SAVING SENIORS AND OUR MOST VULNERABLE CITIZENS FROM AN ENTITLEMENT CRISIS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

MARCH 18, 2013

Serial No. 113–18

Printed for the use of the Committee on Energy and Commerce
energycommerce.house.gov

U.S. GOVERNMENT PRINTING OFFICE

80–803 WASHINGTON : 2013

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON ENERGY AND COMMERCE

FRED UPTON, Michigan
Chairman

RALPH M. HALL, Texas
JOE BARTON, Texas
Chairman Emeritus
ED WHITFIELD, Kentucky
JOHN SHIMKUS, Illinois
JOSEPH R. PITTS, Pennsylvania
GREG WALDEN, Oregon
LEE TERRY, Nebraska
MIKE ROGERS, Michigan
TIM MURPHY, Pennsylvania
MICHAEL C. BURGESS, Texas
MARSHA BLACKBURN, Tennessee
Vice Chairman
PHIL GINGREY, Georgia
STEVE SCALISE, Louisiana
ROBERT E. LATTA, Ohio
CATHY MCMORRIS RODGERS, Washington
GREGG HARPER, Mississippi
LEONARD LANCE, New Jersey
BILL CASSIDY, Louisiana
BRETT GUTHRIE, Kentucky
PETE OLSON, Texas
DAVID B. MCKINLEY, West Virginia
CORY GARDNER, Colorado
MIKE POMPEO, Kansas
ADAM KINZINGER, Illinois
H. MORGAN GRIFFITH, Virginia
GUS M. BILIRAKIS, Florida
BILL JOHNSON, Missouri
BILLY LONG, Missouri
RENEE L. ELLMERS, North Carolina

HENRY A. WAXMAN, California
Ranking Member
JOHN D. DINGELL, Michigan
Chairman Emeritus
EDWARD J. MARKEY, Massachusetts
FRANK PALLONE, JR., New Jersey
BOBBY L. RUSH, Illinois
ANNA G. ESHOO, California
ELIOT L. ENGEL, New York
GENE GREEN, Texas
DIANA DEGETTE, Colorado
LOIS CAPPS, California
MICHAEL F. DOYLE, Pennsylvania
JANICE D. SCHAKOWSKY, Illinois
JIM MATHESON, Utah
G.K. BUTTERFIELD, North Carolina
JOHN BARROW, Georgia
DORIS O. MATSUI, California
DONNA M. CHRISTENSEN, Virgin Islands
KATHY CASTOR, Florida
JOHN P. SARBANES, Maryland
JERRY MCNERNEY, California
BRUCE L. BRALEY, Iowa
PETER WELCH, Vermont
BEN RAY LUJAN, New Mexico
PAUL TONKO, New York

SUBCOMMITTEE ON HEALTH

JOSEPH R. PITTS, Pennsylvania
Chairman

MICHAEL C. BURGESS, Texas
Vice Chairman
ED WHITFIELD, Kentucky
JOHN SHIMKUS, Illinois
MIKE ROGERS, Michigan
TIM MURPHY, Pennsylvania
MARSHA BLACKBURN, Tennessee
PHIL GINGREY, Georgia
CATHY MCMORRIS RODGERS, Washington
LEONARD LANCE, New Jersey
BILL CASSIDY, Louisiana
BRETT GUTHRIE, Kentucky
H. MORGAN GRIFFITH, Virginia
GUS M. BILIRAKIS, Florida
RENEE L. ELLMERS, North Carolina
JOE BARTON, Texas
FRED UPTON, Michigan (ex officio)

FRANK PALLONE, JR., New Jersey
Ranking Member
JOHN D. DINGELL, Michigan
ELIOT L. ENGEL, New York
LOIS CAPPS, California
JANICE D. SCHAKOWSKY, Illinois
JIM MATHESON, Utah
GENE GREEN, Texas
G.K. BUTTERFIELD, North Carolina
JOHN BARROW, Georgia
DONNA M. CHRISTENSEN, Virgin Islands
KATHY CASTOR, Florida
JOHN P. SARBANES, Maryland
HENRY A. WAXMAN, California (ex officio)

CONTENTS

SAVING SENIORS AND OUR MOST VULNERABLE CITIZENS FROM AN ENTITLEMENT CRISIS

MONDAY, MARCH 18, 2013

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 4:00 p.m., in room 2123, Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Present: Representatives Pitts, Burgess, Hall, Shimkus, Blackburn, Lance, Cassidy, Guthrie, Ellmers, Pallone, Christensen, Sarbanes, and Waxman (ex officio).

Staff Present: Clay Alspach, Chief Counsel, Health; Sean Bonyun, Communications Director; Matt Bravo, Professional Staff Member; Sydne Harwick, Staff Assistant; Robert Horne, Professional Staff Member, Health; Carly McWilliams, Legislative Clerk; Monica Popp, Professional Staff Member, Health; Andrew Powaleny, Deputy Press Secretary; Chris Sarley, Policy Coordinator, Environment and Economy; Heidi Stirrup, Health Policy Coordinator; Alli Corr, Minority Policy Analyst; Amy Hall, Minority Senior Professional Staff Member; Elizabeth Letter, Minority Assistant Press Secretary; Karen Nelson, Minority Deputy Committee Staff Director for Health; and Matt Siegler, Minority Counsel.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. The subcommittee will come to order.

The chair will recognize himself for an opening statement.

Medicare and Medicaid are critically important programs that millions of Americans rely on. These programs are in trouble. Doing nothing is not an option. Doing nothing is unfair, particularly to those who can't afford any other options. Doing nothing is irresponsible.

But in the last few years, those who have proposed solutions have been viciously attacked by special interests and their allies on Capitol Hill. When the House passed a budget that charted a path to saving Medicare, many on the other side accused us of trying to, quote, "end Medicare as we know it," end quote. But they offered no solution of their own.

Let me be clear: The status quo spells doom for every American who relies on Medicare or Medicaid for their health care. Both parties need to work together to modernize these programs so they can survive.

Today's hearing is designed to get an accurate picture of the fiscal challenges facing Medicare and Medicaid so we can preserve these programs for the populations they were designed to serve. Without defining the problems these programs face, we cannot assess whether they are serving current beneficiaries in the most efficient and effective manner possible and we cannot strengthen and save them for future generations.

The Medicare program served 49 million beneficiaries in 2012 and, as was noted in a previous hearing, has been on the Government Accountability Office's high-risk list since the list began in 1990. According to the latest Medicare trustees report, Medicare will be insolvent no later than 2024 but as soon as 2017. More recent estimates have predicted insolvency as soon as 2016. That is 3 years from now.

Doing nothing is not an option. Slogans such as "Hands Off My Medicare" and the past refusal of some on the other side of the aisle to even discuss changes to the program will lead to Medicare's collapse. We can begin modernizing these programs now or we can do nothing. If we do nothing, Medicare will not be there for our children and grandchildren. In fact, if we do nothing, Medicare as we know it will not be there for today's seniors in a few short years.

Nearly 60 million Americans are currently enrolled in Medicaid. While Medicaid spending accounts for nearly one-quarter of most State budgets, in my home State of Pennsylvania it is approximately one-third of the entire State budget. Should Pennsylvania choose to expand the program under the Affordable Care Act, approximately 60 percent of the Commonwealth's budget will go to welfare spending, including Medicaid, unfairly crowding out funding for roads, schools, and public safety.

Medicaid costs to the States are expected to grow by nearly $400 million in the next fiscal year, and these costs do not include any costs associated with an expansion. Currently, one in six Pennsylvanians receives Medicaid benefits. If the Governor chooses to expand Medicaid in the Commonwealth, one in four Pennsylvanians will be on the Medicaid rolls.

And this is not just a problem for Pennsylvania. The next 10 years of Federal Medicaid spending will be twice the amount spent in the last 45 years. This is completely unsustainable.

Medicaid was designed as a safety net for our Nation's poorest and sickest people. States are already struggling to serve this core population, and Washington certainly doesn't have extra money lying around either. For a system that is already under tremendous strain, how will adding millions of young, able-bodied adults to Medicaid affect our ability to care for our country's poorest and sickest citizens?

With both Medicare and Medicaid, we face a fundamental issue of fairness. Is it fair that young people are paying into Medicare, when, as of now, the program will not be around for them when they retire? Increasingly, doctors simply can't afford to treat Med-

icaid patients. Is it fair that the President's healthcare law will force millions of disabled and sick Americans to compete with able-bodied 25-year-olds for appointments with those doctors who will still see them?

I look forward to hearing from our witnesses today not just about the challenges we face in preserving these programs but also their solutions to modernize and save Medicare and Medicaid.

Thank you. That concludes my time.

The chair recognizes the ranking member of the Subcommittee on Health, Mr. Pallone, for 5 minutes for an opening statement.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

Medicare and Medicaid are critically important programs that millions of Americans rely on. These programs are in trouble.

Doing nothing is not an option. Doing nothing is unfair, particularly to those who can't afford any other options. Doing nothing is irresponsible.

But in the last few years, those who have proposed solutions have been viciously attacked by special interests and their allies on Capitol Hill. When the House passed a budget that charted a path to saving Medicare, many on the other side accused us of trying to "end Medicare as we know it."

But they offered no solution of their own.

Let me be clear: the status quo spells doom for every American who relies on Medicare or Medicaid for their health care. Both parties need to work together to modernize these programs so they can survive.

Today's hearing is designed to get an accurate picture of the fiscal challenges facing Medicare and Medicaid so we can preserve these programs for the populations they were designed to serve.

Without defining the problems these programs face, we cannot assess whether they are serving current beneficiaries in the most efficient and effective manner possible, and we cannot strengthen and save them for future generations.

The Medicare program served 49 million beneficiaries in 2012, and, as was noted in a previous hearing, has been on the Government Accountability Office's "high risk list" since the list began in 1990.

According to the latest Medicare Trustees report, Medicare will be insolvent no later than 2024, and as soon as 2017. More recent estimates have predicted insolvency as soon as 2016. That's three years fromnow.

Doing nothing is not an option.

Slogans such as "Hands Off My Medicare" and the past refusal of the other side of the aisle to even discuss changes to the program will lead to Medicare's collapse.

We can begin modernizing these programs now, or we can do nothing. If we do nothing, Medicare will not be there for our children and grandchildren. In fact, if we do nothing, Medicare as we know it will not be there for today's seniors-in a few short years.

Nearly 60 million Americans are currently enrolled in Medicaid. While Medicaid spending accounts for nearly one-quarter of most state budgets, in my home state of Pennsylvania, it is approximately one-third of the entire state budget.

Should Pennsylvania choose to expand the program under the Affordable Care Act, over 60 percent of the commonwealth's budget will go to Medicaid, unfairly crowding out funding for roads, schools, and public safety.

Medicaid costs to the state are expected to grow by nearly $400 million in the next fiscal year, and these costs do not include any costs associated with an expansion.

Currently one in six Pennsylvanians receives Medicaid benefits. If the governor chooses to expand Medicaid in the commonwealth, 1 in 4 Pennsylvanians will be on the Medicaid rolls.

And this is not just a problem for Pennsylvania. The next ten years of federal Medicaid spending will be twice the amount spent in the last 45 years.

This is completely unsustainable.

Medicaid was designed as a safety net for our nation's poorest and sickest people. States are already struggling to serve this core population, and Washington certainly doesn't have extra money lying around either. For a system that is already under tremendous strain, how will adding millions of young, ablebodied adults to Medicaid affect our ability to care for our country's poorest and sickest citizens?

With both Medicare and Medicaid, we face a fundamental issue of fairness. Is it fair that young people are paying into Medicare when, as of now, the program will not be around for them when retire?

Increasingly, doctors simply can't afford to treat Medicaid patients. Is it fair that the president's health care law will force millions of disabled and sick Americans to compete with able-bodied 25-year-olds for appointments with those doctors who will still see them?

I look forward to hearing from our witnesses today, not just about the challenges we face in preserving these programs but also their solutions to modernize and save Medicare and Medicaid.

# # #

OPENING STATEMENT OF HON. FRANK PALLONE JR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Chairman Pitts.

Today we will examine Medicare and Medicaid, the safety net programs that afford our seniors, disabled, and low-income Americans access to quality health care. Ensuring the long-term fiscal stability of these programs has been and continues to be a priority of my work in Congress.

Budgets are about more than numbers and dollars. They are real-life expressions of priorities, of choices, and of values. And these choices have an impact on the lives of millions of Americans not just for the fiscal year each budget covers but for future years and future generations.

Now, I know that growing deficits are not good for the future either, but we cannot reduce the deficit and give tax cuts to the wealthy on the backs of our most vulnerable Americans. What Republicans want to do when they talk about painful cuts in the name of fiscal responsibility is to cut the structural foundation of our safety net programs. They want to block-grant Medicaid under the guise of State flexibility. They want to decrease the Medicare rolls and turn seniors' health over to insurance companies. But these changes do nothing to tackle healthcare costs. They simply undermine the program's guarantee of access to care.

So let's be clear and let's use facts. We have deficits because of two unpaid wars, years of unpaid tax cuts to the rich, and a deep recession. Meanwhile, revenues as a percent of GDP from 2009 to 2012 were at the lowest levels seen in 40 years.

But because Republicans made it clear that they will not consider any further changes in revenues, not even to get rid of egregious tax breaks for the wealthiest Americans, their only idea for addressing our budget challenges associated with health care is to shift costs and risk onto seniors and to the most vulnerable Americans who depend on Medicare and Medicaid for health security.

Now, I agree there is more that can be done to make the healthcare system more efficient and economically sustainable. The reality exists that an aging population means more people will rely on Medicare and millions of the uninsured will now have access to healthcare through Medicaid because of the Affordable Care Act.

But there are commonsense reforms that I believe Democrats and Republicans can agree on that would bring greater value into our health system that don't include cost-shifting. The Affordable

Care Act includes a number of provisions designed to both reform healthcare delivery and improve the quality and efficiency of health care. This, I believe, was a huge downpayment on reforming the way Medicare and Medicaid deliver care. And we are already seeing it pay off. Over the last 3 years, Medicare costs per person have grown 1.3 percent slower than growth in the overall economy. And that is a reversal of decades of rising costs.

Healthcare reform was entitlement reform. The ACA decreases the deficit and promotes efficiency and quality. So let's build on that work. Let's have a productive and fair conversation about how to bring more value into these programs and not eviscerate them.

Mr. Chairman, the issue is not whether we reduce the deficit, but how we do so. And that conversation must include a discussion about revenues.

I would now yield whatever time I have to the gentlewoman from the Virgin Islands, Ms. Christensen.

Mrs. CHRISTENSEN. Thank you, Mr. Pallone.

I want to say a word about Medicaid. And I hope that my good friends on the other side of the dais understand that leaving so many Americans without any insurance coverage has severely damaged their health as individuals and our economic health as a Nation. The ACA makes the investment we need to correct this. Cutting $810 billion and restructuring Medicaid as a block grant is the absolutely wrong way to go and will have catastrophic long-term economic and health consequences for the Nation.

I can tell you firsthand what it is like, because we in the territories have always had to struggle under Medicaid caps. Benefits and services have to be limited. Eligibility for us is well below the FPL. We can't provide long-term care to all who need it, and we don't get DSH payments. Our governments end up taking up the slack, and our hospitals are already in crisis. I don't wish that on anyone, not even those who think they want Medicaid as a block grant. Your constituents deserve better, and your districts, States, and this country need us to do better.

The best way to reduce Medicaid costs is by creating good jobs and by fully implementing and funding the Affordable Care Act, not going back to the Bush-era policies that increased poverty and the Medicaid rolls in the first place.

I yield back the time to the ranking member.

Mr. PITTS. The chair thanks the gentleman and, at this point, recognizes the vice chairman of the subcommittee, Dr. Burgess, for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. I thank the chairman for the recognition.

We have all heard the figures. We hear them literally every week. Ten thousand baby boomers become eligible for Medicare every day. At the inception of Medicare, five workers supported every beneficiary. Today there are three; by 2030, there will be only two. The cost pressures are increasing, and we risk the ability to provide access to services for beneficiaries. Spending in Medicare alone is projected to double over the next 10 years. The estimates

are almost $40 trillion in unfunded liabilities, leading to insolvency by 2017.

The Medicaid program, begun in 1965, was created to serve as a safety net for a very narrow population of 5 million very low-income Americans. The program has grown; now it covers over 40 million Americans. Under the Affordable Care Act, it will grow even more: 25 million new individuals, 65 million total Americans. It is counterintuitive given the existing problems that already serve as a barrier to accessing care.

Our country is $16½ trillion in debt. The President came to the House of Representatives last week and explained that he didn't think that was a pressing problem. I disagree. I think that it is.

The issue is, no one knows when it becomes a crisis. No one knows when the Federal Government takes $110 billion down to the Bureau of Public Debt some Tuesday at noon to sell and no one shows up to buy. What happens next? Likely the interest rates rise. Do they go up a little bit, or do they go up a lot? If they go up more than a little bit, what happens to the debt service on the national debt, on that $16.5 trillion? You talk about mandatory spending, that is mandatory spending—spending that is not available for any other program. When we talk about crowding out other programs, that is what is at stake.

And then we saw this weekend in Cyprus, where the Government of Cyprus decided to take very radical action because they felt the pressure from the debt crisis that they are facing. I am not saying that is what is in store for the United States, but you certainly understand that, given the world's situation, that we do need to pay attention. Our debt does matter, despite what the President disclosed to us last week.

So $16½ trillion in debt, Medicaid costs are escalating $400 billion a year. States, even those States that have rejected expansion, like my home State of Texas, will be pressured to save money by reducing benefits or further cutting provider reimbursement.

Now, think about that for a minute, what that means. We always talk about wanting to give patients access to high-quality, accessible care. How is it going to be high-quality, how is it going to be accessible if you keep cutting provider reimbursements and reducing benefits or increasing waiting lines to get that care?

Spending in Medicare and Medicaid is not proportional to the distribution of beneficiaries. Over $400 billion is spent annually on 50 million Medicare beneficiaries. More than half of that amount is for the 10 million individuals eligible for both Medicare and Medicaid. Nearly 1 in 10 of those so-called dual-eligibles have 5 or more chronic conditions, and well over half have mental or cognitive impairments. The most expensive dual-eligible patients, almost 1½ million, comprise 70 percent of the total expenditures for that group.

So we need to address costs, but the underlying system structure is something that needs to be looked at, as well. We must consider reforms that address the structure of this very critical entitlement program. Our heads have been stuck in the sand for too long. We know that the structural and fiscal problems exist. We know that they must be dealt with. The only question is, how long will Amer-

ica and Americans tolerate staring at these problems without fixing them for future generations?

I thank the chairman for yielding, and I will yield back the balance of my time.

Mr. PITTS. The chair thanks the gentleman and now recognizes the ranking member of the full committee, Mr. Waxman, for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you, Mr. Chairman.

Today we have a hearing on the entitlement programs and the economy. There is an implication here that we have to choose one or the other. Unfortunately, in the name of fiscal responsibility and balancing the budget, we are often presented with what I believe is a false choice between securing our Nation's fiscal health and ensuring the health of older, disabled, and low-income Americans.

There are different paths we can take to ensuring the long-term fiscal health of Medicare and Medicaid. The Ryan budget proposal that is going to be on the floor this week, what my Republican colleagues and their witnesses propose in our hearing today, are fundamental structural changes in the programs which, through premium support and privatization for Medicare and block grants for Medicaid, don't hold down the costs but simply shift them to beneficiaries, providers, and States. This path, as I said, doesn't lower costs; it shifts costs in a way that undermines the programs' guarantee of access to care.

The alternative path that we began in 2010 with passage of the Affordable Care Act is to reform entitlement programs through delivery system reform that improves both efficiency and quality. The Affordable Care Act improves access to preventive care that saves dollars and lives. It includes incentives to reward physicians and other providers for better coordinating care and improving health. And it also included policies to cut waste and inefficient care.

Health reform is entitlement reform. It is this kind of reform that builds a better healthcare system for all Americans at the same time that it lowers costs and helps support the long-term sustainability of our public healthcare programs.

Medicare and Medicaid aren't ballooning out of control. These programs are amazingly efficient. Over the next 10 years, Medicare per capita costs are expected to grow at 5 percent per year, as opposed to 6.9 percent in private insurance. On the Medicaid side, the Congressional Budget Office estimates projected Medicaid spending dropping by $200 billion through 2020, and the CMS actuary predicts spending will grow no faster per beneficiary than private insurance.

The problem is the numbers and aging of our society. In the coming years, we will see a growth in the number of people who need Medicare and Medicaid. For Medicare, it is because of the retirement of the baby boomers, and many of these Medicare beneficiaries will also rely on Medicaid. Currently, dual-eligibles are 15 percent of the Medicaid population but account for nearly 40 percent of expenditures.

In Medicaid, millions of Americans who were previously shut out of having insurance, particularly the working poor, will now have access to coverage beginning in 2014. More people clearly means more costs. But the solution should not and cannot be simply to shift costs to States and beneficiaries, but to continue our efforts to improve the value we get from our programs in a thoughtful and sensible way.

Did we know there was going to be a larger population coming on Medicare and Medicaid? Of course we have known this. We have known that we have had a baby boom population. But rather than put money aside to take care of that population, we spent it on two wars without any funding for them, we spent it on tax breaks for the upper-income without paying for them. We worked ourselves into a deep debt, and now the money is not there that we anticipated to use for these programs.

The Republican budget slashes away at the programs that families need most. The Republican budget is built on a hoax. On the one hand, they say it balances in 10 years. On the other, they say, "Repeal Obamacare." The fact is they repeal all of the benefits of Obamacare, including improvements to Medicare like filling in the Medicare Part D donut hole and adding no-cost preventive services, but then they turn around and keep the very Medicare cuts and taxes from the Affordable Care Act that Republicans campaigned against.

Revenues need to be on the table. I don't think most Americans will say, Well, we know there are going to be 70 million more seniors in Medicare; we hope you can make do with dollars that support only half that number. We need to eliminate the tax perks for the wealthiest. It is unjust, especially if, at the same time, we are talking about cutting holes in the safety net for the elderly and the poor.

I yield back my time.

Mr. PITTS. The chair thanks the gentleman.

That concludes the opening statements.

The title of our hearing today is "Saving Seniors and Our Most Vulnerable Citizens from an Entitlement Crisis." The hearing was first scheduled on March 6th. It was cancelled due to the snowstorm. I want to thank the witnesses for rearranging your schedules to accommodate our hearing today.

Our panel is comprised of three distinguished witnesses: first, Mr. James Capretta, senior fellow, Ethics and Public Policy Center; secondly, Mr. Joshua Archambault, director of health care policy and program manager for the Middle Cities Initiative, Pioneer Institute; and, thirdly, Dr. Judy Feder, professor of public policy, Georgetown Public Policy Institute.

Your written statements will be made a part of the record. We ask that you summarize your testimony in a 5-minute opening statement.

The chair recognizes Mr. Capretta for 5 minutes for your opening statement.

STATEMENTS OF JAMES C. CAPRETTA, SENIOR FELLOW, ETHICS AND PUBLIC POLICY CENTER; JOSHUA ARCHAMBAULT, DIRECTOR OF HEALTHCARE POLICY, PROGRAM MANAGER, MIDDLE CITIES INITIATIVE, PIONEER INSTITUTE; JUDY FEDER, PH.D., PROFESSOR OF PUBLIC POLICY, GEORGETOWN PUBLIC POLICY INSTITUTE

STATEMENT OF JAMES C. CAPRETTA

Mr. CAPRETTA. Thank you, Mr. Chairman. It is a real pleasure to be here. Mr. Pallone, other members of the subcommittee. Thank you for the opportunity to testify before you today.

The most serious threat to the Nation's long-term prosperity is the rapid and unfinanced growth of entitlement spending. Left unchecked, spending commitments for these programs will push Federal deficits and debt to levels that many economists fear will precipitate a crisis. Experience shows that the consequences of such a crisis would be especially disastrous for the most vulnerable segments of our society, including those who are dependent on the programs for their financial security and health needs.

The three largest programs are Social Security, Medicare, and Medicaid. In 1973, spending on these programs was 4.8 percent of GDP. Four decades later, that number had jumped to 10 percent of GDP, a 5.2 percentage point jump, which is larger than today's spending on national defense.

In its latest projections, CBO shows the combined spending on Medicare and Medicaid, the health entitlements, growing from about $0.8 trillion in 2012 to $1.8 trillion in 2023. That is a $1 trillion jump in spending and represents 55 percent of all the new resources available in 2023 compared to 2012.

Looking out into the future, the problem is even more daunting. Both CBO and the actuaries who produced the Medicare numbers for the annual trustees report expect healthcare cost inflation, along with the surge in enrollment, to push Federal entitlement spending up very rapidly in the decades ahead. CBO estimates that the combined spending on Medicare, Medicaid, and the health law's new premium subsidy program will rise from 5.4 percent of GDP today to 8.4 percent in 2030.

And these projections assume very deep cuts in what Medicare pays for these services for seniors, an assumption that is highly questionable. Under an alternative scenario that CBO produces, the number could rise to as high as 12.4 percent of GDP, just on the health entitlements, by 2050.

The consequences of various approaches to the problem vary quite a bit. Our budget situation would be far worse if not for large, offsetting budgetary cost reductions that have already occurred. In the 1980s, average defense spending was 5.8 percent of GDP. In the last decade, it was 3.8 percent of GDP, even with the overseas engagements of that decade. All of that savings and more has gone to finance higher entitlement expenses.

There is much concern today about the effects of the sequester. It is quite plain that the reason the blunt instrument of the sequester was enacted in 2011 is due in large part to the unaddressed problem of rising entitlement costs. The cuts are going to have to come from somewhere, and if there is no consensus on entitle-

ments, then the cuts will inevitably fall on discretionary accounts, including education, job training, and public health funding.

One approach to the problem would be to use the provisions of the 2010 healthcare law. There has been much talk about bending the cost curve through those provisions. But it is really important to note that CBO estimated essentially no savings from those provisions when they estimated the bill, and there has been no evidence since then that they will produce any savings. Instead, the 2010 law used the same formula that has been used in the past to hit budget targets, which is large, across-the-board, and indiscriminate cuts in the Medicare program.

In particular, the law included an annual productivity factor adjustment that will reduce payments into institutions on an ongoing basis starting this year. According to the 2012 trustees report, the cuts will push revenue down so much that about 15 percent of all hospitals will be operating in the red by the end of the decade. That number will jump to 25 percent in 2030 and 40 percent by 2050.

The actuaries have made it very clear they don't expect this to happen, and so they produce an alternative set of assumptions for the Medicare program assuming that they will be reversed or partially reversed. When they do that, the projections for Medicare are essentially unchanged from prior to when the law was enacted.

Another approach to solving the problem would be to raise taxes. The Congressional Budget Office did a study for Chairman Ryan last year on, if you solve this problem entirely on the tax side of the equation, what would it take, essentially. They estimated that to close the gap between the current policy and then what would happen with the alternative projections would take about a 33 percent tax increase across the board on income taxes and corporate tax rates—a very, very large tax increase.

Let me conclude by saying that the most significant risk of all of this is for the social safety net, because in the midst of a Federal debt crisis, abrupt changes in policies would be required to continue borrowing at preferential rates in the global market. That has happened to other countries, and it is not out of the question that it could happen here.

Thank you very much.

[The prepared statement of Mr. Capretta follows:]

Testimony Presented to the Health Subcommittee of the
House Energy and Commerce Committee

"Saving Seniors and Our Most Vulnerable Citizens from an Entitlement Crisis"

James C. Capretta
Senior Fellow, Ethics and Public Policy Center and
Visiting Fellow, American Enterprise Institute

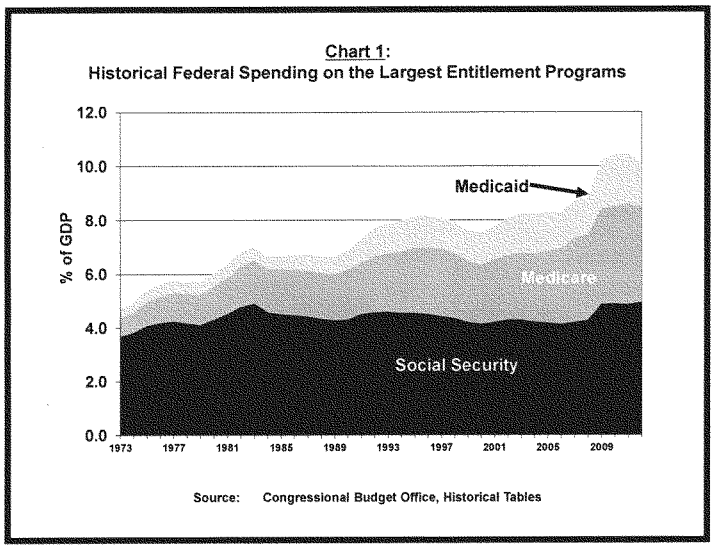
March 18, 2013

Chairman Pitts, Mr. Pallone and other members of the subcommittee, thank you for the opportunity to testify before your committee today.

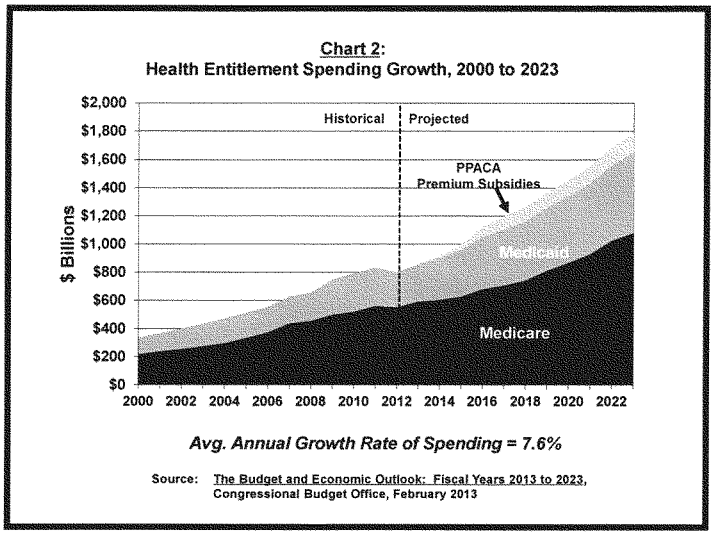
The most serious threat to the nation's long-term prosperity is the rapid and unfinanced growth of entitlement spending. Left unchecked, spending commitments for these programs will push federal deficits and debt to levels that many economists fear will precipitate a crisis. Experience shows that the consequences of such a crisis would be especially disastrous for the most vulnerable segments of our society, including those who are dependent on these programs for their financial security and health needs.

The Dimensions of the Problem

The three largest entitlement programs today are Social Security, Medicare, and Medicaid. According to the Congressional Budget Office (CBO), total spending on these programs was just 4.8 percent of GDP in 1973, as shown in Chart 1. In 2012, four decades later, spending on these programs had reached 10.0 percent of GDP. That jump in spending -- 5.2 percentage points of GDP -- is larger than today's federal commitment to national defense.



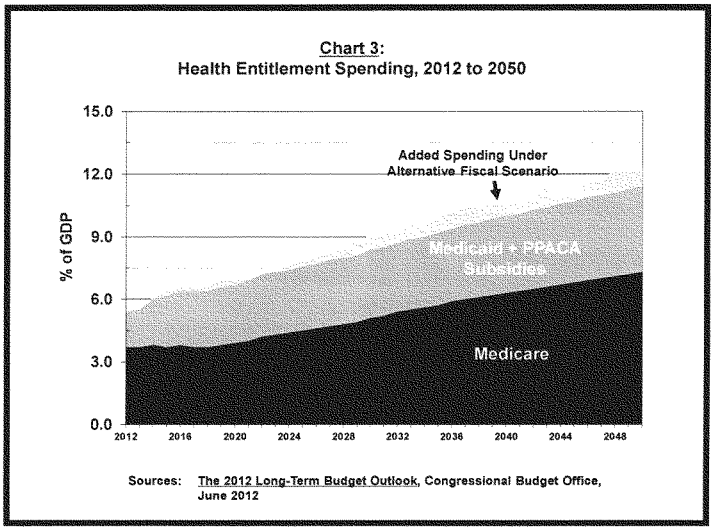
Recently, CBO lowered the expected growth rates for the Medicare and Medicaid programs over the coming decade, but even with an expectation of slower per person spending growth, total spending on these programs is still set to rise very rapidly. As shown in Chart 2, in its latest projections, CBO shows combined spending on Medicare, Medicaid, and the new subsidy program from the 2010 health care law rising from $0.8 trillion in 2012 to nearly $1.8 trillion in 2023. That $1 trillion jump in spending represents 55 percent of the difference between total, non-interest federal spending in 2023 compared to 2012. Put another way, and essentially by default, the major health entitlement programs will crowd out every other possible priority and consume more than half of all additional resources at the federal level.



Looking further out into the future, the problem is even more daunting. Both CBO and the actuaries who produce the Medicare projections for the annual trustees' report expect health care cost inflation, along with a surge in enrollment in the programs, to push federal health entitlement spending up rapidly in the coming decades. In projections released last summer, CBO estimated that the combined spending on Medicare, Medicaid, and the health law's new premium subsidy program would rise from 5.4 percent of GDP today to 8.4 percent in 2030 and 11.4 percent in 2050, as shown in Chart 3.

And these projections assume very deep cuts in what Medicare pays those providing services to seniors -- an assumption that is highly questionable. CBO provides an additional long-term projection to take into account the possibility -- and some would say the likelihood -- that these cuts will be reversed or altered in some

fashion in the future. Under the "alternative fiscal scenario," spending on the major health entitlement programs is expected to rise to 12.4 percent of GDP in 2050.



The Consequences of Various Approaches to the Problem

Our budget situation today would be far worse if not for large offsetting budgetary cost reductions that have made some room in the budget for higher entitlement spending. In the 1980s, average defense spending was 5.8 percent of GDP. But after the Cold War ended, there was a major drawdown in defense commitments that continued even during the Iraq and Afghanistan wars. Between 2000 and 2009, defense spending averaged 3.8 percent of GDP -- a full two percentage points of GDP less than two decades earlier. All of that savings, and more, has gone to higher entitlement expenses.

Unfortunately, there is no more room for such major defense cutting, which is why rising entitlement costs are now causing significant dislocation in the rest of the budget. In August 2011, the President and Congress enacted the sequester that is now cutting domestic discretionary programs across the board by 5 percent. Many in Congress are worried that these cuts will reduce the level of services provided to the American people, and there is special concern for what the cuts might mean for the most vulnerable Americans. It is quite plain that the reason the blunt instrument of the sequester was enacted in 2011 is due in large part to the unaddressed problem of rising entitlement costs. The budget must be cut somewhere, and if there is no consensus on entitlement savings, then the cuts will inevitably fall on the discretionary accounts, including education, job-training programs, and public health funding.

One approach to the problem would be to attempt to control costs in the health entitlement programs through the lowering of what the federal government pays for various medical services. This approach to cost control was featured heavily in the 2010 health care law. Since the law was enacted, there has been a great deal of attention on certain reforms, such as accountable care organizations, that some analysts hope will "bend the cost curve" by altering how services are rendered to patients. But there's no evidence that this will occur, and the savings from such provisions were essentially non-existent in CBO's estimates of the law.

Instead, the 2010 law achieved large savings in Medicare the same way savings, at least on paper, have been achieved in the past -- with large downward revisions in what Medicare pays for services. In particular, the law included an

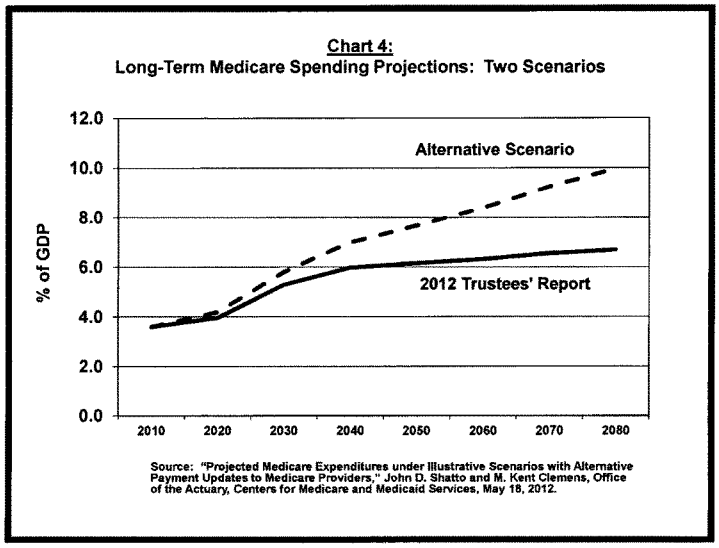
annual "productivity factor" adjustment that will reduce payments to institutions providing care, including hospitals, to levels that are well below what the actuaries expect will be necessary to cover the cost of caring for Medicare patients. According to the 2012 Trustees' Report, the cuts will push revenue down so much that about 15 percent of all hospitals and other institutional providers of care will have negative total margins -- meaning they will be operating in the red and in danger of insolvency. The predictable response of these institutions will be to take steps to limit their losses by avoiding Medicare patients. And that will mean seniors will begin to find it harder to find providers who will care for them. The actuaries expect the percentage of "underwater" providers will reach 25 percent by 2030 and 40 percent by 2050.[1]

The actuaries have also made it very clear that they don't expect this to happen because the political pressure from inadequate access to care among seniors would force policymakers to enact revisions and increase payment rates. This is the primary reason why the actuaries have made it plain that the projections of Medicare spending under current law are unrealistic. It is also why, in each of the last three years, they have issued alternative projections of Medicare costs, simultaneous with the annual trustees' report, that assume higher reimbursement rates. As shown in Chart 4, under the latest alternative projection, Medicare spending rises even more rapidly in the decades ahead and reaches nearly 10 percent of GDP by the end of the projection period.

---

[1] 2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds, April 2012, p. 217 (http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2012.pdf).

Another approach to solving the problem would be to raise taxes to cover the added costs of rising entitlement spending. In 2030, the total cost of the Medicare and Medicaid programs will be at least 8.4 percent of GDP, a full 3 percentage points above the spending level in 2012. It might be possible to cover this added cost through hikes in either income or payroll taxes, or possibly both, but the tax hikes would have to be very large.



For instance, as of 2013, the federal individual income tax is expected to generate revenue equivalent to about 7.8 percent of GDP. Increasing that by 3 percentage points would thus imply a nearly 40 percent tax hike across the board. Such a hike would hit above-average-income households especially hard, but the middle class and lower middle class would not be spared. For a median household

income, a 40 percent income tax hike would amount to $400 per year in today's terms.[2]

Of course, relying entirely on income tax hikes to cover Medicare's long-term cost increases would fundamentally change the nature of the program, away from an earned benefit financed by payroll taxes to a benefit financed by general taxation, and thus more like a transfer payment. But covering Medicare's added costs with payroll tax hikes would hit the middle class even harder than income taxes and would be especially burdensome on younger Americans who would be forced to pay for Medicare twice -- once for the coming generation of retirees, and then again for their own health care needs in retirement. Covering the added Medicare costs implicit in the actuaries' alternative scenario -- roughly 3 percent of GDP over the long run -- with payroll taxes would imply doubling today's Medicare tax rate of 2.9 percent of earned income (this is the rate that applies to all but the highest income households). Doubling the Medicare payroll tax would mean nearly $1,500 in higher taxes for households with annual wages of about $50,000.

Conclusion

The most significant risk of all for those dependent on the nation's social safety net is that, in the midst of a federal debt crisis, abrupt changes in policies would be required to continue borrowing at preferential rates in the global market. That has certainly happened to other countries that were mired in debt, and it is not out of the question that it could happen here.

[2] Calculated using CBO's supplementary tables accompanying the report, "The Distribution of Household Income and Federal Taxes, 2008 and 2009," July 2012 (http://www.cbo.gov/publication/43373).

The federal government's outstanding debt now stands at about 73 percent of GDP. CBO expects the debt burden to rise to 77 percent of GDP over the next decade, and those projections assume no economic downturn or spike in interest rates. There is now a very clear and real risk that, with a bad break or two, the U.S. could find itself struggling to service its debts without significant, near-term changes in spending commitments.

It would be far better for all concerned if policymakers began today to lower the risk of such a crisis by moving forward with sensible reforms of the nation's major entitlement programs. There is still time to enact changes that are gradual enough to protect today's retirees from abrupt changes even as the reforms ensure that the programs can be sustained for future generations. Reforms of this kind are never without controversy but it would be far better to take on difficult challenges now than to wait for the crisis to be upon us.

Mr. PITTS. The chair thanks the gentleman and now recognizes Mr. Archambault for 5 minutes for your opening statement.

STATEMENT OF JOSHUA ARCHAMBAULT

Mr. ARCHAMBAULT. Thank you, Chairman Pitts and Ranking Member Pallone, members of the committee. Thank you for this opportunity to bring a local perspective to this important issue of protecting our most vulnerable citizens from the entitlement crisis. My name is Josh Archambault, and I serve as the director of healthcare policy at a nonpartisan think tank, Pioneer Institute, in Massachusetts.

This afternoon, I would like to focus on Medicaid, a program, especially in States with historically generous eligibility, such as Massachusetts, that may foreshadow some of the underlying issues that are sure to be exacerbated under the Affordable Care Act.

Medicaid outcomes that deserve a closer look include the tremendous budget pressure in States and the crowding out of billions of dollars of spending on other public priorities; the reaction of State leaders to cut access to benefits and hike taxes to fund the program; and the increasing inability of patients to access providers, which may lead to worse health outcomes. In my opinion, as long as the program remains in place in its current form, these problems will persist, and we will fail to protect the most vulnerable.

Lawmakers in all States, red or blue, have been prevented from investing in our kids and our communities due to the ballooning costs of Medicaid. For example, in 2012, 35 States funded elementary and high schools at a lower level than in 2008. This translated into fewer teachers in the classroom and less police officers on the street. Sadly, these tradeoffs fall disproportionately hard on vulnerable communities.

Even with the Federal Government offering to pay a significant portion of the ACA's Medicaid expansion costs, any additional spending does not come free. The Federal portion of the additional $638 billion will have to come either from higher taxes, from our sluggish economy, or from cuts in the budget.

While supporters argue that the State portion of the additional spending will be minimal, roughly $33 billion, it cannot be denied that many States are struggling to pay for their current program. As a result, State leaders have cut access to benefits and hiked taxes to fund the program. In 2010, 15 States cut benefits in Medicaid; in 2011, 18 States did.

Putting aside the debate over the generosity of Medicaid programs in each State for just one moment, we know the pain of these cost-containment strategies are felt most strongly by the beneficiaries themselves. Instead of being able to vote with their feet and take their business elsewhere, they are stuck with these top-down decisions that dictate their insurance coverage, and the outcome has been poor access to providers and worse care outcomes for those on Medicaid.

The Federal Government has placed restrictions on how States can manage costs in the program. As a result, the prime tool to save money is to decrease payment rates to providers. States that have already expanded Medicare eligibility tend to pay for it by cutting reimbursement rates to finance the expansion. Over time,

this has resulted in underpayment of doctors and hospitals and more providers refusing to treat those on Medicaid. This trend prevents many recipients from gaining even basic access to specialists. As a result, when Medicaid patients are admitted into a hospital, they are often sicker. Lower rates also may account for more ER visits by a Medicaid patient. This form of care is both uncoordinated and expensive.

In 2010, at least two-thirds of States cut provider reimbursement rates. In 2011, 39 States did. And in 2012, almost all 50 States cut rates. Recently the administration encouraged further cuts. As a result, access issues are likely to get worse, making it harder for even the most vulnerable on Medicaid to find a physician to see them.

In 2011, a GAO study documented that children on Medicaid often have worse access to physicians than those with no insurance coverage at all. For many years, as Massachusetts has provided coverage to a much higher income level than in most other States, access remains a problem. Even the commonwealth with the highest per capita doctor ratio in the Nation still has a problem with access.

A simple anecdote illustrates this problem well. A Boston-area Medicaid recipient was provided a list of eligible providers by the Medicaid office and yet failed to find one accepting new patients after calling over 20 doctors.

Policymakers should be concerned about the string of troubling outcomes that are appearing more often in the academic literature, and these studies raise legitimate questions about the quality of care being provided. If Medicaid outcomes were presented as part of a business, it is my opinion it would be shut down because it is not serving its consumers well and, in some cases, may be hurting their health. Reform requires a departure from the current mindset that having access to a Medicaid card is the same as having access to a doctor.

Thank you so much for your time.

[The prepared statement of Mr. Archambault follows:]

STATEMENT BY
JOSH ARCHAMBAULT, MPP

Hearing on "Saving Seniors and Our Most Vulnerable Citizens from an Entitlement Crisis"
Committee on Energy and Commerce
Subcommittee on Health

United States House of Representatives
March 6, 2013

Josh Archambault
Director of Healthcare Policy
Center for Healthcare Solutions
Pioneer Institute
85 Devonshire St, 8th Fl
Boston, MA
617-723-2277 ext 205
josh@pioneerinstitute.org

Summary of Testimony on
"Saving Seniors and Our Most Vulnerable Citizens from an Entitlement Crisis"
Josh Archambault, Pioneer Institute

The testimony highlights some of the challenges being encountered at the state level on entitlements, especially in Medicaid.

Discusses how Medicaid:

1) Has put tremendous pressure on state budgets, crowding out billions of dollars of spending on other public priorities,
2) Has forced state leaders to cut access to benefits and hike taxes to fund the program, and is
3) Leaving patients increasingly unable to access providers, which can lead to worse health

All three of these outcomes hurt the most vulnerable citizens in our country. Medicaid beneficiaries are captive to the whims of bureaucrats. Instead of being able to vote with their feet and take their "business" elsewhere, they are stuck with the top down decisions that dictate their insurance coverage. This approach is blunt and not sophisticated enough to take into account the real health differences amongst the vulnerable. As long as the current program remains in place, these problems will persist and we will fail to protect the most vulnerable

States such as Massachusetts with historically generous Medicaid programs can serve to illustrate the challenges that are encountered under the current healthcare entitlement crisis, and may also foreshadow some of the underlying issues that will be exacerbated under the Patient Protection and Affordable Care Act's (ACA) Medicaid expansion.

If Medicaid outcomes were presented as a business model, it would be shut down because it was not serving its consumers well, and in some cases may be hurting their health, all the while spending hundreds of billions annually.

Chairman Pitts, Ranking Member Pallone, and Members of the Committee,

Thank you for this opportunity to bring a local perspective to the important issue of protecting our most vulnerable citizens from the entitlement crisis. My name is Josh Archambault, and I serve as the director of healthcare policy at a non-partisan state-based think tank, Pioneer Institute, located in Boston, Massachusetts.

This morning I would like to highlight some of the challenges being encountered at the state level on entitlements, focusing primarily on Medicaid. Medicaid serves to illustrate the challenges that are encountered under the current healthcare entitlement crisis, especially in states with historically generous programs, such as Massachusetts. The experience of our state may also foreshadow some of the underlying issues that are sure to be exacerbated under the Patient Protection and Affordable Care Act (ACA), as roughly 20+ million individuals will be joining Medicaid.

My testimony will focus primarily on three outcomes under the current Medicaid program that point to the crisis at hand. Medicaid as currently constituted:

1) Has put tremendous pressure on state budgets, crowding out billions of dollars of spending on other public priorities,
2) Has forced state leaders to cut access to benefits and hike taxes to fund the program, and is
3) Leaving patients increasingly unable to access providers, which can lead to worse health outcomes.

Sadly, Medicaid has been afflicted by concerns over its quality, access, and financing for decades. The current payment structure of the program has codified perverse incentives that reward states when they spend an additional dollar, but disincentivizes state efforts to encourage efficiencies in care delivery and fight waste, fraud, and abuse. As long as the current program remains in place, these problems will persist and we will fail to protect the most vulnerable.

1) Medicaid puts tremendous pressure on state budgets, crowding out other public priorities.

Under the ACA, Medicaid is projected to increase spending by an additional $638 billion by 2022.[1] While supporters of the law argue that the state portion of additional spending will be minimal, $21 billion in premium contributions plus $12 billion in administrative costs,[2] it cannot be denied that many states are struggling to pay for the current program.

Medicaid is now the single largest line-item in the budget in numerous states, and has been so for the last four fiscal years.[3] For example, in Massachusetts it accounts for roughly 36 percent of the entire budget.[4] Medicaid is clearly crowding out spending on other state priorities. This sentiment was expressed strongly in a Bipartisan Policy Center report, "Reforming Medicaid Waivers: The Governors' Council Perspective on Federalism Today," in which both Democratic and Republican Governors commented on the "significant burden" that Medicaid places on states.[5] A July 2012 bipartisan report from the State Budget Crisis Task Force also stated, "Medicaid spending growth is crowding out other needs."[6]

Lawmakers in all states, red or blue, are being prevented from investing in our kids and communities due to the ballooning cost of Medicaid. One only has to look to spending trends to see the tradeoffs being made. For example, in 2012, 35 states funded elementary and high

---

[1] Congressional Budget Office, "ACA Insurance Coverage Effects," February 21, 2013, Available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900_ACAInsuranceCoverageEffects.pdf

[2] It should be noted that any new enrollment among the previously eligible population prompted by awareness of the Medicaid expansion will not be financed by the federal government at the enhanced match rate. Howard, P. and Holtz-Eakin, D., "A Medicaid Rebellion?" City Journal, Winter 2011.

[3] Harvard Kennedy School, Fels Institute of Government at University of Pennsylvania, and American Education Foundation, "The State of the States: Full Report 2012," The States Project, Available at: http://www.thestatesproject.org/wp-content/uploads/2012/Full_Report.pdf

[4] Patrick, D., "An Act making appropriations for fiscal year 2014," Supplemental material, Expanding Access to Affordable, Quality Health Care, Issues in Brief, Available at: http://www.mass.gov/bb/h1/fy14h1/exec_14/hbudbrief3.htm

[5] Bipartisan Policy Center, "Reforming Medicaid Waivers: The Governors' Council Perspective on Federalism Today," March 2012, Available at: http://bipartisanpolicy.org/sites/default/files/Federalismpercent20Paper.pdf

[6] State Budget Crisis Task Force, "Report of the State Budget Crisis Task Force," July 2012, Available at: http://www.statebudgetcrisis.org/wpcms/wp-content/images/Report-of-the-State-Budget-Crisis-Task-Force-Full.pdf.

schools at a lower level than in 2008.[7] Additionally, total infrastructure spending is down 20 percent since 2009.[8] This translated into fewer teachers in the classroom, less police officers on the street, and more structurally deficient bridges and roads. Moreover, the impact falls disproportionally on vulnerable communities.[9]

Even with the federal government offering to pay a significant portion of the ACA's Medicaid expansion costs, any additional spending does not come "free." The projected $638 billion in additional costs will have to come either from higher federal taxes drawn from our sluggish economy, or from cuts in the budget, which will likely leave less money for other worthy programs. A recent Harvard Kennedy School, University of Pennsylvania, and American Education Foundation study calculates that the state and local government unfunded liability to be $7.3 trillion, $1.2 trillion of which is for healthcare benefits.[10] Finding any new money for Medicaid highlights the challenges ahead and the deep entitlement crisis that our country faces.

2) State leaders have cut access to benefits and hiked taxes to fund the program,

In 2010, 15 states cut benefits in Medicaid.[11] In 2011, 18 states eliminated, reduced, or restricted benefits. For example in 2010, Massachusetts cut dental coverage including filings, root canals, crowns and dentures, and also moved legal immigrants out of the subsidized Commonwealth Care program to reduce costs. States such as Arkansas, California, Kansas,

---

[7] Oliff, P., Mai, C. and Leachman, M., "New School Year Brings More Cuts in State Funding for Schools," Center on Budget and Policy Priorities, Updated September 4, 2012.
[8] Easton, N., "The next entitlement crisis: Medicaid spending threatens education," CNN.com, December, 3, 2012.
[9] Harvard Kennedy School, Fels Institute of Government at University of Pennsylvania, and American Education Foundation, page 16. The report draws the line between increasing Medicaid spending which leads to crowding out of state level education funding, and a heavier reliance on local tax revenue for school funding. "...school funding based on local tax revenue may disadvantage low-income communities. The same tax rate in a low-income community will raise fewer funds than in a high-income community."
[10] The States Project, "The State of the States: Full Report 2012," Available at: http://www.thestatesproject.org/wp-content/uploads/2012/Full_Report.pdf
[11] "State Actions to Close Budget Gaps" Presentation to the NCSL Fiscal Leaders Seminar, 2010 Phoenix, Arizona.

Kentucky, Louisiana, Maine, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Utah and West Virginia have all put limits on drug coverage.[12] In a controversial move, Arizona opted to drop coverage for some organ transplants in December of 2010.[13]

Putting aside the debate over the generosity of Medicaid programs in each state for a moment, the real losses of these cost containment strategies are endured by the beneficiaries, as they are captive to the whims of state bureaucrats. Instead of being able to vote with their feet and take their "business" elsewhere, they are instead stuck with top-down decisions that dictate their insurance coverage. This approach is blunt and not sophisticated enough to take into account the real health differences amongst the vulnerable.

Increasing costs have also led to additional taxes. States have continued to increase questionable provider taxes, in order to maximize federal reimbursements, and others such as Massachusetts and Indiana have raised taxes to help offset the expenses of an expanding Medicaid program.[14] As long as the current program remains in place, these problems will persist and we will fail to protect the most vulnerable.

3) Poor Access to Providers and Worse Health Outcomes

Largely due to the program management structure of Medicaid, the federal government has placed restrictions on how states can manage costs in the program. As a result, the prime tool to "save" money is to adjust payment rates for providers. States that have already expanded Medicaid eligibility tend to pay for it by cutting provider reimbursement rates. Over time, this

[12] Galewitz, P. "States Cut Medicaid Drug Benefits to Save Money," Kaiser Health News, July 24, 2012.
[13] Bialik, C., "Health Studies Citied for Transplant Cuts Put Under the Knife," *Wall Street Journal.* December 18, 2010.
[14] Massachusetts raised the cigarette tax to help pay for the federally subsidized Commonwealth Care program, but the end result also freed up additional money for Medicaid.

has resulted in underpayment of doctors and hospitals,[15] and subsequently more and more providers refusing to treat those on Medicaid.[16] This trend prevents many recipients from gaining access to basic and specialist care. As a result, when Medicaid patients are admitted into a hospital, they often suffer from a higher level of co-morbidity than privately insured patients, and with more serious illnesses.

Low reimbursement rates may also account for the elevated number of emergency department (ED) visits by Medicaid patients. They are roughly twice as likely to visit an ED compared to both the uninsured and Medicare patients, and four times more likely than the privately insured.[17] To make matters worse, in Massachusetts, 55.1 percent of visits to the ED in FY 2010 were deemed "avoidable/preventable" for Medicaid beneficiaries.[18] This form of care is providing uncoordinated, expensive care to patients and costing our country billions.

In 2010, at least 2/3 of the states reduced provider rates.[19] In 2011, 39 states lowered provider payments, and 46 states expected to do so again in 2012.[20] Just recently the Administration encouraged states to further cut reimbursement levels.[21] As a result, access issues are likely to get even worse in the near future. In addition, with tens of millions joining the program under the ACA, the sickest of those on Medicaid today will find it even harder to find a physician to see them.

---

[15]Medicaid typically pays physicians 56 percent of the amount that private insurers pay

[16]Decker, S., "In 2011, Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help," Health Affairs, Vol. 31, No. 8 (August 2012), pp. 1673–1679

[17] Haislmaier, E., "Should States Opt Out of the Health Law's Medicaid Expansion?" *The Wall Street Journal*, February 18, 2013.

[18] Compared to 43 percent for the privately insured . Division of Health Care Finance and Policy, "Efficiency of Emergency Department Utilization in Massachusetts," August 2012.

[19] National Conference for State Legislators, "State Strategies to Manage Budget Shortfalls," Budgets & Revenue Committee, 2011 Legislative Summit, August 9, 2011.

[20]Smith, V., Gifford, K., Ellis, E., Rudowitz, R., and Snyder, L. "Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012." Kaiser Commission on Medicaid and the Uninsured, October 2011." Available at: http://www.kff.org/medicaid/upload/8248.pdf

[21] Pear, R., "States Can Cut Back on Medicaid Payments, Administration Says," *The New York Times*, February 25, 2013.

With the ACA's Medicaid expansion, the experiences in states like Massachusetts, Illinois, and California support this growing concern over access.

Concerning Access Issues in Massachusetts

For many years, the Commonwealth has provided coverage to a much higher income level than most other states, some of which are reflected in the expansion under the ACA. [22] (See Appendix 1) Even though Massachusetts has the highest per capita doctor ratio of any state in the country, access is still a problem for those on Medicaid.[23] According to an annual survey conducted by the Massachusetts Medical Society, only 54 percent of internal medicine and 64 percent of family medicine offices accept Medicaid patients. To provide some context, Medicare acceptance rates in the state hover closer to 85-90 percent. The problem of access for Medicaid patients looks even worse when one digs deeper to observe geographical differences and admittance to specialists. For example, in Barnstable County on Cape Cod, only 14 percent of offices accept Medicaid.[24]

Anecdotal evidence can illustrate this problem as well. A Boston-area Medicaid recipient was provided a list of eligible providers by the Medicaid office, and yet failed to find one accepting new patients after calling 20+ doctors.[25] However, access issues are not isolated to Massachusetts. Other states with robust Medicaid programs have experienced some of the same issues and have also found detrimental effects on children.

Concerning Access Issues for Children in Illinois

---

[22] For example, while the national average for providing coverage to non-working parents is 37 percent and 63 percent of the federal poverty Level (FPL) for working parents, Massachusetts sits at 133 percent FPL for both (which is largely mirrored under the ACA). In additional, Massachusetts unlike most other states, has no income eligibility limit for people with disabilities. The state also spends 46percent more overall per enrollee per year. ($8,066 compared to a national average of $5,535).

[23] United States Census Bureau, "The 2012 Statistical Abstract: State Rankings: Doctors Per 100,000 Population, 2007" U.S. Department of Commerce, available at: http://www.census.gov/compendia/statab/rankings.html

[24] Massachusetts Medical Society, "2012 MMS Patient Access to Care Studies," August 2012.

[25] Goodman, J., "Parallel Universes," National Center for Policy Analysis's Health Policy Blog, February 16, 2011.

A New England Journal of Medicine article highlighted the divergence in access for children on Medicaid and Children's Health Insurance Program (CHIP) when compared to those on private insurance in Cook County. In a random sample of specialists, children described as having a "serious medical condition" were denied an appointment 66 percent of the time if they said they had Medicaid, compared with 11 percent for those on private insurance. For those that did accept Medicaid, the wait times for an appointment were twice as long, 42 days for Medicaid patients compared to 20 days.

Concerning Access Issues for Children in California

A 2005 study published in *Urology* found that for boys on Medi-Cal (Medicaid in California) 96 percent of offices would accept privately insured patients, while only 41 percent would accept Medi-Cal.[26] Tellingly, 75 percent of the offices that did not accept Medicaid patients were unable to suggest another office that would.[27] While these states have had some serious problems with access, a 2011 Government Accountability Office (GAO) study captured the problem nationally for kids.

Is Being Uninsured Better for Access Than Medicaid?

The GAO study documented that children on Medicaid often have worse access to physicians than those with no insurance coverage at all. Of the roughly 1,000 doctors surveyed, 53 percent were not accepting new Medicaid patients, 45 percent were not accepting new uninsured patients, and 21 percent were not accepting new privately insured patients. However, the situation was even worse for those looking for a primary care doctor, as only 23 percent

[26]Hwang, A., Hwang, M. Xie, H., Hardy, B. and Skaggs, D., "Access to Urologic Care for Children in California: Medicaid Versus Private Insurance," *Urology*, Vol. 65, No. 1 (2005), pp. 170–173.
[27]Bisgaier, J. and Rhodes, K., "Auditing Access to Specialty Care for Children with Public Insurance," *New England Journal of Medicine*, June 16, 2011, pp. 2324–2333,http://www.nejm.org/doi/full/10.1056/NEJMsa1013285 (accessed November 7, 2012).

would accept Medicaid patients, and only 17 percent of specialists were open for business. [28]

Interestingly, the GAO survey also asked for doctors' motivations for not participating in the Medicaid program. Low reimbursement rates lead the way with 94 percent saying it greatly or somewhat limited their willingness to take Medicaid patients. Billing requirements and paperwork burdens also topped the list (87 percent), delays in payments and difficulty in provider enrollment and program stipulations also garnered significant support (85percent), and difficulty referring patients to other providers registered as a major concern (78percent).

It should be noted that factors such as the complexity of a patient's health or non-compliance were not primary drivers for non-participation. As some scholars have suggested, this reflects the worse possible outcome for Medicaid as doctors find it to have not only low payments, but also "burdensome requirements, excessive paperwork, and unresponsive bureaucrats."[29] As long as the program remains in its current form, these problems will persist.

Conclusion

It is impossible to infer a causal relationship between Medicaid participation and poor health outcomes without conducting a randomized controlled experiment, yet policymakers should be concerned about the strong correlation of troubling outcomes that are appearing more often in the academic literature.[30]

These studies raise legitimate questions about the quality of care being provided to some of our most vulnerable residents. If Medicaid outcomes were presented as a business model, it would be shut down because it was not serving its consumers well, and in some cases may be

---

[28]GAO, "Most Physicians Serve Covered Children but Have Difficulty Referring Them for Specialty Care" GAO-11-624, Jun 30, 2011

[29] Roy, A., "GAO: Children on Medicaid Have Worse Physician Access Than Uninsured Children," *Forbes.com,* July 5, 2011.

[30]Dayaratna, K., "Studies Show: Medicaid Pateients Have Worse Access and Outcomes than the Privately Insured," Heritage Foundation, Backgrounder #2740, November 9, 2012.

hurting their health.

Furthermore, the problems of Medicaid leak out into the general marketplace driving up the cost of middle-class workers' insurance. A 2008 Milliman study found that the average family pays an additional $1,800 in premiums because of cost-shifting due to low Medicaid reimbursement rates.[31]

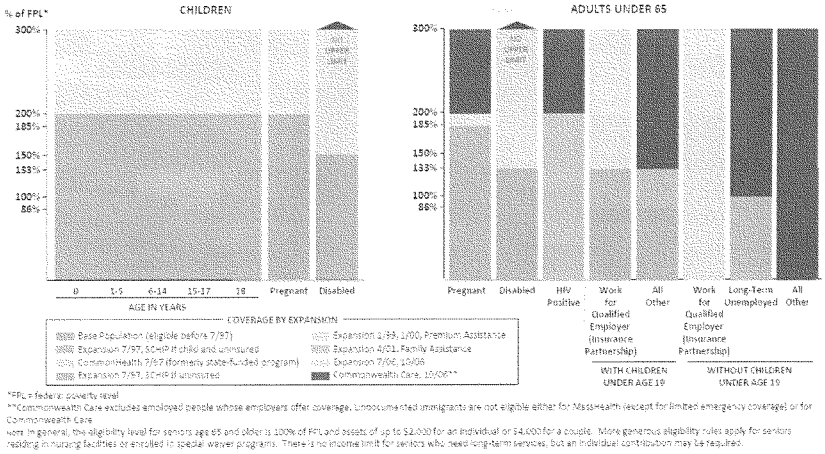
I trust that you will take these concerns seriously as you consider the best way forward to both protect the most vulnerable among us, and address the entitlement crisis. This is not a false choice between cutting benefits or simply raising taxes to fix the problem. It requires creative thinking and a true partnership with states to eradicate the billions of dollars of waste, fraud, and abuse that is preventing the level of care to be targeted at those that need it the most. It requires a departure from the current mindset that having access to a Medicaid card is the same as having access to a doctor. It requires us all to ask the tough question—are the billions we are spending as a country serving the best interest of the beneficiaries and of the taxpayers?

I appreciate the opportunity to share some of my thoughts with you all today, and look forward to answering any questions you may have.

[31] Fox, W. and Pickering, J., "Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers," Milliman Client Report, December 2008.

Appendix 1.

MASSHEALTH ELIGIBILITY OVERVIEW



*FPL = federal poverty level

**Commonwealth Care excludes employed people whose employers offer coverage. Undocumented immigrants are not eligible either for MassHealth (except for limited emergency coverage) or for Commonwealth Care

Note: In general, the eligibility level for seniors age 65 and older is 100% of FPL and assets of up to $2,000 for an individual or $4,000 for a couple. More generous eligibility rules apply for seniors residing in nursing facilities or enrolled in special waiver programs. There is no income limit for seniors who need long-term services, but an individual contribution may be required.

Source: Massachusetts Medicaid Policy Institute, "MassHealth: The Basics: Facts, Trends and National Context," Updated June 2012.

Mr. PITTS. The chair thanks the gentleman and now recognizes Dr. Feder for 5 minutes to summarize your opening statement.

STATEMENT OF JUDY FEDER, PH.D.

Ms. FEDER. Thank you, Chairman Pitts and Ranking Member Pallone and members of the committee.

I am pleased to be with you today to speak on the future of Medicare and Medicaid. Continuing to slow growth in these invaluable programs is essential to meeting the needs of an aging population, but these programs are neither doomed nor in crisis. Briefly summarizing my written testimony, let me explain why.

First, per-person costs in Medicare and Medicaid have consistently grown more slowly than private insurance premiums despite these programs' focus on older and disabled people with the greatest healthcare needs. In fact, in the past 3 years, Medicare's per-beneficiary costs have grown so slowly—practically zero last year—that CBO has reduced its Medicare spending projections for the next decade by more than $500 billion, on top of the $500 billion-plus in savings from measures taken in the Affordable Care Act. CBO has also reduced its Medicaid projections for that period, excluding ACA coverage expansions, by more than $200 billion.

Second, what that means is that it is not growth in spending per beneficiary but growth in the number of beneficiaries that has become the primary driver of increased Medicare and Medicaid spending. It is this growth in the elderly population, as we baby boomers turn age 65, that requires us to actively promote the payment and delivery reforms initiated by the Affordable Care Act to make our healthcare system more efficient. There is no status quo in our healthcare system or in our public programs, Mr. Chairman. All our programs are in a state of active change, aiming to improve efficiency.

Third, as these innovations develop—and they will take time to develop—there are additional measures we can take not in Medicaid. Given already constrained provider payment rates and existing opportunities for State flexibility, proposals that would secure more than modest savings, like block grants or per capita caps, would shift costs to States and reduce access to care. But on Medicare, as part of a balanced deficit-reduction package, we can refine existing payment mechanisms at the same time we promote their reform.

My testimony includes a few examples of refinements that reduce unnecessary overpayments and promote efficiency. These measures and others are not, as critics claim, arbitrary or unjustified cuts that endanger access or quality. On the contrary, as MedPAC emphasizes, they actually enhance provider efficiency. And if too great a gap emerges between public and private payments, the solution is not to have Medicare pay more; it is to revoke cost containment across the whole healthcare system through a collaboration among public and private payers in payment design and payment constraints.

Fourth, only so much can be expected of reducing Medicare costs per beneficiary. A balanced deficit-reduction package must therefore include new revenues to serve an aging population. As the elderly population doubles over the coming decade, it is no less nec-

essary for the Federal Government to invest in health care than it was for State and local governments to invest in education, as they did, when the very same people began entering public school 60 years ago.

An alternative course of action, changing entitlement structures through vouchers or block grants or adopting an overly ambitious savings target that could produce the same result, would fail to serve the growing elderly population, undermining some of the most vulnerable members of our society, while shifting costs and actually increasing healthcare costs. Such measures might save Federal dollars, but keep in mind that half of Medicare beneficiaries have family incomes of less than $25,000 and they already spend 15 percent of their budgets on health care.

Such action cannot be justified on grounds of fiscal responsibility. Stabilizing the debt in the coming decade at 73 percent of the economy would require another $1½ trillion in deficit reduction and would give policymakers time to identify the further steps necessary to reduce costs throughout the healthcare system in coming years. And it will enable us to meet our responsibilities to an aging population, rather than abdicate those responsibilities by radically restructuring Medicare through premium support vouchers or by restructuring or severely cutting Medicaid or other programs that protect low-income Americans.

Thank you.

Mr. PITTS. The chair thanks the gentlelady.

[The prepared statement of Ms. Feder follows:]

Financing Medicare and Medicaid

Testimony of Judy Feder[1] and Paul N. Van de Water[2]

Before the
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives

March 18, 2013

[1] Judy Feder is an Urban Institute Fellow and Professor and former Dean, Georgetown Public Policy Institute.

[2] Paul Van de Water is a Senior Fellow, Center on Budget and Policy Priorities.

Chairman Pitts, Ranking Member Pallone, and members of the subcommittee, I appreciate the invitation to appear before you today on the importance of preserving Medicare and Medicaid. Budgetary entitlements of many kinds are designed to guarantee Americans adequate protection in case of illness, disability, or economic misfortune. Efforts to control the costs of health care entitlements (including Medicare and Medicaid), must continue, if we are to meet the needs of an aging population.

But Medicare and Medicaid are not in crisis. Responsible reforms, now underway, can achieve fiscal responsibility while sustaining these programs' fundamental insurance protections. By contrast, proposals to restructure Medicare through vouchers or Medicaid through block grants would undermine the very guarantee that these programs are designed to provide.

Medicare and Medicaid are essential to the health and financial well-being of the elderly, disabled, and poor. Their costs per enrollee have consistently grown more slowly than private insurance premiums, despite their focus on populations with the greatest health care needs. Over the past 40 years, Medicare spending per enrollee has grown by an average of one percentage point less than comparable private health insurance premiums.[3] Medicaid provides acute health care coverage at a cost of 27 percent less per child, and 20 percent less per non-elderly adult, than private coverage;[4] it is also the nation's primary payer for long-term care services and supports.

In fiscal year 2012, Medicare spending per beneficiary increased by an extraordinarily low 0.4 percent — well below the 3.4-percent growth in gross domestic product (GDP) per capita. Over the 2010-2012 period, Medicare spending per beneficiary grew at an annual rate of 1.9 percent, while GDP per capita increased by 3.2 percent a year.[5]

The financial outlook for Medicare and Medicaid has improved significantly in the past three years. The Affordable Care Act (ACA) reduced projected Medicare spending by $555 billion between 2011 and 2020.[6] The Congressional Budget Office's (CBO) projections of Medicare spending over the 2011-2020 period have fallen by an additional $511 billion since late 2010 for other reasons.[7] CBO's Medicaid projections for that period, excluding the ACA coverage expansions, have declined by more than $200 billion as well.[8]

Rather than growth in spending per beneficiary, growth in the number of beneficiaries has

---

[3] Office of the Actuary, Centers for Medicare & Medicaid Services, National Health Expenditure Tables, January 2013, table 21, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf.

[4] Leighton Ku and Matthew Broaddus, "Public and Private Insurance: Stacking Up the Costs," *Health Affairs* Web Exclusive, June 24, 2008.

[5] Richard Kronick and Rosa Po, *Growth in Medicare Spending per Beneficiary Continues to Hit Historic Lows*, ASPE Issue Brief, U.S. Department of Health and Human Services, January 7, 2013.

[6] Congressional Budget Office, *The Budget and Economic Outlook: An Update*, August 2010, p. 63.

[7] Paul N. Van de Water, "Projected Medicare Spending Has Fallen by More than $500 Billion, *Off the Charts Blog*, February 19, 2013, http://www.offthechartsblog.org/projected-medicare-spending-has-fallen-by-more-than-500-billion/.

[8] Edwin Park, "Projected Medicaid Spending Has Fallen by More than $200 billion," *Off the Charts Blog*, March 13, 2013, http://www.offthechartsblog.org/projected-medicaid-spending-has-fallen-by-more-than-200-billion/

become the primary driver of increased Medicare and Medicaid spending. Even if cost growth remains moderate, Medicare and Medicaid spending will keep rising as more baby boomers become eligible for benefits. As baby boomers age, states will also face a considerable increase in the need for long-term care. [9] Between now and 2035, federal spending on Medicare and Medicaid is projected to increase by slightly more than 3 percent of GDP. By way of comparison, state and local government spending on education grew by a similar amount between 1950 and 1975, as the boomers entered primary and secondary school.

Growth in the elderly population makes it essential that we continue efforts to make our health care system more efficient. Effectively implementing the payment and delivery reforms of the Affordable Care Act is an essential next step. The ACA's research and pilot projects should yield important lessons about how to encourage coordinated and efficiently delivered care that lowers costs while maintaining or improving quality. While waiting for these efforts to bear fruit, are their additional measures we can take?

In Medicaid, there is little room for savings from efficiency, given already constrained provider payment rates and existing opportunities for state flexibility. Most proposals that would secure more than very modest federal savings — such as a block grant or per capita cap — would do so by shifting costs to states. If that occurs, states are likely to cut eligibility, benefits, or provider payments and hence reduce beneficiaries' access to care.

In Medicare, policymakers can enact measures now, as part of a balanced deficit-reduction package, that can reduce spending by refining current payment methods without jeopardizing the quality of care or access to care. Restoring the Medicaid rebate on prescription drugs for low-income beneficiaries,[10] eliminating overpayments to Medicare Advantage plans,[11] and refining payment mechanisms for post-acute care[12] are a few examples of policies likely to increase value for the Medicare dollar. Critics who dismiss Medicare payment reforms, especially to hospitals, as "arbitrary cuts" ignore MedPAC evidence that they promote sorely needed efficiency in health care delivery.[13] Though too great a gap between Medicare and private payments can endanger access to care, the solution is not to have Medicare pay more. Rather it is to promote cost containment across the whole health care system through collaboration among public and private payers in designing and constraining rates or in setting overall health care budgets.

Only so much can be expected, however, of reducing Medicare costs per beneficiary. A balanced

---

[9] Judy Feder and Harriet Komisar, "The Importance of Federal Financing to the Nation's Long-term Care Safety Net," Scan Foundation, February 2012, http://www.thescanfoundation.org/sites/thescanfoundation.org/files/Georgetown_Importance_Federal_Financing_LTC_2.pdf.

[10] Richard Frank and Jack Hoadley. "The Medicare Part D Drug Rebate Proposal: Rebutting an Unpersuasive Critique." *Health Affairs Blog*, December 28, 2012.

[11] Judy Feder, Steve Zuckerman, Nicole Lallemand and Brian Biles, "Why Premium Support? Restructure Medicare Advantage, Not Medicare." Washington: The Urban Institute, 2012

[12] Kaiser Family Foundation, *Policy Options to Sustain Medicare for the Future*. January 2013, Option 2.42.

[13] Medicare Payment Advisory Committee, *Report to the Congress, Medicare Payment Policy*, Chapter 3, March 2012.

deficit-reduction package must therefore include new revenues to deal with an aging population. As the elderly population doubles over the coming decades, it is no less necessary for the federal government to invest in their health care, efficiently delivered, than it was for state and local governments to invest in education sixty years ago when the very same people began entering public schools.

An alternative course of action, changing entitlement structures through vouchers or block grants (or adopting an overly ambitious savings target that could produce the same results) would fail to serve the growing elderly population— harming some of the most vulnerable members of society while shifting costs to states, individuals, and employers and failing to address the underlying causes of health cost growth. Indeed, some proposals — such as raising the age of eligibility or vouchers for Medicare — would actually raise total health care costs. Such measures might save federal dollars, but they shift risk onto beneficiaries who can ill afford to pay them. Keep in mind that half of Medicare beneficiaries have incomes of less than $25,000 (including their spouse's income) and that Medicare households spend 15 percent of their budgets on out-of-pocket health costs — three times that of those not on Medicare.

Such action cannot be justified on grounds of fiscal responsibility. The key fiscal policy goal for the medium term should be to stabilize the federal debt relative to the size of the economy. Since late 2010 Congress has enacted nearly $2.8 billion in deficit reduction — 70 percent of that through spending cuts. Another $1.5 trillion in deficit reduction would stabilize the debt at 73 percent of GDP over the latter part of this decade.[14]

Stabilizing the debt in the coming decade would give policymakers time to identify the further steps that will be needed to slow the growth of health care costs throughout the U.S. health care system without impairing the quality of care. And it will enable us to meet our responsibilities to an aging population, rather than abdicate those responsibilities by radically restructuring Medicare — by replacing Medicare's guaranteed coverage with a premium support voucher — or by restructuring or severely cutting Medicaid or other programs that protect low-income Americans.

---

[14] Richard Kogan, Robert Greenstein, and Joel Friedman, *$1.5 Trillion in Deficit Savings Would Stabilize the Debt Over the Coming Decade,* Center on Budget and Policy Priorities, February 11, 2103, http://www.cbpp.org/files/2-11-13bud.pdf.

Mr. PITTS. That concludes the opening statements. I will begin questioning and recognize myself for 5 minutes for that purpose.

Mr. Capretta, I read over your testimony, and I must say I am very concerned for our most vulnerable citizens if we don't fix these problems. Do you believe we have a healthcare access and coverage crisis on our hands if these valuable programs for our most vulnerable citizens are not strengthened?

Mr. CAPRETTA. I do think that the problems in Medicaid are becoming worse rather than better and that the coming enrollment tidal wave as part of the healthcare law in 2014 will exacerbate the problems that are already existing in the program.

It is quite apparent in many regions of the country that Medicaid participants are already struggling to get the same level of access—anywhere close to the same level of access as mainstream insurance. And we are about to enroll 15 million more people nationwide in the program on the sort of acute care side of Medicaid, from providing access to primary care, emergency care, specialist care. And every study that I have looked at shows that that will exacerbate the problem quite substantially because the supply of physicians willing to take care of those patients is fairly constrained. It is not likely to go up rapidly, even from the training of new physicians in the coming years.

And so, yes, I have a real concern that you see in some parts of the country—California, for instance. Emergency rooms are crowded very heavily with people that are on the Medicaid program. That problem will become worse in 2014 and 2015.

Mr. PITTS. You discuss in your testimony the unsustainable Medicare cuts in Obamacare. With more than 14 million Americans depending on the Medicare Advantage program today, what do you think the Obamacare cuts and the even more recent proposed Obama administration changes mean for the beneficiaries enrolled?

Mr. CAPRETTA. Well, the estimates are that the combined effect of the regulatory changes they are proposing, along with the statutory cuts, are that Medicare payments are going to go down by 7 to 8 percent in 2014 compared to 2013.

So what we have had here is a temporary period where the administration really tried to artificially pump up Medicare Advantage, frankly, and put a new bonus program in that was really outside the normal process of demonstrations, pumped a lot of money into the program—sort of unfounded, in my opinion—and then now they have taken that away, and they are going to cut back on the payments quite a bit post some of the activity last year.

And I think the effect is going to be very predictable. There are going to be plan withdrawals. There are going to be a lot of Medicare Advantage people pushed out of their program. The actuaries assume the number of enrollees will go down by a few million in the next few years.

Mr. PITTS. Dr. Archambault, you note the added cost to States associated with the Medicaid expansion. Many States, including my home State of Pennsylvania, have not agreed to an overexpansion of the Medicaid program, which could cost the State approximately $5 billion over 10 years. Yet others are trying to sell the enhanced Federal match to States as free money and criticize Governors for rejecting the expansion.

From your perspective, is the expansion not a risky investment for States, one that could cost them billions in the long run?

Mr. ARCHAMBAULT. Yes, it certainly is, in my opinion. I think when you talk to State legislators, they will say something like, Well, we face an X-million-dollar shortfall in Medicaid this year, and it is unaffordable, and 10 percent of that is even more unaffordable.

So I certainly think from both a State budget perspective, it is going to put some real strain on their budgets going forward if you enroll additional folks. And as I highlighted in my testimony, certainly Federal dollars are not free. The taxpayers that are constituents that pay both State and Federal taxes will feel that pinch in the future.

Mr. PITTS. Now, from your experience and review of the Medicaid programs undergoing past expansions, you note in your testimony that the most vulnerable often suffer. Today the committee released a staff report outlining major reasons for Medicaid reform, which shows the program is already struggling to serve the most vulnerable.

What will a dramatic expansion of the Medicaid program mean for the program's current citizens who already struggle to access services, like the disabled, who often have long waiting lists for home or community-based care initiatives, when resources will have to be diverted to cover the growing cost of an expansion rather than to serving them?

Mr. ARCHAMBAULT. You know, I think you highlight a very important point going forward, that as you add millions of additional people into an already strained and broken system, it is the folks that have the most difficult health needs that maybe already struggle to find a primary care doctor or a specialist who are going to be even more disadvantaged in getting access to those people because there will be so many more people in front of them in line.

We have multiple examples around the country. I know that the Committee on Oversight and Government Reform released a bipartisan report highlighting the billions of dollars in fraud and waste that we have seen in the New York Medicaid program for disabled folks. And I think it just highlights some of those issues that already exist in this program and need to be addressed with real, meaningful reform going forward.

Mr. PITTS. My time has expired.

The chair recognizes the ranking member of the subcommittee, Mr. Pallone, for 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman.

I wanted to ask my questions of Dr. Feder.

A number of recent reports, including the National Health Expenditure Report, and projections from the Congressional Budget Office have highlighted the slowing in Medicare cost growth. And the Affordable Care Act has a number of provisions designed to both reform healthcare delivery and improve the quality and efficiency of health care. A GAO report a couple weeks ago raised concerns about the long-term sustainability of some of the reforms. Estimates based on the GAO report project that if the reforms are sustained, it could result in as much as $13 trillion in deficit reduction over the next 75 years.

So I just wanted to ask if you could assess what impact the ACA is having on Medicare cost growth and the sustainability of the delivery system reforms designed to improve quality and efficiency. Can you help us get our hands around the sustainability issue?

And then, last, we rely on a lot of economic models to project costs out into the future. How reasonable are these 75-year projections that are made by GAO and others?

Ms. FEDER. Well, first of all, Mr. Pallone, the GAO report that you are referring to and the estimate of unsustainability was a gross misrepresentation of what can be called a projection. Those large numbers of unsustainability were based on assumptions that came from the requester, Senator Sessions, that ignored both the cost savings that are in the Affordable Care Act and the revenues associated with the Affordable Care Act. If you ignore both of those, it is not surprising that you come up with a problem.

The GAO report, like CBO estimate after CBO estimate, shows that, as the law is written, that the expansions are indeed sustainable, and in coming decades—in this decade, they actually modestly reduce the deficit; in the subsequent decade, they significantly reduce the deficit.

Now, the actions in the Affordable Care Act that control costs include measures that CBO does score, as shown in these estimates, which are elimination of overpayments to providers and to MA plans that have been recognized by experts for sometime as excess and overpayment. But, in addition, the Affordable Care Act has put in motion innovation in healthcare delivery to move not only the Medicare program and the Medicaid program but also the entire healthcare system away from a system that rewards more and more and more expensive services and instead rewards providers for efficiently delivering quality care through better coordination, better involvement of consumers in their own care, and avoidance and reduction of hospital use.

Those innovations are just getting under way, but those mechanisms have considerable potential for improving the efficiency not just of the public programs but of the healthcare system overall.

Mr. PALLONE. Thank you.

Let me ask you—I know you got into this a little in your testimony. You said the past 3 years have seen a dramatic slowing in the rate of increase of Medicare per-beneficiary costs. At the same time, changing demographics and aging of the population is projected to increase the number of Medicare beneficiaries from 50 million today to almost 90 million by 2040. So even if per capita beneficiary costs remain stable relative to GDP, the increase in number of beneficiaries will drive cost growth.

Just talk a little more about the relative contribution of excess cost growth or spending per beneficiary and increasing enrollment as drivers of Medicare cost growth. And is it reasonable to think that controlling costs alone without considering revenue, which I mentioned in my opening statement, is a realistic approach to funding Medicare?

Ms. FEDER. I think given the slowdown in Medicare cost growth, that the amount of what is called excess cost growth, which is above inflation, has diminished substantially in terms of projecting the future cost projections of per capita costs or of total costs.

What is happening is that the costs are being driven by the aging of the baby boom generation. As several of you referred to in your testimony, this is not something that is a surprise. The baby boomers have been coming—I am at the front of them and proud to be one—for a long time. It is the numbers of people on Medicare who are now driving the overall cost growth.

Mr. PALLONE. Well, then what about the revenue aspect?

Ms. FEDER. I am glad you went right there. The revenue has become critical in that respect.

And I mentioned in my testimony that the State and local governments increased their spending on schools when we baby boomers entered school by about the same percentage as we are now looking to increase costs in Medicare. And that investment is essential. We simply don't abandon the baby boom generation, who were working hard and contributing. We need to support the care that baby boomers will need through enhanced revenues, at the very same time that we are continually improving the efficiency of the program and getting value for the dollar.

Mr. PALLONE. Thank you.

Mr. PITTS. The chair thanks the gentleman and now recognizes the vice chairman of the committee, Dr. Burgess, for 5 minutes for questions.

Mr. BURGESS. I thank the chairman for the recognition.

Mr. Archambault, let me ask you a practical question. And I realize we are in a congressional hearing, so a practical question isn't really fair game, but I am going to ask it anyway.

If you have, I mean, assuming a State that is going to do the Medicaid expansion under the Affordable Care Act, and you have a young person who is 20 years of age—well, let's say 27 years of age, who is at 135 percent of the Federal poverty level, their care is going to be matched, the cost of their care is going to be paid for by the Federal Government, 100 percent match. Is that correct?

Mr. ARCHAMBAULT. Will we assume in that State that is doing the expansion they also have a State-based exchange that is open?

Mr. BURGESS. Well, they will be below the statutory rate—I mean, if there is a statutory—there is statutory language in the Affordable Care Act that says if you are below 138 percent of the Federal poverty level, you have to go into the Medicaid.

Mr. ARCHAMBAULT. Yes——

Mr. BURGESS. Now, I don't know how the Supreme Court decision actually changed that.

I guess what I am getting at is, if that same person who is 28 years of age covered at 100 percent match actually gets pregnant during the course of that coverage year, then are they bumped back down to the 54 percent or 57 percent match? Do they drift in and out of that? Who keeps track of that?

Mr. ARCHAMBAULT. I think you are right, Representative. I think you raise a very good question about some of the churn concerns that we have in and out of the Medicaid program; who has responsibility at the State level versus the Federal level on all these eligibility terminations.

Mr. BURGESS. Well, in fact, we learned during all of the difficulties with the Deepwater Horizon—and not this subcommittee but another subcommittee of the full committee had a field hearing

down in Louisiana. And I was somewhat startled by the variance in earnings that people can have and that someone might earn their entire yearly income of $50,000, $60,000 in May and June if they happen to be a shrimper in the Gulf Coast off Louisiana.

So who is going to be responsible for putting that person on Medicare when times are tough and in the exchange and then figuring out what sort of subsidy they get in the exchange when the shrimp are coming in?

Mr. ARCHAMBAULT. Yes, I think there is a huge technology lift that is being required and expected of States and the Federal Government to be able to tell whether somebody is here legally, how much money they make, whether they qualify for subsidies or not. And we are very concerned about that ability going forward.

Mr. BURGESS. Well, and it is not just an esoteric or academic question, because there was someone from HHS who is in charge of the technology piece addressing AHIP this past week and seemed to, in the report in the CQ HealthBeat that I read, was significantly concerned about their ability to produce what they are supposed to be able to produce by October 1st. Because on October 1st people are supposed to go live and go online and sign up for this. Is that correct?

Mr. ARCHAMBAULT. Yes, that is correct.

Mr. BURGESS. Well, let me just also say that, you know, I so welcome your testimony. I was privileged to be in the Supreme Court on the second day of the oral arguments last year. It didn't turn out the way I thought it was going to.

But I was very concerned when I heard the Solicitor General say that people showing up in the emergency room without insurance are what are driving the costs up for the rest of us. And, actually, your testimony referencing the Milliman study about the cost-shifting due to low Medicaid reimbursement rates is really the cost driver that we ought to be concerned about.

And, in fact, it is hard for me to understand how we are fixing that underlying problem of cost-shifting by expanding the program that is causing the problem in the first place. Maybe you could enlighten me as to how that is going to work.

Mr. ARCHAMBAULT. Representative, I think you raise——

Mr. BURGESS. It is fair to say it ain't.

Mr. ARCHAMBAULT. Yes, it ain't. And I think you have an even broader question, which is the cost-shift onto small business, in particular, when you under-reimburse for Medicaid.

Mr. BURGESS. Well, thank you. And I really appreciate everyone being here today.

Mr. Capretta, let me just ask—you heard part of my opening statement. I am concerned about the fact that the dual-eligible—we talk about a dual-eligible population as if it is a monolithic group, but they are not. And we all know that there are subgroups within that group that cost a great deal more than some of their other counterparts.

How, really, as a health policy person, how do you go about trying to get your arms around the scope of that problem so that it makes sense? I mean, you have people that may cost an average of $59,000 a year for their care if they have five chronic conditions

and people who may cost a fifth of that. How do you reconcile all of those differences within that group?

Mr. CAPRETTA. Well, the heart of the problem is that many of those beneficiaries are in unmanaged fee-for-service Medicare but the Federal Government put them in or they defaulted into an unmanaged system or were in it for a long time, their health deteriorates, they are in an unmanaged system, no one is really watching over the full spectrum of care, and then they end up in a situation where they need a lot of intensive intervention with Medicaid as well as Medicare, and the two programs are not coordinated.

So I think, frankly, the heart of the problem is that Medicare has too many beneficiaries in an unmanaged system and they end up falling through the cracks.

Mr. BURGESS. Thank you, Mr. Chairman. I will yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentlelady from the Virgin Islands, Dr. Christensen, for 5 minutes for questions.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman.

And I just needed to point out that the Affordable Care Act did increase the reimbursement rates of Medicaid as well as made other improvements to that and Medicare.

Dr. Feder, while making up only 25 percent of the Medicaid population, the elderly and people with disabilities account for two-thirds of Medicaid spending. Many consumers and advocates are concerned about the loss of essential services, especially to these two vulnerable groups, in the name of reducing the debt and balancing the budget.

I am especially concerned about how proposals that would cap Federal Medicaid funding would affect these populations. As you heard in my opening statement, we have firsthand experience in the territories with capped Federal funding for Medicaid. It hasn't made it more efficient; they haven't made people better off. It has just shifted the burden onto the territories, the localities, and the families. And I am sure the same would happen here.

So can you tell me what the implications are for low-income families, senior citizens, and persons with disabilities if the Federal Government were to cap or otherwise limit Medicaid funding, particularly for the frail seniors and disabled individuals who are likely to need long-term-care services?

Ms. FEDER. Dr. Christensen, you rightly recognize from your experience that a large part of the Medicaid program does go toward long-term care as well as health care for people with disabilities. And any effort to cap that program so that it doesn't grow with the demand for care and with the cost of care will fall—the burden will fall on—or will place a burden on beneficiaries.

We know that the people who are receiving long-term care from Medicaid pretty much throughout the Nation are receiving—they are not receiving excessive care. They get pretty much less care than they need. In many States, they would like to move more aggressively to provide home and community-based care, but unfortunately that does not necessarily reduce costs. It may increase them.

And the States will be, I believe, in the future sorely pressed to keep up with the growth in the elderly population and the demands it places. To simply put a lid on the program spending, on the Fed-

eral contributions, is to leave the States holding the bag for this growing elderly and disabled population, unable to serve them and forced to make significant choices as to who would get services and who would not.

And it is not about flexibility. The States have flexibility. It is about who is going to get served. And somebody is going to be in serious trouble.

Mrs. CHRISTENSEN. Right. And you have already answered the question about shifting the costs. This is not going to control costs. It is just going to shift the beneficiaries in the States.

Ms. FEDER. That is completely correct.

Mrs. CHRISTENSEN. Yes.

Can you talk about how better care coordination and other delivery reforms can improve care in Medicaid? You have already said—well, can you answer that for me?

Ms. FEDER. Sure. The whole idea is to move away, as Jim was referring to, from a system that does not enable people or providers to work together to coordinate and integrate people's care.

And so we have in the Affordable Care Act a number of measures to achieve that goal, the coordination, whether it is the accountable care organizations or the medical homes or the health homes in Medicaid, a host that would start rewarding providers for working together to coordinate care.

Mrs. CHRISTENSEN. On another question, as a physician, I was really surprised by some of the assertions in Mr. Archambault's written testimony regarding Medicaid and the health outcomes of people who are covered by Medicaid.

For example, he suggested Medicaid may be harmful rather than supportive of improved health. And I know you are familiar with the Oregon health study and others that show better self-reported physical and mental health in Medicaid recipients compared to those who are uninsured. And he cited the GAO study, and his testimony says that it documented that children on Medicaid have worse access to physicians than those with no insurance at all. But the GAO study actually shows that 78 percent of physicians nationally were participating in Medicaid.

So we understand that there are challenges to Medicaid, as in all insurance, but I would like to ask you to comment on those studies and what the evidence shows about the impact of Medicaid on access and outcomes.

Ms. FEDER. Yes, I, too, was surprised, Dr. Christensen. And as you said, Medicaid is improving access by, in the Affordable Care Act, increasing the payments to primary care physicians.

But the research literature quite consistently shows that Medicaid beneficiaries look very different from the uninsured and look quite like the privately insured population in terms of their having a medical home, a doctor whom they see in terms of their visits, and in terms of their health status.

So Medicaid is of enormous value. We have seen this recently in what was a natural experiment in Oregon——

Mrs. CHRISTENSEN. Yes.

Ms. FEDER [continuing]. which was not contaminated by what—we sometimes can't tell the difference whether they are sicker or the populations look the same, which absolutely I think astounded

its own authors, as to what a difference that Medicaid made to people's health outcomes and health services use.

Mrs. CHRISTENSEN. Thank you.

I yield back to the chairman.

Mr. PITTS. The chair thanks the gentlelady and now recognizes the gentleman from Texas, Mr. Hall, for 5 minutes for questions.

Mr. HALL. Thank you, Mr. Chairman. And I do thank you for this hearing. It is certainly helpful because it is going to give opportunity for us Members to understand the financial challenges and everything facing our Nation and also hear from experts as to why doing nothing to improve it is not the answer we are listening for. And I would say this is one thrust that Members on both sides are very interested in, Republicans, Democrats, whatever. This is a major problem.

And I think the chairman started out with this question to Mr. Capretta and to Mr. Archambault, and I think your answer was that you do believe that seniors and our most vulnerable citizens are facing an access-to-care crisis. That is a gimme, isn't it?

Mr. CAPRETTA. Are you directing that to me?

Mr. HALL. Yes, sir.

Mr. CAPRETTA. Yes, I did answer in the affirmative. Yes, I do think there are some serious access problems, particularly in the Medicaid program.

Mr. HALL. And do you feel that Washington is ignoring this crisis?

Mr. CAPRETTA. The Affordable Care Act, the healthcare law, tried to address it with a temporary Federal matching rate increase. But it is a 2-year program, and the nature of the problem is much, much larger than what they put on it. So I don't think it has been addressed adequately.

Mr. HALL. Well, do you think it is—I guess I am asking—I was in the Texas Senate from 1962 to 1972, and a Congressman came down to Austin, Texas, to tell us they had two wonderful new programs and that one, if we weren't careful, one could cost around $500 million—I mean, could cost around $200 million a year; and the other, Medicaid, if we weren't just quite careful and really watching it, it could cost maybe almost half that much.

I regret to say that in 45 years Medicaid went from zero to $400 billion a year and Medicare is now $600 billion a year. Those are correct. That is in the ballpark, isn't it?

Mr. CAPRETTA. That is correct, yes.

Mr. HALL. How fair do you think that really is to youngsters that are 20, 21, 25, or 30? I can't imagine anybody being that young. But how really fair is it to ask them to be paying into a program that we can't honestly guarantee it is going to be around the day, in any way like it is today, when they become eligible for the program? What do you say to those youngsters?

Mr. CAPRETTA. That is a very good point and an excellent question. I think you are probably in a difficult position with them because they are facing large—if the programs are left unreformed, they will end up paying probably three times: once for the current generation, once for their parents' generation, and once for their own generation. And that is really not what was intended.

Especially in the Medicare context, the idea was it was a contributory program where across generations you roughly paid the same, and then you got an earned benefit in retirement for your health needs. The way it is shaping up is there is a big push to continually raise the tax rate financing the program so that future generations of retirees are going to pay way, way, way more than previous generations.

Mr. HALL. The Medicare trustees, in their 2012 report, lay out two dates for insolvency. The first and most likely reported suggests the Medicare trust fund will be bankrupt in 2024. And the second—and some suggest it is the more realistic of the two—puts the date of insolvency at 2017, just 4 short years away.

What number should we believe?

Mr. CAPRETTA. I hate to dodge the question but probably both, because they really tell you two different things.

The first is, the 2024 date tells you when there are simply no more reserves in the trust fund, so any claims that come into the Medicare program at that time will probably—the law is a little unclear—probably be paid at basically 75 cents on the dollar. So that is essentially what would happen after 2024 if the trust fund is allowed to go totally to zero.

2017 is when the trust fund is running a cash deficit. So, essentially, that means the Federal Government is going to have to borrow even more money out in the outside world to cover Medicare's expenses. That is kind of the time when you should start worrying about the overall finances of the Federal Government.

Mr. HALL. I thank you.

I yield back.

Mr. PITTS. The chairs thanks the gentleman and now recognizes the gentlelady from Illinois, Ms. Schakowsky, for 5 minutes for questions.

Ms. SCHAKOWSKY. Everyone here agrees that we have a growing aging population. We know that. And I appreciate my colleague from Texas saying, let's talk about practicalities. But are we really, as a Congress, not just as Democrats or Republicans, talking about how to practically address these problems without causing more pain for the elderly in America? People over 65 are making a median income of $22,000 a year, a Social Security benefit averaging $15,000 a year, out of which, let's remember, that is where the Medicare premiums come from. So you can't even talk about these programs separately.

Are you kidding me, that we are going to, tomorrow, see the passage of a budget that not only repeals Obamacare, meaning a number of the improvements to the total healthcare system, some of the things that account for the reduction in spending on Medicare, and that turns it into a voucher program, that cuts Medicaid by turning it into a block grant by $810 billion over 10 years? Can't we do better than that?

I mean, this whole conversation just drives me crazy. Old people are going to—they are going to grow in numbers. Poor people are going to continue to grow in numbers if we do those things.

So why don't we sit down and figure out those practicalities? My colleague raised some issues that I think do need to be dealt with. We can do this.

I wanted to ask Dr. Feder a couple of questions about payment. In terms of Medicaid, the Republican budget would block-grant Medicaid, as I said. Can you explain how block-granting Medicaid would severely restrict Medicaid's ability to protect those that fall on hard times, such as the economic downturn that we are still living through?

Ms. FEDER. Well, Ms. Schakowsky, it is exactly the opposite of the attention or the serious consideration you want to get to meeting the needs of the growing elderly population, would be to slam a lid on the funds that States have to deal with not only elderly and disabled people but other low-income people.

There is not enough flexibility in life to enable States to deal more efficiently with this population, which is often claimed. States have flexibility to manage care in their programs. The only flexibility this would give them would be to essentially deny care to eligible people and would cut rates even further.

Ms. SCHAKOWSKY. Let me give an example. In Cook County, we have already expanded the Medicaid program. And what we are seeing are things like a woman with Stage IV cervical cancer, a stage that community health centers rarely see at that stage, or a man with advanced testicular cancer, again, something rarely seen.

So my question, if they had been insured, if they had been able to get Medicaid at an earlier point, I mean, are we really saving money if we cut these people off from the kind of preventative or appropriate intervention here?

Ms. FEDER. Well, you are, I think, right to point out that when people are insured, we have lots of evidence that shows that people get care earlier, they get better care, and they are less likely to die than people who don't have insurance. I can't tell you that that means that we won't save anything because, unfortunately, letting people die without care can mean spending less money. But that is not the way this society ought to operate and take care of its own.

I hear a lot of concerns about what are purported problems in the Affordable Care Act from comments today, but, as I understand it, that many of these Members are planning to repeal the very coverage that would prevent the people from being seen only at that last minute.

Ms. SCHAKOWSKY. Let me just end with this. What I see in the plans that have been suggested on the Republican side is cost-shifting. We say the Federal Government can't afford it, but, frankly, what the American people are concerned more about than the debt in this country is their own budgets, their own inability to get what they need. Why would we want to exacerbate those problems? Let's work together.

I yield back.

Mr. PITTS. The chair thanks the gentlelady and now recognizes the gentleman from Illinois, Mr. Shimkus, for 5 minutes for questions.

Mr. SHIMKUS. Thank you, Mr. Chairman.

I appreciate you all being here. It is an important debate and discussion we are having.

And I like my friend from Texas, Mr. Hall's comments on just the solvency of these programs, the 2017 date, the 2024 debate. I also

do that in discussions with Social Security, which is 2035 I think. And the way I try to explain it to my constituents: Absent reform—and this is a letter from the from Social Security Administration. When you retire, you get a letter. The fifth paragraph says, If we do nothing, you are going to get, in essence, 75 percent of your promised benefits.

Because there is a trust fund, as I understand it, and the money is going—as we pay money in, it pays out to beneficiaries. But when you trip these dates, then only what gets paid out is what is in that fund. So that is why Social Security will be—someone who is expecting a $1,000 Social Security check will end up getting, on that date, left unchanged, a $750 check.

I see, Mr. Capretta, you are shaking your head.

Mr. CAPRETTA. Yes.

Mr. SHIMKUS. Is that how you understand that whole system?

Mr. CAPRETTA. That is right.

Mr. SHIMKUS. And you are saying that that is true for the Medicare fund on 2017 or 2024, depending upon how we calculate that date.

Mr. CAPRETTA. It would be true in 2024, yes. They would only be able to pay out claims financing at the level of revenue coming in at that point. So if the revenue is only covering 75 percent of the total claims that are being filed by hospitals on behalf of patients, the law is ambiguous about how that will be handled. It doesn't say exactly how to handle it. The presumption is you just pay a percentage of the total claim.

Mr. SHIMKUS. Because there is no provision for us right now, under current law, to borrow money to keep the new changed delta. I mean——

Mr. CAPRETTA. When the trust fund is depleted of reserves, there is no ability, under current law, for it just to run in the red.

Mr. SHIMKUS. So Medicare pays, in essence, 70 percent of private care costs. I mean, I don't know if you know that or not. That is what I——

Mr. CAPRETTA. It is a little bit more than that, but that is in rough terms right.

Mr. SHIMKUS. So if these insolvency date hits, then they are going to end up paying——

Mr. CAPRETTA. Seventy percent of that.

Mr. SHIMKUS. A huge——

Mr. CAPRETTA. Yes.

Mr. SHIMKUS. So it could be 30, 35 percent to the providers——

Mr. CAPRETTA. Right.

Mr. SHIMKUS [continuing]. Who are providing care.

Mr. CAPRETTA. It recognizes the law has already cut the reimbursement rates quite a bit. The main provisions of saving money in the Medicare program that have been discussed today at the hearing are provisions that simply apply across-the-board reductions to every facility in the country that is providing services to Medicare patients. It didn't distinguish amongst any of them based on quality or anything else. It essentially applied an across-the-board cut to every provider.

Mr. SHIMKUS. Now, let me ask a question, because then you talk about revenue, right? Maybe a solution would be more revenue.

But under the Obamacare, the healthcare law, we increase Medicare taxes by leveling the 3.8 percent tax on unearned income, do we not?

Mr. CAPRETTA. That is correct. For anyone above $200,000 a year in annual income if you are an individual, $250,000 for couples.

Mr. SHIMKUS. So this must help that fund, shouldn't it?

Mr. CAPRETTA. Well, it didn't go into the Medicare trust fund, though. This portion of that tax increase was dedicated to financing the rest of the bill.

Mr. SHIMKUS. So a 3.8 tax on unearned income on the Obamacare healthcare law did not go to help prop up these insolvency issues on Medicare.

Mr. CAPRETTA. Correct.

Mr. SHIMKUS. Well, that is unfortunate, if there is a funding problem.

We also talked a lot during the debate, even in the Presidential campaign—and I had Secretary Sebelius right at the table you are at, who in essence agreed that they had double-counted the depletion of Medicare dollars into two directions. They double-counted, in essence, I said $500 billion, but now we know it is like $716 billion.

How did we double-count that, or how did—and we voted against the law—how did those who support the law, how did they double-count, how did the administration double-count hundreds of billions of dollars?

Mr. CAPRETTA. They cut the Medicare payment rate, as we discussed, by about $500 billion.

Mr. SHIMKUS. Arguing that they are saving Medicare.

Mr. CAPRETTA. And they are taking basically $500 billion, reducing what Medicaid is paying to providers. That $500 billion was used under what you call the PAYGO scorecard that is used in Congress to make sure legislation is at least deficit-neutral or a little better. They used that $500 billion to show a positive balance on the PAYGO scorecard. That is one scorecard. And then they deposited it into the second scorecard, the trust fund scorecard, to pay future Medicare claims. So they did spend the money twice.

Mr. SHIMKUS. Thank you very much.

Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and now recognizes the ranking member of the full committee, Mr. Waxman, for 5 minutes for questions.

Mr. WAXMAN. Thank you, Mr. Chairman.

Dr. Feder, the title of today's hearing is "Saving Seniors and Our Most Vulnerable Citizens from an Entitlement Crisis." It seems that the term "entitlement" has come to mean different things to different people. Too often, people think of entitlements through the narrow lens of the programs that provide the social safety net for our seniors and the most vulnerable in our society without considering the fiscal impact of tax entitlements—tax deductions, exclusions, credits, and other tax preferences—which disproportionately benefit well-to-do Americans. One could call those entitlements.

Can you talk about entitlements, both those providing essential services to seniors and low-income Americans and those providing

tax breaks to more affluent Americans, and the relative role of each in the context of protecting the most vulnerable in our society and addressing our long-term debt?

Ms. FEDER. Yes, Mr. Waxman.

I think that we should start with the recognition that an entitlement is a commitment on the part of the Federal Government to provide benefits to as many people who qualify for that benefit appear in a given year without a constraint through the appropriations process. And when we apply that definition, the benefits that come through the Tax Code are the very same kinds of entitlements as benefits as those that come through direct spending. And that has, I think, been recognized by the Congressional Budget Office and others for many years. That is why we call them tax expenditures.

There are some tax expenditures that do benefit low-income people, like the earned income tax credit and like the refundable tax credits in the Affordable Care Act. But the vast majority of tax expenditures for health care, for housing, for pensions, are disproportionately overwhelmingly benefitting the better-off. Because the higher your income, the more you benefit from not paying taxes on those dollars.

It can be argued that that spending is crowding out some of the spending that we—improved spending that we need for middle-income and lower-income populations.

Mr. WAXMAN. Exactly the argument we hear for spending on entitlements.

Ms. FEDER. I beg your pardon?

Mr. WAXMAN. That is exactly the argument we hear for spending on Medicare and Medicaid.

Ms. FEDER. That that is crowding out, not——

Mr. WAXMAN. Yes.

Ms. FEDER. You are quite right. And what I am saying, and I think that I am getting your point, is that by spending on the better-off in tax entitlements, it is that that is very much a part of the crowd-out.

Now, I would also say that I don't know that I would eliminate all of those. I would not eliminate the tax benefit because we need the risk-pooling that it provides. But for high-income people, we do not need to be providing so many benefits.

Mr. WAXMAN. Well, some have argued that cutting only spending entitlements while shielding tax entitlements would have a highly regressive impact. Is that what you are saying?

Ms. FEDER. It surely would.

Mr. WAXMAN. OK.

My Republicans colleagues have proposed keeping tax levels at about 18 percent of GDP. With what we know about the aging of our population and the increasing need for health coverage under Medicare and Medicaid, is it realistic to keep revenues at that level?

Ms. FEDER. No. It simply is not. And when you hear of concern for State budgets and when proposals are being made to actually shift more costs to States, whether it is health care or if we look at long-term care, which is borne primarily by the Medicaid program, and different rates of aging in different States, the notion

that we would deal with these kinds of issues without generating, raising additional revenues is really unconscionable.

Mr. WAXMAN. I was troubled by some of the accusations in the testimony of Mr. Archambault, and I believe they deserve to be fact-checked.

First, Mr. Archambault asserts that Medicaid is not serving its customers well and, in some cases, may be hurting their health.

Dr. Feder, isn't it true that the Medicaid program is completely optional for States? States are not required to provide Medicaid; isn't that correct?

Ms. FEDER. Yes, sir.

Mr. WAXMAN. So if Governors really believed that Medicaid was harming their residents' health, do you believe they would continue to fund the program?

Ms. FEDER. Sounds pretty peculiar to me.

Mr. WAXMAN. Many Governors, even Republican ones, have already opted to participate in the Medicaid expansion offered as a part of the Affordable Care Act because it is good for their States and good for their citizens. Moreover, there is empirical evidence showing that Medicaid improves health; isn't that accurate?

Ms. FEDER. Yes, sir.

Mr. WAXMAN. In 2008, Oregon conducted a randomized, controlled experiment on how expanded access to Medicaid affects health. The results are very encouraging. The group who received coverage under Medicaid had substantively and statistically higher utilization of preventive and primary care, low out-of-pocket medical expenses and lower medical debt, and better physical and mental health than the control group.

Can you comment on the assertions in Mr. Archambault's testimony?

Ms. FEDER. We had discussed that earlier, so I can do it briefly.

I think that the evidence you have presented is what the—the predominant evidence on the value of Medicaid in terms of improving people's health and enabling them to get care. There is no question about it.

Mr. WAXMAN. Thank you.

Thank you, Mr. Chairman.

Mr. SHIMKUS [presiding]. The gentleman's time has expired.

The chair now recognizes the gentleman from New Jersey, Mr. Lance, for 5 minutes.

Mr. LANCE. Thank you very much, Mr. Chairman.

And good afternoon to the panel.

To Dr. Feder, good afternoon. You gave us a figure, and I just didn't hear it. I gather Medicaid, at the moment, spends roughly $400 billion a year; is that right?

Ms. FEDER. I beg your pardon?

Mr. LANCE. Medicaid is roughly $400 billion a year? And I was interested in your testimony regarding long-term care. What percentage is in long-term care?

Ms. FEDER. Long-term care is about a third of total Medicaid spending. Spending on the elderly and disabled—and for the low-income disabled, Medicaid is providing not just long-term care but health care—the two populations together absorb about two-thirds of Medicaid spending.

Mr. LANCE. And by "long-term care," do we mean nursing home care, by and large?

Ms. FEDER. Not necessarily. We mean help with basic tasks of daily living, which can happen in nursing homes but also happen at home and in community daycare centers and other places.

Mr. LANCE. And, obviously, with an aging population, the baby boomers, there are going to be more people who are going to need——

Ms. FEDER. That is correct.

Mr. LANCE [continuing]. Long-term care.

Have you analyzed models that might be different from the model that we utilize today in America? I would hope it would be less expensive, but perhaps it would not be less expensive, care from one's residence as opposed to care in the nursing home?

Ms. FEDER. There has been a movement over several years, as it sounds as though you are quite familiar with, Mr. Lance, to treat people at home where they want to stay, or help people at home where they want to stay. And on a per-person basis, it is cheaper than putting them a nursing home.

But we need to better serve that population. They are underserved throughout the Nation. And that requires additional investment.

Mr. LANCE. That would impress me as an area where we might work together in a bipartisan capacity, as undoubtedly there are going to be more people needing long-term care given the aging population and particularly regarding those who are baby boomers.

Ms. FEDER. I think that would be a wonderful thing, Mr. Lance. And I would appreciate—or would offer any assistance in that regard that I can.

Mr. LANCE. Thank you.

Regarding tax expenditures—and I understand that this is a newer debate in America, but it is a debate currently occurring in our country. To you, Dr. Feder, or to other distinguished members of the panel, what is the largest tax expenditure at the moment in the country?

Ms. FEDER. I think the largest tax expenditure is the exclusion of employer-paid premiums from taxable income.

Mr. LANCE. Yes.

Other members of the panel, is that the largest tax expenditure?

Mr. CAPRETTA. Yes, that is true.

Mr. LANCE. Yes. And I have stated in my campaigns for office that I do not favor taxation of that, and that has been welcomed by those who elect me to office.

And I think it would be extremely difficult to tax those healthcare policies. Does the panel believe that it is at all realistic that Congress, whatever its configuration, would actually do that?

Ms. FEDER. Well, if I—and following up on Congressman Waxman's questions——

Mr. LANCE. Yes?

Ms. FEDER [continuing]. I think that what is important to recognize is that if the Congress is proposing to put a lid on spending for Medicare or Medicaid programs, that to ignore the expenditures that disproportionately go to higher-income people——

Mr. LANCE. I understand that point.

Ms. FEDER. And I think that is the context in which it is made. The other proposal——

Mr. LANCE. So do you favor taxation, Dr. Feder, of the portion——

Ms. FEDER. The proposals that I have seen that make sense to me—and we actually are doing something very much like that in the Affordable Care Act. I think that the proposals that I have seen that make some kind of sense are the proposals that would limit the tax breaks for higher-income people. But I would not favor taxing all those benefits.

Mr. LANCE. You would not favor taxing all of those benefits.

Yes?

Mr. CAPRETTA. It is important to recognize that the healthcare law did, in a sense, impose a tax on those benefits on high-cost plans.

Mr. LANCE. Yes. Thank you.

Mr. CAPRETTA. And it was not based on income. It was across the board.

Mr. LANCE. It was across the board. Thank you.

In your testimony, Dr. Feder, you do say, "Stabilizing the debt in the coming decade would give policymakers time to identify the further steps that will be needed to slow the growth of healthcare costs throughout the U.S. healthcare system without impairing the quality of care." I believe I agree with that statement.

At what level do you think it would be best, given the current situation, to stabilize the debt?

Ms. FEDER. Well, in my testimony I cited the work that has been done at the Center on Budget and Policy Priorities advocating that we stabilize that percentage at 73 percent of GDP.

Mr. LANCE. And what is it at the moment? It is a little higher, isn't it?

Ms. FEDER. I apologize. I don't want to misstate a figure, so I will just provide that for you later.

Mr. LANCE. Thank you very much.

Thank you, Mr. Chairman.

Mr. SHIMKUS. The gentleman's time has expired.

The chair recognizes the gentleman from Georgia, Mr. Barrow, for 5 minutes.

Mr. BARROW. I thank the chairman.

Critics of the two warring tribes in Washington can find plenty to criticize on both sides. There will be folks who criticize Democrats for having a blind faith in the future and sort of ignoring the long-term trends and problems here, having some faith in our ability to solve this problem down the road. Folks can criticize folks on the other side of the aisle for basically saying this is so ominous, so bad, we just have to get out of the business, we have to cost-shift, we have to get out of the business of subsidizing the current model because it is just way too much for the taxpayers to bear.

Both sides, it seems to me, that stereotype, seem to agree on something. They seem to accept the current level of spending and the current projections and the trends as being sort of—the best of all possible worlds—some sort of a given. And I challenge that assumption.

I happen to think that this whole approach that most folks tend to agree on is, what are we going to do about how to pay for this, sort of ignores the real challenge here. And that is, what are we spending our healthcare dollars on? And what are the things we can do that would have a big impact on what we are spending on but would also alleviate the underlying problems that people are facing.

I look at the scourge of Alzheimer's and the scourge of diabetes as being a whole lot more than the public tab associated with both of those diseases, just to take two large, big-ticket items for example. If we could crack the Alzheimer's code, for example, I think we would have a big impact on Medicaid's viability and the burden that it is carrying all over the country. If we could crack the problem, the current trends of letting diabetes set up in the course of people's lives during their work life and most of the bills coming due only during Medicaid's time on the healthcare watch, we could have a big impact on Medicaid. But, more importantly, we could alleviate the suffering of millions that really is not accounted for in any of the discussion that we have been having on this committee.

So my question to you all is, if you want to attack the problem in terms of putting the technology out in front of the mandates, instead of figuring out how we are going to pay for business as usual, but what can we invest in that will make for business as unusual, that can actually affect what we are having to spend money on in a big way?

And I am not talking about nanny-state stuff that has no practical chance of success. I am talking about things we can hit if we make a good investment, a solid investment, a war on this or a war on that, that would have a big payoff not just in terms of the public's share of the healthcare expense in this country but also the suffering that people are experiencing in their lives.

What are the two or three things that you all say we ought to wage a war on to get at that would have a big impact on Medicare's budget, Medicaid's budget, and also the bottom line of what we are funding?

Because I regard this whole approach as sort of taking the current state of affairs as a given. And I look at this in terms of we are missing the challenge of trying to find those breakthroughs, those things that would take a serious, concerted, coordinated effort of research and development and deployment to actually make a big impact not only on people's lives but also in terms of our Nation's healthcare budget.

What would you suggest we go after if that is the approach we want to take?

I want to make the bad things we are paying for obsolete, not just be arguing about who is going to have to pay for them. I want to make the things that are driving our budget ox into the ditch and making people's lives miserable and make those things obsolete, rather than just figure out who is going to pay for them.

Who is going to take a stab at helping us understand where we need to go in that direction?

Mr. CAPRETTA. Well, it is a big, big question. I am sympathetic to your point of view, actually. I think it is a big challenge, though, to have the certainty that some kind of public intervention is going

to have enough of a payback and certainty that you don't need to make other adjustments.

So, in other words, my first point to you——

Mr. BARROW. I recognize that if we solved a lot of problems that are killing people off at a certain age, we would have a little bit more in terms of pension. Maybe there would be a shift on the reliance on the pension benefits of folks who are living longer and healthier lives.

Mr. CAPRETTA. No, no, what I am trying to say is that let's assume we made a big intervention in the areas you are talking about—and I am about to mention one that I agree with you on—it is so uncertain that it will have the payoff we both would like to see, that you still have to make other adjustments in the entitlement programs, because you can't bank on that having the 20-year effect we are both looking for.

But having said that, I do think that there are opportunities, especially in the area of diabetes, to make some progress. I think there are a lot of untreated and undertreated people with that condition that are heading into their Medicare years quite soon. And if we did a better job of coordinating care for that population, there is an opportunity—and I was part of a study that looked at this carefully—there is an opportunity to bring down some of that burden with some level of certainty associated with it.

It won't solve our budget problems, though, I am afraid to say, unfortunately, because there are some expenditures involved in providing better care for them too

Mr. BARROW. Dr. Feder, my time is running out. Have you got something you want to add?

Ms. FEDER. I was just going to add, I think that when Jim talks about investing in diabetes and in prevention and primary care, that is precisely what the changes, payment and delivery reforms in the Affordable Care Act are aimed to promote. It is to enhance our focus on primary care and coordinate care at early stages when there are early difficulties in order to prevent the use of costly services later on that actually could be prevented.

Mr. BARROW. Just so you know, I am not interested in something that is high-maintenance, low-impact. I want low-maintenance, high-impact. That is what I am looking at.

Thank you.

Mr. SHIMKUS. The gentleman's time has expired.

Ms. SCHAKOWSKY. Mr. Chairman, I am wondering if I could offer something to put in the record.

Mr. SHIMKUS. What are you——

Ms. SCHAKOWSKY. This is a statement by Ron Pollack from Families USA.

Mr. SHIMKUS. OK. Without objection, we will accept the submission.

Ms. SCHAKOWSKY. Thank you.

[The information appears at the conclusion of the hearing.]

Mr. SHIMKUS. That chair now recognizes the vice chairman of the full committee, Mrs. Blackburn, for 5 minutes.

Mrs. BLACKBURN. Thank you, Mr. Chairman.

Just one comment I wanted to get in before I—I do have a couple of questions. Ms. Feder mentioned earlier that there was an in-

crease in provider payments in Obamacare for Medicaid providers. And I just want to note that that is actually going to be a 2-year bump——

Ms. FEDER. That is correct.

Mrs. BLACKBURN [continuing]. And not a full-time, long-term payment. So basically what we are doing there is setting up another one of these cliffs. It will be a new SGR cliff because the money goes away after 2 years.

And what we find out and what we hear from our Governors and one of the reasons so many of our State legislatures are having such heartburn over the Obamacare issues is because you put money in, then you take money out, and then what happens with those Medicaid beneficiaries? And where are they going? How are you going to pay for this?

And, quite frankly, I have to tell you that we all are compassionate and want to make certain that people have access to affordable care. But having the Federal Government put their hand further into that healthcare pot does not solve the problem; it makes it worse. It makes it worse.

What we want to do and what I have heard from my colleagues across the aisle even—I am happy to hear them talk about solving this problem and this access-to-care problem, because the more Federal intervention you have, the worse the situation gets, the more limited is your access to care.

And what we have found in Tennessee—and I will make Mr. Pallone's day. He knows I can't sit here and not say "TennCare." What we found through the—are you familiar with TennCare, Ms. Feder?

Ms. FEDER. I am.

Mrs. BLACKBURN. And you know what a miserable failure it was and how we had a Democrat Governor that had to come remove 180,000 people from the rolls and restructure it.

And one of the lessons learned is that having access to the queue is not the same thing as having access to the physician. And that is something that you see—I continue to ask everybody, show me a public option plan, show me a Federal mandate plan that gives you greater access, greater outcomes, and a lower cost. The truth is, Ms. Feder, there is not one on the face of the earth, not one, that has successfully done that.

Mr. Capretta, I have a couple of questions for you. I sit in these hearings and I hear a lot about, every time we look at something to save Medicare, to keep it solvent for a long period of time, trustees have told us it is going broke. Every time we do that, we are accused of trying to drive grandma and grandpa off the cliff. And I find it so incredibly unfortunate, but I think that the real crime is to sit by and do nothing and say we are just going to be content with the status quo and not look at how we solve this problem.

Tell me where you are with looking at these trustee reports. What are your thoughts?

Mr. CAPRETTA. Well, the latest CBO estimates actually are pretty interesting. They did lower Medicare's future expenditure rates going forward.

But the largest reduction, actually, was in the drug benefit, believe it or not. There is a lot of talk about Medicare and what it

does and doesn't do and so on, but the drug benefit is essentially a competitive program driven entirely by private plans. It has been very competitive.

Mrs. BLACKBURN. And it works?

Mr. CAPRETTA. And it works. The average annual growth rate——

Mrs. BLACKBURN. And it is successful?

Mr. CAPRETTA. The average annual growth rate from 2007 to 2012 is a little bit more than 2 percent a year, well below the average for the rest of the program.

And the largest downward adjustment CBO made in their estimates going forward was in the drug benefit, despite the fact that the healthcare law expanded the program by closing the donut hole.

So there is a model out there of competition and private choice and consumer choice that is working. It has actually driven a lot of costs out of the program.

Mrs. BLACKBURN. All right. I appreciate that.

I want to talk with you, also—obesity. Mr. Barrow mentioned Alzheimer's, which is a disease I am so familiar with because of my dad and my mother-in-law, both of whom have died with Alzheimer's. And I share his desire to crack that code. I think the other one is obesity.

And you have had some interesting analysis on this. And what do you think, if we could reduce the obesity rates in seniors, what kind of impact would that have on the Medicare program?

Mr. CAPRETTA. It would have a very positive impact if we could do it. I think the challenge is the certainty of knowing which policy levers to pull that can deliver for sure on the outcome.

I am all for trying to address this problem, in some way, to some degree. I think it will positively affect especially diabetes in the program, where there is a big chunk of dollars associated with that.

So we don't have a silver bullet, but I think some additional public attention for people that are aging into Medicare with that problem is worth your attention.

Mrs. BLACKBURN. Thank you.

I yield back.

Mr. SHIMKUS. The gentlelady's time has expired.

The chair now recognizes the gentleman from Virginia, Mr. Griffith, for 5 minutes.

Mr. GRIFFITH. Thank you, Mr. Chairman.

According to the CBO, Medicaid will cost the Federal Government $5 trillion over the next 10 years, with as much as $638 billion of that directly linked to the expansion of Medicaid from PPACA. Recently, Governor McDonnell laid out the need for vast reform to make Virginia's Medicaid program more cost-effective before the Commonwealth can consider an expansion of those benefits in that program.

The Governor has laid out five tenets for Medicaid reform: one, service delivery through an efficient, market-based system, including more managed and coordinated care; two, reducing financial burdens to the State by getting an assurance from the Federal Government that the expansion will not increase the national debt;

three, maximize the waivers that currently exist to achieve administrative efficiencies through streamlining of payment and service delivery; four, obtain buy-in from healthcare stakeholders in the State for statewide reform; and, five, achieve greater flexibility by changes to Federal law, including more value-based purchasing, cost-sharing, mandatory engagement in wellness and preventive care, the development of high-quality provider networks, and flexibility around essential health benefits.

The Virginia Hospital and Health Care Association has said that they will cooperate. The reforms that Virginia is now discussing are on a par or similar to what we have discussed here in the Energy and Commerce Committee, at least on our side of the aisle. And that flexibility with Medicaid programs I think many States desire.

So, Mr. Archambault, do you agree with Governor McDonnell that we need to have these Medicaid reforms and that not only Virginia but other States should be exploring these types of reforms and that we should be a partner with them? If you could explain.

Mr. ARCHAMBAULT. Yes, Mr. Griffith, as I think the Governor has laid out and put his finger on a number of the issues that exist in the current program.

And this is a bipartisan issue. You have Governors who have put in waiver requests that take over a year to get any response from the administration on whether they can move forward or not. So, certainly, I think both Republicans and Democrats at the State level see the value of greater flexibility. And I think anything that Congress can do to grant that flexibility would be a move in the right direction.

Mr. GRIFFITH. And you say that there are Democratic Governors as well as Republican Governors who desire this flexibility?

Mr. ARCHAMBAULT. That is true. I mean, we have one in Rhode Island, in which they have been working on these issues for years, trying to get flexibility. And they got some additional flexibility to move forward.

Mr. GRIFFITH. And do you think that is because they sense, as the Founding Fathers did, that perhaps the individual States should experiment and find what works best, and then others can copy if they wish?

Mr. ARCHAMBAULT. I think that is right. I mean, we even have an example in Connecticut with a Democratic Governor in which they expanded recently in Medicaid, and they found that it was more expensive than they initially anticipated; asked for flexibility from the administration, and it was denied.

So I think there is certainly the need and a recognition on both sides of the aisle at the State level of this issue.

Mr. GRIFFITH. Mr. Capretta and Mr. Archambault, both, what do you think that we can do to better serve the States as they try to figure out ways to be more efficient?

I will start with you, Mr. Capretta, since Mr. Archambault has had a couple minutes.

Mr. CAPRETTA. Sure. I think this year is a historic opportunity to move ahead with some more Medicaid flexibility year. Here you have an administration who would like the States to do a very large-scale expansion, which the Supreme Court said is entirely op-

tional at this point. Many States are holding back, thinking about it.

I think they have a great deal of leverage and you and the Congress have a great deal of leverage to say, Before we do anything more to put more people into the program, let's come to a consensus about what the basic rules are for who is running what.

Mr. GRIFFITH. For those who may not follow Virginia politics closely, that is exactly what the Virginia General Assembly did, was they said, We are going to set up a special group to consider expansion that the President and PPACA encourages, but we are not going to expand until we have seen reforms that make it so that we can afford to do that expansion.

And so you are recommending that perhaps we take that Virginia model and see if we can't help encourage other States to do that by giving them the flexibility.

Mr. CAPRETTA. I think there is a real pernicious effect. I worked in the administration, did a lot of Medicaid waivers in my previous job in a previous administration. There is a little bit of an unusual and pernicious effect on one-off negotiations between an administration and a State. There ought to be rules that apply to every State that are fair to taxpayers across the country, and not special deals given to some States over others.

Mr. GRIFFITH. All right. I appreciate that.

I only have 6 seconds left. Mr. Archambault?

Mr. ARCHAMBAULT. I think a great example is welfare reform. You had a lot of States figure out how to do it at the local level first, and then there were—the same rules applied to all States.

Mr. GRIFFITH. And I have to go, but I would be remiss if I didn't mention that Virginia led on that one, as well.

Thank you very much.

I yield back, Mr. Chairman.

Mr. PITTS [presiding]. The chair thanks the gentleman and now recognizes the gentleman from Kentucky, Mr. Guthrie, for 5 minutes for questions.

Mr. GUTHRIE. Thank you very much, Mr. Chairman. I appreciate being here.

We talked about 2024 as the date that Medicaid goes insolvent. And that is if you believe a lot of the different accounting systems in the healthcare bill and the SGR goes away. Things like that happen even to get to 2024.

But let's assume we get to 2024 before Medicare goes insolvent. So if somebody is 66 in 2024, we don't know how the law is going to treat them. That is what the testimony has been here today. Will it be 75 percent of 70 percent payments to hospitals and doctors? We just don't know that.

I don't know if anybody would disagree with me on the panel, but we don't know what will happen if Medicaid goes insolvent in 2024, which is what the President's healthcare bill that was voted on by the majority does.

So if it goes insolvent in 2024 and we don't know how 66-year-olds are going to be treated—we do know that if we pass the Ryan budget, someone who is 66 years old in 2024 will have Medicare as we know it today.

And just take me; I am a baby boomer. I was born in 1964, on the end of it. So if you are 65 today—today, if you are 65, as we speak today you are on Medicare, do you hope to live to be 76? With our healthcare system, I think most people do hope to live to 76.

So what we are telling people today, we have no idea how you are going to have Medicare when you are 76 years old, unless we put a plan in place, which this side has put forth. A lot of people say, In Washington nobody ever tries to solve problems. We have known this is coming, both parties have known this is coming for a long time. Baby boomers are just a fact; it is a fact of the life. But we do have a plan. If you are 65 years old today, when you are 76 you will have Medicare as you know it.

And so what are we talking about doing the difference? Well, people will say, well, we need a balance of revenue. The President went around the country last year saying if we just asked the millionaires and billionaires, defined at $250,000 or more, to pay more, nobody is going to have to make any changes. Well, that is $80 billion. The President got $60 billion of the $80 billion in the fiscal cliff bill. I don't know if anybody in this room would say that is enough to solve the problem with Medicare.

Even if you got the additional $20 billion he promised—even though the 3.8 Medicare tax on unearned income didn't go into the Medicare side. So asking the rich to pay more, the fiscal cliff bill, the $60 billion didn't go to stave off Medicare. It was spent, essentially, in the fiscal cliff bill, most of it was spent on other projects. So when you say we just need to raise taxes to put it back into Medicare, I mean, we have seen what has happened twice just recently.

So what are we offering? I think—is Medicare Part D a good program? And people think Medicare Part D—you said it is the cost of—people are saying Medicare costs per beneficiary have slowed, and a lot of it is due to Medicare Part D.

So what we are saying is, oK, instead of—I think we had one panelist say, well, when baby boomers retire—they built schools when they had baby boomers; therefore, they are just going to have to pay more for us to be retired. So I am telling my children—my daughter is 19. In 30 years she will be 49. One hundred percent of all Federal revenues is supposed to go to Social Security, Medicare, and Medicaid at that point. So I am telling my daughter when she is my age she needs to wake up and go to work so my generation can be retired. That is what we are telling them. I mean, what else are they going to have? They are not going to have anything else.

But what we are saying, if we adopt a program like Medicare Part D for the rest of Medicare, not only can somebody that is 65 years old today have Medicare till they pass away as they know it and as it is, our children and grandchildren can have Medicare delivered to them in a way—did the majority change Medicare Part D in the bill? They did change some benefit within Medicare Part D, but they certainly didn't change the way it is delivered.

And so I don't know why it is so radical. If it was so bad to do the other parts of Medicare like Medicare Part D, then why wasn't it changed during the healthcare bill? It wasn't.

And so what we can say today, we can say, Children and grandchildren, my generation is retiring, you just owe it to us? Or we can say, Children and grandchildren, we are going to promise to people who are near retirement because politicians promised them things that we had no idea how to pay for but they organized their life around it so we are going to honor it? That is what this budget that is coming out tomorrow does. It honors the promise we made to people at or near retirement.

But instead of asking our younger people to pay more, let's change the program in a way that we know works, because Medicare Part D works, and present it, give them an opportunity to have to not go to work every day to pay for my generation to be retired, go to work every day so hopefully someday when they have grandkids and they have grandkids, they can have the America that our parents have given to us.

And I think that is what our generation owes them. They don't owe us. We owe them. That is what the American dream has been about.

And I yield back my time.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from Louisiana, Dr. Cassidy, for 5 minutes.

Mr. CASSIDY. Hey, Mr. Capretta.

Mr. CAPRETTA. Hello, Doctor.

Mr. CASSIDY. Que pasa?

Mr. CAPRETTA. Very well.

Mr. CASSIDY. So, as I gather—and I was looking up the CBO, Erskine Bowles—but if we do nothing, what, by 2035 or thereabouts Medicare, Medicaid, Social Security, and interest on the debt will consume 100 percent of Federal tax revenue?

Mr. CAPRETTA. I think that is about right, yes.

Mr. CASSIDY. It was something like that, and I somehow wondered off where I should be.

And I also believe I know it is true that current law says that we cannot, under current law, transfer dollars from the general fund to the Medicare trust fund. Medicare trust fund, by law, is supposed to be self-sufficient, correct?

Mr. CAPRETTA. The Medicare hospital insurance trust fund is in that circumstance, yes, that is correct.

Mr. CASSIDY. So when A goes bankrupt, there is no more?

Mr. CAPRETTA. When it runs out of reserves, there is no—you have to change the law to put more money into it.

Mr. CASSIDY. Dr. Feder, is reform worse than bankruptcy? Because if we know, according to current law, that after, what, 2024 there is no money, that people will not have any dollars in Medicare Part A, is reform worse than—is reform——

Ms. FEDER. Mr. Cassidy, it is not——

Dr. CASSIDY [continuing]. Worse than bankruptcy?

Ms. FEDER [continuing]. Quite accurate to say people will not have any dollars in Medicare Part A. As has been said, they would not—that Medicare Part A dollars would fall short of full expenses——

Mr. CASSIDY. No, no, no, that is when it is bankrupt, right?

Mr. CAPRETTA. Well, bankrupt, and that is—there would still be revenue coming in that——

Ms. FEDER. There is still revenue——

Mr. CASSIDY. Well, it will be pay-as-you-go.

Ms. FEDER. The short story there is——

Mr. CASSIDY. Yes, but——

Ms. FEDER [continuing]. It is never bankrupt.

Dr. CASSIDY [continuing]. It is going to be 10 percent or it is going to be 20 percent.

Ms. FEDER. No. Well, no. Wait. We said it is 70 percent. And the other——

Mr. CASSIDY. No, it is 70 percent now.

Ms. FEDER. The other percent—no, I don't think so.

But the other part of the story is that we are not doing nothing now. I have heard it said several times today that "if we do nothing." We are not doing nothing.

Mr. CASSIDY. OK. Now, the accountable care organizations have never been shown to save money relative to——

Ms. FEDER. Well, of course they haven't been shown to save money, because they are brand-new and we are piloting them.

Mr. CASSIDY. No, no, no. They had demonstration projects which were deliberately selected to be places that had integrated health care that——

Ms. FEDER. I hear your concern about the previous pilots, and I think—but there are design features, for example, in the pioneer ACOs, who are sharing risk as well as sharing savings, that have greater potential, in addition to which they are not the only demonstrations that are being——

Mr. CASSIDY. Now, by the way, ACOs—I am sorry, I don't mean to interrupt, but I just have so little time. ACOs count upon having a capitated or a per-beneficiary payment, correct?

Ms. FEDER. No, they are shared—they are paid toward a—there is a target on their spending.

Mr. CASSIDY. So their——

Ms. FEDER. And they share savings or bear—or some of them bear risk.

Mr. CASSIDY. So, ultimately, there is a sense of—and IPAB, for example, assumes a global budget for Medicare.

Ms. FEDER. Well, that is a different question. An ACO is not the same as an IPAB.

Mr. CASSIDY. So is a cap inherently wrong?

Ms. FEDER. Well, let me just—there is not a cap in the ACO savings. There is a shared risk—or an ACO program—there is shared savings.

What I think is wrong is to cap dollars and assume that we know how to deliver the services. So you——

Mr. CASSIDY. So New York State is——

Ms. FEDER [continuing]. Assume a delivery mechanism. And I also would say that an arbitrary cap that is significantly slower than the rate of increase in healthcare spending puts beneficiaries at risk.

Mr. CASSIDY. So New York Mayor Cuomo, Governor Cuomo, I am told, is putting a global cap on Medicaid. Is that wrong?

Ms. FEDER. I do not think programs should be globally capped. I think they——

Mr. CASSIDY. So is there no limit to the exposure of the Federal taxpayer to how much they can spend?

Ms. FEDER. What I believe is that we need to adopt specific policy measures that do generate savings without——

Mr. CASSIDY. Well, we know historically——

Ms. FEDER [continuing]. Shifting risk to beneficiaries. It is shifting risk to beneficiaries——

Mr. CASSIDY. I am sorry. There is limited time. There is limited time.

We know historically that New York, for example, has really gamed that system. So New York, which has half the population of California, has a program which is 25 percent more expensive. There are people in disabilities who are getting paid by New York Medicaid $5,000 a day.

Ms. FEDER. I think the way to address problems in spending is to adopt specific policy measures to make the system more efficient, which we know how——

Mr. CASSIDY. Now, we know that——

Ms. FEDER [continuing]. Some of which we know how to do.

Mr. CASSIDY. We know that Medicaid is very difficult to reform. Mr. Archambault just said that it takes a year, sometimes longer, to get a waiver. That doesn't really seem to be the flexibility or the agility——

Ms. FEDER. Oh, I would say that Medicaid has made a lot of changes in recent years, that we have for moms and kids an extensive reliance on managed care plans, some of which is good and some of which is not good. So there has been plenty of reform in Medicaid programs, whatever——

Mr. CASSIDY. But that wasn't the point. The point is that the flexibility that would give States the ability to sometimes shut this sort of thing down could take over a year.

Ms. FEDER. What I have heard ignored and in the previous comments is that what your budget is proposing is to take $800 billion out of the Medicare program.

Mr. CASSIDY. You are kind of dodging the point, my point being that there is no ability—or put it this way. If it takes a year to 2 years or sometimes never to get the flexibility to address this, it shows that our ability to address it isn't quite agile.

Ms. FEDER. I simply disagree on——

Mr. CASSIDY. Mr. Archambault, is it true it takes over, sometimes, a year or 2 years to get those waivers?

Mr. ARCHAMBAULT. I think there are multiple States. New Mexico is an example. Florida is an example in which it took at least a year, if not more. State of Oregon, Democratic Governor, took a while to get permission for their waiver, as well. Yes.

Mr. CASSIDY. So I am almost out of time, but thank you very much.

Ms. FEDER. You are welcome.

Mr. CASSIDY. I yield back.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentlelady from North Carolina, Mrs. Ellmers, for 5 minutes for questions.

Mrs. ELLMERS. Thank you, Mr. Chairman.

And thank you to our panel.

I would like to start off by saying, Dr. Feder, you had made some comments regarding the budget and that the budget basically repeals Obamacare and that that, in your opinion, is not a good thing. I would say that I completely disagree with that.

And I am very concerned about access to care for patients, whether they be patients who are receiving Medicaid or Medicare patients. I think that is really what is in jeopardy here, and quality of care. Those are some of the things that we have to be addressing and looking at. We are all talking about pay-for, and that is very, very important, but it is really access to care and quality of care.

So, having said that, the discussion about the States and the Governors who have decided to or been opposed to expanding Medicaid is an issue. In North Carolina, for instance, Pat McCrory, Governor Pat McCrory, has not elected to expand the Medicaid program. And his quote is, "Our Medicaid system is broken, and I cannot expand a brokensystem." Now, I understand the Governors that have, but I also understand that is also information that they are receiving, and good intentions are, I think, what is happening here.

And I would just like to cite—I know there were some other studies that were being discussed about how—and you had made comments that someone who was put on Medicaid essentially will receive the same health care and the same quality as someone who was on a private healthcare insurance plan. And I would dispute that.

In fact, the study that I most recently became familiar with is the 2010 University of Virginia study, which released a landmark study showing that surgical patients—and this is surgical patients that they cite—on Medicaid have a 13 percent higher chance of dying than an individual with no insurance at all, keeping in mind, of course, that the death rate or the mortality of a surgical patient with healthcare insurance is about 1.3 percent, so that is statistically pretty small.

But 13 percent higher than someone with no insurance at all and 97 percent higher if that person is on Medicaid. Now, that is in stark contrast with some of your theories and, basically, some of the studies that you have already cited.

Having said that, obviously, this study shows, yes or no, that putting someone on Medicaid is not necessarily giving them better health care?

Ms. FEDER. No.

Mrs. ELLMERS. OK. Now, were you familiar with the study?

Ms. FEDER. No, I was saying my understanding of that, or of similar studies—I would have to check that particular——

Mrs. ELLMERS. Yes.

Ms. FEDER [continuing]. Is that it is of considerable importance, when you do a study, to compare costs under different insurance programs, that you recognize the health status or differences in the health status——

Mrs. ELLMERS. And I believe this study actually does that. So I would encourage you——

Ms. FEDER. My concern is that——

Mrs. ELLMERS. I would encourage you to familiarize yourself with this particular study——

Ms. FEDER. And I——

Mrs. ELLMERS [continuing]. Because it breaks it down.

Ms. FEDER. It runs counter to so much else——

Mrs. ELLMERS. Now, how can you justify or how can you say to an individual that would be put on Medicaid as a result of the expansion of Obamacare, essentially, how can you say to them that you really feel that they are going to be getting better health care?

Ms. FEDER. Because I have a host of evidence that shows that people who get Medicaid have better access to care than people without health insurance and that they live longer as a result. I am very comfortable in making that judgment.

Mrs. ELLMERS. So, in your opinion, putting more people on Medicaid is really the answer, not necessarily putting forward a budget or passing a budget that is actually a pro-growth economy——

Ms. FEDER. No, I actually think——

Mrs. ELLMERS [continuing]. To get people off of Medicaid?

Ms. FEDER. I actually think, Mrs. Ellmers, that that is a very broad statement. What we are talking about is the expansions in the Affordable Care Act, which I think will be of huge benefit to the population, whether through Medicaid or through exchanges. And I would hope that all States would see the value to their populations and go along with that expansion.

Mrs. ELLMERS. Mr. Archambault, are you familiar with the University of Virginia study?

Mr. ARCHAMBAULT. I am, yes.

Mrs. ELLMERS. Why is it that when patients are put on Medicaid that there is this discrepancy? Because there would be this natural assumption that if you are put on a Medicaid plan, that all of a sudden you are going to get better health care and you are going to have a better outcome.

Mr. ARCHAMBAULT. Without specifics to that program in Virginia and how it is treated, I think what that study illustrates is that the history of under-reimbursing doctors has led to some unexplainable results in the program and inconsistent-quality care being provided. And I am not sure we fully understand why yet. There are a lot of theories.

Mrs. ELLMERS. Yes.

Mr. ARCHAMBAULT. But consistently in the academic literature we are seeing more and more examples in which the quality of care is less than those on private insurance.

Mrs. ELLMERS. OK. Thank you very much. And my time has run out. I appreciate this testimony. Thank you.

Mr. PITTS. The chair thanks the gentlelady.

That concludes the Members' questions at this point. If you have additional questions, you may submit them to the witnesses. I remind Members that they have 10 business days to submit questions for the record, and I ask the witnesses to respond to the questions promptly.

This was an excellent hearing, excellent testimony. Thank you very much for coming today.

And Members should submit their questions by the close of business on Monday, April 1st.

With that, the subcommittee is adjourned.

[Whereupon, at 5:57 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Center on Budget and Policy Priorities

820 First Street NE, Suite 510
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

center@cbpp.org
www.cbpp.org

March 6, 2013

Testimony of Paul N. Van de Water

Senior Fellow, Center on Budget and Policy Priorities

Before the
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives

Financing Medicare and Medicaid

Mr. Chairman, Ranking Member Pallone, and members of the subcommittee, I appreciate the invitation to appear before you today.

Medicare and Medicaid are essential to the health and financial well-being of the elderly, disabled, and poor. They are also very cost-effective. Over the past 40 years, Medicare spending per enrollee has grown by an average of one percentage point less than comparable private health insurance premiums.[1] Medicaid provides acute health care coverage at a cost of 27 percent less per child, and 20 percent less per non-elderly adult, than private coverage;[2] it is also the nation's primary payer for long-term care services and supports.

The financial outlook for Medicare and Medicaid has improved significantly in the past three years. The Affordable Care Act (ACA) reduced projected Medicare spending by $555 billion between 2011 and 2020.[3] The Congressional Budget Office's (CBO) projections of Medicare spending over the 2011-2020 period have fallen by an additional $511 billion since late 2010 for other reasons.[4] CBO's Medicaid projections for that period, excluding the effects of the ACA, have declined by more than $200 billion as well.

---

[1] Office of the Actuary, Centers for Medicare & Medicaid Services, National Health Expenditure Tables, January 2013, table 21, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf.

[2] Leighton Ku and Matthew Broaddus, "Public and Private Insurance: Stacking Up the Costs," *Health Affairs* Web Exclusive, June 24, 2008.

[3] Congressional Budget Office, *The Budget and Economic Outlook: An Update,* August 2010, p. 63.

[4] Paul N. Van de Water, "Projected Medicare Spending Has Fallen by More than $500 Billion, *Off the Charts Blog,* February 19, 2013, http://www.offthechartsblog.org/projected-medicare-spending-has-fallen-by-more-than-500-billion/.

CBO has reduced its projections of Medicare spending in response to the very low spending growth in the past three years. Medicare spending per beneficiary in fiscal year 2012 increased by only 0.4 percent — well below the 3.4-percent growth in gross domestic product (GDP) per capita. Over the 2010-2012 period, Medicare spending per beneficiary grew at an annual rate of 1.9 percent, while GDP per capita increased by 3.2 percent a year.[5]

No one knows how long this good news will continue, although many experts have concluded that a substantial part of the slowdown reflects ongoing structural changes in the health care system. But even if cost growth remains moderate, Medicare and Medicaid spending will keep rising as more baby boomers become eligible for benefits. Between now and 2035, as the baby boomers retire, federal spending on Medicare and Medicaid is projected to increase by slightly more than 3 percent of GDP. By way of comparison, state and local government spending on education grew by a similar amount between 1950 and 1975, as the boomers entered primary and secondary school.

We can't do much about the aging of the U.S. population, but we can and must continue efforts to make our health care system more efficient. Effectively implementing the cost-control provisions of the Affordable Care Act is an essential next step. The ACA's research and pilot projects should yield important lessons about how to deliver health care in ways that lower costs while maintaining or improving quality. While waiting for these efforts to bear fruit, what additional savings can we achieve in our health programs?

In Medicaid, most proposals that would secure more than very modest federal savings — such as a block grant, per capita cap, or restrictions on states' use of provider taxes — would do so by shifting costs to states. If that occurs, states are likely to cut eligibility, benefits, or provider payments and hence reduce beneficiaries' access to care.

In Medicare, policymakers can enact measures now, as part of a balanced deficit-reduction package, that would achieve significant savings over ten years without jeopardizing the quality of care or access to care. But adopting an overly ambitious savings target could result in measures that largely shift costs to states, individuals, and employers and harm some of the most vulnerable members of society, yet fail to address the underlying causes of the unsustainable growth in costs across the health care system. Indeed, some proposals — such as raising the age of eligibility — would actually raise total health care costs. It must also be kept in mind that half of Medicare beneficiaries have incomes of less than $25,000 (including their spouse's income) and that Medicare households spend 15 percent of their budgets on out-of-pocket health costs — three times that of those not on Medicare.

The key fiscal policy goal for the medium term should be to stabilize the federal debt relative to the size of the economy. Since late 2010 Congress has enacted nearly $2.8 billion in deficit reduction — 70 percent of that through spending cuts. Another $1.5 trillion in deficit reduction would stabilize the debt at 73 percent of GDP over the latter part of this decade.[6]

---

[5] Richard Kronick and Rosa Po, *Growth in Medicare Spending per Beneficiary Continues to Hit Historic Lows*, ASPE Issue Brief, U.S. Department of Health and Human Services, January 7, 2013.

[6] Richard Kogan, Robert Greenstein, and Joel Friedman, *$1.5 Trillion in Deficit Savings Would Stabilize the Debt Over the Coming Decade,* Center on Budget and Policy Priorities, February 11, 2103, http://www.cbpp.org/files/2-11-13bud.pdf.

Stabilizing the debt in the coming decade would give policymakers time to identify the further steps that will be needed to slow the growth of health care costs throughout the U.S. health care system without impairing the quality of care. But it's neither necessary nor desirable to accomplish this by radically restructuring Medicare — for example, by replacing Medicare's guaranteed coverage with a premium support voucher — or by restructuring or severely cutting Medicaid or other programs that protect low-income Americans.

Written Statement for the Record by
Ron Pollack, Executive Director, Families USA
For the U.S. House of Representatives
Committee on Energy and Commerce, Subcommittee on Health
Hearing on "Saving Seniors and Our Most Vulnerable Citizens from an Entitlement Crisis"

Monday, March 18, 2013

Chairman Pitts, Ranking Member Pallone, and members of the Committee on Energy and Commerce, Subcommittee on Health:

I submit this statement for the record on behalf of Families USA, a national nonprofit, non-partisan organization dedicated to the achievement of high-quality, affordable health care for all Americans. We believe we must protect our seniors and most vulnerable citizens from an entitlement crisis. For those who rely on Medicaid for their health care, an "entitlement crisis" would occur from a reduction or restructuring of the program that shifts more of the cost burden onto the seniors and families who cannot afford it.

Medicaid Helps Millions of Americans

Millions of Americans rely on Medicaid for health care and long-term care. More than 15.6 million seniors and people with disabilities rely on Medicaid, which is the largest payer of long-term supports and services, including home- and community-based care. Medicaid cuts would force states to reduce nursing home and home-care coverage, which would shift a larger burden onto individuals who need long-term care and onto their families. That would place a further strain on our struggling middle class.

Medicaid also provides health care for millions of low-income children and families. The program is integral to women's health, as more than two-thirds of all adult Medicaid enrollees are women. Communities of color disproportionately count on it for their health care.

Medicaid Is a Lean Program

Medicaid is a program that has little fat to cut. Administrative costs in Medicaid are extremely low. More than 96 percent of federal Medicaid spending goes to pay for health care and long-term care for program enrollees, not overhead. Payment rates for providers in Medicaid are already lower than rates for Medicare and private insurance. Cutting rates further could mean that more providers would be unwilling to participate in the program. And although health care costs are rising faster than inflation, Medicaid costs are rising more slowly than health care costs in the private market.

Medicaid Provides Good Health Care

Americans with Medicaid like their health care. One study found that *54 percent* of adults with Medicaid rated their health plan a "9" or "10" on a 1 to 10 scale (with 10 being the highest).[1] Several studies have shown that having Medicaid is far better than being uninsured.

---

[1] Department of Health and Human Services, Agency for Healthcare Research and Quality, *2011 Consumer Assessment of Healthcare Providers and Systems Survey Chartbook*, "Overall Rating of Health Plans," report generated May 2, 2012. Based on 2011 reported satisfaction for adults in Medicaid and adults in private commercial insurance.

Cutting Medicaid Would Shift Costs to the States and Damage Local Economies
Medicaid is an invaluable tool for states when economic downturns or natural disasters hit, because of the program's ability to expand to serve additional people in crisis. Any cut or restructuring of Medicaid—whether it be by block granting the program, instituting a per capita cap, or by limiting provider taxes—is simply a cost shift to states and families. Federal Medicaid spending stimulates economic activity and job growth in the states. Cutting Medicaid while state economies are still struggling would severely jeopardize states' financial recovery.

Cutting Medicaid Would Jeopardize the Affordable Care Act's Expansion of Medicaid
As of the writing of this statement, more than 15 states and the District of Columbia have signaled that they plan to cover the uninsured in their state by expanding the Medicaid program as allowed by the Affordable Care Act. Support for the Medicaid expansion includes both Democratic and Republican governors. However, if cuts or changes are made to Medicaid, it would send the wrong signal to states about the federal government's commitment to the program.
We agree that we must help seniors, low-income families and other vulnerable Americans from facing an entitlement crisis. That is why we believe cuts or structural changes to Medicaid would be devastating to the millions of Americans who rely on the program for their health and well-being. As our economy struggles to recover, now is not the time for the federal government to scale back its support for Medicaid or shift costs to states and families.

○