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TESTIMONY OF PAUL N. VAN DE WATER
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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.