Written Testimony of

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before the

The House Oversight Committee
Subcommittee on Intergovernmental Affairs

on

"Examining 'Backdoor' Spending by Federal Agencies"

December 11, 2018

Mr. Chairman and Members of the Committee,

Thank you for the opportunity to testify today on regulatory policy issues. I am Robert Weissman, president of Public Citizen. Public Citizen is a national public interest organization with more than 500,000 members and supporters. For more than 45 years, we have advocated with some considerable success for stronger health, safety, consumer and other public protections and more generally for government and corporate accountability. We have long focused on separation of powers issues, understanding that the Constitution's diffuse allocation of governmental powers works to combat abuse of power and strengthen our democracy.

The Committee is performing a useful service by examining mandatory appropriations. The automatic nature of such appropriations makes it important that Congress monitor them and periodically undertake a more formal review, appropriately through the Committee hearing and investigative process.

In my testimony today, I want to highlight the following points regarding mandatory appropriations:

First, mandatory appropriations do not by their nature pose constitutional problems.

Second, not only is there no formal constitutional issue with mandatory appropriations, Congressional establishment of mandatory appropriations is completely compatible with the spirit of the Constitution's tax and spend clause and its general obligation to carefully guard taxpayer monies and ensure they are spent wisely.

Third, the overwhelming share of mandatory appropriations are allocated to Social Security, Medicare and payment of interest on the national debt. Subjecting any of these to annual appropriations, or to sequestration, would be seriously damaging to American society and the American economy and, in the case of Social Security and Medicare, represent a violation of a sacred covenant to and among the American people.

Fourth, to say that mandatory appropriations are constitutionally proper is to suggest neither than they should avoid scrutiny nor that they be immune to reform.

My testimony is divided into two portions. In the first section, I discuss constitutional, procedural and practical issues with mandatory appropriations. In the second, I focus on several Medicare spending reform options. The most pressing such reform is to lower Medicare Part D expenditures on pharmaceutical purchases, by empowering Medicare to negotiate purchase prices with pharmaceutical manufacturers.

I. The Positive Role of Mandatory Appropriations

A. Mandatory appropriations are constitutionally permissible and appropriate

The Constitution confers on Congress the authority to spend money on behalf of the American people. Congress's taxing and spending authority is established in Article I, Section 8, Clause 1:

> The Congress shall have Power to lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States; but all Duties, Imposts and Excises shall be uniform throughout the United States.

What the Constitution does not do is establish a process by which the Congress must wield its spending authority. Congress is not bound to pay for debts and provide for the common defense and general welfare through our current appropriations process. For example, Congress is not bound to appropriate on an annual basis. It could appropriate exclusively over a two- or five-year period if it chose, for example. And because the Constitution does not require it to treat all appropriations in the same fashion, Congress can establish some appropriations on an annual basis and others on a mandatory basis.

What is constitutionally required is that Congress remain the exclusive appropriator, and this is true as to both annual and mandatory appropriations. It is Congress that establishes mandatory appropriations, not the executive or the judiciary. And Congress always maintains the power to alter what it has previously designated to be a mandatory appropriation, however it chooses.

Mandatory appropriations are not just a permissible, they are an appropriate exercise of Congressional power. Congress may reasonably determine that certain spending obligations are so important and/or that the structure of certain programs or spending obligations are such that they should be funded by mandatory appropriations. It does not follow that every important program should be subject to mandatory appropriations – and, of course, Congress should not fund anything that does not meet a threshold level of public consequence – nor that every mandatory appropriation should remain such. But the concept of mandatory appropriations is completely compatible with Congress's proper exercise of the spending authority.

B. Congress imposes taxes and typically legislates on a permanent basis

For perspective on mandatory appropriations, it should be noted that Congress's taxing and spending powers emanate from the same clause of the Constitution. As with mandatory appropriations, Congress generally treats taxes on a mandatory or permanent basis. That is, Congress sets tax rates and an overall tax code, and those rates and the code remain in place permanently, unless and until subject to subsequent congressional action. As with mandatory appropriations, Congress's approach is wholly compatible with the text and spirit of the Constitution.

The exception to permanent tax provisions are those with sunset clauses, and those exceptions prove the rule. They also illustrate how Congress can modulate its use of long-term taxing and spending measures, when it chooses.

The tax example is relevant not just because Congress's taxing and spending authority emanates from the same clause of the Constitution. The tax code itself contains manifold examples of what might be considered mandatory appropriations – tax expenditures, which the Congressional

Budget Office estimates total more than $1.5 trillion.[1] As with other mandatory appropriations, mandatory or permanent tax expenditures are perfectly compatible with the constitutional order. However, as with other mandatory appropriations, tax expenditures also need careful monitoring by Congress. Indeed, the accountability concerns regarding tax expenditures are heightened as compared to other mandatory appropriations, because tax expenditures are so much less publicly visible, and because tax policy is so uniquely subject to abuse and manipulation by narrow vested interests.

Of course, Congress generally legislates on a permanent basis, whether to establish a new regulatory regime for the financial sector, naming post offices or establishing copyright standards. These legislative actions often have enormous impacts on the lives of Americans. While Congress could stipulate they apply only for one year, it typically does not, recognizing both that Americans need more certainty in their lives than could be afforded by annual votes on every law, and that Congress does not have the institutional capacity to undertake such a practice even if it were desirable.

C. Congress correctly treats the largest categories of mandatory appropriations

The largest categories of mandatory appropriations are Social Security, Medicare and payment of interest on the national debt. Congress has acted appropriately in treating spending in each of these areas as mandatory appropriations. Revisiting those decisions would be a mistake and reversing any of them would be a colossal blunder.

Social Security and Medicare are not run-of-the-mill government programs. They are covenants with the American people: guarantees of retirement income and health care coverage for seniors. They are promises made to each of us as individuals: we each pay into the system during our working years, and retirement support and health insurance will be available to us in our retirement or older age. (Social Security of course also includes promises to those with disabilities that impede their ability to maintain gainful employment and to spousal and child survivors of a deceased who was eligible for Social Security benefits.) It would be unconscionable to violate that trust by putting up for grabs whether seniors could count on adequate funding for Social Security or Medicare, either by subjecting spending on Social Security and Medicare to annual appropriations, or by making such spending subject to sequestration.

It would be enormously economically disruptive, as well, for retirees count on Social Security – for more than half of seniors, it provides half or more of their income; for one in five, it accounts for 90 percent or more of their income.[2] Uncertainty about Social Security would throw their lives into turmoil, as well as require them to alter retirement decisions. If anything, uncertainty around Medicare would be even more tumultuous. Not only do seniors rely on Medicare for their health insurance; health providers count on it to insurer a major portion of their customer base.

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[1] Joshua Stein, Tax Expenditures, Congressional Budget Office, March 17, 2017, available at: https://www.cbo.gov/publication/52493.

[2] Center for Budget and Policy Priorities, "Top Ten Basic Facts About Social Security," August 14, 2018, available at: https://www.cbpp.org/research/social-security/policy-basics-top-ten-facts-about-social-security.

Health industry markets would be significantly disrupted if there were year-to-year uncertainty around funding of Medicare.

Similarly, it would be wrong to throw into doubt the U.S. commitment to pay its debts – debts incurred with the full faith and credit of the United States. Apart from the moral quandary of calling into question the ability of the United States' ability – or, more accurately, willingness – to pay its debts, subjecting debt payments to annual appropriations or sequestration would likely have catastrophic economic consequences. A Treasury Department report concludes that a default on U.S. debt "would be unprecedented and has the potential to be catastrophic: credit markets could freeze, the value of the dollar could plummet, and U.S. interest rates could skyrocket, potentially resulting in a financial crisis and recession that could echo the events of 2008 or worse."[3]

II. Enhancing Mandatory Appropriation Spending Efficiency: Opportunities for Medicare Reform

To conclude that mandatory appropriations pose no constitutional problem and that the largest mandatory appropriations should continue to be treated as such does not imply that mandatory appropriations should escape scrutiny. In this section of my testimony, I focus on two ways to obtain significant Medicare savings and a third way to significantly increase Medicare's per patient efficiency.

Medicare itself operates on an extremely efficient basis, with administrative costs totaling around 2 percent,[4] a small fraction of the 12 percent of annual budgets spent by private insurers on Medicare.[5]

But Medicare could save billions of dollars annually if Part D were permitted to negotiate drug prices, and it could score vast per patient savings if Medicare Advantage were eliminated or scaled back, and if Medicare were expanded to cover all Americans.

A. Medicare Drug Price Negotiation

The most obvious and urgent savings available in mandatory spending is reducing Medicare's drug expenditure.

By law, Medicare Part D is not allowed to "interfere with the negotiations between drug manufacturers and pharmacies and [Part D plan] sponsors."[6] While Medicare Part D plan

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[3] Sabrina Siddiqui, The Potential Macroeconomic Effect of Debt Ceiling Brinkmanship, U.S. Treasury Department, October 2013, available at: https://www.treasury.gov/initiatives/Documents/POTENTIAL%20MACROECONOMIC%20IMPACT%20OF%20DEBT%20CEILING%20BRINKMANSHIP.pdf.

[4] Medicare Advantage has higher overhead costs than even private insurance, at around 19 percent. Nick Buffie, Overhead Costs for Private Health Insurance Keep Rising, Even as Costs Fall for Other Types of Insurance, Center for Economic and Policy Research, February 6, 2017, available at: https://bit.ly/2l6XVB0.

[5] Nick Buffie, Overhead Costs for Private Health Insurance Keep Rising, Even as Costs Fall for Other Types of Insurance, Center for Economic and Policy Research, February 6, 2017, available at: https://bit.ly/2l6XVB0.

[6] 42 USC 1395w-111(i).

sponsors can obtain substantial rebates from both drug manufacturers and pharmacies, the federal program is prohibited from leveraging its purchasing power to realize economies of scale due to this noninterference clause. This prohibition on negotiation is as irrational as policy comes: The U.S. government grants patent and other monopolies to drug manufacturers, then it takes on a mandate to purchase pharmaceuticals from the drug monopolists, while at the same time denying itself the authority to negotiate price. There is no legitimate justification for this policy, which guarantees the price gouging of American taxpayers and consumers.

And, indeed, the policy was not the result of careful analysis and consideration. Instead, it was the result of the corrupting political influence of Big Pharma, including a revolving door arrangement to benefit former chair of the House and Energy Committee Billy Tauzin. Tauzin ensured that the new Medicare Part D drug purchasing program would prevent Medicare from negotiating drug prices. Then, as the Medicare Part D legislation was being signed into law, he negotiated a new job heading up PhRMA, the industry trade association.[7]

Predictably, refusing to leverage bulk purchasing negotiating authority in purchase arrangements with monopolists leads to price gouging and dramatic overspending. Big Pharma purposely obscures its prices, charging very different prices to different purchasers and confusing matters further with a bewildering array of discounts and rebates. But when appropriate data are analyzed, the results are stark: With a researcher from Carlteon University, we were able to compare the prices paid for pharmaceuticals by Medicare Part D with those paid by the Veterans Health Administration (VHA). We found that if, in 2014, Medicare Part D were able to negotiate similar prices to those negotiated by the VHA on the same brand-name drugs, it would save $16 billion a year.[8] The savings would almost surely be larger now than they were four years ago. Moreover, there is every reason to assume that Medicare Part D, if empowered to negotiate prices, could obtains savings significantly greater than the VHA is able to, simply because of the scale of Medicare purchases.

The Carlteon-Public Citizen study found that:

- Medicare Part D pays almost twice as much for drugs as the median OECD price. After including rebates, brand-name drugs cost Medicare Part D 198 percent of the median costs for the same brand-name drugs in the 31 OECD countries.

- Medicare Part D pays on average 73 percent more than Medicaid and 80 percent more than the Veterans Health Administration for brand-name drugs.

- Medicare is unable to use its latent negotiating power to reduce incentives and reimbursement for non-innovative "me-too" drugs. Under current Medicare Part D pricing, non-innovative "me-too" drugs are priced as much or more than older, equally

[7] Mike Stuckey, "Tauzin Aided Drug Firms, Then They Hired Him," NBC News, March 22, 2016, available at: http://www.nbcnews.com/id/11714763/t/tauzin-aided-drug-firms-then-they-hired-him/#.XA3OD-JOl9B.
[8] Marc-Andre Gagnon and Sidney Wolfe, Mirror, Mirror on the Wall: Medicare Part D Pays Needlessly High Brand-Name Drug Prices Compared with Other OECD Countries and with U.S. Government Programs, July 11, 2015, available at: https://www.citizen.org/sites/default/files/2269a.pdf.

effective versions. By paying inflated prices for drugs that do not provide value for money, Medicare Part D artificially increases the returns and incentives for non-innovative "me-too" drugs to the detriment of new innovative medicines for unmet needs.

There are serious health costs, as well as well as monetary costs, to inflated drug prices under Medicare Part D. Non-adherence to drug regimens due to price – the cost of drugs, co-pays and deductibles – is at epidemic levels, with one in six Americans reporting they skipped drug treatments because of the cost of medicines.[9] The result is needless suffering from treatable conditions and frequently worsened health and increased costs as conditions preventable with drug treatment require more aggressive interventions.

There is absolutely no mystery about how to bring down Medicare Part D spending. Medicare must simply be given the authority to negotiate lower prices, with enforcement power to deploy against companies that do not agree to reasonable prices. One mechanism, used effectively by the Veterans Health Administration (as well as private plan providers), is a formulary: If a drug maker will not agree to a reasonable price, the drug is excluded from coverage. Although in some cases this might potentially leave useful drugs excluded from coverage, in practice this rarely occurs, because manufacturers do not want to forego large, very profitable sales – for sales even at half at what Medicare is now paying will remain extremely profitable for manufacturers. Representative Cummings and others have proposed legislation for Medicare negotiation with a formulary backstop. An alternative or complementary mechanism to a formulary is licensing: When a brand-name manufacturer refuses to agree to a reasonable price, the government would authorize generic competitors to enter the market and provide the product affordably, while paying a reasonable royalty to the brand-name company. The attractiveness of the licensing approach is that it avoids even the hypothetical problem of important drugs not being available. Representative Cummings has joined Representative Doggett in proposing Medicare Part D negotiation with a licensing backstop. In practice, however, neither licensing nor use of a formulary is likely to occur with any frequency; brand-name companies will not be willing to opt out of Medicare, which by itself represents roughly 7 percent of the global pharmaceutical market, and so they will instead agree to negotiate reasonable prices.

B. Medicare Advantage

Medicare Advantage plans are now on track to constitute 37 percent of the Medicare market in 2019,[10] thanks in some part to improper promotional efforts by the Trump administration. These plans have a long record of receiving overpayments and disadvantaging Medicare. One study estimated that Medicare overpayments to private plans cost the federal government more than $280 billion from 1985-2012.[11] The Affordable Care Act aimed to cut back on overpayments to

[9] Steven Morgan, Cost-Related Adherence to Prescribed Medicines Among Older Adults, Commonwealth Fund, June 12, 2017, available at: https://www.commonwealthfund.org/publications/journal-article/2017/jun/cost-related-non-adherence-prescribed-medicines-among-older.

[10] 2019 Medicare Advantage and Part D Prescription Drug Program Landscape, CMS, September 28, 2018, available at: https://www.cms.gov/newsroom/fact-sheets/2019-medicare-advantage-and-part-d-prescription-drug-program-landscape.

[11] Ida Hellender, David U. Himmelstein, Steffie Woolhandler, Medicare Overpayments to Private Plans, 1985-2012, International Journal of Health Services, April 1, 2013, available at: https://journals.sagepub.com/doi/10.2190/HS.43.2.g.

Medicare Advantage, but a federal court invalidated the Act's Overpayment Rule in September 2018, removing the enforcement mechanism to ensure Medicare Advantage plans are not paid more for any particular treatment than Medicare would spend on the same treatment. So long as Medicare Advantage persists, there must be rock-solid controls against overpayments.

But the cost problem with Medicare Advantage goes beyond overpayments to a more structural problem that can only be cured by significantly scaling back or eliminating Medicare Advantage. A persistent problem in the private insurance market, and certainly when private insurers operate in markets alongside of backstop public insurers, is cherry picking: the phenomenon of private insurers limiting their coverage pool to lower-risk parties – which, in the case of health insurance, means healthier people. This problem is pervasive in the seniors' health insurance markets and is practically unavoidable: Medicare Advantage insurers can offer lower premiums with less access to the more expensive treatments and services that less healthy people need. The result is to leave traditional Medicare with a pool of less healthy people, raising its per patient cost. Various reforms have sought to address this problem, but the structural incentives for cherry picking consistently lead insurers to find ways around regulatory controls.

A 2017 GAO study found that sicker seniors were more likely to switch from Medicare Advantage to traditional Medicare. It concluded that roughly one third of the Medicare Advantage plans with high disenrollment rates were biased against sick people (presumably prompting sick people to leave the plan when they become ill. "In these contracts, beneficiaries in poor health were substantially more likely (on average, 47 percent more likely) to disenroll relative to beneficiaries in better health."[12] Similarly, a 2015 study found that high-cost patients were more likely to drop out of Medicare Advantage and enroll in traditional Medicare than the reverse. The disparities were stark. The authors found "that the switching rate from 2010 to 2011 away from Medicare Advantage and to traditional Medicare exceeded the switching rate in the opposite direction for participants who used long-term nursing home care (17 percent versus 3 percent), short-term nursing home care (9 percent versus 4 percent), and home health care (8 percent versus 3 percent)."[13]

Gaming of Medicare Advantage is a defining trait of the system. Regulators are completely unable to maintain pace with the gaming innovations of the industry, all of which end up imposing additional, wasteful costs on Medicare. Earlier this year, the Wall Street Journal reported on the extent of "crosswalking," where Medicare Advantage insurers carve up and merge plans in order to maintain high ratings from Medicare, ratings which translate into substantial bonus payments from Medicare.[14] The Journal analysis focused on examples from UnitedHealth, finding:

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[12] General Accountability Office, Medicare Advantage: CMS Should Use Data on Disenrollment and Beneficiary Health Status to Strengthen Oversight, April 2017, available at: https://www.gao.gov/assets/690/684386.pdf.
[13] Momotazur Rahman, et. al., High-Cost Patients Had Substantial Rates Of Leaving Medicare Advantage And Joining Traditional Medicare, Health Affairs, October 1, 2015, available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4676406.
[14] Anna Wilde Mathews and Christopher Weaver, "Insurers Game Medicare System to Boost Federal Bonus Payments," Wall Street Journal, March 11, 2018, available at: https://www.wsj.com/articles/insurers-game-medicare-system-to-boost-federal-bonus-payments-1520788658?redirect=amp#click=https://t.co/uejwbhXnoQ.

> Heading into 2016, UnitedHealth, the biggest Medicare Advantage insurer, merged plans covering 162,088 members, across more than 15 states including Indiana, Texas and Georgia, into a contract that had included just 1,729 members in Rhode Island and Massachusetts, who were enrolled in special plans for nursing-home patients. Before the consolidation, the rating on the small contract was 4.5 stars. The larger plans carried ratings of 3 and 3.5 stars—too low to get bonuses.
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> After the merger, the larger contract—using the Medicare number of the smaller one—still rated 4.5 stars. The bonuses applied to the combined enrollment of about 164,000, along with new members who signed up that year. The move resulted in at least an additional $63.7 million flowing to UnitedHealth, the Journal calculated, based on the membership of the plans at the end of 2015.
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> For 2016, UnitedHealth moved plans with 624,973 members at the end of the prior year into higher-bonus contracts, according to the Journal's analysis, and it did the same thing the next year for plans with 594,016 members.

Analysts from JPMorgan Chase concluded that Humana generated an extra $600 million from employing the tactic, according to the Journal. The Journal analysis found that multiple "insurers have used the maneuver to shuffle plans covering more members into higher-rated setups over the past few years—including around 1.45 million people for 2018."[15]

C. Medicare-for-All

As noted, Medicare operates with extreme efficiency, and outside of the pharmaceutical context, it is successful at establishing reasonable reimbursement rates. But as one among many payers, Medicare is not able to prevent certain inefficiencies in the broader health care market. If Medicare were improved and expanded – with stronger and broader coverage, for all Americans – it could achieve dramatic per patient savings. Expanding Medicare to cover all Americans would obviously increase its overall spending and require new taxes, but it would mean significant savings on a per capita basis – and all Americans would have access to coverage, better than available under Medicare or private plans now.

The largest savings that Medicare would wring from Medicare-for-All is eliminating the wasteful spending by the health care sector on administrative costs. The key would be to move away from per-treatment billing and instead relying on global budgets. Hospitals and other medical providers would receive an overall payment based on the patients they serve and the treatments they provide, and then they could get on with the business of providing care. The arrangement would be no different than the ways police stations or public libraries are funded; libraries don't send a bill to the city treasurer each time a person checks out a book. The potential available savings are tremendous:

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[15] Anna Wilde Mathews and Christopher Weaver, "Insurers Game Medicare System to Boost Federal Bonus Payments," Wall Street Journal, March 11, 2018, available at: https://www.wsj.com/articles/insurers-game-medicare-system-to-boost-federal-bonus-payments-1520788658?redirect=amp#click=https://t.co/uejwbhXnoQ.

- Administrative costs consume an astounding 25 percent of U.S. hospital spending, far above most comparable countries, due largely to the costs of billing.[16] If hospital administrative spending were brought in line with more efficient countries, the U.S. could save more than $150 billion each year on hospital spending alone.[17]

- Researchers have found that American medical practices spent almost four times more money than Canadian doctors on dealing with payment issues, $82,000 per physician annually compared to $20,000.[18] The same study found that nurses in the United States spend more than 10 times as much as their Canadian counterparts interacting with payers. Most of the discrepancy in hours spent was consumed in nurses spending time obtaining prior authorizations from insurance companies.

- Processing bills, coupled with expenses for collection of unpaid bills, accounts for half or more of medical practice's administrative costs -- between 50 and 60 percent, according to a 2005 study published in Health Affairs.[19]

A Medicare-for-All system would also be able to rationalize spending on expensive renovations and health care technology. With global budgeting, institutions would maintain a separate budget for capital expenditures, such as on medical equipment and expansions of facilities, apart from operating expenditures. Such purchases impose upfront costs on providers. Once purchased, they create incentives to provide unnecessary care to recoup their investments.[20] By requiring separate budgets for the purchases of expensive medical equipment and other expansions, Medicare-for-All would ensure that such purchases are warranted by a community's needs and would thus reduce unnecessary spending, both on the capital expenses themselves as well as on spending for related services. Instead of having every hospital compete by purchasing complex new technology or building fancy new hospital wings, city and regional capacity would be considered to ensure adequate coverage.

Conclusion

Given their desirability and constitutional permissibility, Congress has reasonably and properly put in place a system of mandatory appropriations, with spending focused on Social Security, Medicare and interest payments. This system is functional and should be maintained, but it require ongoing monitoring. In many areas, including especially Medicare, significant, positive reforms could be achieved.

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[16] David U. Himmelstein, et al., A Comparison of Hospital Administrative Costs in Eight Nations: US Costs Exceed All Others by Far, 33 Health Affairs 1586-1594, 1589 (2014).
[17] David U. Himmelstein, et al., A Comparison of Hospital Administrative Costs in Eight Nations: US Costs Exceed All Others by Far, 33 Health Affairs 1586-1594, 1593 (2014).
[18] Dante Morra, et al., US Physician Practices Versus Canadians: Spending Nearly Four Times As Much Money Interacting With Payers, 30 Health Affairs 1443-1450, 1445 (2011).
[19] James G. Kahn, et al., The Cost Of Health Insurance Administration In California: Estimates For Insurers, Physicians, And Hospitals, 24 Health Affairs 1629-1639, 1633 & 1634 (2005).
[20] U.S. Government Accountability Office, Medicare: Higher Use of Advanced Imaging Services By Providers Who Self-Refer Costing Medicare Millions, September 2012, available at: https://bit.ly/2CDgusT. Dan Munro, Why Physician Self-Referrals Have to Stop Now, Forbes, January 26, 2015, available at: https://bit.ly/2ArvYPd.

Thank you for the opportunity to testify today, and we look forward to continuing to work with the committee on a shared agenda for the American people.