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**STATEMENT BY ROBERT GREENSTEIN,
EXECUTIVE DIRECTOR,
ON THE NEW REPORTS FROM THE
SOCIAL SECURITY AND MEDICARE TRUSTEES**

The reports demonstrate again that policymakers will need to take action to shore up Social Security and Medicare finances, with the challenge being more modest in Social Security and more daunting in Medicare.

Social Security

The reports show that Social Security will be able to pay full benefits until 2041 and to pay 75 percent-78 percent of benefits after 2041, the year in which the program's trust funds will be exhausted. This year's estimates show some improvement over last year's; the Trustees' estimate of the size of the shortfall is about one-eighth smaller than last year's — the largest improvement since 1983 — largely as a result of changes in methodology and assumptions related to immigration.

Policymakers must restore Social Security's long-term solvency. But they do not need to make radical changes in the program's structure to do so. If they act in the coming years, a balanced package of relatively modest changes in both the program's revenues and its benefits, phased in gradually, can meet this goal. The longer they wait to act, however, the more painful the choices will become.

In addition, while Social Security's contribution to the nation's long-term fiscal problems is significant, we should not overstate it. If Congress makes permanent the 2001 and 2003 tax cuts without paying for them, the cost over the next 75 years will be about *three times* the size of the Social Security shortfall over this period.

Medicare

The issues facing Medicare are more challenging. The Medicare Hospital Insurance program's projected shortfall over the next 75 years is more than double the shortfall in Social Security, and Medicare's financing problems are much more difficult to solve. This is because Medicare's coming financial imbalances stem *not* from the nature of Medicare (or mainly from demographic pressures), but rather from the continuing sharp rise in health care costs throughout the U.S. health care system, in the public and private sectors alike. For the past 30 years, Medicare costs per beneficiary have risen at a nearly identical rate as health care costs per beneficiary systemwide.

As David Walker, until last week the Comptroller General, said, “[F]ederal health spending trends should not be viewed in isolation from the health care system as a whole. For example, Medicare and Medicaid cannot grow over the long term at a slower rate than cost in the rest of the health care system without resulting in a two-tier health care system”¹ Congressional Budget Office Director Peter Orszag has made similar points.

Policymakers cannot solve Medicare’s problems in the absence of larger reform throughout the U.S. health care system that lowers costs to the extent possible and — in particular — slows the rate at which health care costs increase in the future. The needed reductions in projected Medicare costs cannot be achieved in isolation from changes that address health costs systemwide unless policymakers are willing to institute increasingly draconian cuts in health care for tens of millions of elderly and disabled Medicare beneficiaries who cannot afford to buy large amounts of supplemental health care on their own.

This does not mean that policymakers can or should do nothing to make changes in Medicare itself to restrain the program’s costs. For example, federal policymakers have established an impressive expert advisory commission to advise them — the Medicare Payment Advisory Commission (MedPAC) — which has recommended an array of Medicare economies and efficiencies. Faced with intensive lobbying by the health insurance industry and other health care industry interests, however, Congress and the President have failed in recent years to enact many of MedPAC’s recommendations.

Most egregious is their failure to adopt MedPAC’s longstanding and most significant recommendation — to halt the massive overpayments to private insurance companies in the Medicare Advantage program (the privatized part of Medicare). MedPAC reports that these companies are paid *13 percent more on average than it would cost to treat the same patients under regular Medicare*, and CBO estimated last year that MedPAC’s proposal to pay the insurance companies the same (rather than more) than it costs to treat the same patients in Medicare would save about \$150 billion over 10 years. This one step alone would extend Medicare solvency by 18 months, according to Medicare’s actuaries. Yet when the House of Representatives had the courage to adopt this recommendation last year, the White House threatened a veto, the insurance companies spent millions of dollars lobbying against it, and this needed reform died in the Senate.

The bottom line is this: In the years ahead, policymakers will need to summon the courage both to make hard choices in Social Security and Medicare *and* to reform the U.S. health care system — as well as to raise the revenues that will be needed if Americans at all income levels are to benefit from coming advances in medicine and to age with dignity. Policymakers also will need the fortitude not to heed the unfortunate messages of those who would shield the health insurance companies, extend every tax cut, privatize Social Security and Medicare, and increasingly strand millions of elderly and disabled Americans of modest means.

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The Center on Budget and Policy Priorities is a nonprofit, nonpartisan research organization and policy institute that conducts research and analysis on a range of government policies and programs. It is supported primarily by foundation grants.

¹ “Long-Term Fiscal Issues: The Need for Social Security Reform,” Statement of David M. Walker, Comptroller General of the United States, before the Committee on the Budget, U.S. House of Representatives, February 9, 2005, page 18.