MEDICARE AND THE FEDERAL BUDGET

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MEDICARE AND THE FEDERAL BUDGET

WEDNESDAY, MAY 8, 2002

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

The committee met, pursuant to call, at 10:04 a.m. in room 210, Cannon House Office Building, Hon. Jim Nussle (chairman of the committee) presiding.

Members present: Representatives Nussle, Gutknecht, Collins, Thornberry, Culberson, Putnam, Spratt, McDermott and Davis.

Chairman NUSSLE. Good morning. This is the full committee hearing on Medicare and the Federal budget, and we welcome our witnesses and our guests here today. Nobody would argue that improving Medicare coverage is long overdue, and not many would argue that Medicare has failed to keep up with health care in general or private health care coverage. At a time when medicine is advanced to the point where we can treat more and more conditions with medicines, Medicare's benefit package does not even offer a prescription drug benefit or coverage. Nor does it provide consistent coverage for many preventative treatments, support coordinated management of chronic diseases, or for that matter offer catastrophic coverage.

But the program also is facing huge financial liabilities leading to unsustainable spending levels in the Federal budget in years to come. If you look at Medicare as a whole, taking into account both the Hospital Insurance Trust Fund—HI Trust Fund—and the Supplemental Insurance Trust Fund, Medicare's dedicated revenues are lower than program expenditures even today. As a result Medicare must draw increasing amounts from general revenues within the budget. And with increases in health care costs and demographic changes such as more beneficiaries, longer life expectancy and smaller workforce-to-beneficiary ratios, this problem will only get worse. Therefore, as we look to address the weaknesses in Medicare's coverage, Congress must also ensure that the program is strengthened and preserved so it remains viable for generations to come.

It is for that reason that in this committee a little over a month ago, we passed a budget that included $350 billion over the next 10 years, including money up front, in order to preserve and strengthen Medicare and modernize Medicare with a prescription drug benefit. Let me make it clear in case anyone wasn't paying attention or wasn't listening at the time, it was to include both. It is not just for prescription drugs. If we only take a prescription drug benefit and add it to an already out-of-control Medicare pro-

gram which is not serving the needs of seniors or not paying the bills of many parts of the country, particularly mine in Iowa, we will do no benefit to the Medicare program or to the seniors that it serves. It is for that reason that we included $350 billion of new resources in this budget to do both, modernize, preserve and strengthen Medicare, and to include a prescription drug benefit, not one or the other.

That is one of the purposes of today's hearing, to review Medicare's current condition. Start with the process of strengthening and preserving the program. We will specifically review the impact of Medicare on the Federal budget, address gaps in Medicare coverage, review the factors that will drive Medicare costs, and gain insight into the impact current Medicare reform proposals may have in the Nation's health care system and the Medicare program.

Testifying today we are honored to have Dr. Thomas R. Saving, who is a Medicare trustee; Joe Antos, who is a resident scholar at the American Enterprise Institute; and Judy Feder, who is the dean of policy studies from the Public Policy Institute, Georgetown University. We welcome all three of you to our hearing today.

With that I would turn to my friend and colleague Mr. Spratt for any comments he would like to make.

Mr. SPRATT. Thank you, Mr. Chairman. Let me thank our witnesses for coming and testifying to us about a topic of vital importance, particularly to 35 to 40 million Americans. Without this program I am not sure where they would be, frankly. But as the Budget Committee, when we look at the budget, the items that attract our attention first, are those that are spikes in the budget. Not only are they substantial programs, but their rate of increase is inexorably continual year to year with a few exceptions, like 1999 in the wake of the Balanced Budget Agreement of 1997.

So the questions before us are numerous, and we are glad to have your help in sorting through them. The chairman says that we have provided $350 billion in a reserve account, but there are a number of different claims upon that account. One is Medicare modernization. Nobody knows what it is, much less what it will cost. The other is the drug benefit, and everybody's estimate is that $300 billion, $350 billion is a minimal estimate of what an adequate drug coverage program would cost. And then finally, there is on the table before us submitted by MedPAC, our own designated consultants on Medicare—there is on the table a request of $174 billion in provided payment adjustments. You can't squeeze that much blood out of $350 billion worth of turnips unfortunately.

So we have got some hard questions. What do we do? And aggravating those problems is the fact that the budget assumes that Medicare will cost $225-billion less than CBO assumes over the next 10 years. If CBO is right, not only do we have a reserve fund which won't satisfy all the claims, but we also have an understatement in the Medicare accounts that is substantial. In other words, we have got problems, and we are going to need your help in sorting them out.

Thank you for coming, and we look forward to your testimony.

Chairman NUSSLE. With unanimous consent all members will have 7 legislative days to put a statement in the record at this point, an opening statement. Without objection, so ordered.

[The information referred to follows:]

PREPARED STATEMENT OF HON. ADAM PUTNAM, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

The 107th Congress has been tasked with securing America's future. As Americans reach retirement their future is dependent on their health security. The Budget Committee has gathered here today in an effort to ensure personal health security for our senior citizens, while also ensuring economic security for the Medicare system and future generations of Medicare recipients.

Medicare is our nationwide health insurance program for the aged and certain disabled persons. Over its nearly 35 year history, it has provided important protections for millions of Americans. However, the program is facing a number of problems. One concern is that Medicare's financing mechanisms will be unable to sustain the program in the long run. Many are also concerned that the program's structure, which in large measure reflects both the health care delivery system as well as political considerations in effect at the time of enactment, has failed to keep pace with the changes in the health care system as a whole.

My major concern is the solvency of the Medicare program. Currently, the Medicare Hospital Insurance Trust Fund is projected to become insolvent by 2029 and according to the Congressional Budget Office, the total Medicare Program is already generating huge liabilities: in 2003, Medicare will require $71 billion in general revenues; over 10 years, Medicare will require $1.2 trillion in general revenues. Moreover, Medicare spending will eventually nearly quadruple its share of the economy.

I recognize the need to modernize the Medicare program and endorse a balanced approach to strengthen and preserve this vital program. The budget resolution passed by the House of Representatives provides $350 billion in a reserve fund for Medicare modernization, including prescription drug coverage.

We must create a fair and responsible Medicare program that has improved benefits for its current customers while remaining a stable, solvent program for the future. Medicare's outmoded benefit does not cover prescription drugs, provide consistent coverage for many preventive treatments, support coordinated management of chronic diseases, or offer catastrophic coverage.

Currently, the major focus has been on providing prescription drug coverage for beneficiaries. We must provide our seniors with a prescription drug plan that will lower the costs of prescription drugs now so senior citizens can better afford the medicines they need to live healthier and improve their quality of life. The plan must also keep all of Medicare's benefits financially secure. Failing to provide stable funding for a new Medicare drug benefit is reckless policy that could have substantial adverse effects on the ability of seniors to get the prescription drugs they need. The fiscal year 2003 budget resolution allows for up to $5 billion to begin the implementation of prescription drug coverage.

Today, I am interested to hear how the $350 billion, including the $5 billion for this year will be used to improve the Medicare program. I am eager to know that the funds allocated in the House Budget Resolution will be used to secure the future of American's health.

QUESTIONS

1. In my district, we no longer have any Medicare HMOs remaining. In the last 3 years they have all left. The HMOs were inefficient; they could not even perform a proper referral. The care they provided was substandard. With no HMOs left though, all the patients have come back to Medicare and are creating a burden on the system. How will any reform plans address this problem? Are there plans to improve Medicare HMOs? Are there plans to encourage them to return to areas they have vacated?

2. There is great concern regarding the Medicare physician payment formula. Currently there is legislation (HR 3351, Bilirakis) to change the conversion factor from 5.4 percent to 0.9 percent. The legislation also calls for a Medicare Payment Advisory Commission to develop a new formula that more fully accounts for changes in the unit costs of providing physicians' services. What is the projected cost to Medicare that this change would create? Is there any other possible solution?

3. In my district, I have a group of physicians have not gotten paid by Medicare in the last 3 months. They are beginning to enter into dire financial situations. If they receive an "advance" on the payment there is a 15-percent charge. They are being charged to receive the payment they are already entitled to, and that is already late. It is no surprise that physicians are beginning to discontinue accepting Medicare patients. If patients do not receive care from a physician they often become sicker and end up in the hospital emergency room, which creates a bigger

drain on the Medicare system than if the doctors could just get paid initially. How is a Medicare reform plan going to address the needs of these physicians so they can provide quality care to Medicare beneficiaries?

4. There are several cases in my district, regarding the Medicare Program Safeguards Auto/Liability Department, and I have heard numerous complaints from local attorney's regarding this department. Whenever the attorney has a personal injury/liability case they have to get subrogation lien information from Medicare. A process that should take a couple of days is taking a year with Medicare. The process includes: notifying all of the Medicare carriers that are involved in that particular case, getting the claim amount, when the research comes back they may have to get additional information from the attorney and then calculate the amount. Even so, 1 year is a long time for the attorney to have in his possession all of this money. Medicare also states that the attorney cannot issue a check to his client before they have come up with a figure, because if Medicare doesn't get their money right away the attorney will be held responsible for paying Medicare along with reimbursement penalties and interest. In reality, the attorney's are trying to reimburse Medicare, but having trouble finding out what is owed. They have no way of knowing what amount their client is entitled to or what the settlement will be until Medicare figures the lien amount. If Medicare could perform more efficiently, these patients could have their money before it is too late. Medicare will have $350 billion to improve its efficiency and modernize it systems. Is it going to be possible?

Chairman NUSSLE. Our witnesses today, your entire statements will be made part of the record as well, and you may summarize your testimony as you see fit.

With that, I believe we are going to begin with Dr. Saving. We welcome your testimony at this time.

STATEMENT OF THOMAS R. SAVING, PH.D., MEDICARE TRUSTEE

Mr. SAVING. Thank you, Mr. Chairman. I want to get the right set of slides up here. As Congress considers legislation to add a prescription drug benefit to Medicare, it is important to understand the financial condition of current Medicare. Both of you have alluded to that condition, and in the recently released 2002 trustees' report even though we show slightly better short-term news coupled with slightly worse long-term news from the perspective of the total Federal budget, part of that is trust fund exhaustion dates that have been extended by a small amount. But those things really hide the reality of the demands that these programs, the elderly entitlement programs in general, are going to place on the Federal budget. And what I want to do is to review briefly some things that you can get out of the trustees' report, if you spend the time. If you don't spend the time, you might miss some of these things.

One is the whole idea of the three elderly programs together. Let me give you a feel for that, because these three programs together—in spite of the fact that 78 percent of Part B expenditures, Medicare Part B expenditures, last year were paid by general revenue transfers, as you know, the idea of the premiums is to be 25 percent of—but we only set those premiums at the beginning of the year. We estimate what is going to happen in Part B. The cost of Part B rose significantly last year, greater than we expected, so as it turns out, premiums only covered roughly 22 percent of Part B. But in spite of the fact that 78 percent of Part B expenditures were paid by general revenue, surpluses in Social Security and Medicare Part A were sufficient so that the three programs together—Social Security, Medicare Part A and Medicare Part B—made net contributions to the U.S. Treasury that were equal to 2.5 percent of

Federal income tax revenues, and you can see that if you look at this chart.

You can see that the cost ratio—that the revenues are above the costs of these programs, and, in fact, those surpluses are going to continue to rise. They are going to peak in 2004, just 2 years from now. Then they are going to start to fall very rapidly so that by 2010, these three programs together are going to be requiring a transfer of resources from the general revenue of the Treasury. And, in fact, that transfer is going to grow very rapidly, and I will give you an idea of where that is headed.

Here we have the Social Security and Medicare funding shortfalls as a percent of Federal income tax revenues, and you can see a couple of the things that are very important. In fact, by 2015 we are going to be transferring more than 6.5 percent of all projected Federal income tax revenues to these three programs, and 2015 is 1 year before the Social Security program goes into deficit. So these three programs together already are going to be reacquiring 6.5 percent of Federal income tax revenues, whereas in 2004 they are going to be contributing an amount equal to 3 percent of Federal income tax revenues. So you are going to go from a set of programs which basically contribute to the Treasury, 3 percent of Federal income tax revenues, to programs that are going to be taking 6.5 percent of Federal income tax revenues. By 2020, they are going to be taking 16 percent of Federal income tax revenues; and by 2030, that is the year that we project that the HI Trust Fund is going to be exhausted, these programs are going to be taking 35 percent of Federal income tax revenues. By 2040, the year before we say the Social Security Trust Fund is going to be exhausted, these programs are going to be requiring more than 44 percent of all Federal income tax revenues.

Clearly these programs are out of control, and you can see from just looking at this chart that the three programs together are going to be taking by 2075, in the end, the way the trustees think about it, some 75 percent of all Federal income tax revenues. Clearly that can't happen, and the question is: What do we do about it?

Another way of thinking about this problem, I think a useful way of looking at it, is to ask yourself the commitments that we made under current law, what are the value of these commitments if we consider them in the same way we consider the commitments to pay the government debt? And if you calculate the accrued benefits, the future promises that we have made, you can see that the Social Security benefits are equivalent of almost $13 trillion and Medicare benefits are almost $18 trillion of debt. In contrast, the currently held public debt is about $3.4 trillion. The Social Security debt, and since this is a Medicare hearing, the Social Security debt—while a lot of the press is about Social Security, and we are saying that Social Security is in dire straits, the Medicare problem is bigger than the Social Security problem.

Mr. McDERMOTT. Mr. Chairman, may I ask a question to clarify? You said $18 trillion. Over what period?

Mr. SAVING. If we just look at current people who are going to ultimately be eligible to receive Medicare, and we estimate using the 2002 trustees' report what those payments are going to be, that is a promise in a sense, if we treat that as a promise we made to

people, and now we are calculating what is the present value of that promise and how much we would have to have as an asset right now to be able to pay the promises that we have made in the future. That is what this is, and that is really what—go ahead. I am sorry.

Mr. MCDERMOTT. For what period; is that $18 billion a year?

Mr. SAVING. No. I am sorry. This is the current value. If you had $18 billion in real assets right now, you could pay the projected Medicare costs of all the people who are currently alive and eligible for Medicare, their future payments. That is what this is. It says, let us take everyone who is currently eligible for Medicare. Let us forget about everyone else that is coming after them. Let us just take those people. Let us calculate what we project they are going to use as Medicare expenditures in the future, and ask ourselves how much would we have to have in our bank account to actually cover their expenses, and that is a number like $18 trillion.

Mr. SPRATT. Mr. Saving, if you back out the existing payroll tax revenues, what is the net present value?

Mr. SAVING. In a sense—talking about the unfunded number, but the—we will see it in a moment. This is really just what the debt is, and part of the debt is paid, of course, by revenues. One way to pay for this debt is to increase revenues, as we will see later on, and I think we will want to do that.

The unfunded liability is smaller than that, and I don't have the number. Maybe my associate has it.

No. I can get that for you. At the moment I don't have it right here.

Mr. SPRATT. This is the gross liability.

Mr. SAVING. Exactly. These are the gross liabilities, just the way the Federal debt is a gross liability in a sense. These are the gross liabilities in the systems, not the unfunded liabilities. The unfunded liabilities are significant, as you can see as we get further along.

Here is the situation with current Medicare. You have got three sources of revenue for Medicare. You have got payroll taxes, you have that portion of the tax on Social Security benefits that goes to Medicare, and then we have the premiums. And you have two sources of premiums, although one of those is very small, and that is the premiums for individuals who are not eligible for Medicare Part A, but choose to take Part A as if it were some insurance program. They are allowed to do that.

The primary premium source that we are discussing here, of course, is the Part B premium, and you can see that Medicare is already in deficit. As you look at this, and this comes right from the 2002 trustees' report, you will see that the costs of Medicare A and B together are going to fall slightly over the next 2 years. Now, you might say if this thing is going so badly, where is that fall going to come from? Part of that fall is our programming in of reduced physician reimbursements, and we recognize as trustees, and this came up in the trustees meeting in March, this is already having an impact on the availability of physicians' services for Medicare beneficiaries, and we recognize that we are programming in—we are just going to pay physicians less and ignore the impact

that is going to have on supply of physician services for Medicare patients.

It is clear that that is not any kind of a long-run solution, and that is where this reduction in expenditures—a very brief one—is coming from, but you can see what is going to happen. At the point where we say the HI Trust Fund is going to be exhausted, 2030, you can see 20-something percent of Federal income tax revenues are going to have to be transferred to Medicare. Right now Medicare is taking about 5 percent of Federal income tax revenues. We are transferring to Medicare Parts A and B, and we already know that Medicare is in deficit. That is going to rise very slowly actually between now and 2010, and looking at the graph, it is only going to be 6 percent, we estimate, in 2010.

Then it is going to start to rise rapidly. It will be 8½ percent of Federal income tax revenues by 2015, 12 percent by 2020, and by 2030 again, the year in which we say the HI Trust Fund is going to be exhausted, more than a fifth of all the Federal income tax revenues are going to have to be transferred to this program.

So over the next 20 years the benefits as a percent of earnings are expected to grow 50 percent, implying a contemporaneous tax rate. If you were to actually pay the Medicare system through—and this comes back to the issue of revenues—a tax rate of 6.33 percent in 2022 would be enough to fund Medicare in that year on a pay-as-you-go kind of basis. By 2030 all the baby boomers will have retired, and the Medicare tax necessary to make these payments would be 8.12 percent, and they will continue to rise, reaching 10 percent by 2040 and 18.3 percent by 2080.

We are talking about very significant effects of the current Medicare program, and all this time, of course, tax revenues are going to be rising, that is premium revenues, because premiums right now are $648 a year. That is about 6.3 percent of an average retiree's Social Security benefit, and they are going to rise to $3,000 by 2070, and that will be about 13 percent of scheduled Social Security benefits.

So the premium burden—and that doesn't mean we shouldn't have a premium burden, but the premium burden is going to be rising, but that comes from the fact that our current forecasts are that medical care expenditures are going to be rising at 1 percentage point faster than per capita gross domestic product, and that pretty much says what has been happening. That is, seniors consume—when their income goes up—a lot more medical care, and perhaps because a lot of things have become available that allow for quality of life enhancement, and I think quality of life enhancement is important. And as I said, some of the times I look at people, and I tell them I actually even have a Medicare card even though I am still employed by the university. It is a secondary payer; so I have never collected anything from Medicare, but it is a card.

And I see nothing wrong in trying to maintain quality of life as we know, but currently elderly entitlement payments are out of control. If nothing is done, and I think this is an important point, the combination of Social Security and Medicare are going to exhaust more than 72 percent of the Federal budget that remains at the current budget share of gross domestic product. These pro-

grams today only account for 37 percent of that Federal budget. So you are looking at these programs doubling in size relative to the Federal budget.

Now, in spite of those funding changes, Medicare offers kind of second-rate coverage, and I think that point was made here. The role of pharmaceuticals in health outcomes is much more important than it was when Medicare was established. There isn't any doubt about that, and in spite of the increased efficacy of pharmaceuticals in health outcomes, current Medicare makes non-pharmaceutical components cheaper than pharmaceuticals, and if we are trying to do an efficient outcome, we would want people to consume more pharmaceuticals and less physician care. But the way Medicare is structured, it encourages them to actually do things that are more expensive than pharmaceuticals, so as a result, Medicare recipients have incentives to substitute physician and other covered components of health care for what would be less expensive and more efficient pharmaceutical treatment.

Essentially the current structure of Medicare discriminates against pharmaceuticals and results in more costly and less effective health care. That said, given the bleak financial future of Medicare, what can be done to bring the pharmaceutical coverage into the program without further endangering the financial future of the program? And that is the issue that this committee is discussing today. You have to take steps that make both providers and beneficiaries care about the cost of care. That is important.

One approach toward this end is to combine Parts A and B of current Medicare into one program. This new program should include pharmaceutical coverage, just as the standard health care coverage for the working population does. You would want to include catastrophic coverage. The latter issue would eliminate the need for beneficiaries to purchase Medigap, and if you could get rid of first dollar coverage, you could have a very significant effect on health care costs. In fact, I have argued before that the competition for the first dollars of Medicare patients is a huge market, and that kind of competition by providers would reduce costs for everyone.

I have a dream—often when I drive to Dallas to visit my children, I see these signs, billboards, and those signs are for LASIK surgery. If you have seen those signs yourself, you know that the biggest number on the sign is the price, what LASIK surgery costs. And I keep dreaming of the day when I am going to see a billboard for a doctor or a hospital where the most dominant thing on the billboard is the price to try to attract people by lowering prices. And if you see a billboard for a hospital, which you do, price is never mentioned because nobody cares what it costs, and if the customers don't care what it costs, you can be sure that the providers don't care what it costs. They love to provide high-cost services for patients who don't care what it costs.

And then third, we must increase the premium of health care markets to work. In our current approach of fixing the price of medical services—MedPAC was just mentioned—MedPAC essentially circumvents normal market forces. If we give beneficiaries a greater role in the choice of health care plan in a way similar to the FEHBP, we can increase provider competition. And we have to make a greater effort to make all Medicare beneficiaries equally de-

sirable to providers, and that is a real issue: how do we keep skimming individuals?

So basically, in the debate concerning changes in Medicare, we allow an addition of prescription drug benefits, it is important to consider how these changes will impact on current Medicare's precarious financial condition, and we are projecting these huge deficits as trustees. We don't like to present bad news. Unfortunately, the way these programs are structured, they are heading toward a real financial crisis. It is not clear how we are going to accomplish adding something which I think is important, drug benefits, in order to change the pricing structure so that people will have incentives to buy the efficient combination of pharmaceuticals, physicians and hospitalization; and to accomplish that at the same time finding a way to pay for the costs that are down the road, are coming down the road, that are going to take a huge share of the Federal budget.

Thank you.

Chairman NUSSLE. Thank you, Doctor.

[The prepared statement of Dr. Saving follows:]

PREPARED STATEMENT OF THOMAS R. SAVING, PH.D., MEDICARE TRUSTEE

As Congress considers legislation to add a prescription drug benefit to Medicare, it is important to understand the financial condition of current Medicare. In less than a decade the combined Social Security and Medicare programs will go from providing net revenue to the Treasury to requiring a revenue transfer. Even though this year's Trustees' Report shows slightly better short-term news coupled with slightly worse long-term news, from the perspective of the total Federal budget, these programs will impose significant costs even in the near term. The fact that the Trustees 2002 estimates of Trust Fund exhaustion dates are 3 years later for Social Security and 1 year later for Medicare HI has obscured the reality that the demands of these programs on the rest of the budget will begin in just a few years. A total budget perspective is important because though Social Security and Medicare HI have Trust Funds, when revenues into the combined system fall below expenditures, real resources must come from somewhere else in the Federal budget.

The total budget perspective good news is that, in spite the fact that last year almost 78 percent of Medicare Part B expenditures were paid by general revenue transfers, surpluses in Social Security and Medicare Part A were sufficient so that these three programs, Social Security, Medicare Part A and Medicare Part B, made a net contribution to the U.S. Treasury that was equal to more than 2.5 percent of total Federal income tax receipts. By 2004, the contribution of these programs to Federal coffers will grow to more than 3 percent of projected Federal income tax receipts.

The bad news that is after 2004, in just two short years, this net surplus will begin an accelerating decline. By 2010, just 8 years from now, the 2004 contribution of 3 percent of total income tax receipts to the U.S. Treasury will become a deficit. Rather than providing funds that add to Federal income tax revenues, these programs will require a transfer from these same Federal income tax receipts and begin to impinge on other Federal programs. Moreover, the magnitude of the required transfer from Federal income tax receipts will grow rapidly so that by 2015 more than 6.5 percent of all Federal income tax receipts will have to be transferred to meet program expenditures.

The problem doesn't end in 2015 because the required transfers will continue to grow rapidly. By 2020, in order to maintain current program benefits, these three programs will require a transfer from the Treasury of almost 16 percent of all Federal income tax receipts. The transfer will grow to more than 35 percent of Federal income tax revenues by 2030 and by 2040, a year before the current estimate of Social Security Trust Fund exhaustion and almost 10 years before newly entered workers will retire, these programs will require almost 44 percent of total Federal income tax receipts.

In spite of Social Security's problems getting most of the press, Medicare is already in deficit and its' financing future is much more ominous. Last year, Medicare Part A and Medicare Part B together, required a transfer from the U.S. Treasury

that was equal to more than 5 percent of total Federal income tax receipts. By 2010, just 8 years from now, and at the front end of the baby boomer retirement wave, Medicare will require the transfer of more than 6 percent of all Federal income tax receipts to pay benefits forecast by the Trustees under current law. This transfer will grow rapidly so that by 2015, the year before the Trustees forecast that HI expenditures will exceed HI revenues, 8.5 percent of all Federal income tax receipts will have to be transferred to Medicare.

Because of the expected growth in health care cost, the required transfers will continue to grow rapidly. By 2020, in order to maintain current program benefits, Medicare will require a transfer from the Treasury of 11.9 percent of all Federal income tax receipts. The transfer will grow to more than 21 percent of Federal income tax revenues by 2030, the year before the Trustee's forecast the exhaustion of the Medicare HI Trust Fund. By 2040, a year before the current Trustees estimate of Social Security Trust Fund exhaustion and almost 10 years before newly entered workers reach retirement age, Medicare will require a transfer of more than 28 percent of total Federal income tax receipts in order to maintain current law benefits.

Over the next 20 years, forecast Medicare benefits as a percent of earnings will grow 50 percent implying a contemporaneous tax rate of 6.33 percent in 2022. By 2030, all the baby boomers will have retired, and the tax rate necessary to pay their benefits in that year is 8.12 percent. If the status quo intergenerational financing of Medicare is maintained, tax rates will continue to rise reaching 10.0 percent of payroll in 2040 and 18.13 percent of payroll in 2080. All during this time premiums for Part B will also be rising, from their 2002 level of $648 per year, or about 6.3 percent of an average retiree's Social Security benefit to premiums will rise to $3,000 in 2075, about 13 percent of average scheduled Social Security benefits.

As these figures make clear, Medicare, as it is currently structured, is going to become more and more of a general revenue transfer financed program. In 2001, 25 percent of Medicare expenditures were financed from general revenues. This proportion rapidly rises as the baby boomers retire. In 2010 more than 27 percent of Medicare expenditures will be general revenue financed and by 2015 more than one-third of all Medicare expenditures will be financed via general revenue transfers. The size of the required general revenue transfer continues to rise rapidly reaching almost 40 percent of expenditures by 2020, and 47 percent by 2025. By 2030, the year before we as Trustees forecast that the Medicare HI Trust Fund will be exhausted, more than 52 percent of all Medicare expenditures will be financed by transfers from general revenues and by 2040 almost 60 percent of all Medicare expenditures will be financed via transfers from general revenues.

Clearly, elderly entitlement programs are out of control. If nothing is done, by 2060, the combination of Social Security and Medicare will exhaust more than 72 percent of a Federal budget that remains at the current budget's share of the nation's gross domestic product. By way of comparison, these two programs today account for only 37 percent of Federal expenditures.

The promises implied by the Social Security and Medicare programs are essentially debts that must be paid by future taxpayers. Using the estimated costs of Social Security and Medicare from the 2002 Trustees Reports, we can calculate the size of Social Security and Medicare debt. This exercise is useful because it points out the staggering size of the promises we have made compared to what we usually refer to as the public debt. In 2001, the value of U.S. Treasury debt held by the public was $3.32 trillion. In contrast, the present value of Social Security promises was $12.92 trillion and the present value of Medicare promises was a staggering $17.4 trillion. Between now and the time it takes for the baby boomers to move through retirement, we will have to pay off all of this Medicare and Social Security debt. In doing so we must bear in mind that the retired baby boomers are going to eat real food, live in real houses, drive real cars and use real hospitals, doctors and nurses. The young will have to produce all this output, essentially paying off the huge debt by consuming less while the retired baby boomers consume more of the nation's output.

These numbers, while staggering, are not meant to frighten, although they are frightening. They are based on the best estimates that we as Trustees of the Social Security and Medicare trust funds are able to put together. If not meant to frighten, they surely represent a sobering reality. The question to ask as you consider changing Medicare is: How any changes will impact on Medicare's already dismal financial future?

CHANGING MEDICARE FOR THE 21ST CENTURY

In spite of the substantial funding challenges facing Medicare, as it is currently structured, Medicare offers second rate coverage of health related episodes. The role of pharmaceuticals in health outcomes is much more important than it was at the inception of Medicare. In spite of the increased efficacy of pharmaceuticals in health outcomes, current Medicare makes non-pharmaceutical components of care cheaper than pharmaceuticals. As a result, Medicare recipients have incentives to substitute physician and other covered components of health care for what would be less expensive and more efficient pharmaceutical treatment. Essentially, the current structure of Medicare discriminates against pharmaceuticals and results in more costly and less effective health care.

This said, given the bleak financial future of Medicare, what can be done to bring pharmaceutical coverage into the program without further endangering the financial future of the program?

First, we must take steps to make both providers and beneficiaries care about the cost of care. One approach toward this end is to combine both Parts A & B of current Medicare into one program. This new program should include pharmaceutical coverage just as standard health coverage for the working population does.

Second, we must include catastrophic coverage. This latter issue would eliminate the need for beneficiaries to purchase Medi-Gap coverage. In fact, Medi-Gap would disappear from the market because of adverse selection. Without Medi-Gap's first dollar coverage, users of the health care system would begin to care about cost. Importantly, if users care about cost, providers would quickly begin to care about costs. These incentives would result from a single, higher deductible on the unified package. Suddenly, cost reducing technological developments would begin to have the same benefits to providers as they do in other industries. We might begin to see billboards for health procedures similar to those we see for LASIK surgery, where price plays the dominant role. I dream of the day when I will see a billboard for a doctor or hospital where the most dominant thing is the price of the service being offered.

Third, we must increase the freedom of health care markets to work. Our current approach of fixing the price of medical services through MedPac essentially circumvents normal market forces. If we give beneficiaries a greater role in the choice of health care plan in a way similar to the Federal Employee Health Benefit Plan approach, we can increase provider competition. To do so, however, requires that we make a greater effort to make all Medicare beneficiaries equally desirable to providers.

THE CHOICE BETWEEN TAX FINANCING AND SAVING

As we have seen, Medicare will require substantial transfers from the rest of the Federal budget. Without substantial restructuring, simply adding prescription drug coverage will increase Medicare's costs. Medicare's funding gap, even as projected without a prescription drug benefit, gives rise to considering other funding alternatives. One such alternative to have people save more for their retirement. Additional savings now can be used to lessen the tax burden required under the present financing arrangement.

Comprehensive Social Security reform proposals often include increased savings as a key component, but in the context of Medicare reform, increased saving is seldom mentioned. Because Medicare is an in-kind benefit conditional on use of the health care system, benefit growth is affected by both changing preferences and changing technology. As a result, identifying the right amount of additional saving is difficult. But regardless of the difficulty in forecasting, funding future Medicare will require imaginative ways to meet its costs.

Current Medicare reform proposals address Medicare's growing financial burden by advocating increased competition in the delivery of care. In the longer term, Congress will need to think about funding alternatives including incentives to save for retirement health care.

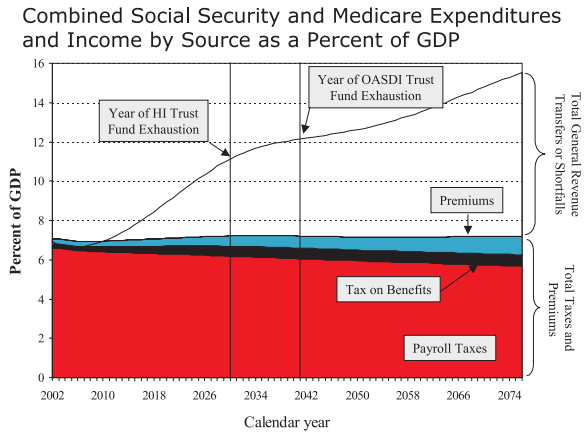
CONCLUSION

In the debate concerning changes in Medicare that will allow the addition of a prescription drug benefit, it is important to consider how these changes will impact on current Medicare's precarious financial condition. The deficits projected by the Trustees in the 2002 Annual Report of the Boards of Trustees are especially significant. If no changes are made in Medicare, it will rapidly become the tail that wags the Federal budget dog. By 2030, Medicare alone will require more than 21 percent of all Federal income tax revenues. When coupled with the transfers to pay cur-

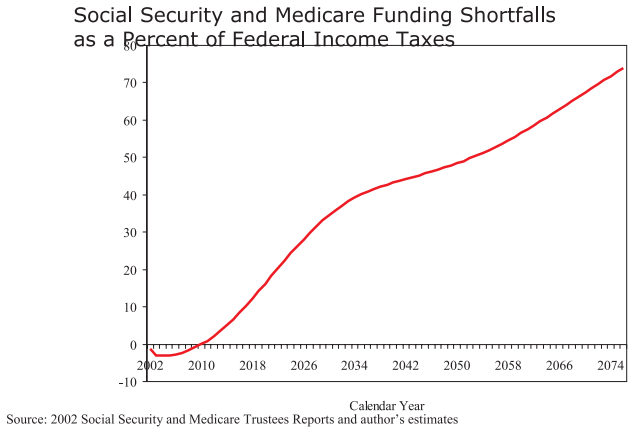
rently scheduled Social Security benefits, total transfers of general revenues to keep these programs intact will require more than 35 percent of Federal income tax revenues in 2030. If other Federal programs are to remain at anything like their current size, dramatic action will be required.

Thus, as we change Medicare to update its coverage, we should introduce incentives for market forces to work toward controlling the future cost of care. The impetus to incorporate prescription drugs into Medicare presents a unique opportunity to bring Medicare into the 21st century. Redo Medicare so that the need for beneficiaries to purchase Medi-Gap will be eliminated. The elimination of Medi-Gap will increase incentives for users and providers alike to care about cost. We should rethink both the structure and financing of Medicare. A new Medicare that combines Parts A & B and includes both prescription drug and catastrophic coverage into a single entity with a combination of premium and tax financing is a start. We must then make the market for this new Medicare one where the normal forces of competition work to control the cost of medical care. This can be accomplished if both users and providers care about cost.

SLIDES PRESENTED AT HEARING



Source: 2002 Social Security and Medicare Trustees Reports and author's estimates



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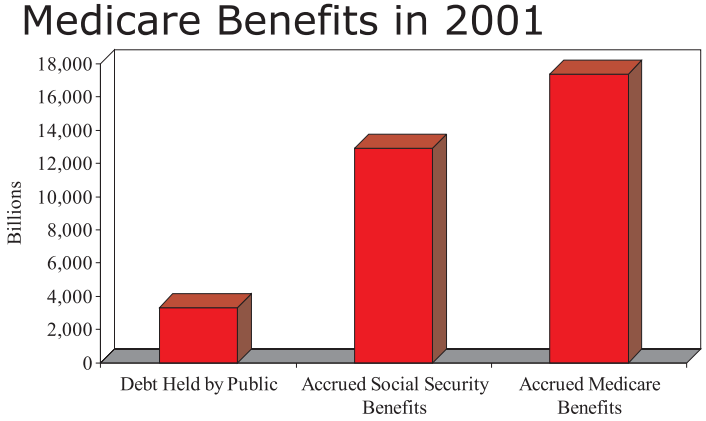
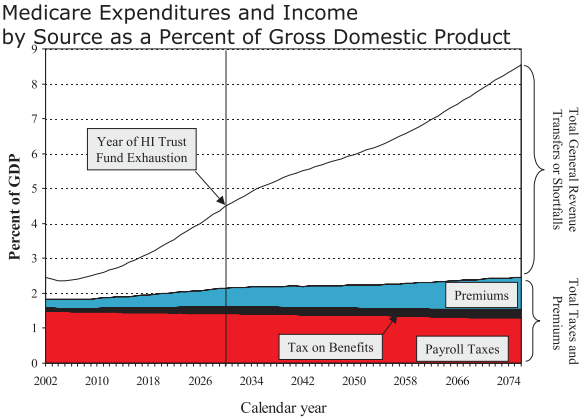


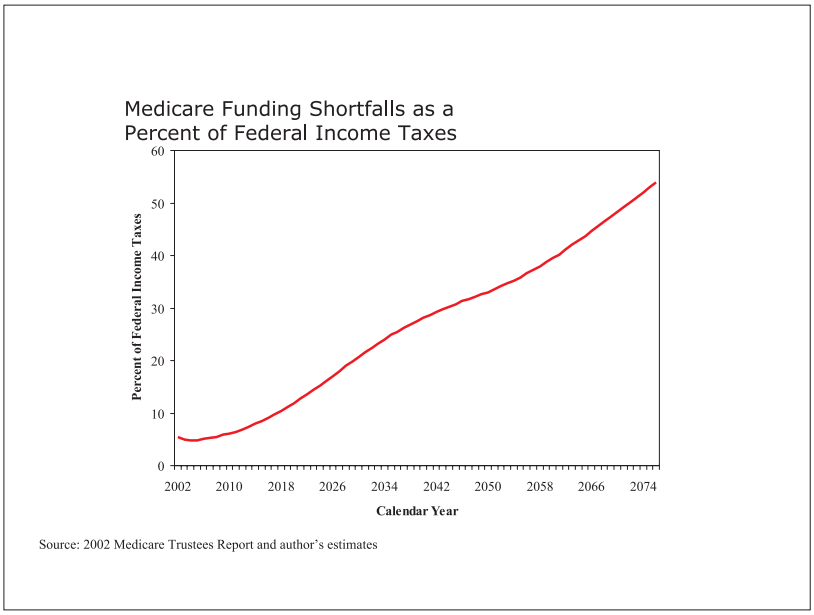
Composition of Total Debt in 2001

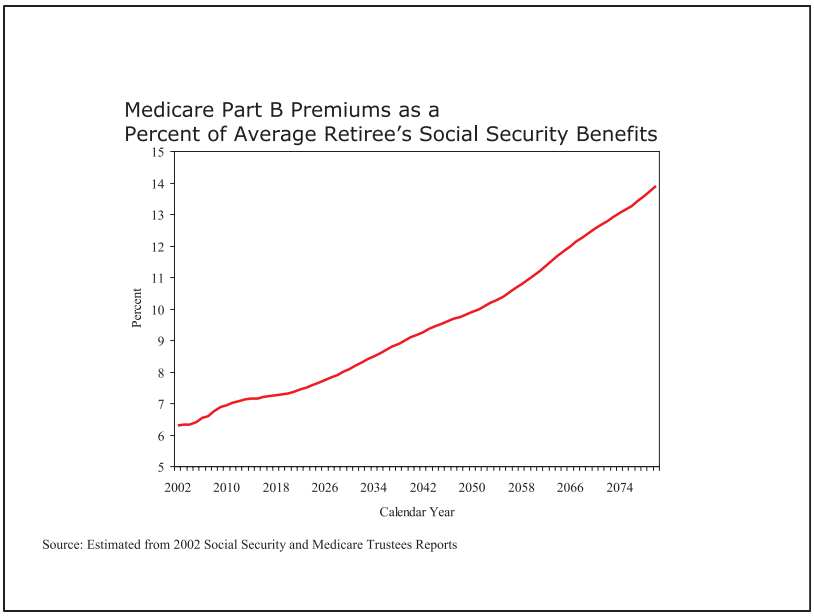
Category	Billions	% of GDP
Debt held by the public	3,320	32.70
Accrued Social Security Debt	12,919	127.24
Accrued Medicare Debt	17,404	171.42
Total	**33,643**	**331.36**

Sources: 2003 Federal Budget, Unpublished Social Security Administration estimates (2001), and authors' calculations.

Medicare Expenditures and Income by Source as a Percent of Gross Domestic Product







Chairman NUSSLE. Next is Dr. Joe Antos, and we welcome you to the committee, and pleased to receive your testimony.

STATEMENT OF JOSEPH R. ANTOS, PH.D., RESIDENT SCHOLAR, AMERICAN ENTERPRISE INSTITUTE

Mr. ANTOS. Thank you, Mr. Chairman.

Chairman NUSSLE. There is a microphone button you need to push.

Mr. ANTOS. Thank you, Mr. Chairman, for that reminder.

Medicare is a vitally important program. It has given seniors access to affordable, high-quality health care. But Medicare is in crisis. As the latest report from the Medicare trustees makes clear, Medicare spending is projected to grow rapidly for the foreseeable future, outstripping growth in the economy and in Federal revenues. Yet Medicare has not met—could we have a blank screen there for a while? Thanks. Yet Medicare has not met the needs of beneficiaries nor the concerns of health care providers.

First, beneficiaries are increasingly vocal about gaps in Medicare's benefit package, particularly the failure to offer coverage for prescription drugs. In addition, Medicare leaves beneficiaries exposed to potentially unlimited costs because it does not offer catastrophic protection. Beneficiaries obviously want greater insurance coverage since many of them purchase expensive Medigap policies, but the Medicare program has been unable to respond to these clear consumer demands.

Second, providers criticize what they view as inadequate payments for services. Payment issues, as we know, are on the top of Congress' "to do" list. The furor over mandated cuts in physician payment has led to reports that doctors would drop out of Medicare. It is not entirely clear how significant a problem that is right now, but obviously it is a danger. In any event, Medicare's payment formulas often do not reflect actual conditions in the local health care market. It can take years to make changes in the formulas despite clear evidence that there is a problem.

Third, Medicare's administration is unnecessarily complex and inflexible. The proliferation of regulations, manual instructions and other guidance is meant to clarify how to satisfy program requirements in specific real world circumstances. But the process breeds errors, uncertainty and mistrust on all sides.

Medicare's crisis is not just a financial problem that will occur sometime in the distant future. The crisis is pervasive, reflecting longstanding defects and rigidities in the Medicare program, and it is happening now. How can we transform Medicare to be responsive to beneficiaries and to provide better value for the taxpayer? The Federal Employees Health Benefit Program offers an example of what could be achieved. Such an approach could provide more meaningful health plan choices to beneficiaries than are now available under Medicare+Choice with safeguards to assure reliability and high quality. Micromanagement and formula-driven payment rates could be replaced by a flexible approach to administration based on negotiation and market information. It would be a big change.

A competitive strategy, even one based on an operating model such as the Federal employees health program, must be developed carefully and will take time. Congress is likely to take more immediate steps to address some of the deficiencies of the current program. A risk of that approach, in other words doing temporary actions now, is that some policy decisions could hinder subsequent restructuring efforts, or at least forego an opportunity to foster reform.

Medicare drug prescription benefit is a case in point. Adding a stand alone drug benefit could retard progress on broader reform and reduce the program's financial liability in the long term unless other program changes also remain to improve incentives in the program. A drug benefit ideally would be part of the broader reform and the benefit, that benefit, would be part of an integrated package of benefits provided by health plans participating in the Medicare program.

Let us consider the long-run impact of a stand alone drug benefit on Medicare's finances. And how do I get this started? I want the first slide. That slide. OK. Thank you.

The first slide plots Medicare spending in revenue as a percentage of GDP. Dedicated revenue, which is the bottom line there, counts funds specifically earmarked for Medicare. That includes the Medicare payroll tax, part of the tax on Social Security benefits and premium revenues. According to Medicare trustees, I copied from their report, program spending will climb from about 2.3 percent of GDP—no, go back.

Mr. SAVING. I am trying to be your assistant.

Mr. ANTOS. Thank you. Of course, you are worth what you are paid.

Program spending will climb from 2.3 percent of GDP in 2000 to 4.5 percent of GDP in 2003. You can see that top red line. That is doubling costs for the program in real terms. That is roughly equivalent to a Medicare program costing $450 billion this year rather than the $250 billion that is expected in 2002.

What about that gap? The gap between spending and dedicated revenue represents the amount of general revenues that would go into Medicare. As you can see, general revenue transfers to Medicare would rise to 2.4 percent of GDP by 2030.

Now let us add a drug benefit. The example I use is the Clinton drug proposal. According to the latest estimate from the Congressional Budget Office, the Clinton proposal would increase Federal spending by $512 billion between 2005 and 2012. Premiums would be about $29.50 a month in the first year, 2005. I might add that when you look at this slide, the solid lines are the lines you just saw showing the current law program and the dotted lines indicate what happens when you add the benefit. And forgive me, my computer drawing skills aren't that great. The program really does start in my calculation in 2005, in spite of the way it might look.

In 2010, CBO estimates that the proposal would increase Medicare spending by about $100 billion, which is about six-tenths of a percent of GDP. Premium revenue would equal about $24 billion in that year, or less than two-tenths of a percent of GDP, and you can see that even with a quite generous drug benefit, the near-term impact on Medicare finances is relatively modest. However, by 2030 the cost of the drug benefit could grow dramatically.

I had to make an arbitrary assumption, and I assumed that per capita drug spending in this program would grow at a constant 10 percent a year, which is roughly the rate of growth of per capita drug spending that CBO estimates this proposal would have in the last 2 years of the program—in their estimate, 2011 and 2012. Under that assumption total Medicare spending would jump to 6.6 percent of GDP in 2030. That is roughly equivalent to increasing

the size of today's Medicare program by an additional $400 billion, an increase larger than the budget for all non-defense discretionary programs combined.

Premiums from the drug benefit would grow more slowly, increasing Medicare revenue by about four-tenths of a percent of GDP. As a result, Medicare's financing gap would increase to about 4.1 percent of GDP in 2030, nearly doubling the draw on general revenues that was projected for that year by the Medicare trustees. This calculation demonstrates the potential financial consequences of adding a generous but underfunded benefit to Medicare without additional reforms.

Of course, it is impossible to predict actual spending patterns 30 years in advance or, for that matter, 1 year in advance, but I think the example does give an indication of the power this kind of proposal could have on the Medicare financing problem.

We clearly have a dilemma on our hands. On one hand, even though a full reform package is not ready, Congress has an opportunity to provide some needed help to Medicare beneficiaries by enacting a stand alone drug benefit. On the other hand, such a benefit could substantially increase the financial pressures on Medicare and could seriously impede future efforts to resolve other fundamental problems in the program.

As I said earlier, a drug benefit should be an integral part of the broader reform rather than an add-on to the current program, but there are policy options that could minimize the risks of a stand alone benefit. In my written statement I sketch out one such option, which combines a drug discount card with a cash subsidy for low-income people, a tax-deferred saving option for others, and catastrophic insurance protection. Such an approach might provide an opportunity to test a market-based approach in Medicare without having to resolve some very difficult issues that are at the heart of broader reform efforts.

That completes my statement, Mr. Chairman. Thank you.

[The prepared statement of Dr. Antos follows:]

PREPARED STATEMENT OF JOSEPH R. ANTOS, PH.D., RESIDENT SCHOLAR, AMERICAN ENTERPRISE INSTITUTE

Mr. Chairman and members of the committee, thank you for inviting me to testify today. My name is Joseph Antos. I am a resident scholar at the American Enterprise Institute for Public Policy Research in Washington, where I concentrate on health economics. I am also an adjunct professor at the University of North Carolina, Chapel Hill, School of Public Health. Previously I was the assistant director for health and human resources at the Congressional Budget Office, where much of my work addressed the challenges facing the Medicare program.

My testimony will focus on the need to modernize and reform Medicare. The program enjoys broad popularity for its success in making high quality medical care affordable for seniors. But Medicare is also widely criticized for offering inadequate benefits, being unresponsive to the concerns of health care providers regarding both payment for services and administrative complexity, and rapidly rising program costs. Congress is considering actions that could improve Medicare in some of those dimensions. The decisions that are made this year particularly decisions on a prescription drug benefit could have a significant impact on the long-term viability of the program.

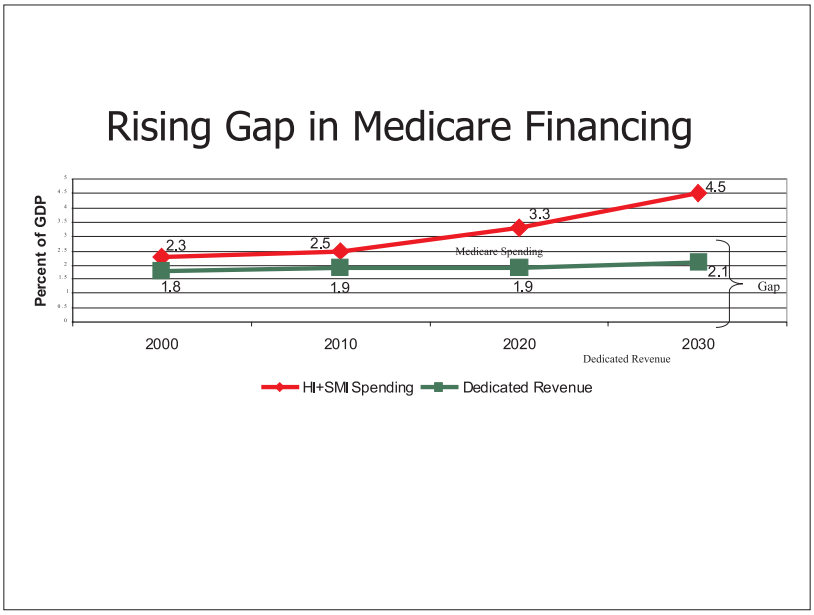
CHALLENGES FACING MEDICARE

The financial challenges facing Medicare are well known, and were recently reemphasized by the annual report of the Medicare trustees. The program will spend $250 billion this year for hospital, physician, and other health services provided to

40 million elderly and disabled Americans. Over the next decade, Medicare spending is expected to grow about 7 percent a year, outstripping growth in the economy and in Federal revenues. That projection does not reflect increases in provider payments that may be enacted this year, nor does it include the cost of a Medicare prescription drug benefit.

The long-term outlook for Medicare financing is driven by demographics and the increasing use of health services among Medicare beneficiaries. By 2030, about 78 million people will be enrolled in the program when most baby boomers will have become eligible for Medicare, and as longevity continues to increase. At the same time, the working age population will grow more slowly, resulting in a drop in the ratio of workers to beneficiaries. Thus Medicare spending will rise more rapidly than the resources available to finance it.

According to the Medicare trustees, program spending will climb from 2.3 percent of GDP in 2000 to 4.5 percent of GDP in 2030 (see figure 1). In today's dollars, each percentage point of GDP is equal to about $100 billion. Medicare's budgetary impact in 2030 would be roughly equivalent to additional program spending of about $200 billion in 2002.



The rapid growth in program spending will not be matched by a similar growth in revenues that are specifically dedicated to Medicare. Those dedicated revenues consist of payroll taxes, taxes on Social Security benefits, and premiums paid by beneficiaries. According to the Medicare trustees, the discrepancy between total Medicare expenditures and dedicated revenues was 0.5 percent of GDP in 2000. By 2030, the gap is projected to rise to 2.4 percent of GDP. The funding gap is currently made up through transfers from general revenues; such transfers will rise sharply over the next few decades unless significant changes are made to the structure of Medicare.

Other developments have given strong impetus to Medicare reform. The public has grown increasingly vocal about the inadequacies of Medicare's benefits, which reflect what a reasonable health insurance policy covered in 1965. Unlike most comprehensive insurance products available today, Medicare does not cover outpatient prescription drugs and provides no protection against very large medical costs. Many beneficiaries find that they have less health insurance coverage once they reach 65 than when they were covered by a health plan at work.

Beneficiaries often purchase supplemental private insurance to fill in some of the gaps in Medicare coverage, and to reduce the uncertainty they have about paying their share of the cost of Medicare-covered services. Such coverage can be a significant financial burden, however, costing thousands of dollars in annual premiums. Some beneficiaries find a low-cost alternative to Medigap by enrolling in a

Medicare+Choice plan. But many health plans have dropped out of Medicare+Choice in recent years, and the remaining plans have pared back their benefits.

The provider community has become outspoken about the perceived inadequacy of Medicare payment. Physician payment rates were cut 5.4 percent in 2002, and are expected to drop a total of 18.2 percent by 2005. That has spurred a backlash from the physician community, with the possibility that seniors in some locales could have difficulty finding a doctor. Payment add-ons for skilled nursing facilities are scheduled to expire over the next 6 months, and the 15 percent reduction in home health payments that Congress has delayed for several years is scheduled to take effect in October. Those payment changes have raised concerns about access to appropriate care for seniors, although there is little evidence thus far to suggest that access has become a significant problem.

Providers have been vocal about what they see as the unnecessary complexity and inflexibility of Medicare administration. According to a recent study by the General Accounting Office (GAO), for example, Medicare contractors provide information to physicians that is often difficult to use, out of date, inaccurate, and incomplete. The carriers provide telephone and Web-based information to physicians, but only 15 percent of the test questions fielded by GAO were answered completely and accurately. The Centers for Medicare and Medicaid Services (CMS) was criticized for failing to provide sufficient performance standards or oversight for contractors.

Medicare+Choice plans also have experienced payment and administrative difficulties that have contributed to the exodus of health plans from the program in the past several years. Because of payment formulas intended to reduce the geographic variation in payments to health plans and encourage plans to expand into underserved markets, most Medicare+Choice plans received 2-percent annual increases in their payment rates since 1999 even though their costs were rising 8 percent a year or more. In addition, uncertainty about future payment policy changes and a heavy regulatory burden has made Medicare+Choice an unattractive market for many health plans.

RISKS OF PIECEMEAL POLICY CHANGES

The problems facing Medicare seem to have mushroomed in the past few years, but they reflect defects and rigidities in the design of the program that have persisted since 1965. Changing the Medicare benefit package literally requires an act of Congress. Consequently, Medicare has not kept up with rapid advances in medical care. Medicare payment rates often do not reflect conditions facing providers and health plans in their local markets, and rate setting mechanisms are slow to adapt to new economic realities. The formal regulatory process is complex, and the proliferation of manual instructions and other guidance in the shadow regulatory process meant to clarify how the regulations should apply in specific real world circumstances often lead to errors, uncertainty, and mistrust.

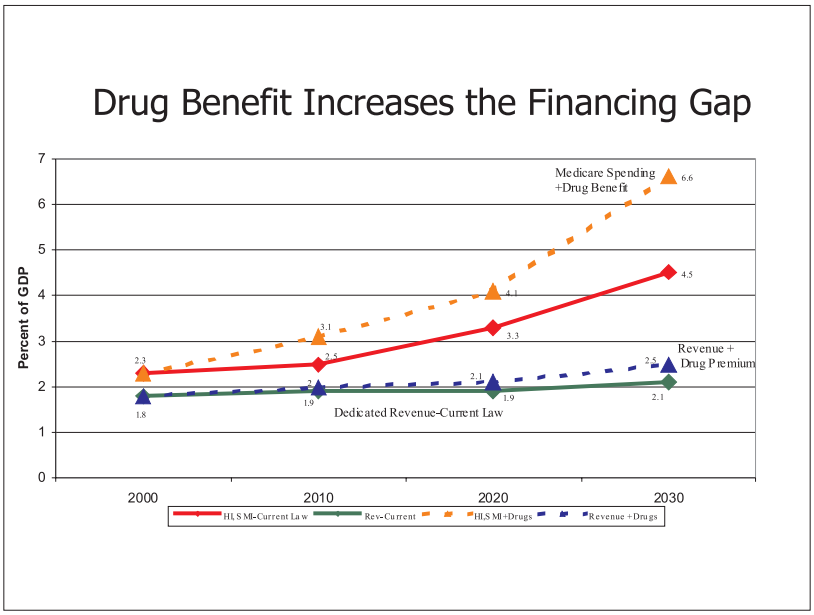
Restructuring Medicare to give beneficiaries realistic choices among competing health plans, similar to the way the Federal Employees Health Benefit Program (FEHBP) operates, could alleviate many of the problems in the current system. Such an approach could provide more meaningful health plan choices to beneficiaries than are now available under Medicare+Choice, with safeguards to assure reliability and high quality. Micromanagement and formula-driven payment rates could be replaced by a flexible approach to administration based on negotiation and market information.

A competitive strategy, even one based on an operating model such as FEHBP, must be developed carefully. The administration has indicated an intention to present such a plan in the future. Until then, Congress is likely to take other steps to address some of the most important deficiencies of the current Medicare program. A risk of that approach is that some policy actions could hinder subsequent restructuring efforts, or at least forego an opportunity to foster reform.

The Medicare prescription drug benefit is a case in point. Adding a stand alone drug benefit could retard progress on broader reform and reduce the program's financial viability in the long term unless other program changes also were made to improve incentives in the program. A drug benefit ideally would be part of the broader reform, and the benefit would be part of an integrated package of benefits provided by health plans participating in the Medicare program.

To illustrate the possible long-run impact of a stand alone drug benefit, I estimated how much Medicare costs and revenues might increase over the next 30 years under the Clinton prescription drug proposal (see figure 2). The benefits under the proposal are fairly generous: no deductible, 50 percent co-insurance for the first $2,000 of spending, and stop-loss above $5,000 of total spending. According to the latest estimate from the Congressional Budget Office (CBO), the Clinton proposal

would increase Federal spending by $512 billion between 2005 and 2012. Premiums would be $29.50 a month in 2005.



In 2010, CBO estimates that the proposal would increase Medicare spending by $100 billion, or about 0.6 percent of GDP. Premium revenue would equal $24 billion in that year, or less than 0.2 percent of GDP. Even with a generous drug benefit, the near-term impact on Medicare finances is quite modest, widening the gap between total program spending and dedicated revenues by 0.4 percent of GDP.

By 2030, however, the cost of the drug benefit could grow dramatically. I assumed that per capita drug spending would grow at a constant 10 percent a year. Under that assumption, total Medicare spending would jump to 6.6 percent of GDP in 2030. That is roughly equivalent to increasing the size of today's Medicare program by an additional $400 billion larger than the budget for all non-defense discretionary programs combined.

Premiums from the drug benefit would grow more slowly, increasing Medicare revenue by about 0.4 percent of GDP. As a result, Medicare's financing gap would increase to about 4.1 percent of GDP in 2030 nearly doubling the draw on general revenues that was projected by the Medicare trustees.

This calculation demonstrates the potential financial consequences of adding a generous but underfunded benefit to Medicare without additional reforms. The actual impact of adding such a benefit depends on the specific design of the proposal and on other factors that cannot be foreseen with any accuracy, including the future path of pharmaceutical innovation, the impact of drug coverage on the use of other health care services, and changes in the incidence of specific diseases among the Medicare population. Those factors might reduce the long-run fiscal impact of a drug benefit but they might also increase that impact.

DRUG BENEFIT AS A STEP TO REFORM

Medicare reform will probably not be accomplished in one sweeping action. As we have seen with other attempts to reform the health system, it is difficult to obtain consensus from health policy experts on the best approach to reform. It may be even more difficult to convince the public that a massive change in the way they obtain health care will (eventually) be good for them. Moreover, we cannot foresee all of the developments and reactions that might occur in response to major system change.

Phasing in reform can provide information about market reactions and allows mid-course corrections. A reform plan that has flexibility to accommodate to changing circumstances in the health care market has a greater chance of success than one that attempts to resolve every problem at the outset. A carefully designed pre-

scription drug benefit could provide an opportunity to test market-based approaches to Medicare reform.

There are clear risks associated with a stand alone prescription drug benefit. But there are policy options that could minimize those risks, and might also serve as a transition to broader reform. One approach, called the Prescription Drug Security (PDS) Card program, combines a drug discount card with insurance protection from high-end drug expenses. Low-income Medicare beneficiaries would be eligible for an annual cash subsidy perhaps as much as $600 toward the cost of their first-dollar drug expenditures. Their premiums for catastrophic drug coverage would also be subsidized. Higher-income beneficiaries would not receive a subsidy. They would be able to contribute to their own prescription drug cash account on a tax-deductible basis and participate in catastrophic drug insurance. They would also receive any discounts for pharmaceutical purchases that are available from their plan.

The PDS card account would work like a debit card, allowing beneficiaries to draw down their deposit when they make prescription purchases. The account could be augmented with contributions from relatives, religious organizations, or other charitable groups. Beneficiaries would be able to keep any unspent funds in their accounts for health expenses in subsequent years.

Such a program would allow Medicare beneficiaries to select from a number of competing plans that offer drug coverage. Plans would have the flexibility to offer a variety of benefit and premium options. The program would target assistance to the most needy, i.e., low-income beneficiaries without other drug coverage. By providing a fixed subsidy rather than an open entitlement to benefits, the program gives enrollees an incentive to shop wisely.

Unlike a traditional Medicare benefit, administration of the PDS card program would be modeled after FEHBP. The administering agency would provide broad direction on required benefits and other policies, negotiate premium offers with plans, and provide information to Medicare beneficiaries on their options and the performance of individual plans.

A prescription drug program of this sort could be a laboratory for development of broader Medicare reform. Unlike a pure discount card approach, it would provide a subsidy for low-income beneficiaries and true insurance protection against unforeseeable, large drug costs. Such a program would create an administrative infrastructure that is flexible and consumer-focused. Since it would initially be a stand alone benefit, a competitive drug program could be implemented without having to resolve some difficult issues that are at the heart of proposals to restructure Medicare. Nonetheless, lessons from a competitive drug program could fruitfully be applied to the larger reform.

CONCLUSION

The Medicare trustees have once again reminded us that the Medicare program is on an unsustainable trajectory. Decisions made by Congress this year will have consequences well beyond the 10-year budget window. There is an opportunity this year to provide some needed help to Medicare beneficiaries through a prescription drug benefit, but there is the risk that such a benefit could increase long-run fiscal pressures and retard progress on the broader reform that is needed. A well designed prescription drug plan, however, could be a step toward that reform.

Chairman NUSSLE. Dr. Feder, welcome, and we are pleased to receive your testimony at this time.

STATEMENT OF JUDY FEDER, PH.D., DEAN OF PUBLIC POLICY, PUBLIC POLICY INSTITUTE, GEORGETOWN UNIVERSITY

Ms. FEDER. Thank you, Mr. Chairman and members of the committee. It is a pleasure to be with you this morning to testify on behalf of myself and my George Washington University colleague Jeanne Lambrew.

My goal today is to remind you that Medicare is one of our Nation's greatest achievements, and that as a Nation, we have the obligation and the capacity to sustain and extend that achievement to provide affordable health insurance, including prescription drugs, to seniors and to people with disabilities.

First and foremost, Medicare is not broke or broken, nor in crisis. Medicare works. It provides affordable health insurance for the Na-

tion's elderly and some of its disabled citizens without the problems that plague health insurance for younger Americans, and it is as good or better than the private sector in managing health care cost growth. Faced with high rates of expenditure growth and trust fund concerns in the 1990s, policymakers responded with payment rate changes that dramatically slowed Medicare cost growth and kept its per beneficiary cost increases lower than those in the Federal Employees Health Benefit Program and the private sector.

Health care costs are a problem for the Nation, not just Medicare, but recent experience demonstrates that policymakers have the tools they need to manage Medicare costs. Indeed the Congressional Budget Office and the Office of Management and Budget showed confidence in these tools with their estimates of the relatively low growth rates for Medicare costs in the future. And as we have heard from Dr. Saving, the report on the Medicare trust fund found solvency through the year 2030, one of the longest periods of solvency for the trust fund in the program's history.

The strengths of Medicare financing must be looked at well beyond the situation of the trust fund. What the security of financing really rests on is the strength of our economy. A recent analysis by Marilyn Moon of the Urban Institute shows how much better off future taxpayers will be, even taking Medicare cost growth and necessary spending into account. By Dr. Moon's estimates, the gross domestic product per worker will rise by more than 50 percent between the year 2000 and the year 2035. Or, another way to say it is people will be 50-percent richer than they are today, and that growth is only 3 percentage points lower when Medicare needs are taken into account than when they are ignored. So they would be 53-plus percent richer if we didn't meet Medicare's needs. They will be 50-percent richer if we do. That seems hardly a problem, let alone a crisis. Stated simply, the Nation's economy is strong enough to pay for Medicare beneficiaries' future health care costs.

What then is Medicare's most pressing need? It is not a change in managing what Medicare already covers. It is, rather, a change to cover what Medicare currently excludes, and we are focusing here on the gap in prescription drug coverage. I would argue that it is a travesty that the population that is over the age of 65 and people with disabilities who most need prescription drug coverage are without that protection when the working-age population has it available to them.

Over the next decade, Medicare beneficiaries will spend an estimated $1.8 trillion on prescription drugs. Those costs and needs are there with or without a Medicare prescription drug benefit. The issue is who is going to bear those costs. Although there is widespread agreement on the need for Medicare's prescription drug benefit, as you know, there is considerable disagreement on what constitutes an adequate benefit, that is, what should be the distribution of prescription costs between seniors and taxpayers; on its affordability; and on the priority it ought to have in our public spending.

As I said, seniors' drug costs are estimated at about $1.8 trillion over the next 10 years. A Medicare drug benefit designed similar to the benefit that you have—and I have as the wife of a Federal retiree—in the Federal Employees Health Benefit Program would

cost an estimated $750 billion over the next 10 years, covering less than half benificiaries' actual prescription drug costs. This committee, Mr. Chairman, as you indicated earlier, has endorsed a benefit and additional Medicare spending of $350 billion, woefully short of meeting beneficiaries needs in the future.

Can we do better? The administration has testified elsewhere on this subject and has implied that we cannot, as have the previous speakers; that the resources are not there to meet the needs of the current Medicare program and of a new prescription drug benefit. But the fact is that what is missing is not resources, it is the priority that we give to meeting these needs. In fact, combining what the President's budget would spend in new dollars on Medicare with the proposed spending on tax cuts that is in the budget, the budget already includes the $750 billion that could be applied fully to a Medicare drug benefit. Moreover, according to analyses performed by the Center on Budget and Policy Priorities, proposed extensions of the tax cut beyond 2010 would cost $4.1 trillion in that second decade compared to the $1.2 trillion cost of the additional amount of drug coverage. In other words, the cost of the proposed tax cuts that some feel are a priority exceed by more than threefold the cost of a prescription drug benefit. It is hard to reconcile the claim that a prescription drug benefit is a priority while at the same time eliminating the revenues needed to support it.

On the source of funding, there is also an issue: what ought to be the appropriate financing mechanism for a Medicare prescription drug benefit? The administration has challenged the use of both the Hospital Insurance Trust Fund as a source of funding—that is, the existing trust fund—and general revenue financing. No one has proposed the first, and the administration itself has used the second.

It is important to remember when we look at the financing system of Medicare that general revenues have always been a part of Medicare spending. It is inappropriate to consider the need for such revenues as a "financing gap." General revenues are a longstanding appropriate and progressive source of financing both for the existing Medicare program and for a new benefit, prescription drugs.

In conclusion, the facts suggest that the biggest challenge facing Medicare today is not its cost growth or even its long-term affordability, but the lack of a prescription drug benefit. Medicare has contributed, and will in the immediate future continue to contribute, to longer and healthy lives for our Nation's elderly and some of its disabled citizens. But its historical protection against the economic consequences of high health care costs is now threatened by rising drug costs and its lack of a drug benefit. By 2012, Medicare beneficiaries are projected to spend more on prescription drugs than Medicare is projected to spend on all Part B services combined, according to the Congressional Budget Office. A $750 billion prescription benefit would cover less than half of prescription drug costs of Medicare beneficiaries, but would certainly be meaningful support for the seniors and disabled people who are bearing those burdens. It costs far less over time than the extension of the tax cut.

The question here, I would urge you to recognize, is not a matter of affordability, it is a matter of our priorities. Thank you.

Chairman NUSSLE. Thank you.

[The prepared statement of Dr. Feder follows:]

PREPARED STATEMENT OF JUDITH FEDER, DEAN OF PUBLIC POLICY, GEORGETOWN UNIVERSITY

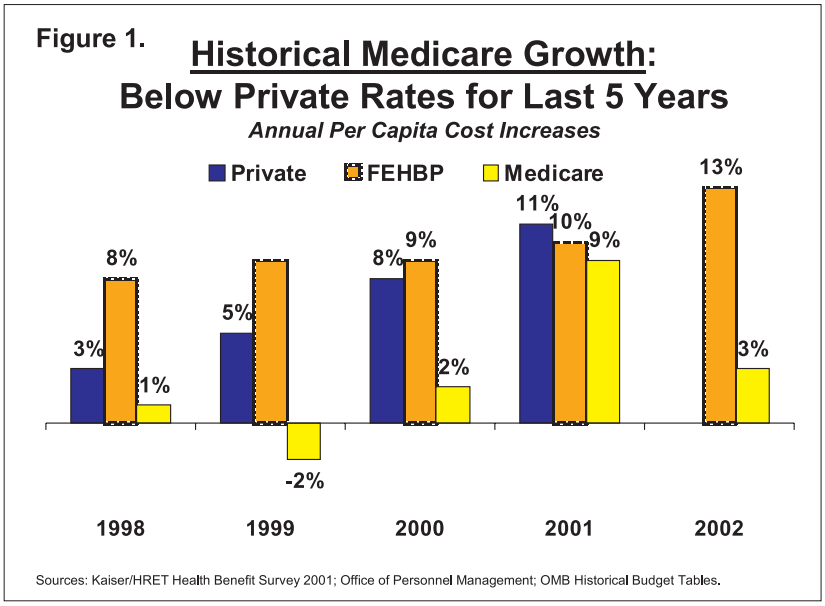
Chairman Nussle, Congressman Spratt, and distinguished committee members, thank you for the opportunity to offer this testimony about Medicare and the Federal budget. My goal today is to remind you that Medicare is one of our Nation's greatest achievements and that, as a nation, we have both the obligation and capacity to sustain and extend that achievement to provide affordable health insurance, including prescription drugs to seniors and to people with disabilities.

MEDICARE WORKS

The issue of Medicare reform is neither new nor simple. Defining Medicare's problems, let alone coming to consensus over solutions, has been controversial. Discussions of Medicare and the Federal budget often define the "problem" as the gap between projected payroll tax revenues and health care spending that will result from the aging of the population. An all-too-common reaction is to declare Medicare fiscally "unsustainable" and to call for a retraction of government responsibilities for the health care of the elderly. But this approach obscures the real challenge of an aging population and ignores Medicare's fundamental purpose.

For more than 30 years, Medicare—with some significant help from Medicaid for low-income elderly and for long-term care—has provided affordable health insurance of the Nation's elderly citizens without the problems that plague health insurance for younger Americans. Medicare is nearly universal, avoids dividing the healthy from the sick and the poor from the better-off, and provides reliable coverage with a choice of providers.

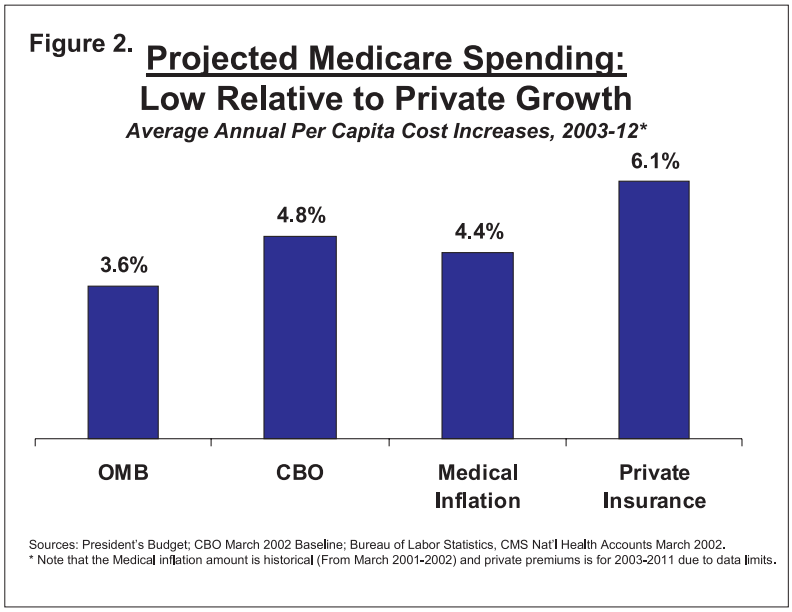
Limiting the government's liabilities for health care will not make those liabilities go away. Rather, it will shift them back to elderly, people with disabilities and their families. And Medicare's signal advantages—its ability to spread risk and to make insurance affordable—will be lost. That is not solving the problem; it is abdicating responsibility. Instead our goal should be to assure that Medicare has adequate financing to provide effective health insurance in the future as it does today.



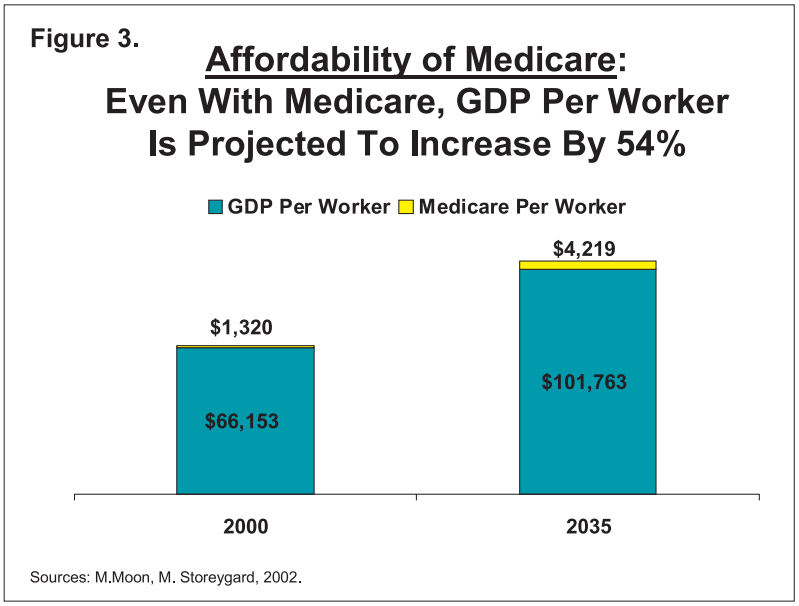
Our ability to achieve that goal is enhanced by Medicare's fiscal performance. Health care is expensive. But Medicare is as good and often better than the private sector in managing cost growth. Faced with high rates of expenditure growth and trust fund problems in the 1990s, policy makers responded with payment rate

changes that dramatically slowed Medicare cost growth. In the past 5 years, Medicare's average growth rate per beneficiary was significantly lower than that of the private sector or the Federal Employees' Health Benefits Plan (FEHBP) (Figure 1). Although the cost of health care is an issue for the entire Nation (not Medicare alone) and there will always be controversy about whether Medicare is paying too much or too little, recent experience demonstrates that policymakers have the tools they need to manage Medicare's costs.

The Medicare baseline projections for the next 10 years recognize the effectiveness of these tools for the future as well as the past. Both the Congressional Budget Office (CBO) and the Office of Management and Budget (OMB) are projecting average Medicare growth rates per beneficiary that are low: 4.8 and 3.6 percent for the next 10 years[1] at or below medical inflation (4.4 percent from March 2001 through 2002) and well below projected private premium growth projections (6.1 percent for 2002 through 2010) (Figure 2). Medicare has not grown this slowly for any past 10-year period.[2] Similarly, in its most recent report, the Medicare Trustees project that the Hospital Insurance Trust Fund will be solvent through 2030. Few previous Trustees' projections have been more optimistic than this.



Our ability to support the Medicare program goes well beyond the strength of the Trust Fund. Most critical to that support is the strength of our economy. A recent analysis by Marilyn Moon suggests how important it is to examine projected Medicare cost growth in the context of overall economic growth. Her analysis demonstrates that future taxpayers will be substantially better off than current taxpayers, even taking Medicare cost growth into account. By her estimates, GDP per worker will rise by 53.8 percent between 2000 and 2035, even taking into account Medicare spending projections. Without Medicare, this projected increase in GDP per worker would be 57 percent (Figure 3). Stated simply, this Nation's economy will likely grow strongly enough to pay for Medicare beneficiaries' future health care costs.[3]



A PRESCRIPTION DRUG BENEFIT IS MEDICARE'S MOST PRESSING NEED

Medicare's biggest challenge is not better managing what it already covers; instead, it is covering what it currently excludes: prescription drugs. Prescription drugs have become an integral part of modern medicine, often preventing disease, managing chronic illness and even curing certain conditions. Seniors and people with disabilities disproportionately rely on prescription drugs. According to recent CBO testimony, Medicare beneficiaries account for 15 percent of the population but 40 percent of the spending on outpatient prescription drug spending. The average Medicare beneficiary will spend over $2,400 on prescription drugs next year, and nearly one-in-five beneficiaries (17 percent) are expected to spend more than $5,000 by 2005. Over the next decade, Medicare beneficiaries are projected to spend $1.8 trillion on prescription drugs; with or without a Medicare drug benefit.[4]

Not only do Medicare beneficiaries have a greater need for prescription drugs; they also disproportionately lack coverage for it. Depending on how one counts, anywhere from 25 to 42 percent of Medicare beneficiaries lack prescription drug coverage for all or part of the year.[5] This problem is worse for older and rural beneficiaries. Over time, most experts suggest that the proportion of beneficiaries who lack drug coverage will grow as the cost of Medigap policies with drug coverage rises, the drug benefits in Medicare managed care plans become less generous and more scarce, and employers continue to cut back on retiree health coverage.

A PRESCRIPTION DRUG BENEFIT IS AFFORDABLE

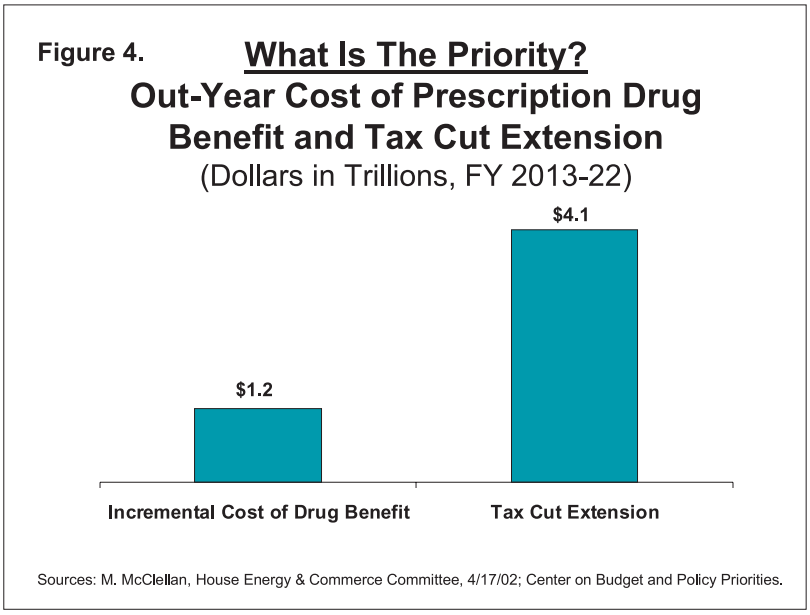
There is a widespread consensus on the need for a Medicare prescription drug benefit. What is lacking is agreement on what constitutes an adequate benefit, the distribution of prescription drug costs between seniors and taxpayers, its affordability, and its priority.

Substantial differences exist in the scope of proposed prescription drug benefits. This committee allocated $350 billion over 10 years for a benefit; the Senate Budget Committee allocated $500 billion. And it would cost an estimated $750 billion over 10 years to provide seniors with a benefit comparable to the benefit Members of Congress receive through the Federal Employees Health Benefits Program.

Recently, administration testimony implied that the Nation cannot afford a $750 billion drug benefit: "The excess costs of $400 billion in the first 10 years would balloon to $1.2 trillion in the next ten, just when the baby boomers are counting on Medicare." The testimony continues to claim that a drug benefit of this size would,

by 2030, be "equivalent to a tax of $2,170 (in today's dollars) on every working American."[6]

But, the administration's analysis suggests that its concern is not affordability, it is priorities. In fact, combining what the President's budget spends on Medicare and its tax cuts, the budget already includes $750 billion that could be applied fully to a Medicare drug benefit.[7] Moreover, in the second decade, the extension of the tax cut would cost, according to the Center on Budget and Policy Priorities,[8] $4.1 trillion, compared to the administration's estimated $1.2 trillion cost of the additional amount of drug coverage (Figure 4). And, it is not until well after 2020 that the cost per worker of a drug benefit exceeds that of the cost per worker of a tax cut, according to a forthcoming analysis by the Center on Budget and Policy Priorities; in 2020, the average tax cut cost per worker ($1,579 in 2002 dollars) would still exceed that of the cost per worker of the entire $750 billion drug benefit ($1,064). Thus, it is hard to reconcile the claimed priority given to a prescription drug benefit with the proposal to eliminate the revenues needed to support it.



On the source of funding, the administration has challenged the use of both the Hospital Insurance Trust Fund and general revenue financing. Specifically, it claims that funding a prescription drug benefit from the Trust Fund would cut its insolvency in half, and that funding it through a mechanism like the Supplemental Medical Insurance Trust Fund represents "accounting gimmicks."[9] Corroborating this concern, the administration omitted general revenue funding from its displays of the current Medicare program's financial health in its budget documents, despite its legal, 35-year history of supporting Part B services. On prescription drug financing, no one has proposed the first, and the administration itself has used the second. General revenue funding supports outpatient services in Medicare today; it is a more progressive way to finance benefits than a payroll tax increase; and, while weakened, the budget outlook is strong enough to support this use of funds. The fact that the administration's own $190 billion Medicare allocation is drawn from general revenues raises the question of where and, more importantly, why the administration is drawing lines about legitimacy of the funding of this critical benefit.

CONCLUSION

The facts suggest that the biggest challenge facing Medicare today is not its cost growth or even its long-term affordability but its lack of a prescription drug benefit. Medicare has contributed and will, in the immediate future, continue to contribute to longer and healthier lives for our Nation's elderly. But its historical protection of seniors against the economic consequences of high health care costs is now threatened by rising drug costs and its lack of a drug benefit. By 2012, Medicare bene-

ficiaries are projected to spend more on prescription drugs than Medicare is projected to spend on all Part B services combined, according to CBO. A $750 billion prescription drug benefit would cover less than half of prescription drug costs of Medicare beneficiaries. It costs far less, over time, than the extension of the tax cut. The question here is not affordability, it is priorities.

ENDNOTES

The views expressed in this paper do not represent those of Georgetown or George Washington University.

1. From Crippen DL. (March 7, 2002). Projections of Medicare and Prescription Drug Spending. Testimony before the Committee on Finance, U.S. Senate. Washington, DC: Congressional Budget Office. Assumes projected beneficiary growth of 1.7 percent over the 2003–12 period.
2. Reischauer R. (March 2002). Presentation at the American Enterprise Institute.
3. Moon M, Storeygard M. (March 2002). Solvency or Affordability? Ways to Measure Medicare's Financial Health. Menlo Park, CA: The Henry J. Kaiser Family Foundation.
4. Crippen, 2002.
5. CBO defines uninsured as lacking drug coverage throughout the year (25 percent); Laschober MA, Kitchman M, Neuman P, Stabic AA. "Trends in Medicare supplemental insurance and prescription drug coverage, 1996–1999," Health Affairs. February 27, 2002, Web Exclusive, pp. W127–W138 define coverage as point in time (38 percent); and Briesacher B, Stuart B, Shea D. Drug Coverage for Medicare Beneficiaries: Why Protection May be in Jeopardy. New York (NY), The Commonwealth Fund, January 2002 define it as the number who lack drug coverage for part or all of the year (42 percent).
6. McClellan M. (April 17, 2002). "Creating a Medicare Prescription Drug Benefit: Assessing Efforts to Help America's Low-Income Seniors." Testimony before the Committee on Energy and Commerce, U.S. House of Representatives. Washington, DC: White House Council of Economic Advisors.
7. The President's budget includes $603 billion for tax cuts and $169 billion for Medicare for fiscal year 2003–12, according to CBO's Analysis of the President's Budget.
8. Friedman J; Greenstein R; Kogan R. (April 16, 2002). The administration's Proposal to Make the Tax Cut Permanent. Washington, DC: Center on Budget and Policy Priorities.
9. McClellan, 2002.

Chairman NUSSLE. I had some questions, but I guess to start off with, I am tempted to allow rebuttal. It seems it is pretty rare where we have a hearing where we have such a difference of opinion on the panel over the state of Medicare and its future. I am not going to paraphrase Dr. Feder's testimony, but suffice it to say it appears that what you are suggesting is that you don't necessarily believe there is a crisis in Medicare, and that if we would merely repeal the tax cut, that everything would seem to work out just fine.

That having been said, Dr. Antos or Dr. Saving, do you want to respond to that at all? My understanding from your testimony is that the general revenue transfers to Medicare would far exceed a simple repeal of the so-called tax cut. So, Dr. Saving——

Mr. SAVING. I think that is correct, Mr. Chairman. The real issue here—and the estimates that I have made of the general revenue transfers as a percent of projected Federal income tax revenues allow Federal income tax revenues to stay at the same percentage of the gross domestic product they are now, so they really don't account for any of the tax cut that is going to occur later on, assuming that that tax cut would reduce the share of Federal income tax revenues or gross domestic product.

So in effect our estimate from the trustees report is that that share of Federal income tax revenues in 2030—and I should say that the deficits that we are discussing stay the same no matter

what the trust fund is. I mean, if you could arbitrarily make the trust fund 100 million times what it is so that it would never run out, you would have to transfer exactly the same amount of money from income tax revenues because there isn't anything in the trust fund. It is just an accounting entry that says that—and legally, of course, you can't pay benefits unless the trust fund has these accounting entries, but in the end they are accounting entries. They are not real output.

And I think it is important to understand that when the baby boomer—and this is an issue of two things. One of them is increased longevity, and the second one is population shock, meaning that the baby boomers moving through the population, providing a huge amount of resources when they were working, and consuming a huge amount of resources when they retire. When that happens, and if Dr. Antos is right in his estimates of what the drug benefit is going to cost, and I am a person—I think all three of us here are saying that an efficient Medicare system should include a drug benefit. So that is not really at issue here.

What is at issue here is what are the funding issues that have to be dealt with if you are going to do this. And if we are accepting Dr. Antos' numbers, currently from the trustees we would estimate that by 2030, 21 percent of all Federal income tax revenues are going to have to be transferred to Medicare. That is four times what we are now transferring to Medicare off of Federal income tax revenues.

Chairman NUSSLE. Just so we are clear, that is compared today at what percent?

Mr. SAVING. Five percent. Right now an amount equal to 5 percent. We are going to be at 21 percent. If Dr. Antos is right, that number is going to be 36 percent, and coupled with the Social Security transfer, one-half of all Federal income tax revenues are going to have to be transferred to these elderly entitlement programs. And right now, remember, these three programs together are actually contributing an amount equal to 2.5 percent of Federal income tax revenues. So we are going to go from being able to spend this money on fighting terrorism or anything else to having to take half of all the Federal income tax revenues and transfer them to these programs. All the other programs are going to be much smaller, and if you would add Medicaid to that, then you would have almost nothing left over for anything else that the Federal Government does.

I think this is a significant problem. It is not going to be solved by the trust fund. I think we need a prescription drug benefit for efficiency purposes, but we also have to recognize reality. Putting our head in the sand and saying these resources are going to come from somewhere is not going to do it. It is real resources the elderly are going to consume—when I was on the commission, the baby boomers when they retire are going to eat real food, drive real cars, and live in real houses and use real hospitals and doctors when they consume medical care. Somebody is going to have to produce that stuff. We have to find a way to get resources to provide the elderly with what they are going to be consuming and to let workers keep something for themselves. That is the challenge, and it is a tough one.

Chairman NUSSLE. Dr. Antos.

Mr. ANTOS. I would add to that, I think, an obvious point. We all agree that the Medicare benefit isn't adequate, and it became inadequate because of the structure of the program in the first place. One of the goals of reform is to make it possible for consumer demand to be satisfied. There is no question where consumer demand is on prescription drugs. There is very little question on where consumer demand is on wanting additional insurance protection, but we have a program that is locked in concrete.

Part of the idea of reform is to make it possible for what consumers want to actually materialize on less than a glacial basis. Furthermore, it is perfectly clear that with a virtual doubling over the next 30 years of the number of people in the Medicare program, we are going to be spending more money. There is no question about that, and I don't think any of us disagree with that. The question is are we going to have the program that we really want? I am speaking personally now. Unlike Tom, when I reach 65, I will be using Medicare. Is that program going to be a good program, or am I going to find that my insurance protection suddenly dropped through the floor? That is our goal.

Chairman NUSSLE. Dr. Feder.

Ms. FEDER. First a clarification, Mr. Chairman. The slide that was up earlier and my comments on comparing the costs of a tax cut with the costs of a drug benefit were not addressed at repealing tax cuts that Congress has enacted. They focus on new tax cuts that are proposed in the President's budget or the extension—this particular slide is making the tax cut permanent, extending the tax cut into the next decade. I haven't even addressed repeal; that would make additional revenues available to meet these needs.

The second issue I would like to raise, I think you are quite right: there are tremendous differences in the way we, as speakers, see the Medicare financing situation. I think that differences reflect how we compare rising Medicare costs to other changes. There is no question that health care costs are rising, and that the costs per beneficiary are rising, and the number of beneficiaries is increasing. But to asses whether we face an "affordability crisis," we have to look at these costs in the context of the rest of the economy. And what I have indicated to you, which is not present in others' comments, is that the economy is growing substantially even when we assume moderate growth assumptions. As a result, we as a Nation will be, as I indicated to you, 50 percent richer in 30 years and consequently have the resources to decide how we want to spend those resources and how we want to provide quality of life for our Nation's seniors.

Finally, on the issue of the benefit problem which Dr. Antos just mentioned, the absence of prescription drug benefits in Medicare is, I would argue, not a function of Medicare's structure. It, again, is a question of choices and political priorities. We have a good prescription drug benefit in the Federal Employees Health Benefits Program because that is what Congress chooses to provide Federal employees and Members of Congress, and it includes prescription drugs. We have the capacity to make a similar political choice for Medicare beneficiaries. We have just not done so.

Chairman NUSSLE. I am dying to ask who "we" is when you say we haven't done so. I don't recall my last 8 years seeing a White House prescription drug benefit that has been proposed. A couple of nice lofty goals that came down, but I think there are a lot of political choices being made.

I would suggest to you that I believe the costs are out of control, and that in my area in Iowa, it is not serving as good a program, and it is not paying its bills the way that it may be in the area that you live. So that is part of the reason why we not only wanted to include in this budget, as we have the last number of budgets, a prescription drug benefit, but also an ability to modernize the program and to strengthen it, because it is just not paying the bills in Iowa. Maybe it is in your area, but it isn't in our area. And I understand why seniors may not recognize that, but the people providing the care certainly do realize that, and it is going to become pretty difficult to keep and, as both of our other witnesses said, attract and continue to keep these physicians and hospitals and other health care providers in some of these underserved areas if the program continues as it is.

So with that, Mr. Spratt.

Mr. SPRATT. Dr. Feder, I thought I saw you wanting to respond when the chairman said he had not seen a proposal for prescription drugs floated by the White House in the last 8 years.

Ms. FEDER. I was tempted to respond, but I wasn't sure it was necessarily totally wise. But as a member of the Clinton administration——

Chairman NUSSLE. You are welcome to respond to that.

Ms. FEDER. I didn't think it was unwelcome on your part, sir. I just wasn't sure I needed to mention it.

A prescription drug benefit was most definitely a part of the Clinton Health Security Act. And in more recent years, before the Clinton administration ended, we had a prescription drug benefit on the table.

So I was surprised that you had said it wasn't mentioned.

Chairman NUSSLE. Well, if I could—just so I understand. Was this in bill form? Was this written in bill form?

Ms. FEDER. The Medicare prescription drug coverage was part of the Clinton Health Security Act.

Chairman NUSSLE. I understand. But was this a proposal in bill form?

Ms. FEDER. In bill form. It was in the bill.

Chairman NUSSLE. In what bill? We are going to have to go back to the record here, because I served on the Ways and Means Committee. We never got a bill. Now, we got some goals.

The same criticism currently exists for this administration, I would hasten to add.

Ms. FEDER. And when you asked who "we" is, it is all of us as a nation that have not made this a priority, when you said that earlier.

Chairman NUSSLE. You mentioned it was Congress. I just wanted to make sure that the record reflected that it was more than just Congress who made that political decision.

Ms. FEDER. That is a fair point, in general.

Chairman NUSSLE. I am sorry to interrupt.

Mr. SPRATT. Dr. Feder, for the record, would you like to briefly outline what the Clinton prescription drug package contained?

Ms. FEDER. It would be a challenge for me to remember the bill as it was proposed in 1993. But I believe the more recent proposal resembled proposals that have been on the table, that are being discussed today. The one that—actually that Dr. Antos used as the basis for his cost projections was the proposal toward the end of the Clinton administration.

Mr. SPRATT. There is a premium of about how much?

Mr. ANTOS. It is a no-deductible plan, 50 percent co-insurance for the first $2,000 of drug spending; no coverage between $2,000 and $5,000 of drug spending, where most of the drug spending is; and then what we economists call stop-loss coverage above $5,000, in other words, the program would pay for the whole cost above $5,000.

The premium would start in the first year, 2005, at $29 a month. And like all comprehensive proposals, the premium grows every year.

Mr. SPRATT. In all of these proposals, a couple of things have been lacking in the cost estimates. Number one, only modest assumptions are made about what can be attained through the use of the government's clout as the purchasing agent, in effect, for 35 to 40 million people, a huge coalition of purchasers.

How do we measure that? What can we reasonably expect can be accomplished in the way of price reduction from the government's collective efforts to purchase on behalf of 35 to 40 million beneficiaries?

Mr. ANTOS. Mr. Spratt, that is a very good question, a question that CBO has struggled with for the last several years and will continue to struggle with.

I think the issue has to do with how much flexibility and leeway the particular benefit allows for the management of those prescription drug costs. Not just prices, but even more importantly, the actual use of drugs. The latest figures strongly suggest that more than half of the increase in total prescription drug cost in this country stems from increases in the use of drugs, moving to newer, more expensive drugs, using more drugs. Price is a lesser issue.

And so it seems like only a few months ago I remember discussing this very question with my colleagues at CBO. The issue was: Did an individual bill allow drug plans use the tools that they now have at their disposal to aggressively manage costs, or were there going to be restrictions on what they could do? I believe that—I believe CBO should speak for itself here, but I believe that the estimate that the CBO had done for the Clinton-style plan assumed that there would be restrictions, fairly rigid restrictions, on how costs could be managed and how consumer demand could be directed.

The House-passed bill from last year, on the other hand, is a bill that places drug plans at risk for costs. It does provide reinsurance, but it does put them at risk. And it gives them more ability to use tools such as multi-tiered co-payments, formularies, mail order and the like.

A lot depends on the structure of the benefit.

Mr. SPRATT. The second thing that we don't hear much about, or see in these cost estimate systems, is a kind of dynamic scoring, which we discussed last week. We seldom get any calculation of the savings that might be realized in inpatient care, the most expensive form of health care as a result of having adequate maintenance drugs and other acute care drugs available for outpatients.

Surely there is some savings to be realized there, or otherwise why are we taking these medications?

Nevertheless, you never see that calculation factored into any of the estimates. Can you give us an idea of what you think realistically, over a period of years, ought to be factored in to account for the inpatient savings if you have a drug program? Any of you?

Mr. ANTOS. Let me try that first, if you don't mind. It is a very tough question, of course. Let me explain a little about CBO's thinking about this question, which isn't going to be all that helpful to any of us on this, I don't think.

The issue for CBO is: What is the incremental effect of a drug benefit? As we know—from data collected from Medicare beneficiaries—that somewhere around two-thirds of Medicare beneficiaries have some form of prescription drug coverage. Some of them have very good coverage now through employer plans, for example, and some of them have coverage through Medigap plans, and that is pretty bad.

If there is a comprehensive drug benefit enacted, then the question that CBO confronts is, how much will actual drug usage increase, given that a lot of people now have coverage, and the people who don't have coverage use about two-thirds of the prescription drugs that people with coverage use today. And so this is really an incremental kind of calculation.

As a result, while they are very, very concerned and interested in this issue, they have, in particular, been focusing on some work by Frank Lichtenberg at Columbia University, who has demonstrated some pretty impressive results along these lines. Nonetheless, they have to bring those results down to this kind of incremental scoring.

So I would say the bottom line here for me is that there is no question that a drug benefit will bring real medical benefits to Medicare beneficiaries in terms of better outcomes, more sensible approaches to health care and, ultimately, in terms of some potential cost savings. But in terms of bill scoring, I agree with my former colleagues. It is really tough to know right now how much of an impact that would have in the short run. In the long run, it could be quite large.

Ms. FEDER. I wish I could give you an estimate, Congressman. I can't do that. But I can give you an example that is, I believe, supportive of your concern that it ought to be addressed.

There was a study some years ago following a cutback in drug coverage in Medicaid, I believe in Connecticut, that examined its effect on Medicaid spending. And the finding was, that—Steve Sumerai was the author—the finding was that a reduction in the availability of prescription drugs led to—I don't remember the magnitude—but an increase in nursing home costs, another area of considerable concern. And I do think we are seeing a decline in the availability of prescription drug coverage for seniors, which would

have the kind of effect I just described, as well as effects on hospital use and whatever.

And with due respect—Joe knows I am sympathetic to the problems of cost estimating—but CBO does take on a number of challenges with great boldness; this would not seem to be beyond its capacity.

Mr. SPRATT. Dr. Saving. You have got a fit name for a conservative economist, by the way.

Mr. SAVING. Economists tend to be what you would refer to as conservative, because economists understand constraints.

Other people may live in unconstrained worlds, but the real world appears to have real constraints attached to it. And I think—as my testimony argued, I think that a prescription drug benefit is important to have efficiency in medical outcomes. There is no question that pharmaceuticals are playing a much larger role than they used to, and we need to do this.

The issue is, who is going to pay for it, when the individuals who are consuming the medical care, which is now happening, and once you give them a benefit and make these things cost much less, we know they are going to consume more of them. That is the simplest idea. Then your point is, to what extent is this efficiency gain that I have addressed—and I think we all have, actually—going to offset some of that?

Secondly, those individuals that used to pay for the pharmaceuticals—and now the general taxpayers are going to pay for them—they are actually better off. And so you might justify, in a sense, raising premiums or other kinds of sources of revenue for this system, because you are simply transferring current expenditures from one group of people to another. And the question is, who should pay? And is there an efficiency gain?

We certainly know from anything that we have done in the past, where we decided to make something free that wasn't free before, we almost always underestimate what it is going to cost us, that the increase in expenditures is going to be significant.

Mr. SPRATT. You showed us a big spike—$18 billion, as I recall—as probably the gross liability, present value, for all benefits that would be drawn by those who are now eligible for them if the system were to take no new entrants in the future.

If we don't have additional tax transfers to meet some of that, do you have any estimation of how much cost would have to be wrung out of the program over a period of 10 years, 15 years, 20 years, in order to accomplish solvency by cost reduction alone?

Mr. SAVING. Yes, in fact, I do. I have what percentage of these programs are—I have got it right here somewhere; I will find it in a moment—are going to actually be funded by transfers. Because that is actually what the question is.

Right now, we are 25 percent of—in 2001, 25 percent of Medicare expenditures were financed from general revenues. In 2010, it will be like 27 percent. By 2020, 40 percent of all of the expenditures are going to be financed by general revenues.

Mr. SPRATT. You are speaking with a sense of inevitability.

Mr. SAVING. Well, these are our trustees' estimates. These are the best estimates that we have of what is going to happen. Nothing is inevitable. We don't pretend, as trustees, that what we put

in the trustees report is what the numbers have to be, but they are our best estimates of what is going to happen. And we will be—under the current program we will be financing some 40 percent of Medicare with general revenue transfers. This is 2020; 47 percent by 2025.

Mr. SPRATT. By 2025, 47 percent——

Mr. SAVING. Of these things are going to be financed with general revenue transfers. So you would have to cut the program in half in a little over 20 years to——

Mr. SPRATT. That is not realistic, in your estimation?

Mr. SAVING. I don't think it is realistic. I think we need to—but we have to understand that these programs are significantly underfunded for the future.

Mr. SPRATT. Which means, if you can wring some of the costs out, so much the better. If you can get more efficiency——

Mr. SAVING. If you can raise revenue.

Mr. SPRATT. There is a high probability that we will make substantial additional transfers from general revenues to sustain the program?

Mr. SAVING. That is exactly right. That is going to happen. You will be doing that. I don't think you can avoid it. You may be able to, by some of the reforms that perhaps have been suggested for Social Security, finding ways to prepay some of this to make the current working—to get the current working population to pay for some of their future medical care, to set something aside to pay for their own medical care in the future. That has been suggested for Social Security. And Social Security has gotten a good bit of the press, sort of, on reform.

But we may want to think about this at some point down the road for Medicare, which is really part and parcel of taking care of the elderly. I mean, it is actually part of the retirement program. I mean, it is all one piece of a thing. We have just decided to separate out one little piece of what the elderly consume.

Actually, it is a very big piece that the elderly consume. That is medical care. I mean, we haven't done that for bread; for cars; or for houses, but we have done it for medical care. We could just as well have one big, elderly entitlement number, and people could decide whether they wanted a fancier house or more medical care. But we are not doing that. We are giving them an "in-kind" kind of a benefit.

Mr. SPRATT. So if we make the tax cut permanent in 2012, it will be a very short-lived accomplishment because, you are telling me, in 2024 we will need 47 percent of all tax revenues collected?

Mr. SAVING. No. Be careful. No.

What I said was that 47 percent of the Medicare program will be funded by general revenue transfers. That is not a percentage of Federal income tax revenue.

Mr. SPRATT. Excuse me. I misstated it. But still it is a substantial amount.

Mr. SAVING. It is going to be a substantial number. And the Federal income tax revenues that I am using to project this don't account for any tax cuts. I mean, they are really letting Federal income tax revenues remain at the same percentage of gross domestic product they are today, they were last year—actually, last year,

so before any real tax cuts took place basically, because most of those tax cuts are in the future. We are keeping that the same.

So it also accounts for all of the growth in the economy that we are projecting. We are not assuming that Federal income tax revenues are static; they are going to grow with the economy. But these programs are just going to grow much faster than the economy.

And, of course, the increased longevity is not bad. I am certainly a person that is all for increased longevity. But it is expensive for these programs. We have to recognize that and prepare for it. I think we would be remiss in our duty if we don't prepare and understand the facts, even though the facts may be frightening. We need to know what those are and be ready for them, so that we can keep those programs in place as we go forward.

Mr. SPRATT. Thank you very much.

Chairman NUSSLE. Mr. Collins.

Just before Mr. Collins begins, this is a vote on the previous question on the floor, which at least puts the possibility forward we may have to adjourn the hearing in order to vote on the passage of this rule to consider the steel disposition on the floor.

Mr. Collins.

Mr. COLLINS. Thank you, Mr. Chairman.

Ms. Feder, in your comments, I may have misunderstood what you were saying. But I thought you did indicate that the actual savings in health care costs would exceed the prescription drug benefit cost.

Ms. FEDER. I mean to say that. The comparison that I have made several times is a comparison of the cost of the proposed additional tax cuts to the cost of a drug benefit.

Mr. COLLINS. This was prior to even mentioning the word "tax"?

Ms. FEDER. I am sorry that I can't identify what is concerning you. I didn't mean to say that.

Mr. COLLINS. Maybe I just misunderstood you. But I thought you did say something about the savings based on the requirement of health care, based on having the prescription drug available, those savings would exceed the actual cost.

Ms. FEDER. No, I did not say that.

Mr. COLLINS. Well, I misunderstood you there.

But there are some savings to be gained; is that not kind of the rationale?

Ms. FEDER. I think that was in our conversation with Congressman Spratt, yes.

Mr. COLLINS. But is that not some of the reason, probably, that the private sector—and you mentioned the Federal Employees Health Benefit Program—do have prescription drug programs, because it does keep a person current with medicine that will enable them to maybe not have to have certain procedures in either outpatient or inpatient.

Ms. FEDER. Well, I think that the way to look at the structure of benefits in the private sector is that benefits for workers, including Federal employees, are designed to attract workers and have consequently responded to changes in medicine. Adding drugs is a way of providing better benefits for workers. With Medicare, a direct choice has to be made by the executive and the Congress to include a new benefit.

Mr. COLLINS. Well, you are getting right to my point. The private sector insurance, whether it be a private policy, an HMO policy, or whatever it may be, is a private sector. They do make choices about offering prescription drugs, whether it is additional benefit for an employee or what.

But it does have a positive effect on the health care of the individuals, as you mentioned. You enjoy, and I do, too, the prescription drug coverage that we have.

That is somewhat different, quite different, from Medicare, even though Medicare is basically structured like an HMO. But it is run by the Congress. The policy is set by the Congress. We have to set policy to adapt to new medicines, new procedures, and we are way behind the curve for doing all of those—quite different from private sector insurance.

Now, we have tried to do some of this with Medigap. We have tried do some of it with the Medicare+Choice. But where we have fallen short is that we don't have the same type or same ratio of payment as the private sector, because we are a government-run HMO, the most inefficiently run HMO in the country, policy set by Congress. A lot of it is set by politics rather than just plain reality and need.

And I am going to vote. Thank you.

Chairman NUSSLE. Just to inform members, there are three votes on the floor. We will go to Mr. McDermott's questions and then we will adjourn the hearing for those votes.

Mr. McDermott.

Mr. MCDERMOTT. I wanted to commend the chairman for having this hearing. And I am sorry there are so few members here, because I think it is one of the biggest issues we face.

I came out of medical school in 1963. I remember that every senior citizen at that time was in the private insurance industry. And we came along with this government program and ripped them out of the private sector and put them into this awful Socialist program, which has now obviously got some concerns.

One of the things that I listened to here, and I have been listening—I was on the Medicare Commission, and I have been listening to this for the last 4 or 5 years, ever since Newt Gingrich said he wanted Medicare to wither on the vine. I know now, in Seattle, people cannot get physicians to accept more people into their practice.

The wife of the first Asian judge in the State of Washington came up to me at a meeting and said, "I turned 65 and no one will take me into their practice as a Medicare patient." So we have done quite a lot of fixing here in the last 6 or 8 years.

But I hear the one that you are talking about. And you keep talking about this Federal Employees Health Benefit program and what a good program that is. I had a little discussion with my mother the other day. A few months ago I turned 65, and my mother is 92.

Now, what you are telling me is that the solution to Medicare is to put my mother into the Federal Employees Health Benefit program with me, because I have a drug benefit. I pay for my pharmaceuticals through my plan, and all my mother has to do now, she gets this voucher from the government, and she puts it in and she

pays like I do, about $45 or $65 or $70 a month. If she pays $70 a month, she would have the same thing I do in the Federal Employees Health Benefit Plan.

Is that what you are you telling me? You are seriously sitting there and talking about bringing my 92-year-old mother in on the same basis that I am, on there?

Mr. ANTOS. Mr. McDermott, no.

Mr. MCDERMOTT. Oh, you are not?

Mr. ANTOS. No, I am not.

Mr. MCDERMOTT. Tell me what—because you keep talking about the Federal Employees Health Benefit program, like that is the one we are going to stick people into. Are you are going to adjust this, because my mother is 92 and I am—you know—are we going in that same program together, hand in hand?

Mr. ANTOS. Mr. McDermott, you are raising a very important point. What I was trying to say was that I believe Medicare needs to be a program, it needs to be on its own, but it needs to find a better way to manage itself, manage its physicians, its other providers of health care; and manage its benefits and find a way to make it possible for people to actually get some satisfaction of their real health care needs.

Mr. MCDERMOTT. Let me stop you. You are talking about a voucher system, right? Are you? That is what I have. I have a voucher system as a Federal employee.

Mr. ANTOS. Yes. And your voucher is a somewhat adjustable voucher. It depends to some extent on what health plan you take.

Mr. MCDERMOTT. But my mother would get a fixed amount of money from Federal Government, and she would go out on the street with me, buying a policy.

Mr. ANTOS. That is not at all clear that that is the way it would work.

Mr. MCDERMOTT. Well, how would a voucher system work for all of those old people?

Mr. ANTOS. First of all, it would be implausible to start such a program by immediately requiring that everybody now in Medicare change what they are doing. That is unreasonable. And I don't think any of us would support that.

Instead, this is—the idea behind this is to gradually, over time, phase in a system that will allow people to make their wishes known and use the resources that they, in fact, are using now in a more sensible way, in a way that gives them the kind of health care that they actually need and want.

Mr. MCDERMOTT. I understand you are phasing in. We phased in working longer under Social Security from 65 to 67. So you are saying that in the year 2020 or 2015, at that point, every senior citizen will get a voucher. Up to that point, folks will have the same program that we have today.

In 2015, when you are 65, you will then just get a voucher to go out and buy whatever you can. That is how you would have to phase it in.

Mr. ANTOS. It is a pretty complicated issue.

There are lots of ways to phase a program like this in. One way to do it is to allow people to voluntarily—to go into that type of a program.

But we are not just talking about a voucher. I mean, in some sense, the Medicare+Choice program is kind of a voucher program, it is just that beneficiaries don't hold the piece of paper in their hand.

We are talking about a fundamental change in the way that the Medicare program would look at its own operation, a reduction in the kind of micromanagement that we now see, a reduction or an increase in the—in the interaction, the positive interactions that are possible between health plans, providers and the program.

It would require a new kind of agency, the kind of agency that you heard—as you said, you have heard this for many years—the kind of agency that the commission recommendation suggested, that would have a different approach, a less heavy-handed approach to the benefit.

Mr. MCDERMOTT. Thank you very much.

I want to thank the chairman. And I hope that this won't be the last time we discuss this issue, because I think there—that the Members need to hear you go through what the circumstances and the nuances of this really are. Because it sounds like you can manage this all by cutting costs, by sort of giving everybody a fixed amount. Everybody will be in the Medicare+Choice, when, in fact, 80 percent of the people in the country don't have Medicare+Choice available to them.

So the question then is how—I mean, that is what I hope we can come back and talk another time about.

Thank you, Mr. Chairman.

Chairman NUSSLE. I agree with the gentleman. I would hope we can, too. We have done that today, I think calmly and respectfully. That is what we need in order to solve this. I would agree this is probably the most profound issue we are facing here on the committee, long-term.

I had indicated that we were going to come back. We have been told by members that we don't have any that are able to come back after the three votes on the floor. So I will thank our panelists for their fine testimony today and the great discussion that we have had.

Mr. McDermott and others are correct. We will need to revisit this issue many times in the future.

Parenthetically, Dr. Feder, I appreciate your clarification on 1993. I was speaking about—we were talking past one another. So you are correct. I apologize for that.

Ms. FEDER. I was going to run home and make sure it was in there.

Chairman NUSSLE. Well, I have checked with my staff. And I don't like the record to reflect inappropriately.

We appreciate the testimony of all three of you. With that, the committee is adjourned.

[Whereupon, at 11:30 a.m., the committee was adjourned.]

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