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ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

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MEMORANDUM

December 5, 2014

To: **Committee on Energy and Commerce Democratic Members and Staff**

Fr: **Committee on Energy and Commerce Democratic Staff**

Re: **Hearing on "Setting Fiscal Priorities"**

On Tuesday, December 9, 2014, at 10:30 a.m. in 2123 Rayburn House Office Building, the Subcommittee on Health will hold a hearing entitled, "Setting Fiscal Priorities."

I. BACKGROUND INFORMATION

Our nation is facing a challenging revenue and spending situation. After a decade of anemic economic growth that undercut revenues, several rounds of tax cuts that did not rekindle economic growth, two unpaid-for wars, and the resulting higher debt service, the nation saw a $12.7 trillion shift in its fiscal fortunes. Legislation (both tax cuts and spending policy), a weakened economy, interest, and unpaid for wars all contributed to the swing from being in the black to being in the red.

The retirement of the large Baby Boom generation is expected to lead to a long-lasting shift in the demographic profile of the United States. For the major mandatory health care programs, Medicare and Medicaid, enrollment growth is an important factor in increasing the share of the spending relative to the size of the economy, but increasingly expensive health care is another important driver.

The major driver of long-term federal spending growth is the expectation that total public and private health spending will grow faster than the economy. In 2013, National Health Expenditures (NHE) grew 3.6 percent to $2.9 trillion, the fifth consecutive year of slow growth ranging from 3.6 percent to 4.1 percent, and the lowest growth rate since

1960.[1] As a share of total health spending, households (28 percent) and the federal government (26 percent) accounted for the largest shares.[2] The retirement of more than 70 million baby boomers is an important factor in the growth of health care spending. Since 2009, health spending as a percent of Gross Domestic Product (GDP) has remained at 17.4 percent;[3] most of the increase in the Medicare spending as a percentage of GDP from 2013 to 2035 is projected to result from the effects of aging and growth in the number of beneficiaries.[4] Nevertheless, growth due to rising medical prices, utilization of more services, and growing intensity of services (e.g., MRI instead of an x-ray) is also a concern. Rising health care costs are not unique to Medicare and Medicaid; private health care costs are growing at similar rates.

While this hearing will focus primarily on the entitlement programs, it is clear that spending cuts alone cannot address the nation's fiscal situation without causing dire harm to beneficiaries. In the recent past, Republicans' tax policies have suggested a target for tax policy of having revenues equal to 18 percent of GDP. Revenues at 18 percent of GDP are insufficient to pay for spending. The last time the budget was in surplus in 2001, revenues were at 20.6 percent of GDP. With an additional 70 million beneficiaries who will soon rely on Medicare for their primary source of health coverage, that number will only become more insufficient in the future.

II. MEDICARE – FACTS AND FIGURES

Medicare provided comprehensive health coverage to over 52.3 million aged and disabled beneficiaries in 2013, at a cost of $585 billion.[5] In 2013, Medicare expenditures accounted for roughly 20 percent of the federal budget.[6] Net outlays for Medicare grew by 3 percent in 2012, a slower rate of growth than any recorded since 2000 with only a

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[1] Centers for Medicare & Medicaid Services, *National Health Expenditures 2013 Highlights* (Dec. 2014) (online at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html).

[2] *Id.*

[3] *Id.*

[4] R. Kronick and R. Po, *ASPE Issue Brief: Growth In Medicare Spending Per Beneficiary Continues to Hit Historic Lows* (Jan. 7, 2013) (online at http://aspe.hhs.gov/health/reports/2013/medicarespendinggrowth/ib.pdf).

[5] Congressional Budget Office, *CBO's April 2014 Medicare Baseline* (Apr. 14, 2014) (online at http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205-2014-04-Medicare.pdf).

[6] Kaiser Health News, *Growth in U.S. Health Spending IN 2013 Is Lowest Since 1960* (Dec. 3, 2014) (online at http://kaiserhealthnews.org/news/growth-in-u-s-health-spending-in-2013-is-lowest-since-1960/).

modest increase by 2.2 percentage points in 2013.[7] Medicare spending per beneficiary is projected to increase by just 0.3 percent in 2014 and by 0.7 percent per year over the 2010-2014 period – well below the growth in GDP per capita.[8]

Medicare costs have grown at a consistently slower rate than the private sector. Over the last 40 years, Medicare's per capita spending has grown at an average annual rate of 7.5 percent, compared with 9.1 percent annual growth in premiums for comparable private health insurance.[9] Medicare, like private-sector health insurance, faces cost pressures stemming from growth in prices, utilization, and intensity of services provided. Between 1970 and 2010, Medicare spending per enrollee grew by an annual average of 1 percentage point less than comparable private health insurance premiums.[10]

III. HEALTH REFORM OVERHAULED MEDICARE

The Affordable Care Act (ACA) saved more than $555 billion over ten years in Medicare, primarily through provider payment changes aimed at promoting efficiency.[11] Based on recent CBO projections, Medicare spending over the 2011-2022 period will decrease by an additional $715 billion as compared to their August 2010 baseline projection (and an additional $395 billion in Medicaid spending) in part due to slower growth rates but also the delivery system reforms inherent within the ACA.[12] Similarly, the most recent Medicare Trustees report now project the Medicare Hospital Insurance (HI) Trust Fund to remain solvent until 2030, an additional four years over last year's

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[7] Congressional Budget Office, *CBO's April 2014 Medicare Baseline* (Apr. 14, 2014) (online at http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205-2014-04-Medicare.pdf).

[8] Centers for Medicare and Medicaid Services, *2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (July 28, 2014) (online at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2014.pdf).

[9] Centers for Medicare & Medicaid Services, *National Health Expenditures (NHE) Tables- Table 21* (Dec. 2014) (online at hhttp://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html).

[10] House Committee on Energy and Commerce Subcommittee on Health, Testimony of Senior CBPP Fellow Paul N. Van de Water, *Saving Seniors and Out Most Vulnerable Citizens from an Entitlement Crisis* (113th Cong.) (Mar. 6, 2013).

[11] Congressional Budget Office, Letter to John Boehner on H.R. 2, Repealing the Job-Killing Health Care Law Act (Feb. 18, 2011).

[12] Congressional Budget Office, *Revisions to CBOs Projections of Federal Health Care Spending* (July 18, 2014) (online at http://www.cbo.gov/publication/45581).

estimate, and project lower expenditures through 2016 than had previously been estimated.[13]

Some of the main ACA policies that were projected to promote efficiency include: the productivity adjustment to payment updates and related provisions ($205 billion); the reforms to Medicare Advantage ($145 billion); reformed home health payments ($28 billion); and the Independent Payment Advisory Board ($24 billion).[14] And results are already coming in from ACA-related initiatives to improve care and reduce costs. The Centers for Medicare and Medicaid Services (CMS) recently reported that the Medicare Shared Savings Program and Pioneer ACOs have generated $417 million in savings for the Medicare program.[15] According to an Agency for Healthcare Research and Quality report released this week, an estimated 50,000 fewer patients died in hospitals and approximately $12 billion in health care costs were saved as a result of a reduction in hospital-acquired conditions from 2010 to 2013.[16] Similarly, the 30-day all cause hospital readmission rate is estimated to have dropped to 17.8 percent in 2012 and an additional 10 percent in 2013 (or 150,000 fewer hospital readmissions in 2013).[17] In the Medicaid Strong Start program, the elective birth delivery rates have fallen by 48 percent, meaning fewer at-risk newborns, and fewer admissions to the neonatal intensive care unit.[18]

Health reform may generate more savings than official estimates suggest. The ACA also includes numerous provisions that did not generate significant scoreable savings, or even had a small cost, that nevertheless have the potential to incentivize a more efficient health care delivery system. These "delivery system reforms" include

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[13] Centers for Medicare and Medicaid Services, *2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (July 28, 2014) (online at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2014.pdf).

[14] Office of the Actuary, *Estimated Financial effects of the "Patient Protection and Affordable Care Act," As Amended* (Apr. 22, 2010) (online at http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/PPACA_2010-04-22.pdf).

[15] Centers for Medicare and Medicaid Services, *FACT SHEET: Medicare ACOs continue to succeed in improving care, lowering cost growth* (Sept. 16, 2014).

[16] Agency for Healthcare Research and Quality, *Interim Update on 2013 Annual Hospital-Acquired Condition Rate and Estimates of Cost Savings and Deaths Averted From 2010 to 2013* (Dec. 2014) (online at http://www.ahrq.gov/professionals/quality-patient-safety/pfp/interimhacrate2013.pdf).

[17] Centers for Medicare & Medicaid Services, *Fact Sheet: Delivering Better Care at Lower Cost is Working* (Sept. 16, 2014).

[18] Centers for Medicare & Medicaid Services, Fact Sheet: Lower Costs, Better Care: Reforming Our Health Care Delivery System (Feb. 28, 2013).

developing, testing, and expanding new payment arrangements that improve quality and reduce costs; promotion of primary and preventive care; informing providers on quality measures and resource use; and researching the relative effectiveness of different medical interventions for the same condition. These activities hold significant promise for controlling spending while improving quality of care.

IV. ADDITIONAL PROPOSALS TO REFORM MEDICARE PAYMENT AND CARE DELIVERY

A. Opportunities to Improve Value in Medicare

There is general consensus that health care, including Medicare, needs to move from a volume-based to a value-based system. While cost growth per beneficiary in Medicare has consistently remained below that seen in the private insurance market, it has still been subject to the same fee-for-service (FFS) delivery system incentives driving high intensity, high cost care. As pointed out in the March 2013 MedPAC Report, the "fundamental problem" with the current Medicare FFS payment system is that providers are paid based on the volume of services provided, without regard to the quality or value of the services. The report goes on to state that payment reforms and delivery system reforms, "such as medical homes, bundling, and accountable care organizations (ACOs) need to be monitored and successful models adopted on a large scale.[19]
Other policy proposals have been explored to reduce spending by refining current payment methods without jeopardizing the quality of or access to care. These include restoring the Medicaid rebate on prescription drugs for low income Medicare beneficiaries,[20] eliminating overpayments to Medicare Advantage plans,[21] refining payments in post-acute care,[22] and equalizing payments for similar patients seeking similar care in hospital outpatient departments and physician offices.[23]

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[19] Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy* (Mar. 2013) (online at http://www.medpac.gov/documents/Mar13_entirereport.pdf).

[20] Richard Frank and Jack Hoadley, *The Medicare Part D Drug Rebate Proposal: Rebutting and Unpersuasive Critique,* Health Affairs Blog (Dec. 28, 2012).

[21] J. Feder et al., *Why Premium Support? Restructure Medicare Advantage, Not Medicare*, Washington: The Urban Institute (2012).

[22] Kaiser Family Foundation, *Policy Options to Sustain Medicare for the Future* (Jan. 2013) (Options 2.42).

[23] Medicare Payment Advisory Commission, *Report to Congress: Medicare and the Health Care Delivery System* (June 2013) (online at http://www.medpac.gov/documents/reports/jun13_ch02.pdf?sfvrsn=0).

B. <u>Post-Acute Care Reform</u>

Of particular note, much consternation has been expressed over Medicare post-acute care (PAC) spending and variation in care. Independent analysts have noted a number of observations and concerns with Medicare's incentives and payments for these services:

- Research has shown the similarity of patients treated in different PAC settings, yet there is stark variation in reimbursement rates across settings of care.[24] [25]
- On average, post-acute care providers have healthy Medicare margins (7-14 percent), while beneficiaries, on the other hand, have average incomes of only $22,500.
- The for-profit status of facilities may affect service use that takes advantage of flaws in the SNF prospective payment system – yielding higher profit margins for potentially unnecessary care. [26]
- There are no financial incentives for hospitals to refer patients to the most efficient setting so that patients receive the most optimal but lowest cost care. [27]
- Currently, quality of care and patient outcomes cannot be compared across settings, making it impossible to compare the efficacy of services across settings.

Below is an illustrative list of recent proposals related to PAC, including those in the President's fiscal year 2015 budget, which estimate savings from these policies at $112.5 billion over ten years,[28] and related MedPAC.[29]

- Market Basket Adjustments for various post-acute care providers ($97.9 billion savings)
- Modify Criteria Required to be an Inpatient Rehabilitation Facility ($2.4 billion savings)
- Site Neutral Payments for Certain Conditions Treated in Inpatient Rehabilitation Facilities (IRF) and Skilled Nursing Facilities (SNF) ($1.6 billion savings)

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[24] B. Gage et al., *Post-Acute Care Payment Reform Demonstration: Report*, Prepared under Contract to the Centers for Medicare and Medicaid Services (2011).

[25] Medicare Payment Advisory Commission, *Report to the Congress, Medicare Payment Policy* (Mar. 2014).

[26] *Id.*

[27] Medicare Payment Advisory Commission, *Report to the Congress, Medicare Payment Policy* (Mar. 2014).

[28] Office of Management and Budget, The White House, *The President's Budget for Fiscal Year 2015* (online at http://www.whitehouse.gov/omb/budget).

[29] For additions details on PAC proposals see House Committee on Energy and Commerce, *Subcommittee on Health Hearing entitled "Keeping the Promise: Site of Service Medicare Payment Reforms" Memorandum* (May 20, 2014) (online at http://democrats.energycommerce.house.gov/sites/default/files/documents/Memo-HE-Site-of-Service-Medicare-Payment-Reforms-2014-5-20.pdf).

- Expand the SNF Value-based Purchasing Program (<$1.9 billion savings)
- Expand Bundled Payments for Post-Acute Care Providers ($8.7 billion savings)
- Long-Term Care Hospital (LTCH) Reform

C. <u>Medicare Benefit Redesign</u>

MedPAC and others have looked at redesigning Medicare's benefit package as a strategy to simplify and consolidate the benefits in the different programs, protect beneficiaries from high out of pocket spending, and reduce (unnecessary) discretionary care. Many of the proposals are also designed to reduce federal spending. However, it is important to differentiate changes designed for the benefit of beneficiaries, those motivated entirely by the desire to reduce federal spending, and those in which there are elements of both. Unfortunately, most of the proposals aimed at achieving federal savings do so by reducing care (both necessary and unnecessary) and by shifting costs to beneficiaries.

Many of the proposals, including those by MedPAC and the Kaiser Family Foundation[30] include several elements: a combined deductible for Parts A & B (~$500) or a more rational difference between the two deductibles; a limit on out-of-pocket catastrophic spending (~$5,000); a standard co-payment or co-insurance that could vary by the type of service; and Medigap reforms that limit first-dollar coverage or account for the increased utilization that can result from first dollar coverage. These proposals stress the value of aligning benefit redesign with other reforms designed to promote use of high-value services and MedPAC's proposal specifies that improving beneficiary benefits is linked and not severable from reforming Medigap supplemental coverage and limiting first-dollar coverage.

Federal savings are achieved in these proposals in one of two ways—either through decreased utilization, based on the barrier/disincentive created by increased cost sharing or by cost-shifting to beneficiaries and third party payers. According to the analysis done by the Kaiser Family Foundation, between 50 percent and 71 percent of beneficiaries would pay more under the proposed plans. The impact to individual beneficiaries would depend in part on their relative utilization of services (inpatient and outpatient). There are concerns about the potential impact of cost-sharing on an older, poorer, and less healthy Medicare population.[31,32]

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[30] Medicare Payment Advisory Commission, *Report to Congress: Medicare and the Health Care Delivery System* (June 2012) (online at http://www.medpac.gov/documents/Jun12_EntireReport.pdf).

[31] Medical Payment Advisory Commission, *Report to Congress: Medicare and the Health Care Delivery System* (June 2012) (online at http://www.medpac.gov/documents/Jun12_EntireReport.pdf).

Beneficiary advocacy organizations have expressed concerns about proposals to redesign the Medicare benefit structure and have pointed out that low income protections are inadequate in the current Medicare program. While Medicaid provides supplemental coverage for those who qualify, individuals who are "near poor"—those with incomes too high to qualify for low-income programs but still living on limited incomes—are most at risk. An increased deductible for Part B services as well as other higher cost-sharing will make necessary care unaffordable and would lead many people to defer this care.

V. REPUBLICAN FISCAL PRIORITIES: PRIVATIZING MEDICARE, SHIFTING COSTS TO SENIORS AND PEOPLE WITH DISABILITIES

On April 1, 2014, Chairman Paul Ryan introduced the House Republican budget for fiscal year 2015, again pursuing the Republicans' plan to end Medicare as we know it. The Republican budget protects tax breaks for the very wealthy at the expense of seniors and the most vulnerable members of our society.

Republican plan undermines traditional Medicare and increases costs for seniors and people with disabilities. For nearly 50 years, Medicare has provided a lifeline for tens of millions of seniors and people with disabilities. The cornerstone of the program has been affordability, guaranteed benefits across the country, and the ability for local physicians to treat patients without interference from insurance bureaucrats. The Republican plan would undo these protections. While the Republican budget claims to repeal the ACA in its entirety, it appears to retain ACA revenues and spending cuts, and will dramatically increase the number of uninsured by approximately 25 million. And despite Republican rhetoric and unsubstantiated numbers to the contrary, the Republicans' latest formulation for the voucher proposal does little to save money, according to a Congressional Budget Office (CBO) analysis of a similar plan.[33] Seniors in traditional Medicare could see their premiums rise by an average of 25 percent[34] and insurance companies will have greater incentives to cherry-pick healthier beneficiaries, leaving sicker and older beneficiaries in traditional Medicare. Key elements of the proposal include (for more details, see attached the Democratic Ryan Budget Fact Sheet):

- Turns Medicare into a voucher to use toward the purchase of private insurance plans or traditional Medicare
- Turns Medicare over to private plans, putting benefit decisions back in the hands of insurance bureaucrats with minimal practical oversight

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[32] R. H. Brook et al., *The Effect of Coinsurance on the Health of Adults: Results from the Rand Health Insurance Experiment,* RAND Corporation (Dec. 1984) (online at http://www.rand.org/content/dam/rand/pubs/reports/2006/R3055.pdf).

[33] Congressional Budget Office, *A Premium Support System for Medicare: Analysis of Illustrative Options* (Sept. 18, 2013).

[34] *Id.*

- Raises the eligibility age to 67
- Retains Medicare Advantage savings and cuts Medicare benefits, including benefit improvements from the ACA

VI. MEDICAID – FACTS AND FIGURES

Medicaid fills gaps in the private insurance market. Medicaid covers individuals generally shut out of private insurance, either because it is unaffordable, unavailable, or doesn't cover the benefits needed. Medicaid covers low-income families who cannot afford premiums, but also people with disabilities for whom private insurance is either unavailable or inadequate, such as long-term care for children and adults with severe mental or physical disabilities. And by design, Medicaid expands during economic downturns, since eligibility is based on low income levels. Enrollment of children and adults (usually parents) tends to grow markedly during recessions when jobs are scarce, and to flatten out during periods of economic growth. Congress, in the last two recessions, provided temporary increased federal Medicaid matching funds to relieve pressure on state budgets.

Medicaid provided health care assistance for an estimated total of 72.2 million people, or about one of every five persons in the U.S., for at least one month in 2012. Total federal Medicaid outlays in 2012 were $250.5 billion. This was 58 percent of total Medicaid spending, a decrease from 64 percent in 2011 due to the expiration of temporary increases in the federal matching rate in June 2011.[35]

In 2012, the elderly and disabled represented 26 percent of the Medicaid population, but accounted for 64 percent of Medicaid spending. Dual-eligible Medicaid and Medicare beneficiaries account for nearly half of Medicaid spending. Per-beneficiary spending in Medicaid varies greatly depending on beneficiary needs. Coverage for adults and children is the least expensive, with the average per enrollee cost for 2012 estimated at $2,700 and $4,101, respectively. Average costs for elderly and disabled beneficiaries, however, were an estimated $15,688 and $17,255, respectively.[36]

In 2012, long-term services and supports (LTSS) accounted for 30 percent of total Medicaid spending, and Medicaid paid for nearly half (40 percent) of LTSS.[37] These

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[35] Department of Health & Human Services, *2013 Actuarial Report on the Financial Outlook for Medicaid* (2013) (online at http://medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/downloads/medicaid-actuarial-report-2013.pdf).

[36] *Id.*

[37] The Henry J. Kaiser Family Foundation, *Medicaid and Long-Term Services and Supports: A Primer* (July 30, 2014) (online at http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/).

benefits are generally not available in either Medicare or private insurance. The Department of Health and Human Services (HHS) estimates that 70 percent of people age 65 and over will need some form of long-term care services during their lives.[38] Thus, as the number of elderly Americans is expected to more than double in the next 40 years, Medicaid spending for long-term services and supports is projected to increase.[39]

VII. STATE FLEXIBILITY AND CARE DELIVERY INNOVATION

States have broad flexibility to manage their Medicaid programs. States can and do use tools such as prior authorization, case management, and private managed care organizations to manage costs and promote efficiency. For example, in 2011, nearly three-quarters of Medicaid beneficiaries (primarily children and families) were enrolled in some form of managed care.[40]

Since the ACA there has been extraordinary activity and innovation for Medicaid. CMS has granted Health Care Innovation Awards to states to implement compelling new ideas to deliver better health, improve care, and lower costs. These innovations include multi-payer collaboratives to improve access to primary, coordinated care; higher quality, lower cost access to emergency mental health services; and the prevention of chronic disease. In addition CMS is in the process of awarding organizations up to $1 billion to design and test multi-payer payment and delivery models that deliver high-quality care and improve health system performance.[41]

States also have flexibility in determining sources of funds used to finance the state share of their Medicaid programs, but must comply with federal limits on financing overall Medicaid costs. States may receive funds to finance the state share from health care providers, such as hospitals, and local governments. For example, a state may levy taxes on health care providers which are treated as revenue for the state and then directly appropriated to the Medicaid agency. In the early 1990s, Congress established federal requirements to limit states' use of provider taxes and other financing mechanisms.[42]

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[38] United States Department of Health and Human Services, *Who Needs Care?* (online at http://longtermcare.gov/the-basics/who-needs-care/).

[39] Commission on Long-Term Care, *Report to the Congress* (Sept. 30, 2013) (online at http://ltccommission.lmp01.lucidus.net/wp-content/uploads/2013/12/Commission-on-Long-Term-Care-Final-Report-9-26-13.pdf).

[40] Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP* (June 2014) (online at http://www.macpac.gov/reports/2014-06-13_MACPAC_Report.pdf?attredirects=0).

[41] Centers for Medicare and Medicaid Services, *Health Care Innovation Awards* (accessed Dec. 5, 2014) (online at http://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/).

[42] Government Accountability Office, *Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants*

VIII. BENEFITS TO MEDICAID COVERAGE AND ACA EXPANSION

Analyses by the Center for Family and Children (CFC)[43] and Kaiser Family Foundation[44] show that Medicaid enrollees have comparable access to care as those with private coverage and much better access and lower cost barriers than the uninsured. The Kaiser Family Foundation also found that not only is access to care comparable between Medicaid and employer-sponsored insurance (ESI) enrollees, but that Medicaid patients receive services at significantly lower costs. Furthermore, Medicaid provides a platform for financial security to help families move out of (or not fall farther into) poverty.[45] A recent study of adults enrolled in Oregon Medicaid showed that having Medicaid virtually eliminated the risk of catastrophic expenditures, the likelihood of medical debt was reduced by more than 20 percent, and the proportion of the population who borrowed money or skipped payments on other bills to pay medical expenses was decreased more than half.[46]

As a result of the ACA and a subsequent Supreme Court ruling, states have the option to expand Medicaid eligibility to all Americans with incomes under 138 percent of the federal poverty level (FPL). The federal government covers 100 percent of the cost of expanding to this newly eligible population in the first three years and then phases down to 90 percent. Currently, 29 states have chosen to expand their programs.[47] Between October 2013 and September 2014, over 9.1 million additional individuals enrolled in Medicaid, which was largely due to states expanding Medicaid eligibility.[48]

Improved CMS Data Collection (July 29, 2014) (GAO-14-627) (online at http://www.gao.gov/assets/670/665077.pdf).

[43] The Henry J. Kaiser Family Foundation, *What Difference Does Medicaid Make?* (May 2013) (online at http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8440-what-difference-does-medicaid-make2.pdf).

[44] Georgetown University Health Policy Institute Center for Children and Families, *Medicaid Providers Needed Access to Care* (Feb. 2013) (online at http://ccf.georgetown.edu/wp-content/uploads/2013/02/access-factsheet.pdf).

[45] Kaiser Commission on Medicaid and the Uninsured, *What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care?* (Aug. 2013).

[46] Kronick, Richard and Andrew B. Bindman, New England Journal of Medicine (May 2, 2013).

[47] Statereforum, *Map: Where States Stand on Medicaid Expansion Decisions* (accessed Dec. 5, 2014) (online at https://www.statereforum.org/Medicaid-Expansion-Decisions-Map?gclid=CI_CxtHPrcICFY4AaQodjQwAbw).

[48] This includes individuals who were previously eligible for Medicaid but were not enrolled. Centers for Medicare & Medicaid Services, *Medicaid & CHIP: September 2014 Monthly Applications, Eligibility Determinations and Enrollment Report* (Nov. 19, 2014) (online at http://www.medicaid.gov/medicaid-chip-program-information/program-

CBO projects that additional states will expand coverage so that, by 2018, about 80 percent of the potential newly eligible population will be in states that have expanded coverage.[49] The CMS Actuary estimates that Medicaid enrollment will grow to 80.9 million in 2022.[50]

Because some states have chosen to not expand their Medicaid eligibility levels, nearly 4 million poor uninsured adults fall into a "coverage gap" by having incomes above their states' Medicaid eligibility limits but below the lower limit for Marketplace premium tax credits.[51] States that chose to expand, however, have experienced a significant decrease in costs associated with uncompensated care—the unreimbursed cost of care provided by hospitals to people who are uninsured or underinsured and unable to pay for their care. The Assistant Secretary of Planning and Evaluation recently conducted a study and found that hospitals in Medicaid expansion states saw reductions in uninsured admissions from 28 to 33 percent compared to one year prior, resulting in decreased uncompensated care costs.[52]

IX. REPUBLICAN PROPOSALS FOR MEDICAID REDESIGN

A. Relaxed Federal Oversight

Republicans claim federal Medicaid requirements place undue burden on states, which inhibits their ability to identify misuse and ensure program integrity. One example cited is the Maintenance of Effort (MOE) requirement. But the MOE provisions do *not* affect any of the tools and initiatives that states (and the federal government, which jointly administers Medicaid) use to combat fraud and abuse or to maintain program integrity. Repeal of the MOE, would

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information/medicaid-and-chip-september-2014-application-eligibility-and-enrollment-report.pdf).

[49] Congressional Budget Office, *The 2014 Long-Term Budget Outlook* (July 2014) (online at http://www.cbo.gov/sites/default/files/45471-Long-TermBudgetOutlook_7-29.pdf).

[50] Department of Health & Human Services, *2013 Actuarial Report on the Financial Outlook for Medicaid* (2013) (online at http://medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/downloads/medicaid-actuarial-report-2013.pdf).

[51] The Henry J. Kaiser Family Foundation, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid: An Update* (November 12, 2014) (online at http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/).

[52] Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Impact of Insurance Expansion on Hospital Uncompensated Care Costs in 2014 (September 24, 2014) (online at http://aspe.hhs.gov/health/reports/2014/uncompensatedcare/ib_uncompensatedcare.pdf).

mean that states could sharply cut eligibility in their Medicaid programs.[53] Moreover, the MOE already includes an exception for states experiencing or projecting a deficit to permit Medicaid eligibility restrictions for certain non-pregnant, non-disabled adults.

B. Cost Shifting

The Republican solution to address federal Medicaid spending would shift the financial burden of the cost of health care for low income, elderly individuals in long-term care, and disabled individuals on to states, providers, families, and beneficiaries. The Republican proposal would grant additional "flexibility" to raise out of pocket costs and reduce benefits and would allow "maximum flexibility in designing a cost-sharing framework across all health care services and incomes."[54] Cost-shifting causes low-income people to decrease their use of essential health services and other care, and can trigger the subsequent use of more expensive forms of care such as emergency room visits and hospitalizations.[55]

Another proposal is to limit states' use of provider taxes and other financing mechanisms, which would shift additional costs to states and could result in program cuts with implications for Medicaid providers and beneficiaries.

C. Block Grants and Per Capita Caps

The 2014 Republican budget plan cuts federal Medicaid funding by over $1 trillion over the next ten years, by repealing the ACA's Medicaid Expansion and converting the program into a fixed block grant whose funding bears no relation to the actual need for services.[56] The Republican plan asserts that the block grant would ease states' fiscal burdens, improve the safety net for low-income Americans, and provide

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[53] J. Solomon, *Repealing Health Reform's Medicaid Provision Would Weaken Coverage, Not Fight Fraud,* Center on Budget and Policy Priorities (Aug. 24, 2012) (online at http://www.offthechartsblog.org/repealing-health-reforms-medicaid-provision-would-weaken-coverage-not-fight-fraud/).

[54] House Committee on Energy and Commerce and Senate Committee on Finance, *Making Medicaid Work: Protect the Vulnerable, Offer Individualized Care, and Reduce Costs* (May 1, 2013) (online at http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/analysis/20130501Medicaid.pdf).

[55] L. Ku, *Charging the Poor More for Health Care: Cost-Sharing in Medicaid*, Center on Budget and Policy Priorities (May 7, 2003) (online at http://www.cbpp.org/cms/index.cfm?fa=view&id=1938).

[56] House Budget Committee, Minority, *Fact Sheet: GOP Budget Hurts Medicaid* (Apr. 8, 2014) (online at http://democrats.budget.house.gov/sites/democrats.budget.house.gov/files/FS-Medicaid_FINAL.pdf).

better access to care among beneficiaries. However, in a CBO analysis provided to Chairman Ryan at his request of a similar block grant from the House's budget plan in 2012, CBO concluded that unless states increased their own Medicaid funding substantially to make up for the Republican plan's significant Medicaid funding cuts, they would have to take such steps as reducing eligibility levels, covered health services, and/or the already low payment rates to health care providers, as well as increase beneficiaries' cost sharing. These steps would inevitably lead to more uninsured low-income people and reduced access to care.[57] States should continue to have the flexibility to build a better health care system for all Americans in ways that simultaneously strengthen the long term sustainability of this indispensable public health care program.

Instead of converting Medicaid into a block grant, an alternative Republican solution suggests that a "per capita cap" be imposed on future federal Medicaid funding.[58] Under this approach, federal assistance to each participating state would be limited to a fixed dollar amount per each of the four major beneficiary groups defined by the CBO: aged, blind and disabled, children, and adults.[59] Per capita cap proposals would limit federal financial participation on a state-specific basis and would result in a cost shift from the federal government to the states. Like block grants, per capita cap proposals are accompanied by a loosening of beneficiary protections in Medicaid, such as allowing states to eliminate benefits, increase (or charge) premiums, and increase (or charge) cost sharing.

X. WITNESS LIST

Panel I:

Mark Miller
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Medicare Payment Advisory Commission

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[57] Congressional Budget Office, *The Long-Term Budgetary Impact of Paths for Federal Revenues and Spending Specified by Chairman Ryan* (Mar. 2012) (online at http://cbo.gov/sites/default/files/cbofiles/attachments/03-20-Ryan_Specified_Paths_2.pdf).

[58] Chairman Fred Upton and Senator Orrin Hatch, House Committee on Energy and Commerce and Senate Committee on Finance, *Making Medicaid Work: Protect the Vulnerable, Offer Individualized Care, and Reduce Costs* (May 1, 2013) (online at http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/analysis/20130501Medicaid.pdf).

[59] *Id.*

Panel II:

Marc Goldwein
Senior Policy Director
Center for a Responsible Federal Budget

Chris Holt
Director of Health Care Policy
American Action Forum

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