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THE 2008 MEDICARE TRUSTEES REPORT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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

ONE HUNDRED TENTH CONGRESS

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THE 2008 MEDICARE TRUSTEES REPORT

TUESDAY, APRIL 1, 2008

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

The Subcommittee met, pursuant to notice, at 10:00 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (Chairman of the Subcommittee), presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
March 25, 2008
HL–22

CONTACT: (202) 225–3943

Health Subcommittee Chairman Stark Announces a Hearing on the 2008 Medicare Trustees Report

House Ways and Means Health Subcommittee Chairman Pete Stark (D–CA) announced today that the Subcommittee on Health will hold a hearing on the 2008 Medicare Trustees report with Chief Actuary Richard S. Foster. **The hearing will take place at 10:00 a.m. on Tuesday, April 1, 2008, in Room 1100, Longworth House Office Building.**

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

BACKGROUND:

The Social Security Act requires the Board of Trustees for the Medicare program to report annually to the Congress on the current and projected financial condition of the Medicare Hospital Insurance (HI) and the Supplementary Medical Insurance (SMI) trust funds. The Trustees, who are designated in statute, include the Secretary of the Treasury (who is the Managing Trustee), the Secretary of Labor, the Secretary of Health and Human Services, the Commissioner of Social Security and the Administrator of the Centers for Medicare and Medicaid Services (CMS). In addition, the statute requires that there be two public trustees, both of whom cannot be from the same political party, who are appointed by the President and confirmed by the Senate for 4-year terms. The CMS Office of the Actuary, led by Chief Actuary Richard Foster, is responsible for preparing the report. The *2008 Annual Report* was released today and can be found at: *http://www.treas.gov/offices/economic-policy/reports/medicare-report-2008.pdf*.

Ensuring the sound management of Medicare is one of Congress' most important responsibilities. This annual report provides a valuable update on the program's status and important information with respect to projections of future expenditures, enrollment and other trends.

In addition, the 2003 Medicare legislation (P.L. 108–173) created a new mechanism designed to cap Medicare's funding when certain criteria are met. Under the law, the Trustees must project whether more than 45 percent of Medicare's funding will come from general revenues within seven years of the report's date. If that projection occurs in two consecutive reports, a warning is issued. The law then requires the President to send legislation to Congress to reduce general revenue spending to less than the target within the window in question. The 2007 report contained this warning; consequently, President Bush sent Congress proposed legislation in February that minimally addressed the issue by increasing costs on beneficiaries. According to the 2008 report, the threshold will be crossed in the next seven-year window.

In announcing the hearing, Chairman Stark stated, **"Reviewing the Trustees' Report is a core part of Congress's oversight responsibilities, and one I take seriously. Medicare is critically important to the 44 million beneficiaries who rely on it for health care and financial peace of mind. While the program faces demographic challenges in the future, those can be dealt**

with if there is a bipartisan commitment to preserve and improve the program. We should not succumb to alarmist claims that the sky is falling. The most important immediate step we can take to help Medicare's financial outlook is to eliminate the Medicare Advantage overpayments. This corporate pork fattens insurance company profits while unnecessarily draining program resources. I can't take seriously the claims of concern from those who protect these excessive payments at the expense of beneficiaries, taxpayers and the program's future."

FOCUS OF THE HEARING:

The hearing will focus on the 2008 Medicare Trustees' Report.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "*110th Congress*" from the menu entitled, "*Committee Hearings*" (*http://waysandmeans.house.gov/Hearings.asp?congress=18*). Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record*." Once you have followed the online instructions, completing all informational forms and clicking "submit" on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You ***MUST REPLY*** to the email and ***ATTACH*** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business **Tuesday, April 15, 2008**. **Finally**, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

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

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

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

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

Chairman STARK. Good morning. Thank you for joining us. The Subcommittee will commence with its hearing on the 2008 Social Security Medicare Trustees' Report. I thank the members for joining us, and hope you will join me in welcoming Rick Foster, who is the chief actuary at the Centers for Medicare and Medicaid Services. He and his staff do the analysis needed to complete the trustees' report each year.

We appreciate the hard work that your staff does, Rick, on advising us on the status of Medicare trust funds, and Medicare, generally. I would like to thank you, in particular, for your efforts. Medicare provides care for more than 44 million individuals, and we owe it to those beneficiaries, as well as the taxpayers, to keep note of the financial health of the program.

The Bush administration likes to use the new 45 percent trigger as a scare tactic. It's an arbitrary measure. We can talk more about that later. But it fails to indicate anything useful about the health of the Medicare program. We designed in the 1960s, Medicare to draw funding from general revenues. That's what it's doing.

Part D was created by Congress and President Bush, and was intentionally designed to be predominantly financed by general revenues. The general revenues, I think, pays about three-quarters of the tab. The beneficiaries pay about 25 percent, through premiums.

I think it was disingenuous of the administration to send us a trigger bill that only pushes the trigger back a year, and does absolutely nothing to extend the trust fund solvency date. They tucked in a whole lot of controversial proposals that really aren't related to the funding of Medicare.

The administration rejected their own budget, and sent us policies that, as drafted, really do nothing to improve solvency. The only policy that the actuaries—I guess that's you—scored: "increases cost to beneficiaries," and "undermines the universal nature of the program" "making wealthy people pay a higher premium" is kind of a double-whammy.

They're already paying—it's probably the most progressive tax we have. They pay their 2.45 or 4.9 percent on—or is it 1.45 all the way up. If they make tens of millions of dollars on Wall Street, they pay the premium on that entire $10 million of earned income, and they don't get any different benefit than somebody at the minimum wage. Why we should ask them then to pay even more escapes me.

So, I think the trigger dance is a political exercise. Medicare is not in crisis, and the House did act to protect it. We passed, with bipartisan support, the CHAMP Act. CHAMP would have postponed the trigger by three years, a lot better job than what the President is suggesting in his bill.

Basically, Medicare overpayments—Medicare Advantage overpayments—are what is causing the principal problem in Medicare today. It seems to ring kind of hollow when we don't, in fact, deal with the real problem.

I love to quote Republicans, and I'm going to make Mr. Camp guess whose quote this is. But it was written—oh, it's yours, March 14th. "So, where are we? Congress decided in 2003 to enhance the

market for high deductible indemnity insurance plans with greater tax subsidies for the premiums and the deductible health savings accounts. They also decided to spend whatever it takes to move the Medicare program out of HHS and into AHIP, using Medicare money to provide special preferences for individually owned fee-for-service indemnity insurance. The money the insurance company cannot make from CMS, they make from restricting access to provider networks with whom they have negotiated prices," and so on.

My former partner in crime, former Senator, Dave Derenberger wrote that on March 14th, and he is but he was a perceptive guy when we worked together years ago on the Medicare issue.

But let me hear first from Mr. Camp, and then we will welcome any comments that Mr. Rick Foster cares to make about his testimony.

Mr. CAMP. Well, thank you, Mr. Chairman, and thank you for holding the hearing today. I appreciate, Mr. Foster, your being here. Well, if any of you saw roll call, today is April Fools Day, but it might as well be Groundhog Day, because last year we were in this same room at roughly the same time, listening to Mr. Foster talk about how the Medicare program is going bankrupt.

Yet, since then, Congress has failed to enact any real changes as program costs continue to grow, and the date of Medicare's insolvency draws nearer.

We will hear today that the health insurance, or HI trust fund, which finances Medicare Part A, is now projected to be exhausted by 2019. We should not be surprised that Medicare continues to face a funding crisis. The majority has done nothing to responsibly reform the program or control costs.

Mr. Foster will also point out that the trustees' spending projections for the supplemental medical insurance, or SMI trust fund, which finances both Part B and Part D, will continue to increase dramatically. This means that Medicare beneficiaries will continue to face higher premiums and lower Social Security checks, because Congress has failed to reduce Medicare spending.

In fact, the problems facing the Part B program are actually worse than the trustees' report would have you believe. Medicare spending on Part B is actually understated, because their estimates assume that physician payments will be reduced by 10 percent this year, and 5 percent every year for the next 10 years. This means that Part B premiums which have more than doubled since the year 2000 will reach unaffordable levels in just a few years.

One lone bright spot in the trustees' analysis should be highlighted, however. Compared to the estimate that was prepared in 2003, Part D costs are now 37 percent lower. While some of my colleagues characterize Part D as a legislative failure, Part D is the only part of Medicare that has a lower-than-expected rate of growth.

Drug plans have successfully negotiated deeper-than-expected discounts with drug companies, and are offering attractive plans to seniors at lower-than-expected cost. It is not a coincidence that the private market has been able to deliver a medical benefit below budget.

If we are looking for ways to reduce program spending, we can certainly apply some of these market-driven and competition-based

reforms to the rest of the Medicare Program. This Committee is required by law to send a bill to the House floor by June 30th to protect Medicare's solvency in the short term. As MedPac said in their March report, "Time is of the essence."

I hope that we can, together, take the opportunity that this presents to address the threats facing Medicare. The failure to do so is unacceptable, because the financial pressures threatening Medicare only grow greater with each passing year.

Mr. Chairman, I hope that we can find a responsible bipartisan agreement to address this looming crisis. I yield back the balance of my time.

Chairman STARK. Any other Members have statements they would like to appear in the record? Without objection, they will be placed there.

Mr. Foster, your entire testimony will be placed in the record, without objection. I would like to recognize you to enlighten us, or expand on it in any way you are comfortable.

STATEMENT OF RICHARD S. FOSTER, CHIEF ACTUARY, CENTERS FOR MEDICARE AND MEDICAID SERVICES, BALTIMORE, MARYLAND

Mr. FOSTER. Thank you very much. Chairman Stark and Representative Camp, and other distinguished Members of the Subcommittee, thank you for inviting me here to testify today about the financial outlook for the Medicare program.

I will briefly summarize the most significant findings from the new 2008 Medicare Trustees Report that was issued a few days ago.

I would also like to recognize a few folks from my office who are here with me today——

Chairman STARK. Please.

Mr. FOSTER [continuing]. Including Clare McFarland, Suzanne Codespote, and John Shatto. There are also some folks from our Office of Legislation here, who have accompanied me. If it is all right, my presentation will take a little longer than the 5-minute limit.

Chairman STARK. Please.

Mr. FOSTER. Thank you, sir. First, let me start with some background. The purpose of the Trustees Report is to evaluate the financial status of the Medicare trust funds, and specifically: Are the income and the assets of a given trust fund sufficient to enable the payment of benefits and administrative expenses under that program?

This is admittedly a somewhat narrow question. But it's also a fundamentally important question, since the existence of a positive trust fund balance is what gives us the statutory authority to make the benefit payments. So, a narrow question, but an important one.

Now, of course, it's not the only question that can be asked. You often hear discussion about the long-range financial sustainability of Medicare.

You also hear the question asked, "What is the impact of Medicare on the Federal budget?" These are important questions, also, but they are quite different from the issue of trust fund financial status. If people treat them interchangeably, which they sometimes do, then the results could be confusing.

So, I will be talking about the financial status of the trust funds, initially, and a little later on about the combined Medicare outlook.

Medicare, of course, has three trust fund accounts. There is the Hospital Insurance, or Part A, trust fund. Then, since the Medicare Modernization Act, the Supplementary Medical Insurance trust fund has two separate accounts: one for Part B, the traditional physician services and outpatient benefit; and the other for the new Part D drug benefit.

The payments that are made to Part C of Medicare, namely, the Medicare Advantage program, those payments are drawn from the Part A and the Part B accounts. There is no separate Part C for the Medicare Advantage trust fund.

By law, each trust fund and each account has its own explicit source of financing, and there is no provision for sharing assets back and forth, or making loans across—from one trust fund to another, et cetera. As a result, it is necessary to evaluate the financial status of each trust fund account, individually, by itself.

We will start with the Hospital Insurance trust fund. As you know, most of the financing for this trust fund comes from a portion of the FICA and SECA payroll taxes in particular, Mr. Chairman, the 1.45 percent paid by employees matched by another 1.45 percent paid by employers. Self-employed people pay the combined total.

The HI financial status shown in the new Trustees Report, overall, is quite similar to that shown in last year's report. So, perhaps this is—will be fairly Groundhog Day-ish, as Mr. Camp mentioned.

The cost for hospital insurance is expected to exceed the level of tax revenues in 2008 and all future years. Now, the difference between the cost and the tax revenues can be met for a while by using interest earnings on the assets, and for a while longer by redeeming those securities, turning them back into the treasury, and getting our cash back.

However, the assets are projected to be exhausted in 2019 without corrective legislation. Now, that's the same year as shown in last year's report, but it's now early in the year, rather than late in the year, as it was before.

The slight worsening in the outlook in the short term for the HI trust fund is due to slightly lower projected tax revenues, and slightly higher projected expenditures.

In addition, the change reflects the impact of correcting an accounting error that was discovered late in 2007. In particular, under a new accounting system, certain Part A hospice benefits were inadvertently paid from the Part B account of the SMI trust fund.

That was a mistake in the design of the program. It has been corrected for future payments, but we will need to make a transfer, an adjustment, of about $12.6 billion from the HI trust fund back to the general fund, and then from the general fund to the Part B account, in order to put each account back where it would have been, in the absence of this problem.

In the long run for the HI trust fund, the gap between projected expenditures and scheduled income just grows wider and wider. By the end of the 75-year projection period, the scheduled tax revenues

would be sufficient to cover only less than a third of the projected benefits. So, that's a pretty major deficit.

Turning now to the Part B account in the Supplementary Medical Insurance trust fund, the Part B account is financed entirely differently from Part A. In particular, roughly 25 percent of the financing for Part B comes from premiums paid by beneficiaries, and the other 75 percent, roughly, comes from Federal general revenues.

There is an annual redetermination of the premiums and general revenue financing under current law. As a result, that means that Part B income will always match Part B expenditures. The trust fund account will never go broke under current law.

It is worth noting that we have had fairly large Part B premium increases in recent years, and similar increases in the general revenues. That's been in order to rebuild the Part B account assets to a fully adequate level. They had been far below this level for some time period.

If you include the $12.6 billion transfer, or adjustment for the hospice payment problem, then the assets of the Part B account now are at a fully sufficient level, and that's the first time that has happened since 2002. So, that is something we were glad to see.

Of course, with Part B, as well as Part D and Part A, for that matter, the concern has to do with expenditure growth rates. For Part B, over the last 5 years, growth has averaged not quite 10 percent per year. That is despite the fact that the payment updates for physicians, is the biggest category of Part B expenditures have been either zero percent or fairly low, by historical standards.

So, despite the restrained position updates, the growth rate has still averaged almost 10 percent over the last 5 years.

I believe the problems with the physician payments are well known to this Subcommittee. In particular, under current law, we estimate that in July 2008, the middle of this year, we would have to reduce payment rates to physicians by 10.6 percent. Then, the following January 2009, we would have to reduce them by another 5 percent. Then, for each of the next seven Januaries, through 2016, we would have to reduce them by a further 5 percent each year.

It is implausible that the payment rates could be reduced so much for many reasons that I don't have to explain. But certainly Congress has overridden the scheduled decreases in each of the last 5½ years, and I would guess that you are likely to continue doing that, under the circumstances.

Therefore, the projected Part B expenditures shown in this year's Trustees Report, as in the last several, understate the true likely cost of the program, and they probably understate it by anywhere between 10 to 20 percent, in the long range.

Turning to the Part D account in the SMI trust fund, this, of course, is a valuable new benefit for enrollees, but it does add significantly to the cost of the Medicare Program. Part D is financed somewhat like Part B, in that general revenues make up the largest share, currently about 77 percent of the total revenues. Beneficiary premiums also contribute to it, and they are currently about 9 percent of costs.

We also receive the special payments by states on behalf of dual Medicare-Medicaid beneficiaries. Currently, those are about 14 percent of the total. But that would decline over the next 10 years, as the percentage requirement specified in the MMA decreases.

The good news here is that the projected cost of Part D in the first 10 years—I should say the next 10 years—is about 17 percent lower than we showed in last year's report. So, once again, the actual costs have come in lower than we expected, and that has affected our projection for future years.

They are also, as Representative Camp mentioned, considerably lower, about 37 percent lower, than our original estimates back in 2003. If there is time later on, I would be happy to describe the factors underlying these updates or revisions in the cost estimates.

Because the financing for Part D is also reset each year to match expected costs, then Part D will also be in financial balance indefinitely.

On the other end, we are expecting, or projecting, Part D costs to grow at about 11 percent per year over the next 10 years, with about 3.5 percent of that being growth and further enrollment.

I will take just a moment to talk about total Medicare. We looked at the three accounts individually, from a financial status standpoint. But it's also useful to look at the total cost of Medicare, and how it's financed.

The basic challenge with financing Medicare—and this also applies to virtually any other health care program you can think of, public sector or private sector in the U.S. is that expenditures tend to grow by increases in the number of beneficiaries, of course, but also by growth in the wages and prices that are paid to health service workers and for the services that are purchased in the health care sector.

In addition, beneficiaries tend to get more services over time, greater utilization of services. The services themselves get fancier over time. So, we refer to that as intensity, or the average complexity of services, which grows too, generally in ways that are more expensive.

Collectively, these factors, combined, result in cost growth that is significantly faster than the rate of increase in workers' average earnings, or in the economy at large.

So, in addition to this ongoing problem associated with health cost growth rates, we also have a demographic impact. The number of beneficiaries, with the retirement of the Baby Boom, will increase significantly more rapidly in future years than the number of workers. This factor is well known, we've been talking about it for decades now. We are now on the verge of it actually happening.

Total Medicare costs are projected to increase from their current level of about 3.2 percent of gross domestic product to not quite 11 percent at the end of the 75-year projection period.

This rapid cost growth, if it continues, will also have significant implications for beneficiaries. For example, beneficiary premiums and beneficiary cost sharing would go up, as a percentage of their income, for many people, to quite high levels over such a long period.

In addition, there are implications for the Federal budget. The cost of the general revenues would represent a growing share of Federal income taxes or other revenues.

I will mention briefly the 45 percent trigger under section 801 of the Medicare Modernization Act. The way this works is if the difference between expenditures, total Medicare expenditures, and Medicare dedicated revenues—that's principally payroll taxes, premiums, income taxes on Social Security benefits, and the state payments—exceeds 45 percent of total expenditures within the first 7 years of the trustees' projection, then the trustees have a determination of "excess general revenue Medicare funding."

If there are two successive such determinations, then that triggers a Medicare funding warning. This test was met in the 2007 Trustees Report, and that resulted in the first Medicare funding warning. As well as the proposed Medicare Funding Warning Response Act of 2008, which the President sent to you folks in February of this year.

Now, in the new Trustees Report, we once again have a projection of crossing the 45 percent within the 7 years. That ends up triggering a new Medicare funding warning all over again, which will, again, require a legislative proposal and response following the next budget.

The funding warning itself and the test that underlies it, I think, are useful measures of the magnitude of general revenues and how much of the financing for Medicare comes from general revenues. I think that can help call attention to the impact on the Federal budget that is associated with the general revenue transfers to Medicare.

However, despite the title, a Medicare funding warning should not be interpreted as an indication that trust fund financing is necessarily inadequate. Assessing the adequacy of financing can only be done by looking at the separate accounts, as I mentioned before. For that purpose, you have to look at all the sources of financing, including the general revenues that are provided for by current law and the interest income that is provided for by current law.

Well, I will sum up by saying that, based on these projections, the Board of trustees has recommended prompt attention to the financial challenges facing Medicare. I can think back as part of my own career for 35 years now, and throughout that time the Office of the Actuary at CMS and at Social Security has assisted both Congress and the Administration in finding solutions to financing problems. I will pledge the Office of the Actuary's continuing assistance on your behalf, as you continue to struggle with how best to meet these challenges.

I would be happy to answer any questions.

[The prepared statement of Richard Foster follows:]

The Financial Outlook for Medicare

Testimony before the
House Committee on Ways and Means, Subcommittee on Health
April 1, 2008

by

Richard S. Foster, F.S.A.
Chief Actuary
Centers for Medicare & Medicaid Services

Chairman Stark, Representative Camp, distinguished Subcommittee members, thank you for inviting me to testify today about the financial outlook for the Medicare program as shown in the newly released 2008 annual report of the Medicare Board of Trustees. I welcome the opportunity to assist you in your efforts to ensure the future financial viability of the nation's second largest social insurance program—one that is a critical factor in the income security of our aged and disabled populations.

The financial outlook for the Medicare program, as shown in the new Trustees Report, is not markedly different from the findings in last year's report. Overall, the outlook is slightly better, with actual costs in calendar year 2007 of $432 billion, an amount that was 1.5 percent lower than previously estimated. Most of this difference is attributable to slower growth in inpatient hospital expenditures than had been estimated.

The financial status of the Medicare trust funds must be evaluated separately for each fund and for each account within the funds. I will first summarize the Trustees' findings for the separate accounts and subsequently address the overall cost of Medicare and the "Medicare funding warning" that is triggered again this year.

The Hospital Insurance (HI) trust fund once again does not meet the Trustees' formal test for short-range financial adequacy. The depletion of the HI trust fund is projected to occur early in 2019, the same year as was projected in last year's Trustees Report. Beginning in 2008, HI dedicated revenues are projected to fall increasingly short of program expenditures, eventually covering less than one-third of estimated costs by the end of the Trustees' 75-year projection period.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) created two separate accounts within the Supplementary Medical Insurance (SMI) trust fund—one for Part B, which continues to cover the traditional SMI services, and one for the new Part D, which provides subsidized access to prescription drug coverage. Because of the annual redetermination of financing for both Parts B and D, each account will remain in financial balance indefinitely under current law. SMI costs, however, are projected to continue increasing at a faster rate than the national economy and beneficiaries' incomes, raising concerns about the long-range affordability of scheduled financing.

Background

Over 44 million people were eligible for Medicare benefits in 2007. HI, or Part A of Medicare, provides partial protection against the costs of inpatient hospital services, skilled nursing care, post-institutional home health care, and hospice care. Part B of SMI covers most physician services, outpatient hospital care, home health care not covered by HI, and a variety of other medical services such as diagnostic tests, durable medical equipment, and so forth. SMI Part D provides subsidized access to prescription drug insurance coverage as well as additional drug premium and cost-sharing subsidies for low-income enrollees. A Part D subsidy is also payable to employers who provide qualifying drug coverage to their Medicare-eligible retirees.

Only about 22 percent of Part A enrollees receive some reimbursable covered services in a given year, since hospital stays and related care tend to be infrequent events even for the aged and disabled. In contrast, the vast majority of enrollees incur reimbursable Part B costs because the covered services are more routine and the annual deductible was only $131 in 2007. Similarly, a large proportion of Part D enrollees have reimbursable prescription drug costs, given the common occurrence of prescriptions, the preponderance of zero-deductible plans, and the significant proportion of low-income enrollees, for whom the deductible does not apply.

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

SMI enrollees pay monthly premiums: $96.40 for the standard Part B premium in 2008 and an average premium level of about $25 for Part D standard coverage in 2008. For Part B, the monthly premiums cover a little more than 25 percent of program costs with the balance paid by general revenue of the Federal government and a small amount of interest income. Beginning in 2007, there is a higher "income-related" Part B premium for those individuals and couples whose modified adjusted gross incomes exceed specified thresholds. When the income-related premium is fully phased in (in 2009), beneficiaries exceeding the threshold will pay premiums covering 35, 50, 65, or 80 percent of the average program cost for aged beneficiaries, depending on their income level, compared to the standard premium covering 25 percent. Part D costs are met through monthly premiums, which are designed to cover 25.5 percent of the cost of the basic benefit for an individual, with the balance paid by Federal general revenues and certain State transfer payments.

The Part A tax rate is specified in the Social Security Act and is not scheduled to change at any time in the future under present law. Thus, program financing cannot be modified to match variations in program costs except through new legislation. In contrast, the premiums and general revenue

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

financing for both Parts B and D of SMI are reestablished each year to match estimated program costs for the following year. As a result, SMI income automatically matches expenditures without the need for legislative adjustments.

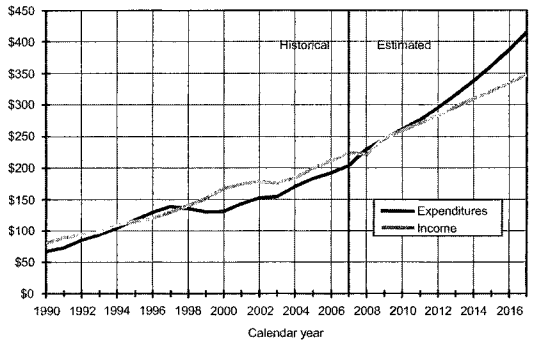
Each component of Medicare has its own trust fund, with financial oversight provided by the Board of Trustees. My discussion of Medicare's financial status is based on the actuarial projections contained in the Board's 2008 report to Congress. Such projections are made under three alternative sets of economic and demographic assumptions, to illustrate the uncertainty and possible range of variation of future costs, and cover both a "short range" period (the next 10 years) and a "long range" period (the next 75 years). The projections are not intended as firm predictions of future costs, since this is clearly impossible; rather, they illustrate how the Medicare program would operate under a range of conditions that can reasonably be expected to occur. It is important to note that the results shown in this year's report continue to be significantly more uncertain than those in past reports prior to enactment of the MMA. In particular, the Part D projections are estimated with only limited actual program experience. In addition, the Part B cost projections almost certainly understate the actual future cost of this component, due to the impact of the "sustainable growth rate" payment mechanism for physician services under current law. The projections shown in this testimony are based on the Trustees' "intermediate" set of assumptions.

Short-range financial outlook for Hospital Insurance

Chart 1 shows HI expenditures versus income since 1990 and projections through 2017. For most of the program's history, income and expenditures have been very close together, illustrating the pay-as-you-go nature of HI financing. The taxes collected each year have been roughly sufficient to cover that year's costs. Surplus revenues are invested in special Treasury securities—in effect, lending the cash to the rest of the Federal government, to be repaid with interest at a specified future date or when needed to meet expenditures.

During 1990-97, HI costs increased at a faster rate than HI income. Expenditures exceeded income by a total of $17.2 billion in 1995-97. The Medicare provisions in the Balanced Budget Act of 1997 were designed to help address this situation. As indicated in chart 1, these changes—together with subsequent low general and medical inflation and increased efforts to address fraud and abuse in the Medicare program—resulted in a decline in Part A expenditures during 1998-2000 and trust fund surpluses totaling $61.8 billion over this period. (Part of this decrease was attributable to the shift of a substantial portion of home health care costs to Part B, which improved the financial status of the HI trust fund but did not reduce Medicare costs overall.) After 2000, Part A expenditures and income converged slightly, as the Balanced Budget Refinement Act and the Benefit Improvement and Protection Act increased Part A expenditures and the 2001 economic recession resulted in lower payroll tax income for Part A.

Chart 1—HI expenditures and income
(in billions)



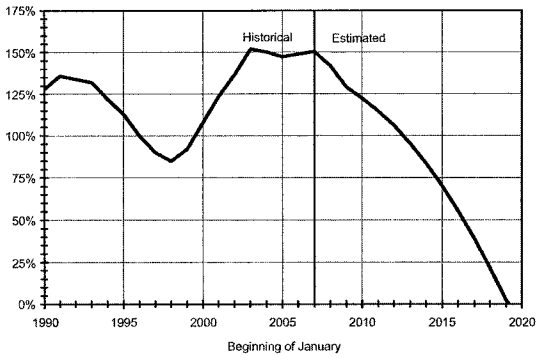
Starting in 2004, the MMA increased Part A expenditures, through higher payments to rural hospitals and to private Medicare Advantage health plans. Moreover, the growth rate of expenditures is expected to continue to exceed growth in revenues.[2] Total HI income, including interest earnings, is expected to be less than expenditures in 2010 and all years thereafter. (HI dedicated revenues alone are estimated to fall short of total expenditures beginning this year.) Note that even relatively small changes in growth trends for either income or expenditures could have a very significant impact on the projected difference between these cash flows. In particular, the onset of deficits in the HI trust fund could occur somewhat earlier or later than this intermediate projection.

Chart 1 also shows an upward shift in the level of HI expenditures from 2007 to 2008 and a temporary dip in income in 2008. These patterns are related, and they arise from the identification and correction of an accounting error. Specifically, a new, integrated accounting system for Medicare was phased in starting in 2005. This system inadvertently paid Part A hospice benefits from the Part B account of the SMI trust fund. As a result, Part A expenditures were too low in 2005-2007 (and Part B expenditures were too high, by the same amount). The problem was identified and corrected for future payments in September 2007, and the HI expenditures projected for 2008 and later reflect the full level of hospice benefits. The assets of the HI trust fund will be adjusted downward by approximately $12.6 billion in June 2008 to return the portfolio to the position in which it would have been if the hospice payment misallocation had not occurred. The adjustment is counted against HI income for 2008 in chart 1.

[2] Health care costs, including those for Medicare, increase in proportion to the number of beneficiaries, the increase in the average price per service, the number of services performed ("utilization"), and the average complexity of services ("intensity"). In contrast, HI payroll tax revenues increase only as a function of the number of workers and the increase in average earnings.

The Board of Trustees has recommended maintaining HI assets equal to at least one year's expenditures as a contingency reserve. As indicated in chart 2, HI assets at the beginning of 2008 represented 142 percent of estimated expenditures for the year. Future asset growth, reflecting the diminishing difference between income and expenditures described above, is projected to be significantly slower than expenditure growth in 2008 and later. After 2010, as assets are drawn down to cover the annual deficits, the trust fund balance would decline and would be exhausted early in 2019 under the Trustees' intermediate assumptions.

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



The projected exhaustion date for the HI trust fund is the same year as was projected in last year's report but at an earlier point within the year, due to slightly lower projected payroll tax income and slightly higher projected benefits than previously estimated, together with the asset adjustment to compensate for the hospice cost misallocation.

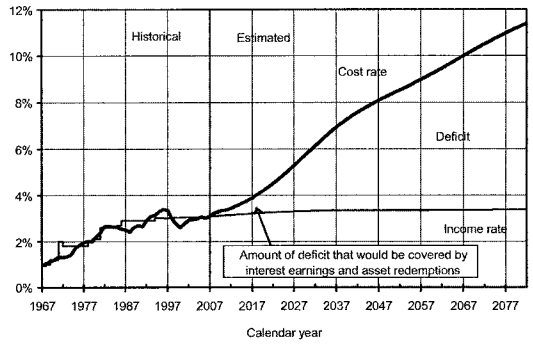
Long-range financial outlook for Hospital Insurance

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

Past income rates have generally followed program costs closely, rising in a step-wise fashion as the payroll tax rates were adjusted by Congress. Income rate growth in the future is minimal, due to the fixed tax rates specified in current law. Trust fund revenue from the taxation of Social Security benefits increases gradually, because the income thresholds specified in the Internal Revenue Code

are not indexed. Over time, an increasing proportion of Social Security beneficiaries will incur income taxes on their benefit payments.

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



Past HI cost rates have generally increased over time but have periodically declined abruptly as the result of legislation to expand HI coverage to additional categories of workers, raise (or eliminate) the maximum taxable wage base, introduce new payment systems such as the inpatient prospective payment system, and make other changes. Cost rates decreased significantly in 1998-2000 as a result of the Balanced Budget Act provisions together with strong economic growth. After 2000, however, cost rates increased, partly because of the Balanced Budget Refinement Act and the Benefit Improvement and Protection Act. Cost rates are expected to continue increasing in 2008 and later and to accelerate significantly as the baby boom generation enrolls in Medicare, beginning in 2011. By the end of the 75-year period, scheduled tax income would cover only 30 percent of projected expenditures.

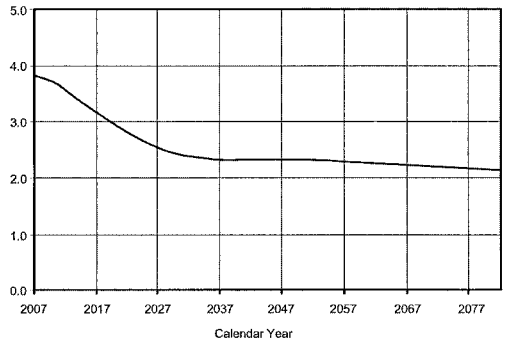
The average value of the financing shortfall over the next 75 years—known as the actuarial deficit—is 3.54 percent of taxable payroll. For illustration, this deficit could be closed by an immediate increase of 1.77 percentage points in the HI payroll tax rate, payable by employees and employers, each. If, instead, no changes were made until the year of asset exhaustion, then the HI payroll tax rate would require an increase of about 2.23 percent (employees and employers, each). Note, however, that such changes would correct the deficit only "on average." Initially, HI revenue would be significantly in excess of expenditures, but by the end of the period, only about one-half of the projected annual deficit would be eliminated. The long-range deficit could also be eliminated by many other approaches involving revenue increases and/or expenditure reductions, but its magnitude poses a very daunting challenge to policy makers.

Per-person HI costs are expected to increase faster than per-worker tax revenues due to health care price inflation and increases in the utilization and intensity of services. Collectively, these factors generally exceed the growth in average earnings per worker, on which HI taxes are based. Important

demographic factors contribute further to this growth differential. The effect of the baby boom generation on Medicare and Social Security is relatively well known, having been discussed by actuaries and others for the last 35 years. Basically, by the time the baby boom cohorts have enrolled in Medicare, there will be about 75 percent more HI beneficiaries than there are today, but the number of covered workers will have increased by only about 20 percent. When the HI program began, there were 4.5 workers in covered employment for every HI beneficiary. As shown in chart 4, this ratio was about 3.8 workers per beneficiary in 2007. When the baby boom joins Medicare, the number of beneficiaries will increase more rapidly than the labor force, resulting in a decline in this ratio to about 2.4 in 2030 and 2.1 by 2080 under the intermediate projections. Other things being equal, there would be a corresponding increase in HI costs as a percentage of taxable payroll.

There are other demographic effects beyond those attributable to the varying number of births in past years. In particular, life expectancy has improved substantially in the U.S. over time and is projected to continue doing so. The average remaining life expectancy for 65-year-olds increased from 12.4 years in 1935 to 18.0 years currently, with an estimated further increase to about 22 years at the end of the long-range projection period. Medicare costs are sensitive to the age distribution of beneficiaries. Older persons incur substantially larger costs for medical care, on average, than do younger persons. Thus, as the beneficiaries age, over time they will move into higher-utilization age groups, thereby adding to the financial pressures on the Medicare program.

Chart 4—Workers per HI beneficiary



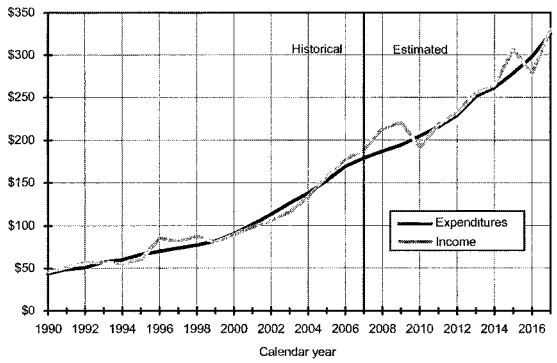
Financial outlook for Supplementary Medical Insurance Part B

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

Chart 5 presents estimates of the short-range outlook for Part B. In contrast to the HI program, the income and expenditure curves for Part B remain closely related in the future. As noted previously, Part B premiums and general revenue income are reestablished annually to match expected program costs for the following year. Thus, the program will automatically be in financial balance, regardless of future program cost trends.[3]

The income amount shown in chart 5 for 2008 includes a planned reimbursement of about $12.6 billion in recognition of the inadvertent charges made to the Part B account to cover the costs of certain Part A hospice benefit payments. As described previously, this cost misallocation occurred as a result of the introduction of a new accounting system, and the problem was corrected late in 2007 for future payments. The lump sum adjustment will repay the Part B account, with interest, for the inadvertent payments in 2005-2007.

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

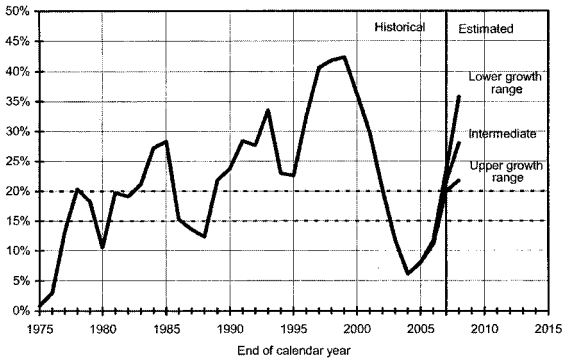


As shown in chart 5, Part B expenditures exceeded income during 1999-2004, resulting in account deficits over this period totaling $26.8 billion. These deficits resulted in part from greater-than-expected increases in physician, outpatient hospital, and certain other Part B costs. They also occurred due to a series of legislative acts that overrode scheduled reductions in Medicare physician fees after the financing rates had already been set for a year. In particular, the Consolidated Appropriations Resolution of 2003 (CAR) and the MMA raised Part B costs above the prior-law levels used to establish beneficiary premiums and general revenue financing. This pattern continued with the Deficit Reduction Act of 2005 (DRA), the Tax Relief and Health Care Act of 2006 (TRA), and the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA).

[3] The occasional odd patterns in the projected revenues occur when the normal January 3rd payment date for Social Security benefits falls on a Saturday, Sunday, or holiday. In such cases, payment is advanced to the next earlier business day—which is generally December 31st of the prior year. This situation will affect calendar-year Part B receipts in 2009-2010 and again in 2015-2016.

The resulting deficits in the Part B account drew down assets to a level that was well below the range needed for contingency purposes, as shown by the dotted lines in chart 6. Consequently, beneficiary premiums and matching general revenue financing were increased substantially for 2004, 2005, 2006, and 2007.[4] These increases, together with the planned $12.6-billion asset adjustment in June 2008, restored Part B assets to an adequate level at the end of 2007—the first such occurrence since 2002.[5] Assets are estimated to increase further by the end of 2008 under current law. A somewhat lower (but still adequate) level would result in the likely event that legislation is enacted to override a scheduled 10.6-percent reduction in physician payment rates for the second half of 2008.

Chart 6—Actuarial status of the Part B account in the SMI trust fund
(assets minus liabilities as percentage of following year's expenditures)



As suggested by the preceding discussion, the projected Part B expenditures shown in the 2008 Trustees Report are unrealistically low due to the structure of physician payments under current law. Future physician payment increases must be adjusted downward if cumulative past actual physician spending exceeds a statutory target. By the start of 2003, actual spending was already above the target level. The CAR, MMA, and DRA raised physician payments for 2004-2006 without raising the allowable target spending to match. The TRA raised the physician fee schedule update for 2007 and increased the target for 1 year, but specified that the 2008 physician fee update be computed as if the 2007 update had not been changed. Similarly, the 2007 MMSEA raised the physician fee schedule update for the first half of 2008, but the update for the second half will be computed as if the first 6 months of the year had not been changed. Together, these factors yield estimated reductions in physician payment rates of about 10.6 percent for July 2008, another 5 percent for

[4] The increases were 13.4 percent, 17.4 percent, 13.2 percent, and 5.6 percent, respectively, for these 4 years.

[5] The adequacy of the Part B contingency reserve is measured on an incurred basis. For this purpose, the June 2008 asset adjustment is treated as an "account receivable" item at the end of 2007 and is included in assets. In the absence of this factor, Part B assets would be at the lower end of the adequate range.

January 2009, and an additional 5 percent for nearly every year during 2010-2016.[6] Because an aggregate 41-percent reduction in physician fees from current levels is implausible, the projected Part B expenditures shown in the 2008 Trustees Report must be considered substantially understated. By extension, costs shown for SMI, and for Medicare in total, are also understated. In the likely event that Congress continues to override the reductions in physician fees that would be required under current law, actual Part B costs could be roughly 10 to 20 percent higher than projected, and a greater increase in premium and general revenue financing would be required to match program costs and maintain assets at the necessary level.

Financial outlook for Supplementary Medical Insurance Part D

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

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

Chart 7 shows actual Part D costs in 2004-2007 and estimates through 2016. For the Part D program, the financial operations in 2004 and 2005 related only to the prescription drug discount card and low-income transitional assistance. The full Medicare prescription drug coverage became available in 2006. Part D income and outgo have been, and will continue to be, in virtually exact balance automatically due to (i) annual adjustments of premium and general revenue income to match costs, and (ii) a flexible appropriation process under which general revenues are appropriated to the trust fund account on a daily basis as needed to cover that day's outlays. As a result of this latter feature, there is no need to maintain a contingency reserve in the Part D account.[7]

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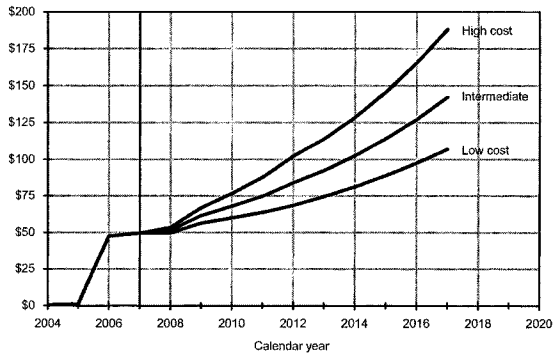
[6] Following customary practice, the Medicare Trustees Report describes the *average* change in physician payment rates over specified periods. For example, it shows a decrease of about 10 percent for the second half of 2008 compared to the second half of 2007. Similarly, it indicates that the level for 2009 under current law would be 10 percent lower than the average level for 2008. These differences in average levels can be confused with the more commonly used physician update percentages described in the text above.

[7] Individual Part D plans would normally maintain contingency reserves in case actual costs during the year exceed their expectations.

Chart 7—SMI Part D expenditures and income under alternative assumptions
(in billions)



The Part D expenditure projections shown in the 2008 Trustees Report are significantly lower than those in the 2007 report and substantially lower than the original projections from 2003. The improvement relative to last year's Trustees Report arises primarily from three factors. First, actual benefit costs in 2006 were lower than we (and the Part D plans) had estimated. In addition, the actual drug manufacturer rebates reduced Part D expenditures by 8.6 percent in 2006, significantly above the assumed level of about 5 percent. Finally, the projected cost growth trend for the next several years, which is based on our projected growth in prescription drug spending nationally, is somewhat lower than in last year's report. Collectively, these effects reduce projected Part D spending in 2008-2017 by $129 billion or about 17 percent compared to last year's report. The actual future cost of Part D remains uncertain, however, as illustrated by the projection range shown in chart 7, because only limited data are available to date on the actual operations and cost of the program.

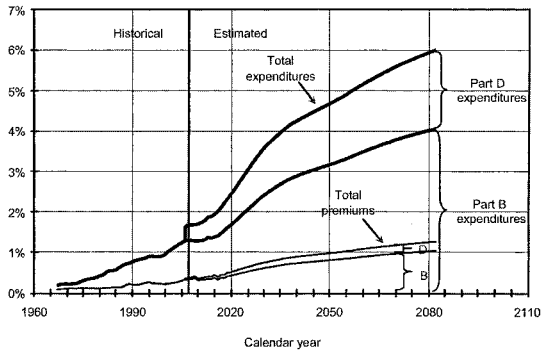
Long-range outlook for Supplementary Medical Insurance overall

Chart 8 shows projected long-range SMI expenditures and premium income as a percentage of GDP. Under present law, Part B beneficiary premiums will continue to cover about 25 percent of total Part B costs, with the balance drawn from general revenues. Similarly, Part D beneficiary premiums are designed to cover 25.5 percent of the basic Part D benefit, on average. Because many enrollees qualify for the Part D low-income subsidy and do not have to pay full (or any) premiums , and because the low-income subsidy and retiree drug subsidy costs are not financed through premiums, total premium revenues currently represent about 9 percent of total Part D costs. The balance is paid by general revenues (77 percent) and State transfers (14 percent).[8] SMI expenditures are projected to increase at a significantly faster rate than GDP, for largely the same reasons underlying HI cost growth. For most of the past 15 years, prescription drug spending has been the fastest growing

[8] These percentages are estimates for 2008; the balance will shift somewhat over time as the State requirement declines from 90 percent to 75 percent of the forgone cost of prescription drugs for full dual beneficiaries and as the Part D national average bid and low-income subsidy benchmark demonstration programs are completed.

component of national health care costs. Consistent with that trend, the Medicare prescription drug spending under Part D is projected to initially grow faster than either Part A or Part B.

Chart 8—SMI expenditures and premiums as a percentage of GDP

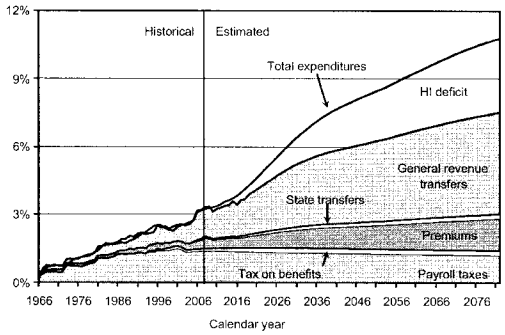


Although each SMI account is automatically in financial balance, the program's continuing rapid growth in expenditures places an increasing burden on beneficiaries and the Federal budget. In 2010, for example, a representative beneficiary's Part B and Part D premiums would require an estimated 11 percent of his or her Social Security benefit, and another 14 percent would be needed to cover average deductible and coinsurance expenditures for the year. By 2080, about 29 percent of a typical Social Security benefit would be needed to pay the Part B and Part D premiums, and about 37 percent would be required for copayment costs. Similarly, Part B and Part D general revenues in fiscal year 2010 are estimated to equal about 11 percent of the personal and corporate Federal income taxes that would be collected in that year, if such taxes are set at their long-term, past average level, relative to the national economy. Under the same assumption, projected Part B and Part D general revenue financing in 2080 would represent over 39 percent of total income taxes.

Combined HI and SMI expenditures

The financial status of the Medicare program is appropriately evaluated for each trust fund account separately, as summarized in the preceding sections. By law, each fund is a distinct financial entity, and the nature and sources of financing are very different between the two funds. This distinction, however, frequently causes greater attention to be paid to the HI trust fund—and especially its projected year of asset depletion—and less to SMI, which does not face the prospect of depletion. It is important to consider the total cost of the Medicare program and its overall sources of financing, as shown in chart 9. Interest income is excluded since, under present law, it would not be a significant part of program financing in the long range.

Chart 9—Medicare expenditures and sources of income as a percentage of GDP



Combined HI and SMI expenditures are projected to increase from 3.2 percent of GDP in 2007 to 10.8 percent in 2082, based on the Trustees' intermediate set of assumptions. The addition of Part D increased total Medicare costs by about 13 percent in 2006, and this increment is expected to ultimately grow to more than 20 percent. In past years, total income from HI payroll taxes, income taxes on Social Security benefits, HI and SMI beneficiary premiums, and SMI general revenues was very close to total expenditures. Beginning in 2008, overall expenditures are expected to exceed the aggregate amount of these non-interest financing sources, with the growing difference arising from the projected imbalance between HI tax income and expenditures. Throughout the long-range projection period, SMI revenues would continue to approximately match SMI expenditures.

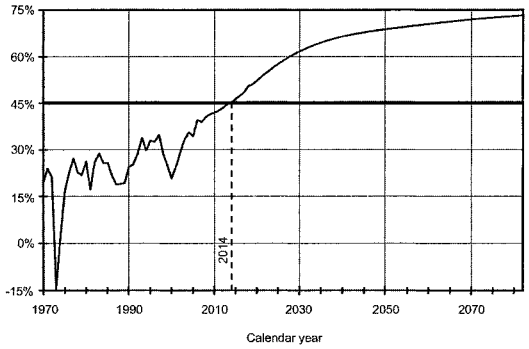
Over time, SMI premiums and general revenues would continue to grow rapidly, since, under current law, they would keep pace with SMI expenditure growth. HI payroll taxes are not projected to increase as a share of GDP, primarily because no further increases in the tax rates are scheduled under current law. Thus, as HI sources of revenue become increasingly inadequate to cover HI costs, SMI premiums and general revenues would represent a growing share of total Medicare income. Within the next 5 years, under current law, general revenues are expected to constitute the largest source of Medicare financing.

Chart 10 shows the past and projected differences between Medicare's total outlays and its "dedicated financing sources," expressed as a percentage of total outlays. This ratio is estimated to reach 45 percent of outlays within the next 7 fiscal years.[9] As required under section 801 of the MMA, the Board of Trustees has issued a determination of "excess general revenue Medicare funding," the third such determination. The corresponding determinations in the 2006 and 2007 reports triggered a "Medicare funding warning" last year. Section 802 of the MMA required the President to submit to Congress, within 15 days after the release of the FY 2009 Budget, proposed

[9] The dedicated financing sources are principally HI payroll taxes, the portion of income taxes on Social Security benefits that is allocated to the HI trust fund, beneficiary premiums, and the special State payments to Part D. These sources of dedicated revenues are depicted in the bottom four layers in chart 9.

legislation to respond to the warning. Accordingly, the President submitted the proposed "Medicare Funding Warning Response Act of 2008" in February this year, and Congress must now consider it on an expedited basis. Because the difference is again projected to exceed 45 percent within the first 7 years in the 2008 annual report—specifically in 2014—a determination of projected "excess general revenue Medicare funding" is again issued, and another "Medicare funding warning" is thereby triggered.

Chart 10—Projected difference between total Medicare outlays and dedicated financing sources, as a percentage of total outlays



Currently, most of the difference between Medicare expenditures and dedicated revenues is financed by the Part B and Part D general revenue transfers provided by law. The remainder of this difference equals the amount by which HI expenditures exceed HI tax income and premiums. This gap can be met initially by using a portion of the interest earnings on the assets of the HI trust fund and subsequently, through 2018, by redeeming the assets of the trust fund. The cash required for the payment of interest and the redemption of assets is drawn from the general fund of the Treasury.

Over time, the difference between expenditures and revenues is projected to continue to increase under current law—reflecting not only further growth in statutory general revenue transfers to Medicare, as costs for Parts B and D continue to increase, but also the widening shortfall of HI tax income compared to expenditures. Although the statute labels the total difference as "general revenue Medicare funding," it is important to note that there is no provision in current law to address the projected HI trust fund deficits once the fund's assets are depleted. In particular, it would not be possible to transfer general revenues to HI to make up the difference.

The comparison of expenditures versus dedicated revenues, as called for by section 801 of the MMA, is a useful measure of the magnitude of general revenue financing for Medicare plus the HI trust fund deficit. Similarly, the test underlying a "Medicare funding warning" can help call attention to the impact on the Federal Budget associated with the general revenue transfers to Medicare. The "Medicare funding warning," however, should not be interpreted as an indication

that trust fund financing is inadequate. That assessment can be made only by comparing each trust fund account's expenditures with all sources of income provided under current law, including the statutory general fund transfers and interest payments.

Conclusions

In their 2008 report to Congress, the Board of Trustees emphasizes the continuing financial pressures facing Medicare and urges the nation's policy makers to take steps to address these concerns. They also argue that consideration of further reforms should occur in the relatively near future, since the earlier that solutions are enacted, the more flexible and gradual they can be. Finally, the Trustees note that early action increases the time available for affected individuals and organizations—including health care providers, beneficiaries, and taxpayers—to adjust their expectations.

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

Chairman STARK. Thank you. As we have discussed, we pay Medicare Advantage plans more than we pay fee-for-service. What effect, in terms of months, I guess, or years, do these Medicare Advantage overpayments have on the trust fund solvency, or on Medicare solvency?

Mr. FOSTER. If the law were changed such that the Medicare Advantage benchmarks were set at the same level of cost as fee-for-service, then we estimate that would extend the solvency of the HI trust fund by about 18 months.

Because we are currently projected to go broke early in 2019, that would move us into the end of 2020. But it's an 18-month period, much like last year.

Chairman STARK. Okay. Because Part B premiums are based on the total expected expenditures for Part B, which includes the payments to Medicare Advantage plans, is it not true that people paying Part B premiums have them increased—they are increased for all beneficiaries, even though only maybe 20 percent actually use Medicare Advantage?

Everybody else in Medicare has to pay more to cover the increased costs of these Medicare Advantage plans. Is that—and about how much is that?

Mr. FOSTER. Yes, sir. That's correct. We estimate that, as of 2009, the additional premium for Part B associated with the higher benchmarks for Medicare Advantage is about $3 per month.

Chairman STARK. Last year was $2.

Mr. FOSTER. I think

Chairman STARK. What happened?

Mr. FOSTER. Well, these are both rounded, so the reality may be a little closer together.

Chairman STARK. If Medicare Advantage rates had been equalized as we did in the CHAMP Act, would the 45 percent trigger have been tripped?

Mr. FOSTER. No, sir. With that change, it would not have been tripped or triggered in this year's report. But, instead, we would have expected the ratio to cross 45 percent in 2016, rather than 2014.

Chairman STARK. As you know, the private plans calculate what's called a medical loss ratio. We insisted that that be made part of our Medigap plans, and even though we don't pay—the government doesn't pay—for Medigap plans.

Now, a recent GAO report found that a third of all the Medicare Advantage plans appear to have loss ratios lower than 85 percent, meaning they spent more than 15 percent of their revenue on overhead and profit, and less than 85 percent of beneficiaries.

Do you think it would be a good idea to require Medicare Advantage plans to meet some minimum loss ratio standards?

Mr. FOSTER. Possibly. I don't have a very clear-cut answer for you, I'm afraid.

On the one hand, you could argue that, with the degree of competition out there, it's not terribly common that you would have very low medical loss ratios.

On the other hand, one can argue that it shouldn't be terribly common, either, for a plan to have that high of an administrative cost, or that high of a profit margin.

There is a different argument that can be made in favor of the proposal, and that has to do with what I perceive as one of the limitations of the way Medicare Advantage is currently set up: that is while there is a lot of competition within Medicare Advantage, it's mostly directed toward who can provide the best benefit package, or the most attractive-looking benefit package.

But it's awfully hard for beneficiaries to figure out which is the most efficient plan. "Where do I get the best benefit package for my money?" because it's—unless you're an actuary, it's awfully hard to determine the value of the different benefit packages.

So, if medical loss ratios were published, it would be one way of signaling to beneficiaries that this plan is more efficient than this other plan. It would help them make an informed decision.

Another, and probably much more direct way, would be to do what the House of Representatives did in your version of the MMA, which was to require the rebates to be paid directly to the enrollees, and the amount to be directly identified. The enrollees could turn right around and then spend the rebates them for extra coverage, if they felt like it, but then you would have a clear-cut price signal, and that would improve people's ability to choose an efficient plan.

The other issue with publishing the MLR ratios is one that we're continuing to look at. It makes some of us a little uneasy about what this might do to the nature of competition among the plans, if every plan knew what every other plan's cost factors were. So, that's one we're still struggling with a bit.

I think that's as much as I can think of on the subject.

Chairman STARK. I couldn't help—thinking of two final questions—nobody has threatened to fire you in the past couple of years, have they?

Mr. FOSTER. No, sir. If anybody did, I was oblivious.

Chairman STARK. Okay.

Mr. FOSTER. So, I think that means nobody has.

Chairman STARK. All right, but help me. I have been looking—and I don't think this goes to your competence—but it is interesting that in 1998, 10 years ago, you reported to us that we were going to be broke today, in 2008.

Now, you were just off—your current report says it will be 2019. That means, instead of 10 years in 1998, you should have said 21 years. That was—you were off by a country mile.

Now, what have you done, or what have we done, or what has anybody done, to suggest to folks who aren't actuaries—and I might add that, as we look back, we were going to go broke in 1999, 2001, 2002—and what is it that happens, what is going to happen over the next 10 years to save us, as happened between 1998 and today to save us?

Mr. FOSTER. That's an excellent question. I can speak about this a little bit.

In 1998, of course, the projections reflected the estimated impact of the Balanced Budget Act 1997, which, as you remember, was a

very hard-hitting piece of legislation. So, our estimates were built into the 1998 projections.

Now, in practice, some of the BBA impacts were greater than we estimated. In particular, you remember the provision about transferring certain of the home health visits from Part A to Part B?

Chairman STARK. Mm-hmm.

Mr. FOSTER. In practice, it turned out that more of these visits ended up qualifying as Part B, and relatively fewer as Part A, than we originally thought. So, that was one factor.

Another factor was that of the home health agencies themselves misunderstood the interim limits. As a result, they cut back on their own services far more than they needed to under the law. That reduced costs. It was unfortunate, but the law was complicated, and they were acting very cautiously. So, for both reasons, home health costs for both reasons for Part A were significantly less than we had estimated at the time.

Now, similarly, skilled nursing costs came in less than we had thought they would, based on the actual experience.

Something else interesting happened following 1998, and that was that, for the first time in the history of Medicare, what we called a case mix index for Part A—this is the average complexity of inpatient hospital admissions went down. Normally, that goes up roughly by 1 percent per year, because hospitals treat more complicated cases over time.

But, starting in 1998, it actually went down, and it went down for about 5 years in a row, to the tune of, on average, 1 percent per year. By perhaps the strangest of coincidences, most of the reduction occurred in coding of cases for simple pneumonia versus respiratory infection, and with or without complications for the DRGs that were paired at that time. By coincidence, perhaps, and perhaps not, that's exactly what the Department of Justice was investigating for a major hospital chain at the time.

So, one way or the other, we experienced these negative case mix changes, rather than positive. That helped quite a bit, too.

There are probably some other factors, in addition to these. We will think them through and add, for the record, anything beyond that. But the short answer is it was not so much policy changes, but changes in actual experience, including the fraud and abuse, the BBA impacts being——

Chairman STARK. If I could just follow on that one more time, I don't know whether actuaries have a range of certainty, as they do in political polling. They say, you know, "This was within five points of being accurate."

When you're talking about going out 75 years, is there—are you—do you have the same certainty on your projections for 5 and 10 as you do for 40 years out, or is there a cliff out there somewhere, where you've got more guess and less empirical certainty?

Mr. FOSTER. Well, I think it's fair to say the farther out you go, the less certainty you can have.

For the next few years, we hope that we can do a pretty good job. In real life, of course, it may be that the costs for any given type of service in 2008, instead of increasing by X percent, which we might now estimate, they could easily increase by, say, 2 or 3

percentage points more than that, or 2 or 3 percentage points less than that.

Now, over time, estimation differences like that can often average out, but not necessarily. You can have a sustained faster trend.

The value of the long-range projections is not that we think we can actually predict with any kind of confidence what will happen. If we thought that, or if we could actually do that, then we would be someplace else making millions of dollars, I think, in the stock market, rather than being actuaries.

Nonetheless, there is value to them, because it enables us, or the Board of Trustees, to tell you folks, the nation's policy makers, that, under reasonable conditions that we think could reasonably happen, here is what the program would look like. It's either okay or not okay. But we should never kid ourselves, or place too much emphasis or reliance on what are inherently uncertain projections.

Chairman STARK. Thank you so much. Mr. Camp, would you like to——

Mr. CAMP. Well, thank you, Mr. Chairman. Mr. Foster, you mentioned that Part B premiums would be reduced by $3 as a result of cutting Medicare Advantage plans. If I understood your testimony, if we completely limit Medicare Advantage for about nine million seniors, we would extend the life of the program about two years. Is that what you said?

Mr. FOSTER. Yes, sir, about 18 months.

Mr. CAMP. Well, forgive me if I don't start throwing the confetti; that's not very long. Can you tell me the impact on the Part B premium from the physical payment provision in the CHAMP bill that spent $67 billion over 10 years?

Would you please tell me in your answer, how much would the Part B premium increase? There is a significant increase in Part B spending.

Mr. FOSTER. Let me check just a second to see if we have that.

Mr. CAMP. All right. Well, if you would like to get back to me in writing, I would appreciate an answer in writing.

Mr. FOSTER. I will reply to you.

Mr. CAMP. Also, Medicare Advantage plans, is it accurate to say about 87 percent of their dollars are used on medical expenses, and about 4 percent of that would be profit? Is that your understanding, after your analysis?

Mr. FOSTER. Almost. In other words, the total percentage for administrative costs and profit margin is about 13 percent.

Mr. CAMP. Yes. About 19 percent is administrative, which I would call disease management, all of those other things, and about 4 percent is profit.

Mr. FOSTER. That's correct.

Mr. CAMP. I would break those two down. The CHAMP Act required only 85 percent be spent on medical. So, actually, the CHAMP Act required less to be spent on medical than we're finding in reality, is that correct?

Mr. FOSTER. Well——

Mr. CAMP. I see nodding behind you, so——

Mr. FOSTER. The 13 percent is an average.

Mr. CAMP. An average, we're talking on average, yes.

Mr. FOSTER. It's not——

Mr. CAMP. On average, Medicare Advantage plans spend about 87 percent on medical. The CHAMP bill, on average, required about 85 percent being spent on medical. So, the CHAMP bill required slightly less to be spent on medical than is current practice.

Mr. FOSTER. I guess I would quibble just a little bit. I agree with you, generally, but the 85 percent was a limit, I thought not a average. In other words, no plans could go beyond the limit.

Mr. CAMP. Yes, it was you could not go beyond that. But actually, in reality, we're seeing they spend about 87 percent. You would agree with that. So, I appreciate that.

Mr. FOSTER. Yes.

Mr. CAMP. On Part D—obviously, the costs on this program are much lower than you projected. Is that, in part, because plans were able to negotiate deeper discounts from drug manufacturers than you had anticipated?

Mr. FOSTER. Yes, sir, it is. In particular, while we anticipated a vigorous level of competition among Part D plans, we thought that it would take a few years, 2 or 3 years, for that competition to be fully reflected in the lowest retail discounts, the best rebates, et cetera.

So, we thought that eventually the savings off of a retail level from retail discounts, manufacturer rebates, and utilization management would increase to about 25 percent after a few years. In real life, in 2006, the plan started off at about 27 percent right off the bat, and it has since grown to just about 30 percent.

Mr. CAMP. So, it's about 37 percent lower in 2008 than the original in 2003.

Tell me, what are the differences between last year and this year, in terms of Part D's estimates? How far off are we—were you on that?

Mr. FOSTER. For the first 10 years, which would be 2008 through 2017, the total projected cost over that period is about 17 percent lower in the new projections, compared to last year's.

Mr. CAMP. All right.

Mr. FOSTER. Now, that's due to three factors, primarily. First, and most important, that is the actual experience of plans in 2006 was lower, not only than we estimated, but also lower than the plans themselves had estimated in their bids. So, the actual costs came in lower.

In addition, the level of rebates that the plans received from the drug manufacturers was about 8.6 percent in the first year, and is slightly higher now. We had been estimating about 5 percent, which was a prevailing good figure at the time.

The third factor is that, for projecting the trend growth rate of prescription drug costs for Medicare, we use our drug projections for national health spending, overall. Between last year and this year, we have reduced that trend slightly in the first few years. So, those factors together result in the 17 percent——

Mr. CAMP. So, it's not just because the number of low-income beneficiaries enrolled is lower than projected. It's these other factors you have mentioned?

Mr. FOSTER. That is a relevant factor, but it has more to do with the difference between our original estimates back in 2003——

Mr. CAMP. I see.

Mr. FOSTER. And the current estimates. About 7 percentage points out of the 37 percent that you mentioned are attributable to lower enrollment, generally.

Mr. CAMP. Okay.

Mr. FOSTER. Much of that is due to about roughly one's million fewer low-income subsidized beneficiaries than we had originally estimated.

Mr. CAMP. But that's not the case between your estimates last year and your estimates this year.

Mr. FOSTER. No. We were much closer in that regard after the very first projection.

Mr. CAMP. All right. Thank you very much. Thank you, Mr. Chairman.

Chairman STARK. Mr. Doggett?

Mr. DOGGETT. Yes. Thank you so much for your testimony and your work.

In order to accurately assess the experience under Part D, do you believe it would be valuable for congressional support agencies and researchers to have access to the actual claims data for Part D plans?

Mr. FOSTER. I believe it would be, if the proper controls were in place to limit the privacy considerations.

Mr. DOGGETT. You're aware that CMS proposed a regulation way back in October 2006, but they still, after all that time, have not finalized a rule for the release of that data.

Mr. FOSTER. Yes, sir, that's correct. It went out as an NPRM, as you say. We received comments, which I believe were all or almost all favorable.

Mr. DOGGETT. Yes, sir.

Mr. FOSTER. It has been under discussion internally since then.

Mr. DOGGETT. Right. The lack of action on that is actually being used as an excuse for not supplying data that this Subcommittee has been trying to get now for almost a year on what appears to be CMS spending $100 million on retroactive drug coverage for dual eligibles that—it's unclear whether any benefit was obtained from it.

Also, is there an actual overpayment to Part D plans of about $4 billion for plan year 2006 by CMS?

Mr. FOSTER. Yes, sir. The way the process works is that plans submit bids——

Mr. DOGGETT. Right.

Mr. FOSTER. First Monday in June. They have to live with those bids; they can't go back and change them. We make payments to the plans that include a direct premium subsidy, which reflects the overall national cost the way the premium formula allocates it to Medicare.

We also pay them estimated amounts for the catastrophic reinsurance benefits. This is just a standard monthly amount in advance, which later on will be reconciled against the actual plan costs.

Mr. DOGGETT. Yes. Actually though, it took CMS about nine months after the plan year ended for 2006 before they realized that they had overpaid the drug plans $4 billion, did it not?

Mr. FOSTER. It took quite a while to get the data systems working accurately enough——

Mr. DOGGETT. Yes, right.

Mr. FOSTER. In order to make the calculation.

Mr. DOGGETT. Almost another year.

Mr. FOSTER. We all would have liked it to have been much quicker——

Mr. DOGGETT. Yes, sir. As far as any success in Part D being attributable to competition, that's not the main reason the costs had been lower than they were projected.

Mr. FOSTER. We don't consider it the biggest reason.

Mr. DOGGETT. In fact, when you look at dual eligible, isn't it true that the Part D plans have been unable to match the low prices that were achieved in the state Medicare programs before Part D ever took effect?

Mr. FOSTER. That's correct. I would be glad to explain why, if you like.

Mr. DOGGETT. If I have time, we will go back. If not, perhaps you can supplement in writing.

As far as the concerns with the latest projection that Medicare is about to go insolvent, and the trigger, is it correct that the only piece of the President's trigger legislation that actually will have any effect from his proposals, in view of this projected insolvency, is any effect on Medicare financing is his proposal to raise drug benefit premiums for middle and higher income beneficiaries.

Mr. FOSTER. Basically, yes. The Title III with the income-related premium——

Mr. DOGGETT. The impact of that will be to postpone the trigger date from 2013 to 2014.

Mr. FOSTER. Yes, sir.

Mr. DOGGETT. So, we have a crisis described, and the reaction of the administration is a significant amount of rhetoric, but a proposal to resolve that for at least one year as their answer.

Let me ask you about a different area, which is those people, some of the poorest beneficiaries who receive—or should be receiving extra help through the LIS program.

Is one of the reasons that the drug price that the Part D expenditures are less than what was originally projected, the fact that we have a much lower enrollment rate for those poor people that are entitled to extra help, or the low-income subsidy?

Mr. FOSTER. That is one of the factors, sir. It's not the only one——

Mr. DOGGETT. I think——

Mr. FOSTER. One of the factors.

Mr. DOGGETT. It has been very difficult to ascertain which excuse the CMS would rely on to explain that. But what is the current projection of how many people are eligible for extra help, versus how many people are receiving it?

Mr. FOSTER. The current projection and I will look it up for you, so I don't get it wrong—is 12 million. But, John, do you remember 12 point what?

Mr. DOGGETT. Well, it went down from——

Mr. FOSTER. Yes, 12.5 million is the current estimate.

Mr. DOGGETT. Right. That is down from 13.2 million people that were eligible in the previous projections.

Mr. FOSTER. That is correct.

Mr. DOGGETT. Other than making CMS look better about a job it's not doing very well, is there any other good explanation for why the number has decreased?

Mr. FOSTER. Well, let me tell you where the numbers come from, and you can decide for yourself, sir.

Mr. DOGGETT. Thank you.

Mr. FOSTER. In our original estimates, back in 2003, we used the Current Population Survey. It was at a time that a recession was going on. We estimated actually more than 14 million eligible.

A year or two later, we converted to using a different data source that is considered more accurate. Still a survey, but more accurate. That lowered it to the 13.2 million that you mentioned.

Most recently, this past fall, we have used an update of that Survey of Income and Program Participation data, and for a later year, as well. That has lowered it to the 12.5.

Now, any time we quote any of these figures we like to say we believe it's about 12.5, plus or minus a lot, plus or minus maybe another 2 million, because of the uncertainties associated.

It is true enough. I won't try to make excuses for CMS or for Social Security—everybody is sensitive about the charge that we haven't done enough to find these people who are eligible. I think, in fact, there has been a good faith effort. I am much more confident there has been a good faith effort than I am about exactly whether it's 12.5 or 10.5 or 14.5.

Mr. DOGGETT. How many people do you think are eligible who are not receiving extra help today?

Mr. FOSTER. Well, our best estimate right now is the total eligible is the 12.5 million. We estimate the number in 2008 who will get the extra help, to be 9.8 million. So, the answer differences between those two.

Mr. DOGGETT. Thank you. Thank you, Mr. Chairman.

Chairman STARK. Mr. Johnson, would you like to inquire?

Mr. JOHNSON. Thank you, Mr. Chairman. He didn't let you answer that question concerning the differences between state and Federal. Can you answer it now?

Mr. FOSTER. Certainly, sir. It's clear enough that the Part D plans with pharmacy benefit managers had negotiated very effective rebates from manufacturers. They're doing just as well as anybody else in the industry doing this.

It is tough to compare that to the rebates that are provided by law under the Medicaid program. In particular I am going to give you a couple of examples generic drugs, under the Medicaid rules, get an automatic 11 percent rebate. Almost never in the private sector do you have rebates paid on generic drugs. They are so inexpensive to begin with, it's just not done. So, that's a statutory advantage that Medicaid has.

In addition, the rules for the rules for Medicaid indicate over time, if the average manufacturer price of a particular drug increases faster than the CPI, then that difference above the rate of CPI growth has to be rebated back to these state Medicaid programs.

Over time, that accumulates to be a lot. So, if you look at the total value of rebates for Medicaid compared to total spending for drugs, it's over 30 percent. You can't negotiate your way to that level.

Mr. JOHNSON. Okay, thank you. Well, you indicate that Medicare Part B premiums doubled over the last 6 years, while D premiums remain stable.

Why do these two programs behave so differently? Can we learn any lessons from Part D and apply them to Part B?

Mr. FOSTER. A good part of the difference, sir, is that Part B is a well-established, long-standing program; Part D is quite new.

With Part B, we have the ability to have a pretty good understanding of how much the premiums will go up by, and how much they need to go up by. For a mature program, for health care generally, you would expect that to be in the range, per person, of anywhere from 5 to 8 percent. That's what they have been, other than our acceleration to rebuild the trust fund account assets, which raise the increases somewhat.

For Part D, when the plans first came in to bid on this, many of them didn't have a lot of data on drug costs for older people. Some did; some didn't. In particular, right about the same time that Part D got started actually, a couple of years before we had a sudden slow-down in the growth trend for prescription drugs, generally. Prescription drugs had been increasing at double-digit rates for about a decade-and-a-half. In 2004 and 2005, it suddenly slowed down to only in the 5 to 7 percent range, about half of what it had been.

In addition, the competition has helped, in terms of getting the greater discounts, et cetera. So, these factors combined, so far, have resulted in quite low premium increases for Part D. That will probably change in the next few years.

Mr. JOHNSON. Do you think that a defined contribution system might help, or not?

Mr. FOSTER. Well, that's a tough one, sir. Let me give you kind of a necessarily general answer.

First of all, let me say it would represent, of course, a quantum change, compared to what we have now.

Mr. JOHNSON. I know.

Mr. FOSTER. We stay out of the policy aspects: "Is this a good idea?" "Is this a bad idea?"

But the biggest factor that results in health care costs increasing faster than the economy is technology. Most medical technology is cost-increasing, because the people developing it know that there is a ready market for any better technology, even if it is quite a bit higher cost. They know that insurance will pay for most of it, and they know it will be adopted. So, most of the research out there is directed toward new technology that would be better and cost more.

If you went to a defined contribution, or a global budget sort of approach, there would be many concerns associated with it. You can look in Canada, you can look in England, you can look at other countries with long waiting lines for many kinds of services, and you can say, "I don't want that for me."

But if you did that, nonetheless, would you then have the possibility of changing the nature of the technology development? Most technology results in lower costs, over time. We have fancier cars, fancier computers, and the cost hasn't gone up to the same degree as the utility. So, if a defined contribution approach led to technology development that turns to cost decreases, we would have a fighting chance, but only a chance, of reducing the growth rate of health care costs.

Mr. JOHNSON. Thank you for your responses. Thank you, Mr. Chairman.

Chairman STARK. Thank you. Mr. Thompson?

Mr. THOMPSON. I thank you, Mr. Chairman. Thank you, Mr. Foster, for being here.

I just want to touch on, for a moment, the greater issue, and that is that the growth in health care costs are a bigger problem than just as it pertains to the public programs, such as Medicare.

The local newspaper in my district recently reported that in and I will quote "In both public and private sectors, health care costs are escalating at rates far above inflation. On average, between 1970 and 2006, Medicare spending increased by 8.7 percent per person each year, while private health insurance spending increased by 9.7 percent per person." So, this is a much bigger issue that we need to figure out how to get our arms around.

The newspaper went on to editorialize that the next President and congress must address a host of issues if we're going to be able to fix this. They mention three: the fact that the Medicare payroll tax has not been increased since 1985; the flawed structure of the prescription drug benefits begun in 2006 means that private insurance companies in the program are paid 13 percent more on average than under regular Medicare; and that the Bush tax cuts of 2001 and 2003 are straining the Federal budget, including the portion of Medicare that's paid out of general revenues. Those tax cuts expire in 2008 and 2010, providing room for discussion of the future of the government health spending programs.

Just—I think it is important to note that I don't think we are ready to fall off the cliff, but I think it's a bigger problem than some before me have mentioned. I think this lays a pretty good road map as to how we got there, and what we need to do.

Mr. Stark had mentioned the issue regarding Medicare Advantage plans. I want to follow up on that, if I could, for just a second. In terms of the dollar amounts of Medicare payments, Medicare Advantage plans are now the second largest provider group, after inpatient hospitals, and they even bypass physicians.

So, since the MA plan is paid out of both the hospital insurance and the supplementary medical insurance trust funds, should we think about adding information to future trustees reports that captures the effects of Medicare Advantage payments on the trust funds, and the program's financial outlook?

Mr. FOSTER. I think that would be useful, sir.

Mr. THOMPSON. How do we do that? Can we just——

Mr. FOSTER. Well, we start——

Mr. THOMPSON. Serve as notice that that's what we want to do, or——

Mr. FOSTER. We will start by my apologizing to you, because I read through the transcript of last year's hearing, and you raised exactly the same question. You asked, if you should write to the Board of Trustees, and I said, "That would be fine, or you can write to us, and we will pass it on, or you can just ask us." You said, "Like, right now?" I said, "Sure." Then I forgot. So, I apologize. Normally, I do better than that.

Mr. THOMPSON. I was further down the dais then.

Mr. FOSTER. No, sir. We are equal opportunity, in terms of requests from Congress.

However, let us consider this as a reiteration of your interest in this. This time I promise we will not forget. We will bring this up with the Board of Trustees on your behalf, and see where it takes us.

Mr. THOMPSON. Okay, thank you. The Chairman doesn't have to crack his gavel or anything?

Mr. FOSTER. Well, if the Chairman wanted to give me a call in about January of next year, that would be helpful. But, otherwise, we will try our best to remember.

Mr. THOMPSON. Well, I would hope that we could make that happen this year.

The—I want to talk a little bit about the 45 percent trigger. Is there any rationale for setting the threshold of general revenue financing for Medicare at 45 percent?

Mr. FOSTER. I'm not aware of any technical rationale for it. I believe it was set primarily in answer to the questions, "When might this first be triggered? What level would it have to be?"

Mr. THOMPSON. Is there any reason for me or anyone else to think that the 45 percent is the right amount of general fund revenue financing?

Mr. FOSTER. Clearly, Medicare has been financed, in significant part, from general revenues from the very beginning, in 1965. If it's a collective judgment as to at what level should be concerned, that's, I think, about all you can say for it.

Mr. THOMPSON. The 2006 report projected the 45 percent threshold would be crossed in 2012. In the 2007 report, the date was pushed back to 2013. In this year's report, the data is again pushed back to 2014.

How much volatility is there in this calculation, and can you say with any certainty that the 45 percent general revenue warning won't be pushed back yet again next year?

Mr. FOSTER. There is a certain amount of variability in it, obviously. Measures such as, the 45 percent test, or even the hospital insurance trust fund depletion date can be fairly sensitive, certainly, to changes in legislation, but even to changes in actual experience, the most recent data, changes in assumptions, et cetera.

I would say the 2014 expectation in the current report, if we've done our job well, would have a 50/50 chance of being either later or earlier.

Mr. THOMPSON. So, it's safe to say that the language created in the trigger—in the statutes—is filled with ideology. Or at least I will—maybe you can't, but I will say that.

Do you think it is helpful to be throwing around terms like "funding warning," "crossing the threshold," "cause for alarm"?

Mr. FOSTER. I don't think it's cause for alarm. I would prefer a different title, myself. But I think the test itself has some use.

Mr. THOMPSON. Thank you very much.

Chairman STARK. Ms. Tubbs Jones, would you like to inquire?

Ms. TUBBS JONES. Mr. Chairman, thank you very much. Mr. Foster, good afternoon or good morning, still, okay. How are you?

Mr. FOSTER. I am doing pretty well, thank you.

Ms. TUBBS JONES. Good. I want to focus in on Part D for a moment, sir, and talk to you about initially, when Part D was implemented, there was a whole discussion around whether or not the Secretary of Health and Human Services should have the ability to negotiate best price on behalf of recipients of Part D under Medicare.

I am wondering whether, in the Trustees' Report and the work you have done over this past year, can you discuss with us, is there a reduction in cost under Part D for prescription drugs for Medicare beneficiaries. If there is not, is there, in fact, the ability—or would you believe that you ought—the Secretary should have the ability—to negotiate best price, and would it have an impact on the costs that Medicare beneficiaries are paying right now?

Mr. FOSTER. A couple of thoughts here. The first is that the Part D plans themselves are, without question, negotiating a pretty favorable level of discounts and rebates, et cetera. As I think I mentioned earlier, compared to a regular retail level of drug costs, in Part D plans, the average reduction off that is over 30 percent. So, that's pretty good.

Now, part of your question is: could CMS, could the Secretary, do a better job than that? I would have to give you a conditional response on that, because it depends on what tools they would have.

With some of the legislation that has been introduced in the last couple of years to give the Secretary such authority, there have also been very significant constraints on what tools would be available for the negotiation.

For example, if you go to a drug manufacturer and suggest, "I will put your drug in a favored place in my formulary in exchange for this very good rebate," then you will probably get a decent rebate out of it.

But if you didn't have a national formulary of some kind, and you just had to negotiate on the good will of the companies, and the hopes that they would give you a good rebate because of public attention, or whatever, it wouldn't be nearly as effective, in our view, as what's happening currently. So, we didn't see any savings from that kind of proposal.

Alternatively, if you used the power of the 800-pound gorilla, the Federal Government power, and mandated prices, then, much as we've seen with Medicaid, where that sort of thing happens by law, you could certainly get a deeper discount, a greater level of rebates.

Ms. TUBBS JONES. Is there any disadvantage to that, using the 800-pound gorilla?

Mr. FOSTER. There are a couple of disadvantages that occur to me. One is that it's hard to know where to stop.

We have seen many instances of national price setting over the years that just don't work for very long. Right away, people try to

get around it. Right away, whatever we, in our collective wisdom, think might be the right level turns out not to be the right level after very long.

A good example of that was the Part B-covered drugs under Medicare. For many years, the prices that were set by law were way too high. The actual transaction prices were much lower, and that was addressed in recent legislation.

So, the other problem is, if you do get a little carried away, and you force a very low level of drug prices on the manufacturers, then do you risk their not being willing to sell you the drugs, or do you risk the research and development the standard sorts of arguments you hear that might have an impact on the development of future drugs?

Ms. TUBBS JONES. Well, my concern is, taking in consideration all the things that you have laid out, and also the things that are in your report, is to operate in the best interests of the seniors in America, who are out here, struggling to pay for health care, struggling to pay for gas, struggling to pay for food in the economy that we're operating in, and still being able to purchase their prescription drug benefit. What operates best for them?

Mr. FOSTER. Well, what's best for them, of course, may not be best for other people or organizations. But what's best for the beneficiaries, obviously, is the lowest premiums possible.

Ms. TUBBS JONES. Exactly. So, how do we get what's best for them?

Mr. FOSTER. I think I would suggest that we are pretty far along the way toward what's best for them, already. It's not necessarily optimal, if you speak in big pictures.

For example, we had the suggestion earlier about a defined contribution plan. If you're willing to make quantum changes in the nature of a program, and you essentially start from scratch in some respects, there might be other ways.

But what's happening right now, with these good discounts and rebates that are negotiated is a vast improvement for anybody who didn't have drug coverage beforehand. The prices they now have access to are much, much better. It's a subsidized benefit, of course, so their premiums are quite low, generally speaking.

Ms. TUBBS JONES. Mr. Chairman, if you would just allow me to ask this question, and perhaps get a written response, I am interested in—in light of the fact that we have a doughnut hole in the prescription—in the Part D coverage, what's happening to the seniors out here who fall into the doughnut hole, who pay the premium and their drug costs continue, they still have to pay the drug costs?

I would like to have a written response, Mr. Foster, at some point, around that issue. I am sure my colleagues, as well, would like to know what's happening to the senior citizen doughnut hole.

Mr. FOSTER. We would be happy to——

Ms. TUBBS JONES. Thank you, Mr. Chairman.

Chairman STARK. Mr. Kind, if you——

Mr. KIND. Thank you, Mr. Chairman. Thank you, Mr. Foster, for being here and offering this update on where we're going, fiscally.

Just to dovetail into where Ms. Stephanie Tubbs Jones has left off with you, over the recess, I, like many of my colleagues, were

holding listening sessions. It kept coming up in the course of these—because I was really probing some of the seniors out there participating in Part D, and the new prescription drug plan, how they were faring in it.

Some of the county aging officers there were telling me that they were noticing more and more people hitting this doughnut hole sooner in the year, and more of them being captured under it. At that point, a couple of the other seniors spoke up and said, "Yes, you know, I hit the doughnut hole last year," and I asked them, "Well, what did you do when you encountered that?"

They said, "Well, it came down to a choice of making my home mortgage payment, my heating oil, or the prescription drugs. Of course, we decided to stop taking the prescription medications, in light of these other choices that we were facing."

Were you able to determine in the trustees' report how much of an impact reduction in the Part D drug costs were due to the fact of seniors hitting the doughnut hole, and not hitting the catastrophic level, and therefore, incurring those expenses?

Mr. FOSTER. We always model the proportion of drug expenses that we expect to be below the deductible, or between the deductible and the initial coverage limit, in the doughnut hole, in the catastrophic area, et cetera.

I don't think—and I am going to check with John Shatto here, momentarily—that we have yet had time to do any person-by-person analysis, other than looking at aggregate amounts, and seeing how they shape up, in order to do the projections.

Mr. KIND. Yes, I think that would be helpful, if there was a way for—maybe in the next trustees' report, if you're able to go back and try to capture that data for us, as well.

It really hearkens back to an additional problem, or frustration, that we have had with the MA plans, generally, and that is, you know, we're just having a hard time getting any information on the utilization of these plans.

Obviously, we're offering a higher reimbursement rate. That was one of my chief concerns in the passage of the Medicare Modernization Act. This new Part D aspect, as you're talking about, is the largest expansion of entitlement spending since the 1960s, with no ability to pay for it.

Now we're having a hard time even finding out what the patient is receiving. We are determining under the plans what they're offering, and they claim that, because of the higher reimbursement rate, they're able to offer more. But we're not sure what that means to the typical patient, what type of utilization that they're receiving.

Would that aspect be helpful for CMS to have, and to be able to report back, as well, to us what type of utilization or outcomes these patients are receiving under the MA plans?

Mr. FOSTER. Yes, sir. I think, for the policy making community at large, broader access to the claims data would be a good thing. We have access to it ourselves. But, for example, the research office at CMS does not. So, it could only help, I think.

Mr. KIND. Yes. Obviously, we will have some confidentiality issues to deal with there, but I think those could be easily addressed.

I mean, if we are going to get a real grip on where these expenses are going, and what the real value or benefit is going to be, I think that would be quite crucial to obtain.

Finally, again, Ms. Tubbs Jones talked about the negotiating power that we may have in the Federal Government under the Part D plan. In the state of Wisconsin, we have had a very popular bipartisan senior care program that does allow some negotiation within, and it's resulting in huge cost savings.

I would assume—and I think I heard from your testimony—that if some of the similar tools are used that are currently being utilized under Medicaid programs, that might be an additional area of cost savings under Part D, as well. Is that correct?

Mr. FOSTER. They are already being used very effectively. The question is, could they be even more effective?

It's not clear to me, absent a national formulary, without those tools applied nationally, that you could do any better.

Mr. KIND. All right. Thank you, Mr. Foster. Thank you, Mr. Chairman.

Chairman STARK. Mr. Becerra, would you like to inquire?

Mr. BECERRA. Thank you, Mr. Chairman. Mr. Foster, thank you very much for being with us. I know most—much of what we talked about is really an estimate, projections of what we think will happen. Obviously, things can change. We know that the solvency of the Medicare Trust Fund has fluctuated over the years. It is always difficult to get precise measurements.

Can you give me a sense? I know in your report you talk about our costs to administer our different Medicare programs. What are the administrative costs to administer Medicare's Part A or Part B programs?

Mr. FOSTER. For administering the fee-for-service, or actually, for administering Medicare overall, I should say all aspects, all administrative costs that Medicare pays directly that percentage is about 1.5 percent.

Mr. BECERRA. Let's make sure we understand what we're talking about.

To administer the fee-for-service program, where we reimburse doctors or hospitals for providing the direct care to Medicare beneficiaries, the cost of administering that health care program under Medicare is about 1.5 percent?

Mr. FOSTER. Yes, that is correct. It is also correct to say for Medicare at large. It is a subtle factor that we make certain statutory payments to Medicare Advantage plans and to Part D plans. These plans themselves have administrative costs, but our payments under the law only reflect administration in a very minor way. They are not directly allocated and identified as administrative.

Mr. BECERRA. Okay. So, those are the costs that the government, in essence, pays in administering the Medicare program, about a percent and a half. You mentioned there are other costs: the Part C program, Medicare Advantage, which is operated by the health plans, the insurance industry.

Do we have a sense of what their administrative costs are?

Mr. FOSTER. Yes, sir. Currently, for the Medicare Advantage plans, the average administrative cost, including the gain/loss mar-

gin, or so-called profit margin, is about 13 percent. So, about 9 percent admin and about 4 percent for a gain/loss.

Mr. BECERRA. So, about 13 percent?

Mr. FOSTER. Thirteen.

Mr. BECERRA. Thirteen percent to administer, in essence, a parallel program of health care under Medicare that uses a different format. The insurance industry offers a plan, versus the fee-for-service model, which is the more traditional model.

Mr. FOSTER. Yes, sir.

Mr. BECERRA. If we were to expand the Medicare Advantage program, the health insurance industry plan that provides Medicare fully out to reflect the size of the current fee-for-service program, what would that 13 percent amount to, in terms of dollars?

Mr. FOSTER. The first rough approximation would be about 13 percent of total Medicare expenditures, which are in the $450 billion range these days.

Mr. BECERRA. So, over—about 50 billion or so dollars? If it's 13 percent, and it's $450 billion, 13 percent is—10 percent would be $45 billion, so something over $45 billion to $50 billion?

Mr. FOSTER. Yes. Now, let me put one caveat on that. One of the key reasons that the Medicare administrative cost percentage is so low is that we have a giant economy of scale.

Mr. BECERRA. Yes.

Mr. FOSTER. We process over a billion claims every year, or people do it on our behalf. If you had a national Medicare Advantage system of some kind, then each of the Medicare Advantage plans would be a lot bigger than it is today.

Mr. BECERRA. Right. So, they could reduce their costs——

Mr. FOSTER. Yes, sir.

Mr. BECERRA. Because the economies have scaled, as well.

Mr. FOSTER. Yes, sir. Probably not to the 1.5 percent range, but——

Mr. BECERRA. If they were to keep their profit margin at 4 percent, just the profit margin exceeds by a factor of about three, the costs the total cost of administering fee-for-service through the government system.

Mr. FOSTER. Yes, sir. Of course, for Medicare, the government program, we don't have a profit margin.

Mr. BECERRA. Right.

Mr. FOSTER. In fact, I live in fear of the day that we introduce a profit and loss-sharing arrangement for employees.

Mr. BECERRA. Well, so we're talking about Medicare living on the edge these days, because of the increasing cost of providing medicine and medical services. We take a look at the cost differential in providing services through traditional fee-for-service, which most seniors are accustomed to, versus through the health insurance plans.

My sense is that, unless the insurance plans can get their costs down, or reduce their profit margins some as well, of what they expect to make, their administrative costs will continue to far exceed the costs that traditional Medicare, fee-for-service Medicare, has running through the government to give people access to their private doctors and private hospitals.

So, you haven't said to me anything that would make me believe that the insurance plans, under Medicare Advantage, will at any point be able to compete, at least administratively, in terms of cost, with what we have through traditional fee-for-service Medicare.

Mr. FOSTER. Well, let me say that, under current law, because of the nature of the benchmarks, and the way the payment formula works, clearly we are spending more on beneficiaries in Medicare Advantage plans, on average, than we would if they were in fee-for-service.

But your question really goes to the issue of whether the private health plans can come in with a lower cost than Medicare fee-for-service normally attains. In certain parts of the country, they can, and they routinely do. Generally, the urban areas, which have relatively high fee-for-service costs, many of the HMOs and PPOs can have a plan cost that is less than the prevailing fee-for-service level.

Now, of course, they have to offset their relatively high administrative and profit portion of their cost by either negotiating lower payment rates for the health care services than Medicare fee-for-service rates, or by managing utilization and trying to avoid unnecessary costs, or by getting the most cost-effective services. In some parts of the country, they can do that, but certainly not all in parts.

Mr. BECERRA. Thank you. I see my time has expired, so I will end with the final comment that I think—I appreciate your point, that there are ways that a plan can try to figure out how to be competitive, and perhaps reduce the costs so that they are less than what the traditional Medicare fee-for-service program costs us to run.

But I still figure that, unless those profit margins are reduced, it's going to be difficult, at any point, for a private plan to compete with the traditional fee-for-service plan, when your cost—given the scale of the economy here—for the government is a 1.5 percent cost. But I appreciate the point. I yield back.

Chairman STARK. Mr. Emanuel, would you like to inquire?

Mr. EMANUEL. Thank you, Mr. Chairman. If Xavier wants to stay, because my question is similar—and feel to jump in at any point. I want to press this point, because I think it's important, as we look at the trust fund issue.

You had answered, I think earlier, one of the questions I wanted to ask, which was about the fact that you could add about 18 months to the trust fund if you paid the Medicare Advantage plans similar—rather than have 113 percent of fee for service, or 150 being the high end, if you paid them on the same level, you would add about 18 months, I think, was your answer, a year-and-a-half.

Mr. FOSTER. Yes, sir.

Mr. EMANUEL. Okay. On this point and I think it's valuable if you're trying to compare apples to apples, would you so there would be no dispute in the future if we're all citing you and I think you don't want to be cited any more but if you were to compare that, is it still 1.5 percent to 13 percent?

Where can you—how do we get to a point that you can tell us that their administrative costs are 13 percent and traditional Medicare is X? Okay?

Mr. FOSTER. I'm not sure I follow the question, entirely, Mr. Emanuel. But if I'm understanding correctly, it's certainly true enough that these smaller plans that are not nationwide——

Mr. EMANUEL. Right.

Mr. FOSTER [continuing]. That don't have the economy of scale, that have to pay marketing expenses, have to have a profit margin——

Mr. EMANUEL. Right.

Mr. FOSTER [continuing]. Et cetera, their administrative costs will be higher than what we typically experience for Medicare fee-for-service.

If those plans can achieve savings in other ways that more than offset the higher administrative cost, then maybe they can still be competitive directly against fee-for-service, and have a lower cost, overall. Some plans clearly do; many don't.

Mr. EMANUEL. Well, go ahead, then, Xavier.

Mr. BECERRA. I thank the gentleman for yielding. But, in a way, these plans can reduce their costs and be more competitive, compared to traditional fee-for-service, if they, in essence, cherry pick. They go after healthier seniors, they go after younger seniors, and reduce their overall costs of providing service, because there is a threshold at which no one can go under, in terms of the cost.

One of the reasons why it costs us so little, providing traditional fee for service, is because—but you said, it's economy of scale, and we don't ask for profit. We don't ask seniors to pay for the government to make a profit off of providing health care.

Mr. EMANUEL. Let me say what I was trying to get at, and it's not, obviously, hidden here, which is if you were trying to extend the life of the trust fund, and make sure Medicare is healthy, everything should be on the table, whether that's overpaying for a service, where you're paying sometimes 113 to 150 percent of fee-for-service. Or, B, if your administrative costs between 1 entity is 13 percent and another entity is 1.5 percent, that would be another place where you could look before we do anything else to the beneficiaries—not that that is to say exclusive.

Now, when we had a debate the other day, four Democrats and four Republicans—Congressman Ryan from Wisconsin acknowledged that maybe, you know, the actual Medicare Advantage notion that we're paying over what we should be paying over is a place to look for savings.

So, my whole point in asking you for a fair comparison was, what are the dollars there that you think are available, and that nobody can say, "Well, you're really comparing apples and oranges here?"

What are the dollars that are available, and how much dollars would come if you could—were comparing apples to apples? That's what I'm trying to get at.

Mr. FOSTER. Yes, sir. I see. I don't think, as a practical matter, you could just look at the relatively high administrative cost of MA plans and say, "Okay, we're going to force them to have lower administrative costs." You could do that to a point, but at some point the plans would say, "We can't."

Mr. EMANUEL. I understand. That would be repeating, like, the 1990s. Got that.

Mr. FOSTER. Somewhat, yes.

Mr. EMANUEL. Right.

Mr. FOSTER. Now, you could do it through the following way. This, again, is a bit of a quantum change. But if you implemented competition between the private plans without the relatively high-level benchmarks the competition of the private plans, with benchmarks based on their bids and combined that in with fee-for-service Medicare as well, then what we think you would find is that in some parts of the country, the private plans would actually be quite competitive, and would be a cheaper cost than fee-for-service is now.

In many other parts of the country, it would be the other way around. The private plans could not compete effectively against the fee-for-service level of cost.

But if you did that, and were willing to live with what are non-trivial consequences——

Mr. EMANUEL. Yes.

Mr. FOSTER. Then you would take advantage of whichever form of health care delivery is more effective in a given area by area, you would get a lower cost, overall.

Mr. EMANUEL. Mr. Chairman, I know my time is up, but at some point I would love to have a discussion about: A, looking at fee-for-service; and then B, kind of patient wholeness and doctors, and a different way of paying for a service, and what we could see for savings. I know we don't have time for that type of discussion, but I think it's worthy, as we look at changes. Okay?

Chairman STARK. I think that makes sense.

Mr. CAMP. If the gentleman would yield?

Chairman STARK. Yes.

Mr. CAMP. I do think there is a difference between private fee for service and coordinated care, which we often call ultimate Medicare Advantage, which—there is a difference there. Coordinated care actually bids below traditional Medicare. But that's why we kind of lump all this together sometimes when we talk about them. I think there is a difference.

Mr. FOSTER. Well, and I might add, typically there are bids that are, in fact, somewhat higher than traditional fee-for-service because of the admin cost.

Mr. EMANUEL. They have to do certain things, administratively, and pay for certain things that Medicare, because of the size, doesn't.

On the other hand, I do think one of the things that one day we're going to look at is, rather than fee-for-service as a payment method, is a different type of structure that will save on health care costs because a doctor and a hospital have a different type of—a way to see the way they would take care of a patient as another way to control costs.

Mr. FOSTER. It has great potential.

Mr. EMANUEL. Yes. You are a man of few words. Thank you.

Chairman STARK. Would you have some further inquiry, Mr. Camp?

Mr. CAMP. Well, just to ask, we had sort of this discussion about the profit margins. I do think it's important to say that Medicare plans have, on average, a 4 percent profit margin.

But I do think it's important to say that the nursing homes and home health organizations, on average, have what profit margin?

Mr. FOSTER. I can provide that for the record; I don't have it handy.

Mr. CAMP. I believe it is in double digits, though, is it not? Around 11 percent?

Mr. FOSTER. It wouldn't surprise me.

Mr. CAMP. Yes. Well, if we could, get that in the record. So, I think we need to look at, you know, all of this together, and not just say that because Medicare Advantage plans are at 4 percent, that that's unacceptable, when we have other sectors that are much, much higher than that, which we're not addressing in the same way. I'm not suggesting we should.

Mr. EMANUEL. Would my colleague yield for a second?

Mr. CAMP. Yes.

Mr. EMANUEL. As we look at places of savings—and, again, Mr. Chairman, this would be one area I would be interested in—is whether Medicare could ever provide data to if we dealt earlier with chronic illnesses—heart, diabetes, et cetera, some of the basic 3 or 4—earlier than 65, what savings could we see in Medicare? You could say the overall health care system, but your purview is Medicare.

What savings could there be resulted to Medicare if people—I don't know, call it 58 to 64, 55 to 65—were put into and required, as a participation in Medicare years later, were part of a chronic illness management? What savings could be looked at? Can I ask that question, or no?

Mr. CAMP. Yes, I have yielded.

Chairman STARK. I am pretty sure you already did. So——

Mr. EMANUEL. That doesn't mean the Chairman allowed me.

Mr. CAMP. It's on my time, I would like to hear the answer.

Mr. FOSTER. Sure, I think——

Mr. EMANUEL. Right, I understand.

Mr. FOSTER. Potentially, it would have favorable impacts.

Mr. EMANUEL. This is like Agatha Christie. "Then There Were None." So, there are only four of us, so don't worry about it.

Mr. FOSTER. It would be tough to estimate the financial impact of that. It's not to say we couldn't try. It would be tough, because you have this classic trade-off. On the one hand, people would be in better health, as a result of some of the kinds of steps you talked about, and for some period of time they have lower per-person costs than they probably would have, otherwise.

On the other hand, they would tend to live longer, and incur more services over their full lifetime, as a result. When you look at it on that basis, many of these studies indicate that perhaps you would not really save anything.

Now, the world would be a better place, and that's a good thing, even if you did not have savings. But it's that kind of trade-off that makes it very difficult to estimate.

Mr. EMANUEL. Can I ask one question?

Mr. CAMP. Yes, yes.

Mr. EMANUEL. The fact is and I understand the trade-off I mean, one of the before somebody gets into Medicare, and given all the advantages and I don't mean Medicare Advantage plans, but

all the advantages of Medicare if part of participation was an earlier improvement of one's health, I think you would see the financial health in Medicare because if we're looking at savings, and given we know the costs associated with the three or four chronic illnesses are huge, I think that should be a place that we look——

Mr. CAMP. Just reclaiming my time, as we're talking about savings, what are the top three reasons Part D costs are lower than you had projected?

Mr. FOSTER. Well, generally speaking, the first of the top three reasons is that the drug cost growth, overall, has been a lot less than we estimated, following a decade-and-a-half of double-digit growth rates. That was partly attributable to a lot of efforts to steer people to use generic equivalents, rather than brand-name drugs. The efforts have been very successful, and the generic rate is now over 60 percent in Part D, and in the country, generally.

The second reason we talked about a little bit before, about the negotiated retail discounts and rebates, et cetera.

Mr. CAMP. Their ability to negotiate discounts——

Mr. FOSTER. Yes——

Mr. CAMP [continuing]. From the drug manufacturers.

Mr. FOSTER. The third reason—and this was the smallest of the three—was that there were somewhat fewer enrollees than we had originally estimated.

Mr. CAMP. All right. Thank you. Thank you, Mr. Chairman.

Chairman STARK. Did you have a second inquiry?

Rich, if you would, just—the—we have heard—you have heard Mr. Doggett on some other issues, but we are having a difficult time determining what Medicare Advantage plans actually provide, as if I can make that difference, as opposed to offer.

You could offer something that only a small percentage of the plan enrollees take, and you're not giving them much. Or, you can offer them $50 in dental care, and we know that that ain't going to get you very far toward getting your teeth cleaned.

Could we—don't you think that we should get actual data on these Medicare Advantage plans, in terms of the actual provision of benefits?

I know there is an anti-competitive issue, but it seems to me that that could be dealt with in some kind of confidential sense, at least with the Committee.

Mr. FOSTER. I think it would be useful and informative in the bigger picture, which is what you're describing——

Chairman STARK. Yes.

Mr. FOSTER. A GAO study or analysis, for example, that kind of thing.

Let me mention what we do already, which is a cousin of this. By law, my office has to review all the bid submissions for all the MA plans and all the Part D plans, and that's about 9,000 individual bids in the course of a year.

For the MA plans, when they indicate their expected cost experience for the coming year, they're supposed to be estimating that based on their actual past experience, not only for the standard covered benefits under Medicare, but also for any supplemental coverage that they offer.

So, we look to see whether their bid for the cost is consistent with their actual past experience. For the bid review, we can do that only on a kind of a cursory basis, but we periodically audit these plans in much greater detail, and that's one of the things we look at.

So, if you had a plan, for example, that offered half-a-dozen different kinds of extra services or care, but in real life they were not providing them——

Chairman STARK. Those people weren't taking them. They would provide them.

Mr. FOSTER. Either way.

Chairman STARK. People signed up.

Mr. FOSTER. Exactly right. Either way. Then we would see a mismatch between their claimed cost for the coming year, and their actual past experience—and we would investigate that.

Chairman STARK. Well then, is there enough data, and would it be available to GAO? We don't have to get into this issue of anti-competitive stuff.

For GAO to do a report for us using the data that you would have in these bid submissions, and comparing it with previous years' costs so that we could begin to get some idea of what actually was being provided is would you say there is enough broad data around so that we could go ahead with that?

Mr. FOSTER. Probably.

Chairman STARK. Maybe.

Mr. FOSTER. Yes. Well, I would say probably.

Chairman STARK. Okay.

Mr. FOSTER. I hesitate only because we don't get individual claims level data from the MA plans.

Chairman STARK. No, but you get the aggregate.

Mr. FOSTER. We get their aggregate data, yes.

Chairman STARK. So, if they say they're going to offer $50 for a pair of eyeglasses each year, whatever, they have an aggregate amount in their bid, you'd know about how many people they had in last year. Could you find out how much they actually spent the year before on eyeglasses?

Mr. FOSTER. Yes, that would be the way it could be done.

Chairman STARK. Okay. Well, from that, I think we could then begin to see which benefits were used, what they cost, and get some better understanding than just this idea that there is lots of benefits. That's pretty hard for either of us to know.

Mr. CAMP. Well, I think that you get this data, but CMS doesn't. I don't quite understand why GAO can't get that from you, but they apparently can't.

Chairman STARK. They can't? Can they?

Mr. FOSTER. Well, here we're talking about for the MA plans, not Part D. For Part D, there was an explicit statutory prohibition of the broader use of the Part D data. It has to be for payment purposes, which is why we get it.

Mr. CAMP. I see. So, they can't get that.

Mr. FOSTER. Right. For the MA data, I don't see any reason why they couldn't. Now, some of my staff may yell at me after this hearing about: "Do you realize what you said?" But I think it could be done.

Chairman STARK. We might, then, to get around this—let GAO provide some review, even of Part D, as long as it was not able to identify any particular competitive plans, and get a little bit better idea of what we're doing. That would be very useful.

Have—at any point in your 75-year estimates, did you see, or do you—or did your reports show that the Medicare Advantage would cost less on a per-beneficiary basis than traditional fee-for-service?

Mr. FOSTER. No, sir, not under current law.

Chairman STARK. Okay. I guess my last request is for a table. In—you used to produce a table in the trustees' report that showed Medicare cost sharing as a percentage of Social Security, and now you just have a graph. Could you give us a—give us that in kind of a tabular form, as you—as has shown up in the past?

Mr. FOSTER. Yes, sir. That would be no problem.

Chairman STARK. Would you send that on to us? I would appreciate it very much.

I guess, unless anybody else wants to chime in, we could let Mr. Foster go to lunch with our deep and abiding thanks to you and your staff, with the sad reflection that you have generated enough questions here that we are probably going to flood you with inquiries over the next month. But we appreciate much your participating with us this morning.

Unless—with Mr. Pomeroy's concurrence, we—the hearing is adjourned.

Mr. FOSTER. Thank you, sir.

[Whereupon, at 11:45 a.m., the hearing was adjourned.]

[Questions for the Record follow:]

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Office of the Actuary

May 13, 2008

The Honorable Pete Stark
Chairman
House Ways and Means Subcommittee on Health
1135 Longworth House Office Building
Washington, DC 20515

Dear Chairman Stark:

Thank you for the opportunity to testify before the House Ways and Means Subcommittee on Health regarding "The 2008 Medicare Trustees Report" on April 1, 2008.

Enclosed is the edited transcript, along with our answers for the record to the transcript questions. A similar letter also has been sent to Representatives Camp and Tubbs Jones.

If you have any questions or need additional information, please do not hesitate to contact me.

Sincerely,

Richard S. Foster
Chief Actuary

Enclosures

COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH
PUBLIC HEARING
"THE 2008 MEDICARE TRUSTEES REPORT"
APRIL 1, 2008

These are the answers for the record to be inserted into the transcript for this hearing:

Lead-in:

MR. CAMP: Well, thank you, Mr. Chairman. Mr. Foster, you mentioned that Part B premiums would be reduced by $3 as a result of cutting Medicare Advantage plans. And, if I understood your testimony, if we completely limit Medicare Advantage for about nine million seniors, we would extend the life of the program about two years. Is that what you said?
MR. FOSTER: Yes, sir, about 18 months.

Mr. CAMP: Well, forgive me if I don't start throwing the confetti; that's not very long. Can you tell me the impact on the Part B premium from the physical payment provision in the CHAMP bill that spent $67 billion over 10 years? And would you please tell me in your answer, how much would the Part B premium increase? There is a significant increase in Part B spending.

Mr. FOSTER: Let me check just a second to see if we have that.

Mr. CAMP: All right. Well, if you would like to get back to me in writing, I would appreciate an answer in writing.

INSERT: Page 27, line 636

Mr. FOSTER: Thank you, sir. It appears we do not have that here today so we'll send a letter to you and to the Health Subcommittee at large, transmitting that information under separate cover.

Ms. TUBBS JONES: Mr. Chairman, if you would just allow me to ask this question, and perhaps get a written response, I am interested in—in light of the fact that we have a doughnut hole in the prescription—in the Part D coverage, what's happening to the seniors out here who fall into the doughnut hole, who pay the premium and their drug costs continue—they still have to pay the drug costs? And I would like to have a written response, Mr. Foster, at some point, around that issue. I am sure my colleagues, as well, would like to know what's happening to the senior citizen doughnut hole.

INSERT: Page 49, line 1184

Mr. FOSTER: We would be happy to. As you requested, we'll send a letter to you and to the Health Subcommittee at large, transmitting that information under separate cover.

Mr. CAMP: Well, just to ask, we had sort of this discussion about the profit margins. And I do think it's important to say that Medicare plans have, on average, a four percent profit margin. But in this administrative fee—and you often—which—administration portion is the disease management, the pharmaceutical therapy, the other kinds of things that you aren't getting in traditional Medicare, as you've said in your testimony. But I do think it's important to say that the nursing homes and home health organizations, on average, have what profit margin?

INSERT: Page 64, line 1562

Mr. FOSTER: The Medicare Payment Advisory Commission (MedPAC) estimates that, in 2006, freestanding skilled nursing facilities had profit margins on their Medicare business averaging 13.1 percent of revenues. Their corresponding estimate for home health agencies was 15.4 percent. It's not straightforward to compare profit margins for health insurance plans, such as Medicare Advantage plans or private HMOs and PPOs, with profit margins for health care providers, such as nursing homes and home health agencies. We will separately provide a more comprehensive response on this issue to you and to the Health Subcommittee at large.

Mr. STARK: Okay. And, I guess my last request is for a table. In—you used to produce a table in the trustees' report that showed Medicare cost sharing as a percentage of Social Security, and now you just have a graph. And could you give us a—give us that in kind of a tabular form, as you—as has shown up in the past?

INSERT: Page 72, line 1754

Mr. FOSTER: Yes, sir. That would be no problem. We will separately provide the table to you and to the Health Subcommittee at large.

[Submissions for the Record follow:]

Statement of Thomas F. Wildsmith

The American Academy of Actuaries is a national organization formed in 1965 to bring together, in a single entity, actuaries of all specializations within the United States. A major purpose of the Academy is to act as a public information organization for the profession. Academy committees, task forces and work groups regularly prepare testimony and provide information to Congress and senior federal policymakers, comment on proposed federal and state regulations, and work closely with the National Association of Insurance Commissioners and state officials on issues related to insurance, pensions and other forms of risk financing. The Academy establishes qualification standards for the actuarial profession in the United States and supports two independent boards. The Actuarial Standards Board promulgates standards of practice for the profession, and the Actuarial Board for Counseling and Discipline helps to ensure high standards of professional conduct are met. The Academy also supports the Joint Committee for the Code of Professional Conduct, which develops standards of conduct for the U.S. actuarial profession. The American Academy of Actuaries' Medicare Steering Committee appreciates the opportunity to provide comments on the 2008 Medicare Trustees Report. Each year, the Boards of Trustees of the Federal Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) Trust Funds report to Congress on the Medicare program's financial condition. The Medicare program provides health coverage for the aged and for certain individuals with disabilities. The trustees' report is the primary source of information on the financial status of the Medicare program, and the American Academy of Actuaries proudly recognizes the contribution that members of the actuarial profession have made in preparing the report and educating the public about this important issue.

The projections of Medicare's financial status in the 2008 Medicare trustees' report are consistent with the projections in the 2007 report. The HI trust fund, which pays for hospital services, will be depleted slightly earlier in 2019 than was previously projected. HI expenditures will again exceed HI non-interest income this year. In addition, Medicare expenditures will continue to consume an increasing share of federal outlays and GDP. The trustees conclude, "The projections shown in [the] report continue to demonstrate the need for timely and effective action to address Medicare's financial challenges—both the long-range financial imbalance facing the HI trust fund and the heightened problem of rapid growth in expenditures."

The following statement examines more closely the findings of the trustees' report. The American Academy of Actuaries' Medicare Steering Committee concludes that the Medicare program faces serious short-term and long-term financing problems. As highlighted in the 2008 Medicare trustees' report:

- The HI trust fund fails to meet the test of short-range financial adequacy because HI trust fund assets will fall below annual expenditures within the next 10 years.
- The HI trust fund also fails to meet the test of long-range actuarial balance. HI expenditures will exceed HI non-interest income this year. By 2019, when trust fund assets are projected to be depleted, tax revenues would cover only 78 percent of program costs, and this share will decrease rapidly thereafter. The trust fund depletion date is projected to arrive slightly earlier in 2019 than was projected last year, due in part to slightly lower projected payroll tax income and slightly higher expenditures than previously estimated.
- The value in today's dollars of the HI deficit over the next 75 years is $13 trillion. Eliminating this deficit would require an immediate 122 percent increase in payroll taxes or an immediate 51 percent reduction in benefits, or some combination of the two. Delaying action would require more drastic tax increases or benefit reductions.
- The SMI trust fund includes accounts for the Part B program, which covers physician and outpatient hospital costs, and for the Part D program, which covers the prescription drug benefit. The SMI trust fund is expected to remain solvent only because its financing is reset each year to meet projected future costs. Projected increases in SMI expenditures will require significant increases in beneficiary premiums and general revenue contributions over time.

- Medicare's demand on the federal budget, measured as the HI income shortfall and the general revenue contribution to SMI, is projected to increase rapidly.
- For the third year in a row, the difference between Medicare outlays and dedicated revenues exceeds 45 percent within the next seven years, thereby again triggering the Medicare funding warning. As a result, the next president must propose legislation to reduce this share within 15 days of the next budget submission. Congressional action is not guaranteed, however, and depending on what action, if any, is taken, other financing problems could remain.
- Medicare expenditures are also projected to increase rapidly as a share of GDP and of total federal revenues, thereby threatening Medicare's long-term sustainability.
- The increasing costs of the Medicare program reflect the increasing costs of the health care system as a whole. Efforts to control spending in the Medicare program should be considered within the broader context of the entire health care system.

The committee recommends that policymakers implement changes to improve Medicare's financial outlook. The sooner such corrective measures are enacted, the more flexible the approach and the more gradual the implementation can be. Failure to act now may necessitate far more onerous actions later.

SHORT–TERM FINANCING OF MEDICARE

To assure short-range financial adequacy of the HI trust fund, the Medicare trustees recommend that trust fund assets equal or exceed annual expenditures for each of the next 10 years. This level would serve as an adequate contingency reserve in the event of adverse economic or other conditions. For the next several years, the trust fund assets are expected to significantly exceed annual expenditures. However, trust fund assets are projected to fall below annual expenditures during 2012. As a result, the HI trust fund fails the test of short-range financial adequacy.

LONG–TERM FINANCING OF MEDICARE

The Medicare program has three fundamental long-range financing problems:

1. Income to the HI trust fund will soon become inadequate to fund the HI portion of Medicare benefits;
2. Medicare's demands on the federal budget are increasing; and
3. Paying currently promised Medicare benefits will place an increasing strain on the U.S. economy.

Each of these problems is discussed in more detail below.

Medicare HI Trust Fund Income Will Soon Become Inadequate to Fund HI Benefits

In terms of trust fund accounting, Medicare consists of two parts, each of which is financed separately. Hospital Insurance (HI) pays primarily for inpatient hospital care (Part A); Supplementary Medical Insurance (SMI) pays primarily for physician and outpatient care (Part B) and prescription drugs (Part D). Like the Social Security program, Medicare makes use of trust funds to account for all income and expenditures, and the HI and SMI programs operate separate trust funds. Taxes, premiums, and other income are credited to the trust funds, which are used to pay benefits and administrative costs. Any unused income is added to the trust fund assets, which are invested, as required by law, in U.S. government securities, for use in future years. Note, however, that the trust fund assets represent loans to the U.S. Treasury's general fund. As a result, the buildup of Medicare trust funds is essentially used to fund other government spending.

The 2008 Medicare trustees' report highlights the long-term financing problems facing the program:

- The HI program is funded primarily through earmarked payroll taxes. From 1998 through 2004, HI payroll taxes and other non-interest income exceeded HI expenditures, and the trust fund accumulated assets. In 2005, however, HI non-interest income fell below HI expenditures and has continued to fall short since then. Beginning in 2010, HI expenditures are projected to exceed all HI income, including interest. At that point, the HI trust fund will need to begin redeeming its assets—U.S. government securities—in order to pay for benefits. If the federal government is experiencing unified budget deficits at the time these securities need to be redeemed, either additional taxes will

need to be levied to fund the redemptions, or additional money will need to be borrowed from the public, thereby increasing the public debt.

- By 2019, HI trust fund assets are projected to be depleted. At that time, tax revenues are projected to cover only 78 percent of program costs, with the share decreasing further thereafter. The HI trust fund depletion date is projected to arrive a little earlier in 2019 than projected in the 2007 Medicare trustees' report, due in part to slightly lower projected payroll tax income and slightly higher expenditures than previously estimated.
- The value in today's dollars of the HI deficit over the next 75 years is $13 trillion, or 3.5 percent of taxable payroll over the same time period. Eliminating this deficit would require an immediate 122 percent increase in payroll taxes or an immediate 51 percent reduction in benefits, or some combination of the two. Delaying action would require more drastic tax increases or benefit reductions. Projections over an infinite time horizon would increase the shortfall to $34 trillion, or 6.1 percent of taxable payroll. Given the uncertainty of projections 75 years into the future, however, extending these projections into the infinite future can only increase the uncertainty, so that these results can have only limited value for policymakers.
- The SMI program is financed through beneficiary premiums that cover about a quarter of the cost. Federal general tax revenues cover the remaining three quarters.[1] The SMI trust fund is expected to remain solvent, but only because its financing is reset each year to meet projected future costs. Projected increases in SMI expenditures, therefore, will require increases in beneficiary premiums and general revenue contributions over time.

Medicare's Demand on the Federal Budget Is Increasing

Another way to gauge Medicare's financial condition is to view it from a federal budget perspective. In particular, this assessment determines whether Medicare receipts from the public (e.g., payroll taxes, beneficiary premiums) exceed or fall short of outlays to the public. Under this approach, interest income on the HI trust fund assets and contributions from general revenues to the SMI program are ignored, because they are essentially intragovernmental transfers between the general fund and the Medicare trust funds. As a result, the difference between public receipts and public expenditures for Medicare reflects any HI income shortfall and the general revenue share of SMI.

Table 1 reports the HI income shortfall and the general revenue contribution to the SMI program in 2007 and projections over the next 10 years. Recall that the SMI program is designed for about three-quarters of its expenditures to be funded through general revenues. In 2007, Medicare expenditures already exceeded public receipts by $174 billion. This amount is expected to grow over the next 10 years; the cumulative difference between Medicare expenditures and public receipts is projected to total $2.9 trillion over this period.

Beginning in 2010, when HI expenditures are projected to exceed HI public receipts plus interest income on trust fund assets, the HI trust fund will need to begin drawing down its assets, further increasing Medicare's demand on the federal budget. Unless payroll taxes are increased or benefits reduced, HI trust fund assets are projected to be depleted in 2019. There is no current provision allowing for general fund transfers to cover HI expenditures in excess of payroll tax revenues.

For a longer-term view of Medicare's demand on the federal budget, Table 2 reports the HI income shortfall and the SMI general revenue contribution over the next several decades, as a share of GDP. The HI income shortfall and SMI general revenue contribution are projected to grow dramatically—from 1.4 percent of GDP in 2008 to 7.8 percent of GDP in 2080. This will increase considerably the pressures on the federal budget, unless HI income shortfalls or SMI general revenue contributions are reduced.

A provision of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) intends to address these financial challenges. Basically, if in two consecutive trustees' reports general funding sources are projected to account for more than 45 percent of Medicare spending within the next seven years, the admin-

[1] Part B beneficiaries pay monthly premiums covering about 25 percent of program costs (beginning in 2007, Part B premiums became income-related, with higher income enrollees paying more than 25 percent of costs); general revenues cover the remaining 75 percent of costs. Part D premiums will be set at about 25 percent of Part D costs. However, because of low-income premium subsidies, beneficiary premiums will cover only about 9 percent of total Part D costs in 2008. State payments on behalf of certain beneficiaries will cover about 14 percent of costs and general revenues will cover the remaining 77 percent of costs.

istration is required to recommend ways to reduce this percentage.[2] Options would include reducing spending (e.g., benefit cuts, delayed eligibility, reduced provider payments), increasing revenues (e.g., raising payroll taxes, raising beneficiary premiums), or some combination thereof. The president's proposal must come within 15 days of the next budget submission. The provision was first triggered in 2007, and in response President Bush submitted legislation in February 2008. Congress is now required to consider the legislation on an expedited basis. There is no requirement, however, that any legislation be enacted.

The 2008 Medicare Trustees' Report projects that the 45 percent threshold will first be reached in 2014. Because last year's report also projected that the threshold would be reached within seven years, the requirement is triggered again this year. The triggering of this provision draws attention to the need to manage the demand Medicare places on the federal budget, and provides policymakers the opportunity to address the financial situation of the program and to limit the burden the program places on the federal budget. Congressional action is not guaranteed, however, and depending on what action, if any, is taken, other financing problems could remain. For instance, legislative changes reducing general revenue funding might have no impact on HI solvency.

Medicare Is Projected to Place Increasing Strains on the Economy

A broader issue related to Medicare's financial condition is whether the economy can sustain Medicare spending in the long run. To gauge the future sustainability of the Medicare program, we examine the share of GDP that will be consumed by Medicare. As shown in Table 3, total Medicare spending is projected to consume a greater share of GDP over time. In 2007, total Medicare spending was 3.2 percent of GDP. Spending is expected to rise to 6.3 percent of GDP in 2030 and 10.7 percent of GDP in 2080. (Notably, this measure understates the share of the economy devoted to health spending among the elderly and disabled, because Medicare imposes cost sharing and does not cover all health products and services utilized.)

Considering Medicare spending in conjunction with Social Security spending further highlights the strain these programs place on the economy. Social Security spending as a share of GDP increases more modestly than Medicare over the next several decades, and as a result, Medicare spending is expected to exceed that of Social Security in 2028. Combined, Medicare and Social Security expenditures equaled 7.5 percent of GDP in 2007. This share of GDP is projected to increase to 12.3 percent in 2030 and 16.5 percent in 2080.

Medicare and Social Security expenditures are even more striking when considered relative to total federal revenues. The trustees report that total federal revenues have historically averaged about 18 percent of GDP. Using this average, about 40 percent of all federal revenues in 2008 will be used to pay Medicare and Social Security benefits. If no changes are made to either program and federal revenues remain at 18 percent of GDP, this share is expected to increase to nearly 80 percent in 2050, and by 2080, Medicare and Social Security spending would equal over 90 percent of total federal revenues.

These projections highlight the increasing strains that Medicare, especially in conjunction with Social Security, will place on the U.S. economy. Moreover, increased spending for Medicare may crowd out the share of funds available for other federal programs.

If we are to avoid this trend, reforms must be made to address the rapid growth in Medicare expenditures. It is important to recognize that the problem of rising health care spending in the Medicare program reflects spending growth in the U.S. health system as a whole. Therefore, unless spending in the health system as a whole is addressed, implementing options to control Medicare spending may have limited long-term effectiveness.

CONCLUSION

The American Academy of Actuaries' Medicare Steering Committee continues to be very concerned about Medicare's long-range financing problems. HI non-interest income is already falling short of outlays this year and the HI trust fund is projected to be depleted as soon as 2019. Medicare will likely place increasing demands on the federal budget, even with the provision that alerts Congress when the program's reliance on general revenue sources is becoming large. The program's sus-

[2] More specifically, a determination of "excess general funding" is triggered if for two consecutive trustees' reports the difference between Medicare outlays and dedicated financing sources (HI payroll taxes, HI share of income taxes on Social Security benefits, Part D state transfers, and beneficiary premiums) exceeds 45 percent of Medicare outlays within seven years of the projection.

tainability is also called into question as currently promised benefits will require increasing shares of both GDP and total federal revenues.

The committee recommends that policymakers implement changes to improve Medicare's financial outlook. We agree with the 2008 trustees, who state in their report:

> "The sooner the solutions are enacted, the more flexible and gradual they can be. Moreover, the early introduction of reforms increases the time available for affected individuals and organizations—including health care providers, beneficiaries, and taxpayers—to adjust their expectations."

The Academy's Medicare Steering Committee is ready to provide the analysis and technical expertise of our member health actuaries in responding to issues regarding the future of the Medicare system. Other Academy publications include Medicare Reform Options, How Is Medicare Financed? What Is the Role of the Medicare Actuary? and Evaluating the Fiscal Soundness of Medicare. These and other Academy publications are available at www.actuary.org/medicare/index.htm.

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