Financing Medicare and Medicaid

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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