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Questions for the Record Response
Energy and Commerce Committee
Subcommittee on Health
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1. *According to information released by the Actuary of the Centers for Medicare and Medicaid Services (CMS), drug spending is projected to hold steady for the foreseeable future at about 10 to 15 percent of National Health Expenditures. However, the actuary did note that the emergence of specialty drugs presents cost challenges for some payers. This is especially the case in Medicaid where individuals receive life-saving cures may churn in and out of the program based on their income. Unlike the de facto price control in the Medicaid program, the Medicare program has the benefit of a competitive program with varying formularies and plans, where a senior can pick a plan that meets his or her needs. So, have any of you thought about targeted policies that give plans and states more control over their drug spending?*

    - With the discussions surrounding specialty drugs becoming more prevalent, the ability of states to manage this portion of their Medicaid budgets is critical. The Part D program provides an excellent template for allowing beneficiaries flexibility to chose a formulary that best meets their needs. Allowing states to bring similar competitive market pressures into their Medicaid programs is an excellent idea. Unfortunately, the current administration has a track record of hostility toward the choice and competition that exists within the Medicare Part D program, having targeted the fundamentals of this program with multiple rulemaking efforts aimed at undermining its success.

2. *There have been five bipartisan plans to help save Medicare introduced in this president's term: (1) Rivlin-Domenici (2) Rivlin-Ryan (3) The Fiscal Commission (4) Simpson Bowles's own plan, and (5) a plan by former Senator Joe Liberman and Senator Tom Coburn. The Lieberman-Coburn plan has been proposed in legislative text and was scored by the Actuary of the Medicare program. The Actuary said that, if the legislation was adopted, it would prevent Medicare's insolvency for decades and reduce seniors' premiums so they would be lower than under current law. Can you talk about what you think are the most viable pieces of these five proposals?*

    - Each of these proposals offers a variety of bipartisan changes to the Medicare program. Most importantly, these are structural reforms to Medicare and do not focus simply on cutting payments to providers, which would just decrease access to care for beneficiaries. Moving forward, the Medicare benefit must be modernized to preserve it for future generations and those beginning to receive benefits now, and these proposals all work toward that goal.

3. *CBO has estimated that repealing or delaying the IRS' authority to fine Americans for failing to buy government-approved coverage, otherwise known as the individual mandate, would result in tens of*

billions of dollars in savings for federal tax payers. Taking away IRS' authority to punish Americans under Obamacare seems like such a common sense proposal to limit government and save taxpayer dollars. One objection to this idea we often hear is that an individual mandate is necessary to cover pre-existing conditions. However, isn't it true that we can cover pre-existing conditions without the individual mandate while ensuring market stability through other mechanisms? (e.g. Medicare late enrollment penalties, high-risk pools, continuous coverage underwriting protections, etc.)

- Yes. During the transitional phase, options like high-risk pools can be used to ensure coverage for individuals with pre-existing conditions. Going forward there are alternative methods through which individuals can maintain coverage even with a pre-existing condition. The use of continuous coverage provisions and programs like COBRA ensure that those who need coverage can still receive it despite a circumstantial change or life event. Further, the individual mandate is not a catch-all for including individuals that do not wish to purchase health care coverage (and help spread the costs of more expensive enrollees). The individual mandate contains fourteen exclusions, some of which may not require documentation; so the mandate itself may not serve the purpose it was designed to anyway.

4. *The Affordable Care Act/"Obamacare" took more than $700 billion to spend on new government programs not for seniors. One of the big pay-fors for the bill was across the board annual reductions in growth rates of Medicare payments for hospitals. Under the law, these cuts are scheduled to continue to be reduced each year, permanently. As a result, the Actuary of the Medicare program has said that if these cuts continue as outlined in the law, either (a) up to 15 percent of hospitals could close, and many hospitals would stop taking Medicare patients, or (b) Congress reverses the cuts, increasing the rate of Medicare spending and accelerating the insolvency of the program. In your view, would it be better to scrap these reductions and replace them with other policies – and if so, why?*

   - The best choice is none of the above. Medicare is in need of full-scale benefit modernization. The program is facing closing hospitals, reduced access to care and eventual insolvency, so we should think outside of these two policy change boxes. Medicare is in need of a more competitive, targeted model for the program. Additionally, the cuts hit two parts of the program that are most important to its long-term reform. Cuts to Medicare Advantage and home health services undermine efforts to make the program more competitive, cost-effective and tailored to beneficiary needs. It should also be noted that these cuts do not have to happen if some of the spending created by the ACA is scaled back. As mentioned in my testimony, reducing the subsidy eligibility requirements below current levels has great savings potential.

5. *MACPAC has recommended creating a statutory option for states to implement 12-month continuous eligibility for children in CHIP. To what extent does a 12-month continuous eligibility option result in CHIP coverage for individuals from families with incomes above the CHIP eligibility thresholds? How does a 12 month continuous eligibility policy affect the required premiums and cost*

sharing for an enrollee? Could it result in an enrollee paying more or less than required based on their current income?

- Though it decreases churn, the downside to 12 month continuous eligibility is the lack of accuracy in eligibility and potentially in premium payments. This type of continuous enrollment decreases the frequency of re-determining eligibility for the program, and allows for some income fluctuation (where families could be paying more or less than was initially determined) while shorter eligibility timeframes may identify those that are no longer eligible for CHIP more quickly, saving federal and state dollars. For example, a family member could start a new job with a higher salary in the middle of an eligibility year, and the family's CHIP premiums will not change to reflect this increase in pay for another 6 months.

6. *The Affordable Care Act/ Obamacare authorized CHIP through fiscal year 2019, but did not include funding for the program beyond 2015 even though the Act required a Maintenance of Effort for the program for these additional four years. Can you please provide us with a sense of the negative effects the MOE has on states, as they seek to manage their Medicaid and CHIP programs effectively?*

- First, it is important to recognize the budgetary implications of the way the ACA includes CHIP provisions. By only providing funding through 2015, and requiring coverage through 2019, the ACA score did not include the cost of continuing the program for those additional four years, but assumes that the program will continue with later Congressional appropriation. This budgetary gimmick disregards the negative impacts for states and the uncertainty for children enrolled in the program.

  The impacts of this irresponsible move vary according to the way each state has structured its CHIP program. For states that have a CHIP program joined with their Medicaid program, the children that are currently enrolled in CHIP (and receiving the higher federal CHIP match) will join state Medicaid rolls – receiving the lower Medicaid match – if funding is not reauthorized. These states could experience a hole in their budgets due to the decrease in the federal matching rate from CHIP to Medicaid. For states with separate CHIP programs, states would have the option to enroll these children in plans that the HHS Secretary deems comparable to CHIP coverage, or impose waiting lists or enrollment caps.

  The score also ignores an increase in the federal match offered to states, since the match begins after funding reauthorization would be required. The ACA includes a 23 percent increase to the CHIP enhanced federal medical assistance percentage (the e-FMAP) beginning in October of 2015. This increase will bring the average federal CHIP contribution to an unnecessary 93 percent, drastically increasing CHIP spending.

http://americanactionforum.org/research/primer-the-childrens-health-insurance-program-chip

7. *Under the ACA, households at 400 percent of the federal poverty level (with incomes of nearly 100k) have and will receive subsidies to purchase coverage on the exchange. In your testimony, you note that reducing this subsidy level to 300 percent of federal poverty would result in savings of nearly $181 billion. As Congress considers proposals to reduce federal spending, doesn't it make sense to first look at federal subsidies for upper-middle class households?*

   - Yes. The subsides are in place to help those that cannot add the high cost of ACA exchange plans into their families' already tight budgets. The median household income hovers around $66,000 for the US. Subsidies are offered to families far above this mark, and the use of these tax payer dollars should be reassessed. We need to roll back the ACA's excessive spending, subsidies for higher earning individuals and families is a good place to start.

8. *One objection to the above proposal is that Americans above 300 percent of federal poverty will receive no subsidies, but still be forced to pay for ACA's expensive benefit mandates – leaving them without affordable coverage options. To address this issue, would it also make sense to allow any American to buy a catastrophic plan and reduce other ACA benefit mandates to promote affordability?*

   - It would absolutely make sense to allow for the greater availability of catastrophic plans in the individual market. For some beneficiaries, the catastrophic plans make the most sense financially, and these plans allow for coverage when financial stakes are higher, while still providing a few preventive care services. As mentioned in my written testimony, eliminating the age limits on purchasing catastrophic plans through the exchanges could save $16 billion from 2015-2023. This decrease in spending is the result of more individuals choosing catastrophic plans, which do not receive subsidy dollars.

9. *Physicians face a 21 percent cut in Medicare payments this April as a result of the Sustainable Growth Rate (SGR). A one-year "doc-fix" to avoid this cut would cost about $15 billion, and a permanent fix, depending on the details, could cost anywhere from $120 to $180 billion. A lot has been made about the need to "pay for" this fix. Isn't this just a budgetary snafu? Why should we have to offset stopping cuts to doctors that we all know won't actually happen?*

   - If it were possible to permanently repeal the sustainable growth rate without providing a pay-for, it would have been accomplished by now. While the cut to physician reimbursement has long been deemed untenable by Congress, the process of patching the cuts has still yielded savings, demonstrating a broad commitment to budget neutrality, even if Medicare spending itself increases.

     As I mentioned in my written testimony, there is much potential for savings through relatively moderate changes to benefits provided under the ACA. If some of these changes were implemented, additional federal dollars would be freed to be applied toward the repeal of SGR.

Additionally, changes to the SGR should be made with an eye toward realistic cost control. Any proposal to replace the SGR should be expected to generate some savings in and of itself. Whether those savings are readily scorable is another question.

10. *Medicare Spending grew last fiscal year by only 2.7 percent – the fourth lowest growth rate in history – despite a 3.8 percent increase in the number of beneficiaries. In large part because of these recent trends, the Congressional Budget Office has revised down its future health care cost projections significantly. The agency now projects Medicare spending between 2012 and 2021 to be more than $500 billion lower than projections they made in March of 2011. In light of this good news, why should Congress be concerned about an increase in health care costs, and Medicare spending in particular?*

    - When looking at the current slow-down in Medicare spending it is important to recognize two things. One, this is not the first time that Medicare spending projections have slowed, and two, all of the past slow-downs have been short lived. Federal health care spending is still on pace to nearly double in the next 25 years – and this should be cause for Congressional concern. Additionally, even if excess cost growth in Medicare maintains this historically low growth, the problem doesn't go away. Increasing enrollment in Medicare and an aging population will create budget short falls regardless of the rate at which cost grows.

http://americanactionforum.org/insights/health-care-expenditures-success-cycle-or-something-else

11. A*lthough our annual deficits have declined by about two thirds since 2009, you argue that the long term debt will exceed the size of the economy sometime in the 2030s and will double the size of the economy between 2045 and 2080 as health and retirement spending continue to grow and revenues fail to keep up. What is the practical impact of that level of debt on the American people? Is this something the average American really needs to worry about?*

    - I believe this question was intended for Mr. Goldwein

12. *Seniors across the country rely on Medicare to meet their basic health care needs. What should we tell those folks back home that are worried about the need to make changes to the program. Should they be worried or concerned?*

    - Seniors and those approaching Medicare age should be concerned with the stability of the benefits offered by the program they paid into throughout their careers. Though beneficiaries currently in the program do not have to worry about short term changes, Congressional action should be taken to modernize Medicare, preserving the benefit for the future. Specifically, those enrolled in Medicare Advantage plans will begin to feel the cuts the ACA imposes on the program in the form of benefit reduction. The American Action Forum estimated that MA enrollees saw $1,538 worth of benefit cuts in 2014 alone, and it will only get worse over time.

http://americanactionforum.org/research/medicare-advantage-cuts-in-the-affordable-care-act-april-2014-update

13. *There was a lot of discussion on the first panel of the hearing regarding Medicare benefit modernization reforms. Can you discuss how cost-sharing reform can benefit both beneficiaries and Medicare?*

- Since 2015 marks the 50 year anniversary of the Medicare program, it is only appropriate to discuss its modernization. Some cost sharing reforms were proposed this year by the Congressional Budget Office that suggested greater beneficiary involvement by those enrolled in traditional Medicare. CBO suggests three options: changing current cost-sharing to include a single annual deductible of $650 with an annual cap on expenses of $6,500, placing limitations on Medi-gap plans preventing first dollar coverage, or a combination of the two. If both policies are implemented, the savings generated in Medicare could reach $111 billion by 2024, preserving the program for future generations and decreasing federal spending. By modernizing the program, the benefits promised to current enrollees can continue and the program will be available to future populations. Congress should also consider increased cost sharing requirements for wealthy Medicare beneficiaries.

https://www.cbo.gov/sites/default/files/cbofiles/attachments/49638-BudgetOptions.pdf