

Financing Medicare and Medicaid

Testimony of Judy Feder¹
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Chairman Pitts, Ranking Member Pallone, and members of the subcommittee, I appreciate the invitation to appear before you today on setting fiscal priorities and 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 contribute to reducing projected long-run deficits while sustaining these programs' fundamental insurance protections. By contrast, proposals to restructure Medicare through vouchers or Medicaid through block grants or *per capita* caps 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 more than 40 years, Medicare spending per enrollee has grown by an average of one percentage point less than comparable private health insurance premiums.² 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;³ it is also the nation's primary payer for long-term care services and supports.

Medicare spending has recently been growing at an historically low rate. Medicare spending per beneficiary is projected to increase by just 0.3 percent in 2014 and by 0.7 percent a year over the 2010-2014 period — well below the growth in gross domestic product (GDP) per capita.⁴

The financial outlook for Medicare and Medicaid has improved significantly in the past four years. The Congressional Budget Office (CBO) initially estimated that the Affordable Care Act (ACA) would reduce projected Medicare spending by \$555 billion between 2011 and 2020.⁵ CBO's projections of Medicare spending over the 2011-2020 period have fallen by an additional \$715 billion since late 2010, and its Medicaid projections have declined by \$395 billion.⁶ Medicare spending per beneficiary in 2014 is expected to be \$1,200 lower than CBO projected in 2010.⁷

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

² Office of the Actuary, Centers for Medicare & Medicaid Services, National Health Expenditure Tables, January 2014, table 21, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf>.

³ Leighton Ku and Matthew Broaddus, "Public and Private Insurance: Stacking Up the Costs," *Health Affairs* Web Exclusive, June 24, 2008.

⁴ 2014 *Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, July 28, 2014, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2014.pdf>.

⁵ Congressional Budget Office (CBO), *The Budget and Economic Outlook: An Update*, August 2010, p. 63.

⁶ CBO, *Revisions to CBO's Projections of Federal Health Care Spending*, July 28, 2014, <http://www.cbo.gov/publication/45581>.

⁷ Tricia Neuman and Juliette Cubanski, "The Mystery of the Missing \$1,200 Per Person," Kaiser Family Foundation, September 29, 2014, <http://kff.org/health-costs/perspective/the-mystery-of-the-missing-1000-per-person-can-medicare-spending-slowdown-continue/>.

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 boomers age, states will also face a considerable increase in the need for long-term care.⁸ Between now and 2035, federal spending on Medicare, Medicaid, and related programs is projected to increase by 3 percent of GDP.⁹ 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 there 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.¹⁰

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,¹¹ eliminating overpayments to Medicare Advantage plans,¹² and refining payment mechanisms for post-acute care¹³ 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 evidence from the Medicare Payment Advisory Commission (MedPAC) that they promote sorely needed efficiency in health care delivery.¹⁴ Though too great a gap between Medicare and private payments can endanger access to care, the solution is not to have Medicare pay

⁸ 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.

⁹ Richard Kogan, Kathy Ruffing, Paul N. Van de Water, and William Chen, *CBPP’s Updated Projections Show Long-Term Budget Outlook Is Significantly Improved but Remains Challenging*, Center on Budget and Policy Priorities, May 5, 2014, <http://www.cbpp.org/cms/index.cfm?fa=view&id=4139>.

¹⁰ Edwing Park and Matt Broadus, “Medicaid Per Capita Cap Would Shift Costs to the States and Place Low Income Beneficiaries at Risk,” Center on Budget and Policy Priorities, October 4 2012 <http://www.cbpp.org/cms/index.cfm?fa=view&id=3846>

¹¹ Richard Frank and Jack Hoadley. “The Medicare Part D Drug Rebate Proposal: Rebutting an Unpersuasive Critique.” *Health Affairs Blog*, December 28, 2012.

¹² Judy Feder, Steve Zuckerman, Nicole Lallemand and Brian Biles, “Why Premium Support? Restructure Medicare Advantage, Not Medicare.” Washington: The Urban Institute, 2012.

¹³ Kaiser Family Foundation, *Policy Options to Sustain Medicare for the Future*. January 2013, Option 2.42.

¹⁴ Medicare Payment Advisory Committee, *Report to the Congress, Medicare Payment Policy*, Chapter 3, March 2012.

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. New revenues are therefore needed 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.

Advocates of so-called premium support argue that Medicare's experience with private Medicare Advantage (MA) plans portends federal savings and greater efficiency were Medicare transformed from a defined-benefit to a defined-contribution plan — under which beneficiaries would receive a voucher and be required to choose among competing private plans as well as traditional Medicare. However, MedPAC continues to find that MA plans cost the federal government more, on average, than traditional Medicare and that plans continue to benefit financially from serving healthier patients.¹⁵ At the same time, a recent comprehensive review of the literature finds, in general, that research is inadequate to support quality comparisons and cites evidence that Medicare beneficiaries — especially these needing a lot of care — rate traditional Medicare more favorably than MA plans in terms of quality and access to care.¹⁶

Further, there is no question that premium support raises the fundamental concern of a cost shift from the federal government to beneficiaries, as it severs the tie between federal contributions and a beneficiary's costs. The more constrained the defined contribution, the greater the shift. But even a defined contribution tied to average plan costs would increase out-of-pocket costs for the substantial numbers of beneficiaries — including those needing above-average amounts of care — remaining in the traditional program.¹⁷

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 \$26,000 (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. Some other proposals for changes to Medicare — such as raising the age of eligibility — would actually raise total as well as beneficiaries' health care costs.

¹⁵ Edwin Park, *New Research Shows Limits of Risk Adjustment in Protecting Traditional Medicare under Premium Support*, Center on Budget and Policy Priorities, September 12, 2014, <http://www.cbpp.org/cms/index.cfm?fa=view&id=4202>.

¹⁶ Marsha Gold and Giselle Casillas, *What Do We Know About Health Care Access and Quality in Medicare Advantage Versus the Traditional Medicare Program?*, Kaiser Family Foundation, November 2014, <http://files.kff.org/attachment/what-do-we-know-about-health-care-access-and-quality-in-medicare-advantage-versus-the-traditional-medicare-program-report>.

¹⁷ CBO, *A Premium Support System for Medicare: Analysis of Illustrative Options*, September 18, 2103,

Restructuring Medicare and Medicaid cannot be justified on grounds of fiscal responsibility. Since late 2010 Congress has enacted \$4.1 trillion in deficit reduction — 77 percent of that through spending cuts.¹⁸ As a result, the Congressional Budget Office now projects that the federal debt will remain roughly stable as a share of GDP between now and the end of the decade.¹⁹ At the same time, the nation is experiencing historically low growth in health care spending.²⁰

Policymakers clearly have 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, so that we can meet our responsibilities to an aging population. The nation’s fiscal capacity does not provide an excuse to 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.

¹⁸ Richard Kogan and William Chen, *Projected Ten-Year Deficits Have Shrunk by Nearly \$5 Trillion Since 2010, Mostly Due to Legislative Changes*, Center on Budget and Policy Priorities, March 19, 2014.

¹⁹ CBO, *An Update to the Economic and Budget Outlook: 2014 to 2024*, August 2014.

²⁰ Micah Hartman et al, “National Health Spending in 2013,” *Health Affairs*, December 2014, <http://content.healthaffairs.org/content/early/2014/11/25/hlthaff.2014.1107.full>.