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THE TRUE COST OF PPACA: EFFECTS ON THE BUDGET AND JOBS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

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THE TRUE COST OF PPACA: EFFECTS ON THE BUDGET AND JOBS

WEDNESDAY, MARCH 30, 2011

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:02 a.m., in room 2123 of the Rayburn House Office Building, Hon. Joe Pitts (chairman of the subcommittee) presiding.

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

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

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. The subcommittee will come to order.

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

We had a very instructive field hearing, our first, in Harrisburg last week, on the 1-year anniversary of the signing of PPACA. What we heard about the health reform law's costs on Pennsylvania alone was chilling. Governor Corbett stated that after the Medicaid expansion had gone into effect, roughly one in four Pennsylvanians would be on the program. According to the Acting Secretary of the Department of Public Welfare, Gary Alexander, Medicaid currently accounts for 30 percent of the state budget. That is more than all but two other States: Illinois and Missouri. And if PPACA is fully implemented, that percentage will double to 60 percent of their state budget by fiscal year 2019–20. This is simply not

sustainable for my home state, or any other. And the numbers don't look much better for the Federal Government, either.

On March 18, 2011, CBO released its preliminary analysis of the President's fiscal year 2012 budget. CBO's estimate of total spending on coverage expansions in PPACA grew from $938 billion last March for fiscal years 2010 through 2019 to $1.445 trillion for fiscal years 2012 through 2021. That is a 54 percent increase in federal spending.

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

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

They are also being buried under thousands of pages of regulations, with thousands more to come, with which they will have to comply, and they will bear the cost of compliance on their own. Or, like Case New Holland, a major manufacturer with operations in Pennsylvania, testified at the field hearing last week, they already expect to spend $126 million over the next decade just to comply with this law, and that is $126 million that won't go towards expanding their business or creating new jobs.

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

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

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

The subcommittee will come to order.

The chair will recognize himself for an opening statement.

We had a very instructive field hearing in Harrisburg last week, on the 1-year anniversary of the signing of PPACA.

What we heard about the health reform law's costs on Pennsylvania alone was chilling.

Governor Corbett stated that after the Medicaid expansion had gone into effect, roughly 1 in 4 Pennsylvanians would be on the program.

According to the Acting Secretary of the Department of Public Welfare, Gary Alexander, Medicaid currently accounts for 30% of the state budget—that is more than all but two other states (Illinois and Missouri)—and if PPACA is fully implemented, that percentage will double to 60% by FY19–20.

This is simply not sustainable for my home state, or any other.

And the numbers don't look much better for the federal government, either.

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CBO's estimate of total spending on coverage expansions in PPACA grew from $938 billion last March (for fiscal years 2010–2019) to $1.445 trillion (for fiscal years 2012–2021)—a 54% increase in federal spending.

As you may remember, candidate Obama promised his health care plan would cost "$50–65 billion a year when fully phased in."

CBO, however, projects that the real cost of the coverage expansions will be $229 billion in 2020 and $245 billion in 2021—four times the levels of spending candidate Obama promised.

And what about the jobs PPACA was supposed to create? Then Speaker Pelosi stated in February of last year that the law would "create 4 million jobs—400,000 jobs almost immediately."

Yet, as Mr. Elmendorf told the House Budget Committee last month, he expects the law will cost 800,000 jobs by 2021.

That may be because the law contains perverse incentives for businesses not to grow.

Small businesses are hesitant to go over 50 employees, and incur a penalty for each full-time employee who does not have "proper insurance"—as defined by the government.

They are also being buried under thousands of pages of regulations—with thousands more to come—with which they'll have to comply. And they'll bear the cost of compliance on their own.

Or, like Case New Holland—a major manufacturer with operations in my district -which testified at the field hearing last week, they already expect to spend $126 million over the next decade just to comply with the law.

And that's $126 million that won't go towards expanding their business and creating jobs.

We are receiving reports almost weekly that show that the true cost of Obamacare is worse than what any of us expected—higher premiums, more federal health spending, fewer jobs, less access, and people losing the coverage they currently have and like.

Not only does the law not achieve its stated goals, the true cost of Obamacare is too high for our states, too high for the federal government, and too high for the private sector.

I thank our witnesses for being here today, and I yield the remainder of my time to Dr. Burgess.

Mr. PITTS. I will yield the remainder of my time to Dr. Burgess.

Mr. BURGESS. I thank the chairman for the recognition.

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

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

After the bill became law, our actuary from the Centers for Medicare and Medicaid Services released his findings to the Congress and estimated the overall national health expenditures would be increased by some $311 billion, a significant difference from the $142 billion in savings that was advertised merely a month before. So I authored last year a Resolution of Inquiry requesting the transfer of internal Health and Human Services communications related to the date of Mr. Foster's report. The Congressional Budget Office and the Chief Actuary do model different things, and this has been pointed out to me by some of our witnesses this morning. But both are essential components to determining the cost, the true cost of the Affordable Care Act, and really should have made available to the Members of Congress before, before, before the vote was taken last year.

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

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

Why was Congress negligent in our responsibility to see the impact that this law would have on the health care system, the cost of the health care system? The Administration knew that it would take Mr. Foster time to complete his model, but did the Administration push us to have that vote before we could have access to the actual date? And this is the question that needs to be answered this morning.

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

Mr. PITTS. The chair thanks the gentleman and recognizes the ranking member of the subcommittee, Mr. Pallone, for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

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

The Republicans seem to wish that if they just click their heels three times, we could return to that magical time in the last decade when they controlled both Houses of Congress and the White House and, as they would tell it, business prospered and fiscal responsibility was the name of the game, except that is not what happened. When President Bush came to office, he inherited a surplus projected to total $5.6 trillion over 10 years, and he managed to swiftly squander that, leaving President Obama a nicely wrapped $1.3 trillion deficit in 2009. Under President Bush's watch, the number of uninsured increased by 6 million nationwide. Small businesses, which make up the majority of the uninsured in America, were hurt especially hard during this time. While 57 percent of small businesses were able to offer health insurance in

2000, only 46 percent were able to by the end of the Bush Administration, and it would have just gotten worse. By the time President Obama took office, national health expenditures surpassed $2.4 trillion in 2009, more than three times as much as it was in 1990. The percentage of income families spent on employer-sponsored health insurance rose from 12 to 22 percent from 1999 to 2009 during the Bush Administration, and those without insurance were even worse off. For many families who had worked hard, saved hard and planned for the worst, they couldn't stay in the black if their kid got sick or denied health insurance for life due to a preexisting condition or if they themselves got sick with a tough disease and quickly ran through their insurance plan's annual limits.

So understanding this, President Obama and the Congress including this committee didn't just sit around and whine about the previous 8 years under Bush; they stood up and led. And we are very proud of the health care reform, the economic certainty, insurance reform, and coverage expansions will offer families across the Nation. We are glad that small business owners like Rick Poore, who will testify later this morning, are now eligible for tax credits today to cover their employees, and in the future Rick will be able to leverage the purchasing power of small business owners across the Nation through the State exchanges so that more of his money can be invested in his business and more of his energy can be devoted to innovation.

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

So if the Republicans want to spend another Wednesday morning discussing the true effects of the Affordable Care Act today, I am game, but I think we really need to get back to work and try to create jobs instead of wasting our time trying to repeal health reform. I mean, it is how many weeks now since you first repealed the act and of course the Senate rejected it? We have had nothing but hearings for the most part on either repealing the bill, repealing part of the bill, defunding the bill, now, you know, another hearing talking about the financial aspects of the bill. It just never seems to end.

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

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

Many of the claims we are going to hear today about the so-called true cost of the Affordable Care Act are likely to be shocking but that is not because the Affordable Care Act is dangerous or because it is not working. Instead, it is because these claims are at best gross exaggerations and at worst complete fabrications. Let us

be clear: the Affordable Care Act is the largest deficit-reducing bill enacted by Congress in the last decade. It will reduce the deficit by $210 billion over the next 10 years, and by $1.2 trillion over the following decade, and it will do so while continuing to help families and small businesses.

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

Mr. PITTS. The chair thanks the gentlelady and now recognizes the chairman of the full committee, Mr. Upton, for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

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

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

We have also heard about how PPACA imposes a paperwork nightmare on small businesses. The law, as we know, requires a tax filing for every transaction over $600. The House has voted to repeal this massive paperwork cost on American employers. However, our job does not end there. PPACA includes dozens of new paperwork requirements that force businesses to report to HHS, the Department of Labor, and the IRS. Job creation is our top priority, which is why we cannot ignore the fact that PPACA reduces employment.

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

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

[The prepared statement of Mr. Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON

Mr. Chairman, thank you for holding this hearing. We just marked the one-year anniversary of the health care bill being signed into law. Yet today will be the committee's first chance to fully explore the true fiscal impact the law will have on our country.

Since PPACA was signed into law, most revelations have fallen into one of the following categories: 1) news that the law will cost much more than our Democrat colleagues told us—imposing a massive burden on future generations; 2) news that

job creators are facing higher financial and administrative costs as a result of PPACA 3) news that health care costs will rise, and 4) news that PPACA has jeopardized both access to and the quality of health care for American seniors, job creators, and families.

First, let's discuss the true monetary cost of PPACA. Last week, the Congressional Budget Office noted that the coverage provisions of PPACA would cost $1.445 trillion from FY2012–2021. This is up from a ten-year cost of $938 billion when the bill was signed into law last March. This is not a change in CBO's scoring. Indeed, the CBO estimates for the overlapping years are remarkably consistent. The larger figure simply proves that Washington Democrats tried to hide the true ten-year cost of the bill by delaying its startup. Based on these new estimates, the real ten-year cost of the law will be $2 trillion if we are lucky and much more if we are not.

Second, let's look at the economic costs. Job creators around the country have spoken loud and clear. PPACA imposes massive new burdens on them that stifle growth and job creation. Many of the country's largest employers reported hundreds of millions of dollars in losses as a result of this law—jeopardizing investment and jobs when we need them the most.

The Majority scheduled a hearing last year to examine the losses companies were forced to report because of the law, indicating doubt that the law they championed could force such immediate harm. However, the hearing was abruptly cancelled when it became clear that the facts undermine the case for PPACA. Rather than study these massive new costs, my Democrat colleagues decided to sweep the matter under the rug.

We have also heard how PPACA imposes a paperwork nightmare on small businesses. The law requires a tax filing for every transaction over $600. The House has voted to repeal this massive paperwork cost on America's employers. However, our job does not end there. PPACA includes dozens of new paperwork requirements that force businesses to report to HHS, the Department of Labor, and the IRS.

Employers who originally supported PPACA are growing increasingly skeptical. In a recent interview, the CEO of Starbucks explained that upon further inspection, the new health care law would impose too great of a burden on job creators.

We have also heard from the Director of the Congressional Budget Office, Doug Elmendorf, on how PPACA reduces employment. In recent testimony before the House Budget Committee, Mr. Elmendorf stated that 800,000 jobs would be lost because of PPACA.

Third, we must consider the cost to patient care, in both access and quality. We already know low-income Americans face significant access problems in the Medicaid program because of low reimbursement rates for providers. PPACA extends the same problems to Medicare by reducing payment rates to unsustainable levels. As CMS Chief Actuary Rick Foster's analysis shows, Medicare payments fall sharply below those of private insurers and even below the Medicaid program.

Finally, the health care law has actually increased the cost of health care coverage -exactly the opposite of what proponents claimed would happen. As Mr. Foster has noted, the health care law increases overall national health expenditures by $311 billion. CBO has told us that by 2016, individual premiums will rise by $2,100 as a result of PPACA.

To date, HHS has issued more than 1,000 waivers to exempt health plans and employers from the expensive new regulations imposed by health care law. Last week, a member of this committee and supporter of the law suggested his hometown should receive a waiver. I think we should go one step further: we should lift the burden of PPACA from all Americans and repeal it.

Thank you again for holding this hearing. The American people deserve to know the true costs of this law. I would like to thank Larry Schuler from the great state of Michigan for agreeing to testify and present his perspectives on the new law. Mr. Chairman, I yield back the balance of my time.

Mr. GINGREY. I thank the chairman for yielding.

Mr. Chairman, it was just interesting to hear the ranking member of the subcommittee a few minutes ago talk about how the Democrats came to the rescue after 8 years of Republican inaction on health care reform, essentially saying just don't sit there, do something. Well, I think my colleague, Dr. Burgess, a fellow OB/GYN physician, would remember our OB/GYN motto, don't just do something, sit there, in managing labor and delivery. And the point I am making is to rush to judgment to do something just to get

something done oftentimes is a huge mistake, and I think that is the way our side of the aisle feels in regard to PPACA, the Affordable Care Act, because it doesn't accomplish any of the goals that were set out. It is not good for patients. It is not good for consumers. It is certainly not good for corporate America and it is not good for the taxpayer.

So bottom line is, this is a bad bill, not that the idea of reforming health care is a bad thing to do but certainly the priority of doing it as a number one or number two thing in the 111th and 110th Congress when we had 16 million people out of work in this country and probably 25 million underemployed, an unemployment rate of 10 percent, deficits. He said they inherited a $1.4 trillion deficit. Well, how about the next year when it was $1.6 trillion? Who inherited that? And how about the $5 trillion worth of additional debt that was piled on to the taxpayer by the Democrat Majority since they took control in 2007? So I think their priorities are all wrong and backwards in regard to this, and I am really interested in hearing from our witnesses, the first panel, of course, CBO, Mr. Elmendorf, and our CMS Actuary, Mr. Foster, because we need this information.

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

Mr. UPTON. I yield to Ms. Blackburn.

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

I yield back.

Mr. PITTS. The chair thanks the gentlelady and now recognizes the ranking member, Mr. Waxman.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you very much, Mr. Chairman.

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

These are the facts. When President Bush came to office, he inherited a surplus projected to total $5.6 trillion over 10 years. When President Obama came to office, he inherited a deficit in 2009 of $1.3 trillion for that one year alone. The deficit widened, I would remind my colleagues on the other side of the aisle, be-

cause we went into the deepest recession since the Great Depression, which meant fewer revenues and greater expenditures, widening the deficit more.

President Bush did not think national debt was a high priority. Instead, rather than pay it off, he passed a series of reckless tax increases that enriched the wealthy at the expense of everyone else. Those tax cuts, like the Medicare prescription drug bill and two wars launched under President Bush, were not paid for. They were charged straight to the national credit card. And that is how you take a $5.6 trillion surplus and turn it into a massive deficit.

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

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

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

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

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

Well, let us go back to our adult conversation. Republicans keep telling us that we can't afford the reforms to Medicare that the ACA proposed. Now they are telling us that once we repeal the ACA, we need to pass much larger cuts to Medicare and Medicaid in order to pay for tax cuts for the very richest Americans. Majority Leader Eric Cantor said in a speech just last week, talking about Social Security, Medicare, and Medicaid: "We are going to have to come to grips with the fact that these programs cannot exist if we want America to be what we want America to be."

How dare he say these programs cannot exist. This is not the America people want. The Affordable Care Act is entitlement re-

form done responsibly. It is time we stopped trying to repeal it and moved on to real work and real legislation.

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

I yield back my time.

Mr. PITTS. The gentleman's time is expired. The chair thanks the gentleman.

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

Mr. PITTS. Is there any objection? Without objection, the gentleman is recognized for 1 minute.

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

Mr. PITTS. Without objection, so ordered.

[The prepared statement of Mr. Dingell follows:]

PREPARED STATEMENT OF HON. JOHN D. DINGELL

Today, nearly 4 months into the 112th Congress, this Committee is holding yet another political show for the benefit of pundits here inside the Beltway.

It is abundantly clear that without major reform to our health system the status quo is unsustainable. After hard decisions, hours of debate and deliberation, Congress passed and the President signed the Affordable Care Act.

Defunding the Affordable Care Act is not legislating. This is like taking an eraser to an answer on a test, and then leaving it blank because you don't have a better solution.

If my friends on the other side of the aisle want to defend the Nation's bottom line, then why did they offer H.R. 2, repealing the Affordable Care and increasing the federal deficit by $210 billion?

If my friends on the other side of the aisle want to create jobs, why repeal the Affordable Care Act, which will add 400,000 jobs a year for the next 10 years?

American families need help now. They need protection from insurance companies dropping their coverage, they need help in providing health coverage for their college students, and they need help to afford their prescriptions under Medicare—these are all real solutions ACA provides to families today and solutions my friends on the other side of the aisle would repeal and replace with nothing.

Thank you.

Mr. PITTS. The chair thanks the gentleman.

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

Our first witness is Doug Elmendorf, who is the Director of the Congressional Budget Office. Before he came to CBO, Mr. Elmendorf was a senior fellow in the Economic Studies Program at the Brookings Institution. Next, we will hear from Rick Foster, who

serves as the Chief Actuary at the Office of the Actuary at the Centers for Medicare and Medicaid Services.

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

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

STATEMENT OF DOUGLAS ELMENDORF

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

In brief, we estimate that the legislation will increase the number of non-elderly Americans with health insurance by roughly 34 million in 2021. About 95 percent of legal non-elderly residents will have insurance coverage in that year compared with a projected share of 82 percent in the absence of that legislation and about 83 percent today. The legislation generates this increase through a combination of a mandate for nearly all legal residents to obtain health insurance, the creation of health insurance exchanges operating under certain rules and through which certain people will receive federal subsidies and the significant expansion of Medicaid.

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

In addition to the provisions related to insurance coverage, PPACA and the Reconciliation Act also reduce the growth of Medicare's payments for most services, impose certain taxes on people with relatively high income and made various other changes to the tax code, Medicare, Medicaid and other programs. As you can see in figure 1, those provisions will on balance reduce direct spending and increase revenues, providing an offset to the cost of the coverage provisions. According to our latest comprehensive estimate of the legislation, the net effect of all the changes in direct spending and revenues is a reduction in budget deficits of $210 billion over the 2012–2021 period.

Not surprisingly, observers have raised a number of challenges to our estimates. Let me comment briefly on the three most common areas of concern that I have heard. First, some analysts have asserted that we have misestimated the effects of the changes in law. Those concerns run in different directions. Some analysts be-

lieve that the subsidies will be more expensive than we project while others maintain that the Medicare reforms will save more money than we project. Certainly, projections of the effects of this legislation are quite uncertain and no one understands that better than the analysts at CBO and JCT. Our estimates depend on myriad projections of economic and technical factors as well as on assumptions about the behavioral responses of families, businesses and other levels of government. All of these projections and assumptions represent our objective and impartial judgment based on our detailed understanding of federal programs, careful reading of the research literature and consultation with outside experts. In addition, our estimates depend on a line-by-line reading of the specific legislative language. Our goal is always to develop estimates that are in the middle of the distribution of possible outcomes, and we believe we have achieved that goal in this case.

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

Another example of concern about budget conventions involves the Hospital Insurance trust fund, which covers Medicare part A. The legislation will improve the cash flow in that trust fund by hundreds of billions of dollars over the next decade. Higher balances in the fund will give the government legal authority to pay Medicare benefits for longer than otherwise but most of the savings will pay for new programs rather than reduce future budget deficits, and therefore will not enhance the government's economic ability to pay Medicare benefits in future years. We wrote about those issues as the legislation was being considered in the Congress.

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

[The prepared statement of Mr. Elmendorf follows:]



Congressional Budget Office

Testimony

Statement of
Douglas W. Elmendorf
Director

CBO's Analysis of the Major Health Care Legislation Enacted in March 2010

before the
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives

March 30, 2011

This document is embargoed until it is delivered at 10:00 a.m. (EDT) on Wednesday, March 30, 2011. The contents may not be published, transmitted, or otherwise communicated by any print, broadcast, or electronic media before that time.

CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

Chairman Pitts, Congressman Pallone, and Members of the Subcommittee, thank you for inviting me to testify about the Congressional Budget Office's (CBO's) analysis of the Patient Protection and Affordable Care Act (PPACA, Public Law 111-148) and the provisions of the Health Care and Education Reconciliation Act of 2010 (hereafter called "the Reconciliation Act," P.L. 111-152) that are related to health care.

CBO and the staff of the Joint Committee on Taxation (JCT) have provided the Congress with extensive analyses of the legislation both before and after its enactment in March 2010. My statement summarizes the major results of those analyses—in particular, the projected effects of those laws on the federal budget (over the first 10 years and the subsequent decade), health insurance coverage, Medicare, premiums for health insurance, and labor markets.

Summary

Among other things, PPACA and the Reconciliation Act will do the following: establish a mandate for nearly all legal residents of the United States to obtain health insurance; create insurance exchanges through which certain individuals and families will receive federal subsidies to substantially reduce the cost of purchasing health insurance coverage; significantly expand eligibility for Medicaid; permanently reduce the growth of Medicare's payment rates for most services (relative to the growth rates projected to occur under prior law); impose an excise tax on health insurance plans with relatively high premiums; impose certain taxes on individuals and families with relatively high income; and make various other changes to the federal tax code, Medicare, Medicaid, and other programs.

Estimated Effects on Health Insurance Coverage

CBO and JCT estimate that PPACA and the Reconciliation Act will increase the number of nonelderly Americans with health insurance by about 32 million in 2016 and about 34 million in 2021.[1] About 95 percent of legal nonelderly residents will have insurance coverage in 2021, compared with a projected share of about 82 percent in the absence of that legislation (and an estimated 83 percent currently). In 2021, approximately 24 million people will purchase their own coverage through insurance exchanges, and Medicaid and the Children's Health Insurance Program (CHIP) will have roughly 17 million additional enrollees, CBO and JCT estimate. Compared with the number projected under prior law, about 6 million fewer people will purchase individual coverage directly from insurers, and about 1 million fewer people will obtain coverage through their employer. About 23 million nonelderly residents will remain uninsured: About one-third of that group will be unauthorized immigrants, who are not eligible to participate in Medicaid or the insurance exchanges; another quarter will be eligible for Medicaid but are not expected to enroll;

1. See Congressional Budget Office, "Estimate of the Effects of the Insurance Coverage Provisions Contained in the Patient Protection and Affordable Care Act (Public Law 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152)" (March 2011).

Table 1.

Estimated Budgetary Effects of the Enactment of PPACA and the Health Care Provisions of the Reconciliation Act

(Billions of dollars, by fiscal year)

	March 2010 Estimates		February 2011 Estimates		March 2011 Estimates	
	2010-2019	2012-2019	2012-2019	2012-2021	2012-2019	2012-2021
Effects on the Federal Budget Deficit						
Insurance coverage provisions[a]						
Gross cost	938	931	934	1,390	971	1,445
Net cost	788	778	733	1,042	794	1,131
Other provisions affecting direct spending	-492	-498	-477	-732	n.a.	n.a.
Other provisions affecting revenues	-420	-412	-376	-520	n.a.	n.a.
Net Increase or Decrease (-) in the Deficit	**-124**	**-132**	**-119**	**-210**	**n.a.**	**n.a.**
Memorandum:						
Effects on Outlays	401	393	417	604	n.a.	n.a.
Effects on Revenues	525	524	536	813	n.a.	n.a.

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Notes: The March 2010 estimates come from CBO's cost estimates for PPACA and the Reconciliation Act released in March 2010. The February 2011 estimates were produced using the CBO baseline projections of revenues and outlays available in early 2011, and the March 2011 estimates were taken from CBO's March 2011 baseline projections.

PPACA = Patient Protection and Affordable Care Act; Reconciliation Act = Health Care and Education Reconciliation Act of 2010; n.a. = not available.

a. The gross cost of insurance coverage provisions reflects additional spending for Medicaid and the Children's Health Insurance Program, exchange subsidies and related spending, and tax credits for small employers. The net cost of insurance coverage provisions reflects that spending partly offset by penalties paid by uninsured individuals and employers, excise taxes on high-premium insurance plans, and other effects of the provisions on tax revenues and outlays.

and the remaining fraction will include individuals who are ineligible for subsidies, are exempt from the individual mandate, choose not to comply with the mandate, or have some combination of those characteristics.

Estimated Budgetary Effects from 2012 to 2021: Direct Spending and Revenues

The legislation will have a number of effects on the federal budget—including added spending to subsidize the purchase of health insurance and increased outlays for Medicaid, as well as reductions in outlays for Medicare and added revenues from taxes, fees, and penalties. On net, CBO and JCT's latest comprehensive estimate is that the effects of the two laws on direct spending and revenues related to health care will reduce federal deficits by $210 billion over the 2012–2021 period (see Table 1).

The Most Recent Comprehensive Estimate. CBO and JCT's most recent comprehensive estimate of the budgetary impact of PPACA and the Reconciliation Act was in relation to an estimate prepared for H.R. 2, the Repealing the Job-Killing Health Care Law Act, as passed by the House of Representatives on January 19, 2011. H.R. 2 would repeal the health care provisions of those laws. CBO and JCT estimated that repealing PPACA and the health-related provisions of the Reconciliation Act would produce a net *increase* in federal deficits of $210 billion over the 2012–2021 period as a result of changes in direct spending and revenues.[2] Reversing the sign of the estimate released in February provides an approximate estimate of the impact over that period of enacting those provisions. Therefore, CBO and JCT effectively estimated in February that PPACA and the health-related provisions of the Reconciliation Act will produce a net *decrease* in federal deficits of $210 billion over the 2012–2021 period as a result of changes in direct spending and revenues. The projected net reduction in deficits is the difference between $813 billion in projected additional revenues and $604 billion in projected additional outlays.

The provisions related to health insurance coverage—which affect both outlays and revenues—were projected to have a net cost of $1,042 billion over the 2012–2021 period; that amount represents a gross cost to the federal government of $1,390 billion, offset in part by $349 billion in receipts and savings (primarily revenues from penalties and other sources). The other provisions related to health care and revenues will reduce budget deficits by an estimated $1,252 billion over that 10-year period—including $520 billion in revenues, mostly from new taxes and fees, and $732 billion in outlay savings for Medicare and other federal health care programs (see Figure 1). Those outlay savings reflect the net effect of some provisions that will reduce direct spending—such as lower payment rates in Medicare—and others that will increase direct spending, such as the expansion of Part D benefits and mandatory funding for a number of grant, research, and other programs.

Comparison with the March 2010 Estimate. That February 2011 estimate differs somewhat from the estimate that CBO prepared when the legislation was being considered. In March 2010, CBO and JCT estimated that PPACA and the provisions of the Reconciliation Act related to health care would produce a net reduction in federal deficits of $124 billion over the 2010–2019 period as a result of changes in direct spending and revenues.[3] The difference between the two estimates does not reflect any substantial change in the estimation of the overall effects of the two laws. CBO has seen no evidence to date that the steps that will be taken to implement the

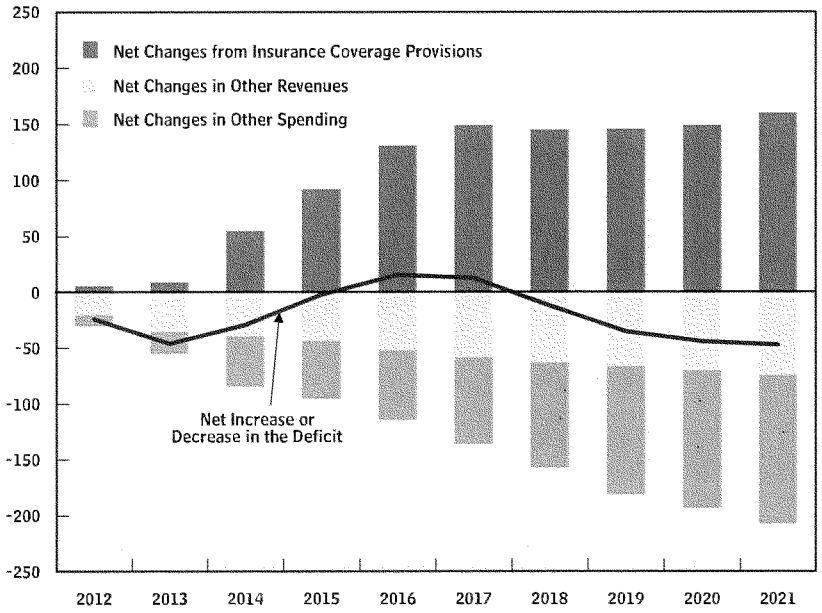
2. See Congressional Budget Office, cost estimate for H.R. 2, the Repealing the Job-Killing Health Care Law Act (February 18, 2011). That document and the others by CBO that are cited in this testimony are available on the agency's Web site (www.cbo.gov); many of the documents that were published in 2009 and 2010 are contained in Congressional Budget Office, *Selected CBO Publications Related to Health Care Legislation, 2009-2010* (December 2010).

3. See Congressional Budget Office, cost estimate for H.R. 4872, the Reconciliation Act of 2010 (March 20, 2010).

Figure 1.

Estimated Effects of PPACA and the Health Care Provisions of the Reconciliation Act on the Federal Budget

(Billions of dollars, by fiscal year)



Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Notes: These estimates from February 2011 were produced using the CBO baseline projections of revenues and outlays available in early 2011.

Coverage provisions include the excise tax on high-premium insurance plans.

PPACA = Patient Protection and Affordable Care Act; Reconciliation Act = Health Care and Education Reconciliation Act of 2010.

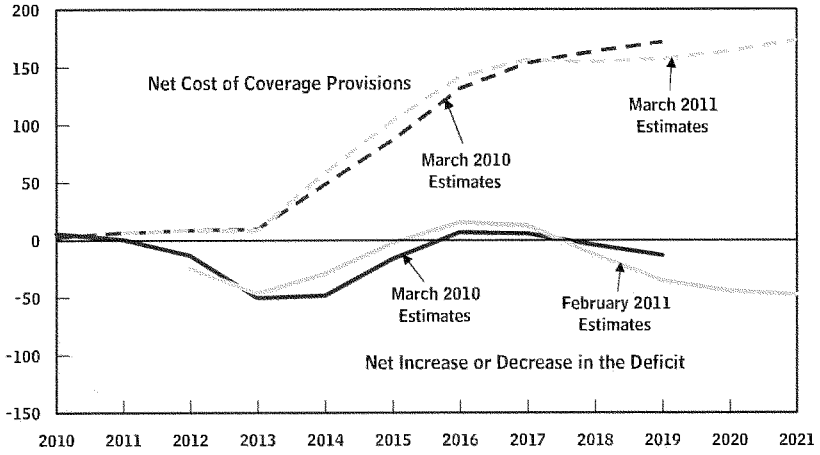
legislation—or the ways in which participants in the health care and health financing systems will respond to that legislation—will yield overall budgetary effects that differ significantly from the ones projected earlier.

Instead, the difference between the two estimates is primarily attributable to the different time periods they cover. In particular, including the years 2020 and 2021 in the analysis results in a substantially larger estimated decrease in budget deficits; in those two years alone, the legislation will decrease federal deficits by a total of about $90 billion. Over the eight years that are common to the two analyses—2012 to 2019—enactment of PPACA and the health-related provisions of the Reconciliation Act was

Figure 2.

Comparison of CBO's 2010 and 2011 Estimates for PPACA and the Health Care Provisions of the Reconciliation Act

(Billions of dollars, by fiscal year)



Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Notes: The March 2010 estimates, which cover 2010 to 2019, come from CBO's cost estimates for PPACA and the Reconciliation Act released in March 2010. The March 2011 estimates were taken from CBO's March 2011 baseline projections for 2011 to 2021; the February 2011 estimates, based on a cost estimate covering 2012 to 2021, were produced using CBO's baseline projections of revenues and outlays available in early 2011.

Coverage provisions include the excise tax on high-premium insurance plans.

PPACA = Patient Protection and Affordable Care Act; Reconciliation Act = Health Care and Education Reconciliation Act of 2010.

projected last March to reduce federal deficits by $132 billion, whereas the February 2011 estimate implies that the legislation will reduce deficits by $119 billion (see Figure 2).

The Most Recent Estimate of the Effects of Coverage Provisions. CBO's baseline budget projections that were issued earlier in March 2011, like the baseline projections issued in January 2011 and August 2010, reflect the impact of PPACA and the Reconciliation Act on revenues and various spending programs.[4] In some cases, those effects are implicit in broader revenue or spending categories, so the total projected

4. See Congressional Budget Office, *Preliminary Analysis of the President's Budget for 2012* (March 18, 2011).

impact of the laws cannot be readily identified; in other cases, the impact of those laws can be separately identified. The provisions related to expanding health insurance coverage fall in the latter category; compared with the estimate released in February, they are now projected to increase deficits by an additional $90 billion over the 2012–2021 period, bringing the total net cost of those provisions as result of changes in direct spending and revenues to $1,131 billion over that period.[5] CBO has not updated its estimate of the effects of the other provisions of the legislation because those effects are not separated out in the agency's baseline projections.

How does the current estimate of the cost of expanding health insurance coverage compare with the estimate that was prepared when the laws were enacted? Again, the difference between the two estimates is primarily attributable to the different time periods they cover. Over the eight years that are common to the two analyses (2012 to 2019), the provisions related to health insurance coverage were projected last March to result in gross costs of $931 billion and net costs (after accounting for penalty payments, receipts from the new excise tax on high-premium health insurance plans, and certain other effects) of $778 billion. CBO and JCT now estimate gross costs of $971 billion and net costs of $794 billion over that eight-year period, increases of 4 percent and 2 percent, respectively.[6]

The estimates summarized above focus on direct spending and revenues because those are the figures that are relevant for the pay-as-you-go law and Congressional rules and because those effects will occur without any additional legislative action. The legislation will also affect discretionary spending (that is, spending subject to future appropriation action) in ways that are discussed below. Following standard procedures for the Congressional budget process, the estimates do not include any effects of the legislation on overall economic output. However, last summer, CBO estimated that the effects of the legislation on overall employment would be small.

Estimated Budgetary Effects from 2012 to 2021: Discretionary Spending

Discretionary costs will arise from the effects of the legislation on several federal agencies and on a number of new and existing programs. CBO expects that the Internal Revenue Service (IRS) and the Department of Health and Human Services (HHS) will incur costs of between $5 billion and $10 billion each over 10 years to carry out their responsibilities for implementing the legislation.

PPACA includes a number of authorizations for future appropriations, which might or might not result in additional appropriations. CBO estimated that such provisions authorizing specific amounts, if fully funded, would result in appropriations of

5. See Congressional Budget Office, "Estimate of the Effects of the Insurance Coverage Provisions Contained in the Patient Protection and Affordable Care Act (Public Law 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152)" (March 2011), cited earlier.

6. Over that eight-year period (2012 to 2019), the current estimate of the net cost of the coverage provisions ($794 billion) is about 8 percent *higher* than the February 2011 estimate ($733 billion)—but the latter was about 6 percent *lower* than the March 2010 estimate ($788 billion).

$106 billion over the 2010–2019 period. Updating those estimates for the 2012–2021 period would result in authorizations of just under $100 billion. However, most of those authorizations—accounting for about $85 billion—are for activities that were already being carried out under prior law or that were previously authorized and that PPACA authorized for future years; for example, that amount includes an estimated $39 billion for ongoing activities of the Indian Health Service and $34 billion for continued grants to federally qualified health centers.[7]

Impact on the Federal Budget Beyond the First 10 Years

CBO does not generally provide cost estimates beyond the 10-year projection period, but certain Congressional rules require some information about the budgetary impact of legislation in subsequent decades, and many Members have requested analyses of the long-term budgetary impact of the broad changes in the health care and health insurance systems that will result from these laws. That impact, however, becomes more and more uncertain the farther into the future one projects. Over a longer time span, a wide range of changes could occur—in people's health, in the sources and extent of their insurance coverage, and in the delivery of medical care—that are very difficult to predict but that could have a significant effect on federal health care spending, both under current law and under the law prior to passage of PPACA and the Reconciliation Act.

Therefore, CBO developed a rough outlook for the second decade after enactment by grouping the elements of the legislation into broad categories and assessing the rate at which the budgetary impact of each of those broad categories will increase over time. On the basis of its February 2011 analysis, CBO effectively projected that PPACA and the Reconciliation Act would reduce federal budget deficits by an amount in a broad range around one-half percent of gross domestic product (GDP) for the 2022–2031 period, assuming that all provisions of the legislation were fully implemented. That estimate has not been updated since the February analysis.

Other Effects of the Legislation

CBO has also analyzed the legislation's impact on the "federal budgetary commitment to health care," a term that the agency uses to describe the sum of net federal outlays for health programs and tax preferences for health care; on premiums for health insurance; and on labor markets.

Effects on the Federal Budgetary Commitment to Health Care. In its February 2011 analysis, CBO estimated that PPACA and the Reconciliation Act would increase the federal budgetary commitment to health care by $464 billion over the 2012–2021 period. The net increase in that commitment is driven ptimarily by the expansion in coverage, which would be partly offset by other factors such as the decrease in other

7. PPACA and the Reconciliation Act also include mandatory appropriations for certain grants, research, and other programs. The costs of those provisions are included in the estimates of the legislation's effects on direct spending.

federal health care spending (primarily for Medicare) and the imposition of the excise tax on high-premium insurance policies in 2018.

In contrast, CBO anticipates that those laws will decrease the federal budgetary commitment to health care in the decade following the 10-year projection period, assuming that the provisions of current law remain unchanged. The estimated effect in later years differs from that in the first decade because the budgetary impact of provisions that reduce the commitment is projected to grow faster than the impact of provisions that increase it.

Effects on Health Insurance Premiums. Under PPACA and the Reconciliation Act, premiums for health insurance in the individual market will be somewhat higher than they would otherwise be, CBO and JCT estimate, mostly because the average insurance policy in that market will cover a larger share of enrollees' costs for health care and provide a slightly wider range of benefits.[8] The effects of those differences will be offset in part by other factors that will tend to reduce premiums in the individual market; for example, purchasers in that market will tend to be healthier than they would have been under prior law, leading to lower average costs for their health care. Although premiums in the individual market will be higher on average, many people will end up paying less for health insurance—because the majority of enrollees purchasing coverage in that market will receive subsidies via the insurance exchanges.

Premiums for employment-based coverage obtained through large employers will be slightly lower than they would otherwise be; premiums for employment-based coverage obtained through small employers may be slightly higher or slightly lower.

Effects on Labor Markets. The legislation will affect some individuals' decisions about whether and how much to work and some employers' decisions about hiring workers. CBO estimates that the legislation, on net, will reduce the amount of labor used in the economy by a small amount—roughly half a percent—primarily by reducing the amount of labor that workers choose to supply. That net effect reflects changes in incentives in the labor market that operate in both directions: Some provisions of the legislation will discourage people from working more hours or entering the workforce, and other provisions will encourage them to work more. Moreover, many people will be unaffected by those provisions and will face the same incentives regarding work as they otherwise would have.

Because the legislation will affect individuals' decisions on both whether to participate in the workforce and the number of hours they work, its effect on employment is difficult to predict. If the legislation did not affect the average number of hours worked per employed person, CBO projects that it would reduce household employment in 2021 by about 800,000. However, because the legislation will probably affect average

8. See Congressional Budget Office, letter to the Honorable Evan Bayh providing an analysis of health insurance premiums under the Patient Protection and Affordable Care Act (November 30, 2009).

hours worked among those employed, the effect on employment will be somewhat different.

Uncertainty Surrounding the Estimates

The projections of the budgetary impact and other impacts of health care legislation are quite uncertain because assessing the effects of making broad changes in the nation's health care and health insurance systems—or of reversing scheduled changes—requires assumptions about a broad array of technical, behavioral, and economic factors. CBO and JCT, in consultation with outside experts, have devoted a great deal of care and effort to analyzing health care legislation in the past few years, and the agencies strive to develop estimates that are in the middle of the distribution of possible outcomes. Nevertheless, the actual outcomes will surely differ from those estimates.

As with all of CBO's cost estimates, the estimates described in this testimony reflect an assumption that the provisions of current law otherwise remain unchanged throughout the projection period and that the legislation being analyzed is enacted and implemented throughout that period in its current form. CBO's responsibility to the Congress is to estimate the effects of proposals and of current law as written and not to forecast future legislation. The budgetary impact of PPACA and the Reconciliation Act could be quite different if key provisions of that original legislation are subsequently changed or not fully implemented.

In fact, CBO's cost estimate for the legislation noted that it will put into effect a number of policies that might be difficult to sustain over a long period of time. The combination of those policies, prior law regarding payment rates for physicians' services in Medicare, and other information has led CBO to project that the growth rate of Medicare spending (per beneficiary, adjusted for overall inflation) will drop from about 4 percent per year, which it has averaged for the past two decades, to about 2 percent per year on average for the next two decades. It is unclear whether such a reduction can be achieved through greater efficiencies in the delivery of health care or will instead reduce access to care or the quality of care (relative to the situation under prior law). Also, the legislation includes a provision that makes it likely that exchange subsidies will grow at a slower rate after 2018, so the shares of income that enrollees have to pay will increase more rapidly at that point, and the shares of the premiums that the subsidies cover will decline.[9] Such possibilities could lead to pressure on lawmakers to adjust those policies.

9. For further discussion of some of these issues, see Congressional Budget Office, "The Effects of Health Reform on the Federal Budget," *Director's Blog* (April 12, 2010) and "Uncertainty in Estimates for Health Care Legislation," *Director's Blog* (March 19, 2010).

Overview of the Budgetary Effects in the First Decade

On March 20, 2010, CBO and JCT published estimates of the budgetary impact of PPACA and the Reconciliation Act. Those estimates covered 2010 through 2019, the period used for Congressional budget enforcement procedures when the legislation was being considered (in calendar years 2009 and early 2010).

CBO subsequently incorporated PPACA and the Reconciliation Act into its baseline budget projections published in August 2010 and January 2011. Revisions to baseline projections reflect the enactment of legislation, changes in CBO's economic forecast, and updates to the agency's projection methods and assumptions. Revisions to baseline projections can result in new estimates of the effects of existing laws that appear separately in the projections. However, such revisions do not result in new estimates of the effects of existing laws that are interwoven with the effects of other laws. For PPACA and the Reconciliation Act, the effects of the provisions related to insurance coverage can be separately identified in CBO's baseline projections, but many of the effects of other provisions cannot be separately identified.

On February 18, 2011, CBO and JCT published an estimate of the budgetary impact of H.R. 2, the Repealing the Job-Killing Health Care Law Act, which would repeal PPACA and the health-related provisions of the Reconciliation Act. That cost estimate covered 2012 through 2021, the period covered by CBO's current baseline projections. Reversing the sign of that estimate provides an approximate estimate of the impact of PPACA and the health-related provisions of the Reconciliation Act over that later time period. The figure is only approximate because the cost estimate for H.R. 2 did not include the effects of funding provided by the health care legislation that has already been obligated or spent and because it incorporated the effects of subsequent legislation that modified certain aspects of the original legislation.

Most recently, CBO released its March 2011 baseline projections. As with the preceding two sets of baseline projections, the latest ones incorporated the budgetary impact of PPACA and the Reconciliation Act. However, as noted above, many of the effects of provisions not related to health insurance coverage cannot be separately identified.

The evolution of estimates does not indicate any substantial change in the overall effects of PPACA and the Reconciliation Act from what CBO and JCT projected in March 2010. In its ongoing monitoring of developments, CBO has seen no evidence to date that the steps that will be taken to implement that legislation—or the ways in which participants in the health care and health financing systems will respond to that legislation—will yield overall budgetary effects that differ significantly from the ones projected earlier.

CBO will continue to update its budget projections as the outlook for various economic and technical factors changes. In cases in which PPACA and the Reconciliation Act created a new flow of spending or revenues that is tracked separately—such as outlays for the subsidies provided through the insurance exchanges or collections of new excise taxes—the direct effects will be observable and can be compared with the

original estimates. But any indirect effects of those provisions on other aspects of the budget will not be identifiable. Moreover, for provisions that affect an existing flow of spending or revenues—such as Medicare outlays or income tax receipts—the effects will not be identifiable. Therefore, comparing all elements of the laws' ultimate impact with the amounts estimated at the time of their enactment will not be possible.

Estimates of the Impact of Enacting PPACA and the Reconciliation Act Made in March 2010

In March 2010, CBO and JCT estimated that enacting PPACA and the Reconciliation Act would produce a net reduction in federal deficits of $143 billion over the 2010–2019 period as a result of changes in direct spending and revenues.[10] That figure comprised $124 billion in net reductions deriving from the health care and revenue provisions of those laws and $19 billion in net reductions deriving from the education provisions.

The net decrease in deficits from enacting all of those provisions except those affecting education had three major components (see Table 1 on page 2):

- PPACA and the Reconciliation Act contained a set of provisions designed to expand health insurance coverage that was estimated to increase federal deficits. The costs of those coverage expansions—which include the cost of the subsidies to be provided through the exchanges, higher outlays for Medicaid and the Children's Health Insurance Program, and tax credits for certain small employers—will be partially offset by revenues from the excise tax on high-premium insurance plans and net savings from other coverage-related effects. For the 2010–2019 period, those provisions yielded estimated gross costs of $938 billion and estimated net costs (after accounting for the offsets just mentioned) of $788 billion.

- The legislation also included a number of other provisions that were estimated to reduce net federal outlays (primarily for Medicare) by $492 billion over the 2010–2019 period.

- Apart from the effect of provisions related to insurance coverage, the legislation will increase federal revenues in various ways, mostly by increasing the Hospital Insurance payroll tax and imposing fees on certain manufacturers and insurers. The additional revenues were estimated to equal $420 billion over the 2010–2019 period.

All told, those provisions of PPACA and the Reconciliation Act were estimated to increase direct spending by $401 billion and to increase revenues by $525 billion over

10. See Congressional Budget Office, cost estimate for H.R. 4872, the Reconciliation Act of 2010 (March 20, 2010).

the 2010–2019 period, yielding the net estimated savings of $124 billion over those 10 years (as noted above).

Estimates of the Impact of Repealing PPACA and the Health Care-Related Provisions of the Reconciliation Act Made in February 2011

In February 2011, CBO and JCT estimated that repealing PPACA and the health-related provisions of the Reconciliation Act would produce a net increase in federal deficits of $210 billion over the 2012–2021 period as result of changes in direct spending and revenues.[11] Reversing the sign of the estimate released in February provides an approximate estimate of the impact of those provisions over that period. Therefore, CBO and JCT effectively estimated in February that PPACA and the health-related provisions of the Reconciliation Act will produce a net decrease in federal deficits of $210 billion over the 2012–2021 period as result of changes in direct spending and revenues.

That net decrease in deficits has the same three major components as the net decrease in deficits estimated last March:

- The provisions designed to expand health insurance coverage were estimated to yield gross costs of $1,390 billion and net costs (after accounting for the offsets mentioned above) of $1,042 billion over the 2012–2021 period.
- The other provisions affecting direct spending were estimated to reduce net federal outlays (primarily for Medicare) by $732 billion over the 2012–2021 period.
- The provisions affecting federal revenues (apart from those related to insurance coverage) were estimated to increase revenues by $520 billion over the 2012–2021 period.

Altogether, those provisions of PPACA and the Reconciliation Act were estimated to increase direct spending by $604 billion and to increase revenues by $813 billion over the 2012–2021 period.

The estimated 10-year reduction in deficits for enacting PPACA and the Reconciliation Act that is implied by the February estimate differs from the 10-year reduction in deficits that CBO and JCT estimated in March 2010 for enactment of that legislation. The difference between the two estimates is primarily attributable to the different time periods they cover. In particular, including the years 2020 and 2021 in the analysis results in a substantially larger estimated decrease in budget deficits; in those two years alone, the legislation will decrease federal deficits by a total of about $90 billion, CBO estimates. That larger decrease in deficits in later years reflects the fact that the net costs of the coverage provisions are projected to rise more slowly than the combined effect of the factors that will reduce deficits (the decrease in other direct

11. See Congressional Budget Office, cost estimate for H.R. 2, the Repealing the Job-Killing Health Care Law Act (February 18, 2011).

spending and the increase in other revenues). Over the eight years that are common to the two analyses—2012 to 2019—enactment of PPACA and the health-related provisions of the Reconciliation Act was projected last March to reduce federal deficits by $132 billion, whereas the February 2011 estimate shows that those provisions will reduce deficits by an estimated $119 billion (see the second and third columns of Table 1 on page 2).

The remaining (relatively modest) differences between the two estimates arise from several factors. First, some of the funding provided by the legislation has been obligated or spent and thus is not included in the estimate of the effects of repealing the legislation. Second, subsequent legislation has already modified the laws enacted last March, so the estimate of H.R. 2 did not include a reversal of all of the provisions of the original legislation. Specifically, the Medicare and Medicaid Extenders Act of 2010 (P.L. 111-309) increased the amount that could be recovered from enrollees in insurance exchanges whose actual income in a year differed from the figure used to determine their tax credit for health insurance premiums. That legislation was estimated to reduce net federal payments for subsidies through the health insurance exchanges. Third, the estimates prepared last March were based on the projections of economic conditions, health care costs, federal spending and revenues, and other factors that CBO published in March 2009. In particular, the economic outlook is now somewhat different, and CBO and JCT made a number of technical changes to their spending and revenue projections related to the provisions of PPACA and the Reconciliation Act.

Updated Estimates of the Impact of the Coverage Provisions of PPACA and the Reconciliation Act Made in March 2011

CBO's March 2011 baseline projections include somewhat different estimates for the coverage provisions of PPACA and the Reconciliation Act. Specifically, over the 2012–2021 period, those provisions are now estimated to yield gross costs of $1,445 billion and net costs (after accounting for the offsets mentioned above) of $1,131 billion (see Table 2).

The March 2011 estimate of the net cost of the insurance provisions represents a $90 billion increase (over 10 years) since the previous estimate. CBO made a number of technical modifications to its models for health insurance coverage; as a result of those modifications, slightly fewer low-income people are projected to be eligible for Medicaid, and slightly more are expected to be eligible for subsidies through the health insurance exchanges. Altogether, the upward revision of $90 billion reflects the following changes: a $47 billion reduction in the impact on Medicaid and CHIP outlays; a $100 billion increase in exchange subsidies and related spending; a $41 billion reduction in revenues from other effects of the coverage provisions (including the excise tax on high-premium insurance plans); and smaller changes in other payments related to coverage provisions.

CBO's current estimate of the net cost of the coverage provisions differs from the original estimate issued in March 2010 primarily because of the different time periods

Table 2.

Estimated Budgetary Effects of the Insurance Coverage Provisions of PPACA and the Reconciliation Act

(Billions of dollars, by fiscal year)

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Total, 2012-2021
Effects on the Federal Budget Deficit												
Medicaid and CHIP outlays[a]	0	0	0	30	55	77	84	87	93	97	105	627
Exchange subsidies and related spending[b,c]	0	2	2	23	55	87	104	115	123	130	137	777
Small-employer tax credits[d]	4	5	5	7	8	5	2	2	2	2	2	41
Gross Cost of Insurance Coverage Provisions	4	6	7	60	118	169	189	204	218	229	245	1,445
Penalty payments by uninsured individuals	0	0	0	0	-2	-5	-5	-5	-5	-6	-6	-34
Penalty payments by employers[d]	0	0	0	-4	-8	-9	-10	-11	-12	-13	-14	-81
Excise tax on high-premium insurance plans	0	0	0	0	0	0	0	-12	-20	-24	-29	-87
Other effects on tax revenues and outlays[e]	2	3	2	3	-4	-13	-17	-20	-22	-22	-22	-113
Net Cost of Insurance Coverage Provisions	**7**	**9**	**9**	**59**	**104**	**142**	**157**	**155**	**158**	**164**	**174**	**1,131**

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Notes: These estimates were produced using CBO's March 2011 baseline projections of federal revenues and outlays. They do not include federal administrative costs that would be subject to appropriation.

Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit. Numbers may not add up to totals because of rounding.

PPACA = Patient Protection and Affordable Care Act; Reconciliation Act =Health Care and Education Reconciliation Act of 2010; CHIP = Children's Health Insurance Program.

a. Under current law, states have the flexibility to make programmatic and other budgetary changes to Medicaid and CHIP. CBO estimates that state spending on Medicaid and CHIP in the 2012–2021 period would increase by about $60 billion as a result of the coverage provisions.

b. Includes spending for high-risk pools and the net budgetary effects of proposed collections and payments for reinsurance and risk adjustment.

c. Numbers may not match those shown in the table "CBO's March 2011 Baseline: Health Insurance Exchanges" located on CBO's Web site because different related items were included in the two tables.

d. The effects of this provision on the deficit include the associated effects of changes in taxable compensation on tax revenues.

e. The effects are almost entirely on tax revenues. CBO estimates that outlays for Social Security benefits would increase by about $4 billion over the 2012–2021 period and that the coverage provisions would have negligible effects on outlays for other federal programs.

covered in the analysis. Over the eight-year period that is common to both analyses (2012 to 2019), the net cost of the coverage provisions estimated in March 2011 ($794 billion) is 2 percent higher than the March 2010 estimate ($778 billion) (see Figure 2 on page 5). For those years, the current estimate is 8 percent *higher* than the February 2011 estimate ($733 billion), but that projection was 6 percent *lower* than the March 2010 estimate.

Effects on Discretionary Spending

Implementing PPACA and the Reconciliation Act will affect not only direct spending and revenues but also annual spending subject to future appropriation actions. Those effects on disctetionary spending arise from provisions of the legislation that affect a variety of federal programs and agencies. The legislation establishes a number of new programs and activities, and it authorizes new funding for existing programs. By its nature, however, discretionary spending is subject to future acts of the Congress through the annual appropriation process; that process could lead to greater or smaller costs than the sums authorized by PPACA.[12]

The discretionary costs associated with last March's legislation fall into two broad categories:

- The costs that will be incurred by federal agencies to implement the new policies established by the legislation, such as administrative expenses for the Internal Revenue Service and the Department of Health and Human Services in carrying out key requirements of the legislation, and

- Explicit authorizations for spending by a variety of grant and other programs; in many cases, specified funding levels for one or more years are provided in the legislation, although in other cases, the legislative language authorizes the appropriation of "such sums as necessary."

CBO estimated that costs to the IRS of implementing the eligibility determination, documentation, and verification processes for premium and cost-sharing credits would probably total between $5 billion and $10 billion over 10 years. In addition, CBO estimated that HHS would require similar amounts over 10 years to implement the changes in Medicare, Medicaid, and CHIP.

12. In addition to such spending that is subject to appropriations, PPACA and the Reconciliation Act created a number of new programs or requirements for which the legislation provided direct appropriations. Those amounts that were appropriated by the legislation are included in CBO's estimate of direct spending (as discussed previously).

CBO estimated that the provisions authorizing the appropriation of specific amounts, if fully funded by future laws, would result in appropriations of $106 billion over the 2010–2019 period.[13] Updating those estimates for the 2012–2021 period would result in authorizations of just under $100 billion.[14] Most of those authorizations—amounting to about $85 billion—were for activities that were already being carried out under prior law or that were previously authorized and that PPACA authorized for future years; for example, that amount includes an estimated $39 billion for ongoing activities of the Indian Health Service and $34 billion for continued grants to federally qualified health centers.[15]

The estimates discussed above are not included in CBO's estimate of direct spending under PPACA and the Reconciliation Act or in the effects of that legislation on deficits (as discussed earlier in this testimony) because the newly authorized funding is subject to future appropriation actions. The budgetary costs for carrying out those authorizations will be counted at the time and to the extent that the authorized amounts are appropriated, as is the case for all discretionary funding authorized and then ultimately appropriated by the Congress.

Effects on Insurance Coverage

PPACA and the Reconciliation Act included numerous provisions that will affect insurance coverage, including the following:

- The requirement that nearly all legal U.S. residents obtain health insurance;
- The establishment of health insurance exchanges and the provision of subsidies for certain individuals and families who purchase coverage through the exchanges;
- The requirements that insurers accept all applicants, not limit coverage for preexisting medical conditions, and not vary premiums to reflect differences in enrollees' health;
- The requirement that insurers extend coverage for dependent children up to age 26;

13. CBO has not estimated the amount of appropriations required to implement activities for which PPACA authorized the appropriation of "such sums as necessary."

14. The estimate of authorizations of specific amounts is lower for the 2012–2021 period than for the 2010–2019 period because it excludes the amounts authorized for 2010 or 2011 and because, in most cases, the authorization period expires before 2020.

15. For more information, see Congressional Budget Office, letter to the Honorable Jerry Lewis about potential effects of the Patient Protection and Affordable Care Act on discretionary spending (May 11, 2010); and "Additional Information about the Potential Discretionary Costs of Implementing PPACA" (May 12, 2010).

- The expansion of Medicaid coverage to include most nonelderly people with income below 138 percent of the federal poverty level;[16]
- The penalties on certain employers if any of their workers obtain subsidized coverage through the exchanges;
- The tax credits for small employers that offer health insurance; and
- The excise tax on insurance policies with relatively high premiums.

Changes in Insurance Coverage and Federal Budgetary Flows

According to CBO and JCT's most recent estimates, PPACA and the Reconciliation Act will increase the number of nonelderly Americans with health insurance by about 32 million in 2016 and about 34 million in 2021 (see Table 3). The share of legal nonelderly residents with insurance coverage in 2021 will be about 95 percent, compared with a projected share of about 82 percent in the absence of that legislation (and an estimated 83 percent currently). About 23 million nonelderly residents will remain uninsured; about one-third of that group will be unauthorized immigrants, who are not eligible to participate in Medicaid or the insurance exchanges; another quarter will be eligible for Medicaid but are not expected to enroll; and the remaining fraction will include individuals who are ineligible for subsidies, are exempt from the mandate to obtain insurance, choose to not comply with the mandate (and take the risk of paying a penalty), or have some combination of those characteristics.

That projected increase of 34 million in the number of insured people in 2021 reflects a number of differences relative to circumstances in the absence of PPACA and the Reconciliation Act. Approximately 24 million people will purchase their own coverage through insurance exchanges, and Medicaid and CHIP will have roughly 17 million additional enrollees. Partly offsetting those increases will be net reductions, relative to the number projected under prior law, of about 6 million people purchasing individual coverage directly from insurers and about 1 million people obtaining coverage through their employer.[17]

CBO and JCT estimate that PPACA and the provisions of the Reconciliation Act affecting health insurance coverage will result in a net increase in federal deficits of $1,131 billion over fiscal years 2012 through 2021. That estimate includes a

16. The legislation established the eligibility threshold for Medicaid at 133 percent of the federal poverty level, but 5 percent of applicants' income is disregarded, raising the effective threshold to 138 percent of the federal poverty level.

17. Under the legislation, certain employers can allow all of their workers to choose among the plans available in the exchanges, but those enrollees will not be eligible to receive subsidies via the exchanges (and thus are shown in Table 3 as enrollees in employment-based coverage rather than as enrollees in plans purchased via the exchanges). Nearly 4 million people are projected to obtain coverage in that way in 2021, bringing the total number of people enrolled in exchange plans to about 28 million in that year.

Table 3.

Estimated Effects of PPACA and the Reconciliation Act on Insurance Coverage

(Millions of nonelderly people, by calendar year)

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Effects on Insurance Coverage, by Source											
Coverage Under Prior Law[a]											
Medicaid and CHIP	37	37	37	36	35	35	35	35	35	36	35
Employer	152	154	157	159	161	163	163	163	163	163	162
Nongroup and other[b]	25	25	25	26	26	27	28	28	28	29	30
Uninsured[c]	55	55	54	54	53	53	54	54	55	56	57
Total	269	271	272	274	276	277	279	281	282	284	285
Increase or Decrease (-) in Coverage											
Medicaid and CHIP	*	*	*	9	12	16	16	16	16	16	17
Employer	3	3	3	6	3	-1	*	-1	-1	-1	-1
Nongroup and other[b]	*	*	*	-3	-4	-5	-5	-6	-6	-6	-6
Exchanges	0	0	0	9	14	22	23	23	24	24	24
Uninsured[c]	-3	-3	-3	-21	-26	-32	-33	-33	-33	-34	-34
Uninsured and Insured Populations Under Current Law											
Nonelderly Uninsured People[c]	52	51	51	32	27	21	20	21	22	23	23
Insured People as a Percentage of the Nonelderly Population											
All U.S. residents	81	81	81	88	90	93	93	92	92	92	92
U.S. residents except unauthorized immigrants	83	83	83	90	93	95	95	95	95	95	95

Continued

$627 billion increase in net federal outlays for Medicaid and CHIP and $777 billion in exchange subsidies and related spending. In addition, the tax credit for certain small employers who offer health insurance is estimated to cost $41 billion over 10 years. Those costs will be partly offset by higher revenues or lower costs, totaling about $314 billion over the 10-year budget window, from four sources: an increase in net revenues from the excise tax on high-premium insurance plans, totaling $87 billion; penalty payments by uninsured individuals, increasing revenues by $34 billion; penalty payments by employers, increasing revenues by $81 billion; and other budgetary effects, mostly on tax revenues, associated with shifts in the mix of taxable and nontaxable compensation resulting from changes in employment-based health insurance coverage, which will decrease deficits by $113 billion.[18]

18. Changes in the extent of employment-based health insurance affect federal revenues because most payments for that coverage are tax-preferred. If employers increase or decrease the amount of compensation they provide in the form of health insurance (relative to prior-law projections), CBO and JCT assume that offsetting changes will occur in wages and other forms of compensation—which are generally taxable—to hold total compensation roughly the same. Such effects also arise for specific elements of the legislation (such as the tax credits for small employers); those effects are included within the estimates for those elements.

Table 3. Continued

Estimated Effects of PPACA and the Reconciliation Act on Insurance Coverage

(Millions of nonelderly people, by calendar year)

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Memorandum:											
Exchange Enrollees and Subsidies											
Number with unaffordable offer from employer[d]				*	1	1	1	1	1	1	1
Number of unsubsidized exchange enrollees				1	2	4	4	4	4	4	4
Average exchange subsidy per subsidized enrollee (Dollars)				4,610	5,320	5,450	5,630	6,120	6,460	6,740	7,080

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Notes: These estimates were produced using CBO's March 2011 baseline projections of federal revenues and outlays.

Figures for the nonelderly population include only residents of the 50 states and the District of Columbia.

PPACA = Patient Protection and Affordable Care Act; Reconciliation Act = Health Care and Education Reconciliation Act of 2010; CHIP = Children's Health Insurance Program; * = between -500,000 and 500,000 people.

a. Numbers reflect average annual enrollment; people reporting multiple sources of coverage were assigned a primary source. To illustrate the effects of the 2010 health care legislation, which is now current law, changes in coverage are shown relative to coverage projections in the absence of that legislation, or under "prior law."

b. Other coverage includes Medicare. The effects of the proposal are almost entirely on nongroup coverage.

c. The count of uninsured people includes unauthorized immigrants and people who are eligible for, but not enrolled in, Medicaid.

d. Workers who would have to pay more than a specified share of their income (9.5 percent in 2014) for employment-based coverage could receive subsidies through an exchange.

Effects on Employment-Based Insurance

On balance, the number of people obtaining coverage through their employer will be about 1 million lower in 2019 through 2021 under PPACA and the Reconciliation Act than under prior law, CBO and JCT estimate. The net change in employment-based coverage under that legislation will be the result of several flows, which can be illustrated using the estimates for 2019:

- About 6 million to 7 million people who would have had an offer of employment-based coverage under prior law will not have an offer under current law. That estimate represents about 4 percent of the roughly 160 million people projected to have employment-based coverage. The businesses that choose to not offer coverage as a result of last year's legislation will tend to be smaller employers and employers with predominantly lower-wage workers—people who will be eligible for Medicaid or subsidies through the exchanges—although some workers who will not have

employment-based coverage because of the legislation will not be eligible for such subsidies. Whether those changes in coverage will derive from existing coverage that is dropped or a lack of new offers of coverage is difficult to determine.

- Another 1 million to 2 million people will have an offer of employment-based coverage but will be covered via the exchanges instead. Under the legislation, workers with an offer of employment-based coverage will generally be ineligible for exchange subsidies, but that "firewall" will presumably be enforced imperfectly, and an explicit exception to it will be made for workers whose offer of employment-based coverage is deemed unaffordable.

- About 7 million to 8 million people not covered by an employment-based plan under prior law will have that coverage under PPACA. That estimate reflects the combined impact of the insurance mandate, the penalties for employers, and the tax credits for small employers—which will lead some employers who would not have offered coverage before to the passage of PPACA to offer it and will lead some people to take up existing offers.

Some commentators have expressed surprise that CBO and JCT do not expect a much larger reduction in employment-based insurance coverage owing to PPACA and the Reconciliation Act, in light of the expansion of eligibility for Medicaid and the subsidies for individual insurance coverage created by that legislation. However, the legislation leaves in place substantial financial advantages for many people to receive insurance coverage through their employers, and it provides some new incentives for employers to offer insurance coverage to their employees. The key considerations include these:

- Although workers with low family income whose employers do not offer health insurance will be eligible for coverage through Medicaid or for significant subsidies through the insurance exchanges, middle-income workers will not be eligible for Medicaid and will be eligible for more moderate subsidies through the exchanges, and high-income workers will not be eligible for any subsidies. Most large firms—which are the predominant source of health insurance now—have a mix of higher-income and lower-income workers, so not all of their employees would be eligible for exchange subsidies if those employers decided not to offer coverage. Furthermore, nondiscrimination provisions in the Internal Revenue Code discourage firms from offering health insurance benefits to more highly paid employees while not offering them to lower-paid employees.

- Employment-based insurance receives a significant subsidy through the tax exclusion for employer-paid premiums, which will provide a continuing incentive for employers to offer coverage (even after high-premium plans face an excise tax beginning in 2018). The value of the tax exclusion for workers who obtain health insurance through their employer is usually proportional to their combined tax rates for payroll taxes and for federal and state income taxes—which usually do not

apply to the employer's contribution to the insurance premiums or to the employee's contribution. For higher-income workers, that tax subsidy typically amounts to 25 percent or more of the premiums. The subsidy will not be available to workers whose employers drop coverage and who end up purchasing insurance through an exchange.

- The administrative costs involved in operating and managing health insurance plans will be higher in the exchanges than they will be for large employers, principally because administering plans (including handling enrollment and the payment of premiums) for many individual policyholders is more expensive than administering them for a single employer. That advantage for employers will encourage employees to continue seeking employment-based coverage and thus will encourage employers to keep offering it.

- The mandate and penalties for individuals will lead more workers to want health insurance coverage. Because employers design benefit packages to appeal to their current and potential workers, that increased demand for health insurance will tend to boost the number of employers that offer insurance and the number of workers who obtain it.

- PPACA and the Reconciliation Act applied both sticks and carrots to employers to encourage them to offer insurance to their employees. Firms with more than 50 employees that do not offer insurance and have at least one employee who receives an exchange subsidy are subject to a penalty of up to $2,000 per full-time worker (beyond the first 30 such workers). Firms with fewer than 25 employees and with average annual wages of less than $50,000 may be eligible for a tax subsidy that covers a percentage of the premiums. Before 2014, for the smallest and lowest-wage firms, the credit covers up to 35 percent of the employer's payments for premiums; for 2014 and later, the credit will cover up to 50 percent of the employer's payments but only for two years.

- Employers who drop coverage and leave their employees to purchase insurance on their own will generally have to raise their cash compensation to compete with employers who continue to offer health insurance. Some evidence of such substitution has been found in studies that examine the wages of workers with differing job-related insurance benefits. Further evidence of such substitution can be seen at the aggregate level, where the share of national income devoted to compensation has been fairly steady during the past few decades, as rising costs of health benefits have been offset by slower growth of wages and salaries.

Other analysts who have carefully modeled the nation's existing health insurance system and the changes in incentives for employers to offer insurance coverage created by last year's legislation have reached conclusions similar to those of CBO and JCT. The Office of the Actuary at the Centers for Medicare and Medicaid Services concluded that, on net, about 1 million fewer people would have employment-based coverage

under PPACA in 2019.[19] Analysts at the Urban Institute estimated that such coverage would have diminished by about half a million people, on net, if the legislation had been fully implemented in 2010.[20] Analysts at the Lewin Group predicted a net reduction in employment-based coverage of about 3 million people, assuming full implementation in 2011.[21] Other analysts have concluded that employment-based coverage might increase: Analysts at RAND estimated that the number of workers offered, although not necessarily enrolled in, employment-based coverage would increase, on net, by about 14 million when the health care legislation was fully phased in.[22]

There is clearly a tremendous amount of uncertainty about how employers and employees will respond to PPACA and the Reconciliation Act, and there is little direct evidence on the issue up to now. Models of the insurance system are based on observed differences in behavior in response to more modest changes in incentives, but last year's legislation is much more sweeping in its nature.

Recent surveys of employers regarding their plans for offering health insurance coverage after Medicaid has been expanded and insurance exchanges are in place are broadly consistent with CBO and JCT's analysis. However, those surveys probably do not convey much real information at this point, because firms do not know very much yet about how last year's legislation will affect the market for health insurance. For example, firms have not experienced the added demand for coverage from their workers who will be subject to the insurance mandate, and very little evidence exists about how the insurance exchanges will operate.

Effects on Medicaid and CHIP Coverage

CBO and JCT estimate that the coverage provisions of PPACA and the Reconciliation Act will increase the number of Medicaid and CHIP beneficiaries by about

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19. Richard S. Foster, *Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended* (Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of the Actuary, April 22, 2010), www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf.

20. Matthew Buettgens, Bowen Garrett, and John Holahan, *America Under the Affordable Care Act* (Washington, D.C.: Urban Institute, December 2010), www.urban.org/uploadedpdf/412267-america-under-aca.pdf.

21. The Lewin Group, *Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers,* Staff Working Paper No. 11 (Falls Church, Va.: The Lewin Group, June 2010), www.lewin.com/content/publications/LewinGroupAnalysis-PatientProtectionandAffordableCareAct2010.pdf.

22. Christine Eibner, Peter S. Hussey, and Federico Girosi, "The Effects of the Affordable Care Act on Workers' Health Insurance Coverage," *New England Journal of Medicine*, vol. 363, no. 15 (2010), p. 1394. RAND analysts also estimated that the Senate-passed bill (H.R. 3590) would increase employment-based coverage, on net, by about 6 million people in 2019. See Jeanne S. Ringel and others, *Analysis of the Patient Protection and Affordable Care Act (H.R. 3590)* (Washington, D.C.: RAND Corporation, February 2010), www.rand.org/content/dam/rand/pubs/research_briefs/2010/RAND_RB9514.pdf.

17 million in 2021 and will increase federal spending for those programs by $627 billion over the 2012–2021 period (see Table 2 on page 14). Those estimates reflect the following provisions of the legislation:

- PPACA and the Reconciliation Act expand eligibility for Medicaid to nearly all legal residents of the country with income below 138 percent of the federal poverty level.

- The legislation provides that the federal government pay a substantially higher share of Medicaid costs for newly eligible enrollees than it will pay for previously eligible enrollees. The matching rates for newly eligible enrollees will be 100 percent from 2014 through 2016 and will then decline to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent thereafter.[23]

- The legislation requires nearly all individuals to have health insurance coverage, and if they do not comply, it generally imposes penalties.[24] CBO and JCT expect that the mandate and its associated penalties will increase Medicaid enrollment among both those who will become newly eligible for the program under the legislation and those who were eligible before the legislation.

- PPACA and the Reconciliation Act establish maintenance-of-effort requirements for states as a condition of receiving federal Medicaid funding. Those requirements prohibit states from establishing, for certain periods of time, eligibility standards, methodologies, or procedures that are more restrictive than those in effect when the legislation was passed. Specifically, states are required to maintain such effort for adults though 2013 and for children through 2019. CBO expects that, after 2013, nearly all states will eliminate Medicaid coverage for adults with income above 138 percent of poverty. Similarly, CBO expects that, after 2019, about half of the states will cease participating in CHIP, while the remaining states will reduce eligibility levels for CHIP. Adults and children no longer eligible for Medicaid and CHIP will become eligible for subsidies in the insurance exchanges to the extent that they meet other applicable eligibility requirements.

- The legislation establishes streamlined eligibility determinations for Medicaid and subsidies through the insurance exchanges. Under that policy, people who apply for coverage through a health insurance exchange but are found to be eligible for Medicaid are to be enrolled in that program. Similarly, people who apply for Medicaid but whose income would qualify them for subsidies through the exchanges are to be enrolled for those subsidies.

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23. The average federal share for current enrollees is about 57 percent. Starting in 2014, the average federal share, taking into account the rate for people newly eligible under PPACA's provisions, will range between 60 percent and 62 percent, depending on the year.

24. The penalties apply to all people with income above the threshold at which filing a federal tax return is required, which, depending on the filing status of the household, is about 80 percent to 90 percent of the federal poverty level.

Relative to the situation under prior law, the coverage provisions of PPACA and the Reconciliation Act are estimated to increase state governments' outlays for Medicaid by about $60 billion over the 2012–2021 period. That estimate reflects the flexibility states have to defray some of the additional costs associated with that legislation by making programmatic changes to Medicaid and CHIP. The costs accruing to the states from the legislation are greatest in the later years of the 10-year projection period because the federal share of Medicaid costs for newly eligible enrollees will decline from 100 percent between 2014 and 2016 to 90 percent after 2019.

By comparison, last March CBO estimated that the coverage provisions of PPACA and the Reconciliation Act would increase state spending for Medicaid by $20 billion over the 2010–2019 period. The difference between those two estimates mostly reflects the different time periods they cover.

In addition to the coverage provisions discussed here, other provisions of PPACA and the Reconciliation Act will also affect states' costs for Medicaid. The legislation reduced federal allotments for hospitals that treat a disproportionate share of low-income individuals, altered Medicaid prescription drug policies, changed community-based long-term care benefits, and made other changes that might affect states' Medicaid spending as well. CBO has not estimated the effects of those provisions on states' outlays for Medicaid.

Additional Effects on Spending for Medicare, Medicaid, and Other Programs

Many of the provisions of PPACA and the Reconciliation Act apart from those related to insurance coverage will affect spending under Medicare, Medicaid, and other federal programs. That legislation made numerous changes to payment rates and payment rules in those programs, established a voluntary federal program for long-term care insurance through the Community Living Assistance Services and Supports (CLASS) provisions, and made other changes to federal health programs.

In February 2011, CBO and JCT estimated that repealing the provisions of PPACA and the health-related provisions of the Reconciliation Act that were not related to insurance coverage would produce a net increase in direct spending of $732 billion over the 2012–2021 period. Reversing the sign of that estimate provides an approximation of the impact of enacting those provisions over that period. Therefore, CBO and JCT effectively estimated in February that enacting the provisions of PPACA and the Reconciliation Act unrelated to insurance coverage will produce a net decrease in direct spending of $732 billion over the 2012–2021 period.

A few provisions of the legislation account for most of those projected savings: changes to Medicare's payment rates in the fee-for-service sector and to Medicare Advantage plans; reductions in Medicaid and Medicare payments to "disproportionate share hospitals" (hospitals that treat a disproportionate number of low-income people); and establishment of a long-term care insurance program (the CLASS Act).

The estimated savings also reflect numerous other provisions of the legislation that CBO estimates will have more modest budgetary effects within the 10-year projection period. Some of those provisions, however, could have significant effects on the health care delivery system and on Medicare spending in the long run. Finally, the net savings of $732 billion includes the additional spending generated by other provisions of the legislation, such as an expansion of Part D benefits and the appropriation of funds for a number of new or expanded activities.

Changes to Payment Rates in Medicare

In February 2011, CBO estimated that the permanent reductions in the annual updates to Medicare's payment rates for most services in the fee-for-service sector (other than physicians' services) and the new mechanism for setting payment rates in the Medicare Advantage program will reduce Medicare outlays by $507 billion during the 2012–2021 period. That figure excludes interactions between those provisions and others—namely, the effects of the changes in the fee-for-service portion of Medicare on payments to Medicare Advantage plans and the effects of changes in both the fee-for-service portion of the program and in the Medicare Advantage program on collections of premiums for Part B (Supplementary Medical Insurance).

The estimated savings from those changes in payment rates are quite close to the savings that CBO estimated originally, for the overlapping period of 2012 through 2019. For that period, the estimated gross savings for the fee-for-service updates and the Medicare Advantage provisions—taking into account interactions between spending in the fee-for-service sector and payments to Medicare Advantage plans but not the effects on collections of Part B premiums—was $399 billion in the original estimate in March 2010 and $400 billion on the basis of CBO's updated estimate in February 2011.

By CBO's estimates, enrollment in the Medicare Advantage program in 2017 and later years will be about 60 percent of the enrollment that would have occurred in the absence of PPACA and the Reconciliation Act.

Disproportionate Share Hospitals

Both Medicare and Medicaid provide additional payments to hospitals that serve a disproportionate number of low-income patients. PPACA and the Reconciliation Act modified the formulas used to calculate such payments under Medicare and the state-specific allotments that determine such payments under Medicaid. On the basis of CBO's February 2011 estimate, last year's legislation is projected to reduce direct spending for Medicare's and Medicaid's payments to disproportionate share hospitals by $57 billion over the 2012–2021 period.

The CLASS Act

CBO's February 2011 analysis indicates that implementation of the long-term care insurance program established by the CLASS Act will reduce federal deficits by $86 billion over the 2012–2021 period. Under those provisions, active workers will

be able to purchase long-term care insurance, usually through their employer. Premiums will be set to cover the full cost of the program as measured on an actuarial basis. CBO projects that the program's cash flows excluding interest earned on income from premiums will show net receipts for a number of years, followed by net outlays in subsequent decades. In particular, the program will pay out far less in benefits than it will receive in premiums over the 2012–2021 period. In CBO's March 2011 baseline, the estimated 10-year reduction in federal deficits owing to the Class Act is reduced to $83 billion.

Other Provisions with Significant Programmatic or Budgetary Effects

The provisions described above account for about $650 billion of the $732 billion in net savings over the 2012–2021 period stemming from the provisions of PPACA and the Reconciliation Act unrelated to insurance coverage. Numerous other provisions and interactions among provisions account for the remaining $82 billion in net savings. Many of those provisions will reduce spending, whereas others will increase it. The provisions that will reduce spending make a variety of changes to prior law, including establishing a mechanism to reduce the growth rate of Medicare spending if projected growth exceeds a given target, initiating a number of programs intended to modify the health care delivery system, and adjusting payments for prescription drugs in Medicaid. Most of the provisions that will increase spending establish new benefits or expand existing ones in Medicare and Medicaid; increase payment rates for some providers; or provide funding for grant, research, and other programs.

PPACA created the Independent Payment Advisory Board (IPAB), which has the obligation to reduce Medicare spending relative to what would otherwise occur if the rate of growth in spending per beneficiary is projected to exceed a target rate that is based on inflation (for 2015 through 2019) or growth in the economy (for 2020 and subsequent years). In its February 2011 estimate, CBO concluded that the rate of increase in spending would probably exceed the target rate in some years, and that the IPAB, therefore, would have to intervene to reduce the growth of Medicare spending. CBO estimated that those actions would result in $14 billion in savings over the 2012–2021 period. In CBO's March 2011 baseline, by contrast, the rate of growth in Medicare spending per beneficiary is projected to remain below the levels at which the IPAB will be required to intervene to reduce Medicare spending. As a result of that reduction in projected Medicare spending, CBO's March baseline does not include any savings from actions by the IPAB.

PPACA and the Reconciliation Act include numerous provisions intended to identify opportunities and create incentives for providers to make changes to the health care delivery system that will reduce costs and improve the quality of care. Those provisions involve a wide variety of approaches, some making relatively specific changes and others establishing a process to develop information that could guide decisions on future changes. The more specific provisions include establishing payment incentives to report measures of the quality of care, creating payment incentives to lower costs and improve quality by establishing a shared-savings (or accountable care

organization) program, bundling payments for different aspects of care for a single medical event or condition, and imposing payment penalties for readmissions or medical conditions acquired in the process of receiving health care. By contrast, provisions that seek to develop information that could inform future decisions about the delivery of health care include activities designed to improve how the quality of health care is measured, the expansion of research on outcomes of medical care, and the development of a mechanism to test innovations and to implement those that reduce costs and improve quality. In CBO's estimation, many of those initiatives will reduce spending to some extent—generally either by changing providers' behavior directly or by identifying interventions that will result in changes in providers' behavior.

PPACA and the Reconciliation Act will reduce Medicaid spending for prescription drugs, compared with the level under prior law, as a result of provisions that increase rebates paid by manufacturers of prescription drugs and make other changes to drug reimbursement policy.

PPACA and the Reconciliation Act will also increase spending, relative to the level under prior law, for several programs. In Medicare, the legislation will increase spending for the Part D drug benefit by gradually reducing the coverage gap (sometimes known as the doughnut hole) for people whose spending exceeds the initial coverage level. In Medicaid, spending for benefits will increase as a result of provisions that created new options for states to provide community-based long-term care services and temporarily raised payments for certain primary care providers. In addition, the legislation provided mandatory funding for a number of grant, research, and other programs, including funding for a Prevention and Public Health Fund and grants for programs providing home visits for mothers and young children.

Impact on the Federal Budget Beyond the First Decade

CBO does not generally provide cost estimates beyond the 10-year projection period. Over a longer time span, a wide range of changes could occur—in people's health, in the sources and extent of their insurance coverage, and in the delivery of medical care—that are very difficult to predict but that could have a significant effect on federal health care spending, both under current law and under the law before the passage of PPACA and the Reconciliation Act. Nonetheless, certain Congressional rules require some information about the budgetary impact of legislation in subsequent decades, and many Members have requested analyses of the long-term budgetary impact of proposed broad changes in the health care and health insurance systems.

Estimates of Long-Term Budgetary Effects

CBO and JCT assessed the budgetary effects of PPACA and the Reconciliation Act in the decade following the 10-year projection period by grouping the elements of that legislation into broad categories and assessing the rate at which the budgetary impact of each of those broad categories would increase over time. On the basis of its February 2011 analysis, CBO projected that PPACA and the Reconciliation Act would

reduce federal budget deficits during the 2022–2031 period by an amount that is in a broad range around one-half percent of GDP, assuming that all provisions of the legislation were fully implemented. The imprecision of that estimate reflects the greater degree of uncertainty that attends to it, compared with CBO's year-by-year dollar estimates for the regular 10-year projection period. That estimate has not been updated since the February analysis.

CBO has not extrapolated those estimates farther into the future. Federal spending and revenues under the legislation depend crucially on the evolution of the health care and health insurance systems—systems that were already undergoing rapid change before the passage of PPACA and the Reconciliation Act and that the legislation would alter in myriad ways. Moreover, the legislation has significant conflicting implications for deficits: On the one hand, it will substantially expand eligibility for Medicaid and provide subsidies through insurance exchanges; on the other hand, the legislation will raise additional revenues and significantly decrease Medicare outlays, largely by reducing payment rates for many types of health care providers relative to the rates that would have been paid under prior law but also by making other specific changes in the program and establishing a mechanism designed to control the growth of the program's costs. As a result of those conflicting forces, fairly small errors in projecting the effects of some provisions that will increase or decrease deficits could produce notable errors in projecting the net impact of the legislation.

Consequently, CBO does not believe that it has a sufficient analytic basis for evaluating the effects of the legislation on the growth rate of spending over the very long run. However, in view of the projected budgetary effects between 2022 and 2031, CBO anticipates that in subsequent decades PPACA and the Reconciliation Act will probably continue to decrease budget deficits relative to those that would have occurred under prior law.

Key Considerations in Evaluating Long-Term Budgetary Effects

The calculations of longer-term effects are based on the assumption that the provisions of PPACA and the Reconciliation Act will remain unchanged throughout the next two decades. However, those laws put into effect a number of policies that may be difficult to sustain over a long period of time.

Specifically, last year's legislation restrains the rate of increase in payment rates for many providers of Medicare services to less than the expected rate of increase in the cost of the providers' inputs, in expectation of ongoing productivity improvements in the delivery of health care. If providers do not improve their productivity sufficiently rapidly to offset the reductions in payment rates, those rates will fall over time relative to the cost of providing services. By holding the rate of increase in payment rates below what would have prevailed under prior law, PPACA will generate savings that are projected to increase considerably during the next 10 years and in the decade beyond that. However, it is unclear the extent to which providers will achieve greater efficiencies in the delivery of health care and the extent to which cost pressures will

instead reduce access to care or diminish the quality of care (relative to the situation under prior law) outcomes that might increase pressure on the Congress to increase payments to providers. It is also unclear whether and how the Congress would respond to such pressure if it arose and what effects the response would have on total federal health care spending, revenues, and deficits.

Last year's legislation will restrain the increases in Medicare payment rates for many providers other than physicians. At the same time, the so-called sustainable growth rate mechanism—which has been in effect since 1997—is projected to cause Medicare's payment rates for physicians' services to be reduced sharply during the next few years. That mechanism has frequently been modified (either through legislation or administrative action) to avoid an abrupt and large reduction in those payment rates that might have reduced Medicare beneficiaries' access to physicians' services.

On the basis of the cuts in payment rates under PPACA and the Reconciliation Act, along with the effects of the sustainable growth rate mechanism, CBO projects that Medicare spending per beneficiary (adjusted for inflation) will increase at an average annual rate of less than 2 percent during the next two decades—compared with the rate of roughly 4 percent that has occurred over the past two decades (a figure that excludes the effect of establishing the Medicare prescription drug benefit).

Another provision that may be difficult to sustain will slow the growth of federal subsidies for health insurance purchased through the insurance exchanges. For enrollees who receive subsidies, the amount they will have to pay depends primarily on a formula that determines what share of their income they have to contribute to enroll in a relatively low cost plan (with the subsidy covering the difference between that contribution and the total premiums for that plan). Initially, the percentages of income that enrollees must pay are indexed so that the subsidies will cover roughly the same share of the total premiums over time. After 2018, however, an additional indexing factor will probably apply; if so, the shares of income that enrollees have to pay will increase more rapidly, and the shares of the premiums that the subsidies cover will decline.[25] Whether a widening gap between subsidies and premiums will increase pressure on the Congress to adjust the subsidy schedule and how the Congress might respond are uncertain.

If those provisions and others will subsequently be modified or implemented incompletely without offsetting changes in federal policies, then the effects that PPACA and the Reconciliation Act have on federal spending, revenues, and deficits could be quite different from the ones that CBO estimated. However, CBO does not forecast future changes in law or assume such changes in its estimates of the budgetary effects of legislation.

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25. Beginning in 2019, enrollees will pay a higher percentage of income to enroll in a given plan if the total cost of exchange subsidies in the prior year exceeded 0.504 percent of GDP. Although it is uncertain when that threshold will be reached, CBO projects that it will become increasingly likely to be reached over time because the exchange subsidies are projected to grow faster than GDP.

Other Effects of the Legislation

CBO has also analyzed the legislation's impact on the "federal budgetary commitment to health care," a term that CBO uses to describe the sum of net federal outlays for health programs and tax preferences for health care; on health insurance premiums; and on labor markets.[26]

Effect on the Federal Budgetary Commitment to Health Care

In its February 2011 estimate for repealing PPACA and the Reconciliation Act, CBO in effect projected that the legislation would increase the federal budgetary commitment to health care by $464 billion over the 2012–2021 period.[27] That increase is driven primarily by the federal cost of expanding insurance coverage, which will be partly offset by other factors such as the decrease in other federal health care spending (primarily for Medicare) and the imposition of the excise tax on insurance policies with relatively high premiums.

However, CBO estimated that PPACA and the Reconciliation Act would decrease the federal budgetary commitment to health care in the decade following the 10-year projection period. The estimated effect in later years differs from the effect in the first decade because the effects of those provisions that will tend to reduce the federal budgetary commitment to health care (such as the reduction in Medicare spending and the imposition of the high-premium excise tax) were estimated to grow faster than the effects of provisions that will tend to increase it (primarily the coverage expansions). As with the longer-term estimate of overall budgetary effects, that projection incorporated an assumption that the provisions of the legislation will be fully implemented.

Effect on Health Insurance Premiums

Members have also requested information about the effects of the legislation on health insurance premiums. On November 30, 2009, CBO released an analysis, prepared with JCT, of the impact of PPACA as it was originally proposed on average premiums for health insurance in different markets.[28] Although CBO and JCT have not updated the estimates provided in that letter, the estimated effects of PPACA and the Reconciliation Act as enacted would probably be quite similar.

In particular, premiums for health insurance in the individual market will be somewhat higher on average under PPACA and the Reconciliation Act than under prior law, mostly because the average insurance policy in that market will cover a larger

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26. For additional discussion of the term federal budgetary commitment to health care, see Congressional Budget Office, letter to the Honorable Max Baucus regarding different measures for analyzing proposals to reform health care (October 30, 2009).

27. In March 2010, CBO estimated that PPACA and the Reconciliation Act would increase the federal budgetary commitment to health care by $390 billion over the 2010–2019 period.

28. See Congressional Budget Office, letter to the Honorable Evan Bayh providing an analysis of health insurance premiums under the Patient Protection and Affordable Care Act (November 30, 2009).

share of enrollees' costs for health care and provide a slightly wider range of benefits. The effects of those differences will be offset in part by other factors that will tend to reduce premiums in the individual market; for example, insurers will incur lower administrative costs per policy, and enrollees will tend to be healthier (because the subsidies provided through the exchanges and the individual mandate to obtain insurance are expected to result in an influx of enrollees with below-average spending for health care). Although premiums in the individual market are expected to be higher on average under PPACA and the Reconciliation Act than under prior law, many people will end up paying less for health insurance because the majority of enrollees purchasing coverage in that market will receive subsidies via the exchanges.

Premiums for employment-based coverage obtained through large employers will be slightly lower on average under PPACA and the Reconciliation Act than under prior law, reflecting the net impact of many relatively small changes. Average premiums for employment-based coverage obtained through small employers may be slightly higher or slightly lower (reflecting uncertainty about the impact of the legislation on premiums in that market).

Effect on Labor Markets

The legislation will affect some individuals' decisions about whether and how much to work and employers' decisions about hiring workers.[29] According to CBO's August 2010 analysis, the legislation, on net, will reduce the amount of labor used in the economy by a small amount—roughly half a percent—primarily by reducing the amount of labor that workers choose to supply.[30] That net effect reflects changes in incentives in the labor market that operate in both directions: Some provisions of the legislation will discourage people from working more hours or entering the workforce, and other provisions will encourage them to work more. Moreover, many people will be unaffected by those provisions and will face the same incentives regarding work as they otherwise would have.

Since the legislation will affect individuals' decisions on both whether to participate in the workforce and the number of hours they work, its effect on household employment is difficult to predict. According to CBO's projections, if the legislation only affects the number of individuals who participate in the workforce (and not the average number of hours worked per employed person), it will reduce employment in 2021 by about 800,000 relative to what would otherwise have occurred; however, because the legislation will probably affect the average number of hours worked as well, the effect on employment will be somewhat different.

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29. For a general discussion about the potential effects of health care legislation on labor markets, see Congressional Budget Office, *Effects of Changes to the Health Insurance System on Labor Markets*, Issue Brief (July 13, 2009).

30. See Congressional Budget Office, *The Budget and Economic Outlook: An Update* (August 2010).

The net reduction in the supply of labor is largely attributable to the substantial expansion of Medicaid and the provision of subsidies that will reduce the cost of insurance obtained through the insurance exchanges. Those changes in law will effectively increase individuals' financial resources, which will encourage some people to work fewer hours or to withdraw from the labor market. In addition, the phaseout of the subsidies as income rises will effectively increase marginal tax rates, which will also discourage work. But because most workers who are offered insurance through their job will be ineligible for the subsidies and because most people will have income that is too high to be eligible for Medicaid, those effects on financial resources and marginal tax rates will apply to only a small segment of the population.

Other provisions in the legislation are also likely to diminish people's incentives to work. Changes to the insurance market, including provisions that prohibit insurers from denying coverage to people because of preexisting conditions and that restrict how much premiums can vary with an individual's age or health status will increase the appeal that health insurance plans offered outside the workplace have for older workers. As a result, some older workers will choose to retire earlier than they otherwise would.

In contrast, another feature of the Medicaid expansion removes an existing disincentive to work for many low-income individuals. People currently become ineligible for Medicaid if their income rises above a certain level; for working parents, the median income threshold for eligibility among states was 64 percent of the federal poverty level in 2009. The health care legislation will allow parents to work and still qualify for Medicaid until their income exceeds 138 percent of the poverty level. Moreover, parents whose income exceeds the new threshold may be able to work and receive the subsidies for insurance purchased through the exchanges.[31]

Employers' decisions to hire workers will also be affected in some cases by the health care legislation. Employers with 50 or more employees will be required to pay a penalty if they do not offer insurance or if the insurance they offer does not meet certain criteria and at least one of their workers receives a subsidy from an exchange. Those penalties, whose amounts are based on the number of full-time workers in the firm, will, over time, generally be passed on to workers through reductions in wages or other forms of compensation. However, firms generally can not reduce workers' wages below the minimum wage, which will probably cause some employers to respond by hiring fewer low-wage workers. Alternatively, because firms are penalized only if their full-time employees receive subsidies from exchanges, some firms may instead hire more part-time or seasonal employees.

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31. The wider availability of subsidies could also affect the employment decisions of people with disabilities. Disabled people whose income is below 400 percent of the federal poverty level will be able to receive subsidized health care without leaving the work force and enrolling in such programs as Disability Insurance (DI) or Supplemental Security Income (SSI). As a result, some disabled workers who would otherwise be out of the work force might stay employed or seek employment; however, other disabled workers might leave the work force earlier than they otherwise would because, unlike DI, neither Medicaid nor subsidies offered through the exchanges will require people to wait before they can receive benefits.

More generally, the health care legislation may shape the labor market or the operations of other segments of the economy in ways that are difficult to anticipate or quantify. For example, the legislation could influence labor markets indirectly by making it easier for some employees to obtain health insurance outside the workplace and thereby enabling workers to take jobs that better match their skills. Some firms, however, might invest less in their workers—by reducing training, for example—if the probability of retaining those workers declines. To the extent that changes in the health insurance system lead to better health among workers, the nation's economic productivity could be enhanced. It is not clear, however, whether such changes would have a substantial impact on overall economic productivity or output. Moreover, many of the effects of the legislation may not be felt for several years because it will take time for workers and employers to recognize and to adapt to the new incentives.

Mr. PITTS. The chair thanks the gentleman and recognizes Mr. Foster for 5 minutes for an opening statement.

STATEMENT OF RICHARD FOSTER

Mr. FOSTER. Thank you. Chairman Pitts, Representative Pallone, other distinguished subcommittee members, thank you for inviting me here today to testify about the financial impacts of the Affordable Care Act.

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

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

I am very pleased to have the opportunity to appear with Doug Elmendorf. Now, I know you probably saw the press reports of a cage match or a possible fight between us or various humorous things like that but I am afraid the reality is far less dramatic. Doug and I and our staffs, we are all public servants and our goal is just to try to do the best job we can to provide valuable technical information for you all. That is all we are trying to do. I am not running for president. I suspect you are not either. And if nominated, I know what would happen with either one of us.

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

I want to say just a couple words about concerns that I have had and have expressed with one important aspect of the Affordable Care Act, and that has to do with the annual payment updates under Medicare for most categories of providers. Specifically, these annual payment updates are based on the increase in a market basket of prices that providers have to pay to pay for wages or rent or energy costs or supplies, you name it. It is based on that increase in prices, input prices, minus the overall economywide increase in productivity, which is about 1.1 percent per year. Now, this adjustment, which is permanent, this will happen forever until

you all decide maybe it should be changed, but this adjustment will be a strong incentive for providers to economize, to get rid of any inefficiency, waste, et cetera, be as efficient as possible, but I believe it is doubtful that many health providers can improve their own productivity enough to match the level of economy-wide productivity. Now, if they can't, then the consequences are that Medicare provider payment rates for most providers would grow about 1.1 percent per year less than their input prices or their input costs, and unless they can improve their productivity to match, eventually they would become unable or unwilling to provide services to Medicare beneficiaries. Now, long before that would happen, I think Congress would step in and change the basis to prevent such access or quality problems, but if that happens, that means the Medicare savings we have estimated would be lower. Actual Medicare costs would be higher than any of our estimates.

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

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

[The prepared statement of Mr. Foster follows:]

The Estimated Effect of the Affordable Care Act on Medicare and Medicaid Outlays and Total National Health Care Expenditures

Testimony before the
House Energy and Commerce Committee,
Subcommittee on Health
March 30, 2011

by

Richard S. Foster, F.S.A.
Chief Actuary
Centers for Medicare & Medicaid Services

Chairman Pitts, Representative Pallone, distinguished Subcommittee members, thank you for inviting me to testify today about the impact of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, on the Medicare and Medicaid programs and on total health expenditures in the U.S.

I would like to begin by saying a little about the role of the Office of the Actuary at the Centers for Medicare & Medicaid Services. We have the responsibility to provide actuarial, economic, and other technical assistance to policy makers in the Administration and Congress on an independent, objective, and nonpartisan basis. Our highest priority is to help ensure that policy makers have the most reliable technical information possible as they work to sustain and improve Medicare and Medicaid. The Office of the Actuary has performed this role on behalf of Congress and the Administration since the enactment of these programs over 45 years ago. We have also provided actuarial estimates for various past national health reform initiatives, including the proposed Health Security Act in 1993-1994 and the Affordable Care Act as it was developed and enacted in 2009-2010.

I am appearing before your Committee today in my role as an independent technical advisor to Congress. My statements, estimates, and other information provided in this testimony are my own and do not represent an official position of the Department of Health & Human Services or the Administration. Unless noted otherwise, the estimates used in this testimony are drawn from my memorandum of April 22, 2010, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended." This memorandum and the other documents to which I refer are available on the CMS website at http://www.cms.gov/ActuarialStudies/. We have since updated many of these estimates for use in the President's 2012 Budget and in a forthcoming article on national health expenditure projections. Although some of the updates are significant, they do not substantially change the overall outlook for the financial effects of the Affordable Care Act as described in this testimony.

Affordable Care Act

The March 2010 health care reform legislation, generally known as the Affordable Care Act, affects nearly every aspect of health care in the U.S. Among its many provisions expected to have a significant financial effect, the Act:

- Mandates coverage for health insurance in 2014 and later.
  - Establishes Health Insurance Exchanges.
  - Provides Federal subsidies for Exchange insurance premiums and cost-sharing requirements.
  - Provides temporary tax credits for small businesses that offer health coverage.
  - Imposes penalties on some individuals who forgo coverage.
  - Imposes penalties on large employers that do not offer health insurance to workers.
- Expands Medicaid eligibility and makes other changes to Medicaid and the Children's Health Insurance Program (CHIP).
  - Increases income threshold from less than 100 percent of the Federal Poverty Level (FPL) to 138 percent.
  - Extends coverage to those without specific non-income qualifying factors (e.g., disability).
  - Increases Medicaid prescription drug rebates.
  - Reduces Medicaid disproportionate share hospital (DSH) expenditures.
  - Introduces Medicaid "Community First Choice Option" and other changes to encourage home and community-based services.
  - Raises Federal matching rates for States with existing childless-adult coverage expansions.
  - Temporarily increases Medicaid payments to primary care physicians.
  - Extends CHIP funding for 2014 and 2015.
- Implements numerous Medicare changes.
  - Permanently reduces Medicare payment updates for most categories of providers by the increase in economy-wide multifactor productivity (approximately 1.1 percent per year).
  - Reduces Medicare Advantage payment benchmarks and permanently extends the authority to adjust for coding intensity.
  - Reduces Medicare DSH payments and refines imaging payments.
  - Creates an Independent Payment Advisory Board together with Medicare expenditure growth rate targets.
  - Increases the HI payroll tax rate by 0.9 percentage point for individuals with earnings above $200,000 and families above $250,000 and raises Part D premiums for single enrollees with incomes above $85,000 or couples above $170,000.
  - Phases out the Part D coverage gap ("donut hole").
  - Initiates numerous quality- and coverage-related Medicare provisions, including reporting of physician quality measures, reducing payments in cases involving hospital-acquired infections, reducing readmissions, and implementing evidence-based coverage of preventive services.
  - Creates a Center for Medicare and Medicaid Innovation in CMS for testing alternative models of health care delivery systems, payment methods, etc. and establishes a Medicare Shared Savings Program for accountable care organizations (ACOs).

- Implements certain immediate insurance reforms.
  - Minimum coverage requirements.
  - Pre-existing Condition Insurance Plan for those uninsured for at least 6 months.
  - Federal reinsurance for employer-sponsored early retiree plans.
  - Expansion of dependent coverage to age 26.
- Creates Federal Community Living Assistance Services and Supports (CLASS) long-term care insurance program.
- Supports comparative effectiveness research.
- Adds new taxes and fees.
  - Excise tax on high-cost employer health plans.
  - Taxes or fees on insurance plans, prescription drug manufacturers, device makers.
  - Additional 0.9-percent HI payroll tax on high earners.
  - Additional 3.8-percent tax on high investment returns and other non-earnings income.

As described in more detail in my April 22, 2010 memorandum, the Affordable Care Act is estimated to reduce the number of uninsured persons in the U.S. by 34 million in 2019. Approximately 18 million would gain Medicaid coverage as a result of the expansion of eligibility criteria. (In addition, roughly 2 million people with employer-sponsored health insurance would enroll in Medicaid for supplemental coverage.) Another 16 million uninsured persons would receive individual insurance coverage through the newly created Exchanges, with the majority of these qualifying for Federal premium and cost-sharing subsidies. Finally, we estimate that the number of individuals with employer-sponsored health insurance would decrease slightly overall, reflecting both gains and losses in such coverage under the Affordable Care Act.

Estimated impact of Affordable Care Act on Federal expenditures

The table shown on the following page presents the estimated financial effects of selected provisions in the Affordable Care Act on the Federal Budget in fiscal years 2010-2019. For convenience of presentation, the provisions of the legislation are grouped into six major categories:

(i) Coverage provisions, which include the mandated coverage for health insurance, the expansion of Medicaid eligibility, and the additional funding for CHIP;

(ii) Medicare provisions;

(iii) Medicaid and CHIP provisions other than the coverage expansion and CHIP funding;

(iv) Provisions aimed in part at changing the trend in health spending growth;

(v) The CLASS program; and

(vi) Immediate health insurance reforms.

The estimated costs and savings shown in the table are based on the effective dates specified in the law as enacted. We assume that employers and individuals would take roughly 3 to 5 years to fully adapt to the new insurance coverage options and that the enrollment of additional individuals under the Medicaid coverage expansion would be completed by the third year of implementation. Because of these transition effects and the fact that most of the coverage provisions would be in effect for only 6 of the 10 years of the budget period, the cost estimates shown in this memorandum do not represent a full 10-year cost for the new legislation.

Estimated Federal costs or savings under selected provisions of the Affordable Care Act

[Costs (+) or savings (–) in billions]

	Fiscal Year										Total,
Provisions	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-19
Total*	$9.2	−$0.7	−$12.6	−$22.3	$16.8	$57.9	$63.1	$54.2	$47.2	$38.5	$251.3
Coverage†	3.3	4.6	4.9	5.2	82.9	119.2	138.2	146.6	157.6	165.8	828.2
Medicare	1.2	−4.7	−14.9	−26.3	−68.8	−60.3	−75.2	−92.1	−108.2	−125.7	−575.1
Medicaid/CHIP	−0.9	−0.9	0.8	4.5	8.6	5.1	4.6	3.4	1.3	1.7	28.3
Cost trend‡	—	—	—	—	−0.0	−0.1	−0.2	−0.4	−0.6	−0.9	−2.3
CLASS program	—	−2.8	−4.5	−5.6	−5.9	−6.0	−4.3	−3.4	−2.8	−2.4	−37.8
Immediate reforms	5.6	3.2	1.2	—	—	—	—	—	—	—	10.0

* Excludes Title IX revenue provisions except for sections 9008 and 9015, certain provisions with limited impacts, and Federal administrative costs.

† Includes expansion of Medicaid eligibility and additional funding for CHIP ($410.3 billion total in 2010-2019), plus Federal premium, cost-sharing, and small business subsidies ($537.9 billion total), less individual and employer penalties for nonparticipation ($119.9 billion total). Updated estimates for the President's 2012 Budget show a similar total cost for these coverage provisions through fiscal year 2019 but with a significantly higher cost for the Medicaid expansion and a correspondingly lower net cost for the Exchange-related subsidies. See discussion of Medicaid estimates below for additional information.

‡ Includes estimated non-Medicare Federal savings from provisions for comparative effectiveness research, prevention and wellness, fraud and abuse, and administrative simplification. Excludes impacts of other provisions that would affect cost growth rates, such as the productivity adjustments to Medicare payment rates (which are reflected in the Medicare line) and the section 9001 excise tax on high-cost employer plans.

As indicated, the provisions in support of expanding health insurance coverage (including the Medicaid eligibility changes and extended CHIP funding) are estimated to cost $828 billion through fiscal year 2019, net of penalty receipts from nonparticipating individuals and employers. The Medicare, other Medicaid and CHIP, growth-trend, CLASS, and immediate reform provisions are estimated to result in net savings of about $577 billion, leaving a net overall cost for this period of $251 billion before consideration of additional Federal administrative expenses and the increase in Federal revenues that would result from the excise tax on high-cost employer-sponsored health insurance coverage and certain other revenue provisions. (The new Supplementary Medical Insurance revenues from fees on brand-name prescription drugs under section 9008 of the Affordable Care Act, and the higher Hospital Insurance payroll tax income under section 9015, are included in the estimated Medicare savings shown here.) The Congressional Budget Office and the Joint Committee on Taxation have

estimated that the total net amount of Medicare savings and additional tax and other revenues would somewhat more than offset the cost of the national coverage provisions, resulting in an overall reduction in the Federal deficit through 2019.

Estimated impact of Affordable Care Act on Medicare expenditures and revenues

Net Medicare savings are estimated to total $575 billion for fiscal years 2010-2019. Substantial savings are attributable to provisions that would, among other changes, reduce Part A and Part B payment levels and reduce future "market basket" payment updates by the increase in economy-wide multifactor productivity ($233 billion); eliminate the 2014 spending authorization for the Medicare Improvement Fund ($27 billion); reduce DSH payments ($50 billion); reduce Medicare Advantage payment benchmarks and permanently extend the authority to adjust for coding intensity ($145 billion); freeze the income thresholds for the Part B income-related premium for 9 years ($8 billion); implement an Independent Payment Advisory Board together with strict Medicare expenditure growth rate targets ($24 billion); and increase the HI payroll tax rate by 0.9 percentage point for individuals with earnings above $200,000 and families above $250,000 ($63 billion). Other provisions would generate relatively smaller amounts of savings, through such means as reporting physician quality measures, reducing payments in cases involving hospital-acquired infections, reducing readmissions, refining imaging payments, increasing Part D premiums for higher-income beneficiaries, and implementing evidence-based coverage of preventive services.

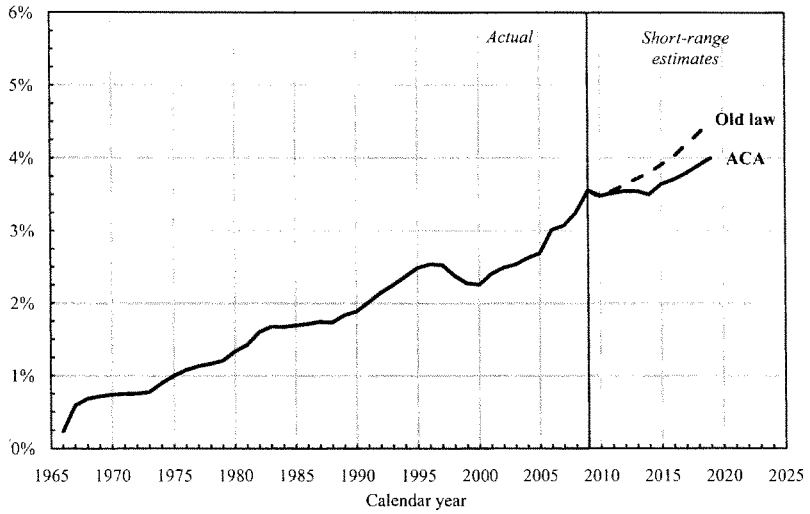
These savings are slightly offset by the estimated costs of closing the Part D coverage gap ($12 billion); reducing the growth in the Part D out-of-pocket cost threshold ($1 billion); extending a number of special payment provisions scheduled to expire, such as the postponement of therapy caps ($5 billion); and improving preventive health services and access to primary care ($6 billion).

As noted below, the Affordable Care Act authorizes a substantial program of research, development, and testing for innovative new health delivery systems and payment methods. This program has significant potential for improvements in the quality and cost efficiency of health care, but its effects on Medicare expenditures cannot be assessed until specific plans have been developed and tested.

The following chart shows actual past Medicare expenditures as a percentage of gross domestic product (GDP), together with estimated future amounts for 2010-2019 under the Affordable Care Act and under the prior law. Of the estimated net total Medicare savings of $575 billion over this period, $486 billion is attributable to a net reduction in Medicare expenditures (with the balance due to increased revenues from taxes and fees). The chart illustrates the expenditure impact only.

By 2019, the net reduction in Medicare expenditures is estimated to be 0.5 percent of GDP, which represents an 11-percent decrease from the level projected prior to the Affordable Care Act. This percentage reduction would grow larger over time as a result of the compounding effect of the slower annual updates in Medicare payment rates for most categories of health care providers.

Medicare expenditures before and after the Affordable Care Act
(as a percentage of GDP)



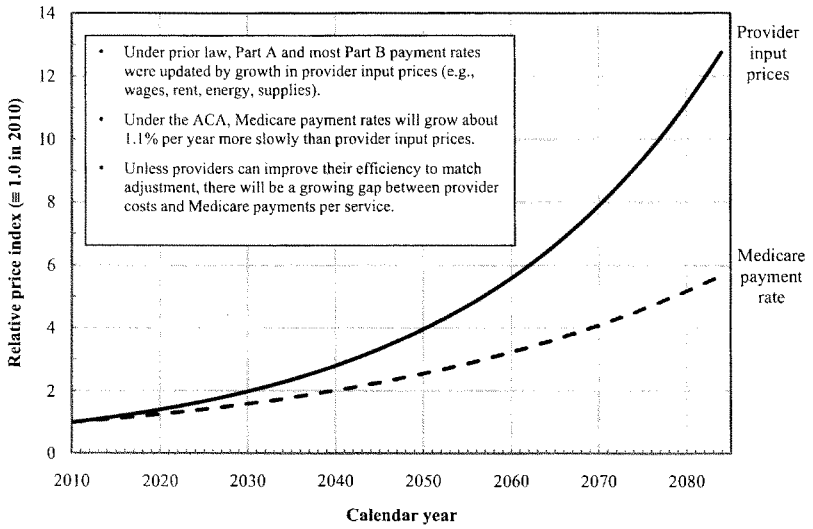
Based on the estimated savings for Part A of Medicare, and using the 2010 Trustees Report as a baseline, the assets of the Hospital Insurance trust fund would be exhausted in 2029 compared to 2017 under the prior law—an extension of 12 years. The combination of lower Part A costs and higher tax revenues results in a lower Federal deficit based on budget accounting rules. However, trust fund accounting considers the same lower expenditures and additional revenues as extending the exhaustion date of the HI trust fund. In practice, the improved HI financing cannot be simultaneously used to finance other Federal outlays (such as the coverage expansions) and to extend the trust fund, despite the appearance of this result from the respective accounting conventions. Conversely, expenditure reductions under Part B translate directly to lower financing requirements from general revenues and beneficiary premiums, since financing is re-established annually to match program costs. Thus, in the case of Part B, the savings under the Affordable Care Act are not needed to help pay for future benefit costs, and the full reduction in Federal general revenues attributable to such savings can be used to offset other Federal costs, such as those arising under the health reform coverage expansions. (Part D expenditures will increase under the Affordable Care Act, requiring additional Federal general revenue financing.) More detailed information on the financial status of the Medicare trust funds is available in the 2010 Medicare Trustees Report; an updated assessment will be shown in the forthcoming 2011 report.

It is important to note that the estimated savings for one category of Medicare provisions may be unrealistic. The Affordable Care Act requires permanent annual productivity adjustments to

price updates for most providers (such as hospitals, skilled nursing facilities, and home health agencies), using a 10-year moving average of economy-wide private, non-farm productivity gains. While such payment update reductions will create a strong incentive for providers to maximize efficiency, it is doubtful that many will be able to improve their own productivity to the degree achieved by the economy at large.[1]

The following chart illustrates the very large differential that would accumulate over long periods between the prices that health care providers have to pay to obtain the inputs they need to provide health care services and the corresponding Medicare payment rates. In practice, providers have few alternatives to paying market-based increases in wages and fringe-benefit costs for their employees. Similarly, price increases for office space, energy, utilities, and medical equipment and supplies are generally outside of providers' control.

Cumulative increase in provider input price vs. Medicare payment rate
(for providers subject to productivity adjustments under current law)



Over time, a sustained reduction in payment updates, based on productivity expectations that are difficult to attain, would cause Medicare payment rates to grow more slowly than, and in a way

[1] The provision of most health services tends to be very labor-intensive. Economy-wide productivity gains reflect relatively modest improvements in the service sector together with much larger improvements in manufacturing. Except in the case of physician services, I am not aware of any empirical evidence demonstrating the medical community's ability to achieve productivity improvements equal to those of the overall economy. The Office of the Actuary's most recent analysis of hospital productivity highlights the difficulties in measurement but suggests that such productivity has been small or negligible during 1981 to 2005. (See http://www.cms.hhs.gov/HealthCareFinancingReview/downloads/07-08Winterpg49.pdf.)

that was unrelated to, the providers' costs of furnishing services to beneficiaries. Thus, providers for whom Medicare constitutes a substantive portion of their business could find it difficult to remain profitable and, absent legislative intervention, might end their participation in the program (possibly jeopardizing access to care for beneficiaries). Simulations by the Office of the Actuary suggest that roughly 15 percent of Part A providers would become unprofitable within the 10-year projection period as a result of the productivity adjustments.[2] Although this policy could be monitored over time to avoid such an outcome, changes would likely result in smaller actual savings than described here for these provisions.

In their 2010 report to Congress on the financial status of the program, the Medicare Board of Trustees cautioned:

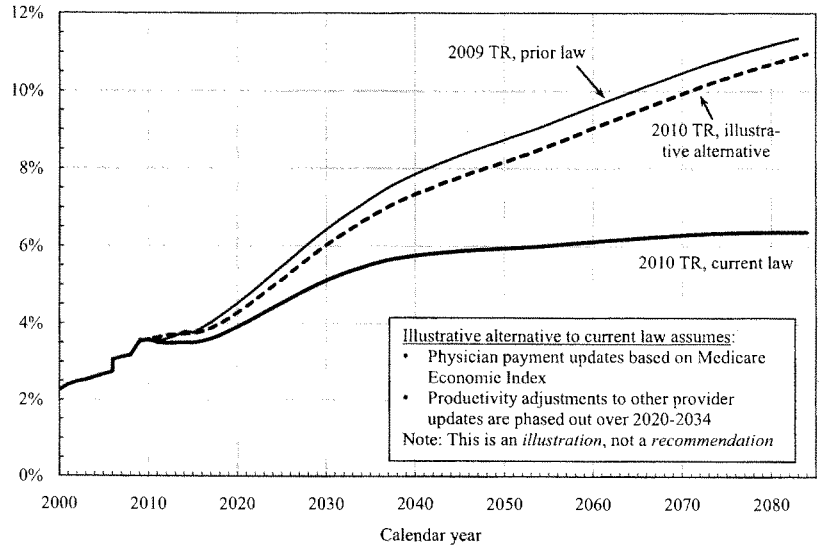
> The Affordable Care Act improves the financial outlook for Medicare substantially. However, the effects of some of the new law's provisions on Medicare are not known at this time, with the result that the projections are much more uncertain than normal, especially in the longer-range future. For example, the ACA initiative for aggressive research and development has the potential to reduce Medicare costs in the future; however, as specific reforms have not yet been designed, tested, or evaluated, their ability to reduce costs cannot be estimated at this time, and thus no specific savings have been reflected in this report for the initiative.
>
> Another important example involves lower payment rate updates to most categories of Medicare providers in 2011 and later. These updates will be adjusted downward by the increase in productivity experienced in the economy overall. Since the provision of health services tends to be labor-intensive and is often customized to match individuals' specific needs, most categories of health providers have not been able to improve their productivity to the same extent as the economy at large. Over time, the productivity adjustments mean tbat the prices paid for health services by Medicare will grow about 1.1 percent per year more slowly than the increase in prices that providers must pay to purchase the goods and services they use to provide health care services. Unless providers could reduce their cost per service correspondingly, through productivity improvements or other steps, they would eventually become unwilling or unable to treat Medicare beneficiaries.
>
> It is possible that providers can improve their productivity, reduce wasteful expenditures, and take other steps to keep their cost growth within the bounds imposed by the Medicare price limitations. Similarly, the implementation of payment and delivery system reforms, faeilitated by the ACA research and development program, could help constrain cost growth to a level consistent witb the lower Medicare payments. These outeomes are far from certain, however. Many experts doubt the feasibility of such sustained improvements and anticipate that over time the Medicare price constraints would become unworkable and that Congress would likely override them, much as they have done to prevent the reductions in physician payment rates otherwise required by the sustainable growth rate formula in current law.
>
> The annual report to Congress on the financial status of Medicare must be based on current law. In this report, the productivity adjustments are assumed to occur in all future years, as required by the Affordable Care Act. In addition, reductions in Medicare payment rates for physician services, totaling 30 percent over the next 3 years, are assumed to be implemented as required under current law, despite the virtual certainty that Congress will continue to override these latter reductions.
>
> In view of the factors described above, it is important to note that the actual future costs for Medicare are likely to exceed those shown by the current-law projections in this report. We recommend that the

[2] The simulations were based on actual fiscal year 2007 Medicare and total facility margin distributions for hospitals, skilled nursing facilities, and home health agencies. Provider revenues and expenditures were projected using representative growth rates and the Office of the Actuary's best estimates of achievable productivity gains for each provider type, and holding all other factors constant.

projections be interpreted as an illustration of the very favorable financial outcomes that would be experienced if the productivity adjustments can be sustained in the long range—and we caution readers to recognize the great uncertainty associated with achieving this outcome. Where possible, we illustrate the potential understatement of Medicare costs and projection results by reference to an alternative projection that assumes—for purposes of illustration only—that the physician fee reductions are overridden and that the productivity adjustments are gradually phased out over the 15 years starting in 2020.

The following chart shows long-range projections of total Medicare expenditures, as a percentage of GDP, under three scenarios. The substantial impact of the Affordable Care Act on expenditures is apparent by comparing the current-law projections from the 2010 Trustees Report (which includes the effect of all ACA provisions) to the corresponding projections from the 2009 Trustees Report (pre-ACA). Medicare expenditures in 2030 are currently projected to be about 20 percent lower than shown in the 2009 report, primarily as a result of the Affordable Care Act provisions. By 2050 and 2080, the projected difference increases to 32 and 43 percent, respectively.

Long-range projections of Medicare expenditures under current law, prior law, and an illustrative alternative to current law
(as a percentage of GDP)



The growing difference between the current-law and prior-law projections in the long range is primarily attributable to the compounding effect of the slower Medicare price updates. To help assess the potential understatement of Medicare costs under current law, the Board of Trustees asked the Office of the Actuary to make projections under an illustrative alternative to current

law. The alternative assumes that (i) Medicare payment updates for physicians would be based on the Medicare Economic Index, rather than the sustainable growth rate (SGR) formula, and (ii) the productivity adjustments to most other categories of providers would be gradually phased out after 2019. As indicated in the chart above, Medicare costs under the illustrative alternative to current law would be substantially greater than the current-law projections. It is important to note that the illustration represents only a means by which to consider the potential understatement of costs under current law. No endorsement of the illustrative payment changes by the Trustees, CMS, or the Office of the Actuary should be inferred.

Estimated impact of Affordable Care Act on Medicaid and CHIP

Based on our April 22, 2010 memorandum, the Affordable Care Act was estimated to add a total of $455 billion to aggregate Medicaid expenditures during fiscal years 2010-2019, an increase of about 8 percent.[3] Federal expenditures represent the great majority ($434 billion) of this projected cost, equivalent to a 13-percent increase compared to prior law. State expenditures were projected to expand only $21 billion (or about 1 percent). The Federal government's share of the cost increase is relatively larger than for current Medicaid expenditures because the Affordable Care Act specifies a much higher Federal matching rate for newly eligible beneficiaries, ranging from 100 percent in fiscal years 2014, 2015, and 2016 to 90 percent by 2020 and beyond.

The most significant provision, measured by its impact on expenditures and enrollment, is the expansion of Medicaid eligibility to all persons under age 65 living in families with incomes below 138 percent of FPL beginning in 2014. This expansion was projected to add more than 20 million Medicaid enrollees by 2019, an increase of about one-third compared to the prior law (including an estimated 2 million individuals with employer-sponsored health insurance who would enroll for supplementary coverage through Medicaid). About three-quarters of the additional enrollees are expected to be adults and the remaining one-quarter to be children.[4] The percentage increase in Medicaid expenditures will be considerably lower than the increase in enrollment, since adults and children have much lower average health care costs than aged and disabled enrollees.

The Affordable Care Act also provides for additional funding for the CHIP program, for 2014 and 2015, which would increase such expenditures by an estimated $29 billion.

The total net Federal cost of the other Medicaid and CHIP provisions is estimated to be $28 billion in fiscal years 2010-2019 and reflects numerous cost increases and decreases under

[3] Our original estimate for the increase in Medicaid outlays was based on an assumption that Social Security benefits would continue to be included in the definition of income for determining Medicaid eligibility. If a strict application of the modified adjusted gross income definition is instead applied, as is now expected, then an additional 5 million or more Social Security early retirees would be potentially eligible for Medicaid coverage. This change, together with later information on the planned implementation of other provisions, results in a significantly higher projected cost for the Medicaid expansion (and a correspondingly lower cost estimate for the Exchange subsidies).

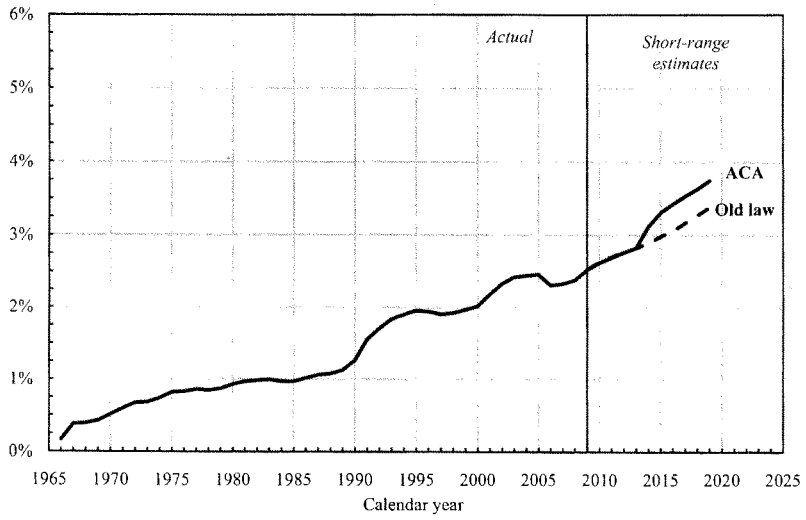
[4] In addition to the higher level of allowable income, the Affordable Care Act expands eligibility to people under age 65 who have no other qualifying factors that would have made them eligible for Medicaid under prior law, such as being under age 18, disabled, pregnant, or parents of eligible children.

the individual provisions. Those with significant Federal savings include various provisions increasing the level of Medicaid prescription drug rebates ($24 billion) and reductions in Medicaid DSH expenditures ($14 billion). Interactions between the different sections of the Affordable Care Act, such as the lower Medicare Part B premiums, contribute an additional $9 billion in reduced Medicaid outlays.

The key provisions that would increase Federal Medicaid and CHIP costs are the Medicaid "Community First Choice Option" and other changes to encourage home and community-based services ($29 billion), higher Federal matching rates for States with existing childless-adult coverage expansions ($24 billion), a temporary increase in payments to primary care physicians ($11 billion), and increased payments to the Territories ($7 billion). The net impact of the Medicaid and CHIP provisions on State Medicaid costs is a reduction totaling $33 billion through fiscal year 2019. These savings result in part because certain of the provisions reallocate costs from States to the Federal government.

The following chart shows past Medicaid and CHIP expenditures (Federal plus State) as a percentage of GDP, together with 10-year projections under the Affordable Care Act and prior law.

Medicaid/CHIP expenditures before and after the Affordable Care Act
(as a percentage of GDP)

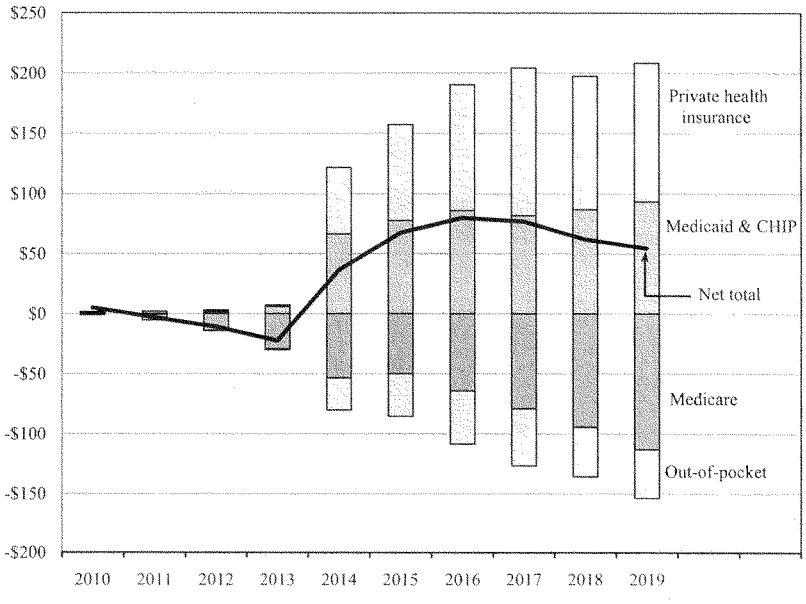


Estimated impact of Affordable Care Act on total national health expenditures

The estimated effects of the Affordable Care Act on overall national health expenditures (NHE) are shown by the "net total" curve in the following chart. In aggregate, we estimate that for calendar years 2010 through 2019, NHE would increase by $311 billion, or 0.9 percent, compared to prior law. Year by year, the relative increases are largest in 2016, when the coverage expansions would be fully phased in (2.0 percent), and gradually decline thereafter to 1.0 percent in 2019.

Estimated effect of the Affordable Care Act on total national health spending

[Estimated increase (+) or decrease (–) in annual spending, in billions)]



The net total increase in NHE reflects several large—and largely offsetting—effects on expenditures by private health insurance, Medicare, Medicaid, and individuals' own out-of-pocket costs, as shown by the columns in the chart above. Health expenditures are expected to increase by about $200 billion annually due to the substantial expansions of coverage under the Affordable Care Act. Numerous studies have demonstrated that individuals and families with health insurance use more health services than otherwise-similar persons without insurance. Under the health reform legislation, by 2019 an estimated 34 million currently uninsured people would gain comprehensive coverage through the health insurance Exchanges, their employers, or Medicaid.

The availability of coverage would typically result in a fairly substantial increase in the utilization of health care services, with a corresponding impact on total health expenditures. These higher costs would be partially offset by the sizable discounts imposed on providers by State Medicaid payment rules and by the significant discounts negotiated by private health insurance plans. We estimate that the net effect of the utilization increases and price reductions arising from the coverage provisions of the Affordable Care Act would increase NHE in 2019 by about 3.4 percent.

The Affordable Care Act will also affect aggregate NHE through the Medicare savings provisions. We estimate that these impacts would reduce NHE by roughly 2.4 percent in 2019, assuming that the productivity adjustments to Medicare payment updates can be sustained through this period. The legislation would have only a slight impact on the utilization of health care services by Medicare beneficiaries (subject to the caveat mentioned previously regarding possible access issues if Medicare payment rates become inadequate). As shown in the chart, the Medicare savings accumulate rapidly, principally due to the compounding effect of the slower payment updates for most categories of providers.

As indicated in the chart, out-of-pocket spending would be reduced significantly by the Affordable Care Act (an estimated net total decline of $237 billion in calendar years 2010-2019). This reduction reflects the net impact of (i) the substantial coverage expansions through Medicaid and the health insurance Exchanges, (ii) the significant cost-sharing subsidies for low-to-middle-income persons with Exchange coverage, (iii) the maximum out-of-pocket limitations associated with the qualified health benefit, (iv) lower cost-sharing payments by beneficiaries in fee-for-service Medicare, (v) higher cost-sharing payments by Medicare Advantage enrollees, and (vi) the increases in workers' cost-sharing obligations in plans affected by the excise tax on high-cost employer-sponsored health insurance coverage.

A number of the other provisions in the Affordable Care Act would also affect national health expenditures during 2010-2019, although the magnitude of these effects would be much smaller than the financial effects of the coverage expansions and Medicare savings provisions. These other provisions include the immediate insurance reforms in Title I; comparative effectiveness research; the excise tax on high-cost employer health plans; fees on health insurance plans and on manufacturers and importers of brand-name prescription drugs; and an excise tax on non-personal-use retail sales by manufacturers and importers of medical devices. The effects of these provisions are included in the respective categories of national health expenditures shown in preceding chart.

Compared to prior law, the *level* of total national health expenditures is estimated to be higher through 2019 under the Affordable Care Act, but two particular provisions of the legislation would help reduce NHE *growth rates* after 2016. Specifically, the productivity adjustments to most Medicare payment updates would reduce NHE growth by about 0.10 to 0.15 percent per year. In addition, the excise tax on high-cost employer health plans would exert a further decrease in NHE growth rates of an estimated 0.05 percent in 2019 and slightly more than that for some years thereafter. Although these growth rate differentials are not large, over time they would have a noticeable downward effect on the level of national health expenditures. Such an outcome, however, would depend critically on the sustainability of both provisions. As

discussed previously, the Medicare productivity adjustments could become unsustainable even within the next 10 years, and over time the reductions in the scope of employer-sponsored health insurance could also become an issue. For these reasons, the estimated reductions in NHE growth rates after 2016 may not be fully achievable.

Conclusions

The Affordable Care Act makes far-reaching changes to most aspects of health care in the U.S., including mandated coverage for most people, required payments by large employers not offering insurance, expanded eligibility for Medicaid, Federal premium and cost-sharing subsidies for many individuals and families, a new system of health benefits Exchanges for facilitating coverage, and a new Federal insurance program in support of long-term care. Additional provisions will reduce Medicare outlays, make other Medicaid modifications, provide more funding for the CHIP program, add certain benefit enhancements for these programs, and combat fraud and abuse. Federal revenues will be increased through an excise tax on high-cost insurance plans; fees or excise taxes on drugs, devices, and health plans; higher Hospital Insurance payroll taxes for high-income taxpayers; higher Medicare Part D premiums for high-income enrollees; a new tax on investment revenues and other unearned income; and other provisions.

In our independent capacity as technical advisors to the Administration and Congress, the Office of the Actuary at CMS has estimated the effects of the non-tax provisions of the Affordable Care Act on Federal outlays, overall national health expenditures, and health insurance coverage in the U.S. Our estimates are based on available data sources and what we believe are reasonable assumptions regarding individual, employer, and health plan responses to the legislation, together with analyses of the likely changes in the cost and use of health care services. In view of the complexity and scope of these changes, estimates of their financial and other effects are necessarily very uncertain. As the Affordable Care Act provisions are finalized through regulations, and as providers, employers, and individuals respond to the requirements and opportunities in the legislation, we will continue to monitor developments and to update our estimates for Medicare, Medicaid, CHIP, and total national health expenditures as necessary.

I hope that the information presented here is of value to policy makers, and I pledge the Office of the Actuary's continuing assistance to the joint effort by the Administration and Congress to determine optimal solutions to the financial challenges associated with health care in the U.S. I would be happy to answer any questions you might have.

Mr. PITTS. The chair thanks the gentleman. I thank the panel for their opening statements and I will now begin the questioning and recognize myself for 5 minutes for that purpose.

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

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

Mr. PITTS. Does the 800,000 figure account for employers that choose to avoid creating jobs in order to avoid the 50-employee threshold that triggers PPACA's employer mandate?

Mr. ELMENDORF. Again, Mr. Chairman, we did not explicitly the model the effects of the 50-employee threshold. We focused on maybe 10 other aspects of the legislation that we thought would have more significant effects on employment.

Mr. PITTS. OK. Does the 800,000 figure account for the new employer paperwork requirements in PPACA such as the 1099 filing provision and the variety of reporting requirements to Department of Labor and Treasury and HHS included in PPACA that will shift employer resources away from investment towards regulatory compliance?

Mr. ELMENDORF. Mr. Chairman, it is not obvious to me why the 1099 forms would have a significant effect on employment, and no, we did not incorporate any such effect in this estimate.

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

Mr. ELMENDORF. Mr. Chairman, in our analysis of the effects of changes in health insurance payments by employers, we recognize that both logic and evidence suggest that changes in particular aspects of compensation to employees tend to be offset by changes in other aspects of their compensation, so one can see in the aggregate data for the United States a rise in health spending by employers over the past several decades but also a slower rise in cash compensation, and economists think those factors are related. So we think that changes in to the extent that employers pay more for health care and some would pay more under this legislation, some would pay less under this legislation, we have not tried to tote this up. In any case, we think there would be offsetting changes in the cash compensation that employers would provide.

Mr. PITTS. Mr. Foster, proponents of PPACA argue that U.S. health spending of 16 percent of GDP is unsustainable and claim

that PPACA bends the cost curve. Does PPACA change this dynamic for the better or the worse?

Mr. FOSTER. We have estimated this question for the first 10 years. As I mentioned briefly, we estimate that the legislation increases the overall amount of total health spending in the United States by roughly one percentage point. In terms of the growth rates and what happens in the future, initially the growth rates are higher because we are spending more but there are certain factors that would tend to reduce the growth rates in the longer term. A good example is the productivity adjustments for Medicare payment updates. The real question is, how long can that work? They will help slow Medicare spending growth but they may not be viable indefinitely.

Mr. PITTS. Can you explain how a strict application of modified gross adjustment could greatly expand Medicaid eligibility under PPACA and increase the cost to both Federal Government and States?

Mr. FOSTER. Yes, sir. In the legislation, to achieve consistency between the definition of eligibility for Medicaid and the definition of eligibility for exchange subsidies, Congress decided to use modified adjusted gross income as the basis for determining income. Now, prior to this point for Medicaid, almost all States or perhaps all have included Social Security benefits in their definition of income for purposes of determining eligibility. With modified adjusted gross income, in contrast, for most people, only a small portion, if any, of their Social Security benefits would be included in that definition of income. So if you consider Social Security early retirees, under 65, who are potentially eligible for the Medicaid expansion and you then don't count $10,000 or $20,000 a year of Social Security benefits in their income, many of them can potentially qualify for Medicaid if you use that strict definition of modified adjusted gross income.

Mr. PITTS. The chair thanks the gentleman and now recognizes the ranking member, Mr. Pallone, for 5 minutes for questioning.

Mr. PALLONE. Thank you, Mr. Chairman. I wanted to address my questions to Mr. Elmendorf.

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

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

hearing was, of course, on this hidden mandatory spending and that is what the markup will be about tomorrow.

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

Mr. ELMENDORF. Yes, Congressman.

Mr. PALLONE. OK. So it wasn't hidden. What about section 4002, the prevention and public health fund? Did you know about that?

Mr. ELMENDORF. Yes, Congressman.

Mr. PALLONE. So that wasn't hidden either. And about what funding for school-based health centers? Did you know about that?

Mr. ELMENDORF. Yes, Congressman.

Mr. PALLONE. So it seems that we couldn't slip much past you, try as the Republicans think we might. It is also true that, I guess it was Congressman Jerry Lewis, Appropriations Committee, he said that there is about $100 billion in new discretionary funding in the bill that, of course, was hidden, that we were trying to hide. But I see you mention in your testimony that $85 billion of that is what actually—well, actually it was just reauthorization of preexisting programs like the Indian Health Service or the Community Health Centers. I was the sponsor of the Indian Health Care Improvement Act that was included in the bill. So $85 billion of this $100 billion in discretionary was actually just reauthorization of preexisting programs like the Indian Health Service. Is that correct?

Mr. ELMENDORF. Yes, that is right, Congressman.

Mr. PALLONE. All right. I mean, reauthorization of existing programs is of course a standard practice in this committee, both under the Democrats and the Republicans.

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

Mr. ELMENDORF. Yes, that is right.

Mr. PALLONE. Did you update your cost estimate for the Affordable Care Act?

Mr. ELMENDORF. No, we did not do a comprehensive re-estimate of the effects of the act.

Mr. PALLONE. Did you increase your cost estimate for the Affordable Care Act by $500 billion, which I think was suggested in a press release by Chairman Upton?

Mr. ELMENDORF. So again, Congressman, the last comprehensive estimate we have done for the act was part of our February estimate of the effects of repealing the act as encompassed in H.R. 2.

Mr. PALLONE. So you didn't increase your cost estimate by $500 billion?

Mr. ELMENDORF. Again, at least in February, we have made no new estimates of the comprehensive effects of the legislation.

Mr. PALLONE. Do you have any expectation that a new cost estimate would continue to show that the Affordable Care Act reduces the deficit?

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

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

Thank you, Mr. Chairman.

Mr. PITTS. The gentleman's time is expired. The chair recognizes the vice chairman of the committee, the gentleman from Texas, Dr. Burgess, for 5 minutes for questioning.

Mr. BURGESS. I thank the chairman for the recognition.

Mr. Elmendorf, of course you did appear before this committee in the run-up to the passage of H.R. 3200 but you might not recognize it because when you were in that day, the television cameras weren't on, the lights were off, no recorder was at the end of the table, no one was in the audience section. It was obviously an unofficial briefing that you had with at the time what was I recall described as a back-of-the-envelope calculation. We never had a formal hearing on the Congressional Budget Office's opinion on the passage of H.R. 3200 and we certainly, certainly never had any sort of hearing on the budgetary effects of H.R. 3590 because at the time you were here testifying before us, H.R. 3590 was a bill that had been passed by the House of Representatives that dealt with housing issues and not with health care issues. Is that correct?

Mr. ELMENDORF. Yes. I have testified to this committee but it was early in 2009 before the legislative action that you are describing, Congressman.

Mr. BURGESS. Well, were you called in for a briefing, as I recall, and again, there was no recorder, no testimony was taken down. The lights were off, the cameras were off. It was kind of a closed-door cloak-and-dagger type of hearing or briefing as I recall.

Mr. ELMENDORF. I am confident I did not come to a cloak-and-dagger affair, Congressman. I don't remember the precise circumstances but I think——

Mr. BURGESS. I recall them vividly. That is why I am reminding you of them. Well, let me just ask you a question about the funding that is in the bill, and this is just for me. You are required to interpret the cost of things under existing law, so under existing law in the Patient Protection and Affordable Care Act subtitle B, patient-centered outcomes research, establishing comparative effective clinical effectiveness research, in the section under funding of comparative effective clinical effectiveness research for fiscal year 2010

and each subsequent fiscal year, amounts in the patient-centered outcomes research trust fund shall be available without further appropriation to the institute to carry out this section. How do you quantify that?

Mr. ELMENDORF. I am sorry. I wasn't sure myself, Congressman. I am told there were specified amounts available——

Mr. BURGESS. That is the problem. We aren't, either. But go ahead.

Mr. ELMENDORF. I am told in the legislation there are specified amounts made available to he Patient-Centered Outcomes Research Institute.

Mr. BURGESS. Well, for fiscal year 2010 and each subsequent fiscal year, and there is no limit put on that so I have got to assume that is until the second coming, amounts in the patient-centered outcomes research trust fund under section 9511 of the Internal Revenue Code shall be available without further appropriations to the institute to carry out this section, without further appropriation. Now, Chairman Pallone or Ranking Member Pallone talks about how we reauthorized several provisions of existing law in the Affordable Care Act. Fair enough. But this wasn't an existing provision. This did not go through authorization through this committee. It is never going to be reauthorized by this committee. No oversight of this funding is going to occur by this committee, and these funds, we don't even know the top dollar figure, are appropriated it looks to me like in perpetuity. Is that a fair reading of this statute?

Mr. ELMENDORF. So I think it is important for me to distinguish between mandatory funding and authorization for future discretionary appropriations. The——

Mr. BURGESS. And in fact, I don't know that I have time to get into that.

Mr. ELMENDORF [continuing]. Our estimate including whatever——

Mr. BURGESS. These provisions should be authorized. We are an authorizing committee. Ranking Member Pallone pointed that out. That is what we do. We authorize these programs. We subsequently in future years reauthorize them to ensure that they are working properly, at least if we are performing up to standards the American people should be holding us to, but in this instance, we don't get a chance. So the anxiety that a lot of people have is there is funding like this strewn throughout the language of 3590 and it is going to be very, very difficult for future Members of Congress to get a hold of these funding streams and understand are they performing as they are supposed to. The language makes it difficult, makes it difficult for you to tell us really how much money we have obligated the taxpayer to spend on this. Whether it is mandatory or discretionary, they don't care. Honestly, they don't care. They want to know how many dollars they are spending and whether those dollars are being invested wisely, if they are getting an appropriate return on investment. How do we advise them? How do you advise them?

Mr. ELMENDORF. All I can say, Congressman, is that the mandatory funding is included in this page after page of our cost estimate row by row, and if there are specific questions about individual

rows, then I hope that you and your colleagues will come and ask us.

Mr. BURGESS. I have a specific question about a specific section of the law that was signed into law a year and a week ago, and I would appreciate it if you—I see my time is up, but if you could get back to us that estimate.

Mr. ELMENDORF. We will do that, Congressman.

Mr. PITTS. The gentleman's time is expired. The chair recognizes the ranking member of the committee, Mr. Waxman, for 5 minute for questions.

Mr. WAXMAN. Mr. Chairman, last week, I mentioned in my opening, Eric Cantor, the Majority Leader, gave a speech at the Hoover Institute where he talked about Social Security, Medicare and Medicaid, and he said, "We are going to have to come to grips with the fact that these programs cannot exist if we want America to be what we want America to be." Well, I can't come to grips with that statement because it would be a back to the future, to a time when seniors and people with disabilities lived in poverty without financial and health security.

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

Mr. ELMENDORF. I believe the legislation passed last December had—I am not sure I know the answer to that question.

Mr. WAXMAN. The tax cut bill.

Mr. ELMENDORF. I am sorry. I mean——

Mr. WAXMAN. Well, I understand.

Mr. ELMENDORF. I don't know it offhand.

Mr. WAXMAN. I understand it is around $700 billion.

Mr. ELMENDORF. That sounds in the right ballpark to me, Congressman.

Mr. WAXMAN. And now focusing just on the upper income tax cuts and the estate tax, I would like you, if you don't have it off the top of your head, to give us an estimate of what it cost just to extend those for another 10 years.

Mr. ELMENDORF. I can provide that to you later, Congressman.

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

Mr. ELMENDORF. Yes, Congressman. By our estimates, it does.

Mr. WAXMAN. They say that to govern is to choose, and we know what Republicans choose. They choose to cut Medicare, Medicaid and health insurance for middle-income American families to pay for tax cuts for the rich.

Mr. Elmendorf, your re-estimate of the President's budget projects some relatively modest changes in projected spending for Medicare and Medicaid and health insurance exchange tax credits. According to your letter to Senator Inouye, in table 6 mandatory outlays on tax credits are projected to be about $54 billion higher over the next 10 years while spending on Medicare and Medicaid is projected to be about $339 billion lower for a reduction in direct

spending of $277 billion from these health programs. Is that correct?

Mr. ELMENDORF. It sounds right to me, Congressman. I don't have the letter in front of me.

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

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

Mr. WAXMAN. As I understand it, 2 percent per capita compared to 4 percent historically, but we would like to get you to submit that for the record.

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

Mr. FOSTER. Yes, sir, I do. As I have cautioned, it is not clear that all of the provisions will be viable indefinitely.

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

Mr. ELMENDORF. That is right, Congressman.

Mr. WAXMAN. Mr. Foster, considering these low growth rates in per capita spending, would you characterize the growing costs of Medicare over the next 10 years as primarily driven by increasing population or by increasing spending per person?

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

Mr. WAXMAN. And the Medicare spending growth that we have seen recently has been primarily driven by increased enrollment due to the recession. Is that an accurate statement?

Mr. FOSTER. In recent years, that is basically correct.

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

Mr. FOSTER. We would expect that, yes, sir.

Mr. WAXMAN. Thank you.

Thank you, Mr. Chairman.

Mr. PITTS. The gentleman's time is expired. The chair recognizes the gentleman from Illinois, Mr. Shimkus, for 5 minutes for questioning.

Mr. SHIMKUS. Thank you, Mr. Chairman. It is curious that the extension of the Bush tax cuts occurred under a Democrat-controlled House, a Democrat-controlled Senate, and signed by a Dem-

ocrat President. That is just for the record. The extension of the Bush tax cuts was passed by a Democrat House, a Democrat Senate and signed by a Democrat President. I don't know how many years you guys you want to run against George Bush but it obviously gets a little old. You guys might find new targets.

It is good to see you all here. I became ranking member of the Health Subcommittee after the passage of the law and I think we asked numerous times for you all to come in opening hearing to discuss the budgetary aspects, to be denied every time, and I would agree with my colleague, Mr. Burgess, that Mr. Elmendorf, you came but you didn't come with the press available, with people in the galleries with the TV cameras on, without any open, transparent system for us to talk to the American public about the cost of this bill. So we are glad to see you, and I know being bean counters, that puts you crossways with both sides as we try to drive our issue.

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

Mr. FOSTER. I am sorry. If you——

Mr. SHIMKUS. If you back out the Medicare cuts. I don't know if we have ever cut Medicare in the history of this government.

Mr. FOSTER. Yes. If you left out or don't consider for the moment the Medicare savings provisions, then the expansion of coverage for Medicaid——

Mr. SHIMKUS. Well, you say Medicare savings, we say Medicare cuts. Same terminology, right?

Mr. FOSTER. It is a reduction in expenditures.

Mr. SHIMKUS. Right.

Mr. FOSTER. Call them whatever you like.

Mr. SHIMKUS. OK. I will call them cuts, you can call them savings, but there are cuts to what we are all paying for Medicare right now.

Mr. FOSTER. Anyway, back to your original question, the expansions of coverage through Medicaid and the federal subsidies for the exchange coverage would increase total national health expenditures by something in the range of 3½ percent and then the savings that you get, or the cuts, if you prefer, from the Medicare provisions reduces——

Mr. SHIMKUS. My issue is, we are triple counting. I mean, 2 weeks ago we got the Secretary to say we double counted. My issue now is that we are really triple counting because we are assuming we are going to cut $500 billion from Medicare that we are not going to do. So if we are not going to do that, we attribute that savings to extending the solvency of the Medicare trust fund, which

we are not going to do, and we are not going to have the $500 billion to pay for the expansion of the health care law. So the Secretary was right when she said she double counted that but if we don't do the Medicare cuts, we are triple counting the same $500 billion.

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

Mr. SHIMKUS. And that is our concern. We appreciate you being here, and I yield back my time.

Mr. ELMENDORF. Mr. Chairman. I am sorry, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman.

Mr. ELMENDORF. Mr. Chairman, I am sorry.

Mr. PITTS. Who seeks recognition?

Mr. ELMENDORF. I realize it is my turn but I actually have a better answer to Congressman Burgess's question and I see that he is still here.

Mr. PITTS. Go ahead.

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

Mr. BURGESS. And the total dollar figure then is?

Mr. ELMENDORF. And the total dollar figure, I don't have that offhand but it is in our table and we can provide that to you.

Mr. PITTS. All right. The chair thanks the gentleman and now recognizes the gentlelady from California, Ms. Capps, for 5 minutes for questions.

Mr. Gonzalez.

Mr. GONZALEZ. Thank you very much, Mr. Chairman, and to the witnesses, thank you for your service and thank you for joining us here today.

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

Mr. ELMENDORF. Yes, Congressman.

Mr. GONZALEZ. So that means you work for Congress, you work for all of us, whether there is an R or a D following our names. Is that correct?

Mr. ELMENDORF. Yes, sir.

Mr. GONZALEZ. And I am sure during this debate you had meetings with Members of Congress that requested to meet with you and you responded to questions posed both by Democrats and Republicans?

Mr. ELMENDORF. Yes, we did.

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

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

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

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

Now, they also knew that if they just simply said repeal that the American people wanted a little more than that. So they said oK, repeal and replace. They haven't gotten to the replace part yet but I don't want to be unfair because I think there is a proposal out there and that is by Congressman Paul Ryan, my colleague, chairman of the House Budget Committee, and he has a thing called the roadmap. Now, I am not sure if the Republican leadership or the conference has adopted the roadmap. It may still be in the Republicans' glove box, I believe. They haven't pulled it out and actually started to follow it. But one of the proposals was to basically transform Medicare into a voucher program. My understanding that it is by its very design, and I believe, Mr. Elmendorf, you have some knowledge of Mr. Ryan's roadmap and his plans for Medicare. My question to you is, would the roadmap and turning Medicare into a voucher program place the burden on the individual and by its very design not keep up with the cost of what an insurance product would be made available to that recipient or beneficiary? Do you have an opinion on that roadmap and basically its consequences?

Mr. ELMENDORF. Congressman, as you know, we prepared an extensive analysis of the specifications in the roadmap proposal a little over a year ago. It is the case, and we said this again last fall in analyzing a related proposal that Chairman Ryan put to the fiscal commission which involved providing vouchers to participants in Medicare, and we noted that voucher recipients would probably have to purchase less extensive coverage or pay higher premiums than they would under current law for two reasons. First, because the savings to Medicare come from increasing the amount of those vouchers at a slower pace than we estimate Medicare spending would grow by under current law, and secondly, because future beneficiaries would have to go into the private market to buy insur-

ance and they are likely to pay more in the private market for the same package of benefits than it costs to provide that through Medicare today.

Mr. GONZALEZ. Thank you.

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

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

Mr. GONZALEZ. Thank you very much. Thank you, Mr. Chairman.

Mr. PITTS. The gentleman's time is expired. The chair recognizes the gentleman from Michigan, Mr. Rogers, for 5 minutes for questions.

Mr. ROGERS. Thank you, Mr. Chairman. I do find it interesting that my colleagues are seeking to talk about everything other than the bill that has been passed into law, and I find it interesting today for the first time we have had an opportunity to talk about some of the flaws, especially in their claim that this is a budget reducer when they have used a 10-year window, 6 years of services, 10 years of taxes, disingenuous at best to the American people but we have established today that in fact cuts half a trillion dollars from Medicare. Oops, they didn't want to tell you about that, did they? And what is the impact today to the real person out there who is trying to keep their job or find a job is that health care premiums have gone up and people are losing their coverage today because of this bill. I wouldn't want to talk about this bill either if I were you. As a matter of fact, the Administration now has had to give—they haven't updated it. It is 1,040 waivers that impacts about 3 million Americans and said you don't have to follow the law because it will either, A, increase your premiums, or B, you will lose the health care that you want to keep. So they had to say, guess what, you 3 million Americans, the rest of America, you are stuck with this thing, you 3 million Americans, don't worry about it, don't follow the law. You are right. I wouldn't want to talk about what this bill is doing to real working Americans today either. Pretty frustrating. I hope we will get more changes to talk about the details of this bill. I do have a couple of quick questions, if I can.

Mr. Foster, when you did the calculation, you calculated that 20 percent of small business employers would no longer offer health insurance, so by the way, that is one out of five small businesses

will no longer offer health insurance to their employees, something else I wouldn't want to talk about. But I am curious about how you got there. The average cost in a State like Michigan, about $15,000 per employee, and the penalty for not offering insurance under Obamacare is $2,000 per employee, and I don't know you have been around many small businesses outside of the Beltway here but they are absolutely under assault from cost increases, fuel cost increases, mandates that are increasing the cost of their products. Pretty difficulty decisions have to be made, which is one of the reasons a place like my State is still suffering one of the highest unemployment percentages in the country. So if you are a small business owner and you are facing $15,000 per employee to try to do the right thing or $2,000 that you just send off to the Federal Government, get to throw them off your plan, you have got to help me understand how you get to only 20 percent of small employers are going to throw their folks off their health insurance that they enjoy today. Can you help me understand that?

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

Mr. ROGERS. So I understand it, you think it is beneficial for them to drop their coverage and send people to the federal exchange. Did I understand that correctly?

Mr. FOSTER. For certain categories, primarily businesses with relatively low-income workers.

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

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

Mr. FOSTER. The 20 percent is an assumption. We won't know until down the road when we see what happens.

Mr. ROGERS. And it is an assumption, as you said today, Mr. Chairman, based on behavior, and if you have been in a small business with these kind of cost increases, you are going to throw people off your insurance. That is why we all ought to be angry about what this bill is doing to the working men and women of the United States.

Mr. PITTS. The gentleman's time is expired. The chair now recognizes the ranking chairman emeritus, the member from Michigan, Mr. Dingell, for 5 minutes for questions.

Mr. DINGELL. Mr. Chairman, I thank you for your courtesy.

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

Mr. FOSTER. Yes, sir.

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

Mr. FOSTER. In some years, not all years, yes, sir.

Mr. DINGELL. Thank you. The IPAB target, I would remind everybody, calls for Medicare spending target of GDP plus one starting after 2019 and an even higher target for 2015 to 2019 period. The Affordable Care Act seems to have brought projected Medicare spending down. Is that correct? Yes or no.

Mr. FOSTER. Yes.

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

Mr. FOSTER. I would have to think about that one, sir.

Mr. DINGELL. Now, do you believe that it would be possible to pay for the entire cost of fixing SGR, which would be about $300 million out of savings in Medicare? Yes or no.

Mr. FOSTER. That would be tough. I would have to call that one more like a no.

Mr. DINGELL. All right. But we could make some progress in that direction, could we not?

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

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

Mr. FOSTER. I don't have a good answer for you, sir. I could study it for you, but we have not looked at it recently.

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

Mr. FOSTER. I disavowed them. I don't remember that the letter was addressed exactly to you. I think it was addressed to the Administrator.

Mr. DINGELL. So——

Mr. FOSTER. But there is no truth to that.

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

Mr. FOSTER. No, sir.

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

Mr. FOSTER. That is correct.

Mr. DINGELL. Now, Mr. Foster, you testified before the Ways and Means Committee that you were instructed by the Bush Administration to withhold information from the public. Is that true?

Mr. FOSTER. I was ordered to give the information to the Administrator of the agency and he would then pass it on as he saw fit to the requester.

Mr. DINGELL. So you were not to convey to the public then the information, you were to have it carefully filtered through the Administrator. Is that right?

Mr. FOSTER. Information requested by Congress, certain information. That is correct.

Mr. DINGELL. Very good. Thank you, Mr. Chairman. I appreciate your courtesy.

Mr. BURGESS [presiding]. The chair recognizes the gentlelady from North Carolina, the vice chair of the full committee, Ms. Myrick.

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

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

Mr. FOSTER. The concern that I and others have is, imagine a provider whether it is a hospital or a home health agency or a lab

or whatever, and in order to provide the services, they have to pay for certain inputs. They have to pay salaries for their staffs and themselves. They have to pay for energy costs and for rent or whatever arrangement they have, mortgages for their property. They have to buy supplies. So they have these input costs.

Mrs. MYRICK. Right.

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

Mrs. MYRICK. Right.

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

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

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

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

Mr. FOSTER. Yes, higher prices in the form of for the devices or the insurance plans. We think they would be passed through, yes.

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

I yield back, Mr. Chairman.

Mr. BURGESS. Will the gentlelady yield to me for a further question on physician reimbursement?

Mrs. MYRICK. Yes.

Mr. BURGESS. Mr. Elmendorf, if I could just stay on the subject of physician reimbursement, in the Medicaid arena, states are under some budget shortfall constraints. One of the low-pressure circuits where this gets pushed out is physician reimbursement, one of the only areas that that they can control. Now, the Supreme Court recently agreed to hear arguments in the Independent Living Center of Southern California versus Maxwell Jolly. If the Court rules against the states and says the states arbitrarily set reimbursement rates too low so that people didn't have access to a provider, the states and the Federal Government could be on the book for those increases in provider rates. Have you looked at the budgetary impact of a Court decision if the Court rules against the States?

Mr. ELMENDORF. No, Congressman, we have not studied that, to my knowledge.

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

Mr. ELMENDORF. So Congressman, I think the only piece of the legislation that directly affects provider rates in Medicaid was an increase in payments to certain sorts of primary care physicians.

Mr. BURGESS. But did you ever consider——

Mr. ELMENDORF. Those costs are included in our estimate of the costs of the legislation.

Mr. BURGESS. Did you ever consider the cost of allowing CMS to set those rates?

Mr. ELMENDORF. In Medicaid, no, Congressman, I don't think that we did.

Mr. BURGESS. I will yield back myself. I yield to Ms. Capps for 5 minutes, recognized for questions.

Mrs. CAPPS. Thank you, Mr. Chairman, and thank you both for testifying today.

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

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

Mr. ELMENDORF. Yes, Congresswoman.

Mrs. CAPPS. Thank you. And Mr. Elmendorf, your written testimony also states that the Affordable Care Act will cover 32 million of the uninsured by 2016. Is that correct?

Mr. ELMENDORF. Yes, Congresswoman.

Mrs. CAPPS. Thank you. Despite claims to the contrary, it is not tricky math. If we make smart investments, we can cover more people while reducing the deficit overall. But all of this goes away with repeal. And what is the replacement bill Republican leadership supports? Mr. Chairman, I would point my colleagues to an article published this week by the Bloomberg Business Week and it is entitled "The Republican Response to Obamacare." This article is clear—despite the claims I hear from detractors of the law, according to a new Bloomberg analysis, GOP alternatives would save less than $5 billion a year, perhaps six-tenths of a percent of what health care costs in 2009, and this is compared to the $210 billion saved by the ACA over the next decade. Furthermore, the Republican alternative to the health reform bill would actually increase the number of uninsured people from 50 million in 2010 to 52 million in 2019, according to CBO's estimation. And when looking at any of the represented Republican alternatives, not a single person would have guaranteed access to health coverage at an affordable price. So when we talk about saving money, let us be clear: the Affordable Care Act is the largest deficit-reducing bill enacted by Congress in the last decade and there have been no alternatives from the Republican leadership to even come close to helping so many while saving so much.

Another area, and this is for you, Mr. Foster. Another area where I think we should set the record straight is on how the Affordable Care Act strengthens the health care workforce and creates jobs. Critics have said that there will be a shortage of medical professionals, particularly primary care doctors and providers in rural parts of the country, and they use this claim to advocate repeal, trying to pit those who already have insurance against those who will gain it through the law. But they ignore the fact that the Affordable Care Act has taken numerous steps to address these shortages. For example, it strengthens and expands the National Health Service Corps and community health centers providing primary care to communities most in need across our Nation. It creates a new program to train primary care physicians in the community called the teaching health centers, which will provide new doctors and give them the expertise they need to work in a community setting and give communities access to needed care. Americans will have better access to preventive and primary care. In short, we are training more providers, paying them more and providing more access points for primary care. Now, the Administration estimates that these policies will combine to create 16,000 new providers in the workforce over the next 5 years, and proposals in the President's 2012 budget will add yet another 4,000 providers to that number.

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

Mr. FOSTER. Oh, I think it will.

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

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

Mr. PITTS. The gentlelady's time is expired. The chair recognizes the gentleman from Pennsylvania, Dr. Murphy, for 5 minutes for questions.

Mr. MURPHY. Thank you. I appreciate the opportunity to finally have a chance to talk to both of you now that the bill is passed and it is the law.

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

Mr. FOSTER. None that I can think of.

Mr. ELMENDORF. I am not sure what you mean by borrow from Social Security.

Mr. MURPHY. Well, some of the money I understand came from Social Security for this bill. Is that true?

Mr. ELMENDORF. Well, the bill does have some effects on the flow of money into the Social Security trust fund.

Mr. MURPHY. How much is that?

Mr. ELMENDORF. I believe there is a net increase in the flow of money to the Social Security trust fund.

Mr. MURPHY. More goes into Social Security with this bill or——

Mr. ELMENDORF. It goes into Social Security by our estimate because there is a shift in the distribution of compensation from nontaxable——

Mr. MURPHY. How much?

Mr. ELMENDORF [continuing]. Health insurance——

Mr. MURPHY. How much? How much?

Mr. ELMENDORF. I think it is perhaps around $10 billion over 10 years.

Mr. MURPHY. But more goes into Social Security or more comes out of Social Security?

Mr. ELMENDORF. So more money goes into the Social Security trust fund. There may be ways in which somewhat more——

Mr. MURPHY. OK. I need to move on. And how much money is coming out of Medicare to go into helping to pay for the health care bill?

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

Mr. MURPHY. The cuts to what?

Mr. ELMENDORF. Cuts to payments to Medicare providers and other changes in the Medicare program.

Mr. MURPHY. Wait, wait. So by paying less to providers, meaning hospitals and doctors, we already have a long-term of doctors who are not accepting Medicare and Medicaid, and unfortunately, the only solution here that Congress sees is well, let us just pay them less, instead of reform, let us pay them less. And yet, Mr. Foster, you said a couple minutes ago that you thought this would bring more providers but we are going to pay them less. This doesn't make sense to me. How are you going to pay people less that they don't even want to cover it now and we are going to somehow entice them into doing this? If I gave you a 25 percent cut in your salary, will you say hey, sign me up?

Mr. ELMENDORF. To be clear, Congressman, the cuts in payments to physicians in Medicare under the sustainable growth rate mechanism of prior law——

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

Mr. ELMENDORF. Congressman, I am not aware of exactly what the Secretary——

Mr. MURPHY. All right. Also, we had another secretary talk about the CLASS Act, and she said to me that it did appear from the estimates from CBO that because the money was accounted for to provide this long-term insurance fund but also it was said if we didn't do this there would be a $86 billion loss to the health care fund, that that was double booking instead. Was she not telling us the truth?

Mr. ELMENDORF. I don't know what the Secretary said to you. I can talk about our analysis of the CLASS.

Mr. MURPHY. Mr. Foster, are you aware of that?

Mr. FOSTER. Well, I think I would bet you a Coke that she did not say there is double counting. I would be happy to explain.

Mr. MURPHY. That would be great. Could you get back to me on that because I would like that.

Mr. FOSTER. Sure.

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

Mr. FOSTER. No, I don't.

Mr. MURPHY. Could you get back to us with that?

Mr. FOSTER. Sure.

Mr. ELMENDORF. So Congressman, I can say in our analysis of premiums——

Mr. MURPHY. I just need a number. And do we have a number?

Mr. ELMENDORF. I don't have a number for that piece offhand.

Mr. MURPHY. Thank you. School-based health centers, what is that going to cost? Does someone know?

Mr. ELMENDORF. I am sorry.

Mr. MURPHY. Would you be willing to get us that information?

Mr. ELMENDORF. Yes, of course, Congressman.

Mr. MURPHY. Thank you.

Mr. ELMENDORF. Well, it is all public. I just——

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

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

Mr. MURPHY. But 1,000 have asked for waivers. If you could provide us some economic analysis of what that also means for us too, also what it would mean, if you could provide us information on the number of people who may lose their jobs, because we are hearing from small employers saying I am not going to hire more, I am going to try and keep it under 50. Do we have an analysis of that number of jobs and the loss of federal revenue from that? Does anybody have that?

Mr. ELMENDORF. Again, Congressman, in reports we issued before and in my written testimony for today, we talk about the effects we think will take place in the labor market.

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

With that, I yield back. Thank you.

Mr. PITTS. The gentleman's time is expired.

Mrs. CAPPS. Mr. Chairman, I apologize. I had intended to make a unanimous consent request to insert an article from the Bloomberg Business Week entitled "The Republican Response to Obamacare" at the end of my 5 minutes, and I neglected to do so. May I do so now, please?

Mr. PITTS. Can we see the article?

Mrs. CAPPS. Of course.

Mr. PITTS. The chair recognizes the gentlelady from Wisconsin, Ms. Baldwin, for 5 minutes for questions.

Ms. BALDWIN. Thank you, Mr. Chairman.

I agree with my colleagues that we must reduce the deficit and work towards a balanced federal budget. However, we have to be smart about the priorities and the choices that we make and we need to be smart if we are going to cut spending without compromising job creation and our economic recovery and frankly our future. The Republican spending bill, H.R. 1, clearly illustrates the new Majority's choices and priorities. This measure threatens jobs

and our fragile economic recovery and slashes vital services to the American people. Republicans have prioritized cutting health care services to our most vulnerable populations without considering the consequences of such actions, and once again Republicans have targeted critical safety-net programs like Medicaid and Medicare.

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

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

Mr. Elmendorf, I am really perplexed at how Republicans can claim that a bill your agency scored as reducing the deficit is actually contributing somehow to our alleged spending problems, and I would like us to reflect upon and consider what really contributes to our Nation's deficit. How much, Dr. Elmendorf, does the CBO anticipate will be spent on the wars in Iraq and Afghanistan over the next 10 years according to your January baseline?

Mr. ELMENDORF. So I don't remember the number, Congresswoman. As you understand, our baseline for discretionary spending takes the current levels of spending and simply extrapolates those out.

Ms. BALDWIN. There are a lot of assumptions that are in there. Does $1.7 trillion sound familiar to you?

Mr. ELMENDORF. I am sorry, Congresswoman. I really don't know the answer to that.

Ms. BALDWIN. Well, how about the Bush tax cuts and the extension of the Bush tax cuts, tax cuts that provide income and estate tax cuts to the very wealthy? How much does the January CBO baseline indicate that that will cost to extend over the next 10 years?

Mr. ELMENDORF. So we reported in January that extending the income tax and estate and gift tax provisions now scheduled to expire at the end of next year would cost about $2.5 trillion over the coming decade and then would also result in about a half a trillion dollars of additional interest payments.

Ms. BALDWIN. Because we are borrowing the money for these tax cuts. OK. So I know you don't have the figure at your fingertips on the wars and that includes some estimates, but from my reading of the CBO January baseline, between the wars and the tax cuts, we are looking at nearly $5 trillion, all of it borrowed money, all of it completely unpaid for, and yet the Republican solution to the deficit is to repeal a law adding an additional $210 billion to the

deficit and leaving vulnerable Americans without access to health care.

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

Mr. PALLONE. Mr. Chairman?

Mr. PITTS. The chair thanks the gentlelady.

Mr. PALLONE. Mr. Chairman, could I ask if——

Ms. BALDWIN. I would yield to the gentleman my remaining time.

Mr. PALLONE. No, I just wanted to ask about a unanimous consent request. Ms. Capps had made a unanimous consent request, which I think that Dr. Burgess has seen now, so I just wanted to see if that——

Mr. PITTS. Without objection, it will be entered into the record.

Mr. PALLONE. Thank you.

[The information appears at the conclusion of the hearing.]

Mr. PITTS. The chair thanks the gentleman and recognizes the gentleman from New Jersey for 5 minutes, Mr. Lance.

Mr. LANCE. Thank you very much, Mr. Chairman. Good morning to you both.

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

Mr. ELMENDORF. So Congressman, your description of the law sounds right to my expert team behind me. What we have written before and in the testimony today is that actually there are some reasons that firms might end up hiring more part-time and seasonal employees because of the way in which some of the penalties that face firms only if they have part-time employees who are seeking subsidies through the exchanges and not part-time employees. So there are some cross currents in the legislation. Of course, the effects of these provisions will only be in place a number of years from now, which even our forecast of a relatively slow economic recovery suggests that we will be moving our way back toward more traditional levels of unemployment in this country, so I am not diminishing the concern about effects on employment but I think one of the starting points should not be today's unemployment rate but that which would be in place in the future.

Mr. LANCE. Well, I agree with that. I have had constituents in my office who are greatly concerned about this, constituents who do cover their part-time employees, and this concerned supermarkets in the area and they do what I think is the right thing in covering their part-time employees, or they certainly are looking

to do that but they believe that there might be a disincentive. Thank you for that.

Mr. Foster, and I think Dr. Murphy referenced this as well, the 2.3 percent excise tax on medical devices, do you anticipate that these fees and excise taxes would generally be passed through to health consumers in the form of higher prices and higher insurance premiums? And as I understand it, they would be placed on devises like pacemakers.

Mr. FOSTER. Yes, sir, we think that would be the typical reaction would be to raise the prices of the products to cover the higher costs associated with the fees or the taxes.

Mr. LANCE. And from my perspective as a matter of public policy, I do not think that that is a good idea because I think that these devices are expensive enough already.

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

Mr. ELMENDORF. Yes, that is right, Congressman, and that flow, that reduction in employment in some places is part of the overall story that we modeled.

Mr. LANCE. Yes. Thank you very much.

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

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

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

Mr. CASSIDY. So we are really talking 25 million will now be on Medicaid if we have income disregard for Social Security benefits?

Mr. FOSTER. Not every one of them would end up there. They would be eligible but many would have already have employer retiree coverage.

Mr. CASSIDY. So ballpark figure, though, just so we can know, how many will be on Medicaid if you have income disregard for Social Security?

Mr. FOSTER. So 24.7 million.

Mr. PITTS. Dr. Elmendorf, did you want to respond?

Mr. ELMENDORF. That factor was taken into account in our estimate, Congressman.

Mr. CASSIDY. And so your final number is what?

Mr. ELMENDORF. So we expect that the increase in Medicaid and CHIP enrollment under the legislation will be 17 million by 2021.

Mr. CASSIDY. So there is a discrepancy there. OK. Thank you.

Mr. PITTS. The gentleman's time is expired. The chair recognizes the gentleman from New York, Mr. Engel, for 5 minutes.

Mr. ENGEL. Thank you very much, Mr. Chairman, and let me first say, you know, here we go again, just one week after the one-year anniversary of this Affordable Care Act the subcommittee is holding yet another hearing attempting to undermine it and what the true costs that we should be talking today are what would have happened if we had not taken action. The Affordable Care Act makes health care affordable for the middle class and has halted a steady rise in health costs that led us to much of our budgetary woes over the years. For all the talk of the sky falling, my Majority colleagues have repeatedly failed to provide any alternative ideas that would come remotely close to accomplishing what the Affordable Care Act does. They had 6 years of control of the House, Senate and White House and provided no leadership on this issue. All we have are alarmist sound bites and false platitudes and even more frightening are the true costs that will come if the new Majority places spending caps or block grants Medicaid, as they propose to do. These actions will not save money, it will simply abdicate responsibility and shift costs to State providers and beneficiaries.

Now, let me say that Secretary Sebelius and Assistant Secretary Greenlee disagree with some of my Republican colleagues who have been saying that there is double counting in letters they have sent to Ranking Members Waxman and Pallone. This is Secretary Sebelius and Assistant Secretary Greenlee have sent letters to Mr. Waxman and Mr. Pallone saying that there is not double counting, and the Secretary gives this example, and I quote from her: "In the same way when a baseball player hits a homer, it both adds one run to this team's score and also improves his batting average. Neither situation involves double counting." So I would like to submit these letters for the record.

Mr. PITTS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. ENGEL. Thank you, Mr. Chairman.

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

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

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

Mr. ENGEL. Mr. Foster?

Mr. FOSTER. The present value of the general revenues for Part D over that 75-year period are estimated to be about $7.2 trillion.

Mr. ENGEL. Thank you. Seven point two trillion dollars. Based, as you said, on the most recent trustee's report, the unfunded obligation is $7.2 trillion. Did the Medicare Modernization Act include other provisions increasing revenues or cutting spending that might come close to generating the resources to meet the $7.2 trillion obligation from general revenues?

Mr. FOSTER. No, it was clearly a new expenditure for a new program.

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

Thank you, Mr. Chairman. I yield back.

Mr. PITTS. The gentleman's time is expired. The chair recognizes the gentleman from Georgia, Dr. Gingrey, for 5 minutes.

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

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

Mr. FOSTER. Yes, sir.

Mr. GINGREY. Two weeks ago, Assistant Secretary Greenlee was here stating before this committee and the department that she said the Department of Aging, which she chairs, promised to work with you before moving forward on implementing the CLASS program. Secretary Sebelius in her own words gave her pledge to work with this committee to ensure that the CLASS program is truly sustainable before the Administration proceeds with program oper-

ations. Mr. Foster, will you make a similar commitment to me today that you will work with this committee to conduct in our role as Chief Actuarial a full and objective assessment of the Administration's plan for CLASS to ensure the program is truly sustainable including weighing the impact that any proposed premium increases will have on consumer participation in this program? Will you make that pledge to me?

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

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

Mr. FOSTER. We could.

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

Now, look, let me walk you through a couple of charts because you talked about this earlier, and these are taken from simulations that your staff have performed and then maybe we can get you to comment on that. This first chart basically shows that because of Obamacare cuts, Medicare rates will be lower than Medicaid rates by 2019. That is right here as it drops below Medicare rates, and that by the 75-year period Medicare payments would only be one-third, only one-third of the relative current private pay rates and one-half of Medicaid by the 75-year mark. Now, we have another chart I want my colleagues to look at, and if you will pay attention to this one, the second one shows a comparison of relative rates for inpatient hospital services only, and the key point here is that both the Medicare and Medicaid rates collapse together because Medicaid under current law cannot pay more than Medicare upper limit requirements for hospital service. At the end of the scoring window, hospitals would be paid 37 percent of private pay rates for both Medicare and Medicaid.

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

Mr. FOSTER. Well, if you leave out some of the adjectives, I would probably agree with most of what you just said. The concern is that these payment reductions or the slower growth in payment rates

won't be sustainable in the long term, and if that happens, then the savings that are generated by those won't occur because you all will have to override them to prevent problems with access. To the extent that those savings are used to help pay for the cost of the coverage expansions under the Affordable Care Act, then that ability to pay for——

Mr. GINGREY. And providers will have no choice but to shift that cost to the private market, thus raising the cost of private health insurance.

Mr. FOSTER. That is one way they might react. It is not clear——

Mr. GINGREY. And I thank you for your testimony. Thank you for your patience, Mr. Chairman.

Mr. PITTS. The gentleman's time is expired. The chair recognizes the gentleman from New York, Mr. Weiner, for 5 minutes for questions.

Mr. WEINER. Thank you, Mr. Chairman.

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

Mr. FOSTER. That was our estimate.

Mr. WEINER. So in other words, you can save money and you extend the life expectancy as you see in my charts. Is that true?

Mr. FOSTER. Both of these happen.

Mr. WEINER. Yes, those things both happen. Now, does that mean that there is anything nefarious about them? Are we defying the laws of economic gravity? Are cats going to start sleeping with dogs? Or does this sometime happen in laws that you make changes that both save money and extend the life of a program that some of us support and some of us oppose? Is that true?

Mr. FOSTER. The issue is that a given dollar of savings, your first chart with a dollar.

Mr. WEINER. Right. This one here. Hold on. Let me get it for the viewers.

Mr. FOSTER. I like that one best. Your first chart with a dollar, that dollar can be used to spend in real life to help pay for the coverage expansions or it can be used to help pay for Medicare.

Mr. WEINER. Right.

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

Mr. WEINER. Adds to the——

Mr. FOSTER [continuing]. Taxes we get. That actual cash goes into the general fund that is used for whatever purpose——

Mr. WEINER. Right.

Mr. FOSTER [continuing]. Treasury needs to use it for.

Mr. WEINER. I appreciate that. I just wanted to make it clear that this is another one of these non-issues, and it is fascinating, I should say, that the same people that are objecting to all of these things are people who frankly apparently want there to be deeper

cuts in Medicare, or they are actually schizophrenic on Medicare. Some of them deride single-payer health care plans but seem to love this one. Suddenly they are the defenders of Medicare, and they were the ones that apparently opposed single-payer health care plans, which is what Medicare is.

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

Mr. FOSTER. Yes, sir.

Mr. WEINER. Before this bill was passed, did small businesses get a 35 percent tax credit for offering health insurance to their workers, before it was passed? I will help you with this one. The answer is one. It goes to 50 percent after the exchanges are set up. Small businesses under this law get a 50 percent tax credit for offering health insurance to their workers. Democrats support a tax credit for people offering health insurance and the Republicans are against it because if you repeal this bill, it would disappear. So let me say that again. Democrats who supported this bill now can proudly say small businesses get a 35 percent tax credit for every single dollar they spend for health care and in 2017 it goes up to a full 50 percent. Republicans want to eliminate that small business tax credit. That is the bottom line here. We have a bill that takes the idea of using tax reductions for small businesses and helps them provide insurance for more workers.

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

Mr. ELMENDORF. Yes, it does, Congressman.

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

Mr. ELMENDORF. If you reduce private health spending.

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

Mr. ELMENDORF. Medicare has lower administrative costs than certainly the small group and non-group markets.

Mr. WEINER. And no profits obviously. They take no money for profits?

Mr. ELMENDORF. That is right.

Mr. WEINER. Thank you very much.

Mr. PITTS. The gentleman's time is expired. The chair recognizes the gentleman from Louisiana, Dr. Cassidy, for 5 minutes.

Mr. CASSIDY. Just a quick comment. Medicare also has potentially 10 to 20 percent of its receipts going out in fraud, so maybe there is something to be said for overhead.

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

Mr. FOSTER. Yes, that is one reaction we would probably anticipate.

Mr. CASSIDY. So it is a probable. It is not just kind of maybe out there but it a probable. I think history would say that is true.

Mr. ELMENDORF. Congressman, can I just add, there are some conflicting forces, though, in this law, so there are reductions in Medicare payment rates. There are also some people who today otherwise would the law would be uninsured would then be having health insurance——

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

Mr. Foster, the next thing to say is, we know that in times past, and you may have even written this to the effect, that when there is a cliff in SGR, Congress will almost always, in fact, has always increased that back up. Now, I guess my question for you is, I think you do behavioral modifications. You look at a piece of legislation and you can see wow, sure, this is the parameters given to us but the contortions given to us do not reflect reality. There should be a codicil, if you will. There should be some addendum that says, you know, using behavioral health, we would discount the effective savings. It seems like you should have used that same methodology as regards this cliff that is going to affect Medicare and the resulting hydraulic effect upon private insurance rates driving them up 15, maybe 25 percent. Any comments upon that?

Mr. FOSTER. Well, it is actually an excellent point in terms of anticipating what kinds of reactions might happen. We do this where we have a good basis for it and where it affects, for example, the

financial status of Medicare or estimating Medicare or Medicaid costs. We don't do it in every case. For example, if there is cost shifting by hospitals or other providers because the Medicare or Medicaid payments are inadequate, they cost shift to private insurance.

Mr. CASSIDY. Driving up the cost for the privately insured. What we are really saying is cost shifting is driving up the cost. This bill through its cost-shifting mechanism drives up the cost for the privately insured. OK. Continue.

Mr. FOSTER. Yes, and there is some disagreement about to what extent that happens. It is hard to measure.

Mr. CASSIDY. But going back to my point, wouldn't it have been wise for you to discount the savings given that the behavioral aspect of Congress is to hold providers harmless for the SGR, as one example?

Mr. FOSTER. Well, it depends on what you are measuring, sir. If you are measuring federal expenditures and Medicare saves money but private health insurance gets more expensive, that may not affect federal expenditures.

Mr. CASSIDY. Then that is a good point, because really, you are only looking at federal spending. In a sense, by law you are required not to consider the fact that we are driving up costs for privately insured.

Mr. FOSTER. Well, we also look at total national health expenditures.

Mr. CASSIDY. I saw that, and that rises. So even though the federal supposedly saves, the fact that there is national health expenditures that rise means that somebody is eating it, and it is probably the States and the privately insured.

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

Mr. FOSTER. Not in this particular instance.

Mr. CASSIDY. Let me go to the next point. Everybody is talking about—clearly, press reports say that the reason that this was offloaded upon the states is that it saved the Federal Government money but clearly it is going to cost the States a heck of a lot of money, and so I have here a Lewin report, the impact of expenditures. Mr. Waxman, whom I have great respect for, spoke about an adult conversation. According to this Lewin report, under this Obamacare bill, his State is going to have increased Medicaid expenditures of $4.8 billion over a 5-year period. Louisiana is going to be $1.5 billion. Texas is over $4 billion as well. So is it well to concede that although federal expenditures are going down, in the case of California it will be $4.8 billion higher, Texas $4 billion, Louisiana $1.5 billion higher? We just cost shifted from the feds to the States?

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

Mr. CASSIDY. So you would dispute the Lewin report?

Mr. FOSTER. If I understood what they were saying correctly. I would want to look at it carefully.

Mr. CASSIDY. I will submit that to the record once I get ahold of it.

Mr. PITTS. The gentleman's time is expired. The chair recognizes the gentleman from Ohio, Mr. Latta, for 5 minutes for questions.

Mr. LATTA. Well, thank you, Mr. Chairman, and gentlemen, thanks very much for your indulgence this morning. I really appreciate you being here. And Mr. Elmendorf, it is good to see you again from my time on the Budget Committee. As always, I am glad to see you come before the committee and hear your input.

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

In the one paragraph, you say, "In fact, CBO's cost estimate for the legislation noted it will put into effect a number of policies that might be difficult to sustain over a long period of time," and then you go on to state that, "It is unclear whether such a reduction can be achieved through greater efficiencies in the delivery of health care or will instead reduce access to care or the quality of care relative to the situation under prior law." And we heard Mr. Foster talking a little bit earlier in regards to the economizing the efficiencies that have to be done. It is kind of interesting because you are both kind of going the same way. First, under what we call the doc fix, how much was the doc fix before the law went into effect? Do you remember what that number was for the 10-year period?

Mr. ELMENDORF. How much would it cost over the 10-year period?

Mr. LATTA. Right.

Mr. ELMENDORF. I think the estimate was about $250 billion as of a year or so ago. I am not exactly sure.

Mr. LATTA. OK. And did the health care law look at the doc fix at all?

Mr. ELMENDORF. The health care law did not adjust payments to physicians in Medicare.

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

Mr. ELMENDORF. So access to care, the first issue we discussed here about in Medicare, which pays significantly less to physicians than Medicare does today and it varies across States but on average, it is harder for Medicaid patients to find physicians who will treat them than it is for patients in Medicare or patients with private insurance, and so one of the measures of access is whether

people can find doctors to treat them. Quality is a harder thing to measure in medical care, and part of the legislation that we are discussing in fact is an effort to increase the dissemination of quality measures and to develop new quality measures. That is a harder thing to look up. I think those are the sorts of concerns that we have spoken about and the Office of the Actuary has spoken about as well.

Mr. LATTA. And again, going back, again, knowing, understanding that you are looking at a snapshot of what is being given you, the information that is given to you at that very moment in time to make your analysis on, was anything ever talked about during that time about reducing that care or that quality of care and what that would do the system at that time or to the people that would have to try to get the care?

Mr. ELMENDORF. So a sentence much like this one has appeared in a succession of our cost estimates beginning at the point where this feature was a prominent part of the legislation that we were providing analysis of. I don't know what consideration these issues were given. I want to just emphasize one point, Congressman. You said several times we were given certain things. I want to be clear, what we were given is a piece of legislation. What we bring to that is our experience and evidence that analysts have developed.

Mr. LATTA. Right, and that is what I mean. We are looking at a snapshot of what is given to you, that you are not going out and getting that information, that you are told what you are supposed to look at.

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

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

Mr. LATTA. Well, thank you very much. I appreciate your testimony, and I yield back, Mr. Chairman.

Mr. PITTS. The gentleman's time is expired. The chair recognizes the gentleman from Kentucky, Mr. Guthrie, for 5 minutes.

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

Mr. Elmendorf, you sent Mr. Lewis, our former ranking member, a letter saying about the appropriations process, the appropriations

part of it, saying that there was a list of new activities for which PPACA includes only a broad authorization for appropriations of such sums as necessary and for those activities the lack of guidance made it difficult for you to come up with a score or necessary amounts. You can bring that forward.

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

Mr. ELMENDORF. Yes.

Mr. GUTHRIE. And then the Kaiser Health News reported that a member of the Administration, Donald Berwick, the Administrator of Centers for Medicare and Medicaid Services, was talking with the States talking about the pressure for Medicaid, and he said to them, it was reported in Kaiser Health News, he was sensitive to that situation but his solutions, however, were to point States to funding that he said is already available to them such as subsidies to establish insurance exchanges. And I would have to guess that if what the Administration think should happen to help States through the budget crises with Medicaid, that is going to be far more than $2 billion. So my question is, what assumptions did you make? And the Secretary said this in a meeting on March 3rd, I think it was, that she has complete—there are no limits on how much she can spend in this provision. There is no limit. She said that. And she has no need for additional Congress authority to spend it. Obviously a member of the Administration says you can spend it to help States plug their Medicaid budget hole. So what assumptions did you use to get the $2 billion?

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

Mr. GUTHRIE. But if the Administrator of Medicaid Services is correct and it is available, he said he points to solutions to point to States to funding that he said is already available to them such as subsidies to help establish health insurance exchanges so those subsidies are used in a way that helps the States. Because you could facilitate enrollment by granting more money for Medicaid to get more people enrolled in the health care exchange, because that would follow under the law. I know you can't model that behavior.

Mr. ELMENDORF. So under this section, this I believe, limits grants to activities related to establishing insurance exchanges, and so I don't think the changes in enrollment or activities related to establishing an exchange. It is certainly the case that this $2.1 billion number might be too low. It might also be too high in our

judgment. We tried to put it in the middle of the distribution of possible outcomes.

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

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

Mr. CASSIDY. Mr. Foster, I think that issue is, is that in the aggregate there is less spending in states but because New York is such a high-cost state, all the savings frankly come from New York and a few other states like that—Massachusetts—but if you take the people who are not eligible at less than 138 percent of federal poverty and you move them up, that is why California, which has a lot of poverty, even though it has a high main per capita income, it is going to be $4.8 billion from 2014 to 2019 in increased Medicaid expenditures. Again, does that seem reasonable to you that maybe New York is offsetting everybody else?

Mr. FOSTER. I am sure there are significant state-by-state variations in the net impact. We have only estimated the overall national, not the individual States.

Mr. GUTHRIE. Thank you.

Mr. PITTS. I thank the gentleman and recognize the vice chairman for one follow-up.

Mr. BURGESS. Thank you, Mr. Chairman. I appreciate the courtesy.

Mr. Foster, in your prepared testimony you say you are here today in your role as an independent technical advisor to Congress. Perhaps offline you can expound for us what triggers that role as different from the Chief Actuary to the Centers for Medicare and Medicaid Services. And the reason I feel this is important and the reason I asked for the Resolution of Inquiry last year is, what triggers that role. Now, we were in sort of a rush to pass a year ago the Patient Protection and Affordable Care Act and I cannot escape the feeling that we were asked to vote on that bill before we had all of the data. So really my question to you is very simple: do you feel we had the full picture March 23, 2010, or March 21, 2010, when this vote was called on the floor of the House in your role as an independent technical advisor to Congress, not as the Chief Actuary for Centers for Medicare and Medicaid Services?

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

Mr. BURGESS. Were you able to convey to the Speaker of the House that information, that you did not have a figure that you were comfortable with prior to Congress taking a vote on something of this magnitude?

Mr. FOSTER. The Speaker of the House did not ask us. Various members of the House and Senate did ask us from time to time

could we have something, could we have it prior to the vote that was scheduled. I think in all instances, we were not able to produce our estimates, to complete them before the vote actually occurred. Now, our goal was to do that but it was too hard within the time available.

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

Mr. FOSTER. If the vote were delayed, clearly, yes——

Mr. BURGESS. In retrospect, do you think Congress would have benefited from having your opinion on the cost of this legislation?

Mr. FOSTER. On a good day, I think our advice is useful.

Mr. PITTS. All right. The ranking member has a follow-up question. Mr. Waxman.

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

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

Mr. WAXMAN. And did you ever give a final estimate of the actual bill that has passed the Congress?

Mr. FOSTER. Yes, sir, on April 22nd.

Mr. WAXMAN. Were you prevented from giving the Congress all the information it should have had when the Medicare prescription drug bill was voted on in the House?

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

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

Mr. FOSTER. Not in every case. We tried our best but it was a difficult circumstance.

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

Mr. FOSTER. That is correct.

Mr. WAXMAN. Thank you. I yield back.

Mr. PITTS. All right. The chair thanks the gentleman and that concludes the round of questioning for the first panel. Members who have other questions will submit them in writing. We ask the

witnesses to respond promptly to those. The chair thanks the first panel and now——

Mr. WAXMAN. Mr. Chairman, before we go to the second panel, may I ask a parliamentary inquiry?

Mr. PITTS. Yes. The gentleman will state his parliamentary inquiry.

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

Mr. PITTS. If the gentleman will suspend?

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

Mr. PITTS. The chair will be happy to respond after talking to counsel and make it a part of the record.

Mr. WAXMAN. Thank you very much.

Mr. PITTS. The chair thanks the gentleman. I will ask the second panel to please take their seats and I will introduce them at this time. We will now hear from the second panel with their opening statements. We will hear first from Douglas Holtz-Eakin. Mr. Holtz-Eakin is an economist by training. He has studied the effects of numerous health care policy proposals in the past and is a former director of the Congressional Budget Office. Next we will hear from Mr. David Cutler, the Otto Eckstein Professor of Applied Economics at Harvard University. We will then hear from a trio of business owners and hear their thoughts on the impact of the new law. First will be Philip Kennedy, who is the President of Comanche Lumber Company, a small business located in Oklahoma. Next we will hear from Rick Poore, the President of Design Wear/Velocitee, a tee shirt design company located in Nebraska. Finally, we will hear from Larry Schuler, the President of Schu's Hospitality Group, which runs several restaurants in the State of Michigan.

We will make your written testimony a part of the record and we ask that you please summarize your opening statements in 5 min-

utes, and I will now recognize Mr. Holtz-Eakin for 5 minutes for his opening statement.

STATEMENTS OF DOUGLAS HOLTZ-EAKIN, PRESIDENT, AMERICAN ACTION FORUM; DAVID CUTLER, OTTO ECKSTEIN PROFESSOR OF APPLIED ECONOMICS, HARVARD UNIVERSITY; PHILIP K. KENNEDY, PRESIDENT, COMANCHE LUMBER COMPANY; RICK POORE, PRESIDENT, DESIGN WEAR/VELOCITEE; AND LARRY SCHULER, PRESIDENT, SCHU'S HOSPITALITY GROUP

STATEMENT OF DOUGLAS HOLTZ-EAKIN

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

And lastly, when I say I testify and these views are my own, the forum has associate with it a vast number of experts with areas of expertise ranging from energy policy to education policy to any number of things, and I would not pretend to speak on their behalf and so these are my views as a researcher in both economic and health policy, and I want to emphasize that.

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

And indeed, the more general point is that those deficits and debt represent a huge impediment to economic growth. They are a promise of higher future taxes or higher future interest rates or both or in worst-case scenarios a financial crisis reminiscent of 2008, and I believe it is a mistake at this point in time to enact something like the Affordable Care Act, which in my view will make our fiscal situation worse, not better. It is past common sense

to believe that you can set up two new entitlement spending programs that grow at 8 percent a year as far as the eye can see. That is the CBO growth rates. Tax revenues won't grow that fast. The economy won't grow that fast. And increasing new entitlement spending as a result will make our budget problems worse, not better. We missed an opportunity to fix our real problems in Medicare and Medicaid, and that is a huge part of my reservation about this last.

Past that, I will make a couple of points about the structure. As I laid out in some detail, the structure of the mandates, the employer mandate in particular, are an impediment to growth, particularly for small businesses where we see the mandate kick in at 51 employees, and because of the nature of the phase-outs, if you hire a higher quality labor force, you get subject to greater costs. The insurance market reforms themselves covering more benefits will make premiums more expensive. The variety of insurer fees, taxes on medical devices and other things will raise premiums, not lower them. That will compete with other resources that could be used for hiring or increasing wages and will hurt labor market performance. And many of the new taxes, in particular the 3.8 percent surtax on net investment income, are of exactly the same character we have seen in recent debates over broader tax policy. They will affect small businesses, taxes passed through entities, through the individual income tax, and as a result something like a trillion dollars of business income which is reported on individual taxes will be subject to higher tax rates and hurt economic performance.

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

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

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

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The True Cost of the Patient Protection and Affordable Care Act

Douglas Holtz-Eakin, President
American Action Forum*

March 30, 2011

Introduction

Chairman Pitts, Vice-Chairman Burgess, Ranking Member Waxman and members of the Committee, I am pleased to have the opportunity to appear today to discuss the costs of the Patient Protection and Affordable Care Act (ACA). In this testimony, I wish to make five major points:

- At a time when sound policy requires low taxes and reductions in present and future transfer spending, the ACA moves dramatically in the wrong direction;
- The mandates and tax provisions in the ACA will have detrimental impacts on employment growth, wages, and economic growth;
- The impact of ACA will be more expensive health insurance, putting employers in the position of either reduced wage rates, fewer employees, or dropping insurance coverage;
- The ACA has strong incentives to drop health insurance coverage, and to the extent that employers pursue these incentives, taxpayers face tremendous upside risk to the cost of the ACA; and
- Even without unexpectedly large numbers of employers dropping coverage, the ACA will exacerbate an already-dangerous fiscal outlook.

Let me pursue each in additional detail.

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* The opinions expressed herein are mine alone and do not represent the position of the American Action Forum. I am grateful to Ike Brannon, Cameron Smith, Michael Ramlet, and Matt Thoman for assistance. All errors are my own.

Policy Response to the Fiscal Threat

The primary policy problem facing the United States is the projected continued explosion of federal debt. If left unchecked, the debt will corrosively erode the Nation's economic foundations, engender future financial crises, hamstring the ability of the United States to project is values around the globe, and diminish its ability to secure its citizens safety.

The source of these threats is commitments to federal spending that rise above any reasonable metric of taxation for the indefinite future. Period. There is a mini-industry devoted to producing alternative numerical estimates of this mismatch, but the diagnosis of the basic problem is not complicated. The diagnosis leads as well to the prescription for action. The budget problem is primarily a spending problem and correcting it requires reductions in discretionary outlays and the growth of large mandatory spending programs.

As an example, using the President's 2012 Budget, the CBO projects that over the next decade the economy will fully recover. Despite this, the deficit in 2021 will be $1.2 trillion and nearly 5 percent of Gross Domestic Product. The problem is not revenues, which are projected in 2021 to be 19.3 percent of GDP, well more than the historic norm of 18 percent. Instead, the deficit derives from spending. Federal outlays in 2021 are expected to be 24.2 percent of GDP, higher than the 20 percent that has been business as usual in the postwar era.

The fiscal future outlined above represents a direct impediment to job creation and growth. The United States is courting downgrade as a sovereign borrower and a commensurate increase in borrowing costs. In a world characterized by financial market volatility stemming from Ireland, Greece, Portugal, and other locations this raises the possibility that the United States could find itself facing a financial crisis. Any sharp rise in interest rates would have dramatically negative economic impacts; even worse an actual liquidity panic would replicate (or worse) the experience of the fall of 2008.

Alternatively, businesses, entrepreneurs and investors perceive the future deficits as an implicit promise of higher taxes, higher interest rates, or both. For any employer contemplating locating in the United States or expansion of existing facilities and payrolls, rudimentary business planning reveals this to be an extremely unpalatable environment.

In short, cutting spending is a pro-growth policy move at this juncture. As summarized by a recent American Action Forum study, the research indicates that the best strategy to both grow and eliminate deficits is to keep taxes low and reduce public employee costs and transfer payments.[1] Unfortunately, the ACA moves in precisely the wrong direction. It contains trillions of dollars of new transfer

[1] See http://americanactionforum.org/news/repairing-fiscal-hole-how-and-why-spending-cuts-trump-tax-increases

spending, combined with hundreds of billions of dollars in new taxes. It is the wrong economic policy at a pivotal moment in U.S. economic history.

Employer Mandate and Tax Impacts on Jobs and Growth

The United States' economy has endured a severe recession and is currently growing slowly. The pace of expansion remains solid and unspectacular. In many ways this is not surprising. As documented in Rogoff and Reinhart (2009), economic expansions in the aftermath of severe financial crises tend to be more modest and drawn out than recovery from a conventional recession.[2] Accordingly, it is imperative that policy be focused on generating the maximum possible pace of economic growth. More rapid growth is essential to the labor market futures of the millions of Americans without work. More rapid growth will be essential to minimizing the difficulty of slowing the explosion of federal debt to a sustainable pace. More rapid growth will generate the resources needed to meet our obligation to provide a standard of living to the next generation that exceeds the one this generation inherited.

Unfortunately, key provisions of the ACA are inconsistent with strong, pro-growth policies. In what follows, I focus on three in particular: mandate costs, administrative burdens, and tax increases.

Employer Mandate Costs
Among the key aspects of the ACA is its mandate to cover employees with health insurance. Focusing first on those employers with more than 50 workers, beginning in 2014, those firms must pay a penalty if any of their full-time workers receive subsidies for coverage through the exchange. The penalty is equal to the lesser of $3,000 for each full-time worker receiving a premium credit, or $2,000 for each full-time worker, excluding the first 30 full-time workers. The fees are paid monthly in the amount of $1/12^{th}$ of the specified fee amounts. Firms with fewer than 50 employees are exempt from the so-called employer "play or pay" penalties if they do not offer coverage and their workers receive a subsidy in the exchange.

From the perspective of economic performance, the most important point is that the *best* possible impact is that the firm is already offering insurance, no individual ends up receiving subsidies and triggering penalties, and thus costs are unaffected. In every other instance, health insurance costs will compete with hiring and growth for the scarce resources of those firms.

One might think that the same situation prevails for the smallest firms – those under 50 employees – who are exempt from the coverage mandate. Unfortunately, for these firms, the greatest impact is the tremendous impediment to expansion.

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[2] See *This Time Is Different: Eight Centuries of Financial Folly*, by Carmen M. Reinhart and Kenneth Rogoff, 2009.

Suppose for example that a firm does not provide health benefits. Hiring one more worker to raise employment to 51 will trigger a penalty of $2,000 per worker multiplied by *the entire workforce*, after subtracting the first 30 workers. In this case the fine would be $42,000 (21 (51-30) workers times $2,000). How many firms will choose not to expand?

Proponents of the ACA like to point toward the fact that small businesses will receive aid in the form of a small businesses tax credit, ostensibly offsetting the burdens outlined above. Unfortunately, the credit is available only for employers with fewer than 25 workers and those in which average wages are under $50,000. Thus, the cost and growth impacts for those with 26 to 50 employees remains unchanged. Moreover, the credit is not a permanent part of the small business landscape. An employer may receive the credit only until 2013 and then for two consecutive tax years thereafter. Thus, the credit is available for a maximum of six years.

Turning to the credit itself, to be eligible the employer must pay at least 50 percent of the premium. The credit is equal to 35 percent of employer contributions for qualified coverage beginning in 2010, increasing to 50 percent of the premium in 2014 and thereafter. The amount of the credit is phased-out for firms with average annual earnings per worker between $25,000 and $50,000. The amount of the credit is also phased-out for employers with between 10 and 25 employees.

The combination of requirements for premium contributions, limitations on employees, limitations on earnings, and phase-outs has surprised the small business community. In particular, the reform's strict definition that a firm is only a small business if it has 25 or fewer employees proved convenient to the legislators who crafted the bill. This narrow definition has led to a number of studies that assert that more than 80 percent of small businesses will be eligible for the tax credit.

Even those studies that recognize the limitation imposed by the 25-employee limit tend to overstate the likely penetration of the credit. For example, the Small Business Majority and Families USA recently estimated that 84 percent of the nation's 4.8 million businesses that employ 25 or fewer employees will be eligible for the tax credit.[3] Unfortunately, the net impact of the credit in offsetting the cost burden of the ACA will depend not upon *eligibility* but rather on *receipt* of the tax credits. This distinction was noted early in the debate by the Congressional Budget Office. In November 2009 when the law was being considered before Congress, CBO found that, "A relatively small share (about 12 percent) of people with coverage in the small group market would benefit from that credit in 2016."[4]

A more useful study focuses on the estimated number of small firms who would qualify for the small business health insurance tax credit. A recent analysis

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[3] See, http://www.smallbusinessmajority.org/_pdf/tax_credit/Helping_Small_Businesses.pdf

[4] See, http://cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf

conducted by the National Federation of Independent Business (NFIB) found that the total number of firms that offer health insurance and pay more than half of their employees' premium costs, as mandated under ACA, is more likely 35 percent of all firms with less than 25 employees.[5]

In the same way that the mandate provides an implicit tax on growth, the structure of the small business tax credit will raise the effective marginal tax rate on small business expansion. For this reason, the credit may discourage firms from hiring more workers or higher-paid workers. Consider two examples.

In the first, employers will have an incentive to avoid increases in the average rate of pay in their firm. Suppose that the average wage in a small (3 worker) firm is $25,000 and the owner decides to add a more highly paid supervisor being paid $50,000. This will raise the average wages in the firm to $31,250 there by *reducing* the tax credit per worker from $2,100 to $1,596.[6] In effect, the structure of the credit raises the effective cost of adding valuable supervisory capacity.

In this example, total credits to the firm are essentially unchanged ($6,300 to $6,384) by raising the average wage. If the new supervisor were paid $75,000 however, total credit payments would fall from $6,300 to $4,368. The lesson is clear in that the structure of the credit can impose large effective tax rates on raising the quality of the labor force for those receiving the small business credit.

Similar incentives affect the decision to hire additional workers because the overall tax credit falls by 6.7 percent for each additional employee beyond 10 workers. This is a very strong disincentive to expanding the size of the firm. Using the example above, suppose that the firm has 10 employees and total credits received were $21,000. The firm's total subsidy will peak at $21,840 with the hiring of the 13th worker. Thus, a firm employing 13 workers would get a total tax credit of $21,840 while a firm employing 24 workers would receive a total credit of only $3,360.[7]

The upshot is that the small business tax credit is a mixed economic blessing. Relatively few firms will qualify for the credit and be able to offset the costs of health insurance. For those that do qualify, receipt of the credit imposes a new regime of hidden effective marginal tax increase on improvements in scale and quality.

Tax Increases

The Act raises more than $700 billion in tax revenue from an excise tax on high-premium plans; reinsurance and risk adjustment collections; penalty payments by employers and uninsured individuals; fees on medical device manufacturers,

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[5] See, http://www.nfib.com/nfib-on-the-move/nfib-on-the-move-item?cmsid=52099

[6] This example assumes the employer contributes $6,000 toward insurance for each employer.

[7] See, http://www.ncpa.org/pdfs/ba703.pdf

pharmaceutical companies, and health insurance providers; and other revenue provisions. There is no theory or empirical research on job creation that suggests that large tax increases will spur employment. Taken at face value, one should be skeptical that ACA will not harm the pace of overall economic recovery.

There are two taxes of particular interest contained in ACA. Section 9015 increases the Medicare HI tax by 0.9 percentage points on wages in excess of $200,000 ($250,000 for couples filing jointly, $125,000 for married individuals filing separately), and also applies to self-employed earnings.

Sec. 1402 of HCERA imposes a 3.8 percent Medicare contribution tax on individuals, estates, or trusts of the lesser of net investment income or the excess of modified adjusted gross income over the threshold amount. The threshold amount is $250,000 for joint returns, $125,000 for married filing separately, or $200,000 for any other case. Both taxes are effective for taxable years beginning after 2012.

The first point to note is that these taxes have nothing to do with Medicare finance. While gross inflows may be credited to the HI trust fund, these dollars will finance the expansion of the new insurance subsidy entitlement program.

The second point to note is that these taxes apply to the labor and investment earnings of pass-thru entities taxed through the individual income tax. Thus, they are targeted at precisely the same group of individuals most likely to be business owners or entrepreneurs. The Joint Committee on Taxation projects that $1 trillion in business income will be reported on individual income tax returns in 2011. Notably, of that $1 trillion, roughly one-half, $470 billion, will be reported on returns that are likely to be the new surtaxes.[8]

This has the potential to impact employment. According to the Small Business Administration, there are almost 120 million private sector workers in the United States. Slightly more than half those workers, 60 million, work for small businesses. About two-thirds of the nation's small business workers are employed by small businesses with 20 to 500 employees. According to Gallup survey data conducted for the National Federation of Independent Business (NFIB), half of the small business owners in this group fall into the surtax brackets. This means there is a pool of more than 20 million workers in those firms directly targeted by the higher marginal tax rates. This is likely a conservative estimate as it ignores flow-through entities with one to 19 workers.

A final tax impact of the ACA is that the impact of phase-outs of refundable credits may have even more perverse growth consequences. As noted in Brill and Holtz-

[8] The Joint Committee on Taxation analysis does not take into account the impact on small, non-publicly-traded "C" corporations. There are several million of these entities, which will likely be adversely affected by the marginal rate increases on ordinary and capital income.

Eakin (2010) the phase-outs in insurance subsidies contribute to high effective marginal tax rates.[9] The effect is to raise to as high as 41 percent the effective marginal tax rate on some of the lower-income U.S. workers. This has implications for the ability of families to rise from the ranks of the poor, or to ascend toward the upper end of the middle class. This growth and mobility is the heart of the American dream and is the most pressing issue at this time.

ACA and Health Insurance Premiums

Health care reform was presumed to encompass both expansion of affordable insurance options and provision of quality medical care at lower costs. The reality of the ACA could not be more different. Objective analysts have uniformly concluded that the new law raises – not lowers – national health care spending.[10] The rising bill for national health care spending will, in turn produce sustained upward pressures on health insurance premiums.

In addition, the law's array of insurance market reforms will increase premiums. Barring limits on annual and lifetime out-of-pocket spending, coverage of pre-existing conditions for children, and the ability for children to stay on parents' policies, are all initiatives that enhance benefits. These benefits must necessarily be covered by higher premiums.

These features of the law are increasingly well understood, much to the dismay of insurance consumers. However, other aspects of the new law are less appreciated. In particular, the financing of the health care law will have significant implications for purchasers of insurance as well.

As noted above, ACA raises more than $700 billion in tax revenue from an excise tax on high-premium plans; reinsurance and risk adjustment collections; penalty payments by employers and uninsured individuals; fees on medical device manufacturers, pharmaceutical companies, and health insurance providers; and other revenue provisions.

The impact of these fees on medical device manufacturers, insurers, and pharmaceutical companies is important and not well understood. To understand better, consider the fee on health insurers. The fee amounts to a *de facto "health insurance premium* tax" that will raise the cost of health insurance for American families and small employers. Specifically, under the law, an annual fee applies to

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[9] Brill, Alex and Holtz-Eakin, Douglas, "Another Obama Tax Hike." *Wall Street Journal,* February 4, 2010. See also, Douglas Holtz-Eakin and Cameron Smith, "Labor Markets and Health Care Reform, 2010. http://americanactionforum.org/files/LaborMktsHCRAAF5-27-10_0.pdf

[10] See http://www1.cms.gov/ActuarialStudies/Downloads/S_PPACA_2010-01-08.pdf or http://www.cbo.gov/ftpdocs/117xx/doc11705/08-18-Update.pdf.

U.S. health insurance providers, with the intent of raising nearly $90 billion over the next 10 years. The aggregate annual fee for all U.S. health insurance providers begins at $8 billion in 2014 and then rises thereafter. (See Table 1.)

Table 1
Aggregate Insurance Fees

Year	Fee
2014	$ 8 billion
2015	$11.3 billion
2016	$11.3 billion
2017	$13.9 billion
2018 & Beyond [11]	$14.3 billion
Total through 2020	$87.4 billion

To see the implications for insurance costs, one must examine how it affects individual insurers. Each firm will be liable for a share of the aggregate fee, which is calculated in two steps. First, each company will compute the total premiums affected by the law using the formula outlined in Table 2. For example, an insurer with net premium revenues of $10 million is unaffected. In contrast, an insurer with net premiums of $100 million will have $62.5 million ($12.5 million from the 50 percent component between $25 million and $50 million, and $50 million from the remainder). The aggregate fee is apportioned among the insurers based on their shares of the affected premiums. Importantly, the fees are not deductible for income tax purposes.

Table 2
Fraction of Premiums Counted

Annual Net Premiums	Fraction
Less than $25 million	0
$25 million to $50 million	50 percent
$50 million or more	100 percent

So far, seemingly so good, for families and small employers, as insurers have to pay this new "health insurance premium tax." Unfortunately, this ignores the influence of market forces. For any company, as it sells more insurance policies it will incur a greater market share, and thus a greater share of the $87 billion. That is, with each policy sold, the firm's total tax liability rises; precisely the structure of an excise tax. Firms don't really pay taxes; they attempt to shift them to suppliers, workers, or customers. Thus, it is important to distinguish between the *statutory incidence* of

[11] The statute provides that after 2018 the insurance fee is equal to the amount of the fee in the preceding year increased by the rate of premium growth for the preceding calendar year.

the premium tax – the legal responsibility to remit the tax to the Treasury – and the *economic incidence* – the loss in real income as a result of the tax.

Insurance companies will have to send the premium tax payments to the Treasury, so the statutory incidence is obvious. However, a basic lesson of tax policy is that people pay taxes; firms do not. Accordingly, the economic burden of the $87 billion in premium taxes must be borne by individuals. Which individuals will bear the economic cost?

The imposition of the premium tax will upset the cost structure of insurance companies, raising costs per policy and reducing net income (or exacerbating losses). Some might argue that the firms will simply "eat the tax" – that is simply accept the reduction in net income. For a short time, this may well be the case. Unfortunately, to make no changes whatsoever will directly impact companies' abilities to make investments in health IT programs, wellness initiatives and disease management tools. Ultimately, this hurts individuals and small employers who won't have access to the types of tools and programs that can improve the quality of care and lower costs. Trying to retain the *status quo* also hurts the return on equity invested in the firm. Because insurance companies compete for investor dollars in competitive, global capital markets, they will be unable to both offer a permanently lower return and raise the equity capital necessary to service their policyholders.

Importantly, these impacts will be felt equally by the not-for-profit insurers. Non-profits have comparable resource needs for disease management, wellness efforts, or IT equipment. They also have equity capital demands, as they rely on retained earnings as reserves to augment their capital base. Bearing the burden of the tax means lower access to these reserves and diminished capital, harming their ability to continue serving policyholders effectively.

In short, all insurers – *for profit* and *non-profit* alike – will seek to restructure in an attempt to restore profitability, with the main opportunity lying in the area of labor compensation costs. To the extent possible, firms will either reduce compensation growth, squeeze labor expansion plans (or even lay off workers), or both. However, there are sharp limits on the ability of companies to shift the effective burden of excise taxes onto either shareholders (capital) or employees (labor). Moreover, their ability to do so diminishes over time as capital and labor seek out better market opportunities.

The only other place to shift the tax cost is onto customers – i.e., families and small businesses. This economic reality is reflected in the Congressional Budget Office and Joint Committee on Taxation revenue estimating procedures. Specifically, they apply a 25 percent "offset" to the estimated gross receipts of any excise tax. In terms of the premium tax, this convention has two important implications. First, if the aggregate fee were recognized as a premium excise tax that carried incentives to shift some of the burden via lower dividends, capital gains, and wages, then the aggregate fee will overstate the net budget receipts. To the extent this happens,

receipts of income-based taxes will fall; hence the need for an offset to the gross receipts of the excise tax.

The second implication is that the remainder of the tax is passed on to consumers. That is, the offset is not 100 percent meaning that the non-partisan consensus-based revenue estimators have concluded that the vast majority of the burden of excise taxes will *not* be borne by shareholders or workers.

If market conditions make it impossible for insurers to absorb the economic burden of the premium tax, they will have no choice but to build the new, higher costs into the pricing structure of policies. In this way, the economic burden of the tax is shifted to the purchasers of health insurance. In particular, the more competitive markets are for equity capital and hired labor, greater is the fraction of the burden that will be borne by consumers.

The implications for purchasers of health insurance are obvious and unambiguously negative. In addition, as employers pay more for health insurance, they will have to shave back on cash wage increases, and thus taxable compensation. Thus the health insurance premium tax will have the perverse effect of lowering personal income and payroll taxes.

To top things off, the new law has an especially unpleasant feature for those facing higher premiums: the fees are not tax-deductible, but higher premiums will be taxable.

This non-standard tax treatment matters a lot. If an insurance company passes along $1 of premium taxes in higher premiums and cannot deduct the cost (fee), it will pay another $0.35 in taxes. Accordingly, the impact on the insurer is $0.65 in net revenue *minus* the $1 fee. Bottom line: a loss of $0.35. (The problem gets worse when you consider that the $1 of additional premium is also subject to other state-level premium taxes and in some cases a state income tax.)

To break even, each insurer will have to raise prices by $1/(1-0.35) or $1.54. If it does this, the after-tax revenue is the full $1 needed to offset the fee. This has dramatic implications for the overall impact of the premium taxes. Instead of an upward pressure on premiums of $87.4 billion in fees over the next 10 years, the upward pressure will be $134.6 billion.

This line of reasoning is sometimes met with skepticism, and countered with the notion that consumers will simply be unwilling to accept a higher price. Evidence suggests that this is not true, but suppose the counter-argument is taken at face value. To the extent that firms accept a lower rate of return, they will be less able to attract capital. Similarly, to the extent they reduce employment in response to the tax (or cut wages and lose skilled employees to better opportunities), they will again suffer in their ability to expand their scale of operations. In short, insurers that attempt to adjust entirely on the cost side will be unable to maintain their

operations at a competitive level, and will lose market share or even exit the industry entirely. For health insurance markets as a whole, this reduces competition. The bottom line for consumers is the same: higher prices.

To gain a rough empirical feel of an average $87 billion health insurance premium tax, I employ publicly-available data on Yahoo! Finance.[12] Those data indicate that the earnings for the industry called "Health Care Plans" were roughly $16 billion. The average annual aggregate fee of $8.7 billion is a substantial impact on the cost structure and profitability of the companies; roughly one-half of the net earnings.

Could insurers absorb the fee and remain competitive in the market for equity capital? As a whole, the overall profit margin is shown as 4.2 percent. Assuming no change in behavior, a 50 percent decline on a sustained basis would make it impossible to obtain the financing needed to compete. Accordingly, it will be a matter of competitive reality for the insurers to pass the fee to consumers in the form of higher health insurance premiums.

The health insurance fee will likely quickly and almost completely be incorporated, resulting in higher insurance premiums. The premium tax alone means that American families will pay as much as $135 billion more in insurance premiums over the next 10 years. Incorporating the impact of medical devices and pharmaceuticals raises the total impact.

The final channel by which ACA affects insurance costs are through the mandates regarding insurance benefit designs. Mandating greater benefits will unambiguously raise the costs of insurance. However, one widely-touted promise of the ACA was that if you "like your health plan, you can keep it."

In this regard, it is important to note that the interim final rules governing insurance copayments, deductibles, premium increases, and employer contributions are so strict that that even conservative estimates by the Department of Health and Human Services (HHS) indicate a majority of Americans will be unable to keep their existing health care coverage by 2013.[13] A more realistic estimate, accounting for the response from American businesses since the rules were released, places the likely percentage of plans without grandfathered status well above the HHS' high-end estimate of 69 percent of plans by 2013.[14] Thus it appears that the interim final rules ensure that grandfathered status will be lost in the near-future and that a substantial majority of Americans will face higher costs.

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[12] See http://biz.yahoo.com/p/522qpmd.html.

[13] "Group Health Plans and Health Insurance Coverage Rules Pertaining to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act. Federal Register. Volume 75. Page 34571

[14] "2010 UBA Health Plan Survey." United Befit Advisors. October 2010.

ACA and Employer-Sponsored Insurance

Today about 163 million workers and their families receive health insurance coverage from their employers. Proponents of the ACA insisted that a key tenet of was to build on this system of employer-sponsored coverage.

Roughly one-half of the $900 billion of spending in the ACA is devoted to subsidies for individuals who do not receive health insurance from their employers. These subsidies are remarkably generous, even for those with relatively high incomes. For example, a family earning about $59,000 a year in 2014 would receive a premium subsidy of about $7,200. A family making $71,000 would receive about $5,200; and even a family earning about $95,000 would receive a subsidy of almost $3,000.

By 2018, subsidy amounts and the income levels to qualify for those subsidies would grow substantially: a family earning about $64,000 would receive a subsidy of over $10,000, a family earning $77,000 would receive a subsidy of $7,800 and families earning $102,000 would receive a subsidy of almost $5,000.

An obvious question is how employers will react to the presence of an alternative, subsidized source of insurance for their workers, which can be accessed if they drop coverage for their employees. The simplest calculation focuses on the tradeoff between employer savings and the $2,000 penalty (per employee) imposed by the ACA on employers whose employees move to subsidized exchange coverage. Consider a $12,000 policy in 2014, of which the employer would bear roughly three-quarters or $9,000. A simple comparison of $9,000 in savings versus a $2,000 penalty would seemingly suggest large-scale incentives to drop insurance.

Unfortunately, the economics of the compensation decision are a bit more subtle than this simple calculation. Health insurance is only one portion of the overall compensation package that employees receive as a result of competitive pressures. Evidence suggests that if one portion of that package is reduced or eliminated – health insurance – and another aspect – wages – will ultimately be increased as a competitive necessity to retain and attract valuable labor. Thus, the key question is whether the employer can keep the employee "happy" – appropriately compensated and insured – *and* save money.

As Table 3 outlines, the answer is frequently "yes" – thanks to the generosity of federal subsidies. To see the logic, consider the first row of the table, which shows the implications for a worker at 133 percent of the Federal Poverty Level (FPL) or $31,521 in 2014. We project that this worker will be in the 15 percent federal tax bracket, which means that $100 of wages (which yields $85) is needed to offset the loss of $85 dollars of employer-provided health insurance (which is untaxed). Consider now a health insurance policy worth $15,921, of which the employer picks up 75 percent of the cost. The employer's contribution to health insurance of $11,941 is the equivalent of a wage increase of $14,048 to the worker.

Do the economics of ACA ever suggest that employer's could drop? Yes. The employer would receive $14, 176 in subsidies – *more than the value of the lost health insurance.* On paper, they could take a pay cut and be better off. Clearly, the employer comes out way ahead – $11,941 less the penalty. Obviously, there is room for the employer to actually improve the worker's life by having a small pay raise and the same insurance and still save money. This is a powerful, mutual incentive to eliminated employer-sponsored insurance.

The remaining rows of Table 3 repeat this calculation for workers at ascending levels of affluence. For example, at 200 percent of the FPL, the "surplus" between the pay raise required to hold a worker harmless ($4,936) and the firm's cash-flow benefit from dropping coverage ($9,941) has narrowed, but the bottom line decision in the final column is the same. Indeed, the incentives are quite powerful up to 250 percent of FPL, or $59,250. Only for higher-income workers do the advantages of untaxed health insurance make it infeasible to drop insurance and re-work the compensation package.[15]

How big could this impact be? In round numbers, at present there are 123 million Americans under 250 percent of the FPL. Roughly 60 percent of Americans work and about 60 percent of those receive employer-sponsored insurance. This suggests that there are about 43 million workers for whom it makes sense to drop insurance.[16]

CBO estimated that only 19 million residents would receive subsidies, at a cost of about $450 billion over the first 10 years. This analysis suggests that the number could easily be triple that (19 plus an additional, say, 38 million in 2014) – meaning the price tag would be $1.4 trillion.

In contrast, the CBO predicted that only 3 million individuals who previously received coverage through their employers will get subsidized coverage through the new exchanges. One mechanism that would reduce employer drop is if high-wage workers continue to receive insurance and non-discrimination rules force employers to offer insurance to all workers – even those for whom it makes sense to drop coverage. For those firms dominated by lower-wage workers this is unlikely to succeed as it will be possible to use the accumulated savings to retain the few high-wage workers. Or, there may be incentives for firms to "out-source" their low-wage workers to specialist firms (that do not offer coverage) and contract for their skills. In any event, the massive federal subsidies are money on the table inviting a vast reworking of compensation packages, insurance coverage, and labor market relations.

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[15] Notice that what this really means is that an *existing* federal subsidy (via the tax code) trumps the new federal subsidy!

[16] This is likely an upper bound estimate as there is a positive correlation between wage levels and the probability of having insurance.

Table 3
Health Care Reform and Employer-Sponsored Insurance in 2014
(Employer Health Plan = $11,941)

Percent of Federal Poverty Level	Income[1]	Tax Bracket[2]	Wage Equivalent of Employer Health	Federal Subsidies[4]	Required Pay Raise[5]	Employer Free Cash Flow[6]	Employer Drop Decision[7]
133%	$31,521	15%	$14,048	$14,176	($128)	$9,941	Drop
150%	$35,550	15%	$14,048	$13,385	$663	$9,941	Drop
200%	$47,400	25%	$15,921	$10,985	$4,936	$9,941	Drop
250%	$59,250	25%	$15,921	$7,530	$8,391	$9,941	Drop
300%	$71,100	25%	$15,921	$5,187	$10,734	$9,941	Keep
400%	$94,800	28%	$16,585	$2,935	$13,650	$9,941	Keep

1. Income calculated based on 2009 FPL for a family of four of $22,050 (HHS), indexed to CPI projections (CBO)
2. Tax bracket calculated based on 2010 tax brackets, indexed to CPI projections (CBO)
3. Computed as CBO estimate of Silver Plan in 2016, indexed to 2014 ($11,941), and divided by (1-Tax Rate)
4. Estimated federal insurance subsidy
5. Wage equivalent minus subsidies
6. Value of insurance plan minus $2,000 penalty
7. Drop if required pay raise is greater than free cash flow

ACA and the Budget Outlook[17]

The United States faces a daunting budgetary outlook, with the Administration's budget displaying an unsustainable debt spiral emerging over the next decade. In this context, the fiscal consequences of the newly-enacted Patient Protection and Affordable Care Act are of extreme importance.

The Context: An Approaching Fiscal Train Wreck
The federal government's unsustainable long-run fiscal posture has been outlined in successive versions of the CBO's *Long-Term Budget Outlook*. In broad terms, over the next 30 years, the inexorable dynamics of current law will raise outlays, or committed federal expenditures, from about 20 percent of Gross Domestic Product (GDP) to anywhere from 30 to 40 percent of GDP.[18] Any attempt to keep tax revenues at their post-war norm of 18 percent of GDP will generate an

[17] This sections draws heavily on Holtz-Eakin and Ramlet "Health Care Reform Is Likely To Widen Federal Budget Deficits, Not Reduce Them," *Health Affairs*, 2010.
[18]Congressional Budget Office. The Long-Term Budget Outlook. Washington (DC): Congress of the United States; June 2009.

unmanageable federal debt spiral. In contrast, a strategy of ratcheting up taxes to the 30 to 40 percent of GDP needed to match the federal spending appetite would likely be self-defeating as it would undercut badly-needed economic growth.*

The policy problem is that spending rises above any reasonable level of taxation for the indefinite future. This diagnosis leads as well to the prescription for action. Over the long-term, the budget problem is primarily a spending problem and correcting it requires reductions in the growth of large mandatory spending programs and the appetite for federal outlays.

This depiction of the federal budgetary future has been unchanged for a decade or more. However, the most recent Administration budget shows that in part due to the financial crisis, recession, and policy responses, the problem has become dramatically worse and will arrive more quickly than forecast. The federal government ran a fiscal 2010 deficit of $1.3 trillion. Going forward, there is no relief in sight. Over the next ten years, according to the CBO's preliminary analysis of the President's Budgetary Proposals for Fiscal Year 2012, the deficit will never fall below $748 billion dollars.[19] In 2021, the deficit will be nearly 5 percent of GDP, or roughly $1.2 trillion, of which over $900 billion will be devoted to servicing debt on previous borrowing.

As noted above, the budget outlook is not the result of a shortfall of revenues. The CBO projects that over the next decade the economy will fully recover and revenues in 2021 will be 19.3 percent of GDP – over the historic norm of 18 percent. Instead, the problem is spending. Federal outlays in 2021 are expected to be 24.2 percent of GDP – about $1.6 trillion higher than the 20 percent that has been business as usual in the postwar era.

As a result of the spending binge, in 2021 public debt will have more than doubled from its 2008 level to 90 percent of GDP and will continue its upward trajectory.

The Budgetary Impact of the Patient Protection and Affordable Care Act
In light of the fiscal threat from growing spending, the budgetary impacts of the Act are central to any discussion of its merits. We begin by reviewing the CBO cost estimate that concludes the Act will serve to lower projected deficits over the next ten years and beyond. After our summary review, we proceed by analyzing the budgetary implications of altering certain assumptions.

The final score of ACA with reconciliation amendments was released publicly on March 20, 2010.[20] The CBO and the Joint Committee on Taxation estimated the Act would lead to a net reduction in federal deficits of $143 billion over ten years with

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[19] http://www.cbo.gov/ftpdocs/121xx/doc12103/2011-03-18-APB-PreliminaryReport.pdf

[20]Congressional Budget Office. H.R. 4872, Reconciliation Act of 2010. Washington (DC): Congress of the United States; 2010 March.

$124 billion in net reductions from health care reform and $19 billion derived from education provisions.[21]

Total subsidies in the Act exceed $1 trillion dollars over ten years and include insurance exchange tax credits for individuals, small employers tax credits, the creation of reinsurance and high risk pools, as well as expansions to Medicaid and the Children's Health Insurance Program. To finance the subsidies and reduce the deficit, total cost savings are projected to be nearly $500 billion based on reductions in annual updates to Medicare fee-for-service payment rates, Medicare Advantage rates, and Medicare and Medicaid disproportionate share hospital (DSH) payments. In addition to the cost saving measures, the Act raises more than $700 billion in tax revenue from an excise tax on high-premium plans; reinsurance and risk adjustment collections; penalty payments by employers and uninsured individuals; fees on medical device manufacturers, pharmaceutical companies, and health insurance providers; and other revenue provisions.

To gain a rough feel of the longer-run impacts, consider extrapolating to the years 2020 to 2029 using CBO's estimated compounded annual growth rates. Under this crude approach, the ACA is expected to yield an additional $681 billion in deficit reduction.

The prospect of these savings is important given the daunting fiscal outlook. But they raise an important question: is it really likely that a large expansion of public spending will reduce the long-run deficit? The answer, unfortunately, hinges on provisions of the legislation that the budget office is required to take at face value and not second-guess.

A more realistic assessment emerges if one strips out gimmicks and budgetary games and reworks the calculus. As shown in Table 4 a wholly different picture emerges: the ACA would raise, not lower, federal deficits, by $554 billion in the first ten years and $1.4 trillion over the succeeding ten years.

The list of budgetary features embedded in the CBO score begins with the fact that the Act front-loads revenues and backloads spending. That is to say the taxes and fees it calls for began immediately in 2010, but its new subsides are largely deferred until 2014. This contributes to the illusion that the ACA reduces the deficit. Note that if revenues were delayed to start in 2014, the Act's 2010-2019 net deficit impact would be $66 billion lower.

Additional budgetary provisions of interest fall into four scenarios: unachievable savings, unscored budget effects, uncollectible revenue, and already reserved

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[21] To analyze the fiscal impact of health care reform, we have removed the education revenues from the government takeover of all federally financed student loans.

premiums. Table 4 summarizes the annual impact of each scenario and extrapolates the fiscal impact to 2029.

The first adjustment, labeled "Unachievable Savings", removes spending cuts that the Centers for Medicare and Medicaid Services (CMS) will ultimately be unable to implement. These are composed of cost reductions through Medicare market basket updates, the Independent Payment Advisory Board, Medicare Advantage interactions, and the Part D premium subsidy for high-income beneficiaries. While the specifics of each differ, these provisions share two features. First, the ACA does not fundamentally reform Medicare in such a manner that will permit it to operate at lower budgetary cost. Accordingly, when the time comes to implement these savings (or those developed by the Independent Payment Advisory Board) CMS will be faced with the possibility of strongly limited benefits, the inability to serve beneficiaries, or both. As a result, the cuts will be politically infeasible, as Congress is likely to continue to regularly override scheduled reductions. A vivid example is the Medicare Physician Payment Updates. Each year since 2002 the "sustainable growth rate" formula in current law has imposed cuts in payments to physicians under Medicare. And each year Congress has overridden these same cuts.

Table 4
(billions of dollars unless otherwise noted)

Adjustments	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
CBO Projected Subsidies	4	11	13	9	70	125	181	204	219	236	1072
CBO Projected Cost Savings	2	-2	-11	-18	-43	-51	-59	-75	-91	-109	-455
Unachievable Savings	0.1	1.4	4.9	10	20.1	25.7	32.3	41.7	52.1	64.8	253.5
Unscored Budget Effect	8	14.7	16.5	18	18.3	20.4	23.4	26.2	29.3	34.7	274.6
Subtotal	10.1	14.1	10.4	10	-4.6	-4.9	-3.3	-7.1	-9.6	-9.5	73.1
CBO Projected Tax Revenues	0	-8	-15	-43	-77	-90	-114	-123	-131	-141	-739
Uncollectable Revenue	0	-1	-2	-5	1	6	14	18	22.2	26.8	78
Premiums Reserved	0	0	5.4	8.8	10	11.3	11.1	9.1	7.6	7	70.2
Subtotal	0	-9	-11.6	-39.2	-66	-72.7	-88.9	-95.9	-101.2	-107.2	-590.8
Net Change in Projected Deficit	14.1	16.1	11.8	-20.2	-0.6	47.4	88.8	101	108.2	119.3	554.3
Percentage of GDP	*0.10*	*0.11*	*0.08*	*0.12*	*0.00*	*0.27*	*0.50*	*0.55*	*0.58*	*0.62*	*2.90*

Massachusetts and Tennessee provide recent examples where insurance coverage expansion has led to substantial cost increases, instead of savings. In 1994, Tennessee implemented a massive Medicaid expansion (eventually covering 500,000 additional residents). A decade later, the state abandoned the experiment after costs more than tripled from $2.5 billion in 1995 to $8 billion in 2004, consuming one-third of the state budget. When the experiment unraveled in 2005, 170,000 enrollees were dropped. More recently in April 2010, Tennessee

announced that, due to cost overruns, the program would need to cut an additional 100,000 people from Medicaid rolls.[22]

In Massachusetts, the state's Special Commission on the Health Care Payment System has produced payment recommendations in the wake of passing an individual insurance mandate, but the commission has so far failed to bend the cost curve on medical inflation (growing 8 percent annually in Massachusetts).[23] The federally impaneled Independent Payment Advisory Board would likely follow a similar trajectory.

The second adjustment, "Unscored Budget Effects", highlights acknowledged costs that are not included in the CBO score. To operate the new health care programs over the first ten years, future Congresses will need to vote for $274.6 billion in additional spending. This spending includes the discretionary costs for the Internal Revenue Service (IRS) to enforce and the CMS to administer insurance coverage, explicitly authorized health care grant programs, and the Medicare Physician Payment Reform Act, which revises the sustainable growth rate for physician reimbursement.

Adjustment three, "Uncollectable Revenue", questions the political will of Congress and directly refers to the excise tax on high-premium, "Cadillac" health plans. This tax was supposed to start immediately in the Senate's version of ACA. After intense lobbying by organized labor, Congress relented and pushed the tax back to 2018. This raises the possibility that it will prove politically infeasible to ever implement the tax. Thus, the scenario shows the impact of not collecting the associated tax revenue of $78 billion over the next ten years.

The final adjustment, "Reserved Premiums", focuses on the CLASS Act premiums for long-term care insurance and the potential increase in Social Security receipts. In principle, these receipts should be reserved to cover future payments and not be devoted to short-term deficit reduction. Specifically, the scenario shows the implications of reserving the $70 billion in premiums expected to be raised in the first ten years for the legislation's new long-term care insurance.

In addition to this accounting sleight of hand, the legislation uses $53 billion for deficit reduction from an anticipated increase in Social Security tax revenue. The CBO estimates that outlays for Social Security benefits would increase by only about $2 billion over the 2010-2019 period, and that the coverage provisions would have

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[22] Wadhwani A. Tennessee removes about 100,000 people from Medicaid rolls. Kaiser Health News. 2010 Apr 8. Available from:
http://www.kaiserhealthnews.org/Stories/2010/April/08/TennCare.aspx

[23] Kowalczyk L. Pay for care a new way, state is urged. The Boston Globe. 2009 July 19. Available from:
http://www.boston.com/news/local/massachusetts/articles/2009/07/17/pay_for_care_a_new_way_state_is_urged/?page=2

a negligible effect on the outlays for other federal programs. If Social Security revenues do rise as employers shift from paying for health insurance to paying higher wages, the extra money raised from payroll taxes should be preserved for the Social Security trust fund.

What is the bottom line? Removing the potentially unrealistic annual savings, reflecting the full costs of implementing the programs, acknowledging the unlikelihood of raising all of the promised revenues, and preserving premiums for the programs they are intended to finance, produces a radically different bottom line. The Act generates additional deficits of $562 billion in the first ten years. And, as the nation would be on the hook for two more entitlement programs rapidly expanding as far as the eye can see, the deficit in the second ten years would approach $1.5 trillion.

Of course, this is not the only source of budgetary uncertainty. Proponents point toward the possibility that the Act will "bend the curve" more than anticipated, thereby reducing health care spending in federal programs and beyond. In this light, it is important to note that if federal subsidies do not grow at all between 2020 and 2029 – a herculean reduction in annual spending growth of 3.4 percentage points – it will reduce outlays by under $500 billion. That is, extraordinary success in bending the cost curve amounts to less than one-third of the downside budgetary risks embedded in the Act.

The future of the Patient Protection and Affordable Care Act is likely to be even more important than its passage. In light of the extraordinarily precarious state of federal fiscal affairs and the enormous downside risks presented by the Act, one can only hope that every future effort is devoted to reducing its budgetary footprint.

Conclusion

The ACA will have a dramatic impact on the evolution of labor market incentives, economic growth, and the budget outlook over the near term. Unfortunately, at a time when job growth and controlling spending to restore fiscal balance are top policy priorities, its true cost will be become apparent in the form of diminished growth, slower labor market recovery, and greater fiscal distress. Thank you and I look forward to answering your questions.

Mr. PITTS. The chair thanks the gentleman and recognizes Mr. Cutler for 5 minutes.

STATEMENT OF DAVID CUTLER

Mr. CUTLER. Mr. Chairman, Mr. Pallone and members of the committee, I appreciate the invitation to appear before you today.

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

First, we need to eliminate wasteful spending, not valuable spending, so we need to be careful about how we cut. Second, we need to reduce the overall level of spending, not simply shift costs from one payer to another. Many proposals would shift costs around without reducing the overall level of spending. The key question is finding areas where we can accomplish both of those goals, where we can both reduce wasteful spending and not just shift costs. The health policy literature suggests there are three areas where that is possible. One is by improving the management of acute and postacute care for patients who are very sick and who receive more care than almost all physicians believe is necessary. Second is greater attention to prevention, where we spend a good deal of additional money by not having prevented disease, and third is reducing excessive administrative spending, which takes anywhere from 10 to 15 percent of medical care costs without bringing any commensurate benefits.

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

Second, you need to reward doing the right thing, not doing too much, not doing too little but doing the right amount. Physicians are frustrated, not because cannot treat individual patients, which they can, but because they know the system sends them off in directions that are counterproductive, that the only way to earn enough to keep their practice in business is to do more, to do things that are uncoordinated because coordination has expenses but no revenues and to not focus on prevention. The Affordable Care Act affects these incentives in a number of ways including direct payment innovation such as higher reimbursement for preventive care services, bundled payments for acute and postacute medical services, shared savings or capitation payments for accountable provider groups that assume responsibility for continuum of patents' care, pay-for-performance incentives for Medicare providers, in-

creased funding for comparative effectiveness research, the Independent Payment Advisory Board and an Innovation Center in the Centers for Medicare and Medicaid Services to test and disseminate new care models, an excise tax on high-cost insurance plans to provide incentives to reduce wasteful spending there, increased emphasis on wellness and prevention. This set of policy reforms, I should note, is neither a Democratic list nor a Republican list. It draws on both sides of the spectrum. Former CMS or HCFA administrators from both Democratic and Republican Administrations stress these are the single most important steps we can take to reduce the amount of inefficient medical spending in the United States.

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

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

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

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

[The prepared statement of Mr. Cutler follows:]

HARVARD UNIVERSITY, FACULTY OF ARTS AND SCIENCES
DEPARTMENT OF ECONOMICS

DAVID M. CUTLER
OTTO ECKSTEIN PROFESSOR OF APPLIED ECONOMICS

TESTIMONY OF DAVID M. CUTLER
Otto Eckstein Professor of Applied Economics
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Before the
Committee on Energy and Commerce
U.S. House of Representatives

Summary

There are two important rules that need to guide any discussion of cost containment. First, we need to eliminate wasteful spending, not valuable spending. Second, we need to reduce the overall level of spending, not simply shift costs from one payer to another.

The question that faces policy analysts, therefore, is finding areas where money can be saved while simultaneously improving care quality. The health policy literature suggests there are three areas where costs can be saved: (1) improved management of acute and post-acute care; (2) greater attention to prevention; and (3) reducing excessive administrative spending. At least one-third of medical spending is not associated with improved health, implying waste of about $750 billion annually.

The Affordable Care Act has a number of provisions designed to address these areas of cost savings. These include direct payment innovations such as higher reimbursement for preventive care services, bundled payment for acute and post-acute medical services, shared savings or capitation payments for accountable provider groups that assume responsibility for the continuum of a patient's care, and pay-for-performance incentives for Medicare providers; increased funding in comparative effectiveness research; an Independent Payment Advisory Board and an innovation Center in the Center for Medicare and Medicaid Services to test and disseminate new care models; an excise tax on high cost insurance plan; increased emphasis on wellness and prevention; and standardization of costly and burdensome administrative practices.

The effect of these change on medical spending, federal and state budgets, and job growth are profound. I estimate that over the next decade, the Affordable Care Act will reduce national medical spending by over $500 billion, reduce the federal budget deficit by over $400 billion, and lead to the creation of 250,000 to 400,000 jobs annually. The urgent need is for this Congress and administration to work together to ensure that the Affordable Care Act is as successful as it can be.

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March 30, 2011

TESTIMONY OF DAVID M. CUTLER
Otto Eckstein Professor of Applied Economics
Harvard University

Before the
Committee on Energy and Commerce
U.S. House of Representatives

Mr. Chairman, Mr. Pallone, and members of the committee, I appreciate the invitation to appear before you today to discuss the topic of "The True Cost of the Patient Protection and Affordable Care Act (the Affordable Care Act)." My name is David Cutler, and I am the Otto Eckstein Professor of Applied Economics at Harvard University. I have appointments in the Department of Economics, the Kennedy School of Government and the School of Public Health at Harvard. I have studied the health care industry for over 20 years and have written extensively about the economic and fiscal consequences of health care reform.

The high level and rapid growth of medical spending in the United States is an enormous policy challenge, and understanding how the Affordable Care Act affects those costs is extremely important. High medical costs have an immediate effect on family budgets, by reducing the amount that families can spend on housing, clothing, education, and other important goods and

services. In addition, high costs for businesses lead to a variety of labor market impediments.[1] These include people feeling locked into their current job,[2] reduced business startups, and reduced employment, especially of lower wage workers.[3] Further, high medical spending, when combined with constant or falling tax collections, pose a strain on budgets at all levels of government. Thus, policy must focus on constraining medical spending.

That said, not all policies to lower medical spending are the same. There are two important rules that need to guide any discussion of cost containment:

o *We need to eliminate wasteful spending, not valuable spending.* Cutting payments across-the-board is not a good policy unless measures are put in place to ensure that the provision of valuable care is enhanced and that the most vulnerable members of our society are protected from the adverse effects that could result from indiscriminate cost reductions. Those measures are included in the Affordable Care Act, as described below.

o *We need to reduce the overall level of spending, not simply shift costs from one payer to another.* It would be easy for businesses to reduce their spending on medical care; they could simply stop providing health insurance and let their employees buy individually. While this would lower business costs, it would raise spending by families. Indeed, family spending would

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[1] Gruber, Jonathan, "Health Insurance and the Labor Market," in Anthony J. Culyer and Joseph P. Newhouse, eds., *Handbook of Health Economics*, Volume 1A, Amsterdam: North-Holland, 2000; Janet Currie and Brigitte Madrian, "Health, Health Insurance and the Labor Market," in Orley Ashenfelter and David Card, eds., *Handbook of Labor Economics*, 1(3), Amsterdam: North-Holland, 1999, 3309-3416.

[2] Brigitte Madrian, "Employment-Based Health Insurance and Job Mobility: Is There Evidence of Job-Lock?," *Quarterly Journal of Economics*, 1994, 109(1), 27-54.

[3] Neeraj Sood, Arkadipta Ghosh, José Escarce, "Employer-Sponsored Insurance, Health Care Cost Growth, and the Economic Performance of U.S. Industries", *Health Services Research*, 44(5), October 2009, 1449 -1464; Katherine Baicker and Amitabh Chandra, "The Labor Market Effects of Rising Health Insurance Premiums", *Journal of Labor Economics*, 24(3), July 2006, 609-634.

likely increase by more than business spending fell, since the administrative costs of individual insurance are many times greater than the administrative costs of group coverage. Similarly, governments could reduce their liability for medical care by shifting costs to individuals – requiring higher premiums for Medicare beneficiaries or restricting eligibility for Medicaid. But this too is a shift of costs that may lead to an increase in the overall level of medical spending, not a reduction in expenses.

OPPORTUNITIES TO REDUCE MEDICAL SPENDING

The question that faces policy analysts, therefore, is finding areas where money can be saved while simultaneously improving care quality. The health policy literature suggests there are three areas where money can be saved and quality simultaneously improved:

o *Improved management of acute and post-acute care.* When people develop acute illnesses, they receive care that is uncoordinated, frequently inappropriate, and provided in settings that are more expensive than needed. For example, the Dartmouth Atlas shows that Medicare beneficiaries who live in areas of the country that spend more receive more medical care, but their health is no better.[4] The magnitude is such that nearly one-third of Medicare spending could be eliminated by bringing spending in more expensive areas to the level of less expensive areas. Another study shows significant unnecessary hospital readmissions, again in the Medicare population. Nationally, about 20 percent of Medicare beneficiaries are readmitted

[4] Fisher, Elliott, et al., "The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care." *Annals of Internal Medicine* 2003a, 138: 273–87; Fisher, Elliott, et al., "The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care." *Annals of Internal Medicine* 2003b, 138: 288–98.

to a hospital within one month of a previous discharge.[5] In the best health systems, the rate is close to 5 percent.[6] The difference between these rates is tens of billions of dollars annually, and needless suffering for many families.

Improvement in acute and post-acute care management has been demonstrated numerous times. The journal *Health Affairs* recently profiled 15 successful organizations.[7] The Institute of Medicine has reported on several more.[8] Organizations such as the Cleveland Clinic, Geisinger Health System, Group Health Cooperative, Intermountain Health Care, Kaiser Permanente, Massachusetts General Hospital, the Mayo Clinic, and the Virginia Mason Medical Center all have achieved high quality, lower cost outcomes. These organizations are not concentrated geographically, nor do they share particular demographic characteristics of enrollees. Rather, they have three other features in common: (1) they use information technology to learn what works and what does not; (2) they have removed themselves from the fee-for-service payment grid and instead use volume-neutral or value-based payments; and (3) they have freed up employees to do the right job, by training leaders who facilitate quality improvement and empowering employees to make the right care the heart of their mission. All of this would be possible to replicate nationally, but not without major changes in how medical care is structured.

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[5] Stephen F. Jencks, et al., "Rehospitalization among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine,* 2009; 360: 1418-1428.
[6] Maureen Bisognano and Amy Boutwell, "Improving Transitions to Reduce Readmissions," *Frontiers of Health Services Management*, Spring 2009, 25(3), 3-10.
[7] Profiles of Innovation in Health Care Delivery, *Health Affairs*, March 2011.
[8] Institute of Medicine, *The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Summary.* Washington, DC: The National Academies Press, 2010.

o *Increased attention to prevention.* Prevention extends lives, and in many cases lowers medical spending as well.[9] Thus, preventing acute illnesses is a second way to lower medical costs and improve the quality of care. There are several aspects of prevention: primary prevention (mammograms, colonoscopies, obesity reduction programs, and the like), secondary prevention (medication for diabetes, high cholesterol, and other chronic diseases to prevent acute events), and tertiary prevention (reducing the risk of hospital readmission, as noted above). Primary, secondary, and tertiary prevention are all poor in the United States. For example, only 43 percent of diabetic patients in the United States report receiving recommended screening for diabetes.[10] That is about average internationally, but far below the best countries. Two-thirds of diabetics in the United Kingdom and nearly 60 percent of diabetics in the Netherlands report having received all recommended screenings. Thus, we know we can do better.

There are several features of the British and Dutch health care systems that likely contribute to their better prevention. First, providers in these countries regularly use information technology. Eighty-nine percent of British physicians and 54 percent of Dutch physicians have extensive access to electronic medical records and decision support systems, compared to only 26 percent of U.S. physicians.[11] Physicians cannot help patients manage their care if they do not know what care their patients have and have not received. Second, both the United Kingdom and the Netherlands encourage a team-based approach to care provision. In the Netherlands, physicians have established after-hours cooperatives to provide care on nights and weekends. The United

[9] Dana P. Goldman, et al., "The benefits of risk factor prevention in Americans aged 51 years and older," *American Journal of Public Health*, 2009, 99(11), 2096-101.
[10] Cathy Schoen, Robin Osborn, Sabrina K.H. How, et al., "In Chronic Condition: Experiences of Patients with Complex Health Care Needs, in Eight Countries, 2008," *Health Affairs*, 2009, 28(1), w1-w16.
[11] Cathy Schoen, Robin Osborn, Michelle M. Doty, et al., "A Survey of Primary Care Physicians in Eleven Countries, 2009: Perspectives on Care, Costs, and Experiences," *Health Affairs*, 2009, 28(6), w1171-w1183.

Kingdom has national call centers for the same purpose. Third, physicians are rewarded for care coordination in both countries. Performance on quality measures has been an important part of physician compensation in the United Kingdom since the early 2000s, and the same is true – though to a more limited extent – in the Netherlands. Neither care coordination nor good outcomes are rewarded in the U.S. health care system, especially Medicare. Fourth, nurses are allowed to play a key role in organizing care in the United Kingdom and the Netherlands. While neither the United Kingdom nor the Netherlands have more nurses than the United States, both countries allow nurses greater autonomy in helping care for patients. The United States could well implement a system like that in these other countries. But will require significant change in the way that medical care is delivered.

o *Eliminating excessive administrative costs.* Spending on administration is much higher than in the United States than in other countries, and is much greater than any analyst suggests is needed. For example, the Institute of Medicine estimated that providers and payers in the United States spend $361 billion on billing and insurance-related administrative costs, of which about half are not associated with improved system operation.[12] The McKinsey Global Institute, the Medical Group Management Association, the American Medical Association, and the association of America's Health Insurance Plans also suggest that administrative costs are excessive.[13]

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[12] Institute of Medicine, *The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Summary.* Washington, DC: The National Academies Press, 2010; James G. Kahn, et al., "The cost of health insurance administration in California: estimates for insurers, physicians, and hospitals," *Health Affairs,* 2005; 24(6), 1629-39.

[13] McKinsey Global Institute, *Accounting for the Cost of US Health Care: A New Look at Why Americans Spend More,* Washington, D.C.: McKinsey Global Institute, 2008; Medical Group Management Association, "Administrative Simplification for Medical Group Practices," MGMA Position Paper, June 2005; Stephen J. Ubl and others, Letter to President Obama, May 11, 2009, available at http://www.whitehouse.gov/assets/documents/05-11-09_Health_Costs_Letter_

Excessive administrative costs are a result of several factors: credentialing processes that differ for each insurer and care organization; claims submission and payment processes that are not standardized; and eligibility verification that is needless complex. There is no doubt that these costs could be reduced. Credentialing has been partially streamlined in some areas, and could be streamlined further. There are proposals for standardizing claims submission, payment notification, and eligibility verification, and statewide examples in Massachusetts and Utah that could be expanded. The major impediment to reducing administrative waste is not lack of knowledge, but instead lack of willpower. The Health Insurance Portability and Accountability Act gave the Department of Health and Human Services the authority to streamline administrative costs, but this was pursued only haphazardly. The Affordable Care Act provides additional authority and the means to carry this out.

Summary. All told, the amount of excessive medical spending is staggering. A rough consensus among experts, including a recent consensus document from the Institute of Medicine, is that at least one-third of medical spending is not associated with improved health. This implies waste of about $750 billion annually.[14] Many experts in medical care delivery suggest that the amount of excessive spending is even higher. To put this in perspective, the lower bound is about the entire spending of the American Recovery and Reinvestment Act of 2009. Thus, the United States wastes approximately a stimulus bill every year on medical spending that is not associated with improved health.

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to_the_President.pdf;
[14] Institute of Medicine, *The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Summary.* Washington, DC: The National Academies Press, 2010.

THE IMPACT OF THE AFFORDABLE CARE ACT ON COST SAVINGS

The Affordable Care Act has provisions that address each of these three areas of excessive spending. Before highlighting these areas, it is important to note that the Affordable Care Act builds upon the HITECH Act passed as part of the American Recovery and Reinvestment Act of 2009. The HITECH Act provided the funding and incentives to make medical records electronic. The next step is to create incentives to use those records appropriately and change in the delivery of services to promote better care, not just more expensive care. Together, the two pieces of legislation bring the medical system to the point where significant productivity improvements are possible.

Many provisions of the Affordable Care Act will affect costs in the areas of noted above. For example, Accountable Care Organizations will have incentives to both limit hospital readmission rates and to prevent episodes of illness through better chronic care management. They will also streamline administrative costs within the systems. For simplicity, I delineate the provisions of the Affordable Care Act in two groups: those that are primarily designed to affect the provision of medical services; and those that are primarily related to administrative simplification.

Provisions related to the delivery of medical services. The Affordable Care Act begins the process of a wholesale restructuring of how Medicare and private insurers pay for medical care, moving away from payment-for-volume and towards payment-for-value. Within the Medicare and Medicaid programs, the specific provisions of the Act include:

Direct payment innovations, including higher reimbursement for preventive care services and patient-centered primary care, bundled payment for acute and post-acute medical services, shared savings or capitation payments for accountable provider groups that assume responsibility for the continuum of a patient's care, and pay-for-performance incentives for Medicare providers;

Increased funding for comparative effectiveness research, to enhance our knowledge of what medical care is helpful, and what is not;

Distinguishing medical care providers on the basis of cost and quality, making that data available to providers, consumers, and insurance plans, and providing financial incentives for relatively low-quality, high-cost providers to improve their care;

An Independent Payment Advisory Board to recommend structural changes to Medicare, along with an Innovation Center in CMS to sponsor and encourage innovative care delivery models;

An excise tax on high-cost insurance plans, to provide incentives for firms with high spending to lower those costs; and

Increased emphasis on wellness and prevention, through lower cost sharing for preventive care, mandatory nutrition labeling at chain restaurants, employee wellness discounts, and dedicated funding for prevention and public health.

Together, these provisions should have a profound effect on the delivery of medical services. They bring to Medicare the same management tools and incentives that underlie the care delivered in the best medical systems in the country, and in the best businesses outside of medical care.

Additional provisions affecting administrative simplification. One of the least noted features of the Affordable Care Act are the provisions addressing administrative simplification. In particular, Sections 1104 and 10909 of the Act establish uniform operating rules for claims submission, adjudication, and other communications between providers and insurers. They also extend the areas where standardization is sought. In combination with the transformation to electronic medical records, these provisions will lay the foundation for a major reduction in the administrative burden of medicine.

THE FISCAL AND ECONOMIC IMPACTS OF THE AFFORDABLE CARE ACT

Estimating the impact of any reform bill on medical spending and the economy is difficult, let alone one with as many pieces as the Affordable Care Act. Partly as a result of this uncertainty, the Congressional Budget Office and the Office of the Actuary assume only minor savings from the delivery system provisions in the legislation. For example, CBO estimated that the parts of the law noted above will cost $10 billion over the 2010–2019 period, while the Office of the Actuary determined savings of only $2 billion.

Other estimates, however, suggest that an aggressive approach to changing the delivery of medical services could result in significantly greater cost reductions. Consider, for example, the

30 percent or more of medical care that is estimated to be wasteful. How rapidly would an improved system be able to eliminate this waste? If the waste could be eliminated in 10 years, the implied reduction in costs relative to trend is 3 percent annually. An efficiency initiative that took 20 years would lower costs relative to trend by 1.5 percentage points annually.

Studies of the American economy as a whole suggest that information intensive industries have productivity growth of 1.5 percentage points annually above other industries.[15] However, medical care is more complex than most industries. Thus, cost savings in medical care may be somewhat slower. For this reason, I consider savings of 1.0 to 1.5 percentage points annually a reasonable expectation for the impact of the type of reforms included in the Affordable Care Act.[16] Relative to cost savings of this magnitude, the Business Roundtable suggests a larger potential reduction in spending,[17] as do health care groups such as the American Medical Association and American Hospital Association.

The impact of cost savings of this magnitude are profound. Figure 1 shows the effect on national medical spending of a reduction in cost growth of 1.5 percentage points annually. I project that **national spending on health care will decline relative to trend** by over $500 billion in the first decade, by $3.5 trillion in the second decade, and by nearly $5 trillion in the third decade. These

[15] Stephen D. Oliner, et al., "Explaining a productive decade," *Brookings Papers on Economic Activity*, 2007, 1: 81–137.

[16] David M. Cutler, Karen Davis, and Kristof Stremikis, *The Impact of Health Reform on Health System Spending*, Center for American Progress and the Commonwealth Fund, May 2010; Melinda Beeuwkes-Buntin and David Cutler, *The Two Trillion Dollar Solution: Saving Money by Modernizing the Health Care System*, Center for American Progress, June 2009; David Cutler, "How Health Care Reform Must Bend the Cost Curve," *Health Affairs*, 2010, 29(6), 1131-1135.

[17] Hewitt Associates, *Health Care Reform: Creating a Sustainable Health Care Marketplace*, Washington, D.C.: Business Roundtable, 2009; Stephen J. Ubl and others, Letter to President Obama, May 11, 2009, available at http://www.whitehouse.gov/assets/documents/05-11-09_Health_Costs_Letter_to_the_President.pdf;

savings would translate into enormous savings for the federal budget. In comparison to the Congressional Budget Office estimates that the Affordable Care Act will save about $130 billion over the next decade, assuming reasonable savings from the provisions noted above suggests **budgetary savings of over $400 billion over the first decade**. The savings in subsequent decades would be even greater, as cost savings cumulate.

If the Affordable Care Act were repealed, the ability to achieve cost savings would be very significantly reduced, even were tight constraints on Medicare and Medicaid substituted instead. The Affordable Care Act will save money not by mandating any specific level of savings, but by incentivizing better care.

Insurance premiums would decline with reductions in overall medical spending, and this would lead firms to hire more workers. **Improving the productivity of the medical sector by 1 to 1.5 percent per year would create 250,000 to 400,000 jobs annually over the next decade.** Jobs would be created in virtually all industries with the exception of health care, where more efficient production should allow for some reduction in administrative staff. Estimates from other groups suggest job creation along the same lines. The President's Council of Economic Advisers used a different methodology but reached a similar conclusion.[18] And a recent Urban Institute study agrees that long-term cost savings are the major determinant of the employment effects of health reform, though they do not provide a specific jobs estimate.[19]

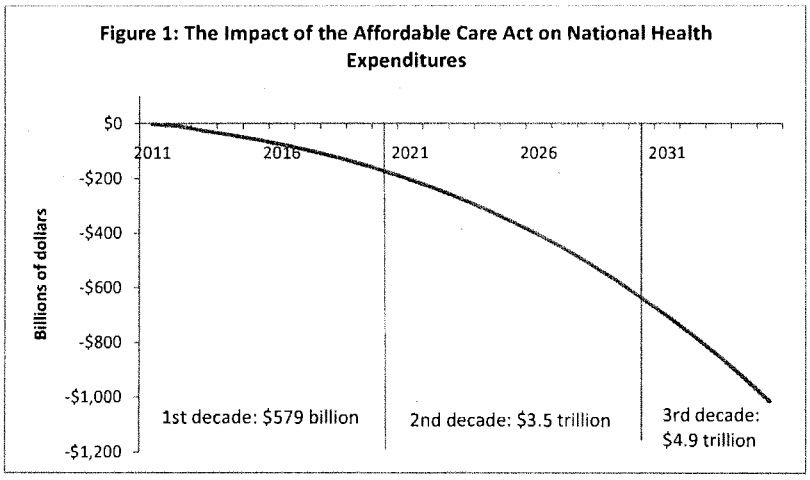
[18] Executive Office of the President, Council of Economic Advisers, "The Economic Case for Health Care Reform," June 2009; Executive Office of the President, Council of Economic Advisers, "The Economic Case for Health Care Reform: Update," December 2009.
[19] John Holahan and Bowen Garrett, "How Will the Affordable Care Act Affect Jobs?" Washington D.C.: The Urban Institute, March 2011.

Of course, other provisions of the Affordable Care Act will affect employment as well. But those provisions will affect employment in different directions and on net have a minor impact on job creation. Expanded insurance coverage will increase demand for health care workers, while reductions in Medicare and Medicaid spending will lower demand. Universal coverage will increase the ability of workers to change jobs or leave the labor force entirely, while reductions in costs for small firms and some large firms will boost employment there. As virtually all analysts note, these effects will roughly cancel out. The major impact of the Affordable Care Act on employment will stem from its impact on overall medical spending.

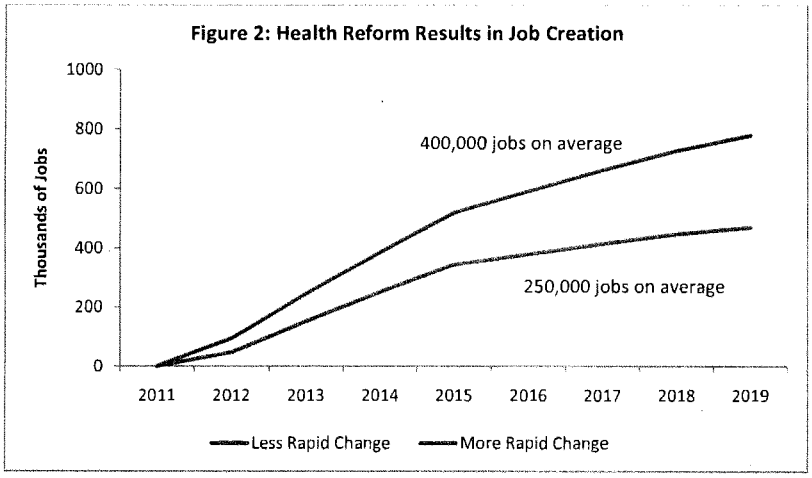
SUMMARY

In sum, economic research on the potential impact of the Affordable Care Act is clear: the Affordable Care Act creates an opportunity for changes in the way that medical care is delivered that will cut the growth of medical care costs; improve the fiscal situation of federal, state, and local governments; and spur job creation. The issue for this Congress is how to strengthen the Affordable Care Act. There are many provisions of the Act that could be stronger, and some that ought to be reconsidered. In the former category are provisions to speed new program models in all parts of Medicare and Medicaid. There are steps to address this in the Affordable Care Act, but they could and should be strengthened. By working together with the administration, this Congress can help set the path for an era of health reform that is valuable for our economic health as well as our personal health.

Thank you again for the opportunity to meet with you. I would be happy to answer any questions that you might have.



Data are from David Cutler, "How Health Care Reform Must Bend the Cost Curve," *Health Affairs*, 2010, 29(6), 1131-1135.



Data are from David Cutler and Neeraj Sood, "New Jobs Through Better Health Care," Washington, D.C.: Center for American Progress, 2010.

Mr. PITTS. The gentleman's time is expired. The chair thanks the gentleman and recognizes Mr. Kennedy for 5 minutes.

STATEMENT OF PHILIP K. KENNEDY

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

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

We have roughly 50 full-time employees, sometimes more, sometimes less, depending on the time of the year, because the bulk of our business occurs in the spring and summer months. Comanche currently offers a generous health plan to our employees. Over half of us take advantage of this coverage, including me. Comanche pays approximately 50 percent of the premiums for our employees and offers two different high-deductible plan options, one with a $1,500 deductible and another more comprehensive plan with a lower $1,000 deductible. Fortunately, we have been able to get good rates because Oklahoma has good free market laws that encourage competition among insurance companies for my business. However, premiums have been climbing. In order to prevent large increases, we have had to make tough choices which have included increasing our plans' deductibles and implementing a more tiered prescription drug plan.

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

There are many other aspects of the law that will increase Comanche's premiums including numerous taxes on health industries including taxes on medical devices, prescription drugs and small business health insurance that will be passed on to me and my employees in the form of higher premiums. While these new insurance rules and taxes are problematic, their impact pales in comparison to what will happen when the new mandates kick in. Beginning in January 2014, businesses with 50 or more employees will be punished with fines if they don't offer a certain level of coverage. Even more troubling is the fact that businesses that over qualified plans

might still be fined just as much. It is ironic that the fine for businesses that don't offer coverage is $2,000 per employee while the fine for a business that does offer coverage is $3,000 per employee plus the cost of paying for coverage. Considering that Comanche's profits are about 1 percent, I am sure you can see how these fines would dramatically impact our business.

It appears that to avoid these fines, I can either reduce my staff to less than 50 full-time employees or consider alternative staffing like employing part-time workers or outsourcing. I can't imagine why a law would incent these actions at a time when our economy is struggling to recover from such a terrible recession, but as a business owner my job is to protect the business, keep the doors open and sell building materials. I hope I will not have to seriously consider these choices but the health care law may force my hand as well as that as many other small business people.

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

In conclusion, I understand that given the existing political realities in Washington, a total repeal of the health care law is an unlikely proposition for now. However, I am hopeful that this subcommittee and your colleagues in the House and Senate will start on repairing and eliminating the most erroneous mandates and provisions starting with the repeal of the employer mandate. Your decisions can either help or hinder us. The law you create can either foster an environment to give small business owners greater confidence and certainty to grow and generate new jobs or one that does just the opposite. Regrettably, the new health care law is already doing the latter. Congress needs to take action to rectify this problem.

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

[The prepared statement of Mr. Kennedy follows:]

THE HOUSE COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH
on behalf of the
U.S. CHAMBER OF COMMERCE
By
Phil Kennedy
Owner and President
Comanche Lumber Company Inc.

Summary of Written Testimony

Introduction

Overview of Comanche Lumber Company, Inc.

Company's Health Care Offerings

Impact of the PPACA on Comanche Lumber Company, Inc.

Conclusion

Statement of the U.S. Chamber of Commerce

ON: "True Cost of PPACA: Effects on the Budget and Jobs"

TO: The House Committee on Energy and Commerce's Subcommittee on Health

DATE: March 30, 2011

The Chamber's mission is to advance human progress through an economic, political and social system based on individual freedom, incentive, initiative, opportunity and responsibility.

The U.S. Chamber of Commerce is the world's largest business federation, representing the interests of more than three million businesses and organizations of every size, sector, and region.

More than 96 percent of the Chamber's members are small businesses with 100 or fewer employees, 70 percent of which have 10 or fewer employees. Yet, virtually all of the nation's largest companies are also active members. As a result, we are particularly cognizant of both the problems with which smaller businesses grapple, as well as those issues facing the business community at large.

Besides representing a cross-section of the American business community in terms of number of employees, the Chamber represents a wide management spectrum across many varied types of business and location. Each major classification of American business—manufacturing, retailing, services, construction, wholesaling, and finance—is represented. Also, the Chamber has substantial membership in all 50 states.

The Chamber's international reach is substantial as well. In addition to the U.S. Chamber of Commerce's 115 American Chambers of Commerce abroad, an increasing number of our member companies engage in the export and import of both goods and services and have ongoing investment activities. The Chamber favors greater international competitiveness and opposes artificial U.S. and foreign barriers to international business.

Positions on national issues are developed by a cross-section of Chamber members serving on committees, subcommittees, and task forces. More than 1,000 business people participate in this process.

Statement on
"True Cost of PPACA: Effects on the Budget and Jobs"
Submitted to
THE HOUSE COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH
on behalf of the
U.S. CHAMBER OF COMMERCE
By
Phil Kennedy
Owner and President
Comanche Lumber Company Inc.
Lawton, OK
March 30, 2011

Chairman Pitts, Ranking Member Pallone and distinguished members of the Subcommittee, thank you for inviting me to testify before you today on the impacts of the new health care law on my business and employees. I commend your efforts in holding this important hearing to better understand the effects this complex and onerous 'reform' will have on the ability of businesses to grow and create jobs as we are required to sort out and contend with the labyrinth of regulations and cloud of mandates now hanging over our heads.

I am Phil Kennedy, Owner and President of Comanche Lumber Company Inc., which is located in Lawton, Oklahoma. I am here to speak with you today on behalf of the U.S. Chamber of Commerce. I have the honor of serving on the Board of Directors of the U.S. Chamber of Commerce and as Past Chairman of the State Chamber of Oklahoma and Past Chairman of the Lawton-Fort Sill Chamber of Commerce and Industry. I am also owner of Southern Hardlines, Inc., a floor covering and decorating supplier and am a partner in a number of other small businesses in Lawton. In addition to my business activities, I believe it is important to give back to the Lawton community which has been so good to my family. I serve on the Board of the Comanche County

Memorial Hospital Foundation and the Great Plains Technology Center Foundation. I am also the Past President of the Lawton-Fort Sill United Way.

The U.S. Chamber of Commerce is the world's largest business federation, representing the interests of more than three million businesses and organizations of every size, sector, and region. More than 96 percent of the Chamber's members are small businesses with 100 or fewer employees, 70 percent of which have 10 or fewer employees. Yet, virtually all of the nation's largest companies are also active members. Therefore, the Chamber is particularly cognizant of the problems of smaller businesses, as well as the issues facing the business community at large.

Company Background

Before remarking on the daunting challenges posed by the new health care law, I want to share with you a little information about our family-owned business. Comanche Lumber Company, Inc. began operating in Lawton, Oklahoma, in October 1967 in what was once the Rock Island Railroad Depot building, located at the corner of Railroad Street and Southwest 'C' Avenue.

My father and mother, Norman and Christine Kennedy, began selling lumber and building materials for new home construction and remodeling projects for a growing Lawton, and operated for the first five years without a forklift or any other material handling equipment. It truly was a family business. My dad would work inside the store during the day and deliver the orders in the evening, after the store was closed, loading and unloading all materials by hand. My mom was

integrally involved keeping the books for the business. I have fond memories as a child of spending countless hours at our family business.

As Lawton grew, so did Comanche Lumber Company, venturing into the floor covering market in 1982 and occupying land up and down Railroad Street to house the inventory. In 1990, the company outgrew the old Depot building and purchased the structure at #2 SW 'C' Avenue. This building became Comanche Home Center, an Ace Hardware Store and Lumber facility. The old Rock Island Railroad Depot was torn down, and replaced with new, covered storage units that today house our large lumber and building material inventory.

As I took over the family business, I wanted to make sure the company continued to grow as we moved forward into the 21st century. We were already members of Allied Building Stores (ABS) and Ace Hardware. In 2001, we took another major step forward with the company by joining another buying group – Carpet One, the world's largest floor covering retailer. In 2004, we added a new warehouse to help house the growing inventory of the finest flooring and decorating products in Southwest Oklahoma.

I credit my father and mother for not only starting and successfully running this business over the years, but for also instilling in me a strong work ethic, a deep appreciation for our business' greatest asset, our employees, and a profound sense of pride in our community. We care greatly about providing outstanding service and quality products to our customers. What began as a simple lumberyard almost forty-four years ago has become one of Lawton's leading building material retailers. We remain independently owned and operated and a strong member and supporter of the

Lawton community. In addition, we are a major supplier of the lumber, nails and other materials used for construction projects at Fort Sill, a United States Army base that is home of the U.S. Army Field Artillery School as well as the Marine Corps' site for Field Artillery MOS school, U.S. Army Air Defense Artillery School, the 31st Air Defense Artillery Brigade, the 75th Fires Brigade and the 214th Fires Brigade. As we like to say, for 44 years we have helped people build it right.

Our products are often used in the construction of military housing on the base at Fort Sill. It is very rewarding to know that our materials are being used to improve housing for men and women serving in our Armed Forces and their families who sacrifice so much for our country. Whether through direct sales to Fort Sill or to contractors doing work there, we are humbled and honored to play our small role in improving the quality of life of the Soldiers and Marines stationed there and helping them fulfill their critical mission. Our staff also takes personal pride in this because many of their spouses service in the U.S. Armed Forces.

For the past couple of years, we have hovered around 50 full-time employees, sometimes dipping just below and sometimes cresting just above this mark depending on the time of the year. With the bulk of our business occurring in the spring and summer, we also hire some part-time employees to assist us. This year has been a struggle for the business. Starting in January, we have reduced staffing levels through natural attrition which hopefully will help us avoid any further need to scale back. But as I wade through the new health care law and begin to grasp the mandates and their bearing on my business, I am deeply concerned.

Health Care

Comanche currently offers a generous plan to our employees – about 50 percent of us take Comanche up on this coverage offering, including me. Many others are covered by their spouses or other plans. We pay about 50 percent of the premium for employees that elect the higher deductible options ($1500), and also offer a more comprehensive plan with a lower, $1000 deductible. I am able to get good rates for Comanche's health insurance benefits because Oklahoma has good free-market laws that encourage competition among insurance companies for my business. However, premiums continue to climb. In order to prevent large increases, we have had to make some tough choices, including increasing our plans' deductibles and implementing a more tiered drug formulary structure.

It is my understanding that the new health care law includes a number of new insurance rules billed as "patient protections," such as requiring free preventatives services, requiring plans to allow "adult children" to be added as dependents, placing restrictions on annual and lifetime limits, and other changes. While this sounds nice, it certainly lessens our flexibility in changing plan design to restrict premium growth. Changes such as maximum out-of-pocket limits and maximum deductibles similarly will guarantee that premiums will be harder to control. Even with the flexibility we had, over the past two years the premiums for the plan have increased about 30 percent.

Other aspects of the law that will increase Comanche's premiums include the numerous new taxes on health industries including taxes on medical devices, prescription drugs, and small business

health insurance. The director of the Congressional Budget Office has testified that these taxes will be passed on to me and my employees in the form of higher premiums.

While these new insurance rules and taxes are problematic, their impact pales in comparison to what will happen when the new mandate kicks in January of 2014. The mandate will basically punish businesses that have 50 or more employees by fining them if they don't offer a certain level of coverage. Even if a business does offer a "qualified plan," it still might be fined just as much. Ironically, the fine for businesses that don't offer coverage is $2,000 per employee… and the fine for a business that does offer coverage is $3,000 per employee, plus the cost they're paying for coverage. In other words, it may be more cost-effective for Comanche to drop its coverage under the new mandate. Considering that Comanche's profits are about 1 percent, I am not sure how we could afford to pay these fines.

It seems that there is one way for me to avoid paying these fines – I can either get (and stay) under 50 employees, or I can start forcing employees to part-time status, making them independent contractors, outsourcing certain services, and taking similar efforts to negate the fines. It seems strange that the law would incent these choices at a time when the economy is struggling to recover from such a terrible recession. I don't understand it, but as a business owner my job is to protect the business, keep the doors open, and sell lumber. I hope I don't have to do any of this, but the health care law may force my hand, as well as that of many other small business people. I do not want to lose anyone on my payroll, but if it comes down to laying off a few employees or being saddled with these fines, I won't have a choice.

If Comanche doesn't offer health insurance, I suppose many of my employees will have no choice but to try and obtain coverage through the new exchanges. I do not know what kinds of plans will be allowed in an exchange, what the minimum level of coverage will look like or cost, or whether there will be a big enough pool and enough competing plans to make coverage in an exchange affordable. I hope high-deductible plans will still be offered, but that is unclear in the legislation.

I know that my fellow small businessmen (and women) will not be allowed to shop among competing health insurers across state lines. I understand the exchange is supposed to create a new "marketplace" for purchasing insurance, but that doesn't mean that small businesses are going to be able to create favorable pools and have more negotiating power against insurance companies. Real health reform would have included ideas like this, instead of just taxing, subsidizing and dramatically increasing my paperwork burdens which the new 1099 provision would place on me.

Small business owners were hopeful that health reform would rein in health care costs and bend the so-called cost-curve down. However, looking through the bill I don't see anything about *real* medical liability reform other than vague acknowledgment (termed "sense of the Senate") that "States should be encouraged to develop and test alternatives." It seems to me that if we really want to address rising costs, medical liability reform should be tackled head on. We need to fix the existing civil litigation system and instead of merely saying it needs to be fixed.

Conclusion

I understand that given the existing political realities in Washington, DC, a total repeal of the health care law by Congress is an unlikely proposition for now. However, I am hopeful that this Subcommittee and your colleagues in the House and Senate will focus on repairing or eliminating the more onerous mandates and provisions which saddle businesses with burdens that actually encourage us not to expand our business and astoundingly discourage job creation. The bottom line is that your decisions can help or hinder us. By that I mean the laws you create will either foster an environment that gives small business owners greater confidence and certainty to grow and generate new jobs, or one that does just the opposite. Regrettably, this new health care law is already doing the latter and Congress must take the necessary action to rectify it.

Thank you for this opportunity to testify, and I look forward to your questions.

Mr. PITTS. The chair thanks the gentleman. The gentleman's time is expired. The chair recognizes the gentleman, Mr. Poore, for 5 minutes for an opening statement.

STATEMENT OF RICK POORE

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

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

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

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

Concerning the employer responsibility requirement, we have got to remember two facts. First, over 95 percent of our Nation's businesses have less than 50 workers and won't be impacted. Second, 96 percent of businesses with more than 50 workers already offer coverage. If some larger businesses complain that paying for health coverage will harm their ability to create jobs, remember that when they don't pay, the rest of us pay their way for them and that hurts my ability to create jobs. Imagine if my competition decided they didn't want to pay wages anymore but I was held responsible for their payroll. That is effectively what we are doing with cost shifting in health care.

Recent data from insurers in Nebraska and Kansas City, national companies like United Health Group and Coventry, show encouraging increases in small business coverage. The tax credits are already helping small businesses offer coverage, save money and

plow those savings back into businesses. We will get even more help when the exchanges open. I need that kind of broad risk pooling and bargaining power and a Nebraska exchange to lower costs.

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

Small business people, in conclusion, above all are problem solvers. We wake up every day looking for a better way to do our business. We take whatever pitch is thrown at us and we do what we can with it. My best employees become problem solvers for me. Problem solving is what Americans send you guys to Washington to do, and there is a funny thing about solutions I have found is that most solutions aren't perfect right out of the box. You don't scrap them; you make a start in the right direction and then you change course and correct the course as you need. One thing for sure, our country and our economy can't afford to go back to a health system that doesn't work for small business. I already know that it won't work. We have got to move forward.

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

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

[The prepared statement of Mr. Poore follows:]

Statement of Rick Poore, owner of DesignWear, Inc, dba Shirts101.com in Lincoln, Nebraska and member of the Nebraska Main Street Alliance

To: Health Subcommittee of the House Energy & Commerce Committee

Hearing on: "True Cost of PPACA: Effects on the Budget and Jobs"

March 30, 2011

Introduction

Chairman Pitts, Ranking Member Pallone, and members of the Health Subcommittee,

Thank you for the invitation to testify today on behalf of my business and small businesses in Nebraska and across the country in the Main Street Alliance network. I appreciate the opportunity to share my business's story with health care issues and discuss what the health law means for small business job creation.

My name is Rick Poore, and I'm the owner of DesignWear, Inc (doing business as Shirts101.com) in Lincoln, Nebraska. I'm also an active member of the Main Street Alliance small business network. I've been a small business owner for 17 years. I started my business, a custom screen printing business, in Lincoln in 1994. We started with three employees, and over the years we've grown to employ 29 people.

I've been offering a group health plan to my employees and paying a large portion of the costs since 2000 or so. It felt like the right thing to do, offering health coverage. It also made good sense from the perspective of employee morale and retention. But it hasn't been easy to sustain. Since we started offering coverage, our rates have gone up every single year – several times in excess of 30 percent – forcing me to cut back on benefits to keep the premiums within reach.

Two years ago, under the pressure of ever-mounting costs, I switched to a new insurer, Coventry, that specializes in small business coverage. They do their rating differently, spreading risk and costs more evenly across younger and older enrollees. It means the premiums for my youngest workers are a little higher, but for everyone who's older, they're a lot lower. I can subsidize some additional cost of the insurance, making it more affordable for my younger employees, and it's still markedly cheaper overall for me.

In fact, if I'd kept the same benefit levels when we switched insurers two years ago, we'd be paying about the same amount now as we were paying then – I would have experienced virtually no increase in

premiums over the last two years. That's pretty unheard of. (Instead, we took the opportunity to improve our benefits significantly – so we're paying more, but it's for greater value.)

I am lucky to have finally found this option, but still there are no guarantees. For years I was at the mercy of an insurance company's whim because I only had the leverage of ten or twenty employees. This principle of pooling risk across the younger and older and healthier and sicker, this is exactly what the new health insurance exchanges, which I'll discuss more later, are designed to do.

The Impact of Runaway Health Insurance Costs Without Health Reform

The country is counting on small businesses to create the jobs that will put people back to work and jumpstart the economy. But the situation we've put small businesses in with health insurance costs over the last 20 years is seriously impeding our ability to do that.

If you want to talk about a job-killer, you don't need to look any further than runaway health insurance costs. I've seen insurance costs consume an ever increasing share of my business income – as I said, my rates went up every single year until I switched to my current insurer, and the increases have far outstripped inflation or my other labor costs. Small businesses across the country have found their ability to create new jobs seriously undermined by health insurance costs that have more than doubled in the last 10 years.

Before the passage of health reform, for all those years of steep premium hikes, we had no tools to control off-the-charts rate increases or ensure that small businesses were getting value for our premium dollars. Without any bargaining power, small businesses like mine were left at the losing end of a "my way or the highway" negotiation.

As a result, more and more small businesses were priced out of the market. By 2009, only 30 percent of businesses with less than 50 employees in Nebraska offered health insurance, compared to 96 percent

of businesses with 50 or more workers. Nationally, it was 41 percent compared to 96 percent.[1] Facing unsustainable rate increases, small businesses have been forced to either drop coverage, cut benefits and end up with a watered down plan that isn't worth much, or pay a king's ransom (taking money away from other productive uses) for a plan that actually provides some security.

The Patient Protection and Affordable Care Act is finally changing the game on health care and giving small businesses tools and opportunities to control costs and increase value. From the small business tax credits to stronger rate review and the value for premiums requirement, the health law is already throwing a lifeline to small businesses, creating opportunities for businesses to offer health coverage, save money on premiums, and plow those savings back into business investment and job creation. We'll get even more help in 2014 when the new competitive marketplaces for health insurance (the state health insurance exchanges) open for business, giving small businesses greater transparency, better choices, broader risk pooling, and more bargaining power.

The argument that the Affordable Care Act will cost our economy jobs ignores reality. It ignores our experience of the last 10 years, where the lack of any concerted response to skyrocketing insurance costs left small businesses in the lurch and undermined our ability to create jobs. The unlevel playing field for small businesses and the near impossibility of getting good, affordable coverage in a small business locked people into jobs with large employers that offered health security for themselves and their families, stifling the American spirit that drives innovation.

The real threat to job creation going forward would be to repeal or undermine the health care law, to return to a system that stacks the deck against small businesses, a system where insurance premium hikes knock the wind out of us every year in the absence of effective measures to level the playing field.

1 Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, Medical Expenditure Panel Survey – Insurance Component, Table II.A.2(2009) Percent of private-sector establishments that offer health insurance by firm size and State: U.S., 2009, http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2009/tiia2.htm

Preventing Cost-Shifting and Protecting Jobs by Ensuring Everyone Contributes

While some may raise concerns about the health law's employer responsibility requirement for businesses with more than 50 workers, we have to remember two important facts. First, over 95 percent of our nation's businesses have less than 50 workers, and so will not be touched by this requirement. Second, 96 percent of businesses with more than 50 workers already offer health coverage.[2]

As a small business owner who offers good health coverage and pays a large share of the cost, I find it difficult to sympathize with the complaints of larger companies that choose not to offer decent health coverage to their employees and pay a fair share. Through that choice, they're shifting the cost of health care for their workforce onto others – specifically, onto me and every other business owner who is paying for health coverage.

If some businesses over the 50 employee threshold complain that paying their fair share toward health care will harm their ability to create jobs, we've got to remember that when they don't pay, the rest of us are paying their way for them, and that hurts *our* ability to create jobs. This is anti-competitive. Imagine if a larger screen printer in Lincoln, my direct competition, decided to stop paying wages and I was held responsible for making his payroll. It may sound crazy, but that's effectively what we're doing with health care when larger businesses choose not to offer it and pass the costs along to the rest of us.

Not only is this anti-competitive, it's also inefficient (since more workers left without insurance leads to less preventive care and more costly ER visits), driving up costs in the system overall. And that means a negative net impact on our ability to create jobs.

The employer responsibility provision reinforces what the vast majority of larger employers already do, and ensures that responsible employers – both large and small – who offer health benefits aren't

2 Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, Medical Expenditure Panel Survey – Insurance Component, Table II.A.2(2009) Percent of private-sector establishments that offer health insurance by firm size and State: U.S., 2009, http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2009/tiia2.htm

undercut by competitors who shun this responsibility. In this way, ensuring that larger employers pay their fair share will help protect and create jobs for our economy.

Small Businesses Moving Forward on Health Care

Small businesses are eager to put the health care nightmares of the past behind us and move forward. Already, news reports are suggesting that more small businesses are signing up for health coverage since the passage of the new law – both in Nebraska and across the country:

- A February 1 article in the *Lincoln Journal Star* reported that Blue Cross and Blue Shield of Nebraska saw a 34 percent increase in health insurance sales to small businesses for 2011.[3]
- In the six months after the Affordable Care Act was signed into law, UnitedHealth Group added 75,000 enrollees in small businesses with less than 50 workers, according to the *Los Angeles Times*.[4]
- Blue Cross Blue Shield of Kansas City recently reported a 58 percent increase in small businesses purchasing insurance since April 2010, the first month after the passage of the ACA.[5]
- And my insurer, Coventry, a national company that focuses on small businesses, added new business to cover 115,000 more workers in the first nine months of 2010.[6]

Some of these encouraging numbers are likely thanks to the small business tax credits in the Affordable Care Act, which are effective for tax year 2010 and offer thousands of qualifying Nebraska small businesses a credit of as much as 35 percent on their health premium costs if they offer coverage and pay at least 50 percent of the premiums. Thanks to the tax credit, smaller businesses that have endured year after year of punishing rate increases are finally seeing their after-tax health insurance costs go down for the first time in memory.

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3 Mark Andersen, "Blue Cross sees big jump in small-business policies," Lincoln Journal Star, February 1, 2011, http://journalstar.com/business/local/article_df475fde-14b1-588a-92ba-d3fa7e9a3e84.html.
4 Noam N. Levey, "More small businesses are offering health benefits to workers," *Los Angeles Times*, December 27, 2010, http://www.latimes.com/health/healthcare/la-fi-health-coverage-20101227,0,5024491.story [Hereinafter Levey].
5 Levey.
6 Levey.

But a business doesn't have to qualify for the new tax credit to benefit from the health care law and get into a better position to create jobs. For small businesses across the country, whether you get the credit or not, there's a lot to look forward to as more provisions of the law take effect this year and going forward.

Small Business Benefits of the Affordable Care Act and Implications for Job Creation

The Affordable Care Act includes a number of provisions that will give states and small businesses new tools to get a handle on health insurance costs and allow us to invest in job creation. These measures include:

- **Stronger rate review:** The law gives states new tools and resources to strengthen review of insurance rate increases and protect small businesses from the unreasonable rate hikes we've endured for so many years. This is one of the most direct ways to protect small businesses and help us do our part to create jobs and grow the economy. Given the high level of market concentration in the health insurance industry and its negative effects on competition, we need this stronger rate review to protect us from unreasonable and unjustifiable rate increases.
- **A value for premiums requirement:** The new minimum medical loss ratio (MLR) requirement will ensure that small businesses are getting good value for our premium dollars. By requiring insurance companies to spend at least 80 percent of premiums collected from small group and individual customers on health costs (as opposed to administrative costs, advertising, lobbying, executive compensation, and profits) or pay a rebate if they fail to meet the requirement, we will increase the value of insurance or decrease its cost – or both.
- **New competitive marketplaces for health insurance:** In 2014, the state health insurance exchanges will give small businesses more transparency, better choices, broader risk pooling and more bargaining power by allowing us to band together to shop for coverage.
- **Reduced cost-shifting:** As the provisions above help more small businesses (and others) gain health coverage and start paying into the system, those of us who already provide coverage will see the "hidden tax" we pay now to cover cost-shifting from uncompensated care decrease, lowering our costs overall.

Health Insurance Exchanges in Microcosm

For my business, I'm especially looking forward to the new health insurance exchange and the big increase in risk pooling and bargaining power it will mean for my business to be able to band together with other businesses across Nebraska. The way I see it, my experience with my current insurer – specifically, the way they spread risk more evenly across our group and how that's helped us control costs – is a microcosm of how things should work with the new insurance exchange.

I can't wait to join a Nebraska health insurance exchange that gives me access to a combined risk pool and a joint purchasing bloc with thousands of other small businesses. If we create an active purchaser exchange that negotiates better deals on our behalf, then we'll have both economies of scale and some serious muscle at the bargaining table. There are more than 40,000 private sector firms in Nebraska with less than 50 employees that could be eligible to join the exchange, and these firms employ about 230,000 people.[7] Talk about increasing my bargaining power.

Recent Trends in Insurance Rates

I want to make one point about continuing rate increases by health insurers. I know many insurers are pursuing steep rate increases again this year, and I know insurance lobbyists are trying to blame these increases on the new law. That claim is not based in reality – it doesn't hold up.

Insurers have found an excuse to raise their rates every year, as my experience of non-stop increases for more than a decade indicates. If they're raising rates again this year, it's *in spite of* the health care law, not *because* of it. If anything, they're taking the opportunity to push through one more steep increase before measures in the law that will help rein in these increases take effect.

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7 Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, 2009 Medical Expenditure Panel Survey – Insurance Component, Table II.A.1(2009) Number of private-sector establishments by firm size and State: United States, 2009, http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2009/tiia1.htm; Table II.B.1(2009) Number of private-sector employees by firm size and State: United States, 2009, http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2009/tiib1.htm

Even executives from the insurance industry have admitted the new law is not to blame for their rate increases. A senior vice president at Harvard Pilgrim in Massachusetts told *The New York Times* recently that only one percentage point of this year's increases was due to the new law.[8] In return for this single point increase, we'll have access to free preventive services that will help reduce long-term costs, people will no longer face annual or lifetime limits, and families can keep young adult children on their policy up to age 26, among other things. That sounds like good value and a smart investment for a single point increase.

As for medical inflation – the rising costs of care itself – we have to remember it's taken us decades to dig ourselves into the hole we're in. It's going to take more than one year to dig ourselves out.

Conclusion

Small businesses are benefiting already from the new law and looking forward to more improvements around the corner. Our country and our economy can't afford to send us back to a health system that stacks the deck against us. We've got to keep moving forward.

With proper implementation of the health law, we can level the playing field for small businesses and begin to get control of insurance costs. That will allow small businesses to focus on what we do best: creating jobs, serving our communities, and building local economies across Nebraska and across the country.

Thank you.

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8 Robert Pear, "As Health Costs Soar, G.O.P. and Insurers Differ on Cause," *The New York Times*, March 4, 2011, http://www.nytimes.com/2011/03/05/health/policy/05cost.html?_r=1&emc=tnt&tntemail1=y

Statement of Rick Poore: One-Page Summary

Introduction

I've been a small business owner for 17 years, and now employ 29 people. I've been offering a group health plan since 2000 or so. Since we started offering coverage, our rates have gone up every year. Two years ago, I switched to a new insurer that does rating differently, spreading risk and costs more evenly. This is saving me money. I see it as a preview of the new health insurance exchanges coming in 2014.

The Impact of Runaway Health Insurance Costs Without Health Reform

Small businesses have found their ability to create new jobs undermined by health insurance costs that have more than doubled in the last 10 years. The argument that the ACA will cost our economy jobs ignores our experience of the last 10 years, where skyrocketing insurance costs and the lack of any concerted response undermined our ability to create jobs. The real threat to job creation would be to repeal the health care law and return to a system that stacks the deck against small businesses.

Preventing Cost-Shifting and Protecting Jobs by Ensuring Everyone Contributes

While some may raise concerns about the health law's employer responsibility requirement, we have to remember two facts. First, over 95 percent of our nation's businesses have less than 50 workers, and so will not be touched by this requirement. Second, 96 percent of businesses with more than 50 workers already offer health coverage. If some businesses over the 50 employee threshold complain that paying for health care will harm their ability to create jobs, we've got to remember that when they don't pay, the rest of us pay their way for them, and that hurts *our* ability to create jobs. This is anti-competitive.

Small Businesses Moving Forward on Health Care

Small businesses are eager to put the health care nightmares of the past behind us and move forward. Already, news reports are suggesting that more small businesses are signing up for health coverage since the passage of the new law – both in Nebraska and across the country.

Small Business Benefits of the Affordable Care Act and Implications for Job Creation

The Affordable Care Act includes a number of provisions that will give states and small businesses new tools to get a handle on health insurance costs and allow us to invest in job creation. These measures include stronger rate review, the value for premiums (MLR) requirement, and the state insurance exchanges. Together, these provisions that control costs and expand coverage will reduce cost-shifting.

Recent Trends in Insurance Rates

Insurers find an excuse to raise rates every year. If they're raising rates again this year, it's *in spite of* the health care law, not *because* of it. Even executives from the insurance industry have admitted the new law is not to blame for their rate increases.

Conclusion

Small businesses are benefiting already from the new law and looking forward to more improvements around the corner. Our country and our economy can't afford to send us back to a health system that stacks the deck against us. We've got to keep moving forward.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentleman, Mr. Schuler, for 5 minutes.

STATEMENT OF LARRY SCHULER

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

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

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

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

What this means for my restaurants and our employees that, depending on the time of year and the number of hours worked by our team, we could be considered a large applicable employer and subject to the most stringent employer mandates in the law some months but not in others. In addition, our employees could be full-time employees one month and part-time employees the next. Using our 2010 employment numbers, the calculations for our largest location would put us over the 50 full-time-equivalent threshold. In 2010, on the average, we employed 33 full-time employees and 26 full-time equivalents working part time hours for a total of 59 full-time equivalents that place us over the threshold and subject us to the coverage and penalty requirements of the law. We employ 24 seasonal part-time employees and five seasonal full-time employees as well, for a total of 38 full-time employees to whom we would be required to offer coverage under the new law as a large employer. Should all 38 employees opt in to the coverage, we would see a 282 percent cost increase to the business over current premiums from $2,067 monthly or $24,808 annually today to $7,892 a month or $94,669 annually. If we chose not to offer coverage at all, we would pay an average of $1,375 monthly or $16,500 annually in penalties. The penalties would be less than what we are paying for health care now.

Faced with these very large increases in coverage cost which do not take into consideration the likely premium increases, it will be extremely difficult for us to absorb these costs and continue offering coverage. We cannot raise many prices high enough to cover these costs and to do so would drive away customers who are just

beginning to return to our tables. Our only option would be to closely manage our workforce hours to be able to eliminate ten full-time equivalents from our staff and remain below the 50 full-time-equivalent large employer threshold.

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

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

Mr. PITTS. Could you wrap up?

Mr. SCHULER. Without legislation change, I would probably shorten the number of days.

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

[The prepared statement of Mr. Schuler follows:]



Statement
On behalf of the
National Restaurant Association

ON: TRUE COST OF PPACA: EFFECTS ON THE BUDGET AND JOBS

TO: SUBCOMMITTEE ON HEALTH, U.S. HOUSE ENERGY & COMMERCE COMMITTEE

BY: LARRY SCHULER, OWNER
SCHU'S GRILL & BAR AND SCHULER'S RESTAURANT OF MARSHALL
MARSHALL, MICHIGAN

DATE: MARCH 30, 2011

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Statement on
True Cost of PPACA: Effects on the Budget and Jobs
Before the
Subcommittee on Health, U.S. House Energy & Commerce Committee
By
Larry Schuler, Owner
Schu's Grill & Bar and Schuler's Restaurant of Marshall
Marshall, Michigan

On behalf of the
National Restaurant Association

March 30, 2011

Chairman Pitts, Ranking Member Pallone, and members of the Subcommittee on Health of the House Energy & Commerce Committee, thank you for this opportunity to testify before you today on behalf of the National Restaurant Association. It is an honor to be able to share with you the impact the Patient Protection and Affordable Care Act ("PPACA") is having on businesses like mine, particularly in our ability to create jobs.

My name is Larry Schuler. I am an independent restaurateur operating a 4th generation family business with my father Hans, as well as two of my own operations. Schuler's Restaurant of Marshall, Michigan is an institution in the community and has been known as such since my great-grandfather opened the business back in 1909. My grandfather and father continued in the business as have I. In 1990, I opened a casual themed restaurant called Schu's Grill and Bar in downtown St. Joseph, and also a seasonal business called S.O.S.—Schu's on Silver Beach—right on the beach. My children Jenna, Kaitlin, and Rob have all worked as fifth generation Schulers at Schu's Grill and Bar and S.O.S.

I have had the distinct honor to serve as President of the Michigan Restaurant Association in 2002-2003, as my grandfather Winston Schuler had done in 1965, and continue to be involved with both the Michigan Restaurant Association and the National Restaurant Association.

THE RESTAURANT AND FOOD SERVICE INDUSTRY IS UNIQUE AND THESE CHARACTERISTICS INCREASE THE IMPACT OF THE NEW HEALTH CARE LAW

The National Restaurant Association is the leading business association for the restaurant and food service industry. Its mission is to help its members, such as myself, establish customer loyalty, build rewarding careers, and achieve financial success. The industry is comprised of 960,000 restaurant and foodservice outlets employing 12.8 million people who serve 130 million guests daily. Restaurants are job creators. Despite being an industry of predominately small businesses, the restaurant industry is the

nation's second-largest private-sector employer, employing over nine percent of the U.S. workforce.

The restaurant and food service industry is unique for several reasons. First and foremost, small businesses dominate the industry—with more than seven out of ten eating and drinking establishments being single-unit operators. We also employ a high proportion of part-time, seasonal, and temporary workers. Restaurants are employers of choice, especially for employees looking for flexible work hours.

Our workforce is typically young, with nearly half under the age of 25. We also have a high average workforce turnover rate relative to other industries—75 percent average turnover rate in 2008 compared to 49 percent for the overall private sector. In addition, the business model of the restaurant industry produces relatively low profit margins of only four to six percent before taxes, with labor costs being one of the most significant line items for a restaurant.

The National Restaurant Association supports repeal of this law and the development of new health care reform that promotes an affordable health insurance system in America that functions well for low-profit per employee, labor-intensive, industries, such as the restaurant and hospitality industry. Restaurants are proponents of cost containment in the health care system.

Our industry's goal is to lower the cost of employer provided and employee accessed health insurance by passing real health care cost containment measures and by eliminating the current employer mandate. The restaurant and food service industry wants health care reform, but PPACA is not the solution.

THE LAW'S IMPACT ON RESTAURANT INDUSTRY JOBS

Growth and success in the restaurant industry means opening more restaurants and locations, which in turn mean jobs in our communities. For some time, I have been considering several options to expand our businesses, including adding a management contract and another restaurant location. Up until recently, when I closely examined the impact of this new law on my businesses, I had not taken into account the additional costs and burdens this law imposes. I am now reexamining these expansion options and may not take on that additional growth.

The uncertainty of the regulatory process and the many rules that are yet to be clarified and fully defined worry me. The cost increase estimates we have done will only increase as we know more about this law. As a business owner, you plan several years in advance. Thus, 2014, when the most serious employer requirements take effect, is not that far away. Regulatory implementation is moving ahead at full-steam and it seems like a new requirement comes to light every day that is even more burdensome than the last.

Entrepreneurs, like me, are used to dealing with uncertainty and risk. We do so by preparing as best we can for the unknown. We have a glimpse of what is to come and

have already begun preparing for the full implementation of this new law to preserve our businesses. It requires close examination of our employment base and how we handle it going forward. We are already an industry that utilizes many part-time employees and I believe we will see an even greater trend towards that type of employment in our industry because of this law.

RESTAURANT INDUSTRY CHALLENGES WITH PPACA

As we witness the implementation of this new law by the agencies, we have discovered troubling challenges that need to be addressed. We are actively participating in the regulatory process to address these challenges.

While we would prefer repeal of PPACA, serious changes need to be made to its implementation now to avoid serious job dislocation in our industry not just in 2014, but right now, as we begin attempts to comply with its new requirements. In addition, many of the new requirements impact all employers, regardless of size, and come into effect well before January 1, 2014. Below is a brief mention of the industry's main concerns and suggested changes.

THE EMPLOYER MANDATE SHOULD BE REPEALED

The requirement that large applicable employers' offer minimum essential coverage to full-time employees or face penalties will create a significant cost escalation for employers offering such coverage. Our industry forecast shows that the combined penalties will become the largest cost-driver for restaurateurs after 2014.[1] Thus, we call on Congress and the President to eliminate the costly employers' mandate.

THE DEFINITION OF FULL-TIME EMPLOYEE SHOULD BE BASED ON A 40 HOUR WORK WEEK

The new law redefines full-time employment as 30 hours per week, which will have significant implications for business management and employee work hours in the industry. I have spoken with fellow restaurateurs and everyone agreed that one of the biggest impacts will come from this change in definition.

As a result of this change in the definition of a full-time employee, the industry will very closely manage employees' hours to 29 hours or less. In practice, it will mean a larger employee base, working less hours—no more than 25 hours to avoid bumping into the cap—and an increase in labor and training costs, already one of the most significant line item costs for our businesses. For the employees, it will mean the need to get a second and third job to make up for lost hours and, thus, income.

In addition, compliance is nearly impossible without guidance on what "any given month" actually means. For consistency and to avoid having employers cut the hours of

[1] Specifically, this would be the case for those who currently offer coverage today and will be considered 'large applicable employers" under the new law.

part-time workers below the new 30 hours threshold, it makes sense to continue basing full-time work under the current 40 hour work week standard.

COMPLIANCE TIMELINES MUST BE CONSISTENT AT 120 DAYS

The inconsistent timelines will cause unnecessary increased costs for restaurateurs. Currently the employer waiting period is 90 days, a seasonal employee is defined as working 120 days or less, and the definition of full-time employee considers hours worked per week in any given month. A consistent 120 day compliance timeline should exist for all of these provisions.

ELIMINATE MINIMUM ESENTIAL COVERAGE REQUIREMENT FOR LOW PROFIT-PER EMPLOYEE INDUSTRIES

The new law requires employers to offer a certain level of coverage to satisfy the mandate requirements that low profit-per-employee industries, like ours, will find difficult to comply. In fact, we fully expect many restaurants that are already operating on the margins of profitability to close. We would also urge you to allow catastrophic coverage to be an option for employers to offer their employees to satisfy current or any future coverage requirement.

Sixteen to twenty-four year olds make up the majority of the industry's workforce. If an individual under 30 years of age can purchase catastrophic coverage to satisfy the individual mandate, employers should be able to offer this same coverage to employees to satisfy the employer mandate obligations.

REPEAL THE EXPANDED 1099 REQUIREMENTS

We also call on Congress to repeal the expanded 1099 information reporting requirements contained in the new law. This is a bipartisan issue—one that almost everyone agrees must go away. Both the House and the Senate have voted to repeal this provision.

The 1099 repeal bill should be sent as soon as possible to the President for his signature. Otherwise, businesses will have to start wasting money, time, and resources this year to start preparing to comply with this requirement because our systems would have to be up and running when the mandate starts on January 1, 2012. There are more pressing challenges that we must address as the implementation of this law continues to move forward than complying with a requirement that most in Congress agree needs to be repealed.

AUTO-ENROLLMENT REQUIREMENT IS DUPLICATIVE AND SHOULD BE ELIMINATED

This requirement will increase employer costs and create greater exposure to penalties or free choice vouchers. This provision poses additional administrative burdens for our industry, especially due to the high turnover rate the industry experiences. The

applicability of the waiting period to this provision must also be clarified through regulations.

ZERO PAYCHECKS AND PPACA

Paychecks of zero or negative value are common in the restaurant industry, as tipped employees receive most of their income in tips paid by the customer. The paychecks paid by the restaurant sometimes cannot even cover the required federal and state taxes that must be applied. Today, if an employee chooses to participate and take health care coverage offered at the restaurant, they would pay their portion of the premium. If the employee contribution is not paid through the paycheck, then, it is paid directly to the insurer to maintain coverage. Today, if payment for the coverage is not received, coverage is dropped for nonpayment. However, under the new law, if that employee were dropped from an employer's plan and, instead, obtained a premium tax credit and used it to purchase coverage on the exchange, the employer would be penalized.

THE IMPACT OF PPACA ON MY BUSINESS

My businesses are typical of many restaurants in our industry. Each of my 3 restaurant locations is a distinct entity: a Sub-S Corporation with shared ownership with my father, and two Limited Liability Corporations fully owned by me, one of which is solely a seasonal business.

For the most part each of these businesses employs different employees with some overlap. We have a large group of seasonal employees that include a number of college students, some who work seasonally for us multiple times per year. The law defines a single employer based on the common control clause in the tax code and so based on the ownership of these restaurants we must consider the employees of all three restaurants as one employee pool for the purposes for the health care law.

Yet other benefits, such as 401(k), will continue to be offered separately by each company, making benefits administration more complicated. Our employees appreciate the flexible scheduling the industry is known for, and their hours can fluctuate greatly based on the time of year. For one of our locations, average hours worked during the 2nd quarter range from 18 to 35 hours per week, while the 4th quarter is our busy season and hours average 40 to 65 hours per week for the same employees.

We are very close to the fifty full-time equivalent workers threshold. How many hours our part-time employees work will determine if we are a "large applicable employer" or not. What this means for my restaurants and our employees is that depending on the time of year and the number of hours worked by our team, the three entities considered together could be considered a large applicable employer and subject to the most stringent employer mandates in the law some months, but not others.

In addition, our employees could be full-time employees one month and part-time employees the next, changing the obligation we have as a large applicable employer to each of them under the new law. Like so many of my peers, how closely employee's hours are managed may determine if we are above or below the large applicable employer threshold of 50 full-time equivalent employees.

We recently completed a detailed analysis of the new law's impact on our restaurants, including the impact of the seasonality of our business. We examined four different work periods in each quarter throughout the year[2] for just one of our restaurants (the S-corp) and first considered the cost impact to the business if all full-time employees were offered and took our plan.[3] We also considered the costs if half of the regular and seasonal full-time employees to whom coverage would be required to be offered declined the coverage.

Lastly, we considered the penalty amount we would be required to pay if we decided to no longer offer coverage to our employees. This is not something we want to do, as we are very proud of the fact that we have offered full medical coverage to our employees for a long time. Not only is it the right thing to do, but in such a competitive industry, where good employees who stay with the company for a long time are rare, offering coverage like we have does create a competitive advantage for a business like mine. Employee loyalty also keeps training costs to a minimum. The restaurant and foodservice industry experiences such high turnover rates that attracting and retaining employees is a top priority for all restaurant operations.

We first calculated the number of full-time equivalent (FTEs) employees just for this one location as defined in the law, using real 2010 employment numbers.[4] Whether combined with the other restaurants as one employer or not, this one location would put us over the 50 FTE threshold. We feel that we are a small business yet this law considers us a "large applicable employer." Here, we present the average of our analysis and what follows are the breakouts by quarterly periods examined.

In 2010, on average, the restaurant employed 33 full-time employees and 26 full-time equivalents working part-time hours, for a total of 59 FTEs that place us over the threshold and subject to the coverage and penalty requirements of the law. We employed 24 seasonal part-time employees and 5 seasonal full-time employees as well, for a total of 38 full-time employees to whom we would be required to offer coverage under the new law as a large applicable employer.

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[2] Work periods are based on payroll periods in looking at the employment data for our restaurant in 2010. (Qtr 1) Period 2: 1/25/10 – 2/21/10; (Qtr 2) Period 6: 5/17/10 – 6/13/10; (Qtr 3) Period 9: 8/09/10 – 9/5/10; and (Qtr 4) Period 13: 11/29/10 – 12/26/10.

[3] We had to assume that current premium rates would apply and that we would continue to contribute 50 percent towards the premium. However, premiums will continue to increase and there is also a possibility that depending on how minimum essential coverage is defined, our current plan may not satisfy the requirements for large applicable employers. This would also cause an increase in our premiums as well.

[4] For compliance purposes, all employees of each of the three locations would be combined into one pool, however currently there are two different health care plans between the three businesses.

Should all 38 employees opt-in to the coverage, we would see a 282% cost increase to the business over current premiums. Today, we insure 7 employees at a cost of $2,067 monthly/$24,808 annually. This would jump to $7,892 per month or $94,669 per year, if all 38 full-time employees opted into our coverage.

If we assume our pick-up rate is 50 percent and half of those eligible opted in for coverage (19 employees) the cost increase would be 141% over current premiums, or $4,979 monthly/$59,754 annually. If we chose not to offer coverage at all, we could pay on average $1,375 monthly/$16,500 annually in penalties.

The penalties are less than what we are paying for health care now. We believe that offering health care coverage is the right thing to do. However, faced with these very large increases in coverage costs, which do not take into consideration the likely premium increases, it will be extremely difficult for us to absorb these costs and continue offering coverage.

We cannot raise menu prices high enough to cover these costs and to do so would drive away the customers who are just beginning to return to our tables. Our only option will be to closely manage our workforce's hours to be able to eliminate 10 FTEs from our staff and remain below the 50 FTEs large applicable employer threshold. Across the industry, part-time will probably be 25 hours or less on average in a week, impacting the number of jobs some of our employees may need to take on. It is not something I want to do, but given that this law will only increase my costs, I will have to do what I can to keep our 4th generation family business profitable and operating.

My fellow restaurateurs are thinking about this law in the same context as I am. As a result, we are all taking a second look at any expansion opportunities we had been considering because of the additional burden and cost, which is somewhat still undefined. Because this law is so complicated and there remain so many unanswered questions about how it would function, it is extremely difficult to know how to expand and handle the hurdles you know will be coming at you.

Every fellow restaurateur I talk to says that they feel in the dark, that they had no idea just how complicated and burdensome this law is. I fear that there are many in our industry who, despite our efforts to educate them about these challenges, do not yet realize the magnitude of the impact this law will have on their businesses. At the very least, this law and the requirements it imposes on employers will impact all of our decisions going forward, especially in regards to our employee base.

Quarter 1: Large Applicable Employer with 55 FTEs.

This is one of the slowest work periods for our restaurant given the slowdown in customer traffic following the holidays in January to February. We have determined that during the first quarter, we had 26 full-time employees working an average of 30 hours per week with an additional 29 full-time equivalents for a total of 55 FTEs. In addition we had 18 seasonal part-time employees and 3 seasonal full-time employees. Since we

would be required to offer coverage to all full-time employees, including seasonal full-time employees past the allowed waiting period, we could be required to offer 29 employees coverage.

If all of these employees accepted our offer and took the coverage, assuming current premium rate and our 50 percent employer contribution, the business would experience a 200 percent increase in premiums to be paid just for this 4 week period. Should half of those 29 employees opt out of our offer of coverage, we would experience a 100 percent increase in premium cost. And, finally, if we were to no longer offer coverage and instead decide to pay the $2,000 annual penalty per full-time employee (including seasonal full-time employees), we would be subject to no penalty.

The law allows an employer to consider the number of their full-time employees minus 30 for the purposes of calculating this penalty. Since we have 29 regular full-time and seasonal full-time employees combined in this period, we would have zero employees for whom to pay the penalty.

Quarter 2: Large Applicable Employer with 60 FTEs.

During the second quarter, we employed 31 full-time employees and 29 full-time equivalents working part-time hours for a total of 60 FTEs. In addition, we employed 22 seasonal part-time employees and 3 seasonal full-time employees. We employed a total of 34 full-time employees in this time period. Should all 34 full-time employees accept our offer of coverage it would represent a 245% increase in premium costs for that month.

If half of the full-time employees opted out of our coverage, it would represent a 123% increase in premiums for us during just that month. If we chose to pay the penalty for not offering any coverage, we would be subject to a $667 penalty per month for this period of time.[5]

Quarter 3: Large Applicable Employer with 59 FTEs.

During the third quarter, we employed 38 full-time employees and 21 full-time equivalents working part-time hours for a total of 59 FTEs. We employed 31 seasonal part-time and 4 seasonal full-time employees. We employed a total of 42 full-time employees—both regular and seasonal—in this time period. Should all full-time employees accept our coverage offer, it would represent a 318% increase in premiums for the business.

If half of these employees opted out it would represent a 159% increased cost. If we decided to pay the penalty, then it would be assessed as $2,000 per month for this period because, with the 30 employee discount, we would be paying the penalty on 12 employees.

[5] 34 full-time employees minus 30 multiplied by $166.67 equals $667.

Quarter 4: Large Applicable Employer with 61 FTEs.

During the fourth quarter, we employed 38 full-time employees and 23 full-time equivalents working part-time hours for a total of 61 FTEs. In addition, we had 25 seasonal part-time staff and 9 seasonal full-time employees. In total, we had 47 full-time employees to whom we would be required to offer coverage. If they all accepted the offer of coverage, it would mean a 364% increase over our current premiums. If half declined, it would be a 182% increase. If we decided to pay the penalty, then it would be assessed as $2,833 per month for this period because, with the 30 employee discount, we would be paying the penalty on 17 employees.

Currently, we offer coverage and 7 employees opt-in to take our plan in one of our restaurants. However, with the requirements of the new law on the individual, this will greatly impact how many employees will opt-in to take our offer of coverage. I have one employee who has worked for us for a very long time. He is a valuable member of our team, and health care coverage has been offered to him many times over the years.

He has a wife who also works, and a child who will be going into the armed forces soon. However, he chooses not to take advantage of the major medical coverage we offer but instead chooses it as more take-home pay. And, we aren't talking a lot of money for the premiums per month—only $90 per month for an individual and $180 per month for a family. There are a lot of employees in our industry, like this particular employee of mine, who have an option and simply do not wish to take it.

Another issue that impacts my situation in particular is the lack of consistency in compliance timelines. The new law allows for a maximum waiting period of 90 days before coverage must be offered or an employer is considered as not offering coverage. However, a seasonal employee is defined as working 120 days or less.

The new law requires that a large applicable employer offer seasonal employees who work full-time (more than 30 hours on average a week) coverage. One of my LLC's is strictly a seasonal business that is open 107 days a year, from the week before Memorial Day weekend until the week after Labor Day weekend. We do employ a few employees before that time to get the operation ready for business, but most work full-time during this time.

As I understand this portion of the new law, in 2014, I am now required to offer my seasonal full-time employees in this restaurant coverage from day 91 through day 107 or pay the penalty for that month on each of them for not offering coverage.

There are two solutions to this. First, Congress could change the waiting period and make it consistent with the seasonal employee definition of 120 days. Such a change in the waiting period time would prevent driving up the cost of my premiums by ensuring that such a group of people would not be added to insurance roles one month, just to be dropped the next. An employer could also just pay the penalty for one month, but that does not achieve anyone's goal of reducing cost or offering the uninsured coverage.

Second, I could shorten the number of days I will be open to 89 to avoid the complexity and cost of being open an additional 17 days.

This is the perfect example of how this new law will drive the way restaurants across the country will run their businesses. It will certainly change it dramatically and likely change the dynamics of our workforce as well.

HEALTH CARE REFORM RESTAURANTS SUPPORT

The restaurant and food service industry has long supported health care reform that controls costs and in turn makes affordable coverage available to more people. One of the key factors of cost-reduction is informed consumer choice in health care product purchasing. The new health care law does not address the rising costs of health care coverage and, in some instances, works to increase costs by limiting the use and flexibility of cost-reducing policies.

The National Restaurant Association supports allowing purchasing across state lines. For many years, the industry has supported health care pooling arrangements that provide small businesses increased options for affordable health care. Pooling statewide or nationwide would work to achieve lower rates for employees' health care coverage.

The Association long supported the bipartisan Small Business Health Options Program Act (SHOP Act), a concept that was used in developing the SHOP exchanges in the law. Mr. Chairman, we also support your bipartisan Small Business Cooperative for Healthcare Options to Improve Coverage for Employees Act (Small Business CHOICE Act) that would allow all businesses to form cooperatives of similar to risk pools and provide coverage for high-cost claims. We continue to encourage Chairman Pitts of this Subcommittee and Representative Nydia Velázquez (D-NY) to reintroduce the bill again in this Congress, and for the Congress to consider including it in alternatives to replace PPACA.

The new health care law limits the use and flexibility given to Health Savings Accounts (HSA), Health Reimbursement Arrangements (HRAs), and Flexible Spending Accounts (FSAs). No longer can over-the-counter medicines be reimbursed by these cost-reduction tools without a prescription by a doctor.

Opinion polling the Association conducted several years ago shows that 70 percent of restaurant employees have a strong interest in HSAs. We support expansion of the flexibility in use and contribution amounts to these accounts as a means to give consumers the ability to control and reduce their own health care costs. In addition, the law restricts contributions to FSAs beginning in 2013. We support repeal of this provision, as FSAs reduce health care costs for consumers.

The industry supports health insurance coverage portability options that put control of health care decisions in the individual consumers' hands. To provide coverage to a mobile workforce, allow uninterrupted coverage, and extend coverage to the

uninsured, tax laws and insurance regulations should permit employees to take their coverage with them when they change jobs. Given that restaurant employees change jobs more often than other workers, such an option would be of great benefit to them.

Tort-related matters have contributed to the increasing cost of health insurance and medical care through law-suit abuse. The skyrocketing health insurance premiums caused by frivolous suits hurt both employers and employees. The National Restaurant Association supports medical malpractice reform to address one of the cost-drivers of health insurance premiums.

IN CONCLUSION, LET US WORK TOGETHER TO FIND A SOLUTION THAT BOTH LOWERS HEALTH CARE COSTS AND PROVIDES BETTER BENEFITS WITHOUT BANKRUPTING THE RESTAURANT INDUSTRY

Since enactment of PPACA, the National Restaurant Association has been attempting to constructively shape the regulations. Nevertheless, there are limits to the scope of change we can achieve through regulations, particularly if those charged with their drafting choose to ignore the industry's comments. Ultimately, PPACA itself needs to be repealed or drastically changed to mitigate the most harmful effects on the restaurant industry.

The National Restaurant Association will continue to be active in urging Congress to either repeal or pass major legislative changes to PPACA because some of the fundamental problems cannot be fixed through regulations alone. The National Restaurant Association looks forward to working with this Committee and all of Congress on these and other important issues to improve health care for our employees without sacrificing their jobs in the process.

Thank you again for this opportunity to testify today on the true cost of the new health care law and its negative impact on jobs in the restaurant industry and my businesses in particular.

Mr. PITTS. The chair thanks the gentleman. I thank the panel for your opening statements. I will now begin the questioning and recognize myself for 5 minutes, and I will start with you, Mr. Schuler.

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

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

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

Mr. KENNEDY. We definitely would be considering that because of the new regulations and what that entails as far health insurance, and are currently even looking at that as we go about making sure that what levels we have as far as employees and that has become a decision factor in our progressing forward in growth whereas used to we would want to grow as much as possible. Now as we grow above 50 we have another item we have to consider and how that would impact us as far as cost and whether those actual costs can be offset by profits that we make.

Mr. PITTS. Thank you.

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

Mr. HOLTZ-EAKIN. No, they cannot. They will be gone in the first 10 years and additional funds will have to be found after that.

Mr. PITTS. All right. CBO estimates that $53 billion in Social Security payroll taxes are used to offset the cost of the new entitlement and Medicaid expansion in PPACA. Can those funds be used to pay for both PPACA and future Social Security benefits?

Mr. HOLTZ-EAKIN. Same story is true. Those will be gone in the first 10 years and additional funds will be needed to be found to make good on Social Security promises.

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

Mr. HOLTZ-EAKIN. It is not accurate. Federal accounting notwithstanding, the money will be spent only once and cannot both extend the Medicare program and pay for the insurance subsidies.

Mr. PITTS. Proponents of the bill argue that PPACA costs under $1 trillion over 10 years during its passage. However, the CBO score of the bill was artificially low because the other side of the

aisle delayed the bill's major spending until 2014. Now, we recently found out that with just 2 more years of spending, PPACA's spending estimates shot up to $1.44 trillion. However, this number still doesn't account for the full 10 years of implementation. If we extrapolate CBO's estimates to the full 10 years, what would you estimate the real cost of the bill to be?

Mr. HOLTZ-EAKIN. I think over a full 10 years, fully implemented, this bill is easily going to exceed $1.6, $1.8 trillion.

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

Mr. HOLTZ-EAKIN. As I recall, it reduced it by about $250 billion over the first 10 years.

Mr. PITTS. How much?

Mr. HOLTZ-EAKIN. By about $250 billion in the first 10 years.

Mr. PITTS. And the score for the health care law also did not include nearly $115 billion in the discretionary program cost to run Obamacare. Is that not correct?

Mr. HOLTZ-EAKIN. That is my understanding, yes.

Mr. PITTS. The chair thanks the panel and will recognize now the ranking member, Mr. Pallone, for 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman. I am going to try to get one question in for Mr. Cutler and one for Mr. Poore, so bear with me if we can try to split the time between you.

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

Mr. Cutler, you have done work on what effects the bill will have on the job market. Your study predicts that the health reform will strengthen the economy and the job market by creating 250,000 to 400,000 jobs a year for the next decade. I just want you to elaborate on your study and explain to us how the health care reform is a job creator, not a job killer, and talk about some of the other factors that I mentioned.

Mr. CUTLER. Thank you, Mr. Pallone. Health insurance costs are an absolutely critical indicator for hiring. Industries in which more

businesses are providing health insurance to their workers have grown less rapidly than industries where fewer employers provide health insurance, and that is particularly true in the United States in comparison to other countries. And so the central, the fundamental issue about any health care reform is what will it do over time to the cost that businesses face for health insurance. As I discussed in the testimony and in the opening statement, the Affordable Care Act contains essentially all of the tools that economists and policy analysts have put forward for reducing the costs of medical care over time. It is my belief that what those provisions will do is to reduce premiums by the end of this decade by about $2,000 per person relative to what they would have been. That will free up money for firms that are now providing insurance, that are thinking about providing insurance but are on the margin, and allow them to take that money and use that to grow businesses, to pay higher wages, to do anything of the things that businesses would like to do that they have been stifled from doing.

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

Mr. PALLONE. All right. Thank you. And thank you for also limiting your answer so I can get to Mr. Poore.

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

A lot of this comes from the State exchanges once those State exchanges are up, so I just wanted you to describe how you think these State exchanges will affect your business and other small businesses in the country.

Mr. POORE. Well, first of all, I think that we are already starting to see more small businesses getting coverage. Statistics are showing that from Coventry and several others. But for me alone, every year my insurance guy would come in and say listen, your rates are going up 16 percent or 23 percent, and I would say, you know, Troy, why is that. And he was like, well, you are just a little group. And so I said Troy, if I had 10,000 people in my risk pool, would my rates go down; well, absolutely. So that is where the exchanges come in for me. You know, if I can shop and get—once again, just going back for a minute, Troy would also come in and he would give me two companies, three plans from each, and that was my choice, but a big company or like a service employees, not service employees but like public employees, the State offers this broad—

they almost already have exchanges running that I don't have access to so I am kind of hamstrung that way right now.

In the last 2 years, I have been able to keep my rates from going up. I have actually added some benefits. My rates have gone up over 2 years 16 percent. That is the lowest increase in rates that I have ever seen in 11 or 12 years of offering insurance, and the only reason they went up is because I was putting—I was lowering my deductible and I was lowering my out-of-pocket, so if I would have left it the same, I might actually be level, which, believe me, if there is anybody that has ever—I have never had a situation where my rates didn't go up. It a pretty phenomenal statement to be able to make.

Mr. PALLONE. Thank you.

Mr. BURGESS [presiding]. The gentleman's time is expired. I recognize myself for 5 minutes for the purpose of questions.

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

Mr. CUTLER. I believe we did very well on both counts.

Mr. BURGESS. All right. Let me ask Mr. Holtz-Eakin. How did we do on both counts?

Mr. HOLTZ-EAKIN. I think you are 0-for-3 actually.

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

Mr. CUTLER. What we are seeing is the difficulties of the current system as they are being mapped out. Remember, this legislation takes effect over a number of years.

Mr. BURGESS. Correct.

Mr. CUTLER. Mr. Poore said the creation of the exchanges will be a very big——

Mr. BURGESS. Let me ask you another question.

Mr. CUTLER [continuing]. Factor for small businesses but those come in a few years.

Mr. BURGESS. Well, Dr. Holtz-Eakin, do you have an opinion as to is the system working well?

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

Mr. BURGESS. One of the things I never understood, we had these hearings when Mr. Pallone was chairman and people would come in and talk to us about expanding Medicaid and the various federal programs and public options. We never asked Mitch Daniels to come in here and talk to us about how he was able to hold down costs for his State employees with the Healthy Indiana plan by 11 percent over 2 years. Those same 2 years, standard PPO insurance was going up 7 or 8 percent. Medicare and Medicaid, as it turned out retrospectively, were going up 10 and 12 percent. You just have to ask yourself why you wouldn't look to the States as laboratories and found out what is working and see if perhaps there is some applicability to the greater world at large and perhaps we wouldn't be so disruptive to Mr. Kennedy and Mr. Schuler. Mr. Poore is apparently doing oK with the system as it is written today.

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

Mr. CUTLER. One of the issues with Medicare has been that it has been very difficult to make the program modernized when every single change has to go through the Congress at a glacial pace, and I think that has been a complaint from both sides of the aisle.

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

Cost shifting, yes, the uninsured, Dr. Holtz-Eakin, caused some cost shifting but what about the cost shifting from Medicare and Medicaid and what did we do with the vast expansion of Medicaid into the Affordable Care Act? Are those people going to have a doc-

tor or are they still going to show up at the same emergency room they have always gone to?

Mr. HOLTZ-EAKIN. I think CMS Actuary Foster evinced some concern about the future of Medicare, about access to providers, given the cost shifting that goes on there, 77 cents on the dollar relative to private payers. I am deeply pessimistic about the future of Medicaid where outside of the near term federal pickup of the tab at 50 cents on the dollar, we are simply not going to see access, particularly to primary cares physicians, and we know they show up in ERs at far too high a rate. So to use that as the mechanism for coverage expansion I think was one of the unwise choices of the act.

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

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

Mr. CASSIDY. We in Louisiana have great affection for Bo Pelini. I wish you all the best in the Big Ten.

Mr. POORE. It has been great.

Mr. CASSIDY. As long as you don't play LSU, we are rooting for you, buddy.

Mr. POORE. It has been great. He is a great guy.

Mr. CASSIDY. Listen, how many employees do you have?

Mr. POORE. Twenty-nine.

Mr. CASSIDY. OK. As I read this bill, if you have 25 employees or less, average income of $25,000, you get a 50 percent tax credit.

Mr. POORE. I should fire four of them.

Mr. CASSIDY. And if you lose four of them by whatever reason, would you go back up to 29 and lose this tax credit?

Mr. POOR. Absolutely. I can't do the business I have got right now.

Mr. CASSIDY. That is good. Others tell me differently, but thank you for your response.

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

Mr. CUTLER. Thank you for the question. What we have seen in the past few years in both Medicare and Medicaid and private insurance is that the number of services people receive goes up and as a result governments and private insurers lower the rates that they pay. What will work in the health care system is to run that in reverse, to figure out which services are not worth——

Mr. CASSIDY. So you are postulating that we are going to have more efficient delivery of care, and even though we are taking out according to that cliff, we are going to pay physicians 31 percent

less than they currently receive, somehow we are going to be held harmless.

Mr. CUTLER. Our best guess of most experts is that at least one-third of medical spending is completely wasteful and the——

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

Mr. CUTLER. I do believe that is one of the mechanisms.

Mr. CASSIDY. Now, I am struck that there is an article published frankly last week in the New England Journal of Medicine in which these people look at the accountable care organization and says that basically looking at the CMS demonstration project, which was structured frankly to find a positive result, and indeed they found that over 3 years they all lost money. Eight of the ten in physician groups and the demonstration did not receive any shared savings in the first year. In the second year, six of ten did not. In the third, half of the participants were still not eligible, and they point out that these were structured, these were already existing groups that had gamed the system to have a positive result. They all lose money over the first 3 years. I don't see these ACOs as this huge, efficiency-generating cost savings. This article suggests not. Why do you hold that position?

Mr. CUTLER. What we know is that some organizations are able to do extremely well including if you look at, say, the Mayo Clinic or the Cleveland Clinic or Geisinger Health Care.

Mr. CASSIDY. Which I think were included here, certainly Geisinger was.

Mr. CUTLER. Now, those tend not to be in those organizations. Most of the demonstrations were not there. So those organizations have figured out how to improve the quality of care and save money. Other organizations are still learning how. The failures are generally because they don't have the right information systems in place because they still work off of fee-for-service payment basis and so the doctors still know that doing more is the way you earn more or because they haven't figured out how to efficiently manage the practices that are involved.

Mr. CASSIDY. Excuse me. I am not seeing the list of people here but I actually think it has groups that were well established but I do think I am taking from you that what you are arguing is the theoretical benefit, nothing that has been actually demonstrated. If you will, it is a hope by and by but it is not the experience currently.

Mr. CUTLER. Actually it is the experience of a number of organizations across the country.

Mr. CASSIDY. I haven't seen that data, and this is a review of those CMS demonstration projects. If you can refute this article, I would appreciate that.

Mr. CUTLER. The Institute of Medicine just published a lengthy volume in which they went through a number of the successful examples and they estimated——

Mr. CASSIDY. I have not seen a single ACO article that suggests that, but please forward that.

Mr. CUTLER. I will indeed.

Mr. CASSIDY. Secondly, regarding preventive services, again, I am a physician, preventive services have never been shown to save money unless it is immunizations or maybe the management of obesity by increasing premiums for those who don't lose weight. This article actually eviscerates that ability. And so when you postulate that preventive services will save money, there is no empiric data for that.

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

Mr. CASSIDY. Your testimony mentions colonoscopies, cholesterol checks, but that hasn't really been shown. You are speaking about reducing readmissions?

Mr. CUTLER. Some of those, if you look at the studies, actually do save money. Some just extend life but don't save money.

Mr. CASSIDY. Which of those would save money? Because colonoscopy does not. I am a gastroenterologist and so——

Mr. CUTLER. Obesity reduction saves money.

Mr. CASSIDY. Now, the obesity reduction actually saves money, according to people like Safeway by increasing premiums for those who do not enter into a weight-loss reduction program but I am struck that the PPACA basically does away with that. And so it seems like you are endorsing something that PPACA does away with.

Mr. CUTLER. I am not sure I agree with that. The Affordable Care Act has the discount for wellness management, 30 percent which can increase to 50 percent.

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

Mr. PITTS. The gentleman's time is expired. The chair recognizes the gentleman from Georgia, Dr. Gingrey, for 5 minutes.

Mr. GINGREY. Mr. Chairman, thank you.

I am going to address my first question to Mr. Cutler. Is it Mr. Cutler or Dr. Cutler?

Mr. CUTLER. I am officially a Dr. Cutler but I am happy either way.

Mr. GINGREY. Well, the brain power sitting at the witness table, I feel a little sheepish calling any of you Mister unless you are Brits, but in any regard, I will address my first question then to Mr. Cutler.

In the March 2010 Wall Street Journal op-ed, you wrote that there have been several broad ideas offered to bend the cost curve over the last decade including medical malpractice reform. As you might know, I have a very keen interest in that as a practicing physician and Member of Congress. Do you believe that this Con-

gress, unlike the last, should finally address medical malpractice reform, and what is its potential impact on health care cost?

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

Mr. GINGREY. Well, let's move on to that same question then, Mr. Cutler. I will move to Mr. Holtz-Eakin, our former CBO director, and ask really the same question. What Mr. Cutler said doesn't really jibe with what I think my fund of knowledge tells me in regard to defensive medicine and the actual cost. I mean, even the CBO, Mr. Elmendorf, said $54 billion over 10 years. That is a lot of bread. But I think it is a lot more than that. I think it could very easily be $150 billion annually because some of the doctors on the Energy and Commerce Committee could tell you in their practices how much ordering of very expensive imaging procedures in particular and drawing a lot of blood. I could go on and on and on. But I would like for you to comment on that same question.

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

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

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

Mr. HOLTZ-EAKIN. At the heart of it is the notion that the spending will go up as we have seen these long-term projections for Medicare and Medicaid go up for a long, long time. CBO has put these out and Medicare and Medicaid go up from 4 percent of GDP to 12 or 20 percent over the next several decades, and for a long time the presumption has been by any reasonable analyst, you can-

not tax your way out of that problem. You have to take on the spending. What the Affordable Care Act does is essentially recreate that spending and promise to tax its way out of it, and I don't view that as a plausible economic proposition. We are not going to raise the Cadillac tax so high to make this balance over the long term. You have got to control the growth of spending, and no analyst outside of David has come in and believed that this controls the spending growth.

Mr. GINGREY. Mr. Cutler, you are shaking your head. I have got 20 seconds left if you would like to weigh in on that. I will cut you off if I decide to, but go ahead.

Mr. CUTLER. If you look at what the Business Roundtable has said, they said that this way of making reforms would lead to big changes in cost savings. If you look at what the American Medical Association has said, what the American Hospital Association has said, what the Association of America's Health Insurance Plans have said, all of them have said that this is the way to go and that they believe that this is the potential for saving enormous amounts of money.

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

Mr. PITTS. The chair thanks the gentleman and recognizes the ranking member, Mr. Waxman, for 5 minutes.

Mr. WAXMAN. Thank you, Mr. Chairman.

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

Mr. POORE. To be honest, no, for mainly the reason you gave. I have never had a national commerce guy call me but I don't have $86 million in the bank, either. So to be frank, I really don't believe that—I mean, they lost their credibility when they did that, when they accepted money from the insurance lobby.

Mr. WAXMAN. Then they are no longer representing businesses, they are representing——

Mr. POORE. In a lot of ways I don't think——

Mr. WAXMAN. But I want to use my time to ask another question in my limited time, but I thank you very much for your contribution to this hearing.

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

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

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

Mr. CUTLER. I think cuts of that magnitude would be catastrophically bad. If you run through this past recession, the Great Recession, without the ability to expand Medicaid by having the Federal Government be able to do that, you would have produced millions more uninsured people, people suffering lack of care, substantially worse health outcomes, hospitals and physicians that go under because they are overwhelmed by the number of uninsured people, and at the same time you would not have achieved any real reductions because the block grant itself does nothing to actually figure out how to run the system better. What we need to do is save money in Medicaid and throughout the health care system by running systems better, not by just shifting costs and making bad times be even worse.

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

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

Mr. WAXMAN. Thank you very much. Thank you, Mr. Chairman.

Mr. PITTS. The gentleman's time is expired.

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

Thank you. This subcommittee hearing is now adjourned.

Mr. WAXMAN. Mr. Chairman, we will hold the record open for your comment on the policy for the committee for the future on——

Mr. PITTS. We will give you that in writing. I understood that the staff had talked to your staff about hat.

Mr. WAXMAN. Without objection, can we just put it into the record and we will look forward to getting that.

Mr. PITTS. Without objection, so ordered.

[Whereupon, at 1:35 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Bloomberg Business Week
Politics & Policy March 24, 2011

The Republican Response to Obamacare

According to a Bloomberg analysis, GOP alternatives would save less than $5 billion a year, or less than 1 percent of what health care cost in 2009

By Lisa Lerer and Drew Armstrong

Two weeks after Republicans took control of the House in January, they kept a key campaign promise and voted to repeal President Barack Obama's health-care law. The Democratic Senate later rejected the repeal, but House Republicans say they still plan to "replace Obamacare with something that's a lot better," says Fred Upton, chairman of the House Energy and Commerce Committee. Their focus, he says, is to lower the cost of care.

Yet according to a Bloomberg analysis, the alternatives suggested so far—ranging from limiting malpractice lawsuits to allowing insurers to sell across state lines—would save less than $5 billion a year. That's less than 0.6 percent of the $836 billion the government spent on health care in 2009. "None of these proposals get to the heart of what the issue is, which is to really address cost," says Ashish Kaura, a health-care analyst with Booz & Co. "They nibble around at the margins."

The Congressional Budget Office, the legislature's research arm, projects that Obama's law, which celebrated its first anniversary on Mar. 23, will reduce the deficit by $143 billion by 2019. Republicans say that estimate is too rosy and doesn't account for fast-rising medical costs that are driving up insurance premiums and Medicare and Medicaid spending. In making repeal a key issue, Republicans are opening themselves to attacks in the 2012 elections if they can't offer convincing alternatives that maintain the bill's deficit reductions while tamping down health-care costs.

Some of their proposals, such as exempting abortion from federal funding, would have little economic impact. Others, such as creating "high-risk pools" for those with preexisting conditions and keeping people up to age 26 on their parents' insurance, are already features of Obama's law.

At the top of the Republicans' wish list: curbing medical malpractice lawsuits. Proponents say the ease of suing physicians and the likelihood of winning sizable verdicts cause doctors and hospitals to perform costly, duplicative tests out of caution, raising insurance prices. The CBO estimates that limiting lawsuits would save about $54 billion over 10 years and reduce total medical expenditures by just 0.5 percent. Actual savings could be less. Since 2003, Texas has limited noneconomic damages in malpractice suits to $250,000. Yet Medicare costs in the state are second only to New Jersey, according to *The Dartmouth Atlas of Health Care*. In the region around McAllen, a Texas city along the Mexico border, the average patient costs Medicare $15,695 per year, higher than anywhere except Miami. The malpractice proposal just "chips away" at costs, says Joseph Antos, a health policy expert at the Republican-leaning American Enterprise Institute, who supports the idea.

Another leading plan would let health insurers sell their products across state lines, something now prohibited by federal law. Certain states, including New York, have rules requiring insurers to cover specific benefits or guarantee coverage to people with preexisting conditions. Some also limit how much premiums can rise as people get older. Those mandates drive up the cost of insurance. People in states such as New York should be able to save money by purchasing coverage in a less regulated state, say Republicans.

But according to the CBO, only the healthy would benefit, since they could shop around for the best deals. Sick people would stay in the more regulated states, where coverage protections are stronger. That would drive up prices for everyone in those markets, which would have a larger proportion of sick people. The CBO says the plan would save the government about $7.4 billion over a decade, a modest amount in annual terms, since it would encourage people to use post-tax dollars to buy cheaper coverage in other states rather than accept work-provided benefits, which are tax-exempt.

Helping small businesses band together when negotiating policies, another Republican proposal, also yields little in the way of cost savings. Even large businesses with tens of thousands of employees have little bargaining power in the health-care market. "If GM can't control costs, do you think a small group of firms in Texas can?" says Uwe Reinhardt, a Princeton University health economist. "They would never have enough clout against the hospitals."

Republicans also want to expand health savings accounts, which are coupled with a high-deductible insurance plan. Until a person reaches the annual limit, which can run to $3,000 or more, they pay for all their care—from a flu shot to a quadruple bypass—out of a pretax savings account. Economists who support the idea say that since consumers are directly paying for care, they'll shop for lower-cost treatment or use fewer health-care services. Reinhardt says the change would mostly benefit high-income consumers, who would use the accounts to shield income from taxes. "HSAs are not a cost-containment device," he says. And the CBO estimates it would reduce federal tax revenue by $300 million from 2009 to 2018.

Republicans argue that small changes can add up to big savings. Says Representative Phil Gingrey (R-Ga.), an obstetrician who leads the GOP Doctors caucus: "A billion here and a billion there, and the next thing you know you're talking about real money." And Upton, the Michigan congressman, adds that "it would be a mistake for anyone to think the entirety of proposals for health-care reform are already on the table."

The bottom line: *Republican proposals to control health-care costs would save the government only about $5 billion a year, or 0.6 percent.*

Lerer is a reporter for Bloomberg News. Armstrong is a reporter for Bloomberg News.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary
Administration on Aging

Washington D.C. 20201

March 30, 2011

The Honorable Henry A. Waxman
Ranking Member
Energy and Commerce Committee
U.S. House of Representatives
Washington, D.C. 20515

Dear Representative Waxman:

Thank you for your March 23, 2011 letter seeking clarity in my statements before the House Committee on Energy and Commerce, Subcommittee on Health hearing on March 17, 2011. I appreciate the opportunity to provide a more comprehensive response to questions regarding the estimated savings attributed to the Community Living Assistance Services and Supports (CLASS) program by the Congressional Budget Office (CBO).

As I stated in my testimony, the goals of the CLASS program are to provide an opportunity for individuals to take responsibility and prepare financially for their own long-term needs, support consumer choices related to their own care and living arrangements, and facilitate independence and community living. The law clearly states that the program must be able to pay for benefits with the premiums it takes in and that no taxpayer dollars may be used to pay for CLASS benefits.

We continue to explore several areas within our statutory flexibility to strengthen the CLASS program, and President Obama and Secretary Sebelius have pledged to use the discretion already provided in the law to make necessary changes to ensure that CLASS meets its programmatic goals and is financially solvent and stable.

As I testified at the Subcommittee hearing, the CBO estimates the Affordable Care Act will reduce the deficit by $210 billion in the first decade and $1 trillion in the next decade. In developing these estimates, CBO is following the same budgeting methods put into law in 1990 and used for more than two decades. These budgeting practices have been used by the Medicare program for many years. Since 1981, the CBO and the Medicare Trustees have prepared estimates for specific statutory changes that would achieve savings in Medicare and extend the solvency of the Medicare Part A Trust Fund while contributing to deficit or surplus calculations. For example, this process was used to estimate savings during the Balanced Budget Act of 1997 and the Deficit Reduction Act of 2005.

As Joseph Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute, recently testified in the same hearing before the Energy and Commerce Committee Subcommittee on Health, this approach is a method that has been in use for many years and is not a budgeting gimmick and should not be considered double counting.

To better understand these budgetary calculations, it is important to note that the premium revenues of the CLASS program, like other trust fund revenues, are part of the larger unified federal budget. Under current budget practices, CLASS revenues and costs are taken account of on an annual basis. Therefore, CLASS premiums are treated as revenue and in the absence of CLASS expenditures contribute to deficit reduction. When CLASS benefits become payable they will be treated as reductions against accumulated premium revenue. This is similar to the treatment of revenues and expenditures from the Medicare Trust Fund.

CLASS premiums will be deposited into a trust fund called the CLASS Independence Fund, which will be managed by the Secretary of the Treasury and Board of Trustees. A primary function of the Board of Trustees is to review program operation and ensure that CLASS is actuarially sound and fiscally solvent over the 20 and 75 year periods stipulated in the law. This is particularly important because no taxpayer funds may be used to pay for CLASS program benefits.

Thank you again for the opportunity to testify before the Subcommittee and for your important questions. We remain strongly committed to transparency as we work to strengthen the CLASS program, and look forward to working with you and your colleagues to ensure responsible and successful implementation. A similar response has also been provided to Representative Pallone.

Sincerely,

Kathy Greenlee

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

March 30, 2011

The Honorable Henry A. Waxman
Ranking Member
Energy and Commerce Committee
U.S. House of Representatives
Washington, D.C. 20515

Dear Representative Waxman:

Thank you for your March 23, 2011 letter regarding my statements before the Committee on Energy and Commerce on March 3, 2011. I remain committed to working with you and your colleagues to ensure successful implementation of the Affordable Care Act, and appreciate the opportunity to respond directly to questions regarding efficiencies in the Medicare program.

It is important to reiterate the facts: the new law will not cut guaranteed benefits for seniors or alter the current protections for Medicare beneficiaries. In fact, the Affordable Care Act will add benefits such as free prevention services, an annual wellness visit, and a phase-out of the Medicare donut hole in the prescription drug benefit. Moreover, by reducing waste, fraud, and abuse and cracking down on overpayments, the law will lower beneficiary premiums, reduce beneficiary cost sharing and, as I stated in my testimony, slow the projected growth rate of Medicare over 10 years, extending the life of the Medicare Hospital Insurance Trust Fund by 12 years.

As I have testified, the Congressional Budget Office (CBO) estimates that the Affordable Care Act will reduce the deficit by $210 billion in the first decade and $1 trillion in the next decade. Additionally, the Medicare Trustees estimated that the Medicare trust fund will remain solvent for an additional 12 years because of changes called for in the Affordable Care Act.

In developing these estimates, CBO and the Trustees are following the budgeting methods put into law in 1990 and used for more than two decades. Similarly, since 1981, Republican and Democratic Congresses alike have enacted at least ten laws that the CBO and the Medicare Trustees estimated would achieve savings in Medicare, extending the solvency of the Medicare Part A Trust Fund and reducing the deficit. For example, this process was used to estimate savings during the Balanced Budget Act of 1997 and the Deficit Reduction Act of 2005.

As Joseph Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute, recently testified before the Energy and Commerce Committee Subcommittee on Health, this budgeting method has been in use for many years and is not a budgeting gimmick. CBO is not double counting.

To better understand these budget calculations, it is important to note that the Medicare savings, like other trust fund savings, are part of a larger deficit calculation. Under these longstanding budget practices, Medicare spending is part of the unified federal budget. Therefore, program changes that reduce the growth in spending contribute to reducing the budget deficit. When these changes specifically affect Medicare Part A spending, they also favorably affect solvency projections for the Hospital Insurance Trust Fund.

Paul Van de Water, a Senior Fellow at the Center on Budget and Policy Priorities, also recently testified that there is no double counting in recognizing that Medicare savings improve the status of both the Federal budget and the Medicare Trust Funds. He gave an example, "In the same way, when a baseball player hits a homer, it both adds one run to his team's score and also improves his batting average. Neither situation involves double-counting."

Thank you again for your letter and for seeking clarity in my responses to these important questions. I look forward to continuing to work with you and your colleagues to responsibly implement the Affordable Care Act and deliver its benefits to the American people. A similar response has also been provided to Representative Pallone.

Sincerely,

Kathleen Sebelius

Kathleen Sebelius

The LEWIN GROUP®



HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING—**WITH REAL-WORLD PERSPECTIVE.**

The Impact of the Medicaid Expansions and Other Provisions of Health Reform on State Medicaid Spending

Staff Working Paper #12

Prepared by: John Sheils
Kathy Kuhmerker
Randy Haught
Joel Menges
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December 9, 2010

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About The Lewin Group

The Lewin Group is a health care and human services policy research and management consulting firm. We have over 25 years of experience in estimating the impact of major health reform proposals. The Lewin Group is committed to providing independent, objective and non-partisan analyses of policy options. In keeping with our tradition of objectivity, The Lewin Group is not an advocate for or against any legislation. The Lewin Group is part of Ingenix, Inc., which is a wholly owned subsidiary of the UnitedHealth Group. To assure the independence of its work, The Lewin Group has editorial control over all of its work products.

Executive Summary

The Affordable Care Act of 2010 (ACA, or the Act) requires most Americans to have health insurance.[1] To assure access to affordable coverage, the Act expands the Medicaid program to cover all adults living below 133 percent of the federal poverty level (FPL), including non-aged childless adults who generally are not eligible for the current Medicaid program. The Act also provides a new premium subsidy program for people living below 400 percent of the FPL ($88,000 for a family of four).

In this study, we focus on the impact of health reform on state spending for Medicaid and the Children's Health Insurance Program (CHIP). This includes the impact of several key provisions of the Act including:

- The cost of covering newly-eligible adults;
- Increases in enrollment among currently eligible people;
- Enrollment reductions due to increased employer coverage under the Act;
- New prescription drug rebates for Medicaid Managed Care Organization (MCO) plans;
- Other increases in rebates;
- The increase in federal matching funds for states that already cover adults to at least 100 percent of the FPL (the federal matching percentage is increased to 90 percent for childless adults in these states by 2020); and
- Reductions in federal disproportionate share hospital (DSH) payments of $14.1 billion nationally over the 2014 through 2019 period.

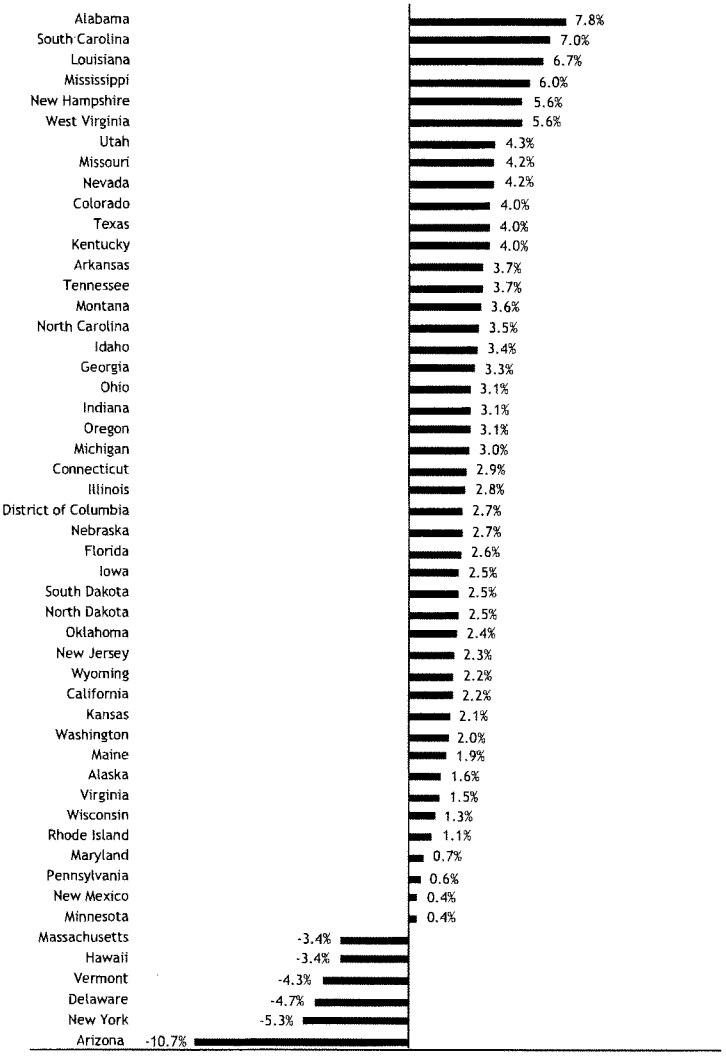
We estimate that the number of people enrolled in Medicaid or CHIP will increase by 17.4 million people by 2019 under the ACA. The Act will increase Medicaid spending by $421.3 billion over the 2014 through 2019 period, of which states would pay $17.4 billion (i.e., 4.1 percent of total new spending). For states, this is an average increase in spending of 1.1 percent over this period. However, the impact will vary across states, ranging from a spending increase of 7.8 percent in Alabama to an actual reduction in state spending of 10.7 percent in Arizona (***Figure ES-1***).

We estimate that state Medicaid spending would be reduced under the Act in Arizona, Delaware, Hawaii, New York, Massachusetts, and Vermont. All of these states see little new enrollment because they already cover most childless adults living below 133 percent of the FPL. These states also benefit from an increase in the federal match under the Act for the childless adults they already cover (reaching 90 percent by 2020, the same percentage that states that do not currently cover this group will receive for this expansion population in 2020). By contrast, states that currently have only limited coverage for adults - such as Alabama and Mississippi - will tend to see the largest percentage increases in state government spending.

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[1] The bill exempts certain individuals from the requirement to have insurance including undocumented immigrants, people who do not have enough income to be able to file taxes, and people who would find that the cost of insurance exceeds 8 percent of income.

Figure ES-1
Percent Change in State Medicaid Spending for 2014 through 2019 by State



States with large Medicaid managed care programs will also benefit substantially from the new rebates required for prescription drugs provided in managed care organizations. These include states with substantial enrollment in managed care plans such as Arizona, Pennsylvania, and California. This is especially true for Arizona, which currently enrolls all of their covered population in managed care plans.

This analysis covers only the Medicaid impacts of health reform and does not provide state level analyses of other elements of the Act that will have significant impacts on state and local government costs under the bill. For example, as employers, state and local governments that do not cover all of their full-time employees are required to pay a significant new penalty. Significant changes in employer coverage and spending will affect state tax revenues, in addition to having direct effects on the health system.

The Act will have a major impact on uncompensated care and safety net programs. Uncompensated care could be reduced by up to two-thirds as 30 million or more people become insured nationwide. Public hospitals and clinics would see increased revenues from newly insured patients that will now be covered by Medicaid or privately insured patients. Payer mix will change significantly for all types of providers now serving the uninsured. Expected increases in health services utilization for newly insured people also raise questions about the adequacy of physician supply in many areas.

All estimates of the impact of health reform are dependent upon key assumptions concerning the strength of the economy and the ways in which employers, consumers, insurers, and providers respond to elements of the Act. For example, in this analysis we relied upon economic projections developed by the Congressional Budget Office (CBO) at the national level. However, the recession and the recovery will be very different across states, with different cost implications for state governments.

The Lewin Group data and models of the heath care system provide impact analyses at both the state and county levels. We have used the model to develop estimates of changes in coverage and spending for several state governments. We are also using these data to evaluate the impact of the ACA on individual counties and metropolitan areas. In particular, the models can be used to estimate the effects of reform under various assumptions and alternative economic scenarios that are specific to individual state health systems and economies.

In addition to these services, the models can be used to evaluate options for reducing the cost of state Medicaid and CHIP programs within the maintenance of effort requirements of the Act. For example, states have the option of using alternative "benchmark" benefits packages rather than the Medicaid benefit. Also, states that now have adult income eligibility levels above 133 percent of the FPL have the option of reducing eligibility to 133 percent of the FPL. We have also assisted several states in identifying ways of minimizing costs and maximizing federal matching funds. Any or all of these alternatives could impact the findings presented in this paper.

Introduction

The Affordable Care Act of 2010 (ACA) requires most Americans to have health insurance.[2] To assure access to affordable coverage, the Act expands the Medicaid program to cover all adults living below 133 percent of the federal poverty level (FPL), including both parents and non-aged childless adults. The Act also provides a new premium subsidy program for people living below 400 percent of the FPL ($88,000 for a family of four).

In this study, we focus on the impact of health reform on state spending for Medicaid and the Children's Health Insurance Program (CHIP). This primarily includes the cost of covering newly-eligible adults and increases in enrollment among currently eligible people. It also includes changes in prescription drug rebates under the Act and increases in federal matching funds for state that already cover childless adults. States will also see a reduction in federal disproportionate share hospital (DSH) payments under the Act as the number of uninsured is reduced.

Our analysis differs from prior state-level estimates of Medicaid impacts in that we look at more than just the cost of expanded eligibility under the program. We include estimates of the effects of the drug rebate provisions and the reductions in DSH payments under the Act. We also present estimates that reflect changes in access to employer coverage under the Act and the impact this will have on Medicaid and CHIP enrollment. We do not, however, include the effects of the temporary increase in reimbursement rates for primary care providers required under the bill. This should have little impact on state spending because the federal government will pay the full cost of these payment increases.[3]

We present our analysis in the following sections:

- Current Medicaid and CHIP eligibility;
- Changes in Medicaid and CHIP eligibility under the Act;
- Changes in Medicaid and CHIP spending under health reform;
- Net impact of reform on state Medicaid spending; and
- Understanding health reform at the state level.

A. Current Medicaid and CHIP Eligibility

Eligibility for the existing Medicaid and the Children's Health Insurance Program (CHIP) varies substantially across states. Under current law, children are typically eligible for either Medicaid

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[2] The ACA exempts certain individuals from the requirement to have insurance including undocumented immigrants, people who do not have enough income to be able to file taxes, and people who would find that the cost of insurance exceeds 8 percent of income.

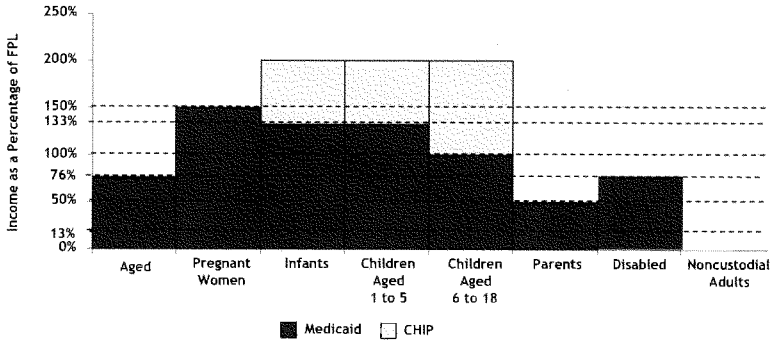
[3] The Act requires states to increase provider reimbursement rates for primary care providers to 100 percent of Medicare payment levels for similar services for 2013 and 2014, after which, states are permitted to return to lower payment rates for these services. The federal government will pay the full amount of the cost for increasing these payment rates.

or the CHIP programs if their family income is less than 200 percent of the FPL, although many states have raised the eligibility level to 300 percent or more of the FPL. Pregnant women are typically eligible through 150 percent of the FPL.

Custodial parents are typically eligible for Medicaid if their income is below an average of about 50 percent of the FPL, although this varies widely by state. For example, the income eligibility level for parents varies from 17 percent of the FPL in Arkansas to 206 percent of the FPL in Maine. Also, in all but seven states, non-disabled adults without custodial responsibilities for children (i.e., childless adults) are not eligible at *any* level of income (***Figure 1***).[4]

The federal government currently matches state spending for Medicaid and CHIP according to a Federal Medical Assistance Percentage (FMAP). Federal matching rates vary across states based upon differences in state per capita personal income levels and other factors. Although the federal contribution varies by state, the federal government currently pays for about 57 percent of the Medicaid program and about 71 percent of the CHIP program.

Figure 1: Medicaid and CHIP Eligibility for a "Typical State" Under Current Law [a/]



a/ Figures are roughly based upon average income eligibility levels across states by eligibility group.
Source: Program data from the Centers for Medicare and Medicaid Services.

In ***Figure 2*** we present state-level projections of enrollment and spending under the existing Medicaid and CHIP programs without health reform for each state over the 2014 through 2019 period.[5] These are the first six years that eligibility expansions under the health reform legislation will apply. These estimates are based upon enrollment and expenditure data for Medicaid and CHIP for 2008 and 2009, which we projected through 2019 based upon

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4 Childless adults are defined to include people age 19 to 64 who are not qualified as disabled and who do not have custodial responsibilities for children.

5 The March 2010 CBO projections of enrollment and spending without the ACA reflect that without the ACA, federal funding for CHIP is authorized through 2013 only.

enrollment and spending trends assumed by the Congressional Budget Office (CBO) in their March 2010 baseline budget assumptions.

The CBO develops a baseline projection of average monthly enrollment and spending which includes enrollment and spending projections for Medicaid and CHIP for the next ten years. In their March 2010 baseline projections, CBO projects that average monthly enrollment in Medicaid and CHIP would reach 63.6 million people in 2010 (57.6 million Medicaid and 6.0 million CHIP). CBO projects that without the ACA, enrollment would have declined to 60.2 million people by 2014 based on their assumption that the economy will improve after 2010, thus reducing enrollment. After 2014, the CBO assumes a return to historical growth rates, with steady enrollment growth through 2019, when enrollment will reach 62.4 million people.

We need to adjust these figures to limit our analysis to only those qualifying for full coverage under Medicaid. The CBO estimates include all people receiving benefits under Medicaid and CHIP including those with only partial coverage, such as people receiving family planning services only and Medicare recipients for whom Medicaid pays only the Medicare Part B premium. When we exclude those with only partial coverage, we estimate total enrollment in Medicaid and CHIP would have reached 54.7 million in 2019 without health reform.[6] Based on CBO projections, total spending without health reform would be about $3.6 trillion over the 2014 through 2019 period. The state share of spending over this period would be $1.5 trillion with the federal government paying $2.0 trillion.

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[6] Our enrollment estimates are based upon enrollment for December 2009 as compiled by Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured. The Kaiser numbers have been standardized to comparable definitions of enrollment, which excludes people receiving partial benefits, such as family planning or Medicare Part B payments only. We did not use enrollment data for 2010 because the programs are expected to reach a peak level of enrollment during 2010 due to the recession and will start to fall in 2011. Our judgment was that the 2009 data are more indicative of enrollment in the years of recovery following 2010.

Figure 2: Projections of Enrollment and State and Federal Spending for Medicaid and CHIP by State Without Health Reform: 2014-2019

	Medicaid/CHIP Enrollment in 2019 Without Reform (thousands) [a/]	Expenditures for Medicaid/CHIP Without Reform: 2014-2019 (millions) [b/]		Total Expenditures Without Reform (millions)	Federal Matching Percentage (FMAP) [c/]	
		State Share	Federal Share		Medicaid	CHIP
Alabama	839.2	$13,408	$28,793	$42,201	68.01%	77.98%
Alaska	105.8	$4,494	$4,799	$9,293	51.43%	65.00%
Arizona	1,323.9	$26,617	$51,407	$78,024	65.75%	76.10%
Arkansas	597.1	$9,489	$25,614	$35,103	72.78%	79.96%
California	7,985.3	$207,062	$210,938	$418,000	50.00%	65.00%
Colorado	563.1	$16,747	$16,997	$33,744	50.00%	65.00%
Connecticut	497.6	$23,176	$23,241	$46,418	50.00%	65.00%
Delaware	191.0	$5,635	$5,716	$11,350	50.21%	67.21%
District of Columbia	157.9	$4,433	$10,368	$14,800	70.00%	79.00%
Florida	2,990.8	$68,890	$84,918	$153,808	54.98%	68.82%
Georgia	1,651.9	$27,096	$51,149	$78,245	65.10%	75.73%
Hawaii	253.0	$5,721	$6,825	$12,545	54.24%	66.25%
Idaho	225.5	$3,893	$8,914	$12,808	69.40%	78.20%
Illinois	2,537.9	$61,023	$62,330	$123,353	50.17%	65.14%
Indiana	1,047.7	$21,735	$42,343	$64,078	65.93%	76.56%
Iowa	443.3	$10,814	$18,963	$29,777	63.51%	73.84%
Kansas	314.8	$9,419	$14,476	$23,896	60.38%	71.34%
Kentucky	848.5	$14,501	$35,670	$50,171	70.96%	80.04%
Louisiana	1,059.2	$20,640	$43,361	$64,001	67.61%	74.53%
Maine	296.6	$8,162	$15,233	$23,394	64.99%	74.66%
Maryland	815.4	$30,190	$30,664	$60,853	50.00%	65.00%
Massachusetts	1,263.4	$57,000	$57,790	$114,790	50.00%	65.00%
Michigan	1,954.9	$37,662	$65,214	$102,876	63.19%	76.05%
Minnesota	742.1	$35,923	$36,139	$72,062	50.00%	65.00%
Mississippi	673.8	$9,859	$30,971	$40,830	75.67%	82.31%
Missouri	904.0	$25,901	$47,277	$73,178	64.51%	74.30%
Montana	112.5	$2,677	$5,599	$8,276	67.42%	76.77%
Nebraska	226.6	$6,567	$10,170	$16,736	60.56%	70.91%
Nevada	267.7	$6,880	$7,015	$13,895	50.16%	66.13%
New Hampshire	141.6	$6,434	$6,460	$12,894	50.00%	65.00%
New Jersey	967.7	$50,470	$51,450	$101,921	50.00%	65.00%
New Mexico	484.9	$9,329	$23,496	$32,825	71.35%	78.85%

Figure 2: Projections of Enrollment and State and Federal Spending for Medicaid and CHIP by State Without Health Reform: 2014-2019 (continued)

	Medicaid/CHIP Enrollment in 2019 Without Reform (thousands) [a/]	Expenditures for Medicaid/CHIP Without Reform: 2014-2019 (millions) [b/]		Total Expenditures Without Reform (millions)	Federal Matching Percentage (FMAP) [c/]	
		State Share	Federal Share		Medicaid	CHIP
New York	5,163.3	$243,775	$244,766	$488,542	50.00%	65.00%
North Carolina	1,499.8	$37,146	$70,008	$107,154	65.13%	75.30%
North Dakota	69.9	$2,077	$3,568	$5,646	63.01%	72.25%
Ohio	2,088.2	$49,606	$86,633	$136,239	63.42%	74.58%
Oklahoma	664.3	$13,250	$24,263	$37,513	64.43%	75.46%
Oregon	482.8	$12,524	$21,270	$33,794	62.74%	74.00%
Pennsylvania	2,302.1	$76,058	$92,869	$168,927	54.81%	68.95%
Rhode Island	184.8	$9,261	$10,467	$19,727	52.63%	67.08%
South Carolina	727.9	$13,571	$32,294	$45,865	70.32%	79.03%
South Dakota	111.7	$2,565	$4,354	$6,919	62.72%	72.88%
Tennessee	1,377.7	$25,404	$48,590	$73,994	65.57%	76.10%
Texas	3,591.5	$94,004	$135,871	$229,875	58.73%	72.39%
Utah	285.3	$4,548	$11,628	$16,176	71.68%	79.79%
Vermont	145.6	$4,095	$5,840	$9,934	58.73%	71.10%
Virginia	863.1	$28,371	$28,769	$57,141	50.00%	65.00%
Washington	1,097.4	$32,008	$32,247	$64,255	50.12%	65.00%
West Virginia	367.0	$6,116	$17,525	$23,641	74.04%	81.27%
Wisconsin	1,084.9	$20,568	$31,333	$51,901	60.21%	72.11%
Wyoming	71.5	$2,568	$2,595	$5,163	50.00%	65.00%
Total US	54,663.3	$1,519,362	$2,039,192	$3,558,553	57.07%	71.00%

a/ Based upon average monthly enrollment in December 2009 projected to 2019 using CBO March 2010 baseline assumptions on enrollment growth through 2019. These estimates reflect the CBO assumptions that the economy improves by the middle of the decade. Estimates exclude people receiving only partial benefits such as recipients of family planning services and Medicare beneficiaries receiving payment of their Medicare Part B premium. Estimates include enrollment in the CHIP program.

b/ Based upon state-level spending in 2008 projected through 2019 using CBO assumptions on enrollment and expenditure growth through 2019. Expenditures do not include administrative costs, accounting adjustments, or expenditures in the U.S. Territories.
http://www.statehealthfacts.org/comparemaptable.jsp?ind=177&cat=4

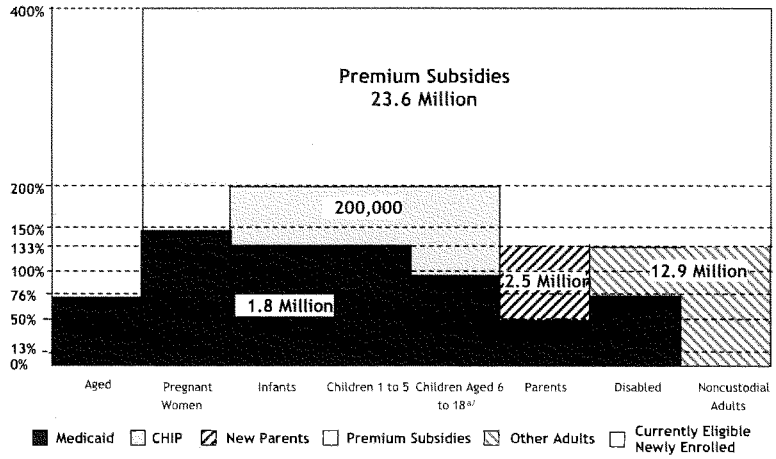
c/ Original FMAP for 2010 without additional amount included in the American Recovery and Reinvestment Act (ARRA).
http://www.statehealthfacts.org/comparemaptable.jsp?ind=695&cat=4

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

B. Changes in Medicaid and CHIP Eligibility under the Act

Effective January 1, 2014, the Act requires states to cover all adults under age 65 with incomes up to 133 percent of the FPL ($14,404 single; $19,378 married couples), including parents with children and non-aged individuals without custodial responsibilities for children (*Figure 3*). The federal government will pay 100 percent of the cost of this expansion for adults through 2016. Starting in 2017, the percentage of costs paid by the federal government for these adults will phase down to 90 percent by 2020, leaving states to pay the remaining 10 percent.

Figure 3: Number of People Affected by Expansions in Publicly Subsidized Coverage under the Act



Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

States are required to maintain existing Medicaid eligibility levels until the new premium subsidies become available in 2014. At that time, states that already cover adults above 133 percent of the FPL are permitted to reduce these eligibility levels to 133 percent of the FPL. These individuals would be eligible for the premium and cost-sharing subsidies available through the newly established exchanges. States must also cover children between 100 percent and 133 percent of the FPL under Medicaid rather than under the CHIP program.

States are also required to maintain their CHIP programs through 2019. Federal CHIP funds are authorized through 2015 only, although many states will draw down their allotment of CHIP funding after 2016. Beginning in 2016, the match rate for CHIP is increased by 23 percentage points, up to a maximum of 100 percent, to permit states to draw down their federal CHIP funds more quickly. When a state's federal CHIP funds are exhausted, the matching rate for these children reverts to the regular Medicaid matching rate.

We estimate that these changes will result in a net increase in Medicaid enrollment of about 17.4 million people by 2019. These include 2.5 million newly eligible parents and 12.9 million newly eligible childless adults. This also includes a net increase in enrollment of 2.0 million people among currently eligible but not enrolled groups. In addition, we estimate that about 23.6 million people will receive premium subsidies through the exchange. ***Figure 4*** presents our estimates of changes in enrollment for the 50 states and the District of Columbia.

These estimates also reflect changes in the availability of employer coverage as a result of the Act. For example, the Act provides a small employer tax credit to encourage employers to offer coverage. The Act also creates a penalty of up to $2,000 per worker for firms that do not offer insurance to their workers. On the other hand, many firms are likely to discontinue their coverage once subsidized coverage becomes available to their workers.

In an earlier Lewin Group analysis of the health reform bill, we estimated that up to 14 million people would acquire employer coverage nationally, largely as a result of newly created employer plans.[7] This includes about 1.6 million people shifting from Medicaid to private insurance ***(Figure 4).*** However, we also estimated that 17 million people would lose employer coverage in cases where employers choose to discontinue their plans. This would result in about 3.7 million people who now have employer coverage shifting to Medicaid nationwide.

Methods: Estimation of Eligibility and Enrollment

We estimated the impact of these coverage expansions using the March Current Population Survey (CPS) data for 2007 through 2009. These data provide the detailed health coverage information required to estimate the number of people potentially eligible for Medicaid and CHIP under current law and under the expansions for people in each of the 50 states and the District of Columbia.

We used the Lewin Group Health Benefits Simulation Model (HBSM) to estimate eligibility using the income eligibility rules used in each state. We incorporate a correction for underreporting of Medicaid enrollment in surveys such as the CPS for each individual state. We projected coverage to future years based upon the March 2010 baseline projections developed by the Congressional Budget Office, which assume an improved economy by 2014.

We simulated the decision for newly eligible people to enroll in the program based upon a multivariate model of enrollment in the existing program which reflects differences in enrollment by age, income, employment status, and demographic characteristics. The simulation results in average enrollment of about 75 percent of newly eligible uninsured people and 39 percent for newly eligible people who have access to employer health insurance. HBSM simulates eligibility on a month-by-month basis to capture part-year eligibility for the program.

[7] "Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Government, Employer, Families and Providers," Staff Working Paper # 11, June 8, 2010. http://www.lewin.com/content/publications/LewinGroupAnalysis-PatientProtectionandAffordableCareAct2010.pdf

Figure 4: Changes in the Number of People Covered under Medicaid and CHIP under the ACA in 2019 (thousands) [a/]

	Medicaid/CHIP Enrollment Without Reform [b/]	Current Enrollees Shifting to Private [c/]	Currently Eligible [d/]		Newly Eligible [e/]		Total Net Change in Enrollment	Percent Change in Enrollment
			Children: Medicaid and CHIP	Parents	Parents	Non-custodial Adults [f/]		
Alabama	839.2	-16.4	17.8	26.6	70.6	244.1	342.7	40.8%
Alaska	105.8	-2.6	2.7	3.8	5.8	36.7	46.4	43.8%
Arizona	1,323.9	-57.6	49.1	90.8	1.1	14.3	97.8	7.4%
Arkansas [g/]	597.1	-17.9	11.1	17.9	56.7	161.7	229.5	38.4%
California	7,985.3	-251.3	219.7	374.2	193.6	1,791.2	2,327.3	29.1%
Colorado	563.1	-18.6	31.9	39.6	33.0	218.1	304.2	54.0%
Connecticut	497.6	-16.8	8.1	19.9	3.0	149.3	163.5	32.9%
Delaware	191.0	-4.4	2.4	6.3	1.8	4.7	10.8	5.6%
District of Columbia	157.9	-3.6	1.1	4.4	0.0	29.1	31.0	19.6%
Florida	2,990.8	-78.2	131.2	86.5	239.3	824.9	1,203.6	40.2%
Georgia	1,651.9	-47.0	61.7	49.4	135.9	463.6	663.7	40.2%
Hawaii	253.0	-4.7	3.1	6.3	6.8	55.9	67.4	26.6%
Idaho	225.5	-8.4	9.8	7.2	24.8	65.7	99.1	44.0%
Illinois	2,537.9	-62.8	43.0	77.4	14.5	652.8	724.9	28.6%
Indiana	1,047.7	-27.4	22.0	33.5	65.0	240.4	333.4	31.8%
Iowa	443.3	-13.9	9.3	16.8	25.1	104.1	141.5	31.9%
Kansas	314.8	-12.1	14.1	13.3	29.5	118.1	163.0	51.8%
Kentucky	848.5	-19.5	14.8	30.9	54.9	217.3	298.5	35.2%
Louisiana	1,059.2	-22.0	32.3	28.1	91.9	279.3	409.6	38.7%
Maine	296.6	-6.8	2.3	8.6	1.2	51.0	56.2	18.9%
Maryland	815.4	-18.7	15.6	26.4	10.3	257.4	291.0	35.7%
Massachusetts	1,263.4	-42.8	0.6	3.0	1.6	14.5	-23.1	-1.8%
Michigan	1,954.9	-36.7	29.6	91.4	66.6	524.2	675.1	34.5%
Minnesota	742.1	-26.8	20.1	35.1	31.0	206.2	265.6	35.8%
Mississippi	673.8	-15.7	18.2	22.5	65.8	185.3	276.1	41.0%
Missouri	904.0	-30.7	27.7	34.0	80.6	278.3	390.0	43.1%
Montana	112.5	-4.0	4.0	5.7	11.9	52.3	69.9	62.1%
Nebraska	226.6	-6.9	8.5	7.8	19.5	72.3	101.3	44.7%
Nevada	267.7	-10.5	20.7	10.9	28.0	106.9	156.0	58.3%
New Hampshire	141.6	-4.9	2.5	5.0	8.5	51.4	62.5	44.2%
New Jersey	967.7	-35.5	38.6	44.1	8.0	350.6	405.8	41.9%
New Mexico	484.9	-13.3	17.8	23.6	16.5	109.6	154.2	31.8%

Figure 4: Changes in the Number of People Covered under Medicaid and CHIP under the ACA in 2019 (thousands) [a/] (continued)

	Medicaid/CHIP Enrollment Without Reform [b/]	Current Enrollees Shifting to Private [c/]	Currently Eligible [d/]		Newly Eligible [e/]		Total Net Change in Enrollment	Percent Change in Enrollment
			Children	Parents	Parents	Non-custodial Adults [f/]		
New York	5,163.3	-166.6	53.1	170.0	0.2	121.1	177.8	3.4%
North Carolina	1,499.8	-44.0	45.8	56.1	132.0	450.5	640.4	42.7%
North Dakota	69.9	-1.8	2.2	2.5	4.8	24.7	32.5	46.6%
Ohio	2,088.2	-37.7	34.8	86.4	36.7	639.6	759.7	36.4%
Oklahoma	664.3	-19.3	20.9	19.5	58.6	169.1	248.9	37.5%
Oregon	482.8	-16.0	17.5	38.3	29.3	199.1	268.3	55.6%
Pennsylvania	2,302.1	-51.9	42.8	68.2	99.1	563.1	721.3	31.3%
Rhode Island	184.8	-5.6	3.2	7.3	0.0	47.0	51.9	28.1%
South Carolina	727.9	-15.5	16.3	39.1	30.6	242.9	313.3	43.0%
South Dakota	111.7	-3.3	3.8	3.0	9.0	31.3	43.8	39.3%
Tennessee	1,377.7	-31.8	22.4	58.2	42.2	295.6	386.6	28.1%
Texas	3,591.5	-182.7	306.7	153.3	491.4	1,129.0	1,897.7	52.8%
Utah	285.3	-12.0	19.3	10.6	31.7	98.5	148.1	51.9%
Vermont	145.6	-5.3	1.5	5.0	0.5	2.5	4.3	2.9%
Virginia	863.1	-25.8	31.2	25.4	76.3	300.8	407.9	47.3%
Washington	1,097.4	-27.0	19.1	49.2	25.0	265.5	331.7	30.2%
West Virginia	367.0	-8.1	4.4	11.5	27.4	104.0	139.2	37.9%
Wisconsin	1,084.9	-25.6	13.5	32.5	5.6	234.0	260.0	24.0%
Wyoming	71.5	-1.9	2.2	2.4	6.7	26.1	35.4	49.5%
Total US	54,663.3	-1,620.2	1,552.3	2,089.4	2,510.3	12,875.2	17,407.1	31.8%

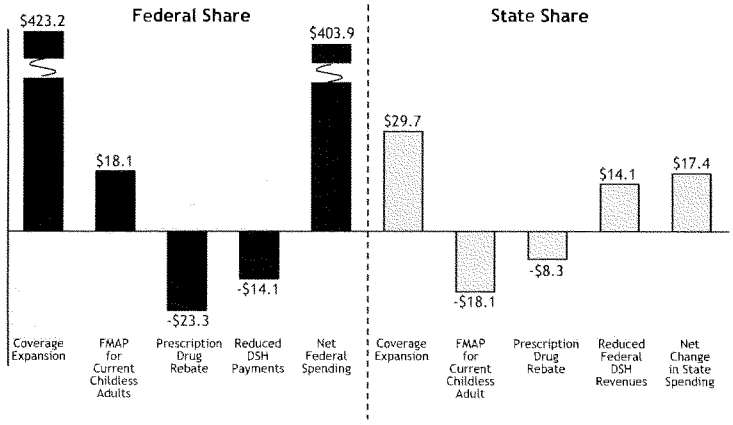
a/ Estimates include Medicaid and CHIP enrollment.
b/ Based upon enrollment in December 2009 projected to 2019 using CBO assumptions on enrollment growth through that year.
c/ Includes currently enrolled working families who take coverage from an employer who decides to start offering coverage as a result of the ACA. These include employers who start to offer coverage due to the small employer tax credit, the penalty for not offering coverage, or in response to changes in premiums due to rating reforms.
d/ Includes currently eligible but not enrolled children who automatically become covered as a newly eligible parent becomes covered under the expanded Medicaid program. Also includes increased enrollment among currently eligible but not enrolled people in response to the penalty for remaining uninsured. Under the Act, the penalty applies only to adults with incomes over the tax filing threshold.
e/ Based upon an HBSM simulation of expanding eligibility for Medicaid in each state. We simulate the decision for newly eligible people to enroll in the program based upon a multivariate model of enrollment in the existing program which reflects differences in enrollment by age,

income, employment status, and demographic characteristics. The simulation results in average enrollment of about 75 percent of newly eligible uninsured people and 39 percent for newly eligible people who have access to employer health insurance.
f/ Includes adults who do not otherwise qualify as aged, disabled, or a parent with custodial responsibilities for children.
g/ Estimates are relative to the Arizona 2010 baseline spending projection, which predates the state's discontinuation of CHIP and the proposition 204 Section 1115 eligibility expansion.
Source: Lewin Group Estimates using the Health Benefits Simulation Model (HBSM).

C. Changes in Medicaid and CHIP Spending under Health Reform

Total spending under the Medicaid and CHIP programs will increase by $421.3 billion over the 2014 through 2019 period under the Act (see ***Attachment A***). This is roughly a 12 percent increase in total program spending of $3.6 trillion over this period without health reform. The federal share of spending would increase by $403.9 billion (19.1 percent) over this period, while state Medicaid spending would increase by $17.4 billion (1.1 percent).

Figure 5: Summary of Changes in Spending for States and the Federal Government for Medicaid and CHIP: 2014-2019 (billions)



Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

These estimates include the cost of increased enrollment in Medicaid and three other major features of the Act. These include the increase in Medicaid enrollment, the increase in prescription drug rebates under the ACA, and a scheduled reduction in Federal Disproportionate Share Hospital (DSH) payments of $14.1 billion. It also reflects increased federal matching funds for states that already cover childless adults under an 1115 Medicaid Waiver.

1. Expanded Enrollment

Most of the increase in spending for both the federal and state governments would be attributed to the expansion in eligibility and other enrollment shifts under the Act. As discussed above, we estimate that Medicaid enrollment will increase by 17.4 million people under the act by 2019. Total spending for these people would be $452.9 billion over the 2014 through 2019 period, with the federal government paying $423.2 billion, which does not include the effect of other provisions affecting spending such as the changes in drug rebates. States would pay $29.7 billion of the costs for these newly enrolled people, which is about 6.6 percent of total spending under the Medicaid expansion.

The 17.4 million newly enrolled people include 2.5 million newly eligible parents and 12.9 million newly eligible childless adults. We also project an increase in enrollment among currently eligible but not enrolled children and adults. This includes 1.5 million children under Medicaid or CHIP and about 2.1 million parents of children now enrolled in Medicaid. This would be partly offset by a shift of 1.6 million current enrollees to private insurance in cases where employers decide to start offering insurance in response to the small employer tax credit and the penalties for non-insuring employers.

Methods: Enrollment for Currently Eligible Children and Parents

We assume that currently eligible but not enrolled children will be enrolled as a newly eligible parent becomes covered under Medicaid. Also, we assume that eligible families will enroll in instances where the parent loses employer coverage because their employer decides to discontinue their health plan (discussed above). We also simulated a small increase in enrollment due to the penalty for Medicaid eligible people with income high enough to be required to pay taxes.

The 17.4 million person increase in Medicaid and CHIP enrollment represents a 31.8 percent increase in program enrollment nationwide. All states except Massachusetts would experience increased enrollment ranging from 2.9 percent in Vermont to 62.1 percent in Montana (***Figure 4 above***). Enrollment increases will be less than 6 percent in states that already cover childless adults to the FPL or higher income levels such as New York, Delaware, and Vermont.

Enrollment in Massachusetts actually declines by 1.8 percent, which reflects the state's existing program to cover the uninsured. Massachusetts already has a coverage mandate and has expanded eligibility for parents and childless adults under Medicaid, resulting in only a small increase in enrollment due to the ACA eligibility expansions. At the same time, we estimate that about 43,000 Massachusetts Medicaid and CHIP recipients will become covered by an employer plan under the Act, in response to the small group tax credit and the penalty for not offering coverage. This results in a net reduction in enrollment of 23,100 people in 2019.

2. State Spending for Medicaid

As discussed above, we estimate that state Medicaid spending will increase by $17.4 billion nationwide. ***Figure 6*** presents our estimates of the impact the program will have on state Medicaid spending including changes due to increased drug rebates, changes in federal DSH payments, and changes in federal matching rates for states that already cover childless adults through 100 percent of the FPL under an 1115 Medicaid Waiver.

We show that the state share of Medicaid spending would increase over the 2014 through 2019 period for all states except Delaware, New York, Hawaii, Massachusetts, Vermont, and Arizona. These states do not experience an increase in state costs because they have already extended eligibility to parents and childless adults and generally benefit from the increased federal match for the childless adults they now cover.

Figure 6: Changes in State Medicaid and CHIP Spending for Major Provisions of the ACA: 2014-2019 (millions) [a/]

	State Medicaid/CHIP Spending Without Reform [b/]	Take Private Coverage [c/]	Currently Eligible Newly Enrolled [d/]	Newly Eligible Parents [e/]	Newly Eligible Childless Adults [e,f/]	Increased Match For Expansion States [g/]	Changes in Drug Rebates [h/]	Illustrative Reduction in Federal DSH Payments [i/]	Net Change in Spending Under ACA	Percent Change in Spending
Alabama	$14,245	-$152	$310	$75	$331	$0	$20	$520	$1,104	7.8%
Alaska	$4,726	-$52	$69	$6	$34	$0	$5	$11	$73	1.6%
Arizona [j/]	$27,901	-$478	$1,095	$1	$24	-$2,953	-$771	$109	-$2,974	-10.7%
Arkansas	$10,137	-$139	$186	$65	$228	$0	$13	$26	$379	3.7%
California	$222,772	-$2,908	$6,051	$172	$1,352	$0	-$1,030	$1,203	$4,839	2.2%
Colorado	$17,855	-$264	$689	$29	$203	$0	-$54	$116	$719	4.0%
Connecticut	$23,991	-$156	$301	$3	$113	$0	$28	$418	$707	2.9%
Delaware	$5,867	-$69	$98	$2	$7	-$324	$8	$3	-$276	-4.7%
District of Columbia	$4,595	-$26	$48	$0	$23	$0	-$47	$127	$126	2.7%
Florida	$72,587	-$898	$1,830	$216	$972	$0	-$422	$201	$1,900	2.6%
Georgia	$28,920	-$419	$811	$130	$506	$0	-$371	$306	$963	3.3%
Hawaii	$5,998	-$68	$70	$5	$41	-$136	-$79	$25	-$142	-2.4%
Idaho	$4,140	-$78	$95	$27	$83	$0	$5	$11	$142	3.4%
Illinois	$64,997	-$538	$1,450	$16	$506	$0	$74	$331	$1,838	2.8%
Indiana	$22,819	-$266	$424	$71	$294	$0	-$192	$365	$696	3.1%
Iowa	$11,395	-$198	$267	$32	$133	$0	$12	$43	$287	2.5%
Kansas	$9,950	-$135	$213	$31	$120	$0	-$89	$67	$207	2.1%
Kentucky	$15,242	-$211	$342	$66	$292	$0	-$83	$199	$604	4.0%
Louisiana	$21,861	-$182	$352	$93	$380	$0	$31	$783	$1,457	6.7%
Maine	$8,549	-$61	$86	$1	$40	-$137	$10	$222	$161	1.9%
Maryland	$32,246	-$244	$573	$12	$227	$0	-$466	$120	$223	0.7%
Massachusetts	$60,615	-$682	$35	$1	$17	-$941	-$499	$0	-$2,068	-3.4%
Michigan	$39,625	-$466	$1,075	$69	$571	$0	-$537	$460	$1,172	3.0%
Minnesota	$37,481	-$244	$487	$25	$160	$0	-$378	$89	$140	0.4%
Mississippi	$10,555	-$109	$207	$72	$290	$0	$11	$168	$638	6.0%
Missouri	$27,012	-$346	$517	$98	$363	$0	-$163	$665	$1,133	4.2%
Montana	$2,857	-$60	$71	$14	$66	$0	$3	$7	$101	3.6%
Nebraska	$6,950	-$77	$131	$21	$83	$0	$9	$23	$189	2.7%
Nevada	$7,289	-$129	$279	$26	$109	$0	-$32	$52	$306	4.2%
New Hampshire	$6,681	-$70	$77	$8	$44	$0	$5	$312	$377	5.6%

Figure 6: Changes in State Medicaid and CHIP Spending for Major Provisions of the ACA: 2014-2019 (millions) [a/] (continued)

	State Medicaid/CHIP Spending Without Health Reform [b/]	Take Private Coverage [c/]	Currently Eligible Newly Enrolled [d/]	Newly Eligible Parents [e/]	Newly Eligible Childless Adults [e,f/]	Increased Match For Expansion States [g/]	Changes in Drug Rebates [h/]	Illustrative Reduction in Federal DSH Payments [i/]	Net Change in Spending Under ACA	Percent Change in Spending
New Jersey	$54,389	-$283	$844	$8	$231	$0	-$402	$877	$1,275	2.3%
New Mexico	$10,031	-$87	$226	$14	$105	$0	-$222	$9	$45	0.4%
New York	$210,298	-$1,265	$1,383	$0	$64	-$13,420	$236	$1,777	-$11,226	-5.3%
North Carolina	$39,336	-$464	$730	$136	$555	$0	$50	$374	$1,382	3.5%
North Dakota	$2,203	-$23	$36	$5	$26	$0	$2	$9	$55	2.5%
Ohio	$52,150	-$478	$1,299	$49	$721	$0	-$702	$711	$1,599	3.1%
Oklahoma	$14,083	-$242	$278	$62	$201	$0	$16	$23	$338	2.4%
Oregon	$13,218	-$188	$490	$31	$224	$0	-$180	$26	$403	3.1%
Pennsylvania	$79,558	-$911	$1,013	$95	$537	$0	-$1,433	$1,162	$464	0.6%
Rhode Island	$9,943	-$54	$103	$0	$31	$0	-$84	$117	$113	1.1%
South Carolina	$14,169	-$159	$427	$36	$316	$0	-$36	$413	$995	7.0%
South Dakota	$2,718	-$36	$47	$10	$35	$0	$3	$10	$68	2.5%
Tennessee	$26,475	-$218	$628	$43	$341	$0	$32	$143	$969	3.7%
Texas	$100,649	-$1,628	$3,313	$406	$1,049	$0	$112	$770	$4,022	4.0%
Utah	$4,854	-$110	$159	$33	$105	$0	$6	$15	$209	4.3%
Vermont	$4,236	-$72	$11	$0	$0	-$170	$6	$41	-$184	-4.3%
Virginia	$30,183	-$333	$561	$77	$328	$0	-$301	$129	$461	1.5%
Washington	$33,121	-$437	$797	$26	$255	$0	-$275	$313	$679	2.0%
West Virginia	$6,404	-$80	$128	$38	$167	$0	$12	$94	$360	5.6%
Wisconsin	$21,572	-$217	$408	$6	$174	$0	-$191	$107	$286	1.3%
Wyoming	$2,708	-$31	$49	$7	$33	$0	$3	$0	$61	2.2%
Total US	**$1,562,160**	**-$17,041**	**$31,166**	**$2,470**	**$13,113**	**-$18,081**	**-$8,332**	**$14,100**	**$17,395**	**1.1%**

a/ These estimates reflect the phase-in of provisions under the law and reflect lags in enrollment that are expected in the early years of the program. Costs are based upon reported spending amounts in the Medical Expenditures Panel Survey (MEPS) data for people with similar characteristics, which reflect the unique demographic characteristics of the newly eligible populations. The MEPS data are adjusted to simulation year based upon CBO projections of expenditure growth for adults. Estimates include the CHIP program.
b/ Based upon state-level spending in 2008 projected to 2019 using CBO assumptions on enrollment and expenditure growth through 2019.
c/ Includes currently enrolled working families who take coverage through an employer who decides to start offering coverage as a result of the incentives created under the ACA. These include employers who start to offer coverage due to the small employer tax credit, the penalty for not offering coverage, or in response to changes in premiums due to rating reforms.

d/ Includes currently eligible but not enrolled children who automatically become covered as a newly eligible parent becomes covered under the expanded Medicaid program. Also includes increased enrollment among currently eligible but not enrolled people in response to the penalty for remaining uninsured. (This applies only to adults with incomes over the tax filing thresholds that are subject to penalties.)
e/ Based upon an HBSM simulation of expanding eligibility for Medicaid in each state. We simulated the decision for newly eligible people to enroll in the program based upon a multivariate model of enrollment in the existing program which reflects differences in enrollment by age, income, employment status and demographic characteristics. The simulation results in average enrollment of about 75 percent for newly eligible uninsured people and 39 percent for newly eligible people who have access to employer health insurance.
f/ Includes adults who do not otherwise qualify as aged, disabled, or a parent with custodial responsibilities for children.
g/ The law would gradually increase the federal matching percentage to 90 percent by 2020 for non-custodial adults already covered under a Medicaid 1115 Waiver. These states include Arizona, Delaware, Hawaii, Maine, Missouri, New York, and Vermont.
h/ The Act increases the rebates received by Medicaid from prescription drug companies, including increases in rebate amounts and rebates for Medicaid beneficiaries covered by states under private health plans. Recently released guidance from the Department of Health and Human Services (DHHS) indicate that many states will share in these increased rebates.
i/ The ACA would reduce federal Medicaid Disproportionate Share Hospital Payments by $14.1 billion over the 2014 through 2019 period. (DSH are supplemental payments to hospitals serving a disproportionate share of Medicaid beneficiaries and/or uninsured people). The ACA requires the Secretary of DHHS to develop rules for allocating the cuts to states in proportion to the number of uninsured in the state, which is reduced for states designated as "low" DSH states. The reduction does not apply to DSH funds used to fund an expansion under an 1115 Waiver. We illustrated the potential impact of this provision using a formula that is generally consistent with what is required in the legislation.
j/ Estimates are relative to the Arizona 2010 baseline spending projection, which predates the state's discontinuation of CHIP and the proposition 204 Section 1115 eligibility expansion.
Source: Lewin Group Estimates using the Health Benefits Simulation Model (HBSM).

Our estimate of the effect of health reform in Arizona is complicated by the fact that just prior to the ACA, Arizona eliminated its CHIP program beginning June 15, 2010, and its adult coverage expansion (proposition 204) beginning January 1, 2011. Under the maintenance of effort (MOE) provisions of the ACA, the state must maintain its current Medicaid and CHIP programs as of March 23, 2010. This means that the state must reinstate these programs to continue to qualify for federal Medicaid funding. Arguably, the net cost of the ACA for Arizona should include the cost of reinstating this coverage due to the ACA MOE provisions. This would more than offset the savings we present in ***Figure 6*** for Arizona, resulting in a substantial net increase in estimated spending.[8]

3. Prescription Drug Rebates

States will save $8.3 billion over the 2014 through 2019 period from increased prescription drug rebates under the Act. Under current law, drug manufacturers are required to pay rebates to Medicaid for drugs provided under the fee-for-service Medicaid program. In addition, many states negotiate "supplemental" rebates with drug manufacturers.

The ACA requires manufacturers to begin paying rebates on drugs provided through Medicaid managed care organizations (MCOs).[9] For brand name drugs, the minimum rebate is increased from 15.1 percent of average manufacturer price (AMP) to 23.1 percent of AMP. Rebates for generic drugs are increased from 11.0 percent of AMP to 13.0 percent of AMP. It also changes how the additional inflationary rebate on line extensions of a brand name drug is calculated.

In addition, the Act requires that the amounts "attributable" to these increased rebates be passed on (offset) to the Federal government. In a recent letter to State Medicaid Directors (SMDL#10-019), issued September 28, 2010, CMS provided guidance that this offset would apply only to rebate dollars that are collected above and beyond what would have been received under the previous rebate formulas.

Methods: Modeling the Prescription Drug Rebate Provisions of the ACA

To estimate the impact of the drug rebate provisions in ACA, we estimated state-level pharmacy expenditures under fee-for-service (FFS) and Medicaid managed care using Medicaid Statistical Information System (MSIS) data. For Medicaid FFS expenditures, we estimated a net increase in pharmacy costs of approximately 1.5 percent due to a decrease in supplemental rebates. For Medicaid MCO expenditures, we estimated savings of approximately 30 percent as MCO utilization will now have access to the large Federally-mandated rebates. These impacts will be shared by the states and the Federal government. In addition, we estimated that the Federal government will save an additional 4 percent due to increased rebate levels mandated by the ACA.

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[8] The Joint Legislative Budget Committee (JLBC) of the Arizona state legislature estimated that if the cost of reinstating these programs is included, the coverage provisions of the Act will actually increase by $6.7 billion over the 2011 through 2019 period. See: "Analysis of the Cost of Federal Health Care Legislation," JLBC report, March 30, 2010.

[9] This will only affect plans where prescription drugs are included in the MCO capitation. Medicaid already receives rebates for prescription drugs provided as a "carve out" from the MCO plan.

We estimate that about half of all states will see net savings as a result of these changes in drug rebate policy. Savings will be particularly large for states that currently have a large portion of their covered population enrolled in MCOs with the drug expense included in the capitation amount (i.e., state where a pharmacy "carve in" model is used), where the drug manufacturers must start to pay a rebate. These include Arizona, California, and Pennsylvania.

However, in response to these increases in required rebates, drug manufacturers are expected to be less willing to provide supplemental rebates to states. Consequently, we estimate that when these reductions in supplemental rebates are included, about half of the states will experience a net reduction in rebates.

4. Disproportionate Share Hospital Payments (DSH)

The ACA will reduce payments to states under the Disproportionate Share Hospital (DSH) program. Under the DSH program, the federal government makes payments to states that are intended to provide additional funds for hospitals treating a disproportionate share of the Medicaid and uninsured populations. However, several states have used some or all of these funds to pay for an expansion in eligibility and coverage under a Medicaid 1115 Waiver program. The Congressional Budget Office (CBO) estimates that payments will be $8.1 billion in 2010 (excluding amounts added under the economic recovery legislation), rising to $10.5 billion by 2019.[10]

The Act specifies that total federal DSH payments will be reduced by $14.1 billion over the 2014 through 2019 period, reflecting the expected reduction in the number of uninsured under the ACA. Reductions will be as follows:

- $0.5 billion in 2014
- $0.6 billion in 2015
- $0.6 billion in 2016
- $1.8 billion in 2017
- $5.0 billion in 2018
- $5.6 billion in 2019
- $4.0 billion in 2020

The Act does not specify the amount of the reductions by state, but directs the Secretary to develop a methodology subject to several guidelines specified in the legislation. The methodology must:

- Impose the largest percentage reductions on states with the largest projected percentage reductions of uninsured or those that do not target funds to hospitals with high volumes of Medicaid recipients or uncompensated care;

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[10] "Spending and Enrollment Data for CBO's March 2010 Baseline: Medicaid", Congressional Budget Office, http://www.cbo.gov/ftpdocs/115xx/doc11521/CHIP.pdf

- Take into account the extent to which the DSH allotment is included in the budget neutrality calculation for an expansion in coverage under an 1115 Waiver; and
- Impose a smaller percentage reduction on the 16 states designated as "low-DSH" states.

For illustrative purposes, we estimated the amount of the DSH reduction for each state using an algorithm that meets the general requirements specified in the legislation. We assumed the DSH reductions would not apply to the portion of DSH used to fund 1115 Waiver expansions. We assumed that the percentage reduction in DSH is in proportion to the percentage of the population without insurance. We also assumed that the DSH reductions are reduced by 50 percent for low-DSH states and that the amounts are then adjusted to the amount of the DSH reduction required under the Act. These estimates should be treated as illustrative only because the algorithm developed by the Secretary is likely to differ from our assumed specifications.

We present our illustrative estimates of these DSH reductions by state in ***Figure 6*** above. DSH payments would be reduced by about $1.2 billion in California, $1.8 billion in New York, and $1.2 billion in Pennsylvania. However, six states would see a reduction in DSH of less than $10.0 million over the 2014 through 2019 period, primarily because they currently receive little DSH funding.

5. *Increased Match for Childless Adults in Expansion States*

As discussed above, the federal matching percentage is increased for states that already cover all adults to at least 100 percent of the FPL under an 1115 Waiver. These are called "expansion states" and include: Arizona, Delaware, Hawaii, Massachusetts, Maine, New York, and Vermont. The Act would gradually increase the federal matching percentage for non-custodial adults from the current state matching percentage (typically 50 percent) to 90 percent between 2014 and 2019. Thus, by 2020, the federal matching percentage will be 90 percent for all non-custodial adults in all states, including those now covering some portion of this group.

Although consistently defined data for these populations are difficult to obtain, we developed estimates of the amount of spending attributed to these groups from published studies of coverage for childless adults. We estimate that this provision will reduce state spending for Medicaid by $18.1 billion over the 2014 through 2019 period (***Figure 6 above***). State savings from this provision will be $13.4 billion in New York, $3.0 billion in Arizona, and $941 million in Massachusetts.[11]

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[11] The Joint Legislative Budget Committee (JLBC) of the Arizona state legislature has estimated that the change in FMAP for childless adults will reduce state spending by $3.6 billion over this same period, compared with our estimate of $3.0 billion. See: Analysis of the Cost of Federal Health Care Legislation," JLBC report, March 30, 2010.

Methods: Estimating Impact of Increased Federal Match for Childless Adults

Our estimates of the impact of increasing the federal matching rate for childless adults in based upon enrollment data and spending figures from several sources. Because enrollment and cost data generally are not reported separately for non-custodial adults, we relied on prior studies of the impact of covering childless adults under Medicaid. For this reason, the actual figures may differ from those presented here.

State	Childless Adults	Average Cost in 2010	Total Cost (millions)
Arizona [a,b/]	212,941	$7,361	$1,560
Delaware [c,d/]	21,307	$5,240	$111
Hawaii [d,e/]	11,550	$4,792	$54
Massachusetts [d,f/]	68,200	$4,750	$324
Maine [b,c/]	13,594	$4,872	$66
New York [a,b,g/]	782,638	$5,904	$4,621
Vermont [h/]	18,142	$4,016	$73

a/ "Expanding Medicaid to Low-income Childless Adults under Health Reform: Key Lessons from State Experiences," Kaiser Commission on Medicaid and the Uninsured, July 2010.
b/ "Covering Low-income Childless Adults in Medicaid: Experiences from Selected States," Center for Health Care Strategies, Inc. August 2010.
c/ "Medicaid Enrollment in 50 States," The Kaiser Commission on Medicaid and the Uninsured, September 2009.
d/ Per-capita costs for adults adjusted to 2010, Kaiser Commission, State Health Facts.
e/ Lewin Group estimate using the Current Population Survey data for data Hawaii in 2008-2010.
f/ MassHealth Essential Program, Governors Budget FY2011, http://www.mass.gov/bb/h1/fy11h1/brec_11/act_11/ho40001405.htm; and http://www.massmedicaid.org/~/media/MMPI/Files/2009_04_30%20masshealth%20enrollment%20by%20plan%20type.pdf
g/ "Enrolling Childless Adults in Medicaid: Lessons from the New York Experience and opportunities in Health Reform," Medicaid Institute at United Hospital Fund, October 2010.
h/ Overview of Health Care Programs, "Medicaid Budget Document, state fiscal year 2010", Office of Vermont Health Access. Lewin Group allocation of enrollees to childless adults category using CPS data for Vermont.

D. Net Impact of Reform on State Spending

As discussed above, state Medicaid spending will increase by $17.4 billion over the 2014 through 2019 period under the ACA, which is an average increase of about 1.1 percent over that period. However, the impact of health reform on Medicaid and CHIP spending varies from an increase of 7.8 percent in Alabama, which has the nation's second lowest eligibility level for parents (24 percent of FPL), to actual savings of 10.7 percent in Arizona (***Figure 7***).

In general, states that have covered parents and childless adults to higher income levels (e.g., 100 percent of the FPL) tend to do better than states that currently have only very limited eligibility for non-aged adults. Also, states with large Medicaid managed care programs will tend to see substantial increases in rebates under the managed care drug rebate provisions of the Act, such as Arizona, California, and Pennsylvania.

Medicaid spending would actually be reduced under the Act in six states including Arizona, Delaware, Hawaii, New York, Massachusetts, and Vermont. All six of these states already cover a substantial portion of adults below 133 percent of the FPL. In particular, Arizona's program (under MOE coverage levels) covers both parents and adults to 200 percent of the FPL and, therefore, benefits from the increased matching rate for this group under the Act. Arizona also

sees substantial savings from the managed care rebates because most of the Arizona Medicaid population is covered under managed care.

The Act includes another provision that could result in savings to states. Under the Act, states with eligibility levels above 133 percent of the FPL for parents and/or childless adults are permitted to reduce their income eligibility levels to the minimum level of 133 percent of the FPL. This could affect 417,600 people in twelve states (***Figure 7***). State spending for Medicaid would be reduced by $3.8 billion over the 2014 through 2019 period if all states exercised this option.

A summary of the changes in Medicaid spending for states and the federal government by state is presented in ***Attachment A***.

E. Understanding Reform at the State Level

The estimates presented here are dependent upon key assumptions concerning the strength of the economy and the ways in which employers, consumers, insurers, and providers respond to elements of the Act. We relied upon economic projections developed by the Congressional Budget Office (CBO) at the national level. These assumptions predict a decline in Medicaid enrollment after 2010 with enrollment growth returning to historical growth rates after 2014. We also used CBO assumptions on per-capita benefits cost growth of about 3 percent. However, the recession and the recovery are likely to differ across states with different cost implications for state governments.

Our estimates are also sensitive to assumptions about how the program will be implemented and the ways in which employers, health plans, and consumers respond to the Act. In general, we rely upon economic studies of historical enrollment for eligible people and we assume little net change in the number of people with employer coverage. All of these assumptions are somewhat speculative and may differ from actual behavior.[12] It will be important to show the range of impacts the Act will have under alternative assumptions. These include:

- Participation rate for newly eligible people;
- Take-up among currently eligible but not enrolled;
- Enrollment and spending under alternative assumptions on the number of employers offering/discontinuing coverage;
- The impact of alternative economic assumptions; and
- The rules ultimately adopted for setting the reductions in DSH funding by state.

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[12] For a discussion of methods used to model the Act see: "Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers," The Lewin Group, June 8, 2010; http://www.lewin.com/content/publications/LewinGroupAnalysis-PatientProtectionandAffordableCareAct2010.pdf

Figure 7: Potential Savings From State Option to Discontinue Medicaid Coverage for Adults over 133 Percent of the Federal Poverty Level: 2014-2019 [a/]

	Required Changes in Spending for States Under the ACA: 2014-2019 [b/]		Currently Covered Adults over 133% of FPL in 2014 (thousands) [c/]	State Savings From Eliminating Coverage for Adults over 133% of FPL: 2014-2019 (millions) [d/]	Net Change in Spending Assuming Coverage for this Group is Eliminated: 2014-2019 (millions)
	Amount (millions)	Percent Change in State Spending			
Alabama	$1,104	7.8%	0.0	$0	$1,104
Alaska	$73	1.6%	0.0	$0	$73
Arizona	-$2,974	-10.7%	0.0	$0	-$2,974
Arkansas	$379	3.7%	0.0	$0	$379
California	$4,839	2.2%	0.0	$0	$4,839
Colorado	$719	4.0%	0.0	$0	$719
Connecticut	$707	2.9%	-20.8	-$211	$497
Delaware	-$276	-4.7%	0.0	$0	-$276
District of Columbia	$126	2.7%	-4.7	-$37	$89
Florida	$1,900	2.6%	0.0	$0	$1,900
Georgia	$963	3.3%	0.0	$0	$963
Hawaii	-$142	-2.4%	0.0	$0	-$142
Idaho	$142	3.4%	0.0	$0	$142
Illinois	$1,838	2.8%	-73.3	-$684	$1,154
Indiana	$696	3.1%	-7.0	-$74	$622
Iowa	$287	2.5%	-0.4	-$6	$281
Kansas	$207	2.1%	0.0	$0	$207
Kentucky	$604	4.0%	0.0	$0	$604
Louisiana	$1,457	6.7%	0.0	$0	$1,457
Maine	$161	1.9%	-12.8	-$125	$36
Maryland	$223	0.7%	0.0	$0	$223
Massachusetts	-$2,068	-3.4%	0.0	$0	-$2,068
Michigan	$1,172	3.0%	0.0	$0	$1,172
Minnesota	$140	0.4%	-37.6	-$373	-$233
Mississippi	$638	6.0%	0.0	$0	$638
Missouri	$1,133	4.2%	0.0	$0	$1,133
Montana	$101	3.6%	0.0	$0	$101
Nebraska	$189	2.7%	0.0	$0	$189
Nevada	$306	4.2%	0.0	$0	$306
New Hampshire	$377	5.6%	0.0	$0	$377
New Jersey	$1,275	2.3%	-46.4	-$403	$872
New Mexico	$45	0.4%	0.0	$0	$45
New York	-$11,226	-5.3%	-167.1	-$1,384	-$12,610
North Carolina	$1,382	3.5%	0.0	$0	$1,382
North Dakota	$55	2.5%	0.0	$0	$55
Ohio	$1,599	3.1%	0.0	$0	$1,599
Oklahoma	$338	2.4%	0.0	$0	$338
Oregon	$403	3.1%	0.0	$0	$403
Pennsylvania	$464	0.6%	0.0	$0	$464

Figure 7: Potential Savings From State Option to Discontinue Medicaid Coverage for Adults over 133 Percent of the Federal Poverty Level: 2014-2019 [a/] (continued)

	Required Changes in Spending for States Under the ACA: 2014-2019 [b/]		Currently Covered Adults over 133% of FPL in 2014 (thousands) [c/]	State Savings From Eliminating Coverage for Adults over 133% of FPL: 2014-2019 (millions) [d/]	Net Change in Spending Assuming Coverage for this Group is Eliminated: 2014-2019 (millions)
	Amount (millions)	Percent Change in State Spending			
Rhode Island	$113	1.1%	-8.9	-$94	$19
South Carolina	$995	7.0%	0.0	$0	$995
South Dakota	$68	2.5%	0.0	$0	$68
Tennessee	$969	3.7%	0.0	$0	$969
Texas	$4,022	4.0%	0.0	$0	$4,022
Utah	$209	4.3%	0.0	$0	$209
Vermont	-$184	-4.3%	-5.3	-$79	-$263
Virginia	$461	1.5%	0.0	$0	$461
Washington	$679	2.0%	0.0	$0	$679
West Virginia	$360	5.6%	0.0	$0	$360
Wisconsin	$286	1.3%	-33.2	-$307	-$21
Wyoming	$61	2.2%	0.0	$0	$61
Total	**$17,395**	**1.1%**	**-417.6**	**-$3,777**	**$13,618**

a/ Beginning in 2014, states that cover adults above 133 percent of the FPL have the option of discontinuing this coverage, leaving these individuals eligible for coverage in the exchange, where premium subsidies are available.
b/ Lewin Group estimates using the Health Benefits Simulation Model (HBSM).
c/ Estimated from the CPS survey data on incomes for people reporting Medicaid coverage by state. Estimates are based upon a month-by-month simulation of eligibility using the state's income eligibility rules, which enables us to identify beneficiaries with incomes between 133 percent of the FPL and the state's upper income eligibility level.
d/ Estimated savings are based upon MEPS data on spending for people with similar characteristics.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

This analysis covers only the Medicaid impacts of health reform and does not provide state level analyses of other elements of the Act that will have significant impacts on State and Local government costs under the bill. These effects on state government and the state health care system include:

- As employers, state and local governments that do not cover all of their full-time employees are required to pay a significant new penalty;
- Changes in employer coverage and spending will affect state tax revenues, in addition to direct effects on the health system;
- Uncompensated care could be reduced by up to two-thirds as 30 million or more people become insured nationwide;
- Public hospitals and clinics would see increased revenues from newly insured patients that will now be covered by Medicaid or privately insured patients;

- Payer mix will change significantly for all types of providers now serving the uninsured; and
- Expected increases in health services utilization for newly insured people raise questions about the adequacy of physician supply in many areas.

The Lewin Group data and models of the heath care system provide a platform for simulating these effects at both the state and county levels. In particular, the models can be used to estimate the effects of reform under various assumptions and alternative economic scenarios that are specific to individual state health systems and economies.

In addition to these services, we can evaluate options for reducing the cost of state Medicaid and CHIP programs within the maintenance of effort requirements of the Act. For example, states have the option of using alternative "benchmark" benefits packages rather than the Medicaid benefit. Also, states that now have adult income eligibility levels above 133 percent of the FPL have the option of reducing eligibility to 133 percent of the FPL. We have also assisted several states in identifying ways of minimizing costs and maximizing federal matching funds.

Attachment A: Changes in Spending For Medicaid and CHIP under the ACA for States and the Federal Government (millions) [w]

	Changes in State Spending under ACA			Changes in Federal Spending under ACA			Total Spending under ACA		
	Without Health Reform	Change in Spending	Total Spending under ACA	Without Health Reform	Change in Spending	Spending under the ACA	Without Health Reform	Change in Spending	Total Spending under ACA
Alabama	$14,245	$1,104	$15,349	$30,573	$10,191	$40,764	$44,818	$11,295	$56,113
Alaska	$4,726	$73	$4,799	$5,044	$1,036	$6,080	$9,770	$1,110	$10,880
Arizona	$27,901	-$2,974	$24,928	$53,873	$2,850	$56,723	$81,774	-$124	$81,651
Arkansas	$10,137	$379	$10,517	$27,347	$7,592	$34,938	$37,484	$7,971	$45,455
California	$222,772	$4,839	$227,611	$226,648	$38,974	$265,622	$449,420	$43,813	$493,233
Colorado	$17,855	$719	$18,574	$18,105	$6,145	$24,251	$35,960	$6,864	$42,824
Connecticut	$23,991	$707	$24,698	$24,056	$2,602	$26,658	$48,046	$3,309	$51,356
Delaware	$5,867	-$276	$5,591	$5,950	$420	$6,370	$11,817	$144	$11,961
District of Columbia	$4,595	$126	$4,721	$10,748	$493	$11,241	$15,343	$619	$15,962
Florida	$72,587	$1,900	$74,487	$89,434	$30,611	$120,045	$162,022	$32,510	$194,532
Georgia	$28,920	$963	$29,884	$54,552	$15,884	$70,437	$83,473	$16,848	$100,320
Hawaii	$5,998	-$142	$5,856	$7,153	$1,134	$8,287	$13,150	$992	$14,142
Idaho	$4,140	$142	$4,282	$9,475	$2,820	$12,295	$13,615	$2,962	$16,577
Illinois	$64,997	$1,838	$66,835	$66,332	$13,768	$80,099	$131,329	$15,605	$146,934
Indiana	$22,819	$696	$23,515	$44,441	$8,834	$53,275	$67,260	$9,531	$76,790
Iowa	$11,395	$287	$11,682	$19,973	$4,269	$24,242	$31,368	$4,556	$35,924
Kansas	$9,950	$207	$10,157	$15,285	$3,733	$19,018	$25,234	$3,940	$29,175
Kentucky	$15,242	$604	$15,846	$37,480	$8,951	$46,431	$52,723	$9,555	$62,278
Louisiana	$21,861	$1,457	$23,317	$45,908	$11,601	$57,510	$67,769	$13,058	$80,827
Maine	$8,549	$161	$8,710	$15,951	$964	$16,915	$24,499	$1,125	$25,625
Maryland	$32,246	$223	$32,469	$32,720	$5,717	$38,437	$64,966	$5,940	$70,906
Massachusetts	$60,615	-$2,068	$58,547	$61,405	-$44	$61,361	$122,021	-$2,112	$119,909
Michigan	$39,625	$1,172	$40,797	$68,584	$15,850	$84,434	$108,209	$17,022	$125,231
Minnesota	$37,481	$140	$37,621	$37,698	$4,374	$42,072	$75,179	$4,514	$79,693
Mississippi	$10,555	$638	$11,194	$33,136	$9,410	$42,546	$43,691	$10,048	$53,739
Missouri	$27,012	$1,133	$28,145	$49,296	$10,969	$60,264	$76,308	$12,102	$88,410
Montana	$2,857	$101	$2,958	$5,972	$2,067	$8,039	$8,828	$2,169	$10,997
Nebraska	$6,950	$189	$7,139	$10,759	$2,687	$13,446	$17,710	$2,876	$20,586
Nevada	$7,289	$306	$7,595	$7,426	$3,515	$10,941	$14,715	$3,820	$18,536
New Hampshire	$6,681	$377	$7,058	$6,708	$1,014	$7,722	$13,389	$1,391	$14,780
New Jersey	$54,389	$1,275	$55,664	$55,369	$5,146	$60,515	$109,758	$6,421	$116,179

Attachment A: Changes in Spending For Medicaid and CHIP under the ACA for States and the Federal Government (millions) [a/] (continued)

	Changes in State Spending under ACA			Changes in Federal Spending under ACA			Total Spending under ACA		
	Without Health Reform	Change in Spending	Total Spending under ACA	Without Health Reform	Change in Spending	Spending under the ACA	Without Health Reform	Change in Spending	Total Spending under ACA
New Mexico	$10,031	$45	$10,075	$25,243	$2,747	$27,989	$35,273	$2,792	$38,065
New York	$210,298	-$11,226	$199,072	$211,289	$12,396	$223,685	$421,587	$1,171	$422,757
North Carolina	$39,336	$1,382	$40,719	$74,100	$17,724	$91,824	$113,437	$19,106	$132,542
North Dakota	$2,203	$55	$2,257	$3,782	$824	$4,606	$5,984	$879	$6,863
Ohio	$52,150	$1,599	$53,749	$91,044	$18,988	$110,032	$143,194	$20,587	$163,781
Oklahoma	$14,083	$338	$14,421	$25,773	$6,760	$32,533	$39,857	$7,098	$46,954
Oregon	$13,218	$403	$13,621	$22,438	$6,667	$29,105	$35,656	$7,070	$42,725
Pennsylvania	$79,558	$464	$80,022	$97,114	$13,027	$110,141	$176,673	$13,491	$190,163
Rhode Island	$9,943	$113	$10,056	$11,225	$606	$11,831	$21,168	$719	$21,887
South Carolina	$14,169	$995	$15,165	$33,713	$9,066	$42,779	$47,882	$10,062	$57,944
South Dakota	$2,718	$68	$2,786	$4,612	$1,149	$5,761	$7,330	$1,217	$8,547
Tennessee	$26,475	$969	$27,444	$50,630	$10,379	$61,008	$77,105	$11,347	$88,453
Texas	$100,649	$4,022	$104,671	$145,328	$38,691	$184,018	$245,977	$42,712	$288,689
Utah	$4,854	$209	$5,062	$12,404	$3,651	$16,055	$17,258	$3,860	$21,117
Vermont	$4,236	-$184	$4,052	$6,040	$27	$6,067	$10,276	-$157	$10,119
Virginia	$30,183	$461	$30,644	$30,581	$10,132	$40,713	$60,765	$10,593	$71,358
Washington	$33,121	$679	$33,800	$33,365	$6,788	$40,153	$66,485	$7,467	$73,953
West Virginia	$6,404	$360	$6,765	$18,348	$5,262	$23,610	$24,753	$5,623	$30,375
Wisconsin	$21,572	$286	$21,858	$32,854	$4,380	$37,233	$54,426	$4,665	$59,091
Wyoming	$2,708	$61	$2,769	$2,734	$1,049	$3,784	$5,442	$1,110	$6,553
Total US	**$1,562,160**	**$17,395**	**$1,579,555**	**$2,110,015**	**$403,891**	**$2,513,906**	**$3,672,175**	**$421,286**	**$4,093,461**

a/ Includes changes in spending due to expansions in eligibility, member movement due to new employer coverage, changes in drug rebates, increased federal matching percentage for expansion states, and changes in federal Disproportionate Share Hospital (DSH) payments.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).



New Jobs Through Better Health Care

Health Care Reform Could Boost Employment by 250,000 to 400,000 a Year this Decade

David Cutler Center for American Progress
Neeraj Sood Leonard D. Schaeffer Center for Health Policy and Economics

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Introduction and summary

One in ten Americans remains out of work today as the two-year-long Great Recession gives way at last to a slow economic recovery. Dealing with persistent unemployment is one of the top priorities of President Barack Obama and the leaders of Congress. One important way to create jobs is to slow the growth of medical spending. If health care cost increases slow down, then businesses will find it more profitable to expand employment, and workers will more readily move into those new jobs.

This paper will demonstrate the potential impact of health care reform on employment growth in the new decade, examining two recent studies and then combing their estimates of potential employment growth. The first study, by health economists Neeraj Sood at the Leonard D. Schaeffer Center for Health Policy and Economics and School of Pharmacy at the University of Southern California, and Arkadipta Ghosh and José Escarce at Mathematica and University of California Los Angeles, shows the significant negative impact of rising health care costs on employment as firms struggle with health costs that they cannot pass along fully to workers or consumers.[1] The second study, by health economists David Cutler of Harvard University and Karen Davis and Kristof Stremikis of the Commonwealth Fund, estimates that health care reform will slow the growth of health care costs and health insurance premiums.[2]

In the analysis that follows, we combine these two studies to show that health care reform could increase the number of jobs in the United States by about 250,000 to 400,000 per year over the coming decade.

The impact of health care costs on employment

Rising health care costs affect employment in two basic ways. On the employer side, employer-paid health premiums are a cost of business, just as wages and salaries are. Reducing the growth of health insurance premiums would therefore enable employers to hire more workers, according to economic theory, holding wages and other benefits constant. On the worker side, most workers are willing to give up wage and salary payments in order to receive employer-paid health insurance. When health insurance premiums rise, therefore, workers who value health insurance as part of the job are often willing to accept lower wages in exchange for the higher benefits.[3] Conversely, when costs fall, a large part of the impact will be on higher wage and salary payments. A major effect of health care reform that lowers employer premium growth will therefore be to raise middle-class wages.

But the wage offset is not dollar-for-dollar for all workers. Firms have little ability to reduce wages for workers at or near the minimum wage or for workers with fixed employment contracts. Rising health insurance premiums will thus lead to more job losses among these types of workers while falling premiums will increase employment. Similarly, not all workers value employer-provided health insurance at its cost—either because their overall income is low or because they have health insurance from another source (perhaps a spouse). For these workers, the lower wages that rising health insurance premiums necessitate induce them to leave the labor force or move into part-time jobs (with no health benefits). Reducing the growth of health insurance premiums would allow employers with full-time positions to pay higher wages and allow such workers to return to jobs they would prefer.

A recent study, "Employer-Sponsored Insurance, Health Care Cost Growth, and the Economic Performance of U.S. Industries," by University of Southern California economist Neeraj Sood and his colleagues Arkadipta Ghosh and Jose Escarce, estimates how the growth of health care costs that exceed the growth in gross domestic product—called "excess cost growth" in economic parlance—affects three important economic outcomes in U.S. industries:

- Employment.
- Gross output (the total value of sales in the industry).
- Value added to gross domestic product (sales net of factor inputs).

They analyze these relations using data from 38 industries over the 19-year period— 1987-2005.

The study posited that the effect of excess cost growth on economic outcomes depends on the percentage of workers with employer-provided insurance. The growth in health insurance premiums should have a greater effect on employment in industries that have a larger percentage of workers with employer-provided insurance because the increase in labor costs is greater in those industries. The study looked at this by relating employment in the industry to the share of workers with employer-provided insurance and that share interacted with medical spending as a percentage of GDP. To control for other factors influencing employment, the study controlled for unionization, labor productivity, and sector-specific trends in employment.

The study by Sood and his colleagues demonstrated a clear negative relation between the share of workers with employer-provided health insurance and industry growth in the United States. Over the period 1987 to 2005, for example, the workforce in the amusement and recreation industry—where about 29 percent of workers have insurance through their jobs—grew by about 2.1 percent. In contrast, in the hotel industry—where 54 percent of workers have employer-provided insurance—the workforce grew about 1 percent. And in the paper industry—where about 85 percent of workers have insurance—the workforce shrank by 1.9 percent.

The results with the additional controls clearly show that excess growth in health insurance premiums has adverse effects on employment, output and value added to GDP, and that the effects are greater in industries where high percentages of workers have employer-provided insurance. The study by Sood and his colleagues finds that every 10 percent reduction in excess health care cost growth—a decrease in cost growth from 2.2 percentage points above GDP to 1.98 percentage points—leads to about 120,000 more jobs.

To further rule out the possibility that these economic effects reflected some industry-wide factor rather than the true effect of rising health insurance costs, the study compared U.S. industries with their Canadian counterparts. Since Canada has publicly-financed universal health care, employment growth trends in its industries are not influenced by health insurance costs. Conversely, industry-level changes such as product innovation or labor outsourcing would affect Canadian and U.S. employers in the same way.

In contrast to the results in the United States, there is no significant relationship between industries with more employer-provided health insurance in the United States and employment changes in Canadian industries. The lack of a relationship confirms the evidence that health care cost and premium increases have an adverse effect on employment growth.

When employment declines in one industry, some workers move out of the workforce entirely, while others take jobs in other industries where health insurance is less prevalent. The analysis in the first study combines both of these effects, but for the purposes of estimating overall job growth associated with health care reform we need to separate out

the two. Greater entry of workers into the labor force as a whole would affect total employment, while movement of workers from one industry to another would not (though it would have other benefits).

To estimate the labor force effect of changes in health care costs, we adjusted the estimates from the study done by Sood and his co-authors using results from displaced workers. The data from the Bureau of Labor Statistics' 2002 Displaced Worker Supplement of the Current Population Survey show that among displaced workers who cannot find employment in the same industry, about 26 percent leave the labor force and the remaining 74 percent obtain employment in other industries or are unemployed but actively seeking work.[4] We thus multiplied the employment response to health care premiums by 26 percent to obtain the labor force impact of rising health care premiums. The results of this analysis will be combined with the results of the second study examined in the next section to calculate the potential effects of health care reform on employment.

The impact of health care reform on health insurance premiums

National health care reform now being considered in Congress will help modernize American health care and will affect employer-provided health insurance premiums in several ways. To gauge the consequences, we employ the estimates from David Cutler of Harvard University and Karen Davis and Kristof Stremikis of the Commonwealth Fund in the second study examined in this paper, "Health System Impacts of Health Reform Proposals."[5]

An initial impact of reform is savings associated with lower administrative expenses in insurance, especially for small- and medium-sized firms. Administrative costs range from 5 percent for the largest firms to 30 percent or more for small firms. The higher costs for these businesses are associated with the marketing, underwriting, and brokers' fees charged by health insurance companies. Creating health insurance exchanges is forecast to lead to significant reductions in these administrative expenses. Selective marketing and individual underwriting will not be permitted in exchanges, and brokers' fees should decline with greater competition. Cutler and his co-authors estimate that insurance exchanges should lower average employer-paid premiums by about 2 percent.

The second impact of reform is to change the incentives in current payment systems, and thus encourage higher quality, lower cost care. Estimates show that large savings are possible in a number nf areas of medicine, among them:

- Reducing the number and cost of high-cost illnesses through better coordination of care (for example, fewer people needing to be re-hospitalized after an initial hospitalization).
- Lowering unit prices of health care services that are more expensive in the United States than in other developed countries (for example, operating rooms and scanners that are run at less than full capacity).
- Streamlining excessive administrative costs that neither improve quality nor patient satisfaction.

Aspects of the health reform legislation now before Congress that would promote more efficient care include bundling payments for different health care providers to encourage practice of more coordinated care, increased use of pay-for-performance systems for providers rather than the pay-per-visit system used by most insurers, and greater funding

to support health care transitions, such as between hospitals and outpatient care, and for so-called medical homes, a primary care model that emphasizes coordinated care for the patient. These reforms would initially be implemented within the Medicare program, but are expected to extend to privately insured patients as reforms take hold, as has happened in the past.[6]

Cutler and his co-author estimate cost reductions from these initiatives of about 0.75 percentage points annually after a phase-in period, or 6 percent by 2019. Other work suggests savings as high as 1.5 percentage points annually are feasible.[7] These cost reductions will enable employers who gain from these increased efficiencies to hire more workers and enable employees to seek higher wages as rising health care costs slow down.

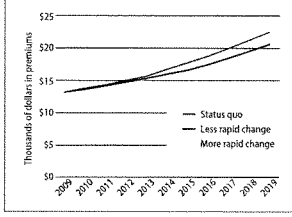
Other aspects of reform will affect premiums by influencing the generosity of benefits. Some small firms will pay more for insurance because the quality of the coverage they offer will increase. Most firms, however, offer relatively generous benefits and thus would not be greatly affected. The Congressional Budget Office estimates that health care reform will increase premiums at small firms by zero to 3 percent.[8]

The reform legislation also includes an excise tax on employer-sponsored health plans offering more generous benefits, so-called "Cadillac" plans. CBO estimates that this excise tax will reduce premiums for small and large employers by 9 percent to 12 percent. Overall, these changes in benefit generosity will reduce premiums for employers. In this report, however, we focus on the modernization aspects of the reform and do not include the employment effects of reform that stem from changes in benefit generosity.

Figure 1 shows the potential effects of reform on premium growth. We assume that health care reforms do not affect premiums until 2012 and that health insurance exchanges are created in 2013. In Figure 1 we consider two alternatives: one where health system modernization reduces premiums by 0.75 percentage points annually, and, alternatively, one where modernization reduces premiums by 1.5 percentage points annually. In the first scenario, premiums in 2019 are lower by 8.4 percent. In the second scenario, premiums are lower by 12.3 percent. If Congress fails to pass health care reform and the status quo remains, premiums would increase by 71 percent—or nearly $10,000—by the end of 2019.

FIGURE 1
The consequences of health care reform on premium growth

Estimated change in employer-based health insurance premiums due to health care reform



Source: Based on the calculations in David Cutler, Karen Davis, and Kristof Stremikis, "Health System Impacts of Health Reform Proposals" (New York and Washington: The Commonwealth Fund and the Center for American Progress Action Fund, December 2009)

Impact of health care reform on number of jobs

The premium changes estimated by Cutler and his co-authors can be used to predict employment changes using the results in the first study by Sood and his colleagues. We focus on private sector wage and salary jobs in this analysis. We exclude public-sector jobs from the analysis as public employers' response to rising health care costs might differ from that of private employers.

Figure 2 shows the impact of slowing premium growth on employment in 2016 in different industries. We estimate more than 200,000 new jobs in manufacturing and nearly 900,000 jobs in services.

Two additional aspects of reform will affect employment. First, employment in the health care industry will be affected by the amount spent on medicine. Reductions in administrative expenses will reduce the need for clerical workers, and better health care delivery could shift workers from inpatient to more appropriate outpatient settings. We assume that the effect of health care spending on the need for health care workers is proportional to total dollars spent, that is, a 1 percent decline in health care costs or premiums results in a 1 percent decline in employment in the health care industry.[9] The total change in health spending and premiums we model is from the second study by Cutler and his co-authors. They estimate that overall medical costs will decline by about 4 percent and premiums will decline by 8.4 percent in 2019.

In addition, some firms will be affected by the "pay-or-play" requirements for employers. These requirements mandate that firms with 50 or more employees that do not offer insurance coverage—and in the case of the Senate bill have people who

FIGURE 2

The consequences of declining health insurance premiums

Estimated impact of a 6 percent decline in U.S. health insurance premiums on employment by industry

Industry	Percent of workers with employer-sponsored insurance[1]	Change in employment, 2016[2]
Agriculture, mining, and construction		
Agriculture, forestry, fishing, and hunting	20%	6,026
Mining	68%	10,738
Construction	37%	76,339
Manufacturing	65%	202,109
Trade		
Wholesale trade	57%	87,750
Retail trade	39%	154,557
Transportation and communication		
Transportation and warehousing	55%	66,689
Utilities	80%	10,219
Services		
Information	63%	48,606
Financial activities	66%	141,480
Professional and business services	44%	231,262
Educational services	61%	55,808
Leisure and hospitality	25%	89,638
Other services	48%	304,537

1 Author calculations based on 2008 Current Population Survey.

2 Author calculations as outlined in the issue brief.

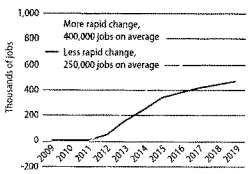
receive a subsidy in the exchange—pay fines ranging from $750 to $3,000 per worker. We estimate that these requirements will reduce the number of jobs by about 80,000.[10] Yet most of this reduction in employment would be offset by an increase in spending associated with providing coverage to the 30 plus million currently uninsured Americans who would become insured by the legislation.

Figure 3 shows the forecast of total job creation under two scenarios—less rapid change versus more rapid change in insurance premiums. Relative to baseline employment forecasts from the Employment Projections Program at the U.S. Department of Labor, we estimate that moderate medical savings from health care modernization as envisioned under the legislation now before Congress would lead to an average of 250,000 additional jobs created annually. Under the larger assumption about savings due to health care reform, 400,000 new jobs a year would be created on average.

FIGURE 3

Health care reform results in job creation

We estimate that reform will create between 250,000 and 400,000 jobs annually on average over the next decade.



Source: Authors' calculations based on results above.

We show the employment increase continuing over a decade, although changes in the out years are more speculative. At some point, higher labor demand exhausts labor supply, and wages will adjust—even for low-wage workers and workers who do not value health insurance on the job. The point at which this will set in is not easy to predict, however.

Conclusion

We estimate that health care reform that reduces premium growth will add between 250,000 and 400,000 jobs annually over the next decade.

Our estimates of net job creation compare favorably with other estimates by other economists, which are generally based on less complete data. Katherine Baicker and Amitabh Chandra of Harvard University, for example, use data on malpractice premiums across areas to estimate the impact of rising health insurance premiums on employment.[11] They estimate that a 10 percent reduction in premiums would increase employment by 1.6 percentage points, very similar to the estimate by Neeraj Sood, Arkadipta Ghosh, and Jose Escarce that we highlight.

In earlier work by one of the authors of this report, Cutler, along with Brad DeLong of University of California, Berkeley and Ann Marie Marciarille of McGeorge School of Law, the authors estimate that cost savings of the type considered here would increase employment among low-wage workers by 90,000.[12] Additional employment effects for workers above the lowest wages would add to the total. Finally, President Obama's Council of Economic Advisors recently estimated that health care reform would create 320,000 additional jobs for some period of time.[13] Thus, a number of studies with very different methodologies reach a similar conclusion about the labor market implications of major health care reform.

Clearly, health care reform that reduces premium growth is economic policy as well as health policy. The reform goals of a healthier America are well understood. In this paper, however, we demonstrate a less emphasized point about the health care reform legislation currently before Congress—if successful, its provisions can lower the costs of business and increase both the number of jobs by 250,000 to 400,000 annually over the next decade and increase wage growth.

Health care reform that includes even more robust measures to contain health care costs could further enhance job creation. In an economy that has lost 5 million jobs in the past year and where wages have stagnated for many years, this is a strong reason to pass health care reform that contains growth in health care costs and modernizes the U.S. health care system.

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David Cutler is Otto Eckstein Professor of Applied Economics at Harvard University and Senior Fellow at the Center for American Progress.

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Acknowledgements

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Endnotes

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2 David Cutler, Karen Davis, and Kristof Stremikis, "Health System Impacts of Health Reform Proposals" (New York and Washington: The Commonwealth Fund and the Center for American Progress Action Fund, December 2009).

3 Lawrence Summers, "Some Simple Economics of Mandated Benefits," *American Economic Association Papers and Proceedings*, 79(2) (May 1989): 177–183; Jonathan Gruber, "The Incidence of Mandated Maternity Benefits," *American Economic Review*, 84(3) (June 1994): 622–641.

4 Ryan Helwig, "Worker Displacement in 1999-2000," *Monthly Labor Review* (June 2004): 54 – 68.

5 In addition to the factors we discuss, other aspects of reform will influence government or out-of-pocket spending. We do not consider these factors.

6 Two cases in point: Prospective Payment for hospitals, which was implemented in Medicare in the early 1980s and adopted by the private sector in subsequent years, and the Resource Based Relative Value Scale for physicians, which followed the same path a decade later.

7 Melinda Beeuwkes-Buntin and David Cutler, "The Two Trillion Dollar Solution: Saving Money by Modernizing the Health Care System" (Washington: Center for American Progress, June 2009).

8 Letter to the Honorable Evan Bayh, Congressional Budget Office, November 30, 2009.

9 Empirically, this overstates the degree to which employment in health care tracks spending growth. Between 1999 and 2008, for example, medical spending increased by 88 percent but employment increased by only 27 percent.

10 Health care reform might impose a fee of $750 to $3000 per employee for firms that do not offer insurance coverage. We estimate that such fee might increase labor costs by up to 8 percent. Based on estimates of labor demand elasticity from prior studies we estimate that this will reduce employment among workers in affected firms by about 3.6 percent. Health Data from the 2008 Medical Expenditure Panel Survey show that 97.4 percent of employees in firms with 50 or more workers have employer sponsored insurance and these firms represent 73 percent of the workforce. This implies that about 1.9 percent or about 2.4 million workers work in firms with 50 or more employees that do not offer insurance. Given that about 2.4 million workers will be affected, a 3.6 percent reduction in jobs translates to about 80,000 jobs.

11 Katherine Baicker and Amitabh Chandra, "The Labor Market Effects of Rising Health Insurance Premiums," *Journal of Labor Economics*, 24(3) (July 2006): 609-634.

12 David Cutler, Brad DeLong, and Ann-Marie Marciarille, "Why Obama's Health Plan is Better," *Wall Street Journal*, September 16, 2008, p. A25.

13 Executive Office of the President, "The Economic Case for Health Care Reform" (Council of Economic Advisers June 2009); Executive Office of the President, "The Economic Case for Health Care Reform: Update" (Council of Economic Advisers, December 2009).

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The Center for American Progress is a nonpartisan research and educational institute dedicated to promoting a strong, just and free America that ensures opportunity for all. We believe that Americans are bound together by a common commitment to these values and we aspire to ensure that our national policies reflect these values. We work to find progressive and pragmatic solutions to significant domestic and international problems and develop policy proposals that foster a government that is "of the people, by the people, and for the people."

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2. Improving insurance design.
3. Understanding how public policy affects medical innovation.
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5. Improving comparative effectiveness and outcomes research.

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STATEMENT FOR THE RECORD

BEFORE THE HOUSE SUBCOMMITTEE ON HEALTH

ON THE

TRUE COST OF PPACA: EFFECTS ON THE BUDGET AND JOBS

MARCH 30, 2011

JOHN ARENSMEYER
FOUNDER & CEO
SMALL BUSINESS MAJORITY

This testimony is submitted in support of the small business perspective on the Patient Protection and Affordable Care Act and its impact on America's 28 million small businesses and the economy as a whole.

Small Business Majority is a nonprofit, nonpartisan small business advocacy organization founded and run by small business owners and focused on solving the biggest problems facing small businesses today. We represent the 28 million Americans who are self-employed or own businesses of up to 100 employees. Our organization uses scientific opinion and economic research to understand and represent the interests of small businesses.

We are testifying in support of the Affordable Care Act, which will help reduce the cost of insurance and medical care while making coverage affordable, fair and accessible. Our research shows that reforming our broken healthcare system has been and still is one of small business owners' top concerns, and that the majority of small employers believe reform is needed to fix the U.S. economy. It also shows that small businesses support key provisions in the law, specifically ones that help them better afford insurance, such as tax credits and insurance exchanges, and those that contain costs. Controlling skyrocketing costs is esseutial to ensuring small businesses' ability to obtain high-quality, affordable healthcare for themselves, their families and tbeir employees. Our research also shows that absent reform, these costs would continue to escalate, undermining small businesses' success and our economic recovery. The new law goes a long way toward fixing our broken system and stemming these spiraling costs, while helping to create jobs and stimulate the economy.

Our research, which is discussed in more detail below, shows the impact this legislation will have on small businesses and reveals that small businesses support many provisions in the law, especially those that benefit tbem immediately, such as the small business tax credits. In July 2010, Small Business Majority partnered with Families USA to determine the number of small businesses eligible for a tax credit on their 2010 tax returns, one of the key provisions of the Affordable Care Act.

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- We found that more than 4 million small businesses would be eligible to receive a tax credit for the purchase of employee health insurance in 2010. [1]

We also recently commissioned a national survey of 619 small business owners to determine their views on the tax credits and insurance exchanges, another crucial provision of the Affordable Care Act for small businesses. The survey, which was released on Jan. 4, 2011, found that:

- Both the tax credits and the exchanges, once they take effect, make small business owners more likely to provide healthcare coverage to their employees;
- One-third of employers who don't offer insurance said they would be more likely to do so because of both the small business tax credits and the insurance exchanges;
- 31% of respondents who currently offer insurance said the tax credits and the exchanges will make them more likely to continue providing coverage. [2]

However, the poll also found that the vast majority of small business owners don't know the tax credits or exchanges exist to help them afford coverage.

As the debate around healthcare reform continues, it's important to understand the consequences a return to the status quo would have on small businesses and our fragile economy.

- Without reform, small businesses would pay nearly $2.4 trillion in healthcare costs by 2018, and $52.1 billion in small business profits and 178,000 small business jobs would be lost as a result of high premiums.[3] They would also lose $4 billion per year in healthcare tax credits and many small business protections, including a ban on denying coverage for preexisting conditions. This provision will provide much-needed help to many Americans, including the legions of self-employed individuals—many who currently can't get coverage because of this reason;
- Without reform, small businesses would be robbed of their ability to pool their buying power through state insurance exchanges, and the various cost controls the ACA puts in place would also be lost;
- A return to the status quo would mean an end to the tough enforcement measures in the law, which are saving billions in Medicare waste, fraud and abuse. This would result in higher taxes for employers and employees to fund Medicare, and higher taxes mean fewer jobs.

Small businesses create 70% of new jobs in our country. Spending less on health insurance will help them generate larger profits, which will help speed our journey down the road to economic recovery.

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[1] Families USA and Small Business Majority, A Helping Hand for Small Businesses: Health Insurance Tax Credits, July, 2010, http://smallbusinessmajority.org/small-business-research/tax-credit-study.php.
[2] Small Business Majority, Opinion Survey: Small Business Owners' Views on Key Provisions of the Patient Protection and Affordable Care Act, Jan. 4, 2011, http://smallbusinessmajority.org/small-business-research/small-business-healthcare-survey.php.
[3] Small Business Majority, The Economic Impact of Healthcare Reform on Small Businesses, July 2009, http://www.smallbusinessmajority.org/small-business-research/economic-research.php.

My testimony highlights the issues of greatest importance to small businesses in the Affordable Care Act. It explains what we have learned from our scientific research about both the opinions of small employers and the economic impact of reform on small businesses, including the consequences repealing the Act would have on them and the economy overall. The key issues are:

- Why healthcare costs are killing small businesses and sapping our economic vitality;
- What a return to the status quo would mean for small businesses and the economy;
- How the ACA is already helping small businesses afford insurance and provide their employees with coverage;
- Small businesses' No. 1 priority: Controlling the skyrocketing cost of health insurance and how the ACA tackles this problem;
- Why sharing the responsibility will strengthen our small businesses, their employees and the economy.

Healthcare Costs are Killing Small Business and Sapping Our Economic Vitality

National surveys of small business owners consistently show that the cost of health insurance is their biggest overall problem. In fact, the crushing costs of healthcare outranked fuel and energy costs and the weak economy for 78% of small business people polled by the Robert Wood Johnson Foundation in 2008.[4]

Small businesses are at a disadvantage in the marketplace largely because our small numbers make rates higher. According to research supported by the Commonwealth Fund, on average we pay 18% more than big businesses for coverage.[5] Small businesses, including the self-employed, need a level playing field to succeed and continue as the job generators for the U.S. economy.

We hear stories every day from small business owners who can't get coverage because they've been sick in the past or the health plans they are offered are outrageously priced. Louise Hardaway, a would-be entrepreneur in the pharmaceutical products industry in Nashville, had to give up on starting her own business after just a few months because she couldn't get decent coverage—one company quoted her a $13,000 monthly premium.

Many other businesses maintain coverage for employees, but the cost is taking a bigger and bigger chunk out of their operating budgets. It's common to hear about double-digit premium increases each year, eating into profits and sometimes forcing staff reductions. Small business owner Walt Rowen, owner of Susquehanna Glass Co. in Columbia, PA, was quoted a 160% premium increase from his carrier last year, forcing him to find a new plan. These rising bills frequently force business owners to hack away at the insurance benefit to the point where it's little more than catastrophic coverage. That

[4] Robert Wood Johnson Foundation, Study shows small business owners support health reform, 2008, http://www.rwjf.org/coverage/product.jsp?id=36558.
[5] J Gabel et al, Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii is Up, Wyoming is Down, *Health Affairs*, May/June 2006, http://content.healthaffairs.org/content/25/3/832.full.

leaves employees with huge out-of-pocket expenses or a share of the premium they can't afford, forcing them to drop coverage. That concerns Larry Pierson, owner of a mail-order bakery in Santa Cruz, California, who says "the tremendous downside to being uninsured can be instant poverty and bankruptcy, and that's not something my employees deserve."

Small business owners want to offer health coverage, and our surveys show that most of them feel they have a responsibility to do so. Small Business Majority conducted surveys of small business owners in 17 states between December 2008 and August 2009.[6] Our key findings included:

- An average of 67% of respondents said reforming healthcare was urgently needed to fix the U.S. economy;
- An average of 86% of small business owners who don't offer health coverage to their employees said they can't afford to provide it, and an average of 72% of those who do offer it said they are struggling to afford it.

It should be noted that respondents to these surveys included an average of 15% more Republicans (39%) than Democrats (24%), while 27% identified as independent.

The exorbitant cost of insurance means that many small businesses are forced to drop coverage altogether. According to the Kaiser Family Foundation, 54% of businesses with fewer than 10 employees don't offer insurance.[7]

This makes small business employees a significant portion of the uninsured population. Of the 45 million Americans without health insurance in 2007, nearly 23 million were small business owners, employees or their dependents, according to Employee Benefit Research Institute estimates.[8] And nearly one-third of the uninsured—13 million people—are employees of firms with less than 100 workers.[9]

With staffs of 5, 10 or even 20 people, small businesses are tight-knit organizations. Owners know their employees well and depend on each employee for their businesses' success. They don't want to see their valuable employees wiped out financially by a health problem, or ignore illnesses because they can't afford to go to the doctor.

The Affordable Care Act addresses all these issues and more. Without reform, we will impede our overall economic growth. Small businesses with fewer than 100 employees employ 42% of American workers.[10] Traditionally, small businesses lead the way out of recessions. Continuing to address the healthcare crisis by implementing the Affordable Care Act is essential to our vitality as a nation. A repeal of this landmark legislation

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[6] Small Business Majority, State Surveys Highlight Small Business Support for Healthcare Reform, August 2009, http://www.smallbusinessmajority.org/small-business-research/opinion-research.php.
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[10] U.S. Bureau of Census, 2006 County Business Patterns

would send our primary job creators back into in a broken system that threatens their competitiveness, discourages entrepreneurism and jeopardizes our economic recovery.

What a Return to the Status Quo Would Mean for Small Businesses and the Economy

The shock of returning to the status quo would reverberate throughout the U.S. economy. The nonpartisan Congressional Budget Office (CBO) projects repealing the law would add $230 billion over the next 10 years to the federal budget deficit, and more than $1 trillion in the decade to follow. The national debt is already at its limit, and expanding the deficit would only cause additional lack of confidence in our nation's ability to recover from the recession.

When you examine what repeal would mean financially for America's 28 million small businesses, the picture is even bleaker. In June 2009, Small Business Majority commissioned noted economist and Massachusetts Institute of Technology professor Jonathan Gruber to apply his healthcare economics microsimulation model to the small business sector. He focused on businesses with 100 or fewer employees.[11] Our research showed that without reform:

- Small businesses would pay nearly $2.4 trillion over the next 10 years in healthcare costs for their workers;
- A staggering 178,000 small business jobs, $834 billion in small business wages, and $52.1 in profits would be lost due to these healthcare costs;
- Nearly 1.6 million small business workers would continue to suffer from "job lock," where they are locked in their jobs because they can't find a job with comparable benefits. This represents nearly one in 16 people currently insured by their employers.

In a recent article he wrote for the Center for American Progress, Gruber again addressed the issue of job lock.[12] He noted that "such a system significantly distorts our labor markets by forcing individuals to stay in jobs that offer health insurance rather than to move to newer and more productive positions where coverage is not available. Millions of U.S. workers are not moving to better jobs or starting new businesses because there is nowhere to turn for insurance coverage should they leave their jobs."

The Affordable Care Act remedies this problem and levels the playing field to support entrepreneurs willing to take a risk and start a new enterprise. Insurance reforms provided in the new law protect these entrepreneurs, and the insurance exchanges established by the law allow the self-employed and small businesses to pool together for lower premium rates.

The Center for American Progress has also weighed in on what small businesses would lose if the Affordable Care Act were repealed. The percentage of small businesses offering

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[11] Small Business Majority, The Economic Impact of Healthcare Reform on Small Businesses, July 2009, http://www.smallbusinessmajority.org/small-business-research/economic-research.php.

[12] J Gruber, Be Careful What You Wish For, Repeal of the Affordable Care Act Would Be Harmful to Society and Costly for Our Country, *American Progress*, Jan 2010, http://www.americanprogress.org/issues/2011/01/aca_repeal.html.

coverage has decreased from 68% in 2000 to 59% in 2007; repeal would ensure that this downward spiral would continue. Since 40% of small employers spend more than 10% of their payroll on healthcare costs, repeal would cause those already providing insurance to do so at the expense of increased wages. This would result in less profits, business investment and job creation. Additionally, repeal would mean small businesses would continue to pay on average 18% more for health insurance than large firms. And they won't get the financial relief tax credits and insurance exchanges will provide.[13]

Healthcare reform will also reduce the "hidden tax" associated with health insurance. Repeal would keep this tax in place. The uninsured often delay treating their health problems until they become severe, and public and charity programs pick up a share. However, a portion remains unpaid. To cover the cost of this uncompensated care, health providers charge higher rates when the insured receive care, and these increases get shifted to consumers and small businesses in the form of higher premiums. This creates a "hidden health tax" that inflates the cost of premiums.[14]

Instead of helping us move forward, a repeal of the healthcare law would send us back to the status quo and ensure that small businesses will be unable to play their historical role as the country's primary job creators. In fact, Harvard professor David Cutler projects repeal would destroy 250,000 to 400,000 jobs annually over the next decade, increase medical spending by $125 billion by the end of this decade and add nearly $2,000 annually to family insurance premiums.[15] His summary of what repeal would do to the country is as dismal as it is succinct: "It would hurt family incomes, jobs, and economic growth."

The Affordable Care Act Is Already Helping Small Businesses Afford Insurance and Provide Their Employees with Coverage

Our research shows that small business owners are more likely to provide insurance to their employees because of the tax credits and exchanges provided through the new healthcare law. As I mentioned in my introduction, our most recent research includes a national survey of 619 small business owners that was conducted from November 17-22, 2010.[16] We wanted to gauge how entrepreneurs view two critical components of the Affordable Care Act: the small business tax credits—a provision allowing businesses with fewer than 25 employees that have average annual wages under $50,000 to get a tax credit of up to 35% of their health insurance costs beginning in tax year 2010—and health insurance exchanges—online marketplaces where small businesses and individuals can band together to purchase insurance starting in 2014. The survey's key findings include:

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[13] Center for American Progress, What Will Happen to Small Business if Health Care is Repealed, 2010, http://www.americanprogress.org/issues/2010/07/small_biz_reform.html.

[14] Kathleen Stoll and Kim Bailey, Hidden Health Tax: Americans Pay a Premium (Washington: Families USA, May 2009).

[15] D Cutler, Repealing Health Care is a Job Killer, Center for American Progress, 2010. http://www.americanprogress.org/issues/2011/01/jobs_health_repeal.html

[10] Small Business Majority, Opinion Survey: Small Business Owners' Views on Key Provisions of the Patient Protection and Affordable Care Act, Jan. 4, 2011, http://smallbusinessmajority.org/small-business-research/small-business-healthcare-survey.php..

- One-third (33%) of employers who don't offer health insurance said they would be more likely to do so because of the small business tax credits;
- 31% of respondents—including 40% of businesses with 3-9 employees—who currently offer insurance said the tax credits will make them more likely to continue providing insurance;
- One-third (33%) of respondents who currently do not offer insurance said the exchange would make them more likely to do so;
- The same is true for those who already offer insurance, with 31% responding that the exchange would make them more likely to do so;
- However, most respondents are not familiar with the exchange or the tax credits; only 31% of respondents are familiar with the exchange and 43% are familiar with the tax credits.

We believe that once the public, and small business owners in particular, become more familiar with the new law, they will understand the financial benefits and cost savings it provides. In fact, a Kaiser Family Foundation study conducted in January 2010 found that although the public was divided overall about reform, they became more supportive when told about key provisions. After hearing that tax credits would be available to help small businesses provide coverage to employees, 73% said it made them more supportive, and 63% felt that way after learning that people could no longer be denied coverage because of preexisting conditions.[17]

The huge number of small businesses eligible for a credit on their 2010 tax returns shows how wide-ranging the benefits of the ACA are: Small Business Majority and Families USA's study on the number of small businesses eligible for a tax credit on their 2010 tax returns shows that more than 4 million small businesses are eligible.[18] That equates to 83.7% of all small businesses in the country. Perhaps even more encouraging is that more than 90% of small businesses in 11 states are eligible to receive the tax credits, with nearly 1.2 million small businesses nationally eligible to receive the maximum credit.

A recent RAND Health study also examined the impact of the Affordable Care Act on health insurance coverage for workers at small companies. It found that once the new law takes full effect, the percentage of employers that offer insurance will increase from 57% to 80% for firms with fewer than 50 employees, and from 90% to 98% for firms with 51 to 100 employees.[19] Additionally, a study released Jan. 24, 2011 by the Urban Institute (funded by the Robert Wood Johnson Foundation) also shows the positive benefits of the ACA on America's employers. The study debunks claims that the ACA would erode employer-sponsored coverage by providing incentives for employers to stop offering coverage, or that businesses would face increased costs as a result of reform. To the contrary, the study found that overall employer-sponsored coverage under the ACA would not differ significantly from what coverage would be without reform, but that in

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[17] Kaiser Family Foundation, Americans Are Divided About Health Reform Proposals Overall, But the Public, Including Critics, Becomes More Supportive When Told About Key Provisions, Jan. 22, 2010, http://www.kff.org/kaiserpolls/kaiserpolls012210nr.cfm.

[18] Families USA and Small Business Majority, A Helping Hand for Small Businesses: Health Insurance Tax Credits, July, 2010, http://smallbusinessmajority.org/small-business-research/tax-credit-study.php.

[19] RAND Corporation, "How Will the Affordable Care Act Affect Employee Health Coverage at Small Businesses?" 2010, http://www.rand.org/pubs/research_briefs/RB9557/index1.html.

fact employer-sponsored insurance premiums will fall noticeably, by nearly 8%, and total spending on healthcare by small businesses will also decrease by nearly 9% because of healthcare exchanges and other provisions of the new law.[20]

Analysis after analysis shows that the new healthcare law holds significant promise toward empowering small businesses to provide their employees with health insurance, and to be able to do so without breaking the bank. Instead of repealing the small business health care tax credit, Congress should be examining how to expand it in order to provide more support to small business.

Small Businesses' No. 1 Priority: Controlling the Skyrocketing Cost of Health Insurance, and How the Affordable Care Act Tackles this Problem

Small business owners are deeply concerned about the exponentially rising cost of health insurance. As Harvard University economics professor David M. Cutler notes, while family health insurance premiums have increased 80% in the past decade after adjusting for inflation, median income has fallen by 5%.[21] When people have less disposable income to spend at local small businesses, small business owners feel the squeeze.

We know from our opinion surveys that small business owners want reform to lower these skyrocketing costs and believe it will be good for the economy overall.[22] The Affordable Care Act includes many provisions to contain costs. These measures will be felt throughout the entire healthcare system, lowering premium costs to small business owners and consumers alike. The Congressional Budget Office estimates the new law will lower federal deficits by more than $143 billion over the next 10 years, and by more than $1 trillion in the following decade. While there is still more that can be done to contain costs within the system, the new law is a great start. It moves our healthcare system toward greater financial stability and provides improved access to affordable, quality care for small business owners and their employees.

Along with small business tax credits and insurance exchanges, the ACA controls costs by reining in administrative costs for small businesses. As previously noted, small businesses pay 18% more on average than large businesses for comparable health policies. This is largely due to high administrative costs, which can be up to 30% of premiums. The law includes administrative simplification programs, helping to put the country on a path to lower-cost, standardized administrative transactions, processes and forms. Additionally, it establishes insurer efficiency standards that require 80% of premium dollars be spent on care, not administrative overhead and executive compensation, for small group and individual plans. For large groups plans, the standard will be 85%. All of these measures will lower the time doctors have to spend on paperwork.

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[20] Urban Institute, "Employer-Sponsored Insurance Under Health Reform: Reports of Its Demise Are Premature," Jan. 24, 2010, http://www.rwjf.org/coverage/product.jsp?id=71749&cid=XEM_749842.
[21] D Cutler, Repealing Health Care Is a Job Killer, Center for American Progress, 2010, http://www.americanprogress.org/issues/2011/01/jobs_health_repeal.html.
[22] Small Business Majority, State Surveys Highlight Small Business Support for Healthcare Reform, 2009, http://smallbusinessmajority.org/small-business-research/opinion-research.php.

The ACA also includes numerous reforms in Medicare that will reward value of care, not the volume of care. It requires the Department of Health and Human Services (HHS) to adopt value-based purchasing and payment methods for Medicare reimbursements for both physicians and hospitals, and move away from the fee-for-service system that is so costly and inefficient. What's more, cost containment measures made to Medicare will have a ripple effect to other areas of the system, further reducing costs. Harvard professor David Cutler points out the steps the Affordable Care Act takes to cut these costs:

- Payment innovations including greater reimbursement for preventive care services and patient-centered primary care; bundled payments for hospital, physician, and other services provided for a single episode of care; shared savings approaches or capitation payments that reward accountable provider groups that assume responsibility for the continuum of a patient's care; and pay-for-performance incentives for Medicare providers;
- An Independent Payment Advisory Board with the authority to make recommendations that reduce cost growth and improve quality in both the Medicare program and the health system as a whole;
- A new Innovation Center within the Centers for Medicare and Medicaid Services, or CMS, charged with streamlining the testing of demonstration and pilot projects in Medicare and rapidly expanding successful models across the program;
- Profiling medical care providers on the basis of cost and quality and making that data available to consumers and insurance plans, and providing relatively low-quality, high-cost providers with financial incentives to improve their care;
- Increased funding for comparative effectiveness research;
- Increased emphasis on wellness and prevention.[23]

Rather than focusing on repeal, lawmakers should focus on improving healthcare reform, especially when it comes to cost containment. While the new law is a good start toward fixing our system and strengthening our economy, we should be bolstering it even more by including additional cost containment provisions. This will bring health inflation down and help businesses create more jobs.

Sharing the Responsibility: Strengthening Our Small Businesses, Their Employees and the Economy

The Affordable Care Act requires that all residents purchase insurance—a requirement that, while not uniformly popular, is necessary in order for reform to be successful. It will ensure a broad distribution of health risks in the market and help bring down costs. While this requirement has spawned contentious debates, we found that many small businesses are willing to help share the responsibility of providing insurance if it means lower costs overall and better quality insurance. Opinion polling we conducted shows that:

[23] David Cutler, Repealing Health Care Is a Job Killer, Center For American Progress, Jan. 7, 2011, http://www.americanprogress.org/issues/2011/01/jobs_health_repeal.html.

- Small businesses are willing to share the responsibility for making health insurance affordable along with insurers, healthcare providers, individuals and government, according to an average of 66% of respondents. By state, those agreeing with the concept of shared responsibility ranged from 59% to 72%.[24]

We've also found that because so many small businesses are bombarded with misinformation, it has made it increasingly difficult for them to determine what the law actually requires of them. Most small business owners are surprised to learn that they won't be required to provide insurance. Businesses with fewer than 50 employees, which accounts for 96% of small businesses,[25] are exempt from all requirements in the law. Businesses with 51 employees or more will be required to provide insurance, however 96.5% of these businesses already cover their workers.[26]

The provision that all Americans purchase insurance was included in the law because businesses and the American people made it clear that they wanted to continue an employer-based health insurance system, not a government healthcare system, such as Medicare for all or Canadian-style healthcare insurance. Because 96% of employers with 51 or more employees are providing health insurance as well as paying federal taxes, it would not be fair to let 4% of employers have a free ride at the expense of the 96% of employers currently offering insurance, and at the same time have their employees covered by taxpayer funds to provide health insurance. Additionally, without the free-rider provision large employers would have an incentive to stop providing health insurance and let taxpayers provide coverage for their employees.

Small businesses today offer health benefits to attract and retain good employees and to be competitive with large businesses. This will continue under reform, except that now these small businesses will have the benefit of buying health insurance through the state insurance exchange—creating market leverage like that of big companies, while driving down and stabilizing costs for their employees.

Conclusion

Healthcare reform is not an ideological issue; it's an economic one. Small business owners know this, which is why they overwhelmingly support reforming our broken system and containing the skyrocketing cost of insurance.

Without healthcare reform, small businesses will once again be mired in a system that drains their coffers and stunts their growth—disabling them from playing their vitally important role as the nation's jobs creators. Harvard professor David Cutler is right when he concludes that repeal is "bad economic policy. The effort to repeal health reform will make our current problems worse."[27] We hope Congress will spend its time focusing

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[24] Small Business Majority, State Surveys Highlight Small Business Support for Healthcare Reform, August 2009, http://smallbusinessmajority.org/small-business-research/opinion-research.php.
[25] U.S. Small Business Administration, Office of Advocacy, based on data provided by the U.S. Census Bureau, Statistics of U.S. Businesses, 2006.
[26] Medical Expenditures Panel Survey, Insurance Component, Table I.A.2, 2008, available online at http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2008/tia2.pdf.
[27] D Cutler, Repealing Health Care is a Job Killer, Center for American Progress, 2010. http://www.americanprogress.org/issues/2011/01/jobs_health_repeal.html

on ways to make implementation of the Affordable Care Act as smooth as possible, and instead of trying to dismantle it, fix the parts that need improvement. Our small businesses and our economic recovery depend on it.

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED TWELFTH CONGRESS

Congress of the United States
House of Representatives
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Majority (202) 225–2927
Minority (202) 225–3641

RULE 1. GENERAL PROVISIONS

(a) Rules of the Committee. The Rules of the House are the rules of the Committee on Energy and Commerce (the "Committee") and its subcommittees so far as is applicable.

(b) Rules of the Subcommittees. Each subcommittee of the Committee is part of the Committee and is subject to the authority and direction of the Committee and to its rules so far as is applicable. Written rules adopted by the Committee, not inconsistent with the Rules of the House, shall be binding on each subcommittee of the Committee.

RULE 2. MEETINGS

(a) Regular Meeting Days. The Committee shall meet on the fourth Tuesday of each month at 10 a.m., for the consideration of bills, resolutions, and other business, if the House is in session on that day. If the House is not in session on that day and the Committee has not met during such month, the Committee shall meet at the earliest practicable opportunity when the House is again in session. The chairman of the Committee may, at his discretion, cancel, delay, or defer any meeting required under this section, after consultation with the ranking minority member.

(b) Additional Meetings. The chairman may call and convene, as he considers necessary, additional meetings of the Committee for the consideration of any bill or resolution pending before the Committee or for the conduct of other Committee business. The Committee shall meet for such purposes pursuant to that call of the chairman.

(c) Notice. The date, time, place, and subject matter of any meeting of the Committee scheduled on a Tuesday, Wednesday, or Thursday when the House will be in session shall be announced at least 36 hours (exclusive of Saturdays, Sundays, and legal holidays except when the House is in session on such days) in advance of the commencement of sueh meeting. The date, time, place, and subject matter of other meetings when the House is in session shall be announced to allow

Members to have at least three days notice (exclusive of Saturdays, Sundays, and legal holidays except when the House is in session on such days) of such meeting. The date, time, place, and subject matter of all other meetings shall be announced at least 72 hours in advance of the commencement of such meeting.

(d) Agenda. The agenda for each Committee meeting, setting out all items of business to be considered, shall be provided to each member of the Committee at least 36 hours in advance of such meeting.

(e) Availability of Texts. No bill, recommendation, or other matter shall be considered by the Committee unless the text of the matter, together with an explanation, has been available to members of the Committee for three days (or 24 hours in the case of a substitute for introduced legislation). Such explanation shall include a summary of the major provisions of the legislation, an explanation of the relationship of the matter to present law, and a summary of the need for the legislation.

(f) Waiver. The requirements of subsections (c), (d), and (e) may be waived by a majority of those present and voting (a majority being present) of the Committee or by the chairman with the concurrence of the ranking member, as the case may be.

RULE 3. HEARINGS

(a) Notice. The date, time, place, and subject matter of any hearing of the Committee shall be announced at least one week in advance of the commencement of such hearing, unless a determination is made in accordance with clause 2(g)(3) of Rule XI of the Rules of the House that there is good cause to begin the hearing sooner.

(b) Memorandum. Each member of the Committee shall be provided, except in the case of unusual circumstances, with a memorandum at least 48 hours before each hearing explaining (1) the purpose of the hearing and (2) the names of any witnesses.

(c) Witnesses. (1) Each witness who is to appear before the Committee shall file with the clerk of the Committee, at least two working days in advance of his or her appearance, sufficient copies, as determined by the chairman of the Committee of a written statement of his or her proposed testimony to provide to members and staff of the Committee, the news media, and the general public. Each witness shall, to the greatest extent practicable, also provide a copy of such written testimony in an electronic format prescribed by the chairman. Each witness shall limit his or her oral presentation to a brief summary of the argument. The chairman of the Committee or the presiding member may waive the requirements of this paragraph or any part thereof.

(2) To the greatest extent practicable, the written testimony of each witness appearing in a nongovernmental capacity shall include a curriculum vitae and a disclosure of the amount and source (by agency and program) of any federal grant (or subgrant thereof) or contract (or subcontract thereof) received during the current fiscal year or either of the two preceding fiscal years by the witness or by an entity represented by the witness.

(d) Questioning. (1) The right to interrogate the witnesses before the Committee shall alternate between majority and minority members. Each member shall be limited to 5 minutes in the interrogation of witnesses until such time as each member who so desires has had an opportunity to question witnesses. No member shall be recognized for a second period of 5 minutes to interrogate a witness until each member of the Committee present has been recognized once for that purpose. The chairman shall recognize in order of appearance members who were not present when the meeting was called to order after all members who were present when the meeting was called to order have been recognized in the order of seniority on the Committee.

(2) The chairman, with the concurrence of the ranking minority member, or the Committee by motion, may permit an equal number of majority and minority members to question a witness for a specified, total period that is equal for each side and not longer than thirty minutes for each side. The chairman with the concurrence of the ranking minority member, or the Committee by motion, may also permit committee staff of the majority and minority to question a witness for a specified, total period that is equal for each side and not longer than thirty minutes for each side.

(3) Each member may submit to the chairman of the Committee additional questions for the record, to be answered by the witnesses who have appeared. Each member shall provide a copy of the questions in an electronic format to the clerk of the Committee no later than ten business days following a hearing. The chairman shall transmit all questions received from members of the Committee to the appropriate witness and include the transmittal letter and the responses from the witnesses in the hearing record.

RULE 4. VICE CHAIRMEN; PRESIDING MEMBER

The chairman shall designate a member of the majority party to serve as vice chairman of the Committee, and shall designate a majority member of each subcommittee to serve as vice chairman of each subcommittee, other than the Oversight and Investigations Subcommittee. The vice chairman of the Committee or subcommittee, as the case may be, shall preside at any meeting or hearing during the temporary absence of the chairman. If the chairman and vice chairman of the Committee or subcommittee are not present at any meeting or hearing, the ranking member of the majority party who is present shall preside at the meeting or hearing.

RULE 5. OPEN PROCEEDINGS

Except as provided by the Rules of the House, each meeting and hearing of the Committee for the transaction of business, including the markup of legislation, and each hearing, shall be open to the public, including to radio, television, and still photography coverage, consistent with the provisions of Rule XI of the Rules of the House.

RULE 6. QUORUM

Testimony may be taken and evidence received at any hearing at which there are present not fewer than two members of the Committee in question. A majority of the members of the Committee shall constitute a quorum for those actions for which the House Rules require a majority quorum. For the purposes of taking any other action, one-third of the members of the

Committee shall constitute a quorum.

RULE 7. OFFICIAL COMMITTEE RECORDS

(a)(1) Journal. The proceedings of the Committee shall be recorded in a journal which shall, among other things, show those present at each meeting, and include a record of the vote on any question on which a record vote is demanded and a description of the amendment, motion, order, or other proposition voted. A copy of the journal shall be furnished to the ranking minority member.

(2) Record Votes. A record vote may be demanded by one-fifth of the members present or, in the apparent absence of a quorum, by any one member. No demand for a record vote shall be made or obtained except for the purpose of procuring a record vote or in the apparent absence of a quorum. The result of each record vote in any meeting of the Committee shall be made publicly available in electronic form on the Committee's website and in the Committee office for inspection by the public, as provided in Rule XI, clause 2(e) of the Rules of the House, within 24 hours. Such result shall include a description of the amendment, motion, order, or other proposition, the name of each member voting for and each member voting against such amendment, motion, order, or proposition, and the names of those members of the committee present but not voting. The chairman, with the concurrence of the ranking minority member, may from time to time postpone record votes ordered on amendments to be held at a time certain during the consideration of legislation.

(b) Archived Records. The records of the Committee at the National Archives and Records Administration shall be made available for public use in accordance with Rule VII of the Rules of the House. The chairman shall notify the ranking minority member of any decision, pursuant to clause 3 (b)(3) or clause 4 (b) of the Rule, to withhold a record otherwise available, and the matter shall be presented to the Committee for a determination on the written request of any member of the Committee. The chairman shall consult with the ranking minority member on any communication from the Archivist of the United States or the Clerk of the House concerning the disposition of noncurrent records pursuant to clause 3(b) of the Rule.

RULE 8. SUBCOMMITTEES

(a) Establishment. There shall be such standing subcommittees with such jurisdiction and size as determined by the majority party caucus of the Committee. The jurisdiction, number, and size of the subcommittees shall be determined by the majority party caucus prior to the start of the process for establishing subcommittee chairmanships and assignments.

(b) Powers and Duties. Each subcommittee is authorized to meet, hold hearings, receive testimony, mark up legislation, and report to the Committee on all matters referred to it. Subcommittee chairmen shall set hearing and meeting dates only with the approval of the chairman of the Committee with a view toward assuring the availability of meeting rooms and avoiding simultaneous scheduling of Committee and subcommittee meetings or hearings whenever possible.

(c) Ratio of Subcommittees. The majority caucus of the Committee shall determine an appropriate ratio of majority to minority party members for each subcommittee and the chairman shall negotiate that ratio with the minority party, provided that the ratio of party members on each subcommittee shall be no less favorable to the majority than that of the full Committee, nor shall such ratio provide for a majority of less than two majority members.

(d) Selection of Subcommittee Members. Prior to any organizational meeting held by the Committee, the majority and minority caucuses shall select their respective members of the standing subcommittees.

(e) Ex Officio Members. The chairman and ranking minority member of the Committee shall be ex officio members with voting privileges of each subcommittee of which they are not assigned as members and may be counted for purposes of establishing a quorum in such subcommittees. The minority chairman emeritus shall be an ex officio member without voting privileges of each subcommittee of which the minority chairman emeritus is not assigned as a member and shall not be counted for purposes of establishing a quorum on any such subcommittee.

RULE 9. OPENING STATEMENTS

(a) Written Statements. All written opening statements at hearings and business meetings conducted by the committee shall be made part of the permanent record.

(b) Length. (1) At full committee hearings, the chairman and ranking minority member shall be limited to 5 minutes each for an opening statement, and may designate another member to give an opening statement of not more than 5 minutes. At subcommittee hearings, the subcommittee chairman and ranking minority member of the subcommittee shall be limited to 5 minutes each for an opening statement. In addition, the full committee chairman and ranking minority member shall each be allocated 5 minutes for an opening statement for themselves or their designees.
(2) At any business meeting of the Committee, statements shall be limited to 5 minutes each for the chairman and ranking minority member (or their respective designee) of the Committee or subcommittee, as applicable, and 3 minutes each for all other members. The chairman may further limit opening statements for Members (including, at the discretion of the Chairman, the chairman and ranking minority member) to one minute.

RULE 10. REFERENCE OF LEGISLATION AND OTHER MATTERS

All legislation and other matters referred to the Committee shall be referred to the subcommittee of appropriate jurisdiction within two weeks of the date of receipt by the Committee unless action is taken by the full Committee within those two weeks, or by majority vote of the members of the Committee, consideration is to be by the full Committee. In the case of legislation or other matter within the jurisdiction of more than one subcommittee, the chairman of the Committee may, in his discretion, refer the matter simultaneously to two or more subcommittees for concurrent consideration, or may designate a subcommittee of primary jurisdiction and also refer the matter to one or more additional subcommittees for consideration in sequence (subject to appropriate time limitations), either on its initial referral or after the

matter has been reported by the subcommittee of primary jurisdiction. Such authority shall include the authority to refer such legislation or matter to an ad hoc subcommittee appointed by the chairman, with the approval of the Committee, from the members of the subcommittees having legislative or oversight jurisdiction.

RULE 11. MANAGING LEGISLATION ON THE HOUSE FLOOR

The chairman, in his discretion, shall designate which member shall manage legislation reported by the Committee to the House.

RULE 12. COMMITTEE PROFESSIONAL AND CLERICAL STAFF APPOINTMENTS

(a) Delegation of Staff. Whenever the chairman of the Committee determines that any professional staff member appointed pursuant to the provisions of clause 9 of Rule X of the House of Representatives, who is assigned to such chairman and not to the ranking minority member, by reason of such professional staff member's expertise or qualifications will be of assistance to one or more subcommittees in carrying out their assigned responsibilities, he may delegate such member to such subcommittees for such purpose. A delegation of a member of the professional staff pursuant to this subsection shall be made after consultation with subcommittee chairmen and with the approval of the subcommittee chairman or chairmen involved.

(b) Minority Professional Staff. Professional staff members appointed pursuant to clause 9 of Rule X of the House of Representatives, who are assigned to the ranking minority member of the Committee and not to the chairman of the Committee, shall be assigned to such Committee business as the minority party members of the Committee consider advisable.

(c) Additional Staff Appointments. In addition to the professional staff appointed pursuant to clause 9 of Rule X of the House of Representatives, the chairman of the Committee shall be entitled to make such appointments to the professional and clerical staff of the Committee as may be provided within the budget approved for such purposes by the Committee. Such appointee shall be assigned to such business of the full Committee as the chairman of the Committee considers advisable.

(d) Sufficient Staff. The chairman shall ensure that sufficient staff is made available to each subcommittee to carry out its responsibilities under the rules of the Committee.

(e) Fair Treatment of Minority Members in Appointment of Committee Staff. The chairman shall ensure that the minority members of the Committee are treated fairly in appointment of Committee staff.

(f) Contracts for Temporary or Intermittent Services. Any contract for the temporary services or intermittent service of individual consultants or organizations to make studies or advise the Committee or its subcommittees with respect to any matter within their jurisdiction shall be deemed to have been approved by a majority of the members of the Committee if approved by

the chairman and ranking minority member of the Committee. Such approval shall not be deemed to have been given if at least one-third of the members of the Committee request in writing that the Committee formally act on such a contract, if the request is made within 10 days after the latest date on which such chairman or chairmen, and such ranking minority member or members, approve such contract.

RULE 13. SUPERVISION, DUTIES OF STAFF

(a) Supervision of Majority Staff. The professional and clerical staff of the Committee not assigned to the minority shall be under the supervision and direction of the chairman who, in consultation with the chairmen of the subcommittees, shall establish and assign the duties and responsibilities of such staff members and delegate such authority as he determines appropriate.

(b) Supervision of Minority Staff. The professional and clerical staff assigned to the minority shall be under the supervision and direction of the minority members of the Committee, who may delegate such authority as they determine appropriate.

RULE 14. COMMITTEE BUDGET

(a) Administration of Committee Budget. The chairman of the Committee, in consultation with the ranking minority member, shall for the 112th Congress attempt to ensure that the Committee receives necessary amounts for professional and clerical staff, travel, investigations, equipment and miscellaneous expenses of the Committee and the subcommittees, which shall be adequate to fully discharge the Committee's responsibilities for legislation and oversight..

(b) Monthly Expenditures Report. Committee members shall be furnished a copy of each monthly report, prepared by the chairman for the Committee on House Administration, which shows expenditures made during the reporting period and cumulative for the year by the Committee and subcommittees, anticipated expenditures for the projected Committee program, and detailed information on travel.

RULE 15. BROADCASTING OF COMMITTEE HEARINGS

Any meeting or hearing that is open to the public may be covered in whole or in part by radio or television or still photography, subject to the requirements of clause 4 of Rule XI of the Rules of the House. The coverage of any hearing or other proceeding of the Committee or any subcommittee thereof by television, radio, or still photography shall be under the direct supervision of the chairman of the Committee, the subcommittee chairman, or other member of the Committee presiding at such hearing or other proceeding and may be terminated by such member in accordance with the Rules of the House.

RULE 16. SUBPOENAS

The chairman of the Committee may, after consultation with the ranking minority member, authorize and issue a subpoena under clause 2(m) of Rule XI of the House. If the ranking minority member objects to the proposed subpoena in writing, the matter shall be referred to the

Committee for resolution. The chairman of the Committee may authorize and issue subpoenas without referring the matter to the Committee for resolution during any period for which the House has adjourned for a period in excess of 3 days when, in the opinion of the chairman, authorization and issuance of the subpoena is necessary. The chairman shall report to the members of the Committee on the authorization and issuance of a subpoena during the recess period as soon as practicable but in no event later than one week after service of such subpoena.

RULE 17. TRAVEL OF MEMBERS AND STAFF

(a) Approval of Travel. Consistent with the primary expense resolution and such additional expense resolutions as may have been approved, travel to be reimbursed from funds set aside for the Committee for any member or any staff member shall be paid only upon the prior authorization of the chairman. Travel may be authorized by the chairman for any member and any staff member in connection with the attendance of hearings conducted by the Committee or any subcommittee thereof and meetings, conferences, and investigations which involve activities or subject matter under the general jurisdiction of the Committee. Before such authorization is given there shall be submitted to the chairman in writing the following: (1) the purpose of the travel; (2) the dates during which the travel is to be made and the date or dates of the event for which the travel is being made; (3) the location of the event for which the travel is to be made; and (4) the names of members and staff seeking authorization.

(b) Approval of Travel by Minority Members and Staff. In the case of travel by minority party members and minority party professional staff for the purpose set out in (a), the prior approval, not only of the chairman but also of the ranking minority member, shall be required. Such prior authorization shall be given by the chairman only upon the representation by the ranking minority member in writing setting forth those items enumerated in (1), (2), (3), and (4) of paragraph (a).

RULE 18. WEBSITE

The chairman shall maintain an official Committee website for the purposes of furthering the Committee's legislative and oversight responsibilities, including communicating information about the Committee's activities to Committee members and other members of the House. The ranking minority member may maintain an official website for the purpose of carrying out official responsibilities, including communicating information about the activities of the minority members of the Committee to Committee members and other members of the House.

RULE 19. CONFERENCES

The chairman of the Committee is directed to offer a motion under clause 1 of Rule XXII of the Rules of the House whenever the chairman considers it appropriate.

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED TWELFTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115

Majority (202) 225–2927
Minority (202) 225–3641

June 3, 2011

Mr. Douglas W. Elmendorf
Director
Congressional Budget Office
402 Ford House Office Building
Washington, D.C. 20515

Dear Mr. Elmendorf:

Thank you for appearing before the Subcommittee on Health on Wednesday, March 30, 2011, to testify at the hearing entitled "The True Cost of PPACA: Effects on the Budget and Jobs."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for 10 business days to permit Members to submit additional questions to witnesses, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and then (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions by the close of business on Friday, June 17, 2011. Your responses should be e-mailed to the Legislative Clerk, in Word or PDF format, at Allison.Busbee@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts

Joe Pitts
Chairman
Subcommittee on Health

cc: Frank Pallone, Jr., Ranking Member,
Subcommittee on Health

Attachment

Questions for the Record
CONGRESSIONAL BUDGET OFFICE

The Honorable Phil Gingrey

1. **From an economic and actuarial perspective, which has a greater risk of adverse selection—the market for health insurance, or the market for long-term care insurance?**

Adverse selection is the phenomenon whereby a disproportionate number of people who expect to have higher-than-average costs enroll in an insurance plan. Adverse selection (and even the potential for adverse selection) results in higher average premiums and thus lower enrollment than would otherwise occur. In the extreme, an insurance market may break down because of adverse selection: In such cases, the higher premiums drive away potential purchasers who expect to incur relatively low costs, leaving fewer and fewer enrollees, of whom an increasingly large proportion are high-cost, requiring even higher premiums.

The potential for adverse selection may result in plans offering less comprehensive coverage than would otherwise exist in an attempt to avoid enrollees with relatively high costs. The potential for adverse selection is high (for either type of insurance) in situations when (1) enrollment is low, (2) premiums are not allowed to vary on the basis of the health status of a new applicant, and (3) potential policyholders are better able to predict their use of benefits than is the insurer.

Both health insurance and long-term care insurance have characteristics that heighten the possibility of adverse selection and various tools exist for mitigating that risk. CBO is not aware of any definitive information about which of those two markets may face a greater risk of adverse selection.

Insurers of both kinds have sometimes dealt with low enrollment, which has led insurers to abandon certain service areas or cease offering particular types of policies. State policies differ on the extent to which they permit health insurers to vary premiums on the basis of health status, a practice known as medical underwriting. Most states place at least some restrictions on medical underwriting in the small group market, although those restrictions vary widely in their stringency. By contrast, the majority of states do not restrict medical underwriting in the non-group health insurance market. Likewise, private long-term care insurers may take into consideration an applicant's health status and family medical history in determining the premium they will charge.

The government's Community Living Assistance Services and Supports (CLASS) program would not have been allowed to vary premiums in this way but would have used a vesting period and a work requirement to try to mitigate adverse selection: Among the

requirements to be eligible for benefits, enrollees would have had to pay premiums for at least five years and to earn a certain minimum amount of wages or self-employment income during the first five years in which premiums are paid. Despite those requirements, the Department of Health and Human Services has concluded that adverse selection would have made that program untenable and will not implement it.

2. Do you believe that the CLASS Act as written can be implemented without requiring mandatory participation in the government program?

The law directs the Secretary of Health and Human Services (HHS) to set premiums based on an actuarial analysis of the 75-year costs of the program that ensures solvency throughout such 75-year period. In its analysis of the budgetary effects of the program, CBO produced estimates that it judged to be in the middle of the distribution of possible outcomes. Those outcomes included a number of possibilities—that HHS would implement the program (without mandatory participation) and it would be viable; that HHS would implement the program and it ultimately would not be self-sustaining; or that the department would decide not to implement the program because it would not be actuarially sound. CBO believed, at that time, that each of those outcomes was possible, reflecting the concerns that many observers expressed about the challenges of implementing such a program.

Implicit in those estimates was the expectation that there was a significant probability that HHS would undertake to implement the program and some chance that it would be viable, especially because of the authority given to the Secretary to ensure its solvency. There was also a significant risk that the CLASS program would attract too many enrollees in poor health—people who might not be able to obtain coverage from a private insurer. In that case, premiums would have had to be high in order to maintain actuarial balance, and such high premiums would have depressed enrollment. High premiums and low enrollment would have contributed to more adverse selection and future financial instability of the program. In fact, the Secretary has now concluded that the program cannot be operated without mandatory participation so as to ensure its solvency.

3. Secretary Sebelius has publicly commented that if HHS believes the CLASS Act is going to be insolvent, the program will not be implemented. If HHS makes such a declaration, or fails to implement the program due to solvency concerns, at what point would CBO adjust its budgetary baseline accordingly?

CBO's baseline is regularly updated three times a year—usually in January, March, and August. In addition, for the purposes of estimating the impact of proposed legislation, CBO takes into account definitive administrative actions that occur in between baseline updates. Examples of such administrative actions include publication of a final regulation and final guidance to states about aspects of the Medicaid program. When such a definitive action occurs, CBO incorporates its effects in its current-law estimates that are the basis for projecting the impact of legislation, and the subsequent baseline update incorporates the change in projected spending or revenues that results from that action. Because the Secretary has now made a definitive, official statement that the CLASS program will not be implemented, the budgetary impact of any subsequent legislation will be measured against a current-law projection that does not include a CLASS program.

4. CBO's update on the Long-Term Budget Outlook, released last June, included an alternative fiscal scenario under which several PPACA-related provisions would not be implemented in the years after 2020, because CBO concluded "those policies may be difficult to maintain over the long term." Included in those provisions are "the continuing reductions in updates for Medicare's payment rates, the constraints on Medicare imposed by IPAB, and the additional indexing provisions that will slow the growth of exchange subsidies after 2018." Should the three provisions outlined above NOT be implemented after 2020—as CBO's alternative fiscal scenario assumes—what would be the fiscal and budgetary impact of PPACA as a whole in the law's second decade?

CBO has not separately identified the effect of not implementing the specific policies that might be difficult to maintain over the long term that we identified in our June 2010 *Long-Term Budget Outlook*. However, we have conducted similar analyses on two occasions. On March 19, 2010, we sent a letter to Congressman Ryan that provided information about the effects on the federal budget beyond the 2010-2019 period if several policies (including the three you asked about) were not implemented. In particular, he asked what would occur if:

- The excise tax on insurance plans with relatively high premiums—which will take effect in 2018 and for which the thresholds will be indexed at a lower rate beginning in 2020—was never implemented;

- The annual indexing provisions for premium subsidies offered through the insurance exchanges continued in the same way after 2018 as before—in contrast to the arrangements specified by the Reconciliation Act of 2010 (P.L. 111-152), which will slow the growth of subsidies after 2019;

- The scheduled reductions in payment rates for physicians under Medicare did not take effect, and instead, those rates were adjusted as specified in H.R. 3961; and

- The Independent Payment Advisory Board—which will be required, under certain circumstances, to recommend changes to the Medicare program to limit the rate of growth in that program's spending, and whose recommendations will go into effect automatically unless blocked by subsequent legislative action—was never implemented.

CBO concluded that, if the changes described above were made to PPACA and the Reconciliation Act, the net effect of the legislation would be an *increase* in federal budget deficits during the decade beyond 2019 relative to those projected under prior law—with a total effect during that decade in a broad range around one-quarter percent of GDP.

That letter can be found at:

http://www.cbo.gov/ftpdocs/113xx/doc11376/RyanLtrhr4872.pdf

We provided a similar analysis to Chairman Ryan on February 18, 2011, which addressed the impact of leaving certain policies in place, rather than repealing them as specified in H.R. 2. That letter can be found at:

http://www.cbo.gov/ftpdocs/120xx/doc12070/hr2RyanLtr.pdf

5. CBO has previously opined that the 40 percent "Cadillac tax" on high-cost plans will lead insurers to modify their benefit packages, for instance by raising deductibles and co-payments or making other steps to trim benefits. However, PPACA also includes an essential benefits package—a group of benefits that individuals must purchase in order to meet requirements of the law's individual mandate. Because the "Cadillac tax" threshold is only updated annually according to CPI inflation, the cost of the mandated benefits could well rise faster than the "Cadillac tax" threshold is increased.

a. Do you agree that it is possible—even likely—that sooner or later ALL employer plans will be subject to the "Cadillac tax"—because the mandated benefits will grow faster that the threshold for triggering the tax?

b. If an employer cannot avoid the "Cadillac tax" because of the requirements of the essential benefits package, who would bear the economic burden of this 40 percent levy?

c. Under this scenario, what will be the distributional impact at the margin of the 40 percent "Cadillac tax" when compared to a cap on the income and payroll tax exclusion provided to employer-sponsored health insurance?

d. Should such a scenario occur whereby an employer cannot modify benefits to avoid the "Cadillac tax," do you believe employers would continue to maintain coverage for their employees?

e. For the reasons outlined above, do you believe that the revenue generated from the "Cadillac tax" could eventually exceed the revenue generated from the income tax?

CBO works in close coordination with the staff of the Joint Committee on Taxation (JCT) on tax-related estimates. In particular, JCT spearheaded our combined efforts to estimate the budgetary impact of the excise tax provisions of PPACA and the Reconciliation Act. (JCT is responsible for determining official estimates of revenue changes that would result from any amendments to the Internal Revenue Code.) Therefore, for detailed information about estimates related to this provision, JCT would be the best source. The following are some general thoughts on the issues raised by your questions.

Generally, the rate of growth of health insurance premiums paid by employers will, on average, be larger than the growth in the excise tax thresholds. Thus, over time, more employers will be subject to the excise tax. The extent to which this occurs will depend on the extent to which the growth in medical costs exceeds the growth in prices overall.

Over the long term, the burden of the tax will fall on firms' employees. Most economists generally expect that, on average, an employee's total compensation—including wages, fringe benefits, and any taxes on those amounts—will equal his or her contribution to the revenue of the firm. Thus, for employees enrolled in plans whose premiums exceed the relevant excise tax threshold, their employers will probably pay less in wages and other forms of compensation, keeping total compensation about the same.

Employers subject to the excise tax will be liable for excise tax payments on the amount of the total insurance premium (plus other amounts subject to the tax) that exceeds the threshold. Because of this disincentive to offer coverage, CBO and JCT estimate that some employers will drop coverage rather than pay the excise tax. But many employers potentially subject to the excise tax will continue to offer coverage because their

employees will still continue to benefit from the income and payroll tax exclusions for health insurance premium amounts below those thresholds. We expect that most firms will avoid paying the excise tax by reducing the value of the benefit packages they offer.

The Honorable Bill Cassidy

1. **Can you please explain why your testimony indicates that Medicaid outlays will continue to increase every year between 2016 and 2020 by an average of $5.6 billion per year despite a flat level of Medicaid enrollment and a decrease in federal funding obligations for the newly eligible Medicaid population? In addition, what is the countervailing cost on state budgets?**

CBO estimated that the cost of adding approximately 17 million new enrollees to Medicaid and the Children's Health Insurance Program (CHIP) as a result of last year's health care legislation will grow from $77 billion in 2016 to $105 billion in 2021—in percentage terms, an average of about 6.4 percent per year, and in dollar terms, an average of about $5.6 billion per year—primarily because of rising prices for the medical services that those programs provide and to lesser extent because of changes in the utilization of medical services. Such changes in utilization can include the increasing use of new drugs, devices, or technologies. For example, over the 2000-2010 period, Medicaid spending per capita grew by an average of about 6 percent per year, reflecting a combination of price inflation and growth in the utilization of medical services.

CBO estimates that state spending for Medicaid and CHIP will increase by $60 billion over the 2012-2021 period because of the coverage provisions in last year's health care legislation.

2. **Did the CBO presume that there was cost savings in PPACA associated with expanding access? How much savings were scored due to this? What evidence does the CBO have to prove this is true? Please provide references.**

CBO expects that the federal government will incur significant additional costs as a result of the insurance coverage provisions of the Patient Protection and Affordable Care Act (PPACA). (The net savings projected to result from the new law stem from other provisions.) An estimated 17 million people will be added to the Medicaid and CHIP programs by 2021, and 24 million people will receive subsidies toward the purchase of private health insurance plans offered through exchanges. In March 2011, CBO estimated the additional federal costs in that year to be about $240 billion.

Because health insurance reduces the price individuals must pay to providers to obtain care, those individuals who newly obtain insurance under PPACA are expected to increase their use of medical services and spend *more* for health care than they did while uninsured. Even after accounting for that increase in health care spending among the otherwise uninsured, CBO estimates that, on average, the newly insured will have somewhat lower health care costs than those who would have been insured even if PPACA had not gone into effect. That gap reflects CBO's assessment that, on average,

people without insurance have a lower propensity to use health care services—a tendency that would persist if they became covered under the new program. Those estimates are based on a review of the literature of the health status of the uninsured and original analysis by CBO. For a more complete discussion of the key research findings regarding the effects of gaining insurance coverage on health care use and spending, see CBO's report entitled *Key Issues in Analyzing Major Health Insurance Proposals*, Chapter 3, pages 71-76.[1]

3. **Your testimony states that Accountable Care Organizations (ACOs) can reduce costs. However, according to a March 23rd New England Journal of Medicine article "*The ACO Model-A Three-Year Financial Loss?*" health care entities specifically chosen to succeed as ACOs in demonstration projects more often than not failed to save money. What will happen when ACOs are implemented in "real world settings"? What is the estimated savings attributed to the adoption of ACOs and when are those savings estimated to begin? Did CBO include start- up costs and cost associated with implementation in rural areas in its estimate? If so, were savings different?**

Sections 3022 and 10307 of the Patient Protection and Affordable Care Act (Public Law 111-148) establish a Medicare shared savings program, under which groups of providers of services and suppliers may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization (ACO), and ACOs that meet quality performance standards established by the Secretary will be eligible to receive payments representing a share of the estimated savings realized by Medicare. CBO estimated that those sections will lead to savings in Medicare beginning in fiscal year 2013 and, after accounting for the shared savings payments to ACOs, will reduce gross Medicare spending in the fee-for-service sector by $4.9 billion over the 2010-2019 period.

Unlike CBO's estimate, which addresses only effects on the federal budget, the article cited does not focus on costs or savings accruing to the Medicare program. Rather, the article focuses on financial losses incurred by physician group practices that participated in the Physician Group Practice (PGP) demonstration program. The article notes that "high up-front investments make the model a poor fit for most physician group practices;" and suggests that the Centers for Medicare and Medicaid Services (CMS) "could limit participation in the Medicare Shared Savings Program to a narrow group of provider organizations that can absorb the likely financial losses in the early years of participation."

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[1] http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf

Neither conclusion is surprising. In fact, CBO's estimate that the shared savings program will generate savings for Medicare was predicated on the expectation that CMS would design the shared savings program so as to make the program attractive only to physician groups and clinically integrated organizations with a relatively large number of Medicare patients. Because the payments to ACOs under the shared savings program will be based on spending benchmarks reflecting historical experience, the program will make substantial payments to organizations that don't actually generate savings for Medicare—simply as a result of natural variation in the costs of treating patients with any particular set of characteristics. That variation in cost per beneficiary declines as the number of patients increases. Consequently, designing the rules of the shared savings program so as to limit participation by organizations that do not have relatively large numbers of Medicare patients is necessary to minimize the amount of "windfall" bonus payments and to maximize the likelihood that the program will reduce Medicare spending.

CBO focused on estimating the effects of the provision on Medicare spending and did not analyze the costs that would be borne by participating organizations—either nationwide or on an urban/rural basis.

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED TWELFTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115

Majority (202) 225–2927
Minority (202) 225–3641

June 3, 2011

Mr. Richard Foster
Chief Actuary
Center for Medicare and Medicaid Service
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Mr. Foster:

Thank you for appearing before the Subcommittee on Health on Wednesday, March 30, 2011, to testify at the hearing entitled "The True Cost of PPACA: Effects on the Budget and Jobs."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for 10 business days to permit Members to submit additional questions to witnesses, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and then (3) your answer to that question in plain text.

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Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts

Joe Pitts
Chairman
Subcommittee on Health

cc: Frank Pallone, Jr., Ranking Member,
Subcommittee on Health

Attachment

The Honorable Phil Gingrey

1. **From an economic and actuarial perspective, which has a greater risk of adverse selection—the market for health insurance, or the market for long-term care insurance?**

   Health insurance and long-term care insurance are both potentially subject to adverse selection by individuals who might seek to obtain coverage because they know they have an above-average likelihood of the insured risk. Since long-term care insurance typically involves a much longer commitment and higher potential costs, the risk of adverse selection for such coverage would generally be greater than for health insurance.

2. **Do you believe that the CLASS Act as written can be implemented without requiring mandatory participation in the government program?**

   Absent either (i) mandatory participation requirements, (ii) premium subsidies, or (iii) effective underwriting standards, long-term care insurance would be subject to severe adverse selection problems. The CLASS program, as enacted, did not include any of these mechanisms; accordingly, I opined that the program was unlikely to be sustainable. During implementation planning, consideration was given to stronger work requirements and other measures in lieu of underwriting. However, none of these measures was consistent with the statutory provisions governing the CLASS program, and ultimately the Secretary of HHS suspended its implementation.

3. **Did anyone within HHS' Office of Planning and Evaluation discuss their modeling of the CLASS Act with you prior to enactment of PPACA on March 23, 2010? If so, what was the substance of those conversations? Did anyone from the Office of Planning and Evaluation (or other offices within the federal government outside of the actuary's office) tell you they were of the conclusion that the CLASS Act as written in the bill was fundamentally flawed—or did they provide information that would lead you to draw the conclusion that they were of that opinion?**

   The Office of the Actuary was not directly involved with HHS' modeling of the CLASS program. We were, however, aware that the Office of the Assistant Secretary for Planning and Evaluation (ASPE) was working with an actuarial contractor to estimate the premium

levels that would be required. In addition, in conversations with ASPE and OMB officials, it was widely acknowledged that the CLASS program, as originally drafted, would be subject to serious problems with adverse selection. ASPE worked with members of the Senate HELP Committee staff to develop a number of revisions to the proposal designed to reduce the risk of adverse selection, but ultimately the changes were not included in the final language as enacted.

4. **Last May, CMS spent $18 million sending out a mailer to all Medicare beneficiaries telling them the health care law would "keep Medicare strong and solvent." While CMS Administrator Berwick submitted comments to the Finance Committee indicating that "CMS consults with OACT whenever its actuarial expertise is relevant"—which presumably would apply to any mailer making claims about Medicare's solvency—Secretary Sebelius pointedly declined to answer a question from eight senators who wrote asking whether your office was consulted on this mailer's content. Were you, or anyone within your office, consulted before this mailer was distributed to beneficiaries?**

   To the best of our recollection, no one in the Office of the Actuary was asked to review the beneficiary mailer in question before it was distributed.

5. **If you were not previously consulted regarding the Medicare mailer, do you have any concerns about the accuracy or completeness of claims made within it?**

   The mailer on Medicare and the new health care law, which was sent to Medicare beneficiaries in May 2010, focuses on benefit improvements, efforts to combat fraud and abuse, reduced premiums and cost-sharing payments, and other positive aspects of the Affordable Care Act. It does not describe certain other elements of the legislation that might be viewed with concern by many beneficiaries. If we had been asked to review the mailer, we would have recommended a more complete and balanced summary of the legislation's effects on the Medicare program, and we would have advised against some of the language used because of its misleading nature.

Responses by Richard S. Foster
Chief Actuary
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
December 14, 2012

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED TWELFTH CONGRESS

Congress of the United States
House of Representatives
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Minority (202) 225–3641

June 3, 2011

Dr. Douglas Holtz-Eakin
President
American Action Forum
1401 New York Avenue, N.W. Suite 1200
Washington, D.C. 20005

Dear Dr. Holtz-Eakin:

Thank you for appearing before the Subcommittee on Health on Wednesday, March 30, 2011, to testify at the hearing entitled "The True Cost of PPACA: Effects on the Budget and Jobs."

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Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts

Joe Pitts
Chairman
Subcommittee on Health

cc: Frank Pallone, Jr., Ranking Member,
Subcommittee on Health

Attachment

I believe that Medicaid waivers are a desirable policy that allow states the flexibility to innovate and provide better services for their Medicaid populations. While those at CMS need to do their jobs and thoroughly review waiver applications, the time should be kept to a minimum. As for the state budgetary impact, the magnitudes would depend on the goals of the waiver. It seems unlikely that a state would seek a waiver that would raise its costs in an undesirable way, so the presumption must b that a waiver provides savings and that it is costly to delay a new program or initiative. An additional cost would be any time and money needed to design (and perhaps implement) a less-attractive "plan while waiting for a decision.

The Honorable Cathy McMorris Rodgers

1. As you know, waivers give states more flexibility in how they implement their Medicaid programs. Flexibility in most scenarios means cost savings. In your opinion, what impact does CMS's delayed response to Section 1115 waiver requests have on state budgets? I'll give you one example, Washington State submitted a waiver application and it took CMS about one year -- give or take a few weeks -- to finalize its approval. In the meantime, the State was prevented from moving forward to address its budget crisis. I know this delay cost the state money at a time when the state can least afford it (the state of Washington is facing a $5.7 billion deficit over the next two years).