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TESTIMONY OF PAUL N. VAN DE WATER
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Committee on the Budget
U.S. House of Representatives

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

Our landmark public programs — Social Security, Medicare, and Medicaid — are bulwarks in defending the well-being of America's seniors and people with disabilities. Social Security provides a wage-indexed, inflation-protected benefit that is the foundation of retirement security. Thanks to Medicare, seniors are the one part of the population in which health insurance coverage is almost universal. Medicaid fills the gaps in Medicare protection for those with very low incomes and is the nation's primary payer for long-term care services and supports.

Despite the vital roles they play, Social Security, Medicare, and Medicaid are under attack. Increasingly, we see proposals to restructure them in ways that would undermine their ability to protect against the risks of income loss and high health care costs. Some propose making large cuts in scheduled Social Security benefits or diverting a portion of payroll tax contributions into private accounts. Others suggest phasing out traditional Medicare and replacing it with vouchers to purchase private insurance. Still others would end the shared federal-state fiscal responsibility in Medicaid and substitute a fixed federal block grant. Some recommend all of the above.

These proposals have some key aspects in common and also share some serious deficiencies. Time does not allow a thorough analysis of each one, but let me offer a few comments.

Few seniors are living on Easy Street, and most have little capacity to bear additional economic risks. Social Security benefits are modest.[1] The average Social Security benefit is only about $1,175 a month, or $14,100 a year. That's less than 30 percent above the poverty line. Some 95 percent of retired workers — and even larger percentages of disabled workers and aged widows — receive monthly benefits of less than $2,000. Moreover, most beneficiaries have little significant income from other sources. In 2008, the typical (or median) elderly beneficiary had a total household income of only about $20,000 a year, most of it from Social Security. Dependence on Social Security rises with

[1] Kathy A. Ruffing and Paul N. Van de Water, *Social Security Benefits Are Modest*, Center on Budget and Policy Priorities, January 11, 2011.

advancing age, as fewer people work, out-of-pocket health care costs rise, and other income sources are depleted. Social Security will be even more critical for today's younger workers, since few of them will be covered by employer-sponsored defined-benefit pension plans.

Social Security, Medicare, and Medicaid are also highly cost-effective, and privatization — in whole or in part — is likely to increase costs, not reduce them. Social Security's administrative expenses amount to only 1 percent of benefit payments. In Medicare, administrative expenses are roughly 2 percent for traditional Medicare and 11 percent for Medicare Advantage plans.[2] The near-universal coverage of Social Security and Medicare holds down benefit costs by protecting against adverse selection in purchasing annuities and health coverage.[3] The average cost of health coverage for a Medicaid beneficiary is significantly lower than under private insurance (after adjusting for differences in health status), despite Medicaid's more comprehensive benefits and significantly lower cost-sharing charges, because of Medicaid's lower payment rates to providers and lower administrative costs.[4]

The main driver of the federal government's long-term fiscal imbalance is the rising per-person cost of health care throughout the economy. Growth in federal health care costs is *not* driven by factors that are unique to public programs. To the contrary, for 30 years, per-beneficiary spending in Medicare and Medicaid has grown at rates *nearly identical* to those for the overall health care system. And during the past decade, Medicaid costs per beneficiary grew much more slowly than costs for employer-sponsored insurance and costs across the health care system as a whole.[5] Medicare and Medicaid can and should take the lead in slowing the growth of costs, as they have done in the past, but they cannot get too far out in front. Attempting to force big cuts in federal health spending without also restraining the growth of private health-care costs would simply shift costs to vulnerable elderly, disabled, and other beneficiaries (and limit their access to needed care) or to state taxpayers.

Fortunately, the new health reform law takes important steps to slow the growth of health care costs. The Affordable Care Act contains almost every cost-containment provision that policy analysts have considered effective in reducing the growth of medical spending. These include:

- *Payment innovations,* such as bundled payments and accountable care organizations, that will reward providers based on the value of their care, not the volume of their procedures;

- *An excise tax on high-cost insurance plans* to make consumers more cost-sensitive and discourage excess utilization;

- *An Independent Payment Advisory Board* that will develop and submit proposals to reduce cost growth and improve quality in both Medicare and the health care system as a whole;

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[2] Congressional Budget Office, *Designing a Premium Support System for Medicare,* December 2006, p. 12.

[3] Adverse selection occurs when people with poorer-than-average health are more likely to purchase health insurance coverage, or when people with longer-than-average life expectancy are more likely to purchase annuities.

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

[5] John Holahan, Lisa Clemans-Cope, Emily Lawton, and David Rousseau, *Medicaid Spending Growth over the Last Decade and the Great Recession, 2000-2009*, Kaiser Commission on Medicaid and the Uninsured, February 2011.

- *A Center for Medicare and Medicaid Innovation* that will test, evaluate, and foster rapid expansion of new ways to increase the value of care;

- *A Federal Coordinated Health Care Office* that will test and evaluate new systems of care to integrate benefits more effectively and lower costs for dual eligibles (low-income Medicare beneficiaries who also receive Medicaid);

- *Measures to inform patients and payers about the quality of health care providers;*

- *Additional tools and funding to fight health-care fraud;*

- *More funding for comparative effectiveness research;* and

- *Steps to promote wellness and prevention.*

Slowing the growth of health care costs is one of our nation's most pressing economic challenges, and success will benefit employers, workers, and taxpayers. The effort will require an ongoing process of testing, experimentation, and rapid implementation of what is found to work. The health reform law begins that process. Congress should work to assure effective implementation of the Affordable Care Act, not to undermine the programs that form the bedrock of health and income security for seniors, persons with disabilities, and those with low incomes.