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3 HEARING ON THE TRUE COST OF PPACA: EFFECTS ON THE BUDGET AND

4 JOBS

5 WEDNESDAY, MARCH 30, 2011

6 House of Representatives,

7 Subcommittee on Health

8 Committee on Energy and Commerce

9 Washington, D.C.

10 The Subcommittee met, pursuant to call, at 10:02 a.m.,
11 in Room 2123 of the Rayburn House Office Building, Hon. Joe
12 Pitts [Chairman of the Subcommittee] presiding.

13 Members present: Representatives Pitts, Burgess,
14 Whitfield, Shimkus, Rogers, Myrick, Murphy, Blackburn,
15 Gingrey, Latta, McMorris Rodgers, Lance, Cassidy, Guthrie,
16 Upton (ex officio), Pallone, Dingell, Engel, Capps,
17 Schakowsky, Gonzalez, Baldwin, Weiner and Waxman (ex
18 officio).

19 Staff present: Allison Busbee, Legislative Clerk;
20 Howard Cohen, Chief Health Counsel; Paul Edattel,
21 Professional Staff Member, Health; Julie Goon, Health Policy
22 Advisor; Ryan Long, Chief Counsel, Health; Jeff Mortier,
23 Professional Staff Member; Monica Popp, Professional Staff
24 Member, Health; Heidi Stirrup, Health Policy Coordinator;
25 Phil Barnett, Democratic Staff Director; Alli Corr,
26 Democratic Policy Analyst; Tim Gronniger, Democratic Senior
27 Professional Staff Member; Purvee Kempf, Democratic Senior
28 Counsel; Karen Lightfoot, Democratic Communications Director,
29 and Senior Policy Advisor; and Karen Nelson, Democratic
30 Deputy Committee Staff Director for Health.

|
31 Mr. {Pitts.} The subcommittee will come to order.

32 The chair recognizes himself for 5 minutes for an
33 opening statement.

34 We had a very instructive field hearing, our first, in
35 Harrisburg last week, on the one-year anniversary of the
36 signing of PPACA. What we heard about the health reform
37 law's costs on Pennsylvania alone was chilling. Governor
38 Corbett stated that after the Medicaid expansion had gone
39 into effect, roughly one in four Pennsylvanians would be on
40 the program. According to the Acting Secretary of the
41 Department of Public Welfare, Gary Alexander, Medicaid
42 currently accounts for 30 percent of the State budget. That
43 is more than all but two other States, Illinois and Missouri.
44 And if PPACA is fully implemented, that percentage will
45 double to 60 percent of their State budget by fiscal year
46 2019-20. This is simply not sustainable for my home State,
47 or any other. And the numbers don't look much better for the
48 Federal Government, either.

49 On March 18, 2011, CBO released its preliminary analysis
50 of the President's fiscal year 2012 budget. CBO's estimate
51 of total spending on coverage expansions in PPACA grew from
52 \$938 billion last March for fiscal years 2010 through 2019 to
53 \$1.445 trillion for fiscal years 2012 through 2021. That is

54 a 54 percent increase in federal spending.

55 As you may remember, President Obama when he was running
56 promised his health care plan would cost \$50 billion to \$65
57 billion a year when fully phased in. CBO, however, projects
58 that the real cost of the coverage expansions will be \$229
59 billion in 2020 and \$245 billion in 2021 - four times the
60 levels of spending that President Obama had promised.

61 And what about the jobs PPACA was supposed to create?
62 Then-Speaker Pelosi stated in February of last year that the
63 law would create ``4 million jobs, 400,000 jobs almost
64 immediately.'' Yet, as Mr. Elmendorf told the House Budget
65 Committee last month, he expects the law will cost 800,000
66 jobs by 2021. That may be because the law contains perverse
67 incentives for businesses not to grow. Small businesses are
68 hesitant to go over 50 employees and incur a penalty for each
69 full-time employee who does not have proper insurance, as
70 defined by the government.

71 They are also being buried under thousands of pages of
72 regulations, with thousands more to come, with which they
73 will have to comply, and they will bear the cost of
74 compliance on their own. Or, like Case New Holland, a major
75 manufacturer with operations in Pennsylvania, testified at
76 the field hearing last week, they already expect to spend
77 \$126 million over the next decade just to comply with this

78 law, and that is \$126 million that won't go towards expanding
79 their business or creating new jobs.

80 We are receiving reports almost weekly that show that
81 the true cost of Obamacare is worse than what any of us
82 expected--higher premiums, more federal health spending,
83 fewer jobs, less access, and people losing the coverage they
84 currently have and like. Not only does the law not achieve
85 its stated goals, the true cost of Obamacare is too high for
86 our States, too high for the Federal Government, and too high
87 for the private sector.

88 I would like to thank all of our witnesses for being
89 here today.

90 [The prepared statement of Mr. Pitts follows:]

91 ***** COMMITTEE INSERT *****

|
92 Mr. {Pitts.} I will yield the remainder of my time to
93 Dr. Burgess.

94 Dr. {Burgess.} I thank the chairman for the
95 recognition.

96 Today we are faced with the question, is the Affordable
97 Care Act affordable. We don't know. We didn't know when
98 this committee passed a health care bill last year called
99 H.R. 3200. Mercifully, that bill died a natural death in the
100 Speaker's office and H.R. 3590, as everyone knows, was signed
101 into law a year and a week ago.

102 But even today, we don't know about the essential
103 benefits package. We don't know about the cost of setting up
104 the exchanges. All of this remains shrouded between a veil
105 of obscurity.

106 After the bill became law, our actuary from the Centers
107 for Medicare and Medicaid Services released his findings to
108 the Congress and estimated the overall national health
109 expenditures would be increased by some \$311 billion, a
110 significant difference from the \$142 billion in savings that
111 was advertised merely a month before. So I authored last
112 year a Resolution of Inquiry requesting the transfer of
113 internal Health and Human Services communications related to
114 the date of Mr. Foster's report. The Congressional Budget

115 Office and the Chief Actuary do model different things, and
116 this has been pointed out to me by some of our witnesses this
117 morning. But both are essential components to determining
118 the cost, the true cost of the Affordable Care Act, and
119 really should have made available to the Members of Congress
120 before, before, before the vote was taken last year.

121 If the intent of reforming the health care system was
122 indeed to bend the cost curve, then it looks like mission
123 accomplished. Unfortunately, we bent it in the wrong
124 direction.

125 Now, I acknowledge that the Congressional Budget Office
126 had an impossible job, and most Members of Congress do
127 recognize that, and I guess I would just ask the question, if
128 we rely solely on the Congressional Budget Office when we
129 know they have an impossible job, if we rely solely on their
130 numbers, are we in fact not facing reality. What if their
131 assumptions are off by just a little bit? The result of
132 maybe 5 percent of employers dropping coverage and moving
133 employees into the exchanges. What effect does that have on
134 the cost of the subsidies in the exchanges when that kicks in
135 a few years' time? Probably an average of tens of billions
136 of dollars.

137 Why was Congress negligent in our responsibility to see
138 the impact that this law would have on the health care

139 system, the cost of the health care system? The
140 Administration knew that it would take Mr. Foster time to
141 complete his model, but did the Administration push us to
142 have that vote before we could have access to the actual
143 date? And this is the question that needs to be answered
144 this morning.

145 Thank you, Mr. Chairman. I will yield back.

146 [The prepared statement of Dr. Burgess follows:]

147 ***** COMMITTEE INSERT *****

|
148 Mr. {Pitts.} The chair thanks the gentleman and
149 recognizes the ranking member of the subcommittee, Mr.
150 Pallone, for 5 minutes for an opening statement.

151 Mr. {Pallone.} Thank you, Mr. Chairman. We are back
152 from another week off in Congress and it is time for the
153 Republicans to try to repeal, defund or criticize the health
154 care reform again. It is pretty clear that the Republicans
155 believe that if you just keep saying the same thing over and
156 over again, it will start to be believed. Just fire up the
157 old talking points, throw in a little righteous indignation
158 and you are good to go. And that would be just fine if we
159 were all talk-radio stars, but we are not. We have a job to
160 do. We are legislators. We are supposed to be trying to
161 turn the economy around and create jobs. But here we are to
162 talk again about the Affordable Care Act, which is just the
163 Republicans' reheated arguments about repeal and replace,
164 except they forgot to replace it with anything to speak of.

165 The Republicans seem to wish that if they just click
166 their heels three times, we could return to that magical time
167 in the last decade when they controlled both Houses of
168 Congress and the White House and, as they would tell it,
169 business prospered and fiscal responsibility was the name of
170 the game, except that is not what happened. When President

171 Bush came to office, he inherited a surplus projected to
172 total \$5.6 trillion over 10 years, and he managed to swiftly
173 squander that, leaving President Obama a nicely wrapped \$1.3
174 trillion deficit in 2009. Under President Bush's watch, the
175 number of uninsured increased by 6 million nationwide. Small
176 businesses, which make up the majority of the uninsured in
177 America, were hurt especially hard during this time. While
178 57 percent of small businesses were able to offer health
179 insurance in 2000, only 46 percent were able to by the end of
180 the Bush Administration, and it would have just gotten worse.
181 By the time President Obama took office, national health
182 expenditures surpassed \$2.4 trillion in 2009, more than three
183 times as much as it was in 1990. The percentage of income
184 families spent on employer-sponsored health insurance rose
185 from 12 to 22 percent from 1999 to 2009 during the Bush
186 Administration, and those without insurance were even worse
187 off. For many families who had worked hard, saved hard and
188 planned for the worst, they couldn't stay in the black if
189 their kid got sick or denied health insurance for life due to
190 a preexisting condition or if they themselves got sick with a
191 tough disease and quickly ran through their insurance plan's
192 annual limits.

193 So understanding this, President Obama and the Congress
194 including this committee didn't just sit around and whine

195 about the previous 8 years under Bush; they stood up and led.
196 And we are very proud of the health care reform, the economic
197 certainty, insurance reform and coverage expansions will
198 offer families across the Nation. We are glad that small
199 business owners like Rick Poore, who will testify later this
200 morning, are now eligible for tax credits today to cover
201 their employees, and in the future Rick will be able to
202 leverage the purchasing power of small business owners across
203 the Nation through the State exchanges so that more of his
204 money can be invested in his business and more of his energy
205 can be devoted to innovation.

206 I am very proud that the Affordable Care Act will
207 control health care spending by making important delivery
208 system changes that reward quality, not quantity of care. We
209 are proud that Americans will no longer be held hostage to
210 insurance companies as a result of the reforms in our
211 legislation, and I will remind you that the Congressional
212 Budget Office has estimated the Affordable Care Act will
213 reduce the deficit by \$124 billion by 2019 and further cuts
214 the deficit by \$1.2 trillion in the second 10 years.

215 So if the Republicans want to spend another Wednesday
216 morning discussing the true effects of the Affordable Care
217 Act today, I am game, but I think we really need to get back
218 to work and try to create jobs instead of wasting our time

219 trying to repeal health reform. I mean, it is how many weeks
220 now since you first repealed the act and of course the Senate
221 rejected it? We have had nothing but hearings for the most
222 part on either repealing the bill, repealing part of the
223 bill, defunding the bill, now, you know, another hearing
224 talking about the financial aspects of the bill. It just
225 never seems to end.

226 So I would now yield the remaining time to my colleague
227 from California, Representative Capps.

228 [The prepared statement of Mr. Pallone follows:]

229 ***** COMMITTEE INSERT *****

|
230 Mrs. {Capps.} Thank you, Mr. Pallone. To underscore
231 what you have just said, we have been in session for 10 weeks
232 now and the Majority has yet to produce a plan to create jobs
233 or strengthen the economy. Instead, our Republican
234 colleagues are here yet again to live in the past and attack
235 the Affordable Care Act.

236 Many of the claims we are going to hear today about the
237 so-called true cost of the Affordable Care Act are likely to
238 be shocking but that is not because the Affordable Care Act
239 is dangerous or because it is not working. Instead, it is
240 because these claims are at best gross exaggerations and at
241 worst complete fabrications. Let us be clear: the
242 Affordable Care Act is the largest deficit-reducing bill
243 enacted by Congress in the last decade. It will reduce the
244 deficit by \$210 billion over the next 10 years, and by \$1.2
245 trillion over the following decade, and it will do so while
246 continuing to help families and small businesses.

247 And as I yield back, the very sections of the bill the
248 Republicans are trying to defund are the provisions which
249 will reduce the deficit. I yield back.

250 [The prepared statement of Mrs. Capps follows:]

251 ***** COMMITTEE INSERT *****

|
252 Mr. {Pitts.} The chair thanks the gentlelady and now
253 recognizes the chairman of the full committee, Mr. Upton, for
254 5 minutes for an opening statement.

255 The {Chairman.} Well, thank you, Mr. Chairman. I too
256 thank you for holding this hearing. We just did mark the 1-
257 year anniversary of the health care bill being signed into
258 law last week yet today will be the committee's first chance
259 to fully explore the true fiscal impact the law will have on
260 our Nation's budget and job creation.

261 Last week the CBO noted that the coverage provisions of
262 PPACA would cost \$1.445 trillion for fiscal year 2012 through
263 2021. This is up from a 10-year cost estimate of \$938
264 billion when the bill was signed into law. This is not a
265 change in CBO scoring. Indeed, the CBO estimates for the
266 overlapping years are remarkably consistent. The larger
267 figure simply proves that if you take away some of the
268 gimmicks, mainly paying for only 6 years of benefits in the
269 first decade, that the cost far exceeds \$1 trillion and will
270 likely top \$2 trillion over a full 10 years.

271 We have also heard about how PPACA imposes a paperwork
272 nightmare on small businesses. The law, as we know, requires
273 a tax filing for every transaction over \$600. The House has
274 voted to repeal this massive paperwork cost on American

275 employers. However, our job does not end there. PPACA
276 includes dozens of new paperwork requirements that force
277 businesses to report to HHS, the Department of Labor, and the
278 IRS. Job creation is our top priority, which is why we
279 cannot ignore the fact that PPACA reduces employment.

280 In recent testimony before the House Budget Committee,
281 Mr. Elmendorf stated that 800,000 jobs would be lost because
282 of the new health care law. We should be creating jobs, not
283 destroying them, which is why many of us believe that we
284 should repeal this job-destroying bill. Many of us believe
285 that we must repeal the uncertainty that it is causing
286 businesses and the hundreds of billions of dollars in new
287 taxes and mountains of paperwork.

288 I would yield the balance of my time to Dr. Gingrey.

289 [The prepared statement of Mr. Upton follows:]

290 ***** COMMITTEE INSERT *****

|
291 Dr. {Gingrey.} I thank the chairman for yielding.

292 Mr. Chairman, it was just interesting to hear the
293 ranking member of the subcommittee a few minutes ago talk
294 about how the Democrats came to the rescue after 8 years of
295 Republican inaction on health care reform, essentially saying
296 just don't sit there, do something. Well, I think my
297 colleague, Dr. Burgess, a fellow OB/GYN physician, would
298 remember our OB/GYN motto, don't just do something, sit
299 there, in managing labor and delivery. And the point I am
300 making is to rush to judgment to do something just to get
301 something done oftentimes is a huge mistake, and I think that
302 is the way our side of the aisle feels in regard to PPACA,
303 the Affordable Care Act, because it doesn't accomplish any of
304 the goals that were set out. It is not good for patients.
305 It is not good for consumers. It is certainly not good for
306 corporate America and it is not good for the taxpayer.

307 So bottom line is, this is a bad bill, not that the idea
308 of reforming health care is a bad thing to do but certainly
309 the priority of doing it as a number one or number two thing
310 in the 111th and 110th Congress when we had 16 million people
311 out of work in this country and probably 25 million
312 underemployed, an unemployment rate of 10 percent, deficits.
313 He said they inherited a \$1.4 trillion deficit. Well, how

314 about the next year when it was \$1.6 trillion? Who inherited
315 that? And how about the \$5 trillion worth of additional debt
316 that was piled on to the taxpayer by the Democrat Majority
317 since they took control in 2007? So I think their
318 priorities are all wrong and backwards in regard to this, and
319 I am really interested in hearing from our witnesses, the
320 first panel, of course, CBO, Mr. Elmendorf, and our CMS
321 Actuary, Mr. Foster, because we need this information.

322 So if there is any time remaining, I will just yield
323 that back. Mr. Upton controls the time I guess.

324 [The prepared statement of Dr. Gingrey follows:]

325 ***** COMMITTEE INSERT *****

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326 The {Chairman.} I yield to Ms. Blackburn.

327 Mrs. {Blackburn.} I want to welcome our witnesses
328 today, and to the witnesses and my colleagues, I would just
329 remind you all, in Tennessee we had an experiment called
330 TennCare. TennCare eventually consumed 35.3 percent of our
331 State's budget before Governor Bredesen took action to try to
332 get this under control. This was public option health care
333 and it was the experiment for public option health care, and
334 I would like to hear from our witnesses today if there ever
335 been any, any project where you gambled on making all these
336 short-term expenses in order to receive long-term savings.
337 From our research work, you can't find an example. It is one
338 of the dangers we have in Obamacare.

339 I yield back.

340 [The prepared statement of Mrs. Blackburn follows:]

341 ***** COMMITTEE INSERT *****

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342 Mr. {Pitts.} The chair thanks the gentlelady and now
343 recognizes the ranking member, Mr. Waxman.

344 Mr. {Waxman.} Thank you very much, Mr. Chairman.

345 I find this hearing to be sadly ironic. The Republican
346 members of the House have frequently complained about the
347 growth in spending in government health programs. We hear on
348 a daily basis about how Medicare and Medicaid are
349 jeopardizing the financial health of this country, and about
350 how it is time that we had an adult conversation about
351 spending. Yes, let's have an adult conversation. Adult
352 conversations start with facts.

353 These are the facts. When President Bush came to
354 office, he inherited a surplus projected to total \$5.6
355 trillion over 10 years. When President Obama came to office,
356 he inherited a deficit in 2009 of \$1.3 trillion for that one
357 year alone. The deficit widened, I would remind my
358 colleagues on the other side of the aisle, because we went
359 into the deepest recession since the Great Depression, which
360 meant fewer revenues and greater expenditures, widening the
361 deficit more.

362 President Bush did not think national debt was a high
363 priority. Instead, rather than pay it off, he passed a
364 series of reckless tax increases that enriched the wealthy at

365 the expense of everyone else. Those tax cuts, like the
366 Medicare prescription drug bill and two wars launched under
367 President Bush, were not paid for. They were charged
368 straight to the national credit card. And that is how you
369 take a \$5.6 trillion surplus and turn it into a massive
370 deficit.

371 Health care has played a role in this drama. In the
372 future, increasing numbers of baby boomers and stubborn
373 health care spending growth will put pressure on our budget,
374 without question. But the deficit crisis we find ourselves
375 in is a man-made crisis, in fact, it is a Republican-made
376 crisis.

377 CBO projects that growth in Medicare under the
378 Affordable Care Act, will be slowed to historically low rates
379 on a per capita basis, to just 2 percent per year over the
380 next 2 decades, compared to a 4 percent per capita
381 historically. Projected spending on Medicare would fall well
382 below even projected annual growth in GDP per capita, which
383 CBO pegs at 3.7 percent over the next 10 years. Medicaid,
384 too, has historically had slow growth on a per capita basis
385 relative to private health plans. Over the last decade,
386 Medicaid costs grew 4.6 percent per person per year, compared
387 to 7.7 percent for employer-sponsored premiums.

388 Now, the gentleman on the other side of the aisle said

389 he didn't know why we went into this reform of health care.
390 Well, things were not great. Fifty million people couldn't
391 get health insurance. Health care costs were increasing so
392 rapidly. We needed to do something. The Republicans
393 evidently said let things go as they are going and they were
394 going in the wrong direction.

395 The Affordable Care Act has been the largest deficit-
396 reducing bill passed by Congress in the last decade so it is
397 true to its name, affordable care. So our current deficit
398 crisis right now is not about health care.

399 In addition, the Affordable Care Act covers 32 million
400 Americans. Republicans never offered anything to do that.
401 The health care bill stops insurance practices that would
402 deny care to people who have to look to the private market.
403 It would protect them from being excluded because of previous
404 conditions and other arbitrary insurance practices, which
405 they had to do because they didn't have everybody else in the
406 pool.

407 Well, let us go back to our adult conversation.
408 Republicans keep telling us that we can't afford the reforms
409 to Medicare that the ACA proposed. Now they are telling us
410 that once we repeal the ACA, we need to pass much larger cuts
411 to Medicare and Medicaid in order to pay for tax cuts for the
412 very richest Americans. Majority Leader Eric Cantor said in

413 a speech just last week, talking about Social Security,
414 Medicare, and Medicaid: ``We are going to have to come to
415 grips with the fact that these programs cannot exist if we
416 want America to be what we want America to be.''

417 How dare he say these programs cannot exist. This is
418 not the America people want. The Affordable Care Act is
419 entitlement reform done responsibly. It is time we stopped
420 trying to repeal it and moved on to real work and real
421 legislation.

422 Mr. Chairman, I just think that we hear these
423 complaints, complaints, complaints from the other side of the
424 aisle. What do they have to offer? If what they have to
425 offer is to cut back on Medicare and Medicaid and Social
426 Security, they will create jobs because the elderly and the
427 poor are going to have to find work but they are not going to
428 find them, they are just going to have to do without the care
429 and we are going to have more uninsured.

430 I yield back my time.

431 [The prepared statement of Mr. Waxman follows:]

432 ***** COMMITTEE INSERT *****

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433 Mr. {Pitts.} The gentleman's time is expired. The
434 chair thanks the gentleman.

435 Mr. {Waxman.} Mr. Chairman, I was supposed to use less
436 time and yield it to Mr. Dingell. At some point can we give
437 him a minute? May I ask unanimous consent that Mr. Dingell
438 be given 1 minute?

439 Mr. {Pitts.} Is there any objection? Without
440 objection, the gentleman is recognized for 1 minute.

441 Mr. {Dingell.} Mr. Chairman, I thank my good friend. I
442 have an excellent statement. It denounces this hearing. It
443 denounces the purposes of my Republican colleagues. It
444 denounces the fiction that we are going to be hearing this
445 morning from the other side of the aisle. I would urge my
446 colleagues to read it. It will benefit everybody, and I am
447 sure you will enjoy reading this and I thank you, and I ask
448 unanimous consent to submit my remarks.

449 Mr. {Pitts.} Without objection, so ordered.

450 [The prepared statement of Mr. Dingell follows:]

451 ***** COMMITTEE INSERT *****

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452 Mr. {Pitts.} The chair thanks the gentleman.

453 We have two panels today. Each of the witnesses has
454 prepared an opening statement that will be placed in the
455 record. I will now introduce the first panel of two
456 witnesses.

457 Our first witness is Doug Elmendorf, who is the Director
458 of the Congressional Budget Office. Before he came to CBO,
459 Mr. Elmendorf was a senior fellow in the Economic Studies
460 Program at the Brookings Institution. Next, we will hear
461 from Rick Foster, who serves as the Chief Actuary at the
462 Office of the Actuary at the Centers for Medicare and
463 Medicaid Services.

464 Dr. Elmendorf, we ask you to please summarize. You are
465 recognized for 5 minutes for your opening statement at this
466 time.

|
467 ^STATEMENTS OF DOUGLAS ELMENDORF, DIRECTOR, CONGRESSIONAL
468 BUDGET OFFICE; AND RICHARD FOSTER, CHIEF ACTUARY, CENTERS FOR
469 MEDICARE AND MEDICAID SERVICES

|
470 ^STATEMENT OF DOUGLAS ELMENDORF

471 } Mr. {Elmendorf.} Thank you, Chairman Pitts, Congressman
472 Pallone and members of the subcommittee. I appreciate the
473 opportunity to testify today about CBO's analysis of the
474 Patient Protection and Affordable Care Act and last year's
475 Reconciliation Act. Together with our colleagues on the
476 staff of the Joint Committee on Taxation, we provided to the
477 Congress numerous analyses of this act and the legislation
478 leading up to it, and my written statement summarizes that
479 work.

480 In brief, we estimate that the legislation will increase
481 the number of non-elderly Americans with health insurance by
482 roughly 34 million in 2021. About 95 percent of legal non-
483 elderly residents will have insurance coverage in that year
484 compared with a projected share of 82 percent in the absence
485 of that legislation and about 83 percent today. The
486 legislation generates this increase through a combination of
487 a mandate for nearly all legal residents to obtain health

488 insurance, the creation of health insurance exchanges
489 operating under certain rules and through which certain
490 people will receive federal subsidies and the significant
491 expansion of Medicaid.

492 According to our latest estimate, the provisions of the
493 law related to health insurance coverage will have a net cost
494 to the Treasury from direct spending and revenues of \$1.1
495 trillion during the 2012-2021 decade. That amount is larger
496 than CBO's original estimate of the cost of those provisions
497 during the 2010-2019 decade that represented the 10-year
498 budget window when the legislation was originally estimated.
499 That increase is due almost entirely to the shift in the
500 budget window. As you can see in figure 2 in front of you,
501 the revisions in any single year are quite small.

502 In addition to the provisions related to insurance
503 coverage, PPACA and the Reconciliation Act also reduce the
504 growth of Medicare's payments for most services, impose
505 certain taxes on people with relatively high income and made
506 various other changes to the tax code, Medicare, Medicaid and
507 other programs. As you can see in figure 1, those provisions
508 will on balance reduce direct spending and increase revenues,
509 providing an offset to the cost of the coverage provisions.
510 According to our latest comprehensive estimate of the
511 legislation, the net effect of all the changes in direct

512 spending and revenues is a reduction in budget deficits of
513 \$210 billion over the 2012-2021 period.

514 Not surprisingly, observers have raised a number of
515 challenges to our estimates. Let me comment briefly on the
516 three most common areas of concern that I have heard. First,
517 some analysts have asserted that we have misestimated the
518 effects of the changes in law. Those concerns run in
519 different directions. Some analysts believe that the
520 subsidies will be more expensive than we project while others
521 maintain that the Medicare reforms will save more money than
522 we project. Certainly, projections of the effects of this
523 legislation are quite uncertain and no one understands that
524 better than the analysts at CBO and JCT. Our estimates
525 depend on myriad projections of economic and technical
526 factors as well as on assumptions about the behavioral
527 responses of families, businesses and other levels of
528 government. All of these projections and assumptions
529 represent our objective and impartial judgment based on our
530 detailed understanding of federal programs, careful reading
531 of the research literature and consultation with outside
532 experts. In addition, our estimates depend on a line-by-line
533 reading of the specific legislative language. Our goal is
534 always to develop estimates that are in the middle of the
535 distribution of possible outcomes, and we believe we have

536 achieved that goal in this case.

537 A second type of critique of our estimates is that
538 budget conventions hide or misrepresent certain effects of
539 the legislation. I will mention two of the prominent
540 examples that I have heard. As one example, the numbers I
541 have just cited involve changes in direct spending and
542 revenues because that is what is relevant for pay-as-you-go
543 procedures and because those changes will occur without any
544 additional legislative action. However, PPACA and the
545 Reconciliation Act will also affect discretionary spending
546 that is subject to future appropriations. We noted many
547 times that we expect the cost to the Department of Health and
548 Human Services and the Internal Revenue Service of
549 implementing the legislation will probably be about \$5
550 billion to \$10 billion each over the next decade. PPACA also
551 includes authorizations for future appropriations. Those
552 referring to specific amounts total about \$100 billion over
553 the decade with most of that funding applied to activities
554 that were being carried out under prior law such as programs
555 of the Indian Health Service.

556 Another example of concern about budget conventions
557 involves the Hospital Insurance trust fund, which covers
558 Medicare part A. The legislation will improve the cash flow
559 in that trust fund by hundreds of billions of dollars over

560 the next decade. Higher balances in the fund will give the
561 government legal authority to pay Medicare benefits for
562 longer than otherwise but most of the savings will pay for
563 new programs rather than reduce future budget deficits, and
564 therefore will not enhance the government's economic ability
565 to pay Medicare benefits in future years. We wrote about
566 those issues as the legislation was being considered in the
567 Congress.

568 A third type of critique is that PPACA and the
569 Reconciliation Act will be changed in the future in ways that
570 will make deficits worse. As with all of CBO's cost
571 estimates, the ones for this legislation reflect an
572 assumption that the legislation will be implemented in its
573 current form. We do not intend to predict the intent of
574 future Congresses that might choose to enact different
575 legislation. At the same time, we emphasize that the
576 budgetary impact of this legislation could be quite different
577 if key provisions were changed and we highlighted certain
578 provisions that we expect might be difficult to sustain for a
579 long period of time. Thank you.

580 [The prepared statement of Mr. Elmendorf follows:]

581 ***** INSERT 1 *****

|
582 Mr. {Pitts.} The chair thanks the gentleman and
583 recognizes Mr. Foster for 5 minutes for an opening statement.

|
584 ^STATEMENT OF RICHARD FOSTER

585 } Mr. {Foster.} Thank you. Chairman Pitts,
586 Representative Pallone, other distinguished subcommittee
587 members, thank you for inviting me here today to testify
588 about the financial impacts of the Affordable Care Act.

589 The Office of the Actuary at the Centers for Medicare
590 and Medicaid Services provides actuarial, economic and other
591 technical support and information to policymakers both in the
592 Administration and in Congress. We do so on an independent,
593 objective and nonpartisan basis, and we have performed this
594 role throughout the last 45 years since the enactment of
595 Medicare and Medicaid.

596 I am accompanied today by two folks, John Shatto, who is
597 a fellow of the Society of Actuaries, and he is the director
598 of our Medicare and Medicaid Cost Estimates Group sitting
599 right behind me, and by Laming Kai, who is a PhD in economics
600 and is one of our senior economists. Both are members our
601 health reform modeling team.

602 I am very pleased to have the opportunity to appear with
603 Doug Elmendorf. Now, I know you probably saw the press
604 reports of a cage match or a possible fight between us or
605 various humorous things like that but I am afraid the reality

606 is far less dramatic. Doug and I and our staffs, we are all
607 public servants and our goal is just to try to do the best
608 job we can to provide valuable technical information for you
609 all. That is all we are trying to do. I am not running for
610 President. I suspect you are not either. And if nominated,
611 I know what would happen with either one of us.

612 Now, Doug has already talked about the overall impacts
613 on expenditures and revenues under the Affordable Care Act so
614 I won't go over that same material. I will mention that we
615 have estimated the impact of the Affordable Care Act on total
616 national health expenditures from all sources, not just
617 federal expenditures, not just for Medicaid or Medicare but
618 everything, and that increase, Chairman Pitts, you quoted
619 earlier. We estimated a net increase overall of about \$311
620 billion through fiscal year 2019. There are substantial
621 increases, of course, associated with the coverage expansions
622 in the legislation through Medicaid and the exchange private
623 health insurance but there are partially offsetting
624 reductions in national health spending, principally because
625 of the lower Medicare expenditures. And there would also be
626 lower out-of-pocket costs for individuals because so many
627 more of them would have health insurance coverage and for
628 other reasons.

629 I want to say just a couple words about concerns that I

630 have had and have expressed with one important aspect of the
631 Affordable Care Act, and that has to do with the annual
632 payment updates under Medicare for most categories of
633 providers. Specifically, these annual payment updates are
634 based on the increase in a market basket of prices that
635 providers have to pay to pay for wages or rent or energy
636 costs or supplies, you name it. It is based on that increase
637 in prices, input prices, minus the overall economy-wide
638 increase in productivity, which is about 1.1 percent per
639 year. Now, this adjustment, which is permanent, this will
640 happen forever until you all decide maybe it should be
641 changed, but this adjustment will be a strong incentive for
642 providers to economize, to get rid of any inefficiency,
643 waste, et cetera, be as efficient as possible, but I believe
644 it is doubtful that many health providers can improve their
645 own productivity enough to match the level of economy-wide
646 productivity. Now, if they can't, then the consequences are
647 that Medicare provider payment rates for most providers would
648 grow about 1.1 percent per year less than their input prices
649 or their input costs, and unless they can improve their
650 productivity to match, eventually they would become unable or
651 unwilling to provide services to Medicare beneficiaries.
652 Now, long before that would happen, I think Congress would
653 step in and change the basis to prevent such access or

654 quality problems, but if that happens, that means the
655 Medicare savings we have estimated would be lower. Actual
656 Medicare costs would be higher than any of our estimates.

657 Let me finish by saying that I pledge the Office of the
658 Actuary's continuing assistance to you all and your
659 colleagues and to the Administration as you work to continue
660 to determine optimal solutions to the high cost of health
661 care in the United States.

662 Thank you, and I would be happy to answer any questions.

663 [The prepared statement of Mr. Foster follows:]

664 ***** INSERT 2 *****

|
665 Mr. {Pitts.} The chair thanks the gentleman. I thank
666 the panel for their opening statements and I will now begin
667 the questioning and recognize myself for 5 minutes for that
668 purpose.

669 Mr. Elmendorf, your testimony states that the health
670 care law will reduce employment by roughly 800,000 by 2012
671 because PPACA encourages some people to work fewer hours or
672 withdraw from the labor market altogether. You also
673 attribute some of the job reduction to higher marginal tax
674 rates included in PPACA. I would like to explore what other
675 factors were included and excluded when you calculated this
676 number. Does this 800,000 job reduction figure account for
677 employers who will reduce employment in order to avoid the
678 50-employee threshold that triggers PPACA's employer mandate?

679 Mr. {Elmendorf.} Mr. Chairman, we did not explicitly
680 model that provision. There are a number of factors that we
681 did incorporate in reaching this estimate. We didn't try to
682 quantify every single aspect of the law. We tried to
683 quantify the ones that we thought were most significant.

684 Mr. {Pitts.} Does the 800,000 figure account for
685 employers that choose to avoid creating jobs in order to
686 avoid the 50-employee threshold that triggers PPACA's
687 employer mandate?

688 Mr. {Elmendorf.} Again, Mr. Chairman, we did not
689 explicitly the model the effects of the 50-employee
690 threshold. We focused on maybe 10 other aspects of the
691 legislation that we thought would have more significant
692 effects on employment.

693 Mr. {Pitts.} Okay. Does the 800,000 figure account for
694 the new employer paperwork requirements in PPACA such as the
695 1099 filing provision and the variety of reporting
696 requirements to Department of Labor and Treasury and HHS
697 included in PPACA that will shift employer resources away
698 from investment towards regulatory compliance?

699 Mr. {Elmendorf.} Mr. Chairman, it is not obvious to me
700 why the 1099 forms would have a significant effect on
701 employment, and no, we did not incorporate any such effect in
702 this estimate.

703 Mr. {Pitts.} How about, does the 800,000 figure account
704 for the employer resources that will have to shift toward
705 providing more expensive health coverage as a result of the
706 new mandates and the essential benefits package included in
707 PPACA?

708 Mr. {Elmendorf.} Mr. Chairman, in our analysis of the
709 effects of changes in health insurance payments by employers,
710 we recognize that both logic and evidence suggest that
711 changes in particular aspects of compensation to employees

712 tend to be offset by changes in other aspects of their
713 compensation, so one can see in the aggregate data for the
714 United States a rise in health spending by employers over the
715 past several decades but also a slower rise in cash
716 compensation, and economists think those factors are related.
717 So we think that changes in to the extent that employers pay
718 more for health care and some would pay more under this
719 legislation, some would pay less under this legislation, we
720 have not tried to tote this up. In any case, we think there
721 would be offsetting changes in the cash compensation that
722 employers would provide.

723 Mr. {Pitts.} Mr. Foster, proponents of PPACA argue that
724 U.S. health spending of 16 percent of GDP is unsustainable
725 and claim that PPACA bends the cost curve. Does PPACA change
726 this dynamic for the better or the worse?

727 Mr. {Foster.} We have estimated this question for the
728 first 10 years. As I mentioned briefly, we estimate that the
729 legislation increases the overall amount of total health
730 spending in the United States by roughly one percentage
731 point. In terms of the growth rates and what happens in the
732 future, initially the growth rates are higher because we are
733 spending more but there are certain factors that would tend
734 to reduce the growth rates in the longer term. A good
735 example is the productivity adjustments for Medicare payment

736 updates. The real question is, how long can that work? They
737 will help slow Medicare spending growth but they may not be
738 viable indefinitely.

739 Mr. {Pitts.} Can you explain how a strict application
740 of modified gross adjustment could greatly expand Medicaid
741 eligibility under PPACA and increase the cost to both Federal
742 Government and States?

743 Mr. {Foster.} Yes, sir. In the legislation, to achieve
744 consistency between the definition of eligibility for
745 Medicaid and the definition of eligibility for exchange
746 subsidies, Congress decided to use modified adjusted gross
747 income as the basis for determining income. Now, prior to
748 this point for Medicaid, almost all States or perhaps all
749 have included Social Security benefits in their definition of
750 income for purposes of determining eligibility. With
751 modified adjusted gross income, in contrast, for most people,
752 only a small portion, if any, of their Social Security
753 benefits would be included in that definition of income. So
754 if you consider Social Security early retirees, under 65, who
755 are potentially eligible for the Medicaid expansion and you
756 then don't count \$10,000 or \$20,000 a year of Social Security
757 benefits in their income, many of them can potentially
758 qualify for Medicaid if you use that strict definition of
759 modified adjusted gross income.

760 Mr. {Pitts.} The chair thanks the gentleman and now
761 recognizes the ranking member, Mr. Pallone, for 5 minutes for
762 questioning.

763 Mr. {Pallone.} Thank you, Mr. Chairman. I wanted to
764 address my questions to Mr. Elmendorf.

765 Mr. Chairman, I am sure you could tell from my opening
766 statement that I am very frustrated because I feel that, you
767 know, you come here and you did the best and we were using
768 your numbers because we are supposed to in deciding the cost
769 of the legislation, and of course, if we didn't go by CBO or
770 if CBO said that things cost too much, then they would
771 criticize us, and then we finally came up with a bill that
772 actually resulted in some significant deficit savings and
773 they said well, you know, those numbers aren't actually good,
774 so the whole purpose of this hearing is essentially to
775 challenge you and say essentially that we don't agree with
776 what you are doing. But of course, if we hadn't followed it,
777 then we would be criticized because we didn't follow you.

778 So I just wanted to go through some of the things
779 because tomorrow I understand we are going to have a markup
780 on some bills that we had a hearing on just before the break,
781 and Representative Bachmann and members of this committee are
782 claiming that there is about \$105 billion in hidden spending
783 that was snuck into the bill without you or the American

784 people knowing about it, and the hearing was, of course, on
785 this hidden mandatory spending and that is what the markup
786 will be about tomorrow.

787 So let me just go through and find out whether any of
788 this really was hidden from you. First of all, we considered
789 a bill that would repeal funding for section 1311, the health
790 insurance exchange planning and establishment grants. Did
791 you know about that funding stream?

792 Mr. {Elmendorf.} Yes, Congressman.

793 Mr. {Pallone.} Okay. So it wasn't hidden. What about
794 section 4002, the prevention and public health fund? Did you
795 know about that?

796 Mr. {Elmendorf.} Yes, Congressman.

797 Mr. {Pallone.} So that wasn't hidden either. And about
798 what funding for school-based health centers? Did you know
799 about that?

800 Mr. {Elmendorf.} Yes, Congressman.

801 Mr. {Pallone.} So it seems that we couldn't slip much
802 past you, try as the Republicans think we might. It is also
803 true that, I guess it was Congressman Jerry Lewis,
804 Appropriations Committee, he said that there is about \$100
805 billion in new discretionary funding in the bill that, of
806 course, was hidden, that we were trying to hide. But I see
807 you mention in your testimony that \$85 billion of that is

808 what actually--well, actually it was just reauthorization of
809 preexisting programs like the Indian Health Service or the
810 Community Health Centers. I was the sponsor of the Indian
811 Health Care Improvement Act that was included in the bill.
812 So \$85 billion of this \$100 billion in discretionary was
813 actually just reauthorization of preexisting programs like
814 the Indian Health Service. Is that correct?

815 Mr. {Elmendorf.} Yes, that is right, Congressman.

816 Mr. {Pallone.} All right. I mean, reauthorization of
817 existing programs is of course a standard practice in this
818 committee, both under the Democrats and the Republicans.

819 Now, I want to go back over your deficit numbers. CBO
820 and JCT analyzed all of the revenue and spending changes in
821 the health reform law and estimated that it would reduce the
822 deficit by \$210 billion over 10 years and by about half of 1
823 percent of GDP or \$1.2 trillion in the following decade.
824 Recently in your routine updating of your baseline
825 projections, you made some changes to your projections of
826 spending in Medicare, Medicaid and health insurance
827 exchanges. Is that correct?

828 Mr. {Elmendorf.} Yes, that is right.

829 Mr. {Pallone.} Did you update your cost estimate for
830 the Affordable Care Act?

831 Mr. {Elmendorf.} No, we did not do a comprehensive re-

832 estimate of the effects of the act.

833 Mr. {Pallone.} Did you increase your cost estimate for
834 the Affordable Care Act by \$500 billion, which I think was
835 suggested in a press release by Chairman Upton?

836 Mr. {Elmendorf.} So again, Congressman, the last
837 comprehensive estimate we have done for the act was part of
838 our February estimate of the effects of repealing the act as
839 encompassed in H.R. 2.

840 Mr. {Pallone.} So you didn't increase your cost
841 estimate by \$500 billion?

842 Mr. {Elmendorf.} Again, at least in February, we have
843 made no new estimates of the comprehensive effects of the
844 legislation.

845 Mr. {Pallone.} Do you have any expectation that a new
846 cost estimate would continue to show that the Affordable Care
847 Act reduces the deficit?

848 Mr. {Elmendorf.} So I can't say anything too firmly,
849 having not done the estimate, but I will say that I think
850 given the magnitude of the deficit reduction that we
851 projected based on our February estimate of the effects of
852 repeal, I would be surprised if a new estimate that we did
853 today showed a different sign of the effect on the deficit,
854 although of course the precise number would be somewhat
855 differently presumably.

856 Mr. {Pallone.} Okay. I mean, I am not trying to be too
857 critical of Chairman Upton, I like him, but he put out this
858 press release last week. He said with that \$500 billion, and
859 I think it is somewhat misleading and I guess the Washington
860 Post said it was widely inflated and earned a three
861 Pinocchios rating from the Washington Post fact checker
862 column. Whatever. My only point is that nothing has really
863 changed here, and I think that the effort on the part of the
864 Republicans to basically discredit you is baseless.

865 Thank you, Mr. Chairman.

866 Mr. {Pitts.} The gentleman's time is expired. The
867 chair recognizes the vice chairman of the committee, the
868 gentleman from Texas, Dr. Burgess, for 5 minutes for
869 questioning.

870 Dr. {Burgess.} I thank the chairman for the
871 recognition.

872 Mr. Elmendorf, of course you did appear before this
873 committee in the run-up to the passage of H.R. 3200 but you
874 might not recognize it because when you were in that day, the
875 television cameras weren't on, the lights were off, no
876 recorder was at the end of the table, no one was in the
877 audience section. It was obviously an unofficial briefing
878 that you had with at the time what was I recall described as
879 a back-of-the-envelope calculation. We never had a formal

880 hearing on the Congressional Budget Office's opinion on the
881 passage of H.R. 3200 and we certainly, certainly never had
882 any sort of hearing on the budgetary effects of H.R. 3590
883 because at the time you were here testifying before us, H.R.
884 3590 was a bill that had been passed by the House of
885 Representatives that dealt with housing issues and not with
886 health care issues. Is that correct?

887 Mr. {Elmendorf.} Yes. I have testified to this
888 committee but it was early in 2009 before the legislative
889 action that you are describing, Congressman.

890 Dr. {Burgess.} Well, were you called in for a briefing,
891 as I recall, and again, there was no recorder, no testimony
892 was taken down. The lights were off, the cameras were off.
893 It was kind of a closed-door cloak-and-dagger type of hearing
894 or briefing as I recall.

895 Mr. {Elmendorf.} I am confident I did not come to a
896 cloak-and-dagger affair, Congressman. I don't remember the
897 precise circumstances but I think--

898 Dr. {Burgess.} I recall them vividly. That is why I am
899 reminding you of them. Well, let me just ask you a question
900 about the funding that is in the bill, and this is just for
901 me. You are required to interpret the cost of things under
902 existing law, so under existing law in the Patient Protection
903 and Affordable Care Act subtitle B, patient-centered outcomes

904 research, establishing comparative effective clinical
905 effectiveness research, in the section under funding of
906 comparative effective clinical effectiveness research for
907 fiscal year 2010 and each subsequent fiscal year, amounts in
908 the patient-centered outcomes research trust fund shall be
909 available without further appropriation to the institute to
910 carry out this section. How do you quantify that?

911 Mr. {Elmendorf.} I am sorry. I wasn't sure myself,
912 Congressman. I am told there were specified amounts
913 available--

914 Dr. {Burgess.} That is the problem. We aren't, either.
915 But go ahead.

916 Mr. {Elmendorf.} I am told in the legislation there are
917 specified amounts made available to the Patient-Centered
918 Outcomes Research Institute.

919 Dr. {Burgess.} Well, for fiscal year 2010 and each
920 subsequent fiscal year, and there is no limit put on that so
921 I have got to assume that is until the second coming, amounts
922 in the patient-centered outcomes research trust fund under
923 section 9511 of the Internal Revenue Code shall be available
924 without further appropriations to the institute to carry out
925 this section, without further appropriation. Now, Chairman
926 Pallone or Ranking Member Pallone talks about how we
927 reauthorized several provisions of existing law in the

928 Affordable Care Act. Fair enough. But this wasn't an
929 existing provision. This did not go through authorization
930 through this committee. It is never going to be reauthorized
931 by this committee. No oversight of this funding is going to
932 occur by this committee, and these funds, we don't even know
933 the top dollar figure, are appropriated it looks to me like
934 in perpetuity. Is that a fair reading of this statute?

935 Mr. {Elmendorf.} So I think it is important for me to
936 distinguish between mandatory funding and authorization for
937 future discretionary appropriations. The--

938 Dr. {Burgess.} And in fact, I don't know that I have
939 time to get into that.

940 Mr. {Elmendorf.} --our estimate including whatever--

941 Dr. {Burgess.} These provisions should be authorized.
942 We are an authorizing committee. Ranking Member Pallone
943 pointed that out. That is what we do. We authorize these
944 programs. We subsequently in future years reauthorize them
945 to ensure that they are working properly, at least if we are
946 performing up to standards the American people should be
947 holding us to, but in this instance, we don't get a chance.
948 So the anxiety that a lot of people have is there is funding
949 like this strewn throughout the language of 3590 and it is
950 going to be very, very difficult for future Members of
951 Congress to get a hold of these funding streams and

952 understand are they performing as they are supposed to. The
953 language makes it difficult, makes it difficult for you to
954 tell us really how much money we have obligated the taxpayer
955 to spend on this. Whether it is mandatory or discretionary,
956 they don't care. Honestly, they don't care. They want to
957 know how many dollars they are spending and whether those
958 dollars are being invested wisely, if they are getting an
959 appropriate return on investment. How do we advise them?
960 How do you advise them?

961 Mr. {Elmendorf.} All I can say, Congressman, is that
962 the mandatory funding is included in this page after page of
963 our cost estimate row by row, and if there are specific
964 questions about individual rows, then I hope that you and
965 your colleagues will come and ask us.

966 Dr. {Burgess.} I have a specific question about a
967 specific section of the law that was signed into law a year
968 and a week ago, and I would appreciate it if you--I see my
969 time is up, but if you could get back us to that estimate.

970 Mr. {Elmendorf.} We will do that, Congressman.

971 Mr. {Pitts.} The gentleman's time is expired. The
972 chair recognizes the ranking member of the committee, Mr.
973 Waxman, for 5 minute for questions.

974 Mr. {Waxman.} Mr. Chairman, last week, I mentioned in
975 my opening, Eric Cantor, the Majority Leader, gave a speech

976 at the Hoover Institute where he talked about Social
977 Security, Medicare and Medicaid, and he said, ``We are going
978 to have to come to grips with the fact that these programs
979 cannot exist if we want America to be what we want America to
980 be.'' Well, I can't come to grips with that statement
981 because it would be a back to the future, to a time when
982 seniors and people with disabilities lived in poverty without
983 financial and health security.

984 Dr. Elmendorf, what was the approximate cost of
985 extending the Bush tax cuts in the legislation that was
986 passed last December?

987 Mr. {Elmendorf.} I believe the legislation passed last
988 December had--I am not sure I know the answer to that
989 question.

990 Mr. {Waxman.} The tax cut bill.

991 Mr. {Elmendorf.} I am sorry. I mean--

992 Mr. {Waxman.} Well, I understand.

993 Mr. {Elmendorf.} I don't know it offhand.

994 Mr. {Waxman.} I understand it is around \$700 billion.

995 Mr. {Elmendorf.} That sounds in the right ballpark to
996 me, Congressman.

997 Mr. {Waxman.} And now focusing just on the upper income
998 tax cuts and the estate tax, I would like you, if you don't
999 have it off the top of your head, to give us an estimate of

1000 what it cost just to extend those for another 10 years.

1001 Mr. {Elmendorf.} I can provide that to you later,
1002 Congressman.

1003 Mr. {Waxman.} I believe that the OMB budget lists the
1004 cost of extending those tax cuts along with the interest
1005 costs as almost a trillion dollars, but I would like to
1006 submit it for the record. That is a huge number and that is
1007 just from the tax cuts for the wealthiest Americans alone.
1008 So you take a trillion dollars, and then we look at the
1009 Affordable Care Act. It has the opposite effect of actually
1010 reducing the deficit. Isn't that correct?

1011 Mr. {Elmendorf.} Yes, Congressman. By our estimates,
1012 it does.

1013 Mr. {Waxman.} They say that to govern is to choose, and
1014 we know what Republicans choose. They choose to cut
1015 Medicare, Medicaid and health insurance for middle-income
1016 American families to pay for tax cuts for the rich.

1017 Dr. Elmendorf, your re-estimate of the President's
1018 budget projects some relatively modest changes in projected
1019 spending for Medicare and Medicaid and health insurance
1020 exchange tax credits. According to your letter to Senator
1021 Inouye, in table 6 mandatory outlays on tax credits are
1022 projected to be about \$54 billion higher over the next 10
1023 years while spending on Medicare and Medicaid is projected to

1024 be about \$339 billion lower for a reduction in direct
1025 spending of \$277 billion from these health programs. Is that
1026 correct?

1027 Mr. {Elmendorf.} It sounds right to me, Congressman. I
1028 don't have the letter in front of me.

1029 Mr. {Waxman.} So projections for spending on health
1030 programs are down relative to your prior baseline. You also
1031 note in your testimony that spending growth in Medicare is
1032 projected to be very low on a per capita basis over the
1033 budget window. Is that correct? What is your estimated
1034 growth rate?

1035 Mr. {Elmendorf.} We did reduce slightly the growth rate
1036 of spending by the Federal Government for Medicare and for
1037 Medicaid over the 10-year budget window. I don't have the
1038 actual growth rates at hand. They are still of course
1039 substantial growth rates.

1040 Mr. {Waxman.} As I understand it, 2 percent per capita
1041 compared to 4 percent historically, but we would like to get
1042 you to submit that for the record.

1043 Mr. Foster, do you agree that cost growth in Medicare is
1044 very restrained in the next 10 years or so?

1045 Mr. {Foster.} Yes, sir, I do. As I have cautioned, it
1046 is not clear that all of the provisions will be viable
1047 indefinitely.

1048 Mr. {Waxman.} So we all agree that Medicare cost growth
1049 has been brought to be a very low level, so low that in CBO's
1050 baseline the triggers for the Independent Payment Advisory
1051 Board are not tripped anymore. Isn't that correct, Dr.
1052 Elmendorf?

1053 Mr. {Elmendorf.} That is right, Congressman.

1054 Mr. {Waxman.} Mr. Foster, considering these low growth
1055 rates in per capita spending, would you characterize the
1056 growing costs of Medicare over the next 10 years as primarily
1057 driven by increasing population or by increasing spending per
1058 person?

1059 Mr. {Foster.} There are still factors of each. I would
1060 consider them comparable order of magnitude. We have the
1061 baby boom generation moving into Medicare these days, of
1062 course, with the people turning 65, so the enrollment is
1063 growing about 3 percent per year, and the cost per person for
1064 Medicare is also growing in the rough vicinity of 3 percent
1065 per year, which is much lower than average or normal because
1066 of the Affordable Care Act provisions.

1067 Mr. {Waxman.} And the Medicare spending growth that we
1068 have seen recently has been primarily driven by increased
1069 enrollment due to the recession. Is that an accurate
1070 statement?

1071 Mr. {Foster.} In recent years, that is basically

1072 correct.

1073 Mr. {Waxman.} So in effect, Medicaid is fulfilling its
1074 essential safety-net function. Once the economy recovers,
1075 Medicaid costs will go down again because fewer people will
1076 need the help. Is that a correct statement?

1077 Mr. {Foster.} We would expect that, yes, sir.

1078 Mr. {Waxman.} Thank you.

1079 Thank you, Mr. Chairman.

1080 Mr. {Pitts.} The gentleman's time is expired. The
1081 chair recognizes the gentleman from Illinois, Mr. Shimkus,
1082 for 5 minutes for questioning.

1083 Mr. {Shimkus.} Thank you, Mr. Chairman. It is curious
1084 that the extension of the Bush tax cuts occurred under a
1085 Democrat-controlled House, a Democrat-controlled Senate, and
1086 signed by a Democrat President. That is just for the record.
1087 The extension of the Bush tax cuts was passed by a Democrat
1088 House, a Democrat Senate and signed by a Democrat President.
1089 I don't know how many years you guys you want to run against
1090 George Bush but it obviously gets a little old. You guys
1091 might find new targets.

1092 It is good to see you all here. I became ranking member
1093 of the Health Subcommittee after the passage of the law and I
1094 think we asked numerous times for you all to come in opening
1095 hearing to discuss the budgetary aspects, to be denied every

1096 time, and I would agree with my colleague, Mr. Burgess, that
1097 Mr. Elmendorf, you came but you didn't come with the press
1098 available, with people in the galleries with the TV cameras
1099 on, without any open, transparent system for us to talk to
1100 the American public about the cost of this bill. So we are
1101 glad to see you, and I know being bean counters, that puts
1102 you crossways with both sides as we try to drive our issue.

1103 But 2 or 3 weeks ago we had Secretary Sebelius here, and
1104 she admitted on tape in the transcript that the law really
1105 double counts Medicare savings. She admitted that, in fact,
1106 her final word was both the Medicare savings that is
1107 attributed to extending the solvency of the Medicare trust
1108 fund is also the same dollars that is used to pay for the
1109 health care law, which I would agree with her, and that has
1110 been part of the actuary think. We understand you have to
1111 score what we give you, obviously 6 years of benefits, 10
1112 years of taxes. You know, we know that you have to score
1113 what is given. But in some of the testimony, especially on--
1114 and this is directed to Mr. Foster. If you back out the
1115 Medicare cuts in the bill, what would be the total increase
1116 in national health expenditures?

1117 Mr. {Foster.} I am sorry. If you--

1118 Mr. {Shimkus.} If you back out the Medicare cuts. I
1119 don't know if we have ever cut Medicare in the history of

1120 this government.

1121 Mr. {Foster.} Yes. If you left out or don't consider
1122 for the moment the Medicare savings provisions, then the
1123 expansion of coverage for Medicaid--

1124 Mr. {Shimkus.} Well, you say Medicare savings, we say
1125 Medicare cuts. Same terminology, right?

1126 Mr. {Foster.} It is a reduction in expenditures.

1127 Mr. {Shimkus.} Right.

1128 Mr. {Foster.} Call them whatever you like.

1129 Mr. {Shimkus.} Okay. I will call them cuts, you can
1130 call them savings, but there are cuts to what we are all
1131 paying for Medicare right now.

1132 Mr. {Foster.} Anyway, back to your original question,
1133 the expansions of coverage through Medicaid and the federal
1134 subsidies for the exchange coverage would increase total
1135 national health expenditures by something in the range of 3-
1136 1/2 percent and then the savings that you get, or the cuts,
1137 if you prefer, from the Medicare provisions reduces--

1138 Mr. {Shimkus.} My issue is, we are triple counting. I
1139 mean, 2 weeks ago we got the Secretary to say we double
1140 counted. My issue now is that we are really triple counting
1141 because we are assuming we are going to cut \$500 billion from
1142 Medicare that we are not going to do. So if we are not going
1143 to do that, we attribute that savings to extending the

1144 solvency of the Medicare trust fund, which we are not going
1145 to do, and we are not going to have the \$500 billion to pay
1146 for the expansion of the health care law. So the Secretary
1147 was right when she said she double counted that but if we
1148 don't do the Medicare cuts, we are triple counting the same
1149 \$500 billion.

1150 Mr. {Elmendorf.} Congressman, to be clear, when we give
1151 you a cost estimate, it counts each and every provision of
1152 the law once and only once. It is certainly the case that if
1153 those Medicare cuts or savings do not ultimately come to
1154 pass, then the deficit reduction effect of PPACA plus
1155 whatever future legislation took back those cuts, that
1156 combination of law would not have the same effect in reducing
1157 budget deficits that we estimate PPACA to have by itself.

1158 Mr. {Shimkus.} And that is our concern. We appreciate
1159 you being here, and I yield back my time.

1160 Mr. {Elmendorf.} Mr. Chairman. I am sorry, Mr.
1161 Chairman.

1162 Mr. {Pitts.} The chair thanks the gentleman.

1163 Mr. {Elmendorf.} Mr. Chairman, I am sorry.

1164 Mr. {Pitts.} Who seeks recognition?

1165 Mr. {Elmendorf.} I realize it is my turn but I actually
1166 have a better answer to Congressman Burgess's question and I
1167 see that he is still here.

1168 Mr. {Pitts.} Go ahead.

1169 Mr. {Elmendorf.} Congressman, section 6301 of PPACA
1170 specifies amounts to be transferred to the Patient-Centered
1171 Outcome Research Institute trust fund, some from a tax on
1172 health insurance premiums and the amount that we estimate for
1173 that was estimated by our colleagues and staff on the Joint
1174 Committee on Taxation based on the specified tax rate in the
1175 law. It also specifies transfers from Medicare in amounts
1176 that I am told are specified in dollar terms, and then
1177 further amounts from the general fund that are specified.

1178 Dr. {Burgess.} And the total dollar figure then is?

1179 Mr. {Elmendorf.} And the total dollar figure, I don't
1180 have that offhand but it is in our table and we can provide
1181 that to you.

1182 Mr. {Pitts.} All right. The chair thanks the gentleman
1183 and now recognizes the gentlelady from California, Ms. Capps,
1184 for 5 minutes for questions.

1185 Mr. Gonzalez.

1186 Mr. {Gonzalez.} Thank you very much, Mr. Chairman, and
1187 to the witnesses, thank you for your service and thank you
1188 for joining us here today.

1189 Mr. Elmendorf, you are the Director of the Congressional
1190 Budget Office, correct?

1191 Mr. {Elmendorf.} Yes, Congressman.

1192 Mr. {Gonzalez.} So that means you work for Congress,
1193 you work for all of us, whether there is an R or a D
1194 following our names. Is that correct?

1195 Mr. {Elmendorf.} Yes, sir.

1196 Mr. {Gonzalez.} And I am sure during this debate you
1197 had meetings with Members of Congress that requested to meet
1198 with you and you responded to questions posed both by
1199 Democrats and Republicans?

1200 Mr. {Elmendorf.} Yes, we did.

1201 Mr. {Gonzalez.} You have an open-door policy, you are
1202 accessible, so it doesn't require a hearing with the lights
1203 on and the cameras and the reporter in order for a Member to
1204 become acquainted with specific budgetary facts that you may
1205 provide them as a result of any proposal. Is that correct?

1206 Mr. {Elmendorf.} Congressman, we are certainly
1207 available to explain our estimates and the logic that lies
1208 behind them to you or any of your colleagues at any time, but
1209 of course, I am not going to get in the middle of a question
1210 about when this committee or others should be holding
1211 hearings.

1212 Mr. {Gonzalez.} And I agree, but I venture to guess, we
1213 probably get more information from your office outside of the
1214 hearing process. That is the point I was trying to make.

1215 Now, I know my colleagues have indicated that we rushed

1216 to judgment, why did we do what we did, but nearly 2 years
1217 ago, Steve Pearlstein writing in the Washington Post in the
1218 middle of this said, ``Among the range of options for health
1219 care reform, there is one that is sure to raise your taxes,
1220 increase your out-of-pocket medical expenses, leave more
1221 Americans without insurance and guarantee that wages will
1222 remain stagnant. That is the option of doing nothing.'' We
1223 didn't think that was an option. We were in the majority.
1224 We made it a priority. And there was plenty of debate,
1225 plenty of information out there, and I know what the present
1226 Majority is attempting to do after the fact.

1227 Now, they also knew that if they just simply said repeal
1228 that the American people wanted a little more than that. So
1229 they said okay, repeal and replace. They haven't gotten to
1230 the replace part yet but I don't want to be unfair because I
1231 think there is a proposal out there and that is by
1232 Congressman Paul Ryan, my colleague, chairman of the House
1233 Budget Committee, and he has a thing called the roadmap.
1234 Now, I am not sure if the Republican leadership or the
1235 conference has adopted the roadmap. It may still be in the
1236 Republicans' glove box, I believe. They haven't pulled it
1237 out and actually started to follow it. But one of the
1238 proposals was to basically transform Medicare into a voucher
1239 program. My understanding that it is by its very design, and

1240 I believe, Mr. Elmendorf, you have some knowledge of Mr.
1241 Ryan's roadmap and his plans for Medicare. My question to
1242 you is, would the roadmap and turning Medicare into a voucher
1243 program place the burden on the individual and by its very
1244 design not keep up with the cost of what an insurance product
1245 would be made available to that recipient or beneficiary? Do
1246 you have an opinion on that roadmap and basically its
1247 consequences?

1248 Mr. {Elmendorf.} Congressman, as you know, we prepared
1249 an extensive analysis of the specifications in the roadmap
1250 proposal a little over a year ago. It is the case, and we
1251 said this again last fall in analyzing a related proposal
1252 that Chairman Ryan put to the fiscal commission which
1253 involved providing vouchers to participants in Medicare, and
1254 we noted that voucher recipients would probably have to
1255 purchase less extensive coverage or pay higher premiums than
1256 they would under current law for two reasons. First, because
1257 the savings to Medicare come from increasing the amount of
1258 those vouchers at a slower pace than we estimate Medicare
1259 spending would grow by under current law, and secondly,
1260 because future beneficiaries would have to go into the
1261 private market to buy insurance and they are likely to pay
1262 more in the private market for the same package of benefits
1263 than it costs to provide that through Medicare today.

1264 Mr. {Gonzalez.} Thank you.

1265 Mr. Foster, are you familiar with the subject matter
1266 that I just posed the question to Mr. Elmendorf and do you
1267 have an opinion as to what would be the consequences of such
1268 a transformation, major transformation in changing of
1269 Medicare into a voucher program?

1270 Mr. {Foster.} The basic idea behind the voucher program
1271 includes all that you have said, and there is the hope that
1272 by allocating less money over time for Medicare and Medicaid
1273 that this would have an impact on the development of research
1274 for new medical technology. A lot of the technology we get
1275 is very expensive, as you know. Some of it has wonderful
1276 effects, very dramatic, useful, and some of it is not so
1277 useful. If there was a way to turn the research and
1278 development community focus into developing cost saving
1279 technology rather than cost increasing, that could help slow
1280 the cost growth and then the voucher payment increases might
1281 be enough. Now, there is an ``if'' in there and it is a big
1282 ``if.'' It does pose risks of the type that you mentioned,
1283 that the voucher payments could become inadequate.

1284 Mr. {Gonzalez.} Thank you very much. Thank you, Mr.
1285 Chairman.

1286 Mr. {Pitts.} The gentleman's time is expired. The
1287 chair recognizes the gentleman from Michigan, Mr. Rogers, for

1288 5 minutes for questions.

1289 Mr. {Rogers.} Thank you, Mr. Chairman. I do find it
1290 interesting that my colleagues are seeking to talk about
1291 everything other than the bill that has been passed into law,
1292 and I find it interesting today for the first time we have
1293 had an opportunity to talk about some of the flaws,
1294 especially in their claim that this is a budget reducer when
1295 they have used a 10-year window, 6 years of services, 10
1296 years of taxes, disingenuous at best to the American people
1297 but we have established today that in fact cuts half a
1298 trillion dollars from Medicare. Oops, they didn't want to
1299 tell you about that, did they? And what is the impact today
1300 to the real person out there who is trying to keep their job
1301 or find a job is that health care premiums have gone up and
1302 people are losing their coverage today because of this bill.
1303 I wouldn't want to talk about this bill either if I were you.
1304 As a matter of fact, the Administration now has had to give--
1305 they haven't updated it. It is 1,040 waivers that impacts
1306 about 3 million Americans and said you don't have to follow
1307 the law because it will either, A, increase your premiums, or
1308 B, you will lose the health care that you want to keep. So
1309 they had to say, guess what, you 3 million Americans, the
1310 rest of America, you are stuck with this thing, you 3 million
1311 Americans, don't worry about it, don't follow the law. You

1312 are right. I wouldn't want to talk about what this bill is
1313 doing to real working Americans today either. Pretty
1314 frustrating. I hope we will get more changes to talk about
1315 the details of this bill. I do have a couple of quick
1316 questions, if I can.

1317 Mr. Foster, when you did the calculation, you calculated
1318 that 20 percent of small business employers would no longer
1319 offer health insurance, so by the way, that is one out of
1320 five small businesses will no longer offer health insurance
1321 to their employees, something else I wouldn't want to talk
1322 about. But I am curious about how you got there. The
1323 average cost in a State like Michigan, about \$15,000 per
1324 employee, and the penalty for not offering insurance under
1325 Obamacare is \$2,000 per employee, and I don't know you have
1326 been around many small businesses outside of the Beltway here
1327 but they are absolutely under assault from cost increases,
1328 fuel cost increases, mandates that are increasing the cost of
1329 their products. Pretty difficulty decisions have to be made,
1330 which is one of the reasons a place like my State is still
1331 suffering one of the highest unemployment percentages in the
1332 country. So if you are a small business owner and you are
1333 facing \$15,000 per employee to try to do the right thing or
1334 \$2,000 that you just send off to the Federal Government, get
1335 to throw them off your plan, you have got to help me

1336 understand how you get to only 20 percent of small employers
1337 are going to throw their folks off their health insurance
1338 that they enjoy today. Can you help me understand that?

1339 Mr. {Foster.} Sure. I will give it a try. As part of
1340 this, you have to estimate the behavioral response of
1341 providers, individuals, businesses, any number of groups, and
1342 employers are one of the most important groups. Now, for
1343 some employers, of course, if you are a small enough
1344 business, then you are not affected and you get some
1345 subsidies to help out, but for businesses that tend to have
1346 relatively low-income workers, it can turn out to be sort of
1347 a win-win for them to drop their formal health insurance
1348 coverage and assist their employees in getting coverage
1349 through the exchange.

1350 Mr. {Rogers.} So I understand it, you think it is
1351 beneficial for them to drop their coverage and send people to
1352 the federal exchange. Did I understand that correctly?

1353 Mr. {Foster.} For certain categories, primarily
1354 businesses with relatively low-income workers.

1355 Mr. {Rogers.} That is interesting. I am going to add
1356 that to my list today, that the bill encourages small
1357 businesses to drop their coverage and send people on the
1358 federal exchange. Brilliant, absolutely brilliant.

1359 Here is the other problem with your 20 percent. Maybe

1360 you can help me out. And there is going to be a great second
1361 panel here. One of the restaurant owners did the
1362 calculation. He only has 33 full-time employees and roughly
1363 26 full-time equivalents working part-time hours totaling 59
1364 full-time employees, and then he has seasonal and full-time
1365 employees for certain parts of the year and not parts of the
1366 year. The restaurant business is a pretty tough business, as
1367 you know. Margins are very small. Sometimes the business is
1368 up, sometimes it is down. In a State like Michigan, it tends
1369 to be more seasonal, given the tourist season. If he follows
1370 the law as it is, right, and under your equation he would be
1371 one of those that would want to do that, but it is a 282
1372 percent cost increase and it is done because of the way you
1373 calculate part-time employees as a full-time employee. So he
1374 is one of those folks who is going to get caught right in the
1375 middle of this thing that should be getting the subsidies but
1376 because the way you calculate or the law calculates, I don't
1377 know if you have made that calculation in that 20 percent
1378 number. Did you?

1379 Mr. {Foster.} The 20 percent is an assumption. We
1380 won't know until down the road when we see what happens.

1381 Mr. {Rogers.} And it is an assumption, as you said
1382 today, Mr. Chairman, based on behavior, and if you have been
1383 in a small business with these kind of cost increases, you

1384 are going to throw people off your insurance. That is why we
1385 all ought to be angry about what this bill is doing to the
1386 working men and women of the United States.

1387 Mr. {Pitts.} The gentleman's time is expired. The
1388 chair now recognizes the ranking chairman emeritus, the
1389 member from Michigan, Mr. Dingell, for 5 minutes for
1390 questions.

1391 Mr. {Dingell.} Mr. Chairman, I thank you for your
1392 courtesy.

1393 Mr. Foster, these questions will be yes or no. Medicare
1394 growth per beneficiary is projected to be extremely low over
1395 the next 10 to 20 years. CBO's baseline has an average per
1396 capita growth of 2 percent over the next two decades compared
1397 with a historical growth of about 4 percent. Is that
1398 correct?

1399 Mr. {Foster.} Yes, sir.

1400 Mr. {Dingell.} Mr. Foster, in fact, the growth is so
1401 low that it doesn't even surpass projected GDP growth per
1402 capita over the next 10 years, which is projected to be 3.7
1403 percent in CBO's baseline. That is 2 percent versus 3.7
1404 percent. Is that a fact?

1405 Mr. {Foster.} In some years, not all years, yes, sir.

1406 Mr. {Dingell.} Thank you. The IPAB target, I would
1407 remind everybody, calls for Medicare spending target of GDP

1408 plus one starting after 2019 and an even higher target for
1409 2015 to 2019 period. The Affordable Care Act seems to have
1410 brought projected Medicare spending down. Is that correct?
1411 Yes or no.

1412 Mr. {Foster.} Yes.

1413 Mr. {Dingell.} Now, it seems that Medicare spending is
1414 projected to grow so slowly over the next 10 years it would
1415 be difficult to reduce that spending without cutting benefits
1416 or kicking people out of the program. Is that true?

1417 Mr. {Foster.} I would have to think about that one,
1418 sir.

1419 Mr. {Dingell.} Now, do you believe that it would be
1420 possible to pay for the entire cost of fixing SGR, which
1421 would be about \$300 million out of savings in Medicare? Yes
1422 or no.

1423 Mr. {Foster.} That would be tough. I would have to
1424 call that one more like a no.

1425 Mr. {Dingell.} All right. But we could make some
1426 progress in that direction, could we not?

1427 Mr. {Foster.} The Affordable Care Act has some pretty
1428 steep savings provisions in it. It cuts a lot of money out
1429 of the program. Does it cut all of it? Is there something
1430 left? Of course. But you couldn't lower the payment rates
1431 much more than they are already lowered.

1432 Mr. {Dingell.} Now, what about proposals that would
1433 reduce Medicare spending even further like the Ryan-Ribble
1434 proposal to voucherize Medicare. CBO says that the proposal
1435 would reduce Medicare and Medicaid spending by 20 percent
1436 relative to the post-Affordable Care Act baseline. Would you
1437 have concerns about the magnitude of that cut? Yes or no.

1438 Mr. {Foster.} I don't have a good answer for you, sir.
1439 I could study it for you, but we have not looked at it
1440 recently.

1441 Mr. {Dingell.} Now, there was a statement that was made
1442 publicly which went like this: we are concerned by recent
1443 press reports that HHS may have had prior access to
1444 information that Mr. Foster used in his April report prior to
1445 Congressional consideration but did not share the information
1446 with the public or the Congress. Mr. Burgess filed a
1447 Resolution of Inquiry demanding documentation of the
1448 communications between the Secretary's office and the
1449 Actuary's office in pursuit of these claims. At that time
1450 the committee did not approve Mr. Burgess's resolution
1451 because we observed that there was no fire to all this smoke.
1452 Mr. Foster, you yourself disavowed these claims in a letter
1453 to Mr. Burgess. Is that true?

1454 Mr. {Foster.} I disavowed them. I don't remember that
1455 the letter was addressed exactly to you. I think it was

1456 addressed to the Administrator.

1457 Mr. {Dingell.} So--

1458 Mr. {Foster.} But there is no truth to that.

1459 Mr. {Dingell.} Now, this question then. Did Secretary
1460 Sebelius or any Executive Branch official attempt to
1461 interfere with your work on the Affordable Care Act or to ask
1462 you to delay or change the release of your estimates? Yes or
1463 no.

1464 Mr. {Foster.} No, sir.

1465 Mr. {Dingell.} Now, I would note that a little more
1466 recently during the debate over the Medicare Prescription
1467 Drug Improvement and Modernization Act of 2003, MMA, Bush
1468 Administration officials repeatedly stressed that the
1469 legislation would cost \$400 billion. However, the
1470 Administration had in its possession estimates from you, Mr.
1471 Foster, suggesting the cost would be in total somewhere
1472 between \$500 and \$600 billion. Is that correct?

1473 Mr. {Foster.} That is correct.

1474 Mr. {Dingell.} Now, Mr. Foster, you testified before
1475 the Ways and Means Committee that you were instructed by the
1476 Bush Administration to withhold information from the public.
1477 Is that true?

1478 Mr. {Foster.} I was ordered to give the information to
1479 the Administrator of the agency and he would then pass it on

1480 as he saw fit to the requester.

1481 Mr. {Dingell.} So you were not to convey to the public
1482 then the information, you were to have it carefully filtered
1483 through the Administrator. Is that right?

1484 Mr. {Foster.} Information requested by Congress,
1485 certain information. That is correct.

1486 Mr. {Dingell.} Very good. Thank you, Mr. Chairman. I
1487 appreciate your courtesy.

1488 Dr. {Burgess.} [Presiding] The chair recognizes the
1489 gentlelady from North Carolina, the vice chair of the full
1490 committee, Ms. Myrick.

1491 Mrs. {Myrick.} Thank you, and thank you all for being
1492 here. It is interesting, as has been commented on before,
1493 that we really aren't talking about the bill today and the
1494 specifics of the bill.

1495 But I wanted to ask Mr. Foster, can you explain how the
1496 Medicare payment policies featured in PPACA put providers out
1497 of business? We have talked about that many times but
1498 nothing has been discussed here today about providers and
1499 Medicare payments.

1500 Mr. {Foster.} The concern that I and others have is,
1501 imagine a provider whether it is a hospital or a home health
1502 agency or a lab or whatever, and in order to provide the
1503 services, they have to pay for certain inputs. They have to

1504 pay salaries for their staffs and themselves. They have to
1505 pay for energy costs and for rent or whatever arrangement
1506 they have, mortgages for their property. They have to buy
1507 supplies. So they have these input costs.

1508 Mrs. {Myrick.} Right.

1509 Mr. {Foster.} Now, these input costs go up over time by
1510 wages or by general prices, and in the past Medicare payment
1511 updates for these providers have been based on the average
1512 price increase in this market basket of inputs. Under the
1513 Affordable Care Act, this update will be reduced by about 1.1
1514 percent per year. Now, if you have to pay your own staff
1515 some amount and you pay them 1 percent per year less than
1516 what somebody else is paying everybody year to year, then
1517 your staff is going to become somebody else's staff.

1518 Mrs. {Myrick.} Right.

1519 Mr. {Foster.} Now, a provider perhaps can become more
1520 efficient but if they can't become efficient enough, then our
1521 reimbursement increases will not keep pace with their growth
1522 and cost, and then they have a choice. If it gets to the
1523 point they just can't afford to do this, they will have to
1524 stop. They might keep trying with lower quality, which is
1525 not good. They might keep trying and go out of business.
1526 More likely, you all would have to step in and say we are
1527 having problems with beneficiaries finding access to

1528 services, and you would have to ease those adjustments.

1529 Mrs. {Myrick.} It is already happening in our area
1530 because there is a large number of doctors and a growing
1531 number of doctors who right now today are refusing to take
1532 Medicare patients, and they just won't do it because they say
1533 they are in the hole. They start out in the hole and it is
1534 getting worse. And so, I mean, that is something that for
1535 the future is very frightening from the standpoint of who is
1536 going to provide the care.

1537 Mr. {Foster.} We have seen with physicians and Medicaid
1538 that there are some difficulties with Medicaid enrollees
1539 having access to physicians, especially specialists, and
1540 under current law, we expect that Medicare prices for
1541 physicians because of the sustainable growth rate formula
1542 would very quickly become less than Medicaid prices where
1543 there is already an access problem.

1544 Mrs. {Myrick.} I have another question. The health
1545 reform law imposes a 2.3 percent excise tax on categories of
1546 medical devices including devices like pacemakers, which are
1547 very common. Do you anticipate that these fees and the
1548 excise tax would generally be passed through to health
1549 consumers in the form of higher prices and higher insurance
1550 premiums?

1551 Mr. {Foster.} Yes, higher prices in the form of for the

1552 devices or the insurance plans. We think they would be
1553 passed through, yes.

1554 Mrs. {Myrick.} Which again is not going to help the
1555 consumer. I mean, this bill is supposed to help the consumer
1556 and then we end up doing things within the bill that are
1557 going to make it more difficult for the consumer, cost them
1558 more money in the long run, and I think that is one of the
1559 things all of us share is the actual cost of what this is
1560 going to be in the future, which we really don't know.

1561 I yield back, Mr. Chairman.

1562 Dr. {Burgess.} Will the gentlelady yield to me for a
1563 further question on physician reimbursement?

1564 Mrs. {Myrick.} Yes.

1565 Dr. {Burgess.} Mr. Elmendorf, if I could just stay on
1566 the subject of physician reimbursement, in the Medicaid
1567 arena, States are under some budget shortfall constraints.
1568 One of the low-pressure circuits where this gets pushed out
1569 is physician reimbursement, one of the only areas that that
1570 they can control. Now, the Supreme Court recently agreed to
1571 hear arguments in the Independent Living Center of Southern
1572 California versus Maxwell Jolly. If the Court rules against
1573 the States and says the States arbitrarily set reimbursement
1574 rates too low so that people didn't have access to a
1575 provider, the States and the Federal Government could be on

1576 the book for those increases in provider rates. Have you
1577 looked at the budgetary impact of a Court decision if the
1578 Court rules against the States?

1579 Mr. {Elmendorf.} No, Congressman, we have not studied
1580 that, to my knowledge.

1581 Dr. {Burgess.} But it has been a topic of concern
1582 amongst providers for years, and to our knowledge, I mean,
1583 you just have to wonder, was this considered during the
1584 health care debates as they happened? Did the Congressional
1585 Budget Office ever estimate the potential budgetary impacts
1586 of allowing the Centers for Medicare and Medicaid Services to
1587 set provider rates, and if so, what was the budgetary impact
1588 of such a standard?

1589 Mr. {Elmendorf.} So Congressman, I think the only piece
1590 of the legislation that directly affects provider rates in
1591 Medicaid was an increase in payments to certain sorts of
1592 primary care physicians.

1593 Dr. {Burgess.} But did you ever consider--

1594 Mr. {Elmendorf.} Those costs are included in our
1595 estimate of the costs of the legislation.

1596 Dr. {Burgess.} Did you ever consider the cost of
1597 allowing CMS to set those rates?

1598 Mr. {Elmendorf.} In Medicaid, no, Congressman, I don't
1599 think that we did.

1600 Dr. {Burgess.} I will yield back myself. I yield to
1601 Ms. Capps for 5 minutes, recognized for questions.

1602 Mrs. {Capps.} Thank you, Mr. Chairman, and thank you
1603 both for testifying today.

1604 All the talk of repeal, defund, dismantle, it is easy
1605 enough to do here in a hearing room hundreds of miles from
1606 home, but this past week I heard again from constituent after
1607 constituent who has gained new protections, new piece of
1608 mind, new hope from the Affordable Care Act, and they don't
1609 want their benefits taken away. They don't want to wait
1610 again while their kids are sick and uninsured or while they
1611 need to choose between paying for their medicine or their
1612 electric bill, but it isn't all about the benefits to
1613 families and small businesses. It is also about taking steps
1614 to address the overall cost of health care in this country.

1615 Mr. Elmendorf, you stated in your testimony that CBO's
1616 most recent comprehensive estimate of the repeal of the
1617 Affordable Care Act would increase the deficit by \$210
1618 billion over the 2012-2021 period. Is that correct?

1619 Mr. {Elmendorf.} Yes, Congresswoman.

1620 Mrs. {Capps.} Thank you. And Mr. Elmendorf, your
1621 written testimony also states that the Affordable Care Act
1622 will cover 32 million of the uninsured by 2016. Is that
1623 correct?

1624 Mr. {Elmendorf.} Yes, Congresswoman.

1625 Mrs. {Capps.} Thank you. Despite claims to the
1626 contrary, it is not tricky math. If we make smart
1627 investments, we can cover more people while reducing the
1628 deficit overall, but all of this goes away with repeal, and
1629 what is the replacement bill Republican leadership supports?
1630 Mr. Chairman, I would point my colleagues to an article
1631 published this week by the Bloomberg Business Week and it is
1632 entitled ``The Republican Response to Obamacare.'' This
1633 article is clear despite the claims I hear from detractors of
1634 the law, according to a new Bloomberg analysis, GOP
1635 alternatives would save less than \$5 billion a year, perhaps
1636 six-tenths of a percent of what health care costs in 2009,
1637 and this is compared to the \$210 billion saved by the ACA
1638 over the next decade. Furthermore, the Republican
1639 alternative to the health reform bill would actually increase
1640 the number of uninsured people from 50 million in 2010 to 52
1641 million in 2019, according to CBO's estimation. And when
1642 looking at any of the represented Republican alternatives,
1643 not a single person would have guaranteed access to health
1644 coverage at an affordable price. So when we talk about
1645 saving money, let us be clear: the Affordable Care Act is
1646 the largest deficit-reducing bill enacted by Congress in the
1647 last decade and there have been no alternatives from the

1648 Republican leadership to even come close to helping so many
1649 while saving so much.

1650 Another area, and this is for you, Mr. Foster. Another
1651 area where I think we should set the record straight is on
1652 how the Affordable Care Act strengthens the health care
1653 workforce and creates jobs. Critics have said that there
1654 will be a shortage of medical provisionals, particularly
1655 primary care doctors and providers in rural parts of the
1656 country, and they use this claim to advocate repeal, trying
1657 to pit those who already have insurance against those who
1658 will gain it through the law. But they ignore the fact that
1659 the Affordable Care Act has taken numerous steps to address
1660 these shortages. For example, it strengthens and expands the
1661 National Health Service Corps and community health centers
1662 providing primary care to communities most in need across our
1663 Nation. It creates a new program to train primary care
1664 physicians in the community called the teaching health
1665 centers, which will provide new doctors and give them the
1666 expertise they need to work in a community setting and give
1667 communities access to needed care. Americans will have
1668 better access to preventive and primary care. In short, we
1669 are training more providers, paying them more and providing
1670 more access points for primary care. Now, the Administration
1671 estimates that these policies will combine to create 16,000

1672 new providers in the workforce over the next 5 years, and
1673 proposals in the President's 2012 budget will add yet another
1674 4,000 providers to that number.

1675 Mr. Foster, I want to ask you, I have about a minute
1676 left, do you agree that funding for the policies I mentioned
1677 from the Affordable Care Act could help expand the number of
1678 providers in the primary care field?

1679 Mr. {Foster.} Oh, I think it will.

1680 Mrs. {Capps.} I think that is very critical to
1681 understand. I wanted to have this on the record. I am
1682 concerned that some of the assumptions in your estimates are
1683 based on what you call a relatively fixed workforce supply,
1684 but the Affordable Care Act and other provisions are trying
1685 to change that. I also think it is worth pointing out that
1686 tomorrow we will mark up a bill to eliminate one of these
1687 workforce programs. Yes, actually, cutting workforce and
1688 jobs programs in the economy. So at a very time when it is
1689 being demonstrated that we can actually create more jobs and
1690 actually save more money, we are doing the reverse. We are
1691 trying to eliminate programs that will work to this effect.

1692 And with that being said, I yield back the balance of my
1693 time.

1694 Mr. {Pitts.} The gentlelady's time is expired. The
1695 chair recognizes the gentleman from Pennsylvania, Dr. Murphy,

1696 for 5 minutes for questions.

1697 Mr. {Murphy.} Thank you. I appreciate the opportunity
1698 to finally have a chance to talk to both of you now that the
1699 bill is passed and it is the law.

1700 A few questions here. How much money did this bill
1701 borrow from Social Security?

1702 Mr. {Foster.} None that I can think of.

1703 Mr. {Elmendorf.} I am not sure what you mean by borrow
1704 from Social Security.

1705 Mr. {Murphy.} Well, some of the money I understand came
1706 from Social Security for this bill. Is that true?

1707 Mr. {Elmendorf.} Well, the bill does have some effects
1708 on the flow of money into the Social Security trust fund.

1709 Mr. {Murphy.} How much is that?

1710 Mr. {Elmendorf.} I believe there is a net increase in
1711 the flow of money to the Social Security trust fund.

1712 Mr. {Murphy.} More goes into Social Security with this
1713 bill or--

1714 Mr. {Elmendorf.} It goes into Social Security by our
1715 estimate because there is a shift in the distribution of
1716 compensation from non-taxable--

1717 Mr. {Murphy.} How much?

1718 Mr. {Elmendorf.} --health insurance--

1719 Mr. {Murphy.} How much? How much?

1720 Mr. {Elmendorf.} I think it is perhaps around \$10
1721 billion over 10 years.

1722 Mr. {Murphy.} But more goes into Social Security or
1723 more comes out of Social Security?

1724 Mr. {Elmendorf.} So more money goes into the Social
1725 Security trust fund. There may be ways in which somewhat
1726 more--

1727 Mr. {Murphy.} Okay. I need to move on. And how much
1728 money is coming out of Medicare to go into helping to pay for
1729 the health care bill?

1730 Mr. {Elmendorf.} I am not sure what you mean by coming
1731 out of Medicare. There are savings because of the cutbacks
1732 in payments to Medicare providers and because of the extra
1733 tax revenue going into the Hospital Insurance trust fund, the
1734 HI trust fund that deals with Part A of Medicare ends up with
1735 stronger cash flow over this next period than it would
1736 otherwise.

1737 Mr. {Murphy.} The cuts to what?

1738 Mr. {Elmendorf.} Cuts to payments to Medicare providers
1739 and other changes in the Medicare program.

1740 Mr. {Murphy.} Wait, wait. So by paying less to
1741 providers, meaning hospitals and doctors, we already have a
1742 long-term of doctors who are not accepting Medicare and
1743 Medicaid, and unfortunately, the only solution here that

1744 Congress sees is well, let us just pay them less, instead of
1745 reform, let us pay them less. And yet, Mr. Foster, you said
1746 a couple minutes ago that you thought this would bring more
1747 providers but we are going to pay them less. This doesn't
1748 make sense to me. How are you going to pay people less that
1749 they don't even want to cover it now and we are going to
1750 somehow entice them into doing this? If I gave you a 25
1751 percent cut in your salary, will you say hey, sign me up?

1752 Mr. {Elmendorf.} To be clear, Congressman, the cuts in
1753 payments to physicians in Medicare under the sustainable
1754 growth rate mechanism of prior law--

1755 Mr. {Murphy.} All right. Let me move on. We did have,
1756 however, Secretary Sebelius here in front of this committee
1757 saying it was double accounting to have money come from
1758 Medicare and also saying it was going into paying for this
1759 health care bill. Was she lying to us?

1760 Mr. {Elmendorf.} Congressman, I am not aware of exactly
1761 what the Secretary--

1762 Mr. {Murphy.} All right. Also, we had another
1763 secretary talk about the CLASS Act, and she said to me that
1764 it did appear from the estimates from CBO that because the
1765 money was accounted for to provide this long-term insurance
1766 fund but also it was said if we didn't do this there would be
1767 a \$86 billion loss to the health care fund, that that was

1768 double booking instead. Was she not telling us the truth?

1769 Mr. {Elmendorf.} I don't know what the Secretary said
1770 to you. I can talk about our analysis of the CLASS.

1771 Mr. {Murphy.} Mr. Foster, are you aware of that?

1772 Mr. {Foster.} Well, I think I would bet you a Coke that
1773 she did not say there is double counting. I would be happy
1774 to explain.

1775 Mr. {Murphy.} That would be great. Could you get back
1776 to me on that because I would like that.

1777 Mr. {Foster.} Sure.

1778 Mr. {Murphy.} Now, there is also increased tax on
1779 medical devices, and you said this would be passed on to
1780 consumers. Do we know how much this is going to cost
1781 families and how much it is going to increase insurance
1782 costs? Do you have a number on that?

1783 Mr. {Foster.} No, I don't.

1784 Mr. {Murphy.} Could you get back to us with that?

1785 Mr. {Foster.} Sure.

1786 Mr. {Elmendorf.} So Congressman, I can say in our
1787 analysis of premiums--

1788 Mr. {Murphy.} I just need a number. And do we have a
1789 number?

1790 Mr. {Elmendorf.} I don't have a number for that piece
1791 offhand.

1792 Mr. {Murphy.} Thank you. School-based health centers,
1793 what is that going to cost? Does someone know?

1794 Mr. {Elmendorf.} I am sorry.

1795 Mr. {Murphy.} Would you be willing to get us that
1796 information?

1797 Mr. {Elmendorf.} Yes, of course, Congressman.

1798 Mr. {Murphy.} Thank you.

1799 Mr. {Elmendorf.} Well, it is all public. I just--

1800 Mr. {Murphy.} The number of people who will lose their
1801 private insurance, I think originally the bill thought 9
1802 million. We are seeing some estimates of some accounting
1803 firms saying that number may be 50 or 60 or 80 million. Do
1804 we have a readjusted number of how many you think will lose
1805 their private plan, given that 1,000 people have also asked
1806 for waivers? Do we have another update on how many people
1807 will lose their private plan?

1808 Mr. {Elmendorf.} So Congressman, as part of our March
1809 baseline projections and what it is included in my written
1810 testimony, we have slightly different estimates on the
1811 effects on private insurance coverage. We do not expect
1812 anything like the sort of dropping of employer-sponsored
1813 insurance that you--

1814 Mr. {Murphy.} But 1,000 have asked for waivers. If you
1815 could provide us some economic analysis of what that also

1816 means for us too, also what it would mean, if you could
1817 provide us information on the number of people who may lose
1818 their jobs, because we are hearing from small employers
1819 saying I am not going to hire more, I am going to try and
1820 keep it under 50. Do we have an analysis of that number of
1821 jobs and the loss of federal revenue from that? Does anybody
1822 have that?

1823 Mr. {Elmendorf.} Again, Congressman, in reports we
1824 issued before and in my written testimony for today, we talk
1825 about the effects we think will take place in the labor
1826 market.

1827 Mr. {Murphy.} Similarly, in terms of the pharmaceutical
1828 issues too, and all these issues that we are looking at here,
1829 it is a matter of having updates on all these, but what we
1830 are all hearing from employers is the loss of jobs, increased
1831 costs of private health insurance, costs of medical devices,
1832 increased costs of prescription drugs, and I know we are
1833 talking on some levels of what this means for federal
1834 revenue. I am not sure we are doing analysis of what this
1835 means for the average family in America and the average
1836 employer, so I hope we can have that information too, and if
1837 you would be willing to provide that for us, I would be
1838 grateful.

1839 With that, I yield back. Thank you.

1840 Mr. {Pitts.} The gentleman's time is expired.

1841 Mrs. {Capps.} Mr. Chairman, I apologize. I had
1842 intended to make a unanimous consent request to insert an
1843 article from the Bloomberg Business Week entitled ``The
1844 Republican Response to Obamacare'' at the end of my 5
1845 minutes, and I neglected to do so. May I do so now, please?

1846 Mr. {Pitts.} Can we see the article?

1847 Mrs. {Capps.} Of course.

1848 Mr. {Pitts.} The chair recognizes the gentlelady from
1849 Wisconsin, Ms. Baldwin, for 5 minutes for questions.

1850 Ms. {Baldwin.} Thank you, Mr. Chairman.

1851 I agree with my colleagues that we must reduce the
1852 deficit and work towards a balanced federal budget. However,
1853 we have to be smart about the priorities and the choices that
1854 we make and we need to be smart if we are going to cut
1855 spending without compromising job creation and our economic
1856 recovery and frankly our future. The Republican spending
1857 bill, H.R. 1, clearly illustrates the new Majority's choices
1858 and priorities. This measure threatens jobs and our fragile
1859 economic recovery and slashes vital services to the American
1860 people. Republicans have prioritized cutting health care
1861 services to our most vulnerable populations without
1862 considering the consequences of such actions, and once again
1863 Republicans have targeted critical safety-net programs like

1864 Medicaid and Medicare.

1865 Meanwhile, the measure, H.R. 1, does little to rein in
1866 excess military spending like weapons system that the
1867 Pentagon doesn't even want or eliminate government handouts
1868 to Big Oil or even eliminate tax breaks for
1869 multimillionaires. Today we spend millions of dollars each
1870 day in Afghanistan and Iraq, spending that is certainly
1871 protected in H.R. 1. And tangentially, I just read yesterday
1872 that the Pentagon reported that war funding in Libya has
1873 already surpassed the half-billion-dollar mark, \$550 million
1874 specifically was reported yesterday.

1875 Today we are here at this hearing to discuss the costs
1876 of the health care reform law passed a year ago, a law that
1877 my colleagues on the other side of the aisle seek to repeal,
1878 repeal it outright. Let me remind my colleagues that
1879 repealing the health care reform law would add \$210 billion
1880 to our federal deficit over the next 10-year time horizon.
1881 That number comes from the Congressional Budget Office.

1882 Dr. Elmendorf, I am really perplexed at how Republicans
1883 can claim that a bill your agency scored as reducing the
1884 deficit is actually contributing somehow to our alleged
1885 spending problems, and I would like us to reflect upon and
1886 consider what really contributes to our Nation's deficit.
1887 How much, Dr. Elmendorf, does the CBO anticipate will be

1888 spent on the wars in Iraq and Afghanistan over the next 10
1889 years according to your January baseline?

1890 Mr. {Elmendorf.} So I don't remember the number,
1891 Congresswoman. As you understand, our baseline for
1892 discretionary spending takes the current levels of spending
1893 and simply extrapolates those out.

1894 Ms. {Baldwin.} There are a lot of assumptions that are
1895 in there. Does \$1.7 trillion sound familiar to you?

1896 Mr. {Elmendorf.} I am sorry, Congresswoman. I really
1897 don't know the answer to that.

1898 Ms. {Baldwin.} Well, how about the Bush tax cuts and
1899 the extension of the Bush tax cuts, tax cuts that provide
1900 income and estate tax cuts to the very wealthy? How much
1901 does the January CBO baseline indicate that that will cost to
1902 extend over the next 10 years?

1903 Mr. {Elmendorf.} So we reported in January that
1904 extending the income tax and estate and gift tax provisions
1905 now scheduled to expire at the end of next year would cost
1906 about \$2.5 trillion over the coming decade and then would
1907 also result in about a half a trillion dollars of additional
1908 interest payments.

1909 Ms. {Baldwin.} Because we are borrowing the money for
1910 these tax cuts. Okay. So I know you don't have the figure
1911 at your fingertips on the wars and that includes some

1912 estimates, but from my reading of the CBO January baseline,
1913 between the wars and the tax cuts, we are looking at nearly
1914 \$5 trillion, all of it borrowed money, all of it completely
1915 unpaid for, and yet the Republican solution to the deficit is
1916 to repeal a law adding an additional \$210 billion to the
1917 deficit and leaving vulnerable Americans without access to
1918 health care.

1919 Mr. Chairman, again, this is about making smart choices,
1920 and I am disappointed with the choices that the Majority is
1921 making right now. I yield back the balance of my time.

1922 Mr. {Pallone.} Mr. Chairman?

1923 Mr. {Pitts.} The chair thanks the gentlelady.

1924 Mr. {Pallone.} Mr. Chairman, could I ask if--

1925 Ms. {Baldwin.} I would yield to the gentleman my
1926 remaining time.

1927 Mr. {Pallone.} No, I just wanted to ask about a
1928 unanimous consent request. Ms. Capps had made a unanimous
1929 consent request, which I think that Dr. Burgess has seen now,
1930 so I just wanted to see if that--

1931 Mr. {Pitts.} Without objection, it will be entered into
1932 the record.

1933 Mr. {Pallone.} Thank you.

1934 [The information follows:]

1935 ***** COMMITTEE INSERT *****

|
1936 Mr. {Pitts.} The chair thanks the gentleman and
1937 recognizes the gentleman from New Jersey for 5 minutes, Mr.
1938 Lance.

1939 Mr. {Lance.} Thank you very much, Mr. Chairman. Good
1940 morning to you both.

1941 Dr. Elmendorf, it is my understanding that under PPACA
1942 there is an inconsistent rule regarding part-time employees.
1943 As I understand it, on one hand it does not require a group
1944 health plan to provide employees who work fewer than 30 hours
1945 per week, the minimum essential coverage under the pay-to-
1946 play rules that take effect in 2014. However, any group
1947 health plan that does cover part-time employees must comply
1948 with the act's coverage mandates that go into effect in 2011.
1949 From my perspective, I think that this might have the net
1950 effect to incentivize those businesses to drop all health
1951 care coverage for part-time employees, and with the State-
1952 based exchanges not coming into effect until 2014, wouldn't
1953 this be adding to the current pool of uninsured? Dr.
1954 Elmendorf, did CBO examine that situation, sir?

1955 Mr. {Elmendorf.} So Congressman, your description of
1956 the law sounds right to my expert team behind me. What we
1957 have written before and in the testimony today is that
1958 actually there are some reasons that firms might end up

1959 hiring more part-time and seasonal employees because of the
1960 way in which some of the penalties that face firms only if
1961 they have part-time employees who are seeking subsidies
1962 through the exchanges and not part-time employees. So there
1963 are some cross currents in the legislation. Of course, the
1964 effects of these provisions will only be in place a number of
1965 years from now, which even our forecast of a relatively slow
1966 economic recovery suggests that we will be moving our way
1967 back toward more traditional levels of unemployment in this
1968 country, so I am not diminishing the concern about effects on
1969 employment but I think one of the starting points should not
1970 be today's unemployment rate but that which would be in place
1971 in the future.

1972 Mr. {Lance.} Well, I agree with that. I have had
1973 constituents in my office who are greatly concerned about
1974 this, constituents who do cover their part-time employees,
1975 and this concerned supermarkets in the area and they do what
1976 I think is the right thing in covering their part-time
1977 employees, or they certainly are looking to do that but they
1978 believe that there might be a disincentive. Thank you for
1979 that.

1980 Mr. Foster, and I think Dr. Murphy referenced this as
1981 well, the 2.3 percent excise tax on medical devices, do you
1982 anticipate that these fees and excise taxes would generally

1983 be passed through to health consumers in the form of higher
1984 prices and higher insurance premiums? And as I understand
1985 it, they would be placed on devices like pacemakers.

1986 Mr. {Foster.} Yes, sir, we think that would be the
1987 typical reaction would be to raise the prices of the products
1988 to cover the higher costs associated with the fees or the
1989 taxes.

1990 Mr. {Lance.} And from my perspective as a matter of
1991 public policy, I do not think that that is a good idea
1992 because I think that these devices are expensive enough
1993 already.

1994 Dr. Elmendorf, I believe the CBO estimates between that
1995 between 6 and 7 million Americans who would have to have
1996 offered employee-based coverage before the health care law
1997 was passed would not be offered coverage under current law.
1998 Is it true that Americans would likely be employees of small
1999 businesses or low-wage employees?

2000 Mr. {Elmendorf.} Yes, that is right, Congressman, and
2001 that flow, that reduction in employment in some places is
2002 part of the overall story that we modeled.

2003 Mr. {Lance.} Yes. Thank you very much.

2004 Mr. Chairman, I would be willing to give my remaining
2005 time to whoever would like it, Dr. Burgess or Dr. Cassidy.

2006 Dr. {Cassidy.} Mr. Foster, just to follow up a question

2007 that was asked of Dr. Elmendorf, and I am not sure, this is
2008 not confrontative, just to explore, the effect of excluding
2009 the Social Security from the Medicaid income eligibility
2010 criteria, I think someone said could increase the number of
2011 enrollees by some significant number, maybe 5 million, and
2012 Mr. Foster, I am not clear, when you all say 17 to 20 million
2013 people will be enrolled in Medicaid, does that take into
2014 account the fact that the effective income threshold will now
2015 be 138 percent for those Social Security recipients?

2016 Mr. {Foster.} Well, in our original estimates for the
2017 Medicaid expansion, we estimated 20 million people would
2018 become newly covered. That took into account the 138 percent
2019 because of the income disregard but at that time we assumed
2020 that the policy would continue, that Social Security benefits
2021 would continue to count as earnings in meeting this test.
2022 With the strict definition of modified adjusted gross income
2023 then for most such people Social Security benefits would not
2024 count or not very much of them would count. That would
2025 potentially increase the number of Medicaid-eligible people
2026 under the expansion by 5 million or more.

2027 Dr. {Cassidy.} So we are really talking 25 million will
2028 now be on Medicaid if we have income disregard for Social
2029 Security benefits?

2030 Mr. {Foster.} Not every one of them would end up there.

2031 They would be eligible but many would have already have
2032 employer retiree coverage.

2033 Dr. {Cassidy.} So ballpark figure, though, just so we
2034 can know, how many will be on Medicaid if you have income
2035 disregard for Social Security?

2036 Mr. {Foster.} So 24.7 million.

2037 Mr. {Pitts.} Dr. Elmendorf, did you want to respond?

2038 Mr. {Elmendorf.} That factor was taken into account in
2039 our estimate, Congressman.

2040 Dr. {Cassidy.} And so your final number is what?

2041 Mr. {Elmendorf.} So we expect that the increase in
2042 Medicaid and CHIP enrollment under the legislation will be 17
2043 million by 2021.

2044 Dr. {Cassidy.} So there is a discrepancy there. Okay.

2045 Thank you.

2046 Mr. {Pitts.} The gentleman's time is expired. The
2047 chair recognizes the gentleman from New York, Mr. Engel, for
2048 5 minutes.

2049 Mr. {Engel.} Thank you very much, Mr. Chairman, and let
2050 me first say, you know, here we go again, just one week after
2051 the one-year anniversary of this Affordable Care Act the
2052 subcommittee is holding yet another hearing attempting to
2053 undermine it and what the true costs that we should be
2054 talking today are what would have happened if we had not

2055 taken action. The Affordable Care Act makes health care
2056 affordable for the middle class and has halted a steady rise
2057 in health costs that led us to much of our budgetary woes
2058 over the years. For all the talk of the sky falling, my
2059 Majority colleagues have repeatedly failed to provide any
2060 alternative ideas that would come remotely close to
2061 accomplishing what the Affordable Care Act does. They had 6
2062 years of control of the House, Senate and White House and
2063 provided no leadership on this issue. All we have are
2064 alarmist sound bites and false platitudes and even more
2065 frightening are the true costs that will come if the new
2066 Majority places spending caps or block grants Medicaid, as
2067 they propose to do. These actions will not save money, it
2068 will simply abdicate responsibility and shift costs to State
2069 providers and beneficiaries.

2070 Now, let me say that Secretary Sebelius and Assistant
2071 Secretary Greenlee disagree with some of my Republican
2072 colleagues who have been saying that there is double counting
2073 in letters they have sent to Ranking Members Waxman and
2074 Pallone. This is Secretary Sebelius and Assistant Secretary
2075 Greenlee have sent letters to Mr. Waxman and Mr. Pallone
2076 saying that there is not double counting, and the Secretary
2077 gives this example, and I quote from her: ``In the same way
2078 when a baseball player hits a homer, it both adds one run to

2079 this team's score and also improves his batting average.
2080 Neither situation involves double counting.'' So I would
2081 like to submit these letters for the record.
2082 Mr. {Pitts.} Without objection, so ordered.
2083 [The information follows:]

2084 ***** COMMITTEE INSERT *****

2085 Mr. {Engel.} Thank you, Mr. Chairman.

2086 Now, it is interesting that my colleagues on the other
2087 side of the aisle talk about how much the Affordable Care Act
2088 is going to cost. I would like to remind them that when
2089 Republicans passed the Medicare Modernization Act in 2003,
2090 they did not offset its costs. CBO estimated the bill would
2091 add \$394 billion to the deficit over 10 years, and CBO is our
2092 official scorekeeper.

2093 So let me ask Mr. Elmendorf, how much will the
2094 prescription drug benefit draw from general revenues over 75
2095 years, which is the traditional long-term horizon used for
2096 actuarial projections in the Medicare trustee's report?

2097 Mr. {Elmendorf.} I am sorry, Congressman. I don't have
2098 the answer to that question offhand. Maybe Rick does, based
2099 on their own estimates of the Office of the Actuary.

2100 Mr. {Engel.} Mr. Foster?

2101 Mr. {Foster.} The present value of the general revenues
2102 for Part D over that 75-year period are estimated to be about
2103 \$7.2 trillion.

2104 Mr. {Engel.} Thank you. Seven point two trillion
2105 dollars. Based, as you said, on the most recent trustee's
2106 report, the unfunded obligation is \$7.2 trillion. Did the
2107 Medicare Modernization Act include other provisions

2108 increasing revenues or cutting spending that might come close
2109 to generating the resources to meet the \$7.2 trillion
2110 obligation from general revenues?

2111 Mr. {Foster.} No, it was clearly a new expenditure for
2112 a new program.

2113 Mr. {Engel.} Yes, so the answer is no. I agree with
2114 that. CBO's net score for the Medicare Modernization Act was
2115 \$394 billion, which included nearly \$410 billion in new
2116 spending for the prescription drug benefit and only about \$16
2117 billion in offsetting savings over 10 years. This means the
2118 vast majority of the prescription drug benefit costs, \$394
2119 billion over the first 10 years, was added to the deficit.
2120 So my Republican friends seem to be saying do as I say, not
2121 as I do, and I think one of my colleagues before had
2122 mentioned how the tax breaks for the rich and the estate tax
2123 breaks and everything else just keeps adding trillions and
2124 trillions and trillions of dollars to the deficit, and when
2125 my friends on the other side of the aisle were in control for
2126 6 years passing Medicare Part D, they didn't seem to care
2127 about the deficit then but I guess, you know, whenever you
2128 have the newfound religion, it is great, but I think we also
2129 need to be consistent.

2130 Thank you, Mr. Chairman. I yield back.

2131 Mr. {Pitts.} The gentleman's time is expired. The

2132 chair recognizes the gentleman from Georgia, Dr. Gingrey, for
2133 5 minutes.

2134 Dr. {Gingrey.} Mr. Chairman, I thank you, and I think I
2135 will use a little baseball analogy. Like my friend from New
2136 York, I think he said that in this double-counting issue when
2137 a player hits a home run, it is one run and he also adds to
2138 his batting average. I would like to say that also when
2139 Casey strikes out, he loses and the team loses and there is
2140 no joy in Mudville, and I would say in this particular case
2141 of the Obamacare bill, Obama being Casey and the team being
2142 the American people, Casey struck a big out and the American
2143 people are suffering as a result.

2144 Mr. Foster, in the opening page of your testimony, you
2145 state that it is the role of the CMS Actuary, your role, to
2146 provide economic actuarial and other technical assistance to
2147 policymakers and the Administration and Congress on an
2148 independent, objective and nonpartisan basis. Is that
2149 correct?

2150 Mr. {Foster.} Yes, sir.

2151 Dr. {Gingrey.} Two weeks ago, Assistant Secretary
2152 Greenlee was here stating before this committee and the
2153 department that she said the Department of Aging, which she
2154 chairs, promised to work with you before moving forward on
2155 implementing the CLASS program. Secretary Sebelius in her

2156 own words gave her pledge to work with this committee to
2157 ensure that the CLASS program is truly sustainable before the
2158 Administration proceeds with program operations. Mr. Foster,
2159 will you make a similar commitment to me today that you will
2160 work with this committee to conduct in our role as Chief
2161 Actuarial a full and objective assessment of the
2162 Administration's plan for CLASS to ensure the program is
2163 truly sustainable including weighing the impact that any
2164 proposed premium increases will have on consumer
2165 participation in this program? Will you make that pledge to
2166 me?

2167 Mr. {Foster.} Yes, sir. Let me add to that just
2168 briefly. The responsibility for administering the CLASS
2169 program is in Ms. Greenlee's part of the agency. They have
2170 hired a Chief Actuary to help determine the CLASS premiums,
2171 help do the actuarial aspects, a fellow named Robert Yee, who
2172 is very good. He has contacted me to want to run by us some
2173 of their thoughts, some of their efforts to make this
2174 workable.

2175 Dr. {Gingrey.} Well, let me quickly ask you, I need to
2176 move on to another question, is it truly necessary to have
2177 another actuary doing that work for the CLASS program? Can
2178 you not in your capacity as Chief Actuary for CMS continue to
2179 do that same kind of work for the CLASS Act? Could you not?

2180 Mr. {Foster.} We could.

2181 Dr. {Gingrey.} Absolutely. Well, look, let me first of
2182 all commend you in regard to your analysis of the Medicare
2183 cuts, which are critical elements of Obamacare. As you know,
2184 these cuts were doubly counted, and Secretary Sebelius said
2185 as much. They pay for the major part of the entitlement
2186 expansion as well as so-called extending the life of Part A
2187 trust fund.

2188 Now, look, let me walk you through a couple of charts
2189 because you talked about this earlier, and these are taken
2190 from simulations that your staff have performed and then
2191 maybe we can get you to comment on that. This first chart
2192 basically shows that because of Obamacare cuts, Medicare
2193 rates will be lower than Medicaid rates by 2019. That is
2194 right here as it drops below Medicare rates, and that by the
2195 75-year period Medicare payments would only be one-third,
2196 only one-third of the relative current private pay rates and
2197 one-half of Medicaid by the 75-year mark. Now, we have
2198 another chart I want my colleagues to look at, and if you
2199 will pay attention to this one, the second one shows a
2200 comparison of relative rates for inpatient hospital services
2201 only, and the key point here is that both the Medicare and
2202 Medicaid rates collapse together because Medicaid under
2203 current law cannot pay more than Medicare upper limit

2204 requirements for hospital service. At the end of the scoring
2205 window, hospitals would be paid 37 percent of private pay
2206 rates for both Medicare and Medicaid.

2207 So let me make two quick statements. First, these
2208 Medicare cuts are the major pay for for this \$2 trillion
2209 entitlement expansion which begins in 2014 and goes through
2210 the 10-year period of 2023. Second, there is no chance that
2211 these Medicare cuts will remain on the books in future years
2212 based on your analysis. Putting the two statements together
2213 means that in the next decade, Obamacare will add
2214 dramatically to the budget deficit because it will not be
2215 paid for. Mr. Foster, can you comment on that?

2216 Mr. {Foster.} Well, if you leave out some of the
2217 adjectives, I would probably agree with most of what you just
2218 said. The concern is that these payment reductions or the
2219 slower growth in payment rates won't be sustainable in the
2220 long term, and if that happens, then the savings that are
2221 generated by those won't occur because you all will have to
2222 override them to prevent problems with access. To the extent
2223 that those savings are used to help pay for the cost of the
2224 coverage expansions under the Affordable Care Act, then that
2225 ability to pay for--

2226 Dr. {Gingrey.} And providers will have no choice but to
2227 shift that cost to the private market, thus raising the cost

2228 of private health insurance.

2229 Mr. {Foster.} That is one way they might react. It is
2230 not clear--

2231 Dr. {Gingrey.} And I thank you for your testimony.
2232 Thank you for your patience, Mr. Chairman.

2233 Mr. {Pitts.} The gentleman's time is expired. The
2234 chair recognizes the gentleman from New York, Mr. Weiner, for
2235 5 minutes for questions.

2236 Mr. {Weiner.} Thank you, Mr. Chairman.

2237 I don't have the fancy charts my colleagues have but I
2238 just want to do the double counting thing. If you save money
2239 with a policy change in the bill by having good ideas in the
2240 bill, could you not only save money but extend Medicare from
2241 2017 to 2029? Is that the effect of the bill?

2242 Mr. {Foster.} That was our estimate.

2243 Mr. {Weiner.} So in other words, you can save money and
2244 you extend the life expectancy as you see in my charts. Is
2245 that true?

2246 Mr. {Foster.} Both of these happen.

2247 Mr. {Weiner.} Yes, those things both happen. Now, does
2248 that mean that there is anything nefarious about them? Are
2249 we defying the laws of economic gravity? Are cats going to
2250 start sleeping with dogs? Or does this sometime happen in
2251 laws that you make changes that both save money and extend

2252 the life of a program that some of us support and some of us
2253 oppose? Is that true?

2254 Mr. {Foster.} The issue is that a given dollar of
2255 savings, your first chart with a dollar.

2256 Mr. {Weiner.} Right. This one here. Hold on. Let me
2257 get it for the viewers.

2258 Mr. {Foster.} I like that one best. Your first chart
2259 with a dollar, that dollar can be used to spend in real life
2260 to help pay for the coverage expansions or it can be used to
2261 help pay for Medicare.

2262 Mr. {Weiner.} Right.

2263 Mr. {Foster.} The same dollar can't be used twice for
2264 each purpose. That takes \$2. Now, because of the accounting
2265 mechanisms, both of them will happen, but if I may, let me
2266 explain why briefly. The savings for hospital insurance
2267 under the Affordable Care Act are quite large. The actual
2268 cash that we no longer have to spend because of lower
2269 expenditures--

2270 Mr. {Weiner.} Adds to the--

2271 Mr. {Foster.} --taxes we get. That actual cash goes
2272 into the general fund that is used for whatever purpose--

2273 Mr. {Weiner.} Right.

2274 Mr. {Foster.} --Treasury needs to use it for.

2275 Mr. {Weiner.} I appreciate that. I just wanted to make

2276 it clear that this is another one of these non-issues, and it
2277 is fascinating, I should say, that the same people that are
2278 objecting to all of these things are people who frankly
2279 apparently want there to be deeper cuts in Medicare, or they
2280 are actually schizophrenic on Medicare. Some of them deride
2281 single-payer health care plans but seem to love this one.
2282 Suddenly they are the defenders of Medicare, and they were
2283 the ones that apparently opposed single-payer health care
2284 plans, which is what Medicare is.

2285 Let me just ask you this question. I heard some of Mr.
2286 Rogers' questions and I just want to make sure we understand
2287 it. This bill has a 35 percent tax credit for small
2288 businesses that offer health insurance for their workers. Is
2289 that true?

2290 Mr. {Foster.} Yes, sir.

2291 Mr. {Weiner.} Before this bill was passed, did small
2292 businesses get a 35 percent tax credit for offering health
2293 insurance to their workers, before it was passed? I will
2294 help you with this one. The answer is one. It goes to 50
2295 percent after the exchanges are set up. Small businesses
2296 under this law get a 50 percent tax credit for offering
2297 health insurance to their workers. Democrats support a tax
2298 credit for people offering health insurance and the
2299 Republicans are against it because if you repeal this bill,

2300 it would disappear. So let me say that again. Democrats who
2301 supported this bill now can proudly say small businesses get
2302 a 35 percent tax credit for every single dollar they spend
2303 for health care and in 2017 it goes up to a full 50 percent.
2304 Republicans want to eliminate that small business tax credit.
2305 That is the bottom line here. We have a bill that takes the
2306 idea of using tax reductions for small businesses and helps
2307 them provide insurance for more workers.

2308 Can I ask you gentlemen this question? We have heard
2309 what the Republicans are against as far as health care is
2310 concerned. We know in this country that before health reform
2311 was passed, real incomes in this country were flat despite
2312 the fact that corporate profits, we went through a pretty
2313 boom period in this country. Is it not the case that one of
2314 the reasons that that happened, that businesses were doing
2315 pretty well, the market was doing pretty well, there was a
2316 lot of cash in the system before we had the big Bush
2317 collapse, but is it not true that one of the reasons that
2318 income stayed flat is because employers because of the
2319 explosion in costs for health care had to put every spare
2320 dollar they had into health insurance rather than giving
2321 wages? Doesn't it--maybe Mr. Elmendorf is the best person to
2322 answer this. Doesn't the explosion of health care costs put
2323 downward pressure on other elements of employment costs like

2324 wages?

2325 Mr. {Elmendorf.} Yes, it does, Congressman.

2326 Mr. {Weiner.} So if you reduce the amount of health
2327 care costs or move that burden to a program that provides
2328 competition like an exchange, that lower burden on health
2329 care costs will mean that at least in theory employers will
2330 have the ability now to take some of that money into wages?
2331 Is that not true, Mr. Elmendorf?

2332 Mr. {Elmendorf.} If you reduce private health spending.

2333 Mr. {Foster.} Right. Which of course is the goal that
2334 we all have, and Mr. Elmendorf, I don't know if you have this
2335 at your fingertips. Do you happen to know whether the health
2336 care offered by Medicare is more efficient, meaning having
2337 less overhead and profits, than private insurance?

2338 Mr. {Elmendorf.} Medicare has lower administrative
2339 costs than certainly the small group and non-group markets.

2340 Mr. {Weiner.} And no profits obviously. They take no
2341 money for profits?

2342 Mr. {Elmendorf.} That is right.

2343 Mr. {Weiner.} Thank you very much.

2344 Mr. {Pitts.} The gentleman's time is expired. The
2345 chair recognizes the gentleman from Louisiana, Dr. Cassidy,
2346 for 5 minutes.

2347 Dr. {Cassidy.} Just a quick comment. Medicare also has

2348 potentially 10 to 20 percent of its receipts going out in
2349 fraud, so maybe there is something to be said for overhead.

2350 Mr. Foster, you mentioned how there may be different
2351 ways, okay, so Dr. Gingrey showed how if we hit this cliff,
2352 Medicare and Medicaid payments to physicians and hospitals
2353 will decrease dramatically relative to private insurance, and
2354 you mentioned that there are different ways that they can
2355 compensate for that. Now, I have an article here from
2356 Milliman from 2008 which speaks about the hydraulic effect
2357 and how in the Milliman article, this is 2008, they estimate
2358 that significant discounts in Medicaid cause a hydraulic
2359 effect, driving up the cost of private insurance, and that it
2360 is possible that there would be 15 percent lower health
2361 insurance cost were it not for Medicaid paying below the
2362 providers' actual cost of doing business. Now, it seems as
2363 if, knowing that there is a lot of things possible, but it
2364 seems most likely that this hydraulic effect will be
2365 exacerbated by this kind of cliff that we see with Medicaid
2366 and Medicare. Will you accept that?

2367 Mr. {Foster.} Yes, that is one reaction we would
2368 probably anticipate.

2369 Dr. {Cassidy.} So it is a probable. It is not just
2370 kind of maybe out there but it a probable. I think history
2371 would say that is true.

2372 Mr. {Elmendorf.} Congressman, can I just add, there are
2373 some conflicting forces, though, in this law, so there are
2374 reductions in Medicare payment rates. There are also some
2375 people who today otherwise would the law would be uninsured
2376 would then be having health insurance--

2377 Dr. {Cassidy.} I will say that, reclaiming my time, Dr.
2378 Elmendorf, only because I have limited time, I think the
2379 experience in Massachusetts says that broadening access does
2380 not control cost. I think that argument has been effectively
2381 diminished. But if I can go back to Mr. Foster, not to be
2382 rude, but I just have limited time.

2383 Mr. Foster, the next thing to say is, we know that in
2384 times past, and you may have even written this to the effect,
2385 that when there is a cliff in SGR, Congress will almost
2386 always, in fact, has always increased that back up. Now, I
2387 guess my question for you is, I think you do behavioral
2388 modifications. You look at a piece of legislation and you
2389 can see wow, sure, this is the parameters given to us but the
2390 contortions given to us do not reflect reality. There should
2391 be a codicil, if you will. There should be some addendum
2392 that says, you know, using behavioral health, we would
2393 discount the effective savings. It seems like you should
2394 have used that same methodology as regards this cliff that is
2395 going to affect Medicare and the resulting hydraulic effect

2396 upon private insurance rates driving them up 15, maybe 25
2397 percent. Any comments upon that?

2398 Mr. {Foster.} Well, it is actually an excellent point
2399 in terms of anticipating what kinds of reactions might
2400 happen. We do this where we have a good basis for it and
2401 where it affects, for example, the financial status of
2402 Medicare or estimating Medicare or Medicaid costs. We don't
2403 do it in every case. For example, if there is cost shifting
2404 by hospitals or other providers because the Medicare or
2405 Medicaid payments are inadequate, they cost shift to private
2406 insurance.

2407 Dr. {Cassidy.} Driving up the cost for the privately
2408 insured. What we are really saying is cost shifting is
2409 driving up the cost. This bill through its cost-shifting
2410 mechanism drives up the cost for the privately insured.
2411 Okay. Continue.

2412 Mr. {Foster.} Yes, and there is some disagreement about
2413 to what extent that happens. It is hard to measure.

2414 Dr. {Cassidy.} But going back to my point, wouldn't it
2415 have been wise for you to discount the savings given that the
2416 behavioral aspect of Congress is to hold providers harmless
2417 for the SGR, as one example?

2418 Mr. {Foster.} Well, it depends on what you are
2419 measuring, sir. If you are measuring federal expenditures

2420 and Medicare saves money but private health insurance gets
2421 more expensive, that may not affect federal expenditures.

2422 Dr. {Cassidy.} Then that is a good point, because
2423 really, you are only looking at federal spending. In a
2424 sense, by law you are required not to consider the fact that
2425 we are driving up costs for privately insured.

2426 Mr. {Foster.} Well, we also look at total national
2427 health expenditures.

2428 Dr. {Cassidy.} I saw that, and that rises. So even
2429 though the federal supposedly saves, the fact that there is
2430 national health expenditures that rise means that somebody is
2431 eating it, and it is probably the States and the privately
2432 insured.

2433 I think I am getting from you that you could have done
2434 behavioral intervention but for whatever reason, your
2435 methodology, you chose not to do so.

2436 Mr. {Foster.} Not in this particular instance.

2437 Dr. {Cassidy.} Let me go to the next point. Everybody
2438 is talking about--clearly, press reports say that the reason
2439 that this was offloaded upon the states is that it saved the
2440 Federal Government money but clearly it is going to cost the
2441 States a heck of a lot of money, and so I have here a Lewin
2442 report, the impact of expenditures. Mr. Waxman, whom I have
2443 great respect for, spoke about an adult conversation.

2444 According to this Lewin report, under this Obamacare bill,
2445 his State is going to have increased Medicaid expenditures of
2446 \$4.8 billion over a 5-year period. Louisiana is going to be
2447 \$1.5 billion. Texas is over \$4 billion as well. So is it
2448 well to concede that although federal expenditures are going
2449 down, in the case of California it will be \$4.8 billion
2450 higher, Texas \$4 billion, Louisiana \$1.5 billion higher? We
2451 just cost shifted from the feds to the States?

2452 Mr. {Foster.} Most of what is in the bill goes the
2453 other way around. There are many provisions that reduce the
2454 States' share of cost and increase the federal share.
2455 Overall, the State cost is not great. I have specific
2456 estimates that we can provide for the record.

2457 Dr. {Cassidy.} So you would dispute the Lewin report?

2458 Mr. {Foster.} If I understood what they were saying
2459 correctly. I would want to look at it carefully.

2460 Dr. {Cassidy.} I will submit that to the record once I
2461 get ahold of it.

2462 Mr. {Pitts.} The gentleman's time is expired. The
2463 chair recognizes the gentleman from Ohio, Mr. Latta, for 5
2464 minutes for questions.

2465 Mr. {Latta.} Well, thank you, Mr. Chairman, and
2466 gentlemen, thanks very much for your indulgence this morning.
2467 I really appreciate you being here. And Mr. Elmendorf, it is

2468 good to see you again from my time on the Budget Committee.
2469 As always, I am glad to see you come before the committee and
2470 hear your input.

2471 You know, I think everybody has been talking to Mr.
2472 Foster so maybe I can talk to you for a couple of minutes
2473 here. You know, even when I was on the Budget Committee, I
2474 always enjoyed reading your statements when you came before
2475 the committee, and also, you know, one of the things that we
2476 have been talking about this morning about physician
2477 services, etc., talking on page 9 under the heading
2478 ``uncertainty surrounding the estimates,'' and again, from my
2479 days on the Budget Committee, I understand that you are given
2480 a snapshot. We are looking at a snapshot at that time of the
2481 information that you are given to make an estimate on. But I
2482 find it interesting in your statement just a few things if
2483 you could comment on.

2484 In the one paragraph, you say, ``In fact, CBO's cost
2485 estimate for the legislation noted it will put into effect a
2486 number of policies that might be difficult to sustain over a
2487 long period of time,'' and then you go on to state that, ``It
2488 is unclear whether such a reduction can be achieved through
2489 greater efficiencies in the delivery of health care or will
2490 instead reduce access to care or the quality of care relative
2491 to the situation under prior law.'' And we heard Mr. Foster

2492 talking a little bit earlier in regards to the economizing
2493 the efficiencies that have to be done. It is kind of
2494 interesting because you are both kind of going the same way.
2495 First, under what we call the doc fix, how much was the doc
2496 fix before the law went into effect? Do you remember what
2497 that number was for the 10-year period?

2498 Mr. {Elmendorf.} How much would it cost over the 10-
2499 year period?

2500 Mr. {Latta.} Right.

2501 Mr. {Elmendorf.} I think the estimate was about \$250
2502 billion as of a year or so ago. I am not exactly sure.

2503 Mr. {Latta.} Okay. And did the health care law look at
2504 the doc fix at all?

2505 Mr. {Elmendorf.} The health care law did not adjust
2506 payments to physicians in Medicare.

2507 Mr. {Latta.} Thank you. And my next question is,
2508 because also following up, you know, we have some doctors
2509 that are on the committee, but when we are talking about,
2510 what worries me is when we are talking about achieve through
2511 greater efficiencies or, and I would like to ask this, reduce
2512 access to care or the quality of care. Could you define
2513 those two, reducing the access to care or the quality of care
2514 that you would be looking at when you made that statement?

2515 Mr. {Elmendorf.} So access to care, the first issue we

2516 discussed here about in Medicare, which pays significantly
2517 less to physicians than Medicare does today and it varies
2518 across States but on average, it is harder for Medicaid
2519 patients to find physicians who will treat them than it is
2520 for patients in Medicare or patients with private insurance,
2521 and so one of the measures of access is whether people can
2522 find doctors to treat them. Quality is a harder thing to
2523 measure in medical care, and part of the legislation that we
2524 are discussing in fact is an effort to increase the
2525 dissemination of quality measures and to develop new quality
2526 measures. That is a harder thing to look up. I think those
2527 are the sorts of concerns that we have spoken about and the
2528 Office of the Actuary has spoken about as well.

2529 Mr. {Latta.} And again, going back, you know, again,
2530 knowing, understanding that you are looking at a snapshot of
2531 what is being given you, the information that is given to you
2532 at that very moment in time to make your analysis on, was
2533 anything ever talked about during that time about reducing
2534 that care or that quality of care and what that would do the
2535 system at that time or to the people that would have to try
2536 to get the care?

2537 Mr. {Elmendorf.} So a sentence much like this one has
2538 appeared in a succession of our cost estimates beginning at
2539 the point where this feature was a prominent part of the

2540 legislation that we were providing analysis of. I don't know
2541 what consideration these issues were given. I want to just
2542 emphasize one point, Congressman. You said several times we
2543 were given certain things. I want to be clear, what we were
2544 given is a piece of legislation. What we bring to that is
2545 our experience and evidence that analysts have developed.

2546 Mr. {Latta.} Right, and that is what I mean. We are
2547 looking at a snapshot of what is given to you, that you are
2548 not going out and getting that information, you know, that
2549 you are told what you are supposed to look at it.

2550 Let me ask this real quick because time is running out
2551 here. In the second to the last sentence it says, ``So that
2552 the shares of income that enrollees have to pay will increase
2553 more rapidly at this point.'' How much is that increase, do
2554 you think? Any idea on that?

2555 Mr. {Elmendorf.} It depends on how the economy unfolds.
2556 The word in the sentence of likely that exchange subsidies
2557 will grow more slowly is because we don't know what the
2558 economic outcome will be, but I can't quantify the exact
2559 change offhand in our baseline estimates, but we can look
2560 those up for you, Congressman.

2561 Mr. {Latta.} Well, thank you very much. I appreciate
2562 your testimony, and I yield back, Mr. Chairman.

2563 Mr. {Pitts.} The gentleman's time is expired. The

2564 chair recognizes the gentleman from Kentucky, Mr. Guthrie,
2565 for 5 minutes.

2566 Mr. {Guthrie.} Thank you, Mr. Chairman. First, I want
2567 to comment on the small business tax credits. My
2568 understanding, they are only for 2 years and it is only for
2569 employees of 25 or less, so if you are a small business with
2570 25 or less, you can be subsidized with a tax credit for 2
2571 years and that tax credit goes away. Therefore, you are
2572 going to choose either to continue expensive health
2573 insurance, which is going to driven higher by this bill, or
2574 drop it. Second of all, if you are a small business, which I
2575 consider a small business with 51 employees, I have a lot of
2576 them in my district, you have no tax credit and mandated to
2577 provide health insurance or you choose to put people into the
2578 exchange and make that other part, and I don't know if you
2579 all look at that type of behavior when you do that, but I
2580 want to go with a question.

2581 Mr. Elmendorf, you sent Mr. Lewis, our former ranking
2582 member, a letter saying about the appropriations process, the
2583 appropriations part of it, saying that there was a list of
2584 new activities for which PPACA includes only a broad
2585 authorization for appropriations of such sums as necessary
2586 and for those activities the lack of guidance made it
2587 difficult for you to come up with a score or necessary

2588 amounts. You can bring that forward.

2589 The second point, though, is there was one that in
2590 section 1311(a)(1) where the Secretary--and I will just read
2591 it--`it is the amount necessary to enable the Secretary to
2592 make awards for State-based exchanges. These awards can be
2593 used to facilitate enrollment in the exchange,' and you
2594 estimate that at \$2 billion. I believe that is the number.

2595 Mr. {Elmendorf.} Yes.

2596 Mr. {Guthrie.} And then the Kaiser Health News reported
2597 that a member of the Administration, Donald Berwick, the
2598 Administrator of Centers for Medicare and Medicaid Services,
2599 was talking with the States talking about the pressure for
2600 Medicaid, and he said to them, it was reported in Kaiser
2601 Health News, he was sensitive to that situation but his
2602 solutions, however, were to point States to funding that he
2603 said is already available to them such as subsidies to
2604 establish insurance exchanges. And I would have to guess
2605 that if what the Administration think should happen to help
2606 States through the budget crises with Medicaid, that is going
2607 to be far more than \$2 billion. So my question is, what
2608 assumptions did you make? And the Secretary said this in a
2609 meeting on March 3rd, I think it was, that she has complete--
2610 there are no limits on how much she can spend in this
2611 provision. There is no limit. She said that. And she has

2612 no need for additional Congress authority to spend it.
2613 Obviously a member of the Administration says you can spend
2614 it to help States plug their Medicaid budget hole. So what
2615 assumptions did you use to get the \$2 billion?

2616 Mr. {Elmendorf.} So we estimate that outlays for grants
2617 under the section would be \$2.1 billion over the 2011-2015
2618 period at which point the program ceases. Those estimates
2619 are based on the costs of implementing other programs in the
2620 government that we believe are similar in their structure,
2621 not in the precise substantive purpose, of course. And that
2622 is the way we do estimates in general of the cost of
2623 implementing various programs is to try to look for analogies
2624 and other things the government has been doing, and so far
2625 CMS has announced awards of \$49 million for planning grants.
2626 We think that there will be, as I said, about \$2 billion
2627 spent over the 5 years in total.

2628 Mr. {Guthrie.} But if the Administrator of Medicaid
2629 Services is correct and it is available, he said he points to
2630 solutions to point to States to funding that he said is
2631 already available to them such as subsidies to help establish
2632 health insurance exchanges so those subsidies are used in a
2633 way that helps the States. Because you could facilitate
2634 enrollment by granting more money for Medicaid to get more
2635 people enrolled in the health care exchange, because that

2636 would follow under the law. I know you can't model that
2637 behavior.

2638 Mr. {Elmendorf.} So under this section, this I believe,
2639 limits grants to activities related to establishing insurance
2640 exchanges, and so I don't think the changes in enrollment or
2641 activities related to establishing an exchange. It is
2642 certainly the case that this \$2.1 billion number might be too
2643 low. It might also be too high in our judgment. We tried to
2644 put it in the middle of the distribution of possible
2645 outcomes.

2646 Mr. {Guthrie.} I understand what you had to do. You
2647 had to take a similar model. I understand your modeling
2648 requirements. But my point that I am making, the people in
2649 the Administration are taking a far broader term than that.
2650 I think facilitate enrollment in the exchanges is a broad
2651 term, and obviously people in the Administration seem to
2652 think that way. At least somebody that should require Senate
2653 confirmation made that comment.

2654 But I would like to yield the last 30 seconds to my
2655 friend from Louisiana.

2656 Dr. {Cassidy.} Mr. Foster, I think that issue is, is
2657 that in the aggregate there is less spending in States but
2658 because New York is such a high-cost State, all the savings
2659 frankly come from New York and a few other States like that--

2660 Massachusetts--but if you take the people who are not
2661 eligible at less than 138 percent of federal poverty and you
2662 move them up, that is why California, which has a lot of
2663 poverty, even though it has a high main per capita income, it
2664 is going to be \$4.8 billion from 2014 to 2019 in increased
2665 Medicaid expenditures. Again, does that seem reasonable to
2666 you that maybe New York is offsetting everybody else?

2667 Mr. {Foster.} I am sure there are significant State-by-
2668 State variations in the net impact. We have only estimated
2669 the overall national, not the individual States.

2670 Mr. {Guthrie.} Thank you.

2671 Mr. {Pitts.} I thank the gentleman and recognize the
2672 vice chairman for one follow-up.

2673 Dr. {Burgess.} Thank you, Mr. Chairman. I appreciate
2674 the courtesy.

2675 Mr. Foster, in your prepared testimony you say you are
2676 here today in your role as an independent technical advisor
2677 to Congress. Perhaps offline you can expound for us what
2678 triggers that role as different from the Chief Actuary to the
2679 Centers for Medicare and Medicaid Services. And the reason I
2680 feel this is important and the reason I asked for the
2681 Resolution of Inquiry last year is, what triggers that role.
2682 Now, we were in sort of a rush to pass a year ago the Patient
2683 Protection and Affordable Care Act and I cannot escape the

2684 feeling that we were asked to vote on that bill before we had
2685 all of the data. So really my question to you is very
2686 simple: do you feel we had the full picture March 23, 2010,
2687 or March 21, 2010, when this vote was called on the Floor of
2688 the House in your role as an independent technical advisor to
2689 Congress, not as the Chief Actuary for Centers for Medicare
2690 and Medicaid Services?

2691 Mr. {Foster.} In either role I do the same thing, which
2692 is give you an honest answer to an honest question. What
2693 happened was, the legislation was complicated. It took our
2694 team working on this some period of time from the time we got
2695 the legislation until we could produce an estimate we were
2696 comfortable with.

2697 Dr. {Burgess.} Were you able to convey to the Speaker
2698 of the House that information, that you did not have a figure
2699 that you were comfortable with prior to Congress taking a
2700 vote on something of this magnitude?

2701 Mr. {Foster.} The Speaker of the House did not ask us.
2702 Various members of the House and Senate did ask us from time
2703 to time could we have something, could we have it prior to
2704 the vote that was scheduled. I think in all instances, we
2705 were not able to produce our estimates, to complete them
2706 before the vote actually occurred. Now, our goal was to do
2707 that but it was too hard within the time available.

2708 Dr. {Burgess.} But it not like the train was going to
2709 run off the railroad bridge if the vote didn't happen on
2710 March 21st. We could have voted on April 21st, could we have
2711 not, and had time for your independent technical advice?

2712 Mr. {Foster.} If the vote were delayed, clearly, yes--

2713 Dr. {Burgess.} In retrospect, do you think Congress
2714 would have benefited from having your opinion on the cost of
2715 this legislation?

2716 Mr. {Foster.} On a good day, I think our advice is
2717 useful.

2718 Mr. {Pitts.} All right. The ranking member has a
2719 follow-up question. Mr. Waxman.

2720 Mr. {Waxman.} Mr. Foster, no one delayed you from
2721 getting your estimate, you just weren't able to get the
2722 estimate in the time you had hoped. Is that correct?

2723 Mr. {Foster.} Well, that is correct. I mean, for CBO
2724 and Doug, you got the legislation early on because nobody
2725 wanted to finalize it without knowing the effects. We never
2726 got the legislation until it was announced publicly. We
2727 could only start at that point to do our work, so we were
2728 constantly behind you.

2729 Mr. {Waxman.} And did you ever give a final estimate of
2730 the actual bill that has passed the Congress?

2731 Mr. {Foster.} Yes, sir, on April 22nd.

2732 Mr. {Waxman.} Were you prevented from giving the
2733 Congress all the information it should have had when the
2734 Medicare prescription drug bill was voted on in the House?

2735 Mr. {Foster.} There were two or three instances where
2736 we gave the information to the head of the agency, who did
2737 not pass it on. That was investigated by OIG and GAO. The
2738 legal opinions that came out of that indicated in my opinion
2739 that we in fact have the right to serve independently on your
2740 behalf, and ever since those legal opinions came out, we have
2741 delivered responses to your requests directly and--

2742 Mr. {Waxman.} But at the time we were voting on the
2743 prescription drug bill, you didn't have that opinion that
2744 would allow you to communicate with us directly and therefore
2745 you did not communicate with us directly in the Congress?

2746 Mr. {Foster.} Not in every case. We tried our best but
2747 it was a difficult circumstance.

2748 Mr. {Waxman.} Well, the distinction I would make for
2749 the benefit of my colleague is that in that instance, the
2750 Republican Administration stopped the information or tried to
2751 prevent the information from coming to Congress. No one in
2752 the Congress or the Administration tried to stop you from
2753 communicating your best judgments on the estimates for this
2754 health care bill. Is that a correct statement?

2755 Mr. {Foster.} That is correct.

2756 Mr. {Waxman.} Thank you. I yield back.

2757 Mr. {Pitts.} All right. The chair thanks the gentleman
2758 and that concludes the round of questioning for the first
2759 panel. Members who have other questions will submit them in
2760 writing. We ask the witnesses to respond promptly to those.
2761 The chair thanks the first panel and now--

2762 Mr. {Waxman.} Mr. Chairman, before we go to the second
2763 panel, may I ask a parliamentary inquiry?

2764 Mr. {Pitts.} Yes. The gentleman will state his
2765 parliamentary inquiry.

2766 Mr. {Waxman.} I am not objecting to this witness
2767 testifying but we have Mr. Holtz-Eakin testifying. He is
2768 associated with American Action Forum. We don't know where
2769 they get their funding. That is not disclosed. We don't
2770 know if they get any government grants because their funding
2771 has not been disclosed. There is a rule that says we will
2772 have truth in testimony, and when a witness testifies they
2773 have to disclose some information about funding. Mr. Holtz-
2774 Eakin has maintained that he is testifying as an individual
2775 and not representing his group, so my inquiry to you is, what
2776 is the standard that we have? When can we have a witness
2777 come before us and be able to just say they are going to
2778 testify as an individual and not have to make the disclosure
2779 that they would otherwise be required to make? What standard

2780 should have to consider for the future?

2781 Mr. {Pitts.} If the gentleman will suspend?

2782 Mr. {Waxman.} If the chair would want to get further
2783 inquiry and put on the record, that would be helpful to us.
2784 I am not asking for an immediate answer, but it seems to me
2785 we need to have a standard that we all understand because
2786 some witnesses are required to give disclosures and evidently
2787 Mr. Holtz-Eakin is not required to give a disclosure because
2788 he is testifying as an individual. When do we let people
2789 testify as an individual and therefore not make disclosures
2790 and what circumstances do we require those disclosures? I
2791 just want us to know the policy. You don't have to do it off
2792 the top of your head but I think we ought to make it clear.

2793 Mr. {Pitts.} The chair will be happy to respond after
2794 talking to counsel and make it a part of the record.

2795 Mr. {Waxman.} Thank you very much.

2796 Mr. {Pitts.} The chair thanks the gentleman. I will
2797 ask the second panel to please take their seats and I will
2798 introduce them at this time. We will now hear from the
2799 second panel with their opening statements. We will hear
2800 first from Douglas Holtz-Eakin. Mr. Holtz-Eakin is an
2801 economist by training. He has studied the effects of
2802 numerous health care policy proposals in the past and is a
2803 former director of the Congressional Budget Office. Next we

2804 will hear from Mr. David Cutler, the Otto Eckstein Professor
2805 of Applied Economics at Harvard University. We will then
2806 hear from a trio of business owners and hear their thoughts
2807 on the impact of the new law. First will be Philip Kennedy,
2808 who is the President of Comanche Lumber Company, a small
2809 business located in Oklahoma. Next we will hear from Rick
2810 Poore, the President of Design Wear/Velocitee, a tee shirt
2811 design company located in Nebraska. Finally, we will hear
2812 from Larry Schuler, the President of Schu's Hospitality
2813 Group, which runs several restaurants in the State of
2814 Michigan.

2815 We will make your written testimony a part of the record
2816 and we ask that you please summarize your opening statements
2817 in 5 minutes, and I will now recognize Mr. Holtz-Eakin for 5
2818 minutes for his opening statement.

|
2819 ^STATEMENTS OF DOUGLAS HOLTZ-EAKIN; DAVID CUTLER, OTTO
2820 ECKSTEIN PROFESSOR OF APPLIED ECONOMICS, HARVARD UNIVERSITY;
2821 PHILIP K. KENNEDY, PRESIDENT, COMANCHE LUMBER COMPANY; RICK
2822 POORE, PRESIDENT, DESIGN WEAR/VELOCITEE; AND LARRY SCHULER,
2823 PRESIDENT, SCHU'S HOSPITALITY GROUP

|
2824 ^STATEMENT OF DOUGLAS HOLTZ-EAKIN

2825 } Mr. {Holtz-Eakin.} Thank you, Mr. Chairman, Ranking
2826 Member Pallone, Vice Chairman Burgess. In light of the
2827 gentleman's comments prior to the panel, I do want to clarify
2828 first that I signed and submitted a truth in testimony form
2829 prior to testifying today and was executed truthfully, so I
2830 am not sure what that question about, and that the American
2831 Action Forum itself is in compliance with all the best
2832 practice guidelines of the Independent Sectors Principles for
2833 Good Governance and Ethics, and certainly the legal
2834 requirements of the IRS as approved by this Congress. So I
2835 want to get that on the record.

2836 And lastly, when I say I testify and these views are my
2837 own, the forum has associate with it a vast number of experts
2838 with areas of expertise ranging from energy policy to
2839 education policy to any number of things, and I would not

2840 pretend to speak on their behalf and so these are my views as
2841 a researcher in both economic and health policy, and I want
2842 to emphasize that.

2843 I appreciate the chance to be here today. This is
2844 obviously a sweeping and important piece of legislation that
2845 arrives at a crucial moment in America's history, and that
2846 moment is one in which the top threat to our Nation, both its
2847 economic prosperity and its national security, is the
2848 projected future deficits and rising debt that we see under
2849 any reasonable projection over the next 10 years. My reading
2850 of the evidence and what I lay out in my testimony is that if
2851 one wishes to produce simultaneously rapid economic growth,
2852 which I believe is an imperative, given the large number of
2853 Americans who are out of work and the resources we will need
2854 to meet all our private and public demands and bring the
2855 fiscal situation under control, one needs to follow the
2856 successes around the globe and those successes are
2857 characterized by keeping taxes low and cutting government
2858 spending, in particular government payrolls and transfer
2859 programs, the kinds of spending that need to be cut, and from
2860 that perspective the Affordable Care Act goes in exactly the
2861 wrong direction. It raises \$700 billion in new taxes over
2862 the next 10 years and adds \$1 trillion in new transfer
2863 spending and continued past that.

2864 And indeed, the more general point is that those
2865 deficits and debt represent a huge impediment to economic
2866 growth. They are a promise of higher future taxes or higher
2867 fewer interest rates or both or in worst-case scenarios a
2868 financial crisis reminiscent of 2008, and I believe it is a
2869 mistake at this point in time to enact something like the
2870 Affordable Care Act which in my view will make our fiscal
2871 situation worse, not better. It is past common sense to
2872 believe that you can set up two new entitlement spending
2873 programs that grow at 8 percent a year as far as the eye can
2874 see. That is the CBO growth rates. Tax revenues won't grow
2875 that fast. The economy won't grow that fast. And increasing
2876 new entitlement spending as a result will make our budget
2877 problems worse, not better. We missed an opportunity to fix
2878 our real problems in Medicare and Medicaid, and that is a
2879 huge part of my reservation about this last.

2880 Past that, I will make a couple of points about the
2881 structure. As I laid out in some detail, the structure of
2882 the mandates, the employer mandate in particular, are an
2883 impediment to growth, particularly for small businesses where
2884 we see the mandate kick in at 51 employees, and because of
2885 the nature of the phase-outs, if you hire a higher quality
2886 labor force, you get subject to greater costs. The insurance
2887 market reforms themselves covering more benefits will make

2888 premiums more expensive. The variety of insurer fees, taxes
2889 on medical devices and other things will raise premiums, not
2890 lower them. That will compete with other resources that
2891 could be used for hiring or increasing wages and will hurt
2892 labor market performance. And many of the new taxes, in
2893 particular the 3.8 percent surtax on net investment income,
2894 are of exactly the same character we have seen in recent
2895 debates over broader tax policy. They will affect small
2896 businesses, taxes passed through entities, through the
2897 individual income tax, and as a result something like a
2898 trillion dollars of business income which is reported on
2899 individual taxes will be subject to higher tax rates and hurt
2900 economic performance.

2901 And so as I tried to lay out fairly carefully in my
2902 written submission, the Affordable Care Act has costs that at
2903 this point in time I view as unwise for this country. It
2904 expands deficits. It imposes new impediments to firm-level
2905 growth and more broadly represents bad economic policy at a
2906 time when we need to put a premium on growing faster as a
2907 Nation.

2908 I thank you, and I look forward to your questions.

2909 [The prepared statement of Mr. Holtz-Eakin follows:]

2910 ***** INSERT 3 *****

|
2911 Mr. {Pitts.} The chair thanks the gentleman and
2912 recognizes Mr. Cutler for 5 minutes.

|
2913 ^STATEMENT OF DAVID CUTLER

2914 } Mr. {Cutler.} Mr. Chairman, Mr. Pallone and members of
2915 the committee, I appreciate the invitation to appear before
2916 you today.

2917 The high level and rapid growth of medical spending in
2918 the United States is an enormous policy challenge and
2919 understanding the Affordable Care Act will affect that is
2920 extremely important. As we consider that, there are two
2921 principles that I think ought to guide that discussion.

2922 First, we need to eliminate wasteful spending, not
2923 valuable spending, so we need to be careful about how we cut.
2924 Second, we need to reduce the overall level of spending, not
2925 simply shift costs from one payer to another. Many proposals
2926 would shift costs around without reducing the overall level
2927 of spending. The key question is finding areas where we can
2928 accomplish both of those goals, where we can both reduce
2929 wasteful spending and not just shift costs. The health
2930 policy literature suggests there are three areas where that
2931 is possible. One is by improving the management of acute and
2932 postacute care for patients who are very sick and who receive
2933 more care than almost all physicians believe is necessary.
2934 Second is greater attention to prevention, where we spend a

2935 good deal of additional money by not having prevented
2936 disease, and third is reducing excessive administrative
2937 spending, which takes anywhere from 10 to 15 percent of
2938 medical care costs without bringing any commensurate
2939 benefits.

2940 To give you a sense of the total, most experts estimate
2941 that about \$750 billion to \$1 trillion a year is spent on
2942 medical care that has relatively low value to patients or no
2943 value to patients. The Affordable Care Act is designed to
2944 address those sources of inefficiency and it does so in a
2945 number of different ways. The philosophy behind the
2946 Affordable Care Act is straightforward. First, get the right
2947 information to people so that we know what works and what
2948 doesn't. As one friend of mine told me once, name a business
2949 that ever got better without knowing what it was doing. It
2950 is important to note that the HITECH provisions of the
2951 American Recovery and Reinvestment Act of 2009 are centrally
2952 linked to those of the Affordable Care Act because they
2953 create the foundation for learning that information.

2954 Second, you need to reward doing the right thing, not
2955 doing too much, not doing too little but doing the right
2956 amount. Physicians are frustrated, not because cannot treat
2957 individual patients, which they can, but because they know
2958 the system sends them off in directions that are

2959 counterproductive, that the only way to earn enough to keep
2960 their practice in business is to do more, to do things that
2961 are uncoordinated because coordination has expenses but no
2962 revenues and to not focus on prevention. The Affordable Care
2963 Act affects these incentives in a number of ways including
2964 direct payment innovation such as higher reimbursement for
2965 preventive care services, bundled payments for acute and
2966 postacute medical services, shared savings or capitation
2967 payments for accountable provider groups that assume
2968 responsibility for continuum of patients' care, pay-for-
2969 performance incentives for Medicare providers, increased
2970 funding for comparative effectiveness research, the
2971 Independent Payment Advisory Board and an Innovation Center
2972 in the Centers for Medicare and Medicaid Services to test and
2973 disseminate new care models, an excise tax on high-cost
2974 insurance plans to provide incentives to reduce wasteful
2975 spending there, increased emphasis on wellness and
2976 prevention. This set of policy reforms, I should note, is
2977 neither a Democratic list nor a Republican list. It draws on
2978 both sides of the spectrum. Former CMS or HCFA
2979 administrators from both Democratic and Republican
2980 Administrations stress these are the single most important
2981 steps we can take to reduce the amount of inefficient medical
2982 spending in the United States.

2983 In addition, in very little noticed provisions, the
2984 Affordable Care Act takes a major step to reduce burdens to
2985 administrative practices. Particularly sections 1104 and
2986 10909 lay the foundation for reducing administrative burden,
2987 which I believe could be reduced by half and save the
2988 American people approximately 10 percent of medical spending
2989 simply by getting of administrative costs, not services that
2990 are no longer needed.

2991 The effect of these changes on medical spending, on
2992 federal and State budgets and on job growth are profound. I
2993 estimate that when you are able to do this, the Affordable
2994 Care Act will reduce national medical spending by over \$500
2995 billion in the next decade. It will reduce the federal
2996 budget deficit by over \$400 billion and lead to the creation
2997 of 250,000 to 400,000 jobs annually.

2998 The urgent need is for this Congress and the
2999 Administration to work together on these ideas that are
3000 neither Democratic nor Republican ideas but they are ideas
3001 that come from across the spectrum of thinkers and people in
3002 the health care sector to work together to ensure that the
3003 Affordable Care Act is as successful as it can be.

3004 Thank you again for the opportunity to be here and I
3005 look forward to answering any questions you might have.

3006 [The prepared statement of Mr. Cutler follows:]

3007 ***** INSERT 4 *****

|
3008 Mr. {Pitts.} The gentleman's time is expired. The
3009 chair thanks the gentleman and recognizes Mr. Kennedy for 5
3010 minutes.

|
3011 ^STATEMENT OF PHILIP K. KENNEDY

3012 } Mr. {Kennedy.} Chairman Pitts, Ranking Member Pallone
3013 and distinguished members of the subcommittee, thank you for
3014 inviting me to testify before you today on the effects that
3015 this complex and erroneous reform will have on my business.
3016 My name is Phil Kennedy and I own Comanche Lumber Company,
3017 Incorporated, located in Lawton, Oklahoma. I am here to
3018 speak to you on behalf of the U.S. Chamber of Commerce today.

3019 My family began operating Comanche Lumber Company in
3020 1967. As Lawton grew, so did Comanche Lumber Company,
3021 eventually adding flooring and decorating products. What
3022 began as a simple lumberyard almost 44 years ago has become
3023 one of southwest Oklahoma's leading building material
3024 retailers. Today we remain independently owned and operated
3025 and a strong member and supporter of the Lawton community.
3026 However, the past few years have been difficult. As I waded
3027 through the new health care law, I began to grasp the
3028 mandates and their bearing on my business. I am deeply
3029 concerned about the future of my family's business.

3030 We have roughly 50 full-time employees, sometimes more,
3031 sometimes less, depending on the time of the year, because
3032 the bulk of our business occurs in the spring and summer

3033 months. Comanche currently offers a generous health plan to
3034 our employees. Over half of us take advantage of this
3035 coverage, including me. Comanche pays approximately 50
3036 percent of the premiums for our employees and offers two
3037 different high-deductible plan options, one with a \$1,500
3038 deductible and another more comprehensive plan with a lower
3039 \$1,000 deductible. Fortunately, we have been able to get
3040 good rates because Oklahoma has good free market laws that
3041 encourage competition among insurance companies for my
3042 business. However, premiums have been climbing. In order to
3043 prevent large increases, we have had to make tough choices
3044 which have included increasing our plans' deductibles and
3045 implementing a more tiered prescription drug plan.

3046 I understand the new law includes a number of new
3047 insurance rules billed as patient protections which require
3048 free preventive services and place restrictions on annual and
3049 lifetime limits, among other things. While new services may
3050 sound nice, we must realize they are not free. Instead,
3051 these new mandates will hamper the flexibility to modify
3052 plans' designs and restrict premium growth. Even with the
3053 flexibility we had over the past two years, our premiums have
3054 increased roughly 30 percent.

3055 There are many other aspects of the law that will
3056 increase Comanche's premiums including numerous taxes on

3057 health industries including taxes on medical devices,
3058 prescription drugs and small business health insurance that
3059 will be passed on to me and my employees in the form of
3060 higher premiums. While these new insurance rules and taxes
3061 are problematic, their impact pales in comparison to what
3062 will happen when the new mandates kick in. Beginning in
3063 January 2014, businesses with 50 or more employees will be
3064 punished with fines if they don't offer a certain level of
3065 coverage. Even more troubling is the fact that businesses
3066 that over qualified plans might still be fined just as much.
3067 It is ironic that the fine for businesses that don't offer
3068 coverage is \$2,000 per employee while the fine for a business
3069 that does offer coverage is \$3,000 per employee plus the cost
3070 of paying for coverage. Considering that Comanche's profits
3071 are about 1 percent, I am sure you can see how these fines
3072 would dramatically impact our business.

3073 It appears that to avoid these fines, I can either
3074 reduce my staff to less than 50 full-time employees or
3075 consider alternative staffing like employing part-time
3076 workers or outsourcing. I can't imagine why a law would
3077 incent these actions at a time when our economy is struggling
3078 to recover from such a terrible recession, but as a business
3079 owner my job is to protect the business, keep the doors open
3080 and sell building materials. I hope I will not have to

3081 seriously consider these choices but the health care law may
3082 force my hand as well as that as many other small business
3083 people.

3084 Small business owners were hopeful that health care
3085 reform would rein in health care costs and bend the so-called
3086 cost curve down. However, looking through the bill I don't
3087 see any real medical liability reform other than the vague
3088 acknowledgement that says States should be encouraged to
3089 develop and test alternatives. It seems to me that if really
3090 want to address rising costs, medical liability reform should
3091 be tackled head on. We need to fix the existing civil
3092 litigation system instead of merely saying it needs to be
3093 fixed. Real health reform would include ideas like this.
3094 Instead, the law just taxes, subsidizes and dramatically
3095 increases my paperwork burdens by provisions such as the 1099
3096 reporting.

3097 In conclusion, I understand that given the existing
3098 political realities in Washington, a total repeal of the
3099 health care law is an unlikely proposition for now. However,
3100 I am hopeful that this subcommittee and your colleagues in
3101 the House and Senate will start on repairing and eliminating
3102 the most erroneous mandates and provisions starting with the
3103 repeal of the employer mandate. Your decisions can either
3104 help or hinder us. The law you create can either foster an

3105 environment to give small business owners greater confidence
3106 and certainty to grow and generate new jobs or one that does
3107 just the opposite. Regrettably, the new health care law is
3108 already doing the latter. Congress needs to take action to
3109 rectify this problem.

3110 Thank you for the opportunity to testify and I look
3111 forward to your questions.

3112 [The prepared statement of Mr. Kennedy follows:]

3113 ***** INSERT 5 *****

|
3114 Mr. {Pitts.} The chair thanks the gentleman. The gm's
3115 time is expired. The recognizes the gentleman, Mr. Poore,
3116 for 5 minutes for an opening statement.

|
3117 ^STATEMENT OF RICK POORE

3118 } Mr. {Poore.} Chairman Pitts, Ranking Member Pallone and
3119 members of the subcommittee, it is nice to see so many of you
3120 here. Thanks for having me to testify today. My name is
3121 Rick Poore and I own DesignWear, a screen printing and
3122 embroidery business in Lincoln, Nebraska. I am also a member
3123 of the Main Street Alliance, a network of small businesses,
3124 as well as the Lincoln Independent Business Association.

3125 I have been a small business owner for 17 years and I
3126 started with three employees and now we have 29. I offer
3127 insurance to my employees and pay for part of it. I would
3128 rather have my employees worried about the product we are
3129 producing rather than whether Timmy can get his medicine and
3130 put food on the table at the same time. But every year our
3131 premiums go up, sometimes over 30 percent over the last 10
3132 years. At the same time, in an effort to keep things
3133 affordable, our benefits were whittled away until we had
3134 nothing left but the insurance equivalent of a fig leaf.
3135 Only in the last 2 years have I been able to keep premiums
3136 under control without giving up benefits and in fact adding
3137 benefits.

3138 The country counts on small businesses to create jobs.

3139 You hear it all the time. If you want to talk about job
3140 killing, you look no further than the runaway health care
3141 costs that I have experienced. Small businesses' ability to
3142 create jobs has been seriously undermined by insurance costs
3143 more than doubling in 10 years. We saw a lot of years of
3144 steep increases with no tools to do anything about it.
3145 Without a lot of choice and bargaining power, I stood a
3146 better chance at a carnie game at the midway than I did
3147 against my insurance company.

3148 The Affordable Care Act is finally changing that in my
3149 favor. The argument that the health care law will cost our
3150 economy jobs ignores the lessons of the last decade where it
3151 was the lack of action by Congress to curb skyrocketing costs
3152 leaving small businesses in the lurch. The real threat to
3153 job creation is the threat of repealing this law and going
3154 back to a system that stacks the deck against me, diverting
3155 money away from investment and growth.

3156 Concerning the employer responsibility requirement, we
3157 have got to remember two facts. First, over 95 percent of
3158 our Nation's businesses have less than 50 workers and won't
3159 be impacted. Second, 96 percent of businesses with more than
3160 50 workers already offer coverage. If some larger businesses
3161 complain that paying for health coverage will harm their
3162 ability to create jobs, remember that when they don't pay,

3163 the rest of us pay their way for them and that hurts my
3164 ability to create jobs. Imagine if my competition decided
3165 they didn't want to pay wages anymore but I was held
3166 responsible for their payroll. That is effectively what we
3167 are doing with cost shifting in health care.

3168 Recent data from insurers in Nebraska and Kansas City,
3169 national companies like United Health Group and Coventry,
3170 show encouraging increases in small business coverage. The
3171 tax credits are already helping small businesses offer
3172 coverage, save money and plow those savings back into
3173 businesses. We will get even more help when the exchanges
3174 open. I need that kind of broad risk pooling and bargaining
3175 power and a Nebraska exchange to lower costs.

3176 I know insurance lobbyists are trying to blame recent
3177 rate increases on the new law but insurers find an excuse to
3178 raise rates every year. If they are raising them again, then
3179 it is in spite of the law, not because of it. Even insurance
3180 executives admit this. One in Massachusetts said recently
3181 that only one point of his company's increases this year were
3182 due to the new law.

3183 Small business people, in conclusion, above all are
3184 problem solvers. We wake up every day looking for a better
3185 way to do our business. We take whatever pitch is thrown at
3186 us and we do what we can with it. My best employees become

3187 problem solvers for me. Problem solving is what Americans
3188 send you guys to Washington to do, and there is a funny thing
3189 about solutions I have found is that most solutions aren't
3190 perfect right out of the box. You don't scrap them; you make
3191 a start in the right direction and then you change course and
3192 correct the course as you need. One thing for sure, our
3193 country and our economy can't afford to go back to a health
3194 system that doesn't work for small business. I already know
3195 that it won't work. We have got to move forward.

3196 When I was first approached about this, I had to think
3197 about what year I started the business, and I was talking to
3198 my wife, and as a habit I don't think a lot of businesspeople
3199 look back that much. I think they look forward as much as
3200 they can. There is just not a lot of time for looking back.
3201 So that is what I am asking you guys to do. You can call it
3202 Obamacare if you like but I kind of call it Rick Care. By
3203 moving forward, you can level the playing field for small
3204 businesses allowing us to focus on creating jobs and building
3205 our local economies.

3206 Thanks again for having me, and it is something I am not
3207 really used to doing, so thanks.

3208 [The prepared statement of Mr. Poore follows:]

3209 ***** INSERT 6 *****

|
3210 Mr. {Pitts.} The chair thanks the gentleman and
3211 recognizes the gentleman, Mr. Schuler, for 5 minutes.

|
3212 ^STATEMENT OF LARRY SCHULER

3213 } Mr. {Schuler.} Thank you for this opportunity to
3214 testify on the new health care law on behalf of the National
3215 Restaurant Association. My name is Larry Schuler and I am an
3216 independent restaurateur operating a fourth-generation family
3217 business.

3218 Small businesses dominate the industry with more than
3219 seven out of ten eating and drinking establishments being
3220 single-unit operators. We also employ a high proportion of
3221 part-time, seasonal and temporary workers. Our workforce is
3222 typically young with nearly half under the age of 25. Growth
3223 and success in the restaurant industry means opening more
3224 restaurants and locations, which in turn means jobs in our
3225 communities.

3226 When I closely examined the impact of this new health
3227 care law on my businesses, I began to reexamine my expansion
3228 plans and may now not take an additional growth on. My
3229 written testimony submitted for the record outlines some
3230 specific fixes the industry is calling for but I would like
3231 to use my time to outline for you how the new health care law
3232 affects my business specifically.

3233 My businesses are typical of many restaurants in our

3234 industry. We have a large group of seasonal employees that
3235 include a number of college students, some who work
3236 seasonally for us multiple times per year. We are very close
3237 to the 50 full-time equivalent worker threshold. How many
3238 hours our part-time employees work will determine if we are a
3239 large applicable employer or not.

3240 What this means for my restaurants and our employees
3241 that depending on the time of year and the number of hours
3242 worked by our team, we could be considered a large applicable
3243 employer and subject to the most stringent employer mandates
3244 in the law some months but not in others. In addition, our
3245 employees could be full-time employees one month and not
3246 part-time employees the next. Using our 2010 employment
3247 numbers, the calculations for our largest location would put
3248 us over the 50 full-time-equivalent threshold. In 2010, on
3249 the average, we employed 33 full-time employees and 26 full-
3250 time equivalents working part time hours for a total of 59
3251 full-time equivalents that place us over the threshold and
3252 subject us to the coverage and penalty requirements of the
3253 law. We employ 24 seasonal part-time employees and five
3254 seasonal full-time employees as well for a total of 38 full-
3255 time employees to whom we would be required to offer coverage
3256 under the new law as a large employer. Should all 38
3257 employees opt in to the coverage, we would see a 282 percent

3258 cost increase to the business over current premiums from
3259 \$2,067 monthly or \$24,808 annually today to \$7,892 a month or
3260 \$94,669 annually. If we chose not to offer coverage at all,
3261 we would pay an average of \$1,375 monthly or \$16,500 annually
3262 in penalties. The penalties would be less than what we are
3263 paying for health care now.

3264 Faced with these very large increases in coverage cost
3265 which do not take into consideration the likely premium
3266 increases, it will be extremely difficult for us to absorb
3267 these costs and continue offering coverage. We cannot raise
3268 many prices high enough to cover these costs and to do so
3269 would drive away customers who are just beginning to return
3270 to our tables. Our only option would be to closely manage
3271 our workforce hours to be able to eliminate ten full-time
3272 equivalents from our staff and remain below the 50 full-time-
3273 equivalent large employer threshold.

3274 The industry will begin to closely manage employees'
3275 hours to 29 or less. In practice, it will mean a larger
3276 employer base working less hours, no more than 25 hours to
3277 avoid bumping into the cap, and an increase in labor and
3278 training costs. For employees, it will mean the need to get
3279 a second and third job to make up the lost hours and thus
3280 income.

3281 Another issue that impacts my situation is the lack of

3282 consistency in compliance timelines. The new law allows for
3283 a maximum waiting period of 90 days before coverage must be
3284 offered or an employer is considered as not offering
3285 coverage. However, a seasonal employee is defined as working
3286 120 days or less. The new law requires that a large
3287 applicable employer offer seasonal employees who work full
3288 time coverage. One of my businesses is strictly seasonal,
3289 open 107 days a year from the week before Memorial Day
3290 weekend until the week after Labor Day weekend. In 2014, I
3291 will be required to offer my seasonal full-time employees
3292 coverage from day 91 through day 107 or pay the penalty for
3293 that month on each of them for not offering coverage.

3294 Mr. {Pitts.} Could you wrap up?

3295 Mr. {Schuler.} Without legislation change, I would
3296 probably shorten the number of days.

3297 I thank you again for the opportunity to testify today
3298 on the true costs of the new health care law and its negative
3299 impact on the jobs of the restaurant industry and my business
3300 in particular. I look forward to addressing your questions.

3301 [The prepared statement of Mr. Schuler follows:]

3302 ***** INSERT 7 *****

|
3303 Mr. {Pitts.} The chair thanks the gentleman. I thank
3304 the panel for your opening statements. I will now begin the
3305 questioning and recognize myself for 5 minutes, and I will
3306 start with you, Mr. Schuler.

3307 You mentioned you are considering closing your seasonal
3308 operation for a couple of weeks in order to avoid some of
3309 PPACA's requirements. You may continue to elaborate further
3310 on that.

3311 Mr. {Schuler.} Thank you. To avoid the complexity
3312 costs of being open those additional 17 days, it will be
3313 easier for me to manage the business to that shortened time
3314 period so I will not be required to do that.

3315 Mr. {Pitts.} Mr. Kennedy, in your testimony you
3316 mentioned that PPACA provides the wrong incentives for job
3317 creation at a time when we are still struggling to recover
3318 from a recession. Specifically, you state that PPACA
3319 incentivizes you to get below the employer mandate threshold
3320 of 50 workers. Would you elaborate further on that, please?

3321 Mr. {Kennedy.} We definitely would be considering that
3322 because of the new regulations and what that entails as far
3323 health insurance, and are currently even looking at that as
3324 we go about making sure that what levels we have as far as
3325 employees and that has become a decision factor in our

3326 progressing forward in growth whereas used to we would want
3327 to grow as much as possible. Now as we grow above 50 we have
3328 another item we have to consider and how that would impact us
3329 as far as cost and whether those actual costs can be offset
3330 by profits that we make.

3331 Mr. {Pitts.} Thank you.

3332 Mr. Holtz-Eakin, I would like to go through a few points
3333 regarding the score of PPACA to give us some broader context
3334 of what these numbers mean, and I would also like to explore
3335 what burdens have been imposed on taxpayers and States that
3336 by their nature wouldn't be reflected in CBO's score. CBO
3337 estimates that \$86 billion in premiums from the new long-term
3338 care program known as the CLASS program are used to offset
3339 the cost of the new entitlement in Medicaid expansion in
3340 PPACA. Can those funds be used to pay for both PPACA and
3341 future CLASS program benefits?

3342 Mr. {Holtz-Eakin.} No, they cannot. They will be gone
3343 in the first 10 years and additional funds will have to be
3344 found after that.

3345 Mr. {Pitts.} All right. CBO estimates that \$53 billion
3346 in Social Security payroll taxes are used to offset the cost
3347 of the new entitlement and Medicaid expansion in PPACA. Can
3348 those funds be used to pay for both PPACA and future Social
3349 Security benefits?

3350 Mr. {Holtz-Eakin.} Same story is true. Those will be
3351 gone in the first 10 years and additional funds will be
3352 needed to be found to make good on Social Security promises.

3353 Mr. {Pitts.} Now, some proponents of the law have
3354 claimed that Medicare cuts included in PPACA can both pay for
3355 new entitlement spending and finance future benefits. Is
3356 this an accurate statement? Would you elaborate on that?

3357 Mr. {Holtz-Eakin.} It is not accurate. Federal
3358 accounting notwithstanding, the money will be spent only once
3359 and cannot both extend the Medicare program and pay for the
3360 insurance subsidies.

3361 Mr. {Pitts.} Proponents of the bill argue that PPACA
3362 costs under \$1 trillion over 10 years during its passage.
3363 However, the CBO score of the bill was artificially low
3364 because the other side of the aisle delayed the bill's major
3365 spending until 2014. Now, we recently found out that with
3366 just 2 more years of spending, PPACA's spending estimates
3367 shot up to \$1.44 trillion. However, this number still
3368 doesn't account for the full 10 years of implementation. If
3369 we extrapolate CBO's estimates to the full 10 years, what
3370 would you estimate the real cost of the bill to be?

3371 Mr. {Holtz-Eakin.} I think over a full 10 years, fully
3372 implemented, this bill is easily going to exceed \$1.6, \$1.8
3373 trillion.

3374 Mr. {Pitts.} All right. The original House health care
3375 bill included the doc fix but the provision was taken out
3376 towards the end of the process. This is despite the fact
3377 that PPACA uses Medicare cuts to fund a new entitlement
3378 program rather than fix the SGR that we all agree is a real
3379 problem. How much did the removal of the SGR artificially
3380 lower the cost of the health care law?

3381 Mr. {Holtz-Eakin.} As I recall, it reduced it by about
3382 \$250 billion over the first 10 years.

3383 Mr. {Pitts.} How much?

3384 Mr. {Holtz-Eakin.} By about \$250 billion in the first
3385 10 years.

3386 Mr. {Pitts.} And the score for the health care law also
3387 did not include nearly \$115 billion in the discretionary
3388 program cost to run Obamacare. Is that not correct?

3389 Mr. {Holtz-Eakin.} That is my understanding, yes.

3390 Mr. {Pitts.} The chair thanks the panel and will
3391 recognize now the ranking member, Mr. Pallone, for 5 minutes
3392 for questions.

3393 Mr. {Pallone.} Thank you, Mr. Chairman. I am going to
3394 try to get one question in for Mr. Cutler and one for Mr.
3395 Poore, so bear with me if we can try to split the time
3396 between you.

3397 Let me start with Mr. Cutler. Opponents of the

3398 Affordable Care Act claim that the law will kill jobs. They
3399 argue that requiring employers to offer health insurance and
3400 to improve their benefits will increase the costs of labor.
3401 Now, I don't think that is true. I think that in fact the
3402 Affordable Care Act helps to create thousands of jobs in the
3403 public and private health care sectors. In June 2010, funds
3404 were allocated to train more than 16,000 new primary care
3405 providers including physicians, physician assistants and
3406 nurses. It seems logical that the newly insured 30 million
3407 people will need doctors, nurses and other health care
3408 personnel to meet their medical needs. Now, the Republican
3409 critics say they fear the country might not have enough
3410 doctors and hospitals to serve those people but my answer is
3411 a growing workforce, more jobs and improved efficiencies.
3412 Specifically, less spending on health care premiums will free
3413 up money for business to invest in a new workforce. Now, the
3414 CBO said today that to the extent that changes in the health
3415 insurance system lead to improved health status among workers
3416 and the nation's economic productivity would be enhanced.

3417 Dr. Cutler, you have done work on what effects the bill
3418 will have on the job market. Your study predicts that the
3419 health reform will strengthen the economy and the job market
3420 by creating 250,000 to 400,000 jobs a year for the next
3421 decade. I just want you to elaborate on your study and

3422 explain to us how the health care reform is a job creator,
3423 not a job killer, and talk about some of the other factors
3424 that I mentioned.

3425 Mr. {Cutler.} Thank you, Mr. Pallone. Health insurance
3426 costs are an absolutely critical indicator for hiring.
3427 Industries in which more businesses are providing health
3428 insurance to their workers have grown less rapidly than
3429 industries where fewer employers provide health insurance,
3430 and that is particularly true in the United States in
3431 comparison to other countries. And so the central, the
3432 fundamental issue about any health care reform is what will
3433 it do over time to the cost that businesses face for health
3434 insurance. As I discussed in the testimony and in the
3435 opening statement, the Affordable Care Act contains
3436 essentially all of the tools that economists and policy
3437 analysts have put forward for reducing the costs of medical
3438 care over time. It is my belief that what those provisions
3439 will do is to reduce premiums by the end of this decade by
3440 about \$2,000 per person relative to what they would have
3441 been. That will free up money for firms that are now
3442 providing insurance, that are thinking about providing
3443 insurance but are on the margin, and allow them to take that
3444 money and use that to grow businesses, to pay higher wages,
3445 to do anything of the things that businesses would like to do

3446 that they have been stifled from doing.

3447 In addition, by creating a universal coverage system, we
3448 will no longer have people locked into jobs because they are
3449 worried about getting insurance or not starting new
3450 businesses because a member of their family is ill and won't
3451 be able to afford it and all the rigidities that come from
3452 people being scared about health care, which is very common,
3453 will disappear and that will create more entrepreneurship in
3454 the economy as well.

3455 Mr. {Pallone.} All right. Thank you. And thank you
3456 for also limiting your answer so I can get to Mr. Poore.

3457 Mr. Poore, Rand estimates that small businesses will
3458 increasingly offer health coverage--now we are talking about
3459 the Affordable Care Act. Rand estimates that small
3460 businesses will increasingly offer health coverage because
3461 they will have the same purchasing power as large employers
3462 as well as access to more choices. It also reports, Rand
3463 reports, that the Affordable Care Act will increase the
3464 number of small employers, those under 50, who offer health
3465 insurance up from, say, 57 percent to 85 percent. So
3466 basically they are talking about all the different advantages
3467 that the Affordable Care Act would provide.

3468 A lot of this comes from the State exchanges once those
3469 State exchanges are up, so I just wanted you to describe how

3470 you think these State exchanges will affect your business and
3471 other small businesses in the country.

3472 Mr. {Poore.} Well, first of all, I think that we are
3473 already starting to see more small businesses getting
3474 coverage. Statistics are showing that from Coventry and
3475 several others. But for me alone, every year my insurance
3476 guy would come in and say listen, your rates are going up 16
3477 percent or 23 percent, and I would say, you know, Troy, why
3478 is that. And he was like, well, you are just a little group.
3479 And so I said Troy, if I had 10,000 people in my risk pool,
3480 would my rates go down; well, absolutely. So that is where
3481 the exchanges come in for me. You know, if I can shop and
3482 get--once again, just going back for a minute, Troy would
3483 also come in and he would give me two companies, three plans
3484 from each, and that was my choice, but a big company or like
3485 a service employees, not service employees but like public
3486 employees, the State offers this broad--they almost already
3487 have exchanges running that I don't have access to so I am
3488 kind of hamstrung that way right now.

3489 In the last 2 years, I have been able to keep my rates
3490 from going up. I have actually added some benefits. My
3491 rates have gone up over 2 years 16 percent. That is the
3492 lowest increase in rates that I have ever seen in 11 or 12
3493 years of offering insurance, and the only reason they went up

3494 is because I was putting--I was lowering my deductible and I
3495 was lowering my out-of-pocket, so if I would have left it the
3496 same, I might actually be level, which, believe me, if there
3497 is anybody that has ever--I have never had a situation where
3498 my rates didn't go up. It a pretty phenomenal statement to
3499 be able to make.

3500 Mr. {Pallone.} Thank you.

3501 Dr. {Burgess.} [Presiding] The gentleman's time is
3502 expired. I recognize myself for 5 minutes for the purpose of
3503 questions.

3504 Mr. Holtz-Eakin and Mr. Cutler, you have both been at
3505 this a long time. You both remember the summer of 2009,
3506 specifically August of 2009. My little sleepy town hall
3507 meetings that I would hold typically attracted one or two
3508 dozen people, attracted 1,000 or 2,000 people. They were
3509 concerned about what they saw the Congress of the United
3510 States doing but what I heard over and over again was, number
3511 one, if you are going to do anything, please don't mess up
3512 what is already working for arguably 65 percent of the
3513 country; if you have to fix some things for some people, do
3514 so without being disruptive, and number two, if you are going
3515 to do anything at all, could you please help us with cost.
3516 So I would ask you both to be brief as you can but how did we
3517 do on those two requests? Mr. Cutler, if you will go first

3518 and then we will go to Mr. Holtz-Eakin. Did we mess it up
3519 for people and did we hold down costs?

3520 Mr. {Cutler.} I believe we did very well on both
3521 counts.

3522 Dr. {Burgess.} All right. Let me ask Mr. Holtz-Eakin.
3523 How did we do on both counts?

3524 Mr. {Holtz-Eakin.} I think you are oh for three
3525 actually.

3526 Dr. {Burgess.} Well, Mr. Cutler, let me just ask you,
3527 how is it indicative that we didn't alter the system for
3528 people who thought it was working, thought it was working
3529 okay, although they are concerned about cost but now we have
3530 got, what is it, 1,040 waivers. We have got whole States
3531 asking for waivers. We have got Anthony Weiner of New York
3532 asking for a waiver, for crying out loud. Is this indicative
3533 of a system that is well functioning and has matured to the
3534 point where you think it is in good shape?

3535 Mr. {Cutler.} What we are seeing is the difficulties of
3536 the current system as they are being mapped out. Remember,
3537 this legislation takes effect over a number of years.

3538 Dr. {Burgess.} Correct.

3539 Mr. {Cutler.} Mr. Poore said the creation of the
3540 exchanges will be a very big--

3541 Dr. {Burgess.} Let me ask you another question.

3542 Mr. {Cutler.} --factor for small businesses but those
3543 come in a few years.

3544 Dr. {Burgess.} Well, Dr. Holtz-Eakin, do you have an
3545 opinion as to is the system working well?

3546 Mr. {Holtz-Eakin.} No. I mean, in the end the
3547 fundamental issue was the size of the Nation's health care
3548 bill. Insurance was just a layer on top of that. And so you
3549 could have the world's finest insurance exchanges but we
3550 haven't solved the fundamental problem. As a result,
3551 insurance will continue to get more expensive and that is
3552 what the American people are upset about.

3553 Dr. {Burgess.} You know, one of the things I never
3554 understood, we had these hearings when Mr. Pallone was
3555 chairman and people would come in and talk to us about
3556 expanding Medicaid and the various federal programs and
3557 public options. We never asked Mitch Daniels to come in here
3558 and talk to us about how he was able to hold down costs for
3559 his State employees with the Healthy Indiana plan by 11
3560 percent over 2 years. Those same 2 years, standard PPO
3561 insurance was going up 7 or 8 percent. Medicare and
3562 Medicaid, as it turned out retrospectively, were going up 10
3563 and 12 percent. You just have to ask yourself why you
3564 wouldn't look to the States as laboratories and found out
3565 what is working and see if perhaps there is some

3566 applicability to the greater world at large and perhaps we
3567 wouldn't be so disruptive to Mr. Kennedy and Mr. Schuler.
3568 Mr. Poore is apparently doing okay with the system as it is
3569 written today.

3570 Now, Mr. Cutler, you were a fan of the Independent
3571 Payment Advisory Board but you know virtually everyone on the
3572 House side was not, and in my opinion, the Independent
3573 Payment Advisory Board really is indicative of one of the
3574 problems with the Patient Protection and Affordable Care Act
3575 in that the House bill, as bad it was, never got a fair
3576 hearing in a conference committee. The Senate passed a bill
3577 before Christmas Eve. They lost a critical Senate vote in
3578 Massachusetts 2 weeks later, and it was, you just have to
3579 pass this thing in the House, and as I alluded to earlier,
3580 the Senate bill did have a House number and it previously
3581 passed the House as a housing bill so that actually
3582 structurally was able to work and also conveniently, since
3583 there was a lot of tax increase in the bill, it started in
3584 the House of Representatives technically, although it
3585 actually did not, but what do you make of the Independent
3586 Payment Advisory Board now? You said it would be apolitical
3587 and yet you have groups that are opting or politicking to be
3588 left out of it. Is it working?

3589 Mr. {Cutler.} One of the issues with Medicare has been

3590 that it has been very difficult to make the program
3591 modernized when every single change has to go through the
3592 Congress at a glacial pace, and I think that has been a
3593 complaint from both sides of the aisle.

3594 Dr. {Burgess.} But in expediting, by saying if Congress
3595 can't agree what those cuts are going to be, they reject the
3596 current cuts that are presented, they can't come up with
3597 their own cuts, and on the following April 15th the Secretary
3598 just implements what the board put forward. I don't know.
3599 That is giving up a lot of constitutional authority that I
3600 think many of us, at least on the Republican side, have
3601 problems with, and I rather suspect our friends on the
3602 Democratic side of the dais had difficulty as well.

3603 Cost shifting, yes, the uninsured, Dr. Holtz-Eakin,
3604 caused some cost shifting but what about the cost shifting
3605 from Medicare and Medicaid and what did we do with the vast
3606 expansion of Medicaid into the Affordable Care Act? Are
3607 those people going to have a doctor or are they still going
3608 to show up at the same emergency room they have always gone
3609 to?

3610 Mr. {Holtz-Eakin.} I think CMS Actuary Foster evinced
3611 some concern about the future of Medicare, about access to
3612 providers, given the cost shifting that goes on there, 77
3613 cents on the dollar relative to private payers. I am deeply

3614 pessimistic about the future of Medicaid where outside of the
3615 near term federal pickup of the tab at 50 cents on the
3616 dollar, we are simply not going to see access, particularly
3617 to primary care physicians, and we know they show up in ERs
3618 at far too high a rate. So to use that as the mechanism for
3619 coverage expansion I think was one of the unwise choices of
3620 the act.

3621 Dr. {Burgess.} Yes, why wouldn't they show up to the
3622 ER? It is the same place they used to go when they were
3623 uninsured. They see the same doctor. They get the same
3624 hospital room. In fact, many will not even sign up for
3625 Medicaid because why go to the bother, what I have always
3626 done is go to the emergency room and get the care.

3627 My time is expired. I will recognize the gentleman from
3628 Louisiana, Dr. Cassidy, for 5 minutes.

3629 Dr. {Cassidy.} We in Louisiana have great affection for
3630 Bo Pelini. I wish you all the best in the Big Ten.

3631 Mr. {Poore.} It has been great.

3632 Dr. {Cassidy.} As long as you don't play LSU, we are
3633 rooting for you, buddy.

3634 Mr. {Poore.} It has been great. He is a great guy.

3635 Dr. {Cassidy.} Listen, how many employees do you have?

3636 Mr. {Poore.} Twenty-nine.

3637 Dr. {Cassidy.} Okay. As I read this bill, if you have

3638 25 employees or less, average income of \$25,000, you get a 50
3639 percent tax credit.

3640 Mr. {Poore.} I should fire four of them.

3641 Dr. {Cassidy.} And if you lose four of them by whatever
3642 reason, would you go back up to 29 and lose this tax credit?

3643 Mr. {Poor.} Absolutely. I can't do the business I have
3644 got right now.

3645 Dr. {Cassidy.} That is good. Others tell me
3646 differently, but thank you for your response.

3647 Mr. Cutler, earlier when I was speaking with Mr. Foster,
3648 he accepted the premise of that 2008, I think, Milliman
3649 article that there is a hydraulic effect, particularly as we
3650 see the Gingrey chart where there is this cliff and there is
3651 going to be this inevitable increase. In fact, I am struck
3652 in Nebraska, they are estimating that in 2014 to 2019 there
3653 will be 189 million increased dollars spent on Medicaid on
3654 Nebraska, so undoubtedly an increased tax burden. You just
3655 disregard that. I am not quite sure why.

3656 Mr. {Cutler.} Thank you for the question. What we have
3657 seen in the past few years in both Medicare and Medicaid and
3658 private insurance is that the number of services people
3659 receive goes up and as a result governments and private
3660 insurers lower the rates that they pay. What will work in
3661 the health care system is to run that in reverse, to figure

3662 out which services are not worth--

3663 Dr. {Cassidy.} So you are postulating that we are going
3664 to have more efficient delivery of care, and even though we
3665 are taking out according to that cliff, we are going to pay
3666 physicians 31 percent less than they currently receive,
3667 somehow we are going to be held harmless.

3668 Mr. {Cutler.} Our best guess of most experts is that at
3669 least one-third of medical spending is completely wasteful
3670 and the--

3671 Dr. {Cassidy.} Now, I am struck--just because we are
3672 short of time, I don't mean to be rude, obviously if we could
3673 pick out that one-third, wouldn't it be great. It is just so
3674 hard to pick one that one-third. I am a practicing
3675 physician. I still see patients. It is that one-third that
3676 is critical, eye of the beholder, if you will. Do you see
3677 accountable care organizations as being one of the mechanisms
3678 by which we squeeze out this waste?

3679 Mr. {Cutler.} I do believe that is one of the
3680 mechanisms.

3681 Dr. {Cassidy.} Now, I am struck that there is an
3682 article published frankly last week in the New England
3683 Journal of Medicine in which these people look at the
3684 accountable care organization and says that basically looking
3685 at the CMS demonstration project, which was structured

3686 frankly to find a positive result, and indeed they found that
3687 over 3 years they all lost money. Eight of the ten in
3688 physician groups and the demonstration did not receive any
3689 shared savings in the first year. In the second year, six of
3690 ten did not. In the third, half of the participants were
3691 still not eligible, and they point out that these were
3692 structured, these were already existing groups that had gamed
3693 the system to have a positive result. They all lose money
3694 over the first 3 years. I don't see these ACOs as this huge,
3695 efficiency-generating cost savings. This article suggests
3696 not. Why do you hold that position?

3697 Mr. {Cutler.} What we know is that some organizations
3698 are able to do extremely well including if you look at, say,
3699 the Mayo Clinic or the Cleveland Clinic or Geisinger Health
3700 Care.

3701 Dr. {Cassidy.} Which I think were included here,
3702 certainly Geisinger was.

3703 Mr. {Cutler.} Now, those tend not to be in those
3704 organizations. Most of the demonstrations were not there.
3705 So those organizations have figured out how to improve the
3706 quality of care and save money. Other organizations are
3707 still learning how. The failures are generally because they
3708 don't have the right information systems in place because
3709 they still work off of fee-for-service payment basis and so

3710 the doctors still know that doing more is the way you earn
3711 more or because they haven't figured out how to efficiently
3712 manage the practices that are involved.

3713 Dr. {Cassidy.} Excuse me. I am not seeing the list of
3714 people here but I actually think it has groups that were well
3715 established but I do think I am taking from you that what you
3716 are arguing is the theoretical benefit, nothing that has been
3717 actually demonstrated. If you will, it is a hope by and by
3718 but it is not the experience currently.

3719 Mr. {Cutler.} Actually it is the experience of a number
3720 of organizations across the country.

3721 Dr. {Cassidy.} I haven't seen that data, and this is a
3722 review of those CMS demonstration projects. If you can
3723 refute this article, I would appreciate that.

3724 Mr. {Cutler.} The Institute of Medicine just published
3725 a lengthy volume in which they went through a number of the
3726 successful examples and they estimated--

3727 Dr. {Cassidy.} I have not seen a single ACO article
3728 that suggests that, but please forward that.

3729 Mr. {Cutler.} I will indeed.

3730 Dr. {Cassidy.} Secondly, regarding preventive services,
3731 again, I am a physician, preventive services have never been
3732 shown to save money unless it is immunizations or maybe the
3733 management of obesity by increasing premiums for those who

3734 don't lose weight. This article actually eviscerates that
3735 ability. And so when you postulate that preventive services
3736 will save money, there is no empiric data for that.

3737 Mr. {Cutler.} There are different kinds of preventive
3738 services. The ones which clearly save money are, for
3739 example, tertiary prevention, that is someone is in the
3740 hospital with congestive heart failure or COPD. We know that
3741 if a nurse visits them within a couple of days after the
3742 hospital, they are less likely to be readmitted in the
3743 hospital. You can take the readmission rate--

3744 Dr. {Cassidy.} Your testimony mentions colonoscopies,
3745 cholesterol checks, but that hasn't really been shown. You
3746 are speaking about reducing readmissions?

3747 Mr. {Cutler.} Some of those, if you look at the
3748 studies, actually do save money. Some just extend life but
3749 don't save money.

3750 Dr. {Cassidy.} Which of those would save money?
3751 Because colonoscopy does not. I am a gastroenterologist and
3752 so--

3753 Mr. {Cutler.} Obesity reduction saves money.

3754 Dr. {Cassidy.} Now, the obesity reduction actually
3755 saves money, according to people like Safeway by increasing
3756 premiums for those who do not enter into a weight-loss
3757 reduction program but I am struck that the PPACA basically

3758 does away with that. And so it seems like you are endorsing
3759 something that PPACA does away with.

3760 Mr. {Cutler.} I am not sure I agree with that. The
3761 Affordable Care Act has the discount for wellness management,
3762 30 percent which can increase to 50 percent.

3763 Dr. {Cassidy.} So I will look at that and if I am wrong
3764 I will stand corrected, but it is my understanding we no
3765 longer decrease premiums for those who do not participate in
3766 stop smoking or obesity reduction. Thank you very much.

3767 Mr. {Pitts.} The gentleman's time is expired. The
3768 chair recognizes the gentleman from Georgia, Dr. Gingrey, for
3769 5 minutes.

3770 Dr. {Gingrey.} Mr. Chairman, thank you.

3771 I am going to address my first question to Mr. Cutler.

3772 Is it Mr. Cutler or Dr. Cutler?

3773 Mr. {Cutler.} I am officially a Dr. Cutler but I am
3774 happy either way.

3775 Dr. {Gingrey.} Well, the brain power sitting at the
3776 witness table, I feel a little sheepish calling any of you
3777 Mister unless you are Brits, but in any regard, I will
3778 address my first question then to Mr. Cutler.

3779 In the March 2010 Wall Street Journal op-ed, you wrote
3780 that there have been several broad ideas offered to bend the
3781 cost curve over the last decade including medical malpractice

3782 reform. As you might know, I have a very keen interest in
3783 that as a practicing physician and Member of Congress. Do
3784 you believe that this Congress, unlike the last, should
3785 finally address medical malpractice reform, and what is its
3786 potential impact on health care cost?

3787 Mr. {Cutler.} There are a number of areas in which I
3788 think the legislation could be strengthened, and that is one
3789 where I personally would strengthen the legislation some.
3790 Most of the estimates of the impact of malpractice reform on
3791 medical spending suggest that the direct spending impact and
3792 the reduction in defensive medicine would be relatively
3793 small, on the order of 4 percent or so. What I think it is
3794 important for is in sending a signal to physicians and the
3795 physician community that we are serious about freeing them to
3796 practice care in the right way, not in the way that just
3797 earns you money.

3798 Dr. {Gingrey.} Well, let move on on that same question
3799 then, Mr. Cutler. I will move to Mr. Holtz-Eakin, our former
3800 CBO director, and ask really the same question. What Mr.
3801 Cutler said doesn't really jibe with what I think my fund of
3802 knowledge tells me in regard to defensive medicine and the
3803 actual cost. I mean, even the CBO, Mr. Elmendorf, said \$54
3804 billion over 10 years. That is a lot of bread. But I think
3805 it is a lot more than that. I think it could very easily be

3806 \$150 billion annually because some of the doctors on the
3807 Energy and Commerce Committee could tell you in their
3808 practices how much ordering of very expensive imaging
3809 procedures in particular and drawing a lot of blood. I could
3810 go on and on and on. But I would like for you to comment on
3811 that same question.

3812 Mr. {Holtz-Eakin.} This issue has been around for a
3813 long time. I think there is no question that malpractice
3814 reform should be on the table. How much would come out of
3815 the Nation's health care bill really revolves around the
3816 degree to which practice patterns have been dictated
3817 implicitly by some defensive medicine driven by lawsuits or
3818 if it is really just the way groups practice and so new
3819 doctors come in and they are told this is the way we
3820 practice. Is that really just a matter of caution or is it
3821 deeply imbedded in a reaction to the legal environment. We
3822 don't know how big that will be and that has been the
3823 conundrum for a long, long time.

3824 Dr. {Gingrey.} Well, the President of course has
3825 promised and we hope that there would be something in the
3826 Affordable Care Act that was not. We heard earlier testimony
3827 that this would save a tremendous amount of money. I don't
3828 know what the true value is but I think it is time for us to
3829 get that done.

3830 Mr. Holtz-Eakin, I am going to stay with you.
3831 Proponents of this law argue that the bill will help reduce
3832 the deficit in the second and third decades of
3833 implementation, not just this first 10-year period. Doesn't
3834 this claim rest on the assumption that the dramatic
3835 reductions in Medicare and massive tax increases on employer-
3836 sponsored health coverage of working-class America stays in
3837 effect? Can you explain how ever-increasing taxes are used
3838 to offset the massive increases in spending that are
3839 contained in the Affordable Care Act?

3840 Mr. {Holtz-Eakin.} At the heart of it is the notion
3841 that the spending will go up as we have seen these long-term
3842 projections for Medicare and Medicaid go up for a long, long
3843 time. CBO has put these out and Medicare and Medicaid go up
3844 from 4 percent of GDP to 12 or 20 percent over the next
3845 several decades, and for a long time the presumption has been
3846 by any reasonable analyst, you cannot tax your way out of
3847 that problem. You have to take on the spending. What the
3848 Affordable Care Act does is essentially recreate that
3849 spending and promise to tax its way out of it, and I don't
3850 view that as a plausible economic proposition. We are not
3851 going to raise the Cadillac tax so high to make this balance
3852 over the long term. You have got to control the growth of
3853 spending, and no analyst outside of David has come in and

3854 believed that this controls the spending growth.

3855 Dr. {Gingrey.} Mr. Cutler, you are shaking your head.
3856 I have got 20 seconds left if you would like to weigh in on
3857 that. I will cut you off if I decide to, but go ahead.

3858 Mr. {Cutler.} If you look at what the Business
3859 Roundtable has said, they said that this way of making
3860 reforms would lead to big changes in cost savings. If you
3861 look at what the American Medical Association has said, what
3862 the American Hospital Association has said, what the
3863 Association of America's Health Insurance Plans have said,
3864 all of them have said that this is the way to go and that
3865 they believe that this is the potential for saving enormous
3866 amounts of money.

3867 Dr. {Gingrey.} Well, that might be true with a policy
3868 like this you end up forcing all of the doctors who practice
3869 privately to sell their subspecialty practices to charitable
3870 hospitals who bill under Part A rather than Part B and
3871 eventually then the Federal Government will have control over
3872 the whole ball of wax and then we will have national health
3873 insurance. I yield back, Mr. Chairman.

3874 Mr. {Pitts.} The chair thanks the gentleman and
3875 recognizes the ranking member, Mr. Waxman, for 5 minutes.

3876 Mr. {Waxman.} Thank you, Mr. Chairman.

3877 Mr. Poore, I want to ask you a question. As we heard

3878 today, the U.S. Chamber of Commerce prides itself on being
3879 the world's largest business federation, representing the
3880 needs of businesses large and small alike, but it seems to me
3881 that when the chamber accepted \$86 million from the health
3882 insurance industry, companies such as Cigna and United Health
3883 Group, to lobby against health reform, it gave up any
3884 credibility it had to represent small businesses. The Small
3885 Business Majority released a study to demonstrate what would
3886 happen to small businesses without health reform. The
3887 findings show that 178,000 small business jobs, \$834 billion
3888 in small business wages and \$52 billion in small business
3889 profits would be lost due to high health care premiums, and
3890 over 1.5 million small business employees would continue to
3891 fall victim to job lock. If the chamber claims to represent
3892 small businesses, then why does it oppose health reform
3893 provisions that would prevent small businesses from facing
3894 these challenges? Do you feel that the U.S. Chamber of
3895 Commerce represents you as a small business owner?

3896 Mr. {Poore.} To be honest, no, for mainly the reason
3897 you gave. I have never had a national commerce guy call me
3898 but I don't have \$86 million in the bank, either. So to be
3899 frank, I really don't believe that--I mean, they lost their
3900 credibility when they did that, when they accepted money from
3901 the insurance lobby.

3902 Mr. {Waxman.} Then they are no longer representing
3903 businesses, they are representing--

3904 Mr. {Poore.} In a lot of ways I don't think--

3905 Mr. {Waxman.} But I want to use my time to ask another
3906 question in my limited time, but I thank you very much for
3907 your contribution to this hearing.

3908 We are once again, after we talked about the Affordable
3909 Care Act, which is a bill that reduces the deficit in
3910 responsible ways, extends coverage to over 30 million people
3911 while freeing people from job lock and fighting insurance
3912 company abuses. We are now hearing from the Republicans
3913 whose next step is to undermine health reform by destroying
3914 its foundation, the Medicaid program. The Republicans are
3915 about to unveil a budget that by all media accounts and
3916 statements from Republican Budget Committee members will
3917 block grant Medicaid to create hundreds of billions of
3918 dollars in savings, some reporting as high as \$850 billion.
3919 At the same time, we could expect the budget to extend the
3920 Bush tax cuts permanently. The exorbitant price tag for
3921 extending those cuts just for the wealthiest Americans is
3922 striking \$950 billion. The current Republican Majority is
3923 not serious about deficit reduction. They are about
3924 ideological stances that help the rich get richer while the
3925 middle class and poor are attacked from every side.

3926 Who is it they are targeting in the Medicaid program?
3927 Thirty million children, 14 million seniors and persons with
3928 disabilities, 1 million nursing home residents, 3 million
3929 home and community-based care residents, all who are relying
3930 on Medicaid, and Medicaid is an efficient program. Medicaid
3931 cost per enrollee growth was 4.6 percent between 2000 and
3932 2009. That is slower than premiums in employer-sponsored
3933 insurance and national health expenditures. Current Medicaid
3934 spending increases criticized by the right are merely because
3935 the program works as intended, to help people who have lost
3936 their jobs and health insurance during the recession, not
3937 because of excessive cost growth on a per-enrollee basis.
3938 Hundreds of billions of dollars in cuts to Medicaid is a
3939 blind ax that will merely shift costs to the States, to
3940 providers and mostly to beneficiaries who will go without
3941 care.

3942 Dr. Cutler, can you talk about what such large cuts in
3943 Medicaid would mean for States' economies, for families and
3944 for providers?

3945 Mr. {Cutler.} I think cuts of that magnitude would be
3946 catastrophically bad. If you run through this past
3947 recession, the Great Recession, without the ability to expand
3948 Medicaid by having the Federal Government be able to do that,
3949 you would have produced millions more uninsured people,

3950 people suffering lack of care, substantially worse health
3951 outcomes, hospitals and physicians that go under because they
3952 are overwhelmed by the number of uninsured people, and at the
3953 same time you would not have achieved any real reductions
3954 because the block grant itself does nothing to actually
3955 figure out how to run the system better. What we need to do
3956 is save money in Medicaid and throughout the health care
3957 system by running systems better, not by just shifting costs
3958 and making bad times be even worse.

3959 Mr. {Waxman.} And in order to pay for this program,
3960 which has been a successful program, and it is a lifeline.
3961 It is a safety-net program. In order to pay for this, we are
3962 refusing to ask the people at the very top 1 percent to pay
3963 their fair share of taxes so the people at the very bottom
3964 will just be thrown to the bottom of society without access
3965 to the care they desperately need.

3966 Mr. {Cutler.} A very large share of economists agree
3967 that over time we need to reduce medical spending and to
3968 raise revenue, particularly from higher-income people whose
3969 incomes have gone up a lot. Those two facts are not in much
3970 dispute.

3971 Mr. {Waxman.} Thank you very much. Thank you, Mr.
3972 Chairman.

3973 Mr. {Pitts.} The gentleman's time is expired.

3974 In conclusion, I would like to thank all of the
3975 witnesses and the members that have participated in today's
3976 hearing. This was an excellent panel. I want to remind
3977 members that they have 10 business days to submit questions
3978 for the record, and I ask that the witnesses all agree to
3979 respond promptly to those questions.

3980 Thank you. This subcommittee hearing is now adjourned.

3981 Mr. {Waxman.} Mr. Chairman, we will hold the record
3982 open for your comment on the policy for the committee for the
3983 future on--

3984 Mr. {Pitts.} We will give you that in writing. I
3985 understood that the staff had talked to your staff about hat.

3986 Mr. {Waxman.} Without objection, can we just put it
3987 into the record and we will look forward to getting that.

3988 Mr. {Pitts.} Without objection, so ordered.

3989 [Whereupon, at 1:35 p.m., the Subcommittee was
3990 adjourned.]