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HEALTH REFORM: LESSONS LEARNED DURING THE FIRST YEAR

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

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HEALTH REFORM: LESSONS LEARNED DURING THE FIRST YEAR

WEDNESDAY, MARCH 16, 2011

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:12 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Bingaman, Kerry, Wyden, Nelson, Menendez, Carper, Cardin, Hatch, Grassley, Snowe, Roberts, Ensign, Cornyn, and Thune.

Also present: Democratic Staff: Russ Sullivan, Staff Director; David Schwartz, Acting Chief Health Counsel; Chris Dawe, Professional Staff; and Callan Smith, Research Assistant. Republican Staff: Chris Campbell, Staff Director; Jay Khosla, Chief Health Policy Advisor; and Kim Brandt, Chief Health Care Investigative Counsel.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The hearing will come to order.

Abraham Lincoln said, "You cannot escape the responsibility of tomorrow by evading it today." Health reform looked ahead to the responsibility of tomorrow. It asked, will quality, affordable care remain accessible if costs continue to rise?

Health care reform took responsibility for tomorrow by solving the challenges of today. It protected one of our most important responsibilities: Medicare. One year ago, Medicare was set to go bankrupt in just 7 years. Health care reform extended the life of the program by 12 more years, until at least 2029.

A year ago, Medicare only paid health care professionals to provide care when seniors were sick. Medicare, too often, was a system that only treated sickness, and that meant it was costly. We knew these costs were over-burdening Medicare and our entire health care system. We spent nearly 2 years studying the problems. We worked together to craft a law that lowered costs and shifted the focus of our system to prevention and wellness.

Today, Medicare does not just care for you when you are sick; it is a true health care system. Under the health care reform law, seniors receive an annual wellness visit. Seniors can schedule a visit, even if they are not sick. They can receive screenings and tips on how to manage and prevent conditions like diabetes or high blood pressure.

Madam Secretary, I look forward to hearing from you today about how these visits are working for seniors. A year ago, seniors faced a Medicare program that focused on the quantity of care they received, and not the quality of the care they received. Medicare paid hospitals more if the patient got an infection that could have been avoided, and paid hospitals less if they successfully avoided infections. A year ago, each of a patient's doctors would perform the same test because they had not been encouraged to work together and share results.

Health reform increases payments to hospitals for providing high-quality care. The law gives hospitals incentives to prevent avoidable illness. And the law improves quality by increasing the number of primary care physicians. These doctors can better keep track of patient care. They can make sure patients are seeing the right specialists, and they can help specialists avoid repeating tests, procedures, and options that have already been completed or considered.

To encourage primary care, the Affordable Care Act pays doctors more to practice primary care. That is already producing results. Dr. Tom Roberts, who has been an internist in Missoula, MT for 30 years, said health care reform has "already had a direct impact on our ability to provide good medical care for the citizens of Missoula and surrounding counties." Then he added, "We are in a much better position to continue to support the kind of primary care services that are vitally important moving forward."

A year ago, seniors had to pay more for their prescription drugs, and that meant seniors did not always get the treatment they needed. The Medicare prescription drug benefit covered the first $2,800 in costs, and catastrophic coverage kicked in after seniors spent $6,300. But there was a coverage gap in between, often called the "donut hole."

Today, health care reform is closing that gap in coverage. Already, more than 3.5 million seniors received a check for $250 that helped cover the cost of their prescriptions in 2010. This year, seniors who hit the donut hole will receive a discount of 50 percent off the cost of their prescriptions, and the gap will be eliminated entirely by the year 2020.

A year ago, the standards to prevent waste, fraud, and abuse in Medicare were not tough enough. As a result, criminals were able to rip off Federal health care programs. Too often, these programs paid fraudulent claims without enough review. The new health reform law provides enforcement officials with unprecedented new tools. These tools prevent fraud before it occurs.

Because of the changes in the Affordable Care Act, Medicare is stronger than ever. But now we face new challenges. We face those who want to roll back these benefits and weaken Medicare. So let us continue to confront the challenges of tomorrow. Let us continue to protect and strengthen Medicare today.

[The prepared statement of Chairman Baucus appears in the appendix.]

The CHAIRMAN. Senator Hatch?

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH

Senator HATCH. Thank you, Mr. Chairman, for helping to schedule this very important hearing. It comes on the anniversary of the Patient Protection and Affordable Care Act becoming law.

Now, whether this is a welcome anniversary depends on one's perspective. When I listen to my fellow Utahans and Americans from coast to coast who were left footing the bill for this misguided health law, I get a very, very different assessment. For struggling families, any marginal benefits from this law are far outweighed by the heavy-handed intervention in their health care by, you guessed it, Washington bureaucrats.

For seniors, the cuts to a Medicare program that is already nearing bankruptcy in order to fund another new entitlement and expand an existing one are beyond irresponsible. For taxpayers, the decision to pay for this law with over $813 billion in tax increases was the last thing that our struggling economy needed.

The more Americans get to know this law, the less they like it. In the end it may have been over 2,000 pages long, but Americans understood it both simply and soundly. In short, at the President's urging, Democrats passed a $2.6-trillion health care law, with massive new subsidies for coverage and without addressing the long-term costs of care. All of this is paid for with billions in new taxes and by taking from an already struggling entitlement.

This simple understanding is closer to the mark than that of the supposedly sophisticated who sold this massive spending bill as somehow saving money. Citizens understood that the historic expansion of Federal power and the creation of new bureaucracy would never increase efficiencies and make health care more accessible.

So, one year later, what do we know about this law? What has it given us? As it turns out, the American people are closer to the mark than all of the liberal editorialists who pushed for this law: $2,100 in higher premiums; 800,000 fewer jobs; $118 billion in new unfunded State mandates on top of the $175 billion that the States were already in the hole; $311 billion in higher health care costs; $529 billion in Medicare cuts to fund new entitlement spending; $813 billion in new taxes; and $2.6 trillion in new Federal spending.

It would be hard to devise a more economically destructive piece of legislation. Just last week, the Congressional Budget Office concluded that "growth in health care costs will almost certainly push up Federal spending significantly relative to GDP under current law."

So much for bending the cost curve. And let us keep in mind that all of this damage comes before the Medicaid expansions and the new premium subsidies for the health law's insurance exchanges. Now, it is reasonable to assume, given the history of Federal spending programs, that the original cost estimates for these coverage expansions are substantially understated.

Yet Americans' opposition to this law is not only owing to it being bad policy. In the eyes of citizens, its original sin was its lack of transparency. Americans understood that the true cost of this health law was being hidden from them.

According to the President's budget, a permanent fix to Medicare's Physician Payment formula will cost taxpayers nearly $370 billion over the next 10 years. That is in addition, by the way. But, instead of fixing this problem, the health law cut $529 billion from Medicare and directed it toward new entitlement spending that is itself unsustainable. This was simply irresponsible.

But it was also misleading, as it double-counted the savings from Medicare. The chief Medicare actuary, the administration's own Chief Actuary, was crystal clear on this point. He said, "In practice, the improved Part A financing cannot be simultaneously used to finance other Federal outlays, such as the coverage expansions under PPACA, and to extend the trust fund."

Now, this double-counting and lack of transparency on costs that stained the health law and its origins continued as the administration sought to implement the new law. According to the Congressional Research Service, roughly 83 percent of the final rules implementing the health law circumvented public comment, which is generally required by Federal law.

I guess this administration's pledge on transparency simply became another slogan that was discarded when it became an inconvenience in implementing their agenda. Just yesterday, my colleague Senator Enzi and I reminded the administration of its troubling failures when it comes to briefing Congress on the health law's implementation. This includes a failure to respond to nearly 67 percent of Republican requests. One year later, with its flaws only more evident, I suspect it is starting to dawn on more members of this body as well.

I want to thank our chairman again, as well as our witnesses for appearing here today. I do look forward to today's testimony and what should be a lively question and answer session. Thanks, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

[The prepared statement of Senator Hatch appears in the appendix.]

The CHAIRMAN. I am now pleased to welcome three witnesses. Actually, they are on two separate panels. First is our Health and Human Services Secretary, Kathleen Sebelius. She will appear on our first panel.

Our second panel will feature Dr. Paul Van de Water, senior fellow at the Center on Budget and Policy Priorities, and Dr. Douglas Holtz-Eakin, president of the American Action Forum.

I would remind all of you to please keep your statements fairly short—5, 6 minutes. For you, Madam Secretary, you can maybe go a couple, 3 minutes longer; it is up to you. Your statement will automatically be in the record. For the other panelists, I encourage them to stick within the 5 minutes. Thank you very much.

Madam Secretary, it is an honor to have you here. This is the first anniversary, and there will be many, many more as, at each one, we look forward to progress. Thank you very much for appearing before us.

STATEMENT OF HON. KATHLEEN SEBELIUS, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Secretary SEBELIUS. Well, thank you, Chairman Baucus and Ranking Member Hatch, and members of the committee. It is good to be back with you at the Finance Committee to discuss the Department's implementation of the Affordable Care Act during the last year.

In the year since the Act became law, our department has worked closely with Secretaries Geithner and Solis, with Governors, with State insurance commissioners, with doctors, nurses, and other health care providers, with consumer and patient advocates, employers, health plans, and other stakeholders to deliver the law's key benefits to the American people.

In that time we have had the opportunity to see the law through the eyes of the people who are being helped every day, people like John Bartell from Colorado, who was able to afford his hip surgery after joining a pre-existing condition plan, or Jenny Bass from Connecticut, whom I met with here in DC, whose family was able to keep their farm, in part because of the action her State took to block unreasonable insurance rate increases.

Earlier this year, President Obama laid out a vision for how America can win the future by building on a foundation for long-term growth that will allow families and businesses to thrive. The Affordable Care Act is an essential component of that growth.

My written testimony provides more detail, but I want to quickly highlight the ways that the Affordable Care Act is already delivering a stronger and more sustainable Medicare for the 45 million people Medicare serves.

Yesterday, Attorney General Eric Holder and I were in Detroit, holding one of our series of fraud summits to continue the focus on stamping out waste, fraud, and abuse in Medicare and other health care programs. We are continuing to build on the success of recent years, including the record $4 billion in recoveries made in fiscal year 2010.

Now, those efforts are helped immeasurably by the new resources and authorities granted by the Affordable Care Act. The important changes have begun to produce savings for taxpayers and have extended the life of the Medicare trust fund, and they give us tools to build a state-of-the-art data system for prevention and tougher penalties for prosecution.

Thanks to the Affordable Care Act, Medicare beneficiaries also enjoy better quality care, better access to care, and a more patient-centered care delivery system that helps to improve outcomes and reduce costs.

We provide immediate assistance to people struggling with high prescription drug costs. As the chairman said, we have had over 3 million seniors and other beneficiaries who have reached the premium Part D donut hole last year and received a one-time $250 rebate check. One of them, Lester Pross from Kentucky, wrote to me that he took his $250 right to the pharmacy to help pay his bill.

Now, this year, those beneficiaries who reach the donut hole receive even greater assistance, with a 50-percent discount on brand-name prescription drugs purchased over the year. The full cost of

those drugs is also counted toward the amount a person needs to get out of the gap, substantially narrowing the gap in Part D coverage. Many of the individuals this will help are people living with chronic conditions. The assistance is critically important to them and their families, as we hear every day.

At the same time, Medicare beneficiaries are now receiving critical preventive services in an annual wellness visit that is now part of their overall Medicare benefits. As of February 23, nearly 152,000 people have seen their doctors for one of these wellness visits, and that benefit just started in January of this year. We are convinced that the investment in prevention and wellness will help people with Medicare stay healthier and reduce their costs going forward.

This year, HHS has also improved its oversight and management of the Medicare Advantage program. We have had more tools to negotiate with, and those efforts are paying dividends for seniors and for the trust fund. Now, according to the MedPAC report issued just on the 15th of March, we currently have about 11.4 million beneficiaries enrolled in Medicare Advantage, 24 percent of the overall beneficiaries, the highest number ever. That enrollment is up 6 percent in 2011.

The good news for the beneficiaries is that premiums are down 6 percent. Access to Medicare Advantage remains strong, with more than 99 percent of Medicare beneficiaries having a choice of Medicare Advantage plans as an alternative to original Medicare. Those trends actually fly in the face of the predictions that were being made during the course of the debate of the Affordable Care Act, that the Medicare Advantage program was being harmed.

Perhaps the area with most promise is our work to improve quality and safety of care for people with Medicare. Over the years, beneficiaries eligible for Medicare and Medicaid, known as the so-called dual-eligibles, have been a large driver of cost in the health care system. The population makes up just a sixth of Medicare beneficiaries, but it counts for well over a third of the cost.

Now, there's been historically a terrific lack of coordination between the programs, which too often leads seniors to being readmitted to hospitals and seeing multiple providers. By expanding their access to primary care and to specialists when they need them, we know we can keep seniors healthier and lower their costs also. So the Affordable Care Act established a Federal coordinated health care office to better coordinate the care provided to this population.

In December, we announced that States can apply for resources to support the design of new demonstration projects that integrate the full range of care, support, and service that dual-eligibles receive, reducing waste, lowering costs, and improving outcomes.

In addition to strengthening Medicare for those who need it today and protecting it for our children and grandchildren tomorrow, the new law is also continuing to strengthen the economy. The Congressional Budget Office, again, recently confirmed that the new law reduces the Federal deficit by $230 billion over the next decade, and by more than $1 trillion by the end of the following decade.

Over the last year, our department has focused on working with Congress and our partners across the country to implement the law quickly and effectively. In the coming months, I look forward to working with all of you to continue those efforts and make sure that Americans can take full advantage of all that the law has to offer.

Thank you again, Mr. Chairman, for inviting me back to the Finance Committee. I look forward to our conversation.

The CHAIRMAN. Thank you, Madam Secretary, very much.

[The prepared statement of Secretary Sebelius appears in the appendix.]

The CHAIRMAN. I would just like to go over three provisions which are helping Americans. I will give it back to you, the ones that you think are most important that have helped Americans the most, early on. It can be the donut hole, it can be the age 26, it can be more efficient Medicare Advantage, it can be the wellness visits.

But just what do you think has really made a difference here, the couple, two, or three things that it is important for Americans to know about? I suspect, frankly, that a lot of Americans just do not know about some of the benefits of the legislation. So I would like you to just tell people what they are.

Secretary SEBELIUS. Well, Mr. Chairman, I think there is no question that some of the early insurance changes have helped particular categories of folks, folks who are locked out of the market with pre-existing health conditions, have a high-risk pool. Families now have the opportunity to get health insurance for their children with pre-existing conditions. Families can keep a young adult on a family plan. Prevention is being pushed and promoted across the country. That is a big change.

I think addressing for the first time the underlying drivers for health care costs, with delivery system changes that are about to really take hold, everything from the Accountable Care Organizations to our work with the dual-eligibles, can be enormously helpful not only to those Americans without insurance coverage, but to all Americans who really should deserve higher quality care at a lower cost. We now pay for volume, we do not pay for value. That change is under way and holds huge promise to addressing the deficits in our system.

Finally, I think, Mr. Chairman, the third category probably is the overall assistance that it will make to ordinary Americans who no longer will face bankruptcy because of a health outcome, who will have the peace of mind that they can leave jobs and move throughout this economy without being job-locked by insurance coverage, with the development of the new State-based exchanges. That has not kicked in yet—it does not occur until 2014—but we are working hard with States to have that new marketplace up and running by 2014 and to give those choices to, particularly, small business owners and individuals that they have never had before.

The CHAIRMAN. One of the provisions in the new Act that I think is most important is not well-known either. I think it is sort of the sleeper. It is sort of the stealth provision. It is going to make a real difference. The real key, I think, is to find ways that effectively reduce the rate of growth of costs. Some of these numbers that Sen-

ator Hatch pointed out about cost increases, there are various ways to explain those, but it is somewhat true. I mean, costs are going up. But it is not because of the bill. Actually, the bill is lowering the rate of increase in the growth of costs.

But that does not answer the problem or solve the problem. We still have to lower the rate of growth of costs much more than we already have. I do believe that there are a lot of provisions in this bill which will help accomplish that result, but one of them is delivery system reform.

Secretary SEBELIUS. You bet.

The CHAIRMAN. And it is Accountable Care Organizations, all of that. If you could give us a little accounting of how far along you are, how this committee could help you proceed further. Because that, in 3 years, I think is going to pay rich dividends in terms of lowering the rate of growth of health care costs in this country. If you could just give us a little idea. Do not pull any punches. Tell us what needs to be done, and how well you are doing.

Secretary SEBELIUS. Well, Mr. Chairman, the $500 billion that Senator Hatch referred to, as you know, is a slowing down of the growth rate of Medicare, it is not a cut to the overall Medicare spending. It is an attempt to slow down the growth rate. It was projected to be about an 8-percent growth rate. This now is projected to be at closer to a 6-percent growth rate, and I think, if you look at the long-term deficit projections and the impact that Medicare has on those deficit projections, there is no question that the Affordable Care Act made a significant step toward addressing some of that. A lot of that is based on the projections about the delivery system changes that I think are incredibly important.

I travel across the country a lot, and I talk to hospital CEOs and providers who are wildly enthusiastic about the opportunity to actually receive payment for strategies that will keep people healthier, and not just when they go into a hospital, to do everything from working on hospital-acquired infections, which we know not only kill over 100,000 people a year, but extend hospital stays dramatically and can be dramatically lowered, because it is happening in some systems.

To Accountable Care Organizations—the rules should be available within this month on Accountable Care Organizations. I can tell you, across this country, physicians, the physicians system, hospital organizations, are very enthusiastic about participating in strategies that actually coordinate care, provide better outcomes, and lower costs. That is the whole goal of the Accountable Care Organizations, and they are eager to be a part of it.

The Center for Innovation is going to help us look at strategies for the so-called dual-eligibles, the population whom we know—as a former Governor, 40 percent of Medicaid costs are accountable to these so-called dual-eligibles who qualify for both Medicaid and Medicare, and yet often they have very uncoordinated, very expensive care delivery that really does not yield higher results.

So we have a whole series of tools that we have never had before with the Centers for Medicaid and Medicare, and are implementing those rules, after lots of input from providers across the system.

The CHAIRMAN. I appreciate that.

There are two votes now occurring in the Senate, but I want to keep this hearing going. So, we will have rolling attendance here. I am going to leave. Senator Hatch will take over. There are just going to be a lot of audibles here as to who is going to be chairing and who is going to be called on in the next, oh, about 20, 30 minutes. But thank you very much, Madam Secretary. I will be back.

Senator Hatch?

Senator HATCH. Well, thank you, Mr. Chairman.

Welcome, Madam Secretary. I just want to point out, the $209 billion out of Medicare Advantage is a cut, not a slowing of rates. There is a reason that some have said that enrollment and extra benefits in Medicare Advantage will decline by nearly 50 percent.

Second, health care spending, according to the CBO, post-passage, will increase by $311 billion. Now, this is not my number, this is CBO's.

Let me get to a question. It will take me a few minutes to get to it, Madam Secretary. You have a tough job, I acknowledge that. It is one of the most difficult jobs in government. But last month you testified before this committee and committed to working with Congress to implement this new health law. And while I appreciate that commitment, it stands in stark contrast to the fact that many congressional requests for information about the law are not receiving timely responses. There have been at least 52 congressional requests for information regarding implementation of the health law submitted to your department since the middle of last year, and to date 67 percent of those requests are still awaiting responses.

Now, your department has also still not responded to questions for the record submitted by members of this committee from when you last testified over a month ago. Now, this ongoing failure to provide information to us relating to the implementation of the new law and to respond to congressional inquiries directly undermines Congress's ability to conduct oversight and assess the impact that this law is having on patients, employers, States, and taxpayers.

Now, going forward, will you commit to having your department respond to all congressional requests, including letters and hearing questions for the record, I would hope within 30 days of the request? Can you commit to that?

Secretary SEBELIUS. Senator, I certainly will commit to responding to requests as quickly as we possibly can. We are working diligently to provide volumes of material to both the House and the Senate on a regular basis, and we take transparency and oversight very seriously, and I certainly will remind my staff to be as timely as possible. We want to be accurate, we want to be complete, and we are working hard to do just that.

Senator HATCH. Well, I do not think 30 days is too big a request. I think you ought to try to do that within a reasonable period of time. There is a lot of interest in this health care bill by both those who are for and those who are against it, but I would like to see you do that.

Now, Madam Secretary, States are facing a collective $175 billion budget shortfall, the worst State budget crisis since the Great Depression. The financial situation, as bad as it is for States now—this law enacted the largest expansion of Medicaid since its incep-

tion, covering half of those newly "insured" through this government program.

The Joint Congressional Committee report on State government found that PPACA will cost State taxpayers at least $118.04 billion more through 2023. Now, as a former Governor, I know you can appreciate this terrible burden and costs that are placed on the backs of our taxpayers through State mandates.

Now, I have had the Congressional Research Service look into the waiver provided under section 1115 of the Social Security Act, and they confirmed that you have the appropriate authority to lift the maintenance of effort requirement. Now, will you utilize your authority to help cash-strapped States avoid gutting education, law enforcement, and other State priorities?

Secretary SEBELIUS. Well, Senator, as you know, I am a former Governor, and I know that Medicaid is a significant State expenditure. It is about 16 percent, on average, of State budgets. We are working very, very closely with my former colleagues and the new Governors across the country.

In fact, we have about 17 State teams in place and are in the process of looking at everything from individual 1115 waivers to strategies to lower Medicaid costs. In 2014, when the Medicaid expansion is scheduled to be in place, as you know, the Federal Government is picking up 100 percent of the costs of the newly eligible Medicaid recipients for a period of 3 years, and gradually that cost sharing decreases to a high of 90/10.

Senator HATCH. How is the Federal Government going to do that? I mean, it is broke.

Secretary SEBELIUS. Well, I think that the expansion is paid for as part of the overall health care bill. As you know, this is one of the few acts passed in health care in a long period of time that is fully paid for within the confines of the legislation so that, unlike the Part D prescription benefit, which was not paid for and continues to add to the deficit, the Affordable Care Act is fully paid for.

The other thing, I think, Senator——

Senator HATCH. But even——

Secretary SEBELIUS [continuing]. That is not taken into account when State numbers are looked at is the extraordinarily high cost of uncompensated care, which right now falls onto a lot of States and community hospitals, estimated in 2008 to be over $43 billion. So when we look at Medicaid expansion, I think it has to also be measured against, what is the cost of having uninsured folks miss work, what is the cost on hospital systems of uncompensated care, what is the cost to providers who do not have a payment system at all and who are delivering pro bono coverage? A lot of those costs are currently picked up in State budgets.

Senator HATCH. Well, my time is up. But even CBO said it will cost States an additional $60 billion. State governments are saying $118 billion through 2023. It just does not make sense to me. But my time is up.

Senator Grassley is next, and then after Senator Grassley——

Senator GRASSLEY. Am I next?

Senator HATCH. Well, Senator Bingaman was next, but he is not here. So, you are next.

Senator GRASSLEY. All right.

Senator HATCH. And let me just say, after you will come Senator Wyden.

Senator GRASSLEY. All right.

Madam Secretary, I have three questions I want to ask. I will take a half minute to ask each question, and I would ask you to take 60 seconds to answer each question.

A week ago, your department issued a waiver allowing the State of Maine to waive medical loss ratios applied to insurers. Your Deputy, Steve Larsen, wrote in a waiver letter to Maine that applying the medical loss ratio regulation "has a reasonable likelihood of destabilizing the Maine individual health insurance market." Maine can now use the 65-percent medical loss ratio standard. Why 65? Why not 70, 75? If you are allowing Maine to essentially drive their own medical loss ratio standard, why shouldn't every other State? Why could Iowa not use 75, Utah 73, Montana 68, et cetera, et cetera, if those States determine that, to make that level, that lessens the destabilization of their market? If Maine is essentially driving its own medical loss ratio, why should every other State not have its own?

Secretary SEBELIUS. Senator, it is not a 60-second answer, but I will try to speak quickly. I am sorry Senator Snowe is not here, because she asked me about this the last time I was here. Maine has a particular situation of only two insurers in the market. One has a 70-percent market rate, the other has a 30-percent market rate. I do not know that there is any other State in the country that looks like that.

We have worked very closely with the Maine Insurance Commissioner. We will work very closely with regulators on the ground in other States to look at their particular situation. It was determined in Maine that to uninsure 30 percent of the population at this time before the exchanges were up and running would be a huge disadvantage to those in that population. But we are listening to the regulators. It is a State-wide ratio, and in Maine they have a very particularly small market with a different situation.

Senator GRASSLEY. Madam Secretary, your department has granted well over 1,000 waivers. Yesterday in the House, Steve Larsen testified that 95 percent of the waiver requests you have received have been granted. That is 94 percent. That strikes me as a very high percentage. Can you convince the committee that you are not simply granting nearly every waiver that you get to limit the amount of griping and complaining you get between now and, say, November the 12th? Until you are more transparent with the process, you have earned this kind of criticism.

Secretary SEBELIUS. Senator, the waiver that you are speaking about deals with one section of the Affordable Care Act, and it is the ability of policies to pay out up to $750,000. Again, we were given specific language in the statute about market disruption. We are looking at those cases. Before there is an available affordable option to have an alternative to the so-called "mini-med" policies, the vast majority of them have been granted. Some coverage is better than no coverage.

Senator GRASSLEY. There is a case pending before the Supreme Court commonly referred to as *Maxwell-Jolly*. Madam Secretary, in

a brief filed in that case, the Justice Department asserts that your department will be issuing a Notice of Proposed Rulemaking for section 1396(a), and then some subsections of the Social Security Act next month.

Madam Secretary, given that your actions in writing a regulation here could have a greater impact on the Medicare program than the certainty of the maintenance of effort issue, and perhaps the Affordable Care Act in general, would you commit to this committee to fully brief us before taking action, particularly since the section of law in question you have suddenly decided to write regulations for has been around since 1968 and has not been touched for the last 22 years?

Secretary SEBELIUS. Senator, we will certainly keep the committee briefed as we move forward with the rulemaking process. I am aware that discussions are under way with the Solicitor General about appeals in that case. I know that they have not made a determination, but we will certainly follow the existing protocol with rulemaking.

Senator GRASSLEY. Do you have a regulation about ready to come out? That is the question.

Secretary SEBELIUS. I cannot tell you the status of the regulation. I have not been briefed on the final——

Senator GRASSLEY. Well, then answer the question in writing.

Secretary SEBELIUS. I would be happy to.

Senator GRASSLEY. And brief us according to what you said.

Thank you. Senator Bingaman, I guess.

Senator BINGAMAN. Madam Secretary, thank you for being here. Thanks for your service. This is a very important job you have, obviously, in implementing this new law, and we appreciate the good effort you are making.

Let me ask about Medicare Advantage. One of the big concerns expressed by many of my colleagues who were not in favor of the health care reform bill was that enacting the changes that were contained in it related to Medicare Advantage would be disastrous for people who receive their health care through a Medicare Advantage program. You say in your testimony here that Medicare Advantage enrollment in 2011 is up 6 percent, and average premiums are down 6 percent compared to 2010.

I just wonder if you could explain some of the factors that you think might explain both of those changes. Why would there be more people enrolling in Medicare Advantage now than was the case a year ago, and why would we see a reduction in premiums?

Secretary SEBELIUS. Well, Senator, while the law does not lock companies into delivering Medicare Advantage plans throughout the country, we have a very robust system of Medicare Advantage choices. I think all but 1 percent of Medicare beneficiaries have a choice, and even that 1 percent has a fee-for-service Medicare as an option to traditional Medicare.

We were given some tools in the Affordable Care Act to allow us to negotiate for the rate-setting of Medicare Advantage, and that turned out to be fairly successful in terms of making sure, first of all, that beneficiaries did not pay more out-of-pocket costs, which had been a trend of companies shifting payments onto beneficiaries. And we made sure that companies were not cherry-

picking the market by not providing care for folks who could be more seriously ill.

And finally, we made sure that beneficiaries got the best bang for their buck, so that we were able to negotiate rates that indeed have turned out to be, on average, about 6 percent lower. MedPAC did confirm, in their report 2 days ago, that we have the highest level ever of Medicare Advantage enrollees, about 24 percent. But I think the good news also carries on to the traditional Medicare beneficiaries who have, frankly, paid more for their traditional Medicare because of the over-payment to Medicare Advantage programs.

So gradually, over the course of the Affordable Care Act, that over-payment will be leveled out, and the dire predictions that this would destroy Medicare Advantage, it would get rid of people's options, it would drive companies out of the market, have not been borne out at all by what has happened.

Senator BINGAMAN. Let me also ask about—you talk here in your testimony again about, in 2012, CMS will implement a demonstration that builds on the quality bonus payments that are authorized in the Affordable Care Act. This is, again, for Medicare Advantage plans, as I understand it.

Secretary SEBELIUS. Yes.

Senator BINGAMAN. And the purpose of this is to accelerate quality improvements. You talk about how these enhanced incentives will help to provide a smooth transition as Medicare Advantage payments are gradually aligned more closely with Medicare fee-for-service. Could you describe a little more what those quality improvement efforts are and how you see that benefitting people who are getting their care through Medicare Advantage?

Secretary SEBELIUS. Well, again, Senator, I think in the past it was a plan design, if I am correct about my history, that was to encourage companies to come into the marketplace. So the original strategy was to pay more than traditional fee-for-service Medicare to companies to provide a private alternative. That over-payment, if you will, of about $1,000 per beneficiary was not based on care results, was not based on quality results, it was just a market strategy to draw companies in. After gathering information for years, it has become apparent that there really was not a health/quality differential for the additional dollars spent.

So what the Affordable Care Act does is set up a different structure. It gradually reduces just the general over-payment, but puts in place instead a quality improvement bonus based on outcomes for, particularly, beneficiaries with difficult and chronic conditions, to make sure that Medicare beneficiaries who chose Medicare Advantage plans are indeed getting quality results. It is a 5-star system, as you say. It will be measured.

It is, I think, part of our delivery system transformation, to really begin to look at aligning payment incentives with quality outcomes, encouraging better care to beneficiaries so that this strategy, I think—what we saw this year, beneficiaries are already getting the advantage of seeing the 5-star, 4-star, 3-star ratings. We had an increase in beneficiaries choosing 5-star plans. It is a way that they get more information, and it is a way, I think, that our payment system incentivizes quality.

Senator BINGAMAN. Thank you very much. My time is up.

Senator Wyden?

Senator WYDEN. Thank you.

Madam Secretary, thank you. I appreciate what you and the President are trying to do in terms of giving the States more flexibility. The law, as you know, says that in 2017 a State could get a waiver and set up a plan without an individual mandate, without an employer mandate. There would be considerable freedom with respect to the exchanges, and you and the President have advocated now moving that up to 2014, and there is a bipartisan bill, of course, here in the Senate to do that.

One of the areas that has not gotten much attention, and I want to go over this with you, deals with the fact that I believe fixing the entitlement programs means you have to reinvent Medicaid. You have to reinvent Medicaid to hold down costs and improve quality. To me, that means creating new choices in a remade health marketplace. It seems to me you want to move in that direction as well.

I just want to get this part on the record. My understanding is that you all would support the ideas—we look at reinventing Medicaid—of giving a State the option to say that their poor people could shop for health care coverage on these insurance exchanges. Of course, these exchanges are much like what we have in Congress, and, as we start to introduce choice and competition, poor folks would be brought into that kind of concept as well. I have seen information on the HHS website on this point as well. Could you just outline your thoughts on that?

Secretary SEBELIUS. Certainly, Senator. As you know, Medicaid is really a State/Federal partnership. What I think is occurring across the country is really very encouraging, and not new. States are really eager to implement innovations and are looking at their markets and their populations and their challenges with very new and innovative ideas, and, frankly, new tools that they have never had before.

So I think we are eager and are very much in dialogue with States across the country that are looking at everything from—I mean, we have a couple of States that say they would like to be a State-wide Accountable Care Organization and include all the public and private markets in that plan. We have others that are looking at new strategies, as I said, for the dual-eligible.

What we know about Medicaid is that 5 percent of the Medicaid enrollees account for over 50 percent of the costs, and there are again some very exciting ideas about ways that, not only can care be better coordinated and better delivered, but at significantly lower costs. We are eager to work with States on a whole variety of ideas, but certainly competition is one of them. Some States may open up exchanges. I mean, this is really a kind of State-based dialogue that is under way with some new tools that they have never had before.

Senator WYDEN. I appreciate that. What I have sought, and what Senator Scott Brown has sought, is to be able to say to Governors, look, as long as you hit these targets, you can pretty much do your thing. The President, in effect, said that when he made the announcement to the Governors.

I want to ask you about just one other point that I have been pleased about. My understanding is, you could actually get what amounts to a coordinated waiver. You could get a waiver that would let you out from the individual mandate, let you out from the employer mandate, give you the freedom with exchanges, make the kinds of changes we just talked about with respect to Medicaid and letting people shop.

And this could have benefits for both the private sector and the public sector, because one of the parts of what I have been concerned about is the possibility that employers would say, you know, maybe I ought to pay the fine and get out of health care. My workers can go to Medicaid. Well, with one of these waivers, the employers in a State could get relief from the employer mandate.

A State could have an opportunity to have the freedom to come up with its own system without an individual mandate, get a waiver from Medicaid flexibility. You are receptive to the idea of States having these coordinated waiver applications so we could get benefits to the private and public sector, is that not correct?

Secretary SEBELIUS. Yes, Senator. I think, again, this idea does not become a reality unless there is congressional action, but I can tell you there are already a lot of Governors who are enthusiastically looking at strategies that would fit their State. What, as you know, may work in Oregon may not work so well in Florida, or Kansas, or Utah.

I think the idea is around the goal of insuring the same number of people, not adding to the Federal deficit, not shifting huge costs onto the beneficiaries. If there are strategies that work, public and private, all in, all payer, those are certainly ones that should be discussed at the State level and brought to the waiver process.

Senator WYDEN. My time is up. I only want, both in the Congress and the country, for folks to know that is in the law now.

Secretary SEBELIUS. Yes. As far as the date.

Senator WYDEN. In 2017.

Secretary SEBELIUS. That is correct.

Senator WYDEN. The hope here is, on a bipartisan basis, we can move that to 2014 so the States will not have to do their work twice. I commend you for it.

Senator Roberts?

Senator ROBERTS. I thank my friend and colleague.

Madam Secretary, thank you for being here. I know you have an extremely busy schedule.

I was in Kansas over this past work period, and I talked to our Kansas patients, providers, and advocates, people whom you know and who know you, about the President's executive order. This is the one that is supposed to take care of the regulatory overkill on the cost-benefit yardstick. The President said that they were duplicative, costly, and in some cases just stupid, which I was really encouraged by when I heard about that. But I also heard about, and found out it was not only necessary to read the bill, but to read the regulations, which is a full-time job, which is why I have people behind me who do that and then report to me. But at any rate, I am very concerned about that.

There was a stakeholder roundtable in Topeka. It is the first time I think they all got together. We had everybody, Kathleen. We

had the ambulance drivers, we had the druggists, we had hospice, we had the hospital administrators, doctors, nurses, you name it. It was the first time I think that they all got together and discussed feedback and what they were concerned about. Every representative at that meeting had a concern with regulations, and the sheer volume of that was just extraordinary. I promised them I would summarize them and send them to you, and obviously I hope for a response so we could have a better dialogue.

The number-one concern I heard was a fear of the impact of future regulations, especially those regulations for implementing feedback and their potential to have a further and greater impact on jobs and the economy, and the economy of that provider, whether or not that provider could actually stay in business.

I want to underscore, those concerns were even greater than the impacts that we discussed during the health care debate. As you know, we went to the HELP Committee, we went to the Finance Committee, and then we went to Harry Reid's committee, and then we had the bill. Then we tried to look at it since that time.

It is my understanding that a number of the PPACA rules have been issued as interim final rules, and therefore with limited stakeholder input. That really concerns me. In my letter to the President last week—and I sent it to the President, not to you. I knew it would get to you eventually. It is dated March 10, and I know you have not had a chance to look at it. I doubt if it has come down to you by now. But I am going to give you a copy. I thought maybe you could go over it at halftime at the KU game or the K State game when you are watching. Probably more K State than KU, but then that is beside the point.

At any rate, I encouraged the administration to limit the use of this regulatory process and take every available opportunity to get feedback from those who would be most affected by these regulations. I encouraged the administration to review any comments you have received on these regulations.

So my question to you is, do you commit to only using the interim final rule process in the most limited and necessary fashion, and through that do you commit to getting stakeholder input through a designated comment period so the folks whom I met with and whom you know and whom you would meet with—matter of fact, that might not be a bad idea—so that they could at least have some input? In short, the people whom you know in Kansas, and I know in Kansas, who are trying to do their best with PPACA but are worried about regulations, can they at least have time so that they can have some input?

Secretary SEBELIUS. Well, Senator, I share your concerns, that input from stakeholders is critical. We have been trying to balance what were fairly daunting 2010 deadlines with getting that feedback as quickly and promptly as possible, doing everything from webinars to open periods. But we are certainly eager to have stakeholder input. I have met with a number of the people who probably were in the room with you, Maynard Oliverius and others, who are willing and eager to participate in the Accountable Care Organizations. But yes, we are looking for ways——

Senator ROBERTS. Well, we invited Maynard in, but we kicked him out after about 5 minutes. No. But at any rate, go ahead.

Secretary SEBELIUS. Well, I share your concern, and we are certainly looking for ways to get the maximum input as we move through——

Senator ROBERTS. But I know that you will move forward with that. I took advantage of all that input, which lasted for about 3 hours. We have 34 regulations here that they sort of broke down into different categories. I am going to give them to you. My letter will work down through the process to you after a while.

I had another question, but I can ask it for the record. My time is up. I do not know what we are going to do here. Do you want to rewrite the bill now, or what? [Laughter.]

Secretary SEBELIUS. We can talk about brackets.

Senator WYDEN. In my college basketball days, before we had the 24-second clock, we used to just dribble in the corner.

Senator ROBERTS. Dribble in the corner.

Senator WYDEN. So I am not going to quite——

Senator ROBERTS. Have you voted on the second vote?

Senator WYDEN. I have not. There are about 10 minutes left. I was going to ask one quick question. What is the Senator's pleasure?

Senator ROBERTS. Since I have the time, can I ask my brief question, then I will yield you the remainder of the time?

Senator WYDEN. Of course. Of course.

Senator ROBERTS. And I will throw you the ball. All right.

Secretary SEBELIUS. Are you dribbling in the corner or are you coming to the basket? I just need to know.

Senator ROBERTS. He is dribbling in the corner.

Secretary SEBELIUS. Because I am playing defense here. [Laughter.]

Just give me a signal.

Senator ROBERTS. It is the full court press. [Laughter.]

Secretary SEBELIUS. All right. Got it.

Senator ROBERTS. All right.

The executive order. It is a fine executive order, but there are loopholes. The loopholes are this: if you are sitting as Secretary, like you, in front of a regulatory agency, and you are doing the public good while you are excluded from this cost-benefit yardstick that the President issued with his executive order to get a hold of all these regulations—which, by the way, is the number-one issue that pops up in Kansas: "What on earth are you doing back there, passing all these regulations that do not make any sense? They are counterproductive, they do not meet a cost-benefit yardstick, and they are about to put me out of business." That is the speech that you hear. I always say I am not a "you" guy, I am an "us" guy, and then we go from there.

Now, there are exemptions. One is, are you doing the public good? The other is, are you a sub-agency or an independent agency? If so, you are exempted. Then we have this—and this is the one that I think that you are under, I am not sure. This is, "Where appropriate and permitted by law, each agency may consider and discuss qualitatively"—I am talking about this executive order by the President, and this is the part where I have the most concern—"values that are difficult or impossible to quantify, including equity, human dignity, fairness, and distributive impacts."

If that is not an amorphous statement, I do not know what is. You and I could sit down and talk about that for 6 hours and we would not be able to come up with any kind of a directive or any kind of a conclusion, other than just to take the whole thing, wad it up, and put it in a wastepaper basket somewhere.

Now, which one of those exemptions do you fall under, or do you fall under any? And are you making the best effort to try to apply the regulations to the President's executive order?

Secretary SEBELIUS. We are doing the latter. That has been the directive of the President, not just for future regulations, but he has asked us all as cabinet members, and our offices, at the top of this list, to review prior regulations and to look at, not only gathering input from stakeholders, but to go through a very strenuous process of looking at duplicative information, regulations that are outdated, outmoded.

Senator ROBERTS. You are doing that?

Secretary SEBELIUS. We are absolutely starting the process.

Senator ROBERTS. And it is a priority?

Secretary SEBELIUS. Yes. Yes, sir.

Senator ROBERTS. I have 34 of them for you to take a look at.

Secretary SEBELIUS. All right. Thank you.

Senator ROBERTS. I thank my colleague, who is no longer dribbling but has left the court. [Laughter.]

Secretary SEBELIUS. Are you going to take a shot, or are you just going?

Senator ROBERTS. I have already taken my shot. [Laughter.]

The CHAIRMAN. Thank you, Senator.

I might add, too, we just now repealed a statute, a small business statute, because it was useless. It was causing more problems than it was solving. It is an example of the Congress repealing, getting rid of, dead weight. The more we can keep doing that in the executive branch, the better. That is not just an idle statement, Madam Secretary. I hear this constantly from businesses of all sizes, that our country is changing, and not for the better, in their view. We are becoming like an old Third World country, we are so hidebound. It is almost Lilliputian, with all the strangulation, with all the rules and regulations, and they are always on, and people just feel it. They feel it, sometimes with new legislation passed. So I just strongly urge you to be very vigorous and slash, just cut.

It is not going to go too far here, but it reminds me of Joseph Shumpeter, the economist. It is creative destruction. You have to destroy to create. You have to destroy to create. I am not urging you to be draconian about that. Exercise a little common sense with it. But there is that dynamic: you have to cut to create. I urge you to go pretty far, because you will be surprised at the energy and synergy that that will create.

Senator Ensign?

Senator ENSIGN. Thank you, Mr. Chairman.

Madam Secretary, welcome. I just want to quote from the President: "Under the plan, if you like your current health insurance, nothing changes except your costs will go down by as much as $2,500." Do you remember that quote? It was quoted quite often by the majority party, claiming that premiums were going to go down.

Well, I actually just got off the phone with one of our larger employers in the State of Nevada, and most people recognize this name, Steve Wynn. I asked him if I could quote him, which he said was all right. He is probably the most employee-friendly employer that we have in the State of Nevada for years. Unions love him, his workers love him; he treats them like gold. He does everything he possibly can.

Well, these are the statistics that he just gave me. From 2005 to 2010, they had a steady rate of increase in the premiums of around 8 percent a year, which is high. We all agree that that is high. This year, his premiums went up by 12 percent, almost a 50-percent increase in the rate of growth. What did that mean to the people who are working for him? That means that his people—he took on some of those costs, but not all of them. The average worker who works for the Wynn Resorts now will pay an extra $800 to $900 a year. So the premiums did not go down, they actually went up. He, based on the people and experts he has working for him, has studied the system, and he thinks that actually things are going to get worse in the future, not better.

Also, their plan worked with other plans across the valley. One of the big selling points was, well, we are going to have fewer people going to emergency rooms. They have had no decrease in the number of people going to emergency rooms, but they have had a decrease in the number of doctors now practicing.

So I guess some of the promises—and this is just an anecdote, obviously. But I have talked to employer after employer after employer across the State of Nevada, and small employers had much larger increases than what he just had. I have had people tell me, the small employers, that their premium increases were as much as a 35-percent increase this year, and that was even with increasing the co-pays for their employees. So I guess the bottom line is, at least what I am seeing in the State of Nevada, is that the health care reform bill is driving up costs, not doing what it was promised, to drive down costs.

How would you respond to that?

Secretary SEBELIUS. Well, Senator, I do not think there is any question that costs are continuing to increase. I think, unfortunately, that trend, it is almost impossible to say what the trend would have been absent the bill. I can tell you that the status quo, as I think you and I would both agree, was totally unsustainable and unacceptable.

I, in fact, am somewhat stunned that Mr. Wynn's premiums have gone up at that slower pace during those 5 years, because that was not the average. The average during those years was, people were seeing over 100-percent rate increases over that period of time.

Senator ENSIGN. That is because they have implemented a lot of things in his employ that try to work with their employees to encourage healthier behaviors and things like that. They have been doing some of the same things that Safeway has been doing, to try to hold those premiums. But the point that he made is, for 5 years they basically had a level of 8 percent per year.

Secretary SEBELIUS. Well, the insurance industry overall has indicated that, in this last 12 months, there are not significant cost drivers related to the implementation of the Affordable Care Act.

That is what the industry is saying as they analyze their rates. They are saying it is the underlying rise in health care costs and the underlying utilization of health care. Again, the Affordable Care Act, I think for the first time, has some delivery system changes which have never been part of the dialogue before.

I think, not only will they impact what Mr. Wynn's employees are seeing in the private sector, but they certainly will impact the long-term deficit in the public sector. Those are clearly not showing up in the first 6 or 7 months of implementation of the bill, because the structures are not even in place yet.

Emergency room decreases, I would suggest, Senator, will not occur until the vast majority of uninsured have access to insurance coverage, and that does not occur until 2014. So some of the examples that you cite absolutely are under way, not only in Nevada, but in other States around the country. But as this law is gradually implemented, I think you will see a change in those dynamics.

Senator ENSIGN. The next issue I want to address is basically the waivers. We have seen, now, over 1,000 waivers that have been granted, and for various reasons. But we do not know a lot of what those reasons are, and obviously you have to protect proprietary information. But we have introduced legislation basically to find out, why are different people getting different waivers? What is the justification why one person is getting it, why one person is not getting it? I guess, can we ask for more transparency in that process?

Secretary SEBELIUS. Absolutely, Senator. The waiver, again, is about one feature of the bill. It is the $750,000 annual fee. We are collecting information this year. But because it turns out that the State Insurance Departments had very little information about these so-called "mini-med" plans, the vast majority of people who have come to the department with this plan, saying, absent this we will drop coverage altogether, we have granted waivers to. The only ones, it is my understanding, as a framework that were not granted waivers, that 6 percent——

Senator ENSIGN. These were not just mini-med plans, though, that were granted waivers.

Secretary SEBELIUS. The vast majority absolutely are. They are the so-called under-funded—I mean——

Senator ENSIGN. I thought half of the plan——

Secretary SEBELIUS [continuing]. They are not comprehensive plans.

Senator ENSIGN. I thought half the plans that were granted waivers were union plans.

Secretary SEBELIUS. No, sir. I think your information is incorrect. We will absolutely get you that information. Steve Larsen just testified.

Senator ENSIGN. And also, if we can get a copy basically of the rationale for those plans.

Secretary SEBELIUS. Yes. Absolutely. We will give you the criteria.

Senator ENSIGN. And the criteria.

Secretary SEBELIUS. Yes.

Senator ENSIGN. And why each one was granted or not granted.

Secretary SEBELIUS. Well, we can give you the criteria, yes, that was used to make those decisions. Yes, sir.

Senator ENSIGN. Not just the criteria, but then——

Secretary SEBELIUS. Well, there are not a thousand different reasons. They either met the criteria or they did not. What I am telling you is, 94 percent of them met the screening criteria, and that is what I would be happy to provide you.

Senator ENSIGN. All right. Thank you, Mr. Chairman.

Senator HATCH. Senator Cardin?

Senator CARDIN. Thank you, Mr. Chairman. Madam Secretary, thank you very much for your leadership on this issue. I very much appreciate your response to Senator Ensign as it relates to premiums. But we know from millions of health care consumers, they have gotten either better benefits or better value for what they were spending in health care.

We know that there are over a million children now who are qualified to be under their parents' health insurance policy who would not have been prior to the passage of the Affordable Care Act, under the provision now that allows families to keep children on the policies to age 26. We also know there are millions of seniors, over 3 million, who were helped in getting coverage for the coverage gap for prescription drugs, the so-called donut hole, and now have wellness examinations. So they are clearly better off than they were a year ago.

We know that there are millions of consumers of health insurance who are now getting better value because of the protections we put in the bill to require that the premium dollars, the lion's share, go for benefits rather than for expensive overhead or profits. So we have made some progress. We have also given protection on issues such as access to emergency care, and the list goes on and on and on.

And then we know that we are saving costs in our health care system. It has been 12 months, but a lot of the changes are going to take time to see the impact. The one I liked the most, just to emphasize, is what we have done for the qualified health center. I know what is happening in my State of Maryland with the use of the qualified health centers. I know we are going to keep people out of emergency rooms, which is going to save all of us money so that our costs and hospital care for those of us who have insurance will be a little bit less because of those.

And, of course, the management of wellness programs, use of health information technology, the management of readmissions to hospitals, you add all that up—but I think it is unrealistic to expect it could have any major impact on a premium that was already in the works that people received during the course of this year. So, I just really want to go on record saying that I thank you for your leadership, and the millions of people in this Nation and the thousands in Maryland who are getting much better value for their health care expenditures today than they got last year as a result of the enactment of the Affordable Care Act.

I do have one question I want to ask you, unrelated to that, and that is to minority health and health disparities. One of the provisions that I was very proud that got into the Affordable Care Act is to put a real spotlight on dealing with health disparities and minority health issues. We know that the incidence of asthma is twice as high in the minority community. We know that deaths from

heart attacks or heart disease are 33 percent higher. We know infant mortality rates are higher, and the list goes on and on and on.

The law now establishes you as the reporting person for a lot of the information related to strategies dealing with minority health and health disparities. I just really want to get your assessment as to how you will be dealing with this issue as the Secretary, and how we can be helpful in advancing areas that will not only be the right thing for our Nation to do, but we have a study that was done in Maryland by Johns Hopkins University and University of Maryland Medical Center that showed that we could save as much as $260 billion if we address this issue in an aggressive way. So this is also a cost issue.

Secretary SEBELIUS. Well, Senator, first of all, I share your focus and commitment in that area of health disparities. It is not only good for minority communities, but I would say it is good for the country. We have done a pretty good job at HHS of gathering statistics. We have not done a particularly good job in the past of closing the gap, and that has really been a priority of mine. So we have a first-ever kind of strategic action plan which will be out in about a month, and I would be delighted to come and brief you and your staff about the steps that we think are the four or five most important steps with measurable outcomes that we can take.

The Affordable Care Act not only, I think, in the expansion of the Community Health Centers—which deliver affordable and high-quality care—but certainly in making coverage finally available to all Americans by 2014, makes a huge step in access. The Affordable Care Act also has very important strategies about minority workforce recruitment. Having culturally competent, familiar providers will be part of this strategy; making sure that we have accurate mapping of where the under-served areas are and connecting providers to those under-served areas as part of this; the Community Transformation Grants, which are going to be significant efforts in major areas to look at everything from wellness and prevention. But coordinated care for chronic diseases, which again are far higher in minority communities, is part of what the prevention fund will focus on.

So I would say throughout the bill there are, again, resources and tools and really directions, thanks to your leadership and that of your colleagues, that make sure that we focus attention on what has been a pretty static gap in health outcomes and make sure, as we improve overall public health, that we pay particular attention to those communities where the gap has been most serious.

Senator CARDIN. Thank you.

Thank you, Mr. Chairman.

Senator HATCH. Senator Thune?

Senator THUNE. Thank you, Mr. Chairman.

Madam Secretary, welcome back. Thank you for joining us today and providing answers and insights on where we are with regard to the health care bill.

In our previous exchange last month, we talked about the CLASS Act. You told me that the program was "totally unsustainable" as it was written in the law, and you made that assessment based upon actuarial models developed within HHS. Is that correct?

Secretary SEBELIUS. I said I did not think, as written, it could be implemented in a sustainable fashion. Yes.

Senator THUNE. Right. But that was based upon some actuarial studies that were done, analysis?

Secretary SEBELIUS. I think I told you we had just hired the actuary who came from Genworth, who is now going to be our Chief Actuary. I think it is based on some modeling that was done. Yes, sir.

Senator THUNE. We, in a briefing with several Republican staffers, Richard Frank, the Deputy Assistant Secretary for policy, told my staff that your department's Office of Planning and Evaluation conducted its first actuarial analysis of the CLASS program before the law was enacted. Did your department's first actuarial analysis of the CLASS program, made early in 2010 before its enactment, indicate that the program was totally unsustainable?

Secretary SEBELIUS. Senator, I know that during the course of the discussion we had some concerns about some of the threshold levels that were in the bill, and there was a contemplation of amendments to the bill as it progressed through the Senate due to, I think, the Byrd rule and some other issues that are part of the Senate rules. They were not included as part of the final amendments, but the Department was given broad discretionary authority and a very clear direction that we could not rely on taxpayer backup for the plan, and that it had to be solvent. So we have taken that direction very seriously.

Senator THUNE. To the extent that the actuarial analysis is available out there, is it something that you could provide to me and my staff, or to this committee so that we could review the information that was available about the financial solvency of this proposal?

Secretary SEBELIUS. I assume, Senator. I cannot tell you exactly what is available, but I will go back to Richard Frank and figure out what he referred to with your staff, sure.

Senator THUNE. And you mentioned that you were contemplating various amendments to it as it was moving through. I offered an amendment on the floor to strike it for the reasons that we talked about that I have indicated to you earlier, that the program was unsustainable, and that was what CBO, I think, had accurately concluded, at least in the second decade in the out-years. But it was a significant offset and pay-for in the bill. So I guess my question would be, were there discussions that were held with members of the Senate or House who had the ability to make changes in the CLASS program in the bill prior to its enactment?

Secretary SEBELIUS. Senator, as I said, there were lots of discussions about CLASS. I think that the concern, at least in the discussions that I was involved in, always was the balance between helping to fulfill what was really a commitment to a lot of Americans who currently find themselves with no options about community living and aging in place, to making sure that there was not an unfunded entitlement put forward. Those discussions continued, and they are ones that we are continuing to have with both a community of advocates, but also with the financial advisors that we have.

Senator THUNE. I mean, it seems to me, at least, that if there were concerns along the lines that you mentioned, and as this was

being debated up here, that members of Congress should have known about the CLASS program's problems before voting to approve the law.

So, I guess what I am trying to get at here is, to the degree that there was that sort of information available, why it was not conveyed to Congress, or, if it was, were there discussions—I mean, obviously we were not privy to any of those, but it strikes me at least that this thing is a runaway train. We thought that at the time. I still believe that today. You have indicated that, without some significant changes or authority to try to fix it, that it is unsustainable.

Secretary SEBELIUS. Again, Senator, we have that authority. We take the direction very seriously, that it has to be a solvent program, not only in the first 5 years or the first 10 years, but on into the future. That depends on, I think, the income threshold, the earning threshold which we are taking very serious looks at. It depends on the enrollment projections, and there are ways to shift those enrollment projections upward or downward, and that is a key component to make sure it is not, from the outset, an adversely selected pool.

So all of those issues which are modeled in the private insurance market—I think we have gotten the best expert. Genworth is the company that really knows this space better than any. Their chief actuary is now the chief actuary for the CLASS program. We are reaching out to stakeholders, but we take that direction very seriously, that this has to be a program that is modeled on into the future as being sustainable.

Senator THUNE. Well, my time has expired, Mr. Chairman. But I guess the only thing I would say is, to the degree that that actuarial analysis or that modeling is available, as I mentioned earlier, if you could make that available to us, I would certainly welcome the opportunity to review that.

Secretary SEBELIUS. Thank you.

The CHAIRMAN. Thank you, Senator, very much.

Senator Carper, you are next.

Senator CARPER. Thank you, Mr. Chairman. Thank you very much.

The CHAIRMAN. Any time.

Senator CARPER. Madam Secretary, welcome. Nice to see you.

Secretary SEBELIUS. Thank you.

Senator CARPER. I chair a subcommittee, an oversight subcommittee in the Homeland Security and Governmental Affairs Committee, that enables us to look into a lot of financial management—in some cases mismanagement—in the Federal Government. About a week or two ago, one of your top people, Peter Budetti, was with us. The subject was the Improper Payments Act, something that many people know about.

But President Obama signed into law last year legislation that Senator Coburn, I, and others had worked on. It basically says, not only do we want agencies to identify improper payments, usually over-payments, we want them to identify them, report them, stop making them and going out to recover the money that has been overpaid, or mispaid, and to recover that money. Going forward, we

directed that Federal managers be evaluated, at least in part, on their compliance with the improper payments law.

Last year, improper payments totaled about $125 billion—$125 billion! That does not include most of the Department of Defense, it does not include Medicare Part D. Out of the $125 billion, roughly $45–50 billion was Medicare. Peter Budetti spoke to us, and he said one of the administration's goals between now and 2012 is to cut that, we will say $48-billion number, in half.

My question to you is: how does the Affordable Care Act, the health care reform legislation, strengthen you and give you some of the tools that you need to be able to reduce improper payments from roughly $50 billion a year to $25 billion a year? Eric Holder tells us that, separate and apart from that, fraud in Medicare could be as much as $60 billion.

And whether it is $60 billion, $50 billion, or $40 billion, that is a lot of money that is separate and apart from the improper payments. But we are talking about a lot of money, and, in a day of deficit reduction when we are looking for every dime that we can save, how can you use the legislation, the law of the land today, to help us reduce improper payments and Medicare fraud?

Secretary SEBELIUS. Well, I think, Senator—the Attorney General and I were just in Detroit yesterday in our series of fraud summits, which we are having in the so-called "hot spots," places where fraud activity seems to be higher than normal. Not only are we instituting new protections within the Centers for Medicare and Medicaid Services, thanks to the Affordable Care Act, but also a new predictive modeling that has been used in the private sector for a long time, but has not been available in CMS, to watch billing aberrations. New strike force teams are on the ground. We are up to nine. We intend to expand at least by two in the near future, and then look at resources, which are Office of Inspector General agents working with the U.S. Attorneys, working with the local law enforcement officers to really be very nimble about shutting these aberrations down. But I think that Dr. Budetti would be the first to tell you that we do not feel we can prosecute our way out of this activity. We really need to set up much higher firewalls at the front end to prevent it.

So some of the data systems—we are re-credentialing providers in the highest-risk area, making it much more difficult, frankly, to hang out a shingle and just start billing Medicare. We are training millions of seniors across the country to be the eyes and ears on the ground of the patrol. Then we have set up a series of checks within CMS about billing practices that we feel can help us dramatically lower, as you correctly said—the payment system is not necessarily fraud. Some of it might be fraud, but it is not necessarily symbolic of fraud. Some of it is over- and under-payment. So again, we are updating our routine surveys and updating our equipment so that we are much more able to pay accurately the first time.

Senator CARPER. We tried to give you a number of new tools, and I am encouraged to hear that you intend on using them.

Secretary SEBELIUS. Absolutely.

Senator CARPER. And with improper payments of almost $50 billion, not counting Part D, Medicare Part D, and with fraud as high as maybe $60 billion a year, we need every tool you can muster.

The other thing I want to talk about is obesity. We are intent on reducing obesity in this country today, an age when one-third of the people in our country are overweight or are on their way to being obese. In the case of Japan, we spend twice as much for health care as Japan, and they cover everybody. We spend twice as much. They get better results. One of the reasons why is, they have done a much better job with obesity and trying to keep people from becoming overweight.

My second question is, how can we ensure there are public investments in obesity reduction, programs are adequately measured, they are coordinated, and they are effective? For example, would it be possible to put all the federally funded anti-obesity efforts maybe on one website so that States and other stakeholders could easily access information and resources in these anti-obesity programs?

Secretary SEBELIUS. Well, I think the website is a good idea. We do have, I think for the first time with the Recovery Act investments, community strategies that are in place across the country in urban centers, in rural centers. Some are health systems, some are entire communities, some are school-based projects, really with a very dedicated measurement tool. So we have never had good data on what it does take to change behavior patterns, buying patterns, eating patterns for folks. I think we will have that data for the first time. We are sharing the information about those strategies with folks across the country.

We have lots of mayors and policymakers and officials who have signed up to be part of the "Let's Move" strategy, which, as you know, Senator, is aimed at reducing childhood obesity in a generation. The First Lady's spotlight on this, I think, has been enormously helpful in getting the word out.

We are about to launch also the menu labeling initiatives as part of the Affordable Care Act, which will, for the first time, again, give more information to consumers about what choices they are making when they order food and shop for food and buy food for their kids. The FDA also is under way with front-of-package labeling, which, again, is more information for consumers. So we are trying to address this in a variety of strategies.

I think the bill that you all passed at the end of last year, the Nutrition Act, which, for the first time in a very long time, updates standards for nutrition for school breakfasts and lunches, and gives additional revenue to schools for healthier foods, incentives for local farmers is, again, a wonderful strategy that will not only be helpful in the farm communities and be helpful with fresh fruit, but should have a very positive impact on our children.

Senator CARPER. Good.

Mr. Chairman, I would just say, in the spirit of March Madness, the NCAA basketball players, we need a full court press on obesity. The Secretary has just gone over some of the things that we are doing. I think that they are all smart things. One of the things that Senator Murkowski, Senator Harkin, and I worked on is menu labeling.

Later this year—I think your regulations will be out in a couple of months—when people go into a chain restaurant, 15 restaurants or more across the country, they will have a menu board. On the board will be what is being ordered, price, calories. If we have a menu, what is being ordered, price, calories, and information on about 10–12 additional items: fats, transfats, the real thing, verifiable upon request. It is just one thing. We need to be doing all these things. As you know, a major driver in health care in this country is obesity, being overweight. We have to get—this is a bad pun—our arms around it. I think I am encouraged that maybe we are starting to. So, keep it up. Use those tools. Thank you.

The CHAIRMAN. Thank you, Senator. It is clear that chronic disease is a huge driver, cost driver, in this country. It is obesity, it is cardiac care, it is all the various forms of diabetes, all the various chronic care illnesses.

I remember once I was following a cardiologist on his rounds in a hospital in Missoula, MT. We visited all of his patients. It just struck me, hit me like a 2 × 4: one-third of his patients were overweight, one-third of his patients were smokers, and the other third were assorted. I mean, there is no question that a lot of the excess cost is due to chronic disease, and it can be addressed. I compliment you for being such a persistent advocate of addressing these issues. You have mongoose tenacity, Senator, and I really appreciate that.

Senator CARPER. I think that is a compliment.

The CHAIRMAN. That is a compliment.

Madam Secretary, as we address health care costs—and I do believe that there are all kinds of reasons for this bill, but one of them is to reduce the rate of growth of health care costs. I wish, frankly, we had spent more time on that. In fact, I wish in retrospect, when we were advocating the bill the last couple of years, we spent more time on costs up-front rather than coverage, per se, because it gave detractors an opening.

Nevertheless, that is history. One of the cost drivers, I think, is over-utilization. It is over-utilization in lots of different areas. This causes a lot of waste in our system. One of the questions I have is, what is the Department doing, and CMS doing, on addressing this problem of over-utilization? That is, physicians ordering procedures that are not needed, in various specialties, hospitalizations not needed.

I do not know if you saw the most recent Atul Gawande article. I am sure you read that. I think it was in New Jersey. It was stunning that there were 240 admissions to one hospital by the same person in a 5-year period, as I recall. That is nuts. When I talk to business people, well, part of it is defensive medicine. That is what causes over-utilization. Some say that our system is biased toward it. That is, the incentives are more for quantity than quality.

So, I am just asking you, what is being done about this? I think a lot more should be done about this than I am aware of. I might be wrong, but I think the Dartmouth study has a website that shows utilization in various parts of the country, and I regret to say that my State is not the best in a couple of cities in terms of subspecialties.

But my one thought might be just to highlight all that. Just tell all the world, tell America and all these different hospitals and all these different specialties, what the utilization rate is, for starters. But how do we address over-utilization? I want you to be honest: how do we address the issue of over-utilization in America?

Secretary SEBELIUS. Well, Mr. Chairman, I think that, again, you provided a framework in the Affordable Care Act which has really never been part of the public payment system in the past. The public payment system has been aligned with more procedures bringing in more income. There is very little in the way of compensation for issues that did not involve some kind of test or procedure or visit.

So, aligning the incentives, as the Affordable Care Act does for the first time, with appropriate care strategies, with wellness visits, with giving doctors the opportunity to get into systems of care, of medical homes, where keeping people out of the hospital becomes—you get paid for that strategy more than enrolling folks in the hospital. So we have a whole series of tools that were not part of the payment system. I think that is very helpful.

I think we are making the kind of utilization information much more transparent. Medicare information is now available, and people can look at, not only the cost of issues, but the kind of procedures that are being provided from hospital to hospital, from State to State, and do comparisons.

You mentioned Dr. Gawande's recent article. We actually had the authors, the hot-spotters who are running these new strategies for very high-cost patients, in to talk about ways that we could be informed by their systems. It is the kind of work we are doing on the so-called dual-eligibles, where often people are seeing 20 to 30 different providers, getting a whole host of different prescriptions. There is not any coordinated care.

So the kinds of strategies of bundling care, of having Accountable Care Organizations, of looking at what happens when a patient leaves the hospital to make sure that that after-care is coordinated, all of those are a part of the tools in the Affordable Care Act that we are taking very seriously and implementing as we speak.

The CHAIRMAN. I appreciate that. This is a crisis, the cost increases in this country, health care costs. I just say, we can, together, perform a terrific service if we just, with very serious dedication, address the rise and growth of cost increases in this country. I believe, frankly, that a lot more transparency is helpful. Just the disinfectant of sunshine is very potent.

Years ago I was on the EPW Committee, and we had this—I have forgotten what the act was called. We enacted a law here in Congress that revealed the pounds of pollutants that polluters were emitting from their smokestacks: nitrogen oxides, for example, sulfur dioxides, all the different pollutants. It had a tremendous salutary effect. Tremendous. It was not a regulation, it was just the information. When the American public knew which were the biggest polluters, man, those companies, they did not want that, so they, on their own, found ways to break it down.

So I urge you to find ways to do the same thing here. I will tell you something else that is going to happen. The private sector is very, very creative and talented. A lot of these entrepreneurs are

going to take all this new data and start developing software, some new programs to help the public, and so forth. So what you do, you can align with the private sector and get these creative juices flowing with a lot more data about what is going on. I am only talking now about utilization.

Secretary SEBELIUS. Right.

The CHAIRMAN. There are a lot of other subjects, too.

Secretary SEBELIUS. Well, Mr. Chairman, you are singing from our hymnal. We believe strongly that Medicare, being the largest sort of insurer in the world, has enormous data that is very helpful, not only to private sector purchasers, but also to consumers, to inform consumers, to keep them aware. So we have been engaged in an effort over the last year and a half to really push Medicare data out into the public domain in user-friendly, free, transparent ways, and we have a whole project under way called the Community Health Data Initiative, which does just this and has now lots of those entrepreneurs who are taking the data and reformatting it in ways that will be helpful to purchasers, to policymakers, to consumers, to moms. So, that effort is very much under way. I could not agree more that people really—the more they know about their own health care, their own cost drivers, their own system, the smarter choices they can make.

The CHAIRMAN. I appreciate that. You have been extremely patient. My time has more than expired. I do not want you to have to come up here every week, or every month. But could you give us a status report on just that one last project you talked about?

Secretary SEBELIUS. Yes, I would be delighted to.

The CHAIRMAN. Where you are.

Secretary SEBELIUS. Yes.

The CHAIRMAN. What your plans are.

Secretary SEBELIUS. Yes.

The CHAIRMAN. Where you hope to be a year from now, et cetera. I am only going to ask that one project. Thank you.

Secretary SEBELIUS. Yes, sir.

The CHAIRMAN. Thank you.

Senator Wyden, I am told that you have the last word.

Senator WYDEN. With your graciousness, Mr. Chairman. Thank you very much.

Just a question, Madam Secretary, if I could, about end-of-life care, because it seems to me the legislation gives us the prospect to start a new debate about end-of-life care in this country, and I think a much more constructive approach that brings people together. What I am speaking about—you and I have talked about it before.

The bill, for the first time, would give folks—older people, for example—the ability to get the hospice benefit without giving up the prospect of curative care. So, no longer are people being pitted against each other. I know you are going forward with the implementation of this. I would like to hear a little bit of your thoughts about it.

But just as you answer the question, would that not be the opportunity to lay a foundation for a new approach to discussing end-of-life issues, these incredibly emotional, difficult questions that even divide families? The fact that, in the bill, folks can get the

hospice benefit for the first time without giving up the prospect of curative care, strikes me as laying the foundation for a new approach on end-of-life issues. I wonder what your thoughts are.

Secretary SEBELIUS. Well, Senator, I think that not having to make those Sophie's Choice decisions is certainly an important step forward. I do think—and I will just use my own situation as an example. My mother spent the last 10 weeks of her life in 3 different hospitals, flown from hospital to hospital.

I hesitate to even imagine how many procedures were done during that period of time, and how many strategies used, and how many teams of doctors. But looking back on that situation with my siblings and my father, all of us wished that there had been an opportunity at a much earlier stage, and probably well before that 10 weeks, to have my mother have engaged in a robust discussion with her caregivers, and then inform the family of those choices.

So, I do think that having opportunities to have patients talk to their doctors well before—I mean, I was at the Gundersen Lutheran Medical System in Wisconsin, and heard some very compelling testimony from the head of the hospital system, who said one of the problems really with conversations is, we wait until someone is in a crisis situation, or wait until there is no possibility for that patient to engage.

Their theory is, the first time anyone has contact with the hospital system, a conversation should be held with that patient, should become part of their record and updated on a regular basis, whether they are in to have a baby or anything else. So I think this is an area where I think patients and families tell me they really want to be informed, they want to be involved, they want to be engaged. But I think having the bill address that difficult situation of an either/or is certainly an important step.

Senator WYDEN. If you could, just for the record—and I thank you for the extra time, Mr. Chairman—give us in writing the implementation progress that has been made, because I know you are working on the rule.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Actually, we should thank the Secretary for the extra time. Another Senator just arrived, Madam Secretary. We promised the Secretary we would be finished by about 11:45.

Senator NELSON. All right. So that means I have minus 8 minutes.

The CHAIRMAN. To lift-off. [Laughter.]

Senator NELSON. Well, I cannot create more time.

The CHAIRMAN. No, no. You go ahead, very briefly.

Senator NELSON. All right.

The CHAIRMAN. With the indulgence of the Secretary.

Senator NELSON. I want to thank you already for explaining how you are going after fraud, making them do those background checks. I want to thank you also for having explained earlier today how we are winning on Medicare Advantage by taking away all of the extra payments that insurance companies were getting and how you are making that where Florida actually has a reduction in the premiums for Medicare Advantage up to this point, while at the same time having a significant increase of people enrolling in

Medicare Advantage. So that is certainly a winner up to this point, and we will continue to go on that.

Can you just briefly, since you have to go, tell us about your excitement about Accountable Care Organizations really doing something?

The CHAIRMAN. And show how really excited you really are. [Laughter.]

Secretary SEBELIUS. Pardon me?

The CHAIRMAN. I am sorry. Just show how really excited you really are.

Senator NELSON. Just like I am.

Secretary SEBELIUS. I am very excited. Well, I can tell you, providers around the country are very excited. I have been really encouraged by, not only hospital executives and their providers talking to us about the opportunity to deliver better care at lower costs—and they are very eager to participate in this transformation—but community health centers working with hospitals, provider organizations working on their own care strategies that people know can work. And they really have felt either that the incentives have not been there for them to align that practice, or that they would be financially penalized by delivering the kind of care that they think is quite possible.

So I have been across this country. We will have these rules out in the very near future. I cannot tell you the level of enthusiasm I see, not only in our office, but in the provider community, for having a platform that allows better care delivery, allows them to be paid for that, and that they feel can really lower the overall costs—improve health, improve patient care, and lower costs—and they are very, very eager to participate. As you know, Senator, this is an entirely voluntary initiative. We are not forcing anyone; this is not a federally directed program, but the enthusiasm in the provider community is enormous.

The CHAIRMAN. Thank you, Madam Secretary, very, very much. I might add, I want to amend my request on the report that you are going to give, the status report, remember, I asked you about?

Secretary SEBELIUS. That one thing?

The CHAIRMAN. Yes. I only have one more. ACOs. Status report on ACOs, Accountable Care Organizations. How are you doing? How are they coming along? Again, the plan, et cetera.

Secretary SEBELIUS. Will do.

The CHAIRMAN. Thank you very, very much.

Secretary SEBELIUS. Yes, sir.

The CHAIRMAN. Thank you. You have been very, very generous, Madam Secretary. Thank you very much.

Senator Wyden will now chair. Our next panel is Douglas Holtz-Eakin and Paul Van de Water.

Mr. Holtz-Eakin, you go first.

Senator WYDEN. Gentlemen, thank you very much. We appreciate your patience here this morning. We will make your prepared statements a part of the record. If you could take maybe 5 minutes or so and summarize your views, that would be helpful. Then we will have some questions.

Let us begin with you, Dr. Holtz-Eakin.

STATEMENT OF DOUGLAS HOLTZ-EAKIN, Ph.D., PRESIDENT, AMERICAN ACTION FORUM, WASHINGTON, DC

Dr. HOLTZ-EAKIN. Well, thank you, Acting Chairman Wyden, and members of the committee.

I have submitted a lengthy statement for the record. Five minutes cannot do justice to my misgivings about the Affordable Care Act, even after a year, but the three points I would stress in my brief opening would be that it represents a real missed opportunity in reforming Medicare, which remains a budgetary and financial danger; it is more appropriate to reform Medicaid, as you mentioned in your remarks in the first panel, than to expand it in its current form; and, third, that the Affordable Care Act is damaging budgetary and economic policy.

Just let me say a word or two about each of those three points. First, with Medicare, it remains on shaky financial ground. The dubious trust fund accounting that has been highlighted in the first panel does not hide the fact that the money coming in is going out for two new entitlement programs and will not be available for future Medicare benefits, regardless of the accounting.

The second thing I am concerned about is that, since no analyst has looked at this law and decided that it will in fact bend the cost curve and slow the growth of health care spending, it is quite unlikely that the Medicare provider cuts in the law will stick. As a result, those funds will have to go out, and Medicare will be under even more shaky financial ground. Then finally, if they were able to stick, it would have made more sense to fix the SGR. It is a real missed opportunity to take care of a problem that has plagued Congress for years.

Then lastly, in Medicare, I am deeply concerned about the future of Medicare Advantage. It is an important program, especially for low-income minority seniors, and the financing of it in the Affordable Care Act puts it on shaky ground. It is also the kind of health care that we should value. It is a coordinated benefit that offers the opportunity for a higher and better value proposition.

On Medicaid, the Affordable Care Act expands the program in which beneficiaries have deep difficulty finding providers, end up in emergency rooms at much higher rates than even the uninsured, and, with the maintenance of effort requirements, is now an extremely costly mandate on the States. I applaud the efforts of Ranking Member Hatch, and in the House, Congressman Upton, to really take on some flexibility in Medicaid; $118 billion over the next decade is something they simply cannot afford at this point in time. Even more flexibility is needed, as you have talked about, under the law itself—your efforts with Senator Brown.

Then lastly, on the budget and economic front, I am convinced that, even with the reports of my former organization, the Congressional Budget Office, on the record, this is a dangerous budgetary move at this point in time. This committee is well-aware of the projected future debt increases in the United States. They represent a fundamental threat to our prosperity, and even our freedom.

Setting up two new entitlement spending programs, insurance subsidies and the CLASS Act, that the CBO estimates will grow at 8 percent a year as far as the eye can see, that is faster than the economy will grow. That is faster than any measure of revenues

will grow. There is no way that one can do that and close the budgetary gap. We are making it worse at a time when it is already a great danger.

I think those future deficits, which are a promise of higher interest rates, higher taxes, or both, are a fundamental impediment to growth in the United States, and for that reason the Affordable Care Act represents a big anti-growth step at a time that is very important, when we have 8 million Americans out of work.

At the same time, in the Act there are $500 billion worth of taxes, and there are extensive mandates and requirements on what is one-fifth of our economy. That cannot be a growth strategy. To layer on top of it a trillion dollars in spending, I think, is a quite questionable move at this point in time.

I also noted in my testimony, I disagree, respectfully, with the CBO's estimate that only 19 million individuals will end up in the exchanges. I think with this much money on the table, we will see employers drop coverage. This is quite likely to be 2, and as much as 3 times as expensive as they think.

Then lastly, the front-loading of the taxes, the insurance reforms that cover more benefits, all lead to higher premiums in the near term, especially for small businesses. Those higher premiums are a cost they are going to have to shift, and the likely burden is going to be borne by workers in the form of lower wages or lost employment opportunity. So I would say that, after a year, we know some things about the Affordable Care Act. They are not entirely heartening from the point of view of entitlement reforms for Medicare and Medicaid, and for the outlook for the economy and the budget.

Thank you.

Senator WYDEN. Thank you. We will have some questions in a moment.

[The prepared statement of Dr. Holtz-Eakin appears in the appendix.]

Senator WYDEN. Mr. Van de Water?

STATEMENT OF PAUL VAN de WATER, Ph.D., SENIOR FELLOW, CENTER ON BUDGET AND POLICY PRIORITIES, WASHINGTON, DC

Dr. VAN DE WATER. Well, thank you, Senator.

Given the lateness of the hour, the small attendance, and the fact that I have submitted my statement for the record, I would just like to comment on a few of the points that Doug Holtz-Eakin has made.

First of all, when we look at the budgetary effects of the Affordable Care Act, it is extremely important to put this in the context that Secretary Sebelius has just laid. We have to remember that the Affordable Care Act is projected to cover 32 million more Americans, and it is estimated by the Congressional Budget Office, where both Doug Holtz-Eakin and I have formerly worked, that the law will be paid for—in fact, in the long run, more than paid for.

Obviously, paying for the expansion in coverage requires some reductions in the growth of spending, as the Secretary has outlined, requires some increases in taxes, but we have to focus on the expansion coverage as well as the way that it is paid for.

Second, Doug said that no one has estimated that the Affordable Care Act would bend the cost curve. That is flatly incorrect. The Congressional Budget Office has indicated that, after the initial increase in Federal spending, which of course will come about as we cover those 32 million more Americans, that the Federal commitment to health care spending in the second decade will be lower than it would have been in the absence of the law.

The CMS actuaries who produced projections of national health expenditures have said much the same thing. They showed an initial increase in health spending as more people are covered, but then the growth rate declines, and extrapolating the actuaries' projections in the second decade suggests that national health spending again will be smaller, ultimately, as a result of the Affordable Care Act.

I would also like to comment on the so-called double-counting issue, which we have been discussing—Doug and myself and our colleagues—I would say rather fruitlessly now for the past year. This is not a new charge, yet the Congressional Budget Office still tells us that the Affordable Care Act will reduce the Federal deficit modestly in its first 10 years, substantially in its second decade, and the Medicare actuary still tells us that the Affordable Care Act will extend the life of the Hospital Insurance Trust Fund by approximately 12 years.

Whether or not there is double-counting, whatever it may mean, this argument has no practical input in terms of the deficit projections or the projections for the solvency of the trust fund.

Finally, a few words about the costs to States of expanding Medicaid. According to CBO, the Federal Government will pay 92 percent of the cost of the Medicaid expansion through 2021, with States responsible for only $60 billion of that amount, an increase of only 2.6 percent over what they would have spent in the absence of health reform.

But most important, that number has to be taken in the context of other savings that the States will incur by no longer having to pay as much for the cost of uncompensated care of people who have been without health insurance. So, when that factor is considered, as well as the State's modest increase in Medicare costs, the Medicaid expansion is not projected to impose a substantial burden on the States.

With that, I will end and turn to your questions.

The CHAIRMAN. Well, thank you both.

[The prepared statement of Dr. Van de Water appears in the appendix.]

The CHAIRMAN. On that last point, so what is the net for States? I mean, the Medicaid expansion. As you pointed out, Uncle Sam is picking up 92-some percent of the bill. If you are cutting it out, reducing uncompensated care for States, do you have a figure?

Dr. VAN DE WATER. I do not have a precise estimate, Mr. Chairman. But the analysts at the Urban Institute who have a model for projecting these costs have said that they believe that the reduction in the cost of uncompensated care could offset a substantial portion, or even more than offset the cost to the States of the Medicaid expansion.

The CHAIRMAN. Is it your judgment that, although costs are increasing—it is true. I have talked to individuals, small businesses, others who are concerned about the increase in premiums. Is it your view that—well, it is my view, first, that those premiums would be going up anyway, and the goal here is to try to reduce the rate of growth of health care costs and the rate of growth of the premiums. Without putting words in your mouth, do you think that premiums would go up higher or not quite as high if there was no law?

Dr. VAN DE WATER. Mr. Chairman, for that I rely again on the estimates of my former colleagues, and Doug's former colleagues, at the Congressional Budget Office. They have estimated that for large employers, which are the source of insurance coverage for most Americans, premiums could fall by up to 3 percent as a result of the Affordable Care Act. There would probably be a very small decrease in premiums for small employers, and people in the individual health insurance market would end up paying less for a given benefit package.

The CHAIRMAN. So the answer to the question is——

Dr. VAN DE WATER. The answer is yes. The Affordable Care Act is estimated to reduce premiums.

The CHAIRMAN. Compared with no law. If the law were not passed, then are you saying that probably the premiums would go up at a higher rate?

Dr. VAN DE WATER. Yes. Again, that is not my estimate, that is the Congressional Budget Office's estimate.

The CHAIRMAN. The Congressional Budget Office. Now remind everybody here, who is the Congressional Budget Office? Just so the world knows.

Dr. VAN DE WATER. Oh. The Congressional Budget Office is the congressional staff office, nonpartisan office, established by the Congressional Budget Act to provide its best estimates to you and other members of the Congress about the budgetary and economic effects of pending legislation.

The CHAIRMAN. And you said it is a nonpartisan office.

Dr. VAN DE WATER. Absolutely, sir.

The CHAIRMAN. And it serves both the House and the Senate?

Dr. VAN DE WATER. Indeed.

The CHAIRMAN. And it is staffed with professionals?

Dr. VAN DE WATER. Yes, sir.

The CHAIRMAN. And it has a reputation of not tipping the balance one way or the other. Is that correct?

Dr. VAN DE WATER. That is correct. I mean, like any estimates, there is always a degree of uncertainty, but the Congressional Budget Office aims to produce an estimate and get as close as possible to the middle of the expected outcome.

The CHAIRMAN. Well, I appreciate that. I am not going to get into this—which I think is a sterile and specious—debate about double-counting. I will put in the record an article from the *Washington Post* on this issue, which basically included a silly discussion, and other sides have been using it themselves.

[The article appears in the appendix on p. 47.]

The CHAIRMAN. The analogy really is, for me, if you are a baseball player and you have RBIs, runs batted in, and it is a certain

number, and you have all the players on the team, you add the total all up, and it is not going to equal what the runs batted in for the team is. They are just two separate components, one is part of the other, and so forth. I am not going to get into a debate over it, but to be honest I am kind of disappointed when people raise that discussion, because it is really missing the whole point.

Dr. VAN DE WATER. Mr. Chairman, I agree with your argument, your point that this is a sterile argument. If I might add one thing, I mentioned in my——

The CHAIRMAN. I also think it is specious.

Dr. VAN DE WATER. Indeed. I mentioned in my prepared statement that this argument has just surfaced in the past year, and that for decades, when estimates were being done for legislation, people recognized that changes in Medicare could both reduce the deficit and improve the status of the Hospital Insurance Trust Fund. As I said, I knew that was the case from my experience at CBO.

But it was recently brought to my attention that, when Congress was considering the Balanced Budget Act of 1997, which I am sure you remember very well, the Senate Republican Policy Committee issued a legislative notice in which they themselves pointed out that that very piece of legislation would both help produce a balanced budget, and also extend the life of the Medicare trust fund.

The CHAIRMAN. Thank you. My time has expired.

Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman.

Dr. Holtz-Eakin, let me ask you a question on the waiver issues. I appreciated the point that you made in a couple of your articles where you said conservatives ought to take these proposals seriously. I appreciate that.

What I would like to hear you outline is, you also say that the States ought to get wider latitude, I think, than what we have talked about. Now, our proposal and current law says that you would not have to have an individual mandate, you would not have to have an employer mandate, you would have a lot of flexibility in terms of the exchanges and something that you and I, I think, share a similar view on: poor people would have new choices. Poor people would actually be brought into a private sector marketplace.

I think it has been the view with Senator Brown and I that, in effect, States could pretty much do almost anything that they sought to do, as long as they could hit the coverage kind of targets. So, when you say wider latitude is needed, tell me what else you think ought to be part of the debate, because I want to reach out to the conservative folks, and progressive folks. I remember the first conversation I had with Senator Scott Brown. He said, this is about States' rights. This is about letting States go off and do their own thing. So, when someone like yourself says there ought to be wider latitude, I want to reach out and hear your thoughts.

Dr. HOLTZ-EAKIN. Well, I think we share a lot of the same objectives. One of the things we now know is that the States are under a lot more pressure than we initially thought a year ago because of their budgets.

Senator WYDEN. Correct.

Dr. HOLTZ-EAKIN. And because it looks like the number of, for example, new retirees—if the income rules are as I understand them, they will disregard their Social Security as part of the income. That means they will qualify for Medicaid instead of being in the exchanges, so the actual burdens are bigger than the CBO estimated at the time.

If you say to a State, all right, you have big budget problems, there will be more people on Medicaid than we anticipated, you have to hit coverage targets, and you have to hit benefit requirements, they do not have many tools. Once you say there is so many people and there is so much in the way of benefits, they have to get efficiencies, which means you have to give them great latitude on delivery system models so they can get efficiencies and get some savings. I also think that they should get some flexibility on the benefit packages. I think that would be an enormous help. It makes a lot of sense.

The last piece is the migration between Medicaid and the exchanges, where, as I mentioned to you in one of our conversations, there is research in Health Affairs—and I will get the details wrong, but the spirit of it is, if you look at the area at about 133 percent of the Federal poverty line, there are about 20 million folks who are on the border of Medicaid versus exchange eligibility, and they will transition back and forth at a rapid rate.

That is an administrative nightmare for a State to be taking them out of one program, putting them in another, and then turning around and putting them back. They will probably get disruptions in their coverage, and maybe even their providers. It does not make any sense, without having the flexibility to take the Medicaid dollars and go in the exchange and stay in private insurance. I think those are all good ideas.

Senator WYDEN. I think, clearly, there is an opportunity for progressive folks and conservative folks to work together here. That is one of the reasons I find this coordinated waiver that the Secretary was talking about attractive, because on this point of employers dropping coverage, I think it is clear there is considerable concern.

If a State says they are going to come in with a waiver proposal to drop the individual mandate and drop the employer mandate, this gives employers more opportunities to offer affordable coverage, not send their low-income workers to either Medicaid or workers above it to the exchange. I would like to follow up with you on that and continue to work with you.

A question for both of you. It is on a point you made, Mr. Chairman, that I think is really the ball game, and that is this chronic care question. It is clear from the latest research that the bulk of the Medicare dollar goes to a relatively small percentage of the population, folks with heart disease, stroke, diabetes, these kinds of conditions.

Senator Carper has done yeoman work focusing on prevention so that we would have fewer folks at some point on Medicare without all those health concerns, but right now we still have to address this. Do either of you have any thoughts on how it would be possible to promote additional efficiencies, and particularly coordination of chronic care services—because I think there is a fair amount of duplication there—and generate some savings?

Since I was pummeling Dr. Holtz-Eakin first, why don't you start that, Dr. Van de Water, and then you could follow up. But the prospect of savings on this point, the chairman, I think, is spot-on with respect to the question of cost. Senator Carper's point makes sense for the long term, but we have to figure out how people can get good-quality chronic care today, and at the same time not break the bank. Your thoughts, Dr. Van de Water?

Dr. VAN DE WATER. Senator, I do not have anything to add to what Secretary Sebelius said on this issue earlier. The Affordable Care Act itself sets up a number of pathways to improving delivery of chronic care, including, particularly, the efforts to do various demonstration projects, and certainly, of course, the Federal coordinated care office to focus on the Medicare/Medicaid dual-eligibles who, as the Secretary said, represent a large part of the cost of the program.

I do not know that anyone can say that he or she knows which of these new ventures will prove most successful, exactly how they are going to work out, but the approach of the Affordable Care Act, which is to set up a variety of things to try, to try to implement quickly the things that work, abandon the things that do not work, and move on to new efforts, is the right approach.

Senator WYDEN. I am over my time. Mr. Chairman, can Dr. Holtz-Eakin just answer?

The CHAIRMAN. Yes. Briefly. You are over your time, but just briefly. Senator Hatch has been very patient here.

Senator HATCH. No, no.

Dr. HOLTZ-EAKIN. I think, briefly, what we know is that expensive people are those with multiple co-morbidities, many of them chronic, and that identifying effective practice patterns is something that is a top priority, and coordinating their care across providers has to be an essential part of this. Fee-for-service medicine fails at both of those, so we have to move away from it.

My reservation with the Affordable Care Act is that Medicare Advantage is an operating entity which coordinates, which can give you lots and lots of discovery of effective practice patterns, that has a financial incentive to manage these patients effectively, especially the duals. These are low-incomes and minorities, in many cases. So it is a high-value delivery system. To scale it back, I think, is a mistake.

Senator WYDEN. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Hatch?

Senator HATCH. Well, thank you, Mr. Chairman.

Dr. Holtz-Eakin, I know that our esteemed chairman thinks that the double-counting argument is specious, but health care law contains more than $500 billion in cuts to the Medicare program, which were claimed by the administration not only to improve Medicare solvency, but also to fund new entitlement spending at the same time.

Now, furthermore, the nonpartisan Congressional Budget Office said, on December 23, 2009, "The key point is that the savings in the Hospital Insurance Fund under the PPACA would be received by the government only once, so they cannot be set aside to pay

for future Medicare spending and at the same time pay for current spending on other parts of the legislation or other programs."

In fact, the Department's own actuary also agreed with this viewpoint in his memorandum on April 22, 2010 when he said the following: "In practice, the improved HI financing cannot be simultaneously used to finance other Federal outlays, such as coverage expansions under PPACA, and to extend the trust fund, despite the appearance of this result from the respective accounting conventions."

Now, do you agree with the CMS's actuary's view that you cannot use the same dollar to extend the solvency of the Medicare Part A trust fund while you are also using it to pay for new Federal spending?

Dr. HOLTZ-EAKIN. I completely agree. The trust fund will not contain real resources to pay benefits.

Senator HATCH. Then how are they getting away with this? How are they getting away with this by saying there is no double-counting here? I mean, here are two eminent solutions of their own. Can you answer that question?

Dr. HOLTZ-EAKIN. This, I believe, is simply a very misleading presentation of the budgetary facts. The fact that it is longstanding does not change the fact that it is misleading. You cannot pretend that you have extended the life of the trust fund unless there are resources to pay future benefits and simultaneously pay current benefits under the insurance exchanges. That is just not possible. So you either pay for the current benefits or you put the money away for the future, you cannot do both.

The CHAIRMAN. I might—I am sorry.

Senator HATCH. Well, let me continue. I am coming to the conclusion this is the Unaffordable Care Act, not the Affordable Care Act. States are facing a collective $175 billion budget shortfall. I do not know anybody who disagrees with that. This is the worst State budget crisis since the Great Depression.

Now, the 2009 so-called economic "stimulus" package and the Patient Protection and Affordable Care Act imposed new Medicaid eligibility restrictions on the States called "maintenance of effort" requirements. Now, this lack of flexibility made it especially challenging for States to solve these unprecedented State budget crises, and the majority of Governors have asked Washington for relief from these successive constraints. States are being forced to cut education, law enforcement, and make completely unrealistic cuts to Medicaid providers, jeopardizing access to care for the most vulnerable beneficiaries.

Now, Dr. Holtz-Eakin, could you comment on the effect of the MOE requirements during the current State fiscal crisis?

Dr. HOLTZ-EAKIN. Well, as I mentioned in my opening remarks, I wanted to applaud your efforts and those of Congressman Upton, to take on this issue. States are fiscally strapped. Some of their efforts and the degree of severity are actually best documented by work that has been done at Dr. Van de Water's organization, and the MOE requirements are a mandate that they spend money they simply do not have. They need flexibility to control their budgets, and they do not have that flexibility. I think at this point in time it is an especially big budgetary injustice to these States.

Senator HATCH. Where is the Secretary going to get the money for that 3-year period of time when they are going to pay for all this stuff?

Dr. HOLTZ-EAKIN. They believe that they can borrow those dollars on international markets. I am less sanguine about the U.S. outlook and believe this is a very dangerous law for that reason.

Senator HATCH. Well, I just saw where PIMCO is selling off U.S. bonds and not taking any more. Now, if that does not send a message, I do not know what in the world does. Yet, they seem to think there is a never-ending fount of money to just pay for this.

Look, there are good things in every bill, I suppose, in health care and things that both sides would have agreed on. But these type of things, personally, they are driving me out of my gourd. I mean, I cannot believe that they continue to get away with this—we can just pay for everything even though costs are going to go up, regardless.

Dr. HOLTZ-EAKIN. We have not changed the trajectory of national health care spending. That is the fundamental problem. It is the missed opportunity in this reform. The budgetary consequences I consider to be dire, and I am deeply concerned about. For those reasons, I think it is the wrong move at this juncture in our history.

Senator HATCH. Do you think this bill is going to bend the curve, to use their terms?

Dr. HOLTZ-EAKIN. No. No.

Senator HATCH. What do you think about that? What is it going to do, then?

Dr. HOLTZ-EAKIN. I believe that the underlying pace of health care cost growth will remain essentially unchanged, and we will layer on top of that additional insurance requirements that will make insurance more expensive, and even worse, we will damage the pace of economic growth, because this is a bad economic policy toward a big part of our economy, and thus the resources that we will have available to address both those higher costs will be lower.

Senator HATCH. And you said it is going to be one-fifth of the American economy?

Dr. HOLTZ-EAKIN. It is growing too fast.

Senator HATCH. Do you really think it will be one-fifth of our economy?

Dr. HOLTZ-EAKIN. Twenty percent of GDP, yes. We are on track to get there.

Senator HATCH. Jeepers. All right, Mr. Chairman. That is all I have.

The CHAIRMAN. I am tempted to get into this double-counting, but I am going to refrain.

Senator HATCH. I would like that. I would like you to do that.

The CHAIRMAN. Well, I would, too, because I would like to expose it. But nobody's mind is going to be changed with this argument, so I am not going to get into it. We are past it. We can move to the present. The present is, we have a law. It is not going to be repealed. The question therefore is, how do we make it work? How do we make it work well? Nothing is perfect. This is a large statute. It is well-intended, and I think its results are going to be, over time, definitely positive.

I predict it is going to be somewhat like Social Security. Ten years after the passage of Social Security, 10 years after the passage of Medicare, people look back and say, yes, that was the right thing to do because we made improvements along the way on each of those two, as we will make improvements here along the way.

So I am just going to let each of you—I do not want to get into these political arguments. Just constructively, what are the one or two things that you think we need to do to make it work better? We know it is not going to be repealed. We know that. It is a fact. Either one of you can start, it does not make any difference.

Dr. VAN DE WATER. Well, there are many areas. I guess, maybe I can comment briefly on two. First of all, Senator Thune was asking Secretary Sebelius about the CLASS Act. Clearly, many of us, myself included, have written about the issues that we faced in making sure that CLASS is solvent, but I think the Secretary has indicated that the Department of Health and Human Services is fully aware of all of those issues and is making every effort to use the flexibility of the law to make sure that CLASS is implemented in a fiscally responsible way. So I think that is one example.

The CHAIRMAN. That is a problem. I was not in favor of the CLASS Act, I must tell you, for all the reasons people decry it. But it is there. Now we have to do what we can with it.

Dr. VAN DE WATER. So I think that is, in fact, a good example, in answer to your question, of where we need to work.

The CHAIRMAN. As to that, what else?

Dr. VAN DE WATER. Secondarily, I have some concerns about an issue which is pending in the Congress currently, which is the issue of, to what extent people who receive tax credits for premiums and suffer a change or benefit from a change in circumstances which could require them to have to repay a large amount of that credit even though it was correctly received at the time, I think care has to be taken in redesigning those repayments.

The CHAIRMAN. Right. That is interesting. We are debating that right now. Frankly, a lot of Senators are trying to get their hands around it. Do you have any off-the-top-of-your-head thoughts of how that might be modified?

Dr. VAN DE WATER. It is a very complicated issue. My basic point is that, in doing that, one has to be careful to make sure that people do not face the risk of repayments that are so large and that are trying to recoup money that actually was correctly paid in the first place——

The CHAIRMAN. Right.

Dr. VAN DE WATER [continuing]. And so as to deter participation and undo the fundamental point of the coverage expansion.

The CHAIRMAN. All right.

Dr. Holtz-Eakin, how do we make this better?

Dr. HOLTZ-EAKIN. So, if you roll the clock back to the beginning of the debate, there was a much greater bipartisan agreement on delivery system reforms——

The CHAIRMAN. Yes. That is correct.

Dr. HOLTZ-EAKIN [continuing]. And great divergence on the coverage. I believe, going forward, that is the way to think about this. Quite frankly, the road to health care hell is paved with demonstration projects. We are not going to bend the curve with all

these demonstrations. We need stronger delivery system reforms. That is a way both sides should be able to agree to go. That is the cost problem. I would simply repeal the CLASS Act. It is broken, it cannot be fixed, and it is expensive.

On the insurance subsidies, you have, I think, a big problem in that they are just too rich, and thus the encouragement for employers to drop. I think you need to be cognizant of their budgetary costs for that reason. They are also unfair in that you are going to have one family that has employer-sponsored insurance and gets nothing, and then another family that is identical and is getting up to 10 percent of their income or more in Federal subsidies; that is just not going to hold. So, I believe it is budgetarily sensible, fairer, to scale back those insurance subsidies. They are simply too generous in the law. We understand that we want to help deserving Americans, but you cannot over-promise, and this bill does.

The CHAIRMAN. Delivery system reform. Can you expand on that a little bit? What do you have in mind there?

Dr. HOLTZ-EAKIN. Well, I believe that we have to make stronger efforts to simply get rid of fee-for-service medicine in America, period. I would personally also like to see stronger budgets on these efforts. So, one of the reasons I believe it is desirable to sort of block out Medicaid is, you give a fixed budget and let them go work on it in the States and at the Federal level. I think using more of Medicare Advantage as a bridge to something that looks like a premium is actually sensible and will give you better delivery system reforms as well. So, we can talk about this at greater length; it takes a while.

The CHAIRMAN. It does.

What about the effort to build in control costs with an IPAB?

Dr. HOLTZ-EAKIN. Say again. I could not hear.

The CHAIRMAN. IPAB. I have forgotten the name of this outfit.

Dr. HOLTZ-EAKIN. The Independent Payment Advisory Board?

The CHAIRMAN. Yes. That is the one. Yes. What do you think of that?

Dr. HOLTZ-EAKIN. I think it sounds like MedPAC on steroids. As an alumnus of MedPAC, I think it will be comparably effective.

The CHAIRMAN. That is a bit ambiguous.

Dr. HOLTZ-EAKIN. I am not optimistic that it will ever be allowed to substantially affect the trajectory of Federal health programs.

The CHAIRMAN. Because?

Dr. HOLTZ-EAKIN. Because Congress will override it if it is inconvenient. That is the history of it. It has already, in the statute, been given limited tools. It cannot charge beneficiaries more; we cannot touch certain aspects of the delivery system for 10 years. If you start out constraining it, you have set the precedent that you do not really want it to do what you say this job is. I am not optimistic.

The CHAIRMAN. Well, it is there. We have to figure out how to make it work. Things can be repealed. You are right.

You have made a lot of provocative statements, both of you, that take more time to explore. But I thank you very much. That is why I invited you in the first place, because you are both so thoughtful and so helpful. So, thank you both, very much.

The hearing is adjourned.

[Whereupon, at 12:33 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Hearing Statement of Senator Max Baucus (D-Mont.)
One Year after the Enactment of Health Care Reform
As prepared for delivery

Abraham Lincoln said:

"You cannot escape the responsibility of tomorrow by evading it today."

Health reform looked ahead to the responsibility of tomorrow. It asked: will quality, affordable care remain accessible if costs continue to rise? Health reform took responsibility for tomorrow by solving the challenges of today. It protected one of our most important responsibilities: Medicare.

One year ago, Medicare was set to go bankrupt in just seven years. Health care reform extended the life of the program by twelve years after that, until at least 2029.

A year ago, Medicare only paid health care professionals to provide care when seniors were sick. Medicare was too often a system that only treated sickness, and that meant it was costly. We knew these costs were overburdening Medicare and our entire health care system.

We spent nearly two years studying the problems. We worked together to craft a law that lowered costs and shifted the focus of our system to prevention and wellness.

Today, Medicare doesn't just care for you when you get sick. It is a true health care system.

Under the health reform law, seniors receive an annual wellness visit. Seniors can schedule the visit even if they aren't sick. They can receive screenings and tips on how to manage or prevent conditions like diabetes or high blood pressure. Madame Secretary, I look forward to hearing from you today about how these visits are working for seniors.

A year ago, seniors faced a Medicare program that focused on the quantity of care they received, not the quality of the care delivered. Medicare paid hospitals more if a patient got an infection that could have been avoided and paid hospitals less if they successfully avoided infections.

A year ago, each of a patient's doctors would perform the same test, because they hadn't been encouraged to work together and share results.

Health reform increases payments to hospitals for providing higher quality care, the law gives hospitals incentives to prevent avoidable illnesses, and the law improves quality by increasing the number of primary care physicians.

These doctors can better keep track of patient care. They can make sure patients are seeing the right specialist. And they can help specialists avoid repeating tests, procedures and options that have already been completed or considered.

To encourage primary care, the Affordable Care Act pays doctors more to practice primary care. That's already producing results.

Dr. Tom Roberts has been an internist in Missoula, Montana, for 30 years.

He said health reform has "already had a direct impact on our ability to provide good medical care to the citizens of Missoula and the surrounding counties," and he added that, "We are in a much better position to continue to support the kind of primary care services that are vitally important moving forward."

A year ago, seniors had to pay more for their prescription drugs, and that meant seniors didn't always get the treatment they needed. The Medicare Prescription Drug Benefit covered the first $2,800 in costs, and catastrophic coverage kicked in after seniors spent $6,300, but there was a coverage gap in between, often called the "donut hole."

Today, health reform is closing that gap in coverage. Already, more than 3.5 million seniors received a check for $250 that helped cover the cost of their prescriptions in 2010. This year, seniors who hit the donut hole will receive a discount of 50 percent off the cost of their prescriptions, and the gap will be eliminated entirely by 2020.

A year ago, the standards to prevent waste, fraud and abuse in Medicare were not tough enough. As a result, criminals were able to rip off federal health care programs. Too often, these programs paid fraudulent claims without enough review.

The new health reform law provides enforcement officials with unprecedented new tools. These tools prevent fraud before it occurs.

Because of the changes in the Affordable Care Act, Medicare is stronger than ever. But now we face new challenges. We face those who want to roll back these benefits and weaken Medicare.

So let us continue to confront the challenges of tomorrow, and let us continue to protect and strengthen Medicare today.

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The Washington Post

Sebelius and "Double-Counting" of Medicare Savings

By Glenn Kessler

"What's the $500 billion in cuts for? Preserving Medicare or funding the health-care law?"
—Rep. John Shimkus (R-Ill.), March 3, 2011

"*Both.*"—Health and Human Services Secretary Kathleen Sebelius

Aha! The double-counting of Medicare funds for the new health care has been admitted by the Obama administration. At least that's what Republicans claimed as the video clip above went viral on the Internet.

On the face of it, Sebelius' answer seems rather strange. As one web headline put it, "Sebelius Cracks! Admits the Obamacare Books Were Cooked."

But on another level, Sebelius is telling the truth, though somewhat inartfully. There is really nothing quite as nefarious about the process as some critics suggest, though one could argue that the process is wrong. A lot of this has to do with the strange and complicated way that the U.S. federal budget is calculated, so let's take a trip through the numbers.

The Facts

When President Bill Clinton signed the Balanced Budget Act of 1997, then House Speaker Newt Gingrich (R-Ga.) was one of the speakers. "On Medicare, we came together and we saved the system for at least a decade," he declared. How could he make this claim? Through the same double-counting that Republicans now decry.

The Fact Checker especially frowns on hypocrisy, and Republicans should acknowledge that they have gladly played this game before, including under President George W. Bush. Even a reformed gambling addict has to admit he once had a gambling problem.

But, on the other hand, a strong case can be made that there is no double-counting going on at all. It's simply a case of looking at the same money in different ways. In other words, it is not double-counting, but counting different things.

You may have $1,000 on deposit at a bank. Those are certainly your assets, but the bank looks at that money differently: money to make more loans. It's the same $1,000 but it is counted differently on your books and the bank's books.

A similar thing is going on here. The health care law reduced predicted expenditures for Medicare by nearly $500 billion, resulting in budgetary savings that the law uses to help pay for the health care changes. That's the money in the bank; it means the U.S. government will not need to set aside as many Treasury securities to fund Medicare.

Meanwhile, because Medicare spending has been reduced, the solvency of Medicare has been extended. That's the other side of the ledger—the bank's view, so to speak. The accounting for Medicare solvency is a different matter than the current spending in the budget, though it has implications for the long-term budget health.

Here's how the Balanced Budget Act of 1997 was described at the time: "Along with saving $247 billion over five years, the Act also extended the solvency of Medicare's trust fund for at least 10 years." You can argue about how this extra money is spent—the Balanced Budget Act of 1997 spent it on tax cuts and a children's health plan—but in theory there was more money in the bank. (Footnote: some of the Medicare cuts in the 1997 act turned out to be so onerous they were pared back or not implemented.)

Just because both parties have done this sort of accounting, a case certainly can be made that any real Medicare savings should be set aside—in a "lockbox," as former vice president Al Gore famously put it.

In fact, just because Medicare solvency has been extended, if the money saved on Medicare is used for other purposes, the long-term financial health of the government does not necessarily improve. That's because, in the words of the Congressional Budget Office, it "would not enhance the ability of the government to redeem the bonds credited to the trust fund to pay for future Medicare benefits." Indeed, under the health care law, the nation's gross public debt increases, though analysts disagree on the importance of that fact.

Some argue that the increase in the gross debt is evidence of double-counting but the CBO has said that focusing on the health care law's impact on the gross debt is not very illuminating: "That measure of debt conveys little information about the federal government's future financial burdens and has little economic meaning."

In any case, it is a fiction that the Medicare trust fund (and the Social Security trust fund) simply holds "worthless IOUs." IOU is just another way of saying bond. These bonds are backed by the full faith and credit of the U.S. government. No president or Congress would risk defaulting on these bonds because it would ruin the nation's financial standing.

The bonds are a real asset to Social Security and Medicare, but they also represent an obligation by the rest of the government. Like any entity that issues debt, such as a corporation, the government will have to make good on its obligations, generally by taking the money out of revenue, reducing expenses or issuing new debt.

The Pinocchio Test

Sebelius is correct when she says the same savings is doing two things at once. Whether this is double-counting is in the eye of the beholder, but under the accounting rules that both parties have used for decades, this is considered an acceptable practice. As the debate on entitlements heats up, and new savings in Medicare are identified, the real question should be how those savings are applied, not whether the accounting is bogus.

Two Pinocchios to Republicans who keep flogging this issue without acknowledging their own past complicity.

STATEMENT OF HON. ORRIN G. HATCH, RANKING MEMBER U.S. SENATE COMMITTEE ON FINANCE HEARING OF MARCH 16, 2011 HEALTH REFORM: LESSONS LEARNED DURING THE FIRST YEAR

WASHINGTON – U.S. Senator Orrin Hatch (R-Utah), Ranking Member of the Senate Finance Committee, delivered the following opening statement at a committee hearing with Health and Human Services (HHS) Secretary Kathleen Sebelius examining the impact of the $2.6 trillion health overhaul one year after the President signed it into law:

Thank you Mr. Chairman for helping to schedule this important hearing. It comes on the anniversary of the Patient Protection and Affordable Care Act becoming law. Whether this is a welcome anniversary depends on one's perspective.

When I listen to the Utahns, and Americans from coast to coast, who were left footing the bill for this misguided health law, I get a very different assessment.

For struggling families, any marginal benefits from this law are far outweighed by the heavy-handed intervention in their healthcare by Washington bureaucrats.

For seniors, the cuts to a Medicare program that is already nearing bankruptcy, in order to fund another new entitlement and expand an existing one, are beyond irresponsible.

And for taxpayers, the decision to pay for this law with over $813 billion in tax increases was the last thing our struggling economy needed.

The more that Americans get to know this law, the less they like it.

In the end, it might have been over 2,000 pages long, but Americans understood it both simply and soundly.

In short, at the President's urging, Democrats passed a $2.6 trillion health care law, with massive new subsidies for coverage, and without addressing the long-term costs of care.

All of this was paid for with billions in new taxes and by taking from an already struggling entitlement.

This simple understanding is closer to the mark than that of the supposedly sophisticated who sold this massive spending bill as somehow saving money.

Citizens understood that the historic expansion of federal power and the creation of new bureaucracy would never increase efficiencies and make care more accessible.

So one year later, what do we know about this law?

What has it given us?

As it turns out, the American people were closer to the mark than all of the liberal editorialists that pushed for this law.

$2,100 in higher premiums.

800,000 fewer jobs.

$118 billion in new unfunded state mandates.

$311 billion in higher health care costs.

$529 billion in Medicare cuts to fund new entitlement spending.

$813 billion in new taxes.

And $2.6 trillion in new federal spending.

It would be hard to devise a more economically destructive piece of legislation. Just last week, the Congressional Budget Office concluded that "growth in health care costs will almost certainly push up federal spending significantly relative to GDP under current law."

So much for *bending the cost curve*.

And let's keep in mind that all of this damage comes before the Medicaid expansions and the new premium subsidies for the health law's insurance exchanges.

It is reasonable to assume, given the history of federal spending programs, that the original cost estimates for these coverage expansions are substantially understated.

Yet Americans' opposition to this law is not only owing to it being bad policy. In the eyes of citizens, its original sin was a lack of transparency. Americans understood that the true cost of health law was being hidden from them.

According to the President's budget, a permanent fix to Medicare's physician payment formula will cost taxpayers nearly $370 billion over the next ten years.

But instead of fixing this problem, the health law cut $529 billion from Medicare and directed it toward new entitlement spending.

This was simply irresponsible.

But it was also misleading, as it double counted the savings from Medicare.

The Chief Medicare Actuary — the Administration's chief actuary — was crystal clear on this point. He said, "[i]n practice, the improved Part A financing cannot be simultaneously used to finance other Federal outlays (such as the coverage expansions under PPACA) and to extend the trust fund . . ."

This double counting and lack of transparency on costs that stained the health law in its origins continued as the Administration sought to implement the new law.

According to the Congressional Research Service, roughly 83 percent of the final rules implementing the health law circumvented public comment, which is generally required by federal law.

I guess this Administration's pledge on transparency simply became another slogan that was discarded when it became an inconvenience in implementing their agenda.

Just yesterday, my colleague, Senator Enzi, and I reminded the Administration of its troubling failures when it comes to briefing Congress on the health law's implementation. This includes a failure to respond to nearly 67 percent of Republican requests.

One year later, with its flaws only more evident, I suspect it is starting to dawn on more members of this body as well.

I thank the Chairman again, as well as our witnesses, for appearing here today. I look forward to today's testimony and what should be a lively question and answer session. Thank you.

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Health Reform: Lessons Learned During the First Year

Douglas Holtz-Eakin
President, American Action Forum*

March 16, 2011

Chairman Baucus, Ranking Member Hatch and Members of the committee, thank you for the privilege of appearing today. In this written statement, I hope to make the following points. One year after the passage of the Patient Protection and Affordable Care Act (ACA):

- The health care reform remains a missed opportunity for Medicare reform. Medicare is in deep financial distress that cannot by disguised by gimmicky trust fund accounting, will be unlikely to successfully absorb the planned provider cuts in the ACA, and lacks a real fix to the broken Sustainable Growth Rate (SGR) mechanism;

- Medicaid will be deeply stressed by the ACA, as states lack the flexibility to balance the mandates and coverage expansions and beneficiaries continue to have difficulty in achieving access to providers; and

- It has become obvious that the ACA is not a route to more jobs in America. Instead, its toxic mix of mandates, higher taxes, explosive spending, and deficits are a drag of the already-weak economic recovery.

Let me discuss these in turn.

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*The views expressed in this testimony are my own and do not represent those of the American Action Forum. It relies heavily on papers with my co-authors Michael Ramlet and Cameron Smith, who I also thank for their assistance and wise counsel. All errors are my own.

A Missed Opportunity for Medicare Reform

A dominant characteristic of health care in the United States is its expensive fragmentation and focus on acute-care episodes. These features feed growth in spending per capita. Fee-for-service Medicare is illustrative in this regard. It has programs for "hospital" (Part A), for "doctors" (Part B), and for "drug companies" (Part D). These compartmentalized programs are dedicated to ensuring that various providers receive their payments in a fee-for-service system. Doctors and hospitals are paid for the individual services for patients; and the more they do, the more they are paid. This system is focused on payments to providers, not on the health of families. This system is not centered on quality of care and gives scant regard to coordinating the decisions of the various medical providers, and it does not reward preventive care.

The Sustainable Growth Rate System and Reform

Because the fee-for-service system is overly expensive, the Medicare program is in financial distress. In particular, each year the Congress struggles to fit the program within the Sustainable Growth Rate (SGR) mechanism for physician reimbursements. Health care reform should first and foremost have centered on reforms to Medicare and its financing as a top priority. Instead of focusing on eliminating flaws in the system, the Congress instead enacted annual Medicare payment reductions to inpatient acute hospitals, inpatient rehabilitation facilities, and long-term care hospitals.

These started October 1, 2010 and are reflected in the inflation updates for Medicare payments. Beginning in rate year 2011, inpatient acute hospitals and inpatient rehabilitation facilities will receive a 0.25 percent reduction, and long-term care hospitals will undergo a 0.5 percent reduction.

As shown in Table 1, the reimbursement reduction to Medicare Part A providers is expected to produce $196 billion in cost savings over the next ten years compared to prior law. Coupled with the $136 billion that the Congressional Budget Office (CBO) projects may be saved from setting Medicare Advantage rates at fee-for-service (FFS) payment levels, a real opportunity arose for the White House and Congressional advocates to improve the long-term fiscal health of the Medicare program.

Unfortunately rather than applying the potential cost savings of the new healthcare reform law toward securing Medicare's future, the Administration and Congress diverted the $332 billion dollars toward new entitlement programs. The decision to not improve Medicare solvency threatens to reduce patient access for seniors and will lead to a substantial increase in annual premiums for Medicare beneficiaries over the next ten years.

TABLE 1: AVAILABLE MEDICARE SAVINGS ($ Billions)											
CBO Projections[1]	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2010 - 2019**
Reductions in Annual Updates to Medicare FFS Payment Rates	0	-1	-5	-9	-13	-19	-25	-33	-41	-51	-196
Medicare Advantage Rates based on FFS Service Rates	0	-2	-6	-9	-13	-17	-19	-21	-23	-25	-136
Total Medicare Savings	**0**	**-3**	**-11**	**-18**	**-26**	**-36**	**-44**	**-54**	**-64**	**-76**	**-332**

After years of Congress overriding the Medicare sustainable growth rate (SGR) formula for physician payments, beneficiaries now face a growing problem that physicians no longer accept new Medicare patients. If the SGR were to go into effect today, physicians would receive a draconian reimbursement cut. Both parties acknowledge the formula is currently unsustainable, but the healthcare reform law did nothing to reset or restructure the fee schedule.

At the time of passage, it would have been possible to more than cover the cost ($174.7 billion) of eliminating the cumulative overspending in the SGR formula and restarting it last year. Or, more aggressively, one could have replaced the proposed cuts with annual updates equal to 0 percent up to 2 percent. This would have served to genuinely strengthen the existing Medicare program and ensured physician access to the millions of baby boomers approaching retirement.

The Medicare Trust Funds

Proponents of the ACA argue that its Medicare provider cuts and certain tax increases (notably the investment income surtax) make Medicare more solvent. It is not possible to reconcile these claims with the simultaneous claim that they offset the cost of their new health insurance entitlement. Simply put, one cannot have it both ways. It is not possible to claim that the health reform both extends the life of Medicare's Hospital Insurance (HI) trust fund and does not add to the deficit.

As an economist, I am quite sure of this fact. However, I understand that current authorities matter. So, I will note that the Congressional Budget Office (CBO) and the Administration's Actuary at the Centers for Medicare and Medicaid Services (CMS) have highlighted the fact that hundreds of billions of dollars in Medicare savings are essentially being double-counted under the new law.

In particular, CMS noted that "In practice, the improved HI financing cannot be simultaneously used to finance other Federal outlays (such as coverage expansions under the ACA) and to extend the trust fund, despite the appearance of this result from the respective accounting conventions." Similarly, CBO has opined that "The

[1] Cost estimates from the Congressional Budget Office Letter to Speaker Nancy Pelosi, U.S. House of Representatives, 20 March 2010.

key point is that savings to the HI trust fund under PPACA would be received by the government only once, so they cannot be set aside to pay for future Medicare spending and, at the same time, pay for current spending on the other parts of the legislation or on other programs...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."

A Wrong Turn on Medicare Advantage

Medicare has a long and successful history of developing and expanding private-sector managed care options for beneficiaries. These plans have been very successful in attracting and serving Medicare beneficiaries, and providing expanded benefits, cost-effective care, and superior results. The ACA reverses this policy by substantially tilting the policy playing field against Medicare Advantage. This policy u-turn will not only harm current members by reducing benefits and increasing premiums, it will disadvantage all beneficiaries by reducing their access to private plan choices. Looking forward, budgetary pressures are likely to place a premium on efficient delivery of care, raising the importance of preserving Medicare Advantage to ensure that we protect the infrastructure now in place that may be critical to addressing Medicare's long-term cost challenges.

Innovative MA plan designs that are priced below Medicare's benchmark rate create added value for beneficiaries. Private plans are able to provide Medicare benefits at a cost below the established benchmark by implementing several proven approaches to managing cost and quality:

- having members receive care from a contracted network of providers,
- altering the Medicare benefit design to encourage cost effective utilization behaviors by members (for example, reducing the cost of primary care physician visits to encourage members to get appropriate care for chronic conditions), and
- providing innovative programs like disease and high risk care management for members with advanced illness or multiple, chronic conditions.

In 2010, the majority of MA plans, 66 percent, chose to apply rebate dollars toward reduced cost sharing. The remaining 34 percent of rebate dollars were spent on offering additional benefits like vision and dental care.[2]

The use of rebate dollars for reduced cost sharing has made the MA program critical to lower-income seniors. A disproportionate share of low-income beneficiaries selects MA

[2] A Data Book: Healthcare Spending and the Medicare Program," *MedPAC,* June 2010.

as their source of supplemental Medicare coverage.[3] Experience following the passage of the Balanced Budget Act suggests that without the MA program, many of these lower-income Medicare beneficiaries will revert to traditional Medicare because they will not be able to afford the high premiums of a Medicare Supplement plan; they also will not be able to afford the higher cost sharing under traditional Medicare, leaving them unable to effectively access the health care system to meet their medical needs.

Medicare Advantage also relieves pressure on State Medicaid programs that would otherwise be responsible for many of the lowest-income MA beneficiaries. Notably, MA is the most common coverage choice among Medicare beneficiaries with incomes between $10,000 and $20,000. In 2008, 25 percent of beneficiaries in this income bracket chose an MA plan compared to 21 percent with traditional fee-for-service Medicare, 19 percent who enrolled in a Medigap policy, and 18 percent receiving Medicaid benefits.

With Medicaid eligibility set to expand dramatically under the ACA in 2014, the role of MA plans in relieving pressure on states will be even more critical. States are especially struggling with aging Medicaid beneficiaries who otherwise might enroll in MA plans. Ultimately, the effects of the ACA's MA cuts may be felt most by states.

With the positive results shown by Medicare Advantage plans in serving its members, it is concerning that Congress would make a policy u-turn on its support of the program. The Patient Protection and Affordable Care Act reverses decades of deliberate policy decisions to support use of effective private sector incentives and innovation for the benefit of the Medicare program and its beneficiaries. This includes cutting a total of $206.3 billion from the MA program.

Medicaid: Reform not Expansion

Medicaid is the cornerstone of the Patient Protection and Affordable Care Act. Despite a questionable track record, Congress built the reform around it. The ACA relies heavily on expanding Medicaid, which pays much less for physicians' services than Medicare and insurance, to cover the uninsured. The new law would bring 16 million Americans—one-half of the estimated 32 million who will receive new insurance coverage—into Medicaid, covering Americans making up to 138 percent of the federal poverty level.

Exacerbating the Patient Access Problem

America faces a primary care crisis. In a widely cited survey by the Commonwealth Fund, only 27 percent of adults could easily contact their physician over the telephone; obtain care or medical advice after hours, and experience timely office

[3] Medicare Current Beneficiary Survey Access to Care Files, 2008 (CMS).

visits.[4] Unable to access routine medical care, Americans increasingly turn to the most expensive care delivery setting– the emergency room.

In August of 2010, the Department of Health and Human Services reported that the number of emergency department visits in the U.S. had increased by 23 percent for the most recent reported decade, topping off at 117 million visits in 2007.[5]

Nowhere is this costly problem more acute than among Medicaid enrollees. The National Hospital Ambulatory Medical Care Survey revealed that Medicaid enrollees access care through the emergency room at twice the rate of the uninsured and privately covered populations. In part, greater emergency room use among Medicaid patients reflects low reimbursement rates in the state programs. In 2008, Medicaid reimbursements averaged only 72 percent of the rates paid by Medicare, which are in turn below the rates paid by private insurers. [6]

TABLE 2: ER VISITS (MILLIONS) BY PAYER TYPE

	Private	Medicaid	Uninsured
Covered Population (M)[a]	174.1	36.2	43.3
Total ER Visits (M)[b]	45.580	29.379	17.926
ER Visits Per Person	0.3	0.8	0.4
Percentage of Annual U.S. ER Visits[b]	*39.0%*	*25.2%*	*15.3%*

Source: National Health Statistics Reports - U.S. Department of Health and Human Services
a. Health Insurance Coverage Trends, 1959 - 2007; NHSR #17; July 2009
b. National Hospital Ambulatory Medical Care Survey, 2007; NHSR #26; August 2010

Primary care physicians in many states have simply stopped seeing Medicaid enrollees. In August, Texas doctors threatened to drop Medicaid in the face of even steeper reimbursement reductions. [7] The cost of limited access to primary care is especially apparent in Massachusetts; ironically the state model for the Obama Administration's healthcare coverage expansion. Medicaid patients from July 2007 through March 2008 visited the emergency room at a rate more than three times that of privately insured patients.

The decision to push insurance coverage through a major expansion of Medicaid

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[4] Beal A, Dotty M, Hernandez S, Shea k, Davis K. Closing the divide: how medical homes promote equity in healthcare. New York (NY): Commonwealth Fund; 2007.
[5] Niska R, Bhuiya F, Xu J. National Hospital Ambulatory Medical Care Survey: 2007 Emergency Department Summary. National health statistics reports; no 26. Hyattsville, MD: National Center for Health Statistics. 2010.
[6] Zuckerman S, Williams A, Stockley K. Trends in Medicaid Physician Fees, 2003-2008. Health Affairs, 28, no.3 (2009).
[7] Garret R. Texas doctors threaten to drop Medicaid out of fear of more fee cuts. The Dallas Morning News.

ensures a greater number of emergency room visits. What remains open to investigation is the exact rate at which patients will access care in the most costly care setting. In addition, as patients grapple with even more crowded emergency rooms, what will be the negative impact on their access to life-saving care in a real emergency?

A Costly Mandate to the States

Adding financial insult to medical injury, Medicaid spending currently consumes about 22 percent of state budgets, crowding out spending on everything from education to infrastructure. It is also part of the trifecta of federal programs—Medicare, Medicaid, and Social Security—driving the federal budget over a deficit cliff. In 2011, the federal and state governments are projected to spend $466 billion on Medicaid, with costs rising about 8 percent a year. Under the new law, Medicaid will spend an additional $443 billion by 2019—hardly evidence of the cost control that Obama promised for health-care reform.

Defenders of ACA's Medicaid expansion point out that the federal government will pick up 100 percent of those new costs for the first several years after 2014, when the law goes into effect, paring back to 90 percent in 2020. This will leave the states on the hook for just $21 billion in new costs by 2020, they say.

But the Medicaid expansion remains fiscally intolerable nonetheless. For one thing, $21 billion isn't an insignificant sum, especially at the state level; for another, it doesn't include up to $12 billion more in administrative costs. Many state budgets are in such perilous condition that they can't afford any new outlays; they need, in fact, to cut spending. Also, those who claim that the ACA won't impose new costs on the states don't take into account the 11 million uninsured Americans who are currently eligible for Medicaid but have never bothered to enroll. In 2014, once ACA's mandates require everyone to carry insurance or pay a penalty, many of these eligible but non-enrolled people will presumably sign up. And unfortunately for the states, these enrollees would be covered not under the generous federal matching rate that the Affordable Care Act establishes but under the pre-Obamacare rate, which varies by state but is much more onerous. Finally, even federal spending doesn't come free of charge to the states. That $443 billion will come either from higher federal taxes, which will drain funds from an already anemic private economy, or from cuts elsewhere in the federal budget, which will leave less money available to support state budgets.

The Need for Pro-Growth Policies

The United States' economy has endured a severe recession and is currently growing slowly. The pace of expansion remains solid and unspectacular. In many ways this is not surprising. As documented in Rogoff and Reinhart (2009), economic expansions in the aftermath of severe financial crises tend to be more

modest and drawn out than recovery from a conventional recession.[8] Accordingly, it is imperative that policy be focused on generating the maximum possible pace of economic growth. More rapid growth is essential to the labor market futures of the millions of Americans without work. More rapid growth will be essential to minimizing the difficulty of slowing the explosion of federal debt to a sustainable pace. More rapid growth will generate the resources needed to meet our obligation to provide a standard of living to the next generation that exceeds the one this generation inherited.

Unfortunately, key provisions of the ACA are inconsistent with strong, pro-growth policies. In what follows, I focus on three in particular: mandate costs, administrative burdens, and tax increases.

Employer Mandate Costs

Among the key aspects of the ACA is its mandate to cover employees with health insurance. Focusing first on those employers with more than 50 workers, beginning in 2014, those firms must pay a penalty if any of their full-time workers receive subsidies for coverage through the exchange. The penalty is equal to the lesser of $3,000 for each full-time worker receiving a premium credit, or $2,000 for each full-time worker, excluding the first 30 full-time workers. The fees are paid monthly in the amount of $1/12^{th}$ of the specified fee amounts. Firms with fewer than 50 employees are exempt from the so-called employer "play or pay" penalties if they do not offer coverage and their workers receive a subsidy in the exchange.

From the perspective of economic performance, the most important point is that the *best* possible impact is that the firm is already offering insurance, no individual ends up receiving subsidies and triggering penalties, and thus costs are unaffected. In every other instance, health insurance will compete with hiring and growth for the scarce resources of those firms.

One might think that the same situation prevails for the smallest firms – those under 50 employees – who are exempt from the coverage mandate. Unfortunately, for these firms, the greatest impact is the tremendous impediment to expansion. Suppose for example that a firm does not provide health benefits. Hiring one more worker to raise employment to 51 will trigger a penalty of $2,000 per worker multiplied by *the entire workforce*, after subtracting the first 30 workers. In this case the fine would be $42,000 (21 (51-30) workers times $2,000). How many firms will choose not to expand?

Proponents of the ACA like to point toward the fact that small businesses will receive aid in the form of a small businesses tax credit, ostensibly offsetting the burdens outlined above. Unfortunately, the credit is available only for employers

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[8] See *This Time Is Different: Eight Centuries of Financial Folly*, by Carmen M. Reinhart and Kenneth Rogoff, 2009.

with fewer than 25 workers and those in which average wages are under $50,000. Thus, the cost and growth impacts for those with 26 to 50 employees remains unchanged. Moreover, the credit is not a permanent part of the small business landscape. An employer may receive the credit only until 2013 and then for two consecutive tax years thereafter. Thus, the credit is available for a maximum of six years.

Turning to the credit itself, to be eligible the employer must pay at least 50 percent of the premium. The credit is equal to 35 percent of employer contributions for qualified coverage beginning in 2010, increasing to 50 percent of the premium in 2014 and thereafter. The amount of the credit is phased-out for firms with average annual earnings per worker between $25,000 and $50,000. The amount of the credit is also phased-out for employers with between 10 and 25 employees.

The combination of requirements for premium contributions, limitations on employees, limitations on earnings, and phase-outs has surprised the small business community. In particular, the reform's strict definition that a firm is only a small business if it has 25 or fewer employees proved convenient to the legislators who crafted the bill. This narrow definition has led to a number of studies that assert that more than 80 percent of small businesses will be eligible for the tax credit.

Even those studies that recognize the limitation imposed by the 25-employee limit tend to overstate the likely penetration of the credit. For example, the Small Business Majority and Families USA recently estimated that 84 percent of the nation's 4.8 million businesses that employ 25 or fewer employees will be eligible for the tax credit.[9] Unfortunately, the net impact of the credit in offsetting the cost burden of the ACA will depend not upon *eligibility* but rather on *receipt* of the tax credits. This distinction was noted early in the debate by the Congressional Budget Office. In November 2009 when the law was being considered before Congress, CBO found that, "A relatively small share (about 12 percent) of people with coverage in the small group market would benefit from that credit in 2016."[10]

A more useful study focuses on the estimated number of small firms who would qualify for the small business health insurance tax credit. A recent analysis conducted by the National Federation of Independent Business (NFIB) found that the total number of firms that offer health insurance and pay more than half of their employees' premium costs, as mandated under ACA, is more likely 35 percent of all firms with less than 25 employees.[11]

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[9] http://www.smallbusinessmajority.org/_pdf/tax_credit/Helping_Small_Businesses.pdf

[10] See, http://cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf

[11] See, http://www.nfib.com/nfib-on-the-move/nfib-on-the-move-item?cmsid=52099

In the same way that the mandate provides an implicit tax on growth, the structure of the small business tax credit will raise the effective marginal tax rate on small business expansion. For this reason, the credit may discourage firms from hiring more workers or higher-paid workers. Consider two examples.

In the first, employers will have an incentive to avoid increases in the average rate of pay in their firm. Suppose that the average wage in a small (3 worker) firm is $25,000 and the owner decides to add a more highly paid supervisor being paid $50,000. This will raise the average wages in the firm to $31,250 there by *reducing* the tax credit per worker from $2,100 to $1,596.[12] In effect, the structure of the credit raises the effective cost of adding valuable supervisory capacity.

In this example, total credits to the firm are essentially unchanged ($6,300 to $6,384) by raising the average wage. If the new supervisor were paid $75,000 however, total credit payments would fall from $6,300 to $4,368. The lesson is clear in that the structure of the credit can impose large effective tax rates on raising the quality of the labor force for those receiving the small business credit.

Similar incentives affect the decision to hire additional workers because the overall tax credit falls by 6.7 percent for each additional employee beyond 10 workers. This is a very strong disincentive to expanding the size of the firm. Using the example above, suppose that the firm has 10 employees and total credits received were $21,000. The firm's total subsidy will peak at $21,840 with the hiring of the 13th worker. Thus, a firm employing 13 workers would get a total tax credit of $21,840 while a firm employing 24 workers would receive a total credit of only $3,360.[13]

The upshot is that the small business tax credit is a mixed economic blessing. Relatively few firms will qualify for the credit and be able to offset the costs of health insurance. For those that do qualify, receipt of the credit imposes a new regime of hidden effective marginal tax increases on improvements in scale and quality.

Tax Increases

The Act raises more than $700 billion in tax revenue from an excise tax on high-premium plans; reinsurance and risk adjustment collections; penalty payments by employers and uninsured individuals; fees on medical device manufacturers, pharmaceutical companies, and health insurance providers; and other revenue provisions. There is no theory or empirical research on job creation that suggests that large tax increases will spur employment. Taken at face value, one should be skeptical that ACA will not harm the pace of overall economic recovery.

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[12] This example assumes the employer contributes $6,000 toward insurance for each employer.

[13] See, http://www.ncpa.org/pdfs/ba703.pdf

There are two taxes of particular interest contained in ACA. Section 9015 increases the Medicare HI tax by 0.9 percentage points on wages in excess of $200,000 ($250,000 for couples filing jointly, $125,000 for married individuals filing separately), and also applies to self-employed earnings.

Sec. 1402 of HCERA imposes a 3.8 percent Medicare contribution tax on individuals, estates, or trusts of the lesser of net investment income or the excess of modified adjusted gross income over the threshold amount. The threshold amount is $250,000 for joint returns, $125,000 for married filing separately, or $200,000 for any other case. Both taxes are effective for taxable years beginning after 2012.

The first point to note is that these taxes have nothing to do with Medicare finance. While gross inflows may be credited to the HI trust fund, these dollars will finance the expansion of the new insurance subsidy entitlement program.

The second point to note is that these taxes apply to the labor and investment earnings of pass-thru entities taxed through the individual income tax. Thus, they are targeted at precisely the same group of individuals most likely to be business owners or entrepreneurs. The Joint Committee on Taxation projects that $1 trillion in business income will be reported on individual income tax returns in 2011. Notably, of that $1 trillion, roughly one-half, $470 billion, will be reported on returns that are likely to be the new surtaxes.[14]

This has the potential to impact employment. According to the Small Business Administration, there are almost 120 million private sector workers in the United States. Slightly more than half those workers, 60 million, work for small businesses. About two-thirds of the nation's small business workers are employed by small businesses with 20 to 500 employees. According to Gallup survey data conducted for the National Federation of Independent Business (NFIB), half of the small business owners in this group fall into the surtax brackets. This means there is a pool of more than 20 million workers in those firms directly targeted by the higher marginal tax rates. This is likely a conservative estimate as it ignores flow-through entities with one to 19 workers.

A final tax impact of the ACA is that the impact of phase-outs of refundable credits may have even more perverse growth consequences. As noted in Brill and Holtz-Eakin (2010) the phase-outs in insurance subsidies contribute to high effective marginal tax rates.[15] The effect is to raise to as high as 41 percent the effective

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[14] The Joint Committee on Taxation analysis does not take into account the impact on small, non-publicly-traded "C" corporations. There are several million of these entities, which will likely be adversely affected by the marginal rate increases on ordinary and capital income.

[15] Brill, Alex and Holtz-Eakin, Douglas, "Another Obama Tax Hike." *Wall Street Journal,* February 4, 2010. See also, Douglas Holtz-Eakin and Cameron Smith, "Labor

marginal tax rate on some of the lower-income U.S. workers. This has implications for the ability of families to rise from the ranks of the poor, or to ascend toward the upper end of the middle class. This growth and mobility is the heart of the American dream and is the most pressing issue at this time.

ACA and Health Insurance Premiums

Health care reform was presumed to encompass both expansion of affordable insurance options and provision of quality medical care at lower costs. The reality of the ACA could not be more different. Objective analysts have uniformly concluded that the new law raises – not lowers – national health care spending.[16] The rising bill for national health care spending will, in turn produce sustained upward pressures on health insurance premiums.

In addition, the law's array of insurance market reforms will increase premiums. Barring limits on annual and lifetime out-of-pocket spending, coverage of pre-existing conditions for children, and the ability for children to stay on parents' policies, are all initiatives that enhance benefits. These benefits must necessarily be covered by higher premiums.

These features of the law are increasingly well understood, much to the dismay of insurance consumers. However, other aspects of the new law are less appreciated. In particular, the financing of the health care law will have significant implications for purchasers of insurance as well.

As noted above, ACA raises more than $700 billion in tax revenue from an excise tax on high-premium plans; reinsurance and risk adjustment collections; penalty payments by employers and uninsured individuals; fees on medical device manufacturers, pharmaceutical companies, and health insurance providers; and other revenue provisions.

The impact of fees on medical devices, insurers, and pharmaceutical companies is important and not well-understood. To understand better, consider the fee on health insurers. The fee amounts to a *de facto "health insurance premium* tax" that will raise the cost of health insurance for American families and small employers. Specifically, under the law, an annual fee applies to any U.S. health insurance provider, with the intent of raising nearly $90 billion over the next 10 years. The aggregate annual fee for all U.S. health insurance providers begins at $8 billion in 2014 and then rises thereafter. (See Table 3.)

Markets and Health Care Reform, 2010.
http://americanactionforum.org/files/LaborMktsHCRAAF5-27-10_0.pdf

[16] See http://www1.cms.gov/ActuarialStudies/Downloads/S_ACA_2010-01-08.pdf or http://www.cbo.gov/ftpdocs/117xx/doc11705/08-18-Update.pdf.

Table 3
Aggregate Insurance Fees

Year	Fee
2014	$ 8 billion
2015	$11.3 billion
2016	$11.3 billion
2017	$13.9 billion
2018 & Beyond [17]	$14.3 billion
Total through 2020	$87.4 billion

To see the implications for insurance costs, one must examine how it affects individual insurers. Each firm will be liable for a share of the aggregate fee that is calculated in two steps. First, each company will compute the total premiums affected by the law using the formula outlined in Table 4. For example, an insurer with net premium revenues of $10 million is unaffected. In contrast, an insurer with net premiums of $100 million will have $62.5 million ($12.5 million from the 50 percent component between $25 million and $50 million, and $50 million from the remainder). The aggregate fee is apportioned among the insurers based on their shares of the affected premiums. Importantly, the fees are not deductible for income tax purposes.

Table 4
Fraction of Premiums Counted

Annual Net Premiums	Fraction
Less than $25 million	0
$25 million to $50 million	50 percent
$50 million or more	100 percent

So far, seemingly so good, for families and small employers, as insurers have to pay this new "health insurance premium tax". Unfortunately, this ignores the influence of market forces. For any company, as it sells more insurance policies it will incur a greater market share, and thus a greater share of the $87 billion. That is, with each policy sold, the firm's total tax liability rises; precisely the structure of an excise tax. Firms don't really pay taxes; they attempt to shift them to suppliers, workers, or customers. Thus, it is important to distinguish between the *statutory incidence* of the premium tax – the legal responsibility to remit the tax to the Treasury – and the *economic incidence* – the loss in real income as a result of the tax.

Insurance companies will have to send the premium tax payments to the Treasury, so the statutory incidence is obvious. However, a basic lesson of tax policy is that

[17] The statute provides that after 2018 the insurance fee is equal to the amount of the fee in the preceding year increased by the rate of premium growth for the preceding calendar year.

people pay taxes; firms do not. Accordingly, the economic burden of the $87 billion in premium taxes must be borne by individuals. Which individuals will bear the economic cost?

The imposition of the premium tax will upset the cost structure of insurance companies, raising costs per policy and reducing net income (or exacerbating losses). Some might argue that the firms will simply "eat the tax" – that is simply accept the reduction in net income. For a short time, this may well be the case. Unfortunately, to make no changes whatsoever will directly impact companies' abilities to make investments in health IT programs, wellness initiatives and disease management tools. Ultimately, this hurts individuals and small employers who won't have access to the types of tools and programs that can improve the quality of care and lower costs. Trying to retain the *status quo* also hurts the return on equity invested in the firm. Because insurance companies compete for investor dollars in competitive, global capital markets, they will be unable to both offer a permanently lower return and raise the equity capital necessary to service their policyholders.

Importantly, these impacts will be felt equally by the not-for-profit insurers. Non-profits have comparable resource needs for disease management, wellness efforts, or IT equipment. They also have equity capital demands, as they rely on retained earnings as reserves to augment their capital base. Bearing the burden of the tax means lower access to these reserves and diminished capital, harming their ability to continue serving policyholders effectively.

In short, all insurers – for profit and non-profit alike – will seek to restructure in an attempt to restore profitability, with the main opportunity lying in the area of labor compensation costs. To the extent possible, firms will either reduce compensation growth, squeeze labor expansion plans (or even lay off workers), or both. However, there are sharp limits on the ability of companies to shift the effective burden of excise taxes onto either shareholders (capital) or employees (labor). Moreover, their ability to do so diminishes over time as capital and labor seek out better market opportunities.

The only other place to shift the tax cost is onto customers – i.e., families and small businesses. This economic reality is reflected in the Congressional Budget Office and Joint Committee on Taxation revenue estimating procedures. Specifically, they apply a 25 percent "offset" to the estimated gross receipts of any excise tax. In terms of the premium tax, this convention has two important implications. First, if the aggregate fee were recognized as a premium excise tax that carried incentives to shift some of the burden via lower dividends, capital gains, and wages, then the aggregate fee will overstate the net budget receipts. To the extent this happens, receipts of income-based taxes will fall; hence the need for an offset to the gross receipts of the excise tax.

The second implication is that the remainder of the tax is passed on to consumers. That is, the offset is not 100 percent meaning that the non-partisan consensus-based

revenue estimators have concluded that the vast majority of the burden of excise taxes will *not* be borne by shareholders or workers.

If market conditions make it impossible for insurers to absorb the economic burden of the premium tax, they will have no choice but to build the new, higher costs into the pricing structure of policies. In this way, the economic burden of the tax is shifted to the purchasers of health insurance. In particular, the more competitive markets are for equity capital and hired labor, greater is the fraction of the burden that will be borne by consumers.

The implications for purchasers of health insurance are obvious and unambiguously negative. In addition, as employers pay more for health insurance, they will have to shave back on cash wage increases, and thus taxable compensation. Thus the health insurance premium tax will have the perverse effect of lowering personal income and payroll taxes.

To top things off, the new law has an especially unpleasant feature for those facing higher premiums: the fees are not tax-deductible, but higher premiums will be taxable.

This non-standard tax treatment matters a lot. If an insurance company passes along $1 of premium taxes in higher premiums and cannot deduct the cost (fee), it will pay another $0.35 in taxes. Accordingly, the impact on the insurer is $0.65 in net revenue *minus* the $1 fee. Bottom line: a loss of $0.35. (The problem gets worse when you consider that the $1 of additional premium is also subject to other state-level premium taxes and in some cases a state income tax.)

To break even, each insurer will have to raise prices by $1/(1-0.35) or $1.54. If it does this, the after-tax revenue is the full $1 needed to offset the fee. This has dramatic implications for the overall impact of the premium taxes. Instead of an upward pressure on premiums of $87.4 billion in fees over the next 10 years, the upward pressure will be $134.6 billion.

This line of reasoning is sometimes met with skepticism, and countered with the notion that consumers will simply be unwilling to accept a higher price. Evidence suggests that this is not true, but suppose the counter-argument is taken at face value. To the extent that firms accept a lower rate of return, they will be unable to attract capital. Similarly, to the extent they reduce employment in response to the tax (or cut wages and lose skilled employees to better opportunities), they will again suffer in their ability raise their scale of operations. In short, for insurers that attempt to adjust entirely on the cost side will be unable to maintain their operations at a competitive level, and will lose market share or even depart the industry entirely. For health insurance markets as a whole, this reduces competition. The bottom line for consumers is the same: higher prices.

To gain a rough empirical feel of an average $87 billion health insurance premium tax, I employ publicly-available data on Yahoo! Finance.[18] Those data indicate that the earnings for the industry called "Health Care Plans" were roughly $16 billion. The average annual aggregate fee of $8.7 billion is a substantial impact on the cost structure and profitability of the companies; roughly one-half of the net earnings.

Could insurers absorb the fee and remain competitive in the market for equity capital? As a whole, the overall profit margin is shown as 4.2 percent. Assuming no change in behavior, a 50 percent decline on a sustained basis would make it impossible to obtain the financing needed to compete. Accordingly, it will be a matter of competitive reality for the insurers to pass the fee to consumers in the form of higher health insurance premiums.

The health insurance fee will likely quickly and nearly completely be incorporated into higher insurance premiums. The premium tax alone means that American families will pay as much as $135 billion more in insurance premiums over the next 10 years. Incorporating the impact of medical devices and pharmaceuticals raises the total impact.

The final channel by which ACA affects insurance costs are the mandates regarding insurance benefit designs. Mandating greater benefits will unambiguously raise the costs of insurance. However, one widely-touted promise of the ACA was that if the American people "like your health plan, you can keep it."

In this regard, it is important to note that the interim final rules governing insurance copayments, deductibles, premium increases, and employer contributions are so strict that that even conservative estimates by the Department of Health and Human Services (HHS) indicate a majority of Americans will be unable to keep their existing health care coverage by 2013.[19] A more realistic estimate, accounting for the response from American businesses since the rules were released, places the likely percentage of plans without grandfathered status well above the HHS' high-end estimate of 69 percent of plans by 2013.[20] Thus it appears that the interim final rules ensure that grandfathered status will be lost in the near-future and that a substantial majority of Americans will face higher costs.

The Response of Small Businesses to Higher Costs

The previous sections have outlined the direct and indirect cost pressures that will prevail under the health care reform law. Small businesses will react to these incentives in order to prosper to the greatest extent possible. In the process, there

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[18] See http://biz.yahoo.com/p/522qpmd.html.

[19] "Group Health Plans and Health Insurance Coverage Rules Pertaining to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act. Federal Register. Volume 75. Page 34571

[20] "2010 UBA Health Plan Survey." United Befit Advisors. October 2010.

will be attempts to shift these financial burdens away from the businesses themselves. That is, the ultimate cost of the ACA's small business provisions may be shifted to other parties.

One obvious strategy is to raise prices to cover the newly-imposed costs, thereby shifting the costs to consumers. At present, economic weaknesses undercut pricing power, making it unlikely that this channel will prevail for some time to come. However, to the extent that the economy recovers, shoppers relying on small business goods and services will find prices stiffening to match increases in health insurance costs.

An alternative route will be to pass increases in health care costs to workers in the form of slower wage growth. Of course, it may not be possible to pass along the full cost in the form of lower wages. If a full-time worker is at or near the minimum wage, it will not be possible to offset higher costs with lower wages. Instead, employer's will be forced to shorten hours or drop workers altogether. The Lewin Group estimates that there will be a loss of employment between 157,300 and 366,200 people if ACA were fully implemented in 2011. Specifically for small businesses (less than 500 employees), Lewin estimates that employment losses will be between 50,200 and 113,000 jobs.[21]

The final possibility is that small business owners will attempt to absorb these cost increases out of scarce business capital. In this instance, the reduced liquidity (especially at a time of credit market tightness) will raise the probability of the failure of small businesses.[22]

ACA and Employer-Sponsored Insurance

Today about 163 million workers and their families receive health insurance coverage from their employers. Proponents of the ACA insisted that a key tenet of was to build on this system of employer-sponsored coverage.

Roughly one-half of the $900 billion of spending in the ACA is devoted to subsidies for individuals who do not receive health insurance from their employers. These subsidies are remarkably generous, even for those with relatively high incomes. For example, a family earning about $59,000 a year in 2014 would receive a premium subsidy of about $7,200. A family making $71,000 would receive about $5,200; and even a family earning about $95,000 would receive a subsidy of almost $3,000.

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[21] See, http://www.lewin.com/content/publications/LewinGroupAnalysis-PatientProtectionandAffordableCareAct2010.pdf

[22] The importance of capital market constraints is demonstrated in Holtz-Eakin, Douglas, David Joulfaian, and Harvey S. Rosen. 1994. "Sticking it Out: Entrepreneurial Survival and Liquidity Constraints." *Journal of Political Economy* (February):53-75.

By 2018, subsidy amounts and the income levels to qualify for those subsidies would grow substantially: a family earning about $64,000 would receive a subsidy of over $10,000, a family earning $77,000 would receive a subsidy of $7,800 and families earning $102,000 would receive a subsidy of almost $5,000.

An obvious question is how employers will react to the presence of an alternative, subsidized source of insurance for their workers, which can be accessed if they drop coverage for their employees. The simplest calculation focuses on the tradeoff between employer savings and the $2,000 penalty (per employee) imposed by the ACA on employers whose employees move to subsidized exchange coverage. Consider a $12,000 policy in 2014, of which the employer would bear roughly three-quarters or $9,000. A simple comparison of $9,000 in savings versus a $2,000 penalty would seemingly suggest large-scale incentives to drop insurance.

Unfortunately, the economics of the compensation decision are a bit more subtle than this simple calculation. Health insurance is only one portion of the overall compensation package that employees receive as a result of competitive pressures. Evidence suggests that if one portion of that package is reduced or eliminated – health insurance – and another aspect – wages – will ultimately be increased as a competitive necessity to retain and attract valuable labor. Thus, the key question is whether the employer can keep the employee "happy" – appropriately compensated and insured – *and* save money.

As Table 5 outlines, the answer is frequently "yes" – thanks to the generosity of federal subsidies. To see the logic, consider the first row of the table, which shows the implications for a worker at 133 percent of the Federal Poverty Level (FPL) or $31,521 in 2014. We project that this worker will be in the 15 percent federal tax bracket, which means that $100 of wages (which yields $85) is needed to offset the loss of $85 dollars of employer-provided health insurance (which is untaxed). Consider now a health insurance policy worth $15,921, of which the employer picks up 75 percent of the cost. The employer's contribution to health insurance of $11,941 is the equivalent of a wage increase of $14,048 to the worker.

Table 5
Health Care Reform and Employer-Sponsored Insurance in 2014
(Employer Health Plan = $11,941)

Percent of Federal Poverty Level	Income[1]	Tax Bracket[2]	Wage Equivalent of Employer Health Plan[3]	Federal Subsidies[4]	Required Pay Raise[5]	Employer Free Cash Flow[6]	Employer Drop Decision[7]
133%	$31,521	15%	$14,048	$14,176	($128)	$9,941	Drop
150%	$35,550	15%	$14,048	$13,385	$663	$9,941	Drop
200%	$47,400	25%	$15,921	$10,985	$4,936	$9,941	Drop
250%	$59,250	25%	$15,921	$7,530	$8,391	$9,941	Drop
300%	$71,100	25%	$15,921	$5,187	$10,734	$9,941	Keep
400%	$94,800	28%	$16,585	$2,935	$13,650	$9,941	Keep

1. Income calculated based on 2009 FPL for a family of four of $22,050 (HHS), indexed to CPI projections (CBO)
2. Tax bracket calculated based on 2010 tax brackets, indexed to CPI projections (CBO)
3. Computed as CBO estimate of Silver Plan in 2016, indexed to 2014 ($11,941), and divided by (1-Tax Rate)
4. Estimated federal insurance subsidy
5. Wage equivalent minus subsidies
6. Value of insurance plan minus $2,000 penalty
7. Drop if required pay raise is greater than free cash flow

Do the economics of ACA ever suggest that employer's could drop? Yes. The employer would receive $14, 176 in subsidies – *more than the value of the lost health insurance.* On paper, they could take a pay cut and be better off. Clearly, the employer comes out way ahead – $11,941 less the penalty. Obviously, there is room for the employer to actually improve the worker's life by having a small pay raise and the same insurance and still save money. This is a powerful, mutual incentive to eliminated employer-sponsored insurance.

The remaining rows of Table 5 repeat this calculation for workers at ascending levels of affluence. For example, at 200 percent of the FPL, the "surplus" between the pay raise required to hold a worker harmless ($4,936) and the firm's cash-flow benefit from dropping coverage ($9,941) has narrowed, but the bottom line decision in the final column is the same. Indeed, the incentives are quite powerful up to 250 percent of FPL, or $59,250. Only for higher-income workers do the advantages of untaxed health insurance make it infeasible to drop insurance and re-work the compensation package.[23]

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[23] Notice that what this really means is that an *existing* federal subsidy (via the tax code) trumps the new federal subsidy!

How big could this impact be? In round numbers, at present there are 123 million Americans under 250 percent of the FPL. Roughly 60 percent of Americans work and about 60 percent of those receive employer-sponsored insurance. This suggests that there are about 43 million workers for whom it makes sense to drop insurance.[24]

CBO estimated that only 19 million residents would receive subsidies, at a cost of about $450 billion over the first 10 years. This analysis suggests that the number could easily be triple that (19 plus an additional, say, 38 million in 2014) – meaning the price tag would be $1.4 trillion.

In contrast, the CBO predicted that only 3 million individuals who previously received coverage through their employers will get subsidized coverage through the new exchanges. One mechanism that would reduce employer drop is if high-wage workers continue to receive insurance and non-discrimination rules force employers to offer insurance to all workers – even those for whom it makes sense to drop coverage. For those firms dominated by lower-wage workers this is unlikely to succeed as it will be possible to use the accumulated savings to retain the few high-wage workers. Or, there may be incentives for firms to "out-source" their low-wage workers to specialist firms (that do not offer coverage) and contract for their skills. In any event, the massive federal subsidies are money on the table inviting a vast reworking of compensation packages, insurance coverage, and labor market relations.

ACA and the Budget Outlook[25]

The United States faces a daunting budgetary outlook, with the Administration's budget displaying an unsustainable debt spiral emerging over the next decade. In this context, the fiscal consequences of the ACA are of extreme importance.

The Context: An Approaching Fiscal Train Wreck. The federal government's unsustainable long-run fiscal posture has been outlined in successive versions of the CBO's *Long-Term Budget Outlook*. In broad terms, over the next 30 years, the inexorable dynamics of current law will raise outlays, or committed federal expenditures, from about 20 percent of Gross Domestic Product (GDP) to anywhere from 30 to 40 percent of GDP.[26] Any attempt to keep taxes revenues at their post-war norm of 18 percent of GDP will generate an unmanageable federal debt spiral. In contrast, a strategy of ratcheting up taxes to the 30 to 40 percent of GDP needed

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[24] This is likely an upper bound estimate as there is a positive correlation between wage levels and the probability of having insurance.

[25] This sections draws heavily on Holtz-Eakin and Ramlet "Health Care Reform Is Likely To Widen Federal Budget Deficits, Not Reduce Them," *Health Affairs*, 2010.

[26] Congressional Budget Office. The Long-Term Budget Outlook. Washington (DC): Congress of the United States; June 2009.

to match the federal spending appetite would likely be self-defeating as it would undercut badly-needed economic growth.*

The policy problem is that spending rises above any reasonable level of taxation for the indefinite future. The diagnosis leads as well to the prescription for action. Over the long-term, the budget problem is primarily a spending problem and correcting it requires reductions in the growth of large mandatory spending programs and the appetite for federal outlays.

This depiction of the federal budgetary future has been unchanged for a decade or more. However, the most recent Administration budget shows that in part due to the financial crisis, recession and policy responses the problem has become dramatically worse and will arrive more quickly. The federal government ran a fiscal 2009 deficit of $1.4 trillion – the highest since World War II – as spending reached nearly 25 percent of GDP and receipts fell below 15 percent of GDP. In each case, the results are unlike those experienced during the last 50 years.

Going forward, there is no relief in sight. Over the next ten years, according to the CBO's analysis of the President's Budgetary Proposals for Fiscal Year 2011, the deficit will never fall below $700 billion dollars.[27] In 2020, the deficit will be 5.6 percent of GDP, roughly $1.3 trillion, of which over $900 billion will be devoted to servicing debt on previous borrowing.

The budget outlook is not the result of a shortfall of revenues. The CBO projects that over the next decade the economy will fully recover and revenues in 2020 will be 19.6 percent of GDP – over $300 billion more than the historic norm of 18 percent. Instead, the problem is spending. Federal outlays in 2020 are expected to be 25.2 percent of GDP – about $1.2 trillion higher than the 20 percent that has been business as usual in the postwar era.

As a result of the spending binge, in 2020 public debt will have more than doubled from its 2008 level to 90 percent of GDP and will continue its upward trajectory.

The Budgetary Impact of the Patient Protection and Affordable Care Act. In light of the fiscal threat from growing spending, the budgetary impacts of the Act are central to any discussion of its merits. First is a review of the CBO cost estimate that concludes the Act will serve to lower projected deficits over the next ten years and beyond. After the summary review, there is an analysis of the budgetary implications with certain assumptions altered.

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[27] Congressional Budget Office. An Analysis of the President's Budgetary Proposals for Fiscal Year 2011. Washington (DC): Congress of the United States; 2010 March

The final score of ACA with reconciliation amendments was released publicly on March 20, 2010.[28] The CBO and the Joint Committee on Taxation estimated the Act would lead to a net reduction in federal deficits of $143 billion over ten years with $124 billion in net reductions from health care reform and $19 billion derived from education provisions.[29]

Total subsidies in the Act exceed $1 trillion dollars over ten years and include insurance exchange tax credits for individuals, small employers tax credits, the creation of reinsurance and high risk pools, as well as expansions to Medicaid and the Children's Health Insurance Program. To finance the subsidies and reduce the deficit, total cost savings are projected to be nearly $500 billion based on reductions in annual updates to Medicare fee-for-service payment rates, Medicare Advantage rates, and Medicare and Medicaid disproportionate share hospital (DSH) payments. In addition to the cost saving measures, the Act raises more than $700 billion in tax revenue from an excise tax on high-premium plans; reinsurance and risk adjustment collections; penalty payments by employers and uninsured individuals; fees on medical device manufacturers, pharmaceutical companies, and health insurance providers; and other revenue provisions.

To gain a rough feel of the longer-run impacts, consider extrapolating to the years 2020 to 2029 using CBO's estimated compounded annual growth rates. Under this crude approach, the ACA is expected to yield an additional $681 billion in deficit reduction.

The prospect of these savings is important given the daunting fiscal outlook. But they raise an important question: is it really likely that a large expansion of public spending will reduce the long-run deficit? The answer, unfortunately, hinges on provisions of the legislation that the budget office is required to take at face value and not second-guess.

A more realistic assessment emerges if one strips out gimmicks and budgetary games and reworks the calculus. As shown in Table 6 a wholly different picture emerges: the ACA would raise, not lower, federal deficits, by $554 billion in the first ten years and $1.4 trillion over the succeeding ten years.

The list of budgetary features embedded in the CBO score begins with the fact that the Act front-loads revenues and backloads spending. That is to say the taxes and fees it calls for began immediately in 2010, but its new subsides are largely deferred until 2014. This contributes to the illusion that the ACA reduces the deficit. Note

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[28]Congressional Budget Office. H.R. 4872, Reconciliation Act of 2010. Washington (DC): Congress of the United States; 2010 March.

[29] To analyze the fiscal impact of health care reform, we have removed the education revenues from the government takeover of all federally financed student loans.

that if revenues were delayed to start in 2014, the Act's 2010-2019 net deficit impact would be $66 billion lower.

Additional budgetary provisions of interest fall into four scenarios: unachievable savings, unscored budget effects, uncollectible revenue, and already reserved premiums. Table 6 summarizes the annual impact of each scenario and extrapolates the fiscal impact to 2029.

The first adjustment, labeled "Unachievable Savings", removes spending cuts that the Centers for Medicare and Medicaid Services (CMS) will ultimately be unable to implement. These are composed of cost reductions through Medicare market basket updates, the Independent Payment Advisory Board, Medicare Advantage interactions, and the Part D premium subsidy for high-income beneficiaries. While the specifics of each differ, these provisions share two features. First, the ACA does not fundamentally reform Medicare in such a manner that will permit it to operate at lower budgetary cost. Accordingly, when the time comes to implement these savings (or those developed by the Independent Payment Advisory Board) CMS will be faced with the possibility of strongly limited benefits, the inability to serve beneficiaries, or both. As a result, the cuts will be politically infeasible, as Congress is likely to continue to regularly override scheduled reductions. A vivid example is the Medicare Physician Payment Updates. Each year since 2002 the "sustainable growth rate" formula in current law has imposed cuts in payments to physicians under Medicare. And each year Congress has overridden these same cuts.

Table 6
(billions of dollars unless otherwise noted)

Adjustments	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
CBO Projected Subsidies	4	11	13	9	70	125	181	204	219	236	1072
CBO Projected Cost Savings	2	-2	-11	-18	-43	-51	-59	-75	-91	-109	-455
Unachievable Savings	0.1	1.4	4.9	10	20.1	25.7	32.3	41.7	52.1	64.8	253.5
Unscored Budget Effect	8	14.7	16.5	18	18.3	20.4	23.4	26.2	29.3	34.7	274.6
Subtotal	10.1	14.1	10.4	10	-4.6	-4.9	-3.3	-7.1	-9.6	-9.5	73.1
CBO Projected Tax Revenues	0	-8	-15	-43	-77	-90	-114	-123	-131	-141	-739
Uncollectable Revenue	0	-1	-2	-5	1	6	14	18	22.2	26.8	78
Premiums Reserved	0	0	5.4	8.8	10	11.3	11.1	9.1	7.6	7	70.2
Subtotal	0	-9	-11.6	-39.2	-66	-72.7	-88.9	-95.9	-101.2	-107.2	-590.8
Net Change in Projected Deficit	14.1	16.1	11.8	-20.2	-0.6	47.4	88.8	101	108.2	119.3	554.3
Percentage of GDP	*0.10*	*0.11*	*0.08*	*0.12*	*0.00*	*0.27*	*0.50*	*0.55*	*0.58*	*0.62*	*2.90*

Massachusetts and Tennessee provide recent examples where insurance coverage expansion has led to substantial cost increases, instead of savings. In 1994, Tennessee implemented a massive Medicaid expansion (eventually covering 500,000 additional residents). A decade later, the state abandoned the experiment

after costs more than tripled from $2.5 billion in 1995 to $8 billion in 2004, consuming one-third of the state budget. When the experiment unraveled in 2005, 170,000 enrollees were dropped. More recently in April 2010, Tennessee announced that, due to cost overruns, the program would need to cut an additional 100,000 people from Medicaid rolls.[30]

In Massachusetts, the state's Special Commission on the Health Care Payment System has produced payment recommendations in the wake of passing an individual insurance mandate, but the commission has so far failed to bend the cost curve on medical inflation (growing 8 percent annually in Massachusetts).[31] The federally impaneled Independent Payment Advisory Board would likely follow a similar trajectory.

The second adjustment, "Unscored Budget Effects", highlights acknowledged costs that are not included in the CBO score. To operate the new health care programs over the first ten years, future Congresses will need to vote for $274.6 billion in additional spending. This spending includes the discretionary costs for the Internal Revenue Service (IRS) to enforce and the CMS to administer insurance coverage, explicitly authorized health care grant programs, and the Medicare Physician Payment Reform Act, which revises the sustainable growth rate for physician reimbursement.

Adjustment three, "Uncollectable Revenue", questions the political will of Congress and directly refers to the excise tax on high-premium, "Cadillac", health plans. This tax was supposed to start immediately in the Senate's version of ACA. After intense lobbying by organized labor, Congress relented and pushed the tax back to 2018. This raises the possibility that it will prove politically infeasible to ever implement the tax. Thus, the scenario shows the impact of not collecting the associated tax revenue of $78 billion over the next ten years.

The final adjustment, "Reserved Premiums", focuses on the CLASS Act premiums for long-term care insurance and the potential increase in Social Security receipts. In principle, these receipts should be reserved to cover future payments and not be devoted to short-term deficit reduction. Specifically, the scenario shows the implications of reserving the $70 billion in premiums expected to be raised in the first ten years for the legislation's new long-term care insurance.

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[30] Wadhwani A. Tennessee removes about 100,000 people from Medicaid rolls. Kaiser Health News. 2010 Apr 8. Available from:
http://www.kaiserhealthnews.org/Stories/2010/April/08/TennCare.aspx

[31] Kowalczyk L. Pay for care a new way, state is urged. The Boston Globe. 2009 July 19. Available from:
http://www.boston.com/news/local/massachusetts/articles/2009/07/17/pay_for_care_a_new_way_state_is_urged/?page=2

In addition to this accounting sleight of hand, the legislation uses $53 billion for deficit reduction from an anticipated increase in Social Security tax revenue. The CBO estimates that outlays for Social Security benefits would increase by only about $2 billion over the 2010-2019 period, and that the coverage provisions would have a negligible effect on the outlays for other federal programs. If Social Security revenues do rise as employers shift from paying for health insurance to paying higher wages, the extra money raised from payroll taxes should be preserved for the Social Security trust fund.

What is the bottom line? Removing the potentially unrealistic annual savings, reflecting the full costs of implementing the programs, acknowledging the unlikelihood of raising all of the promised revenues, and preserving premiums for the programs they are intended to finance, produces a radically different bottom line. The Act generates additional deficits of $562 billion in the first ten years. And, as the nation would be on the hook for two more entitlement programs rapidly expanding as far as the eye can see, the deficit in the second ten years would approach $1.5 trillion.

Of course, this is not the only source of budgetary uncertainty. Proponents point toward the possibility that the Act will "bend the curve" more than anticipated, thereby reducing health care spending in federal programs and beyond. In this light, it is important to note that if federal subsidies do not grow at all between 2020 and 2029 – a herculean reduction in annual spending growth of 3.4 percentage points – it will reduce outlays by under $500 billion. That is, extraordinary success in bending the cost curve amounts to less than one-third of the downside budgetary risks embedded in the Act.

The future of the Patient Protection and Affordable Care Act is likely to be even more important than its passage. In light of the extraordinarily precarious state of federal fiscal affairs and the enormous downside risks presented by the Act, one can only hope that every future effort is devoted to reducing its budgetary footprint.

Conclusion

The ACA will have a dramatic impact on Medicare, Medicaid, and the economy – especially the evolution of labor market incentives, economic growth, and the budget outlook over the near term. Unfortunately, at a time when real health care reform and policies to promote job growth and controlling spending to restore fiscal balance are top policy priorities, not all of these impacts are beneficial. Thank you and I look forward to answering your questions.

STATEMENT OF

KATHLEEN SEBELIUS

SECRETARY

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

ON

"HEALTH REFORM: LESSONS LEARNED DURING THE FIRST YEAR"

BEFORE THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

MARCH 16, 2011

U.S. Senate Committee on Finance

Hearing on "Health Reform: Lessons Learned During the First Year"

March 16, 2011

Chairman Baucus, Ranking Member Hatch, and Members of the Committee, thank you for the opportunity to discuss our department's implementation of the Affordable Care Act and the enormous difference it has made in the lives of Americans since it was signed into law almost a year ago. Millions of Americans across the country are already benefiting from this law, including more than 100 million people currently enrolled in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). In addition, the law has provided valuable new benefits and assistance for individuals and small businesses, helping to make coverage more affordable and ending some of the worst abuses of insurance companies.

Over the past year, we have worked closely with doctors, nurses, other health care providers, consumer and patient advocates, employers, Governors, State Insurance Commissioners, health plans, and interested citizens to deliver many of the law's key benefits to the American people. These benefits include establishing a new Patient's Bill of Rights that puts American consumers and their families back in control of their health care coverage; offering new preventive care benefits for Medicare beneficiaries; improving seniors' access to affordable, life-saving medications; and implementing new tools to fight fraud and return money to the Medicare Trust Funds and Treasury, as well as new reforms that keep premiums down by bringing transparency and accountability to our health insurance markets. I am proud to say that we have met deadlines, established strong working partnerships, and begun laying the groundwork for reforms that will take effect in the years to come. This law means real improvements for beneficiaries and consumers now and in the future.

The Affordable Care Act has also begun to change the way that Americans receive their health care, resulting in improved value, more coordinated care and more transparent choices. My department is committed to continuing to implement the Affordable Care Act in a thoughtful and responsible manner so that Americans of all ages an in all parts of this country can realize the law's benefits.

Immediate Benefits for Individuals and Small Businesses

It has not quite been a year since the passage of the Affordable Care Act, and already Americans are seeing changes and benefits from the law. The Patient's Bill of Rights gives millions of Americans important new health insurance protections. For example, insurers can no longer cancel coverage when individuals get sick just because they made a mistake with their paperwork. Insurers can also no longer put lifetime dollar limits on essential benefits – limits that often meant coverage was gone when people needed it most. By 2014, most annual dollar limits on essential benefits will also be a thing of the past. Patients have greater freedom to choose their own doctor and to go to the nearest emergency room when they are injured or in a life-threatening situation.

In addition, more than 5,000 businesses, state and local governments, and employee trusts are participating in a new program under the Affordable Care Act that gives them relief from soaring retiree health care costs and retains coverage for Americans 55 to 64 years of age. More than 4 million small businesses have been notified that they may be eligible for a tax cut to help them provide coverage for their workers – a benefit that's already making a difference, with the number of small firms offering health benefits rising for the first time in a decade. By slowing the growth of health care costs, the new law will free businesses to invest in their own growth and create new jobs.

The health law also holds insurers accountable and will help bring down premiums. It ensures every significant health insurance rate increase will undergo a thorough review and provides $250 million in grants to States to bolster their rate review process. For the first time, insurers will be held accountable for the way they spend consumer premiums. The new medical loss ratio regulations released last year implement the statutory requirement that insurers spend at least 80 or 85 percent, depending on the market, of premium dollars on health care and quality improvement efforts instead of marketing and CEO bonuses. Those who don't meet the standard will have two choices: reduce premiums or send rebates to their customers. In addition, the Department recognizes State flexibility. The law allows for a temporary adjustment to the

individual market MLR standard if the State requests it and demonstrates that the 80 percent MLR standard may destabilize their individual insurance market.

We are already seeing indications that the MLR and rate review policies are causing insurance companies to think twice about their premium increases and, in some cases, reducing the size of their annual updates.

Improved Value for Seniors and People with Disabilities

The Affordable Care Act is making Medicare stronger and more sustainable. People with Medicare will have access to improved guaranteed benefits every year, and Medicare's long-term sustainability is stronger as a result of efficiencies, new tools, resources to reduce waste and fraud, and slower growth in Medicare costs. These important changes will produce savings for the taxpayers and help to prolong the life of the Medicare Hospital Insurance Trust Fund. These changes will also benefit people with Medicare by keeping their cost sharing lower than under the law previously, as well as by keeping Part B premiums lower. Thanks to the Affordable Care Act, Medicare beneficiaries will enjoy better quality care, better access to care, and a more innovative care delivery system that will improve outcomes and reduce cost. Here are just a few examples:

Improving Medicare beneficiaries' access to life-saving medicines: As a result of new provisions in the Affordable Care Act, people with Medicare are receiving immediate relief from the cost of their prescription medications. More than 3 million eligible seniors and people with disabilities who reached the Part D prescription drug coverage gap in 2010 received help through a one-time, tax-free $250 rebate check to help reimburse them for out-of-pocket costs in the Part D prescription drug coverage gap known as the "donut hole." In addition, people with Medicare Part D will pay a smaller share of their prescription drug costs in the coverage gap every year from now until 2020, when the coverage gap will be closed. This year, eligible Medicare beneficiaries will get a 50 percent discount on covered brand name prescription drugs in the coverage gap.

Increased access to preventive care: Thanks to the Affordable Care Act, people with Medicare are eligible to receive critical preventive care, like mammograms and colonoscopies, with no coinsurance or deductible. Beneficiaries also have access to a new annual wellness visit this year. Improving access to preventive care can improve early detection and treatment options, potentially reducing the cost of care and improving the health of our Medicare population in the long run.

High quality Medicare Advantage benefits: This year, HHS has improved its oversight and management of the Medicare Advantage (MA) program. The results for the 2011 plan year show that when the Centers for Medicare & Medicaid Services (CMS) strengthens its oversight and management of MA plans, seniors and people living with disabilities will have clearer plan choices that, on average, offer improved protections and stable benefits at lower premiums. Contrary to projections of its decline, in 2011 MA enrollment is up six percent and average premiums are down six percent compared to 2010, while benefit and cost-sharing levels remain roughly the same. Access to MA remains strong, as more than 99 percent of Medicare beneficiaries have a choice of MA plans as an alternative to Original Medicare. As part of the Administration's national strategy for implementing quality improvement in health care, CMS is also working to create new incentives for all MA plans to improve the care they offer to Medicare beneficiaries. Beginning in 2012, CMS will implement a demonstration that builds on the quality bonus payments authorized in the Affordable Care Act by providing stronger incentives for plans to improve their performance, thereby accelerating quality improvements. These enhanced incentives will help to provide a smooth transition as MA payments are gradually aligned more closely with costs in the Medicare fee-for-service program.

Increased support for primary care: Thanks to the Affordable Care Act, physicians have better incentives to provide vital primary care services to Medicare beneficiaries. Beginning January 1, 2011, the Affordable Care Act provides for a new 10 percent bonus payment for primary care services furnished by a primary care practitioner and for major surgical procedures furnished by a general surgeon in a health professional shortage area. Primary care practitioners of family medicine, internal medicine, geriatric medicine or pediatric medicine, as well as

general surgeons, nurse practitioners, clinical nurse specialists, and physician assistants could be eligible to receive this new incentive.

Coordinated Care and Partnership with States

The Affordable Care Act not only provides new benefits to individuals and families, it is beginning to change the way care is delivered. Too often, health care takes place in a series of fragments or episodes. We need to make it possible for entirely new levels of seamlessness, coordination, and cooperation to emerge among the people and the entities that provide health care, so as to smooth the journeys of patients and families – especially those coping with chronic illness – through their care over time and in different places.

For example, coordination is critically needed in providing care provided to beneficiaries eligible for both Medicare and Medicaid, also known as dual-eligibles. The Affordable Care Act established a Federal Coordinated Health Care Office to improve coordination of the care provided these beneficiaries. This population consists of the most vulnerable and chronically ill beneficiaries, who represent 15 percent of Medicaid enrollees and 39 percent of Medicaid expenditures and 16 percent of Medicare enrollees and 27 percent of Medicare expenditures. These individuals have not been well served by our current system. Dual eligibles need to navigate two separate systems: Medicare for coverage of basic health care services, and Medicaid for coverage of long-term care supports and services, and help with Medicare premiums and cost-sharing. The Federal Coordinated Health Care Office will work to better streamline care for dual-eligibles, while also developing strategies to provide these beneficiaries full access to the items and services that will result in better health care outcomes. Last December, we announced that States may apply for resources to support the design of new demonstration projects, with funding for up to 15 State program design contracts of up to $1 million each. These design contracts will support the development of new models that integrate the full range of acute, behavioral health, and long-term care supports and services for dual eligible individuals.

The Affordable Care Act is also responsible for other efforts to improve the coordination of care for Medicaid beneficiaries such as the creation of health homes, where teams of health care

professionals will be paid to coordinate care for Medicaid beneficiaries with chronic conditions. States will receive 90 percent Federal match for eight fiscal quarters for services rendered to beneficiaries in health homes. The Department made funding available on January 1, 2011 and seven States have expressed either interest in learning more about or taking up this option.

Finally, while not explicitly part of the Affordable Care Act, I recently directed CMS to conduct an unprecedented level of outreach to States to help them strategize on ways to improve the efficiency of their Medicaid programs in light of current State budget challenges. To accomplish this task, CMS has created Medicaid State Technical Assistance Teams (MSTATs) who are ready to provide intensive and tailored assistance to States on day-to-day operations as well as on new initiatives. As of early March, CMS has been contacted by 19 States for technical assistance.

As a result of the flexibility and extra support provided to States by the Affordable Care Act, Connecticut, Minnesota and the District of Columbia expect to provide Medicaid coverage to over 180,000 people who were previously uninsured or covered using state-only funds. Connecticut and the District of Columbia are well on their way to accomplishing their goals, having already enrolled more than 88,000 people – Minnesota's expansion just began on March 1 and they expect to enroll 95,000 previously uninsured or State-only beneficiaries in Medicaid. The Administration is committed to ensuring that Medicaid is a strong and vibrant part of the health care system and we want to work with States to ensure that is the case.

Program Integrity

As we move forward with new and exciting benefits and care models, we are redoubling our efforts to minimize waste, fraud, and abuse in Federal health care programs. A greater focus on program integrity is integral to the success of health care reform. The Affordable Care Act offers additional front-end protections to keep those who commit fraud out of Federal health care programs, as well as new tools for deterring wasteful and fiscally abusive practices, promptly identifying and addressing fraudulent payment issues, and ensuring the integrity of our programs. Recently, CMS consolidated Medicare and Medicaid program integrity efforts into one office, the Center for Program Integrity. The Affordable Care Act enhances this organizational change by providing CMS with the ability to improve its program integrity capabilities and by providing

an opportunity to jointly develop Medicare, Medicaid and CHIP policy on these new authorities. For example, many Affordable Care Act provisions, such as enhanced screening requirements for new providers and suppliers, apply across the programs.

The Affordable Care Act provided new tools to help tailor interventions to address areas of the most significant risk. Enhanced screening requirements for providers and suppliers to enroll in Medicare, Medicaid and CHIP, along with oversight controls such as temporary enrollment moratoria and a temporary withhold on payment of claims for new durable medical equipment suppliers, will allow us to better focus our resources on addressing the areas of greatest concern and highest dollar impact. Applying knowledge from our Medicare experiences, we issued proposed regulations and a State Medicaid Director letter last fall and are actively working with States to tailor the use of Recovery Audit Contractors to the Medicaid context.

Finally, through the Health Care Fraud Prevention and Enforcement Action Team, or "HEAT," CMS has joined forces with our law-enforcement partners at the Department of Justice (DOJ) and the Department of Health and Human Services' (HHS) Office of Inspector General (OIG) to collaborate and streamline our efforts to prevent, identify, and prosecute health care fraud.

Conclusion

The accomplishments listed above are just some of the many benefits that the Affordable Care Act has provided. I have personally seen the difference this law will make. Today, as we approach the one-year anniversary of the Affordable Care Act, we should reflect on all the good the law has accomplished for Americans already. There are names and faces that go along with this law and we are moving forward with real rights and reforms that are improving people's lives every day.

Since March of last year, our Department has focused on working with Congress and our partners across the country to implement this law quickly and effectively. In the coming months, I look forward to working with all of you to continue that work and make sure that Americans can take full advantage of all that the law has to offer. Thank you for your time.

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TESTIMONY OF PAUL N. VAN DE WATER
Senior Fellow, Center on Budget and Policy Priorities

Before the
Committee on Finance
United States Senate

Mr. Chairman, Senator Hatch, 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.[1] CBO has reiterated that finding several times, most recently in a letter to Speaker Boehner in mid-February.[2]

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 unfounded.[3]

In these remarks I will focus on dispelling the misconceptions that have arisen in two areas — health reform's effects on Medicare and on state budgets.

Health Reform and 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. The cost estimate is quite clear on that point.

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

[2] Elmendorf, Letter to the Honorable John Boehner, February 18, 2011.

[3] 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.

The effect of the Affordable Care Act (ACA) 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 that health reform will extend the solvency of the Hospital Insurance trust fund by about 12 years.[4] There's no double-counting involved in recognizing that Medicare savings improve 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.

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 Medicare Hospital Insurance trust fund. Senators rightly claimed credit for this result, and no one made charges of double-counting.

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 off the mark 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 James 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, which is why it has recommended for a number of years that payment rates be adjusted for productivity gains. MedPAC finds that hospitals with low Medicare profit margins often have inadequate cost controls, not inadequate Medicare payments.[5]

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.

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

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

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."[6]

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 nor the Rivlin-Domenici plan, nor any other such effort, 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.

Health Reform and State Budgets

In recent weeks, CBO's estimate of the cost of expanding Medicaid has also come under attack. Under the ACA, state Medicaid programs will be required to cover all non-elderly people up to 133 percent of the poverty line starting in 2014. The federal government will pick up the vast majority of states' costs in covering the newly eligible. It will pay 100 percent of those costs in the first three years, with the federal share phasing down to 90 percent in 2020 and thereafter.

Because of this generous match, the Medicaid expansion is a good deal for the states. According to CBO, the federal government will pay 92 percent of the costs of the expansion through 2021, with states responsible for $60 billion — an increase of only 2.6 percent over what they would have spent in the absence of health reform. The state share includes the cost of covering individuals who are already eligible for Medicaid but not enrolled, as well as those who will become eligible in 2014. As a result of the expansion, Medicaid and CHIP will cover 18 million more low-income adults and children by 2021 than they do today, most of whom would otherwise be uninsured.[7]

Some Members of Congress have released a report that provides competing, and considerably larger, estimates of the cost to states of expanding Medicaid under the Affordable Care Act.[8] That report is unreliable, however, and its estimates are overstated. As my colleague January Angeles has explained, the report cherry-picks worst-case scenarios from various studies that have widely varying scopes and time periods.[9] Moreover, a number of these state estimates rest on highly flawed assumptions, including inflated participation rates for individuals eligible for Medicaid, overstated estimates of the costs per newly enrolled beneficiary, and inclusion of costs that are not required under the ACA. In addition, very few of the analyses cited in the report consider how health reform

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

[7] Elmendorf, Letter to the Honorable John Boehner.

[8] Orrin Hatch and Fred Upton, *Medicaid Expansion in the New Health Law: Costs to States*, March 1, 2011. http://energycommerce.house.gov/media/file/PDFs/030111MedicaidReport.pdf.

[9] January Angeles, *Report on Costs to States of Expanding Medicaid Relies on Seriously Flawed Estimates*, Center on Budget and Policy Priorities, forthcoming.

will produce savings for states in providing health care to their uninsured residents; current state costs for uncompensated care are substantial. Such savings could offset much or all of the costs of the expansion, according to analysts from the Urban Institute.[10] All things considered, the Medicaid expansion does not impose a substantial fiscal burden on states.

[10] John Holahan, "Briefing on Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL," Kaiser Commission on Medicaid and the Uninsured, May 26, 2010.

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