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HEALTH CARE LAW'S IMPACT ON THE MEDICARE PROGRAM AND ITS BENEFICIARIES

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

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HEALTH CARE LAW'S IMPACT ON THE MEDICARE PROGRAM AND ITS BENEFICIARIES

THURSDAY, FEBRUARY 10, 2011

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

The committee met, pursuant to call, at 10:00 a.m., in Room 1100, Longworth House Office Building, the Honorable Dave Camp [chairman of the committee] presiding.

[The advisory of the hearing follows:]

HEARING ADVISORY

Chairman Camp Announces Hearing on the Health Care Law's Impact on the Medicare Program and its Beneficiaries

Thursday, February 3, 2011

House Ways and Means Committee Chairman Dave Camp (R–MI) today announced that the Committee on Ways and Means will hold a hearing to examine what impact the health care overhaul will have on Medicare and Medicare beneficiaries. **The hearing will take place on Thursday, February 10, 2011, in 1100 Longworth House Office Building, beginning at 10:00 A.M**.

In view of the limited time available to hear the witness, 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. A list of invited witnesses will follow.

BACKGROUND

The health care overhaul enacted last year included one-half trillion dollars in Medicare program savings from 2009–2019. As a result of these policies, the actuaries at the Centers for Medicare and Medicaid Services (CMS) have warned that beneficiaries' access to care could be jeopardized, nearly 9 in 10 seniors could lose their retiree prescription drug coverage, and millions of seniors are expected to lose their Medicare health plans.

In announcing this hearing, Chairman Camp said, "**It is the Committee's responsibility to oversee the Medicare program and to fully understand the impact the recently enacted health law will have on the seniors and disabled Americans who rely on it. This hearing will allow the Committee to better understand the challenges created by the Democrats' health care overhaul so that we can assess what actions may be necessary to ensure that Medicare beneficiaries have continued access to needed health care services**."

FOCUS OF THE HEARING:

The hearing will examine the impact of the enactment and implementation of the "Patient Protection and Affordable Care Act" (P.L. 111–148) and the "Health Care and Education Reconciliation Act of 2010" (P.L. 111–152) will have on the Medicare program and its beneficiaries.

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 "Hearings." 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 online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Thursday, February 24, 2011**. 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 or (202) 225–3625.

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 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.

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.

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

Chairman CAMP. The committee will come to order.

Good morning. I want to welcome everyone here and also extend a special welcome to our guests, Donald Berwick, the Administrator at the Centers for Medicare & Medicaid Services, and Richard Foster, Chief Actuary for the Centers for Medicare & Medicaid Services.

Dr. Berwick, despite three separate requests from the Republicans on the committee to our Democrat counterparts in the last Congress, this is the first time you have actually been invited and appeared before this committee—or any House committee, for that matter—so we have been especially looking forward to having you here for what I hope will be an informative and spirited discussion about the impact the Democrats' new health care law will have on Medicare, our seniors, and other beneficiaries who depend on the program to meet their health care needs.

I would note that the spending that runs through your agency is greater than what is spent by the Department of Defense. So not only do we have a constitutional responsibility to conduct this oversight, we have a clear fiscal responsibility to the American people, given the amount of tax dollars that you control.

And if I were going to pick a subtitle for this hearing, I might well borrow a line from Charles Dickens, "It was the best of times, it was the worst of times," because, to be honest, as I read through the testimony of our two witnesses and looked back through the information we have seen from CMS, I see two very contrasting perspectives appearing from the same agency.

On the one hand, we have Dr. Berwick, who has repeatedly touted the benefits of the health care law. In testimony before the Sen-

ate Finance Committee last November, Dr. Berwick stated that "Medicare's long-term sustainability is stronger than ever as a result of the new efficiencies, new tools, and resources to reduce waste and fraud and slow growth in Medicare costs."

On the other side, you have Mr. Foster and his team in the CMS Office of the Actuary, who has a 180 degree perspective on the new health care law. In report after report, the Office of the Actuary has provided a bleak outlook about the future of Medicare resulting from the new health care law. This is due in large part to the fact that there are more than one half million dollars in cuts to Medicare that have been made in an effort to finance the law. Those changes include massive cuts to hospitals, cuts to home health agencies, cuts to skilled nursing facilities, and cuts to hospice providers.

The concern of many on the committee is the impact of this law and the potential to either lose access to health care services or be forced to pay more for the services they need. Sadly, that is already happening, from those who depend on local hospitals, to folks who depend on Medicare Advantage plans, to retirees receiving retiree drug coverage, to seniors who will pay higher prices.

For example, the Medicare actuaries predict that because of the cuts in the Democrats' health care laws, 725 hospitals, 2,352 nursing homes, and 1,587 home health agencies will become unprofitable. It is no wonder they warn that seniors' access to care could be jeopardized. Three Pennsylvania hospitals have been put up for sale, and drastic changes in the new health care law were cited as a factor in that decision.

CBO has predicted that beneficiaries who remain in the Medicare Advantage plan will see their annual out-of-pocket costs increase by an average of $816 by 2019. The Medicare Trustees predict that 5.8 million seniors will lose their current retiree drug plan provided by their former employer because of the Democrats' health care law, and another 1.7 million seniors who would have otherwise received an offer of retiree prescription drug coverage in the future will no longer have this option.

And, finally, despite the claims that Medicare donut hole changes will solve the costs facing seniors, the reality is that CBO has predicted that Part D premiums will increase by 4 percent this year and 9 percent for all seniors by 2019 as a result of the Democrats' health care law.

These are just a few concerns, and I am sure there are more concerns that will be identified today, including the very fuzzy Washington math that has led some to characterize the financing of the law as a Ponzi scheme.

Given the impact the new health care law will have on Medicare and the Nation's seniors, it is my hope that in today's hearing we can have an honest and open airing about how CMS plans to institute these cuts while still meeting the long-term needs of our Nation's seniors and Medicare beneficiaries.

I now yield to Ranking Member Levin to make an opening statement.

Mr. LEVIN. Thank you, Mr. Chairman; and we welcome our two witnesses. I think this will be an opportunity to shatter many of the myths that have been spread about health care reform.

For more than 45 years, Medicare has offered important health benefits for senior citizens and people with disabilities and has safeguarded financial stability for them and their families. The Affordable Care Act builds on the program's strengths and I emphasize that by investing in Medicare's future, improving benefits, reducing costs for beneficiaries, and getting a better deal for taxpayers.

During the health reform debate and in the time since its enactment, health reform opponents have relied on myths and scare tactics to create fear and uncertainty among Medicare beneficiaries. What is really most scary is the plan from Republicans to privatize Medicare through a voucher system. So let's set the record straight, and we will have more of that today on health care reform and its impact on Medicare.

The Act strengthens Medicare's future, improves benefits for senior citizens and people with disabilities, and saves money for taxpayers.

Fact one: The Act lowers cost to Medicare beneficiaries in improved benefits. Thanks to Medicare payment reforms and efforts to eliminate waste and fraud, beneficiaries will save on average almost $200 on their Part B premiums by 2019, and cost sharing also will go down by more than $200.

Fixing the donut hole created by the Republican plan was a key improvement of the Act. We offered immediate assistance with drug costs by providing $250 to over 3 million people. This year, seniors who hit the donut hole will save an average of $500. By 2020, the donut hole will close completely. Finally, seniors will reap benefits due to this elimination of cost sharing for most preventive services and the creation of a new annual physical benefit.

Fact two: The Act significantly strengthens Medicare's financial footing. The Act extends solvency of the trust fund by 12 years.

Fact three: The Act modernizes the Medicare program. It contains an array of delivery reform systems to ensure that the program rewards value over volume. In fact, health care experts, including more than 270 leading economists, agree that the Act creates a more disciplined and effective health care system.

Fact four: The Act includes tough new fraud-fighting tools that are projected to save taxpayers approximately $5 billion. The law empowers CMS to stop fraud before it happens.

But there is one more point that needs to be stressed, and it is the Republican agenda to repeal reform. The repeal agenda would reverse the progress we have made. It would raise beneficiary costs and substantially shorten Medicare solvency. It would end delivery innovations and stop important new fraud-fighting powers in their tracks.

My Republican colleagues focus on repealing health care reform and privatizing it by turning it into a voucher system. The repeal agenda shifts medical expenses back onto seniors and their families. When we passed Medicare, it was to fix these very problems to ensure that seniors would no longer have to spend their retirement in poverty or in fear of the next illness. Repeal would do more than turn back the clock, it would rip off its hands. That is a fact we cannot ignore and a possibility we will not accept.

Chairman CAMP. Well, thank you.

Dr. Donald Berwick is the Administrator for the Centers for Medicare & Medicaid Services. As Administrator, Dr. Berwick oversees the Medicare, Medicaid, and the Children's Health Insurance Program. Together, these programs provide care to nearly one in three Americans.

Before assuming the leadership of CMS, Dr. Berwick was President and Chief Executive Officer of the Institute for Health Improvement, Clinical Professor of Pediatrics and Health Care Policy at the Harvard Medical School, and Professor of Health Policy and Management at the Harvard School of Public Health. He is also a pediatrician, adjunct staff in the Department of Medicine at Boston's Children's Hospital, and a consultant in pediatrics at Massachusetts General Hospital.

Dr. Berwick, your full written statement will be made part of the record. You have 5 minutes to address the committee, whereupon the members will question you for 5 minutes each.

So, Dr. Berwick, welcome to the committee, and you have 5 minutes.

STATEMENT OF DONALD M. BERWICK, M.D., M.P.P., ADMINISTRATOR, CENTERS FOR MEDICARE & MEDICAID SERVICES

Dr. BERWICK. Thank you, Mr. Chairman. I appreciate the chance to appear here. It is a privilege and an honor to serve as the Administrator and also to get a chance to be in dialogue with you now and in the future.

I am a physician, I am a pediatrician, I am the son of a physician, and I am the father of a newly minted physician. Almost three-quarters of a century span the time between when my father first hung out his shingle in a small town in Connecticut where I grew up and when my daughter Jessica showed up last year for her first day as a primary care resident.

My own career is sort of a bridge also between them, from the typewriters that my father used to the computers that Jessica uses, from ignorance about how genes worked to the decoding of the human genome, from helplessness in the face of almost all cancers to cures for many cancers, from the time before Medicare when seniors lived in fear of medical bankruptcy to now when they do not.

The Affordable Care Act is a bridge, too. It is our Nation's answer to many of the problems that modern health care brings, along with its successes. It is our answers to the questions about health care coverage.

Will we make sure that our neighbors don't need to be afraid that they are going to lose health insurance when they get sick or not be able to get it in the first place? The answer is yes. People with preexisting conditions will be able to get insurance and insurance companies will not be allowed to withdraw coverage from those who become ill. Yes, children under 26 can be covered under their parents' insurance policies.

Will Medicare beneficiaries get the drugs that they need at the prices they can afford? The answer is yes now. We have sent over 3 million tax-free rebate checks to seniors to get them through the donut hole. We have discounts now of 50 percent for covered pre-

scription drugs for people in the donut hole. By 2020, we will close the donut hole completely.

Will we invest in prevention for seniors, not just treat them for the heart attacks and strokes and cancers they could have avoided? The answer is yes. We will add annual wellness checks and cost-free screening tests like mammography and colonoscopy to Medicare benefits.

In some ways, though, the biggest question of all I know is one that concerns you, which is, can we afford to do that? Is getting the care that we want and that we need—care for everybody—sustainable? The answer to that also is yes.

Not only does the Affordable Care Act make Medicare fiscally stronger, it also provides us with the tools to make health care better. And as in the rest of what we do, doing things right is less costly than doing things wrong.

Can we afford to meet the needs of patients and families? Yes. We cannot afford not to. When a patient gets an avoidable surgical infection or when two different doctors who don't have a way to coordinate their care mistakenly prescribe two drugs for Mr. Green that ought not to be taken together, the patient, the family, and society all bear the higher costs of the complications. When Mrs. Miller stops taking her medicines because she can't afford them, she will suffer the stroke that will become her greater burden and ours. The diabetes that we fail to prevent or to detect early will become the heart attack or the amputation or the kidney failure that will cost far more in suffering and in dollars to treat later.

It is a terrible mistake, in my opinion, to think that the route to affordable health care is to deny people insurance, care, and treatment. That is a very bad plan. Instead, the proactive, patient-centered investments that the Affordable Care Act and Medicare and Medicaid themselves represent are our Nation's best hope for the sustainable excellent health care to which we aspire. Better care, better health, and lower costs through improvement of care, they come together. They are a package deal.

Let me focus on one particular case, the Medicare Advantage program, which I know you have concerns about. You are concerned about the strength of the program. We actually have some quite exciting new data just now on enrollments and premiums.

Despite earlier projections of enrollment declines and premium increases, the actual data we now have in 2011 shows that enrollment in Medicare Advantage increased 6 percent, to more than 12 million beneficiaries. On average, beneficiaries have seen a 6 percent reduction in their premiums, and there is a 5 percent increase in the number of beneficiaries who are now in four- and five-star Medicare Advantage contracts this year versus last year. That translates into more beneficiaries being in lower-cost and higher-quality plans.

Higher-quality care is what I want for all patients. When I practiced pediatrics, I did everything I possibly could to make sure that my patients had the best medical care possible. I fought for a bone marrow transplant for a young boy for whom that was the last possible chance for success. He got the transplant, and he lived. I made sure that kids with asthma got the most modern treatment we had and that their mothers and their fathers and their school-

teachers understood how to help them. I made sure that immunizations were up to date, that obese kids knew that they had options, because you can never underestimate the value of prevention.

And now, at CMS, I get to do the same for Medicare and Medicaid and CHIP beneficiaries and for the millions more who will benefit from a healthier private insurance market. It is the same plan. Quality pays. If you want to thrive, don't run away from a problem. Do things right. Better care, better health, and lower costs through improvement. That was my father's plan, that is my daughter's plan, and every day at CMS it is our plan.

Thank you.

[The prepared statement of Donald M. Berwick, M.D., follows:]

This Testimony is Embargoed until 10:00 AM on February 10th 2011

STATEMENT OF

DONALD M. BERWICK, M.D., M.P.P.

ADMINISTRATOR,
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

THE IMPACT OF THE AFFORDABLE CARE ACT ON THE MEDICARE PROGRAM AND MEDICARE BENEFICIARIES

BEFORE THE

U.S. HOUSE COMMITTEE ON WAYS AND MEANS

FEBRUARY 10, 2011

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

U.S. House Committee on Ways and Means
Hearing on the Impact of the Affordable Care Act on the Medicare Program and Medicare Beneficiaries
February 10, 2011

Chairman Camp, Ranking Member Levin, and Members of the Committee; thank you for the opportunity to appear before you to discuss the Affordable Care Act. Millions of Americans across the country are already benefiting from this law, including more than 100 million people currently enrolled in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). Over the last eleven months, the Centers for Medicare & Medicaid Services (CMS) has worked closely with doctors, nurses, other health care providers, consumer and patient advocates, employers, insurers, and interested citizens to deliver many of the law's key benefits to the American people: from establishing a new Patients' Bill of Rights that puts American consumers and their families back in control of their health care coverage, to sending $250 checks to more than three million seniors and other beneficiaries who reached the Medicare Part D coverage gap in 2010, to new reforms that keep premiums down by bringing transparency and accountability to our health insurance markets.

Because of the Affordable Care Act, more Americans have affordable health insurance coverage, along with protections that help them keep coverage when they need it most – in times of health crisis and to manage chronic conditions. CMS has new tools to fight fraud that will return money to the Trust Funds and the Treasury. Medicare beneficiaries have new benefits and lower costs, including first-dollar coverage of key preventive benefits, assistance with prescription drug costs, and an annual Wellness Visit with the physician of their choice. We have met deadlines, established strong working partnerships, and begun laying the groundwork for reforms that will take effect in the years to come. This law means real improvements for Medicare beneficiaries, now and in the future.

That's why the House vote to repeal this law was unfortunate. At a time when there is so much more important work to be done to rebuild our economy, we cannot afford to re-fight this legislation, and in the process, take benefits away from individuals, bring back all the worst

practices of the insurance industry, raise premiums for families, increase health costs for businesses, and add more than $1 trillion to the deficit by the end of the next decade.

As a pediatrician, I have witnessed both the best and the worst of the American health care system. I had the opportunity to practice pediatrics for 20 years in an organization that promoted integrated care, and saw firsthand the enormous difference that a doctor, nurse, and patient working together can make in health care outcomes. I have devoted my career to the belief that all patients deserve access to high quality health care, regardless of who they are or whether they live in a large city or a small rural community. High quality health care does not necessarily mean the most expensive health care. It means safe care, free from medical injuries, errors and infections; it means reliable care, based on the best available science; and it means person-centered care, in which each patient is treated with dignity and respect for his or her own unique preferences.

CMS can help lead health care improvement in many ways. With new provisions in the Affordable Care Act, CMS has the opportunity to work with others in both the public and private sectors to make real advancements in the nation's health care delivery systems that will improve the quality of life and quality of care for millions of Medicare beneficiaries and other Americans. We all agree that we want the highest quality health care system possible, a system that coordinates and integrates care, eliminates waste, and encourages prevention of illness. With over 100 million people currently enrolled in Medicare, Medicaid, and CHIP, and millions more gaining patient protections we oversee in private insurance, CMS has an important role to play in improving our nation's health care delivery system. We are striving to meet this challenge, while attending diligently to the crucial, day-to-day work of our operations and preserving and enhancing the integrity of our payments, our programs, and the Trust Funds.

Success at CMS

In the last several months, I've also gotten the chance to see this new law through the eyes of the people it helps every day. In talking to people from around the country and reading the letters I've received, I've learned firsthand how the law is giving Americans more freedom in their health care choices and more security in their coverage.

New Insurance Coverage Benefits

It has been only eleven months since the passage of the Affordable Care Act, but already Americans are seeing changes and benefits from the law. The Patients' Bill of Rights gives millions of Americans important new health insurance protections. For example, insurers can no longer cancel coverage when individuals get sick just because they made a mistake with their paperwork. Insurers can also no longer put lifetime dollar limits on essential benefits – limits that often meant coverage was gone when people needed it most. By 2014, most annual dollar limits on essential benefits will be a thing of the past.

In addition, more than 5,000 businesses, local governments, and unions are taking advantage of a new program under the Affordable Care Act that gives relief from soaring retiree health care costs. More than 4 million small businesses have been notified that they may be eligible for a tax cut to help them provide coverage for their workers – a benefit that's already making a difference. By slowing the growth of health care costs, the new law will free businesses to invest in their own growth and create new jobs.

The new law also holds insurers accountable and will help bring down premiums. It ensures every significant health insurance rate increase will undergo a thorough review and provides $250 million in grants to States to bolster their rate review process. For the first time, insurers will be held accountable for the way they spend consumer premiums. The new medical loss ratio regulations released last year implement the statutory requirement that insurers spend at least 80 or 85 percent, depending on the market, of premium dollars on health care and quality improvement efforts instead of marketing and CEO bonuses. Those who don't meet the standard will have two choices: reduce premiums or send rebates to their customers. We are already seeing indications that these policies are causing insurance companies to think twice about their premium increases and, in some cases, reducing the size of their annual updates.

Beginning in 2014, the law will allow individuals, families, and small business owners to pool their purchasing power through new State-based Exchanges. Millions will qualify for tax credits to help them buy coverage through the Exchanges. Under the new law, it is estimated that a

family of four making about $33,000 could save nearly $10,000 in premiums, beginning in 2014, if they purchase coverage in the Exchange. A family of four making $56,000 could save up to $6,000 each year, by purchasing Exchange coverage. The Affordable Care Act has brought real change to the health insurance marketplace that has immediately benefited thousands of Americans, and will improve coverage and provide real savings for millions more.

Help for Medicare Beneficiaries

The Affordable Care Act is also making Medicare stronger and more sustainable. People with Medicare are getting improved guaranteed benefits every year, and Medicare's long-term sustainability is stronger as a result of efficiencies, new tools, resources to reduce waste and fraud, and slower growth in Medicare costs. These important changes will produce savings for the taxpayers and help to prolong the life of the Medicare Hospital Insurance Trust Fund. These changes will also benefit people with Medicare by keeping their premiums and cost sharing lower than under the law previously. Thanks to the Affordable Care Act, Medicare beneficiaries will enjoy better quality care, better access to care, and a more innovative care delivery system that will improve outcomes and reduce cost.

Here are just a few examples:

- **Helping Medicare beneficiaries maintain access to life-saving medicines:** As a result of new provisions in the Affordable Care Act, people with Medicare are receiving immediate relief from the cost of their prescription medications. To date, over 3 million eligible seniors and people with disabilities who reached the Part D prescription drug coverage gap in 2010 received help through a one-time, tax-free $250 rebate check to help reimburse them for out-of-pocket costs in the Part D prescription drug coverage gap known as the "donut hole." In addition, every year until 2020, people with Medicare Part D will pay a smaller share of their prescription drug costs in the coverage gap. In 2011, eligible Medicare beneficiaries will get a 50 percent discount on covered brand name prescription drugs in the coverage gap and will only pay 93 percent of the cost of generic drugs in the coverage gap, versus 100 percent in 2010. By 2020, we will have closed the coverage gap.

- **Increased support for primary care:** Thanks to the Affordable Care Act, physicians have better incentives to provide vital primary care services to Medicare beneficiaries. The Affordable Care Act, beginning January 1, 2011, provides for a new 10 percent bonus payment for primary care services furnished by a primary care practitioner and for major surgical procedures furnished by a general surgeon in a health professional shortage area. Primary care practitioners of family medicine, internal medicine, geriatric medicine or pediatric medicine, as well as general surgeons, nurse practitioners, clinical nurse specialists, and physician assistants could be eligible to receive this new incentive.

- **Increased access to preventive care:** Thanks to the Affordable Care Act, people with Medicare can now get critical preventive care, like mammograms and colonoscopies, with no co-pay or deductible. Improving access to preventive care can improve early detection and treatment options, potentially reducing the cost of care and improving the health of our Medicare population in the long run.

- **New tools and authorities to fight fraud:** New authorities in the Affordable Care Act offer additional front-end protections to keep those who commit fraud out of Federal health care programs, as well as new tools for deterring wasteful and fiscally abusive practices, promptly identifying and addressing fraudulent payment issues, and ensuring the integrity of our programs. CMS is pursuing an aggressive program integrity strategy that will prevent fraudulent transactions from occurring, so the government will not need to depend as heavily on tracking down fraudulent providers and pursuing claims rife with fraud, waste, and abuse. CMS also now has the flexibility needed to tailor resources and activities in previously unavailable ways, which we believe will greatly support the effectiveness of our work.

  The Affordable Care Act provides CMS with additional tools to help the Agency tailor interventions to address areas of the most significant risk. Enhanced screening requirements for providers and suppliers to enroll in Medicare, along with oversight controls such as a temporary enrollment moratorium and pre-payment review of claims for high risk providers, will allow the Agency to better focus its resources on addressing the areas of greatest concern and highest dollar impact.

Further, through the Health Care Fraud Prevention and Enforcement Action Team, or "HEAT," CMS has joined forces with our law-enforcement partners at the Department of Justice (DOJ) and the Department of Health and Human Services' (HHS) Office of Inspector General (OIG) to collaborate and streamline our efforts to prevent, identify, and prosecute health care fraud.

- **High quality Medicare Advantage benefits:** This year, CMS has improved its oversight and management of the Medicare Advantage (MA) program. The results for the 2011 plan year show that when CMS strengthens our oversight and management of MA plans, seniors and people living with disabilities will have clearer plan choices offering better benefits. In 2011, premiums are lower and enrollment is projected to be higher than ever before. In fact, the insurers that participate in Medicare Advantage have projected 5 percent growth in enrollment in this part of the program. As part of CMS' national strategy for implementing quality improvement in health care, CMS is also working to create new incentives for all MA plans to improve the care they offer to Medicare beneficiaries.

Improving Coordination and Access to Care

In addition to giving Americans more control over their health care and strengthening Medicare, the Affordable Care Act provides for expanded access to and better integration of care for many Americans who need it.

"Integrated care" is the care we need when we have a chronic disease, or are journeying through the health care system from place to place or doctor to doctor. We want seamlessness. We want coordination. We do not want to keep having to tell our story over and over again to multiple providers, or to be afraid that one doctor will not know what medications another doctor has already given us. We know for sure that integrated care is better care – safer, more likely to get us to the treatments we really need, less likely to confuse us, and, overall, less costly than the opposite – disintegrated, fragmented care. The problem is that our fragmented care system has a lot of trouble offering us integrated care when we need and want it.

We need to help integrated care thrive in America. Too often, health care takes place in a series of fragments or episodes. We need to make it possible for entirely new levels of seamlessness, coordination, and cooperation to emerge among the people and the entities that provide health care, so as to smooth the journeys of patients and families – especially those coping with chronic illness – through their care over time and place.

Thanks largely to the Affordable Care Act, CMS has a new cross-cutting resource to accelerate progress in improving care access and coordination for Medicare, Medicaid, and CHIP beneficiaries, focusing on individuals, integration of care, and prevention: the Center for Medicare and Medicaid Innovation. The Innovation Center will test and study the most promising innovative payment and service delivery models. In doing so, the Innovation Center will work collaboratively with relevant Federal agencies and clinical and analytical experts, as well as local, national and regional providers, States and beneficiary organizations to identify and promote systems changes that could improve quality and outcomes for patients while containing or reducing costs.

The Affordable Care Act also established a Federal Coordinated Health Care Office to improve coordination of the care provided to beneficiaries eligible for both Medicare and Medicaid, also known as dual eligibles. This population consists of the most vulnerable and chronically ill beneficiaries, who represent 15 percent of enrollees and 39 percent of Medicaid expenditures and 16 percent of enrollees and 27 percent of Medicare expenditures. These individuals have not been well served by our current system. Dual eligibles need to navigate two separate systems: Medicare for coverage of basic health care services, and Medicaid for coverage of long-term care supports and services, and help with Medicare premiums and cost-sharing. The Federal Coordinated Health Care Office will work to better streamline care for dual eligibles, while ensuring they receive full access to the items and services that will result in better health care outcomes. Last December, we announced that States may apply for resources to support the design of new demonstration projects, with funding for up to 15 State program design contracts of up to $1 million each. These design contracts will support the development of new models

that integrate the full range of acute, behavioral health, and long-term supports and services for dual eligible individuals.

In addition, the Affordable Care Act provides other immediate resources, including $11 billion in funding for community health centers to increase services, improve facilities and train and support more health care professionals to work in the areas where they are needed most.

These combined efforts represent a new chapter for people with Medicare, who will have the benefit of a Medicare system that is more efficient and integrated and provides higher quality, more effective care.

Looking Forward

The many new services and reforms I have highlighted are important and immediate steps by which the Affordable Care Act improves access, coordination, and the affordability of health care for all Americans. However, there are even more exciting benefits that will come online in the near future that will improve the health care system for all Americans.

The Affordable Care Act includes unprecedented new tools that will enable us to reinvigorate our nation's focus on the quality, value, and outcomes of care, and help the public and the private sectors produce a new system that is better for patients, families, communities, and the health care workforce. These innovative provisions will enable CMS to work with our partners in the private sector to improve care coordination, increase patient safety, offer beneficiaries more information and more control over their care, and achieve better outcomes. The Act allows us to better align incentives for quality care and move towards seamless, integrated care. This will help health care providers and patients better tackle the problems of fragmentation and unreliability in care, which can erode health and satisfaction and add cost to taxpayers without adding anything of value to patients. These efforts to improve the quality of care will provide real improvements for both Medicare beneficiaries and all Americans.

To me, improving health care delivery has three major, overarching goals: first, providing better care for individuals – care that is more effective, more patient-centered, timely, and more

equitable; second, assuring better health for populations by addressing underlying causes of poor health, like physical inactivity, behavioral risk factors, and poor nutrition; and third, reducing costs by improving care, eliminating waste and needless hassles, reducing preventable complications in care, and coordinating care for patients who are journeying through the system. To be absolutely clear, I am talking about reducing costs while improving the quality of care individuals receive.

Securing Affordable Coverage for All Americans

The new insurance reforms produced by the Affordable Care Act require strong administrative support to be successful. To that end, we recently announced the shift of an important new office to CMS. The Office of Consumer Information and Insurance Oversight (OCIIO) was initially established under the HHS Office of the Secretary to facilitate the collaboration of experts within HHS, the Department of Labor, and the Department of the Treasury during initial policy and program development of OCIIO and the early stages of implementing the Affordable Care Act. As more Affordable Care Act initiatives become operational, we believe that CMS has the best resources to achieve successful implementation of these programs and authorities. In addition, this realignment under CMS will result in administrative savings and organizational efficiencies.

Over the last nine months, HHS had been developing a business plan for OCIIO based on the legislative requirements of the Affordable Care Act and implementing regulations. Through this process, HHS and CMS determined that moving OCIIO to CMS will help to capture the efficiencies afforded through the specific expertise and experience of both agencies. This will allow HHS to leverage CMS' infrastructure and to better ensure effective coordination of insurance programs and other insurance options available to the American people.

The new Center for Consumer Information and Insurance Oversight (CCIIO) within CMS will be responsible for making sure that the new insurance market rules, such as prohibitions on rescissions and on pre-existing condition exclusions of children, are followed. The new Center will, for example, oversee the new medical loss ratio rules and assist States in reviewing insurance premium rates.

The new Center will also oversee the development of the Health Insurance Exchanges (Exchanges), which will be operational in all 50 States in 2014. These Exchanges are central components of the Affordable Care Act and are the result of a concept that has a long history of bipartisan support. Under the Act, States have until 2014 to begin coverage in Exchanges for their citizens. As part of our partnership with the States, we are again providing resources to help them get these Exchanges up and running on time. We have provided Exchange Planning Grants to 48 States plus the District of Columbia, and we recently announced the availability of funds for States to begin the work to establish Exchanges. We will continue to work closely with governors, State regulators, and legislators to provide them with information and resources to complete this critical work on time. Millions of Americans will gain coverage through a qualified health plan in the Exchanges and many of these individuals will be eligible for premium tax credits. Exchanges will allow individuals to shop for coverage in a way that permits easy comparisons of coverage options based on price and quality.

Improving Care for Individuals

I strongly believe that every single American can and should always receive the highest quality care, no matter where they live or happen to seek care. CMS will continue its role as a leader and partner in encouraging safer and better care in hospitals, clinics, physician offices, and long-term care, and other settings. I know we can get there, because I have seen hospitals and other providers throughout our nation repeatedly demonstrate that bold and exciting progress is possible. CMS is working to make the "best care" in America the norm in health care, for everyone.

Several Affordable Care Act provisions will help CMS move in this direction. Here are a few examples:

- **Value-Based Purchasing (VBP):** Allows us to measure and reward excellence in hospitals, physician offices, and elsewhere. As we begin to implement the value-based purchasing reforms contained in the Affordable Care Act, we will be moving away from a system that rewards providers based on the volume and quantity of care they provide; rather, we will pay for value and quality of care. This approach puts the Medicare

beneficiary first and provides clear incentives for quality improvement by more prudently targeting Medicare dollars to providers who improve care.

- **Specific focus on Hospital-Acquired Conditions (HACs):** These conditions consist of complications that patients acquire while receiving care that is supposed to help them. Not all HACs are preventable, but a great number can be avoided. For example, the Centers for Disease Control and Prevention (CDC) has estimated that each year, almost 100,000 Americans die and millions suffer from hospital-acquired infections alone. In addition to pain, suffering, and sometimes death, these complications could add as much as $45 billion to hospital costs paid each year by taxpayers, insurers, and consumers.[1] The HHS OIG has reported that 44 percent of adverse events experienced by Medicare beneficiaries in October 2008 were preventable, and that these complications cost the Medicare program an extra $119 million in that one month.[2]

  We know of hospitals in this country that, through improvements in their health care processes, have virtually eliminated some forms of infections that other hospitals still think are inevitable. To create incentives for hospitals to prevent such infections and other adverse events, the Affordable Care Act includes a Medicare payment reduction for hospitals that have a hospital-acquired condition rate that is much higher than average, beginning in fiscal year 2015. Prior to each fiscal year, affected hospitals will receive confidential reports regarding their HAC rate during the applicable period. In addition, the Secretary will publicly report the measures used for the payment adjustments on the Hospital Compare website,[3] after giving hospitals the opportunity to review and submit corrections to such information. The Affordable Care Act also requires CMS to issue Medicaid regulations that apply Medicare HAC payment policies to Medicaid when appropriate.

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[1] The Direct Medical Costs of Healthcare-Associated Infections in U.S. Hospitals and the Benefits of Prevention, March 2009, http://www.cdc.gov/ncidod/dhqp/pdf/Scott_CostPaper.pdf.
[2] Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries, November 2010, http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf.
[3] http://www.hospitalcompare.hhs.gov/.

- **Reducing unnecessary hospital readmissions:** We know that about one in every five Medicare beneficiaries discharged from the hospital will be re-admitted within 30 days of discharge. The Medicare Payment Advisory Commission (MedPAC) estimates that Medicare spends $12 billion annually on potentially preventable readmissions (based on 2005 data).[4] Proper attention to care transitions, coordination, outreach, and patient education and support could all prevent readmissions and allow these patients to recover at home where they would prefer to be, rather than reentering the hospital with complications. The Affordable Care Act sets forth a course for hospitals to focus on reducing preventable hospital readmissions by linking financial incentives to readmission rates and by providing assistance and support to hospitals to improve transitional care processes. We will also make readmission rate information for all patients in each hospital participating in the program publicly available online.

- **Quality bonus payments in Medicare Advantage:** Beginning in 2012, the Affordable Care Act introduces quality bonus payments into the MA program as part of the national strategy for implementing quality improvement in health care. MA plans will be paid a quality bonus payment (QBP) based on their rating using CMS' 5-star quality rating system. To provide a strong incentive for MA plans to improve performance, CMS will pursue a national demonstration project running from 2012 through 2014 that rewards all the plans receiving three stars or higher with tiered QBPs. The demonstration will test whether providing scaled bonuses will lead to more rapid and larger year-to-year quality improvements in MA program quality scores, compared to the current law approach to computation of QBPs.

- **Medical Homes:** We must examine approaches to promote effective "home bases" for patients, rooted in primary care, to help patients navigate and understand the complex health care system on which they rely, and to help them be more proactive with prevention and detecting potential complications before any damage is done.

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[4] Medicare Payment Advisory Commission (MedPAC) Report to the Congress, June 2007.

- **Accountable Care Organizations (ACOs):** The Affordable Care Act directs CMS to establish a shared savings program that promotes coordination of services under the Medicare program and accountability for the quality of care delivered to a patient population through ACOs by January 2012. ACOs should be thought of primarily as a care delivery organization, and not just as a financing mechanism. Eligible ACOs are groups of providers and suppliers that meet the requirements for participation in the shared savings program, which include having an established mechanism for joint decision making. The program will encourage ACOs to make investments in infrastructure and redesigned care processes for high quality and efficient service delivery.

Better Health for Populations

Our system is often faulted for its focus on health care for the sick, instead of promoting better health for all. CMS is implementing a variety of initiatives that will encourage prevention and move towards the goal of improving the health of Medicare beneficiaries and the entire population. CMS can meaningfully contribute to improving prevention of a variety of health problems, including obesity and cardiovascular disease, as well as improving perinatal outcomes. In addition to expanding health insurance coverage, the Affordable Care Act provides meaningful and affordable coverage of preventive health services.

- **Annual Wellness Visit:** While Medicare already covers a comprehensive package of preventive benefits as well as a one-time "Welcome to Medicare" exam for new beneficiaries, before the enactment of the Affordable Care Act, Medicare did not cover annual check-ups for beneficiaries. As of January 1, 2011, Medicare now covers an annual "wellness visit" at no cost to the beneficiary, so beneficiaries can work with their physicians to develop and update a personalized prevention plan. This new benefit will provide an ongoing focus on prevention that can be adapted as a beneficiary's health needs change over time.

- **Removing financial barriers to preventive services:** While Medicare covers a range of screening and preventive benefits, many of these services have been underutilized, in part because out-of-pocket costs have presented a financial barrier for beneficiaries. As of

January 1, 2011, all preventive services covered by Medicare that are recommended with an A or B rating by the U.S. Preventive Services Task Force are available to beneficiaries free of charge (without having to pay coinsurance or apply the Part B deductible) if the services are obtained from a participating physician or provider. These important benefits include tests and procedures that may either prevent illnesses or detect them at an early stage when treatment is likely to work best, such as screenings for breast, cervical, and colorectal cancers, and screenings for cardiovascular disease, diabetes, and osteoporosis.

- **More prevention in Federally Qualified Health Centers (FQHCs):** As of January 1, 2011, the scope of Medicare-covered preventive services furnished in FQHCs has significantly expanded. FQHCs provide primary care services for all age groups in medically underserved areas or medically underserved populations across the nation.

As we undertake these initiatives, it can be hard to visualize the exact type of systemic change that will result, and what it will mean to the millions of Americans who depend on Medicare for their health care. But I believe our efforts, taken together, will have a tangible, positive impact on the everyday lives of America's seniors.

Let's imagine one of the millions of Medicare beneficiaries who suffer from multiple chronic illnesses. She's 70 years old, and has high blood pressure and diabetes. She did not go for annual physicals, so her diabetes was not diagnosed for years. In previous years, she has hit the Medicare Part D coverage gap, so she has had trouble paying out-of-pocket for her medication. She breaks her pills in half to make them last longer, or sometimes skips doses altogether, which eventually lands her in the hospital. Her diabetes makes her more susceptible to infections, and like many Americans who are hospitalized, she contracts an infection, which requires an even longer hospital stay. She is finally discharged, but no one has coordinated follow-up care with her doctors. Without appropriate follow-up care, she is back in the hospital three weeks later. All of this care costs the Medicare program a great deal of money, not to mention the untold amount of unnecessary suffering that this person experiences.

The Affordable Care Act changes this story. Since free annual physicals provide an opportunity to focus on her personal risk factors, she receives a screening that identifies pre-diabetes before it progresses. In a post-Affordable Care Act world, our beneficiary is now able to afford all of her prescribed medications because her costs in the prescription drug coverage gap are lower. If she does need hospital care, her infection risk is reduced because the hospital has incentives to establish procedures to protect her from infections. Her care is coordinated upon discharge, because the hospital knows it will face a penalty if she is readmitted for a preventable condition. This woman is healthier, happier, and the Medicare program has paid less for her care. This is what the Affordable Care Act really means to America's seniors: care that is higher quality, better coordinated, and more affordable. This is why it is so important that the Affordable Care Act remain in place.

Stronger Program Integrity

This Administration is strongly committed to minimizing waste, fraud, and abuse in Federal health care programs. CMS recognizes the importance of having strong program integrity initiatives that will deter criminal activity and attempts to defraud Medicare. I share your commitment to ensuring taxpayer dollars are being spent only on legitimate items and services. Our beneficiaries deserve a Federal health care system that they can trust is secure, and the American public deserves to know that their tax dollars are not being wasted or misspent.

Due to prompt pay requirements in Medicare, our claims processing systems were built to quickly process and pay claims. CMS pays 4.8 million Medicare claims each day, approximately 1.2 billion Medicare claims each year. Nevertheless, with the new tools provided to CMS under the Affordable Care Act, we are steadily working to incorporate additional and better fraud and improper payment prevention activities into our claims payment and provider enrollment processes where appropriate so we can keep from paying improper claims in the first place.

As a part of our efforts, CMS is keenly focused on the President's ambitious goal of reducing the Medicare fee-for-service error rate by half by 2012. While continuing to be vigilant in detecting and pursuing problems when they occur, we are also pursuing prevention of improper payments

before they occur. We are reexamining our claims and enrollment systems to enhance our ability to prevent improper payments while still promptly compensating honest, hard-working providers. This overhaul includes: more prepayment review, promoting the electronic submission of medical records, and expanding the scope of post-pay medical reviews. When improper payments do occur, we are working to quickly identify and recover those payments.

CMS is currently integrating predictive modeling as part of an end-to-end solution that is transparent, measurable, and triggers effective, timely administrative actions. Innovative risk scoring technology applies a combination of behavioral analyses, network analyses, and predictive analyses that are proven to effectively identify complex patterns of fraud and improper claims and billing schemes. Given the changing landscape of Medicare and Medicaid fraud, any successful technology will need to be nimble and flexible, identifying and adjusting to new schemes as they appear.

CMS is very excited about the potential of new data analysis and prediction tools to improve the Agency's ability to prevent payment of fraudulent claims. Before CMS expands data analytic tools to prepayment claims application, we will apply the risk scoring engine to post-payment claims to rigorously test the underlying analytics. This will accomplish three things: First, it will help us ensure that these analytics will not produce false positives that would disrupt payments and business for legitimate claims from legitimate providers or interfere with beneficiary access. Second, we will identify the most efficient analytics in order to appropriately target resources to the highest risk claims or providers. Third, incorporating this approach to our pre-payment processes will likely require significant systems changes. Therefore, applying these analytics to post-payment data while the pre-payment integration is built will allow both refinement of the algorithms and identification of bad actors in near real time.

How Can We Get to Where We Want to Be

Building an improved Medicare program and health care delivery system must be a collaborative effort. CMS cannot do this alone, and neither can government as a whole. Achieving high quality care will require participation and leadership at all levels – including Congress, States, insurers, employers, health providers and professionals, organizations, associations, patients,

families and communities. CMS is working to partner extensively with all health care stakeholders in pursuit of our common goals for improving care for Medicare beneficiaries and all Americans.

States will have an integral role to play in the implementation of delivery system changes and other Affordable Care Act provisions. CMS is committed to ensuring that States have the tools they need to succeed at addressing these challenges. Just last week, the Secretary sent a letter to all State governors to address their concerns regarding current State fiscal conditions. HHS stands ready to immediately assist States with new "rapid response" teams, and the Secretary's letter outlined several options for States to more efficiently manage their Medicaid programs. These options include managing care for high cost enrollees more effectively through new payment models and more coordinated care, purchasing drugs more efficiently, and improving Medicaid program integrity. Additionally, CMS has already conducted a number of outreach sessions and meetings with State stakeholders to discuss topics such as Medicaid payment practices, health homes, and primary care practice support. CMS will also rely on input from States as we design guidance and implement other changes and improvements.

Health care providers who are directly interacting with patients each day are crucial partners in this reform effort. They need stable and predictable payments in order to be able to play their key roles as foundations of delivery system reform. To ensure that Medicare beneficiaries continue to have appropriate access to necessary physician services, the Administration supports permanent, fiscally responsible reform to the Sustainable Growth Rate methodology for physician payment.

Conclusion

The Affordable Care Act has had a dynamic effect on Medicare beneficiaries and people with disabilities. Since last March, CMS has worked tirelessly to implement the many new programs and authorities that the Act has provided us. CMS has a responsibility to improve access, quality, and efficiency of care for all our Medicare beneficiaries, while protecting the fiscal integrity of this program in the long term. The Affordable Care Act has already had a positive impact on Medicare beneficiaries, as well as for the millions more who can now have greater

options and protections in their private health insurance. In the coming months, I look forward to working with Congress to continue that work and make sure that Americans can take full advantage of all the benefits, protections, and freedoms that the law has to offer.

Chairman CAMP. Thank you, Dr. Berwick. Your time has expired, but your full statement will be made part of the record.

Dr. Berwick, is the British health care system, the National Health Service, a good model for us to follow here in the United States?

Dr. BERWICK. Mr. Chairman, I have seen and worked in many countries. Every country finds its own solution to its own problems. America needs an American solution to the American health care problem, and the Affordable Care Act is certainly that—or the beginning of that. It is a system that balances public and private payment. It depends heavily on the private health care sector. It is a

good partnership between the Federal Government and States. It is the American way to an American health care system that is sustainable.

Chairman CAMP. Well, regarding the British National Health Service, you made a statement—and that is a service that is notoriously known for rationing care—you said, "I fell in love with the NHS. To an American observer, the NHS is such a seductress."

Are you still in love with the NHS? Is this still a view you subscribe to?

Dr. BERWICK. There are strengths and weaknesses for every health care system around the world. We have a lot to learn from each other. But I say again, the American health care system needs an American solution. That is what excites me about the Affordable Care Act. It puts a stake in the ground about the kind of system we can have based on the heritage of our system, the assets we have, our investment in our own public trust, and this extraordinary partnership between public and private care. We are on the route to a solution that fits our country, and that is what really counts.

Chairman CAMP. Would that be a yes or a no?

Dr. BERWICK. I am saying that every country finds its own solution. There are strengths in the British health care system. There are strengths in every health care system I have seen and enormous weaknesses in all of them. We are all struggling with the same issues.

Chairman CAMP. You also wrote, "I admit to my own devotion to a single-payer mechanism as the only sensible approach to health care finance I can think of." Do you still feel that a government-run, single-payer health care system is the only sensible approach?

Dr. BERWICK. I am really excited by the promise the Affordable Care Act offers, Mr. Chairman, to American health care. I think we have found our way to a really open door here now to a solution to the American health care problem. It is an investment in better care, better health, and lower costs through the improvement of care. And as I understand that law more and more, I see more and more tools that our country now has to make care exactly what it should be for every single person.

Chairman CAMP. Is that a yes or a no to my question? I am having trouble understanding whether you still believe that the single-payer system is the only sensible approach.

Dr. BERWICK. I think the Affordable Care Act is a sensible approach for America, and we are seeing progress already. I think we will see immense progress if we stick with this law. I can see the potential for helping our country actually use innovation, an improvement of quality of care, transparency, putting control in the hands of patients. We are going to find our way to a better health care system, and this is an exciting opportunity.

Chairman CAMP. If I could have a simple yes or no answer. You said one time that "competition, in short, will hurt you, not help you." Now that you will be in charge of setting up exchanges, determining what health benefit plans will look like, analyzing premiums, do you still feel that competition in health care is a bad

thing? And I think we need some clarity from you. Is this a yes or a no?

Dr. BERWICK. Competition certainly has a place in our health care system. It is the American way to excellence in many forums. There are other areas in which providing public support to people through a publicly financed system helps, too. There is not a simple yes or no answer to your question, Mr. Chairman; and I think the Affordable Care Act strikes a superb balance between public and private sector investment and better care.

Chairman CAMP. You have also said that any health care funding plan that is just, equitable, civilized, and humane must redistrict wealth from the richer among us to the poor and less fortunate. Is this a view you still subscribe to?

Dr. BERWICK. Statement of fact, Mr. Chairman, sick people tend to be poorer and poor people tend to be sicker; and if we are investing in the health of our neighbors and our Nation, we are going to have to take care of the sicker and poorer in our country. And we have done that. That is why Medicare and Medicaid are there in the first place.

Chairman CAMP. And you think wealth redistribution is the way to go about achieving that goal?

Dr. BERWICK. Poor people tend to be sicker, and sicker people tend to be poor. And if we really want to help each other we are going to have to understand that and address it, and we have in our public policy. That is where Medicaid came from in the first place, Mr. Chairman.

Chairman CAMP. We have heard that this legislation will mean that most preventative care will now be free because of this new health care law. And you once wrote that one over-demanded service is prevention—annual physicals, screening tests, and other measures that supposedly help catch diseases early. Do you still feel that preventative care isn't too high of a demand?

Dr. BERWICK. Mr. Chairman, I am a pediatrician. I have spent my life in preventive services. The whole idea in taking care of children is to give them effective prevention so they don't get the diseases that we will later pay the price for. There is effective prevention and ineffective prevention. The Affordable Care Act is a tremendous investment in getting people effective preventive services. That is why they cover mammography and colonoscopy now at no copayment for the patient. That is why we introduced the annual wellness physical. Effective prevention is the best investment we can make in higher quality, better life, and lower cost.

Chairman CAMP. Well, I would take it that is a "no" then. I would take it that you do not feel that preventative care is in too high of a demand.

Dr. BERWICK. I am sorry, Mr. Chairman, I don't understand.

Chairman CAMP. The question I asked you was, after reading your quote, do you still feel that preventative care is in too high demand? And I guess from our answer you do not feel that preventative care is in too high demand.

Dr. BERWICK. I must say, Mr. Chairman, I don't recognize your quote. I am telling you what I think, which is that effective prevention——

Chairman CAMP. You wrote it once. It was in your writings. I am quoting your writings. I am reading it from "We can cut costs and improve care at the same time," by Donald Berwick, Medical Economics Office, August 12, 1996, page 186.

Dr. BERWICK. I believe we can cut costs and improve care at the same time by investing in effective care, and that certainly includes investing in effective preventative services, which is what the Affordable Care Act at last allows us to do for seniors who now can be protected from strokes and heart attacks and complications of diabetes as never before.

Chairman CAMP. So the answer is, no, you don't feel that preventative care is in too high demand.

Dr. BERWICK. Is in too high demand?

Chairman CAMP. That is what I am asking.

Dr. BERWICK. I believe that offering effective preventive services is a terrific investment for our Nation, and that is what the Affordable Care Act does.

Chairman CAMP. All right. Mr. Levin may inquire.

Mr. LEVIN. I was going to say, that I think it is important that everybody hear your answers.

Dr. BERWICK. Thank you.

Mr. LEVIN. And so the mic will be clear. And I am glad that the chairman asked you these questions so that the air can be cleared when it is often, I think, misrepresented and so we can move on and you can provide the services that you have been trained to provide. I am glad those questions were asked. I don't think you were surprised.

Let me just ask you, in terms of separating fact from myth, Mr. Camp, in his opening statement, talked about more than one half trillion dollars in cuts to Medicare. Would you comment on that?

Dr. BERWICK. We have an unsustainable health care system now. That is the problem we are struggling with no matter which side of the aisle you are on. We have a system that our country is having trouble affording, and it is failing to meet the needs of many of its citizens, and we are trying to navigate our way to a solution.

I think the Affordable Care Act offers an opportunity to offer every American better care, not just those in Medicare and Medicaid, but everyone a better system, safer, more effective, more patient-centered. There are investments in innovation. There are investments in continuity of care so that patients with chronic illness who need to be handed off well from hospital to home or from doctor to doctor can get that kind of support. These all improve the quality of care, And through that we are going to see costs fall over time.

The Affordable Care Act has many potential elements in it that will, I think, in the long run result in savings for our country and for beneficiaries themselves.

Mr. LEVIN. So when there is a reference to a half trillion dollar cuts in Medicare, these so-called "cuts" relate in most cases to the rate of increase in reimbursements and payments to providers; isn't that true?

Dr. BERWICK. We are on an unsustainable trajectory, and we need to find a way to lower costs. The Affordable Care Act is link-

ing reimbursement to providers more and more to the quality of what they do. Instead of paying for care in fragments or pieces or high volume care alone, we are orienting more and more payment in this country, on the public and private side both, to paying providers for excellence, for producing the care that we want and need.

An example would be infections in hospitals. There are hospitals all over this country that now have reduced many forms of infection to zero. I have visited those hospitals. I have seen them. The question now is, if it can be done there, can it be done everywhere? The answer is, yes, if we invest in it. The Affordable Care Act invests in innovations that would allow things like infection control to be spread all over the country now. Every single hospital offering excellence at the level that the best currently do, that lowers costs and improves quality at the same time. And that is a plan that will get us to a more sustainable health care system and in the end a more sustainable Medicare Trust Fund, Medicaid system, and health care as a whole.

Mr. LEVIN. Do you want to comment on this claim that 5.8 million seniors will lose their current retiree drug plan provided by their former employer, also in the statement of our chairman?

Dr. BERWICK. We are in a transitional mode in American health care. The Affordable Care Act helps the retiree drug programs with a retiree drug subsidy. Businesses will make their decisions about continuing or not continuing their retiree drug plans, and the beneficiaries will choose among the things available to them. And I am sure there will be some shifts.

You know, the Part D program, the alternative to the retiree drug program, in many cases has been strengthened immensely over the past year or two now. We have strong evidence of a much better supply in the Part D program. And we have the 50 percent drug discount for brand name drugs so that some retiree drug beneficiaries will choose to move over to Part D because it is a better plan for them.

Mr. LEVIN. Thank you.

Chairman CAMP. Thank you.

The Chairman of the Health Subcommittee, Mr. Herger, may inquire.

Mr. HERGER. Thank you, Mr. Chairman; and, Dr. Berwick, I want to thank you for being here this morning. I appreciate your dedication to creating a high-quality health care system, but I think we have some very fundamental disagreements about how to achieve that goal.

Chairman Camp highlighted your past support for a single-payer system and your comment that "competition, in short, will hurt you, not help you." Dr. Berwick, do you believe competition and market forces are good or bad for health care in light of your quote?

Dr. BERWICK. On the whole, good, Congressman Herger. We can see that in the durable medical equipment bidding system, for example, in which we are using market forces to enhance the benefits to beneficiaries, reduce their costs of durable medical equipment, at the same time assuring a supply of excellent DME. That program alone has reduced the spend for the nine areas that the DME program was tried in by 32 percent. Extrapolating to the

country as a whole, that would be a saving over the next 10 years of $27 or $28 billion, of which $17 billion gets returned to the Medicare Trust Fund and $11 billion to the beneficiaries. That is constructive use of competition in a very important arena, increasing excellence, increasing transparency, decreasing costs, and increasing the well-being of the people who use those products and services.

Mr. HERGER. So, in other words, you don't agree with your statement where you said "competition, in short, will hurt you, not help you?"

Dr. BERWICK. There are instances where competition is very helpful, and I have just cited one. There are instances where it is probably less useful. But in a rural setting where there is only a single hospital, critical access hospital, and that is the only supply in town, we can't use competition as the major lever for improvement in that. We have to reach out and help that setting and make sure that it can supply the goods and services and excellence that that community needs. Sometimes it helps; sometimes it doesn't.

But the answer to your question before, do I think competition can help? The answer is, yes, in many cases absolutely.

Mr. HERGER. Which is directly opposite of what your quote was. But the reason that I and many others find your past statements troubling is because America was built on the free enterprise system. Going back to our Founding Fathers, Americans have always believed that free people working in free markets make better decisions than any king or dictator or government bureaucrat could ever make for them, and that is what this health care debate is fundamentally about. Are we going to stick with the free enterprise system that has brought about the greatest prosperity in the history of the world or are we going to hand over the keys to the government? Will we trust patients' own doctors to determine the best course of medical treatment or will we leave that decision up to a district bureaucrat who has never met the patient?

You are now overseeing an agency that provides health care benefits to more than 11 million beneficiaries in Medicare Advantage and 19 million in Medicare prescription drug plans. Congress designed Medicare Advantage and Medicare Part D to give senior citizens a choice of plans so they can pick the plan that works best for them instead of being forced into a one-size-fits-all government plan.

Given your repeated statements expressing skepticism about the private health care market and competition, how will you reconcile your personal beliefs with your responsibility to administer these programs that are built on the principles of competition and consumer choice?

Dr. BERWICK. Congressman, I can't think of a better example of American-style competition benefiting everyone than, say, with the evolution right now of the Medicare Part C program, the Medicare Advantage program. Look at what is happening: more transparency, more negotiation, more visible understanding by beneficiaries of the quality of the plans they can choose from, an open market in the Medicare and You handbook and on the Web where they can search for the plan they want and then they buy it. And what happens? Quality goes up and costs go down. That is the free

market at work with the support of Medicare to make this a transparent environment in which the beneficiary can make choices. We are interested in more choice, not less, and it is working.

Mr. HERGER. And I couldn't agree with you more. But I hope you recognize that what you have just said in your statements and answers to Chairman Camp are very different, very different than these quotes that you have made in the past, but thank you very much.

Chairman CAMP. Thank you. The gentleman's time has expired.

Mr. Johnson is recognized.

Mr. JOHNSON. Thank you, Mr. Chairman, and Doctor.

You know, the administration and Democrats here in Congress made promises to seniors about their health care and unfortunately didn't live up to them. In many cases, the law's provisions are going to harm, not help, Americans primarily by raising premiums and reducing access. I mean, the Medicare actuaries warn that the one-half trillion dollars in Medicare cuts in the Democrat health care law are so drastic that providers might end their participation in the program, probably jeopardizing access to care for beneficiaries.

You know as well as I do there are docs that are getting out of Medicare now because they can't deal with it. And I don't know if you have a private office or not, but most of the docs I know have to hire two or three extra people just to track the administrative work that goes along with that Medicare junk.

The Congressional Budget Office also expressed concern that it is unclear if the law's Medicare cuts can be sustained and whether this slower rate of growth will be accomplished through greater efficiency or instead reduce access to care or diminish the quality of care for Medicare beneficiaries.

In Texas, more than 300 doctors have dropped the Medicare program in the last 2 years—you are aware of that, I am sure—including 50 in the first 3 months of 2010. Some docs feel the only way they can have control over their practice is to stop taking Medicare patients. Of course, not all docs drop out of the program. Some doctors are choosing to increase fees, reduce staff wages and benefits and reduce charity care. Those alternatives don't sound good to me.

As a CMS administrator, how do you plan to prevent seniors from being denied access to care as a result of the massive Medicare cuts in the program?

Dr. BERWICK. It is tough times for all. Everyone is tightening their belt in this economy. I know that. But let me say that I have never been more optimistic about the future of the health care system in our country with the Affordable Care Act in our hands. I am told now that the participation in the Medicare system is the highest this year than it has ever been in history among physicians. The Affordable Care Act was supported by the American Medical Association, the American Hospital Association, professional societies, and trade associations. I don't think they would be supporting an Act that they think spells doom for them.

Mr. JOHNSON. Well, how do you account for 300 doctors dropping it in Texas?

Dr. BERWICK. Not everyone agrees with the Affordable Care Act, of course, but the associations, whose job is to make sure that

the wellbeing of their part of the industry proceeds well, are supporting this act. They know that the future lies in better care, better health, and lower cost; and I think they are interested in engaging with us—with us on the public and private side both—in making health care better. That is what they say to me when they meet with me.

I have been going all over the country meeting with hospital leaders and professional leaders, and I think everybody that I am speaking with knows we have got to navigate our way to a better health care system together in public and private partnership, and I think we are headed in that direction.

Mr. JOHNSON. I don't know how you plan to prevent seniors from being denied access. What kind of steps are you going to put in place so you can identify a problem before it becomes a crisis?

Dr. BERWICK. More transparency, more knowledge about what is going on, more linkage of quality to payment.

Mr. JOHNSON. And how do you do that if the docs refuse to be part of Medicare anymore?

Dr. BERWICK. Ninety-six percent of the docs are participating in Medicare, and they are more than willing to work with us, the ones that I have met with. They know that in the long run better care is the answer for them, for their patients, and for the sustainability of the country. And we are going to work hard with the providers of care all over this country to make that care better. They know in the long run that that is how they will do the best for their patients, and that is what counts.

The hospitals want to be safer, they want to be higher quality, and we will work with them to get them in that direction. In the end, extra readmission that shouldn't have happened because we dropped the ball helps no one. Hospitals know that, doctors know that, and we are going to work for better care. That will be why people came into health care in the first place and why they will want to stay there.

Mr. JOHNSON. Well, I don't know how you are going to get to the docs that quit the system because they can't stand it.

Thank you, Mr. Chairman.

Chairman CAMP. Thank you.

Mr. Rangel is recognized.

Mr. RANGEL. Thank you so much, Mr. Chairman; and, Doctor, thank you so much for sharing with us the knowledge that you have so that our government can do a better job which you and your family have dedicated your life to.

I just want to correct the record, because the chairman had indicated in his opening statement that three Catholic Universities in Pennsylvania were closed because of the Affordable Care Act. They rushed to make certain that some of us knew that the Affordable Care Act had nothing to do at all with the sale and that they had indicated that they wanted to do this long before the Act. The president is a Roman Catholic nun, and she is the one that wanted to clarify the record and her support for the Act.

Having said that, it just amazes me as to the opposition to this revolutionary concept of broad national coverage. What is your guesstimate of the number of Americans that have health insurance coverage?

Dr. BERWICK. The number that have health insurance coverage?

Mr. RANGEL. That have health coverage of some kind.

Dr. BERWICK. I don't know the exact number. I know that we have closed the gap a lot with the Affordable Care Act that now have access to——

Mr. RANGEL. I heard it is about 30 percent that don't have coverage.

Dr. BERWICK. As the Affordable Care Act gets into play, we are going to be closing that by over 30 million Americans that will have coverage.

Mr. RANGEL. But these people somehow manage to get health care even though they are not covered by insurance; is that true?

Dr. BERWICK. That is true.

Mr. RANGEL. And normally—not normally, but many of them go to emergency clinics in order to get this health care, and it is my understanding that this is a very expensive way to get health care treatment.

Dr. BERWICK. You are absolutely right, Congressman. It is you pay me now or you pay me later. When the patient comes in and you detect their diabetes early, they don't get kidney failure later. If they don't have access to care, complications will occur and they will show up later in the emergency room or the safety system and they will be expensive in a different way, right out of our public treasury, often.

Mr. RANGEL. When I was a kid, things were that you never went to see a doctor unless you were sick, but now I think it is abundantly clear that you can prevent so many serious illnesses, as you said in your testimony, by being able to go without having enormous cost to prevent these things from happening.

Dr. BERWICK. Absolutely right. We know the Director of the Centers for Disease Control, Dr. Frieden, has pointed out that with three or four simple, preventive steps we could reduce hundreds of thousands of heart attacks and strokes and other cardiovascular diseases in our country.

Mr. RANGEL. Now if you already have coverage and you are paying your premiums, are not included in the premiums the costs for the people who don't have coverage?

Dr. BERWICK. Eventually, it comes around. Somebody has to pay.

Mr. RANGEL. So if those who have premiums can find some way to reduce the costs of those who are not insured, does that not mean that your premium should be expected to be lowered?

Dr. BERWICK. Your premiums can be lowered. And in the long run the savings will be there because somewhere in the tax system and wages and in premiums that money will be saved and will come back into the American economy instead of being wasted in ill health that we could have avoided.

Mr. RANGEL. And so if we could develop a plan where most all people one way or the other would be able to get preventive care, would be able to get some type of care to prevent them from being hospitalized or prevent their illnesses from becoming chronic, then everybody not only gets the better quality of care but the cost per capita is dramatically lower.

Dr. BERWICK. Exactly, Congressman.

Mr. RANGEL. Now if that is true—I guess coming from Lenox Avenue in Harlem, New York—that those who have coverage probably take the attitude, I got mine, Jack, it is up to you to get yours. Because I think we have done a terrible job. And I want to thank the Republican majority for giving us a second chance of really showing the benefits of the program. Because the law is complicated.

But if you have a child with a precondition, you can better appreciate it today. If you have a kid that is under 26 and you couldn't get coverage, if you have high costs for prescription drugs, all of these things, the public is beginning to understand what is in the bill.

So I would like to take this opportunity to thank the Republican majority for giving us an opportunity not only to defend the bill that this committee majority was so proud of playing a major part in and giving us an opportunity not just to defend but to point out that, in the short and long run, this is best for our Nation; and I appreciate your patience with us.

And, Mr. Chairman, these hospitals that you referred to have sent out a release that I would like unanimous consent to be included in the record in saying sale it was, but it had nothing to do with the law that is before the committee.

Chairman CAMP. Without objection.

Chairman CAMP. The gentleman's gratitude to the majority is duly noted. His time has expired, and Mr. Brady is recognized.

Mr. BRADY. I, too, am grateful. Republicans oppose this health care plan because it won't lower prices for Americans, it will drive people out of plans they prefer, we can never hope to afford it, and a lot of companies that provide health care today are going to drop them, none of which we think is the right solution for health care reform in America.

So let's get specific. How many seniors have lost their Medicare Advantage plan since President Obama's plan was put in place?

Dr. BERWICK. Congressman, there is always turnover in Medicare Advantage. I don't know the exact the number that have changed——

Mr. BRADY. No, these aren't turnovers. How many have been forced out of their preferred Medicare Advantage plan? Your agency says 700,000. Are they right?

Dr. BERWICK. That is a turnover number. They can choose to be in Medicare Advantage or not. It is a system in which people can choose——

Mr. BRADY. No. Your actuaries said 700,000 seniors have already been forced out of their preferred Medicare Advantage plan. Is your agency correct?

Dr. BERWICK. Medicare Advantage plans are a market system in which beneficiaries can choose, and they——

Mr. BRADY. Is your actuary, their report accurate?

Dr. BERWICK. What I know right now, sir, is enrollment in Medicare advantage plans is up 6 percent this year. People are exercising their choices, and they have choices.

Mr. BRADY. Is that a little misleading since the cuts on Medicare Advantage haven't taken place yet?

Dr. BERWICK. Well, we are seeing heavy marketing by Medicare Advantage, by Medicare Advantage plans. There is growth in those plans. There are reductions in premiums——

Mr. BRADY. If you could send back to us how many seniors have lost their Medicare Advantage plan, been forced out of their preferred plan, by State, I would appreciate it.

How many seniors will lose their preferred Medicare Advantage plan under the President's new national health care plan?

Dr. BERWICK. Medicare Advantage options are robust for Medicare Advantage beneficiaries, and they choose the plan that meets their needs——

Mr. BRADY. Your actuaries say 7.4 million. Are your people correct?

Dr. BERWICK. We are seeing an increase, sir, in the enrollment in Medicare Advantage——

Mr. BRADY. Because the cuts haven't taken place.

Dr. BERWICK. We are seeing investments in Medicare Advantage plans——

Mr. BRADY. If you could get me that answer. I am not trying to interrupt, but since you already have these numbers, it would be great to refer to them.

Dr. BERWICK. We will be happy to——

Mr. BRADY. How many of those—in the Part D prescription plan for seniors, how many of those have lost their preferred plan since the President's plan took place?

Dr. BERWICK. Sir, the number of sound options, meaningful choices for Medicare beneficiaries in both C and D are increasing; and beneficiaries are taking advantage of those higher rates.

Mr. BRADY. Your agency says 3 million this past year have already been forced out of their plan. Are your actuaries right?

Dr. BERWICK. We are seeing turnover in Medicare Part D and C, as we always do. Some plans, when you are leaving the market——

Mr. BRADY. How many seniors in Part D have been automatically enrolled in a Medicare Part D plan that costs them more?

Dr. BERWICK. I don't know the answer to that, sir.

Mr. BRADY. Your folks say 1.5 million. Can you provide both for Part D and those forced into a higher cost plan, can you provide that to us by State?

Dr. BERWICK. Happily.

Mr. BRADY. The donut hole, the way that was closed is highly flawed, creates cost shifting within it. For the 90 percent of seniors who do not reach the donut hole, can you guarantee that they will not see higher premiums as a result of closing the donut hole for those who are not in it and not touched by it?

Dr. BERWICK. As a result of closing the donut hole?

Mr. BRADY. Yes.

Dr. BERWICK. Part D premiums rose slightly this year from I think $29 or $30, on average. I am not quite sure I understand what you mean that their premiums will rise as a consequence of closing the donut hole.

Mr. BRADY. Yes. Because you are cost shifting within the donut hole. You are taking the 90 percent who do not reach it and taking

the cost of closing it and applying it to them. Your actuaries say their premiums will go up.

Dr. BERWICK. Congressman, what I know is that a patient that gets to the donut hole and needs their medications to preserve their life and their health and their function, if they can't afford them, they get sicker, and we end up paying and their families——

Mr. BRADY. So can you guarantee for seniors who are not in the donut hole that their premiums won't go up?

Dr. BERWICK. It is so important to provide people medications when they reach that donut hole, and I think that we are seeing much more confidence on the part of seniors that they can get the medications they can't afford.

Mr. BRADY. Does the Deceptive Trade Practices Act apply to ObamaCare?

Dr. BERWICK. Does the Deceptive Trade Practices Act apply to ObamaCare? Is that your question?

Mr. BRADY. I am being only halfway factitious. It seems to me none of the promises made to our seniors under the President's national health care plan will come true. Many are forced out of their plans, will see higher premiums. That is why Republicans are serious about coming back with better solutions for seniors.

Dr. BERWICK. Congressman——

Chairman CAMP. The gentleman's time has expired. If you would like to submit a response in writing, you are certainly welcome to do that.

Dr. BERWICK. Thank you.

Chairman CAMP. Mr. Tiberi is recognized for 5 minutes.

Mr. TIBERI. Thank you, Mr. Chairman, for having this hearing today. And kind of dovetailing on Chairman Brady's comments about Republicans wanting to have better solutions for seniors kind of goes along with my line of questioning.

It was disappointing to hear the ranking member express concern in the rhetorical fashion that he did with respect to this hearing and what Republicans believe. Why Republicans voted to repeal this bill is because we do care about the impact of this bill to real people, and having $500 billion taken out of the system is a good reason to have this hearing today and get information from Dr. Berwick and Mr. Foster and continuing the discussion. Because, Dr. Berwick, thank you for doing what you are doing and being here today, but we represent a lot of people in a lot of different parts in this country.

In my district in central Ohio—and Mr. Levin has been to my district, not on my behalf, but he has been to my district—there are doctors, there are seniors, there are hospital administrators, there is the largest—Dr. Berwick, the largest Medicare Advantage provider in my district is a nonprofit Catholic hospital. And they are all very, very concerned about the impact that this bill, this law has with seniors. Not insurance companies, not wealthy seniors, I am talking about real people.

My dad has a sixth-grade education. My mom has an eighth-grade education. They are on Medicare. My physician—Dr. Randy I will call him—a primary care physician, his father-in-law lost his primary care physician because he no longer was going to take Medicare patients. So my physician, Dr. Randy, said, Dad, I will

find you a doc. I know a lot of doctors out there. Columbus, Ohio, is the 15th largest city in America. This doctor friend of mine could not find a doctor for his father-in-law because nobody would take new Medicare patients based upon the new law. So he is now taking his father-in-law as a new patient, which he said he would never do.

A lady in my district, Joan, came to me teary eyed because her mother, a Medicare patient, first lost her Medicare Advantage program, so she had to go into Medicare fee-for-service—and I just give you this as examples—and then lost her doctor, who said I am done with Medicare.

We have a large city. We have four healthy hospitals, three of which are very concerned about the new law. We have a doctor's association—unlike the American Medical Association—the Ohio State Medical Association, who oppose the bill, who support repeal. They want reform. Don't get me wrong. They want reform, but they are very concerned about what this legislation does.

Mr. TIBERI. And so I understand what the minority has said. I appreciate your testimony. But the reality on the ground that I see, as a son of seniors, as someone who wants to improve our health care system, who wants better access, who wants lower cost, who really wants people to keep what they have, which is one of the President's goals, a wonderful goal by the way, Dr. Berwick, I thought the President was spot-on on that, but the reality on the ground, at least in central Ohio, is people are not being able to keep what they have. Seniors are frightened that they are losing coverage in reality that they had and they liked, that they chose. Seniors are frightened that they are losing doctors.

My mom lost her doctor. And when you are 70 years old and you have had a doctor for a long time and you build a really good relationship with that doctor, you are frightened to face a situation where now you have to go on to another doctor that you don't know who that is going to be, but you are talking with other seniors. My mom and dad walk every morning at a local mall, a senior's club, and we know what they are talking about. Are there going to be any doctors left that take senior citizens? And this is a year after this bill went into effect.

And Dr. Berwick, you are a physician. These physicians talk to their patients and they express concern about the new health care bill, many of whom supported it when it first was talked about, but opposed it in the end.

So my question to you is let's not talk about the statistics, let's talk about what I say, what you say, what the chairman says, to constituents who on the ground, are seeing a reality that is much different than the rhetoric of when this bill passed and what the goals were. People are losing the coverage they had, and they are losing their doctors, and their doctors are blaming the bill.

Dr. BERWICK. And your question, Congressman.

Chairman CAMP. If you want to respond briefly, the gentleman's time just expired; I will give you a few seconds to answer and then you can supplement it in writing.

Dr. BERWICK. I am meeting all the time, Congressman, with doctors and I have the same objective you do. We need a robust medical profession, a strong support to that profession. And we are

committed to that, you and I both are. I am hearing a different story. The physicians I meet with want to participate in the change of health care that the Affordable Care Act offers. They are actively engaging in issues related to changing the form of care to make it sustainable, better for them and their patients. And I think we can get there and apparently, unlike you, I think the Affordable Care Act provides a very strong foundation for that progress, for the professions as well as for the beneficiaries.

Mr. TIBERI. Thank you.

Chairman CAMP. Thank you. Mr. Stark is recognized.

Mr. STARK. Thank you, Mr. Chairman. Thank you for holding this hearing and thank you, Dr. Berwick, for being here to enlighten us.

The Affordable Care Act has a variety of initiatives to modernize the Medicare program and make sure that we are, I hope, recognizing value more than volume.

What has your value as you move among the provider community across the country, and what is the reaction you are hearing?

Dr. BERWICK. To the modernization of health care, it is excitement, it is excitement everywhere. We are seeing it first in some of the information technology work that is going on now. We are finally at the threshold of really modernizing information technology for the providers of care and the beneficiaries of this care in this country. It is going to make a tremendous difference.

Beyond that, physicians today can be very frustrated by the fragmentation in the health care system. People move from place to place and get dropped. The Affordable Care Act has in it the opportunity now to reward and support continuous seamless care. So the patient with diabetes that is seeing three or four different doctors knows that her journey is being crafted. We will be able to build accountable care organizations, move payment toward bundled payment, link payment to quality of care for both health plans and hospitals, so that continuity gets established.

Doctors all over this country and providers of care are quite excited about this progress into a better care system. And Congress in its wisdom has given us these gifts of the Innovation Center in the Affordable Care Act and the Federal Coordinated Health Care Office for dual eligibles. I can't tell you how important these are. The Innovation Center is going to liberate all of the imagination around the country, place by place, community by community, to find better ways to deliver care.

And when a hospital in Nebraska or Maine develops a better way to make patients safer or to take better care of someone with multiple sclerosis, we can learn about that and spread that news all over the country. We are on the threshold of a tremendous boost in innovation, creativity and spread of better care around this country. And the doctors know that. That is what they are talking to me about.

Mr. STARK. Would it be your understanding that—I guess this isn't a yes or no, but that there is a positive role for government to play in the delivery of medical care in this country, and that that could be led by the Members of Congress if they decided to work together and do it?

Dr. BERWICK. We are already doing it. I mean it is a catalytic role. You have set the stage for the health care system to do what it wants to do for doctors to thrive and commit themselves to patients. You do that as you provide the resources to help them make care more continuous, safer, to invest in prevention like the Affordable Care Act does.

But let's make no mistake about it. Government has no role at all in the encounter between the doctor and patient. Honoring the sanctity of that consulting room is really, really key. I am totally committed to that. But we set the stage for those two people to meet each other and work together when things are done right. So it is a combination of government support, encouragement, reward, and the confidence and the commitment that professionals have when they encounter patients, and the patients have when they are confident in the professional. It is a balance.

Mr. STARK. Thank you very much for what you are doing. And I look forward to, as I know members of our committee do, to working with you over the next couple of years to see that we can improve the system and with your cooperation. Appreciate it very much. Thank you.

Dr. BERWICK. Thank you, Mr. Stark. Thank you for your leadership.

Chairman CAMP. Thank you. Mr. Davis is recognized.

Mr. DAVIS. Thank you, Mr. Chairman. Your comment on health care being liberated, the private sector has been innovating for decades and sharing common information among the professions. I just find it hard to believe, to talk about innovation in the context that we have, in a variety of issues from programmatic perspectives to the issue just recently discussed.

I didn't go to Harvard, I went to West Point. And the one thing I would have to say at the beginning of this, listening to this hearing, having watched my mother navigate through the system that was managed by your agency, and we talk about affordability and innovation, in the world where I grew up, both academically and professionally, these answers would be called equivocation. There are straight yes-and-no answers about cuts on issues. And I think it is very important to share the truth of this and avoid the posturing for the lives to save that we want to save.

Successful physicians that I know are known for their candor as well as their bedside manner in sharing factually what is before people. I have not heard one doctor, save one who is in a very different place politically than the rest of the entire Kentucky Medical Association, whose head I met with yesterday, who has not said this is going to limit their capacity, increase their overhead, increase their cost and is going to cause a very serious problem for senior citizens.

When you talked about competitive bidding being a good thing, it is not pay me now or pay me later. It is pay me now and pay me later. Directly, I have a long term DME provider that is well established in my community, lost their ability to bid. A California company won. And coming on the back side of this, because they had no local capacity to deliver, guess who they turned around to subcontract with? The company that had been doing the business at a lower cost before.

The, let's say, counter-intuitive answers are not here. And admittedly I am not a doctor. One of my opponents once played one on television, but I will have to say that I am most disappointed in the lack of candid answers on these issues, because we want to help you improve this system. It has been made more complicated by the bill. And in my other life it would be "read the problem." If you read the bill, it does not connect the dots by creating 162 new agencies, commissions, and boards. Cutting direct benefit and increasing taxes is not a recipe for improved capacity. I want increased access.

In coming to that, many of my constituents are on Medicare Advantage. Do you know how many people are actually in the program, Dr. Berwick?

Dr. BERWICK. About 12 million, I believe.

Mr. DAVIS. That is correct. It is about 12 million people. Do you know how many people were in the program in 2005?

Dr. BERWICK. I don't, sir.

Mr. DAVIS. It is about 5.3 million, less than half of what it is today. So the market working competitively, seniors were moving to this as a preferred program of choice. And I think the numbers say something about the popularity, don't you?

Dr. BERWICK. Yes. I think Medicare Advantage has tremendous opportunities embedded in it as well as significant problems.

Mr. DAVIS. Well, I would say that the customers tend to vote with their feet, no different than the doctors who are pulling out of Medicare in droves. I am seeing the same thing happening in the Ohio Valley. I am in the same vicinity as Mr. Tiberi here. We are seeing that happen in the medical profession.

It is getting to a point because of this bill—I have a daughter who wants to go to medical school, has been told by seven different physicians not to go because of the truncation and the complication in the health care system that is going to be placed upon future physicians.

But coming back to Medicare Advantage, your own actuaries said last year, as Mr. Brady pointed out, that 7.4 million seniors would lose their coverage in Medicare Advantage. Is your actuary correct?

Dr. BERWICK. The actuary is making predictions of the future, sir. What I have is the evidence before us today. We have——

Mr. DAVIS. I didn't ask you that question. I asked you, is your actuary correct in his calculations?

Dr. BERWICK. The actuary is making a prediction. I can't judge whether he is correct or not. What I can tell you are the facts now, sir——

Mr. DAVIS. I will go back to our academic education. The commander is responsible for what the unit does or fails to do. I am not interested in an academic salon answer.

Is your actuary correct in the assumptions that your department submitted to this committee?

Dr. BERWICK. Sir, I am not a commander.

Mr. DAVIS. You are the leader of—you lead a budget larger than the Defense Department, sir. Please answer the question.

Dr. BERWICK. I lead an agency in which the growth rate of Medicare Advantage this year is 6 percent and the actuary pre-

dicted a decrease. So the actuary's prediction was incorrect. Our Medicare Advantage is healthier now than it ever was before.

Mr. DAVIS. So if the Medicare Advantage is a good program, then why would he say that the people are going to be cut out of the program by the very legislation that you are advocating?

Dr. BERWICK. What I am saying is that I have the facts on the ground before me now, and the facts are that Medicare Advantage is looking stronger and stronger. We are seeing plans invest in expansion of Medicare Advantage. We are seeing robust choices for beneficiaries, 26 choices per county on average in this country, average premiums going down 6 percent, enrollment going up 6 percent. That looks like a very robust program. And these are smart businessmen out there. People who run the Medicare Advantage plans are investing in a future that looks pretty bright to them, or I don't think they would be investing in the way we are seeing them invest right now. Medicare Advantage looks healthy.

Mr. CAMP. Thank you. The gentleman's time has expired.

Mr. Reichert is recognized.

Mr. REICHERT. Thank you, Mr. Chairman.

Doctor, thank you for being here today. I am not a doctor either, but I have been a patient many times. So I am looking at the system as most Americans would, from that side of the issue. I am disappointed too, as Mr. Davis has stated, in the way that you are answering or not answering some of the questions. So I hope that you understand our frustration here with some of your responses.

Most Americans are just trying to figure this thing out. They need your help to do that. A lot of people are listening today. This is streamed live C–SPAN, so there will be a lot of Americans listening to your words.

You obviously support the Affordable Care Act. We had a witness in a couple of weeks ago whose name is Austan Goolsbee. Do you know him?

Dr. BERWICK. Yes.

Mr. REICHERT. Chairman of the Council of Economic Advisory. He said that the health care bill would increase access, decrease costs, increase benefits, reduce the deficit, and people would be allowed to keep their health care if they wanted to. Do you agree with those statements? Does the bill accomplish those things?

Dr. BERWICK. It appears to be, yes.

Mr. REICHERT. It that a yes?

Dr. BERWICK. Yes.

Mr. REICHERT. Is there anything at all in the bill that you would change?

Dr. BERWICK. We are going to learn over time. That is a complex question.

Mr. REICHERT. But you have had some time to read the bill and look at the bill. Is there anything that stands out in your mind that you would change?

What don't you like about the bill? Or is it all good.

Dr. BERWICK. It is a very complicated bill, sir.

Mr. REICHERT. Is there anything about the bill you don't like?

Dr. BERWICK. Right now I am implementing the bill——

Mr. REICHERT. Yes or no, I guess, because I am not going to get a straight answer. Is there anything about the bill that you would change? Yes? No?

Dr. BERWICK. Over time, we are going to learn about this bill, sir, and I can tell you——

Mr. REICHERT. From what you know today. From what you know today, sir, is there anything that you would change?

Dr. BERWICK. In the whole——

Mr. REICHERT. Can you tell me when the $206 billion cuts to Medicare Advantage begin?

Dr. BERWICK. Well, right now the payments are stabilized.

Mr. REICHERT. When do the $206 billion cuts begin? What is the target date, the set date? What year?

Dr. BERWICK. The cuts are phased in over time. It depends on the plan.

Mr. REICHERT. When do they begin?

Dr. BERWICK. It depends on the plan——

Mr. REICHERT. What year do the cuts begin? Can you give me a year?

Dr. BERWICK. It is variable depending on the plan and the area, sir.

Mr. REICHERT. In 2017, $206 billion in cuts will begin to take place. Your actuaries say, as Mr. Davis has asked you, that there would be 7.4 million seniors then leaving that system, losing their health care. So the statement that you agreed with earlier that Mr. Goolsbee also agreed with—you can keep your health care if you want to—isn't a true statement. Even the President of the United States has said in a public forum, which I was present at, he said there may have been some—in regard to this statement that you can keep your health care plan if you like it, he said there may have been some language snuck into the bill that runs contrary to that premise.

Now, if there is language in the bill that runs contrary to this premise, and according to the President it does, would you change that language?

Dr. BERWICK. Sir, Medicare Advantage——

Mr. REICHERT. Would you change the language if there is language in the bill, as the President says there is, that got snuck into the bill, would you change the language that prohibits people from keeping the health care they like? Would you change the language, sir?

Dr. BERWICK. People on Medicare Advantage——

Mr. REICHERT. Would you change the language, sir, if there is language in the bill? That is a yes-or-no question. If there is language in the bill, yes or no?

Dr. BERWICK. I would love to be able to answer your question yes or no. I cannot, sir.

Mr. REICHERT. Why can't you answer the question? It is a simple question. If there is language in the bill that says, as the President has said, that runs contrary to the promise that you can keep your health care if you like it, why would you not say "yes" to that question, that I will change that language because we believe and we have said over and over again, if you like your health care plan, you can keep it. Why would you not change that language?

Dr. BERWICK. Congressman, to me——

Mr. REICHERT. Why would you not change that language, sir? Answer the question.

Dr. BERWICK. Sir, you are asking a hypothetical question, sir. What I can tell you is our job——

Mr. REICHERT. No, sir, I am not. The President of the United States has made this statement. There is language in the bill——

Mr. LEVIN. Mr. Chairman, I need to object.

Mr. REICHERT. Well, it is my time, Mr. Camp.

Chairman CAMP. If the gentleman from Washington State would suspend. Mr. Levin.

Mr. LEVIN. I will find a way to object. I think we have to let witnesses answer questions, sir. This is not the Star Chamber.

Chairman CAMP. Back to regular order. The gentleman from Washington's time is about to expire, so you have about 2 or 3 seconds left, and then we will leave a few seconds for Mr. Berwick to answer the question.

The gentleman is entitled to an answer to his question.

Mr. REICHERT. Mr. Chairman, I would just ask for a straight answer from the witness. Thank you, and I yield back.

Chairman CAMP. Mr. Berwick, you have a few seconds, as I have done to the minority, to respond to the question.

Dr. BERWICK. Mr. Chairman, I am not aware of any such language in the bill, and the question to me sounds hypothetical.

Chairman CAMP. Thank you.

Mr. McDermott is recognized.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Dr. Berwick, you have given a bravura performance in political theater. You have been brought to a stage today and put into a play that you really don't want to be in; you want to be doing your job. This is a stage being set to get rid of Medicare. The Republicans have never liked Medicare. When Harry Truman proposed it in 1946, the Republicans started talking of socialized medicine, playing on the fears of what was going on in the Soviet Union. They have used these fear and misinformation tactics then, and they are using them again here today.

Now, when Medicare passed in 1965, most Republicans voted no. And what we are really doing here today is trying to poke holes in the bill. But we have been here 100 days, and the committee has laid no proposal on the table to make it better. Everybody is talking about what is wrong with it. Bill Frist said, don't repeal, make it better.

So all we have in front of us is one plan that is on the table, Paul Ryan's road map. He wants to give a voucher to every senior citizen in this country. Now, let's be serious. The point of that is that the Republicans believe that seniors need to put more skin in the game. And I want to be crystal clear here. Seniors already spend one third of their income on health care. They can't afford any more skin in the game.

So whatever I hear here is really about the Paul Ryan plan. And I would like you to take the time to tell us what you think will happen when they repeal or begin to undercut and destroy this and work toward putting a voucher plan, because that is the only thing they have put on the table, and I believe that all the Republicans

are for it, because none of them have stood up and said, we don't want a voucher system, we want to make this system better, we hate ObamaCare. We want to get rid of it and put in the voucher system. So tell us what a voucher system would do to seniors in this country.

Dr. BERWICK. It would put them at risk. People, they already have skin in the game. Their bodies are in the game. The whole idea here is to give seniors security so they don't have to wake up in the morning wondering whether they can get to the care that they need and that will help them preserve long and fruitful lives.

Mr. MCDERMOTT. Do you think seniors could take a 6- or $7,000 dollar voucher out at age 75 and get a health care plan?

Dr. BERWICK. Not a senior whose actuarial risks are 11- or $12,000—or worse if they get something—a worse disease than that. We are putting them at risk. We are partners with the seniors in Medicare. We have got their backs. I wake up every day thinking about how to help these beneficiaries make sure they can get the care they want and they need. I think that is an important role to fill. And my colleagues in CMS have the same commitment.

Sending them out on their own to go navigate this very difficult system, which isn't always friendly to their needs, is not the right answer. And taking the law down strikes me as a terrible answer. It means taking away the wellness visits we have just added, removing access, first-dollar access to preventive coverage. It means putting the people in the doughnut hole back at risk now, so the lady I met in Atlanta, who can't afford her medications right now, is going to have her blood pressure rise and get a stroke as a result of that.

It means, by the way, that we decrease our focus on quality because this law has in it unparalleled tools for transparency and improvement of care through measurement, support to quality, and rewarding quality. In this bill, we now can reward hospitals for making their care safer. We couldn't do that before. Because of this bill, we can reward Medicare Advantage plans that reach 3- or 4- or 5-star levels with more and more reward. That is going to focus the whole industry on doing better for the beneficiary. When the bill goes away, that goes away.

This bill gives us tools to fight fraud and abuse at a level never possible before. Do we want to let the criminals get away now? Just let them out scot-free, by taking the law away; it makes no sense to me. The bill is going to invest in a transparency of beneficiaries and the public at large and providers can find out much more because of this bill about their own performance.

Mr. MCDERMOTT. Do you think that if seniors understood what a voucher plan really meant, they would be in favor of it, as opposed to the Medicare plan that we have and we are trying to amend and make better?

Dr. BERWICK. I don't think; I know. I have been out talking to seniors. And when I go to senior centers and I explain this bill and I tell them where we are, they applaud. They want this. They understand how this bill works in their interests and how when I go to work every morning I have their interest in mind. A voucher system says go out on your own, God bless you, I hope you do okay.

Mr. MCDERMOTT. Can I clarify one other thing?

Chairman CAMP. The gentleman's time has expired.

I do think it is important to note for the record that the Republican plan on health care that was introduced in the Congress was the only plan that was scored by the Congressional Budget Office that reduced premiums across the board, did not cut Medicare, and did not increase taxes.

And with that, I would recognize the gentleman from Louisiana.

Mr. BECERRA. Mr. Chairman, I hope that if we are going to be allowed to comment in between, outside of regular order——

Chairman CAMP. When you are the chair, you will be allowed to comment.

Mr. BECERRA. We will ask for regular order as often as we can.

Chairman CAMP. Dr. Boustany has the time.

Mr. BOUSTANY. Dr. Berwick, I too come from a family line of physicians. I am a cardiac surgeon and know of the importance of the doctor-patient relationship as you do.

How do you reconcile your views on provider oversupply? You have made multiple statements with regard to oversupply in markets and so forth, your actuary's concerns about shortages, which are real, and the prospect of those shortages getting worse with the current reimbursement rates that inevitably will be cut. We are seeing reimbursement pressures on physician practices. We already have shortages. Would you agree that we have a shortage in primary care physicians in this country?

Dr. BERWICK. We have a shortage of primary care in this country, yes.

Mr. BOUSTANY. Physicians?

Dr. BERWICK. Physicians and nurses. Yes.

Mr. BOUSTANY. Do you agree that we have a shortage of general surgeons in this country?

Dr. BERWICK. In some areas we do, sir.

Mr. BOUSTANY. What about rural areas?

Dr. BERWICK. Some rural areas are having trouble with access to general surgery, I know that.

Mr. BOUSTANY. I think it is more widespread than you seem to be suggesting, sir. How do you reconcile your view with this? Because your statements seem contrary to what your actuaries are saying.

Dr. BERWICK. Sir, please explain to me what contradiction you see. I will be happy to address it.

Mr. BOUSTANY. Well, the contradiction is we are going to see shortages——

Dr. BERWICK. Yes.

Mr. BOUSTANY. And worsening shortages, which will hurt access to care for seniors and particularly folks who live in rural communities.

Dr. BERWICK. Yeah. Well, again, the actuary is making a prediction here. What I see in the Affordable Care Act is an investment in expansion of primary care and primary care services. I think over time it will have that effect, investments in health centers, teaching——

Mr. BOUSTANY. Reclaiming my time, sir. Without fixing the reimbursement system, we are going to see more and more physi-

cians either opting out for early retirement, we are seeing fewer people going into medicine. How do you reconcile this?

Dr. BERWICK. I agree with that. The President has committed to fixing the SGR problem, which we are absolutely committed to working with you and your colleagues on, in trying to get past that. That is a serious looming problem in the health care system for sure. And as——

Mr. BOUSTANY. That leads me to my next question, because you have talked often about rewarding quality versus quantity, and yet in your testimony I see nothing but platitudes and nothing specific to suggest the path you are going to take on this. And I suggest that there is going to be a lot of work that this committee is going to have to do, to dig down working with you on this issue.

Dr. BERWICK. I will be happy to work with you, sir. Within the work outlined for us in the Affordable Care Act and other legislation, there are very specific ways in which quality will be linked to payment, hospital-based, value-based purchasing, physician modifiers——

Mr. BOUSTANY. But we have seen those specifics. Those are platitudes. I understand what needs to be done in terms of quality. I have done that in hospitals. I took a community hospital from being sort of average to the top 100 hospital in cardiac surgery. I understand those things. But we have to get beyond the platitudes on changing this reimbursement system, because it is at the heart of access problems for seniors and particularly for rural families, because we are going to see access problems. This reimbursement issue is causing physician shortages.

Dr. BERWICK. Sure. Congressman, I assure you the specifics are there, they are out there, and I would be happy to work with you at any point afterward to explain what those specifics are. And I welcome your comments and improvements in those specifics.

Mr. BOUSTANY. Thank you. Now, with regard to technology, you have made a number of statements that seem to be of concern to me, obviously, about downplaying the importance of new technology innovation in health care. We have an innovation tax in this bill that is going to hurt innovation, I believe, in the long run. But you have made statements—I will quote one. "One of the drivers of low value in health care today is the continuous entrance of new technologies, devices, and drugs that add no value to care."

Can you explain that.

Dr. BERWICK. Of course, yes. Some new devices, drugs, are miracles. They save lives and they add tremendous value to care. Others do not.

Mr. BOUSTANY. So who should decide?

Dr. BERWICK. Professions, the scientific community——

Mr. BOUSTANY. So when you suggest there should be a national policy, who is going to make those decisions?

Dr. BERWICK. A national policy.

Mr. BOUSTANY. National policy, that is what I am referring to. You referred to a national policy. In fact your quote is, "If we had a national policy, it would allow us to know the difference."

Dr. BERWICK. Investments in supports to the scientific community to allow us to understand more and more about what works and what works better than other things is very important——

Mr. BOUSTANY. So let me ask you this. Back in the 1950s when a surgeon saw a patient die from a pulmonary embolus, he put his mind to work on this and he actually came up with an idea. And working in his garage, he put together the first heart-lung machine. Would that have fit into national policy? What impediments would there have there been?

Chairman CAMP. The gentleman's time is expired. If you want to respond quickly to that.

Dr. BERWICK. I am very excited by the Innovation Center and what it can offer for people exactly like that all over the country. We have a good idea. We now have the ability to help him invest further in that idea and grow as a country as a whole.

Chairman CAMP. The gentleman's time has expired. Mr. Heller is recognized.

Mr. HELLER. Thank you, Mr. Chairman.

Dr. Berwick, I appreciate you being here today. I am going through some of your quotes and I know we have heard some of them already today, but frankly I think they are worth repeating, quotes like "The NHS is not a national treasure, it is a global treasure." "The decision is not whether or not we will ration care, the decision is whether we will ration care with our eyes open." Quotes like "Competition in short will hurt you, not help you." Another one, "I admit to my devotion to a single payer mechanism as the only sensible approach to the health care finance I can think of." And finally, "Any health care funding plan must redistribute wealth from the richer among us to the poor."

Sometimes reading your quotes, Dr. Berwick, I wonder what country we live in.

Having said that, I have a significantly large district and, as you know, this health care bill significantly reduces the funding for the Medicare Advantage program. Nearly one-third of all Medicare beneficiaries in my district are enrolled in the Medicare Advantage, and that is more than 100,000 seniors in my largely rural district.

You just made a comment that you go to these senior centers and you talk to them and they applaud you on what this new program, this new care provided for them. I go to senior centers in my district and try to explain the new health care system to them, and I assure you, I don't get a round of applause.

You just said that it is a good model. I guess my question is how you, in your mind, say that this is a good deal for seniors if the net Medicare savings is $575 billion in this piece of legislation, and yet the amount reinvested in the Medicare benefits is $24 billion? If you are going to take $575 billion out of the Medicare system, what benefits do seniors have with only $24 billion put back in?

Dr. BERWICK. The projections, as you heard earlier, say that copayments in Parts A and B are going to go down by $200 a year by 2019; fee-for-service premiums will be down by $200; the doughnut hole will have closed and seniors will no longer be afraid of losing their drug benefits; and out-of-pocket costs in American health care are projected to go down $237 billion. This is a very good deal for seniors and a very good deal for America.

Mr. HELLER. So do you believe protecting the patient-doctor relationship is a goal of this health care bill?

Dr. BERWICK. Definitely.

Mr. HELLER. Do you believe that patients, their families, their doctors, should be the ultimate authority for the individual health decisions?

Dr. BERWICK. I believe—yes, I do.

Mr. HELLER. Do you believe one of the goals of the health care bill is streamlining the system so patients can navigate it more easily?

Dr. BERWICK. Yes, I do.

Mr. HELLER. If that is the goal of the health care bill, wouldn't a reasonable person think that 100 new boards, agencies, and programs would violate all three of those questions?

Dr. BERWICK. I think the health care bill will accomplish all of the goals you just articulated: a smoother, more seamless care. I can name the parts of the bill that will help us do that as a Nation in partnership between the public and the private sector. We can see how quality will be improved as a result of this bill and costs will fall as a result of the improvement of quality. People will be better off because of this bill, I am sure of it.

Mr. HELLER. Maybe in another country. Thank you. Thank you, Mr. Chairman.

Chairman CAMP. All right, thank you. Mr. Lewis is recognized.

Mr. LEWIS. Thank you very much, Doctor, for being here. Thank you for your service. As one member, I must tell you that I love your testimony, not just like it but I loved it. And I love your response, your answers to the questions. This is my beginning of my 25th year here, and you have been one of the better witnesses. And I just want to thank you. Thank you and your family for your great service.

Dr. BERWICK. I can't help saying, Congressman, what an honor it is to be in the same room as you.

Mr. LEWIS. Thank you, sir.

Doctor, what would happen to cost sharing for Medicare beneficiaries if reform was repealed?

Dr. BERWICK. Costs would go up for beneficiaries if reform is repealed, beginning just with the drug coverage issue. Seniors are very, very dependent on access to medications. It preserves their health and their life and their vitality, and they know it. If this bill were repealed, more and more seniors will lack access to the drugs that they really need. If this bill is repealed, they won't be able to get as easily the preventive services they need that will keep them healthy over time. A little bit less directly, because this bill so much invests in delivery system reform, making care better, smoother. Ask a senior who is seeing four or five different doctors, taking three or four medications, what her life is like in a fragmented health care system. It is a nightmare. She can't be sure that two doctors are prescribing drugs that are not incompatible with each other. She can't be sure that her lab test report will go to the right place.

Delivery system reform, improvement of care is what is behind this bill. That is where we will end up, a better care system to be a doctor in, to be a nurse in, to be a patient in. We can make care safer. If this bill goes away, we don't have a plan anymore then for crafting the kind of journeys our patients and our families and our communities really want. Costs will go up. Health care quality will

go down. The bill is an open door to the new American health care system that we really want and all need and can afford.

Mr. LEWIS. Doctor, if the Affordable Care Act was repealed, would those 3 million seniors who receive $250 from the government have to pay that money back?

Dr. BERWICK. We are looking at that now. I hope we don't ever have to face that question for real.

Mr. LEWIS. Doctor, like Mr. Rangel and others, when I was growing up in rural Alabama as a young child, I never saw a doctor, never went to a doctor. Tell me what is in this bill that would help children growing up, poor people in rural America, black, white, Latinos, Asian American, Native American, or growing up and just happen to be poor, family can't afford a doctor. Do you think this is a major step toward providing health care for all of our people and especially young people?

Dr. BERWICK. Yes. High-quality health care, which is what we all want, begins with health care. You have to be able to get to it. And this bill assures the old and the young and millions of people that they can get access to the care that then can be made great for them. If they can't get in, they can't get help.

If this bill goes away, people will wake up in the morning, tens of millions of Americans will wake up wondering whether they are going to lose their health care coverage and not be able to get it. Children and adults. We are talking about a bill that has in it now a guaranteed issue of insurance to children despite preexisting conditions. That is a major step forward. That means a kid who has asthma, who happens to be in transition, their parents between jobs, cannot be denied access to health care insurance as a result of this bill. Take that away, you hurt that child.

Mr. LEWIS. Thank you very much, Doctor.

Mr. CAMP. Thank you. Mr. Gerlach is recognized.

Mr. GERLACH. Thank you, Mr. Chairman.

Doctor, thank you for testifying today. To switch gears just a bit, one of the gaping holes, in my opinion, in the health care enactment last year was the lack of medical liability reform legislation. And it was interesting to hear the President in the State of the Union indicate his support for medical liability reform.

Do you support medical liability reform legislation?

Dr. BERWICK. Yes, I do, Mr. Gerlach.

Mr. GERLACH. Do you support a cap on noneconomic losses?

Dr. BERWICK. I support an exploration now in the country as to what forms of improvement in the medical liability system would actually work to the benefit of patients and the quality of the system. I don't know exactly what those will be, but I think we have got to start on that process.

Mr. GERLACH. Are you aware of the State statutes in California and Texas that do have cap on noneconomic losses?

Dr. BERWICK. It is not my area of specialty and it is not CMS' direct area; but, yes, I am aware of them.

Mr. GERLACH. So you are open to Federal legislation that would include languages that supports caps on noneconomic loss?

Dr. BERWICK. Sir, I am not in a position to commit myself right now to what I think about any particular set of solutions, but I think we need to begin the national exploration for solutions. In-

deed we are, the Agency of Health Care Research and Quality has demonstration projects underway now, but we need more. And I was happy to see that in the President's language.

Mr. GERLACH. In your testimony, you have the sentence, "CMS has new tools to fight fraud that will return money to the trust funds and the Treasury."

What new tools does the agency have to really ferret out the waste, fraud, and abuse that is contained in the system?

Dr. BERWICK. Two big kinds of tools, I would call them detection tools, which will allow us to identity patterns of abuses; abuse of the public trust and actually criminal behaviors. And working very closely with the Department of Justice and the FBI and others, we are engaging in more and more enforcement with quite a bit of return. I think the return on investment calculation shows something like 6.8 to 1 for the dollars we are putting into that. That is the pay-and-chase part of enforcement.

The other part, very exciting for me, is prevention. Why do these people get into the system in the first place? So we now have rules out there that will eventually allow us to prequalify Medicare providers at different tiers of risk by screening them in advance, in some cases in the riskiest levels, with actual criminal background checks that will keep the criminals out of the system in the first place.

Mr. GERLACH. Last fall I had a constituent that came to me. He sought medical care for a knee problem. The doctor prescribed a knee brace for him. A knee brace was then provided, and under the reimbursement schedule of Medicare, the provider was provided $686 for a knee brace. My constituent then went online and found online that same knee brace for the cost of $194.

So how is it that Medicare, if you are searching for opportunities to find where the waste is, why is it reimbursing a $194 knee brace for $686?

Dr. BERWICK. Congressman, I would love to look into that particular case with you afterwards if you are willing to do that with me.

Mr. GERLACH. I will submit all the documentation with you, and I have been corresponding back and forth with your branch on this, but keep getting a bureaucratic answer as to why the schedule is the way it is. And I would like to have a more specific answer to why we are paying $686 for a $194 knee brace.

Dr. BERWICK. I am delighted to pursue that with you. I will note that the DME competitive bidding system will more and more allow us to get much better deals for our beneficiaries and for the Congress as my board. I think it is really important for us to be acting in a market system on behalf of beneficiaries to find the best deals for them.

Mr. GERLACH. Thank you, Doctor. Thank you, Chairman.

Chairman CAMP. Dr. Price is recognized.

Mr. PRICE. Thank you, Mr. Chairman.

Welcome, Dr. Berwick. I too am a third generation physician. My father and my grandfather were docs, as you are a family of three generations of physicians. But I really think you missed your calling. I think you would have made a great lawyer for all of the reasons that we can imagine.

The issue here isn't between Democrats and Republicans, isn't whether or not Americans have access to the highest quality of care. The issue is whether or not patients and families are going to be in charge of that care, or government is going to be in charge of that care. And by and large, our friends on the other side of the aisle believe that government can make better decisions about this than people.

You in your answers have confirmed that you basically believe the same thing as well, that government needs to be in place to be able to make these decisions for people because clearly they wouldn't be able to make them themselves. So it gets down to who decides. Who is going to decide these fundamental questions about health care?

In the sale of this bill, as has been cited, the President said, and many of our friends on the other side said, Don't worry; if you like the kind of health care coverage that you have you can keep it. Is that true?

Dr. BERWICK. That the President said that.

Mr. PRICE. No. Is it true that if you like what you have, you can keep it?

Dr. BERWICK. I don't understand your question, Congressman.

Mr. PRICE. Are there any Americans that have lost coverage that they liked?

Dr. BERWICK. There is always turnover in the supply——

Mr. PRICE. That is not the question. The question is, because of this bill, there are Americans that have lost the coverage that they want and in fact can't have the coverage that they like.

Dr. BERWICK. Dr. Price, my answer is that there is turnover always in what is available to beneficiaries——

Mr. PRICE. Dr. Berwick, that is not responsive to the question, which is why you see the frustration up here.

Dr. BERWICK. Yes, I know it.

Mr. PRICE. The fact of the matter is, there are millions of Americans who have health care coverage, have had health care coverage, and that coverage is going away because of this law. And that is what they are concerned about. Many of them were out on the lawn of the Capitol over the past 2 years, expressing this frustration. Were they wrong?

Dr. BERWICK. What I am hearing from the beneficiaries is that they have more choices, more options, they are able to find the care——

Mr. PRICE. Dr. Berwick, with all due respect, you are hearing from beneficiaries who are selected by individuals to come and give you a story that is not reflective of the real world. The real word is reflected by the individuals right here who are going home and hearing from their constituents, patients that you and I used to care for, that they are no longer able to get the coverage and the treatment that they desire.

I want to move to quality. Quality is the pivotal issue in this.

Dr. BERWICK. Yes.

Mr. PRICE. And the question is, who is going to decide what quality health care is? Because as you know, treating thousands of patients, what is the right treatment for one patient, even with the same diagnosis, isn't necessarily what is right for another patient,

because patients are unique and it takes those patients and families and doctors together making those decisions.

Do you believe that that is the case?

Dr. BERWICK. Yes, I do sir. The importance of addressing the needs of every single individual patient is at the heart of my——

Mr. PRICE. Who ought to make that final decision about what treatment that patients receives?

Dr. BERWICK. The doctor and the patient.

Mr. PRICE. The doctor and the patient. If I were to tell you that this law violates that principle and that your agency has the power to negate a decision made by a patient and the doctor, would you agree with me?

Dr. BERWICK. No, I would not.

Mr. PRICE. So if we can demonstrate that in fact that is the case, then you will be supportive of us changing this law to make it so that doctors and families and patients are in fact given the right to make that clinical decision; is that correct?

Dr. BERWICK. Dr. Price, I honor the encounter between the doctor and the patient. I also think this law gives us as a country tremendous tools for turning the lights on to understanding the quality of the care that is going on——

Mr. PRICE. Dr. Berwick, I will show you line and verse of this law that I believe removes that, through the Independent Payment Advisory Board, through the Comparative Effectiveness Research Council. There are many who believe that you support rationing and have said that. Do you support rationing of care?

Dr. BERWICK. I abhor rationing. My entire life has been spent fighting rationing. There is no substance whatsoever to the concept that I support rationing.

Mr. PRICE. I appreciate that, because we are going to be able to demonstrate for you how this bill—this bill—provides for rationing of care in this Nation. And I welcome your participation in making certain that it is overturned.

In my brief time left, I want to make certain I get to the physicians who are trying their hardest to take care of patients in this country. Many are concerned about the likelihood that they see coming down the pike that their licensure will be tied to participation in this plan.

Can you state unequivocally that you believe that physicians' licensure in a State to practice medicine ought not be tied to participation in any health care plan?

Dr. BERWICK. Dr. Price, I am not aware of the issue that your question refers to. If you are willing to talk with me afterwards about it, I would be happy to——

Mr. PRICE. Do you believe that physician licensure ought to be tied to physician participation in any plan?

Dr. BERWICK. I don't understand your question, sir, and I apologize for that. I would be happy to talk with you about it afterwards and you can explain it to me.

Mr. PRICE. I look forward to that. Thank you.

Dr. BERWICK. Thank you, Dr. Price.

Chairman CAMP. The gentleman's time has expired. And I will say that, Doctor, you are able to answer in writing at a later time if you so choose to do that.

Chairman CAMP. Mr. Neal is recognized for 5 minutes.

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

Dr. Berwick, first of all, a word of thanks. Your medical DNA is in Massachusetts.

Dr. BERWICK. It is.

Mr. NEAL. What arguably is the Mecca of health care delivery in the country. I think that any State would be envious of the first-class hospitals that we have, including the teaching hospitals which are evenly distributed across the entire Commonwealth. The law that is under assault here this morning has high customer satisfaction across the State. North of 77 or 78 percent of the people are satisfied with the delivery that they have witnessed.

Now the term "actuary" has been thrown around here frequently. Could you succinctly tell us what an actuary does Doctor?

Dr. BERWICK. I regard our actuary as a kind of consultant. He looks at the financial situation of the agency and of the trust funds, and he advises us on what he thinks about them and their future.

Mr. NEAL. Thank you. And let me bring you to the next point. At rotary clubs and chamber of commerce get-togethers and neighborhood events, our friends on the other side are going to be routinely asked, Do you favor a ban on preexisting condition? And I can tell you, the chorus from them is going to be yes. Do you favor a cap on out-of-pocket expenses? Yes. Do you favor keeping children on their parents' health care until they are 26? The answer is going to be yes. Do you offer and support more preventive care? Yes. How about more women's health care? Yes.

Do you favor, based upon the actuarial references they have made today, getting there through the mandate which the insurance industry would say it is the only way that it can be done? How might you respond to that?

Dr. BERWICK. Well, I agree with all of the above. The not having preexisting conditions keep you from getting insurance seems to be only logical. Why would we have a system in which if you need the care, you cannot get the care? That makes no sense at all.

So we want a system in which people can be guaranteed they can get care, even if they don't need it, which is the idea behind this law. You have to have an individual mandate of some form; otherwise the whole thing unravels, because then people who don't need insurance won't buy it until they do need it, and the whole actuarial calculation falls apart. It is simply logic. It is mathematically true. I didn't invent that.

Mr. NEAL. Something that an actuary might assert?

Dr. BERWICK. Absolutely.

Mr. NEAL. Dr. Berwick, would you talk a little bit just in the closing minutes that I have to give you kind of a forum here, would you tell me what you intend to with waste, fraud, and abuse and the cost-saving mechanisms you are putting in place with Medicare in particular?

Dr. BERWICK. Yes. There are actually two parts to that. I have learned a lot since I have arrived. There is more fraud and abuse than I thought. I now can see the data. I also know that we can root it out and find it, and with the tools given us in the Affordable Care Act now and the support of Congress, we will stop the criminals and we will stop the abuse and we will stop the waste. We

are diligent about that. My deputy, Peter Budetti, is doing a great job and the Administration is fully committed to it. And I now understand how important and possible that is.

There is the other area of error which is not the same as waste, fraud, and abuse. There are honest errors. There are errors that get in because of billing and coding systems. We have to work on those also. The President has set a goal of by 2012 reducing the Medicare error rate by half. We are on track. We will do that. And that also will help us have a much more—better stewardship of the public trust in support of a better health care system.

Mr. NEAL. So that number that we have seen of $50 billion annually could be attributed to fraud; is that an accurate number in your estimate?

Dr. BERWICK. It is sometimes misinterpreted to be the number that applies to Medicare. That is not true. That number is a rough estimate of fraud and abuse costs for the American health care system as a whole, which of course affects the private payers and providers as well as the public side of payment. But that is a large number and it seems to be there.

Mr. NEAL. Thank you very much, Doctor.

Chairman CAMP. Thank you. Mr. Buchanan is recognized.

Mr. BUCHANAN. Thank you, Mr. Chairman, for the opportunity for this hearing today. It is very important.

Dr. Berwick, I represent a part of Florida. We have probably more seniors than any other district in the country. We have 155,000 that are on Medicare. I do a lot of town halls. I have got one this Saturday. What comes up with a lot of them is the whole thing on Medicare Advantage. We have 30,000 that have been on Medicare Advantage. I don't know what that number is today. But the general perception in all these places is that they are going to lose their Medicare Advantage.

And you are saying, yet that it is ticking up. I don't see it. I don't hear it. And it is something you have to deal with. You have a heck of a PR problem if you are saying that it is moving the other way.

Dr. BERWICK. Congressman, I agree with you. We have a communication problem. I can tell it from the questions I am getting. People have a lot of misconceptions about Medicare Advantage. It is stronger now than it was before. There are quality measurements now that apply to it. There are bonuses that will be awarded to stronger and more effective Medicare Advantage plans. Enrollment is going up. And I think that the Medicare Advantage plans are seeing the business opportunities and the growth——

Mr. BUCHANAN. I have a couple of other questions.

So you would disagree with Richard Foster, his assessment that millions of Medicare Advantage recipients will lose their coverage? That was something that he said.

Dr. BERWICK. He is making a prediction, sir, and it is his job. What I can see is the facts on the ground. Now, he predicted a decrease in Medicare Advantage this year. It is not going down; it is going up. We are seeing decreases in premiums, a healthier system. So he is doing his best at prediction. But I can see the facts, and the facts are that the system looks stronger every day, and the plans are behaving as if this is a good area to be in because——

Mr. BUCHANAN. Well, give me the facts of how many people have dropped off, how many are adding? Because I would like to see that so I can communicate that back to our district.

He also mentioned two-thirds of hospitals are already losing money under terms of Medicare patients, and the ObamaCare is going to make it much worse, and they are talking about hospitals having to shut down. What is your response to that?

Dr. BERWICK. My response is I meet with the hospital industry all the time now. I regard them as key partners, and we have been working together. They know and I know that the solution for them and for Medicare and for the country is better care, to move the forms of care delivery toward higher and higher quality. That reduces costs. It improves care and it makes them more robust.

I got an e-mail yesterday from Denver Health where they now have documented, through improvement of processes in that hospital, $100 million of savings while making——

Mr. BUCHANAN. Let me get to this last key point. You call the law the Affordable Care Act. But let me just mention to you that I met with a large company in our area, one of the largest employers. His health care cost went up this year, same employees, went up $1.5 million.

Another pharmacist—we went there to talk about issues for small pharmacists and then he hands me on the way—he said Congressman, I just got my bill, it went up 22 percent. I was chairman of the Florida chamber and chairman of our local chambers, I can tell you with small businesses throughout Florida, throughout our region, it is going up 20 percent a year. They are saying, what is this health care bill going to do?

Are you out talking to any people that are in business or create 15, 20 jobs? Everybody is very, very concerned. They don't see the savings. It is, across the board, substantial increases. How do you respond to that?

Dr. BERWICK. All the time I see it, Mr. Buchanan, and that is sort of the point I want to make. It is not the law that is doing that, it is the state of American health care. It is fragmented, it is not paid for correctly. It is a heritage of a system with high levels of lack of coordination, safety problems, infections, injuries to patients——

Mr. BUCHANAN. People see this as just another big entitlement program. They are not seeing where, for a family of four, and a small businesses is going to pay half or 25, they are not seeing any reductions. They don't see anything coming down the road. Is this just another big entitlement program? Is that what we are talking about here?

Dr. BERWICK. I would be happy to meet with them and with you, sir, because the answer lies in the Affordable Care Act——

Mr. BUCHANAN. By the way, I would love to have you come down. It is real nice in February in Sarasota. Come down, meet with our business people and talk to them.

Dr. BERWICK. What I would explain to them is that their interests and the interests of our patients in our Nation lie in making better care, making care get better, and then I can show them, and be happy to talk with you, about the elements of the bill that will

allow us to move the country toward better and better care, safer, more reliable, more streamlined——

Mr. BUCHANAN. One other point. Our cardiologists wrote you a letter. They would love to meet with you. Many of them are concerned about being able to stay in business because of the substantial cuts on Medicare. I am sure you have got a lot of this feedback. What are you doing about it?

Dr. BERWICK. I am meeting regularly with specialty societies and talking with physicians. They, like I, know that if they can work together with us and with the private sector to make health care better, smoother, more streamlined, safer, costs will go down. That makes the system more sustainable and in the end will be the foundation for their incomes to remain where they want them to be.

Chairman CAMP. The gentleman's time has expired. Mr. Smith is recognized.

Mr. SMITH. Thank you, Mr. Chairman. Thank you, Dr. Berwick for being here today.

I do want to touch on an issue. My concerns are that the complexity of health care is compounded with this new legislation, and therefore making it—especially in rural areas, the job of medical professionals even more difficult. The last two annual OPPS rules have included provisions requiring a physician be onsite and available whenever an outpatient procedure is being performed, regardless of its simplicity. I understand CMS takes the position this change is a clarification of existing policy and not a new rule. I also appreciate CMS taking action to suspend its enforcement for the critical access hospitals most impacted by it.

However, the fact is the rule wasn't impacting hospitals until it was restated in 2010, and many of the small towns and hospitals affected don't have enough practitioners to meet the letter of this rule. And actually the people who will suffer, the patients in small community hospitals, but certainly the distance between facilities is very great but this would further compound it.

I will ask in writing, for the record, questions relating to that so we can get some specific responses.

But when you look at this new legislation that is now law, I am concerned that the addition of over 100 new agencies adds to the complexity. Do you see any mechanism in the law that does not actually centralize discretionary authority in these agencies rather than out among the health care professionals across our country?

Dr. BERWICK. Let me go back to your point about the rural hospitals, because they are related. I think it is very important for us to remain mindful of what it is like to give care in every setting around the country and to make that more feasible. That is one of the reasons why we delayed implementation of the physician direct supervision rule while we reconsider those requirements for rural and critical access hospitals. We also included rural hospitals under 100 beds, as you know, as well as critical access hospitals. So I am very sensitive to the issue you are raising.

The more general issue of complexity is of serious concern, and we need to make sure that every step we take in implementing this law is value added, that it makes things easier for patients and beneficiaries——

Mr. SMITH. I mean, of the over 100 new agencies, do they not have some discretionary authority that did not previously exist?

Dr. BERWICK. I am committed to simplification, sir. What I want to have is, no matter how many agencies are involved, I want to make sure that the beneficiaries' needs are addressed and that the doctors and hospitals that you are concerned about are feeling that when Medicare takes an action, it is something that they understand and it is value added and not just bureaucracy. I am thoroughly committed to that. You saw the President's executive order just 2 weeks ago talking about simplifications of regulations and procedures. Medicare is going to be very much a part of that direction of work.

Mr. SMITH. I just want to bring the message that many health care professionals, almost all of them that I talk to, are very nervous about this, about the power of the government increasing and telling them what to do, when to do it, how to do it, not to do it, whatever the case might be.

And I just had a very positive experience at my local hospital relating to a family member in the last few months, where I stood amazed at how great our current system is, and certainly I do not want to jeopardize that.

And I yield back.

Dr. BERWICK. We share that in common, Congressman. Thank you.

Chairman CAMP. Mr. Becerra is recognized.

Mr. BECERRA. Thank you, Mr. Chairman. Dr. Berwick, thank you very much for being here and for all your testimony.

I wouldn't be surprised if anyone is watching, this is somewhat confused. A lot of consumers aren't quite sure they are beginning to reap the benefits of—as my colleague Mr. Neal pointed out, that no longer can an insurance company discriminate against them because of a preexisting condition. All of a sudden they are finding that their recent graduate child from some college, who can't yet find a job, is still able to stay on the health insurance coverage of that parent. So they are beginning to see the benefits, but I don't doubt that some of them are confused, because they hear all of these anecdotal stories or they hear about these projections or they hear about these scare tactics, death panels and all the rest.

But I think you started off your testimony by saying, where we are being told that seniors should be very scared when it comes to HMO Medicare that they are going to lose their insurance coverage, that it is just the opposite.

Can you repeat what the actual numbers show, not the projections or the speculation is?

Dr. BERWICK. The projections were of a decrease in enrollment to Medicare Advantage. This year we are seeing a 6 percent increase in enrollment. There are now, on average, 26 Medicare Advantage plans available in every county in this country on the average. We have made those choices more meaningful. A lot of them need two plans. The nonsense that was there, that there really wasn't any difference, they are gone now. And when a beneficiary looks at their options, they are meaningful options. They can scan down a list of Medicare Advantage plans and pick out and say that

is the one I want, that is the one that meets my needs. Equal choices being exercised, and lower cost.

Mr. BECERRA. I was about to go there. The other scare tactic is seniors in America, be afraid because your costs are going to rise. And those are the scare tactics and the projections. What is the actual result on paper?

Dr. BERWICK. On average, the Medicare Advantage premiums are down 6 percent this year. Now, that is not for every single person. Some people will choose a Medicare Advantage plan where the premium goes up because it has a different benefit structure that they prefer. But the average premium went down this year not up.

Mr. BECERRA. Let me make sure I understand this. Some 3 million beneficiaries under Medicare, close to 3 million seniors, got a $250 tax-free check to help them pay for their prescription drugs if they fell into this doughnut hole.

Dr. BERWICK. Over 3 million if they fell in the doughnut hole in 2010. This year, if they are in the doughnut hole, they will see a 50 percent reduction in the prices, in the cost they are paying for many brand-name drugs.

Mr. BECERRA. Hopefully we will be able to continue to have you come and others testify about what actually is in the bill, not what might be or is projected to be in the bill.

The other thing I wanted to get into—let me make sure I understand this—you are within the Federal Government, as I am, as every one of my colleagues is, so you qualify for the Federal Employee Health Benefit program for your health care.

Dr. BERWICK. I do.

Mr. BECERRA. And everything that I understand from the bill, and having helped push that through and get it enacted and knowing how we are going to try to reduce the costs, one of the things we try to do is give people choices. And as we, you and I, and every one of my colleagues has a choice of plans through the Federal Health Employee Benefit plan, this new law, historic new law, will give a lot of Americans a choice in what plan they decide to select; is that correct?

Dr. BERWICK. Many choices, more meaningful choices.

Mr. BECERRA. And just as Members of Congress and you and other members of the Federal Government receive government support, public support to help pay for the cost of your health care plan, of each of our health care plan, so under this new historic law will Americans get some support, public support—some would say government support—for the cost or the paying of those health care plans.

Dr. BERWICK. That is correct.

Mr. BECERRA. Now, some would say that is a government takeover. And I think I did a quick survey. I think that plan, which is now law as a result of the historic passage of health care reform last year, which now gives Americans those same choices through these options, this marketplace and exchange of options that will be available, and with some Federal subsidies, taxpayer-subsidized assistance, is very similar to what we get, each and every one of the members of this committee get for health care as well. In fact my recollection is the subsidy that Members of Congress, Republican and Democrat, get for their health care under the Federal

Employee Health Care Benefit plan is actually greater than the taxpayer support that will be provided in subsidies for the new law; is that correct?

Dr. BERWICK. I believe so.

Mr. BECERRA. So every time we hear folks talk about government takeover of health care, it is interesting, it is not good enough for the American consumer, but it is okay for Members of Congress to continue to get government-sponsored health care, and it is okay to have the choices there; but to give that to the American people seems like we are not quite hearing the full story. So I hope we will have a chance to hear you more often and talk to us more about the implementation of the legislation. And I thank you for your testimony.

Dr. BERWICK. Thank you, Congressman.

Chairman CAMP. Thank you. Mr. Schock is recognized.

Mr. SCHOCK. Thank you, Mr. Chairman.

Thank you, Dr. Berwick, for being here. I had a real-life story myself this week. I was back on my district work period and I had some time with my father, which is sometimes rare. He is a family physician. And he is a young man. He is 62 and he informed me that he is calling it quits, much to my surprise. Six kids in his family, five of them are doctors, and not a single one of them is convinced this is going to be good for their profession.

And so I guess I challenge you when you suggest that this association or that association or this group or that group supports it. When I go home every weekend, I go home during these district work periods and I run into doctor after doctor after doctor who tells me this is going to be bad for their profession.

Mr. SCHOCK. So I just put that out there as not some statistical fact but a reality check, for me at least, in my district and specifically in my family.

Would you agree that most Americans get their health insurance from their employer—private health insurance, but those who have private health insurance get it from their employer at this point?

Dr. BERWICK. I think it is about 160 million people, yes.

Mr. SCHOCK. Is that most Americans who have private health insurance?

Dr. BERWICK. It is the majority, I think.

Mr. SCHOCK. Okay. Are you aware last year, when this bill first passed, that publicly held companies—specifically, again, coming back home to my home area, Caterpillar Tractor Company, which is in Peoria, other companies like Verizon, John Deere, had to submit to the SEC what one provision would do to their bottom line, specifically the change to the Medicare Part D reimbursements; and for Caterpillar it was a $100 million hit to their bottom line. Are you aware of that?

Dr. BERWICK. I was not, but please go ahead.

Mr. SCHOCK. You were not aware of that.

Dr. BERWICK. No.

Mr. SCHOCK. Well, let me back up. Your assumption is that the bill as it stands, as it has been passed, will lower health care costs for employers in the long term.

Dr. BERWICK. I believe that by improving care in America, which this bill takes a long step toward, care will become more affordable for everybody, not just Medicare, and better.

Mr. SCHOCK. But specifically my question is, since most Americans get their health care coverage from their employer, my constituents are specifically interested, do you believe that the employers' health care that they are paying for will become less expensive?

Dr. BERWICK. The route to that goal, which is my goal, is the improvement of care. And so the improvement of care affects all. We are not going to make a better American health care system—doctors, nurses, hospitals, all of us together—only for Medicare and Medicaid beneficiaries. That would be impossible. So the agenda of making care better, safer, more reliable, smoother, more seamless, that is a benefit to all. And yes, indeed, if successfully executed—and I think that is what our country is headed for now—- altogether, public and private, it will benefit the private side as well as the public side of payment.

Mr. SCHOCK. Well, I find that interesting, because I have heard that a lot when I am in Washington, D.C. But are you aware of any publicly traded company who has to put out for the public their books and for their investors their projections on cost, any publicly traded company who is predicting their health care costs going down over the next 5 years?

Dr. BERWICK. I wouldn't know that, Congressman. What I know is that it is possible to get there, and we are going to be changing that way of thinking over time by making care better. I want to work with the private sector, employers, hospitals, professional societies, those who give care, and health plans altogether, to make care better.

Have you ever seen a patient with a post-operative infection that they didn't need to get? Do you understand what that costs in time and morbidity? Well, that could be a private-paid patient or a public-paid patient. It is still costing money.

So I want to change the game in American health care with my colleagues in the private sector to make that care safer and better. And when we do that, the care will get more affordable. And I am not an accountant or a stockbroker, but I bet you will see companies around this country understand that their health lies in a healthier health care system, which is what we are headed for.

Mr. SCHOCK. Again, at the end of the day I think we are interested in the realities, with all due respect. And the realities are most major companies—and, again, I am not aware of any, you don't seem to be aware of any major employers who are providing health care coverage health insurance premiums going down, nor are there predictions that their health care coverage will be going down.

I have one final question since my time is about to expire. And it is with regard to, you are aware of the two Federal courts that have now ruled that individual mandate portion of the health law unconstitutional.

Dr. BERWICK. Two have held one way, two the other.

Mr. SCHOCK. Okay. I am curious, if the administration is required by the justice system to stop implementing this law, how you plan to comply with that.

Dr. BERWICK. You will have to speak with my colleagues in the Department of Justice and others more qualified than I to answer that question. Right now, my job is to forge ahead and try to make American health care improve, protect the beneficiaries, and implement the provisions of the law unless and until I am told otherwise.

Mr. SCHOCK. Have there been any discussions in the Department relative to that?

Chairman CAMP. The gentleman's time has expired.

Mr. Doggett is recognized. Time is very short, and we are trying to get everybody in.

Mr. DOGGETT. Thank you, Mr. Chairman.

Dr. Berwick, thank you for your distinguished service and your candor this morning.

We know that an earlier generation of Republicans fought Lyndon Johnson in getting Medicare created in the first place with the same fervor that our Republican colleagues are fighting health insurance reform today. We know that Newt Gingrich was determined to let Medicare wither on the vine and had the support of some of the Republicans who continue to serve on this committee. And now they have laid out a roadmap—you have discussed it with Dr. McDermott—where their ultimate goal is to move seniors to the uncertainty of vouchers, away from the guarantees that Lyndon Johnson signed into law in Medicare, and to shift responsibility to seniors to meet their health care needs, to fend for themselves with private insurance companies to provide for their needs.

That is the longer-term goal. But in the short-term goal, it has become increasingly apparent when you cut through all of their repeal rhetoric that what they are really presenting to seniors and individuals with disabilities is a plan to increase the cost of their health care.

I would like to go through and itemize how this Republican plan will increase the cost of health care for seniors and individuals with disabilities who rely on Medicare.

Under existing law that you administer today, if a senior needs a mammogram, colorectal cancer screening, bone mass measurement, will they have to make any copay?

Dr. BERWICK. Not as we implement the law.

Mr. DOGGETT. And so if we repeal that guarantee of no copayment, seniors will have to pay more for those services. Their health care costs under the Republican plan will increase, will they not?

Dr. BERWICK. For those services, yes.

Mr. DOGGETT. Let's discuss the effect of seniors and the increased costs that Republicans want to impose on them right now with the bill that they have already passed with reference to prescription drugs. The best estimate I have seen through the Assistant Secretary for Planning and Valuation—and I would ask you about this—is that the average individual who would reach this donut hole gap in coverage—a gap in coverage created by the Republicans with their prescription drug plan a few years back—when they reach that gap today in 2011, each of those people on

average will get a little over $500 in benefits under existing law, total benefits to Medicare beneficiaries of about $2 billion in savings this year under the law. Does that sound about right?

Dr. BERWICK. That is correct. And when we get to 2019 or 2020——

Mr. DOGGETT. And so what the Republicans are proposing in repealing that law is to hike the cost for prescription drugs to seniors in America this year by over $2 billion, over $500 apiece for those who enter the prescription drug gap.

You have discussed this with Mr. Lewis, but do you have a mechanism under their increased health care bill to demand of seniors that they give back the $250 that we gave them through this bill last year for prescription drugs—about 3 million people you said.

Dr. BERWICK. Yes, over 3 million. I hope we don't have to——

Mr. DOGGETT. Is there any mechanism there? Because I assume under their repeal bill we are going to be asking seniors not only to pay more this year but to give back the $250 that they received if they reached that gap last year.

Now what about on the issue of the Part B premium that we asked seniors and individuals with disabilities to pay? Under existing law, according to all the estimates you have seen, won't those premiums be lower than if we adopt the Republican higher senior cost bill? Won't those seniors have to pay more for the Part B premium if Republicans are successful in their attack on Medicare?

Dr. BERWICK. Yes, I believe they would.

Mr. DOGGETT. And with reference to Mr. Camp's assertion that some Part D premiums could go up for seniors, that is true only to the extent that they get more coverage under this bill; isn't that true?

Dr. BERWICK. Yes, they have a selection.

Mr. DOGGETT. And any increase is really fairly modest.

And finally, with reference to the "Medi-scare" argument, that seniors are going to lose the ability to select their own doctor, there are actually incentives under the law that they want to repeal to pay your primary care doctors more under Medicare than they have received at any time in the history of Medicare, isn't that right?

Dr. BERWICK. That is correct.

Mr. DOGGETT. And that ought to give seniors not only lower health care costs but more choice than they have ever enjoyed in the history of Medicare, don't you agree?

Dr. BERWICK. I agree.

Mr. DOGGETT. Thank you very much for your service and for your candid answers. I hope that we can work together to ensure that this Republican plan to eventually privatize Medicare through a voucher system, but in the meantime, this year, the hike cost to every senior and individual with disabilities who relies on the Medicare system, that that plan—they can call it repeal, they can call it an attack on President Obama, whatever they want to, but we have to stop this Republican plan to increase seniors' cost.

Thank you.

Chairman CAMP. Thank you.

Ms. Jenkins is recognized.

Ms. JENKINS. Thank you, Mr. Chairman; and thank you, Dr. Berwick, for being here.

As you all know, the Independent Payment Advisory Board, the IPAB, created under the new health care law is charged to determine whether Medicare is spending more than is budgeted and, if so, to offer fixes to cut back on Medicare spending that are then fast tracked with very little opportunity for congressional input. While I have numerous concerns with this board—including the 15 unelected bureaucrats who will serve on it and the lack of congressional oversight and approval of their recommendations—I am also concerned as to whether rural issues will be addressed and protected by it.

Currently, most hospitals were granted a 10-year exemption from any changes proposed by this board, but critical-access hospitals were not included in that exemption. Kansas has one of the largest number of critical-access hospitals in the country, and any further cuts or payments could determine whether they keep their doors open.

Can you please just speak to us on this issue and further challenges that rural Medicare patients have accessing care and whether or not they will be protected by this board?

Dr. BERWICK. Well, the board, as you know, does not lie within CMS. It is independent. The President supports the Independent Payment Advisory Board, and I support the Administration.

With respect to rural health care, my commitment could not be stronger, Congresswoman. I care deeply about that sector. It is crucial to Americans. It is crucial to the health of our system as a whole. Indeed, some of the best care I have ever seen in the country emerges in the rural sectors, and I think that gives us an opportunity to learn from them and spread ideas elsewhere.

That is one of the reasons why I did suspend enforcement of the physician supervision rule in the critical access and rural hospitals that I was asked about before. I want to make sure that we don't do anything that impedes not just good care but fabulous care in the rural settings. I am committed to that.

The Affordable Care Act gives us a chance to understand more about the input costs in rural hospitals. We will be looking carefully at that. But it is a sector I care a lot about, and I look forward to working with you to make it a healthier and healthier part of our health care system.

Ms. JENKINS. Are you willing to work with the administration to give the critical-access hospitals the same exemption?

Dr. BERWICK. I am happy to talk with you further about that, Congresswoman. It is not an issue that I know in any detail.

Ms. JENKINS. Okay. And I just wanted to follow up on my colleague from Illinois and his discussion about what the Supreme Court could be asked to do.

I visited with many small businesses and large businesses in my district in Kansas, and many of them are investing a tremendous amount of money in implementing a law which one of the cornerstones is the individual mandate. And I am just curious, do you think it really is in the best interest of the American people for us to continue to implement this law, spending a whole lot of taxpayer dollars before we have a final judgment?

Dr. BERWICK. Congresswoman, I am not a lawyer. I can't deal with the legal aspects of that. I will take counsel from the members of the administration that are there to help me understand what to do.

I think the Affordable Care Act is good for America, and my job right now is to make sure that that goes as well as it possibly can. That is what I am committed to do every single day, make care better for our beneficiaries, and I will continue to do that.

Ms. JENKINS. Do you have any idea what the price tag is that business is having to spend that will be lost should the individual mandate be overturned?

Dr. BERWICK. Business is a key stakeholder in the American health care system, and those costs are not sustainable now. Businessmen can tell you that as well as our beneficiaries can. We have to solve that problem. The Affordable Care Act gives us a chance to build an American health care system that will thrive, that is sustainable, that is higher quality and lower cost. That is where the interests of our public investment in health care law is, and that is where the interests of businesses lie. That is what I am keeping my eye on right now, better care for everyone and lower cost through improvement.

Ms. JENKINS. So you have no idea how much will be lost in the economy because of businesses——

Dr. BERWICK. I have a better idea of what will be lost in our economy if we don't get American health care on track. It ought to be going toward better care through care redesign and better services to patients, safer care, better care.

Ms. JENKINS. Do you have any idea what the cost to CMS will be? How much will be spent that will be lost should the individual mandate be found unconstitutional?

Dr. BERWICK. I don't have a particular number there, no, Congresswoman.

Ms. JENKINS. No. Okay.

How do you suggest that we might recoup any of the loss that you do incur should that happen?

Dr. BERWICK. Why don't we address that downstream? I hope this law survives. It is a great law, and I look forward to being able to continue to implement it.

Ms. JENKINS. So you don't have any plan to recoup the costs?

Dr. BERWICK. I go to work to try to make care better for beneficiaries, Congresswoman. That is my job, and that is what I am doing right now.

Chairman CAMP. Time has expired.

Mr. Thompson is recognized.

Mr. THOMPSON. Thank you, Mr. Chairman.

Dr. Berwick, thank you very much for being here and for your excellent testimony.

I agree with one of the previous speakers who said anyone watching this is probably wondering what in the world could possibly be going on; and some probably even think it is Democrats versus Republicans, a partisan deal here. So I would like to just add in a couple of comments that I have that have been made by advocacy groups for seniors.

This committee hearing is on Medicare and the effect on seniors, and the same groups that work hard to make sure seniors have access to good quality health care have spoken out on this.

Families USA said Medicare's benefits are improved under the Affordable Care Act.

The Center for Medicare Advocacy said Medicare reforms included in the Affordable Care Act do not reduce Medicare's guaranteed benefits, they improve Medicare and help safeguard the Medicare Trust Fund.

The Alliance for Retired Americans says that this measure strengthens the Medicare program, provides protections to millions of Americans against insurance company abuses, makes prescription drugs more affordable, and provides prevention and wellness screenings as well, which will enhance the quality of life for our Nation's seniors.

The Leadership Council of Aging Organizations said that millions of Americans have already benefited because of this bill and that the economic and physical health of seniors and their families will continue to benefit as the law is implemented further.

Do you agree with that, Dr. Berwick?

Dr. BERWICK. I agree with all of those, yes.

Mr. THOMPSON. Let me ask you, in my little district in northern California, what would happen to the 10,300 seniors in my district who hit Part D donut hole if my Republican friends are successful in repealing this health care legislation?

Dr. BERWICK. I assume many of them would have to choose between medicines and other things that they want in their lives. I have seen seniors that have to choose between medicine and food. I have met seniors who can't afford their medicine, stop taking it, and face the consequences of doing that, stopping their anticoagulants, stopping their blood pressure medicine, having their diabetes get worse because they can't afford to control it; and they are scared.

Mr. THOMPSON. And you may have answered this question before. I apologize. I had competing hearings this morning. But those same seniors, what would happen with the $250 check that they received to help pay for their medicines during the time they are in the donut hole? Would they have to send that $250 back?

Dr. BERWICK. I believe we are looking at that issue right now just to make sure we understand what would have to happen, and I do not have an answer yet. I fear that might be the case. I don't even want to think about it if I don't have to.

Mr. THOMPSON. Mr. Doggett mentioned that primary care doctors get an incentive to be able to provide the health care that we all know has been lacking and helped lead to the situation where health care in our country was unsustainable. I think it is also important to note that rural doctors also get an increase in their reimbursement rates. In my area, and in any rural area in the country, this is a huge, huge issue as to how we attract doctors to provide health care for the many, many seniors that live in rural areas.

And I just can't emphasize enough how important preventive health care is. Not only is it good for individuals who receive it, but it saves so much money, so many health care dollars when you can

detect a problem early on and fix it. What would happen to the 110,000 Medicare beneficiaries in my district who right now, today, under the law that we passed, receive free preventive services and free annual wellness exams? Would they lose this under the Republicans bill?

Dr. BERWICK. They would have higher copayments if they want it, and some of them would avoid it. We now know, due to good science and research, that a colonoscopy allows detection of colon cancer at early stages. It saves lives. It keeps you from dying of colon cancer because we find the colon cancer earlier. So there are beneficiaries in your district who wouldn't have a colonoscopy because they couldn't afford it if this law is withdrawn, their cancers will advance, they will die of colon cancer, and their lives would otherwise have been saved.

Mr. THOMPSON. Thank you.

And one final question, Doctor. If our Republican friends are successful in repealing this legislation and passing their bill, what would happen to the solvency of the Medicare program?

Dr. BERWICK. According to the Medicare Trustees Report from the Actuary, the Medicare Trust Fund life is extended from 2017 to 2029, 12 years of extension of Medicare.

Mr. THOMPSON. So Medicare would be shortened.

Chairman CAMP. Thank you. The gentleman's time has expired.

I appreciate Dr. Berwick for extending in time here. We will have one more person, questions, and then what we will do is recess for 5 minutes, and then we will reconvene for a second panel.

So Mr. Paulson is recognized for 5 minutes.

Mr. PAULSEN. Thank you, Mr. Chairman and Dr. Berwick.

The issue of geographic disparities in Medicare payment is a long-standing problem that has resulted in unfair low payments to health care providers in Minnesota and other high-quality, low-cost States. In fact, well-documented studies show that a variation of Medicare payments are not tied to quality and efficiency. But, for example, the Dartmouth Atlas of Health Care puts Minnesota in the bottom quintile of per-enrollee Medicare payments, yet on measures that indicate high quality of care, like avoiding hospitalizations for conditions that can be treated and handled in a different setting that is more appropriate for care for patients with chronic conditions, et cetera, Minnesota ranks really highly.

How will this new health care law ensure that the Medicare beneficiaries in my district or in Minnesota, these high-quality, low-cost States, are going to have the same access to services as those in other parts of the country?

Dr. BERWICK. Congressman, I know this issue very well, and it is a very important one to make sure that payment is fair and adequate and that geographic variation and costs are well respected in the payment system.

Under the Affordable Care Act, there are actually three different processes under way right now. An Institute of Medicine study on input costs for geographic areas that will be due back to us in May or June—and probably in enough time to map that into payment rules for 2012. The Secretary has been required by the law to have a study of geographic variation and costs for hospitals that will be due at the end of the year, also available for use in 2012. And there

is a really important longer term Institute of Medicine study underway now on geographic variation in Medicare as a whole, cost and quality variation. Based on this information, I think we will be able to craft much more rational regulation and policy to help make sure that payment is fair and equitable and respects the variation in costs and outcomes in different areas.

Mr. PAULSEN. And, Dr. Berwick, I think this is essential to actually get to the crux of the problem. This has been an ongoing issue, and my physician community has certainly talked about it for a long period of time.

Let me ask this, too. One of the fundamental shortcomings I believe of the health care law as well is the failure to recognize that in some States like Minnesota we have a pretty low uninsured rate and a well-functioning marketplace, that costs could rise in the presence of unnecessary and unwarranted regulation from now the Federal Government. For example, the new State exchanges are likely to require new levels of certification of health plans, essential benefit offerings, and even network adequacy standards. These activities are now currently overseen by our Department of Commerce. Why do we need Washington or the Federal Government to ensure that Minnesota's Department of Commerce is acting appropriately right now?

Dr. BERWICK. I would be happy to talk with you afterwards, Congressman, about the various kinds of administrative costs you are talking about. We do, under the law, have the opportunity now to help States set up enrollment systems which are new and crafted for the enrollment processes that appear under the law through exchanges, integrating exchange and Medicaid enrollment, for example. You know, there is a 90–10 Federal match for that, 90 cents out of every dollar that States have put into that kind of administrative process will come from the Federal Government. So I would be happy to talk with you further if you would like about the concerns you have about those administrative procedures.

Mr. PAULSEN. And I actually would be interested in that because I want to make sure that the new law does not provide any additional layers of regulation that would stifle, I guess, innovation and raise costs.

And I will give you another example, too. I have heard that there is something like 250,000 pages of additional regulations that are going to come out of this law. That is certainly going to be a challenge if it is a heavily bureaucratic load that is put from a top-down perspective down on our providers in an already very tangled and unwieldy behemoth of health care regulation that is out there right now, and I hear that from my providers on a regular basis.

Dr. BERWICK. Yes, sir. I would be concerned as you are.

Let me make it clear. My attitude, from my view as administrator, is a partnership with providers and States; and making things harder for them isn't a good idea. I am interested in my job of making sure the Federal Treasury Funds are protected and beneficiaries are protected, but I think we can do that in partnership. And if you are concerned about regulatory burden, I am, too; and we should talk about it.

Mr. PAULSEN. Thank you, Dr. Berwick.

I just want to follow up one more time on this Medicare Advantage issue because it has been forecasted that about $200 billion out of the Medicare Advantage program is going to be cut or overhauled; and that is going to be, according to our next witness, Mr. Foster, who is coming forward, about a 50 percent reduction in enrollment.

When I travel around my district and around Minnesota, it is very clear that seniors enrolled in Medicare Advantage are worried about losing benefits or the Medicare Advantage options altogether. For the past year, the administration has been trying to reassure seniors that nothing is going to change, but I don't believe that is the case. You talked about the 6 percent rise in Medicare Advantage for 2011. Obviously, a lot of provisions of the law have not been phased in, but let me just ask you this: I am worried we are going to go back to the days when seniors in Minnesota, for instance, don't have the same options as seniors in Miami or in New York City. Do you agree that Minnesota seniors should have the same Medicare options as seniors in Miami or in New York City or around the country?

Dr. BERWICK. I think they should have robust options, as beneficiaries all over the country should; and I think they are getting them with the improvements that we are seeing in the Medicare Advantage system right now. I don't want your seniors to be worried. The Medicare Advantage program is stronger for them, it is more available to them, and the choices are more meaningful now, and they need to know that. And, yes, I am committed to their options.

Mr. PAULSEN. Thank you.

Chairman CAMP. Thank you. The gentleman's time has expired.

Thank you, Dr. Berwick, for being here today and for your testimony. Thank you for extending the time before the committee and accommodating as many members as possible. You can see by the member participation that the issues before your department are of great importance to the people we represent and to America's seniors. So thank you for your testimony about the effects of implementation of this health care law.

If members would like to, they can submit in writing to you any questions and you can be happy to respond.

Yes, the gentlewoman from Nevada.

Ms. BERKLEY. Thank you for recognizing me.

Do you think in the future we might be able to make this a little more equitable? Perhaps if those sitting in the more expensive seats had 4 minutes to question, those of us in the cheap seats might have had an opportunity to question the witness. I was very patient and very anxious to do that.

Chairman CAMP. What we will do is, on the second panel, we will start with where we left off. Dr. Berwick had limited time. Many times our witnesses come without time limit. Dr. Berwick had a time limit, as does happen on occasion.

Ms. BERKLEY. This has happened a few times; and, frankly, it was Mr. Berwick that I wanted to question.

Chairman CAMP. All right. Thank you.

Yes, Doctor.

Dr. BERWICK. Mr. Chairman, first, I want to thank you for having me here. I enjoyed it, and I really welcome a chance to join you any time. And with respect to any members who would like to meet with me personally, that is an open door. I will be happy to do that at any point.

Chairman CAMP. Maybe that is something that can be arranged. Thank you.

The committee will stand in recess until 12:30.

[Recess.]

Chairman CAMP. The committee will reconvene for our second panel; and I want to welcome Richard S. Foster, the Chief Actuary for the Centers for Medicare & Medicaid Services.

Since 1995, Mr. Foster has been Chief Actuary for the Centers for Medicare & Medicaid Services. He is responsible for all the actuarial and other financial analyses for the Medicare and Medicaid programs.

Previously, he served as Deputy Chief Actuary for the Social Security Administration for 13 years. He is a fellow of the Society of Actuaries and a member of the American Academy of Actuaries, American Statistical Association, American Economic Association, National Academy of Social Insurance, and Senior Executives Association. Welcome to the committee.

Mr. Foster, you will have 5 minutes to give us your testimony. Your full written statement will be made part of the record. Welcome to the Ways and Means Committee. You have 5 minutes.

STATEMENT OF RICHARD S. FOSTER, CHIEF ACTUARY, CENTERS FOR MEDICARE & MEDICAID SERVICES

Mr. FOSTER. Thank you, Chairman Camp, Representative Levin, and distinguished Members of the Committee. Thank you for inviting me to testify today about the impact of the Affordable Care Act on the Medicare program and its beneficiaries.

The Office of the Actuary and CMS provides actuarial, economic, and other technical assistance to policymakers in both the administration and in Congress; and we do so on an independent, objective, and nonpartisan basis. We have performed this role throughout the last 45 years, since enactment of Medicare and Medicaid.

I am accompanied today by Suzanne Codespote, ASA, who is the Deputy Director of our Medicare and Medicaid Cost Estimates Group, and also by my special assistant, Cathy Curtis, Ph.D. My statements are my own and do not necessarily represent an official position of the Department of Health and Human Services.

Considerably more information about the financial status of Medicare and the impact of the Affordable Care Act on the program is available in my written testimony, in my April 22 memorandum on the Affordable Care Act, and of course in the 2010 Medicare Trustees Report.

The Affordable Care Act has numerous provisions affecting Medicare and its financial operations. We estimate in the first 10 years, 2010 through 2019, that the Act would result in Medicare savings that total $575 billion over this period. Most of that is in the form of lower expenditures, about $486 billion. Those lower expenditures, as of 2019, represent a reduction of 11 percent in expendi-

tures for Medicare compared to what would have happened under the old law.

Now the magnitude of the reduction continues to increase over time. We estimate by 2030 that the reduction in expenditures will be 20 percent; in 2050, 32 percent; and in 2080, 43 percent. The Act is estimated to reduce the long-range Hospital Insurance Actuarial Deficit by four-fifths. It is also estimated, as we have heard, to postpone the exhaustion of the HI trust fund by 12 years, using the 2010 Trustee's report baseline.

I note that the HI savings under the Affordable Care Act cannot directly be used to both offset the cost of the coverage expansions in the health reform act and at the same time to pay for future HI benefits. There are budget and trust fund accounting conventions that result in both these conclusions, and we can discuss this issue further if it would be helpful.

As most of you know, I have had some concerns about one particular provision of the Affordable Care Act which has to do with reducing the payment updates, the annual payment updates for most categories of Medicare providers, other than physicians, by the increase in economy-wide productivity. Now these lower payment updates will provide a strong incentive for hospitals and other providers to be as efficient as possible, but it is doubtful that many providers, other than physicians, can improve productivity to match economy-wide levels. Possible consequences are that the payment rates for the affected providers will grow at about 1.1 percent slower than the increase in those providers' input prices, in other words, the input prices they have to pay for wages, office space, energy supplies, things like that. So unless providers can improve their productivity or make efficiency gains otherwise, over time the payment rates will become inadequate to cover input costs. If that happens, and absent legislation to do anything about it, then providers might have to end participation in Medicare, and that leads to possible issues with access to care for Medicare beneficiaries.

Now, more likely, Congress would act to override the productivity adjustments if this occurs, as you had to do many times with the physician payment system under current law; and, if so, then that implies that the actual future costs for Medicare would be quite a bit higher than we have projected under current law.

To help illustrate the possible understatement of the current law cost projections, the trustees use an illustrative alternative to current law and show a projection based on that.

[The statement of Richard S. Foster follows:]

This Testimony is Embargoed until 10:00 AM on February 10th 2011

The Estimated Effects of the Affordable Care Act on Medicare

Testimony before the
House Committee on Ways and Means
February 10, 2011

by

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

Chairman Camp, Representative Levin, distinguished Committee members, thank you for inviting me to testify today about the financial and other impacts on the Medicare program from the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.

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

I am appearing before your Committee today in my role as an independent technical advisor to Congress. My statements, estimates, and other information provided in this testimony are my own and do not represent an official position of the Department of Health & Human Services or the Administration. Unless noted otherwise, the estimates used in this testimony are drawn from my memorandum of April 22, 2010, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," and from *The 2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. These reports and the other documents to which I refer are available on the CMS website at http://www.cms.gov/ActuarialStudies/. We are in the process of updating many of these estimates for use in the President's 2012 Budget, the 2011 Medicare Trustees Report, and a forthcoming article on national health expenditure projections. Although some of the updates will be significant, they will not substantially change the overall outlook for the effects of the health reform act on Medicare as described in this testimony.

Affordable Care Act

The March 2010 health care reform legislation, generally known as the Affordable Care Act, affects nearly every aspect of health care in the U.S. As noted in my April 22, 2010 memorandum, the Affordable Care Act will significantly increase the proportion of people in the U.S. with health insurance by expanding eligibility for Medicaid and by implementing Federal premium and cost-sharing subsidies for individuals and families with incomes below 400 percent of the Federal Poverty Limit. Many of the Act's provisions apply to the Medicare program,

resulting in lower costs and additional revenues. As part of the changes expected to have a significant financial effect on Medicare, the Act:

- Reduces "market basket" payment updates by varying amounts by type of provider during 2010-2019 and permanently reduces the annual Medicare payment updates for most categories of providers by the increase in economy-wide multifactor productivity (approximately 1.1 percent per year).
- Reduces Medicare Advantage payment benchmarks and rebate percentages, varies rebate percentages and plan bonuses by plan quality ratings, and permanently extends the authority to adjust for coding intensity.
- Reduces Medicare disproportionate share hospital (DSH) payments, refines imaging payments, expands competitive bidding for durable medical equipment, and eliminates the 2014 spending authority for the Medicare Improvement Fund.
- Creates an Independent Payment Advisory Board together with Medicare expenditure growth rate targets for the purpose of slowing Medicare cost growth. The Board's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings over a 10-year period.
- Increases payment rates for rural providers.
- Increases the HI payroll tax rate by 0.9 percentage point for individuals with earnings above $200,000 and families above $250,000 and raises Part D premiums for single enrollees with incomes above $85,000 and couples above $170,000. Freezes income thresholds for Part B and Part D income-related premiums at 2010 levels through 2019.
- Phases out the Part D coverage gap ("donut hole") and reduces payment rates for Part B and Part D biosimilar generic drugs.
- Initiates numerous steps to improve the quality of Medicare services, including reporting of physician quality measures, reducing payments in cases of hospital-acquired infections, reducing payments for hospital readmissions, and implementing evidence-based coverage of preventive services.
- Adds certain new preventive health services, including coverage of an annual wellness visit, and eliminates remaining cost-sharing requirements on most preventive services.
- Expands existing programs and adds new ones to combat fraud and abuse in Medicare.
- Creates a Center for Medicare and Medicaid Innovation in CMS for testing alternative models of health care delivery systems, payment methods, etc. and establishes a Medicare Shared Savings Program for accountable care organizations (ACOs). In addition, begins (or extends funding for) a series of demonstrations and pilot programs designed to evaluate specified payment methodologies and incentives and implements additional value-based purchasing programs.

Estimated impacts of Affordable Care Act on Federal expenditures and total national health expenditures

It is useful to consider the financial effects of the Affordable Care Act on Medicare in the context of the Act's overall impacts on the Federal Budget and on total national health expenditures. There has been some confusion in the press and elsewhere regarding these two

sets of results. The legislation is estimated to substantially increase gross Federal expenditures in support of expanded health care coverage (approximately $948 billion total in fiscal years 2010-2019), with about half of this cost offset by lower Medicare expenditures ($486 billion). The net increase in Federal health expenditures is thus about $462 billion over the period, with this budgetary cost offset by other provisions such as the penalties from nonparticipating employers and individuals plus additional Medicare and other revenues.

The budgetary impacts described above are similar in some ways to the effect of the Affordable Care Act on total health expenditures in the U.S., but the two concepts are fundamentally different. For example, in certain instances the Act increases the share of existing Medicaid expenditures paid by the Federal government. These changes will raise Federal spending on health care but have little or no impact on overall national health expenditures. Conversely, the excise tax on high-cost employer health insurance plans is expected to reduce total health expenditures in 2018 and later, with minimal impact on Federal health expenditures. Both financial measures are useful and legitimate for their intended purposes, but one cannot be used to answer questions related to the other. The balance of this section describes the Federal budget and national health expenditure impacts in more detail.

As shown in my April 22, 2010 memorandum, the Affordable Care Act is estimated to reduce the number of uninsured persons in the U.S. by 34 million in 2019. The following table summarizes the estimated financial effects of selected provisions of the Affordable Care Act on the Federal Budget in fiscal years 2010-2019.

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

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

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

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

† Includes Federal costs for coverage expansion through expanded Medicaid eligibility, additional funding for CHIP, tax credits for small employers who offer coverage, and premium and cost-sharing subsidies for private health insurance coverage through Exchange policies, less Federal receipts from penalties for large employers who do not offer coverage and for affected individuals who do not obtain health insurance coverage.

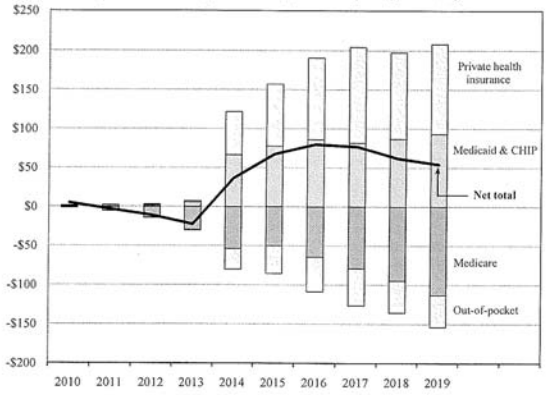
‡ Includes estimated non-Medicare Federal savings from provisions for comparative effectiveness research, prevention and wellness, fraud and abuse, and administrative simplification. Excludes impacts of other provisions that would affect cost growth rates, such as the productivity adjustments to Medicare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

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

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

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

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



The net total increase in NHE reflects several large—and largely offsetting—effects on expenditures by private health insurance, Medicare, Medicaid, and individuals' own out-of-pocket costs, as shown by the columns in the chart above. Health expenditures are expected to increase by about $200 billion annually due to the substantial expansions of coverage under the Affordable Care Act. Numerous studies have demonstrated that individuals and families with health insurance use more health services than otherwise-similar persons without insurance. Under the health reform legislation, by 2019 an estimated 34 million currently uninsured people would gain comprehensive coverage through the health insurance Exchanges, their employers, or Medicaid. The availability of coverage would typically result in a fairly substantial increase in the utilization of health care services, with a corresponding impact on total health expenditures. These higher costs would be partially offset by the sizable discounts imposed on providers by State Medicaid payment rules and by the significant discounts negotiated by private health insurance plans. We estimate that the net effect of the utilization increases and price reductions arising from the coverage provisions of the Affordable Care Act would increase NHE in 2019 by about 3.4 percent.

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

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

Estimated impact of Affordable Care Act on Medicare expenditures and revenues

As indicated above, net Medicare savings are estimated to total $575 billion for fiscal years 2010-2019. Substantial savings are attributable to the provisions that would reduce Part A and Part B payment levels and reduce future "market basket" payment updates by the increase in economy-wide multifactor productivity ($233 billion); eliminate the 2014 spending authorization for the Medicare Improvement Fund ($27 billion); reduce DSH payments ($50 billion); reduce Medicare Advantage payment benchmarks and permanently extend the authority to adjust for coding intensity ($145 billion); freeze the income thresholds for the Part B income-related premium for 9 years ($8 billion); implement an Independent Payment Advisory Board together with strict Medicare expenditure growth rate targets ($24 billion); and increase the HI payroll tax rate by 0.9 percentage point for individuals with earnings above $200,000 and families above

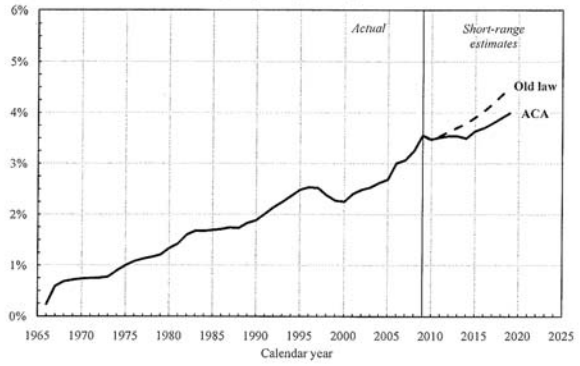
$250,000 ($63 billion). Other provisions would generate relatively smaller amounts of savings, through such means as reporting physician quality measures, reducing payments in cases involving hospital-acquired infections, reducing readmissions, refining imaging payments, increasing Part D premiums for higher-income beneficiaries, and implementing evidence-based coverage of preventive services.

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

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

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

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



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

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

It is important to note that the estimated savings for one category of Medicare provisions may be unrealistic. The Affordable Care Act requires permanent annual productivity adjustments to price updates for most providers (such as hospitals, skilled nursing facilities, and home health agencies), using a 10-year moving average of economy-wide private, non-farm productivity gains. While such payment update reductions will create a strong incentive for providers to maximize efficiency, it is doubtful that many will be able to improve their own productivity to the degree achieved by the economy at large.[1]

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

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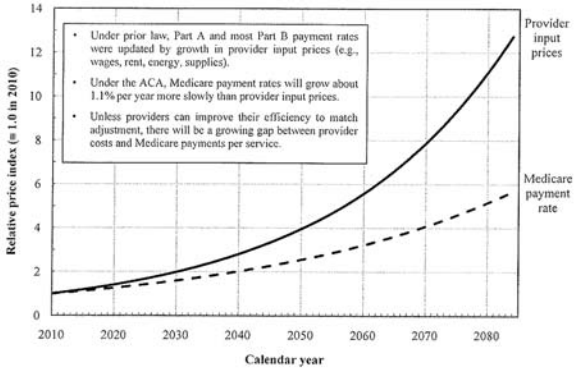
[1] The provision of most health services tends to be very labor-intensive. Economy-wide productivity gains reflect relatively modest improvements in the service sector together with much larger improvements in manufacturing. Except in the case of physician services, I am not aware of any empirical evidence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

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



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

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

> The Affordable Care Act improves the financial outlook for Medicare substantially. However, the effects of some of the new law's provisions on Medicare are not known at this time, with the result that the projections are much more uncertain than normal, especially in the longer-range future. For example, the ACA initiative for aggressive research and development has the potential

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

to reduce Medicare costs in the future; however, as specific reforms have not yet been designed, tested, or evaluated, their ability to reduce costs cannot be estimated at this time, and thus no specific savings have been reflected in this report for the initiative.

Another important example involves lower payment rate updates to most categories of Medicare providers in 2011 and later. These updates will be adjusted downward by the increase in productivity experienced in the economy overall. Since the provision of health services tends to be labor-intensive and is often customized to match individuals' specific needs, most categories of health providers have not been able to improve their productivity to the same extent as the economy at large. Over time, the productivity adjustments mean that the prices paid for health services by Medicare will grow about 1.1 percent per year more slowly than the increase in prices that providers must pay to purchase the goods and services they use to provide health care services. Unless providers could reduce their cost per service correspondingly, through productivity improvements or other steps, they would eventually become unwilling or unable to treat Medicare beneficiaries.

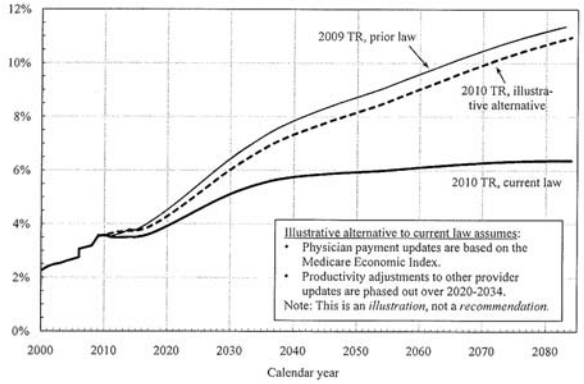
It is possible that providers can improve their productivity, reduce wasteful expenditures, and take other steps to keep their cost growth within the bounds imposed by the Medicare price limitations. Similarly, the implementation of payment and delivery system reforms, facilitated by the ACA research and development program, could help constrain cost growth to a level consistent with the lower Medicare payments. These outcomes are far from certain, however. Many experts doubt the feasibility of such sustained improvements and anticipate that over time the Medicare price constraints would become unworkable and that Congress would likely override them, much as they have done to prevent the reductions in physician payment rates otherwise required by the sustainable growth rate formula in current law.

The annual report to Congress on the financial status of Medicare must be based on current law. In this report, the productivity adjustments are assumed to occur in all future years, as required by the Affordable Care Act. In addition, reductions in Medicare payment rates for physician services, totaling 30 percent over the next 3 years, are assumed to be implemented as required under current law, despite the virtual certainty that Congress will continue to override these latter reductions.

In view of the factors described above, it is important to note that the actual future costs for Medicare are likely to exceed those shown by the current-law projections in this report. We recommend that the projections be interpreted as an illustration of the very favorable financial outcomes that would be experienced if the productivity adjustments can be sustained in the long range—and we caution readers to recognize the great uncertainty associated with achieving this outcome. Where possible, we illustrate the potential understatement of Medicare costs and projection results by reference to an alternative projection that assumes—for purposes of illustration only—that the physician fee reductions are overridden and that the productivity adjustments are gradually phased out over the 15 years starting in 2020.

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

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



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

Estimated effects of Affordable Care Act on out-of-pocket payments by Medicare beneficiaries

In addition to the effects of the Affordable Care Act on Medicare expenditures and revenues, it is useful to assess its financial and other impacts on beneficiaries. The Act expands coverage, primarily by adding certain preventive services, eliminating cost-sharing requirements for most preventive services that still had such requirements, and phasing out the Part D coverage gap (or "donut hole"). The legislation also has the potential to improve the quality and cost-efficiency of care through the design, testing, evaluation, and nationwide implementation of innovative new

health care delivery systems and payment methods. The ultimate effect of these innovations cannot be determined at this time but will become clearer as specific ideas are tested.

Somewhat similarly, the potential for Medicare payment rates to become inadequate, with adverse consequences for beneficiary access to care, cannot be determined at this time. Careful monitoring of payment levels by CMS and the Medicare Payment Advisory Commission (MedPAC) should provide sufficient advance notice to Congress if payment rates become an issue.

Various provisions of the Affordable Care Act will affect Medicare beneficiaries through the average level of coinsurance payments, premiums for Part B and Part D, and the amount of extra benefits provided to beneficiaries enrolled in Medicare Advantage. Medicare beneficiaries have the option of receiving their coverage through the traditional fee-for-service program or through a private Medicare Advantage (MA) health plan. As of 2010, more than one-fourth of Medicare beneficiaries were enrolled in MA plans. Since the Affordable Care Act has very different effects on these two programs, the beneficiary out-of-pocket impacts will be analyzed separately.

Fee-for-service Medicare

For individuals enrolled in the traditional Medicare program, the expenditure reductions under the Affordable Care Act are expected to cause a reduction in the average coinsurance amounts, as shown in the following table. For Part A, the savings under the Act would result in lower beneficiary coinsurance payments for inpatient hospital and skilled nursing care. These effects are the result of the application of the productivity adjustments to the Medicare "market basket" payment updates. For Part B, the average reduction in beneficiary coinsurance is significantly larger than for Part A, since almost all Medicare enrollees have physician or other Part B services in a year, versus a minority with Part A services. The estimated program savings result in an associated reduction in average annual coinsurance payments that reaches $47 for Part A and $160 for Part B by 2019. These estimates assume that the productivity adjustments to Medicare payment updates can be sustained through this period.

Average coinsurance impact for fee-for-service Medicare beneficiaries
(estimated change in yearly per capita amount)

CY	Part A	Part B	Part D
2010	$0	$6	−$37
2011	−$1	−$13	−$86
2012	−$4	−$37	−$94
2013	−$8	−$54	−$117
2014	−$13	−$66	−$126
2015	−$18	−$83	−$145
2016	−$23	−$101	−$162
2017	−$29	−$119	−$188
2018	−$37	−$138	−$221
2019	−$47	−$160	−$259

The coinsurance payments for Part D enrollees will be significantly reduced by the Affordable Care Act, with the average reduction reaching $259 per year by 2019. This impact is largely due

to phasing out the Part D coverage gap, commonly referred to as the "donut hole." Specifically, the following four provisions will affect the coverage gap.[3]

(i) Beginning in 2011, a 50-percent price discount on brand-name drugs is established for prescriptions that are dispensed once a beneficiary reaches the coverage gap, paid for by pharmaceutical companies.

(ii) The 50-percent price discounts described in (i) are counted as part of a beneficiary's true out-of-pocket (TrOOP) spending and therefore will not change the point at which the beneficiary reaches the threshold for catastrophic coverage.

(iii) Coverage for brand-name and generic drug expenditures in the existing coverage gap will be phased in, beginning in 2013 and 2011, respectively, reducing enrollees' cost-sharing requirement to 25 percent by 2020.

(iv) The maximum out-of-pocket spending limit for 2014 through 2019 will increase at a slower rate.

The next table shows the estimated impacts on Part B and Part D standard premiums resulting from the Affordable Care Act, on a monthly and annual basis. Expenditure reductions under Part B translate directly to lower financing requirements from general revenues and beneficiary premiums, since financing is re-established annually to match program costs. In addition, Part B will receive revenues from the fees on manufacturers and importers of brand-name prescription drugs. Since no changes were made in the existing statutory provisions for Part B beneficiary premiums and general revenue matching amounts, which by law are set each year at a level adequate to finance Part B expenditures, these additional revenues would result in an excessive level of financing for Part B and an unnecessary accumulation of account assets. To maintain Part B assets at an appropriate contingency level, a negative "premium margin" will be incorporated, reducing beneficiary premium rates and matching general revenues by an amount equal to the new revenues from prescription drug fees. The estimated Part B premium impacts shown below reflect such reductions. As before, the estimated Part B premium reductions depend in significant part on the viability of the productivity adjustments to payment updates.

Estimated fee-for-service Medicare beneficiary premium impact

	Part B premium		Part D premium	
CY	Monthly	Annual	Monthly	Annual
2010	$0.00	$0	$0.00	$0
2011	−$1.60	−$19	$0.51	$6
2012	−$4.40	−$53	$0.14	$2
2013	−$6.00	−$72	$0.00	$0
2014	−$7.50	−$90	$0.05	$1
2015	−$9.40	−$113	$0.16	$2
2016	−$11.60	−$139	$0.19	$2
2017	−$14.10	−$169	$0.58	$7
2018	−$16.00	−$192	$1.07	$13
2019	−$18.20	−$218	$1.66	$20

[3] The estimated reduction in average Part D coinsurance in 2010 is attributable to the one-time $250 rebates for enrollees with costs in the coverage gap.

Part D premiums are estimated to be slightly higher as a result of the Affordable Care Act. By statute, the base beneficiary premium for Part D is 25.5 percent of the national average bid amount plus the estimated catastrophic reinsurance value. Providing additional coverage for prescription drugs dispensed in the coverage gap will cause an increase in costs for the prescription drug plans and therefore an increase in the average Part D premium rate. Slightly offsetting this increase in premiums is the anticipated movement of many of the Medicare beneficiaries currently enrolled through the retiree drug subsidy (RDS) program to Part D plans. This enrollment shift is expected to result from the loss of tax deductibility for employer costs reimbursed by the RDS payments, as well as from the improvement in the Part D benefit due to filling in the coverage gap. Since RDS beneficiaries have lower drug costs than average, the Part D premium for all enrollees is estimated to be reduced.

The standard premium impacts shown above are for a typical beneficiary. Beginning in 2007, beneficiaries with incomes that exceeded a certain threshold were required to pay higher premiums to receive Part B.[4] The Affordable Care Act freezes the thresholds at the 2010 level through 2019. Consequently, through 2019, there will be steady, incremental increases in the number of individuals subject to the higher premium rates. It is estimated that 10 percent of Part B beneficiaries (5.6 million) will be subject to the higher Part B premium in 2019, compared to 8 percent (4.5 million) under the prior law.

The Affordable Care Act also requires higher, income-related premiums for Part D enrollees, using the same income thresholds as Part B. By 2019, it is estimated that 8 percent of Part D enrollees (3.4 million) will have to pay a higher Part D premium. The following table shows the 2011 Part D income-related additional monthly and annual premium adjustment amounts to be paid by beneficiaries who file individual tax returns (including married individuals filing separately who lived apart from their spouses for the entire taxable year), or who file joint tax returns. The adjustment amounts are payable in addition to the standard enrollee premium for a given prescription drug plan.

Part D income-related premium adjustment amounts in 2011

Beneficiaries who file individual tax returns with income:	Beneficiaries who file joint tax returns with income:	Part D income-related monthly adjustment amount	Part D income-related annual adjustment amount
Less than or equal to $85,000	Less than or equal to $170,000	$0.00	$0
Greater than $85,000 and less than or equal to $107,000	Greater than $170,000 and less than or equal to $214,000	$12.00	$144
Greater than $107,000 and less than or equal to $160,000	Greater than $214,000 and less than or equal to $320,000	$31.10	$373
Greater than $160,000 and less than or equal to $214,000	Greater than $320,000 and less than or equal to $428,000	$50.10	$601
Greater than $214,000	Greater than $428,000	$69.10	$829

Note: The monthly premium adjustment amounts to be paid by beneficiaries who are married, but file separate returns from their spouses and lived with their spouses at any time during the taxable year, are $50.10 for beneficiaries with incomes greater than $85,000 but less than or equal to $129,000 and $69.10 for those with incomes greater than $129,000.

[4] The high-income threshold for 2011 through 2019 is $85,000 for individuals and $170,000 for married couples filing a joint tax return.

Medicare Advantage

Payments to Medicare Advantage plans are generally based on the costs in fee-for-service Medicare. Therefore, the provisions of the Affordable Care Act that produce the reductions in Medicare premiums and coinsurance amounts described above would produce a corresponding reduction in the out-of-pocket spending for MA enrollees. These reductions are expected to be more than offset by the changes made to the prospective MA payments in the legislation.

Under the prior law, MA payment benchmarks were generally in the range of 100 to 140 percent of fee-for-service costs. The Affordable Care Act sets the 2011 MA benchmarks equal to the benchmarks for 2010 and specifies that, ultimately, the benchmarks will equal a percentage (95, 100, 107.5, or 115 percent) of the fee-for-service rate in each county. During a transition period, the benchmarks will be based on a blend of the prior ratebook approach and the ultimate percentages. The phase-in schedule for the new benchmarks will occur over 2 to 6 years, with the longer transition for counties with the largest benchmark decreases under the new method.

The Affordable Care Act also introduces MA bonuses and rebate levels that are tied to the plans' quality ratings. The law specifies that, beginning in 2012, benchmarks will be increased for plans that receive a 4-star or higher rating on a 5-star quality rating system.[5] The bonuses will be 1.5 percent in 2012, 3.0 percent in 2013, and 5.0 percent in 2014 and later, and are subject to the same phase-in schedule as the benchmarks. An additional county bonus, which is equal to the plan bonus, will be provided on behalf of beneficiaries residing in specified counties. The percentage of the "benchmark minus bid" savings payable as a rebate, which historically has been 75 percent, will also be tied to a plan's quality rating. In 2014, when the provision is fully phased in, the rebate share will be 50 percent for plans with a quality rating of less than 3.5 stars, 65 percent for a quality rating of 3.5 to 4.49, and 70 percent for a quality rating of 4.5 or greater.

The new provisions will reduce MA rebates to plans and thereby result in less generous benefit packages. MA plans use rebate revenues to reduce Medicare coinsurance requirements, add extra benefits such as vision or dental care, and/or reduce enrollee premiums for Part B or Part D of Medicare. The following table shows the impact of the Affordable Care Act on the average annual per capita rebate, as estimated at the time of enactment. The reduction in the average MA rebate was estimated to grow steadily as the ACA benchmark and other changes phase in and to reach about $1,500 in 2019.[6]

The reduction in MA rebates will cause a large increase in the out-of-pocket costs incurred by MA enrollees. As mentioned previously, this effect will be somewhat offset by the impact on plan costs from the reductions in fee-for-service Medicare. The net effects of the reduced MA rebates and the decreases in the out-of-pocket costs are shown in the last column of the table. The result is a decrease in beneficiary out-of-pocket spending of $30 for 2010 and then substantial increases in such costs that begin in 2011 and reach an estimated $873 in 2019.

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[5] In November 2010, CMS announced the Medicare Advantage Quality Bonus Payment Demonstration, which will apply a sliding scale bonus to plans with at least 3 stars.

[6] As a result of (i) lower-than-expected MA plan bids in 2009 and 2010, and (ii) no further adjustment to the 2011 MA payment formula for "excess diagnosis coding intensity," updated estimates would indicate somewhat higher average rebate levels under both the prior law and the Affordable Care Act. The estimated reductions in average MA rebates due to the ACA would remain very similar to the amounts shown in the table.

Estimated impact on beneficiary out-of-pocket spending for MA enrollees
(estimated change in yearly per capita amount)

CY	ACA impact on the average MA rebate: Prior-law rebate	Current-law rebate	Reduction in MA rebate	Impact from FFS provisions	Net out-of-pocket impact of the ACA
2010	$1,093	$1,093	$0	−$30	−$30
2011	$1,143	$684	$459	−$113	$346
2012	$1,181	$522	$660	−$186	$473
2013	$1,240	$399	$841	−$250	$591
2014	$1,311	$278	$1,034	−$295	$739
2015	$1,311	$142	$1,169	−$357	$812
2016	$1,372	$84	$1,288	−$422	$866
2017	$1,441	$20	$1,421	−$498	$923
2018	$1,509	$42	$1,468	−$575	$892
2019	$1,580	$43	$1,537	−$664	$873

The reductions in the value of MA benefit packages because of the lower rebate levels are expected to significantly reduce the attractiveness of many MA plans relative to fee-for-service Medicare. In our April 22, 2010 memorandum, we estimated that in 2017, when the MA provisions will be fully phased in, enrollment in MA plans would be lower by about 50 percent (from a projected level of 14.5 million under the prior law to about 7.3 million under the new law).[7]

Conclusions

The Affordable Care Act makes far-reaching changes to most aspects of health care in the U.S., including mandated coverage for most people, required payments by large employers not offering insurance, expanded eligibility and other provisions for Medicaid, Federal premium and cost-sharing subsidies for many individuals and families, a new system of health benefits Exchanges for facilitating coverage, and a new Federal insurance program in support of long-term care. Federal revenues will be increased through an excise tax on high-cost insurance plans; fees or excise taxes on drugs, devices, and health plans; higher Hospital Insurance payroll taxes for high-income taxpayers; a new tax on investment revenues and other unearned income; and other provisions.

Numerous provisions will reduce Medicare outlays, increase trust fund revenues, add certain benefit enhancements, further combat fraud and abuse, and support research into innovative health delivery systems and payment mechanisms, with the goal of improving both the quality and efficiency of Medicare services. These provisions will affect not only the financial status of the Medicare trust funds but also beneficiary out-of-pocket costs for premiums and cost-sharing requirements. The provisions of the Affordable Care Act are expected to have a very different effect on beneficiaries' out-of-pocket costs depending on whether they are enrolled in fee-for-

[7] Reflecting the same factors cited in footnote 6, together with later data on the sensitivity of MA enrollment to changes in supplemental benefit value, an updated estimate of the enrollment reduction under the Affordable Care Act would be about 40 percent, from a prior-law level of 14.6 million in 2017 to about 8.7 million under the new law.

service Medicare or a Medicare Advantage plan. For beneficiaries in fee-for-service Medicare, out-of-pocket costs for coinsurance amounts and premiums will be significantly reduced by the ACA, assuming the continuing viability of the slower payment rate updates for most categories of health providers. For individuals enrolled in Parts A, B, and D, average costs will be reduced each year beginning in 2010, and the difference will reach an estimated $664 in 2019. MA enrollees will experience the opposite effect. Their out-of-pocket costs will be higher by an estimated $873 in 2019. It should also be noted that for certain beneficiaries with relatively high incomes, their premiums for Parts B and D will increase as a result of the Affordable Care Act.

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

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

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Chairman CAMP. Mr. Foster, your time has expired, but we will make your full statement a part of the record.

Mr. BLUMENAUER. is recognized for 5 minutes.

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

Mr. Foster, good to see you again.

I am interested in exploring three points with you. You were here, I thought I saw, for much if not all of the previous discussion. You heard one of my colleagues describe with dismay, I believe it was my friend from Pennsylvania, who talked about somebody with a knee brace that under the existing schedule was $686 versus $194 that could be obtained just going on the Internet.

Have you examined the current system's trend lines in terms of its sustainability? You are talking about problems under the Affordable Care Act. Absent the Affordable Care Act, have you done a projection of what America's health care looks like in terms of deterioration of quality, of people being shed by plans, other plans being shut down? Do you have a report on that? Have you examined it?

Mr. FOSTER. We don't have a formal report. We try to keep up with these various kinds of issues, yes.

Mr. BLUMENAUER. Would you say that it is safe to assume that if we don't do something that the trend lines are actually worse in terms of people losing care, costs exploding, inefficiencies in the system?

Mr. FOSTER. Without question, something needs to be done. Because historically, for a variety of reasons, health care costs have grown faster than people's wages or the economy at large, and that can't be sustainable indefinitely over time.

Mr. BLUMENAUER. I take that to say that you acknowledge that it is actually worse if we don't do something, that people are going to lose care, that quality is going to go down, that the budget is going to be broken if we don't something.

Mr. FOSTER. I don't know about worse or better. That is something I would have to think about.

Mr. BLUMENAUER. I would appreciate it if you would, because you have thought about it here. You have made the decision that actuarially, and your assumptions, your hunches, being around here for a long time, that you think some of this isn't going to happen. I would appreciate if you would add your intellect to what the consequences are for the current system absent doing something, whether it is going to be better or worse.

My second point, I wonder if you had a chance to look at the Republican roadmap that my good friend and colleague Paul Ryan has advanced that actually posits greater reductions in Medicare spending over time. And I would ask if you think that is greater or less likely that Congress would stand by and allow greater reductions. If you think there are problems under the existing Act, would there be greater or lesser reductions under my friend Paul Ryan's approach?

Mr. FOSTER. My office looked at Mr. Ryan's plan several years ago when he first developed it. We discussed with him at the time—and it continues to be the case—that if you have a voucher program for Medicare and Medicaid and the voucher payments increase at a slower rate than health care costs are increasing, then over time people cannot buy as comprehensive an insurance coverage as they started out, and at some point that can become quite an issue. So there are risks to either approach. They are different in nature, but they both exist.

Mr. BLUMENAUER. I don't want to catch you unawares, but I would respectfully request that you think about that, maybe look at them and if you have an opinion about which is the greater risk of Congress caving, those draconian cuts or the things that are imposed under the Affordable Care Act, at some point.

I would like to turn to Medicare Advantage, because this is one of the areas that you think there is instability. You were here when

Dr. Berwick testified that current Medicare Advantage enrollment increased 6 percent to more than 12 million beneficiaries. You heard that, on average, beneficiaries have seen a 6 percent reduction in their premiums. And you heard, most important, there is a 5 percent increase in the people who are investing in the better, higher-quality programs. I mean, there are some that give health club memberships that aren't very good programs, and we don't want to subsidize ones that aren't doing a very good job. I note in my community you get about $586 on average, and we have the highest percentage of Medicare Advantage in the country. In Louisiana, there is one that is over $1,300 a month.

Chairman CAMP. The gentleman's time has expired.

Mrs. BLACK. is recognized for 5 minutes.

Mrs. BLACK. Thank you, Mr. Chairman; and thank you, Mr. Foster, for being here.

As part of the Democrats' health care law, employers who provide retiree drug coverage can no longer deduct that subsidy, the so called "RDS," and we have seen companies take huge write-offs as a result of this tax increase. And an example of that has already been talked about in the last session with AT&T with $1 billion and Deere and Company with $150 million. These are big numbers, and it means that less money will be available for investment and creating jobs.

But my question relates to the impact on seniors. The President reiterated on Sunday, "If you have health care that you like, you keep it." In your opinion, does the Democrats' health care law provide further incentive for these companies to drop the retiree drug coverage plan, resulting in seniors losing their coverage?

Mr. FOSTER. Yes to the first part, probably not to the second part. In other words, without the tax deductibility, that changes the financial balance, so we expect that many employers will drop their retiree drug coverage because of these changes. We also expect that most of them—not all—most of them will help get their retirees into regular Part D prescription drug plans.

Mrs. BLACK. As a follow-up to that, how is this going to affect the regular Part D moving forward?

Mr. FOSTER. It won't make a lot of difference. Instead of Medicare paying a Federal subsidy for these same people within the retiree plans, will pay a Federal subsidy for them within the Part D plan.

Mrs. BLACK. I see.

Mr. FOSTER. It will slightly decrease the premiums. Because these tend to be lower-cost people. They have had full employment histories, so it will help bring down the overall cost within the Part D plan world but not by very much.

Mrs. BLACK. I want to go in another direction that really hasn't been mentioned much here. There was some talk in the last section about how these senior groups have promoted the recent reform, and AARP was certainly a part of that. However, as a part of the new law, insurance companies are required to spend 80 to 85 percent of the premium on government-approved spending services and this is called that medical loss ratio. However, Medigap policies that seniors purchase to supplement traditional Medicare are only required to meet a medical loss ratio of 65 percent. And AARP

and United are a part of this. And while I am not in support of government mandating how private industry operates, do you think that the MLR policy should be applied equitably across the line?

Mr. FOSTER. Well, I confess that is not an issue that I have thought much about, and I don't get into policy issues, but you could probably make a good case that if it makes sense in general then it would make sense for the broader spectrum, including Medigap policies.

Mrs. BLACK. Well, I would think that most people would agree that if we are going to do something we should do it equally and that if we have one particular company that is advocating for a policy and then gets the break to be less, that does not seem to be very fair.

Mr. FOSTER. There is one other difference that I would mention, which is, when you think of a normal health insurance policy like a private insurance policy that covers the whole gamut of health care services, there is sort of a lot of money to work with. If you think about a Medigap policy, which wraps around Medicare, it is a much lower dollar value policy. So to the extent that you have given administrative costs, they are going to tend to represent a greater share for a small dollar policy. So you might not be able to do 80 or 85 percent, but, on the other hand, you could certainly specify a loss ratio standard that is perhaps somewhat higher than the existing one.

Mrs. BLACK. Thank you.

I yield back my time, Mr. Chairman.

Chairman CAMP. Thank you.

Mr. PASCRELL. is recognized.

Mr. PASCRELL. Thank you, Mr. Chairman.

Mr. Foster, it is good to see you again.

At many town hall meetings that I have attended, Mr. Foster, it has been my goal to dispel some of the myths that we have heard discussed today and other days. Seniors have been grateful as they have begun benefiting from health care reform, for example, in getting a $250 check—which doesn't seem much to you or me but means a lot to a lot of seniors—to help them pay for prescription drugs under Medicare. I don't have any trick questions about that, but I just wanted to lay the facts out.

Mr. FOSTER. I appreciate that.

Mr. PASCRELL. Well, I am not finished yet, though.

I also learned something this morning. It seems like both sides are convinced that we finally laid it out, chapter and verse—and would you confirm this—that there are no cuts in guaranteed benefits under the Medicare program? Could you verify that? Except we are not talking about the private plans, we are not talking about doing away with gym privileges, we are talking about substance, and you know what I am talking about.

Mr. FOSTER. Yes, sir. There are no cuts in what is referred to as guaranteed benefits, in other words, the standard Medicare benefit package. In fact, that has been expanded.

Mr. PASCRELL. Thank you very much for your conciseness. I hope people will choose to go back and read the bill, which we were accused of not doing, but that is a fact of life.

Now I want to ask you something which I would ask you to be as precise as you can be. I want to talk a little bit about how health care reform creates what I would consider to be positive incentives for providers to focus on the quality of their care, thereby benefiting seniors.

I understand that your office did not score innovative ideas such as hospital value-based purchasing or the Independence at Home Demonstration program as part of your analysis. In fact, I look at the sheet from the estimated Medicare costs, and Section 3003, the expansion of the Physician Feedback Program, sections 3006, 3007, value-based purchasing, which I know you believe in, but you did not score. I am not criticizing. I am going to ask you a question.

CMS Innovation Centers, the Medicare Shared Savings program, National Program on Payment Bundling—I have seen a lot written about that in the last 3 or 4 years—Hospital Readmissions Reduction Program. Let me ask you this question: Don't any of these specific areas—I could name five more—have any potential for savings? And why specifically were they not scored? Because you did score some other things.

Mr. FOSTER. Sure. In a number of cases, we actually did estimate savings. For example, for the lower payments for readmissions, unnecessary readmissions, the hospital-acquired conditions, what it really depends on, sir, is when you have enough information about how the proposal will actually work. On some of these, for example, at the time of enactment the Medicare Shared Savings program was not adequately specified for us to be able to estimate what the impact would be.

Mr. PASCRELL. So it wasn't a question that you thought that they would not work, it was a question—and correct me—it was a question of gathering enough information to say that they definitely would work. Am I putting words in your mouth?

Mr. FOSTER. Only slightly. It is a question of having enough information to determine that they work well, they don't work so well, as the case may be.

Mr. PASCRELL. So you are not questioning whether these things would work.

Mr. FOSTER. I am saying we don't always have an opportunity or enough information to try and figure that out.

Mr. PASCRELL. Well, let's take the five things that I mentioned. You would think, from what I have read and what I have looked into—to my amateur abilities—that we could possibly save a heck of a lot of money if these things work as well as they are expected to work.

Mr. FOSTER. There is the potential in almost all of these. But if I may give you one example.

Mr. PASCRELL. Sure.

Mr. FOSTER. The Medicaid Shared Savings program, as you know, the regulation is due out within another couple of weeks. We have been working closely with the folks on that. The original design of the regulation we estimated would actually increase costs. The design was modified somewhat to lower the cost, and the current version now achieves some degree of savings overall.

Chairman CAMP. Thank you.

Mr. PASCRELL. This is quite a bit of money we are talking about here now.

Chairman CAMP. The gentleman's time has expired.

Mr. PASCRELL. Thank you.

Chairman CAMP. Mr. Crowley is recognized.

Mr. CROWLEY. It is unusual, two for the road here.

Chairman CAMP. We are playing catch-up.

Mr. CROWLEY. Thank you, Mr. Chairman.

I want to just follow up on the line of questioning of Mrs. Black as it pertains to the corporate tax advantage that she mentions will be phased out in 2013, what is, in effect, a case of, in my opinion—and I think many—double dipping. Now I would hope that my Republican colleagues aren't defending double dipping, but that is what it sounded like to me.

The loophole that will expire in 2013 pertains to a law that allows businesses to deduct the value of that subsidy twice. They can exclude the 28 percent from their income and at the same time deduct 28 percent from their income for tax purposes. If that is not double dipping, I don't know what is. The health care reform legislation closes that loophole by allowing businesses to deduct this money once rather than getting a double deduction on taxpayer dollars. These businesses will still get a generous subsidy to help them cover retiree prescription drug costs, and they still get to exclude that benefit from their income. They just don't get to do it twice and double the deduction on the backs of taxpayer dollars.

But, Mr. Foster, what I want to do is follow up on the questioning of my colleague from New Jersey just a bit more. One of the Affordable Care Act's greatest tangible benefits was the assistance it provided to our seniors with high prescription drug costs, particularly those who got caught in what is known as the Medicare Part D donut hole or coverage gap. The law gave every senior who was hit in that coverage gap in 2010 a check for $250; is that correct?

Mr. FOSTER. Yes, the ones who made it to the coverage gap.

Mr. CROWLEY. That is the equivalent of 7,300 seniors in my district alone and over 3 million seniors nationwide. These are checks that seniors have already received that they are already using to help them to pay for the high cost of prescription drugs. Is it true that the Republicans' efforts to repeal the Affordable Care Act, which each of my colleagues on the other side of the aisle voted for, as if it had not been enacted would force seniors to return that $250 check that they received to help them with the cost of prescription drugs? Would that be the case?

Mr. FOSTER. If the legislation were repealed entirely and retroactively, including provisions that have already taken effect, then, yes, in theory you would have to pay back those rebate checks.

Mr. CROWLEY. Let me ask you this question: If that were the case, if they had to pay back those checks—and that would amount to over $650 million that has been paid out—is it possible that when seniors are forced to return those $250 checks that they got that they would have to pay interest on those $250 checks as well? It is $650 million. I assume that had that stayed in the Treasury that it would have accumulated some interest. Would they have to pay the interest back on those checks as well?

Mr. FOSTER. I am not aware of any situation, if there is a benefit or an overpayment and a recovery, that interest is involved.

Mr. CROWLEY. But it is quite possible they may have to pay interest on it.

Mr. FOSTER. I have not seen it before.

Mr. CROWLEY. So then it would be a loss to the Treasury, the interest that would have otherwise been gone had it remained where it was.

Mr. FOSTER. In effect——

Mr. CROWLEY. It is quite possible.

Mr. FOSTER. Right.

Mr. CROWLEY. Thank you.

My Republican colleagues have said that they want to completely take away all funding for the Affordable Care Act, and they have made it clear that they will use the continuing resolution to cut off any funds for the implementation of this law. Will this mean that the remaining seniors who hit the prescription drug coverage gap towards the end of 2010, just like their neighbors, and are waiting desperately for the help will now be denied the check that is rightfully theirs if funding for this were to be cut off?

Mr. FOSTER. Again, if it is repealed in its entirely and retroactively.

Mr. CROWLEY. Thank you.

Mr. Foster, the Department of Health and Human Services estimated that under the Affordable Care Act Medicare beneficiaries—seniors—who have hit the prescription drug coverage gap will each save $526 this year alone as a result of further closing the coverage gap. By 2020, when the gap is fully closed, each beneficiary will save $1,540. This means a total savings of $8.8 billion in savings to a projected 5.7 million beneficiaries.

If the Affordable Care Act were repealed, Medicaid beneficiaries would effectively see an $8.8 billion cut just from this particular provision being repealed; is that true?

Mr. FOSTER. I would have to look up the figures, but those are in the right ballpark.

Mr. CROWLEY. Thank you. I thank you for your honesty and your candor, and I thank the chairman.

Chairman CAMP. Mr. Foster, would you agree that health care spending and rising health care costs are the most significant drag on our Nation's fiscal health?

Mr. FOSTER. Oh, I don't know about that. They certainly represent——

Chairman CAMP. Or a significant drag on our Nation's fiscal health?

Mr. FOSTER. Well, certainly, yes.

Chairman CAMP. And one of the claims that is often made is that this health care law will "bend the curve" of health care spending. In your expert analysis, would you say that their law increases or decreases national health expenditures?

Mr. FOSTER. We have estimated that overall national health expenditures would increase under the health reform act.

Chairman CAMP. So a significant drag on our economy is actually made worse under this law.

My second question is, the nonpartisan Congressional Budget Office has made clear that the Medicare "savings" as a result of the health care law can't be counted twice, first to shore up the solvency of the Medicare program and then also pay for a new health care entitlement. Your office's April 22, 2010, report on the effects of the law on the Medicare Trust Fund pointed out, "In practice, the improved Part A financing cannot be simultaneously used to finance other Federal outlays, such as the coverage expansions under the PPACA, and to extend the trust fund, despite the appearance of this result from the respective accounting conventions."

Can you sort of settle for this committee with a yes or no answer if the funds that are designated to finance a new entitlement under the health care reform law, can they be simultaneously used to make the Medicare trust fund more solvent?

Mr. FOSTER. Not directly, no.

Chairman CAMP. So what is the implication of that truth about the solvency of the Medicare program and on the alleged deficit reduction in the Democrats' health care law?

Mr. FOSTER. Well, what I would like to do would be to explain it as follows: Clearly, there are very large Medicare savings under the health reform act. Those savings, the actual cash that shows up in higher payments, higher taxes, whatever, that is loaned to the rest of government. The Medicare trust funds get Treasury bonds, IOUs.

Mr. FOSTER. The money is immediately spent. Whether for the purpose of offsetting the cost of the coverage expansions or building roads or whatever, it is spent. In a few years when we need the money, we can cash in those Treasury bonds and it has to be repaid with interest. But the original money we are talking about, if it was $100 in higher taxes, the $100 is spent. It is gone. We now need the $100. We will get it back, but Treasury will have to come up with a new $100 to pay it back for us. So to spend $100 for the ACA and $100 for Medicare takes $200, and the original $100 can only be used once.

Chairman CAMP. So the costs of the bill are understated.

Mr. FOSTER. I think that is a different issue.

Chairman CAMP. I wanted to just touch on something else. Health and Human Services, HHS, spent about $20 million to convince seniors that the health care law was good for Medicare. And one of the first attempts to do that was the caller mailing that was glossy, that went out to seniors to inform them of a number of new government programs, even though they were ineligible for many of those programs.

Was your office asked to review the Medicare mailer that went to seniors or to review the scripts that appeared in the media that were aimed at seniors? Did your office review those?

Mr. FOSTER. No, we were not asked and we did not look at them.

Chairman CAMP. I would like you to comment on two statements included in the Medicare mailer and to just give your comments on whether those were accurate, inaccurate, or misleading. One was it keeps Medicare strong and solvent. Is that inaccurate or misleading, given that the Medicare cuts are unsustainable and that the, quote, savings are double-counted as you mentioned ear-

lier in your testimony, double-counted as both trying to extend the Medicare solvency and also pay for a new entitlement?

Mr. FOSTER. Technically and in an important way, the savings for Medicare under the Affordable Care Act do extend solvency. Now we lend the money out, we get it back, we can continue paying benefits longer than before. Now, there is the appearance and good bit of reality of the double-counting so that is an issue. But technically it does help in that regard.

Chairman CAMP. The quote that Medicare benefits won't change whether you get them through original Medicare or Medicare Advantage plan, is that an accurate statement?

Mr. FOSTER. I will be quite honest. I have been troubled with that statement. We had the question earlier about the guaranteed benefits. It is true enough that the, quote, guaranteed benefits which are the original fee-for-service package, nobody is reducing that. That actually expands a little bit. It is also true that for Medicare Advantage enrollees, their extra benefits, their lower cost-sharing, their lower premiums will be reduced under the Affordable Care Act.

Chairman CAMP. And when you reviewed whether this legislation, quote, bent the cost curve or not, did it include any analysis of the physician payment formula or any extension of that or a, quote, doctor fix, as it is often called here?

Mr. FOSTER. No, not directly. Other than the original Ways and Means Committee bill, the legislation did not have a doctor fix it in it.

Chairman CAMP. So that is a fairly significant cost to Medicare that has not been accounted for or included in this legislation?

Mr. FOSTER. Yes. It has been treated as a separate issue.

Chairman CAMP. So in response to my question about increasing or decreasing health care spending, even your analysis would be pretty significantly understated if this were included.

Mr. FOSTER. The cost of a permanent fix for the SGR system over 10 years is about $300 billion. That provision was not in the Affordable Care Act. It is a continuing issue, as you know, but that is roughly the cost.

Chairman CAMP. So that would mean health care expenditures would increase by that additional amount over that period?

Mr. FOSTER. That is correct.

Chairman CAMP. Thank you. Mr. Levin may inquire.

Mr. LEVIN. Mr. Foster, welcome. And I think this may give us an opportunity for further reference to the facts.

You answered the question of the chairman about benefits. The guaranteed benefits are different than the extra benefits under the Advantage programs; isn't that true.

Mr. FOSTER. Yes, sir, that is correct.

Mr. LEVIN. See, there tends to be always confusion or an attempt to confuse. For example, there were references done earlier today, cuts in the payments. So let me just quickly review your testimony because I think it is important to get to the facts. On page 3, you say that it is estimated that the number of uninsured persons in the U.S. would reduce it by 34 million. You don't challenge that, do you?

Mr. FOSTER. No, sir, that is our best estimate.

Mr. LEVIN. Good. You then, going to page 5, say that expenditures are expected to increase by about 200 billion due to the substantial expansions of coverage under the Affordable Care Act. So if 34 more million are insured, it is likely the costs will go up overall, no?

Mr. FOSTER. Yes, that is correct.

Mr. LEVIN. So let me just go on to page 5, and you talk about the Medicare savings. There have been references here to cuts in Medicare payments. Isn't it more accurate to say that these cuts will come from a reduction in the increase in Medicare payments?

Mr. FOSTER. There are a lot of each. Certainly for the productivity adjustments that I mentioned, that is a slower growth in payment updates. If you think of the disproportionate share of hospital payments, that is a flat-out reduction in the level. So there are examples of each.

Mr. LEVIN. So to simply talk about cuts, as has been done in many of the statements, including advertisements, whatever, about over $500 billion, half trillion in cuts in Medicare payments, much of that is in the reduction of the increase in Medicare payments; isn't that correct?

Mr. FOSTER. Yes. A significant part of it is in that form.

Mr. LEVIN. Also, bending the curve; when we talk about bending the curve, we are talking about bending the curve in terms of the rate of increase in bending the curve in the rate of payments to providers, are we not?

Mr. FOSTER. Bending the curve generally refers to slowing the overall rate of health care costs growth, not necessarily how it might be done.

Mr. LEVIN. But it also, when we talk about bending the curve, there is an effort, it indicates an effort to try to bring down the cost of the payments to those who provide care, no?

Mr. FOSTER. Well, clearly that is one way that the Affordable Care Act works to try to slow the growth of health care costs.

Mr. LEVIN. And it really does try to do that, does it not?

Mr. FOSTER. Yes, sir, primarily through the Medicare productivity adjustments.

Mr. LEVIN. Now, I just want to finish by referring to that, because there is a statement to take. There is an indication, an effort often, to take somewhat qualified statements of yours and to indicate that essentially it is sure to happen. And I think that we need to look at your testimony, because you say on page 8, Although this policy could be monitored over time to avoid such outcome, changes would likely result in smaller actionable savings than described for these provisions.

Essentially what you are doing is projecting. For example, you did as to the Advantage programs, and so far this year it has turned out your projections are wrong. Right?

Mr. FOSTER. I would stop short of calling them wrong without appearing to be defensive. The real issue is 2011 is not much affected by the Affordable Care Act. 2012 through 2017, there will be big effects. There are factors unrelated to our estimate of the Affordable Care Act that have resulted in 2011 Medicare Advantage enrollment increasing by more than we thought it would.

Chairman CAMP. All right, thank you. Mr. Herger is recognized.

Mr. HERGER. Thank you, Mr. Chairman.

Mr. Foster, the President and his administration have repeatedly said that we must pass their health care overhaul because controlling health care costs would help the economy.

On June 2, 2009, the Council of Economic Advisers said, quote, we estimate that slowing the annual growth rate of health care costs by 1.5 percentage points would increase real growth domestic product relative to the no-reform baseline by over 2 percent in 2020, closed quote.

The President's economic advisers also stated that slowing cost growth would lower the unemployment rate. The President's economists also argue that slowing the growth rate of health care costs raises standards of living by freeing up resources that can be used to produce other desired goods and services, closed quote.

Based on your analysis, will the Democrats' health care law slow the rate of health care costs so we can get these outcomes like more growth and more jobs?

Mr. FOSTER. Overall, the Affordable Care Act increases total health spending and it increases Federal spending on health care. There are some factors in there that would help slow the growth rate further out in the projection period. One of the largest of those factors is the one that I question the long-range viability of.

Mr. HERGER. And Mr. Foster, in an auxiliary report to the Medicare Trustees 2010 Report, CMS actuaries predicted that under the new health care law by 2019, Medicare payment rates will be lower than current Medicaid rates. In your recent testimony before the House Budget Committee, you confirmed that the best-case scenario under current law is that Medicare rates will be equal to Medicaid rates in 10 years.

What impact would these rates have on beneficiaries' access to care?

Mr. FOSTER. If Medicare payment rates become lower than the current level for Medicaid, which in fact would happen over time under the Affordable Care Act, then it raises questions about the ability of beneficiaries to have access to care. Within the Medicaid program, as I am sure you know, there are a number of studies that suggest access has been something of a problem and getting worse. So you basically have to provide a reasonable payment rate for physicians and hospitals and anybody else in order to enable them to provide health care services to Medicare beneficiaries or anybody else.

Mr. HERGER. That would be a major problem, wouldn't it? I mean, we are already seeing a problem of doctors not taking new patients. And to think that that would be more dramatically affected, does that concern you?

Mr. FOSTER. It concerns me primarily because I think this would tend to happen over time, and whether it is 10 years or 20 years or somewhat longer is a little bit hard to say, but I believe it will happen. I believe you folks, Congress at large, would have to respond to it because it makes no sense to have a Medicare program where Medicare beneficiaries cannot get access to care.

So I believe you would have to override the provisions and that would result in a higher cost than we now project under current law. That is my primary concern.

Mr. HERGER. Thank you Mr. Foster.

Chairman CAMP. All right. Mr. Rangel is recognized.

Mr. RANGEL. Thank you, Mr. Chairman. And welcome back, Mr. Foster.

I would want you to clarify your status as an independent analysis. I gather it is not your job to evaluate whether or not you think this program is good, bad, whether it is going to work or whether it is not going to work. But one thing you did say is that it would increase medical costs. And I wonder whether your job title and responsibility would say that while it would initially increase the amount of money the Federal Government is paying, that in terms of prevention and the fact that everyone will have access to health care, does it come within your protocol to determine whether or not in the long run medical costs would be reduced as a national expenditure?

Mr. FOSTER. The which part of medical costs, sir.

Mr. RANGEL. Overall medical costs. In other words, many of us lay people believe that if indeed people who now have no coverage, that we are paying for their very high emergency costs and we are paying for it through the Federal Government, we are paying for it with increased premiums, actually the Federal Government initially would be paying more money for health care. But would you evaluate what is preventing from happening that would also cost money? Is that a part of your responsibility?

Mr. FOSTER. Yes, sir. You correctly stated that we don't evaluate whether a proposed policy is a good idea or a bad idea. Our role is to help policymakers understand the technical aspects. Will something work the way they intend? Will something have a savings or a cost? And we try very hard to do that. Evaluating the policy implications, of course, that is your job and we don't step on your toes in that regard.

Now, in terms of your specific question, we do try to estimate the impact of the Affordable Care Act on total national health expenditures, taking all the factors you mentioned into account, either directly or implicitly.

Mr. RANGEL. How long have you been doing this?

Mr. FOSTER. Today it seems like quite a while, sir.

Mr. RANGEL. I know the feeling.

Mr. FOSTER. I don't mean to be a wise guy. I have been working as an actuary for 38 years now, 16 years as chief actuary of CMS.

Mr. RANGEL. And how many of those years have you advised the Federal Government?

Mr. FOSTER. All of them.

Mr. RANGEL. And I assume if indeed you deviated in terms of being political, you would never have survived all of these different administrations for 38 years?

Mr. FOSTER. If anybody thought I was taking a political role or allowing political beliefs or preferences to affect my work and my office's work, my own staff would be the first ones to throw me out of the office.

Mr. RANGEL. And I think my recollection is correct that you have taken on quite a few administrations in terms of what they wanted and what your reports indicated.

Mr. FOSTER. I would like to think that we have offered sound, objective, technical advice to many administrations, some of the time for which it was appreciated.

Mr. RANGEL. Very wisely put.

Could you evaluate what would happen in terms of health costs if indeed we were using a voucher system instead of the one that is outlined in this bill, and the health costs for the potential patient would be higher than the voucher? What would happen fiscally as relates to overall health costs?

Mr. FOSTER. There is certainly a possibility that if the voucher payments don't increase fast enough, people might have very limited insurance options, very low-value insurance, or perhaps no options at all.

The hope, I believe, and I am sure Representative Ryan could explain this better, is that it would change the underlying nature of health care cost increases. That is a worthy goal for everybody. But it involves risks that if you try to do it through a voucher program or you try to do it through lower and lower relative payments under Medicare for providers, that either the vouchers are inadequate or the payments are inadequate, and you can't buy what you would like to buy. That is the risk.

Mr. RANGEL. So the risk would not be just the Treasury in terms of costs, but it would be the potential patient. I mean, I think also I would like to ask if they raise the age of Medicare in order to be eligible, what impact would that have fiscally? Well, you could—I would like to follow through on the chairman's suggestion that we send you questions, and I appreciate your services to this committee and to our country.

Chairman CAMP. Thank you. Mr. Johnson is recognized.

Mr. JOHNSON. Thank you, Mr. Chairman. Thank you for being here, Mr. Foster. The health care law cuts Medicare payments to hospitals by more than $150 billion according to our estimates, and that estimate includes the impact of several provisions, the market basket reduction and the permanent loss of their annual productivity adjustment.

MedPAC's latest data estimates the inpatient hospitals will have Medicare margins of a negative 5 percent in 2009. And is it possible that some hospitals might be forced to cut back their staffs to survive the cuts and may be reducing the quality of care provided to seniors and other patients?

Mr. FOSTER. That is a conceivable outcome. I would like to think that MedPAC and my office and others would continue to monitor the situation and advise you all, and if something like that happened, you would step in and say that we want to change the law to avoid that outcome.

Mr. JOHNSON. Well, how would we change the law? We are cutting the amount that we are paying them, so what would you have to do, increase the pay?

Mr. FOSTER. Basically yes, sir. If you passed a law that said I personally get paid, say, half of what I am getting paid now, I would probably quit. And if you came back and said, okay, we will pay you what you used to get, I would probably come back.

Mr. JOHNSON. That is what is happening in our hospitals, at least in the Texas arena. You know nurses, docs, and practitioners

are laying off. They have to pay salaries and rent, and those are still going up, as you know. They will be paid less than cost of goods. And do you think that is sustainable in the long term?

Mr. FOSTER. It is possible if they can improve their productivity at much better rates than they ever have historically, which is perhaps not likely, or if they can get rid of the admittedly significant level of inefficiency that exists, if they can take other steps through innovations and joining in provider organizations, ACOs and so forth, then all of that is possible. Now, what I am afraid of is it may not be probable.

Mr. JOHNSON. I agree with you totally, and thank you for your testimony. Mr. Chairman, I yield back.

Chairman CAMP. Thank you. Mr. Brady is recognized.

Mr. BRADY. Thank you, Chairman, and thank you, Mr. Foster, for joining us. I am concerned about the damage that will be done for our seniors as a result of this new health care law.

Dr. Berwick wasn't able to answer a number of my questions on the impact, so I went to your report to get the answers and I want to confirm them. I am concerned that many seniors that get prescription drug benefits under Medicare will have higher Part D costs because of the flawed way in which the doughnut hole is supposedly closed.

On page 13 of your report, you say, "Providing additional coverage for prescription drugs dispensed in the coverage gap, the doughnut hole, will cause an increase in costs for the prescription drug plans and therefore an increase in the average Part D premium rate."

In plain English, are you saying that prescription Part D premiums will increase for seniors who are not in the doughnut hole?

Mr. FOSTER. They would increase for all Part D enrollees who pay premiums. In other words——

Mr. BRADY. Including those who are not in the doughnut hole?

Mr. FOSTER. Their premiums would increase, on average, not by very much. The amount is shown in the table on page 12. Now, for people who make it to the coverage gap, where the coverage gap——

Mr. BRADY. That I understand. I have some more questions.

The second point you make on Medicare Advantage, the new provisions will reduce Medicare Advantage rebates to plans and thereby result in less generous benefit packages, an estimated $1,500 a year over time. In plain English, is that saying that seniors within Medicare Advantage will have less benefits under the new health care bill?

Mr. FOSTER. Yes, sir.

Mr. BRADY. On the same page, "The reduction in Medicare Advantage rebates will cause a large increase in the out-of-pocket costs incurred by Medicare Advantage enrollees, estimated $873 more a year over time." In plain English, does that mean seniors in Medicare Advantage will have to pay more as a result of this new health care law?

Mr. FOSTER. If the Medicare Advantage plan benefit package, in other words the supplemental benefit package, stays the same——

Mr. BRADY. They will have to make up the difference out of their pocket.

Mr. FOSTER. Enrollees will have to make up the difference.

Mr. BRADY. That is my fear.

Final point. There is concern that the way this new health care plan was structured, it punishes seniors who are getting their retirement plan through their business that they retire from, versus those perhaps of State, Federal Government workers. Removing the tax deductibility of their assistance for their medicines is going to have an impact.

You say here, that you have, quote, the anticipated movement of many of the Medicare beneficiaries currently enrolled through the retiree drug subsidy program of Part D plans.

Does that mean that you anticipate seniors who are currently getting medicine help through their retirement plan from their business will be either forced or will move to the Medicare plan, as a result of the cut in their health—under this health care plan.

Mr. FOSTER. Yes, sir. As a result of the change in the tax status of the subsidy payments to employers.

Mr. BRADY. They left in place that subsidy help in its entirety for those government workers on retirement plans. Do you anticipate government workers being forced off or leaving their plan for Medicare?

Mr. FOSTER. I don't have any idea. I think it is a somewhat different issue.

Mr. BRADY. Well, it is the impact of removing the subsidy. When it was put in place they were equal. Workers in a government retirement plan and workers in a business plan were treated equally. That parity is now gone with removal of the tax deductibility that was done to make them whole. So at this point at least, you didn't at least estimate that, unlike private sector workers, government workers will not be leaving their plan?

Mr. FOSTER. No. Again, it is a little bit different, sir. For the retiree drug subsidy within Medicare, you had an employer who was paying the drug cost for drug insurance for his or her retired workers. The employer could deduct that full amount.

Mr. BRADY. I know how it works.

Mr. FOSTER. And the Medicare payment through the retiree drug subsidy to the employer was not counted as income and did not reduce the amount that the employer could deduct.

Mr. BRADY. At some point we need to continue this discussion, because I think there is a direct correlation there. So thank you, Mr. Chairman.

Ranking Member Levin. Thank you. The gentleman's time has expired.

Mr. STARK. is recognized.

Mr. STARK. Thank you, Mr. Chairman. Thank you for having this hearing and welcome back, Mr. Foster.

In Medicare Advantage, under the ACA, would Medicare benefits be reduced?

Mr. FOSTER. The traditional Medicare benefit package would not be affected. The extra benefits that most plans offer would definitely be reduced over time.

Mr. STARK. The ACA extends solvency by about 12 years, correct?

Mr. FOSTER. Yes, sir, based on the 2010 trustee's report baseline.

Mr. STARK. And ACA lowers cost-sharing under Part B saving beneficiaries at the doctors' offices; is that correct?

Mr. FOSTER. Yes, sir, for fee-for-service beneficiaries.

Mr. STARK. And it reduces out-of-pocket spending for prescription drugs, does it not?

Mr. FOSTER. Yes, sir, by closing the coverage gap.

Mr. STARK. And the ACA leaves Part B premiums which are presently made up of Social Security deductions the same; is that correct?

Mr. FOSTER. It would actually for fee-for-service beneficiaries, actually all beneficiaries, it would lower the Part B premiums.

Mr. STARK. And would repeal raise costs for beneficiaries and reduce solvency?

Mr. FOSTER. It would essentially do the opposite of everything that the ACA did; in other words, putting it back where it had been.

Mr. STARK. Can I go back just very quickly to the Medicare Advantage benefits? It has always been a concern of mine that the benefits offered in Medicare Advantage are far different from those that are actually used. In other words, a Medicare Advantage plan may offer trips to China and all kinds of things that the members of the Medicare Advantage plan would have no possible chance to use. Do you have any figures that relate to the benefits "offered," and as opposed to those that are actually used?

Mr. FOSTER. Directly, no. Indirectly, yes. In other words, when a plan submits a bid for Medicare Advantage, and they have to specify the per-member-per-month cost of the various supplemental coverages that they offer, they have to justify that cost based on the past experience of the cost for those provisions.

Mr. STARK. How much they actually paid out?

Mr. FOSTER. Yes. So you can't have too much of a difference there without our challenging it and asking for a justification for the difference.

Mr. STARK. So it would be difficult for those plans to offer spurious benefits that are just there in name only but aren't really very attractive to the members; is that fair?

Mr. FOSTER. I am sure it happens to some degree in some cases, the gym club memberships perhaps, that kind of thing.

Mr. STARK. For me, they don't do me much good. Thank you very much.

Thank you, Mr. Chairman.

Chairman CAMP. Thank you. Mr. Tiberi is recognized.

Mr. TIBERI. Thank you, Mr. Chairman. Thank you for being here, sir. Medicare Advantage is voluntary; right, sir?

Mr. FOSTER. Yes, sir.

Mr. TIBERI. So you can sign up or you can drop off.

Mr. FOSTER. That is right.

Mr. TIBERI. Every senior I have talked to who is on Medicare Advantage said that they liked the Medicare Advantage plan they

are on because it offers them a comprehensive health care package whereas Medicare fee-for-service does not.

Do you know off the top of your head how many, what percentage of seniors who are on Medicare, traditional Medicare fee-for-service, are in another additional plan, whether it be Medicaid, Medigap, retiree coverage?

Mr. FOSTER. It is a fairly high percentage.

Mr. TIBERI. Like maybe 90?

Mr. FOSTER. Probably not quite that high, but 75 perhaps. I could look those up for you.

Mr. TIBERI. I would love that number. Thank you sir.

[The information follows: Did not receive]

Mr. TIBERI. So is it fair to say that under the current system, Medicare fee-for-service is not meeting the needs of most seniors because they are choosing other forms of coverage?

Mr. FOSTER. I would put it it slightly differently. I would agree generally, but I would put it slightly differently. The Medicare benefit package, the fee-for-service package is not exceptionally generous. It has significant cost-sharing requirements and it doesn't have catastrophic coverage protection. So most Medicare beneficiaries who are able to seek additional coverage, either through Medigap or they have it through their employer plans, or if you are low income you have it through Medicaid just in order to avoid the risk of financial catastrophe.

Mr. TIBERI. And most Medicare Advantage beneficiaries do not seek that additional coverage, correct?

Mr. FOSTER. Generally not. Many plans have catastrophic coverage but not all.

Mr. TIBERI. So if you reduced the number of enrollees on Medicare Advantage and they go in Medicare fee-for-service, then they will have an additional out-of-pocket expense, potentially a new Medigap, that they would have to pay for.

Mr. FOSTER. Typically.

Mr. TIBERI. Do you know who the largest Medigap provider is in America?

Mr. FOSTER. United Health Care.

Mr. TIBERI. Is it affiliated with any other organization?

Mr. FOSTER. Like AARP.

Mr. TIBERI. Are they the largest?

Mr. FOSTER. I don't know.

Mr. TIBERI. Could you get that information? Could CMS provide that?

Mr. FOSTER. I could try to find out.

[The information follows: Did not receive]

Mr. TIBERI. So is it safe, then, to say that if you are in a position to gain market share, you would be opposed to the Medicare Advantage program to continue to exist if you were a provider of an additional product?

Mr. FOSTER. I am sorry, I didn't quite understand.

Mr. TIBERI. If you were in the business of providing coverage for seniors and you are providing that holistic coverage as an addition to Medicare fee-for-service, the more Medicare fee-for-service beneficiaries there are, the better it is potentially for you to supplement your business by offering more coverage to supplement Med-

icaid fee-for-service. Meaning if there are fewer Medicare Advantage beneficiaries, they have to go back in the Medicare fee-for-service, so you would be potentially benefited.

Mr. FOSTER. Yes, you would have a broader market opportunity.

Mr. TIBERI. Because the odds are that if you are no longer on Medicare Advantage, you would need something other than just Medicare fee-for-service based upon what we already know, right?

Mr. FOSTER. Yes, sir.

Mr. TIBERI. So is it fair to say that what Mr. Ryan is trying to do, what he has been criticized for trying to do, doesn't acknowledge the fact that most Medicare—most, the majority, you said 75 percent, look forward to the number—but most Medicare fee-for-service individuals today don't believe that they have enough coverage, therefore are either supplementing their coverage. So it is not fair because we are not, to be critical, we are not comparing apples to apples. Is that fair?

Mr. FOSTER. Well, fee-for-service Medicare by itself is a basic package without catastrophic protection or some other features.

Mr. TIBERI. And what Mr. Ryan is also providing is a basic package that is for the senior.

Mr. FOSTER. That is correct.

Mr. TIBERI. Thank you. I appreciate that. I yield back.

Chairman CAMP. Thank you. Mr. Davis is recognized.

Mr. DAVIS. Thank you, Mr. Chairman.

Mr. Foster, I appreciate the work that you have done to try to make sense of the health care law and the impact it will have on seniors' coverage under Medicare. You do an important job. I thank you for your service. Surviving 38 years in the mosh pit of politics is a credit to a Job-like stability of mind to be able to keep focus.

Mr. FOSTER. Or limited mental faculties.

Mr. DAVIS. I think that is over in the United States Senate, probably, where we would find that.

But earlier this morning, many of us would asked Dr. Berwick his thoughts about the numbers that your office has put out. I come from an operations and planning background where the metrics are everything and the assumptions behind the metrics are really how you can formulate effective policy decisions, make business decisions, and have some adequate degree of predictability about the way trends are going.

I understand that there is no actuarial formula that is is perfect, unless you had the ability to see into the future. And I am sure you would not be working here if that were the case. You would have clients in other places. But the projections are hypothetical, but they are very critical to understand how these assumptions would play out for policy.

And I think that I felt rather uncomfortable this morning asking specific questions that are based on data and not getting an answer.

But I was wondering, technically speaking, if you can take a moment to explain for us the role of your office and how you do what you do. If you could give us kind of a sound-bite version of that, outside of it being perceived by many non-numerically-oriented folks as kind of a black art to come up with things that can get

batted around. I would like to hear your perspective on how you come to your conclusions.

Mr. FOSTER. Sure. There are many techniques for estimation, cost projection, that actuaries use both in government and in the private sector. The better the data, the better job we can do. It is hard, of course, when you have something new, not tried before, where it is hard to predict people's behavioral response, people, employers, whatever.

We have a staff of about 90 percent people in the Office of the Actuary at CMS. They are all sharp, above average, handsome and beautiful respectively, and they work very hard to try to estimate the financial and other impacts of any proposal that is asked of us.

Mr. DAVIS. Well, following on that, the nonpartisan Congressional Budget Office has made clear that Medicare savings as a result of the health care law can't be counted twice; first, to shore up solvency of the Medicare program while also paying for a new health care entitlement program. Further, your office's April 22, 2010, report on the effects of the Democrats' health care law, and the Medicare Trust Fund pointed out—and I am quoting—In practice, the improved party financing cannot be simultaneously used to finance other Federal outlays, such as the coverage expansions under the PPACA, and to extend the trust fund, despite the appearance of this resolve from respective accounting conventions.

I was wondering if you could tell us about this double-counting issue, maybe elaborate for us a little bit.

Mr. FOSTER. I would be glad to. It is nothing new, but it is relevant and important. I will go back to the example that I used a bit ago, where suppose under the Affordable Care Act a given worker has to pay $100 higher hospital insurance payroll tax. So that hundred dollars, the true cash, the hundred dollars is sent to the Treasury. The Treasury credits the Hospital Insurance Trust Fund with $100 Treasury security, and then the money goes into the general fund, and from there it is spent pretty much immediately, whether it is to offset the cost of the coverage expansions under the Affordable Care Act or for SSI benefits or anything else. But the money is spent.

Now, later on, a couple years down the road, we need our hundred dollars so we cash in our Treasury security, we get the $100 back with some interest. Obviously, it is not the same $100. That money is already spent. We need to spend $100, so Treasury has to come up with $100, say, by borrowing that much to then give to us. So the original $100 can't both spend $100 over here for coverage expansions and $100 over here for HI. On the other hand, because of the way the trust funds are set up, we do get the help when we need it in the future. I don't know if that helps or not.

Mr. DAVIS. That helps very much. I think a few of my colleagues' assumptions on the other side of the aisle remind me of a production manager once who quipped they were losing money on every product, but they would make it up on volume. And we certainly want to avoid that. Thank you very much for your service. I yield back.

Chairman CAMP. Thank you.

Mr. MCDERMOTT. is recognized.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

It is good to see you, Mr. Foster. We haven't seen you for a while. You have been around as long as I have been here, so I have got to see you on a number of occasions and I liked what you said earlier: You like to know how it actually works.

And as I look at Medicare, Medicare's administrative cost is 3 percent. That is the generally accepted figure. Do you accept that figure?

Mr. FOSTER. The way it is normally calculated it is actually quite a bit lower. If you look at all the Federal and related administrative costs for Medicare, it represents about 1.3 percent of total expenditures.

Mr. MCDERMOTT. 1.3 percent.

Mr. FOSTER. Yes, sir.

Mr. MCDERMOTT. Now, insurance companies' administrative costs are estimated on average about 14 percent, sometimes as high as 40 in the individual market; is that correct?

Mr. FOSTER. Yes, sir. That is in the ballpark, depending on the nature of the insurance.

Mr. MCDERMOTT. So if Mr. Ryan and the Republicans succeed in moving to a voucher system—that is, we hand 5,700 or 6,300 or whatever amount to seniors every month—how will that administrative cost on the insurance companies, will that be an added cost on top of what they are getting already? I don't understand where that administrative cost goes.

Mr. FOSTER. Well, any insurance premium that you see, just about any will normally include amounts to cover the medical expenses and also the administrative costs and whatever profit margin is built in. So under Mr. Ryan's plan, a voucher pavement would help a beneficiary purchase some level of coverage that would include the cost of administering the program.

Mr. MCDERMOTT. And when you look at it from the two standpoints of the government and the senior citizen, the government cost would go down if we had a voucher system; is that correct?

Mr. FOSTER. Yes, sir.

Mr. MCDERMOTT. And what would happen to the costs to the senior citizen, above the voucher? Would that pay for their cost, do you think?

Mr. FOSTER. It would depend on how the voucher amount is escalated each year. If it grows at a slower rate than health care costs——

Mr. MCDERMOTT. That is what Mr. Ryan is talking about, less than the medical inflation rate.

Mr. FOSTER. In his original proposal, that is correct. I believe it is—the modified version with Dr. Alice Rivlin, it would grow at a faster rate. But if you assume that the voucher payment increases more slowly than health care costs, then over time people would initially have to buy less comprehensive coverage. Now, that might help them purchase health care more prudently because they have more of a direct financial stake in it.

Mr. MCDERMOTT. You mean as they are getting older, they would be buying less health care coverage. Is that what you are saying?

Mr. FOSTER. Yes. Whether it is an individual who is getting older or a new person who comes along and qualifies for Medicare,

they might buy a catastrophic coverage instead of more comprehensive one. What I am saying is that can feed back into how much they spend.

Mr. MCDERMOTT. Does that make sense, that as you get older you need less health care coverage?

Mr. FOSTER. No. Of course, obviously, as people age, they typically run into higher health care costs. The issue here would be, how is the voucher handled? Is it adjusted for age? Is it one amount for all, and the insurance companies have to provide guaranteed issue regardless of age. Those are details to be worked out.

Mr. MCDERMOTT. So it would be—you would have to have some kind of regulatory system to make sure that insurance companies would sell a policy to an 85-year-old who had had several cancers.

Mr. FOSTER. Yes, I think that would be required.

Mr. MCDERMOTT. You couldn't get away without regulation; you would need the Federal Government involved in it?

Mr. FOSTER. I would tend to think so. In fact, I think Mr. Ryan's plan has that sort of thing involved. But as I said before, it has been a couple of years since I looked at it.

Mr. MCDERMOTT. Would his be called a government takeover of health care?

Mr. FOSTER. You would probably have to ask him that question, sir.

Mr. MCDERMOTT. Do you see any way that you can make the system that we put in last year in law better?

Mr. FOSTER. Sure.

Mr. MCDERMOTT. Give me a couple of suggestions.

Mr. FOSTER. Okay. If you think about Medicaid for a minute, the expansion of Medicaid eligibility applies to people under 65. So picture somebody who is 63 or 64 and qualifies for the Medicaid coverage. They turn 65, and of course they qualify for Medicare, and they then would no longer qualify for Medicaid. So that is, I hate to use the word "notch" for reasons you all remember, but I think that would represent a notch in benefit coverage. So that is a limitation that I think will need to be addressed.

Let me give you one other example, if I may——

Chairman CAMP. Your time has expired. If you want to complete that in writing that would certainly be welcome.

Mr. MCDERMOTT. Thank you.

[The information follows: Did not receive]

Chairman LEVIN. Mr. Reichert is recognized.

Mr. REICHERT. Thank you, Mr. Chairman. Welcome, and I am pleased to hear your answers to the questions that my colleague, Mr. McDermott, asked. I asked a similar question of the previous witness and didn't get an answer as to what he might change or improve in the health care law, so thank you for those answers.

I want to sort of stick to the theme that I was with earlier this morning, and that is if you like your health care plan you can keep it, and specifically for seniors. So as I understand the health care current law, there are substantial cuts to Medicare in the area of $200 billion. And according to your figures, by 2017 you are predicting that maybe 50 percent of the seniors who would otherwise

enroll in Medicare will probably not enroll in Medicare. Is that an accurate statement?

Mr. FOSTER. Yes, sir. We have estimated that about 50 percent of the people who would have been enrolled in Medicare Advantage plans would no longer be enrolled under the Affordable Care Act. A slightly better updated estimate is closer to 40 percent.

Mr. REICHERT. So if that happens, would it be fair to assume that there could be a large reduction in enrollment; in this large reduction in enrollment, there could be fewer choices in plans offered?

Mr. FOSTER. Yes. We have not modeled the number of plans that could be offered, but the private plans like to offer a certain kind of benefit package consistent with HMO's or PPO practice. If they can no longer offer that package because of the reduced Medicare rebates that are payable, then they might choose to exit the market.

Mr. REICHERT. So those seniors that are in those plans, because of the reduction of the choices that might be made available, would no longer be able to keep the health care plan that they like?

Mr. FOSTER. I anticipate that is what will happen.

I might add that that is not going to happen in 2011. It is going to happen gradually, between 2012 and 2017.

Mr. REICHERT. So while your report doesn't speak to the contraction of plans, can you give me your opinion on which plans would most likely survive in that sort of scenario?

Mr. FOSTER. We anticipate that it would vary geographically. The payment rates will be directly tied to Medicare fee-for-service costs in the area in question. In some parts of the country, fee-for-service expenditures are very, very high. South Florida comes to mind, obviously. In areas like that, the Medicare Advantage plans can comfortably have a cost under the fee-for-service level and they should be able to continue and do pretty well.

Mr. REICHERT. So would it be fair to say, too, that plans with a larger market share might be those that survive?

Mr. FOSTER. I would have to think about that. They get an economy of scale, so that would probably help. But that is not the biggest factor, I don't think.

Mr. REICHERT. So what about the Medigap insurance? Would that be one of those you think that would still be around as plans are reduced through Medicare Advantage cuts?

Mr. FOSTER. Yes. There is a distinction. The Medicare Advantage plans have different payment rules and they are governed by Medicare. The Medigap plans are overseen by the States, but that is a voluntary program that individuals decide to do on their own or not. It is unrelated to Medicare Advantage.

Mr. REICHERT. But as Medicare Advantage plans go away, seniors are going to have to make a choice to go someplace, as Mr. Nunes said, or Mr. Tiberi said, they are going to have to go somewhere, and Medigap would be one of those.

I just find it interesting that, I don't know if you are aware or not, but Mr. Herger and I have been investigating AARP's strong financial public support of this health care bill and their interest in the Medigap insurance plans. And as Medicare Advantage dis-

appears, Medigap insurance, United, for example, stand to gain a lot in my opinion. Would you agree with that statement?

Mr. FOSTER. Well, I think that if our projection ends up being correct, as I have every reason to expect, and something like 6 to 7 million people, beneficiaries, leave Medicare Advantage plans, many of them, perhaps most of them, will want auxiliary coverage and Medigap will be the most straightforward way to get it.

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

Chairman CAMP. Thank you. Dr. Boustany is recognized.

Mr. BOUSTANY. Thank you, Mr. Chairman. And, Mr. Foster, thank you for appearing before the committee today.

Mr. Foster, it is my understanding that the insurance experts, many insurance experts outside of government, all conclude that the long-term care program in this law, the so-called CLASS act, is likely to suffer from severe adverse selection, and the program will primarily appeal to less healthy enrollees and this will drive up premiums.

This month, a report by the Center for Retirement Research concluded that without adjustments, adverse selection will create a death spiral of rising premiums and declining participation. It noted that even with regulatory changes by the administration, premiums may never reach an affordable level for middle-class households.

So, considering your prior warnings, written warnings to Congress in April of 2010, do you agree with the conclusion that CLASS, as structured by the new health law, is likely to suffer from severe adverse selection in a death spiral of unaffordable premiums?

Mr. FOSTER. I certainly agree that, as written, the CLASS program would be subject to various severe adverse selection which could cause the so-called death spiral or assessment spiral. It may be possible administratively to adjust the program enough to make it viable, and I know people are working to that end.

Mr. BOUSTANY. But if indeed these premiums were to go up, clearly folks that are on Medicare, who have looked for some way to provide for their long-term care needs, will suffer. Is that true?

Mr. FOSTER. Well, the CLASS program I think was designed to try and meet two different sets of needs. One is as a form of Federal long-term care insurance for younger people, who over a long period would participate and then qualify for benefits——

Mr. BOUSTANY. Right. But the Medicare program today doesn't cover long-term care so it is really targeted for that population. Prior planning, obviously.

Mr. FOSTER. Well, the other thing it tried to accomplish was for people who were in not so good health or who are older, to give them an opportunity to acquire long-term care insurance.

Mr. BOUSTANY. So you have real concerns about the solvency of this program as it is constructed today.

Mr. FOSTER. Yes, sir, I do.

Mr. BOUSTANY. Thank you.

I want to change tracks now and just pursue a line of questioning I had with the previous witness with regard to physician shortages reimbursement linkage that is there. And in your testimony you describe unless providers could reduce their cost per

service correspondingly through productivity improvements or other steps, they would eventually become unwilling or unable to treat Medicare beneficiaries, and that is because of declining reimbursements that are built into the system. Is that correct?

Mr. FOSTER. Yes, sir, for affected providers like hospitals and skilled nursing facilities, et cetera.

Mr. BOUSTANY. Right. So if that is the case, that is clearly going to hurt access for Medicare patients and most likely be very acute in rural areas where there is obviously less opportunities for these institutions in rural communities to make appropriate adjustments.

Mr. FOSTER. Yes, sir. If over some period of time, the reimbursement rates become inadequate and you don't do anything about it, then I think access would be a significant issue.

Mr. BOUSTANY. And we heard some platitudes about innovations in reimbursement, but no specific detail. And further down in your testimony, you talk about some of these payment system reforms and delivery system reforms facilitated through the research programs that are described in the bill. But you say that these outcomes are far from certain, and many experts doubt the feasibility of such sustained improvements, and anticipate that over time Medicare price constraints would become unworkable and that Congress would likely override them, much as they have done to prevent reductions in physician payment rates, otherwise required by the sustainable

Mr. BOUSTANY. So I take that to mean that Congress will make adjustments to prevent these kinds of draconian cuts which were built into the original assumptions on cost savings for the bill, and so we won't achieve some of those cost savings and in fact we are perpetuating the same problem. Is that a fair statement?

Mr. FOSTER. Yes. That is a reasonable summary of my concern.

Mr. BOUSTANY. Thank you. And I sense that you don't have a lot of confidence in these prospective delivery system and reimbursement reforms that are being talked about. I mean, we have created a bureaucratic entity, but we don't really know what is going to materialize there.

Mr. FOSTER. I have a lot of optimism, but it remains to be seen whether it can be fulfilled.

Mr. BOUSTANY. Thank you.

Thank you, Mr. Chairman.

Mr. JOHNSON. Thank you.

Mr. Lewis is recognized.

Mr. LEWIS. Thank you very much, Mr. Johnson.

I thank you, Dr. Foster—Mr. Foster.

Mr. FOSTER. Mr. Foster. Dr. Foster is my father.

Mr. LEWIS. Okay. Well, thank you, Mr. Foster, for being here. Thank you for your service for many, many years.

Let me just ask you, Mr. Foster, is it true that for the first two decades all of the plan paid by 95 percent?

Mr. FOSTER. Are you asking whether the Medicare Advantage plan started off being paid 95 percent of the traditional level of cost?

Mr. LEWIS. Yes.

Mr. FOSTER. Yes, sir, that is correct.

Mr. LEWIS. Prior to health reform, did Medicare overpay Medicare Advantage plan?

Mr. FOSTER. Subsequent to the Medicare Modernization Act, the benchmarks for payments to private plans and the payment levels were clearly such that for a given beneficiary Medicare tended to pay roughly 12 to 15 percent more than if that person had been in fee-for-service.

Mr. LEWIS. What percentage of beneficiaries are enrolled in private plans?

Mr. FOSTER. Currently, it is about 27 percent.

Mr. LEWIS. Let me ask you another question: Do fee-for-service beneficiaries pay higher Part B premiums to cover these overpayments?

Mr. FOSTER. Yes, sir. The fact that the Medicare Advantage enrollees to date have a higher per-person cost for Medicare, that higher cost feeds through to Part B and affects the Part B premium, which is paid by all Part B enrollees. Now that difference will shrink over time under the Affordable Care Act.

Mr. LEWIS. Many of my colleagues keep asserting that benefits will be reduced, but I want to clarify that there will not be a reduction of Medicare benefits even for those in private plans. Is that right? Am I right?

Mr. FOSTER. Not in this case, sir. For the people who are in the private plans, they will actually see an outright reduction in their total——

Mr. LEWIS. But will those in Medicare benefits?

Mr. FOSTER. If you are referring to the traditional Medicare.

Mr. LEWIS. No, the guaranteed benefits.

Mr. FOSTER. Yes, there is no change in those, other than to expand them a little bit.

Mr. LEWIS. Thank you very much.

Mr. JOHNSON. Thank you.

Mr. Paulsen, do you wish to question?

Mr. PAULSEN. Thank you, Mr. Chairman. I would like to ask maybe one or two questions. Thank you, Mr. Foster.

I was just going to ask your perspective. The health care law includes now multiple potential Medicare payment reductions for all health care providers, and in addition there will be significant pressure and requirements to improve quality outcomes at the same or reduced costs. So layering on top of that now we have this new medical device tax in the new law that will make the tools these providers need to achieve their quality outcomes much more expensive because that tax is likely to begin to be passed on to health care providers and consumers as well. Do you see how the medical device tax is in conflict or direct conflict with the goals to improve patient care and reduce costs within our health care system?

Mr. FOSTER. The tax on the medical devices, I agree with your assessment that that tax is likely to be passed on through a higher price for the devices, which would, other things being equal, raise health care expenditures.

Mr. PAULSEN. Thank you, Mr. Chairman.

I will have one other question.

I think one of the elements of the accountable care organization oversight model that is included as a part of this shared savings,

this means if an ACO, as its known, succeeds in reducing costs by a certain amount and also meets selected quality measures, the hospitals and the physicians that are in the ACO will each receive a share of the savings that were generated. So this type of arrangement in which providers essentially have a financial interest to reduce care has been part of the several gain-sharing demonstration programs that are currently under way.

Independent monitoring of each ACO or shared savings program site must be an essential part of the ACO program to ensure that these financial incentives are appropriate and do not induce providers to limit a patient's treatment options and negatively affect quality of care. Can you comment regarding independent monitoring of ACOs, just independent monitoring of these accountable care organizations?

Mr. FOSTER. Well, I think what I would say is, obviously, you do have to monitor the quality that is part of the program, that you don't want providers to stint on care or avoid services that are really necessary. If they can avoid unnecessary services, that is great for everybody, but you do have to make sure, because of the financial incentive, that it doesn't go too far.

Mr. PAULSEN. Thank you, Mr. Foster.

Mr. Chairman, I yield back.

Mr. JOHNSON. Thank you.

Mr. Berg, do you care to question?

Mr. BERG. Mr. Foster, your office authorized an appendix to the Medicare Trustees 2010 report in which you question the Trustees' projections that Medicare party solvency would be extended. And you stated that their estimates do not represent the best estimate of actual future Medicare expenditures. I understand your office does not typically issue an ancillary report to the annual Medicare Trustee's Report giving an alternative projection. What were the key concerns that you had with the Trustees' report that compelled you to issue this ancillary report?

Mr. FOSTER. Well, there are two factors there, sir. One is, by law, I am required to certify that the assumptions and methods used in the Trustees' report are reasonable. In my comment in that certification I said that the current law projection is probably not a reasonable projection, given that the current law itself may not be viable, some of the provisions may not be viable.

Now, in addition to that, we issued an auxiliary memorandum with the illustrative alternative projection that showed, under a different version of the law, if the parts that we worried about the viability—the physician payments and the productivity adjustments—if those are assumed to go away, to be overridden, then what would the cost look like?

Now we had done that in the past just for the physician SGR issue, and the Trustees have asked us to do this. So I wouldn't say I am at major odds with the Trustees in any respect. We all recognize the concerns and want to make sure the public understands and you understand the concerns.

Mr. BERG. One additional question. As you know, the health care law cuts Medicare Advantage by $206 billion, according to the CBO. Can you elaborate on how these cuts will impact enrollee benefits and premiums and plan availability?

Mr. FOSTER. Under the current law, if a plan's cost is lower than the so-called "benchmark" level, then the difference, a portion of the difference—and to date it has been 75 percent—it is paid to the plans in the form of a rebate. They have to use the rebate amounts to either reduce cautionary requirements or add extra benefits, like dental or vision coverage, or reduce Part B or Part D premiums.

Now under the Affordable Care Act, the benchmarks will be reduced significantly and the percentage, what used to be 75 of this difference, benchmark versus bid, that will be reduced to 50 percent, although it can be increased for quality bonuses. But the bottom line is the rebate amounts are going to be reduced substantially. And in the written testimony, we estimate about $1,500 on average by 2019. So that will cut back to the tune of $1,500 the extra benefits that can be offered.

Now the MA beneficiaries will also benefit from the fee-for-service effects. They will have to pay a lower Part B premium and other changes. So they gain from that but not as much as they lose from the lower benchmarks.

Mr. BERG. Thank you. I will yield back my time.

Mr. JOHNSON. Thank you.

Mr. Levin, Do you have one more comment?

Mr. LEVIN. Well, just as a follow up to that last question about Medicare Advantage programs.

Mr. Foster, I think if your testimony is taken as a whole and not taken apart just for some advantage, talking about Medicare Advantage, it is clear that essentially a lot of Medicare beneficiaries were subsidizing extra benefits for others and that subsidization essentially led to an advantage for Medicare Advantage plans. Now that advantage is being reduced and, as a result, a large number, the larger percentage of people covered by Medicare won't be subsidizing advantages for others.

As that advantage is reduced, I think you would agree that there are other ways for carriers to make up the difference. They can become more efficient, no? The insurance carrier can become more efficient?

Mr. FOSTER. Yes, sir, there is potential for that.

Mr. LEVIN. Indeed, I think there is a recent report from one of them that have reduced premiums because of the more efficient way that care is being delivered. And one can very readily argue that the reduction in that subsidy will lead to more carefully and effectively delivered health care.

Mr. FOSTER. At the margin, I think you are probably correct. In the big picture, I don't think that is enough to counteract the changes of the benchmarks.

Now I might add, because I don't want anybody to misunderstand me, I have no position on the policy issue of whether it makes sense or does not make sense for one group of Medicare beneficiaries to get an advantage and another group not to get it. That is a policy issue. That has been the case for the Medicare Advantage enrollees, benefit from the nature or the design of the formula for payment. That has been very valuable and has been very popular. To the extent that the Affordable Care Act removes most of that advantage, is that good policy? That is for you all to decide.

Mr. LEVIN. I think you described it accurately. A lot paid for an advantage for a minority, and we are now reducing that advantage. Hopefully, reducing a subsidy paid for by the majority can lead to more effective delivery of care.

Thank you very much.

Mr. JOHNSON. Thank you, Mr. Levin.

And I want to thank you, Mr. Foster. I appreciate your lengthy stay with us this morning, and I would ask that if any members want to submit questions that you be allowed to provide written responses for the record, if you would.

With that, this hearing is adjourned.

[Whereupon, at 2:15 p.m., the committee was adjourned.]

[Submissions for the Record follow:]

Prepared Statement of Mr. RANGEL
Bad Rap? Health Care Law Blamed for Sale of Catholic Hospitals
October 18, 2010
by Lori Robertson

Republicans are claiming the new health care law is a "main reason" for the sale of three Catholic hospitals in Pennsylvania. And a conservative Catholic group is running a radio ad saying it is "the" reason. But the hospitals' CEO says his words are being twisted and the new law isn't the "precipitating factor" behind the sale.

The hospital group says in a news release that "[t]he rationale for our initiative has been mischaracterized by certain politicized media outlets and severely distorted by some special interest groups." Here's what that refers to:

- A press release from the Republican staff of the House Ways and Means Committee claims: "Three Catholic hospitals in Pennsylvania have been put up for sale, with ObamaCare cited as a main reason for the decision."
- And a radio ad from a group called CatholicVote.org says the hospitals "are calling it quits. . . . The reason? Obamacare." The ad calls for the defeat of Democratic Reps. Paul Kanjorski and Chris Carney—both of whom are Catholic and voted for the health care law.

The origin of these claims is an interview given to a local television station by Kevin Cook, CEO of Mercy Health Partners in Scranton, Pa., regarding the decision to sell three hospitals. Cook told WNEP–TV in an October 6 segment that the three hospitals in the Scranton area were "doing well" and were "ahead of budget for the year." But, he said, "it's more a decision when we look out over the landscape of health care over the next five years . . . we understand that a different level of investment may be required than what we can facilitate on our own." The reporter then says that "much of that required investment" was a result of the new health care law. Cook is shown saying: "Health care reform is absolutely playing a role. But was it the precipitating factor in this decision? No. But was it a factor in our planning over the next five years? Absolutely."

Those sound bites quickly evolved as the story was picked up by blogs and the conservative press, and by the GOP, which issued its release two days later, on Oct. 8. That same day, however, the Catholic Health Association issued a statement calling the reports "alarmist" and "false."

CHA President Carol Keehan, Oct. 8: Reports that health reform is the primary motive behind the sale are completely false, misleading and politically motivated. Deliberations to sell the facilities began well before the Affordable Care Act became law and did not hinge on enactment of the legislation.

Here it should be noted that Sister Keehan is a Roman Catholic nun with long experience running Catholic hospitals and with Medicare regulations, but she also advocated strongly for passage of the new health care law. President Obama awarded her one of the 21 pens he used at the signing ceremony. So she's not a neutral source.

On the same day, however, Cook himself posted a similar disclaimer on the hospitals' website:

Mercy Health Partners' CEO Cook, Oct. 8: The rationale for our initiative has been mischaracterized by certain politicized media outlets and severely distorted by some special interest groups.

Discussions about mergers, acquisitions and strategic partnerships have been conducted in our health care community for years–long before the passage of the Affordable Care Act. Our decision announced last week was due to many factors.

None of this stopped CatholicVote.org from airing its radio ad, which it first posted to its YouTube site on Oct. 11. The ad targets Democratic Reps. Kanjorski and Carney, both of whom are in toss-up races, according to the Cook Political Report. The group, a 501(c)(4) advocacy organization, is running the ad primarily on talk radio. It says: "Mercy Hospital CEO Kevin Cook said that President Obama's health care law is absolutely playing a role in their decision to close their doors. Paul Kan-

jorski and Chris Carney are both Catholic and each claim to represent us in Washington." The ad says both voted for the health care law and urges voters to "say goodbye to Paul Kanjorski and Chris Carney."

The following day, Mercy's CEO went back on the air, saying in another TV interview that his words were being twisted. In the follow-up story, a WNEP reporter says that Cook "claims opponents of health care reform are twisting his words out of context" and that "Cook says health care reform is a small factor, but a factor, because its cost and impact is unclear." Cook himself stresses that the hospitals are "not closing," as the radio ad claims. And Cook says it's "disappointing that a decision that we made that was in the best interest of this community has been politicized in the way it has."

In fact, the hospitals' original Oct. 6 press release announcing the sale cited long-term issues, and didn't mention the new law: "For more than two decades area hospitals have endured lower than average reimbursements for care and a static population base. This has, at times, resulted in empty hospital beds and the duplication of services." An editorial in the Scranton Times Tribune echoed that assessment, saying: "Just about everyone in the regional health care industry has known for some time that Scranton no longer can sustain three independent full-service community hospitals. Mercy and Moses Taylor hospitals and Community Medical Center all have considered sales or mergers while vigorously shedding services and staff."

Even in Cook's initial TV interview, he said the law wasn't "the precipitating factor." So how does CatholicVote.org justify its claim that "the" reason to "close" the hospitals is "Obamacare"? We asked the group's president, Brian Burch. He said that how big a role the law played could be debated, but "the fact of the matter is, it was a factor." He says the ad uses Cook's exact words, saying the law is "absolutely playing a role." As for the CEO's subsequent statements, Burch said: "I think he's trying to backtrack on his statement."

Gladys Bernet, a spokeswoman for Mercy Health Partners, told us that Cook didn't bring up the health care law as a factor in the original TV interview, but he was responding to the reporter's question. She says the "mistake" was that his "response was too nuanced." If you listen to his comments carefully, she says, Cook says that the health care law was a factor in long-term planning. But, "was it the precipitating factor in this particular decision? No." Says Bernet: "That's a very nuanced answer."

Nuance, however, rarely makes it into political messages.

Correction, Oct. 18: We originally wrote that Sister Keehan was present at the White House signing ceremony for the health care law. That's incorrect. She was traveling and could not attend the ceremony, according to the Catholic Health Association.

Families USA, Statement

Families USA is a national nonprofit, nonpartisan organization for health care consumers. Our mission is to ensure that all Americans have access to high-quality, affordable health care. Families USA has a strong interest in the protection of Medicare beneficiaries. We submit these comments to the House Committee on Ways and Means with regard to the Hearing on the Health Care Law's Impact on the Medicare Program and Its Beneficiaries.

For more than a year, opponents of the Patient Protection and Affordable Care Act (Affordable Care Act) have erroneously charged that health reform was enacted at the expense of Medicare and its beneficiaries. This is simply not true. Medicare's benefits are improved under the Affordable Care Act. And although Medicare's future spending is lower under the health law than it was projected to be prior to enactment, this reduction is not the result of across-the-board reductions in payments or from reductions in benefits. The savings come from making Medicare work better by improving the way health care providers deliver care; modernizing how Medicare pays for services; and eliminating waste, fraud, and abuse.

Improving Medicare Benefits

Closing the Doughnut Hole

When the Medicare Part D prescription drug program was created in 2003, it included a gap in coverage known as the doughnut hole. When in the coverage gap, a beneficiary had to pay 100 percent of the cost of the prescription drugs purchased.

In 2010, the coverage gap began once the beneficiary paid $2,830 for prescription drugs and ended once prescription drug costs reached $6,440. This meant that a beneficiary with significant prescription drug needs was responsible for $3,610 in out-of-pocket costs before catastrophic coverage started.

The Affordable Care Act closes that gap, saving beneficiaries money and improving access to needed medications. In 2010, any beneficiary who fell into the coverage gap received $250 to help defray the cost of medications. In 2011, once a beneficiary spends $2,840, he or she reaches the doughnut hole. However, beneficiaries will no longer pay 100 percent of the cost of drugs. Now, beneficiaries will pay 50 percent of the cost of brand-name prescription drugs and 93 percent of the cost for generic drugs. Each year until 2020, the discount provided will increase, until the coverage gap is closed.

Improving Access to Preventive Services

Prior to the Affordable Care Act, Medicare beneficiaries were liable for deductibles and co-insurance for some preventive services, even if those services were covered by Medicare. If Medicare did not cover the service, such as an annual physical exam, the beneficiary had to pay the full cost of the service. Since these costs could be unaffordable for Medicare beneficiaries, they may have foregone these services.

The Affordable Care Act recognizes the importance of preventive health care, both in terms of how it can improve people's health and in terms of the savings it can create for the health care system. That's why, for the first time in the history of the Medicare Program, as of January 1, 2011, beneficiaries will no longer have to pay out of their own pockets for preventive services like cancer screenings or mammograms. Medicare will also be able to add coverage in the future for new preventive services that are found to be effective.

The Act also gives beneficiaries the option to spend more time with their doctor at their annual physical (or wellness visit) to develop a personalized prevention plan together. These plans include information about the beneficiary's current health status and a schedule for preventive services that the beneficiary should get over the next five to 10 years. These changes mark an important shift in Medicare's approach toward helping beneficiaries stay well, rather than only treating them when they are sick.

Moderating Premiums

Most Medicare beneficiaries will see slower growth in their Medicare Part B premiums than they would have seen if the Affordable Care Act had not passed. By 2018, Medicare Part B premiums for most beneficiaries are estimated to be $200 less per year than they otherwise would have been.

Improving Medicare's Financial Outlook

Technological advances in health care services have caused care to become more expensive, and as a result, Medicare spending continues to increase. To ensure the sustainability of the program, it is necessary to make changes that improve and modernize the way services are paid for. In 2009, the Medicare trustees estimated that the Medicare trust fund would be insolvent by 2017, meaning that, after that date, the trust fund wouldn't have sufficient money to cover all of Medicare's estimated costs. In order to extend the life of the trust fund and to improve benefits for people with Medicare, the Affordable Care Act makes carefully targeted changes to the program to achieve $418 billion in savings between now and 2019.[1] These changes extend the life of the Medicare trust fund by 12 years to 2029.

While $418 billion over 10 years is a considerable spending reduction, it is important to understand that the savings are only a small amount compared to the total spending that will occur in the program over the same period of time. Over the next 10 years, Medicare will still spend about $6.7 trillion (down from a projected $7.1 trillion before the law was passed).[2] While the annual growth in spending will decrease from 6.8 percent to 5.5 percent, the program's spending will still grow by more than 5 percent per year over the next 10 years. In other words, the Medicare Program will spend more in 10 years than it does now (the rate of growth will just

[1] Centers for Medicare and Medicaid Services, Affordable Care Act Update: Implementing Medicare Cost Savings, (Washington: August 2010), available online at *http://www.cms.gov/apps/docs/ACA-Update-Implementing-Medicare-Costs-Savings.pdf*.

[2] Kaiser Family Foundation, Medicare Spending and Financing Fact Sheet (Washington: August 2010), available online at *http://www.kff.org/Medicare/upload/7305-05.pdf*.

be slower), meaning that it will continue to be able to meet the needs of beneficiaries today and in the future.

Historically, spending reductions are not unusual, and compared to other legislation, the reductions in the Affordable Care Act are modest.[3] For example, in 1997, faced with a forecast that the Medicare trust fund would become insolvent by 2001, Congress enacted substantial changes to the Medicare Program, which were estimated to reduce future Medicare spending by 12 percent over 10 years.[4] By contrast, the Affordable Care Act is projected to reduce Medicare spending by about 5 to 7 percent over 10 years.

Achieving Cost Savings

So how are these cost savings in Medicare achieved? The savings are achieved by giving health care providers incentives to work together to provide high-quality, efficient care and by eliminating waste, fraud, and abuse. These measures not only save money, but they also improve care for beneficiaries.

Encouraging Coordination among Health Care Providers

Under Medicare's current fee-for-service payment system, health care providers are paid for each individual service they provide to a patient. This means that the more services they provide, the more money they are paid. This incentive to provide more care is a major contributor to increasing health care costs. The Affordable Care Act begins the process of moving away from the fee-for-service payment system and toward a value-based system, where health care providers are paid based on the value of the care they provide.

All providers can lower costs and improve the quality of care, thereby improving the value of that care, by working together to coordinate patient care. One of the new payment mechanisms created by the Affordable Care Act allows doctors, hospitals, and other health care providers to join together to form accountable care organizations (ACOs). Providers in an accountable care organization will take responsibility for the cost and quality of the health care delivered. If the accountable care organization delivers high-quality care at lower costs, the providers in the accountable care organization can share in the savings they generate. For example, by working together, health care providers can avoid duplicating tests and can monitor a patient's prescription drugs to make sure the patient is not taking medications that interact poorly, among other things. This new payment approach will create an estimated $5 billion in savings for the Medicare Program. Just as importantly, it will improve the quality of the care that beneficiaries receive and lay the groundwork for more substantial savings and improvements in the future.

Eliminating Waste, Fraud, and Abuse

The Affordable Care Act takes significant steps to protect Medicare by cracking down on waste, fraud, and abuse. The law provides relevant agencies with an additional $350 million over the next decade to hire more investigative personnel to aggressively monitor and prevent waste, fraud, and abuse in the system.

The health reform law will require Medicare providers to go through stricter screenings, such as background checks and site visits, to ensure that fraudsters, such as a doctor who bills for services he or she never provided, never enter the program to begin with. In addition, the Affordable Care Act imposes harsher fines and penalties on Medicare participants who submit false information on applications and claims. With stronger penalties, "bad actors" should be deterred from committing fraud and abusing the system.

The nonpartisan Congressional Budget Office (CBO) estimates that every $1 that is invested to fight fraud results in $1.75 in savings. The provisions in the law to fight waste, fraud, and abuse are expected to save the Medicare program about $5 billion over the next 10 years.

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[3] Jennifer O'Sullivan, Medicare: History of Part A Trust Fund Insolvency Projections (Washington: Congressional Research Service, March 28, 2008), available online at *http://aging.senate.gov/crs/Medicare14.pdf*.

[4] Kaiser Family Foundation, Medicare Savings in Perspective: A Comparison of 2009 Health Reform Legislation and Other Laws in the Last 15 Years (Washington: December 2009), available online at *http://www.kff.org/healthreform/upload/7983-02.pdf*.

Paying for High-Quality Care

Among the ways that the health reform law begins to rein in unnecessary spending while also improving the care beneficiaries receive is by encouraging hospitals to prevent avoidable readmissions and hospital-acquired conditions. Once these changes are fully implemented, they will save the Medicare Program more than $11 billion.

Sometimes it is necessary for a patient to be readmitted to the hospital shortly after being discharged—for example, if the patient must have multiple surgeries to treat his or her condition. But sometimes, a patient must be readmitted for a reason that could have been avoided, such as complications from not taking medication properly because no one explained how the medication would need to be taken.[5] Hospitals can decrease the number of avoidable readmissions by providing better care when the patient is in the hospital and by improving communication with patients (and their care givers) and other health care providers who care for the patient. That way, patients know how to care for themselves when they leave the hospital and their doctors know, for example, what tests were performed while the patient was in the hospital and the medications the patient is taking.

Beginning in 2013, hospitals that have high rates of readmissions for certain health conditions will see their Medicare payment rates reduced. To avoid a reduction in their payments, hospitals will need to implement programs to improve the quality of care that patients receive while in the hospital and ensure that patients, care givers, and health care providers receive proper information when patients are discharged from the hospital.

The Affordable Care Act also builds on existing efforts to improve care and save money when patients are still in the hospital. Since October 2008, Medicare has imposed a financial penalty on hospitals each time a patient experiences certain hospital-acquired conditions, such as an injury from falling, bedsores, or an object being left in a patient during surgery. The Affordable Care Act takes this a step further. Starting in 2014, each hospital's record for hospital-acquired conditions will be posted online publicly at *www.hospitalcompare.hhs.gov*. In addition, if a hospital has a high rate of certain hospital-acquired conditions, its total Medicare payment will be reduced by 1 percent.

Modernizing Medicare's Payment System

The majority of Medicare savings under the Affordable Care Act come from altering the way hospitals, nursing homes, and other health care facilities are paid. Traditionally, Medicare increases payments to hospitals and other health care facilities each year using a complicated formula. Each hospital gets this increase regardless of whether it is providing good-quality, efficient care. The health reform law changes this.

The Affordable Care Act reduces these annual adjustments over the next 10 years. The purpose of this change is to encourage hospitals and other health care facilities to improve their productivity through increased efficiency. Each year, other industries increase their productivity by improving their efficiency so that they provide more for less, which lowers costs for consumers. The health reform law applies this same principle to the health care industry, which will save the Medicare Program $205 billion over 10 years.

Some people have questioned whether hospitals will be able to continue to operate after these payment reductions take effect. But the hospital industry agreed to these payment reductions, acknowledging that they will gain from the millions of newly insured people and that savings can be achieved through improved efficiencies, such as preventing duplications of tests by using electronic health records to monitor the care that a patient has already received.[6] Also, hospitals will be able to avoid some of the payment reductions by providing high-quality care. Beginning in 2012, hospitals that meet certain performance levels will receive higher Medicare payments.

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[5] The Medicare Payment Advisory Commission (MedPAC), in its 2007 report to Congress, estimated that about 18 percent of patients were readmitted to the hospital within 30 days of being discharged, and of that, about 13 percent were potentially avoidable. MedPAC estimated the cost to Medicare for potentially avoidable readmissions within 30 days of discharge was $12 billion. Available online at *http://www.medpac.gov/chapters/Jun07_Ch05.pdf*.

[6] Ceci Connolly and Michael Shear, *Hospitals Reach Deal with Administration, The Washington Post*, July 7, 2009, available online at *http://www.washingtonpost.com/wp-dyn/content/article/2009/07/06/AR2009070604053.html*.

Leveling the Playing Field between Original Medicare and Medicare Advantage

In recent years, overpayments to Medicare Advantage plans have been identified as a substantial source of waste within the Medicare system. These plans were established in the eighties with the expectation that they would lower Medicare costs by providing coverage more efficiently. Instead, Medicare Advantage plans have been paid an average of 14 percent more than it would have cost to treat the same beneficiaries in original Medicare. In 2009, that was equal to about $1,138 per beneficiary, for a total of $11.4 billion in overpayments. As a result of this increased cost, Medicare Part B premiums are about $3.00 more per month than they otherwise would be for all Medicare beneficiaries, not just those in these private plans. While these overpayments generated considerable profits for the private insurance companies, they did not benefit the Medicare trust fund. Instead, they moved up the insolvency of the trust fund by 18 months.

In 2011, under the Affordable Care Act, payment rates for Medicare Advantage plans are frozen at 2010 levels. Despite this freeze in payments, analysis of the Medicare Advantage market for 2011 shows that Medicare beneficiaries were able to choose among, on average, 24 Medicare Advantage plans by county. Premiums remained essentially stable from 2010 to 2011, which is a significant difference from 2009 to 2010, when premiums increased by 22 percent.[7] In addition, estimates show that Medicare Advantage will experience a 5 percent increase in enrollment in 2011.[8] Beginning in 2012, rates will be reduced over a 3- to 7-year period so that costs are closer to those of original Medicare. High-quality plans will receive bonus payments of 5 to 10 percent. These changes will save the Medicare Program $145 billion.

Opponents of health reform claimed that these changes would result in beneficiaries who are enrolled in Medicare Advantage plans losing their coverage. In fact, Medicare beneficiaries will not lose coverage for Medicare's guaranteed benefits, which include hospital inpatient coverage and doctor visits, among other things. Each private plan will have to make a business decision about how it wants to operate under the new payment system. Plans that are not able to provide health coverage efficiently may reduce coverage or withdraw from Medicare. But high-quality, efficient plans will continue to offer coverage, and the new quality bonuses may make these plans more attractive.[9] Furthermore, everyone with Medicare will always have the option of getting coverage through original Medicare if they no longer like their Medicare Advantage plan.

Conclusion

As the health care system advances and new, more expensive treatments become available, the Medicare Program must also adjust to meet the changing needs of beneficiaries. It must ensure that it can continue to offer the coverage that millions of seniors and people with disabilities have come to rely on. The Affordable Care Act takes important steps to ensure that Medicare is there for Americans in the future, while improving benefits for tens of millions of beneficiaries, improving their access to care while lowering their out of pocket costs.

American College of Physicians, Statement

The American College of Physicians (ACP) is pleased to submit the following statement for the record of the above referenced hearing. ACP is the largest medical

[7] Marsha Gold, Gretchen Jacobson, Anthony Damico, and Tricia Neuman, *Medicare Advantage 2011 Data Spotlight: Plan Availability and Premiums* (Washington: Kaiser Family Foundation, October 2010), available at *http://www.kff.org/Medicare/upload/8117.pdf*.

[8] Centers for Medicare and Medicaid Services, *Medicare Advantage Premiums Fall, Enrollment Rises, Benefits Similar Compared to 2010* (Washington: September!, 10), Aavailable online at *http://www.cms.gov/apps/media/press/release.asp?Counter=3839&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+-2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date.*

[9] Humana Inc. President and chief executive officer Michael B. McCallister "told industry analysts during a conference call to discuss quarterly earnings that Medicare Advantage remains a tremendous opportunity and acknowledged that he's been surprised that more competitors haven't ventured into the market." "On the Call: Humana CEO Michael McCallister," *Associated Press/BloombergBusinessWeek*, August 2, 2010, available online at *http://www.businessweek.com/ap/financialnews/D9HBFU5G0.htm*.

specialty organization and the second-largest physician group in the United States. ACP members include 130,000 internal medicine specialists (internists), related subspecialists, and medical students. Internists specialize in the prevention, detection, and treatment of illness in adults. Our membership includes physicians who provide comprehensive primary and subspecialty care to tens of millions of patients, including taking care of more Medicare patients than any other physician specialty.

ACP appreciates the Committee's interest in the effect of the Affordable Care Act (ACA) on the Medicare Program and its beneficiaries. The College believes that this legislation contains important and essential provisions to begin to address America's severe shortage of primary care physicians for adult patients, improve benefits for preventive services, empower patients and physicians to make patient care decisions based on the best evidence of clinical effectiveness, and extend the solvency of the Medicare Part A Trust Fund. We also recognize that the legislation can and should be improved, and we urge the Committee to seek bipartisan common ground on a plan to permanently repeal the Sustainable Growth Rate (SGR) formula, to further support the value of primary care in Medicare payments, and to initiate reforms to make the costs and financing of the program sustainable over both the short- and long-term while reducing the federal budget deficit.

Our statement will particularly focus on the continued need for payment and delivery system reforms to support the value of care provided by primary care physicians. The ACA supports this goal by beginning to reform payment and delivery systems. Other provisions of the law, not under the jurisdiction of this committee, will fund training programs that have a proven record of producing more primary care physicians who practice in areas of the country with the greatest need. Given the major role played by the Medicare program in financing care for America's senior and disabled citizens and the fact that so many other payers follow Medicare's lead, the Medicare payment reforms initiated by the ACA are of particular significance to the program and its beneficiaries.

Why Is It So Important to Address the Shortage in the Delivery of Primary Care?

Investment in primary care is essential to achieving a high performing, efficient and effective health care system. An ACP analysis of over 100 annotated research studies shows that the availability of primary care physicians in a community is positively associated with better outcomes and lower costs of care.

Yet the United States is facing a growing shortage of physicians in key specialties, most notably in general internal medicine and family medicine—the specialties that provide primary care to most adult and adolescent patients. A recent peer-reviewed study projects that there will be a shortage of up to 44,000 primary care physicians for adults, even before the increased demand for health care services that will result from near universal coverage is taken into account. A case in point is the Commonwealth of Massachusetts. While the state has been able to achieve coverage for nearly all of its residents, shortages of primary care physicians have led to long waits for appointments.

The looming primary care physician shortage stems from the fact that the demand for primary care in the United States is expected to grow at a rapid rate while the nation's supply of primary care physicians for adults is dwindling and interest by U.S. medical school graduates in pursuing careers in primary care specialties is steadily declining. Primary care physicians provide 52% of all ambulatory care visits, 80% of patient visits for hypertension, and 69% of visits for both chronic obstructive pulmonary disease and diabetes, yet they comprise only one-third of the U.S. physician workforce, and if current trends continue, fewer than one out of five physicians will be in an adult primary care specialty.

With the aging of the U.S. population, a greater proportion of our citizens are enrolled in the Medicare program. Older Americans—with increasing incidences of chronic diseases—are especially disadvantaged by the shortage of primary care physicians to care for them.

Even with the ACA's policies that are beginning to address the crisis in primary care, the United States will likely continue to face a shortage of primary care physicians for adults, as well as shortages in other critical physician specialties, but this shortage will be much more severe if the ACA's policies to reform payment and delivery systems and to ensure adequate workforce capacity are under-funded or repealed.

The following ACA provisions help address this crisis in primary care and further contribute to the delivery of higher quality, more effective and efficient care to our Medicare and, in some cases, Medicaid beneficiaries and enrollees in private insur-

ance plans. The College strongly supports the continued implementation and funding of these provisions.

I. *Payment and Delivery System Reforms*

Primary Care Incentive Program

This program begins to address inequities in payments for primary care by providing a 10 percent bonus payment, in addition to the usual Medicare fee schedule amount, for designated primary care services provided by internists, family physicians, geriatricians and pediatricians. In order to qualify for the bonus, at least 60 percent of Medicare allowed charges of these physicians must consist of the designated primary care services: office, nursing facility, domiciliary, and home services. The bonus program took effect on January 1, 2011 and will continue through 2015.

This important ACA provision begins to address disparities in payments that are major barriers to physicians entering and remaining in primary care specialties. A new report by the Council on Graduate Medical Education recommends that compensation to primary care physicians be increased to 70 percent of the average payment for other physician specialties in order to train and retain a sufficient supply of primary care physicians. While the Primary Care Incentive Program falls considerably short of COGME's recommendation, it will result in the largest sustained increase in payments to primary care physicians in decades. Congress should sustain this critically important program, while enacting further reforms to support the value of primary care.

Center for Medicare and Medicaid Innovation

There is substantial agreement that the current Medicare resource-based fee-for-service (FFS) payment system for physicians directly contributes to unnecessary expenditures and undervalues the value of care provided by internal medicine specialists and other primary care physician specialties. It provides an incentive for physicians and other healthcare professionals to deliver services of marginal or uncertain value. The ACA accelerates the adoption and dissemination of alternatives to conventional fee-for-service by establishing a new Center for Medicare & Medicaid Innovation (CMMI). The CMMI will allow the Centers for Medicare and Medicaid Services (CMS) to test models that promote broad payment and practice reform within Medicare (as well as Medicaid and the Children's Health Insurance Program) with a particular focus on reforming primary care payments while preserving or enhancing the quality of care.

Importantly, the ACA provision authorizing the CMMI requires that it consider models to promote broad payment and practice reform in primary care, including patient-centered medical home (PCMH) models for high-need individuals, and models that transition primary care practices away from fee-for-service based reimbursement. The PCMH is a care model that has received substantial support from a variety of physician organizations, businesses, health plans, and patient advocacy groups. It is typically delivered by a team of healthcare professionals within a physician-led primary care practice and it requires delivery of care that centers on the needs and preferences of the patient. It expands care access, it promotes improved care coordination/integration, it promotes care management and education toward care self-management where appropriate, and it is based on the development of processes to ensure continuous quality improvement. The model also recognizes the importance of integrating into patient care members of the medical neighborhood, including specialty and subspecialty practices, hospitals and other related care providers, including compensating non-primary care specialists for their essential contributions to coordinating care with a patient in a PCMH. A recent review of early results of PCMH demonstration projects reflects its potential to improve care quality, patient access and lower costs.

The concept of encouraging adoption by Medicare of the PCMH model has a long legacy of bipartisan support. When Republicans were in control of the 109th Congress, legislation was enacted to require that Medicare initiate a demonstration project to enroll Medicare patients in Patient-Centered Medical Homes, and Republicans and Democrats alike have continued to recognize the importance of encouraging broad adoption of PCMHs in Medicare and other programs.

Also of significance is the provision allowing for the rapid testing and implementation into the federal healthcare system of those payment changes found to be effective. The Secretary has authority to broadly implement into the Medicare program aspects of projects that have been found to be successful without the necessity of

further legislative approval. Through the CMMI, the ACA will encourage innovation and adoption of delivery system and payment reforms to allow Medicare patients to receive services of high quality and effectiveness, while helping to ensure the efficient use of limited federal resources.

Medicare Shared Savings Through Accountable Care Organizations

The ACA instructs the Secretary to implement, no later than January 1, 2012, a *voluntary* shared savings program that promotes accountability for services delivered to a defined Medicare fee-for-service (FFS) patient population with the goals of increasing the quality and efficiency of services delivered. The College supports the implementation and evaluation of this program. It directly provides an incentive for physicians and other healthcare professionals to improve care integration and efficiency while, at the same time, helping to ensure improved quality of delivered care. It also correctly recognizes the importance of primary care as a foundation of these Accountable Care Organization efforts. Finally, it is structured, at least legislatively, to allow entrance into the program of a variety of different types collaborating practices. This flexibility serves to promote innovation that will help better serve our Medicare beneficiaries. The College will monitor the rule making process very closely to ensure that this flexibility is maintained upon implementation—particularly the ability of small practices that provide the majority of care under Medicare to participate effectively within this program. This integrated model of payment appears quite promising. CMS should have the resources to implement and evaluate it effectively as an alternative payment model under Medicare.

Identifying and Correcting Mis-Valued Services Paid Under the Medicare Physician Fee Schedule

The ACA contains a provision, which took effect in March, 2010, which promotes identification and correction of mis-valued physician fee schedule services. The physician fee schedule drives approximately $80 billion in annual Medicare payments for physician services and substantially affects payments made by other payers. Congress included the provision on the belief that too little attention is devoted to monitoring whether services have become overvalued or mis-valued. Mis-valued services distort incentives and can contribute to the overuse or underuse of specific services on the basis of financial, as opposed to clinical, reasons. In addition, inappropriate valuation of services affects physicians' decisions to enter or remain in specialty fields that perform undervalued services. Payments to primary care physicians, and other physician specialties that primarily provide undervalued evaluation and management services, have been significantly adversely affected by these mis-valued service codes.

The provision contains two main parts: providing direction to the Secretary of the Department of Health and Human Services (HHS) largely for identifying and correcting mis-valued services; and requiring the Secretary of HHS to establish a process to validate relative value units for physician fee schedule services. The College continues to support and participate in the current process in which the American Medical Association's Relative Value Update Committee (RUC) provides recommendations to CMS regarding changes in the value of physician services. At the same time, we believe that the Secretary needs to have the capability and responsibility to better confirm and validate these recommendations, and expand on the recommendations provided by the RUC—particularly regarding over-valued services.

Until new payment models that more effectively promote high quality and efficient care are designed and implemented on a widespread basis, ensuring adequate resources within CMS to refine the current Medicare physician fee schedule remains crucial. This helps to ensure that services are delivered for appropriate clinical, not financial, reasons and it helps increase the entrance of qualified physicians and other healthcare professionals into primary care and other fields that are adversely affected by the undervaluation of their services.

II. *Improved Benefits in the Traditional Medicare Program*

Coverage of Preventive Services

The ACA provides incentives for Medicare beneficiaries to obtain preventive services which will lead to the prevention and treatment of health problems. (Incentives are also provided for Medicaid recipients and the privately insured.) Beginning in 2011, the Act eliminates coinsurance, deductibles and copayments for approved preventive services and tests. These include blood-pressure and cancer screenings, mammograms, Pap tests, and immunizations. Also beginning in 2011, Medicare

beneficiaries became eligible for a new benefit, an annual wellness exam that includes a wellness check-up and personalized prevention plan at no cost to the patient.

Depending on the results of the wellness exam, patients will be provided with a 5–10 year plan for screenings and other preventive services as well as advice and referrals for educational services covering weight loss, physical activity, smoking cessation and nutrition.

The prevention of disease is an important aspect of care delivered by internal medicine specialists. As a result of the ACA, 50 million Medicare patients are now able to take advantage of these positive incentives for improved health status through preventive services.

Phase Out of the "Doughnut Hole"

The ACA provides subsidies to reduce and eventually eliminate the "doughnut hole," the gap in coverage in which the enrollee is responsible for the full cost of prescription drugs once an initial period of coverage is exceeded. Prior to enactment of the ACA, once in the doughnut hole, beneficiaries were required to bear all of the cost of prescription medication until a catastrophic threshold was reached.

Beginning in 2011, the ACA requires that drug manufacturers provide a 50 percent discount on brand name prescriptions while the beneficiary is in the doughnut hole. In addition, Medicare total cost calculations will include the non-discount price of the drugs. Thus beneficiaries will be able to reach the catastrophic threshold more quickly while benefiting from decreased out-of-pocket spending.

Beginning in 2011, a federal subsidy is phased in for generic drugs so that the coinsurance is reduced from 100 percent to 25 percent by 2020 for beneficiaries within the doughnut hole.

As it is estimated that about 25 percent of beneficiaries fall into the doughnut hole in a given year, these ACA provisions provide a valuable benefit to millions of America's seniors.

III. *Empowering Patients and Physicians to Make Informed Decisions*

Funding for Comparative Effectiveness Research to Inform Clinical Decision-making

From the perspective of practicing physicians and their Medicare (and other) patients, the insufficient availability of data about what works best for whom creates critically important limitations for the clinical decision-making process. Each day, in the privacy of the examination room, patients are treated for conditions for which there are numerous treatment options. This includes treatment for common conditions, such as intermittent heartburn, more serious chronic conditions, such as high blood pressure or diabetes, and immediate life-and-death issues, such as choosing the best approach for the treatment of acute coronary syndrome or an aortic dissection. The limited availability of valid data to supplement the physician's clinical experience and professional knowledge—data that compare the clinical effectiveness of different treatments for the same condition—makes it difficult to ensure that an effective treatment choice is made, one that meets the unique needs and preferences of the patient.

The ACA helps to address this issue by establishing an independent, non-profit, tax exempt corporation, known as the "Patient-Centered Outcomes Research Institute" (PCORI) to provide comparative effectiveness information to clinicians and patients. The law also funds the development of shared decision making tools to translate the results of the research into information that is understandable by patients and that can be the basis of shared decision-making with their personal physicians. In this way, Medicare patients and their physicians will be empowered to make informed, and therefore improved, health decisions based on the best and most recent evidence of clinical effectiveness.

IV. *Additional Needed Legislation*

ACP believes that Congress should enact additional legislation to facilitate further payment and delivery system reforms that recognize and support the value of care provided by internists and other primary care physicians.

Repeal of the SGR Formula

It is essential that the Medicare Sustainable Growth Rate (SGR) formula be repealed and replaced with a new framework that provides predictable, positive and

stable updates for all physician services and protects primary care from experiencing cuts in payments due to increases in utilization in other physician services. This could be accomplished by one or more of the following options, potentially in combination with each other: (1) setting a floor, e.g., at no less than the percentage annual increases in the cost of delivering services, on payment updates for primary care services, (2) providing higher spending targets for primary care than for other categories of services, should Congress decide to replace the SGR with separate spending targets for distinct categories of services, (3) exempting practices that are organized as a PCMH, and that are recognized as such by a process established by HHS, from payment reductions in any given calendar year and (4) exempting primary care services from budget neutrality adjustments resulting from changes in relative values and behavioral offset assumptions.

More Effective Medical Liability Reforms

ACP is one of more than 100 physician membership organizations that have endorsed H.R. 5, the "Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011." Introduced by Representative Phil Gingrey, MD, this bill would enact proven reforms to reduce the costs of defensive medicine, including caps on non-economic damages. We also are encouraged that President Obama said in his State of the Union address that he is willing to "look at other ideas to bring down costs, including one that Republicans suggested last year—medical malpractice reform to rein in frivolous lawsuits." Realizing that this issue is outside the jurisdiction of the Ways and Means Committee, ACP agrees that there is an opportunity now for Congress to work with the president on a bipartisan basis to address the enormous costs of defensive medicine, which contribute to higher spending by the Medicare program.

The ACA authorizes grants for state programs to improve patient safety and test alternatives to the traditional medical liability tort system. Although such grants may help identify effective ways to improve patient safety and reduce the costs of defensive medicine, the ACA did not do enough to address the costs of defensive medicine and to ensure that patients who are truly injured by medical negligence get the compensation they need for their injuries.

Although estimates of the cost of defensive medicine vary, one recent study estimates the cost at $55.6 billion annually—more than half of the estimated annual federal spending under the ACA. Other experts believe that the cost of defensive medicine is much higher. The cost of defensive medicine leads to higher Medicare spending because the program ends up paying for unnecessary services, services that are billed to the program because physicians fear being sued if they don't order every extra marginal test and treatment available. Such excess Medicare spending leads to higher out-of-pocket costs to Medicare enrollees, contributes to the growing federal deficit, and undermines the long-term financing of the program. The tens of billions of dollars wasted each year on defensive medicine could free up funding to provide coverage to many millions of Americans, to fund other needed programs, and/or to reduce the federal budget deficit.

Tort reform and changes in legal standards concerning professional liability are needed to remove a major impediment that inhibits physicians from responsibly ordering tests and procedures based primarily on clinical and cost-effectiveness in accord with practice guidelines.

In addition to the proven reforms in H.R. 5, ACP believes that health courts offer a promising approach that should be broadly tested nationwide. Under today's judicial system, judges and juries with little or no medical training decide medical malpractice cases. The majority of medical malpractice cases involve very complicated issues of fact, and these untrained individuals must subjectively decide whether a particular provider deviated from the appropriate standard of care. Therefore, it is not at all surprising that juries often decide similar cases resulting in very different outcomes.

The concept of health courts (also called "medical courts") is a specialized administrative process where judges, without juries, experienced in medicine would be guided by independent experts to determine contested cases of medical negligence. The health court model is predicated on a "no-fault" system, which is a term used to describe compensation programs that do not rely on negligence determinations. The central premise behind a no-fault system is that patients need not prove negligence to access compensation. Instead, they must only prove that they have suffered an injury, that it was caused by medical care, and that it meets whatever severity criteria applies; it is not necessary to show that the third party acted in a negligent fashion.

Conclusion

While ACP acknowledges the strong disagreements between Republicans and Democrats on many aspects of the ACA, the legislation contains provisions that have enjoyed the support of both parties. To be clear, ACP does not believe that the ACA should be repealed, but we do believe that Congress should seek common ground on building and improving upon the law, particularly as it relates to payment and delivery system reforms.

Both parties have long supported the need to improve and reform payment policies to support the value of primary care, to fund primary care training programs, and to improve the quality of services delivered. These are not Democratic or Republican issues, but the right thing to do for Medicare and other patients and constituents. The College is hopeful that such programs will continue to find bipartisan support in the 112th Congress. ACP stands ready to assist in bringing the two parties together on these important issues. Together we can achieve the very best health care system possible for America's seniors and all of its citizens.

America's Health Insurance Plans, Statement

I. Introduction

America's Health Insurance Plans (AHIP) is the national association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. Our membership includes sponsors of Medicare Advantage health plans and Medicare Part D prescription drug plans who have a long history of providing high quality coverage to Medicare beneficiaries and a strong commitment to the long-term success of the Medicare program. Our members also participate in other public programs and offer a broad range of health insurance products in the commercial marketplace.

We appreciate the committee's interest in examining the impact of the Affordable Care Act (ACA) on the Medicare program and the 48 million Americans it serves. The provisions of the new law—most notably, the deep funding cuts—have far-reaching implications for the quality of care, benefits, and choices available to Medicare beneficiaries. The law's impact will be particularly severe for the 11 million seniors who have chosen to enroll in Medicare Advantage plans because they value the improved quality of care, additional benefits, and innovative services these plans provide.

Our statement focuses on two areas:

- We review data and research findings demonstrating the impact the ACA will have on beneficiaries who rely on the Medicare Advantage program to meet their health care needs.
- We review the success Medicare Advantage plans have achieved in improving health care quality and patient care for beneficiaries, and the importance of preserving private health plan choices to achieve greater value and efficiency throughout the entire Medicare program.

II. The Impact of the ACA on Medicare Advantage Enrollees

According to the Congressional Budget Office (CBO),[1] the ACA will *directly* reduce funding for the Medicare Advantage program by an estimated $136 billion over ten years (2010–2019). CBO further estimates that, because of the linkage between Medicare Advantage payment benchmarks and Medicare fee-for-service (FFS) spending, the ACA's Medicare FFS reimbursement changes will *indirectly* reduce funding for Medicare Advantage by an additional $70 billion over ten years. These deep funding cuts—combined with the new premium tax that begins in 2014—pose a serious threat to the health benefits and choices of the nation's 11 million Medicare Advantage enrollees.

Under the ACA, Medicare Advantage payment benchmarks for 2011 are frozen at 2010 levels—meaning that plans did not receive rate increases this year to account for recent health care cost growth. Despite this rate freeze, Medicare Advantage plans are continuing to offer affordable plans to Medicare beneficiaries, with most plans making little change in premiums from 2010 while continuing to offer robust benefits. These offerings demonstrate that Medicare Advantage plans are working

[1] CBO, Selected CBO Publications Related to Health Care Legislation (2009–2010), December 2010, pages 29–34.

hard to continue to provide value to Medicare beneficiaries in light of the ACA funding cuts.

In future years, however, beneficiaries likely will begin to see the impact of the ACA funding cuts, since the cuts become increasingly larger with each passing year. CBO's estimates show that the Medicare Advantage cuts for 2012 ($6 billion), 2013 ($9.4 billion), and 2014 ($13.1 billion) are many times larger than the cuts for 2011 ($1.8 billion). As the cuts become deeper in 2012 and beyond, plan sponsors will be challenged in their efforts to cushion the blow for beneficiaries.

The magnitude of this challenge is highlighted by projections that have been released by CBO, the Office of the Actuary of the Centers for Medicare & Medicaid Services (CMS), and the Heritage Foundation. These projections clearly demonstrate that the ACA will adversely impact enrollment in the Medicare Advantage program, reduce benefits, and increase out-of-pocket costs for enrollees.

Lower Enrollment

Both CBO and the CMS Chief Actuary have projected major declines in Medicare Advantage enrollment as a direct result of the funding cuts in the ACA.

According to CBO,[2] the ACA will cause enrollment in Medicare Advantage plans in 2019 to be 4.8 million lower—dropping from 13.9 million to 9.1 million—than was projected prior to the law's enactment. This represents a 35 percent decline in enrollment by 2019.

The CMS Chief Actuary[3] projects an even larger decline, stating: "We estimate that in 2017, when the MA provisions will be fully phased in, enrollment in MA plans will be lower by about 50 percent (from its projected level of 14.8 million under the prior law to 7.4 million under the new law)."

The departure of millions of Medicare beneficiaries from the Medicare Advantage program, as anticipated by both CBO and the CMS Chief Actuary, will translate into lower health care quality and reduced value for the affected beneficiaries and an overreliance on the fragmented Medicare FFS program. We discuss these issues in greater detail beginning on page 6 below.

Additional Benefits Reduced and Out-of-Pocket Costs Increased

For Medicare Advantage enrollees who are able to stay in the program, the ACA's funding cuts will have a significant impact on the benefits they receive and the out-of-pocket costs they pay. Historically, Medicare Advantage plans have provided enrollees additional benefits beyond those offered in the Medicare FFS program, including vision, hearing, dental, and health and wellness programs. The ability of plans to continue to offer these extra benefits will be severely compromised as deeper funding cuts are implemented in the coming years.

CBO projects that the average value of additional benefits provided by Medicare Advantage plans in 2019 will be $67 per month under the ACA; this represents a 50 percent cut from the $135 per month amount that was projected prior to enactment of the new law.

Similarly, the CMS Chief Actuary states that the ACA will "result in less generous benefit packages" for Medicare Advantage enrollees. Noting that plan sponsors use rebates to provide extra benefits and reduce cost-sharing for enrollees, the CMS Chief Actuary indicates[4] that the average rebate per enrollee dropped sharply from $1,093 in 2010 to $684 in 2011, and will decline further to $43 by 2019. (Under the Medicare Advantage payment formula, rebates are based on how a plan's bid compares to the benchmark.) The CMS Chief Actuary also has estimated that, taking into account both the Medicare Advantage and Medicare FFS provisions of the new law, beneficiaries will face higher out-of-pocket costs of $473 per enrollee in 2012, $812 per enrollee in 2015, and $923 per enrollee in 2017.

These findings are reinforced by research the Heritage Foundation[5] has conducted on the ACA's impact on benefits for Medicare Advantage enrollees. This study reached the following conclusions:

- By 2017, individuals who would have been enrolled in Medicare Advantage plans under prior law will lose an average of $1,841 in benefits due to the

[2] CBO, Selected CBO Publications Related to Health Care Legislation (2009–2010), December 2010, pages 29–34.

[3] CMS Chief Actuary, Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended, April 22, 2010.

[4] CMS Chief Actuary, Letter to Senator Charles Grassley, October 8, 2010.

[5] Heritage Foundation, Reductions in Medicare Advantage Payments: The Impact on Seniors by Region, September 14, 2010.

Medicare Advantage funding cuts alone. Such beneficiaries will lose a total of $3,714 when the effects of the entire bill, including Medicare FFS cuts, are considered. This latter figure represents a 27 percent reduction in benefits relative to what would have been provided under prior law. The aggregate loss for all beneficiaries nationwide is estimated to be $55 billion annually by 2017.

- The loss of benefits will vary widely across the nation, with beneficiaries in the hardest-hit counties facing cuts almost five times as large as cuts for those in the least-hit counties. Even in counties where the impact is least severe, the average beneficiary will lose at least 15 percent of his or her benefits by 2017.
- Beneficiaries in the following states will face the largest benefit losses in 2017 as a result of the ACA's Medicare Advantage funding cuts: Louisiana ($5,092 per beneficiary), Texas ($4,732), Hawaii ($4,693), New York ($4,512), and New Mexico ($4,177).

Impact on Low-Income and Minority Beneficiaries

In evaluating the impact of the ACA's funding cuts, it is important to recognize the crucial role the Medicare Advantage program plays as a health care safety net for many low-income and minority Medicare beneficiaries.

In December 2010, AHIP published a study[6] showing that Medicare Advantage plans are a valuable choice for low-income and minority beneficiaries, particularly those who are not eligible for Medicaid and do not have employer-sponsored retiree benefits. For many of these individuals, Medicare Advantage may be their only option for comprehensive, affordable coverage.

Key findings of this AHIP study include the following:

- Among Medicare beneficiaries who were not enrolled in Medicaid or employer-based supplemental coverage and who had annual incomes between $10,000 and $20,000 in 2008, 37 percent chose Medicare Advantage plans, 30 percent purchased Medigap supplemental policies, and 33 percent were covered by the Medicare FFS program alone.
- Nationwide, 25 percent of African-American Medicare beneficiaries and 29 percent of Hispanic beneficiaries were enrolled in Medicare Advantage plans. By comparison, 21 percent of all Medicare beneficiaries were enrolled in Medicare Advantage plans.
- Sixty-nine percent of all minority beneficiaries enrolled in Medicare Advantage in 2008 had incomes below $20,000. By comparison, 37 percent of White Medicare Advantage enrollees had incomes below $20,000.

These findings demonstrate that Medicare Advantage plans are important to many minority beneficiaries and many low-income beneficiaries who cannot afford the high out-of-pocket costs they would incur under the Medicare FFS program. These vulnerable beneficiaries will pay a heavy price if the ACA's Medicare Advantage funding cuts are fully implemented.

The previously-cited study by the Heritage Foundation also addresses this concern, estimating that 70 percent of the ACA's cuts to the Medicare Advantage program will be imposed on beneficiaries with annual incomes below $32,400 in today's dollars. This study also estimates that these cuts will cause Hispanics to lose $2.3 billion in benefits and African-Americans to lose more than $6.4 billion in benefits, while also causing nearly 300,000 Hispanics and more than 800,000 African-Americans to lose access to Medicare Advantage plans. The study describes the Medicare Advantage cuts as "a regressive tax that disproportionately punishes low-income and minority seniors."

Lessons From Balanced Budget Act of 1997

We urge the committee to consider the lessons learned following the deep funding cuts that the Balanced Budget Act of 1997 (BBA) imposed on the Medicare health plan program, known at that time as "Medicare+Choice." Following the enactment of this law, Medicare health plan enrollment initially remained stable, but eventually Medicare beneficiaries saw their health plan choices diminish as many health plans were forced to withdraw from the program or limit their service areas due to inadequate funding and excessive regulatory burdens. Over the next several years, from 1999–2003, nearly 2.4 million Medicare beneficiaries were forced to change

[6] AHIP Center for Policy and Research, Low-Income & Minority Beneficiaries in Medicare Advantage Plans, December 2010.

plans or return to the Medicare FFS program due to the unintended consequences of the BBA. If the ACA's Medicare Advantage funding cuts are fully implemented, another generation of Medicare beneficiaries will likely experience similar disruptions in their health coverage.

III. The Value Provided by Medicare Advantage Plans

Medicare Advantage plans have a strong track record of pioneering new innovations and strategies for improving health care quality, promoting the efficient delivery of health care services, and advancing an evidence-based health care system. As a result, the Medicare Advantage program offers a solid foundation for modernizing the broader Medicare program to meet the health care needs of current and future generations of beneficiaries.

Evidence of Quality Improvement

Over the past 18 months, AHIP's Center for Policy and Research has conducted a series of increasingly expansive studies comparing certain utilization measures, including hospital readmission rates, for enrollees in the Medicare Advantage program and the Medicare FFS program. Recognizing that reducing preventable hospital admissions has become an important national priority, and a goal of the ACA, for achieving both quality improvement and cost control, health plans have developed a variety of innovative programs that are revitalizing primary care, improving care transitions, and helping patients achieve better health outcomes.

Our research findings demonstrate that these strategies are succeeding in helping to keep patients out of the hospital and avoid potentially harmful complications. The most recent AHIP studies on hospital readmissions include the following findings:

- Based on a risk-adjusted comparison of patterns of care among patients enrolled in two large, multi-state Medicare Advantage HMO plans and in the Medicare FFS program, we found that the Medicare Advantage plans improved health care for their enrollees by reducing emergency room visits by 24 percent, reducing hospital readmissions by 39 percent, reducing certain potentially avoidable hospital admissions by 10 percent, and reducing inpatient hospital days by 20 percent.[7]
- Based on an analysis of hospital discharge datasets in nine states, we found that risk-adjusted hospital readmission rates were about 27–29 percent lower in Medicare Advantage than in Medicare FFS for each enrollee, 16–18 percent lower for each person with an admission, and 14–17 percent lower for each hospitalization.[8]
- Based on an analysis of data on gaps in time between hospital admissions and discharges in five states, we found that risk-adjusted 30-day readmission rates per hospitalization were about 12–18 percent lower in Medicare Advantage than in Medicare FFS, that risk-adjusted 30-day readmissions per patient with an admission were 12–27 percent lower in Medicare Advantage among patients with at least one admission, and that 30-day readmissions per enrollee (including enrollees not hospitalized in a year) were 22–43 percent lower in Medicare Advantage.[9]

All of these studies consistently show that Medicare Advantage plans are reducing the need for preventable hospitalizations. As a result of this success, health insurance plans not only are improving the health and well-being of their enrollees, but also achieving greater efficiencies and cost savings for the Medicare program and for taxpayers.

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[7] AHIP Center for Policy and Research, Working Paper: Comparisons of Utilization in Two Large Multi-State Medicare Advantage HMOs and Medicare Fee-for-Service in the Same Service Areas, December 2009.

[8] AHIP Center for Policy and Research, Working Paper: Using State Hospital Discharge Data to Compare Readmission Rates in Medicare Advantage and Medicare's Traditional Fee-for-Service Program, May 2010.

[9] AHIP Center for Policy and Research, Using AHRQ's 'Revisit' Data to Estimate 30–Day Readmission Rates in Medicare Advantage and the Traditional Fee-for-Service Program, October 2010.

Innovative Programs and Tools

A recent AHIP publication [10] provides plan-specific examples of the types of programs and services that health plans have implemented to reduce preventable hospital readmissions and emergency room visits. Examples of these programs include the following:

- Expanding patient access to urgent care centers, after-hours care, and nurse help lines to give patients safe alternatives to emergency rooms for non-emergency care;
- Arranging for phone calls and, in some cases, in-home visits by nurses and other professionals to ensure that follow-up appointments are kept, medications are being taken safely, care plans are being followed, medical equipment is delivered, and home health care is being received;
- Offering intensive case management to help patients at high risk of hospitalization access the medical, behavioral health, and social services they need;
- Arranging for home visits by multidisciplinary teams of clinicians who provide comprehensive care, teach patients and their caregivers how to take medications correctly, and link families with needed community resources; and
- Revamping physician payment incentives to promote care coordination and improved health outcomes.

Health plans have developed a wide range of tools and strategies to improve quality and efficiency, and build an evidence-based health care system. The value of these health plan initiatives was recognized by a July 2010 study [11] published by the American Enterprise Institute for Public Policy Research. This study focused on geographic variations in both Medicare spending and utilization of services, noting that variation in the public sector exceeds variation in the private sector by about 2.8 times for outpatient visits and 3.9 times for hospital days.

In explaining this finding, the study notes that private payers have multiple tools for directing health care resources, including directing patients "toward preferred providers who deliver more efficient care using benefits management or through preferred networks." The authors conclude, "To reduce spending and more appropriately limit geographic variation in utilization among Medicare beneficiaries, the program should consider the utilization-management techniques employed in the private sector as a model."

The ACA attempts to introduce a number of these initiatives to the Medicare FFS program. However, we are skeptical that these efforts will be as effective as ongoing health plan programs. Health plans routinely offer health risk assessments to help identify high risk populations in need of specific services. These assessments, combined with the use of a patient's information on frequency and usage of health care services, enables the health plan to provide care management models, disease management programs, prescription drug support, home care, and tailored outreach to Medicare Advantage enrollees to meet their specific needs. While health plans have been highly successful in using this information to improve patient care, the Medicare FFS program lacks the infrastructure and coordination that are needed across providers to address the specific needs of each individual patient.

Fraud Prevention Initiatives

Preventing health care fraud is another essential ingredient of any strategy for achieving quality improvement. Health plans devote substantial resources to fraud prevention programs that identify individuals who provide care under false credentials, deliver medically unnecessary services, or make treatment decisions based on illegal referral relationships. These investments play a key role in improving patient care.

AHIP recently released a report [12] highlighting efforts by health plans to prevent and detect health care fraud. This report outlines survey findings on the cost savings achieved from these initiatives, the types of programs health plans have implemented, and the future of fraud detection and prevention programs.

Survey respondents included a cross-section of health plans ranging from small, regional companies to large, multi-state commercial carriers. Among the large com-

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[10] AHIP Center for Policy and Research, Innovations in Reducing Preventable Hospital Admissions, Readmissions, and Emergency Room Use, June 2010.

[11] American Enterprise Institute for Public Policy Research, Addressing Geographic Variation and Health Care Efficiency: Lessons for Medicare from Private Health Insurers, July 2010.

[12] AHIP Center for Policy and Research, Insurers' Efforts to Prevent Health Care Fraud, January 2011.

panies in the survey, estimated net savings from anti-fraud operations (savings less costs) exceeded $3 per enrollee, resulting in an estimated total net savings of nearly $300 million in 2008. For the medium-sized companies reporting, estimated net savings were about $1 per enrollee and 2008 total net savings were about $10 million. For smaller companies, estimated net savings were about $2.70 per enrollee, and total net savings reported were approximately $5 million in 2008.

Survey respondents were asked to estimate only the costs and savings directly attributable to their anti-fraud efforts. These estimates do not include the impact of deterrence, which is likely the largest associated savings from insurers' anti-fraud programs. The knowledge that health plans have robust anti-fraud measures and controls likely prevents inappropriate billings or claims from occurring in the first place.

Patient Safety Initiatives

On another front, health plans regard patient safety as a top priority under their quality improvement initiatives. Plans have developed and implemented several approaches to improve patient safety and increase awareness of safety-related issues, including efforts to reduce healthcare-acquired infections and prevent "never events" (i.e., serious reportable events that should never occur in a health care setting and are associated with patient death or serious disability).

Specific patient safety strategies used by health plans include using evidence-based care and national benchmarks to prevent infections and improve surgical safety. This includes, for example, providing physicians with tool kits based on a standardized set of procedures and instructions to create a consistent approach to infection prevention. Other examples include training providers and hospitals on error reduction techniques, and pre- and post-surgical team briefings in order to maintain consistency of safe practices across providers.

Health plans also have developed innovative payment models to incentivize hospitals to reduce hospital-acquired conditions and infections. Such models reward providers that meet performance targets and include additional per-patient per-month quality payments. The structure of these programs include root-cause analysis of never events, communication with patients/families when never events or serious reportable events occur, and forums to discuss best practices and lessons learned.

Other priorities include tracking and reporting infection rates at the hospital and physician level and reporting them internally and publicly (where state requirements exist). Some health plans have enhanced their quality improvement and monitoring programs by requiring providers or hospitals to identify gaps in care and recommend changes to improve patient care safety systems. Others require reporting of adverse events to designated patient safety organizations.

Health plans use nationally-recognized measures of patient safety for never events, serious reportable events, surgical safety indicators, and preventable medical errors, specifically from CMS, the National Quality Forum, Leapfrog, the Joint Commission, and others. Health plans have informed us that by working in collaboration with network hospitals, they have helped achieve the following measureable improvements in patient safety:

- Health plan network hospitals participating in such improvement programs have reduced the rate of central line bloodstream infections well below the national average. For example, one health plan measured its 2010 rate for central-line infections at 0.96, compared to the national rate of 1.96, as reported by the Centers for Disease Control and Prevention (CDC).
- Health plan network hospitals also reduced cases of ventilator-associated pneumonia by 70 percent, to less than 1.5 per 1,000 ventilator days in over two years (2008–2010).
- Over an eight year period (2002-present), one health system succeeded in reducing the number of ventilator-associated pneumonia cases by 97 percent and the number of central bloodstream infections by 91 percent.

Preserving Medicare Health Plan Choices

Looking forward, it is important to maintain a stable Medicare Advantage program and preserve private health plan choices to achieve greater value and efficiency throughout the entire Medicare program.

If the ACA funding cuts are fully implemented, millions of Medicare beneficiaries will be forced into the inefficient Medicare FFS program. This, in turn, will undermine the broader health reform goals of enhancing quality and patient safety, improving efficiency and value, and containing costs. Expanding enrollment in the out-

dated Medicare FFS program will result in more beneficiaries receiving fragmented care that is poorly coordinated under a system that prioritizes volume over quality. Meanwhile, reducing enrollment in Medicare Advantage will result in fewer beneficiaries receiving coordinated care and benefiting from the innovations that private sector health plans have pioneered.

We urge Congress and the Administration to reconsider the ACA funding cuts to ensure that Medicare Advantage remains viable and can serve as a foundation for building a modernized Medicare program that provides access to high quality health care.

IV. Conclusion

Thank you for considering our perspectives on the ACA and its impact on the Medicare program. We stand ready to work with the committee to strengthen health care choices and benefits for our nation's Medicare beneficiaries.

Alliance for Retired Americans, Statement

The Alliance for Retired Americans would like to thank the Committee on Ways and Means for holding this hearing on the impact of the Patient Protection and Affordable Care Act on the Medicare program and Medicare beneficiaries. The Alliance appreciates the opportunity to reiterate its support for the health care law and provide examples from our members who are benefiting from its provisions.

Founded in 2001, the Alliance is a grassroots organization representing more than 4 million retirees and seniors nationwide. Headquartered in Washington, D.C., the Alliance and its 30 state chapters work to advance public policy that strengthens the health and economic security of older Americans by teaching seniors how to make a difference through activism.

The health law is particularly important for seniors, who spend a larger share of their retirement income on medical care. The law makes improvements to the Medicare program by providing added benefits, enhancing health care quality and extending the solvency of the program by 12 years. Seniors have already begun to reap the benefits of the law. In 2010, 3.4 million seniors who fell in the Part D doughnut hole coverage gap received a $250 payment to help with the costs of their medications. Beginning this year, seniors are eligible to receive free annual check ups. In addition, they will no longer have to pay any cost-sharing for life-saving preventive screenings for diseases such as diabetes and cancer. Seniors who fall in the doughnut hole will get a 50% discount for brand name drugs and a government subsidy toward the costs of their generic medications. These are the first steps towards closing the entire doughnut hole, which will occur in 2020.

The Affordable Care Act restructures government payments to Medicare Advantage (MA) plans to keep them more in line with that of traditional Medicare. The law reduces the overpayments to MA plans and prohibits the MA plans from charging higher co-payments than traditional Medicare. By 2014, MA plans must spend 85% of enrollee premiums on health care, rather than on administrative costs, executive pay or insurance company profits. MA plans that provide good quality care will receive bonuses. These changes emphasize quality and efficiency and will reduce costs for the government as well as Medicare beneficiaries.

In the future, seniors can expect improved medical care, because the Medicare program begins to reform the health care delivery system by implementing pilot programs such as bundling, patient-centered medical home, value-based purchasing and Accountable Care Organizations. These programs encourage providers to promote efficiency and coordinate care, which will ultimately lead to better quality care for seniors.

Already, we have heard from Alliance members how the added benefits have improved their lives. One such individual is Bob Meeks from Tampa, Florida who has astronomical medical costs due to several medical conditions. He pays $265 a month for Advair and $175 for Nexium. His out-of-pocket costs are $4,000 a year, and that does not include his wife's out-of-pocket costs. While he has tried to substitute with generic or comparable drugs, oftentimes the medications are not available in a generic or the comparable drugs are not as effective. In 2010, he received the $250 check providing him needed assistance toward his medications. Another individual is Mary Ellen Wlaysewski from Glenndale, New York who fell in the doughnut hole in September of last year. Ms. Wlaysewski was diagnosed with breast cancer and has to take Arimidex, which costs $1,066.84 for a 3 month supply through a mail order pharmacy. She is expecting her check soon.

Then there is James Cassidy of Easton, Pennsylvania who has such high medical bills that he fell in the doughnut hole in March of last year and stayed in the doughnut hole for the rest of the year. James has diabetes and his insulin alone costs $300 a month. He also suffers from heart disease and his heart medications costs about $250 a month. He said that the $250 check helped him because it allowed him to buy a month's supply of his heart medication. James says that sometimes he has cut his pills in half and other times he has gone without, because the drugs were unaffordable. This year, James will receive a 50% discount on brand name medications and a 7% discount on generic drugs when he falls in the doughnut hole. The provisions of the Affordable Care Act will help him better afford his medications.

Then there is Demmi Murphy of Jacksonville, Florida who is in her forties and is disabled. She receives Social Security Disability and is covered under Medicare. She hit the doughnut hole in June 2010. One of her medications costs $1,283 a month and the others are anywhere between $300 and $400 a month. The doughnut hole check did help her, and she looks forward to the drug discounts this year.

Finally, there is Olivia Babis, a 35 year old woman from Polk County, Florida, who suffers from an autoimmune disease. While her husband does have health insurance through his job, there is a one-year exclusion for pre-existing conditions. There is also an annual cap, which she would exceed within 6 months. Olivia is currently on Medicaid. Although both she and her husband have college degrees, he had to get a job that pays $9 an hour, so that she could qualify for Medicaid. She is grateful that the new health law has a provision prohibiting insurers from excluding individuals with pre-existing conditions and establishing annual limits. While these provisions do not go into full effect until 2014, she is hopeful it will cover her in the near future. If the law is repealed, she will have to continue to rely on Medicaid.

Millions of seniors are counting on the drug discounts in the Affordable Care Act to help them afford their medications this year and in the future. They are glad the days of having to choose between food or medicine or having to cut their pills in half are mostly behind them. An additional 32 million Americans have either begun getting coverage through the dependant care provision, the early retiree coverage, or the high risk pools or are anxiously awaiting 2014 to purchase insurance through the exchanges. If the health care law is repealed, these individuals will be thrown back to the mercy of insurance or pharmaceutical companies.

In addition to improvements under Medicare, the new law enacts several new initiatives to address the long-term care needs of older and disabled Americans, including the Community First Choice Option, which creates a new state plan option under Medicaid to provide community based attendant supports and services to individuals with disabilities who are Medicaid eligible and who require institutional level of care. The law also creates the Community Living Assistance Services Support Act (CLASS), which creates a national long-term care insurance program financed through voluntary payroll deductions that will provide benefits to enrollees unable to perform two or three activities of daily living. These are extremely important provisions for current and future retirees.

The Alliance for Retired Americans strongly supports the Affordable Care Act, because of the numerous provisions that are helping retirees afford health care both now and in the future. Repealing it would negatively affect millions of older and retired Americans. The law strengthens the Medicare program, provides protections to millions of Americans against insurance company abuses, makes prescription drugs more affordable, and provides prevention and wellness screenings, all of which enhance the quality of life for our nation's seniors. We thank the Committee for the opportunity to submit this testimony.

Campaign for Better Care, Statement

The *Campaign for Better Care* appreciates the opportunity to submit a statement for the record on the Impact of the Affordable Care Act on Medicare beneficiaries.

The Campaign for Better Care (*www.campaignforbettercare.org*) is a broad-based coalition of consumer organizations with a direct stake in improving the health and quality of life for older adults with multiple health conditions and their family caregivers. We are committed to ensuring that new models of care delivery and payment, including Accountable Care Organizations (ACOs) and Patient Centered Medical Homes (PCMH), provide the *comprehensive, coordinated, patient- and family-centered* care that individuals want and need.

Changing the way health services are delivered and paid for is key to fulfilling the promise of high quality, patient- and family-centered care for millions of Americans. Our fragmented delivery system has failed those who rely on it the most. Hardest hit are vulnerable populations, including older adults with multiple chronic conditions, and their family caregivers, who struggle to navigate an impossibly complex health care system without the help they need. This population uses the most health care services, at the highest cost. Because no one is helping them coordinate their care, they suffer the poorest health outcomes.

The ACA can help address these problems. In addition to improving health care coverage and affordability, the law makes significant advances in improving the way health care services are delivered and paid for, moving us toward a health system that rewards value over volume, promotes better coordinated care, and is oriented around the needs of patients and families.

Changing How Care is Delivered

Nine out of ten older Americans (age 65 and older) have at least one chronic health condition and 77 percent have multiple chronic conditions.[i] These are the people who could most benefit from better coordination of care. Yet, to date, our health care system—including Medicare—has not risen to the challenge.

The ACA promotes innovative new ways to deliver health care that will promote higher quality, better coordinated, more efficient care. These new approaches should foster better communication and coordination among health care providers, patients and family caregivers, and help prevent problems like harmful drug interactions, unnecessary hospitalizations, conflicting diagnoses, and failure to connect people with community based services that can help them manage their health.

Improving Medicare

Medicare is a lifeline that offers older Americans secure health coverage. But there are notable gaps in Medicare's coverage that cost beneficiaries millions of dollars out of pocket and often prevent older persons—particularly those with numerous chronic conditions—from getting the care they need.

The ACA fills in some of these gaps—making Medicare more affordable for millions of older Americans. Because of the ACA, Medicare beneficiaries can now get an annual physical and access to a number of preventive services, such as mammograms and colorectal screenings, without expensive out of pocket costs. And the ACA's changes to the donut hole will save these beneficiaries thousands of dollars. Last year, beneficiaries who fell in the "donut hole" received a $250 rebate. This year, they will benefit from 50 percent off brand name drugs in the donut hole. By 2020, the donut hole will be closed.

The newly established Federal Coordinated Health Care Office will work to improve coordination between Medicare and Medicaid for dually eligible beneficiaries and help to ensure that care for this population is more efficient.

Changing How We Pay for Care

The current health care system pays for care based on volume not value. The ACA begins to link payment to provider performance and quality of care, providing much-needed incentives for quality improvement. Increasing Medicare and Medicaid payment for primary care providers will help to ensure that patients have ready access to good primary care, which is particularly important for older adults struggling with multiple chronic conditions, who need a higher level of care coordination and care management.

Improving the Quality of Care

The new law includes policies that will help us move away from a system that values quantity over quality—and toward a system that prioritizes effective delivery of the right care, at the right time, for the right patients. New policies will link payment to quality and provider performance, creating much needed incentives for quality improvement by hospitals, physicians, nursing homes, home health providers and others.

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[i] Machlin, S., Cohen, J., & Beauregard, K. (2008). Agency for Healthcare Research and Quality. *Health Care Expenses for Adults with Chronic Conditions, 2005.* (Statistical Brief #203). Retrieved July 22, 2009, from http://www.meps.ahrq.gov/mepsweb/data_files/publications/st203/stat203.pdf.

Changing the Health Care Workforce

The ACA also makes strengthening and expanding the health care workforce a priority. It supports programs aimed at increasing the supply of qualified primary care providers, and training our health care workforce so it better meets the complex health needs of older patients.

Conclusion

The ACA offers us an opportunity to make our health care system more efficient and more patient- and family-centered, which is critically important for older patients with multiple health problems and their family caregivers. As a nation, we simply cannot afford to delay implementing the new law. The health and well-being of millions of Americans—including older and chronically ill persons—depends on it.

Center for Medicare Advocacy, Statement

The Center for Medicare Advocacy, Inc. is a national, non-profit organization that works on behalf of older people and people with disabilities to ensure fair access to affordable and comprehensive health care. We submit this statement for the record of the Hearing on the Health Care Law's Impact on the Medicare Program and its Beneficiaries, held before the House Ways & Means Committee on February 10, 2012.

Last year Congress passed two statutes, collectively referred to as the *Affordable Care Act,*[1] to extend health insurance to millions of Americans who are uninsured, to improve quality of care for all Americans, to reduce spiraling increases in health care costs, and to reduce the deficit. Some misstated reports about changes made by health care reform to Medicare have resulted in public fear of cuts to Medicare benefits.

The Center for Medicare Advocacy wants to be very clear for the record: Medicare reforms included in the *Affordable Care Act* do not reduce Medicare's guaranteed benefits; they improve Medicare and help safeguard the Medicare Trust Fund.

THE AFFORDABLE CARE ACT STRENGTHENS THE MEDICARE PROGRAM AND RETAINS ITS GUARANTEED BENEFITS

The health care reform law expands Medicare coverage, by eliminating cost-sharing for preventive services, adding a yearly wellness visit, limiting some cost-sharing in private Medicare plans, closing the Part D "Donut Hole," and creating opportunities for exciting new delivery systems to promote coordination of care.

Further, perhaps of most significance, the changes made to Medicare by the *Affordable Care Act* extend the solvency of the Medicare Part A (hospital insurance) trust fund. **The Medicare Trustees now project that the Trust Fund will remain solvent through 2029, rather than through 2017, or an extension of 12 years.[2] According to the Center on Budget and Policy Priorities, the most recent projection by the Trustees is among the most favorable projections made by the Medicare Trustees in the last 21years.[3]**

The *AffordableCareActC:/Users/nuehlecke/AppData/Local/Microsoft/Windows/users/WeeklyAlerts/Website/www.medicareadvocacy.org/InfoByTopic/Reform/*10_10.28.*ReformDoesntCutBenefits.htm*_edn1#__**edn1 achieves savings in the Medicare program through a series of payment reforms, service delivery innovations, and increased efforts to reduce fraud, waste, and abuse. The actual projected reduction in Medicare spending is $428 billion over 10 years, after $105 billion in new Medicare spending** is taken into consider-

[1] Pub. L.111–148, the Patient Protection and Affordability Care Act of 2010 (PPACA or ACA), on March 23, 2010, and Pub. L. 111–152, the Health Care and Education Reconciliation Act of 2010 (HCERA), on March 30, 2010.

[2] *2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds,* August 5, 2010, *http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2010.pdf.*

[3] Paul N. Van der Water, *2010 Medicare Trustee Report Shows Benefits of Health Reform and Need for Its Successful Implementation* (Center On Budget and Policy Priorities, August 16, 2010) http://www.cbpp.org/cms/index.cfm?fa=view&id=3265.

ation.[4] It is important to stress again that none of the payment reforms affect Medicare's guaranteed benefit packages. In fact, the law specifically states that the guaranteed benefits in Medicare Part A and Part B will not be reduced or eliminated as a result of changes to the Medicare program.[5]

MOST MEDICARE CUTS ARE TO PRIVATE INSURANCE PLANS

The greatest amount of savings in Medicare, about $130 billion over 10 years, will be achieved by reducing overpayments to private Medicare Advantage (MA) plans[6] that serve only 24% of all Medicare beneficiaries.[7] These are the insurance plans that contract with the Centers for Medicare & Medicaid Services (CMS) under Medicare Part C to provide benefits to those who voluntarily enroll. MA plans *must* provide all of the guaranteed benefits under Part A and Part B; they *may* provide additional benefits with moneys they receive in excess of the cost of providing the guaranteed benefits.

Under the funding mechanism in effect before enactment of the *Affordable Care Act*, MA plans were paid, on average, 9%—13% more than the traditional Medicare program to provide the same coverage. These extra payments resulted in Medicare Part B premiums being $3.35 higher per month for all beneficiaries in 2009, and resulted in the Federal Government (and taxpayers) spending $14 billion more than it would have paid had Medicare Advantage plan enrollees remained in the traditional Medicare program. The Medicare Payment Advisory Commission (MedPAC) had recommended to Congress for years that the benchmarks used to evaluate MA plan bids should be set at 100% of traditional Medicare costs, to achieve financial neutrality between payment rates for traditional Medicare and private plans.[8] Instead, billions of dollars were wasted − jeopardizing the solvency of the Medicare Trust Fund, and increasing costs for all Medicare beneficiaries and for taxpayers.

The *Affordable Care Act* phases in changes to the MA overpayments in order to curtail this waste, starting with a freeze in Medicare payments to MA plans for 2011. These changes are not as extensive as those recommended by MedPAC, however, and the new payment mechanism will not achieve the financial neutrality recommended by MedPAC. **As a result of the new payment formula, plans in some lower-paid counties, generally rural and suburban areas, will continue to receive payments that exceed the traditional Medicare amount.**[9] The new payment structure also provides for an increase in payments by up to 5% for plans that receive four or more stars on the CMS star rating system.[10] In other words, the *Affordable Care Act* protects beneficiaries and strengthens the Medicare Advantage program by rewarding MA plans that provide higher quality care and reducing wasteful payments to those that do not provide additional value.

MEDICARE ADVANTAGE OPTIONS REMAIN ROBUST FOR 2011

Many people in the health care industry predicted that the change in MA payments would result in fewer MA plans contracting with CMS, higher premiums, and reduced benefit packages. CMS announced at the end of September 2010, however, that these predictions were not accurate. According to CMS, MA plan premiums for 2011 are, on average, $1 less than in 2010, and most beneficiaries continue to have numerous choices of Medicare Advantage plans.[11]

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[4] CBO March 20, 2010; Joint Committee on Taxation Revenue Estimates, JCX–17–10 (March 20, 2010).

[5] PPACA (Pub. L. 111–148), § 3602.

[6] CBO March 20, 2010; Joint Committee on Taxation Revenue Estimates, JCX–17–10 (March 20, 2010) http://www.jct.gov/publications.html?func=startdown&id=3673.

[7] *Medicare Advantage Fact Sheet* (Kaiser Family Foundation Sept. 2010), http://www.kff.org/medicare/upload/2052–14.pdf.

[8] Report to Congress, Medicare Payment Policy (March 2010); www.medpac.gov/documents/Mar_10Ch04.pdf.

[9] B.Biles, G. Arnold, Medicare Advantage Payment Provisions (G.W.U. March 2010), available at http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_8C515659–5056–9D20–3D3985C6A1BBC2A5.pdf.

[10] HCERA § 1102.

[11] "Medicare Advantage Premiums Fall, Enrollment Rises, Benefits Similar Compared To 2010 Wide Range Of Medicare Health And Drug Plan Options Continues In 2011" (CMS Sept. 21, 2010); *http://www.cms.gov/apps/media/press/release.asp?-Counter=3839&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays-=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date.*

Many MA plans that chose to leave the Medicare market in 2011 did so as a result of changes made by the *Medicare Improvement for Patients and Providers Act of 2008* (MIPPA),[12] not the *Affordable Care Act*.

Those who point to the cuts in the overpayments to MA plans as proof that Medicare benefits were reduced by health care reform legislation fail to acknowledge that **the *Affordable Care Act* improves benefits offered by MA plans.** For example, the new law sets limits on the amount of cost-sharing plans can charge for chemotherapy administration services, renal dialysis services, and skilled nursing care services.[13] Further, starting in 2014, 85% of MA plan revenues must go towards benefits, not profits, or plans may be subject to sanctions.[14]

HEALTH CARE REFORM LINKS PAYMENT TO QUALITY OUTCOMES

The *Affordable Care Act* moves towards linking payment to quality outcomes for entities that provide services to Medicare beneficiaries. Health care reform emphasizes efforts to measure quality and to provide payment for only those services and procedures that meet certain quality of care standards. As stated above, Medicare Advantage plans may be entitled to bonus payments if they score highly on quality measures. In addition, hospitals will be given incentives to reduce hospital acquired conditions with respect to hospital discharges starting in 2015.[15]

Medicare payments also may be reduced for certain providers in the future if they do not provide high quality health care. For example, beginning in 2012, hospital payments may be reduced if a hospital is determined to have excessive readmissions for identified conditions or procedures that are high volume or high cost and for which the readmission rate is high. A readmission is defined as a return to the same or a different hospital for the same condition within a time frame to be specified by the Secretary of Health and Human Services (HHS).[16]

INDEPENDENT PAYMENT ADVISORY BOARD (IPAB) PROTECTS MEDICARE BENEFITS

It is anticipated that another $15.5 billion in savings to the Medicare program will be achieved from 2014–2019 through the workings of the Independent Payment Advisory Board (IPAB), a new quasi-governmental body which will take over from Congress the function of establishing Medicare payment policies, will be able to achieve.[17] The *Affordable Care Act* includes strict parameters for IPAB activity. It must submit proposals to Congress to reduce Medicare spending if statutorily-defined parameters are met. These proposals will go into effect if Congress does not act. Most importantly, the *Affordable Care Act* prohibits the IPAB from changing eligibility or benefits, reducing the Part D low-income subsidy, or rationing care.[18]

The beneficiary protections built in to the IPAB by the *Affordable Care Act* are in stark contrast to other recommendations currently under discussion to control increased Medicare and other health care costs and to reduce the deficit. For example, the National Commission on Fiscal Policy and Reform (Fiscal Commission) recommended changing current Medicare cost-sharing by creating a single annual deductible of $550 for Part A and Part B services.[19] Further, Congressman Paul Ryan, Chair of the Committee on the Budget, would change the benefit and cost-sharing structure of the current Medicare program. His *Roadmap for America's Future* would eliminate the guaranteed benefits available to all beneficiaries under Medicare and that are protected by the *Affordable Care Act.* Instead, he would offer older people and people with disabilities $11,000 to purchase a private insurance plan,[20] essentially changing Medicare into a capped dollar voucher program.

In addition to changing Medicare from a uniform, defined benefit health insurance program to a defined contribution plan, Congresman Ryan's proposal does not take into account that Medicare was enacted in 1965 because private insurance compa-

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[12] Section 162 of the Medicare Improvements for Patients and Providers Act of 2008, Pub. L. 110–225 required private fee for service Medicare Advantage plans to have provider networks in most areas of the country, effective January 1, 2011.

[13] PPACA § 33203.

[14] HCERA § 1103. A plan's contract must be terminated if the plan fails to have a Medical Loss Ratio of 85% for 5 consecutive years.

[15] PPACA § 3008.

[16] PPACA § 3025.

[17] CBO March 20, 2010; Joint Committee on Taxation Revenue Estimates, JCX–17–10 (March 20, 2010).

[18] PPACA § 3403(c), adding Section 1899 of the Social Security Act.

[19] In 2011, the Part B deductible is $162, and the Part A deductible is $1,132 per spell of illness.

[20] http://www.roadmap.republicans.budget.house.gov/Issues/Issue/?IssueID=8520.

nies did not want to offer insurance to older people and people with disabilities. There is no guarantee that these same insurance companies would want to offer insurance to this population again, particularly if the *Affordable Care Act's* prohibition of discrimination against people with pre-existing conditions is eliminated.

MILLIONS OF PEOPLE ARE ALREADY BENEFITING FROM THE *AFFORDABLE CARE ACT*

The Center for Medicare Advocacy provides direct assistance to thousands of Medicare beneficiaries in Connecticut each year, and assists beneficiaries, their families and their advocates who live in the other 49 states and the District of Columbia through phone calls, electronic inquiries, and educational efforts. The following examples explain how the beneficiaries we assist have already been helped by the *Affordable Care Act,* or will be helped by health reform in the future:

- Ms. M in Arizona and Mr. B in New York are Medicare beneficiaries with different health care statuses. Like millions of other Medicare beneficiaries, both are eligible for health care reform's a new *Annual Wellness Visit* wellness visit that will include a health risk assessment to establish or update their medical and family history, create a list of current providers and suppliers involved in providing medical care—including a list of prescriptions, take measurements of height, weight, body mass index, blood pressure and other routine measurements, and detect cognitive impairments. They will pay no cost-sharing for the visit or for the preventive services that are recommended to each of them during the visit.
- Mr. G. in Florida and Ms. K. in Connecticut are two of the millions of Medicare beneficiaries with high prescription drug costs. When they enter the Part D "doughnut hole" in 2011, as they did in 2010, they will no longer have to pay the full cost of their medicine, but will pay only 50% of the cost of brand name drugs and 93% of the cost of generic drugs.
- Mr. W., a Virginia beneficiary with multiple chronic conditions, including diabetes, joined a Medicare Advantage plan when he first became eligible for Medicare. Changes to the Medicare Advantage program limit the likelihood that he will pay more than people in traditional Medicare for high cost services and add an out-of-pocket limit to his health care costs. The Medicare Advantage plan in which he is enrolled rates highly on the quality rating scale, meaning that his health plan will be eligible for quality bonus payments. Mr. W. also enters the Part D doughnut hole each year and anticipates spending substantially less for his prescriptions starting in 2011.
- Ms. C in Texas has Alzheimer's disease and resides in a long-term care facility. In 2010, she spent approximately three (3) months in a Long-Term Care Hospital (LTCH) as a result of poor quality care in a number of settings. Ms. C was originally sent to an acute care hospital from the long-term care facility to have a wound (bed sore) on her toe treated. She went to the LTCH for an acquired illness (MSRA), either from the acute hospital or at the long-term care facility. While in the hospital, she experienced multiple hospital acquired infections before she finally returned to the long-term care facility. The Affordable Care Act creates quality and payment incentives to ensure that Ms. C and other beneficiaries like her receive the highest quality of care and are not hospitalized as a result of avoidable health care incidents.
- Ms. J. in Massachusetts has multiple chronic conditions that need monitoring and coordination. She will benefit from new delivery systems such as Accountable Care Organizations and Medicaid Homes designed to improve coordination and quality of care for people like her.
- Ms. S. in California is eligible for the Part D Low-Income Subsidy that pays her drug plan premium, eliminated the Donut Hole, and reduces her cost-sharing for drugs. Changes to how CMS determines which Medicare Prescription Drug Plans qualify as Low-Income Subsidy plans provide her more stability and continuity in drug plan coverage, and mean that she is less likely to have to change drug plans in order to receive the full subsidy.
- Ms. G. in Pennsylvania was a plaintiff in a law suit challenging how people who are dually eligible for Medicare and Medicaid receive assistance with their Medicare premiums and cost-sharing. The new Federal Coordinated Health Care Office, created by the *Affordable Care Act,* will help ensure that the most vulnerable Medicare beneficiaries, those who are eligible for both Medicare and Medicaid, will not encounter barriers that prevent them from receiving the full array of benefits and services for which they are eligible.

CONCLUSION

The *Affordable Care Act* slows the growth in future Medicare spending by reducing wasteful overpayments to private Medicare Advantage plans, by restructuring up-dates in payments to many providers, and by tying payments to improved quality of care. In addition, the *Affordable Care Act* helps beneficiaries by reducing out-of-pocket costs, adding new benefits and promoting quality care. **Health care reform does not reduce Medicare benefits, it adds to them. It does not endanger Medicare's financial future, it saves billions of dollars for the Trust Fund, extends the projected solvency of the program by over a decade, and cuts billions of dollars in wasteful spending. The *Affordable Care Act* creates a stronger Medicare program for the 47 million older people and people with disabilities who rely on Medicare for their health care coverage today, and for the millions who will follow tomorrow.**

Respectfully submitted,

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Executive Director

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Health Industry Distributors Association, Statement

The Health Industry Distributors Association (HIDA) is the professional trade association that represents the interests of over 600 medical-surgical products distributor companies operating throughout the United States. Our members deliver life-saving healthcare products to more than 220,000 points of care including over 195,000 physician offices, 5,700 hospitals and 16,000 nursing home and extended care facilities in the nation and are committed to promoting safety and savings throughout the healthcare supply chain.

Medical products distributors offer the nation's providers on-demand access to over 200,000 medical products essential for patient care. Providers value this "one-stop shopping" resource, as it helps them manage supply costs and focus time and resources on patient care. All products sold by a medical products distributor are sold to a healthcare provider. As such, virtually every patient procedure is supported in some way by products supplied by a distributor.

The majority of distributors are small businesses. Over a quarter of the industry earns annual revenues under $1 million dollars. The healthcare distribution sector employs 65,000 people nationwide. Distributors' average 1.3% annual profit margin is among the lowest in healthcare, requiring distributors to operate at extremely high levels of efficiency.

On behalf of HIDA, we applaud your efforts to ensure that Medicare beneficiaries continue to have uninterrupted access to life-saving medical products. As such, we appreciate the opportunity to provide comments on provisions within the *Patient Protection and Affordable Care Act* (P.L. 111–148) and the *Health Care and Education Reconciliation Act of 2010* (P.L. 111–152) that are poised to negatively impact the delivery of healthcare. Further implementation of the following provisions could hinder our members' ability to continue delivering these critical services in a streamlined manner. Specifically, HIDA would like to provide comments on the following provisions:

- Section 6410 of P.L. 111–148, Adjustments to the Metropolitan Statistical Areas (MSAs) for Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Acquisition Program; and
- Section 9006 of P.L. 111–148, Expansion of Information Reporting Requirements.

Comments on Adjustments to the Metropolitan Statistical Areas for Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Acquisition Program, Section 6410, Patient Protection and Affordable Care Act (P.L. 111–148)

HIDA supports competition in healthcare. As currently devised, Medicare's "competitive bidding" system is anything but competitive. It empowers the Federal Government to choose "winners and losers," reduces competition, limits patient and provider access to critical healthcare products, and adds layers of bureaucracy and cost

to the system. Section 6410 further expands Round Two of Medicare's competitive bidding program for DMEPOS to 91 MSAs from the current nine, a nine-fold increase. Expanding Round Two of the program by 91 MSAs prior to evaluating the impact of Round One on beneficiaries, providers and suppliers seems imprudent. As such, HIDA has several suggestions for improving the program, these include:

- Expanding the parameters of the current Government Accountability Office (GAO) program report mandate to include the impact of the competitive bidding program on Skilled Nursing Facilities, Nursing Facilities and Intermediate Care Facilities (Medical Place of Service Codes 31, 32, and 54) in each Round One MSA, and delaying further expansion of the DMEPOS competitive bidding program until the effects of Round One can be fully assessed; and
- Exempting the enteral product category (e.g., intravenous nutrients) from competitive bidding or including an "any willing provider" provision to ensure that all licensed, accredited and bonded suppliers are able to participate.

The competitive bidding program, in its current form, is positioned to reduce competition and patient choice, and eliminate jobs at a time when the Federal Government is trying to preserve and create them. Competitive bidding changes Medicare's basic premise from beneficiaries having access to "any willing provider," to a selection process that over time will significantly reduce the number of entities to which Medicare beneficiaries will have access. During the rebid of Round One, approximately 1,011 licensed, accredited and bonded suppliers submitted bids in hopes of participating in the new program. Of those 1,011 suppliers only 356 companies were offered contracts by the Centers for Medicare and Medicaid Services (CMS). Those not offered a bid are barred from participating in the program for three years (i.e., contracts are required to be rebid once every three years). Many of these smaller, regional supplier companies do not have the overhead to sustain their businesses without revenue from Medicare Part B. If a significant number of suppliers are eliminated, market competition will diminish, prices will increase, quality will erode, and patient choice will be limited.

Furthermore, Medicaid and many private insurance companies tend to replicate Medicare reimbursement policies, further intensifying the negative impact on small businesses. Similar proposals are already under consideration by state Medicaid programs (e.g., KS, CA, OH, TX) as a way to rein in costs.

In addition to the program's negative impact on small businesses, competitive bidding is poised to jeopardize quality of care for millions of Medicare beneficiaries in skilled nursing facilities (SNFs). The competitive bidding program is designed for patients who live within their homes and the program does not account for the highly specialized, exacting care required of SNF patients. Patients in a SNF are among the population's most ill and frail. They require 24/7 direct clinical coordination and care by their nurses, doctors, and other healthcare professionals. The acuity level of the SNF patient population is such that they require institutional care. In contrast, a typical homecare patient does not require this level of care.

Life-sustaining enteral nutrients, equipment and supplies—one of the nine product categories included in Round One are not well suited for the competitive bidding program. CMS indicated in its 2004 report to Congress on the demonstration programs in Polk County, Florida and San Antonio, Texas that most enteral nutrients are supplied to SNF residents. The report further states that enterals were not compatible with the demonstration program specifically due to complex issues involving SNFs. HIDA understands first-hand the various complexities involved in the distribution of products into SNFs (e.g., the level of clinical management and services required in institutionalized settings compared to that for non-institutionalized beneficiaries), as our members are uniquely impacted by the competitive program as suppliers of enteral nutrients, equipment and supplies.

Moving to a national competitive bidding program for DMEPOS raises many serious questions related to cost, access, beneficiary protections, and market-based competition. Taking these factors into consideration, HIDA feels that CMS should not move forward with further implementation of Round Two of program until the impact of Round One on Medicare beneficiaries within SNFs, suppliers and providers is fully evaluated and understood.

Comments on the Expansion of Information Reporting Requirements, Section 9006, Patient Protection and Affordable Care Act (*P.L.* 111–148)

The new IRS 1099 reporting requirements on businesses that purchase goods and services in the amount of $600 or more from corporations or individuals are quite onerous and will result in a considerable amount of additional paperwork for small-

er, regional medical products distributors. HIDA supports the recent bipartisan calls for repeal of the new reporting requirements which will allow distributors to focus on growing their businesses, creating jobs and delivering life-saving medical products to healthcare providers.

Thank you for reviewing our concerns and considering our comments. We appreciate the opportunity to suggest important modifications to the healthcare reform legislation that should be implemented to ensure that patients and providers continue to have uninterrupted access to life-sustaining medical products.

Please contact HIDA's Vice President of Government Affairs, Linda Rouse O'Neill at *rouse@hida.org*, or (703) 838–6125 with any questions.

LeadingAge, Statement

LeadingAge commends the Ways and Means Committee for holding this hearing on the impact of the Affordable Care Act on seniors. We believe the new law has had a number of positive and significant effects on the delivery of health care and long-term services and supports to seniors, and we continue to support its implementation.

LeadingAge is an association of 5,500 not-for-profit organizations dedicated to expanding the world of possibilities for aging. We advance policies, promote practices and conduct research that supports, enables and empowers people to live fully as they age.

One of the most important aspects of the Affordable Care Act for seniors was the reduction in the growth of Medicare spending, which will help to preserve the life of the Medicare trust fund. In 2009, before the enactment of healthcare reform, the Medicare trustees predicted that the trust fund would be exhausted by 2017. The trustees pointed to both the increase in the number of individuals eligible for Medicare and to accelerating health care costs as the factors endangering the financial stability of the Medicare trust fund.

In developing the Affordable Care Act, Congress made some hard choices, imposing spending restrictions on the program that the Congressional Budget Office projects will total $500 billion over ten years. As a result, the Medicare trustees subsequently estimated that the trust fund can continue to finance the Medicare program for many more years. In view of widespread concern over the size of the federal budget deficit and the growth of entitlement spending, we hope the committee will take into account the Medicare savings already achieved under the Affordable Care Act.

The healthcare reform law increases consumer long-term services and supports options while also improving transitions between levels of care. Medicare and other insurance programs currently finance services provided primarily in hospitals, skilled nursing facilities and physician offices; services at home and in the community get relatively little coverage. As a result, individuals released from a hospital frequently have to be re-hospitalized, at significant expense to Medicare and other insurance plans, because they have not received the services they needed to get well.

The expansion of home- and community-based options under the Affordable Care Act, including Money Follows the Person, Independence at Home and Community First Choice, will help consumers obtain long-term services and supports in the least restrictive and most cost-effective setting. Several demonstration programs for which the ACA provides—transitional care, prevention of hospital readmissions, patient-centered medical homes, and accountable care organizations are just a few examples—show great promise for better integrating health and long-term services and supports. Ultimately these demonstrations could point the way toward real reform of our health care delivery system, improving care and services as well as reducing health care costs.

Healthcare workforce needs also are addressed under the Affordable Care Act. We already face a severe shortage of nurses and direct care workers who provide the bulk of paid long-term services and supports. This problem will only worsen as increasing numbers of elders come to need long-term services and supports at the same time that nurses and direct care workers in the baby boomer generation reach retirement age. In addition, the vast majority of those providing long-term services and supports are family caregivers. They serve on an unpaid basis, frequently with little or no training or other help with care that can become quite complex.

The Affordable Care Act contains several provisions to meet these needs. The new law increases loan amounts in the existing federal nursing student loan program. It authorizes new training opportunities for direct care workers, a crucial provision

that will help to improve the quality of long-term services and supports. The law would fund geriatric care centers to provide training in geriatrics, chronic care management and long-term care for faculty in health professions schools and for family caregivers. The law also would expand geriatric care awards to advanced practice nurses, clinical social workers, pharmacists and psychologists, increasing the number of health care professionals knowledgeable about the special needs of older people, the age group that makes the most use of the nation's health care system.

The Affordable Care Act addresses a long-neglected issue by establishing the Community Living Assistance Services and Supports (CLASS) program. CLASS creates a consumer-financed, premium-based, voluntary insurance plan to help people needing long term services and supports remain in their homes and communities. The enactment of CLASS followed decades of discussion over how the nation might better address appropriate financing for these critical services and more than five years of legislative development, debate, and hearings. The program gained the support of over 250 consumer, provider, and faith-based organizations from AARP and the Alzheimer's Association to Easter Seals and the Paralyzed Veterans of America.

Ten million Americans today need long term services and supports—including 4 million under age 65. As the baby boomers age into retirement, these numbers will more than double. Without CLASS, Medicaid would remain the nation's default insurance plan for long-term services and supports. Medicaid is an open-ended, taxpayer-funded entitlement program that already is straining federal and state budgets. This system fails to provide realistic opportunities for personal planning, requires people to spend-down into poverty before receiving the help they need, fails to support family caregivers adequately, leads to higher acute care costs and is fiscally unsustainable, given the baby boomers' coming explosive needs.

While private long-term care insurance policies and tax incentives for their purchase have been available for approximately thirty years, fewer than ten percent of seniors have this coverage. Even fewer people under age 65 have long-term care insurance policies. This kind of coverage will continue to be an important source of financing for long-term services and supports. However, even if the rate of long-term care insurance policy purchases accelerates beyond current projections, private insurance will not provide enough of an alternative to Medicaid funding of long-term services and supports in the coming decades.

The CLASS plan promotes personal responsibility, puts choice in the hands of consumers, saves Medicaid money, and doesn't rely on taxpayer funds. CLASS is totally voluntary. Its cash benefit approach allows consumers to choose the type of help they want. It saves Medicaid money, according to the Congressional Budget Office. It is not a government entitlement program and stands on its own financial feet. The ACA prohibits the use of taxpayer funds to pay for benefits under CLASS. The program was strengthened by the Gregg amendment, which requires premiums to be set at levels that will keep the program solvent over a 75-year period based on actuarial analysis.

Because of the numerous ways in which the Affordable Care Act benefits seniors, LeadingAge continues to support the new law. We look forward to continuing to work with Congress on its effective implementation.

William L. Minnix, Jr.
President and CEO
LeadingAge (formerly American Association of Homes and Services for the Aging)

Medicare Rights Center, Statement

The Medicare Rights Center is a national, independent nonprofit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through individual counseling and advocacy, educational programs and public policy initiatives. We provide services through six different hotlines to individuals, caregivers and professionals who need answers to Medicare questions or help securing coverage and getting the health care they need. Our work directly representing people with Medicare gives us a unique perspective on the Affordable Care Act (ACA).

The ACA includes several important improvements to Medicare that will give older adults and people with disabilities access to more affordable and higher quality health care. Such improvements include:

- Increased prescription drug coverage by closing the Medicare Part D coverage gap, known as the "doughnut hole"
- Expanded access to affordable preventive care services

- Investment in delivery system reforms that will better coordinate the care people with Medicare receive
- Better coverage for people with pre-existing conditions and disabilities

First, the ACA closes the coverage gap, or doughnut hole, in the Medicare prescription drug benefit. Over 3 million individuals fall into the doughnut hole each year, and many of these individuals have multiple chronic conditions, some of them life threatening. Since the advent of the Part D drug benefit in 2006, the Medicare Rights Center has handled hundreds of calls from clients who have entered the doughnut hole, and their stories spotlight the issue. Stories include individuals who must skip doses, split their pills or forgo medications altogether because of the high out-of-pocket costs of prescription drugs when they are in the doughnut hole.

Ms. G, a client from Arizona, called Medicare Rights Center because she is in the doughnut hole and cannot afford her medications. She has diabetes, a heart condition and high blood pressure, and is currently on 16 medications. She also has very high hospital bills. Ms. C's income is $2,400 per month, so she does not qualify for a program that would help her pay for the cost of her medical bills or drugs. The closure of the coverage gap will help Ms. C afford her medically necessary prescriptions that help prevent her serious health conditions from getting worse.

Ms. C, a client from New York, takes several medications, including a very expensive anti-cancer medication to keep her cancer at bay. She called the Medicare Rights Center when she learned from her pharmacist that she was approaching the doughnut hole. She said that she would be able to avoid the doughnut hole if she did not take her anti-cancer medication, but wanted to know if there was any assistance she could receive that would allow her to afford and take this medication. Due to her income, Ms. C had limited options. Medicare Rights advised her that a far too common option was to ask doctors for free samples of medications in order to sustain treatment if no other assistance was available. Without closure of the doughnut hole, Ms. C will face unaffordable drug costs. If she is unable to access her medication, the chances of her cancer recurring are increased.

The ACA will improve the experience of Ms. G, Ms. C and others who in the past have faced similar financial hurdles to accessing their medications. In 2010, individuals in the doughnut hole were eligible to receive a $250 rebate on drug costs. This year, pursuant to the ACA, they will receive a 50 percent discount on brand-name drugs, and by 2020 the doughnut hole phase-out will be complete, which means individuals will pay the standard 25 percent cost-sharing for their medications.

Also, the ACA aims to transform the way that all Americans, including people with Medicare, think about their care and engage the health system. The law emphasizes prevention and allows for the provision of new or expanded preventive services under Medicare. In addition to providing annual wellness exams and prevention plans to people with Medicare, the ACA eliminates consumer cost-sharing for many Medicare-covered services recommended by the United States Preventive Services Task Force, such as mammographies and screenings for heart disease and osteoporosis. This increased access to affordable preventive services will improve Americans' health and could reduce long-term costs to the health care system. By eliminating barriers to preventive services, the law encourages healthy behaviors and allows consumers to personally invest in their care.

Ms. C, a client from Oklahoma, called Medicare Rights Center because she wanted to quit smoking. Her doctor prescribed a medication to assist her in her efforts, but her drug plan would only cover the drug if she agreed to attend smoking cessation counseling sessions, which Medicare covered, but with cost-sharing. Now, as a result of health reform, Ms. C, and those in similar situations, will be able to go to smoking cessation counseling sessions free of charge.

Ms. C, like many others, wanted to take steps to become healthier and improve her quality of life. The ACA helps people with Medicare be able to take these initial steps.

But the ACA's effort to empower patients to be more involved in their own care goes beyond the elimination of cost-sharing for preventive benefits. The law invests in delivery system reforms that aspire to emphasize patient-centered models of care and to better coordinate the care patients receive. These reforms will hopefully create greater efficiency in the program that will bolster Medicare's financial outlook without sacrificing consumers' quality of and access to care. For example, the ACA increases reimbursements to doctors who provide primary care, thereby offering them incentives to enter this practice area. The bill also provides incentives to doctors or groups of doctors to create "medical homes" and "Accountable Care Organizations," wherein they coordinate the care that patients receive from a variety of providers. According to a 2006 MedPAC report, the average person with Medicare sees five doctors. However, there is no incentive in the current Medicare system for doc-

tors or other care providers to talk with each other. In fact, the Medicare Rights Center often must facilitate these conversations and the exchange of information across care settings through our casework, or our clients must do so for themselves, which can be difficult, especially in times of acute illness.

While we all have many questions about how these new models and reforms will work and are currently engaged with other stakeholders to ensure that consumer protections remain central to reforms, all parties must ensure that we are getting the highest value for our healthcare dollars. The ACA aims to address this issue in a responsible way that does not just pass higher costs on to Medicare consumers.

In addition to these improvements, health reform improves coverage for people with pre-existing conditions and those with disabilities who do not yet qualify for Medicare. Americans under 65 with Social Security Disability Insurance have to wait two years before they are eligible for Medicare coverage. In many cases, these individuals and other individuals who are uninsured and have a pre-existing condition can now join states' high-risk pools, which were created by the ACA, and receive insurance coverage while they wait for Medicare. Most important, in 2014, they will have access to even more insurance options in the form of plans offered on state-based health exchanges and expanded Medicaid. This means that people in the two-year waiting period, one of the populations most in need of affordable, high-quality care, will now be better able to access affordable coverage. Allowing people better access to care before they enroll in Medicare should also mean that they require less care once they become Medicare eligible. No longer will people have to play the waiting game as their condition worsens and require more acute and potentially more expensive care before Medicare becomes available to them.

The ACA takes positive steps this year, as noted above, to provide significant benefits to people with Medicare and planned delivery system reforms will help to ensure that people with Medicare have continued access to high-quality, affordable care.

Submitted by Joseph Baker,
President, Medicare Rights Center

National Partnership for Women & Families, Statement

The National Partnership for Women & Families submits this written statement on the impact of the Affordable Care Act (ACA) on older women. The National Partnership is a non-profit, non-partisan consumer organization with 40 years of experience working to make life better for women and families by promoting access to quality health care, fairness in the workplace, and policies that help women and men meet the dual demands of work and family.

Access to affordable, quality health care is central to the well-being of women and families. It is a key determinant of their quality of life, their economic security, and their ability to thrive, prosper and participate fully in our society. This is especially true for older women.

Women 65 and older make up more than half the nation's Medicare beneficiaries and comprise 70 percent of the oldest beneficiaries (ages 85 and older). They are the primary consumers of health care—using more health care services as they age. And because women tend to live longer than men, older women are more likely to have chronic conditions, many of which can be costly to treat and can affect all aspects of their lives.[1]

As caregivers and patients, women bear the brunt of poor care coordination in our current health care system—often having to navigate the system alone. Worse too, older women are more vulnerable than men to increasing health care costs—having earned less during their working years[2] and often having scaled back their careers and compromised their economic security to meet family caregiving responsibilities.[3]

But the Affordable Care Act lays the groundwork for improving quality and care coordination so that older women and caregivers are better protected. Our written statement highlights some of the ways the ACA helps older women.

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[1] Anderson, G. (2007). *Chartbook, Chronic Conditions: Making the Case for Ongoing Care.* Johns Hopkins University. Retrieved October 1, 2009, from http://www.fightchronicdisease.com/news/pfcd/documents/ChronicCareChartbook_FINAL.pdf.

[2] U.S. Census Bureau, Current Population Survey, 2009 Annual Social and Economic Supplement, Table PINC–05: Work Experience in 2008—People 15 Years Old and Over by Total Money Earnings in 2008, Age, Race, Hispanic Origin, and Sex, *online at* http://www.census.gov/hhes/www/cpstables/032009/perinc/toc.htm.

[3] National Alliance for Caregiving and AARP. (2009). *Caregiving in the U.S. 2009,* 14; 59.

Lower Costs, Immediately

Medicare is a critical program that offers older women secure, essential health coverage. It protects millions of older women who otherwise could not purchase coverage in the private market, which historically has been plagued by gender rating and other forms of discrimination. However, prior to enactment of the Affordable Care Act, there were some notable gaps in traditional Medicare coverage. In particular, annual wellness visits were not covered, leaving beneficiaries to pay out of pocket for critical preventive services. Beneficiaries also had to cover the full cost of prescription drugs once they reached the "donut hole"—leaving them on the hook for nearly $3500 out of pocket.

As of January 1st, older women on Medicare are able to get a free annual physical. This will include time for their health care providers to conduct a comprehensive health risk assessment and create a personalized prevention plan. And older women—whether they are Medicare beneficiaries or continue to purchase private health insurance—will be able to access a number of preventive services, such as mammograms and colorectal screenings, without expensive copays.

Older women are also benefitting from more affordable drug coverage—saving thousands of dollars over the next ten years—as the ACA closes the "donut hole." Last year, beneficiaries who fell in the "donut hole" received a $250 rebate. This year, they will benefit from 50 percent off brand name drugs in the "donut hole." By 2020, the "donut hole" will be closed.

Retired women over age 55 who are not eligible for Medicare will also benefit from the new temporary reinsurance program provided for in the ACA. It lowers retiree health costs and encourages employers to continue to offer coverage.[4]

Safer Care

A goal of our reformed health care system is to get and keep patients healthy. This would seem self-evident but, in the past, too often interaction with the health care system has actually harmed patients. For instance, nearly one in every five Medicare patients discharged from the hospital is readmitted within 30 days,[5] and each year, about 1.7 million health care associated infections occur in hospitals, resulting in about 100,000 deaths.[6]

The Affordable Care Act prioritizes and invests in efforts to improve patient safety. More attention and resources will go toward making sure older women are safe when they transition from a hospital to home or another facility—the most dangerous point in the continuum of care for vulnerable patients.[7] In addition, starting in 2015, Medicare will begin to reduce payments to hospitals that have the highest rates of hospital-acquired conditions, like falls, pressure ulcers and infections.

Women with multiple chronic illnesses, who in some cases take more than 50 separate prescriptions each year,[8] will benefit from new medication management services. Pharmacists will perform comprehensive medication reviews to identify, resolve, and prevent medication-related problems, and/or educate and train patients and caregivers about their medications to help reduce dangerous medication interactions and medical errors.

Better Care

Millions of Americans have suffered needlessly because our health care system is not providing comprehensive, coordinated, quality care to those who need it most. Nine in 10 older Americans (age 65 and older) have at least one chronic health condition and 77 percent have multiple chronic conditions.[9] Yet our system is not equipped to provide the help these patients need. Large numbers of older adults with multiple chronic health conditions are left on their own to navigate often-conflicting diagnoses and instructions from multiple specialists. They report duplicate tests and procedures, conflicting diagnoses for the same set of symptoms, and con-

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[4] The reinsurance program will reimburse employers for 80 percent of the costs of retiree health benefit claims between $15,000 and $90,000.

[5] Jencks SF, Williams MV, Coleman EA, Rehospitalizations among patients in the Medicare fee-for-service program, *New Engl J Med,* 2009;360(14):1418–1428.

[6] National Healthcare Quality Report, 2009. P. 108.

[7] Parry, C., E. A. Coleman, J. D. Smith, J. Frank, and A. M. Kramer. 2003. The care transitions intervention: A patient-centered approach to ensuring effective transfers between sites of geriatric care. *Home Health Care Services Quarterly* 22(3):1–17.

[8] Berenson, R. & Horvath, J. (2002). *The Clinical Characteristics of Medicare Beneficiaries and Implications for Medicare Reform.* Prepared for: The Center for Medicare Advocacy Conference on Medicare Coordinated Care, Washington, DC. Available at: www.partnershipforsolutions.org.

[9] Machlin, S., Cohen, J., & Beauregard, K., op. cit., pg. 5, Figure 1.

tradictory medical information.[10] This lack of coordination and communications puts their health at grave risk.

The Affordable Care Act is a significant—indeed, unprecedented—advance in changing the way we pay for and deliver health care so that patients can receive high quality care. The ACA created the Center for Medicare and Medicaid Innovation to test, evaluate and rapidly expand new care delivery models that improve quality and care coordination. And, if evidence shows that these new care delivery models foster patient-centered care, improve the quality of care patients receive, and reduce costs, the Innovation Center will be able to expand the model broadly across the Medicare and Medicaid programs.

One of the models that the Innovation Center has begun to test is the patient-centered medical home. This new model pays primary care practices to better coordinate and manage the care of patients, ensuring that they have someone in the health care system who looks out for their interests and is available when they need help. Eight states have been selected to take part in the Multi-Payer Advanced Primary Care Practice Demonstration, where Medicare will join ongoing multi-payer demonstrations to provide one million beneficiaries with medical homes. In addition, up to 500 Federal Qualified Health Centers will have the opportunity to participate in an Advanced Primary Care Practice Demonstration and provide patient-centered, coordinated care to nearly 200,000 low-income Medicare beneficiaries.

To ensure older women understand their health care options and receive the care they want, the ACA also calls for the development and use of shared decision making tools which help patients and their caregivers understand the risks and benefits of treatment options and make informed decisions about their care.

Long Term Savings

There is little dispute that our skyrocketing health care costs are unsustainable and disastrous, for the country, for individuals and for families. In particular, costs related to treating chronic conditions could soon overwhelm patients, families and caregivers and are already straining the system badly.

As the new law begins to bend the cost curve, older women are likely to see decreasing health care costs. The traditional payment system undermines quality through perverse incentives for *quantity* of service regardless of quality, value or appropriateness. For example, doctors are paid for the number of tests they run—not for the time it takes to talk patients about their preferences and values, nor whether what they prescribe actually makes their patients healthier.

The Affordable Care Act takes critical steps to begin to change the way we pay for care. The new law opens the door for important payment reforms that will move us away from a system that pays for volume of services to one that pays for value by supporting primary care and rewarding better quality, coordination and communication among providers, patients and family caregivers. This will lead to more affordable care for older women and help ensure the Medicare program is around for the long haul.

Stronger Health Care Workforce

Low reimbursement rates and a lack of training and support have led to a shortage of health care practitioners trained in primary care and geriatrics. To ensure that we have a health care workforce capable of delivering the care older women need, the reform law will increase payments for primary care services under Medicare and Medicaid and provide enhanced training and support for nurses and other primary care providers.

Family caregivers—who are mostly wives and adult daughters—will benefit from new supports that help them care for their loved ones while also taking care of themselves. For example, the Affordable Care Act establishes Geriatric Education Centers (GECs) to support training in geriatrics, chronic care management, and long term care issues for family caregivers, as well as health professionals and direct care workers. The GECs are required to train family caregivers at minimal or no charge and to incorporate mental health and dementia best care practices into their curricula.

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[10] Anderson, G. (2007). *Chartbook, Chronic Conditions: Making the Case for Ongoing Care.* Johns Hopkins University. Retrieved October 1, 2009, from *http://www.fightchronicdisease.org/news/pfcd/documents/ChronicCareChartbook_FINAL.pdf.*

Conclusion

The Affordable Care Act is helping millions of older women. Repeal of the law would be a painful and unnecessary step backward for women and the loved ones they care for. We need to move forward to implement the Affordable Care Act to ensure older women can benefit from the high quality, patient- and family-centered health care system they urgently need.

Submitted by, Debra L. Ness, President

National Senior Citizens Law Center, Statement

HEALTH REFORM LAW BENEFITS LOW INCOME OLDER ADULTS

The National Senior Citizens Law Center continues to support full enactment of the Affordable Care Act based on what the law does to make health care for low income older adults more accessible, affordable and of higher quality.

We remain focused on ensuring effective implementation, especially in areas where low-income older adults are affected.

In addition, NSCLC has long opposed judicial activism and remains committed to fighting legal challenges to the health reform law in the courts.

How Health Reform Helps Low Income Older Adults

The ACA contains key elements that will benefit all seniors and several that are targeted to helping low income older adults in particular. Here are some examples:

- **Medicaid funding begins this year for providing more long term care at home versus in a nursing home.** A recent NSCLC report on the impact of the Supreme Court's 1999 Olmstead Ruling, NSCLC called on states to take full advantage of expanded home and community based options that are built into the new law. In poll after poll, seniors and their families consistently have favored care at home to institutionalization.
- **Better quality of care for close to nine million seniors and persons with disabilities who are eligible for both Medicare and Medicaid (dual eligibles).** The law creates an "Office of Dual Eligibles" that is already working to improve the delivery of care to dual eligible seniors currently struggling to navigate systems that are far too complex and confusing.

The country's low income older adults will also benefit from closing of the donut hole in Medicare prescription drug coverage, the addition of an annual wellness visit to Medicare, and of course the ending of insurance industry practices such as denying coverage because of age, gender or pre-existing conditions. Poor elders are often the target of abusers and the law contains funding for far greater efforts to prevent elder abuse.

Why Court Challenges Matter

The cases brought by several states focus on doing away with the individual mandate, but NSCLC argues that doing so would jeopardize the balance the law achieves between requiring people to have health insurance and forcing insurance companies to cover those who are already sick, too old or happen to be women.

For older adults without health insurance and a pre-existing condition, a court decision that finds the individual's responsibility to have health insurance unconstitutional could be particularly problematic. The result would be the denial of health coverage to nearly half of all older adults between age 55 and 64. Recent studies show the percentage could be even higher.

The states in question, led by Republican governors and attorneys general, have launched an attack on Congressional power to enact social legislation. NSCLC is confident that the Supreme Court, when and if asked to rule on one of these cases, will ultimately find the requirement by Congress that individuals have minimum health coverage constitutional.

The National Senior Citizens Law Center is a non-profit organization whose principal mission is to protect the rights of low-income older adults. Through advocacy, litigation, and the education and counseling of local advocates, we seek to ensure the

health and economic security of those with limited income and resources, and access to the courts for all. For more information, visit our Web site at www.NSCLC.org.

For more information contact:
Kevin Prindiville
Deputy Director

Roundtable on Critical Care Policy, Statement

Chairman Camp and Ranking Member Levin and other Members of the Committee, we thank you for holding this important hearing to examine the Patient Protection and Affordable Care Act's (PPACA) impact on the Medicare program and its beneficiaries. The Roundtable on Critical Care Policy supports the Committee's commitment to ensuring that the reforms authorized by PPACA will be implemented in a way that improves the efficiency and effectiveness of our health care system by transforming the way health care is delivered in this country.

Established in 2009, the Roundtable on Critical Care Policy is a nonprofit organization that provides a forum for leaders in critical care and public health to advance a common federal policy agenda designed to improve the quality, delivery and efficiency of critical care in the United States. The Roundtable brings together a broad cross-section of stakeholders, including the nation's leading medical professionals with specialized training in critical care, patient groups, academia, public health advocacy and industry.

The Roundtable is supportive of Acting Administrator for the Centers for Medicare and Medicaid Don Berwick's simultaneous pursuit of the "Triple Aim": improving the experience of care, improving the health of populations, and reducing per capita costs of health care. However, as the Committee moves forward with overseeing the implementation of these goals and develops additional policies to strengthen and modernize Medicare, the Roundtable encourages the Committee to consider proposals focused on improving the care for those beneficiaries who are critically ill and injured.

Each year, over five million Americans are admitted into traditional, surgical, pediatric, or neo-natal intensive care units (ICUs).[1] The ICU is one of the most costly areas in the hospital, representing 13% of all hospital costs, with the total costs of critical care services in the U.S. exceeding $80 billion annually.[2] Providers of critical care require specialized training, the care delivered in the ICU is technology-intensive, treatment is unusually complex due to what may be a patient's system—or multiple system—challenges or failures, and outcomes have life or death consequences. Approximately 540,000 individuals die each year after admission to the ICU, and almost 20% of all deaths in the U.S. occur during a hospitalization that involves care in the ICU.[3]

Despite the significant role critical care medicine plays in providing high-quality health care, the PPACA did little to address the challenges that plague the critical care delivery system. A failure to address these challenges could jeopardize patient safety and do little to bend the curve on rising health care costs.

Multiple studies have documented that the demands on the critical care workforce—including doctors, nurses, and respiratory therapists—are outpacing the supply of qualified critical care practitioners. A 2006 study by the Health Resources & Services Administration found that the current demand for intensivists—physicians with special training in critical care—will continue to exceed the available supply due largely to the growing elderly population, as individuals over the age of 65 consume a large percentage of critical care services.[4] Studies by patient safety organizations, such as the Leapfrog Group, have found that intensivist-led ICU teams have been "shown to reduce the risk of patients dying in the ICU by 40%"[5] The

[1] Society of Critical Care Medicine. Critical care statistics in the United States. http://www.sccm.org/AboutSCCM/Public%20Relations/Pages/Statistics.aspx.

[2] Halpern Na, Pastores SM. "Critical Care Medicine in the United States 2000–2005: An analysis of bed number, occupancy rates, payer mix and costs," *Critical Care Medicine* 37 no. 1 (2010).

[3] Angus DC, Barnato AE, Linde-Zwirble WT, et al. "Use of Intensive care at the end of life in the United States: an epidemiologic study" *Critical Care Medicine* 32 (2004).

[4] Health Resources and Services Administration Report to Congress: The Critical Care Workforce: A Study of the Supply and Demand for Critical Care Physicians. Requested by: Senate Report 108–81. Available at: *http://bhpr.hrsa.gov/healthworkforce/reports/criticalcare/default.htm. Accessed November 2010.*

[5] The Leapfrog Group. Fact Sheet. *http://www.leapfroggroup.org/about_us/leapfrog-factsheet.*

current and projected critical care workforce shortages pose significant patient safety concerns.

While PPACA included several initiatives to expand the health care workforce, they were largely focused on expanding primary care. However, a solution cannot be reached solely by adding to the workforce; we must also find ways to improve the efficiency of the existing workforce. That is why the Roundtable enthusiastically supports a provision included in PPACA that prioritizes within the newly established Centers for Medicare and Medicaid Innovation (CMMI) the testing of models that make use of electronic monitoring—specifically by intensivists and critical care specialists—to improve inpatient care.

The Roundtable strongly urges the Committee to ensure that, as the Administration moves forward with new payment and delivery reforms, initiatives aimed at improving the quality of care delivered to the critically ill and injured are made a priority. Earlier this year, researchers at the Johns Hopkins Bloomberg School of Public Health found that hospitals in Michigan that implemented the Keystone Project, an ICU quality improvement initiative funded by the Agency for Healthcare Research and Quality, decreased an elderly person's likelihood of dying while hospitalized by 24 percent."[6] The Administration and Congress needs to support similar initiatives to ensure we continue to make progress in improving health outcomes for our critically ill and injured beneficiaries.

The Roundtable also believes that policy changes are necessary to meet the needs of our most vulnerable patients during advanced illness. A recent study by the Dartmouth Institute for Health Policy and Clinical Practice found that "one in three Medicare cancer patients spend their last days in hospitals and intensive care units," and that "clinical teams aggressively treat patients with curative attempts they may not want, at the expense of improving the quality of their life in the last weeks and months."[7] The Roundtable encourages the Committee and the Administration to find ways to work together on this issue.

And lastly, another challenge facing critical care medicine is the notable absence of research on the availability, appropriateness, and effectiveness of a wide array of medical treatments and modalities for the critically ill or injured. At present, many of the current, high-cost treatments delivered in the ICU lack comparative effectiveness data. Yet in 2009 when the Institute of Medicine released its mandated report recommending 100 topics to be given priority for comparative effectiveness research funding, few of these topics related to critical care. Moreover, current federal research efforts are partitioned and scattered across the government and throughout the National Institutes of Health's (NIH) 27 institutes, making it difficult to coordinate existing research and identify gaps.

As Members look to address these issues in the future, we hope that you will consider some of the reforms included in the "Critical Care Assessment and Improvement Act" that was introduced late last year by Congresswoman Tammy Baldwin and will be re-introduced this year. The legislation would authorize a much needed assessment of the current state of the critical care delivery system, including its capacity, capabilities, and economic impact. In addition, the bill would establish a Critical Care Coordinating Council within the NIH to coordinate the collection and analysis of information on current critical care research, identify gaps in such research, and strengthen partnerships. Lastly, the bill authorizes a number of initiatives to bolster federal disaster preparedness efforts to care for the critically ill or injured.

The Roundtable on Critical Care Policy appreciates the opportunity to submit a statement for the record and looks forward to working with the Committee to strengthen our health care delivery system.

Submitted by: Executive Director Stephanie Silverman

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[6] Agency for Health Care Research and Quality, "Landmark Initiative to Reduce Healthcare-Associated Infections Cuts Death Among Medicare Patients in Michigan Intensive Care Units," January 31, 2011 http://www.ahrq.gov/news/press/pr2011/haimiicupr.htm.

[7] The Dartmouth Institute For Health Policy & Clinical Practice, "Nearly One Third of Medicare Patients with Advanced Cancer Die in Hospitals and ICUs; About Half Get Hospice Care" Press Release November 16, 2010.

MATERIAL SUBMITTED FOR THE RECORD

Questions for the Record:

Member Question(s) Submitted for the Record

Witness Name: Dr. Donald Berwick
Hearing Date: Feb. 10, 2011

General Committee Questions:

Dr. Berwick, as you may know, as part of the 2003 Medicarea Modernization Act, Congress required Part D plans to utilize Medication Therapy Management (MTM) programs to help beneficiaries improve prescription drug adherence and minimize adverse drug interactions. Can you please detail how many beneficiaries each year since 2006 have participated under MTM programs, and the total yearly management or dispensing fees paid by Part D Plans in relation to MTM programs. Further, according to CMS' 2010 Medicare Part D Medication Therapy Management Programs Fact Sheet, the agency noted that it is "exploring meaningful performance measures" for MTM programs. Can you please detail the performance measures that are under consideration by CMS?

Question 1: Can you please detail how many beneficiaries each year since 2006 have participated under MTM programs?

Answer 1: Based on plan-reported data, there have been approximately 9.1 million beneficiaries participating in MTM programs across five years from 2006 through 2010. This is not a count of distinct beneficiaries – if a beneficiary participated each year; he or she is counted for each year in which the beneficiary participated in an MTM program. We only have numbers in aggregate. The number of beneficiaries identified by plans as participating in MTM in any given year ranged from 1.3 million to 2.8 million between 2006 and 2010.

Year	# of MTM Participants
2006	1,385,382
2007	2,649,354
2008	2,824,330
2009	2,328,720
2010	2,598,351
Total	9,136,783

Question 2: What is the total yearly management or dispensing fees paid by Part D Plans in relation to MTM programs?

Answer 2: MTM is part of a plan's administrative costs in its bid and thus these costs are not reimbursed by CMS on a service level or broken out separately to CMS.

Question 3: Can you please detail the performance measures that are under consideration by CMS?

Answer 3: CMS has been working with and monitoring MTM measures that are in development in the Pharmacy Quality Alliance (PQA). The PQA is a consensus-based alliance committed to improving medication use and medication related services across the health care system. The PQA measures around MTM are currently going through data validation and testing. One measure of particular interest to CMS is the percentage of MTM-eligible beneficiaries who received a Comprehensive Medication Review (CMR).

Questions on behalf of Mr. McDermott:

Hearing on the Health Care Law's Impact on the Medicare Program and its Beneficiaries

Topic
Discussion of the new End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and the transition adjustor

Background
On January 1, 2011, CMS initiated a new ESRD Prospective Payment System (PPS) for dialysis facilities. The new reimbursement is called a "bundled" payment since it reflects all of the costs of providing care to dialysis patients, except for oral drugs, and is widely believed to be the forerunner for the manner in which CMS will pay other providers. Because the "bundled" payment is new and very different from the manner in which dialysis facilities were being reimbursed before January 1, the law creating the program (Medicare Improvements for Patients and Providers Act) provided that each facility could choose to opt into the new program or phase-in over a four year period.

To remain budget neutral during this four-year transition period, the Agency devised a transition adjustment that would be driven by the number of dialysis facilities that opt out of the transition period and receive payment solely under the new PPS. In the final regulation, CMS estimated that only 43 percent of the facilities would opt into the new program; however, the reality is that 98 percent of the facilities opted into the new system. Based on the faulty estimate, CMS will be reducing payments by 3.1 percent or $6.75 per treatment in 2011. This reduction is much higher than necessary given the actual number of facilities choosing to enter the new program.

The Northwest Kidney Centers, which operates multiple dialysis facilities within my district, serves more than 1,400 patients in western Washington. Like most other dialysis facilities, the Northwest Kidney Centers opted to move directly into the new ESRD bundle system. Under the 3.1 percent transition adjustment proposed by CMS, the Northwest Kidney Centers estimates it will lose $1.1 million in 2011 for the 1,050 Medicare insured patients they serve because the transition adjustor has not been modified.

Question 1: It is vital that CMS move quickly to substitute the actual number of facilities that will be paid under the new ESRD PPS system for the estimated number it is currently using. Can you explain why CMS has not yet calculated the transition adjustor using the actual number of facilities that moved into the bundle earlier this year? When does the

Agency plan to correct the adjustor? Is CMS willing to take action to waive the rulemaking requirement and recalculate the transition adjustment based upon the actual number of facilities that have opted out of the transition period?

Answer 1: When adopting a new payment system under Medicare, CMS is often statutorily required to ensure that aggregate payments (with the exception of any applicable inflation update) are the same as those under the previous payment system. In this case, we were required to ensure that payments under the new ESRD prospective payment system (PPS) were, in aggregate, 98 percent of the total payments that would have been made under the previous basic case-adjusted composite payment system. In order to meet this requirement, we applied a transition budget neutrality adjustment factor of 3.1 percent to ESRD payments in the calendar year (CY 2011) ESRD PPS final rule.

As described in the final rule, CMS' calculation of this factor was based on the best available data to estimate payments during the transition period. At the same time, we acknowledged that the adjustment may not reflect actual choices made by the ESRD facilities regarding opting out of the ESRD PPS transition. However, we noted that the adjustment would be updated each year of the transition (CY 2012 and CY 2013) to reflect actual data on providers electing to opt-out of the transition.

As a result of the information available to CMS on the number of facilities opting out of the transition, on April 1, 2011, CMS issued an interim final rule revising the ESRD transition budget-neutrality adjustment finalized in the CY 2011 ESRD PPS final rule to reflect the actual election decisions of ESRD facilities to receive 100 percent payment under the ESRD PPS for renal dialysis services furnished on or after January 1, 2011. This revision will result in an increase in payments by replacing a negative 3.1 percent adjustment with a zero percent adjustment for renal dialysis services furnished April 1, 2011 through December 31, 2011.

Topic
Discussion of the new End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and the transition adjustor

Background
The Centers for Disease Control and Prevention's National Guidelines for the Prevention of Catheter Infections state that patients living with catheters must maintain their hygiene, and when doing so must cover their catheters with secure, impermeable waterproof dressings that keep the catheter dry while they shower or bathe. Medicare has always covered these types of dressings for catheter patients under Part B as a home supply benefit.

Question 2: Last July, CMS began denying this cost- and life-saving benefit to fragile Medicare beneficiaries on dialysis. Why was this change made under Part B?

I also understand that a clarification was recently issued to say that these waterproof dressings are covered under the dialysis composite rate payment. But Medicare's written

policy states that the composite rate covers costs associated with the dialysis treatment, which it defines as the period of three to four hours over which dialysis occurs.

Patients do not shower or bathe during dialysis. Additionally, the list of codes that are covered by the dialysis composite rate expanded bundle does not include any code for the waterproof dressings recommended by the CDC. This clarification seems in contradiction to the policy it aims to clarify.

Therefore I would like to inquire what Medicare is doing to ensure that patients receive these dressings that save lives and possibly millions in preventable costs?

Answer 2: CMS shares your commitment to ensuring that ESRD patients receive quality care under the Medicare program. Through various initiatives, including the new ESRD prospective payment system (PPS), the ESRD quality incentive program, and the collection of data on infection control, CMS has worked actively to implement reforms that support quality of care in this critical area of the Medicare program.

With regard to this specific issue, we considered this matter carefully. Our analysis included a review of Medicare policies as they relate to dressings used for showering and bathing, meetings with a leading manufacturer of these items, and, most importantly, thoughtful consideration of patients' clinical needs.

As you know, beginning January 1, 2011, ESRD facilities are paid for all renal dialysis items and services that patients require, including renal dialysis items and services that are used in the home, based on full payment under the new ESRD PPS or through a blended payment reflecting both the previous composite payment system and the new ESRD PPS. To the extent that waterproof dressings are determined to be medically necessary, an ESRD facility would provide them and be paid by Medicare in this way. Paying for these items through a separate code under Part B would represent duplicate payment. To provide further clarification on this issue for ESRD facilities, CMS issued a manual revision on January 28, 2011, stating that all medically-required dressings or protective coverings used during or after dialysis to protect a dialysis patient's access site, including for example, coverings used for day to day activities such as bathing, are considered to be ESRD related items, and included in the payment under the PPS.

Questions on behalf of Mr. Pascrell:

Dr. Berwick, regarding health care reform's ability to improve the quality of care for seniors, I want to bring up the topic of healthcare-associated infections. As you know, the Department of Health and Human Services acknowledged this problem and proposed a series of recommendations through the 2009 HHS Action Plan to prevent healthcare-associated infections. Congress included these recommendations in the initial phase of Hospital Value Based Purchasing (VBP) program that begins in fiscal year 2013.

However, the recent CMS proposed rule on Hospital Value Based Purchasing only includes one of the seven measures from the HHS Action Plan.

Question 1: Can you share with me CMS' timeline for incorporating the remaining six measures into the VBP program?

Answer 1: As required by law, the measures used to gauge hospital performance under VBP must be those that are part of the hospital Inpatient Quality Reporting (IQR) program, as well as the HCAHPS survey. The IQR measure set includes both process measures and outcome measures, and hospitals are familiar with them because they have been reporting them for a number of years. A measure must be included on Hospital Compare for one year prior to its being selected for use under the hospital VBP program.

Incorporation of the Healthcare-Associated Infections (HAI)Action Plan measures into the Hospital IQR program and subsequently, into the Hospital VBP program is a high priority of the Agency, and we are working to do this as soon as possible.

Last year, we adopted two of the HAI measures into our hospital reporting system that can be included in the Hospital Value-Based Purchasing program once they have been on the Hospital Compare website for one year. The first is on central line-associated bloodstream infections, for which reporting began in January of this year. The second is on Surgical site infections, which hospitals will begin reporting in January of 2012. In addition, in the proposed rule on the Medicare hospital inpatient prospective payment system (IPPS) for FY 2012 that was issued on April 19th, we are proposing to require hospital reporting of four additional HAI measures from the HHS Action Plan:

- Catheter Associated Urinary Tract Infection
- Central Line Insertion Practices Adherence Percentage
- C. Difficile
- Methicillin-resistant Staphylococcus aureus (MRSA)

If these measures are incorporated in the Inpatient Quality Reporting Program in the final rule issued later this year, they can also be included in the Hospital VBP program after they have been reported on Hospital Compare for one year.

HAIs are among the leading cause of death in the United States. In the coming years, we will work to enhance and strengthen the HAI measure set and to include them in the hospital VBP program. Our intent is for this measure set to play a strong and vital role in the future determination of value-based incentive payments.

Second, Dr. Berwick, as you may know in 2005, CMS created the imputed wage index floor for states, like New Jersey, that are considered by the federal government to be all-urban states for Medicare payment purposes through regulation.

This floor corrected years of unequal treatment for New Jersey's hospitals by providing them with benefits similar to those granted to healthcare institutions in 49 other states through the rural hospital wage index floor.

This floor is set to expire this year and I believe that this floor needs to be made permanent. Other states have a permanent floor in place, except NJ. This is about equity, fairness, and leveling the playing field with other states.

Question 2: Do you support making this floor permanent this year?

Answer 2: Current law requires that the area wage index for any hospital that is located in an urban area of a State may not be less that the area wage index for hospitals located in rural areas in that State. This provision is commonly known as the "rural floor." While there is a statutory requirement for the *rural* floor, there is no such requirement for the *imputed* rural floor. Concerns have been expressed, as I understand it, that both the rural floor and the imputed rural floor policies create a benefit for a minority of States that is funded by a majority of States, including States that are overwhelmingly rural in character. I would be happy to discuss with you any concerns you may have about the imputed rural floor policy generally, and its specific impact on New Jersey hospitals.

Finally, Dr. Berwick, as you may know nationally, the skilled nursing sector employs 1.7 million Americans and generates over $200 billion in economic activity. In my state, skilled nursing facilities employ more than 53,000 people and generate nearly $10 billion annually in economic activity, which makes the skilled nursing sector the nation's second largest health employer.

Also, as you know, Medicare and Medicaid have a significant impact on the skilled nursing sector.

Question 3: Recognizing the fiscal pressures at the state level to reduce Medicaid funding to these health care providers, is there any way you can assure these providers that there are no additional cuts that will come from CMS in the next year?

Answer 3: CMS recognizes the important contribution of skilled nursing facilities (SNFs) to the economy and also understands that there are fiscal pressures at the state level to reduce Medicaid funding to SNFs. Further, we will continue to act as responsible stewards of the Medicare Trust Funds and make sure that SNFs are receiving accurate payment for the beneficiaries they are serving. At the same time, at its December 2, 2010 public meeting, the Medicare Payment Advisory Commission (MedPAC) reviewed many factors, including indicators of beneficiary access, the volume of services, the supply of providers, access to capital, and 2009 data showing that the aggregate Medicare margin for freestanding SNFs was 18.1 percent. Based on this information, MedPAC determined that Medicare payments to SNFs appear more than adequate.

Questions on behalf of Dr. Price:

Question 1: During the hearing, I asked you the following question: "Who ought to make that final decision about what treatment that patient receives?" to which you responded, "The doctor and the patient." How do you see increased government control of the physician-patient relationship as fitting into the patient-centered model?

Answer 1: There are two parts to your question.

First, in terms of the government's role and the law – the Affordable Care Act is built to protect and strengthen the system of private insurance in this country. It is built on the foundation of our current system. And it is designed to be implemented in full partnership with the States. The Secretary – who is a former governor- says that unlike most Federal laws that tell States to do things and don't make them partners or give resources, this is an exceptionally state-friendly law.

It strengthens public programs like Medicare. These changes, like lower prescription drug costs, and more preventive services, are strongly supported by beneficiaries.

Second, I strongly oppose any proposal that would place the government between the doctor and the patient. Unfortunately, care controls are present in the health system today. Insurance companies ration care based solely on costs. Arbitrary coverage limits reduce quality and shift costs to American families and health care providers. Low payments or lack of coverage can block access to life-saving treatments. This situation is economically and morally wrong.

I strongly oppose arbitrary limits on the care Americans receive. The Affordable Care Act gives states and consumers tools to stop these kinds of limits on care. For example, since September 23, 2010, insurers can no longer deny children with pre-existing conditions health care coverage in this country or attach arbitrary limits on what they would and wouldn't pay for.

Question 2: There are numerous provisions in the bill that would provide for the creation of quality measures. These provisions often give the Secretary of Health and Human Services wide discretion when developing the measures. First, how is the government best suited to foster the development and selection of these measures? What steps will you take and what protections will be put into place to ensure that physicians are behind the development and selection of these measures?

Some examples of these provisions include:

*** Section 10407 provides for the creation of a National Diabetes Report Card that will, in part, include information on quality of care. The Secretary is only required to consult with the Director of the Centers for Disease Control and Prevention.**

*** Section 10331 provides for the creation of a "Physician Compare" website that will provide for the reporting of performance information. To the extent practicable, PPACA requires the information to include an assessment of patient health outcomes, an assessment of the continuity and coordination of care transitions, an assessment of efficiency, and an assessment of the safety, effectiveness, and timeliness of care. Although the bill specifies that these measures must be "scientifically sound", the Secretary is only required to "take into consideration" input from multi-stakeholder groups.**

Answer 2: We have a number of exciting initiatives underway in the Department. In Medicare, we are working on a value based purchasing agenda by integrating measures into Medicare

payment systems for the end stage renal disease and inpatient hospital contexts. In Medicaid, for adults, CMS recently released a proposed core set of adult quality measures for public comment, as required by the Affordable Care Act. The adult quality measures are for voluntary reporting by Medicaid and are to be finalized by January 1, 2012. CMS will work with States to report data on these measures. For children, on February 14, 2011, CMS released a letter to State Health Officials and written guidance for voluntary reporting of the core set of child quality measures that were published in January 2010. This effort is funded through the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). CMS is also working with States to report data on these measures.

But much more needs to be done to advance quality initiatives and improve the quality of care patients receive. We need a more coordinated focus on quality, which is what the National Strategy for Health Care Quality would provide. The Secretary developed this Strategy through a participatory, transparent, and collaborative process that reached out to a range of stakeholders, including provider groups, for comment. This process culminated in a request for public comment on a proposed approach to the effort and a draft set of principles and priorities. More than 300 groups, organizations, and individuals provided comments, representing all sectors of the health care industry and the general public. We also need better outcomes data to be able to identify gaps and monitor progress, in which the new health reform law invests. And we need an additional focus on provider reporting and payment based on performance, which the bills prioritize.

Information and transparency are key to the quality initiative, to measure the quality of the health care we are currently receiving, and over time, how it improves. Patient safety in health care settings is a key priority and focus for CMS. We are evaluating policies and options related to Healthcare Acquired Conditions and hospital readmissions, as well as overall patient safety issues, to determine the best way to address these concerns. We are also consulting with other agencies within the Department to develop a coordinated approach to improve patient care. Additionally, through the Interagency Working Group for Health Care Quality, there is now a common platform for collaboration, cooperation, and consultation among relevant Federal agencies regarding quality initiatives, as a means to ensure alignment and coordination of quality efforts in the public sector and with private sector initiatives.

Question 3: At a rally in Holmdel, New Jersey on July 16, 2009, President Obama said, "Let me be exactly clear about what health care reform means to you. First of all, if you've got health insurance, you like your doctors, you like your plan, you can keep your doctor, you can keep your plan. Nobody is talking about taking that away from you." During the hearing, when I asked whether individuals that like their coverage will be able to keep it, you responded, "[T]here is turnover always in what's available to the beneficiaries." Your own actuary, Richard Foster, estimates that by 2017 enrollment in Medicare Advantage plans will be lower by about 50 percent due to "reductions in the value of MA benefit packages because of the lower rebate levels [which] are expected to significantly reduce the attractiveness of many MA plans relative to fee-for-service Medicare." Would you define a 50 percent reduction in enrollment over seven years as "turnover"?

Answer 3: This Administration has embarked on a path to strengthen and improve Medicare Advantage. Despite the CMS Actuary's estimates and projections last year, I'm happy to report that the actual enrollment data for Medicare Advantage in 2011 shows a 6 percent increase in enrollment this year, with more than 190,000 new Medicare Advantage enrollees in the program.

Question 4: There are provisions in the bill that will threaten patient-centered care. Specifically, Section 6301 of PPACA creates the Patient Centered Outcomes Research Institute. The bill states that the Secretary will not be prevented "from using evidence or findings from such comparative clinical effectiveness research in determining coverage, reimbursement, or incentive programs under such title based upon a comparison of the difference in the effectiveness of alternative health care treatments in extending an individual's life due to that individual's age, disability, or terminal illness." If this research can be used to determine coverage and reimbursement, how will this not directly interfere with the physician-patient ability to determine which treatment is best for the patient?

Answer 4: Let me be clear. I strongly oppose any proposal that would place the government in between the doctor and the patient. I strongly oppose arbitrary limits on the care Americans receive.

This provision will enhance the physician-patient ability to determine which treatment is best for the patient, not interfere with it. Section 6301(c) of the Affordable Care Act states clearly that the Secretary is not authorized "to deny coverage of items or services… solely on the basis of comparative clinical effectiveness research." This research will be publicly available and widely disseminated so that it can aid physicians in guiding appropriate care for patients, helping them to prescribe care based on the benefit that patients might gain. For example, if doctors learn from this research that a brand name drug works as well as a similar type of generic, or a procedure associated with many side effects works nearly as well as a different procedure with fewer side effects, they can use this information to help patients make choices that are right for their unique health care needs.

Question 5: I sent a letter to your office on December 2, 2010 asking for clarification on how an August 27, 2010 DMEPOS final rule would affect the use of "consignment closets." I wanted to follow up and see if you could provide an answer to this letter.

Answer 5: Thank you for your letter. Consignment closet arrangements involve a physician, or other provider, giving patients supplies at the physician's or provider's location without requiring ownership of the supplies. These arrangements have not been affected by the DMEPOS final rule, and are not expressly prohibited, provided such arrangements comply with the DMEPOS supplier standards, as well as applicable Medicare laws, rules, and regulations. We will provide clarifying guidance through the Web site of our DMEPOS enrollment contractor, the National Supplier Clearinghouse. This guidance will confirm that nothing in the aforementioned regulation prevents DMEPOS suppliers from entering into consignment closet arrangements that comply with applicable Medicare laws, rules, and regulations.

Questions on behalf of Mr. Reichert:

Question 1: Last year as part of your 2011 hospital outpatient prospective system (HOPPS) proposed rule your agency determined that OPPS costs incurred by the Dedicated Cancer Centers exceed the OPPS costs provided at other PPS hospitals. As required under the Affordable Care Act, CMS was directed to make an "appropriate adjustment" for Cancer Centers to reflect those higher costs. I was pleased to see CMS recognize these Cancer Centers are underpaid for their services. However, I am concerned that CMS failed to bring real parity to these Cancer Centers as compared to other PPS hospitals. Specifically, I understand CMS did not take into account the significant Medicare outpatient concentrations as compared to that of other PPS hospitals. Since the inception of HOPPS, Congress has afforded these dedicated Cancer Centers permanent "hold harmless" protection under this payment system. It would be my hope that CMS will consider the high outpatient concentration and set these Cancer Centers reimbursement at a more appropriate level moving forward. Treatment in the outpatient setting is better for patients and less costly than inpatient care. The centers should not incur large losses by doing the right thing for patients and the Medicare program.

Answer 1: CMS is extremely concerned about the impact that the steep rise in healthcare costs has on all Americans, especially the impact these costs have on Medicare beneficiaries and Medicaid recipients. During the comment period for the Hospital Outpatient Prospective Payment System (OPPS) proposed rule for CY 2011, many commenters pointed out the likelihood of much greater cost-sharing for Medicare beneficiaries seeking care at these institutions should we finalize our cancer hospital adjustment as proposed. However, with few exceptions, the statute requires that the beneficiary co-payment apply to OPPS payment to a hospital, including any enhanced OPPS payment received by a cancer hospital under Section 3138.

Section 3138 of the Affordable Care Act requires the Secretary to first study cost differences with respect to ambulatory payment classification groups under the OPPS between the 11 designated cancer hospitals and other Medicare-participating hospitals. The Secretary shall make an appropriate adjustment under the statute, if the Secretary determines that the cost incurred by those cancer hospitals with respect to the ambulatory payment classification groups exceed those costs incurred by other hospitals under the OPPS. During the rule's comment period, CMS received a great volume of thoughtful comments on our study of cancer hospitals' costs and the proposed adjustment. In response to these comments, CMS agreed to study the issue for another year and will again discuss the issue in our CY 2012 rulemaking cycle.

Question 2: It is vital that CMS move quickly to substitute the actual number of facilities that will be paid under the new ESRD PPS system for the estimated number it is currently using. Can you explain why CMS has not yet calculated the transition adjustor using the actual number of facilities that moved into the bundle earlier this year? When does the Agency plan to correct the adjustor? Is CMS willing to take action to waive the rulemaking requirement and recalculate the transition adjustment based upon the actual number of facilities that have opted out of the transition period?

Answer 2: When adopting a new payment system under Medicare, CMS is often statutorily required to ensure that aggregate payments (with the exception of any applicable inflation update) are the same as those under the previous payment system. In this case, we were required to ensure that payments under the new ESRD prospective payment system (PPS) were, in aggregate, 98 percent of the total payments that would have been made under the previous basic case-adjusted composite payment system. In order to meet this requirement, we applied a transition budget neutrality adjustment factor of 3.1 percent to ESRD payments in the calendar year (CY 2011) ESRD PPS final rule.

As described in the final rule, CMS' calculation of this factor was based on the best available data to estimate payments during the transition period. At the same time, we acknowledged that the adjustment may not reflect actual choices made by the ESRD facilities regarding opting out of the ESRD PPS transition. However, we noted that the adjustment would be updated each year of the transition (CY 2012 and CY 2013) to reflect actual data on providers electing to opt-out of the transition.

As a result of the information available to CMS on the number of facilities opting out of the transition, on April 1, 2011, CMS issued an interim final rule revising the ESRD transition budget-neutrality adjustment finalized in the CY 2011 ESRD PPS final rule to reflect the actual election decisions of ESRD facilities to receive 100 percent payment under the ESRD PPS for renal dialysis services furnished on or after January 1, 2011. This revision will be applied prospectively and results in an increase in payments by replacing a negative 3.1 percent adjustment with a zero percent adjustment for renal dialysis services furnished April 1, 2011 through December 31, 2011.

Questions on behalf of Mr. Roskam:

Question 1: Dr. Berwick, you have stated there will be no guaranteed benefit cuts to Medicare. However, according to Mr. Foster and the CMS Actuaries, Medicare reimbursement will be lower than Medicaid reimbursement in just over ten years. In 75 years, Medicare payments will be one-third of what they are presently. Will new Medicare beneficiaries have their access to healthcare services jeopardized because of unsustainable Medicare cuts in PPACA? Are these Medicare "savings" sustainable?

Answer 1: CMS is working to make the "best care" in America the norm in health care, for everyone. We are implementing several Affordable Care Act provisions designed to improve the quality of care for those enrolled in our programs. The Affordable Care Act contains provisions designed to help avoid preventable hospital readmissions by linking financial incentives to readmission rates and by providing assistance and support to hospitals to improve transitional care processes. It also requires CMS and providers to focus on the prevention of infections, conditions, and other complications that patients acquire from the care that is supposed to help them.

We believe that providing productivity adjustments that will bring hospitals and doctors in line with other aspects of our economy in terms of growth rates is a reasonable and fiscally responsible step to take, and the Affordable Care Act allows us to do that.

Medicare participation rates have been historically very high – well above 90 percent. In 2010, the total Medicare provider participation rate was 95.8 percent (932,737 providers). This is the highest participation rate in the history of the Medicare program, and represents an increase of 0.4 percent from 2009. Additionally, the physician participation rate for Medicare FFS in 2010 was 97.1 percent. The vast majority of States, according to 2006 data, have a provider participation rate of 90 percent or better.

CMS will continue to monitor participation levels and other indicators of access to care to ensure Medicare beneficiaries have access to the care they need.

Question 2: Dr. Berwick, the Medicare actuaries also stated that 15% of Medicare Part A providers will be unprofitable within ten years and jeopardize access to care absent legislative intervention. This equates to 725 hospitals, 2,352 nursing homes, and 1,587 home health agencies. I represent a hospital that is part of an even more vulnerable subset of this group of providers. A number of Illinois hospitals are significantly dependent on Medicare – over 60% and do not receive any special add-on payments, such as DSH or IME. Not only are these hospitals disproportionately impacted by the market basket and productivity adjustments, but these hospitals will not be able to make up the difference with newly insured patients because Medicare is clearly their predominant payor. I am very concerned about the viability of these hospitals and beneficiary access to these important communities. Does CMS share the concern about this subset of hospitals? Does CMS have administrative tools to fix this access and viability problem or will it rely on Congressional intervention? If Congress must intervene to prevent the cuts in a manner similar to the "doc fix," will the promised spending (insurance subsidies and Medicaid expansion) contribute to the deficit?

Answer 2: I recognize the challenging environment that hospitals are currently facing. The Affordable Care Act contains a number of provisions that will help hospitals improve care and lower costs, including efforts related to hospital readmissions, value based purchasing, and hospital acquired conditions. Moreover, by expanding coverage, the Affordable Care Act will dramatically reduce the amount of uncompensated care that hospitals currently absorb, and will ensure that patients are able to appropriately access hospital services. Improvements in care and coverage from these provisions will benefit hospitals' bottom line, will benefit the health care system as a whole – and most importantly, will benefit our beneficiaries.

Question 3: Dr. Berwick, in your written testimony it says, "CMS is currently integrating predictive modeling as part of an end-to-end solution that is transparent, measurable, and triggers effective, timely administrative actions. Innovative risk scoring technology applies a combination of behavioral analyses, network analyses, and predictive analyses that are proven to effectively identify complex patters of fraud and improper claims and billing schemes. Given the changing landscape of Medicare and Medicaid fraud, any successful technology will need to be nimble and flexible, identifying and adjusting to new schemes as

they appear." I tried to improve the original healthcare bill, HR 3200, with a fraud mitigation amendment using predictive modeling but it was rejected on a partisan basis in this Committee. It is encouraging to see CMS moving towards this method of fraud detection and prevention in public programs. I would like to see the technology moved pre-payment more quickly. What significant systems changes will be needed to move this process pre-payment? What can Congress do to assist CMS in this process? What is the timeline for (a) post-payment review and (b) pre-payment review of claims?

Answer 3: CMS is expanding its Integrated Data Repository (IDR) which is currently populated with five years of historical Part A, Part B and Part D paid claims, to include near real time pre-payment stage claims data; this additional data will provide the opportunity to analyze previously undetected indicators of aberrant activity throughout the claims processing cycle. CMS intends to develop shared data models and is pursuing data sharing and matching agreements with the Department of Veterans Affairs, the Department of Defense, the Social Security Administration, and the Indian Health Service to identify potential waste, fraud, and abuse throughout Federal health care programs. Also, the Affordable Care Act requirement that States report an expanded set of data elements from their Medicaid Management Information System (MMIS) will strengthen CMS' program integrity work both within State Medicaid programs and across CMS. This robust State data set will be harmonized with Medicare claims data in the IDR to detect potential fraud, waste and abuse across multiple payers.

CMS will implement an innovative risk scoring technology that applies effective predictive models to Medicare. Innovative risk scoring technology applies a combination of behavioral analyses, network analyses, and predictive analyses in order to identify complex patterns of fraud and improper claims and billing schemes. CMS is integrating the advanced technology as part of an end-to-end solution that will trigger effective, timely administrative actions by CMS as well as referrals to law enforcement when appropriate. Prior to applying predictive models to claims prepayment, CMS will rigorously test the algorithms to ensure a low rate of false positives, allowing payment of claims to legitimate providers without disruption or additional costs to honest providers; confirm that the algorithms do not diminish access to care for legitimate beneficiaries; and identify the most efficient analytics in order to appropriately target resources to the highest risk claims or providers. Given the changing landscape of health care fraud, any successful technology will need to be nimble and flexible, identifying and adjusting to new schemes as they appear.

Further, the Small Business Jobs Act of 2010 provided $100 million, beginning in FY 2011 to phase-in the implementation of predictive analytics in Medicare FFS. The Small Business Jobs Act of 2010 additionally provides that the Secretary shall start to phase-in the use of predictive analytics technologies to Medicaid and CHIP beginning April 1, 2015. The new predictive modeling technology will incorporate lessons learned through pilot projects. For example, in one pilot, CMS partnered with the Federal Recovery Accountability and Transparency Board (RATB) to investigate a group of high-risk providers. By linking public data found on the Internet with other information, like fraud alerts from other payers and court records, we uncovered a potentially fraudulent scheme. The scheme involved opening multiple companies at the same location on the same day using provider numbers of physicians in other states. The

data confirmed several suspect providers who were already under investigation and, through linkage analysis, identified affiliated providers who are now also under investigation.

Question 4: In the summer of 2009, the DuPage County State's Attorney's Office (SAO) entered into an agreement with the Illinois Department of Public Health (IDPH) to begin a new program designed to protect residents of long-term residential healthcare facilities and nursing homes in DuPage County from criminal abuse, neglect, and financial exploitation. The agreement with IDPH supplemented IDPH's existing administrative investigations and Illinois State Police's criminal investigation procedures such that IDPH provided copies of any complaints that it received to the SAO so that the office could screen the complaints for possible criminal investigation. After screening a complaint and determining that a criminal investigation was warranted, the SAO would request (and receive) copies of any follow-up reports done by IDPH investigators. Upon receipt, prosecutors and investigations reviewed these follow-up reports for law enforcement purposes and took whatever steps were appropriate based, in part, on the findings of the IDPH's investigators.

This program was working and effective until CMS intervened. In late summer of 2010, CMS informed the IDPH that it was no longer allowed to release the records sought by the SAO even though the records were sought for law enforcement purposes. After months of communication and conversation, CMS acknowledged that the Federal Administrative Code allows the release of these reports for the purpose sought by the SAO [45 CFR Subtitle A §5.9(b)(7)]. However, CMS has asserted that it is not permitted to authorize the release of these reports because CMS does not "have a policy in place" to facilitate the process. In the meantime, the SAO has not been able to review IDPH's reports of abuse and neglect for several months. It is my understanding that IDPH only requires that CMS grant permission to resume providing copies of its reports to the SAO. Can we quickly work together with the DuPage County State's Attorney's Office to resolve this dilemma and protect residents of long-term residential facilities and nursing homes from abuse, neglect, and financial exploitation?

Answer 4: Thank you for your commitment to protecting residents of long-term care facilities and for raising this concern. The Centers for Medicare & Medicaid Services (CMS) is happy to work quickly with you, the State, and the County to resolve this concern.

CMS has been working with the State to resolve this issue and put in place a data use agreement (DUA) for the Federal complaint records it is seeking. As you may know, currently CMS does not have a DUA with the DuPage County State's Attorney's Office (SAO) or with the Illinois Department of Public Health (IDPH) to share data under the new program mentioned, nor is CMS a party to such a DUA to provide copies of any Federal complaint records that it received to the SAO so that the office could screen the records for possible criminal investigation.

In addition, written CMS guidance to States on this matter is forthcoming.

Questions on behalf of Mr. Tiberi:

Dr. Berwick, I have several concerns and request information as it pertains to the competitive bidding program for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), as required by the Medicare Modernization Act of 2003. Specifically, I am concerned about the impact this program will have on small independent providers and the number of jobs that will be lost.

As you know, CMS initiated its DMEPOS Competitive Bidding program for Medicare Beneficiaries and Contract Suppliers on January 1, 2011.

Question 1: For each month in CYs 2010 and 2011, what was the total number of DME supplier claims in each Durable Medical Equipment Regional Carrier (DMERC)?

Answer 1: Thank you for your interest in the DMEPOS competitive bidding program. We have instructed our contractors to extract the data you have requested. We anticipate that we will have such data within the next two weeks and will provide it to you under separate cover as soon as it is available.

Question 2: For each month in CYs 2010 and 2011, what was the total number of beneficiary DME claims in each DMERC?

Answer 2: As mentioned above, we have instructed our contractors to extract the data you have requested. We anticipate that we will have such data within the next two weeks and will provide it to you under separate cover as soon as it is available.

Question 3: For each month in CYs 2010 and 2011, what is the total number of active DME provider numbers in each DMERC?

Answer 3: As mentioned above, we have instructed our contractors to extract the data you have requested. We anticipate that we will have such data within the next two weeks and will provide it to you under separate cover as soon as it is available.

Question 4: When ACO's are implemented under the law, how will ACO's operate as intended with so few DME suppliers following implementation of Competitive Bidding.

Answer 4: The Medicare Shared Savings Program is intended to encourage providers of services and suppliers (e.g., physicians, hospitals and others involved in patient care) to create a new type of health care entity, known as an "accountable care organization" (ACO) that agrees to be held accountable for improving the health and experience of care for individuals and improving the health of populations. Studies have shown that better care often costs less, because coordinated care helps to ensure that the patient receives the right care at the right time, with the goal of avoiding unnecessary duplication of services and preventing medical errors. The goal of an ACO is to deliver seamless, high quality care for Medicare beneficiaries, instead of the fragmented care that has so often been part of fee-for-service health care.

The intent of the Medicare DMEPOS Competitive Bidding Program is to set more appropriate payment amounts for DMEPOS items, which will result in reduced beneficiary out-of-pocket expenses and savings to taxpayers and the Medicare program. The program does not affect the beneficiary's choice of physician or treating practitioner. Rather, under the program, suppliers of durable medical equipment, prosthetics, orthotics, and supplies compete to become Medicare contract suppliers. All contract suppliers were required to comply with Medicare enrollment rules, be licensed and accredited, and meet financial standards. Further, in determining how many contract suppliers would be needed to meet beneficiary demand, CMS used conservative estimates, over-estimating the number of needed contract suppliers to meet such demand. Accordingly, during Round 1 of the program, CMS awarded 1,217 contracts to suppliers to furnish certain medical equipment and supplies in the nine competitive bidding areas. While we continue to monitor the implementation of Round 1, we are pleased to report that implementation of the program is going very smoothly.

Question on behalf of Mr. Berg:

Question 1: According to the Medicare Actuaries' April 22 report on the health care law, 7.4 million seniors would lose their plan by 2017 as a result of the $206 billion in cuts to Medicare Advantage. This will be a 50 percent reduction from what enrollment was expected to be before the law was enacted. Doesn't this mean that seniors won't be able to keep the plan they have and like?

Answer 1: This Administration has embarked on a path to strengthen and improve Medicare Advantage. Despite the CMS Actuary's estimates and projections last year, I am happy to report that the actual enrollment data for Medicare Advantage in 2011 shows a 6 percent increase in enrollment this year, with more than 190,000 new Medicare Advantage enrollees in the program.

Claims, Beneficiary, and Supplier Summary Data by DME MAC for 2010 and 2011
Tab 1 - Number of Submitted Claims
All Jurisdictions
Sorted by Jurisdiction
PDAC Receipt Dates: 01/01/2010 - 02/28/2011
Claims Received by PDAC Through 02/28/2011
Ad Hoc: 35335

NORIDIAN® Administrative Services LLC

	Number of Submitted Claims													
Jurisdiction	Jan 10	Feb 10	Mar 10	Apr 10	May 10	June 10	July 10	Aug 10	Sept 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11
A	947,371	971,148	1,231,971	1,127,974	1,059,021	1,155,838	1,124,583	1,162,534	1,141,702	1,137,936	1,102,019	1,204,434	1,036,668	1,043,530
B	1,090,298	1,157,713	1,434,285	1,329,981	1,217,179	1,334,108	1,392,339	1,444,270	1,399,418	1,300,926	1,290,373	1,465,606	1,217,933	1,187,485
C	2,095,717	2,232,182	2,722,134	2,495,497	2,312,217	2,534,020	2,587,894	2,576,203	2,555,169	2,452,606	2,471,734	2,617,472	2,183,593	2,283,761
D	1,093,169	1,130,396	1,413,711	1,286,241	1,181,258	1,304,579	1,312,424	1,270,164	1,283,275	1,247,122	1,181,526	1,403,048	1,229,076	1,243,677

Source of Report: PDAC Reporting
Run Date: 03/14/2011
Final Claims, Include Denied Claims
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Claims, Beneficiary, and Supplier Summary Data by DME MAC for 2010 and 2011
Tab 2 - Number of Beneficiaries with Submitted Claims
All Jurisdictions
Sorted by Jurisdiction
PDAC Receipt Dates: 01/01/2010 - 02/28/2011
Claims Received by PDAC Through 02/28/2011
Ad Hoc: 35335

NORIDIAN® Administrative Services LLC

	Number of Beneficiaries with Submitted Claims													
Jurisdiction	Jan 10	Feb 10	Mar 10	Apr 10	May 10	June 10	July 10	Aug 10	Sept 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11
A	580,411	582,483	693,574	660,619	635,322	687,215	668,548	683,092	674,537	678,088	660,537	699,875	617,241	610,197
B	674,815	694,160	802,635	773,641	734,925	788,950	800,379	841,284	815,622	784,581	773,614	839,027	726,284	702,787
C	1,318,948	1,354,214	1,562,026	1,499,836	1,429,784	1,531,881	1,534,318	1,552,373	1,536,044	1,501,221	1,512,371	1,569,774	1,338,136	1,351,825
D	679,898	694,770	794,023	763,329	727,100	781,735	777,024	773,097	774,034	762,766	738,339	818,802	741,897	734,370

Source of Report: PDAC Reporting
Run Date: 03/14/2011
Final Claims, Include Denied Claims
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Claims, Beneficiary, and Supplier Summary Data by DME MAC for 2010 and 2011
Tab 3 - Number of Suppliers with Allowed Amounts by Jurisdiction
All Jurisdictions
Sorted by Jurisdiction, Amount Allowed Category
PDAC Receipt Dates: 01/01/2010 - 02/28/2011
Claims Received by PDAC Through 02/28/2011
Ad Hoc: 35335

		Number of Suppliers with Allowed Amounts													
Jurisdiction	**Amount Allowed Category**	**Jan 10**	**Feb 10**	**Mar 10**	**Apr 10**	**May 10**	**June 10**	**July 10**	**Aug 10**	**Sept 10**	**Oct 10**	**Nov 10**	**Dec 10**	**Jan 11**	**Feb 11**
A	$1.00 - $999.99	9,877	9,418	9,607	9,699	9,482	9,365	9,200	9,352	9,491	9,524	9,828	9,761	10,258	10,457
A	$1,000.00 - $9,999.99	6,828	6,485	7,602	7,266	7,158	7,588	7,544	7,645	7,532	7,596	7,460	8,017	7,439	6,785
A	$10,000.00 - $49,999.99	1,354	1,278	1,427	1,392	1,428	1,444	1,413	1,397	1,374	1,372	1,349	1,378	1,359	1,293
A	$50,000.00 - $99,999.00	371	392	457	457	407	454	461	492	476	481	440	477	417	424
A	$100,000 and over	275	291	375	347	300	336	334	370	352	322	335	362	326	344
B	$1.00 - $999.99	9,406	9,608	9,612	9,454	9,125	8,851	8,693	8,872	8,873	9,025	9,613	9,389	9,801	10,073
B	$1,000.00 - $9,999.99	7,381	7,056	7,747	7,727	7,507	7,731	7,816	7,833	7,704	7,823	7,511	8,176	7,784	7,260
B	$10,000.00 - $49,999.99	1,640	1,684	1,787	1,832	1,804	1,828	1,805	1,800	1,759	1,770	1,742	1,743	1,704	1,627
B	$50,000.00 - $99,999.00	468	468	567	509	511	520	553	557	545	556	534	562	509	479
B	$100,000 and over	306	318	428	397	363	400	426	437	435	410	396	469	373	366
C	$1.00 - $999.99	16,080	15,045	14,961	15,284	15,941	16,092	16,632	17,471	17,641	17,339	17,214	16,566	16,723	16,189
C	$1,000.00 - $9,999.99	10,393	9,789	11,277	11,016	10,459	11,247	11,341	11,102	10,786	11,220	11,027	11,564	11,103	10,015
C	$10,000.00 - $49,999.99	3,868	3,967	4,020	4,109	4,065	4,068	4,064	4,001	4,019	3,998	4,066	4,014	3,981	3,917
C	$50,000.00 - $99,999.00	1,079	1,161	1,312	1,280	1,238	1,303	1,330	1,328	1,299	1,257	1,235	1,304	1,108	1,100
C	$100,000 and over	597	646	886	769	696	785	808	810	900	739	810	856	642	680
D	$1.00 - $999.99	9,342	8,991	8,887	9,043	9,459	9,432	9,697	9,787	9,920	9,837	10,195	9,780	10,135	10,198
D	$1,000.00 - $9,999.99	6,428	6,303	6,911	7,202	6,704	7,117	7,010	7,018	6,848	6,871	6,583	7,352	6,851	6,511
D	$10,000.00 - $49,999.99	2,008	1,984	2,109	2,170	2,129	2,163	2,140	2,103	2,123	2,128	2,082	2,068	2,017	1,974
D	$50,000.00 - $99,999.00	575	606	702	637	611	668	653	653	681	625	601	693	672	644
D	$100,000 and over	343	349	463	421	382	408	430	436	412	416	377	479	383	395

Source of Report: PDAC Reporting
Run Date: 03/14/2011
Final Claims, Include Denied Claims
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Claims, Beneficiary, and Supplier Summary Data by DME MAC for 2010 and 2011
Tab 4 - Number of Suppliers with Allowed Amounts - Nationwide
All Jurisdictions
Sorted by Amount Allowed Category
PDAC Receipt Dates: 01/01/2010 - 02/28/2011
Claims Received by PDAC Through 02/28/2011
Ad Hoc: 35335

	Number of Suppliers with Allowed Amounts													
Amount Allowed Category	**Jan 10**	**Feb 10**	**Mar 10**	**Apr 10**	**May 10**	**June 10**	**July 10**	**Aug 10**	**Sept 10**	**Oct 10**	**Nov 10**	**Dec 10**	**Jan 11**	**Feb 11**
$1.00 - $999.99	33,676	31,963	30,694	31,600	33,126	32,205	32,501	33,562	34,322	34,169	35,297	33,324	34,993	35,196
$1,000.00 - $9,999.99	29,136	27,571	31,200	30,970	29,653	31,514	31,550	31,424	30,689	31,415	30,532	32,902	31,174	28,631
$10,000.00 - $49,999.99	8,285	8,370	8,662	8,851	8,755	8,833	8,777	8,618	8,613	8,650	8,619	8,573	8,416	8,187
$50,000.00 - $99,999.00	2,417	2,537	2,901	2,771	2,705	2,832	2,870	2,925	2,867	2,788	2,684	2,878	2,617	2,549
$100,000 and over	1,397	1,488	2,020	1,805	1,609	1,797	1,874	1,917	1,976	1,742	1,786	2,019	1,593	1,658

Source of Report: PDAC Reporting
Run Date: 03/14/2011
Final Claims, Include Denied Claims
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