THE FISCAL CONSEQUENCES OF THE HEALTH CARE LAW

HEARING

BEFORE THE

COMMITTEE ON THE BUDGET
HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

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THE FISCAL CONSEQUENCES OF THE HEALTH CARE LAW

WEDNESDAY, JANUARY 26, 2011

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

The committee met, pursuant to call, at 9:40 a.m. in room 210, Cannon House Office Building, Hon. Paul Ryan [chairman of the committee] presiding.

Present: Representatives Ryan of Wisconsin, Garrett, Simpson, Campbell, Calvert, Akin, Cole, Price, McClintock, Chaffetz, Stutzman, Lankford, Black, Ribble, Flores, Mulvaney, Huelskamp, Young, Amash, Rokita, Guinta, Van Hollen, Schwartz, Kaptur, Blumenauer, McCollum, Yarmuth, Pascrell, Honda, Ryan of Ohio, Wasserman Schultz, Moore, Castor, Tonko, and Bass.

Chairman RYAN. The hearing will come to order.

I welcome all to the first House Budget hearing of the 112th Congress.

Before we get started, I want to thank ranking minority member Chris Van Hollen for his cooperation in getting the committee rules adopted and with this hearing and for starting a little early so we can get a head start on the day.

Why is this the Budget Committee's first hearing and why is it focused on health care? Well, let's just put it very simply. Our fiscal problem is a health care problem. Health care spending is driving the explosive growth in our spending and our debt.

The new health care law was sold under the guise of fiscal responsibility. The claim was that the government would spend trillions of dollars, add millions to a new government-controlled health care program, and create two new open-ended health care entitlements, all in order to lighten our budgetary burden. Most Americans understand that something is just not adding up here. Today's hearing is intended to peel back the layers of the law and its maze of mandates, dictates, controls, tax hikes, and subsidies.

Many try to distort our criticism of the health care law and say that we are criticizing the CBO. Actually, quite the opposite is true. I think CBO does a very good job. We ask them to do a lot under short notice, and they perform very admirably. The analysis performed by the CBO, Mr. Foster, and others enable us to unpack the law's budgetary smoke and mirrors and reveal its true fiscal impact.

We face a choice of two futures, and nowhere is this choice more clearly defined as it is in health care. Down one path lies the managed decline of a government-run system on the verge of bank-

ruptcy. There is an alternative path, and it is a path that leads to true choice and competition in health care. It is modeled after the health care system that we ourselves in Congress enjoy; and it puts patients first, with providers competing for our business.

But before we can get there, we must reject the notion that a centrally planned, bureaucratically run health care system can produce more favorable outcomes than the one managed by doctors and patients.

Do we want a system that is command and controlled, price controlled, formulaically controlled by government, or do we want a system where the patient is the center, where the patient is sovereign, where they get to decide, where providers—doctors, hospitals, insurers—compete against each other for our business or do we want them competing for favoritism from a shrinking pool of government resources?

While I am opposed to the President's health care law, I want to find solutions to these problems. That is why I have worked with Democrats to come up with other proposals to try and find answers to these.

Alice Rivlin and I most recently teamed up on a proposal in the Fiscal Commission. She and I don't see eye to eye on everything, but we tried to come together with a compromise to try to find a way to fix some of these problems to address our health care problems and our fiscal problems. I hope we can continue to build bipartisan support for policies that create incentives in our health care system to enhance quality, reduce costs, and promote patient satisfaction.

It is an honor to welcome our first witness, Rick Foster, Chief Actuary for the Centers of Medicare and Medicaid Services. Time and again, Rick's unbiased actuarial reports have proved difficult to square with the claims made by the law's proponents, specifically with respect to the direction of health care spending as a result of this law.

After Rick's testimony, we will hear from a panel of three witnesses. Dennis Smith, the newly confirmed Secretary of Health Services in my home State of Wisconsin. Dennis has tremendous experience in this area, having served as Medicaid Director at HHS under the previous administration. He will give us a sense of what the impact of the law is on the States.

Next, Jim Capretta, former associate and director at the Office of Management and Budget. Few in my mind have made as compelling a case as Jim on both the costly consequences of this law and the path forward to advance real reform.

And we will hear from Paul Van de Water from the Center for Budget and Policy Priorities. Paul has an impressive background, and I welcome his thoughts to advance an informed debate on this critical issue.

I look forward to today's discussion. I thank our witnesses for joining us and starting a little early.

With that, I would like to yield to Ranking Member Van Hollen for an opening statement.

[The statement of Mr. Ryan follows:]

PREPARED STATEMENT OF HON. PAUL RYAN, CHAIRMAN, COMMITTEE ON THE BUDGET

Welcome all, to the first House Budget Committee hearing of the 112th Congress. This is an immensely consequential time for the Congress, and our Federal Government in general. It is a time in which this committee will play an exceptionally important role. I welcome the opportunity to tackle the challenges we face: the stakes are very high—but so are the potential rewards.

I also offer my congratulations to Chris Van Hollen on being selected as Ranking Member on this committee. Chris is an eloquent spokesman for his party's views and principles, and I look forward to many vigorous, and I hope enlightening, debates on issues that are so critically important to our country right now.

One of those, of course, is health care—and specifically the health care legislation enacted last year. It remains a highly contested subject, and the more Americans learn about the legislation, the more questions and doubts they have.

We in America enjoy a strong and innovative health care system. But its costs, including those of the Federal Government, are out of control. The average cost of a health insurance policy for a family of four doubled between 2000 and 2007, and is projected to double again in the next seven years. And because the federal government has made a large and open-ended commitment to the health security of most Americans, health care costs have a huge impact on our federal budget. The Congressional Budget Office says Federal spending on health care, as a percentage of the economy, will double over the next 25 years—crowding out spending for anything other than health care and Social Security.

To put it simply, our fiscal problem—in which government debt is approaching the size of the entire economy—is a health care problem.

The Democrats' health care legislation was sold as a way of addressing both—but whether that's true is seriously in doubt. Our first witness today has said that any health care savings resulting from the law will be more than offset by higher expenditures for coverage expansions. The Director of the Congressional Budget Office has said the legislation will not substantially reduce the upward pressure on health care spending.

In short, this Washington-centered health care overhaul—with its maze of mandates, dictates, controls, tax hikes, and subsidies—will very likely accelerate the rise in health care costs. Many of these costs will be foisted onto the states, as the bill's Medicaid expansions will strain their budgets even further.

Today's hearing is intended to peel back the layers of this complex law, to sweep aside the budgetary smoke and mirrors, and to examine its effects on health care costs and, consequently, on our nation's finances.

Our witnesses today will help clarify these issues.

First is Rick Foster, Chief Actuary for at the Centers for Medicare and Medicaid Services. Due to his role, Rick can offer a clear and thoroughly unbiased of the fiscal effects of the health care law.

We'll hear from Dennis Smith, Secretary of Health Services in my own state of Wisconsin, Dennis can speak today about the new Medicaid obligations this law will force on states such as Wisconsin.

And we'll also hear from Jim Capretta, a former associate director at the Office of Management and Budget and currently a fellow working on health care issues at the Ethics and Public Policy Center.

No one has done a better job than Jim of exposing gimmicks in the health care law that hide its true costs.

We are at a fiscal crossroads, with two very different futures waiting for us at the end of two very different paths. One path leads to the managed decline of a government-run system on the verge of bankruptcy. Harsh austerity, severe benefit cuts and massive tax increases wait for us at the end of this path.

The other path leads to true choice and competition as reflected in the health care reform proposals that I and some of my colleagues, such as Tom Price, have put forward in Congress.

Putting patients first—contributing a defined amount to their health security and making doctors and hospitals compete for their business—would put the focus in health care on quality, cost, efficiency and patient satisfaction, just as it is in almost every other business.

I am proud to have worked with former Clinton administration budget director Alice M. Rivlin to advance some of these reforms. It is possible to build bipartisan support for policies that allow consumers and patients to make choices for themselves, even as the government provides sensible oversight of the marketplace.

We all understand that, for too many Americans, the health care system isn't working. Nobody is talking about going back to the status quo. But we cannot forge a bipartisan way forward until we remove this partisan roadblock.

With that, I will yield to Ranking Member Van Hollen for an opening statement.

Mr. VAN HOLLEN. Thank you, Mr. Chairman.

I want to join the chairman in welcoming Mr. Foster and the other witnesses here today. I have to say at the outset that many of us are disappointed that the first hearing of the Budget Committee, rather than focusing on jobs and the economy, is focused on looking backwards and repealing the health care reform bill.

As the President indicated last night in the State of the Union address, there are going to be issues, of course, that arise with the health care reform bill and we should work together to address those issues as they come up. But relitigating the whole health care reform bill we think is a mistake and doesn't focus our resources, energy, and attention on the really pressing problems for the American people, getting more people back to work, getting the economy in full gear going forward. That being said, we do believe that today's hearing and other hearings on the health care reform bill will help eliminate many of the myths and misunderstandings that came up in connection with the health reform legislation.

We on the Democratic aisle a few weeks ago before the vote had a hearing where we invited our constituents from around the country to testify on that bill. It was an unofficial hearing, because the majority decided to press forward with repeal without having any hearing in this Congress, listening to the benefits that have already begun to kick in for millions of Americans.

We heard testimony from moms and dads, sisters and brothers, who talked about the fact that they like the fact that no longer will their kids be kicked off of a health insurance policy or denied coverage to begin because they have a preexisting condition like asthma or diabetes.

We heard from parents that really like the assurance that their children could stay on their health insurance policy until they were age 26.

We heard from small businesses that are taking advantage of the tax credits to provide more affordable coverage for their employees. A recent Forbes article indicated that that tax credit benefit has exceeded beyond expectations.

We heard from senior citizens who as of January 1 get a little bit more help in covering the costs of their medicines when they fall into the donut hole.

So millions of Americans in the last 10 months have begun to recognize important benefits of that legislation.

Now, I know our colleagues on the other side of the aisle will say, well, we are going to get rid of all of this and put back in some of that stuff. The reality is between the years 2000 and 2006 health insurance premiums in this country doubled. They went up 100 percent. Congress and the former President did nothing during that period of time.

Under the health care reform bill, if you look at the CBO January letter, you will find that, over a period of time, premiums will begin to come down in the employer insurance market and that people's out-of-pocket costs in the individual market will go down over a period of time.

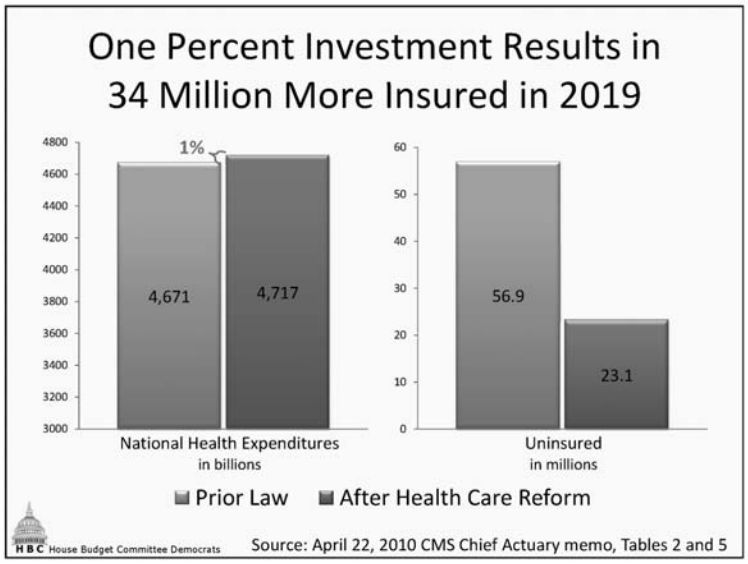
So we believe we should be focused on trying to fix those areas like the 1099 small business burden that I think there is common

agreement should be changed, rather than relitigating this whole issue.

Now, just a word on the deficit reduction benefits of the health care reform bill. Because, obviously, the Congressional Budget Office most recently in its January letter indicated that over the first 10 years we would save, we would reduce the deficit by $230 billion under the health care reform law as passed; and over the 20-year period, it would be $1.4 trillion in deficit reduction benefits. The CBO, as we all know, is an independent, nonpartisan entity; and I think we would all agree that we will have budget and fiscal chaos if we decide at our own whim and initiative to throw out CBO numbers.

Now today we are going to focus on, as the Chairman said, what CBO was given to score; and I actually think this will help illustrate the fact that the CBO numbers are real. Now I know we would like—I hope we will have the CBO come at some point and testify on their own deficit reduction package, rather than sort of take an indirect approach to those numbers. But I think what we are going to find—and I am looking forward to the testimony of Mr. Foster—is that indeed the CBO numbers are something that, while he cannot independently verify because that is not his total area of expertise, that they are built on what we believe are important assumptions.

Just two quick slides I want to look at the outset, and then I will conclude my remarks.



This first one is based on the analysis that Mr. Foster did in April of 2010. It takes a chart of total national health care expenditures in the year 2019 if the health care reform bill is implemented as enacted. Those are the columns to the left. The columns to the right are the number of people who will now receive health insurance and be able to get preventative care, just like Members of

Congress can get through their insurance, get the health care they need when they need it through their insurance.

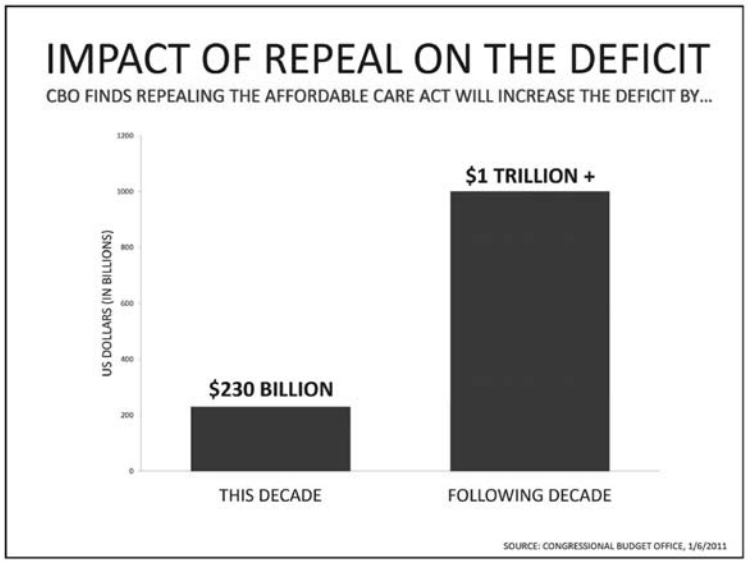
The estimates are between 32 and 34 million Americans—CBO says 32 million, Mr. Foster says 34 million Americans—will get that additional coverage. That is on the right. You can see directly the benefits.

We have heard a lot of talk about how this is going to be a huge expenditure. And if you look at national health care expenditures, in—let's go back—in the year 2019, that is just 9 years from now—and this is taking Mr. Foster's slide with the bill as enacted—you are talking about a 1 percent difference with the health care reform bill, 1 percent difference in the health care reform bill and getting 32 to 34 million more Americans covered.

I think if you look at the remainder, we will be hearing from Mr. Foster, as you go into the outyears and begin to bend the cost curve if you implement this bill as enacted, you actually get to a point where national health expenditures as a result of passage and implementation of the new law actually will be less than if we had done nothing.

So we look forward to the testimony of Mr. Foster and others as we go forward this morning.

I conclude with this slide, which are the CBO numbers, which show the savings for the first 10 years and then the savings from a deficit perspective for the second 10.



Thank you very much, Mr. Chairman.

Chairman RYAN. Let me just say we have a difference of opinion on some of these things. I appreciate the gentleman's remarks.

I know they don't want us to get into relitigating the health care law, but I think everybody would agree the debt problem is a health care problem, and we are going to have to relitigate that to get to a real solution, because we haven't fixed the debt problem yet.

So, with that, I want to welcome Rick. You have come here a number of times. We have seen you over at Ways and Means. We really appreciate your professionalism and the time you have taken in your career to dedicate to these issues.

The floor is yours.

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

Mr. FOSTER. Thank you——

Chairman RYAN. You have to pull it closer.

Mr. FOSTER. Thank you, Chairman Ryan, Representative Van Hollen, and distinguished committee members——

Chairman RYAN. Can you pull it a little closer, Rick? We can't hear you that well. Pull it right next to your face.

Mr. FOSTER. I remember these microphones. Is that any better?

Okay. They always come through in the end, just like Congress.

Chairman Ryan, Representative Van Hollen, and distinguished members of the committee, thank you for inviting me to testify today about the impact of the Affordable Care Act on Medicare, on Medicaid, and on national health expenditures in the U.S.

The Office of the Actuary at CMS provides actuarial, economic, and other technical assistance to policymakers both in the administration and in Congress. We do this on an independent basis, objectively, and also on a nonpartisan basis. The Office of the Actuary has performed this role for more than the last 45 years, since even before the enactment of the Medicare program.

I am appearing today in my role as an independent adviser to Congress; and I am joined by John Chateau, who is a Fellow of the Society of Actuaries. He is the Director of our Medicare and Medicaid Cost Estimates Group in the Office of the Actuary. My statements are my own and do not necessarily represent an official position of the Department of Health and Human Services.

Over the last couple of years, we have generated a lot of information about the financial coverage and other effects of the draft health reform legislation and then Affordable Care Act as it was finally enacted. My written testimony has a lot of detail. There is even more detail than that in the memorandum that Representative Van Hollen mentioned, our April 22nd, 2010, detailed memorandum on the financial impacts.

Also, the 2010 Medicare Trustees Report has a lot of information about the financial status of Medicare under the Affordable Care Act.

We also have a September, 2010, article that has projections of national health expenditures under the new legislation; and we just recently came out with our 2010 actuarial report on the financial outlook for Medicaid, which is now available on the CMS Web site, as are all these other documents.

The Affordable Care Act has a major impact on the coverage status or the insured status of people in the U.S. As Representative Van Hollen mentioned, we have estimated that by 2019 the number of people who lack health insurance would be reduced by about 34 million people because of the Affordable Care Act. As part of this, it increases Medicaid enrollment by an estimated 20 million; and it would also provide private health insurance through the

health insurance exchanges to an estimated 16 million people who were previously uninsured.

Now, the overall impact on people who currently have employer-sponsored health insurance is mixed. For many people, they would now have the opportunity to get this coverage, or at least they would be more inclined to take the coverage that is currently offered. For some other people, however, their employers might be more inclined to drop the coverage that already exists. On balance, we saw only a slight reduction, a very small reduction, in the total, but keep in mind that is made up of an increase followed by a decrease.

The Affordable Care Act has effects for Federal expenditures and, within that, for the Medicare program and the Medicaid program; and it also has effects on total U.S. health care spending. I will run briefly through the key pieces of these.

Our estimate for the period fiscal years 2010 through 2019, during which the reforms are only partially implemented, our estimate is that the coverage expansions through Medicaid and through the exchange coverages would increase Federal costs by a total of about $828 billion; and that is a net total, taking into account the additional penalty receipts we would receive for employers or individuals who did not participate or did not offer or have health insurance coverage.

About half of the $828 billion net increase is due to the expansion of Medicaid coverage; and the other half, roughly, is due to the Federal subsidies that will be available for people with exchange coverage and low enough levels of income.

The projected Medicare savings under the Affordable Care Act are estimated to offset about $575 billion of this total cost that I just mentioned. Some of this, the largest part, is made up through lower payment rates to Medicare providers and lower payment updates in the future, which together over this 10-year period would save about $233 billion.

The Act also specifies lower Medicare Advantage benchmarks, the payment comparisons that private health insurance plans are judged against when Medicare sets their payment rates. We estimate that would save $145 billion over this period. And then there are higher hospital insurance payroll taxes, an additional 0.9 percent for people with high levels of earnings, and that would generate another $63 billion.

There are a number of other smaller impacts, both within Medicare and Medicaid and also in the immediate insurance reforms, the class of Federal long-term care insurance program and so forth that we can talk about in more detail if it would be helpful.

We have estimated, as we saw in the chart earlier from Representative Van Hollen, that the Affordable Care Act Care Act would cause an increase in total national health expenditures in the U.S. The total over the 2010-2019 period is estimated to be $311 billion, which is, as his graph showed, a little less than 1 percent.

As you would expect from our conversation just now, there is a substantial increase in total health spending associated with the coverage expansions. People, individuals, and families who have health insurance tend to spend considerably more for health care

than people who do not have health insurance. So with 34 million more people gaining health insurance, you would expect a higher level of expenditures. That is offset somewhat because many of these people will be on Medicaid where the payment rates to providers are very low. So it is a relatively inexpensive way of giving people health insurance coverage, and it has its own set of issues that we could talk about.

There are partially offsetting reductions in total national health expenditures because of the Medicare savings; and, also, there are lower out-of-pocket payments by individuals. When people get health insurance coverage, typically they don't have to pay nearly so much. They will get more services, but the cost sharing on the new higher level of services is typically less than what they were paying when they had to pay everything for a lower level of services. So we would also expect a significant level of reduction in out-of-pocket costs.

As many of you know, the Board of Trustees for Medicare and I have expressed some concerns about the Medicare provider payment reductions that are required under the Affordable Care Act. In particular, the Act specifies permanent annual payment updates for most categories of providers that equal the increase in their input prices. In other words, the price increases they have to pay to get office space, to pay energy, to pay fringe benefits for their staff, their wages, supplies, you name it.

Normally in the past, that is how we have updated provider payments, by the increase in their input prices. In the future, under the Affordable Care Act, we will pay them based on the increase in their input prices minus the increase in economy wide, multifactor productivity.

There are reasons for considering such a change, but it is doubtful that many health care providers can match or have their own productivity increase at the same rate as in the economy at large, where you have manufacturing and other high-productivity sectors.

Now, over time, the payment rates, the Medicare payment rates, for affected providers will grow at a rate that is about 1.1 percent less than the increase in their input prices. Unless providers can improve their productivity or find other efficiencies, over time the payment rates will become inadequate to cover their input costs. Without legislation to do something about all of this, providers might have to end their participation in Medicare and that would have possible adverse consequences for beneficiaries' ability to access health care.

Now, much more likely than that scenario is, if the payment rates become inadequate, you and your colleagues will act to do something about the inadequate payment rates, much as you have had to do for many years now to address the physician payment reductions that would be required under current law because of the sustainable growth rate formula. But if Congress does have to act to override these payment adjustments, that means that actual future costs for Medicare would be higher, considerably higher in fact, than what we are projecting under current law. Put another way, the Medicare savings we just discussed under the Affordable Care Act would be lower.

I would like to sum up by saying that there is a substantial degree of uncertainty associated with anybody's projections of the financial impacts of the Affordable Care Act. It is very difficult to anticipate and accurately predict how individuals or employers or health care providers will respond to the many new features and different aspects of health care that result from the Affordable Care Act. We will be paying close attention to new information as it becomes available, and we will update our estimates periodically to reflect the new information.

I hope this information will be helpful to you all and to your colleagues as you continue to debate these difficult issues, and I would like to pledge the Office of the Actuary's continuing assistance to your efforts to determine the optimal solutions to the financial and other challenges facing health care in the U.S.

I would be happy to answer any questions you have.

[The prepared statement of Richard S. Foster follows:]

PREPARED STATEMENT OF RICHARD S. FOSTER, F.S.A., CHIEF ACTUARY, CENTERS FOR MEDICARE & MEDICAID SERVICES

Chairman Ryan, Representative Van Hollen, distinguished Committee members, thank you for inviting me to testify today about the impact of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, on the Medicare and Medicaid programs and on total health expenditures in the U.S.

I would like to begin by saying a little about the role of the Office of the Actuary at the Centers for Medicare & Medicaid Services. We have the responsibility to provide actuarial, economic, and other technical assistance to policy makers in the Administration and Congress on an independent, objective, and nonpartisan basis. Our highest priority is to help ensure that policy makers have the most reliable technical information possible as they work to sustain and improve Medicare and Medicaid. The Office of the Actuary has performed this role on behalf of Congress and the Administration since the enactment of these programs over 45 years ago. We have also provided actuarial estimates for various past national health reform initiatives, including the proposed Health Security Act in 1993-1994 and the Affordable Care Act as it was developed and enacted in 2009-2010.

I am appearing before your Committee today in my role as an independent technical advisor to Congress. My statements, estimates, and other information provided in this testimony are my own and do not represent an official position of the Department of Health & Human Services or the Administration. Unless noted otherwise, the estimates used in this testimony are drawn from my memorandum of April 22, 2010, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended." This memorandum and the other documents to which I refer are available on the CMS website at *http://www.cms.gov/ActuarialStudies/*. We are in the process of updating many of these estimates for use in the President's 2012 Budget and in a forthcoming article on national health expenditure projections. Although some of the updates will be significant, they will not substantially change the overall outlook for the financial effects of the Affordable Care Act as described in this testimony.

AFFORDABLE CARE ACT

The March 2010 health care reform legislation, generally known as the Affordable Care Act, affects nearly every aspect of health care in the U.S. Among its many provisions expected to have a significant financial effect, the Act:

- Mandates coverage for health insurance in 2014 and later.—Establishes Health Insurance Exchanges.
  - –Provides Federal subsidies for Exchange insurance premiums and cost-sharing requirements.
  - –Provides temporary tax credits for small businesses that offer health coverage.
  - –Imposes penalties on some individuals who forgo coverage.
  - –Imposes penalties on large employers that do not offer health insurance to workers.

• Expands Medicaid eligibility and makes other changes to Medicaid and the Children's Health Insurance Program (CHIP).—Increases income threshold from less than 100 percent of Federal Poverty Level (FPL) to 138 percent.

–Extends coverage to those without specific non-income qualifying factors (e.g., disability).

–Increases Medicaid prescription drug rebates.

–Reduces Medicaid disproportionate share hospital (DSH) expenditures.

–Introduces Medicaid "Community First Choice Option" and other changes to encourage home and community-based services.

–Raises Federal matching rates for States with existing childless-adult coverage expansions.

–Temporarily increases Medicaid payments to primary care physicians.

–Extends CHIP funding for 2014 and 2015.

• Implements numerous Medicare changes.—Permanently reduces Medicare payment updates for most categories of providers by the increase in economy-wide multifactor productivity (approximately 1.1 percent per year).

–Reduces Medicare Advantage payment benchmarks and permanently extends the authority to adjust for coding intensity.

–Reduces Medicare DSH payments and refines imaging payments.

–Creates an Independent Payment Advisory Board together with Medicare expenditure growth rate targets.

–Increases the HI payroll tax rate by 0.9 percentage point for individuals with earnings above $200,000 and families above $250,000 and raises Part D premiums for single enrollees with incomes above $85,000 or couples above $170,000.

–Phases out the Part D coverage gap ("donut hole").

–Initiates numerous quality- and coverage-related Medicare provisions, including reporting of physician quality measures, reducing payments in cases involving hospital-acquired infections, reducing readmissions, and implementing evidence-based coverage of preventive services.

–Creates a Center for Medicare and Medicaid Innovation in CMS for testing alternative models of health care delivery systems, payment methods, etc. and establishes a Medicare Shared Savings Program for accountable care organizations (ACOs).

• Implements certain immediate insurance reforms.—Minimum coverage requirements.

–Pre-existing Condition Insurance Plan for those uninsured for at least 6 months.

–Federal reinsurance for employer-sponsored early retiree plans.

–Expansion of dependent coverage to age 26.

• Creates Federal Community Living Assistance Services and Supports (CLASS) long-term care insurance program.

• Supports comparative effectiveness research.

• Adds new taxes and fees.—Excise tax on high-cost employer health plans.

–Taxes or fees on insurance plans, prescription drug manufacturers, device makers.

–Additional 0.9-percent HI payroll tax on high earners.

–Additional 3.8-percent tax on high investment returns, other non-earnings income.

As described in more detail in my April 22, 2010 memorandum, the Affordable Care Act is estimated to reduce the number of uninsured persons in the U.S. by 34 million in 2019. Approximately 18 million would gain Medicaid coverage as a result of the expansion of eligibility criteria. (In addition, roughly 2 million people with employer-sponsored health insurance would enroll in Medicaid for supplemental coverage.) Another 16 million uninsured persons would receive individual insurance coverage through the newly created Exchanges, with the majority of these qualifying for Federal premium and cost-sharing subsidies. Finally, we estimate that the number of individuals with employer-sponsored health insurance would decrease slightly overall, reflecting both gains and losses in such coverage under the Affordable Care Act.

ESTIMATED IMPACT OF AFFORDABLE CARE ACT ON FEDERAL EXPENDITURES

The table shown on the following page presents the estimated financial effects of selected provisions in the Affordable Care Act on the Federal Budget in fiscal years 2010-2019. For convenience of presentation, the provisions of the legislation are grouped into six major categories:

(i) Coverage provisions, which include the mandated coverage for health insurance, the expansion of Medicaid eligibility, and the additional funding for CHIP;

(ii) Medicare provisions;

(iii) Medicaid and CHIP provisions other than the coverage expansion and CHIP funding;

(iv) Provisions aimed in part at changing the trend in health spending growth;

(v) The CLASS program; and

(vi) Immediate health insurance reforms.

The estimated costs and savings shown in the table are based on the effective dates specified in the law as enacted. We assume that employers and individuals would take roughly 3 to 5 years to fully adapt to the new insurance coverage options and that the enrollment of additional individuals under the Medicaid coverage expansion would be completed by the third year of implementation. Because of these transition effects and the fact that most of the coverage provisions would be in effect for only 6 of the 10 years of the budget period, the cost estimates shown in this memorandum do not represent a full 10-year cost for the new legislation.

Estimated Federal costs or savings under selected provisions of the Affordable Care Act

[Costs (+) or savings (–) in billions]

Provisions	Fiscal Year 2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-19
Total*	$9.2	−$0.7	−$12.6	−$22.3	$16.8	$57.9	$63.1	$54.2	$47.2	$38.5	$251.3
Coverage†	3.3	4.6	4.9	5.2	82.9	119.2	138.2	146.6	157.6	165.8	828.2
Medicare	1.2	−4.7	−14.9	−26.3	−68.8	−60.3	−75.2	−92.1	−108.2	−125.7	−575.1
Medicaid/CHIP	−0.9	−0.9	0.8	4.5	8.6	5.1	4.6	3.4	1.3	1.7	28.3
Cost trend‡	—	—	—	—	−0.0	−0.1	−0.2	−0.4	−0.6	−0.9	−2.3
CLASS program	—	−2.8	−4.5	−5.6	−5.9	−6.0	−4.3	−3.4	−2.8	−2.4	−37.8
Immediate reforms	5.6	3.2	1.2	—	—	—	—	—	—	—	10.0

* Excludes Title IX revenue provisions except for sections 9008 and 9015, certain provisions with limited impacts, and Federal administrative costs.

† Includes expansion of Medicaid eligibility and additional funding for CHIP.

‡ Includes estimated non-Medicare Federal savings from provisions for comparative effectiveness research, prevention and wellness, fraud and abuse, and administrative simplification. Excludes impacts of other provisions that would affect cost growth rates, such as the productivity adjustments to Medicare payment rates (which are reflected in the Medicare line) and the section 9001 excise tax on high-cost employer plans.

As indicated, the provisions in support of expanding health insurance coverage (including the Medicaid eligibility changes and extended CHIP funding) are estimated to cost $828 billion through fiscal year 2019, net of penalty receipts from nonparticipating individuals and employers. The Medicare, other Medicaid and CHIP, growth-trend, CLASS, and immediate reform provisions are estimated to result in net savings of about $577 billion, leaving a net overall cost for this period of $251 billion before consideration of additional Federal administrative expenses and the increase in Federal revenues that would result from the excise tax on high-cost employer-sponsored health insurance coverage and certain other revenue provisions. (The new Supplementary Medical Insurance revenues from fees on brand-name prescription drugs under section 9008 of the Affordable Care Act, and the higher Hospital Insurance payroll tax income under section 9015, are included in the estimated Medicare savings shown here.) The Congressional Budget Office and the Joint Committee on Taxation have estimated that the total net amount of Medicare savings and additional tax and other revenues would somewhat more than offset the cost of the national coverage provisions, resulting in an overall reduction in the Federal deficit through 2019.

ESTIMATED IMPACT OF AFFORDABLE CARE ACT ON MEDICARE EXPENDITURES AND REVENUES

Net Medicare savings are estimated to total $575 billion for fiscal years 2010-2019. Substantial savings are attributable to provisions that would, among other changes, reduce Part A and Part B payment levels and reduce future "market basket" payment updates by the increase in economy-wide multifactor productivity ($233 billion); eliminate the Medicare Improvement Fund ($27 billion); reduce DSH payments ($50 billion); reduce Medicare Advantage payment benchmarks and permanently extend the authority to adjust for coding intensity ($145 billion); freeze the income thresholds for the Part B income-related premium for 9 years ($8 billion); implement an Independent Payment Advisory Board together with strict Medicare expenditure growth rate targets ($24 billion); and increase the HI payroll tax rate by 0.9 percentage point for individuals with earnings above $200,000 and fami-

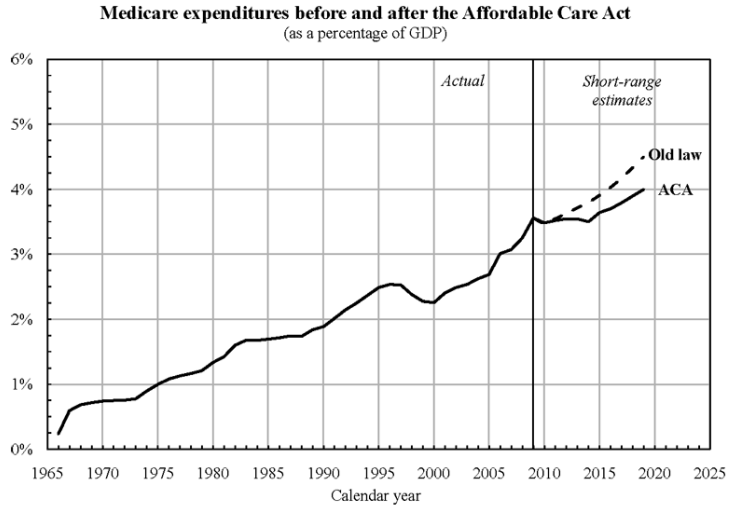
lies above $250,000 ($63 billion). Other provisions would generate relatively smaller amounts of savings, through such means as reporting physician quality measures, reducing payments in cases involving hospital-acquired infections, reducing readmissions, refining imaging payments, increasing Part D premiums for higher-income beneficiaries, and implementing evidence-based coverage of preventive services.

These savings are slightly offset by the estimated costs of closing the Part D coverage gap ($12 billion); reducing the growth in the Part D out-of-pocket cost threshold ($1 billion); extending a number of special payment provisions scheduled to expire, such as the postponement of therapy caps ($5 billion); and improving preventive health services and access to primary care ($6 billion).

As noted below, the Affordable Care Act authorizes a substantial program of research, development, and testing for innovative new health delivery systems and payment methods. This program has significant potential for improvements in the quality and cost efficiency of health care, but its effects on Medicare expenditures cannot be assessed until specific plans have been developed and tested.

The following chart shows actual past Medicare expenditures as a percentage of gross domestic product (GDP), together with estimated future amounts for 2010-2019 under the Affordable Care Act and under the prior law. Of the estimated net total Medicare savings of $575 billion over this period, $486 billion is attributable to a net reduction in Medicare expenditures (with the balance due to increased revenues from taxes and fees). The chart illustrates the expenditure impact only.

By 2019, the net reduction in Medicare expenditures is estimated to be 0.5 percent of GDP, which represents an 11-percent decrease from the level projected prior to the Affordable Care Act. This percentage reduction would grow larger over time as a result of the compounding effect of the slower annual updates in Medicare payment rates for most categories of health care providers.

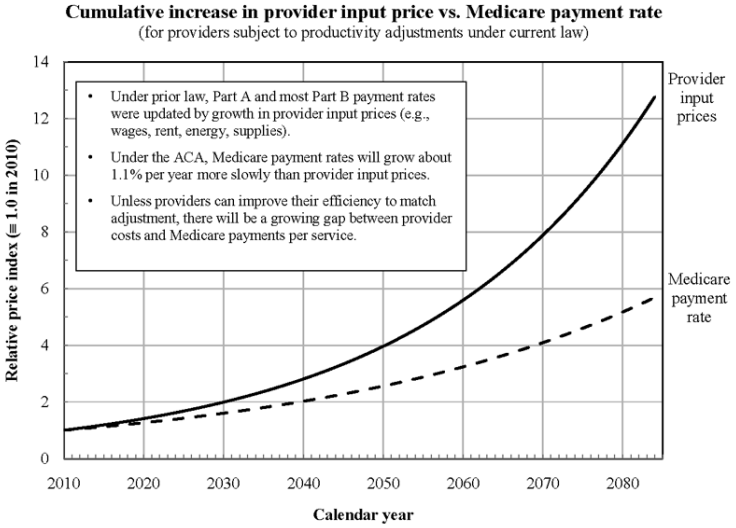


Based on the estimated savings for Part A of Medicare, the assets of the Hospital Insurance trust fund would be exhausted in 2029 compared to 2017 under the prior law—an extension of 12 years. The combination of lower Part A costs and higher tax revenues results in a lower Federal deficit based on budget accounting rules. However, trust fund accounting considers the same lower expenditures and additional revenues as extending the exhaustion date of the HI trust fund. In practice, the improved HI financing cannot be simultaneously used to finance other Federal outlays (such as the coverage expansions) and to extend the trust fund, despite the appearance of this result from the respective accounting conventions. Conversely, expenditure reductions under Part B translate directly to lower financing requirements from general revenues and beneficiary premiums, since financing is re-established annually to match program costs. Thus, in the case of Part B, the savings under the Affordable Care Act are not needed to help pay for future benefit costs, and the full reduction in Federal general revenues attributable to such savings can be used to offset other Federal costs, such as those arising under the health reform coverage expansions. (Part D expenditures will increase under the Affordable Care

Act, requiring additional Federal general revenue financing.) More detailed information on the financial status of the Medicare trust funds is available in the 2010 Medicare Trustees Report.

It is important to note that the estimated savings for one category of Medicare provisions may be unrealistic. The Affordable Care Act requires permanent annual productivity adjustments to price updates for most providers (such as hospitals, skilled nursing facilities, and home health agencies), using a 10-year moving average of economy-wide private, non-farm productivity gains. While such payment update reductions will create a strong incentive for providers to maximize efficiency, it is doubtful that many will be able to improve their own productivity to the degree achieved by the economy at large.[1]

The following chart illustrates the very large differential that would accumulate over long periods between the prices that health care providers have to pay to obtain the inputs they need to provide health care services and the corresponding Medicare payment rates. In practice, providers have few alternatives to paying market-based increases in wages and fringe-benefit costs for their employees. Similarly, price increases for office space, energy, utilities, and medical equipment and supplies are generally outside of providers' control.



Over time, a sustained reduction in payment updates, based on productivity expectations that are difficult to attain, would cause Medicare payment rates to grow more slowly than, and in a way that was unrelated to, the providers' costs of furnishing services to beneficiaries. Thus, providers for whom Medicare constitutes a substantive portion of their business could find it difficult to remain profitable and, absent legislative intervention, might end their participation in the program (possibly jeopardizing access to care for beneficiaries). Simulations by the Office of the Actuary suggest that roughly 15 percent of Part A providers would become unprofitable within the 10-year projection period as a result of the productivity adjustments.[2] Although this policy could be monitored over time to avoid such an outcome,

[1] The provision of most health services tends to be very labor-intensive. Economy-wide productivity gains reflect relatively modest improvements in the service sector together with much larger improvements in manufacturing. Except in the case of physician services, I am not aware of any empirical evidence demonstrating the medical community's ability to achieve productivity improvements equal to those of the overall economy. The Office of the Actuary's most recent analysis of hospital productivity highlights the difficulties in measurement but suggests that such productivity has been small or negligible during 1981 to 2005. (See *http://www.cms.hhs.gov/HealthCareFinancingReview/downloads/07-08Winterpg49.pdf.)*

[2] The simulations were based on actual fiscal year 2007 Medicare and total facility margin distributions for hospitals, skilled nursing facilities, and home health agencies. Provider revenues and expenditures were projected using representative growth rates and the Office of the Actuary's best estimates of achievable productivity gains for each provider type, and holding all other factors constant.

changes would likely result in smaller actual savings than described here for these provisions.

In their 2010 report to Congress on the financial status of the program, the Medicare Board of Trustees cautioned:

The Affordable Care Act improves the financial outlook for Medicare substantially. However, the effects of some of the new law's provisions on Medicare are not known at this time, with the result that the projections are much more uncertain than normal, especially in the longer-range future. For example, the ACA initiative for aggressive research and development has the potential to reduce Medicare costs in the future; however, as specific reforms have not yet been designed, tested, or evaluated, their ability to reduce costs cannot be estimated at this time, and thus no specific savings have been reflected in this report for the initiative.

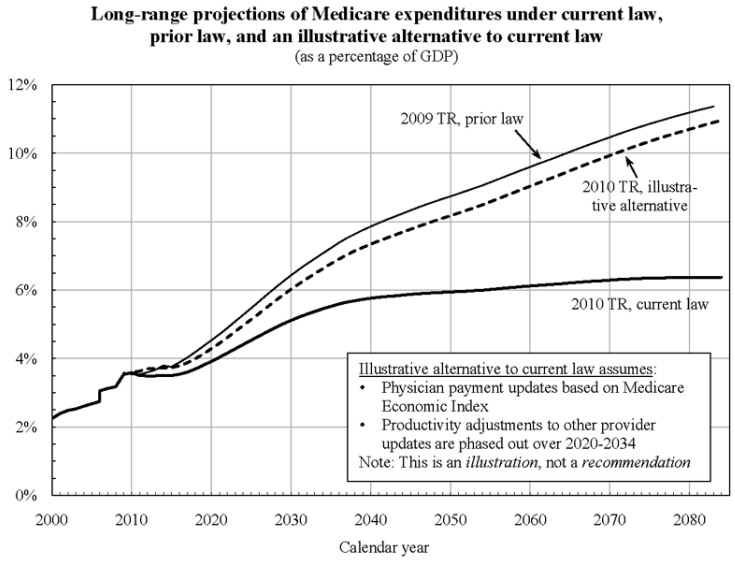
Another important example involves lower payment rate updates to most categories of Medicare providers in 2011 and later. These updates will be adjusted downward by the increase in productivity experienced in the economy overall. Since the provision of health services tends to be labor-intensive and is often customized to match individuals' specific needs, most categories of health providers have not been able to improve their productivity to the same extent as the economy at large. Over time, the productivity adjustments mean that the prices paid for health services by Medicare will grow about 1.1 percent per year more slowly than the increase in prices that providers must pay to purchase the goods and services they use to provide health care services. Unless providers could reduce their cost per service correspondingly, through productivity improvements or other steps, they would eventually become unwilling or unable to treat Medicare beneficiaries.

It is possible that providers can improve their productivity, reduce wasteful expenditures, and take other steps to keep their cost growth within the bounds imposed by the Medicare price limitations. Similarly, the implementation of payment and delivery system reforms, facilitated by the ACA research and development program, could help constrain cost growth to a level consistent with the lower Medicare payments. These outcomes are far from certain, however. Many experts doubt the feasibility of such sustained improvements and anticipate that over time the Medicare price constraints would become unworkable and that Congress would likely override them, much as they have done to prevent the reductions in physician payment rates otherwise required by the sustainable growth rate formula in current law.

The annual report to Congress on the financial status of Medicare must be based on current law. In this report, the productivity adjustments are assumed to occur in all future years, as required by the Affordable Care Act. In addition, reductions in Medicare payment rates for physician services, totaling 30 percent over the next 3 years, are assumed to be implemented as required under current law, despite the virtual certainty that Congress will continue to override these latter reductions.

In view of the factors described above, it is important to note that the actual future costs for Medicare are likely to exceed those shown by the current-law projections in this report. We recommend that the projections be interpreted as an illustration of the very favorable financial outcomes that would be experienced if the productivity adjustments can be sustained in the long range—and we caution readers to recognize the great uncertainty associated with achieving this outcome. Where possible, we illustrate the potential understatement of Medicare costs and projection results by reference to an alternative projection that assumes—for purposes of illustration only—that the physician fee reductions are overridden and that the productivity adjustments are gradually phased out over the 15 years starting in 2020.

The following chart shows long-range projections of total Medicare expenditures, as a per-centage of GDP, under three scenarios. The substantial impact of the Affordable Care Act on expenditures is apparent by comparing the current-law projections from the 2010 Trustees Report (which includes the effect of all ACA provisions) to the corresponding projections from the 2009 Trustees Report (pre-ACA). Medicare expenditures in 2030 are currently projected to be about 20 percent lower than shown in the 2009 report, primarily as a result of the Affordable Care Act provisions. By 2050 and 2080, the projected difference increases to 32 and 43 percent, respectively.



The growing difference between the current-law and prior-law projections in the long range is primarily attributable to the compounding effect of the slower Medicare price updates. To help assess the potential understatement of Medicare costs under current law, the Board of Trustees asked the Office of the Actuary to make projections under an illustrative alternative to current law. The alternative assumes that (i) Medicare payment updates for physicians would be based on the Medicare Economic Index, rather than the sustainable growth rate (SGR) formula, and (ii) the productivity adjustments to most other categories of providers would be gradually phased out after 2019. As indicated in the chart above, Medicare costs under the illustrative alternative to current law would be substantially greater than the current-law projections. It is important to note that the illustration represents only a means by which to consider the potential understatement of costs under current law. No endorsement of the illustrative payment changes by the Trustees, CMS, or the Office of the Actuary should be inferred.

ESTIMATED IMPACT OF AFFORDABLE CARE ACT ON MEDICAID AND CHIP

The Affordable Care Act is estimated to add a total of $455 billion to aggregate Medicaid expenditures during fiscal years 2010-2019, an increase of about 8 percent. Federal expenditures represent the great majority ($434 billion) of this projected increase, equivalent to a 13-percent increase compared to prior law. State expenditures are projected to expand only $21 billion (or about 1 percent). The Federal government participation is relatively larger than for current Medicaid expenditures because the Affordable Care Act specifies a much higher Federal matching rate for newly eligible beneficiaries, ranging from 100 percent in fiscal years 2014, 2015, and 2016 to 90 percent by 2020 and beyond.

The most significant provision, measured by its impact on expenditures and enrollment, is the expansion of Medicaid eligibility to all persons under age 65 living in families with incomes below 138 percent of FPL beginning in 2014. This expansion is projected to add more than 20 million Medicaid enrollees by 2019, an increase of about one-third compared to the prior law (including an estimated 2 million individuals with employer-sponsored health insurance who would enroll for supplementary coverage through Medicaid). About three-quarters of the additional enrollees are expected to be adults and the remaining one-quarter to be children.[3] The

[3] In addition to the higher level of allowable income, the Affordable Care Act expands eligibility to people under age 65 who have no other qualifying factors that would have made them eligible for Medicaid under prior law, such as being under age 18, disabled, pregnant, or parents of eligible children. The estimated increase in Medicaid enrollment is based on an assumption that Social Security benefits would continue to be included in the definition of income for determining Medicaid eligibility. If a strict application of the modified adjusted gross income defini-

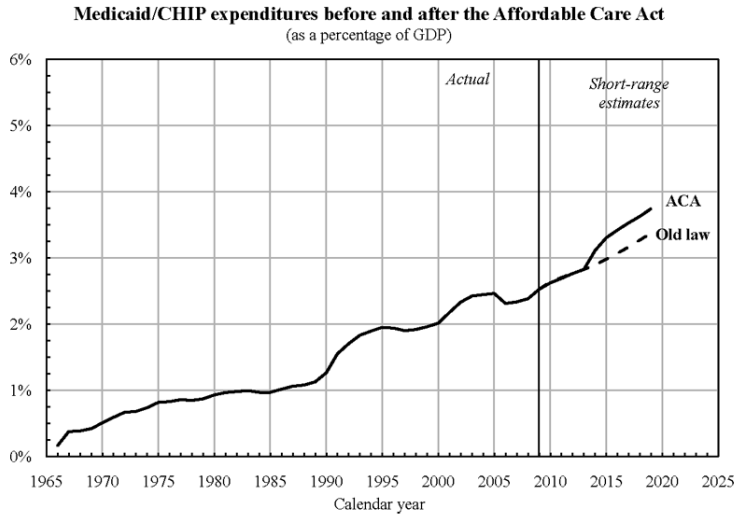
percentage increase in Medicaid expenditures will be considerably lower than the increase in enrollment, since adults and children have much lower average health care costs than aged and disabled enrollees.

The Affordable Care Act also provides for additional funding for the CHIP program, for 2014 and 2015, which would increase such expenditures by an estimated $29 billion.

The total net Federal cost of the other Medicaid and CHIP provisions is estimated to be $28 billion in fiscal years 2010-2019 and reflects numerous cost increases and decreases under the individual provisions. Those with significant Federal savings include various provisions increasing the level of Medicaid prescription drug rebates ($24 billion) and reductions in Medicaid DSH expenditures ($14 billion). Interactions between the different sections of the Affordable Care Act, such as the lower Medicare Part B premiums, contribute an additional $9 billion in reduced Medicaid outlays.

The key provisions that would increase Federal Medicaid and CHIP costs are the Medicaid "Community First Choice Option" and other changes to encourage home and community-based services ($29 billion), higher Federal matching rates for States with existing childless-adult coverage expansions ($24 billion), a temporary increase in payments to primary care physicians ($11 billion), and increased payments to the Territories ($7 billion). The net impact of the Medicaid and CHIP provisions on State Medicaid costs is a reduction totaling $33 billion through fiscal year 2019. These savings result in part because certain of the provisions reallocate costs from States to the Federal government.

The following chart shows past Medicaid and CHIP expenditures (Federal plus State) as a percentage of GDP, together with 10-year projections under the Affordable Care Act and prior law.



ESTIMATED IMPACT OF AFFORDABLE CARE ACT ON TOTAL NATIONAL HEALTH EXPENDITURES

The estimated effects of the Affordable Care Act on overall national health expenditures (NHE) are shown by the "net total" curve in the following chart. In aggregate, we estimate that for calendar years 2010 through 2019, NHE would increase by $311 billion, or 0.9 percent, compared to prior law. Year by year, the relative increases are largest in 2016, when the coverage expansions would be fully phased in (2.0 percent), and gradually decline thereafter to 1.0 percent in 2019.

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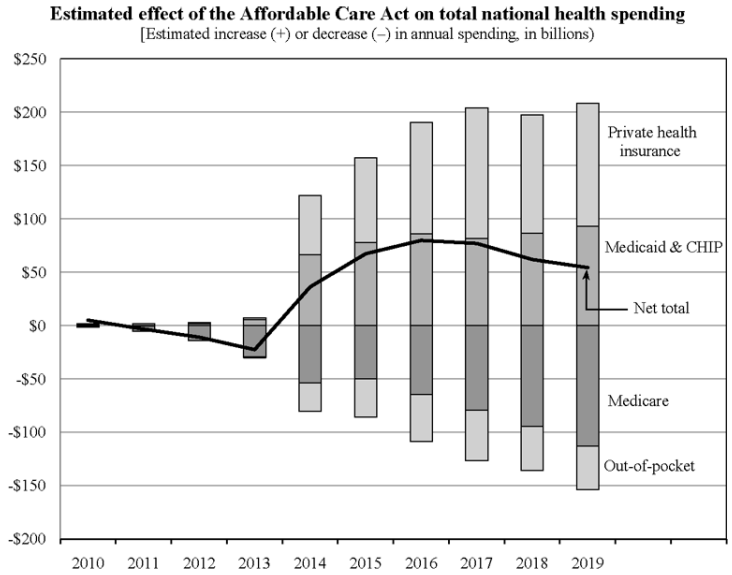
tion is instead applied, as may be intended by the Act, then an additional 5 million or more Social Security early retirees would be potentially eligible for Medicaid coverage.



The net total increase in NHE reflects several large—and largely offsetting—effects on expenditures by private health insurance, Medicare, Medicaid, and individuals' own out-of-pocket costs, as shown by the columns in the chart above. Health expenditures are expected to increase by about $200 billion annually due to the substantial expansions of coverage under the Affordable Care Act. Numerous studies have demonstrated that individuals and families with health insurance use more health services than otherwise-similar persons without insurance. Under the health reform legislation, by 2019 an estimated 34 million currently uninsured people would gain comprehensive coverage through the health insurance Exchanges, their employers, or Medicaid. The availability of coverage would typically result in a fairly substantial increase in the utilization of health care services, with a corresponding impact on total health expenditures. These higher costs would be partially offset by the sizable discounts imposed on providers by State Medicaid payment rules and by the significant discounts negotiated by private health insurance plans. We estimate that the net effect of the utilization increases and price reductions arising from the coverage provisions of the Affordable Care Act would increase NHE in 2019 by about 3.4 percent.

The Affordable Care Act will also affect aggregate NHE through the Medicare savings provisions. We estimate that these impacts would reduce NHE by roughly 2.4 percent in 2019, assuming that the productivity adjustments to Medicare payment updates can be sustained through this period. The legislation would have only a slight impact on the utilization of health care services by Medicare beneficiaries (subject to the caveat mentioned previously regarding possible access issues if Medicare payment rates become inadequate). As shown in the chart, the Medicare savings accumulate rapidly, principally due to the compounding effect of the slower payment updates for most categories of providers.

As indicated in the chart, out-of-pocket spending would be reduced significantly by the Affordable Care Act (an estimated net total decline of $237 billion in calendar years 2010-2019). This reduction reflects the net impact of (i) the substantial coverage expansions through Medicaid and the health insurance Exchanges, (ii) the significant cost-sharing subsidies for low-to-middle-income persons with Exchange coverage, (iii) the maximum out-of-pocket limitations associated with the qualified health benefit, (iv) lower cost-sharing payments by beneficiaries in fee-for-service Medicare, (v) higher cost-sharing payments by Medicare Advantage enrollees, and (vi) the increases in workers' cost-sharing obligations in plans affected by the excise tax on high-cost employer-sponsored health insurance coverage.

A number of the other provisions in the Affordable Care Act would also affect national health expenditures during 2010-2019, although the magnitude of these effects would be much smaller than the financial effects of the coverage expansions

and Medicare savings provisions. These other provisions include the immediate insurance reforms in Title I; comparative effectiveness research; the excise tax on high-cost employer health plans; fees on health insurance plans and on manufacturers and importers of brand-name prescription drugs; and an excise tax on non-personal-use retail sales by manufacturers and importers of medical devices. The effects of these provisions are included in the respective categories of national health expenditures shown in preceding chart.

Compared to prior law, the level of total national health expenditures is estimated to be higher through 2019 under the Affordable Care Act, but two particular provisions of the legislation would help reduce NHE growth rates after 2016. Specifically, the productivity adjustments to most Medicare payment updates would reduce NHE growth by about 0.10 to 0.15 percent per year. In addition, the excise tax on high-cost employer health plans would exert a further decrease in NHE growth rates of an estimated 0.05 percent in 2019 and slightly more than that for some years thereafter. Although these growth rate differentials are not large, over time they would have a noticeable downward effect on the level of national health expenditures. Such an outcome, however, would depend critically on the sustainability of both provisions. As discussed previously, the Medicare productivity adjustments could become unsustainable even within the next 10 years, and over time the reductions in the scope of employer-sponsored health insurance could also become an issue. For these reasons, the estimated reductions in NHE growth rates after 2016 may not be fully achievable.

CONCLUSIONS

The Affordable Care Act makes far-reaching changes to most aspects of health care in the U.S., including mandated coverage for most people, required payments by large employers not offering insurance, expanded eligibility for Medicaid, Federal premium and cost-sharing subsidies for many individuals and families, a new system of health benefits Exchanges for facilitating coverage, and a new Federal insurance program in support of long-term care. Additional provisions will reduce Medicare outlays, make other Medicaid modifications, provide more funding for the CHIP program, add certain benefit enhancements for these programs, and combat fraud and abuse. Federal revenues will be increased through an excise tax on high-cost insurance plans; fees or excise taxes on drugs, devices, and health plans; higher Hospital Insurance payroll taxes for high-income taxpayers; a new tax on investment revenues and other unearned income; and other provisions.

In our independent capacity as technical advisors to the Administration and Congress, the Office of the Actuary at CMS has estimated the effects of the non-tax provisions of the Affordable Care Act on Federal outlays, overall national health expenditures, and health insurance coverage in the U.S. Our estimates are based on available data sources and what we believe are reasonable assumptions regarding individual, employer, and health plan responses to the legislation, together with analyses of the likely changes in the cost and use of health care services. In view of the complexity and scope of these changes, estimates of their financial and other effects are necessarily very uncertain. As the Affordable Care Act provisions are finalized through regulations, and as providers, employers, and individuals respond to the requirements and opportunities in the legislation, we will continue to monitor developments and to update our estimates for Medicare, Medicaid, CHIP, and total national health expenditures as necessary.

I hope that the information presented here is of value to policy makers, and I pledge the Office of the Actuary's continuing assistance to the joint effort by the Administration and Congress to determine optimal solutions to the financial challenges associated with health care in the U.S. I would be happy to answer any questions you might have.

Chairman RYAN. Thank you, Rick—Mr. Foster.

Let me get into the sustainability of the cost-saving claims surrounding this law. I want to look at your analysis dated April 22nd of the new law.

On page 10 of your analysis—and you came to the Fiscal Commission, which I served on, and went through great detail on this—I will just quote a couple of things, because I am trying to understand sort of the reliability of these cost savings.

"Simulations by the Office of the Actuary suggest that roughly 15 percent of Part A providers will become unprofitable within the 10-year projection period as a result of productivity adjustments."

Are you basically saying within a 10-year period you believe about 15 percent of Part A providers just will stop taking Medicare or will go bankrupt?

Mr. FOSTER. If nothing else happens other than they have these lower payment rates under the Affordable Care Act, then we looked provider by provider for hospitals, skilled nursing facilities, and home health agencies and determined that 15 percent of them within the 10 years would have total facility margins, profit margins, that were negative. In other words, these were providers that start off now with some positive level but that would turn negative within the 10 years because of the difference in Medicare payment rates.

Now, the response to that, we didn't go into that. Would they merge? Would they go out of business? How else would they deal with it?

Chairman RYAN. Which leads to the next two paragraphs down, where you say, "In general, limiting cost growth to a level below medical price inflation alone would represent an exceedingly difficult challenge. Actuarial Medicare cost growth per beneficiary was below the target level in only four of the last 25 years, with three of those years immediately following the Balanced Budget Act of 1997. The impact of the BBA prompted Congress to pass legislation in 1999 and 2000 moderating many of the BBA projections."

So basically what you are saying is not unlike what happened in the last decade. Congress went too far from the perspective of providers and took a lot of the savings back, and you are basically suggesting that is probably the kind of pressure we are going to face again?

Mr. FOSTER. Yes. The possibility is definitely there.

In the Balanced Budget Act, of course, we did see then a few years later the Balanced Budget Refinement Act and the Benefit Improvements and Protection Act that had to undo some of the Balanced Budget Act savings.

I would like to mention, Representative Ryan, that the quote you referred to has to do with the Independent Payment Advisory Board, which is charged with keeping Medicare cost growth rates during 2015 through 2019 to increase no more than the average of the regular CPI and the medical CPI. That is the demanding target that I referred to, and the fact that it has only happened a few times in history is judged against that standard, the average of the CPI and the medical CPI.

Chairman RYAN. And that is the basic claim for the savings in the second decade in the outyears are based upon the feasibility of those savings claims, correct?

Mr. FOSTER. In part. The standard for the growth rate is eased up, and it becomes the growth in GDP plus 1 percent that is an easier target to meet. Much of the savings in the second decade and third, fourth, fifth, et cetera, would come from the compounding effect of these lower price increases that Medicare

will pay to providers. When something grows at 1.1 percent per year slower, that compounds to a lot over long periods of time.

Chairman RYAN. I think that is a very important point. Because, as we look at different plans to deal with this, to deal with health care, to modernize Medicare, it is important to compare against current law. Current law has enormous unfunded liabilities. PPACA does try to lower the prices, lower the cost curves, lower reimbursements. All plans do that. So when we are taking a look at Medicare reform plans, I think it is fair to say the current trajectory is not sustainable, and the best question is how best to go about doing it and what actually is reliable, what actually is sustainable going forward.

You did something in the last trustees' report that I don't know I have seen before. You put an appendix to this most recent trustees' report which I found very interesting. I wanted to kind of get into that very briefly. I will just quote a couple of paragraphs from this to try and understand what you are getting at here.

In the appendix to the trustees' report, you more or less say, "For these reasons, the financial projections shown in this report for Medicare do not represent a reasonable expectation for actual program operations in either the short run as a result of the unsustainable reduction in physician payment rates or the long range because of the strong likelihood that the statutory reductions in price updates for most categories of Medicare providers will not be viable."

You continue to say, "While Part B projections in this report are reasonable in their portrayal of future costs under current law, they are not reasonable as an indication of actual future costs. Current law would require physician fee reductions totaling an estimated 30 percent over the next 3 years, an implausible result. By the end of the long-range projection period, Medicare prices for hospitals, skilled nursing facilities, home health, hospice, ambulatory, surgical center, diagnostic laboratory, and many other services would be less than half their level under prior law."

I think, if I recall, at the Commission you said that within 10 years Medicare will be reimbursing providers at rates less than Medicaid. Is that the case?

Mr. FOSTER. Yes, with two caveats. If you look at the average overall for Medicaid reimbursement levels or payment levels to providers and if you assume they stay at about the same relative level, not be ratcheted down further and further, then within 10 years under current law Medicare rates on average would actually be lower than that.

Now, there is a provision in the current law that says you can't pay Medicaid any more than Medicare pays, so that provision would tend to prevent this from happening. But it is an illustration of the fact that the accumulating lower price updates will have a significant effect.

Chairman RYAN. So the best-case scenario under those contrasting laws is they are on par with Medicaid?

Mr. FOSTER. Yes, that is right.

Chairman RYAN. Yes. In some States, about 50 percent of providers won't even take it. So I think this just illustrates that this issue is going to have to—we are going to have to go at this again.

This is not resolved, this is not fixed, and we have our own collision course coming.

I want to get into one more thing, and then I want to turn time over, because I understand the two of us don't have 5-minute rules, and I want to be respectful of everybody's time.

I just want to get into whether we can count a dollar twice. Is it possible to use Medicare savings like that in this new health care law to make the Medicare Trust Fund more solvent and to pay for a new health care entitlement? Can the same savings accomplish both goals? If the savings are used for the new entitlement, what does that mean for Medicare's long-term solvency? That is the key, critical, double-counting thing. There is an issue with trust fund accounting, and there is an issue of what actually happens.

If you could just highlight that and illustrate that for me, I would appreciate that.

Mr. FOSTER. Sure, I would be glad to.

My answer is a definitive yes and no. There has been a lot of discussion of this, of course. What I would like to do is explain how it works, and you can all judge for yourselves.

It is best done by an example. Suppose that a given person will pay $100 more in Medicare hospital insurance payroll taxes as a result of the Affordable Care Act. So that person pays the extra $100, and it is credited to the Hospital Insurance Trust Fund. What that means is the trust fund gets a Treasury security worth $100, and it is a bond or whatever, and it will be repaid with interest whenever we need it. Now, the actual $100 bill, the $100 in cash, sits in the general fund of the Treasury and it can be used for any purpose needed to meet Federal Government expenditures. Whether that is helping offset the cost of the coverage expansions under the Affordable Care Act or anything else, that is what will happen. That $100 will be spent pretty much immediately.

Now, the fact that a new amount of $100 came into the Treasury, that reduced the Federal budget deficit that would have otherwise occurred by $100. So, so far, this Medicare savings does reduce the Federal budget deficit and can be used to help pay for other expenditures.

Now, in the future, when we need that $100, we have a Treasury bond or an IOU, a pretty good IOU, that says we can cash that in and be repaid with interest. So when we need that money, we will turn in the bond, we will get the $100, we will pay that $100 for the Medicare hospital insurance purpose. So it does also extend the life of the trust fund.

Now, the obvious catch—or at least I hope it is fairly obvious—is that $100 can't be spent as $100 towards health care reform and as $100 towards Medicare expenditures. That takes $200. You only have $100. So you cannot directly use that money to do both purposes, and it would be essentially double accounting to imply that you can do it directly.

On the other hand, because of the budget accounting principles and the trust fund accounting principles, both of these things happen. It reduces the deficit and extends the trust fund. The key thing is when you go back to pay back that $100, when you turn in the bond, then Treasury has to find another $100 someplace, either by borrowing it, which is usually the case, or another source

of taxation or lower expenditures. So when we spend the $100 for Medicare, it has to be given to us from another source.

I hope that clearly lays out how the process works.

Chairman RYAN. And is that essentially why you put an appendix to the trustees' report this time?

Mr. FOSTER. Not that so much, Mr. Ryan, as it was that the current law projections very likely understate the future costs because of these price adjustments, the SGR physician payments, et cetera. In our April 22nd memo and in our subsequent memos, we have noted that you can't use the same $100 for both purposes.

Chairman RYAN. Okay. So the two takeaways from the April 22nd memo and the appendix to the trustees' report—which, like I said, I have not seen that before—are you believe these are unsustainable, the savings, and $1 cannot be counted twice.

Mr. FOSTER. Yes. The $1 can't be counted twice. In terms of the unsustainability, that is more judgmental, but I think almost every expert I have talked to thinks there is only a limited likelihood that that could work in the longer term.

Chairman RYAN. Thank you.

Mr. Van Hollen.

Mr. VAN HOLLEN. Thank you, Mr. Chairman; and, Mr. Foster, thank you for your testimony.

I want to pick up on this line of questioning the chairman was pursuing, because I think what you said was very important and it is important that everybody in this room understand what you said.

Let's take your example of another $100 coming in from the Medicare payroll tax. That $100 comes from the U.S. Government. That doesn't make the Medicare system any worse off, does it, the $100?

Mr. FOSTER. Not any worse off than the situation before the $100 arrived.

Mr. VAN HOLLEN. Correct. It doesn't do any harm to the Medicare payment system, correct?

Mr. FOSTER. That is correct.

Mr. VAN HOLLEN. Okay. That $100 does go in, as you said, as part of deficit reduction, does it not?

Mr. FOSTER. That is correct.

Mr. VAN HOLLEN. Correct. So it is not a gimmick, is it, to say that $100 helps reduce the Federal deficit?

Mr. FOSTER. No. By normal budget accounting practices, it reduces the Federal budget deficit. In real life, that is exactly what would happen.

Mr. VAN HOLLEN. Right. That reduces the Federal deficits by $100, correct?

Mr. FOSTER. Yes. It is $100 of new revenues that didn't exist before.

Mr. VAN HOLLEN. Exactly. What you are saying is obviously true, that the same dollar cannot be used to actually pay future Medicare costs. But, at the same time, what you are saying is the way the system works is that that dollar that goes to deficit reduction or something else is credited to the Medicare account. Isn't that correct?

Mr. FOSTER. That is correct.

Mr. VAN HOLLEN. Okay. So in that sense the obligation of the Federal Government to the Medicare program would allow it to be extended, isn't that correct?

Mr. FOSTER. Yes. Under the trust fund accounting laws.

Mr. VAN HOLLEN. Yes. Look, this is obvious. I appreciate you are saying it wasn't a gimmick, because it does reduce the Federal deficit in that example by $100. Now, there is no doubt—and if you find real savings, if the law is implemented as is, you also get deficit reduction from savings in Medicare, correct?

Mr. FOSTER. That is right.

Mr. VAN HOLLEN. Ms. Allison Schwartz is going to be talking about the reforms that were in the health care reform bill that we believe will help bend the cost curve and find productivity savings within the system.

As I understand your earlier point, it was partly a political point, right, which is that we will achieve the Medicare savings unless this House and the Senate and the President all agree to change the law, is that correct?

Mr. FOSTER. I would argue with you a little bit on how I meant to characterize it. It probably becomes a political issue if the payment rates end up not being sustainable.

Mr. VAN HOLLEN. Correct.

Mr. FOSTER. That was my point.

Mr. VAN HOLLEN. No, I appreciate that. If they are not sustainable, that would have to happen.

Mr. FOSTER. Yes.

Mr. VAN HOLLEN. Just a quick point on the SGR, because you referenced that. This is the doc fix. This is an example of how Congress has had to make adjustments. Isn't it the case we would have to deal with the SGR fix, the doc fix, whether or not we passed health care reform?

Mr. FOSTER. It has to be dealt with one way or the other. It is clearly not working.

Mr. VAN HOLLEN. If the Congress had never passed the health care reform law, if we never even talked about it, this Congress would still have to deal with that cost of the SGR, right?

Mr. FOSTER. Yes, that is correct.

Mr. VAN HOLLEN. Thank you.

Now, as the chairman said, we have to make policy choices here and figure out the best way forward. I think we all agree that health care costs in this country have been on a very steep upward path and that they are unsustainable and the health care reform law begins to make changes to try and change that. As I said, Congresswoman Schwartz will be dealing with that.

But I would like to point up a comparison. Because the chairman mentioned in his opening remarks that there is an alternative plan. What I would like to put up is a page from the CBO letter, analysis of the committee, of the chairman's plan, of the roadmap plan as it relates to Medicare.

Let me give you a copy. Why don't you pass these out on your side. Obviously you can't read it, so we are handing out hard copies.

So this, as I said, is based on the January, 2010——

Chairman RYAN. Looking at this, it says it works.

Mr. VAN HOLLEN [continuing]. CBO analysis.

Mr. Foster, in your testimony, if you look at page 5, at the bottom of the page there is a paragraph that, by 2019, the net reduction in Medicare expenditures is estimated to be half a percent of GDP. Do you see that?

Mr. FOSTER. Yes.

Mr. VAN HOLLEN. And your response to the chairman's questions were that these reductions could conceivably, unless adjusted productivity changed and other changes were made, could lead to some unsustainability, isn't that right?

Mr. FOSTER. Sooner or later, they are almost bound to.

Mr. VAN HOLLEN. The chairman asked you a question about in 2019: What would be its impact on providers? I would just ask you to look at this CBO analysis—if someone could get Mr. Foster a copy, if he doesn't have one. But what it references is the year 2020. This is the implementation of the roadmap scenario which the chairman referenced. You see that they have the alternative fiscal scenario, which is sort of current law, and you have got Medicare expenditures there at 4.5 percent of GDP. Do you see that? It is the 2020 column, second one down, 4.2 percent.

Mr. FOSTER. 4.2 percent, yes.

Mr. VAN HOLLEN. Then you see under the roadmap plan, if you look under Medicare as a percent of GDP, 3.7 percent. Do you see that? The difference is 0.5 percent of GDP.

Now, in this part of the roadmap plan, that is the first 10 years, that is before the voucher part gets kicked in. So those savings are assumed as a result of a number of things, including reducing general fund support for Medicare and that kind of stuff.

But if you were to take that amount of money, 0.5 percent, out of GDP through of that method, you would raise the same concerns as you have raised with respect to the Affordable Care Act, correct?

Mr. FOSTER. Possibly. It depends a lot on how it is done, and I will confess it has been a couple of years since I have taken a close look at Chairman Ryan's roadmap, so I don't remember the specifics of the short-term Medicare proposals.

If they are done largely through slower updates for providers, I would have exactly the same concern. If they were done through other mechanisms that addressed the, say, fraud, waste, and abuse or inefficiency within the current health care system, that might be a lot more sustainable.

We could look and provide an answer for the record.

Mr. VAN HOLLEN. Right. Well, I mean, in the Affordable Care Act we are going after fraud, waste, and abuse, too, correct?

Mr. FOSTER. Sure.

Mr. VAN HOLLEN. So we get those savings in the Affordable Care Act, correct?

Mr. FOSTER. There is a lot that can be done.

Mr. VAN HOLLEN. If we have got more on fraud, waste, and abuse, I think all of us would be very interested in knowing that. But I would urge you to take a look at the assumption the CBO made in reaching that so-called Medicare savings in the first 9 years of the Ryan roadmap, because it is things like reduce the annual inpatient hospital market basket factor, the same kind of things that we were talking about, except it doesn't include a lot

of the reform elements that were included in the last 10 years to actually achieve those savings. I would like you to take a look at that.

Now, beyond 2020, under the chairman's roadmap plan you developed a—it turned into a voucher system. In other words, the Medicare recipient, the senior citizen, is going to get handed a voucher, and the savings are achieved because that voucher has a declining value over a period of time. So it is less money to pay for the very real costs that you were talking about that health care providers face.

So wouldn't you have similar concerns with respect to the sustainability component, except for the fact that the risk in many ways is shifted directly onto the Medicare beneficiary?

Mr. FOSTER. I would say there are concerns or risks in both cases. We have already talked about the productivity adjustments and are provider payment rates adequate. With a voucher proposal for Medicare, if the voucher payments are indexed at an amount lower than the prevailing increase in costs or per capita costs for health care, then you would have a different sort of risk, the risk, nonetheless, that over time the voucher amounts might not be adequate for people to use to purchase significant health care coverage.

Mr. VAN HOLLEN. Meaning that a senior citizen on Medicare would have a voucher that may not be able to cover the same benefits as today, correct?

Mr. FOSTER. That is possible, yes.

Mr. VAN HOLLEN. If we could just go to this last slide here——

No, that is not it. It is a handout, actually. It is on the back page.

Now, Mr. Foster, if you could go to page 9 of your testimony, you have got a graph that sort of plots the Medicare expenditures. Again, this is the percent of GDP under the current law, meaning as the Affordable Care Act was passed, and then you have got the very top line which shows the trajectory if we hadn't passed the Affordable Care Act, and then you have an illustrative different example, right?

Mr. FOSTER. That is right.

Mr. VAN HOLLEN. So I would now just like to compare that to the figure 3, which is, again, CBO's January analysis of the Medicare component of the chairman's plan.

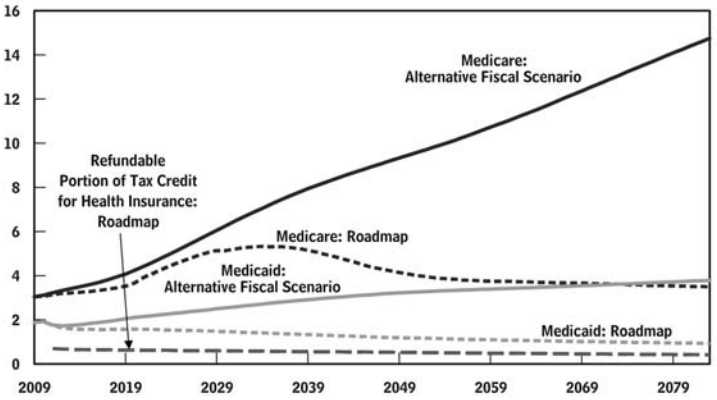
If you look at that, as your chart shows, if you had done nothing, under current law, it is off the charts. We all agree with that. But if you adopt the chairman's proposal, you get dramatic reductions as a percent of GDP. Because as we discussed, that value of the voucher that the senior citizen is getting is going down and down and down and down; and in fact, at the end of the day, as a percent of GDP, he takes it much lower by reducing the value of that voucher the senior is getting.

So wouldn't you have similar concerns—I think you said you have similar concerns, but from a different direction, meaning the senior citizen has got to try to get health care services with something that is worth a lot less?

Figure 3.

Federal Health Care Spending Under CBO's Alternative Fiscal Scenario and the Roadmap

(Percentage of gross domestic product)



Source: Congressional Budget Office based on the agency's *The Long-Term Budget Outlook* (June 2009).

Notes: The alternative fiscal scenario deviates from CBO's baseline projections, incorporating some changes that policymakers have regularly adopted in the past and others that may occur.

The Roadmap is legislation introduced by Congressman Paul Ryan on January 27, 2010, entitled Roadmap for America's Future Act of 2010, with specifications provided by his staff.

Mr. FOSTER. With both of these kinds of proposals and also other kinds of proposals, there is one sort of potential saving grace. As I think most of you recognize, almost all medical technology, new developments, new devices, treatments, drugs, you name it, most of it is cost increasing. That is different from what we experience with manufacturing cars or computers or telephones or whatever. There, the new technology generally gets you lower costs at the same time as you get better things.

Now, if there is a way to turn around the mindset for the people who do the research and development of new medical technology and to get them to focus more on cost-reducing technology and less on cost-increasing technology, if you can go that, then one of the biggest components of rapid health care cost growth turns it to your side, to your advantage, and away from being part of the problem.

Now, with either a voucher system that puts a lot of pressure on what you can buy for health insurance or, to a somewhat lesser extent, the payment updates for Medicare providers or certain other kinds of things, if you can put that pressure on the research and development community, you might have a fighting chance of changing the nature of new medical technology in a way that makes lower costs like this possible and more sustainable.

I would say the roadmap has that potential. There is some potential for the Affordable Care Act price reductions, although I am a little less confident about that. And we haven't yet talked, but per-

haps in a minute with Representative Schwartz, about innovations, the possibility there.

Mr. VAN HOLLEN. Thank you, Mr. Chairman.

Chairman RYAN. Thank you, Mr. Van Hollen.

Mr. Campbell.

Mr. CAMPBELL. Thank you, Mr. Chairman.

I don't think anyone knows more about the roadmap than the gentleman who wrote it, so I will yield back to the chairman for some comments.

Chairman RYAN. I find it interesting that the ranking member spent most of his time not talking about the health care law we are having a hearing on today but about an individual member's proposal.

Let me just say a couple of things just to clear the air.

Under my proposal, Medicare spending as a percentage of GDP never goes down from where it is today. It is actually higher at the end of the window. Point number one.

Point number two, we grandfathered the existing population at current Medicare growth rates. The short-term savings are about half of what PPACA is, and this scenario he is talking about applies to people 54 and below. People 55 and above grow at current rates, unlike the current law which we just now went through. That is another point we will have to get into—and we ought to do a hearing on this—about how best to reform Medicare.

We know we are making promises to people in the future that will not be kept, that the government simply cannot keep. So the question is, what is the best way to proceed, what is the most humane way to proceed, and what is the best way to reform this program so we get more bang for our buck, so that we turn health care spending into a virtuous cycle, like Mr. Foster just said, instead of a vicious cycle which spins our debt and deficit out of control. Do we empower consumers or do we price control from the government? What works best?

So I can go through point by point refutation of every one of those things that was done right there, only to simply say Medicare is the biggest driver of our debt. We are all kidding ourselves if we think the program can just go on as is; and the sooner we address it, the better off everybody is. The better we can guarantee my mom, who has been on it for a number of years, and everybody else's mom and dad can have the program they organize their lives around and that future retirees have a program they actually can count on. That is the purpose of this particular bill that I introduced; and that, hopefully, is the purpose of what we are all trying to achieve.

With that, Mr. Campbell.

Mr. VAN HOLLEN. Mr. Chairman, just for 30 seconds?

Chairman RYAN. Sure.

Mr. VAN HOLLEN. You referenced in your opening comments the fact that there was an alternative path forward, and I assume you were talking about your proposal. And the point is that you are right with respect to the percent of GDP you don't go over current GDP. But part of the testimony, as I understand from Mr. Foster, as he looks at both issues there are similar questions raised. So with respect to that component.

Thank you, Mr. Chairman.

Mr. CAMPBELL. Thank you, Mr. Chairman.

Mr. Foster, on August 7 of last year, the President said in part, "The steps we took this year to reform the health care system have put Medicare on a sounder financial footing. Reform has actually added at least a dozen years to the solvency of Medicare."

In making that statement, he is referring to CBO's score, which includes the Medicare tax that is your allegorical $100 that you referred to earlier, is that correct?

Mr. FOSTER. That is correct, although the estimate of the 12 years was our estimate and the Board of Trustees, not the CBO's.

Mr. CAMPBELL. Okay, but he is using the allegorical $100.

Okay, then when he signed the bill, in his signing statement he said, "This legislation will also lower costs for families and for businesses and for the Federal Government, reducing our deficit by over $1 trillion in the next two decades."

In making that statement about the deficit, he is not also using the Medicare tax, your $100 allegorical payment?

Mr. FOSTER. Yes, he is.

Mr. CAMPBELL. So you can say it is legitimate, based on the scoring, to say you can add a dozen years to solvency of Medicare or that you can reduce the deficit, but it is not correct to say both simultaneously, is that correct?

Mr. FOSTER. Almost. Both will happen as a result of the same one set of savings under Medicare, but it takes two sets of money to make it happen. It happens directly for the budget deficit from the Medicare savings. And then when we need the money to extend the Hospital Insurance Trust Fund, we have a promissory note—it is an IOU. It is not a worthless IOU, but it is an IOU—and Treasury has to pay that money back. But they have to get it from someplace. That is the missing link.

Mr. CAMPBELL. Okay. You just can't do both at the same time.

This reminds me, Karen Bass, former speaker of the California Assembly, isn't here, but when I was in the California Assembly there was a tobacco tax proposed, and the idea was it was going to reduce smoking and reduce the deficit. As we went through, we realized you can claim one or claim the other, but it is not going to do both. Because if people keep smoking, you will reduce the deficit. If people stop smoking, it is not going to raise any more money. And you may stop smoking, but you won't reduce the deficit.

This is the same sort of thing. We are taking this same $100, allegorical $100, this same tax, and in one side saying, oh, we are going to reduce the deficit, and on the other side, we are going to extend Medicare. But it just simply can't do both.

Let me ask one other in my remaining 2 minutes.

What I also heard you say, I believe, is that the downstream consequences of the payment, the Medicare, the reduced payments that doctors may get aren't necessarily factored into all the scoring. Is that a correct description of sort of what you said?

Mr. FOSTER. Yes, sir, that is correct. Directly, we build in the impact on lower Medicare expenditures.

Now, there are potential secondary impacts. If the payment rates become inadequate, if nothing is done about it and providers exit

the market or refuse to treat Medicare patients, then you have some not very pleasant potential consequences. You can't find a doctor. Your local hospital will no longer treat Medicare. We do not model those secondary impacts.

Mr. CAMPBELL. Right. Yeah. Okay. And that to me is one of the great problems with this bill. Now this is all anecdotal, I admit. But since the bill has come out, in California insurance costs have gone way up, in part because of the mandated additional coverages. I have been approached by a number of people working for companies who have said that their company is either going to—they were getting a Cadillac policy—and they would reduce the policy, increase the cost. Other companies are going to drop health care for all of their employees in order to have them go into the exchange. And a number of doctors have told me they are either not going to accept Medicare and Medicaid or they are simply going to retire earlier. So these are a lot of actions and activities that private individuals are making out there in the world today, have already made as a result of this health care bill. Those reactions are not really modeled, is that correct, in the scoring.

Mr. FOSTER. Generally speaking, they are not. We do have a lengthy set of caveats about various concerns that we were aware of but which we had no way of estimating.

Mr. CAMPBELL. Right. And to me, just before my time runs out, is one of the great huge faults in this bill is that it does not include the real-world impacts that real-world people will do as a result of this miserable bill. I yield back.

Chairman RYAN. Ms. Schwartz.

Ms. SCHWARTZ. Thank you, Mr. Chairman and ranking member.

Mr. Foster, I appreciate some of the things you have said. It is sometimes hard to almost figure out where to start here a little bit—and I appreciate your testimony. Let me just say just a couple of things. And then really I do want to focus in on a comment in your written testimony—and you have made it orally here—that there is—and I think your words are exactly, that there is real potential, a significant potential to improve quality and efficiency through the innovations that are in this law. It is not a bill. It is a law. And it is already being implemented.

Before I get there, I did just want to say that—it has already been said by Mr. Ryan and I don't expect to you respond to this—that we will not keep our promises to future seniors. And I just want to disagree with that. Certainly on this side of the aisle, we will keep our promises to future seniors. And that is in part why we did this bill, because of the rising rate of growth of cost in health care and getting the best value for our dollar could be improved upon. And we wanted to reduce costs for the government and for businesses and for families. And I appreciate your acknowledgement of the savings that are in this law.

And what I wanted to ask you about specifically is you reference in a general way the innovations in this law. And there are really kind of two sets. There are some that are really going forward, mandated, if you will, on some of our providers. And you talk about some of those. The productivity adjustments, the reductions in overpayments to insurance companies, something that Medicare Advantage—I think some of my other colleagues are going to talk

about that, reductions in payments, the potential of the independent payment advisory board, and even the coverage of part B and part D, those changes.

But there are other areas as well, such as reducing the preventable hospital readmissions and really holding hospitals more accountable for reducing the hospital-acquired infections; bundle payments which are going forward; the 2 percent pay-for-performance for hospitals, so that we are going to hold back, and if you do well, send you that money, but if you don't, not. Really pushing, really pretty aggressively I think, to reduce errors, to reduce infections, to improve quality in our hospitals and reduce costs as a result.

So we are also—the other set are, as you point out, more innovative, have been tried, functioning. I think one of my other colleagues is going to talk about some of the health systems across this country that are doing a much better job than others on coordinated care, integrated care, and the improved quality and cost savings from that.

But patient-centered medical homes for those with chronic diseases, the potential for cost savings are keen. Pennsylvania just got $33 million under this law. Five other States got it as well, to begin to implement these provisions: health information technology, accountable care organizations, health innovation zones, primary care being enhanced.

So in my last 1½ minutes, would you agree, as you said in your testimony, that these innovations have the potential, significant potential of improving quality, improving access, and reducing costs not just for Medicare beneficiaries but for all patients, because providers will do it for all patients?

Mr. FOSTER. I certainly agree that the potential is there. Some of the things you mentioned are relatively straightforward changes. I wouldn't include them in the innovation category. They are just changes that can be made. Like Medicare Advantage payment benchmarks, you could raise them, you could lower them.

Ms. SCHWARTZ. And that is happening?

Mr. FOSTER. Yes. When I think of the innovations, I think of the creation of the Center for Medicare and Medicaid Innovation within CMS. Some of the other programs, the shared savings program for accountable care organizations, the bundled payment demonstration, things like this. Many of these do, in fact, have potential, and some of the things we don't even know about yet, some of the things that have yet to be designed or specified or tested or evaluated. I am a big believer in research.

Ms. SCHWARTZ. So evaluating them and moving ahead on the ones that work is very important?

Mr. FOSTER. Yes. I think it is a good way to help—well, the motto of the Society of Actuaries—there is a quote from John Ruskin and that is, "The work of science is to substitute facts for appearances and demonstrations for impressions." We can talk about these things; but if we don't try them, then we won't really know if they work or not.

Ms. SCHWARTZ. I don't have a lot of time left. But are you aware of some of the work that is being done already by CMS to move fairly—I want to say aggressively, but that may not be perceived

as a positive—but to move very actively, proactively, forward to not only test these models but to grow these models?

Mr. FOSTER. Yes. We have been assisting with that effort.

Ms. SCHWARTZ. Right. And because there is choice for patients and choices for providers, because it is not that government-controlled their choices there are going to be a lot of variety in the kind of delivery system and payment reforms out there to improve quality and improve savings.

Mr. FOSTER. There is definitely room for improvement. If I may, I would like to make one comment on that. There is the potential—and we don't know how much yet—hopefully a lot. But the process will tell us. One aspect that perhaps concerns many people, although many people don't know about it is, as the law is written, most of these innovations can be adopted nationwide if the Secretary of HHS determines that they improve quality or don't harm it, and that the chief actuary of Medicare determines that they either reduce costs or they don't increase costs.

The standard for testing whether they increase costs or not is against current law. Current law, with all the provider of payment reductions, with the 30 percent physician cut, all of that. So it actually is a pretty tough hurdle to meet in terms of allowing these to go forward.

Mr. CAMPBELL [presiding]. Ms. Schwartz, I am afraid we are way over time.

Ms. SCHWARTZ. I think we are up to the challenge.

Mr. CAMPBELL. Mr. Calvert.

Mr. CALVERT. Thank you, Mr. Chairman. Medicare Advantage has been brought up. The minority health care law included significant cuts to the Medicare Advantage Program, a program which covers about 50 percent of beneficiaries in my district. What changes would seniors experience with these cuts?

Mr. FOSTER. As a general rule, the Affordable Care Act reduces the Medicare Advantage payment benchmarks. Now, under the old law, these benchmarks were typically in the range of 100 to 140 percent of a corresponding fee-for-service cost, and under the new law, they will be in the range of 95 to I believe it is 115 percent. So the benchmarks are reduced. In addition, the share of the difference between a benchmark and the plan bid, the portion of that that is paid to the plan in the form of rebates will be reduced. That proportion is reduced. You can get some of it back through——

Mr. CALVERT. That was one of my seniors back home in the district.

Mr. FOSTER. I am sure I had nothing to do with it.

So the amount of money that Medicare Advantage plans will have in future years to reduce the cost-sharing requirements of regular Medicare, to add extra coverage or extra benefits or to reduce other premiums, part D premiums or part B premiums, will be smaller. There is no question about that. It will be smaller.

Mr. CALVERT. Well, then, would seniors that currently have Medicare Advantage plans, can they expect to keep the current plan or benefits once those cuts are fully implemented?

Mr. FOSTER. We would expect that the reductions are sufficient, that about one-half—eventually one-half of the current Medicare Advantage enrollees would end up either dropping out of their

Medicare Advantage plan or no longer having a Medicare Advantage plan to participate in because it boils down to a choice. Right now the plans are fairly popular because of all the extra coverage, and people might be willing to put up with some degree of utilization management, for example, in order to get these other advantages. In the future, as the extra benefits are reduced significantly, they will be less likely to enroll.

Mr. CALVERT. So there will be less people in Medicare Advantage. What would they do then? Would they just shift into traditional Medicare do you believe? Or would they buy additional insurance?

Mr. FOSTER. All of the above. Some would move into fee-for-service Medicare and probably purchase Medigap coverage. Others would switch to—some of the people who might lose their given plan would switch to a different Medicare Advantage plan, if there is one available that still looks attractive.

Mr. CALVERT. So to put it simply, the services would be reduced but their costs would increase?

Mr. FOSTER. Potentially both. In other words, the extra benefits they get would be reduced; and if they stay on their Medicare Advantage plan, they might have to pay a higher premium as well.

Mr. CALVERT. Do you estimate the number of beneficiaries would be affected by these cuts? Do you have a number on that?

Mr. FOSTER. We do. We could add it to the record.[4]

Mr. CALVERT. I appreciate that. Thank you, Mr. Chairman.

Chairman RYAN [presiding]. Ms. Kaptur.

Ms. KAPTUR. Thank you very much, Mr. Chairman. Welcome, Mr. Foster. I just want to place a short statement on the record that the health insurance marketplace today has caused consumers to lack real choice in affordable insurance plans and, in fact, the marketplace lacks real competition. I voted for the Affordable Health Care Act because I believe it will restore competition. Meanwhile, much like Wall Street, the health insurance industry has been earning record profits by denying access to insurance and coverage to millions of our fellow citizens and by raising the cost of premiums to unaffordable levels. Many firms even deem you ineligible for insurance due to your gender or, amazingly, if you have bunions, calling them preexisting conditions.

So exactly how much profit have these insurance giants been making off of denying insurance to the American people and by denying claims more and more every year? Well, look at the top five mammoth corporations that often avoid taxation even by holding some of their accounts offshore. In 2009, just the top five firms, United Health Group, WellPoint, CIGNA, Aetna and Humana made $9.537 billion in profits. That is a staggering number. And I might say, each of them contributed significantly to political campaigns to Congress. For just those five, $2,768,156. That is something to think about and why there is such a fight at the national level to try to get affordable choices in insurance to the American people.

[4] EDITOR'S NOTE: The committee had not received the requested information prior to its publication deadline.

My concern is, the concentrated power of insurance companies as gatekeepers over the American people's health care is far too great. Restoring real competition among plans will give our consumers more choices of plans, just like Congress has. And with that competition, if you believe in competition, the private plans that will be available on the exchanges will give people choices for the first time in decades.

I wanted to ask Mr. Foster, have you ever been in receipt of data or related reports that show you the tax avoidance that these insurance companies employ in order to avoid paying their fair share in our country, reports that might come to you from other agencies? Have you ever seen those?

Mr. FOSTER. No, we do not study that kind of report.

Ms. KAPTUR. Yes. Could I ask you to again restate for the record from your testimony how many uninsured persons in the United States will be able to be insured under the Affordable Care Act?

Mr. FOSTER. We estimate that by 2019, the number would be 34 million.

Ms. KAPTUR. Imagine that, 34 million people. Not 34,000, not 3 million; 34 million people. That is over three times the size of just Ohio. That is a staggering number, and one that I am proud to have voted for a plan that will help to cover them.

May I ask you, in your testimony, according to your analysis, what would be the out-of-pocket spending reductions to our Nation's citizens under the new law?

Mr. FOSTER. In total, over the 10 years through 2019, the reduction is $220 billion, $227 billion.

Ms. KAPTUR. You are very close; $237 billion of savings to the American people who are struggling right now just to pay their heating bills in my part of the country, just to pay their property taxes, just to make it through the food banks crowded with people who are unemployed, that is a real accomplishment. That savings can actually be put to greater use.

And I wanted to ask you, in your testimony, you talk about 16 million uninsured persons would receive individual insurance coverage through the newly created exchanges. Do you have any estimate of how many of those would be small businesses? I come from a small business family that had to sell its business years ago because our father got sick and couldn't get health insurance. Do you have an estimate of the people that would get insurance, what subset might be small business people?

Mr. FOSTER. Deep within our model, that result is there. We have not actually tabulated it separately but we could do that for you.

Ms. KAPTUR. I would greatly appreciate that information for the record.[5]

Ms. KAPTUR. Thank you very much. Thank you, Mr. Chairman.

Chairman RYAN. Mr. Cole.

Mr. COLE. Thank you, Mr. Chairman. Thank you, Mr. Foster. It is very thoughtful and helpful testimony.

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[5] EDITOR'S NOTE: The committee had not received the requested information prior to its publication deadline.

I want to focus in on the Medicaid portion of both your testimony and the program. How many of the 34 million people that are going to receive insurance are going to receive it through Medicaid?

Mr. FOSTER. We estimate that 18 million would have their primary coverage through Medicaid.

Mr. COLE. So over half.

Mr. FOSTER. Yes. And another 2 million who have employer-sponsored coverage would be eligible to sign up for supplementary coverage under Medicaid.

Mr. COLE. And how will we pay for those additional 18 to 20 million people?

Mr. FOSTER. Well, Medicaid is funded jointly by the Federal Government and States, from general revenues almost exclusively. The Federal Government's share, of course, initially is almost 100 percent, grading down to 90 percent.

Mr. COLE. What provisions have we made to help State governments pick up their portion of the cost, the additional and new cost of insuring this much larger population?

Mr. FOSTER. Well, none that I can think of off the top of my head.

Mr. COLE. So in other words we are expecting State governments—most of whom are facing record deficits right now or fiscally challenging situations—they just have to come up with the money?

Mr. FOSTER. Their share of it, of course. Their share is relatively small compared to traditionally what Medicaid has done.

Mr. COLE. Let me ask you this. You mentioned in your testimony that Medicaid reimbursement rates were comparatively low compared to other forms. What sort of models do you have on whether or not physicians are going to accept these 18 to 20 million new Medicaid patients that we are going to put in the system at very low reimbursement rates?

Mr. FOSTER. We have raised the question. In other words, will there be enough physician and other provider supply to meet the new demand because of the additional people with insurance? We have not attempted to model quantitatively what the answer would be.

Mr. COLE. So is it fair to say that we might provide coverage but we don't have a guarantee that we are going to be able to provide care to people that we put in the system?

Mr. FOSTER. In the short term, that concerns us as a possibility.

Mr. COLE. And finally, is there any discussion of actually requiring physicians to take Medicaid patients?

Mr. FOSTER. Not that I am aware of. It is not to say that there isn't, but I have not run across it.

Mr. COLE. One additional question along these lines. How comfortable are you that, since we are funding this out of general revenue primarily at the Federal level and at the State level, you know, the money is going to be there? I mean, you just assume it is going to be there?

Mr. FOSTER. Fundamentally, yes. When Congress passes a law and the President signs it, there is a law on the books that says something shall happen. Then we assume that that thing will happen.

Mr. COLE. But you don't have any assumption as to whether or not we are going to raise taxes or simply borrow the money, I assume?

Mr. FOSTER. That is correct.

Mr. COLE. Do you want to hazard a guess as to which of the two we are likely to do?

Mr. FOSTER. I think I will leave that up to you all.

Mr. COLE. I think the record speaks for itself in that regard. Thank you very much for the testimony.

Chairman RYAN. Mr. Blumenauer.

Mr. BLUMENAUER. Thank you, Mr. Chairman. Thank you, Mr. Foster.

I must say that having an actuary before us talking about the policy was interesting, and I spent some time going back looking at the role of the science, the actuarial science and trying to comport that with what we are talking about here today. And you are put in a very difficult position because you are making judgments about what politics—how they are going to play out. And you referenced, for instance, the SGR that Congress didn't follow through on. And you are concerned that those same forces may be at work in the elements of reform in the bill that is before us.

Can you quantify the difference, for example, of the pressure that may be exhibited on our legislation that we are discussing today as opposed to my good friend, the chair's road map that will have a voucher for everybody, that will be dramatically ratcheted down in the future? Can you quantify the likelihood that he will be able in 2080 to deliver on a voucher that is a quarter of the size that it is today in purchasing power as opposed to the likelihood of this legislation going forward as written? Can you quantify the difference between those two?

Mr. FOSTER. Perhaps partially. What we could do would be to compare payment levels, utilization rates and so forth. It would be supported by either approach, as there was an earlier attempt this morning to do that. But we could see, as objectively as possible, how they compared to each other. Total payments over time as a percentage of GDP.

Mr. BLUMENAUER. The same pressure, if you are going to have a radical reduction in the amount of support for older Americans, the same pressure would be there that we see on SGR and what you are claiming in this, would it not?

Mr. FOSTER. Again, it depends. Potentially, yes. It depends a lot on the nature of the changes.

Mr. BLUMENAUER. And that is one of the things I want to get at. Mr. Chairman, with your permission, I would like to enter in the record a letter that you and Ranking Member Van Hollen had received from eminent economists, including your friend Alice Rivlin, dated January 26.

Chairman RYAN. Without objection.

[The information follows:]

January 26, 2011.

Hon. PAUL RYAN, *Chairman;* Hon. CHRIS VAN HOLLEN, *Ranking Member,*
U.S. House of Representatives, Committee on the Budget, Washington, DC 20515.

DEAR CHAIRMAN RYAN AND REPRESENTATIVE VAN HOLLEN: Congress this week is holding hearings on the economic impact of health care reform. We write to convey

our strong conclusion that leaving in place the Patient Protection and Affordable Care Act of 2010 will significantly strengthen our nation's economy over the long haul and promote more rapid economic recovery in the immediate years ahead. Repealing the Affordable Care Act would cause needless economic harm and would set back efforts to create a more disciplined and more effective health care system.

Our conclusion is based on two economic principles. First, high medical spending harms our nation's workers, new job creation, and overall economic growth. Many studies demonstrate that employers respond to rising health insurance costs by reducing wages, hiring fewer workers, or some combination of the two. Lack of universal coverage impairs job mobility as well because many workers pass up opportunities for self-employment or positions working for small firms because they fear losing their health insurance or facing higher premiums.

Second, the Affordable Care Act contains essentially every cost-containment provision policy analysts have considered effective in reducing the rate of medical spending. These provisions include:

- Payment innovations such as greater reimbursement for patient-centered primary care; bundled payments for hospital care, physician care, and other medical services provided for a single episode of care; shared savings approaches or capitation payments that reward accountable provider groups that assume responsibility for the continuum of a patient's care; and pay-for-performance incentives for Medicare providers.
- An Independent Payment Advisory Board with authority to make recommendations to reduce cost growth and improve quality within both Medicare and the health system as a whole
- A new Innovation Center within the Centers for Medicare and Medicaid Services charged with streamlining the testing of demonstration and pilot projects in Medicare and rapidly expanding successful models across the program
- Measures to inform patients and payers about the quality of medical care providers, which provide relatively low-quality, high-cost providers financial incentives to improve their care
- Increased funding for comparative effectiveness research
- Increased emphasis on wellness and prevention

Taken together, these provisions are likely to reduce employer spending on health insurance. Estimates suggest spending reductions ranging from tens of billions of dollars to hundreds of billions of dollars. Because repealing our nation's new health reform law would eliminate the above provisions, it would increase business spending on health insurance, and hence reduce employment.

One study concludes that repealing the Affordable Care Act would produce job reductions of 250,000 to 400,000 annually over the next decade. Worker mobility would be impaired as well, as people remain locked into less productive jobs just to get health insurance.

The budgetary impact of repeal also would be severe. The Congressional Budget Office concludes that repealing the Affordable Care Act would increase the cumulative federal deficit by $230 billion over the next decade, and would further increase the deficit in later years. Other studies suggest that the budgetary impact of repeal is even greater. State and local governments would face even more serious fiscal challenges if the Affordable Care Act were repealed, as they would lose substantial resources provided under the new law while facing the burdens of caring for 32 million more uninsured people. Repeal, in short, would thus make a difficult budget situation even worse.

Rather than undermining health reform, Congress needs to make the Affordable Care Act as successful as it can be. This would be as good for our economy as it would be for the health of our citizens.

Sincerely,

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Mr. BLUMENAUER. That points out that this legislation, unlike SGR, unlike my friend's road map, has every single cost containment element that the experts have been calling for.

Isn't that a significant difference between the SGR collapse and what we have going forward? Aren't the elements in here?

Mr. FOSTER. The potential benefits.

Mr. BLUMENAUER. Were those elements in the SGR for cost containment?

Mr. FOSTER. No.

Mr. BLUMENAUER. Isn't that a significant difference?

Mr. FOSTER. Yes, it is.

Mr. BLUMENAUER. Okay. Let me just conclude.

Mr. FOSTER. I would add to that, given the opportunity.

Mr. BLUMENAUER. Super. And if I have time, I would love to have you do that. But one of the things I would like to focus on is the opportunity to squeeze value out of this system. I come from a region in the country that provides quality care. In fact, it is better-than-average care for half the cost of some areas of the country that provide less quality care. In fact, if everybody practiced medicine the way that it is practiced in metropolitan Portland, we

wouldn't be having quite the urgency of the deficit. Isn't there a great deal of value to be squeezed out of the existing system?

Mr. FOSTER. Yes. I would word it slightly differently. You can improve the value you get for the expenditures by improving quality. There are lots of opportunities there. There are also opportunities to squeeze out waste and inefficiency in unnecessary treatments.

Mr. BLUMENAUER. Great. And I think that is an appropriate caveat, because what we are committed to doing is to provide better quality of care because right now we have areas of the country that are spending in a profligate fashion that aren't providing quality care, a ratio of 2 to 1, the evidence is strong that we have seen.

And I guess the reason I wanted to add this letter to the record and why I am less concerned than our actuarial friend here is that unlike in the past, we have worked to put cost containment and quality improvement into this bill. Some of us would strengthen those reforms. If Congress has the guts to follow through, we will have better care for less cost. If we don't have the guts to follow through, then we are going to blow the system up, whether it is my friend's voucher that will be blown up in the future or it is the current program that is driving us over the cliff.

So I hope we can, as a Congress, look to how we accelerate reform to reward value over volume and look deep at what is different today than the problems that our friend has mentioned in the past.

Thank you very much.

Chairman RYAN. Dr. Price.

Mr. PRICE. Thank you, Mr. Chairman. And congratulations on gaining the gavel.

Dr. Foster, I want to thank you for your testimony today and I think you have brought to light a number of interesting areas that frankly weren't discussed in their entirety through the discussion over the past 2 years.

Health care is a dynamic activity, and there are real people behind the numbers that we talk about here, not just the folks providing the care, but the patients. So the consequences of the decisions that we make here affect real lives.

I want to talk about that a little bit, following up on some of the discussion that Mr. Cole addressed. We heard throughout this whole debate and the adoption of the bill by the President and others, our friends on the other side, that if you like what you have, you can keep it; that whole point that if you like your health insurance, you can keep it. And as has been pointed out here, Medicare Advantage, you stated that half of the individuals receiving their coverage through Medicare Advantage would be dropping it or no longer having that plan. Is that an accurate reflection of what you said?

Mr. FOSTER. That is our estimate. And the number for Mr. Calvert—although I believe he has had to leave—it was 7.4 million people.

Mr. PRICE. Seven point four million people will not be able to continue in the coverage that they currently have?

Mr. FOSTER. That is right.

Mr. PRICE. And I don't want to ask an actuary a political question. But it is some of my assessment that some of those 7.4 million

people, individuals, actually like what they have and they aren't going to be able to keep it, as a consequence of this legislation.

Mr. Cole talked about the Medicaid participation by physicians. And I think it is incredibly important. As a physician, I know that many of my former colleagues, the reimbursement rates, the moneys that they receive for caring for Medicaid patients don't even cover the costs of providing that care. You have found that in your assessment as well?

Mr. FOSTER. There are studies out there for Medicaid, looking at the adequacy of payment rates or the level. It varies quite a lot by State, as I am sure you know. If I remember it correctly, for physician payments, the lowest State had payment rates for physicians that were about 37 percent of Medicare's. Most States were more in the 70 or 80 percent range.

Mr. PRICE. And we are headed in that direction with Medicare, are we not? That chart in your testimony on page 7, your chart cites the difference between the provider input prices that you mentioned and the Medicare payment rate there. And this delta, this difference here will move the Medicare reimbursement towards the direction of the Medicaid reimbursement in many States, that is lower and making it so that more physicians, under your testimony, are going to have a more difficult time keeping their doors open for Medicare patients; is that accurate?

Mr. FOSTER. Yes. Unless physicians can improve their productivity or take other steps.

Mr. PRICE. And do you have any idea or sense about the percent of physicians that are not participating in Medicaid right now?

Mr. FOSTER. No, I don't. There are surveys out there. What I believe I remember is that in the most recent one I saw, that about 15 percent of physicians nationwide said they were no longer taking or treating Medicaid patients.

Mr. PRICE. And that number is moving up as the reimbursement moves down. I want to address another issue on how some of this was paid for. You mentioned in your testimony the taxes on insurance plans, prescription drug manufacturers, and device makers. You talked about the fact that technology improvements in health care actually increase costs. What is the reason for that?

Mr. FOSTER. Well, I will give you two examples. You know, of course, that in recent years it is possible to implant a defibrillator in a patient with congestive heart failure or some other similar problem. And the implantable defibrillators are very expensive, and the technology didn't exist even a few years ago for this kind of procedure or its benefits. So many of the new technologies are very valuable, can help sustain life or improve the quality of the person's care.

Let me give you another example. And you will understand this one better than I do. For years and years, the dye that is injected in a person's veins when they do body scans and so forth, there was a dye that had a very, very low rate of adverse side effects, next to nothing. And it was cheap. Everybody used it. A better dye came along that took the very low rate of adverse side effects and cut it roughly in half. It was negligible to begin, and now it is even less so.

Mr. PRICE. I am running out of time.

Mr. FOSTER. And it costs 10 times as much. Everybody is using the new one.

Mr. PRICE. If you tax device manufacturers, do you not get less innovation and technology?

Mr. FOSTER. I suspect what happens if you just tax device makers is you get a higher price for the devices.

Mr. PRICE. Thank you. I yield back.

Mr. COLE [presiding]. Mr. Yarmuth.

Mr. YARMUTH. Thank you very much, Mr. Chairman. Thank you for your testimony, Mr. Foster.

I hate to use my time for this, but I need to clear up an impression that was left in Mr. Cole's questioning of you as to the effect of the Affordable Care Act on Medicaid. I am afraid the impression was left that all of a sudden, the States are liable for expenditures to cover the expanded Medicaid eligibility citizens, when in fact the Affordable Care Act has the government pick up 100 percent of that additional cost for the rest of this decade; isn't that correct?

Mr. FOSTER. For the first 3 years.

Mr. YARMUTH. For first 3 years, and then 90 percent.

Mr. FOSTER. Ninety percent in 2020 and later.

Mr. YARMUTH. Right. And the cost of doing that to the Federal Government is accommodated by the increased revenues and the savings that were implemented in the law so that the net result of expanding the coverage under Medicaid to the deficit is not a negative figure; is that correct? According to CBO.

Mr. FOSTER. Yes. For the Federal deficit, that is correct.

Mr. YARMUTH. Right. Exactly. Thank you.

As I read your testimony, and I appreciated it very much, it seems to me that the only real hesitation you have is over this effect on providers in terms of whether or not the plan can actually result in the fiscal impact that we believe and CBO believe that it has. Is that a new concern? I mean, isn't that the concern that existed prior to even consideration of the Affordable Care Act?

Let me ask—and I have a vested interest in this. I admit, my brother runs a home health care company. I am a stockholder. I have to make that clear. But back in the late 1990s, there was a severe drop in the reimbursement to home health care companies. About half the companies in the country went out of business for the same effect that you are warning of in your testimony.

Mr. FOSTER. Adequate payments for providers for the services they give to Medicare beneficiaries is important. It has always been important to Congress and the administration.

Mr. YARMUTH. Right.

Mr. FOSTER. So there had been concerns in the past, like the home health example you mentioned and some others that can come to mind like physical therapy.

Mr. YARMUTH. Right.

Mr. FOSTER. We anticipate or we see the potential for such concerns to be very widespread in the future.

Mr. YARMUTH. Right. And let's say hypothetically under Chairman Ryan's road map which relies on pressure from both insurance companies and from individuals on providers to lower the cost of care—and in his document it says: With individuals controlling their own health care dollars, providers will be encouraged to com-

pete for business by increasing quality and charging more competitive prices.

So in order to get the effect that he is projecting in terms of cost, he relies on pressure from a different source—competitive pressure as opposed to government mandate. But it still could have the effect of putting undue or unprofitable—putting providers in an unprofitable position, could it not? Because there is always going to be a problem no matter what we do.

Mr. FOSTER. Well, the potential is there, as we talked about earlier.

Mr. YARMUTH. Whether it is an insurance company putting pressure on providers, whether it is the government putting pressure on providers, or whether it is a consumer saying, I don't want to pay that much for your service, it is always a possibility.

Mr. FOSTER. With the provider of payment rates, if it ends up that a provider can just not cover his or her input costs, then that is a pretty clear-cut problem. The ability of a private insurance plan is to compete against each other, which they already do, but could be intensified under this kind of proposal. That has got the ability to get to your lowest bottom-dollar cost consistent with appropriate quality. But again, there are risks in both approaches that would need to be monitored.

Mr. YARMUTH. Exactly. Let me ask you a quick question about the CBO's track record and projecting effects of legislation on cost. In 1982 and 1983, the hospital prospective payment plan projected a savings of $10 billion over a period of 3 years. It was actually $21 billion. They underestimated the savings by 50 percent. The Balanced Budget Act which we have referenced, actually the savings that CBO projected were exceeded 50 percent greater in the first year, 113 percent greater the second year. And in Medicare part D, the projected costs over the first year was actually 40 percent lower than they projected. So CBO has actually had in recent history, the last couple of decades anyway, a track record of actually underestimating the savings or overestimating the cost to the government in their projections. Is that not accurate? My time is up, but you can answer that.

Mr. FOSTER. I don't know their specific track record. I do know that we have from time to time overestimated or underestimated. I would like to think that it is about balanced. But, one way to find out.

Mr. YARMUTH. Thank you very much.

Mr. COLE. Mr. McClintock.

Mr. MCCLINTOCK. Thank you, Mr. Chairman.

Two quick questions. We have touched on them, but just true or false: The two principal promises that were made in support of ObamaCare were, one, that it would hold costs down. True or false?

Mr. FOSTER. I would say false more so than true.

Mr. MCCLINTOCK. Okay. The other promise that Dr. Price had just touched on was the promise that if you like your plan you can keep it. True or false?

Mr. FOSTER. Not true in all cases.

Mr. MCCLINTOCK. A few years ago, I had a fellow come to me—I was in the State legislature at the time. He had lost his job. He was in the private insurance market, went around trying to find

coverage. He was turned down because of a preexisting condition. He had bursitis. He said, I don't care about the bursitis. That is a nuisance. I will take care of that. Just write me a policy to cover everything except the bursitis. And the response was, we would love to write you such a policy but we can't; it is against the law.

Has there been any data on how much access has been denied because of nonlife-threatening conditions like bursitis, or I believe Ms. Kaptur mentioned bunions earlier?

Mr. FOSTER. Not to my knowledge. The various State insurance departments might well have some feeling for that but I do not, I am afraid.

Mr. MCCLINTOCK. I rather suspect if we restored to people the freedom to obtain insurance policies tailored to their own needs, the lack of access to health insurance would drop substantially. There is an organization that runs a Web site called coverageforall.org.

Chairman RYAN [presiding]. Will the gentleman yield for just a brief second? There is a vote on. And my intention is just to keep it rolling. So Mr. Honda is going to be next. So we are going to keep it going just in the interest of time. And I will stay until near the end, when Mr. Rokita will come back and relieve me to go vote, and we will just keep this going.

Mr. MCCLINTOCK. It is run by a private foundation. The head of that foundation tells me that they get tens of thousands of inquiries every month and are able to find insurance for these folks either in the private or public sector, about 99 percent of them anyway. Has there been any study on what is the percentage of uninsured who can either afford private insurance plans who simply haven't availed themselves of it or have qualified for public plans and have not availed themselves of them?

Mr. FOSTER. We do have data on that in our model for estimating the health reform proposals. And it is not uncommon to see people who are young, good health status that have the option of employer coverage and they just don't take it.

Mr. MCCLINTOCK. Well, the head of this foundation says that they are able to place 99 percent of the folks who make inquiries. Do you have any data that would support or refute that number?

Mr. FOSTER. We could tabulate these numbers from our sample. But I don't know the results off the top of my head. We find many other people—and this is a bit surprising—where they might be eligible for Medicaid or they might be eligible for their employer plan, and they have actually fairly high health care costs, and yet they still don't sign up, even though it would be in their best interest financially, but something is preventing them from doing it, either a lack of understanding or maybe they can't afford their share of the premiums. So there is a lot of variation out there in people's insurance status.

Mr. MCCLINTOCK. Final question. You have looked at this issue pretty carefully. If you could design the ideal system, what would it look like?

Mr. FOSTER. For health care in the U.S. overall?

Mr. MCCLINTOCK. In 60 seconds or less.

Mr. FOSTER. Well, if I had a really good answer for that, I probably would be wealthy and doing something else. I would be happy to talk with you and your staff further about possibilities.

Mr. MCCLINTOCK. I will yield back.

Chairman RYAN. Mr. Honda.

Mr. HONDA. Thank you, Mr. Chairman. And let me commend you for having these hearings. I think that without this hearing and without passage of the Affordable Health Care Act, we would not have this great conversation and this question-and-answer period. And I appreciate, Mr. Foster, your expertise. In fact, I am kind of in awe of it. And I appreciate the information that we have here that if we did not move on the Affordable Care Act, there would be approximately 34 million people without insurance coverage at a cost of 1 percent of increasing the costs.

One of the things I find very interesting in this process, Mr. Chairman, is that Mr. Foster is helping us identify some of the land mines that we need to look at in order to move forward and improve this affordable health care plan. We knew at the beginning that it is not the perfect plan. But I do know that there are a lot of people who are going to be helped with this.

And part of the robust dialogue and the debate is about identifying these kinds of land mines, one of which is—you talked about innovation. And I appreciate the comment about the cost of innovation that would be added to this kind of an effort. And I think that it bears well for people in my district, Silicon Valley, to listen to that. And what I mean by that is there is a lot of money spent on NASA research, which we must do and you support that, I believe. It is the product development research that could be more costly. And one of the good examples is that every time we have a new invention or a new innovation for a telecom or a wireless, we have to buy a new gadget. That is expensive. But if you can create the addition to a gadget that already exists and add that to an existing BlackBerry, say, the cost of the new innovation would be greatly reduced. So I think that that is one great thought that you brought up. And I think that is a policy I think we need to look at when we start to put money into product development research, and make that distinction from NASA research. And I think that it will also reduce a lot of equipment that is going to be out there that is going to end up being surplused, and then we have more stuff that we have to get rid of. Would that be an accurate statement of what you meant by the increased costs in technology?

Mr. FOSTER. I suppose that is a piece of it. What I really had in mind was, doctors want to save patients' lives and give them better lives. Device makers and drug makers, they all want to do the same thing too. Many of these people, of course, want to make a good living while they are at it. But it all starts with treating people better and more effectively.

There is a lot more focus and attention given on coming out with a new device or a new technique that will have a big impact no matter what the cost is, because with widespread insurance coverage, we only see as patients a small part of the total cost.

Mr. HONDA. Correct.

Mr. FOSTER. There is much less of the innovation and the research and development that goes into coming up with an existing

treatment and making it more efficient, less costly with the same quality outcome. And I think that will change in the future, but only with forces that tend to drive it to change.

Mr. HONDA. And thus your example about a negligible side effect. You have one that is even less than that, but 10 times the cost in making it happen. And I think that is a point well taken. We see that in virus when we try to come up with inoculations, but we could look at a viral approach versus using eggs. And I think that that is one of the admonitions that you are probably talking about. So it is one that I take very seriously, and I appreciate your input on this.

And I appreciate this process, Mr. Chairman. Thank you very much. And I think that the point is this: We start it and that is the good thing. Without the start, we would not have this debate, this dialogue, and I think the people of this country deserves this kind of work, where we really tease out all the issues so that when we come to another point, we may come closer to agreeing.

So to the witnesses and to yourself, Mr. Chairman, thank you for coming. We appreciate it.

Chairman RYAN. I thought we were going to have a member back. Perhaps they aren't going to voice-vote the second vote. So I will recess subject to the end of these last votes.

[Recess.]

Chairman RYAN. The hearing will come to order.

We are just going to take Members as they come back. Next in line is Mr. Ribble from Wisconsin.

Mr. RIBBLE. Thank you, Chairman Ryan. I appreciate being here. Mr. Foster, thank you for attending this hearing today. I appreciate that as well.

Today's Budget Committee hearing is the first one that I have ever attended as a Member of Congress, but controlling our Federal budget is one of the reasons that I came here. It was a big part of why I decided to enter, after 30 years in the private sector, the race to become a Congressman.

Last night we heard from the President. He is also concerned about our budget and about the deficits. I have heard the President on many occasions, as well as Members of Congress, talk about our Federal Government heading down an unsustainable path. Last night I was pleased that he talked about his children and his concern for his children. I have two grandchildren, and I am concerned for them as well. So I was very pleased that I was asked to serve on this committee, and I am pleased that you came here to talk to us today.

I recognize, I think all Americans recognize, there is going to be some level of shared sacrifice that we are all going to have to participate in if we are to create a fiscal path that is sustainable. But I do have just a few questions, and then I will yield back to the chairman.

Referring to your testimony on page 7, I would just like to read one statement you made: "Over time, a sustained reduction in payment updates based on productivity expectations that are difficult to attain would cause Medicare payment rates to grow more slowly than and in a way that was unrelated to the providers' cost of furnishing services to beneficiaries. Thus, providers for whom Medi-

care constitutes a substantive portion of their business could find it difficult to remain profitable, and, absent legislative intervention, might end their participation in the program, possibly jeopardizing access to care for beneficiaries. Simulation by the Office of the Actuary suggests that roughly 15 percent of providers would become unprofitable within the 10-year projection period as a result of the productivity adjustments."

Given this concern, do you believe that it is going to be more likely or less likely that students who might be considering a career in medicine, whether it be doctors or nurses, any type of health care providers—do you believe it would be more likely they would enter given this scenario or less likely?

Mr. FOSTER. Well, that is a good question that I hadn't thought about a whole lot. I think for somebody who thinks about the issue, that they would recognize health care in the U.S. is going to remain a growth industry for decades to come. Many people who go into medicine, of course, want to help other people. I would think there would still be a lot of interest. My bigger concern would be will Medicaid be paying enough to attract those doctors into treating Medicaid patients; and likewise with Medicare, will the payment rates be sufficient to attract doctors' interests.

Mr. RIBBLE. I would agree with you with that same concern. If, in fact, fewer medical providers will provide services, either to Medicare or Medicaid, and the access to supply goes down, demand is going to continue to go up based on all the charts I saw today. In fact, demand is going to increase dramatically. The concern I have is that the supply of providers is going to go down for this.

Given that concern, do you anticipate either increases in costs or a big shift in costs to people who are not in that program, where the shifting gets worse, given the fact that supply will go down?

Mr. FOSTER. There are very possible sort of macroeconomic effects like that. In other words, if a doctor has the choice between—if a doctor has a potentially, unlimited, unworkable amount of patients he or she could receive, would the doctor want to take the private health insurance payments with a negotiated payment rate, or Medicaid or Medicare, where it is administratively set and could become inadequate? It is not hard to figure that one out, although many doctors want to help everybody. If the supply of providers, doctors or other facilities or whatever—if the supply of available care goes down, then it is likely that, where possible, prices for that remaining supply would go up.

We cautioned about many of these potential macroeconomic effects in our April 22nd memo at some length, but we also acknowledged that we don't have the ability to really test how serious are these concerns, how likely, how difficult if they, in fact, occur.

Mr. RIBBLE. Thank you, Mr. Foster.

I yield back, Mr. Chairman.

Chairman RYAN. Ms. Wasserman Schultz.

Ms. WASSERMAN SCHULTZ. Mr. Chairman, thank you.

I want to focus on seniors and the costs of the Affordable Care Act and how it affects seniors, because our Republican colleagues on the other side of the aisle have talked about wanting to reduce costs for seniors, yet seemingly the repeal of the Affordable Care Act would actually increase costs potentially.

Specifically, Mr. Foster, could you tell us if Medicare fee-for-service beneficiaries will see their premiums and coinsurance go up, or down, as a result of the Affordable Care Act?

Mr. FOSTER. Generally speaking, if the Affordable Care Act were repealed, then the cost-sharing requirements and the premiums for fee-for-service beneficiaries would increase. The reason is that because of the lower payment rates for providers, most categories of providers, under the Affordable Care Act, if the payment, the allowed charge for a payment, is lower, then your 20 percent coinsurance on that rate is also lower, and if the payment rates are not reduced, then you don't get that gain or that improvement in coinsurance.

Ms. WASSERMAN SCHULTZ. And can you focus a little bit on the part D component, the effects of the Affordable Care Act on the part D premiums and how that would impact seniors?

Mr. FOSTER. Yes. For part D, the drug benefit, in part because of the phasing out of the coverage gap or the so-called donut hole, that raises the cost of the program somewhat and would result in somewhat higher part D premiums as a result.

Ms. WASSERMAN SCHULTZ. And arguably that would be offset by the considerable reduction for seniors participating in part D in their out-of-pocket costs as a result of the donut hole being closed over time, correct?

Mr. FOSTER. I think that is correct, but I am going to ask John Chateau if he has an opinion.

Yes. He said for those who reach the coverage gap, that would be the case.

Ms. WASSERMAN SCHULTZ. Thank you.

Just a follow-up question. On the subject of prescription drug benefits again, specifically, when our colleagues on the other side of the aisle passed the Medicare Modernization Act in 2003 that created the Part D program, its costs were not offset. CBO at the time estimated that the bill would add $394 billion to the deficit over 10 years. This was a bill that was unpaid for. What is the traditional long-term horizon for actuarial projections in the Medicare trustees' report? How many years?

Mr. FOSTER. Seventy-five years.

Ms. WASSERMAN SCHULTZ. And, according to projections, how much will the prescription drug program draw from general revenue over that 75-year period?

Mr. FOSTER. Let me look up an answer for you, since I don't remember everything off the top of my head.

Ms. WASSERMAN SCHULTZ. Thank you.

Mr. FOSTER. Well, I will tell you what. This one I am going to look up in the trustees' report myself so I don't tell you anything wrong.

Ms. WASSERMAN SCHULTZ. Thank you very much.

While he is looking up the answer, do you mind if my time not tick off?

Chairman RYAN. Go ahead, timekeeper.

Ms. WASSERMAN SCHULTZ. I don't want to run out of time while he is thumbing through the pages. Thank you.

Chairman RYAN. Turn it back on now.

Mr. FOSTER. The Federal cost, the Medicare cost for part D as a percentage of GDP is currently about 0.4 percent. Yes, that is an average figure which I will quote, also. That 0.4 percent currently is going to increase over time as the cost goes up at a faster rate than GDP. At the end of the 75-year period, for example, it would be about 1.75 percent. The average that Diana Meredith was so helpful finding for me, the average over the entire 75-year period is about 0.7 percent of GDP.

Ms. WASSERMAN SCHULTZ. And what does that translate to in dollars?

Mr. FOSTER. That is a good question. How much is GDP these days, $15 trillion?

Ms. WASSERMAN SCHULTZ. Would about $7.2 trillion in present value terms be accurate?

Mr. FOSTER. Oh, for the whole 75 years, that sounds like the right ballpark. That is the total cost over the entire time period.

Ms. WASSERMAN SCHULTZ. One of the concerns is you have CBO's score of the Medicare Modernization Act, which included nearly $410 billion in new spending for the prescription drug benefit, but it also showed, between the puts and takes in Medicare and Medicaid and revenues, that netted out to about $16 billion in savings over 10 years. So the vast majority of the prescription drug benefit's cost, $394 billion over the first 10 years, was added to the deficit, is that correct?

Mr. FOSTER. I believe that is correct. I don't remember any other legislation designed to offset the cost of the Medicare Modernization Act.

Ms. WASSERMAN SCHULTZ. Just to wrap up, is it reasonable to assume that projected out over 75 years that the unpaid portion of the prescription drug benefit would reach into the trillions of dollars?

Mr. FOSTER. Yes.

Ms. WASSERMAN SCHULTZ. Thank you very much.

Thank you, Mr. Chairman. I yield back.

Chairman RYAN. Mr. Huelskamp.

Mr. HUELSKAMP. Thank you, Mr. Chairman. I appreciate the opportunity to ask a few questions.

Mr. Foster, I appreciate you being here. I know you had some earlier discussion about the number of providers that would become unprofitable in the next 10-year period under this law. Is there a certain breakdown on what types of providers that might disappear, refuse to provide services? I wonder if you could describe that a little bit more in detail.

Mr. FOSTER. Yes, I can.

We looked at three categories of providers: hospitals, including both their inpatient and outpatient sides; skilled nursing facilities; and home health agencies. What we found in terms of the proportion of each category that would become unprofitable as a result of the productivity payment adjustments, they were fairly similar. So that 15 percent figure that I mentioned holds about right for each of the three categories.

Mr. HUELSKAMP. In addition, were there any disparities in geographical breakdown on those numbers of providers with the cuts that were contained within the law?

Mr. FOSTER. There might well be. We did not look to see the most effective providers, whether they were concentrated in one part of the country or another. That could be done, but we haven't done it at this time.

Mr. HUELSKAMP. Do you not already have data about that effectiveness for different geographical regions?

Mr. FOSTER. We certainly have the cost report data from every single facility provider in the whole country, and we can tabulate that data along the lines you are describing. Most of our analysis is done at a national level, but we could do that.

Mr. HUELSKAMP. I would appreciate that detail on a rural versus urban breakdown.[6]

Mr. HUELSKAMP. Mr. Foster, the numbers I have heard from rural hospitals is that actually perhaps a quarter to a third of those would disappear. What kind of options would Medicare patients have if the hospitals disappeared?

Mr. FOSTER. The situation you described, if the hospitals could no longer participate because of inadequate payment rates, would be fairly catastrophic in terms of its impact on Medicare beneficiaries, not to mention other patients in the area. It is for that reason that I am relatively convinced that if the payment rate became inadequate and were seen to be approaching inadequacy that Congress would act to do something about the payment rates to prevent exactly that scenario from happening.

Mr. HUELSKAMP. To repeat your earlier testimony again, the estimates, I presume that scenario would never be reached, but you believe it would be reached fairly quickly?

Mr. FOSTER. I think there is a strong likelihood of that, yes, sir.

Mr. HUELSKAMP. As far as CMS, is there an expectation of how close services should be available to Medicare patients?

Mr. FOSTER. How close? You mean in terms of just physical distance?

Mr. HUELSKAMP. Physical distance, availability. When we talk about the massive cuts proposed in this bill for Medicare, particularly in rural areas, I am just wondering what is the principle involved here? I have not heard much concern, not from you but from CMS, about that lack of providers and how far we expect them to go to receive services under the massive cuts in the bill.

Mr. FOSTER. I think there are such concerns. They show up in different ways, for example, within the Medicare Advantage world and provider networks, likewise part D, pharmacy networks, what kind of distances are there and what is allowed to form a reasonable network. There are any number of hospitals that have been in some danger of going out of business that have been classified as critical access hospitals or sole community providers. So I think the concern is there.

Mr. HUELSKAMP. And are there any other proposals that you would suggest, other than potentially restoring the proposed cuts in the law, to prohibit this catastrophic event?

Mr. FOSTER. I would propose that we, the Office of the Actuary, you, Members of Congress, MedPAC working on your behalf, CBO,

[6] EDITOR'S NOTE: The committee had not received the requested information prior to its publication deadline.

that we all pay very close attention to the adequacy of payment rates and any potential access problems and act sooner rather than later if these problems develop, as I think they may well.

Mr. HUELSKAMP. I appreciate that, Mr. Foster.

I also served for many years at the State government level, and we have already seen that occur in Medicaid. If we end up in that same situation in Medicare, it doesn't matter how much insurance you have if you don't have a provider. This bill assumes there will be providers, or this law presumes that. We will have a catastrophic situation, and I am very disappointed the former Congress did not look closely at that matter.

I appreciate your answers to the question, and I yield back my time.

Chairman RYAN. Ms. Moore.

Ms. MOORE. Well, thank you so much, Mr. Chairman, for yielding, and I want to thank Mr. Foster for appearing. Rumors that actuaries are boring have been greatly exaggerated.

Mr. FOSTER. Can I have that in writing, please?

Ms. MOORE. This has been a really great discussion. I have learned a lot. I wasn't on any of the committees of jurisdiction that put the bill together.

So we started out with the chairman making a definitive statement that I agreed with totally, that our fiscal problem in this country is a health care problem. I was wondering if you agreed with that statement? Is it a fiscal problem? Then I have read other sort of independent reports. I am reading a report here by Henry Aaron—not the famous Hank Aaron—from the Brookings Institute. He coauthored it with David Cutler, Professor of Applied Economics at Harvard, and Alice Rivlin, Greater Washington Research of the Brookings Institution, that say that current health care expenditures are now $2.6 trillion. They are projected to reach $4.5 trillion in 2019.

In your testimony, Mr. Foster, you said that health care expenditures would be something like—what did you say—7.6 percent, they would rise by 2019. Can you remind me of what you said in your testimony?

Mr. FOSTER. Well, I am trying to remember. I talk a lot, and then I forget some of it.

Ms. MOORE. Right. So I guess the first thing I want to clarify is that, absent this bill, health care costs are rising at an unsustainable level already. Would you not agree with that?

Mr. FOSTER. They are rising at a rate that certainly is causing problems and will continue to cause problems. Whether it is sustainable or not, that is in the eye of the beholder. But it is a rate that could not go on forever at that rate.

Ms. MOORE. Right. There has been a great deal of discussion about the impact of this bill and the costs of it being unsustainable. I guess what I really wanted to clarify is that, for businesses, for individuals, people in the individual market, absent being on Medicare, Medicaid, being the poor, health care costs are unsustainable with the current growth rate.

So the real question that I have is based on the next statement I think my chairman made, is that Medicare is the biggest driver of the debt. The question I want to know is, is the cost of care for

Medicare being driven by the private sector, the increases in the costs in the private sector, or is Medicare driving those costs upward? I was confused by all this discussion.

Mr. FOSTER. Sure. The answer is that the factors that affect health care cost growth tend to affect it in all categories, whether it is Medicare, Medicaid.

Ms. MOORE. No, but I am saying is the pricing in the private market the determinant of how much—you say that Medicare and Medicaid doctors are receiving lower than what is happening in the private sector, is that correct?

So, in other words—my time is expiring. I am just going to make a statement and say that the fiscal problem is the fact that we aren't bending the cost curve in the private sector. So that is what this bill is intended to do. This notion that—so you say in your testimony that this bill, if implemented, would have grown by 7.2 percent by 2019 but will grow instead by 6.9 percent if this is implemented as we anticipate. And I think that that is extremely important to point out, that it is not Medicare and Medicaid that are responsible for these unsustainable health costs; it is that we have got to bend the cost curve.

Now, the fact there are going to be so many more patients, Medicare, Medicaid, 34 million, according to your testimony, more people who are insured, shouldn't that, based on what we know about insurance, bring the costs down? Shouldn't that be, the mandate to have insurance, shouldn't that in fact be something we can assume would bring the cost of health care down, more people, having the risk spread across 34 million more people? Shouldn't that bring the private sector costs down?

Mr. FOSTER. It can. The factor you are talking about is if you can get a broad risk pool of average health people, not just the high-cost ones, but the high-cost, the medium, the low-cost, everybody, and if you can avoid what actuaries refer to as adverse selection, where people get insurance only when they need it and that tends to drive up costs, then you would have every reasonable expectation that the premiums that the insured people would have to pay would better match this average risk level. And I think in fact that will happen with the exchange coverage and a mandated coverage.

Ms. MOORE. Thank you so much for that testimony, Mr. Foster. The cost curve and premiums will go down with more coverage of more people and that it is private-sector insurance that is driving the cost up, not Medicare. Thank you for those clarifications.

I yield back.

Mr. FOSTER. And I would just add, I wouldn't agree with all of that, but I would be happy to discuss it.

Ms. MOORE. I get the last word, sir. I don't think you get the last word.

Mr. FOSTER. I apologize.

Chairman RYAN. Mr. Mulvaney.

Mr. MULVANEY. I would be happy to yield 30 seconds of my time to the presenter.

Ms. MOORE. I don't think you can yield time to the presenter, Mr. Chairman.

Mr. MULVANEY. I am joking, Ms. Moore.

Ms. MOORE. I just want to make sure. Did I miss out on the rules package?

Mr. MULVANEY. That is fine.

Mr. Foster, thank you very much. I thank you for sticking around while we had to come and go for that vote.

I have what is probably an academic question for somebody who is just trying to figure out government accounting versus what I consider to be ordinary, real-world accounting.

I want to go back to that $100 example you gave earlier of these additional revenues coming into the general fund for Medicare. The Treasury issues this bond, this private debt essentially over to Medicare, and that is essentially how that additional $100 both reinforces the condition of the trust fund and helps reduce the deficit, giving rise to some accusations that maybe it is double counting. But I think what you told us today is that that transaction is unwound at the back end and we only count it one time.

Here is my question: When that $100 flows into the Treasury and the Treasury issues that bond—we will use that term—which is a private debt of the United States Government, doesn't that in and of itself increase the debt of this government?

Mr. FOSTER. It does.

Now, the national debt is counted two different ways. One way counts all of it, including amounts owed to Federal trust funds, including Medicare; and another way is to look at the national debt excluding the Federal trust funds. I think the latter method is more commonly looked at.

Mr. MULVANEY. Right. In terms of the debt ceiling, don't we count both of those things?

Mr. FOSTER. I will leave that up to somebody else who knows the answer better than I do.

Mr. MULVANEY. Is it fair to say that that transaction, while it doesn't impact the deficit, this $100 transaction that you walked through, that it actually helps the deficit, to use the previous example, does reinforce for at least a period of time the condition of the Medicare trust fund, does also increase the private debt of this country?

Mr. FOSTER. The $100 bond does increase the total gross Federal debt.

Mr. MULVANEY. Thanks, Mr. Foster.

That is all I have. I yield back the balance of my time, Mr. Chairman.

Chairman RYAN. You will learn to use it all. Everybody does.

Ms. Castor.

Ms. CASTOR. Thank you very much, Mr. Chairman.

Welcome, Mr. Foster.

I appreciate having this hearing on the fiscal benefits of the Affordable Care Act, and I am very interested in health policy and really like a good discussion and debate. But I have to tell you, the folks I represent back home, they don't want to relitigate and refight the old health care battle. Yes, they want us to improve it, but they went through that for a couple of years, and they want us to focus on jobs and the economic recovery as our primary responsibility. But here we are.

What I am hearing back home is that they are really appreciating these new reforms, eliminating the discrimination based upon preexisting conditions. There are so many of our neighbors and family members, people that we know, that have had cancer, they might be in remission, asthma, children with diabetes, now they can get insurance.

I hear from a lot of parents that are welcoming the opportunity to keep their kids that are coming out of college on their policy. And seniors in Florida, we have quite a number, a high percentage, really like the improved Medicare benefits. So I think the discussion of repeal is causing great instability, and we need to focus on moving forward.

One of the things is we can't—when you explain to folks that repeal is going to blow a $230 billion hole in the deficit, they just don't understand how we can be so off track on the new Congress.

But one of the areas where the Affordable Care Act achieves substantial cost savings is what we did to eliminate the government subsidies and overpayments going to the private health insurance companies under Medicare Advantage.

For a number of years, we were receiving expert advice about these overpayments of 14 percent overpayments. The Medicare Payment Advisory Committee, an independent group, said that those overpayments were no help to the taxpayers and the higher subsidies were straining Medicare's already shaky financials. They said, rather than improving efficiency, Medicare Advantage "has instead become a program in which there are few incentives for efficiencies." That was MedPAC Chairman Glenn Hackbarth in April, 2007.

"There is no longer financial neutrality to the private plans because incentives push the costs higher than traditional Medicare. Overpaying in the short run, especially overpaying indiscriminately without requirements, is never a strategy for achieving long-run efficiency."

We know now that, under the law, taking all of that expert advice from the MedPAC and other groups, that we are, according to the nonpartisan CBO, achieving savings of $136 billion. It simply wasn't fair to have folks on traditional Medicare and other taxpayers providing a subsidy to the private health insurance companies.

You heard from Ms. Kaptur who said—what was it—$9.5 billion in profits and CEO salaries. Let's put that money back into health services for our seniors and the health system. And that is what the Affordable Care Act does.

It just wasn't fair. Because what you were doing with that Medicare Advantage, by giving them, the health insurance companies, more money, you didn't say we want something for that subsidy. You didn't say we want more cost containment. You didn't say for that subsidy we want better outcomes or higher quality or better care or coordination. There was no incentive. Instead, those administrative costs were going up, up, up.

Now, Mr. Foster, CBO's nonpartisan analysis says we are going to save $136 billion on that piece. But I notice your analysis says we are going to save even more, $145 billion, is that correct? Could you explain why you see greater cost savings there?

Mr. FOSTER. I would be glad to.

With any sort of proposal like this, or provision, you can try to estimate its future impact over the next 10 years, but it requires a lot of assumptions. You have to figure out, okay, how many people will still be in the plans, how many people would there have been in the plans under the old law, and then the comparison of the payment rates is fairly mechanical. But the behavioral change, do people drop out of plans or not, that is very hard to do.

So it is not surprising that two independent organizations like CBO and the Office of the Actuary would come up with somewhat different estimates for this provision, the $136 billion versus the $145 billion. In fact, it might be a little surprising that we are that close.

Ms. CASTOR. Moving forward, what is the percentage now in the private plans versus traditional Medicare?

Mr. FOSTER. Twenty-four percent was the last I heard.

Ms. CASTOR. So one-quarter. And I don't know if you see the same ads that I see every time there is open enrollment. These are still very healthy plans, and they are going to compete. It is always amazing to me the full-page ads in the paper, and they really helped, besides political campaigns, all of the TV stations helped make a profit. So, obviously, there was so much in administrative costs and marketing costs going there, and I am looking forward to implementing this Act and making sure that those monies, rather than subsidies and high CEO salaries and big profits, go into the health services for those on Medicare.

I thank you very much.

Chairman RYAN. Mr. Rokita.

Mr. ROKITA. Thank you, Mr. Chairman; and thank you, Mr. Foster, for sticking this out.

One maybe not so quick question, there has been mention made that at least one side of the aisle wants to keep good on its promises to seniors. The idea that one group or other has a monopoly on that is surprising to me and disappointing to me something like that would be said. But putting that silliness, which it is, aside for a minute, I would like your opinion and direct answer on this.

If you do not change the health care, quote, unquote, reform law that is in effect, if you do not change Medicare law and policy, isn't it true that the only way you can cover seniors, you can make good on the promises to seniors currently and in the future, is to do one or a combination of the following: raise taxes; put the costs on the backs of our kids and grandkids by the government issuing more debt; or, three, ration care, which you could argue to my question is a change in the law. Is there any other way?

Mr. FOSTER. If you look at the financial outlook for Medicare and we see a big gap for the Hospital Insurance Trust Fund between promised benefits and scheduled revenues, and we see for Parts B and D that the costs go up and the general revenues and premiums have to go up automatically to match them, and you say, okay, what can you do about Part A, the Hospital Insurance Trust Fund, then fundamentally you either have to raise the tax rates that support the program or scale back on the benefit coverage. Either of those requires a change in the law.

Likewise, the idea of rationing care, which I would address with the greatest of reluctance, rationing care would take a change in the law, also.

Mr. ROKITA. Right, but you understand the point of my question, which was don't change the other parts of the law, except the only way to do this would be to raise taxes, debt-load our kids, or ration care. That is the only way to keep the promise in the other parts of the law aside from that, is that correct? I think you just said it. Is there any other way? I am not trying to trick you. I just want to know if I am missing something.

Mr. FOSTER. Certainly raising taxes to finance what is promised at current levels, et cetera, would work, with various implications. If you reduced benefits, I wouldn't say that the Medicare package is very luxurious to begin with, so there may not be a lot of room there. Under current law, you can't borrow to finance Part A of Medicare. You can borrow to financial the general revenues for Parts B and D. So that is allowed by current law.

The rationing of the care, right now the law says to providers at large, provide these treatments to Medicare beneficiaries and we will pay you. We have talked earlier about the situation if the payment rates become inadequate and beneficiaries might have trouble finding a doctor or other provider to help care for them. But I see that not as the formal sense of rationing care as generally thought of, where if somebody is 100 years old and needs a hip replacement, we can't afford to do it.

Mr. ROKITA. I appreciate what you are saying.

Mr. Chairman, I will yield back, with a request that if we are going to talk about keeping our promises to seniors, we do it in a more genuine way and recognize that we are talking about kids, grandkids, higher taxes, or rationing.

Thank you.

Chairman RYAN. Ms. Bass.

Ms. BASS. Yes. I just wanted to make a couple of points and ask you a rather narrow question. Just on the personal level—I am new here. This is my third week here. But last year when health care reform was passed and signed by the President it was a very, very exciting moment for me personally and also professionally.

Personally, you know, I remember the day I got the letter in the mail as a parent saying that my daughter, once she turned 23, would no longer be covered. I think that prior to this debate most parents didn't even know that was the way it was, until you received that letter. Then you are left with nothing really to do about it. So having that solved or at least extended until a child or young adult is 26 I know is a great relief for parents around the country.

Then just personally, on Tuesday, February 1st, as the new Members will be able to sign up for health care, I will be able to include my stepdaughter under coverage. She would have never been able to be covered before. She is 19. She had leukemia when she was 6. A preexisting condition like that would have pretty much eliminated her from ever having health insurance.

On a professional level, I spent many years working in the emergency room, and a lot of times I think in this debate when we are talking about the 31 or 32 million people not now covered, you want to talk about having care rationed, that is the population that

has care rationed. But it is also a population that costs a tremendous amount to our country, because they wind up in the emergency room.

I would see people who would wait months to receive treatment because they had nowhere to go and then, by the time we saw them, they could have been at the end stage of their cancer or requiring surgery. Where if they had had adequate health care, they would have never been put in that position to begin with. So sometimes I think when we are talking about the 30 million who are not covered we are thinking about maybe our moral or social obligation to cover them. But, putting that aside, just the fiscal impact of having people not covered, I think oftentimes we lose the point of that in this debate.

In terms of the question, my question centers on the potential savings from payment innovation. The Act includes numerous pilots that are aimed at learning what type of payment arrangements will best promote efficiency and quality, but yet your office hasn't really scored any savings from that, and I wanted to know the reason for that. Did you not score any savings because you don't think they will work, or because you don't have the information, or what is your reason for not looking at that?

Mr. FOSTER. It is really the latter, the insufficient information, particularly at the time that the health care law was being enacted. As we said earlier, there is a lot of potential good things to come out of innovation for higher quality, lower cost, et cetera. But for us to estimate a specific result, we have to know something specific that is going to be considered. And because there was not sufficient specifications or provisions underlying most of these, we were not able to.

Ms. BASS. Do you have any opinions about them, some of the projects proposed, the pilots?

Mr. FOSTER. Sure. In a general sense, you only have to talk to our administrator, Don Burwick, for maybe 3 minutes before you hear all about the potential for reducing waste, being more efficient in the provision of health care, and you are converted. And he is right. There is a lot of services that are unnecessary. There is a lot of waste that happens. There is a lot of efficiency that could be improved. So these alternative methods do have the potential to do all of the above.

Ms. BASS. Thank you.

Let me also just say that we were very excited in California to be receiving the extra support that was needed, definitely, that the plan provides for, that the bill provides for in the first few years. Thank you.

Mr. FOSTER. If I may follow up very briefly, one of the programs that you referred to is the Medicare shared savings program for ACOs, and Mr. Chateau and other team members in our office are working right now to estimate the specific potential for costs or savings from implementing this through regulations and the regulations coming out probably in the next few weeks.

Ms. BASS. Great. So in the next few weeks we would know what those savings potentially would be?

Mr. FOSTER. Right.

Ms. BASS. Thank you.

Chairman RYAN. Mr. Pascrell.

Mr. PASCRELL. Thank you, Mr. Chairman. I am glad we clarified I think through the hearing many things. And by the way, Mr. Chairman, I think that we have heard enough over the last year and a half to indicate we ration health care now. It was one of the reasons why we worked to correct that situation, and we certainly, none of us who worked in Ways and Means, wanted to create a worse situation than we already had. Rationing occurs now under the present system, proof positive. There is enough data for that.

So now we know that—and you said, Mr. Foster—correct me if I am wrong—that premiums will go down in the exchanges which are about to take place in a few years, that it will go down because we spread the risk rather than the same folks getting the bill. Now we are spreading it across one of the basic foundations of what reform is. We have individual mandates. That will be debated. It will be debated in the courts.

But if you only get insurance when you are sick, in other words, if you don't have it, as opposed to making it a mandate, then the costs we do know is much higher than it ordinarily would be. Point number one. Do you agree or disagree with that?

Mr. FOSTER. I largely agree, if I could elaborate just a little bit.

In terms of the premiums going down, certainly if you have a risk pool that is mostly made up of people who desperately need the insurance because of their high cost and nobody else, that is a high premium insurance policy.

Mr. PASCRELL. Right.

Mr. FOSTER. If you have people who have some risk of health care cost and they want insurance against that, but they are not high cost currently, they could just become so, and they are included in the pool, then the premium comes down. There are other factors that affect whether premiums increase or decrease, one of which is the Affordable Care Act mandates certain minimum standards for coverage, which could tend to raise the coverage and therefore the premium that goes with it.

Mr. PASCRELL. Thank you. So on the other side of these increases in premiums, given the scenario which I just presented, what about Medicare premiums? Congresswoman Wasserman Schultz referred to this before. How do we get to deal with that?

Now, you, the Office of Actuary, stated very clearly that Medicare will be preserved and strengthened through this legislation. There are two points I want to put before you. I want to ask if you agree or you disagree and then, if you would, tell us why. It will lower annual premiums by nearly $200 per beneficiary; and, B, it will lower annual average coinsurance by over $200 per beneficiary. Is this true or not true?

Mr. FOSTER. Yes. If you look at the coinsurance impact for fee for service beneficiaries, and it is important to distinguish between fee for service and those in Medicare Advantage.

Mr. PASCRELL. What is the direction we are going in throughout this legislation?

Mr. FOSTER. It is more fee for service.

Mr. PASCRELL. That is correct.

Mr. FOSTER. Yes, that is correct.

As you mentioned earlier, because of the lower payment rates to providers, that translates into lower coinsurance within Part A, Part B, and Part D for fee for service beneficiaries and of the order of magnitude that you cited. There are also premium impacts for Part B.

Mr. PASCRELL. In conclusion, Mr. Foster, and thank you for your testimony, we can't really score or we can't really come up with a number that makes sense, can we, in dealing with the benefit of a proven preventive care. Let's take that one for example. That is a tough thing to score, isn't it?

Mr. FOSTER. Yes, sir, it is.

Mr. PASCRELL. Yet in the very foundation of this legislation, which is now the law of the land, the very foundation is to make sure that we mandate those preventive examinations, and I would think they would be no better used than with our senior population. Would you agree or disagree with that?

Mr. FOSTER. Preventive care I think is very valuable, very helpful for all patients, and given the much higher propensity for older people to have health conditions, all the more so for them.

Mr. PASCRELL. Thank you, Mr. Foster.

Thank you, Mr. Chairman.

Chairman RYAN. Mr. Tonko.

Mr. TONKO. Thank you, Mr. Chairman.

Mr. Foster, the measure that passed as a repeal bill last week was somewhat silent on the $250 checks that have already been issued to seniors who qualified with that threshold level in the pharmaceutical piece. What is your thinking if the law were to be—if that were to be enacted into law in terms of how—whether or not the seniors would have to repay those checks to the government?

Mr. FOSTER. Well, in fairness, I don't actually know. If the law were repealed retroactively and all the provisions that have already taken effect, such as the Part D rebate checks for people in the coverage gap, along with everything else, if all that was put back the way it had been, then in theory I think I was quoted as saying that people would have to pay back those amounts.

Mr. TONKO. Thank you.

In terms of the provider network, the various organizations that you thought would be hurt into the future, my recollection was that these organizations that speak for the providers had endorsed the measure, the Affordable Care Act, and I would assume they moved forward with that endorsement because it responded to their own special needs. Do you think that they saw the additional 34 million people being covered and the resources that are put into play because of that as a growth potential for them?

Mr. FOSTER. I am sure they did. As you referred to, for example, the hospital industry was comfortable with a certain level of payment reductions through Medicare, in part because they saw many more patients that would now be insured and could pay, as opposed to were not insured and could not pay. I think they saw that as a fair deal, one that they could live with.

There is one catch to this. I am not sure they considered adequately the additional people with insurance coverage, the 34 million. That is what we refer to as a level shift. You get 34 million

more people with coverage, and it pretty much stays that way in time. It goes up a little bit.

With the productivity adjustments, that is a growth rate change. It affects the level in the first year, more in the second year, more in the third year, forever. I think they looked at the first 10 years and balanced it out and said, this looks okay. I am not sure they looked beyond the 10 years and thought about it.

Mr. TONKO. I would assume that they did the long-term and short-term analyses, and speaking in favor of the legislation really meant a lot to a lot of people, because they were concerned about the provider networks. But I appreciate your response.

Thank you, Mr. Chairman.

Chairman RYAN. Thank you.

Mr. Foster, thank you very much for your time today. I appreciate it.

This concludes the first panel of witnesses. Let me introduce our next panel.

First, we will start off with Dennis Smith, the Secretary of the Wisconsin Department of Health services. Then we will have James Capretta, a Fellow at the Ethics and Public Policy Center, followed by Paul Van de Water, a Senior Fellow at the Center on Budget and Policy Priorities.

First off, I want to start by asking the witnesses, since this is a panel of three, I want to ask if we can try to stick to 5 minutes for your opening presentations. That way we can get to members' time. We are going to have a vote I think at 1:30, so let's see if we can get as much through before that vote hits.

Secretary Smith, welcome. It is fantastic to have you back home in Wisconsin. May I trust you are a Packer fan now?

Mr. SMITH. Absolutely, Mr. Chairman.

Chairman RYAN. Good. So why don't we start of off with you, Secretary Smith.

STATEMENTS OF DENNIS G. SMITH, SECRETARY, WISCONSIN DEPARTMENT OF HEALTH SERVICES; JAMES C. CAPRETTA, FELLOW, ETHICS AND PUBLIC POLICY CENTER; AND PAUL N. VAN DE WATER, SENIOR FELLOW, CENTER ON BUDGET AND POLICY PRIORITIES

STATEMENT OF DENNIS G. SMITH

Mr. SMITH. Thank you very much, Mr. Chairman, for inviting me today, and I hope that the lesson of Wisconsin, we believe we have a very important and impressive story to tell in the ongoing national debate over the controversial new law.

Wisconsin is going to, quite frankly, look at this in terms of we have already achieved a level of insurance that is greater than what is expected under the national law. We have a very competitive health insurance market already; and, on balance, more people in Wisconsin will face greater costs than they will in additional benefits. So I think there will be a lot of talk about what does the new law really mean for us.

Oftentimes at the national level you look at averages. You look at the entire country. I would suggest that it is critically important

to look at individual States and what is going on within the specific populations.

Again, as you average everything out, the previous panel, there was a lot of discussion about $100 in the trust fund and in the Federal budget. In the individual market that actuaries have already looked at, if you want to start talking about 100 people within the individual market, you are going to say to those 100 people, if it is a cross-section as we have across the age groups, 25 percent of you are going to receive a decrease in your premium, in your individual market, and that decrease is going to be worth about 20 percent.

If you only talk to that 25 percent of the group, they are going to be pretty happy with you. But 75 percent of that group is going to receive an increase in their premium, on average almost 25 percent increase in their premium. Ten percent of those individuals in that group are going to receive a premium increase of greater than 50 percent.

In terms of the impact across the State, we estimate that PPACA will cost the taxpayers of Wisconsin $560 million per year, and this figure assumes very little loss of employer-sponsored health insurance, which I suggest is the key to all of this. Because we have made assumptions about people's behavior and we have assumed employers are not going to drop their current health insurance coverage. If our assumption is wrong, then the estimates are going to be extremely different than what we have been told.

Medicaid expansions under PPACA that are associated will cost the State $1.12 billion between 2014 and 2019. These are additional—basically individuals who—Wisconsin is already a very generous State. We already have a childless adult population. We have already extended coverage to many of those individuals. So the woodwork effect of people who are already eligible and gaining coverage.

This will be partially offset, though, by a movement out of the existing Medicaid program. Approximately 122,000 children, parent caretakers, and pregnant women with incomes above 133 percent of poverty will move off of Medicaid and onto the new subsidies. That will reduce the cost to the State of about $543 million.

Then there are some additional extra subsidies, enhanced match rates in PPACA, that will reduce the cost to the State by about another $100 million. But, again, those are enhanced match rates. Those are not buying anybody new coverage. That is simply taking the money out of the State budget and offloading it to the Federal Government. It doesn't matter to the taxpayers where the money is coming from.

Then the balance of the impact to the State is really an unknown to us at this point in time, because it all depends on how the Federal Government defines the maintenance of effort definition in the law of whether or not there will be further buyouts of State programs.

There is about, in terms of the overall impact, roughly around 350 percent of the poverty line, that you will have additional costs that will outweigh your additional benefits under the law. Median family income in Wisconsin is around 400 percent FPL, so a major-

ity of the households in Wisconsin will face greater costs than they will in any additional benefits.

There will be displacements of people in the program. At least 475,000 people in Wisconsin will lose their current coverage. Again, much of this money will be devoted to not insuring new people but simply shifting the cost of the pot where the money comes from. Our actuaries estimate that 46 percent of individuals who will move into the public subsidies, either through Medicaid or the new tax credit, already have private coverage.

Thank you, Mr. Chairman, for the courtesy. I look forward to your questions.

[The prepared statement of Dennis G. Smith follows:]

PREPARED STATEMENT OF DENNIS G. SMITH, SECRETARY, WISCONSIN DEPARTMENT OF HEALTH SERVICES

Thank you, Chairman Ryan, for convening this important hearing, "The Fiscal Consequences of the Health Care Law." Ranking Member Van Hollen and members of the Committee, I appreciate the opportunity to join you today to examine the fiscal consequences of the Patient Protection and Affordable Care Act (PPACA). The impact of the PPACA on state budgets, families, individuals, employers, the health insurance industry, health care providers, and our national economy is still slowly rising above the horizon and has yet to come into full view.

Wisconsin has an important and impressive story to tell that may be useful in the ongoing national debate over this controversial new law. Wisconsin has been a leader and innovator in health care reform for more than two decades. In Wisconsin, a higher percentage of our citizens already have health care coverage than has been forecast for national peak coverage. According to the Centers for Medicare and Medicaid Services (CMS), the percentage of our citizens with health insurance coverage will reach nearly 94 percent at its peak. However, the University of Wisconsin Population Health Institute estimates that nearly 95 percent of Wisconsin citizens already have access to health insurance. Wisconsin has achieved this high level of coverage without an individual mandate and without guaranteed issue, while maintaining a robust and competitive insurance market.

The Wisconsin Department of Health Services (DHS) has retained expert actuarial consultants to analyze the impact of PPACA on individuals, employers, and the various insurance markets. While our work still continues and we understand that the federal government must resolve a number of substantial issues before we will know the full fiscal impact of PPACA, there are some preliminary findings that we hope will be helpful. Further, the state is developing a sophisticated mock-up of a web-based intake system that might be considered a first generation of how parts of an exchange might work in terms of eligibility and selection of health plans. We hope the experience of Wisconsin will be helpful as Congress and the Administration make critical decisions that must be made over the next 18 months, well before the major parts of PPACA go into effect.

The prospect of adding another 16-20 million individuals nationally to Medicaid is clearly a concern for the states both in terms of financing and in providing access for the Medicaid population. Wisconsin currently faces a Medicaid shortfall of about $214 million in the current fiscal year that must be closed by the end of June. For state fiscal year 2012 and state fiscal year 2013, the combined Medicaid shortfall is about $1.8 billion. We know that we are not alone as most states are also struggling with increasing caseloads in a weak economy.

The best solution to ease the tremendous pressures on state budgets is to get people back to work. Between February 2008 and December 2008, our monthly enrollment of children increased by 15,691. Our monthly enrollment of adults with children during this same period grew by 12,500 (February is used for comparable available data among groups; pregnant women and childless adults are not included as program changes were implemented that affected enrollment). Between December 2008 and December 2009, our monthly enrollment of children increased by 55,802 and the monthly enrollment of adults with children grew by 46,837. In other words, enrollment between December 2008 and December 2009 grew three times faster than between February 2008 and December 2008.

In December 2010, our monthly enrollment of children had increased by another 15,357 from the previous year and adults with children increased by 28,621. So in December 2010, our monthly enrollment of children and adults with children was

nearly 174,000 higher (32 percent) than in February 2008. Our total Medicaid enrollment surpassed 1 million individuals for the first time in June 2009 and in December 2010, enrollment reached 1,159,153 individuals out of a statewide population of roughly 5.5 million people. According to Census Bureau estimates, there are 1.4 million children in Wisconsin, of which 374,615 are below 150 percent of the Federal Poverty Level. So current enrollment represents 109 percent of the Census Bureau's estimates of the number of children below 150 percent FPL in 2008/2009 and about 30 percent of all children in Wisconsin.

Getting everyone fully back to work would have a significant impact on the state budget. By way of comparison, if enrollment were to return to the February 2008 levels, the combined federal and state savings would be more than $1 billion.

Some of the most important reasons and assurances originally given for the enactment of the new law appear to be fading. Individuals indeed will lose their current coverage. The cost of health care continues to go up, not down. And most important of all, the promised level of savings for American families will not materialize. We estimate that PPACA will cost the taxpayers of Wisconsin $560 million per year. And, this figure assumes relatively little loss of employer sponsored health insurance. Since Wisconsin has already achieved much of what is envisioned under PPACA in terms of coverage and without the most controversial provisions of the new law, the people of Wisconsin will want to clearly understand what, then, is the gain to be realized?

We estimate that the additional state cost associated with the Medicaid expansion provisions of PPACA from 2014 to 2019 will total $1.12 billion. These costs will occur due to the addition of approximately 85,000 childless adults, the woodwork effect and take-up rates of individuals currently eligible but not enrolled, and additional months of coverage that will be added by reducing the "churning effect."

These costs will be partially offset by the reduction in enrollment of approximately 122,000 children, parents/caretakers, and pregnant women with income above 133 percent FPL who are already currently enrolled. The movement out of Medicaid to the new federal tax credits will save the state approximately $579.4 million between 2014 and 2019. This will reduce the state cost of PPACA to $543 million.

PPACA includes enhanced matches for the State Children's Health Insurance Program (SCHIP) that we estimate will reduce the cost to the state by another $109 million, leaving the net cost of PPACA to the state of $433 million.

However, this net number will be impacted by the pending federal policy decision about the definition of maintenance-of-effort (MOE), who is a newly eligible individual, and whose income is counted in determining eligibility. If, depending on these definitions, the federal government "buys out" our childless adult population, we estimate that cost to the federal budget will be nearly $1 billion, which then would become additional savings to the state to offset our costs. It is unclear whether the Congressional Budget Office (CBO) or the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS) have assumed the federal government would buy out all of the states' childless adult programs in its fiscal analysis of PPACA.

But simply switching from state dollars to federal dollars does not buy additional coverage. At the end of the day, it matters little to taxpayers whether they are paying for the cost of PPACA through their federal income tax to finance new entitlement spending or higher debt, their state income tax, their local property tax, or higher premiums. There is no doubt PPACA will move hundreds of billions of dollars around in additional benefits and additional costs. It appears that the net impact per family will likely break around 350 percent of FPL. That is, if your income is below 350 percent FPL, the additional benefits of PPACA will be greater than the additional costs to you. But if you are above 350 percent FPL, the additional costs will likely be greater than the additional benefits. Median family income in Wisconsin for a family of four is equal to about 400 percent FPL. In other words, the additional costs of PPACA will exceed the additional benefits for a majority of individuals and families in Wisconsin.

One of the major promises of health care reform was that individuals would keep their current coverage. This clearly will not be the case. At least 457,000 people in Wisconsin will likely be displaced from their current coverage. This includes 160,000 individuals from the individual market, 175,000 individuals from employer-sponsored coverage and 122,000 individuals, including children, who are currently in our public programs. Analysis of the impact on small group coverage is ongoing, but it is likely that there will be disruption in that market as well. Moreover, the level of losses in employer-sponsored health insurance is widely debated.

Insurance generally involves the assessment, management, and mitigation of risk. PPACA seems to invite risk. It is fair to conclude that no one really knows, for example, how employers will behave, especially in these times of economic uncer-

tainty. Actual experience in Wisconsin also shows how difficult it is to predict total costs because of the variance in the estimates of the numbers of uninsured and the uncertainty about take-up rates. For example, in comparing actual enrollment numbers to the estimates of uninsured children according to the U.S. Census Current Population Survey (CPS), the take-up rate for children with family income below 150 percent of the Federal Poverty Level (FPL) thought to be uninsured was 107 percent and the take-up rate for children with family income between 150 percent and 200 percent FPL thought to be uninsured was 140 percent.

Our actuaries estimate that 46 percent of individuals who will move into public subsidies either through Medicaid or the new tax credit entitlement already have private coverage. When you add in the federal "buy out" of existing state coverage, a substantial amount of the new federal spending will simply replace federal dollars for existing private sector or state dollars without insuring a single new individual.

Our actuaries' analysis clearly shows that PPACA creates winners and losers. Looking back on the debate over PPACA, important details were missing or blurred as data was aggregated and averages masked significant swings among age groups. For example, according to the preliminary actuarial analysis conducted for the state, overall premiums for the individual market will increase 6.6 percent. However, when we look at member distribution, the variation across groups is significant. 75 percent of those in the individual market will receive an increase in premiums with an average impact of nearly 25 percent. The other 25 percent will receive an average decrease in premium of nearly 20 percent. Moreover, 30 percent in the individual market will face premium increases between 25 and 50 percent and 8.5 percent will face increases of more than 50 percent. Clearly, it will be cheaper for many individuals to simply pay the new federal tax to remain uninsured, knowing they will be able gain entry to the market at a later time. Such dramatic swings will not stabilize the market, they will disrupt it.

Policymakers should look closely at those who face these premium increases. Those who receive a decrease in premium have an average age of 48 while those who will receive an increase in premium have an average age of 31. In other words, the younger, working age population that generally have lower earnings and face the greatest costs associated with raising children will face substantially greater premium increases than those older individuals who are reaching their peak earning power and face lower costs associated with raising children.

Of the individuals our actuaries estimate will enroll in coverage through the health exchange, two-thirds already have coverage through employer-sponsored health insurance or the non-group market.

We are also concerned that greater federal regulation could lead to fewer health plans available to the people of Wisconsin. An individual in the Madison zip code area can choose from 12 health insurance companies offering a total of 324 plans. There are more than 30 companies offering a health insurance product in the individual and small group market throughout Wisconsin. The largest company in terms of premiums has just 12 percent of the individual market. That is a healthy competitive environment that the federal government should not interfere with. But PPACA requirements on benefits and rating practices will significantly disrupt the current individual and small group markets.

Wisconsin can also provide a glimpse into the changes ahead in the insurance distribution system itself as consumers gain access to health exchanges. Our online application tool, ACCESS has recently been highlighted by the Kaiser Commission on Medicaid and the Uninsured in its brief, Optimizing Medicaid Enrollment: Spotlight on Technology. ACCESS was developed, implemented, and enhanced over a period of 7 years and allows individuals and families to apply for medical assistance, childcare, and food stamps. While technology can improve productivity, it costs about $287 to process an application at the county level.

While ACCESS is an important tool, our experience demonstrates that reliance solely on a technology will not work for many individuals. The University of Wisconsin Population Health Institute recently concluded an evaluation on the utilization of ACCESS and found that the choice of application methods and the accuracy of enrollment systems vary significantly. ACCESS applicants were the least likely to be determined eligible for coverage compared to phone applications, walk-in, and mail-in applications. Only 69 percent of ACCESS applicants turned out to be eligible, suggesting an exchange will handle a high volume of individuals who will not be eligible for Medicaid or the new tax subsidies. Our own exit survey on the health insurance prototype shows that one-third of individuals responded that the tool did not provide enough information to make a decision on finding and purchasing health insurance. Finally, our experience with auto-enrolling childless adults shows substantial churning among individuals. There are clearly limitations and risks associated with reliance on sharing information across various government databases.

ACCESS and our prototype are exciting and impressive tools. We are already well ahead of most states in building these on-line tools. But what we have built is still the easier parts. We estimate it will still take us another 2.5 years to implement the core functionality of an Exchange. That assumes the federal government will release all necessary guidance in a timely manner and that we will be able to leverage only the systems we currently have. While we are and should be optimistic, we also need to be realistic.

To put this in context, consider that the planning and development of a new Medicaid Management Information System (MMIS) is a 9 to 12 month process. Procurement itself takes another 12 months. It took the state 46 months to implement our new MMIS and another 6 months to obtain CMS certification for a total of 76 months. Is it realistic that this timeframe can be cut in half across the nation? If all of the various federal agencies involved in the implementation of exchanges cannot complete their work this year it is difficult to imagine how 50 states and the District of Columbia will be able to meet the readiness assessment required by law in 2013.

Mr. Chairman, implementation of PPACA as the law currently stands will cause a significant disruption across the nation. There is still a great deal of uncertainty as to the impact of PPACA on state and family budgets, on workers, and employers. Wisconsin already has achieved the coverage rates aspired to under PPACA. We have a strong, competitive health insurance market, which we want to preserve and protect. All of the gains Wisconsin has made should not be put at risk.

Chairman RYAN. Thank you very much.

Mr. Capretta.

STATEMENT OF JAMES C. CAPRETTA

Mr. CAPRETTA. Mr. Chairman, Mr. Van Hollen, members of the committee, thank you for the opportunity to participate in this very important hearing.

Entitlement spending was a problem even before the enactment of the Patient Protection and Affordable Care Act. In 1975, the combined costs of Social Security, Medicare, and Medicaid was 5.4 percent of GDP. In 2009, those entitlement programs cost 10.1 percent of GDP. That jump in spending, 4.7 percent of GDP, is the main reason it is so difficult to bring the Nation's budget closer to sustainable fiscal balance.

Every year we are spending more and more to fill entitlement promises made years ago, and we really haven't hit the rough patch yet. Over the coming two decades, we are about to add 30 million new people to the category age 65 and older. As these baby boomers enroll in Social Security and Medicare, costs will soar. We were therefore already racing towards a budget entitlement crisis before the health law was passed. The key question is, did it make the problem better or worse?

The President argued that it would make it better, essentially with the catch phrase "health reform is entitlement reform," but I think we need to examine that question quite carefully.

To begin with, it is important to note that the law is the largest entitlement expansion since the 1960s. It will add, as has been discussed already a number of times, at least 15 to perhaps 20 million people to the Medicaid program, another 15 to 20 million people to the new insurance subsidies through the exchanges. How then does a law which increases spending by nearly $1 trillion over the next decade reduce the deficit? The only way is by cutting spending by amounts in excess of the new spending commitments and by raising taxes. So although the legislation has often been described as a deficit reduction measure, it might be more accurate to say that

it is a very large spending bill that, at least on paper, is paid for by even larger tax increases.

But these numbers don't actually tell the whole story, and I want to go through a couple of things just to highlight some issues that might raise questions about the deficit reduction included in the CBO numbers.

First, the CLASS Act. The argument that the new law reduces the deficit is dependent pretty heavily on the CLASS Act. The CLASS Act is a new long-term care insurance program. You might think because the score is for $70 billion in new premiums in the next 10 years that it is a deficit reducer, but, in truth, the CLASS Act is actually a budgetary time bomb. Every actuarial analysis that has been done on it shows that it will suffer from very severe adverse selection.

It is a voluntary program. The people who enroll in it quite rationally will be the people the most likely to benefit from it. Their premiums will be therefore relatively high because of the risk pool. But, overall, the premiums will fall well short of what is needed to cover implicit benefit promises. Over time what is likely to happen, as every study that has looked at it has said, is that benefits will have to be either reduced very dramatically on the vulnerable citizens who enrolled or pressure will build for another Federal bailout. So this program is actually unstable. The idea that it contributed to deficit reduction is not really a good characterization to the public about what is really going on with this program.

Next, I want to talk about the premium subsidies in the insurance exchanges. Census data show that there are about 111 million people under the age of 65 who are living in households with incomes between 135 and 400 percent of the poverty line. A CBO estimate shows 19 million of these people in this income category will get the new premium assistance in 2019. Now if that were to happen, if 90 million more people will be outside staying in job-based coverage and not on the exchanges, it would actually be quite unfair to many low-wage workers.

As I tried to show in my testimony on chart one, a couple of researchers from the Urban Institute have done a very careful study of the differential subsidies between the employer-based system and the exchanges. As you can see in the chart, on the low wage of the income scale for households below about $60,000 or $50,000 a year in annual cash income, they would be far better off in the exchanges than the employer-based system because the value of the exchange subsidies far exceeds the tax break. However, they are not eligible to go into the exchanges. So, in a sense, you are going to have two households living right next to each other, one inside the exchange and one out; and the one inside the exchange will get up to $3,500 or $4,000 more inside the exchange than out.

You have got serious disequilibrium associated with this kind of differential. And my only judgment is—and this was not part of the CBO estimate, but I do believe, you know, sometimes we can question the assumptions. My own judgment is that, over time, this kind of instability will get corrected so that people will be treated equally and fairly. Eventually, all the people who would get the larger subsidy structure and entitlements through the new entitlement program will end up there, and it will cost a lot more to pay

for that. That will be essentially buying the base, which they didn't want to do when you are writing the bill. But, over time, it is very difficult to give an entitlement away to one person but not an equally qualified alternative.

I see that I am running out of time here, Mr. Chairman. I will enter the rest of my testimony for the record. There are a couple of other points that could be made, but I will save those for Q&A. Thank you.

[The prepared statement of James C. Capretta follows:]

PREPARED STATEMENT OF JAMES C. CAPRETTA, FELLOW, ETHICS AND PUBLIC POLICY CENTER

Mr. Chairman, Mr. Van Hollen, and members of the Committee, thank you for the opportunity to participate in this very important hearing on the fiscal consequences of the health care law.

The most serious threat to the nation's long-term prosperity is projected large fiscal deficits over the years and decades ahead. And the main reason the nation's budget deficits are expected to remain at dangerously high levels for the foreseeable future is because of the rapid growth of entitlement spending.

Importantly, entitlement spending was a problem even before the enactment of the Patient Protection and Affordable Care Act (PPACA). In 1975, the combined cost of Social Security, Medicare, and Medicaid was 5.4 percent of GDP. In 2009, these entitlement programs cost 10.1 percent of GDP.

That jump in spending—4.7 percent of GDP—is the main reason it is so difficult to bring the nation's budget closer to sustainable fiscal balance. Every year, we are spending more and more to fulfill entitlement promises made years and decades ago, leaving less and less to finance other priorities, even as the growing levels of entitlement spending puts enormous pressure on taxpayers.

And we haven't even hit the really rough patch yet. Over the coming two decades, the United States will undergo an unprecedented demographic transformation, as the baby boom generation moves from its working years into retirement. The number of Americans age 65 and older will rise from 41 million in 2010 to 71 million in 2030. As these baby boomers enroll in Social Security and Medicare, costs will soar.

We were therefore already racing toward a budget and entitlement crisis before the health care law was considered and passed. Indeed, for the proponents of the legislation, that became a primary argument for its enactment. The president argued that his health care plan would begin to address the entitlement problem, at least from the perspective of the health programs. "Health reform is entitlement reform" was the catch-phrase.

But is that really the case? Did the new health care law ease the entitlement and budget crisis, or did it make matters even worse? That is the crucial question, and this Committee should be commended for taking it up as one of the first items for discussion in this new Congress. I believe the evidence is overwhelming that the new law will make matters not better, but far worse.

The most noteworthy characteristic of the new law is that it is the largest entitlement expansion since the 1960s. So, at a time when the federal budget is already buckling under the weight of existing entitlement programs, the new law stands up three new ones which will enroll tens of millions of Americans into taxpayer-financed programs promising permanent access to uncapped benefits. Moreover, spending on these new entitlements is expected to grow at rates that are above the level of growth of the economy or general inflation.

How then does a new law which increases spending by nearly $1 trillion over the period 2010 to 2019 reduce the federal deficit (by about $130 billion over ten years according to the Congressional Budget Office and by a modest amount in the decade after that)? The only way is by raising taxes and cutting spending by amounts in excess of the new spending commitments. According CBO's estimate of the final legislation, spending reductions will bring the net increase in spending down to about $430 billion over the next decade. The tax hike to pay for this spending will total about $560 billion over the same period.

Thus, although the legislation has often been described by proponents as a deficit reduction measure, it might be more accurate to say that it is a very large spending bill, offset, at least on paper, by even larger tax increases.

But even these numbers do not tell the whole story. It is also important to look carefully at the assumptions underlying these estimates to determine if the prom-

ised deficit reduction will occur in reality, or just on paper. There are a number of reasons to be very skeptical in this regard.

THE CLASS ACT

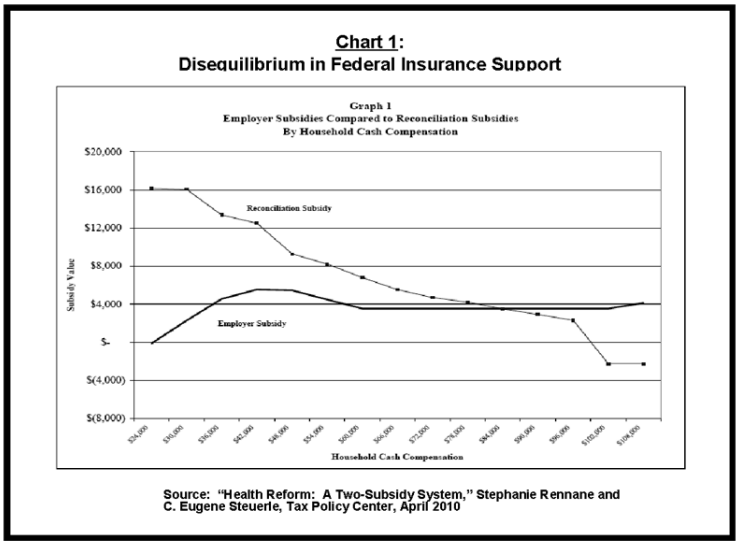
The argument that the new law reduces the federal budget deficit over the coming decade rests in large part on the supposed deficit reduction from the creation of the Community Living Assistance Services and Supports Act, or CLASS Act, which is a new long-term care insurance entitlement program. CBO's estimate assumes that $70 billion in supposed deficit reduction through 2019 is to come from the CLASS Act.

But, in truth, the CLASS Act is another budgetary time-bomb waiting to explode, not a solution that produces deficit reduction. In the short term, because the program is brand new and no one is eligible for benefits until they have paid in for five years, premiums are collected and no benefits are paid—producing what appears to be a temporary surplus. But beyond the visible ten-year window, those premiums are needed to pay long-term care insurance claims.

Moreover, every actuarial analysis done on the program indicates it will suffer from severe adverse selection. That is, it will attract mainly enrollees who expect to need the benefit. The result is that individual premiums are likely to be quite high because too few healthy workers will enroll. Overall premiums will fall well short of what is needed to cover the implicit benefit promises. Pressure will then build for a future taxpayer bailout to avoid imposing cuts on the vulnerable citizens who elected to enroll and pay premiums. In short, this program is not going to solve our entitlement crisis. Indeed, it is a perfect illustration of why federal entitlement spending is our central budgetary problem.

DISEQUILIBRIUM IN FEDERAL INSURANCE SUBSIDIES

The new law promises members of households with incomes between 135 and 400 percent of the federal poverty line new premium subsidies if they get their coverage through the new state-run "exchanges." Census data show that today there are about 111 million Americans under the age of 65 who are living in households with incomes in that range. But CBO estimates that only 19 million people will be getting the new premium assistance in 2019. They assume the other 90 million Americans will stay in job-based plans.



If that were really to happen, it would be terribly unfair. As Stephanie Rennane and Eugene Steuerle of the Urban Institute have documented, the new premium subsidies in the exchanges are worth far more to low- and moderate-wage workers than today's federal tax preference for employer-paid premiums (see Chart 1). For instance, a household of four with compensation of $60,000 in 2016 would get $3,500

more in government assistance if they moved from employer coverage to an exchange. The extra subsidies would be even more for lower wage workers.

The new law thus sets up a situation where two families with identical compensation totals from their employers can get very different levels of federal support depending on where they get their insurance.

In my judgment, that's not likely to be a politically stable situation. Pressure will build on elected leaders to treat every American equally. That is likely to lead to regulatory and legislative decisions making it easier for workers now in job-based plans to migrate to the exchanges.

Over time, what is likely to happen is that those who would be better off in the exchanges will end up there, one way or another, even as higher wage workers retain the tax advantage for job-based coverage. As the labor market segregates, costs will soar well above the $1 trillion in new spending over ten years currently projected for the law.

AMT–LIKE BRACKET CREEP

The new law relies heavily on tax increases to cover the new entitlement spending. According to CBO's latest long-term budget projections, by 2035, the tax increases in the new law will collect revenue equal to 1.2 percent of GDP, which is very substantial. In today's terms, that's a $180 billion tax increase, every year.

How can that be, given that the tax hikes do not go nearly that high in the first decade? The answer is AMT-like bracket creep. The new tax on high-cost insurance plans, sometimes called the "Cadillac" tax, applies to policies with premiums for families above $27,500 in 2018. That threshold will only grow with general consumer inflation in 2020 and beyond, not growth of health costs. Thus, by 2030, the tax will be binding on many millions of Americans' insurance plans.

Similarly, the new Medicare taxes on wages and other sources of income apply only to individuals with incomes above $200,000 per year beginning in 2013 ($250,000 for couples). But those income thresholds are fixed; they won't rise with inflation at all. In very short order, that means these taxes will begin hitting middle-class Americans with massive tax hikes. By 2030, inflation will have eroded the $200,000 threshold so that it is the equivalent of $130,000 today (assuming 2.5 percent annual inflation).

THE MEDICARE PAYMENT RATE REDUCTIONS

The largest spending reduction in Medicare comes from automatic reductions in the inflation updates for hospitals and other institutional providers of care. The notional rationale is that these cuts represent productivity improvement in the various institutions getting Medicare payments. The reductions, amounting to a 0.4-0.5 percentage point reduction off the normal inflation update for Medicare payments, will occur every year, in perpetuity. The compounding effect of doing this on a permanent basis would be massive savings in Medicare—if they really were implemented. CBO says the cuts will generate $156 billion over the first decade alone.

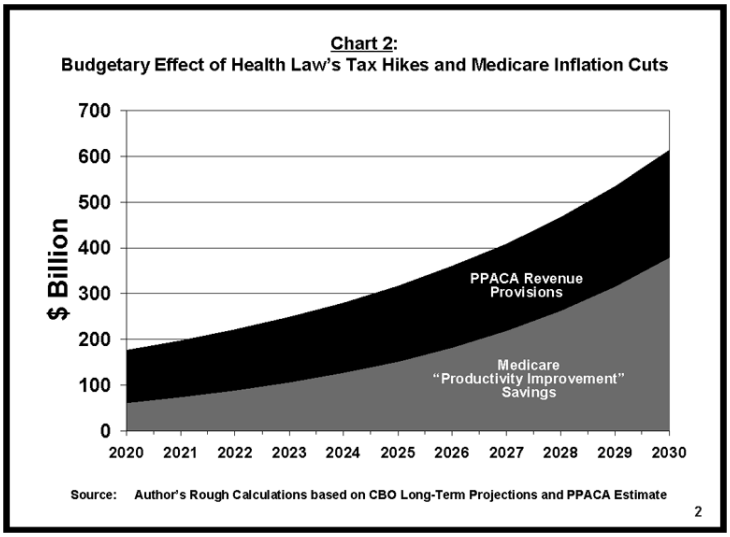
But there are strong reasons to suspect these cuts will not be sustained. Medicare's actuarial team, led by Richard Foster, has warned repeatedly that these cuts are not viable over the medium and long-term because they would jeopardize access to care for seniors. The cuts would push average Medicare payments to levels that are below what Medicaid is expected to pay, and the network of providers willing to take care of Medicaid patients is notoriously constrained. It is hard to imagine political leaders allowing Medicare to become less attractive to those providing services than Medicaid is today.

It's worth noting here that these cuts in payment rates do not constitute "delivery system reform," which the administration has often stated is what it is trying to achieve with the Medicare changes in the new law. These cuts in inflation updates will hit every institution equally, without regard to whether or not the institution is treating its patients well or badly. The savings that are expected from other reforms, such as Accountable Care Organizations, are minor by comparison.

THE BUDGETARY EFFECT OF TAX HIKES AND MEDICARE CUTS IN A SECOND DECADE

The administration and others have noted frequently that CBO's cost estimate indicates the possibility of modest deficit reduction in the second decade after 2019 (although CBO notes that such an estimate carries more uncertainty than its ten-year projections). But the expectation of long-term deficit reduction is entirely dependent on huge spending reductions from the Medicare inflation cuts and from more and more middle-class Americans paying higher taxes under the new law's tax provisions.

As shown in Chart 2, the tax hikes from the new law plus the savings from the "productivity adjustment" in Medicare would generate about $180 billion in "offsets" in 2020. By 2030, the spending cuts and tax hikes from these provisions will have more than tripled, to over $600 billion. If these taxes and spending cuts do not materialize, the new law will be a budget-buster of significant proportions.



DEBT SUBJECT TO LIMIT

Both CBO and the Medicare actuaries have both noted that the Medicare cuts and payroll tax hikes which are supposed to improve the solvency of the Medicare hospital trust fund in the new law can only be counted once, not twice. Here is how CBO put it in a Director's blog post from December 2009:

"To describe the full amount of HI trust fund savings as both improving the government's ability to pay future Medicare benefits and financing new spending outside of Medicare would essentially double-count a large share of those savings and thus overstate the improvement in the government's fiscal position."

In other words, these taxes and cuts in Medicare either improve the government's ability to pay future Medicare claims, or they pay for a new entitlement program—but not both.

One way to see that clearly is by looking at the impact of the health care law on debt subject to limit. According to CBO, the new law will increase that debt, by about $230 billion over the coming decade, because the Medicare tax hikes and spending cuts are double-counted instead of devoted to deficit reduction.

CONCLUSION

Mr. Chairman, you and your colleagues on this committee face a daunting challenge. The nation is rushing rapidly toward a fiscal crisis, driven by excessive borrowing and debt. Even before the health law was enacted, it was necessary to reform the nation's entitlement programs to bring spending commitments more in line with what the country can afford. Now, with enactment of the health law, the climb to a balanced budget got much steeper.

The solution is to start by unwinding what was just passed and replacing it with a program that constitutes genuine entitlement reform.

Chairman RYAN. All of your submitted testimony will be included in the record, and we can get it in Q&A.

Mr. Van de Water.

STATEMENT OF PAUL N. VAN DE WATER

Mr. VAN DE WATER. Thank you. Mr. Chairman and members of the committee, I appreciate the invitation to appear before you today.

Last March, the Congressional Budget Office estimated that the health reform legislation would reduce the deficit modestly in its first 10 years but substantially in the following decade. The CBO has reiterated that finding several times, most recently in its letter to Speaker Boehner 3 weeks ago. Heretofore, both supporters and opponents of a law have generally accepted, if only begrudgingly, the CBO cost estimate is the best, unbiased estimate available of that law's effects on the Federal budget.

In the case of health reform, however, critics have attempted to discredit the CBO estimate by charging that the law relies on several budgetary gimmicks. The Center on Budget and other analysts have explained time and again why these charges are groundless. In these remarks, I will focus on dispelling the misconceptions that have arisen in one particular area, health reform's budgetary effects on Medicare.

First, as you have discussed extensively already this morning, critics have claimed that CBO's cost estimate double counts the Medicare savings. This assertion is readily disproved just by reading the estimate. CBO counts everything once and only once. It counts the Medicare savings once. It doesn't count anything twice. The effect of health reform on the financial status of the Medicare trust funds is distinct from the law's effects on the Federal budget.

Rick Foster, the Medicare actuary, has affirmed more than once again this morning that health reform will extend the solvency of the Hospital Insurance Trust Fund by about 12 years. There is no double counting involved in recognizing that Medicare savings improves the status of both the Federal budget and the Medicare trust funds. In the same way, when a baseball player hits a homer, it both adds one run to his team's score and also improves his batting average. Neither situation involves double counting.

Second, again, as has already been discussed, critics contend that the Medicare savings and health reform should not be taken seriously because they will not be allowed to go into effect. This claim is wrong for several reasons. In part, it reflects the misreading of history. The record shows that Congress has repeatedly adopted measures to produce considerable savings in Medicare and has let them take effect.

A colleague and I carefully examined every piece of major Medicare legislation enacted in the past 20 years. We have found that virtually all of the Medicare savings in these laws were successfully implemented. The often-cited sustainable growth rate formula for physicians is the exception and not the rule. Even so, Congress has cut physician payment rates more than CBO originally estimated.

The Medicare actuary Rick Foster, as you have heard, has raised questions about the sustainability of one category of savings, the reductions in payment rates to reflect economy wide gains in productivity. Although his concerns deserve a serious hearing, as you have given them this morning, other experts do see more room to

extract efficiencies and improve productivity in the health care sector.

The Medicare Payment Advisory Commission, your expert advisory body on Medicare payment policies, expects that Medicare should benefit from productivity gains in the economy at large. MedPAC finds that hospitals with low Medicare profit margins often have inadequate cost controls, not inadequate Medicare payments.

Because the productivity adjustments are now law, Congress would have to pass a new law to stop them from going into effect. And under the statutory pay-as-you-go rules, that future legislation would have to be paid for so that it didn't increase the deficit.

Bringing deficits under control will require making difficult trade-offs and tough political decisions on both taxes and spending, especially for health care. If we can't count any provision that is controversial and might later be changed, we would have to conclude that many proposals, including the Bowles-Simpson proposal, Rivlin-Domenici plan, and Congressman Ryan's road map, would not really reduce the deficit. In fact, if we can't count any provision that a later Congress might reverse, we can't do serious deficit reduction at all.

Thank you very much.

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

PREPARED STATEMENT OF PAUL N. VAN DE WATER, SENIOR FELLOW, CENTER ON BUDGET AND POLICY PRIORITIES

Mr. Chairman, Mr. Van Hollen, and members of the committee, I appreciate the invitation to appear before you today.

When Congress was about to enact health reform last March, the Congressional Budget Office (CBO) estimated that the legislation would reduce the deficit—modestly in its first ten years, but substantially in the following decade.[7] CBO has reiterated that finding several times, most recently in a letter to Speaker Boehner three weeks ago.[8]

Heretofore, both supporters and opponents of a law have accepted, if only begrudgingly, the CBO cost estimate as the best unbiased analysis available of that law's effects on the federal budget. In this case, however, critics have attempted to discredit the CBO estimate by charging that the health reform law relies on several budgetary gimmicks. The Center on Budget and Policy Priorities and other analysts have explained time and again why these charges are groundless.[9]

In these remarks I will focus on dispelling the misconceptions that have arisen in one particular area—health reform's budgetary effects on Medicare.

First, critics have claimed that CBO's cost estimate double-counts the Medicare savings. This assertion is readily disproved. Let's be very clear. CBO counts everything once and only once. It counts the Medicare savings once. CBO doesn't count anything twice. Just read the cost estimate.

The effect of health reform on the financial status of the Medicare trust funds is distinct from the law's effect on the federal budget. The Medicare actuary has affirmed more than once, most recently just last week, that health reform will extend the solvency of the Hospital Insurance trust fund by about 12 years.[10] There's no double-counting involved in recognizing that Medicare savings improve the status

[7] Douglas W. Elmendorf, Director, Congressional Budget Office, Letter to the Honorable Nancy Pelosi, March 20, 2010.

[8] Elmendorf, Letter to the Honorable John Boehner, January 6, 2011.

[9] James R. Horney and Paul N. Van de Water, House-Passed and Senate Health Bills Reduce Deficit, Slow Health Care Costs, and Include Realistic Medicare Savings, Center on Budget and Policy Priorities, December 4, 2009; Paul N. Van de Water and James R. Horney, Health Reform Will Reduce the Deficit, Center on Budget and Policy Priorities, March 25, 2010; Paul N. Van de Water, Debunking False Claims About Health Reform, Jobs, and the Deficit, Center on Budget and Policy Priorities, January 7, 2011.

[10] Richard S. Foster, Chief Actuary, Centers for Medicare & Medicaid Services, Memorandum to the Honorable Pete Stark, January 18, 2011.

of both the federal budget and the Medicare trust funds. In the same way, when a baseball player hits a homer, it both adds one run to his team's score and also improves his batting average. Neither situation involves double-counting.

By the way, CBO accounted for deficit reduction in exactly this way in previous Congresses, under both political parties. For example, the Balanced Budget Act of 1997 and the Deficit Reduction Act of 2005 (both of which were passed by Republican Congresses) included Medicare savings that were counted as both reducing the deficit and also improving the outlook for the Hospital Insurance trust fund. No one raised claims of double-counting when these bills were enacted.

Second, critics sometimes contend that the Medicare savings in health reform should not be taken seriously because they will not be allowed to go into effect. This claim is wrong for several reasons.

In part, this charge reflects a misreading of history. The record demonstrates that Congress has repeatedly adopted measures to produce considerable savings in Medicare and has let them take effect. My colleague Jim Horney and I carefully examined every piece of major Medicare legislation enacted in the past 20 years; we found that virtually all of the Medicare savings in this legislation were successfully implemented. The oft-cited sustainable growth rate formula for physician payments is the exception rather than the rule. Even so, Congress has cut physician payment rates more than CBO estimated for the original provision.

The Medicare actuary has raised questions about the sustainability of one particular category of Medicare savings in health reform—the reductions in payment updates for most providers to reflect economy-wide gains in productivity. Although these concerns deserve a serious hearing, other experts see more room to extract efficiencies and improve productivity in the health care sector. Notably, the Medicare Payment Advisory Commission (MedPAC), Congress's expert advisory body on Medicare payment policies, generally expects that Medicare should benefit from productivity gains in the economy at large. MedPAC finds that hospitals with low Medicare profit margins often have inadequate cost controls, not inadequate Medicare payments.[11]

Because the productivity adjustments are now law, Congress would have to pass a new law to stop them from taking effect. Under the statutory pay-as-you-go rules, that future legislation would have to be paid for, so that it didn't increase the deficit.

In any event, both CBO and the Medicare actuary have always assumed in their projections that the laws of the land will be implemented, rather than hazard guesses about how future Congresses might change those laws. Surely no one would want estimates to be based on such speculation. Dr. Gail Wilensky, who ran Medicare under President George H.W. Bush, has expressed it this way: "It would be very hard to know what you would use if you didn't use current law—whose view you would use."[12]

Finally, these issues must be viewed in the context of reducing projected long-run federal budget deficits. Bringing deficits under control will require making difficult trade-offs and tough political decisions on both taxes and spending, especially for health care. If we can't count any provision that is controversial and might later be changed, we would have to conclude that neither the Bowles-Simpson proposals, the Rivlin-Domenici plan, nor Congressman Ryan's Roadmap would really reduce the deficit. In fact, if we can't count any provision that a later Congress might reverse, we can't do serious deficit reduction.

Chairman RYAN. Thank you, Mr. Van de Water.

Let me just start off by reading from the CBO Doug Elmendorf blog posting in 2009.

"To describe the full amount of H.I. Trust Fund savings as both improving the government's ability to pay future Medicare benefits and financing new spending outside of Medicare would essentially double count a large share of those savings and thus overstate the improvement of the government's fiscal position."

So I think we have a little bit of dispute on that.

Secretary Smith, I want to ask you, you just threw out a lot of statistics because you have your own actuaries in Wisconsin mak-

[11] Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, March 2010, pp. 6-7, 36.

[12] Remarks at a forum sponsored by the American Enterprise Institute, August 6, 2010.

ing their own estimates. Go through that one more time, just very briefly. How many people are you projecting will lose the current coverage they have? What proportion of people in Wisconsin will see an increase in their insurance premiums? And how many people are you projecting will go from their private current coverage they enjoy into the exchange?

Those are basically three questions I wanted to get at because you went through that pretty fast. I appreciate you compressing your testimony into 5 minutes.

Mr. SMITH. Yes, sir. And, again, we have only been on the job 3 weeks, so these are the actuaries that the previous administration hired.

Chairman RYAN. The Democratic administration.

Mr. SMITH. Yes, sir. And had done the work there. So we estimate a couple of different things.

One, again sort of the break point. There are people who will get additional benefits and they will outweigh any additional costs to them. There are others who will get additional costs and additional benefits, but the costs will outweigh the benefits. If the break point seems to be around about 350 percent of poverty, that if you are below that, more benefits than costs; above that, more costs than benefits.

Given that the median family income in household income in Wisconsin is around 400 percent, then that suggests the majority will have greater costs than they will in benefits. The number of people who are moving out of their current coverage is about 475,000 individuals. Those include people who are in the individual market who already, again, have health insurance coverage, people who are currently on Medicare that are at higher income levels who will move off Medicaid which would be savings to the State. But then those are Federal dollars that are being paid for that. And then a small migration out of the employer market. But those are the individuals you know. And, in Wisconsin, the total population is about 5.5 million people. So close to 10 percent of the people will have their current insurance coverage disrupted.

Chairman RYAN. Mr. Capretta, you are a number cruncher, and you have gone into this quite a bit. Bring up your chart, the Urban Institute chart, if you could. Because that is Gene Steuerle's——

Mr. CAPRETTA. It is, yes.

Chairman RYAN. This is the question I am trying to get at, and I don't know if anybody really knows how to measure this very well, the interplay between shifting—employers dumping people into the exchange. And this is an issue I think we have got to get into.

I personally don't think we are quite capturing this at CBO. I will just give you a couple anecdotal conversations I have had with large employers in Wisconsin. I don't think we appreciate this. We are going to have a competitive dumping situation from my perspective from just experiences with employers.

A large employer in my district, privately held corporation, multigenerations have held this, lots of employees. Their competitors are publicly traded. They have gotten the signal from their competitors that they plan on basically putting their people in the exchange because it is a $2,000 per person fine instead of the

$15,000 to $17,000 they are now paying for employer-sponsored health insurance. This employer does not want to discontinue this benefit package. They don't want to discontinue providing what, for them, I think is about a $17,000 per year package. But when their competitors in a manufacturing industry, in a very low-margin business, are going to have about a $15,000 per employee cost advantage they feel they have no choice but to dump their employees into the exchange.

So that kind of conversation is occurring around boardrooms all around Wisconsin. I know that for a fact, because I have talked to lots of employers who are telling me that, and I can only imagine that that same kind of conversation is occurring around America.

So give us a sense of how you see this interplay occurring between employers deciding whether it is in their interest for competitive reasons or other reasons to keep offering insurance which will have to be actuarial equivalents to the exchange or whether they will put their people in the exchange, given that a lot of people will actually be better off at the lower end of the income or salary or pay scale. What interplay do you see coming? What are alternative scenarios that are probably more likely to reality? And then what are the fiscal consequences of that if these different kinds of projections bear out?

Now, granted, we are stabbing at this. But if we are off by a few magnitudes, the cost of this thing could explode. Give us a sense of that.

Mr. CAPRETTA. Sure. First of all, just to be fair to CBO and others, I mean, this is incredibly complicated, and we have a sample size of one, Massachusetts being the only State that is really in this. And so the ability to model this out and understand how it will play it out over a decade is very difficult.

Having said that, I think the point you are making is the right one, which is there is so much more money available in the exchanges than out of it for the low-wage population, as this chart shows, the break point in terms of being better off outside the exchange is way upwards of about $80,000 a year. So, below that, everybody would be better off in the exchange, rather than getting the tax preference for the employer-paid premium plan.

Employers obviously have a mix of employees. So any firm that has predominantly low-wage workers almost surely would want to go into the exchange. Even if they are above 50, pay the penalty. The penalties are factored into this calculation for the employer. So you could still pay the penalty and still be better off. Okay? That is what is likely to happen on the low wage. For small firms with lots of low-wage workers, they are probably going to end up in the exchanges.

Now for firms that have a mix of high-wage and low-wage workers, you know, who knows what will happen over time. I mean, for them, if they put everybody in the exchange, the high-wage workers would be worse off, too, and they wouldn't like that. So they are going to have to figure out a way to either keep going with their plan, which CBO assumes, or they are going to have to figure out a way to maybe separate into two different kinds of companies, one that is predominantly low wage to take advantage of this new exchange and one that is predominantly high wage.

I believe as new firms form, as new companies are built, this will be one issue—not the only issue, but it will be one important issue they take into account when deciding how to structure their workforce and how to organize their company because there is so much Federal money involved here.

Doug Holtz-Eakin, the former director of CBO, has looked at this and said, if the break point is at about 250 percent of poverty, if you just assume all of those workers in one way or another end up in the exchanges over time and are not retained in the job-based system, the extra costs over just the first decade would be another $1 trillion. So we are talking—if you are off, as you said, Mr. Chairman, by just a little bit here, you are talking many, many, many more subsidies going out the door.

Chairman RYAN. And your point is what percent of that PL in this chart?

Mr. CAPRETTA. In this chart, it is as high as—I can't see the numbers from here, but it is about $80,000, I believe. Yes, it is about $80,000 in household income. This is in 2016 numbers.

Chairman RYAN. You said you wanted to add to your testimony?

Mr. CAPRETTA. Oh, the only thing I wanted to mention, the last point I wanted to mention—I ran out of time—was really in chart two. I don't know if chart two could be brought up.

This goes back to Chief Actuary Foster's point about the Medicare productivity improvements and the revenue provisions that are also in the bill. You can't see it on this chart up above. But the black there is actually the tax increases associated with the new health care law, and the gray area is the savings associated with the Medicare productivity improvement savings. Okay?

So we saw a cost estimate that went out to about 2019 from CBO that showed a number for each of those, okay? And then in the second decade, as Paul mentioned, they are saying that there is a broader health care or deficit reduction going on in the second decade. I think it is important to realize that the second decade deficit reduction that is in that CBO letter is tied up almost entirely in these two things, the new revenue that is supposedly going to be collected as well as the productivity improvement provision in Medicare.

As Mr. Foster repeated over and over again, the compounding effect of taking a slice off of the payment update every year in perpetuity is massive. You might get away with it for 5, maybe even 10 years. But to assume you are going to have that kind of wedge going out over the long run is really hard to believe.

Just to give you the numbers, if you calculate it out, the amount of deficit reduction or the amount of offsets produced by just these two items is about $180 billion in 2020, and it would grow just from these two items to over $600 billion in 2030.

Now the tax side we haven't talked about too much. It is similar to the productivity improvement item. There is a new payroll tax here on wages for the Medicare program as well as nonwage income for Medicare, supposedly going to apply to everybody above $200,000 a year if you are an individual, $250,000 if you are a couple.

Chairman RYAN. That is unindexed $250,000?

Mr. CAPRETTA. That is unindexed, not even to the CPI. It is the same number in perpetuity. Okay? So, by 2030, this will not be $250,000 in today's income. The $200,000 number will erode to about $130,000. So you are talking about pushing more and more middle-class wage earners into this tax, generating huge revenue in the second decade. That is how they get to the deficit reduction.

Chairman RYAN. Like the AMT, correct?

Mr. CAPRETTA. Correct.

Chairman RYAN. I can go on and on. I want to be generous with everybody else's time.

Mr. Van Hollen.

Mr. VAN HOLLEN. Thank you, Mr. Chairman.

Mr. Van de Water—thank you all for your testimony. I just want to go over some of the points you raised and dig into a little more detail, because a lot of the talk around here has been based on the CBO's deficit reduction numbers. We didn't have CBO here today. Instead, we had the chief actuary of CMS, Mr. Foster, who did a good job. But I think we should also focus on this deficit reduction issue, and his testimony was pretty clear. I don't know if you were here when he walked through the example of if you increase the Medicare payroll tax, $100 comes in. He pointed out that, in fact, that $100 is $100 towards deficit reduction. Were you here for that?

Mr. VAN DE WATER. Yes, I was, sir.

Mr. VAN HOLLEN. And he clearly stated right here on the record that that is not a gimmick. Were you here for that?

Mr. VAN DE WATER. Yes, I was.

Mr. VAN HOLLEN. So our colleagues on the committee on the Republican side of this committee put out a chart where they put the Medicare double-counting gimmicks under the rubric of deficit reductions. But there are separate points, aren't they, with respect to double-counting and the Medicare Trust Fund versus counting toward the deficit?

Mr. VAN DE WATER. Yes, sir. I think that is a very good way of explaining it. This discussion about so-called double counting I think has succeeded in complicating what is basically a pretty simple situation.

The primary issue that is being discussed is what is the effect of the health reform legislation on the Federal deficit? That is what the CBO cost estimate addresses. And one can determine quite readily by looking at the estimate itself whether any particular item is being counted twice. And if you look at the estimate, you would find quite clearly that that is not the case. As I have sometimes joked, if there is one thing that the CBO is good at, it is doing arithmetic.

Mr. VAN HOLLEN. Thank you.

Let's just go to a couple of other items on this chart that was put out by the majority on the Budget Committee. Let's go to Social Security taxes, because that relates in some ways to the conversation we are having, except on the Social Security side.

Mr. VAN DE WATER. It is exactly the same issue.

Mr. VAN HOLLEN. And there what it is as a result of something we should talk a little bit more about, which is that there is a greater tax on some of the very high costs, what we will call Cad-

illac plans that some employers will choose to reduce the amount of compensation paid their employees in the form of health care benefits and increase it in the form of wages, correct?

Mr. VAN DE WATER. Yes, that is correct.

Mr. VAN HOLLEN. And in fact the chairman is not here. But under one of his plans he also eliminates the so-called tax expenditure for health benefits, correct?

Mr. VAN DE WATER. Yes.

Mr. VAN HOLLEN. So we, under this plan, do that, but we phase it in over a longer period of time, and we don't totally eliminate it, correct?

Mr. VAN DE WATER. Correct.

Mr. VAN HOLLEN. So that is new wages. And then there are FICA Social Security taxes on those new wages, correct?

Mr. VAN DE WATER. Yes.

Mr. VAN HOLLEN. And those are new income to the U.S. Government, right?

Mr. VAN DE WATER. Yes.

Mr. VAN HOLLEN. Ergo, that is deficit reduction, correct?

Mr. VAN DE WATER. Yes.

Mr. VAN HOLLEN. All right. So that is Social Security taxes, not gimmicks. It goes to deficit reduction.

Now let's go to the appropriations issue that the majority has raised. Are you familiar with that issue?

Mr. VAN DE WATER. Yes, I am, sir.

Mr. VAN HOLLEN. Now, under the bill, the CBO estimates that there are about $115 billion of government funding required to implement the reform, is that right?

Mr. VAN DE WATER. Not exactly. There are $115 billion in authorizations over 10 years included in the bill. But a lot of that, however, is, well, very important, desirable programs, not items that are absolutely, positively essential to implement health reform. The parts that, in my view, are the essential implementation pieces are much, much smaller. It is the amount that the Department of Health and Human Services and the Treasury Department will require to administer the new law, and CBO says that those pieces are only in the order of $10 billion to $20 billion over the first 10 years.

Mr. VAN HOLLEN. All right. And that is the point I wanted to get at. And much of that is already authorized under current law, isn't that right?

Mr. VAN DE WATER. Absolutely. And, moreover, as you members well know, often things get authorized and not appropriated.

Mr. VAN HOLLEN. Right. And that money will be subject to the appropriations process here; and all of our colleagues, Republicans and Democrats, will have a chance to vote on whether or not to have that funding, correct?

Mr. VAN DE WATER. Yes.

Mr. VAN HOLLEN. Okay. Thank you.

Now with respect to—were you here for Mr. Foster's testimony about the doc fix numbers and how, even if we had never heard of the health care reform bill, we would still have to deal with that issue?

Mr. VAN DE WATER. Yes.

Mr. VAN HOLLEN. All right. The last issue—and on the CLASS Act, I think there are some fair issues that have been raised on some of the timing issues. And it is for that reason, actually, that it wasn't included under the pay-as-you-go rules. It was treated separately as part of this bill. So maybe we can have a discussion about the long-term impact of that, although it is unquestionable that it leads to deficit reduction in this time period, isn't that correct?

Mr. VAN DE WATER. Yes.

Mr. VAN HOLLEN. So, again, I appreciate it. Because this hearing was largely convened to try to rebut the notion of CBO's deficit numbers; and I think it has been pretty clear through the testimony of Mr. Foster, as confirmed by you, that what they put under the category of gimmicks is, in fact, legitimate deficit reduction. Do you agree?

Mr. VAN DE WATER. Yes, I do.

Mr. VAN HOLLEN. All right. Thank you.

Mr. ROKITA [presiding]. Thank you, Mr. Van Hollen.

The chair claims a bit of time.

I would like Witness Capretta to respond to a few things, if he could.

First of all, this double-accounting issue. I enjoy baseball. I have played baseball. It seems to me the analogy made by Mr. Van de Water is less than perfect, and I wanted you to comment on that.

And, secondly, I would like you to comment on this repeal of the tax exclusion issue, if you would, please. Given your experience, I don't want to be——

Mr. CAPRETTA. Sure. First, on the double-accounting issue, I think if you listen carefully to Mr. Foster—I know everybody did—but, actually, when you strip it all away, he said what is happening here is we are spending the $1 twice. That is what is happening because of the accounting conventions. The same dollar is being spent twice by the bill the way the trust fund accounting works. Okay? It is being used to pay for, under PAYGO, a new entitlement program, and it is being used to pay future Medicare claims.

Now he is saying that that is just a current law convention that has been in place for a long time, which is true. But to say that the same dollar is not being spent twice is not true. It is being spent twice. That is why it is double counting.

Now, CBO did—as the chairman, Chairman Ryan, already articulated, the point of bringing this up is that you can only spend the money not once, not twice. And if you want to claim it for deficit reduction, fine. It should be applied entirely to deficit reduction, not to spending on a new entitlement program.

If you had done Medicare reform, saved all the money, reduced the Nation's debt, sort of improved the fiscal position of the government to pay future Medicare claims, that would have spent the money once. That would have been really save savings, and you would have actually improved the ability of the government to pay Medicare in the future. That is not what happened. So that is why it is double counting.

Secondly, one way to get a view into this a little bit is to get a look at something that is coming up in the next few months, which is debt subject to limit, right? Now we have two different kinds of

debt. We have debt held by the public and we have debt which is held by the public plus governmental trust funds.

If you look at what has happened under the bill, according to CBO, using the same numbers that everybody has been talking about today, debt subject to limit, this bill will make that go up faster than it would have under prior law because it is issuing more debt to the Medicare Trust Fund. Okay? If we had saved all of the Medicare cuts, that would not have happened. We would have not increased debt subject to limit under the bill. So we have double counted the money. We are going to spend it twice, and debt subject to limit is going to go up from this bill, not down.

Mr. ROKITA. Thank you, sir. Sounds like a gimmick to me.

Repeal of the tax exclusion.

Mr. CAPRETTA. Oh, pardon me. You asked that as well.

This is really ironic, actually, that this has come up here. A couple of things to say about that.

First is that the new tax is a tax on high-cost insurance plans, and it doesn't start until 2018. But once it starts, it is going to be indexed at a very low rate. So the threshold will be about $27,500 for a family coverage plan in 2018, but then in 2019 and 2020 and 2021 and beyond, that $27,500 number will only go up by consumer inflation, not by health care costs. It is all factored into that revenue number I was showing before. By the end of a 10-year period this new tax would apply to a lot more people than it would if it had been indexed to health care costs generally.

It is a huge revenue item. I agree with Mr. Van Hollen. It would actually raise a lot of money if it was in place.

But I think there is something to be questioned here. We start the new entitlement here in 2014, large expansion in entitlement programs in 2014. Because of political reasons, they delayed the tax until 2018. Actually, the current President will never actually collect this tax. Even if he is re-elected for a second term, it will be collected by another President. It is so controversial that people that are opposed to it in the first place are already promising to get rid of it entirely. I am very worried that this revenue will never materialize.

Mr. ROKITA. Thank you, Mr. Capretta. I am going to use the questions I asked you as my questions as a member and then go right to questions from the other side.

Ms. Schwartz. Thank you.

Ms. SCHWARTZ. I appreciate the opportunity to talk about how we are going to go forward in the future. I think the notion—and I think Mr. Van de Water mentioned this—is sort of the supposition of this whole hearing is that we can't trust the CBO, and you can't actually believe that the law, as written, is ever going to be implemented. Well, if that is actually the case, then how do we ever go forward on anything? I think that was sort of mentioned.

I mean, the point was just made that we expect that there will be new revenues and cost savings, but, in fact, we don't trust any of them. But what is happening here, I have to say, is that the notion that we should therefore just repeal this law and go back to nothing and our conversation—not only did we work on this for 2 years and incorporate a lot of different ideas to save costs for businesses and for the government and for families, but, you know, we

have been talking about this for three decades. And I would imagine from every State point of view, every family, and every business and from the Federal Government, we really look at a way forward to create the consumer protections, the patient protections that we have talked about on our side this morning for existing condition coverage for children, covering your young adult children. We can talk about all of those.

But the opportunity to pay for the donut hole rather than see that just be deficit increases, that was talked about. I think we heard $7 trillion over 75 years if we repeal this bill and do nothing. The innovations in payment and delivery system all would be repealed. So even if you say, I don't know how much it is going to save, I don't know how much greater quality and efficiency would be accomplished, we don't want to do any of them is kind of stunning I think in a way, just because we are not exactly sure how many billions of dollars we will save. It could be many billions or just a few billions. But not to do any of it because we are not exactly sure is somewhat astounding.

Of course, leave on the table the 50 million Americans who mostly show up in the ER and use health care so inefficiently—and all the employers, I know that we have talked about before, who are seeing 10, 20, 30, 40 percent increases from one year to the next who will look at this legislation and say, will I continue to provide actually this law, health coverage for my employees, or not? What works best for me?

What didn't get mentioned when that question came up was that in Massachusetts the one experience we have, as was mentioned, the fact is that, even with a much smaller penalty—I think it was $500 or $700 a year if they didn't provide coverage—that is just an increase in the number of employers who paid health coverage for their employees. It was the expectation that they would as well as a way to attract employees, and there was employer pressure to do it. So that was mentioned as the one experience that we have.

So the notion that they are going to drop this and lose the tax benefits, which they do, the government sees more money that will then be able to be used for the exchanges. Opportunity for new primary care doctors, being able to provide the right kind of care. I mean, almost everybody agreed on that, that we ought to do more about that. We do that in this law.

So I are think that really the only question that I have is for Mr. Van de Water, that I would say, is it truly better to set aside all these consumer protections, all these opportunities for lower cost for businesses and families? The cost savings to the government the CBO has scored and even Mr. Foster talked about could definitely occur and start all over again, take another decade or so to figure this out and just let Medicare not see some of these benefits and reductions and not see individuals and families or employers see these benefits. That is really what we are looking at.

So I would just ask you as to whether you want to make a statement about that, about whether we should proceed to do everything we can to have this law work for the American people or should we just set it aside and—which isn't going to happen—or keep talking about setting it aside and not encourage the use of all the tools that are in this law to reduce costs and to improve quality and effi-

ciency and cover more Americans. That is really the choice we have.

Mr. VAN DE WATER. I definitely agree with you on that.

In your discussion with Rick Foster earlier, you listed all of the major cost control provisions that are in the new legislation. I think it was Mr. Blumenauer—I am not sure—who referred to the letter that a number of economists issued. I happened to be one of them which identifies some of the really important cost control elements in the Affordable Care Act; and I do believe that it would be far better to proceed to see what works, to move expeditiously to implement those things that do, to move equally expeditiously to get off of those things that don't, and to make progress in the direction of cost control.

Mr. ROKITA. Thank you, Ms. Schwartz.

Mr. Mulvaney for 2 minutes, and then we will adjourn.

Mr. MULVANEY. Very briefly, because we have to go over and vote. So I will keep my question very short and start it with Mr. Smith. But anyone should feel free to kick in.

Mr. Smith, I appreciate your testimony regarding what it is going to cost Wisconsin. My understanding in talking to my folks back home in South Carolina is that our number is about $900 million. So we feel your pain.

Here is my question: When you gave your testimony today about the number of folks who will drop off of the private health care systems and fall into Medicaid, which the State is partially responsible for, was the number that you gave us, did that consider that math in coming up with that number?

Mr. SMITH. Yes. We assume that there are shifts among this population.

Mr. MULVANEY. So my follow-up to anybody on the panel is, did the CBO do the same thing? Did the CBO assume that a certain number of people were going to fall off of private care and onto Medicaid when it scored this bill?

Mr. SMITH. There is some assumption. But the assumption about the employer, they assumed very little employer drop mainly because of the experience in Massachusetts. I would reflect that Massachusetts' experience was when economic times were relatively good. Without additional Federal subsidies—I mean, to use Massachusetts as a model I think is questionable because the economic times are totally different and these huge new Federal subsidies are——

Mr. MULVANEY. And the bigger issue—and I don't want to cut you off—Mr. Van de Water, I will let you comment on this one, but we are running out of time—is did the CBO score the cost to the States?

Mr. VAN DE WATER. Yes, it did, and that was exactly the point that I was going to make, that both CBO and Mr. Foster, the Medicare actuary, have almost exactly the same estimate for the additional Medicaid cost to the States over the first 10 years, approximately $20 or $21 billion, which is only about 1 percent of State Medicaid costs and is much, much less on a national basis than the numbers that are being cited by Mr. Smith. So there are some serious questions about how Mr. Smith's numbers comport with the estimates both to the Medicare Actuary and the CBO.

Mr. SMITH. If I may, again, whether it is coming out of the State budget or the Federal budget doesn't really make too much difference to the taxpayer.

Mr. MULVANEY. That is my point. Sooner or later somebody is going to have to pay for it. If these numbers are wrong in Wisconsin, but I understand they were generated by a previous Democrat administration, then we have evidently made the same mistake in South Carolina. My guess is that if you go around the country, not everybody is making the same mistake.

Thank you, gentlemen. We do need to go.

Chairman RYAN [presiding]. Two minutes to each. How does that sound? Because these gentlemen are busy.

So let's go to Ms. Kaptur and then to Mr. Pascrell.

Ms. KAPTUR. Very good.

Gentlemen, thank you for your testimony.

Mr. Smith, how long have you been with the State of Wisconsin as Secretary of Health and Human Services?

Mr. SMITH. About 3 weeks, ma'am.

Ms. KAPTUR. About 3 weeks, okay. And may I ask, prior to that, could you state your career history?

Mr. SMITH. Most of my career has been in public service. I spent most—I have spent almost 8 years running the Medicaid program at the Federal level, the Centers for Medicare & Medicaid Services. So Rick Foster was a colleague during that period of time, ran the Virginia Medicaid program, various State and local—and have worked on the Hill as well.

Ms. KAPTUR. Okay. And would you know at this point the major Wisconsin insurance plans that operate either in the region you are working in Madison or Statewide?

Mr. SMITH. I am learning them at a time. Our regions—again, our markets are very different from the northern region to southeast. I am learning those markets now. We have a very competitive market in the individual market. Our top company in terms of the individual market as a percentage of premiums is only 12 percent.

Ms. KAPTUR. What is that company, sir?

Mr. SMITH. I believe it is Blue Cross. But 12 percent as being the top suggests that we have got great competition, and we want to protect it.

Ms. KAPTUR. All right. Let me just say to Mr. Capretta, does your organization receive any outside funding for its support, the policy center that you represent?

Mr. CAPRETTA. We are funded, of course. We get funding from philanthropies, from some corporations.

Ms. KAPTUR. Are any of these insurance related?

Mr. CAPRETTA. I don't think so. I can check for the record, but I don't think so.

Ms. KAPTUR. All right. If you could provide that.

[The information follows:]

The Ethics and Public Policy Center has not received funding from health insurers in its current fiscal year (which began in July 2010). In our 2009-2010 fiscal year, the support that we received from insurance-related sources amounted to about 1 percent of our expenses for the year.

Ms. KAPTUR. I wanted to ask Mr. Smith, are you aware of a company called the United Health Group? Do they function in Wisconsin.

Mr. SMITH. They do. Yes, ma'am.

Ms. KAPTUR. All right. Are you aware that their CEO in 2006 got the largest corporate parachute in the history of corporate America, walked away from his company with $1.1 billion? I wanted to ask you, do you think that is egregious?

Mr. SMITH. Again, I have no judgment on what the shareholders——

Chairman RYAN [continuing]. If we are going to make this vote.

Mr. SMITH. Again, my concern in Wisconsin is, the PPACA could consolidate the health care market and reduce competition. It is the large corporations who always have the grace—advantage when something like this comes along because they have the margins and squeeze out the smaller firms, and that is what I want to avoid.

Ms. KAPTUR. I agree that it is a competitive marketplace. That is my key objective as well.

Chairman RYAN. Mr. Pascrell.

Mr. PASCRELL. If indeed Wisconsin, Mr. Chairman, has true competition, then wouldn't your citizens in Wisconsin—and I am asking this rhetorically—be getting more value for your dollar, not less in comparison to other States? Could you explain why the annual Wisconsin health insurance cost ranking report released in December states the following: Every region of the State of Wisconsin has suffered higher health insurance hyperinflation than the national average. Wisconsin's health insurance premiums have increased, Mr. Chairman, 198 percent over the last decade compared to 130 percent nationally. How do you explain that?

Mr. SMITH. I am not familiar with the data, sir. I don't have an explanation.

Mr. PASCRELL. I am not making these numbers up, I can assure you, Mr. Smith. It comes right from the annual report, the annual Wisconsin health insurance costs.

And, secondly, you mentioned in your testimony several times about the importance and significance of creating jobs, correct?

Mr. SMITH. Yes, sir.

Mr. PASCRELL. Yet your Governor just sent back $900 million on high-speed rail, money of which went to Iowa and Illinois, 15,000 jobs down the tubes. How do you explain that?

Chairman RYAN. Let me just interject. He is the Secretary of Health Services. He is not the Secretary of Transportation.

Mr. PASCRELL. I know. I am making a point here because the criticism from the noble other side is that this is a job killer. And it is nice to use words like that. But we need to be talking out of one side of our mouth, don't you agree with that?

Chairman RYAN. I appreciate it, and I would say that that 15,000 number is a real bogus number. We can rescind that money so it doesn't go anywhere so we can get this debt under control.

Mr. PASCRELL. It is going to Iowa and Illinois.

Chairman RYAN. Is the gentleman done?

Mr. PASCRELL. Thank you, Mr. Chairman.

Chairman RYAN. Thank you.

Only because we have 9 seconds left in this vote, we need to wrap this thing down. The three of you, thank you very much for taking your time and for your indulgence and for your testimony. I appreciate it.

This hearing is adjourned.

[Whereupon, at 1:30 p.m., the committee was adjourned.]

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