“Examining CMS’s Efforts to Fight Medicaid Fraud and Overpayments”
Opening Statement of Chairman Ron Johnson
August 21, 2018

Good morning and welcome.

This is our second hearing in recent weeks on Medicaid fraud and overpayments. Most agree that the billions of federal dollars wasted through Medicaid fraud and overpayments is a problem—the accelerating growth of Medicaid only makes the problem more pressing. As a businessman from a manufacturing background, I believe that the first step in the problem-solving process is to properly define the problem. That was the purpose of our first hearing. Today, we meet to discuss potential solutions.

As we discussed in our June hearing, the nation’s healthcare financing system is broken and is increasingly dependent on the government. With overall health spending now 17 percent of gross domestic product, the government’s share of health care spending has more than doubled since 1960.

Much of this unsustainable growth is due to Medicaid. While Medicaid is a valuable program for those in need, it consumes an ever-larger portion of the federal budget. Conceived in the 1960s as a small program to help poor people cover medical bills, Medicaid enrolled just four million people in its first year. The per-enrollee cost then was $222.

Today, Medicaid has grown into the nation’s largest health insurer, covering more than 70 million people, at a total cost of $554 billion per year. Per enrollee, Medicaid costs are nearly $8,000, a 3,491 percent increase since 1966. In the next seven years, the government predicts that federal Medicaid spending will increase another 96 percent, in significant part because of the Affordable Care Act’s Medicaid expansion. The expansion has cost more than even the Centers for Medicare & Medicaid Services projected.

Government watchdogs have warned CMS for 15 years about Medicaid’s vulnerability to fraud and overpayments, and the Committee has found that CMS has not taken basic steps to fix the problems. As a result, Medicaid overpayments to providers are $37 billion per year, a 157 percent increase since 2013. Increasingly, the program is funding fraudsters whose primary goal is self-enrichment.

Today, we welcome CMS Administrator Seema Verma who is here to provide testimony regarding CMS’s new Medicaid program integrity initiatives, announced in June of this year. We also welcome back Comptroller General Gene Dodaro, who helped us to understand the problem of Medicaid fraud and overpayments. Mr. Dodaro testified in June that CMS’s new initiatives were “a good first step, but not nearly enough.” I welcome his testimony today.

We all share the same goal of making the Medicaid program more efficient and accountable to the people it was intended to help. I look forward to a valuable discussion about what CMS can do to improve Medicaid and protect federal taxpayer dollars.