NATIONAL CAPITOL CONTRACTING

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FULFILLING THE MISSION OF HEALTH AND RETIREMENT SECURITY

Thursday, March 17, 2011

House of Representatives

Committee on the Budget

Washington D.C.

The Committee met, pursuant to call, at 10:00 a.m., in Room 210, Cannon House Office Building, Hon. Paul Ryan, [Chairman of the Committee] presiding.

Present: Representatives Ryan, Garrett, Akin, McClintock, Stutzman, Lankford, Black, Mulvaney, Huelskamp, Young, Rokita, Van Hollen, Schwartz, Doggett, Yarmuth, Pascrell, Honda, Moore, Castor, Tonko, and Bass.

Chairman Ryan. All right, let’s get started, we like to start on time around here. So, first of all, I want to thank the witnesses. The hearing will come to order. I will start with a brief opening statement, then turn it over to my friend, Mr. Van Hollen.

Let me just say, welcome to this important hearing on the future of our country. Medicare, Medicaid, and Social Security are very important programs that provide health and retirement security to millions of Americans. The principle aim of this hearing is to make clear that trying to protect the government's major entitlement programs by simply maintaining the status quo is, in fact, the surest way to destroy them.

Medicare, Medicaid, and Social Security are growing at unsustainable rates, building up trillions of dollars in debt and unfunded promises that jeopardize the programs themselves, and the federal budget, and, ultimately, the entire U.S. economy. The longer Congress waits, the more we kick the can, the worse the problems become, leading to an inevitable crisis that will force deep, wrenching, sudden changes with profound effects on program beneficiaries.

The fundamental missions of these programs, to ensure health and retirement security for all Americans, can be achieved, but only through honest leadership and real reform. By taking action now, Congress can develop gradual prospective

changes, keeping promises to those now in or near retirement, while securing the program for future retirees.

I thank the distinguished panel of bipartisan experts for joining us today to share their views on the sustainability of our safety net. I am happy to see my friend, a woman I have profound respect for, Alice Rivlin, with whom I worked on the President's fiscal commission to put forward solutions to the unsustainable trajectory of federal health care spending. Few people in Washington know more about these issues and have more credibility in addressing them than Alice does. Jim Capretta, former Associate Director at OMB, is also with us today. Few, in my mind, have made as compelling a case as Jim on the path forward to advance real reform.

And you cannot have a hearing like this without having Chuck Blahous, who is one of the nation's foremost experts in retirement programs, and a trustee of the Social Security program. He will give us his thoughts. And I am also happy to have Paul Van de Water of the Center for Budget and Policy Priorities. While we do not always agree on the policy path forward, Paul, I welcome your thoughts in advance, and I appreciate your informed contribution to the debate.

For the past several months, a number of us have been saying, “We need to have a serious, honest conversation with the American people about these problems.” Well, the time for that

conversation is now. And I firmly believe that the American people are ready for this. They have had enough instability in their lives lately, and they deserve a federal health and retirement safety net that they can actually count on.

If Congress wants to avoid defaulting on federal health and retirement programs, it must advance solutions that free the nation from the shadow of debt, strengthen its health and retirement safety net, and protect those in and near retirement from severe disruptions. If, and only if, we act now, reforms can be phased in gradually, conducive to economic growth and consistent with our historic commitment of leaving the next generation of Americans with a more prosperous future and secure nation. With that, I want to yield to my friend, the Ranking Member Mr. Van Hollen, for an opening statement.

[The prepared statement of Paul Ryan follows:]

**********INSERT 1**********

Mr. Van Hollen. Thank you, Mr. Chairman. Happy St. Patrick's Day to you and others. And I want to join the Chairman in welcoming our witnesses here today.

As the Chairman said, Social Security, Medicare, and Medicaid are essential to the health and retirement security of millions of Americans. The challenge before us is to make these vital programs sustainable over the long haul, given the spending growth trends. These trends, as we all know, are due to aging of our population and the fact that per capita health care costs, both private and public, have grown faster than the economy. So I hope we can come together to ensure that the long-term viability and integrity of these programs can be put in place as we put our nation on a fiscally stable path.

About one year ago, about one year ago, many in this Congress began to tackle the challenge of rising per capita health costs by enacting the Affordable Care Act. That law begins to address what every expert knows; that the rising cost of health care is not unique to Medicare and Medicaid. Those costs are endemic to the entire health care system. In fact, for 30 years, the per beneficiary spending in Medicare and Medicaid has grown at virtually the same rate as those for the overall health system. And over the last decade, the Medicaid per beneficiary costs actually grew more slowly than the rest of the health care system. By contrast, in the private market for

individual coverage, premiums more than doubled between the years 2000 and 2008, as insurance industry profits quadrupled. The Affordable Care Act will begin to bring down the per capita costs of health care throughout the system, including in Medicare. As the independent, non-partisan Congressional Budget Office has told this committee, it will also reduce the federal deficit by $210 billion over 10 years, and by more than a trillion over 20 years. It includes virtually every cost containment provision recommended by health care experts. Dr. Rivlin and Dr. Van de Water made those points in a January 6, 2011 letter to this committee, where they joined others in warning that, and I quote, “Repealing the Affordable Care Act would cause needless economic harm and would set back efforts to create a more disciplined and more effective health care system,” end of quote.

The health care reform law includes numerous Medicare reforms, including mechanisms to slow down the growth of systems costs, new tools to crack down on fraud, and the elimination of excessive taxpayer subsidies to manage care insurance companies. The response to these important reforms was a barrage of campaign attack ads aimed at seniors, accusing Democrats of slashing Medicare. So Democrats here welcome an honest debate about how we can strengthen and sustain Medicare, Medicaid, and Social Security. We recognize that a variety of measures are

necessary to accomplish that objective, but we will vigorously oppose any effort to undermine the integrity of those programs.

You do not need to be a history buff to know that Republicans in earlier Congresses fought the establishment of Medicare and Social Security just as ferociously as they are fighting the Affordable Care Act today. And we will fight any budget plan that extends deficit-busting tax breaks for millionaires and the wealthiest Americans and at the same time, rolls back Medicare and Medicaid health services, and Social Security protections for seniors and the disabled, in the name of deficit reduction.

And, Mr. Chairman, that brings me to my last point. As you have said, and I think everybody on this committee knows, any serious and comprehensive approach to reducing the deficits and the debt must ensure that we do not undermine our economic recovery, and requires us to examine the full range of ideas proposed by the President's bipartisan fiscal commission, as well as the Rivlin-Domenici debt reduction task force.

So I hope that before this committee considers its 2012 budget, we will also have hearings, and we have had some discussions, I know we have a tight schedule, but I hope we will also have hearings on the major issue of tax reform and tax earmarks, as well as the recommendation of both those bipartisan groups, regarding some of the wasteful and unnecessary spending

in the Pentagon and some of the national security agencies. Otherwise, we will be sending the message that, despite the good work of the bipartisan commission and the Bipartisan Policy Center, the only targets for deficit reduction are the Domestic Discretionary Programs, a very small 12 percent, that we spend a lot of time debating and the very important issues that are subject of our hearing today. So I hope we will not limit ourselves just to those two areas, but expand our conversation as we put together our budget.

Thank you, Mr. Chairman.

[The prepared statement of Chris Van Hollen follows:]

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Chairman Ryan. Thank you, Mr. Van Hollen. As you know, we are on tight schedules around here, but I want to do everything we can to get all of these issues out on the table, and over the course of our session, we will clearly do that. That is just, as you and I discussed, kind of a scheduling complication.

I want to ask our witnesses, you have all testified here before, if you could summarize your testimony into five minutes. Your full written statements will be included in the record. And we will just start with Dr. Rivlin and then move on down the line, Dr. Rivlin, the floor is yours.

STATEMENTS OF ALICE M. RIVLIN, THE BROOKINGS INSTITUTION AND GEORGETOWN UNIVERSITY; CHARLES P. BLAHOUS, RESEARCH FELLOW, HOOVER INSTITUTION AND PUBLIC TRUSTEE FOR SOCIAL SECURITY; JAMES C. CAPRETTA, FELLOW, ETHICS AND PUBLIC POLICY CENTER; PAUL N. VAN DE WATER, SENIOR FELLOW, CENTER ON BUDGET AND POLICY PRIORITIES

STATEMENT OF ALICE M. RIVLIN

Ms. Rivlin. Thank you, Mr. Chairman. And thank you for holding this important hearing. As you and Mr. Van Hollen have emphasized, Americans are counting on Medicare, Medicaid, and Social Security. And the biggest challenge facing budget policymakers is to ensure that the promises represented by these programs are met in ways that are affordable and fiscally sustainable for the long run.

In the last year and a half, I have served on both the commissions that have been mentioned. And I will talk today mainly on, about the proposals for Medicare reform in the task force on debt reduction that I co-chaired with my good friend Pete Domenici. The challenge for Medicare reform is to restrain the growth of this large federal program in ways that help the

whole health care system deliver care more efficiently and effectively, and to do this without shifting the cost of caring for Medicare beneficiaries to other payers, or causing providers to drop out of Medicare.

Medicare, as you know, is still largely a fee-for-service system in which the government is obligated to pay the bills presented for specified services to eligible beneficiaries. There are few incentives now built into the system for providers to deliver care efficiently or effectively, costs vary widely from one provider to another, and the government has no way of restraining the total cost of the program.

The Affordable Care Act includes important provisions aimed at improving health outcomes and reducing cost growth. And I believe, as Representative Van Hollen emphasized, that it would be a mistake to repeal the Affordable Care Act. However, the impact and timing of these reforms is still uncertain. And therefore, the bipartisan policy task force recommended several cost-saving reforms in the short run, followed by a gradual transition of Medicare to a premium support, or defined contribution program, which would incent efficient delivery, while controlling the rate of growth of Medicare costs.

That means that, beginning in 2018, Medicare beneficiaries would have a choice of remaining in the fee-for-service Medicare, or going to a Medicare Exchange, where they could

choose among competing private health plans. The health plan would receive a fixed payment, risk-adjusted for the age, health, and status of the beneficiary, and would not be able to cherry-pick the least costly beneficiaries.

In the first year, the subsidy for those choosing the Exchange would be equal to the average subsidy of traditional fee-for-service Medicare. In subsequent years, the growth of the subsidy for both options would be limited to the growth of GDP, plus one percent. Now this is lower than the projected growth. If the cost of fee-for-service Medicare rises faster than the GDP plus one, those electing to stay in that system would pay a premium to cover the additional cost.

I think there are two reasons for shifting to a premium support model for Medicare. One is that the total subsidy would be controllable. Taxpayers would be making a defined contribution. Congress could, of course, vote to increase the subsidy faster than GDP growth plus one, but the budgetary consequences of doing so would be explicit. The other reason is that competition on a well-managed exchange can be expected to attract beneficiaries to health plans that organize themselves to provide the most effective care at the lowest price. The Medicare Exchange would be charged with providing the beneficiary with clear customer-friendly information about the plan's benefits, and costs, and health outcomes.

Is that at five minutes? I cannot see it.

Chairman Ryan, as you know, and I have drafted a skeletal version of the premium support proposal for consideration by the Simpson-Bowles Commission. We were not sufficiently persuasive. But that plan differs slightly from the Domenici-Rivlin version, in that it would phase in much slower. The proposed premium support resembles the current structure of Medicare Advantage, but we think there are important differences, and that it would work considerably better.

I will leave it at that, although my written statement does emphasize both Medicare reforms, which I think are more difficult, the fact that it is important to cap and phase out the employer-provided health exclusion under the tax code, and we strongly support Social Security reform to make Social Security safe and secure for future beneficiaries. Thank you, Mr. Chairman.

[The prepared statement of Ms. Rivlin follow:]

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Chairman Ryan. Mr. Blahous.

STATEMENT OF CHARLES P. BLAHOUS

Mr. Blahous. Thank you, Mr. Chairman, Mr. Ranking Member, and all the members of the distinguished committee. It is an honor to appear before you today to discuss the challenges facing Social Security, which, as you both said in your opening statements, is a cornerstone of retirement security for millions of Americans. Pursuant to the five minute time limitation, I would just like to make three main points from my written testimony.

First point is that, by any measure, Social Security faces a significant long term financing shortfall. Costs of the program are going to grow dramatically over the next couple of decades, as more baby boomers hit the retirement roles. So that under current law, by the 2030s, this one federal program alone would absorb roughly one out of every six taxable dollars that American workers earn. And even if we succeed in financing these rising costs within the general budget through that time, if we fail to act to address Social Security finances, the program will become insolvent in 2037, and benefits would be cut by 22 percent across the board.

The second point I would make is that costs in Social Security are growing for three very specific reasons. The first

of these is the aging of the population. The second is the method of financing the program. And the third is the current Social Security benefit formula.

Social Security costs grow primarily because there will be many more beneficiaries to support as the baby boomers leave the ranks of workers and join the ranks of retirees. According to the 2010 trustees report, we will have over 90 million beneficiaries by the mid-2030s, and we will only have two taxpaying workers to support each person receiving Social Security benefits. This is down from a ratio of over three to one just before the baby boomers began to retire.

The second reason that costs grow is simply the way that we finance the program. The program is financed, benefits are paid from incoming tax revenues contributed by workers. Therefore, the program finances are especially sensitive to changes in the ratio of taxpaying workers to collecting beneficiaries.

The third reason that costs rise is rooted in program amendments that were enacted in the 1970s. If we still had the benefit formula in place that was established by Franklin Roosevelt, we would not actually have a financing shortfall right now. But in the 1970s, there were a series of benefit expansions, the most notable of which causes initial benefit payments to rise more rapidly than inflation. Basically, each succeeding class of Social Security beneficiaries is given

benefits that are higher than the preceding class, relative to inflation.

Now put these three factors together: population aging, the method of program financing, and the increase in per capita benefit levels; the result is a prescription for significantly rising tax burdens on younger generations.

The third point I would make is simply that delay is very costly. Now this has become something of a cliché. You have probably heard a lot of analysts come in and say to elected decision makers that this is better done sooner, rather than later. But it is very important to understand that there are real adverse consequences, real harm is caused to real people as we delay dealing with this.

If we fix Social Security today, our choices would be comparatively benign. We could fix the shortfall entirely without changing benefits for people now in retirement, or on the verge of retirement. We could do it without raising taxes. Not everyone would prefer to do it that way, but we could do it without raising taxes. And we could also ensure, even if we did not raise taxes, that future beneficiaries get benefits that are at least as high as today's retirees get, even relative to inflation.

So our choices, in sum, are not that bad yet. But if you go to the opposite extreme, the no action scenario, things look

very bleak. There is the 22 percent benefit reduction that I referred to earlier. But I would submit to this committee that this is actually a gross understatement of how bad the costs of delay are. And the reason for that is that, I think we have something of a bipartisan consensus, that it is wrong to change benefits for people after they start collecting them. That it is not fair to cut the benefits of the 95 year old widow.

So we have to reframe the question; if we want any benefit changes we make to take place prospectively, then how soon do we have to start making them? Well, if you wait until 2037, you could wipe out the entirety of benefit payments to new retirees and still not balance the system. So you start working backwards, and asking yourselves, “How soon do we have to get started?” The answer is quite soon. If you do not want to raise taxes on workers, if you do not want to change benefits for people within five years of retirement, you probably need to legislate in just the next couple of years. Beyond that point, you almost certainly have to raise taxes substantially on workers, or affect people closer to retirement.

Before I close, Mr. Chairman, I would just like to briefly address one objection that is often raised against dealing with Social Security. It is occasionally said that Social Security reform should not be pursued because the program is not a significant contributor to the larger federal deficit. I

respectfully submit to this committee that this is not the best way to think about the Social Security problem. Even if it were true, and it is not true, by the way; Social Security is a significant contributor to the long term fiscal imbalance. But even if it were true, Social Security, as a self-financing program, has to be brought into balance. And this is more easily done sooner rather than later.

These larger budget issues are very important, but they are primarily relevant to Social Security because they establish that we will not be able to tap general revenues in any significant way to bail out the Social Security program. And this only highlights the importance of Social Security being able to stand on its own.

Now obviously you, as legislators, will have to make the best tactical judgments as to the best process. If separating Social Security from the larger budget discussion enables us to enact reforms more swiftly, this is a strong argument for separation. But if it causes us to delay action, then this would be a strong argument against it.

In conclusion, I would simply summarize with sentences from an article I recently authored with Robert Greenstein of the Center on Budget and Policy Priorities, “Social Security faces a significant shortfall, which policy makers would be better off addressing sooner rather than later. Reasonable and well-

intentioned people will have differences over the best way to do so, but we have a common interest in doing it at the earliest possible time." Thank you.

[The prepared statement of Mr. Blahous follows:]

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Chairman Ryan. Thank you. I am sorry to wind you there. A vote has hit, we have got 13 minutes left in the vote. Let's get through these two gentlemen, and if you could stick to your five minutes that would be great. Then we will recess and all come back after two votes. Mr. Capretta.

STATEMENT OF JAMES C. CAPRETTA

Mr. Capretta. Thank you, Mr. Chairman, Mr. Van Hollen, for holding this hearing. It is a very important topic. The budget problems we are experiencing today are directly related to the fact that health costs have risen dramatically over the past four decades. In some sense, we are already living in the long run cost problem.

In 1975, the federal government spent 1.3 percent of GDP on Medicare and Medicaid. In 2010, spending on just those two programs had risen to 5.5 percent of GDP. That is more than 400 percent growth. Why are health care costs rising so rapidly?

The prevailing view has been that the federal government health programs experience rapidly rising costs because they are victims of the runaway cost train that is pulling the entire system down the tracks at too rapid a rate. But this point of view ignores the crucial role of existing governmental policy. At present, the vast majority of Americans get their health insurance through one of three sources, Medicare, Medicaid for

the low income, and employers for the working-age population and their families. In each instance, the federal treasury is underwriting rapid costs escalation, because there is no limit to what Uncle Sam will pay as the premiums rise.

In Medicare, most beneficiaries are in fee-for-service with no cost sharing at the point of service, due to supplemental insurance. The result of this arrangement is hardly surprising. The volume of services paid for by Medicare has been on a steady and steep upward trajectory for decades. The real price Medicare paid for physician fees dropped between 1997 and 2005 by five percent. That is the real price paid for physician services went down, but volume went up by more than enough that total spending on physician services rose by 35 percent in real terms.

Medicaid fuels cost growth because it is financed with a flawed statement of federal-state matching payments. In this arrangement, if a governor of a state wants to cut their state's Medicaid costs, they have to cut the program by $2.32 to save $1. Not surprisingly, most state politicians do not find this to be attractive.

The federal tax treatment of employer-sponsored coverage provides a similar incentive for higher costs. Rather than economizing, its unlimited tax break for health insurance premiums means that health benefits are preferred to cash wages

in many instances.

The key question is: what process is most likely to succeed in bringing about continual and rapid improvement in the productivity and quality of patient care? That is what is needed to slow the pace of rising costs. One view is that the government can help engineer more cost-effective health care delivery. That is the thought that animated the accountable care organizations in the new health care law, the Medicare pilot projects, the $10 billion Center for Medicare and Medicaid Innovation.

But that has been tried, even though not in such a large way, but it has been tried many times in the Medicare program, in the past. And it has failed. There is an alternative, and it is a functioning marketplace with cost-conscious consumers. In 2003, Congress built such a marketplace for the new prescription drug benefit. There is a competitive structure with a defined contribution fixed independently of the plan chosen by the beneficiaries. At the time of enactment, there were many pronouncements that it would never work, that no plans would participate, that it would be too complex, that the beneficiaries would prefer a one size fits all program run by the government, and the government could negotiate a better deal on its own. All of those assumptions were proven wrong. The program has come in 40 percent below expectations, in terms of

costs.

We need to do something similar in Medicare, in the rest of Medicare, on a prospective basis. As Chuck mentioned, these reforms in Medicare can be the same as they are in Social Security. They do not have to affect existing beneficiaries, or even those who are about to enter the program. On a prospective basis, we need to model the rest of Medicare, something along the lines of what we did in the prescription drug program.

In Medicaid, a similar approach would allow for more seamless coverage between those who are on the Medicaid program and those who earn a little bit more and move into the working-age private insurance system. As it stands today, when someone leaves Medicaid, they often have a spell of un-insurance because there is no coordination between the public program and private coverage.

In the employer setting, if we move to a tax credit approach that is universal for all households, it would be, in a sense, a universal coverage program. Because if someone did not take up this tax credit and use it to buy insurance, they would forgo the entire amount of this new subsidy. So it is, in this sense, a universal coverage program that would allow everybody in America to have a good health insurance plan.

Finally, I would just note that some have said that this shifts all the costs on the beneficiaries. That is only true if

there is no productivity change from this kind of a shift. But if you assume, as I do, that moving toward this kind of an approach actually changes the dynamic of the health system toward higher productivity, higher quality, more patient-focused system. Then we can actually get a better system that is fiscally sound, as well as better for the patients. Thank you.

[The statement of Mr. Capretta follows:]

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Chairman Ryan. Thank you. Mr. Van de Water.

STATEMENT OF PAUL N. VAN DE WATER

Dr. Van de Water. Mr. Chairman, Mr. Van Hollen, and members of the committee, I appreciate the opportunity to be here this morning. As you, Mr. Chairman, and my colleagues have already stated, Social Security, Medicare, and Medicaid are bulwarks in protecting the health and retirement security of America's seniors and persons with disabilities. Nonetheless, increasingly, we are seeing proposals to restructure these programs in ways that would undermine their ability to protect against the risks of income loss and high health care costs.

Some propose making large cuts in scheduled Social Security benefits, or partially privatizing the program. Others suggest phasing out traditional Medicare and replacing it with vouchers to purchase private insurance. Still others would end the state-federal partnership in Medicaid, and substitute a fixed federal block grant. In my view, these proposals all share serious deficiencies.

Few seniors are living on Easy Street, and most have little capacity to bear additional economic risk. Social Security benefits are modest. The average Social Security benefit is only $1,175 a month, or about $14,000 a year. That is not quite 30 percent above the poverty line. Some 95 percent of

beneficiaries receive benefits of less than $2,000. Moreover, most beneficiaries have little significant income from other sources.

Dependence on Social Security rises with advancing age. As fewer people work, out of pocket health care costs rise, and other income sources are depleted. Social Security will be even more critical for today's younger workers when they retire, since few of them will be covered by employer-sponsored and fine benefit pension plans.

Social Security, Medicare, and Medicaid are also highly cost-effective. Their administrative costs are low, and the new universal coverage of Social Security and Medicare holds down benefit costs by protecting against adverse selection in purchasing annuities and health coverage.

Mr. Chairman, in your opening remarks, you talked about how changes are needed. And with that I agree. Social Security's solvency should be strengthened, and further efforts are needed to slow the growth of health care costs. But where I disagree with some of my colleagues, and perhaps with you, is on the solutions. Social Security can be made solvent through modest changes, and it should. And second, an important thing to do, as Dr. Rivlin has also said, is to move forward effectively to implement the Affordable Care Act and the cost containment measures that have already been enacted.

In my view, the fundamental structures of these programs are sound, and they can be improved, and our country's fiscal situation strengthened, by making incremental changes, and without fundamentally changing the nature of what we have today. Thank you very much.

[The prepared statement of Mr. Van de Water follows:]

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Chairman Ryan. Thank you very much. We will recess until we come back, then we will start with questions.

[Recess]

Chairman Ryan. Dr. Rivlin, I want to give you a chance to expound upon your earlier comments with respect to your Medicare reforms; you have pioneered a lot of this. The Domenici-Rivlin plan, how it is different from the one that you and I authored, phase-ins, the treatment of traditional fee-for-service, and why you made those decisions.

Ms. Rivlin. Yes, Mr. Chairman. I think the main difference is the phase-in. What you had in the roadmap, and we retained it in the version that we did together, was a very slow phase-in that would give the premium support only to new applicants, that is new eligibles, as they became eligible for Medicare in 2021. And they would not be allowed to stay or to go into the fee-for-service system, although everybody who was already in it would be staying in it. And that means that, even after 10 years, there would only be people under 75 in Premium Support.

When we did the Domenici-Rivlin plan, we wanted to phase it in much sooner. And we thought that putting an option out there for everybody to be in Premium Support would put downward pressure on all health costs, because the private plans that were competing in the Premium Support system, we hope, would be

providing service more efficiently. And if the people elected state in fee-for-service, and that went up faster, they could choose a more efficient plan. So that was the reasoning.

Chairman Ryan. In your fee-for-service structure, which would occur alongside your premium support structure, you proposed balance billing in the fee-for-service side? You are capping at certain rates, as you know.

Ms. Rivlin. Yes. I think we did not work out all the details of how it would work, but the concept was that if the cost, the average subsidy under the fee-for-service system, was rising faster than GDP plus one then people who stayed in it would have to pay an additional premium. I think we would have to put together parts A and B, and maybe D, but we already have a premium in B, so if you put those two together, you have a mechanism for charging a premium.

Chairman Ryan. I see, so it is a defined contribution fee-for-service system, capped at the same growth rate that the premium support system is capped at.

Ms. Rivlin. That is the basic idea.

Chairman Ryan. Yes, and if cost pressures occur higher than the beneficiary would bear the difference. And you would give them the ability to do that, meaning the ability of providers to get that.

Ms. Rivlin. Right.

Chairman Ryan. Yes, okay. Mr. Blahous. I heard about this morning, I did not see MSNBC yesterday. But the Senate Majority Leader Harry Reid said that he would consider looking at Social Security quote, “two decades from now,” end quote. You touched on this in your testimony, but could you specifically describe the effect of waiting to reform Social Security on those who are in or near retirement? And what effect would that have on younger generations if we wait to address Social Security reform two decades from now?

Mr. Blahous. Sure. As I indicated in my written testimony and oral remarks, delay basically concentrates the effects of any adverse consequences on a shrinking number of people. And so any particular generation is going to be harder hit the longer you delay. Now, waiting all the way until the 2030s is basically a nightmare scenario from the standpoint of younger generations, because basically you are completely exempting the baby boom generation, which is a historically large generation, from making any contribution to the problem. The consequence is that, if you hold off until the 2030s, you are in a position where either you are going to have to reduce benefits fully by a quarter, roughly, or increase worker tax burdens by roughly one-third, or a combination of those two very severe outcomes.

I think there is another very important point to make, which is that delay brings into fundamental question whether we

can fix the system at all. Remember, in 1983, we came within months of not being able to send out the checks. It is hard to fix Social Security, simply because Republicans and Democrats disagree. And they disagree under the best of circumstances. Right now, the long term Social Security shortfall is already substantially bigger today than the one they fixed in 1983. If you measure it by the same methodology, the accounting methods have changed since then, so a lot of people do not realize this, but if you measure it the same way, we already have a bigger problem to solve.

As this problem mounts and the gap that Republicans and Democrats have to close with each other gets bigger and bigger, we increase the risk that we may not be able to get an agreement on a solution, and have a chaotic and disruptive consequence.

Chairman Ryan. The present value of the unfunded promise is 5.3 trillion, is that correct?

Mr. Blahous. Right. The last trustee's report, it was $5.4 trillion in present value, and that assumes the trust fund is an asset. If you count the general revenue obligations to the trust fund, it is about $7.9 trillion in the last trustee's report.

Chairman Ryan. And if we delay, every year, how much, on average, does that increase by every year of delay?

Mr. Blahous. It is in the hundreds of billions. Having

the liberty of some imprecision, my guess, the 75 year shortfall probably rises by about $400 billion a year in present value. That is a rough guess. The so-called infinite horizon's shortfall would rise by more. But even this, I would submit, understates the true cost of delay. Because the true cost of delay is affected by the fact that we do not want to cut benefits for people once they hit the rolls. So you have a bigger share of that shortfall that is politically inviolate.

Chairman Ryan. How confident are you on these projections? The reason I ask that is, we were told just a year ago, or two years ago, we were going to have Social Security surpluses through 2017. Then we had these economic problems, and now CBO is telling us we are going to have permanent cash deficits from now on. So, permanent cash deficits starting in 2011, when we thought we were not going to be in that situation for another six years.

Given the deterioration of what we call baselines, the economy, what is the downside of all of this?

Mr. Blahous. Well, this is very important, because the trustees' projections have long been subject to debate. Are their projections too optimistic, are they too pessimistic, what have you? So there is a range of uncertainty around the projections. I think the most important thing to understand, that even with a great diversity of possible outcomes, for

fertility, for longevity, for economic growth, the system is going to become insolvent sometime within the next half century.

And there is just as much risk that the problem will arrive much sooner, as there is reason to hope that it might be delayed by a few years. There is a 95 percent confidence band in a probabilistic analysis that the trustees perform each year. Last year there was not a single scenario in that 95 percent confidence band where the system did not become insolvent. So the chances of this problem not happening is almost negligible.

Chairman Ryan. Mr. Capretta, you touched on this a little bit in your testimony. We spend more money on health care per person than any other industrialized country in the world, by about two and a half times, I think. So we spend a lot of money on health care, just through taxpayers. As you mentioned, between Medicare, Medicaid, the tax exclusion, that is something like 4.5 trillion over the next ten years. And that is, I think, a low-ball estimate. That is just for Medicaid and the tax exclusion, I think, for the under-65 population.

And clearly these programs are growing at such an unsustainable rate that they will crash the economy, bring insolvency, and give us a debt crisis. And a core problem with that, and I think everybody agrees with this, is health inflation. So, how do we get at the root source and cause of health inflation? There are basically, from my perspective, two

schools of thought around here on how to do this. One is, have the government more firmly involved and more centrally directing the system in reforms through various mechanisms, formulas, price controls and things like that. The other is more of a consumer-directed, patient-centered system, to try and inject competition into the system, like we have seen in other sectors of our economy.

I am trying to do justice to both schools of thought. But what I am trying to get at is, how do we get ourselves on a virtuous cycle? Because we are in a vicious cycle right now. The more money we put into it, the more inflation gets out of our control, the worse our deficit and debt become. How do we get this sector of our economy operating like the other sectors of our economy, where we are improving productivity, where we are actually lowering price increases, where we are actually rewarding performance, where we are actually increasing quality, lowering costs? And a lot of folks say, “We just cannot do this in health care, because health care's so different. Health care is, you know, a personal issue, it is so different.”

The reason I can see you, and your name, and the clock, is I got LASIK surgery, you know, 10 years ago. And LASIK surgery is an out-of-pocket expenditure. It cost me $4,000, then. I got it in Madison, at this place called Davis Duehr Dean, and ever since then, they have revolutionized this Excimer laser

three times. It costs about $1,600 now. So the price has gone down, the quality has gone up. And that is just one area in health care. But it strikes me that it is not as if this sector, large sector, very important sector of our economy, is not immune from those market forces occurring.

So how do we get ourselves onto a virtuous cycle, where we are stretching our health care dollars more, we are getting better quality in health care, and health inflation is not destroying our system, in health care and our budget?

Mr. Capretta. Well, I very much agree with your premise here, which is, that is the key. How do we get on that virtuous cycle? And I do think the answer is to move away from a system where, on the margins, the Treasury is paying for a good portion of the cost inflation. In other words, what is happening today is that taxpayers are essentially underwriting extra inflation, because the way Medicare operates, the way Medicaid operates, and the way the employer-based system operates, as premiums go up, and automatically part of it is paid for by the tax system. That takes a tremendous incentive out of the system to adjust itself.

So I think the first step is to recognize that government budget policy is already part of the problem. And addressing that, then, can start to have the opposite effect.

Now, when I was last before this committee in January, this

same topic came up quite a bit with, the witness who preceded me made a lot of news, it was the Chief Actuary for the Medicare program. He was asked about this a number of times. And his response was, very cautious; I do not want to speak for him. But he basically said, there is a hope that, when you move toward a system where consumers have limited support from the government, but also freedom to choose, that that will then incent, through competition and choice, the kind of dynamic you just referred to.

And he also said, and I think this is very important, that it is not clear that the other approach, the approach you described, Mr. Chairman, that a centralized management of the system can get that kind of productivity leap that we really need. And in fact, if you look at the history of how Medicare has operated over the years, there is a strong incentive in the program. To really get productivity improvement, you have to start making choices. You have to say, “This delivery system is highly efficient, and this other one is not. And we are going to reward the high efficiency one.” Okay.

The Medicare program has a very difficult time doing that, because you have to pick winners and losers. The private system can do that a lot better than a public system. The public system ends up saying, usually, “We are going to pay everybody the same, at a low rate.” That is how they cut costs, okay.

But to really get productivity improvement in the health system, you have to start saying, “We are going to reward the high achievers. We are going to reward high value and low cost.” And to do that, that usually happens more easily in a market system than in a government system.

Chairman Ryan. I could go on but in the interest of time, Ranking Member Mr. Van Hollen.

Mr. Van Hollen. Thank you, thank you, Mr. Chairman. I am going to, I guess I will come back to that. But just to follow up on that point that was made. I think the American people would be surprised to learn that the private insurance market is working really well in terms of cost containment. As I referenced in my earlier remarks, between the years 2000 and 2008, health care premiums doubled in the individual private markets. So this is part of a larger conversation on the whole health care thing.

If I could, Dr. Rivlin, I want to turn to health care in a minute. But first I want to address a couple of the other, larger issues with respect to our efforts to reduce deficits and our debt. And I want to thank you for your service to our country, in many capacities, most recently, of course, both as a member of the President's Bipartisan Fiscal Commission and as the co-chair of the Rivlin-Domenici Commission.

Now, with respect to the Bipartisan Fiscal Commission, you

of course, supported the final result, but you made some important comments in your letter accompanying that report. And, with respect to the fiscal commission report, you said, and I quote, that you "would have shifted the plan's overall balance more toward revenue increase and less toward spending cuts," end quote. And then you went on to say, quote, that you "do not believe it is wise, or even feasible, to cap federal revenues at 21 percent of GDP."

Now, we have had a conversation this morning, a little bit, about how this is a very important subject that we are tackling today. But really, to get to the bottom of the deficit, that issue, we have got to expand that issue. I would say that, there is an article in The Wall Street Journal today that Mr. Camp, the Chairman of the Ways and Means Committee, is going to try and bring down the top marginal rate to 25 percent. I don not know how he is going to do it, but it will be a huge, huge tax break, again, for the folks, highest income folks in the country.

So if you could just explain what you meant when you said, quote, you "do not believe it is wise, or even feasible, to cap federal revenues at 21 percent of GDP."

Ms. Rivlin. Right. We have this surge of retirees moving into our retirement programs. We have talked about this all through this hearing, how that puts upward pressure on Social

Security spending, Medicare, and Medicaid. And although I support the reforms that will bend the curve in health care and I want to put Social Security on a firm basis, I don not believe it is realistic that we are going to be able to do the right thing by this much larger aging population and hold federal spending and revenues at 21 percent.

So, in the Domenici-Rivlin plan, it goes up to 23, and I think that is more realistic. But we are going to have to fight hard to stay there. The upward pressures on the health care spending programs are enormous. And the challenge is very great.

And as to tax reform, I saw the article about the Camp plan, and he served with Chairman Ryan and myself on the fiscal commission. The mistake there, I think, is to make it revenue-neutral. We are going to need more revenues. We need tax reform. And I think the kind of reform that Representative Camp is talking about is feasible, it is feasible to bring the rates down, but only if you get rid of almost all of, the loopholes and special provisions. And those go to upper income people differentially.

So you can have a tax reform with lower rates and still have a more progressive impact. And we show how to do that in the Domenici-Rivlin plan.

Mr. Van Hollen. Thank you. According to The Wall Street

Journal article, if you brought the top marginal rate down to that level, you would have to find $2 trillion in savings through the other deductions, over the next 10 years; big, big number, when we say we want to reduce deficits and debt.

In your letter accompanying the Fiscal Commission report, you also said, and I quote, you "worry that cutting discretionary spending sharply as soon as fiscal year 2013 may slow the economy," end quote. As you know, HR 1 that passed in the House, cut significantly deeper, even immediately. We have recognized that we all have to tighten our belts, but given the fact that you were worried about the impact on jobs and the economy of immediate, deep cuts by 2013, I assume you have similar concerns about immediate, deep cuts of the magnitude we are talking about, on the economy and jobs.

Ms. Rivlin. I think the cuts in 2011, which we are halfway through already, would, of the magnitudes being talked about by the Republicans would be ill-advised. But my main problem with that is, it is a distraction from the long-run problems that we are talking about today, which are the really important things to think about as we bring our debt under control.

Mr. Van Hollen. Right. And let me get now to the question of the Medicare reforms that you have been talking about. Because as you know, when Congress established Medicare back in the 1960s, one of the main reasons we did it is because seniors

and disabled citizens had a very difficult time finding affordable health care, given the health care risks they posed. That was the whole engine behind Medicare.

Now, we have already tried several efforts at privatizing different parts of Medicare. You referred to one of them in your testimony, with respect to the Medicare Advantage plans. What we have discovered so far is that, in order to prevent some of them from dropping out, they actually had to increase the federal taxpayer subsidy beyond the subsidy for the fee-for-service Medicaid, up to 114 percent.

So here is my question. In your proposal, you say you want to put in this voucher, premium support program, whatever you want to call it, by the year 2018. You have also said that you strongly support the Affordable Health Care Act, and that it would be a big mistake to get rid of it. And you have commented about the importance of the exchanges, which are set up under the Affordable Care Act, which as you know, would take place in the year 2014.

So my question to you is this, that will give us some sense, will it not, about the extent to which this kind of exchanges and premium support can, in fact, lower costs? And why would not we make sure that we wait to see how effective that is, before we make the decision to experiment with the folks in Medicare? And maybe that was the purpose of your

timing, for 2018. But it seems to me that we have a lot of people who are not insured, who are going to come into this exchange seeking more affordable health care. Let's see how it works on them, 2014, before we turn all the seniors in Medicare into this experiment. What do you, what, what do you think of that?

Ms. Rivlin. Well, in the first place, we did not turn all of the seniors in Medicare in to this program. We gave them an option starting in 2018, by which time we hope we will have some experience with exchanges. And this would be a new Medicare Exchange, a national exchange, rather than state by state. But I think the importance of beginning to reform Medicare is that if you keep waiting until you get more evidence, you have the same problem that Charles Blahous was talking about. The longer we wait before we start doing something, the more expensive it is and the harder it is. So, I think 2018 is not too soon to offer an option to seniors to be on a well-organized exchange.

Mr. Van Hollen. Yes, my point was that we will have a pretty good idea in the year 2014, so I guess your timing would work. In other words, if that experiment was great, you know, but, but I just would not want to make a decision today with a pretty fragile population. Because it does shift the risks of increasing health care costs more onto the recipients, on the seniors.

Ms. Rivlin. If they choose it.

Mr. Van Hollen. Right. Well, as I understand it, either way. In other words, either you stay in the traditional Medicare system, but if the costs there rise faster, you have to pay more, or you get a voucher, where if it does not keep pace with the cost, you have to pay more. But I do not want to get in great detail right now, because I have limited time.

Dr. Van de Water, one of the proposals that has been kicking around out there is to block grant Medicaid. In other words, say, the federal government is going to hand over its entire share of Medicaid to the states, no strings attached, blank check, do what you want with it.

Now, I think you know that under Medicaid, while the majority of recipients are not seniors in long-term care and disabled individuals, at least 50 percent of the money spent in Medicaid goes there. Could you talk about what impact a block grant of Medicaid would have, on all the populations? Because at the end of the day, I think people are going to have to ask themselves the question: which populations do they want to drop? Or what benefits do they want to drop? And I would just end by pointing out what you did in your testimony, which is, under Medicaid, in fact, the growth in costs has been far lower than in the private insurance market. If you could just comment on that.

Dr. Van de Water. Yes, Mr. Van Hollen. From my point of view, shifting Medicaid to a block grant, changing the current federal-state partnership to some extent flies in the face of how one should construct a sound federal fiscal system.

First of all, it is quite clear that only the federal government can take responsibility for counter-cyclical fiscal actions, and clearly Medicaid is a very cyclical program. Costs go up substantially in periods of economic downturn, as we are still experiencing. And secondly, there is also a limited extent to which states can take responsibility for helping low-income people. States have to maintain a competitive tax situation. So no one state can get too far ahead there. So for both of those reasons, it is important that the federal government play a major role in Medicaid.

The proposals to block grant Medicaid have as their stated aim, to reduce federal spending. And the result, therefore, is to place increasing burdens on states. The block grant proposals typically have, as part of them, elements that would further increase state flexibility in Medicaid. But I think of all the evidence suggests the room to increase efficiencies in Medicaid is quite limited, for precisely the reason that you indicated; that as in health care, generally a small proportion of the sickness beneficiaries account for a very large proportion of the cases.

The implication is under a block grant, states would face increasing shortfall. And they could deal with that in one of two ways, either through increasing taxes on their residents, or through squeezing beneficiaries. And again, as you suggest in your question, that ultimately many categories of beneficiaries would be affected, but certainly including particularly the elderly and persons needing long-term service and support, and children, as well.

Mr. Van Hollen. Thank you, Mr. Chairman. Like the Chairman said, Social Security, all these areas are areas we could have a full discussion. Maybe we will have a chance later to come back to it. But time is out, thank all the witnesses.

Chairman Ryan. And I just want to say, in the interest of our, our interest of having a bipartisan dialogue, Dr. Rivlin is our Republican witness who has come and spoke on behalf of the health care law. So that is how we try to do things around here. Mr. Garrett.

Mr. Garrett. Thank the Chair again for this very important meeting. I guess the seminal issue with regard to Social Security, is do we have a problem? And I say that somewhat tongue in cheek. But if you were listening to the floor this past week, members from the other side of the aisle, discussing Social Security, off other issues, but bringing up Social Security, said there is no problem. That what we are all

discussing here is fear-mongering. That there is still a positive cash flow going into Social Security at this point in time. I think we have heard it from the panel, but in 10 seconds, from Dr. Blahous or Dr. Van de Water, can we assure the other side of the aisle who was on the floor this past week that we do have a problem with Social Security, that needs to be addressed today?

Mr. Blahous. I have no qualms in saying we have a substantial financing problem in Social Security.

Mr. Garrett. And the cash flow?

Dr. Van de Water. It is clear that Social Security does face a long-run shortfall. Social Security is not running a deficit this year. One comes up with that result only if you ignore the important and substantial interest receipts that the program receives from its trust fund assets.

Mr. Garrett. But you have to consider that, correct?

Dr. Van de Water. That having been said I agree with Chuck, that Social Security is facing a shortfall that should be addressed. The question is how to address it.

Mr. Garrett. Right. And on that point will be a follow-up question, then; one of the ways, both of you comment on this, and maybe this is too simple to put it, to go back to the way FDR originally intended it. And to do so, you talked about the issue of indexing, one element of that, correct?

Dr. Van de Water. Right.

Mr. Garrett. The other element of it, though, would be, basically, a raising of the taxes, as the same tax rates, I mean the tax increase, and who would be subjected to it, the other element of that, correct? If we had done, if we do those things, hypothetically, that would solve the problem, but keep benefits at the same approximate level where they are today?

Dr. Van de Water. Well, I am not advocating this.

Mr. Garrett. I am not advocating it either.

Dr. Van de Water. Technically, if the initial benefit formula grew exactly at the rate of inflation going forward, that by itself would eliminate the financing shortfall, and you would not have to increase taxes at all. Now, as it happens, we can actually afford, then, the projected tax revenue stream, a rate of benefit growth that is somewhat in excess of inflation. And to the extent that Congress decided to increase Social Security taxes, obviously be able to pay an even higher rate of benefit growth beyond that.

Mr. Garrett. So, Dr. Van de Water, just comment on that. Because your comment before is that, saying that the rates we are paying out, benefits you are receiving right now in Social Security keeps you at just about the poverty level, per individuals. And so if we just take those steps alone, that would just basically keep people at the same level. Would you

be advocating keeping people at that level, as far as a benefit?

Dr. Van de Water. No, I would not, sir. And let me first of all say that, while I agree with Chuck on a lot of issues, I do disagree with his characterization of the original structure of Social Security. Prior to 1972, Social Security benefits were adjusted for inflation for real wage growth, on an ad hoc basis. In 1972, those adjustments were made automatic, and the process was refined in 1977, because the '72 version had a technical flaw.

But the basic approach, even before the automatic adjustments were formalized was to maintain benefits roughly constant in relation to a worker's pre-retirement earnings. And I believe that is an appropriate standard, and one we should attempt to stick with. I am not advocating against any benefit reductions, but I do think we need to look at benefits in relation to what a person earned during his or her working years, not simply in relation to the poverty level.

Mr. Garrett. I appreciate that. And very quickly, I only have a minute left, Dr. Rivlin, with regard to the proposals and with regard to premium support, two quick questions on that. One of the problems with premium support, I have heard, I think actually from folks in the Brookings Institute, is that the adequacy of that support going forward, and you touched upon this in your testimony, and whether or not that can actually be

capped later, basically put an adequate level without coming back to Congress to raise that, which Congress would be probably inclined to do, as we have with Doc Fix and otherwise. And secondly, the timeline to be able to implement this; you are looking at about 2018. Who would we be affecting by going to a premium support model? Would we, we would not be affecting people who are 65 or older, but would we be affecting people younger than that? What would the implications be of that?

Ms. Rivlin. In the proposal, as we drafted it in Domenici-Rivlin, in 2018, everybody who was eligible for Medicare would have the option, but it would be an option of moving into premium support instead of staying in fee-for-service Medicare. And there might be an advantage to do that if, as we hope, the competition among clients does give people better care at a lower cost. But they would not have to move.

Mr. Garrett. Right. And the issue on the premium support, the fact that the adequacy of that premium support would be adequate over time, short of coming back to Congress and seeking additional appropriation as that amount goes forward?

Ms. Rivlin. That is a question, really, because we cannot tell what will happen to health care costs. If the reforms in the Affordable Care Act, and all of those pilots about better payment systems and better delivery systems, if those produce good results, and I am hopeful that they will, then premium

support would be a mechanism for the plans choosing the best results and, but we cannot really tell. I think there is a good deal of uncertainty about whether the pilot programs and the research and all of the things that were called for, will actually produce results.

Mr. Garrett. Thank you.

Chairman Ryan. Thank you. Ms. Schwartz.

Ms. Schwartz. Thank you, Chairman. And thank you to the panel. I was going to, I would submit, to everyone in this panel, I am going to submit for the record, a correction from the last hearing we had, nothing to do with the current panelists. Because I wanted to call attention to an incident that occurred at last week's budget hearing, in which a colleague of mine not only attributed false statements to me, but also breached the basic rules of decorum and civility in the house. He is a freshman, so he may not have understood those rules.

But, I do not want to take the time at this hearing, but I know a colleague of mine had to do this before. But he really attributed false statements about an hour and a half, two hours after I made them. And I will submit, for the record, a repeat of what I said last time, about how we got to where we are over the last decade, before the great recession. Just a couple of years ago, relating particularly to Part D expenditures, the two

wars that were not paid for, and the tax cuts that were not paid for, and how that attributed to the fiscal problem. I think the panelists would understand what I am talking about, but it really is a point for the record, for some of the members, and the way we actually try and conduct these hearings. And I know the Chairman was not here, I do not think, but I think he would have been equally distressed by them, had he heard them.

So let me just move on to what is really a very important topic for us to deal with, which is, of course, cost containment and entitlement reform. Two questions I am going to try and get to in my time, which is that, one, as Dr. Rivlin pointed out, there are really important reforms and modifications and flexibility provided, in the health law, related to paid performance for hospitals, the different kind of payment opportunities in accountable care organizations and health innovation zones. I believe many people have said we have incorporated into the health law all of the good ideas about how we can both improve quality, improve outcomes, and reduce costs over time.

You pointed out, there are no guarantees, but there is enormous opportunity to do that. And I just wanted you to really reiterate how your feelings about the importance of implementing those reforms, and what repeal would do, if we were to take away those opportunities and begin again, and not in

fact, move our providers and all the payment systems to a better system of reimbursement and improved quality.

Ms. Rivlin. Right. I do believe that almost every idea about improving quality and reducing cost was incorporated in some way, usually as a pilot program, into the Affordable Care Act. And we need to fund it, and we need to record the results, and get them out there so that people can see what is a better system.

Ms. Schwartz. And to grow them. The word "pilot" sometimes means to people that we are going to just do a few of these. The difference between a pilot and a demonstration, as you know, is that they can grow, they can be as big, they can be used as much as we want them to.

Ms. Rivlin. Yes, and if they work, they can influence the whole system. So I think there is great potential there. I also believe in the exchanges. And that we need to fund those, get them working well, and see if this approach does produce good results.

Ms. Schwartz. Right. And the purpose of those exchanges is, as you know, is because the individual marketplace is such a failure in this, the private market. The individual marketplace is the most expensive and inaccessible, that it is very difficult for individuals to buy affordable coverage, meaningful coverage. And so, the reason for the exchanges is just that, is

to help provide a marketplace where they can compare coverage. And we do not know how that is going to work, but we do know that you have to fix a failed system that does not provide for that.

And yet, your suggestion is that we offer to seniors some support, for them to be able to buy insurance in an exchange. And yet, healthy, younger individuals have had a very hard time buying insurance. Do you think that only the healthiest, youngest seniors would be able to find affordable, meaningful coverage in an exchange, and only the very sickest seniors would stay on fee-for-service Medicare, making fee-for-service Medicare even more expensive per person?

Ms. Rivlin. No, not if we were to set up the exchanges in the way that we envision.

Ms. Schwartz. So you are saying there really have to be regulations, this would have really clear federal regulations on the way it would be done, for it to work?

Ms. Rivlin. Yes. It has to be an organized exchange in which they have clear choices.

Chairman Ryan. Thank you. Mr. Akin.

Mr. Akin. Thank you, Mr. Chairman. Just a couple things that I have noticed in some of the questioning, and it is an interesting point, and that is that supposedly a lot of cost growth in private insurance. Now my understanding, and anybody

wants to take a shot at this they can, Mr. Capretta, maybe start with you. My understanding is the reason for the cost growth in private insurance is because of cost shifting.

I mean, when I think back, I am getting a little long in the tooth, before the Civil War, maybe not quite that bad, but, it used to be that a lot of people had what is called a major medical policy. And those were pretty reasonable and affordable policies. But over time, as different corporations and all would bid the price, they would get discount prices on health insurance that was then balanced, the major medical policy had to pick up the difference from the hospitals. It is my understanding there was cost shifting. Is that why it would appear sometimes that a private policy looks like it is going up because it is really paying for other people as well? And if not, what does cause it to go up?

Mr. Capretta. Well, I think that could be part of it. Certainly there is lots of evidence that public programs paying below market rates does result in private insurers being charged more for similar treatments that then drive up premiums on the private side. So that does occur. But I think the issue in the private health system is, we do not really have a marketplace today, actually.

I think, fundamentally, it is incorrect to sort of say that we have a private market in health insurance today, in large

part because it is dominated, of course, by employer-provided insurance. And that insurance enjoys a tax break, federal tax break, that then most observers of the health system have said, over the years, contributes substantially to, you know, moving more compensation into health and out of cash, okay. So one reason why people's wages have not gone up very much in the last 10 or 15 years is because so much of it has gone toward health care. And that, then, contributes to health inflation, as well, okay, so I think it is really incorrect to think that today's system is an observation of a private economy at work, because it is sorted very substantially by the current federal tax break.

Mr. Akin. So I think the Chairman's example of LASIK surgery would be more like a free market, because the government was not involved in that at all. It was a cash-type business, and as the years progressed, the technology improved. And the price goes down, the quality goes up. So that is more of an isolated, free market system, while you are saying the other is very heavily influenced by all of the other players, first of all a tax policy for big corporations, and second of all, the impact of Medicare and Medicaid in the other place.

Mr. Capretta. That is correct.

Mr. Akin. Okay. The second question, there was discussion, and this is sort of interesting. I have heard on

this committee a number of times, repeatedly, mostly from the Democrats, that cutting government spending could hurt the economy. And that is sort of a weird idea to me. I always thought that we had examples from JFK, and Reagan, and Bush, that when we would reduce taxes, we could keep government spending down that tended to help the economy grow. Relative to what we are talking about here today, if we try to do some things in Social Security where we are not spending as much on Medicare because we have come up with a better system, does that endanger the economy, or does not that really make the economy stronger, if we can address the tremendous deficit that we are looking at?

Ms. Rivlin. Let me try that. I think, when you are in a recession, or coming out of a recession slowly, as we are now, there is a risk that if you cut government spending too rapidly, you will endanger the recovery. But in the long run, the biggest danger to our economy and our future prosperity is the rising debt that we are facing, for all the reasons we have been talking about here. And I think the major point that people ought to keep in their heads is, if we have a debt crisis, then we will have a deeper recession than we are in now, and it will be harder to get out of it. So the point is, we can have any size government we want, but we have got to pay for it.

Mr. Akin. I appreciate your answers. Thank you, Mr.

Chairman.

Chairman Ryan. Mr. Doggett.

Mr. Doggett. Thank you, Mr. Chairman. I certainly agree with you that we need a serious discussion with the American people about these issues. I think, though, that the issue is whether or not that discussion is narrowed to the sole question of how Americans want to compromise and reduce the level of their retirement security. And I think we need a much broader focus.

Dr. Rivlin, you testified yesterday, along with the former Republican Chairman of the Senate Budget Committee.

Ms. Rivlin. I do not think he is a former Republican, he is a former Chairman.

Mr. Doggett. No, he is an active Republican, but he is a former Budget Chair, to be sure, Senator Domenici. And you both testified, I believe, that you can do all the things that you talked about this morning, and the other witnesses, with reference to retirement security. And if we fail to include the revenue side, as you responded to Mr. Van Hollen, if you fail to address the revenue side, we will fail to get our fiscal house in order, is that correct?

Ms. Rivlin. Yes, I believe that we cannot cut spending, especially as the baby boom generation retires, enough to solve this problem, on the spending side alone.

Mr. Doggett. At a time when the revenue to Gross Domestic Product, or economy ratio, is at the lowest level in over 60 years, you certainly did not embrace the notion that the Republicans are advancing, in today's Wall Street Journal, that we can add another $2 trillion of tax cuts to the burden that we already have, with reference to debt, did you? Neither of you.

Ms. Rivlin. I do not read Mr. Camp's proposal as adding $2 trillion. The thing that distresses me about Mr. Camp's proposal is that he says it is revenue-neutral. And I do not think we can afford revenue-neutral. We need more revenue going forward.

Mr. Doggett. And Senator Domenici agreed with you in testimony yesterday. And I think the problem here, we talk about a serious discussion, is that that serious discussion really needs to begin in the House Republican Caucus. The mythology that we can assure our military security, our educational security, our retirement security, without any additional revenue, is a mythology that just does not comport with reality and the challenges that our country faces. And very interrelated, as you pointed out this morning, is this question of rising health care cost.

And I think you would agree, Dr. Rivlin, that when you talk about Medicare and Medicaid, we are really talking about parts of a broader question of how, in America, we can continue to

improve the quality of health care and contain the cost of that health care in a way that it can be affordable for the taxpayer and for the individual. And with reference to that, I do not know of a broader attempt to deal with this difficult issue, did not go far enough, in my opinion, but a broader and more comprehensive attempt, than the attempt to rein in health insurance monopolies last year through the Affordable Health Care Act. Just one example of our efforts that I know you support its comparative effectiveness.

Republicans keep saying, they do not want to know what works. They have attempted to limit the funding for implementation of looking at comparative effectiveness plans. They do not want to eliminate their privatization experiment with paying $1,100, $1,200 more per beneficiary of Medicare advantage, another way that we sought to reduce cost. You certainly support comparative effectiveness investigation, do you not? To be sure we know what works?

Ms. Rivlin. I do. And I think the Affordable Care Act contains many provisions that would help us learn how to deliver more effective care, and at lower cost.

Mr. Doggett. Now, Dr. Van de Water, my concern is about shifting more risk to individual retirees. And I know Dr. Blahous, having been the Executive Director for the Bush attempt to, what we feel is to privatize Social Security, feels that

that is a better way to go. But is it your feeling that privatizing Social Security and shifting more risk by eliminating Medicare for those who are 65 or 66, and moving to a voucher plan, that that will provide either the fiscal security or the retirement security that generations of retiring Americans need and deserve?

Dr. Van de Water. Well, let's distinguish, look at both Social Security and Medicare, briefly. As far as Social Security is concerned, I think Social Security's importance should, you know, should be maintained in the future, particularly in the light of the shrinkage of defined benefit pension plans in the private sector. I sometimes describe Social Security privatization as an idea whose time has passed. At one point, when large numbers of workers had defined benefit pension plans, there was an argument that putting that together with Social Security meant we were over-weighted in that direction. That certainly is not the case today.

Social Security is now going to be the only defined benefit pension plan that most workers have, and I think it is important to retain that as a base on which people can build their 401(k)s, other retirement arrangements, and their personal savings.

As far as Medicare is concerned, I think, as the dialogue this morning has already confirmed, I mean, particularly the

discussion early on between the Chairman and Dr. Rivlin, the details of how a premium support plan is set up are very important. Congresswoman Schwartz asked, a moment ago, about the structuring of the market that would be required. Now, I am not a great fan of premium support under any circumstances, but in the form that Dr. Rivlin has laid it out, in her proposal with Senator Domenici, they have attempted to deal with these issues. In other versions, those issues are not dealt with as well.

Chairman Ryan. Thank you. I just want to keep the time going, so everybody has a chance.

Mr. Doggett. Thank you, Mr. Chairman.

Chairman Ryan. Mr. McClintock.

Mr. McClintock. I would begin by pointing out to the gentleman that revenues are important, and they come in one of two ways. Revenues come from economic growth and expansion; that is the healthy way. The unhealthy way is by extracting higher taxes at the expense of economic growth and expansion, and that ultimately becomes a self-defeating exercise.

I wanted to follow-up on Mr. Akin's question regarding the private health market. The Chairman makes a very good point. He references his LASIK surgery, that is entirely done outside of the government, or private insurance markets, simply a cash transaction. As he described that, I was reminded of whole-body

imaging. We are seeing the same thing there. We are now seeing reports of general practitioners that are simply withdrawing from the insurance market, withdrawing from the government support market, and simply going on a cash basis, fees-for-service, entirely outside of that process.

So, Mr. Capretta, you mentioned that a lot of the costs, and of course, the Ranking Member also makes a good point, that "Hey, the private insurance market has doubled in cost between 2000 and 2008." Mr. Capretta, you make the point, a lot of that is government intervention. Is that the principle cost driver in the private insurance market? Because we are certainly seeing a decrease in costs, and an increase in quality, in the cash market.

Mr. Capretta. You know, this is a very important question. I would argue that the number one reason why our health delivery system looks the way it does today, actually, the number two reason is probably the employer tax provision. But the number one reason is actually Medicare fee-for-service. Medicare fee-for-service, good as it is in terms of providing security to our elderly population, the health system has basically been built up around its structure. And the way it works is that you have a fee-for-service insurance program. And most seniors also have, in addition to that, supplemental coverage. So between retiree wraparound plans, Medigap plans that they buy in the

private market, or Medicaid for the low-income seniors, the vast majority of seniors at the point of service pay no additional cost sharing.

So fee-for-service only really works if there is some cost sharing on the part of the participant. Because, otherwise, you know, it is a, basically, a claim gets filed, it gets paid by the government. So if the beneficiaries are not paying anything at the point of service, and the government is paying, you know, claims any that come in, you have got a system that is really built for volume. And our whole, much of our medical system has been built up around that.

There was a very famous article, well-known article, that was written a year or so ago, in the New Yorker Magazine, by Atul Gawande, about McAllen, Texas, and how they have a high volume, very intensive delivery structure. Why did that happen there? The number one reason there was Medicare fee-for-service. It is a good program in the sense that it is providing good security, but it is driving fragmentation and lack of coordination in our health system in a way that is very costly.

Mr. McClintock. So have we entered a vicious cycle, where the principle cost driver in the Medicare system is rising medical costs, and the reason for rising medical costs is government interference?

Mr. Capretta. Well, there is some truth to that, yes, that

it is sort of a circle, yes. That government policy is driving up costs, and then, to try to make up for that, they cut fees. In other words, the predominant way of trying to get costs under control over the last, I would say, 30 years, has been to reduce the payment rates that public insurance has paid for individual treatments in a fee-for-service environment. There have been some other efforts around that, but the main way has been to try to reduce the fee structure. That tends to then also drive up volume even more. So it has gotten into a little bit of a cycle of cost increases, pay cuts, cost increases, and pay cuts.

Mr. McClintock. Mr. Blahous, is there any way for us to honor the commitments we have made to everybody in the Social Security system, and yet move that system to an actuarially sound foundation?

Mr. Blahous. Absolutely. But again, I would stress, it is much easier to do that the sooner you act.

Mr. McClintock. And again, very briefly, what would you recommend we do, to accomplish that?

Mr. Blahous. Well, if you are asking my policy views, I tend to regard the two biggest sources of our fiscal problem as being population aging, and growth in the per capita value of benefits. CBO did a report in 2003 where they said, if you look at cost growth and Social Security, 55 percent of it is population aging, 45 percent is excess cost growth in the

benefit formula. So I would start with both of those things. I have to think, you have to look at the retirement age, I think you have to look at the benefit formula as well.

There is also a set of changes I think, personally, should be made, to improve the program's impact on labor force participation decisions. There are a lot of aspects of the Social Security system that are designed, basically, to drive people out of the workforce, because they reflect the 1935 design. Everything from the actuarial adjustments for early and delayed retirement, to the way that your personal wage history is tracked. All of these things basically punish you if you decide to add an extra year of work and continue to pay taxes. And I think we should change some of those.

Chairman Ryan. Thank you. Mr. Yarmuth.

Mr. Yarmuth. Thank you, Mr. Chairman. Thanks to all of the panel. One of the things that becomes pretty clear when you are either discussing Dr. Rivlin and Senator Domenici's plan, or the roadmap that the Chairman has proposed, most of the ideas coming from the Republican side result in some kind of increased shifting of risk to senior citizens, when we are talking about the Medicare program. At least that is my observation.

So I would, what I would like to ask is, particularly Dr. Van de Water and Dr. Rivlin, what do you think, since we know that right now, of all Social Security recipients, senior

citizens, about two-thirds rely on Social Security for at least half their income, and one-third rely on Social Security for their entire income. How much cost-shifting or risk-taking do we think is reasonable to move toward the senior citizens under Medicare? Do you have a sense, what percentage of their income now is consumed by health care cost, and what it might be reasonable to assume we could do? What the impact of these proposals might be.

Dr. Van de Water. If I could start, and then pass it on to Dr. Rivlin. I think your basic diagnosis of the situation is correct, that we do have to be careful in avoiding shifting additional risk onto those beneficiaries who are least able to bear it. In my view, any plan to restore Social Security's solvency needs a balance between scaling back future benefits and raising taxes, and I think it has to be designed in a way that protects low-income beneficiaries. And with that, I will pass it on to Dr. Rivlin, since I think the proposal that she and Senator Domenici have made, while I would not endorse it in all respects, is a reasonable illustration of how that might be done.

Mr. Yarmuth. Yes, Doctor.

Ms. Rivlin. I think you pose the dilemma very well. We have a very expensive system of providing health care for older people, and we have more and more older people. I do not

believe that we can afford, in the long run, to keep fee-for-service Medicare, because it is going to get more and more expensive. And because of the impact, I do not agree with everything Dr. Capretta said, but it does, instead of Medicare leading the whole system toward better efficiency, it in many ways deters it.

So, we have to balance shifting more risk onto older people, and I would shift it more onto upper-income older people. And the need to get Medicare into a sustainable long-run posture, so that it is more efficient and providing better service for less money. That does not mean we are going to spend less over time; we are not going to spend as much more as we will, on this trajectory.

Mr. Yarmuth. Well, I think everybody agrees with that, that is the goal we ought to establish. The how-to is a little bit more difficult. In your report with Senator Domenici, you talked about potential savings in other areas of the government as well, and we focused today on Social Security, Medicare, and obviously they are long-term drivers of potential increase in the debt. It is my understanding that Senator Domenici and you concluded that waste and abuse in the Defense Department, if you just crack down on that, could save over $1 trillion over the next six years. Is that correct?

Ms. Rivlin. I do not remember the exact number, but we

proposed a hard freeze, meaning no increase in nominal dollars, for Defense, for five years. And we believe that we can have a strong Defense if we use our Defense dollars more efficiently. And Secretary Gates has been one of the leaders in trying to do that. It requires reform in the procurement system, more contributions to the tri-care system on the part of retirees, and a better ratio of the tooth-to-tail, as they say, in defense. And I think we can do that and still be the strongest nation in the world, by a long shot.

Mr. Yarmuth. Correct. Well, thank you for that, and I hope maybe we can have a hearing on that in this committee, as well. I would love to ask another question, but my time is rapidly ending, so I will yield back. Thank you, Mr. Chairman.

Mr. Lankford. [Presiding] Thank you very much. Mrs. Black, Tennessee.

Mrs. Black. Thank you, Mr. Chairman. And I thank the panel for being here today. I do not think there is any doubt about us all agreeing that the debt crisis is here upon us. And we all do agree on that. I know that there is a difference of agreement on what we should do on these very large programs that are consuming 60 percent of our budget. And yet, if you were to look at what the public appears to think that the answer is, they think fraud, waste, and abuse, and cutting out our Foreign Aid, will solve our problem. And, obviously, that is not going

to solve the problem. But I would like to hear from each of you, how you believe that we can get the public to understand the problem that we have, and that we need to make some changes. I would like to hear your opinion on that.

Ms. Rivlin. I think the public is actually way ahead of politicians. When you get a group of average citizens in a room and say, “Here is the problem, we have this looming debt, and if we go on doing what we are doing, we will have a huge crisis. Now, what do you think we ought to do about it?” And we have done this quite a lot. They come up with pretty sensible solutions. And they are, as in both of the two commission reports, a little of this and a little of that.

They are willing to cut benefits on entitlement programs, they are willing to hold firm on discretionary spending, once they understand what that means, and they are willing to raise revenues as well. And the evidence from groups of citizens brought together to solve this problem is, I think, rather encouraging.

Mrs. Black. Doctor, I do want to say that, what I am reading in most of the publications now, when the public is asked, they do not see Medicare, Medicaid, and Social Security as being a part of the solution. They continue to say, “waste, fraud, abuse, and cutting foreign aid.” That is what I am even hearing in my town halls, back in my district.

Ms. Rivlin. Right. But that is because they have not realized that they have to make choices. I think it is the responsibility of politicians to bring this problem home. To say, "We have to make some choices here," and not to say, "It is all very simple, it can be solved by growth," or "It can be solved by getting out waste, fraud, and abuse." That is not true, and I believe that political campaigns on both sides have not helped the public to understand, we have got a big problem here, and we have got to make choices.

Mrs. Black. Anyone else? Would you like to jump in there, Doctor?

Mr. Blahous. I would just say that, I mean, I have been working on Social Security reform for 15, 20 years now. And the one thing that I have learned is that I have no earthly idea how to communicate to the general public the real urgency of the problem. I wrote, recently, a book about Social Security reform. And I did say, in the book, that I thought our public debate about Social Security was not where it should be. And there is a lot of blame to throw around for that. And I think there is blame that goes both sides of the aisle, I think there is blame that goes to the advocacy groups, I think there is blame that goes to the press. There is a lot of blame to be allocated.

But I actually singled out, in my book, one particular

community, for criticism. And that is the community of which I am a part right now, which is the community of scholars, and academics, and people in think tanks. Because too often, I think, people in positions like mine have a tendency to want to, kind of, echo the predilections of their funding sources, or their political allegiances, when people in positions like mine are actually in a very privileged position, where we are somewhat immune from the political pressures that face all of you. And so I would point the finger of responsibility back to those of us on this panel, because I think there is a much better job that needs to be done by people in our position to explain these issues to the public.

Mr. Capretta. I am not like Chuck, I do not have any particular expertise in this area. I think you do more than me, all of you here do more than I, but I guess I would just generally say that there is a difference, I think, a little bit, between polling responses that people give to off-the-cuff questions, and a reasoned discourse that they enter into with average citizens, as Dr. Rivlin referred to. And, in general, my confidence is pretty high that in the old saying that we will do the right thing after trying everything else, right? So I think a reasoned discourse around our choices, and the difficulties of them, will lead to the correct solution.

Mrs. Black. Dr. Van de Water?

Dr. Van de Water. I think Chuck Blahous is a little bit too hard on himself. Chuck and my colleague Bob Greenstein, as Chuck mentioned in his testimony, wrote a paper a few months ago, outlining the dimensions of the Social Security financing issues and the reasons why the problem is real, and why solving the problem sooner rather than later would be a good thing to do. And Chuck and my organization do not have the same perspective on how to solve the problem, but we do agree on the dimension of it. And I think that that kind of information can be made more widely available.

Mrs. Black. Thank you.

Mr. Lankford. Thank you. Mr. Pascrell.

Mr. Pascrell. Thank you, Mr. Chairman. My friend from Tennessee asked some pertinent, interesting questions. I must inform her, and I do seriously respect your position, but that movie has been seen over and over again. We started this mess in 2001. And for me to have to sit here and listen to the reruns, instead of looking to the future, because this is what politics and government should be about. Where will our people be tomorrow, and two years from now? We heard this in 2002, we heard it in 2003. In fact, at that time, the head of OMB was Mr. Daniels. And he said then that revenues declined two years in a row, fiscal year 2004 he is saying this, the first such phenomenon in over 40 years.

Why did revenues decline in those two years? Revenues declined in 2002 by seven percent, the largest percentage decline since 1946. And, as it turned out, the 2001 tax cut was the right policy, he said. And he concluded that we need to have another tax cut, which they did, reducing revenues and, quote unquote, “strengthening investor confidence by ending the double taxation of shareholder dividends.” Thank you, Mitch Daniels.

And what did we have? No growth in jobs. Nada. Zero. I do not know how else to say it. We did not have what they said we were going to have. The greatest contributor to the deficit, look at the facts, and we go over it over and over again. Mr. Chairman, people in my district tell me they appreciate Medicare and Social Security, not because they have been polled on it. So I want honest discourse. That is exactly what we need. Real discourse that remembers where we have been, and the old movies that we have seen.

We kept the basic structure, but included new delivery and payment reforms in the health care reform. In fact, we did begin the process of changing the entitlement programs. If you read one-third of the health care bill, which is devoted to Medicare and Medicaid, I cannot reiterate enough; health care reform was the beginning of entitlement reform. I said, the beginning. No one could deny health care reform extended the

life of Medicare by 12 years. To date, the only action this majority has taken at entitlement reform was the vote to repeal health care reform.

Some of our witnesses today believe the best way to reform Medicare would be, partially, to privatize it. Our Chairman also supports this idea through his roadmap to make Medicare a voucher program. Clear and simple, we have seen this over the last two years. I want to have a vote on this. I think I deserve a vote. Everybody here deserves a vote. And Chairman, I would like to ask the Chairman, through the Chair, are we going to get a vote, are we going to get an opportunity to vote on the voucher program, which is our answer to changes that must be made in Medicare?

I want to know, right now, are we going to have this? This idea is a bold idea. The Chairman's idea. And I think we should talk about it. I think we should have discourse about it. And I think we should have that discourse right here. I encourage you, I encourage you to bring this up as we mark up the budget resolution. Do you support having such a vote on the roadmap? And is this what this committee is going to do.

Let me ask that question first, and the Chairman is not here. So let me continue, if you wish to answer it, go ahead. According to Standard and Poor's index on health care, in 2010, health costs covered by private insurance rose by 7.75 percent,

compared to Medicare, which increased at a modest 3.3 percent. The report is here, it is succinct, it is in the Standard and Poor indexes, it is very uncomplicated to read this. Medicare, as it is currently structured, controls costs better than private insurers.

And Weiner was right in today's Politico, when he said we have dealt with the opposite of what the loyal opposition is saying. This is the core of the matter here, Mr. Chairman. This is the core of the matter. It is the record. Block grants and vouchers are not the answer. If we are talking about controlling costs for our budget, I do not see the sense in moving seniors from a lower-cost insurance provider to a higher-cost insurance provider, do you, Mr. Van de Water?

Mr. Lankford. Actually, there is not time to be able to respond to that. Time has expired.

Mr. Pascrell. Can he answer the question? The question is over. Can he answer?

Mr. Lankford. Your time has expired about 30 seconds ago on that, actually, though. We will let you follow up on that in a coming question, if that fits in well. Will that be all right? Mr. Mulvaney.

Mr. Mulvaney. Thank you, Mr. Chairman. Happy St. Patrick's Day, everybody. With a last name like Mulvaney, I cannot help but be in a good mood today, which is rare for a

budget meeting, I can tell you that. You sit here long enough, as you can tell. So let's focus today on some positives, maybe. Ms. Rivlin, I will begin by disagreeing with you slightly. You said that the folks back home, while they might believe that something has to be done, they have not yet figured out that they have to make tough choices. I would suggest to you that it is us, up here, who have not figured that out yet. That, as we go around the debate today, everybody seems to say, “Well, we need to do something.”

But face it, Washington, in my mind at least, as someone who has only been here a couple weeks, is not famous for making its tough choices. But I did hear some things today, from your testimony, from the questions that you have gotten, that we seem to agree on, which is that we all want to keep the basic promises. There is no one up here trying to abrogate our responsibilities, there is no one up here trying to break the social contract. We are trying to figure out how to do it. And what I have also heard is that, in order to do that, we have to do something. We have to do something.

My understanding of the law is that if we do nothing, then, in the next 25 years or so, the benefits will be cut across the board, 22 percent. That is without any additional congressional action. When you get your check in the mail 20 years from now, it will automatically be 22 percent smaller than it would have

otherwise been. So we have to do something, and we seem to agree on that. We also seem to agree that we have to do something sooner rather than later. Now, there will be disagreements as to what sooner or later means, and there obviously will be disagreements as to what the structure of the change will be. But let's start the discussion by focusing on the things that we agree on.

And let me make a suggestion to you, then, with that backdrop. If someone came to you today and said, “You know, let's not do anything for 20 years. Let's do absolutely nothing about this for 20 years.” Can you help me understand, each of you, and we will start with Mr. Van de Water because you did not get a chance to answer the last question. If we do nothing, where are we in Social Security 20 years from now? And if you could keep the answer short enough to give everybody a chance to respond to that, that would be great.

Dr. Van de Water. Yes, Mr. Mulvaney. You are quite correct, under the current financing schedule, that the Social Security program will face a problem in 2037, and at that point, if nothing is done, benefits would have to be cut by approximately 22 percent. Clearly, it would be, I have said several times today, I agree with Chuck Blahous, that it would be better, other things may equal to solving that problem sooner rather than later.

But the difficulty is coming together on some sort of a plan on which to do it. And certainly I would say that, if it were my choice, I would rather not act sooner, if it meant adopting what I thought was a very poor solution. But I would rather wait if I got a better solution. Chuck might feel the same way, although his view of a good solution and a bad solution might be exactly the opposite of mine.

Mr. Mulvaney. Mr. Capretta?

Mr. Capretta. Well, in the next 20 years, the population aged 65 and older is going to go from about 41 million, roughly, today, to I think about 71 million in 2030, something like that. So we will have added a pretty good, sizable portion to the population over that. As a consequence of that, the amount of spending that will be associated with these major entitlement programs will probably go up by about five percentage points of GDP. So we spend, in rough terms, roughly 10 percent of GDP on Social Security, Medicare, and Medicaid. In 20 years, it will be roughly 15 percent of GDP.

So you are adding a pretty good size to our budget without any new way to pay for it. I doubt that we will get through that kind of pressure in our budget without major dislocation of some sort. We would have to, probably would stumble our way into a very major and punitive tax increase and, maybe, simultaneous to that, still have a debt crisis, because you

would end up running up a lot of debt.

Mr. Mulvaney. Mr. Blahous, very briefly.

Mr. Blahous. Well, I see three major effects [inaudible] in the system, as costs in the system rise over the next 20 years. To the point where, although it is allocated between payroll taxes and income taxes, workers are having to shell out $1 out of every $6 they earn to keep Social Security going. That is the first effect. The second effect is, when you act, you get the most unfair solution possible. If you wait until that point, you are going to have net benefit losses of four percent of the wage income of younger generations. That is a net loss. That is not the total burden of Social Security. That is the amount they would lose, even if they got back all the benefits they were promised. Third is, you might not be able to get it done. We already have a bigger problem to solve than they had in 1983. They almost did not solve it, on the brink of insolvency. We should not assume we are going to be able to solve it without chaotic consequences in the 2030s.

Mr. Mulvaney. Ms. Rivlin, we are not going to get a chance to get your answer, we are out of time, I apologize. I would put it to you, and to everybody at the meeting that that is exactly what the majority leader in the Senate suggested last night that we do, nothing, for 20 years. That is what the Senate is suggesting, as of last night. Thank you.

Mr. Lankford. Mr. Honda.

Mr. Honda. Mr. Chairman, I would like to yield 30 seconds to Mr. Pascrell, so that Dr. Van de Water can respond to the last question that he had.

Mr. Lankford. No issue with that.

Dr. Van de Water. I believe that the question was about Medicare's record and cost increases. And I would simply agree with what Mr. Pascrell said, and say that result shows up not only in the recent Standard and Poor's data that he cited, but also, if you look at the comparisons that the CMS actuary puts out, and the national health expenditure accounts, comparing growth of private health insurance and Medicare, for comparable benefits over a long period of time, you find exactly that same result. So I think, yes, you are right, that Medicare's record in holding down the rate of growth of costs is much better than some of my colleagues here have given it credit for.

Mr. Pascrell. Thank you, Mr. Van de Water, thank you, Mr. Chairman, thank you, Mr. Honda.

Mr. Honda. Thank you. Dr. Rivlin, early on, you mentioned that, when we were talking about HR-1 activities, you indicated that what we are doing right now is a serious distraction. Could you elucidate us, or, you know, expand on that comment about serious distraction from what, and what is it that we should be doing?

Ms. Rivlin. I was referencing the intense debate and negotiation over the continuing resolution for 2011. However one feels about how that should come out, it is a very small amount of money for a very short time, and I believe it is a distraction from the serious issue that this committee is focused on today; the long run growth of entitlements and other spending beyond revenues. We have got to fix that to avoid a serious debt crisis and nothing that we do on the remaining months of 2011 is going to affect that very much.

Mr. Honda. Thank you, Dr. Rivlin. You also mentioned that you have a plan with Chairman Ryan that turns Medicare into a program much like the Affordable Care Act, by creating regulated exchanges, offering certified insurance products populated by socialized buyers. You have stated that this will unleash innovation that will greatly reduce costs. In that case, would not you agree that the Affordable Care Act, the only genuine entitlement reform either party has passed into law this century, will unleash the same innovation, reducing health care costs and addressing our deficit and debt?

Ms. Rivlin. I hope so. I strongly believe that the Affordable Care Act has the potential to bend the cost curve. I also believe in the exchanges, as a mechanism. I have failed to understand why Republicans believe in exchanges, perhaps, for Medicare, as the Chairman and I have suggested, but not in the

context of the Affordable Care Act. There seems to me a disconnect in the thinking, but that is where it is.

Mr. Honda. If I heard you correctly, did I hear you say that you and the Chairman had, come up with this joint plan, but the Chairman himself does not support the idea, the concept of exchange in this plan?

Ms. Rivlin. No, he does support it for Medicare premium support. But I am not going to speak for the Chairman.

Mr. Honda. I do not, I do not expect you to.

Ms. Rivlin. But Republicans, in general, have not supported the Affordable Care Act, which also includes exchanges.

Mr. Honda. And the vote on that, Affordable Care Act, is not, I believe that they just about all have voted for repeal. Dr. Van de Water, I have almost a minute, little over, not quite a minute. You were shaking your head a couple of times when Dr. Capretta was responding to Mr. McClintock's question. Would you explain why you were shaking your head on that one?

Dr. Van de Water. Oh, I apologize for shaking my head.

Mr. Honda. No, I read motions and we are human.

Dr. Van de Water. It is hard to remember the question. But I think the issue was the same as with regard to Mr. Pascrell's question about Medicare's role in controlling costs. I think that describing Medicare as the source of cost growth

rather than as a way of controlling it is, in some ways, 180 degrees from the situation. In fact, in many cases, Medicare has taken the lead in efforts to control costs, through introducing new payment arrangements such as the DRG arrangements for hospitals and the prospective payment for physicians. So I think that that, I suspect, is what I had in mind.

Mr. Honda. Thank you, Mr. Chairman. Perhaps the witnesses, in their closing comments, can explain to me, explain to us, the issue of increased revenues. What that means, and where does it come from. Perhaps later.

Mr. Lankford. Yes. Perhaps in the days to come, or the moments to come. All right, Mr. Huelskamp.

Mr. Huelskamp. Thank you, Mr. Chairman. I appreciate the conferees being here today. And I am going to start with admitting that I do have a particular bias. I spent 14 years in the state legislature, and struggled with the issue of Medicaid. And I would be curious of a couple comments, starting with Dr. Rivlin, and then Mr. Capretta. Your thoughts on the issue, the Medicaid block grants proposal, which is being seriously considered, I believe. So, Dr. Rivlin, your thoughts on block grants, to turn them over to the states for further approach.

Ms. Rivlin. I think Medicaid is a very difficult issue for everybody, because we all want the most vulnerable people to get

Medicare. But the program is not working extremely well. In the Domenici-Rivlin plan, we suggested, we did not actually recommend it, we suggested that one way would be, one way to reduce costs was to get rid of the matching and to divide the program between federal responsibility, which might be for the younger people, and state responsibility, which might be for long-term care, those are of comparable sizes.

But there are other ways to do it. I do not think a block grant is a solution by itself, unless there are quite strong maintenance of effort and other provisions that keep states from just bailing out of the program. And, but I think one could do that.

Mr. Huelskamp. Mr. Capretta.

Mr. Capretta. I very much agree with Dr. Rivlin on the issue of the matching payment program. First of all, Medicaid's big and complicated, you really can divide it into, sort of, two parts. It has an acute care part, with lots of people, but the spending is relatively low. And there is the disabled and elderly population on Medicaid, which is a more complicated question, and most of the spending is associated with them.

But for the acute care portion of it, in particular, I think the real question is, how do you get away from this matching approach, which creates all kinds of distortions at the state level? As I indicated in my testimony, because of the way

the matching program works, many states, even though they would certainly like to save a lot of money in Medicaid, if they take out $1, they only get to keep maybe 30 cents of it, okay. So this incentive to go through that political process is quite low. And it turns out that many states have kind of gone in the opposite direction, which is, to figure out ways to get more federal matching money for things that used to be state-only money. And so they go through a lot of exercise in that, and then they try to minimize, in all fairness, the pain that is associated with their own state contribution through a lot of different mechanisms.

So the matching program has created a number of distortions, it has inflated Medicaid costs. I think the key is to get away from that, and to get toward a system of defined contribution. I, very much in terms of the exchange program, I think exchanges actually probably would be a good idea for the Medicaid population. Trying to get them into a system of defined contributions so that they are making some choices about their coverage, much like the working-age population.

Mr. Huelskamp. And I appreciate that. One of my frustrations has been that, for states that have occasionally asked for waivers for that particular approach, multiple administrations of both parties have not looked kindly on those proposals. But I think, in the history of our country,

obviously with potential for innovation at the state level, my other bias is, I do not think all the answers to health care innovation are in this town. And we will see enormous changes in Medicaid, whether it is my home state of Kansas, where we actually have a doctor who is also Lieutenant Governor heading up a task force on doing that.

And, but if we want innovation, we want changes, we want to bend the cost curve, there are other solutions and answers out there, and I appreciate the recognition of the cost-sharing. But you are absolutely right, it is actually not cutting back, it is going forward. If we spend $1 dollar, we get free money from Washington there is a dollar and a half, and it is been always a big argument for growing budgets, whether or not you make any changes to the health care system. You cannot. It is just about more money or less money, and not a lot of those waivers. But then, we cannot secure proper waivers there.

But on the other hand, with the President's health care plan, you know, we have over 1,000 waivers already granted for that. And then we still do not have the particular waivers we want in Medicaid. So I think we will see some real innovation there going on, and the defined contribution is certainly a way to go. So I appreciate that, and thank you, Doctor, as well. Thank you, Mr. Chairman.

Mr. Lankford. Thank you. Mr. Tonko.

Mr. Tonko. Thank you, Mr. Chair. While we are here today debating programs like Social Security and Medicare, in terms of profit margins and the bottom line, I think it bears reiterating that Social Security is not a campaign promise. It is the real contract on America, and spoken with America. Our constituents have paid in hard-earned dollars, fulfilling their responsibility in that contract. And every proposal I have heard coming out of the majority lately entails the federal government defaulting on its end of the bargain, cutting benefits for my constituents, our constituents, benefits that they have a legal, moral, and political right, I believe, to collect. Meanwhile, we turn a blind eye to tax expenditures grossly skewed to benefit the wealthy, at a far greater cost to our nation.

So Dr. Van de Water, I would like to, I have asked the committee to bring up a chart prepared by your organization, now, on this screen. You would never know it listening to our debates around here lately, but tax expenditures in this country well exceed our annual spending on so-called entitlement programs. Dr. Van de Water, can you explain this chart, please, for a bit?

Mr. Van de Water. Not having had the benefit of LASIK surgery, I cannot actually see it very well.

Thank you. This chart, the pink and red bar on the left,

shows total estimate of individual tax expenditures, and it compares those with the middle bar, cost of Medicare and Medicare, and the right bar being Social Security. And it just shows that if you added up all the individual and corporate tax expenditures, that there are larger either than Medicare and Medicaid put together, or Social Security by itself. And I think it just suggests that there is room to help restore solvency to Social Security and to maintain Medicare and Medicaid through modestly paring back on tax expenditures, rather than having to slash the benefits of the programs. And I think that Dr. Rivlin has referred to much the same thing.

Mr. Tonko. So to sum it up, then, tax expenditures exceed, as we can see, the total annual cost of Medicare and Medicaid combined. They also, as we can see, exceed the cost of Social Security. They exceed the cost of non-security discretionary spending that the majority is so keen on eliminating. And yet Representative Ryan’s roadmap, which is a starting point for your budget discussions this year, proposes decreasing revenue, raising taxes on the middle class, lowering taxes on the wealthy, and cutting benefits under Medicare and Social Security. As I see it, we are asked to cut health and retirement entitlements to pay for tax entitlements for the wealthy. Dr. Van de Water, I know you are familiar with the recommendations of the Simpson-Bowles Commission. What concerns

me most about the commission's proposals and about the Ryan roadmap is that we are talking about cutting basic benefits for our seniors, our retirees, our widows, our children, and the disabled. My question for you, Dr. Van de Water, is, do you think that these proposed benefit cuts will, to use the title of today's hearing, fulfill the mission of health and retirement security?

Mr. Van de Water. Well both the roadmap and Bowles-Simpson are long and complicated, but let me just focus on the Social Security part of both. The Bowles-Simpson proposal relies, to my mind disproportionately, on cutting back Social Security benefits. The mix between benefit cuts and revenues is 60-some-odd percent benefit cuts, averaged over the first 75 years, but in fact it is about 80 percent benefit cuts at the end of that period. I think that probably some modest benefit cuts are inevitable, but I certainly think the Bowles-Simpson plan is heavily over-weighted in that direction and the Ryan roadmap even more so, since as I recall that exclusively involves benefit cuts and nothing in the way of revenue increases.

Mr. Tonko. And your thoughts on eliminating the taxable cap to bring more dollars into the trust fund? Or any other proposals that you would back?

Mr. Van de Water. Certainly, the limit on earnings subject to the Social Security tax has shrunk in the sense that it

captures a smaller proportion of total earnings today than it did back in the late 1970s and early ’80s, on account of the growing disparity in earnings. And I think it certainly would be a good idea to increase the cap so it gets back towards covering at least 90 percent of earnings, as it did not all that long ago.

Mr. Tonko. Thank you very much.

Mr. Lankford. Thank you. Dr. Van de Water, I apologize. We seem to always be gaveling you out. You seem to be the last question on a lot of these things. So, Mr. Young.

Mr. Young. First, I would like to thank all our panelists for your time here today. This has been a very instructive conversation and I appreciate your help. I am going to build upon an earlier reference by Dr. Rivlin, the health exchanges. I happen to have opposed the Affordable Care Act, for the record, but not on the grounds of the exchanges. There are those of us who, on principled and intellectually honest grounds, opposed that act because of the individual mandates and certain other provisions. And I know that you are aware of that, I just did not want anyone to infer otherwise from your comments.

Ms. Rivlin. Thank you.

Mr. Young. Mr. Capretta, CBO projects, regarding the Affordable Care Act, that 23 million people will be enrolled in

these new health exchanges. Do you believe this is a conservative estimate, or something that is perhaps not generous enough in terms of those who will end up in those exchanges?

Mr. Capretta. I tend to view that as being slightly on the conservative side. Maybe more than slightly. The reason is that first of all, I think the number of people who are subsidizing the exchanges because CBO says that though some people will go into the exchanges and not be subsidized. But the number of people subsidizing the exchanges will be about 19 million, if I remember right. And I think the numbers being subsidized could be substantially higher than that, because I think the subsidy structure inside the exchanges is quite a bit more generous on the low end of the wage scale compared to the tax preference that people would get from an employer-based plan. So there would be a tremendous magnet for particularly people on the low side of the wage scale to get their insurance through the exchanges because their after-tax income, if you will, would go up quite a bit if that were to be the case.

Now, CBO and others have said that first of all, in Massachusetts, there has not been a lot of that yet. And number two, there are rules in the law that say if an employer puts their low-wage workers in the exchanges, they have to put their high-wage workers in there too. And the high-wage workers would not like that because they would be worse off. So the question

is what is going to happen? Will the labor markets start to segregate over time? There is so much money at stake associated with these subsidies and the exchanges, though, I believe, as the history of entitlements has been over the last four decades, the population tends to grow with the money available. And so I really strongly believe that the number who could end up in the exchanges, once employers figure out how to rearrange themselves, take advantage of it to the maximum extent possible, the number could be well, well above 19 million.

You have to understand that the population that the subsidies are aimed at is huge. It is between 133 and 400 percent of the poverty line would be eligible for discounts in the exchanges, potentially, if you look at the census data for people under the age of 65, that is potentially about 110 million people. So you know, we are looking at a very substantial entitlement expansion if everybody ended up in them. Now I do not expect all of them to, but one estimate by a former CBO director looked at this and said, if just everybody under 250 percent of the poverty line ended up in the exchanges, the amount of spending in the bill would go up, in rough terms, by about $1 trillion over 10 years.

Mr. Young. Thank you. Dr. Rivlin, this next question is directed your way. You know, I have been sharing with my constituents for some time that those who have the greatest

stake in entitlement reform, all variants of it, are those who are the most vulnerable. They depend disproportionately upon the continued existence of Social Security, of Medicaid, and to the extent we can address this earlier rather than later, it will certainly benefit those populations more than others. It was brought to my attention, a recent column by Ruth Marcus in the Washington Post, and she describes herself in the column as a Deficit Panda as opposed to a Deficit Hawk.

Ms. Rivlin. Yes, I liked that.

Mr. Young. And I think that was elegant. I am going to quote a bit from that and just get your brief comments. We do not have a whole lot of time left. She writes, in part; "Then there is the group about which we deficit pandas care most: the poor and working poor. They are at the greatest risk from a financial crisis, not merely because of the prospect of losing jobs. Higher interest rates would drive up housing costs while budget pressures would further squeeze funds for public housing. Spending on education from preschool through college would be threatened, income inequality would increase, educational failures would slow economic growth." We have about 15 seconds left. Do you agree with her assessment?

Ms. Rivlin. I do, and I think those who worry most about the vulnerable, and in the context of entitlement programs particularly, need to keep in mind that if we do not fix this

debt problem, we are in deep trouble. And people who suffer most in a recession are the poor and the working poor. But that does not mean that we cannot fix the entitlement programs in a way that does protect the vulnerable. And in the Social Security plan in Domenici-Rivlin, we do that.

Mr. Young. You and I agree on that important point, and I do believe from my first reading of it, is that you succeed in that endeavor. Thank you.

Mr. Lankford. Thank you. Ms. Castor.

Ms. Castor. Thank you Mr. Chairman, and thanks to all the panelists for being here today. Mr. Capretta, I was very surprised to hear you hold up Medicare Part D as a model for us here in the Budget Committee, because when it was adopted, it was not paid for. There were no offsets, there was no dedicated financing, and I think that was very irresponsible. It has added a great deal to our national debt. Do you know how much it has added to the deficit and debt, Medicare Part D?

Mr. Capretta. I do not, no. Not off the top of my head. I probably could calculate it.

Ms. Castor. Well, the latest estimate is $385 billion. You were with OMB, and Dr. Blahous, you were an advisor to the President at that time. I know the estimate then was $407 billion. Now, thankfully, it is only $385 billion, but why did you think adding that amount to the deficit and debt was a good

idea?

Mr. Capretta. I will take this question if you want me to. First of all, it is important to recognize that both sides. It was on a bipartisan basis that people were pursuing prescription-drug coverage in 2002 and 2003. The major alternatives, actually, that were offered as substitutes for the bill at the time it was passed by a lot of those who eventually opposed the bill and did not cut the cost or did not pay for it. They actually would have added even more debt and more spending.

Ms. Castor. But that does not get to the question of why.

Mr. Capretta. No, no. I just want to make sure you are clear that there is a bipartisan consensus at that time to pass a prescription-drug benefit and Medicare.

Ms. Castor. So, there is a lot of responsibility to go around.

Mr. Capretta. I just want to make sure the record is clear about what the alternative was. The other point is that at the time, the reason why there was a lot of momentum to pass a prescription drug benefit was because it was the only major insurance program in the United States, and it was for seniors, that did not have coverage.

Ms. Castor. You are not answering my question on why it was unpaid for, and why you thought it was a good idea to push ahead. Dr. Blahous, do you have an answer?

Mr. Capretta. Well I was about to get to that if you wanted me to, but go ahead, Chuck.

Mr. Blahous. I mean, speaking very broadly here, because at the time I was Social Security only and was not involved with the prescription drug discussions at all, but I think Jim said it exactly right. President Bush had campaigned on a prescription drug benefit, there was a sense that Medicare needed to be modernized to include a prescription-drug benefit, and I think the Bush White House saw its role in this as basically, within the realm of the possible, which was, “We are going to pass a prescription drug benefit,” trying to make sure that was done in the least cost way.

Ms. Castor. All right, then the second part of the question is, why did you tie the hands of Medicare to negotiate? A lot of cost estimates now that if Medicare had the ability to negotiate, that we could save an additional $20 billion plus, maybe more. The extension of existing price-negotiation with Medicare would really help us as we talk about entitlements and Medicare savings. Five years now into Medicare Part D, price status shows that Part D plans are failing to deliver on the promise that you mentioned in your testimony, Mr. Capretta, that competition would bring down prices.

The adopted approach has not resulted in drug prices that are comparable to the low prices negotiated by the Veterans’

Administration. Your structure that prohibits Medicare from using its negotiating clout on behalf of the 43 million seniors and others in Medicare to obtain low drug prices is costing us all money. It is costing seniors, it is costing taxpayers much more than it should. I think, moving forward, our budget framework needs to consider Medicare Part D becoming more cost-effective by eliminating the prohibition that prevents Medicare from bargaining for better prices. Do you all have a comment on that, Dr. Rivlin?

Ms. Rivlin. Yes, I think that giving Medicare more negotiating power would have been a good thing. And I would also like to point out that we did not do Medicare prescription-drug in the 1990s when I was OMB director. We did not because we did not have a way of paying for it, because we were working under the PAYGO rules. And what happened after 2002 was, the PAYGO rules went away and that was the consequence.

Ms. Castor. Thank you very much.

Mr. Lankford. Thank you. Mr. Rokita.

Mr. Rokita. Thank you Mr. Chairman. Thank you to the witnesses for coming today. I apologize, I had to leave in the middle of this to go to another committee and badger another set of witnesses. But I am back now, and have a couple of hopefully quick questions. I just want to go right down the line, if I could, so if you could keep it real short. I am still digesting

your testimony as I alluded to but Dr. Rivlin, would you be in favor of doing a needs test for Medicare? Am I understanding things right, or not?

Ms. Rivlin. We already have an income-adjusted premium in Part B. Yes, I think that the premium can be adjusted to income.

Mr. Rokita. In terms of services, are you willing to give the safety net, which I call a safety hammock now, rein it in a little bit?

Ms. Rivlin. I think we would have to have a much more specific discussion about what you had in mind before I could give you a yes or no answer.

Mr. Rokita. But the concept would be okay?

Ms. Rivlin. The concept of upper-income people paying more is okay with me, and we have already done that.

Mr. Rokita. Doctor?

Mr. Blahous. Specifically on Medicare or on Social Security?

Mr. Rokita. Well, I will skip you, since you are Social Security. I was thinking about Medicare. Mr. Capretta?

Mr. Capretta. Well, I agree with Dr. Rivlin. I am for needs-testing the Medicare program going forward, even more than we have done. We have done it already to some extent, and I think even more could be done going forward. That is not the

solution to the whole problem, though. You would need to do a lot more than that.

Mr. Rokita. Okay, thank you. Doctor?

Mr. Van de Water. Yes, I think that having income-tested premiums, as we now do, is a reasonable thing to do, and that could perhaps be modestly expanded. But as far as doing the means-testing through the tax system is clearly the efficient way to do it. Having a separate means-testing system for the benefits, I think, does not make sense at all.

Mr. Rokita. Okay, thank you. Dr. Rivlin, you mentioned that you had focus groups and you would lay out the problem and everyone would come up with solutions. I agree with that from my anecdotal evidence in doing town halls. My question to you, specifically and very briefly is, were these groups willing to cut their own benefits or were they talking about future benefits?

Ms. Rivlin. Yes, I mean, I have found even groups of seniors are willing to consider cuts. They are very concerned about their grandchildren when they really focus on what the problem is.

Mr. Rokita. Thank you very much. Dr. Blahous -- am I pronouncing that correctly?

Mr. Blahous. Yes.

Mr. Rokita. Thank you. You are a Social Security trustee.

You said if we do not address the issues within a couple years, we may not get this kind of opportunity going forward. You also said you had no earthly idea how to communicate the problem. I am going to give you an earthly one to shoot down. I get this nice color brochure that tells me how much I am going to get in Social Security if and when I retire, and all that sort of thing. It is about four or five pages. You are familiar. What is prohibiting us from laying out the problem there? And if there are some laws prohibiting it, maybe you can help me change those?

Mr. Blahous. There are actually no laws prohibiting it. And it is actually material that Congress has occasionally wrestled with in the past, and directed Social Security Administration to include additional information in it.

Mr. Rokita. Do you have to wait for Congress?

Mr. Blahous. No. The Social Security Administration can make periodic revisions to this. Now as you would imagine, whenever they make revisions people on both sides of the aisle Congress look very carefully over their shoulders as they do so to make sure that they are not slanting it one way or the other. But it is periodically revised.

Mr. Rokita. That is fine. And as this panel has pointed out, this is not political anymore. This is about the solvency of a nation, in my opinion the greatest one the world has ever

seen. So I do not know why we cannot use that as a medium. Go ahead, Doctor, if you like.

Mr. Van de Water. Just to add very, very quickly. It is my recollection that the Social Security Statement already contains some information about the long-run financing issues.

Mr. Rokita. Not like this. Not with the charts. Not like the good conversation that we are having today and that this nation needs to have, but I appreciate it.

Mr. Van de Water. Well, clearly not to that extent.

Mr. Rokita. Yes okay. Can I see the tidal wave chart? Do you have it ready? There is been talk that raising taxes would be a huge help in solving this problem. Someone, it was maybe not at this hearing today, but I have heard that would be the only solution that is needed. I want each of you to tell me if I am reading this chart wrong. If I understand it right, by just past 2021, if this government confiscated everything this nation produced, we would still not be able to pay for these programs. Is that accurate or not?

Ms. Rivlin. In the very long run, yes.

Mr. Rokita. About 2081?

Ms. Rivlin. Yes, 2081 is quite a long time from now. I do not expect to live that long.

Mr. Rokita. No, 2025.

Ms. Rivlin. But I think to say we cannot solve this on the

tax side alone, because we would have to raise taxes continuously until they were taking over the whole GDP, which is your point. But we cannot solve it entirely on the spending side alone, either. We have got to do both.

Mr. Rokita. I yield back. Does anyone on the panel disagree with what was said?

Mr. Capretta. I would like to.

Mr. Lankford. I would like to be able to defer that question. We will be able to pick it up, so thank you.

Mr. Capretta. All right.

Mr. Rokita. I yield back. Thank you to all four of you.

Mr. Lankford. Ms. Bass.

Ms. Bass. I think that is working now. I thank the witnesses for taking their time for coming, and I particularly wanted to thank Dr. Blahous. Did I say that correctly? And Dr. Rivlin for your comments that you made about the need to really educate the public, and our responsibility of that on both sides of the aisle. So I wanted to ask a couple of questions to clarify -- I am not sure, I do not believe anybody on the panel is a physician, correct? So I am a former medical professional and so when I hear you talk I am trying to translate some of what you are saying, your language and your theories, into patient care. And so I believe it was Mr. Capretta who was talking about the choices that people would have to make, high

achievers, you talked about productivity in the health care system, and I am trying to understand what that means.

I mean our Chairman, he is not here right now, but he used a comparison with LASIK surgery, and I understand what he was talking about then in terms of that being market-driven, and you can shop around for that. But that is cosmetic surgery. It is elective. It is not a bypass. So could you please explain to me what you were talking about when you were talking about increasing productivity, a high-achieving provider, what does that mean?

Mr. Capretta. Well the actual bill, the Affordable Care Act, tries to do a lot of that through mechanisms of the Medicare program. What they are trying to do is by paying hospitals and physicians in particular and clinics that they are associated with differently depending on how well they perform, that they will reorganize how they do business. The intake of patients, what happens to a patient when they see them, what they do after the patient is discharged, they are trying to make that process of patient care more productive. That is, use less economic resources and deliver better health.

Ms. Bass. Yes, but what I was asking for was your opinion in terms of what needed to be done with Medicare, not so much the Affordable Care Act.

Mr. Capretta. That needs to be done. The question is what

will bring that about more quickly and more rapidly and more continuously. And I tend to be a skeptic that through regulations and Medicare payment adjustments, that that is going to work very well. Because we have tried that in the past. It tends to devolve into across-the-board payment rate reductions instead of more efficiency on the part of providers.

Ms. Bass. And I will ask you in one second. So if not that way, are you suggesting a market formula works?

Mr. Capretta. Absolutely.

Ms. Bass. And if you are, could you please explain what that means for a patient?

Mr. Capretta. Very much like what Dr. Rivlin has proposed as part of premium support, the theory here and the thought is that if you limit what the government is providing to an average-cost plan or perhaps something slightly below an average-cost plan, the beneficiary can then make some choices. They can decide on the insurance type of arrangement they want, plus the delivery structure through which they get their care. If they choose one that is more expensive, they do pay a little bit more out of pocket. If they choose one that is more efficient, they get to keep the savings. That is the structure of what we are trying to get at here and my own judgment is that that will lead to more rapid change on the side of the delivery structure, than trying to push it along through regulation.

Ms. Bass. And I guess my concern, and then I will ask you Dr. Van de Water for your opinion, but my concern about that is that I think it is going to lead to less care. And I think it is going to lead to people making choices that, you know, could result in someone losing their life.

Mr. Capretta. You know, if I could comment on that. It is not really well-known, but the recently passed health care law actually does put in effect a limit on Medicare spending. There is a substantial risk already in place in current law that the beneficiaries actually will not be able to get access to care, despite the talk of delivery-structure reform. That goes towards what they are paying for services, so the Medicare actuary says, “That is likely to fall below what Medicaid pays.”

Ms. Bass. Okay, and I am sorry, I do not mean to cut you out, but I am running out of time, and I want Dr. Van de Water to reply. Thank you.

Mr. Van de Water. Speaking as an economist, I certainly would have to agree with Jim Capretta that cost-sharing, if wisely used, has a role to play in making sure that medical spending is done efficiently. But like you, as I perceive your question is suggesting, I think the role for additional cost-sharing is somewhat limited. It is well-known based on past studies that when people cut back on the amount of care because of cost considerations, they often cut out care that would be

valuable as well as care that might not have been particularly productive, because we as individual consumers are not necessarily good judges of what is helpful and what is not.

Ms. Bass. Right, that is right. Exactly. Thank you.

Mr. Lankford. Thank you. Mr. Stutzman.

Mr. Stutzman. Thank you Mr. Chairman, and thank you panel for being here as well today. I guess just for the record, I wish Mr. Pascrell was here. We were glad that Mitch Daniels came back to Indiana to be our governor, because we have a balanced budget and we have jobs that are being created in Indiana. So just for the record, Mr. Chairman, I would like to state that we were glad to have Mitch Daniels back in Indiana, back from Washington.

Mr. Van de Water, you mentioned future beneficiaries for Social Security would be even more dependent on Social Security in the future, and you stated that view because few of them will be covered by employer-sponsored defined benefit pension plans. Why do you say that and are there not other options out there for individuals personally? And the reason I ask is because when I was 18 years old I was just a farm kid, I started my own personal IRA because I am not expecting Social Security to be there. There are plenty of other options as well. And a new poll just out today shows that 81 percent of Americans fear for Social Security. So I think Americans are getting the message

as well, and seeing that. But there are other options besides defined benefit pension plans. We should not just put all the weight on employers.

Mr. Van de Water. Oh absolutely sir, and I was not meaning to suggest the contrary. Let me just say two things. First of all, why do I expect that fewer retirees in the future will have defined benefit pension plans? Simply if you look at the charts of coverage, in defined benefit pension plans for workers that fraction in private industry has shrunk dramatically in recent years. If you are interested, that chart appears in one of the papers I recently did for the Center on Budget. Obviously Social Security should not be the sole source of retirement income for most people. My older daughter and her husband, who have recently entered the workforce, are putting everything they can into their defined contribution accounts and I definitely encourage them to do so, and you made a good decision when you were younger. Although I might add, not exactly for the reason you said. I believe that Social Security will be there for my children and my new granddaughter. The question is what it is going to look like.

Mr. Stutzman. Yes, exactly. I hope it is as well, and I think if we make decisions today that we can secure for the long term. I guess I would like to just ask for the panel, for each of you, and I think we will start with Dr. Rivlin. CBO says

that the health care reform bill will both reduce debt held by the public and increase debt subject to the limit. How can this be?

Ms. Rivlin. The limit is on gross debt, including the surpluses in the trust funds, and if everything goes as scheduled in the Affordable Care Act, it would improve the prospects of the Medicare trust fund.

Mr. Stutzman. Dr. Blahous?

Mr. Blahous. This is a very important point, because as Dr. Rivlin said, there are savings in the bill that extend the solvency of Medicare. That results in the issuance of additional debt to the Medicare trust fund. The statutory debt subject to limit is basically approximately the gross debt, which includes the debt issued to the trust fund. So in a sense, we are committing additional dollars to paying Medicare benefits in the future, but at the same time those dollars were also used as an offset within the unified budget for the new health entitlement. And because they have been basically committed to both purposes, this causes gross debt to actually rise under the bill.

Mr. Stutzman. Okay, thank you.

Mr. Capretta. Nothing more to say, other than to say that Chuck has got it exactly right.

Mr. Stutzman. Would you like to add to that, Dr. Van de

Water?

Mr. Van de Water. The only thing I would add is, again speaking as an economist, most economists would agree that the measure of the debt we should be looking at for purposes of considering whether or not we are approaching a fiscal crisis is the debt held by the public, not the gross debt, which is important but for other reasons.

Mr. Stutzman. Thank you Mr. Chairman. I yield back.

Mr. Lankford. Thank you. Mrs. Moore.

Ms. Moore. Thank you so much. I have a couple questions, first on Social Security, for Dr. Paul Van de Water and also for Mr. Capretta. You indicated in your testimonies that we needed to make some fixes to Social Security, and Dr. Van de Water, you said we could do that with very modest fixes, and I am suggesting perhaps removing the cap and increasing payroll taxes modestly with wage inflation. Would you agree with that?

Mr. Van de Water. Yes, I would.

Ms. Moore. All right. And Mr. Capretta, you said that we need to fix Social Security without raising taxes. Could you share with me what those ideas are?

Mr. Capretta. I think you might be confusing me with Chuck. I am not sure. I did not have anything in my written testimony about that.

Mr. Blahous. And I, and by the way, I did not.

Ms. Moore. I thought I heard you say we could do it without raising taxes.

Mr. Blahous. It can be done without raising taxes.

Ms. Moore. Okay, maybe I did not. So what would that be? What would the skeleton of that be?

Mr. Blahous. You could do it through a combination of changes to the retirement age, to the benefit formula. There are other things that could be changed, such as the actuarial adjustments for early and delayed retirement, the way the system keeps track of your wage history. A grab bag of things.

Ms. Moore. Do you want to answer, Dr. Rivlin?

Ms. Rivlin. Yes, you could do it. But I think most plans, in order to reduce the burden on the benefit side, would say, “Let’s raise the cap gradually back to the 90 percent of earnings where it started.”

Ms. Moore. Okay, thank you so much. I want to ask a question. I appreciate all your expertise. I think the most stunning testimony, for me here today was yours, Mr. Capretta. You indicated that the cause for increases in Medicare were largely due to the fact that Uncle Sam will just pay any amount that is out there. I think in Dr. Rivlin’s testimony, she cited a couple of things. The rapid increase in health care spending due to ever-expanding medical capabilities, technology, laser surgeries, tummy tucks, whatever. Then Mr. Young came back and

asked you a question about the numbers of people that might be in the exchange. You said it could go as far as up to 110 million people. It sounded almost like we need to recruit you to advocate for the public option. If, in fact, that this unbridled increase in health care costs is due to federal health care spending, employer taxation or tax exemptions and Medicaid and Medicare expenditures, the best thing to do would be to have something like a public option to say, “Hey, we are not going to pay these huge fees anymore. We are going to offer people an opportunity to come into the government public-option exchange.” Respond to that, please.

Mr. Capretta. Well I actually do not agree with that.

Ms. Moore. Well I know you do not.

Mr. Capretta. Just for the record, I do not.

Ms. Moore. But to say that Medicare is driving the health care costs, seems like you have turned it on its head. So what are you saying?

Mr. Capretta. Well maybe I will take on the responsibility of saying yes, I do basically think that is the problem. I mean, Medicare fee-for-service is the dominant payer in most markets.

Ms. Moore. So all we have got to do is just say “We are not going to pay you this anymore”?

Mr. Capretta. No, I did not say that.

Ms. Moore. And that will drive down private health insurance?

Mr. Capretta. Well actually, the delivery structure is the same pretty much for everybody, right? So the question is, why is the delivery structure organized and operating the way it does today? There are a number of reasons, but the number-one reason is Medicare fee-for-service.

Ms. Moore. Okay, can you respond to that, Dr. Rivlin and Dr. Van de Water?

Mr. Capretta. But just for a second, the point is to allow a little bit more, as Dr. Rivlin has proposed, structure where the delivery system can be reformed by beneficiary choice. I think that is the key.

Ms. Moore. Dr. Van de Water?

Mr. Van de Water. I would disagree with Jim on this. When Medicare was established in 1965, it basically followed the payment practice that existed in the private sector at that point. It did not lead, it was following. But after not too many years, as the effects of that system became clear, Medicare started to innovate in many ways. I mentioned that in my answer to Mr. Honda, although I think I actually got things backwards. First, Medicare instituted the DOG systems for hospitals, later the fee schedule for physicians, and in those cases it has become the leader for changing payment mechanisms. Further

changes are needed, but I think Medicare has been in the forefront in many cases.

Ms. Moore. And since the hearing is almost over, I can ask you. There is one other person.

Mr. Lankford. Yes, your time has expired.

Ms. Moore. Sorry. It was just a stunning testimony, I mean. It is such a great education here on this committee. You know, you are going to be educated beyond belief.

Mr. Lankford. Thank you. Let me recognize myself for a moment, for a few questions I wanted to be able to bounce off you briefly, and that is dealing with the incentive. I hear senior adults that will talk about, “Nine hundred dollars is all I have to live on with Social Security,” and they are saying that that does not reach the cost of living, that it is not poverty, and I hear within their question the assumption that all the retirement I will have will be Social Security. What incentives would you recommend for future generations when they think about retirement, to not think about Social Security as the 401(k) sitting out there that is the sole part of their retirement? Have there been incentives that you have seen to be able to encourage people to say, “You need to have your own retirement plan, and this is supplemental to that”?

Mr. Blahous. If I could, I would make a couple of points. One is that I think sometimes, we do not think about this in the

best way in the sense that we say, well people have these challenges to their retirement security, ergo, we need to make bigger promises from Social Security, even beyond what we can now afford. But we have to remember, Social Security is not immune to risk right now. We have a substantial political risk right now. People's benefits can and must be changed under current law, and the political risk, the risks their benefit stream continues to grow the longer that this problem is not dealt with. So we have to be very careful about telling people, "The solution to your retirement-security problem is for the government to make more promises in Social Security that it already does not know how to fund."

Beyond that, I personally am of the view that we should be making changes to Social Security to increase labor force participation in a way that increases the amount of income that people head into retirement with, outside of Social Security. We have a number of ways in which the current system is now designed, basically because it was drawn up in 1935, to drive people out of the workforce. Back then, we were trying to move people out of the workforce. We were trying to move seniors out, we were trying to move housewives out to make room for younger workers. Typical senior, if they extend their working career by a year, they are going to get a negative 50 percent return on any additional payroll taxes they pay. A typical

secondary household earner, usually a woman, gets a negative 33 percent return relative to what she would have gotten by simply staying home and collecting benefits as a nonworking spouse. These are terrible work incentives, and they undermine people's income security in retirement.

Mr. Lankford. So do you have specific proposals that you have put out there and just to give you a chance to think in the academic world?

Mr. Blahous. I have. Yes, I mean, I think there is a lot of things we could do. We could give seniors some relief from the payroll tax when they reach eligibility age, specifically the disability tax because they are not even eligible for disability benefits anymore. We could change the benefit formula. Right now, the way the benefit formula works, it only keeps track of your top 35 years of earnings. So once you get to year 35 and beyond, chances are, if you take a part-time job and transition to your retirement, the system may not even see that income, and you will get no additional benefits for that tax revenue. You could change that benefit formula so it recognizes all your earnings, years of work. I personally would increase the reward for delayed retirement and increase the penalty for early retirement. I think you could offer the delayed-retirement credit as a lump sum, which people tend to respond a bit more than to a small adjustment in their monthly

benefit stream. There is a whole bunch of things like this we could do to repair the Social Security System.

Mr. Lankford. Any other comments on that? Does anybody want to add to it?

Mr. Van de Water. Yes, I agree with some of Chuck's suggestions with regard to increasing incentives for work, but your question was, what about Social Security and encouraging additional savings and other private provisions? And all I would note is that I think the system already does that in two major respects. First of all, because the benefits are modest, averaging, as I said, only about $1,200 a month and at maximum only about $2,000 a year, I think anyone looking at those numbers would say, if at all possible, I would like to have additional savings.

Mr. Lankford. Right. But the perception is, people are not looking at those numbers. They are assuming, when I get to retirement, it is going to be there. Then they get it and find out, "Oh, it is not the numbers that I thought it would be."

Mr. Van de Water. Well that is part of the issue of being informed. And then secondly, because Social Security is not means-tested aside from the taxation of benefits, that also provides a strong incentive to supplement it through private savings and pensions.

Mr. Lankford. Okay, thank you. Mr. Woodall, I am going to

recognize you at this time as well and yield back 34 seconds. Any other questions at this point? There are no other questions in it, then thank you very much for coming. I appreciate your time and giving up one more moment to be able to come and be before this hearing time. This hearing is adjourned.

[Whereupon, at 1:06 p.m., the committee adjourned subject to the call of the Chair]

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