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1995 BOARD OF TRUSTEES ANNUAL REPORT ON THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY INSURANCE TRUST FUNDS

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

MAY 9, 1995

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TUESDAY, MAY 9, 1995

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

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

Also present: Senators Simpson, Baucus, Bradley, Pryor, Graham, and Moseley-Braun.

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

The CHAIRMAN. The Committee will come to order.

This is the first in a series of four hearings on the subject of Medicare.

I might say, Max, what I am going to try to do, since we have votes at 10:30, is try to finish with these two witnesses, then take a break, and then have the public trustees. Mr. Walker cannot get here until 11:00 o'clock anyway, but at least that is my proposed time schedule.

As we have looked at Medicare over the years, and looked at the reports of the trustees, I do not know why any of us would be surprised that Medicare is bankrupt. This year we will pay out more money in Medicare benefits than we take in.

The only reason that the Medicare trust fund has what you might call a surplus is that it does have some Government bonds, which it is liquidating. They will all be gone by the year 2002. Then it will have no money, other than what comes in from taxes. And the taxes will be far short of paying the benefits. And no one in the Government has any authority to change the benefit structure by fiat, or nobody has the authority to make some payments and not others. It just is bankrupt.

And each year, we put off fixing it, or make it slightly more difficult. We will face the same problem on Social Security, although not as soon. But in about 15 or 20 years, it will be paying out more money than it takes in, and then it will run out of all of its bonds a decade or so after that.

And I suppose we can postpone facing both problems. But every year it becomes more difficult. I understand the politics involved in

the current Medicare dispute. The Democrats say that the Republicans want to use the savings to pay for tax cuts for the wealthy.

At least in this Committee, I have not found overwhelming enthusiasm for tax cuts until we balance the budget—if we balance the budget. And that battle will start today in the Budget Committee in the Senate. And there will be a knock-down, drag-out battle there, and I am sure there will be on the floor, about the subject of should we even try to get to a balance or not? I support that, but I certainly do not support tax cuts if we do not get there.

So I am hoping, in the context of the debate today, we can concentrate on Medicare. It is someplace between $147 and $165 billion short. That is what we need to get by the year 2002 to keep Medicare solvent for only 10 years—not for 25 years—for 10 years. And I do not mean 10 years after 2002. I mean 10 years from today.

And there are only two ways that I know of to narrow the $147 to $165 billion shortfall. One is to raise taxes, and I do not know anybody who is talking about raising taxes. The other is to slow the growth of Medicare from its current 10 percent plus to something more like 7 percent. That would close the shortfall.

If we do not do one or the other, an argument is often made that we ought to do it in the context of overall health reform. But even the President's bill last year, if it had been adopted part and parcel, would not have closed the Medicare deficit.

So I hope the answer is not let us enact the President's health reform bill. It is not going to be enacted anyway, but it would not have solved the problem all by itself. Apart from the budget issue, apart from health reform, Medicare is a problem. Medicare is going bankrupt, and we have an obligation—Republicans and Democrats—to try to keep it from going bankrupt.

Senator Baucus?

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

Senator BAUCUS. Thank you very much, Mr. Chairman.

Mr. Chairman, I think that if we reflect a bit, we will realize that here in Washington we often lose the forest for the trees. I am afraid we may be doing just that with Medicare.

So I hope we can begin by remembering what life was like for older Americans before Medicare. Before we created Medicare, our senior citizens lived in fear. Everyone over 60 knew that private insurance was shaky and expensive at best, and would cost them much more every year. And a serious illness, or even a common ailment that required treatment but did not threaten life, was not only a health problem, but something that could reduce a whole family to poverty.

Today Medicare has removed that fear from our lives. Those of us with short memories have forgotten it ever existed. But let me tell you about some people who do not.

Two weeks ago, I spent some time at the senior citizens center in Great Falls, MT. The people there know exactly what Medicare and Social Security mean to their lives. It means a little financial security, some faith that illnesses will be treated, and that families will not be wiped out by the cost—125,000 Montanans are eligible

for Medicare, and each one of them knows exactly what Medicare means.

Listen to Margaret and Frank Jackson of Billings, Montana, who wrote me last week, and I quote, "Social Security and Medicare are not only necessary, they are absolutely essential to our survival in Montana. Higher costs, such as higher property taxes, increase in school levies, fuel in a cold climate and medicine take a toll. There is just too much month at the end of our money. Needless to say, additional cuts would put a burden on us."

Or Joyce Hert, also from Billings, "I am 58 years old and, for the last 18 years, have had chronic obstructive pulmonary disease, asthma, emphysema, Renoir's disease, degenerative arthritis, and a disease of the connective tissue. My medication costs approximately $677 a month. Please do not turn your back on those of us who need Social Security and Medicare."

The leadership now proposes something like a $250 billion cut in Medicare—staggering—a reduction of nearly a quarter in Medicare services by the year 2002. To add insult to injury, the House would do it in part for tax cuts for Americans who are already very wealthy.

Now some in the Senate want to do the same—not all in the Senate, but some in the Senate want to do the same. And what would it mean if this happens? Montana Medicare beneficiaries would pay up to $800 more a year out of their own savings. These are people who live on fixed incomes. And $800 bucks is an awful big bite.

We would see thousands of operations and hospital stays put off. Thousands of people would decide to go without home health care. And as the Federal Government cut reimbursement, more rural hospitals would be pushed to the edge, forced to choose between serving their patients and remaining solvent.

Some Montana hospitals get 60 percent of their revenue from Medicare. This plan would hit them like a wrecking ball.

Now it may well be that we need to make changes in Medicare. But we have to be realistic. The answer is not, however, to simply approach Medicare reform as a budget-cutting device because we are talking about preserving essential health services for 125,000 senior citizens in my State, and 30 million seniors across our country. We are talking about good, middle-class Americans like the Jacksons.

And, above all, we must not use Medicare as a piggy bank. Do not take money that buys health care for senior citizens and use it for a tax break for rich individuals and big corporations.

Perhaps some changes lie ahead. But if they do, they should be made for the single purpose of keeping Medicare services for senior citizens and people with disabilities.

It is an issue of good faith on the part of the Government and basic essential health services for Americans.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Baucus.

Senator Pryor, as you know, we have votes at 10:30. No opening statement?

Senator PRYOR. I am very cooperative, Mr. Chairman. I have no statement, thank you.

The CHAIRMAN. I thank you very much.

Our first panel this morning is Secretary of Health and Human Services, Donna Shalala, and Shirley Chater, the Commissioner of Social Security. We appreciate your both coming, and we will do the best we can to accommodate your schedule, and try to finish by 10:30.

STATEMENT OF HON. DONNA E. SHALALA, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Secretary SHALALA. Thank you very much, Mr. Chairman.

Mr. Chairman, Members of the Committee, thank you for the opportunity to testify before you on the hospital insurance trust fund. Before I begin the discussion, let me call the Committee's attention to a matter in which I know you have great interest.

This administration has stepped up our efforts against waste, fraud and abuse in the Medicare and the Medicaid programs. We are doing a better job as watchdogs of the taxpayer's dollars.

Let me illustrate this for you. I brought a chart with me. Successful prosecutions and sanctions in 1994 added up to $8 billion in fines, penalties and savings for the American people. This is the largest amount in the history of the Department. And there is much more.

Last week, at the White House Conference on Aging, President Clinton announced that, as part of the Vice President's reinventing Government initiative, the administration has formed a multi-State effort to identify cases of Medicare and Medicaid fraud, and to prosecute those who willingly cheat the Government and victimize the public.

We call it Operation Restore Trust. This is the first step in our aggressive plan to reduce fraud, waste and abuse in the Medicare and Medicaid programs. We will shortly be sending you a legislative proposal to insure strong investments for this effort. And we look forward to bipartisan support for this important legislation.

The first step we have already taken is an unprecedented partnership of Federal, State and private agencies in 5 States, with nearly 40 percent of all Medicare and Medicaid beneficiaries in New York, Florida, Illinois, Texas and California. For every dollar we spend on this operation called Restore Trust, we will save $6 to $8 dollars in reduced spending and court awards.

It is an effort that makes fiscal sense, and will assure all Americans that we will not tolerate these crimes against our seniors and the disabled.

It includes a voluntary disclosure pilot program that will allow companies to come forward with evidence of fraud, or with errors they have discovered within their own organizations. Participation by the public, including physicians and beneficiaries, will be crucial to the success of Operation Restore Trust. A special hotline for the public to report fraud and abuse will be put into effect later this month.

Our responsibility to our seniors is one that this administration takes very seriously, and Operation Restore Trust is part of that responsibility. The solvency of the health insurance trust fund is another.

Mr. Chairman, turning to the matter of today's hearing, I want to quote the words of Franklin Roosevelt, who gave voice and vision to this country's desire to provide income and health security to older Americans. Roosevelt once wrote that, "As Americans, we always hope there is a better life, a better world beyond the horizon." It is reaching that horizon and protecting our older Americans that brings us here today.

As you know, my fellow Medicare trustees and I recently reported that the HI trust fund will be depleted in the year 2002. The Clinton administration believes that this is a major problem that deserves serious bipartisan attention.

Let me begin by describing the HI trust fund and the services it supports for older Americans. The fund primarily pays for inpatient hospital care, and also covers expenditures for home health services for skilled nursing care and hospice care.

In 1994, it paid for $104.5 billion in services for 32.5 million aged and 4 million disabled beneficiaries.

The trust fund is financed primarily by payroll taxes. Employees contribute 1.45 percent of wages, and there is a matching contribution by employers.

However, in the years to come, as you pointed out, trust fund expenditures are expected to rise more rapidly than trust fund revenues. There are two major explanations. There is a current and anticipated increase in the number and complexity of medical services, and also a demographic shift will occur with the aging of the baby boom generations.

As that shift occurs, a larger percentage of our population will be eligible for Medicare, and a correspondingly smaller percent will pay the taxes to support the trust fund. What does this mean?

The 1995 HI trustees' report projects roughly another 7 years of solvency. The fund is exhausted in 2002. These are well understood trends. Over the past 15 years, the trustees for Republican and Democratic Presidents have projected the date of insolvency to be anywhere from 1987 to 2005. And each year, they recommended that Congress take action to protect the fund.

When this President took office on January 20, 1993, he inherited an escalating deficit and a Medicare trust fund that was projected to be insolvent in 1999. Twenty-seven days later, he proposed, and then helped to pass, an historic deficit reduction plan, OBRA 93, that included several strong policies to strengthen the economy and the trust fund.

Indeed these proposals pushed out the insolvency date by 3 full years. The fact is that any significant changes in Medicare, whether in financing, eligibility, benefit provisions, or payment rates will actually affect the entire health care system, a point the President has made over and over again.

Therefore, this administration believes that strong action to avoid depletion of the HI trust fund should not be undertaken by looking at Medicare alone. Instead, we believe that we must consider this issue in the larger context of health reform, as the trustees recommended.

We need an approach to protecting Medicare that is both bold and balanced. The President has repeatedly called for meaningful bipartisan action on health reform. Some incremental measures

have been proposed, which may help, but they are far from sufficient.

For example, we vigorously support managed care as one of the choices available to Medicare beneficiaries. This administration has been more aggressive in expanding HMO enrollment by Medicare beneficiaries than any others. And we are seeking ways to improve the choices for Medicare beneficiaries, including the development of a new PPO option.

Overall, managed care enrollment is currently growing at an average rate of over 1 percent per month over the last year.

Last year, we had a 16 percent increase over the previous year. In addition, 74 percent of all Medicare beneficiaries have at least one managed care plan available in their area.

However, we do not believe that financial coercion should be used to force seniors into HMO's. Neither do we believe that managed care is the cure to all the troubles of the trust fund. Even the Congressional Budget Office acknowledged that managed care will not achieve the savings required to maintain the trust fund's solvency.

Medicare savings accounts have also been suggested as a way to help the trust fund. Generally, MSA's would replace Medicare with catastrophic only coverage. They would give beneficiaries tax incentives to save for all of their other health care expenses. Usually that would amount to the first several thousand dollars per year.

While MSA's might have some appeal to the young, to the healthy and to the wealthy, most of our seniors are none of these.

There has also been talk of Medicare vouchers. In such a scheme, Medicare's current guarantee of coverage would be replaced with a check, or a fixed amount, that seniors would use to shop for insurance. We have deep concerns that vouchers have the potential of leaving our chronically ill seniors who are the most vulnerable, and whose treatment is the most expensive, without effective coverage.

Let there be no mistake, solutions focused solely on Medicare could cause great harm. Let me give you a few examples. Reductions in payments to providers would have significant effects on their overall financial condition. This is particularly true for facilities whose patients are predominately Medicare beneficiaries or uninsured persons, whether they are located in inner cities or rural areas.

In fact, large reductions in Medicare payments would have a devastating effect on urban hospitals that are already providing a disproportionate share of uncompensated care. Large reductions in Medicare payments could also endanger rural hospitals.

Nearly 10 million Medicare beneficiaries, 25 percent of the total, live in rural America, where there is often only a single hospital in their county. These rural hospitals tend to be small, and serve primarily Medicare patients. Significant reductions in Medicare revenues will cause many of these hospitals, which already are in financial distress, to close or to turn to local taxpayers to increase what are often substantial local subsidies.

For example, in 1993-1994, for 56 percent of rural hospitals, Medicare payments were less than the hospital's cost for treating their Medicare patients. For 29 percent of rural hospitals, their total revenues did not meet their costs. Rural residents are more likely than urban residents to be uninsured. So the practice of off-

setting the effects of Medicare cuts by shifting costs to private payors is much more difficult for small rural hospitals.

Moreover, rural hospitals are often the largest employer in their communities. Closing them will result in job loss and physicians leaving these communities. Other providers may shift their costs on to payors who do not have the market power to negotiate advantageous rates.

This means that, ultimately, many small businesses and individuals, those Americans who are already paying the highest health insurance premiums, will shoulder even larger shares of health care costs.

Large cuts in Medicare could also hurt beneficiaries, about 75 percent of whom have incomes below $25,000. I would like to repeat that. Seventy-five percent of the Medicare beneficiaries in this country have incomes under $25,000.

For the typical beneficiary, out-of-pocket health costs represent 21 percent of their income. Increasing out-of-pocket costs would be the equivalent of reducing their Social Security. Dr. Chater will provide you with more information about the income position of Social Security recipients.

But attempts to restore the solvency of the trust fund cannot undermine our commitment to provide health security for older Americans, right now and in the future.

Mr. Chairman, we cannot destroy Medicare in order to save it. This administration takes seriously its responsibility to current and future Medicare beneficiaries to insure the solvency of the trust fund.

HCFA continues to make many program changes to improve the efficiency of the Medicare system. As a result, on a per-enrollee basis, Medicare grew at a slower rate than the private sector between 1984 and 1993—7.7 percent, compared to the private sector's 9.8 percent.

Medicare continues to compare favorably with the private sector. For the years 1996 to the year 2000, CBO has projected that the average annual per-capita growth rate for Medicare will be 8.2 percent. This rate only slightly exceeds the growth rate of 7.2 percent for private health insurance.

As we address these issues, we must remember that Medicare does not stand alone. It is an integral part of a larger health care system, as well as a larger part of the Federal budget.

Therefore, the congressional budget process cannot be divorced from the attempt to assure the solvency of the trust fund. We continue to insist that incremental health reform, and not tax cuts for wealthy Americans, should be the context for long-term solutions to the problems of the trust fund.

Last week, in a speech at the White House Conference on Aging, which was able chaired by Senator Pryor, President Clinton challenged all of us to put aside partisan differences and address the long-term needs of Medicare and Medicaid.

He was very clear in saying that he does not support the status quo. And he was equally clear in saying that he does not support proposals that will slash these programs and worsen the health care available to hard-working American families. He emphasized that we must put the American people first.

Let me quote directly from the President. "I will evaluate proposals to change Medicare and Medicaid, based on the issues of coverage, choice, quality, affordability and cost."

With these principles in mind, we look forward to working with the Congress to develop lasting solutions to Medicare's fiscal problems, to reaching for a horizon in which all Americans enjoy long-term health security.

Thank you. After Dr. Chater's statement, I would be happy to answer any questions you may have.

[The prepared joint statement of Secretary Shalala and Commissioner Chater appears in the appendix.]

The CHAIRMAN. Dr. Chater?

STATEMENT OF HON. SHIRLEY S. CHATER, COMMISSIONER OF SOCIAL SECURITY, WASHINGTON, DC

Commissioner CHATER. Thank you, Mr. Chairman, and Members of the Committee.

It is my pleasure to join you today in my capacity as a member of the board of trustees for the Medicare Trust Funds. This is a new responsibility for the Commissioner of Social Security, one created by last year's legislation establishing independent-agency status for the Social Security Administration.

In my role as trustee, even though I was a trustee for only 1 day, I was a signatory on the 1995 annual report of the board of trustees of the Federal Hospital Insurance and Supplementary Medical Insurance Trust Funds. As you know, that report was issued on April 7.

I will not spend time today outlining the details of that report, since that has already been done for you by the Secretary, but I would like to say that the trustees collectively believe that Medicare reform must be accomplished within the context of broad-based health care reform.

As part of this discussion today, I think it is important to devote attention to the link between Medicare reform and elderly Social Security beneficiaries. To our Nation's senior citizens, both Medicare and Social Security are vitally important. Every person age 65 and older, who is eligible to receive Social Security benefits, is also eligible for Medicare Part A hospitalization insurance.

And, for that matter, most of America's Social Security beneficiaries also elect to enroll in Medicare Part B which, as you know, covers outpatient care and physician reimbursements through payment of an individual premium.

To our elderly citizens then, health care and Social Security income each represent an important commitment that their Government has made to them.

I would like to talk for a moment about these older Americans. For millions of elderly men and women, their Social Security checks serve as the sole barrier that stands between them and poverty. For approximately 2 out of 3 senior citizens, Social Security represents more than 50 percent of their income. For 25 percent of our seniors, Social Security is 90 percent of what they have to live on. And for 14 percent, Social Security is all they have.

The average retired worker receives $698 a month. The median annual income for elderly households is approximately $17,000.

This is less than half the median income for households of all ages. In other words, these are not people who have room in their lives for significant belt-tightening.

I speak of these seniors because I think it is important that we understand the potential human consequences tied to this issue. To take a narrow approach, making severe cuts in Medicare, rather than working to reform Medicare within the broader context of health care reform, runs the significant risk of harming some of the most vulnerable members of our society, individuals who believe very strongly that Medicare and Social Security together represent a commitment that their Government has made to them.

The board of trustees, in the 1995 report, expressed the view that Congress should, and I quote, "address the projected financial imbalance in both the short range and long range through specific program legislation as part of broad-based health care reform."

I would add, Mr. Chairman, that we can better protect our low-income elderly citizens by taking this kind of comprehensive approach.

I thank you for inviting me to testify on these issues, and I look forward to continuing to work with this Committee, both as the Commissioner of Social Security and as a trustee of the Social Security and Medicare trust funds.

Thank you.

[The prepared joint statement of Commissioner Chater and Secretary Shalala appears in the appendix.]

The CHAIRMAN. Commissioner, do we agree with the figures that this fund is going to be someplace between $147 and $165 billion short for a 10-year fix, not a long-term fix?

Commissioner CHATER. I believe those are the figures I have heard, yes.

The CHAIRMAN. All right. And are we agreed that even President Clinton's health bill last year would not have cured the short-term problem, let alone the long-term problem?

Commissioner CHATER. The President's bill last year did much to increase the years of solvency for the HI trust fund.

The CHAIRMAN. I believe CBO has said that it did not cure the short-term solvency problem.

Commissioner CHATER. It added 5 years, so that it did contribute to solving the short-term solvency problem. What it did not do is solve the long-term solvency problem.

The CHAIRMAN. Now, Commissioner Chater, you said that it should be solved within the context of broad health care reform.

As the President's bill would not have solved that, what are you suggesting that broad health care reform should be?

Commissioner CHATER. I think that after we take a look at the final budget resolution, we can begin to explore the solutions to that problem in a bipartisan way, in the context of broad health care reform, where both the private sector as well as the public sector is included in our analysis.

The CHAIRMAN. If this problem is ex cathedra, the budget problem, why do we have to wait for that? Why is it related to that?

Commissioner CHATER. Well, obviously, I think this administration wants to see what the final budget resolution looks like, so that we know where to go from there.

The CHAIRMAN. But what difference does it make what the budget resolution is, if we have to cure Medicare apart from the budget resolution?

Secretary SHALALA. Senator, I think the point that both the Commissioner and I are making is the President's very clear point. And that is that he wants to see the final budget resolution to be assured that the Medicare proposals are not being used to finance a tax cut for the wealthiest Americans.

Second, we believe that one cannot solve the Medicare long-term solvency problem in a narrow way because of the implications of dealing with the public part of the health care system and not the private part of the health care system.

We are concerned about cost shifting. We are concerned about rural America and the impact on hospitals that are already on the margins. We are concerned about small businesses that already pay very high health insurance costs in this country. And we are concerned about the adequacy and the quality of the kinds of choices that would be available to Medicare recipients.

So we see the system as a public/private system. And we believe that looking at Medicare must be done in that context.

The CHAIRMAN. Madam Secretary, you and I know what we are talking about. What you just said is so much pap. It does not say anything.

Let us assume that there is not going to be a tax cut. Let us assume that the budget resolution says, when it comes out, that there will not be one unless we happen to balance the budget. Then what should we be doing about Medicare?

Secretary SHALALA. Then what we should have is a broad-based discussion, with Medicare in the context of a broader discussion of health care reform, and take the first incremental steps towards health care reform.

It is dangerous to make the Medicare recipients pay for the solvency of the system, without looking at the implications of that for the private health care system in this country.

The CHAIRMAN. Now say that again.

Secretary SHALALA. That if what we do is look narrowly at the Medicare system, and not look at it within the context of the entire health care system in the United States, and not look at the implications for severe cuts in Medicare, not only for the Medicare recipients who can barely pay what they are paying now, but for the rest of the system where we may cost-shift, it would be irresponsible.

The CHAIRMAN. You talk about cost-shifting. Who is the biggest under-payor of medical costs in this country now?

Secretary SHALALA. Medicaid

The CHAIRMAN. And Medicare.

Secretary SHALALA. And Medicare is also an under-payor. And if we make them more of an under-payor, then what we are doing is shifting the costs to those who now pay insurance, to hospitals that are already at the margins. And that is the point we are trying to make here.

The CHAIRMAN. It looks to me like you have got a conflicting argument though. First you give us some figures that private costs have gone up more than Medicare costs. Is there any possibility

that they have gone up more? Those were through 1993, not since 1993. Is there any possibility they went up more because the Federal Government was under-paying its bills and the costs were shifted to the private sector?

Secretary SHALALA. There is some evidence that that took place. What we want to do is to make sure that does not continue to happen by slashing the Medicare system in this country, and shifting the costs onto the private sector.

And our deepest concern is that large corporations are cutting very good deals for themselves with HMO's and other health care providers. And the cost-shift from these deals would be segmented onto small businesses, onto individuals in the insurance market. That would cause a very severe hardship on providers that have no way of absorbing those cost-shifts, like big urban public hospitals, academic health centers and rural hospitals.

Therefore, that is why we have to make sure that we deal with the issue of unintended consequences.

During the health care debate, Mr. Chairman, a large part of our discussion was that what you are doing here affects what happens in the private market. Therefore, it is very important to look at this as a system which is inextricably linked. That is the only point the President is making.

The CHAIRMAN. Senator Pryor?

Senator PRYOR. Yes. Thank you, Mr. Chairman.

I wonder if you, Madam Secretary, would give us a time line from where we are in May of 1995. There is some discrepancy about when the system is going to be in a chaotic situation, I guess I would say. How long do we have to fix the system? What are our time limits?

Secretary SHALALA. Well, we obviously have 7 years until the system simply runs out of money, and cannot pay its bills.

Senator PRYOR. How many years?

Secretary SHALALA. Seven.

Senator PRYOR. Seven.

Secretary SHALALA. Between now and the year 2002, until the system simply cannot pay its bills.

Senator PRYOR. I know that there are several proposals for commissions. Senator Rockefeller has recently introduced a bill requiring, I guess, a commission at a time certain. And there are other commission ideas at a time certain to report. Do you have any idea or feel for when a commission should start to work, and when it should complete its task?

Secretary SHALALA. We obviously have 7 years. And the President has made very clear in both his December letter and his State of the Union speech, and two letters from the Chief of Staff, that he believes that the discussion about dealing with the Medicare problem ought to happen this year.

Most experts believe that we ought to devise both a short-term and a longer-term strategy. But there is no question that sometime during the course of this year, this discussion ought to take place.

Senator PRYOR. Thank you.

In line with Senator Packwood's question about some of the providers, tell me, if you would be so kind, about those providers out there in the marketplace who are perhaps—I do not want to say

over-billing—over-using the system to the disadvantage of the consumer. Do we have those figures?

Secretary SHALALA. Well, I think what you are talking about is our concerns about over-utilization and double-billing, and the fraud in the system.

One of the things that I think we have done a very effective job with this year, within the limitations of our resources and our authority, is to go after over-billing and some of the other kinds of fraud in the system.

What we have said is that we need a much more energetic effort, a different kind of approach, much more intensive approach, that actually changes the culture of the Medicare system. And that is what the President proposed in Operation Restore Trust.

Senator PRYOR. There has also been a recent suggestion by one of the House leaders. I think that suggestion was to give the Medicare beneficiaries a 10 percent refund for all the fraud and abuse that they can detect.

Now do we have anything like this in current law?

Secretary SHALALA. You are talking about the Speaker's suggestion that we have an 800 number. I do not know what kind of history he studied, but I think he forgot the 1863 law, which I think is called the Quitam Law.

We actually have on the books a law that allows Medicare beneficiaries to receive 10 to 30 percent of recoveries under current law. That law has been in place since 1863. It was put in place during the Civil War.

If I remember the story correctly, it all came out of the military. The Army ordered mules, and they got donkeys. And they were so furious that they put in place a law that allows an individual, under this new civil false claims act, to file a false claim suit. The Attorney General represents them. And they can get a percentage of the money from the settlement.

Since 1988, we have gotten settlements of over $240 million. And the beneficiaries have gotten over $25 million. This year alone, there were 43 suits so far involving HHS programs.

So I think what the Speaker did not realize is that we already have a law on the books. We have had it since the Civil War. There are lots of individuals, Medicare beneficiaries, that are already filing under this law. We have been aggressive in pursuing these complaints, and they have collected a lot of money on their own.

Senator PRYOR. Madam Secretary, thank you.

Mr. Chairman, in the interest of time, and I know we have another panel, and we have a vote at 10:30, I am going to relinquish the balance of my time.

The CHAIRMAN. Thank you, David.

Senator Graham?

Senator GRAHAM. Thank you, Mr. Chairman.

Madam Secretary, there have been some suggestions made as to how to reduce the cost of Medicare in order to divert money either to balancing the budget, paying for tax cuts, or reinvesting in Medicare itself.

I would like to mention a couple of those, and get your thoughts as to what the likely effect those cuts would have on other segments of the health care system.

One of those is raise the age of eligibility for Medicare from its current 65 to 67, or some more advanced age. What effect would that change likely have on the public sector, such as the Medicaid system, as well as private financiers of health care service?

Secretary SHALALA. We would not rule anything out. If we are committed to a bipartisan process that is broad enough, we ought to be willing to think about all these issues. But let me give you my first reaction, which really comes out of our very detailed health care discussion last year and the year before.

If we delay health insurance for seniors beyond the retirement years, what we will do is increase the number of people who have no health insurance in this country.

What has increasingly happened in the reorganization of private companies is that we have a group of people over 55 who have no health insurance once they are pushed out of their companies.

What we would do is put off later and later their ability to get access to private health insurance. I would think that increasing the number of people without insurance would be the exact opposite of what we want to do. And that may well be one result.

While I would not rule anything out, I think that we would have concerns about people into their sixties. Some of these people may shift onto the Medicaid system. In fact, the expansion of the Medicaid system has covered up the deterioration of private health insurance attached to jobs in this country, since more and more people have gotten into Medicaid as they have lost their health insurance.

So I think it would move in the opposite direction, and we would have to look at it extremely carefully.

Senator GRAHAM. Another proposal is to increase the cost to the beneficiaries, either in the form of additional premiums or copayments, or other deductibles, direct financial responsibilities. What effect would that have?

I understand that States and the Federal Government are currently paying a number of those costs under Medicaid for medically-indigent Americans. What would be the likely impact of Medicare increasing the cost to the beneficiaries?

Secretary SHALALA. Well, of course, what it would do is, for those for whom Medicaid pays their cost sharing, is increase the burden on the Medicaid program. It is a perfect example of looking just at Medicare, without looking at its implications for both the public and the private system. Because what we would do is shift additional costs on Medicaid.

Since the discussion about Medicaid is to cap the program, it would actually make it very difficult for the States because it would mean that they would have a whole new population and new costs associated with the Medicaid program. That is a straight cost-shift to the States and to the Medicaid program.

Senator GRAHAM. Another suggestion as to how to cut Medicare for either its own self-preservation, or for purposes of tax cuts or budget balancing, is to eliminate some of the special recognition to high Medicare cost facilities.

We know that particularly rural hospitals, who have a disproportionate number of Medicare patients, receive a Medicare supplement in order to pay those additional costs. What would be the effect if that kind of program were to be eliminated?

Secretary SHALALA. Well, for States that have urban public hospitals and rural hospitals that get money for the uninsured, most of these hospitals are at the margins now. We are talking about severely damaging the safety net for hospitals in this country which treat large numbers of the uninsured.

Again, our deep concern is the unintended consequences of severe cuts in Medicare on what has been a health safety net in this country, which has picked up the uninsured, in addition to our concerns about small businesses and other people who do not get the kind of discounts in the market available to larger employers.

Senator GRAHAM. Thank you, Madam Secretary.

The CHAIRMAN. Do you have a couple more that you would like to ask?

Senator GRAHAM. No, Mr. Chairman.

The CHAIRMAN. Senator Moseley-Braun? Welcome.

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

I am going to pass at this time. I strongly support the Secretary's efforts in regard to Medicare, and I may have questions later.

As you know, I did not get a chance to hear her entire statement, so I want to catch up on her.

The CHAIRMAN. I am not quite sure I know what the Secretary's efforts are. [Laughter.]

Senator MOSELEY-BRAUN. They are good, Mr. Chairman. [Laughter.]

The CHAIRMAN. No matter what.

Is this a fair statement, Madam Secretary? The administration is basically going to have no suggestions until they see the budget resolution passed.

Secretary SHALALA. That is a fair statement.

The CHAIRMAN. So if we are going to cure Medicare at the time we are adopting the budget resolution, it is going to have to be done by Congress alone, without the President's input.

Secretary SHALALA. We consider the budget resolution, as you do, the first step in the budget discussion in this Congress. And I think that statement is somewhat unfair.

What the President has said is that he wants assurance that we are not going through this process to finance tax cuts for the wealthiest Americans and, therefore, would like to wait and see the budget resolution.

Second, he is anxious to participate in a bipartisan process, that is a process that recognizes that Medicare alone cannot be expected to cure its own solvency problem, that this is part of a larger health care discussion, in which the first steps ought to be taken after that budget resolution is passed, and is part of the broader budget discussion.

The CHAIRMAN. I understand what you are saying. It is the first time in my memory that I recall the administration not just being passive, but absent in the budget resolution debate. It is as if they simply choose not to participate at all.

I realize this is a Congressional budget resolution, but it is an unusual position of the administration to simply say we do not want to see it, we do not want to hear it, we do not want to speak it.

Secretary SHALALA. Senator Packwood, we have done just the opposite. We have brought our budget to the Congress. Before we sent that budget up, and in his own State of the Union, and in statements by the Chief of Staff, the President laid out a very clear message that we believe that incremental health reform ought to be part of the discussion this year, as part of the budget process. And the Medicare solvency issue ought to be within that context.

The CHAIRMAN. In the broadest sense, you are right. The President talked about health care reform. But in the budget he presented, it did utterly nothing to solve the deficit problem of Medicare. And that is where we are now.

And, so far, we have had no suggestions. I understand why not. I just want to make it clear that the administration chooses not to be a player in this at the moment.

Secretary SHALALA. Mr. Chairman, I really think that that is unfair. From the moment the President took office, we have been working on the health care issue. And we have taken a series of steps, from OBRA 93, which added 3 years, and improved the solvency of the HI trust fund, to the President's own health care reform proposal, to the President's commitment in this year's budget that he wanted a broad bipartisan discussion.

Containing public health care costs have always been central to his insistence that we deal with it as part of the efforts to both reduce the deficit, which he is committed to, and get us closer to balancing the budget.

He has never moved away from his position that public health care costs needed to be slowed down, but he also has not moved away from his position that you could not do it by dealing just with the public system, that there is a relationship between the public system and the private system, that it did not stand alone and, therefore, should not be treated alone, but as part of the discussion.

The CHAIRMAN. Senator Baucus? And then Senator Bradley.

Senator BAUCUS. Thank you, Mr. Chairman.

Maybe this question was asked but, Madam Secretary, I would be curious as to your reactions about the managed care options and ideas with respect to Medicare that seem to be floating around. That is, seniors would have a choice. I do not know what the proposals will be, but do we have an idea what they may be?

I would like your thoughts about the degree to which managed care helps to solve the problem seniors face and, second, from a budget perspective.

Secretary SHALALA. Let me make a couple of statements. First, this administration strongly supports managed care as an option, and as a choice for seniors. We do not think it is a solution for rural America because there simply are not managed care options in rural America. However, in some parts of rural America, there is increasingly an interest in developing HMO's, or even the PPO option that we have been talking about.

Second, neither the administration nor CBO see short-run savings out of this transition of giving more choices to seniors.

Now some of that is because of experience. While we have been accused of paying current Medicare HMO's too much, 95 percent of the fee-for-service costs in the area, that is because the first people who joined HMO's have been healthier. And we actually do not

have a pricing structure yet that reflects the real mix of the Medicare population. We are working carefully on that with the industry.

In the long run, we believe increasing the choices, but making sure that it is a quality system, is exactly the direction we ought to go in. And, in fact, managed care for many senior citizens not only will be their choice, but will indeed give us some of the efficiencies that we would like to increase in the system.

And, as you know, we are working hard. We now have over 73 percent of the seniors in this country living in areas where they can choose a managed care plan. And we are rapidly increasing the number of options they have.

We had a 16 percent increase in the number of Medicare recipients that moved into managed care. We had a 63 percent increase in the number of Medicaid recipients who moved into managed care.

So no one can accuse us of not being enthusiastic about it. None of the health economists that I know believe that this is going to be a short-term savings benefit.

Senator BAUCUS. How do you deal with the problem of managed care programs taking the most healthy seniors? How do you deal with that?

Secretary SHALALA. Well, if you give people their choice, then it is not easy to mandate some kind of a mix. What we need to do is work out a payment system in which the managed care industry does not believe that it is taking this huge financial risk, if it takes a broader mix.

Frankly, as long as there is choice there, and we have an adequate payment system that recognizes health status, for example, I think that we should allow choice to make up the mix of the system. What we do not want is discrimination. We do not want a managed care operation to discourage the participation of people who are a higher health risk.

Finally, let me point out that there is not a lot of experience with seniors in managed care in this country. It is a relatively new phenomenon and, to be fair to the industry, which has been enthusiastic about working with us, both in Medicare and Medicaid, most of their experience has been with a healthier population.

So while we are moving rapidly, we are in fact moving together to make sure that we have proper safeguards in place, and that our new pricing approaches will be sensitive to the differences in areas.

Seniors tend to move in where they have managed care experience. In Oregon, the Chairman's State, people are moving more rapidly to managed care because there is a lot of experience with managed care.

The CHAIRMAN. We are approaching 50 percent.

Secretary SHALALA. That is right.

The CHAIRMAN. And we expect to be at 80 percent within 5 years.

Secretary SHALALA. If you go to Florida, where Senator Graham is, the seniors have been more wary, even though they have been offered lots of different kinds of benefits. They are much more skeptical because they have not had experience in their own fami-

lies or themselves with managed care, and they have moved somewhat more slowly.

In fact, seniors tend to track the broader population in their areas. But we have some hope in Florida that there will be more participation.

Senator BAUCUS. I am sorry I missed your statement, and you may have addressed this subject. But, very briefly, what are some of the non-Clinton health care reform proposals to address the underlying structural problems of Medicare, other than just lopping dollars off the top?

We are not going to have a Clinton health care plan this year, so one, two, three, what are you going to do?

Secretary SHALALA. I think that, while we have not been specific, we obviously did something last year that increased coverage.

What the President has done is laid out principles. And that is, what you do not want to do is reduce the number of people who have health insurance while you are trying to get more efficiencies into the Medicare system. Because what you do then is to put institutions at risk.

So coverage is important. We are making certain that we have a quality system at the end of the line; we increase the amount of choice, while we are building more efficiencies into the system and; we make sure that the cost containments are fair, so we are not putting rural hospitals at risk.

You have the community medical center, for example, in Missoula, Montana, which is very dependent on Medicare patients. It actually lost money last year. If we slash Medicare, that hospital will be in severe trouble.

Senator BAUCUS. And there are other hospitals like that too.

Secretary SHALALA. Exactly.

Senator BAUCUS. Thank you.

The CHAIRMAN. Senator Bradley?

Senator BRADLEY. Thank you very much, Mr. Chairman. Madam Secretary, welcome. It is good to see you, as always.

You know, consistency is not always the hallmark of a politician. And least of all is it the hallmark of the House Republicans. And I make a real distinction between the House Republicans and the Senate Republicans. The Senate Republicans are usually wiser, take a longer-term view, are more open to discussion with the other side. They are basically more intelligent.

The CHAIRMAN. Do you want extra time? [Laughter.]

Senator BRADLEY. I think that is enough. So that is the premise that I start with, you understand.

But for as long as I have been in the Senate, the Medicare trust fund has been in danger and about to run out. And, in the last couple of weeks, we have had the panic button pushed—crisis, crisis. We now have to cut Medicare to save the system.

So you would assume that people who were concerned about the stability of the Medicare trust fund would do nothing to endanger that or deplete that trust fund.

And yet, we see in the House contract an action which runs directly contrary to the professed desire to save the trust fund.

I would like to try to see if we cannot quantify this. In 1993, we passed a provision which raised the amount of Social Security

which would be subject to tax for 15 percent of the seniors, from 50 percent to 85 percent. And we specifically designated that the revenue from this tax would go to shore up the Medicare trust fund.

And now we have a group saying that you cannot do anything to deplete the Medicare trust fund. In fact, we have to cut Medicare more deeply in order to avoid a catastrophe. Yet, at the same time, they have taken an action that depletes the Medicare trust fund.

So I am curious if you could tell us about the repeal of that tax on the wealthiest 15 percent of the seniors. How much revenue does that remove from the Medicare trust fund?

Secretary SHALALA. It removes $34 billion, which means that the fund would go bankrupt almost 1 year earlier.

Senator BRADLEY. So, essentially, the action speeds up the potential bankruptcy?

Secretary SHALALA. Exactly. It moves in the opposite direction of what we are talking about here.

Senator BRADLEY. It seems to be contradictory to me. Does it not seem contradictory to you?

Secretary SHALALA. It is very contradictory.

Senator BRADLEY. I mean, how could people argue one thing with one hand, and another thing with the other? Do they think that we would not see it?

Secretary SHALALA. I do not know, Senator.

Senator BRADLEY. Did they think that nobody would understand that they were saying on the one hand that we want to take revenue away from the Medicare trust fund and, on the other hand, saying we want to cut Medicare benefits more deeply to make up for that?

It could even be argued that you want to cut Medicare benefits for 85 percent of the people in order to preserve the absence of a tax on 15 percent of the people.

Secretary SHALALA. Right.

Senator BRADLEY. So now that that point is established, let me ask you how——

The CHAIRMAN. Your time is up. [Laughter.]

Senator BRADLEY. Oh, there is a vote. I see.

How serious is this Medicare trust fund issue? Do you really think it is a serious issue? As I say, I have heard this ever since I have come into the Senate. We have been on the brink of a Medicare trust fund crisis because of a variety of facts which have always receded into the future.

Secretary SHALALA. It is a serious issue. We have some time to deal with it. We have been told about it over the last 15 years by each group of trustees, under each President.

It has been a serious issue for the Reagan administration, for the Bush administration, and for the Clinton administration.

Overall health care costs growth, as you well know, is also a serious issue, which the President has tried to address. In fact, this administration has a much lower baseline—$200 billion—because of some things we have done, and some things that have happened in the private sector. The overall economy has gotten better.

But if we are going to deal with the deficit, we do indeed need to slow down the growth of the public part of health care costs. Our

only point is that you cannot do that without looking very carefully at the implications of growing private health care costs.

Senator BRADLEY. So are you saying that the Medicare trust fund is in better shape today than it was 2 years ago?

Secretary SHALALA. It is in better shape than it was when we came to office. The projections were then for 1999.

Senator BRADLEY. So this crisis that we are now hearing about existed in 1991, 1990?

Secretary SHALALA. It did.

Senator BRADLEY. But it did not seem to energize the House Republicans at that point, did it?

Secretary SHALALA. It did not seem to energize anyone at that time. And it was not until the President took office that we actually began to add years in a systematic way, with OBRA 93 adding 3 years. It was 1999 when we started the administration.

Senator BRADLEY. Is that $35 billion over 5 years?

Secretary SHALALA. It is $34 billion over 7 years.

Senator BRADLEY. Seven.

The CHAIRMAN. I might add just one footnote of information. In the 1990 budget deal, we added $30 billion in revenues and $43 billion in savings, we hope. We never quite got as much as we hoped, but that was our estimate. Then, in 1993, we added another $53 billion in revenues, and we hope $55 billion in saving. Whether we get that or not, I do not know.

But I think where we may have run the string out is looking for any additional revenues, whether it is an increase in the HI tax. Here I am putting aside for a moment the action of cutting the Social Security tax.

But I think if anyone thinks that we are going to significantly add revenues to solve the problem, they are dreaming. We have added significant revenues in the last two major budget deals. We did in 1990, and then in the President's budget in 1993.

We do have a vote. Let me ask that, if there are other questions of the Secretary or the Commissioner, because I would like to let them go if we can. We have three votes, so we are going to be gone about 45 minutes.

Senator MOSELEY-BRAUN. No questions, Mr. Chairman.

The CHAIRMAN. Bob?

Senator GRAHAM. I have no questions, Mr. Chairman.

The CHAIRMAN. Madam Secretary, Madam Commissioner, thank you very much.

We will come back and hear the two public trustees, Stanford Ross and David Walker. Mr. Ross, may I see you just a minute, if you would come up here?

[Whereupon the Committee recessed at 10:36 a.m., to reconvene at 11:35 a.m.]

The CHAIRMAN. Gentlemen, I apologize. There were three votes, and we took 10 or 15 minutes between the second and third vote.

Commissioner Ross, you have been here before and probably gone through that. There was just nothing we could do about it.

We have with us today Stanford Ross and David Walker, the two public trustees. I do not know why they are not called private trustees, but public trustees. They participated in the report, and had a separate report of their own. They are both expert in their

fields. Mr. Ross used to be the Social Security Commissioner. David Walker is an expert and a CPA in public finance.

We look forward very much to your suggestions. And I apologize for making you wait.

Mr. Ross?

STATEMENT OF STANFORD G. ROSS, PUBLIC TRUSTEE, FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY INSURANCE TRUST FUNDS, WASHINGTON, DC

Mr. ROSS. Thank you, Mr. Chairman. It is our pleasure to be here, and we thank you for the opportunity to testify today.

Mr. Walker and I have provided you with a joint statement, as public trustees. In order to maximize the value of our limited time before the Committee, I would ask that you enter our statement into the record. Then Mr. Walker and I would each like to make some individual remarks on our own behalf.

The CHAIRMAN. We are happy to listen at length to the two of you.

Mr. ROSS. Thank you, sir.

As you pointed out, the public trustees are part-time positions that were created when the Social Security trust funds were replenished in 1983, to represent the public interest in this important process of public accountability.

During the 5 years that we have done this, we have done it on a non-partisan basis, in which we have agreed on all statements, and issued them jointly. And that spirit, we believe, is very important when approaching this subject of Medicare.

The 1995 reports on both the HI trust fund and the SMI trust fund show alarming financial results. While the financial status of the HI program improved somewhat in 1994, the HI trust fund continues to be severely out of financial balance, and is projected to be exhausted in about 7 years.

The SMI trust fund, while in balance on an annual basis, shows a rate of growth of costs which is clearly unsustainable. Moreover, this fund is projected to be 75 percent or more financed by general revenues. So that, given the general budget deficit problem, it is a major contributor to the larger fiscal problems of the nation.

As we also emphasized in our 1993 and 1994 public trustees' messages, we continue to believe that the Medicare program is clearly unsustainable in its present form. We had hoped for several years that comprehensive health care reform would include meaningful Medicare reforms, and that comprehensive health care reform would eventually reduce the rate of growth of health care costs, and thus the financing shortfall facing Medicare.

However, with the results of the last Congress, it is now clear that Medicare reform needs to be addressed urgently, as a distinct legislative initiative.

We also strongly believe that Medicare reform should be included as an integral part of any broader health care reform initiative which may be considered in the future.

I would like to emphasize today some historical aspects of the long-term effort to adapt the Social Security and Medicare programs to changing economic and social conditions, drawing particu-

larly on my experience as Commissioner of Social Security in the late 1970's, and as a public trustee for the last 5 years.

When viewed in historical perspective, the long-term financing problems of these programs that are before us today are not recent occurrences. And the solutions are likely to be complicated to conceive and difficult to enact.

The Social Security program was first enacted by the Congress in 1935, in a limited form. The program expanded slowly over the next 37 years and, in fact, did not reach full maturation until the amendments of 1972.

The Medicare program was enacted in 1965. Although a Federal health care program was considered in 1935, only after some 30 years did such a program get enacted, and then only for the elderly and disabled, as a logical expansion of the Social Security system.

The extraordinary prosperity of the post-war period, from 1945 to roughly 1972, allowed benefits to be expanded, and the elderly to share in the economic success of the immediate post-war period.

The result of the matured Social Security program and the new Medicare program was to remove many elderly from poverty, and generally to enhance the security and well-being of workers who were disabled or retired.

However, beginning shortly after 1972, with the oil shocks, stagflations and the more unsettled circumstances of the 1970's, the Social Security system reflected the economic and social stresses of the time. It became clear that changes were necessary to adapt the program to these changed circumstances and those projected for the future.

Thus, major retrenchments in the program came in the form of amendments in 1977 and 1983. On each occasion, the Congress, on a bipartisan basis in a complex package of structural changes, both raised payroll taxes and reduced benefits, in the interest of providing long-term financial stability to the program.

The Medicare program was subject to a series of targeted cost containment enactments in the 1980's, and has repeatedly been the subject of Congressional concerns over the past decade. Many changes have been enacted with the cooperation of Democratic Congresses and the Republican administrations of Presidents Reagan and Bush.

I believe it is clear from even this briefly capsulized history, that it is entirely possible—indeed absolutely necessary—to successfully adapt the Social Security and Medicare systems to changing circumstances and, in particular, to the economic and social conditions that are anticipated to prevail in the next century.

Moreover, the key to accomplishing needed changes is to make programmatic changes. That is, changes in which the programs are reformed on their own terms to provide long-term financial stability for them.

History shows that changes proposed essentially to achieve deficit reduction, or as part of any kind of a legislative program that is not perceived to preserve and maintain these programs for the benefit of not just current beneficiaries, but workers who will become beneficiaries in the years ahead, do not fare well.

In my judgment, deficit reduction and Social Security and Medicare reforms, which are both vital priorities for the nation, can best be achieved when pursued independently of each other.

Substantive reform bills will have budgetary consequences as a natural outgrowth of the way the Government does its accounting. There should be a concerted effort not to confuse budgetary issues and programmatic issues, since needed changes can and should be compatible with both ways of looking at legislative changes.

Bipartisanship in developing a broad consensus for change is essential to successfully adapting the Social Security and Medicare systems.

I firmly believe that the problems these programs presently present are serious, and need to be addressed promptly. Perhaps the most important step we can take right now is to find ways for people of all persuasions to work together to bring these programs into long-term financial stability.

Some reforms can be accomplished through incremental changes to Medicare, as a distinct legislative initiative, while others will depend on achieving broader-based health care reforms. But, whatever the approach to be taken, the problems are serious, and it is urgent to get the reform process started as soon as possible.

In particular, massive public education about the issues and reforms will be vital to their effectiveness and efficacy.

Finally, I would submit that, despite the difficulties over the last 20 years in achieving needed adaptations, our present Social Security and Medicare programs have continued to serve the country well.

It is my strong belief that the Social Security and Medicare programs are fundamentally sound, and that it is vital to the welfare of the nation in the 21st century that they be adapted now in ways to keep them sound in changing circumstances.

By making relatively small changes soon and gradually, more radical disruptive changes can be avoided in the future.

I will be happy to answer any questions you may have about either our testimony submitted for the record or my personal testimony today.

I thank you once again for the opportunity to appear before you, and commend you for your sincere commitment in holding these hearings, and trying to provide leadership vital to achieving needed reforms.

The CHAIRMAN. Mr. Ross, thank you.

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

The CHAIRMAN. Mr. Walker?

STATEMENT OF DAVID M. WALKER, PUBLIC TRUSTEE, FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY INSURANCE TRUST FUNDS, ATLANTA, GA

Mr. WALKER. Thank you, Mr. Chairman.

It is my understanding that the Committee has been provided with a copy of our full joint statement. Therefore, in the interest of time, I will focus my remarks on comments which, for the most part, go beyond that joint statement.

My comments will be based on the fact that I am a concerned and informed private citizen who also happens to be a former public trustee of Social Security and Medicare, a former Assistant Secretary of Labor for Pension, Health and Welfare Benefit Programs, and former head of the Pension Benefit Guaranty Corporation.

Mr. Chairman, when viewed on a combined basis, our current Medicare and Social Security programs promise significantly more than this Nation can reasonably be expected to deliver in the next century.

At the same time, the nature, timing and magnitude of the projected financial imbalances facing the Social Security—meaning the OASI and DI programs—and the Medicare—meaning the HI and SMI programs—are distinctly different.

Clearly, the projected financial imbalance in the HI program is our most serious and immediate concern, since the projected cost rate for this program far exceeds the projected income rate, and the HI trust fund is projected to become insolvent in the year 2002.

In addition, the HI trust fund is projected to experience a negative total cash flow beginning next year in 1996. And furthermore, a fact that has not been focused on as much lately, the HI program has already been experiencing a negative cash flow, based on premium revenue alone, since 1992.

In addition, the projected escalation in health care costs for both the HI and SMI programs is both alarming and unsustainable. These escalating costs are caused by a variety of factors, including certain factors that are clearly beyond the control of this Committee or, frankly, anyone in this country. These include the increasing dependency ratio, and longer life spans.

As Mr. Ross and I have stated in our public trustees' statements for the last 3 or more years, the Medicare programs are clearly unsustainable in their present form. In my opinion, these programs are in need of fundamental and dramatic reform.

This includes reviewing who is covered, what benefits are provided, how they are provided, and how the programs are financed. There is little question in my mind that the incremental and cost-shifting approaches of the past have about been played out.

In addition, while long-term savings can and should be achieved by more aggressive use of managed-care approaches and tougher enforcement, these initiatives may result in more costs than savings in the short term, based on past program experience. Also, these actions alone will not come close to solving the long-term financing problems of our current Medicare programs.

In my opinion, while the Medicare programs may have been appropriate and affordable in 1965, they clearly will not be in the next century.

This opinion is based on a variety of factors, and mostly fact, such as known demographic trends, escalating health care costs, existing health coverage gaps, the current tax treatment of health care benefits, the projected financial condition of the Medicare programs, the relative financial well-being of the elderly as compared to other cohort groups, the current national debt and projected fiscal budget deficits.

As a result, the time has come to reengineer our Medicare programs in a manner that is fair, fiscally responsible and economically rational.

We must also assure that the reengineered programs are financially sound and sustainable over the longer term.

In my view, any fundamental reexamination of the Medicare program should, preferably—and I underline the word preferably—be pursued within the context of more comprehensive health care reform.

However, from a practical standpoint, we will need to pursue incremental Medicare and health care reforms while we conduct a massive public education campaign in advance of more dramatic and fundamental reforms.

Any broader health care reform initiative, in my view, should include reviewing and reconsidering the appropriate roles of Government, employers and individuals in both the provision and financing of health care, including reconsideration of all existing tax preferences associated with health care.

This broader reform initiative should also focus on what individuals need, and what our Nation can afford, rather than on what benefits are currently being provided and what additional benefits people might like to have.

After all, there is no free lunch. And, to the extent that these programs are not self-sustaining or are otherwise not affordable, they will serve to further mortgage our children's future and exacerbate existing expectation gaps.

Importantly, failure to address escalating health care costs and the financial imbalance in the Medicare program, in a timely and effective manner will have serious long-term adverse economic as well as inter-generational consequences.

We must have the courage, the vision and the commitment to deal with the fundamental financial imbalance in the Medicare programs and our other health-care-related challenges in a timely, comprehensive and, most importantly, non-partisan manner.

Delay will only serve to increase the difficulty and the severity of any related changes. In addition, failure to effectively address the financial imbalance in the Medicare programs will likely have long-term adverse consequences on the Social Security program.

History has shown that Congress, when it delays, has tended to take from any relatively well-financed programs to give to those in financial trouble. And, Mr. Chairman, I underline the words relatively well-financed, because none of these programs are well financed over the long term.

In fact, as you know, the most recent example was in OBRA 93, with the increase in income inclusion of certain Social Security benefits on certain beneficiaries from 50 percent of 85 percent. The additional tax revenue that was achieved from that additional income inclusion did not go into the OASI trust fund, where it was needed. It went into the HI trust fund. This a perfect example of how that shell game can occur. In my opinion, this type of action is inappropriate, and should not continue. Each social insurance program should be designed to stand on its own two feet.

In summary, as an informed and concerned private citizen, and a father of two, I am extremely concerned that this Nation faces

a number of looming crises, including a retirement and intergenerational crisis. We must have the courage, the vision and the commitment to deal with these looming crises in a timely, effective and non-partisan manner.

In my opinion, it is time for statesmanship, not partisan rhetoric. It is time for actions, not words. And it is time to focus on benefit security, not tax cuts, and not benefit enhancements.

Doing so is critical to the long-term competitive posture and economic security of this Nation, the economic security of our children and grandchildren, and the retirement security of American workers and retirees.

As such, I stand ready to assist the Congress, address this important challenge in a reasoned, responsible and non-partisan manner.

In my opinion, Mr. Chairman, we need to do at least four things, and we would be happy to get into specific questions and answers if you would like.

First, we need to make selected, incremental Medicare and health care reforms.

Second, we need to conduct a massive public education campaign to educate the American public as to the nature, extent and magnitude of the challenge that we face in the Medicare and health care area.

Third, we need to establish a bipartisan-type blue ribbon panel, such as a Greenspan-type commission, to serve as a mechanism to explore more dramatic and fundamental changes, and to look at and consider both the policy and the political aspects of the necessary decisions.

And, fourth, we need to enact much more dramatic and comprehensive health care reforms before the end of this century.

Mr. Chairman, that concludes my statement. I would be happy to answer any questions that you or other Committee members may have.

The CHAIRMAN. As I look around, there are a handful of people in the room, less than a handful of reporters, hearing what I think is the most important testimony we are going to have on this subject, and the most balanced testimony we are going to have.

You guys are both experienced in politics, and you know the politics of what is going on. And you both say bipartisanship. I do not know if we can.

Mr. Walker, my greatest fear is that we may do what you suggested. We may borrow from the Social Security fund, and transfer it to the Medicare fund, and say there, now Medicare is solvent for the next 10 years.

That is not even a budget solution, let alone any other solution. All that does is pull Social Security down from maybe 2030 to 2020, or 2015. And if we wait, it is no longer a plane crash, it is now the Titanic in about the year 2010 or 2015.

My children are 28 and 24. This is going to explode at just about the time that they are in their peak earning years of 45 or so. And, unless I miss my guess, when both Social Security and Medicare run out of bonds—assuming we were going to transfer funds—in about 2015, and no change has been made in either the benefit structure of Social Security, or perhaps we have added prescription drugs and long-term care to Medicare. Who knows what we may

add? We are looking at payroll taxes of a minimum of 10 or 11 percent each, I think, and maybe 12 or 13 percent each, depending upon benefits.

At that stage, the generational warfare that you predict is going to happen. And a lot of people 30, 35, 40 are simply going to say that they will not elect to office people who are going to tax us 20 or 22 or 24 percent right off the top. I am talking about both ends of it.

And those who are beneficiaries are going to say you have broken faith with America, because we did not take the steps now that need to be taken.

I want to plumb both of you fellows rather deeply, if I can. I do not think we are going to undertake what we might call massive health reform this Congress. I am not sure we exactly know what to do. You made some very perceptive comments, not only about benefit structure, but tax preferences. We should approach all of those. We have been afraid to approach them.

We came close on the tax preferences last year, and we got hit on all sides of it. One is that it is regressive because, by and large, the people that have fringe benefits are making $20,000, $30,000 or $35,000. We are not talking about expensive health plans. We are talking about $250 a month for average workers, and that adds up to billions and billions of dollars. We did not approach it.

We can make the assumption that we are not going to do major health restructuring in the next 2, 3 or 4 years partly because we honestly are not sure exactly what works. Lord knows, I hope we do not borrow from the pension fund and shift it over to the HI fund and say, there. That would be the ultimate in irresponsibility. And, if the assumption is correct that we are someplace on just a short-term fix, I mean $147 and $165 billion short—and I think that is probably in the range—what should we do?

You two guys are Republican and Democrat. You can give us a bipartisan recommendation. What should we do to cure that immediate deficit?

Mr. WALKER. Well, I think there are some incremental things that we can look at, and we will be happy to provide more information for the record.

But I think we are looking at trying to slow the growth of spending. Let us keep in mind, nobody is talking about cutting anything in real terms, it is slowing the growth of spending.

The CHAIRMAN. And nobody is talking about any significant tax increases.

Mr. WALKER. No. I have not heard anybody talking about tax increases. We have done that the last few years, and so we are now trying to slow the growth of spending.

There are certain things that you can look at. First, you can look at expanding the prospective payment system concepts to other parts of the Medicare system. You can look at competitive bidding for certain existing managed care options.

You can look at the reimbursement rate, and the current structure of existing managed care options. Right now, people are getting reimbursed at 95 percent of the average cost, and there is some adverse selection going on there. This approach is not the most efficient, cost-effective way to do it.

In addition, I think we are eventually going to have to look at what can be done in some areas with regard to second surgical opinions, and other aspects of managed care. There are situations today where the incentives in our system are such to do more, more and more in situations which not only do not make sense economically, but may not make sense for the beneficiary.

I can give you a personal example myself that is close to home. I had a grandfather who passed away within the last year and a half, who had open heart surgery at 89. All the incentives in our system are to say, do it. The doctors are encouraged to say do it. The hospitals are encouraged to say do it. The nursing home is encouraged to say do it. The family is encouraged to say do it, because you obviously love your grandparents. And everybody is encouraged to say yes.

And Medicare is structured such that the vast majority of the costs are paid by Medicare. In that particular case, it was done. It cost hundreds of thousands of dollars. My grandfather wished that it had not been done after it happened.

The CHAIRMAN. You say he wished that it had not been done?

Mr. WALKER. He wished that it had not been done. And he signed a living will after that because it did not improve his quality of life. It did not significantly extend his life. So one of the things we are going to have to look at are just the incentives in the system. We want to be able to do what is right for the beneficiary, but also what is economically rational. Part of that is education, and part of that is incentives.

Mr. ROSS. I would add the following. Organizations like CBO and GAO have laundry lists of possible technical changes that could operate in the short run, and other changes that could operate in the long run.

The heart of the matter is that all of those changes involve difficult political judgments. And it is extremely important to focus on the process, so that those political judgments can be made in as fair and rational a manner as possible.

And I think it is important to try to create a process where it is not just a one-time lurching thing, and then it is like it is fixed, but it is not fixed.

When I see these charts, or hear somebody like Senator Bradley, whom I have the greatest respect for, say that this has been a crisis-type problem his whole time in the Senate, one of the reasons is that it is always the short-term fix. And then there is no follow-through and staying with it.

For example, some of the cost containment methods of the 1980's may not be working as well in the 1990's. The flexibility and the ability to move with changing conditions are not built in. So I would say that I know you are having a series of four hearings, and you will hear a lot of so-called technical solutions.

I have been at conferences, for example, like at the AEI. And I hear these people talk about things like risk-adjusted vouchers. And half the trade press there, I know, does not fully understand them, much less my 90-year-old mother in a retirement facility.

Somehow, if you are going to change the incentives, you are going to have to bring the knowledge about what you are doing to the people who are going to be affected by it.

And I think perhaps that involves setting in place a Greenspan-type commission to get things going, and then maybe taking some of these independent agencies that have been created by the Congress in the past, like the Prospective Payment Commission and the Physician Payment Commission, and seeing if there is not an overall kind of independent Medicare commission that can keep bringing proposals for adjustments back to the Congress on a continuing, follow-through basis.

I believe the cooperation of the administration is essential, both in the Greenspan-type commission, and with something like a kind of enhanced physician payment and hospital prospective payment commission.

That has worked in the past. It worked in 1983 and, frankly, it worked during the 1980's. And I think it is going to happen in the 1990's. It is just a question, when the rhetoric cools down, of people recognizing that they are going to have to get together and cooperate.

Mr. WALKER. Mr. Chairman, I think it is important to reinforce that there are politics and policy in this. And there are really two segments of what we need to do.

Yes, there are some incremental short-term things that ought to be done, which can help insure benefit security and enhance the financial condition of the Medicare program and, as an incidental factor, also help with regard to the budget deficit too. That is the way the beans are counted under our system.

But there is the longer-term, more dramatic and more comprehensive Medicare and health care reform that we are going to have to do, and I think for that, it is absolutely essential that we go with something like a Greenspan-type commission, or something like that, because we are talking about major changes.

Mr. ROSS. I would add one other point, if I might, Mr. Chairman. And that is, as I sat here and observed the hearing prior to the break, 2002 is not a date that is fixed in stone. That is simply the date under the best estimate. Experience changes from year to year. That is why we also do a pessimistic and optimistic scenario. And Armageddon could come sooner.

We also know how long it sometimes takes Congress and the public to see which ideas that might technically provide some relief actually will be acceptable, and which ones will not. You cannot make sound political judgments in a vacuum. It will have to take airing the possible solutions and getting feedback, and people sort of taking time.

So the sense that there is a lot of time, I think, is mistaken. The time to start is now. There is an urgency which I think is really there.

The CHAIRMAN. There is not any time if 2002 is accurate, let alone if it is shorter. I mean, that is tomorrow. Social Security running out is practically the day after tomorrow.

Any insurance company that had the number of beneficiaries that Social Security does, and was looking at their long-term pros-

pects, and were managing it the way Social Security is being managed, would be sued.

Mr. ROSS. There is one other example I would pick to show what I think underscores the point you make.

The disability fund was about to run out of money, so benefits could not be paid. Mr. Walker and I agreed to recommend the reallocation, with two sets of administration trustees, first under the Bush administration and then the Clinton administration. But we required that they agree to do studies first, so that the Congress could have brought to it material to look at the substantive reforms.

Because, when you do a reallocation like that, the effect was to shorten the time to the final exhaustion of the OASI fund, where the money was reallocated from. And all it really did was buy time and opportunity to fix the disability program.

However, that was last year's problem. And this year's problem is HI. And what I fear is not that benefits will not be paid. They will be paid. The problem is that the fixes are often just very short-term in nature, and do not really address the underlying issues. They simply put off the day of reckoning.

So it is that scenario I fear, where you wait too long, and then you just do something about the crisis. It is like a strep virus. It goes away, and it is not cured, and it comes right back, and the patient is sick again.

The CHAIRMAN. That is why I have this fear of borrowing from the old age fund. I can almost see the scenario. This is politicized. We do not get a Greenspan commission. The Republicans have a budget that has a $250 billion Medicare hole, and we have some kind of commission to say that we will consider it in September.

And the politics are such that the administration is beating us about the ears, we retreat and say let us borrow some money. And the administration says all right. There is our bipartisan fix. That will get us by the 1996 elections. And we borrow enough to maybe get us 3 or 4 years of time.

And, having done it once, we can say, well, that took care of the problem. It does not take care of any problem. It does not take care of the medical problem. It does not take care of the budget problem. It does not take care of any problem. But it would appear to be—I can just see it—an easy way out. And it would be a terrible mistake.

Mr. Walker?

Mr. WALKER. Mr. Chairman, let me give you an analogy that I am fairly familiar with. I think the nature, scope and magnitude of the problem here is greater than the problem we faced leading up to the enactment of ERISA, the Employment Retirement Income Security Act.

And you know that it took about 7 years from the point in time that Congress really got serious and started thinking about it and looking at it, before legislation was actually enacted. That is all the more reason why we need to do it now.

The CHAIRMAN. You are absolutely right. Although, at the end of about 2 years, we knew the problem. It took us 5 years. Now we know it. It took us 5 years to do it. You are right about the mag-

nitude. It is different than the little teeny fixes we have had in previous years.

Senator Moynihan has used a wonderful expression regarding the welfare bill and out-of-wedlock births. He likes to cite St. Louis County, which is now approaching 60 or 65 percent out-of-wedlock births. He says the problem when you have 6 percent out-of-wedlock and 94 percent of the population to take care of it, is totally different than when you have 60 percent. It is not just a quantitative difference, it is a qualitative difference.

And we have reached the stage where this is a qualitative problem that cannot be fixed, in my judgment, by even significant quantity shifts. That would be moving the bonds; that is a quantity shift. It does not solve any of the quality problem.

Mr. WALKER. And I think, clearly, there is a lot of concern to make sure that whatever is done is fair to the elderly. And I think everybody can agree with that. But, quite frankly, Mr. Chairman, I do not think there has been enough focus on being fair to our children and grandchildren.

I notice in the back of the room we have a number of younger individuals who are here, watching this process. And I get very concerned about them, as to what the future will hold unless we finally come to grips and recognize that we need to make promises we can keep, and we need to secure the promises we make, and that inaction has a consequence and a cost.

The CHAIRMAN. I can see the day, 20 years from now, when somebody says, grandad, I love you and I want to support you, but between the two, it is love. [Laughter.]

Twenty years from now, you are a self-employed auto mechanic with a couple of employees. But you are self-employed. You are a CPA, you are a lawyer, and you are looking at a 20 or 22 percent payroll tax, plus income taxes, plus State income taxes.

At some stage, that rubber band will not stretch any further, and there will be a revolt. And it will be a generational revolt if we have made no significant reforms in both health and retirement. And I do not mean just Social Security retirement. I mean almost all of the retirement programs this Government has.

Mr. ROSS. Let me add one point. And that is, the Medicare program was enacted in the mid-1960's. It has never had a thorough review of its structure. My hair has turned gray, being here in Washington since the Kennedy administration, when I first came. I actually worked in the Johnson White House on domestic programs in the mid-1960's. Part A and Part B were a political compromise at that time. They were two different approaches, and two different sets of ideas. And it was hard to pass. At the end, that was the political compromise.

Well, it has endured for 30 years, the time has come to look at the structure of a program that is demonstrating these kinds of problems, and take a fundamental look, make fresh political judgments in light of the information and sophistication that people have in the mid-1990's, so that you set it right for maybe another 30 years.

The CHAIRMAN. It is. It is the ultimate problem with entitlements. So many of them are adopted as a compromise, no question about it. Then 10, 20, 30 years later, everybody involved is con-

vinced they came, at a minimum, with the Bill of Rights, and maybe with Moses. And they should not be changed by the hand of man or woman, only God, and we are not too sure about him.

That is what has happened. You are absolutely right. I remember the history of the compromise. Maybe the judgment at the time was right, that that is what had to be done to pass it. I do not know. But that was 30 years ago.

Well, fellows, I do not have any more. I cannot tell you how much I appreciate what you have done over the years. We may call you back. We may need you over and over for voices of reason, to hopefully heal this breach that I see coming, and could lead us to bad—and I mean very bad—bipartisan answers, for the sake of avoiding the partisan fight, and praying that 3 years later something different will happen.

Mr. ROSS. Well, if there is any way we can help, I know that I have had four stints in Government, and I think this problem is as serious as any problem I have ever dealt with. And I would be happy to help in any way I can.

The CHAIRMAN. Thank you. And Mr. Walker?

Mr. WALKER. Same thing, Senator.

And let me mention one other thing. to talk about the magnitude. If we realize that, ultimately, we are going to have to make reforms in both the Social Security and Medicare programs—in my opinion, clearly more dramatic in Medicare—I think we have to think beyond those programs as well.

I think we have to think about the implications for private pension and health arrangements. What are the implications with regard to our tax laws and regulatory policy, with regard to personal savings, the need to educate people on the need to save and invest for a secure retirement?

So we are really dealing with the tip of a much larger iceberg. And, to the extent we can help, we would be happy to.

The CHAIRMAN. Fellows, thank you very much.

We are adjourned.

[Whereupon, at 12:15 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF SENATOR DAVID PRYOR

Mr. Chairman, thank you for holding today's hearing on the Medicare program. Since its inception thirty years ago, the Medicare program has done a good job at doing what it was designed to do: providing quality, state-of-the-art health care coverage for millions of elderly and disabled Americans who would otherwise be left uncovered. However, we are here today to examine the solvency of the Medicare trust funds—an issue with significant implications for our future. This is an issue that needs to be addressed thoughtfully and independent of partisan politics.

Any changes to Medicare program will likely have far reaching effects on the 34 million beneficiaries it now serves. When considering the future direction of the Medicare program, it is important to consider the make up of the people served by this program. Contrary to commonly held beliefs, Medicare beneficiaries are not wealthy. Over three-fourths of Medicare beneficiaries have incomes below $25,000, and fewer than five percent have incomes exceeding $50,000,

Further, in spite of Medicare, health care consumes a large portion of older Americans' income, and Medicare beneficiaries pay far more for their own health care than the non-elderly. On average, elderly households spent 12 percent of their incomes directly out-of pocket for health care, compared with 3.7 percent for nonelderly households. Some estimates put Medicare beneficiaries' out-of-pocket health expenditures at 21 percent of their income.

Last week I had the honor of chairing the White House Conference on Aging. By far, the delegates' key concern was the preservation of the Medicare program. In fact, it was clear that seniors hold policymakers equally responsible for fulfilling our long-standing commitment to providing health security through Medicare and financial security through the Social Security program. These delegates—who are far from being inside the beltway technicians—are people we should listen to as we grapple with this very difficult issue of financing our Medicare program.

Mr. Chairman, I look forward to working with you and our colleagues on the Committee to ensure the viability of the Medicare program. I am pleased to have the opportunity today to hear from our distinguished panel of witnesses.

PREPARED STATEMENT OF DONNA E. SHALALA AND SHIRLEY S. CHATER

Mr. Chairman and members of the committee:

Thank you for the opportunity to testify on the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds. We are here today as Trustees appointed by the President and as members of the Clinton Administration who—like the Congress—are charged with protecting the Medicare program and its beneficiaries.

The trustees recently reported that the HI trust fund will be depleted in 2002. While the HI trust fund financial balance is a significant problem and deserves our serious attention, let us also remind you that (1) this is not a new problem and (2) the projected life of the trust fund has been extended for three years since 1993.

Due to the actions taken in the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) and a stronger-than-expected economy in 1994, Trust Fund depletion has been delayed from 1999 to 2002. Even with these improvements, however, the Trustees continue to foresee financial problems in the future for the HI Trust Fund.

As we noted, the Trustees' trends and projections have occurred before and are not surprising. In the course of the past 15 years, the Trustees have predicted near-

term financial problems for the trust funds and recommended that Congress take action to slow the growth of Medicare spending to assure trust fund solvency. While we have worked with Congress to improve the outlook of the trust fund, broader issues of health care cost and access limit how much more we can accomplish through Medicare reductions in growth alone.

We are concerned solutions focused solely on Medicare would severely strain many of our fragile health care delivery systems in rural and inner-city communities and could result in cost shifting to small businesses and individuals. We must therefore consider this issue in the context of health reform.

Today, we will focus primarily on the solvency of the HI trust fund. Although the Trustees Report addresses cost growth in both the HI and the SMI trust funds, the issue of greatest concern is the HI trust fund's solvency. The Administration looks forward to working with Congress to strengthen the Medicare program in the context of broader reforms to assure that Medicare remains stable now and in the future.

DESCRIPTION AND BACKGROUND INFORMATION ON THE TRUST FUNDS

Let us begin by describing the HI trust fund and the services it supports for Medicare beneficiaries. The HI Trust Fund primarily pays for inpatient hospital care, but it also covers expenditures for home health services, skilled nursing care, and hospice care. In 1994, the HI Trust Fund paid for $104.5 billion in services for 32 million aged and 4 million disabled beneficiaries.

The HI Trust Fund is financed primarily by payroll taxes. Employees contribute 1.45 percent of wages, and there is a matching contribution by employers. Self-employed individuals contribute 2.9 percent of self employment income. OBRA 93 removed the ceiling on the amount of earnings that are taxable; consequently, this tax applies to all earnings. The Trust Fund also receives income from interest earnings on its assets, revenue from taxation of Social Security benefits, and from miscellaneous sources.

Trust Fund expenditures are projected to rise more rapidly than Trust Fund revenues. Anticipated increases in the number and complexity of medical services are expected to continue to increase expenditure growth rates. Driving the expected imbalance between expenditures and revenues is the demographic shift that will occur with the aging of the baby boom generation. A larger percentage of our population will be eligible for Medicare, and a correspondingly smaller percentage will be paying the taxes that support the Trust Fund.

What does this mean? The 1995 HI Trustees Report projects roughly another 7 years of solvency. The fund is exhausted in 2002. Over the 75 year long-range projection period, the income as a percent of taxable payroll remains relatively level while the cost rate rises steadily.

These are well-understood trends; there is nothing new in this most recent Trustees Report. Over the past 15 years, the Trustees have projected the date of insolvency to be anywhere from 1987 to 2005, and each year they recommend that Congress take action to protect the fund. As noted earlier, in part due to provisions in OBRA 93, Trust Fund depletion has been delayed to 2002.

OBRA 93 eliminated the maximum earnings cap for the HI program, so that the HI tax now applies to all earnings. It also achieved $55 billion in savings from the Medicare program, about $30 billion of which came from providers who are paid through the HI Trust Fund. In addition, OBRA 93 increased the maximum proportion of Old-Age, Survivors, and Disability Insurance (OASDI) benefits subject to Federal income taxes from 50 percent to 85 percent, for only those beneficiaries with the highest incomes. Revenues generated by this provision are dedicated solely to the HI Trust Fund. Unfortunately, as part of its Contract with America, the House has voted to repeal the change in the taxation of OASDI benefits. It is ironic that those who are suddenly interested in the plight of the Medicare trust fund have advocated policies that exacerbate the insolvency of the Medicare trust fund.

EFFECTIVE SOLUTIONS REQUIRE BROADER HEALTH CARE REFORM

Any significant changes in the Medicare program, whether in the financing, eligibility, benefit provisions or payment rates, will effect the entire health care system. Therefore, this Administration believes that strong action to avoid depletion of the Hospital Insurance Trust Fund should not be undertaken by looking at Medicare alone.

Reductions in payments to providers would have significant effects on providers' overall financial condition. This is especially true for providers whose patients are predominantly Medicare beneficiaries or providers who also treat uninsured persons, whether located in inner cities or rural areas.

- Large reductions in Medicare payments would have a devastating effect on a significant number of urban safety-net hospitals. These hospitals already are bearing a disproportionate share of the nation's growing burden of uncompensated care.
  —For large urban public hospitals, which are heavily used by Medicaid and self-pay patients, Medicare is an important source of adequate payment. According to the 1994 Special Report of the National Association of Public Hospitals, while Medicare in 1991 was the payer for only 11 percent of discharges in these institutions, it accounted for almost 20 percent of net operating revenues.
  —For these hospitals on average, in 1991 Medicare accounted for a bigger share of net operating revenues than private payers.
- Large reductions in Medicare payments could also endanger rural hospitals.
  —Nearly 10 million Medicare beneficiaries (25 percent of the total) live in rural America where there is often only a single hospital in their county. These rural hospitals tend to be small and to serve primarily Medicare patients.
  —Significant reductions in Medicare revenues will cause many of these hospitals, which already are in financial distress, to close or to turn to local taxpayers to increase what are often substantial local subsidies.
  —Rural residents are more likely than urban residents to be uninsured. As a result, offsetting the effects of Medicare cuts by shifting costs to private payers is more difficult for small rural hospitals.
  —Rural hospitals are often the largest employer in their communities; closing these hospitals will result in job loss and physicians leaving these communities.

Other providers may shift their costs onto payers who do not have the market power to negotiate advantageous rates. This means that ultimately many small businesses and individuals—those Americans who are already paying the highest health insurance premiums in the nation—will shoulder an even larger share of health care costs.

Large reductions in Medicare reimbursements to providers could also hurt beneficiaries. Significantly cutting payment rates to providers might restrict access for beneficiaries as providers would be less willing to provide services to them. Further, low income beneficiaries would be the hardest hit. According to AARP, out-of-pocket health costs represent 21 percent of income for those over 65 years. In addition, over 75 percent of Medicare beneficiaries have incomes below $25,000. Medicare reductions could increase the cost burden of the nation's most vulnerable elderly—the low-income. Such increases become the equivalent of reducing their Social Security.

Attempts to restore the solvency of the trust fund cannot undermine Medicare's commitment to access to care for elderly persons. We should take care that any efforts to extend the solvency of the trust fund do not put Medicare beneficiaries at undue risk, but at the same time protect the program for them in the future.

Only through focusing on the entire health system will we be able to address issues within Medicare and preserve access for Medicare beneficiaries and underserved populations.

The Administration takes seriously its responsibility to current and future Medicare beneficiaries to insure the solvency of the trust fund. The Health Care Financing Administration (HCFA) continues to make many program changes to improve the efficiency of the Medicare system. For example, hospital prospective payment has contributed to slowing the increase in Medicare expenditures for hospital services. As a result, on a per enrollee basis, Medicare grew at a slower rate than the private sector between 1984 and 1993 7.7 percent compared to the private sector's 9.8 percent.

As we address these issues, we must remember that Medicare does not stand alone. It is an integral part of a larger health care system, and its solvency should be addressed only in the context of that larger system. Broader health care reform will occur only if we work on a bipartisan basis. The Administration looks forward to working with the Congress to develop lasting solutions to Medicare's fiscal problems.

PREPARED STATEMENT OF STANFORD G. ROSS AND DAVID M. WALKER

Mr. Chairman and members of the committee: It is our privilege to testify regarding the financial status of the Medicare Hospital Insurance Trust Fund as shown in the 1995 Annual Report of the Board of Trustees of that fund. As you know, the Public Trustees are part-time officials appointed by the President and confirmed by the Senate to represent the public interest in this important process of public ac-

countability. In our normal activities, Mr. Ross is a lawyer and consultant and Mr. Walker is a CPA and consultant, both with extensive public and private experience in tax, financial and retirement security matters. Pursuant to law, our terms as Public Trustees ended with issuance of the 1995 Trustees Reports on April 3, 1995. Our joint statement reflects the positions we took in those reports.

ROLE OF THE PUBLIC TRUSTEES

As Public Trustees, our primary activities were directed at assuring that the Annual Trust Fund Reports fully and fairly present the current and projected financial condition of the trust funds. During preparation of the Annual Reports over the last 5 years, we participated in the review of the proposed short-range and long-range economic and demographic assumptions and in the decisions made on those assumptions. We attempted to test assumptions, question methodologies and work with the Offices of the Actuary of the Social Security Administration and the Health Care Financing Administration and others in and out of government to seek improvements in the projections. Specifically, we sponsored roundtable discussions with expert panels on key assumptions, including the rate of change in fertility, mortality and real wages. We also sponsored a symposium and publication of papers on how methods and assumptions might be improved to better estimate the future income and health care needs of the elderly and disabled. The goal of these efforts was to assure the American public of the integrity of the process and credibility of the information in these reports.

In addition to our efforts to ensure the integrity of the projections in the trust fund reports, we also worked to improve communications with the Congress and the public regarding these important programs. We are particularly pleased to have provided leadership in returning to one set of intermediate projections, or "best estimates," in the reports, and in conceiving and instituting the increasingly popular *Summary of the Annual Reports,* including an annual "Message From the Public Trustees," as an important part of the reporting process. We also testified before congressional committees and other governmental commissions, and gave speeches and briefings to congressional staffs and other interested parties. Our goal in these activities has been to enhance understanding of the current and projected financial condition of the Social Security and Medicare programs.

A key point we have stressed is that projections ultimately are only estimates and must necessarily reflect the uncertainties of the future. Nevertheless, the projections in the Trustees Reports are useful if understood as a guide to a plausible range of future results and if acted on in a timely and responsible manner. With this purpose in mind, we now turn to the projections in the 1995 report on the Hospital Insurance (HI) Trust Fund but will also mention the status of the Supplementary Medical Insurance (SMI) Trust Fund.

MEDICARE PROGRAM

The 1995 reports on both the HI Trust Fund and the SMI Trust Fund show alarming financial results. While the financial status of the HI program improved somewhat in 1994, the HI Trust Fund continues to be severely out of financial balance and is projected to be exhausted in about 7 years. The SMI Trust Fund, while in balance on an annual basis, shows a rate of growth of costs which is clearly unsustainable. Moreover, this fund is projected to be 75 percent or more financed by general revenues, so that given the general budget deficit problem, it is a major contributor to the larger fiscal problems of the nation.

Currently about four covered workers support each HI enrollee. This ratio will begin to decline rapidly early in the next century. By the middle of the next century, only about two covered workers will support each enrollee. Not only are the anticipated reserves and financing of the HI program inadequate to offset this demographic change, but under all the sets of assumptions, the trust fund is projected to become exhausted even before the major demographic shift begins to occur.

The Trustees note that some steps have been taken to reduce the rate of growth in payments to hospitals, including the implementation of the prospective payment system for most hospitals. Experience to date suggests that this reimbursement mechanism, together with payment limitation provisions enacted by the Congress, has helped to constrain the growth in hospital payments and has improved the efficiency of the hospital industry.

Extension of this payment system to other providers of HI services and further legislation to limit payment increases to all HI providers could postpone depletion of the HI trust fund for about another 5 to 10 years. Much more substantial steps would be required, however, to prevent trust fund depletion beyond 2010 as the baby boom generation begins to reach age 65.

We continue to believe, as we also emphasized in our 1993 and 1994 Public Trustees Messages, that the Medicare program is clearly unsustainable in its present form. We had hoped for several years that comprehensive health care reform would include meaningful Medicare reforms and that comprehensive health reform would eventually reduce the rate of growth of health care costs and thus the financing shortfall facing Medicare. However, with 3 the results of the last Congress, it is now clear that Medicare reform needs to be addressed urgently as a distinct legislative initiative. We also believe strongly that Medicare reform should be included as an integral part of any broader health care reform initiative which may be considered in the future.

There are basic questions with the scale, structure and administration of the Medicare program that need to be addressed. For example, is it appropriate to have a Part A (Hospital Insurance) and Part B (Supplementary Medical Insurance) today, or should this legacy of the political process that enacted Medicare in the mid-1960s be revised to create a unified program? Is it appropriate to combine participants' social insurance tax contributions for Part A and premium payments for approximately one-quarter of Part B with general revenues? If so, what should be the proper combination of beneficiary premiums, taxpayer social insurance contributions, and general revenues? How are each of these kinds of revenue sources to be justified and what rights to benefits and responsibilities to pay benefits are thereby established? How can the program become more cost-effective? How can fraud, abuse and waste be better controlled?

We believe that comprehensive Medicare reforms should be undertaken to make this program financially sound now and over the long term. The idea that reductions in Medicare expenditures should be available for other purposes, including even other health care purposes, is mistaken. The focus should be on making Medicare itself sustainable, making it compatible with Social Security, and making both Social Security and Medicare financially sound in the long term. While Social Security is in far better financial health than Medicare and the changes that will be required in Social Security can be relatively small and gradual if they are begun in the near future, the magnitude of those changes grows each year that action is delayed. Thus, urgent attention to Medicare's financing is critical, but it is important to keep in mind the financing needs of both Social Security and Medicare when making any changes because the resources that are devoted to one area will not be available to the other.

We strongly recommend that the crisis presented by the financial condition of the Medicare Trust Funds be addressed on a comprehensive basis, including a review of the program's financing methods, benefit provisions, and delivery mechanisms. Various groups should be consulted and reform plans developed that will not be disruptive to beneficiaries, will be fair to current taxpayers who will in the future become beneficiaries, and will be compatible with government finances overall. We have attached to our statement the four-page "Message From the Public Trustees" that is included in the *Summary of the 1995 Annual Reports*, as well as our biographical information. We thank you for the opportunity to present our views and will be pleased to answer any questions you may have.

THE PUBLIC TRUSTEES

Six people serve on the Social Security and Medicare Boards of Trustees: the Secretary of the Treasury, the Secretary of Labor, the Secretary of Health and Human Services, the Commissioner of Social Security and two members (of different political parties) appointed by the President and confirmed by the Senate to represent the public. The Boards are required by law to report to the Congress each year on the operation of the four Social Security and Medicare trust funds and the projected financial status of these funds for future years. The Public Trustee positions were created by the Social Security Amendments of 1983. Stanford G. Ross and David M. Walker began four-year terms as Public Trustees on October 2, 1990; and completed their terms with issuance of the 1995 reports on April 3, 1995. In addition to their duties overseeing the trust funds, they have worked to increase public understanding and public confidence regarding Social Security and Medicare.

STANFORD G. ROSS

Stanford G. Ross is a Senior Partner in the law firm of Arnold & Porter in Washington, D.C. Mr. Ross dealt extensively with public policy issues while serving in the U.S. Treasury Department, on the White House domestic policy staff, and as Commissioner of Social Security. He also served as Chair of an Advisory Council on Social Security.

Mr. Ross has taught law at the Georgetown, Harvard, New York University and Virginia Law Schools, and has been a Visiting Fellow at the Hoover Institution, Stanford University. Mr. Ross has served as Chairman of the American Bar Association Tax Section Committee on Social Security and Payroll Tax Problems He has provided technical assistance to various foreign countries on Social Security and tax issues under the auspices of the International Monetary Fund, the World Bank, and the U.S. Treasury Department. Mr. Ross served as President of the National Academy of Social Insurance from January 1990-April 1992, and is a founding member and a member of its Board of Directors. He received a J.D. degree from Harvard Law School and a B.A. degree from Washington University (St. Louis). He is the author of many papers on federal taxation and income security and is a frequent participant in conferences on these subjects.

DAVID M. WALKER

David M. Walker is a partner and worldwide managing director of the compensation and benefits practice of Arthur Andersen LLP based in Atlanta, Georgia. Mr. Walker has held a variety of executive and policymaking positions in the Federal government, including serving as head of two of the three Federal agencies that administer the Employee Retirement Income Security Act of 1974 (ERISA). His most recent full-time government position was Assistant Secretary of Labor for Pension and Welfare Benefit Programs at the U.S. Department of Labor. Mr. Walker served at the Pension Benefit Guaranty Corporation (PBGC) before joining the Department of Labor.

Mr. Walker is a Certified Public Accountant and received his B.S. in accounting from Jacksonville University. He holds a number of leadership positions, including serving as a director of the Association of Private Pension and Welfare Plans (APPWP), chairman of the American Institute of Certified Public Accountants' (AICPAs) Employee Benefit Plans Committee, and vice-chairman of the Legislative Committee for the Southern Employee Benefits Conference. He is a member of a number of other organizations, including the National Academy of Social Insurance and the Editorial Advisory Board of *Journal of Accountancy and Journal of Taxation of Employee Benefits.* He is a frequent speaker, author and expert witness on a variety of compensation, benefits, investment, retirement and related issues.

From "A Summary of the 1995 Annual Reports" of the Social Security and Medicare Boards of Trustees

A MESSAGE FROM THE PUBLIC TRUSTEES

This is the fifth set of Trust Fund Reports on which we have reported as Public Trustees. It is also, under the terms of our appointment, our last report, and we use this occasion to summarize our views on some major aspects of the Social Security and Medicare programs. As representatives of the public, our efforts have been to assure the American public of the integrity of the process and the credibility of the information in these reports. We feel privileged and honored to have been able to take part in this important exercise in public accountability, and want to provide our best advice on directions for change of these important programs in the years ahead.

THE NEED FOR ACTION

During the past 5 years there has been a trend of deterioration in the long-range financial condition of the Social Security and Medicare programs and an acceleration in the projected dates of exhaustion in the related trust funds. To some extent, this has been predictable because when doing annual 75-year projections, an additional deficit year in the 2060s is being added with each new projection. But to some extent, the increasingly adverse projections have come from unforeseen events and from the absence of prompt action in response to clear warnings that changes are necessary. These adverse trends can be expected to continue and indicate the possibility of a future retirement crisis as the U.S. population begins to age rapidly. We urge that concerted action be taken promptly to address the critical public policy issues raised by the financing projections for these programs.

PROJECTIONS AS A GUIDE TO ACTION

We believe it is important for the public and the Congress to understand more about what the projections in the Trust Fund Reports really mean and how they are intended to be used. These projections represent the best estimates the Trustees can make based on the best available information and methodologies. We have, dur-

ing our period of service, attempted to test assumptions, question methodologies and work with the Offices of the Actuary of SSA and HCFA and others in and out of government to seek improvements in the projections. We have also stimulated thought through a symposium and publication of papers on how methods and assumptions might be improved to better estimate the future income and health care needs of the elderly and disabled. Action should be taken to continue and extend survey and other data development efforts and to improve modeling capability regarding the income and health circumstances of future retirees. Such information is critical to the legislative and regulatory activity that will be required for both public and private income security and health care programs in future years.

However, with even the best data and models, projections ultimately are only estimates and must necessarily reflect the uncertainties of the future. They are useful if understood as a guide to a plausible range of future results and if acted on in a timely and responsible manner. They are not helpful if ignored, or if used improperly, or if distorted. We hope that more policymakers will come to grips with the strengths and limitations of projections such as those in the Trust Fund Reports and how those projections can be used most productively.

Social Security Program

The Old-Age and Survivors Insurance Trust Fund shows a deficit of 1.87 percent of payroll in the long run. It is by far the best financed of the trust funds, and we believe strongly that the OASI program can and should be maintained over the long term. Yet even here reforms should be undertaken sooner rather than later to ease the transition to providing financial stability in the next century. We note the recent work of the Bipartisan Entitlement Commission and the current work of the Advisory Council on Social Security regarding the long-term financing of the OASI program. We hope that this kind of work will continue and that this problem will be addressed in a timely fashion.

The condition of the Disability Insurance Trust Fund is more troublesome. While the Congress acted this past year to restore its short-term financial balance, this necessary action should be viewed as only providing time and opportunity to design and implement substantive reforms that can lead to long-term financial stability. The research undertaken at the request of the Board of Trustees, and particularly of the Public Trustees, shows that there are serious design and administrative problems with the DI program. Changes in our society, the workforce and our economy suggest that adjustments in the program are needed to control long-range program costs. Also, incentives should be changed and the disability decision process improved in the interests of beneficiaries and taxpayers. We hope that this research will be completed promptly, fully presented to Congress and the public, and that the Congress will take action over the next few years to make this program financially stable over the long term.

Medicare Program

The most critical issues, however, relate to the Medicare program. Both the Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund show alarming financial results While the financial status of the HI program improved somewhat in 1994, the HI Trust Fund continues to be severely out of financial balance and is projected to be exhausted in about 7 years. The SMI Trust Fund, while in balance on an annual basis, shows a rate of growth of costs which is clearly unsustainable. Moreover, this fund is projected to be 75 percent or more financed by general revenues, so that given the general budget deficit problem, it is a major contributor to the larger fiscal problems of the nation.

The Medicare program is clearly unsustainable in its present form. We had hoped for several years that comprehensive health care reform would include meaningful Medicare reforms. However, with the results of the last Congress, it is now clear that Medicare reform needs to be addressed urgently as a distinct legislative initiative. We also believe strongly that Medicare reform should be included as an integral part of any broader health care reform initiative which may be considered in the future.

There are basic questions with the scale, structure and administration of the Medicare program that need to be addressed. For example, is it appropriate to have a Part A and Part B today, or should this legacy of the political process that enacted Medicare in the mid-1960s be revised to create a unified program? Is it appropriate to combine participants' social insurance tax contributions for Part A and premium payments for approximately one-quarter of Part B with general revenues? If so, what should be the proper combination of beneficiary premiums, taxpayer social insurance contributions, and general revenues? How are each of these kinds of revenue sources to be justified and what rights to benefits and responsibilities to pay

benefits are thereby established? How can the program become more cost-effective? How can fraud, abuse and waste be better controlled?

We feel strongly that comprehensive Medicare reforms should be undertaken to make this program financially sound now and over the long term. The idea that reductions in Medicare expenditures should be available for other purposes, including even other health care purposes, is mistaken. The focus should be on making Medicare itself sustainable, making it compatible with OASDI, and making both Social Security and Medicare financially sound in the long term.

We strongly recommend that the crisis presented by the financial condition of the Medicare Trust Funds be urgently addressed on a comprehensive basis, including a review of the program's financing methods, benefit provisions, and delivery mechanisms. Various groups should be consulted and reform plans developed that will not be disruptive to beneficiaries, will be fair to current taxpayers who will in the future become beneficiaries, and will be compatible with government finances overall.

Institutional Considerations

We have as Public Trustees tried over the past 5 years to provide continuity and improve the institutional framework surrounding the Social Security and Medicare programs. We have bridged two Administrations (one Republican and one Democratic), two Advisory Councils (one appointed by a Republican Administration and one by a Democratic Administration), and many changes in the ex officio Trustees. We have consulted with each of the Advisory Councils, as well as the working group of the prior Public Trustees, the Bipartisan Entitlement Commission, the Notch Commission and many other government entities. We have testified before both the House Ways and Means Committee and the Senate Finance Committee and held regular briefings for Congressional staff on the Trust Fund Reports. We know that with the advent of the new Social Security Administration as an independent agency, many of the institutional relationships in these areas will change. We hope that the Public Trustees in the future will continue to make a contribution towards a coherent institutional structure that serves the interests of the public.

Finally, we note that although the statute provides that one of the Public Trustees must be from each of the major political parties, we have operated as independent professionals on a nonpartisan basis. Every statement we have made over 5 years has been joint and consensual, and without partisan content or political dissonance. We believe these programs are too important to be politicized and urge that a highly professional, nonpartisan approach continue to be followed in future reports to the Congress and the public.

STANFORD G. ROSS, *Trustee.*
DAVID M. WALKER, *Trustee.*

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