# BOARD OF TRUSTEES 2004 ANNUAL REPORTS

## HEARING

BEFORE THE

## COMMITTEE ON WAYS AND MEANS
## U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

SECOND SESSION

MARCH 24 AND APRIL 1, 2004

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# BOARD OF TRUSTEES 2004 ANNUAL REPORTS

**WEDNESDAY, MARCH 24, 2004**

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
*Washington, DC.*

The Committee met, pursuant to notice, at 1:13 p.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Committee) presiding.

The advisory and second advisory announcing the hearing follow:]

# *ADVISORY*

## FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
March 17, 2004
FC–16

CONTACT: 202–225–1721

# Thomas Announces Hearing on Board of Trustees 2004 Annual Reports

Congressman Bill Thomas (R–CA), Chairman of the Committee on Ways and Means today announced that the Committee will hold a hearing to examine the findings and recommendations made by the Boards of Trustees for the Social Security Old-Age and Survivors and Disability Insurance Trust Funds and the Boards of Trustees for the Medicare Hospital Insurance and Supplemental Medical Insurance Trust Funds in their *2004 Annual Reports* on the financial status of these trust funds. **The hearing will take place on Wednesday, March 24, 2004, in the main hearing room, 1100 Longworth House Office Building, beginning at 1:00 p.m.**

In view of the limited time available to hear witnesses, oral testimony will be heard from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

**BACKGROUND:**

The Social Security Act requires the Boards of Trustees for the Social Security and Medicare programs to report annually to the Congress on the current and projected financial condition of the Old-Age and Survivors Insurance (OASI), the Disability Insurance (DI), the Hospital Insurance (HI), and the Supplementary Medical Insurance (SMI) trust funds. Members of both Boards include the Secretary of the Treasury (who is the Managing Trustee), the Secretary of Labor, the Secretary of Health and Human Services, the Commissioner of Social Security, and two members who are appointed by the President and confirmed by the Senate to serve as public trustees for 4-year terms. In addition, the Deputy Commissioner of Social Security serves on the Board of Trustees for the Social Security programs and the Administrator of the Centers for Medicare and Medicaid Services serves on the Boards for the Medicare program. The *2004 Annual Reports* are scheduled to be released in the near future.

Ensuring the financial viability of Social Security and Medicare is one of Congress' most important responsibilities. The annual release of the Trustees' reports provides a valuable update on the programs' fiscal well-being.

The release of the *2004 Annual Reports* on the Medicare HI and SMI trust funds will be particularly timely, because their findings will include an initial evaluation of the impact of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (P.L. 108–173) on the long-term financial situation of the Medicare program. Among other items, the MMA included a provision to make available prescription drug coverage to Medicare beneficiaries. As the MMA is implemented, it will be essential to continue to evaluate the overall fiscal standing of the program. In addition, the report on the OASI and DI trust funds will provide fresh evidence of the financial challenges facing Social Security and the need to act quickly to strengthen the program.

In announcing the hearing, Chairman Thomas stated, "I look forward to this hearing and to the report of the non-partisan Social Security and Medicare Trustees. As we approach the retirement of the baby-boom generation, it is essential that we continue to evaluate the long-term fiscal outlook for both of these important programs."

**FOCUS OF THE HEARING:**

The hearing will examine the findings and recommendations of *The 2004 Annual Reports of the Board of Trustees of the Federal OASDI and HI/SMI Trust Funds.* The hearing will focus on the long-term financial status of the Social Security and Medicare programs.

**DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:**

**Please Note:** Any person or organization wishing to submit written comments for the record must send it electronically to *hearingclerks.waysandmeans@mail.house.gov*, along with a fax copy to (202) 225–2610, by close of business Wednesday, April 7, 2004. In the immediate future, the Committee website will allow for electronic submissions to be included in the printed record. Before submitting your comments, check to see if this function is available. **Finally,** due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-packaged deliveries to all House Office Buildings.

**FORMATTING REQUIREMENTS:**

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. Due to the change in House mail policy, all statements and any accompanying exhibits for printing must be submitted electronically to *hearingclerks.waysandmeans@mail.house.gov,* along with a fax copy to (202) 225–2610, in WordPerfect or MS Word format and MUST NOT exceed a total of 10 pages including attachments. Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. Any statements must include a list of all clients, persons, or organizations on whose behalf the witness appears. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov*.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

# *ADVISORY*

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
March 30, 2004
FC–17–Revised

CONTACT: 202–225–1721

## Thomas Announces a Continuation of the Hearing on Board of Trustees 2004 Annual Reports

Congressman Bill Thomas (R–CA), Chairman of the Committee on Ways and Means today announced that, pursuant to Rule XI, Clause 2(j)(1) of the U.S. House of Representatives, the Committee will hold a continuation of the March 24, 2004 hearing to examine the findings and recommendations made by the Boards of Trustees for the Social Security Old-Age and Survivors and Disability Insurance Trust Funds and the Boards of Trustees for the Medicare Hospital Insurance and Supplemental Medical Insurance Trust Funds in their *2004 Annual Reports* on the financial status of these trust funds. **The hearing will take place on Thursday, April 1, 2004, in the main hearing room, 1100 Longworth House Office Building, beginning at 12:00 p.m.**

All other details of the hearing remain the same. (See full Committee advisory *No. FC–17*, dated March 17, 2004.)

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Chairman THOMAS. Good afternoon. Today we welcome the Secretary of the U.S. Department of the Treasury John Snow, the Managing Trustee, to discuss the 2004 Annual Reports of the Board of Trustees of Social Security and the Medicare Trust Fund. In every Congress since Republicans became a majority in 1995, the Committee on Ways and Means has reviewed the Trustees' findings on the financial future of our most significant entitlement programs. These reports are essential reminders to policymakers of the challenges we face as the baby-boom generation retires and as Americans live longer, healthier lives. This year's report provides us with the first glance at the impact of the Medicare Modernization Act (P.L. 108–173) on the program's future finances and reminds us, since both of these entitlement programs are tied to wages and salary, how much the short-term fluctuations follow the economy. With passage of the new law, Medicare will cover prescription drugs, the cornerstone of modern medicine, and provide other preventive and wellness services as well. That is why Congress intentionally included crucial reforms to balance the increased cost of these new benefits and to ultimately improve the solvency of Medicare if competition is allowed to occur. These efforts did not go as far as some of us would have liked, and as today's report shows there is still more work ahead to maintain solvency.

Turning now to the reports before us, the Hospital Insurance (HI) Trust Fund is moving toward insolvency sooner than expected. To consider a complete picture of all Medicare financing, though, it is useful to look at Medicare expenditures as a percentage of gross domestic product which are expected to grow rapidly from the 3.4 percent in 2003 to 7.7 percent in 2035, and ultimately, once

again projecting out where no one believes any numbers, but 13.8 percent by 2078. It is the trend that is alarming, not any specific set of figures at any particular projected point in time. Clearly without further cost saving reforms, Medicare will consume an ever increasing share of our Nation's resources. Social Security faces similar changes as the Trust Fund's outlays exceed income beginning in 2018, with Trust Fund insolvency coming in 2042. As with Medicare, Congress must consider thoughtful solutions to ensure Social Security's viability for future generations.

Our second panel will focus on the details behind these broad brush strokes. I will be pleased to welcome Douglas Holtz-Eakin, Director of the Congressional Budget Office (CBO), Richard Foster, Chief Actuary at the Centers for Medicare and Medicaid Services (CMS), and Stephen Goss, Chief Actuary at the Social Security Administration (SSA). Of late there has been particular interest in the differing cost estimates generated by the CBO and the CMS on the new Medicare law. Our goal, of course, is to have our witnesses help explain the nature of their different assumptions and the therefore resulting different estimates. All of us know no one has the right answer and time will likely show that both of the estimates are wrong. The goal is to examine the assumptions which produce the numbers and determine if the assumptions underlying the numbers are reasonable and appropriate on a comparative basis. I would now like to recognize the Ranking Member, Mr. Rangel, for any opening statement he might wish to make.

[The opening statement of Chairman Thomas follows:]

**Opening Statement of The Honorable Bill Thomas, Chairman, and a Representative in Congress from the State of California**

Good afternoon. Today, we welcome Treasury Secretary John Snow, the managing Trustee, to discuss the *2004 Annual Reports* of the Boards of Trustees of the Social Security and Medicare. In every Congress since Republicans became the majority in 1995, the Ways and Means Committee has reviewed the Trustees' findings on the financial future of our most significant entitlement programs. These reports are essential reminders to policymakers of the challenges we face as the baby boom generation retires and as Americans live longer, healthier lives.

The year's report provides us with a first glance at the impact of the Medicare Modernization Act on the program's future finances. With passage of the new law, Medicare will cover prescription drugs—the cornerstone of modern medicine—and provide other preventive and wellness services as well. That is why Congress intentionally included crucial reforms to balance the increased costs of these new benefits and to ultimately improve the solvency of Medicare. These efforts did not go as far as some of us would have liked, and as today's reports show us, there is still have more work ahead.

Turning now to the reports before us. The Hospital Insurance Trust Fund is moving toward insolvency sooner than expected. To consider a complete picture of all Medicare financing though, it is useful to look at Medicare expenditures as a percentage of GDP, which are expected to grow rapidly, from 3.4 percent in 2003, to 7.7 percent in 2035, and to 13.8 percent by 2078. Clearly, without further cost-saving reforms, Medicare will consume an ever-increasing share of our nation's resources. Social Security faces similar challenges as the Trust Funds' outlays exceed income beginning in 2018, with Trust Fund insolvency coming in 2042. As with Medicare, Congress must consider thoughtful solutions to ensure Social Security's viability for future generations.

Our second panel will focus on the details behind these numbers. I am pleased to welcome Douglas Holtz-Eakin, Director of the Congressional Budget Office (CBO); Richard Foster, Chief Actuary at the Centers for Medicare and Medicaid Services (CMS); Stephen Goss, Chief Actuary at the Social Security Administration. Of late, there has been particular interest in the differing cost estimates generated by CBO and CMS on the new Medicare law. Our witnesses will help explain the nature of

their differing assumptions and the resulting estimates. Neither one has the "right answer." And time will likely show they are both wrong, as estimates often are.

I would now like to recognize the ranking member, Mr. Rangel, for any opening statement he might make.

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Mr. RANGEL. Thank you. Welcome, Mr. Secretary. I am so sorry that we missed each other by phone because you have always been very courteous in talking with me and other Members prior to these meetings, and it certainly makes me a more gentle person when I get that type of accommodation from people who represent the Administration. This morning I am not going to ask any questions because of the limited time that you have. I am reminded that President Kennedy once said that sometimes the Democratic Party asks too much of its Members. I have known that feeling. As I see where the Republican Party is going today, I think at some point in time many Republicans are going to say that on the question of credibility, sometimes the party is really asking too much of us.

We have people testifying, as we talk on the Hill, as to the credibility that our government had in terms of the quality of intelligence in declaring war and invading Iraq. We have other members of the Administration, like your predecessor, who indicated that the President was focused on Saddam Hussein rather than economic issues. We have people who truly believe in the Democratic Party that it is a mission of the Republicans to destroy Social Security and Medicare, but they believe that politically they cannot do it. So, today we have you testifying that the Social Security system is in trouble and the only way that we can repair it is through privatization. We also know of people in the Republican party that find Medicare repugnant to their beliefs. As you have said that maybe the way to curtail the costs would be to privatize it and to let the free marketplace work its will. We know that unless you can get the Congress to do these things, it is not going to happen. So, when it came time to have the crisis in prescription drugs, we know that Republicans and Democrats know that you would not have had the votes to pass this bill if the true cost of the bill was known.

So, therefore, when our staffs said that we did not have access to the information which the law declares that Republicans and Democrats should have access to the actuary table. We were amazed that staff would tell us that it was refused. We were more concerned when the written record showed the intimidation and how far the majority party was prepared to go to keep the Congress of the United States in the dark. Knowing that if the Congress had known what the Administration knew and failed to share it at our request, that we would not be dealing with the problems that we see now with the prescription drug bill. I think, Mr. Secretary, there comes a time when you start looking at the whole thing, that it is not just the credibility of the Administration, with Democrats and the American people, but indeed throughout the world the credibility of the United States is being reviewed. This pains me as I know that it pains you. I do hope that your response to some questions as it relates to what did you know about the cost and

why did not we know it will make us feel a little more secure. I hope that we can go to the polls on the question of who they want, Democrats and Republicans, and not who do they trust. So, I thank you, Mr. Chairman, for this opportunity and I look forward to hearing from you, Mr. Secretary.

Chairman THOMAS. Mr. Secretary, welcome once again before the Committee. Any written testimony you have will be made a part of the record. I do understand that you are scheduled to introduce the President of the United States and that we have only until about 1:45 p.m. So, I look forward to your statement and the brief opportunity for Members to ask questions and your response. Mr. Secretary?

**STATEMENT OF THE HONORABLE JOHN W. SNOW, SECRETARY, U.S. DEPARTMENT OF THE TREASURY**

Secretary SNOW. Chairman Thomas, Ranking Member Rangel, distinguished Members of the Committee, I want to thank you for the opportunity to appear before you today to talk about the Trustees' reports on the Social Security and Medicare programs. The Trustees met yesterday to complete the annual financial review of the programs and our reports have been sent to the Congress. Let me review first the Social Security Trustees' Report. This year's is little changed from last year's report, actually a little bit better in some ways. It shows that the Social Security program, and this is no surprise to any of you, is seriously underfunded and that it is not financially sustainable in the long run. The fundamental math of Social Security is simply inescapable, as the large baby-boom generation reaches retirement age and the number of workers that are paying into the system declines significantly as a proportion of the total retirees.

While we have some time to fix this problem, inaction is not a responsible option. The President has called for bipartisan efforts to deal with the issue and the sooner that action is taken, the better for all concerned. I think we all know that each year that passes without the needed changes makes the ultimate resolution even more difficult. Personal accounts, in our view, are an important part of a solution to the Social Security system's problems. They would enable younger workers to accumulate a nest egg toward their retirement needs. They would relieve some of the pressure on the system itself. Whatever the ultimate answer here is, it is clear that now is the time to take the steps to preserve and protect Social Security so that our commitments to seniors are kept and so that the needs of our children and grandchildren are met. I think we would all agree with that.

Let me offer a few words on the more serious and pressing issue of the Medicare Trustees' Reports. It reveals even greater challenges than those confronting the Social Security system. While Medicare faces the same shifting demographics that drive the numbers in Social Security, it is additionally affected by the sharp increases in underlying health care costs. You know these numbers, too. From 1998 to 2002, health care costs rose an astonishing 35 percent. Health care spending is growing as a percentage of gross domestic product. It was 15 percent in 2002 and it is surely much higher today. Employer-sponsored health insurance premiums rose

14 percent last year. The negative impact of these rising costs is evident in terms of the economy's performance, job creation, and Federal programs such as Medicare.

Let me first mention the HI Trust Fund for part A. Cash flow for the HI Trust Fund is projected to turn negative this year, compared to 2013 in last year's report. Let me mention at the outset here that the change in HI's financial condition was not caused in any way by the creation of the Medicare prescription drug program which is separately financed, although as the report points out other aspects of that legislation did increase costs under part A, the parts dealing with rural providers and managed care and so on. Taking interest into account, the total Trust Fund is expected to exceed expenditures through 2009 and turn negative in 2010. While the decline in cash flow is substantial and a fairly dramatic change from the last few reports, we saw similar negative cash flows for much of the nineties. In another major finding from the report, the HI Fund is projected to become insolvent in 2019. That would be 7-years earlier than projected in last year's report. Again, I hasten to add that even without the recent legislation, important and good legislation in our view, the fund would be insolvent in 2021. So, the legislation accelerated by 2 of the 9 years to the insolvency point.

It is also important, as the Chairman said in his opening comments, to realize here that the forecasts we are dealing with are based on assumptions whose validity cannot be known with any high degree of certainty. Although uncertainty in these numbers is inescapable, it is also inescapable that we must make public policy judgments given the importance of these programs to current and future beneficiaries. Rising health care costs are placing an enormous burden on the Medicare program which is already under stress from the demographics I have mentioned. In our view, controlling health care costs is the real key to the long-term fiscal sustainability of Medicare and since Medicare bulks so large in the Federal budget deficit, it is also key to controlling the outlook for the Federal budget. The President has shown real leadership in seeking to reduce health care costs without diminishing quality or access to care for our senior citizens through many initiatives he has put forth which you are aware of. We should not forget as well the important reforms in last year's legislation which offers so much promise on this score of controlling health care costs as well. These are real reforms that will help contain health care cost and help to contain their growth relative to gross domestic product and help alleviate the pressure on the Medicare system. Those who depend on Social Security and Medicare urgently need the best efforts of all of us in public life, and those in private life as well, to address these long-term funding issues as laid out in the Trustees' reports. These programs, I am sure you would agree, must be seen as a shared responsibility not a political or partisan matter. Mr. Chairman, thank you very much for the opportunity to appear before you and I look forward to your questions.

[The prepared statement of Secretary Snow follows:]

**Statement of The Honorable John W. Snow, Secretary, U.S. Department of the Treasury**

Chairman Thomas, Ranking Member Rangel, and distinguished members of the Committee, thank you for the opportunity to testify today on the 2004 Social Security and Medicare Trustees' Reports. The Social Security and Medicare Board of Trustees met yesterday to complete the annual financial review of the trust funds and sent the Trustees' Reports to Congress.

Let me start first with the 2004 Social Security Trustees' Report. This year's report is little changed from last year's report. It shows that the Social Security program is seriously under funded and financially unsustainable in the long run. The unfunded obligation is $3.7 trillion on a present value basis over the next 75 years. Cash flows for the trust fund will turn negative in 14 years, in 2018, while the trust fund will be exhausted in 38 years, 2042. Neither date has changed since last year's report.

The fundamental math of Social Security is inescapable as the large baby boom generation reaches retirement age and the number of workers paying into the system declines significantly relative to the number of retirees. While we have some time to fix the problem, inaction is not a responsible option. The President has called for bipartisan efforts to create a permanently sustainable system and he has been right to do so—and the sooner action is taken, the better for all concerned. Each year that passes without needed changes to the program makes the ultimate resolution more difficult.

To provide some perspective on what this means—today, the cost of paying Social Security benefits absorbs 4.3 percent of the nation's GDP. According to the Social Security actuaries, the cost will rise to 6.6 percent by 2078. This would mean that the share of the economy required to fund Social Security benefits would be more than 50 percent higher than it is today—and even that would continue to increase, the further out one looks.

Personal accounts are an important part of the solution to strengthen Social Security as they will enable younger workers to accumulate a nest egg towards their retirement needs. Now is the time to take the steps to preserve and protect Social Security so that commitments to our seniors are kept and the needs of our children and grandchildren are met.

Let me now offer a few words on the 2004 Medicare Trustees' Report. It reveals even greater challenges than those confronting Social Security. While Medicare faces the same shifting demographics as Social Security, it is additionally burdened by sharp increases in underlying health care costs. From 1998 to 2002, health care costs rose 35 percent. Health care spending is growing as a percentage of GDP; its share was nearly 15 percent of our nation's GDP in 2002 and is surely even larger now. Employer-sponsored health insurance premiums rose 14 percent last year alone. The negative impact of rising costs is evident in terms of the economy, jobs, and federal programs such as Medicare.

Cash flow for the Hospital Insurance (HI) Trust Fund is projected to turn negative this year, compared to 2013 in last year's report. At the outset, it is important to note that the change in HI's financial condition was not caused in any way by the creation of the Medicare prescription drug program, which is separately financed. Taking interest into account, total trust fund income is expected to exceed expenditures through 2009. While this decline in cash flow is a substantial change from the last few reports, we saw similar negative cash flows for much of the 1990s. In another major finding from the report, the Hospital Insurance Trust Fund is projected to become insolvent in 2019, seven years earlier than projected in last year's report. For the first time in five years the HI Trust Fund fails the short run test for financial adequacy as the ratio of assets to annual outlays falls below 100 within the next ten years. Again, the principal culprit here is the rising cost of health care, and we need to turn our attention to this underlying fundamental issue.

The Supplementary Medical Insurance (SMI) Trust Fund does not face insolvency per se, because its financing is derived in large part directly from federal general revenues. However, it does pose serious issues for the U.S. economy and federal deficit. SMI expenditures, including those associated with the new prescription drug program, are projected to increase rapidly, resulting in increasing pressures on future federal budgets. General revenue financing for SMI is expected to increase from 0.9 percent of GDP today to 6.2 percent in 2078.

It is important to note that the forecasts we are dealing with in Medicare are based on assumptions whose validity cannot be known with any high degree of certainty. Although uncertainty in these numbers is inescapable, we must make public policy judgments given the importance of these programs to current and future beneficiaries and the fiscal condition of the country.

Rapidly rising health care costs place a great burden on the Medicare program, which is already under stress from the underlying shift in the age distribution of our nation's population. Controlling health care costs is the real key to the long run fiscal sustainability of both Medicare and the federal budget. Indeed, according to this year's Trustees' Report, reducing the projected growth in per beneficiary health care costs to one percentage point lower than the intermediate assumption would reduce the 75-year actuarial imbalance for the HI program from negative 3.12 percent of taxable payroll to negative 1.05 percent. Similarly, lower growth in health care costs would accrue to the federal budget through reductions in projected costs in the SMI program, Medicaid, and other government health care programs. According to the CBO, federal spending on Medicare and Medicaid will rise to 11.5 percent of GDP in 2050, up from 3.9 percent in 2003. If, instead of increasing at the rate of growth of per capita GDP plus 1 percent as assumed, per beneficiary spending were to grow at the rate of per capita GDP itself over the same time period, federal spending on Medicare and Medicaid will rise to only 6.4 percent of GDP in 2050, thus freeing roughly 5 percent of GDP for other activities. Achieving a 1 percentage point reduction in the rate of increase in health care costs should be doable, but it will require the very best efforts of all of us concerned with the issue. Most importantly, I believe this slowdown in cost increases could be accomplished without sacrificing the quality and access to health care that our senior citizens deserve and have come to expect.

Clearly steps must be taken to address growing costs while maintaining high quality care for our senior citizens and, indeed, all citizens. The President has shown real leadership in seeking to reduce health care costs without diminishing quality or access to care. This Administration is committed to helping Americans obtain improved and more affordable health care coverage. Medical liability reform is critical to improve health care quality and reduce costs. We need to help stop harmful costly medical errors and provide liability protection for doctors and nurses who report mistakes in good faith. We need to employ more fully the efficiencies of information technology in the health care sector, such as physician order entry and electronic medical records.

Additionally, health savings accounts will help millions of Americans with medical expenses and encourage saving while putting individuals in charge of their own health care choices. The President has proposed refundable tax credits to help low-income workers purchase health insurance coverage, and proposed allowing small businesses to band together through association health plans, helping America's working families to have greater access to affordable health insurance. We need to give consumers better information to make informed decisions when choosing health care providers. The private sector Leapfrog Group is a leader in this area, as is CMS, by encouraging health care providers to report data on quality, making it widely available to the public. We urge Congress to act on all these important measures.

And let's not forget, reforms in last year's legislation include provisions to promote competition and choice, encourage savings for medical expenses, bring generic drugs to market sooner, improve preventive care coverage, lower the costs of chronic illnesses through disease management programs, and reduce costs and medical errors through e-prescription services. Reductions in fraud and abuse are expected to save $35 billion. These are real reforms that will help contain health care costs, control their growth relative to GDP, and alleviate some of the pressure on the Medicare system.

Moreover, with passage of the Medicare legislation last year, for the first time all seniors will be guaranteed access to affordable prescription drug coverage under Medicare. Beginning in June of 2004, beneficiaries will have access to Medicare-approved prescription drug discount cards, which will save them 10 to 25 percent off the retail price of most prescription drugs. Low-income beneficiaries will also receive $600 per year to help them purchase their medication. And all seniors will have more choices and better benefits under a strengthened and improved Medicare program.

The weighty concerns raised by the Trustees' Reports demand the attention of America's policymakers and the public. Those who depend on Social Security and Medicare urgently need the best efforts of those of us in public life and in the private sector to address the long-term funding issues. These programs should be seen as a shared responsibility, not a political or partisan opportunity.

This Administration will continue its open and honest discussion of the issues facing Social Security and Medicare and remains dedicated to working with Members of Congress to take the steps needed to secure the long-term strength of these vital programs. Thank you for having me here today, I look forward to your questions.

Chairman THOMAS. Thank you very much. To make sure that those Members who do wish to question you, Mr. Secretary, I will be brief. My understanding from the gentleman from New York is that he will suspend any questions he might ask the Secretary for the second panel. I find it interesting to compare the question of solvency, or the other side of the coin, insolvency, in the 2004 report with earlier years when we were grappling with the question of, for example, Medicare insolvency. In 1994, the year prior to the Republicans becoming the majority in the House, there was a 7-year solvency period, projected to be insolvent in 2002. The 2004 report indicates, as you said, 2019. That is a 15-year insolvency point. So, almost certainly more than double the years of previous periods, to just select one particular period in time. Chairman Greenspan came before this Committee several years ago, shortly after we had a Social Security Commission that looked at options to make sure that we could improve the solvency of the Social Security Trust Fund. Clearly, as I recall, even President Clinton talked about increasing the return, the rate of return on the money available as one of the key features.

The Chairman indicated that he was more than willing to try to tackle the problem of Social Security because it was akin to an arithmetical problem. When you turn to Medicare, as no Commission really has except the one that I was honored to cochair with the gentleman from Louisiana, Mr. Breaux, you are dealing with geometric progressions and frankly nonlinear in a multiple of areas, not just age and money. So, it is without a doubt that as people try to estimate changes in the program on a prospective basis there will be differing assumptions. We are going to pursue that with the second panel. As the Secretary of the Treasury, is it any wonder to you that trust funds tied to wages and salaries fluctuate as the economy fluctuates and, as we all know, since 9/11 the economy has stumbled for very basic and understandable reasons, and that it would not then reflect itself in the revenue coming into these trust funds?

Secretary SNOW. Mr. Chairman, as your question suggests, that is perfectly understandable. The returns, the income, is tied to the economy, to wages and in a period of recession and weak economic performance as we had in 2001 and 2002, it is perfectly understandable. In fact, it is what you would expect.

Chairman THOMAS. I believe, as we get to the actuaries, and we begin looking at it fully up to 2 full years were lost off of the solvency table by virtue of the economic performance for part A Medicare. Does the gentleman from Illinois wish to inquire?

Mr. RANGEL. Mr. Chairman, while I have said that I would pass my questioning, I did not mean that the Democratic side would not be entitled to question after you had finished yours.

Chairman THOMAS. They certainly are. Does the gentleman from California wish to question? The other gentleman from California?

Mr. MATSUI. Thank you very much, Mr. Chairman and thank you, Mr. Ranking Member, for allowing me to go next. Thank you, Secretary Snow, for being here with us. I just would like to make

one observation about Medicare, not in the form of a question. The acceleration of the unfunded part of Medicare will accelerate by some 7 years, or the cash flow problem. What you failed to mention is that 2 of the years is because of the legislation that was passed last December, mainly because we are shifting people away from the traditional Medicare system into health maintenance organizations (HMOs) by subsidizing HMOs. Second, obviously, by the rural health issue. So, about 30 percent of the deterioration is due to that legislation. I really want to focus on, however, Social Security because you spent your very early part of your comments regarding it. Assume for a minute that I favor privatizing, as the President does, part of the Social Security system. Assuming for a minute that I want to make, as he does, sure that current recipients and immediately future recipients will undoubtedly maintain their full level of benefits. There is going to be, as the three plans set forth in the President's Commission recommendation, an unfunded liability. That is, it will either have to be made up in spending cuts or tax increases or borrowing perhaps.

For example, plan one has a $1.5-trillion deficit in the first 10 years. Plan two, $1.8 trillion in the first 10 years. Plan three, $1.4 trillion in the first 10 years. Mr. Shaw's legislation, and I would obviously prefer to have him comment on it, but I think it is important just to talk about it because it is offered by a Chair of our Subcommittee. In the first 10 years, Mr. Shaw's plan will have an unfunded liability of $1.4 trillion. The borrowing peak will be in 2048, 44 years from now, when $7.6 trillion will be, either in the form of deficits or tax increases or spending cuts in Social Security. Which one do you think that I should support? If not any of those, then what plan do you propose to come up with in order to make sure we do not increase the deficits, we do not increase the taxes and we do not cut benefits as the President, in fact, has promised to do?

Secretary SNOW. Congressman, of course, the Administration has not picked one of those three or any other option at this point. In appointing the Commission, I think the President advanced the subject enormously by calling public attention to the underfunding and the need to find——

Mr. MATSUI. We all knew about it before he talked about it, so do not assume that we get it from him. We knew about this because we have seen actuarial reports over the last 20 years.

Secretary SNOW. What I am saying is, he helped engender a broad national dialog on this vitally important subject. The issue you are raising of transition costs is really the recognition of the contingent liability. It is there. It is there, and since it is there I would argue it is better to make it explicit than implicit. It is better to make it transparent rather than to hide it.

Mr. MATSUI. If I may just interrupt you, I do not think you answered my question but that is all right. It is not about a contingent liability, it is diverting money from the current payroll tax to private accounts. So, how are you going to make that up in the next 10 to 75 years, which you are going to do by talking about this and by advancing this if it ever became law, you are going to deteriorate the Social Security system. In fact, you are going to advance

the cash flow problem. you are going to actually make the problem that you and I are really concerned about much worse.

Secretary SNOW. What the Commission's plans do, and I think Commission plan two is laid out in some detail in the report of the President's Council of Economic Advisers. What it does, of course, is to provide a transition mechanism to fund the loss of revenues to the retirement system. That takes——

Mr. MATSUI. Reduce benefits.

Secretary SNOW. That is right, for some period of time. Then longer-term, the deficit and the budget are better.

Mr. MATSUI. For some period of time, Mr. Secretary, means that those that are currently retired will have a reduction in benefits.

Secretary SNOW. They will not. No. The President stipulated, in appointing the Commission, that there would not be for those who are retired or near retirement, any reduction in benefits.

Mr. MATSUI. That is the President's position.

Chairman THOMAS. The gentleman's time has expired.

Mr. MATSUI. Thank you, Mr. Chairman.

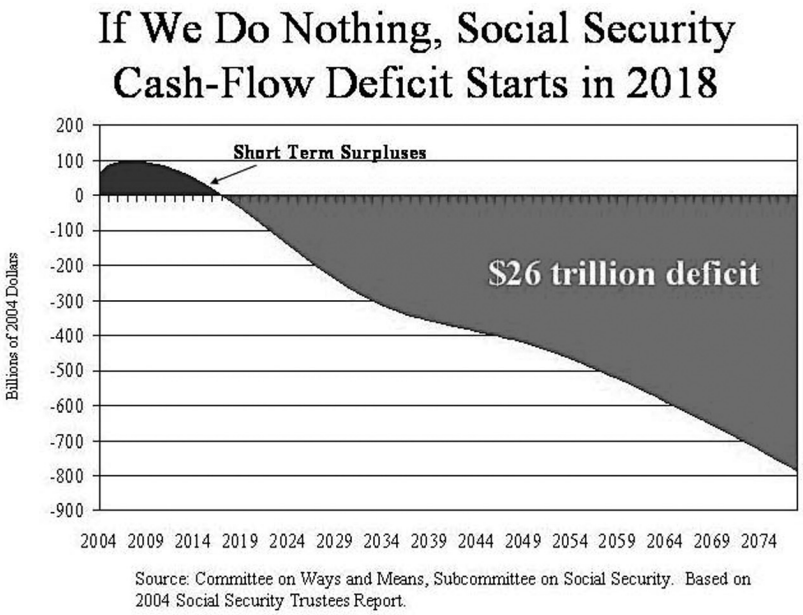
Chairman THOMAS. The gentleman from Florida, the Chairman of the Subcommittee on Social Security, Mr. Shaw, wish to inquire?

Mr. SHAW. Yes, sir. Thank you, Mr. Chairman and I appreciate the gentleman from Illinois letting me go out of turn here in order to ask a couple of questions and also to respond to the Chairman of the Democratic Congressional Campaign Committee who just characterized my plan as causing a huge deficit. What the gentleman from California fails to point out, is that the funds that are put in the individual accounts are an investment, an investment that is going to stand for future payments to future beneficiaries of the Social Security Trust Fund. Also, my plan does not take a dime out of the Social Security Trust Fund, nor does it divert any of the payroll taxes. I might say that under Mr. Clinton, President Clinton, my plan was scored in the long run of over 75 years, as not only saving Social Security for all time, but it also was scored as creating about a $5-trillion surplus instead of over a $26-trillion deficit that we are looking at now if we do nothing. So, I think to characterize or to continue to play politics with Social Security is very bad strategy to be used, particularly at this time.

I might also say that I think that the direction this Committee should be looking at, the warning signs that are being thrown up, whether they are correct or incorrect they are still warning signs, that we have a huge problem here. We need to go and start talking about it. The cash flow problem with Social Security is a huge problem and it is one that we are facing beginning in 2018.

Mr. Secretary, I would like to ask you, the chart that is in the report shows Social Security clash annual flow deficits growing from $16 billion in 2010 to $787 billion in 2078. That is just in 1 year. How can there be a cash flow deficit in Social Security when the Trust Fund balance in 2018, as represented by treasury bills, is $3.7 trillion in today's dollars, the same for 2030 when the cash flow deficit is $256 billion, but the Trust Fund balance is $3.2 trillion? This is a chart I am referring to, that was in the report. I beg your pardon. I am asking that it be passed out.

[The information follows:]




Secretary SNOW. Obviously, what is happening here is we have the baby boom starting in 2010. We have people coming out of the denominator of the equation and going into the numerator. The fundamental math there is expenditures rise and payments do not rise at the same rate. They rise at a much lower rate. The consequence is that wide gap that produces the unsustainability of the system that you are trying to address with your legislation.

Mr. SHAW. Yes, sir. I think it is very important to realize that this is the plan of doing nothing. I am sorry but I think, in looking after my children and my grandchildren, I do not want them facing a $20-some trillion deficit. That is a negative cash flow and somebody is going to have to come up with the dollars beginning in 2018. Now that is a moving target. To sit back and say well, we are not going to run out of Treasury bills, all right fine. You have to get the cash to pay the Treasury bills. This Congress and a future Congress is going to have to start coming up with it. If we start planning now, and start investing money and forward funding Social Security, we can solve this problem without cutting benefits and without running in the red in the long run. We have got to plan ahead. Mr. Secretary, you can comment in the balance of my time.

Secretary SNOW. I would only comment to say that there is not a lot of uncertainty about these numbers. We know the names of the people who are in that cohort of retirees over the period 2010 to 2030, and if they retire as we expect them to do then we are going to produce these numbers. There is nobody coming in behind them to be the workers to fund their retirement. That ratio, which is the all important ratio of people paying in and people drawing down, worsens and worsens and worsens over that long period of

time. We have people living longer. That combination of the baby boomers retirement and people living longer produces this set of numbers about which there cannot be much argument. This is basic math.

Mr. SHAW. Thank you, Mr. Chairman.

Chairman THOMAS. The gentleman's time has expired. The Chair understands the gentleman from Maryland, Mr. Cardin, wishes to inquire?

Mr. CARDIN. That is correct, Mr. Chairman. Thank you very much. Secretary Snow, thank you very much for being with us. You have many responsibilities as Secretary of the Treasury. One of those, of course, is as Trustee of the Medicare Trust Funds. So, I am just interested in finding out the information that you knew as regards to the information on the impact that the Medicare bill that we recently passed and the President signed into law had an effect on the solvency of the Medicare Trust Fund. As that bill was working its way through Congress, it became clear to many of us through the financial information or the scoring we were receiving that the impact on solvency would be minimal since the $400 billion cost was primarily in the prescription drug provisions, because the other provisions had offsets. We now find, through the information that has been made available to us, that the bill will affect the solvency of the Medicare Trust Fund by 2 years, by the action we took in the last bill.

One of the major differences in estimates is the number of Medicare beneficiaries expected to participate in private health insurance plans. That number is dramatically different than what we were operating with in Congress. We originally estimated that the current 9 percent that are in private insurance plans would go up to around 12 or 13 percent. We now find that the U.S. Department of Health and Human Services (HHS) actuaries are projecting that it could be as high as 32 percent, a significant difference. We also now know that for every person who enrolls in a private health care plan, it will cost the Medicare Trust Fund additional funds, because we are paying more than if that person would have stayed in traditional Medicare. My question to you is, were you aware of those numbers before Congress acted on it, that is the participation rates and cost to the Medicare Trust Fund, as Trustee of the Medicare system? If you were aware of it, were you aware that that information was not made available to Congress?

Secretary SNOW. Congressman, I was not aware of the detailed information that you laid out there in your question to me. I did not become aware of the differing estimates in the CBO, for whom I have a very high regard, and the actuaries at CMS, in whom I also have a high regard. I did not become aware of that until sometime in January, as we began to put the President's budget to bed.

Mr. CARDIN. Mr. Secretary, I respect your answer to that, and I find that just as troubling to you as it is to us, that information that is important for us to make judgments was not made available to us. You have responsibilities as a Trustee to make recommendations to the Administration and to Congress, as to the impact that legislation could have on Medicare's insolvency. This is a significant difference, a significant amount of money that, was involved here. I also believe that at times the department was using num-

bers generated by the actuary to show participation, but then used CBO numbers, which were lower on cost, in order to make the bill appear to be less expensive than it actually was. It would seem to me that selecting the more generous numbers from the actuary and from CBO, but not being consistent in using the same information for all of your analysis, would be something that none of us would want to condone. I hope you would agree with that.

Secretary SNOW. The fine points of the differences between these two estimates, I must say, are beyond my ken. I understand that small changes though, as you know, in those assumptions—for instance, CBO's assumption on participation rates being a few percentage points lower than the Administration's, than the Office of Management and Budget's (OMB's) and the actuary's estimate of participation rates, produced a very substantial part of that disparity.

Mr. CARDIN. It was not the Administration, and it was substantial, 12 percent versus 32 percent, which is a huge difference. It was not the Administration. The Administration, I believe, was with the actuaries. It was the CBO's numbers that were substantially different than the actuarial assumption.

Secretary SNOW. I am saying that. We used those numbers in the budget. We used the actuary's numbers in doing the budget and that is when I became aware of the difference.

Mr. CARDIN. Mr. Chairman, I know many of us in Congress believe that the information would have been important for us to have prior to action. It is important that this information get to the right agencies.

Chairman THOMAS. I thank the gentleman. Mr. Secretary, we appreciate the time was slightly over, but to recognize the second Republican to balance out the questioning of the Secretary, the gentleman from Illinois, Mr. Crane, is recognized.

Mr. CRANE. Thank you, Mr. Chairman. Mr. Secretary, some have claimed that Social Security is not going bankrupt because in 2042 payroll tax receipts will be able to finance about three-fourths of the benefits due. Many of those making such claims have also attacked the idea that individuals should be able to invest even some of their payroll taxes in personal accounts. Individuals retiring in 2042 are already paying into Social Security. I am against cutting benefits that have been promised to people paying into the system. Do you see any way to preserve current benefits without allowing individuals to own retirement accounts that does not lead to a tax increase?

Secretary SNOW. Congressman Crane, you are right that there is an automatic reduction in the level of payments at the point at which the Trust Fund can no longer pay the full level of benefits, and that is 2042. We cannot let that happen. That is why moving to these personal accounts now makes so much sense, to find a way to augment the financial condition of the Social Security plan and take some of the burden off of it. That is precisely what would happen. There is no legal obligation to pay at the current level. The obligation is to pay the funds that are available as benefits and that results in that 74 percent declining over time, level of payments. We cannot let that happen.

Mr. CRANE. If Congress does not make changes to Social Security, specifically no individual retirement accounts, no benefit cuts, no tax increases, and no increase in retirement age, what do you think would be the impact on the Treasury?

Secretary SNOW. Well, if no changes are made and we hit the year 2042 and the benefit levels are allowed to fall in accordance with the income levels then it will have a very serious impact on the recipients who I think will feel cheated. They have made their payments in and they are now not able to—the retirees who made their payments in would not then be able to draw down the expected amount of money. If we fund it at current levels, we produce that horrific deficit number that you saw reflected in Congressman Shaw's chart. We are the victim here of plain and simple mathematics, inescapable math. We cannot dodge it. We cannot hide from it. The numbers that were shown are the real numbers in that report. The only way to deal with this is to find the means to supplement the income that Social Security has, that people have who would otherwise draw on Social Security. That is where this idea of the personal accounts makes so much sense.

Mr. CRANE. Thank you, Mr. Secretary. We appreciate your attendance here today, too.

Secretary SNOW. Thank you.

Chairman THOMAS. The Committee thanks you and understands the pressing engagement that you must go to and looks forward to your next testimony before the Committee.

Secretary SNOW. Thank you, very much.

Chairman THOMAS. The Committee would now ask Douglas Holtz-Eakin, the Director of the CBO; Rick Foster, Chief Actuary, CMS; and Stephen C. Goss, Chief Actuary, SSA, if they would please come forward. The Chair welcomes all of you to the Committee and each of you has written testimony which will be made part of the record. If you could address us briefly in your own words prior to Members asking questions, the Chair would ask you to do so. We will start with Dr. Holtz-Eakin and then move across the panel to Mr. Goss and Mr. Foster. Mr. Holtz-Eakin?

**STATEMENT OF DOUGLAS HOLTZ-EAKIN, PH.D., DIRECTOR, CONGRESSIONAL BUDGET OFFICE**

Mr. HOLTZ-EAKIN. The CBO estimates that the Medicare Modernization Act will raise net outlays of the Federal Government by $395 billion over the period of 2004 to 2013. My written statement, which we submit for the record, details the underpinnings of the CBO estimate. It also accounts for the numerous small and technical factors that lead to a difference with the Administration's estimate for the same legislation. The CBO has been working with Congress on prescription drug legislation since 1999. Dozens of CBO staff with advanced training in health policy, health economics, finance and budget analysis have contributed to this effort. Included among them are those with prior or subsequent experience with the OMB, the Health Care Financing Administration and the Medicare Payment Advisory Commission. Their depth and reach have been enhanced through regular consultation with private sector actuaries, reinsurers, financial services experts, pharmacy benefit managers and many others. Our expertise has also been en-

hanced through continuous interactions with congressional staff, and we have benefited greatly from the generosity of our professional colleagues at CMS.

Over the past several years, CBO has deployed this accumulation of skills, data and modeling capability to the challenges of projecting the costs of Medicare in general and the prescription drug legislation in particular. The CBO has provided testimony to Congress—to this Committee on at least three occasions, and to other Committees on up to eight occasions. We have provided nearly 15 documents and letters to the Members including a 2002 study on issues in the design of a prescription drug benefit, and have provided many cost estimates. In 2002, CBO provided over 50 estimates of the cost of drug legislation. With the daunting pace of activity in the past year, the total number of proposals, amendments and formal cost estimates is innumerable but is safely in a range that may approach 10 times that number. This experience has yielded a great respect for our professional colleagues at CMS and a healthy appreciation of the fundamental uncertainties associated with cost estimates in this area. Nevertheless, it is my considered professional judgment that $395 billion was and remains the single best estimate of the cost of this legislation. Chairman Thomas, Congressman Rangel and Members of this Committee, I thank you for the opportunity to appear today and look forward to answering your questions.

[The prepared statement of Mr. Holtz-Eakin follows:]

**Statement of Douglas Holtz-Eakin, Ph.D., Director, Congressional Budget Office**

Chairman Thomas, Congressman Rangel, and Members of the Committee, I am pleased to be here with you today. I understand that one purpose of this hearing is to discuss the Trustees' 2004 reports for Social Security and Medicare that were released yesterday and to assess the impact of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) on Medicare's long-term financial condition. To help provide a basis for that assessment, I will focus my remarks on the Congressional Budget Office's (CBO's) estimate of the MMA's cost over the next 10 years and on the differences between that estimate and the Administration's estimate for that same period. The MMA was a very complex piece of legislation containing many provisions, and CBO's modeling of its costs was correspondingly complex. Rather than try to explain the scoring for all of its provisions, I will concentrate on the two sections of the act that account for nearly all of the net difference between those two estimates: the new prescription drug benefit and the revised payment system for managed care plans under Medicare.

**CBO's Cost Estimate**

CBO has estimated that the MMA will increase mandatory outlays by $395 billion over the 2004–2013 period. Anytime a complex and substantially new program is created, predicting the outcome precisely is difficult, but CBO's estimate was the result of extensive analyses of the pharmaceutical market, the Medicare program, the costs of managed care plans, and the likely responses of potential enrollees. To date, CBO has not received any additional data or studies that would lead the agency to reconsider its conclusions. Therefore, CBO believes that its budgetary estimate is sound and has no reason to revise it.

Table 1 shows the major components of CBO's 10-year cost estimate. The provisions of the MMA that established a prescription drug benefit under Part D of Medicare were estimated to increase mandatory spending by $409 billion on net. Title II of the act, which altered the payment system for managed care plans under Part C of Medicare—and also changed the name of that program from Medicare+Choice to Medicare Advantage—was estimated to cost $14 billion through 2013. (The net costs of providing the new drug benefit to enrollees in Medicare's managed care plans were included in the $409 billion estimate for the Part D provisions.) All of

the legislation's other provisions, which primarily involve the traditional Medicare fee-for-service (FFS) program, were estimated to reduce net outlays by $28 billion.

**Table 1: Major Components of CBO's Cost Estimate for the Medicare Prescription Drug, Improvement, and Modernization Act of 2003**

**(Billions of dollars)**

| | Mandatory Spending, FY 2004–2013 |
|---|---|
| Prescription Drug Benefit Provisions | 409 |
| Medicare Advantage Provisions | 14 |
| All Other Provisions | −28 |
| **Total** | **395** |

Source: Congressional Budget Office.

a. Includes mandatory spending for administration of Part D (in title X of the MMA) and interactions with the Hatch-Waxman Act and importation provisions in title XI; excludes the interaction of Part D with Medicare spending for benefits under Parts A and B (which is included in the estimate for "All Other Provisions"). Those factors account for the difference between the $409 billion estimate for the prescription drug benefit provisions shown above and CBO's $410 billion estimate for title I of the MMA.

Although Table 1 shows the MMA's impact on mandatory spending, a complete estimate of the overall budgetary impact of the legislation must also consider its effect on revenues. CBO estimated that the various revenue effects of the MMA's provisions were largely offsetting. According to the Joint Committee on Taxation, the law would reduce revenues by about $7 billion over 10 years, primarily as a result of provisions to allow qualified taxpayers to establish health savings accounts. At the same time, CBO estimated that the Medicare drug benefit provisions would have the effect of increasing revenues by about $7 billion, as businesses would reduce expenditures on nontaxable health benefits and increase them on taxable forms of compensation. By contrast, the Administration estimated that the health savings account provisions would result in a revenue loss of about $17 billion over the 2004–2013 period and to date has not estimated an indirect effect on revenues resulting from the Medicare drug benefit. While the overall assessment of the MMA's impact on federal deficits or surpluses must take into account all of its effects on spending and revenues, the focus today is on CBO's outlay estimates and how they differ from the Administration's estimates as developed by the actuaries at the Centers for Medicare and Medicaid Services (CMS). Accordingly, I will devote the remainder of my testimony to the main factors affecting estimated outlays for the new prescription drug benefit and for the revised payment system for managed care plans.

### Costs for the Part D Prescription Drug Benefit

CBO's $409 billion estimate for the net costs of providing the prescription drug benefit under the MMA can be separated into several components, as shown in Table 2. Under the law, CBO projected, stand-alone prescription drug plans and integrated health plans under Medicare would incur costs of $507 billion through 2013 to provide the basic statutory drug benefit. Those costs would be partially offset by $131 billion in premium payments made by or on behalf of enrollees. Separate payments to employer-sponsored and union plans providing qualified drug coverage to Medicare-eligible retirees would amount to an additional $71 billion. The law also subsidizes additional drug coverage for certain low-income enrollees, and CBO estimated that those subsidies would cost $192 billion over the 2004–2013 period (including about $1 billion to provide assistance with drug costs in conjunction with the drug discount card program that will operate from mid-2004 through December 2005).

**Table 2: Components of CBO's Cost Estimate for the Medicare Prescription Drug Benefit**

**(Billions of dollars)**

| | Mandatory Spending, FY 2004–2013 |
|---|---|
| Payments to Medicare Drug Plans for Basic Benefits | 507 |
| Beneficiary Premium Payments | −131 |
| Employer and Union Subsidies | 71 |
| Low-Income Subsidies | 192 |
| Federal Medicaid Spending | −142 |
| Transfers from State Medicaid Programs | −88 |
| Effects on Other Federal Programs | −2 |
| **Total** | **409** |

Source: Congressional Budget Office.
Note: Numbers may not add up to totals because of rounding.

CBO also estimated that the Part D prescription drug benefit provisions would reduce other federal outlays in a number of ways. Transferring responsibility for the prescription drug benefits of "dual eligibles" from Medicaid to Medicare would save the federal government an estimated $152 billion in Medicaid spending through 2013. (Dual eligibles are Medicare beneficiaries who are also eligible for full Medicaid benefits.) Those savings would be partly offset by an additional $10 billion in federal outlays for Medicaid resulting from the new law's drug benefit provisions—largely owing to additional spending on benefits for Medicare beneficiaries who would enroll in Medicaid as a result of applying for the low-income drug subsidy program. Thus, net federal Medicaid savings were estimated at $142 billion over 10 years. In addition, the MMA contains a provision that will recapture a portion of the corresponding savings for states on Medicaid drug expenditures, which CBO estimated would reduce federal costs by $88 billion. Finally, the Medicare drug benefit will on net reduce mandatory spending for the Federal Employees Health Benefits (FEHB) program and other federal programs that pay for prescription drugs by about $2 billion.

CBO's cost estimates for prescription drug benefit proposals were based on an analytic structure and a microsimulation model that projects how those proposals would affect a representative sample of Medicare beneficiaries. CBO has used that basic approach to estimate the costs of proposed Medicare prescription drug benefits since 1999, updating it each year to account for new data and refining it to address new provisions. The microsimulation model contains detailed information about beneficiaries' spending for prescription drugs, their supplemental insurance coverage (both public and private), their health status, and their income. The information on drug spending used by CBO is based on data from the 1999 and 2000 Medicare Current Beneficiary Survey, projected forward using CBO's March 2003 economic and technical assumptions—including projected growth rates for drug spending that reflected the most recent CMS estimates for national health expenditures.

**Costs and Premiums for Medicare Drug Plans.** Estimating the costs of providing the basic drug benefit under Medicare involved three basic steps: (1) estimating the number of beneficiaries who would enroll in a Medicare drug plan; (2) estimating the average costs of providing those enrollees with covered benefits (including the administrative costs of doing so); and (3) using the resulting estimate of gross costs to calculate the offsetting premium receipts that would result from the statute's subsidy formulas. Because of the myriad provisions in the law that could affect each of those steps—particularly the costs per enrollee—CBO had to develop a relatively sophisticated modeling capability. Even so, the primary drivers of federal costs remain the drug benefit's design and the premium subsidy (with that subsidy not only determining how gross costs are allocated between enrollees and the government but also affecting participation in such a voluntary program).

In large measure, CBO based its estimates of program enrollment for the drug benefit on the experience of Medicare Part B. Part B is a voluntary program that has a 75 percent premium subsidy and a substantial penalty for late enrollment;

as a result, most but not all Medicare beneficiaries who are eligible for Part B enroll in it. Part D's provisions are quite similar—it is a voluntary program with a 74.5 percent average premium subsidy and significant late-enrollment penalty—and the provisions strongly encourage beneficiaries to enroll when they are first eligible to do so, even if their drug spending is relatively low at the time. Nevertheless, CBO assumed that active workers with drug coverage and some federal retirees would not enroll in Part D, even if they were enrolled in Part B, because the value of any additional drug benefits they would receive would be less than the added premiums they would pay; those projected nonparticipants represent about 7 percent of all Medicare beneficiaries. CBO also assumed that the roughly 6 percent of beneficiaries who are enrolled in Medicare Part A but do not elect to enroll in Part B (some of whom are also active workers) would generally choose not to enroll in Part D. In sum, CBO estimated that 87 percent of all Medicare beneficiaries would participate in the drug benefit in some manner—with about 68 percent enrolling in a Medicare prescription drug plan and the remaining 19 percent receiving drug coverage through a former employer that would be subsidized directly by Medicare.

To estimate costs per enrollee, CBO started with a projection of total outpatient drug spending by the Medicare population in the absence of a new Medicare benefit. That total was then adjusted by several discrete factors:

- a "price effect" to reflect the likelihood that average drug prices will be slightly higher because beneficiaries who currently lack drug coverage will become insulated from those prices;
- a "use effect" to capture changes in demand for drugs resulting from changes in beneficiaries' cost-sharing liabilities (so that their total drug use would increase somewhat if their own out-of-pocket costs fell);
- an adjustment to reflect the degree to which Medicare drug plans will manage the costs of their enrollees (discussed further below);
- and a slight decrease in spending due to the fact that prices negotiated by Medicare drug plans will be exempt from the Medicaid "best price" provision—an exemption that gives those plans more leeway to negotiate steeper price discounts from manufacturers because they will not have to pass on the same discount to Medicaid.

It is important to emphasize that, although CBO sought to model each of those factors separately, they have offsetting impacts and the net effect on drug spending or its components will reflect all of them simultaneously.

In estimating the degree of cost management that Medicare drug plans would achieve on average, CBO focused on three main considerations: the incentives that plans would have to control costs (based on the degree of financial risk they would face); the "tools" that they could use to control spending (such as preferred drug lists and pharmacy networks); and the degree of competition they would face (as expressed through differences in beneficiary premiums and cost-sharing levels among drug plans). Plans bearing meaningful financial risk would lose money if their costs of providing benefits exceeded expectations and thus would have strong incentives to limit those costs as much as possible while still attracting enrollees—but CBO assumed that they would also have somewhat higher administrative costs as a result. A plan's ability to act on those incentives will depend on what mechanisms it can use to secure price discounts and to encourage beneficiaries to use less costly therapeutic alternatives, though trade-offs could arise between the steps they take to control costs and the ease with which enrollees can obtain the drugs of their choice. The extent to which beneficiaries save on their premium by joining a less expensive drug plan is also an important consideration: it provides an incentive for plans to keep their costs low over time to attract and retain enrollees, and it encourages beneficiaries to consider whether the extra premium of a more costly plan is worth paying.

To summarize the effects of incentives and tools on cost management, CBO estimated the "gross drug savings" that would be expected, on average, for a given proposal. Those gross drug savings represent the degree to which costs would be reduced compared with an unmanaged benefit (such as a traditional indemnity insurance plan), and they combine three types of savings from management: savings due to price discounts or rebates from manufacturers and pharmacies; savings from controlling overall drug use; and savings due to changing the mix of drugs used. For the MMA, CBO estimated that drug plans bearing the full level of financial risk as specified by the statute would achieve average gross savings of 20 percent initially, growing to 25 percent over the budget window. That path reflects the gradual widening of the statute's "risk corridors", which will expose plans to greater financial

risk over time.[1] For beneficiaries whose current drug spending already reflects some degree of cost management, however, that spending was adjusted only to capture the incremental savings that would be achieved. CBO also assumed that there was some probability that beneficiaries would be enrolled in reduced-risk or "fallback" drug plans as specified by the law; in those cases, CBO estimated lower gross savings owing both to the reduced financial risk those plans would face and to the less competitive environment in which they would operate.

After applying those adjustments to determine total drug spending by enrollees, CBO estimated the gross costs of providing the drug benefit by applying the statute's benefit-design provisions and adding an estimate of the administrative costs that drug plans would incur. Rather than review all aspects of the benefit design, let me focus on two key features. First, with certain exceptions, the benefit's catastrophic threshold—above which about 95 percent of drug costs are covered—is determined by out-of-pocket costs actually incurred by enrollees. That feature, which is often referred to as the "true out-of-pocket" provision, has the effect of targeting federal assistance to those who lack additional drug coverage. By the same token, though, such coverage is implicitly penalized because the costs that it covers do not count toward reaching the catastrophic threshold.[2] As a consequence, federal costs will depend in part on the extent and sources of any supplemental drug coverage that enrollees may have.

A second key determinant of federal costs is that the standard benefit's deductible, initial coverage limit, and catastrophic threshold are indexed to the projected growth rate in per capita drug expenditures for the Medicare population. As a result, that benefit will, on average, cover about the same share of enrollees' drug costs each year. Table 3 shows CBO's projections for each of those benefit parameters through calendar year 2013 as well as the associated levels of beneficiaries' cost-sharing liabilities or total drug spending. As the table suggests, CBO estimates that per capita drug spending for Medicare beneficiaries will increase at an average annual rate of nearly 9 percent from 2006 to 2013.

Table 3 also shows CBO's estimate of the average monthly premium per beneficiary for each calendar year (which reflects not only covered benefits but also administrative costs, and thus grows somewhat more slowly than the benefit parameters). Although the MMA's subsidy formulas are complex—specifying both a fixed "direct" subsidy and a reinsurance subsidy that varies with spending above the catastrophic threshold—and beneficiaries' premiums will depend on what drug plan they join, CBO estimated average premiums by applying the 74.5 percent average subsidy to average gross costs.

Finally, by multiplying the average gross cost of providing the drug benefit and the average premium by the number of enrollees, CBO generated estimates of total calendar year obligations and receipts; converting those figures into fiscal year outlays yielded CBO's estimates of $507 billion in payments to drug plans, offset by $131 billion in premium receipts, as shown in Table 2.[3]

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[1] Under the MMA's risk-corridor provisions, prescription drug plans whose costs turn out to be somewhat higher than expected will see an increasing share of those costs covered by additional federal payments, while plans with actual benefit costs that are below expected levels will essentially have to reimburse Medicare for a corresponding share of the savings.

[2] In addition, Medigap policies that cover cost sharing for other Medicare benefits are prohibited from including supplemental drug coverage for Part D enrollees, so enrollees desiring such coverage would have to obtain it from another source (such as a former employer or their Medicare drug plan).

[3] CBO's estimate of premium collections assumes that all enrollees have their Part D premiums withheld from their Social Security checks, but net federal outlays would be the same if beneficiaries chose to pay those premiums directly to their drug plans instead since federal payments to those plans and premium receipts would be reduced dollar for dollar.

**Table 3: Standard Drug Benefit Design and Estimated Monthly Premiums**

| | Calendar Year | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 |
| Annual Deductible | $250 | $275 | $300 | $325 | $350 | $380 | $410 | $445 |
| Coinsurance Between Deductible and Initial Coverage Limit (Percent) | 25 | 25 | 25 | 25 | 25 | 25 | 25 | 25 |
| Initial Coverage Limit | | | | | | | | |
| Program spending at limit | $1,500 | $1,646 | $1,808 | $1,946 | $2,115 | $2,115 | $2,460 | $2,666 |
| Beneficiary spending at limit | $750 | $824 | $903 | $974 | $1,055 | $1,055 | $1,230 | $1,334 |
| Total spending at limit | $2,250 | $2,470 | $2,710 | $2,920 | $3,170 | $3,170 | $3,690 | $4,000 |
| Coinsurance Between Initial Coverage Limit and Catastrophic Threshold (Percent) | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Catastrophic Threshold | | | | | | | | |
| Out-of-pocket spending at threshold | $3,600 | $3,950 | $4,350 | $4,650 | $5,050 | $5,450 | $5,900 | $6,400 |
| Total spending at threshold [a] | $5,100 | $4,496 | $6,158 | $6,596 | $7,165 | $7,715 | $8,360 | $9,066 |
| Coinsurance above threshold (Percent)[b] | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 |
| Average Monthly Premium | $35 | $37 | $41 | $43 | $47 | $49 | $54 | $58 |

Source: Congressional Budget Office.
Note: Numbers may not add up to totals because of rounding. Benefit parameters shown here reflect the legislation's rounding rules.
[a] Represents total spending at the catastrophic threshold for individuals without other drug coverage.
[b] For 2006, cost sharing will be the greater of 5 percent coinsurance or a copayment of $2 (for generic and multiple-source drugs) or $5 (for single-source drugs); after 2005, the $2 and $5 amounts are also indexed.

**Participation and Costs for Employer and Union Subsidies.** Currently, a substantial share of Medicare beneficiaries receive coverage for their drug costs through a former employer. As I have noted, though, the extent to which enrollees will reach the standard Medicare drug benefit's catastrophic threshold depends on whether they have such supplemental coverage for their Part D cost sharing. If retirees with such coverage enroll in a Medicare drug plan, therefore, their impact on federal costs will depend on the extent to which their former employer supplements that coverage. The MMA also establishes an additional option for employer and union plans that provide retirees with qualified drug coverage: employers that take that option will receive a tax-free payment directly from Medicare equal to 28 percent of total drug costs in a specified dollar range. To project what federal costs will be, CBO thus had to estimate not only the extent of the drug coverage that those retirees would have but also the mechanism through which that coverage would be subsidized.

Under the MMA, CBO estimated, average federal subsidy payments on behalf of retirees would generally be greatest if they enrolled in a Medicare drug plan and received the basic drug benefit with no supplemental drug coverage. Medicare's average subsidy payment would be reduced if those retirees were instead provided generous wraparound coverage by their former employer; in that case, retirees would not likely reach the basic benefit's catastrophic threshold for out-of-pocket costs. CBO also estimated that the direct payments from Medicare to employer and union plans would be about the same, on average, as the net subsidies that retirees would generate if they enrolled in a Medicare drug plan and retained a generous employer wraparound policy. In other words, those direct Medicare payments to employer and union plans would also be lower, on average, than the net subsidies for retirees who were enrolled in Medicare drug plans and had no additional drug coverage.

Although the favorable tax treatment accorded to those direct payments would make that approach somewhat more attractive, CBO nonetheless concluded that the difference in subsidies under the MMA gives employers a new financial incentive to drop prescription drug coverage for Medicare-eligible retirees. In its estimates, CBO did not assume that all employers would respond to that financial incentive but did project that 2.7 million Medicare-eligible retirees who would have had more generous employer drug coverage in 2006 in the absence of a Medicare drug benefit would not see their former employer supplement the basic Part D benefit. In those cases, it would make most sense for those retirees to enroll in a Medicare drug plan (with their former employer potentially choosing to pay their Part D premium as a means of compensation). At the same time, CBO assumed that nearly all of the remaining retirees with employer-sponsored drug coverage—about 8 million individuals in 2006—would see their employer take the direct subsidy payment from Medicare, both because of its tax advantages and for reasons of administrative simplicity. CBO's estimate of $71 billion in direct subsidy payments reflects the share of drug spending by those retirees that is projected to fall in the covered range.

**Participation and Costs for Low-Income Subsidies.** The MMA established two levels of additional drug benefits for enrollees with sufficiently low income and countable assets: a more generous subsidy for beneficiaries who are either dually eligible for full Medicare and Medicaid benefits or have income below 135 percent of poverty and low assets; and a somewhat less generous subsidy for those with income below 150 percent of poverty and assets below a slightly higher limit. On the basis of an analysis of both administrative and survey data, CBO estimated that 35 percent of Medicare beneficiaries would be eligible for low-income subsidy benefits under the MMA; about 30 percent would be eligible for the more generous subsidy; and 5 percent would qualify for the less generous subsidy.

At the same time, CBO projected that a significant proportion of the eligible population would not apply for the low-income subsidies. CBO's estimate of the number of people who would sign up for low-income subsidies was based on several factors, including historical participation in the Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) programs. The QMB and SLMB programs pay some or all of the premiums and cost sharing under Parts A and B of Medicare for beneficiaries with incomes below 120 percent of the poverty level and limited assets. In those programs, many beneficiaries who are eligible do not enroll. CBO assumed that participation in the low-income subsidy would be somewhat greater than that for other welfare-related programs, however, because MMA allows individuals to enroll at offices of the Social Security Administration.

CBO also estimated that the share of eligible beneficiaries receiving low-income subsidies would rise gradually after the implementation of the Medicare drug benefit. (Unlike the basic drug benefit, which penalizes individuals for late enrollment, the additional low-income subsidies are available at any time with no penalty to

Part D enrollees.) Ultimately, CBO assumed that almost 70 percent of those eligible would receive low-income subsidies under the MMA. About 75 percent of those eligible for the more generous subsidy would receive it, while about 35 percent of those eligible for the less generous subsidy would receive that benefit. Participation rates for the more generous subsidy would be much higher because they would include all dual eligibles, who would participate in the drug benefit by default.

In estimating the costs of the subsidy payments, CBO also assumed that participants would generally have higher average drug costs than beneficiaries who were eligible for those subsidies but chose not to enroll—that is, some adverse selection will occur. The total estimated cost of $192 billion for the low-income subsidies over 10 years also includes the costs of covering the enrollment fees and providing up to $600 of assistance for certain low-income beneficiaries in conjunction with the Medicare drug discount card. For that transitional assistance program, which is scheduled to operate from mid-2004 through December 2005, CBO assumed relatively low take-up—specifically, that about 20 percent of eligible Medicare beneficiaries or about 3 percent of all beneficiaries would enroll—because of its limited benefits and temporary nature. (As an accounting matter, the costs of the low-income subsidies also include the costs of paying all or a portion of enrollees' Part D premiums, rather than treating those subsidy payments as reductions in the premium receipts specified above.)

**Offsetting Federal Savings.** Although this testimony has focused on the various costs of providing the drug benefit under Medicare, the MMA's provisions will also generate offsetting federal savings, both implicitly and explicitly:

- Transferring responsibility for the prescription drug benefits of dual eligibles from Medicaid to Medicare will save the federal government an estimated $152 billion in Medicaid spending through 2013. Those savings will be partly offset by an additional $10 billion in federal Medicaid outlays stemming from the new law's drug benefit provisions—largely from additional spending on benefits for Medicare beneficiaries who will enroll in Medicaid or the QMB and SLMB programs as a result of applying for the low-income drug subsidy program.
- Absent other provisions, those federal Medicaid savings would be accompanied by corresponding savings for the states on their Medicaid costs. The MMA's "clawback" provision, however, will recapture a substantial portion of the states' estimated drug savings, which CBO estimated would further reduce federal costs by $88 billion.
- Finally, CBO estimated that some federal retirees will enroll in a Medicare drug plan; as a result, a portion of their prescription drug costs will be indirectly shifted to Medicare (and is included in the figures provided above). Based on that impact, as well as small effects on other federal programs that pay for prescription drugs, CBO estimated that the Medicare law's drug benefit provisions would reduce mandatory federal spending by about $2 billion.

**Costs for Medicare Advantage Plans**

The MMA's provisions affecting private health plans under Medicare are also quite complicated, so again I will attempt to summarize the key features that affected their scoring. Currently, those health plans—which are primarily health maintenance organizations (HMOs) participating on a county-by-county basis—are required to provide Part A and Part B benefits and are paid on the basis of a statutory formula. To the extent that Medicare's payments exceed their costs of providing the required benefits, plans must presently give the difference to beneficiaries through some combination of additional benefits and premium rebates. To the extent that plans choose to provide premium rebates, the Medicare program retains 20 percent of the difference and the beneficiaries receive the other 80 percent, but if plans provide additional benefits, no such "tax" is imposed. As a result, very few plans offered premium rebates in 2003 (the first year that such rebates were permitted) or 2004. The past few years have also seen a number of plans withdraw from the program, reduce their service areas, or lose enrollees; in part that has occurred because plan costs have grown more rapidly than payment rates, making it more difficult for plans that remain in the program to attract enrollees by offering extra benefits. Prior to passage of the MMA, CBO projected that the share of Medicare beneficiaries in private plans would decline from the current level of 13 percent to about 8 percent.

For 2004 and 2005, the MMA largely retained the existing payment system for private health plans but increased the payment rates (and changed the name of the program from Medicare+Choice to Medicare Advantage). Starting in 2006, however, a revised system will be instituted. The statutory payment rate will be relabeled as the "benchmark" amount, and plans will submit bids that reflect the costs they expect to incur in providing Part A and Part B benefits. Medicare will pay plans their

bids plus 75 percent of the amount by which the benchmark exceeds the bid. Plans must then return that 75 percent to beneficiaries, either as additional benefits or as a rebate on their Part B or Part D premium. Thus, the essential change from current requirements is that—instead of retaining part (20 percent) of the difference between a plan's cost and the statutory payment rate only if the plan returns that difference to beneficiaries as a premium rebate—Medicare will retain part (25 percent) of that difference regardless of whether the plan provides additional benefits or premium rebates.

The MMA also established new rules for preferred provider organizations (PPOs) that operate on a regionwide level; and to encourage participation by those plans, it set up a stabilization fund with an initial balance of $10 billion. Such plans could be offered starting in 2006, and they will generally be subject to the same rules as county-based plans (though the benchmarks for the regional PPOs will be a weighted average of the benchmarks for county-based plans in their region and the bids submitted by the PPOs). Starting in 2010, the MMA also authorized "comparative cost adjustment" demonstration projects in up to six areas of the country; under those demonstrations, the bids of private plans would affect not only the benchmark for the area but also the Part B premium for enrollees in the traditional fee-for-service program in that area.

In analyzing proposals regarding private health plans in Medicare, CBO focused on three factors: the costs those plans would incur, the payments Medicare would make, and the resulting incentives for beneficiaries to enroll—all of which were compared with the status quo. To estimate private plan costs for providing Medicare benefits, CBO examined data on the experience of existing HMOs in Medicare; data comparing payments to doctors and hospitals by private plans and by the Medicare FFS program; and data comparing commercial HMO and PPO costs. One important consideration was that, even though Medicare payment rates in many areas exceed the local average cost of providing benefits in the traditional FFS program, private plans that must negotiate fees with their providers are not offered in those areas. It thus seemed reasonable to infer that, if such plans were made available in those areas, their costs would probably equal or exceed both the Medicare payment rate and local FFS costs. CBO also projected that private plan costs would continue to grow somewhat more quickly than costs in the traditional FFS program for the next few years before converging to the same growth rate.

The upshot of CBO's analysis of the MMA's provisions was that regional PPOs would generally have difficulty providing Medicare benefits at costs that were much less than the benchmarks to which they would be compared. Correspondingly, even in the areas where those plans might become available, beneficiaries would not see substantial premium rebates or extra benefits and thus would have only limited incentives to leave FFS programs and enroll in PPOs. While there would also be some additional enrollment in county-based plans because of the immediate increase in payment rates (and the correspondingly higher benchmarks after 2005), CBO estimated only a small increase in the overall share of beneficiaries enrolled in private plans as a result of the MMA's provisions—and did not ultimately distinguish whether those additional enrollees would be in county-based plans or regional PPOs. CBO's final cost estimate reflected not only the additional costs of those new enrollees (relative to their costs in the FFS program), but also the net costs of the higher payment rates and the revised payment system for beneficiaries already enrolled in private plans.

The $14 billion cost estimate for the MMA's title II provisions included several other components as well. CBO projected modest savings ($0.3 billion through 2013) from the comparative cost adjustment demonstration and offsetting modest costs for a set of other provisions (primarily affecting specific types of plans or payments). More significantly, CBO also assumed that the sums available in the PPO stabilization fund would be spent but did not explicitly model the effect of that spending on beneficiary enrollment (since in that case, estimated spending would not be a function of enrollment).[4]

**Comparison with the Administration's Cost Estimate**

Having laid out the basis for CBO's estimate, I can now discuss how it compares with the Administration's estimate. While the differences between those estimates

[4] Recently, CBO increased its ultimate projection of private plan enrollment from 9 percent to about 13 percent of the Medicare population, but that change has only a negligible effect on federal costs because most of the additional enrollment is projected to occur in areas where the payment rates and benchmarks are based on the local average of costs in the FFS program; in those instances, having an enrollee switch from the FFS program into a private plan does not substantially change federal outlays.

are of obvious interest to Members, they should not overshadow similarities in some of the assumptions underlying our respective projections. Regarding the drug benefit, both CBO and the Administration have assumed that private drug plans will be generally available to provide benefits starting in 2006. We have both assumed broad enrollment by beneficiaries in the basic drug benefit and lower take-up rates for the low-income subsidies. We have both assumed that a substantial minority of retirees who now have drug coverage through a former employer will see that employer choose not to supplement the basic Medicare benefit. And we have both assumed that the drug benefit and clawback provision will generate significant offsetting federal savings via Medicaid. Nevertheless, because the aggregate level of projected drug spending by Medicare beneficiaries is so large—$1.6 trillion between 2006 and 2013, according to CBO estimates—seemingly small differences in the magnitude of those assumptions can translate into large dollar discrepancies.

Table 4 summarizes CBO's understanding of the differences in outlays between the two cost estimates for the Medicare Modernization Act. As you know, the Administration estimated that the MMA would increase net federal outlays for mandatory spending by $534 billion for fiscal years 2004 to 2013, a difference of $139 billion from CBO's estimate for that period. The Administration's estimate is $101 billion higher than CBO's for the drug benefit provisions, and $32 billion higher for the Medicare Advantage provisions. While the estimates for other provisions may have differed somewhat, the net difference in mandatory outlays for those provisions (about $6 billion) is relatively small.

As shown in Table 4, the difference of $101 billion in estimates for the drug benefit has three major components. First, about one-third of that discrepancy ($32 billion) is due to differences in our estimates of total payments to Medicare drug plans for the basic drug benefit (net of beneficiary premiums) and payments to qualified employer and union plans. CBO estimates that those net payments will sum to $448 billion, while the Administration's estimate (excluding intragovernmental transfers) is $479 billion. (The difference between those numbers rounds to $32 billion.)

One source of that difference is that the Administration assumed higher overall participation in the drug benefit—specifically, that 94 percent of all Medicare beneficiaries would enroll. The discrepancy with CBO's estimate of 87 percent participation would appear to account for the entire $32 billion difference in costs, but the Administration's participation figures include a number of federal retirees who would generate intragovernmental transfers that would not count as outlays (for example, from Medicare to FEHB). If those participants are subtracted to get a more comparable measure of enrollment, the difference between CBO's estimated participation rate and the Administration's is smaller—about 3 percent to 4 percent. The principal difference that remains appears to involve Medicare enrollees who decline Part B but are not active workers; CBO assumed they would generally not participate in Part D (for the reasons already outlined), but the Administration assumed that they would enroll.

**Table 4: Differences Between Cost Estimates for the Medicare Modernization Act**

**(Billions of dollars)**

| | Mandatory Outlays, FY 2004–2013 | | |
|---|---|---|---|
| | Administration Estimate | CBO Estimate | Difference (Administration minus CBO) |
| Drug Benefit Provisions | | | |
| Net payments to drug plans and employer/union subsidies | 479[a] | 448 | 32 |
| Low-income subsidies | 239 | 192 | 47 |
| Federal Medicaid spending | −123 | −142 | 18 |
| Other provisions and effects | −85 | −89 | 4 |
| Subtotal | 510 | 409 | 101 |
| Medicare Advantage Provisions | 46 | 14 | 32 |

**Table 4: Differences Between Cost Estimates for the Medicare Modernization Act—Continued**

**(Billions of dollars)**

| | Mandatory Outlays, FY 2004–2013 | | |
|---|---|---|---|
| | Administration Estimate | CBO Estimate | Difference (Administration minus CBO) |
| Net, All Other Provisions | −23 | −28 | 6 |
| **Total** | **534** | **395** | **139** |

Source: Congressional Budget Office.

Note: Numbers may not add up to totals because of rounding. The figures shown here exclude effects of federal revenues, which in combination with the impact on outlays determine the total effect of the legislation on federal budget deficits or surpluses.

[a] Figures shown here for the Administration's estimate exclude $16 billion in intragovernmental transfers from Medicare to federal employers, which do not count as outlays.

The Administration also estimated that per capita costs for the basic drug benefit would be about 4 percent higher than CBO's estimates throughout the period. As my testimony has indicated, costs per capita reflect a variety of provisions and assumptions about the effects of those provisions, so it is difficult to isolate any single factor as the basis for that difference—but CBO's understanding is that the Administration projected slightly lower benefit costs and slightly higher administrative costs. Overall, the differences in number of participants and costs per capita each account for about half of the $32 billion difference in the estimated costs of providing the basic drug benefit.

The second major difference regarding the drug benefit involves the estimates of participation and costs for the low-income subsidies, which account for nearly half ($47 billion) of the overall difference. Here too it appears that the Administration assumed higher take-up of the subsidies, as well as modestly higher costs per participant. Specifically, the Administration estimated that the number of enrollees in the subsidy program after 2009 would be 13 percent to 15 percent higher than CBO projected. The difference is even larger (in percentage terms) for the initial years because CBO assumed that participation would increase gradually to its ultimate level while the Administration used a roughly constant take-up rate. The Administration's estimate of per capita costs is also higher than CBO's, but that disparity shrinks from about 7 percent to 10 percent initially to about 4 percent by 2013.

The third major difference regarding the drug benefit involves savings to Medicaid, which the Administration estimated would be $18 billion lower than CBO's estimate. On net, that difference appears to reflect diverging estimates of what federal Medicaid spending on prescription drugs for Medicare beneficiaries would have been under prior law. In particular, CBO's baseline estimate included $18 billion in federal spending on waiver programs that provide limited drug coverage to low-income Medicare beneficiaries. At the same time, CBO assumed that federal spending on those waiver programs would end once the Part D benefit was implemented—both because Medicaid drug coverage for many of those enrollees would effectively be replaced by the Medicare benefit and low-income subsidies and because Medicaid would generally be precluded from using federal funds to supplement those drug benefits. Consequently, CBO's estimate of the federal savings resulting from the MMA was $18 billion higher than the Administration's estimate.

The other major component of the $139 billion difference in cost estimates—payments to Medicare Advantage plans under title II of the MMA—accounts for $32 billion of the overall difference. That is, CBO estimated that those provisions would increase federal outlays by $14 billion over the period, while the Administration projected a $46 billion increase. As CBO understands it, the basis for the discrepancy lies primarily in differing estimates of the per capita costs that regional PPO plans would incur in providing Medicare's Part A and Part B benefits. The Administration's estimates appear to be based at least in part on a recent PPO demonstration project, in which a number of PPO plans offered to provide those benefits at costs close to the average levels seen in the FFS program for their area. CBO also examined that demonstration project but concluded that those plans would not be indicative of PPO costs generally, in part because the plans most likely chose to participate in areas where their costs were most competitive (and not in areas where their relative costs would have been higher). The fact that those plans were offered almost exclusively in areas already served by Medicare+Choice plans that have pro-

vider networks also suggested to CBO that their experience might not apply in areas where such plans and provider networks were less prevalent.

It may seem counterintuitive that CBO estimated higher per capita costs for PPOs but lower overall federal costs for the legislation—and vice versa for the Administration—but that paradox reflects interactions between those costs, incentives for beneficiaries to enroll, and federal payments under the MMA. As we understand it, the Administration projected that PPO costs in many areas would be noticeably lower than the benchmarks against which those costs would be measured. Beneficiaries, who would receive three-fourths of the difference in the form of premium rebates and extra benefits, would thus have a strong incentive to enroll in those plans. As a result, the Administration estimated that total enrollment in private plans (regional and county-based plans combined) would grow quickly after 2005 and reach 32 percent of the Medicare population by 2013.

At the same time, the Administration apparently estimated that those benchmarks would, on average, exceed the local costs of providing services in the traditional FFS program (which is the baseline against which costs for new enrollees must be measured). Correspondingly, the Administration projected that Medicare's total payments to the PPOs—including the rebates for beneficiaries who enrolled in them—would, on average, exceed the costs in the FFS program, so that federal spending would rise as beneficiaries switched from the FFS program into regional PPOs. By contrast, CBO's estimate that regional PPOs would have higher per capita costs led the agency to conclude that those plans are not likely to be widely available and would have costs close to the benchmarks in those areas where they were offered. Consequently, CBO projected that beneficiary enrollment would be limited and that—even though those enrollees would increase federal costs somewhat—the impact on federal spending would primarily be determined by use of the PPO stabilization fund.

**Conclusion**

I hope that this explanation of the assumptions and methods used in generating CBO's cost estimate—and this analysis of the differences between that estimate and the Administration's—have been helpful to the Committee. Although CBO stands behind its cost estimate and has chosen to respectfully disagree with some of the assumptions the Administration used in developing its projections, CBO also acknowledges that it is difficult to estimate the outcome of such complex legislation precisely. Throughout this process, CBO has sought to be as open as it could about the approach used in estimating the costs of various proposals, both in previous testimony and in a variety of published studies, cost estimates, and letters. This hearing represents another step in that process, and I look forward to answering any questions the Committee Members may have.

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Chairman THOMAS. Thank you, very much. Mr. Goss?

## STATEMENT OF STEPHEN C. GOSS, CHIEF ACTUARY, SOCIAL SECURITY ADMINISTRATION

Mr. GOSS. Mr. Chairman, Ranking Member, Members of the Committee, it is a pleasure to come and speak with you today about the 2004 Annual Report of the Social Security Board of Trustees. As you know, this report is required by law to provide to each of you an assessment of the actuarial status of the Social Security Trust Funds reflecting the provisions specified in current law. This report has been produced and delivered to the Congress now for 65 straight years, starting in 1940. The 2004 Social Security Trustees' Report reflects the combined judgment of the six trustees and their staffs in the development of a number of assumptions that underlay the projections. Moreover, the selection of these assumptions reflects the summary, advice, and research provided by experts from around the world in areas of economics, demography and actuarial science. I have certified on the last page of this report that I believe the assumptions to be reasonable and

that the methods used for the projections are sound and generally accepted within the actuarial profession.

The fundamental projections of the U.S. population and economy produced by my office are used in the Social Security and Medicare Trustees' reports. These provide a solid base upon which projections of program specific costs and income are built. These projections provide a realistic picture of the likely future state of financing of the programs if no changes in law are enacted in the future. The projected financial status of the Social Security program is in good shape in the near term. Both the Old Age and Survivors Insurance and the Disability Insurance Trust Funds are expected to meet to the Trustees' short-range test of financial adequacy by a wide margin. In the longer term, however, the current financing of the Social Security program is expected to be inadequate to permit full payment of benefits scheduled in present law. Based on the Trustees' intermediate assumptions, the current annual excess of tax income over program costs is projected to start declining in 2009 and to reverse in 2018, at which time net redemptions of the Trust Fund assets will be needed to continue full payment of benefits. In 2042, these assets, or reserves, are expected to be exhausted and there will be only sufficient tax income to cover 73 percent of the scheduled benefits. All three of these dates and this percentage are unchanged from last year's report.

New data from a wide variety of sources, improvements in projection methods and a lowering of the ultimate Consumer Price Index (CPI) annual growth rate assumption from 3 percent to 2.8 percent have resulted in a slight reduction in the 75-year actuarial deficit from 1.92 to 1.89 percent of taxable payroll. This slight improvement is also seen in this 75-year open group unfunded obligation of the program, which increased from $3.5 trillion to $3.7 trillion, only half the amount expected based on the change in the valuation date alone. The pattern of the financial outlook is seen more readily in the annual estimates for the program. Lower than expected real wage growth for 2002 and 2003 contributed to slightly smaller program cash flow balances through the next 10 years compared to the 2003 report. However, other changes in data and methods resulted in a net improvement in cash flow balances for years after about 2045.

The result is an annual cash flow shortfall of 5.9 percent of taxable payroll at the end of the 75-year period compared to a shortfall of 6.5 percent which was projected in the 2003 report. This reduction in cash flow shortfalls for the latter half of the long-range period is responsible for the small improvement in the actuarial balance and the unfunded obligations for the period as a whole. Thus, while the annual financial shortfalls projected for Social Security after 2045 are improved somewhat from last year's report, the shortfalls are nonetheless very large. The historically low levels of birth rates experienced starting in the seventies make inevitable the expected declines in the number of workers per beneficiary, and thus the projected increases in the cost of the program as a percentage of taxable payroll. Choices are clear. To strengthen Social Security and maintain solvency beyond 2042, additional revenue can be provided, scheduled benefit levels can eventually be reduced, or some combination of these may be selected. Again, thank

you for the opportunity to be here with you today. I will be happy to answer any questions. Thank you.

[The prepared statement of Mr. Goss follows:]

**Statement of Stephen C. Goss, Chief Actuary, Social Security Administration**

Mr. Chairman, Ranking member, and members of the Committee, it is a pleasure to come and speak to you today about the 2004 Annual Report of the Social Security Board of Trustees. As you know, this Report is required by law to provide to you each year an assessment of the actuarial status of the Social Security Trust Funds reflecting the provisions specified in current law. This Report has been produced and delivered to the Congress now for 65 straight years, starting in 1940.

The 2004 Social Security Trustees Report reflects the combined judgment of the six Trustees and their staffs in the development of a number of assumptions that underlie the projections. Moreover, the selection of these assumptions reflects the summation of all of the advice and research of experts from around the world in the areas of economics, demography, and actuarial science. I have certified on the last page of the Report that I believe these assumptions to be reasonable and that the methods used for projections are sound and generally accepted within the actuarial profession.

The fundamental projections of the United States population and the economy produced by my office are used for both the Social Security and Medicare Trustees Reports. These provide a solid base upon which projections of program-specific cost and income are built. These projections provide a realistic picture of the likely future state of financing of the programs if no changes in law are enacted in the future.

The projected financial status of the Social Security program is good in the near term. Both the Old-Age and Survivors Insurance (OASI) Trust Fund and the Disability Insurance (DI) Trust Fund are expected to meet the Trustees short-range test of financial adequacy by a wide margin.

In the longer term, however, the current financing of the Social Security program is expected to be inadequate to permit full payment of benefits scheduled in present law. Based on the Trustees intermediate assumptions, the current annual excess of tax income over program cost is projected to start declining in 2009 and to reverse in 2018, at which time net redemptions of Trust Fund assets will be needed to continue full payment of benefits. In 2042, these assets, or reserves, are expected to be exhausted, and there will only be sufficient tax income to cover 73 percent of scheduled benefits. Both of these dates, and this percentage, are unchanged from last year's Report.

New data from a variety of sources, improvements of projection methods, and a lowering of the ultimate CPI annual-growth-rate assumption from 3 to 2.8 percent have resulted in a slight reduction in the 75-year actuarial deficit from 1.92 to 1.89 percent of taxable payroll. This slight improvement is also seen in the 75-year open-group unfunded obligation of the program which increased from $3.5 to $3.7 Trillion, only half the amount expected based on the change in the valuation date alone.

The pattern of the financial outlook is seen more readily in the annual estimates for the program. Lower than expected real average wage growth for 2002 and 2003 contributed to slightly smaller program cash-flow balances through the next 10 years, compared to the 2003 report. However, other changes in data and methods resulted in a net improvement in cash-flow balances for years after 2045. The result is an annual cash-flow shortfall of 5.9 percent of taxable payroll at the end of the 75-year period, compared to a shortfall of 6.5 percent in the 2003 report. This reduction in cash-flow shortfalls for the latter half of the long-range period is responsible for the small improvements in the actuarial balance and the unfunded obligations for the period as a whole.

Thus, while the annual financial shortfalls projected for Social Security after 2045 are improved somewhat from last year's report, the shortfalls are still very large. The historically low levels of birth rates experienced starting in the 1970's make inevitable the expected declines in the number of workers per beneficiary and thus the projected increases in the cost of the program as a percentage of the payroll tax base. Choices are clear. To strengthen Social Security and maintain solvency beyond 2042, additional revenue can be provided, scheduled benefit levels can eventually be reduced, or some combination of these may be selected.

Again, thank you for the opportunity to be here today. I will be happy to attempt to answer any questions you have.

Chairman THOMAS. Thank you, very much, Mr. Goss. Mr. Foster?

**STATEMENT OF RICK FOSTER, CHIEF ACTUARY, CENTERS FOR MEDICARE AND MEDICAID SERVICES**

Mr. FOSTER. Chairman Thomas, Representative Rangel, distinguished Members of the Committee, thank you for inviting me to testify again about the financial outlook for the Medicare Program. The Medicare Modernization Act of 2003 clearly introduces the most significant changes to the program since its initial or original enactment in 1965. The new prescription drug benefit will bring Medicare more in line with modern insurance coverage and medical practice, and it will provide a valuable new benefit for all beneficiaries who choose to enroll in it, especially for those with low incomes. At the same time, of course, the new benefit will add substantially to the overall cost of Medicare, we estimate by nearly one-fourth compared to the prior program cost initially and growing to as much as about one-third. I will briefly summarize the most important findings of the 2004 Medicare Trustees' Report and comment just briefly on the differences in cost estimates between my office and the CBO.

You are all very familiar with the differences between the two parts of Medicare, HI or part A; and supplementary medical insurance, which now has Parts B and D in it, a number of differences that are well known. In particular they are financed in a different way by totally different methods. The HI is financed by a portion of the Federal Insurance Contribution Act and the Self-Employment Contributions Act payroll taxes. Those tax rates are fixed in the law and they cannot change without legislation. In contrast, both part B and Part D in the future are financed primarily by general revenues and beneficiary premiums. Those financing rates are adjusted every year by my office to match the expected cost. So, as a result of these different financing bases and because the assets cannot be interchanged, we have to evaluate the financial status of the HI Trust Fund and the part B and D accounts of the Supplementary Medical Insurance Trust Fund individually.

Dr. Holtz-Eakin talked a little bit about the nature of projections. Let me just remind you that in our Trustees' Report to Congress, we project based on current law. We assume no changes other than what is already there in the statute. The projections are necessarily uncertain particularly over longer time horizons like 75 years. Moreover, with the new drug benefit, because there is no past experience to go by and only limited data on drug spending for Medicare beneficiaries, we have an even greater degree of uncertainty than usual. Despite these limitations in short—and long-range projections, we consider them useful for informing policy development. For the HI Trust Fund you know, based on Secretary Snow's presentation, that the financial status has deteriorated since the last report. The projected year of depletion has moved up to 2019. At the end of our 75-year protection period the scheduled tax revenues will be sufficient to cover only one-fourth of the projected expenditures. Only one-fourth.

For the part B account in the Supplementary Medical Insurance Trust Fund the good news is, of course, that it is automatically in financial balance because we reset the financing every year. The bad news is its costs have tended to grow fairly quickly. For example, in the last 4 calendar years, the part B costs have grown at about 10 percent per year on average over that period. Moreover, because of the Consolidated Appropriations Resolution in 2003, together with higher than expected part B costs, we ran a fairly significant deficit in the Trust Fund in 2003, because the legislation came along after we had already set the financing. That resulted in over $10-billion deficit. Moreover, for this year, because of the Medicare Modernization Act, we again anticipate running a deficit with the result that we will have to raise the premium fairly sharply for 2005. We estimate in the Trustees' Report by about 17 percent.

For the Part D account, the new drug benefit, it will be in financial but, again, it will have significant costs. Let me mention just briefly the matter concerning the CBO cost estimates versus ours. I am convinced I know from our end and I am convinced from CBO that we have both operated independently. We have acted independently to use the best assumptions, data and methods that we could to get the best possible cost estimate. The fact that we disagree somewhat in no way means that they tried to tilt their estimates or that we tried to tilt our estimates. It means that the future is uncertain. We have the highest regard for our colleagues at CBO and we value our occasional get-togethers for technical interchanges. Mr. Chairman, I pledge the Office of the Actuary's continuing assistance as you struggle with these financial challenges facing Medicare. Thank you.

[The prepared statement of Mr. Foster follows:]

**Statement of Rick Foster, Chief Actuary, Centers for Medicare and Medicaid Services**

Chairman Thomas, Representative Rangel, distinguished Committee members, thank you for inviting me to testify today about the financial outlook for the Medicare program as shown in the newly released 2004 annual report of the Medicare Board of Trustees. I will also provide information on how our cost estimates for the Medicare Prescription Drug, Improvement, and Modernization Act compare with those of the Congressional Budget Office. I welcome the opportunity to assist you in your efforts to ensure the future financial viability of the nation's second largest social insurance program—one that is a critical factor in the income security of our aged and disabled populations.

The Medicare modernization act (MMA) introduces the most significant changes to the program since its enactment in 1965. The new prescription drug benefit will bring Medicare more in line with modern insurance coverage and medical practice, while providing a valuable new benefit for all beneficiaries who choose to enroll, especially those with low incomes. At the same time, of course, the new drug benefit will add substantially to the overall cost of Medicare.

As you know from the findings in the new Trustees Report, the financial outlook for the Medicare program has deteriorated significantly since last year's report. This change is due in part to the impact of the new legislation, but it also reflects other, unassociated developments in cost and revenue trends. The financial status of the Medicare trust funds must be evaluated separately for each fund and for each account within the funds.

The Hospital Insurance (HI) trust fund does not meet the Trustees' formal test for short-range financial adequacy, which had been met in each of the previous 5 reports. In addition, the depletion of the HI trust fund, which had been projected for 2026 in last year's Trustees Report, is projected to now occur in 2019. Beginning in 2004, HI tax revenues are projected to fall increasingly short of program expendi-

tures, eventually covering only one-fourth of estimated costs by the end of the Trustees' 75-year projection period.

The Medicare modernization act created two separate accounts within the Supplementary Medical Insurance (SMI) trust fund—one for Part B, which continues to cover the traditional SMI services, and one for the new Part D, which provides subsidized access to prescription drug coverage. Because of the annual redetermination of financing for both Parts B and D, each account will remain in financial balance indefinitely under current law. SMI costs, however, are projected to continue increasing at a faster rate than the national economy and beneficiaries' incomes, raising concerns about the long-range cost implications of scheduled financing.

*Background*

Roughly 41 million people were eligible for Medicare benefits in 2003. HI, or "Part A" of Medicare, provides partial protection against the costs of inpatient hospital services, skilled nursing care, post-institutional home health care, and hospice care. Part B of SMI covers most physician services, outpatient hospital care, home health care not covered by HI, and a variety of other medical services such as diagnostic tests, durable medical equipment, and so forth. SMI Part D will initially provide access to prescription drug discount cards and transitional assistance to low-income beneficiaries. In 2006 and later, Part D will provide subsidized access to prescription drug insurance coverage as well as additional drug premium and cost-sharing subsidies for low-income enrollees.

Only about 22 percent of Part A enrollees received some reimbursable covered services during 2003, since hospital stays and related care tend to be infrequent events even for the aged and disabled. In contrast, the vast majority of enrollees incurred reimbursable Part B costs because the covered services are more routine and the annual deductible for SMI was only $100 in 2003.

The HI and SMI components of Medicare are financed on totally different bases. HI costs are met primarily through a portion of the FICA and SECA payroll taxes.[1] Of the total FICA tax rate of 7.65 percent of covered earnings, payable by employees and employers, each, HI receives 1.45 percent. Self-employed workers pay the combined total of 2.90 percent. Following the Omnibus Budget Reconciliation Act of 1993, HI taxes are paid on total earnings in covered employment, without limit. Other HI income includes a portion of the income taxes levied on Social Security benefits, interest income on invested assets, and other minor sources.

SMI enrollees pay monthly premiums ($66.60 for Part B in 2004, and an estimated average level of $37.20 for Part D starting in 2006). For Part B, the monthly premiums cover about 25 percent of program costs with the balance paid by general revenue of the Federal government and a small amount of interest income. For Part D, the transitional assistance and prescription drug discount card costs in 2004 and 2005 will be paid through enrollment fees and general revenues. In 2006 and later, the Part D costs will be met through monthly premiums, which on average will cover 25.5 percent of the cost of the basic coverage, with the balance paid by Federal general revenues, certain State transfer payments, and a small amount of interest income.

The Part A tax rate is specified in the Social Security Act and is not scheduled to change at any time in the future under present law. Thus, program financing cannot be modified to match variations in program costs except through new legislation. In contrast, the premiums and general revenue financing for both Parts B and D of SMI are reestablished each year to match estimated program costs for the following year. As a result, SMI income automatically matches expenditures without the need for legislative adjustments.

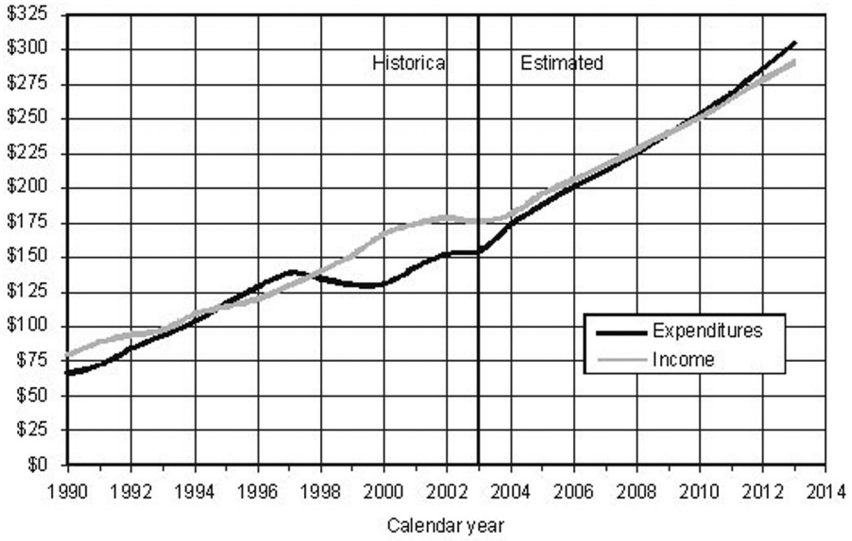
Each component of Medicare has its own trust fund, with financial oversight provided by the Board of Trustees. My discussion of Medicare's financial status is based on the actuarial projections contained in the Board's 2004 report to Congress. Such projections are made under three alternative sets of economic and demographic assumptions, to illustrate the uncertainty and possible range of variation of future costs, and cover both a "short range" period (the next 10 years) and a "long range" (the next 75 years). The projections are not intended as firm predictions of future costs, since this is clearly impossible; rather, they illustrate how the Medicare program would operate under a range of conditions that can reasonably be expected to occur. It is important to note that the results shown in this year's report are even more uncertain than those in past reports due to the changes from the MMA. In particular, the Part D projections are estimated without any actual past program experience. The projections shown in this testimony are based on the Trustees' "intermediate" set of assumptions.

[1] Federal Insurance Contributions Act and Self-Employment Contributions Act, respectively.

*Short-range financial outlook for Hospital Insurance*

Chart 1 shows HI expenditures versus income since 1990 and projections through 2013. For most of the program's history, income and expenditures have been very close together, illustrating the pay-as-you-go nature of HI financing. The taxes collected each year have been roughly sufficient to cover that year's costs. Surplus revenues are invested in special Treasury securities—in effect, lending the cash to the rest of the Federal government, to be repaid with interest at a specified future date or when needed to meet expenditures.

**Chart 1—HI expenditures and income**
(In billions)

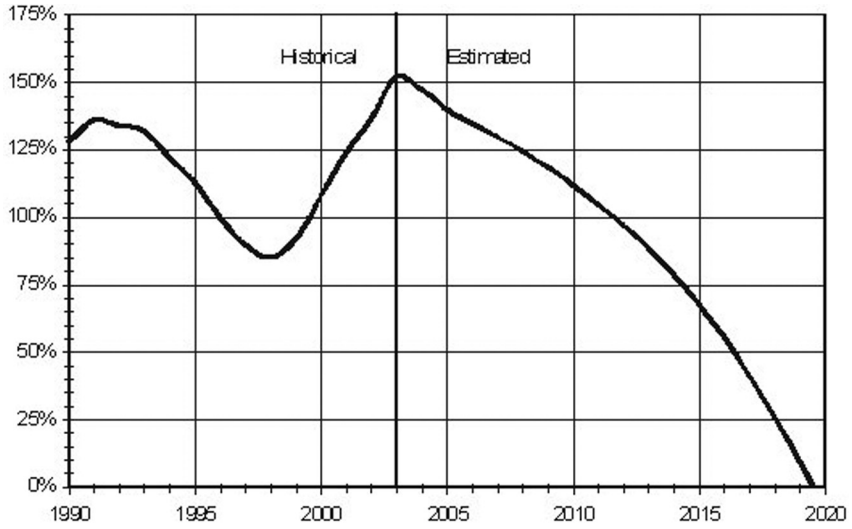



During 1990–97, HI costs increased at a faster rate than HI income. Expenditures exceeded income by a total of $17.2 billion in 1995–97. The Medicare provisions in the Balanced Budget Act of 1997 were designed to help address this situation. As indicated in Chart 1, these changes—together with subsequent low general and medical inflation and increased efforts to address fraud and abuse in the Medicare program—resulted in a decline in Part A expenditures during 1998–2000 and trust fund surpluses totaling $61.8 billion over this period. After 2000, Part A expenditures and income converged slightly, as the Balanced Budget Refinement Act and the Benefit Improvement and Protection Act increased Part A expenditures and the 2001 economic recession resulted in lower payroll tax income for Part A.

Beginning in 2004, the Medicare modernization act is also estimated to increase Part A expenditures, through higher payments to rural hospitals and to private Medicare Advantage health plans. Total HI income, including interest earnings, is expected to slightly exceed total expenditures in 2004 through 2009. (HI tax revenues alone are estimated to fall short of total expenditures beginning this year.) The slightly faster projected growth trend in outlays would result in trust fund deficits starting in 2010 and later. Note that even relatively small changes in growth trends for either income or expenditures could have a very significant impact on the projected difference between these cash flows. In particular, the onset of deficits in the HI trust fund could easily occur several years earlier or later than this intermediate projection.

The Board of Trustees has recommended maintaining HI assets equal to at least one year's expenditures as a contingency reserve. As indicated in Chart 2, HI assets at the beginning of 2004 represented about 152 percent of estimated expenditures for the year. Future asset growth, reflecting the diminishing difference between income and expenditures described above, is projected to be significantly slower than expenditure growth in 2004 and later. After 2009, as assets are drawn down to cover the annual deficits, the trust fund balance would decline and would be exhausted in 2019 under the Trustees' intermediate assumptions.

**Chart 2—HI trust fund assets**
(Assets at beginning of year as percentage of annual expenditures)



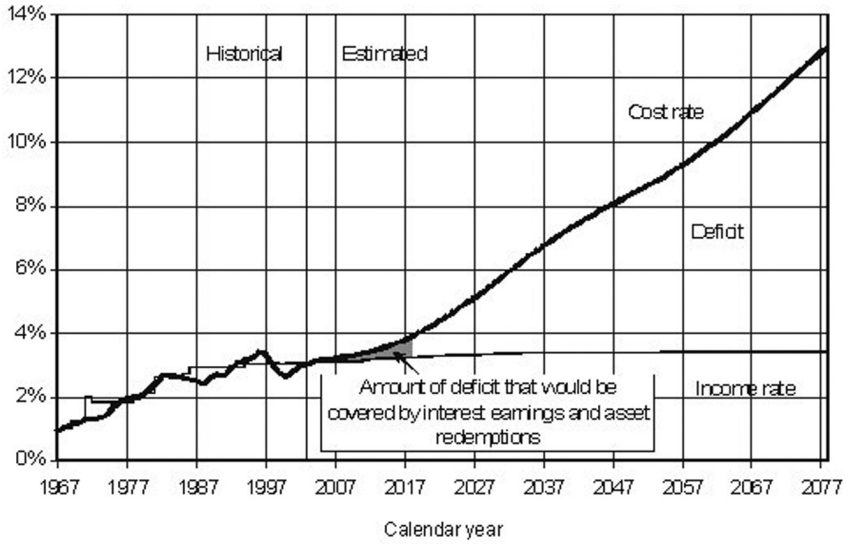

The depletion date estimated in the 2004 Trustees Report represents a significant deterioration of the trust fund financial condition compared to the estimate in last year's report (2026). About 2 years of the total 7-year difference are attributable to the higher Part A costs under the Medicare modernization act. Other factors contributing to the closer exhaustion date for HI are higher incurred spending and lower tax revenues in 2003 than previously estimated (2 years), hospital assumption adjustments to better reflect recent historical experience (1.5 years), improved data on the health status of beneficiaries in private health plans (1 year), and model refinements for certain hospital payments (0.5 year).

*Long-range financial outlook for Hospital Insurance*

The interpretation of dollar amounts through time is very difficult over extremely long periods like the 75-year projection period used in the Trustees Reports. For this reason, long-range tax income and expenditures are expressed as a percentage of the total amount of wages and self-employment income subject to the HI payroll tax (referred to as "taxable payroll"). The results are termed the "income rate" and "cost rate," respectively. Projected long-range income and cost rates are shown in Chart 3 for the HI program.

Past income rates have generally followed program costs closely, rising in a stepwise fashion as the payroll tax rates were adjusted by Congress. Income rate growth in the future is minimal, due to the fixed tax rates specified in current law. Trust fund revenue from the taxation of Social Security benefits increases gradually, because the income thresholds specified in the Internal Revenue Code are not indexed. Over time, an increasing proportion of Social Security beneficiaries will incur income taxes on their benefit payments.

**Chart 3—Long-range HI income and costs under intermediate assumptions**
(as a percentage of taxable payroll)




Past HI cost rates have generally increased over time but have periodically declined abruptly as the result of legislation to expand HI coverage to additional categories of workers, raise (or eliminate) the maximum taxable wage base, introduce new payment systems such as the inpatient prospective payment system, etc. Cost rates decreased significantly in 1998–2000 as a result of the Balanced Budget Act provisions together with strong economic growth. After 2000, however, cost rates increased, partly as a result of the Balanced Budget Refinement Act and the Benefit Improvement and Protection Act. After 2003, cost rates are again expected to increase as the Medicare modernization act is implemented, and to accelerate significantly as the baby boom generation enrolls in Medicare, beginning in about 2010. By the end of the 75-year period, scheduled tax income would cover only about one-fourth of projected expenditures.

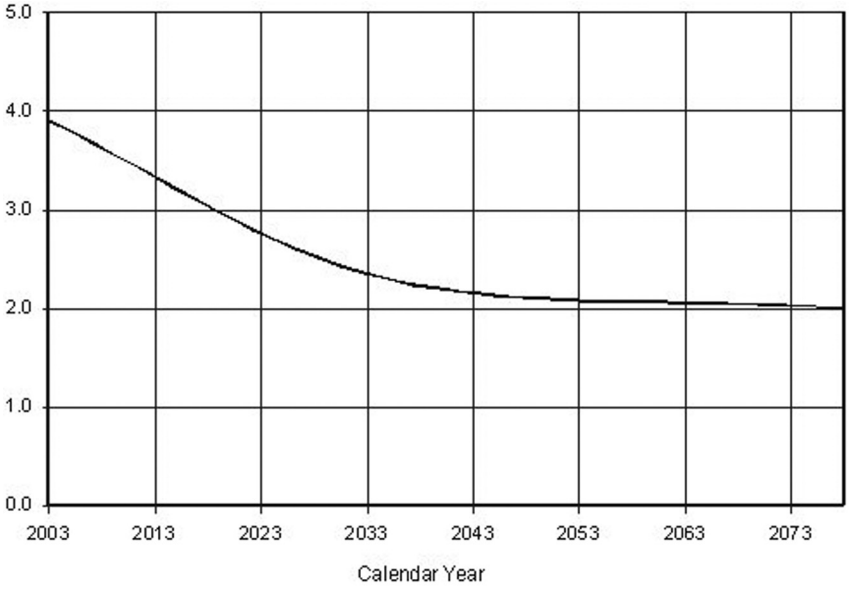
The average value of the financing shortfall over the next 75 years—known as the actuarial deficit—is 3.12 percent of taxable payroll. For illustration, this deficit could be closed by an immediate increase of 1.56 percentage points in the HI payroll tax rate, payable by employees and employers, each. If, instead, no changes were made until the year of asset exhaustion, then the HI payroll tax rate would require an increase of about 2.15 percent, payable by employees and employers, each. Note, however, that such changes would only correct the deficit "on average." Initially, HI revenue would be significantly in excess of expenditures, but by the end of the period, only about one-third of the projected annual deficit would be eliminated. The long-range deficit could also be eliminated by many other approaches involving revenue increases and/or expenditure reductions, but its magnitude poses a very daunting challenge to policy makers.

The effect of the baby boom generation on Medicare and Social Security is relatively well known, having been discussed at some length for the last 30 years. Basically, by the time the baby boom cohorts have enrolled in Medicare, there will be nearly twice as many HI beneficiaries as there are today, but the number of covered workers will have increased by only about 20 percent. When the HI program began, there were 4.5 workers in covered employment for every HI beneficiary. As shown in Chart 4, this ratio was nearly 4.0 workers per beneficiary in 2003. When the baby boom joins Medicare, the number of beneficiaries will increase more rapidly than the labor force, resulting in a decline in this ratio to about 2.4 in 2030 and 2.0 by 2078 under the intermediate projections. Other things being equal, there would be a corresponding increase in HI costs as a percentage of taxable payroll.

There are other demographic effects beyond those attributable to the varying number of births in past years. In particular, life expectancy has improved substantially in the U.S. over time and is projected to continue doing so. The average remaining life expectancy for 65-year-olds increased from 12.4 years in 1935 to 17.5

years currently, with an estimated further increase to about 22 years at the end of the long-range projection period. Medicare costs are also sensitive to the age distribution of beneficiaries. Older persons incur substantially larger costs for medical care, on average, than younger persons. Thus, as the beneficiary population ages over time they will move into higher-utilization age groups, thereby adding to the financial pressures on the Medicare program.

**Chart 4—Workers per HI beneficiary**



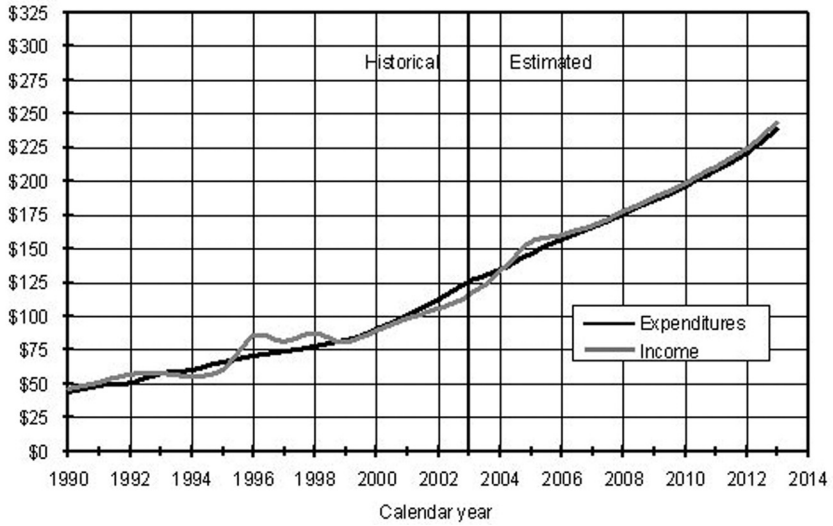

*Financial outlook for Supplementary Medical Insurance*

The financial outlook for SMI is very different than for HI, although rapid expenditure growth is a serious issue for both components of Medicare. The Medicare modernization act established a separate account within the SMI trust fund to handle transactions for the new Medicare drug benefit. Because there is no authority to transfer assets between the new Part D account and the existing Part B account, it is necessary to evaluate each account's financial adequacy separately.

Chart 5 presents estimates of the short-range outlook for Part B. In contrast to the HI program, the income and expenditure curves for Part B are nearly indistinguishable in the future. As noted previously, Part B premiums and general revenue income are reestablished annually to match expected program costs for the following year. Thus, the program will automatically be in financial balance, regardless of future program cost trends.

As shown in Chart 5, however, Part B expenditures have exceeded income in recent years. In particular, in 2003 the Consolidated Appropriations Resolution increased payments to physicians after the Part B financing rates had been set for 2003. For 2004, similarly, the Medicare modernization act increased physician and certain other Part B expenditures after the financing rates had been set for the year. These legislative changes, together with stronger than expected expenditure growth, have decreased Part B assets below levels considered adequate for contingency purposes. To restore balance between Part B income and expenditures, and to rebuild the Part B account assets to a more adequate level, the monthly Part B premium rate and the associated general revenue payments will have to be increased substantially for 2005.

**Chart 5—SMI Part B expenditures and income**
(In billions)



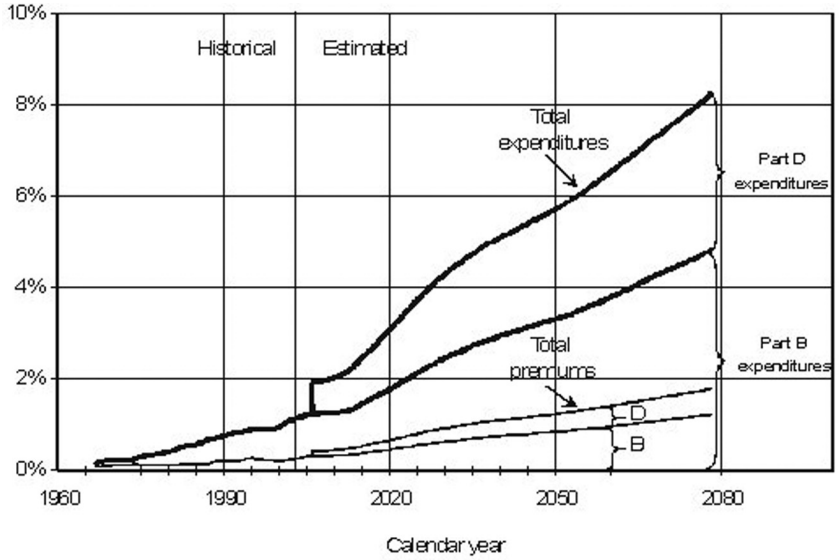

It should be noted that the projected Part B expenditures shown in the 2004 Trustees Report are unrealistically low, due to the structure of physician payments under current law. Future physician payment increases must be adjusted downward if cumulative past actual physician spending exceeds a statutory target. Prior to the MMA, past spending was already above the target level. The MMA raised the physician fee updates for 2004 and 2005, but without raising the target. Together, these factors yield projected physician updates of about—5 percent for 7 consecutive years, beginning in 2006. Multiple years of significant reductions in physician payments per service are very unlikely to occur before legislative changes intervene, but these payment reductions are required under the current law payment system and are reflected in the Part B projections.

Beneficiaries will obtain the new Part D prescription drug benefit by voluntarily purchasing insurance policies from stand-alone companies or through private Medicare Advantage health plans. The costs of these plans will be heavily subsidized by Medicare through a combination of direct premium subsidies and reinsurance payments. Medicare will also provide further support on behalf of low-income beneficiaries and a special subsidy to employers who provide qualifying drug coverage to their Medicare-eligible retirees. The financial risk associated with the private drug plans will be shared between the plan and Medicare. Medicare's cost for the various drug subsidies will be financed primarily from general revenues. A declining portion of the costs associated with beneficiaries who also qualify for full Medicaid benefits will be financed through special payments from State governments.

For the Part D program, the financial operations in 2004 and 2005 relate only to the prescription drug discount card and low-income transitional assistance. Since the general revenue subsidy for this benefit is expected to be drawn daily, no financial imbalance is likely. After 2005, when the Medicare prescription drug coverage begins, Part D income and outgo are expected to remain in balance as a result of annual adjustments of premium and general revenue income to match costs.

Chart 6 shows projected long-range SMI expenditures and premium income as a percentage of GDP. Under present law, Part B beneficiary premiums will continue to cover approximately 25 percent of total Part B costs, with the balance drawn from general revenues. Similarly, Part D beneficiary premiums are designed to cover 25.5 percent of the basic Part D benefit, on average, with the balance paid by general revenues and State transfers. SMI expenditures are projected to increase at a significantly faster rate than GDP, for largely the same reasons underlying HI cost growth. For the past 10 years, prescription drug spending has been the fastest growing major health sector. Consistent with these recent trends, the Medicare prescription drug spending under Part D is projected to initially grow faster than either Part A or Part B.

**Chart 6—SMI expenditures and premiums as a percentage of GDP**

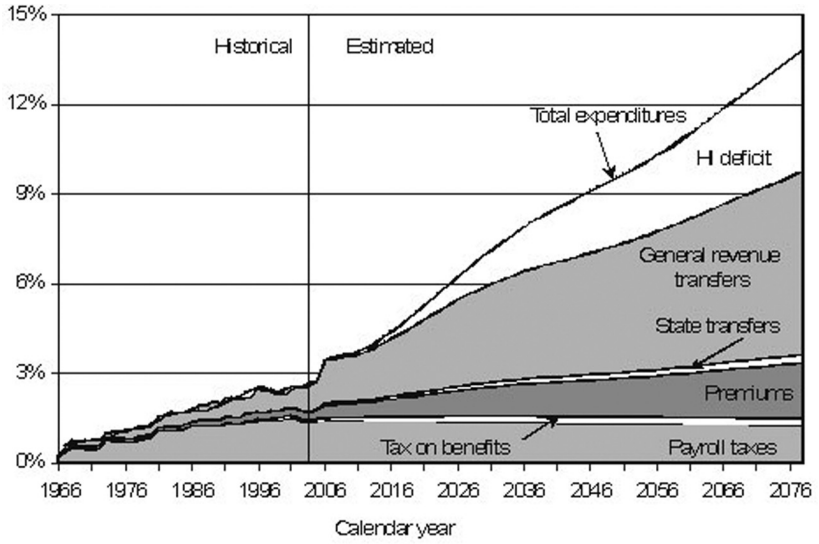



Although SMI is automatically in financial balance, the program's continuing rapid growth in expenditures places an increasing burden on beneficiaries and the Federal budget. In 2010, for example, a representative beneficiary's Part B and D premiums would require an estimated 13 percent of his or her Social Security benefit, and another 23 percent would be needed to cover average deductible and coinsurance expenditures for the year. By 2070, about 30 percent of a typical Social Security benefit would need to be withheld to pay the Part B and Part D premiums and about 54 percent would be required for copayment costs. Similarly, Part B and D general revenues in fiscal year 2010 are estimated to equal 19 percent of the personal and corporate Federal income taxes that would be collected in that year, if such taxes are set at their long-term, past average level, relative to the national economy. Under the same assumption, projected Part B and D general revenue financing in 2070 would represent over 50 percent of total income taxes.

*Combined HI and SMI expenditures*

The financial status of the Medicare program is appropriately evaluated for each trust fund separately, as summarized in the preceding sections. By law, each fund is a distinct financial entity, and the nature and sources of financing are very different between the two funds. This distinction, however, frequently causes greater attention to the HI trust fund—and especially its projected year of asset depletion—and less attention to SMI, which does not face the prospect of depletion. It is important to consider the total cost of the Medicare program and its overall sources of financing, as shown in Chart 7. Interest income is excluded since, under present law, it would not be a significant part of program financing in the long range.

**Chart 7—Medicare expenditures and sources of income as a percentage of GDP**




Combined HI and SMI expenditures are projected to increase from 2.6 percent of GDP in 2003 to about 13.8 percent in 2078, based on the Trustees' intermediate set of assumptions. The addition of Part D is expected to increase total Medicare costs by nearly one-fourth in 2006. In past years, total income from HI payroll taxes, income taxes on Social Security benefits, HI and SMI beneficiary premiums, and SMI general revenues was very close to total expenditures. Beginning in 2004, overall expenditures are expected to exceed aggregate non-interest revenues, with the growing difference arising from the projected imbalance between HI tax income and expenditures—throughout this period, SMI revenues would continue to approximately match SMI expenditures.

Over time, SMI premiums and general revenues would continue to grow rapidly, since they would keep pace with SMI expenditure growth under present law. HI payroll taxes are not projected to increase as a share of GDP, primarily because no further increases in the tax rates are scheduled under present law. Thus, as HI sources of revenue become increasingly inadequate to cover HI costs, SMI premiums and general revenues would represent a growing share of total Medicare income. With the implementation of the Part D drug benefit in 2006, general revenues will become the largest source of Medicare financing. The difference between total Medicare outlays and "dedicated financing sources"[2] is projected to first reach 45 percent of outlays in 2012.

*Conclusions*

In their 2004 report to Congress, the Board of Trustees notes the significant deterioration in the financial outlook for Medicare that has come about as a result of the modernization legislation, higher spending, and lower HI payroll tax revenue. The Trustees emphasize the continuing financial pressures facing Medicare and urge the nation's policy makers to take steps to address these concerns. They also argue that consideration of further reforms should occur in the relatively near future, since the earlier solutions are enacted, the more flexible and gradual they can be. Finally, the Trustees note that early action increases the time available for affected individuals and organizations—including health care providers, beneficiaries, and taxpayers—to adjust their expectations.

I concur with the Trustees' assessment and pledge the Office of the Actuary's continuing assistance to the joint effort by the Administration and Congress to determine effective solutions to the financial problems facing the Medicare program. I would be happy to answer any questions you might have on Medicare's financial issues.

## Appendix

### Summary of Differences Between OACT and CBO Cost Estimates for the Medicare Prescription Drug, Improvement, and Modernization Act of 2003

The Office of the Actuary in the Centers for Medicare & Medicaid Services has estimated that the Medicare modernization act would increase net Federal costs by a total of $534 billion through fiscal year 2013.[1] The corresponding estimate by the Congressional Budget Office is $395 billion. OACT and CBO have independently estimated the cost of the modernization act using the best data, assumptions, and methods that each organization could develop. The following points summarize the nature of the differences in the estimates.

- The estimates differ principally because the future is uncertain, and this uncertainty is reflected in somewhat different assumptions regarding the numerous cost and behavioral factors that will affect actual future costs. In this regard, the difference in estimates is a useful reminder of the inherent uncertainty and a rough indication of the sensitivity of future costs to the underlying cost factors.
- Of the total difference of $139 billion between the estimates, approximately $100 billion relates to Title I of the act, the Medicare prescription drug program:
  - OACT estimates that about 94 percent of all Medicare beneficiaries would enroll in (or otherwise benefit from) the Medicare drug benefit, compared to 87 percent for CBO,[2] and we also estimate a slightly higher average, per-beneficiary value for the standard drug benefit. These factors account for $32 billion of the total difference.
  - While OACT and CBO estimate similar numbers of beneficiaries who are eligible for the low-income drug subsidy, OACT estimates a significantly higher enrollment rate by these individuals. In addition, our estimated average cost for the low-income subsidy per beneficiary is slightly greater than CBO's. Of the total difference in estimated drug costs, the low-income subsidy accounts for $47 billion.
  - The cost to Medicare of providing the drug benefit would be partially offset by net Federal savings for Medicaid. (Federal Medicaid drug expenditures for Medicare beneficiaries would be eliminated, but other Federal Medicaid costs would increase somewhat; as beneficiaries enroll for the Medicare low-income drug subsidy, some will be found to qualify for Medicaid coverage). CBO estimates a greater degree of net Federal Medicaid savings, because their prior baseline projections included a rapidly growing cost for "pharmacy plus" Medicaid waivers. In total, the CBO savings estimate is $18 billion greater than OACT's.
  - The remaining $3 billion of the total difference in Title I estimates is due to a slightly different estimate of State payments on behalf of Medicare beneficiaries who also qualify for full Medicaid benefits.
- $32 billion of the remaining difference in the overall cost estimates is associated with Title II, the Medicare Advantage program. OACT's estimated costs for this title are $46 billion, versus CBO's estimate of $14 billion:
  - CBO's estimate is based on a $10 billion cost for the regional PPO stabilization fund, and $4 billion for the increased MA payment rates. They estimate that about 13 percent of beneficiaries will enroll in private health plans, most of whom would be in local HMOs. Regional PPOs are estimated to have costs somewhat in excess of the prevailing "payment benchmarks," with the result that few such plans could participate and beneficiary enrollment would be minimal.
  - OACT's estimate includes $12 billion for the stabilization fund and another $34 billion due to the higher payment rates starting in 2004 and the restructured payment formula in 2006 and later. We estimate that HMO enrollment would increase from its current level of about 12 percent to 16 percent and that PPO enrollment would also reach 16 percent in 2009 and later. The latter projection is based on estimated PPO costs that are generally below the payment benchmarks, with the result that beneficiaries could qualify for sig-

[1] This estimate excludes Federal administrative costs, other than the $1.5 billion authorized by section 1015 of the act, and the impact on social insurance payroll taxes and general income taxes. An additional Medicare expenditure of $16 billion through 2013 would be made for employer drug subsidy payments to Federal employers.

[2] Beneficiaries in employer-sponsored retiree health benefit programs are included in both percentages.

nificant premium rebates and/or additional benefits. Because these estimated PPO costs typically exceed fee-for-service levels, however, Medicare costs for such enrollees would be higher than under prior law.

- Other differences exist between the OACT and CBO estimates for Titles III through IX. These differences tend to be smaller and are also largely offsetting (with CBO sometimes higher and sometimes lower than our estimates). The remaining $7 billion of the total difference between total estimated costs is explained by these factors.

It is not uncommon for OACT and CBO to differ somewhat in their estimates. For example, CBO's estimated Medicare savings for the Balanced Budget Act of 1997 totaled about $116 billion in the first 5 fiscal years. The corresponding OACT estimate was $152 billion. Similarly, the BBA savings estimates over the first 10 years were $394 billion for CBO versus $517 billion for OACT. I believe that CBO has prepared competent, good-faith estimates for the Medicare modernization act. I prefer the assumptions and methods employed in the Office of the Actuary, and stand behind our own estimates, while recognizing that an uncertain future could prove all of us wrong.

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Chairman THOMAS. Thank you, very much. Mr. Holtz-Eakin, you said that you believe that yours is the single best estimate. My assumption is that Mr. Foster believes his is the single best estimate. Mr. Goss, whenever we look at the Social Security projections, I am always struck by the fact that you do not really do your single best estimate. You do a high and a low and an intermediary. Why don't you just do the single best estimate? Then you would get more questions today.

Mr. GOSS. Well, Chairman Thomas, I was wondering about the fact that I am sitting in the middle here.

Chairman THOMAS. Purely by accident.

Mr. GOSS. I would say that for the Social Security Trustees' report you are exactly right, we do produce an intermediate protection which is generally characterized as the Trustees' best estimate based on their best assumptions for the future.

Chairman THOMAS. You bracket it.

Mr. GOSS. We do bracket it with a high and a low cost estimates. In addition we have, in the last 2 years, also provided a stochastic range. I do believe that the Medicare report does also include a high and low cost estimate.

Chairman THOMAS. Yes, it does, in the long-term because of the uncertainties. I do find it a little bit interesting that we have what I would guess is the high and the low estimate for this particular piece of legislation, and that it is probably most accurate to look at it as a range since neither one is going to be correct. Mr. Holtz-Eakin believes his is the single best estimate. Again, it is not a beauty contest. We are not choosing Mr. Holtz-Eakin over Mr. Foster for reasons that are not grounded in law. The Congressional Budget Act (P.L. 93–344), section 308, says that the CBO is the official scorekeeper and, in fact, Committees are required to include a CBO estimate with each bill reported.

Oftentimes, though, in the very difficult areas, and I want to underscore how difficult it has been for any actuary to attempt to make estimates in an area for which we have had no experience other than previous bills that failed and our re-examination of our previous estimates, deciding that they were not as good as we thought they were when they were issued. So, that is a growth curve and we have moved forward. Oftentimes you will hear from

me or other Members, would you two please get together and talk to each other to see if we can narrow the differences between the estimates, not because we are trying to affect the outcome but because it is very difficult when there is a significant difference for the same proposal from two professional groups. It makes it very difficult.

If we are forced to choose, the law tells us very clearly that Mr. Holtz-Eakin wins. That is the law. That section 402 of the Congressional Budget Act requires estimates for bills reported by Committee. I think another point that needs to be underscored in this dynamic is that not only piece-by-piece do we need provisions scored by the CBO, but we need a complete estimate of the legislation passed by the Committee. That does not mean it is not going to change between Committee action and the floor, between the floor and going to conference, or coming out of conference. What the CBO does is constantly update the estimates. Mr. Foster, when were you able to provide a comprehensive, complete analysis of the legislation that was passed?

Mr. FOSTER. For the total package, we were not able to complete those estimates in their entirety until December 23rd.

Chairman THOMAS. Why were you not able to do that until late in December?

Mr. FOSTER. The complexity of the Medicare Advantage provisions led to very difficult estimating challenges. It involved trying to anticipate the behavior of plans as to whether to participate or not, what their cost would be, and then what the premiums would be and whether beneficiaries would be attracted to these plans or not, in which areas, and in how many numbers, and then the consequences for the cost to the program.

Chairman THOMAS. Would part of the time lag be that you had to get the bill in its entirety prior to making some of those interactive estimates and, in fact, the total estimate?

Mr. FOSTER. Yes.

Chairman THOMAS. So, the statutory underpinning of CBO having to be on horseback with estimates that we are required to accept is a slightly different job than yours, because although we value independent assessments, we are required to accept, piece-by-piece, building an overall cost. The thing that I find most remarkable about Mr. Holtz-Eakin's estimates are the fact that the CBO made an estimate at the end of the conference and then after the bill became law when you did; i.e., they had the information available of the direction that you were going. In their professional estimation, stayed with their number. That, I think, is very telling and notwithstanding how much someone may like your numbers or admire your numbers or admire your professionalism, when you go into the differences between the two programs I think it is quite telling, because as in your testimony, Mr. Foster, you point out that the areas of discrepancy are in the most cutting and problematic areas that are new. For example, the prescription drug benefit. You estimated what percentage of the seniors would enroll in Part D prescription drugs?

Mr. FOSTER. We estimated 94 percent.

Chairman THOMAS. Ninety-four percent. Do you know what the enrollment for part B, Medicare Supplement, is?

Mr. FOSTER. It is about 91 percent of all eligible people.

Chairman THOMAS. Ninety-one percent. Up until recently Medicare part B was a 75 cent on the dollar subsidy if you enrolled in part B, and you got a 91 percent take-up rate. You believe, in this expensive and growingly expensive program, 94 percent will sign up. Mr. Holtz-Eakin, was your estimate?

Mr. HOLTZ-EAKIN. Eighty-seven percent.

Chairman THOMAS. Okay. So, 94, 87, no big deal, right? That is reasonable to assume that it is going to be somewhere between 87 and 94. What is the difference in cost between those two estimates?

Mr. HOLTZ-EAKIN. We would estimate that contributes about $16 billion to the difference between the CMS estimate and ours.

Chairman THOMAS. I think it is about $32 billion when you add the total package, in terms of the high benefit, the low benefit, and the other structures. So, if we are beginning to close the difference between the estimates, the difference between 94 and an 87 percent take-up rate is about $32 billion. The other one, which I think is difficult to estimate because we are moving from a mixed program for seniors, we have a senior health program since 1965. If you are a low-income senior you were treated differently in many aspects of health care needs through the Medicaid program. We finally, because of the prescription drug provision, are consolidating seniors at the Federal level, a uniform program for seniors finally across the Nation, not by the State-by-State basis. I believe this is an area that perhaps is the single largest dollar discrepancy in the two assumptions; is that correct?

Mr. FOSTER. The low-income subsidy, yes, sir.

Chairman THOMAS. The low-income subsidy. You estimated what take-up rate for the low-income subsidy, Mr. Foster?

Mr. FOSTER. Overall, among eligible individuals, in other words with the right income and the right assets, we had about 75 percent. That included all of the Medicaid beneficiaries who we already know about, of course. So, 100 percent for them and a lower percentage for everybody else.

Chairman THOMAS. What was your estimate, Mr. Holtz-Eakin?

Mr. HOLTZ-EAKIN. About two-thirds.

Chairman THOMAS. So, 66 percent for CBO and——

Mr. FOSTER. Seventy-five.

Chairman THOMAS. Seventy-five percent. You know, 66, 75 percent, that is ballpark. How much money difference was that?

Mr. FOSTER. A total of $47 billion.

Chairman THOMAS. Forty-seven billion dollars on which of those two numbers you choose as a take-up rate for low income into new programs where we are just now beginning to move forward. Mr. Foster, would you say that one of the assumptions you made on those extremely high take-up rates versus the CBO was that if we were not going to offer this program at the Federal level, the Federal Government would be more aggressive in advertising the programs, in making people aware of the fact that the new Medicare was available for them? That your assumptions might have been tied to a fairly aggressive publicity campaign?

Mr. FOSTER. We were certainly aware of CMS's intention to have a good beneficiary information campaign for exactly that sort of purpose.

Chairman THOMAS. Did that enter into your assumptions, in terms of the structure, at least as a contributing factor?

Mr. FOSTER. In part, yes.

Chairman THOMAS. Would you have provided a lower assumption if you assume that any of the advertising campaigns would have been significantly attacked or curtailed?

Mr. FOSTER. In the absence of advertising for the new benefit, we would have assumed a lower assumption.

Chairman THOMAS. In the absence of advertising for the new benefit, you would have assumed a lower take-up rate?

Mr. FOSTER. Right.

Chairman THOMAS. One last question, and frankly this is a frustrating one for me and a number of other Members. We have looked at areas where clearly we are going to spend more money. We finally decided to put some money into the rural providers in a way we have not in the past. You folks get out your pencils and all those pluses go to the bottom line. It makes sense because we are going to be spending more money. This Medicare Program also was one of the most significant expansions of preventive and wellness programs with disease management. In fact, we are going to be able to provide for the first time, for every senior entering Medicare, a physical. Now my assumption is if we can get every new entry into Medicare to have a physical, what we are going to be able to do is pick up some of those diseases or tendencies or problems which wind up being enormous costers if ignored. The one that we have been warned about is obviously diabetes, which leads to kidney failure which leads to end-stage renal disease, very expensive, very costly. If we are spending the money for a physical up front, how much money are the taxpayer's going to save over the next 10 or 20 years by not having these problems go to extreme cases and we can intervene early? How much money do we save for those preventive wellness and physicals that we now have in the law? Mr. Holtz-Eakin?

Mr. HOLTZ-EAKIN. In our estimate, we have reviewed the peer-reviewed evidence on the success of disease management programs in cutting overall costs and we could not find comprehensive evidence of large-scale savings, so those are not reflected in our estimate.

Chairman THOMAS. I understand disease management. I mentioned preventive, wellness and physicals.

Mr. HOLTZ-EAKIN. We do not have a specific estimate of savings from those programs in our estimate.

Chairman THOMAS. Mr. Foster.

Mr. FOSTER. I will be glad to provide the answer for the record but I have not personally reviewed the estimates for those specific provisions so I cannot tell you. I will provide it for the record.

[The information is pending.]

Chairman THOMAS. So, significant preventive wellness and detection measures, which cost because you say we are going to spend money on the program, give us no return on savings over a decade or two decades? That all they are, are costers. No one believes that.

That is why they are so strongly supported and included in the legislation. This is just one fundamental reason why estimates are estimates, and anyone who tries to hang their hat on it will find out that there is a lot more vapor than substance in the projections that are made. Thank you very much. Mr. Rangel, you wish to question?

Mr. RANGEL. First, let me thank you, Mr. Chairman, for waiving the 5-minute rule so that we can actually get to the bottom of some of these serious questions that you have raised, as well as observations. I knew that you were good, all three of you. I had no idea that you could determine or guesstimate how much money we save by having preventive medicine. If I had thought that you guys could do this, I would ask you how much productivity could we get if we had an educated work force? How much savings could we have if we had preventive medicine? How many lives could be saved? I wish I had the foresight of the Chairman to even frame those questions, because it sounds like the Democratic national programs in terms of education and health and all of the things that we say cost lives in medicine. Having not known you were that good, let me say this: this may appear to be an awkward time for you but I want you to know how much we appreciate the fact that we are able to attract professionals that are nonpartisan and objective in providing information to guide this Congress to make the important legislative and political decisions.

I am so glad that you have the integrity to make certain that you know that when you lean toward partisanship, you do not just do to personal detriment, but to detriment of the entire professions of which you are honored members. All of you have served well for a number of years. Any awkwardness that you have today I would want you to know it is only to maintain your individual integrity and the integrity of your profession so that this Congress and Congress' that will come would know that we know how to get Democrats and Republican opinions, liberal and conservative opinions, but what we need and we have to maintain are objective opinions like those which you have given over the years. So, Mr. Foster, when, for the first time, did you know that your estimates of the cost of the Medicare prescription drug bill were different and exceeded that of the renowned and respected CBO?

Mr. FOSTER. We first had estimates, Representative Rangel, for the drug provisions in H.R. 1 and S. 1, actually their predecessor packages, in early June. Our estimates for the drug part were significantly greater than the $400 billion target.

Mr. RANGEL. What was your opinion, in terms of your estimate of the cost of the so-called drug part?

Mr. FOSTER. Back then the early estimates for the versions as reported out of the Committees were in the range of $550 billion through fiscal year 2013, just for the drug part.

Mr. RANGEL. You knew that your estimate differed from your colleagues in the CBO?

Mr. FOSTER. I have forgotten exactly when CBO released its first estimates but it was around the same time, I think.

Mr. RANGEL. You knew that they were dramatically different?

Mr. FOSTER. I might have chosen a different word than dramatically, but——

Mr. RANGEL. Strike that. You knew it was different?

Mr. FOSTER. I knew they were different, yes, sir.

Mr. RANGEL. Now who did you share your opinion with?

Mr. FOSTER. That first round of estimates we gave to our then-Administrator, Tom Scully. I believe we also sent copies to Doug Badger in the White House, people at OMB, other people at HHS.

Mr. RANGEL. You do believe, I hope, that your responsibility was to give this type of information when requested to Members of Congress?

Mr. FOSTER. There has been a longstanding practice obviously of having the Office of the Actuary provide technical assistance to Congress when asked. This goes back to the beginning of Medicare and further than that to the beginning of Social Security.

Mr. RANGEL. So, this tradition meant Members of Congress, whether they were Republican or Democrats?

Mr. FOSTER. Yes, sir.

Mr. RANGEL. Did there come a time that the staff of the majority Republican party asked you to share your estimate as to the cost of this bill with them?

Mr. FOSTER. I am sorry, could you repeat the question.

Mr. RANGEL. Did there come a time that the staff of the majority party, the party of the Chairman, asked you to share your estimates with them?

Mr. FOSTER. I do not recall their asking for the overall package costs. They certainly sought technical assistance from time to time on particular issues.

Mr. RANGEL. Did they seek technical assistance in terms of the cost of the prescription drug program?

Mr. FOSTER. I do not remember their asking for the cost of the drug benefit, not the majority staff, sir.

Mr. RANGEL. Then besides Mr. Scully what did you do with this information as related to the cost of the prescription drug program that you found was different, at least than the CBO?

Mr. FOSTER. We gave that to the people who had requested it, primarily Mr. Scully and others in the Administration.

Mr. RANGEL. You had no request, that you know of, from the Republican staff?

Mr. FOSTER. Not for that, no, sir.

Mr. RANGEL. Did you have any requests from the Democratic staff?

Mr. FOSTER. Yes, sir, we did. The Democratic staff of the Committee on Ways and Means had asked, in around mid-June, for a number of specific technical analyses related to H.R. 1. As part of that they requested an overall cost estimate for the package and the impact of the provisions on the date of insolvency for the part A Trust Fund.

Mr. RANGEL. Did you give that to them?

Mr. FOSTER. No, we did not.

Mr. RANGEL. If the Republican staff had requested that same information, would you have given it to them?

Mr. FOSTER. No, I think the answer to that is no. I can explain if you like.

Mr. RANGEL. Well, why did you not give it to the Democrats, since they were the ones that actually asked you for it?

Mr. FOSTER. I recommended to Mr. Scully for two particular technical analyses which your staff had indicated were a high priority, I recommended to him that in fact we had completed these estimates and that they should be released. I thought that they represented legitimate technical questions and we had reasonable answers. Based on our decades-long experience of providing this technical assistance, I did not see any reason not to. So, I made that recommendation to Mr. Scully. By this point in time he had made it clear that we were not to respond directly to requests from Congress anymore, but instead we were to give any such response to him and he would decide what to do with it.

Mr. RANGEL. Did you feel that this type of response from Mr. Scully in any way interfered with your professionalism in terms of what traditionally had been your job as related to responding to Members of Congress and their staff?

Mr. FOSTER. Yes, sir. I thought it was inappropriate. If it had been an issue of our providing the response to Mr. Scully and him promptly providing the response to the requester, that would have been less of a concern. What I perceived was that some responses went out and some responses did not go out. It struck me there was a political basis for making that decision. I considered that inappropriate and, in fact, unethical.

Mr. RANGEL. Let me ask the other two panelists, who are professional and have demonstrated their professionalism since they dedicated themselves to public service. Do either one of you disagree with the conclusions that Mr. Foster had reached, as it relates to his professional integrity in dealing with this question that he was faced with? Mr. Goss?

Mr. GOSS. I would have to say no, I do not disagree with anything that Rick has said. I would suggest, however, and perhaps Doug is in the same situation, I do not know all the details of this so I cannot comment.

Mr. RANGEL. I do not know all of the details either but based on what he said, and I am only talking about the integrity of your office, in the hypothetical if you were faced in the situation which I presented to him and he responded, would you agree with his conclusion?

Mr. GOSS. I agree with Mr. Foster's conclusion, absolutely.

Mr. HOLTZ-EAKIN. I know the standards of conduct for the CBO. If the tradition of nonpartisanship and open access to Congress is as described, then I would agree.

Mr. RANGEL. Mr. Foster, since the integrity of your profession was on the line, what prevented you from disagreeing with Mr. Scully since, in fact, it was really not a Democratic or Republican issue but an issue of your professionalism?

Mr. FOSTER. Nothing prevented me from disagreeing with him. We disagreed quite a bit, sir. I attempted on several occasions to have a discussion with him about the importance of providing the technical assistance, whether or not it might be used to argue against his preferred position or the Administration's position, on the grounds that you all are the top policymakers in the Nation, grappling with the biggest changes to Medicare since the program was enacted. These programs are very complex and the changes are very complex. I argued that you all ought to have the best and

most complete technical information you can get. Suffice it to say I did not prevail in any of those attempts with Mr. Scully. I also attempted to have the same conversation with other folks in the Administration who were much more sympathetic. In the end, the new rules that Mr. Scully put in place prevailed. In terms of my own view of the professional aspect, I did consult a top attorney at CMS in trying to wrestle with the question. Because I knew already, from a professional standpoint, that we serve the public at large. I felt a very strong responsibility on behalf of the public not to withhold technical information that could be useful in this debate. The legal answer I got, and you should know, sir, is that in any conflict or difference between the professional standards of conduct for actuaries in this country and the laws on the books, the laws win. That is a known standard.

Mr. RANGEL. Excuse me. I wish you would say that again because I have a feeling I must conclude, I have a very strong feeling I must conclude, and I wanted to hear your last response. I am so sorry.

Mr. BECERRA. Mr. Chairman, if we could ask Mr. Foster to pull the mike a little closer. It is difficult to hear him.

Chairman THOMAS. Mr. Foster, these are not unidirectional like the old ones, but the top of the mike pointed more toward your mouth might help.

Mr. RANGEL. I want to thank the Chair for your indulgence.

Mr. FOSTER. Can you hear me better now?

Mr. THOMAS. Yes.

Mr. FOSTER. From a professional standpoint, I felt then, and believe now, there is an obligation on behalf of the public for my office to give you the best advice possible when requested. When I consulted the attorney at CMS as to the legal basis, I ended up convinced that the Administrator had the legal right to direct our activities in the way he did. In a difference between a law on the books or the legal right to do so and a professional responsibility to the public and to a client, Congress in this case, the law prevails. However, I was not happy about that. At the point that—well, I had a difficult choice, sir, you can imagine. I could ignore the orders. I knew I would get fired. I was not afraid of that. I did not especially want to be fired but I was not afraid of it. I could comply with the orders and I could resign in protest, which in fact I ultimately decided to do. I ultimately decided to resign in protest because of the inappropriateness of the circumstances we were under. In the end my staff talked me out of that on the grounds that a resignation might make a big splash and have a big impact for a day or 2, but there was grave danger to the office and this longstanding practice in that situation. They convinced me, and perhaps I helped convince myself somewhat, I would be better off working inside the system to get back to the situation that I think, in fact, we are now in wherein Secretary Thompson has gone on record saying this support should be provided on a nonpartisan basis. Mark McClellan, our Administrator-designee, has said the same thing.

Mr. RANGEL. Let me thank you for being persuaded to stay the course. Let me thank your two colleagues because this is not about Mr. Foster. It is not about Republicans and Democrats. This is

about the integrity of the professionals that we depend on to give us information when we need it. You standing with him protects yourself, you protect your profession, and you make certain that we Democrats do not make the same mistakes because we just get carried away with our power. Mr. Foster, you are to be congratulated. Believe me by you making this decision, I am certain that the Secretary and the Administration will be very careful to see that this does not happen with other professionals. Thank you, Mr. Chairman.

Chairman THOMAS. The gentleman's 15 minutes has expired. The gentleman from Illinois wish to be recognized?

Mr. CRANE. Yes, Mr. Chairman.

Chairman THOMAS. Would the gentleman yield briefly?

Mr. CRANE. Certainly.

Chairman THOMAS. Mr. Foster, I have not done this before. Based upon the series of questions and the answers, I would ask you did you and I have a telephone conversation in regard to the concerns on your professional integrity in this Administration?

Mr. FOSTER. Yes, sir, we did.

Chairman THOMAS. Could you convey the gist of the telephone conversation?

Mr. FOSTER. Yes, sir. It was back in June, following the first of these instances which involved a request that your staff had made to me for an estimate, which was ordered to be withheld, which I provided anyway because I had not in fact received that order. My understanding is that Mr. Scully was—well, I know that he was deeply unhappy.

Chairman THOMAS. What was the gist of our conversation?

Mr. FOSTER. I apologize. You called and asked me whether the information in the memo I had sent to you represented my best estimate and my best judgment. I said yes, that it did.

Chairman THOMAS. I said what then?

Mr. FOSTER. You also said that you would be talking with some folks about the threats that you had heard of toward me and that I should not worry about it.

Chairman THOMAS. Did we have a similar conversation? Was that a bit of a deja vu for you?

Mr. FOSTER. I am sorry?

Chairman THOMAS. Did we have a telephone conversation on a similar subject matter at a previous time?

Mr. FOSTER. Back in 1997?

Chairman THOMAS. Yes, when there was an Administration of a different party putting pressure on you not to release information and the gist of my conversation to you at that time was what?

Mr. FOSTER. That is a little further back and a little more forgotten.

Chairman THOMAS. The answer was in your professional opinion if the information you provided was your professional opinion I would defend you in presenting your professional opinion; i.e., identical telephone conversations in two different Administrations. Apparently, the idea of following the law as you indicated, in terms of the flow of information, was present not only in Republican administrations but in Democratic administrations. As a matter of fact, if you will look at report language in the 1997 act, we under-

scored your ability to make those kinds of statements. So, I supported you then. I support you now. If you choose to continue this position as your professional prerogative, I will support you in the future. That does not mean I am always going to agree with their estimates, but I certainly believe the service of providing those estimates is a valuable assistance in making law. I want to thank the gentleman from Illinois for yielding.

Mr. RANGEL. Mr. Chairman, I have a misunderstanding here. This exchange allows me to believe that Mr. Foster gave you his estimates before he was told not to do it. So, you had information that we Democrats could not get and did not share it with us.

Chairman THOMAS. That is not what he said. The gentleman from Illinois.

Mr. RANGEL. That is what it sounded like.

Mr. CRANE. May I reclaim my time? Mr. Goss, several other Members have exuberantly claimed that Social Security is fiscally sound by citing the report's short-term projection that ends in 2013. That claim conveniently allows them to ignore the longer term projections that show that by 2018, just 5 years later, Social Security will no longer be able to rely solely on its tax revenue to cover benefit payments. What would be the consequences of ignoring Social Security's financial challenges and not modernizing the program while it still has a surplus by putting off reform for some future Congress to deal with when the Trust Fund begins to shrink?

Mr. GOSS. We clearly are at a point where we do well to understand that Social Security does have financial shortfalls coming in the future. By acting sooner we clearly have a greater range of possibilities that can be considered. If action were taken relatively soon, it would allow these opportunities to be put into the law so that they could grade in, they could phase in on a more gradual basis. A perfect example of this was the 1983 Social Security amendments (P.L. 98–21) where the normal retirement age was legislated to be increased with a 17-year delay. The increase did not, in fact, start until the year 2000 even though the change was enacted in the year 1983. Therefore, in my judgment, the cost of delaying substantially a serious discussion and movement toward deciding on what should be done for Social Security will be to limit possibilities and perhaps make it more difficult to get the job done.

Mr. CRANE. Thank you, Mr. Goss.

Chairman THOMAS. Does the gentleman from California, Mr. Stark, wish to inquire?

Mr. STARK. Thank you, Mr. Chairman. I want to thank the panel. I just wanted to——

Chairman THOMAS. The Chair would indicate briefly, not on the gentleman's time, that we are going to do as much as we can to return from the Senate time structure to the House time structure. It will be a liberal 5 minutes but it is not going to be 15.

Mr. STARK. I thank the Chair. You mentioned in your testimony, Mr. Foster, in response to Mr. Rangel's question, that there were others or people in the White House who received your June estimates of H.R. 1 and S. 1. I think you mentioned Mr. Badger by name. Can you tell me who the others were, to the best of your recollection.

Mr. FOSTER. Yes, I believe Jim Capretta in the OMB and Jennifer Young, then Acting Assistant Secretary for Legislation at HHS. There would have been some other folks within HHS as well, Legislative Director, for example.

Mr. STARK. So, it would be reasonable to assume when Secretary Thompson told us last month and he answered Mr. Rangel, he said "we knew all along, Congressman Rangel, that our assumptions were higher," that it would not have been a surprise that the Secretary might have known or had an inkling that there were these higher estimates, as well. Is that a fair assumption?

Mr. FOSTER. I do not actually know when the Secretary knew, sir.

Mr. STARK. There was a question that you may have participated in a meeting or a teleconference or a conference call in the presence of or with Mr. Badger where he either answered for you or directed you to refrain from providing any cost estimates or other information to Members or staff from the Committees of jurisdiction. Do you recall this event or these events?

Mr. FOSTER. There were, on occasion, either conference calls or meetings for the purpose of discussing various technical issues with the bill. Mr. Badger and others were typically present. On occasion, I remember him jumping in to answer a question that might have been directed toward me. I do not remember instances where I felt I had not been able to answer a question.

Mr. STARK. I am sure you recognize my limited professional competence in the area of actuarial science, and I am sure you do appreciate our Ways and Means minority health staff's interest and expertise not in actuarial science but in the intricacies of Medicare finance. Would it be a reasonable assumption that somebody as naive in these areas as myself, but with the help of my excellent staff, if we had had your June estimates in the range of $550 billion, would it have been a huge leap for us to suspect that either H.R. 1 or S. 1 or the resulting conference bill would have been far higher than $400 billion?

Mr. FOSTER. I think that would be a reasonable conclusion. The drug provision, of course, was far and away the most expensive component. We had only rough estimates back then of the competition or what became the Medicare Advantage provisions. We generally had estimated those to be a cost of $30 billion to $50 billion. It was anticipated and, in fact, turned out to be the case that everything else, all the other fee-for-service provisions, had a modest overall savings in the neighborhood of $20 billion or $30 billion.

Mr. STARK. So, to summarize, had you not been restrained, or threatened, as the case may be, that in the normal course of events I would have received and Mr. Rangel would have received and others on the Committee and our staff would have received a response to our request of June 17th and on June 19th and with the information that we would have received based on your then-analysis, it would have been logical for us to assume that the cost of H.R. 1 and S. 1 and/or the result would be more in the neighborhood of between $500 billion and $600 billion than between $300 billion and $400 billion?

Mr. FOSTER. Yes. We certainly would have had a rough estimate that we could have conveyed informally to that effect. We

would not have had a final refined estimate until the same December 23rd date that I mentioned.

Mr. STARK. May I take 30 seconds, Mr. Chairman. I would stipulate here that I was a partial author of a bill that cost far more, $900 billion I suspect, although I do not know where that estimate came from. At any rate I recognize that. The issue here is that I am sure people who would have opposed my position knew that was $900 billion. The concern that I have is that we can and often do disagree. We generally, for instance on the Joint Committee on Taxation, we operate with a great deal of reliability on the same set of numbers. I think that is my concern and I would hope it is a bipartisan concern, that in the future we have got to have a real level of confidence that at least the underlying numbers are the same on both sides, and we can proceed then to argue our differences as to what those numbers might be. I thank the Chairman for the extra time.

Chairman THOMAS. The Chair believes that the $900 billion estimate was a CBO figure. Therefore, had Rick Foster estimated yours, it would have been $1.3 trillion or $1.4 trillion, or $1.5 trillion, based upon the testimony that was heard. To make sure that the record is clear, the Chair would call on the gentleman from New York to explain the information he received from staff about the response that Mr. Foster made to him in terms of the telephone conversation we had and the material that was to be provided.

Mr. RANGEL. Yes, Mr. Chairman. I have been informed by staff and reassured by the Chair that the technical assistance information that Mr. Foster gave to the distinguished Chairman prior to the time that the restrictions were placed on you was not the actual estimate of the cost of the prescription drug sector of the bill.

Chairman THOMAS. I thank the gentleman. So, the point that I made that it was not in reference to the same thing that the gentleman was talking about was, in fact, accurate. I appreciate the gentleman's clarification for the record very much. Does the gentleman from Florida, Mr. Shaw wish to inquire?

Mr. SHAW. Thank you, Mr. Chairman. I commend Mr. Rangel for making that clarification. Mr. Foster, you have heard as the Chairman said that the $900 billion figure came from CBO. Perhaps I should ask Mr. Holtz-Eakin, is that correct information on Mr. Stark's bill?

Mr. HOLTZ-EAKIN. I believe that is correct, yes.

Mr. SHAW. So, his curiosity is answered on that. Mr. Foster, have you had an occasion to even look at that bill?

Mr. FOSTER. No, sir.

Mr. SHAW. Based upon what CBO came with, I would guess that you would score it very much higher than the CBO did; is that correct?

Mr. FOSTER. Possibly, but without looking at the provisions——

Mr. SHAW. I understand you cannot answer that directly but I would think that if you use the same assumptions that you used on our bill that you would raise it above the $900 billion because it is a much richer bill as far as benefits were concerned. I have this question for Mr. Holtz-Eakin. Were you present when Secretary Snow was testifying?

Mr. HOLTZ-EAKIN. Yes, I was.

Mr. SHAW. At that time you heard the gentleman from California, Mr. Matsui, inquire using my Social Security reform bill as an example in citing a deficit in that bill; is that correct?

Mr. HOLTZ-EAKIN. Yes, I did.

Mr. SHAW. What concerns me is an accounting process that the Federal Government uses. When you start talking about the accounting system, it is really a cash flow system in which any moneys put out, any revenues put out, can inflate the deficit even though it is invested, whether it is invested in a building or whether it is invested in a retirement account that will eventually be used to help fulfill the obligation of the SSA for the payment of benefits to future retirees. Is that not correct?

Mr. HOLTZ-EAKIN. That was the conversation, yes.

Mr. SHAW. What I am concerned about here is that I believe very strongly that the only sensible approach to save Social Security and to prevent this deficit is to start forward funding Social Security in some way. The problem you get into when you start doing that is you trip over the accounting process that the Federal Government uses. Even though that money is like putting it into a pension plan to take care of the future obligations of a government or of private industry. In the Federal system of accounting it is considered an outlay and that is just the way the system works. When it comes back, however, as you get into the out years and as people begin to retire and utilize their retirement account to help pay their benefits, that will assist the Trust Fund in the payment of the benefits, then that is considered a receipt; is that not correct?

Mr. HOLTZ-EAKIN. This is correct.

Mr. SHAW. It occurs to me that what we are talking about doing is that we should score the deficit as an outlay now so we can, as time goes on, start considering it a receipt. I think that this is a very serious flaw in our system that we should begin to take a look at it. If we are going to be responsible, if we are going to be responsible, and if we care about our kids and our grandkids, we have to start investing in Social Security with real economic assets. Those real economic assets can be in no safer place than they would be in individual retirement accounts, which would be available to help pay the benefits that tomorrow's seniors are looking forward to. Could you comment on that, and the accounting process, and what we might be able to do to solve this situation, the dilemma that we find just because of an irresponsible accounting system?

Mr. HOLTZ-EAKIN. Congressman, the CBO has, for the past several years beginning under my predecessor Dan Crippen, been building the capacity to look not only at the conventional 10-year cost estimate of Social Security proposals but also longer term implications from the perspective of system finances, from the perspective of the broader unified budget, and indeed from the perspective of impact on the economy as a whole. That capacity, although not yet complete, is nearing the ability to examine these proposals in quite great detail, including addressing some of the concerns that you have raised.

I look forward to working with you on that. I would like to take the opportunity to thank Mr. Goss, since he is here today, for the extent of assistance that he has provided the CBO in this under-

taking. It has been quite a big undertaking and we would not have gotten to the point we have without his help.

Mr. SHAW. I also very much appreciate it because I think all of the alarms should be going off, not only on Medicare which is a more immediate problem, but in Social Security which also is an immediate problem because if we do not start investing in individual accounts for tomorrow's seniors, then the impact is going to be greater and it is going to be tougher. Because we need to get those funds into the individual accounts so they can start building. That is the magic. That is how we create a surplus over 75 years is by investing and letting those accounts buildup. It is the only way we are going to promise our kids and our grandkids at least as good a retirement as we have and avoid this economic disaster that could bring our economy down. No economy in the world could survive this type of pending deficit that we are looking at. I thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentleman. Does the gentleman from Michigan wish to inquire?

Mr. LEVIN. Thank you. I just want to be clear what is really the issue here, at least a major issue. It is not which of the best estimates was best, but why the several so-called best estimates or figures were not given to us before we voted. The question really is what the Administration knew before the vote on the conference report surely, and what was not revealed to us. I just wanted to quickly go back over Mr. Thompson's testimony because there was an effort to kind of make Mr. Scully the scapegoat. You testified, Mr. Foster, that information was sent to the White House and to HHS; is that correct?

Mr. FOSTER. Not all of our cost estimates were sent but in a number of cases yes, we sent the estimates to them.

Mr. LEVIN. I asked Secretary Thompson, you knew your actuaries are estimating the cost far higher than CBO quite early on, well before we acted on the Medicare bill, right? You knew that? "We knew that the assumptions were higher." You were told that the amount was higher? "No, Mr. Levin," said Secretary Thompson. "We did not know the final amount because the final 2 days changed the complexity and the direction of the bill." Then I say no, no, but before that your actuaries were saying before the last couple of days that the amount was higher. The Secretary, "our preliminary estimates were higher, yes." My question, you passed that on to the White House? To somebody there? The Secretary, "we passed that on to"—and then I interjected, somebody in the White House knew what your actuaries were saying? The Secretary, "there were individuals in the White House who knew that ours, meaning the actuarial preliminary estimates, were higher, yes, based upon participation." That is the real issue here. Now the final estimate came later on but I think you testified, Mr. Foster, as to the key portions, for example, the difference in the take-up rate, the number of low income beneficiaries enrolled, that amounted to many billions. Those were not basically changed in the final bill, were they?

Mr. FOSTER. Our estimates, you mean, sir?

Mr. LEVIN. The basic material upon which you based your estimates. That material was known well before the final 2 days was it not?

Mr. FOSTER. Yes. Our estimates changed all along as the proposal itself changed, and we tried to keep up with it. The range of our estimates that we were in for the drug cost was typically $500 billion to $600 billion all the way through the process.

Mr. LEVIN. So, that difference cannot be simply attributed to the last 2 days. The difference between you and CBO was always substantial; is that not correct?

Mr. FOSTER. Yes, sir, that is correct.

Mr. LEVIN. So, I think, in a few words, there was a cover up of some basic information and it said the differences maybe were no big deal. Our having all of the facts are a big deal. We were not given them. We were not given those facts. The differential, while it somewhat shifted from time to time, was always there and it was always very, very substantial. We had the right to know. Not only the Administration. They have the right to tell us what they knew and they did not. They did not. It was not only Mr. Scully. Again, people in OMB were given your estimates?

Mr. FOSTER. Some of them, yes, sir.

Mr. LEVIN. People in the White House were given these assessments.

Mr. FOSTER. Some of the estimates, yes.

Mr. LEVIN. Also people in HHS?

Mr. FOSTER. Yes.

Mr. LEVIN. Thank you.

Chairman THOMAS. Does the gentle lady from Connecticut, the Chairman of the Subcommittee on Health, wish to inquire?

Mrs. JOHNSON. I would just note for the record that, Mr. Foster, you did earlier make very clear that the law allows Mr. Scully to control the flow of information and that is just the law. So, while you might not like it, that is where it was. Dr. Holtz-Eakin, did the Democrats ever submit their bill to you for estimation? To be estimated? Did they submit their alternative to you to be estimated?

Mr. HOLTZ-EAKIN. I am sure they submitted many bills. We can get the details for you.

Mrs. JOHNSON. We do have a letter back from you where you do estimate it as roughly $1 trillion. Mr. Foster, did the Democrats submit their bill to you to be estimated?

Mr. FOSTER. No, ma'am.

Mrs. JOHNSON. It is just interesting that, since you think CMS's opinion is so important, that you did not submit your bill to them to be estimated. So, let me just proceed on a couple of lines. First of all, Mr. Foster and Dr. Holtz-Eakin, I have enormous respect for not just you but the staffs behind you that work so hard on our behalf. I do say, Mr. Foster, that as a Member having to make judgments about your work, I have never seen 99 percent of any group do anything. So, to estimate that 99 percent would take up the drug benefit when only 91 percent elected part B, and that is for doctors visits, does seem to be distant from my experience of reality. Ninety-four percent take-up, but in a subgroup to get to the 94 percent you would have to get to 99 percent. So, being the author of the Children's Health Bill and finding out that when we

went out there to try to enlist children for this wonderful health insurance program what we found was enormous numbers of children not registered for Medicaid, which gave them free health care. So, it is very hard to get 99 percent in America to do anything, no matter how good the deal is. Certainly many think the prescription drug Part D benefit is not all that great and would not attract that kind of allegiance.

My point is this, the most controversial part of this bill was the expansion of the private plans. In June, in a memo that you did and that was made public, it was very clear—in fact, you say in that, our preliminary estimate is that about 48 percent of the beneficiaries will participate in HMOs and preferred provider organizations (PPOs). So, everybody had that and everybody knew that was big money. That is underneath this bill, the biggest, most difficult, and one of the most costly issues. So, there were big differences. It was well known you were looking at a number of these issues differently than was CBO, and frankly than were many of us. I thought it was really quite astounding that you came up with the higher estimate because there were going to be more Advantage plans rather than a lower estimate because the competition would be greater because you would have more plans. So, this business of estimating and the judgments involved is complex. Each of us comes to it from our own experience. I respect both of you. We need your work. We learn from your disagreements.

It does concern me that neither of you seemed to take very seriously the portions of the bill that really are going to change Medicare for people with chronic illness, and remember that is most seniors, from an illness treatment program to a preventive program. Now we see Kaiser Permanente making the decision to invest $3 billion. They are going to save $10 million the first year in Hawaii. The hospitals are going to have $6 million annually every year thereafter. Just the cost for medical errors cost our country $35 billion annually and we spend $5.4 billion in Medicare because tests that were taken cannot be gotten to the physician making the decision. So, if we go to electronic health records, if we go to electronic prescribing, that is going to have a big impact on costs. You see the private sector racing down that track at a pace not anticipated.

Last week we had a hearing on quality. Everybody is doing it out there. PacifiCare, in a group that was 90-percent elderly, reduced hospital rates for one group by 98 percent for coronary artery disease, reduced emergency room visits, and it goes on. I will not go through all four of them because I do not have time. Basically, it saved $195 million in just these four programs in a group that was mostly seniors. You look at studies that have been done for us in the journal Heart, they found that heart failure patients and disease management programs reduced hospitalizations 87 percent. I am just astounded that you could cost out every dollar we spent but you could not cost in dollars that we saved. When we have every senior coming into Medicare having a physical to identify early diabetes, hypertension, heart problems and we build in disease management programs it just sort of spins my head that you give us practically no credit for that, essentially no credit for that. In the private sector they are getting lots of savings from that. Un-

fortunately, I used all my time in explaining my question but it is all right because you did not give us the credit so that is that. People ought to understand that these estimates do not take into account the systems changes that we put in place in this bill and that, coupled with what the private sector has learned and is doing, is going to make an enormous impact on the cost. Thank you.

Chairman THOMAS. The answer is either yes or no. Does the gentleman from New York, Mr. Houghton, wish to inquire?

Mr. HOUGHTON. Thank you very much, Mr. Chairman. Gentlemen, nice to see you. I do not want to talk about any cover ups. I do not want to talk about the difference in estimation between the CMS and the CBO. I will ask a very, very simple question to you, Dr. Holtz-Eakin. In your testimony you talk about the union plans assessing the 28-percent employer subsidy provided in the new Medicare law. You are quite sure unions can receive this subsidy? What about the State retiree plans?

Mr. HOLTZ-EAKIN. The union plans can receive the subsidy. State retiree plans, I am not familiar with the provisions. I can certainly check and get back to you.

Mr. HOUGHTON. If you would, I would appreciate it. Chairman Thomas, I am very fast. End of questions.

Chairman THOMAS. The answer is yes, State retirement plans can receive the support, as well. The key was to keep those people in the programs they are in with a modest subsidy rather than assuming the full cost in whatever plan they were in, we believe they will remain in with a portion of the bill. Again, a coster, but no credit whatsoever on the assumptions about the dollar saved over a longer period of time, and so forth, and so forth. The gentleman from Georgia, Mr. Lewis, wish to inquire?

Mr. LEWIS OF GEORGIA. Thank you very much, Mr. Chairman. I want to thank the three members of the panel for being here. Mr. Foster, I want to ask you several questions. I want to thank you for being so responsive. For the record, someone may come along 5 years from now or 10 years or 50 years from now and say what was this all about. So, I am going to ask you some questions and I want you to answer them pretty short and fast so I can get them all in. How long have you been employed by the Federal Government?

Mr. FOSTER. A little over 31 years, sir.

Mr. LEWIS OF GEORGIA. What is your present position?

Mr. FOSTER. Chief Actuary for the CMS.

Mr. LEWIS OF GEORGIA. Mr. Foster, would you be kind enough to describe your role in this position? What do you do?

Mr. FOSTER. My office and I prepare all of the financial projections for Medicare and Medicaid, for the President's budget, and for the annual report to Congress that we are here for today. We estimate the cost of proposed legislation on behalf of the Administration and Congress. We do a number of functions involving current Medicare statutory requirements, such as setting the Part B monthly premiums, setting the Medicare Advantage payment rates, and setting the inpatient hospital deductible. We also set all the price indices that are used for updating Medicare payments like the Medicare economic index, the inpatient hospital market basket,

and so forth. I am sure I left out something important. We do the national health accounts, an estimate of the total spending on health care in all the United States.

Mr. LEWIS OF GEORGIA. Mr. Foster, do you enjoy your work? Do you enjoy your job? Is it a good job?

Mr. FOSTER. Most days, sir, yes.

Mr. LEWIS OF GEORGIA. How many people work under your direction?

Mr. FOSTER. Right now we have 70, sir.

Mr. LEWIS OF GEORGIA. They are good employees?

Mr. FOSTER. Yes, they are outstanding.

Mr. LEWIS OF GEORGIA. Let me ask you something else. Do you recall receiving an e-mail maybe around June 20 from the top aide to Mr. Scully? The e-mail said something like, do not share information with anyone else. The consequences for insubordination are extremely severe.

Mr. FOSTER. Yes, I remember that e-mail well.

Mr. LEWIS OF GEORGIA. When you received this e-mail, what did you do? What did you tell the people working with you? Did you say anything? Did you feel shocked?

Mr. FOSTER. That e-mail and the conversations that went with it put in place a new policy regarding assistance to Congress. We notified the office that we should no longer respond directly. Instead their requests and the responses had to come back to me and I would turn them over to Mr. Scully for disposition.

Mr. LEWIS OF GEORGIA. In all of your 30 years as an employee of the Federal Government or maybe in this particular work, have you ever received anything like this before?

Mr. FOSTER. No, nothing really quite like that.

Mr. LEWIS OF GEORGIA. I thank you for being so responsive and I thank you for being a good public servant. Thank you.

Mr. FOSTER. Thank you, sir. We try.

Chairman THOMAS. I thank the gentleman. The gentleman from California, Mr. Herger, wish to inquire?

Mr. HERGER. Thank you, Mr. Chairman. Mr. Foster, you had mentioned earlier that you were following the law; is that correct? We have precedent but we have the law and you were following the law. Therefore the directives you had through this e-mail were still following the law; is that correct?

Mr. FOSTER. Yes, sir.

Mr. HERGER. Dr. Holtz-Eakin, if I could ask you a question, please, just on the makeup of this legislation. The Medicare Modernization Act includes non-interference language that prevents the Secretary of HHS from interfering in negotiations between private plans and drug manufacturers. In your opinion, do you believe that private plans acting independent of the HHS Secretary will be able to effectively negotiate drug prices for seniors?

Mr. HOLTZ-EAKIN. Our estimate includes the fact that at-risk private prescription drug plans will have both the tools and the incentives to negotiate aggressively and to control costs on behalf of their beneficiaries.

Mr. HERGER. So, you feel that they will be able to effectively do that?

Mr. HOLTZ-EAKIN. Yes. In a letter we wrote in response to an inquiry from Senator Fritz, we indicated that removal of that language would not change the basic estimate of the bill.

Mr. HERGER. Would having the HHS Secretary involved in these negotiations result in lower prices, do you feel?

Mr. HOLTZ-EAKIN. If there were to be language which proactively stipulated that the Secretary enter into negotiations, it would depend on the particular circumstances in which that were to occur. In a separate letter to Senator Wyden on this topic, we did mention that in the cost of single-source prescription drugs, your classic blockbuster drug, and perhaps in fallback plans there might be some opportunity for the Secretary to negotiate price savings. In other circumstances, however, it did not appear to be the case.

Mr. HERGER. If the HHS Secretary were allowed to negotiate drug prices, is it not most likely the case that the Secretary would end up simply setting the prices as is done with the rest of Medicare, rather than truly negotiating these prices where we would tend to get a lower price?

Mr. HOLTZ-EAKIN. It is not possible to know without looking at the precise language and the authority that the Secretary was given in those kids of circumstances.

Mr. HERGER. Thank you. Thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentleman. The gentleman from Maryland wish to inquire?

Mr. CARDIN. Thank you, Mr. Chairman.

Mr. Foster, let me follow up on the information issue because I am, along with I think all Members of this Committee, quite concerned about information that did not get to Congress in time for us to consider it when we had to make policy decisions. Of course, that is where the actuarial information becomes important.

I understand correctly there was a very significant difference between your estimate on the number of Medicare beneficiaries that will participate in private insurance under Medicare versus what the CBO assumes will be participating in private insurance, a difference of between 12 percent and 32 percent approximately.

Mr. FOSTER. Yes, sir.

Mr. CARDIN. That difference has a dramatic impact on cost and could very well influence congressional action on how much additional funds we should make available to private insurance companies under the Medicare Program. Now if I understand correctly, you were instructed that this information, even though it had been requested by Congress, could not be made available directly by you to Congress but had to go through Mr. Scully; is that what happened?

Mr. FOSTER. Yes, any estimates or analysis that we prepared for Congress after about early June were to go through Mr. Scully. We had specific requests from the Ways and Means Democratic staff involving some of the competition in the Medicare Advantage provisions including the cost and any of those would have gone through Mr. Scully.

Mr. CARDIN. Are you aware of whether Congress was informed that this information was available but had to be gotten from Mr.

Scully? That there was a new policy in place? Are you aware that that was communicated to Congress?

Mr. FOSTER. I, myself, passed that information on to individual staff members when the question arose. I do not know if anyone in the Administration announced that more broadly.

Mr. CARDIN. Are you aware of whether any of that information, the information I am referring to on the basic differences between CBO and the actuaries on the cost estimates, whether that was in fact made available to Congress before we were called upon to act?

Mr. FOSTER. I would have to stop and think because, as I said earlier, we never had a final cost estimate for the Medicare Advantage provision until much later on.

Mr. CARDIN. I appreciate that. In your answer to Mr. Thomas's question, you indicated the final numbers were not available until shortly before Christmas. The assumption numbers, the number of participants, and so forth, that was available, was it not?

Mr. FOSTER. Yes, sir.

Mr. CARDIN. That was not made available to Congress?

Mr. FOSTER. In fact, that part of it was for H.R. 1 under a request we had from Mr. Thomas in early June. That is what, in fact, set off the change in policy.

Mr. CARDIN. So, now, I guess the frustrating part here is this; that this information should be made available to all of us for policy discussions. There was a radical change in policy that you were basically instructed to implement. Yet there was no effort made to inform Congress collectively, as an institution, that these policy changes were being made and no chance for Congress to, in fact, focus on that before we were called upon to act on a very important piece of legislation without having the full information before us from the actuaries. Is that not a fair statement?

Mr. FOSTER. I did my best to let folks know that in fact, I could no longer respond directly and that they had to talk to Mr. Scully on that. What happened beyond that, I am not aware of.

Mr. CARDIN. I thank you. I thank you for your testimony and for your straight answers here before our Committee. Thank you, Mr. Chairman.

Chairman THOMAS. Thank the gentleman. The gentleman from Louisiana wish to inquire?

Mr. MCCRERY. Yes. Thank you, Mr. Chairman.

Chairman THOMAS. Will the gentleman yield briefly to me?

Mr. MCCRERY. Yes, sir.

Chairman THOMAS. In the exchange that Mr. Cardin just had with you, in the terms of the information, was in fact the basis of the phone call that I made to you, reinforcing the fact that if, in your professional opinion, the answers you provided were the best that you could do, that I would support and defend your ability to do that. The same basic conversation I had during the Clinton Administration. I thank the gentleman.

Mr. MCCRERY. Dr. Holtz-Eakin, when was the CBO formed? When did it first come into existence?

Mr. HOLTZ-EAKIN. It was created by the Budget Act 1974 (P.L. 93–344) and began operating in 1975.

Mr. MCCRERY. Do you know why the CBO was created by Congress?

Mr. HOLTZ-EAKIN. At that time Congress was involved in a dispute with then-President Nixon regarding the impoundment of funds Congress had appropriated, a dispute that went to the U.S. Supreme Court. In the aftermath of that dispute, the Congress decided to have an independent ability to assess budgetary matters.

Mr. MCCRERY. So, in other words, Congress did not trust the Administration to come forward with estimates for legislation and other things, that they decided that they needed internally, so they created CBO?

Mr. HOLTZ-EAKIN. That is my understanding, yes.

Mr. MCCRERY. So, this is a long history of Congress wanting an independent source for all kinds of things, including estimates of the cost of legislation. In fact, Dr. Holtz-Eakin, is not Congress in its deliberations bound by the estimates of the CBO?

Mr. HOLTZ-EAKIN. In a formal sense it is bound by the decisions of the budget Committees to which we deliver our estimates and whose Members are the ultimate arbiters of cost estimates.

Mr. MCCRERY. In fact, section 308 of the Congressional Budget Act establishes the CBO as the scorekeeper for Congress, does it not?

Mr. HOLTZ-EAKIN. Yes, it does.

Mr. MCCRERY. When we say the scorekeeper, we mean you are the one who has to give us estimates of the cost of bills and it is those estimates on which we much rely; is that not correct?

Mr. HOLTZ-EAKIN. We are obligated to deliver estimates to the Congress. There is the possibility for directed scorekeeping, which alters the official reported score.

Mr. MCCRERY. So, bottom line, we have had estimates in the past from OMB which collaborated with CMS or the Health Care Financing Administration or any number of other government agencies. While some have attempted to use those numbers, sometimes Republicans and sometimes Democrats, for our own political purposes, the fact of the matter is when we are deliberating on legislation in Congress we are bound by the Budget Act to consider the estimate of the CBO in terms of sticking within the budget that we have passed; right?

Mr. HOLTZ-EAKIN. That is the tradition, yes, sir.

Mr. MCCRERY. I would submit that it is the law under the Congressional Budget Act.

Mr. HOLTZ-EAKIN. It is a fine point. We are forced to deliver an estimate. I would pray that you would respect it enough not to change it, but there is the opportunity for them——

Mr. MCCRERY. Certainly, we can pass a law to disregard the estimate, that is true. The law that is on the books says we have to abide by the estimates of CBO when dealing with the budget. So, that is what we did in the case of the Medicare bill. That is what we do in the case of every bill that we consider. If it is a tax bill, obviously the Joint Committee on Taxation does the estimate, but even that comes through the CBO. So, we are bound by that CBO estimate. Now let us get to the substance of the Medicare bill because some have said that this Medicare bill we passed will not do seniors any good, it will not help anybody. In fact, it may even be the end of Medicare. Well, we have one estimate of $395 billion, another of $535 billion or $550 billion, or whatever it is, so evidently

we are spending money on somebody in the next 10 years. I will ask both of you, Mr. Foster and Dr. Holtz-Eakin, in your professional opinion, will the private plan market for a prescription drug benefit proposed by the legislation in fact be in place in 2006? Mr. Foster?

Mr. FOSTER. We believe that it will. We believe there will be interest in this market.

Mr. MCCRERY. Dr. Holtz-Eakin?

Mr. HOLTZ-EAKIN. Yes, we believe it will, as well.

Mr. MCCRERY. In your professional opinion, will the vast majority of Medicare beneficiaries choose to enroll in this drug benefit? Mr. Foster?

Mr. FOSTER. They should because it is a good deal for them and if they wait they will be hit with a late enrollment penalty. So, they should.

Mr. HOLTZ-EAKIN. Our estimate indicates that 87 percent of eligible seniors will take it up.

Mr. MCCRERY. Will significant numbers of low-income individuals elect to enroll in the low-income subsidies which provide comprehensive drug coverage with no gaps in coverage for up to only $5 per prescription? Mr. Foster?

Mr. FOSTER. Yes, sir. We anticipate the great majority of such folks will take advantage of the low-income subsidy.

Mr. HOLTZ-EAKIN. Likewise, we anticipate that.

Mr. MCCRERY. Thank you very much, gentleman. Thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentleman. The gentleman from Michigan wish to inquire?

Mr. CAMP. Thank you, Mr. Chairman. As my colleague mentioned, the CBO was formed under the 1974 Budget Act to give Congress an independent agency to evaluate the costs of legislation. Mr. Holtz-Eakin, I wonder if you could tell me if the estimate for the Medicare Modernization bill was provided to Congress in November of last year; is that correct?

Mr. HOLTZ-EAKIN. The final cost estimate on the bill was delivered shortly after passage.

Mr. CAMP. Shortly after passage. That was at $395 billion from 2004 to 2013; is that correct?

Mr. HOLTZ-EAKIN. That is correct.

Mr. CAMP. Since the time of that estimate and in the intervening release of the CMS data, has this caused you to change your estimate—or not you personally. Has this caused CBO to change the estimate?

Mr. HOLTZ-EAKIN. No, it has not.

Mr. CAMP. Have any of the assumptions underlying the estimate changed since that time?

Mr. HOLTZ-EAKIN. In the course of preparing our baseline estimates of the outlays in the Medicare Program, we have revisited each aspect of the bill. We have made a modest adjustment in the participation in the Medicare Advantage plans but the adjustment had no budgetary consequence.

Mr. CAMP. So, the budget estimate is the same as it was in November of last year?

Mr. HOLTZ-EAKIN. Yes, it is.

Mr. CAMP. I understand that CBO projects that spending on Medicare and Medicaid combined will total $6.9 trillion from 2005 through 2014; is that correct?

Mr. HOLTZ-EAKIN. I do not know the number off the top of my head but it sounds right.

Mr. CAMP. Obviously your estimate of $395 billion for the Medicare Modernization bill affects both Medicare and Medicaid, represents less than 6 percent of this amount. The Administration's estimate at $534 billion represents less than 8 percent of this amount. Is it fair to say whether the final estimate of the bill is $395 billion or $534 billion that the total amount of spending is really only a small portion of the overall spending on Medicare and Medicaid over the next decade?

Mr. HOLTZ-EAKIN. I think that is a fair assessment of the overall contribution and I certainly want to take this opportunity to say that, while we believe we have made a good faith effort to estimate the cost of the bill, we certainly recognize that the final cost could be higher. It could also be lower. It is our attempt to place it in the middle of the plausible range.

Mr. CAMP. On that point, CBO scored the 10-year cost of the initial preventive measures in this bill, the physical, the cardiovascular screening tests, the diabetes screening tests, the lower copayments for diagnostic mammograms in the hospital outpatient setting, that estimate was at $2.2 billion, that that would actually cost money, these preventive programs. The CMS was very close to that, scoring those same provisions at about $2.3 billion over 10 years. So, both organizations estimated that these costs would increase Medicare's costs over time. Yet there are benefits from early detection and treatment of disease and the provision in the bill was designed to detect diseases before they reached later stages which are more expensive to treat. Did any assumption of savings to Medicare over time due to earlier detection and treatment of diseases occur in your estimate?

Mr. HOLTZ-EAKIN. I can go back and consult with my staff on the details of that piece of the legislation. I do know that we have had a great deal of effort placed internally on surveying the research on the degree to which one can find cost savings in the future from outlays in the present in this area. One of the difficulties is that many of these savings do not show up in the score of the bill because the activities are already occurring in the baseline and what shows up as a new additional preventive activity that will produce new additional savings is what gets scored. If there are activities on prevention going on in the baseline, they simply get transferred to the Federal budget. We can get back to you on the details and continue to refine our estimates.

Mr. CAMP. I would appreciate that. Thank you very much. Thank you, Mr. Chairman.

[The information is pending.]

Chairman THOMAS. Thank the gentleman. The gentleman from Massachusetts wish to inquire, Mr. Neal?

Mr. NEAL. Yes, thank you, Mr. Chairman. Mr. Holtz-Eakin, did you say that the final number on the prescription drug bill was not offered until after it had been enacted?

Mr. HOLTZ-EAKIN. We provided estimates regularly throughout the year to both the House and the Senate and both parties. When the conference bill was passed, we produced a 67-page cost estimate detailing the underpinnings. We worked with the Committees to provide updates as they contemplated alternatives. With the passage of the final bill and the receipt of final language, we put out a short cost estimate and we also, at that point, began to put it into our baseline estimates of the cost of Medicare.

Mr. NEAL. So, actually after it was passed you gave a final number?

Mr. HOLTZ-EAKIN. Yes.

Mr. NEAL. Here is part of the problem, I think, that we confront today. This is a follow-up to a couple of earlier assertions that were offered by the other side. I suspect part of this is due to the aggrieved minority here. General Shinseki said that what was being offered to the American people in terms of troop assessments was not accurate. Lawrence Lindsey said that the war in Iraq was going to cost $200 billion to $300 billion. He was fired. General Shinseki was dismissed. We have an Energy Task Force that we are going to have to go to the Supreme Court now so that the public can find out what actually went on inside of those deliberations with the Vice President. Mr. Wilson is set to determine whether or not Niger provided enriched uranium to the Iraqis and his wife is outed as a Central Intelligence Agency agent. We are told there were weapons of mass destruction. There were no weapons of mass destruction apparently. For months we were told there was a link between Iraq and Al Qaeda. The Vice President kept it up after the President said there was not.

The ballot box in the House of Representatives is kept open at 3:00 a.m. in the morning until 6:00 a.m. in the morning to vote on a bill that we now know we did not have accurate numbers to assess the cost of. Television advertisements are utilized here to sell a bill to the American people for which there were faulty assumptions. An actuary, actuaries we all have great respect and regard in this system, people like you sitting here as witnesses. We have the highest regard for you. There are people like myself who beat people up on that side of the table over the Clinton health care bill and then opposed it because we did not get the right numbers. That never happens on the other side in this institution. You give them the wrong numbers, they go along with it. They offer incentives to a Member on the floor to vote for the bill, even with a faulty cost estimate. People wonder why we get upset on this side for the manner in which the minority is treated.

Now one thing I want to say about Chairman Thomas, I know he would not accept false numbers from either side in the Administration. He has that reputation around here. I do know that if he were given faulty numbers he would have said something. The truth is we all know this today, that we were given faulty numbers and then told, or professionals were told not to give us the real numbers. Then we hear this argument today, well, you could be far off in your estimates. I understand that. There is a pattern here that has been offered to the American people for months now about what they should know and what they should not know. That is a very troubling aspect of this debate. I thank the Chairman.

Chairman THOMAS. Thank the gentleman from Massachusetts. The gentleman from Missouri, Mr. Hulshof, wish to inquire?

Mr. HULSHOF. I appreciate it, Mr. Chairman, and I appreciate the gentleman from Massachusetts making the political points. Let me come back and say specifically——

Mr. NEAL. Would the gentleman yield?

Mr. HULSHOF. The faulty——

Mr. NEAL. Those are policy points, Mr. Hulshof. Those are not political points. All of the things that I described happened.

Mr. HULSHOF. Well then let me get directly to the policy.

Chairman THOMAS. The gentleman from Missouri has the time.

Mr. HULSHOF. The quote was from you, faulty cost estimate? Did I state correctly? Faulty cost estimate, is that right? Mr. Holtz-Eakin, on November 20th of 2003 did you write a letter to the Chairman of this Committee in essence saying that the Medicare Modernization Act would cost $395 billion over the 2004 to 2013 period?

Mr. HOLTZ-EAKIN. Yes, I did, and I want to thank you for the chance to make the record correct. The cost estimate was available prior to the vote.

Mr. HULSHOF. You also reiterated, "CBO has not had an opportunity to review the final legislative language and this estimate could change upon completion of that review." Do you remember putting that in this letter to the Chairman?

Mr. HOLTZ-EAKIN. Yes, we are always careful to make sure that we do not pin down an estimate until we see the final legislative language.

Mr. HULSHOF. After the final legislative language was enacted into law, signed by the President, somewhere in that course of legislative activity, your office went back and refigured to see whether or not you were confident in the cost estimate that the CBO gave to this body. Is it not a fact that you stand by that $395 billion cost estimate today just as you did on November 20th, 2003?

Mr. HOLTZ-EAKIN. Yes, I do.

Mr. NEAL. Would the gentleman yield?

Mr. HULSHOF. I see nothing faulty about that cost estimate, Dr. Holtz-Eakin. Now maybe that is just my perspective as a Member on the lower dais, not from Massachusetts, but certainly one that appreciates that Congress—and no disrespect intended, Mr. Foster—but Congress, our official scorekeeper is you, Dr. Holtz-Eakin. The CBO. Now I think it ironic that we have heard today this haranguing—and I respect the fact that information from whatever source is important, especially because as Mr. Stark said, we are not actuarial scientists. So, we rely upon you. To suggest that this $534 billion figure would somehow have caused the other side to come on board? Is that the suggestion? We have heard these complaints and criticisms that this bill, H.R. 1, was not generous enough. So, suddenly are we to believe that if this higher number of $534 billion were, in fact, our official number, that somehow we would have had some additional support on the other side of the aisle? I think that is ludicrous to even suggest it.

To me, the point is among some—not all, and Mr. Neal is a friend and I am not specifically throwing this in your direction, Mr. Neal, and I will yield in a second. Without question we have heard

the words cover up. We have heard an effort to score political points. So be it. It is an election year. To me the real story of today is not these partisan attacks or this issue of credibility and going into the discussion of Niger, about Medicare. The point is the headlines should read, "Medicare, Social Security going bust if Congress fails to act." That, to me, is the headline. I will yield briefly to my friend because I want to get to some questions on the actuarial numbers on the bigger issue, not the political issue. Mr. Neal.

Mr. NEAL. I believe, Mr. Foster, you are an actuary, are you not?

Mr. FOSTER. Yes, sir.

Mr. NEAL. That was my point, that the actuary is the one who came back to us with a long career of distinction, in offering numbers. The President uses the $534 billion mark in his budget.

Mr. HULSHOF. I accept that, Mr. Neal.

Mr. NEAL. That is not a political point. Mr. Hulshof, there is nothing wrong with coming from Massachusetts.

Mr. HULSHOF. There is nothing wrong with Massachusetts, Mr. Neal. It is one of the great 50 states. I would say to the gentleman that somehow talking about yellow cake in Niger and how it relates to this "faulty cost estimate" I think to be a bit of a stretch. Nonetheless my time is running short. Simply to me the real issue here, Mr. Goss, is exactly why you are here. Let me just say this because I know time is short and I wanted to get actually to—and I see the light has just gone. Very quickly, the effect of economic growth on Social Security's finances, the myth out in Missouri—perhaps not in Massachusetts where people are much more sophisticated, Mr. Neal—I say that tongue-in-cheek—is can we grow our way out of this problem or is this an actuarial demographic reality that we have to come to grips with here on Capitol Hill? Mr. Goss, that is the only question I get to ask, and if you could answer it briefly.

Mr. GOSS. Thank you very much. As we indicate in the sensitivity estimates provided in the Trustees' Report there would be a positive effect on the financial status of Social Security if we had stronger real wage growth. In our judgment, it would be fairly modest and it is hardly unlikely that there could be a sufficient increase in economic growth to make a substantial difference.

Mr. HULSHOF. What a great actuarial answer. I appreciate that and I yield back my time.

Chairman THOMAS. I thank the gentleman. The gentleman from Tennessee, Mr. Tanner, wish to inquire?

Mr. TANNER. Thank you very much, Mr. Chairman. I think the real issue here is was there a willful, deliberate withholding of information from Congress about a bill pending of such magnitude, regardless of whether one agrees with the methodology used? Was there a withholding of pertinent information that may have been helpful? Let me ask you this, Mr. Foster, during your career has there been any time other than this incident where you have been unable to communicate with the Members of Congress or the Committees of jurisdiction?

Mr. FOSTER. Yes, sir, on rare occasions.

Mr. TANNER. Let me ask you further then, I have read the excerpts from the Balanced Budget Act 1997 (P.L. 105–33) that give

to you and your office—I will just read the terms. While the Chief Actuary is an official within the Administration, this individual and his or her office must often work with the Committees of jurisdiction in the development of legislation. It goes on to talk about the tradition and also that the conferees consider independent analysis to be consistent with your duties and so forth. Were you aware of this language last June?

Mr. FOSTER. Yes, sir, I was. I called that language to the attention of Mr. Scully and others.

Mr. TANNER. What were you told in that regard?

Mr. FOSTER. The polite version was that the conference language meant nothing.

Mr. TANNER. I think every Democrat and Republican alike on this Committee ought to be outraged at the willful, deliberate, and I would say sinister withholding. Regardless of whether you agree with the methodology or the numbers. That is beside the point. When we write these conference reports, we expect them to mean something, I would hope. I do not care whether it is a Democrat or Republican Administration. We have three separate but equal branches of government in this country. If we ever lose sight of that fact we are in a whole lot more trouble than who is right and who is wrong in terms of the numbers in this situation. So, Mr. Chairman, I appreciate this. Maybe if it means nothing to the people that were there last summer, maybe we ought to rewrite it in the law. Thank you.

Chairman THOMAS. I thank the gentleman. As the author of that language it meant something to me in 1997 when an Administration tried to stifle him and it means something to me today. The fact that we are having this hearing and providing this information on the record, I think, is evidence of that. The gentleman from California, Mr. Becerra, wish to inquire?

Mr. BECERRA. Thank you, Mr. Chairman. Thank you to all the witnesses for your testimony, especially the candor with which you have given us that testimony. We appreciate that very much. Mr. Foster, let me see if I can ask you to clarify a few things as we go forward in this discussion about the estimates and the process that went forward in the passage of the Medicare bill. You mentioned that you had conversations with folks at CMS including Mr. Scully about your projections and you mentioned as well that at one point you had a conversation with an attorney at CMS who advised you that Mr. Scully did have the authority to keep you from disclosing some of that information to Congress. Do you recall the name of that attorney you spoke to?

Mr. FOSTER. Yes, sir. That was our, at the time, Acting Deputy Administrator Leslie Norwalk.

Mr. BECERRA. What was that name?

Mr. FOSTER. Leslie Norwalk.

Mr. BECERRA. The gist of that directive was that Mr. Scully had the authority legally to preclude you from disclosing that information. Did she give you which law she or Mr. Scully referenced to say that the authority existed for them to prevent you from disclosing that information?

Mr. FOSTER. She might have, although I do not think so. I do not remember for sure. This hinged more on the question of constitutional separation of powers.

Mr. BECERRA. I know it was a while ago perhaps that you were told this by the attorney. Can you paraphrase as best you can or can you tell us again what it was she told you that indicated that the law gave Mr. Scully that authority to keep you from disclosing that information?

Mr. FOSTER. The general argument was that with separate branches of government, obviously a congressional and an executive branch, the congressional branch has its own scorekeeper, CBO of course.

Mr. BECERRA. So, it seems to have been related to the separation of powers?

Mr. FOSTER. Yes, sir.

Mr. BECERRA. You mentioned in your earlier remarks that others in the Administration, I do not know if you said requested or received your estimate for the cost of the Medicare bill. Did you say requested or received?

Mr. FOSTER. I probably said both at one time or another.

Mr. BECERRA. Do you recall who requested that information from the White House?

Mr. FOSTER. We had requests for the overall package cost estimate both from Mr. Scully and from Mr. Badger.

Mr. BECERRA. Mr. Badger?

Mr. FOSTER. In the White House.

Mr. BECERRA. Anyone else at the White House?

Mr. FOSTER. I do not believe so.

Mr. BECERRA. I believe you testified that Mr. Badger did receive that information?

Mr. FOSTER. Early on, when we all had only rough estimates for a package cost back in June, I know that information was sent both to Mr. Scully and to Mr. Badger.

Mr. BECERRA. Anyone else at the Administration that you can think of that, to your knowledge, received the information about the cost of the Medicare bill, your projected cost of the Medicare bill.

Mr. FOSTER. Again early on, as I think I mentioned before, Mr. Capretta at the OMB and Ms. Young at HHS.

Mr. BECERRA. What was the name at OMB?

Mr. FOSTER. Jim Capretta. Later on in the process, when we were closer to having a final estimate for the conference agreement, I had a conversation with Mr. Scully telling him the rough magnitude of the estimate.

Mr. BECERRA. Was this before the bill had passed Congress?

Mr. FOSTER. It was about 2 to 3 weeks before the final vote. I do not know if he passed that on to anyone else.

Mr. BECERRA. Is it still your intention to remain as Chief Actuary at CMS?

Mr. FOSTER. I have had more second thoughts lately, I suppose, but yes. We have many initiatives underway that I would like to see through.

Mr. BECERRA. I know that this has probably been a very challenging time for you over the last several months, major legislation,

a lot of duties have been asked of you as well as the other individuals who are here with monumental programs that are critical to the American public. We appreciate what you have done. So, the next question I ask, and I ask you just to give me your own personal opinion. Do you believe you performed professionally in your capacity as Chief Actuary at CMS?

Mr. FOSTER. You are talking about last summer when all this came up, or in general?

Mr. BECERRA. At any time that you have been Chief Actuary. At all times do you believe you have performed professionally as the Chief Actuary for CMS?

Mr. FOSTER. I believe I have and I am aware that last summer was a difficult call. I will think about that one for a long time to come.

Mr. BECERRA. I thank you for the candor. There is an article in today's Hill newspaper that is titled "Bush takes offensive on Foster," by Mr. Bob Cusack. It states—I will just read it and ask a quick question since my time has expired and the Chairman is being gracious. It starts off rattled at the controversy over Medicare scoring shows no sign of waning. The Bush Administration has shifted strategies and now is going after the actuary at the center of what some have called Scoregate. It goes on to mention that at one point Tom Scully—there are at least reports that Tom Scully may have threatened to fire you if you disclose this information. Can I ask one quick question here, and that is, do you feel threatened in your job at this stage?

Mr. FOSTER. No, sir.

Mr. BECERRA. Thank you very much. Thank you, Mr. Chairman.

Chairman THOMAS. Certainly. The gentleman from Washington, Mr. McDermott, wish to inquire?

Mr. MCDERMOTT. Thank you, Mr. Chairman? Mr. Foster, I was on the Budget Committee when they announced that we were going to spend $400 billion for the pharmaceutical benefit. We asked at that time for the parameters. What were the assumptions made about that $400 billion. It became pretty clear to at least us on the Committee who were not made privy to what was going on that they just plucked a number out of the air and put $400 billion into the budget. Did you ever see the assumptions made for that $400 billion number? Did they ever submit those to you and ask you what your estimate was?

Mr. FOSTER. If I remember correctly, Representative McDermott, the $400 billion showed up early on. This predates 2003.

Mr. MCDERMOTT. Yes, it does. It was in the 2002 era.

Mr. FOSTER. In 2003, in the development of the President's framework for Medicare reform, my office had estimated quite a number of packages that would have had a cost of about $400 billion. None of them were ultimately proposed specifically only the more general framework.

Mr. MCDERMOTT. So, you had done a $400-billion package, this is what you can buy for $400 billion?

Mr. FOSTER. Yes, sir.

Mr. MCDERMOTT. So, when they went through the machinations here in the Congress and they wrote the bill in the Conference Committee without the Democrats there, did you know what assumptions they had changed from what you had done previously with your $400 billion package?

Mr. FOSTER. Well, there were many differences in the proposals themselves, compared to the specific illustrative packages we had done for the President early on.

Mr. MCDERMOTT. Could you help us understand how they—I mean, you had given them a way to give a $400 billion package. Apparently it was not sufficient or was deficient somewhere. They added things into it. Did you create the doughnut hole? Was that your idea?

Mr. FOSTER. No, sir, I will take no credit for that one.

Mr. MCDERMOTT. So, you gave a proposal for $400 billion that would have been across the year and people would not have this huge gap?

Mr. FOSTER. No, the doughnut hole goes back years. If you want to go back much earlier back in the Clinton Administration, there was consideration given to a drug benefit, what the design would look like. We were asked for advice. For so much money what could you do? We recommended a catastrophic only coverage, in that regard, using standard classical insurance principles. Of course, with a catastrophic coverage relatively few beneficiaries actually get anything out of the benefit. There was a policy desire to have more people favorably affected, to get something out of the benefit, which meant more up front coverage. When you take the combination of that desire together with a limited availability of money to fund it, that is what led to someone, not me, inventing the doughnut hole.

Mr. MCDERMOTT. So, they just used an old idea. That is really what they put together. They took your $400 billion package and put it in the waste basket and went back and said let us do a catastrophic program and some up fronts so we can attract some votes.

Mr. FOSTER. I am not sure who the "they" is in your sentence.

Mr. MCDERMOTT. It has to be the Republicans because we were not there. They never invited us to the meetings. So, the Conference Committee, when they did that, did they come out of that Conference Committee and hand you all of their assumptions and say this is what we have? Or did they say this is how much money we spent?

Mr. FOSTER. Well, early on in the development of the legislation, of course, there was the Senate Finance version, there was the Ways and Means Chairman's mark. If I remember correctly both of these, because of the cost constraints, had the doughnut hole in the drug benefit formula. I think that idea stayed all the way through the conference. There was a lot of interest along the way in whether something could be done to eliminate the doughnut hole without having the costs explode. Nobody found a solution to that.

Mr. MCDERMOTT. So, what set of assumptions did you do your whatever it is, $550 billion or $539 billion estimate? What assumptions did you use? The same ones they did, and just found more expense?

Mr. FOSTER. Yes, sir. You say assumptions but I am hearing specifications for the proposal. We had access, not quite as quickly as CBO did, but we had access from time to time to the conference agreement as it was being developed. We tried to estimate for those specifications such that in the end our package estimate of $534 billion reflected the final benefit formula from the conference, the $250 deductible, the $2,250 initial coverage limit, the 25-percent coinsurance, all of the above.

Mr. MCDERMOTT. The Conference Committee did not have that estimate when they moved it out? They did not know what your estimate would be?

Mr. FOSTER. I do not know if the conferees had that or not. We had given the information to Mr. Scully.

Mr. MCDERMOTT. Thank you. Thank you, Mr. Chairman.

Chairman THOMAS. Certainly. Does the gentleman from Texas wish to inquire?

Mr. BRADY. Yes, Mr. Chairman.

Chairman THOMAS. Would the gentleman yield briefly?

Mr. BRADY. Yes, sir.

Chairman THOMAS. Mr. Foster, is your responsibility under the law the same as Dr. Holtz-Eakin's?

Mr. FOSTER. No, I would not say so, in general.

Chairman THOMAS. So, the questions that Mr. McDermott asked you about whether you were provided with information at each step along the way to do estimates really is not your job. It is Mr. Holtz-Eakin's job, is it not?

Mr. FOSTER. That is true.

Chairman THOMAS. So, the fact that you did not receive those estimates is not some surprise, since it has never worked that way. That in fact, as was established earlier in testimony, that for a bill to come out of Committee, the CBO has to score it. For each change that is made the CBO has to score it. Do you have to score it?

Mr. FOSTER. No, sir. We respond to requests. If you or anybody else seeks our assistance, we try our best to respond.

Chairman THOMAS. My understanding is that under the law in the administrative branch, that information flows through responsible administrators and they make that decision; is that correct? As your description of the law was conveyed to you by the attorney?

Mr. FOSTER. I believe that is a great description of the law, not necessarily the past practice for many years.

Chairman THOMAS. I understand that and that is another reason why I have made phone calls to you periodically, bucking you up as it were, in terms of your professional responsibilities and our desire for the information, whether that Administration is Democrat or Republican. The gentleman from Texas, thank you for yielding.

Mr. BRADY. Thank you, Mr. Chairman. Mr. Foster, I wish your information would have been made public at the time. I think while I am very comfortable with the CBO's scoring, I think it would have been helpful to the public debate to hear your view that this plan was more attractive and helpful for our poor seniors and that more of our other seniors would have chosen this plan than perhaps had been estimated. I think that would have been

good for the debate to have that. Let me ask you, as far as the CBO scoring, in your view was the CBO estimate fraudulent?

Mr. FOSTER. No, sir, not even remotely.

Mr. BRADY. No, not even remotely?

Mr. FOSTER. That is correct.

Mr. BRADY. Was the CBO scoring an intentional misrepresentation of this bill?

Mr. FOSTER. I am convinced it is not.

Mr. BRADY. You are convinced it is not. Would you characterize the scoring by CBO as an honest interpretation of a very complex bill or something to that effect?

Mr. FOSTER. Yes, sir.

Mr. BRADY. Thank you. I think this is important because we get two or three estimates for many of our bills. We, by law, have to choose CBO. I am comfortable with that. I think this really gets to the heart of the debate today. Let me ask you, as long as you are using your actuarial skills and expertise, today I heard a number of comments and read them, some even by Senator Kerry of Massachusetts, that blame President Bush and his tax relief for the declining state of Medicare. Yet the Medicare Hospitalization Fund is paid for by payroll contributions and the President's tax relief had nothing to do with payroll contributions. The claim that President Bush's tax relief has accelerated the insolvency of the Medicare Hospitalization Fund, is that an accurate—in your actuarial expertise is that accurate?

Mr. FOSTER. There is a relatively minor interaction. Some of our income is from income taxes paid by Social Security beneficiaries on their Social Security benefits. If the marginal tax rates change that can affect our revenue from that source. I would consider that only a fairly negligible impact on the HI Trust Fund.

Mr. BRADY. So, the answer is for the most part it is not very accurate?

Mr. FOSTER. Yes, sir.

Mr. BRADY. It is not very accurate. The Medicare plan has been claimed, that Congress passed, accelerate financial insolvency of Medicare by 2 years is the estimate of the Trustees' Reports. The Democratic plan, promoted by many of the Ways and Means Members here today on the opposite side, was much larger than the plan that we passed. Is it accurate to say that the Democrat Medicare plan, with the higher cost, would have accelerated the insolvency of Medicare when compared to the Republican plan that was passed?

Mr. FOSTER. It would depend entirely on how the cost was financed, sir. I do not remember the specific provisions and how that would happen.

Mr. BRADY. Just for the record, it was financed much as the current one was. I appreciate, I think it is important to note today that the CBO scoring was an honest one, that President Bush's tax relief has not accelerated or changed Medicare in any way, and that the Republican plan was in fact much lower than the Democratic plan that was debated. Thank you, Mr. Chairman. I yield back the balance of my time.

Chairman THOMAS. I thank the gentleman. The gentleman from Texas, Mr. Doggett, wish to inquire?

Mr. MCDERMOTT. Thank you. Thank you very much for your integrity, sir. No one has suggested that the work of the CBO was fraudulent. What is fraudulent is willful interference with your professional judgment, secreting and hiding critical information, and willful disregard of the Congressional Budget Act. The question I would have to you is to be sure I am clear, Mr. Foster. Tom Scully had your best professional judgment as an independent actuary that the true cost of this Medicare bill would far exceed the $400 billion ceiling that the Bush Administration had established. You gave him that information last June?

Mr. FOSTER. For early versions of the legislation last June and then for later versions from time to time.

Mr. DOGGETT. You gave the same information to Doug Badger, the top White House official who occupies a position at the White House similar to Condoleeza Rice on security matters, he is the top health official who briefs President Bush. He had that information that the Administration's bill exceeded the cost of $400 billion by about a third from you back in June of last year?

Mr. FOSTER. Yes, the information back in June, that is correct.

Mr. DOGGETT. You provided the same information to the top health official at the OMB, the top legislative health secretary or acting secretary at HHS. You made that information widely available to the Bush Administration last June. Let me ask you if you have become aware through any source whether any Members of Congress or any members of the staff of this Committee or any other congressional staff gained access to your estimates before this near all-night session of the House that it took to cajole enough people to pass the bill?

Mr. FOSTER. I really do not know who had access to it, sir.

Mr. DOGGETT. You did discuss, you have indicated and the Chairman has indicated, participation rates with him for certain aspects of the plan last June, did you not?

Mr. FOSTER. Yes.

Mr. DOGGETT. I believe Mr. McManus, with his staff, had one of the additional requests for estimated participation rates and that you were told you would be fired if you provided it?

Mr. FOSTER. That is correct.

Mr. DOGGETT. Those participation rates are the building blocks from which you get the cost estimates, are they not?

Mr. FOSTER. Yes, sir.

Mr. DOGGETT. So, it is not just idle academic concern. If someone knows there is a great variance in participation rates, then it does not take a very bright person to recognize there is going to be a great variation in the cost; correct?

Mr. FOSTER. Other things being equal, yes, sir.

Mr. DOGGETT. You also testified that you attempted after these threats to fire you to discuss—I believe your words were attempted to discuss with other members of the Administration the demands that had been placed on you to secret what you considered important and vital information for the Congress to have but which Mr. Scully's improper order denied you the right to submit. Would you identify each of the individuals in the Administration with whom you discussed this problem and their titles?

Mr. FOSTER. Sure. Following the blow up involving Mr. Thomas's request, Scott Whitaker, who is the HHS Chief of Staff, called me to express concern and support both from himself and on behalf of Secretary Thompson. We discussed the issue about the provision and what steps we could take to improve the situation. In addition, a few weeks after that Peter Urbanowitz, who at the time was the Deputy Director of the Office of the General Counsel at HHS, called similarly to express support and to help figure out what could be done.

Mr. DOGGETT. You responded to Mr. Tanner with regard to Mr. Scully's comments on the responsibility as reflected I believe in the language that accompanied the Budget Act. Could you tell the Committee as best you recall what Mr. Scully's words were with regard to that subject?

Mr. FOSTER. In various discussions, going back as far as June 2001, about the role of the Office of the Actuary in providing assistance to Congress, technical assistance, I had tried to make the case with Mr. Scully that you all valued this, using as one piece of evidence the conference language from the Balanced Budget Act where it is fairly clearly laid out what the expectations are and the value placed on that. I also tried just the logical argument that the Nation's top policymakers should have the best information available. When I say that I do not mean that the CBO information is not good. It is very good. There are many situations where CBO might not have been in a position to do a special analysis because of their other workloads or, in some rare cases, we might have a special expertise to make a contribution if requested. So, we had these discussions, or I had these discussions with Mr. Scully. He is not an easy person to have a discussion with.

Mr. DOGGETT. I have found that to be true, also.

Mr. FOSTER. So, he generally was not interested in what was in the conference language. He did early on want to maintain good relations with Congress and from June 2001 to June 2003 we had a system in place where we could respond directly to your requests.

Chairman THOMAS. The gentleman's time has expired.

Mr. DOGGETT. I just want the answer to the last question. What were Mr. Scully's words about the conference report, as best you recall them?

Mr. FOSTER. I think, on at least one occasion his exact words were unprintable. I certainly would not want to repeat them in this setting.

Mr. DOGGETT. Were unprintable?

Mr. FOSTER. Yes, sir.

Mr. DOGGETT. Thank you.

Chairman THOMAS. The gentleman from Texas, Mr. Sandlin, wish to inquire?

Mr. SANDLIN. Thank you, Mr. Chairman. Thank you, Mr. Foster, for coming today. Mr. Foster, I have very few questions about the cover up. I think that has been covered in great detail. You did say, in transmitting this information, or failing to transmit the information, you felt you were following the law; is that correct?

Mr. FOSTER. As best I understood it, yes, sir.

Mr. SANDLIN. Whether it was legal or not you felt it was improper to withhold that information, did you not?

Mr. FOSTER. Yes, sir.

Mr. SANDLIN. You felt like that was not ethical, did you not?

Mr. FOSTER. Yes.

Mr. SANDLIN. Let me ask you, did the enactment of the Medicare reform legislation in any way reduce the solvency of Medicare part A, the HI Trust Fund?

Mr. FOSTER. Yes, sir. We have estimated that the impact of the higher payment rates to managed care plans and to rural providers in the part A Trust Fund advanced the date of depletion by 2 years.

Mr. SANDLIN. By 2 years. So, a part of that, as you just indicated, was due to the payments to HMOs and PPOs; is that correct?

Mr. FOSTER. Yes, sir.

Mr. SANDLIN. So, giving money to these HMOs and PPOs, this private group, contributed to the lack of solvency in the Medicare Trust Fund; correct?

Mr. FOSTER. Contributes to the earlier depletion, yes, sir.

Mr. SANDLIN. Was there ever or is there ever a point in your modeling of this law in which you show a savings due to the managed care plans?

Mr. FOSTER. No, sir, not as currently structured.

Mr. SANDLIN. There is not even a savings after 75 years or even in the famous infinite horizon? It never shows savings; is that correct?

Mr. FOSTER. After the first 25 years we lump everything together in our methodology and project it jointly.

Mr. SANDLIN. In the rest of the budget we just estimate out about 5 years, usually; is that not correct?

Mr. FOSTER. Five or 10.

Mr. SANDLIN. So, it is very difficult to have any confidence whatsoever in numbers that are say 75 years out; is that not correct?

Mr. FOSTER. The further you go the more uncertainty there is.

Mr. SANDLIN. Well, 75 years is a long time, is it not?

Mr. FOSTER. Yes, sir.

Mr. SANDLIN. Now, is it true that under the law that the per-beneficiary private plan payment rates substantially exceed the payment rates provided to traditional fee-for-service under Medicare?

Mr. FOSTER. It varies area-by-area.

Mr. SANDLIN. Overall is that not true, though?

Mr. FOSTER. On average, overall, yes.

Mr. SANDLIN. I think on average it is about 25 percent more goes in the private pay payment plan as opposed to the traditional fee for payment service; is that correct?

Mr. FOSTER. That sounds too high, sir, but we could look into it and provide something for the record.

Mr. SANDLIN. Would it surprise you if that was it?

Mr. FOSTER. It sounds too high.

Mr. SANDLIN. You know it is more?

Mr. FOSTER. On average, yes.

Mr. SANDLIN. Are not the overhead costs higher in the HMOs and PPOs than in the traditional Medicare? Have not studies shown that?

Mr. FOSTER. The administrative costs typically are higher.

Mr. SANDLIN. Now you said, and maybe Mr. Goss or Dr. Holtz-Eakin said that you felt there was a demand in the market for the private care, for the HMO or PPO care; is that correct?

Mr. FOSTER. I believe we were talking about the drug companies at the time.

Mr. SANDLIN. Demand for the drug plan under the Medicare bill, which is a part of the reform.

Mr. FOSTER. Yes, sir.

Mr. SANDLIN. Did you know that 80 percent of the Medicare eligible people that live in rural areas, such as I represent, are not even living in areas where there is any HMO coverage whatsoever? Did you know that?

Mr. FOSTER. Yes, HMOs are not common in rural areas.

Mr. SANDLIN. So, in those areas, actually reducing the ability of them to get this service, and actually beneficiaries residing in those areas where there are no private plans are then effectively receiving lower average Medicare subsidies than folks who live in areas that are covered by HMOs; is that not correct?

Mr. FOSTER. I think I need to think about that a little bit.

Mr. SANDLIN. If there is, in fact—if in fact there is a higher reimbursement to a plan, as opposed to traditional Medicare, if there is no plan available then the folks in the plan areas I will call it are getting higher reimbursements or higher rates than those in the non-plan areas; is that not correct?

Mr. FOSTER. In a rural area where there is no private plan and the beneficiary is in fee-for-service traditional Medicare, there is a whole set of payment rules and mechanisms for the care they receive.

Mr. SANDLIN. They are getting less, as you testified. Let me ask you one other question. As you have testified, there is under the bill no negotiation between the Secretary and the pharmaceutical industry or Medicare and the pharmaceutical industry on the cost of prescription drugs. Is it not true that in the Veterans Administration, however, they are saving about 48 percent in costs through negotiation; is that not right?

Mr. FOSTER. I am less familiar with the Veterans Administration situation.

Mr. SANDLIN. Would that surprise you?

Mr. FOSTER. I do not know one way or the other.

Mr. SANDLIN. Thank you. Thank you, Mr. Chairman.

Chairman THOMAS. The gentleman's time is expired. The gentleman from Wisconsin wish to inquire?

Mr. RYAN. I do, thank you, Mr. Chairman. I guess since I am batting cleanup here, there are a number of points I would like to make. First, I want to just ask a couple of technical questions from the previous questions. With respect to the part A, the HI Trust Fund, and the acceleration of the insolvency by 2 years, to what extent is that attributable to HMOs and/or rural providers? Can you segregate the amount of the acceleration of the insolvency attributed to rural providers and HMOs?

Mr. FOSTER. Yes, sir, only very roughly right now. We could do a more thorough job for you. I would call it about 60 percent due to the higher payment rates for the Medicare Advantage plans and roughly 40 percent for the higher payments to rural providers.

Mr. RYAN. So, rural providers did get a substantial increase in their payments, as well as buttressing the Medicare Advantage program?

Mr. FOSTER. Yes, sir.

Mr. RYAN. It was mentioned earlier from the other gentleman from Texas that the HHS estimate, the CMS estimate, is the true estimate. Is your estimate the true estimate?

Mr. FOSTER. If we could make true estimates, I would not have to be CMS Chief Actuary. I would be out there in the stock market or someplace.

Mr. RYAN. Your estimate is just like somebody else's estimate; correct? It is a good educated guess, just as CBOs?

Mr. FOSTER. They are all estimates. Doug may well be right. I may be wrong. It may be the other way around. It is quite possible we will both be wrong.

Mr. RYAN. It is quite probable both of you are wrong and we will be somewhere in between for all we know.

Mr. FOSTER. We hope it would be in between.

Mr. RYAN. One thing that I think, we have just gone through a long hearing on all of this, and I think people may be confused as to the procedures around here.

Chairman THOMAS. Would the gentleman yield briefly on that point?

Mr. RYAN. Sure.

Chairman THOMAS. The Chair recalls Dr. Holtz-Eakin indicating that what he provided at the $395 billion rate was an intermediate estimate from his ship. It could be lower or higher. The assumption that he is the floor and CMS is the ceiling is not accurate based upon the testimony provided by Dr. Holtz-Eakin. It could be lower than the $395 billion. Is that correct, Mr. Holtz-Eakin, based on your statement?

Mr. HOLTZ-EAKIN. Yes, there is a range of uncertainty around all estimates we provide. It could be lower. It could be higher.

Chairman THOMAS. So, when we are looking for the true estimate, as though someone were withholding the Holy Grail, a statement along those lines probably is designed to draw a conclusion rather than to illuminate. Thank you very much, Mr. Ryan, for yielding.

Mr. RYAN. I thank the Chair. What I want to look at is the differences in the two estimates between CBO and CMS. It is also very important to note that, as has been mentioned earlier, Congress is required to use CBO estimates. When we score legislation all legislation that affects revenues and expenditures, we always have to get a score on its revenue impact or its expenditure impact for purposes of conforming with the budget resolution as driven by the Budget Committee. In each of these cases, we have to use CBO. You always have other scores out there, from OMB, from an independent agency. Nevertheless, in every single occasion, Congress has to use CBO. In looking at the differences between the two estimates on this Medicare bill, you can basically look at the fact that

CMS—and please correct me, the two gentleman if I am wrong, CMS assumes a 94-percent participation rate in the drug plan and CBO assumes 87 percent; is that correct?

Mr. HOLTZ-EAKIN. Correct.

Mr. RYAN. With respect to the low-income subsidies for low-income seniors for prescription drug benefit which the biggest out-of-pocket exposure is, I think, a $5 copay, CMS assumes a 75-percent participation rate in the low-income subsidies and CBO assumes a 70-percent participation rate; is that correct?

Mr. HOLTZ-EAKIN. A little bit lower, actually.

Mr. RYAN. That is right, two-thirds. With respect to the Medicare Advantage programs where seniors get to choose among competing plans very much like we as Federal employees do with our own Federal Employee Health Benefit System, CMS assumes 32 percent of seniors will choose to enroll in either these HMOs or PPOs and CBO assumes 13 percent; is that correct?

Mr. HOLTZ-EAKIN. That is correct.

Mr. RYAN. So, in essence, and those are the big differences between your two estimates, what CMS is simply saying is that more people are going to benefit from this new Medicare law? Is that essentially what you are saying, Mr. Foster, that more individuals will actually choose to benefit from the new prescription drug benefit and these new choices that will be made available to them in their areas

Mr. FOSTER. Yes, sir.

Mr. RYAN. So, from a beneficiary standpoint, whichever of these estimates are true, we have these estimates where at the basic rate, CBO, saying 87 percent of all seniors will benefit from a drug plan, where 66 percent of low-income seniors at least will benefit, and CMS is saying even more people will benefit from this new prescription drug law. I think it is important to point out here that what we are talking here is the differences in how many people will be helped from this new Medicare law. One thing that I think is important at the end of all of this is look at the big numbers we are talking about. Over the next 10 years is it not true that Medicare and Medicaid will spend about $6.9 trillion; is that correct, Mr. Holtz-Eakin or Mr. Foster?

Mr. HOLTZ-EAKIN. Ballpark, yes.

Mr. FOSTER. That is certainly the right ballpark.

Mr. RYAN. About $6.9 trillion. So, when we are looking at a difference of an estimate of about $139 billion, what is the difference in your two estimates over the total course of the next 10 years in the spending of Medicare and Medicaid?

Mr. HOLTZ-EAKIN. We can we look this up.

Mr. FOSTER. For Medicare only, if you look at the March CBO baseline versus the President's budget, the total was actually quite close for Medicare expenditures. In the Trustees' Report, in part because of higher CPI assumptions, we have a somewhat higher level.

Mr. RYAN. One more?

Chairman THOMAS. One more quickly.

Mr. RYAN. One more quick one. We have heard a lot of talk about the doughnut hole here today under this new benefit. According to CBO analysis the typical senior will spend less than $1,900

in prescription drugs in 2006 and will not reach the initial coverage limit of $2,250. One-third of the seniors will be eligible for low-income assistance and will have no gap in coverage regardless of how much they spend. Given these two points, Mr. Holtz-Eakin, what is your estimate of the number of seniors who will experience absolutely no gap in coverage or no doughnut hole under this new Medicare prescription drug benefit?

Mr. HOLTZ-EAKIN. I do not know the number off the top of my head. I am happy to get it to you.

Mr. RYAN. If you could, I would appreciate that.

[The information is pending.]

Chairman THOMAS. I thank the gentleman. The gentleman from North Dakota is recognized for a North Dakota minute.

Mr. POMEROY. I thank the Chairman. I will be very brief. I have just been concerned——

Chairman THOMAS. Time goes very slowly in North Dakota. A North Dakota minute lasts a while.

Mr. POMEROY. I will be very brief. Mr. Foster, I have felt it very unfair that you have been attacked for bringing to light the fact that your cost estimates were precluded from being disclosed to Members of Congress even upon direct inquiry for those estimates. In fact, the Hill newspaper now, "Bush takes offensive on Foster." The article indicates that an actuary has to have proof of assertions that the White House may have had knowledge of your estimates. Are you telling us today that you have directly sent e-mail to someone in the White House of the cost estimate you prepared?

Mr. FOSTER. Yes, sir. For the estimates back in June, the preliminary estimates, there is such evidence.

Mr. POMEROY. There is evidence that the White House received this. Now part of the chattering class, the talk show discussion of all of this, has raised an issue as to whether you are politically motivated in bringing this information to us. Indeed, one talk show pundit was saying "this Foster"—I am quoting now from the Capital Gang program on CNN. "This Foster, this actuary, is a bureaucrat but he is a Democrat. He is—he is very hostile to the Administration." Mr. Foster, are you actively involved with a political party?

Mr. FOSTER. I will be happy to answer your question sir, but only with a brief explanation. For our work, our estimates for Medicare and Medicaid, we very carefully keep any political preferences and any political affiliation out of our work so that we can provide just the best neutral, nonpartisan, et cetera, analysis. Now having said that, I will tell you a short story. Back in 1972, when I was first eligible to vote, I registered as a Democrat so that I could vote against George Wallace in the Maryland primary. I never got around to changing my registration but I will announce to the world, I suppose, that I voted for every Republican presidential candidate ever since 1972 except the 1 year that I wrote in Jack Kemp.

Mr. POMEROY. I am sorry to hear that.

Chairman THOMAS. The gentleman's time is expended to both a North and South Dakota minute.

Mr. POMEROY. I do think that is important to get on the record and the statement made by that talk show pundit that you are hostile to this Administration, are you hostile to this Administration?

Mr. FOSTER. No, sir. I think very highly of Secretary Thompson and I think very highly of President Bush.

Mr. POMEROY. Indeed, do you believe this Administration would have been better served by having the work of your actuarial team come forward in due course into this debate?

Mr. FOSTER. Yes, I do.

Mr. POMEROY. I do not have any other questions, Mr. Chairman. Thank you.

Chairman THOMAS. I thank the gentleman and I want to thank all of you. I want to underscore the gentleman from Missouri's statement. Notwithstanding the nitpicking and the very microscopic examination of the job of actuaries today, when you take a step back and look at the overall picture, this society needs to make some fundamental changes to both the Social Security and the Medicare program if we expect those who are currently paying the bill to receive the benefits that those now enjoy. The hearing stands adjourned.

[Whereupon, at 4:26 p.m., the hearing was adjourned.]

# BOARD OF TRUSTEES 2004 ANNUAL REPORTS

**THURSDAY, APRIL 1, 2004**

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
*Washington, DC.*

The Committee met, pursuant to notice, at 12:10 p.m., in room 1100 Longworth House Office Building, Hon. Bill Thomas (Chairman of the Committee) presiding.

Chairman THOMAS. Good afternoon. Today, we continue the Committee's review of the 2004 Annual Reports of the Board of Trustees of the Social Security and Medicare Trust Funds. Pursuant to U.S. House of Representatives Rule XI, clause 2(j)(1), at the insistence of the minority, four additional witnesses have been called before us to offer testimony on the Trustees' Report on Medicare. The minority is fully within its rights under Rule XI and the Chair has no discretion in that regard. Before us today, one of the witnesses that was requested, Leslie Norwalk, who is the Acting Deputy Administrator for the CMS, and Jeff Flick, who today is the San Francisco Regional Administrator for CMS. Doug Badger, Special Assistant to the President for Economic Policy, had been requested by the minority to appear, and White House Counsel Alberto Gonzales has provided the Committee a letter of explanation on executive privilege. Therefore, Mr. Badger will not appear. Tom Scully, former CMS Administrator, has provided a letter of explanation to the Committee outlining the reasons for his declining the invitation, as well. Without objection, I ask that both letters be entered into the record. The clerks will make sure that

Members have copies of those letters. With that, I would recognize the Ranking Member, Mr. Rangel, for any opening statement he may wish to make.

[The opening statement of Chairman Thomas follows:]

[The information follows:]

**Opening Statement of The Honorable Bill Thomas, Chairman, and a Representative in Congress from the State of California**

Good afternoon. Today we continue the Committee's review of the 2004 Annual Reports of the Boards of Trustees of the Social Security and Medicare.

Pursuant to Rule XI, Clause 2(j)(1) >of the U.S. House of Representatives four additional witnesses have been called before us to offer testimony on the Trustees Report on Medicare.

Leslie Norwalk, Acting Deputy Administrator for the Centers for Medicare and Medicaid Services (CMS) and Jeff Flick, San Francisco Regional Administrator for CMS will provide testimony to us today. Doug Badger, Special Assistant to the President for Economic Policy, will not appear. White House Counsel Alberto Gonzales has provided a letter of explanation on executive privilege. Tom Scully, former CMS Administrator, has also declined to testify, and has provided a letter of explanation to the Committee. Without objection, I ask that both letters be entered into the record.

I would now like to recognize the ranking member, Mr. Rangel, for any opening statement he might make.

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The White House
Washington, DC 20500
*March 31, 2004*

Hon. Bill Thomas
U.S. House of Representatives
Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515–0548

Dear Chairman Thomas:

I am writing in response to your letter of yesterday inviting Doug Badger, Special Assistant to the President for Economic Policy, to appear before the House Committee on Ways and Means tomorrow.

It is longstanding White House policy, applied during administrations of both parties, that members of the White House staff should decline invitations to testify at congressional hearings. Accordingly, on Mr. Badger's behalf, I respectfully decline the invitation to him to testify before the Committee on Ways and Means.

Sincerely,

Alberto R. Gonzales
Counsel to the President

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*April 1, 2004*

Honorable William M. Thomas,
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515–6348

Dear Mr. Chairman:

Thank you for your invitation to appear at a hearing you have scheduled to begin at noon, Thursday, April 1. Unfortunately, for the past ten days I have been traveling, both domestically and abroad, and so I am unable to appear. However, I do have some comments that I believe are relevant to the Committee's inquiry.

I am very proud of my tenure as Administrator of the Centers for Medicare and Medicaid Services (CMS). Among other accomplishments, we worked feverishly with consumer and patient groups, as well as unions and providers, to produce the first health quality measures for nursing homes and home health agencies—and published them in every major paper in the country. We started on the same mission

with hospitals. We also greatly expanded 1 800 MEDICARE and educated millions of seniors about the terrific Medicare and Medicaid benefits to which they are entitled. These are but a few of the accomplishments of which I'm most proud.

Most significantly, with the Administration's help, you and your colleagues on the Committee passed an EXCELLENT Medicare bill that will stand the test of time. Long after the November elections are over, your collective historic achievement will remain. The goal of this Administration and Congress has always been to help low-income seniors. As a result of the action of the Committee, millions of seniors will no longer have to choose between the drugs they need to sustain themselves and their rental payments. This generation of low-income seniors will receive enormous relief, and the next generation of seniors will be far better served by a much more dynamic and consumer-responsive Medicare program that will better meet the health needs of seniors and the disabled of all incomes.

As we all know, there have been longstanding differences between CMS budget assumptions and those articulated by the Congressional Budget Office (CBO). Virtually everyone engaged in the Medicare reform effort knew that these assumptions differed and was also aware of multiple meetings between CMS and CBO to reconcile these differences. In fact, I testified before the Senate Finance Committee in June, 2003, about the differing assumptions generated by CBO and CMS, noting that "it's a fundamental disagreement between our actuaries . . . there are seven or eight fundamental differences."

As Administrator of CMS, it was my responsibility to determine when and how the CMS Chief Actuary should respond to Congressional requests. From the very beginning of my tenure at CMS, Mr. Richard Foster expressed his strongly held view that he, as the head of the Office of Chief Actuary, was independent of me or anyone else within the Executive Branch. Accordingly, Mr. Foster believed that he was free to make decisions about when or how to respond to Congressional inquiries relating to CMS cost estimates generally, and, in particular, the Medicare Reform bill.

Simply put, I disagreed, and there is no question whatsoever that I made it very clear to Mr. Foster, both directly and indirectly, that I, as his supervisor, would decide when he would communicate with Congress. It is a position that I also made very clear to the Republican and Democratic Leadership of the three CMS oversight Committees, beginning with meetings that occurred in the spring of 2001. Moreover, it is also worth noting that even Mr. Foster, in his testimony before this Committee on March 24, admitted that my position was accurate as a matter of law. He indicated during his appearance that he sought legal advice about my view and was told that I was correct.

I believe that I dealt with Mr. Foster, and all other CMS employees under my supervision, openly and fairly during my entire tenure. 1 remain proud of my twenty-five years of strong, bipartisan relations with the Congress, of my personal commitment to improving health care for America's seniors, and of the role I played in assisting with the passage of what I believe will prove to be an achievement of historic proportions.

Sincerely,

Thomas A. Scully

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Mr. RANGEL. Thank you, Mr. Chairman. Even though you said that you had no discretion in extending the hearing, I want to thank you on behalf of the minority for the spirit in which you did extend it and know that we have your support in trying to make certain that the integrity of the professional staff of any administration, Republican or Democrat, is not tainted by partisanship. Even at the last hearing, you demonstrated by reflecting on the past that you have given assurances to staff that when they were coerced into not cooperating with Members of Congress, that you would support them in their effort to come forward. Having said that, we really think that the executive branch on this issue does not enjoy the executive privilege claimed today. The question is whether the executive branch of government actually withheld the information that the true cost of the Medicare bill was up to $450 billion rather than $400 billion.

With the legal interpretations of executive privilege that have been given to us, it is clear that there has to be some conversation that the staff had with the President that they would believe that his testimony would be entitled to executive privilege. If Mr. Badger did not discuss it with the President, then, of course, there is no need to raise the question. If he did discuss it with the President, Members of Congress ought to know whether the President of the United States knew what the facts were and through his subservients said that we shouldn't get that information.

We do know that a lawyer for the Administration did indicate to Mr. Foster that if he shared this information with Members of Congress, that he could get fired. We do know that Mr. Scully has informed us that he talked with the President about these issues. We do know that Mr. Scully apparently ordered Foster to share at least his testimony for us to believe that you could share this information with Republicans but not with Democrats. This is a very serious issue, not just for this hearing but for the integrity of the U.S. House of Representatives and for this Committee.

There are a variety of things at this time, after caucusing with our Members, that I will be asking you. One is to make certain that it is not without discretion but that you would support this inquiry until we get the answers that we need; two, that you subpoena Mr. Badger here; three, that if you see fit not to do that, that we should vote to be able to have him here. I just got a copy of Mr. Scully's letter. I don't know what privilege he has, but he is certainly a key person between the Congress, Mr. Foster, the President, and Mr. Badger, so I would hope that he, too, would be subject to a subpoena, and that at the end of the day, we would know whatever information was withheld, and would know it was not willingly withheld from the Congress. So, knowing that you have demonstrated in 1997 an interest in this subject, I hope that it would not be a minority request but would come from the Chair for the full Committee and, therefore, for the House.

Chairman THOMAS. Does the gentleman wish a response?

Mr. RANGEL. I certainly do.

Chairman THOMAS. I thank the gentleman. The question really hinges on the statement the gentleman made about information that we need or want. The Chair is certainly concerned about information that the Chair and the Committee needs to carry out our legal obligation. When the desire shifts to want, it turns into a question of curiosity. I will tell the gentleman that the letter from the counsel to the President, which I believe he has a copy of, is very brief. It is two short paragraphs, and the operative portion of that, I believe, it is longstanding White House policy applied during administrations of both parties that members of the White House staff should decline invitations to testify at congressional hearings. It is true that at the time this letter is presented indicating that the executive branch wishes to exercise longstanding decisions regarding executive privilege, that at the same time, they have allowed a member of the Administration, notwithstanding the executive privilege, to testify. So, I don't believe the answer is found in the counsel to the President's letter based upon, of course, a decision that they made. They could choose to or not.

In Mr. Scully's letter, which we also just received this morning, I notice on page 2 that Mr. Scully in his letter declining the invitation of the Committee to appear before it on this issue, in the second paragraph on page 2 says, "Moreover, it is also worth noting that even Mr. Foster in his testimony before this Committee on March 24 admitted that my position," Mr. Scully's position, "was accurate as a matter of law. He indicated during his appearance that he sought legal advice about my view and was told that I was correct." One of the reasons I was pleased Ms. Norwalk was able to appear before us for questioning on this issue is that in the questioning by the minority Members, Mr. Foster indicated that Ms. Norwalk in her position at the time was the one who supplied the decision in regard to whether or not Mr. Scully was operating within his legal bounds. That, I believe, is a worthwhile area to examine. Mr. Flick was kind enough to come, and I understand now is the Western Regional CMS, that you had to fly out to make this appearance. We appreciate it.

Mr. Rangel is right. There was a requirement under Rule XI that we have a second hearing, but time, place, and manner is within the purview of the Chair and the Chair wanted to try to respond in as reasonable time as possible so that we could have some continuity in front of us on this issue. Since Mr. Foster appeared to believe that the law allowed Mr. Scully to make the decision the way he did it, I believe the Committee's concern should turn on whether or not that was an appropriate or legal decision, i.e., the need argument. If it is just because of curiosity as to who said what to whom, notwithstanding the fact Mr. Scully was perfectly legal in the decisions that he made, then the Chair would be concerned about simply pursuing a line of questioning on the basis of curiosity.

So, the Chair is here to examine that difference stated very succinctly by the gentleman from New York. Is it a question of need or is it a question of want? The Chair stands ready to exercise the full legal power of the Committee if there is a need. If it is a want, then the Chair would have to examine the level of concern over the want to simply continue to inquire who said what to whom, when, and how, notwithstanding the fact that they had every legal right to make the decision that was made, and that would be the Chair's position in listening to the testimony to determine whether it actually is a need of this Committee or if it is a want of some of the Members of the Committee.

Mr. RANGEL. Mr. Chairman, by your actions in 1997, I think you have proven my position that there is a need that we have integrity with professional actuaries and that they can report the information as needed, not wanted, by the Congress. So, the significance of the legal opinion provided by Ms. Norwalk really doesn't matter. Lawyers can be wrong, and if this person was threatened that you could be fired when they had a legal obligation to inform the Congress, you can dismiss that. Now comes the question, who told the lawyer, who told Mr. Scully that he was authorized to threaten the person who had the legal right to tell us the information we wanted? Of course, when Mr. Badger, who was involved in these conversations, refuses to come to testify exercising executive privilege, then what he is saying is, or implying, is that it was the

President that said that you cannot divulge the discussion that we had.

I would like to say, in concluding my arguments here, that there are so many examples of the executive, not just Ms. Condoleezza Rice, but in the last Administration, Erskine Bowles, Chief of Staff of the President, McLaughley, Podesta, Ruff, Nolan, Quinn, all counsel to the President, assistants to the President, 45 top-rank Clinton people testified under oath. So, we don't want to get into the argument as to the rights of executive privilege. The one question I am asking you, I guess, is that before I ask for a vote on the issue, are you prepared to exercise your discretion as the Chairman of this distinguished Committee to subpoena Mr. Badger to testify?

Chairman THOMAS. Would the gentleman yield once again?

Mr. RANGEL. Yes. Sure.

Chairman THOMAS. I thank the gentleman. As an admitted non-attorney, the Chair is examining not narrow legal points but broader fundamental constitutional points. The legislative powers derive from Article I. The executive power is derived from Article II. There has been a long and colorful legal history of the ability of those who derive their constitutional powers from Article I being able to require those who draw their powers from Article II to do things that those who draw their powers from Article I want them to do. There are those who draw their powers from Article II who have a long and colorful history of trying to get those who draw their powers from Article I to do what those in Article II want them to do, and all of it is refereed by those who derive their constitutional powers from Article III.

Again, the Chair would consider entertaining what I consider to be a significant power not exercised by this Committee in the time of this Chairman's tenure. If we are in pursuit of a legal need, if, in fact, Mr. Scully was operating outside the legal bounds in telling someone under his jurisdiction that the information was information that the executive branch could choose to share or not share, rather than the way the gentleman from New York stated that we had a legal or constitutional right to the information, notwithstanding the Article II provisions which gives rise to the executive privilege, if there was a violation of the law, the Chair stands ready to use whatever tools necessary to get to the bottom of the violation of the law. If it is a question of style in terms of Administration or someone who is frustrated because they aren't an independent operator within an administrative hierarchy, that, then, I don't think reaches the level of the need for a subpoena of testimony.

We have people in front of us who were directly, intimately, and first-person involved in shaping the decisions and the opinions that Mr. Foster exercised at the last hearing. If, in fact, there is a comfort level on the part of the Committee that Mr. Scully exercised the decisions he made well within the law, then the need question, the Chair believes, has been answered. The want question is something that very often doesn't get fulfilled, but the Chair doesn't believe that the powers under Article I extend to simply whims and wants fulfilled using what I consider to be a powerful legal tool. The Chair will go to any lengths to make sure that the law is fol-

lowed. The Chair is not ready to go to any lengths to satisfy someone's whim or curiosity.

Mr. MCCRERY. Mr. Chairman.

Mr. RANGEL. Mr. Chairman, I concur with the direction in which the Chair is going in terms of determining whether he is satisfied there is a need to exercise the awesome power of the subpoena. I have been advised that my ability to call the question for a subpoena has to be at the beginning of a hearing, and further, that we have to have a quorum for that to happen. So, while you are searching for the need, I don't want to lose my rights as a Member to be able to raise the motion. If you can give some type of assurances that the motion to request the subpoena for witnesses and the fact that it would be done in a timely manner when we have a quorum, I have no problem with you searching for the need.

Chairman THOMAS. I ask if the gentleman believes there is a quorum present.

Mr. RANGEL. I would then ask——

Chairman THOMAS. If the gentleman wishes to exercise that right, the Chair would like to make the decision after he has been informed by virtue of the testimony of the witnesses.

Mr. RANGEL. I am saying I have no problem with that as long as you also indicate that I reserve the right to raise the motion without violating the House rules which gives me the right to do it——

Chairman THOMAS. I tell the gentleman the Chair would be somewhat concerned that we may, in fact, lose a quorum and the Chair would not want to deny the gentleman's right based on a quorum call. So, if the gentleman feels that he wants to have the maximum protection of the rules, he probably ought to move the question now, knowing we have a quorum, and hopefully the information that is presented will support the Chair in the belief that this is not a legal need but a want or curiosity.

Mr. RANGEL. In the event that I fail in my motion, I hope if the Chair is satisfied that it is a need and not a want for curiosity, that you still would have the power to exercise——

Chairman THOMAS. If the gentleman would yield, my search for the truth is not influenced by the mere exercise of democratic authority.

Mr. MCCRERY. Mr. Chairman, would you yield?

Chairman THOMAS. Certainly.

Mr. MCCRERY. It seems to me——

Chairman THOMAS. I believe, actually, the gentleman from New York has the time.

Mr. MCCRERY. He is running the clock.

Chairman THOMAS. Notice there is no clock running.

[Laughter.]

Mr. MCCRERY. It seems to me when you come to the question of need versus want, you reference Article I of the Constitution, and one of the responsibilities of the House of Representatives is to allocate money. We were given the power to appropriate. In order to appropriate on behalf of the American people, we have to have the best information available. It seems to me that it is not a want on our part, it is to establish a precedent here about wheth-

er or not we are entitled to the information that is being developed in the government by Federal employees as we carry out our role of oversight. That is what the question here, our need for it, is. It is not to find out the exact number or anything else. It is to find out what is there so that we can make a reasoned judgment. We very often take varying opinions about what the number is and ignore one of them and go with another one. That is not the issue here. The issue is whether we can be barred from knowing that a competent professional has created a model that gives him a number which is at major variance with what was put before us. We were told $400 million—$400 billion, and then we find out that $534 billion was floating around. That is almost—well, I don't know. I am not going to give a percentage. It is a big difference. I think that that is why we need—we could have argued that. We would have had a big argument in here if we had known that other number.

Chairman THOMAS. Well, we had one.

Mr. RANGEL. I yield to the gentleman from Texas.

Mr. DOGGETT. Thank you.

Chairman THOMAS. Does he want an answer, or was that a statement?

Mr. RANGEL. I yield to the Chair to respond.

Chairman THOMAS. I thank the gentleman for yielding. What the gentleman from Washington is asking for was not available because he was looking for facts. What was available was an estimate based upon assumptions which, frankly, when Mr. Foster was in front of us, were challenged by a number of Members of the Committee, especially, as I recall, the gentlewoman from Connecticut, the Chair of the Subcommittee on Health in terms of the take-up rates. In addition to that, Mr. Foster's talents are not unique nor is his model unique. There are others who carry out those various functions. The desire of Congress to get the best information can be provided from a number of sources. If the only factual source was a member of the Administration, in determining a legal decision, the Chair would then be looking at the question of subpoenaing the individual who had the fact which Congress desperately needed.

I do not believe the attempt to subpoena someone to find out if they were within their legal rights to indicate in an administrative hierarchy that an individual was not free to exercise whatever judgment they felt free to exercise absent supervision reaches that level. The gentleman's point is, people who make decisions either had the legal authority or didn't have the legal authority to make them. It is not whether you liked his style in doing it. That wouldn't raise it to a level of subpoena. What we have in front of us is an ability to determine whether or not Mr. Scully operated under the law. That would be the point at which the Chair would make the decision of exercising the subpoena, and the decision of calling it need or want was not the Chair's. It was framed that way by the Ranking Member from New York, and the Chair thanks the gentleman for once again yielding.

Mr. RANGEL. I yield to the gentleman from Texas.

Mr. DOGGETT. There appear to be two different individuals here and two different situations. As I understand with reference

to Mr. Badger, the Condoleezza Rice of health care policy at the White House, as we learned last week, it may be that since they are stonewalling that the subpoena is the only route. With reference to Mr. Scully, as I read his letter, and he, of course, does not enjoy any executive privilege concerning his conversations with the President, but Mr. Scully is not refusing to come, as I understand it. He has simply said that he is tired today. He says, "I have been traveling these past 10 days." Whether we interfered with his nap time or whatever might be the case, perhaps it is just a matter short of a subpoena of simply rescheduling at a time when he is more well-rested and my inquiry would be whether the Chair, perhaps short of going to the extreme of a subpoena, could simply continue this hearing to a time when Mr. Scully is well rested and could come and tell us about his conversations with the President and others on this very important matter.

Mr. RANGEL. I yield to the Chair.

Chairman THOMAS. I thank the gentleman for yielding, and his time is nearly expired. I tell the gentleman from Texas that trying to screen through what I assume to be somewhat facetious remarks that the Chair especially is concerned about issuing a subpoena against a private citizen. Dealing with individuals who are carrying out functions of office under the law is one question, but now simply to find out, as the gentleman characterized, who said what to whom and when, and compelling them to appear before this Committee when what they did was legal is an extension of the power of this Committee that I believe would verge on abuse of the power.

The gentleman declined the invitation which the minority has under Rule XI to extend the hearing. The Chair has complied with that in what I believe was the most efficacious time, place, and manner of response. We have before us two individuals who have direct personal knowledge of decisions that affected Mr. Scully and affected Mr. Foster, and it seems to me that that ought to be something that we would listen to if at the end of the testimony and the questioning period, if there is—it is clear that he operated under the law in exercising his decision, then again, I think it reverts to a manner of style. I am quite sure that Mr. Scully's style doesn't meet the level of desired stylistic behavior that either the gentleman from Washington or the gentleman from Texas would prefer. That does not trigger, in the Chair's opinion, a need to issue a subpoena. That is yet to be determined based upon the testimony and the questions that lie before this second half of the hearing on the Trustees' Report.

Mr. DOGGETT. Mr. Chairman, I am not asking about issuing a subpoena to Mr. Scully. I am just asking if the Chair is declining to extend an invitation to him to come at a time that is more convenient to Mr. Scully to be here, since he is the actor and the person involved rather than one of his assistants.

Chairman THOMAS. Might I respond?

Mr. RANGEL. Yes. I yield to the Chair to respond.

Chairman THOMAS. In looking at the nearly expired time of the Ranking Member, I tell the gentleman that the minority has requested an extension of the hearing under Rule XI. That extension has been granted. The gentleman now seeks to figure out a way to bounce the ball down the street with a continuation of a continu-

ation of a continuation. The Chair's reading of Mr. Scully's letter is he ain't coming.

Mr. RANGEL. Mr. Chairman, in order to protect my right in being timely in raising the motions to subpoena both Mr. Scully and Mr. Badger, I, under House Rule I (1)(2)(k)(6), I move that the Committee issue a subpoena to a witness, Special Assistant to the President for Economic Policy, Doug Badger, to testify before the Committee on Ways and Means as soon as possible at a mutually agreeable time following the upcoming district work period on the subject of cost estimates on the Medicare prescription bill passed by the Congress in 2003 and to provide the Committee by at least 5 days prior to the hearing with documents relevant to this subject.

Mr. MCCRERY. Mr. Chairman.

Chairman THOMAS. The gentleman from Louisiana.

Mr. MCCRERY. Mr. Chairman, I move to table the motion of the gentleman from New York.

Chairman THOMAS. Motion to table is before us. It is not debatable.

Mr. RANGEL. There is not a debate on that?

Chairman THOMAS. It is not debatable on his second. If the gentleman from Louisiana——

Mr. LEVIN. Are we going to shut off debate on this?

Mr. RANGEL. Yes.

Chairman THOMAS. Can the Chair finish his statement? In an attempt to try to create and maintain comity, notwithstanding the gentleman from Louisiana's parliamentary privilege, on a procedural motion, which is not debatable, the underlying motion is. So, the Chair will recognize for a brief period of time the gentleman from Michigan with what the Chair will call a timely request, notwithstanding it came after the motion, to discuss briefly his concerns about the motion.

Mr. LEVIN. Would the Chairman yield?

Chairman THOMAS. The gentleman from Michigan.

Mr. KLECZKA. It seems that other Members also want to talk about the motion. Is the Chairman only restricting the debate on the motion to the gentleman from Michigan?

Chairman THOMAS. The Chair indicated that in an attempt to maintain comity, the Chair would allow the gentleman from Michigan, notwithstanding the fact that the motion to table was timely presented and there is no debate on that motion. If the gentleman from Wisconsin indicates that every Member of the minority is going to debate this, notwithstanding——

Mr. KLECZKA. Well, I am not saying every Member. I am saying more than one Member would possibly like to be heard on the motion.

Chairman THOMAS. The Chair has indicated his willingness to offer comity because the gentleman from Michigan intervened, not timely, but the Chair is willing to entertain that request. If the gentleman from Wisconsin wishes to push his point that the Chair is not following parliamentary procedure because the motion to table was timely presented, the Chair will move to the vote on the motion to table.

Mr. KLECZKA. So, that is a threat, that if I insist on talking on the motion, then Sandy Levin from Michigan doesn't talk? That is——

Chairman THOMAS. I tell the gentleman it is not a threat. It is an attempt by the Chair to follow parliamentary procedure.

Mr. KLECZKA. That is not comity, it is comedy.

Chairman THOMAS. The Committee has before it the motion to table the gentleman from New York's motion, and all those in favor of tabling——

Mr. LEVIN. Mr. Chairman——

Chairman THOMAS. Say aye.

[Chorus of ayes.]

Mr. LEVIN. Mr. Chairman——

Chairman THOMAS. Those opposed?

[Chorus of noes.]

Mr. LEVIN. Mr. Chairman, you recognized me.

Chairman THOMAS. In the opinion of the Chair, the motion to table has passed and the motion——

Mr. RANGEL. I ask for a recorded vote.

Chairman THOMAS. From the gentleman from New York is laid upon the table.

Mr. RANGEL. I ask for a roll call.

Chairman THOMAS. A sufficient number of hands. The clerk will call the roll on the motion to table the gentleman from New York's motion on the subpoena.

Mr. LEVIN. Mr. Chairman, point of information before the vote. I thought you were going to recognize me.

Chairman THOMAS. I tell the gentleman the Chair was willing as a matter of comity to recognize the gentleman, notwithstanding he did not have parliamentary standing. It was clear that other Members on his side of the aisle were not willing to allow the Chair to exercise that comity, and so the Chair was more than willing to exercise the parliamentary right to move to the procedural motion.

Mr. LEVIN. Mr. Chairman, I just want to say that you recognized the gentleman from Louisiana. I don't think you were surprised by the motion he was going to submit. There is no way you are going to shut down discussion of these issues, and you can do it now through this device——

Mr. MCCRERY. Mr. Chairman, I do not believe that this discussion is in order in the middle of a——

Chairman THOMAS. It is not in order——

Mr. LEVIN. It isn't in order——

Chairman THOMAS. It is not in order. A point of information is not the correct reference, but the Chair was allowing the gentleman to express himself in an attempt to continue to maintain comity.

Mr. LEVIN. Comity, then let us have discussion of the motion.

Chairman THOMAS. I tell the gentleman that the Chair attempted to do that, notwithstanding the timely notice of the motion to table. There were Members on his side of the aisle that indicated that the attempt to provide comity by the Chair was not sufficient, which meant the Chair would then not be able to follow parliamen-

tary procedure and the Chair is concerned about that and believes we should.

Mr. LEVIN. Stonewalling won't work. We will state our——

Chairman THOMAS. I tell the gentleman we are in the middle of a roll call——

Mr. RAMSTAD. Regular order.

Chairman THOMAS. The Chair will indicate that he has continued to provide a reasonable opportunity, and since a roll call by a show of hands was called by the minority, the rules indicate that we should now have that roll call.

Mr. RANGEL. I ask unanimous consent that the gentleman from Michigan be allowed to express himself.

Chairman THOMAS. I tell the gentleman that it is not in order during a roll call for anyone to express their position and the clerk will call the roll.

Mr. RANGEL. It was my understanding that unanimous consent——

Mr. RAMSTAD. Regular order.

Mr. RANGEL. Suspend all of the rules. I have asked for unanimous consent——

Chairman THOMAS. Not in the middle of a roll call.

CLERK. Mr. Crane?

Mr. CRANE. Aye.

CLERK. Mr. Crane votes aye. Mr. Shaw?

Mr. SHAW. Aye.

CLERK. Mr. Shaw votes aye. Mrs. Johnson?

Mrs. JOHNSON. Aye.

CLERK. Mrs. Johnson votes aye. Mr. Houghton?

Mr. HOUGHTON. Aye.

CLERK. Mr. Houghton votes aye. Mr. Herger?

Mr. HERGER. Aye.

CLERK. Mr. Herger votes aye. Mr. McCrery?

Mr. MCCRERY. Aye.

CLERK. Mr. McCrery votes aye. Mr. Camp?

Mr. CAMP. Aye.

CLERK. Mr. Camp votes aye. Mr. Ramstad?

Mr. RAMSTAD. Aye.

CLERK. Mr. Ramstad votes aye. Mr. Nussle?

Mr. NUSSLE. Aye.

CLERK. Mr. Nussle votes aye. Mr. Johnson?

Mr. JOHNSON. Aye.

CLERK. Mr. Johnson votes aye. Ms. Dunn?

[No response.]

Mr. Collins?

Mr. COLLINS. Yes.

CLERK. Mr. Collins votes yes. Mr. Portman?

Mr. PORTMAN. Aye.

CLERK. Mr. Portman votes aye. Mr. English?

Mr. ENGLISH. Aye.

CLERK. Mr. English votes aye. Mr. Hayworth?

Mr. HAYWORTH. Aye.

CLERK. Mr. Hayworth votes aye. Mr. Weller?

Mr. WELLER. Aye.

CLERK. Mr. Weller votes aye. Mr. Hulshof?

[No response.]
Mr. McInnis. Mr. McInnis?
Mr. MCINNIS. Yes.
CLERK. Mr. McInnis votes yes. Mr. Lewis of Kentucky?
Mr. LEWIS OF KENTUCKY. Aye.
CLERK. Mr. Lewis of Kentucky votes aye. Mr. Foley?
Mr. FOLEY. Aye.
CLERK. Mr. Foley votes aye. Mr. Brady?
Mr. BRADY. Aye.
CLERK. Mr. Brady votes aye. Mr. Ryan?
Mr. RYAN. Aye.
CLERK. Mr. Ryan votes aye. Mr. Cantor?
Mr. CANTOR. Aye.
CLERK. Mr. Cantor votes aye. Mr. Rangel?
Mr. RANGEL. No.
CLERK. Mr. Rangel votes no. Mr. Stark?
Mr. STARK. No.
CLERK. Mr. Stark votes no. Mr. Matsui?
Mr. MATSUI. No.
CLERK. Mr. Matsui votes no. Mr. Levin?
Mr. LEVIN. No.
CLERK. Mr. Levin votes no. Mr. Cardin?
Mr. CARDIN. No.
CLERK. Mr. Cardin votes no. Mr. McDermott?
Mr. MCDERMOTT. No.
CLERK. Mr. McDermott votes no. Mr. Kleczka?
Mr. KLECZKA. No.
CLERK. Mr. Kleczka votes no. Mr. Lewis of Georgia?
Mr. LEWIS OF GEORGIA. No.
CLERK. Mr. Lewis of Georgia votes no. Mr. Neal?
Mr. NEAL. No.
CLERK. Mr. Neal votes no. Mr. McNulty?
Mr. MCNULTY. No.
CLERK. Mr. McNulty votes no. Mr. Jefferson?
[No response.]
Mr. Tanner?
Mr. TANNER. No.
CLERK. Mr. Tanner votes no. Mr. Becerra. Mr. Becerra?
Mr. BECERRA. Pass.
CLERK. Mr. Becerra passes. Mr. Doggett?
Mr. DOGGETT. No.
CLERK. Mr. Doggett votes no. Mr. Pomeroy?
Mr. POMEROY. No.
CLERK. Mr. Pomeroy votes no. Mr. Sandlin?
Mr. SANDLIN. No.
CLERK. Mr. Sandlin votes no. Ms. Tubbs Jones? Ms. Tubbs Jones?
Ms. TUBBS JONES. No.
CLERK. Ms. Tubbs Jones votes no. Ms. Dunn?
Ms. DUNN. Yes.
CLERK. Ms. Dunn votes yes. Mr. Hulshof?
[No response.]
Mr. Jefferson?
[No response.]

Mr. Becerra?

Mr. BECERRA. No.

CLERK. Mr. Becerra votes no. Mr. Thomas?

Chairman THOMAS. Yes.

CLERK. Mr. Thomas votes yes.

Chairman THOMAS. The clerk will announce the vote.

CLERK. Twenty-three aye, 16 no.

Chairman THOMAS. There being 23 ayes and 16 noes, the motion of the gentleman from New York, Mr. Rangel, is laid on the table.

Mr. RANGEL. Mr. Chairman, under House Rule I (1)(2)(k)(6), I move that the Committee issue a subpoena to a witness, former CMS Administrator, Mr. Thomas Scully, to testify before the Committee on Ways and Means as soon as possible following the upcoming district work period on the subject of cost estimates on the Medicare prescription drug bill passed by the Congress in 2003 and to provide the Committee with all the documents relevant to this subject at least 5 days prior to the hearing——

Mr. KLECZKA. Mr. Chairman, on the motion——

Mr. RANGEL. In support of this motion, Mr. Chair, let me say this. I think that you have extended yourself beyond the mandatory discretion decisions in this Committee. I think you have done it because you feel as a Member of this Committee and certainly as the Chairman that what we do today may in the future dictate how we are treated by Administration officials, and to that extent, I apologize to the witnesses that are here patiently waiting——

Mr. KLECZKA. Will Mr. Rangel yield?

Mr. LEVIN. Mr. Chairman.

Mr. KLECZKA. Mr. Rangel, would you yield, please?

Mr. LEVIN. Mr. Chairman.

Chairman THOMAS. Prior to the Chair——

Mr. RANGEL. I just wanted to complete my thought, and that is while we recognize that the majority has the right to table this motion, I hope they recognize that the damage they are doing is not to me as the Ranking Member or to the minority, but to this Committee as we seek to determine at this hearing what right the executive branch has to deny us information which we are entitled to know. Furthermore, though the decisions may appear to be partisan, I would hope that the majority Members would recognize that this Committee has a longstanding reputation of integrity and of protecting our jurisdiction and making certain that our constitutional rights are not abused.

Mr. LEVIN. Mr. Rangel, would you yield?

Mr. RANGEL. I yield to Mr. Levin, who was denied the opportunity——

Mr. MCCRERY. Point of order, Mr. Chairman.

Mr. RANGEL. To express himself.

Mr. MCCRERY. Point of order, Mr. Chairman.

Chairman THOMAS. The gentleman from Louisiana will state the point of order.

Mr. MCCRERY. The gentleman was recognized for a motion.

Chairman THOMAS. That is correct.

Mr. MCCRERY. He cannot yield time during offering a motion to the Committee.

Chairman THOMAS. That is correct. The gentleman was recognized for the purpose of offering a motion. He has offered a motion——

Mr. RANGEL. I move the——

Chairman THOMAS. He has explained to a degree the motion, and the Chair would indicate that all we are trying to do is get the facts before we make a decision. The gentleman from New York has every right to make a decision before he gets the facts, and that is evidenced by the motion that he has offered.

Mr. LEVIN. Mr. Chairman——

Chairman THOMAS. The Chair would be willing for the purpose of comity to allow the gentleman from Michigan to make some brief points, notwithstanding the fact that the Chair has the ability to recognize except for the structure of in the middle of a roll call vote, and then the Chair would not exercise the recognition but rather to carry out the roll call vote and that is what occurred on the last request by the gentleman from New York.

Mr. RANGEL. Well, I recognize——

Chairman THOMAS. The Chair would attempt to allow a reasonable dialog by recognizing the gentleman from Michigan for any comments he may wish to make on the motion by the gentleman from New York requesting a subpoena for the former Administrator. The gentleman from Michigan?

Mr. LEVIN. Thank you, Mr. Chairman. We need to understand what the question is, what the issue is. It was not when Mr. Foster was here who was right, whether it was $400 billion that was as stated when we were voting on this or $530-some billion that was the actuarial figure. That, there was disagreement. The issue isn't legally whether Mr. Scully had the right to tell Mr. Foster he could not tell people. That is an issue. The main issue is who knew about the actuarial figure? Why wasn't it disclosed in a timely fashion? That is the issue. We voted in this Congress on major legislation while there was information that was hidden from us by some in the Administration and we have a right to know why and who knew. That is the issue. To say this question, therefore, is a matter of curiosity or a whim or a style is absolutely incorrect. It is the knowledge that is the right of the public and the need for there to be truthfulness. I said when Mr. Foster was here that there was a cover-up of this information and we want to know how high up the cover-up went. Mr. Scully says something by his letter. We have a right to have him right here in front of us, under oath, to ask him what he knew, whom he talked to within the White House, under what circumstances and why he did not tell us, the representatives of the people, the information that he knew. That is the issue. So, anybody here can stonewall, and I am sorry my other colleagues cannot speak. They will do it when they inquire of these witnesses. We will find a way, because as we have found out on other occasions, and I close with this, there is no way to hide the truth. I just want to say, I have great respect for Mr. McCrery. For you to move to table and quash discussion of this motion is not going to work. We are going to get this information out one way or the other.

Mr. RANGEL. I move the question, Mr. Chairman.

Mr. MCCRERY. Mr. Chairman.

Chairman THOMAS. The Chair recognizes the gentleman from Louisiana.

Mr. MCCRERY. Mr. Chairman, before I make the motion to table, I would just refer——

Mr. RANGEL. A point of order, Mr. Chairman.

Mr. MCCRERY. Everyone to Mr. Scully's letter——

Mr. RANGEL. Point of order.

Mr. MCCRERY. Which points out clearly——

Mr. RANGEL. Is recognized——

Mr. MCCRERY. That information was available——

Chairman THOMAS. The gentleman from Louisiana will suspend. The Chair recognized the gentleman from Louisiana. He did not recognize the gentleman from Louisiana for the purpose of offering a motion. He recognized the gentleman from Louisiana.

Mr. RANGEL. I'll withdraw my point of order.

Chairman THOMAS. The time is the gentleman from Louisiana's. Would the gentleman like to continue——

Mr. MCCRERY. Thank you, Mr. Chairman. I think the Chairman has been quite generous with allowing the minority to explore this question during Mr. Rangel's presentation early on in this hearing and then by allowing Mr. McDermott and Mr. Levin. Frankly, we could argue about this all day long and some may conclude that that is, in fact, the point of the minority. The facts are that there was information available to the public which would have led any knowledgeable person to conclude that OMB's ultimate assumptions and ultimate estimate of the cost of the Medicare bill were going to be higher than CBO's. Mr. Scully, in fact, according to his letter, testified before the Senate Finance Committee to the fact that his assumptions were different. If you had looked at those assumptions and been familiar with how the estimate on the bill was going to work, you would know that it was going to be higher. You add to that the fact that the minority repeatedly introduced, supported, talked about Medicare bills that cost a lot more than either one of the CBO's estimate or the OMB estimate and I think you see this debate for what it is.

Mr. NEAL. Would the gentleman yield?

Mr. MCCRERY. I will be glad to yield.

Mr. NEAL. Mr. McCrery, is it your position that the Medicare prescription drug bill would have passed in the House of Representatives had the true figure been known?

Mr. MCCRERY. My position is that many more Democrats, according to their rhetoric, would have voted for a bill with a much higher price tag.

[Laughter.

Well, then I suppose you were just introducing things out of folly that cost twice as much. I mean, come on, get real here.

Chairman THOMAS. The gentleman from Louisiana has the time.

Mr. MCCRERY. Let us just get down to what this is all about. This is a lot about politics. We understand that. Everybody in the audience understands that. We have spent enough time on it. We have two witnesses here at the behest of the minority operating fully under the rules of the House, which we recognize, to extend a hearing which we called to try to explore this subject. Under your

rights in the minority, we now have extended the hearing and two of the witnesses which you invited to appear are here and we are waiting to hear their testimony. Enough of the politics. Let's get on with the hearing and then you can all make your remarks——

Mr. SHAW. Mr. Chairman.

Mr. MCCRERY. To try to get that out. I move——

Mr. SHAW. Mr. Chairman.

Chairman THOMAS. I tell the gentleman from Louisiana——

Mr. MCCRERY. I move to table the motion of the gentleman from New York.

Chairman THOMAS. In the opinion of the Chair, the gentleman from Louisiana is debating the point, probably would be considered a preface to his motion, and since the Chair had recognized the gentleman from New York and the gentleman from Michigan, two Members of the minority, the Chair wishes to recognize a second Member of the majority, and the Chair recognizes the gentleman from Florida, Mr. Shaw.

Mr. SHAW. Mr. Chairman, I move to table the motion of the gentleman from New York.

Chairman THOMAS. The gentleman from Florida moves to table the motion of the gentleman from New York. All those in favor?

[Chorus of ayes.]

Those opposed?

[Chorus of noes.]

In the opinion of the Chair, the ayes have it.

Mr. LEVIN. Roll call.

Chairman THOMAS. The Chair will recognize the right of the minority to call the roll, with the understanding that we would like to have the roll call without attempts to gain recognition during the roll call. Will the clerk call the roll?

CLERK. Mr. Crane.

Mr. CRANE. Aye.

CLERK. Mr. Crane votes aye. Mr. Shaw?

Mr. SHAW. Aye.

CLERK. Mr. Shaw votes aye. Mrs. Johnson?

Mrs. JOHNSON. Aye.

CLERK. Mrs. Johnson votes aye. Mr. Houghton?

[No response.]

Mr. Herger?

Mr. HERGER. Aye.

CLERK. Mr. Herger votes aye. Mr. McCrery?

Mr. MCCRERY. Aye.

CLERK. Mr. McCrery votes aye. Mr. Camp?

Mr. CAMP. Aye.

CLERK. Mr. Camp votes aye. Mr. Ramstad?

Mr. RAMSTAD. Aye.

CLERK. Mr. Ramstad votes aye. Mr. Nussle?

Mr. NUSSLE. Aye.

CLERK. Mr. Nussle votes aye. Mr. Johnson?

Mr. JOHNSON. Aye.

CLERK. Mr. Johnson votes aye. Ms. Dunn?

Ms. DUNN. Aye.

CLERK. Ms. Dunn votes aye. Mr. Collins?

Mr. COLLINS. Yes.

CLERK. Mr. Collins votes yes. Mr. Portman?
Mr. PORTMAN. Aye.
CLERK. Mr. Portman votes aye. Mr. English?
Mr. ENGLISH. Aye.
CLERK. Mr. English votes aye. Mr. Hayworth?
Mr. HAYWORTH. Aye.
CLERK. Mr. Hayworth votes aye. Mr. Weller?
Mr. WELLER. Aye.
CLERK. Mr. Weller votes aye. Mr. Hulshof?
[No response.]
Mr. McInnis?
Mr. MCINNIS. Yes.
CLERK. Mr. McInnis votes yes. Mr. Lewis of Kentucky?
Mr. LEWIS OF KENTUCKY. Aye.
CLERK. Mr. Lewis of Kentucky votes aye. Mr. Foley?
Mr. FOLEY. Aye.
CLERK. Mr. Foley votes aye. Mr. Brady?
Mr. BRADY. Aye.
CLERK. Mr. Brady votes aye. Mr. Ryan?
Mr. RYAN. Aye.
CLERK. Mr. Ryan votes aye. Mr. Cantor?
Mr. CANTOR. Aye.
CLERK. Mr. Cantor votes aye. Mr. Rangel. Mr. Rangel?
Mr. RANGEL. No.
CLERK. Mr. Rangel votes no. Mr. Stark?
Mr. STARK. No.
CLERK. Mr. Stark votes no. Mr. Matsui?
Mr. MATSUI. No.
CLERK. Mr. Matsui votes no. Mr. Levin?
Mr. LEVIN. No.
CLERK. Mr. Levin votes no. Mr. Cardin?
Mr. CARDIN. No.
CLERK. Mr. Cardin votes no. Mr. McDermott?
Mr. MCDERMOTT. No.
CLERK. Mr. McDermott votes no. Mr. Kleczka?
Mr. KLECZKA. No.
CLERK. Mr. Kleczka votes no. Mr. Lewis of Georgia?
Mr. LEWIS OF GEORGIA. No.
CLERK. Mr. Lewis of Georgia votes no. Mr. Neal?
Mr. NEAL. No.
CLERK. Mr. Neal votes no. Mr. McNulty?
Mr. MCNULTY. No.
CLERK. Mr. McNulty votes no. Mr. Jefferson?
[No response.]
Mr. Tanner?
Mr. TANNER. No.
CLERK. Mr. Tanner votes no. Mr. Becerra?
Mr. BECERRA. No.
CLERK. Mr. Becerra votes no. Mr. Doggett?
Mr. DOGGETT. No.
CLERK. Mr. Doggett votes no. Mr. Pomeroy?
Mr. POMEROY. No.
CLERK. Mr. Pomeroy votes no. Mr. Sandlin?
Mr. SANDLIN. No.

CLERK. Mr. Sandlin votes no. Ms. Tubbs Jones?
Ms. TUBBS JONES. No.
CLERK. Ms. Tubbs Jones votes no. Mr. Houghton?
Mr. HOUGHTON. Aye.
CLERK. Mr. Houghton votes aye. Mr. Hulshof?
[No response.]
Mr. Jefferson?
[No response.]
Mr. Thomas?
Chairman THOMAS. Aye.
CLERK. Mr. Thomas votes aye.
Chairman THOMAS. The clerk will announce the vote.
CLERK. Twenty-three ayes, 16 no.

Chairman THOMAS. There being 23 ayes and 16 noes, the motion of the gentleman from New York is laid upon the table. The Chair is prepared to allow the witnesses to begin testimony. The Chair will indicate that because this hearing was requested as an extension of the previous hearing, the Chair, to try to accommodate in a timely fashion, called the hearing for today at 12:00 p.m. A previously scheduled hearing in this room is to begin at 2:00 p.m. and the Chair intends not to disrupt the previously scheduled hearing, which was ordered for 2:00 p.m. The Chair will now, first of all, thank Ms. Norwalk and Mr. Flick for appearing before us——

Mr. DOGGETT. Parliamentary inquiry, Mr. Chairman.

Chairman THOMAS. The gentleman from Texas?

Mr. DOGGETT. Do I understand, then, that the testimony from the witnesses and the questions from all Members of this Committee will be limited to a total of 59 minutes or however much is left before 2:00 p.m.?

Chairman THOMAS. I tell the gentleman, no, it was the 2 hours that we had available when the Committee began.

Mr. DOGGETT. At this point, without the Chair having made any prior announcement on this topic, you may not even reach all the Members of this Committee and permit them a right to question. Is that my understanding? I mean, I can just count 5 minutes per person down here, and if everyone takes their time, some Members of the Committee will not be permitted to ask any questions.

Chairman THOMAS. The gentleman is usually very persuasive and perhaps he can persuade some Members not to utilize their full time so he can have a chance——

Mr. KLECZKA. Mr. Chairman, parliamentary inquiry.

Chairman THOMAS. The gentleman from Wisconsin.

Mr. KLECZKA. Mr. Chairman, is it not true that the most powerful Committee in Congress, the Committee on Ways and Means, has other hearing rooms, that we have not only this main hearing room, but there are other rooms throughout the Capitol complex where the next hearing could be conducted? Is that not true so we can continue with this?

Chairman THOMAS. I tell the gentleman, this room was chosen because of the importance and the number of people who are going to attend that hearing. It was on the schedule prior to this, scheduled for 2:00 p.m., and the Chair intends to honor the previously scheduled hearing.

Mr. KLECZKA. Isn't this the same——

Chairman THOMAS. The sooner we can begin, the better we have——

Mr. KLECZKA. Isn't this the same Committee hearing that was scheduled for 10:00 a.m. this morning and it never occurred at 10:00 a.m.?

Chairman THOMAS. No.

Mr. KLECZKA. Are you sure?

Chairman THOMAS. The Chair is willing to recognize the witnesses——

Mr. RANGEL. A parliamentary inquiry, Mr. Chairman.

Chairman THOMAS. The gentleman from New York.

Mr. RANGEL. Does the Chair intend to place the witnesses under oath?

Chairman THOMAS. As long as the Chairman's tenure to this point, no witness has been placed under oath and the Chair would probably begin the inquiry as to the necessity of the oath to inquire both of Ms. Norwalk and Mr. Flick, are you currently employed by the Federal Government?

Ms. NORWALK. Yes.

Mr. FLICK. Yes.

Chairman THOMAS. I believe the answer to that would be yes. In the procedure of being employed, were you required to swear or affirm an oath of allegiance to the United States and its Constitution?

Ms. NORWALK. Yes.

Mr. FLICK. Yes.

Chairman THOMAS. The answer is yes. Beyond that, your goal here is to pursue the truth? The Chair feels comfortable, I will tell the gentleman from New York, that based upon their prior swearing or affirming and their current role, that the Chair believes the testimony by these people who voluntarily have appeared before the Committee who had a choice not to appear will be truthful without the need to push it to an oath-taking procedure.

Mr. RANGEL. Further parliamentary inquiry, Mr. Chairman. In view of the fact that the Chair has now interpreted the need or lack of need for an oath before congressional Committees, would it be in order that the Ranking Member be allowed to have a motion that the witnesses be placed under oath?

Chairman THOMAS. I tell the gentleman that the decision that the Chair made was based upon the same one in terms of need or wants. If the gentleman is questioning witnesses who voluntarily appeared before us who have in their current place of employment sworn an oath of allegiance to the Constitution, the Chair finds virtually no difference between the position of the witness and the position of every Member on this Congress. We, too, are employed by the Federal Government, and we, too, have taken an oath of office. If the gentleman believes that the witnesses, or the concern over the witnesses rises to the point of requiring an oath, the Chair may be prepared for every Member of the Committee to rise and also reaffirm their oath, so that we are all on the same level of concern about our willingness to take oaths and the voracity of our statements.

Mr. RANGEL. Well, I exclude the Members of this Committee, but I move that the witnesses be placed under oath.

Mr. MCCRERY. Mr. Chairman.

Chairman THOMAS. The gentleman from Louisiana?

Mr. MCCRERY. Knowing that it is a violation of Federal law to knowingly tell a falsehood to a government official, I think it would be duplicative, unnecessary, and perhaps even diminish the possibility in the future of getting good witnesses to appear before the Committee. I therefore move to table the motion of the gentleman from New York.

Chairman THOMAS. The gentleman from Louisiana has moved to table the gentleman from New York's——

Mr. DOGGETT. Mr. Chairman, parliamentary——

Chairman THOMAS. Motion. All those in favor, say aye.

[Chorus of ayes.]

Those opposed?

[Chorus of noes.]

In the opinion of the Chair, the ayes have it. The ayes have it and the motion is tabled.

Mr. RANGEL. Record vote.

Chairman THOMAS. A sufficient number of hands. The clerk will call the roll.

CLERK. Mr. Crane?

Mr. CRANE. Aye.

CLERK. Mr. Crane votes aye. Mr. Shaw?

Mr. SHAW. Aye.

CLERK. Mr. Shaw votes aye. Mrs. Johnson?

Mrs. JOHNSON. Aye.

CLERK. Mrs. Johnson votes aye. Mr. Houghton?

Mr. HOUGHTON. Aye.

CLERK. Mr. Houghton votes aye. Mr. Herger?

Mr. HERGER. Aye.

CLERK. Mr. Herger votes aye. Mr. McCrery?

Mr. MCCRERY. Aye.

CLERK. Mr. McCrery votes aye. Mr. Camp?

Mr. CAMP. Aye.

CLERK. Mr. Camp votes aye. Mr. Ramstad?

Mr. RAMSTAD. Aye.

CLERK. Mr. Ramstad votes aye. Mr. Nussle?

Mr. NUSSLE. Aye.

CLERK. Mr. Nussle votes aye. Mr. Johnson?

Mr. JOHNSON. Aye.

CLERK. Mr. Johnson votes aye. Ms. Dunn?

[No response.]

Mr. Collins?

Mr. COLLINS. Yes.

CLERK. Mr. Collins votes yes. Mr. Portman?

Mr. PORTMAN. Aye.

CLERK. Mr. Portman votes aye. Mr. English?

Mr. ENGLISH. Aye.

CLERK. Mr. English votes aye. Mr. Hayworth?

Mr. HAYWORTH. Aye.

CLERK. Mr. Hayworth votes aye. Mr. Weller?

Mr. WELLER. Aye.

CLERK. Mr. Weller votes aye. Mr. Hulshof?

[No response.]

Mr. McInnis?
[No response.]
Mr. Lewis of Kentucky?
Mr. LEWIS OF KENTUCKY. Aye.
CLERK. Mr. Lewis of Kentucky votes aye. Mr. Foley?
[No response.]
Mr. Brady?
Mr. BRADY. Aye.
CLERK. Mr. Brady votes aye. Mr. Ryan?
Mr. RYAN. Aye.
CLERK. Mr. Ryan votes aye. Mr. Cantor?
Mr. CANTOR. Aye.
CLERK. Mr. Cantor votes aye. Mr. Rangel. Mr. Rangel?
Mr. RANGEL. No.
CLERK. Mr. Rangel votes no. Mr. Stark?
Mr. STARK. No.
CLERK. Mr. Stark votes no. Mr. Matsui?
Mr. MATSUI. No.
CLERK. Mr. Matsui votes no. Mr. Levin?
Mr. LEVIN. No.
CLERK. Mr. Levin votes no. Mr. Cardin?
Mr. CARDIN. No.
CLERK. Mr. Cardin votes no. Mr. McDermott?
Mr. MCDERMOTT. No.
CLERK. Mr. McDermott votes no. Mr. Kleczka?
Mr. KLECZKA. No.
CLERK. Mr. Kleczka votes no. Mr. Lewis of Georgia?
Mr. LEWIS OF GEORGIA. No.
CLERK. Mr. Lewis of Georgia votes no. Mr. Neal?
Mr. NEAL. No.
CLERK. Mr. Neal votes no. Mr. McNulty?
Mr. MCNULTY. No.
CLERK. Mr. McNulty votes no. Mr. Jefferson?
[No response.]
Mr. Tanner?
Mr. TANNER. No.
CLERK. Mr. Tanner votes no. Mr. Becerra?
Mr. BECERRA. No.
CLERK. Mr. Becerra votes no. Mr. Doggett?
Mr. DOGGETT. No.
CLERK. Mr. Doggett votes no. Mr. Pomeroy?
Mr. POMEROY. No.
CLERK. Mr. Pomeroy votes no. Mr. Sandlin?
Mr. SANDLIN. No.
CLERK. Mr. Sandlin votes no. Ms. Tubbs Jones?
Ms. TUBBS JONES. No.
CLERK. Ms. Tubbs Jones votes no. Ms. Dunn?
[No response.]
Mr. Hulshof?
[No response.]
Mr. McInnis?
[No response.]
Mr. Foley?
[No response.]

Mr. Jefferson?

[No response.]

Mr. Thomas?

Chairman THOMAS. Aye.

CLERK. Mr. Thomas votes aye.

Chairman THOMAS. The clerk will announce the vote.

CLERK. Twenty aye, 16 no.

Chairman THOMAS. There being 20 ayes, 16 noes, the motion of the gentleman from New York is laid upon the table. The Chair is prepared to allow the witnesses to present testimony at this point.

Mr. DOGGETT. Point of order, Mr. Chairman.

Chairman THOMAS. The Chair——

Mr. DOGGETT. I have a point of order.

Chairman THOMAS. Point of order?

Mr. DOGGETT. Yes, sir.

Chairman THOMAS. The gentleman from Texas on his point of order.

Mr. DOGGETT. Solely. Mr. Chairman, House Rule XI, Clause (2)(j)(2), provides that, quote, "each Committee shall apply the 5-minute rule during the questioning of witnesses in any hearing until such time as each Member of the Committee who so desires has had an opportunity to question each witness." House Rule XI, Clause (2)(j)(1) is the rule of the House to which the Chairman referred that gives him no discretion to deny this hearing. My point of order is that the Chair, by his ruling limiting the time of this hearing to less than an hour and denying me and other Members of the Committee an opportunity to ask any questions is in violation of both House Rule XI, Clause (2)(j)(2) and House Rule XI, Clause (2)(j)(1), since he has converted this appearance of a hearing into a total sham hearing, denying the minority their right to ask questions of these witnesses. I would urge my point of order.

Chairman THOMAS. I tell the gentleman that my ability to reach the level the gentleman from Texas described these hearings pales in comparison. The Chair will indicate that there are many occasions in which hearings that are called have not been successful in exhausting the opportunities of each and every Member. The Chair indicates the time, place, and manner, oftentimes controls the circumstances we find ourselves in. The Chair would like to start the process because the gentleman from Texas has come to a conclusion without the process ever yet having been allowed to begin. He has reached a conclusion which is not yet warranted nor can the point of order be made since the hearing has not ended and every Member has not had their chances for the 5 minutes. So, if the gentleman wants to continue to attempt to make his point so that, in fact, there is no time for any Member, the Chair would consider that dilatory and, therefore, would rule that the Chair would not recognize the gentleman to make a point of order——

Mr. DOGGETT. The Chair has no choice——

Chairman THOMAS. When the point of order might be timely——

Mr. DOGGETT. To recognize me to make a point of order——

Chairman THOMAS. The Chair indicates——

Mr. DOGGETT. I urge my point of order, Mr. Chairman.

Chairman THOMAS. The Chair indicates the gentleman from Texas's inquiry is not timely as a point of order.

Mr. DOGGETT. Mr. Chairman, I urge my point of order——

Chairman THOMAS. It is not timely. The Chair recognizes——

Mr. DOGGETT. If you want to overrule it, fine, but otherwise, I want to appeal this ruling of the Chair.

Chairman THOMAS. The Chair recognizes the witnesses——

Mr. DOGGETT. Mr. Chairman, I urge my point of order and I urge it now. I want a——

Chairman THOMAS. I tell the gentleman——

Mr. DOGGETT. Is there a ruling on the order?

Chairman THOMAS. I tell the gentleman that the Chair recognized the gentleman for a point of order. The point of order——

Mr. DOGGETT. The point of order has been made and the Chair refuses to rule on it——

Chairman THOMAS. The gentleman from Texas made——

Mr. DOGGETT. Since the Chair is acting totally improperly——

Chairman THOMAS. The gentleman's point was not timely.

Mr. DOGGETT. Mr. Chairman, I urge my point of order.

Chairman THOMAS. The point was not timely and the gentleman is now——

Mr. DOGGETT. I take that as a denial——

Chairman THOMAS. Carrying out dilatory tactics.

Mr. DOGGETT. I appeal the ruling of the Chair and I urge——

Mr. MCCRERY. Mr. Chairman.

Chairman THOMAS. I tell the gentleman——

Mr. DOGGETT. I ask for a vote on——

Chairman THOMAS. He was not recognized——

Mr. DOGGETT. The ruling of the Chair.

Chairman THOMAS. For that purpose.

Mr. DOGGETT. Mr. Chairman, you have no discretion when a point of order is made but to entertain that point of order. If you are denying the point of order as not timely, then please do so and I will appeal respectfully your ruling and show you the respect to which you are entitled. I am entitled to a ruling on my point of order. It is privileged and you do not have the discretion to ignore it.

Chairman THOMAS. I tell the gentleman——

Mr. MCCRERY. Mr. Chairman.

Chairman THOMAS. I tell the gentleman on his point of order, which was a conclusion based upon Rule XI, that every Member gets to exercise the 5-minute rule, has not yet ripened.

Mr. DOGGETT. I urge my point of order. If——

Chairman THOMAS. No Member has been denied the right to question. Therefore, Rule XI is not now in violation and the gentleman's point of order is not timely.

Mr. DOGGETT. Mr. Chairman, you have denied my point of order as not ripe and I appeal the ruling of the Chair, respectfully.

Chairman THOMAS. The gentleman was recognized for a point of order. The Chair is telling the gentleman his point of order is not ripe——

Mr. DOGGETT. The Chair is denying——

Chairman THOMAS. Therefore there is no ability to appeal the decision of the Chair.

Mr. DOGGETT. My point of order while attempting to avoid making a ruling which he knows will be appealed. I appeal the ruling of the Chair denying my point of order to have a fair opportunity to ask these witnesses questions.

Chairman THOMAS. I tell the gentleman that he will have a fair opportunity, and until he is denied, his point of order is not timely.

Mr. DOGGETT. Mr. Chairman, I appeal the ruling of the Chair. The Chair has ruled that the point of order is not ripe. That is a denial of the point of order as the Chair clearly knows.

Chairman THOMAS. I will accept the gentleman's argument that the Chair's ruling of the fact that not every Member has been able to exercise their 5 minutes as a point of order is not timely. The Chair believes that point of order is not timely. The gentleman from Texas believes it is and, therefore, appeals the decision of the Chair.

Mr. DOGGETT. Thank you, Mr. Chairman.

Mr. MCCRERY. Mr. Chairman, I don't believe that is debatable, but just in case it is, I move to table the motion of the gentleman to appeal the ruling of the Chair.

Chairman THOMAS. The gentleman's move to table the motion is timely and appropriate. All those in favor of tabling the motion, say aye.

[Chorus of ayes.]

Those opposed?

[Chorus of noes.]

In the opinion of the Chair, the ayes have it——

Mr. DOGGETT. Mr. Chairman, record vote.

Chairman THOMAS. The motion to appeal the decision of the Chair is tabled.

Mr. DOGGETT. Record vote.

Chairman THOMAS. A sufficient number for a record vote. The clerk will call the roll.

CLERK. Mr. Crane?

Mr. CRANE. Aye.

CLERK. Mr. Crane votes aye. Mr. Shaw?

Mr. SHAW. Aye.

CLERK. Mr. Shaw votes aye. Mrs. Johnson?

Mrs. JOHNSON. Aye.

CLERK. Mrs. Johnson votes aye. Mr. Houghton?

Mr. HOUGHTON. Aye.

CLERK. Mr. Houghton votes aye. Mr. Herger?

Mr. HERGER. Aye.

CLERK. Mr. Herger votes aye. Mr. McCrery?

Mr. MCCRERY. Aye.

CLERK. Mr. McCrery votes aye. Mr. Camp?

Mr. CAMP. Aye.

CLERK. Mr. Camp votes aye. Mr. Ramstad?

Mr. RAMSTAD. Aye.

CLERK. Mr. Ramstad votes aye. Mr. Nussle?

Mr. NUSSLE. Aye.

CLERK. Mr. Nussle votes aye. Mr. Johnson?

Mr. JOHNSON. Aye.

CLERK. Mr. Johnson votes aye. Ms. Dunn?

[No response.]

Mr. Collins?
Mr. COLLINS. Yes.
CLERK. Mr. Collins votes yes. Mr. Portman?
Mr. PORTMAN. Aye.
CLERK. Mr. Portman votes aye. Mr. English?
Mr. ENGLISH. Aye.
CLERK. Mr. English votes aye. Mr. Hayworth?
Mr. HAYWORTH. Aye.
CLERK. Mr. Hayworth votes aye. Mr. Weller?
Mr. WELLER. Aye.
CLERK. Mr. Weller votes aye. Mr. Hulshof?
[No response.]
Mr. McInnis?
[No response.]
Mr. Lewis of Kentucky? Mr. Lewis of Kentucky? Mr. Lewis?
Mr. LEWIS OF KENTUCKY. Aye.
CLERK. Mr. Lewis of Kentucky votes aye. Mr. Foley?
[No response.]
Mr. Brady?
Mr. BRADY. Aye.
CLERK. Mr. Brady votes aye. Mr. Ryan?
Mr. RYAN. Aye.
CLERK. Mr. Ryan votes aye. Mr. Cantor?
Mr. CANTOR. Aye.
CLERK. Mr. Cantor votes aye. Mr. Rangel. Mr. Rangel?
Mr. RANGEL. No.
CLERK. Mr. Rangel votes no. Mr. Stark?
Mr. STARK. No.
CLERK. Mr. Stark votes no. Mr. Matsui?
Mr. MATSUI. No.
CLERK. Mr. Matsui votes no. Mr. Levin?
Mr. LEVIN. No.
CLERK. Mr. Levin votes no. Mr. Cardin?
Mr. CARDIN. No.
CLERK. Mr. Cardin votes no. Mr. McDermott?
Mr. MCDERMOTT. No.
CLERK. Mr. McDermott votes no. Mr. Kleczka?
Mr. KLECZKA. No.
CLERK. Mr. Kleczka votes no. Mr. Lewis of Georgia?
Mr. LEWIS OF GEORGIA. No.
CLERK. Mr. Lewis of Georgia votes no. Mr. Neal?
Mr. NEAL. No.
CLERK. Mr. Neal votes no. Mr. McNulty?
Mr. MCNULTY. No.
CLERK. Mr. McNulty votes no. Mr. Jefferson?
[No response.]
Mr. Tanner?
Mr. TANNER. No.
CLERK. Mr. Tanner votes no. Mr. Becerra?
Mr. BECERRA. No.
CLERK. Mr. Becerra votes no. Mr. Doggett?
Mr. DOGGETT. No.
CLERK. Mr. Doggett votes no. Mr. Pomeroy?
Mr. POMEROY. No.

CLERK. Mr. Pomeroy votes no. Mr. Sandlin?
Mr. SANDLIN. No.
CLERK. Mr. Sandlin votes no. Ms. Tubbs Jones?
Ms. TUBBS JONES. No.
CLERK. Ms. Tubbs Jones votes no. Ms. Dunn?
[No response.]
Mr. Hulshof?
[No response.]
Mr. McInnis?
[No response.]
Mr. Foley?
[No response.]
Mr. Jefferson?
[No response.]
Mr. Thomas?
Chairman THOMAS. Aye.
CLERK. Mr. Thomas votes aye.
Mr. MCINNIS. Mr. Chairman, how am I recorded?
Chairman THOMAS. How is the gentleman from Colorado recorded?
CLERK. Mr. McInnis is not recorded.
Mr. MCINNIS. Yes.
CLERK. Mr. McInnis votes yes.
Ms. DUNN. Mr. Chairman, how am I recorded?
Chairman THOMAS. How is the gentlewoman from Washington recorded?
CLERK. Ms. Dunn is not recorded.
Ms. DUNN. Aye.
CLERK. Ms. Dunn votes aye.
Chairman THOMAS. The clerk will announce the vote.
CLERK. Twenty-two aye, 16 no.
Chairman THOMAS. There being 22 ayes and 16 noes, the motion of the gentleman from Texas is laid on the table. The Chair is ready to allow the witnesses to present their testimony. The Chair would indicate that if you have any written testimony, it will be made a part of the record and you can inform us in any way you see fit in the time that you have. I would begin with Mr. Flick and, again, would have Ms. Norwalk.
Mr. Flick.

**STATEMENT OF JEFF FLICK, SAN FRANCISCO REGIONAL ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES, SAN FRANCISCO, CALIFORNIA**

Mr. FLICK. Mr. Chairman, Members of the Committee on Ways and Means, good afternoon. My name is Jeff Flick. I am currently serving as the Regional Administrator for the CMS in the San Francisco Regional Office. I am a career civil servant and my employment with CMS began in January 2001. Shortly after starting work in Washington, D.C., I was detailed into the Office of the Acting Administrator. I worked for a couple of months as a Special Assistant to the Acting Administrator, Michael McMullen. I was working in the Office of the Administrator when Tom Scully was sworn in as the CMS Administrator in May 2001. I continued my work as Special Assistant, working directly with Administrator

Scully until September 2003, when I assumed my current role as Regional Administrator in San Francisco.

I am pleased to be with you today and I assume that you are interested in talking with me regarding an e-mail I sent to Rick Foster in June of 2003 in my capacity as Special Assistant to the Administrator. As Special Assistant to the Administrator, I was largely involved in the day-to-day work of the Administrator. Some people would describe this as keeping the trains running. I tried to make sure that the schedules made sense, appropriate briefing materials were prepared, and so forth, the important work of the agency was accomplished, and yes, I tried to keep the Administrator on schedule. I was rarely, if ever, involved in the details of the work. In fact, it was more than a full-time job simply keeping up with the daily work flow in the Office of the Administrator. In June of 2003, I prepared an e-mail that I sent to Rick Foster. The e-mail was sent to Rick after I had at least one conversation with Rick and after I had several conversations with the Administrator. The e-mail focused on a request from a minority staff member for an impact analysis on a specific provision in the bill. As I recall, the Administrator was very concerned about the analysis and the request for the analysis.

This particular request caught his attention in a way others did not. He suggested to me that at least some of the information that was requested involved provisions that were no longer in the bill. He asked me to contact Rick Foster, requesting that Mr. Foster work up the numbers and send them directly to the Administrator. The Administrator was very clear, "Have Rick send them to me prior to sharing with anyone else." The Administrator indicated to me that he would probably be talking with Rick about this and he emphasized to me that Rick should not release the numbers until I, the Administrator, have a chance to review the information and until I, Tom Scully, explicitly talk with Rick authorizing the release.

Chairman THOMAS. Mr. Flick, let me indicate that normally we would allow witnesses to finish their statements, but we are under the 5-minute rule. The red light has come on. If you could wrap it up in a sentence or two so no one could accuse you of unduly prolonging your testimony.

Mr. FLICK. I see. I relayed the message to Rick through a phone call. I was not convinced that Rick would comply with the request. Later that day, I retrieved an e-mail and gave it to the Administrator. Administrator Scully authorized the release of some information but asked me to contact Rick a second time, confirming the initial instructions, and the Administrator emphasized that if Rick did not adhere to these instructions, it would be outright insubordination and insubordination carries serious consequences. The language in this statement is not exact. I am recalling this from memory to the best of my ability. The actual language may have been more colorful than the text. I was not able to reach Rick by telephone. I comprised an e-mail to communicate the message that the Administrator asked me to convey to Rick. I believe the e-mail I sent to Rick Foster was an accurate reflection of the message I was instructed by Administrator Scully to convey. Thank you, Mr. Chairman. This concludes my remarks.

[The prepared statement of Mr. Flick follows:]

**Statement of Jeff Flick, San Francisco Regional Administrator, Centers for Medicare and Medicaid Services, San Francisco, California**

Mr. Chairman, members of the Ways and Means Committee. Good afternoon—my name is Jeff Flick. I am currently serving as the Regional Administrator for the Centers for Medicare & Medicaid Services (CMS) in the San Francisco Regional Office. I am a career civil servant and my employment with CMS began in January 2001. Shortly after starting work in Washington, D.C., I was detailed into the Office of the Acting Administrator. I worked for a couple of months as a special assistant to the Acting Administrator, Michael McMullan. I was working in the Office of the Administrator when Tom Scully was sworn in as the CMS Administrator in May 2001. I continued my work as a special assistant, working directly with Administrator Scully until September 2003, when I assumed my current role as Regional Administrator in San Francisco.

I am pleased to be with you today and I assume that you are interested in talking with me regarding an email I sent to Rick Foster in June of 2003 in my capacity as special assistant to the Administrator. As special assistant to the Administrator, I was largely involved in the day-to-day work of the Administrator. Some people would describe this as keeping the trains running. I tried to make sure the schedules made sense, appropriate briefing materials were prepared, etc. The important work of the Agency was accomplished and, yes, I tried to keep the Administrator on schedule. I was rarely, if ever, involved in the details of the work. In fact, it was more than full-time job simply keeping up with the daily workflow in the Office of the Administrator.

In June of 2003, I prepared an email that I sent to Rick Foster. This email was sent to Rick after I had at least one conversation with Rick, and after I had several conversations with the Administrator. The email focused on a request from a minority staff member for an impact analysis on a specific provision in the bill. As I recall, the Administrator was very concerned about the analysis, and the request for the analysis. This particular request caught his attention in a way others did not. He suggested to me that at least some of the information that was requested involved provisions that were no longer in the bill. He asked me to contact Rick Foster—requesting that Mr. Foster work up the numbers and send them directly to the Administrator. The Administrator was very clear—have Rick send them to me prior to sharing with anyone else. The Administrator indicated to me that he would probably be talking with Rick about this and he emphasized to me that Rick should not release the numbers until I (the Administrator) have a chance to review the information, and until I (Tom Scully) explicitly talk with Rick authorizing the release.

I relayed this message to Rick (through a phone call) but I was not convinced that Rick would comply with the request of the Administrator. Rick sent an email directly to the Administrator after my conversation with Rick, asking that he (Rick) be allowed to release the information immediately. I retrieved the email and gave it to the Administrator. Administrator Scully authorized the release of some information but he asked me to contact Rick a second time, confirming the initial instructions, and the Administrator emphasized that if Rick does not adhere to these instructions, it is outright insubordination and insubordination carries serious consequences. The language in this statement is not exact. I am recalling this from memory to the best of my ability and the actual language may have been more colorful than the text in this statement.

I was not able to reach Rick by telephone and I comprised an email to communicate the message that the Administrator asked me to convey to Rick Foster. I believe the email I sent to Rick Foster was an accurate reflection of the message I was instructed by Administrator Scully to convey. I believe I shared a copy of the email with Administrator Scully.

Thank you, Mr. Chairman; this concludes my remarks.

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Chairman THOMAS. I thank the gentleman.

Ms. Norwalk.

**STATEMENT OF LESLIE V. NORWALK, ACTING DEPUTY ADMINISTRATOR AND CHIEF OPERATING OFFICER, CENTERS FOR MEDICARE AND MEDICAID SERVICES**

Ms. NORWALK. Good afternoon, Chairman Thomas and Members of the Committee on Ways and Means. My name is Leslie Norwalk. Since November 2001, I have officially served as Counselor to the Administrator at the CMS. For the past year, I have been the Acting Deputy Administrator and Chief Operating Officer of CMS. In this role, I direct the day-to-day operations of CMS. On March 25, 2004, Richard Foster, CMS's Chief Actuary, mentioned my name and referred to me as a, quote, "top attorney at CMS," unquote, in his testimony before this Committee. I understand that the Committee is interested in hearing my recollection about a meeting I had with Mr. Foster and any advice I gave him. On June 13, 2003, Mr. Foster came to see me to discuss a difficult situation and to ask for my help to resolve it. While Mr. Foster sought my advice, I believe that it was in my capacity as Deputy and Chief Operating Officer and not in my capacity as a lawyer. I believe this because my interactions with Mr. Foster in 2003 focused on helping him manage the incredible workload that the Office of the Actuary had from a CMS management perspective. Nevertheless, in discussing his concerns last August, I gave Mr. Foster my opinion about the interplay of the Constitution, the Balanced Budget Act 1997, and its accompanying report language.

During our June 13 meeting, Mr. Foster described the history of his office in providing actuarial support to Congress, including the history surrounding the Balanced Budget Act 1997 legislation and the accompanying report language, as well as his professional responsibilities. Under these authorities, he believed that he had an obligation to report his actuarial analysis to Congress without informing the Administrator of the specifics of the congressional request or his analysis in response to the request. He believed that providing this information to the Administrator compromised his ability to function as he believed the Chief Actuary should. During the meeting, I reviewed the statutory language, which states, quote, "The Chief Actuary shall be appointed by and in direct line of authority to the Administrator," end quote. The accompanying Conference Report language highlights the importance of actuarial analysis in drafting legislation. However, neither the statutory text nor Conference Report language on its face requires the Office of the Actuary to report to or provide internal executive branch information to Congress. While Mr. Foster noted the emphasis in the Conference Report of sharing information with Congress, I explained to him that the Conference Report language does not require sharing information. In any event, the Conference Report language does not have the force of law.

I further explained that a statutory requirement that would mandate the Chief Actuary report directly to Congress would raise serious separation of powers issues under the Constitution. While I am an attorney, my interpretation and advice was provided in my capacity as the Acting Deputy Administrator and Chief Operating Officer, not as an attorney for the agency. Of course, on a daily basis, all executive branch officials interpret the statutes under which we operate. Furthermore, I have consulted with the attor-

neys in the HHS Office of General Counsel and they have informed me that they concur in my interpretation. Mr. Foster is a highly regarded actuary, and consequently, it is not surprising that Members of Congress and the executive branch are interested in his actuarial analysis of items impacting the Medicare, Medicaid, and State Children's Health Insurance Program, programs. Finally, I had no knowledge of any analysis by the Office of the Actuary that scored a complete bill until I returned from Christmas vacation this January. It is my understanding that the only request that was delayed was an impact analysis of an early version of the premium support provision. Thank you.

[The prepared statement of Ms. Norwalk follows:]

**Statement of Leslie V. Norwalk, Acting Deputy Administrator, Centers for Medicare and Medicaid Services**

Good afternoon. Chairman Thomas and Members of the Ways and Means Committee, my name is Leslie Norwalk. Since November 2001, I have officially served as Counselor to the Administrator at the Centers for Medicare & Medicaid Services. For the past year, I have been the Acting Deputy Administrator and Chief Operating Officer of CMS. In this role I direct the day-to-day operations of CMS.

On March 25, 2004, Richard Foster, CMS's Chief Actuary, mentioned my name and referred to me as a "top attorney at CMS" in his testimony before this Committee. I understand that the Committee is interested in hearing my recollection about a meeting I had with Mr. Foster and any advice I gave him.

On June 13, 2003, Mr. Foster came to see me to discuss a difficult situation for him and to ask for my help to resolve it. While Mr. Foster sought my advice, I believe that it was in my capacity as the Deputy and Chief Operating Officer, and not in my capacity as a lawyer. I believe this because my interactions with Mr. Foster in 2003 focused on helping him manage the incredible workload that the Office of the Actuary had from a CMS-management perspective. Nevertheless, in discussing his concerns last June, I gave Mr. Foster my opinion about the interplay of the Constitution, the Balanced Budget Act of 1997 and its accompanying report language.

During our June 13th meeting, Mr. Foster described the history of his office in providing actuarial support to Congress, including the history surrounding the Balanced Budget Act of 1997 legislation and accompanying Conference Report language and his professional responsibilities. Under these authorities, he believed that he had an obligation to report his actuarial analysis to Congress, without informing the Administrator of the specifics of the Congressional request or his analysis in response to the request. He believed that providing this information to the Administrator compromised his ability to function as he believed the Chief Actuary should.

During the meeting, I reviewed the statutory language, which states, "The Chief Actuary shall be appointed by, and in direct line of authority to, the Administrator. . . ." 42 U.S.C. § 1317(b)(1). The accompanying Conference Report language highlights the importance of actuarial analysis in drafting legislation. However, neither the statutory text nor Conference Report language on its face requires the Office of the Actuary to report to or provide internal Executive Branch information to Congress. While Mr. Foster noted the emphasis in the Conference Report of sharing information with Congress, I explained to him that the Conference Report language does not *require* sharing information. In any event, the Conference Report language does not have the force of law. I further explained that a statutory requirement that would mandate the Chief Actuary report directly to Congress would raise serious Separation of Powers issues under the Constitution. While I am an attorney, my interpretation and advice was provided in my capacity as Acting Deputy Administrator and Chief Operating Officer for CMS, and not as an attorney for the agency. Of course, on a daily basis all Executive Branch officials interpret the statutes under which we operate. Furthermore, I have consulted with the attorneys in the HHS Office of General Counsel, and they have informed me that they concur in my interpretation.

Mr. Foster is a very highly regarded actuary, and consequently, it is not surprising that Members of Congress and the Executive Branch are interested in his actuarial analysis of items impacting the Medicare, Medicaid and SCHIP programs.

Finally, I had no knowledge of any analysis by the Office of the Actuary that scored a complete bill until I returned from my Christmas vacation this January.

It is my understanding that the only request that was delayed was an impact analysis of an early version of the premium support provision.

Thank you.

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Chairman THOMAS. Thank you very much, Ms. Norwalk. My understanding, Mr. Flick, and the gist of your comments are that you believe you carried out a ministerial function in not being able to physically communicate to Mr. Foster, but by e-mailing him the Administrator's position on the issue, and that basically was the point, is that correct?

Mr. FLICK. That is correct, Mr. Chairman.

Chairman THOMAS. Ms. Norwalk, you indicated that although Rick Foster in his testimony before us indicated that he saw you as an attorney and you were providing advice to him, he accepted your interpretation and you believe you were providing an understanding of the administrative relationship under the law. I happen to believe that your interpretation of report language is accurate. It does not carry the force of law. I am pleased to know that you have double-checked with the people who have on their door the official title of making sure that the legal decisions are correct, and they have provided you with a comfort level that the decision you made in your capacity as an administrator was, in fact, the correct one had you performed an attorney-client relationship with Mr. Foster. So, what Mr. Scully did in indicating that he did not want information to be released, which, in fact, probably would not have enlightened Congress as much as confused Congress, because my understanding is that with the statement that Mr. Flick made, some of the assumptions that were currently in the model at that time of CMS were positions that had been abandoned by the Congress and, therefore, any cost estimate based on positions abandoned by the Congress would not be accurate and that that was one of the primary motives that Mr. Scully chose not to allow Rick under his administrative capacity to provide that information to Congress. Is that correct?

Ms. NORWALK. That is correct; I did receive counsel from the Office of General Counsel and my understanding is consistent with your explanation of why it was that Mr. Scully did not want the information to be provided at that particular time.

Chairman THOMAS. Does the gentleman from New York wish to inquire?

Mr. RANGEL. Let me once again thank you for your patience. I apologize for the process. Counselor, are you familiar with Public Law 108–199 that, one, prohibits or prevents or attempts—it sanctions the payment of salary of any officer or employee of the Federal Government who prohibits or prevents or attempts to threaten to prohibit or prevent any other office or employee of the Federal Government from having any direct oral or written communication or contact with any Member, Committee, or Subcommittee of the Congress in connection with any matter pertaining to the employment of such other office or employee and pertaining to the department or agency of such office or employee, or in any way, irrespective of whether such communication or contact is initiated of each other office or employee of response or the request or inquiry of

such Member, committee, or Subcommittee. This is included in every appropriation bill and provides sanctions against anyone that interferes from a Federal employee giving information to the Congress. Are you familiar with that?

Ms. NORWALK. I don't believe I have ever read that particular language before.

Mr. RANGEL. Do you believe that the Actuary professionally had an obligation to respond to any Member of the Congress within the four corners of their professional, non-political position, such as the one that was held by Mr. Foster?

Ms. NORWALK. Well, I believe that the statutory language requires that the Chief Actuary is in direct line of authority to the Administrator, so——

Mr. RANGEL. I don't think that is responsive, Counselor.

Ms. NORWALK. Can you restate the question, please?

Mr. RANGEL. Do you believe that the Actuary had a professional responsibility, that was really outlined by the language inserted by Chairman Thomas, that he had a professional responsibility to respond to inquiries made by Members of Congress?

Ms. NORWALK. I believe that Mr. Foster believes he has a professional responsibility, but I do not believe that he has a legal obligation to report.

Mr. RANGEL. So, were you informed by Mr. Scully that the language that was in the Budget Committee report had no legal significance?

Ms. NORWALK. I am sorry?

Mr. RANGEL. The language which was put into the report as related to the Actuary is to provide prompt, impartial, authoritative, and confidential information with respect to the effects of legislative proposals, are you familiar with the language which is in there?

Ms. NORWALK. I am familiar with the language in the Conference Report, yes.

Mr. RANGEL. Do you believe it has no legal merit?

Ms. NORWALK. I believe that it is instructive and helpful, but it does not have any legal weight.

Mr. RANGEL. Therefore, you believe that Mr. Foster had no legal or professional obligation to respond to Members of Congress?

Ms. NORWALK. I believe that Mr. Foster had no legal obligation to report to Congress.

Mr. RANGEL. That if he did report to Congress, you believe that Mr. Scully could have fired this public servant, this civil servant?

Ms. NORWALK. I have not looked into whether or not. One other thing that is actually in the Balanced Budget Act statutory language is that he may only be removed for cause, or for good cause. I have not ever explored whether or not——

Mr. RANGEL. Do you believe that if he had given the information requested by Members of Congress, that Mr. Scully would have had legal cause to fire him?

Ms. NORWALK. I don't know whether or not insubordination rises to good cause.

Mr. RANGEL. Well, what advice did you give to Mr. Foster that allowed him to believe that you were supporting Mr. Scully and

that he could be fired if he shared the information that was requested by——

Ms. NORWALK. It was actually not a part of our discussion. Mr. Foster and I only discussed what he thought was his professional obligation and I pointed out to him that the Conference Report language and the statutory language—first of all, did not require him to report to Congress, and if it had, it may raise separation of powers issues. We did not discuss whether or not his actions which hadn't occurred would have been——

Mr. RANGEL. Well, Mr. Flick, you are not an attorney, right?

Mr. FLICK. That is correct. I am not an attorney.

Mr. RANGEL. You said in colorful and uncolorful language that you thought that it would have reached a point of insubordination and that he could have been fired if he had given that information as requested?

Mr. FLICK. Congressman, I didn't necessarily have an opinion. What I was stating was what the Administrator had instructed me. It was the Administrator who clearly indicated that if Mr. Foster were to ignore clear instructions, that is outright insubordination. That was the Administrator.

Mr. RANGEL. So, you were only in a position of a messenger. You did not know whether he had the right to do it or not. You were just saying that your boss told you to tell him that he is out of there if he did give the information.

Mr. FLICK. That my boss, who was Administrator Scully, clearly indicated that if the instructions, which I believe were clear——

Mr. RANGEL. Okay.

Mr. FLICK. Were ignored, that that is outright insubordination——

Mr. RANGEL. Did you have any discussions with anyone above Mr. Scully—did you discuss this or were you present when Mr. Scully discussed this with the Secretary, Secretary Thompson?

Mr. FLICK. Congressman, I did not.

Mr. RANGEL. Do you know whether or not Mr. Scully discussed this with the President of the United States?

Mr. FLICK. I do not.

Mr. RANGEL. Did you have any discussions with Mr. Scully where he shared with you who else in the White House he discussed this ban on Mr. Foster?

Mr. FLICK. Mr. Congressman, I don't recall any discussions like that. That is not the typical kind of discussion that I would have with Administrator Scully.

Mr. RANGEL. My last question, if I may. Let me congratulate you on your promotion. You do good work and you earned it. Do you believe that it is necessary, or that there is a need for legislators to know when passing a historic Medicare bill—such as the one that was before us—that we know what the actuarial, what the executive branch, believes the cost of that bill would be? Do you believe, based on your past experience, that it is necessary that we have the information as relates to estimates of the costs of such legislation?

Mr. FLICK. Mr. Congressman, I don't personally have an opinion on that. I do know that there was a good bit of discussion about

a set of professional actuaries in CBO and the fact that there is another set of——

Mr. RANGEL. How long have you worked for the Federal Government?

Mr. FLICK. For just over 3 years.

Mr. RANGEL. How long have you interacted with the Congress?

Mr. FLICK. My interaction with the Congress was not very often.

Mr. RANGEL. So, you really don't know what we want and what we need?

Mr. FLICK. That is correct.

Mr. RANGEL. Thank you, Mr. Chairman.

Chairman THOMAS. Certainly. The Chair would indicate the gentleman consumed 7 minutes and 50 seconds.

Mr. RANGEL. You are so kind, Mr. Chairman. I can't tell you how much I feel obligated to you.

Chairman THOMAS. Seven minutes and 56 seconds.

Mr. RANGEL. I am obligated to you.

Chairman THOMAS. Eight minutes. Does the gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON. Thank you, Mr. Chairman. Mr. Flick, in the time that you worked closely with Mr. Scully, did it ever come to your attention that Members of the House from the Democrat side asked Mr. Foster for an estimate of their Medicare prescription drug in its entirety?

Mr. FLICK. No, Congresswoman. That never came to my attention.

Mrs. JOHNSON. Ms. Norwalk, you have worked with Mr. Scully at the top levels of running the agency that is responsible for Medicare for many, many months now, several years. Did you ever see a request from the Democrats or hear about a request from the Democrats to Mr. Foster to estimate the cost of their bill?

Ms. NORWALK. I never saw requests or heard of a request to estimate the cost of an entire bill.

Mrs. JOHNSON. You know, I just want those watching this hearing to understand the extraordinary hypocrisy of what is happening. Some Members have said, don't you think it is necessary to know what the executive branch thinks the cost of a bill is? The very gentleman who just made that statement never thought it was necessary to know what the executive branch thought was the cost of their bill. Never did they make the request to CMS to cost out their bill, even though they brought it to the floor of the U.S. House of Representatives, several different complete bills, which we voted on. They always asked the CBO what the CBO thought was the cost of their bill, as did we because we are, by law, bound by what the CBO thought. Now, they did not think enough of Mr. Foster to ask for his opinion. They did not think enough of what the Administration thought would be the cost of their bill to ask for their opinion. I would have to say, I put in the record some of my great disagreements with Mr. Foster at the last hearing because actuaries do numbers and then they make judgments. I disagree with Mr. Foster that 99 percent of a subgroup would join a government program. I have never seen it happen in my 28 years in government.

So, I disagree with the judgment he made, not necessarily the numbers, but the judgment that proceeded them and caused the numbers. I disagreed with his judgment that there would be 48 percent of people, of seniors, joining the Medicare plans when at their height and their most generous moment, no more than 16 did. I see that my time has not quite run out, but I know it will run out. What I want to put on the record is that we are besmirching the reputations of people who have served our country as administrators at great sacrifice. Mr. Scully has young children. He has a wife. I never saw anyone work harder. He was the very first administrator in our Nation's history to develop health quality measures for nursing homes and publish them, health quality measures for home health and publish them. Don't they care about that? They did not care enough about Mr. Scully's agencies, and Mr. Scully's actuaries' cost of the bill to ask for it, but it is time to say, we need to move forward. We need to remember that all actuaries testify that the majority of seniors are going to get new benefits, are going to sign up for those new benefits under the new Medicare program, and that one-half of the retired women in America will have no deductibles, no premiums, $1 or $2 for generics and $3 or $5 for copayment for brand name drugs. If that isn't progress, I don't know what it is. I am sorry you had to sit here almost an hour-and-a-half while what was basically a totally partisan political process went on that rests on fundamentally a hypocritical view of whose numbers mattered. Thank you, Mr. Chairman.

Chairman THOMAS. The gentlewoman consumed 4 minutes and 30 seconds.

Mrs. JOHNSON. I yield back the balance.

Chairman THOMAS. Does the gentleman from California wish to inquire?

Mr. STARK. Thank you, Mr. Chairman. Mr. Flick, we are talking generally here about estimates that Mr. Foster prepared sometime between May and maybe November of last year.

Mr. FLICK. Yes, sir.

Mr. STARK. Just so you understand what I am about to ask, I asked Mr. Foster if we had had your June estimate in the range of $550 billion, would it have been a leap of faith for us to suspect that H.R. 1 or S. 1 or the resultant conference bill would have been far higher than $400 billion, and Mr. Foster replied, I think that would be a reasonable conclusion. So, basically I am asserting and I want to know if you agree, that there were some estimates that might have led us to think that the total cost would be above $400 billion. Is that a reasonable assumption to your knowledge?

Mr. FLICK. Mr. Congressman, I don't think I can speak specifically to your question.

Mr. STARK. I am speaking generally, that there was some information that might have led to a higher estimate than $400 billion.

Mr. FLICK. The only thing that I can tell you for sure that I was aware of, is that there were a number of impact analyses performed on specific provisions in the bill.

Mr. STARK. In your role, and I suspect you would only know this of Mr. Scully, both Secretary Thompson and Mr. Scully have been quoted numerous times asserting that they shared information with Members or staff involved in the conference throughout

the year. Indeed, my distinguished colleague from Connecticut, Mrs. Johnson, confirmed in March in the New York Times that she had seen such estimates, quoting "absolutely we knew about these numbers," but that she disagreed with the assumptions and disregarded the analysis. To your knowledge, or are you aware through anybody else, and I will just ask you about a series of people here, and of paper or e-mails that you may have transmitted to or from Administrator Scully, and whether any of these people might have received these estimates that were created by Mr. Foster or his staff. Would Speaker Hastert or his staff? You can just say yes or no unless you know that they received some information.

Mr. FLICK. Congressman, it is my understanding that there was a great deal of e-mail traffic regarding estimates of the impact of specific provisions of the bill, and I believe some of those e-mails went to people other than Administrator Scully.

Mr. STARK. Would you be aware of Speaker Hastert or his staff?

Mr. FLICK. I am not aware of Speaker Hastert or his staff.

Mr. STARK. Majority Leader DeLay or his staff?

Mr. FLICK. I don't—I am not aware.

Mr. STARK. Chairman Thomas and our Ways and Means staff?

Mr. FLICK. I am not aware.

Mr. STARK. Chairman Tauzin and his staff?

Mr. FLICK. I am not——

Mr. STARK. Do any of these names——

Mr. FLICK. Congressman, I am not aware of any e-mail traffic going directly to Members of Congress.

Mr. STARK. No, are you aware that they may have received these estimates, whether it was through e-mail or——

Mr. FLICK. I don't know.

Mr. STARK. By hand or over the phone or any other way? Okay. Chairman Johnson or her staff?

Mr. FLICK. No, sir.

Mr. STARK. Majority Leader Frist? Would he have——

Mr. FLICK. Again, I am not aware.

Mr. STARK. Are those e-mails—is there record of that e-mail traffic? Does that exist?

Mr. FLICK. Well, there was a record of the e-mail traffic. I am not sure what the current status is.

Mr. STARK. Fax? Would there be copies of faxes sent back and forth to all these people concerning Mr. Foster's estimates?

Mr. FLICK. There were some faxes sent back and forth. Again, I can't speak to the availability of that information today.

Mr. STARK. So, there were e-mails and faxes regarding estimates and sent to the Hill or to the White House and various places?

Mr. FLICK. There was a good bit of e-mail traffic that involved Administrator Scully.

Mr. STARK. Mr. Chairman, it would certainly seem to me, and I am sure you are one step ahead of me on this, that we should request to see the record of the faxes and the e-mails. That would give us some definitive understanding of who received these estimates and when they received them, and I would ask the Chair if you might consider requesting those or supporting a resolution of inquiry. In other words, you do have these that you mentioned in

your memo, that Chairman Thomas received one and Mr. McManus received one. So, we know from this copy of your e-mail to Mr. Foster that some of these people received this information. I guess that is what we are really trying to find out is, how widely this information was disseminated and what we can assume about it. Mr. Chair, if the gentleman would respond.

Chairman THOMAS. The gentleman's time has expired. The Chair would indicate that if, in fact, the question rises to the level of legal carrying out of duties under the law, the Chair is always interested in looking at information. If it is simply to see who said what to whom from an administrative prerogative, the Chair does not believe that the gentleman's desire to demand information reaches that level. Does the gentleman from Illinois wish to inquire?

Mr. CRANE. No.

Chairman THOMAS. Does the gentleman from Florida wish to inquire?

Mr. SHAW. No. I yield my time.

Chairman THOMAS. Does the gentleman from California, Mr. Matsui, wish to inquire?

Mr. MATSUI. Yes. Thank you very much, Mr. Chairman. I just have a few questions. Mr. Flick, you were the Administrator for the agency, is this correct?

Mr. FLICK. No, Congressman. I was the Special Assistant to the Administrator——

Mr. MATSUI. To the Administrator. I am sorry. You were the Special Assistant to the Administrator——

Mr. FLICK. That is correct.

Mr. MATSUI. So, you made sure that the operation ran on time and all this stuff, is this correct?

Mr. FLICK. That is largely what I did——

Mr. MATSUI. With the exception of the times when either you or Mr. Scully were out of town, you were probably in contact with him quite regularly, in view of the opening statement you made that you made sure he was kept on time, as well?

Mr. FLICK. That is correct, Congressman.

Mr. MATSUI. So, you were in the car with him when he came to testify, perhaps? You were with him pretty much? Your office was right next door to him?

Mr. FLICK. Occasionally, I was with him when he testified. Most of the time, I was back at the office trying to keep things going.

Mr. MATSUI. Keep things going. Now, when he and you talked about the fact that Mr. Foster had this additional information that he was requested to communicate to the Congress, particularly the minority staff of the Committee on Ways and Means, when you had that conversation with him, did he express some regret that he had to do this?

Mr. FLICK. No. He expressed concern regarding the request.

Mr. MATSUI. What was his concern?

Mr. FLICK. The indication that he gave to me is that the request involved information, or at least some information, that wasn't even in the bill anymore.

Mr. MATSUI. Okay. Now, did he at some subsequent time before you left in September for San Francisco, because this request was

continuing, I would imagine, did he express any regret like, I am really sorry I have to do this, but unfortunately, I just have to do this?

Mr. FLICK. No, Congressman, I don't recall any expression of regret.

Mr. MATSUI. Did he at any time talk with you about the fact that the President was concerned about having this information revealed or perhaps the information being sent down to the Democratic staff of the Committee on Ways and Means?

Mr. FLICK. No, Mr. Congressman. We generally didn't talk about whatever conversations he may have had with the President. It wasn't really part of what I do.

Mr. MATSUI. Now, are you saying no——

Mr. FLICK. No.

Mr. MATSUI. You never heard that conversation, I mean, he never talked about the President with you?

Mr. FLICK. That is correct.

Mr. MATSUI. You said generally, he did not discuss this with you at all, about what the President might have thought or anything about the $534 billion?

Mr. FLICK. The only conversation that I recall having with Administrator Scully regarding the President was not business-related. It was simply Administrator Scully expressing that the President was very engaged and cares about Medicare a lot.

Mr. MATSUI. Did he say anything to you about the fact that the President wanted numbers, or was aware of the numbers?

Mr. FLICK. No, he didn't.

Mr. MATSUI. Was there anybody in the White House that he might have made that suggestion to, about the fact that the information should or should not be communicated to the minority staff, the Democratic staff of the Committee on Ways and Means, or any Democratic Member of the House?

Mr. FLICK. No. Congressman, we didn't have those kinds of discussions. The only incident that involved some expression of concern on the part of Administrator Scully was, I think, clearly described in my written statement.

Mr. MATSUI. Is that the only time you talked to him about the fact that he did not want this information transmitted to any Democratic Member or Democratic staff?

Mr. FLICK. Yes. As I recall, Congressman, there were, I think, a fairly large number of requests for technical assistance. Most of the time, those requests were processed quickly and without any concern. This one request was the only time that I was involved in communications of the sort that I described with Mr. Foster.

Mr. MATSUI. Okay. Thank you very much.

Mr. FLICK. Thank you.

Mr. MATSUI. Thank you.

Chairman THOMAS. I thank the gentleman. Does the gentleman from New York, Mr. Houghton, wish to inquire?

Mr. HOUGHTON. No.

Chairman THOMAS. Does the gentleman from Louisiana, Mr. McCrery, wish to inquire?

Mr. MCCRERY. No.

Chairman THOMAS. Does the gentleman from Michigan, Mr. Levin, wish to inquire?

Mr. LEVIN. No, I will pass.

Chairman THOMAS. Does the gentleman from Michigan wish to inquire?

Mr. CAMP. No.

Chairman THOMAS. Does the gentleman from Minnesota wish to inquire?

Mr. RAMSTAD. No.

Chairman THOMAS. Does the gentleman from Maryland, Mr. Cardin, wish to inquire?

Mr. CARDIN. Thank you, Mr. Chairman. I do. First, let me thank both of you for your testimony. I regret we don't have Mr. Badger or Mr. Scully here because the concern here is that the change in the way information was handled from the actuary to Congress was an effort to affect the vote in Congress rather than a matter of good management or separation of powers, and that is the concern that we have. We passed legislation anticipating that we would have access to the Chief Actuary, to the actuaries, and we would be able to get information. The information involved was important. It affected the final cost of a bill that we had to vote on in Congress. The Democratic substitute that we sought was intended to make a point about where we thought we should go, but it would not have a chance in a vote in Congress. It, H.R. 1, was a bill that was going to become law, the vote was very close in Congress, and the actuary's estimates were key. I just really want to give each of you a chance. Again, we don't have Mr. Badger or Mr. Scully, but do you have any information that this policy was, in fact, aimed at affecting a vote in Congress by denying information, information that was important that would affect not only votes of Democrats, but votes of Republicans. Clearly, Congress thought it was getting access to the actuary. We thought that is what the law that we passed required. Do you have any information that the intentions here were to affect the vote in Congress?

Mr. FLICK. Mr. Congressman, I can share this much information with you. Now, please understand, this is my personal opinion, but I believe Administrator Scully very much believed in the idea of providing technical assistance. He favored that, and I believe that happened on a very regular basis at CMS. There was one occasion, which is what I described in my written statement, where there was concern expressed. Outside of that one situation, I believe Administrator Scully very much shared your views and, in fact, was active in trying to make sure that we provided the technical assistance that people were seeking.

Mr. CARDIN. That is why it is troublesome that the information was not made available to Congress. Clearly, the CBO disagreed with some of these numbers, and we could have had a healthy debate about that here. The problem is, when you withhold the information and we have a very close vote and some estimates are what Members who voted for the bill thought was different, it raises serious questions. Additionally, when we have passed a law that we thought required information to be provided freely to Congress, and yet we don't get the information, it raises questions as to whether there was not more involved——

Chairman THOMAS. Would the gentleman yield briefly on that point?

Mr. CARDIN. I would be glad to.

Chairman THOMAS. It won't come out of the gentleman's time. We had testimony from Mr. Foster that he was not able to provide a complete estimate on the bill that we voted on until well into December. So, the idea that the Administration would have a number on the entire bill as we voted on it at the time that we voted on it simple is not creditable based upon the time and the manner in which CMS made the estimates, and I thank the gentleman for yielding.

Mr. CARDIN. I understand that they did not make their final estimates until December. It is the specific information regarding participation in private health care plans and number of people who would go into Part D, it is those differences from CBO that drove additional costs that I think would have been crucial during the debate of the Medicare bill. As you know, the Medicare bill passed by one vote. It was a very close vote on the floor. There are Members who voted for it saying, well, maybe it won't cost $400 billion. Maybe it will be less. We know now that there was information that indicated it would cost far more, at least from the actuary. We can debate whether that is accurate or not, but that information was not made unobstructably available as we thought it would be to Congress and we anticipated.

Ms. NORWALK. If I may comment, Congressman, as Mr. Scully said in his statement from today, he did testify before the Senate Finance Committee in June that there is a fundamental disagreement between our actuaries and the CBO. There are seven or eight fundamental differences regarding the assumptions generated by the actuary's office and the CBO. Senator Baucus in reply, I believe, stated that, "there are clearly differences of opinion, but in some sense that is irrelevant because we go by CBO. That is the organization that decides what these costs are or not." Finally, if I may, please, now on September 30, prior to the vote on the bill, the Wall Street Journal reported that the CBO and Medicare actuaries at CMS remain far apart in how they score the early impact of the provisions. In fact, the article goes on to say that since the CBO expects fewer insurers to participate in Medicare, it tends to minimize the government's cost of helping the plans establish themselves. The CMS is more bullish about the likelihood of plans participating, but this optimism requires its actuaries to warn that up front costs to Medicare could be substantial. It goes on to say, in fact, that there is——

Mr. CARDIN. Ms. Norwalk, I understand what you are saying, and there is no question that CBO and the actuaries disagree. That is not the point. The point is whether there was an intentional effort to deny this information to Congress so that we could have a healthy debate on this issue. There is no question that there were different views here.

Ms. NORWALK. Well, my point is that this article was written in September of last year, not since the bill passed, actually beforehand, and so it was clear that I think there was significant information already in the public, not just between the actuaries——

Mr. CARDIN. Information from the Chief Actuary to Congress has a different credibility level here.

Ms. NORWALK. Right, and as far as I am aware, Congressman, no Member of Congress ever followed-up on this particular article, for example, to ask, because I have never seen any particular letter, for example——

Mr. CARDIN. It was requested——

Ms. NORWALK. To look at this——

Mr. CARDIN. We were going through normal channels.

Chairman THOMAS. The gentleman's time has expired.

Mr. CARDIN. Thank you, Mr. Chairman.

Chairman THOMAS. The Chair understands we are currently with less than 5 minutes to go on a vote on the floor of the House with possibility of a second vote following. So, the Chair would indicate that the Committee will stand in recess until 10 minutes after the last vote on the floor.

[Recess.]

Does the gentleman from Texas wish to inquire?

Mr. JOHNSON. Thank you, Mr. Chairman. Not at this time.

Chairman THOMAS. Does the gentleman from Ohio wish to inquire?

Mr. PORTMAN. Mr. Chairman, I have appreciated the testimony this morning and I have no questions.

Chairman THOMAS. Does the gentleman from Washington wish to inquire?

Mr. MCDERMOTT. Thank you, Mr. Chairman. Mr. Flick, well, actually both of you have asserted there was only one Democratic request that was denied or delayed. You further implied at the suggestion of Mr. Scully that the request in question was on a provision that is no longer relevant. Mr. Foster's testimony here last week directly contradicts that, as does Mr. Flick's e-mail. Last week, Mr. Foster said—where are we here—I will find his quote in a second—that none of the information had been provided. There were a whole series of things that had been asked and none of them were provided. Your e-mail shows that the request was framed in terms of a policy that was included in the Chairman's mark, which was the most current piece of legislation when the request was made. Now, the response was delayed, arguably to reflect what was considered on the floor, but it is patently false to assert it was on a provision no longer in the bill. Equally important, your e-mail, Mr. Flick, describes request number three, which has still not been provided. The request was for an estimated change in beneficiary/government financing share. That has still not been done. I think you can see it is a little tiresome to keep correcting the record, but I am sure you understand that this is relevant and goes directly to the question of Administration stonewalling. Now, I have a question, and you are not a lawyer——

Mr. FLICK. That is correct.

Mr. MCDERMOTT. You said, I think that what you are doing, Mr. Foster, is rising to the level of insubordination and you will be fired. Is that what you communicated to him?

Mr. FLICK. Excuse me, Mr. Congressman. I don't believe I did say that. What——

Mr. MCDERMOTT. You said severe consequences, I think was the term, was it?

Mr. FLICK. I was relating directly to a comment by Administrator Scully——

Mr. MCDERMOTT. So, Mr. Scully had made that determination, that this was grounds for firing him?

Mr. FLICK. Excuse me, Congressman. Mr. Scully indicated to me that if Mr. Foster does not follow the very clear instructions, it is outright insubordination and insubordination carries serious consequences.

Mr. MCDERMOTT. Now, serious consequences. Here we are, talking about words again. Are you talking about firing him?

Mr. FLICK. I don't know the answer to that, Congressman. I did not ask Administrator Scully exactly what he meant when he said consequences. I——

Mr. MCDERMOTT. Was it intended, do you think, to imply to him that he was going to be fired?

Mr. FLICK. The only thing that I can tell you is I believe it was intended to imply that this is a serious matter, and Administrator Scully wanted Mr. Foster to comply with the instructions.

Mr. MCDERMOTT. Ms. Norwalk, you said earlier in your testimony here that you did not know whether or not his releasing that information to the House against the instructions of the Administrator would rise to the level of insubordination and, therefore, cause for firing.

Ms. NORWALK. I believe my testimony, Congressman, was that I was unsure of whether or not such insubordination, if it had occurred, would rise to the level of good cause, consequently——

Mr. MCDERMOTT. You have never given an opinion to Mr. Scully that he could fire——

Ms. NORWALK. That is correct.

Mr. MCDERMOTT. Mr. Foster. So, he made that—whatever threats he made or implied to the people that he contacted over here was made on the basis of his judgment. Now, he is a lawyer, I guess.

Ms. NORWALK. That is correct.

Mr. MCDERMOTT. He has read the law, presumably. He knows what his power is?

Ms. NORWALK. I can't speak to what he read or what he knows, but I would presume.

Mr. MCDERMOTT. Do you think it would be wise to ask the counsel who works for you where you stand on an issue like that?

Ms. NORWALK. If he were to ask the counsel, it would not have been me because the person who provides legal advice to the department at all levels of the department is, in fact, the HHS Office of the General Counsel. So, he would not have asked me.

Mr. MCDERMOTT. Why did Mr. Foster come to you, then?

Ms. NORWALK. Mr. Foster came to me, I believe, in my capacity as the Deputy Administrator and Chief Operating Officer because he wanted to have me help him solve what he saw as perhaps a management problem. He did not come to me, as far as I recall, seeking legal advice.

Mr. MCDERMOTT. He says, I mean, Mr. Scully says that he indicated during his testimony, meaning Mr. Foster, he sought legal

advice about my view and was told I was correct. Now, is that talking about the conversation he had with you?

Ms. NORWALK. I presume that that is what Mr. Foster referred to. However, it is my understanding from my discussion with Mr. Foster that, in fact, when he came to speak to me, it was not in my capacity as an attorney but in my capacity as the Chief Operating Officer, which was typical of our relationship because I managed the day-to-day operations of CMS.

Mr. MCDERMOTT. I thought Mr. Flick did.

Ms. NORWALK. No, I am the Chief Operating Officer and Deputy Administrator, or at least acting in that capacity. Mr. Flick, if I may say, ran the Office of the Administrator as opposed to the entire organization.

Mr. MCDERMOTT. So, he is really irrelevant to what went on in the department? He really was just a scheduler?

Mr. FLICK. Just? Congressman, I will be happy to try to respond to that. I don't know about the word "just," but clearly, that was a big part of my responsibilities, to stay on top of the day-to-day work flow in the Office of the Administrator.

Mr. MCDERMOTT. What did you do before you came to Mr. Scully?

Mr. FLICK. Before coming to government, I spent most of my career in the private health care sector, working in hospitals as both a vice president and a chief operating officer, working as the president of a medical group, and working as a president of a physician hospital organization.

Mr. MCDERMOTT. So, you came into this office with that kind of a background, but they put you at sort of managing his office?

Mr. FLICK. That is correct.

Mr. MCDERMOTT. I still say, Mr. Chairman, we really need to have Mr. Scully come here so we can find out where he got his opinion, whether he actually read the law and thought he could fire him or just could threaten him. I really have the feeling he was threatening him.

Chairman THOMAS. The gentleman's time has expired. He consumed 7 minutes. The gentleman from Pennsylvania?

Mr. ENGLISH. Thank you, Mr. Chairman. I would like to thank the witnesses for their exhaustive and candid testimony today. Mr. Chairman, pursuant to Rule XI, Clause (2)(k)(8), I move that the Committee now adjourn.

Chairman THOMAS. The motion before the Committee is to adjourn. All those in favor, say aye.

[Chorus of ayes.]

Those opposed? In the opinion of the Chair, the ayes have it. The ayes have it and the hearing stands adjourned.

[Whereupon, at 2:40 p.m., the hearing was adjourned.]

[Question submitted from Mr. Cantor to the Honorable Jo Anne B. Barnhart, and her response follows:]

**Question:**

- **Does the SSA support or oppose waiving the 5-month waiting period for receiving disability benefits in cases that the Commissioner determines the waiting period would cause undue hardship to terminally ill beneficiaries?**

- **What is the potential impact of waiving the 5-month waiting period for terminally ill beneficiaries on the Social Security System? How many recipients would this impact?**
- **Are there alternatives to present law that Congress should consider changing in order to provide those who are terminally ill with relief from the 5-month waiting period?**

Answer: This is in response to your letter asking questions that you would have asked had you been able to attend the March 24, 2004 hearing at which Chief Actuary Goss testified. The questions concern waiving the 5-month waiting period for receiving disability benefits in cases where the Commissioner determines that the waiting period would cause undue hardship to applicants who are terminally ill. Unfortunately, significant costs are involved with such a proposal.

We are sensitive to the potential hardships that the 5-month waiting period may cause for terminally ill applicants and their families. We have procedures in place to ensure that their applications are processed as quickly as possible. In addition, people with disabilities whose income and resources do not go over certain limits may be eligible for supplemental security income payments during those 5 months.

Congress has periodically considered legislation to waive the 5-month waiting period requirement for people with terminal illnesses. Several such bills with slightly different approaches have been introduced in the 108th Congress, including a bill you have cosponsored, H.R. 2598.

Our Office of the Chief Actuary has estimated the additional benefit payments that would be made under a similar proposal—one that would eliminate the 5-month waiting period for disability benefits for persons who die, or are expected to die, within 6 months of the onset of their disabling impairment. Payments for months in the waiting period would be made to disabled beneficiaries initially diagnosed as terminally ill but who actually live for more than 6 months after disability onset, with no attempt to recover such payments. Additionally, for beneficiaries expected to survive more than 6 months from disability onset who in fact die from their illness within the 6-month period, a retroactive payment for the waiting period would be due. Assuming such a proposal was effective for applications filed after September 30, 2004, we estimate 5-year program costs of $650 million and 10-year costs of $1,540 million. The estimated number of persons who do not receive Social Security disability benefits in the current year because they do not survive the waiting period is approximately 25 thousand and is projected to increase slightly each year in the future.

Assuming that the 5-month waiting period was automatically waived as causing an undue hardship for all eligible applicants who are terminally ill, the above estimate would be about the same for your proposal. Assuming that the 5-month waiting period was waived for 50 percent of eligible applicants who are terminally ill, and assuming that this half of the population was similar in nature to the total affected population, then the estimated 10-year costs of such a proposal would be $785 million.

[Submissions for the record follow:]

**Statement of Cori E. Uccello, American Academy of Actuaries**

Hearing on Board of Trustees 2004 Annual Reports [1]

American Academy of Actuaries [2, 3]

The American Academy of Actuaries' Medicare Trustees Subgroup appreciates the opportunity to provide comments on the 2004 Medicare Trustees' Report. The Academy is the non-partisan public policy organization for actuaries of all specialties in the United States.

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[1] The following statement focuses on the 2004 Medicare Trustees' Report and does not address the Social Security Trustees' Report.

[2] Other members of the Medicare Trustees Subgroup who were involved in the development of this statement include: P. Anthony Hammond, ASA, MAAA, Chairperson; Roland E.King, FSA, MAAA; Gordon R. Trapnell, FSA, MAAA; and Lynette L. Trygstad, FSA, MAAA.

[3] The American Academy of Actuaries is the public policy organization for actuaries practicing in all specialties within the United States. A major purpose of the Academy is to act as the public information organization for the profession. The Academy is non-partisan and assists the public policy process through the presentation of clear actuarial analysis. The Academy regularly prepares testimony for Congress, provides information to federal elected officials, comments on proposed federal regulations, and works closely with state officials on issues related to insurance. The Academy also develops and upholds actuarial standards of conduct, qualification and practice, and the Code of Professional Conduct for all actuaries practicing in the United States.

## INTRODUCTION AND SUMMARY

Each year, the Boards of Trustees of the federal Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds report to Congress on the trust funds' financial condition. Together, these programs make up the Medicare program for the elderly and for certain disabled Americans. The Trustees' Report is the primary source of information on the financial status of the Medicare program, and the American Academy of Actuaries proudly recognizes the contribution that members of the actuarial profession have made in preparing the report and educating the public about this important issue.

According to the projections in the 2004 Medicare Trustees' Report, Medicare's financial status has deteriorated considerably since last year. The HI trust fund, which pays for hospital services, will be depleted earlier than previously expected and HI expenditures are projected to exceed HI non-interest income this year. In addition, Medicare expenditures will continue to consume an increasing share of federal outlays and GDP. The trustees conclude that "the projections shown in [the] report continue to demonstrate the need for timely and effective action to address Medicare's financial challenges—both the long-range financial imbalance facing the HI trust fund and the heightened problem of rapid growth in expenditures."

This statement examines more closely the findings of the Trustees' Report. The AmericanAcademy of Actuaries' Medicare Trustees Subgroup concludes that the Medicare program faces serious short-term and long-term financing problems. As highlighted in the 2004 Medicare Trustees' Report:

- The HI trust fund fails to meet the test of short-range financial adequacy because HI trust fund assets will fall below annual expenditures within the next 10 years.
- The HI trust fund also fails to meet the test of long-range actuarial balance. HI expenditures are projected to start exceeding HI non-interest income this year. By 2019, when trust fund assets are projected to be depleted, tax revenues would cover only about 80 percent of program costs, and this share will decrease rapidly thereafter. The trust fund depletion date is projected to arrive seven years sooner than projected last year, due in part to higher hospital expenditures, lower payroll taxes, and the increased payments to rural hospitals and private health plans enacted under the new Medicare legislation. Notably, the new prescription drug program does not impact the HI trust fund, because it is included in the SMI trust fund.
- The SMI trust fund, which includes spending for the newly enacted Medicare prescription drug benefit, is expected to remain solvent, but only because its financing is reset each year to meet projected future costs. Projected increases in SMI expenditures, therefore, will require increases in beneficiary premiums and general revenue contributions over time.
- Without payroll tax increases or benefit decreases, Medicare's demand on the federal budget, measured as the HI income shortfall and the general revenue contribution to SMI, is increasing rapidly.
- Medicare expenditures as a share of GDP and of total federal revenues are also increasing rapidly, especially when considered in conjunction with Social Security expenditures, thereby threatening Medicare's long-term sustainability.

We recommend that policymakers implement changes to improve Medicare's financial outlook. The sooner such corrective measures are enacted, the more flexible the approach and the more gradual the implementation can be. Failure to act now may necessitate far more onerous actions later.

## SHORT-TERM FINANCING OF MEDICARE

To assure short-range financial adequacy of the HI trust fund, the Medicare trustees recommend that trust fund assets equal or exceed annual expenditures for each of the next 10 years. This level would serve as an adequate contingency reserve in the event of adverse economic or other conditions. For the next several years, the trust fund assets are expected to significantly exceed annual expenditures. However, trust fund assets are projected to fall below annual expenditures in 2012. As a result, the HI trust fund fails the test of short-range financial adequacy.

## LONG-TERM FINANCING OF MEDICARE

The Medicare program has fundamental long-range financing problems of three kinds:

1. HI trust fund income will soon become inadequate to fund the HI portion of Medicare benefits;
2. Medicare's demands on the federal budget are increasing; and

3. Paying currently promised Medicare benefits will place an increasing strain on the U.S. economy.

Each of these problems is discussed in more detail below. Note that the expenditure numbers cited in this statement include the impact of the new Medicare prescription drug plan and other changes to be implemented under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

**Medicare HI Trust Fund Income Will Soon Become Inadequate to Fund HI Benefits**

In terms of trust fund accounting, Medicare consists of two parts, each of which is financed separately: Hospital Insurance (HI) pays primarily for inpatient hospital care and Supplementary Medical Insurance (SMI) pays primarily for physician and outpatient care, as well as the new Medicare prescription drug benefit. Like the Social Security program, Medicare makes use of trust funds to account for all income and expenditures, and the HI and SMI programs operate separate trust funds. Taxes, premiums, and other income are credited to the trust funds, and are used to pay benefits and administrative costs. Any unused income is added to the trust fund assets, which are invested by law in U.S. government securities for use in future years.

The 2004 Medicare Trustees' Report highlights the long-term financing problems facing the program:

- The HI program is funded primarily through earmarked payroll taxes. Over the last several years, HI payroll taxes and other non-interest income have exceeded benefits paid, and the trust fund has been accumulating assets. Beginning this year, however, HI expenditures are projected to exceed HI non-interest income. And beginning in 2010, HI expenditures are projected to exceed all HI income, including interest. At that point, the HI trust fund will need to begin redeeming its assets—U.S. government securities—in order to pay for benefits. If the federal government is experiencing unified budget deficits at the time these securities need to be redeemed, either additional taxes will need to be levied to fund the redemptions, or additional money will need to be borrowed from the public, thereby increasing the public debt.
- By 2019, HI trust fund assets are projected to be depleted. At that time, tax revenues are projected to cover only about 80 percent of program costs, with the share decreasing further thereafter. The HI trust fund depletion date is seven years earlier than that projected in last year's Medicare Trustees' Report, due in part to higher hospital expenditures, lower payroll taxes, and the increased payments to rural hospitals and private health plans enacted under the new Medicare legislation.[4] Notably, the new prescription drug program does not impact the HI trust fund, because it is included in the SMI trust fund.
- The value in today's dollars of HI shortfalls over the next 75 years is $8.2 trillion, or 3.1 percent of taxable payroll over the same time period. For the first time, the 2004 Medicare Trustees' Report includes projections over an infinite time horizon, which increases the shortfall to $21.8 trillion, or 5.3 percent of taxable payroll. Nevertheless, given the uncertainty of projections 75 years into the future, extending these projections into the infinite future can only increase the uncertainty, so that these results can have only limited value for policymakers.
- The SMI program is financed through beneficiary premiums that cover about a quarter of the cost. Federal general tax revenues covers the remaining three quarters. The SMI trust fund is expected to remain solvent, but only because its financing is reset each year to meet projected future costs. Projected increases in SMI expenditures, therefore, will require increases in beneficiary premiums and general revenue contributions over time.

**Medicare's Demand on the Federal Budget Is Increasing**

Another way to gauge Medicare's financial condition is to view it from a federal budget perspective. In particular, this assessment determines whether Medicare receipts from the public (e.g. payroll taxes, beneficiary premiums) exceed or fall short of its outlays to the public. Under this approach, income from general revenues to the SMI program, which are essentially intragovernmental transfers between the general fund and the Medicare trust funds, are ignored. As a result, the difference

[4] According to the 2004 Medicare Trustees' Report, 2.0 years of the change are attributable to the new Medicare law, 2.0 years to higher spending and lower tax revenues, 1.5 years to assumption adjustments, 1.0 year to improved data on the health status of beneficiaries in HMOs, and 0.5 years to model refinements for certain hospital payments.

between public receipts and public expenditures for Medicare reflects any HI income shortfall and the general revenue share of SMI.

Table 1 reports the HI income shortfall and the general revenue contribution to the SMI program in 2003 and over the next 10 years. In 2003, the HI trust fund ran a surplus (i.e. a negative shortfall) that offset to some extent the general revenue financing of SMI. (Recall that the SMI program is designed such that three-quarters of its expenditures are funded through general revenues.) Nevertheless, Medicare expenditures already exceeded public receipts by $81 billion in 2003. Beginning this year, however, HI expenditures are expected to exceed HI public receipts by about $8 billion, and this HI shortfall plus the SMI general revenue contribution is expected to total $111 billion. Over the next 10 years the cumulative difference between Medicare expenditures and public receipts will total $2.3 trillion.

**Table 1**

**HI Income Shortfall and SMI General Revenue Contribution**
**(Billions of Dollars)**

| Calendar Year | HI Trust Fund | | | SMI Trust Fund | HI Income Shortfall Plus SMI General Revenue Contribution |
|---|---|---|---|---|---|
| | Income[1] | Expenditures | Shortfall | General Revenue Contribution[2] | |
| 2003 | $160.0 | $154.6 | -$5.4 | $86.4 | $81.0 |
| 2004 | 166.1 | 173.8 | 7.7 | 103.2 | 110.9 |
| 2005 | 180.5 | 188.3 | 7.8 | 128.1 | 135.9 |
| 2006 | 190.7 | 200.8 | 10.1 | 182.0 | 192.1 |
| 2007 | 201.2 | 212.6 | 11.4 | 192.9 | 204.3 |
| 2008 | 212.7 | 225.4 | 12.7 | 207.0 | 219.7 |
| 2009 | 224.3 | 239.2 | 14.9 | 221.1 | 236.0 |
| 2010 | 235.6 | 253.2 | 17.6 | 236.1 | 253.7 |
| 2011 | 248.8 | 268.8 | 20.0 | 252.5 | 272.5 |
| 2012 | 262.7 | 285.9 | 23.2 | 274.4 | 297.6 |
| 2013 | 276.0 | 304.8 | 28.8 | 300.0 | 328.8 |
| Total 2004-2013 | $2,198.6 | $2,352.8 | $154.2 | $2,097.3 | $2,251.5 |

[1] HI receipts exclude interest income.

[2] SMI general revenue contribution includes Part B and Part D general revenue contributions.

Source: American Academy of Actuaries' tabulations based on 2004 Medicare Trustees' Report Tables II.B5 and II.C1 (intermediate projection).

Beginning in 2010, when HI expenditures are projected to exceed HI public receipts plus interest income on trust fund assets, the HI trust fund will need to begin drawing down its assets, further increasing Medicare's demand on the federal budget. Unless payroll taxes are increased or benefits reduced, HI trust fund assets are projected to be depleted in 2019, and there is no current provision allowing for general fund transfers to cover HI expenditures in excess of payroll tax revenues.

For a longer-term view of Medicare's demand on the federal budget, table 2 reports the HI income shortfall and the SMI general revenue contribution over the next several decades, as a share of GDP. The HI income shortfall and SMI general revenue contribution are projected to grow dramatically—from less than 1 percent of GDP in 2004 to more than 10 percent of GDP in 2078. This will increase considerably the pressures on the federal budget, unless HI income shortfalls or SMI general revenue contributions are reduced.

## Table 2

### HI Income Shortfall and SMI General Revenue Contribution (Percentage)

| Calendar Year | HI Shortfall | SMI General Revenue Contribution[1] | HI Income Shortfall and SMI General Revenue Contribution |
|---|---|---|---|
| 2004 | 0.02 % | 0.90 % | 0.92 % |
| 2010 | 0.10 | 1.54 | 1.64 |
| 2020 | 0.42 | 2.35 | 2.77 |
| 2030 | 1.06 | 3.26 | 4.32 |
| 2040 | 1.76 | 3.85 | 5.61 |
| 2050 | 2.29 | 4.33 | 6.62 |
| 2060 | 2.82 | 4.95 | 7.77 |
| 2070 | 3.53 | 5.66 | 9.19 |
| 2078 | 4.14 | 6.22 | 10.36 |

[1] SMI general revenue contribution includes Part B and Part D general revenue contributions.

Source: Social Security and Medicare Boards of Trustees Summary of the 2004 Annual Reports, Chart E.

(Although an appendix in the Trustees' Report includes a discussion of the impact of the Medicare trust funds on the federal budget, the long-term projections of the HI income shortfall and SMI general revenue contribution are available only in the Social Security and Medicare Boards of Trustees' summary of the 2004 annual reports. It would be useful if the projections were also presented in the Medicare Trustees' Report.)

The new Medicare law includes a provision intended to address these financial challenges. Basically, if general funding sources account for more than 45 percent of Medicare spending within the next seven years, the administration will be required to recommend ways to reduce this share.[5] Options would include reducing benefits, raising beneficiary premiums, or raising payroll taxes. Congress could then implement the recommendations, but would not be required to do so.

This provision draws attention to the need to manage the demand Medicare places on the federal budget, and sets the stage for future congressional debate over corrective action to limit the burden the program places on general tax revenues. Congressional action is not guaranteed, however, and other financing problems remain.

The 2004 Medicare Trustees' Report projects that the 45 percent threshold will first be reached in 2012, more than seven years into the projection period. Therefore, the administration requirement would not be triggered this year, but could be as soon as two years from now.

**Medicare Will Place Increasing Strains on the Economy**

A broader issue related to Medicare's financial condition is whether the economy can sustain Medicare spending in the long run. To gauge the future sustainability of the Medicare program, we examine the share of GDP that will be consumed by Medicare. As shown in Table 3, total Medicare spending will consume greater

[5] More specifically, a determination of "excess general funding" is triggered if the difference between Medicare outlays and dedicated financing sources (HI payroll taxes, HI share of income taxes on Social Security benefits, Part D state transfers, and beneficiary premiums) exceeds 45 percent of Medicare outlays within seven years of the projection.

shares of GDP over time. In 2003, total Medicare spending was 2.6 percent of GDP. This share is expected to increase to 3.4 percent in 2006, due in large part to the addition of the prescription drug benefit. It is expected to rise to 7.0 percent of GDP in 2030 and 10.9 percent of GDP in 2060.

(Notably, the Centers for Medicare and Medicaid Services (CMS) estimate that Medicare pays for only about half of the total health spending of the elderly and disabled. As a result, this measure understates the share of the economy devoted to total health spending among these groups.)

## Table 3

### Medicare and Social Security Expenditures as a Share of GDP (Percentage)

| Calendar Year | Medicare | Social Security | Medicare Plus Social Security |
|---|---|---|---|
| 2003 | 2.6 % | 4.4 % | 7.0 % |
| 2004 | 2.7 | 4.3 | 7.0 |
| 2005 | 2.8 | 4.3 | 7.0 |
| 2006 | 3.4 | 4.3 | 7.7 |
| 2007 | 3.5 | 4.2 | 7.7 |
| 2008 | 3.6 | 4.2 | 7.8 |
| 2009 | 3.6 | 4.3 | 7.9 |
| 2010 | 3.7 | 4.3 | 8.0 |
| 2020 | 5.1 | 5.3 | 10.4 |
| 2030 | 7.0 | 6.3 | 13.3 |
| 2040 | 8.4 | 6.5 | 15.0 |
| 2050 | 9.6 | 6.5 | 16.0 |
| 2060 | 10.9 | 6.5 | 17.4 |
| 2070 | 12.5 | 6.6 | 19.1 |

Source: American Academy of Actuaries' tabulations based on 2004 Medicare Trustees' Report (plot points for Figure I.E.1) and 2004 Social Security Trustees' Report (plot points for Figure II.D.5).

Considering Medicare spending in conjunction with Social Security's further highlights the strain these programs place on the economy. Social Security spending as a share of GDP increases more modestly than Medicare over the next several decades, and by 2030, Medicare spending exceeds that of Social Security. Combined, Medicare and Social Security expenditures equaled 7.0 percent of GDP in 2003. This share of GDP will increase considerably to a projected 13.3 percent in 2030 and 17.4 percent in 2060.

Medicare and Social Security expenditures are even more striking when considered relative to total federal revenues. The trustees report that total federal revenues have historically averaged about 19 percent of GDP. Using this average, about 40 percent of all federal revenues were used to pay Medicare and Social Security benefits in 2003. If no changes are made to either program and federal revenues remain at 19 percent of GDP, this share is expected to increase to 70 percent in 2030, and by 2070, Medicare and Social Security spending would about equal total federal revenues.

These projections highlight the increasing strains that Medicare, especially in conjunction with Social Security, will place on the U.S. economy. Moreover, increased spending for Medicare may crowd out funds for other federal programs. It is unclear whether the nation will be willing to make these tradeoffs in the future.

If we are to avoid this strain, reforms must be made to address the rapid growth in Medicare expenditures. It is important to recognize, however, that unless the growth in total health expenditures of the elderly and disabled is reduced—not just the share borne by the Medicare program—health expenditures will continue to consume a large and growing share of the economy. Shifting more program costs to workers through increased payroll taxes or to beneficiaries through higher premiums or increased cost sharing may reduce federal outlays for Medicare, but it will not reduce the share of the economy devoted to health expenditures.

**CONCLUSION**

The American Academy of Actuaries' Medicare Trustees Subgroup continues to be very concerned about Medicare's long-range financing problems. With HI non-interest income expected to start falling short of outlays this year, the HI trust fund is expected to be depleted as soon as 2019, seven years earlier than projected last year. In addition, Medicare will likely exact increasing demands on the federal budget, even with the recently enacted provision that alerts Congress when the program's reliance on general revenue sources is becoming unduly large. The program's sustainability is also in question as currently promised benefits will make up increasing shares of both GDP and total federal revenues.

We recommend that policymakers implement changes to improve Medicare's financial outlook. We agree with the 2004 trustees, who state in their report:

> "The sooner the solutions are enacted, the more flexible and gradual they can be. Moreover, the early introduction of reforms increases the time available for affected individuals and organizations . . . to adjust their expectations."

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The Academy is ready to provide the analysis and technical expertise of our member health actuaries in responding to issues regarding the future of the Medicare system. Recent Academy issue briefs include *How Is Medicare Financed?* and *What Is the Role of the Medicare Actuary?* In addition, *Evaluating the Fiscal Soundness of Medicare,* an Academy monograph, outlines how several reform measures could address Medicare's long-term financing problems. The monograph concludes that promising options to improve Medicare's financing problems include increased cost sharing by beneficiaries and increased use of managed care and competitive bidding. Less promising options include lowering payments to providers and increasing the eligibility age for Medicare. These and other Academy publications are available at www.actuary.org/medicare/index.htm.

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**Statement of Don R. McCanne, Physicians for a National Health Program, Chicago, Illinois**

The 2004 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds describes the projected imbalances between the anticipated revenues and the expected growth in expenditures of the Medicare program. The Trustees call for prompt, effective, and decisive action to address this challenge.

As expected, a highly charged political debate rages over the causes of these anticipated net deficits in Medicare funding. Although we will hear much about factors such as the generous payments to Medicare Advantage plans, and the decline in tax revenues supporting the program, one factor predominates above all others: health care costs continue to escalate well beyond the level of inflation.

Health care cost increases are related to expanding and ever more expensive technological advances, along with unrestrained expansion in the capacity of our health care delivery system. We are spending more because we find more ways to spend health care dollars, and because we continue to expand the capacity that allows us to do it.

Approaching the Medicare deficit as an isolated problem will not address the fundamental cause of health cost increases. Rather, the integrity of the Medicare program would be threatened because solutions would be narrowly directed to substantially increasing revenues and/or dramatically reducing benefits. Either a reduction in benefits or an increase in cost sharing by the beneficiary would threaten to im-

pair access to care because of lack of affordability for the individual beneficiary. The alternative of asking taxpayers to fund the increase in Medicare costs would be problematic when considering that they would also be facing the same escalating health care costs.

We already know that regions with higher health care capacity have increased intensity of services but without a commensurate improvement in medical outcomes. Hospitals with greater bed capacity in their intensive care units provide costly and relatively inhumane end-of-life care when less expensive and more compassionate care would be provided in a hospice environment. Physician owned specialty hospitals and medical group owned imaging systems significantly increase capacity and the level of services although there is negligible data available to demonstrate improved outcomes.

Other nations have demonstrated that planning and capital budgeting of capacity can prevent excessive utilization while ensuring adequate capacity to prevent unnecessary queues. The 15.5% of our Gross Domestic Product that we are currently spending on health care is more than enough to ensure appropriate capacity plus fund the operating expenses of our system, with the proviso that we do not waste resources on some of the current excesses of our system. Although health care planning declined after prior efforts, the current level of spending has reached a threshold that now makes it imperative.

The administrative costs of private health plans are significantly greater than those of public programs such as Medicare. But an even greater problem is the profound administrative burden placed on our health care delivery system by our fragmented system of a great multitude of private plans, large public programs, and, for some, no programs at all. In 2003 numbers, an estimated $286 billion in these administrative costs could be recovered and utilized for the deficiencies in health care coverage today. Eliminating administrative waste must be a part of our solution to rising costs.

Although our national policies protect and promote technological development, there is a pressing need to demand value for our private and public investment. Pharmaceutical firms that develop copycat drugs merely for the purpose of restarting the patent clock should no longer be disproportionately rewarded for such noninnovative efforts. Only new products with demonstrated value should be rewarded with higher prices. Also new products developed with public funding should return that investment to the taxpayer through lower prices. We should require that new technological innovations provide both significant medical benefit and value before funding them. And there is ample evidence to demonstrate that prices are much higher in the United States than in other nations. We clearly need a method of negotiating rates and prices to be sure that we are receiving a fair value for our health care investment while allowing a fair but not excessive profit for the manufacturer or provider.

To bring the level of health care cost increases down to near the rate of inflation, we need to control capacity and pay fair prices. Medicare alone cannot have a significant influence on capacity. Although Medicare does have some regulatory control over prices, acting alone inevitably results in inequitable results through cost shifting and unfairness in pricing, while failing to control global costs. And Medicare cannot further reduce administrative waste when it is adding to the administrative burden by being an additional player in our fragmented system.

Replacing our inefficient and wasteful system of funding care with a single public payer would control costs through global budgeting, planning and budgeting of capital improvements, and negotiation of rates and prices. And with the administrative savings made possible by eliminating the waste of the private bureaucracies, we could afford to fund care for everyone while controlling costs on into the infinite horizon. Instead of limiting Medicare reform considerations to revenue increases and benefit reductions, let us adopt systemic reforms that will enable the enactment of comprehensive, affordable coverage for everyone.

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