

DOMESTIC ENTITLEMENTS: MEETING THE NEEDS

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BEFORE THE

COMMITTEE ON THE BUDGET HOUSE OF REPRESENTATIVES

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CONTENTS

	Page
Hearing held in Washington, DC, February 17, 2005	1
Statement of:	
Gail R. Wilensky, Ph.D., senior fellow, Project HOPE	6
Ron Haskins, Ph.D., the Brookings Institute	13
Kent A. Smetters, Ph.D., Associate Professor, the Wharton School, University of Pennsylvania	24
Judith Feder, Ph.D., Dean of Policy Studies, Georgetown University	33
Prepared statement of:	
Dr. Wilensky	9
Dr. Haskins	18
Dr. Smetters	27
Dr. Feder	36

DOMESTIC ENTITLEMENTS: MEETING THE NEEDS

THURSDAY, FEBRUARY 17, 2005

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

The committee met, pursuant to call, at 10:01 a.m., in room 210, Cannon House Office Building, Hon. Jim Nussle (chairman of the committee), presiding.

Present: Representatives Nussle, Barrett, Bradley, Conaway, Diaz-Balart, Mack, McCotter, McHenry, Portman, Putnam, Ros-Lehtinen, Ryun, Simpson, Wicker, Allen, Baird, Capps, Case, Cooper, Cuellar, Davis, McKinney, Moore, Neal, Spratt, and Ryan.

Chairman NUSSLE. Good morning and welcome to the Budget Committee hearing today to discuss the longstanding and, for that matter, worsening problem and challenge regarding overall entitlement spending in the Federal budget.

Today we will hear from an expert panel of witnesses: Gail Wilensky, the senior fellow at Project HOPE; Ron Haskins of The Brookings Institution; Kent Smetters, an Associate Professor at Wharton School of the University of Pennsylvania; and Judy Feder, who is the Dean of Policy Studies at Georgetown University.

We welcome all of our witnesses to the Budget Committee, and we appreciate and look forward to hearing your testimony.

You know, I have to remind myself when I go back home to Iowa from Washington, and really, for that matter, anywhere outside the Beltway, that not all the folks back home realize that we have different kinds of spending in Washington. Most people look at it and say, well, spending is spending; it is a really big budget and you guys spend a whole lot of money. We know that there is discretionary spending, and that is the kind of spending that we review on a regular basis, and on an annual basis; we hold hearings on it. Sometimes we debate at great length on the floor of the House and in committees how many tax dollars will go to a particular program; we argue over a million here and a million there. Yes, it does all add up, but this type of spending only adds up to 39 percent of our total spending.

So we have another kind of spending that is out there, and that is called entitlement—or another word that we use is mandatory spending. In a nutshell, this kind of spending keeps going and growing and going and growing every year, and it is a relatively simple process, it just continues to grow and magnify. Our budget office tells us how much bigger our mandatory spending is expected to get in the next years; we pretty much just say OK and we stick

to that number in the budget, and it keeps going and growing and going and growing. While that is a little simplified for the point of explanation, it is pretty much true, and that is the complication and the frustration of it all.

I have referred to this many times as the Federal Government's auto pilot spending; it is spending that simply continues to grow year after year, largely without much review, modifications, or, for that matter, even oversight by the Congress. Many of the programs that make up our mandatory spending or automatic spending were created, in some instances, decades ago, and they still operate—without too many basic reforms or modernization on the very model and technology, for that matter, that existed at the time that they were first brought into existence.

That is the kind of spending that we are here to talk about today—and specifically why that kind of spending has become an ever-growing problem and challenge and burden for the Federal budget. So let us take a quick look at why the sustained and unchecked growth of these programs has become such a problem.

I would like to show you the chart that we have made up that demonstrates this. [Chart.]

The share of the budget consumed by entitlements, mandatory, or automatic pilot spending, has been growing rapidly since the mid-1970s and now stand at about 54 percent of the budget. So today this makes up over half of the Government's spending. As you can see from the chart, continuing at that rate we are going now, by 2015 that portion will grow to 61 percent and eventually crowd out more and more of the other priorities that threaten really any kind of overall budget control.

So as you can see here, 54 percent today of our budget is automatic, and now only 38 percent of the budget is discretionary. So during the sometimes 3-, 4-, 6-month appropriation process, where we haggle and debate and discuss the appropriation bills that come to the floor, it used to be 13, this year we are going to try a little bit different process—we will argue over only that 38 percent of the budget. Since half of it is defense and homeland security now, really it is even less that gets discussed.

Now let us take a look at why we and our predecessors have let this problem continue unchecked; and two, why, even now, when the problem is staring us in the face and putting in peril funding for every other program whose spending we actually control, why there are still very few who have not only been unwilling to come forward and try to get their hands around this problem—but, for that matter, who are even available to admit that there is a problem.

To answer the first problem, by its very nature, mandatory spending is difficult to control, just by the nature of the word. This spending is tied to a variety of factors outside Congress's control, either political or otherwise, such as: demographics, economic conditions, medical prices, and so on. So as we talked at last week's Social Security hearing, we have got an aging population with longer life expectancies, increasing benefits, and, as we are all well aware, ever-increasing prices and costs for medicine.

Attached to all of this are these mandatory programs, particularly the larger ones, tend to have a never-ending labyrinth of pa-

perwork, layers and layers of Government bureaucracy and, let us face it, huge sums of money that are at stake, and many stakeholders.

Second, at the root of these problems are critical needs that must be met—we are not suggesting that these are challenges that shouldn't be met—such as Medicare payments, Social Security benefits, or other so-called unbreakable commitments that must be fulfilled, such as providing for the needs of our veterans. If the Government is there for anything, it is to help people who cannot help themselves, and many of these programs help people who cannot help themselves.

Just as everyone in this country is somehow touched by one or more of these programs, either themselves, their children, their parents, or even their grandparents, so these programs are highly personal. In many cases, people associate a program in its totality to that one check with their name on it. Even talking about a program as a whole strikes a very personal nerve in a whole lot of people's homes that depend on that safety net. These factors make it especially difficult not only to control so-called entitlement spending, but even to discuss it, and getting it back under control without deserving people worrying that their so-called benefits will be changed, affected, reduced, cut, or eliminated.

So everyone here, certainly myself included, understands that we have a big problem to deal with, not only in getting our hands around it and looking for solutions, but in doing it in a way that is fair to today's program recipients and all those who will need these programs when they get to that point in their particular station of life.

I commend the President for taking steps in his budget to address this problem, by including savings in mandatory programs as part of our effort to get the growth rate under control and to help reduce the current deficit. These recommendations serve as a benchmark for Congress as we develop our budget.

I think it is important to remind everyone that this hearing isn't happening in a vacuum. Congress has already acted to attempt to get our hands around some of the discretionary spending, reduce some of the most obvious examples of waste and fraudulent spending, and to keep our now strong, growing economy continuing to grow. However, over the long run the Federal burden of mandatory spending will become too great for us to simply grow out of the problem; or for the economy to grow; or to just reduce wasteful or necessary spending enough to be able to continue to sustain some of these larger programs.

So not only with our discretionary programs, such as education, the environment, science, defense, get squeezed tighter and tighter, our strong economy—which I think we are all pleased to see creating jobs and helping to reduce our deficits—is also at peril by this growing share of mandatory spending. This problem becomes bigger, more serious, and even more difficult to control with each passing year.

I think that there is, and should be, bipartisan acknowledgment that this is a growing serious problem, and that we hopefully will work to finding bipartisan common sense solutions. I am looking forward to that discussion, and I am certainly interested in the dis-

cussion that we have today. We have got some fine witnesses who can give us their perspective on not only the challenge, but possibly some of the solutions.

So, with that, I will turn it over to my friend and colleague, Mr. Spratt, for any opening comments he would like to make, and I ask unanimous consent that all members be allowed to put an opening statement in the record at this point. Without objection, so ordered.

Mr. Spratt.

Mr. SPRATT. Mr. Chairman, thank you very much. Thank you for calling this hearing.

And I would like to thank each of our witnesses for the efforts they have made and for the time they have taken to come here and testify today. We look forward to hearing your testimony and to asking you further questions about it.

The hearing today focuses on entitlements in the administration's budget for mandatory spending, as we call it, programs like Medicaid, Medicare, and Temporary Assistance for Needy Families (TANF). We don't question whether growing entitlements pose a problem. We do question whether the administration's budget provides sound solutions.

Although we have a budget that is \$427 billion in deficit, the administration is still pushing substantial tax cuts, \$1.6 trillion just to renew and make permanent the tax cuts passed in 2001 and 2003. As a consequence, we find ourselves down in the safety net searching for savings that will offset an enormous deficit for which there is little end in sight.

Among the entitlements in the administration's budget, Medicaid is slated for \$60 billion in gross cuts, \$45 billion in net cuts, over the next 10 years. These cuts may not seem that great given the size of the program and the span of time, 10 years, but they could do real hurt to some of the most vulnerable among us.

Furthermore, as three Governors told us yesterday, Medicaid needs to be reformed. From their point of view, it has to be reformed, restructured. But as they emphasized, the reconfiguration cannot and should not be driven by arbitrary budget numbers. We need to design the kind of system we want to deliver the care that is needed amongst those who are the most needy, and then decide what it costs and change it at the margins so that we can fit it into the budget.

The President's plan for our largest entitlement program really is beyond the scope of this hearing, but Social Security is a matter of great importance. Unfortunately, the full cost of what the President is recommending for Social Security has been omitted from this budget. It is one of the major omissions in this particular budget.

Nevertheless, when we look at the proposal and then look at what the actuaries have told us about likely costs, we know that creating private accounts and allowing workers to divert 4 percentage points off their FICA payments into private accounts, instead of into the Social Security trust fund, will cause the Government to add substantial amounts to national borrowing in the next 20, 30, 40 years.

And the only time frame the administration has given us any number for, 2009 through 2015, during which they would imple-

ment their Social Security proposals, the cost is \$754 billion. If we look at the first 10 years of implementation and use the same numbers, we figure the cost over the first 10 years of full implementation at \$1.5 trillion; and over the second 10 years at \$3.5 trillion. In other words, the first 20 years would cost \$5 trillion in additional debt for the United States to incur, which will inevitably send us looking again, even more seriously, about the safety net program.

Now, Medicare and Medicaid costs are growing, no question about it. If anything, Medicare is a worse problem, long-run, than Social Security. But it should be acknowledged that these costs reflect growing enrollment and rising health-care costs; growing enrollment particularly for Medicaid, particularly because of the recession from which we are just emerging; and the rising health-care cost, medical care costs are not unique or special to Medicare or Medicaid, they reflect what is happening in our whole economy. So in a correct and broad sense, the problem before us when we talk about Medicare and Medicaid is not just the nature of these programs and the costs they are incurring, but the cost of medical care in our society generally.

Both Medicare and Medicaid grew at an average annual rate of 6.9 percent from 2000 to 2003, while private and premiums grew at a rate of 12.6 percent over the same period of time. That should be borne in mind.

We are open to solutions, Mr. Chairman, open to negotiations, because we recognize that if we are going to put the budget back into balance, then programs of this kind have to be part of the equation, if for no other reason than they constitute a large and growing share of the budget. But we also are cognizant of the fact that these programs help the neediest among us, they help the least of these. If we cannot help them, nobody else can. Consequently, we have got to be very, very careful about making arbitrary cuts and arbitrary reductions, as the three Governors we visited with yesterday told us.

So I look forward to the testimony today and the light that you can shed upon these problems, why they are growing, what we can do to make the programs better given the substantial sums of money we are spending upon them. Thank you again for coming.

Chairman NUSSLE. I thank my friend, Mr. Spratt. We have, as I said and as he said, four good witnesses to help us with this discussion today. I will call on them in the order we have here on our witness sheet. We will start with Dr. Gail Wilensky, senior fellow from Project HOPE.

All witnesses' testimony as written will be put in the record, and you may summarize as you see fit.

Welcome back to the committee, Dr. Wilensky. We are pleased to receive your testimony.

**STATEMENT OF GAIL R. WILENSKY, PH.D., SENIOR FELLOW,
PROJECT HOPE; RON HASKINS, PH.D., THE BROOKINGS IN-
STITUTE; AND KENT A. SMETTERS, PH.D., ASSOCIATE PRO-
FESSOR, THE WHARTON SCHOOL, UNIVERSITY OF PENNSYL-
VANIA**

STATEMENT OF GAIL R. WILENSKY

Ms. WILENSKY. Thank you very much, Mr. Chairman. As you have indicated, my name is Gail Wilensky. I am currently a senior fellow at Project HOPE, an international health education foundation. I am formerly an administrator of the Health Care Financing Administration (HCFA), now known as Centers for Medicare and Medicaid Services (CMS), and a former chair of the Medicare Payment Advisory Commission.

My views expressed here are those of an economist, which is my professional training, as well as the experiences that I have had as HCFA administrator and MedPAC chair. They should not be interpreted as positions of Project HOPE.

Most of the attention right now in Washington is being focused on 2006 budgetary issues, but the challenges, as you have indicated, for Medicare and Medicaid grow substantially larger over time. I am going to talk mostly about Medicare, but also a little about Medicaid; a little about the short-term issues and then more about the long-term challenges.

The budget is providing for \$346 billion in outlays for Medicare. This is a substantial increase. If you look at the 2001–2006 period, you see increases that are averaging over 9 percent. Most of the attention right now is focusing on the implementation of the Medicare Modernization Act. That is as it should be. I would like to commend you, as a former HCFA administrator, for including implementation money in the budget. That is all too frequently left out. It is an important part of any new legislation.

The Congressional Budget Office (CBO) projections that were released last month for Medicare indicate that they expect Medicare to grow at an average rate of 9 percent over the 10-year period 2006 to 2015. What it will mean during this time is Medicare will be growing from 2.6 percent of gross domestic product (GDP) to 3.9 percent by 2015. And that is an optimistic assumption because it assumes that the current way of paying physicians, which has resulted in reductions in fees, only to be overturned by the Congress, stays in place. So, in fact, it is likely that the growth in spending over the 10-year period will be larger than what the CBO has estimated.

There has been a fair amount of controversy about the cost of the Medicare prescription drug component. Initially, the difference between the \$395 billion that was estimated by the CBO, as opposed to the \$534 billion by the actuary in the CMS, although in absolute terms substantial, represent actually a very small amount of total Medicare spending over a 10-year period. It happened because of different assumptions about how many people would participate in the voluntary Part D program, how many low-income people would sign up, and how many people would join Medicare Advantage during that 10-year period.

More recently, there has been a big flap about the \$720 billion estimate of the cost of the Medicare Part D program for the years 2006 to 2015. The reason for the change is not very complicated. The first 2 years, 2004–2005, were the cheap years. There was a discount drug program, a low-income support, but not the actual drug benefit, as you well know. The current 10-year projection now drops off those first 2 cheap years and it estimates the cost of the full program at 10 years. There are a lot of things that are difficult to understand about Medicare. This actually isn't one of them. It does give a glimpse of what the true 10-year costs of the program are likely to be.

In talking about longer-term issues, I am going to be relying on the last trustee's report—it is actually almost time for the next one—but I think the issues that they raised are pretty much the issues that we will see again. Using intermediate projections, we see that Medicare is likely to be almost 8 percent of GDP by 2035. By 2024, Medicare will surpass Social Security in spending. Medicare is a program that is not currently as large as Social Security, but it is growing at a faster rate.

Under current estimates, 2019 is the year when the trust fund that pays for Part A of Medicare is scheduled to be depleted of funds. As you probably well understand, it is going to be increasingly important to look at what happens to general revenue, because Part B of Medicare, the part that pays for outpatient hospital and physicians, as well as the new prescription drug Part D, come mostly out of general revenue, and general revenue is likely to start feeling exceedingly pressured.

The Congress will receive reports from the trustees when the general revenue funding of Medicare exceeds 45 percent. Because Part A has been growing slower than expected, the big guess is whether or not the 7-year window that is required for reporting might be triggered in 2005 or not.

There are, I am afraid to say, no easy answers to fixing Medicare, yet alone Medicaid. The first thing, as you know, is that the population who will be going onto Medicare is going to be doubling over the period 2010 to 2030, as the so-called baby boomers retire. In addition, people are living longer, so there will be more people on the program, and they will be on it for a longer time. But it is actually more serious because the baby boom generation is followed by something called the baby bust generation, the unusually small number of cohorts who were born in the generation after 1965.

We have had, at various points, discussions about how changing benefits or changing financing could impact Medicare, and, ultimately, probably some of both will occur. None of these options are easy, either in terms of the economics or in terms of the politics, and I think it is fair to say an important first opportunity was lost when the Medicare Modernization Act was passed, providing a new benefit but not seriously taking on the long-term funding problems of Medicare. I don't believe there was the will, at the time, to do that, but it is too bad that the carrot has already been given and now the hard part is ahead of us.

There are two areas that I think get less attention, and I would like to talk about them as long-term strategies to help us reduce

some of the spending pressures in Medicare. The first is rethinking retirement and the second is learning how to spend smarter.

With regard to the rethinking retirement, we need to start thinking about Social Security and Medicare together. This is not a new concept; it received some renewed attention, however when Chairman Thomas of the Ways and Means Committee talked about it on one of the Sunday morning programs. This doesn't make the reform easier, but it is likely to produce better results.

More importantly is the need to rethink retirement at age 65 as the norm. Again, as you know, this was a convention that was adopted at a time when people didn't normally live to or beyond age 65. While for some individuals, 65 is an important age for retirement because of increasing disabilities; nonetheless, far more survive now beyond 65, sometimes for substantial periods of time, 20 and 30 years, and with far lower rates of disability than used to occur. Social Security is slowly bringing this into acknowledgment by raising the full benefit age from 65 to 67. It is still an age where many people can be in retirement for as much as 40 or 50 percent of the time that they spent in the labor force.

While there has been some increase in the number of people over age 55 who talk about expecting to work beyond the age of 65, or even into their 70s, it is clearly not the norm. It is not the cultural expectation and it is not a policy that receives the full support of the Federal Government in terms of fiscal policies that can support continued labor force participation.

Fortunately, employers will be encouraged to find ways to be more flexible in their employment policies because of that baby bust generation that I mentioned. The shortage of people coming into the labor force will help to encourage employers to find ways to bring in older workers or keep on older workers, just as they found ways to hire women in greater numbers in the 1970s and 1980s.

If the United States, in addition, can learn how to spend smarter on health care through strategies involving paying for performance, health IT, electronic medical records, and, importantly, changes in the tax code, it may be possible to reduce health-care spending growth to rates that are below their historic averages. If this does not happen, we are all in big trouble.

As you have heard, and as I agree, it is difficult to think about fundamentally reforming Medicare without looking at what is going on in health-care spending as a whole. Not surprisingly, when you look over long periods of time, Medicare tracks overall spending pretty closely. It is a big part of overall spending, it is getting to be a bigger part of overall spending, and it represents spending by a very big and important powerful political block of people. It is hard to imagine having overall spending providing different services or different quality for a sustained period than is provided for the Medicare population.

There are a lot of things we can do to spend smarter. The good news is that there are so many things we are doing wrong now in terms of not rewarding the providers who do it right the first time, and that practice in a conservative manner. We have a system that has very sophisticated medical devices, with a very cottage industry 19th century paper system of information. But, to be honest, we

don't really know whether, if we spend smarter, we will just get better value for our money or whether we will really be able to slow down the spending growth. But given the alternatives that are available to us, it is an important step that we need to take.

Let me just say, before I close, a few words about Medicaid. Medicaid involves a somewhat different set of issues, but there are some similarities in terms of the impact on the budgetary pressures that are being felt and the rates of growth that are occurring, annually now at about 8 percent. Predictions over the next decade show similar rates of growth as well.

But the other reason it is important to think about Medicaid along with Medicare is that they cover some of the same or similar populations. While a majority of the people on Medicaid are families, the moms and kids, the majority of money on Medicaid goes to those who are aged and disabled.

This is true even in the last 3-year period, where we have seen substantial increases in Medicaid spending, largely, as it has been reported, attributable to a growth in enrollment. While we may think that that primarily represents the effects of the recession, it is important to understand that even in this period, the impact was primarily from the growth and spending for the aged and disabled, even though their numbers were growing much slower than the growth of moms and kids or the families. Much of the experimentation that has been done in the past decade or decade and a half has involved the moms and kids. It is time now to see whether we can't think of better, smarter ways to provide support to the aged and disabled, and to the so-called dual-eligible?

One last point is that the administration has raised an issue not just of providing flexibility, but trying to go after some of the financial creativity that the States have shown in trying to finance Medicaid expenditures. I think this is a very important step to take in a program that has lots of areas that need to be considered.

Medicaid's primary strategy for moderating spending growth is the fact that it is a matching program. If and when the States find strategies to increase total spending by only increasing Federal spending, rather than by matching, you have fundamentally changed the nature, at least at the fiscal basis, of the Medicaid program. Making sure that this doesn't happen in the future is just one of the many things that needs to change.

On a broader level, the time is long overdue to think about the type of program we would like for our low-income populations for the 21st century. The current program leaves out many very poor people; it covers some people who are substantially above poverty; it provides extremely uncoordinated care for the very expensive dual-eligible population who are both on Medicare and Medicaid; and, finally, very little information is provided on the impact that this major program has on the health status of our most vulnerable low-income populations.

Thank you.

[The prepared statement of Gail Wilensky follows:]

PREPARED STATEMENT OF GAIL R. WILENSKY, PH.D., SENIOR FELLOW, PROJECT HOPE

Mr. Chairman and members of the Budget Committee: Thank you for inviting me to appear before you. My name is Gail Wilensky. I am a senior fellow at Project

HOPE, an international health education foundation. I have previously served as the Administrator of the Health Care Financing Administration (now the Center for Medicare and Medicaid Services) and also chaired the Medicare Payment Advisory Commission. My testimony today reflects my views as an economist and a health policy analyst as well as my experiences at HCFA and MedPAC. I am not here in any official capacity and should not be regarded as representing the views of Project HOPE.

The purpose of my testimony is to consider some of the challenges resulting from our medical care entitlements, Medicare and Medicaid. While most of the attention in Washington is currently focused on 2006 budgetary issues, the challenges from the entitlement programs grow even larger over time. My comments will reflect some of the short term challenges from the entitlements as well as longer-term challenges. The bulk of my testimony will be on the Medicare program but I will also include some observations about the Medicaid program.

MEDICARE'S SHORT TERM ISSUES

The president's budget provides for \$346 billion in outlays, which represents an increase of \$50 billion or 17 percent over last year. For the period 2001–2006, outlays will rise at an average annual rate increase of 9.7%. Since the full drug benefit resulting from the Medicare Modernization Act begins in January of 2006, it is not surprising that most of the focus of this year's Medicare budget is on implementing the new drug benefit and that the budget includes a request for implementation funds. As a former HCFA Administrator, I have observed that including implementation funds is an aspect of new legislation that has been all too frequently overlooked and I commend the Congress for including it in the MMA.

The Congressional Budget Office recently released its projections for the 10 year period, 2006 through 2015. According to CBO, Medicare spending is expected to grow at an average rate increase of 9 percent over the 10 year period, reaching \$766 billion by 2015. Medicare spending which was 2.6 percent of GDP in 2004 is expected to be at 3.9 percent of GDP by 2015. This substantial growth in spending may well be optimistic since it includes several years of reductions in physician fees, which resulted from the sustainable growth rate (SGR) included in the Balanced Budget Act. Since Congress did not let these reductions go into effect for the years 2003, 2004 and 2005, it is not clear how likely the Congress is to let these reductions go into effect over the next few years.

CBO estimates Medicare Part D spending to grow from \$47 billion in 2006 which is a partial year (\$75 billion in 2007) to \$174 billion in 2015, representing 23 percent of Medicare spending by that time. As the Committee is well aware, there has been considerable controversy about the differing estimates of Part D between CMS and CBO. CMS estimated Part D spending at \$534 billion for 2004–2013 and CBO estimated \$395 billion for that same period. These differences primarily reflected different estimates of the percent that would enroll in the voluntary Part D, the percent of low income seniors that would enroll in Part D and the take-up rate by seniors in the new Medicare Advantage program. The difference, while large in absolute terms, represents slightly less than 3 percent of Medicare spending over the period 2004 through 2013.

More recently, there has been a lot of attention given to the estimates of the cost of Part D for the period 2006 to 2015. The Administration estimates that cost at \$720 billion. CBO's estimate of \$796 billion is not exactly comparable because it doesn't allow for some of the adjustments included by the CMS actuary. CBO has also recently reiterated that its current estimate of the program costs for 2004 to 2013 remains almost identical to its original estimate.

The reason for the difference in the estimates for 2004 to 2013 and 2006 to 2015 is not very complicated. The first 2 years of the program involved only the drug discount card program, some low income support and implementation expenses, all of which are relatively low costs. They were in the 10 year estimate made before passage of the bill. The 10 years that start with the next budget, i.e. 2006, lose the first two "cheap" years and add 2 years at the end. The end years are much more expensive because the full program will have been in force for 8 years and because of medical inflation and increasing numbers of seniors. There are a lot of difficult issues to face in Medicare but this difference in numbers is not one of them. However, what these numbers do very effectively is to give a glimpse of the true 10 year costs of the new drug benefit which will only continue to increase over time.

MEDICARE'S LONGER TERM ISSUES

The longer term financial challenges to Medicare are documented annually in the annual report of the Social Security and Medicare Board of Trustees. While we are

only about 2 months from the 2005 report, the 2004 report lays out the issues sufficiently clearly for the purpose at hand. According to their intermediate projections, which includes a medical inflation factor less than the rate experienced, Medicare expenditures will grow to 7.7 percent of GDP by 2035. Medicare's expenditures are currently smaller than Social Security but Medicare costs are expected to exceed those for Social Security by 2024. Looking over the long haul, the full unfunded liability of Medicare has been estimated to be as high as \$28 trillion, \$8 trillion of which is attributable to the new drug benefit.

The HI Trust Fund, which covers Part A of Medicare (inpatient hospital, nursing home and some home health care) and frequently receives the most attention from the public, is projected to exhaust its assets by 2019. HI assets are estimated to decline to 89 percent of annual expenditures by 2013, which would no longer meet the Trustees' test of short range financial adequacy.

In many ways, however, the greater concern should be with the impact of Part B Medicare (which covers outpatient hospital, physician, lab and DME) and Part D (the new Prescription Drug benefit). There is not the same concern about insolvency that there is for Part A but rather the impact that the growth in these two areas will have on the budget and the Treasury. The reason is that Parts B and D are financed partly by premiums and co-payments by the elderly but mostly from general revenue.

As a result of this concern, the Medicare Modernization Act requires that the Trustees monitor when they estimate general revenue funding of Medicare will exceed 45 percent of total Medicare outlays and to report if this will occur within the first 7 years of projections. Since CMS has just reported that Part A costs were lower than expected in 2004 and Part B costs were somewhat higher than expected, there is great interest to see if this will occur with the 2005 report.

NO EASY ANSWERS FOR MEDICARE

Diagnosing the problem with Medicare is much easier than finding viable solutions. There are several pressures that are driving up spending projections, including but not limited to the impending retirement of the baby-boomers. As all of you know, some 78 million baby-boomers will start turning 65 in 2011 and continue reaching retirement age over the next twenty years. This will double the over 65 population currently covered by Medicare.

But it is not just the increasing numbers of individuals who will be eligible for Medicare that becomes the issue. Those reaching 65 can be expected to experience increased longevity which means they will be on Medicare for longer periods of time than their predecessors. And almost as important, the baby-boomers are followed by the "baby-bust" generation, the unusually small numbers of cohorts born the generation after the boomers. This means that just as the ranks of seniors begins to surge, the ratio of workers to support them will begin to decline - a fiscal "double whammy" in the making.

The most obvious types of options—changing benefits, changing eligibility or changing the financing of Medicare can affect the financial future of Medicare but none are easy—either in their politics or in their economics. An important opportunity was lost when the MMA was passed, providing an important new benefit to seniors, without also substantially modifying Medicare. But in fairness to the Congress and the Administration, I do not believe there was the political will at that time to take on these difficult issues. An important and little noticed component of the MMA is the provision that substantially reduces the Part B subsidy for higher-income seniors starting 2007, which could provide an important precedent for introducing other provisions that relate government contributions or subsidies to the income and/or wealth of baby-boomers.

Two others areas may offer the potential to ease future financial burdens from Medicare and need to be explored further. The first is to rethink the whole concept of retirement and the second, is to find ways to "spend smarter."

RETHINKING RETIREMENT

The notion of thinking about pensions or Social Security and Medicare as joint programs for retirees is not a new concept but has received renewed attention following a recent mentioning of it by Chairman Thomas of the Ways and Means Committee. This doesn't make the reform of Social Security and Medicare any easier but may lead to better results.

Even more important, is the need to reconsider retirement at age 65 as the norm. As you probably are aware, the choice of age 65 as an expected retirement age occurred at a time when longevity was far less than it is at present and when the disability rates of those who survived into their sixties and seventies was far greater

than it is today. Social Security is in the process of moving from age 65 to age 67 for full benefits, still an age where the time in retirement could approach 40 percent or more of the time spent in the work force.

While there has been some increase in the numbers of people over age 50 that expect to spend some time in their sixties and even seventies working, it is hardly the norm. Changing this expectation would require changes in fiscal policies as well as cultural expectations regarding retirement in order to encourage continued and more flexible labor force participation. The scarcity of new labor force entrants, associated with the baby bust generation should encourage employers to be more creative in their treatment of seniors just as they were with their employment of women in the 1970s and 1980s. But it is important to make sure that fiscal and other government policies are supportive of continued labor force participation as well.

SPENDING SMARTER

Finally, if the United States can learn to spend smarter in health care, through strategies involving pay-for-performance, health IT, electronic medical records, and importantly, changes in the tax code, it may be possible to reduce the growth in health-care spending to rates that are below their historic averages. This will only happen, if these changes occur in all sectors of health care and not just in Medicare.

To no surprise, over long periods of time, Medicare tracks the rest of health-care spending pretty closely. First, seniors spend substantially more per person than the younger population which means that even when they represented only 12 percent of the population, they accounted for a disproportionate share of spending on health care. As seniors become close to 25 percent of the population, they will have an even bigger effect on overall spending levels. Secondly, their relative growth in numbers combined with their high voting participation rates, will give them even greater political clout than they have had in the past. It is difficult to imagine this powerful group tolerating a health-care system that was in any important way "lesser than" what exists for the rest of the population.

"Spending smarter" is a theme that has received a lot of attention lately. While it seems pretty clear that we can and should have better information on relative cost-effectiveness and clinical-effectiveness of alternative therapies and procedures as well as better incentives for both patients and providers, not much is known on whether this will slow rates of spending growth relative to historic averages or just provide better value for the money spent. Similarly, introducing information systems in health care and making the information side approach the sophistication of the device and procedure side of medicine should provide substantial one-time savings. Whether these changes would reduce rates of spending over time is less clear. However, given the alternatives to slowing spending otherwise available, improving information and incentives, changes to the tax code and adopting modern information systems seems the most promising strategy available.

MEDICAID

Although Medicaid represents a somewhat different set of issues, the sustained impact of a growing Medicaid program has some similar effects on the budgetary pressures which will be felt by the Federal Government. The Federal share of Medicaid spending has increased from \$129 billion in 2001 to \$193 billion for 2006, an average annual increase of 8.3 percent. The CBO predicts that Medicaid will grow at an average rate of 8.7 percent through 2015, reaching \$392 billion for the Federal share by 2015.

It is important to consider the effects of Medicaid along with those of Medicare for several reasons. First, the budgetary effects are significant and the growth rates not dissimilar. Projections by CBO have indicated that if Medicare and Medicaid were to continue to grow at a rate of 2 percentage points faster than the GDP, which is close to its historic average, these two programs would account for 20 percent of the GDP by 2040, the approximate current share represented by the entire Federal budget. If the rates of growth were reduced to GDP plus one, spending on these two entitlements would approximate 12 percent of GDP. Thus, the need to think hard about ways to slow their growth rate is crucial.

The second reason it is important to think about Medicare and Medicaid together is that the majority of expenditures go to the aged and disabled populations even if the majority of Medicaid participants are neither aged nor disabled. A recent study by the Urban Institute indicated that much of the growth in Medicaid spending from 2000 to 2003 was attributable to a growth in enrollment. While that might not sound so surprising since much of that period was characterized by slow job growth coming out of a recession, less attention has been given to the fact that even

here, a majority of the spending growth was attributable to the aged and disabled. This was true even though the numbers of aged and disabled were growing more slowly than the numbers in families.

So much of the experimentation with finding more efficient (or just cheaper) ways to provide in the past has focused on families and not on the aged and disabled but it is the latter two groups that represent the majority of spending and also spending growth. Hopefully some of the flexibility that the Administration is proposing for the provision of long term care services for the elderly and disabled will help spur the state's creativity in these areas.

The states' creativity raises another issue important to a better understanding of Medicaid spending growth. When pressed financially, states have shown substantial creativity in finding ways to increase Federal dollars without a concomitant increase in their own spending. Sometimes the increased spending has gone into additional spending on Medicaid or other health-care programs and sometimes not. In either case, a program that relies on state matching as the primary mechanism for cost control cannot function if the states' are not contributing their appropriate shares. I applaud the Administration for introducing a series of steps to make sure the states are contribution their legally determined match including restricting inter-governmental transfers and Medicaid payments that are in excess of actual costs of services.

On a broader level, the time is long overdue to rethink the type of program for low-income populations that makes sense for the 21st Century. The current program leaves out many very poor individuals, covers some who are very substantially above poverty, provides very uncoordinated care to the so-called "dual-eligibles" who are on both Medicare and Medicaid and provides very little information on the impact that Medicaid and SCHIP has had on the health status of the low income populations being served.

Chairman NUSSLE. Thank you, Dr. Wilensky.

Next we will hear from Ron Haskins. Dr. Haskins is from The Brookings Institute, and Dr. Haskins has also testified before the Budget Committee.

We welcome you back, and we are pleased to receive your testimony.

STATEMENT OF RON HASKINS

Mr. HASKINS. Thank you very much, Chairman Nussle. And Ranking Member Spratt and members of the committee, as a former congressional staffer for the Ways and Means Committee, and as a citizen, as kind of a cranky budget analyst, I am very pleased to come before the committee today. I am also pleased to be of somewhat advanced age, because I think in this debate that we are going to have now, for the fourth time in three decades, about how we are going to get the Federal books in order, it is necessary for everybody to be extremely frank and honest, and it is good to have people involved who don't necessarily have a political future and can call them the way they see them. So I would like to do that.

Chairman NUSSLE. Can we ask what your age is? And do we need to swear you in before we—

Mr. HASKINS. You probably should swear me in, but my age is 61.

Chairman NUSSLE. OK. Thank you.

Mr. HASKINS. Thanks to a program that I am about to condemn, though, I am doing OK.

For the last 2 years at Brookings we have been studying the budget deficit, and I think you can put almost all of us down, both left of center and right of center, as being in the alarmist camp. We think something definitely has to be done about the deficit.

This year we decided to include a political chapter, which Alice Rivlin, a former head of the Congressional Budget Office and Office of Management and Budget (OMB), and Belle Sawhill, a noted scholar, economist, and also a former official in the Clinton administration at the Office of Management and Budget, and we decided to do some interviews. So we talked with 20 budget experts, Washington insiders, people who have been involved in budget deals in the past; people like Bob Reischauer, Rudy Penner, Bill Frenzel, Tom Downey, and several others, 10 Republicans and 10 Democrats.

I would like to tell you, Mr. Chairman, Mr. Spratt, and members of the committee, that there were three factors that all of them saw as crucial to the previous big bargains that involved taxes and spending the Congress has put together, in 1983 for Social Security; in 1986 the big tax reform measure; and the budget deals of 1990, 1993, and 1997. The first is Presidential leadership, the second is bipartisanship, and the third is some external threat that the Members of the Congress saw as saying to them we better do something or there will be serious consequences.

We are, this year, I think for the first time in an obvious way, seeing Presidential leadership. And the President has, for the first time, put a budget on the table that does contain serious cuts, as you can tell. If you read the editorial page of *The Washington Post* and *New York Times*, the sky is falling and so forth, which always happens whenever you have a serious budget proposal. But the President's leadership is somewhat limited because the President would be expected to provide leadership for spending cuts only, not for tax increases.

So this brings us to the second important ingredient of a budget deal, which is bipartisanship. And I think, frankly speaking, that the possibility of next fall, when we pass some huge bill of 2,000 pages, that contains all of our provisions, that they will be almost exclusively cuts. There possibly could be some loophole closings, but I certainly don't think that there is a groundswell of support among Republicans or in the White House for any kind of major tax increases. So that means that the possibility of a bipartisan agreement and substantial deficit reduction that involve both tax increases and spending cuts is probably quite modest.

And, finally, the external threat. Unfortunately, our budget situation is such that these external threats, people talk about them incessantly, but so far nobody has really been hit by them. It is reputed that the Vice President once said in the White House that no one ever lost an election because of a budget deficit. I don't know if that is true or not, but I think that does accurately reflect that the threats are possible in the future. They are not things that we can measure easily. We can't say that this State or this group of people are going to have a serious problem if we don't do something.

The only person that we interviewed that really thought that the threats were about to hit us—by the way, everybody thought there were threats, but they couldn't tell when they would hit. Alice Rivlin, however, was somewhat confident that within the next couple of years, that the markets are going to go, to use her term, wobbly. And when that happens, Members of Congress, Repub-

licans and Democrats, and members of the administration are going to get calls from businessmen, from people on Wall Street, and they are going to say, you need to do something about the deficit.

The other possibilities, of course, are huge falls in the stock market, if the Chinese woke up one morning, decided not to buy our debt anymore. You know, there are a number of external threats that could really drive the Congress to action.

So we have leadership for budget cuts and I think a very low possibility of tax increases. So we probably will not have a bipartisan deal. I think an external threat would be a good thing, but I hope the threat doesn't actually come true before we do something.

Now, the President's plan, as nearly as I can tell, is to do something like cut around \$20 billion next year. And the head of OMB, Mr. Bolton, was reluctant to say what a 5-year figure was, because he thinks estimates are not very accurate, which I think we all agree with, but it is probably something on the order of \$300 to \$350 billion.

The main point of my testimony is that this should be the absolute minimum goal for the Congress, whether it is bipartisan or done primarily by Republicans. I am inclined to think it will be the latter. So you all are looking for at least \$20 billion in cuts, not necessarily the ones the President recommended, but I think that is the place to start.

Now, how do we get there? First, I want to make a couple of procedural comments. The first one is that I think that most scholars agree the PAYGO was a good innovation and served its purpose. Congress figured out eventually how to find its way around PAYGO after the 1997 agreement, but PAYGO was a pretty good procedure and it helped people who were intent on cutting the deficit. You know very well that we have had kind of a lively discussion about PAYGO recently, and there is a great deal of willingness to have PAYGO apply to cuts but not to tax increases, so I don't know exactly how you are going to resolve that, but PAYGO of either form would be helpful.

The second thing, and by far the most important, is reconciliation. I believe we have not done reconciliation since 1997, but reconciliation is definitely a powerful weapon for people who want to cut spending or increase taxes in order to reduce the deficit. And it is especially powerful because it can get around the 60-vote problem in the Senate. So this puts the House on an even par with the Senate when it comes to whatever actions we decide to take, and I think that is critical.

So reconciliation I think is something the Budget Committee should examine very carefully, and it probably would not go unnoticed in this room that reconciliation would give the members of the Budget Committee a lot of leverage that they otherwise would not have, because they can give instructions to the committees of jurisdiction.

And, third, I think we should take another run at the line-item veto. The Congress passed the line-item veto on a bipartisan basis during the Clinton administration. The first time Clinton used it, the Supreme Court found it to be unconstitutional, but there are

lots of ways to do a line item veto, and I think the Budget Committee should look for ways and we should try a new way to have a line item veto.

Now as for specific cuts. I have been asked to talk primarily today about entitlements, like everybody else, and to focus on income security. I present lots of information about past spending and projections in the future among income security programs, but let me bring a few things to your attention.

First of all, compared with Dr. Wilensky's testimony, I think what I am about to tell you could be accurately called cats and dogs, because the spending in question here, compared to Medicare and Medicaid and Social Security is quite modest. But, nonetheless, if we are going to try to get a minimum of \$20 billion, this is a good place to start. There are some good ideas here.

There has been huge growth in recent years, but that is misleading, I believe. If you look at the projections, the growth in income security is going to level off quite a bit; not completely, but will level off quite a bit.

So where would we look if we want to have some cuts in income security? The first place I would look is Federal retirement. Now, I fully realize that sitting before me are Members of Congress who themselves are someday going to be the beneficiaries of Government retirement programs, so I will be cautious in my remarks.

However, the concept that people should be able to retire at age 40, 41, 42, or 43 and get a substantial benefit is part of what is driving our retirement programs off the cliff. We ought to at least have a lively discussion about why don't we wait until people are at least 50, 55, or 60, before they can start drawing these benefits? That alone would dramatically reduce the Federal deficit in the future, and we need to think about the future. The big problems that Dr. Wilensky talked about are coming 10 and 20 and 30 and 40 years down the road.

Second, we could do a lot of things with the COLA. I will talk more about that in just a minute. The cost of living adjustment could be done on a different basis.

And, third, there are other changes that we could make. For example, we could have a new procedure for defining the original benefit. We could use, for example, rather than 3 years, which is now used, the average of the highest 3 years to establish the benefit. We could use the highest 5 years, and that would automatically reduce everybody's benefit, and that would save benefits of dollars. There is a table in my testimony that shows how much it would save.

Secondly, unemployment insurance. I was with the Ways and Means Committee for many years, where I studied unemployment and we had lots of hearings. Unemployment is a program that is far too generous. Now, here is what we have. We have a welfare system now, after 1996, that is hell on wheels requiring people to work. If they don't work, they lose their benefit. And it had a dramatic impact; the roles have declined 60 percent.

And, yet, in unemployment insurance, with people with work history, more education, much more experience in the labor market, the work requirement, which we have in the law but it is observed in the breach, we don't have strong work requirements. If we had

a strong work requirement in unemployment insurance, we would save a lot of money. So that would be one thing that we should do, is have a much stronger work requirement in unemployment insurance. There is no reason people should be able to sit around for 6 months and draw an unemployment insurance check, or even longer than that during a recession.

Third, Supplemental Security Income (SSI). I want to point out to the members of this committee I urge you to go back and look at the changes that we made in 1996. We made a whole series of changes. I had no doubt that those changes would save at least \$50 billion over 10 years. The Rand Corporation studied just the changes in the child SSI program, which I think were quite reasonable and passed Congress on a bipartisan basis and were signed by President Clinton. The Rand Corporation estimates that we saved \$24 billion over 10 years just on the changes in the child SSI program. And I would point out to you that SSI is one of the most rapidly growing programs within the income security super function, so it bears careful examination.

Next, child nutrition. We all know and love the child nutrition programs, and I am going to say something in just a moment about programs for low-income families. But there is a part of the child nutrition program that provides a subsidy for school lunches for people who are not low-income, they are over \$28,000 a year. Now, that could lead to some extreme administrative difficulty, the schools certainly would not like it, there would be all kinds of lobbying, like there would be for any cut, but the principle of subsidizing school lunches for families earning \$50,000, \$60,000, or \$70,000 is something that some Americans might think is not a wise thing to do.

And finally let me say that the wonderful Congressional Budget Office every 2 years publishes a volume that used to be called "Spending and Revenue Options"; it is now called "Budget Options." And as luck would have it, a brand new one came out just this week, and it is full of options for cutting spending; also for raising revenues, which might go somewhat unused on the right side of this aisle.

There are all kinds of great suggestions, and in the area of income security, there are 13. They left one out from 2 years ago, which I don't know why, but I have a table in my testimony that shows you that if we picked up on all the options that they lay out—they are not recommendations from the Congressional Budget Office, but options—we would really save a tremendous amount of money: over 5 years, almost \$26 billion, and over 10 years almost \$76 billion. So that gets you a long ways toward what I think ought to be the absolute minimum that we should try to do.

Now, let me just say I, for most of my adult life, was a researcher, and then I was with the Ways and Means Committee and I was the head of the Welfare Subcommittee, the staff director of the Welfare Subcommittee of Ways and Means. And I am at Brookings now, and the project that I work on is called Welfare Reform and Beyond. So although I am conservative, I do have a special concern with programs for low-income Americans, and, to my way of thinking, low-income Americans, millions of them, have an even

greater claim on public concern at this point because so many of them now work, and work at low-wage jobs.

So I am hoping that, in making budget cuts, you would look carefully at programs that support low-income Americans, and cut where there is waste and abuse and so forth, but be cautious, because these programs support lots of low-income working families that are really dependent on the benefit, and many, many of those families, disproportionately those families are raising the next generation of Americans. So I urge caution.

In conclusion, I think we are on the right path at last. I wish we had started several years ago, but we are on the path of deficit reduction. And under the leadership of this committee, and specially with strong reconciliation recommendations from this committee, Congress and the President could significantly reduce spending. If taxes were on the table, we could do more, and we could do it in a bipartisan fashion, but that is likely not to be the case. But even without taxes we can get at least part of the way there, and that would be better than nothing.

Thank you.

[The prepared statement of Ron Haskins follows:]

PREPARED STATEMENT OF RON HASKINS, SENIOR FELLOW, ECONOMIC STUDIES, THE
BROOKINGS INSTITUTION

Chairman Nussle, Ranking Member Spratt, and Members of the Budget Committee, I consider myself fortunate to address the members of the House Budget Committee. Along with the Appropriations Committee, this committee has the toughest but most important job in Congress this year. Our Nation faces a budget crisis that will soon be of historic proportions. Something must be done—and the buck stops here. As a citizen, a scholar, and a former Congressional staffer, I am honored to have the opportunity to provide some humble advice to you who must make momentous decisions.

The budget problem has two dimensions. First, the short-term deficit is too high. This year the deficit is expected to be around \$427 billion according to the Office of Management and Budget (OMB). Adding the costs of the war in Iraq would push the deficit still higher. If Congress extends the tax cuts, enacts a reasonable adjustment of the Alternative Minimum Tax, and allows domestic discretionary spending to increase in proportion to population growth and inflation, the deficit will average more than \$500 billion over the next decade. Some observers take comfort from the fact that deficits associated with the recessions of the mid-1970s, the early 1980s, and the early 1990s were higher as a percentage of Gross Domestic Product than the current deficit. However, in all these cases Congress and the president took very strong action to reduce the deficits, both by cutting spending and by increasing taxes. But so far in this new century, neither Congress nor the president has taken serious action to reduce the near-term deficits. Worse, the current deficit could be considered more threatening than the former deficits because we are now on the cusp of baby boom retirement, an unfolding event that will place huge strains on federal finances in the decades ahead.

The lack of action on the deficit is perplexing for those of us who played a role in the Republican assault on the deficit after capturing the House and the Senate in the elections of 1994. As Bill Thomas of California, now the Chairman of the Ways and Means Committee said, "We can no longer tolerate mere promises of fiscal restraint. To do so would saddle our children, and children's children, with uncontrollable and runaway deficits" (Congressional Record, 1995). How can it be that in 1995 Republicans believed deficits to be the governmental version of the apocalypse and now many Republicans can muster little more than a yawn when the deficit figures are recited?

Nor do the figures I have presented so far give a complete picture of the magnitude of the deficit threat. The second budget problem we face is the long-term deficit. The leading edge of baby boom retirement begins in 2008 and intensifies in subsequent decades. The Medicare trust fund will be the first to go belly up as a result of additional spending on retirees. According to its trustees in last year's report, Medicare will be in the red by 2019, seven years earlier than the trustees predicted

in their annual report just one year earlier. Once Medicare goes broke, its financial imbalance will intensify dramatically in subsequent years. Social Security, again according to its trustees, is in better financial shape, but only in the sense that it goes broke later than Medicare. The Medicare Trustee's report informs us that the additional resources needed to meet the projected expenditures of Social Security, Medicare, and Medicaid over the next 15 years is \$33.2 trillion (Board of Trustees, 2004, p. 183).

One of the more alarming perspectives on the condition of the federal budget is that if Congress makes the tax cuts permanent, enacts a reasonable fix on the Alternative Minimum Tax, and increases domestic discretionary spending to keep pace with inflation, Gene Steuerle of the Urban Institute and a former Treasury official in the Reagan administration calculates that interest on the debt, Medicaid, Medicare, Social Security, and Defense will consume all federal revenues by 2015, leaving no remaining funds to operate the rest of government (Steuerle, 2003).

These are deeply troubling scenarios that serious and nonpartisan analysts have assured us will occur during our lifetime. We're eating cake, playing our fiddles, and maximizing consumption while passing the bill to our children and grandchildren. Something must be done.

The President has proposed the toughest budget since Republicans and Democrats reached an agreement to balance the budget in 1997. Its cuts in social programs have been widely criticized, often in language of the most alarmist sort (Krugman, 2005). But here is the main point of my testimony: the deficit reduction achieved by the president's budget is the least Congress should do this year. I hope there will be bipartisan agreement on this point, but even if there is not, then Republicans, as the majority party, must accept responsibility for achieving at least the \$20 billion in spending cuts next year and perhaps on the order of \$300 billion over 5 years proposed by the president (Andrews, 2005). Given the size of the deficit and the burden it promises to impose on our children and grandchildren, the Bush cuts which have been so widely criticized are not much more than a promising down payment on the cuts that will be needed to reduce the deficit by half on a permanent basis.

The action needed to cut the deficit by half on a permanent basis would be much easier if Republicans were willing to consider tax increases—or at least consider not extending all the tax cuts put in place since in 2001. Even former Senator Nickles, the immediate past chair of the Senate Budget Committee and one of the strongest supporters of tax cuts, recently told the Washington Post that some “adjustments” might need to be made in tax cuts and other Republican policies (Weisman and Baker, 2005). Most of those who follow politics in Washington seem to believe that it is exceptionally unlikely that Republicans in Congress or President Bush will seriously consider tax cuts. So be it. Republicans are in control of both ends of Pennsylvania Avenue and, if they can hold their votes, they can protect their tax cuts and make them permanent. But if Republicans want to reestablish themselves as the party of fiscal rectitude and to alter the Nation's current course of simply writing checks that our children and grandchildren must cover, it follows that their spending cuts will have to be all the deeper. It would be inconsistent with family values to do any less than prepare for the retirement of the baby boom by getting our fiscal House in order—in this case through truly remarkable cuts in spending.

Last year, for a book on the fiscal crisis published by the Brookings Institution, along with Alice Rivlin, the former head of both OMB and the Congressional Budget Office (CBO), and Isabel Sawhill, a senior official at OMB in the Clinton administration, I wrote a chapter exploring the level of spending cuts that would be necessary to bring the budget into balance within a decade (Haskins et al., 2004). Our search for spending cuts was driven by principles supported by the Republican party; namely, smaller government, minimal government interference in the economy, more power and control at the state level, and a minimum of reliance on new revenues. Figure 1 shows the levels of spending cuts and increased revenues required to balance the budget within 10 years under our budget assumptions. Our spending cuts included:

- \$138 billion in commercial subsidies such as the Export-Import Bank, the Federal Aviation Administration, and various Energy Department programs,
- \$123 billion in devolution of programs such as the entire Department of Education to the state and local level,
- \$7 billion from the list of wasteful spending originated by this committee last year,
- \$58 billion from non-defense discretionary programs, and
- \$74 billion from entitlement programs.

After making this spectacular level of cuts, we still needed \$134 billion in revenues to achieve the \$534 billion in combined spending cuts and revenue increases required to balance the budget in 2014 under our baseline assumptions. To comply

at least in part with Republican goals, the revenue raisers did not include any changes in the personal income tax rates. Rather, revenue was obtained primarily by improved enforcement of the tax code, freezing the estate tax at its 2009 level, and increasing taxes on cigarettes, alcohol, and motor fuels.

Figure 1: A Smaller Government Plan to Balance the Budget in 2014, Primarily by Cutting Spending

<i>Item</i>	<i>Billions of Dollars</i>
Total deficit reduction	687
Minus debt service savings	-153
Subtotal: tax increases and spending cuts to eliminate deficit	534
Plus funding for new initiatives	0
Total: tax increases and spending cuts to eliminate deficit	534
<i>Changes in the budget</i>	
Revenue change	134
Spending cuts	-400
Commercial subsidies	-138
Devolution	-123
Wasteful spending	-7
Non-defense discretionary	-58
Entitlement	-74

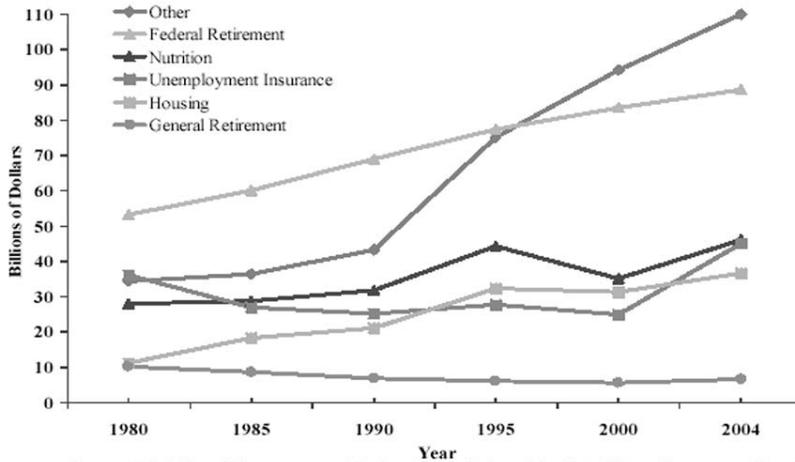
Source: Haskins, Sawhill, and Rivlin, "Getting to Balance: Three Alternative Plans" (authors' calculations), and Congressional Budget Office, "The Budget and Economic Outlook: An Update," August 2003. Sums do not add to totals because of rounding.

A major purpose of the Brookings exercise was to demonstrate the drastic, unprecedented level of spending cuts that would be necessary to actually balance the budget within a decade. Although we did not realize it when we put the deficit balancing plan together last year, this exercise also shows how modest are the cuts proposed by President Bush this year. I would not minimize the difficulty of actually enacting the cuts proposed by the president, as shown by the bitter response they have provoked from advocates, editorial writers, and a number of Democrats in Congress. But perhaps members of this Committee who are preparing to withstand severe criticism for being fiscally responsible will take some comfort from the much greater level of cuts outlined in Figure 1.

In turning to the search for specific places to cut spending, I have been asked by the Chairman to report to the Committee about potential cuts in the Income Security function of the federal budget. Based on the Historical Tables volume from the President's 2006 budget (U.S. Office of Management and Budget, 2005, pp. 53–70), Figure 2 presents changes in spending within each of the six subfunctions that comprise the Income Security function. All the figures are expressed in inflation-adjusted 2004 dollars. Several points are notable. First, the General Retirement subfunction, which consists primarily of railroad retirement, is the least interesting because it is low (under \$10 billion every year) and declining. Second, Unemployment Insurance and Nutrition move in rough accord with the economy—they go up when the economy is in recession and down in times of expansion. Both grew quite considerably during and following the brief recession of 2001 but their growth is now moderating. Housing has grown throughout the period, especially in the mid-1990s and since 2000. Between 1980 and 2004, housing expenses increased from around \$11 billion to over \$36 billion.

Federal Retirement, which includes federal civilian and military retirement and disability programs, has been growing relentlessly. Over the nearly 25 year period, it grew from \$53 billion to nearly \$89 billion. Retirement policy for federal employees deserves special attention. Spending is huge and growing, and given the high level of government employment, this account will continue to be very high in the future. Although controversial, it could be argued that providing retirement benefits to someone who is 42 years old because they have worked for 20 years is somewhat extravagant. Perhaps retirement benefits should not begin until recipients reach 55 or even 60 or 65 years of age. Those currently receiving retirement benefits could continue under the current rules, but those who retire after some future date could be phased in a year at a time to delay their receipt of retirement benefits.

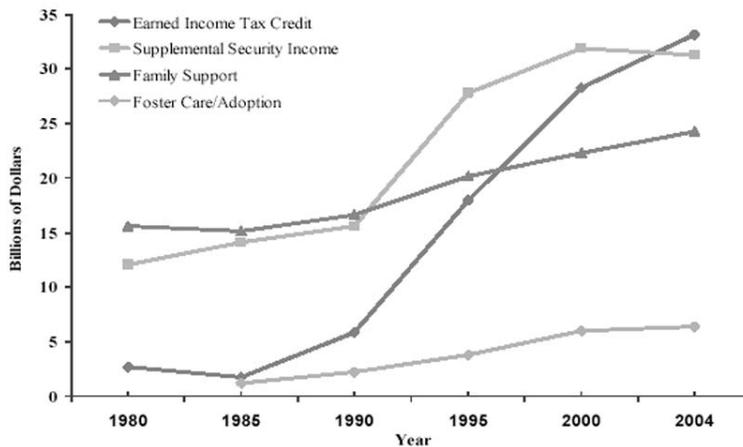
Figure 2: Growth of Income Security Spending by Subfunction, 1980-2004



Source: U.S. Office of Management and Budget. 2005. *Budget of the United States Government, Fiscal Year 2006*

The remaining subfunction is the “Other” category. Figure 3, which portrays the spending history since 1980 of several of the most important constituent programs in the Other subfunction (U.S. Office of Management and Budget, 2005, pp. 135–140), shows that growth is beginning to moderate in Supplemental Security Income (SSI) and foster care/adoption. The only program that appears to be growing rapidly is the Earned Income Tax Credit (EITC), although more recent data show that the rapid growth of EITC has now ended as well. In fact, as the projections in Historical Tables show, all the programs in the Other category moderate their recent rapid growth rates and several actually decline in constant dollars (including the EITC) between 2005 and 2010.

Figure 3: Growth of Outlays for Selected Programs in the “Other” Subfunction of Income Security , 1980 - 2004



There are at least three lessons emerging from these program trends within the Income Security function that can prove instructive to anyone interested in controlling federal spending. The first is represented by SSI. The 1996 welfare reform leg-

islation and associated legislation made very substantial reforms in the SSI program. These included removing drug and alcohol addiction from the list of qualifying conditions for SSI; reducing the number of children receiving SSI by changing the definition of childhood disability and terminating one of the major procedures for determining whether a child was disabled; and ending SSI benefits for noncitizens who enter the country after 1996. The Rand corporation has estimated that just the reforms of the SSI program for children saved nearly \$22 billion over the 10-year period between 1996 and 2005 (Rogowski, 2002). As this example illustrates, Congress can enact modifications to programs by limiting eligibility to produce considerable savings over the years. It should be noted that in the case of SSI, the primary rationale for enacting the program changes that resulted in savings was not to save money but to remove benefits from individuals who, under a reasonable set of criteria, should not be eligible for benefits. It is possible to imagine that the Budget Committee or committees of jurisdiction for SSI and a host of other programs would carefully examine all the programs under their jurisdiction to determine whether program integrity is being maintained.

A second lesson on ways to save money is illustrated by the Family Support line item. The major program in this line item is the Temporary Assistance for Needy Families (TANF) program, formerly Aid to Families with Dependent Children (AFDC). AFDC was an open-ended entitlement welfare program that cost more money almost every year. In the 30 years between 1962 and 1992, enrollment and spending grew in all but 7 years (U.S. Department of Health and Human Services, 2004, p. A9). The authors of the 1996 welfare reform legislation, based largely on principles that suffuse Republican thinking about welfare programs, believed that too many young people who could support themselves were relying on public welfare. AFDC and other welfare programs were, in short, luring people into dependency. In 1996 the program was converted to a block grant with fixed funding and states were required both to limit adults receiving welfare to a maximum of 5 years of benefits and to impose strong work requirements on their caseload. The block grant has kept expenditures on the TANF program flat for nine years. Taking inflation into account, federal spending on TANF, as measured by budget authority, has actually decreased every year. In large part because of the time limit and work requirements (plus a hot economy), families left welfare as never before and took jobs. As a result, cash welfare payments to families dropped from \$12.0 billion in 1995 to \$4.6 billion in 2002, a drop of over 60 percent (U.S. Department of Health and Human Services, 2004, p. A12); and states used most of the money saved to pay for child care and other work supports that helped families stay in jobs (there were also substantial savings on food stamps and Medicaid). Perhaps the best part of the story is that throughout this period, the average total income of these families increased every year and child poverty declined every year. In fact, the decline in child poverty was the first sustained decline since the early 1970s and poverty among black children reached its lowest level ever. Thus, by working rather than remaining on welfare, families had more money, children benefited from reduced poverty rates, and taxpayer payments for welfare declined substantially. Under some circumstances block grants to states constitute both good policy and an effective tool for saving money (Haskins, forthcoming).

A third point illustrated by spending developments in income security programs is that a good economy causes spending in many programs for low-income families to fall. The number of mothers leaving welfare for employment was undoubtedly boosted both by the sweeping changes in welfare programs and by a growing economy that produced jobs these mothers could fill. The fact that mothers were earning money rather than receiving welfare reduced welfare spending on the TANF program. Similarly, outlays on food stamps, the biggest program within the nutrition subfunction in Figure 2, fell substantially as the economy grew between 1995 and 2000. When the economy fell into recession after 2000, spending on food stamps began to rise again. The unemployment insurance program shows an even greater responsiveness to the economy than TANF and food stamps. In 2000, the year before the mild recession of 2001 hit, about \$21 billion was spent for unemployment insurance benefits. After the brief 2001 recession, spending on unemployment benefits jumped to \$27 billion, \$49 billion, and \$51 billion in 2002, 2003, and 2004 respectively. As the pattern of outlays in these three programs demonstrates convincingly, spending leaps dramatically during recessions. It follows that federal policies—including low tax rates and modest regulations—that stimulate the economy will have a major impact on helping reduce the deficit. Conversely, if the Nation enters a recession in the next decade or so, federal spending and as a result the federal deficit will leap far beyond the projections in the CBO baseline.

In pursuing the analysis of potential savings from Income Security programs, I turn now to the very useful volume on Budget Options published by the Congress-

sional Budget Office (Congressional Budget Office, 2005). This volume of possible cuts in spending and increases in revenues is undoubtedly well known to members of the Committee. Of course, CBO does not endorse any of the spending cuts or revenue raisers in the volume, but the volume is tailor-made for a committee looking for ways to reduce spending. Figure 4 summarizes the thirteen possibilities for reducing spending in Income Security programs from CBO's 2005 volume and one from their 2003 volume. Enacting all these cuts would save almost \$26 billion over 5 years and nearly \$76 billion over 10 years.

Figure 4: Potential Savings from CBO's Budget Options Volume

<i>Proposal</i>	<i>2004-2008</i>	<i>2004-2013</i>
Increase housing payments	5.7	18.1
Reduce rent subsidies	0.7	2.8
Eliminate small food stamp benefits	0.5	1.0
Reduce child nutrition subsidy	3.0	6.6
Reduce \$20 exclusion in SSI	0.7	1.5
Sliding scale in SSI	0.5	1.4
Remove SSI ceiling on collection of overpayments	0.4	0.9
Reduce foster care administrative training costs*	0.8	1.6
End trade adjustment assistance program	4.2	9.2
Limit cost-of-living adjustments to federal retirees	4.5	19.4
Increase insurance rate on pension programs	0.8	1.4
Reduce benefits under federal employee's compensation act	0.2	0.4
Modify formula to set federal pensions	1.3	5.2
Restructure contributions to Thrift Savings Plan	<u>2.6</u>	<u>6.2</u>
<i>Totals</i>	<i>25.9</i>	<i>75.7</i>

Source: Congressional Budget Office. 2005. *Budget Options*.

* Congressional Budget Office. 2003. *Budget Options*.

I would not refer to the cuts in Income Security programs outlined by CBO as low-hanging fruit, but they are all reasonable reforms that would do minimum damage to those who would have additional costs imposed on them. Some of the cuts would be criticized because the costs are imposed on low-income individuals or families. However, many of the options could be tailored so that they impose low or even no costs on families below some income criterion, say, the federal poverty line (in which case the savings would be reduced). A few of the options, such as reducing foster care administrative and training costs, limiting the cost-of-living adjustment for federal retirees, and increasing the insurance rate on pension plans would impose no direct costs on poor families.

As this brief analysis of potential spending cuts in the Income Security function demonstrates, there are no painless spending reductions to be made in the federal budget. In policymaking, fool's gold is the search for policies that have all benefits and no costs. The task of budget balancing in which Congress should engage this year is almost always a zero-sum game. My personal view is that, although the pain cannot be avoided, Congress should do its best to distribute the pain across demographic groups and regions of the country. Moreover, as someone who has worked on programs for poor and low-income families for most of my adult life, I think Congress should minimize reductions in benefits for poor families, especially those that work.

But regardless of the specific criteria followed by the Budget Committee and the authorizing committees that must make final decisions, there is no escaping the heavy burden now being imposed on the Nation's future by the federal deficit. We are in the early stages of something very much like a crisis, except that it will last for many decades and will impose costs of uncertain magnitude and timing. The prudent course is to begin making the tough decisions this year that will put the budget on a path that leads to substantial deficit reduction and that will maintain the deficit at an acceptably low level. The minimum level of spending control that Congress should undertake as a first step on this path of fiscal responsibility is to equal the savings in the president's budget.

Many wise budget experts, including noted Republicans (Penner and Steuerle, 2003), believe the Nation is in the early stages of a budget crisis and that the longer we wait, the more pain Congress will inflict on the Nation when it makes the major decisions needed to reduce the deficit—as inevitably it must. We are now entering

crisis, but far too many people are delaying action until we—or more likely, our children—are hit by chaos.

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Chairman NUSSLE. Thank you, Dr. Haskins.

Next we will hear from Dr. Kent Smetters, who is a professor at the Wharton School at the University of Pennsylvania.

We welcome you to the committee, and we are pleased to receive your testimony.

STATEMENT OF KENT A. SMETTERS

Mr. SMETTERS. Thank you, Chairman. I am younger and I am even more cranky, as you will see. Thank you, as well as the rest of the committee, for the opportunity to talk, to speak on the challenges of meeting the Nation's future obligations in domestic entitlement programs. While these programs are a vital source of resources to many families, they also represent huge financial shortfalls over the next couple decades.

Figure 1 in my testimony, which is very similar to the pie chart that you had started out with, Mr. Chairman, which is based on the President's budget, shows that the Nation's three largest entitlement programs—Medicare, Social Security, and Medicaid—will grow rapidly over time and absorb all Federal revenue within the lifetime of a young person today. In fact, by 2075, virtually all Federal tax receipts will go to just these three programs.

In fact, this is an optimistic projection. The reason why, it assumes, consistent with the President's budget, there is no fixed in the Alternative Minimum Tax (AMT), which we all know is a problem. Consistent with the Medicare trustee's assumptions, it assumes that health-care costs grow much slower than they have his-

torically, and these shortfalls, more importantly, don't show the huge shortfalls after 2075, as the baby boomers retire from the Social Security and Medicare system.

There is an alternative way of looking at this, and that is to use present value analysis, to take the present value of all the future cash flow deficits for the Government as a whole, and I present this in Table 2 in the appendix of my testimony. I won't attempt to go into it in detail. But how this works is that the future cash flows are discounted, that is, reduced, by the Government's borrowing rate in order to demonstrate how much money that we needed today if hypothetically invested would place Government policy on a sustainable path.

In the year 2005, based on the President's current budget, the Government currently faces a present value imbalance of \$65 trillion, of which the prescription drug bill comprises \$17 trillion alone. To put it in this context, the total value of all the capital stock in the United States, including all buildings, home, land, is about \$45 trillion. So we owe a lot of money.

Now, how could we deal with this \$65 trillion? Well, hypothetically, one way is we could increase payroll taxes, the Medicare payroll tax, an uncapped earnings, immediately and forever by 22.4 percentage points, thereby more than doubling the current taxes on both employees and employers. Of course, this would send the economy into a tailspin; you wouldn't collect any revenue. This would be obviously a very difficult thing.

So obviously we have to control the growth rate of these payments over time, it is the only way to avoid an economic collapse. If you delayed action—suppose that we just waited 5 years before we did this, we started to do something—this \$65 trillion shortfall in present value increases to \$79 trillion, because it grows with interest just like other Government debt.

So the question is why do we have these huge shortfalls today. And the reason why is because the current budget framework used by the Federal Government encourages policymakers to over-commit. So the obvious example is look at the 5-year or the 10-year budget window. It really substantially underestimates the costs for entitlement program.

A good example of this is the Medicare prescription drug benefit. When it was first before Congress and the President signed it, it was scored at \$400 billion, and there was a controversy that erupted after it was signed and we realized the real cost was going to be \$535 billion. Today the cost is \$724 billion; and that is assuming considerable cost savings actually materialize. That difference between the \$535 billion and the \$724 billion comes simply from moving that 10-year window 2 years. So it just shows the problem with even a 10-year budget horizon.

Now, 75 years may seem like a good horizon too, that is what Social Security and Medicare trustees focus on. As the President's budget, however, points out, even 75-year actuarial calculations on a present-value basis emit large deficits that happen outside that 75-year window.

So a good story to really understand this is back in 1983 we supposedly balanced Social Security for 75 years, and at that point the 75th year was 2057. Now, 22 years later we now face another big

problem with Social Security on a 75-year basis. That 75-year window now is 2079; that is when the 75th year ends. Over 60 percent of the shortfalls that we have today in the 75-year calculation comes from simply moving that 75-year window from 2057 to 2079.

Suppose that we were to hypothetically balance Social Security for 75 years today, either—not my preferred approach—increase taxes or control the growth rate of benefits on a 75-year basis. Then in not 75 years, but just 20 years we will have the same problem that we see today. On the 75-year basis we will have the same 75-year shortfall. So 75 years sounds like a long time, but it really is not.

So a new Federal budget framework that includes the present value of all future Federal sources of revenue and outlays are needed, and not just over a limited time horizon. In my testimony I have a table that shows how that will work. I don't have time to go into that in all detail, but it is basically giving a present value of all sources of Government revenue and outlays.

These types of measures have recently been included just for the Social Security and Medicare programs by the Social Security and Medicare trustees' reports starting in 2003 and now 2004. A technical panel composed of leading economists and actuaries appointed by the independent and bipartisan Social Security Advisory Board has strongly endorsed inclusion of these measures. Yesterday, Chairman Greenspan also endorsed looking at this new approach and also criticized 75-year accounting.

By the way, pay-as-you-go rules, as good as they are, are not going to get around this problem. You can have a pay-as-you-go Social Security or a pay-as-you-go Medicare program that transfers enormous wealth between generations, yet still satisfies those pay-as-you-go rules. You really have to do honest present-value analysis.

Fortunately, the President's budget proposes new measures, to quote them, to "prevent the enactment of legislation that worsens the long-term unfunded obligations of the Federal entitlement programs." Now, the budget doesn't explicitly state what these new measures are, but they are very similar, from their analysis, it appears to be very similar to Table 2 that is your testimony. Senator Lieberman, in 2003, introduced the Honest Government Accounting Act that would help ensure that the Government fully accounts for its implicit and explicit liabilities on this present-value basis.

Although my invitation letter was mainly to focus on the large entitlement programs, let me also talk about a couple of things I was asked to talk about, and that is some of the contingent liabilities in the Federal Government, things like the Pension Benefit Guarantee Corporation, the Terrorism Risk and Insurance Act, FDIC, and so forth. There are arguments pro and con for those programs.

The main thing is that the real liabilities of those programs do not currently show up in the budget. For example, the PBGC right now has \$39 billion in assets but has about \$62 billion in liabilities, so it is going to face very large shortfalls. The President has introduced some ideas for trying to reduce that risk, but still that program faces large risks. The TRIA, the Terrorism Risk and Insur-

ance Act, exposes the Federal Government to up to \$100 billion in losses.

But the fair-market value of neither of those programs shows up in the budget, nor does it for FDIC. In fact, just the opposite. To the extent that the PBGC and FDIC collect some revenue, it actually shows up as a revenue gain to the budget. The actual fair value of those programs, the costs, do not show up.

Under the 1990 Credit Reform Act, which only applies to direct loans and guaranteed loans, there is some present-value analysis that shows up for those programs, like the student loan program, on the budget. But even that is limited, because it is only done on an expected value basis, it doesn't include the market value of risk. Presumably, students default on their loans when it is a bad economy, and there is market risk associated with that. The private sector would charge a lot more. So things like option pricing techniques and things like that which give you the real-market value should be used for these different programs, and they can be used in order to take away the appearance of a zero-cost program that makes it easier for policymakers to just hand out stuff.

I wasn't going to give you my hit list, but given I have 30 seconds, what would I do? If I were in charge, I would just point out that the prescription drug benefit that we just passed, a benefit that not many people are happy with, I should point out, a benefit that we just passed, the present-value cost of that is 1.7 times larger than the entire imbalance in the Social Security system. So we are talking about reforming Social Security today and we just passed something that is 1.7 times larger. It seems to me, if you want to reduce cost, now is the time to do it, before the benefits start to get paid.

Secondly, I think you have to control the growth rate of benefits in the Social Security program. We can argue about whether you increase the retirement age or whether you go to price index, and there are different economic effects of both, but the Social Security program places a \$10.4 trillion shortfall, much smaller than the Medicare program, but still a large shortfall.

Then, finally, regarding the Medicare program, I think health savings accounts are not the magic bullet, but they are certainly a step in the right direction in terms of helping to reform Medicare. But there are still going to be very tough charges required for Medicare.

Thank you for the time to talk.

[The prepared statement of Kent Smetters follows:]

PREPARED STATEMENT OF KENT A. SMETTERS, PH.D., THE WHARTON SCHOOL,
UNIVERSITY OF PENNSYLVANIA

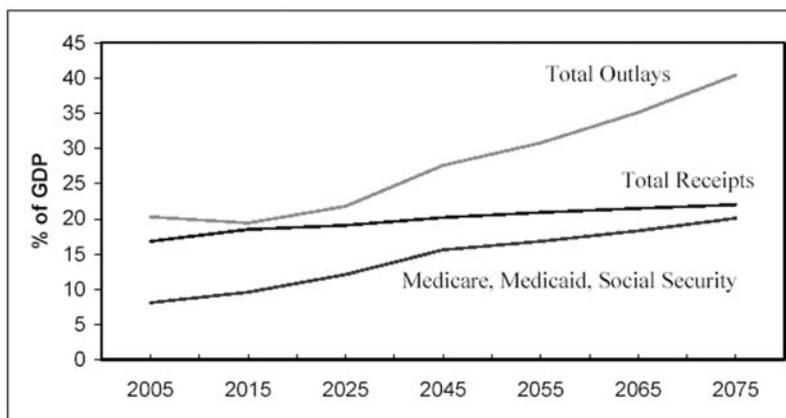
Thank you, Chairman Nussle, and members of the Committee for the opportunity to speak on the challenges in meeting the Nation's future obligations in its domestic entitlement programs. While these programs provide vital resources to many American households, these programs also face enormous financial shortfalls during the next several decades.

The purpose of this testimony is three fold. First, it documents the looming financial problems in the Nation's entitlement programs. Second, it demonstrates how the current Federal budget framework encourages the U.S. Congress to promise more in the form of future entitlement spending than can actually be afforded; conversely, the Federal budget makes it difficult to reduce these unfunded obligations. Third, this testimony shows how various budget frameworks and rules are ineffective at controlling entitlement spending. A new framework is then recommended.

ENTITLEMENT SPENDING DOMINATES THE BUDGET LANDSCAPE

As you can see from Figure 1 (also see Table 1 in Appendix) that is based on the President's 2006 Budget, the Nation's largest three entitlement programs—Medicare, Social Security, and Medicaid—will grow rapidly over time and absorb almost all projected Federal revenue within the lifetime of young people alive today. Medicare represents the largest problem at the Federal level, followed by Social Security and then Medicaid. However, unlike the other two, Medicaid is shared between the Federal Government and the states, and represents a growing problem at the state level.

FIGURE 1



Source: The Presidents 2006 Budget, Analytical Perspectives, p. 209; also see Table 1 in Appendix

Source: The President's 2006 Budget, Analytical Perspectives, p. 209; also see Table 1 in Appendix

Figure 1 is, in fact, fairly optimistic for several reasons. First, it assumes no fix of the Alternative Minimum Tax (AMT). The AMT will continue to tax an increasing number of households over time since the AMT's thresholds are not indexed to prices. Second, consistent with the Medicare Trustees' assumptions, these calculations assume that health-care costs in the future grow at a much slower rate than they have in the past. Third, these calculations don't show the shortfalls after 2075; these financial problems do not subside after the baby boomers generation passes on.

Table 2 in the Appendix presents an alternative perspective that shows the present value of all future cash flow deficits for the government as a whole as well as specifically for the Social Security and Medicare programs. Future cash flow deficits are discounted—that is, reduced—by the government's borrowing rate in order to demonstrate the amount of money needed today (if invested with interest) that would place government policy on a sustainable course. For 2005, the Federal Government currently faces a present value imbalance equal to about \$65 trillion, of which Medicare alone contributes \$63 trillion. The new prescription drug benefit alone costs about \$17 trillion.

This \$65 trillion imbalance is about \$20 trillion more than the value of all U.S. corporations, homes, and land in the United States. This imbalance could, in theory, be eliminated by increasing uncapped (HI) payroll taxes immediately and permanently by an additional 22.4 percentage points, thereby more than doubling the current employer and employee combined payroll tax of 15.4 percent. Of course, such a policy would first send the U.S. economy into a tailspin and collect little revenue. Instead, the growth of entitlement spending must be controlled in order to avoid economic collapse.

Delaying action will place an even larger burden on the economy. Table 2 shows that in 2010, or just 5 years from now, the Nation's present value imbalance will increase to over \$79 trillion if no action is taken. Such an imbalance could, in theory, be eliminated by increasing uncapped (HI) payroll taxes immediately and permanently by an additional 23.9 percentage points. In other words, the required payroll tax increase would increase by 1.5 percent points in just 5 years if no action

is taken. Clearly, quick action is needed to avoid a disintegration of the standard of living in the United States.

BUDGET HORIZONS

Why do we face such a large shortfalls today? The answer is very straightforward: The current Federal budget framework encourages policymakers to over-commit to future entitlement spending because the true long-term costs are not properly tracked in the budget.

The standard 5-year or 10-year projection window, in particular, substantially underestimates the costs of entitlement programs. For example, before Medicare Part D (prescription drugs) was passed by Congress toward the end of 2003, it was scored as having a 10-year cost of \$400 billion between 2004 and 2013. Controversy erupted when it was learned, after the bill was signed into law, that the cost would be closer to \$535 billion over this same time period. Today, the cost of Part D is estimated to equal \$724 billion over the 10-year period between 2006 and 2015, assuming that the cost savings assumed in the score actually materializes. Virtually all of the increase in cost of Medicare Part D, from \$535 billion to \$724 billion, comes from simply shifting the 10-year window to include 2014 and 2015.

In their annual reports, the Social Security and Medicare Trustees have traditionally focused on the “actuarial deficit” that includes the present value of the program’s shortfall over the subsequent 75 years. While 75 years might seem like a long projection window, it is also inadequate:

“Doing the calculations for a 75-year horizon understates the deficiencies, because the 75-year actuarial calculations omit the large deficits that continue to occur beyond the 75th year. The understatement is significant, even though values in the distant future are discounted by a large amount.” (President’s 2006 Budget, Analytical Perspectives, p. 217)

For example, the 1983 Social Security reforms were designed to eliminate Social Security’s shortfall over the subsequent 75 years, that is, until 2057. Today, only 22 years later, Social Security faces another multi-trillion dollar deficit calculated over 75 years, that is, until 2079. Over 60 percent of the Social Security shortfall we see today consists simply of moving the 75-year window to include the new cash flow deficits in the years between 2057 and 2079. The “moving-window problem” is even worse today. If a reform today balanced Social Security for just 75 years, then in just two decades, the new 75-year imbalance would equal the 75-year shortfall that we face today. In other words, attempting to balance Social Security for 75 years only provides about 20 years of actual progress.

In response to this problem, Social Security’s chief actuary, when scoring a proposed piece of legislation, will often determine whether it will allow the Social Security program to become “sustainably solvent.” In particular, he determines whether a proposed legislation eliminates the 75-year imbalance and produces time path of values for the Social Security trust fund that is increasing toward the end of the 75-year window. The critical assumption is that the trust fund will continue to increase in value after the 75th year. This joint criterion, though, has two problems. First, it cannot be used for programs like Medicare that are not self-financing. Second, the joint criterion is easy to “game” with a vast array of different policy reforms that produce additional revenue inside of the 75-year window but require larger outlays after the 75th year, e.g., increasing Social Security’s maximum taxable earnings. In other words, the assumption that the trust fund continues to increase after year 75 simply because it is increasing before year 75 is often incorrect.

REFORMING THE BUDGET FRAMEWORK

A new Federal budget framework, therefore, is needed that includes the present value of all future Federal sources of revenues and outlays, and not just over a limited time horizon. Table 2 provides a summary of a new Federal budget framework that accurately includes the present value of all of the Federal Government’s sources of revenues and outlays into the indefinite future, thereby removing any incentive to over-commit.¹ Table 2 is decomposed into the major spending categories, including Medicare, Social Security, and the rest of Government. Additional details could also be provided within this framework. For example, the present value of Medicaid’s shortfalls and defense spending could be listed under “Fiscal Imbalance in the Rest of Federal Government.”

For the major entitlement programs, Table 2 also decomposes the present value shortfalls in Medicare and Social Security into the present value of overspending on past and living generations (those age 15 and over as well as the deceased) and the present value of overspending on current and future generations (those age 14 and younger as well as the unborn). This generational decomposition is important be-

cause major entitlement programs are mostly financed on a pay-as-you-go basis where taxes on workers are distributed almost immediately as benefits to retirees. Currently, Medicare and Social Security face shortfalls because future tax revenue doesn't equal outlays in present value.

An entitlement program that is financed on a strict pay-as-you-go basis would not produce cash flow deficits and, hence, would not lead to present value imbalances. Nonetheless, it would transfer considerable wealth between generations. The reason is that retirees and near-retirees alive at the time that this policy is enacted are given resources for which they paid little or nothing during their working years. These resources are paid for by younger workers and future generations who must pay additional taxes instead of investing their money and earning investment income. The generational decomposition shown in Table 2 would indicate this transfer.²

These types of new measures have been recently included in their annual reports by the Social Security and Medicare Trustees for those specific programs. The Social Security Trustees began reporting Social Security's present value imbalance, along with its breakdown between generations, in its 2003 Report, and continued with its 2004 Report. A technical panel composed of leading economists and actuaries who were appointed by the independent, bipartisan Social Security Advisory Board "strongly endorsed" the inclusion of these newer measures.³ The Medicare Trustees began including these measures in their 2004 Report.

Present value projections of the type shown in Table 2 have sometimes been criticized as being "sensitive" to the underlying demographic and economic assumptions. While it is true that the dollar value of these imbalances are sensitive to different assumptions, the values of the imbalances relative to the present value of tax receipts or outlays is generally not that sensitive, since both the numerator and denominator move in similar directions.⁴ In other words, the size of the policy reform that is needed to balance entitlement programs is not very sensitive to the key underlying assumptions.

CURRENT REFORM PROPOSALS

The President's 2006 Budget proposes the reenactment of various pay-as-you-go rules on mandatory spending that were formerly in the Budget Enforcement Act, "except that it does not apply to tax legislation. It also does not permit mandatory spending increases to be offset by tax increases." (President's 2006 Budget, Analytical Perspectives, p. 238). It is unclear whether Congress will impose this set of asymmetric constraints on future budget authority. Without these asymmetric constraints, however, the pay-as-you-go requirement would still allow pay-as-you-go entitlement programs to transfer large sums of resources from workers and future generations toward retirees. The pay-as-you-go rule would also prevent positive reforms to entitlement programs that required an upfront investment but produced long-run reductions in unfunded obligations in present value.

The President's 2006 Budget also proposes "new measures to prevent enactment of legislation that worsens the long-term unfunded obligations of Federal entitlement programs." (President's 2006 Budget, Analytical Perspectives, p. 240). The Budget does not explicitly define these measures but its own analysis suggests something close to Table 2. However, the Budget's focus on just entitlement programs could allow for some "gaming" vis-a-vis general revenue transfers unless those transfers are explicitly excluded when calculating the entitlement program's present value imbalance, as in Table 2. Senator Joe Lieberman introduced the Honest Government Accounting Act of 2003 (S. 1915) into the 108th Congress (1st Session) that would help ensure that the government fully accounts for its explicit debt and implicit unfunded obligations. It deserves careful study.

FEDERAL PROGRAMS WITH CONTINGENT LIABILITIES

Although my invitation letter asked me to testify before the Committee on my views "on our challenges in meeting the obligations of domestic entitlement programs," let me close with a few words about the budgetary treatment of several Federal programs with contingent liabilities that represent a non-trivial risk to the budget, including the Pension Benefit Guarantee Corporation (PBGC) and the Terrorism and Risk Insurance Act of 2002 (TRIA). Currently, the PBGC has about \$39 billion in assets and so it can meet its obligations for several years. But the PBGC also has about \$62 billion in liabilities and so it will face large funding shortfalls in the future.⁵ The Administration has proposed a set of new reforms that will reduce the PBGC's likely shortfall, but risks still remain. TRIA exposes the Federal Government to \$100 billion in possible losses after a terrorist act. The fair market values of neither of these contingent liabilities appear in the President's budget.⁶

Instead, these programs, along with other Federal programs such as the FDIC, are treated on a cash flow basis. In fact, quite perversely, premium income collected by the PBGC and FDIC often appears to provide revenue.

Under The 1990 Credit Reform Act, the cost of direct loans and loan guarantees must be recorded in the Budget. This cost is calculated as the present value of all cash flows over the life of the loan, discounted using the interest rates on Treasury securities of the same maturity. This Act, for example, covers the Federal Government's student loan program but does not cover the contingent liabilities noted above. While Credit Reform was a step in the right direction, it still falls short because the true economic costs of the loans and loan guarantees, as reflected in the values that the market would place on the underlying risks, are not incorporated.

Options pricing and other pricing techniques should be used to determine the market value for the contingent liabilities in the PBGC, TRIA, and FDIC program as well as for the programs covered under Credit Reform. A "zero" cost (or, in some cases, a negative cost)—which is currently assumed in the Budget for many of these programs—currently encourages policymakers to create seemingly "free" contingent liabilities.⁷ Requiring that the market values of these programs be included in the budget would remove this bias.

Mr. Chairman, thank you again for the opportunity to share my views with you and the Committee.

TABLE 1.—LONG-RUN FEDERAL BUDGET RANGE ESTIMATES
(As a percent of GDP)

Fiscal years	2005	2015	2025	2045	2055	2065	2075
Receipts	16.8	18.5	19.1	20.2	20.9	21.5	22.0
Outlays	20.3	19.4	21.8	27.6	30.8	35.1	40.4
Discretionary	7.9	5.9	5.9	5.9	5.9	5.9	5.9
Mandatory	10.9	11.6	13.8	16.9	18.0	19.5	21.2
Social Security	4.2	4.4	5.4	6.0	6.1	6.2	6.4
Medicare	2.4	3.3	4.6	7.0	7.9	9.1	10.4
Medicaid	1.5	1.9	2.1	2.6	2.8	3.0	3.3
Other	2.8	2.0	1.7	1.3	1.2	1.1	1.0
Net Interest	1.5	1.9	2.0	4.8	6.9	9.7	13.3
Surplus or Deficit (–)	–3.5	–0.9	–2.7	–7.4	–10.0	–13.6	–18.4

Source: The Presidents 2006 Budget, Analytical Perspectives, p. 209

TABLE 2.—FISCAL AND GENERATIONAL IMBALANCES AT END OF THE YEAR SHOWN
LONG-RUN FEDERAL BUDGET RANGE ESTIMATES
(Billions of constant 2004 dollars)*

Fiscal years	2004	2005	2006	2007	2008	2009	2010
Total Fiscal Imbalance—							
U.S. Federal Government	63,220	65,861	68,564	71,245	73,893	76,570	79,337
Social Security	8,006	8,352	8,710	9,067	9,423	9,784	10,158
Medicare	60,822	63,315	65,805	68,249	70,641	73,044	75,518
Rest of Federal Govern- ment	–5,608	–5,805	–5,951	–6,071	–6,171	–6,258	–6,339
Fiscal Imbalance in Social Security	8,006	8,352	8,710	9,067	9,423	9,784	10,158
Future Benefits less Taxes, those age 15 and over (and de- ceased)	9,549	9,899	10,256	10,610	10,958	11,311	11,676
Future Net Benefits of Living Genera- tions	11,182	11,686	12,205	12,729	13,255	13,787	14,338
Trust Fund	–1,634	–1,787	–1,949	–2,120	–2,297	–2,476	–2,662

TABLE 2.—FISCAL AND GENERATIONAL IMBALANCES AT END OF THE YEAR SHOWN LONG-RUN
FEDERAL BUDGET RANGE ESTIMATES—Continued
(Billions of constant 2004 dollars)*

Fiscal years	2004	2005	2006	2007	2008	2009	2010
Future Benefits less Taxes, those age 14 and below (and un- born)	-1,543	-1,547	-1,547	-1,543	-1,535	-1,527	-1,518
Fiscal Imbalance in Medi- care	60,822	63,315	65,805	68,249	70,641	73,044	75,518
Future Benefits less Taxes and Premiums, age 15+ (+ de- ceased)	24,094	25,430	26,777	28,130	29,483	30,860	32,287
Future Net Benefits of Living Genera- tions	24,375	25,725	27,097	28,465	29,834	31,226	32,668
Trust Fund	-282	-295	-320	-335	-350	-366	-381
Future Benefits less Taxes and Premiums, age 14- (+ unborn) ..	36,728	37,885	39,028	40,118	41,158	42,184	43,231
Fiscal Imbalance in the Rest of Federal Govern- ment	-5,608	-5,805	-5,951	-6,071	-6,171	-6,258	-6,339
Future Outlays	81,323	83,402	85,537	87,576	89,492	91,375	93,304
Future Revenues	-93,266	-96,013	-98,675	-101,168	-103,500	-105,770	-108,055
Living Generations ...	-34,939	-36,156	-37,325	-38,417	-39,431	-40,405	-41,364
Future Generations ...	-58,327	-59,857	-61,350	-62,751	-64,069	-65,365	-66,691
Excess Future Outlays Over Revenues	-11,943	-12,611	-13,138	-13,591	-14,008	-14,395	-14,751
Liabilities to Social Se- curity and Medicare Trust Funds	1,915	2,082	2,269	2,454	2,648	2,842	3,043
Debt Held by the Public	4,421	4,724	4,918	5,066	5,190	5,294	5,368
MEMO Items:							
Present value of GDP	762,921	772,260	790,733	812,819	834,656	855,240	874,525
Present Value of un- capped Payroll	291,063	294,436	301,354	309,630	317,783	325,432	332,577

*Positive numbers add to the imbalance and negative numbers reduce it.

Source: Gokhale and Smetters (2005), "Measuring Social Security's Financial Problems" NBER Working Paper No. 11060, 2005. Based on FY2005 budget information obtained from the Office of Management and Budget and calculated under OMB economic assumptions.

ENDNOTES

1. See Jagadeesh Gokhale and Kent Smetters (2003), *Generational and Fiscal Imbalances*, AEI, 2003, updated in Gokhale and Smetters (2005), "Measuring Social Security's Financial Problems," NBER Working Paper #11060. These calculations are based on the President's 2005 FY Budget assumptions and are currently being updating for the 2006 FY.

2. Similarly, a tax cut in the short term that is financed by an equal present value tax increase in the long term would also change the generational decomposition.

3. 2003 Technical Panel on Assumptions and Methods, Social Security Advisory Board [available at: <http://www.ssab.gov/NEW/documents/2003TechnicalPanelRept.pdf>, check on 2/13/05]

4. See Gokhale and Smetters (2003), op cited. One exception is the assumed growth rate in health-care spending relative to GDP. Following the Medicare Trustees, we used very optimistic projections over the first 75 years (1 percent over GDP); after year 75, we made the even more optimistic assumption of identical growth with GDP. Despite these optimistic assumptions, Medicare still faces a very large present value imbalance.

5. President's 2006 Budget, Analytical Perspectives, p. 104.

6. Currently, the CBO includes an estimate for TRIA in its baseline but OMB does not.

7. See, for example, CBO, "Estimating the Value of Subsidies for Federal Loans and Loan Guarantees," August 2004.

Chairman NUSSLE. Thank you, Dr. Smetters.

Mr. COOPER. Mr. Chairman? I have a parliamentary inquiry. Where are the administration witnesses?

Chairman NUSSLE. The gentleman is not recognized for that purpose.

The last witness for the panel today is the very distinguished Dr. Judy Feder, who has testified before our committee before. She is the Dean of Policy Studies at Georgetown University.

We are very pleased to have you back before the committee, and we are pleased to receive your testimony. Thank you.

STATEMENT OF JUDITH FEDER, PH.D., DEAN OF POLICY STUDIES, GEORGETOWN UNIVERSITY

Ms. FEDER. Thank you, Mr. Chairman.

Mr. Chairman, Mr. Spratt, members of the committee, I am delighted to be with you today, and will try not to be cranky. I am going to round out our discussion by bringing us back to the health-care issues that Dr. Wilensky so ably handled, because that is the area of my expertise.

Medicare and Medicaid expenditures loom large in the conversation on the budget because of the resources they require, both now and in the future. But this committee's appropriate focus on fiscal concerns should not obscure two truths about these programs.

First, they make health care affordable and long-term care available for millions of older, disabled, and low-income Americans who would otherwise lack access to care when they need it. Second, the fiscal challenges facing these programs reflect factors beyond their control: growth in the populations they serve—elderly, disabled, and especially, for Medicaid, low-and modest-income families without health insurance—and growth in the Nation's health-care costs.

Therefore, cuts in Federal funds or structural changes in Federal financing, like arbitrary caps or fixed appropriations or block grants, cannot be justified as promoting efficiency or personal responsibility when it comes to health-care financing. On the contrary, they would cut benefits for or shift cost to the Nation's most vulnerable citizens. Let me talk a little bit about Medicare and Medicaid in turn.

I want to start with a very brief reminder of how much Medicare accomplishes.

In July 2005 we will celebrate the 40th anniversary of Medicare's enactment. The program's explicit goal in 1965 was to assure access to mainstream medical care for the Nation's senior citizens, a promise later extended to some people with disabilities. Medicare has been enormously successful in achieving these goals, and is credited both with extending and enhancing life for older Americans and, equally important, alleviating financial burdens on their families.

These achievements have not been inexpensive. Increases in program costs have actually been a problem for this program, or a political issue, from the program's inception. But again, it is important to note, as Dr. Wilensky said, Medicare's record in containing health-care costs has been at least as strong as, if not stronger

than, the record for private health insurance. Both Medicare and private insurance purchase health care in the same market, and both struggle to balance the need for containing costs with people's need for ever more costly care. Medicare has actually been a leader in promoting that balance, tough as it is.

Rising Medicare costs have not been a function of benefits that are too generous in Medicare. Medicare benefits have been, and even with the newly enacted prescription drug benefit will be, less comprehensive than the benefits in employer-sponsored health insurance provided to the working age population. As a result, beneficiaries face substantial out-of-pocket cost. The typical senior today is estimated to spend more than 20 percent of income on health care, both to receive and supplement Medicare's benefits.

Does Medicare face a fiscal challenge? Absolutely. From its inception, Medicare has been financed through a combination of payroll taxes on the working age population, premiums from beneficiaries, and we must not forget, from the beginning, general revenues. Part A resembles Social Security with a payroll tax-generated trust fund that is dedicated to financing its benefits. And as others have described, the aging of the population will pose a problem for Medicare, as it does for Social Security: it will lead to shortfalls in this trust fund as a larger number of older persons rely on financing from a smaller number of working age taxpayers.

But Part A is the only part of Medicare to which the concept of shortfall applies. It makes no more sense to talk about shortfalls in general revenue-funded portions of Medicare than it does to talk about shortfalls in defense spending or other kinds of spending supported by general revenues. What is important is whether we provide the revenues to meet our needs. They are demands, but not shortfalls.

Now, what makes Medicare's financing challenge different from Social Security's is the growth in its per capita costs. Both programs face an increasing number of seniors; Medicare also faces an increase in health-care cost per senior. Health-care cost growth, however, is not a problem unique to Medicare; it is a problem that faces the entire health-care system. Therefore, any measure that reduces Federal spending on Medicare without slowing growth in the Nation's health-care costs will undermine, not strengthen, the health insurance protection and security that Medicare provides.

Arbitrary caps on Medicare funding would not eliminate the costs of health care, nor would shifts from guaranteed benefits to premium contributions that might be fixed in advance. It would simply shift these costs from the program and from the taxpayers to the individuals who need health care and their families.

Now let me turn to challenges and choices in Medicaid, which will also celebrate the 40th anniversary of enactment in July 2005, and has become the Nation's largest public health insurance program, serving 52 million children, low-income working adults, primarily parents, people with disabilities, and elderly people.

Medicaid's protections, like Medicare's, come at considerable expense not only to Federal, but also to State governments. But again, cost growth is not a problem, or the cost of the services they buy is not a problem that is unique to the Medicaid program; it is, again, a function of the entire health-care system. Nor can it be at-

tributed to Medicaid inefficiency. Rather than reflecting excessive payments to providers, Medicaid is criticized far more frequently for paying too little than too much. Medicaid expenditure growth often reflects increases in the number and kinds of people it serves.

It is clear from an Urban Institute analysis of Medicaid spending between 2000 and 2003, that recent Medicaid cost increases have been largely a function of enrollment increases. In this period, Medicaid spending increased by about a third, not because of expansions of eligibility or dramatic increases in payment, but because of increased demand for Medicaid services largely as a result of the recession. Without expansion of the Medicaid safety net in that period, the Nation would likely have experienced an increase in the number of children without health insurance and an even larger increase than otherwise occurred in uninsured adults.

And for people of all ages who need long-term care, Medicaid is the Nation's safety net. Long-term care is not only expensive—hence, the high per capita costs in Medicaid for older and disabled beneficiaries—but, sadly, its provision is inadequate, as an estimated one in five of the Nation's citizens who need long-term care report getting inadequate service and suffer serious consequences as a result.

It is critical to remember that it is the Medicaid entitlement that makes Medicaid's safety net role possible. The entitlement means that the program serves any individual who qualifies for eligibility. To support these services, the Federal Government provides States open-ended matching funds. The more people who are eligible for service and the more service costs, the more health-care costs, the more States receive in Federal matching funds; the fewer people eligible, the less States receive. Open-ended matching funds enable States to respond to increased need that comes with recession or public-health emergencies, or to support newly available and often expensive treatments like pharmaceuticals, for example, expensive AIDS medications.

Concerns about the costs of Medicaid have historically, and today, led to calls for so-called Medicaid reform. Too often, these proposals would limit the entitlement by imposing arbitrary caps on Federal Medicaid payments or substituting fixed allotments or block grants for open-ended matching financing. Without offering a specific proposal, the President's budget refers to a "modernized Medicaid system" that will give States greater flexibility to serve more people for the same amount of money by changing delivery systems, targeting populations, and providing what is referred to as "appropriate benefit packages."

However, no creativity in delivery can offset likely increase in numbers of people in need and increases in the costs of services over which Medicaid has little, if any, control. With capped funds, States' ability to flexibly expand coverage, provide coverage to currently ineligible, uninsured populations, or to continue to expand home-and community-based long-term care services would be hampered, not enhanced, given the need to cover the inevitably rising costs of existing obligations.

Indeed, with capped Federal funds, so-called flexibility is nothing more than a euphemism for cuts in protections that Federal rules currently do not allow: creating waiting lists for enrollment, favor-

ing some parts of States over others, charging even the poorest beneficiaries out-of-pocket payments for service, and limiting access to any and all services based on fiscal concerns.

As it is sometimes proposed that such limits apply only to what are referred to in Medicaid as optional populations, populations that States are not required to cover, but may choose to cover, it is important to remember that in this category are elderly and disabled people with incomes below the Federal poverty level, but above three-fourths of the Federal poverty level; the majority of elderly Medicaid nursing home residents; pregnant women with incomes above 133 percent of the Federal poverty level; near-poor children and very poor parents. To States, under such a proposal, coverage would become an option, but to the affected population, care would remain a necessity they could not afford.

President Bush has characterized Medicare as, and I quote again, “the binding commitment of a caring Nation.” The language, in my view, should also apply to Medicaid. Yet the administration has offered no proposals to secure these essential commitments. Increasing health-care costs that affect Medicare and Medicaid along with the rest of the health-care system cannot be addressed through caps on malpractice awards or the creation of health savings accounts. Malpractice costs are estimated to count for a very small portion of health-care costs; the caps hurt damaged patients and provide virtually no relief from health-insurance costs, less than half a percent.

Individuals cannot own responsibility for their own health care by managing limited accounts when the bulk of health-care costs are catastrophic and decisions are driven by health-care providers. Meager tax credits for the purchase of private health insurance policies can assure few, if any, of the 45 million uninsured Americans affordable and adequate insurance protection, and cuts in Federal funds for Medicaid do not eliminate the cost of care to vulnerable populations, they shift the burden of bearing those costs to States and to the population at risk.

In 2005, after 40 years of experience with Medicare and Medicaid, we should recognize that investment of our collective resources to protect those among us who become ill or need long-term care enhances the quality of our lives and our strength as a Nation. This is the time to renew and extend their commitment, not to explore ways to abandon it.

Thank you, Mr. Chairman.

[The prepared statement of Judith Feder follows:]

PREPARED STATEMENT OF JUDITH FEDER, PH.D., PROFESSOR AND DEAN,
GEORGETOWN PUBLIC POLICY INSTITUTE, GEORGETOWN UNIVERSITY

Mr. Chairman, Congressman Spratt, and members of the committee, thank you for inviting me to discuss entitlement programs and the Federal budget. My remarks will focus on the health entitlements—most prominently, Medicare and Medicaid, which are my particular area of expertise.

The Medicare and Medicaid programs loom large in discussions of the budget, both because of the resources they currently require and the greater resource demands they will make in the future. However, this committee’s focus on fiscal concerns should not obscure two “truths” about these programs.

First, they make health care affordable and long-term care available for millions of older, disabled, and low income Americans who would otherwise lack access to care when they need it. Second, the fiscal challenges facing these programs reflect factors beyond their control—growth in the populations they serve (elderly, disabled

and, for Medicaid, low and modest income families without health insurance) and in the Nation's health-care costs.

Cuts in Federal funds or structural changes in the structure of Federal financing (like arbitrary caps or fixed appropriations-block grants) cannot be justified as promoting efficiency or personal responsibility in the Medicare or Medicaid programs. On the contrary, they would represent an abdication of the Nation's responsibility to care for its most vulnerable citizens.

CHALLENGES AND CHOICES IN MEDICARE

In July, 2005, we will celebrate the 40th anniversary of Medicare's enactment. This program's explicit goal was to assure access to mainstream medical care for the Nation's senior citizens—a promise later extended to some people with disabilities. Medicare has been enormously successful in achieving those goals, and is credited both with extending and enhancing life for older Americans and alleviating financial burdens on their families.

These achievements have not been inexpensive. Increases in program costs have been a significant concern from the program's inception. However, Medicare's record in containing health-care costs has been as strong if not stronger than the record of private health insurance. Medicare and private health insurers purchase health care in the same health-care system and face the same pressure to balance access to care against controlling the cost of care. Medicare has been a leader in promoting that balance, ahead of the private sector in adopting provider payment methods that promote value for the dollar in the purchase of care.

Although beneficiaries have benefited significantly from the access to health care that Medicare provides, they too have faced significant costs. Medicare benefits have been and, even with the newly enacted prescription drug benefit, will remain less comprehensive than employer-sponsored insurance benefits. As a result, beneficiaries incur substantial out-of-pocket spending and in traditional Medicare have no "stop-loss" or ceiling to protect them against catastrophic costs. The typical senior is estimated to spend more than 20 percent of income on health care, to receive and supplement Medicare's benefits.

From its inception, Medicare has been financed through a combination of payroll taxes on the working aged population, premiums from beneficiaries, and general revenues. Part A resembles Social Security, with a payroll-tax-generated trust fund that is dedicated to financing its benefits. As is true with Social Security, the aging of the population will lead to shortfalls in this trust fund, as a larger number of older persons rely for financing on a smaller number of working-aged taxpayers. (Part A is the only part of Medicare to which the concept of shortfall applies; it makes no more sense to talk about shortfalls for general-revenue-funded portions of Medicare than it does to talk about shortfalls in defense spending.)

What makes Medicare's financing challenge different from Social Security's is the growth in its per capita costs, alongside growth in the number of beneficiaries. Health-care cost growth is not a problem unique to Medicare, however. It is a problem facing the Nation's entire health-care system.

Securing the adequacy of Medicare financing (the Trustees estimate exhaustion of the trust fund in 2019) is an important policy objective. But any measure that reduces Federal spending on Medicare without slowing growth in the Nation's health-care costs will undermine, not strengthen, the security that Medicare provides. Arbitrary caps on Medicare funding would not eliminate the costs of health care; it would simply shift them from the program to the individuals who need health care and their families. Moving from Medicare's guaranteed benefits to "premium support" or contributions to purchase private health insurance would similarly shift risk. Claims that more competition across health plans can slow cost growth have simply not been supported by the evidence. The strongest competition among health plans seems to be to enroll people perceived to have fewer and less costly health needs and to avoid (or disenroll) people with greater, more costly needs. In the absence of mechanisms to overcome this "selection" problem, government pays private insurers more to serve beneficiaries than it would under the traditional system, and individuals who need the most care receive insufficient support.

This problem would be exacerbated if government were to limit its contributions to premiums, regardless of the growth in health-care costs. In these circumstances, not only would those needing the most care face the highest risk, but all beneficiaries would face the burden of even greater out-of-pocket spending. In other words, reliance on private plans does not contain health-care costs; it shifts the risk of bearing them from Medicare to individuals and their families.

Medicare has been enormously successful in assuring access to mainstream medical care for its beneficiaries. Our goal should be to secure the protection it provides, not to shift risks back to the very individuals it aims to protect.

CHALLENGES AND CHOICES IN MEDICAID

July 2005 will also mark the 40 anniversary of enactment of the federal-state Medicaid program. As a safety net for low income Americans who otherwise lack health insurance and the Nation's primary safety net for long-term care, Medicaid has become the Nation's largest public health insurance program. In 2003, Medicaid provided coverage for 25 million children, 14 million adults (primarily low-income working parents), 5 million seniors and 8 million people without disabilities. In the absence of Medicaid, the vast majority of its beneficiaries would be uninsured—and lack the access to medical and long-term care that Medicaid provides.

Medicaid's protections, like Medicare's, come at considerable expense to Federal and state governments. But cost growth cannot be attributed to Medicaid inefficiency. Rather than reflecting excessive payments to providers (Medicaid is criticized far more often for paying too little than too much), Medicaid expenditure growth typically reflects increases in the number and kinds of people it serves.

Urban Institute analysis of Medicaid spending between 2000 and 2003 illustrates the critical role of the Medicaid health insurance safety net. In this period of recession and rising health-care costs, Medicaid spending increased by about a third—not because of expansions of eligibility or dramatic increases in payment. Rather, the increased spending reflected substantial increases in enrollment, as people's incomes declined and employer-sponsored health insurance disappeared. Without expansion of the Medicaid safety net, the Nation would have experienced an increase in the number of children without insurance and an even larger increase than otherwise occurred in uninsured adults.

Although three quarters of Medicaid enrollees are children or their parents, about 70 percent of Medicaid's expenditures are for low income elderly people. Low income people with disabilities do not qualify for private health insurance. And few Americans have insurance for long-term care—the costs for which exceed the incomes of most American families. Responsible for half the revenues received by nursing homes and providing full or partial support for more than half of all nursing home patients, Medicaid is the Nation's only safety net for long-term care.

It is the Medicaid entitlement that makes Medicaid's safety net role possible. The entitlement means that the program serves any individual who qualifies for eligibility. To support these services, the Federal Government provides states open-ended matching funds: the more people who are eligible for service and the more services costs, the more states receive in Federal matching funds; the fewer people eligible, the less states receive. Open-ended matching funds enable states to respond to increased need that comes with recession or public health emergencies or to support newly available treatments, like ever-improving AIDS medications. Medicaid covers an estimated 55 percent of persons living with AIDS and 90 percent of all children living with AIDS. When the number of people affected increases or the costs of treatment rise, Federal funds automatically increase to share the burden.

Concerns about the costs of Medicaid have historically generated policy proposals to limit this entitlement by imposing arbitrary caps on Federal Medicaid payments or substituting fixed allotments or "block grants" for open-ended matching financing. Without offering a specific proposal, the President's budget, refers to a "modernized Medicaid system" that will give state greater flexibility to serve more people for the same amount of money—by changing delivery systems, targeting populations and providing "appropriate benefit packages". However, no creativity in delivery can offset likely increases in numbers of people in need and increases in the cost of services over which Medicaid has little if any control. With capped funds, states' ability to "flexibly" expand coverage—provide coverage to currently ineligible uninsured populations or continue to expand home and community-based long-term care services—will be hampered, not enhanced, given the need to cover the inevitably rising cost of existing obligations. Either that, or expansions will come at the expense of people already in need. Jeanne Lambrew's recent Milbank Quarterly analysis makes abundantly clear that replacing open-ended Federal matching with fixed growth rates or allotments in Federal spending will inevitably fail to provide funds adequate to meet changes in need or changes in cost, leaving people without care.

Indeed, with capped Federal funds, "flexibility" is nothing more than a euphemism for cuts in protection that Federal rules currently do not allow: creating waiting lists for enrollment, favoring some parts of states over others, charging even the poorest beneficiaries out-of-pocket payments for service, and limiting access to any and all services based on fiscal concerns. Previous proposals have limited new "flexi-

bility” to Medicaid’s so-called “optional” populations, keeping Federal requirements in place for “mandatory” population groups—primarily poor children, and elderly and disabled people eligible for Supplemental Security Income (SSI) (that is, with incomes below 74 percent of the Federal poverty level). Without these protections, coverage would likely decline for “optional” populations, which that include elderly and disabled people with incomes below poverty but above 74 percent of the Federal poverty level, the majority of elderly Medicaid nursing home residents, pregnant women with incomes above 133 percent of the Federal poverty level, near poor children and very poor parents. To states, coverage would become an option; to the affected population, care would remain a necessity.

POLICY PRESCRIPTIONS

President Bush has characterized Medicare as “the binding commitment of a caring Nation.” The same language should apply to Medicaid. Yet the administration has offered no proposals to secure these essential commitments.

Increasing health costs that affect Medicare and Medicaid along with the rest of the health-care system cannot be addressed through caps on malpractice awards or the creation of “health savings accounts”. Malpractice costs are estimated to account for about 2 percent of all health-care costs; caps hurt damaged patients and provide virtually no relief from health insurance costs (less than half a percent). Individuals cannot “own” responsibility for their own health care by managing limited accounts, when the bulk of health-care costs are catastrophic and decisions driven by health-care providers. Meager tax credits for the purchase of private health insurance policies can assure few if any of the 45 million uninsured Americans affordable and adequate insurance protection. And cuts in Federal funds for Medicaid do not eliminate the costs of care to vulnerable populations; they shift the burden of bearing these costs to states and the population at risk.

In 2005, after forty years of experience with Medicare and Medicaid, we should recognize that investment of our collective resources to protect those among us who become ill or need long-term care enhances the quality of our lives and our strength as a Nation. This is the time to renew and extend our commitment, not explore ways to abandon it.

Mr. PORTMAN [assuming Chair]. I thank all the witnesses for their testimony. We have a lot of questions for you all, and I will try to be as brief as I can, starting with saying that the information you are giving us today as experts is extremely helpful as we look at the big picture, which is not just the domestic discretionary spending, which is a smaller and smaller part of our budget, but also on the mandatory side.

I would like to start, if I could, just laying out the problem. We know from the projections we have that mandatory spending is projected to rise at about 5.6 percent just over the next 5 years. And as Dr. Wilensky has reminded us, there are some longer-term growth rates that are even higher. I think, if you look at the President’s budget fully adopted, mandatory spending would be about 5.5 percent; and that is the chart you see here. So just to put this in a little perspective, given Dr. Feder’s comments at the end, I think it is important to note that we are not talking about major changes.

With regard to Medicaid in particular—could we put a chart up on Medicaid?

The President is talking about 60 billion over 10 years in changes. The growth rates under Medicare are projected over 10 years, 7.6 percent. We are talking about substantial growth even under the Bush reforms, to 7.3 percent. In fact, if you look at the Bush budget that we got, there are actually, on the health-care side—and Dr. Feder makes a good point that this is related to general health care, not just to Medicaid—there is about \$142 billion in new spending on health-care initiatives.

Subtracting from that the \$60 billion in Medicaid that is reflected here, you end up with actually net new spending of about \$82 billion, as compared to current law, including the entitlement programs. And that new \$142 billion is not in Medicaid, but it is health care, including expanding some of Medicaid, about \$16.5 billion more, the Cover the Kids outreach campaign and so on.

So just to put that in some perspective, at the same time we hear from Dr. Wilensky, which I think is pretty well established now, that Medicaid and Medicare alone could be 20 percent of our gross domestic product by the year roughly 2040, which is what our entire budget is now. So all of our spending on the domestic side, all of our military spending, all of our entitlement spending now is about 20 percent, including interest on the debt; and Medicare and Medicaid alone, by 2040, would consume all of that. And this is why we need your input.

And, Dr. Feder, again, I agree with you that the Medicaid increases, which, as we have seen here, is over 7 percent, and therefore difficult to sustain, in my view, is reflective of health-care cost increases generally. But when you go through the list you think liability reform isn't going to help, HSAs and more competition and transparency is not going to help, tax credits aren't going to help; we just need to invest more. I don't know how we can invest more if it, over the next 35 years, is going to consume, with Medicare, all of our current budget.

I guess I would just ask Dr. Wilensky and Dr. Feder to comment on that, and the other two witnesses feel free to as well. What would the impact be on our economy if we don't begin to figure out a way not to reduce spending, but to restrain and reform?

And when the President talks about more flexibility, and I think about skilled nursing facilities back home and the degree to which, increasingly, Medicaid is being relied upon, it is a very inefficient way to offer health care, and for families to have to go through this process of disgoring their assets and so on, and nursing facilities not getting full reimbursement, but relying more and more Medicaid, certainly there should be some opportunities for some improvements.

And maybe, Dr. Feder, you can answer first, then Dr. Wilensky, and then I will turn to my colleague, Dr. Spratt, to address the witnesses.

Dr. Feder.

Dr. FEDER. Thank you, Mr. Chairman. Let me respond to your bigger points first.

When we look at the projected growth in Federal funding for Medicaid, as for health care in general, one has to look at it always relative to the cost of care. So even if it is growing, we need to know how it is growing relative to the demand of the population, a demand of Medicaid and the cost of services. Any cut in Medicaid, facing a growing demand, is a problem to that program's capacity to provide service, as we can hear from the States. And I don't have to tell you what they are saying about the kinds of pressures they are facing to cut services.

The second point, you are absolutely right about—and I am glad we agree—on the importance of health-care costs. And I would support the suggestions that Dr. Wilensky made with respect to smart-

er purchasing; not just for Medicare, I think for the entire health-care system. There is no excuse for not getting value for the dollar in the entire health-care system. My concern is focusing only on public programs, rather than the system as a whole; and I think we need to do that.

A third issue, how can we possibly sustain this. I think it is a mistake—and a number of economists have made this argument—to look at our resources as a fixed pie. We are a growing economy. It is nicer when we grow faster and when low-income people are benefitting more, but we are a growing economy, and when we look out into the future, our capacity to support a growing elderly population grows, and we mustn't forget that.

Finally, in that respect, it is important to remember that what we take in from those resources in taxes is not a fixed pie. I believe that we are at about the lowest tax rate, at this time in this Nation, that we have experienced in a long time. Revealing what might be a conflict of interest, I am proud to say I am at the lead of the baby boom generation. And I believe, though I hope my earnings are still going up, that I am at the peak of my earning years. So my plea is: tax me now. I can give now. It would reduce burdens on future generations, and the resources would be there to help my generation when we are older.

Finally, I said it before, but you asked a very specific question or mentioned something specific about long-term care. If I could rephrase or state somewhat differently what you said, there is a tremendous concern about a long-term care system that is focused so heavily on nursing home care, rather than on care at home and in the community, where most people would rather receive it. We have made strides in Medicaid in recent years in redressing that balance and community-based care has expanded substantially. Indeed, some of those expansions are threatened by fiscal constraints at the moment. But that is a direction in which I believe that we, as a Nation, would like to go.

I would urge you, however, based on a great deal of evidence, not to be optimistic that that will save money, in part because we have a larger number of people in need than are now receiving care in nursing homes. In fact, the bulk of people who need long-term care now receive it in their home, however inadequately. So I believe we should serve a larger population at home, but I am skeptical that it will actually save money.

Mr. PORTMAN. Thank you.

Dr. Wilensky.

Ms. WILENSKY. The area that is the most promising in reducing growth rates in health-care spending is to learn how to spend smarter. Think about Medicare for a moment. We have spent the last 20 years—and I was Medicare director during this period, so I am including myself in this statement—reimbursing exactly wrong in terms of trying to spend smarter.

Why do I say that? Well, you get exactly the same payment if you are a physician or if you are a hospital and you are best in class or you are just barely above the indictable level. That is fundamentally a bad idea. Trying to change reimbursement so that institutions and individuals who do it right, do it right the first time,

get more money and those who don't do it very well get less is very different from the current system.

This is not very different from what goes on in the private sector. There are small demonstrations, under what is called pay-for-performance that are being started by Medicare. There is a lot of activity going on in the private sector right now where corporations are attempting to start changing how providers are paid. Information systems are another issue, although there are questions about whether Medicare should actually pay physicians or hospitals to adopt new information systems or should change the incentives associated with reimbursement.

I would caution before we go down the road of direct reimbursement. First, it would move us back to a cost-based reimbursement system, which we have now spent 20 years trying to move away from. Secondly, we don't need to pay hospitals to set up cath labs and open heart surgery centers; the reimbursement system drives hospitals to set them up whenever and wherever they can. Some people might say maybe too often.

What we need to think about is how can we change the reimbursement system in the public sector, and in the private sector as well, so that you drive the kinds of changes you want. Sure, you might need to help rural institutions and rural providers who can't easily access the capital they would need in order to make these changes.

We also have a lot of new technology that is going to be coming online, in part thanks to the doubling of the NIH budget. The question is whether we can get information out about comparative cost-effectiveness and comparative clinical effectiveness of these technologies so payors and patients and providers have some idea about what really works when.

Finally, some of the issues that Dr. Feder raised about malpractice or changes in the tax code I think are also important. They are certainly not silver bullets. But, as long as physicians and institutions worry that if they have a bad outcome, they will be subject to liability claims, there will be unhelpful drivers of health-care spending. Maybe introducing patient safety measures into the system would be the "quid pro quo" to bring the warring parties in the Congress together to limit liability, but to do so while providing additional safety to patients.

The notion that only 1 or 2 percent of health-care spending may be attributable to malpractice first is based on a couple of very small studies in the 1980s and, second, denies the fact that 1 or 2 percent of \$1.8 trillion is still a very big number.

Mr. PORTMAN. Plus it doesn't take into account all the defensive medicine.

Ms. WILENSKY. It is very difficult to try to measure defensive medicine. Asking institutions and individuals to put themselves at financial risk, if they have a bad outcome, and at the same time berate them for not practicing in a conservative practice style makes no sense. We have got to take this issue on.

Mr. PORTMAN. I would love to hear from Dr. Smetters and my friend, Dr. Haskins, but in the interest of getting to the other committee members, you will have the opportunity to respond to their questions.

With that, I would like to have the ranking member, Mr. Spratt, inquire.

Mr. SPRATT. Thank you, Mr. Chairman.

Once again to our witnesses, thanks for your testimony.

Could we compare charts? Chart No. 1, which differs significantly from the chart the chairman just showed us, assumes a \$45 billion cut in Medicaid over a 10-year period of time. In truth, the gross cut is \$60 billion. It is not clear to me from reading the President's budget where the other \$15 billion goes. But, in any event, we have taken the \$45 billion net number, and it spreads down over the period of 10 years resulting in an \$8 billion cut in 2015.

Mr. Chairman, as I recall, the two bar graphs you showed were for 1 year, and it was a minor amount, like the amount that is assigned there for 2006, but the cut gets deeper and deeper. Yesterday three Governors came over to meet with us and told us that this was the biggest problem they faced, and they implored us not to force them to redesign the system according to a certain arbitrary budget cost reduction number, but let us work together to reconfigure, restructure, reform the system. Then estimate its costs, then change it at the margins with copays or other provisions in order to shoehorn it into the budget once it is reconfigured and redesigned, but not let the redesign be driven by an arbitrary number.

Would you disagree with that, Dr. Wilensky?

Ms. WILENSKY. That is a better way to go, to redesign the whole system. I object to some of the fiscal strategies that States have used that circumvent the need for them to put up additional funding.

Mr. SPRATT. Upper payment limits and provider taxes, and things of this kind.

Ms. WILENSKY. Exactly. I sympathize with the States that they would prefer to have these strategies available, but I believe it fundamentally circumvents the matching intention of the Congress in setting up the Medicaid program. So I don't disagree that Medicaid is desperately in need to be redesigned. I don't put those changes in quite the same category.

Mr. SPRATT. Let me say, as one State which has been an active user of creative accounting when it comes to Medicare—

Ms. WILENSKY. But not the worst.

Mr. SPRATT. No. Thank you very much. It is done for good motives, too, because the devices that South Carolina uses, and other States which have done the same thing, are mainly to deal with the problem of small rural hospitals, typically, or large urban hospitals, and the devices they use are proxies for some other device that would funnel money to those institutions that serve Medicare and Medicaid population and, therefore, get the lowest rates of reimbursement and need something to stay solvent, frankly.

Let me ask you, Dr. Wilensky, about MedPAC. Are you still on the board?

Ms. WILENSKY. No. My term ended in 2001.

Mr. SPRATT. Are you familiar with their report? And for this year applying the sustainable growth rate—

Ms. WILENSKY. Yes.

Mr. SPRATT (continuing). They indicate that physicians' fees will be reduced by 5 percent.

Ms. WILENSKY. Correct.

Mr. SPRATT. And as I understand it, the President's budget assumes in its cost estimates for the Medicare program that that 5 percent will be implemented and not overturned by Congress. Can you give us an idea of the consequences of that? How does this mechanism work?

Ms. WILENSKY. This was an unfortunate piece of the Balance Budget Act passed in 1997. I was chairing the Physician Payment Review Commission at the time—one of the two predecessor commissions to MedPAC. The problem is that the sustainable growth rate looks only at total spending on physician services. If physician spending is growing faster than allowed for in the budget, the SGR ratchets down fees across the board, which is particularly unfair and inequitable. The conservatively practicing physicians get hit as hard as anyone else.

The concern by the Congress has been, and I think with some cause, that if repeated 5-percent reductions in fees were to go into place, seniors would have trouble getting in to see their physicians. In fact, there is not any such evidence available yet and in fact, the Government Accountability Office (GAO) just released a study that says it does not appear that in 2002 when the 5-percent reduction went into effect, there was a measurable problem.

But the notion of having repeated 5-percent reductions in fees, which is what the law has in place for the next several years, is troublesome, nevertheless.

Mr. SPRATT. Do you think Congress should intercede and reverse that change?

Ms. WILENSKY. I wish they would redesign the whole system of physician payment.

Mr. SPRATT. Only as part of a complete redesign of the whole health system, the whole Medicare system?

Ms. WILENSKY. No, I would do it now. I think they need to redesign the physician payment system. The physician relative value scale is front and center in this notion of paying the same for best in class and worst in class. It is a very disaggregated payment system, unlike the way we pay hospitals on a discharge basis and it is capped with the sustainable growth rate. The way we pay physicians just isn't very smart.

Mr. SPRATT. Wasn't the problem as we bore down on rates as we did in 1990, 1993, and 1997, there was no increase at all in the Medicare Program in 1998 as a result of the BBA of 1997, a phenomenon we haven't seen repeated but there was none. The problem was as we bore down on rates, volume tended to increase to make up for the lower rates. How do you handle that problem if you don't have even this cumbersome thing called a sustainable growth factor?

Ms. WILENSKY. What helped in 1998 is that the economy was booming, so you could have substantial increases in reimbursements without exceeding the sustainable growth rate. The question of whether or not the growth in the economy as a whole ought to govern what we spend on physician spending in the narrow is something else. We don't know if physician spending goes up

whether it is a good thing or a bad thing. In part, it depends on what happens to the outpatient hospital spending and what happens to nursing home and home care. To try to put an arbitrary cap on one area of Medicare spending has never made any sense.

Mr. SPRATT. Could I ask Dr. Feder for her opinion about the sustainable growth factor and what we should do with the otherwise automatically implemented 5 percent cut in physician payment rates?

Ms. FEDER. I think I agree with most of what Gale had to say in terms of the need for refinements in the system and the difficulties with arbitrary caps. That said, you rightly say we have an issue of balancing in the relationship between changes and fees and changes in volume. I think that greater refinement in the system, and I would like to be more precise for you right now but can't, might help us find smarter ways to do that but it has always been a concern, and I don't know where they are now with the Congressional Budget Office, giving you difficulties as I recall in scoring changes you wanted to make because volume increases offset payment reductions.

I think you have rightly identified and I think more work on reimbursement is necessary.

Mr. SPRATT. I am sort of uncovering an irony here in that all of you have sort of decried the increasing cost of providing medical care in our society and in these programs in particular, but testimony we have supports a pretty substantial increase. That has a pretty significant dollar impact on the budget for next year.

Ms. WILENSKY. The dollar impact depends in part on whether or not you are willing to pay less for those who perform poorly. Most of the pay for performance strategies look at add-ons. Practitioners get what they were going to get and those that do it better, get a little more. One question is whether people willing to start to think about spending more for what works, spending less for what doesn't or for institutions that don't provide good outcomes. That is a whole different way to do it.

Mr. SPRATT. Another question about the MedPAC report. It is my understanding that it also indicates that hospitals and Medicare patients are experiencing a negative operating return of -1.5 percent. Do you think that DRG, hospital rates of reimbursement ought to be adjusted because of that negative operating margin?

Ms. WILENSKY. It depends on what you think will happen to the hospitals if you let payments drop to minus 1 or 2 percent. The same with regard to the physicians. You asked me do I think there would be a problem for repeated -5 percent reductions and the answer is repeated -5 percent reductions will start to get into access problems. Will a single -5 percent reduction or -2 percent reduction? Probably not. It is really the same response with regard to the hospitals either across the board or for a year whether or not reductions will cause any problems with regard to access for seniors.

We tend to focus what happens to institutions. Will some of them close? They may. The real question is what happens to access to care for seniors? Does that negatively impact them or not?

Mr. SPRATT. Let me ask you something about the Medicare Modernization Act which you mentioned in your testimony. Buried in

that, for the purposes of most observers because most people were focused on the prescription drug coverage, are provisions that deal with competition for traditional fee-for-service Medicare. In particular, there are subsidies provided to managed care firms offering capitated fees and taking on Medicare patients supposedly at a savings to the traditional program but in fact, these managed care outfits have been making about 107 percent according to GAO, spending about 107 percent according to GAO more than the fee-for-service plan pays. GAO suggests that if you adjusted the profile of the patients who tend to be healthier, they are really spending about 110 percent more.

Nevertheless, because the HMOs were pulling out of Medicare, this bill, as I understand it, subsidizes the continued competition with fee-for-service Medicare. In light of the swelling cost to this program, do you think that subsidy is justifiable?

Ms. WILENSKY. I would like to see them get no more or no less than fee-for-service groups. I think the question is whether so many problems were created by the Balanced Budget Act that it led to the withdrawal of substantial numbers of plans from the Medicare Program. If so, it could justify having 1 or 2 years of extra payment to get them back to Medicare. But there is no question in any long-term period, these groups ought to play on the same ground and by the same rules, the same reporting requirements as fee-for-service institutions. I wish that the direct head-to-head competitive provisions that had been initially in the House bill had made it to the final bill. They did not.

There is an area that we haven't spoken about. It is hard to resolve but important nonetheless; that is, there is tremendous variation in spending in the Medicare Program. Analysts have observed, including Elliott Fisher, a physician at Dartmouth, who looked at what services people get in the areas that are high spenders in Medicare. The answer is not much either in the way of beneficial services or satisfaction to the patient. How to drive down spending in the high spending areas of the country, by which I mean the county-level spending would help enormously but would require rethinking how we reimburse in Medicare. It would also cause a lot of push back politically from those States and counties that now are high spending. This type of change couldn't happen in a single year but it could be done over a 2- or 3-year period.

Mr. SPRATT. Looking at the numbers we have seen here presented for Medicare and Medicaid, it appears they are not exactly run away but they are soaring, increasing at a rapid rate. In fact, when you unpack the reason for their rise in recent times, there are some policy actions that Congress has taken and the administration has supported which have caused it. For example, the Federal Medicaid Assistance Percentage (FMAP), the additional amount of money that was funneled into Medicaid as a counter recessionary move on our part to sort of strengthen the safety net and secondly, Medicare prescription drugs. There has been a fundamental change so this is not something in the system that suddenly has gone out of control, this was something added intentionally. The costs now appear to be more than those expected who voted for it but there are a couple of provisions in there which I wonder

are still justified in light of the additional costs. I think you know what I am talking about.

One is the black letter provision that prohibits the Federal Government from negotiating the price of drugs, the first time in the 22 years I have been in Congress that I have been asked to vote on a provision that would say to an officer of the Government, you are not obligated to cut the best deal you possibly can for the American taxpayer. Do you think it is justifiable particularly now in light of the soaring cost of the Medicare prescription drug coverage?

Ms. WILENSKY. Let us at least use language honestly. Government doesn't negotiate prices, Government sets prices in Medicare. There is no negotiation with the physicians, no negotiations with the hospitals. So the question is should we have administered pricing or Government price setting for prescription drugs as Medicare does elsewhere?

I can only tell you that your CBO and now the CMS Actuary have both said that at least in the near term, they don't believe you would get additional savings over what you will get at least "in the near term" from having a competitive environment. Whether that will hold for 3 or 4 years I think is a real question. I am not sure whether it will or not.

So, let us not talk about negotiation, let us at least just say should we have Government administered pricing or not?

Mr. SPRATT. Let me ask a couple questions and I will let everyone else go. I am sorry, I just have a lot of questions from the testimony you have given.

Mr. Haskins and Mr. Smetters, your testimony struck me because you frankly seemed to be ignoring the elephant in the room. You are worried about the increase in the deficit both recognized and unrecognized because we have cash basis books instead of accrual books and the programs that are increasing at a fast clip but you didn't mention what is now being proposed for the biggest entitlement of all, Social Security.

If I could have Chart No. 8 on the screen, this is what we extrapolate to be the cost of additional borrowing by the Federal Government. If today's workers are allowed to divert 4 percentage points off FICA into private accounts and away from the Public Trust Fund, as you can see there in 2028, the total addition to the national debt is about \$4.9 trillion to the unified deficit. That is in 2028 and you aren't even half way up the slope at that point. That is an enormous amount of borrowing which neither of you mention in your testimony. Do you not regard this as significant or is it just something you happened not to notice?

Mr. SMETTERS. In fact, your chart makes the perfect point. It is very misleading. In particular, the reason why it appears there are transition costs the way you have shown is because the Federal budget is very misleading. It doesn't give the full present-value calculation.

In the President's plan, people who put \$1 into their personal account will receive a benefit reduction discounted by a 3 percent rate of return. Those personal accounts do not require any additional money in present value. You are right, the way you are looking at it.

Mr. SPRATT. It would require the Government to borrow and require the Government to pay debt service on the amounts we borrow.

Mr. SMETTERS. It increases the explicit debt but decreases the implicit debt dollar for dollar. It is a perfect offset. The problem is that the Federal budget looks at the explicit debt, ignores the much larger implicit debt and therefore you say there is a transition cost, whereas in the President's budget, the President's personal account plan, it would require no additional money in present value. I am glad you showed that chart.

Mr. SPRATT. Budgetarily though, we are still faced with the fact that this is debt, real debt. The Federal Government has to go into the bond markets, the capital markets, squeeze out, crowd out other borrowers, borrow \$4.9 trillion over this period of time. Once it is borrowed, semi-annually interest has to be paid. Debt service soars along with debt itself and as a consequence, more and more things the Government traditionally supports have to be crowded out.

Mr. SMETTERS. No, that is incorrect.

Mr. SPRATT. Who is going to pay the debt service then?

Mr. SMETTERS. Public debt goes up by \$1, private saving goes up for \$1, it is a complete wash.

Mr. SPRATT. You can't dip into that \$1 on the private side to pay the debt service or to pay the bond when it comes due.

Mr. SMETTERS. The debt service is, in fact, calculated in the amounts of the benefit reduction in the President's plan. This is why he discounts future benefits at a 3 percent rate of return. In other words, in your personal account, if you make a 3 percent rate of return after inflation, you just meet the benefit reduction in the personal account. That includes the debt service, so it is a complete wash.

Mr. SPRATT. You have different timing periods for incurring of the debt.

Mr. SMETTERS. No, it is the exact same present-value calculation.

Mr. SPRATT. I won't take up the committee's time to argue with you further except to say that the Director of CBO disagreed with you when he testified the other day.

Mr. SMETTERS. The CBO doesn't do the budget correctly either.

Mr. SPRATT. It is real debt, it has to be borrowed, it has to be paid and it has to be services and all of that becomes a burden upon the Federal Government. It becomes almost insuperable in the out years of the President's projections.

Additionally, you barely talked about tax cuts. I guess you have ruled them out as a political possibility but bear in mind 2010, 2011—December 31, 2010, most of these tax cuts expire by design, they sunset. To renew them between 2011 and 2015 costs \$1.66 trillion. That is about a 5-year period of time, so the 10 year cost of renewal is really over \$3 trillion.

Mr. Haskins I believe mentioned several times the fact that no provision was made to fix the alternative minimum tax. That is \$650 billion over the budget time frame. Not a dime even to patch it for 1 year even though the number of tax filings will go up from 4 million to 17 million according to CBO, there is not a dime in the budget to fix that. Finally, the \$322 billion worth of other tax pro-

visions not enacted in 2001, the R&E tax credit, for example, that had to be renewed too, how can we accommodate all these tax cuts, Mr. Haskins, Mr. Smetters, and ever dream of balancing the budget again?

Mr. HASKINS. We can't.

Mr. SPRATT. That is fine. I will take that and rest my case.

Mr. HASKINS. That is what I said in my testimony but nonetheless, even if we don't do anything about taxes.

Mr. SPRATT. You still have huge problems?

Mr. HASKINS. Absolutely, but it is still worthwhile to do as much as you can on the spending side. I realize the Democrats won't particularly like that, but if we are worried about the deficit, there are only two ways to do something about it, raise revenues or cut spending. If we can't raise revenues because the votes aren't there, then cut spending.

Mr. SPRATT. Mr. Smetters, do you want to respond to that?

Mr. SMETTERS. Suppose you didn't extend the tax cuts and on the spending side, suppose we got rid of the Department of Defense, the Department of Homeland Security, and all Federal agencies except payments for Social Security and Medicare and Medicaid? We still would not have enough money. The magnitude of the Social Security, Medicare and Medicaid problems are huge. This is a crucial point. When making the projections for Medicare, they already are assuming huge cost savings. They assume this program grows at 1 percent faster than GDP which is almost hilarious. There are incorporating already enormous cost savings into the program. The program has never grown at 1 percent faster than GDP. It is much, much faster. So we are talking about huge, huge problems here.

Mr. SPRATT. Thank you again for your testimony.

Mr. PORTMAN. Mr. Wicker, the patient one.

Mr. WICKER. Thank you. I am really not very patient but it is nice of you to think that I am.

Along the lines of the overall increase in health-care costs outside of the Federal programs, Dr. Wilensky commented a little about that. Let me ask a twofold question. Are there any industrialized countries that are not experiencing this very same problem? And what about a major factor being the lack of competition in health care?

Dr. Smetters likes health savings accounts. Let me ask you as economists, when you send a lot of money anywhere, the cost, the price seems to go up. To what extent has the cost of health care risen because over time with Medicare, Medicaid, almost universal health insurance, employment-based, without competition in choices, been a major factor in this overall increase in health care?

Ms. WILENSKY. Let me respond to the first part of your question, are we having a problem other or different from problems other countries have had? We tend to look at what we spend per person in this country relative to what other countries, G-7 countries, spend and observe we spend a lot more. We spend less time looking at rates of increase in spending in the United States compared to rates of increase in spending in other G-7 countries. Here we actually look far more similar than we look dissimilar.

A lot of the increased spending probability has to do with increasing medical capabilities as well as other factors such as in-

creasing income and wealth. So in part, this is an issue that all of the developed countries are struggling with because they are all having aging populations. More importantly, they are also all struggling with how to try to take appropriate advantage of new medical technologies.

I am more positive than many of my colleagues in health economics and health policy about health savings accounts but only within a certain venue. I think it is important to give people part of the decision-making with regard to who they see and to understand that quality and price can differ.

As Dr. Feder mentioned early on, there is an unfortunate fact of life about health-care spending and that is it tends to be very concentrated. Spending is very concentrated in relatively small numbers, 1 percent, 10 percent of the population. If you want to really stretch, you can go out to the top 20 percent but basically the top 1 to 10 percent of spenders account for a lot of money. People will blow through any deductible that is in place as soon as they encounter a hospital, certainly by day two and generally by day one.

The question is whether you think health savings accounts and changing the tax treatment of health care to make it neutral for those with employer-sponsored insurance, maybe also cap the tax subsidy for those with extensive employer-sponsored insurance, a favorite remedy for most economists, will change behavior. Whether by getting people involved in the decision-making with the early dollars, you might have them more willing and amenable to have real care coordination for the expensive, "back" dollars, if applicable, there was better information about what really works when, and if there was a change in reimbursement so that those institutions that do it well, do it right the first time are rewarded. Together, would that help?

I think it would but I would be dishonest to say that tax savings or tax changes alone will drive the kind of change that is needed because of the very concentrated spending in health care.

Mr. SMETTERS. I agree, HSAs are not a magic bullet. In terms of other countries, if you actually look at the level of spending as a percentage of GDP, it is not hugely different than the United States. It is higher partly because health care is a luxury good and you spend more as you get richer. As just pointed out, the growth rates are very similar. That means they are going to converge over time.

If you look at what is provided in the Canadian or the UK system, if Hilary Clinton had succeeded in nationalizing the health-care system, President Clinton would not be alive today. Look at the UK or Canadian system, when you need open heart surgery, you don't get it in 3 or 4 days. Their average que is 9 months. The average person dies in the United Kingdom waiting for open heart surgery. Yet what have they achieved with it? Similar growth rates, a smaller level of spending, so we are talking about not much progress for just a very little amount of money.

Ms. FEDER. I actually would make a different point about the international comparisons. First, it is very important to note that all the other industrialized nations have everybody in their health-care coverage systems. We have 45 million people who don't have coverage. I think that is an important point.

Also I think it is absolutely true that every nation is grappling with health-care costs and trying to get value for the dollars. As I understand it, actually Great Britain is making some great strides in trying to build the kinds of information systems perhaps similar to what Dr. Wilensky was talking about to enable them to get greater value for the dollar in their systems.

The other point to make I suppose is that all of these systems view their health-care spending as a budgetary decision and politically engage in the choices they want to make about what they want to spend for their Nation's health care. We don't do that. As I have argued in my testimony, I don't want to do it for the most vulnerable populations and not the whole health-care system but every other nation is trying to do that and do it directly. It might behoove us to make some of those decisions as well.

Mr. PORTMAN. Mr. Wicker, would you like to sum up?

Ms. McKinney for 5 minutes.

Ms. MCKINNEY. Thank you.

Actually the question I have doesn't really pertain to the subject matter of today but because we have four economists, PhDs sitting here, I feel compelled to ask this question that has been asked of me that I have not been able to answer.

One of the benefits of serving on the House Budget Committee, this is my first time on this committee, is that you get to view a lot of charts. These charts are really impressive with the nice color and a lot of red ink lately. My Democratic leader talks about millions and billions and trillions and I cannot fathom millions and billions and trillions. I know that my next door neighbor who has a 22-year-old daughter can't fathom those numbers either. It was Dr. Haskins, I believe, who said we won't balance the budget.

Could each of you explain for me what the impact is on my next door neighbor who has a 22-year-old daughter of deficits and national debt in the trillions of dollars?

Ms. WILENSKY. It depends and the reason it depends is it depends on the economy and it depends on who holds the debt and it depends on whether or not they are willing to continue holding the debt. Most economist in the 1990s thought there would be a real drag on the economy from the deficit and that our interest rates would go up and slow down the economy but it actually didn't happen. As you know, in the 1990s, there was rather robust growth. Other countries were exceedingly willing to hold our debt, did not appear to be a drag. I don't know that I am in a position what would have happened had we been in a different fiscal position but when you are looking at the impact of a deficit as I look at it, although my colleagues may have other answers, it depends in part on the debt relative to the rest of the economy, who is holding the debt, whether they are continually willing to hold the debt and if not, do they engage in activities that drive up the interest rate so as to try to attract people to hold that debt and does that then put a drag on the economy.

Starting in the mid-1980s, there had been predictions of dire results of having continuing deficits that actually did not, as best I can tell, turn out to happen. Having said that, when you look out at what happens when you start looking far into our future with regard to mandatory spending, the entitlement programs and with

regard to the revenues likely to come in, it is hard not to feel concerned. That would be my translation in terms of how I would regard the answer.

Ms. MCKINNEY. But I need it in like a 30 second sound bite.

Ms. WILENSKY. I am not sure right now she is impacted. For right now, I am not sure she has any impact.

Ms. MCKINNEY. OK.

Yes, Dr. Feder.

Ms. FEDER. Let me give it a shot and it will be clear from my answer I am not a Ph.D. in economics. I am a Ph.D. in political science.

I don't remember whether you were the mother or talking to your friend's daughter but I guess if I were speaking to my friend's daughter, I would say that the problem right now is that the Government is not taxing your mom and me and we are spending money without the tax revenue to support it as a nation. That would be as if I went on a spending spree, went to Las Vegas, went to the Caribbean, had a hell of a time and didn't put money away to help you, 22-year-old, as you are starting out in your life, as you start building a career, making modest wages, need some help getting a house, with your education and building your family.

What is happening to the Nation is that we are borrowing this money and we are going to have to pay the piper. Not only are we not helping you with your new home and your education and your child's needs, we are borrowing the hell out of the world's resources. Some day we are going to have to pay for that. It is you who are going to have to pay; and you are also going to have to pay for me because I am going to be old and sick and I am going to need your help.

Ms. MCKINNEY. That is beautiful.

Ms. FEDER. I would like a different story to tell.

Mr. SMETTERS. I agree basically with what was said with one modification. I would say we shouldn't be going to Las Vegas. The problem is not the amount of money. The problem is we don't need to increase taxes, I believe. I think that would have a very detrimental impact on our economy, especially the effective tax rates on U.S. companies are much higher than they are even in Europe. I think the problem is we are over spending and part of that over spending is the prescription drug bill again that we completely unfunded, completely a large burden to future generations.

Ms. MCKINNEY. So you would recommend going to Las Vegas and having a darned good time?

Mr. SMETTERS. No, I would recommend not going to Las Vegas.

Ms. MCKINNEY. Oh, don't have a good time?

Mr. SMETTERS. Don't have a good time. We should live within our means.

Mr. HASKINS. I think the main message is in the long run someone has to pay. The problems that Dr. Wilensky brought up about interest rates, I was a staffer in the Congress in the 1980s and 1990s and everybody was in a panic about the interest rates and it turned out to be the sky is falling, the sky is falling. The sky didn't fall.

Still, if your income is 17 percent gross domestic product and your spending is 20 percent of gross domestic product, which that

looks like the direction in which we are heading, eventually it is going to bite you. So we are spending too much or taxing too little, one of the two. Some people think we are spending too much, some people think we ought to both reduce spending and increase taxes, but the point I have tried to make to this committee is, we are probably not going to raise taxes this year because people like you don't have the votes, so let us at least cut spending.

Ms. MCKINNEY. What does that mean? Does that mean depression? What does it mean?

Mr. SMETTERS. If we increase taxes?

Ms. MCKINNEY. No. When the bill comes due?

Mr. SMETTERS. Sure, but ultimately that means tax increases on future generations. So as I pointed out, suppose we were to try to tax our way out of it and suppose we implemented this tax today, we didn't even pass it along completely to future generations, it would require increasing payroll taxes on uncapped earnings, talking about the Medicare payroll tax, taxes everything by 22 percentage points. That is over a 146 percent tax increase relative to the tax rate today on employers and employees forever. That is assuming we don't just kick the whole can down the road to future generations. I think most economists would agree, that would have an extraordinarily detrimental impact and again, that is assuming all these cost savings the trustees are assuming in terms of Medicare costs only growing 1 percent faster than GDP. This is a very difficult situation that we are in and it could mean economic collapse.

Ms. MCKINNEY. I thank you for your indulgence.

Mr. BRADLEY. Thank you, Mr. Chairman.

Given the lateness of the hour and the fact we have votes in just a few moments, I will pass on any questions.

Mr. MCHENRY [assumes Chair]. Congressman Davis.

Mr. DAVIS. Thank you.

Let me try to be brief given the fact we do have votes coming up.

As we sit here, Chairman Greenspan is testifying before the Financial Services Committee right now. He said something that may be a little surprising coming from the Chairman but it is a very, very eloquent and powerful point. He said the last time he testified before this committee that "Equity and the perception of equity are important pillars in our society." I happen to believe that, I know that certainly John Spratt believes that and a lot of others in the room believe and I am glad Alan Greenspan believes it.

I want to touch on that for a moment because what strikes me is the constant theme, whether we are looking at HSAs as opposed to a different approach to health care, whether we are looking at partial privatization of Social Security versus a more egalitarian approach, whether we are looking at the President's tax cuts versus a more egalitarian set of tax cuts, whether we are looking at the President's budget choices versus a more egalitarian set of budget choices, there is a constant theme. On issue after issue, what we see is a set of policies that are arguably skewed toward some people in society and not others.

Again, HSAs are a great example. Most of the uninsured in this country aren't paying taxes, so therefore any kind of system that is geared around the amount of taxes they can take isn't going to

do them a lot of good or allow them to earn in the 15 percent bracket.

Obviously partial privatization of Social Security will reward the savvy who know something about earnings and investments and probably won't be as impactful for people who don't have that kind of knowledge. The President's tax cuts were enormously generous to people in the top end of our society. The average person in my district got about \$38 a month.

I would like to hear from Dr. Wilensky on that general point because I am concerned as we talk about reform in a number of areas, this persistent inequity and this drive toward policies that favor the few at the expense of the many, that there seems to be a real constancy to that theme in this administration. Do you agree with that, Dr. Wilensky?

Ms. WILENSKY. I don't think I would characterize it that way.

Mr. DAVIS. Do you disagree substantively with any of the examples I laid out?

Ms. WILENSKY. I think the tax cut that was passed initially was a very important factor in jump starting the economy.

Mr. DAVIS. Should it have been more egalitarian or more geared toward the middle class in your opinion?

Ms. WILENSKY. I am not here as a tax expert although public finance is my background. I think how you gear and particularly what happens to the renewal is a serious issue but I think to just blanketly dismiss the notion.

Mr. DAVIS. I am not being blanket, I am asking a specific question. The tax burden on the middle class has stayed relatively constant and it has actually gone up to some degree in the last several years whereas the tax burden on people on the upper end has had a significant amount of decrease. Dr. Feder, you are nodding your head. Do you want to weigh in on this?

Mr. SMETTERS. Could I? A couple of points. I agree with you in terms of equity. I would simply say also look between generations in terms of equity and I don't think we are being equitable that way.

The second point is I am surprised you would be opposed to personal accounts for Social Security. Personal accounts aren't going to help you or not because we already have access to an equity market but look at the bottom 20 percent of people in the income distribution, 9 percent of them have some access to capital markets, one-third of African Americans have some investment in the capital markets. That to the personal accounts helps. It is those people who have finally had a chance to build wealth that don't have access right now.

The personal account system the President is talking about would make it very, very easy to do so.

Mr. DAVIS. The only thing I would add, Mr. Smetters, that may be a little bit of difference is I think if you were to poll the democratic side of the aisle, if we had a blank check to write, I think a lot of us would like the idea of private accounts assuming people could leave it to their children which the President would not allow them to do, assuming a number of other factors but the reality is we don't have a blank check, we have a prospect of trillions of dollars worth of borrowing.

You make a very important and good point about inter-generational equity. Is there a deeper inequity in one generation passing on the cost of what is yet another government reform to the next generation?

Ms. FEDER. I would also say there is a real difference between enhancing the capacity of younger people to invest and have accounts on top of protections that we now have in Social Security as opposed to eliminating some of the Social Security protections and substituting something that is much riskier to individuals. Social security is a kind of insurance, it is about spreading risk and we must hold on to that concept in any policy changes as we move forward.

Mr. DAVIS. If I can just close.

Mr. MCHENRY. The gentleman's time has expired. We have votes and there are others who would like to ask questions, me included. Thank you.

I too am part of the Financial Services Committee and heard Chairman Greenspan testify this morning. I want to read you a portion of his opening statement that is pertinent to our discussion here today. "Beyond the near term, benefits promised to an ever increasing retirement aged population under mandatory entitlement programs, most notably Social Security and Medicare, threaten to strain the resources of the working age population in the years ahead. Real progress on these issues will unavoidably entail many difficult choices but the demographics are inexorable and call for action before the leading edge of baby boomer retirement becomes evident in 2008. This is especially the case because long-term problems, if not addressed, could begin to effect longer dated debt issues, the value of which is based partly on the expectations of developments many years in the future."

Certainly it is much easier to hear Alan Greenspan read that because he actually understands what those words mean. However, I think it is a pertinent question here today, what are the long-term liabilities that we face with entitlement programs going to do to our long-term economic ability to sustain the Government spending we have today, programs accounting for roughly 20 percent of GDP. If that continues on track, that will be 40 percent of GDP just a decade down the road. My question to you, Dr. Smetters is what is the answer? Is it perhaps with Social Security, increasing private savings while reducing long-term unfunded liabilities for the Government? Is it looking at ways to create cost savings through greater efficiency or is it cuts?

Mr. SMETTERS. It has to come in the form of controlling the growth through the benefit increases. In particular, I will be the first to tell you that the personal accounts themselves are not a magic solution. They don't add to the problem, they don't make the problem smaller. You really have to control the growth rate of benefits themselves.

The alternative is to increase taxes and that would collapse the economy. Controlling the growth through the benefits would not collapse the economy and the reason why is because we can still afford under Social Security to pay future generations the same inflation adjusted value of benefits that we pay current retirees. What we cannot afford, which is what current law promises, is to

grow the benefits at a rate faster than inflation. That is the problem.

The reason we have this problem is because current law is actually promising future generations a level of benefits that is actually higher than what current retirees are getting even after you adjust for inflation. We just can't do that with either Social Security or Medicare.

Mr. MCHENRY. But isn't it true with Social Security the demographic shift in this country, the fact we have fewer workers per retiree and getting fewer and fewer in outlying years means that it is not a sustainable system on a pay-as-you-go basis?

Mr. SMETTERS. That is correct. Even after the baby boomers are out of the system, it still has huge cash flow problems. So we do have to think about reducing those benefit sizes. The best approach too would be to increase personal savings I believe through personal accounts because we have a paltry level of personal saving in this country already. That certainly is going to contribute to future economic problems.

Mr. MCHENRY. Thank you.

Mr. HASKINS. May I make a brief comment? Mr. Spratt referred to the elephant in the room. The real elephant in the room is that the Congress won't cut spending. That is the elephant in the room. You could say we ought to increase taxes somewhat but we just spend too much money and we're going to spend too much money in the future. We complicated the problem when we passed the drug benefit. At some point, the Congress is really going to have to do something about spending. That is the elephant in the room as far as I am concerned.

Mr. MCHENRY. I hope to reach out to Ranking Democrat Spratt so we can come up with ways to cut spending and actually fully restrain Government spending. I think that would be a positive thing if we could reach across the aisle and look at ways we could find real cuts.

Chairman Nussle.

Chairman NUSSLE. Yes. Thank you, Mr. Chairman.

First, I would like to thank the gentleman from North Carolina for chairing the hearing and for giving us the chance to ask the panel. I had to step out for a moment so I didn't hear all of the answers so I may retread some ground here.

I wanted to bring to you and other members attention a meeting that Mr. Spratt alluded to and that was with myself and Mr. Spratt and as it turns out, Governors met yesterday with members of the Senate to talk a bit about the challenges regarding Medicaid. The headline from the New York Times I just had a chance to look at is interesting. It says, "Governors in Capital to Talk about Medicaid." The opening paragraph says, "Congress, Governors and the Secretary of Health and Human Services began negotiations Wednesday on the future of Medicaid with a view toward making fundamental changes in the program to control its costs." I can tell you that was not what happened yesterday. There was a lot of whining, there was a lot of complaining, there was a lot of my not in my backyard, please don't cut me, not this year, oh my gosh the sky is falling but I can tell you there was no Congress, Governors and the Secretary of Health and Human Services beginning any

negotiations yesterday about a view to fundamental changes in the program to control its cost.

In fact, interestingly enough, they said, we will come back to you with a plan for next year. My Governor was here, Governor Tom Vilsack of Iowa is quoted. A Democrat said, "The current Medicare system is not sustainable" and goes on to say, "Governors desperately want to slow the growth of Medicaid which they say is eating up State tax revenues they want to use for education."

Going to Mr. Haskins' point, this whole issue or the notion of is there some outside force? I don't think there is any question that the outside force is there. I think you are right. The outside force to control costs, the realization of what it is doing to the Federal budget, to the State budgets, to family budgets, to business budgets, to everything across the board, the out of control costs and nature of health care is an outside pressure that is just growing and is enormous.

What troubles me about not only the article but more than the article, the meeting, maybe they had a different meeting with the Senate but I can tell you that there was no discussion about doing anything this year. They all basically said please wait until next year. As my father always said, tomorrow never comes because by the time you get there it is either today or tomorrow is the next day. Tomorrow never comes. They basically were saying please do this tomorrow was their first message and my message back to them is why are you here then?

My guess is the reason why they are here is because of the "R" word that has crept up which was your second point or another point you made Dr. Haskins and that is reconciliation. The fact that the President has proposed savings of any kind for any reason, and the fact that I have used the term and Senator Gregg, the Chairman of the Budget Committee has used the term, our leadership has used the term and we are starting to hear people talking about reconciliation which is a real process different than PAYGO as it is often called which is I think an illusory process, a way if you want to do it you use it, if you don't want to do it you waive it.

Reconciliation, as we all know, is real and that has forced Governors to come here and basically take that reality and say OK, now we have to talk. We are glad they are here. They should have been here last year, they should have been here the year before. None of this information is new. We know it is unsustainable and I would guess that is a unanimous view of the four of you. Even Dr. Feder, I can't believe you are here saying that the current programs are sustainable. You may have a different opinion on what we do next, that is a different issue but the fact we have a problem, the fact the program is broke and the fact it is not sustainable, I don't think there is any argument. Is there really? You think the program is sustainable?

Ms. FEDER. I think when one uses the kind of language as unsustainable and broke, and you went on to say broken—

Chairman NUSSLE. All right, I won't say broken.

Ms. FEDER. Don't say broken. What I think is that the financing needs attention.

Chairman NUSSLE. It is unsustainable.

Ms. FEDER. I won't say it that way.

Chairman NUSSLE. I will let you argue with my Governor then. He says it is unsustainable.

Ms. FEDER. I think the difficulty with that language is that it implies that we lack the resources to support our commitments. I do not believe that. Whether they are there under existing tax structures or existing Federal/State arrangements, that is another story.

Chairman NUSSLE. All right. That is fair.

Ms. FEDER. We usually agree when we fight it out.

Chairman NUSSLE. It is a difference of context. If the context is we could do away with our military; we could do away with Homeland Security, we could do away with lots of things or we could raise taxes on the rich, just tax the rich, we could do all those things. I understand there are options but at its current rate, is it sustainable? The answer is obviously no.

Ms. FEDER. We have discussed it and I would not use the same language.

Chairman NUSSLE. I will let you argue with my Governor.

Mr. HASKINS. Chairman Nussle, could I add something briefly? Mr. Smetters made the point that by 20—I forget the year—that just Medicaid, Medicare and Social Security, just those three, would require 20 percent of GNP.

Chairman NUSSLE. Which is what our total budget is also.

Mr. HASKINS. You are talking at least 30 percent. Can anybody, including the Democrats in this room, imagine a tax system that is going to take 30 or 35 percent of GNP? It is not going to happen.

Chairman NUSSLE. That may be possible. You can imagine it but is it realistic is a different issue. It is not realistic and it is not sustainable.

Ms. FEDER. If you were to speak differently, talking about health-care programs—

Chairman NUSSLE. I am talking about my Governor. I am not speaking differently.

Ms. FEDER. I will stop if you want but where I wanted to go was to say that if you want to talk about the entire health-care system which is not simply imposing costs on public programs but also on families who are relying on private health insurance and on jobs, it really poses a problem.

When we talk about whether we want to change the rate of growth in our health-care system, I am ready to talk.

Chairman NUSSLE. Thank you and that is my last question to Dr. Wilensky. Could you help us figure out how we can allow the Medicaid program to grow at 5.5 percent a year as opposed to 5.7 percent a year or 7.5 as opposed to 7.4? Is it possible just to slow this down a bit and still deliver a quality product to the people that we want to help? Can we slow down the rate just a little bit? That is what we are asking.

The things you mentioned and have mentioned so many times in the past, can they be employed so that we can continue to spend more money and continue to increase the program but just slow it down just a little bit so we can save a little bit of money over the long term?

Ms. WILENSKY. You probably can. The difficulty with Medicaid is that it tends to be a residual pick-up for populations that aren't picked up in other programs. That really is what makes it hurt.

The reason I say maybe you can is we have done less thinking about how to try to help get a little better deal, a little better value for the aged disabled population. If what sometimes happens is you get a little more efficient, so you bring a few more people in to get services, then you are not going to be any better off.

What we did find when managed care and other strategies were introduced to the moms and kids, the families part, there were some savings that were available but they weren't 5 percent over the time. The question is, could you get .2 of a percent down? Maybe, but there are a lot of other people who might want to come in and receive some of the services who are not quite eligible now or who aren't being brought in by their own States and the big problem is they may well soak up any additional savings that you might have with the current population. That kind of number you ought to be able to do. It is the residual population that we are not taking care of that you don't know what it will do to the Medicaid spending.

Chairman NUSSLE. One of the Governors we met with yesterday on the one hand said, please don't cut, let us do this next year and almost the day before, I think 24 hours before, was announcing the fact they were increasing Medicaid for 20,000 new recipients. It was interesting, please don't cut us, we will work on Medicaid reform, we will do it next year, we will do it tomorrow, but oh, in the meantime, we are going to continue to increase the people who are eligible. It is a fair concern but it is kind of hypocritical or at least it is certainly not consistent with the message.

Lastly, I would ask, there have been some who have suggested that we need a Medpac so to speak advisory committee for Medicaid, that we need some type of an organization who can give us similar advice the way you did when you were on Medpac for Medicare. Would that be an idea that you could endorse or suggest or do you have a better idea of how we could approach this?

Ms. WILENSKY. The problem with a Medpac counterpart for Medicaid is the Federal Government doesn't run Medicaid, it runs Medicare and prescription drugs excluded, it sets the prices, the reimbursement for everything in Medicare and monitors quality.

The States do all of that, so unless you are thinking about changing that arrangement, I am not sure what a Medpac counterpart would do.

A group could try to rethink the issue if we think there are problems with the existing Medicaid program, what would a different Medicaid program look like? That is more of a one-time commission and if it was the Federal Government that would be making the decisions rather than the State, of course a Medpac type of commission would be fine but under the current power sharing which is basically the States run the program with some Federal oversight and a whole lot of Federal money, I am not sure what a commission would do advising the Congress.

Chairman NUSSLE. What about with dual eligibles?

Ms. WILENSKY. I think dual eligibles are really a program that absolutely needs to have reconsideration. It is not a big number but

it is a whole lot of money. The worse part is they don't get very good care. They spend a lot of money, get better care than if they weren't dual eligibles, but for the kind of money that is being spent, it is incredibly uncoordinated for the people who have the most complex medical problems.

Chairman NUSSLE. Thank you, Mr. Chairman.

Mr. MCHENRY. Thank you, Mr. Chairman.

Thank you all for being here today and I appreciate you taking the time to spend a few lovely hours with the House Budget Committee. Thank you again for your testimony. Thank you, Mr. Chairman, for the honor of serving as chairman for a moment.

This meeting is adjourned.

[Whereupon, at 12:30 p.m., the committee was adjourned.]

