

MEDPAC'S ANNUAL MARCH REPORT

HEARING

BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED TENTH CONGRESS

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**MEDICARE PAYMENT ADVISORY
COMMISSION'S ANNUAL MARCH REPORT**

TUESDAY, MARCH 11, 2008

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:04 a.m., in Room 1100, Longworth House Office Building, the Honorable Fortney Pete Stark [chairman of the subcommittee] presiding.
[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
March 04, 2008
HL-21

CONTACT: (202) 225-3943

Stark Announces a Hearing on MedPAC's Annual March Report with MedPAC Chairman Glenn M. Hackbarth

House Ways and Means Health Subcommittee Chairman Pete Stark (D-CA) announced today that the Subcommittee on Health will hold a hearing on the Medicare Payment Advisory Commission's (MedPAC) annual March report on Medicare payment policies with MedPAC Chairman Glenn M. Hackbarth. **The hearing will take place at 10:00 a.m. on Tuesday, March 11, 2008, in the main committee hearing room, 1100 Longworth House Office Building.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from the invited witness only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

MedPAC advises Congress on Medicare payment policies. MedPAC is required by law to submit its annual advice and recommendations on Medicare payment policies by March 1, and an additional report on issues facing Medicare by June 15. In its reports to the Congress, MedPAC is required to review and make recommendations on payment policies for specific provider groups, including Medicare Advantage plans, hospitals, skilled nursing facilities, physicians, and other sectors, and to examine other issues regarding access, quality, and delivery of health care.

In announcing the hearing, Chairman Stark said, **"The Congress relies heavily on MedPAC's expertise when crafting Medicare legislation. MedPAC's recommendations help Medicare remain a reliable partner to providers, while also assuring that beneficiaries and taxpayers are getting the best value for their money."**

FOCUS OF THE HEARING:

The hearing will focus on MedPAC's March 2008 Report to Congress.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, <http://waysandmeans.house.gov>, select "110th Congress" from the menu entitled, "Committee Hearings" (<http://waysandmeans.house.gov/Hearings.asp?congress=18>). Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the on-line instructions, completing all informational forms and clicking "submit" on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You **MUST REPLY** to the email

and ATTACH your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business **Tuesday, March 25, 2008**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225-1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at <http://waysandmeans.house.gov>.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman STARK. If our guests could find a seat, we will begin our annual hearing on the MedPAC March report. Please join me in welcoming Glenn Hackbarth, the chairman of the Medicare Payment Advisory Commission, affectionately known as MedPAC. We appreciate, Glenn, all the work you and your commission do to advise us, and thank you for your leadership.

We rely on MedPAC's analysis and recommendations when—we did rely on it when we wrote the Children's Health and Medicare Protection Act last year. And your recommendations helped shape our legislation as it pertained to Medicare Advantage, physician reimbursement, long-term care hospitals, skilled nursing facilities, home health agencies, dialysis. And I am glad to see that some of our policy ideas to improve benefits for low income beneficiaries have been embraced as MedPAC recommendations.

I would just interject here, I have always felt that this subcommittee—I am not sure all the Members agree with me—but I think ought not to get in the position of recommending procedures or prices because I think if we did, the supplicants would form a line three times around this building as everybody came and asked us to make certain procedures available or set certain prices.

But having said that, we have to doubly rely on MedPAC and parts of CMS who make those decisions because they have professional staff who—I guess they can all speak Latin so they can understand what the procedures are. But it makes your work doubly important because we, I think, have to rely on it.

Many in the provider community balked at some of the provisions in our CHAMP bill. But I would like to remind them that most of that bill was consistent with your recommendations, and in fact, some of our provisions were more generous than what you recommended.

Too often we get twisted up in provider complaints that they can't sustain a market basket shave, so it is good to have you remind us of how high some of the margins become, and that our job is to ensure that Medicare maintains access as well as being prudent purchaser.

We will continue to grapple with the issue of physician reimbursement. I know in the past—and Mr. Camp can speak for himself—the 10 percent cut, as far as we are concerned, is not acceptable. But I am not sure we know how to change the reimbursement of physicians at this point, although I think we both agree that we have to find a better way to do it so we don't run into this problem in the future.

We will keep trying to enact your recommendations regarding Medicare Advantage, although the insurance lobby and others keep trying to stop us from that. Your latest projections tell us that we are overpaying Medicare Advantage plans by about 13 percent.

I don't want to steal your thunder, but your written testimony says that those overpayments worsen or get worse—or decrease the long-range financial sustainability of the Medicare program, and I couldn't agree more. I hope that all those who share my concern for the future of the Medicare program as an entitlement will join me in reining in those overpayments.

One rare area of bipartisan agreement in Medicare was concern over the special needs plans. And last year we passed the Medicare, Medicaid, and SCHIP Extension Act of 2007. The law established a moratorium on special needs plans so that we could have more time to determine how those plans differed from other Medicare Advantage plans and what if any additional value they provide. We appreciate MedPAC's attention to these plans and will work to incorporate your recommendations into any of our special needs plan authorizations.

As always, we continue to look to Medicare payments across provider types to make sure we are appropriately paying for those services. And I look forward to working with my colleagues in getting input and advice from Mr. Hackbarth and the MedPAC staff as we move through our agenda. Thanks again for being here.

I would like to give Mr. Camp a chance to give his opening remarks, and then we will let you proceed, Glenn, in any manner that you would like.

Mr. CAMP. Well, thank you, Mr. Chairman. And thank you, Mr. Hackbarth, for being here and for the work that you do.

I can't emphasize enough my concern about the financial situation of the Medicare program. MedPAC's warning that Medicare is

on a financially unstable path is one that we can't ignore. Significant reforms must be made, and time is of the essence.

The Medicare trustees estimate that the hospital trust fund will go bankrupt in 2019, a mere 11 years from now. If we don't take action to address the unaffordable increases in spending, Medicare expenditures will threaten our nation's economy and put the program at risk, putting seniors and the disabled at risk.

Congress must look to wholesale reforms of the Medicare program as, Mr. Hackbarth, you said in your written statement. The current payment systems and the structure of the delivery system make gains in value difficult to realize. If we continue to simply tinker around the edges, Congress will inevitably be forced to increase taxes, increase beneficiary costs, or cut payments to providers. And we can do much better.

In the coming weeks, Congress will have the opportunity to begin addressing Medicare's financial troubles. The administration has taken the first step by sending Congress a proposal in response to the 45 percent trigger. Their package curbs Medicare spending by improving the quality and efficiency of care, increasing transparency, encouraging adoption of health IT, and limiting taxpayer subsidies to ambulance-chasing trial lawyers. Frankly, even this is just tinkering.

Congress must not let this opportunity pass. Simply burying our heads in the sand will make today's problems much worse and far more expensive. We must put ideological differences aside in order to preserve a program that we all value. We must also move toward a system that pays hospitals and physicians based on the quality of care they provide, not simply on the number of services they order. We must also encourage providers to adopt health information technology that reduces medical errors, saves lives, and save taxpayer money.

Some members today will selectively focus on how MedPAC again recommends cutting more than \$150 billion from the Medicare Advantage program. These cuts would leave 22 states without a single senior enrolled in Medicare Advantage. Those select few who are still fortunate enough to have a plan participating in their area would see their benefits slashed and out-of-pocket costs increase. According to CBO projection, these cuts would reduce Medicare Advantage enrollment by seven million.

MedPAC's stated belief that "financial neutrality" will foster efficiency and innovation is also off-base. The suggestion that plans in Miami, Florida are somehow four times as efficient as plans in Midland, Michigan defies logic. To presume this to be true is irresponsible and harmful to the seniors I represent.

It is unfair to single out Medicare Advantage and the nine million beneficiaries who depend on the program for their health care to address all of the financial problems facing Medicare. I want to be clear that I am not suggesting that we shouldn't look at savings opportunities in the Medicare Advantage arena, including adjusting the benchmarks to recognize true market forces.

At the same time, no provider should be above reform or scrutiny. I appreciate MedPAC's thoughtful recommendations on the many Medicare providers that we will hear about today, not only how they should be reimbursed but how to improve quality in the

various sectors. I also appreciate MedPAC's continued call to provide dialysis providers with an update, something I have long advocated for.

And I thank the chairman, and yield back the balance of my time.

Chairman STARK. If other members have opening statements, they will appear in the record in their entirety without objection.

And Glenn, while normally we would ask a witness presenting to time limit their remarks, why don't you proceed to summarize your testimony however you desire, and at the conclusion of that we will try and drill a little deeper with our inquiries. Why don't you proceed.

**STATEMENT OF GLENN M. HACKBARTH, CHAIRMAN,
MEDICARE PAYMENT ADVISORY COMMISSION, BEND, OREGON**

Mr. HACKBARTH. Thank you, Chairman Stark and Ranking Member Camp, other Members of the Subcommittee. I appreciate the opportunity to talk about our March 2008 report. I will keep my comments very brief so we can spend time on the issues that you want to discuss.

Our March 2008 report includes 21 recommendations, seven related to payment updates under traditional Medicare, seven related to Medicare Advantage, specifically the SNP portion of MA, three related to the Medicare savings programs, two related to quality for skilled nursing facilities, one on indirect medical education, and one on Part D.

For those 21 total recommendations, there were a potential 357 total votes. Of those, 332 were yes votes and 5 no votes and 4 abstentions. So as in the past, we managed to achieve a high level of consensus within the commission about our recommendations.

The one summary statement I would like to make, Mr. Chairman, is that the commission does share the growing concern about Medicare costs. We are not only concerned about the potential burden on taxpayers and on the next generation, we are also concerned that how Medicare pays contributes to cost growth in the whole health care sector. That is having a number of detrimental effects, including adverse effects on coverage. I wish—we all wish—that there were a silver bullet for all of this. But clearly there is none.

For our part, MedPAC recommends a combination of restraint on fee-for-service updates in traditional Medicare, a reduction in Medicare Advantage payments, plus changes in how we pay providers—more accurate pricing, rewards for care coordination, bundling of certain types of services, et cetera.

Because changes in payment systems are complex to design and sometimes even more complex to implement, not to mention uncertain in their effect, we believe it is important to start now, work aggressively to improve our payment systems, and fund CMS appropriately for that task. Meanwhile, in the short run, our focus is on restraint on the Medicare updates for fee-for-service providers and in Medicare Advantage.

It is our belief that encouraging slowing cost growth and improving efficiency requires constant pressure on rates, both in traditional Medicare and Medicare Advantage. In a competitive mar-

ket, the restraint on price, that pressure on price, is more or less automatic and relentless. The market provides it. In Medicare's administered price systems, both on the Medicare Advantage side and traditional Medicare, that restraint must come from the Congress ultimately. And our goal is to help Congress understand the implications of the pricing policies and give you the best advice that we can.

So that is my opening statement, Mr. Chairman, and I am happy to answer any questions about the report.

[The statement of Glenn M. Hackbarth follows:]

Report to the Congress:
Medicare Payment Policy

March 11, 2008

Statement of
Glenn M. Hackbarth, J.D.

Chairman
Medicare Payment Advisory Commission

Before the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

Chairman Stark, Ranking Member Camp, distinguished Subcommittee members. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss MedPAC's March Report to the Congress and our recommendations on Medicare payment policy.

As required by law, the Medicare Payment Advisory Commission reviews Medicare payment policies and makes recommendations each March. In our March report, we consider Medicare fee-for-service (FFS) payment policy in 2009 for acute care hospitals, physicians, outpatient dialysis, skilled nursing, home health, inpatient rehabilitation facilities, and long-term care hospitals. We also make recommendations to reform payments for the Medicare Advantage (MA) plans beneficiaries can join in lieu of traditional FFS Medicare, recommendations specific to special needs plans (SNPs), and recommendations concerning Medicare programs for low income beneficiaries.

With each passing year, the Commission's concern about Medicare's long-term sustainability grows. To slow the growth in Medicare expenditures, we have concluded that the Congress and CMS will need to make changes across a broad front. Our March report focuses on policy recommendations that would limit provider updates to create incentives for greater efficiency, reward quality, and modify payment rates to private plans and providers to ensure that we neither overpay nor underpay for key services. These recommendations build on previous reports which have discussed tools such as pay for performance, comparative effectiveness, and reporting resource use. Other changes, which we will take up in our June 2008 report, will include ideas for altering Medicare's payment systems to reward better coordination of care and efficiency over time and investing in information about comparative effectiveness. Many changes will be needed to achieve long-term sustainability, but changes in Medicare are complex to develop and implement, and the effects are uncertain and unfold gradually. Time, therefore, is of the essence.

The March report also includes recent findings on enrollment and availability for MA plans and the private plans offering the Medicare prescription drug benefit. We provide information on the benefits and premiums of the plans offering the Medicare prescription drug benefit, both the stand-alone prescription drug plans and the prescription drug plans

affiliated with MA plans. We also provide recommendations to increase participation in the Medicare Savings Programs (MSPs) and the low-income drug subsidy (LIS).

Context for Medicare payment policy

Medicare and other purchasers of health care in our nation face enormous challenges. Health care costs are growing faster than the economy and incomes, and quality frequently falls short of patients' needs. Unexplained variations in the use and quality of care in the current system suggest that opportunities exist for reducing waste and improving quality. The Commission has recommended a number of policies to increase the value of care Medicare purchases, including paying differentially for quality, measuring physician resource use to identify those with more or less intense practice patterns, and analyzing comparative effectiveness. However, the underlying incentives in current payment systems and the structure of the delivery system make significant gains in value difficult to realize.

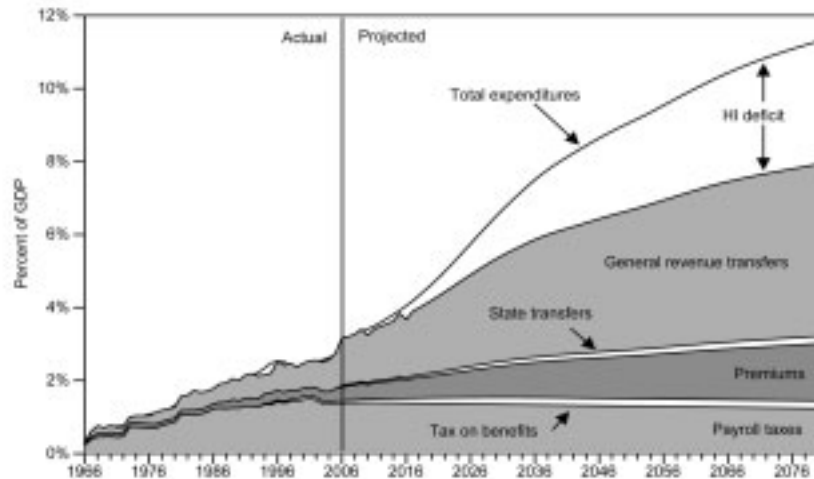
Medicare fills a critical role in our society—ensuring that the elderly and disabled have access to medically necessary care. Along with other payers in our health care system, the program has also helped to finance important strides in medical technology. However, we should use Medicare's considerable resources more wisely. The program rewards increases in the volume and specialized nature of services but not better health outcomes or higher efficiency. Practice patterns of care vary widely by geographic region, often with a poor relationship between quality and spending. Some stakeholders view the program as one in which all providers are entitled to payment, regardless of the quality, efficiency, or sometimes even the need for their services. Unless these aspects of Medicare change, the financial obligation on beneficiaries and future taxpayers will be unsustainable.

The Medicare trustees and others warn of a serious mismatch between the benefits and payments the program currently provides and the financial resources available for the future. Projected levels of spending could also impose a significant financial liability on Medicare beneficiaries, who must pay premiums and cost sharing. Improving the program's long-term financial prognosis will require some combination of expenditure reductions (e.g., benefit adjustments or payment efficiencies) and new financing.

The program's shaky financial outlook is a strong impetus for change. As is true for other purchasers of health care services in the United States, Medicare's spending is growing much faster than the U.S. economy. In addition, CMS began Medicare's new outpatient prescription drug program, Part D, in 2006. This program adds an important benefit to Medicare but greatly expands the program's need for resources. Finally, the leading edge of the baby boomers will become Medicare beneficiaries after 2010, which will also accelerate Medicare spending. These factors will lead Medicare to require an unprecedented share of our gross domestic product.

If Medicare benefits and payment systems remain as they are today, the Medicare trustees note that over time the program will require major new sources of financing for Part A and will automatically require increasing shares of general tax revenues for Part B and Part D. The trustees project that dedicated payroll taxes will make up a smaller share of Medicare's total revenue and that a large deficit between spending for Part A (HI) and revenue from dedicated payroll taxes will develop (Figure 1).

To finance the projected deficit through 2080, the trustees estimate that Medicare's payroll tax would need to increase immediately from 2.9 percent to 6.44 percent of earned income, or HI spending would need to decrease immediately by 51 percent. Delays in addressing the HI deficit would eventually require even larger increases in the tax rate or even more dramatic cuts in spending. The premiums and general revenues required to finance projected spending for Part B and Part D (SMI) services could impose a significant financial liability on Medicare beneficiaries and on resources for other priorities. If income taxes remain at the historical average share of the economy, the Medicare trustees estimate that the SMI program's share of personal and corporate income tax revenue would rise from 11.4 percent today to 25 percent by 2030. For beneficiaries, even though Part D now covers a portion of their spending on prescription drugs, growth in Medicare premiums and cost sharing for SMI services will require more of their incomes, which could lead to financial hardship for some; in 2004, roughly half of all Medicare beneficiaries had family incomes of less than 200 percent of the federal poverty level.

Figure 1. Medicare faces serious challenges with long-term financing

Note: GDP (gross domestic product), HI (Hospital Insurance). These projections are based on the trustees' intermediate set of assumptions. Tax on benefits refers to a portion of income taxes that higher income individuals pay on Social Security benefits that is designated for Medicare. State transfers (often called the Part D "clawback") refer to payments called for within the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 from the states to Medicare for assuming primary responsibility for prescription drug spending.

Source: 2007 Annual Report of the Boards of Trustees of the Medicare Trust Funds.

Other federal programs such as Social Security and Medicaid will also require greater resources at the same time that Medicare spending expands. Some analysts contend that growth in our nation's economy has historically been large enough to finance expansion of both health and nonhealth spending. Other analysts disagree, saying long-term economic growth alone will not be sufficient to bring the country's fiscal position into balance and financing Medicare by increasing the Federal deficit could reduce economic growth. According to this point of view, expounded by the Congressional Budget Office among others, fiscal stability will require a sizable slowdown in the growth rate of spending on health care and may also require a substantial increase in taxes as a share of our nation's economy.

Assessing payment adequacy and updating payments in fee-for-service Medicare

The March report presents the Commission's annual payment update recommendations for FFS Medicare. An update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a prospective payment system is changed. To determine an update, we first assess the adequacy of Medicare payments for efficient providers in the current year (2008). Next, we assess how those providers' costs are likely to change in the year the update will take effect (the policy year—2009). Finally, we make a judgment as to what, if any, update is needed. When considering whether payments in the current year (2008) are adequate, we account for policy changes (other than the update) that are scheduled to take effect through the policy year (2009) under current law.

Competitive markets demand continual improvements in productivity from workers and firms. These workers and firms pay the taxes that finance Medicare. As a prudent purchaser, Medicare's payment systems should encourage providers to produce a unit of service as efficiently as possible while maintaining quality. Consequently, the Commission may choose to apply an adjustment to the update to encourage this efficiency. The Commission begins its deliberations with the assumption that all providers can achieve efficiency gains similar to the economy at large (the 10-year average of productivity gains in the general economy, currently 1.5 percent). But the Commission may alter that assumption depending on the circumstances of a given set of providers in a given year. This factor links Medicare's expectations for efficiency to the gains achieved by the firms and workers who pay taxes that fund Medicare.

Hospital inpatient and outpatient services

Most indicators of payment adequacy for hospital services are positive. The number of Medicare-participating hospitals has increased in each of the past four years. Inpatient and outpatient service volume per beneficiary continues to increase. The quality of care hospitals provide to Medicare beneficiaries is mixed; mortality rates have dropped and CMS's quality indicators have improved, but more adverse event rates (e.g., decubitus ulcer, postoperative pulmonary embolism or deep vein thrombosis) have increased than decreased. Spending on hospital construction has risen substantially in recent years—with increases averaging almost

20 percent in the past two years. For the second year in a row, the median values of many financial indicators (such as days cash on hand and measures of debt service coverage) were among the best ever recorded. This ready access to capital indicates that revenue is sufficient to give the capital markets confidence in the credit worthiness of the industry.

One indicator of payment adequacy is negative—we project an overall Medicare margin for hospitals covered by prospective payments of -4.4 percent in 2008. If all hospitals were efficiently providing Medicare services, this low aggregate margin would be a major source of concern. However, hospital costs and Medicare profitability vary widely. Some hospitals are efficient enough to have low costs, positive Medicare margins, and high quality scores. Other hospitals have higher costs and lower Medicare margins.

To understand what may be driving some hospitals to have low costs and others high costs we investigated the relationship between financial pressure and costs. Some hospitals have strong profits on non-Medicare services and investments and are under little pressure to constrain Medicare costs, while others face losses if they do not constrain costs and generate profits on Medicare patients. To test the relationship between financial pressure and hospitals' costs, we divided hospitals into three levels of financial pressure: high, medium, and low. We tested whether hospitals under high levels of financial pressure from 2001 to 2005 ended up with lower standardized inpatient costs per discharge in 2006.

We found that high levels of financial pressure lead to lower standardized costs. Hospitals under high levels of financial pressure have median Medicare standardized costs of \$5,500 per discharge on average (Table 1). In contrast, hospitals with low levels of financial pressure had standardized costs more than 10 percent higher at \$6,200 per discharge and higher cost growth. The shares of rural, urban, and for profit hospitals in each group were very similar (not shown in chart). Medicare should encourage hospitals to be efficient and control their costs, rather than accommodate high cost growth resulting from lack of financial pressure.

Table 1. Financial pressure leads to lower hospital costs

2006 Financial characteristics (medians)	Level of financial pressure 2002 to 2005		
	High pressure	Medium pressure	Low pressure
Standardized cost per discharge	\$5,500	\$5,800	\$6,200
Annual growth in cost per discharge 2003 to 2006	4.6%	5.4%	5.5%
Non-Medicare margin (private, Medicaid, uninsured)	-1.1%	6.3%	13.6%
Overall Medicare margin	3.7	-3.3	-10.8

Note: High pressure: non-Medicare margin less than 1% and annual net worth growth less than 1% absent any Medicare profits. Low pressure: non-Medicare margin greater than 5% and annual net worth growth greater than 1% absent any Medicare profits. Medium pressure: all others. Standardized costs are adjusted for hospital case mix, wage index, outliers, transfer cases, interest expense, and the effect of teaching and low income Medicare patients on hospital costs. The sample includes all hospitals that had complete cost reports on file with CMS by August 31, 2007.

Balancing the indicators of payment adequacy, the Commission recommends an update of market basket (the projected change in hospital input prices) for inpatient and outpatient services, implemented concurrently with a quality incentive payment program. The initial payment withhold for pay for performance should be 1 percent to 2 percent. An individual hospital's quality performance should determine whether its net increase in payments in 2008 is above or below the market basket increase.

We have also found that the current indirect medical education (IME) adjustment (5.5 percent) substantially exceeds the estimated relationship between teaching intensity and costs per case (2.2 percent). Furthermore, teaching hospitals are not accountable for how they use these IME payments. The payments contribute to a wide gap in Medicare margins between teaching and nonteaching hospitals. IME payments are also highly concentrated; fewer than 300 hospitals received three-quarters of the \$5.8 billion payments in 2006. The Commission again recommends that the Congress reduce the IME adjustment by 1 percentage point to 4.5 percent per 10 percent increment in the resident-to-bed ratio. The savings should be used to fund in part a quality incentive payment policy for all hospitals. Last year, we recommended this change in the IME adjustment concurrent with better severity adjustment in the inpatient PPS. The new MS DRGs will better target payments to hospitals that care for the most severely ill patients than IME subsidies do. Therefore, it is time to move forward with IME payment reform. Our update recommendation, this IME recommendation, and pay for

performance should be viewed as a package that would improve the accuracy of Medicare's payments for acute inpatient services while creating a strong incentive for improving the quality of care.

Physician services

Our analysis finds that most indicators of payment adequacy for physicians are stable. Beneficiary access to physicians is generally good at the national level, with no statistically significant changes from last year, but small numbers of beneficiaries continue to report difficulty making timely appointments with their current physician or finding a new primary care physician (finding a new specialist is less of a problem). There may be local areas where access is more limited, but in those areas those limitations might be a function of physician supply and local population trends—and affect access for private-payer patients as well—and not a reflection on Medicare payment rates. We find that the number of physicians providing services to Medicare beneficiaries has more than kept pace with growth in the beneficiary population in recent years, and per beneficiary service volume grew at a rate of 3.6 percent in 2006. Our claims analysis shows small improvements in the quality of ambulatory care. The ratio of Medicare payment rates to private payment rates in 2006 was 81 percent, slightly lower than the rate in 2005 (83 percent). If Medicare rates were rapidly decreasing in relation to private sector rates, access for Medicare beneficiaries could become a concern. But, in fact, the ratio has been around 80 percent for many years and is higher than in the early to mid-1990s, when Medicare payment rates averaged about two-thirds of commercial payment rates for physician services.

However, the current physician payment system has several flaws that need to be addressed. Although the Congress has acted each year since 2003 to avert a scheduled negative update to the physician fee schedule conversion factor, the sustainable growth rate formula continues to call for substantial consecutive negative updates through 2016. The Commission remains concerned that repeated annual reductions in physician payment rates could threaten beneficiaries' access to physician services. Medicare's current FFS payment system does not systematically reward physicians who provide higher quality care or care coordination, and it offers higher revenues to physicians who furnish the most services—whether or not the services add value. The Commission is also concerned that the current distribution of

Medicare physician payments undervalues primary care services and introduces other distorted incentives that encourage overuse of some services and underuse of others. These deficiencies should be corrected for the Medicare program to promote high-quality health care and avert unsustainable growth in spending.

In consideration of expected input costs for physician services and our payment adequacy analysis, the Commission recommends that the Congress update payments in 2009 for physician services by the projected change in input prices less the Commission's adjustment for productivity growth (currently estimated at 1.5 percent). In addition, the Congress should enact legislation requiring CMS to establish a process for measuring and reporting physician resource use on a confidential basis for a period of two years.

The second part of our recommendation, reporting physician resource use, is intended to improve the value of physician services purchased by Medicare. Information on resource use would be immediately useful to physicians who want to understand their own practice patterns. Our eventual goal is for Medicare to base physician payment rates at least in part on physician resource use, but realistically it will take time for CMS to develop the infrastructure and work constructively with stakeholders to implement accurate and actionable resource use measurement and reporting systems. CMS should begin development now to provide confidential reporting and to be prepared to use the information for public reporting and for payment policy, if and when authorized to do so by the Congress.

Adequacy of payments for dialysis services

Most indicators of payment adequacy for outpatient dialysis services are positive. The growth in dialysis facilities, treatment stations, and dialysis treatments has kept pace with the growth in the number of dialysis patients, suggesting continued access to care for most dialysis beneficiaries. Providers have sufficient access to capital, as evidenced by recent expansions. Quality of care is improving for some measures: use of the recommended type of vascular access has improved and more patients receive adequate dialysis and have their anemia under control. However, patients' nutritional status has not improved. We project that Medicare payments will cover the costs of providing outpatient dialysis services to beneficiaries in 2008 with a margin of 2.6 percent.

Therefore, the Commission recommends that the Congress should update the composite rate in calendar year 2009 by the projected rate of increase in the end-stage renal disease market basket index less the Commission's adjustment for productivity growth.

In addition, the Commission reiterates its recommendation that the Congress implement a quality incentive program for physicians and facilities that treat dialysis patients. Credible measures are available that are broadly understood and accepted. Obtaining information to measure quality will not pose an excessive burden and measures can be adjusted for case mix so providers are not discouraged from taking more complex patients. Also, the Commission again states that Medicare should expand the dialysis payment bundle to include dialysis drugs and other commonly furnished services. Together, these steps will better align incentives for providing cost-effective care and reward providers for furnishing high-quality care.

Skilled nursing facility services

Our indicators of the adequacy of Medicare payments to cover the costs of skilled nursing facility (SNF) services to beneficiaries are generally positive. Beneficiaries continue to have good access to services. The supply of SNFs remained essentially constant, and covered days and admissions per beneficiary have both increased. While access was good for most beneficiaries, those needing expensive nontherapy ancillary services may experience delays in being placed in SNFs. Quality is mixed. Rates of discharge to the community increased over the last two years (a positive trend indicating improved quality) but have returned only to the level reached in 2000, and rates of potentially avoidable rehospitalizations continued to increase (indicating worse quality). Access to capital was good. However, in the late summer, trends in the broader lending market—unrelated to the adequacy of Medicare payments—made borrowing more expensive and more restrictive.

For the sixth consecutive year, aggregate Medicare margins for freestanding SNFs were above 10 percent. We project Medicare margins to be 11.4 percent in 2008. Because all access indicators are positive and SNF payments appear to be more than adequate to accommodate the cost growth, the Commission recommends that the Congress eliminate the update for SNFs in 2009.

As in other sectors, the Commission considers the Medicare margin, rather than the total (all payer) facility margin, to guide its update recommendation for SNFs. Trying to increase total facility margins by subsidizing other payers—such as Medicaid—through Medicare SNF payments would not be effective or advisable. First, the subsidy would be poorly targeted. Facilities with high shares of Medicare payments—presumably the facilities that need revenues the least—would receive the most in subsidies and those with high shares from Medicaid or other payers the least. Second, increasing Medicare’s payment rates could encourage states to reduce Medicaid payments further and, in turn, result in pressure to again raise Medicare rates.

The Commission recommends that CMS adopt a quality incentive payment policy for SNFs. Two measures—rates of community discharge and potentially avoidable rehospitalization—capture key goals for SNF patients, are well accepted, have robust risk adjustment, and avoid the problems associated with the current publicly reported measures. We would expect CMS, over time, to add measures to the quality incentive program that reflect other aspects of SNF care. Before adding measures based on changes in patient condition, however, patient assessment information should be gathered at admission and discharge, so that the measures will be unbiased.

We also recommend that CMS improve the public reporting of the post-acute care quality indicators. CMS should:

- add the rates of community discharge and potentially avoidable rehospitalization to their publicly reported indicators;
- revise the pain, delirium, and pressure sore measures that are currently reported so they are more accurate and evaluate only the care furnished during the SNF stay (and not during the preceding hospitalization); and
- gather patient assessment information at admission and discharge so that the quality measures based on patient assessment information reflect the care furnished to all SNF patients, not just the smaller subset who stay long enough to have a second assessment completed for them.

Home health services

Our indicators for home health are positive. Beneficiaries continue to have widespread access to care. Ninety-nine percent of beneficiaries live in an area served by at least one home health agency, and the number of agencies continues to grow faster than the number of Medicare enrollees. The share of FFS beneficiaries using the home health benefit continues to increase, as does the average number of episodes per home health user. Quality trends are mostly unchanged from previous years. The number of beneficiaries who show improvement in walking, bathing, pain management, transferring, and medication management has increased slightly. However, the rate of unplanned emergency department use by home health patients has not improved, and the number of patients hospitalized has increased slightly. The continuing entry of new agencies and the acquisitions of existing agencies by national home health companies suggest that agencies have adequate access to capital. We project that agency margins will equal 11.4 percent in 2008.

The data on access, quality, volume, and financial performance suggest that most agencies should be able to accommodate cost increases without an increase in base payments.

Therefore, the Commission recommends that the Congress should eliminate the update for home health agencies in 2009.

Inpatient rehabilitation facility services

Our indicators of payment adequacy for inpatient rehabilitation facilities (IRFs) show stable supply and access, decreases in discharges and spending, increased case mix and payments per case, mixed access to capital, and strong margins. This picture arises in part because of CMS's phase in of the renewed enforcement of the 75 percent rule starting in 2005. (The 75 percent rule requires IRFs to have 75 percent of admissions with one or more of a specified list of conditions. The Congress recently rolled back the 75 percent rule, setting the compliance threshold permanently at 60 percent, in one of several provisions of the Medicare, Medicaid, and SCHIP Extension Act of 2007 related to IRF services.)

Discharges and spending, for example, decreased when CMS started to phase in enforcement of the 75 percent rule in 2005 after increasing rapidly following the introduction of the IRF prospective payment system (PPS) in 2002. Renewed enforcement also caused the average

case mix and payments per case to increase from 2004 to 2006, as the patients who were admitted to IRFs had more complex conditions. Despite the decrease in cases, IRF Medicare margins for 2006 were 12.4 percent. We are projecting IRF Medicare margins for 2008 to be 8.4 percent.

Our recommendation for the IRF payment update balances beneficiary access to care with fiscal constraint. IRFs had begun to adapt to existence under the 75 percent rule, with growth in cost per Medicare case now slightly lower than the growth in Medicare payments for the majority of IRFs. The projected margin should be sufficient to accommodate cost increases in 2009. Therefore, the Commission recommends that the Congress should eliminate the update for inpatient rehabilitation services in 2009. (The Congress eliminated the IRF payment rate update for 2009 in the Medicare, Medicaid, and SCHIP Extension Act of 2007.)

Long-term care hospital services

Assessing current payment adequacy for long-term care hospital (LTCH) services is challenging. On the one hand, the growth in LTCH facilities has slowed substantially and the number of LTCH cases has decreased. On the other hand, spending per FFS beneficiary and payments per case have continued to increase and use per FFS beneficiary has been steady. There was no growth in Medicare spending for LTCH services from 2005 to 2006. The evidence on quality is also mixed. Risk-adjusted mortality rates and readmission to acute care hospitals have fallen. Patients also experienced fewer postoperative pulmonary embolisms and deep vein thromboses. However, patients experienced more decubitus ulcers, infections due to medical care, and postoperative sepsis. LTCHs' access to capital is difficult to judge, with analysts divided in their assessments and expectations for the industry.

In addition, it is difficult to determine when use of LTCH services is appropriate and necessary. Frequently, LTCHs entering the program locate in market areas where LTCHs already exist, raising questions about whether there are sufficient numbers of very sick patients to support the number of LTCHs in the community. Seen in this light, recent slowing in growth of facilities, cases, and Medicare spending may indicate that the industry is approaching equilibrium after a period of explosive growth spurred by overpayment and inappropriate admissions.

The Medicare margin for LTCHs based on 2006 cost reports was 9.4 percent. CMS has since made a number of policy changes that reduce payments for LTCHs. These payment policy changes include recalibrating relative weights in 2007, making adjustments for coding improvements, finding new ways to reimburse LTCHs for patients with the shortest lengths of stay, and reducing aggregate payments for high-cost outliers. Due to these changes, we estimate LTCHs' aggregate Medicare margin will be between -1.4 and -0.4 percent in 2008. This range is based on different assumptions about LTCHs' behavior in response to the 25 percent rule—which limits the percentage of patients an LTCH can receive from a host hospital.

Although the interpretation of payment adequacy indicators is complicated, our estimated Medicare margin for 2008 suggests that LTCHs may not be able to accommodate growth in the cost of caring for Medicare beneficiaries in 2009 without an increase in the base rate. Therefore, the Commission recommends that the Secretary update payment rates for LTCH services by the market basket index, less the Commission's adjustment for productivity growth.

Update on Medicare private plans

The Commission supports private plans in the Medicare program. Medicare beneficiaries should have a choice between the FFS Medicare program and the alternative delivery systems that private plans can provide. Private plans have the flexibility to use care management techniques that are not present in traditional FFS, and—if paid appropriately—they have incentives to innovate and be efficient. The Commission supports financial neutrality between payment rates for the FFS program and the MA program. Financial neutrality means that Medicare should pay the same amount, adjusting for risk, regardless of which option a beneficiary chooses. Neutrality is important to spur efficiency and innovation.

However, MA payments are projected to be 113 percent of expected FFS expenditures in 2008 (Table 2). These added expenditures contribute to the worsening long-range financial sustainability of the Medicare program. In addition, plan bids for the traditional Medicare benefit package are projected at 101 percent of FFS, which means that MA plans, on average,

are less efficient than the traditional Medicare program. The overpayment (117 percent) and inefficiency (108 percent) are even greater for private FFS plans—a plan type in which enrollment has more than doubled in the last year.

Table 2. Payments and bids relative to FFS for 2008 and MA enrollment

	Payments relative to FFS expenditures, 2008	Bids relative to FFS expenditures, 2008	Enrollment as of November 2007 (in millions)	Change in enrollment Nov 06 – Nov 07
All MA plans	113%	101%	8.9	18%
Coordinated care plans	113	99	7.2	8
Private fee-for-service plans	117	108	1.7	101

Note: FFS (fee-for-service), MA (Medicare Advantage). Coordinated care plans include health maintenance organizations and preferred provider organizations.

Source: MedPAC analysis of data from CMS on plan bids, enrollment, and fee-for-service expenditures.

Even though we use the FFS Medicare spending level as a measure of parity for the MA program, the Commission does not think that FFS Medicare is an efficient delivery system in most markets. In fact, much of our work is devoted to identifying inefficiencies in FFS Medicare and suggesting improvements in the program. Well-managed systems that coordinate care and select efficient providers should be at least as efficient as traditional Medicare and in most cases should be more efficient.

Payment policy is a powerful signal of what we value. The original conception (in the 1980s) for private plans in Medicare was that they would be a mechanism for introducing innovation into the program while saving money for Medicare (they were paid 95 percent of FFS). To compete effectively with Medicare, private plans would be compelled to do things that traditional Medicare found difficult or that would be difficult to impose on all beneficiaries and providers—for example, selective contracting with efficient providers and effective management and coordination of care. By increasing payment to levels significantly above traditional Medicare, we have changed the signal we are sending to the market: Instead of efficiency-enhancing innovation, we are getting plans (for example, private FFS plans) that are not well designed to manage care or improve quality and have higher cost.

Some argue that the MA program now has additional goals such as addressing perceived geographic inequity in traditional Medicare and increasing benefits—particularly for low income beneficiaries. These may be legitimate goals, but they could be addressed at a lower cost and in a more targeted way through changes in traditional Medicare. For example, MA enrollment is not limited to low income beneficiaries and any subsidy has to be available to all plan enrollees; high income or low income. MSP and LIS only enroll low income beneficiaries, and thus, improving those programs is a more direct way to target benefits to that population.

Enrollment data show rapid growth in private plans. At the end of 2007, about 20 percent of Medicare beneficiaries were enrolled in MA plans and all beneficiaries have access to an MA plan in 2008, with an average of 35 plans available in each county. However, the growth comes mostly from two types of plans—private FFS plans, which have no requirement to coordinate care or report quality measures, and SNPs, which have not yet been fully evaluated.

In addition, although plans are being paid more, clinical quality measures show disappointing results. Commercial and Medicaid plans improved more in clinical measures over the past year than Medicare private plans. New plans in Medicare—those entering the program in 2004 or later—show poorer performance than older plans on clinical indicators of quality. Moreover, some plan types (e.g. private FFS) are exempt from quality reporting requirements; making it difficult for either the beneficiary or the program to judge their value.

Medicare's strengths are low administrative costs and the ability to set prices. Private plans, on the other hand, have greater latitude to coordinate care and to select providers with efficient practice patterns. Paying private plans at 100 percent of FFS coupled with P4P (as the Commission has recommended) creates the incentive for plans to manage care—that is, reduce costs and improve quality. With the resulting savings, plans can offer additional benefits to beneficiaries and in turn attract enrollment. Paying plans more than 100 percent of FFS adds administrative costs, which Medicare pays for, without any incentive for a

commensurate gain in the management of care or in the quality of care. We are now paying some types of plans much more than traditional FFS, seeing lower efficiency, and seeing new plans with poorer quality performance than old plans. We are not receiving value for the additional money.

We are also concerned with the effectiveness of the special needs plans. SNPs, created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, were designed to serve Medicare beneficiaries with special needs, such as those in Medicaid or with chronic conditions. These plans are allowed to limit enrollment to those specific categories of beneficiaries. Recent legislation extended SNPs for another year but prohibited new plans from entering and existing plans from extending their service areas. SNPs require further study to determine whether they provide value to the program. As the Congress, CMS, and the Commission continue to evaluate SNPs, we recommend that:

- The Congress should require the Secretary to establish additional, tailored performance measures for SNPs and evaluate their performance on those measures within three years. SNPs now measure and report the same quality measures as other MA plan types, which are not designed to ensure that SNPs provide specialized care for their targeted populations.
- The Secretary should furnish beneficiaries and their counselors with information on SNPs that compares their benefits, other features, and performance with other MA plans and traditional Medicare. A lack of clear information impedes beneficiaries from learning about and making an informed decision about joining a SNP.
- The Congress should direct the Secretary to require chronic condition SNPs to serve only beneficiaries with complex chronic conditions that influence many other aspects of health, have a high risk of hospitalization or other significant adverse health outcomes, and require specialized delivery systems. CMS has not explicitly defined which chronic conditions are appropriate for SNPs to target. Not all chronic condition SNPs are

sufficiently specialized to warrant targeted delivery systems and disease management strategies and the unique ability to limit enrollment to certain beneficiaries.

- The Congress should require dual-eligible SNPs within three years to contract, either directly or indirectly, with states in their service areas to coordinate Medicaid benefits. Without a contract with states to cover Medicaid benefits, it is difficult to coordinate benefits with Medicaid, which should be a goal of the program. Dual-eligible SNPs are not now required to coordinate benefits with Medicaid programs, and many dual-eligible SNPs operate without state contracts.
- The Congress should require SNPs to enroll at least 95 percent of their members from their target population. The law now requires that SNPs enroll people from their target population. However, SNPs can apply for a waiver permitting them to enroll others. The way CMS has applied that provision is to permit SNPs to enroll anyone, picking and choosing who they want, so long as the target population is a higher percentage of the plan's population than it is of the Medicare population nationally.
- The Congress should eliminate dual-eligible and institutionalized beneficiaries' ability to enroll in MA plans, except SNPs with state contracts, outside of open enrollment. They should continue to be able to change plans during special election periods triggered by life events and also continue to be able to disenroll and return to FFS at any time during the year. Currently, dual-eligible and institutionalized Medicare beneficiaries can enroll and disenroll from MA plans monthly. We have heard reports that this provision contributes to plan marketing abuses.
- The Congress should extend the authority for SNPs that meet the conditions specified in the above recommendations for three years. SNPs' authority to limit enrollment will expire December 2009. In light of SNPs' rapid growth in number and enrollment, we call for a rigorous evaluation to inform our decision about recommending them as a permanent MA option.

Part D enrollment, benefit offerings, and plan payments

The report examines Medicare's prescription drug program as it enters its third year. Our analysis of Part D shows that for 2008 there are more than 1,800 plans and most beneficiaries again have a choice of 50 to 60 stand-alone prescription drug plans (PDPs) in their region. In addition, sponsors are offering more Medicare Advantage–Prescription Drug plans (MA–PDs). Average monthly premiums have increased for 2008 to about \$27 per month, up from the \$23 average for 2007. The average PDP enrollee pays about \$32 per month, while average enrollees in an MA–PD pay about \$13 of their monthly MA premium for Part D benefits. In 2007, around 17 million individuals were enrolled in PDPs and 7 million individuals were in MA–PDs. Enrollees in MA–PD plans are more likely to have enhanced benefits—coverage with an average benefit value higher than basic benefits—than those in PDPs. About 90 percent of Medicare beneficiaries were enrolled in Part D plans or had drug benefits at least as generous as basic Part D coverage from other sources.

Of the 13 million beneficiaries estimated to be eligible for Part D's "extra help" with premiums and cost sharing, more than 9 million were receiving a low-income subsidy (LIS). Plans that bid less than regional threshold values qualify to enroll LIS beneficiaries without charging them a premium. For 2008, about 2.6 million LIS beneficiaries needed to switch to a different plan if they did not want to pay a premium, considerably more than had to switch in the previous year.

Our look at Part D formularies shows:

- Most plans use a three-tier structure that includes one generic tier and two other tiers that distinguish between preferred and nonpreferred brand-name drugs. For 2007, copays for the median enrollee in either a PDP or an MA–PD with a three-tier formulary were \$5 per 30-day prescription for a generic drug, \$28 or \$29 for preferred brand-name drugs, and \$60 for nonpreferred brands.
- In 2007, more than three-quarters of enrollees were in plans with specialty tiers for expensive products, unique drugs, and biologicals. Cost sharing for specialty-tier drugs is typically 25 percent to 30 percent of the plan's negotiated price and enrollees may not appeal cost-sharing amounts as they can for drugs on other tiers.

The Commission is concerned that CMS has not made drug claims data available to congressional support agencies and selected executive branch agencies. Because of the lack of data, there are fundamental questions that the Commission and other organizations cannot answer about how Part D is operating, such as:

- which prescription drugs enrollees are using most widely;
- how much, on average, enrollees are paying out of pocket for their medicine; and
- how many beneficiaries are entering Part D's coverage gap.

Without Part D claims data, it is also very difficult to assess efficiency and quality in the overall delivery of health care (Part A, Part B, and Part D). Therefore, the Commission recommends that the Congress should direct the Secretary to make Part D claims data available regularly and in a timely manner to congressional support agencies and selected executive branch agencies for purposes of program evaluation, public health, and safety.

Increasing participation in the Medicare Savings Programs and the low-income drug subsidy

Although the Medicare Savings Programs (MSPs) and the LIS provide significant financial benefits to enrollees with limited incomes, many eligible beneficiaries do not participate. There are many reasons why individuals might choose not to take advantage of these programs, but researchers have found that the main barriers to enrollment are beneficiaries' lack of knowledge of the programs and the complexity of the application processes. Those eligible but not enrolled in MSPs are more likely than those enrolled in MSPs to report that they did not receive needed health care because of cost. Beneficiaries enrolled in MSP programs are deemed eligible for LIS.

We make three recommendations to increase participation in programs designed to aid beneficiaries with limited incomes:

- First, Medicare beneficiaries, particularly those who are hard to reach, prefer to receive information from personal contact. The State Health Insurance Assistance Programs (SHIPs) are the only part of the National Medicare Education program that provides personal counseling to beneficiaries—but their resources are limited. Increased funding

for SHIPs that provide this one-on-one counseling will give more beneficiaries access to programs for which they are eligible. Therefore, the Commission recommends the Secretary should increase SHIP funding for outreach to low-income Medicare beneficiaries.

- Second, federal minimum MSP income and asset levels have not been revised since the programs were established. If MSP criteria were aligned with LIS levels, beneficiaries could apply for both programs at one time. Beneficiaries would find the process simpler and states and the federal government would realize administrative savings. Therefore, the Commission recommends the Congress should raise MSP income and asset criteria to conform to LIS criteria.
- Third, the Social Security Administration (SSA) is responsible for determining LIS eligibility for those individuals who are not automatically deemed eligible for the subsidy. If MSP and LIS eligibility were based on the same criteria, SSA could screen and enroll beneficiaries for both programs simultaneously, providing MSP access to eligible beneficiaries who have not heard of it but have heard of LIS. The Commission recommends the Congress should change program requirements so that the SSA screens LIS applicants for federal MSP eligibility and enrolls them if they qualify.

Chairman STARK. Thank you. I guess on the Medicare Advantage issue, I am not sure that there is any question that we are overpaying relative to what the same procedures might cost us under the fee-for-service schedules, and that it is a lot of money. I don't know, how many billion dollars a year are we overpaying? Five, \$10 billion a year? I don't know.

Mr. HACKBARTH. Per year, it is about \$10 billion.

Chairman STARK. \$10 billion a year? I want to go back just—we used to have something we called cost-based. How did we used to pay people like Kaiser? We had a term for it.

Mr. HACKBARTH. Yes. Well, if you go way back, there were cost contracts. In fact, they still exist.

Chairman STARK. Cost contracts. But basically, we were paying—let's take Kaiser, which is in my district—on a cost contract formula for, just about as far as I know, the same services they are providing today. But in those days, we paid generally less than 100 percent of fee-for-service.

Now, what troubles me is how can I come to grips or what reason could there be when in the past we were paying somebody like Kaiser, a managed care plan, less than 100 percent—they never came to me and said they were about to go bankrupt or disappear—and all of a sudden we are paying them, I don't know, what in Kaiser's case may be 108 percent today for the same services they provided previously. What possible reason could there be for doing that?

Mr. HACKBARTH. Well, let me just quickly talk about the history. The major change in how we paid private plans was—the first major change—was in 1982, in TEFRA, at which time I worked in the Reagan administration, and we were very excited about the opportunity for private plans to enter Medicare and participate in what were then called risk contracts.

Chairman STARK. Risk contracts. That is right.

Mr. HACKBARTH. Right. And so Kaiser and other participating plans were paid a fixed monthly payment set at 95 percent of the expected Medicare cost for the same population. And what made us excited about it in the Reagan administration was that we thought the private plans could contribute something to Medicare, that properly configured plans could add value for the program and Medicare beneficiaries.

And so the 95 percent formula said, if you can do it for less, you are welcome to come into the program and help the program and help the beneficiaries. In a series of steps after that, of course, we left the 95 percent standard and adopted new payment formulas, which ultimately have led to us paying, on average, 113 percent more.

The major concerns about that policy, paying 113 percent, are two. One, obviously, it increases outlays in the short run, strains the trust funds, and all of that. But from my perspective, perhaps an even bigger concern is that we are shaping the market. We are shaping the type of private plans that come into Medicare. The benchmarks that we use are a signal about what Medicare wants to buy. That is the function of prices in a marketplace.

And basically what we are saying to the marketplace is that we welcome plans to come in and participate in Medicare that basi-

cally mimic Medicare. They offer fee-for-service coverage. They are not adding value. And that is the innovation that we want to buy.

I think that is a luxury that the program can ill afford at this point. What we want is a payment system that encourages innovation, improvements in efficiency, and quality. Plans like private fee-for-service, which are prospering under the existing payment system, are not adding value to Medicare. Their existence, their rapid growth, is a sign the payment system is flawed.

Chairman STARK. How do those private fee-for-service plans, if you will, for the committee—how do they differ from fee-for-service Medicare? What is the difference between a private fee-for-service plan and the old-fashioned standard Medicare fee-for-service?

Mr. HACKBARTH. Well, in terms of what they are required to do, there is really not much difference at all. By statute, they are required to pay providers on a fee-for-service basis. They are not supposed to limit the beneficiary's choice. They are not supposed to link payment to utilization, et cetera. So—

Chairman STARK. How about extra benefits?

Mr. HACKBARTH. Well, they provide extra benefits out of the additional payments that they get over and above the cost of traditional Medicare. In fact, let me just share a couple figures on this.

So in this slide—I assume you can see it—the bottom row there is—

Chairman STARK. It doesn't show up, but that is our—is it in your—

Mr. HACKBARTH. Yes. Okay. So you have—oh, there we go. It is on the screen now. So I am looking at the bottom row, which is private fee-for-service. So on average, the payments to private fee-for-service plans are 117 percent of what Medicare would have cost for the same beneficiaries. Their bids are 108 percent. And then the benchmarks are 120 percent, so they are focusing on areas where the benchmarks are high. And then rebates are 9 percent.

So what this is saying is we are paying them 117 percent of traditional Medicare. Only 9 percent of that is going back into added benefits for Medicare beneficiaries. The other 8 percentage points is going into the higher cost for the plans, whether they be higher utilization rates or higher administrative costs, whatever. So only about half of the overpayment is actually making it to Medicare beneficiaries.

Chairman STARK. And am I correct in assuming that none of us know what if any additional benefits are actually used by the beneficiaries? We know they are “offered,” but we have—there are no records, as I understand it—

Mr. HACKBARTH. Yes.

Chairman STARK [continuing]. As to whether they are actually being consumed or used or have any costs to these private fee-for-service plans.

Mr. HACKBARTH. Yes. Well, under the terms of the Medicare Advantage program, plans are only required to submit limited data that supports the risk adjustment system. They don't have to provide detailed encounter data on all services provided. And without that encounter data, it makes it difficult to assess the value.

Chairman STARK. If it was decided, whether we decided or it was recommended, that many of these extra benefits should be

added as basic benefits in Medicare, is there a more efficient way to provide them?

Mr. HACKBARTH. Well, again, going back to the slide, that row on bids, what that 108 percent number means is that the plans themselves say it costs them 8 percent more than traditional Medicare to provide the basic Medicare Part A and B benefit package. So they are saying they cost more than traditional Medicare.

So if the goal is to provide additional benefits to Medicare beneficiaries, a more efficient way to accomplish that goal would be to do it through traditional Medicare.

Chairman STARK. It is my understanding MedPAC is working on the issue of how to revise the physician reimbursement plan.

Mr. HACKBARTH. Yes.

Chairman STARK. And we will hear from you about that later on?

Mr. HACKBARTH. Yes. Mr. Chairman, could I just add one other point on Medicare Advantage?

Chairman STARK. Sure. Yes.

Mr. HACKBARTH. I do want to point out that, you know, I am focusing on the bottom row there, on private fee-for-service. If you look at the HMO row, there are some private plans that provide the services for less than Medicare's costs. And so the average HMO bid is 99 percent of Medicare costs.

Chairman STARK. Ninety-nine?

Mr. HACKBARTH. Ninety-nine percent. And so in that case—and some HMOs do substantially better than that. So in that case, the private plans are more efficient at providing the additional benefits. I just wanted to make sure that was clear.

Chairman STARK. Can you differentiate at all, I mean, between those that are bidding at par or less with those who are bidding more? I mean, is there any—

Mr. HACKBARTH. What type of plan?

Chairman STARK. Yes, or how they operate. Is there a way you can distinguish statistically how they differ?

Mr. HACKBARTH. I would point to a couple things. One is that there are geographic differences, as Mr. Camp alluded to. In some areas of the country, the traditional Medicare costs are very high and private plans are able—many private plans are able to bid less than the traditional Medicare costs.

In other parts of the country, the traditional Medicare costs are significantly lower and it becomes more difficult for a private plan to bid less than the Medicare fee-for-service costs. So geographic differences are important.

Also, plan type is important. More tightly organized systems like Kaiser Permanente, generally speaking, have lower costs than looser systems like private fee-for-service or large network HMOs.

Chairman STARK. Let me just get one more question in here, and I want to yield to Mr. Camp. He has been patient with my inquiries.

In the area of comparative effectiveness, it is my understanding that we are perhaps one of the few industrialized nations in the world in that doesn't have some form of comparative effectiveness studies, certainly for pharmaceuticals if not for medical procedures.

We came fairly close on a bipartisan basis to—I think we came together on a bipartisan basis that it would be useful for us to have a comparative effectiveness program. My understanding is that we came apart on Blue Cross complaining that if they were going to pay anything, they wanted to control the system. And I personally felt that it had to be at least a private/public partnership.

And in a way to pay for it, we had suggested that the government should pay some and the insurance companies, who would benefit from the use of this data, should pay—I think it was two bucks a year per insured, which hardly seemed—considering how much money they make—a burden for them.

Can you give us an outline of what you would suggest as how we would set up a body to ensure independence, that the effectiveness research had a stable funding source and could maintain its independence? Have you got—I mean, this is what I think MedPAC does, although we pay the full freight, the taxpayers do. How would you suggest we set that up?

Mr. HACKBARTH. Yes. We will actually address this issue in some more detail in our June 2008 report. So it is an issue that is currently under active discussion within the commission.

What we have said to this point is that we think it is critically important that the entity be perceived as independent. The whole idea here is to have an entity that exists to produce the best available information, not just for payors but also for patients and physicians. And given the sensitivity of the topic, it will only be credible and useful if it is seen by all parties as independent.

Second, we believe it is very important that the organization have a secure, stable flow of funds and not be subject to having to ask various parties for money each year. That would limit its effectiveness, limit its ability to invest in major research.

As to the specific mechanism for financing, we have not made a recommendation on that. But it does seem to us that it ought to come from the people who benefit from the research, which includes both the public and private payors. Now, there are various ways that that might be accomplished.

Chairman STARK. Is your board close to unanimous in its agreement with those principles, or are—

Mr. HACKBARTH. Yes.

Chairman STARK. They are?

Mr. HACKBARTH. We are.

Chairman STARK. Well, I am happy to hear that, and look forward to, in your report to us in June or any sooner, that you could let us know what your deliberations decide.

Mr. HACKBARTH. Yes. And I might add that within the commission, it is some of the physician commissioners who have been most articulate about this. As practicing clinicians, they feel that the quality and the amount of information that they get about what works for their patients is less than they would desire, less than they need.

Chairman STARK. Thank you very much.

Mr. Camp.

Mr. CAMP. Thank you.

Mr. Hackbarth, the Medicare Modernization Act in 2003 had a number of provisions to improve Medicare Advantage payments.

Have these changes stimulated growth, particularly in the underserved rural areas? And so have they actually succeeded in providing rural seniors with more options?

Mr. HACKBARTH. Absolutely.

Mr. CAMP. The MedPAC report found that Medicare Advantage plans were paid about 13 percent more than traditional fee-for-service. Did you take into account the value of extra services like dental and vision care, preventive services like annual physicals, free annual physicals, that Medicare Advantage plans provide?

Mr. HACKBARTH. Well, what we are looking at in that number, the 113 percent, is the amount of the payment as opposed to the additional benefits provided.

Mr. CAMP. That is just a raw score. So it does not take into account the issue of benefits?

Mr. HACKBARTH. Well, in the slide that I have up, Mr. Camp, the additional benefits that the plans are providing over and above the basic Medicare benefit package would be reflected in the rebate column. So they are providing services estimated to be 9 percent above the traditional Medicare benefit package, but they are receiving payments equal to 117 percent.

Mr. CAMP. Did you include the value of the assistance Medicare Advantage plans provide in helping beneficiaries with lower co-payments and deductibles as well?

Mr. HACKBARTH. That would be in the rebates, yes.

Mr. CAMP. You also say in your statement that we are not receiving value for the additional money in Medicare Advantage. However, GAO found that beneficiaries in traditional Medicare pay \$800 more per year than those in Medicare Advantage. And the Kaiser Family Foundation report found that while beneficiaries save—all beneficiaries save more money in Medicare Advantage, but on average, those with the highest health care costs save more than \$4,000 a year by being in Medicare Advantage.

Are you familiar with those findings?

Mr. HACKBARTH. Yes. And I think I can explain how they fit into our analysis.

Mr. CAMP. Would you describe those are receiving value, those individuals?

Mr. HACKBARTH. Well, the same additional benefits could be provided by Medicare, traditional Medicare, that is, at a lower cost. The plans themselves say that their costs to provide the Medicare services are higher than traditional Medicare's.

Mr. CAMP. But traditional Medicare doesn't provide those services.

Mr. HACKBARTH. Apples to apples.

Mr. CAMP. So you are assuming that then traditional Medicare would then continue to provide all of those services that we are finding in Medicare Advantage.

Mr. HACKBARTH. Well, to the extent that what the plans are doing in their additional services is filling in deductibles, coinsurance, paying premiums, I think that is a reasonable assumption.

Mr. CAMP. But also dental and vision care and other items.

You mentioned reducing those Medicare Advantage payments also to spur efficiency and innovation. Are you suggesting that the health care delivery systems in North Dakota and Wisconsin are

ten times more inefficient than those in New York and Florida, particularly?

Mr. HACKBARTH. Well, the states that have low traditional Medicare costs would tend to be more efficient, not less efficient. In fact, in many of the low-cost Medicare states, as you know—not all of them, but many of them—also tend to do quite well on quality measures. And so traditional Medicare is providing very good value in those low cost states.

Mr. CAMP. Well, so that is—yes. Those with higher Medicare spending and utilization often have lower health and quality outcomes compared to areas that are—where utilization is much lower. I think that is what you are saying.

Mr. HACKBARTH. I am sorry. Say that again?

Mr. CAMP. I think what you are saying is that benchmarks vary widely across the country, and that you have found that regions with the highest Medicare spending and utilization rates often have health and quality outcomes similar or worse than those areas where utilization is much lower.

Mr. HACKBARTH. Yes. That is correct.

Mr. CAMP. Is that a fair statement?

Mr. HACKBARTH. That is correct.

Mr. CAMP. Are you exploring ways to ensure that seniors in states like Michigan will not continue to subsidize the over-utilization of services by paying higher monthly premiums and deductibles in Florida and other areas?

Mr. HACKBARTH. Yes. Well, much of our work is aimed at trying to improve traditional Medicare so that it incorporates stronger incentives for efficiency and quality. So yes, that is what we spend most of our time trying to do.

Mr. CAMP. Thank you. I see my time has expired, Mr. Chairman. Thank you.

Chairman STARK. Mr. Doggett, would you like to inquire?

Mr. DOGGETT. Thank you very much for your important, continuing work.

I would like to direct your attention first to the section of your report captioned, “Part D Data Still Unavailable for Purposes Other than Payment and the Related Recommendation.” In that portion of your report, you say that in calendar year 2006, Medicare and Medicare beneficiaries under the prescription drug program paid out about \$50 billion in premiums, but “because of gaps in available data, there are fundamental questions that cannot be answered about how Part D is operating.”

I think this is a very troubling finding, and your recommendation to try to get CMS and HHS to do what they are charged under the law already, I believe, to do is very important. I have just been consistently amazed at this administration’s tolerance of waste, fraud, and abuse in the Medicare Advantage program. Apparently it is okay to have waste, fraud, and abuse in government programs as long as it fulfills an ideological imperative and benefits insurance companies.

Specifically, for over eight months I have been trying to determine whether all of \$100 million was wasted or just a large part of it in this program to provide prescription drug assistance to people who weren’t told in a timely way they were entitled to get it,

and the refusal of CMS to go back and take a look at whether all that \$100 million was wasted or just a large part of it.

I asked in this room in June. I asked in October. I asked when Secretary Leavitt was sitting where you are, when he came to testify about the President's budget. I asked again last week in the Budget Committee. CMS continues to refuse to explain what happened to that \$100 million for low income beneficiaries.

Let me ask you: As a nonpartisan research organization with no political agenda, the Medicare Payment Advisory Commission, has the administration—formally or informally—been willing to provide you with the facts that you need concerning either this \$100 million payment or the overall experiment with Part D, \$50 billion? And if not, has that refusal to provide data impaired your work to ensure accountability?

Mr. HACKBARTH. Well, I am not sure about the \$100 million issue, Mr. Doggett. But in general, we have been concerned that we haven't been able to get claims level data on Part D so that we can answer basic questions about how the program is functioning—for example, which drugs are the most frequently used, and how many beneficiaries are entering into the coverage gap, and those sorts of issues. And without that information, we feel we can't advise the Congress on how well the program—Part D, that is—is working.

So we have recommended that Congress pass legislation requiring CMS to provide claims level data to MedPAC and other congressional support agencies, and also executive branch agencies that have health and safety responsibility, like FDA.

Mr. DOGGETT. And you believe they could provide you that data right now; but given their attitude, you feel a mandate is necessary?

Mr. HACKBARTH. Well, my understanding is that there are at least people who believe that they don't have the legal authority to do that right now, which is why we have couched it as a recommendation that Congress enact legislation to make it perfectly clear that CMS is not just authorized but required to give us the data.

And obviously, it ought to be done so in a way that protects confidentiality to beneficiaries. And we have a fairly good track record of dealing with confidential information.

Mr. DOGGETT. If you had that data already, certainly you have mechanisms within your committee to protect confidentiality.

Mr. HACKBARTH. Oh, yes.

Mr. DOGGETT. You would have protected it had you been supplied the data you need to do your job. You have, even without that data, been able to do a great deal of research on the windfall subsidies that Medicare Advantage plans enjoy. They of course don't just go to low income individuals. They go to people of all income ranges.

Do you believe that Medicare Advantage is the best way to assist poor folks, low income individuals, with their health care costs?

Mr. HACKBARTH. No, we don't. We believe that there are other ways that are more targeted and would therefore be more effective at achieving the goal of providing support to low income people.

Mr. DOGGETT. I believe the latest estimate we have is that we will waste about \$150 billion over the next ten years on Medicare Advantage over delivering it through traditional Medicare.

Just one last question, if I may, in another area, Mr. Chairman. And that is with regard to not so much these recommendations as the meeting that you had last week to begin exploring again this question of bundling hospital and physician payments for services around a hospitalization.

As you know, when we had the so-called wrap DRG, there was a concern about bundling radiology, anesthesiology, pathology services all together. Could you just give us a general idea of where you think MedPAC is going with this new bundled payment pilot, and perhaps tell us what type of select conditions might come into play, whether it is high volume, or just generally what are the conditions for which quality has been a persistent problem but for which standard protocols are not available?

Mr. HACKBARTH. Yes. Well, a couple points.

Mr. DOGGETT. Or are available.

Mr. HACKBARTH. First is that we have not made a recommendation yet. We discussed a draft recommendation at our March meeting last week, and we will take up a recommendation in April. But I don't want to prejudge that the commission will endorse that.

The concept that we have talked about is starting with a select number of DRGs, focusing on particular conditions that are high volume and, for example, where there is a lot of variation around readmission rates and the like—focusing on those DRGs and then, for those conditions, bundle together in a single package not just the hospital payment but also the inpatient physician fees, subsequent hospital readmissions within a given window like 30 days after the first admission. And the ultimate goal would be to have a single fixed payment that goes to an organization that then divides it among the physicians and hospitals and others participating in the care.

So that is the basic concept. To get to that true bundled payment, we are likely to recommend some transitional steps that would move us gradually in that direction.

Mr. DOGGETT. Thank you.

Chairman STARK. Mr. Johnson, would you like to inquire?

Mr. JOHNSON. Thank you, Mr. Chairman.

You indicated that rural access has improved beneficiary choice to Medicare Advantage. And what would your proposed cuts do to Medicare Advantage to current beneficiaries' access? Is that going to impair them?

And you need to know that the seniors in my district have asked me not to mess with their Medicare Advantage plans, and I know that Mr. Stark's percentage is way up there on numbers of people in your district who take Medicare Advantage. Compared to mine, you are about five times as many.

Mr. HACKBARTH. Clearly, as I said in response to Mr. Camp, the additional payments that are being made to private plans are, at least some of them, going into added benefits for Medicare beneficiaries. And of course we understand that that is very popular.

But if the goal is to provide added benefits to Medicare beneficiaries, we believe that there are more efficient ways to do that than to funnel the money through—

Mr. JOHNSON. Yes. You made that statement before. You keep saying there are other ways. What are the other ways? Would you care to discuss—

Mr. HACKBARTH. If Congress wants to expand the Medicare benefit package, Congress can do that and it would be at a lower cost than doing it through Medicare Advantage.

Mr. JOHNSON. How can you be sure it would be a lower cost?

Mr. HACKBARTH. The plans tell us so. Again, looking at the table before you, the plans say that it costs them more than traditional Medicare to provide the Medicare benefit package.

Mr. JOHNSON. Well, but you also made the statement that it varies across the country. And how do you equalize that?

Mr. HACKBARTH. Well, let's just go through some of the numbers here. On average, for all Medicare Advantage plans across the country, all types of plans, the average bid is 101 percent of traditional Medicare.

For the private fee-for-service plans, which are, as you know, the most rapidly growing and the most prevalent form in the rural areas, the plans say that it costs them 108 percent of Medicare's cost to provide the traditional Medicare package. So there certainly is variation.

But in the rural areas, the private plans say it would cost us quite a bit more than traditional Medicare to provide these benefits. That is what the plans say. That is what their bids say. So if we want to provide more benefits to Medicare beneficiaries, it is more efficient to do it through traditional Medicare than through private fee-for-service plans.

I would also add that if the goal is to improve geographic equity, if people feel like traditional Medicare is unfair to parts of Texas or to Michigan relative to Florida, the place to fix that is in traditional Medicare, not in paying additional money to private plans in those areas.

When traditional Medicare pays a lot more for—or when Medicare pays a lot more for private fee-for-service in Texas or in Michigan or in South Dakota, a lot of that money is going into higher administrative costs and profit for plans. It is not going to the health care providers in those states that have produced those low traditional Medicare costs. It is going to insurance companies.

So if we want to improve geographic equity in traditional Medicare, fix traditional Medicare. If we want to provide more benefits to Medicare beneficiaries, provide them through traditional Medicare. It is lower cost. It is more targeted.

Mr. JOHNSON. So what you are saying is the government is a better insurer than private industry?

Mr. HACKBARTH. No. Actually, I am not saying that.

Mr. JOHNSON. Yes, you—

Mr. HACKBARTH. Well, this is a critical issue, Mr. Johnson, so I want to be really clear on it.

Is traditional Medicare lower cost, more efficient, than private fee-for-service plans? Yes. The data say so. The data submitted by private fee-for-service plans say so. Is traditional Medicare more ef-

ficient than all private plans? No. Some of them bid less. HMOs, on average, bid less than the cost of traditional Medicare, and some HMOs significantly less than traditional Medicare.

Some private plans are efficient. Others are not. The problem with this payment system is we are rewarding inefficient private plans. In fact, we are encouraging growth in inefficient private plans.

Mr. JOHNSON. Well, I think—would you agree that 75 percent of the people use HMOs?

Mr. HACKBARTH. Seventy-five percent of the enrollment? Yes.

Mr. JOHNSON. Can you tell us? Is that true?

Mr. HACKBARTH. Yes. But the most rapidly growing piece of this is the private fee-for-service.

Mr. CAMP. Would the gentleman from Texas yield just for a point of clarification?

Mr. JOHNSON. Yes. Sure.

Mr. CAMP. Mr. Hackbarth, are the coordinated care plans in a different position than the private fee-for-service? Are those still—I mean, your own data suggests they are providing services more efficiently, yet your testimony seems to lump everybody together. And if you could just clarify those points, I would appreciate it.

Mr. HACKBARTH. Yes. Sure, Mr. Camp. And believe me, I am doing my best to be clear on this. Not all private plans are the same. There is a lot of variation. We tend to, for analysis purposes, group plans into broad categories—private fee-for-service, coordinated care plans, regional PPOs, and the like.

There are variations across those categories. Clearly, private fee-for-service is the least efficient option among the broad categories. Within a category, like coordinated care plans, that includes HMOs and local PPOs, as I recall, there are variations among HMOs in terms of their efficiency. Some of them are much lower cost than traditional Medicare. Some are highest cost than traditional Medicare. So the labels are—

Mr. CAMP. Do you have a conclusion as a category, though?

Mr. HACKBARTH. On average, the HMO category provides the traditional Medicare benefits for less than traditional Medicare.

Mr. CAMP. Thank you, sir. I yield back.

Mr. JOHNSON. Thank you.

Chairman STARK. Ms. Tubbs Jones, would you like to inquire?

Ms. TUBBS JONES. Thank you, Mr. Chairman.

Good morning, sir. How are you?

Mr. HACKBARTH. I am doing well.

Ms. TUBBS JONES. My name is Stephanie Tubbs Jones. I come from Cleveland, Ohio. And I am concerned, and I have kind of looked through this report and I am not sure that it is included in that: You are familiar with all the research that shows that there are significant health disparities, particularly in the delivery of health care for minorities, are you not, sir?

Mr. HACKBARTH. Yes.

Ms. TUBBS JONES. Is there any place in this report where you address the issue of health disparities?

Mr. HACKBARTH. Well, there are places that we take care to look at differences. For example, in—

Ms. TUBBS JONES. Can you refer me to somewhere in the report to do that?

Mr. HACKBARTH. Yes. For example, in looking at dialysis facilities and closure rates, one of the things that we look at is the impact on different populations, including African Americans.

Ms. TUBBS JONES. And what were your findings?

Mr. HACKBARTH. Well, in that case we found that among the closing dialysis facilities, they were somewhat more likely to be facilities that have a disproportionate share of African Americans. It is not a huge disparity, but something that bears watching, we think.

Ms. TUBBS JONES. And the reason you are focusing on that is because end stage renal disease predominates in African Americans and other minorities. Is that correct?

Mr. HACKBARTH. Yes. It is a particular problem.

Ms. TUBBS JONES. And so what do you propose we do to address that particular issue, sir?

Mr. HACKBARTH. Well, in this case, as I said, we found a slight difference and think that it is something that bears watching. We don't think that there is evidence of an overwhelming problem at this point that requires—

Ms. TUBBS JONES. But if you are looking at a population in which it predominates, the slight difference could have a disproportionate impact on that group of folks.

Mr. HACKBARTH. All of the other statistics that we look at in terms of access to care for African Americans in general, the growth in services, et cetera, they all are in line with the needs of the population. So the number that I am saying is a little bit, something that bears watching, is the closure of facilities. Are the ones that are closing disproportionately facilities that serve African Americans?

Ms. TUBBS JONES. So are you saying to me that in terms of health care disparity, the only issue is the closing of end stage renal disease facilities?

Mr. HACKBARTH. We don't look at every issue with an eye towards disparities. No, we don't.

Ms. TUBBS JONES. Is that something you could do?

Mr. HACKBARTH. We would be happy to look at particular issues, yes.

Ms. TUBBS JONES. I mean, I think that in light of the fact that every research is showing that health care disparities predominate, delivery of care to minorities is a big issue for minority communities. It would only make sense that you, who do the report to Congress on Medicare payment policy, would include that in your research.

Could you see that that is something you include moving forward in the future?

Mr. HACKBARTH. Yes. We can take a look at that.

Ms. TUBBS JONES. You are aware, in fact—I am encouraging you to do so. And I am going to stay on this health care subcommittee counting on you to provide that kind of leadership for us.

You are aware that the committee—not the committee, the chair and I requested the GAO to do a study around end stage renal dis-

ease and the impact bundling would have on end stage renal disease?

Mr. HACKBARTH. Yes.

Ms. TUBBS JONES. Is there anything in your research that speaks to that issue?

Mr. HACKBARTH. To bundling?

Ms. TUBBS JONES. Yes. The bundling of Epogen and the impact that it would have on minority communities?

Mr. HACKBARTH. Well, the commission has recommended bundling of ESRD-related services. And we have recommended that when that is done, that there be careful attention paid to incorporating measures of quality.

Ms. TUBBS JONES. But when you made that recommendation, did you have any study upon which you based that it would have any disparate impact on minority communities?

Mr. HACKBARTH. No. We don't have information to show—

Ms. TUBBS JONES. Could you, please—again, I am asking on behalf of the minority communities across this country in whom end stage renal disease predominates—do some research in and around that?

Mr. HACKBARTH. Yes.

Ms. TUBBS JONES. And when we receive this GAO study that we have frequented, that you take a look at that to determine the impact, what impact your decision could have based on the study that they have done?

Mr. HACKBARTH. Yes. Of course we would be happy to do that. I would add, though, that we recommend bundling for ESRD services because we think that that system can produce better quality for all Medicare beneficiaries within end stage renal disease.

Ms. TUBBS JONES. But let me—

Mr. HACKBARTH. The goal is to enhance quality as well as improve efficiency.

Ms. TUBBS JONES. Exactly. But the question I have is: Do you believe that doctors recommend drugs in order to make money versus standing in the stead of doing the job that they are supposed to do, which is to do no wrong?

Mr. HACKBARTH. Some doctors do that, and many do not.

Ms. TUBBS JONES. So upon what do you base that answer that some doctors do that?

Mr. HACKBARTH. That some doctors—

Ms. TUBBS JONES. Do that, what you just—that is what you just said.

Mr. HACKBARTH. I am saying that there are doctors who will do things due to financial motivation, and many who do not.

Ms. TUBBS JONES. And upon what do you base that statement?

Mr. HACKBARTH. You can look at variation in utilization of services, and look at things like how ownership affects utilization recommendations.

Ms. TUBBS JONES. So do you have a research report that says doctors make that kind of recommendation, for profit, versus looking out for the interests of their patient?

Mr. HACKBARTH. Again, I don't know if I am misunderstanding your question. Are there physicians who recommend more because

they are influenced by financial incentives? I say yes, there are some physicians.

Ms. TUBBS JONES. And I am asking you, if you have physicians that do that, do you have a report that shows that they do that?

Mr. HACKBARTH. There is abundant research that shows that there is a relationship between financial incentives and physician utilization decisions. There is research that shows there is a relationship between physician ownership of facilities and their decisions about utilization of those services. We don't produce every bit of research ourselves. We rely on work done by other researchers.

Ms. TUBBS JONES. I would be interested in having someone from the folks that are with you giving me the research that says that doctors would over-prescribe a drug of purposes of profit versus looking out for the interests of their patient. And I am out of time, so I am looking for you to send that to me.

Mr. HACKBARTH. Well, again, the point is that physicians respond to incentives.

Ms. TUBBS JONES. I don't know if anybody in the physician community is sitting out there listening to these blanket statements that you are making, but I am confident by the end of the day you are going to hear from a whole bunch of them.

Mr. HACKBARTH. Well, we have got physicians on MedPAC who would agree with that statement.

Ms. TUBBS JONES. Send it to me. If you have it, I would love to read it. But I am telling you, by the end of the day I am confident you are going to hear from a lot of physicians who agree with that blanket statement you are making about their practice of medicine.

Mr. HACKBARTH. And in fact, just so the record is clear, I did not make a blanket statement. What I said is that some physicians do; most do not.

Ms. TUBBS JONES. I will let the physicians argue with you. Thank you, Mr. Chairman.

Chairman STARK. You are welcome.

Mr. Kind.

Mr. KIND. Thank you, Mr. Chairman, and thank you, Mr. Hackbarth. I appreciate your testimony today, and also MedPAC's work in the report that you submit. Obviously, you give us a lot of policy issues to chew on in the course of the report.

Skilled nursing facilities/home health: I am very concerned about their status back in Wisconsin. Obviously, MedPAC is recommending zero percent.

Mr. HACKBARTH. Right.

Mr. KIND. And that is based on what the Medicare margins are right now, is my understanding. The problem we are facing, however, is the state funding issue, which many of us believe has been inadequate, especially in Wisconsin, for too long. And yet they keep coming to us seeing if there is any type of help or relief in light of the funding shortfall that is occurring at the state level.

You probably weren't paying attention, but a couple of weeks ago we just passed reauthorization of the Higher Education Act, which had a maintenance of funding language in it, basically telling the states, listen. If you are going to make it a policy proposal to re-

duce funding for higher education, don't expect the Federal Government then to come up and make up for the shortfalls in that.

I am just wondering whether or not something like that might be necessary in order to address the skilled nursing facilities and home health issues since Medicare's margins are above and beyond, and yet the state funding seems to suffer each year as we go forward, and then jeopardizing that care back home.

Mr. HACKBARTH. Yes.

Mr. KIND. Did MedPAC look at anything like that?

Mr. HACKBARTH. Well, what we have said is that using Medicare funds to offset Medicaid shortfalls is a mistake.

Mr. KIND. Right.

Mr. HACKBARTH. For two reasons. One, if the Federal Government says, we will assume responsibility for the bottom line of nursing homes and home health agencies, that is the reason for the state and other payors to say, oh, we will reduce the amount we pay because the feds will make up the difference. And that is the issue you are getting at.

The second aspect of it is that if we use Medicare rates to cross-subsidize for low Medicaid payment, the skilled nursing facilities, for example, that are going to get the most money are the ones that have the highest Medicare case loads and the lowest Medicaid case loads. And so the money is not going to go to the right people.

So if you want to fix low Medicaid rates, you have got to fix Medicaid, not do it through Medicare. As to how to fix Medicaid, that is beyond the scope of the Medicare Payment Advisory Commission, so we have not made a specific Medicaid recommendation.

Mr. KIND. Now, let me just relay the sense of frustration again that many of the providers feel back in my district in western Wisconsin. High quality care. One of the lowest reimbursement regions in the entire country. Now, if we were to move forward aggressively, getting e-prescribing, HIT in place with quality of care standards, and move to an outcome or performance-based reimbursement system, how much cost savings do you think that would bring the Medicare system in light of the solvency issues that have been highlighted here today?

Mr. HACKBARTH. From HIT in particular?

Mr. KIND. Yes. From HIT, but also going to a performance-based type of reimbursement system that also deals with the utilization variances from regions.

Mr. HACKBARTH. Yes. I don't know, Mr. Kind, exactly what the number would be. You know, people have looked at some pieces of that. The Rand Corporation, for example, tried to look at the potential long-term savings from HIT. MedPAC specifically has not looked at those issues. But potentially the savings are quite large from improved efficiency.

Mr. KIND. And you are probably familiar with the type of provider initiative that is taking place in Wisconsin, where they are trying to—this new quality collaborative initiative that all the providers have bought into in the state in trying to establish standards, increasing transparency, and getting that data available, which I think makes a lot of sense as long as you can get that type of integration and cooperation across the providers.

But naturally, we do have a solvency issue. But one of the issues coming up this year was going to be the 45 percent trigger issue. Does MedPAC have any thoughts about that 45 percent trigger?

Mr. HACKBARTH. Well, we have not made any recommendation on the 45 percent trigger per se. I would say that, as I said in my opening statement, the commission is very concerned about the solvency of the program and feels a growing sense of urgency about that. So to the extent that the 45 percent trigger reflects the same sense of urgency, that is good news.

The problem with the trigger is that, as you know, it focuses on the portion of the program that is financed through general revenues. And so it is just looking at a piece of the financial picture, not the overall cost of the Medicare program.

And so in that sense, the 45 percent trigger is inadequate to deal with our big picture issue, which is the total cost of the program, whether it is financed from general revenues or the HIT.

Mr. KIND. Right. What are your thoughts on these so-called efficiency payments, trying to incentivize increased efficiencies and cost savings and the delivery of health care? Are they going to be effective? Are they going to—

Mr. HACKBARTH. We have got to move in that direction. We need to move in that direction with care. We need to make sure that the system includes quality measures to assure that we aren't hurting quality as we try to lower costs.

We need to take care that there is appropriate adjustment for patient case mix and severity of illness so there aren't incentives to avoid the sickest patients. But the direction is the direction we need to move. We just need to move there with care and thought.

Mr. KIND. Great. Thank you. Thank you, Mr. Chairman.

Chairman STARK. Mr. Pomeroy, would you like to inquire?

Mr. POMEROY. I do have a few questions. I would first like to pick up on my colleague's comments about the skilled nursing home care reimbursement issue. Now, MedPAC is an advisory committee for Medicare, so maybe MedPAC only needs to look at the Medicare component of reimbursement under CMS. But I believe the responsibilities on us, as members of the Ways and Means Committee, needs to be a little broader even though Medicaid jurisdiction falls principally on the Commerce Committee.

But what we have for the nursing home in North Dakota providing services, much of which is paid for by federal programs, Medicare or Medicaid, is negative margins. They are getting negative margins because they are losing their short on Medicaid reimbursements being below costs, and they have been able to cross-subsidize a little bit with the margin, a favorable skilled nursing care margin on Medicare reimbursements.

So simply to, without attending in any way to the underpayment on Medicaid, hammer now the margins on Medicare, at the end of the day, for the institution we demand provide quality care to the senior in that home, we are only making the job much more difficult.

And I believe that you can even look at it a little more expansively as a Medicare problem as well. If the institutions are, in aggregate, in negative margins because of a federal program, it seems to me we had better be somewhat tempered in what we do on the

Medicare side lest we drive the quality or the availability of care in the nursing home area to where we can't get acceptable outcome for the Medicare reimbursements that we make. We have that as a higher priority personally in the year ahead as we look at this.

But I want to ask you about a few different things. The growth we are seeing in the Medicare Advantage is all in the private fee-for-service side in North Dakota. An awful lot of aggressive marketing has produced some substantial enrollment change recently.

And I just don't see much quantification of the private fee-for-service return for the 17 percent we pay over the cost of Medicare, paying for the benefit on the fee-for-service basis. Is that substantially MedPAC's view as well?

Mr. HACKBARTH. Mr. Pomeroy, again I would refer you to the table that is on the screen. So that last column, the rebates, that is the amount of money that goes back to Medicare beneficiaries in the form of added benefits, reduced premiums.

So of the 117 percent payment, overpayment, 9 percentage points of that 17 is going to the beneficiaries in the form of added benefits. The remaining 8 percent out of the 17 is going into higher plan costs for administration, profit, et cetera. So some of it is making it to beneficiaries, but only about half.

Mr. POMEROY. Yes. For whatever enhanced benefit we want, we are paying \$2 to get a buck's worth of good out there.

Mr. HACKBARTH. Yes. Right. Exactly.

Mr. POMEROY. There ought to be a more efficient way of doing that one.

There is a book I would commend to you, if you haven't read it, "Overtreated: Why Too Much Medicine Is Making Us Sicker and Poorer," written by Shannon Brownlee. The New York Times called it the number one economic book in 2007. And it talks about vast differential in practice patterns not reflected to improved outcomes, in fact potentially inversely related to preferred outcomes, adding costs that the author estimates to be \$500 to \$700 billion a year.

Now, as a system, is Medicare incapable of responding to a practice pattern in one place that is carving people up at a rate that is totally unmatched in other parts of the country without any better outcomes to show for the cost and the trauma to patients?

Mr. HACKBARTH. Well, one of the tools that Medicare has at its disposal is in fact to use private plans. Traditional Medicare has some strengths. It is large. It can get good rates from providers because of its size. It has low administrative costs because of its size. Traditional Medicare's weakness historically has been its inability to change practice patterns and deal with this sort of issue.

And so part of the original thinking around Medicare Advantage was, well, if we allow private plans to come in and they can selectively contract, they can better coordinate care, and the like, they can deal with some of these inappropriate utilization patterns maybe more flexibly than traditional Medicare.

I still believe that is true. The problem with Medicare Advantage is the payment system that we are using rewards inefficiency as well as efficiency.

Mr. POMEROY. All right. Thank you, Mr. Chairman.

Chairman STARK. Thank you.

Mr. Thompson, would you like to inquire?

Mr. THOMPSON. Thank you, Mr. Chairman. I would. Thank you, sir, for being here today and helping us work through these vexing issues.

In the administration's budget, they were silent on the issue of addressing the impending physician rate cuts, which I take to be a silent endorsement of the cuts. And it is interesting because CMS's own actuaries seem to recognize that cuts of this magnitude will impact access to care. As a matter of fact, they said that it would substantially reduce beneficiary access to physician care.

Does MedPAC agree that cuts in the range of 10 percent would have an impact on beneficiaries' access to care? And do you have any comments as to how you think Congress should deal with it?

Mr. HACKBARTH. Yes. It is quite possible that a cut as large as 10 percent would start to affect access to care, in particular in some markets. MedPAC's recommendation is for an increase in physician fees equal to the increase in their input prices minus a productivity factor. It works out to about 1.1 percent.

Mr. THOMPSON. And that would avert any reduction in care to—

Mr. HACKBARTH. Yes. We think a modest increase in the payments is appropriate.

Mr. THOMPSON. I would like to follow up on something our colleague Ms. Tubbs Jones mentioned, and that is the issue of bundling of Medicare payment rates for dialysis. And she said one thing that—she asked you one question that I was somewhat perplexed by your comments, and that is the fact that—the closing of these facilities.

And I didn't hear any mention on your part that there is a nexus between reimbursement rates and the ability of some of these facilities to stay open. And I think that was something that—maybe it is intuitive, but it is important to note that.

It is more than just the reasons that you stated for folks to stay open and continuing to be able to provide care. If they are not getting the reimbursements they need to keep the doors open, they are going to close.

Mr. HACKBARTH. Yes. But could I comment on that, Mr. Thompson?

Mr. THOMPSON. Sure.

Mr. HACKBARTH. Just to be clear, the number of facilities closing in any year is quite small. And maybe somebody can get that number.

Mr. THOMPSON. Well, and the number—

Mr. HACKBARTH. And so I didn't mean to overstate the closure problem. But I was giving it as an illustration of where we have looked in particular at a disproportionate impact on certain communities, like the African American community.

Mr. THOMPSON. The actual number is less important to me than the fact that people who need this care—I mean, it is very, very important—have the ability to do it. I don't know where you live, you know, if you live in the city, or maybe it is easy to get to them. But I represent a district that is largely rural, and it is tough for people to drive—especially to undergo this type of treatment—to drive any great lengths.

And I will stipulate that bundling probably does save money. But I think it is important also to point out that it is more than just saving them money. There is a quality to health care, a quality of health care, an access to that quality of health care issue that I think has to be put in place.

And I am hearing rumors that, given the support for the bundling, that there may in fact be something along those lines. But I think we need to do some better tests than the tests that have been proposed so far.

And I think that those pilots or tests or whatever you are going to—the matrix that you are going to set up to determine the impact that this is going to have on very real people with very serious health problems, that it take into consideration not just the savings associated with this but also the impact it has on someone's access to quality health care. And I would like to see something come out of MedPAC that would address that issue.

Mr. HACKBARTH. We agree that designing the system so that it doesn't just preserve quality but I think can even enhance quality, that should be the objective.

Mr. THOMPSON. We just need to make sure we do the work on the ground so we are not modeling after urban facilities. We need to take into consideration the impact this is going to have on rurals.

And then one last question. The administration held Medicare Advantage Plus harmless, and this has been talked about a little bit already, but in the budget that cut the rates for almost every other provider group.

And it seems to me that in your work, you suggest that the Medicare Advantage plans take up about \$10 billion more for beneficiaries enrolled in those plans. And my question to you is: Without reform, do you see the MA reimbursement rates continuing to tread upward in comparison for fee-for-service? And what can you suggest that beneficiaries are getting that make this extra expenditure worthwhile?

Mr. HACKBARTH. Well, so long as we keep the current payment system, we expect that enrollment will continue to grow. And each new beneficiary is costing traditional Medicare more. So the cost of the program will grow with that additional enrollment. And that is one of the reasons we think it is important to act on this as soon as possible.

Mr. THOMPSON. So \$10 billion today?

Mr. HACKBARTH. It will be bigger in the future so long as you leave these payment incentives in place.

Mr. THOMPSON. Pretty soon we are talking about real money.

Mr. HACKBARTH. Yes. We are at risk in the extreme of taking large portions of the country where traditional Medicare's costs are relatively low and quality relatively high, and moving all those beneficiaries into higher cost fee-for-service plans that add no value over traditional Medicare. And the price tag for that will be very large.

Mr. THOMPSON. And as far as what these beneficiaries are getting for this \$10 billion extra?

Mr. HACKBARTH. Well, again, the table that we have discussed summarizes the data. In the case of private fee-for-service—which

has basically doubled in size; it is the most rapidly growing—doubled in size of the last year; it is the most rapidly growing piece of Medicare Advantage—only about half of the overpayments are going into additional benefits for Medicare beneficiaries.

Mr. THOMPSON. Thank you very much.

Chairman STARK. Mr. Becerra, would you like to inquire?

Mr. BECERRA. Yes, Mr. Chairman.

Mr. Hackbarth, thank you for being with us again. And once again, thank you for the report, your testimony, and the good work that the commission has been doing.

I would like to focus my first question on some of your recommendations pertaining to trying to increase the participation rates by modest income Medicare beneficiaries in the Medicare savings program and in the low income drug subsidy program as well.

You make some specific recommendations, which I think you have made in the past. I know I have heard you say this. One is that the Secretary of Health and Human Services should increase the funding for outreach to low income Medicare beneficiaries that participate in the state health insurance assistance program.

Two, you call on Congress to raise the Medicare savings program income and asset test to conform to the low income drug subsidy criteria that we have, so that you bring them together and let low income folks who happen to have some modest assets still qualify without having to become so poor before they are able to get some assistance to get their Medicare benefits.

And you also talk about Congress changing the program requirements so that the Social Security Administration would be able to screen low income drug subsidy applicants for the federal Medicare savings program to see if they are eligible, and if they are, to be able to enroll them; in essence, a one-stop shop. So that if the state is finding out that these folks qualify, or the SSA is finding out that they qualify for one thing, chances are they will qualify for the other. And rather than have them not know the other, we get them into the boat getting their health care right away.

Mr. HACKBARTH. Exactly.

Mr. BECERRA. You have made these recommendations before. Our bill, the CHAMP bill last year, tried to implement them. We have not gotten there. Why do you keep making these recommendations? Beyond the social desire of trying to get folks who qualify, who are eligible for these benefits to know about them, is there a financial savings as well?

Mr. HACKBARTH. Well, I am not sure that there would be a financial savings, at least not in the first instance. These increase outlays—

Mr. BECERRA. To the overall—

Mr. HACKBARTH [continuing]. It is money well spent.

Mr. BECERRA. Right. To the overall system, I guess I should say.

Mr. HACKBARTH. Yes. No, frankly, the context in which we took on these issues was influenced by the Medicare Advantage debate. A lot of people said, well, Medicare Advantage is providing support for low income beneficiaries. It is making it so that they can get added benefits.

And that is a worthy, important goal. And so we said, well, there are other ways to achieve that goal more efficiently without just sort of spreading money all over the country. Let's target it to low income people. We have vehicles in place, namely, the Medicare savings programs. Let's change the rules there so that they are more effective.

Mr. BECERRA. So we could be more efficient if we were able to target it through these programs that already exist?

Mr. HACKBARTH. Yes. That is our thought.

Mr. BECERRA. Let me ask another question. I know there is a constant debate about the issue of the high deductible health plans, and the health savings accounts that the President has really promoted for quite some time really provide resources for those who are in these high deductible health plans.

These plans, my understanding is, run the risk of being attractive to individuals who, for the most part, are healthy or wealthy. But when you take into account that 80 percent of our health care costs are for 20 percent of the population, it seems to me that the 20 percent that is at most risk of needing health care, they are the folks that are least likely to go into these health savings accounts and these high risk deductible plans because their up-front costs would be too tremendous for them to be able to afford that type of an insurance program.

Any comments?

Mr. HACKBARTH. Well, we have not looked specifically at the issue of the high deductible plans. We do refer to some research in our report that has been done by other people that suggests that, yes, maybe there is a selection effect here, that they are most attractive to people who have relatively high incomes and who are relatively healthy. I would note, though, that it is pretty early in the development of the idea. And so it is probably premature to draw definitive conclusions.

From my own personal perspective, I guess the big question that I have about the effectiveness of the high deductible plans, having been in one myself, actually, is: Are they going to help us deal with the health cost problem, which as you say is that 20 percent of the population that uses 80 percent of the resources.

The people who have multiple chronic illnesses are going to blow through these deductibles. And once they are through the deductible, they basically have first dollar comprehensive coverage. So what is the incentive to reduce costs in the case of the people who use all the money? So are they going to solve our health cost problem? It is hard for me to see how they will do that.

Mr. BECERRA. Well, I thank you for the report because it seems to me you are trying to target these efficiencies that we can inject into the system. And I appreciate that because one of the things we are finding is that we may have disagreements about how to do health care, but I think if we know we can save money and still provide health care, most of us in this Congress would be supportive of that.

So we appreciate the reports and the recommendations that we have gotten from MedPAC. Thank you for your time.

Mr. HACKBARTH. Thank you.

Chairman STARK. Thank you. I had a couple of questions, Glenn.

You continue to recommend a bundled payment for dialysis providers. Do we need to do a demonstration first before moving to a bundled payment system, or do we have enough information to proceed?

Mr. HACKBARTH. I think there is probably enough information to proceed as is, Mr. Stark. I don't think another demo is needed. Having said that, of course, it is very important to take care in the design of a bundled payment to include appropriate case mix adjustment and quality measures.

Chairman STARK. So that would take into account adjustments for minority populations or for rural settings? All those issues that my colleagues have raised today would be taken into account in setting up a bundled payment system, and you have enough information, you feel, to do that?

Mr. HACKBARTH. Well, I think it can be designed to address the legitimate concerns that have been raised.

Chairman STARK. In the area of the for-profit skilled nursing facilities, you project Medicare margins of 11 percent in 2008 in the for-profit groups. Is there a variation in margins between the for-profit and not-for-profit skilled nursing facilities?

Mr. HACKBARTH. Yes. The average Medicare margin for the freestanding facilities I think is projected to be 11 percent. And the margin for the for-profits—this is actually the 2006 data. So the overall average is 13 percent, and the for-profit was 16 percent, and the not-for-profit was 3 percent.

Chairman STARK. Why is that, and what should we do to perhaps bring them closer together?

Mr. HACKBARTH. Yes. We have been concerned for several years now about the system used to pay skilled nursing facilities, and didn't feel like it was appropriately recognizing differences in some types of patients. And there are two particular components that have been troubling to us: how the system pays for non-therapy ancillary expenses, as they are known, which is like drugs and respiratory therapy, things like that; and then how it pays for physical therapy, occupational therapy, and the like.

In the one case, the non-therapy ancillaries, we think the existing system underpays. So these are often complicated patients that we think are not getting enough money from Medicare. On the other hand, the existing system provides very strong incentives to do lots of therapy, and there may be too much profit in that end of the business.

We are looking at a recommendation and we talked about a draft recommendation last week that would change the payment system for non-therapy ancillaries and therapy, and would have the effect of changing these margins. So margins at the for-profit skilled nursing facilities would fall. Profits at the not-for-profit skilled nursing facilities would increase. I would also add that the financial performance of hospital-based skilled nursing facilities would also improve under our recommendation.

Chairman STARK. And you won't get me crosswise with Mr. Pomeroy in saying that we won't be disadvantaging rural providers or inner city providers?

Mr. HACKBARTH. No, I won't. We think it is a fairer payment system that more accurately reflects the needs of the patients being served.

Chairman STARK. Mr. Camp, did you—

Mr. CAMP. Yes. I just had a follow-up to the question you had.

Obviously, MedPAC has recommended in past reports a bundled payment for dialysis services combined with quality monitoring. So this is not a new recommendation.

Mr. HACKBARTH. Right.

Mr. CAMP. But what is new is that CMS has just completed their final report on a potential model for an ESRD bundled payment. In that, I understand there are a number of case mix adjusters.

Are any of those including race?

Mr. HACKBARTH. I don't know. I think the CMS report came out like a week ago.

Mr. CAMP. Yes. I believe none of them. There are 22 case mix adjusters, and none of them are including race.

Do you believe the model that CMS has developed can be used to implement a bundled payment system nationwide that accounts for both individual patient characteristics as well as the smaller dialysis facilities?

Mr. HACKBARTH. Because the report is a recent one, we are still in the process of looking at it. But as you point out, we have said for a number of years now we think a bundled payment is the way to go.

Mr. CAMP. And rather than a pilot program, do you believe a transition might be more appropriate to phase in a bundled payment, similar to the transitions to reform patients to inpatient hospitals, skilled nursing facilities, long-term care hospitals, inpatient rehab facilities?

Mr. HACKBARTH. Yes. In fact, that is a quite common thing in the Medicare program, where you are making a significant change in a payment system to allow a gradual transition. Yes.

Mr. CAMP. And would it also not be suitable to provide a regular update that is built into the baseline, much like other providers?

Mr. HACKBARTH. I am sorry. You are saying a statutory update?

Mr. CAMP. Yes. To provide a regular statutory update that is built into the baseline, which is similar to what other providers receive?

Mr. HACKBARTH. Well, as you know, MedPAC's stock in trade is to look at a variety of different factors to make an update recommendation, things like margins, access to capital, access to care for beneficiaries, et cetera. And those variables change over time. They change year to year in some cases.

And so our basic approach on all updates is that you ought to do an analysis each year to determine an appropriate update, as opposed to writing a baseline that says, oh, they are going to get X percent every year into the future. So if anything, we would like to see everybody on the same footing as dialysis facilities, which is no automatic increases.

Mr. CAMP. So you are suggesting we remove the built-in baseline update for other providers?

Mr. HACKBARTH. We think that determining the appropriate rate increase is something that ought to be done year by year.

Mr. CAMP. And how does that—if that is completely open year to year, doesn't that make long-term planning somewhat difficult, particularly in hospital settings and other large concerns that have a variety of business decisions to make as well as the care of patients?

Mr. HACKBARTH. Well, most businesses don't have guaranteed updates. They have prices set by competitive markets. And they still manage to plan. They make assumptions about what it is going to be. They respond to changes in prices by improving efficiency. The norm—

Mr. CAMP. There is also more choice available in the private sector in many cases than there is in the heart sector. We don't always have the comparable choices available. But I understand the point you are trying to make. I do think it is a little different when there is a sole provider, a community hospital, to say that they are just like the three auto parts stores that are in town. I think there is a bit of a difference there.

Mr. HACKBARTH. Yes. And in cases where there is a sole provider and it is a critical access institution, there aren't readily available alternatives, we ought to target those institutions in particular, as you folks have, and set up special payment systems for those isolated providers. But where there are alternatives, I think that living without price guarantees is the way the economy works in general.

Mr. CAMP. Well, I think in many large cities you have lots of alternatives. But in most of America, there aren't lots of alternatives. So yes, if you live in a large urban setting like Washington, D.C., you have got lots of choices. But even in parts of the city, you have to travel a ways to get to those choices.

So anyway, I appreciate the chairman's time. Thank you.

Chairman STARK. Just one more issue on this dialysis thing. According to your report, we are spending about 26,000 bucks a year for each patient. Right? I think that is in your report somewhere.

Mr. HACKBARTH. Okay. I don't have that number in my head.

Chairman STARK. And the for-profit, there are two big for-profit chains, and their average margin is 7.6 percent. Everybody else is around 2 percent margin.

Is there that big a disparity in quality between the non—those that aren't the two big chains?

Mr. HACKBARTH. As you know, the payment system isn't at all based on quality.

Chairman STARK. No, no. I just wondered if you know. Is there any reason—

Mr. HACKBARTH. Yes. Not that I know of. I don't know that there is a quality advantage in the big chains.

Chairman STARK. So we are paying these guys three and a half times as much, and you don't think there is three and a half times better quality.

I was just looking the other day, and in most every other country in the world, dialysis is done through hospitals. What if—and assuming that we would have to keep the patients happy by having little clinics all over hell's half acre, but the hospitals could run

those, just as they often run outpatient—what if we just—I mean, we are talking about this huge margin. And the hospitals are—none of them have margins near 7 percent. On average, most of our hospitals—what if we just gave this extra money to the hospitals and said, you guys run it? Some hospitals do it as a part of their service. What would be wrong with just turning the whole dialysis program over to our not-for-profit acute care hospital system and give them the margin?

Mr. HACKBARTH. Well, in general, we favor having choices for beneficiaries and competition in the belief that that can make things—

Chairman STARK. But they have a choice—in many areas, they have a choice of hospitals. In some areas where—

Mr. HACKBARTH. Right. But to designate a particular provider type as the only one who can provide a service, particularly what is basically an outpatient service like this one, wouldn't be the approach that MedPAC would normally take. What we try to do is devise payment systems that are neutral to provider types.

Chairman STARK. But this is the only service that we pay for everybody. In other words, if America—I mean, this is socialized medicine. Dialysis is the only procedure that we pay for everybody, and the government pays the whole freight, so that it arguably is a different procedure. And if we are going to set the price, maybe we could set the setting.

And we are also worried about the financial health of the hospitals. And I just suggest that maybe this would be a way to give them a little extra revenue. They certainly have the extra—and in many cases they do do it in hospital settings. It sounds to me like it is some low-hanging fruit that might help our hospital system provide competition, provide access, all those things that—I would be curious to see what you think. See if you can sell that to your board.

Mr. HACKBARTH. It might be a tough sell.

Mr. CAMP. If I might just follow up on one question. There is a different patient mix in the small rural providers and the large dialysis chains, is there not? They are not comparable patient populations, is my understanding.

Mr. HACKBARTH. Well, I honestly don't know—

Mr. CAMP. So the margins would reflect the different population mix and payment mix of those two groups, would they not?

Mr. HACKBARTH. Yes. I don't know that there is a difference, Mr. Camp. Maybe one of my colleagues—

Mr. CAMP. Yes. I think before we draw offhand conclusions on the margin differences between the larger chains and the smaller chains, I think we need to understand is there a different patient mix in those two types of facilities. And I believe you will find there is.

Mr. HACKBARTH. We can provide you a more detailed answer.

Mr. CAMP. Yes. I would appreciate that.

Mr. HACKBARTH. But there might be some differences, small differences, in the patients served among the different types at this point.

The second point I make is—

Mr. CAMP. One may have a larger percentage of Medicare patient, and the other may have other payment? There could be quite a difference there.

Mr. HACKBARTH. Ideally, what you want——

Mr. CAMP. I appreciate the information.

Mr. HACKBARTH. In a bundled payment system, you want a case mix adjustment that deals with difference in patient need.

Chairman STARK. Glenn, thank you. Thank your staff, Mark and the rest, all of you, for helping us through these thorny problems. We will look forward to June report.

Mr. HACKBARTH. June report.

Chairman STARK. Do we get it in June or July? June?

Mr. HACKBARTH. Get it in June, yes. About the 15th of June.

Chairman STARK. Great. Look forward to it. Thank you very much.

Mr. HACKBARTH. Thank you.

[Whereupon, at 11:44 a.m., the subcommittee was adjourned.]

[Questions for Record follow:]



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May 5, 2008

The Honorable Pete Stark
 Chairman, Subcommittee on Health
 Ways and Means Committee
 1102 Longworth House Office Building
 Washington, DC 20515

*Re: Questions for the record from the Ways and Means Subcommittee Hearing entitled:
 "MedPAC's Annual March Report"*

Dear Congressman Stark:

This letter is in response to the questions you sent us on March 25, 2008. Answers to the questions are as follows:

Replies to questions from Ranking Member David Camp

According to the March 2008 Med PAC report, approximately 80 percent of beneficiaries in Medicare Advantage (MA) are enrolled in a coordinated care plan. The same report also highlighted how the most popular form of coordinated care plan (HMO plans) submitted bids for the standard Part A and B benefit that were, on average, below the costs of traditional Medicare. Are HMO plans able to provide the standard Part A and B benefits at an amount lower than traditional Medicare, according to their average submitted bids?

As of March of 2008, 77 percent of enrollees in plans that participate in the MA bidding process are in coordinated care plans, a category that includes HMOs, local PPOs, and regional PPOs. HMOs have nearly 69 percent of the enrollment, and local or regional PPOs have nearly nine percent of the enrollment (with the two categories summing to 77 percent). The remaining 23 percent of MA enrollees are in private fee-for-service (PFFS) plans.

As of 2008, about 80 percent of Medicare beneficiaries have access to an MA HMO operating in their county. In rural areas, only about 44 percent of beneficiaries have access to an HMO. All residents of the United States have access to at least one PFFS plan in their county.

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The average submitted bid for HMO plans indicates that they are able to provide Medicare's Part A and Part B benefit package for less than the cost to the traditional FFS program. In 2008, the enrollment-weighted average HMO bid is at 99 percent of average FFS spending. This is up from 97 percent of FFS in 2006.

If the majority of MA enrollees are in plans that, according to the plan bids, are able to provide the standard Part A and B benefits below the cost of traditional Medicare, what is the basis for your assertion that it would be more efficient to provide extra benefits through traditional Medicare?

What MedPAC has said about plan efficiency is that under the current MA payment policy, extra benefits are provided by efficient plans (with efficiency measured by a plan's ability to bid below 100 percent of FFS), as well as by inefficient plans. Inefficient plans require payments in excess of 100 percent of FFS to provide the Medicare benefit, and their sole source of funding for extra benefits are payments from the Medicare Trust Funds and beneficiary premiums. Whereas in the former case the extra benefits are (in part, at least) a signal that the plan is efficient, in the latter case the ability to provide extra benefits does not mean that the plan is efficient. In the latter case, payments to the health plan, because they are at a level above 100 percent of FFS, are an inefficient use of Medicare dollars and beneficiary premiums.

Another aspect of this question is whether MA plans could be efficient in all areas of the country (i.e., able to provide the A/B benefit package in all parts of the United States for less than FFS). As you point out, only HMOs are able to bid below FFS Medicare levels. Part of the reason HMOs are efficient in MA is that they are achieving economies of scale by operating in more densely populated areas. Almost half of HMO enrollment (49%) comes from 40 urban counties (out of the nearly 1100 urban counties, and 3200 total counties, in the United States). High levels of enrollment within a geographic area enable HMOs to achieve economies of scale—spreading fixed administrative costs over a larger enrollment—and they also allow plans to have better negotiating leverage with providers to secure favorable provider contracts and obtain discounts. However, HMOs still do not generally operate in certain areas, even where benchmarks are very high relative to FFS—that is, HMOs do not see the “business case” for operating in some counties (i.e., they cannot be efficient in some areas).

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Has MedPAC identified any data that would indicate that coordinated care plans would be less efficient in the delivery of additional benefits, in contrast to their ability to provide standard Part A and B benefits at a cost lower than traditional Medicare?

MA HMO bids at an average level of 99 percent of Medicare FFS levels show that some plans, in some counties, can provide the traditional Medicare benefit package at a cost that is less than that of FFS Medicare in that particular county. It would be surprising if HMOs were not able to “compete” against FFS Medicare in the particular geographic areas where Medicare HMOs have been most successful. However, we also know that many plans—including the fast-growing PFFS plans—cannot provide traditional benefits more efficiently than FFS.

There are no data on the administrative costs of having the traditional FFS program offer extra benefits. So we do not know definitively whether the ability to be more efficient than FFS Medicare in some counties translates into an ability to provide benefits that are not part of the traditional Medicare benefit package more efficiently than the Medicare program. However, an important point is that the principal extra benefits that MA plans offer are the reduction in cost sharing for Medicare benefits and the reduction in plan premiums. According to CMS data for 2007, the buy-down of Medicare cost sharing represented \$67 out of \$86 in average net extra benefits for MA enrollees—over three quarters of the total dollars. As CMS noted, the MA buy-down of cost sharing has associated with it “allowed overhead costs for supplemental benefits...allocated to additional benefits and cost-sharing buy-down” (see CMS’s document, *Medicare Advantage in 2007*). That is, cost sharing buy-downs get a proportional allocation of the total plan administration and profit. For example, if a plan bid results in \$100 available as rebate dollars, and the plan decides to use all the rebate to reduce cost sharing, the value of cost sharing reduction for beneficiaries is \$85, if the plan administration and profit charge combined is 15 percent (which is a standard level of administration and profit). In other words, the most common additional benefit—reduced cost sharing—has an administrative “load” associated with the benefit, just as other extra benefits (eyeglasses, hearing aids) have loading for administration and profit.

Has MedPAC estimated what it would cost to have the traditional Medicare program provide all of the extra benefits (reduced cost-sharing, reduced premiums, catastrophic cost protections, free preventive services, annual physicals, dental and vision coverage, disease management, etc.) that are currently being offered in the most popular coordinated care MA plans?

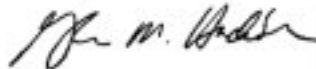
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We have not specifically estimated the cost of having the Medicare program provide the kinds of additional benefits that many MA plans are offering. In MA, the current situation is one of many plans, small and large, across the country, providing a range of extra benefits and incurring administrative costs in providing those benefits. Generally, if Medicare were to provide a new benefit, such as the coverage of hearing aids, it could be provided in a way that capitalized on Medicare's large scale as a purchaser and its relatively low administrative costs (including the absence of profit as a component of such costs). However, private plans may be able to "manage" the provision of extra benefits and thereby reduce costs, with larger MA plans having an advantage over smaller plans in their incurred administrative costs.

HMOs are more efficient than other plan types in providing the Medicare A and B benefit, as indicated by the difference in bids between plan types. However, HMO enrollment is becoming a smaller proportion of total MA enrollment. Increasingly, enrollment in MA is coming from plans with bids for Medicare A/B services that are above Medicare FFS levels. Thus, it is becoming more expensive for the program to provide A/B benefits (as well as extra benefits) through the MA program than it has been in the past. To the extent that enrollment will continue to grow in areas and among plans with bids that are less efficient than the current HMO average, the extra cost to Medicare of providing the A/B benefit through MA plans has to be factored in when evaluating the question of what is the most efficient way of providing extra benefits to Medicare beneficiaries.

Please feel free to follow up with me or Mark Miller, MedPAC's Executive Director (202-220-3700) on any of these issues. Again, we appreciate the opportunity to testify on our March 2008 report and appreciate the Committee's interest in our work.

Sincerely,



Glenn Hackbarth, J.D.
Chairman

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