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2010 AND BEYOND: PREPARING MEDICARE FOR THE BABY BOOMERS

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BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

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CONTENTS

2010 AND BEYOND: PREPARING MEDICARE FOR THE BABY BOOMERS

MONDAY, AUGUST 25, 1997

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Sioux City, IA.

The committee met, pursuant to notice, at 1:30 p.m., in the Auditorium of St. Luke's Regional Medical Center, Sioux City, IA, Hon. Charles Grassley (chairman of the committee) presiding.

Present: Senators Grassley and Hagel.

OPENING STATEMENT OF CHAIRMAN CHARLES GRASSLEY

The CHAIRMAN. It is a privilege for Senator Hagel and I to be here, and so I call this meeting to order. Senator Hagel has joined me not only as a fellow senator and a neighbor to Iowa, but also as a member of the Special Committee on Aging where he is a very active member of that committee. We are in Sioux City today on the very important topic of "2010 and Beyond: Preparing Medicare for the Baby Boomers." This is the first of two field hearings of the Aging Committee this week. The second will be tomorrow in Omaha, and it will focus on Social Security.

I already referred to the fact that you have question cards. We want your questions. We want you not only to ask questions of us; we want you to be able to ask questions of the panelists as well. Again, an address and name are very important for two reasons: One, as I have said, a written response, if we do not give you an oral response; and also, when you get a printed record you are going to want your grandchildren to know that you asked the Senate committee a question.

I know there is a lot of uncertainty about the future of Medicare, especially among younger people, and I have heard it said that young people ask, Will Social Security be around when they retire? Will Medicare be around when they retire? They actually give a higher percentage of response to the fact that they believe in UFOs more than they believe that there is going to be Medicare when they retire.

We have to ask this question, but we also want to ask you to ask it. We are policymakers, but you are part of the process of representative government. We have to ask, "Are they right?" I do not know about UFOs, and I can only give you a personal opinion, and I can only talk for the period of time that I might be a member of Congress.

But I believe that Social Security and Medicare—one for 30 years, and one for 60 years—are a part of the social fabric of Amer-

ican society, and they will remain a part of the social fabric of American society. So I think, although the future of Medicare does not look so bright today, that we have the capability and will provide for the younger people as well.

I have heard it said that when we were balancing the budget that we did not do enough about Medicare, and I do not want to claim that we did anything bold. The bold stuff is the next step. I wish Congress had taken the bold steps it should take, and yet, I can point to one or two votes we had that were relatively bold that I would have never thought that we would have had guts to take this particular year, and those were taken. So I think that we should not be patting ourselves on the back too much, but we have prevented Medicare from going bankrupt in the year 2001.

You can see here that in the year 2001 that when you go below the black line, that is deficit, and that would have been 2001. Congress took action, as represented by the green line, and so you can see that we have delayed the bankruptcy of Medicare to the year 2007.

As the second chart indicates, we are in a position now of still having very much an aging population. You can see that we are going to have, by the year 2010, 39 million Americans in retirement. By the year 2030 we are going to have 69 million Americans in retirement. That very sharp upturn in the red line is baby boomers going into retirement.

It is very important that we concentrate on the year 2010, because that is the biggest demographic change in American history. Medicare is not prepared for that; Social Security is just a little better prepared for that.

This hearing today is an example of why we need to be on top of this. I want to help through my leadership of the Aging Committee—and I have had the help of every one of my colleagues, Republican and Democrat, on this, because this is a very bipartisan committee. We want to set the stage for a national debate on Medicare and Social Security for baby boomers so that we can get a national consensus on this issue very soon. By "very soon" I am talking—not in '97 or '98, but by '99 and the year 2000, we ought to have very serious discussions with some decisions being made on: What do we do for Social Security and Medicare beyond the year 2010?

The reason for that is, quite frankly, if we do not get a national consensus, these issues are so politically sensitive that Congress is going to wait until the year 2006 to make a decision on Medicare, and we are going to wait until the year 2028 to make a decision on saving Social Security from bankruptcy.

There is no reason for Congress to wait that long. We know now the seriousness of the situation, and Congress ought to have the statesmanship to act, but I think preceding that it is necessary to have this national debate. We want to do this through this committee.

Obviously, we have a problem because when Medicare was first enacted, there were five and a half workers for every one retired. Today it is about four for every one retired. In 2030 it is going to be two and two-tenths for every one retired. In the year 2060 only two people will be working for every one retired.

People are living longer. That is nothing for us to complain about. We have measured the goodness of American society and our medicine by the longevity of the American people, and it is something we ought to praise the leaders in that area for.

You might ask: "Do we have to retain the present structure to any great extent in this process?" I think we all have to have a very open mind.

I say to the leaders of senior citizens advocacy groups, like the AARP and the National Council of Senior Citizens, "Please be open-minded about this." We need to consider the generational equity of tapping the resources of the young people to so great an extent that they have to worry, "Will there be Social Security and Medicare when I retire?"

The basic substance of a safety net will be maintained, I am sure, and the extent to which we can maintain it pretty much as originally intended, the better and the less controversy there will be. But I think we have got to be open to different points of view.

Today we have, as I said, experts with us. We are still left with the question of how to do that, and we are a few years away from doing it. But we need to keep this debate going on how to do it.

So we are going to hear from a representative of the Congressional Budget Office. He will show us how serious the problems Medicare really faces are when baby boomers retire. After him we will hear from three other experts. Each has different ideas of how to prepare Medicare for baby boomers.

After all four have given their statements, Senator Hagel and I will respond to the questions or will ask questions before we go to your questions that you have written on the cards.

Senator Hagel.

OPENING STATEMENT OF SENATOR CHUCK HAGEL

Senator HAGEL. Mr. Chairman, thank you. I too wish to add my welcome to our distinguished panelists and to thank all of you for attending today.

As Chairman Grassley pointed out, this is an issue that affects all of us. It crosses over party lines and should never be held captive to politics. I want to thank you, Mr. Chairman, and your staff for the work and the organization that you have put into this to make this hearing today and the hearing on Social Security tomorrow in Omaha a success.

Let me make just some brief comments, and then I know we want to get to our panelists. Mr. Chairman, we all want exactly the same thing, and that is to keep Medicare strong and secure. This program has been important for each generation of older Americans since the 1960s, and we must ensure that Medicare remains solid and dependable for current retirees and for generations to come.

This is a big challenge; one which we at Congress cannot and should not tackle alone. Public input must be a key part of this process. That is why we are holding the hearings today in Sioux City and tomorrow in Omaha.

The Congressional Budget Office estimates net Medicare spending, Part A and Part B, combined for fiscal year 1997 will total over $200 billion. Over the next ten years Medicare spending will

total over $3 trillion. Medicare costs have risen at an average annual rate of 11 percent over the past 15 years. That is faster than any other federal program.

The recently passed Balanced Budget Act will slow the growth of Medicare spending by $385 billion over the next ten years and limit the projected growth and cost to 7.4 percent a year. However, as we will hear today, Medicare will continue to grow faster than the overall budget or the economy.

Medicare now accounts for 11.8 percent of all federal outlays. It is rapidly gaining on net interest payments for the national debt, and that is at 15.2 percent; defense spending at 16.3 percent; and Social Security is the largest federal government program, as you know, at 22.3 percent of the total of all federal outlays.

Earlier this year the Board of Trustees of the Federal Hospital Insurance Trust Fund informed Congress that Medicare Part A hospital insurance financed through payroll taxes would go broke in the year 2001. Senator Grassley alluded to that. Fortunately, the Balanced Budget Act extended the solvency of Part A to the year 2007.

While this is certainly a step in the right direction, 2007 is still only ten years away. The retirement of the baby boomers generation, beginning in the year 2010, will dramatically impact the widening gap between program costs and receipts. If we do not make significant changes in this program, we will be faced with three options: One, major payroll tax increases; two, major cuts in benefits; or three, some combination of both.

I think it is the opinion of Chairman Grassley, many of our colleagues, certainly me, that we believe these three options are unacceptable. If we do, in fact, get in front of this, as Senator Grassley has spoken about, then we do have the time to fix it.

Part B supplemental medical insurance financed through member premiums began, as many of you recall, as a 50/50 proposition and remained so from 1966 through 1974. Seniors paid half; federal income taxes paid half. Today 75 percent comes out of the U.S. Treasury. This means that Part B is not technically in jeopardy of going broke like Part A; however, the more expensive Part B becomes the more expensive the general taxpayers' fixed 75 percent share becomes.

Part B remains solvent by annually blowing an increasingly larger hole in the federal budget rapidly piling onto our national debt. Sustaining Part B in this way is unacceptable. Congress and the President must take the long-term solvency and strength of Medicare and deal with it, make it a top priority.

As Senator Grassley said, the United States Senate this year did cross the line for the first time ever. One of the bodies of Congress did, in fact, put themselves on record in a very strong bipartisan vote addressing three issues in Medicare. It is my understanding that some of our colleagues will be reintroducing some of those elements that were not part of the conference committee; the final report which we did not in the end vote on.

But the fact is the United States Senate did step up and start to take some responsibility and show some leadership in this area. A long way to go.

Above all, Medicare must be taken out of politics. It must not be used as a political weapon. We have a limited amount of time to prepare this program for the challenges presented by the baby boom generation. The sooner we implement long-term reforms, the better.

If we work together with honesty and courage on this and other entitlement issues, we will find solutions which protect today's seniors and preserve programs for our children and our grandchildren. Today's hearing is an important step in the right direction.

Again, Mr. Chairman, I appreciate your leadership. Thank you.

The CHAIRMAN. Before I introduce the panel, I noticed Senator Redwine was in the group. If there are any other elected officials, would you stand, please. If you will introduce yourself, I will be happy to recognize you. I thank you for coming.

I would like to give just a brief introduction. First is Dr. Joseph Antos of the Congressional Budget Office. We refer to that as CBO. It is an agency that we in Congress rely upon for objective information, and Dr. Antos is the assistant director of Health and Human Resources at the Congressional Budget Office. He will present long-term financing situations.

After Dr. Antos we will hear from three witnesses with contrasting views on how to prepare Medicare for baby boomers. First will be Professor Bernstein of Washington University Law School, St. Louis, Missouri. He is a noted expert on both Social Security and Medicare programs. He was a principal consultant to the National Commission on Social Security Reform. I think my staff is passing out their annual reports so you can take that home.

Then Dr. Robert Moffit of The Heritage Foundation in Washington, D.C. Dr. Moffit served in the Reagan Administration in both the Department of Human Services which administered the Medicare program and the Office of Personnel Management, which administers the Federal Employees Health Benefit Plan. He frequently speaks and writes on entitlement reform issues, and he has been to Iowa before for some programs that I have had on this issue many years ago.

Then we will hear from Dr. John Goodman, president of the National Center for Policy Analysis. Dr. Goodman founded the National Center for Policy Analysis in 1983 and has written numerous books and papers on medical savings accounts and other tools for reforming entitlement programs.

Once again, for latecomers, you are encouraged to fill out your card so after we finish questioning here, we can get your questions and concerns before the esteemed panelists.

Would you go in the order that I introduced you, and proceed, please.

STATEMENT OF JOSEPH R. ANTOS, ASSISTANT DIRECTOR FOR HEALTH AND HUMAN RESOURCES, CONGRESSIONAL BUDGET OFFICE

Mr. ANTOS. Thank you, Senator Grassley and Senator Hagel.

Some might say that this is not the time to worry about Medicare problems; they will not be upon us for more than a decade. This month the Congress enacted and the President signed into law the Balanced Budget Act of 1997, which balances the federal budget to 2002 and extends the financial solvency of Medicare's hospital insurance trust fund to 2007. That should take care of short-term financing problems, and the first of the baby boomers do not become eligible for Medicare until 2011.

After three years of hard work in the Congress to make the Balanced Budget Act a reality, surely we or the senators can take time away from Medicare financing problems to consider other policy issues. But as Senator Grassley and Senator Hagel both stated clearly, we should not be lulled into complacency by those recent good developments.

The Balanced Budget Act buys some breathing room for Medicare, but it is only the first step in making Medicare a viable program for the future. The facts are sobering.

Medicare continues to grow faster than the resources available to pay for the program. Although the growth in Medicare spending has moderated in recent years, that spending will grow by 7.4 percent a year over the next decade. That include the effects of the recently passed bill.

Over the same period the Congressional Budget Office (CBO) projects gross domestic product (GDP), will grow by less than 5 percent a year. Incentives built into the current Medicare program are driving that rapid growth in program spending.

Although most beneficiaries have a choice of traditional fee-for-service Medicare or a health maintenance organization (HMO); nearly 90 percent choose the traditional system. That system provides little incentive to either beneficiaries or providers to limit costs. Moreover, Medicare does not realize savings possible from managed care because federal payments to HMOs are linked to costs in the fee-for-service sector, which, as I just mentioned, has no real incentives for cost control.

The Balanced Budget Act opens up new opportunities for beneficiaries to choose managed care and other plans, but payments to those plans will remain linked to costs for the fee-for-service sector. Very little of Medicare's spending growth in the near term is driven by increases in the number of beneficiaries. That will change dramatically after 2010.

The United States is currently in a period of historically low growth in Medicare enrollment as the baby bust generation, born during the Depresssion of the 1930's and the war years of the 1940s, reaches age 65. After 2010, however, the first wave of the baby boomers will reach age 65, and Medicare will grow at exceptionally rapid rates for about two decades. Demand for services under Medicare will increase sharply during that time as succeeding baby boom cohorts continue to enter the program through 2030.

Now, the magnitude of Medicare's long-term financing crisis can be seen by considering some simple arithmetic. "Current law" is

the expression that budgeters in Washington use to mean what would happen to Medicare spending and to other things if there were no future changes in the law. In other words it is our best projection.

You can see that this year we have more than 38 million beneficiaries in the Medicare program. We will spend $209 billion this year for benefits. That averages out to about $5,500 per beneficiary spent this year on Medicare.

Let us take a look at what happens about 15 years from now. In 2015 we will have roughly 50 percent more beneficiaries. We will go from 38 million to more than 53 million beneficiaries, and 2015 is just four or five years into the movement of the baby boom generation. Our spending, however, will increase not by 50 percent but by a factor of about five, from $200 billion to about $1.1 trillion.

What is the reason for that? Between those years Medicare will be experiencing a substantial increase in beneficiaries, but what will really drive the growth, and what has been really driving the growth for several decades now in Medicare, is an increase in the volume of services used by beneficiaries and the cost of those services. So if nothing changes that is what "current law" means; if nothing changes our spending per beneficiary will increase to more than $20,000 a year per person. That is a mighty large increase.

Let us see what happens when we get all the way to 2030. The year 2030 is the last year that the baby boom generation will reach age 65. The number of beneficiaries will have doubled from this year to more than 75 million.

If we do not make any changes in the law, total Medicare spending will increase to $3.5 trillion, or an average of $46,000 per beneficiary. You can see how powerful that growth in the volume of services and the cost of those services is. It is actually more powerful than the growth in the number of beneficiaries.

Let us take a look at what happens if we try to slow the growth of Medicare spending. There is no clear answer to the question, "What is the appropriate growth in Medicare spending over the long term?" I am going to give you an example, which is not necessarily a policy prescription. It is just to give you an idea of what will happen.

The example I am going to use has Medicare spending growing at the same rate as GDP—as the rest of the economy. So here, again, we start off with the same statistics as in 1997.

I am not suggesting a way to make this happen. I am just suggesting that if this were to happen, if we were to restrain Medicare growth to the rate of growth in the economy, what would that mean for spending? In essence, this particular approach puts Medicare on a path of living within its means. It would not be growing faster than the economy's ability to pay for it.

If we move to 2015, you can see that Medicare spending will have dropped significantly. We would have the same number of beneficiaries—53 million—but now we are talking about roughly half of total Medicare spending or about $10,000 per person. That is still a lot of money compared with $5,000 this year, but it is half of what would be spent if we made no changes in the program.

Let us move all the way to the end. You can see what happens. If we maintain control of Medicare spending the country would still

be spending $1.3 trillion, which is, again, roughly six times what we are spending now for only twice the number of people. We would still be spending quite a bit more in 2030 than in 1997, but only about a third of the amount projected under current law.

Those are pretty dramatic numbers. It does indicate that if we can keep spending under control in this fashion, we would still be able to afford more services for more people; more services per person and many more people, but it does indicate that some stringencies would inevitably occur.

Can we spend more than this limited growth scenario? Of course we can. Should we? That is the big question, and that is a real issue for America and for the Congress.

We will be a wealthier country in 2030. We will be better able to afford higher demands for health care. Thus, we could spend more money, but we should keep in mind that spending more for health care means spending less for other worthwhile purposes. That is even assuming a rapidly growing economy; an economy that would be growing at 5.5 percent a year over that time.

I have probably used up most of my time. Let me finish by making a quick observation.

In my written testimony I mention that over the long term there are basically three ways to reduce Medicare spending. One way is to reduce the number of people who are actually eligible for services, and the Congress did consider this year increasing the age of eligibility over a period of time. Another approach is to collect more money—more of the costs for services—from Medicare beneficiaries. The third way is to restructure Medicare to reduce the total cost of health care per beneficiary in a way that ideally would retain the quality of care.

Clearly, if we could find a way, the third approach would be the best approach. I think some of my colleagues here on the panel will be discussing approaches that might achieve that goal.

To conclude, the sharp debates over the past three years reflect how difficult it is to limit the growth of Medicare which is certainly one of the most popular federal programs that has ever existed. Although the Balanced Budget Act has bought the program some time, the looming baby boom generation will impose unprecedented demands on Medicare services.

Thus, we are in the calm before the storm, and there is the danger that the policy process may be stalled by the absence of an immediate crisis. But there is no doubt that what we do and what we fail to do over the next few years will determine whether Medicare will be able to meet the health care needs of not only the baby boom generation but of generations to come. Thank you.

[The prepared statement of Mr. Antos follows:]

CBO TESTIMONY

Statement of
Joseph R. Antos
Assistant Director
for
Health and Human Resources
Congressional Budget Office

on
2010 and Beyond: Preparing Medicare
for the Baby Boomers

before the
Special Committee on Aging
United States Senate
Sioux City, Iowa

August 25, 1997

NOTICE

This statement is not available for public release until it is delivered at 1:30 p.m. (CDT), Monday, August 25, 1997.

CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

Mr. Chairman and Members of the Committee, thank you for the opportunity to discuss the challenge of preparing Medicare for the influx of new beneficiaries when the baby-boom generation begins to reach age 65. The recently enacted Balanced Budget Act of 1997 represents a significant effort to place Medicare financing on a sound basis for the next 10 years. But it only begins to address the much larger financing problems that Medicare will face after 2010. More fundamental program reforms will surely be required to meet those challenges.

MEDICARE FINANCING THROUGH 2007

The Medicare program finances the health care of 38 million elderly and disabled Americans, spending over $200 billion for benefits in 1997. It is the second largest entitlement program; only Social Security is larger. The growth of Medicare spending has long been substantially faster than that of other major federal programs and of the economy. Although the growth of Medicare spending has slowed since the late 1980s and early 1990s, the Congressional Budget Office (CBO) projects that it will continue to outpace the growth of resources that finance it.

Financial Soundness of the Medicare Program

The Congress and the President have taken steps in the Balanced Budget Act of 1997 to slow the growth of Medicare spending. That act reduces Medicare spending by

$385 billion over the next 10 years--a cut that will lower the growth of spending for Medicare benefits to about 7.4 percent a year on average between 1997 and 2007. Unfortunately, Medicare will continue to grow faster than the overall federal budget or the economy (see Table 1). Over the next 10 years, Medicare spending will total more than $3 trillion.

The Balanced Budget Act also extends the solvency of the Hospital Insurance (HI, or Part A) trust fund. HI is financed through a payroll tax paid by current workers and their employers, and the HI trust fund represents the accumulated flows of HI payroll taxes and payments for HI benefits and other expenses. CBO previously projected that the HI trust fund would be depleted--that is, the trust fund balance would fall to zero--in 2001. That depletion date has now been extended to 2007 (see Figure 1). In other words, major policy changes must be made within a scant 10-year period if Medicare is to be a fully functioning program when the baby-boom generation first becomes eligible for benefits.

The solvency of the HI trust fund is, of course, only a partial indicator of Medicare's financial health. Supplementary Medical Insurance (SMI, or Part B) is funded by premiums and general tax revenues. Since general-revenue financing is uncapped, the SMI trust fund cannot be depleted. But SMI outlays have grown faster than general revenues and are projected to continue that faster growth. Consequently, SMI is no more financially sound than is HI.

Table 1.
Medicare Spending Compared with Total Federal Outlays and the Economy (By selected fiscal year)

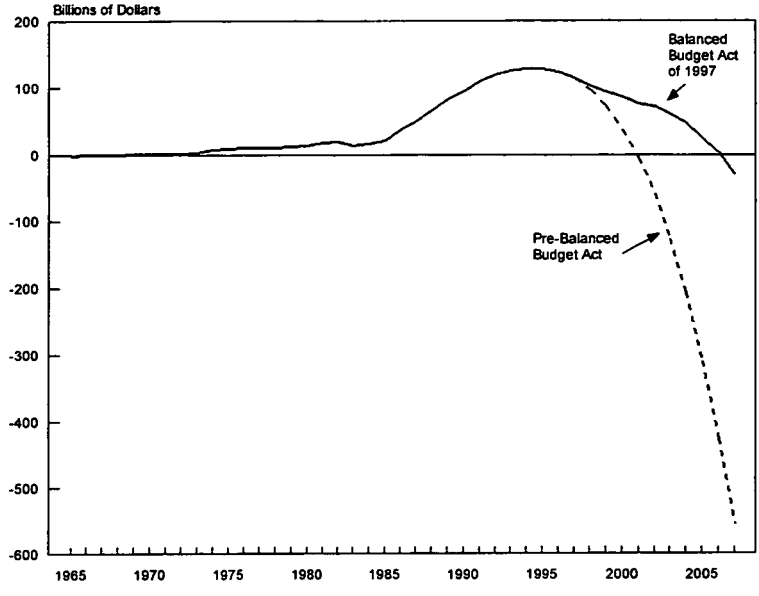
	Outlays (Billions of dollars)				Average Annual Rate of Growth (Percent)		
	1980	1990	1997	2007	1980-1990	1990-1997	1997-2007
Medicare Mandatory Outlays[a]	34	107	209	428	12.2	10.0	7.4
Total Federal Outlays	591	1,253	1,612	2,361	7.8	3.7	3.9
Gross Domestic Product[b]	2,719	5,683	7,955	12,379	7.7	4.9	4.5

SOURCE: Congressional Budget Office.

a. Includes benefits plus mandatory outlays for administration.

b. Gross domestic product for 2007 is based on current law before the Balanced Budget Act of 1997 was enacted.

Figure 1.
Hospital Insurance Trust Fund Balance, Fiscal Years 1965-2007



SOURCE: Congressional Budget Office based on intermediate assumptions from the 1997 Medicare trustees' report.

Sources of Spending Growth

The rapid growth in Medicare spending that has occurred since the 1980s, and that is projected over the next 10 years, reflects increases in three factors: the number of beneficiaries, the volume of medical services delivered to beneficiaries, and the costs of those services. Most of the spending growth stems from the rise in the volume and costs of medical services, which increases Medicare spending per beneficiary, rather than exceptional growth in the number of beneficiaries.

Indeed, the number of Medicare beneficiaries will be growing at a historically slow rate over the next 10 years (see Table 2). At the same time as a relatively small cohort of Depression-era babies are retiring, a much larger group of baby boomers will be in their prime earning years. Those demographic trends provide very favorable circumstances over the next decade for financing Medicare and, in particular, the HI trust fund.

Incentives built into traditional Medicare are driving the rapid growth in program spending. Despite recent growth in enrollment in Medicare health maintenance organizations (HMOs), most beneficiaries remain in fee-for-service Medicare, which provides only limited financial incentives to encourage prudent use of services. Cost-sharing requirements are fairly low, and most beneficiaries have supplemental coverage that pays that cost sharing. Providers have little incentive to

Table 2.
Medicare Enrollment and Workers per Enrollee (By selected calendar year)

	1975	1985	1995	2005	2010	2030
Enrollment (Millions)	24.2	30.2	37.1	42.5	46.7	75.1
Workers per Enrollee	4.1	4.0	3.8	3.6	3.4	2.2
Average Annual Rate of Growth in Enrollment from Preceding Year Shown (Percent)	n.a.	2.2	2.1	1.4	1.9	2.4

SOURCES: Congressional Budget Office and Medicare Board of Trustees (using the intermediate assumptions).

NOTE: n.a. = not applicable.

limit the number or cost of the services they provide under the fee-for-service system, and they know that insurance is picking up all or most of the bill. Moreover, Medicare does not realize the savings possible from managed care because federal payments to HMOs are linked to costs in the fee-for-service sector.

Key Provisions of the Balanced Budget Act of 1997

The Balanced Budget Act changes some of the current program incentives for spending growth and lays the groundwork for future Medicare restructuring. The act gives Medicare beneficiaries new opportunities to enroll in a variety of health plans under Medicare+Choice or remain in the traditional fee-for-service program. Medicare+Choice plans encompass the whole range of plans now available to privately insured people, including HMOs, point-of-service (POS) plans, preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service plans, and plans operated in conjunction with medical savings accounts (MSAs). The act establishes an annual open-enrollment process, and beneficiaries will receive comparative information about the options available to them.

Payment rates to Medicare+Choice plans are adjusted to reduce the current large differences in payment between plans in high-cost urban areas and those in lower-cost rural settings. But those payments remain linked to costs in the fee-for-

service sector, which blunts the incentive for plans to operate efficiently and limits the ability of Medicare to realize savings from those efficiencies.

Payments to health care providers in fee-for-service Medicare are scaled back from the levels anticipated under prior law. In addition, the act establishes new payment methods for nursing facilities, rehabilitation hospitals, outpatient hospital and therapy services, and home health services. Prospective payment will replace cost reimbursement, which may provide some incentives for providers to furnish services in a more efficient manner.

The act shifts over $170 billion in home health spending from HI to SMI between 1998 and 2007. That step is an accounting change rather than a reduction in Medicare spending or a restriction on home health services. Coupled with reductions in payments to hospitals and other providers of services covered by HI, however, the shift extends the depletion of the HI trust fund to 2007. Beneficiaries receiving home health visits under SMI will not be subject to a copayment.

In addition, premiums paid by beneficiaries for SMI will increase, reflecting two changes. First, the premium will be maintained at 25 percent of program costs after 1998, rather than declining as a share of costs as it would under prior law. Second, the shift of some home health services from HI to SMI will cause the premium to increase gradually over seven years.

THE LONG-TERM OUTLOOK

Although the federal budget will be balanced in 2002 as a result of the Balanced Budget Act, that good budgetary news should not make us complacent because the retirement of the large baby-boom generation looms just over the horizon. Their retirement will greatly increase the costs of two government programs that are already large—Social Security and Medicare—unless changes in the programs are made.

In 1996, federal spending for Social Security and Medicare exceeded $500 billion, which was about 7 percent of gross domestic product (GDP). By 2030, when most baby boomers will have retired, those two programs will consume nearly twice as large a portion of national income as they do today—almost 14 percent. Nearly all of the increase in Social Security's share of GDP between now and 2030, and almost two-thirds of the increase in Medicare's share, will occur after 2010 as baby boomers become eligible for those programs.

The projected increase in spending for Social Security is entirely the result of the expected surge in the number of people eligible for benefits. Spending on Medicare, however, is already growing at a much brisker pace than national income because of steep increases in costs per enrollee. Unless ways are found to reduce the growth in Medicare's per capita costs, the addition of the baby boomers to the

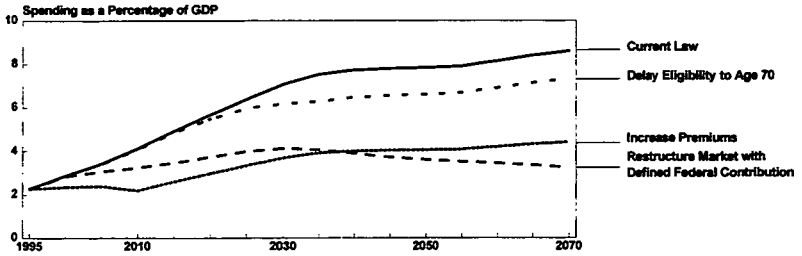
Medicare rolls will place an enormous burden on the federal budget and the economy.

Three fundamental approaches exist for slowing the long-term growth in federal spending for Medicare. The Congress could reduce the number of people eligible for benefits, collect more of the costs from beneficiaries without changing Medicare's structure, or restructure Medicare to reduce total health care costs per beneficiary. The following discussion focuses on the estimated effects on net Medicare spending under a specific example for each of those approaches (see Figure 2). (The estimates were completed before the Balanced Budget Act was passed, and thus they overstate spending levels somewhat.)

CBO's yardstick for comparison was whether the options would keep federal spending on Medicare from growing more rapidly than the economy. Specifically, we used the illustrative goal of limiting net federal spending for Medicare to 4.1 percent of GDP--roughly the level projected for 2010. That yardstick is somewhat arbitrary and does not represent a judgment regarding the desirable level of Medicare spending over the long term.

One way to reduce the number of people eligible for benefits would be to increase the age of eligibility from 65 to 70. That approach would ultimately reduce federal spending for Medicare by almost 15 percent compared with current law.

Figure 2.
Net Medicare Spending as a Percentage of GDP Under Alternative Options



SOURCE: Congressional Budget Office based on the Medicare trustees' reports for 1996.

NOTES: Estimates based on current law before the Balanced Budget Act of 1997 was enacted.

GDP = gross domestic product. Data are plotted at five-year intervals.

Despite those considerable savings, net spending would continue to grow after 2010 as a percentage of GDP, reaching 7.3 percent of GDP by 2070. Further, that approach would do little to lower total health care costs, and it would lengthen the period of time in which people who opted for early retirement under Social Security might have difficulty getting private insurance coverage.

Substantially increasing premiums collected from beneficiaries would also limit federal spending for Medicare. The option we examined was to increase premiums enough to cover 50 percent of Medicare's costs (for both Parts A and B). That would represent a dramatic, perhaps unacceptable, increase: enrollees' premiums cover only about 10 percent of total costs now. Using that approach would keep net Medicare spending as a share of GDP from rising above the target level until 2060. However, raising premiums would shift costs to beneficiaries rather than constrain the growth in total health care costs. Without any changes to improve the efficiency of the Medicare program, premiums would consume an ever larger share of enrollees' income. Indeed, Medicare premiums would equal nearly 30 percent of enrollees' income by 2070, compared with 3.4 percent in 1995.

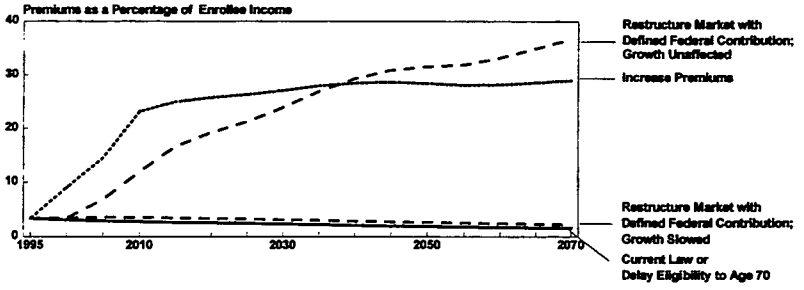
A third approach to slowing the growth of federal Medicare spending would be to restructure the program, giving patients and providers greater incentives to make cost-effective choices. One way to do that would be to set up a system of competing health care plans and limit growth to the amount that Medicare would

contribute toward the premiums charged by the various plans. In such a restructured system, Medicare's fee-for-service sector could be one of the plans, competing for enrollees on the same basis as all other plans.

Because enrollees would be responsible for any excess premium amounts (and would receive rebates for plans costing less than Medicare's contribution), they would have financial incentives to be prudent purchasers of health plans. Also, because plans would be at risk for any costs not anticipated when they determined their premiums, they would have financial incentives to operate efficiently. Control of federal Medicare spending would be assured because the financial risks from higher growth in health care costs would be shifted to health plans and enrollees. Although the federal subsidy per enrollee would be smaller than it is under current law, competition among plans and providers could spur efficiency and increase real health benefits per dollar spent.

However, the effects of that approach on total costs for a basic benefit package—and therefore on the costs that beneficiaries would face—are uncertain. If the incentives for more cost-conscious behavior reduced annual growth in total costs per enrollee only to the rate assumed by Medicare's trustees under current law, premiums paid by enrollees would steadily increase—reaching 37 percent of their average income by 2070 (see Figure 3). If, instead, the growth in costs per enrollee was slowed to match the annual growth in the federal defined contribution, premiums

Figure 3.
Premiums as a Percentage of Enrollee Income Under Alternative Options



SOURCE: Congressional Budget Office based on the Medicare trustees' reports for 1996.

NOTE: Estimates based on current law before the Balanced Budget Act of 1997 was enacted.

Data are plotted at five-year intervals.

would represent only 2.2 percent of the average income of enrollees in 2070.

In practice, the premiums paid by various enrollee groups would vary depending on their choice of health plan. Some basic plans would keep their costs low enough to avoid having to charge supplemental premiums but would undoubtedly tightly restrict access to providers and services. Other plans that charged supplemental premiums could provide wider access and more services. Low-income beneficiaries, including those who are eligible for Medicaid, would find their choices limited to lower-cost plans.

In any case, costs must be reduced substantially if net federal spending for Medicare is to be limited as a percentage of GDP (see Table 3). To keep net spending at or below 4.1 percent of GDP, savings equal to about 50 percent of currently projected spending must be generated annually from 2010 onward. By contrast, the savings expected from the Balanced Budget Act of 1997 are only about 13 percent of projected Medicare spending for the 1998-2007 period.

CONCLUSION

Taming the acceleration in Medicare spending has been a long-standing focus of policymakers. The sharp debates over the past three years reflect how difficult it is

Table 3.
Effects of Three Illustrative Options for Reducing Growth in Net Spending for Medicare (In percent, by calendar year)

Option	2010	2030	2050	2070
Net Federal Spending as a Percentage of GDP				
Continue Current Law	4.1	7.1	7.8	8.6
Delay Eligibility to Age 70[a]	4.1	6.2	6.6	7.3
Collect 50 Percent of Costs from Premiums[b]	2.2	3.7	4.1	4.4
Restructure the Program and Limit Growth in Defined Contribution to 4.2 Percent a Year[c]	3.3	4.1	3.6	3.2
Savings as a Percentage of Projected Spending				
Delay Eligibility to Age 70[a]	1	13	16	15
Collect 50 Percent of Costs from Premiums[b]	47	48	48	49
Restructure the Program and Limit Growth in Defined Contribution to 4.2 Percent a Year[c]	21	42	54	62

SOURCE: Congressional Budget Office based on the Medicare trustees' reports for 1996.

NOTE: Estimates based on current law before the Balanced Budget Act of 1997 was enacted.

a. The age of eligibility for Medicare would be increased to 70 by 2032, phased in from 2003.

b. Premiums for Medicare enrollees would be increased to cover 50 percent of total Medicare (HI and SMI) costs by 2010.

c. Medicare's per-enrollee contribution in 2000 would be set at total per capita costs less 25 percent of Part B costs. That amount would be increased by 6 percent a year through 2005, 5 percent a year through 2010, and 4.2 percent a year thereafter.

to limit growth of that large and popular program. But financing problems in the near term will be dwarfed by the crisis that could occur as the baby-boom generation reaches age 65.

Although federal spending for Medicare could be reduced by increasing the premiums or cost-sharing requirements imposed on beneficiaries, that approach by itself, without changing the options available, could threaten access to medical care for some enrollees. It would reduce federal costs by shifting them to beneficiaries (or to Medicaid, for dually eligible beneficiaries) without establishing mechanisms that might limit growth in the total costs of care.

Broader policy goals would be served by putting policies in place that would lower the growth in total (not just federal) costs of services used by Medicare beneficiaries. Such policies would encourage both beneficiaries and health care providers to make more cost-effective choices than many do now. If successful, that approach would reduce the resources used for health care while ensuring that enrollees would have continued access to medical care. Whether such efficiencies would be achieved, however, is uncertain and would depend on the policies adopted. The one certainty is that Medicare will come to consume an enormous share of national income unless significant changes are made in the program.

MEDICARE ARITHMETIC

	Current Law	Limit Growth to Growth in the Economy
1997		
Spending/Beneficiary	$5,500	$5,500
Number of Beneficiaries	38,100,000	38,100,000
Total Medicare Spending	$209 Billion	$209 Billion
2015		
Spending/Beneficiary	$20,800	$10,800
Number of Beneficiaries	53,200,000	53,200,000
Total Medicare Spending	$1.1 Trillion	$570 Billion
2030		
Spending/Beneficiary	$46,000	$16,800
Number of Beneficiaries	75,140,000	75,140,000
Total Medicare Spending	$3.5 Trillion	$1.3 Trillion

The CHAIRMAN. Professor Bernstein.

STATEMENT OF MERTON C. BERNSTEIN, WALTER D. COLES PROFESSOR OF LAW EMERITUS, WASHINGTON UNIVERSITY IN ST. LOUIS, ST. LOUIS, MISSOURI

Mr. BERNSTEIN. Senator Grassley, Senator Hagel. Good afternoon to all of you. I commend both of you for convening this hearing. It is timely and important.

I would make a few major points. One—and this reiterates something that you have mentioned as well—Social Security and Medicare are great accomplishments. With them about 11 percent of people 65 and over fall below the poverty line. Without them more than half the population of 65 and over would fall below the poverty line. They contribute to increased longevity. Some people look upon that as a problem, but it is also a great accomplishment.

I would suggest to the Senate Committee on Aging that it keep in mind when discussing the projections that Senator Grassley and Dr. Antos have presented, they are just that—projections; they are not predictions.

One witness talks of them as forecasts. They are forecasts the way one would forecast that tomorrow there is a 30 percent chance of rain, but we do not know it is going to rain. So we have to be cautious, have to be careful not to treat projections as if they are what the future holds. Projections are what we can expect if our assumptions are correct, and they are bound not to be correct the farther out you go in the future.

Now, what has been driving the Social Security and Medicare debate, primarily with the public and the media, are the numbers on the chart prepared by the committee. You have all heard those numbers before.

What they add up to is: there were 16 people working under Social Security for each person drawing benefits in 1950; currently there are more than three people at work and if in the next century there are going to be two people at work for each person drawing benefits, it seems that either the burdens are unsupportable or we will have to cut these programs very drastically.

But that is only part, that is only half of the formula for these programs. The other half is what are they making? How productive the economy is determines how much we can afford in the future.

Now, let me give you an example that has particular significance in Iowa and Nebraska. In 1900 39 percent of the work force were farmers. Today, under 32 percent of the work force are farmers. By the logic of the aged dependency ratio, we should be starving; there are not enough farmers.

But we know that is not true, and we know that what has given American agriculture such enormous productive power has been change in technology. Now, the entire economy constantly undergoes changes in technology.

We have been singing the blues about productivity starting in 1973 until the recent past. But productivity has, in fact, been improving in the recent past clearly in manufacturing. Contrary to the impression of some to——

You have not heard me? I will start over. [Laughter.]

Clearly as well in services. You take banking services. Far fewer people produce far more transactions today than was the case ten years ago. Telephone services. Far fewer people are providing far more services than a decade ago. This is even under the official figures.

Now, quite a few business economists are saying that the official productivity data do not fully show how productive we are; that the American economy is generating far more wealth than the productivity figures show; and they say it has got to be so based upon sales and profits. There is no other way to explain why sales are as voluminous as they are, why profits are as high as they are, if there have not been substantial increases in productivity.

Now, I know a few months ago a lot of us were somewhat depressed when Big Blue beat the world champion chess player. It did not sound very promising for the human race perhaps. But it does in a way because what technology can do today, in part due to computer advances, is simply enormous. Engineers today can do things they could not possibly do a decade ago and 20 years ago.

So our potential is enormous. Today Big Blue did what? A billion computations a second. Well, people are working on computers that can do a trillion calculations a second. I ask you to keep in mind the possibility of having far greater wealth than is projected.

Now, I would like to go to one other point, and that is the projections for the cost of medical services. Those are responsible best guesses, but they are guesses. They depend upon what we know and then what our guesses are as to what will happen between now and 2030.

I am sure Dr. Antos would be the first to admit that the figures he presented for 2030 are not what the cost of services are going to be in 2030. That is because these are projections; not predictions.

We may be making some very significant progress on one major variable. The estimates for Medicare fraud are very, very large and very serious. Dr. Moffit presents an estimate that of a $200 billion Medicare program, $23 billion probably represent fraudulent charges.

Now, it is easy to talk about fraud and ways of cutting it out and making up for what is lost. But the Federal Government actually is making inroads on Medicare fraud. HCFA and the Department of Justice and the FBI have made multi-billion dollar settlements for fraud charges under the Medicare and Medicaid programs. Multi-billion dollar settlements; money recovered.

But the money saved is many times more than the recoveries. Why? First, because those who have engaged in fraudulent conduct will stop. So if you collect $1.8 billion dollars today, over a five-year period you have saved almost $10 billion from those malefactors. Also, the others who are engaging in similar conduct may mend their ways.

The last few days have witnessed a tremendous amount of publicity about the Columbia/HCA Healthcare fraud investigation. I do not know what that is going to show, but Columbia/HCA is the largest privately held health-care service in the country with billings of $200 million. That is an enormous amount of money right there. Now, that is far beyond Medicare, of course.

Whistle blowing has driven those investigations and has driven the recoveries to date. People who work for health-care providers are beginning to learn that they can save themselves from going to jail and also perhaps collect very large bounties by blowing the whistle on dishonest health-care providers.

Now, if the fraud amounts to $23 billion a year and we can save just half of that—As Senator Dirksen used to say, "A billion here; a billion there. It gets to be real money after a while."

Now, fraud may be even more than the $23 billion a year. We just do not know. We just do not know how to measure illegal conduct, but we have every reason to believe that it is considerable. So we may be turning the corner on sweating out some of those very considerable Medicare fraud costs.

I would like to make just one other point. Medicare Part B is financed differently than Social Security and Part A, which are financed by payroll taxes. Part B is financed, but only in part, by premiums; 25 percent of the total cost. The Balanced Budget Agreement has continued setting premiums to generate 25 percent of Part B costs.

About 5 percent of Medicare participants have income, current yearly income, of $50,000 or more. It is very hard to justify a subsidy of three-quarters for people who have that kind of income.

So one of the things we should be getting to is to say: The public at large accepts this the latest poll I saw indicates that Medicare participants accept it; that there should be a closer relationship between the amount of the premium and one's income for people above a certain income. And $50,000 has been the amount discussed as the point at which participants should pay more than 25 percent, and that was in the Senate passed a bill a few weeks ago.

I have long opposed, still oppose means testing for Social Security. Adopting this proposal is not a precedent for means testing in Social Security. Social Security's patterns are very different.

In Medicare Part A, higher-income people already pay more for the same package of benefits than do lower-paid people and without—as you know, without any limit on the amount of payroll for the hospital insurance portion of the FICA tax. So we already have payments that vary by earnings within Medicare. We have strong justification for getting billions of dollars from those who can afford it.

One other thing. I would urge you, as you pursue the goal of putting these programs into—on a secured basis, that you adopt two principles. Look before you leap—you are doing that—and try to sweat out unnecessary costs before you start to sweat beneficiaries.

Thank you.

[The prepared statement of Mr. Bernstein follows:]

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PRESERVING MEDICARE WITHOUT RADICAL CHANGE

Radical changes in Medicare are at least premature and very possibly unnecessary. Congress and the President have already taken measures to reduce Medicare outlays bu $115 billion during the next five years. Three measures could ameliorate the funding problems faced by both Part A (Hospital Insurance) and Part B Supplementary Medical Insurance (SMI) for (out-of-hospital services) and may suffice. (1) Eliminating costly provider conflicts of interest, (2) moving more aggressively against extensive and costly fraud, and (3) charging higher premiums to the financially well off would produce tens of billions in savings. Taking these prudent steps would victimize no innocent parties. In contrast, a radical measure like raising the age of eligibility for Medicare would vastly increase the ranks of the uninsured, increase employer health insurance costs, and discourage the employment of older people willing and able to work. Within the past few years, HCFA and the Justice Department have obtained billions from health care providers for improper charges. The growing attention to the investigation of Columbia/HCA Healthcare, the active role of whistle blowers, and the rewards payable to whistle blowers provides a watershed that should discourage Medicare fraud and yield tens of billions of dollars in savings.

Congress and the Administration should explore these measures and their outcomes fully before adopting damaging and possible unnecessary structural changes.

I. Three Measures to Improve Financing Without Raising Tax Rates

A. Ban Health Provider Conflicts of Interest

Studies show that physicians with an ownership interest in testing laboratories over-prescribe

tests. When physicians not only prescribe but fill prescriptions, the same pattern emerges.

Conflicts of interest that pit the Physician against the patient and the Medicare system should be prohibited, as some already are, and the prohibitions enforced. That will save patients the dangers of unnecessary procedures and drugs and also save the Medicare system from unnecessary expenditures.

B. Pursue Costly Fraud - Publicize Bounty System for Whistle Blowers

Medicare and Medicaid fraud victimize patients and cost these federal programs massive amounts. On one day alone, HCFA and the Justice Department announced repayments by providers amounting to $1.4 billion consisting of several cases each involving several hundred million dollars and substantial fines. (The New York Times November 22, 1996 at C1 (National Edition)). These followed recoveries of $379 million and $255 million from other enterprises.

The ultimate savings to Medicare far exceed that amount. For one thing, the fraudulent providers will not repeat their costly actions. So the savings from those providers alone constitute many times more than the dollar amounts of the recoveries. In addition, these governmental actions discourage other providers from attempting like shenanigans - savings untold billions more.

The 1996 Health Insurance Probability and Accountability Act seeks to improve anti-fraud activity. It authorizes payments to those reporting improper billings. Financial incentives for patients to monitor their bills and to provide employees to report unjustified billings will lead to substantial recoveries of improper charges and make health providers more careful. Other existing whistle blower programs provide bounties to those reporting fraud.

But I find that few know of this new provision in law and the applicability of federal whistle blowing legislation before the currently publicized multi-state investigation of Columbia/HCA Healthcare and the divulgence on August 18 of the extensive role played by whistle blowers and their possible rewards. I urge this Committee and Congress to encourage HCFA to make full use of its new authority and to publicize the rewards available.

The Wall street Journal (May 6, 1997) reported a GO A estimate that fraud may infect as much as 10% of Medicare outlays. If we were to root out only half of that, Medicare could save $10 billion a year.

The possibly widespread billing improprieties of Columbia/HCA Healthcare Corporation, with its $20 billion in annual billings, indicates that rooting out fraud is not just a slogan but holds real promise for seriously reducing Medicare outlays. With heightened awareness of bounty programs not only will recoveries multiply but Medicare providers will play it straight. We can be entering a new era in which Medicaid and Medicare fraud become rare. If so, massive savings on outlays will result.

II. Link Part B (Supplementary Medical Insurance) Premiums to Income

A. Higher Pay People Pay More for Medicare Part A

Under current law, all employed people pay the same percentage of pay roll tax, without limit, for Medicare Hospital Insurance (Part A) and receive eligibility for the same package of benefits. Thus higher-pay employees and the self-employed pay more, sometimes many times more, than low-pay and medium pay employees. And HI has paid its own way. Of course, the projections for HI show that its resources, current FICA contributions and earnings on its past surpluses, will fall short

of its outlays. The measure already adopted by Congress and approved by the President delay that undesirable result a decade. During that decade we will see whether fraud and outlays drop.

B. Current Program Subsidizes 75% of Part B Costs

Part B (Supplementary Medical Insurance) presents a different picture. Part B funding comes from premiums. And, through 1998, premiums will continue to be set so that they pay for one-quarter of Part B outlays while general revenues pay for the remaining three-quarters. That set of payments contribute directly and substantially toward the federal deficit. That three-quarters constitutes a sizable subsidy. It may increase after 1998 if premiums pay even less than the 25% of program costs.

C. Part B Subsidy for Well-To-Do Hard to Justify

It is hard to justify such a subsidy for those with ample incomes. So, I urge, along with many others, that individuals and couples whose income, from whatever source, exceeds specified amounts should pay higher premiums than Medicare participants with more modest income.

Using a prior year's tax return as the measure of income makes administrative sense and provides a reasonable measure.

D. Injury and Illness Often Greatly Reduce Income -
Warranting a Mechanism to Adjust Premiums

Serious illness or injury often curtail or even end an individual's earnings. So, an income-related premium arrangement should make available exceptions for those whose incomes decrease

substantially after the year used to measure one's Medicare income - linked premium.

E. Income - Linked Premiums Provides No Precedent for Means-Testing Social Security Cash Program - Programs Differ Greatly

Despite disagreements on many points, a majority of members of the Social Security Advisory Council recommended against means-testing Social Security cash benefits. They gave as their principal reason that such a scheme discourages savings. I agree and have long and vigorously opposed means-testing cash benefits.

However, varying Part B premiums does not provide a precedent for Social Security means-testing. The structures of the two systems differ in important ways. The discouragement to savings argument has little force for Part B premiums which involve far less money than Social Security benefits.

In Social Security and Hospital Insurance, every participant contributes throughout working life, with equal contributions from their employers which, in combination pay the entire cost of the program.

Medicare Part B differs significantly. Receipt of benefits requires the payment of premiums after retirement. Those premiums are set to produce 25% of the program's cost, with 75% coming from general Treasury revenues. The income taxes of moderate - and low - pay working people pay for a portion of that 75% subsidy

So, considerations of fairness argue for requiring premiums related to income for Part B participants whose tax returns show income sufficient to assure that the additional premium is

affordable.

Further, many in the media and public believe that the elderly receive an undue share of federal funds, especially under Medicare. In large measure, this results from the mistaken impression that vast sums are spent uselessly to extend the life of dying elderly patients. While older people have proportionally higher expenses for medical care, the notion that they receive huge amounts of aggressive high-tech care when seriously ills is not correct. (See "Seven Deadly Myths" prepared by the Alliance for Aging Research.) For example, one study summarized in that report shows that critically ill patients 80 and over were less likely to receive "three procedures representing aggressive care - major surgery, dialysis, and right heart catheter placement - than patients under 50". (Page 4) I request that this excellent pamphlet, packed with pertinent information, be placed in the record.

It will take long and valiant work to correct widely heed impression of enormous and disproportionate expenditures for the elderly ill. This efforts should be made. The impression of unfair expenditures for the elderly ill can be ameliorated by requiring higher premiums for Part B from those with ample incomes.

A relatively small part of the Medicare-eligible population would be directly affected by income-related SMI premiums: of the 38 million eligibles, some 1.3 million would pay additional premiums and only about 500,000 would pay the maximum according to CBO estimates.

IV. A More Realistic Long-Term View

Our ability to sustain Medicare without impairment does not depend solely upon the number of people at work for each beneficiary as so much discussion suggests. Under current arrangements,

most of Social Security and Medicare revenue results from the payroll tax and that is determined by the number of people working.

But that's only half the story. If the employed produce and earn more, they contribute more payroll tax. History provides examples of a smaller work force supporting higher living standards for a proportionally larger population. Despite repeated shortening of the workday and workweek and more holidays and longer vacations during this century -- equivalent to reducing the work force -- our economy has generated more goods and services and vastly higher standards of living. Improved productivity also explains why far fewer farmers (40 percent of the work force in 1900 and under 2 percent today) can feed the U.S. with plenty left over to export. Contrary to widespread impression, both manufacturing and service productivity have been improving. Some commentators, including economists for some major corporations, assert that the official figures greatly understate productivity improvements.

Past annual reports of the trustees of the Social Security and Medicare programs point out that slow growth of wages and salaries contribute to the projected shortfalls in these programs. Hence, we should pay more attention to what people earn, not only for their sake but also because of the stake we all have in Social Security and Medicare. Improved earnings will improve program resources significantly and make Medical and Social Security less susceptible to reduction.

Under current practice, each fund's actuaries make projections for a ten-year period (short-term) and a 75-year period (long-term). Indeed, because the projections depend upon many variables which cannot be known in advance, the actuaries make three sets of assumptions -- optimistic, pessimistic, and intermediate, the latter also known as the "best guess."

Several cautions in the use of these projections should be observed. First, they are not predictions. They do not say : "This will happen"; they only say, "Based on our assumptions, these outcomes may result, with the warning that the longer the period of the projections, the more likely they are to deviate from future reality."

This caution applies with special force to medical care costs. We can reasonably assume that, given the expected growth of the population 65 and over, Medicare total costs will increase. But we cannot know with any certainty what the costs of care will be. We do know that in the last few years, medical care cost increases have moderated. Many expect them to rise more rapidly in the future.

In a recent newspaper story on health care costs, one expert said that six months is a long time in this field. He pointed out that even recently no one foresaw the rapid and profound impact of managed care on costs. We should acknowledge how little we can foresee in this complex area. Some treat projections as the literal truth and justify major changes in Social Security and Medicare on the basis of apocalyptic forecasts. It makes no sense to take long-term prognostications literally or even close to literally when change occurs so rapidly in medical care and in insurance arrangements. So a good rule to follow here is: "Look before you leap".

An equally good rule is "Take all cost-cutting steps that do not reduce appropriate care and see how much they save before making any major structural change that injures beneficiaries."

#

SUMMARY

PRESERVING MEDICARE WITHOUT RADICAL CHANGE

I. Three Measures to Improve Financing Without Raising Tax Rates

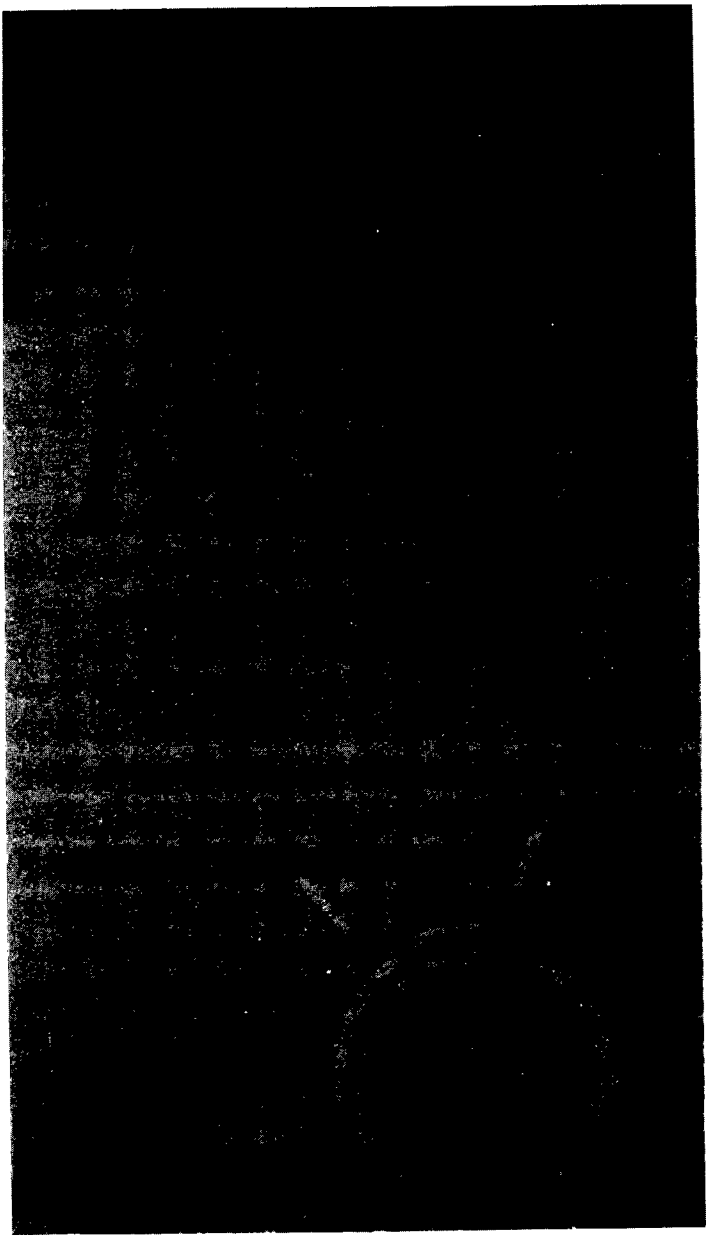
A. Rout Out Health Provider Conflicts of Interest that Boost Program Costs
   1. Studies show overuse where physicians own laboratories and dispense drugs
   2. Physician ownership in HMOs pits doctors against patients
   3. Conflicts of interest imperil patients, prove costly

B. Pursue Costly Fraud - Publicize Bounty System for Whistle Blowers
   1. Fraud settlements already have netted billions
   2. Settlements achieve even larger savings
      (a) eliminate continued violations
      (b) discourage others from like practices
   3. Columbia/HCA Healthcare fraud investigation helped by whistle blowers
   4. Publicity for their role and possible rewards ushers in a new era for Medicare
   5. Providers now under pressure to play it straight and carefully
   6. That should reduce Medicare outlay

C. Boost Program Income
   1. Sole focus on demographic change - fewer at work for each beneficiary - distorts financing problem
   2. 20th Century agriculture shows smaller working population can meet needs of a growing population
   3. Wages lag behind productivity improvement, reducing Medicare revenues
   4. That imperils program, gives all stake in improving employee share of productivity gains

II. Link Part B (Physician Services) Premiums to Income
   A. Higher pay people pay more for Medicare Part A
   B. Current program subsidizes 75% of Part B Costs
   C. Difficult to justify substantial subsidy for those with ample incomes
   D. Injury and illness often greatly reduce income - warranting mechanism to adjust premium during current year
   E. Premium change provides no precedent for means-testing Social Security cash program - programs differ greatly

III. A More Realistic Long-term View
   A. Rapid health insurance and medical care changes make 75-year projections absurd
   B. What U.S. can afford in the future depends upon strength of economy



The Alliance for Aging Research gratefully acknowledges our expert advisory panel for their contributions in developing our report on uncovering the facts about the high cost of the last year of life. We greatly appreciate the support of the Project on Death in America of the Open Society Institute and the Retirement Research Foundation.

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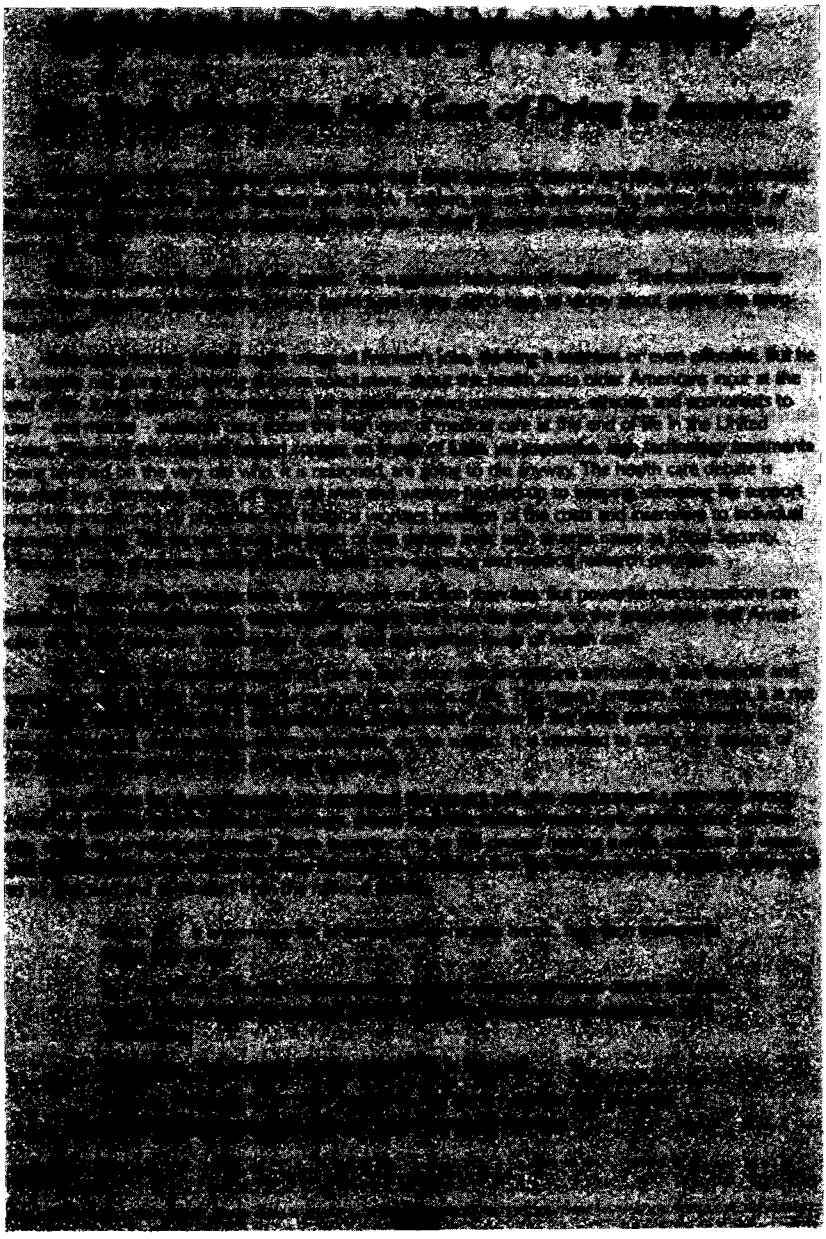
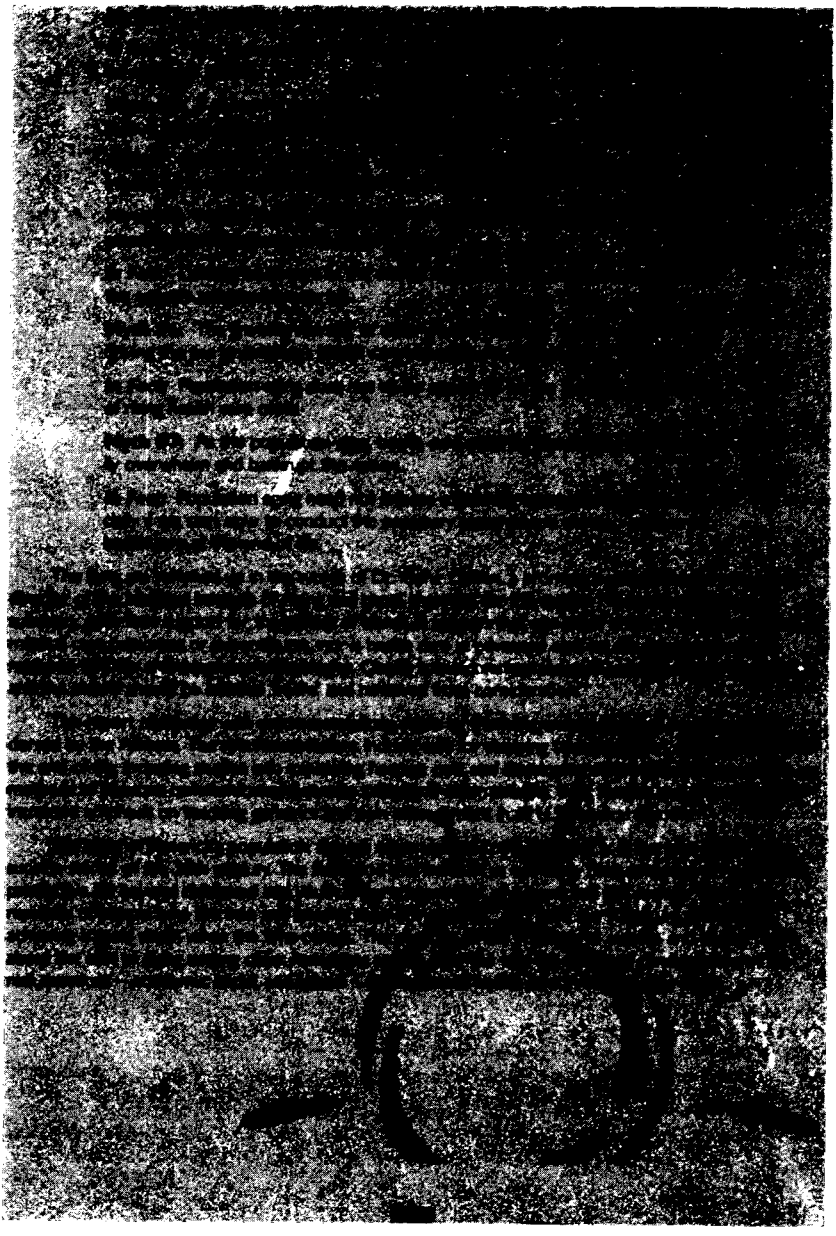
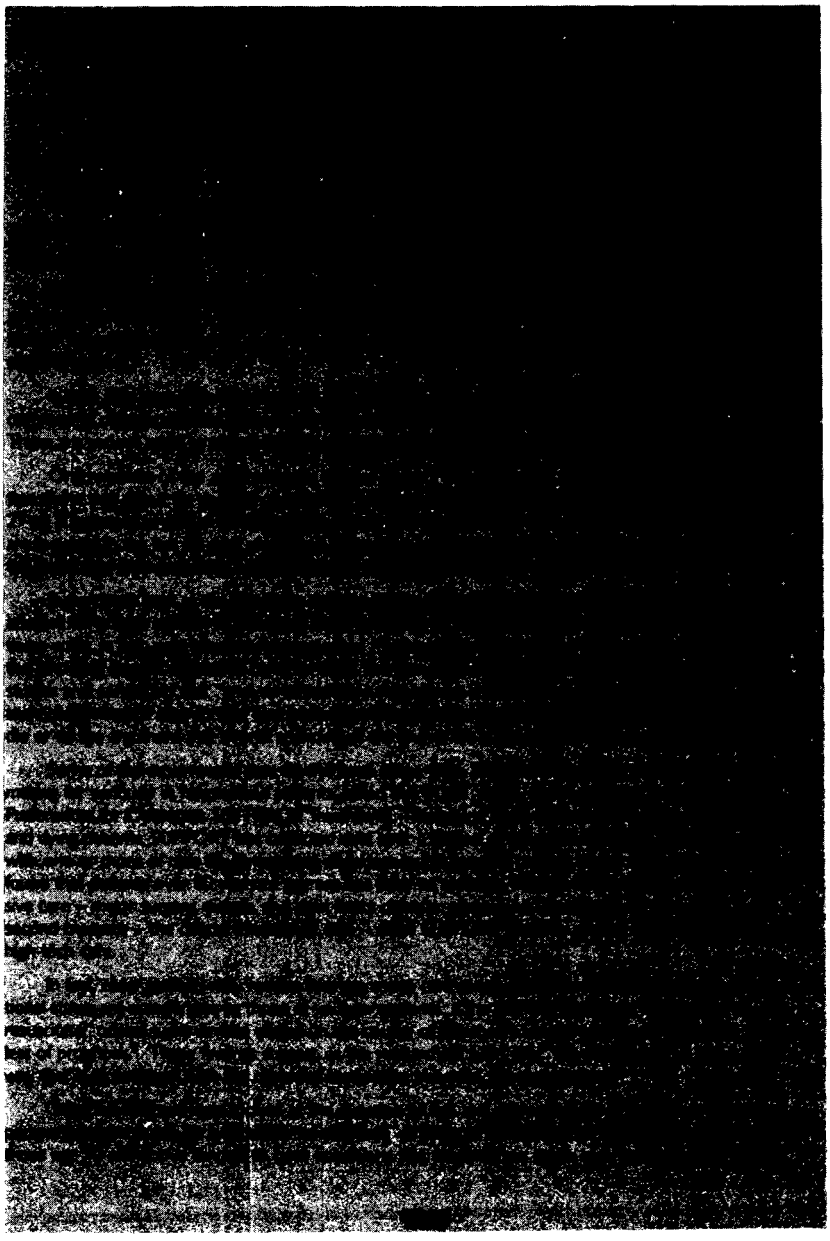
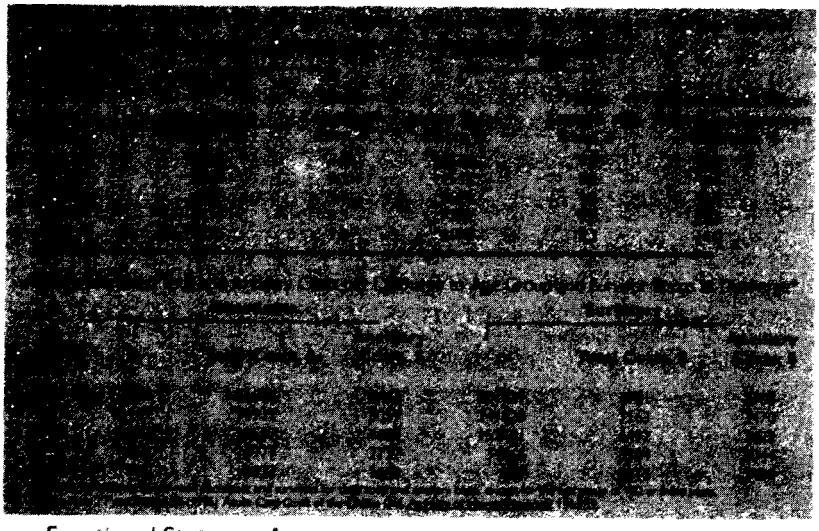
For additional copies contact the Alliance for Aging Research, 2021 K Street, N.W. Suite 305, Washington, DC 20006, (202) 293-2856 (phone), (202)785-8574 (fax).







sixties.[8] And regardless of diagnosis, the oldest people in this study had lower rates of aggressive care than people age 60 to 69. For example, they had lower ancillary charges (charges other than those for the hospital room, such as use of the operating room and radiology services). In addition, people age 80 and older in this study were less likely to be admitted to teaching hospitals and more likely to enter lower cost community hospitals[9]. Again it appears, as the SUPPORT researchers noted, that some informal age based rationing of hospital care is in effect.



Functional Status vs. Age

Who does receive aggressive, high technology care at the end of life? A study of frail patients in a group practice in Palo Alto, California, examined this question. [illegible] functional status (ability to carry out basic activities, such as dressing and bathing) [illegible] In other words, quite reasonably, aggressive care was sought for the healthier patients, and doctors felt justified in not treating aggressively.

Although total expenditures did not differ greatly for the different functional groups in this study, the unimpaired, partially impaired, and totally impaired [illegible] costs by [illegible] of age. Regardless of age, average hospital expenditures were much greater for the partially [illegible] impaired ($3,000) and the partially impaired ($1,100). Physician costs for the totally impaired were about one third those for the unimpaired. On the other hand, nursing home and [illegible] were much sharply higher for the totally impaired than the unimpaired, offsetting [illegible] hospital and physician cost.

Finally, there is no evidence that aggressive care at the end of life [illegible] increasing. Of the [illegible] proportion of total Medicare expenditures for individuals in the last year of life has [illegible] according to a study that tracked costs from 1976 to 1988. Expenditures in the last two years of life also remained the same or [illegible] throughout the period of the study.

These findings suggest that physicians and hospitals are not [illegible] heroic measures to prolong dying, despite the popular misconception. It appears that [illegible] policy that concentrates on supportive care for the elderly who are close to death [illegible] such care is appropriate [illegible] and where [illegible] care be provided and who should [illegible]

MYTH 2

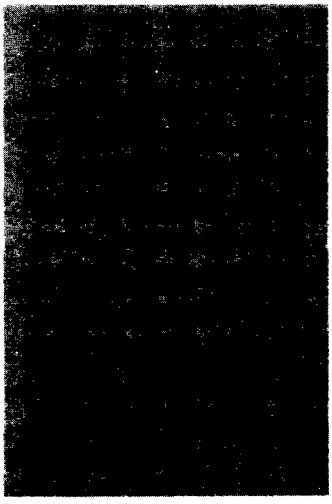
The majority of older Americans die in hospitals.

***Fact:* The majority of older Americans do not die in hospitals and the older people are, the more likely they are to die in nursing homes.**

There is a widespread perception that one reason for the high cost of dying in the United States is that the vast majority of elderly people die in hospitals. The data, however, show otherwise. Data from the National Center for Health Statistics (NCHS) for 1994, the most recent year for which there are data, demonstrate that fewer than half of the deaths among people 65 and older occurred in hospitals. More than half of these deaths occurred in nursing homes or residences.

The trend, moreover, appears to be toward less hospital care for the dying as age increases, in contrast to the popular assumption. The NCHS data on place of death shows a sharp drop in hospital deaths after age 84 and a steady increase in the nursing home as place of death after age 65.

Hospital costs may also decline with age, according to some data. SUPPORT researchers, looking at more than 4,000 adult patients in five medical centers across the country, found that patients 80 and older had estimated hospital costs that were, on the average, $7,161 lower than those for patients under 50.[16] The same trend is apparent in patients 65 and older; in this age group, Medicare payments in the last year of life fall as age at death increases.[17] Similarly, a study of Massachusetts acute care hospitals in 1992 and 1993 found that hospitalization costs peaked between the ages of 70 and 79 and then fell with increasing age. Among those who died in the hospital, costs peaked even earlier, in the 60 to 69 year age group.



Acute vs. Supportive Care

Studies of Medicare costs at the end of life are limited by and large to hospital and physician costs. To estimate end of life costs outside hospitals, several researchers have attempted to look at all health care usage and costs for terminal care. Their findings merit close attention because they show hospital use declining with age, while the use of nursing home and home health care rises dramatically.

The Survey of the Last Days of Life, conducted by the National Institute on Aging, suggests that most older people spend the majority of their last 90 days of life outside of hospitals, although about half transfer to a hospital in the last week or two of life.[17] This study of more than 4,000 deaths in Fairfield County, Connecticut, also found that the number of days that elderly persons spent in nursing homes in the last 90 days of life increased dramatically with age.

Researchers have also looked at nursing home costs. The study of 261 patients in Palo Alto, found that nursing home and home health care costs increased sharply after age 80, even as hospital costs dropped by 50 percent.[18] Likewise, a 1988 study of 4,349 Medicare and Medicaid beneficiaries in Monroe

County, New York, found that the percentage of Medicare and Medicaid expenses for nursing home care rose sharply with age from 24 percent for the "young old" (65 to 74) to 62 percent for the "oldest old" (85 and over).

The National Mortality Followback Survey of 1986 showed that among the 1.5 million people age 65 and older who died that year, 45 percent had a nursing home stay in their last year of life. The percentage rose with increasing age from 16 percent of the young old to 58 percent of the oldest old. The length of stay in nursing homes likewise increased with age. Based on these figures, one researcher has estimated that nursing home costs [illegible] the [illegible] hospital [illegible]. Clearly, the main focus of research and debate should be on [illegible] care for the elderly rather than acute hospital care.

Hospital costs may also decline with age, according to some data. Researchers, looking at more than 4,000 adult patients in five medical centers across the country, found that patients 80 and older had estimated hospital costs that were on the average $7,161 lower than those for patients under 50. The same trend is apparent in patients 65 and older; in this age group, Medicare payments in the last year of life fall as age at death increases.

[illegible] Medicare is provided through hospice services. However, Medicare pays for hospice care only when patients have a life expectancy of less than six months, according to their physicians. In part because of the difficulty of estimating life expectancy, most patients with illnesses that result in death never use Medicare's hospice benefit, or use them only for a few days before death. [illegible] advanced [illegible] expectancy [illegible].

The current debate on physician-assisted suicide reflects the urgent need for research and training in supportive or palliative care. Underlying this debate is the false assumption that suicide is the only practical alternative to the pain, indignity, and depression that too often accompany death from chronic illnesses. However, we already know how to alleviate the suffering in many cases and to make dying a comfortable, worthy part of a full life.

What needs to be done now is to extend this knowledge to all dying patients. Very few physicians currently receive training in end-of-life palliative care, for instance, and many patients do not benefit from the aggressive management of pain that is possible and recommended. Recently, a group of 40 prominent health care organizations issued a declaration of principles for measuring quality of care at the end of life, including aspects of care such as relief of physical and emotional symptoms, support of function and autonomy, and advance care planning.

Clearly, the most critical policy issue in end-of-life care ought not to be whether physician-assisted suicide is a constitutional right. Rather, the most important issue is how to improve supportive care for people with chronic illnesses that will result in death. What are the elements of good supportive care? How will we measure and pay for it? And what will be the impact of the growing numbers of elderly on supportive care services?

MYTH 3

Aggressive hospital care for the elderly is futile; the money spent is wasted.

***Fact:* Many older people who receive aggressive care survive and do well for an extended period.**

One of the most common myths surrounding health care in old age is that aggressive treatment is too often "wasted" on patients who, because of age, cannot benefit from it. The facts are that 1) many older people do benefit from aggressive care and 2) that age alone is not the major determinant of who will benefit.

The benefits of aggressive care for the elderly are demonstrated by Medicare data showing that among beneficiaries who incur high costs, there are about as many who survive as who die in the course of a calendar year. For instance, among those who cost Medicare more than $20,000 in 1978, 24,000 died and 25,000 survived in that year.[26] In four other years, the percent of Medicare enrollees who incurred the highest costs were divided about equally between those who survived and those who died in the course of the year.[27]

These data suggest, retrospectively, that high-cost (or aggressive) care has benefits for people age 65 and over about half the time, if one accepts survival as an indication of benefit. The figures also imply that if it were possible, prospectively, to identify persons who would benefit and persons who would not benefit from aggressive care, physicians and patients together could choose care accordingly.

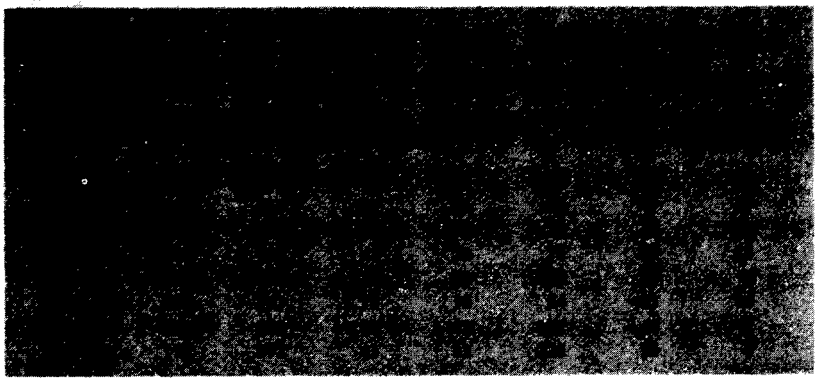
At present, physicians do not have a reliable way to predict the outcome of treatment in elderly patients or, with the exception of terminal cancer, to predict how long a patient has to live with much accuracy.

This idea, however, leads to one of the crucial problems in decision making at the end of life: the difficulty of predicting which patients will survive and which will die. At present, physicians do not have a reliable way to predict the outcome of treatment in elderly patients or, with the exception of terminal cancer, to predict with much accuracy how long a patient has to live. Even the use of complex scoring formulas that take many factors into account fail to yield precise predictions of life expectancy in critically ill patients. The best known of these, the APACHE model (Acute Physiology, Age, Chronic Health Evaluation), has improved the accuracy of predictions in groups of patients but has not proved useful in predicting which individual patients will die.[28]

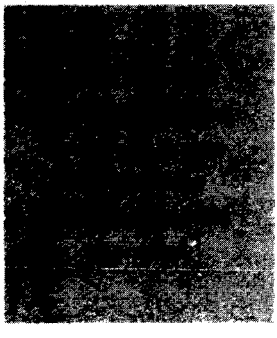
In one of the SUPPORT studies, the researchers found that seven days before death, patients had a median 51 percent likelihood of surviving two months, according to SUPPORT's own prognostic model.[29] Even one day before death, the median likelihood of surviving 2 months was 17 percent.

"While a prognosis of 50 percent for two months is a very serious prognosis," these researchers write, "it is not clear that the public means to categorize persons who still have a "fifty-fifty" chance to live two months as "terminally ill" and certainly not as "imminently dying".

Proportion of SUPPORT patients by disease who would die within [illegible] population as defined by two thresholds, and the rates at which they die within [illegible] within twelve months.



Source: [illegible]



Compounding the problem of prognosis was the markedly different likelihood of surviving two months that emerged for different illnesses and conditions in this study.

One clear fact that does emerge from studies of prognostic models is that age alone is not a good predictor of whether treatment will be successful. Both the APACHE III and the SUPPORT model include age as one prognostic element, along with physiologic and other variables. In neither case does age appear to play a major role, compared to other variables.

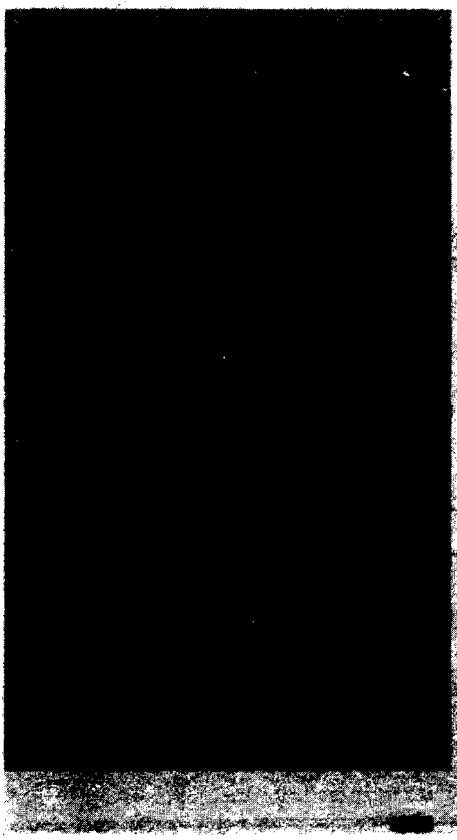
In summary, the common assumption that intensive care for the elderly is futile is not borne out by the evidence. Age alone is not a good basis for making prognoses, and the outcome of aggressive treatment is hard to predict. One of the pressing needs in end of life care is the development of better models to enable physicians to give patients and their families reliable prognoses and particularly to let them know when further aggressive treatment will indeed be futile.

MYTH 4

If all elderly patients had living wills or other kinds of advance directives, it would resolve dilemmas of how aggressively to provide care.

***Fact:* Even when patients have advance directives, they often have little impact on or relevance to end of life decision making.**

Faced with medicine's increasing ability to save and prolong lives with high-technology care, many people have turned to advance directives, such as living wills, to guide decisions about use of such care in the event they are unable to make these decisions themselves near death. The Patient Self Determination Act (PSDA) of 1990 mandated that health care institutions inquire about and document existing advance directives at the time of hospital admission.



Have advance directives fulfilled their promise? Not so far, say researchers who have identified at least three barriers to their use.

One of these barriers appears to be that advance directives are still not well integrated into our health care system. Despite the PSDA's passage, living wills, durable powers of attorney for health care, other kinds of instructions, and "do not resuscitate" orders often do not find their way into patients' medical records.[32] This is not to say that the PSDA has not had any effect – SUPPORT researchers found that following passage of the bill, documentation of existing advance directives in seriously ill patients' medical records rose from six to 35 percent of records. An education and communication effort at the time of hospital entry further boosted this rate.

However, even when advance directives and "do not resuscitate" orders are placed in medical records, they appear to have little impact on care. SUPPORT researchers found, for example, that patients' preferences regarding cardiopulmonary resuscitation (CPR) often were not translated into practice. Among those who said they preferred not to have CPR, nearly half did not have "do not resuscitate" orders written

for them." An intensive educational effort to improve communication between patients, families and physicians made little or no difference in this and other indications of the impact of advance directives.

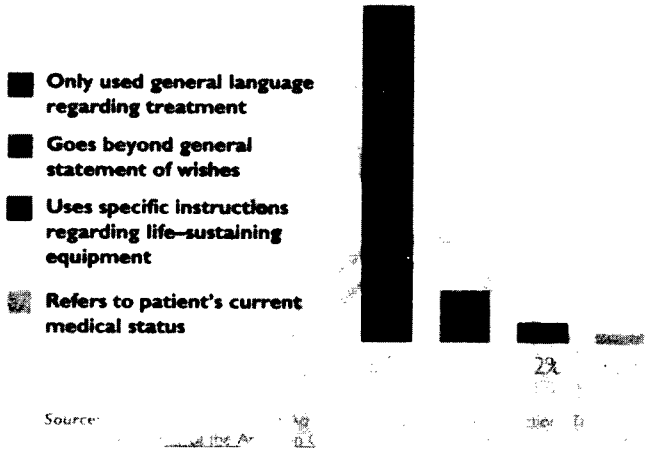
A second barrier to the use of advance directives may be their lack of specificity. SUPPORT researchers, analyzing the content of 688 directives in five hospitals found that the great majority used only the general language found in standard living wills, i.e. a statement that the patient prefers not to prolong dying through artificial means." Only 90, or 13 percent, went beyond the general statement. Just 36 had specific instructions about the use of life-sustaining treatment and only 22 of these referred to the patient's current situation.

A general statement about not prolonging death may be of little use in today's health care environment. "What is ordinarily at stake for very seriously ill patients is not whether efforts to prolong life should ever cease but exactly which efforts and when," SUPPORT researchers conclude.

A third and related barrier to the effectiveness of advanced directives is the clinical problem already mentioned -- the difficulty of predicting when a given patient is near the end of life. Most advance directives embody the concept of not using life sustaining measures when they would be futile. When physicians cannot predict futility, however, such instructions offer little guidance.

The issue, in other words, is complex. Simply getting more patients to write advance directives, even getting more hospitals to incorporate them into patient records, may have little impact in the face of these other barriers. One key focus for research and debate is how to craft advance planning that can make a difference in a patient's experience. In addition, research is needed on systemic hospital changes that could help older patients and their families make informed decisions and specific plans concerning the aggressiveness of care during critical illness.

Language Specificity as Barriers to the use of Advance Directives.



Source:

Myth 5

Putting limits on health care for the very old at the end of life would save Medicare significant amounts of money.

Fact: **Limiting acute care at the end of life would save only a small fraction of the nation's total health care bill.**

Even if physicians and hospitals could predict which patients were near death, limiting acute care would not save the amount of money that many people assume.

Consider Medicare expenditures [illegible] end of life. [illegible] consistently [illegible] percent of all Medicare expenditures [illegible] [illegible] that [illegible] More [illegible] limiting care for these few high cost users would save the country [illegible] few dollars.

For instance, only about three percent of older persons who died in 1978 cost Medicare more than $20,000, and they accounted for only six tenths of one percent of the nation's total health care costs. Similarly, if care had been cut off to the [illegible] percent of Medicare patients who were high cost users in 1993 and who died in that year, national health care costs would have fallen only slightly, from $900 billion to $895 billion. The savings would have amounted to one-half of one percent of total U.S. health care expenditures for that year.[illegible]

Even if physicians could provide reliable prognoses and did curtail acute care for all persons with a very short life expectancy, it is not clear that society would save large amounts of money. Several studies suggest that the cost of hospice and other forms of supportive care can largely make up for savings in acute care.[illegible] According to one rough estimate, if society did limit aggressive care for all persons 65 and older who died, while implementing advance directives and using hospice care, the savings would amount to only 6.1 percent of annual Medicare expenditures and less than one percent of total national health care expenditures.[illegible]

To sum up, aggressive care for the elderly at the end of life does not appear to be a major item in the nation's health care bill nor a potential area for large savings. While we need more information and better policies to guide appropriate end of life care, we cannot assume that simply by limiting aggressive care we could resolve America's problem of spiraling health care costs.

MYTH 6

The growing number of older people has been the primary factor driving the rise in America's health care expenditures over the past few decades.

***Fact:* Population aging does not so far appear to be the principal determinant of rising health care costs.**

Health care costs in the United States have risen sharply in the past three decades not only in actual dollars but also as a proportion of the gross national product. It is easy to jump to the conclusion that this rise stems primarily from the graying of America, because the elderly on average spend more on health care than the nonelderly.

But a close look at the reasons for rising health care costs shows something different. One analysis has shown that between 1973 and 1983, general price inflation accounted for about 60 percent of the growth in national health expenditures, while inflation specific to the health sector of the economy was responsible for another 10 percent.[3] In the following ten years, 1983 – 1993, general inflation accounted for about 40 percent of the rise in national health expenditures, and sector-specific inflation for about 20 percent. Population and other factors remained relatively constant, according to this study.

To measure the effect of aging, the same analysts developed indexes of use per capita and cost per use for most of the components of personal health care. Those indexes show that between 1965 and 2005, the aging of the population has and will add less than one percent per year to the growth of personal health expenditures.[4] Not until after the baby boom generation begins to reach 65, around the year 2010, will population aging have a major effect on health spending.

Other studies support this analysis. In one study, for example, researchers calculated that aging and population growth together account for only about 20 percent of the rise in hospital costs, and about 17 percent of the rise in physician costs between 1987 and 1990.[5] The two factors accounted for about 35 percent of the rise in long-term care costs in this study, but they are still minor, compared to other factors. Inflation and rising gross national products "far outweigh all other causes as explanations of rising health expenditure" in recent decades.[6]

There is no evidence, moreover, that an increasing proportion of resources are being devoted to dying elderly patients, despite the popular perception to the contrary.[7] Medicare data show that although expenditures increased sharply between 1976 and 1988, the proportion of dollars spent on elderly people who died remained about the same. As the authors of this study note, "apparently the same forces that have acted to increase overall Medicare expenditures, inflation, new techniques, and greater intensity of care – have affected care both for decedents and for survivors."

To assume that population aging has been the major source of rising health care costs is a mistake and detracts attention from the more serious determinants of rising costs. As one researcher has commented:

> *"If rising health care costs are due to aging and other external forces, then they are not "my" responsibility, nor can they be blamed on doctors, hospitals, insurance companies, governments, or indeed any of the institutions which should, in fact, be held responsible. By making it seem as if cost increases are inevitable, attention is diverted from the real and difficult choices that must be made and the institutions which make them."*[8]

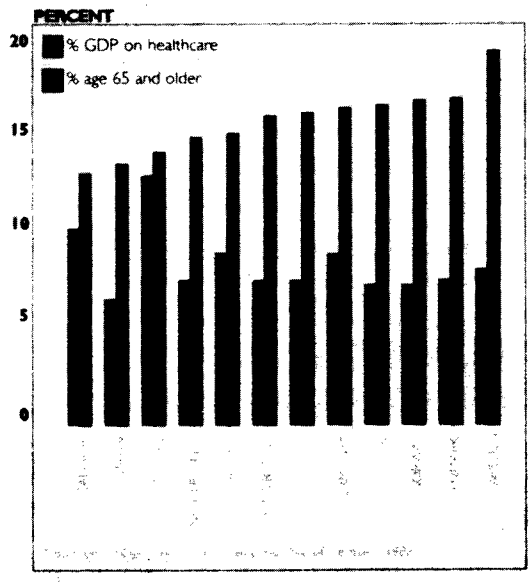
MYTH 7

As the population ages, health care costs for the elderly will necessarily overwhelm and bankrupt the nation.

***Fact:* Population aging need not impose a crushing economic burden, especially if we start now to conduct the necessary research and develop policies on health care at the end of life.**

One image that surfaces repeatedly in the public debate on health care costs is that of the huge wave of baby boomers who will begin turning 65 in 2011. By the year 2030, people age 65 and over will constitute 20.2 percent of our population. Often, in both the popular media and academic writings, the mention of population aging is linked with predictions of economic disaster.

Without doubt, the aging of the baby boom generation will challenge our current system, including the way we provide end of life care. But it is a mistake to consider the challenge insurmountable for two reasons. First, there is some evidence that population aging may not be as great an economic burden as many people assume.

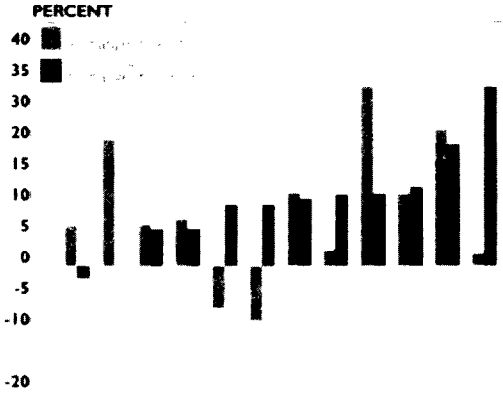


Source: Adapted from data in Schieber, Poullier and Greenewald, 1992, "U.S. Health Expenditure Performance: An International comparison and Data Update" *Health Care Financing Review 13(4): 1–15.*

Second, there is still time. As a society, we have the opportunity, now, to debate these issues and develop policies that are both economically and ethically sound.

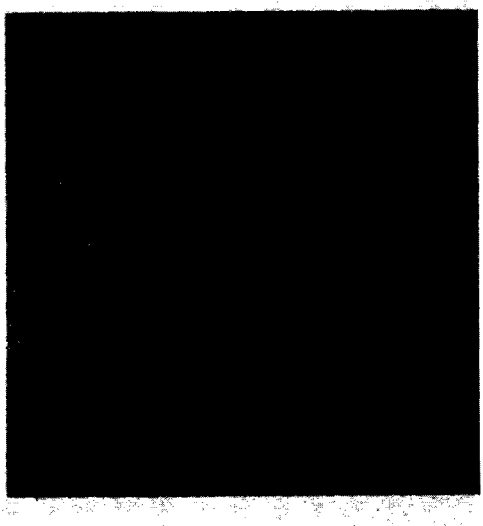
The evidence that population aging may not be as disastrous to the economy as predicted comes from several sources, including cross-cultural studies. In other countries that have already experienced a sharp rise in their older population, health care spending has not risen proportionately.* For example, Japan's population of aged 65 and older increased by 31.9 percent from 1980 to 1990, but its proportion of gross domestic product (GDP) spent on health care rose only 1.6 percent.

Furthermore, cross-national data do not suggest that high proportions of older people are inevitably associated with high health care expenditures. Sweden, for instance, has the highest proportion of people over age 65 among industrialized countries—16 percent—but its percentage of GDP spent on health care is comparable to that of countries with a smaller proportion of older people. In fact, overall, no pattern of relationship emerges from a study of the relationship between population aging and health care spending in industrialized countries, even when we look at spending for people aged 80 and over.



Source: Calculated from data of Schieber, Poullier and Greenwald, 1992. "U.S. Health Expenditure Performance: An International Comparison and Data Update." *Health Care Financing Review, 13(4)*: 1–35.

One concern often cited is the changing ratio between the older users of Medicare and social security benefits and the younger working population who must support these programs. As the population ages, there will be fewer workers in relation to nonworkers. But here again, cross cultural data help put that concern in perspective. Between 1986 and 2040, the U.S. will have a low rate of increase in the ratio of inactive to active citizens compared to Japan, Sweden, France, and other industrialized countries. The U.S. rate of change is projected at 0.238 percent while The Netherlands' is .619 percent and Germany's is .778 percent.[47] As one expert has commented, "an average annual rate of less than one-fourth of one percent for a country like the United States is clearly a manageable increase, given the historical experience of that country in its economic growth and given the possibility of critical change in productivity and worklife time and allocation."[48]



Another indication that health care costs for the elderly may not be headed for disaster comes from a recent study suggesting that the rates of serious illness could be falling in older people. Data from the National Long-Term Care Survey show that the prevalence of seven chronic conditions - dementia, stroke, arthritis, hardening of the arteries, high blood pressure, circulatory disease, and emphysema - declined almost 15 percent among people age 65 and older between 1982 and 1994, with the greatest rate of decline occurring between 1989 and 1994. The most significant declines from 1989 to 1994 occurred for the oldest old and the most disabled people.[49] While more data are needed to confirm this trend, this study does suggest that changes in disease patterns may be emerging.

In the health care scenario of the future, the impact of improved life expectancies is often said to play an important role. As more and more people live into their eighties and nineties, the argument goes, they are bound to place an increasingly serious burden on the health care system. However, a HCFA study shows that the impact of improved life expectancy past age 65 in 2020, considering only demographics and not inflation or developments in technology, will be quite small, amounting to only three percent of the projected increase in Medicare costs.[50]

Finally, there is hope for the future. Consider the direction of much current research on aging, where the emphasis is on low-tech, preventive, and supportive interventions that improve quality of life.[51] The National Institute on Aging, for instance, has major research programs on long-term care and the prevention of frailty and disability among the elderly.

While all of these are promising findings, it would be as grave a mistake to underestimate the challenge posed by population aging as it is to depict it as inevitable disaster. One of the most important tasks now is to address the crucial issues surrounding optimal health care services and health care costs at the end of life, while we still have time. It is critical that we conduct the research, gather the data, and develop policies and practices for end of life health care based on evidence and ethics rather than misconceptions.

SUMMARY

The Alliance for Aging Research, recognizing the growing negative focus on the magnitude of problems and associated societal costs incurred by the elderly, has completed this review to set the record straight. Myths and misinformation abound and with them comes the risk that the elderly population in this country are regarded as a national burden with ever increasing and insolvable problems. We want to head off that possibility along with the risk that misinformed policy-makers, blinded by negative myths and stereotypes about aging, might come to the conclusion that the only approach is to establish arbitrary limits and reductions in the health care resources on which older Americans and their families depend.

Studies in treatment and technology have made American medical prowess the envy of the world and lengthened the lives of many. However, these advances have also created unexpected consequences. Currently in the United States, it is often not death itself that is feared but rather the modern medical nightmare scenario – dying alone, in pain, without dignity, and tethered to expensive machines. In addition, demographics and economic realities have raised a host of ethical and practical issues related to end of life care for the elderly that previous generations did not have to face. These issues are real and must be faced with facts – not the myths that now surround them, fueling ageist attitudes and rhetoric.

We still have the opportunity to debunk the myths. We must address these issues head on and open the lines of communication among those facing death, their families, their health care providers and payers and policy-makers. Realizing the importance of personalized, end of life planning and communicating one's wishes to family and health care providers is only the beginning. A national dialogue involving consumers, patients, and the medical community, both academicians and clinicians, must commence in order for older Americans to be entitled to and ensured of a good death.

RECOMMENDATIONS

- More research on how and where supportive care could be provided at the end of life. What are the essential elements and outcomes of such care and what is the best way to ensure that patients have access to such care?
- More research on the costs of supportive care at the end of life. What are the costs of patients who die in nursing homes, and what can/should be done about these costs? How much of the nation's health care costs are for nursing homes and home health care at the end of life and how will these costs be affected by population aging?
- Development of more accurate methods for predicting and measuring the outcomes of treatment in elderly persons, including life expectancy.
- Mandatory training in geriatrics and end of life care, including pain management and other aspects of palliative care, in all medical schools in the United States.
- More research on the hospice program. For example, what options exist for expanding it to include more patients, and what impact would its expansion have on health costs?
- Development of methods to ensure communication between critically ill elderly patients, physicians, and families concerning patient preferences for aggressive treatment.
- Development of advance directives or other models for advance planning that can be translated readily into medical terms.
- Development of ways to measure the quality of care at the end of life so that it can become one of the criteria by which we choose health care providers and by which providers are paid.

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The CHAIRMAN. Dr. Moffit.

STATEMENT OF ROBERT E. MOFFIT, DEPUTY DIRECTOR OF DOMESTIC POLICY STUDIES, THE HERITAGE FOUNDATION, WASHINGTON, DC

Mr. MOFFIT. Thank you very much, Senator Grassley, Senator Hagel, distinguished colleagues.

It is true that making adjustments to the current system, such as raising retirement age or means testing of Medicare Part B premiums, as Professor Bernstein suggested, can have sound fiscal consequences for the future of the program. I share the views of many, who feel that Medicare should not be viewed simply in budgetary terms.

The question is: Can we do better? It seems to me that we have an opportunity to be very creative and make some fundamental changes in the system in a way that is more directly beneficial to the elderly population who are enrolled in the Medicare program as well as to the taxpayers who so generously support it.

Given the numbers that my colleague, Joe Antos of CBO, has outlined for us, it is certainly unlikely that Medicare is going to remain as it is today. A change in Medicare is inevitable.

But for members of Congress, as well as senior citizens, there should be some controlling questions well beyond the issues of finance, and I would like to share them with you today. Before you make up your mind about how Medicare should be changed, you should ask yourself these basic questions, and so should every current and future retiree, because the answers to these questions are going to determine the kind and quality of health care for the next generation of American retirees.

The first set of questions is: Who, at the end of the day, is going to make the key decisions in the system? These decisions cover a broad field of intimate matters. Who is going to make the decision about what kind of plan you are going to have; what kinds of benefits you will have; what kinds of treatments you will have; what kind of prescription drugs or catastrophic coverage you will have; what will you pay in copayments or deductibles or premiums, and how will you make those payments?

Most importantly, will you be able to choose your own doctors? Who will determine your access to a specialist? Who will decide what treatments or medical procedures are going to be available to you? Are there going to be limits to your medical treatments, and if there are who is going to make those limits? Who is going to make those determinations that treatments are to be limited?

These are key questions to be answered in any program of Medicare reform. They are inevitable. You are going to have to face them.

The issue for America's current and future retirees is simply this: Do you want Congress to make those decisions? Do you want an unelected board appointed by the President to make those decisions? Do you want the officials in the Health Care Financing Administration to make those decisions? Or should individuals and families in consultation with their doctors make those decisions? This is more than just a rhetorical question.

Secondly, a very important principle in Medicare reform is: Who ultimately controls the dollars? More precisely, who is going to control the flow of dollars into the system? These are critical issues.

Who decides how doctors are going to be paid; how much they are to be paid? Remember that the person who controls the flow of the dollars in the system will control the system; the dollars will drive the system; they will shape it and determine the system's character.

There is no easy answer to any of this. But, if we are talking about formal change in Medicare, if we are talking about structural change in Medicare, as Professor Bernstein said, "You should look before you leap."

My colleagues at The Heritage Foundation simply suggest that you look at your own system; the system of health care that is available right now to members of Congress, congressional staff, and federal workers.

After four decades of operation we know well the strengths and the weaknesses of the program that currently covers the federal work force, including members of Congress the Federal Employees Health Benefits Program. We know its strengths, and we know its weaknesses.

On balance the evidence is overwhelming on the positive side of the ledger. It is something that Congress can work with as a model for reform. It is not something that Congress should simply copy every dot, jot, and tittle of, but Congress can work with it to create a new and better system for senior citizens based on consumer choice and competition.

The Federal Employees Health Benefits Program is 37 years old. It is the largest group of insurance in the world. It is unique in the sense that for Americans it is based on the free market principles of consumer choice and competition. Consumers get to choose the plans and the benefits they want from a wide variety of options, and private insurers must compete directly for consumer business at least once a year.

There are over 600 private insurance options nationwide who compete for the business of federal workers and retirees and their families and dependents—altogether approximately 9 million Americans. This is unlike employees in large company plans who are limited to two or three large plans; employees in midsize or smaller companies who invariably have no choice of health plans or benefits or who are forced into HMOs.

Millions of consumers enrolled in the FEHBP can pick and choose from a variety of different sources from traditional fee-for-service plans to preferred provider organizations to various managed care plans. These private plans range from those offered by traditional insurance companies, such as Blue Cross and Blue Shield, to plans sponsored by independent associations and employee and union organizations.

About one-third of all persons enrolled in this system are enrolled in employee organization plans. In Washington, D.C., alone there are 35 different plans available to members of Congress, federal workers and their families. In most areas across the country the competition is between a dozen or two dozen health plan options.

Unlike most company-based plans, in the government's unique insurance program there is no bureaucratic standardization for the health-care benefits package. With the FEHBP instead consumers can pick from a variety of benefits packages ranging from rich fee-for-services packages like the Blue Cross/Blue Shield high option plan to far less expensive managed care plans like geographically based HMOs.

The FEHBP is not governed by price controls, or government fee schedules on doctors. Consumers pick the plans they want and the combination of benefits they want at the prices they wish to pay. Premiums, copayments, deductibles, co-insurance are largely set by the market. Each year the private plans, with their combination of benefits and premiums and copayments are subject to the test of the market.

The intensity of that competition among private plans has, in fact, controlled the costs. In 1997 premiums increased by 2.4 percent, in 1996 by only four-tenths of 1 percent, and in 1995 the premiums actually declined by 3.3 percent.

Senator Hagel, we have called your attention to the success of this for two reasons. Not because it is a perfect system. It can be improved, and federal workers and retirees know, in fact, what the weaknesses are.

But, first of all, it does validate choice. It proves, contrary to what many health-care policy analysts have been saying for so many years, that ordinary Americans can and do make personal choices of health plans and benefits from a wide variety of health insurance options.

The alleged complexity of health insurance is not a valid argument for denying ordinary Americans the right to spend their own money on health insurance plans that they think is best for them. Members of Congress and mailmen have been doing it since 1960.

It is also a politically attractive model for Medicare reform in another sense: It enables members of Congress to present to the public something that has been tested for almost four decades, and it enables members of Congress to say to the rising baby boomer generation, who must be convinced of the need for real change, that they have something that is valid; something that is established; something that can be improved upon.

Very few Americans think that members of Congress, members of the House or Senate, deliberately designed an inferior system for themselves. They are right. Moreover, the success of the federal system means that a similar system of consumer choice and competition can achieve superior benefits including catastrophic and prescription drug coverage at competitive prices.

Finally, I would address the question of fraud. Professor Bernstein noted a figure that I cited. It is actually a Federal Government figure.

Medicare is suffering from a plague of fraud and abuse in the system. Congress enacted the Kennedy-Kassebaum Bill of 1996 in part to try to combat this. Many members of the Congress think the best answer to fraud is to simply impose even greater police authority on the Medicare system.

The New York Times editors frankly had it right in August 1, 1997. The best solution to the scandalous level of fraud and abuse

that is rotting the Medicare program is within the reach of Congress. To quote the New York Times, "The best solution may be like one that currently serves members of Congress and other federal employees." Says the Times, "Medicare should provide the elderly a voucher with a fixed dollar amount to cover the quality health-care plans including traditional fee-for-service coverage. Federal overseers should collect and publicize information about the quality of rival plans so that Medicare enrollees could make informed choices about their health insurance. The overseers would also provide legal coverage for Medicare enrollees who believe that their plans fail to live up to their contracts. A health plan that collects a fixed dollar amount for treating Medicare enrollees would have no reason to overbill Washington for treatments that are inappropriate or dangerous."

Mr. Chairman, I think that the answer to reforming Medicare is close at hand. You are more familiar with it than most Americans, because you are enrolled in it. I was enrolled in it and had the pleasure of being enrolled in it for almost 11 years.

Consumer choice and competition, giving people the opportunity to make decisions about what kind of health-care plans they want at the prices they want to pay; That is the best cost control mechanism ever devised. It is called the free market.

Thank you.

[The prepared statement of Mr. Moffit follows:]

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Congressional Testimony

GIVING BABY BOOMERS A RETIREE HEALTH SYSTEM FIT FOR SENATORS

Testimony before the Special Committee on Aging
United States Senate
August 25, 1997

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The Heritage Foundation

The 1997 budget agreement enacts a reduction in the growth of Medicare spending amounting to $115 billion over five years, and $385 billion over ten years. The Medicare hospitalization trust fund, under the terms of the new law, will be kept solvent for more than ten years. More importantly senior citizens will have a limited choice of health care plans, including preferred provider organizations, provider sponsored organizations, new private fee-for-service options , and a medical savings account (MSA) demonstration project for 390,000 persons, as well as the traditional Medicare fee for service and HMO options.

This limited expansion of plan choice is a modest step toward a new kind of Medicare system. However, the Congress and the White House both tacitly acknowledge that this agreement is a stop-gap measure. It falls far short of a comprehensive structural reform of the Medicare program that will guarantee solid benefits for the next generation of retirees. That is why the new law calls for the creation of a special Medicare commission to report in 1999 on future changes in the program.

Members of Congress at least realize that without fundamental structural reform , a modernization of a program conceived in the 1960s, elderly citizens will be saddled with an inferior health care delivery system and working families will be burdened with huge and unprecedented payroll taxes.

But reform of Medicare goes beyond dollars and cents. Medicare is a bureaucratic monstrosity. According to the Progressive Policy Institute, a moderate Democratic think tank, it is governed

by over 22,000 pages of federal rules, regulations and guidelines. Contrary to what some health policy analysts, focusing on the narrow issue of the administrative costs of processing claims, endlessly repeat, Medicare is *not* a model of administrative efficiency. Doctors and hospitals and patients are drowning is a sea of Medicare paperwork. According to the American Medical Association, doctors today spend an estimated 25 percent of their time complying with blizzard of Medicare paperwork.

Medical benefits and treatments, of course, are set by law and regulation. The General Accounting Office in a major 1994 study on Medicare's benefit setting reported that simple decisions to extend coverage for a medical treatment could take anywhere from 2 months to 12 months. If the medical treatment or procedure is more complicated, it could take several years.

Medicare's pricing for medical services or treatments, of course, is not governed by market forces of supply and demand. It is government administrative pricing. And it is also a case study of bureaucratic inflexibility. Examine recent GAO reports on the subject. Medicare's pricing schemes for doctors and hospitals are incredibly complex and cumbersome. Medicare always pays too much; or it pays too little; or the price controllers in the Medicare bureaucracy don't have enough data-they never have enough data; or they didn't take into account the right factors; or they didn't take into account enough factors. They never do. Reconfiguring the 500 diagnostic related groups (DRGS) for hospital reimbursements, or revisiting the "values" of the components of the Resource-Based Relative Value Scale (RBRVS) for physician payment for over 7000 different coded medical procedures is a never ending process. Likewise, Medicare's

attempts to mirror the success of managed care in the private sector is also instructive. GAO has found that under Medicare's pricing scheme, Medicare paid more for the elderly in its managed care program than it would have if the elderly simply remained in the old fee for service Medicare system.

The congressional concoction of ever more elaborate efforts to control costs or calibrate the "right" prices- 'fair and rational prices"- for thousands of specific medical services in the Medicare program has not only been counterproductive and self- defeating, but it has also encouraged the most ingenious countermeasures by health care providers in every part of the country.

Medicare is plagued, perhaps like no other government program, with outright fraud. Federal investigators estimate that $23 billion is lost to fraud in Medicare; and the $20 billion home health care program is losing as much as 40 cents out of every dollar to what is quaintly referred to as "unnecessary expenditure".

Beyond deliberate fraud, the very structure of Medicare has encouraged clever manipulations of the massively complex system of rules and regulations by an entire class of health industry consultants. As reported in the August 8, 1997 edition of *the Washington Post*, "The regulatory maze has spawned an industry of billing consultants who help health care businesses maximize their reimbursements-and avoid fraud." None of this should be surprising. Forty centuries worth

of experience with government price controls shows that they not only breed black markets, but they also encourage the worst sort of corruption.

Needless to say, the effect of Medicare's "cost control" efforts over the past 30 years-caps, freezes, adjustments and manipulations, has been negligible on the fiscal health of the Medicare program.

When Medicare was enacted in 1966, the government actuaries made future estimates on future expenditures for part a so that the payroll tax could cover projected costs. But the real costs have invariably outrun the official estimates. The reason: Congress likes to add benefits and thus higher costs to the program. Coupled with this, the program was unable to cope effectively, and indeed contributed to, the increases in medical inflation, a condition aggravated by increased utilization by an aging population with a longer life expectancy.

Now, a demographic tidal wave is on the horizon. The rapid aging of the American population is the single most important demographic fact of modern life. The 77 million baby boomers, the biggest bulge in the population pipeline, have not replaced themselves, and the ratio of workers to retirees is going to shift in a decidedly unfavorable direction soon after the turn of the century. According to the nonpartisan Committee for Economic Development, over the next thirty five years, the ratio of active workers to retirees will drop from 3.4 to 1, to only about two workers for each non-working beneficiary, a 41 percent decrease.

Meanwhile the cost of Medicare has grown dramatically, especially in recent years, and is emerging as a major drain on the limited resources of the taxpayer. According to former HCFA actuary Guy King, for every $1 dollar spent by the elderly in Medicare, the taxpayers pay $5. With the rapid aging of the American population, this pattern will accelerate, and the cost of Medicare, and entitlements generally, will reach crisis proportions. According to a 1996 report of the nonpartisan a Committee for Economic Development, "If changes aren't made, combined Social Security and Medicare taxes could consume 28 percent of each working person's paycheck by the year 2030. All this before considering any local, state or federal taxes."

The Necessity for Structural Reform

It is true that making adjustments to the current system-like raising Part B premiums or the retirement age or means-testing of Medicare premiums or deductibles-can have sound fiscal consequences for the future of the program. But Medicare should not be viewed simply in budgetary terms.

We can do better. We have an opportunity to be more creative and make fundamental structural changes in the system in a way that is more directly beneficial for both the elderly enrolled in the program and the working taxpayers who now so generously support it.

The Medicare system is going to be changed. It is inevitable. But for members of Congress, as well as senior citizens, there are some controlling questions well beyond the issues of finance.

Before you make up your mind about how the Medicare system should be changed, you should ask yourself these basic questions. And so should every current and future retiree. They will determine the kind and quality of health care for the next generation of American retirees.

First, who is going to make the key decisions in the system? These decisions cover a broad field of intimate matters: who is going to make the decision about what kind of plan you are going to have; what kind of benefits you will have ; what kind of treatments you will have; what kind of prescription drugs or catastrophic coverage you will have; what you will pay in copayments, deductibles and premiums; and how you will pay; who will choose your doctor; who will determine your access to a specialist; who will decide what treatments or medical procedures are available to you? If there are going to be limits to your medical treatments, who will decide that these treatments are to be limited? These are the key questions to be answered in any program of Medicare reform.

Do we want Congress to make these decisions? An unelected board appointed by the President? Officials of the Health Care Financing Administration? Or should individuals and families, in consultation with their doctor, make these decisions? These are not just rhetorical questions.

Second, who controls the dollars, or more precisely, who controls the flow of dollars in the system? Once again, these are critical issues: who decides how much doctors are to get paid, and how they are to get paid. Remember that those who control the flow of dollars in the system control the system; they drive it, shape it and determine its character.

Using Congress's Health Care System As a Basis for Reform

My colleagues at the Heritage Foundation favor an entirely new model for Medicare, but not one that is either untested or without a long track record in the financing and delivery of high quality medical services. I am speaking, of course, of the Federal Employees Health Benefits Program (FEHBP), a unique consumer-driven system that is based on the two key free market principles of consumer choice and competition . A detailed outline of the Heritage Foundation proposal is presented in the 1995 winter edition of *Health Affairs.*[1]

In 1997, the 37 year old federal health insurance program has over 600 health care options nationwide, ranging from large traditional fee for service plans to geographically based HMO's, competing for the dollars of members of Congress and Congressional staff and federal workers and retirees and their dependents, altogether almost 9 million souls. Congress should not overlook that fact that FEHBP also includes 1.6 million federal retirees and their dependents, including an estimated 200,000 federal retirees remaining in the system who, because of their civil service retirement status, are not eligible for Medicare coverage.

Today's Medicare beneficiaries are rightly concerned about any future changes to the Medicare system. Tomorrow's retirees are going to live well into the next century with the consequences of

[1] Stuart M. Butler and Robert E. Moffit, "The FEHBP as a Model for a New Medicare Program," *Health Affairs*, Vol. 14, No. 4 (Winter 1995), pp. 47-61, and the People-to-People Health Foundation, Project HOPE, http://www.projhope.org/HA/; see also, "Congress's Own Health Plan as a Model for Medicare Reform." Heritage Foundation *Backgrounder* No. 1123, June 12, 1997.

Congressional decisions to be made over the next few years. And, in considering the future direction of change, they should ponder whether members of the Senate and the House of Representatives have been successful in crafting for themselves a first rate system of private health insurance program with a broad range of private plans and choices.

After almost four decades of operation, we know well the strengths and the weaknesses of the FEHBP. On balance, the evidence on the positive side of the ledger is solid. It is something that Congress can work with to create an even better system for senior citizens.

Take the subject of cost control. Historically, in terms of cost control, the FEHBP has outperformed both Medicare and the private employer based insurance. In recent years, the comparative record has been rather dramatic. In 1994, FEHBP registered a total average premium increase of a little more than 3 percent, and 40 percent of all enrollees, including retirees, saw decreases in their premiums. In 1995, the FEHBP premiums decreased by 3.3 percent, a record unmatched in the private sector. In 1996, FEHBP premiums increased just four tenths of one percent. And this year, FEHBP premiums averaged an increase of only 2.4 percent.

The FEHBP is performing even better than its own numbers show. This is true for two reasons. First, in recent years, FEHBP benefits, in a direct reversal of trends in the private sector, have actually gotten progressively richer and even more varied. This has been the case, even as the FEHBP is registering a more competitive premium performance. Secondly, the FEHBP, unlike most private sector employer based plans, covers a large number of retirees, who, *even with*

Medicare coverage, tend to be more expensive than active employees. In recent years, while the federal active employee population has stabilized, the proportion of federal retirees has grown.

Some of the success of the FEHBP has been written off to the character of the federal workforce, a stable group of relatively healthy folks with higher incomes. Contrary to popular misconceptions this is not an ideal insurance pool. Not only is approximately 40 percent of the program's enrollment federal retirees and their survivors, but the workforce itself is also older than the private sector workforce. The average age of federal workers is almost 44 years of age; the average federal salary is little more than $37,000 per year. Given the generally positive experience of the FEHBP, especially for federal workers and retirees, we have something solid to work with in devising a comprehensive reform of the current Medicare program for the next generation. To make the transition to such a new system successful, however, Congressional policy should be governed by three key principles:

First, the decision of current enrollees to opt out of traditional Medicare into a private insurance plan should be purely voluntary. Nobody on Medicare today should be forced to do anything that they do not want to do. If a person likes the current Medicare system as it is today, including the purchase of extra medicgap insurance for catastrophic coverage and prescription drugs, then a person should be able to keep it.

Second, congress should guarantee the maximum flexibility to new retirees to choose or to keep the private insurance plan of their choice. If a person getting ready for retirement, for example, wants to keep their private-company based plan, or a plan sponsored by their union-like many Taft Hartley plans that exist today-they should also be able to do so.

A new Medicare system based on the principles of consumer choice and competition is not incompatible with private employer based insurance for retirees. It should give new retirees an option at the time of retirement. They could keep their private or corporate insurance and secure a Medicare contribution to offset its cost. This kind of option would be especially appealing to corporations which wanted to retain retirement health coverage as an attractive employee benefit. One of the major problems in corporate benefits programs has been the regrettable reduction or scaling back of private sector coverage for retirees. This option would, of course, change those dynamics.

Third, Congress should change Medicare from a defined benefit to a defined contribution system. In any case, this personal choice should be clearly underwritten by a defined government contribution. The federal government would contribute a certain amount toward the cost of a health care plan. In principle, this is what the federal government does for congressional and federal workers and retirees today. There are a wide variety of ways to do this. Perhaps the best option is to have HCFA establish a special Medicare account, with an electronic transfer from the Treasury to a plan of a retirees choice. This is similar to the way

federal payments are made to FEHBP plans of the federal worker's choice today. In transferring the defined contribution, HCFA could cover a certain percentage of the premium for the plan of the person's choice, according to a formula, with a maximum dollar amount of the contribution. For federal workers and retirees, that contribution can be up to 75 percent of the cost of any plan. Again, this is the way the federal government contributes to federal workers and retirees plans. Congress could easily improve on the current federal formula, an arrangement driven more by the peculiar politics of the civil service than a paradigm of market efficiency.

However the determination and the transmission of a defined contribution is accomplished, both in principle and in its economic effects, the retiree would control the flow of money. If the retiree bought a plan that cost less than the government's contribution , they would be able to pocket the savings. If the retiree wanted to purchase more coverage than found in a basic benefits package, they could do so, and pay more, just like federal employees and retirees do today.

By giving Medicare beneficiaries direct control of the dollars, they could use them on the existing Medicare plan, or any variety of private insurance plans, whether independent, association plans or employer or corporate based plans or a medical savings account (MSA) plan with high deductible, catastrophic insurance coverage. Outside of basic consumer protection rules, the use of the government contribution should be *neutral* in terms of the kind of health insurance options that retirees could buy, whether these plans be conventional fee for service plans, plans sponsored by unions or employee organizations, or various managed care options ,

including preferred provider organizations , provider sponsored organizations, or health maintenance organizations.

In this connection, it is well to reaffirm a simple point, especially in the context of the managed care revolution that is sweeping the private sector: expanded consumer choice in the Medicare system is not simply an expansion of managed care options. In recent years HMOs have come under serious criticism for weakening the delivery of high quality health care services. But in a consumer choice system individuals and families can act directly on that criticism and fire their insurance company. Managed care, like other options in the FEHBP, is a matter of personal choice. Today, for example, approximately 30 percent of all federal enrollees are voluntarily enrolled in HMOs. But unlike many private sector employees, they are not forced into them. In designing a future consumer choice system for Medicare, Congress should strive for maximum consumer choice.

Key structural ingredients for Medicare reform

In establishing a consumer choice system in Medicare, Congress would have to make some key decisions on the financing and administration of the program.

1. **Be clear about the amount of the government contribution.** Congress would have to determine the amount of the government contribution and its future increases on the basis of an equitable formula. One possibility is to improve upon the mixed experience of the average area per capita cost(AAPCC) mechanism that Congress has devised for managed

care payments. (Currently the law sets this amount at 95 percent of the average cost of fee for service in a geographical area). Congress should modify it according to demographic or other relevant characteristics.

In any case, the amount of the government contribution and its formula for growth should be explicit. The taxpayers should know, clearly, what they are going to pay, and the beneficiaries should know what they are going to get.

The *per capita* cost of the Medicare program is today approximately $5,000 per beneficiary. This is a substantial base of funding for financing a new consumer choice system for retirees, especially when one considers that the maximum amount that the federal government today contributes to federal worker and retirees, including retirees that do not have Medicare hospitalization , is approximately $1600 per person and $3600 per family. Congress could adjust future contributions on the basis of whatever formula (such as AAPCC) it deems appropriate . That is a political decision and does effect the basic structure of the reform proposal.

2. Vary the government contribution to meet the needs of retirees. The government contribution should be adjusted by age, sex and geography, intended to cover the actuarial equivalent of hospital and physicians services. Using the experience of the FEHBP as a guide, it is not necessary for Congress to adjust it for health status. Age, sex and geography are quite sufficient and account for a substantial portion of risk in health insurance and the demand for medical services. Age, of course, is the most significant factor.

Moreover, Congress should also consider means-testing the government contribution, with a view toward channeling more funding to lower income people and less to higher income people.

3. Establish basic underwriting rules for health insurance. Just as the government contribution should be varied according to age, sex and geography, Congress should establish rules that health insurance premiums for the elderly would also be varied by age, sex and geography. Beyond enforcing basic insurance underwriting standards, Congress should also allow for insurance premium discounts for persons who enroll in preventive health programs, health promotion programs or engage in any other activities that are designed to promote healthful lifestyles.

4. Establish clear standards for private health plans competing for retirees dollars. Somewhat like the role played today by the United States Office of Personnel Management (OPM) in administering the FEHBP, the Health Care Financing Administration (HCFA) could enforce some basic health insurance plan requirements. These basic requirements should guarantee protection for consumers, be fair and equitable to insurance carriers, and reflect OPMs experience in administering limited but effective regulation.

For example, competing private plans should have to meet basic fiscal solvency requirements; provide catastrophic coverage, and, like FEHBP, have a core set of health care benefits including hospitalization and physicians services. A private plan should also clarify its services and its costs in plain English, just like federal plans are required to do so today. This requirement would

enable retirees to pick and choose among plans with greater ease, and reduce or eliminate confusion among consumers. HCFA, of course, assisted by the HHS Inspector General and the Department of Justice, would enforce laws against consumer fraud.

5. Limit the capacity of the federal bureaucracy to restrict consumer choice and competition in a reformed Medicare system. If Congress is opening the front door to a real system of consumer choice and competition by law, it should prevent its progressive destruction through the backdoor by government regulation. The success of the FEHBP is largely attributable to the simple fact that OPM staff have generally pursued a 'passive management' of the system throughout most of its history. The level of government regulation in the FEHBP is remarkably low compared to other government health programs. The reason, of course, is that the heavy lifting in the FEHBP is done by powerful market forces of consumer choice and competition. Moreover, virtually every major problem with the FEHBP is attributable to government policies that frustrate or restrain the market, such as the FEHBP's crude system of "community rating" for insurance which directly contributes to adverse selection problems, or OPMs historic bias against high deductible health insurance plans and flexible spending accounts.

Congress can prevent similar problems from occurring in the new Medicare consumer choice system. If HCFA is to retain regulatory authority over a new consumer choice system, Congress should impose clear restraints on HCFA. Specifically, HCFA should be prohibited from: imposing or administering any system of price controls, fee schedules, caps on premiums or spending restrictions on any competing private health insurance plan; setting up health insurance

cartels, oligopolies, or government- sponsored purchasing cooperatives; imposing government medical practice guidelines on physicians or any other health care providers working through private plans; imposing any comprehensive and detailed standardized benefits package beyond the provision or certification of the *core* categories of benefits; making any determination regarding which treatments or medical procedures a private plan may offer to retirees.

6. Reinvent HCFA into a patient- friendly, physician-friendly institution.

Under a new Medicare choice system, Congress could give HCFA the authority to *certify* competing private plans, making sure that they meet basic benefit, consumer protection and fiscal solving requirements.

Another Possibility: Congress could decide to give HCFA authority to negotiate rates and benefits with private health plans on behalf of senior citizens, just like OPM does today for federal workers and retirees. Alternatively, Congress could simply relieve HCFA of that responsibility altogether, and give the responsibility to the staff at OPM, detailing them to a task which they already perform on a yearly basis. In any case, HCFA should not simultaneously be in the business of running the traditional Medicare program and regulating the private competition. If HCFA is to retain regulatory authority, then Congress should transfer responsibility for running the traditional Medicare program to an independent board or commission, which would have to submit bids and compete for the business of America's senior citizens just like any other private plan.

HCFA would have a new role. Instead of being a regulatory superpower, administering complex price controls and issuing thousands of pages of detailed rules and guidelines, HCA's new role in a consumer choice system would be reduced to adjusting the government contribution to private plans; certifying plans for their fiscal solvency; ensuring protection against fraud and abuse; and making sure that the private plans who compete in the Medicare program meet certain requirements for basic benefits or catastrophic coverage for the elderly. Like the Office of Personnel Management (OPM) in administering the FEHBP, HCFA and its 10 regional offices around the country, could also serve as a basic objective source of comparative plan information. It is likely that, just like the FEHBP, this basic information will be supplemented by private sector plan evaluations, consumer information services , and independent ratings of plan performance by consumer organizations and senior citizen private organizations, such as the American Association of Retired Persons (AARP), among others.

Conclusion

A new Medicare system that looks like the kind of system that covers members of Congress and federal workers and retirees presumably would have the same basic dynamics. In other words, you would have a system with far greater flexibility, unprecedented levels of choice in benefits and plans, and an opportunity for elderly Americans to do what only federal workers and retirees can do now and that is personally pick and choose the plans and benefits they want from a wide variety of options, and pocket the savings of those decisions.

In changing the system in this way, you would, of course, also open up opportunities for private sector organizations and institutions, including professional and trade associations and even religious institutions to sponsor heath plans, or monitor their quality and performance. Recall that today, approximately one third of all persons enrolled in the FEHBP are enrolled in employee organization health plans. And just as the National Association of Retired Federal Employees (NARFE) rates health plans, the AARP and similar organizations could become consumer advocates for elderly citizens.

This structural change brings with it an additional benefit. Just like the FEHBP, a system based on consumer choice and competition, financed on the basis of a defined contribution, would discourage the fraud and abuse that plagues the current Medicare program. As the editors of *The New York Times* of August 1, 1997 have noted, this solution to the fraud problem is the best solution: "Health plans that collect a fixed dollar amount for treating Medicare enrollees will have no reason to overbill Washington for treatments that are inappropriate or dangerous."

The basic idea of a consumer choice system grounded in the experience of the FEHBP has been floated in one form or another by a variety of leaders and institutions, including the American Medical Association, the progressive policy institute and the Federation of American Hospital systems. Details differ. But the use of the FEHBP as a model for reform has been embraced in principle by liberal democrats like senator Ron Wyden of Oregon and conservative republicans like senator Judd Gregg of New Hampshire. The breadth of support for such a reform should not be surprising. We have seen it in operation for almost four decades. And it works.

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The CHAIRMAN. Dr. Goodman.

STATEMENT OF JOHN C. GOODMAN, PRESIDENT, NATIONAL CENTER FOR POLICY ANALYSIS

Mr. GOODMAN. Senator Grassley, Senator Hagel, ladies and gentlemen, the key to understanding the financing problem for Medicare is to appreciate that Medicare, like Social Security, is a pay-as-you-go program. Every dollar that is collected in payroll taxes is spent; is spent the very minute, the very hour, the very day it comes in the door.

Nothing is being saved. No investments are being made in real assets. No cash is being stashed away in bank vaults.

What this means is that next year and the year after that as the costs of this program continue to rise, we are going to have to collect more and more taxes from future taxpayers. Now, how high will those tax burdens become?

Every year the trustees of the Social Security Administration put out a fairly thick report giving their projection about the future. With all due respect to Professor Bernstein, the prudent and the cautious thing to do is to make these projections, because as we pile up these liabilities for future generations, it is interesting and prudent to know exactly what kind of taxes we expect our future workers—many of whom are not yet born—to face. High do we expect their burden to be.

Every year at the National Center for Policy Analysis we get these reports from the actuaries of the Social Security Trustees, and they do not make pleasant reading, I must say. What they show us, though, is that the further we look into the future, the higher the tax burdens are going to be.

So, for example, suppose we take a young person who, say, is turning 18 years of age next year and going off to college. When that person retires he will have to reach the age of 67 before he is entitled to receive any social security benefits, and that will occur in the year 2045.

Suppose we take, then, the Social Security Trustees forecasts and go out to the year 2045 and see what things look like. The actuaries are forecasting in that year just to pay Part A benefits under Medicare we are going to need a payroll tax that takes more than 10 percent of workers' income. In other words, one out of every ten dollars workers earn is going to have to be collected by government just to pay for Part A. Using the same method of calculation for Part B, we are going to need 15 percent of all workers' income to pay Part A as well as Part B benefits.

Now, one of the things that disturbs us at the National Center for Policy Analysis is the disturbing tendency to move things out of one program into another, and especially to shift to the private sector so as to make the burden look less burdensome than it really is.

We note, for example, that Medicare is not the only way we pay medical expenses for the elderly. We also have Medicaid; we have the VA system. Increasingly the government is trying to shift burdens over to employers. It does not matter what pocket you pull it out of. We still have the same total burden.

So what we have done is we have added onto the forecast of the Social Security Trustees our own calculation of other ways of paying for health care for the elderly. When we do that we find in the year 2045, when today's college students will be retiring, that the burden of all government health care for the elderly will be 23 percent of workers' payroll; one out of every four dollars they earn. If we add on Social Security, by the way, we are going to need 40 percent of everything workers earn. This is the intermediate, mainstream forecast of the trustees.

Now, a couple of points about this. Number one, although Social Security is the problem most talked about, the long-term financing crisis of Medicare tends to be ignored. By the time today's college students retire, the burden of Medicare is going to be almost as great as the burden of Social Security. By the time they get through the retirement years, the burden of Medicare will be greater than the burden of Social Security.

The second point I want to make is: That tells us something about the problem of trying to solve this problem by means testing or by charging; higher premiums to the elderly. Suppose, for example, that we said to all of today's college students, "When you retire you are going to have to pay for your own Medicare. We are not going to subsidize it. We are going to collect a premium from you equal to its cost." That would be the equivalent of saying to college students, "When you retire you are not going to get a Social Security check."

In other words, trying to solve the problem of Medicare by charging higher and higher premiums to the elderly means eventually getting rid of Social Security to save Medicare. That, I do not think, is the solution.

Now, the numbers are worse than this. They also publish a pessimistic forecast. On pessimistic assumptions, by the time college students reach retirement age, we are going to need almost 20 percent of payroll in order to pay Part A benefits; one out of every five dollars young people earn. In order to pay Part A and Part B, we will need 30 percent of their income. In order to pay all medical expenses through all the government programs for the elderly, we will need 45 percent of income. When you tack Social Security onto it, we are going to need two-thirds of all income that young people earn.

Now, no one thinks that the government is ever going to be able to collect this kind of tax burden from young people just to pay benefits for the elderly.

I might also say there is a certain sense in which all of this is conservative, even as alarming as the numbers may sound. The actuaries they acknowledged, as all health economists acknowledge, that we cannot stay on the type of path that we are now on.

Over the last decade health costs rose at about twice the rate of growth of the economy as the whole. If you continue on that path for the middle of the next century, health expenses are going to eat up 100 percent of gross national product. That simply cannot happen.

So what the actuaries said is, "Well, look. If we allow that to happen, our numbers are just going to go off the page." So they artificially limited the growth of health care without ever saying how

that is going to happen. That is how they kept their forecast numbers as low as they actually are.

Another problem in all of this is the assumption that the government can actually get the revenue. The tables are assuming that the government can actually collect in taxes the revenue it needs.

In fact, we have discovered whenever there is any major tax increase like this, you usually lose about a third of what you hope to get because there is more avoidance; there is more evasion; people report less taxable income. So a good rule of thumb is to increase everything by a third to get the tax rate you are really going to need to get the money.

What about the trust funds we hear about and are going to hear a lot more about? Actually, I wish we would get rid of these trust funds, Mr. Chairman, because they mislead everyone.

Most countries with pay-as-you-go systems do not even have a trust fund. Our trust funds are simply side accounting entries. When we collect more in Medicare taxes than we pay out in Medicare benefits, we keep track of that. We make a bookkeeping entry. When we pay out more in benefits than we collect in taxes, we subtract from those bookkeeping entries.

Now, technically there are government bonds that are in these trust funds, but they are very special kinds of bonds. The trustees cannot sell them on Wall Street; they cannot sell them to foreign investors. The only thing they can really do is hand them back to the Treasury. So in this sense these are IOUs which the government has written to itself.

Every asset of a trust fund is the liability of the Treasury. They net out to zero. So for the government as a whole, the only way to pay benefits is to go collect taxes or borrow. The trust funds do not allow us to pay benefits.

So what is the solution to the problem? We have heard several recommended so far.

Fraud and abuse. I am against it. We should go out and try to reduce it. But talking about fraud and abuse in the context of the numbers I am giving you is like rearranging the chairs on the deck of the Titanic. It misses the problem.

We have heard about raising the eligibility age, but you need to remember that we are living in an age where people want to retire earlier; not later. If you raise the eligibility age, that means you are just trying to push more cost off onto the retiree. It does not solve the problem.

Raising premiums, making the elderly pay more for their benefits—again, for reasons I have given—that does not solve the problem.

All of this stems from the fact we have a pay-as-you-go system. We have taken a chain letter approach to financing the needs of the elderly, and that is going to work for the current generation of retired people. It is not going to work for your children and grandchildren.

So what we have to do, the only prudent and cautious thing to do, is to move to a system under which young people put aside money in accounts, medical IRAs, medical savings accounts, that build up through time so the young generation saves to pay for its own benefits; it does not expect some future, unborn generation of

workers to carry those huge tax burdens. That is a huge tax burden.

So each generation pays its own way; the family pays its own way; the individual pays his or her own way. After you pass through those filters, only then do you turn to government and ask the young generation to make up any difference.

Those are the kinds of solutions, Mr. Chairman, that we need to think about. We need to be bold. We need to be aggressive. That is the only way that we are going to protect the future for today's young people.

Thank you.

[The prepared statement of Mr. Goodman follows:]

The Future of Medicare

The federal government's own forecasts show that the Medicare program is on a collision course with reality. The taxes that will be needed to pay benefits in the future are far in excess of what taxpayers realistically will be willing to pay. Moreover, we cannot avert disaster by relying on quick fixes and minor changes. The only real solution is to move soon to a fully funded retirement system under which each generation pays its own way.

Forecasts of the Trustees

The key to understanding elderly retirement programs is to recognize that they are all based on pay-as-you-go finance. Social Security and Medicare benefits for today's retirees are paid with taxes collected from today's workers. When today's workers retire, their Social Security and Medicare benefits will have to be paid with taxes collected from future workers. The Medicare and Social Security Trustees make three forecasts, based on different economic and demographic assumptions — "high cost," "intermediate" and "low cost" forecasts. For ease of discussion, I will term these "pessimistic," "intermediate" and "optimistic." People are encouraged to believe that the intermediate forecast is the most likely. But many students of Medicare and Social Security believe that the pessimistic projection more closely reflects our recent experience. (See Table I.)

The analysis that follows is based on the assumptions and forecasts published in the trustees' 1997 reports. For reasons discussed below, these reports are focused on actuarial balance, rather than on future tax burdens. Nonetheless, a presentation of some of the projected tax burdens can be found in the reports and is reproduced as an appendix to this testimony.

Medicare Part A. In 1996, Medicare Part A (the Hospital Insurance Trust Fund which pays primarily for inpatient hospital services) spent $5.3 billion more than it took in. The deficit is projected to grow each year for as far into the future as we care to look. Under the intermediate assumptions, Medicare Part A is forecast to require 9.86 percent — almost one out of every ten dollars — of the taxable payroll by 2040, when today's 22-year-olds retire. (See Table II.) Based on the pessimistic forecast, Medicare Part A will cost 18.78 percent of taxable payroll by 2040. (See Table III.)

These results are highly sensitive to increases in health care costs. In recent years, health care costs have been increasing at twice the rate of real wages. Were this trend to continue, health care spending would consume the entire gross domestic product by the middle of the next century. The Trustees understand that this is impossible, so they have arbitrarily assumed that health care costs will rise at the same rate as hourly wages in their intermediate forecast. The optimistic forecast assumes an annual increase 2 percentage points less and the pessimistic forecast assumes an annual increase 2 percentage points more. But even the optimistic and pessimistic forecasts assume convergence with the intermediate assumptions in the year 2045.

Medicare Part B. Medicare Part B (which primarily pays doctor bills and other outpatient expenses) is financed in part by monthly premiums that currently equal about 25 percent of the cost. General revenue pays the remainder. The Trustees project the government's share as a percentage of GDP. To give a clearer picture of the impact on workers, we have converted the projection to a percentage of Part A's taxable payroll. Under intermediate assumptions, the government's share of Medicare Part B will climb to 5.77 percent of taxable payroll in 2040, assuming that the elderly continue to pay one-fourth of the cost. (This is a conservative assumption; since premiums are restricted to grow no faster than Social Security payments, the elderly's share of Part B costs will fall to about 6 percent by the year 2070 under current law.) According to the pessimistic

forecast, Part B cost will reach 10.99 percent in 2040. The government's combined spending on Parts A and B ranges from one out of every seven dollars (intermediate) to almost one out of three dollars (pessimistic).

As with Medicare Part A, the Trustees have arbitrarily restricted the growth rate of medical costs for Part B. In this case, health care costs are assumed for the intermediate forecast to grow at the same rate as GDP per capita. The optimistic and pessimistic forecasts assume growth rates 2 percentage points lower and 2 percentage points higher, respectively.

Other Government Health Care. Medicare is not the only way we pay for the medical bills of the elderly. We also pay through Medicaid for the poor, the Veterans Administration system and other programs. These expenditures are funded by general revenues. Health economists at the National Center for Policy Analysis have calculated this spending at 40.4 percent of Medicare spending, based on findings reported in the *Health Care Financing Review*. Based on the intermediate assumption, this burden will rise to 7.09 percent of taxable payroll in 2040. Based on the pessimistic assumption the burden will reach 13.51 percent in 2040.

When all health care costs paid by government are combined, the burden ranges from almost one of every four payroll tax dollars (intermediate) to more than two out of every five (pessimistic). In other words, to pay the medical bills of the elderly about the time today's college students retire, government may need to claim upwards of 40 percent of the income of workers at that time. (See Tables IV and V.)

All Elderly Entitlements. Spending on Social Security benefits currently takes about 11.5 percent of taxable payroll. When total Medicare benefits are added in, the figure rises to more than 16 percent of taxable payroll. With other government health care, about 19 percent of the nation's taxable payroll is being spent on elderly

entitlements today. By the year 2040, we have effectively pledged between 40 percent (intermediate) and almost two-thirds (pessimistic) of the income of future workers.

Figures I and II show elderly entitlement spending as a percent of taxable payroll under both the intermediate and pessimistic assumptions. Bear in mind that these forecasts assume that taxable payroll in the future will be the same, whether the tax rate is 15 percent or 80 percent. Experience shows otherwise. In the face of higher tax rates, people work less and avoid or evade taxes more. A good rule of thumb is: you will lose about one-third of the revenue you plan to receive from a significant tax hike.

We have had little experience with tax rates in excess of 35 percent to 45 percent for middle-income taxpayers. But we have had a lot of experience with tax rates above the range for the highest income earners. In general, whenever we have increased the rate for the highest income earners, their total tax payments have gone down, not up. In other words, beyond a certain point, higher tax rates do not collect additional revenue. Although the highest income earners have greatest discretion over how they receive income and the greatest skill at avoiding taxes in the face of high marginal rates, this is a skill that other taxpayers can learn.

The Illusory Trust Funds

Most countries with pay-as-you-go retirement systems don't even have trust funds. We would probably be wise to follow their example. The funds not only mislead people — who think their taxes are actually being invested in something — they distract attention from the real funding problem.

Every payroll tax check sent to Washington is written *to* the U.S. Treasury. Every Social Security benefit check and medical reimbursement check is written *on* the U.S.

Treasury. The trust funds are merely an accounting system — totally unessential to any real activity.

Technically, the trust funds hold interest-bearing U.S. government bonds, representing the accounting surplus of payroll taxes collected minus benefits paid. But these are very special bonds. The trustees cannot sell them on Wall Street, or to any foreign investor. They can only hand them back to the Treasury. In this sense, these bonds are IOUs the government has written to itself.

On paper, the Social Security trust funds have enough IOUs to "pay" Social Security benefits for about 18 months on any given day; the Medicare trust fund can "pay" benefits for not quite one year. In reality, they cannot pay anything. Handing IOUs back to the Treasury does not increase the size of Uncle Sam's bank account one iota. In order for the Treasury to write a check, it must first tax or borrow.

The existence of the trust funds has merely served to mask the unsustainability of our Social Security and Medicare systems in their current form. For example, the annual report of the Trustees of the Social Security trust funds tends to focus almost exclusively on the concept of *actuarial balance*. This treats bonds in the trust funds as assets (the way accountants would do if they were auditing a private pension fund) and ignores the fact that every asset of the trust funds is a liability of the Treasury. For the government as a whole these assets and liabilities net out to zero. If the trust funds were simply abolished, there would be no effect on real economic activity. No private bondholders would be affected. The government would not be relieved of any of its existing obligations or commitments.

Economist Robert Eisner has suggested that we abolish the trust funds or, with the stroke of a pen, double or triple the number of IOUs they hold. Either option would

allow us to dispense with artificial crises and get on to the real problem: how is the Treasury going to pay the government's bills?

Solutions

The alternative to funding retirement benefits by income transfer is to fund benefits by saving. The alternative to creating escalating burdens for each successive generation of workers is for each generation to save for its own retirement benefits and pay its own way. While these ideas may appear radical, they are not without international precedent. Although the vast majority of countries have pay-as-you-go retirement benefits, a number of countries have avoided, or at least limited, the chain-letter approach to retirement income that characterizes our elderly entitlements programs.

If the United States is to move from pay-as-you-go systems to fully funded private systems, we must find a way to make the transition. All serious proposals made to date have involved giving individuals tax deductions or tax credits for deposits to private investment accounts. In return for the right to make such deposits, individuals (roughly speaking) would give up the right to draw a dollar in benefits for each dollar deposited in their private accounts. After a number of years, the private account balances would grow to a point at which the account holders' claims against government programs would be zero. Through such a mechanism, individuals could opt out of Medicare, Social Security and the survivors and disability system as well.

In this way, the U.S. could move quickly toward a private savings alternative to pay-as-you-go social insurance and avoid the financial crisis that looms in our future. The experience of other countries demonstrates that this is an option well worth considering.

FIGURE I

Elderly Entitlement Spending As a Percent of Taxable Payroll

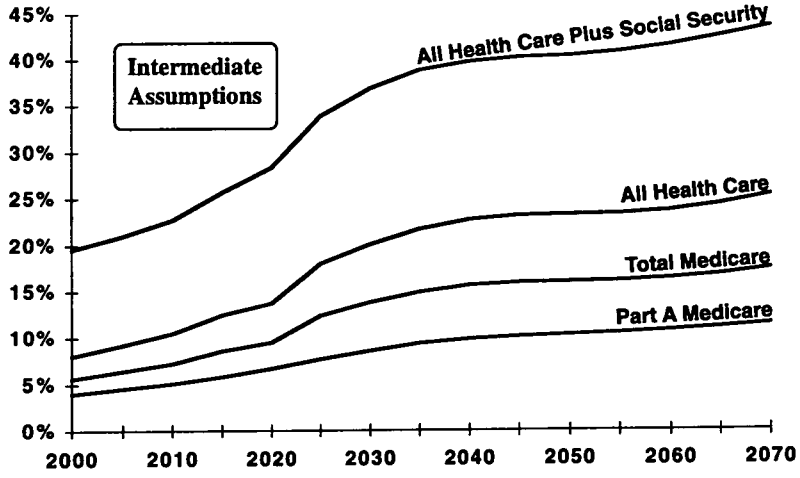

FIGURE II

Elderly Entitlement Spending As a Percent of Taxable Payroll

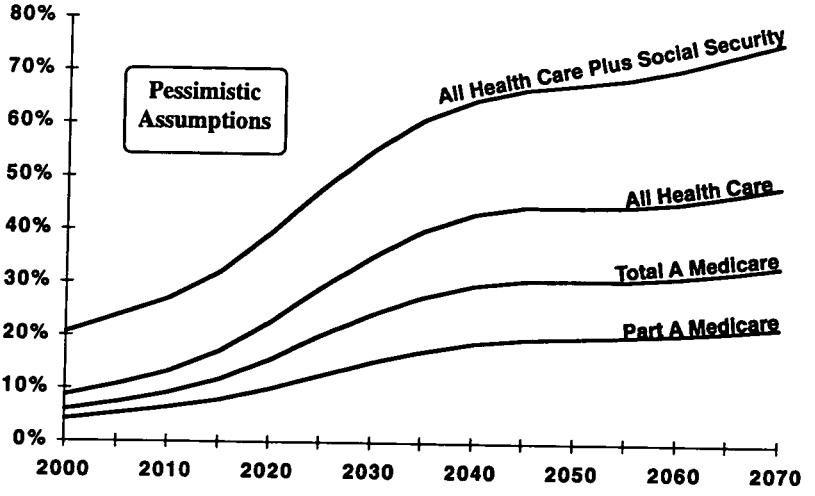

TABLE I

Key Economic and Demographic Assumptions for the Year 2020

Assumption	Recent Experience	Optimistic Projection[1]	Intermediate Projection[2]	Pessimistic Projection[3]
Total fertility rate	1.93[4]	2.2	1.9	1.6
Annual increase in real wages (%)	0.5[5]	1.4	0.9	0.4
Annual increase in consumer price index (%)	4.6[6]	2.5	3.5	4.5
Annual decrease in mortality rate (%)	0.9[7]	0.2	0.5	0.9
Annual increase in hospital costs (%)	12.8[8]	5.6	8.1	10.6

[1]Based on the Social Security Administration's Alternative I assumptions.

[2]Based on the Social Security Administration's Alternative II assumptions.

[3]Based on the Social Security Administration's Alternative III assumptions.

[4]Average number of children per woman of childbearing age for years 1980 to 1995.

[5]Average annual real wage rate for the years 1980 to 1995.

[6]Average annual increase for the period 1980 to 1995.

[7]Average annual decrease in the age/sex-adjusted death rate for the years 1980 to 1995.

[8]Measured as the annual rate of increase in Medicare inpatient hospital insurance payments for the years 1980 to 1995.

Source: *The 1997 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and the Federal Disability Trust Funds* Tables II.D.2 and *The 1997 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund* Tables I.D.1 and II.F.3.

TABLE II

Elderly Entitlement Spending As a Percent of Taxable Payroll[2]

Intermediate Assumptions

Calendar Year	Part A Medicare	Part B Medicare[2]	Other Government Health Care for the Elderly[3]	Social Security
2000	3.96%	1.62%	2.47%	11.49%
2005	4.53%	1.87%	2.84%	11.71%
2010	5.08%	2.20%	3.24%	12.15%
2015	5.82%	2.78%	3.85%	13.20%
2020	6.74%	2.77%	4.22%	14.62%
2025	7.70%	4.65%	5.62%	15.92%
2030	8.63%	5.17%	6.27%	16.78%
2035	9.37%	5.57%	6.78%	17.10%
2040	9.86%	5.77%	7.09%	17.02%
2045	10.17%	5.77%	7.22%	17.00%
2050	10.36%	5.62%	7.21%	17.16%
2055	10.54%	5.51%	7.23%	17.51%
2060	10.80%	5.55%	7.35%	17.84%
2065	11.13%	5.72%	7.58%	18.07%
2070	11.50%	5.99%	7.87%	18.26%

[1] Taxable payroll used to compute all the tax rates in this table is the tax base for the Old-Age, Survivors and Disability Insurance program (referred to as Social Security). It consists of wages and salaries of workers in employment covered by Social Security up to a maximum of $65,400 in 1997 for any worker. Actual taxable payroll for Medicare Part A is larger than that for Social Security because there is no maximum and more workers are covered. See 1997 *Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds*, Table III.A.2. Spending is net of the income tax revenues collected on Social Security benefits. Taxation of benefits is projected to amount to 0.23 percent of taxable payroll in 1997, increasing to 0.64 percent of taxable payroll by the year 2070. See *Board of Trustees Report*, Table II.F.17.

[2] The Part B calculations are based on the Trustees' intermediate projections of the ratio of Part B to Part A as a percentage of gross domestic product, and assume that Part B participants will continue to pay 25 percent of this amount through premiums. See 1997 *Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund*, Table III.A.1.

[3] Includes obligations through all government health programs, including Medicaid and the Veterans Administration. In 1987, per capita spending by people age 65 and over from Medicaid and other government health programs was 40.4 percent of Medicare spending. This study assumes the same relationship over the 75-year projection period. See Daniel R. Waldo, Sally T. Sonnefeld, David R. McKusick and Ross H. Arnett, III, "Health Expenditures by Age, Group, 1977 and 1987," *Health Care Financing Review*, Vol. 10, No. 4, Summer 1989, Table 4.

TABLE III

Elderly Entitlement Spending As a Percent of Taxable Payroll

Pessimistic Assumptions

Calendar Year	Part A Medicare	Part B Medicare	Other Government Health Care for the Elderly	Social Security
2000	4.27%	1.75%	2.67%	11.97%
2005	5.30%	2.19%	3.32%	12.97%
2010	6.40%	2.78%	4.08%	13.74%
2015	7.94%	3.80%	5.25%	15.00%
2020	9.98%	5.54%	7.02%	16.77%
2025	12.49%	7.54%	9.11%	18.57%
2030	15.08%	9.03%	10.96%	19.95%
2035	17.29%	10.27%	12.52%	20.88%
2040	18.78%	10.99%	13.51%	21.45%
2045	19.62%	11.13%	13.92%	22.11%
2050	19.97%	10.84%	13.91%	22.97%
2055	20.28%	10.60%	13.90%	24.11%
2060	20.77%	10.67%	14.14%	25.29%
2065	21.44%	11.02%	14.61%	26.34%
2070	22.16%	11.54%	15.17%	27.31%

See footnotes to Tables II.

TABLE IV

Elderly Entitlement Spending As a Percent of Taxable Payroll

Intermediate Assumptions

Calendar Year	Part A Medicare	Total Medicare	All Government Health Care for the Elderly	All Government Health Care Plus S.S.
2000	3.96%	5.58%	8.05%	19.54%
2005	4.53%	6.40%	9.24%	20.95%
2010	5.08%	7.28%	10.52%	22.67%
2015	5.82%	8.60%	12.45%	25.65%
2020	6.74%	9.51%	13.73%	28.35%
2025	7.70%	12.35%	17.97%	33.89%
2030	8.63%	13.80%	20.07%	36.85%
2035	9.37%	14.94%	21.72%	38.82%
2040	9.86%	15.63%	22.72%	39.74%
2045	10.17%	15.94%	23.16%	40.16%
2050	10.36%	15.98%	23.19%	40.35%
2055	10.54%	16.05%	23.28%	40.79%
2060	10.80%	16.35%	23.70%	41.54%
2065	11.13%	16.85%	24.43%	42.50%
2070	11.50%	17.49%	25.36%	43.62%

See footnotes to Tables II.

TABLE V

Elderly Entitlement Spending As a Percent of Taxable Payroll

Pessimistic Assumptions

Calendar Year	Part A Medicare	Total Medicare	All Government Health Care for the Elderly	All Government Health Care Plus S.S.
2000	4.27%	6.02%	8.69%	20.66%
2005	5.30%	7.49%	10.81%	23.78%
2010	6.40%	9.18%	13.26%	27.00%
2015	7.94%	11.74%	16.99%	31.99%
2020	9.98%	15.52%	22.54%	39.31%
2025	12.49%	20.03%	29.14%	47.66%
2030	15.08%	24.11%	35.07%	55.02%
2035	17.29%	27.56%	40.08%	60.96%
2040	18.78%	29.77%	43.28%	64.73%
2045	19.62%	30.75%	44.67%	66.78%
2050	19.97%	30.81%	44.72%	67.69%
2055	20.28%	30.88%	44.78%	68.89%
2060	20.77%	31.44%	45.58%	70.87%
2065	21.44%	32.46%	47.07%	73.41%
2070	22.16%	33.70%	48.87%	76.18%

See footnotes to Tables II.

The CHAIRMAN. Thank you, Dr. Goodman.

I want you to remember to fill out your cards. When you hold them up, somebody on my staff will come and get them. We want your participation.

I think I am going to call on Senator Hagel to ask questions first, and then I will ask some questions while we are waiting for your questions to come. But at the very least we would like to have the last half-hour be questions from the audience.

Would you please start out.

Senator HAGEL. Thank you, Mr. Chairman. Again, to our distinguished panelists, thank you very, very much. I would like to just pick up a little bit on what Dr. Goodman mentioned in the last couple minutes of his testimony, and that is the medical savings accounts. I would be very interested to ask each of you what you think their future is, their worth is. Is it something we should pursue?

As you know, what we did in the Balanced Budget Act, we put in, what, 590 or 1,000——

The CHAIRMAN. 390.

Senator HAGEL. 390. I am not sure why we stopped at 390.

The CHAIRMAN. It is the same percentage as the 750,000 to the total population that we have as a test for people over 65. It is the same 1½ percent, I believe.

Senator HAGEL. So I would be very interested in getting your thoughts, each of you, on MSAs and their future.

Doctor, we can start with you.

Mr. ANTOS. Thank you. I think Dr. Goodman's point goes way beyond what one might call the experimental program that the Congress just passed. I think his point is similar to the kinds of discussion that people are beginning to have about prefunding Social Security; the idea being that the whole program be prefunded for everyone rather than allowing some people to choose to go into a prefunded program—that is, choosing to build a Medical Savings Account (MSA) program if it suits their convenience and if it is a better deal for them—leaving other people, who might not find that to be such a good deal, in the traditional Medicare program where there is unlimited access to federal resources.

I think that is the problem we have now. We have not given everybody the same incentives to operate fairly in the system. I think that if the MSA experiment appears to fail, it will be because it was not tried in its full form. I do not think that Dr. Goodman's idea is really being tested.

Senator HAGEL. So you look upon MSAs favorably?

Mr. ANTOS. That is a personal view, but let me say that I look very favorably upon prefunding, however you do it.

Mr. BERNSTEIN. Senator Hagel, it seems to me that it is sensible to take ideas and try them out and see how they work. It is very hard to get an experiment of this sort that is one you can—whose consequences you can fully follow.

But certainly, as you know, there have been a good deal of criticism about MSAs; that people who are healthier and have more choices will withdraw from the system, leaving the more expensive cases to the Medicare system and, therefore, run up those costs

rather than spreading them out over the entire Medicare covered population.

As the beginning of Dr. Antos' presentation showed, only a small portion of the 38 million people who participated, who are eligible for Medicare actually draw benefits in any year. But we need the premiums, the contributions from all of them.

So I say, Yes. Let us try it. But, I am really quite dubious of MSAs.

One other point I would like to make about Dr. Goodman's global solution of saying to young people, "Go forth and save and take care of yourselves," If he also would apply that to Social Security, that means that working people are funding two programs; not one. I do not think there is the money to do that.

Mr. MOFFIT. I am in favor of Dr. Goodman's basic idea. I think we ought to have medical savings accounts, and I think we ought to have more of them.

I think it should be a voluntary matter. If somebody feels that a medical savings account with a high deductible plan is best for them, they ought to be able to do it.

Let me respond to Professor Bernstein's concern here about adverse selection in medical savings accounts. I think there is a common assumption, frankly shared by the Congressional Budget Office, that medical savings accounts will be used only by the healthy and wealthy and basically leave everybody else behind. So we would have this tremendous segmentation of the market.

I do not think that is clearly true. Let me explain. If you have thousands of dollars of medical expenses every year and you have a medical savings account option with a high deductible and a catastrophic limit to what you are going to pay, if you are really sick, a medical savings account is maybe exactly what you want in order to cover your costs. The reason is you are going to have catastrophic coverage covering the big back end expenses. So it seems to me that it is not necessarily true that people who are simply healthy and wealthy will do best under the medical savings account option.

I just briefly asked Dr. Goodman about the future. I am not going to step on his lines. But it seems to me the concept of prefunding, especially for long-term health-care reform and Social Security reform, makes a lot of sense.

Just parenthetically I will mention that Great Britain just emerged from a major election in which Labor won overwhelmingly. But in fighting to retain their electoral position, the Tory government made a proposal to completely privatize its entire social security system beginning in the next century. Their proposal was to require young people to have basically a system of compulsory savings, requiring them to take a portion of their payroll tax and to open up an individual savings account which would carry them through the next generation.

The program, in fact, was so striking that the chief spokesman for the Labor Party on the issue, the Honorable Frank Field, who is now the minister for Welfare Reform for the British Labor government said that anybody who did not take advantage of this should have their head examined; again, making the argument that prefunding for future generations would make a lot of per-

sonal and political sense. The other argument that Field advanced was compulsory savings of that sort—and this would apply to the medical savings account—would build over a lifetime and lift the elderly out of future poverty.

Senator HAGEL. Thank you. Dr. Goodman.

Mr. GOODMAN. I just want to add this one thought. The reason we came up with the idea of medical savings accounts and the reason Congress passed these pilot programs was not to solve a long-term problem with Medicare, although they might be used in that way. The reason for the pilot programs is to give people an alternative to HMOs and managed care. In the private sector, the working population and their employers, have discovered they cannot afford traditional fee-for-service medicine. It is just too expensive.

So more and more people are getting pushed into HMOs where your choice of doctors is restricted and your access to tests is restricted. That appears to save some money.

Our idea was: Let us give people an alternative. Let us put money in an account and let people make their own decisions. If they want to go to a more expensive doctor, they can pay higher fees. If they want more tests, they can pay with their own money. Any money they do not spend they get to keep.

This is patient power instead of bureaucracy power. It puts the patient in control, and I think for a lot of people that is going to be a very attractive alternative to managed care bureaucracy.

Senator HAGEL. Dr. Moffit, if I could go back to a couple thoughts you had. Obviously, as we have listened to the four of you, there are some consistent threads that apply throughout.

We hear an awful lot—especially as politicians, and we use the argument a lot—about waste, fraud, abuse. One dynamic that we are not interjecting as much as we should and that I suspect is error. When you have a $200 billion federal government program administered by one federal entity, I presume there is going to be a little error.

That 23 billion in so-called fraud may be more, may be less. I do not know how much would be attributed to error.

One of the consistencies that I sensed in all four of your presentations was a restructuring. Dr. Bernstein, your projections argument, I think, is a good one, but it seems to me if we are going to get our arms around this, in looking at those numbers we looked at here today, doubling everything by year 2030, we are going to have some very significant infrastructure changes.

The other part of that everybody knows. We can use a parallel track of Social Security. That would have to be done over a period of time. We are talking about—I do not know what the cutoff is—maybe those under 40 or 50. I do not know what it is.

Would you start this discussion a little bit in response to my question on the restructuring; the time frame; how you see that happen; where that could go. Then I would be very interested, if anybody else wanted to comment on it.

Mr. MOFFIT. Well, I think Congress made a step in the right direction by allowing greater choice of plans in Medicare. There are different types of managed care plans, so I think you are already moving in this direction.

The argument is that the elderly should have a choice of different plans. I think the mistake you made was requiring all of the plans to have the exact same benefits package; in other words, all of the private plans that are going to be able to compete beginning next year as a result of the budget agreement are going to have the same set of benefits and treatments and procedures that Congress has determined over the past 30 years that Medicare must have.

If you applied this to any other sector of the economy, you would be saying to the private sector, "Look, yes. Give us a choice of different plans, but in your set of new options, make sure you include everything else that was done over the past 30 years." The difficulty that this creates for consumers is if they want something different, if they want a package of benefits that might be different, if they want different medical procedures, they are automatically going to have to pay more overall for them. The private sector, in other words, is not going to be able to offer as easily a different set of benefits at a comparable, competitive price because of the standardization of the benefits.

What I am suggesting is that you open it up. It is better to say that you want to have a set of core benefits. To say, in effect, "Everybody's got to have catastrophic coverage. Everybody has to at least provide hospitalization and physicians' services," and then to establish some mechanism for adding benefits through the market.

My view is, very frankly, you could detail the Office of Personnel Management's existing team that negotiates benefits for private plans in the FEHBP over to Medicare and have them negotiate the rates and benefits for private plan in a reformed Medicare system. You will have a much more open type of system, Senator, than you have today.

But I think Congress going in the right direction. It is just there seems to be a lot of inconsistencies in what Congress has actually done.

It struck me. The budget agreement is a stop gap measure. This is an unfinished task or mission. You have created a commission, the Baby Boomer Commission, that must come up with recommendations in 1999 to overhaul the system. It is a frank acknowledgment, but there is an awful lot to be done.

It seems to me "choice" and "competition' are two watch words in structural reform. Medicare today is governed by 22,000 pages of rules and regulations and guidelines. Doctors and patients and hospitals are swimming in a sea of paperwork. It is driving them crazy.

In order to make doctors comply with all of this, the administrative costs are very high. All of the money being used to comply with this massive paperwork is money that is not being used to take care of the elderly.

Senator HAGEL. Dr. Goodman.

Mr. GOODMAN. I would be willing to bet if 15 years ago we looked at General Motors' health-care plans, we would discover one out of every seven of their dollars was being wasted, and probably there would have been fraud there, too. But General Motors, along with every large employer in the country, decided they could not afford

all of that. That is what the modern health-care revolution is about.

We are going to have to do the same thing with Medicare. It is probably going to work best by contracting with private plans. But as Bob Moffit just said, if you are going to do that, it is very important that beneficiaries have a choice and they not get stuck in some bureaucracy where they are abused. If they do not like the plan they are in, they have to have the ability to go to some other place.

The CHAIRMAN. We have two questions on medical savings accounts. I thank Senator Hagel for bringing these up.

The point basically made by the question is the extent to which we would oppose expanding Medicare MSAs, and I assume the answer for all of us would be that we have demonstration projects and hope to base future decisions on what the demonstration projects show. Even if you are strongly in favor of MSAs, I assume if there is something bad that comes out of the demonstration project, it would make an impact upon anybody making a decision in the future. At least for myself I would take that point of view.

We have one question that is a little bit unrelated to where we are today specifically on the question of baby boomers and Medicare, but would any of the panelists have a comment for a questioner on the subject of covering the cost of long-term care, nursing home care, and the extent to which insurance would be a factor in that?

Could any of you address that?

Mr. ANTOS. Let me take a crack at it. The coverage of long-term care has been a growing problem in this country for at least the last decade. It is a growing problem for a couple of reasons, and one is that with a strong economy and somewhat weakening family ties, more and more children are growing up and moving out of town. It may not happen as much in rural area as it does in urban area, but it still happens.

The big crisis that faces probably every family at some point or another is, "Who is going to take care of Mom? Who is going to take care of Grandma?" It is a serious problem.

Long-term care insurance has not captured the country by storm by any stretch of the imagination. Part of the problem if it is a problem—is that we have the Medicaid program, which serves as the payer of last resort. When your resources are down to the minimum, as defined in your state, Medicaid is there to pick up the expenses of nursing homes and doctors for people who need long-term care.

I think the situation is not likely to resolve itself because long-term care is a lot like private pensions. It is a large expense that would occur many for most of us many years into the future and for which, if we really wanted to be protected, we would have to start saving or buying some kind of an insurance policy fairly early in life; say age 35. That is about the time when a lot of people are thinking about expenses for kids and for their home.

Basically, the time that everybody becomes worried about long-term care is about the time you reach 50. I have reached 50. I began to think about that. Most of your kids are out of your house. Some of them are out of college. In my case, not all of them.

You begin to think about what might happen in the future and what you can do to protect yourself. By that time you only have 10 or 15 years left to try and save some money, and frankly, the rate of increase of long-term care expenses is so great that it is very difficult to do that.

I am very pessimistic about private, long-term care insurance being the principal vehicle by which we will cover these kinds of expenses, but I think it could play a much stronger role than it does now.

Mr. GOODMAN. I agree. I do not think the insurance market can handle this problem, but I think we could handle it if we had a savings program. If young people, say, were required to save 10 percent of their income every year, they get high returns from the capital market.

Then in their retirement years they would have their pension, their health insurance, and money for long-term care. Then when the family sits around and says, "Well, how do we want to organize that?" then they are making decisions about their own money; not someone else's money.

Mr. BERNSTEIN. Joe, I would caution you that those children that are in college may come home.

Mr. ANTOS. Or they may not leave. [Laughter.]

Mr. BERNSTEIN. I think there is a problem that I find is of greater concern to older people and their children than any other. The need for long-term care is a set of problems that strikes fear into the heart of lots of people, and it is not going to go away.

Some of us are lucky, and we can sustain our parents. Many people cannot take care of their parents and continue to work.

We are, in a way, a little bit of history. Like Joe said today and Dr. Goodman said, the private market, insurance market is not going to pick up long-term care. That was the situation in 1960. The private insurance companies were not picking up medical care for people over 65.

Sometimes we just have to say, "We have real costs. We have costs for members of our family that have to be met in a humane way." I do not think that the bulk of the American people want to have the answer be, "Well, you can go on Medicaid. If you have been self-sustaining all of your life, it is okay. You can go broke, and then go on Medicaid." I do not think that is an answer.

The CHAIRMAN. Dr. Goodman, the extent to which some people are in the work force for a long period of time and then maybe out because of long-term unemployment or unemployment, generally or particularly homemakers who decide maybe for a period of time to be home with children in the early ages of life, how does your plan take that into consideration in sustaining a Medicare plan for those people?

Mr. GOODMAN. I think we need to move toward a full, comprehensive system in which all elderly entitlements are prefunded, which means each generation pays its own way where everybody in the work force is required to put away a private savings.

A homemaker staying at home could have claim against deposits being made by her husband. So it is not just the husband's money but the couple's money, the family's money.

Precisely how you do that, I do not know. We need to have a system in which women who move in and out of the labor market nonetheless are building toward a retirement nest egg of their own so they have protection as well as the men.

The CHAIRMAN. I suppose, to some extent, that as far as IRAs for retirement are concerned, Congress made a big step this year for having $2,000 for homemaker IRAs.

Mr. GOODMAN. I am for that.

The CHAIRMAN. You would do the same thing, then, for Medicare or for health care beyond the age of 65?

Mr. GOODMAN. I think we need a mandatory program. If you are going to substitute savings for a pay-as-you-go system, it is got to be mandatory.

People in the work force would have to put aside a percent of their earnings every year that they cannot touch until they are age 65 or until they retire.

The CHAIRMAN. Senator Hagel.

Senator HAGEL. Prof. Bernstein, I wanted to go back to your comments on the projections because I think it is an unnoted dynamic of this debate, and none of us know exactly where all that is going to unfold over the next 30 years.

I have been a critic of the Congressional Budget Office, CBO, for a number of years. To your point, just using the static projection analysis versus the dynamic analysis, we know that things change and tax cuts do produce actions and reactions.

But staying in this particular area, I would be interested in going down a little deeper with you on your point in giving us examples of how we may be off track here not factoring in the productivity and some of the other areas that will change.

Mr. BERNSTEIN. Let me be clear. I think that the Social Security actuaries and the HCFA actuaries are very conscientious people. They take into account all of these factors that we have discussed. The reason we have annual reports of the trustees of these programs is that they make adjustments every year both to accommodate the last year's actual experience and to adjust the long-term projections.

These cautions do not mean that I agree with all that they do. For example, they have assigned zero improvement in employment and earnings to the impact of the Americans with Disabilities Act (ADA). There are about 40 million people who have disabilities. Most of them are unemployed. The actuaries and trustees say, "Well, we do not see that the ban of employment discrimination will require the employment and earnings of the disabled. I think that is wrong.

But one can argue and should argue about each and every one of these assumptions. What I am cautioning against is saying, "We know what is going to happen in 2030. We know what the figures are going to be in 2040." We do not know, and we ought to be very humble about what we do know.

The CHAIRMAN. Joe.

Mr. ANTOS. I would certainly agree with Professor Bernstein that we should be humble about projections. If you really want a good prediction, you have to go to a fortune teller. But if you want a sober look at trends in demographics ask the actuaries. Those

trends are very well known through 2030—everybody who is going to retire through 2030 is now alive.

If you want to take a sober look at recent trends, how about 30 years worth of trends in the growth in spending per beneficiary in the Medicare program, which has never been as low as the growth in spending for health care in the private sector. If you want to take a look at what has happened in the past and then make a judgment about what might happen in the future, then you might well look at projections. Then you will not be very optimistic.

Granted that you do not necessarily want to base your policies on what might happen in 2040 or 2050, but you probably do want to take a look at what is likely to happen in the next 15 years.

Mr. GOODMAN. May I say something?

Senator HAGEL. Yes.

Mr. GOODMAN. Let me tell you what we do know. We do know the biggest problem in this forecast is the fertility rate. Women are not having enough children to replace the U.S. population.

In order for developed countries to replace their population, the average woman of child-bearing age has got to have 2½ children—the 2 to replace a man and a woman. The .1 is because some children die before they reach the age in which they can have children.

We are below that. We are at 1.9. We have been at 1.8. All over the developed world this is a problem. In Europe the average is 1.5. In Germany it is 1.4. In Italy, which is a Catholic country, it is 1.3.

Although these numbers fluctuate up and down over time, there is a long, secular decline in fertility rates all over the world. It has been going on for over 100 years. Therefore, I think it is reasonable to believe it will continue to go on.

What does it mean to be below the replacement rate? It means that eventually, unless you have a lot of immigration, your population is going to peak and start declining. What does that mean for pay-as-you-go systems? It means the burden on taxpayers grows and grows and grows.

So I do not have to do these year-to-year calculations to know that we have a fundamental structural problem that I do not think is going to go away.

Senator HAGEL. Dr. Moffit.

Mr. MOFFIT. I have a variation on a theme, Professor Bernstein makes the point: What do we know will happen in 2030? Of course, we cannot know anything for sure in 2030, and I think Joe Antos at CBO and the government actuaries do the very best jobs they can in making projections for these programs.

But I would ask you to take a sober look backwards on Medicare, going back to 1966. The government actuaries have almost invariably gotten the projections wrong. They said that it would cost X amount, and, in fact, the real costs were X to the tenth power in many of these cases.

Medicare Part A was supposed to take care of itself for a long time. We have raised payroll taxes 23 times to try to cover the cost for Medicare Part A. Why? Because Congress likes to add benefits; Congress likes to impose costs; Congress likes to expand treatments in the program, but does not like the idea of imposing direct and higher payroll taxes. So we switch things over to Medicare

Part B. Then we find out those Medicare Part B projections are wrong too.

If you look back—as dire as Joe Antos' projections are today—they could still be wrong. They could indeed be a lot worse. If you look at what happened over the last 15 or 25 years, it could be very bad.

The CHAIRMAN. Dr. Moffit, this might be a question from a health-care professional in the audience that would be appropriate for you to answer because of your marketplace knowledge.

"HCFA is practicing price-fixing in Medicare/Medicaid reimbursements for any nonfederal entity or organization or corporation. This is illegal. Why is HCFA exempt?"

Mr. MOFFIT. I do not know. except that Medicare itself is a broad government program.

The CHAIRMAN. I think the answer that would be appropriate is the extent to which the competition in the federal program does not make government price-fixing okay, because the marketplace takes care of it at a lot lower growth over the last several years.

Mr. MOFFIT. Especially in the last several years. The performance of the FEHBP over the last few years is remarkable.

In 1995 there was a 3.3 percent decline in FEHBP premiums with enrollees—including retirees getting a lower cost of health-care plan.

The problems you have with any price control regime are recurrent. Price controls do not actually control the costs. What they do is they shift the costs into the private sector. The effect is that working families not only pay twice for Medicare, they pay through payroll taxes and they pay through the general revenues. They also pay for the cost shifting that takes place in the private hospitals and private insurance.

So the taxpayer basically ends up paying three times for Medicare, and we all fool ourselves thinking that somehow or another government price controls control costs. They never really control cost.

But the bad news about price controls is that if, in fact, you really take it seriously, if you think price controls are things that are good for the economy, you are going to starve a certain sector of the economy by not allowing a return on investment; not allowing the normal return on land, labor, and capital in that particular sector of the economy.

The real objective then, is ultimately to discourage the supply of that good for service. People who make arguments for price controls normally do not make the whole argument by saying, "The whole idea behind this policy is to actually have less of it," but that is invariably the economic impact.

The real concern over the long term with price controls, if you take them seriously, is that they are going to reduce the quality of care in Medicare. Doctors are going to be less and less willing to take new Medicare patients, and doctors are going to try and figure out ways to avoid Medicare patients in the future and to cut back on medical services, if they can.

There is only so much you can squeeze. Right now we pay doctors roughly 59 cents on the dollar. We can pay them 49 cents on

the dollar or 39 cents on the dollar. But that is going to have a consequence.

Nobody seriously thinks you can reduce the salary of the chef in a first class restaurant over time and expect the quality of the food and the quality of the service to remain the same. It will not. The same thing is true with regard to the Medicare system.

Mr. GOODMAN. I do not mind the government fixing what it pays. I think that is a prudent thing to do.

The problem is it also fixes what the patient can pay, and that price may or may not be appropriate for a given area. It may be too high or too low. In areas where it is too high, the doctors would have the tendencies to want to waive deductibles and copayments, but now they are not allowed to do that. If it is too low then they would want to charge patients more, but they are not allowed to do that either.

So starting with something that is reasonable, fixing what the government will pay, we have gone on to prevent patient and doctor from reaching reasonable agreement in the medical marketplace.

The CHAIRMAN. Yes, Dr. Antos.

Mr. ANTOS. One other problem that I do not think either Dr. Goodman or Dr. Moffit mentioned is that the traditional, decades long attention by policymakers on fixing prices in Medicare has not resulted in what has been desired over many decades, and that is to limit the growth in Medicare costs.

The fact of the matter is that just focusing in on price does not do it. One also has to find a way to look at the volume of services that are given to beneficiaries. Again, we go back to that basic problem that faces traditional Medicare—it is an unlimited fee-for-service program, an unlimited tap on resources, and there are no particular incentives there for economy.

In a capitated system where there is a fixed payment for services, as Dr. Moffit mentioned, there would be this natural brake on wasteful use of services that would get at this volume problem and would also solve the pricing problem as well.

Mr. BERNSTEIN. But it gives you the problem that insufficient services might be supplied as well. You have to have an incentive there.

Mr. ANTOS. You are exactly right. Unfortunately, we have not devised a system that does not provide incentives that go a little too far in the wrong direction.

Mr. BERNSTEIN. Could I make just one comment, that the federal employee plans have had a very good record. When we take a critical look at them, we ought to take into account that they have been bargained—many of them have been bargained plans since their inception.

Two, that it is a very advantaged group. It is not a high-risk group. You do not have a lot of people engaged in heavy-risk activity. So, to that extent, it may not be typical of your population at large.

The CHAIRMAN. Dr. Moffit, you may want to respond.

Mr. MOFFIT. I sure do. First of all, there are a lot of people in the federal government who are engaged in high-risk activity, so there is high risk there.

Mr. BERNSTEIN. Who are covered by the Federal Employee Liability Act.

Mr. MOFFIT. Okay. But the point is that it is not an ideal insurance pool. If you look at federal employee health care population, roughly 9 million people, you are covering an older work force. The average age of federal workers is approximately 44 years. So, in fact, it is considerably older than the kind of work force that you normally cover in the private sector.

Also, remember that 40 percent of the enrollees right now in the Federal Employees Health Benefits Program are retirees. It is true many of these retirees also are covered by Medicare. A substantial number, about 200,000, are not. In fact, most federal workers were not prior to 1983, and eligible for Social Security benefits. The FEHBP was then enrolled the primary source of their coverage in retirement.

If you look at the private sector right now, what you see is private sector companies dropping insurance coverage especially for retirees. We are cutting back rather dramatically in the private sector.

So, the FEHBP is, in fact, doing better than it really should be, in view of its large contingent of retired workers. It is not an ideal insurance pool in that respect.

One other point. In recent years the benefits have been growing faster in the FEHBP. You have had a progressively richer benefits package at least in the last dozen years.

The CHAIRMAN. I would like to ask one last question and call on Senator Hagel to ask one last question.

I want to refer to this chart again and refer to the fact we had some testimony in March before my committee of a pollster who had taken a poll on how the public views this underfunding problem that we have on Medicare, and 83 percent responded to the fact that if we would take fraud out of Medicare, we would take care of this problem; we would not have an underfunding problem.

To the extent to which there is agreement or disagreement on the panel and the extent to which you have more credibility than those of us who are elected, I would like to have each or maybe one of you speaking for all of you explain that if we could, in fact, take all the fraud out of Medicare and there was not some astute person out there finding a new way to formulate some fraud, would we or would we not still have a problem?

Mr. GOODMAN. We will still have a problem. If you take all the fraud away with a magic wand, you still have a problem.

There is something misleading about that chart. There are a lot of good things in this new budget bill, and you did a lot of good things. But it looks like on that chart we solved all the problems. We have not.

The CHAIRMAN. No. Just for six more years—ten years.

Mr. GOODMAN. So there is a long-term structural problem, which is generated by another chart that you have up there showing the ratio of taxpayers to beneficiaries and, one showing, the growing cost of health care. These problems are not going to go away, and will not be changed by eliminating fraud, they will not be changed by the Balanced Budget Bill.

The CHAIRMAN. Even to the extent to which Professor Bernstein suggested that we ought to take care of this problem before we worry about other problems? If we did, we would still have a problem, right?

Mr. BERNSTEIN. I would agree with that. I do not know and nobody knows the dimensions of just how much we can save with an aggressive and effective antifraud program. It may be more than 23 percent; maybe $46 billion; maybe a good deal less. We have got to find out.

What I am saying is: Proceed with care.

The CHAIRMAN. I believe that is right.

Mr. Antos.

Mr. ANTOS. Let me just mention the number I showed you earlier in 2015. By current law we will be spending in that one year alone $1.1 trillion on Medicare. I do not think there is that much fraud in the system.

The CHAIRMAN. Senator Hagel.

Senator HAGEL. Just one quick observation, and then a question. Something else that has struck me about the comments made by the four of you—and it relates a little bit to what Senator Grassley said about the fraud—is a certain artificialness of ceilings and price controls, cost controls. A concern I have always had more than any other is that we all know that the eventual result of any kind of cost controls or ceilings leads to rations when we drive specialists out of the business and doctors and providers out of business.

That is eventually what will happen here if we do not get control of this problem, and we most likely will not see it for 25 years; maybe sooner.

Mr. GOODMAN. Right now.

Senator HAGEL. Right now. Okay.

We have a bigger problem on our hands than we have even started to discuss here if, in fact, that is going on and will continue to go on. I want to relate one quick story, and I will ask a question.

I remember in the 1970s—and Senator Grassley remembers it very well, and this part of the country does—when we had the infamous beef freeze. Many of our friends were telling us that beef was too expensive, if you recall, so we needed to put controls on the price of beef.

I remember a Congressman I was working for at the time, John McCollister, said, "Well, we can do that, and we can have 49-cents-a-pound hamburger, but the problem with that is there will not be any hamburger on the shelf." That is essentially what we have got underneath this.

Now, the question is—would you all react to this—why do not we take that $5500 a year that the beneficiary gets and give it to them, and it is their responsibility to decide what they want to do with it? Everybody's situation is different. Why do we need the federal government in it?

Anybody want to step up first?

Mr. GOODMAN. I think Bob Moffit had an idea that is close to that. You do not give it to them, but you give them options on how to spend it.

That is what we are moving toward in this new bill, by the way. We are creating a lot more options for senior citizens. They are

going to have a private fee-for-service option; they are going to have a point of service option; they will have a regular medical savings account option and a back ended medical savings account system an HMOs option.

By the way, it is not $5500 for every one of them. If they are older, they get more. If they are——

Senator HAGEL. I understand, but using your rough estimates—

Mr. GOODMAN. They are going to get vouchers, is essentially what is happening. I approve of that. I agree with Bob. I think we need to move more in that direction.

That gives the people who compete for their business incentives to get rid of waste and abuse and provide that quality.

Mr. MOFFIT. I agree. Our view at The Heritage Foundation is to create a system that looks something like the Federal Employee Health Benefits Program. You can do that by establishing a Medicare trust fund that would be like the FEHBP fund.

You can have a direct electronic transfer from the Treasury to the plan of a person's choice. They can pick and choose the plan. If they pick a less expensive plan, they can pocket the savings. If they want to pay more, for one reason or another, or for a very highly specialized set of medical tests and procedures, they can do that too just like Federal workers and retirees and members of Congress do today.

But you need structural change here. You will not have a situation, which you have today, where you have large Medicare contractors in almost every state of the union who are getting money from Washington and funneling it to doctors and hospitals where they themselves do not have a direct and immediate incentive to curb the waste and fraud and abuse that is plaguing the system. Because to these contractors, it is only the government's money.

If, in fact, you have a situation where you are dealing within the private market, and a private firm or a health-care plan is not controlling that fraud and abuse, that undermines their competitive position because it affects their premiums. It means they will have to offer higher premiums. It means they are going to be at a competitive disadvantage if they do not root out fraud and waste and abuse in competing with plans that do.

So that structural change would really change the dynamics. Frankly, that is our view at The Heritage Foundation. Take that $5500 and transfer it to the plan the elderly choose directly.

Senator HAGEL. Dr. Bernstein.

Mr. BERNSTEIN. My limited experience has been that people do not know what they have in their health insurance until they get sick. All of us have difficulty understanding what these packages actually include. They are long, complex.

I get mailings all the time from various organizations offering long-term care plans that are lemons. These are good organizations, but the product is terrible. I do not know how many people realize how deficient the product is.

Everybody here has seen television ads for cancer insurance. Cancer insurance is a lemon. It is a terrible investment. Yet, millions of people bought them.

Now, I do not know whether The Heritage Foundation with its libertarian philosophy says, "Oh. Well, you cannot offer that. There

are only a certain number of reputable plans that have appropriate coverage to which you can apply this."

We have in Medicare a program that offers more choice of physician and provider than any other program going yet, and before you give that away, you have got to be very careful.

Mr. ANTOS. The role of government in health insurance and health care in general, is not just helping to finance it. In fact, the more important role is to set a level playing field for health plans and insurers and other kinds of plans to compete in the market and make sure that those fair rules are observed by everybody. Another important function, as Dr. Bernstein indicated, is to gather information. The government is in the best possible position to gather information and distribute it on fair basis to everybody.

Does the government actually have to operate a health insurance program? Not necessarily. It does not happen everywhere.

We happened to set upon that course in 1965. It does not mean we have to stay there. Indeed, I think the trends strongly suggest that some changes are definitely needed.

If we retain a noncompetitive part of this health-care program, by which I mean the traditional Medicare program, we will continue to have financial problems in it until we choose to deal with them. I think that is an important challenge for the Congress and the government.

The CHAIRMAN. You are all invited to come tomorrow to the College of St. Mary in Omaha if you want to participate in the discussion that we have on Social Security. Those of you who submitted questions that were not quite in line with the expertise of the panel, I will respond to those in writing, if you gave us your address, and I believe everybody did.

First of all, we have had a very diverse panel, and I thank you all very much particularly for coming out here to the Heartland where there is a lot of Iowa common sense to offset the Washington nonsense.

Mr. BERNSTEIN. You are referring to my testimony? [Laughter.]

The CHAIRMAN. It was very Midwestern. You may be the only Midwesterner here, but you have come to the Heartland.

I think that having a discussion of this issue now and getting out ahead of the curve on this issue is very, very important if we are going to make sure that we have a safety net for baby boomers when they go to retirement.

I thank Senator Hagel for coming to Iowa to participate in this. I will reciprocate tomorrow by going to Nebraska. It is not very far into Nebraska, thank God. [Laughter.]

I am sure he would say, "I am not very far into Iowa either."

Senator HAGEL. I will make sure I quote you tomorrow in Nebraska. [Laughter.]

The CHAIRMAN. Well, I do not care. I am not running for President.

Senator HAGEL. I think there are only two of us in the Senate not running for President.

The CHAIRMAN. So we thank you very much for participating, but remember, those of you who are our constituents and Senator Hagel's constituents and even the people from South Dakota, the

process of representative government does not go on just for a two-hour hearing like we have here.

Keep up your communication with us. When you cannot see us face to face, make sure you write us letters. In my case you can expect an answer to your letter; probably Senator Hagel would say exactly the same thing. If you do not get an answer, write me a nasty letter asking me why I did not answer your letter so I can find out how I screwed up, because I take great pride in answering all of my mail because on this issue or any other issue I want to make sure that we build a consensus so that Congress will move.

It is very necessary for the process of representative government opinion from the grass roots to have on these important issues like Medicare and Medicaid and Social Security—more so than a lot of other issues that we deal with in Washington. You are a part of that process today. We want you to continue to be a part of that process.

So, once again, from the panelists, from my colleague and for all of you who are in attendance, I thank you, and the meeting is adjourned.

[Whereupon, at 3:35 p.m., the committee was adjourned.]

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