal would not provide any new money to pay for medical services. The administration says, to the contrary, that they have given us $700 billion, and that will save Medicare until the year 2020.

It seems to me that, under current law, Medicare already has no more IOU's by the year 2008 to bail out the program under current law. Since Medicare is an entitlement program, the Federal Government has to continue paying Medicare benefits, regardless of whether we have so-called extended the solvency by adding more IOU's into the Medicare trust fund. I mean, so what is the benefit of adding new IOU's? Can you comment on that?

Mr. WALKER. My comment, Senator Breaux, deals with how the program is currently structured and has been structured since inception in 1965. It is intended to be, although Congress could change it, to be a social insurance program that is self-financing, primarily through payroll tax revenues.

Under the President's initial proposal, by granting these additional Treasury securities and putting them into the trust fund, that is an unearned gift that goes in the trust fund that would have to be satisfied in the future, on future taxpayers, if you will, to convert that into cash to pay benefits, which represents general revenue financing of HI.

Now, one can have a legitimate debate about whether or not it makes sense to do general revenue financing of HI, but hat is an issue I think that the Congress needs to focus on and debate seriously. The President proposes financing reform, but not program reform.

Senator BREAUX. Does it add any new money, cash, to the Medicare program?

Mr. WALKER. It will add new cash in the future when you end up converting those bonds into cash. But the question is, where do you come up with the cash? Where you come up with the cash is through general revenues, and that means either higher relative tax burdens, lower relative spending, or higher debt held by the public. One of those three has to happen. There is no free lunch here.

Senator BREAUX. But is that not what would happen under the current law?

Mr. WALKER. Well, I think that is an important point, Senator. I think there is a difference here. Let me try to tier it for you, and I may try to do this the next time I testify. What we really have is three levels of activity with regard to Medicare. We have something that I would refer to as commitments. Commitments say that we have a current benefit structure. That represents certain commitments to current retirees, near-term retirees, and future beneficiaries.

Then we have something that I would call obligations. To what extent are those commitments backed by Treasury securities? Because Treasury securities are backed by the full faith and credit of the U.S. Government. They are worth something. So, therefore, to the extent that you have got Treasury securities backing those commitments, then the promise is more secure, obviously, than it is if you do not have Treasury securities.

Then we have something called liabilities. That is basically this month's checks that we are cutting out. I think the key here that we have to recognize is, the fundamental imbalance exists between projected revenues and expenditures for Medicare, which is going to eat up more and more of our economy, which is going to eat up more and more of the budget. That is an issue that we have to deal with. Maybe general revenues might be part of the answer, but Congress has to decide that.

But I thin it also has to decide whether or not it makes sense just to throw money, or throw securities, I might more accurately say, at the issue rather than to deal with some of the heavy lifting, the fundamental, programmatic reforms that are going to be necessary in order to change that growth rate.

Senator BREAUX. I have a bunch more questions.

Senator MACK. Senator Thompson?

Senator THOMPSON. In listening to this from a bit of a distance during the Breaux Commission deliberations and here, in the brief time I have been here, it seems to me that, unfortunately, this is not really a policy discussion or policy debate any more.

Everyone knows, and has known for a long time, what you are saying. You are reiterating what has been said, with new updates, for a long time, the double whammy of the demographics, the higher cost per patient, along with the same problem a little bit further down the road with Social Security.

There cannot be any real debate about that any more, I do not think. I think it has become, unfortunately, a public relations battle. Whether or not the ignorance of the American people rises to the level that the administration thinks that it apparently does, and whether or not putting additional IOU's into the trust fund, at the same time advocating new programs, at the same time opening up the general revenues, whether or not that can be sold, ratcheting down providers and still maintaining the same quality of care, whether or not all that can be sold to the American people, which I think is absurd on its face.

I suppose it is the reason why we even give credence to having hearings on things like this, because we continue to make our arguments in response to these things that are being proposed. But it does not look to me like it is possible. The only real question is how long we can wait.

My own opinion is, of course, the President has decided to make this an election year issue and keep it on the table, not do anything to really move the ball down the court, despite the best efforts of people on both sides of the aisle, is my personal opinion.

But my question to you, I guess, is we have been waiting for some time now. You say we are standing at a crossroads, but we have been at that crossroads for some time. We have been talking about a crossroads, a lot of buses passing by, cars, bicycles. We have been there. Apparently we are going to stay there for a while without the world coming to an end.

Is there any way to tell what price we are going to pay by waiting, let us say, another 4 years? Is it going to be more difficult 4 years from now? Let us just assume the economy remains stable from that standpoint. Can you quantify or qualify how important

it is to begin to do some things structurally now, as opposed to 4 years from now, or 8 or 10 years from now?

Mr. CRIPPEN. The important thing is that the longer we wait, the more drastic the adjustments we are going to have to make. Those adjustments could be in the Medicare program itself—which means tax increases or spending cuts—or in other programs in the budget.

So the longer we wait, the more severe those adjustments are going to be, the less able the private-sector markets will be to adjust, and the less able people will be to plan.

Senator THOMPSON. Mr. Walker, can you narrow it down a little bit any further than that?

Mr. WALKER. Senator, we can provide for the record exactly what the difference would be. I mean, the fact of the matter is, in HI, let us take that as an example. Every year, you run a bigger and bigger deficit.

If you want to go with the current solvency test, which is a 75-year period of time, just for purposes of this discussion, obviously every year you wait the amount of either revenues you have to increase or benefits that you have to end up modifying, or spending rates you have to modify, gets higher. We can provide those numbers for the record.

To give you one example, in the year 2070, which is way on out, the HI tax rate would have to be 7.3 percent of payroll, just HI by itself, not SMI, not OASDI, just HI by itself. Right now, it is 2.9 percent. Obviously, those numbers come back.

Then the question you have to ask yourself is, while the numbers get bigger the longer you wait, does the environment get better? I do not know that, frankly, the environment is ever going to be good for Medicare.

Senator THOMPSON. The real question is, is it ever going to get better than it is today.

Mr. WALKER. I do not know that it is, Senator, let me tell you. The reason I say that is, for Social Security, I believe that can be reformed in a way that exceeds the expectations of all generations of Americans. I truly believe that. There are ways to do that.

For Medicare, there are going to have to be some hard choices. I do not think that is the case. We need to realize that, sooner or later, we have got to get on with it. I do not think it is going to get any easier, candidly.

Senator THOMPSON. It might get a lot worse. I mean, there are all kinds of things that could happen out there with regard to the economy, with regard to projections of per-patient cost. Surplus projections and all of that enters into it, does it not?

Mr. CRIPPEN. The Congressional Budget Office, and I will let Mr. Walker speak for GAO, has rarely over-estimated the cost of a Medicare program.

Senator THOMPSON. Thank you very much.

Senator MACK. For the benefit of my colleagues, let me say, the Chairman's list as to how we arrived, I would be next, followed by Senator Bryan, Senator Gramm of Texas, Senator Graham of Florida, and then Senator Robb.

I am going to go ahead and pursue my questions, and hopefully Senator Roth will be back then to chair the balance of the hearing.

Senator GRAHAM. Mr. Chairman?

Senator MACK. Yes.

Senator GRAHAM. Can I ask indulgence? I will not be able to return and I had wanted to place into the record an editorial from the New England Journal of Medicine of March 4, 1999, entitled "Geriatrics Prevention and the Remodeling of Medicare," which I think is quite consistent with the comments that Senator Moynihan made. Could I ask permission to have this inserted into the record?

Senator MACK. Without objection.

Senator GRAHAM. Thank you.

[The information appears in the appendix at page 111.]

Senator MACK. David, let me pose a question to you. This is as opposed to the macro. It is probably more in the micro area.

But, in your comments on Medicare+Choice, you say, in essence, that Medicare managed care has failed to meet the promise of slowing spending and, because of payment methodology flows, has actually cost the government more than if beneficiaries had remained in traditional fee-for-service. This was mentioned yesterday at our hearings as well.

Would you highlight those payment methodology flaws and give some evidence of this actually costing more when the AAPCC payment rate is pegged to 5 percent lower than the traditional cost in the area?

Mr. WALKER. Obviously, when the program was originally set up, Senator Mack, one of the decisions that had to be made is, what is the reimbursement rate? What do you pay for this? It was decided to do it at 95 percent.

It turns out that, in reality, when the program was rolled out, that there is always the possibility in any type of insurance mechanism to have creaming or adverse selection, where the populations that end up getting served may not have as high of incidence of health care, may not, therefore, have as high of expenditures. Therefore, if you pay 95 percent of an average, if you are dealing with a population that is healthier than the average, you can actually make money on it.

So that is one of the problems that occurred, is that people were making a decision as to whether or not they wanted to be able to get covered under this or not. Therefore, Congress has revisited, and may have to periodically revisit, what the appropriate reimbursement rate should be, and to take other steps to try to minimize creaming or to try to minimize adverse selection.

Senator MACK. Is that the only area? I really am kind of surprised as this number, and that is why I focused on it.

Mr. WALKER. There may be other issues, Senator, that I would be more than happy to look at and get back to you on for the record. We are doing a lot of work in this area. I am familiar with much of it, but not all of it.

Senator MACK. We will follow up with you on that.

Mr. WALKER. Thank you, Senator.

Senator MACK. Dan, let me go to your statement. You indicated in your testimony that, despite its high cost, however, Medicare's benefits are not as generous as those of the majority of private insurance plans. You cite examples of this as drugs, annual

physicals, dental care, and caps on annual expenditures out of pocket.

On the other hand, Medicare, in its present form, has few managed care controls or utilizations and does not encourage responsible use of health care services by beneficiaries. In many ways, it is open ended. A beneficiaries has little incentive to prevent overuse of services. Medicare has not had the ability to curb, or even monitor, this so that excess utilization by beneficiaries or providers is caught and corrected on a timely basis.

Do you have any recommendations in this regard?

Mr. CRIPPEN. On the first point, Medicare's benefit structure is behind, and in some ways does not mirror the private plans that are available. Restructuring to prevent overutilization has two parts. The first part involves people who have chosen a risk plan, at least in the recent past. Most of those risk plans have some benefits for pharmaceuticals and some of the other benefits I mentioned in the testimony. In addition, as suggested in a recent article in Health Affairs, about 65 percent of the elderly have some prescription drug coverage from some source. About half of that 65 percent have such coverage from retirement health plans that they acquired through their work. So there are private plans that supplement Medicare. There are private Medicare plans, through the Choice program, that add benefits, including pharmaceutical.

The second part of how one structures a program to try to prevent a overutilization is the effect of copayments and deductibles—how do you make people a little more responsible in the utilization of their care?

Given the way the system is structured now, there is not much you can do to the Medicare program that is not virtually immediately mirrored in a medigap policy. Very often, with the purchase of these policies—and the purchase of these extra policies is not cheap, by the way—first-dollar coverage is often the case. So you may design things in the current Medicare program, such as copays and others, but a medigap policy might take away whatever incentives you are trying to put in for the marginal utilization of resources.

What this really comes back to, I think, is that I encourage the committee to look at the payment structures, both for fee-for-service and for Medicare+Choice. Some things are happening in how these payment systems are coming about that weren't anticipated, including the risk adjusters that the Congress thought were going to be cost neutral.

The question is, what is the role that risk plays? We really need to think about the types of risk—both financial risk and health care risk—in Medicare, who faces those risks, and how risks affect behavior. There are ways that you might think about restructuring the payment system that would shift the burden of financial risk among health plans, enrollees, and the federal government. Such restructuring would alter the incentives of fee-for-service Medicare to provide too many services, and those of Medicare+Choice to avoid sicker patients who require more expesive care. But given the program's current structure, it is very difficult to do that.

Mr. WALKER. Senator, I think there are two things that are important about anything in life, one of which is incentives, and the

second one is transparency. We have a major problem in health care with regard to both.

We do not have adequate incentives to control consumption, and we do not have adequate transparency in order to make people aware of what costs had been incurred before they get paid. Seventy percent plus costs of health care, which includes Medicare, also private sector, was paid by a third party.

Yes, the costs in the private sector are lower, but there are a lot more incentives for individuals to keep the costs low. There is a lot more transparency for them to understand what costs are being incurred.

The same does not exist with regard to Medicare, Medicaid, and some of these other programs. That is an area we are going to have to take a hard look at, I think. How can you increase incentives and how can you enhance transparency to try to slow costs?

Senator MACK. Let me ask one quick follow-up, if I could. Do you think HMOs have been overpaid?

Mr. CRIPPEN. Well, that is a value judgment. I do not know whether they have been overpaid. I am skeptical about some of the past research showing positive selection by Medicare HMO's.

If you assume that there is positive selection, as the Comptroller said, and decide to pay 95 percent, then HMO's might look for people who only cost 90 percent. So cutting the payment is certainly not a way to go after a problem of risk selection, if there is one. So my answer is twofold. One, I am not convinced yet about the existence of risk selection today; it is certainly not an active phenomenon. Second, cutting payments is not a solution for risk selection if it exists.

Senator MACK. I thank both of you. I need to go vote now.

The CHAIRMAN. Thank you, Senator Mack.

Senator Bryan?

Senator BRYAN. Thank you very much, Mr. Chairman. Very interesting testimony, gentlemen. Mr. Crippen, I apologize. I came in as you were just concluding your statement and I did get the benefit of Mr. Walker's statement.

It may be true, as my colleague from Tennessee observes, that nothing new was shared with us today. But I do want to compliment you on the clarity of your expression. I mean, this is a very complex issue. I think the points that you made were, in my view, very helpful in illuminating our discussion. It is a sobering assessment.

I gather from your testimony, Mr. Walker, both written and oral, is that what you are saying is that the administration's proposal really is more in the nature of a financial Band-Aid. It does not really get to the underlying basis of the reforms that we need to undertake to really restructure the program. Would that be an accurate assessment?

Mr. WALKER. It represents financing reform, but it does not deal with the underlying structural problem which needs to be addressed to make sure that the program is not only solvent, but also sustainable.

Senator BRYAN. And I think what you are warning us, and I think Mr. Crippen made the same observation, is that a decision

that we make today can impact what money is available in the discretionary accounts into the next century.

We are talking about decisions that could foreclose national defense decisions, highway funding, educational funding, which is a priority, certainly, in this Congress, what we would like to do with our National park system. I think that is helpful to have that centered up so that we understand.

I have got to run and vote in a second, but let me ask you this. This committee, and indeed the Senate, went on record 2 years ago as favoring means testing for Part B Medicare, bipartisan support. Unfortunately, it did not receive the kind of consideration I think it ought to have in the House.

How much of this underlying restructuring or reform would some form of means testing give us? I realize that there is a great variation in terms of how far you go on means testing. Is that just on the periphery? Does that give us some real traction in dealing with it? And I am not suggesting that is the only reform, but give us some sense. Paint us a little bit of a picture, if you will. I will ask you to be as brief as you can, because I have got to run catch this vote here.

Mr. CRIPPEN. Senator, I do not have with me our estimates of the savings that could be realized through testing Medicare or income-relating the Part B premium. But such proposals do not speak to either the inadequacies of Medicare benefits (particularly for prescription drugs) or the potential over use of services in traditional Medicare. Although the use of health services may increase somewhat with income, the patterns of use in Medicare are driven more by other factors.

There are more options than just raising taxes, cutting benefits, or income-relating premiums. There is also the option of fundamental reform. I do not know exactly how that reform should be structured, but there is evidence that our current system is inefficient. For example, we have too many cases of people who have what are called ambulatory-sensitive conditions, like diabetes and asthma, who end up being hospitalized because the treatment for them is insufficient, or maybe they are not taking care of themselves as well.

But there are a lot of things you can look at in this system that suggest there is room to improve efficiency without cutting Medicare benefits. That is one of the goals of the reform that Senator Breaux and his commission are debating. So, I do not think that income testing goes to the heart of what you need to do on reform.

Senator BRYAN. Do you agree or disagree with that, Mr. Walker?

Mr. WALKER. Well, I am going to try to respond a little bit differently to what you asked.

Senator BRYAN. All right.

Mr. WALKER. First, on means testing, there is a difference between Part A and Part B.

Senator BRYAN. Yes.

Mr. WALKER. Clearly, you can save money through means testing. Intellectually, I think one might say that there is more of a basis to consider means testing for Part B because it is 75 percent general revenue financing and the rest of it is paid for by premium.

It gets more problematic with regard to Part A because it is payroll tax financed and, therefore, it is more a social insurance program. That is a policy decision, obviously, for the Congress. We can tell you what it will save under different proposals. We probably have done work on that in the past. It is clearly easier to consider, from a conceptual merits standpoint, on Part B, I think, thank it is Part A.

Senator BRYAN. I thank you very much, gentlemen. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Bryan.

Yesterday, I asked Gail Wilensky to undertake a thorough review of all of the factors affecting the level of payment to Choice plans. I think it is a critically important problem. I would hope that you would both contribute to this effort. Do you have any thoughts on it?

Mr. CRIPPEN. We have actually begun, Mr. Chairman, to think about how the structure is going to look in the next few years and how the fee-for-service payments will depart more significantly from the Medicare+Choice payments under current law.

As we have discussed this morning, a number of adjustments have been made already, in terms of taking out graduate medical education, the 5 percent initial discounts or reductions, the blending that will take place in the near term to reduce the higher-cost areas and increase the payments to lower-cost areas, and then on top of that, all of the risk adjuster proposals we have seen.

At least in the short term, Medicare+Choice payments are not tightly lilnked to spending in fee-for-service, one possible result of which is that beneficiaries are being driven into the highest-cost options. We have analysis already under way to give you some information about how that is going to look in the near term. But, clearly, more can be done and needs to be.

As I said in my statement, I think a hearing by you on the payment structure alone would be quite useful to talk about how these systems are evolving, unintended consequences, and how the medical system is developing.

Mr. WALKER. Mr. Chairman, we are doing some work in connection with rates, and also withdrawals from the program. So, obviously, we are more than happy to try to coordinate in constructive way. We are doing some work in the area.

The CHAIRMAN. Well, that would be very helpful. Of course, the sooner, the better, I guess.

Mr. WALKER. I understand.

The CHAIRMAN. Senator Breaux?

Senator BREAUX. I do not have anything else, Mr. Chairman. I would just thank both of our witnesses for their very solid testimony, and we will continue to work with them. Thanks.

The CHAIRMAN. Senator Thompson, do you have anything?

Senator THOMPSON. I was just wondering, getting back on the trust fund concept for a minute and what this means. I think you point out that really the most significant thing that the President's budget does is put us toward a path of beginning to open up Part A to general revenues.

You have been asked about the significance of that. I am wondering if we could get another layer below that, maybe. What are

the purposes for trust funds in general, or can you generalize? Are they originally set up to protect the funds that are in the trusts? Of course, that is an issue with regard to Social Security, or has been.

Is it for accounting purposes, usually? If it is not off-budget, does that matter that much? What is the significance of what we are about to slide into, it looks like? Mr. Walker?

Mr. WALKER. Well, first, it is important to note the fundamental difference between the Medicare HI trust fund and the Social Security trust funds, typically, what you and I would think of as a trust fund. I mean, I know that you have done some pension law. I used to be Assistant Secretary of Labor for ERISA. In the private sector, and frankly even the public sector for State and local government, trust funds are separate and distinct legal entities and they are funded with hard assets.

The purpose of the trust fund is to try to enhance benefit security, it is to try to enhance the ability to be able to meet those promised benefits, those commitments, and they are invested for the exclusive purpose of paying whatever benefits might be covered under the program, if you will.

In the Federal context, it is more of an accounting mechanism. It is more of a budget account because of the way we have chosen to finance it.

Senator THOMPSON. But what is the purpose of it; is it for purposes of transparency, is it for purposes of fiscal discipline?

Mr. WALKER. I would say several things. One, transparency. Number two, to assess the solvency and sustainability of the program under the current financing structure that is being proposed. Third, to provide signals, short-term and long-term signals, with regard to solvency and sustainability that would not exist otherwise in all likelihood if the trust fund concept did not exist. I think those are the primary purposes.

Senator THOMPSON. All right. Thank you.

Do you have anything to add to that?

Mr. CRIPPEN. One thing, Senator, that you might find of interest, if you have not run across it before, is a statement from the President's budget. The director has said that he wished it were not in there and that he would have taken it out had he known. But it has been in a number of budgets.

It is a standard statement of what the trust funds do and what they mean. I will not attribute it to the President per se, but it is a pretty good explanation of what the balances do.

The statement reads, "These balances are available to finance future benefit payments and other trust fund expenditures, but only in a bookkeeping sense. These funds are not set up to be pension funds. Unlike the funds in private pension plans, they do not consist of real economic assets that could be drawn down in the future to fund benefits.

Instead, they are claims on the Treasury that, when redeemed, will have to be financed by raising taxes, borrowing from the public, or reducing benefits or other expenditures. The existence of large trust fund balances, therefore, does not, by itself, have any impact on the government's ability to pay benefits." In short, the trust funds do not do a lot.

Senator THOMPSON. Well, I think that is just an honest statement, regardless of how it cuts. To me, it is probably a vehicle for discipline in this context more than anything else. It does what you are doing here today in saying, you have got to understand now, we are beginning to dip into that vast ocean—hopefully vast—of general revenues. To me, I think there are going to be problems in terms of discipline that we have not done very well with in the past.

One more thing. On the Balanced Budget Amendment of 1997, to what extent can we tell so far how those reforms, Choice and so forth, that are now being phased in have been effective as to what they were hopefully going to do versus what we see their doing? Do we have enough to have a good assessment there yet?

Mr. CRIPPEN. Frankly, no. We do not have enough data to know what is really happening. We do know that outlays are down over what we would have expected after the BBA. But we do not know exactly what is happening in the Medicare+Choice programs. We know that there are providers who are pulling out of markets, as has happened in some of the states represented here by the Committee.

So there is some activity, but we do not know very much about exactly what is happening. One of the things the Chairman has asked the two of us, and others, to do is to see if we can, in the next month or two, figure out what is happening out there. We are going to try to do that, but we cannot tell a lot from the date.

Senator THOMPSON. But, regardless of that, it really has no impact on the fundamentals of what you are talking about.

Mr. CRIPPEN. No. We continue to believe, Senator, that this slowdown that we are seeing at the moment will be temporary because of one-time phenomena and that Medicare spending will be back to a growth rate of 6 percent to 8 percent in the not-too-distant future. We do not know when. But that first graph I left up there for a long time was precisely to make that point. Almost no matter what you do, we are going to have an imbalance.

Mr. WALKER. Senator, it is important to note that the private sector led the public sector in the managed care arena and in making a number of changes in reform of their health care programs, and that, for this year, for 1999, for the first time in several years, they are expecting double digit increases in health care costs for health care.

Senator THOMPSON. Some of them decided they reformed a little too much.

Mr. WALKER. Well, I do not know. The other thing that we face with Medicare to a much greater extent are the demographic issues. So the private sector is obviously experiencing higher costs. I think ultimately we have to expect that we will as well, in part because of technology, in part because of demographics. The demographics for these programs is a lot worse than the typical private sector health care plan.

Senator THOMPSON. The per diem cost you project to go up, is what you are saying.

Mr. WALKER. Right.

Senator THOMPSON. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Thompson.

Gentlemen, we appreciate your being here very much today. It looks like this is going to be a continuous process of working together. Thank you very much.

I will keep the record open so that additional questions can be asked until 7:00 this evening. It may be that some of our Senators did not have the opportunity.

The committee is in recess.

[Whereupon, at 11:40 a.m., the hearing was concluded.]

APPENDIX

ALPHABETICAL LISTING AND MATERIAL SUBMITTED

PREPARED STATEMENT OF HON. DAN L. CRIPPEN

[March 18, 1999]

Mr. Chairman and Members of the Committee, I am pleased to be here today to discuss the financial status of Medicare. My statement will highlight information from the Congressional Budget Office (CBO) on Medicare spending and enrollment patterns in recent years and over the next decade. I will also review the Medicare proposals in the President's budget as well as some of the issues associated with offering a prescription drug benefit in Medicare.

Medicare is the second largest federal entitlement program after Social Security. This year the program will pay for the health care of some 39 million elderly and disabled people at a cost of $216 billion, or 13 percent of federal outlays. Despite its high cost, however, Medicare's benefits are not as generous as those of the majority of private health insurance plans. The program does not cover outpatient prescription drugs, routine physical exams, or dental care. Nor does it cap the amount that beneficiaries pay out of pocket. With prescription drugs, in particular, becoming an increasingly important part of modern medicine, pressure to expand Medicare's benefits is growing, even as policymakers struggle to contain the program's costs.

The rapid growth of Medicare spending, which has remained substantially above growth in the economy, has been a continuing concern of policymakers since the program's creation in 1965. The primary factor driving recent spending growth has been the rise in costs per beneficiary; the eligible population has expanded only slowly. But with the looming retirement of the baby-boom generation, Medicare faces a major demographic challenge that will add significantly to the growth of expenditures. Even if spending per enrollee stabilized, Medicare outlays would rise sharply after 2010. Without significant restructuring, therefore, the program is unlikely to achieve financial stability in the long term.

TRENDS IN MEDICARE SPENDING

The patterns of growth for Medicare and private-sector health spending diverged in the 1990s after both had grown at double-digit rates in the 1980s. A dramatic slowdown in the growth of private health spending in the mid-1990s was not matched until recently by Medicare. Private health insurance spending increased by less than 4 percent a year between 1993 and 1997, while Medicare spending continued to rise at an annual rate of almost 9 percent.

The growth of Medicare spending slowed sharply, however, in 1998. Total outlays, which increased by more than 8 percent in 1997, rose by only 1.5 percent in 1998, and growth continues to be extremely slow in 1999. Part of that slowdown was anticipated; the Balanced Budget Act of 1997 (BBA) lowered the projected growth of Medicare spending by 4 percentage points in 1998. The BBA reduced payment rates for many services and restrained the update factors for payments through 2002. Both fee-for-service providers and Medicare+Choice plans are experiencing lower payment increases as a result.

But actual spending growth has fallen considerably lower than the BBA provisions alone were expected to produce. Several other factors appear to have contributed to this sudden flattening of Medicare expenditures.

- Widely publicized efforts to clamp down on fraud and abuse in the program have resulted in greater compliance by providers with Medicare's payment rules. Those efforts include more rigorous screening of claims by Medicare contractors and tougher enforcement of Medicare laws by the Departments of Justice and Health and Human Services.
- The average time for processing Medicare claims rose dramatically in 1998. Expanded compliance activities combined with major efforts to prepare com-

puter systems for the year 2000 contributed to longer payment lags, which can have a substantial effect on Medicare outlays. An increase of one week, for example, in the average time for processing claims reduces Medicare outlays for the fiscal year by 2.3 percent. But that reduction is only temporary because the delay merely moves outlays into the next fiscal year.

CBO assumes that longer claims-processing times and the effects of improved compliance with payment rules are short-term phenomena that will have little or no effect on Medicare spending in the longer run. Under baseline assumptions, payment lags will begin to return to more typical levels late in 2000, with a catch-up in spending and a resumption of normal spending growth in 2001 and 2002.

Total Medicare outlays will therefore grow at an average annual rate of about 7 percent through 2004, rising to slightly more than 8 percent over the 2004–2009 period, By 2009, total outlays will be almost $450 billion. Much of the increase over the next few years reflects rising expenditures per enrollee; enrollment itself will expand only modestly as the last of the "baby-bust" generation reaches age 65.

Medicare spending will grow substantially faster in the decades after 2009 as the baby boomers begin to turn 65. Between 2010 and 2030, the elderly population will grow at a rate three times faster than between 2000 and 2010. Medicare costs are likely to grow considerably faster than program enrollment, however. The cost per beneficiary of providing health care services, which has risen dramatically in the past, is likely to continue doing so. That anticipated growth reflects advances in medical technology that will raise health care costs and a continued increase in the use of services by beneficiaries.

Based on assumptions used by the Medicare trustees, CBO has calculated that Medicare spending will rise from about 2.5 percent of gross domestic product (GDP) this year to 6.3 percent in 2030 as the last of the baby boomers enrolle in the program. But that projection is likely to be optimistic because it assumes a gradual slowdown in program spending, which would require a significant change in policy. If spending per beneficiary did not slow, Medicare's share of GDP would be higher.

THE MEDICARE+CHOICE PROGRAM

The BBA established the Medicare+Choice program to expand the range of health plans from which beneficiaries could choose and to lay the foundation for a more competitive Medicare system. Building on the existing Medicare risk market, in which all of the plans are health maintenance organizations (HMOs), the program allows a wide variety of health plans—including preferred provider organizations, point-of-service plans, and provider-sponsored organizations—to participate in Medicare.

The BBA also sought to constrain the growth of per capita spending in the Medicare risk sector and to reallocate payments from markets with high payment rates to those with lower rates. In addition, subsidies for medical education were "carved out" of the payments that risk plans receive. The act also required the Health Care Financing Administration (HCFA) to establish a mechanism for adjusting payments to plans to account for variations in costs associated with differences in the health status of enrollees.

The overall growth of per capital payments to Medicare+Choice plans remains tied to spending growth in the fee-for-service sector, but it will be below the fee-for-service rate of increase through 2004. Moreover, the growth in payments will not be uniform among Medicare+Choice markets. In the short term, payments in markets that have above-average fee-for-service costs will grow more slowly than in markets where fee-for-service costs are lower. Markets like those in Florida, New York, and parts of Califomia—which have both high fee-for-service costs and high penetration of managed care plans—will experience relatively slow growth in capitation rates under Medicare+Choice.

The transition to the Medicare+Choice system is proving to be quite rocky. Most plans have received an update of only 2 percent—the minimum increase specified in the BBA—for the past two years. Moreover, HCFA's "megareg" was issued in June 1998, after plans were required to inform HCFA of the additional benefits they would offer and the premiums they would charge in 1999.

Many plans reevaluated their Medicare participation in light of disappointing payment increases, new regulations, and a general retrenchment in the managed care industry in response to rising cost pressures. Some plans dropped out of the program entirely in 1999, others cut back the markets that they served, and few new plans applied to participate. Only about 400,000 beneficiaries were affected by those withdrawals, however, and most of them had other plans in which they could enroll. Additional plans are threatening to leave Medicare in 2000, especially if the phase-in of the new risk-adjustment system begins in 2000 as scheduled. The approach

to risk adjustment that HCFA is adopting will reduce overall payments to the Medicare+Choice sector.

The recent upheavals in the Medicare+Choice market have caused CBO to modify its projections of enrollment growth and spending in that market. The heightened awareness that plans can leave the market is likely to reduce the willingness of some Medicare beneficiaries to enroll in risk plans over the next few years. Moreover, the lower payments that will result from risk adjustment will make it difficult for plans to offer the additional benefits, such as prescription drugs, that were expected to drive enrollment growth.

Despite the possible dampening of enthusiasm for managed care, however, enrollment growth is still predicted to be strong. Consequently, payments to Medicare+Choice plans will soar from $37 billion in 1999 to $141 billion in 2009, which represents an annual growth rate of more than 14 percent. Enrollment growth of almost 9 percent a year accounts for much of that increase, with the remainder coming from growth in payments per enrollee.

Because growth in per-enrollee payments to Medicare+Choice plans is tied to growth in fee-for-service spending, increasing enrollment in those plans does not necessarily curb the rise in Medicare spending. Although adjusting payments for risk will reduce the annual rate of growth of Medicare spending by 0. 1 percentage point through 2004, CBO projects that per-enrollee payments to Medicare+Choice plans will increase in line with fee-for-service spending in subsequent years.

As a consequence of the growth of enrollment in risk plans, enrollment in Medicare's fee-for-service sector will actually drop by about 1.5 million people over the next decade. Yet, despite that decline and cuts in the growth of payment rates for many services, fee-for-service spending will still increase at a rate of more than 5 percent a year, reaching $302 billion in 2009.

MEDICARE PROPOSALS IN THE PRESIDENT'S BUDGET

The President's budget for fiscal year 2000 includes provisions to expand Medicare coverage to new populations and curb spending in the fee-for-service sector. Those proposals would have only minor effects on Medicare spending.[1] In addition, the President proposes to use a transfer from the general fund to shore up the Hospital Insurance (Part A) Trust Fund.

Populations newly eligible for Medicare would include certain people between the ages of 55 and 64 and the working disabled. The costs of those expansions would be more than offset by fee-for-service savings, which would have spillover effects on spending in Medicare+Choice plans and also result in lower premiums for Part B (Supplementary Medical Insurance). The net effect would be mandatory savings of about $19 billion through 2009—a tiny fraction of total program spending.

Policies to Expand Medicare Coverage

The President's proposals to allow certain people under the age of 65 to buy into the Medicare program are similar to proposals that were in his budget last year. Two groups of people would be eligible: those ages 62 to 64 who do not have private health insurance, Medicaid, or other public coverage; and certain workers ages 55 to 61 who lose their health insurance because of a job loss. The terms of participation would differ for the two groups.

A third proposal, to expand Medicare coverage for the disabled, would be part of a broader initiative to allow disabled people to return to work and maintain their health insurance coverage. The initiative would use funding from both the Medicare and the Medicaid programs.

Buy-In for People Ages 62 to 64. Under the Administration's proposal, people ages 62 to 64 could enroll voluntarily in Medicare, provided they did so as soon as they were eligible. Events that would qualify people to enroll include turning 62 or losing employment-based health insurance under certain circumstances between the ages of 62 and 64.

Enrollees would pay premiums in two parts, both of which would be updated annually. Before age 65, they would pay a monthly premium, which would be about $324 in 2001 (the first year of the program). At age 65 and thereafter, they would pay a monthly premium surcharge (in addition to their regular Medicare premiums) to recapture for the government the extra costs that Medicare would pay because the program would attract enrollees who were less healthy than average.

Taking the premiums that enrollees would pay into account, the buy-in for people ages 62 to 64 would cause net Medicare outlays to rise by an estimated $3.3 billion

[1] The budget also includes a $750 million demonstration project to enable Medicare beneficiaries to participate in clinical trials, which would be paid for outside the Medicare trust funds.

through 2009. In that year, about 718,000 people would be enrolled through the buy-in program.

Buy-In for Displaced Workers Ages 55 to 61. The Administration also proposes to allow certain workers ages 55 to 61 who lose health insurance because of a job loss to buy into Medicare. The program would be available only to people who met several eligibility requirements, including having been previously insured and eligible for unemployment insurance benefits. Those restrictions plus high monthly premiums—almost $440 per person in 2001—would ensure that enrollment in the program would be low. CBO estimates that by 2009 only about 50,000 people would be enrolled in the program at any one point in time.

Premiums for the program would be insufficient to cover its costs because it would attract enrollees whose expected medical expenditures were high. But because of low participation, the costs to Medicare would be small. CBO projects that net Medicare outlays would rise by a total of about $300 million through 2009.

Medicare Coverage for the Working Disabled. The President's budget includes provisions under both the Medicare and the Medicaid programs to allow disabled people to return to work and maintain their health insurance coverage. The Medicare proposal would entitle disabled people who returned to work—thereby losing their eligibility for Social Security benefits—to lifetime coverage under Medicare Part A. That entitlement would be available only to people who enrolled in the program during the first 10 years after enactment of the legislation.

CBO estimates that expanding the Medicare entitlement for the disabled would increase outlays by about $1.4 billion through 2009. About 59,000 people would be participating by then—the last year in which people could enroll, according to the proposal. Most likely, however, such an initiative would prove popular enough to be extended beyond 2009.

Policies to Reduce Fee-for-Service Spending

The President is proposing a variety of program changes to reduce fee-for-service spending. The most significant savings would come from direct reductions in payments for certain services. Additional savings would come from measures to improve compliance with Medicare's payment rules and to give hospitals incentives for more efficient performance.

Taken together, the proposals would lower fee-for-service spending by about $10 billion through 2004 and $21 billion through 2009. Because spending growth in Medicare+Choice plans is linked to spending growth in the fee-for-service sector, the reductions in fee-for-service spending would also lower Medicare+Choice spending by about $6.5 billion through 2009. Some of those savings would be offset, however, by the lower Part B premiums that enrollees would pay.

Two of the proposed reductions in payments to providers would account for more than half of the fee-for-service savings. The largest savings would be generated by the proposal to freeze payment rates for inpatient hospital services in 2000, which would reduce payments to hospitals by about $600 million in 2000 and $8.7 billion through 2009. A second proposal would also generate considerable savings from hospitals and other providers. It would further reduce Medicare's payments to hospitals for the bad debts that they incur—those payments having already been lowered under the BBA—and extend the reduction in bad-debt payments to such providers as skilled nursing facilities, federally qualified health centers, and community mental health clinics. Total savings would be about $4.6 billion through 2009.

The President's Trust Fund Proposal

The President also proposes to augment Medicare's financing by transferring funds from the general fund to Medicare's trust fund for Hospital Insurance. Currently, Medicare spending is drawn from two trust funds: the Hospital Insurance (HI) Trust Fund, which pays for Part A services, and the Supplementary Medical Insurance (SMI) Trust Fund, which pays for Part B services. The HI trust fund relies primarily on payroll taxes, which account for 88 percent of its receipts. By contrast, about 75 percent of SMI receipts are transfers from the general fund, with premiums from beneficiaries accounting for the other 25 percent.

HI outlays are growing faster than income, and CBO currently projects that outlays will exceed income by 2007. (If interest payments are excluded, outlays already exceed income.) The trust fund will become insolvent sometime after 2010.

The Administration would postpone the insolvency date for the HI trust fund by transferring $350 billion from the general fund to the trust fund during the next decade. That bookkeeping transaction would increase the balances held in the trust fund and delay the date of insolvency. But the transfer would do nothing to address the underlying problem: rapid growth in spending for Medicare, Social Security, and other federal programs will outstrip total anticipated revenues. Ways must eventu-

ally be found to slow the growth in program spending, which will require major restructuring of Medicare.

A PRESCRIPTION DRUG BENEFIT FOR MEDICARE

Unlike most employer-sponsored health plans, Medicare does not provide coverage for prescription drugs taken on an outpatient basis. The President supported the concept of a prescription drug benefit for Medicare in his State of the Union message, although that proposal was not formally included in the budget. Others, including the National Bipartisan Commission on the Future of Medicare, have also considered the possibility that Medicare might be expanded to cover outpatient drugs.

The Medicare population uses prescription drugs more extensively than the general population because of high rates of chronic illness. Although the elderly represent only about 12 percent of the population, they account for about one-third of spending on prescription drugs. An estimated 80 percent of retired people use at least one prescription drug every day.

In 1995, Medicare beneficiaries spent an average of $600 for prescription drugs, half of which they paid out of pocket. But average out-of-pocket expenditures varied considerably depending on whether beneficiaries had prescription drug coverage from some other source and, if so, the type of coverage they had.

More than 60 percent of Medicare beneficiaries have some form of drug coverage, although the generosity of coverage varies greatly. In 1995, for example, 95 percent of beneficiaries enrolled in HMOs had drug coverage compared with about half of the beneficiaries in fee for service, who may obtain drug coverage through supplementary insurance policies from their former employers, medigap policies that they purchase themselves, or Medicaid. But drug coverage obtained through medigap is costly, and the benefits are limited. Moreover, most HMOs now place an annual cap on prescription drug benefits, which can be as low as $600.

The availability of prescription drug coverage at little or no additional cost to the beneficiary has contributed to the growth of managed care enrollment. But many Medicare HMOs appear to be reducing the generosity of those benefits in response to their rising costs. Smaller-than-expected increases in Medicare capitation payments may also be contributing to that trend.

A new drug benefit in Medicare would be popular with beneficiaries, but the additional program costs would be large. Consider, for example, adding a drug benefit to Medicare Part B beginning in January 2000. In this example, beneficiaries would be responsible for a $250 annual deductible and 20 percent coinsurance, and Medicare would pay all pharmaceutical costs once the beneficiary had paid $1,000 for drugs covered under the benefit during a year. That cap would be reached once the beneficiary had incurred $4,000 in drug expenses.

Under such a proposal, total outlays would increase by about $30 billion in calendar year 2000, CBO estimates. That cost would be partially offset by an additional $7.5 billion in Part B premiums that would be collected.

Adding drug coverage would increase the growth rate as well as the level of Medicare expenditures since prescription drugs are the fastest-growing component of health expenditures. HCFA analysts project that national spending for prescription drugs will grow at an annual rate of almost 10 percent between 2001 and 2007. By comparison, total national health spending will grow by about 7.5 percent a year over the same period.

CONCLUSION

Despite the recent slowdown in spending, Medicare outlays will grow substantially faster than the economy in the foreseeable future. The program will continue to place financial pressures on the federal budget in the near term. Those pressures will intensify over the next decade and beyond as the baby boomers begin to qualify for Medicare and as health care costs per beneficiary rise. The Balanced Budget Act took some important steps to reduce the growth of Medicare spending and foster a more competitive market. The Medicare proposals included in the President's budget would do little to promote the efficient and effective use of health care resources. The long-term financial stability of the program would require additional steps.

Human Impact of a 9.3% Cut to Non-Defense Discretionary Funding

- 76,000 children would lose Head Start services
- 2,100 agents could be cut from the FBI
- Over one million low-income women, infants, and children would lose nutrition assistance each month
- 271,000 veterans would be denied medical treatment

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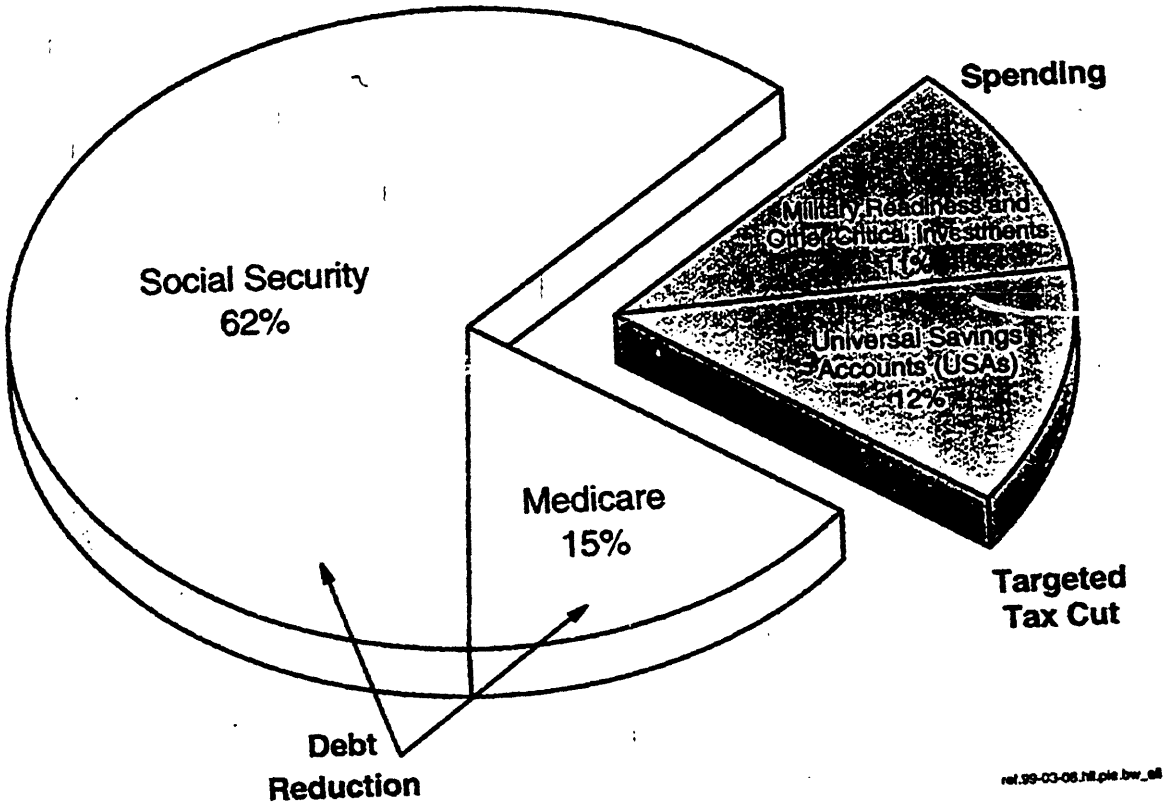
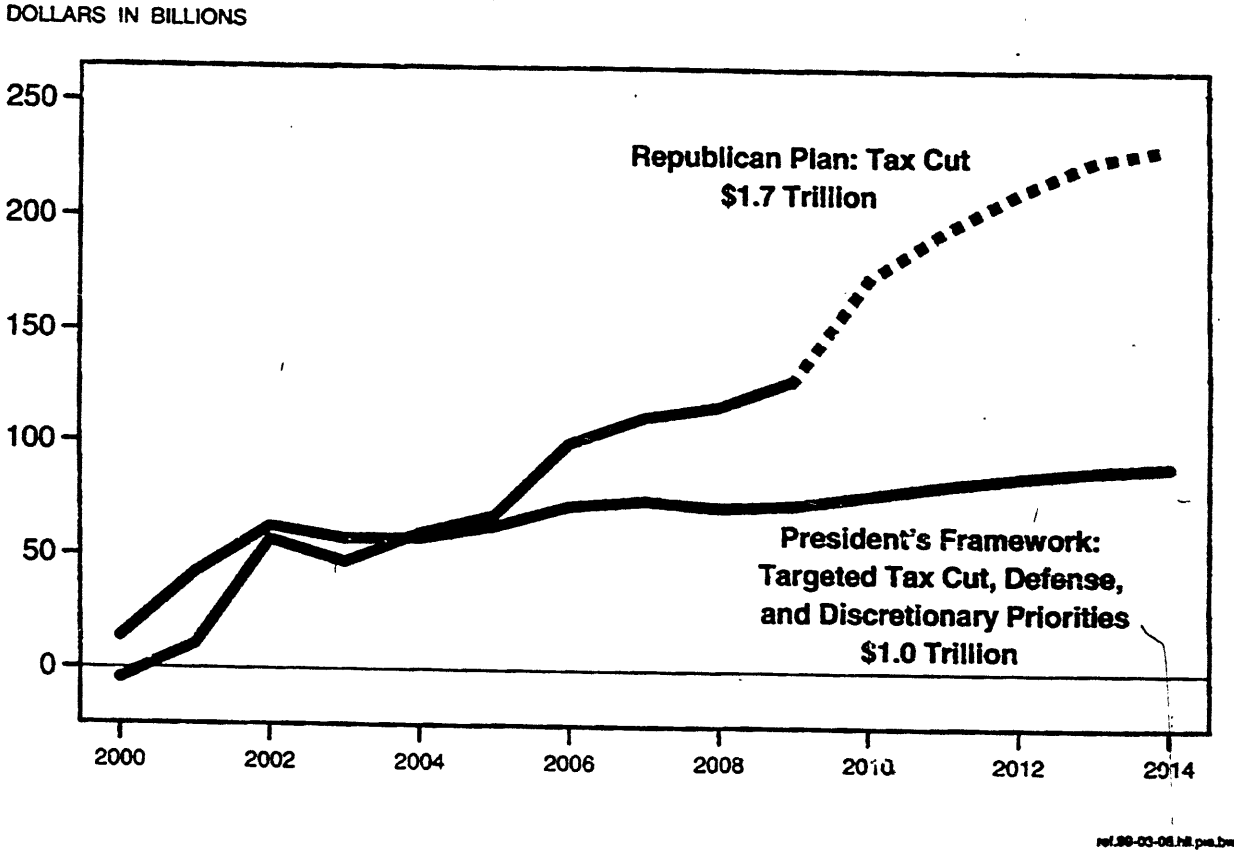
Framework for Social Security and Medicare Reform with Long-Term Fiscal Discipline

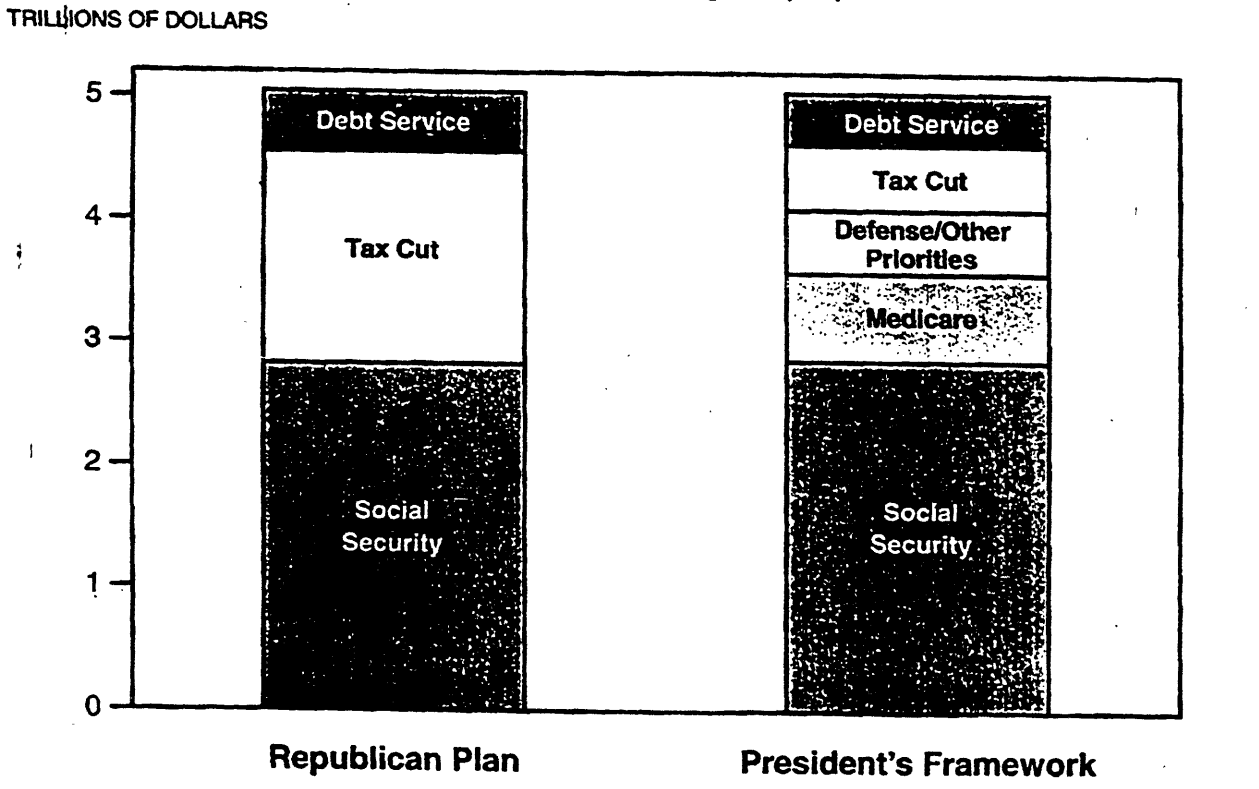


Republican Plan Allows Large Tax Cuts Instead of Funding Medicare

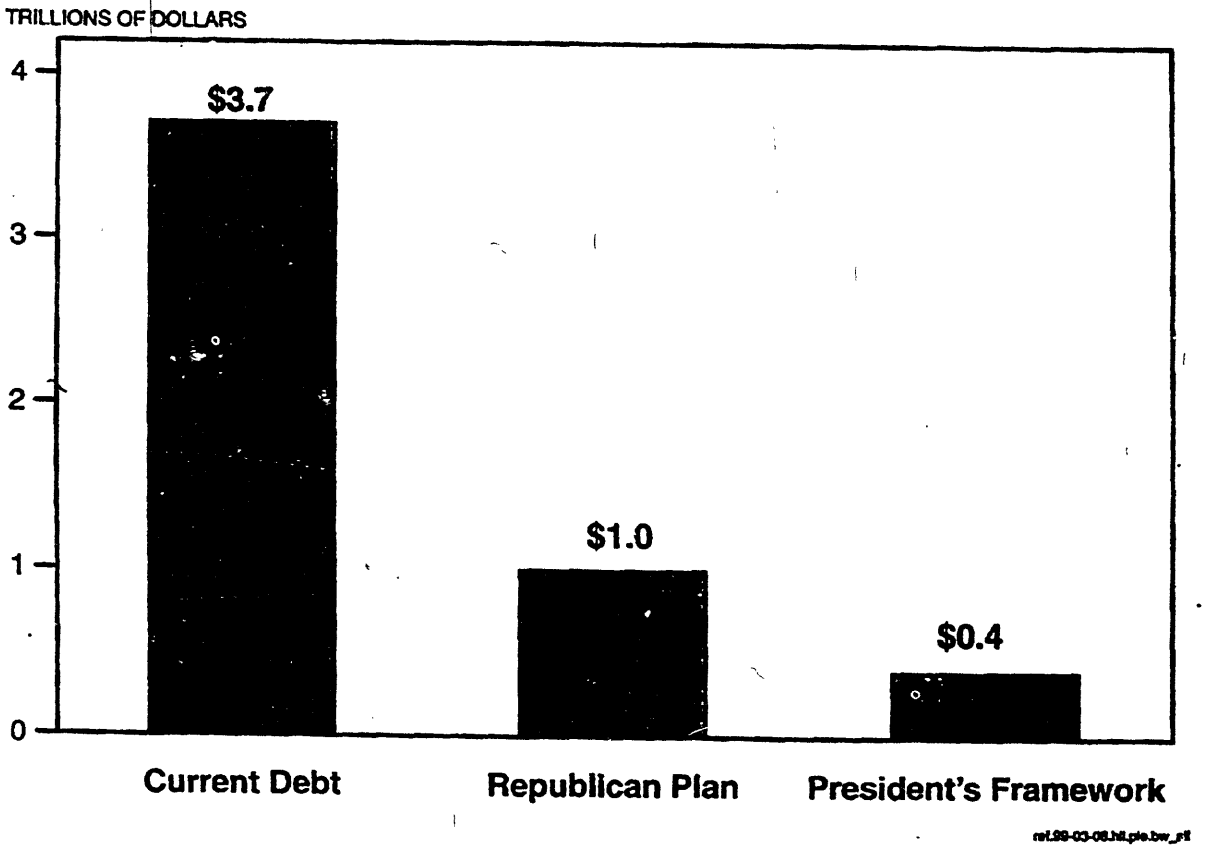


Republican Tax Cut Squeezes Out All Other Priorities Over the Next Fifteen Years

(Allocation of Unified Budget Surplus)

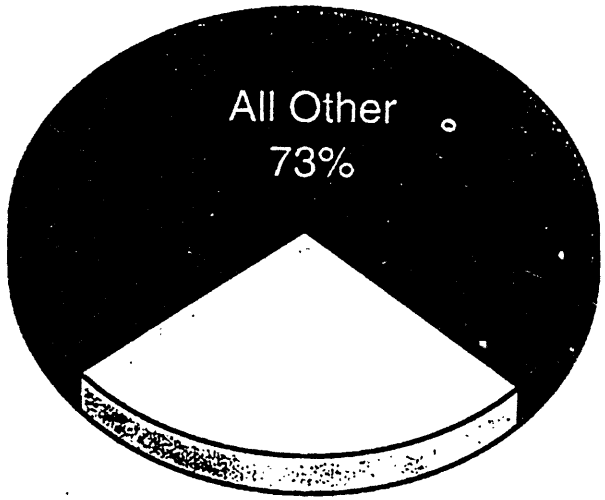


President's Framework Reduces Publicly Held Debt

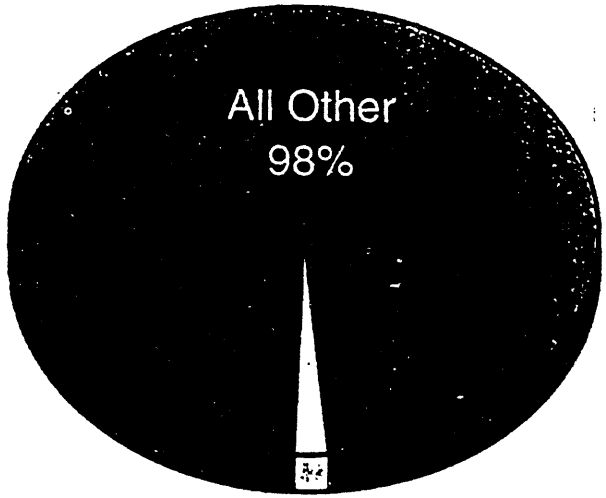


Interest as a Percent of Outlays in 2014

Pre-1993 Baseline



President's Proposal



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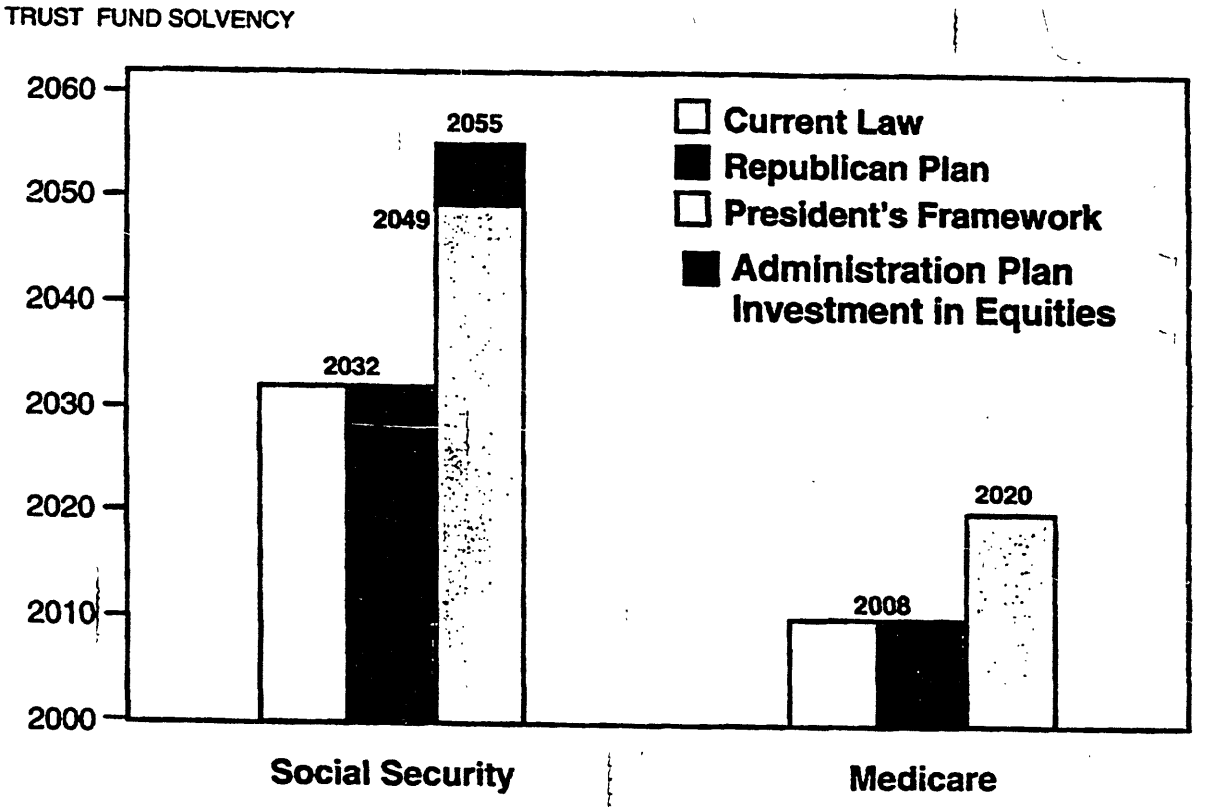
Republican Budget Fails to Extend Solvency of Social Security and Medicare



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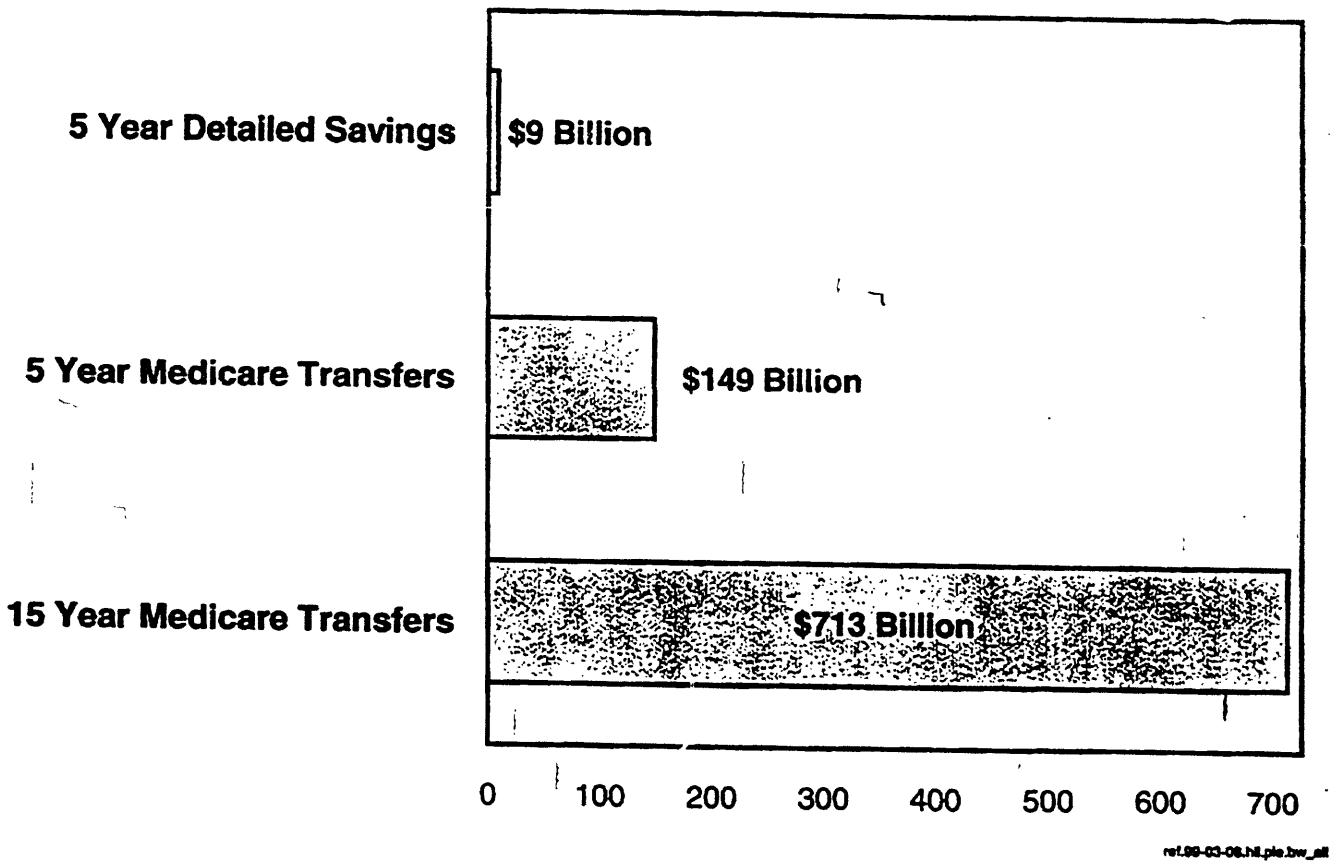
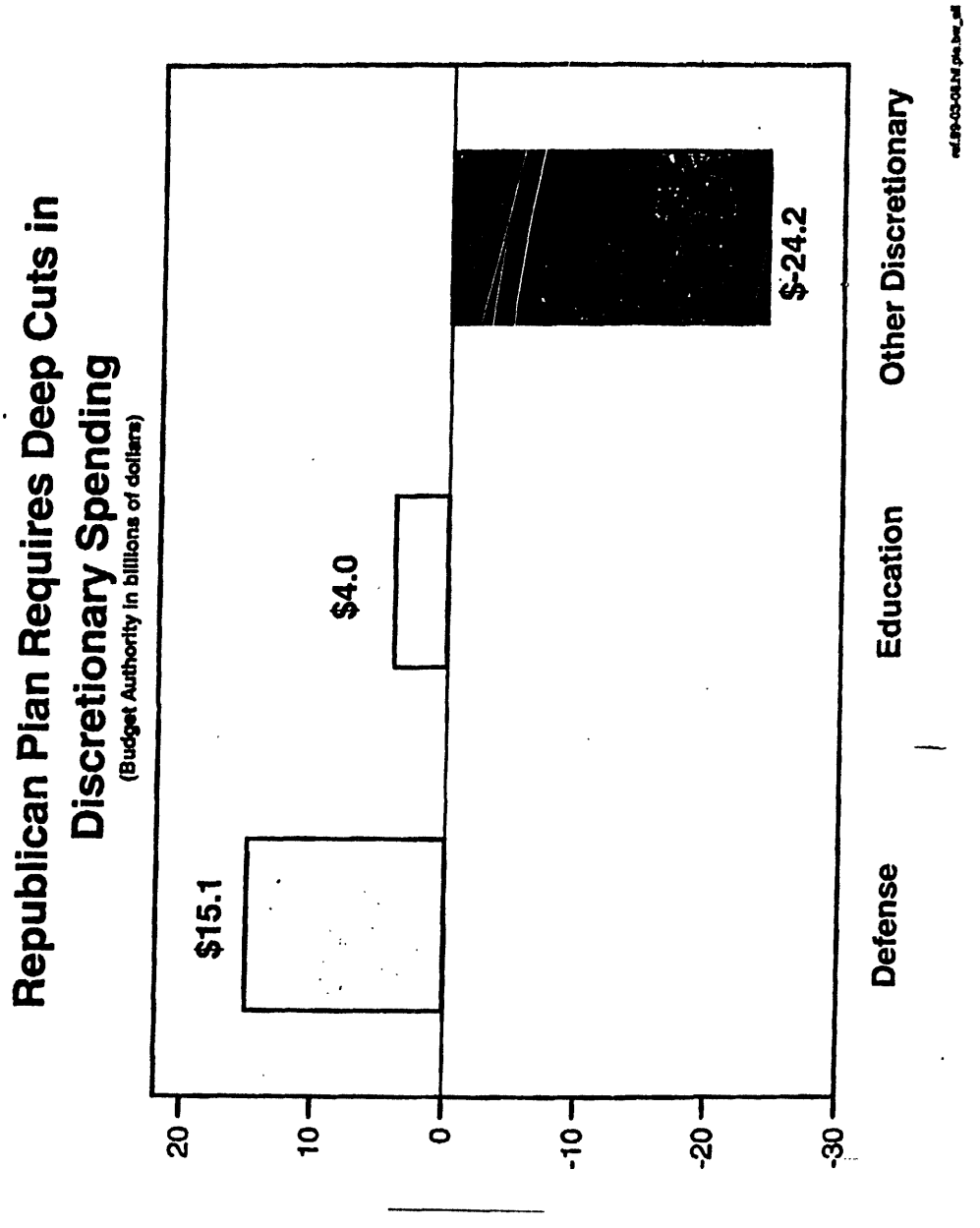
Medicare Savings Proposals Difficult





PREPARED STATEMENT OF HON. DAVID M. WALKER

Mr. Chairman and Members of the Committee:

It is a pleasure to be here today to discuss the President's recent proposal for addressing Medicare and use of the projected budget surpluses over the next 15 years. As you know, I testified last month on the implications of the President's surplus proposals for Social Security. Today, I will briefly reprise our views on the overall fiscal consequences of the proposal, discuss what it does and does not do for the Medicare program, and examine the importance of and difficulty in making fundamental changes to this complex program.

Regarding the President's proposal:

- It would significantly reduce debt held by the public from current levels, thereby also reducing net interest costs, raising national savings, and contributing to future economic growth. This element of the President's proposal would have positive short and long-term effects on the economy.
- It provides a grant (or in the President's word, a 'gift) of a new set of Treasury securities for the Medicare Hospital Insurance (HI) program which would ex-

tend the life of the HI trust fund from 2008 to 2020. It is important to note, however, that these new Treasury securities would constitute a new unearned claim on general funds for the HI program—a marked break with the payroll taxbased financing structure of the program. This would be a significant change that could serve to undermine the remaining fiscal discipline associated with the self-financing trust fund concept.

- It has no effect on the current and projected cash-flow deficits that have faced the HI program since 1992—deficits that taxpayers will continue to finance through higher taxes, lower spending elsewhere or lower paydowns of publicly held debt than the baseline. Importantly, the President's proposal would not provide any new cash to pay for medical services.
- It does not include any meaningful program reform that would slow spending growth in the HI program. In fact, the transfer of these new Treasury securities to the HI program could very well serve to reduce a sense of urgency for reform. At the same time, it could strengthen pressure to expand Medicare benefits in a program that is fundamentally unsustainable in its present form.

The current Medicare program is both economically and fiscally unsustainable. This is not a new message—the Medicare Trustees noted in the early 1990s that the program is unsustainable in its present form. They also noted the need for dramatic and fundamental reform of the program to assure its solvency. With regard to Medicare:

- The program's continued growth threatens to crowd out other spending and economic activity of value to our society. Even if we save the entire surplus, Medicare is projected to more than double its share of the economy by 2050.
- Meaningful reform of this program is urgently needed and such reform will require hard choices. The program changes enacted in 1997 illustrate how difficult even incremental reform is to adopt. Major change requires reshaping the nation's perspective on health care consumption and drawing distinctions between what the nation needs, wants, and can afford both at the national and individual level.
- To be effective and sustainable, reforms must begin soon and be comprehensive in nature. However, the history of entitlement reforms tell us that, to be enduring, such reforms must be introduced gradually after widespread public education in order to garner sufficient support from the system's multiple stakeholders.

Context: Long-term Outlook Is Important

It is important to look at the President's proposal in the context of the fiscal situation in which we find ourselves. After nearly 30 years of unified budget deficits, we look ahead to projections for "surpluses as far as the eye can see." At the same time, we know that we face a demographic tsunami in the future that poses significant challenges for Social Security, Medicare, and our economy as a whole. In this context, it is noteworthy that the President has proposed a longer-term framework for resource allocation than has been customary in federal budgeting.

Although all projections are uncertain—and they get more uncertain the farther out they go—we have long held that a long-term perspective is important in formulating fiscal policy for the nation. Each generation is in part the custodian for the economy it hands the next and the nation's long-term economic future depends in large part on today's budget decisions. This perspective is particularly important because our model and that of the Congressional Budget Office (CBO) continue to show that absent a change in policy, the changing demographics to which I referred above will lead to renewed deficits. This longer-term problem provides the critical backdrop for making decisions about today's temporary budget surpluses.

Surpluses are the result of a good economy and difficult policy decisions. They also provide a unique opportunity to put our country on a more sustainable path for the long term, both for the nation's fiscal policy and selected entitlement programs. Current decisions can help in several important respects: (1) current fiscal policy decisions can help expand the future capacity of our economy by increasing national savings and investment, (2) engaging in substantive reforms of retirement and health programs can reduce future claims, (3) by acting now, we have the opportunity of phasing in changes to Social Security and Medicare programs over a sufficient period of time to enable our citizens to adjust, and (4) failure to achieve needed reforms in the Social Security and Medicare programs will drive future spending to levels that will eventually "squeeze out" most or all discretionary spending, including national defense spending. If we let the achievement of a temporary budget surplus lull us into complacency about the budget, then in the middle of the 21' Century we could face daunting demographic challenges without having built the economic capacity or program and policy reforms to handle them.

The Proposal

Before turning to Medicare specifically, it is important to describe the President's overall proposal for using the surpluses over the next 15 years. The proposal's effects on Medicare are part of a broader initiative to save a major share of the surplus to reduce the debt held by the public and thereby enhance future economic capacity for the nation.

The President proposes to use a significant portion of the total projected unified budget surpluses over the next 15 years to reduce debt held by the public. He also proposes to take some related steps to address the financing problems facing both the Medicare and Social Security programs. His approach to this, however, is extremely complex and confusing.

Specifically, the President proposes to allocate about two-thirds of the projected surplus over the next 15 years to reduce publicly held debt. This portion of his proposal would increase our future economic capacity. At the same time, the President proposes to transfer a like amount to the Social Security and Medicare trust funds in the form of nonmarketable Treasury securities. In effect, the President's proposal would trade debt held by the public for debt held by the Social Security and Medicare trust funds. The administration has defended this approach as a way of assuring both a reduction in debt held by the public and as securing a "first claim" for both Social Security and Medicare on what they call the "debt-reduction dividend" to pay future benefits for those two programs. The HI Program would receive nearly $700 billion in additional Treasury securities—representing nearly 15 percent of total surpluses over the 15 years.[1] This transfer is projected to extend the life of the HI trust fund from 2008 to 2020.

The President's proposal has raised important questions about how the federal government, can promote long term economic security by using today's surplus resources to "save for the future." In the federal unified budget, the only way to save for the future is to run a unified budget surplus or purchase a financial asset. When there is a cash surplus it is used to reduce debt held by the public. Therefore, to the extent that there is an actual cash surplus, debt held by the public falls. This is exactly what happened in fiscal year 1998 when the debt held by the public was reduced by $51 billion.

In the federal budget, trust funds are not vehicles to park "real" savings for the future. They are simply budget accounts used to record receipts and expenditures earmarked for specific purposes. A private trust fund can set aside money for the future by increasing its assets. State governments similarly can "park" surplus resources in "real" pension funds and other trust funds which are routinely invested in "assets" (e.g., readily marketable securities) outside the government. However, under current law, when a trust fund like HI ran a surplus of payroll tax revenues over benefit payments, the excess was invested in Treasury securities and used to meet current cash needs of the government. These securities are an asset to the trust fund, but they are a claim on the Treasury. When a trust fund runs a cash deficit, like HI has been doing since 1992, it redeems these securities to pay benefit costs exceeding current payroll tax receipts.[2] Medicare will be able to do this until 2008 under current law when its trust fund securities will be exhausted. However, in order to redeem these securities, the government as a whole must come up with the cash by either increasing taxes, reducing spending or raising borrowing from the public above the baseline.

Increasing the balances of Treasury securities owned by HI trust funds alone would increase the formal claim that the trust funds have on future general revenues since the trust fund's securities constitute a legal claim against the Treasury. However, increasing the HI trust fund balances alone, without underlying reform does nothing to make the program more sustainable. From a macro perspective, the critical question is not how much a trust fund has in assets, but whether the government as a whole has the economic capacity to finance the trust funds claims to pay benefits now and in the future. From a micro perspective, trust funds can provide a vital signaling function for policy makers about underlying fiscal imbalances in covered programs. However, extending a trust fund's paper solvency without reforms to make the underlying program more sustainable can, in effect, obscure the warning signals that trust fund balances provide.

Government Financing

The President's proposals would enhance the nation's future economic capacity by significantly reducing debt held by the public from the current level of 44 percent of Gross Domestic Product to 7 percent over the 15-year period. The President notes that this would be the lowest level since 1917. Nearly two-thirds of the projected

[1] With the additional interest these new securities would ear, total assets held by the HI trust fund would go up by over $1 trillion.

[2] This may mean either using interest or the principal itself to cover the difference.

unified budget surplus would be used to reduce debt held by the public. Because the surplus is also to be used for other governmental activities, the amount of debt reduction achieved would be less than the baseline (i.e. a situation in which none of the surplus was used), but nonetheless the outcome would confer significant short and long-term benefits to the budget and the economy.

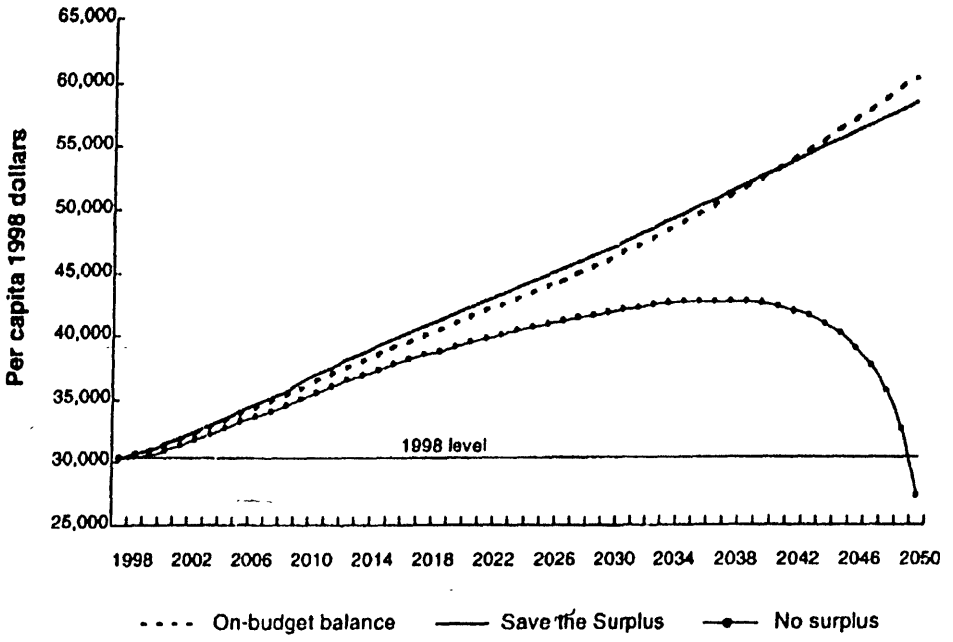
Our previous work on the long-term effects of federal fiscal policy has shown the substantial benefits of debt reduction.[3] One of these is lowering the burden of interest payments in the budget. Today net interest represents the third-largest "program" in the budget, after Social Security and Defense. Interest payments, of course, are a function of both the amount of debt on which interest is charged and the interest rate. At any given interest rate, reducing publicly held debt reduces net interest payments within the budget. For example, CBO estimates that the difference between spending the surplus and saving the surplus is $123 billion in annual interest payments for debt held by the public by 2009—or almost $500 billion cumulatively between now and then. Compared to spending the entire surplus, the President's proposal would also substantially reduce projected interest payments. Lower interest payments lead to larger surpluses; these in turn lead to lower debt which leads to lower interest payments and so on: the miracle of compound interest produces a "virtuous circle." The result would be to provide increased budgetary flexibility for future decision-makers who will be faced with enormous and growing spending pressures from the aging population.

For the economy, lowering debt levels increases national saving and frees up resources for private investment. This in turn leads to increased productivity and stronger economic growth over the long term. Over the last several years, we and CBO have both simulated the long-term economic results from various fiscal policy paths. These projections consistently show that reducing debt held by the public increases national income over the next 50 years, thereby making it easier for the nation to meet future needs and commitments Our latest simulations done for the Senate Budget Committee as shown in figure 1, illustrate that any path saving all or a significant share of the surplus in the near term would produce demonstrable gains in per capita GDP over the long run.[4] This higher GDP in turn would increase the nation's economic capacity to handle all its commitments; in the future.

[3] *Budget Issues: Analysis of Long-Term Fiscal Outlook* (GAO/AIMD/OCE–98–19, October 22, 1997).

[4] The "On-budget balance" path assumes that any surplus in the non Social Security part of the budget is "spent" on either a tax cut or spending increases or some combination but assumes the current law path for the Social Security trust fund. Thus the surplus in the Social Security trust fund remains untouched until it disappears in 2013 after which the unified budget runs a deficit equal to the SSTF deficit. The "Save the Surplus" path assumes no changes in current policies and that budget surpluses through 2024 are used to reduce debt held by the public. The "No Surplus" path assumes that permanent increases in discretionary spending and tax cuts deplete the surpluses but keep the budget in balance through 2009. Thereafter, deficits re-emerge as spending pressures grow.

Figure 1: GDP Per Capita Under Alternate Fiscal Policy Simulations



Source: GAO Analysis

While reducing debt held by the public appears to be a centerpiece of the President's proposal—and has significant benefits—as I noted above, the transfer of a portion of the unified surpluses to the HI trust fund is a separate issue. The transfer is not technically necessary: whenever revenue exceeds outlays and the cash needs of the Treasury, debt held by the public falls.

The President's proposal appears to be premised on the belief that the only the way to sustain surpluses is to tie them to Social Security and Medicare. He has merged two separate questions: (1) how much of the surplus should be devoted to reducing debt held by the public and (2) how should the nation finance these two programs in the future. The President has proposed to save the surplus by, in effect, hiding it in the Social Security and HI trust funds. The additional nonmarketable Treasury securities transferred to the Social Security and Medicare trust funds are recorded as a subtraction from the unified budget surplus—a new budgetary concept. Accordingly, the surplus disappears under this novel scoring approach since these transfers approximate the surplus the President is proposing to save by reducing publicly held debt.[5]

Let me turn now to the question of how the President's proposal would affect Medicare financing.

Impact on Medicare Financing

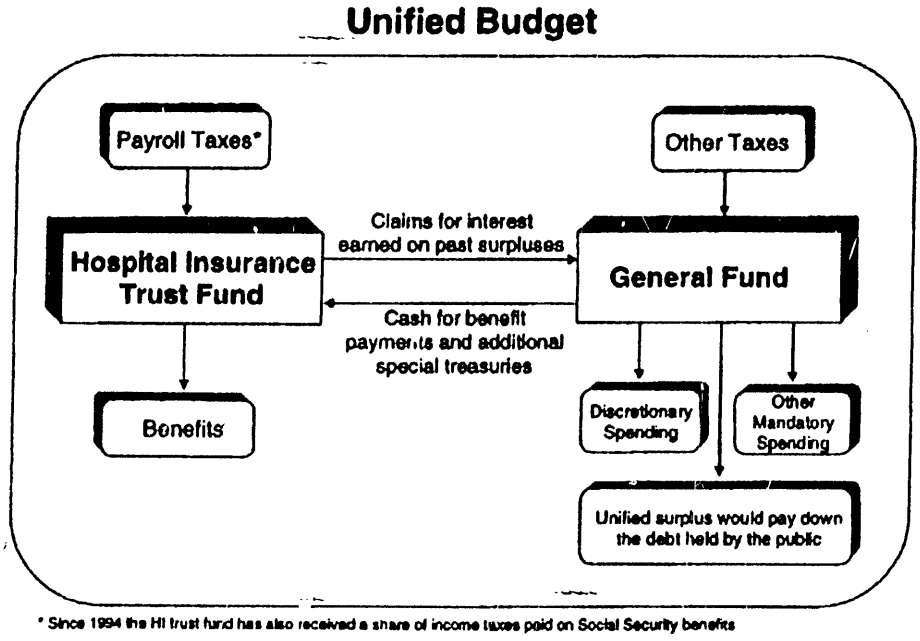
The mechanics of the proposed transfer of surpluses to the Medicare program are, like the transfers to Social Security, complex and difficult to follow. In form they are similar, but the effects on Medicare would be somewhat different. Unlike Social Security, Medicare's HI program has been experiencing a cash flow deficit since 1992—current payroll taxes and other revenues have been insufficient to cover benefit payments and program expenses. Accordingly, Medicare has been drawing on its special Treasury securities acquired during the years when the program generated a cash surplus along with interest on those accumulated balances. In effect, these general fund payments can be viewed as repaying the loan of cash that the trust fund provided the rest of government when the Medicare program was in surplus. In FY1999, the HI program will run a cash deficit of $8 billion. As noted earlier, in order to redeem these securities, the government must either raise taxes,

[5]The President also proposes to use about 13 percent of these surpluses to purchase stocks for Social Security.

cut spending, or increase borrowing from the public. In essence, Medicare has already crossed the point where it is a net claimant on the Treasury—a threshold that Social Security is not currently expected to reach until 2013. Stated differently, the bleeding of the HI trust fund has already started based on the program's annual cash flow deficits.

The current financing flows for the HI program are depicted in figure 2 below. As the figure shows, to help pay benefits in fiscal year 1999, the HI trust fund receives an $8 billion general fund payment for interest it earned on its treasury securities from its past cash surpluses. The HI fund also receives $5 billion for a portion of the income taxes paid on Social Security benefits.

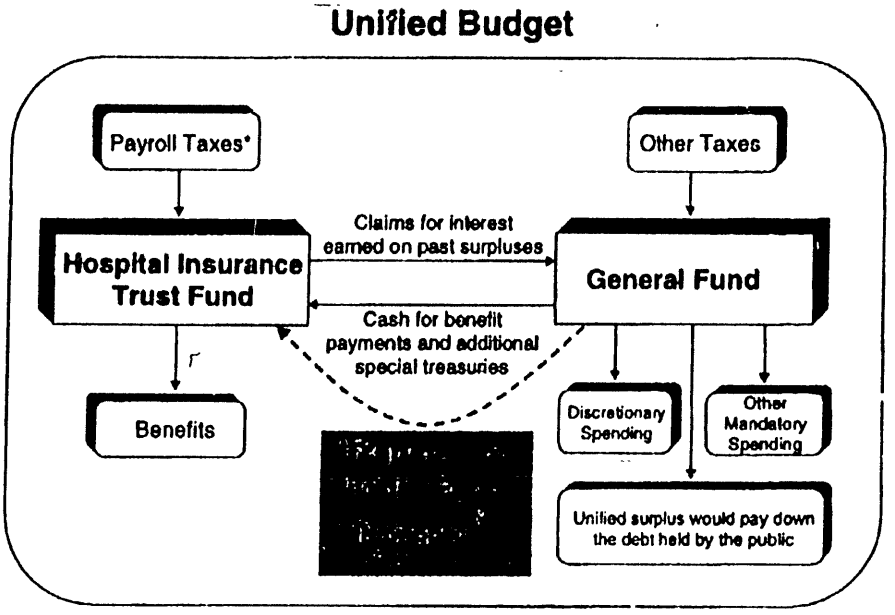
Figure 2: Medicare Flows under Current Law



Source: GAO Analysis

Under the President's proposal, the above scenario would continue. However, as shown in figure 3, at the point where total tax receipts are allocated to pay for government activities, a new financing step would be added to "transfer" a portion of the projected unified budget surpluses to the Medicare HI trust fund. The Treasury would do this by issuing a new set of securities for the HI Trust Fund. Unlike the current securities owed the trust fund, these new securities are not supported by payroll tax surpluses in the program—rather they represent what amounts to a grant or gift. However, it is important to remember that these new securities equal a portion of the excess cash that would be used to reduce the debt held by the public. The Administration argues that the new securities are, in effect, supported by the enhanced economic resources gained by reducing publicly held debt. Nonetheless, we should remember that under the current law baseline—i.e., with no changes in tax or spending policy—this would happen without crediting additional securities to either the Social Security or Medicare trust funds.

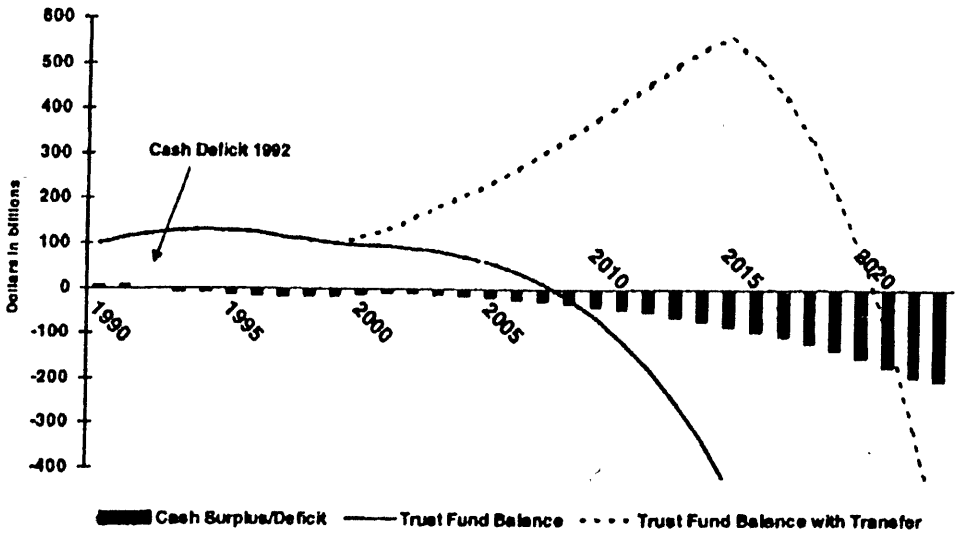
Figure 3: Medicare Flows under President's Proposal



Source: GAO Analysis

The financial consequences of this transfer are depicted in figure 4 below. This graph first shows that by providing the additional Treasury securities, the solvency of the Hospital Insurance Trust Fund would be extended from 2008 to 2020. However, the figure also shows that the President's proposal does nothing to alter the imbalance between the program's tax receipts and benefit payments. It has been in cash deficit since 1992 and remains in a cash deficit even with the new Treasury securities. Thus, the President proposes to provide additional claims on the Treasury, not additional cash to pay benefits.

Figure 4: Medicare Hospital Insurance Trust Fund Financial Outlook under President's proposal



Source: GAO Analysis

Notwithstanding the fact that no real cash is exchanged, the transfer of additional securities to Medicare is a discretionary act with major economic consequences for the future financing of the HI program. As with Social Security, this proposal represents a fundamental shift in the way the HI program is financed. It moves it away from payroll financing toward a formal commitment of future general fund resources for the program for the future. The general fund obligation would begin far earlier than for Social Security. Specifically, the HI Trust Fund would begin drawing on the general fund to redeem these new securities in 2008—well before the full reduction in publicly held debt and associated benefits to the general fund will have been realized under the President's plan. In addition, this is 24 years before the Social Security Trust Fund would begin drawing on the additional Treasury securities that the President is proposing to grant to that program.

The transfer would constitute an explicit general fund subsidy for the HI program—a subsidy whose magnitude is unprecedented for this program. This is true because the newly transferred securities would be in addition to any buildup of historical payroll tax surpluses. Securities held by the trust fund have always represented the value of the loan of its surpluses to the Treasury—annual cash flows in excess of benefits and expenses, plus interest. Under the President's proposal, the value of securities held by the HI trust fund would exceed that supported by earlier payroll tax surpluses and constitute a new and unearned claim on the general fund for the future. In effect, the proposal would shift the financing of the HI Trust Fund to look more like that for the Part B Supplemental Medical Insurance (SMI) Trust Fund. The SMI portion of Medicare obtains 75 percent of its revenues from a general fund subsidy, with the remainder supported by beneficiaries' premiums.

This is a major change in the underlying theoretical design of the HI program. Whether you believe it is a major change in reality depends on what you assume about the likely future use of general revenues under the current circumstances. For example, current projections are that the HI Fund will exhaust its securities to pay the full promised benefits in 2008. If you believe that this shortfall would—when the time came—be made up with general fund moneys, then the shift embedded in the President's proposal merely makes that explicit. If, however, you believe that there would be changes in the benefit or tax structure of the fund instead, then the President's proposal represents a very big change. In this case, less of the long term shortfall would be addressed through future changes in the HI program itself and more would financed through higher taxes or spending cuts elsewhere in the federal budget as a whole. Thus, the question of bringing significant general revenues into the financing of the HI program is a question that deserves full and open debate.

The debate should not be overshadowed by the accounting complexity and budgetary confusion of the President's proposal.

In our view, the proposal carries some significant risks that should be carefully considered by the Congress. One risk is that the transfers to both the Medicare and Social Security trust funds would be made regardless of whether the expected budget surpluses are actually realized. The amounts to be transferred apparently would be written into law as either a fixed dollar amount or as a percent of taxable payroll rather than as a percent of the actual unified surplus in any given year. These transfers would have a claim on the general fund even if the actual surplus fell below the amount specified for the transfers. However, it is important to emphasize that any proposal to allocate surpluses is vulnerable to the risk that those projected surpluses may not materialize. Proposals making permanent changes to use the surplus over a long period of time are especially vulnerable to this risk.

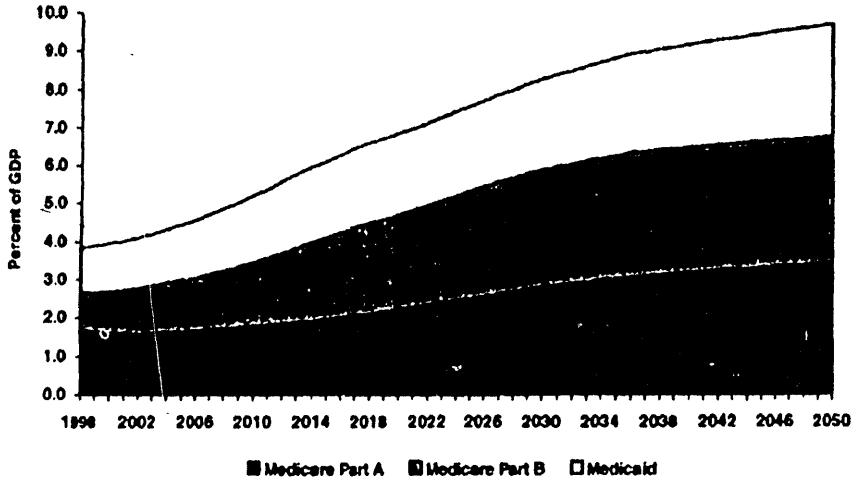
The history of budget forecasts should remind us not to be complacent about the certainty of these large projected surpluses. In its most recent outlook book, CBO compared the actual deficits or surpluses for 19881998 with the first projection it produced five years before the start of each fiscal year. Excluding the estimated impact of legislation, CBO says its errors averaged about 13% of actual outlays. Such a shift in 2004 would mean a surplus $250 billion higher or lower; in 2009 the swing would be about $300 billion. Accordingly, we should consider carefully any permanent commitments that are dependent on the realization of a long-term forecast.

The Compelling Need for Fundamental Program Reform

A more significant risk of the President's proposal is that by appearing to extend financial stability for Medicare, it could very well undercut the incentives to engage in meaningful and fundamental reform of the HI program—reforms which are vital to making the HI program sustainable over the long term. Unlike Social Security, the HI program is already in a negative cash flow position—payroll taxes support 89 percent of spending now and will cover less than one-half 75 years from now. Even in the short term, the HI program's annual outlays grow by several times the rate of general inflation. Although its growth has slowed in recent years, it remains one of the most volatile and uncontrollable programs in the federal budget. According to CBO, the growth of Medicare—both HI and SMI—will increase its share of the economy by nearly a full percentage point over the next 10 years, from 2.5 percent to 3.3 percent of GDP in 2009. By contrast, the share devoted to Social Security is projected to remain relatively flat during this period rising from 4.4 percent of GDP in 1999 to 4.7 percent in 2009.

Over the long term, the program's growth rates are more daunting. Absent any changes, the combined Medicare program (i.e., HI and SMI) is projected to more than double its share of the economy by 2050—from 2.7 percent now to 6.8 percent based on the Medicare Trustees' most recent best estimated assumptions. When coupled with Medicaid, federal health care costs will grow to nearly 10 percent of GDP by 2050, as depicted in figure 5. The progressive absorption of a greater share of the nation's resources for health is, like Social Security, a reflection of the rising share of elderly in the population. However, health care growth rates also reflect the escalating cost growth of health care at rates well exceeding general rates of inflation. Increases in the number and quality of health services fueled by the explosive growth of medical technology has spurred much of this extraordinary cost growth in health care. Consequently, Medicare represents a much greater and more complex fiscal challenge than even Social Security over the longer term.

Figure 5: Medicare and Medicaid as a Share of GDP



Source: GAO's "Save the Surplus" long-term simulation based on HCFA's 1998 intermediate projections for Medicare spending and CBO's May 1998 projections for Medicaid spending.

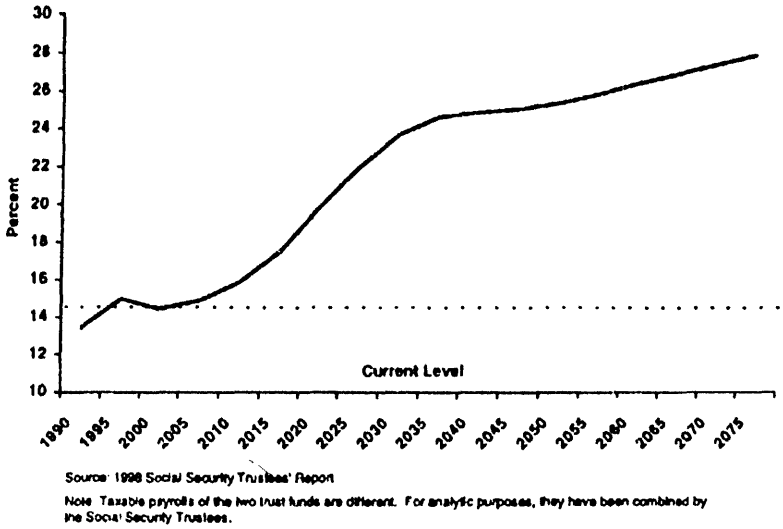
The President's proposal to strengthen the HI program is more perceived than real. Specifically, while the HI Trust Fund will appear to have more resources as a result of the President's proposal, in reality nothing about the program has really changed. The proposal does not represent program reform, but rather a supplemental means to finance the current program. Stated differently, the reform proposed has more form than substance.

What is most alarming is that the President's proposal could induce a sense of false complacency about the financial health of the HI program. The impending insolvency of the HI program sends important signals to policymakers that the program needs to be made more affordable through benefit changes, revenue increases or both. The 2008 date has become an important cue to policymakers that could provide the impetus needed to make the hard choices necessary to promote the solvency and sustainability of the HI program for the long term. Extending the life of the HI Trust Fund without substantive program reform could be a recipe for delay and denial that could increase the ultimate fiscal and social cost of HI program reform. At a minimum, the President's proposal is likely to create a public misperception that something meaningful is being done to reform the Medicare program.

Changes to the HI program should be made sooner rather than later. The longer meaningful action is delayed, the more severe such actions will have to be in the future. As the fastest growing sector of the federal budget, early action to reduce Medicare's costs will have compounding fiscal benefits. Even if the rate of growth is not changed, reducing the base level of spending can produce outyear dividends for the program's finances. Moreover, acting now would allow changes to benefits and health care delivery systems to be phased in gradually so that stakeholders and participants would have time to adjust their saving or retirement goals accordingly.

When viewed together with Social Security, the financial burden of Medicare on the future economy takes on daunting proportions. As figure 6 shows, the cost of these two programs combined would nearly double as a share of the payroll tax base over the long term. Assuming no other changes, these programs would constitute an unimaginable drain on the earnings of our future workers. This does not even include the financing challenges of the SMI program.

Figure 6. Social Security and Medicare's HI Program as a Percent of Taxable Payroll



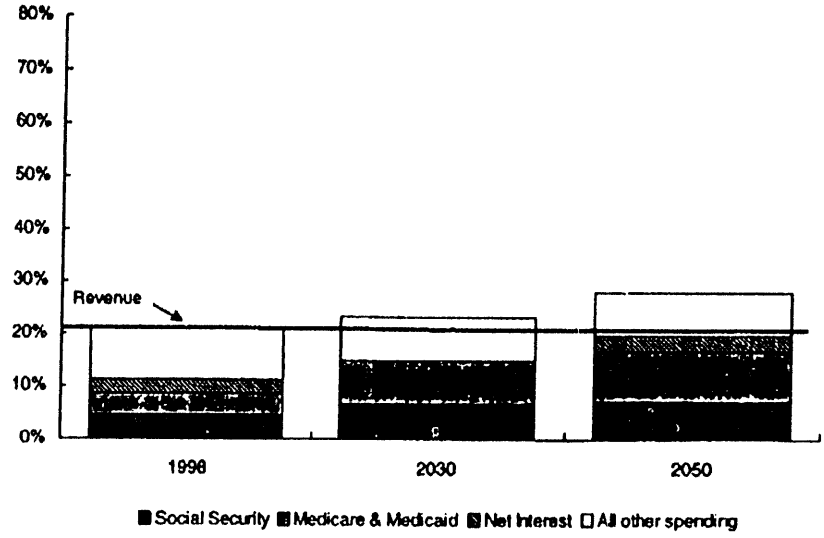
Source: 1998 Social Security Trustees' Report

Note: Taxable payrolls of the two trust funds are different. For analytic purposes, they have been combined by the Social Security Trustees.

There is another reason to take early action to reform both Social Security and Medicare costs. Reducing the future costs of these programs is vital to reclaiming our future capacity as a nation to address other important needs in the public sector. To move into the future without changes in the Social Security, Medicare, and Medicaid programs is to envision a very different role for the federal government. Assuming no financing or benefit changes, our long-term model (and that of CBO) shows a world in 2050 in which Social Security, Medicare, and Medicaid absorb a much greater share of the federal budget. (See figure 7.) Budgetary flexibility declines drastically and there is increasingly less room for programs for national defense, the young, infrastructure, and law enforcement—i.e., essentially no discretionary programs at all. Eventually, again assuming no program or financing changes, Social Security, health and interest take nearly all the revenue the federal government takes in by 2050. This is true **even** if we assume that the entire unified budget surplus is saved and these continued surpluses reduce interest from current levels. As shown in figure 8, the picture below is even more dramatic if we assume the entire unified budget surplus is used.[6] In that scenario lower GDP and higher interest payments lead to a world in which revenues cover only Social Security, health and interest in 2030. And in 2050 revenues do not even cover Social Security and federal health expenditures alone! Although views about the role of government differ, it seems unlikely that many would advocate a government devoted solely to sending Social Security checks and health care reimbursements to the elderly.

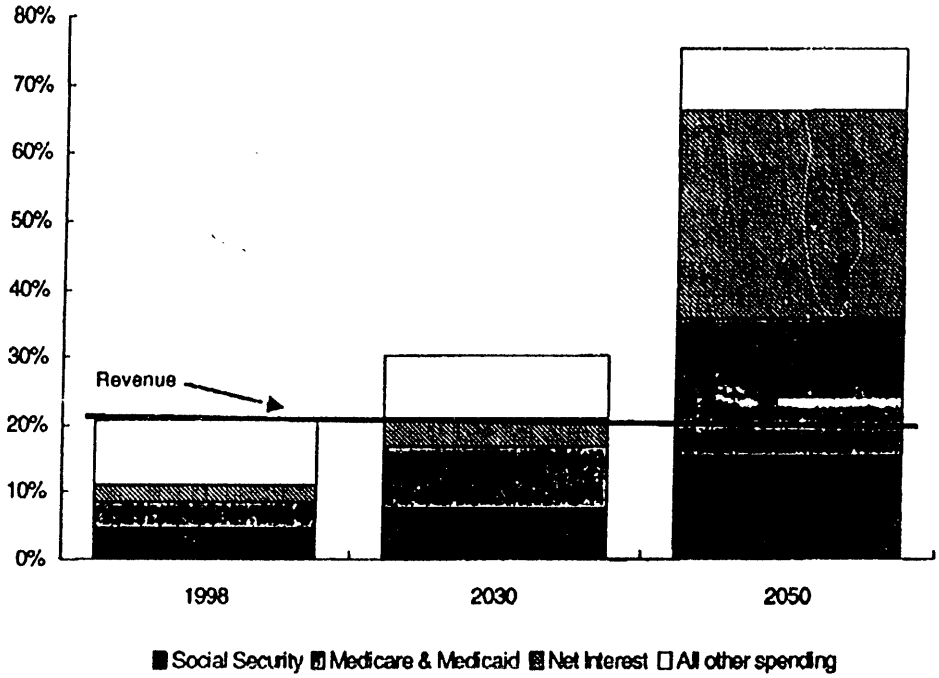
[6]Our "No Surplus" simulation is not a forecast but rather an illustration of the implications of taking fiscal actions that eliminate projected surpluses and the fiscal pressures posed by the aging of the baby boom generation. This simulation shows ever-increasing deficits that result in declining investment, a diminishing capital stock, and a collapsing economy. In reality these economic consequences would inevitably force policy changes to avert such a catastrophic outcomes.

Figure 7: Composition of Spending as a Share of GDP Under "Save the Unified Surplus" Simulation



Source: GAO Analysis

Figure 8: Composition of Spending as a Share of GDP Under "No Unified Surplus" Simulation



Source: GAO Analysis

Mounting Pressures on Medicare Spending Pose Challenges for Long-term Program Viability

It is clear that real and substantive reform of Medicare is essential to achieving the long-term solvency and sustainability for the program itself—it is not a question of whether, but when and how. However, multiple factors complicate and magnify the challenges involved in achieving such fundamental program reform.

Substantial growth in Medicare spending will continue to be fueled by demographic and technological change. Medicare's rolls are expanding and are projected to increase rapidly with the retirement of the baby boom. For example, today's elderly make up about 13 percent of the total population; by 2030, they will comprise 20 percent as the baby boom generation ages. Individuals aged 85 and older make up the fastest growing group of Medicare beneficiaries. So, in addition to the increased demand for health care services due to sheer numbers, the greater prevalence of chronic health conditions associated with aging will further boost utilization.

Compounding the cost pressures of serving a larger and needier Medicare population are the costs associated with the scientific breakthroughs for treating medical conditions and functional limitations. Technological and treatment advances have resulted in more services being provided to more beneficiaries. These services can restore health, reduce pain, increase functioning, and extend lives. Medical miracles abound, such as medications that reduce the permanent damage resulting from heart attacks, hip replacements that improve the health and quality of life for many, and therapy regimens that promote recovery from what previously would have been debilitating strokes. The frequency and intensity of some high-tech services, however, may be of limited clinical value or fail to improve the quality of beneficiaries' lives.

These technological advances feed the public's expectations that more health care is better. Some expect virtually unlimited services to treat any condition. However, the actual costs of health care consumption are not transparent. Third-party payers generally insulate consumers from the cost of care decisions. In traditional Medicare, for example, the impact of the cost-sharing provisions designed to curb the use of services is muted, because about 80 percent of beneficiaries have some form of supplemental health care coverage (such as Medigap insurance) that pays these costs.

The demographic spiral will increase health care needs over the foreseeable future, while technological changes have begun expanding health care demand. But of this demand, how much are "needs" and how much are "wants?" The distinction is blurred by the effect of scientific advances making available new treatments—which may not be universally applicable or necessarily effective—while individuals continue to be insulated from the full costs of care. At the same time, financial incentives to expand service use fail to be held in check by reasonable assessments of what society can afford.

While these financial questions loom, pressure is mounting to update Medicare's outdated benefit design. However, doing so carries with it the potential to exacerbate Medicare's spending trajectory. Consider the case of prescription drug coverage. In 1965, when the program was first established, outpatient prescription drugs were not nearly as important a component of health care as they are now. Used appropriately, pharmaceuticals can cure diseases, improve quality of life, and substitute for more expensive services. Most private insurance options and Medicaid programs recognize these advantages by including pharmaceutical coverage in their benefit packages. Many seek to similarly modernize Medicare's benefits. However, this desired expansion comes at a time when pharmaceutical companies are increasingly marketing their products directly to consumers—raising the spectre that wants will grow well beyond actual needs. Thus, the question of whether to include prescription drugs in Medicare's benefit package illustrates the importance of affordability counterweights to moderate notions of health care wants.

BBA Reforms Overshadowed by Magnitude of the Problem

The kinds of reforms needed to put Medicare on a more sustainable tooting for the future will require hard choices. Real changes in providers' incomes and services to beneficiaries will undoubtedly be necessary. Substantive reform, not simple financing shifts among funds within the budget—which have been all too frequent in the past as a way to delay the inevitable day of reckoning—will be required to address this daunting problem.

Let's not kid ourselves—this will not be easy. The Balanced Budget Act of 1997 (BBA) illustrates how challenging reforms can be for this program. BBA contains what are probably the most significant changes to Medicare since its inception more than 30 years ago, yet it was never intended to substitute for long-term reform. The changes will extend the HI trust fund's solvency to 2008 before the baby boomers even begin to draw on the program. The changes will also result in an estimated $385 billion in lower program expenditures over a 10-year period through a combination of savings from constrained provider fees, increased beneficiary payments, and structural reforms. To make even these incremental changes to Medicare required substantial effort on the part of the Congress.

Effective implementation of the Act has proved daunting to the Health Care Financing Administration (HCFA), as we have recently reported.[7] Moreover, to the extent that these changes have produced new winners and losers among health care providers, pressures to undo the related changes are growing. For example:

- *Introduction of prospective payment for certain Medicare services*: Prospective payment systems will alter how reimbursements are made to skilled nursing facilities, home health agencies, hospital outpatient departments, and rehabilitation facilities. Rather than paying largely whatever costs providers incur, the objective is to fix rates, giving providers incentives to deliver care and services more efficiently. Our work in this area shows that weaknesses in the design and implementation details could substantially erode the expected savings. Furthermore, over the past year, the Congress has faced intense industry pressure to revisit certain BBA provisions that constrain payments to particular groups of providers.
- *Creation of Medicare+Choice*: The BBA established this new program to encourage the expansion of managed care. It represents a first step toward the restructuring of Medicare from two perspectives. The first addresses cost growth through increased reliance on private sector expertise and resources to control costs. The Medicare+Choice provisions addressing health plan and beneficiary participation reflect in part the expectation that increased managed care enrollment will help slow Medicare spending. To date, Medicare managed care has failed to meet that promise and, owing to payment methodology flaws, has actually cost the government more than if enrolled beneficiaries had remained in traditional fee-for-service Medicare. The BBA attempts to correct this problem by mandating several adjustments to Medicare's payments to managed care plans. These are adjustments which industry representatives have sought to delay and which they claim will lead to less rather than greater plan participation in Medicare+Choice.[8]

The second perspective touches on beneficiary expectations. In principle, managed care can reshape consumer behavior. The intent of Medicare+Choice is to provide beneficiaries a greater menu of plan choices that offer additional benefits, like prescription drugs, not covered in traditional Medicare. Simultaneously, however, plans will attempt to manage care, thus resulting in beneficiaries facing limits on both traditional and additional services. In this way, Medicare+Choice would demonstrate that resources are constrained and that expanding choice must involve trade-offs.

The BBA illustrates the temptation to proceed down the slippery slope of federal treasury funding rather than sticking with the more difficult task of attempting meaningful program or financing reforms. The act calls for reallocating a portion of home health spending from the HI program to the SMI program. This is essentially an accounting exercise that moves obligations from the HI trust fund account to SMI. While this reallocation could position policy makers to develop additional structural reforms for this benefit, the movement of home health payments from HI to SMI alone generates little net savings. Similarly, 1993 legislation increased the taxable portion of Social Security benefits and, for all practical purposes, shifted this additional revenue to the HI trust fund. These two shifts illustrate a pattern of taking from Peter to pay Paw.

The lessons learned so far from the BBA experience are twofold. First, passing the legislation is a bold first step, but remaining resolute and effectively implementing the provisions constitute an equally challenging second step. Second, relative to the reforms necessary to align Medicare spending with the nation's priorities for all spending, BBA's changes may represent only a minor excision when major surgery is required to assure the HI program's solvency. The BBA did result in reduced costs and cut the long-term actuarial imbalance significantly. Nonetheless, the HI and SMI programs together, are still projected to grow by nearly a full percentage point of GDP over the next 10 years. The pressures that continue to drive health care spending upward are exacerbated by the undefined boundaries between what the nation and individuals want, need, and can afford.

Conclusions

Budget surpluses provide a valuable opportunity to capture significant long-term gains to both improve the nation's capacity to address the looming fiscal challenges arising from demographic change and aid in the transition to a more sustainable Medicare program. The President's proposal should prompt a discussion about the

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[7] *HCFA Management: Agency Faces Multiple Challenges in Managing Its Transition tot he 21st Century* (GAO/T–HEHS–99–58, Feb. 11, 1999).

[8] See *Medicare Managed Care: Better Risk Adjustment Expected to Reduce Excess Payments Overall While Making Them Fairer to Individual Plans* (GAO/T-HEHS–99–72, Feb. 25, 1999).

importance of the trust fund concept in disciplining spending for Medicare. The President's proposal is both wide ranging and complex, and it behooves us to clarify the consequences for both our national economy and the Medicare program.

A substantial share of projected budget surpluses over the next 15 years would be used to reduce publicly held debt, providing demonstrable gains for our economic capacity to afford our future commitments. Saving a good portion of today's surpluses can help future generations of workers better afford the billowing costs of these commitments, but we must also reform the programs themselves to make these commitments. more affordable and sustainable over the long term.

The transfer of surplus resources to the HI trust fund, which the administration argues is necessary to lock in surpluses for the future, would nonetheless constitute a major shift in financing for the Medicare program. However, it would not constitute real Medicare reform because it does not modify the program's underlying commitments for the future. Moreover, the proposed transfer may very well make it more difficult for the public to understand and support the hard choices necessary for the program's future viability.

While meaningful reform is urgently needed, it will require reshaping the nation's perspective on health care consumption and draw clearer distinctions between needs, wants, and affordability. Complicating this effort is the nation's strong commitment to maintaining and even enhancing the quality of and access to services. Further, we have a history of technological development, which may in some cases make health care delivery more efficient or effective, but sometimes has driven spending up without contributing significantly to the quality or length of life.

Irrespective of whether the President's proposal is enacted or not, the Medicare program is in need of fundamental reform to assure its solvency and sustainability over the long term. There will be many proposals to modify Medicare and to implement fundamental change. I would suggest the following five criteria for evaluating these proposals.

- Affordability: Changes should ensure that the Medicare program consumes a reasonable share of our productive resources and that it does not unduly encroach on other necessary public programs or private sector activities. Retaining the self-financing feature of the HI trust fund will help instill the necessary fiscal discipline that I fear could be eroded through general fund subsidies for the program. Shifting excess expenditures from one sector of the budget to another or transferring the burden to different payers or future generations should not be construed as actions that will make the trust fund solvent or future program commitments sustainable. Rather, there needs to be a fundamental rethinking of the incentives in the current program that promote increased intensity and utilization of services without sufficient consideration of their costs. Proposals that involve early action on modifications to the program to take advantage of the compounding fiscal dividends of savings that are achieved sooner should be preferred.
- Equity: Reforms should not impose a disproportionate burden on particular groups of beneficiaries or providers. It may be that correcting the distortions created by our current system requires substantial reductions in utilization by certain groups of beneficiaries or of certain types of services. Graduated implementation could make the burden of such shifts less onerous.
- Adequacy: Beneficiaries should have appropriate access to health care services, regardless of their individual ability to pay. Further, the tradition of technology development, which has contributed greatly to health and health care in this country, needs to be maintained in a manner that supports cost-effective and clinically meaningful innovations that enhance the quality and length of life.
- Feasibility: Reforming an entitlement defined in specified benefits rather than dollar terms must involve changing the behavior of beneficiaries and providers. A proposal must contain the correct array of incentives to achieve necessary behavioral change. It must also involve mechanisms that an entity like HCFA can implement and monitor. There must also be provisions for a safety valve to recalibrate aspects when the intermediate goals are not achieved.
- Acceptance: Beneficiaries, taxpayers, and providers must reach a consensus on any major changes to ensure their long-term viability. The path for getting there must begin with steps that will make program costs, which today are barely opaque, much more transparent to the public. Sufficient beneficiary and provider education to the realities of the tradeoffs involved may facilitate their acceptance. Further, a phased approach could help ease any disruptions in services or incomes while garnering public approval.

Applying such criteria will require a detailed understanding of the possible outcomes and issues associated with the various elements of proposals. We will be happy to work to provide the data, information, and analysis needed to help policy-

makers evaluate the relative merits of various proposals and move toward agreement on much needed Medicare reforms.

The time has come for meaningful Medicare reform. Delay will only serve to make the necessary changes more painful down the road. We must be straight with the American people, achieving the goal of saving Medicare will require real options and tough decisions to increase program revenues and/or decrease program expenses. There is no "free lunch."

We have an historic opportunity to deal with the temporary surpluses available today and how we do so could position us better to deal with the future. We also have an obligation to execute our fiduciary responsibilities regarding the nation's fiscal health. This involves demonstrating prudent management of the projected unified surpluses. At the same time, we cannot let the comfort afforded by these temporary surpluses lull us into complacency. Instead, we must capitalize on this opportunity to engage in serious entitlement reform.

We at GAO stand ready to help the Congress as you develop effective, equitable, and affordable solutions for Medicare reform. Working together, we can make a positive and lasting difference for our country and the American people.

Comptroller General
of the United States

Washington, D.C. 20548

For Release on Delivery
Expected at 10:00 a.m.
Thursday, March 18, 1999

Addendum to Statement of David M. Walker

Medicare and Budget Surpluses: GAO's Perspective on the President's Proposal and the Need for Reform (GAO/T-AIMD/HEHS-99-113)

This addendum is intended to update my statement prepared for last week's March 10 hearing. Just in the past week, several significant events occurred that have an important bearing on Medicare reform. The National Bipartisan Commission on the Future of Medicare has concluded its deliberations and the President on March 16 announced his intention to draft a substantive Medicare program reform plan for submission to the Congress.

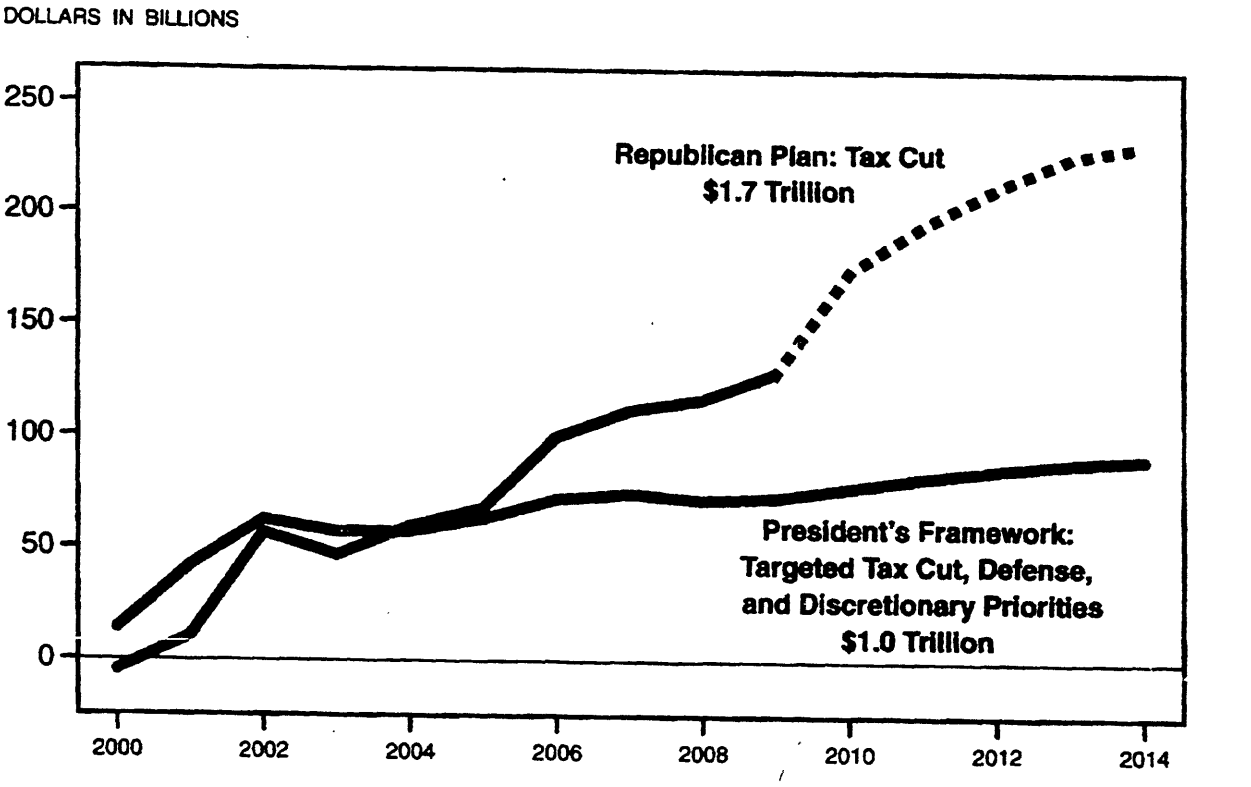
We are heartened by what seems to be an emerging consensus that substantive programmatic reforms are necessary to put the Medicare program on a sustainable footing. As my full statement points out, the President's proposed transfer of new securities to the Hospital Insurance trust fund constitutes a significant financing change by pledging new general revenue funding for the program in the future. However, the President's original proposal for the HI program did not include any meaningful program reforms – reforms which are vital to reducing the program's growth rates that threaten to absorb ever increasing shares of budgetary and economic resources. Extending the ***solvency*** of the HI trust fund must be coupled with real programmatic reforms to strengthen the program's underlying ***sustainability.***

The President's recent announcement is encouraging. He suggested that although substantial new general fund revenues may be needed for the program over the long term, substantive program reforms requiring "difficult political and policy choices" will also be required.

The debate on these issues has already begun with the important work just completed by the National Bipartisan Commission on the Future of Medicare. The Commission's work indeed could be a starting point for the development of a package of programmatic reforms. We should not kid ourselves – reforms will call for hard choices. Congress may want to consider providing new revenues as part of a comprehensive solution, but it may wish to consider making any new financing contingent upon substantive programmatic reforms.

The nation stands at an historic crossroad. The temporary budget surpluses present an historic opportunity to strengthen the long-term economy and the federal budget for the challenges associated with our aging society. Saving a good portion of today's surpluses through such actions as debt reduction can help future generations better afford the ballooning costs of future commitments, but we must also reform programs such as Medicare to make them more sustainable and affordable over the longer term. We at GAO stand ready to help the Congress develop effective, equitable and affordable approaches for Medicare reform.

Republican Plan Allows Large Tax Cuts Instead of Funding Medicare



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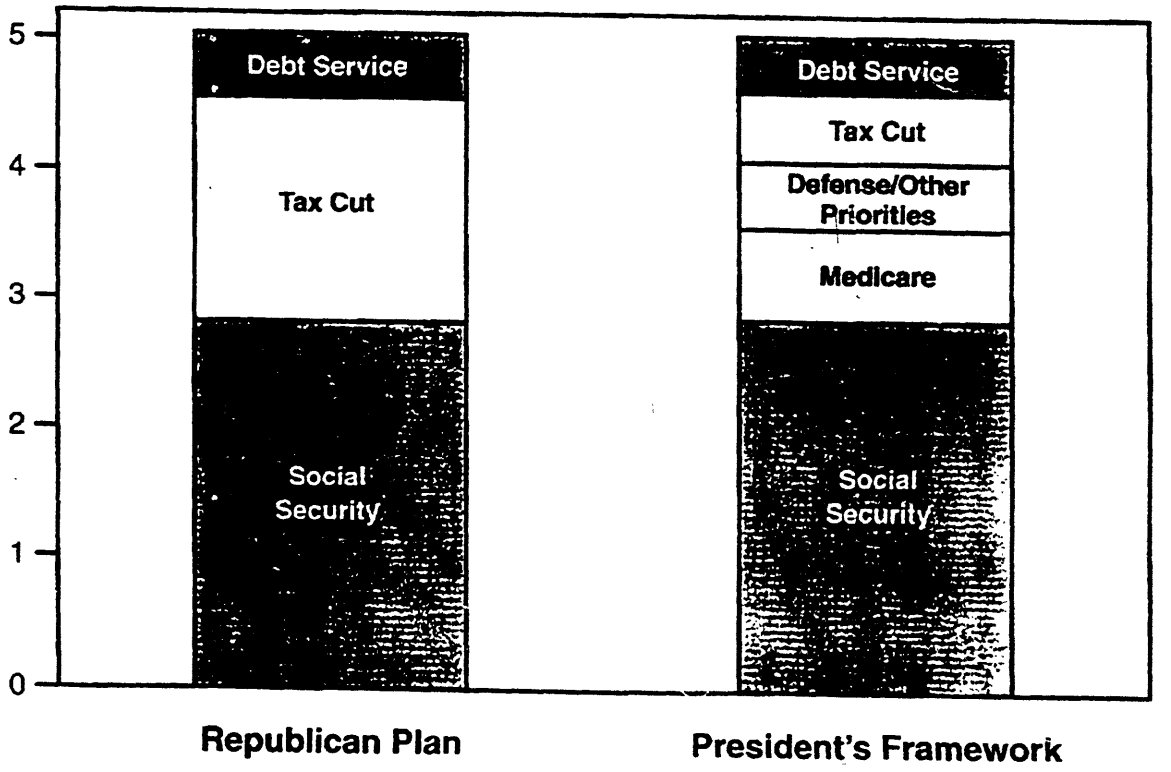
Republican Tax Cut Squeezes Out All Other Priorities Over the Next Fifteen Years

(Allocation of Unified Budget Surplus)

TRILLIONS OF DOLLARS



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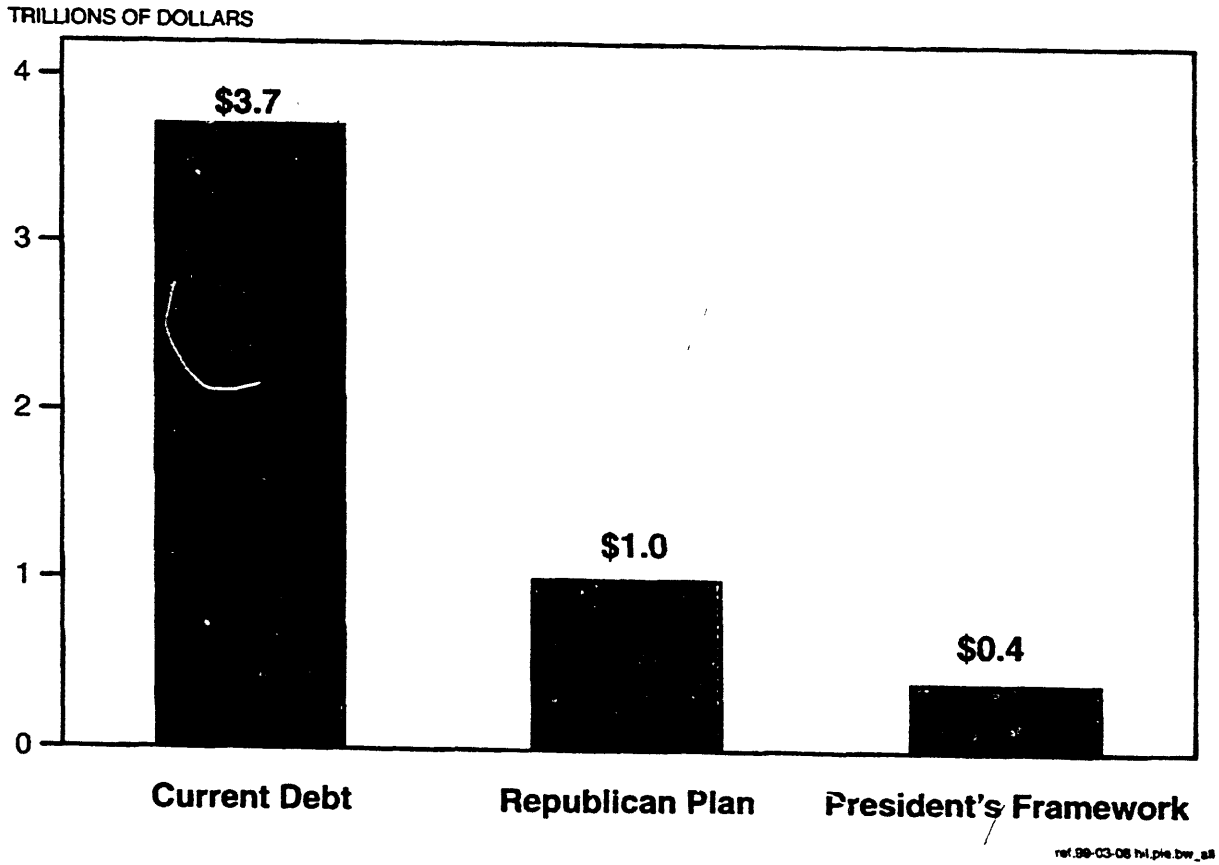
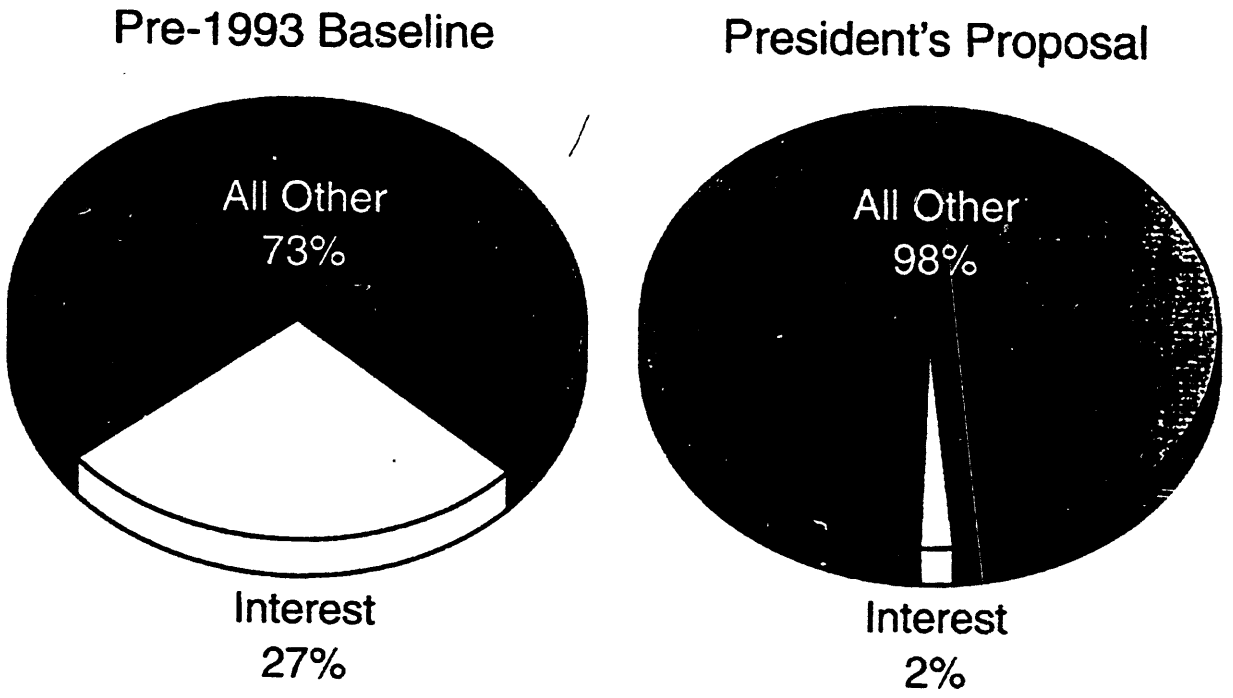
President's Framework Reduces Publicly Held Debt



Interest as a Percent of Outlays in 2014



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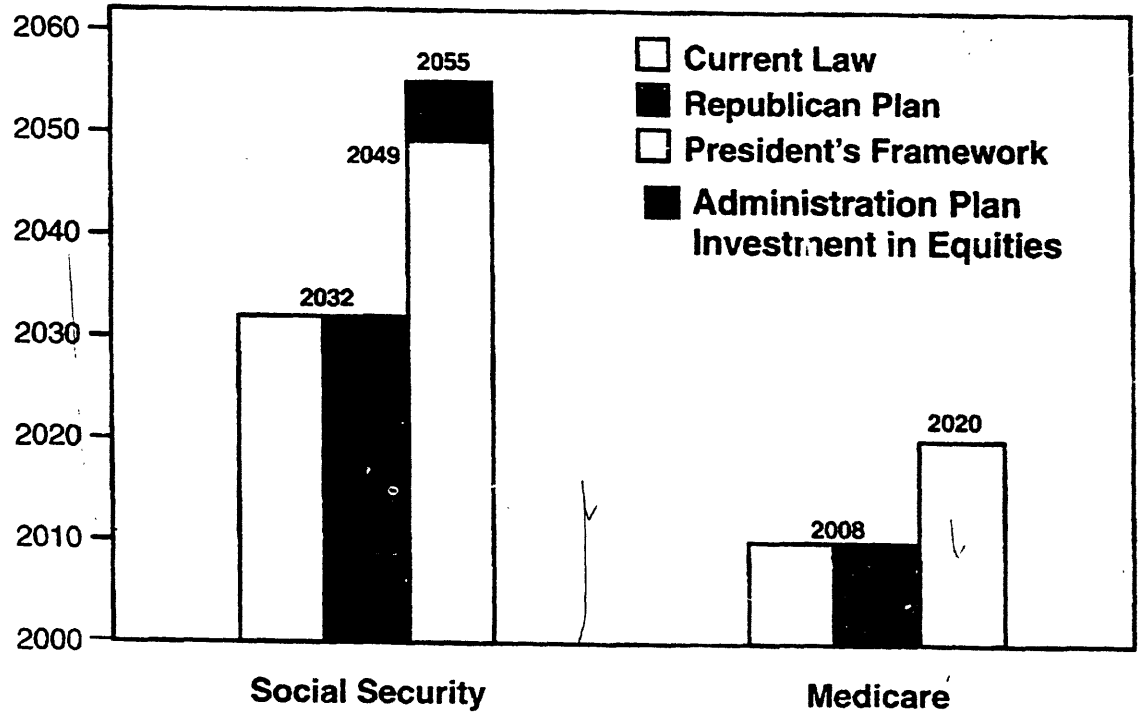
Republican Budget Fails to Extend Solvency of Social Security and Medicare

TRUST FUND SOLVENCY



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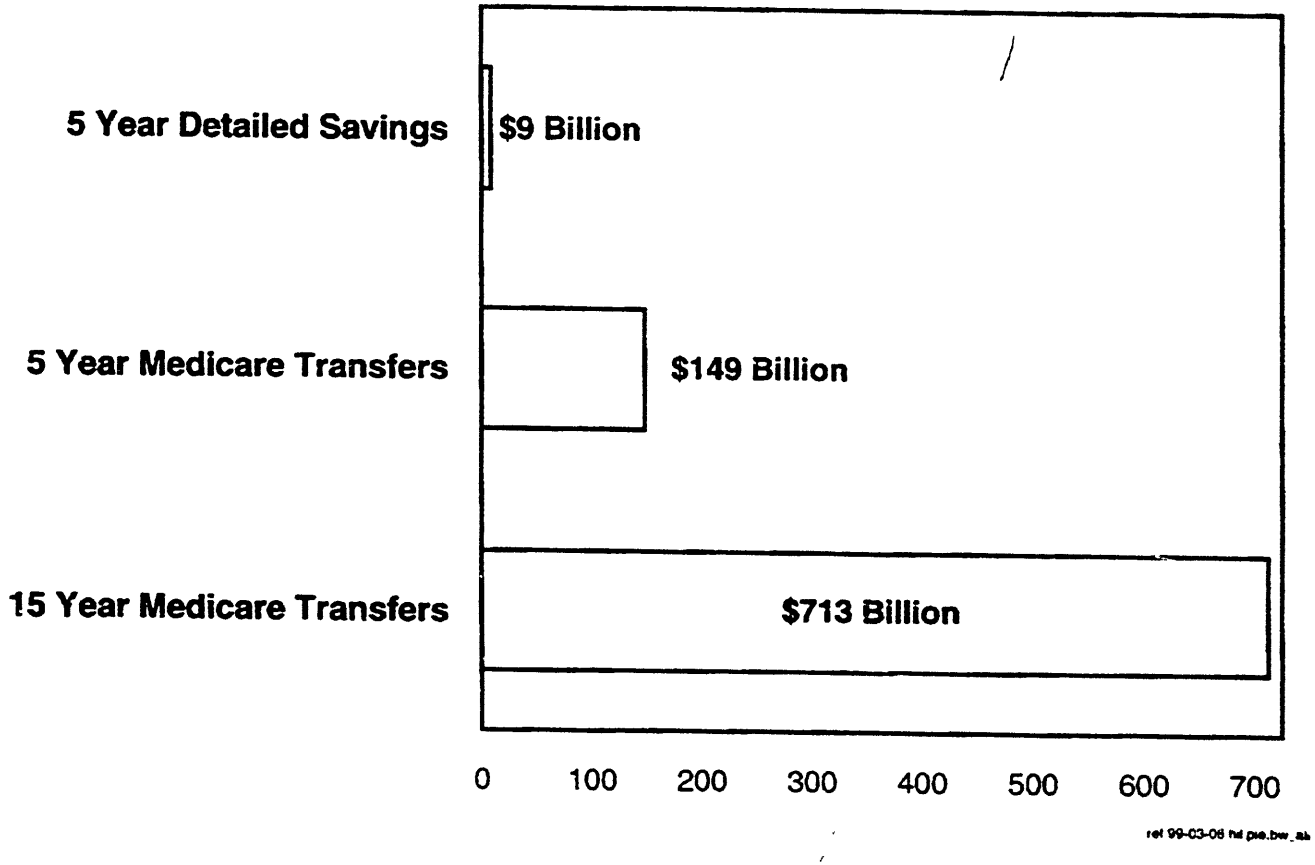
Medicare Savings Proposals Difficult



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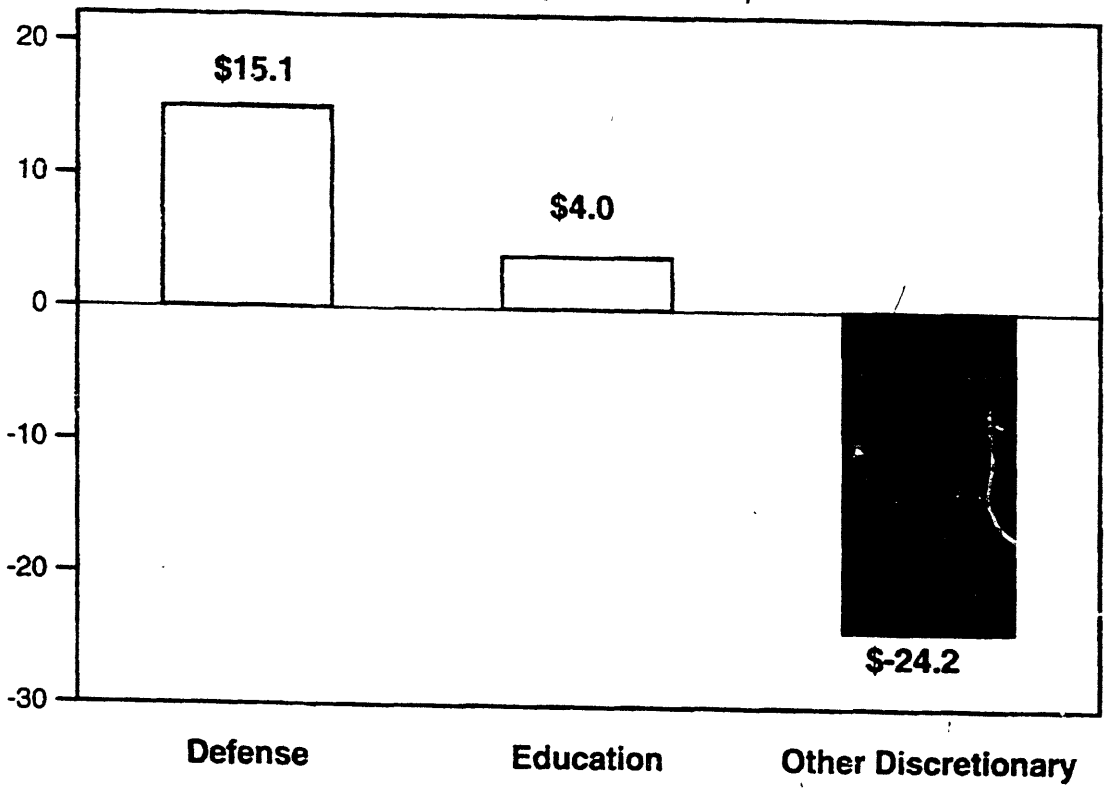
Republican Plan Requires Deep Cuts in Discretionary Spending

(Budget Authority in billions of dollars)



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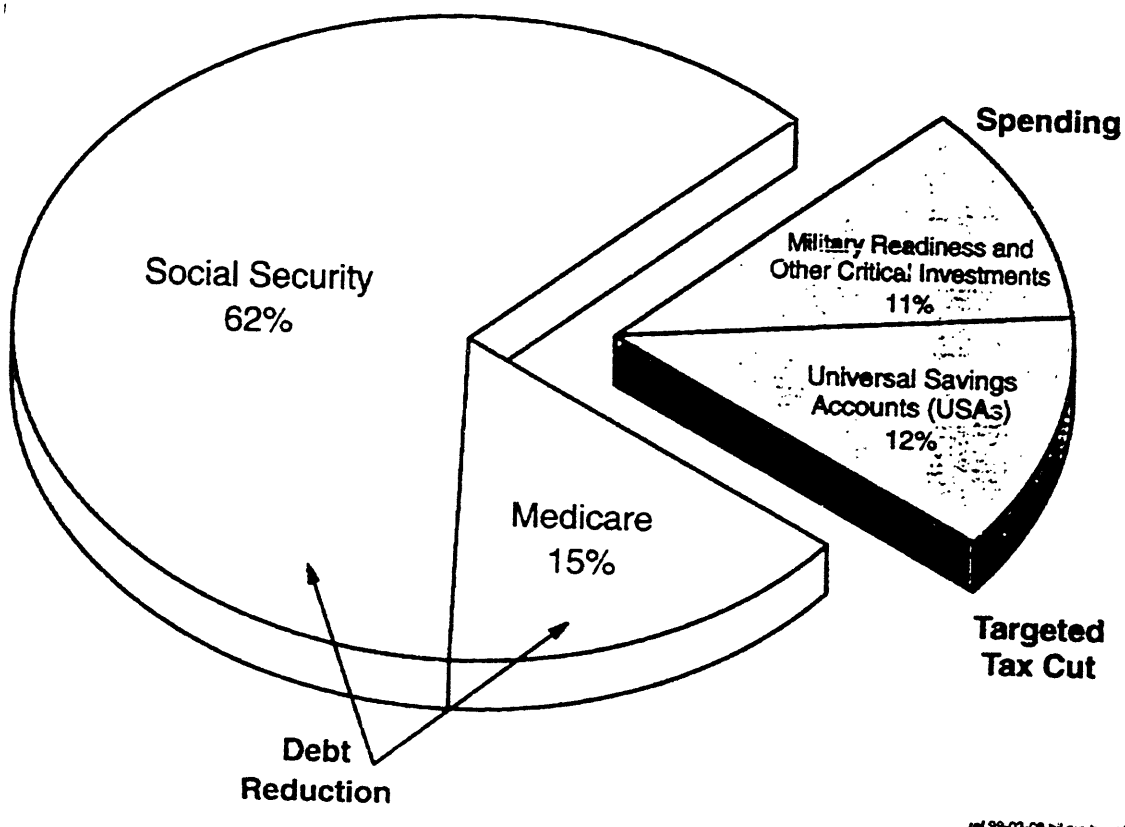
Framework for Social Security and Medicare Reform with Long-Term Fiscal Discipline



COMMUNICATIONS

The New England Journal of Medicine -- March 4, 1999 -- Vol. 340, No. 9
EDITORIAL

Geriatrics, Prevention, and the Remodeling of Medicare

Geriatric medicine has focused primarily on the management of acute and chronic diseases in frail older persons, with much less emphasis on the promotion of health and the prevention of disease than there is in health care for children or middle-aged adults. A growing body of knowledge about disease prevention in later life, including important research by Inouye et al. (1) that is reported in this issue of the Journal, provides a valid basis for strengthening efforts in preventive geriatrics. Given its mission and responsibility, the Medicare program is well positioned to lead such an effort on a national level.

Inouye et al. (1) report a prospective, controlled trial of a multicomponent intervention to prevent delirium in elderly patients hospitalized in an academic medical center. Delirium is a morbid syndrome that develops in 20 to 30 percent of hospitalized elderly patients. (2) It is characterized by the abrupt onset, often at night (as in "sundowning"), of fluctuations in consciousness, inattention, and disorganized thinking. The pathophysiologic basis of delirium is unknown. Preexisting conditions that place patients at increased risk include cognitive impairment, severe acute illness (especially hip fracture or stroke), and visual or hearing impairment. (3,4)

Common factors precipitating delirium include psychotropic drugs, hyponatremia, extracellular volume depletion, adverse effects of general anesthesia, and adverse environmental conditions. Delirium is common, for example, in intensive care units (so-called ICU psychosis). Delirium complicates care and prolongs recovery, thus consuming additional resources. Often people assume incorrectly that delirium is transient, but many patients have cognitive and functional defects that persist for months. (5) Treatment focuses on the correction of precipitating factors, the removal of offending drugs, environmental controls to reduce disorientation, and drugs to control behavior.

In the study by Inouye et al., (1) 426 elderly patients at risk for delirium who were admitted to a single medical ward received an intervention aimed at some of the major risk factors for delirium, including cognitive impairment, sleep deprivation, immobility, hearing and visual impairment, and volume depletion. Patients with profound dementia and those who were delirious on admission were excluded. The control patients were drawn from two "usual care" wards and were matched for age, sex, and base-line risk of delirium with the patients who received the intervention.

The intervention protocols were tailored to individual risk factors and included frequent reorientation and mentally stimulating activities for patients who were cognitively impaired, thrice-daily ambulation or other exercises (for those who were immobile), and visual aids or assistive hearing devices for those who needed them. The intervention reduced the incidence of delirium by 40 percent. Patients at intermediate risk for delirium, according to the number of risk factors, benefited more from the intervention than those at high risk. When delirium developed, it was as severe in the intervention group as in the control group, suggesting that the value of the intervention was in the prevention and not the treatment of delirium.

Surprisingly, the average length of the patients' hospital stay was not influenced by the

intervention. Perhaps other clinical considerations outweighed the presence or absence of delirium in decisions about discharge from the hospital, or perhaps physicians assumed that recovery from delirium might be facilitated by discharge to the patient's home. However, the lack of an effect on the length of hospitalization should not be considered evidence of a lack of savings in cost. Studies of the cost effectiveness of this intervention are still needed, but it is probable that delirium is associated with delayed recovery from acute illness as well as an increased need for services and increased costs after discharge from the hospital.

This study is notable for its focus on prevention rather than treatment, which has been the target of most studies of delirium. This study also overcame some substantial logistic difficulties. One can only imagine the challenge of intensively studying more than 800 acutely ill hospitalized elderly people and performing more than 4800 detailed personal evaluations when the patients always seemed to be away from the ward for tests or being examined by students, residents, or consultants.

Preventive strategies in geriatrics are underdeveloped. Some important progress has been made, as in the prevention of stroke through treatment of isolated systolic hypertension (an important risk factor previously considered to be a harmless accompaniment of "normal" aging) and in the prevention of falls by means of physical training. However, great opportunities remain to prevent or delay geriatric disorders through modifications of lifestyle. For instance, the interrelated characteristics of obesity, a sedentary lifestyle, hyperglycemia, hyperinsulinemia, hyperlipidemia, and hypertension (syndrome X) carry significant risks for the development of coronary heart disease in older persons. (6) However, these risk factors respond to interventions that involve diet and exercise. (7)

Neglect of health promotion late in life seems based on two myths. The first myth is that the increased risk of disease in older persons reflects "normal" aging, which is seen as an inevitable, intrinsic process that is largely genetically determined. The second myth is that the aged body has little plasticity and cannot respond to lifestyle changes. Both myths have been disproved. (8,9)

We now know that risk factors for coronary heart disease and stroke are neither immutable nor largely determined by genetic makeup. Substantial and growing evidence indicates that such established risk factors represent usual rather than "normal" aging and can be modified through lifestyle interventions, including diet and exercise. (8,9) A healthier lifestyle adopted late in life can increase active life expectancy, decrease disability, (10) and reduce health care costs. (11) Combining exercise and dietary interventions, such as the administration of folic acid and vitamin B_6 to reduce plasma homocysteine levels (hyperhomocysteinemia is an important risk factor for coronary heart disease), and smoking-cessation programs might further increase the benefit. Although many questions remain regarding the details of implementation, the time has come for greater emphasis on comprehensive behavioral and medical programs aimed at promoting health and preventing disease among older Americans.

In its new strategic plan, the Health Care Financing Administration (HCFA), which oversees the Medicare program, lists as the first of its goals "to protect and improve beneficiary health and satisfaction." (12) Despite this, Medicare is currently not a health program but rather a health care insurance program. Medicare's primary-prevention initiatives are limited to vaccination against influenza, hepatitis B, and pneumococcal infection. Other preventive services focus on early detection and include screening mammography, screening for colorectal cancer, Pap smears, and measurement of bone density. HCFA recognizes that even these minimal preventive measures are underused and is studying ways to enhance the effectiveness of prevention initiatives.

Current congressional efforts to "reform" Medicare focus primarily on ensuring its continued fiscal stability. The chief new health care service being considered is coverage for outpatient prescription drugs, a valuable benefit discussed in detail by Soumerai and

Ross-Degnan in this issue of the Journal. (13) True reform would balance Medicare benefits by combining prudent purchase of health care services with robust, comprehensive initiatives to promote health and prevent disease. Such an effort, launched in conjunction with a comprehensive review of the current benefits package, would improve Medicare's financial stability, since health care expenses are related to health status, and since reductions in risk factors are associated with reduced expenses.

A broad Medicare-supported prevention program might include payment for exercise, nutrition, and smoking-cessation programs, perhaps offered in senior centers, (14) when these interventions are ordered by a physician for Medicare beneficiaries at documented high risk for disease. As a direct financial incentive, Medicare Part B premiums could be reduced for persons enrolled in health-promotion and disease-prevention programs and for those with low risk profiles, such as nonsmokers. Medicare might also establish requirements for preventive health services in its own managed-care programs. Evaluation of the feasibility and cost effectiveness of such efforts should be a high priority for Congress and HCFA, which must work closely with other federal agencies such as the Agency for Health Care Policy and Research and the National Institute on Aging and with professional organizations and foundations committed to improving the health status of older persons.

Although HCFA's current Healthy Aging Project is a first step in this direction, the initiative must be enhanced and its implementation made a central component of HCFA's strategic plan. Reorientation of the Medicare program toward the promotion of health and the prevention of disease would encourage healthier aging, would be true to Medicare's mission and goals, and could in the long run enhance Medicare's financial stability.

John W. Rowe, M.D.
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EDITORIAL

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References

1. Inouye SK, Bogardus ST Jr, Charpentier PA, et al. A multicomponent intervention to prevent delirium in hospitalized older patients. N Engl J Med 1999;340:669-76.
Return to Text

2. Levkoff SE, Evans DA, Liptzin B, et al. Delirium: the occurrence and persistence of symptoms among elderly hospitalized patients. Arch Intern Med 1992;152:334-40.
Return to Text

3. Schor JD, Levkoff SE, Lipsitz LA, et al. Risk factors for delirium in hospitalized elderly. JAMA 1992;267:827-31.
Return to Text

4. Inouye SK, Viscoli CM, Horwitz RI, Hurst LD, Tinetti ME. A predictive model for delirium in hospitalized elderly medical patients based on admission characteristics. Ann Intern Med 1993;119:474-81.
Return to Text

5. Levkoff SE, Liptzin B, Evans DA, et al. Progression and resolution of delirium in elderly patients hospitalized for acute care. Am J Geriatr Psychiatry 1994;2:230-8.
Return to Text

6. Fried LP, Kronmal RA, Newman AB, et al. Risk factors for 5-year mortality in older adults. JAMA 1998;279:585-92.
Return to Text

7. Hazzard WR. Weight control and exercise: cardinal features of successful preventive gerontology. JAMA 1995;274:1964-5.
Return to Text

8. Rowe JW, Kahn RL. Successful aging. Gerontologist 1997;37:433-40.
Return to Text

9. Rowe JW, Kahn RL. Successful aging. New York: Pantheon, 1998.
Return to Text

10. Vita AJ, Terry RB, Hubert HB, Fries JF. Aging, health risks, and cumulative disability. N Engl J Med 1998;338:1035-41.
Return to Text

11. Russell LB. Prevention and Medicare costs. N Engl J Med 1998;339:1158-60.
Return to Text

12. Health Care Financing Administration Strategic Plan. Baltimore: Health Care Financing

Administration, 1998. (Publication no. HCFA-02135.)
Return to Text

13. Soumerai SB, Ross-Degnan D. Inadequate prescription-drug coverage for Medicare enrollees -- a call to action. N Engl J Med 1999;340:722-8.
Return to Text

14. Wallace JI, Buchner DM, Grothaus L, et al. Implementation and effectiveness of a community-based health promotion program for older adults. J Gerontol 1998;53A:M301-M306.
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