SETTING FISCAL PRIORITIES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

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C O N T E N T S

SETTING FISCAL PRIORITIES

TUESDAY, DECEMBER 9, 2014

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

The subcommittee met, pursuant to call, at 10:30 a.m., in room 2123, Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Burgess, Shimkus, Murphy, Blackburn, Gingrey, McMorris Rodgers, Lance, Griffith, Bilirakis, Ellmers, Pallone, Engel, Schakowski, Green, Barrow, Castor, and Sarbanes.

Staff present: Sean Bonyun, Communicatons Director; Leighton Brown, Press Assistant; Noelle Clemente, Press Secretary; Paul Edattel, Professional Staff Member, Health; Brad Grantz, Policy Coordinator, Oversight and Investigations; Sydne Harwick, Legislative Clerk; Robert Horne, Professional Staff Member, Health; Michelle Rosenberg, GAO Detailee, Health; Chris Sarley, Policy Coordinator, Environment and the Economy; Adrianna Simonelli, Legislative Clerk; Heidi Stirrup, Policy Coordinator, Health; Josh Trent, Professional Staff Member, Health; Tom Wilbur, Digital Media Advisor; Ziky Ababiya, Democratic Staff Assistant; Eddie Garcia, Democratic Professional Staff Member; Kaycee Glavich, Democratic GAO Detailee; and Karen Nelson, Democratic Deputy Staff Director, Health.

Mr. PITTS. The subcommittee will come to order. The Chair will recognize himself for an opening statement.

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

Despite some recent progress in reducing the deficit, the Federal Government faces enormous budgetary challenges. The Congressional Budget Office projects that the annual Federal budget deficit will once again approach the $1 trillion mark in a few short years. At the end of November, the Federal debt surpassed $18 trillion for the first time.

The consequences associated with the Federal Government spending and debt problem can't be overstated. In fact, the former Chairman of the Joint Chiefs of Staff concluded that, quote, "The single biggest threat to our national security is our debt," end quote. Federal spending on healthcare programs is the major driver of the spending and debt challenge that America confronts.

Today's hearing is a critical step as the committee approaches the 114th Congress and considers proposals to tackle this problem. Our biggest challenge is mandatory spending, particularly Medicare and Medicaid, which together accounted for 25 percent of all Federal spending in fiscal year 2013.

Medicare is on an unsustainable trajectory. In fiscal year 2014, it covered some 54 million people at a cost of approximately $618 billion. According to the 2014 Medicare trustees report, the program will become insolvent in 2030, in just 15 years. If Medicare spending accelerates in coming years, as many economists expect, then Medicare's insolvency could come much sooner.

Medicaid expenditures are set to increase dramatically as a result of the Affordable Care Act's Medicaid expansion. Spending on the program is set to double over the next decade, even though it already comprises one in every four dollars in an average State budget.

These programs need to be strengthened and modernized, not just because millions of Americans depend on them for their health care, but also because out-of-control entitlement spending is crowding out other important priorities. For example, researchers, scientists, patient advocates, and many others have consistently told the committee that Congress should consider stabilizing and strengthening the National Institutes of Health as part of the 21st Century Cures Initiative. The NIH and other discretionary program priorities will continue to face budgetary challenges if entitlement program spending continues to take a larger and larger share of the budget.

The late Democratic Senator Paul Simon spoke to this larger issue when he said, quote, "A rising tide of red ink sinks all boats," closed quote. The Federal Government's mandatory spending on entitlement programs threatens Congress' responsibility to spend dollars on programs like the NIH. We need to consider solutions so that we can best target resources to these areas of priority.

Today's hearing is also timely in another respect. Next year, Congress faces a number of important funding cliffs. In March, Congress will need to confront the Medicare physician payment cliff and try to enact a permanent solution to the sustainable growth rate or SGR. In addition, the Affordable Care Act created a funding cliff for the States Children's Health Insurance Program. Funding for the program ends in September.

If Congress is going to tackle these problems and others facing the next Congress, we will need to come up with responsible ways to pay for these issues. Rather than turning to blunt tools like the Medicare sequester, we need policies that drive reform and savings that make sense. In addition, given that the Affordable Care Act has been the law for over 4 years, targeted reductions to the ACA must be on the table as we set fiscal priorities. I hope today serves as a catalyst to continue these important discussions about setting fiscal priorities.

I would like to welcome all of our witnesses on both panels today. I look forward to your testimony, to your recommendations on how to strength and save these critical programs.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

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I would like to welcome of all our witnesses. I look forward to your testimony and your recommendations on how to strengthen and save these critical programs.

Mr. PITTS. And I yield the balance—I don't have much time.

I yield back the balance of my time and recognize the ranking member, Mr. Pallone, for 5 minutes for an opening statement.

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

Mr. PALLONE. Thank you, Chairman Pitts.

As a member of Congress, I believe that Government can help all Americans succeed, including seniors and low-income populations and still continue to strengthen our economy.

While I agree we must do these things with fiscal responsibility, I do not agree that we need to balance the budget on the backs of our safety net programs. Improving and strengthening Medicare and Medicaid for generations to come is a primary goal of mine, but what Republicans want to do when they talk about setting fiscal priorities is to cut the structural foundation of these programs.

For the past 4 years, the Republican budget proposals have turned Medicare into a voucher program and turned Medicaid into block grants. But these changes do nothing to tackle healthcare costs; they simply undermine the program's guarantee of access to care and shift costs to beneficiaries, providers, and States. Shifting costs doesn't curb costs and doesn't shore up the long-term sustainability of our healthcare systems.

The Affordable Care Act began to make improvements to our healthcare system through delivery system reforms that improve both efficiency and quality. And I would argue that the Affordable Care Act was entitlement reform. It expands access to life-saving health care while also reducing Medicare spending. In fact, recent estimates show the increase in Medicare's per-patient costs are at record lows.

In addition, the ACA laid the groundwork to reward value over volume, to incentivize providers to coordinate care and improve health. And that job needs to be finished, so we ought to be setting our priority to send our SGR repeal and replace the bill to the floor before we adjourn for Christmas unpaid for, so that once and for all we can bring real sustainability and predictability to its providers and seniors.

The fact is that we are faced with an inevitable reality, our Nation's baby boomers are aging to the program at very high rates. In fact, 11,000 new seniors become eligible for Medicare every day. Meanwhile, the Medicaid program, as a result of the ACA, will allow millions of uninsured Americans, particularly the working class, to finally gain access to health care. But this doesn't mean we have a spending problem; it means we have a demographics problem. And to address that problem doesn't mean we need to slash the programs that American families need most.

Budgets, in my opinion, are about more than numbers and dollars. They are real-life expressions of priorities, of choices, and of values. These choices have an impact on the lives of millions of Americans, not just for the fiscal year each budget covers but for future years and future generations.

Now, I know that growing deficits are not good for the future but we can't reduce the deficit and give tax cuts to the wealthy on the backs of our safety net programs. Instead, let's build on the ACA and continue to improve the value we get from our programs in a thoughtful and sensible way and find ways to take care of all Americans.

Now, Mr. Chairman, I would like to yield the time that remains to the gentleman from Texas, Mr. Green.

OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Thank you, Mr. Chairman, and thank my ranking member for yielding.

We all share the goal of saving money and bringing down costs through making our healthcare system more efficient. Rewarding value over volume ensures patients have coverage and access to preventative primary care service and reducing uncompensated care should be part of this effort. As we explore key policy decisions facing Congress, cost shifting to the beneficiaries simply passes growing cost onto patients but does not address the true drivers of the growth in healthcare spending.

The Affordable Care Act included a number of numerous delivery system reforms that incentivize a more efficient healthcare delivery system. These activities hold significant promise for controlling spending while improving quality of care. When considering changes in Medicare benefits packages a strategy to bring down overall costs, it is important to recognize the difference between change that is designed for the benefit of the beneficiaries are those driven entirely by reducing Federal spending are those proposals which result in both?

I look forward to hearing from our witnesses this morning and exploring meaningful reforms that protect the most vulnerable populations and provide for the long-term stability of our healthcare system.

And again, I thank my colleague and yield back my 35 seconds.

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

Chair recognizes the vice chair of the Health Subcommittee, Dr. Burgess, 5 minutes for an opening statement.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. Thank you, Mr. Chairman.

Fiscal year 2014, the Government collected over $3 trillion in taxes for the first time, thanks to the generosity of the American taxpayer, and yet, we still had a deficit of almost .5 trillion. With our national debt reaching $18 trillion last month, we face the gravest financial situation in our history, and we must get serious about bringing that number down. If we don't start making difficult decisions now, our children, their children will inherit a burden unlike any generation previously has ever seen.

Under the best reporting, the Medicare Trustees project says that Medicare hospital insurance coverage is only solvent until 2030 and, in fact, it may be exhausted much sooner. Promises made to Medicare recipients exceed the payroll taxes to be collected from those receiving them by well over $100 trillion. Failure to repeal and replace the SGR has now cost over $170 billion over the last decade. Medicare Part B itself surpasses $70 billion in 2012 alone.

This committee did do the right thing in repealing the SGR formula, and, yes, it got it through the floor of the House. We were awaiting activity in the Senate, but as the clock ticks down on what remains in this Congress, it seems unlikely that the Senate is going to act. It is a lost opportunity. If we did the right thing

and enacted the bipartisan bill H.R. 4015, over the next decade, that would cost $144 billion, clearly less than the $170 billion that has been spent over the past decade.

Last year alone, Medicaid grew to an unprecedented almost $450 billion. With the State Children's Health Insurance Program, it is more of the same. The last five trustees reports have indicated that the Social Security's Old Age Survivors and Disability Insurance Program would be depleted by the third decade of this century. Time and again, the Government has promised more money than it has or could ever hope to take in.

And we haven't begun to delve into the discretionary side, but discretionary spending is $492 billion, and if all nondefense discretionary spending were eliminated, it still would not affect our debt. There are certainly investments that must be made, but it is imperative that we invest wisely.

For example, we spend only $500 million annually on Alzheimer's research, but well over $200 billion on care. The Alzheimer's Association reports that if we could delay the onset of Alzheimer's by 5 years, we would save approximately $170 billion in care costs by the year 2030.

Cancer, diabetes, asthma, each finds us in a situation in which we must decide how to prioritize our spending to help the people in a most fiscally responsible manner. We simply cannot ignore the challenges or pretend that they will go away by themselves. It is a hard discussion, but it is one that we must be brave enough to start. That is what we were elected to do. That is what this subcommittee does, and that is what we are here to do today.

I certainly want to thank our witnesses for being here. I look forward to their testimony.

Mr. Chairman, I will yield back the time.

Mr. PITTS. The chairman thanks the gentleman.

We have two panels of witnesses today. On our first panel, we have Dr. Mark Miller, Executive Director, Medicare Payment Advisory Commission. Thank you for coming today. You will be given 5 minutes for an opening statement. Your written testimony will be made part of the record.

The Chair recognizes Dr. Miller for 5 minutes at this time.

STATEMENT OF MARK E. MILLER, EXECUTIVE DIRECTOR, MEDICARE PAYMENT ADVISORY COMMISSION

Mr. MILLER. Chairman Pitts, Ranking Member Pallone, distinguished committee members, thank you for asking the Medicare Payment Advisory Commission to testify today.

As you know, MedPAC was created by the Congress to advise it on a range of Medicare issues. The commission's work is guided by three principles, to assure that the beneficiary has access to high-quality care, to protect taxpayer dollars, and to pay providers and plans in a way to accomplish these two goals.

The Federal Government is carrying a large debt. As the testimony points out, even though Medicare spending has slowed recently as a result of lower utilization and legislative restraint on payment increases, we need to continue to look at this program because the baby boom is transitioning into Medicare and higher per-

beneficiary spending is projected for the future. In the short run, the commission has many recommendations that would move Medicare away from a fragmented system that is unnecessarily expensive towards one that is more focused on coordinated care at a price the taxpayer and the beneficiary can afford.

Examples of short-run recommendations that would both restrain spending and remove financial incentives to focus on certain types of patients include eliminating the automatic updates for profitable fee-for-service provider sectors, like long-term care hospitals and inpatient rehab facilities, and actually reducing payment rates for skilled nursing facilities and home health agencies. It includes site-neutral payments that reduce the incentive to purchase physician practices and bill at the higher outpatient rates for the same services, recommendations that include site-neutral payments for similar patients that are seen in different post-acute care settings, and as you know, from our past research and recommendations, they have resulted in laws that are transitioning to a financially neutral payment between managed care plans and fee-for-service.

Our more recent research and recommendations, if accepted, would produce more competitively set payments for employer-based managed care plans. All of these policies were recommended after careful considerations on the effects of access to services and to plans. And of course, the commission continues to monitor the effects of these policies and report back annually to the Congress.

Examples of short-run recommendations that would better align provider incentives to focus on patient care coordination and also to reduce unnecessary expenditures include an SGR reform plan that would end the annual cycle of short-term patches; a budget-neutral bonus payment for primary care providers and services that would allow physicians and other professionals greater flexibility to coordinate their care around the patient; and readmission penalties, some of which have been put into law, for hospitals, skilled nursing facilities, and home health agencies that would have the effect of discouraging expensive readmissions that disrupt the lives of patients and families.

Examples of short-run recommendations that would better align beneficiary incentives with the incentives outlined above include a major redesign of the traditional fee-for-service benefit where we recommended limiting total out-of-pocket expenses for beneficiaries, rationalizing the deductible, clarifying point-of-service cost-sharing liabilities, giving the secretary authority to alter cost sharing based on the value of a benefit, and imposing an additional charge on supplemental coverage policies to better reflect the cost they impose on the program and to send a clear price signal to the beneficiary. We have also recommended copayments for certain 60-day home health episodes and lowering copayments to as little as zero for low-income beneficiaries who use generic drugs.

In closing, we now have three payment models in Medicare, 30 million beneficiaries and traditional fee-for-service, 5 million are in accountable care organizations, and nearly 16 million are in managed care plans. Each has its own payment rules, risk adjustment and quality measurement criteria. Our most recent report begins a discussion of the future for the Medicare program that ideally would protect the patient by establishing common-risk adjustment

and quality standards across these models, fairness among plans and providers within a market by setting common financial and quality standards, reduce the burden on plans and providers by reducing unnecessary quality reporting and reducing regulations for those who accept risk, and protecting the taxpayer by assuring that the program pays for low-cost, high-quality care in any given market.

I appreciate your attention to my comments, and I look forward to your questions.

[The prepared statement of Mr. Miller follows:]

MEDPAC Medicare Payment Advisory Commission

TESTIMONY

Context for Medicare Payment Policy and Recommendations

December 9, 2014

Statement of

Mark E. Miller, Ph.D.

Executive Director

Medicare Payment Advisory Commission

Before the

Subcommittee on Health

Committee on Energy and Commerce

U.S. House of Representatives

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Chairman Pitts, Ranking Member Pallone, distinguished Committee members. I am Mark Miller, executive director of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning. MedPAC is a Congressional support agency that provides independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program.

Introduction

The Commission's goal is to achieve a Medicare program that ensures beneficiary access to high-quality care, pays health care providers fairly, rewards efficiency and quality, and spends tax dollars responsibly. When we examine Medicare's payment policies across payment models and across different sites of care, we observe several opportunities for policy development. In the testimony that follows, I will first summarize the context for Medicare payment policy in terms of health care spending growth and its impact on beneficiaries, tax payers, and the federal budget. Second, I will discuss the short-run policies the Commission has advanced to improve the Medicare program, both through changes to the level and structure of payments to providers and health plans, and through changes to the incentives faced by Medicare beneficiaries. Last, I will outline the Commission's longer run vision for the Medicare program, to align policies across Medicare's different payment models.

Context for Medicare payment policy

Medicare payment policies must be considered in the broader context of the nation's health care system. Health care accounts for a large and growing share of spending in the United States, more than doubling as a share of gross domestic product (GDP) in the period between 1972 and 2012, from about 7 percent to a little over 17 percent. Growth in spending has slowed somewhat in recent years. Although the causes of this slowdown are debated, a variety of factors could have contributed to the slowdown, including weak economic conditions, payment and delivery system reforms, and a slowdown in the introduction of new medical technologies.

The level of and growth in health care spending significantly affect federal and state budgets, since public spending on health care accounts for nearly half of all health care spending. If this spending continues to consume an increasing share of federal and state budgets, spending for

other public priorities—like education, investment in infrastructure, and scientific research—will be crowded out, and the federal government will have less flexibility to support states because of its own debt and deficit burdens. Medicare spending is projected to consume 15 percent of the federal budget this year. When combined with spending on Social Security, Medicaid, and the health care exchange subsidies, those programs are projected to consume 48 percent of the federal budget this year and their spending is projected to grow rapidly over the decade, averaging 6 percent annually.

Further, health care spending has a direct and meaningful impact on individuals and families. Evidence shows that increases in premiums and cost sharing have negated real income growth in the past decade. Likewise, premiums and cost sharing for Medicare beneficiaries are projected to grow faster than Social Security benefits. The lasting effects of the recent economic recession impacted the income, insurance status, and assets of many people, including Medicare beneficiaries and adults aging into Medicare eligibility.

Medicare spending per beneficiary over the next 10 years is projected to grow at a slower rate than in the past 10 years (4 percent annually compared with 6 percent annually), while the number of Medicare beneficiaries will grow notably faster as the baby-boom generation ages into the program (about 3 percent annually compared with about 2 percent annually in the past). The growth in per beneficiary spending has slowed generally due to a slowdown in the use of health care services as well as modest payment rate increases. That said, the Hospital Insurance trust fund is projected to be exhausted by 2030, and the program still faces substantial deficits over the long term.

There are indications that some share of health care dollars is not spent effectively or is simply misspent. First, the use of health care services varies significantly across different regions of the United States, even after accounting for differences in health status. Yet, studies show that populations in the higher spending and higher use regions do not consistently receive better quality care. Second, the United States has much higher per capita spending on health care compared with other developed countries. This is accounted for by higher payment rates for health care services (e.g., hospital stays, physician services, drugs). Yet, U.S. citizens have shorter life expectancy and poorer average health outcomes than people living in many other

developed countries. Finally, while minority Medicare beneficiaries represent a disproportionate share of high-spending beneficiaries, they tend to experience worse risk-adjusted health outcomes, suggesting that at least a portion of the high spending is not improving the health of minority beneficiaries.

Health care spending and its growth over time puts pressure on employer, government, and family budgets. For the Medicare program, this pressure is particularly acute given the outlook for the federal debt and the projected increases in Medicare enrollment. Medicare trends are undoubtedly influenced by broader trends in the economy and the health care delivery system. But because the Medicare program pays for just over one-fifth of all health care in the United States, it has an important influence on the shape of the health care delivery system as a whole. Therefore, the Commission remains focused on pursuing reforms that control spending and create incentives for beneficiaries to seek, and providers to deliver, high-value health care services.

Short-run policies to improve Medicare

Spending Medicare dollars wisely

The Commission has long emphasized the importance of using Medicare payments to encourage providers to deliver care efficiently.

Fee-for-service payment updates

MedPAC's research shows that provider costs are not immutable; they vary according to how much pressure is applied through payment rates. We find that providers under cost pressure have lower costs than those under less pressure, and Commission analysis demonstrates that providers can provide high-quality care even while maintaining lower costs relative to their peers. These findings have led the Commission to recommend modest and even negative updates to payment rates in the fee-for-service (FFS) payment systems.

The Commission's payment decisions are driven by sector-specific analyses, an orientation toward setting payments for the efficient provider (rather than the average provider), and by the principle that constraining payment updates creates incentives for providers to better control their costs, thus slowing the longer-term growth of Medicare spending. For 2015, the Commission

recommended zero updates for ambulatory surgical centers, outpatient dialysis, inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), and hospices.

Recognizing the need for good stewardship of public dollars, the Commission has also recommended reducing provider payments through rebasing when provider responses to incentives in the payment systems indicate that base rates have become excessive. The Commission has recommended rebasing the payment rates for home health and skilled nursing facility (SNF) services and has reiterated these recommendations for several years.

Revising payment systems to improve accuracy and remove negative incentives

The Commission has long believed that Medicare's payment rates can have a strong impact on provider behavior. Therefore, when setting payment rates, it is important to consider the incentives that they create and ensure that the program is not unintentionally incentivizing poor care. We find that Medicare's current payment systems contain a number of incentives that encourage undesirable provider behavior, including furnishing unnecessary services and avoiding certain patients. Where the Commission has identified payment systems that contain poor incentives, it has made recommendations to correct them.

In 2008 we recommended revising the SNF payment system to eliminate a payment bias favoring rehabilitation therapy services, and in 2011 we made a similar recommendation for the home health payment system. While these recommendations are budget neutral, they are intended to accompany the aforementioned payment rate reductions to ensure that both the level of payment and the incentives within the system are accurate and fair.

Site-neutral payments

MedPAC has also identified areas where the choice of setting to treat a patient is driven by payment differentials between settings. In principle, the Medicare program should pay the same amount for the same service, regardless of the setting in which it is provided, unless payment differentials are justifiable by differences in patient mix, provider mission (e.g., maintaining stand-by capacity for emergencies), or other justifiable factors.

The Commission began its work in this area looking at services that are provided frequently in both freestanding physician offices and hospital outpatient departments, but at different payment

rates. In our March 2012 *Report to the Congress*, we focused on nonemergency evaluation and management (E&M) office visits because they are similar across settings. For these services, it is reasonable to equalize payment rates in the fee schedule for physician and other health professional services and the hospital outpatient prospective payment system (OPPS) because hospitals do not need to maintain standby capacity for E&M visits that are not provided in an emergency department, and because the unit of payment for E&M services is similar across the fee schedule and the OPPS. The Commission recommended that total payment rates for an E&M visit provided in an outpatient department (OPD) should be reduced to the amount paid when the same visit is provided in a freestanding office, which is the lower cost setting.

In our March 2014 *Report to the Congress*, the Commission identified 66 additional ambulatory services frequently performed in freestanding offices that receive higher Medicare payments in OPDs. The Commission recommended these services have their OPD payment rates aligned with the PFS rates, either by setting the rates equal or by reducing the difference from the current level. In order to protect the beneficiary's safety and the hospital's mission, the criteria the Commission used in selecting these services is: (1) the services are frequently provided in physician offices (an indication that the services can be safely and appropriately performed in that setting), (2) the risk profile of patients in the two settings is similar, (3) these services do not frequently occur along with a visit to an emergency department, and (4) the services have comparable units of payment. (This recommendation was packaged with two other hospital-related recommendations in that report.)

In our June 2014 *Report to the Congress* and at our recent Commission meetings, we have identified a set of conditions frequently treated in both the IRF and SNF settings. The beneficiaries receiving these services had similar health profiles (using diagnosis, functional status, and outcomes data), and the services were safely provided a majority of the time in the lower-cost SNF setting. In general, the payments for services in the IRF (including the add-on payments made to IRFs) are as much as 42 percent higher than those in the SNF for treating patients with similar care needs. The Commission is currently discussing a policy to align payments between these two settings for certain conditions. Any policy to address these payment disparities would be accompanied by regulatory relief for the IRFs to allow them to continue to serve these patients, but to streamline the cost of care.

In our March 2014 *Report to the Congress*, the Commission discussed the provision of care for chronically critically ill patients and observed that patients with similar care needs often receive care in different settings, some in LTCHs and others in acute care hospitals (ACHs). LTCHs have positioned themselves as providers of hospital-level care for long-stay chronically critically ill (CCI) patients—patients who typically have long, resource-intensive hospital stays often followed by post-acute care (PAC)—but nationwide most CCI patients are cared for in acute care hospitals, and most LTCH patients are not CCI patients. Medicare pays LTCHs much higher payment rates than those made for similar patients in the ACH. Studies comparing LTCH care with that provided in ACHs have failed to find a clear advantage in outcomes for LTCH users. At the same time, studies have found that, on average, episode payments are higher for beneficiaries who use LTCHs.

To reduce incentives for LTCHs to admit lower acuity patients—who could be appropriately cared for in other settings at a lower cost to Medicare—the Commission recommended that standard LTCH payment rates be paid only for LTCH patients who meet the CCI profile (defined as those who spent eight or more days in an intensive care unit during an immediately preceding acute care hospital stay). LTCH cases that are not CCI would be paid acute care hospital rates. The Commission also recommended that funds that would have been used to make payments under the LTCH payment system instead should be allocated to the inpatient prospective payment system outlier pool to help alleviate the cost of caring for costly CCI cases in acute care hospitals.

Payments to Medicare Advantage plans

The Commission strongly supports a private managed care plan option in Medicare. Beneficiaries should have a choice to select traditional FFS or a managed care setting to fit their care delivery and out-of-pocket (OOP) preferences. Moreover, managed care plans have incentives to control costs and maintain quality, as well as greater flexibility to innovate in plan design, cost sharing, and developing a network for care delivery. However, the Commission has strongly maintained that the Medicare program's payments should not favor one choice over the other. For many years, Medicare's payments favored Medicare Advantage (MA) over traditional FFS—at one point paying 16 percent more for a comparable patient in MA than in FFS. In addition to unnecessary program spending, this system gave rise to inefficient plans. That is,

plans were offering beneficiaries extra benefits not because they were more efficient than FFS, but because the extra benefits were paid for by taxpayers and higher beneficiary premiums. Plans were routinely bidding above the cost of FFS, and the fastest growing type of plan (private fee-for-service plans) did not seek to form networks and manage care, but instead simply processed claims and paid regular FFS rates—all while extracting an extra payment to do so.

To address this inequity, the Commission recommended financially neutral payments between FFS and MA plans. There are two ways to reach financial neutrality: (1) legislatively setting MA payment benchmarks to be equivalent to FFS or (2) having both FFS payments and MA payments determined through a competitively-set benchmark in a given market. The Congress chose the former, transitioning the benchmarks down to an average of FFS spending over time and making higher payments to those plans that have higher quality. Concerns were expressed that these changes would result in plans exiting the program and managed care enrollment falling. On the contrary, plan enrollment growth has continued (approximately 9 percent annually) and plans have remained widely available. In addition, many plans have become less costly relative to FFS (the average bid was 98 percent of FFS for 2014), and there have been savings to the program from reduced overpayments.

Most recently, in our March 2014 *Report to the Congress*, the Commission examined employer-group plans (a type of MA plan with availability limited to retirees whose Medicare coverage is supplemented by their former employer or union) and found that they consistently bid higher than other types of plans because they lack the competitive pressures that non-employer plans face. In 2014, employer-group plans bid on average 95 percent of their benchmarks, versus 86 percent of benchmarks for non-employer plans. To put greater competitive pressure on these plans, the Commission recommended the Congress set payments for employer plans in a manner more consistent with non-employer plans, such as using a national ratio of plan bids to benchmark for non-employer plans and applying that ratio to employer group plans. Also, to create more seamless care delivery in the MA benefit, in the same report the Commission recommended that the hospice benefit be included as part of the benefits that MA plans provide.

Improving care for Medicare beneficiaries

Supporting primary care

The Commission has been concerned about the current state of support for primary care. Primary care is essential to a well-functioning health care delivery system, but the Medicare physician fee schedule undervalues it relative to procedural care and does not explicitly pay for non-face-to-face care coordination. These and other shortcomings of the fee schedule have contributed to compensation disparities between primary care practitioners and specialists to the point that average compensation for some specialties can be more than double the compensation of primary care practitioners, measured either in aggregate or per hour worked. Faced with such compensation disparities, practitioners may increasingly opt for specialty practice over primary care practice, leaving few primary care resources available to provide coordinated care.

In response to those concerns, the Commission has made several recommendations to address the inadequacies of the fee schedule for physician and other health professional services. To rebalance the fee schedule, the Commission has proposed identifying overpriced services and pricing them appropriately, replacing the sustainable growth rate (SGR) formula with payment updates that are higher for primary care than specialty care, and establishing a primary care bonus funded from non-primary care services.

The Commission believes that the additional bonus payments to primary care practitioners enacted on the Patient Protection and Affordable Care Act should continue. While the amount of the primary care bonus payment is not large and will not drastically change the supply of primary care practitioners, allowing it to expire without a replacement sends a poor signal to primary care practitioners. The Commission is considering the option of continuing the additional payments to primary care practitioners, but in the form of a per beneficiary payment—in contrast to the per service payment made through the current primary care bonus program. Replacing the primary care bonus payment with a per beneficiary payment could help Medicare move from a service-visit-oriented FFS payment approach and toward a beneficiary-centered payment approach that encourages care coordination, including the non-face-to-face activities that are a critical component of care coordination. Of course, a per beneficiary payment in itself will not guarantee an increase in care coordination activities because practitioners could use the additional funds for other purposes, but it may be a step in the right direction.

Expand readmission policies to post-acute care providers in FFS

Over the last several years, Medicare has begun moving toward paying providers differentially for the quality of care they provide and the success of their care coordination efforts. This began with a focus on inpatient hospitals and has expanded to other provider types. If value-based payment policies are not applied to all providers who are involved in treating Medicare patients, the quality or care coordination outcomes they desire may not be achieved.

Based on analysis of the sources of variation in Medicare spending across episodes of care, in 2008 the Commission recommended that hospitals with relatively high risk-adjusted readmission rates should be penalized. As of October 2012, a readmission policy now penalizes hospitals with high readmission rates for certain conditions. There are imperfections in the current readmissions penalty policy, and corrections are outlined in the Commission's June 2013 *Report to the Congress*. Despite these imperfections, the penalty has resulted in a decline in readmission rates over the last few years.

In 2011, the Commission began to examine expanding readmission policies to PAC settings to reduce unnecessary rehospitalizations and better align hospital and PAC incentives. If hospitals and PAC providers were at similar financial risk for rehospitalizations, they would have a stronger incentive to coordinate care between settings. Aligned policies would emphasize the need for providers to manage care during transitions between settings, coordinate care, and partner with providers to improve quality. By creating additional pressure in the FFS environment, the policies would also create incentives to move to bundled payments or accountable care organizations (ACOs).

To increase the equity of Medicare's policies toward providers who have a role in care coordination, the Commission has recommended payments be reduced to both SNFs and home health agencies (HHAs) with relatively high risk-adjusted readmission rates. The SNF readmissions reduction program was recommended in the Commission's March 2012 *Report to the Congress*. In March 2014, as part of the Protecting Access to Medicare Act of 2014, the Congress enacted a SNF value-based purchasing program beginning in fiscal year (FY) 2019, which includes readmissions and resource use measures. The home health readmissions

reduction program recommendation was published in the Commission's March 2014 *Report to the Congress.*

Bundled payments

Under bundled payments, Medicare would make a single payment for an array of services provided to a beneficiary over a defined period of time, or an episode of care. There are various configurations for a bundle, but the most common trigger is the hospital admission. The two most common episode definitions are the hospital stay (a bundled payment for hospital services and physician services during the hospital stay) or the hospital stay plus some period (e.g., 30, 60, or 90 days) of PAC (e.g., home health, SNF, and IRF services). While there is variation in hospital and physician services provided during the hospital stay, there are much higher degrees of variation in readmission rates and the utilization of PAC services. A bundled payment either for the hospital stay or for the stay plus a period of PAC, coupled with quality outcome metrics, could help replace inefficient and unneeded care with a more effective mix of services. Bundled payments could also give providers that are not ready, or are unable to participate in more global payment models like ACOs, a way to gain experience coordinating care spanning a spectrum of providers and settings, thus facilitating progress toward larger delivery system reforms.

The Commission recommended testing bundled payments in 2008 and since then has examined a variety of bundle designs. In our June 2013 *Report to the Congress*, the Commission described the pros and cons of key design choices for a bundled payment policy: which services to include in the bundle, the duration of the bundle, how entities would be paid, and incentives to encourage more efficient provision of care. Each decision involves tradeoffs between increasing the opportunities for care coordination and requiring providers to be more accountable for care beyond what they themselves furnish. In that report, we laid out possible approaches to paying providers, comparing an all-inclusive payment made to one entity with continuing to pay providers FFS.

Engaging Medicare beneficiaries

In order to achieve a delivery system focused on coordinated care, both the provider of care and the beneficiary must be engaged. Medicare's FFS benefit design has largely been structurally unchanged since the program's inception. Under FFS, beneficiaries can receive care irrespective

of its effectiveness or the quality of the outcomes it produces, and some beneficiaries are exposed to the risk of significant financial liability.

Redesigning the FFS benefit

The FFS Medicare benefit package has remained essentially unchanged for Part A and Part B since the creation of the program in 1965. Under this structure, beneficiaries in FFS are not protected against high OOP medical expenses. To protect against such high expenses, most beneficiaries have some degree of supplemental coverage. This coverage provides protections but is often a low-value product for the beneficiary. At the same time, research has shown that supplemental coverage can lead to beneficiaries using more discretionary services because they have no financial incentive to consider the value of a service before choosing it. To address these concerns, in 2012 the Commission made a set of recommendations for a redesigned benefit package that give beneficiaries better protection against high OOP spending, while creating financial incentives for them to make better decisions about their use of discretionary care.

Specifically, the Commission recommended that a redesigned traditional FFS benefit include:

- Catastrophic protection through an out-of-pocket maximum;
- Rationalized deductible (or deductibles) for Part A and Part B services;
- Improved OOP predictability by replacing coinsurance with copayments; and
- Secretarial authority to alter or eliminate cost sharing based on the evidence of the value of services, including cost sharing after the beneficiary has reached the OOP maximum.

Under the recommended benefit design, the aggregate beneficiary cost sharing liability would remain unchanged. Beneficiaries who incur very high Medicare spending would see their liability reduced, while others who incur very low Medicare spending will experience higher liability. Some beneficiaries will experience very little change in liability. The added benefit protections would make supplemental coverage less necessary, so the Commission also recommended that an additional charge be placed on supplemental policies to cover at least some of the added costs imposed on Medicare for having first dollar coverage and send a clearer price signal to the beneficiary. Depending on the level of additional charge and the resulting take-up of supplemental coverage, net program savings are realized.

Medicare beneficiaries with limited incomes could have difficulty paying the OOP costs under a reformed benefit design. To address this, the Commission would align the Medicare Savings Programs' income eligibility criteria with the Part D low-income drug subsidy (LIS) income eligibility criteria, effectively increasing the Part B premium subsidy to Qualifying Individuals (QIs) with incomes up to 150 percent of the federal poverty level. This would give them resources to pay their OOP costs at the point of service. The Commission believes this is a targeted and efficient approach to help Medicare beneficiaries with limited incomes with their OOP medical expenses.

Modifying beneficiary copayments

The Commission also finds that there is opportunity within Medicare to help beneficiaries to be more cost conscious when making health care decisions. For example, the Commission has discussed at length alternative value-based payment and cost sharing arrangements, in which coinsurance and/or cost sharing would vary as a function of the clinical value of the service. As an initial step in this direction, in 2011 the Commission recommended implementing a copayment for home health care that is not preceded by a hospital stay. In the same vein, in March 2012, noting that low-income beneficiaries were using more high-cost brand-name drugs with generic substitutes than higher-income beneficiaries, we recommended that Part D cost sharing be changed for LIS enrollees to give them more of a financial incentive (such as no copay for generics) to weigh the benefits of continuing to take brand-name drugs or switching to a generic equivalent.

Long-term vision for Medicare

In addition to the short-term improvements we have offered to improve the Medicare program for beneficiaries, providers, and taxpayers, the Commission is also developing a vision for the program over the long run, one that looks across Medicare's payment models.

Under the current Medicare program, there are now three payment models through which beneficiaries can receive Medicare services: 30 million beneficiaries in are traditional FFS, nearly 16 million beneficiaries are enrolled in MA, and about five million beneficiaries receive their care in ACOs. Traditional FFS pays for individual services according to the payment rates

established by the program. By contrast, under MA, Medicare pays private plans a capitated payment rate to provide the Part A and Part B benefit package to plan enrollees. In the ACO model, an organized group of providers is paid FFS rates, but is held accountable for the Part A and B spending and quality of care for a group of beneficiaries attributed to the ACO. A major issue is that Medicare's payment rules and quality improvement incentives are different and inconsistent across the three payment models. The Commission believes that to reduce the potential inequity and inefficiency caused by these differences, several different program design issues will need to be resolved: setting a common financial benchmark, streamlining quality measurement, establishing common risk adjustment, and offering regulatory relief for providers who accept risk.

Setting a common benchmark

In the June 2014 *Report to Congress*, the Commission explored setting a common spending benchmark—tied to local FFS spending—for MA plans and ACOs. Using an analysis of early results from the Pioneer ACOs, we illustrate that no single payment model is uniformly less costly than another model in all markets across the country. The Commission maintains that to encourage beneficiaries to choose the model that they perceive as having the highest value in terms of cost and quality, the choice should be financially neutral to the Medicare program. This principle is similar to the position the Commission has taken with respect to FFS and MA. In the current context of three payment models, consistent with that principle, the benchmarks should ultimately be equal across payment models within a local market. Equal benchmarks, however, do not mean equal payments, because payments will reflect the various risk profiles of beneficiaries in one payment model versus another, they may be adjusted for quality, and whether a given payment model is more efficient than another.

Streamlining quality measurement

The Commission is considering alternatives to Medicare's current system for measuring the quality of care provided to the program's beneficiaries. A fundamental problem with Medicare's current quality measurement programs, particularly in FFS Medicare, is that they rely primarily on clinical process measures for assessing the quality of care provided by hospitals, physicians, and other types of providers, measures that may exacerbate the incentives in FFS to overuse services and

fragment care. As well, some of the process measures are often not well correlated to better health outcomes, there are too many measures, and reporting places a heavy burden on providers.

We are exploring an alternative to the current measurement system: using population-based outcome measures (e.g., potentially avoidable admissions) to evaluate and compare quality within a local market across Medicare's three payment models. We consider a small set of measures that would be less burdensome to providers and directly related to health outcomes. A population-based approach could be useful for public reporting of quality for all three models and also for making payment adjustments within the MA and ACO models.

Establishing common risk adjustment

Currently, Medicare uses the CMS–hierarchical condition category (CMS–HCC) model to risk adjust MA payments. FFS and ACOs have different approaches to setting payments to capture the relative costliness of different patients or beneficiaries. However, if aligning policies across the three models is a goal, it will be important to consider how risk-adjustment methods affect equity among MA plans, FFS Medicare, and ACOs. For example, if the MA sector can attract low-cost beneficiaries and avoid high-cost beneficiaries, the risk-adjusted payments in the MA sector would exceed what their enrollees would cost in ACOs or FFS Medicare.

Offering regulatory relief for providers taking risk

Many current Medicare regulations are designed to prevent overuse of services and the resulting increase in Medicare spending. They are a reaction to the incentives built into the FFS system to increase volume of services. Over the long run, as the program moves to more risk-based and quality-driven payment models, providers will have much weaker incentives to increase volume and stronger incentives to improve quality. In this environment, many current FFS regulations (e.g., the three-day inpatient stay requirement for SNFs) could be waived for those willing to accept true risk.

Mr. PITTS. Chair thanks the gentleman.

And I will begin the questioning. Recognize myself 5 minutes for that purpose.

Dr. Miller, there have been five bipartisan plans to save Medicare introduced in this President's term. First, Rivlin-Dominici; second, Rivlin-Ryan; third, the Fiscal Commission; fourth, Simpson-Bowles' own plan; and five, plan by former Senator Joe Lieberman and Senator Tom Coburn.

The Lieberman-Coburn plan has been proposed in legislative text and was scored by the actuary of the Medicare program. The actuary said, page 6 of OACT analysis, that if this legislation was adopted, it would prevent Medicare's insolvency for decades and reduce senior's premiums so that they would be lower than under current law.

Please tell us what you think are the most actionable pieces of this proposal for this committee to consider adopting next Congress?

Mr. MILLER. I am not going to be able to comment on this specific proposal. I am not that deep on it. But when you look across those proposals including the one that you named, there are elements of those proposals that also came out of recommendations or at least are consistent with recommendations that the commission has made.

If I remember correctly, and I really am not sure I do, there is a lot of these things and a lot of details, they were focused on some benefit redesign, including catastrophic caps, and I also think that they had something on altering supplemental coverage. The commission has this additional charge. I think they took a different approach where they said supplemental coverage wouldn't be able to cover the first few dollars of coverage in order to assure that the beneficiary had some price signal on a service that they consumed. And those are consistent directions even if they are different mechanisms for achieving the same thing.

I also think that there was some elements in some of those plans to reduce the home health payments, and that is certainly something that came out of our work. Off the top of my head, that is a couple of things.

Mr. PITTS. I want to ask about Medicare benefit redesign proposals. Some of my colleagues on the other side of the aisle have examined MedPAC's recommendation on creating a combined deductible for parts A and B, a catastrophic limit on out-of-pocket spending, and Medigap reforms that would limit first-dollar coverage. The minority is on record in their hearing memo claiming that many patients might see higher cost under these proposal plans.

I think the minority might be overlooking the savings that accrue to a beneficiary over time as a separate 2011 analysis concluded four out of five beneficiaries could save money if such a proposal were adopted.

Could you please discuss the effect that such reforms would have on beneficiaries especially over multiple years and can you comment about whether or not a beneficiary who would otherwise face higher costs could enroll in a Medicare Advantage plan?

Mr. MILLER. OK. I think you have a few questions in there.

The first thing that I would say is benefit redesign, when you think about a catastrophic cap and adjusting the deductible, there is several ways that it can affect the beneficiary. But one thing to keep in mind is, is that what you are doing, and it is almost inescapable is, is you are shifting the liability across the distribution of beneficiaries.

Generally, what you are doing with these things when you go for a catastrophic cap is there is a small set of beneficiaries with very high liability that you help and other beneficiaries who have less healthcare costs have more healthy experiences probably pay more for a deductible. So there is some redistribution.

But the other objective that you are up to here is by setting a catastrophic cap, and, for example, in our recommendation, making copayments as opposed to coinsurance, which is less predictable, the beneficiary has clear a line of sight on what their out-of-pocket liability would be. This would mean that the beneficiary's need to buy a supplemental policy should be less. That is the idea.

And to the extent that beneficiaries say, "I no longer need a supplemental policy," then that is an out-of-pocket expense that they no longer incur and that is a place where they could potentially achieve savings to the beneficiary. So there is some moving around of liability and there is some potential savings, depending on whether the beneficiary continues to carry a supplemental premium.

You asked another question about the impact on the beneficiary. In the short term, it does mean that certain beneficiaries would incur greater liability because they might have a higher deductible, for example. But over time, those beneficiaries run a greater risk, because of their age and just the natural progression of disease, run a greater risk of going into the hospital or hitting the catastrophic cap. And we have done some analysis which we can send to this committee where we show that the percentage of people affected, helped by this, for example, grows from 9 percent in the first year to 30 percent when you go out—or 19 percent when you go out 5 years, 30 percent when you go out 10 years.

So over time, more beneficiaries are likely to benefit from a catastrophic cap or a reconfigured deductible depending on their health experience, which they run greater risk over time.

Mr. PITTS. Chair thanks the gentleman—go ahead.

Are you finished?

Mr. MILLER. I am done. No, go ahead. Sorry.

Mr. PITTS. I thank the gentleman.

And recognize the ranking member, Mr. Pallone, 5 minutes for questions.

Mr. PALLONE. Thank you.

Dr. Miller, in MedPAC's June 2012 report and in your testimony for today's hearing, you note that the proposal for Medicare benefit redesign reduces risk and increases predictability for beneficiaries by adding an out-of-pocket catastrophic cap and a lower combined deductible together with predictable copayments for services. The proposal also recommends a fee on supplemental insurance plans such as Medigap and retiree plans. And as you can imagine, I have heard some concern about this idea.

Your rationale appears to be because first-dollar coverage can encourage inappropriate use of care that Medicare should recover some of the increased program costs that result from this excess use of services. Now, while I agree that an out-of-pocket catastrophic cap would be an improvement, I have concerns about the impact of your proposal on Medigap or supplemental insurance policies, and particularly concerned that these will be viewed as separate and unrelated proposals.

Can you clarify then, are these different policy options, or are the two components of this proposal actually linked to one another?

Mr. MILLER. The commission was really clear on this, I believe, that this was a package of proposals; that you do the benefit redesign, as you outlined there, along with the additional charge on the supplemental coverage.

Mr. PALLONE. OK. Now, I understand your proposal retains current protections for low-income seniors related to cost-sharing and premiums. And one of my concerns is that I believe the current low-income protections are inadequate. I am concerned that taxing or otherwise discouraging these first-dollar coverage supplemental plans would negatively impact the near poor who do not currently qualify for assistance under Medicaid. So could you just comment on that?

Mr. MILLER. Yes. The commission did talk about this quite a bit. There is collective concern that if that is your concern, the Medigap product is not a particularly effective way to get at that. Often, the premiums and the benefits that you get from it just result in dollar churning, if you will, sort of dollar trading, and some of the premiums can be quite high.

What the commission said is if that was a concern, and we made a specific recommendation on this point, would be to alter the Medicare savings programs and go more directly at providing subsidy to the poor and near poor. And specifically what we said is change the income qualification to be consistent with the income qualification for part D (LIS) and raise it to 150 percent of poverty, and then have a premium subsidy for the QI population, which starts to get into some complexity, but for this answer, you have a premium subsidy for the QI beneficiaries.

Then what they do, they are relieved of, let's just call it $1,300 in part B premium, which they can then use to pay for their out-of-pocket copayments and deductibles and that type of thing. And within the package, we would see that as being financed out of the savings that come out of the Medigap portion of the proposal.

Mr. PALLONE. OK. I know we use the term "near poor," but I wish we had a better term than "near poor." It seems so strange.

Let me ask another question. In MedPAC's proposal for redesigning Medicare's benefit package, the commission is clear that two overriding objectives are to give beneficiaries better, more predictable protection against out-of-pocket spending, and to create incentives for them to make better decisions regarding discretionary care.

But many of us would agree there is a need to simplify the structure of Medicare benefits in ways that make it more understandable and user friendly for beneficiaries and provide them with bet-

ter protections by providing out-of-pocket spending caps, like private insurance plans.

So my question is: Unfortunately, the notion of creating incentives for beneficiaries to make better decisions is often looked at only through the narrow lens of increased cost sharing. Can you talk about ways other than cost sharing that benefits can be structured to encourage use of appropriate high-value services and discourage the use of unnecessary services? In 40 seconds or less.

Mr. MILLER. If I follow it, I think there is two comments: One is, the portion of the recommendation that spoke to the secretary's authority to adjust cost sharing on the basis of value, I would just point out, just in case you missed it, that toggle would go both ways. So if a benefit is high value, you could actually lower the cost sharing or zero out cost sharing for your diabetes visit or whatever the case may be.

Mr. PALLONE. Right.

Mr. MILLER. So the toggle doesn't entirely increase cost sharing and could be lower cost sharing, just in case that got by you.

The other thing, I mean, then I think you move to different kinds of ideas. For example, a while back, we made recommendations for prior authorization for very expensive imaging services. I mean, I think then either you have to move in that direction in fee-for-service or move in the direction of a beneficiary being in an accountable care organization or a managed care plan where those kinds of tools are more readily available to manage the beneficiaries experience.

Mr. PALLONE. All right. Thank you.

Mr. PITTS. Chair now recognizes Vice Chair of the Subcommittee Dr. Burgess, 5 minutes for questions.

Mr. BURGESS. Thank you, Mr. Chairman. Before I begin, let me ask unanimous consent to submit written testimony for today's hearing by the Coalition to Preserve Rehabilitation for the record.

Mr. PITTS. Without objection, so ordered.

[The information follows:]

WRITTEN TESTIMONY OF THE

COALITION TO PRESERVE REHABILITATION

BEFORE THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON ENERGY AND COMMERCE
UNITED STATED HOUSE OF REPRESENTATIVES

IN CONNECTION WITH ITS HEARING ON

"SETTING FISCAL PRIORITIES"

DECEMBER 9, 2014

COALITION TO PRESERVE REHABILITATION
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MAGGIE GOLDBERG	CHRISTOPHER AND DANA REEVE FOUNDATION

Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee:

Thank you for the opportunity to submit testimony for the record on behalf of the Coalition to Preserve Rehabilitation ("CPR") in connection with your hearing entitled, "Setting Fiscal Priorities." The CPR Coalition will confine its testimony to Medicare site-neutral payment proposals involving post-acute care (PAC) services. CPR is a consumer-led, national coalition of patient, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities, and chronic conditions may regain and/or maintain their maximum level of health and independent function. Members of the CPR Steering Committee include the Center for Medicare Advocacy, the National Multiple Sclerosis Society, the Brain Injury Association of America, United Spinal Association, and the Christopher and Dana Reeve Foundation.

Rehabilitation and the Medicare Beneficiary

The provision of post-acute care and rehabilitation services is a critical mission of the Medicare program and many post-acute care settings assist beneficiaries in regaining skills, functions and living as independently as possible. Long term acute care hospitals (LTACHs), inpatient rehabilitation hospitals and units (IRFs), skilled nursing facilities (SNFs), and home health care agencies all play an important role in the recovery and rehabilitation of Medicare beneficiaries. The services provided in each of these settings cater to beneficiaries with a particular set of medical and functional needs, which are rarely defined by primary diagnosis alone.

CPR has significant concerns with proposals that treat IRFs and SNFs as though they serve the same population, offer the same level of rehabilitation services, and produce the same outcomes. They do not. MedPAC is currently debating whether to adopt a site-neutral payment proposal between IRFs and SNFs for Medicare patients with certain orthopedic impairments and 17 other undisclosed conditions. We believe that such site-neutral payments raise alarming concerns for Medicare

beneficiaries that could have long-term implications on their ability to access the appropriate level of rehabilitative care in the right setting and at the right time post-injury or illness.

Improving patient outcomes should be the hallmark of any reform to the Medicare program, especially payment or delivery reforms including any site-neutral or bundled payment system that affects some of the most vulnerable Medicare beneficiaries. It is one thing to maintain or improve quality outcomes while making the system more cost-efficient. It is quite another to ultimately save money in post-acute care by redesigning payment and delivery systems in a manner that fails to protect against stinting on patient care and diverting beneficiaries into the least costly setting. Because of these concerns, we strongly urge Congress not to adopt site-neutral payments between IRFs and SNFs prematurely.

Payment Reform Requires Serious Deliberation

All Medicare post-acute care reforms based on site-neutrality that Congress considers should, first and foremost, preserve access to quality rehabilitation services provided at the appropriate level of intensity, in the right setting, and at the right time to meet the individual needs of Medicare beneficiaries. This is, of course, much easier said than done. Meeting this challenge, while making Medicare post-acute care payment policy more efficient, requires serious deliberation. Uniform and current data need to be collected across a variety of PAC settings with a major emphasis on appropriate quality standards and risk adjustment to protect patients against underservice. The IMPACT Act, signed by the President into law this October, now serves that data collection purpose. We request Congress give the Centers for Medicare and Medicaid Services (CMS) sufficient time to collect data under the IMPACT Act's provisions before adopting a short-term, blunt approach to site-neutral payment.

Site-Neutral Payment Creates Financial Disincentives for IRFs to Accept Certain Patients

CPR opposes the site-neutral IRF-SNF proposal to equalize payments for certain unspecified conditions as it is little more than an outright financial disincentive for inpatient rehabilitation hospitals and units to accept certain Medicare patients. These patients include those unfortunate enough to have primary diagnoses including hip fracture, joint replacement, and 17 other conditions that MedPAC has not disclosed to date. This proposal would use Medicare payment policy to essentially bar the door to the rehabilitation hospital based solely on patients' diagnoses, not based on their individual medical and functional needs.

Instituting site-neutral payments between IRFs and SNFs in the manner MedPAC is contemplating will likely create a strong financial disincentive for IRFs to admit certain patients. This financial disincentive will be tied entirely to the primary diagnosis assigned to the patient, without any consideration for the individual's care needs or other comorbid conditions. Such a financial disincentive may well drive IRFs to avoid admitting such patients, depriving these beneficiaries of access to the IRF level of coordinated, intensive rehabilitative care. Conversely, site-neutral payments would benefit SNFs financially.

Site-Neutral Payment Based on Diagnosis May Violate CMS Regulations and Federal Case Law

A site-neutral payment system based on diagnosis would essentially ignore the established, comprehensive, regulatory framework that was developed to determine whether a patient is eligible for care in an IRF. This set of Medicare regulations and manual instructions places a premium on an individual assessment of each patient's rehabilitative and medical needs, physician judgment, and extensive documentation to demonstrate coverage and medical necessity.

This dynamic could easily be described as the use of an impermissible "rule of thumb" for determining coverage. Medicare coverage for inpatient hospital rehabilitation must be determined on

an individual basis.[1] The Medicare program has been very clear that "rules of thumb" are not permissible bases upon which to make a determination of medical necessity and coverage of care.[2] In fact, the Secretary of Health and Human Services explicitly agreed that "denials of admissions, services, and/or Medicare coverage based upon numerical utilization screens, diagnostic screens, *diagnosis*, specific treatment norms, the 'three hour rule,' or other 'rules of thumb' are not appropriate."[3]

Instead, medical review determinations are to be "based on reviews of individual medical records by qualified clinicians, not on the basis of diagnosis alone."[4] The denial of care for patients with the effected condition codes will not be carried out by Medicare contractors, but if the Medicare program makes it financially infeasible for IRFs to admit such patients, the impact will be the same. Patients may be denied care to which they are otherwise entitled based on regulatory coverage criteria that focus on a single factor: diagnosis.

SNFs and IRFs are Not Equivalent

We are extremely concerned that MedPAC seems to view rehabilitation provided in SNF and IRF settings as equivalent. Proponents of site-neutral payments assert they are appropriate because these two settings of care allegedly treat similar patients and achieve equal outcomes regardless of setting. To the contrary, the expertise, staffing, equipment and medical care in SNFs and IRFs are drastically different and we cannot understand how MedPAC does not recognize this fact. The level of medical and therapeutic care available in IRFs is far more intense, complex, and multi-disciplinary.

Furthermore, IRFs are required to provide patients with close medical supervision by a physician with specialized training in rehabilitation, a multidisciplinary, coordinated approach to

[1] Medicare Benefit Policy Manual, CMS. Pub. 100-2, ch. 1, § 110.
[2] *Hooper v. Sullivan*, 1989 WL 107497 (D. Conn.).
[3] *Id.* (emphasis added).
[4] 73 Fed. Reg. 46,370, 46,388 (August 8, 2008).

rehabilitation that includes 24-hour rehabilitation nursing, an intensive therapy program—widely regarded as three or more hours of skilled therapy per day—and licensure and accreditation for hospital level rehabilitation care. SNFs, on the other hand, do not require any of these staffing levels or care coordination.[5] To treat both of these settings as essentially the same will endanger some of the most physically and medically vulnerable Medicare beneficiaries.

Cost-Effectiveness of Rehabilitation in Various Settings

Proponents of site-neutral payments argue that it costs more for Medicare to treat similar patients in IRFs than in SNFs. In fact, because SNFs are reimbursed on a per diem payment system and lengths of stay appear to be significantly greater than in IRFs for these patients, there is a real question as to the cost-effectiveness of treating these patients in SNFs. In addition, MedPAC is not measuring the cost-effectiveness of timely, coordinated and intensive inpatient hospital rehabilitation over the long term, including the impact that a lack of these services may have on Medicaid expenditures on long-term nursing home stays.

From a health care sector perspective, MedPAC's June 2014 Databook illustrates that from 2001 to 2011, home health care and SNF expenditures have contributed more to Medicare post-acute care spending than IRF spending. In 2012, Medicare post-acute care expenditures totaled only $6.7 billion for IRFs, as compared to $18.3 billion for home health agencies and $28.4 billion for SNFs.[6] MedPAC's site-neutral payment proposal appears to be another attempt to drive patients to less intensive, less appropriate rehabilitation settings, rather than the setting that best meets their rehabilitation needs.

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[5] See American Medical Rehabilitation Providers Association, https://www.amrpa.org/newsroom/AMRPA-infographic.png.

[6] See Medicare Payment Advisory Commission, *A Data Book: Health Care Spending and the Medicare Program*, June 2014, http://www.medpac.gov/documents/publications/jun14databookentirereport.pdf?sfvrsn=1, page 112.

Outcomes Between IRFs and SNFs Differ Dramatically

According to a July 2014 report by Dobson | DaVanzo, Medicare data over a two-year period demonstrated that when patients are matched on demographic and clinical characteristics, rehabilitation provided in inpatient rehabilitation hospitals leads to lower mortality, fewer readmissions and emergency room visits, and more days at home—not in a PAC institutional setting—than rehabilitation provided in SNFs for the same condition. In terms of mortality, the starkest difference between the two settings involved patients with stroke, traumatic brain injury, and amputations.

This study demonstrates that care provided in IRFs and SNFs is not the same and that outcomes are, in fact, significantly different as a result of the specific type of services provided in these two different settings. The study also demonstrates the enduring effects of timely, intensive and coordinated rehabilitation provided in an IRF and how these services improve not only the length of beneficiaries' lives, but the quality of their lives as well.[7]

Recent Reports Highlight Quality Concerns in SNFs and Nursing Homes

The coalition's concerns are heightened by the steady flow of reports highlighting lapses and deficiencies in the quality of SNF and nursing home services. An HHS Office of Inspector General (OIG) report from February 2014 found that approximately 22 percent of Medicare beneficiaries faced adverse events, and another 11 percent faced temporary harm events while receiving treatment in SNFs within, on average, 15.5 days following their admission to the SNF. The report stated that 59 percent of these adverse and temporary harm events were either clearly or likely preventable. Inadequate nurse staffing was the cause of many of these adverse and temporary harm events. Over half of the

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[7]See Dobson Davanzo, *Assessment of Patient Outcomes of Rehabilitative Care Provided in Inpatient Rehabilitation Facilities (IRFs) and After Discharge*, July 2014, https://www.amrpa.org/newsroom/Dobson%20DaVanzo%20Final%20Report%20-%20Patient%20Outcomes%20of%20IRF%20v%20%20SNF%20-%207%2010%2014%20redated.pdf. See also study highlights for amputation, traumatic brain injury, stroke, and other patients at American Medical Rehabilitation Providers Association at http://www.amrpa.org/Public/Study_Rehab_Hospitals_Yield_Better_Outcomes.aspx.

beneficiaries that had experienced harm were re-admitted to the hospital, costing Medicare an estimated $208 million in August 2011, and equating to $2.8 billion in FY 2011.[8]

Recent reports raise serious questions about quality and quality reporting in nursing homes. A six-part report by a local Michigan television station in November 2014 highlighted how mistakes in nursing homes caused or contributed to 112 deaths in the state in the past three years.[9] A recent report by the Sacramento Bee in November 2014 found that nine out of ten of California's largest nursing home chains had staffing measures—such as turnover rates—that were below state averages in 2012, when most recent data was available.[10]

The integrity of the very method by which nursing homes report quality data is questioned by many. In October 2014, citing its earlier August 2014 publication, the *New York Times* reported that the rating system for nursing homes "relied so heavily on unverified and incomplete information that even homes with a documented history of quality problems were earning top ratings."[11] Key data does not factor into the rating system, including the percentage of residents given antipsychotic drugs, the percentage of residents discharged to the home and community, and the percentage of residents readmitted to a hospital.[12] An April 2014 report by the Center for Medicare Advocacy found that the

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[8] See HHS Office of the Inspector General, *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries,* February 2014, http://oig.hhs.gov/oei/reports/oei-06-11-00370.pdf.

[9] See Woodtv.com, *Deadly Mistakes: Inside Michigan Nursing Homes*, available at http://woodtv.com/2014/11/10/deadly-mistakes-inside-michigan-nursing-homes/; *Allergies Ignored; Woman Dies after Banana Dessert*," at http://woodtv.com/2014/11/11/allergies-ignored-woman-dies-after-banana-dessert/; *Family Left in Dark after Nursing Home Death*, available at http://woodtv.com/2014/11/11/family-left-in-dark-after-nursing-home-death/; *Died in Vain; No Dignity for Alfie*," available at http://woodtv.com/2014/11/11/died-in-vain-no-dignity-for-alfie/; *Nursing Home Solutions: Fines? Staffing? Culture?*, available at http://woodtv.com/2014/11/11/nursing-home-solutions-fines-staffing-culture/; and *Nursing Home Deaths: What Price for a Life*?, available at http://woodtv.com/2014/11/11/nursing-home-deaths-what-price-for-a-life/.

[10] See The Sacramento Bee, *Nursing Homes Cloak Ownership for Good Reason*, November 2014, http://www.sacbee.com/opinion/editorials/article3792498.html, and *Unmasked: How California's Largest Nursing Home Chains Perform,* November 2014, http://media.sacbee.com/static/sinclair/Nursing1c/index.html.

[11] See The New York Times, *Medicare Revises Nursing Home Rating System*, October 2014, http://www.nytimes.com/2014/10/07/business/medicare-alters-its-nursing-home-rating-system.html?_r=0. See also The New York Times, *Medicare Star Ratings Allow Nursing Homes to Game the System,* August 2014, http://www.nytimes.com/2014/08/25/business/medicare-star-ratings-allow-nursing-homes-to-game-the-system.html.

[12] See The New York Times, *Medicare Revises Nursing Home Rating System*.

"star rating" system "likely reflect[s] facilities' self-reported and unaudited [assertions] that staffing and quality measures have improved,"[13] rather than definitely showing improved quality of care. Finally, in November 2014, the Center for Public Integrity stated that nursing facilities report more nursing staff on Nursing Home Compare than indicated in the facilities' Medicare cost reports.[14]

CPR is not making the case that all SNFs and nursing homes can be painted with the same brush, but these reports heighten our concerns with policies that potentially place vulnerable patients at risk by driving them into settings of post-acute care that may not be able to truly meet their individual needs.

Relaxing IRF Regulations in Conjunction with Site-neutral Payment will Dilute IRF Setting

In MedPAC's November public meeting, echoing Chapter 6 of its June 2014 Report, MedPAC agreed to recommend that IRF regulations be relaxed when implementing site-neutral payments. In the words of the June 2014 Report, this would be accomplished "to level the playing field between IRFs and SNFs."[15] CPR understands how this proposal may appear reasonable and equitable to providers involved, particularly IRFs, but we believe that, ultimately, this will dilute the IRF setting. It will also blur the lines between IRFs and SNFs, and thus, undercut the crucial role of IRFs for the treatment of individuals with some of the most challenging injuries, illnesses, disabilities and chronic conditions. We do not believe that the site-neutral proposals being discussed today will be confined to

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[13] See Center for Medicare Advocacy, The *Myth of Improved Quality in Nursing Home Care: Setting the Record Straight Again*, April 2014, http://www.medicareadvocacy.org/the-myth-of-improved-quality-in-nursing-home-care-setting-the-record-straight-again/.

[14] See The Center for Public Integrity, *Analysis Shows Widespread Discrepancies in Staffing Levels Reported by Nursing Homes*, November 2014, http://www.publicintegrity.org/2014/11/12/16246/analysis-shows-widespread-discrepancies-staffing-levels-reported-nursing-homes.

[15] See Medicare Payment Advisory Commission, *Chapter 6: Site-neutral Payments for Select Conditions Treated in Inpatient Rehabilitation Facilities and Skilled Nursing Facilities*, June 2014, http://www.medpac.gov/documents/reports/chapter-6-site-neutral-payments-for-select-conditions-treated-in-inpatient-rehabilitation-facilities-and-skilled-nursing-facilities-(june-2014-report).pdf?sfvrsn=2, pages 95 and 98.

those same conditions tomorrow. We fear that site-neutral payments will cause Medicare patients to lose access to intensive, coordinated hospital rehabilitation in years to come.

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The disability and rehabilitation community understands the magnitude of the problem that our nation faces in attempting to contain federal health care spending. However, achieving federal savings through what we believe to be short-sighted post-acute care reforms that do not adequately take into account long-term cost-effectiveness, maximal patient outcomes, and the future capacity of our rehabilitation system, is not the path to success.

Thank you for the opportunity to submit written testimony on this important issue.

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Endorsing Organizations

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Center for Medicare Advocacy
Christopher and Dana Reeve Foundation
Disability Rights Education and Defense Fund
National Association for the Advancement of Orthotics & Prosthetics
National Association of State Head Injury Administrators
National Multiple Sclerosis Society
Paralyzed Veterans of America
United Spinal Association

Mr. BURGESS. And again, Dr. Miller, thank you so much for being here and sharing your expertise with us. Let's talk for a minute about the trend of hospital acquisitions, hospital acquiring practices and the consolidation that really seems to have increased dramatically in the past couple of years.

In one of your earlier reports, you discuss the trends of hospital acquisitions costing Medicare more and driving up costs. The report discusses in great detail how this is happening in cardiology. This past May, I asked if the commission had seen this trend in other specialties, specifically oncology. Do you have any additional information that you can share with the subcommittee to add on this or to build on this?

Mr. MILLER. I probably can't do it very well off the top of my head here, but there is some additional information that we could give to you. We took a look at other requests at kind of the trends in radiation therapy and in chemotherapy, and you do see some trends there that are consistent with the things that we have presented previously.

And I would also remind you, and I know this is a detail that would not be readily apparent, in the recommendation that we made on our site-neutral payments, which encompassed about 66-some-odd conditions where we said you should set payment rates equal to or near what is paid in the physician's office, a few of those conditions actually overlap the oncology, you know, drug administration codes and that type of thing.

Keep in mind, in oncology, you have sort of two things happening. The drugs are actually paid comparably. It is really the administration and what goes on around the drugs that are not paid comparably, and our recommendations would affect that. But in any case, we have some of that contemplated in our recommendation, and there is some additional information that I could forward to you or your staff on a particular issue.

Mr. BURGESS. Great. That would be good. Do you recall overall if that trend is a trend upward in the cost curve, or is it a flattening of the cost curve?

Mr. MILLER. Yes, and I am going to do this off the top of my head—which is really a dangerous thing—what I recall from the work that we did is if you look at radiation therapy, it is a lot more oblique. But if you look at chemotherapy, there does seem to be a shift from the office setting to the hospital setting. That is my takeaway there.

Mr. BURGESS. Well, and, again, it would be very helpful if you could provide that information to us.

Mr. MILLER. Uh-huh.

Mr. BURGESS. If there were more parity in reimbursement rates between the outpatients and acute care settings, for example, raising reimbursements in certain settings, lowering it in other settings, how do you think that would affect consolidation?

Mr. MILLER. If there was greater parity, is that what you were saying?

Mr. BURGESS. Parity. Yes.

Mr. MILLER. Well, we think it would have some dampening of the trend. Am I getting the question?

Mr. BURGESS. Yes. And I think, overall how would that affect the cost in the Medicare programs? Do you think that would be a reduction in cost?

Mr. MILLER. Absolutely. I mean, we have made two recommendations, for example, to equalize the payment rates between visits in the physician office setting in the hospital outpatient setting, and then, as I said, develop this criteria and identify these 66 other services that we would set the rates. And for example, on those two, at about 1 billion-plus a year, that would reduce spending of which, you know, just in round numbers, 20 percent of that would be a reduction in the beneficiary's cost sharing, which is something I would just bring us all back to.

I mean, particularly when these services just shift and are billed through the outpatient setting, it is important to keep in mind here, we are not talking about people actually leaving the office and going to the outpatient setting in most instances. They are still going to their physician's office. They are still getting the same service. The payment from the program has gone up and the beneficiary's cost sharing has gone up, and to the tune of about 1 billion, 1.5 billion per year, if these two recommendations were put into place.

Mr. BURGESS. Has the committee looked at what happens to patient access costs with hospital acquisitions of specialties?

Mr. MILLER. You could be asking me one of two questions. We have——

Mr. BURGESS. Well, when a hospital takes over what traditionally has been like a cardiology practice, what are the benefits of the cost of the patient when you move this site of service?

Mr. MILLER. What are the benefits?

Mr. BURGESS. Yes, and what are the costs, well, for the beneficiary? I meant, that is after all where the focus should be.

Mr. MILLER. Yes, our concern is that the benefit to the beneficiary is pretty static, that they are getting the same service. Like I said, in many instances they will walk into the same office, see the same physician, and just pay a higher out-of-pocket.

If there were hospitals sitting here, they would argue that they do this in order to create systems of care and have greater degrees of coordination. We have not seen access problems, and we have not seen a lot of evidence to back up the claim that this results in better coordination or better outcomes for the beneficiary.

Mr. BURGESS. Mr. Chairman, I see my time is expired. I have an additional question on graduate medical education that I would submit for the record. Thank you.

Mr. MILLER. Thank you.

Mr. PITTS. Chair thanks the gentleman.

And now recognizes the gentleman from Texas, Mr. Green, 5 minutes for questions.

Mr. GREEN. Thank you, Mr. Chairman.

Dr. Miller, recent estimates from the Medicare Trustees highlight continued success in reducing spending under the Medicare program. Medicare spending per beneficiaries projected increase by just 0.3 percent in 2014, well below the growth in GDP. Is it correct that Medicare costs have grown at a consistently slower rate

than the private sector and total healthcare spending growth has reached the lowest rates since 1960?

Mr. MILLER. I can't stipulate each of those facts. What I would say is this: There has been a general slowdown in utilization in both the private and in the Medicare sector, so both of those have actually seen slowdowns in spending. I would guess that you are right that Medicare, depending on whether we are talking about growth rates, may be slower than the private sector because commercial insurers still have higher price growth than Medicare had, so just distinguishing between use and price. But there has been a broad-based slowdown in spending on both the private and the Medicare side in terms of utilization in the last few years.

Mr. GREEN. OK. Thank you.

The Centers for Medicare and Medicaid Services recently reported that from 2012 to 2013 hospital readmissions in Medicare were decreased by nearly 10 percent with the help of Medicare's Hospital Readmission Reduction Program, translating to 150,000 fewer hospital readmissions. Congress took further action by enacting readmissions reduction program for nursing homes under the Protecting Access to Medicare Act of 2014, which established a skilled nursing facility value-based purchasing program based on readmission reductions in the fiscal year 2019.

Mr. Miller, what changes to current Medicare reduction programs might you recommend the further increased care coordination and cost reduction?

Mr. MILLER. OK. There are a couple things I think I would say in response to this. You know, ideally what you don't want to do, unless you have to, is impose penalties for these kinds of behaviors or, you know, abhorrent behaviors, high readmission rate. But when you have a fragmented fee-for-service sector you are sort of driven in that direction.

And so what the commission's view kind of works like this: We have recommended a readmissions penalty for hospitals, which has been implemented; as you said, skilled nursing facilities is coming on line; we also have a standing recommendation on home health readmission rates. The view there is, at least the major actors involved in a readmission would have an incentive to avoid it. They have an incentive to talk to each other and stop this kind of stuff from happening. Nobody benefits from this. Extra payments, beneficiary's families.

Now, ideally, where we would be moving to is think of bundled payments or an ACO or a managed care plan where that actually becomes their incentive, because if they can reduce a provider or plan, if they can reduce the readmission, then that actually turns into revenue for them.

Mr. GREEN. Yes.

Mr. MILLER. The other thing I would just say about the penalty, and I won't get into the weeds here, we want the penalties—and we have some specific ideas on this—structured in such a way that people avoid the readmission. In a sense, we don't want the penalty; we want them to avoid the readmission, which is a much more, you know, better event for everybody. And we have some recommendations to change the readmission penalties as they stand to get at that outcome a little more.

Mr. GREEN. OK. Well, and that is the concern, you know. I know the penalty, and the penalty doesn't help anybody, but the goal is to move that behavior so they actually treat that person fully.

Mr. MILLER. We think there is—well, go ahead. It is your time.

Mr. GREEN. And I don't have a lot of time left, but I know over the years we have also had some concerns about infection rates from being in the hospital and there has been efforts to do that. Can you compare in a short time now the readmission rate issue with the penalties compared to what we have tried to do on the broader scale in infection rates at some of our hospital facilities?

Mr. MILLER. Actually, I think I am going to have to come up short here. I am much more familiar with what is going on with the readmission rates. I am aware of the hospital-acquired conditions, measures. I can't give you a good answer on what effects and what observable effects there are. I am just not up to speed on it.

Mr. GREEN. Again, appreciate you being here and thank you.

Mr. MILLER. I apologize.

Mr. GREEN. Chairman, I yield back my time.

Mr. PITTS. Chair thanks the gentleman.

And now recognize the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions.

Mr. SHIMKUS. Thank you, Mr. Chairman.

Dr. Miller, welcome. I like this discussion on this readmission thing because my understanding is the penalty kicks in even if the readmission has no relation to the original hospitalization; is that correct?

Mr. MILLER. Well——

Mr. SHIMKUS. There is a penalty. So, you know, someone is in there for an internal procedure but then they leave and then something else happens, they break their leg, they go in, they are readmitted. There is no discrimination over the cause and effect of why you are penalizing them; is that correct?

Mr. MILLER. Yes, and I am just going to—I am going to parse through this a little bit. You are decidedly correct that people complain that there is not enough definition in the readmission criteria that parses things like a planned readmission or a readmission that is really related to the initial admission.

But I will say two things: First of all, the commission's position is it should be all condition, risk adjusted, potentially preventable, and that is the code word for get the planned ones out of there, and there is probably some clinical judgment that applies to situations like you are saying.

But the key point that I want to get across to you, just in case it is not clear: The penalty doesn't litigate on the basis of readmission by readmission. It looks at the overall rates of the hospital and says, if you are way to the right in the tail, that is where the penalty applies. So even if there is some disconnect, it is not case by case. I would just get that point across to you.

Mr. SHIMKUS. So maybe percentage-wise, based upon the overall admission, readmission rates that deal with that.

Mr. MILLER. Exactly.

Mr. SHIMKUS. I think that is helpful. I would be adverse not to use Sydne in one of her last days—although she's not paying attention to me—in her ability to put charts up.

And I want to have her put up one, because your role is, you know, the Medicare Payment Advisory Committee, and I bring this up all the time just to make sure we highlight the challenges that we face budgetarily and also the importance of your role.

Because even when I go to my two questions, it would be, I would say, nibbling around the edges versus really actuarially trying to make a system whole and the red being mandatory spending that has to go on regardless of what we do. The blue is discretionary. That is what we fight about all the time.

Sydne, you can take that down. I wanted to harass her one last time.

But to my question is, we asked last time you all came on the 340B program and what affect it has on the Medicare program. Can you comment on any ideas that you might have to realize savings in Medicare as it relates to the 340B program?

Mr. MILLER. Yes, we took that statement and statements that other members said on the same point very seriously. And the commission, if I remember correctly, things are running together a little bit, I believe at our November meeting had an extensive discussion about the 340B program, its growth, what the various conflicting incentives were, what, you know, one, the drug manufactures were arguing, what the hospitals were arguing, all of that, because we were asked to kind of paint the picture for the committees.

I just need to quickly say, by and large, all of this program is beyond our jurisdiction. It is not Medicare and it is not administered by CMS, but since the committee has asked, we wanted to lay the picture out and now we will give that to you and you guys will do what you do.

However, there was one thing in it, and we have only noted it for the commissioners at this point. We haven't actually taken action on it, and I think this is what you are getting at. In the outpatient setting, Medicare pays what is called the average sales price plus 6 percent, and that is what Medicare reimburses and there is a whole bunch of details about how that gets calculated. But if the hospital realizes a discount on the 340B then there is some difference between what the hospital acquired that drug at and what Medicare is paying at, and Medicare does not follow that.

And that is as far as we have gotten. We have put that in front of the commission, but I have not much more to say about it than that.

Mr. SHIMKUS. Great. And let me finish up, the President on the part D and Low-Income Subsidy Program, the President's proposal would encourage seniors to increase generic drug use when a viable alternative to a brand name is available. Has the commission taken a position on the low-income subsidy reform, since this policy, we think, could save, obviously, money for both the program and the seniors?

Mr. MILLER. Yes. I don't remember where the President's budget proposal came, whether it was before or after ours. I think it was after. But we made a recommendation a while back on this front, and our point was that even low income—and this is tricky, but even low-income beneficiaries are price sensitive. And if you say, for example, and give the plans the flexibility to say you can zero

out the premium for a generic drug, and keep in mind, this policy would only be in situations where there is a generic substitute, then the beneficiary may gravitate more to that.

Because what we found in the data is, is that you have less generic use in the low-income subsidy population. And I had always had this perception, well, this is because they use extremely expensive specialized drugs, and decidedly, some of them do. But a lot of their profile is the standard drugs for which there are generic substitutes, and so we thought that this would help get some push there.

Mr. SHIMKUS. Thank the chairman.

Mr. PITTS. Chair thanks the gentleman.

And now recognizes the gentlelady from Florida, Ms. Castor, 5 minutes for questions.

Ms. CASTOR. Thank you, Mr. Chairman.

Thank you, Dr. Miller for being here. It is nice to focus on something substantive and especially where some good news in Medicare that we have seen a slowing in growth of health spending, the fifth consecutive year of slower growth. And CMS says this is the slowest growth since 1960, so we need to put that to work in extending the life of the Medicare Trust Fund.

And more good news, the Affordable Care Act reforms are working. We have talked a lot about hospital readmissions and that is quantifiable already. And then we have a lot of reforms dealing with the accountable care organizations and focused on quality over quantity where the jury is still out but it looks promising.

But we still have now this challenge with the baby boomers beginning to retire and they are going to call on Medicare. They are looking forward to coming onto Medicare. It remains very popular. So we have a very important responsibility to ensure Medicare remains strong. I think the past attempts to look for quick solutions like turning it into a voucher, we really need to move away from that divisive dialogue because that is not going to solve anything. It simply shifts costs to beneficiaries that can't afford it.

So the hard work is going to be getting into the details. What is fraudulent? What will help bring greater efficiency? What can we do to bring developments in modern diagnosis medicine treatments to bare to extend the life of the trust fund and provide care?

I want to ask you a variation on what Representative Green was talking about in hospital readmissions but focus on post-acute care settings. Under the current Medicare payment systems there are no financial incentives for hospitals to refer patients to the most efficient or effective setting so that patients receive the most optimal but lowest cost care. Whether a patient goes to a home health agency or skilled nursing facility, for example, seems to depend more on the availability of the post-acute care settings in a local market. The patient and family preferences or financial relationships between providers.

So since patients access post-acute care after a stay in the hospital, what does MedPAC say we should be doing to ensure patients receive care in the right setting after a hospital stay?

Mr. MILLER. I think there is a few things, and I will try and build the answer this way: First of all, in the arriving settings, like a skilled nursing facility or in home health, we think that there are

underlying incentives built into the payment system now that encourage taking some patients and avoiding others. So we think, at a very bumper sticker level, what you want to do is take the physical rehab patients. You want to avoid the medically complex patients. We think that there is some very straightforward analytical adjustments or technical adjustments to the payment system that start to remove those incentives so you get something more of a clinically driven referral instead of a financial referral.

I won't run through all it again, but the notion of having a readmission penalty among the actors of saying you need to do this carefully and get them to the right location. Otherwise, if they come back to the hospital everybody has some impact, then we think that would help.

Ms. CASTOR. OK.

Mr. MILLER. There are also—well, just let me get these two things out quickly. We have also made a whole set of recommendations on accountable care organizations that we any would make those more viable and workable, and within those we think the incentives of all the actors are aligned.

And then the very last thing I will say—I am sorry—is we just had a conversation, I think it was in November, in which the commissioner started to ask themselves, even within fee-for-service should we give hospitals greater flexibility to steer patients on the basis of higher-quality facilities?

Now, that is not a recommendation but that is a discussion that is in progress. Sorry to take your time.

Ms. CASTOR. OK. No, I was interested in your answer.

On Medicare Part D, spending now is well over $60 billion per year and over 10 percent of all Medicare spending. Is MedPAC satisfied right now that the competition among plans—1,100 prescription drug plans, 1,600 Medicare Advantage PDPs, great choices for consumers—is MedPAC satisfied that the competition among plans is providing strong enough incentives for cost saving?

Mr. MILLER. Well, it is interesting you ask that question. We are just about to start talking about that in some greater detail. What we have been noticing over the last few years in part D is that the most rapid growth in the program is our reinsurance portion of the benefit. And so that is raising questions in our mind about whether there is some re-examination of the structure to relook at whether there is a greater degree of competition that could be injected into that program.

I don't have ideas for you right at the moment, but in the back room, those are churning in order to come out in front of the commissioners shortly.

Ms. CASTOR. Good. We will look forward to those.

Thank you.

Mr. PITTS. Chair thanks the gentlelady.

And now recognizes the gentleman from Pennsylvania, Dr. Murphy, 5 minutes for questions.

Mr. MURPHY. Thank you.

Welcome, here Dr. Miller. Good to have you.

I want to talk a little about some of the cost-shifting issues. Basically, I am assuming when we are talking about cost shifting, if a person may be seen in primary care, but if they cannot get the spe-

cialty care they need, that person may face other complications from their illness. Would you agree?

Mr. MILLER. Yes.

Mr. MURPHY. OK. And I saw a recent report that said those persons who sometimes have the greatest problems with readmission are people with low-income families. Would you agree with that?

Mr. MILLER. There is a relationship between readmission rates and income, yes.

Mr. MURPHY. And is that, some of that relation may also be that sometimes people have maybe compliance issues, or perhaps they don't have access to some of the things they need, some of the specialists and medications, et cetera?

Mr. MILLER. I would have a hard time telling you precisely what the mechanisms are. I think there is a relationship there. It might be the things that you are saying. I think there are a lot of things that are said. I think the exact pathways that lead to it are less——

Mr. MURPHY. Let me describe one. I read research reports that say that senior citizens with Medicare with chronic illness, have double the rate of depression and some mental illness. And that when it is untreated depression and chronic illness, that doubles the cost. So access is important to make sure that, under those circumstances, a person, for example, with heart disease or cancer or diabetes, has an increased risk for depression; and, therefore, treating that is an important cost-savings factor.

So therefore, if that is not treated, that is a cost shifting, that instead of providing the psychiatric or psychological care that cost will be borne by further complications with diabetes, cancer, heart disease, pulmonary disease. Does that make sense?

Mr. MILLER. I see that.

Mr. MURPHY. Now, one of the issues I have been deeply concerned about is of access to inpatient psychiatric care for the severely mentally ill. As you may know, Medicare has a 190-day limit on inpatient psychiatric care. But we don't impose this for heart disease, do we, or lung disease or diabetes or cancer? Do we have 190-day limit for those?

Mr. MILLER. There is not a 190-day limit for that.

Mr. MURPHY. So wouldn't you agree that this is discriminatory?

Mr. MILLER. I agree it should be looked at. The facts said I am a little bit hazy on, but as you have presented it, I see your point.

Mr. MURPHY. But with 190 days, though, I mean psychiatric diseases are brain diseases, but should we have a limit on diseases in terms of the number of days you can be treated for that?

Mr. MILLER. The only thing I would like to do is have the room to come back to you on this and make sure I understand what the implications are of agreeing to that is.

Mr. MURPHY. I am not sure what implications you are looking for.

Mr. MILLER. Well, a couple things. There may be limitations on other parts of the benefit that I don't have right at the front of my mind, and I wouldn't want to agree for the commission to say yes without being able to tell you what the cost implication of that would be.

Mr. MURPHY. I understand. Well, and if there are limits, we certainly would like to know that, because the issue becomes one of what is the proper level of care.

Mr. MILLER. Exactly. And that is all I am looking for is some latitude on.

Mr. MURPHY. And if there is 190-day limit for psychiatric care but that is not enough to treat someone.

Mr. MILLER. I hear you and I see the direction of your question. I would just like some latitude to actually think about it and come back to you.

Mr. MURPHY. Can you also then, when you are looking at that, find out how many seniors are affected by this cap? So when looking at the number of seniors, we need to know the costs of that.

Mr. MILLER. That is what I want to make sure I don't mislead you on and say, yes, no problem and then, you know, come back with——

Mr. MURPHY. And I appreciate your thoughtful approach, to this, because we need those kind of facts. When we ignore the mental health needs of seniors with chronic illness and that leads to other costs, we are not saving anybody anything. We multiply those costs.

And so sometimes when there is a resistance within Medicare to change a rule, well, we can't afford more than 190 days, but we will end up doubling the costs of oncology or cardiology or something else. It just doesn't make sense to us. So I hope you will give us a comprehensive look at that issue.

Mr. MILLER. Absolutely. And, you know, I don't want you to take the response as hostile to the ideas. I just don't want to commit the commission to saying, "Sure, go above 190 days" without giving you more complete thought, because we are the kind of people who would look at that and come back to you and say, "If you are going to do that, there may be some other things that you want to do to make it a more episode-based type of approach to the beneficiary's experience."

For example, if the person leaves the inpatient psychiatric facility, is there actually a set of ambulatory visits arranged for that person when they walk out the door? Because I think our experience is, that is where things begin to break down.

Mr. MURPHY. Good to see it, and monitoring and integrating that care. Same thing goes with pharmacology when you see that the mass amounts of medications that people don't follow through on leads to readmission or more complications, et cetera. It is a huge cost.

Thank you so much. We look forward to hearing from you.

Mr. MILLER. I would like to just think about it more holistically. No hostility to the thought.

Mr. MURPHY. No, I appreciate that. Thank you.

I yield back. Thank you.

Mr. PITTS. Chair thanks the gentleman.

Now recognizes the gentlelady from Illinois 5 minutes for questions.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

Thank you, Dr. Miller.

I just want to put in context some of the things we are talking about. The average Medicare beneficiary lives on an income of—half of all Medicare beneficiaries—$23,500 or less, and a quarter of them live on $14,400 or less.

We are talking about how we strengthen Medicare for now and for the future and costs. And we have done a lot, I want to point that out, to actually reduce the costs of Medicare.

The Centers for Medicare and Medicaid Services, CMS, recently reported that the Medicare Shared Savings Program and the Pioneer Accountability Care Organizations, ACOs, that were created by Obamacare have generated about half a billion dollars in savings for the Medicare program.

A recent report by the Agency for Healthcare Research and Quality found that we saved approximately $12 billion in healthcare costs as a result of reductions in hospital-acquired conditions from 2010 and 2013. $10.7 billion in fraud-fighting tools under Obamacare. That is over $23 billion.

But the important thing to me is that it hasn't done anything to reduce the benefits of the people who need it the most. And so I just want to make sure that we have policy solutions that save Medicare money but don't harm beneficiaries.

And there is a recent report that I would like to put into the record. Medicare Rights Center/Social Security Works released a report, "A Winning Strategy for Medicare Savings: Better Prices on Prescription Drugs."

Four strategies, including restoring the Medicare prescription drug rebates, allowing Medicare to negotiate drug prices for part D public option, and a solution—and let's see—securing better discounts for drug manufacturers to close the doughnut hole, promoting cost-effective prescribing for part B prescription drugs.

And I would like to——

Mr. PITTS. Without objection, so ordered.

Ms. SCHAKOWSKY. Thank you.

[The information follows:]

A Winning Strategy for Medicare Savings: Better Prices on Prescription Drugs

July 2014

By: Stacy Sanders and Ben Veghte

MedicareRights.org

The Medicare Rights Center is a national, nonprofit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs and public policy initiatives.

SocialSecurityWorks.org

The mission of Social Security Works is to protect and improve the economic security of disadvantaged and at-risk populations, and, in so doing, to promote social justice for current and future generations of children as well as young, middle-aged and older adults.

With Medicare a target for federal savings, lawmakers propose many ways to cut costs. Unfortunately, many of these strategies involve slashing benefits or shifting costs to seniors and people with disabilities. Often overlooked in this debate is that the federal government can secure significant Medicare savings without worsening the already fragile health and economic wellbeing of most Medicare beneficiaries—most notably by reducing the cost of prescription drugs. There are several viable ways to do so. Paying less for prescription medicines is a winning strategy for the federal government, for American taxpayers, and for Medicare beneficiaries.

Most People with Medicare Cannot Afford to Pay More for Health Care

Proposals to increase premiums, deductibles, and other cost sharing ignore widespread economic insecurity among older Americans and people with disabilities. Half of all Medicare beneficiaries—almost 25 million retirees and people with disabilities—live on annual incomes of $23,500 or less, and one quarter live on $14,400 or less.[1] At the same time, the burden of health care costs for Medicare beneficiaries, including premiums, deductibles and copayments, has risen sharply, increasing by 34% in real terms between 1992 and 2010.[2]

Responsible Savings Solutions for Medicare Prescription Drugs

Fortunately there is considerable scope for Medicare to cut costs, without simply shifting costs to seniors and people with disabilities. Four policy options are readily available to allow Medicare to secure the best possible price on prescription drugs.

Restore Medicare prescription drug rebates.

The most straightforward option for securing savings on Medicare prescription drugs involves simply restoring a discount that used to exist. Prior to the creation of the Medicare prescription drug benefit, the federal government benefited from discounts on prescription medicines for people covered by both Medicare and Medicaid. Reinstating this discount would create considerable savings for Medicare—an estimated $141.2 billion over 10 years.[3]

Upon passage of the Medicare Modernization Act (MMA), millions of older Americans and people with disabilities gained access to prescription drug coverage through private health plans approved by the federal government, commonly known as Medicare Part D. Today more than 35 million Medicare beneficiaries are enrolled in a Medicare prescription drug plan.[4]

While the MMA significantly enhanced health coverage for older Americans and people with disabilities, the law also severely limited the government's ability to control Medicare drug prices. When Part D was created, drug coverage for beneficiaries with both Medicare and Medicaid switched—from Medicaid to Medicare Part D— and the federal government lost the Medicaid discount for these beneficiaries, even though they are still enrolled in both programs. This switch resulted in windfall profits for pharmaceutical manufacturers: according to one analysis, drug companies' profits soared by 34% to $76.3 billion in the first year of the Part D program.[5]

To rectify this, and to secure significant savings, Congress should pass the Medicare Drug Savings Act (S. 740 and H.R. 1588). Championed by Senator Rockefeller (D-WV) and Congressman Waxman (D-CA), this legislation is supported by 19 Senators and over 30 members of Congress.[6] In addition, in his 2015 budget request President Obama proposes restoring Medicare drug rebates, and has consistently championed this common-sense solution.[7] Most importantly, the American people strongly support it. In one national poll, 85% favored "requiring drug companies to give the federal government a better deal on medications for low-income people on Medicare."[8]

Opponents of this proposal often claim that reinstating Medicare drug rebates would make it more difficult for pharmaceutical manufacturers to invest in new medicines. Yet there is no evidence to suggest that innovative spending was curtailed in the years that drug companies were required to pay these rebates.[9] An examination of industry spending trends further suggests that restoring Medicare drug rebates will *not* limit research and development.[10] Analyses show that pharmaceutical manufacturers spend 2 to 19 times as much on on marketing and advertising than they do on research and development.[11]

Allow Medicare to negotiate drug prices for a public Part D option.

Both the Veteran's Administration and state Medicaid programs directly negotiate on prescription drug prices, but the Medicare program is expressly prohibited from participating in the same kind of negotiations. This prohibition was advanced by the MMA and, much like the loss of drug rebates, severely limits the federal government's ability to secure the best prices on Medicare prescription drugs. Yet most Americans—regardless of political party—disagree with this policy: according to a 2012 national poll, 81% of Democrats, 86% of Independents and 70% of Republicans support drug price negotiation in Medicare.[12]

At the same time, several members of Congress support allowing the Medicare program to actively negotiate drug prices under Medicare Part D. Bills such as the Medicare Prescription Drug Price Negotiation Act (S. 117 and H.R. 1102) and the Prescription Drug and Health Improvement Act (S. 77) would restore the federal government's ability to negotiate Medicare drug prices.[13] This proposal is also a cornerstone of the Medicare improvements included in the House Congressional Progressive Caucus' 2015 budget.[14]

Under the Part D program, private health plans negotiate directly with drug manufacturers to set prices. Without administering its own drug program, Medicare has limited tools to entice drug companies to provide rebates (or discounts) on specific medicines. If allowed to negotiate, Medicare would be best positioned to secure a better deal on costs for popular, blockbuster medicines new to the market.[15] The federal government's ability to achieve significant savings would be enhanced by both allowing the federal government to negotiate prices *and* letting Medicare operate its own drug benefit. Legislation introduced by Illinois Senator Dick Durbin and Congresswoman Jan Schakowsky would do just that.

The Medicare Prescription Drug Savings and Choice Act (S. 408 and H.R. 928) would create one or more Medicare-administered drug plans, with a uniform premium and a vetted benefit design to ensure safety, appropriate use and high value care. Additionally, the legislation would allow for drug price negotiations by the federal government. Authorizing the Medicare program to negotiate drug prices, coupled with a public drug benefit, has the potential to save up to $20 billion over 10 years.[16]

Secure better discounts from drug manufacturers to close the Part D doughnut hole sooner.

When first constructed, Medicare Part D included a considerable coverage gap for beneficiaries, more commonly known as the doughnut hole. Under the program's original design, when a beneficiary's drug costs reached a specific cap, the person became responsible for 100% of the cost of their prescription drugs up to a catastrophic limit, with the exception of the lowest income beneficiaries enrolled in low-income assistance.

The Part D doughnut hole posed significant financial and health risks to people with Medicare. Faced with significant costs for prescription drugs, many beneficiaries were shown to forgo essential medicines altogether. In 2009, Medicare beneficiaries without low-income assistance filled an average of 11% fewer prescriptions in nine selected drug classes after falling into the doughnut hole.[17]

To remedy this shortcoming, the Affordable Care Act (ACA) gradually closes the doughnut hole, eliminating the coverage gap altogether by the year 2020. This critical policy fix is being paid for through a combination of taxpayer dollars and discounts made available by drug manufacturers on brand name medications. Since the enactment of the ACA, 7.9 million Medicare beneficiaries have saved an average of $1,265 on prescription drug costs due to the gradual closing of the Part D doughnut hole, amounting to total beneficiary savings of $9.9 billion.[18]

In the Administration's most recent budget request, the President proposes to accelerate closure of the doughnut hole by four years—from 2020 to 2016—by increasing the proportion of pharmaceutical manufacturer discounts on brand name drugs made available for this purpose. Not only would this policy change enhance the affordability of prescription drugs for retirees and people with disabilities, it would save an estimated $16.6 billion over 10 years.[19]

Promote cost-effective prescribing for Part B prescription drugs.

While most Medicare drugs are covered through the Part D program, a small proportion of drugs are covered under Medicare's outpatient benefit, known as Part B. Prescription drugs covered under Part B are most often medicines that must be administered by a doctor. The most commonly used Part B drugs treat cancer, macular degeneration, anemia and arthritis.

In general, Part B drugs tend to be very costly both for the Medicare program and for beneficiaries—accounting for $12.8 billion in Medicare spending in 2011.[20] To determine what it will pay for Part B drugs, Medicare uses a formula based on data reported by drug manufacturers. Based on this formula, Medicare reimburses physician offices, outpatient labs and other providers who provide these drugs at 106% of the determined price.[21]

Recent data released on Medicare reimbursement to physicians reveals that the high cost of these medicines is behind some of the highest spending under Medicare Part B.[22] One analysis finds that "most of the 4,000 doctors who received at least $1 million from Medicare in 2012 billed mainly for giving patients injections, infusions and other drug treatments." Additionally, the data reveal that the Medicare program could save considerably if policies were in place that encouraged the use of less expensive—but equally effective—alternatives to the highest cost drugs. Securing lower prices for the Medicare program on Part B medications would also produce tangible savings for beneficiaries through decreased cost sharing.

Several savings options are available to help the Medicare program secure better prices on Part B-covered medicines. The most straightforward option would simply reduce the percentage at which Part B drugs are reimbursed—from 106% to 103%—saving an estimated $3.2 billion over 10 years.[23] Another option would restore the federal government's ability to set prices for Part B medicines based on the price of the "least costly alternative" among multiple drugs that treat the same condition. Other proposals include allowing the federal government to negotiate Medicare Part B prices, or requiring drug companies to provide a rebate (or discount) for these medications.

Conclusion: Congress Can Find Medicare Savings That Do No Harm

The proposals outlined above would secure significant Medicare savings without harming the health or financial wellbeing of seniors and people with disabilities. Allowing the federal government to secure the best possible prices on prescription drugs is a common-sense solution to secure Medicare savings. By enacting these proposals, Congress could make Medicare more sustainable over the long term without compromising access to or quality of care.

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[10] FamiliesUSA, "No Bargain: Medicare Drug Plans Deliver High Prices," January 2007.

[11] Office of Senator Jay Rockefeller, "Fact Sheet: Medicare Drug Savings and Pharmaceutical Research & Development (R & D)," April 2013.

[12] National Committee to Preserve Social Security and Medicare, "Issue Brief – Medicare Drug Negotiation and Rebates," 2013, available at: http://www.ncpssm.org/PublicPolicy/Medicare/Documents/ArticleID/1138/Issue-Brief-Medicare-Drug-Negotiation-and-Rebates.

[13] Medicare Prescription Drug Price Negotiation Act of 2013, S. 117, 113d Cong. (2013); Medicare Prescription Drug Price Negotiation Act of 2013, H.R. 1102, 113d Cong. (2013); Prescription Drug and Health Improvement Act of 2013, S. 77, 113d Cong. (2013)
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[23] Kaiser Family Foundation, "Policy Options to Sustain Medicare's Future," January 2013, available at: http://kff.org/medicare/report/policy-options-to-sustain-medicare-for-the-future/.

Ms. SCHAKOWSKY. So here is my question, though. I am very concerned that this idea of making sure seniors have and people with disabilities have more skin in the game, that we—the CMS Medigap tool shows that in Evanston, my district, Evanston, Illinois, the average cost of a Medigap plan for someone in good health is between $129 and $318 a month for a Medigap C Plan and $118 to $262 per month for a Medigap F Plan, both of which include deductibles.

But CMS still estimates that, even with these plans offering first-dollar coverage, a senior or person with disability would still spend over $6,000 on health care each year out of pocket.

So why should we ask these Medicare beneficiaries to pay more, eliminating first-dollar Medigap coverage?

Mr. MILLER. Well—and this goes back to the conversation on the benefit design. And I want to be clear. I mean, the Commission——

Ms. SCHAKOWSKY. Dr. Miller, could you pull your microphone closer?

Mr. MILLER. Oh, sorry about that. So nobody has heard anything I have said for the hearing?

Ms. SCHAKOWSKY. No, it is just me. Just me.

Mr. MILLER. So, let's see, where were we? Benefit redesign.

The Commission shares your concern. And, particularly, you had a statement in your—"We should do reform, but we shouldn't harm beneficiaries." OK? There was a lot of discussion about this.

Now, one more time, just to go through this, the benefit redesign works like this: It has a catastrophic cap. So that beneficiary you are talking about now has an additional protection, and particularly the person you are talking about who starts running into $6,000, $7,000, $10,000, that is what a catastrophic cap is all about: Stop, you know, the amount of out-of-pocket headed out the door.

The second thing we would do is have copayments instead of coinsurance. So, you know—and you have had this experience—you pay 20 percent of a bill that you don't know what it is going to be. It is hard to plan for, as opposed to I walk into the physician's office, I pay 20 bucks, or I walk into a specialist's office, I pay 30 bucks; I know what I am going to pay. The thought process in all of this is that the beneficiary has more protection and clearer line of sight.

And to be really clear on this, the Commission's principle was that the beneficiary's liability, as it currently stands, doesn't change under this benefit redesign. So we are not putting more liability on the beneficiary. There is a distributional change, meaning the sick get more coverage. But there is no aggregate change in the liability.

Then we say, if you want to buy that coverage, the coverage would come with a higher price, which reflects the cost that it imposes on the program. But, ideally, you don't need it the way you used to need it because the benefit is better and we expanded the Medicare Savings Program up to 150 percent of poverty to capture that group of people between 135 and 150 who would potentially have a out-of-pocket problem.

Ms. SCHAKOWSKY. I am going to put some further follow-up in writing. Thank you.

Mr. PITTS. All right. The Chair thanks the gentlelady.

I now recognize the gentleman from Georgia, Dr. Gingrey, 5 minutes for questions.

Mr. GINGREY. Mr. Chairman, thank you.

Before I ask my questions of Dr. Miller, I want to ask unanimous consent. In 2012, Dr. Roe, myself, Dr. Barrasso, and Dr. Coburn submitted a report titled "What Happens To Payments to Health Care Providers Participating in Medicare When the Medicare Hospital Insurance Trust Fund Reaches Exhaustion?" Since this is apropos to the discussion, I would like unanimous consent to have that approved for the record.

Mr. PITTS. Without objection.

[The information follows:]

What Happens to Payments to Health Care Providers Participating in Medicare When the Medicare HI Trust Fund Reaches Exhaustion?

When is Medicare's Hospital Insurance Fund Expected to be Insolvent?

The projected exhaustion of the Medicare Hospital Insurance Trust Fund (HI) raises a question regarding whether that possibility would affect the right of providers to receive full payment for services rendered, because Section 1815(a) of the Social Security Act, 42 U.S.C. section 1395g(a), states that "... the provider of services shall be paid ... from the Federal Hospital Insurance Trust Fund..."

According to nonpartisan experts, the Trust Fund could be insolvent in the near future.

- The Chief Actuary of the Medicare program has warned insolvency could hit the HI Trust Fund as soon as 2016.[1]
- The nonpartisan Congressional Budget Office projects the Medicare HI Trust Fund will be insolvent in 2022.[2]

How does Medicare's Hospital Insurance Fund Work?

The Medicare HI Trust Fund is an account maintained on the books of the U.S. Treasury. The system operates on a "pay-as-you-go" basis; current workers and their employers pay taxes on wages, and the self-employed pay taxes on self-employment income. Taxes paid into the HI Trust Fund – along with General Revenue and Medicare enrollee premiums in SMI Trust Fund -- now finance benefits and services for today's beneficiaries.

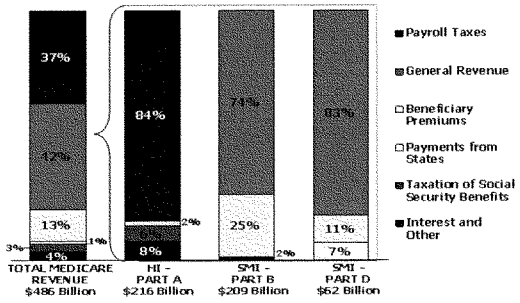

Table from the Congressional Research Service.[3]

What Would Happen If the Trust Fund Became Insolvent?

According to legal analysis from the Congressional Research Service:[4]

> "The practical function of the HI trust fund is that it permits the continued payment of bills in the event of a temporary financial strain (e.g., lower income or higher costs than expected) without requiring legislative action. As long as the HI trust fund has a balance (i.e., there are securities credited to the fund), the Treasury Department is authorized to make payments for Medicare Part A services. If the trust fund is not

[1] https://www.cms.gov/ReportsTrustFunds/downloads/tr2011.pdf
[2] Congressional Budget Office's January 2012 *Budget and Economic Outlook: FY 2012-2022*, http://www.cbo.gov/publication/42905.
[3] 2011 Report of the Medicare Trustees, Table II.B1, and the Kaiser Family Foundation. Note that totals may not add to 100% due to rounding.
[4] Davis, Patricia. "Medicare: History of Insolvency Projections," Congressional Research Service, June 1, 2011 (RS20946)

able to pay all of current expenses out of current income and accumulated trust fund assets, it is considered to be *insolvent.*

"To date, the HI trust fund has never become insolvent, and there are no provisions in the Social Security Act that govern what would happen if that were to occur. For example, there is no authority in law for the program to use general revenue to fund Part A services in the event of such a shortfall.

"In their 2011 report, the Medicare trustees project that the HI trust fund will be exhausted in 2024. At that time, HI would continue to receive tax income from which some reimbursements for health services could be paid; however, there would be insufficient funds to pay for all Part A reimbursements to providers. Unless action is taken prior to that date to increase revenue or decrease expenditures (or some combination of the two), Congress would need to pass legislation that would provide for another source of funding (e.g., general revenues or increased taxes) to make up for these deficits."

Because Medicare is An Entitlement, Will the Program Still Pay Providers, Even if Insolvent?

The Medicare program is a statutory entitlement program. Entitlement authority has been defined as "authority to make payments (including loans and grants) for which budget authority is not provided in advance by appropriation acts to any person or government if, under the provisions of the law containing such authority, the government is obligated to make the payments to persons or governments who meet the requirements established by law."[5] Budget authority is the authority provided by law to enter into obligations that will result in immediate or future outlays involving federal government funds.[6]

According to a publication of the Government Accountability Office, formerly the General Accounting Office:

> Congress occasionally legislates in such a manner as to restrict its own subsequent funding options.... An example ... is entitlement legislation not contingent upon the availability of appropriations. A well known example here is Social Security benefits. Where legislation creates, or authorizes the administrative creation of, binding legal obligations without regard to the availability of appropriations, a funding shortfall may delay actual payment but does not authorize the administering agency to alter or reduce the "entitlement."[7]

Even under an entitlement program, an agency could presumably meet a funding shortfall by such measures as making prorated payments, but such actions would be only temporary pending receipt of sufficient funds to honor the underlying obligation. An otherwise eligible, legitimate provider would remain legally entitled to the balance.[8] An entitlement by definition legally obligates the United States to make payments to any entity who meets the eligibility requirements established in the statute that creates the entitlement.

Antideficiency Act May Prohibit Administration From Taking Actions To Keep Paying Providers

As a legal analysis by the Congressional Research Service notes:[9]

> "A provision of the Antideficiency Act, 31 U.S.C. § 1341, however, prevents an agency—in this case the Centers for Medicare and Medicaid Services—from paying more in reimbursements for health care services than the amount available in the source of funds available to pay the reimbursements for health care services, in this case from the Hospital Insurance Trust Fund. Section 1341, in relevant part, provides that:
>
> > An officer or employee of the United States government or of the District of Columbia government may not—
> >
> > (A) make or authorize an expenditure or obligation exceeding an amount available in an appropriation or fund for the expenditure or obligation;

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[5] 2 U.S.C. §§ 622(9) and 651(c)(2)(C).
[6] 2 U.S.C. § 622(2).
[7] Government Accountability Office, Office of the General Counsel, I *Principles of Appropriations Law* 3-49 (3d ed. 2004), available at http://www.gao.gov.special.pubs/d04261sp.pdf.
[8] *Id.* at 3-49, n. 40.
[9] Swendiman, Kathleen. "Social Security Reform: Legal Analysis of Social Security Benefit Entitlement Issues," Congressional Research Service, June 13, 2011.

> (B) involve either government in a contract or obligation for the payment of money before an appropriation is made unless authorized by law; ...."

The Antideficiency Act prohibits making expenditures either in excess of an amount available in a fund or before an appropriation is made. Therefore, it appears to bar paying more money in reimbursements to providers than the amount of the balance in the Medicare HI Trust Fund primarily because, as noted earlier, payments shall be made to providers from the HI Trust Fund.

Again, the Congressional Research Service explains:[10]

> "Violations of the Antideficiency Act are punishable by administrative and criminal penalties. An officer or employee who violates the act's prohibitions is subject to appropriate administrative discipline, including, when circumstances warrant, suspension from duty without pay or removal from office.[11] An officer or employee who knowingly and willfully violates the act can be fined not more than $5000, imprisoned for not more than two years, or both."[12]

Could Legal Action From Providers Force Medicare to Pay Them?

If the Medicare Hospital Insurance Trust Fund should become insolvent (i.e., unable to pay scheduled payments to providers in full on a timely basis), it appears that providers who should file suit to be paid the difference between the amount that receipts allow paying and the full reimbursement amount to which they are entitled would not be likely to succeed in getting the difference. CRS notes:

> "The Supreme Court in *Reeside* v. *Walker*,[13] held that no officer of the government is authorized to pay any debt due from the United States, whether reduced to a court judgment or not, unless an appropriation has been made for that purpose. To support its holding, the Court cited Article I, § 9, clause 7 of the Constitution, which states that, 'No money shall be drawn from the Treasury, but in consequence of appropriations made by law. The Court reaffirmed this principle in *Office of Personnel Management* v. *Richmond*."[14]

Consequently, unless Congress amends applicable laws, it appears that Medicare enrollees would have to wait until the Trust Funds receive an amount sufficient to pay full reimbursement for health services to receive the difference between the amount that can be paid from the Trust Funds and the full reimbursement amount.

So What Does This All Mean for Providers If Insolvency Actually Occurs?

Medicare's Hospital Insurance program is a statutory entitlement program. Part A Medicare enrollees have a legal right to receive health insurance services if they meet the Medicare Part A eligibility requirements and providers must be paid.

Congress, however, has reserved the "right to alter, amend, or repeal any provision of the Social Security Act (which includes Title 18 which created the Medicare programs) and the U.S. Supreme Court has affirmed Congress's power to modify provisions of the Social Security Act in *Flemming v. Nestor*[15] and subsequent court decisions. [16] Congress may modify provisions of Medicare law as it exercises its constitutional power to provide for the general welfare. For example, Congress could raise the age of eligibility for enrollees for Medicare coverage.

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[10] Swendiman, Kathleen. "Social Security Reform: Legal Analysis of Social Security Benefit Entitlement Issues," Congressional Research Service, June 13, 2011.
[11] 31 U.S.C. § 1349.
[12] 31 U.S.C. § 1350.
[13] 53 U.S. (11 How.) 272, 275 (1850).
[14] 496 U.S. 414, 424-426 (1990).
[15] 363 U.S. 603 (1960).
[16] Swendiman, Kathleen. "Social Security Reform: Legal Analysis of Social Security Benefit Entitlement Issues," Congressional Research Service, June 13, 2011.

When the Medicare Hospital Insurance Trust Fund is exhausted (i.e., unable to pay full reimbursements for health services on time), the Medicare program (CMS/HHS) would not be able to pay providers their full payments at that time because the Social Security Act states that providers shall be paid only from the Hospital Insurance Trust Fund.

CMS officials are bound by the Antideficiency Act, which prohibits paying amounts that exceed the amount available in the source of funds available to pay them. Although the legal right of providers to receive full payments would not be extinguished by the insufficient amount of funds in the Hospital Insurance Trust Fund, a court suit to obtain the difference between the amount in them available to pay partial reimbursements for health services and the full reimbursement amount would not be likely to succeed in getting the difference.

The Supreme Court has held that no officer of the government may pay a debt whether reduced to a court judgment or not unless Congress has appropriated funds to pay it. Consequently, unless Congress amends applicable laws, it appears that hospital providers would have to wait until the HI Trust Fund receives an amount sufficient to pay full reimbursement for Medicare Part A services to receive the difference."

Mr. GINGREY. I want to go back, Dr. Miller, to the line of questioning that Ms. Schakowsky just had, because I think this is hugely important and I want to make sure that I understand it fully. It is somewhat controversial, but it seems like the facts maybe speak for themselves.

You said approximately one in six Medicare beneficiaries had an individually purchased Medicare supplemental insurance policy in recent years, known as Medigap, and no other source of supplemental coverage.

The Kaiser Family Foundation released a report evaluating a proposal that would prohibit Medigap policies from paying the first $550 of enrollees' cost-sharing and requiring that they cover no more than half of Medicare's additional required cost-sharing up to a fixed out-of-pocket limit.

The Kaiser Foundation revealed some notable findings, and let me point those out, three bullet points. If this policy were adopted, four out of five seniors would save money from Medigap reform, and most of those that could face higher cost would instead choose a Medicare Advantage plan. The second bullet point: With this reform, some seniors would save more than $1,000 from Medigap reform. And, thirdly, this policy would also create savings, which would strengthen Medicare.

Given the obvious upside of the policy, why hasn't Congress adopted this policy sooner? And what are the given obstacles to adopting this commonsense policy?

Mr. MILLER. Oh. So the question is why, as opposed to the policy.

Mr. GINGREY. It is, indeed.

Mr. MILLER. I would rather talk to you about the policy, but I guess, just to be very direct, what I would say is that, obviously, the people who sell the Medigap plans would oppose such a policy. And I think one way you could think about trying to navigate this—and just to be clear, this is all your turf—is, you know, there are two ways to think about Medigap reform.

What has been said in the Kaiser study says only products can be sold that don't have first-dollar coverage. So the beneficiary has to pay something in order to get the service. And this is what the Congresswoman was referring to. The other way you could do it—and this is what the Commission said—is you can buy any product you want, first-dollar or not first-dollar, but the charge on it has to reflect the true cost of the policy. Because the policy imposes the cost on the program, and that is not reflected in the premium.

And I think reasonable people could take either of these approaches, say, OK, I am going to say the product has to have this structure, or put an additional charge on it. But the folks who sell Medigap policies are not going to like either of those.

On the beneficiary—I mean, I think the other resistance that you get to this—and it is raised by the beneficiary groups—is what about those people who—and I guess the term is "near poor," at least in this area that we are talking about, where they are not poor enough to be covered by Medicaid but they don't have enough resources to pay their out-of-pocket. And there, I think what the Commission would say is maybe you fill in the Medicare Savings Program up to 150 percent to try and help that crew out.

But I think your resistance is from the Medigap industry, and then I think the beneficiary groups are concerned about that bloc of people who are left without a supplemental.

And one more time, I am just going to say this. Ideally, if the benefit redesign has a catastrophic cap and clearer cost-sharing, the beneficiary's need for this should also be reduced.

Mr. GINGREY. Yes. And, Dr. Miller, I would think that is the most important point, the catastrophic cap.

Mr. MILLER. Yes, because we are talking—I mean, the reason that the Kaiser—I don't have all those facts in my head, but the reason Kaiser said this is a savings to the beneficiary is, I mean, these premiums are, you know, $1,300, $1,400 for these products.

Mr. GINGREY. Right. And many people don't need that. They will never reach that catastrophic cap, and it is really unnecessary.

So, Mr. Chairman, I will yield back 28 seconds. Thank you very much.

Thank you, Dr. Miller.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the gentleman from Maryland, Mr. Sarbanes, 5 minutes for questions.

Mr. SARBANES. Thank you, Mr. Chairman.

You said that the policy impacts the cost of the program. Just give me a couple examples.

Mr. MILLER. The policy?

Mr. SARBANES. The policy with the Medigap, like that the nature of the policy has an impact on the cost to the——

Mr. MILLER. Oh, OK.

Mr. SARBANES [continuing]. Medicare program.

Mr. MILLER. We think the research—if I follow your question, and if not, redirect. We think the research on this is very clear. What happens when you look at the presence of the supplemental coverage, after you adjust for the risk of the patient, you find a lot more discretionary services. So there are more visits, more imaging, more testing, that type of thing. It doesn't affect hospital, emergency room services.

Mr. SARBANES. Right.

Mr. MILLER. That goes on about its business. But these policies, because there is no further——

Mr. SARBANES. But ups utilization that spills over onto the Medicare——

Mr. MILLER. And then that is not reflected——

Mr. SARBANES [continuing]. Coverage side.

Mr. MILLER. And what I have tried to say, and perhaps not clearly, is that doesn't get reflected in the premium.

Mr. SARBANES. Right.

Mr. MILLER. The person purchasing the product gets this package which is priced to just the wrap-around benefit, but there is a cost over here that travels on to the taxpayer and to the beneficiary's broader premium.

Mr. SARBANES. Right. Well, it is obviously very complex, and——

Mr. MILLER. Yes, it is.

Mr. SARBANES [continuing]. It is gratifying that you are approaching it as much based on the reams of data that Medicare has at its fingertips as you possibly can.

I am glad that this discussion, wherever people may come down on it—and, you know, you have the Medigap plans with their perspective, insurers on one side and beneficiaries potentially on the other side, and maybe there is some common ground that can be achieved. But at least the whole discussion is happening within the context of maintaining the basic tenets of the Medicare program, which is that it is guaranteed coverage of one kind or another.

So, in that sense, it is in strong contrast to some of the proposals that we have seen in recent years—for example, the proposal to turn Medicare into a voucher program, which completely upends the basic principles upon which the program is operated for all of these decades and is really at the heart of it.

So we will kind of continue to find our way on what the best sort of outcome is for this discussion, but I am glad it is being done in a kind of fact-based environment and one that doesn't abandon in any way the basic operating principles of the program.

I was curious—and you may have a document like this, but if not, would it be possible to produce for us a document that just kind of takes a Medicare beneficiary who purchases a Medigap plan and says, you know, here is the before picture of how they are managing that situation and here is the after picture under these two or three scenarios in terms of the reform to give us a better sense of, in practical terms, what that looks like from the beneficiary's standpoint?

And maybe what you do is you choose, if there are certain categories of beneficiaries that assemble around one kind of an option currently, take that category, show us the before scenario and show us the after scenario, take the next category and show us the before and the after, just so we can get a sense.

I mean, for example, not all beneficiaries purchase these Medigap plans, as you made very clear, so I don't know if the before and after picture is pertinent to that group or not, but it may be. But certainly for the folks that do, if they fall into some distinct categories that allow for comparison, that would be useful.

Because when we are talking to our constituents and trying to translate this potential policy change to them as beneficiaries, that would be the most useful way to capture the data and the proposal for us. So I don't know if there is something like that, but if it is possible to produce something like that, I think it could be useful.

Mr. MILLER. Yes, there are certainly, in the reports, averages that do that type of thing, but I think your request is a little bit different. You know, could you make it a little bit more directly relevant to the beneficiary, a beneficiary who looks like this——

Mr. SARBANES. You know, and is paying X a month, and when that X a month represents, kind of, on average what a whole category of beneficiaries are paying, you know, this is what would happen under this proposal. That would be helpful.

Mr. MILLER. There might be an illustrative example or two that we could put together that would bring this point home for you. It would be very hard to represent, you know, the full breadth of a beneficiary's experience.

Mr. SARBANES. I understand.

Mr. MILLER. It is going to necessarily be incomplete.

Mr. SARBANES. Right.

Mr. MILLER. But there might be a couple of illustrative examples that we could put together for you.

Mr. SARBANES. Thank you.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the gentleman from New Jersey, Mr. Lance, 5 minutes for questions.

Mr. LANCE. Thank you, Mr. Chairman.

Dr. Miller, there is a growing concern over the high cost of dual-eligible beneficiaries, eligible for both Medicare and Medicaid. As you know better than most, there are two separate funding streams. Different payment rates and coverage rules often create conflicting financial incentives that result in higher costs and poor coordination efforts.

In 2010, the President's fiscal commission recommended giving Medicaid full responsibility for providing health coverage to dual-eligible persons and requiring those persons to be enrolled in Medicaid managed care programs. Would you please comment on the merits of this policy, both pros and cons?

Mr. MILLER. I am not going to be able to. The Commission has not taken that up, per se, and, you know, I am here to represent their view, so there is not a lot I can bring to bear on it.

There have been discussions around things like the dual-eligibles' demonstrations and some of the issues there, and there have been some discussions around those. These kinds of conversations always kind of have a continuum to them, which are, do you take this population and put it in the hands of the State, and then you have to start asking questions about how the Federal dollar follows in that instance? Versus the other approach, which other people have argued, which is—and this is, in a sense, what—not in a sense—directly what happened in part D, where you say, OK, the beneficiary now becomes a Federal responsibility, and then the dollars from the State travel in that direction in order to support this.

The Commission has not broadly, for the dual-eligibles population, talked about, in that continuum, you know, the solution that should be considered. So I can't really give you much there.

Mr. LANCE. Given the aging of baby boomers and climbing rates of obesity and obesity-related disease, do you expect that the cost pressures created by dual-eligibles will continue to increase?

Mr. MILLER. Yes, I think that this is an expensive population and a population that really, you know, is most susceptible to the problems that arise from not coordinating among the clinicians and actually not coordinating more broad social types of services around these particular beneficiaries.

Although I do want to say quickly, we talk about—and I do it, too—duals as kind of a monolithic group of people, and they are very different—cognitive disabilities, physical disabilities. There is a significant range of people within the dual-eligible population.

But that said, I think this is a population where there is need for people to be focused on more care coordination activities, both around their clinical needs and around their social needs. Otherwise, I think the price does go north.

Mr. LANCE. Given the fact that there are different types of people in dual-eligibles, should we differentiate between the different type of person who is in the dual-eligible category?

Mr. MILLER. That is a really fair question, and honestly—and, again, this is a comment that is probably not so much the Commission—my own thinking has gone back and forth.

Sometimes I have had this view that you have to really think about designing programs around specific populations within the dual population. And then, at other times, I have sort of felt like, well, maybe you can think about coordinated care plans but allow benefit flexibility within the plan, for example.

And then there is a whole set of questions that, if the beneficiary stays out in the fee-for-service environment, how you actually build the coordination around that particular environment, which I think continues to be complicated even if you are not dual-eligible.

So I have to tell you, my own thinking has moved around on this, and on any given day I am not sure what answer I would give you on this.

But there has to be, I do think, some more—I think I would say this—some more tailored approach. Because, you know, a cognitive disability is not a physical disability, is not—you know, there are different populations. And so there has to be some flexibility to put the right kinds of providers and services around a given population. There probably does need to be some flexibility there.

Mr. LANCE. Thank you very much.

Mr. Chairman, I yield back 10 seconds.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the gentleman from New York, Mr. Engel, 5 minutes for questions.

Mr. ENGEL. Thank you very much, Mr. Chairman. Thank you for holding today's hearing.

I believe the reforms included in the Affordable Care Act have improved Medicare's long-term fiscal situation and protected beneficiaries' access to guaranteed benefits. And just last week, the Centers for Medicare and Medicaid Services reported that health costs grew just at 3.6 percent in 2013, which is the smallest increase since 1960, and the reforms included in the ACA resulted in the Medicare Trust Fund remaining solvent till 2030, which is 13 years longer than the projected date prior to the passage of the ACA.

With regard to protecting beneficiaries, HHS announced last week that, from 2010 to 2013, there were 1.3 million fewer hospital-acquired conditions, resulting in 50,000 lives saved and $12 billion in healthcare costs avoided. The ACA pushed healthcare providers to improve patient safety by providing Medicare payment incentives to improve the quality of care provided and launching the HHS Partnership for Patients initiative.

Medicaid is a lifeline for many of my constituents. I am pleased so many States, including my home State of New York, have taken this opportunity to expand their Medicaid programs and care for the most vulnerable citizens. However, certain Governors have used the excuse of the uncertain Federal funding for Medicaid as a reason not to expend their programs. I think that is wrong and shortsighted.

Looking only at the dollar figures and associated healthcare spending with regard to the ACA, Medicare, and Medicaid fails to adequately convey the tremendous importance these programs

have to the basic wellbeing and health of millions of vulnerable Americans, young and old. Their value in this respect cannot be understated and should be our primary focus as we look at the long-term fiscal situations surrounding these programs.

Let me ask you, Dr. Miller—let me say this. MedPAC made GME recommendations a few years ago that many people have used to push for Medicare—GME, graduate medical education—cuts. With one in six physicians trained in my home State of New York, I have concerns that cutting Medicare support for GME or physician training would make it very difficult for teaching hospitals and medical schools to carry out their missions. Additionally, these proposals would change the long-established shared investment between medical schools, residency training programs, and the Federal Government to financially support doctor training.

So let me ask you this. By 2025, the Nation will face a shortage of more than 130,000 physicians, split evenly between primary and specialty care. Medical schools from across the country have done their part to address the shortage by increasing enrollment sizes, and teaching hospitals are training residents above their cap. Medicare GME cuts could financially exhaust the ability of teaching hospitals to train additional resident physicians.

With this said, does MedPAC support the notion of cutting Medicare GME funding?

Mr. MILLER. What MedPAC said—MedPAC, in 2010 I think, made a broad recommendation to reform the GME approach in Medicare, and it has the following characteristics.

So the analysis that we did suggested that the curriculums that were current in residency programs were not really focused on team-based care, decision support instruments, that type of thing, getting training outside of the hospital, getting training in rural areas, that type of thing. So we made a recommendation that there needed to be new criteria to have reorganized residency programs. And then we took a little more than half of the indirect medical education funding and said, these dollars should be devoted to entities—and it wouldn't just be hospitals—who are providing this more reformed approach to graduate medical education.

So to try and answer your question directly, we didn't take the dollars out of the system, but we said that the dollars should be allocated differently than they are now. A hospital can be a recipient of it if they are a part of these reformed programs, but they are not necessarily the only entity for which these dollars would be available.

Mr. ENGEL. OK.

Let me quickly switch, and just let me give you a general question. Can you elaborate on what you believe are the most promising efforts under way to encourage providers to deliver high-quality, high-value care?

Because, in your written testimony, you stated that the Commission remains focused on pursuing reforms that control spending and create incentives for beneficiaries to seek and providers to deliver high-value healthcare services.

So what do you believe are the most prominent, promising efforts under way to encourage providers to deliver this kind of high-quality, high-value care?

Mr. MILLER. Well, I mean, it is kind of the whole array of things that I mentioned here. So, you know, there are things in the fee-for-service world like readmission penalties and reformulating the way we pay for skilled nursing facility and home health services. We have made recommendations on accountable care organizations to make them more viable options. We have made recommendations that Congress has adopted on the way we make payments in managed care, and we think that that industry is moving in a much more efficient direction.

There is a very long list here with time out here that—but it is in the testimony. The testimony is basically, from first to the last page, a list to answer your question.

Mr. ENGEL. All right. Thank you.

Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the gentleman from Florida, Mr. Bilirakis, 5 minutes for questions.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it. Thanks for holding this very important, very informative hearing.

And, Dr. Miller, I appreciate your testimony.

My first question: Dr. Miller, one of the great things about the Medicare Part D program design is that it harnesses the forces of choice and competition to reduce costs while improving the options for seniors. Premiums in the program have been basically flat over the last few years, and seniors truly love the program.

I noticed that MedPAC has examined and endorsed a competitively determined Medicare planning bidding system for the future of the Medicare program. Can you talk about the merits of this approach and how it is similar to or different than the Medicare Part D or Medicare Advantage?

And then could you also explain, to what extent would it free Congress from annually having to adopt price controls to pass Medicare's fee-for-service system?

Mr. MILLER. OK.

The first thing I just need to clear up, we did not endorse it. We did publish a chapter and sort of discuss the issues. And what we were trying to do is kind of strike a balance in the policy conversation.

You could take an approach broadly in Medicare like you take in D, where you say there will be a competitively set Government contribution, and then the beneficiary would select a plan, and the plan is either a managed care plan or fee-for-service, even though that is not a plan, and then pay the difference, depending on how expensive it is. So that is the thought, I believe, you are chasing here.

And what we said is that that is a legitimate conversation that should occur, but there is a set of design issues that become extremely important here in how well this is done and how successful it is.

One right off the top that I think a lot of people miss is, in the private sector, there has been tremendous provider consolidation over the last decades. Your questions about the site-neutral payments are all about that kind of phenomenon. And to the extent that there has been greater consolidation, commercial insurers

have had a really hard time holding down payment rates because you have a very consolidated provider in certain markets.

So approaching these competitive models, you have to be very conscious of how you are going to extract reduced prices from these providers who in the private sector actually have consolidated positions. In Medicare, you have administered prices, so you don't deal with that.

Now, the technical, you know, questions about how you deal with that are probably beyond a 5-minute answer, but the first thing to keep in mind is, if these things aren't done right, they can actually cost Medicare money. But there are technical issues to navigate around that.

A couple of other issues are things like this: Do you standardize the benefit, which would say it is very clear to the beneficiary, be very clear to the Congress what they are paying for and what works and what doesn't work, or do you allow complete innovation in the benefit design, or something in between? The MA plans, you have to provide certain services, you have ability to play with the cost-sharing. And so you have to think about that.

Another big issue that you have to think about if you go down these roads is where you set the Government contribution. If you do it at a national level, then there are certain parts of the country where everybody pays, fee-for-service or managed care, and other parts of the country where everybody gets a premium rebate, for lack of a better word, whether you are in managed care or fee-for-service. If you do it within the market, that is probably a more rational way to go at it, but there is probably then some subsidization that is occurring across the country, and you will have to deal with the implications there.

So what we tried to—oh, and then—I hate that this came off as an afterthought—what are we going to do with the low-income? So if there is a premium support here, then how are the low-income going to be handled?

So what we did in this report is just blocked through a set of issues and said, if we are going to have a serious conversation about this, there have to be answers to each one of these issues. And we kind of went through the pros and cons, and we did a little simulation, very static, not high science, but a little simulation of some of the distributional impacts. And I would refer, if you want to have this conversation, refer you to that.

Mr. BILIRAKIS. Very good. Thank you very much.

In November of 2012, CBO issued a paper on the offsetting effects of the prescription drug use on Medicare spending. Basically, proper adherence to a prescription drug regimen in Medicare Part D would provide a savings from hospitalization in Medicare Part A.

Can you talk a little about this spillover effect and savings? Also, do you think that eliminating duplicative medications and proper monitoring of dangerous drug interactions could also add to savings in the Medicare program?

Mr. MILLER. I mean, we decidedly have been—we had some discussion of this on opioids just recently—decidedly concerned about overmedication and, you know, drug-to-drug interaction and that type of thing. And you want to deal with that not just for savings

reasons or even whether it saves or not; you want to focus on that because of the impact on the beneficiary.

Our research is in a little different place than CBO's. We have seen that, we have talked to them, we went through it. I believe they have done it very carefully, and there is a lot to commend it.

Our own research has somewhat more ambiguous results. We see this effect where you get the savings on the hospital side, you know, your better drug compliance reduction and hospital effect. But the hospital effect kind of goes away after 6 months, a year. And we are a bit confused by that, and we are still kind of churning on it ourselves.

You know, great if compliance—I mean, you should probably have compliance for medical and clinical and all the rest of the reasons anyway. If it has a savings effect, great. We are having a little trouble, you know, coming to the same conclusion.

Mr. BILIRAKIS. All right. Thank you.

I yield back, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the gentlelady from North Carolina, Mrs. Ellmers, 5 minutes for questions.

Mrs. ELLMERS. Thank you, Mr. Chairman.

And thank you, Dr. Miller, for being with us today.

I want to go back to some of the discussion of the site-neutrality payments. And I, again, just for the purpose of my questions, want to again clarify, has MedPAC taken a position on whether or not Congress should act on the issue of site-neutral payment reform?

Mr. MILLER. Yes, we have made two recommendations as it relates to E&M visits and then—I won't take you through all the weeds, but——

Mrs. ELLMERS. Uh-huh.

Mr. MILLER [continuing]. The 66 conditions that we carefully identified so that it didn't undercut the hospital's mission and didn't create access issues for the beneficiary and said those should be——

Mrs. ELLMERS. What is the number-one reason that we should address this policy change and reform?

Mr. MILLER. I mean, I would say—you know, I have 17 commissioners, so I don't know, but my number-one reason is that the beneficiary is out-of-pocket. If they are getting the same service——

Mrs. ELLMERS. Yes, the increased cost.

Mr. MILLER. Right.

Mrs. ELLMERS. OK. I just want to—there again, I do want to clarify that. That is what we are seeing, and it seems to be a discussion and a question of, you know, if you are receiving the same care at a facility which is an ambulatory outpatient, you know, minus the hospital, why then is the hospital charging more, I guess I would say, for the consumer.

So, now, getting back to that issue, too, back in June of 2013, the report that came out from MedPAC discussed the cost differences, especially in cardiology. And I think the question was posed at that time, have you seen this in other specialties? And for my purposes today, I am thinking about oncology. Have you also seen this cost increase in oncology?

Mr. MILLER. Right. And you made a specific request in our last hearing, and we delivered to your office a response on this very question. And this is what I was dragging up from my memory to Mr. Burgess' questions.

Mrs. ELLMERS. Uh-huh.

Mr. MILLER. We looked at oncology. We looked at radiation—divided it between radiation therapy and chemotherapy. Kind of oblique results on the radiation therapy side. On the chemotherapy side, it does look like there is an uptick——

Mrs. ELLMERS. Increase.

Mr. MILLER [continuing]. In the outpatient, which is really the billing——

Mrs. ELLMERS. Yes.

Mr. MILLER [continuing]. And, you know, some shift between the physician's office and the outpatient.

Mrs. ELLMERS. OK. Yes. Thank you. Because I am kind of coming off of what Dr. Burgess was asking you about.

I do have another question, which is kind of off my line of questioning here, but I do want to make sure that I address it. It goes in line with what my friend Congressman Shimkus was talking about, some of the issues regarding readmission—I believe it was Mr. Shimkus—the readmission within 30 days and the loss of payment if there is a readmission.

And he addressed the issue of it being possibly a different diagnosis but still receiving that loss of reimbursement. I believe you said it has more to do with the number of readmissions that that particular hospital is having.

But my understanding—and this is what I want to clarify with you—is that it can also be a readmission to a different hospital. And if it is a readmission to the different hospital, how does that process work?

And I am very concerned about this, because my understanding is that we are going to go to an increase in the number of diagnoses of readmissions.

So can you clarify or shed some light on how that process works? Does the initial hospital end up getting the ding if there is a readmission to another hospital within 30 days?

Mr. MILLER. Yes. That is correct.

Mrs. ELLMERS. OK. So there that is. OK. Great.

Next question. And this has to do with North Carolina and Medicare Advantage. I am very concerned. Medicare Advantage facing $200 billion worth of cuts through the ACA. North Carolina, 57,000 Medicare Advantage recipients are being told that their plans will not be offered in 2015.

You know, Kaiser Family Foundation has found this to be true and that other States are not facing the number of cuts to some of these plans.

Can you shed any light on that or any of your—I mean, how can my constituents deal with that, when they like their Medicare Advantage plan so much?

Mr. MILLER. Well, I can't speak to North Carolina specifically in that particular set of plans. We have documented this extensively and will do again next month at our—or, actually, next week at our public meeting.

We have continued to see 9 percent annual growth in managed care enrollment. We have seen more organizations entering. And the average numbers of plans being offered, I think, is still 9 or 10, on average, in any given market. And, of course, some markets, like Miami, have 30, and other markets have 5, but——

Mrs. ELLMERS. Uh-huh.

Mr. MILLER [continuing]. We have seen continued growth in enrollment in this program.

Why those specific plans feel that they have to pull out—and the dilemma for you and your colleagues in the Congress is you want the beneficiary to have access to the plan and have the extra benefits, but I think—and you have to decide this for yourself—you want those extra benefits to be provided because the plan is efficient relative to fee-for-service and has the extra money because they are good at what they do. If you just give them the extra benefit, then you are right back to——

Mrs. ELLMERS. Right.

Mr. MILLER [continuing]. Your debt situation.

Mrs. ELLMERS. Well, thank you, Dr. Miller.

And thank you, Mr. Chairman. I have gone over a little bit, so I apologize. Thank you.

Mr. PITTS. That is all right. The Chair thanks the gentlelady.

Now recognize the gentlelady from Tennessee, Ms. Blackburn, 5 minutes for questions.

Mrs. BLACKBURN. Thank you so much, Mr. Chairman.

And, Dr. Miller, I want to stay right with Mrs. Ellmers' thoughts on Medicare. You just talked about the 9 percent growth in enrollment in a lot of the programs. And one of the things I hear from my seniors is they are beginning to realize that, with the arrival of Obamacare, that you had about $700 billion of cuts that were made to Medicare, to the trust fund, and that that money is now being used for new Government programs that aren't for seniors.

And they are figuring this out because they are asking the questions, why is my plan being terminated, or I don't have as many options, or my copay is higher. And they are looking at this, and they have figured out that that redirection has taken place.

And, of course, they are looking at the pay-fors, and that was the across-the-board annual reductions in the growth rates of Medicare payments for hospitals. And these cuts are scheduled to continue every year permanently. And, as a result, the actuary of the Medicare program has said, basically, you have a couple of choices here; you have up to 15 percent of the hospitals could close and many hospitals could stop taking Medicare patients, or Congress can reverse the cuts and increase the rate of Medicare spending, accelerating the insolvency of the program.

So, in your view, would it be better to scrap the reductions and replace them with other policies? What would be your advice there?

Because you have constituents like Ms. Ellmers who are saying, well, we are beginning to catch the brunt of this, and then you have the hospitals, where they are facing these reductions and they are saying, well, we don't know how we are going to keep our doors open. And I will tell you, quite frankly, I have a lot of rural hospitals that deal with underserved areas.

So what is your thought there? What is the better plan?

Mr. MILLER. OK. Well, I will leave it to the Congress to decide which plan——

Mrs. BLACKBURN. Well, we would just like your insight.

Mr. MILLER. No, I will give you a couple.

Mrs. BLACKBURN. Good.

Mr. MILLER. But, remember, our role here is just to put a set of ideas in front of you and then let the Congress decide what is the right thing.

Mrs. BLACKBURN. Well, and we appreciate that.

Mr. MILLER. Right. And——

Mrs. BLACKBURN. That is what we are looking for, are those thoughts and ideas.

Mr. MILLER. Yes. And I will say two things in response to your question, because there were two things in there, I think, and maybe more, but at least two, that I teased out.

One is, on the managed care plans, regardless of whether Obamacare or whatever the health reforms to the side, the Commission looked at the managed care plans—and this is the exchange I just had here—and said, look, before 2010, every time we enrolled somebody in managed care, it cost the trust fund money. Managed care plans were actually bidding to provide the basic part A and part B benefit at a more cost than fee-for-service. These are the managed care plans who said fee-for-service is broken and we can do better, and they were actually delivering it for greater cost.

So whether there is Obamacare or whatever, the Commission's recommendation was that payment system was broken. And what we were trying to drive it to—and we believe this has happened now—managed care plans that are actually efficient, get the efficiencies, then offer the extra benefits. And we are several years down the road. Enrollment continues to increase, and plans are actually, on average—or some plans—bidding below fee-for-service, proving that they can be more efficient than fee-for-service. I want to emphasize "some plans."

So we think, our view on that, that had nothing to do with any health reform. You know, that is a different world. We were saying that about managed care.

On the fee-for-service side, where you are seeing the cuts and the concerns about hospitals, what I would say to you is we come to you, by law, you know, the law that you created for us to respond to, every year and tell you what we think is the best thing that you should do for hospitals, physicians, skilled nursing facilities, you name it.

And what we do is we look at the current law—and we are not bound by current law in our recommendations. So we have said things to take payment reductions below what is in PPACA, the Accountable Care Act, in some instances, and in other instances we have said, no, they are too low, you need to go up.

So we actually come in—and there was a statement made by the chairman, you know, we need policies that kind of think through the circumstances. And that is what we try and provide to you on an annual basis, is come to you and say, stay with the law here, go below the law here, go above the law here. And that is what we do every year in our March report. So we are trying to help you

navigate whatever your current set of circumstances are on an annual basis.

Mrs. BLACKBURN. Well, and for our constituents who now realize the cuts that Obamacare made to Medicare and how it affects their hospital and their access and the reduced rate that is going back, reimbursement rate going back to those hospitals, it is a very tangible—very tangible consequence of the implementation of this law.

And for seniors who have paid into the Medicare trust fund, this is not working well. So it is going to be worthy of a revisit, because that money is in the trust fund and it is now being used for new programs, not for programs that benefit seniors.

I yield back.

Mr. PITTS. The Chair thanks the gentlelady.

That concludes our round of questions. The Members will have follow-up questions in writing. We will submit those to you, Dr. Miller, and ask that you please respond to those promptly.

Thank you very much for your informative exchange.

While the staff sets up for the next panel, the subcommittee will take a 3-minute recess.

[Recess.]

Mr. PITTS. The subcommittee will reconvene.

And on our second panel today we have Mr. Chris Holt, director of healthcare policy, American Action Forum—welcome; Mr. Marc Goldwein, senior policy director, the Committee for a Responsible Federal Budget; and Dr. Judy Feder, professor of public policy, Georgetown Public Policy Institute.

Thank you all for coming. Your written testimony will be made a part of the record. You will each have 5 minutes to summarize your testimony.

And, Mr. Holt, we will start with you. You are recognized for 5 minutes to summarize.

STATEMENTS OF CHRISTOPHER W. HOLT, DIRECTOR OF HEALTH CARE POLICY, AMERICAN ACTION FORUM; MARC GOLDWEIN, SENIOR POLICY DIRECTOR, COMMITTEE FOR A RESPONSIBLE FEDERAL BUDGET; AND JUDY FEDER, PROFESSOR OF PUBLIC POLICY, GEORGETOWN PUBLIC POLICY INSTITUTE

STATEMENT OF CHRISTOPHER W. HOLT

Mr. HOLT. Thank you, Mr. Chairman, members of the committee. It is certainly an honor to be asked to testify before Congress but particularly for me this subcommittee. With my past work with Representative Murphy and with the committee, having had the opportunity to work with many of you and to come to understand the dedication that you and your staff bring to the important issues that this committee deals with makes this a very humbling opportunity for me, and so I thank you very much for that.

My written statement details some modeling that we have done on Affordable Care Act provisions that—spending provisions that we could dial up or dial down in order to generate some savings. That modeling I am happy to go into if people have questions. I think that those savings could be used to pay for other spending priorities. But I was hoping to take a step back and maybe talk a

little more broadly today about the topic that we are here to discuss.

When I arrived in D.C. 10 years ago as a congressional intern, we had a Federal debt of about $7 trillion. As we all know, today the Federal debt is now past $18 trillion.

We can point fingers and try and lay blame, but the reality is that this is not entirely the fault of one party or the other; we have gotten here together. And I think you can see that if you look at the immediate last two Presidencies. During the Presidency of George W. Bush, we saw the national debt double, and under this Presidency of Barack Obama, we are flirting with doing that again.

So we can argue about whether or not we have a spending problem or a revenue problem, but I hope that we can agree that we have a debt problem.

And while we all have, I am sure, our pet peeves for what is driving that debt accumulation, the 800-pound gorilla in the Federal budget is mandatory spending, which makes up 60 percent of the Federal budget, and, in particular, mandatory spending on health programs, which is about 30 percent of all Federal spending. As this spending continues to grow, it is crowding out discretionary spending, things like defense but also things like funding the NIH.

And so, as we look at that, unfortunately, rather than addressing that looming entitlement crisis, President Obama chose to focus on passing the Affordable Care Act. In doing so, he expanded spending in the Medicaid program and put more people into that broken program.

He also created an entirely new entitlement, these subsidies for the under-65 population available through the health insurance marketplace, and then, all the while, largely ignoring Medicare beyond the $700 billion in cuts that were used to pay for the other priorities, particularly cuts to Medicare Advantage and also to home health.

As we look to the 114th Congress, I think we can recognize that the big policy agenda items that conservatives seek—repealing and replacing the Affordable Care Act, large-scale Medicare and Medicaid reform—are likely out of reach, but we can and should take the opportunities that present themselves to move towards those goals.

And so, in particular, as Congress looks at the entitlement spending, both new and old, that continues to grow, I would remind you that the Budget Control Act has largely left the ACA unscathed. And, as such, I think it is appropriate that, as Congress looks to fund other health priorities, particularly the SGR reform that is coming up, that we can look to the ACA as a mechanism by which those other priorities can be paid for.

And then, finally, briefly, I would say, with an eye towards long-term fiscal priorities, I urge Congress to protect the Medicare Part D and the Medicare Advantage programs. These are excellent blueprints for how entitlements could be structured and should be structured, and they provide a roadmap for moving past the fee-for-service Medicare system today.

And, with that, I am happy to take your questions.

[The prepared statement of Mr. Holt follows:]

Fiscal Priorities in the 114th Congress: Restoring Balance to Federal Health Spending

United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

December 9, 2014

Christopher W. Holt*
Director of Health Care Policy
The American Action Forum

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* The views expressed here are my own and not those of the American Action Forum. I thank Angela Boothe and Conor Ryan for their assistance.

Chairman Pitts, Ranking Member Pallone and members of the Subcommittee, thank you for the opportunity to testify regarding fiscal priorities in the 114th Congress. As a major driver of federal spending, our health care system must be central to this discussion. I would like to make three main points today regarding the fiscal future of the health care system in the 114th Congress.

- First, the expansive spending created by the Affordable Care Act (ACA) will continue to generate fiscal issues for years to come. The ACA was left largely untouched by the Budget Control Act, resulting in unrestrained spending in some of health care's most expensive programs. Next year Congress should rein in this spending and subject the ACA and Medicaid to cost saving reforms.

- Second, making reforms within the exchanges and cutting back on ACA spending will create savings; some of which should be utilized to ensure a sustainable Medicare program for seniors well into the future. In order to preserve Medicare for the next generation, big policy changes must occur, and savings generated through scaling back the excesses of health reform can help pay the way.

- Finally, decreasing ACA spending and applying some of these savings to Medicare reform is just part of the fiscal priorities conversation. Any change undertaken should lay a foundation for a more efficient health care system, and the 114th Congress should work to towards that ultimate objective by focusing on achievable goals in the present.

Reining in ACA Spending

ACA exchange subsidy related spending alone is estimated to cost over one trillion from 2015-2024.[1] Spending on subsidized insurance through the health insurance exchanges, excessively high Medicaid matching funds for the expansion population and other provisions in the ACA will continue to exacerbate our fiscal woes in future years. Congress should prioritize reasonable reductions in the funding for health insurance programs that are currently unsustainable. The American Action Forum (AAF) has examined a few policy options for more targeted spending that will also generate some savings.

Reworking Premium Assistance
Much of the ACA's spending comes from the premium assistance (subsidies) offered through the health insurance exchanges. As a major facet of the legislation, the health insurance exchanges completely remade the individual health insurance market. The Congressional Budget Office (CBO) estimates that $17 billion will be spent in 2014 distributing subsidy dollars; and this spending will only continue to grow. CBO estimates that enrollment will grow to 13 million in 2015, 24 million in 2016 and reach up to 25 million by 2024, costing the federal government $1.032 trillion over the next decade.

In general, subsidies are available to individuals and families between 100 percent and 400 percent of the federal poverty level (FPL).[2] This income range allows for a family of four making as little as $23,850 a year (at 100 FPL) or as much as $95,400 a year (400 percent of

FPL) to receive assistance with their monthly premium. Meanwhile the median family income in the United States was $65,587 in 2013.[3] These subsidy dollars should be targeted, and limited to, those who really need them. The income eligibility level for receiving subsidies can be decreased, while still providing for those families truly in need of assistance. Higher income families would still have the option of exchange plan coverage, but not at the taxpayers' expense.

A more targeted subsidy eligibility range would generate significant savings. AAF estimates[4] that a decrease in subsidy eligibility levels could decrease federal spending by as much as $181 billion from 2015-2023.[5] The following chart demonstrates the savings associated with various decreases in subsidy income eligibility levels:

Table 1: Shifting Subsidy Eligibility Levels and Resulting Decrease in Federal Budget Deficit 2015-2023

Federal Poverty Level for Exchange Subsidy Eligibility	Reduction in the Federal Budget Deficit
400 percent FPL	$0
375 percent FPL	$43 billion
350 percent FPL	$88 billion
300 percent FPL	$181 billion

Increasing the Applicable Income Percentage in Exchanges
Another area where potential savings exist is within the applicable percentage of an individual's income used to determine the contribution to an insurance premium. Currently for individuals making between 100-400 percent FPL, the percentage of their income that is required to go toward purchasing health insurance is on a sliding scale, with individuals earning an income at 100 percent FPL required to contribute 2 percent of their income toward health insurance premiums and those making 400 percent of FPL required to contribute 9.5 percent of their income.[6]

If this sliding scale were shifted to require some individuals to contribute more to their monthly insurance premiums, the federal deficit could decrease by $110 billion from 2015-2023. Shifting the scale upward for individuals making 200-400 percent FPL would generate savings while avoiding increases in cost for low income families in the 100-200 percent FPL range.

In AAF estimates, the applicable income percentage for households that earn between 200 percent and 400 percent of FPL would be moved from a range of 6.3 percent to 9.5 percent to a range of 6.3 percent to 12 percent. The increase would be incremental, raising the contribution for households that earn 250 percent FPL from 8.05 percent to 9 percent, those earning 300 percent of FPL from 9.5 percent to 10 percent, and those earning 400 percent of FPL from 9.5 percent to 12 percent. Though the changes to income contributions are small, the overall savings generated could make a significant dent in federal ACA spending in the exchanges.

Decreasing Medicaid Spending
The ACA allows for the expansion of the Medicaid program to higher income levels and provides historically high federal matching funds for those newly eligible for Medicaid under the expansion. Today, one in five individuals is covered under Medicaid, a number that will continue

to grow if more states opt to expand their Medicaid income eligibility levels as prescribed by the ACA. Medicaid spending is projected to reach $570 billion by 2024 under the ACA, in part due to the large increase in the Federal Medical Assistance Percentage (FMAP) for expansion population Medicaid beneficiaries.[7] The FMAP for the expansion population in 2014 was 100 percent, meaning that the federal government covered 100 percent of the cost of Medicaid beneficiaries made newly eligible under the ACA.

The expansion population FMAP should be a key point of review in the next Congress while looking for opportunities to decrease spending in the ACA. The expansion FMAP is set at an unreasonably high level—never falling below 90 percent—whereas the average FMAP for the legacy Medicaid program hovers around 57 percent.[8] The high matching rate for this population is an incentive for states to prioritize the enrollment of higher income, newly eligible individuals at a lower cost to state budgets than other Medicaid beneficiaries. As a result, there is reasonable concern that states will cover higher income individuals while some of the most vulnerable, lowest income individuals remain on Medicaid waiting lists.

Medicaid expansion matching rates will decline from 100 percent to 95 percent in 2017, to 94 percent in 2018, 93 percent in 2019, and finally to 90 percent in 2020. However, a 90 percent federal share of Medicaid spending is still unsustainable in perpetuity, and a bifurcated FMAP based on income level is unnecessary and bureaucratic. While bringing the FMAP for expansion populations in line with states' traditional FMAP would make the most sense, even moderate reductions in the expansion FMAP will generate savings. If the scheduled decline is accelerated and the match is further decreased to 85 percent by 2020, federal Medicaid spending could be greatly decreased. Taking the FMAP rate from 100 percent to 95 percent in 2017, 90 percent in 2018, and finally to 85 percent in 2019, could reduce the federal budget deficit by $23 billion from 2015-2023.[9]

Making the Exchanges More Competitive

One smaller change to the structure of certified plans in the exchange—known as qualified health plans (QHP)—would allow for plan issuers to design more products at more competitive prices. AAF estimates that providing the option of catastrophic coverage for all ages will result in savings for the federal budget.

In order to purchase a catastrophic plan, individuals must be under thirty years of age. These plans are only designed to provide coverage for high cost health care needs, and most other services must be paid out of pocket by the beneficiary.[10] As a result, subsidies are not provided to individuals who purchase these plans and who would otherwise be eligible for subsidies based on their income. Eliminating age limits on individuals who wish to purchase a catastrophic plan would allow for a decrease in subsidy spending because additional individuals would move to the unsubsidized catastrophic plan if given the option. AAF estimates this small legislative change could result in savings of $16 billion from 2015-2023.

Utilizing Savings to Preserve Medicare

In outlining fiscal priorities for the 114th Congress, the Medicare program should be placed at the top of the list along with ACA reforms. Medicare spending continues to climb, totaling $3.4

trillion in projected federal spending between 2015 and 2019, and policymakers must come to an agreement on payment reforms for the program.[11]

One answer to these continued issues could be changes to the ACA. The savings generated by cutting back on some of the ACA's spending provisions could be leveraged toward a sustainable, viable Medicare program for the next generation. The sustainable growth rate (SGR) must be remedied, and successful entitlement reforms such as Medicare Advantage and the prescription drug benefit known as Medicare Part D should be reinforced as mechanisms to preserve Medicare.

The Sustainable Growth Rate
In March of next year, Congress will again be forced to address SGR. Legislation must be passed that either ends SGR permanently or continues to avoid deep cuts to physician reimbursement.

In recent years, the SGR has been patched to avoid steep cuts.[12] The latest pieces of legislation passed avoided scheduled 24 percent cuts to provider reimbursements, and extended funding with a 0.5 percent increase in physician payment rates. The SGR was designed to control Medicare physician reimbursements, but has instead continued to stifle other federal entitlement reforms because it must constantly be addressed.

For the last decade the SGR cuts have been stopped or altered for fear of losing physician participation in Medicare. However, providing a permanent fix to the SGR comes at a cost. CBO estimates that permanently ending SGR would cost an estimated $118.9 billion.[13] While there is an ongoing debate about the degree to which a permanent SGR fix needs to be offset, the savings generated from the ACA policy changes laid out above could be put toward offsetting some of the cost of overhauling Medicare physician reimbursement policies.

Safeguarding MA and Part D
Along with the financing for SGR repeal, a fiscal priority of the next Congress should be preserving Medicare Advantage (MA) and Medicare Part D.

Medicare Part D is an example of a health care program that has benefited both the federal budget and beneficiaries. The program continues to come in under budget due to its competitive, market-based structure.[14] Earlier this year, this successful benefit came under regulatory attack, threatening to completely undermine the success of the program.[15] The proposed rule would have cost the program up to $10 billion over the next ten years, placing a further burden on the federal budget for Medicare spending. Fortunately, the proposed rule was not finalized, but the risk for increased program costs and increased costs to beneficiaries remains if the administration again seeks to alter the program.

MA was the victim of large cuts under the ACA, in order to offset new spending on subsidy dollars for those enrolling in exchange coverage. As a private sector alternative to the expensive Medicare Fee for Service (FFS) model, MA plan reimbursement cuts will translate directly into decreased benefits for Medicare beneficiaries.[16] According to AAF research, the ACA cuts to MA reimbursement combined with regulatory policy changes will result in an average of $1,538 in lost benefits per MA enrollee in 2015 as compared to pre-ACA levels. It is entirely

appropriate for the next Congress to work to shore up this vital bridge to a post-FFS Medicare using savings derived from the ACA.

Setting Achievable Health Care Goals

Along with preserving key parts of the Medicare program and decreasing ACA spending, smaller goals can be accomplished as well. For example, pieces of the ACA that are unpopular on both sides of the aisle can be eliminated—such as the medical device tax and the independent payment advisory board (IPAB)—and health savings accounts (HSA) should play a larger role in exchange plans.

Most importantly, small, tangible accomplishments can serve as first steps in creating a more market driven health care system. The removal of the medical device tax will encourage innovative device makers to continue operations in the US, and the greater inclusion of HSAs in exchange plans will provide an incentive for consumers to pay closer attention to the health care services they utilize.

Coming to agreements on some provisions of health reform early will set the stage for a productive 114th Congress. It can also create a positive atmosphere for the more significant challenges to come; priorities such as SGR and—even further out—a social security disability insurance (SSDI) solution. In preparation for next year, health care spending will be a continued concern. In setting fiscal priorities for health care, Congress should start with small reforms to the ACA that have the potential for real savings.

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[1] https://www.cbo.gov/sites/default/files/45231-ACA_Estimates.pdf
[2] http://americanactionforum.org/weekly-checkup/aca-subsidy-verification-minefield
[3] https://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-249.pdf
[4] All American Action Forum cost estimates in this testimony were performed using a health insurance microsimulation model originally published by Stephen Parente: Parente, S.T., Feldman, R. "Micro-simulation of Private Health Insurance and Medicaid Take-up Following the U.S. Supreme Court Decision Upholding the Affordable Care Act." Health Services Research. 2013 Apr; 48(2 Pt 2):826-49.
[5] The Congressional Budget Office scored this policy option in November, 2013 and found that it would reduce the deficit by $109 billion. The primary difference in the CBO estimate is a prediction that employer sponsored insurance enrollment will increase by about 4 million, leading to larger tax expenditures. (In fact, they estimate that savings from subsidies to $182 billion over the same time period, which is offset by decreased revenues through the ESI tax exclusion.) Our model does not predict any meaningful change in ESI enrollment.
[6] http://aspe.hhs.gov/HEALTH/REPORTS/2014/PREMIUMS/2014MKTPLACEPREMBRF.PDF
[7] https://www.cbo.gov/sites/default/files/45231-ACA_Estimates.pdf
[8] http://kff.org/health-reform/issue-brief/medicaid-financing-an-overview-of-the-federal/
[9] As estimated by the American Action Forum.
[10] https://www.healthcare.gov/choose-a-plan/catastrophic-plans/
[11] https://www.cbo.gov/sites/default/files/45653-OutlookUpdate_2014_Aug.pdf. pg 12.
[12] http://americanactionforum.org/research/primer-the-sustainable-growth-rate
[13] https://www.cbo.gov/sites/default/files/cbofiles/attachments/49770-SGR-Menu.pdf. Estimate based on freezing payment rates through 2024.
[14] http://americanactionforum.org/research/competition-and-the-medicare-part-d-program
[15] http://americanactionforum.org/research/cms-rulemaking-and-medicare-part-d-stifling-innovation-limiting-access-and
[16] http://americanactionforum.org/research/medicare-advantage-cuts-in-the-affordable-care-act-april-2014-update

Mr. PITTS. The Chair thanks the gentleman.

Now recognize Mr. Goldwein, 5 minutes for an opening statement.

STATEMENT OF MARC GOLDWEIN

Mr. GOLDWEIN. Thank you, Chairman Pitts, Ranking Member Pallone, and other distinguished members of the committee, for inviting me to testify on this important issue.

I would like to focus my remarks this morning on two subjects. First, I would like to make the case for the importance of continuing to focus on slowing Federal healthcare cost growth. And, second, I would like to discuss the policies which I believe have the best chance of making healthcare spending both more effective and more affordable.

I have spent the bulk of my career working with bipartisan efforts to put the debt on a more sustainable path. I worked on the staff of the Simpson-Bowles Fiscal Commission, the Hensarling-Murray Supercommittee, and with a number of Hill offices on an informal basis. Every one of those efforts to stabilize the debt has put identifying reforms to slow the growth of health spending front and center as the central issue.

Unfortunately, the combination of the recent fall in the short-term deficit and the tremendous slowdown in healthcare cost growth has led some to conclude that Medicare and Medicaid reforms are no longer necessary. In my view, this couldn't be further from the truth, especially considering our debt levels are currently at record highs only seen around World War II and are continuing to grow unsustainably if you look into the future. The slowdown in Medicare and in health spending more broadly is hugely encouraging but, for a variety of reasons, should not be used as an excuse to stop reforms.

My written testimony explains this in more detail, but, first of all, a large share of the recent slowdown is due to temporary factors. These include economic and demographic factors, one-time legislative cuts like sequestration, and other temporary events like the recent prescription drug patent cliff that we are sort of falling off right now.

Secondly, the portion of the slowdown which is structural and permanent, some of it is probably because providers expect future changes in fee-for-service, which means, without further congressional action, they will revert and we will lose the gains we have made so far in the slowdown.

Third, slowing healthcare cost growth will not be enough to keep Federal health spending itself under control. The reason is that the primary driver of Federal health spending over the next quarter-century is not actually healthcare cost growth but it is population aging. As a result, the Congressional Budget Office projects that healthcare spending as a share of GDP, Federal healthcare spending, will more than double by the early 2050s, possibly sooner.

And, finally, Congress and the President will have to identify health savings early next year in order to offset either a temporary doc fix or, preferably, a permanent SGR fix—a permanent SGR reform. After all, we have offset 98 percent of doc fixes in the past

and, as a result, generated $165 billion worth of savings, mostly from within the healthcare system.

Now, as Congress does look for savings, there are a number of policies which have the potential for broad bipartisan support. At CRFB, my organization, we like to categorize these savings as benders, savers, or structural reforms. And my advice to this subcommittee is to focus first and foremost on the cost benders, those policies which will structurally change the incentives within Medicare and Medicaid in order to slow the growth of healthcare spending overall, not just shift who bears the burden.

Now, these benders can't offer a free lunch. They can't offer a situation where everybody is better off. But what they can do is offer a discounted lunch, where as a society we are better off and where the winners far outweigh the losers.

CRFB, my organization, the Committee for a Responsible Federal Budget, recently released a plan we call the Prep Plan, which identified a number of these benders and used them to pay for the very thoughtful SGR reform that came out of this committee, along with Ways and Means and Finance.

On the beneficiary side, we included reforms very similar to the MedPAC recommendation. And I want to emphasize that if you modernize Medicare cost-sharing, you can save money for both the taxpayer and the beneficiary. Our plan would save $80 billion over 10 years for the Federal budget and reduce beneficiaries' out-of-pocket costs by about $200 per person per year.

Our plan also looks to change the incentives on the provider side, including by moving to more bundled payments, increasing penalties for unnecessary hospital readmissions, encouraging doctors to administer lower-cost prescription drugs, and rewarding States that move to more efficient payment models within Medicaid.

In addition to these and other benders, which, again, are in my written testimony, you are going to have to look at what we call savers. Now, these are policies where we will save money for the Federal Government by allocating it in a way that is preferable.

There are already a number of these savers that have bipartisan support: increased means testing for Medicare premiums, reductions to certain overpayments to providers, and clamping down on certain scams or certain games played by States in order to increase their Medicaid matches.

You are going to have to look at all of these policies carefully, along with others outside of the health arena, if we truly are to get our health system and our debt under control. There is no magic bullet, but there is an opportunity to work together on a bipartisan basis and begin making reforms now to give us a better healthcare system at a better price.

Thank you for allowing me to testify on this important topic, and I look forward to working with all of you and your staffs.

[The prepared statement of Mr. Goldwein follows:]

Hearing before the House Committee on Energy and Commerce, Health Subcommittee
"Setting Fiscal Priorities: Reforming Health Spending and Strengthening Our Future"
December 9, 2014

Testimony of Marc Goldwein
Senior Policy Director, Committee for a Responsible Federal Budget

Chairman Pitts, Vice Chairman Dr. Burgess, Ranking Member Pallone, and other members of the Subcommittee:

Thank you for inviting me to discuss how our country can best reform and improve our Medicare and Medicaid programs. The fiscal challenges we face as a nation are immense. Despite the recent slowdown in health care cost growth, making additional reforms to Medicare and Medicaid is of central importance to keeping future health care cost growth under control and putting our debt on a sustainable long-term path. Moreover, there are a number of common-sense improvements to Medicare and Medicaid that I believe could and should receive bipartisan support. Thank you for holding this hearing and for inviting me to share my thoughts on these improvements.

I am Marc Goldwein, Senior Policy Director of the Committee for a Responsible Federal Budget (CRFB). CRFB is a non-partisan organization dedicated to educating the public on matters of fiscal importance. Our organization is chaired by former Congressmen Charlie Stenholm, Jim Nussle, and Tim Penny, and the board is made up of past directors of the Office of Management and Budget, the Congressional Budget Office, the Federal Reserve System, the Treasury Department, and the Budget Committees, as well as many of the top experts on budget issues. Until his passing last month, Congressman Bill Frenzel – who served in this body honorably for two decades – also chaired CRFB.[1]

In addition to my work at CRFB, I served as Associate Director of the National Commission on Fiscal Responsibility and Reform (the Simpson-Bowles Fiscal Commission) and as a Senior Budget Analyst for

[1] See http://www.crfb.org/ for more information about the organization.

the Joint Select Committee on Deficit Reduction (the Hensarling-Murray Super Committee), and I have been involved in a number of other bipartisan efforts which have worked to reform and slow the growth of the nation's health care programs.

CRFB also has recently released its own plan – the Paying for Reform and Extension Policies Plan (or the **PREP Plan**) – that would pay for a permanent reform to the Sustainable Growth Rate formula with changes designed to improve incentives within the Medicare program.[2]

Based on my work in these various efforts, it has become increasingly clear that there are no easy choices in health reform, and few if any changes that produce all winners and no losers. Given the vast inefficiency and misaligned incentives in the health care system, however, it is certainly possible to identify reforms that create more or bigger winners than losers by improving the way we deliver and consume health care and reforms that allocate resources to where they are needed most.

Before discussing these policies, I would like to offer some brief context on the country's fiscal situation.

The national debt is currently at a record high and at a level seen only once before as a share of the economy – for a brief period around World War II. Although our annual deficits have indeed declined by about two-thirds since 2009, that decline follows a nearly ***800 percent*** increase brought on by the Great Recession and largely reflects the slow but increasingly apparent economic recovery.[3]

Under current law, deficits are projected to bottom out in 2015 and return to above $1 trillion less than a decade later. Assuming Congress and the President choose to renew the expired tax extenders and

[2] For details, read CRFB's "PREP Plan: Paying for Reform and Extension Policies," November 2014. http://crfb.org/document/prep-plan-paying-reform-and-extension-policies

[3] See CRFB, "Deficit Falls to $483 Billion, But Debt Continues to Rise," October 2014 http://crfb.org/document/report-deficit-falls-486-billion-debt-continues-rise

various other provisions, deficits will never be as low as they were in 2014 and could exceed $1.5 trillion by 2025.[4] As a percent of GDP, deficits will rise to between 4 and 6 percent by 2025.

Under either scenario, debt will exceed the size of the economy sometime in the 2030s and will double the size of the economy between 2045 and 2080 as health and retirement spending continue to grow while revenues do not keep up. According to the Congressional Budget Office (CBO) and most experts, this rise in debt will crowd out productive investment, slow long-term economic growth, raise interest rates throughout the economy, reduce the government's ability to address new needs or respond to emergencies, and increase the fiscal and economic burden on future generations. Ultimately, ever growing debt levels would be unsustainable and, if not stopped proactively, would create the need for abrupt and painful austerity, cause a harmful fiscal crisis, or both.[5]

Avoiding these adverse effects will require addressing the largest and fastest growing components of our budget – Social Security, Medicare, Medicaid, and other health spending – in addition to raising more revenue. Attention on federal health spending is particularly important, since Medicare and Medicaid spending alone has grown from 1.9 percent of GDP in 2000 to 4.8 percent today, and is projected to reach 8.5 percent of GDP by 2050. Meanwhile, discretionary budgets are *declining* as a share of GDP, and revenue is rising, but not fast enough.

The bottom line is that our debt is high and growing, and it will be almost impossible to reverse that trend without addressing the growth of federal health spending.

I would like to make four main points in my remarks today:

1. **Despite the recent slowdown in health care spending, it remains incredibly important that policymakers pursue reforms to reduce future projected health care costs.**

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[4] Ibid.

[5] See Congressional Budget Office, "The 2014 Long-Term Budget Outlook," Page 19. July 2014. www.cbo.gov/sites/default/files/45471-Long-TermBudgetOutlook_7-29.pdf#page=19

2. **Policymakers should focus first and foremost of health cost "Benders" that would improve incentives in order to slow the overall growth of health care spending.**
3. **Policymakers should next look to health cost "Savers," which reduce federal costs by better allocating resources within the federal health programs.**
4. **Given the aging of the population, health reforms will be necessary but not sufficient to put the debt on a sustainable long-term track.**

Our Health Care Cost Problems are Far From Solved

The recent slowdown in health care spending has been impressive, and should be greeted as welcomed news for those concerned about our long-term fiscal situation. At the same time, however, this slowdown should *not* be used as an excuse to delay or desist efforts to reform the Medicare and Medicaid programs.

So far this year, national health expenditures have grown by only 4.7 percent over last year despite the expansion of health coverage from the Affordable Care Act.[6] More relevant for our purposes, Medicare spending last fiscal year grew by only 2.7 percent – the fourth lowest growth rate in history – despite a 3.8 percent increase in in the number of beneficiaries.[7] In other words, per beneficiary costs have actually *shrunk* in nominal terms, despite relatively normal levels of inflation and economic growth.

In large part because of these recent trends, the Congressional Budget Office (CBO) has revised down its future health care cost projections significantly. The agency now projects Medicare spending between 2012 and 2021 to be more than $500 billion lower than projections they made in March of 2011.[8]

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[6] Altarum Institute, "Health spending continues moderate growth through third quarter," November 2014. http://altarum.org/sites/default/files/uploaded-related-files/CSHS_SpendingBrief_November2014_04.pdf

[7] CRFB, "Medicare Registers Fourth Lowest Growth Rate in Program History in 2014," October 2014. http://crfb.org/blogs/medicare-registers-fourth-lowest-growth-rate-program-history-2014.

[8] Loren Adler and Adam Rosenberg, "The $500 Billion Medicare Slowdown: A Story About Part D," *Health Affairs*, October 2014. http://healthaffairs.org/blog/2014/10/21/the-500-billion-medicare-slowdown-a-story-about-part-d/

Both the current slowdown and projected future slowdown represent reasons for hope. But for a number of important reasons, they should not be used an excuse to abandon further health reform efforts. ***Indeed, the Congressional Budget Office still projects that federal health care spending – which consumed 3 percent of GDP in the year 2000 – will grow from less than 5 percent of GDP today to above 6 percent in 2025, 9 percent in 2050, and more than 13 percent by 2085.***

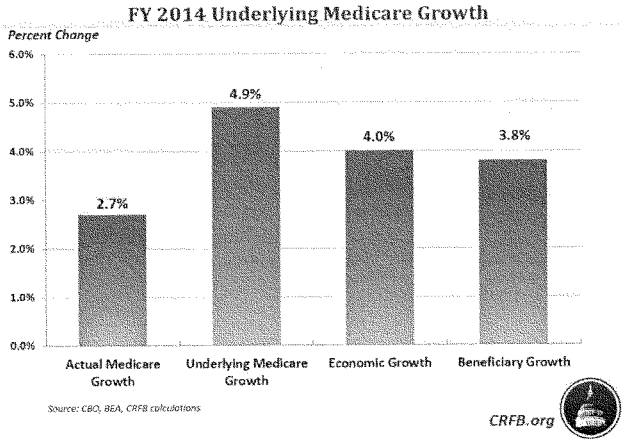
The below discussion focuses on why the recent *Medicare* slowdown is not a reason to abandon health reforms, but the same is largely true for other federal health programs.

A Large Portion of the Slowdown is Likely Temporary

No one fully understands what is driving the slowdown in Medicare spending, and experts disagree on its root causes. At this point, it seems clear that at least some portion of the slowdown represents a structural change in the growth rate of Medicare. However, evidence suggests that a good portion of the slowdown is also due to one-time factors that are unlikely to continue in the future. These one-time factors are legislative, demographic, economic, and idiosyncratic.

Legislative Causes. A portion of the slowdown in the Medicare growth rate is the result of one-time cuts legislated in the Medicare program. Specifically, the Affordable Care Act included a number of reductions to provider and Medicare Advantage payments that went into effect in the last couple years. In addition, the "sequestration" resulting from the failure of the Super Committee reduced most Medicare spending by 2 percent. Our analysis of the growth in Medicare spending between 2013 and 2014 found that when you remove these legislative factors, the underlying growth rate of Medicare was 4.9 percent rather than 2.7 percent.[9] Importantly, this still suggests a reduction in inflation-adjusted per beneficiary Medicare costs, but not nearly as large as the headline number.

[9] See footnote 5.



Demographic Causes. As the baby-boom population enters Medicare, it reduces the average age of Medicare beneficiaries. Younger Medicare beneficiaries in their 60s, not surprisingly, tend to have lower annual health care costs than those in their 70s, 80s, and 90s. According to a working paper by Michael Levine and Melinda Buntin at CBO ("the CBO working paper"), the increase in younger Medicare beneficiaries accounted for about ten percent of the slowdown between 2000-2005 and 2007-2010.[10] Unfortunately, this trend will reverse and worsen as the Baby Boomers age into their 80s and 90s over the next few decades.

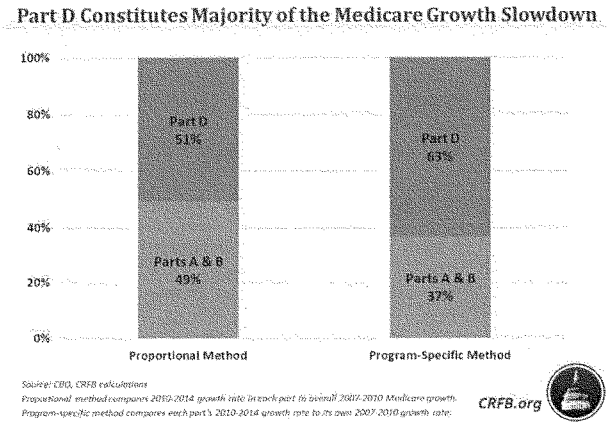
Economic Causes. The "great recession" and accompanying low GDP growth and inflation have likely played a substantial role in slowing overall health care costs in the United States as well as most other developed nations.[11] The CBO working paper attributes as much as one-eighth of the slowdown in

[10] Michael Levine and Melinda Buntin, "Why Has Growth in Spending for Fee-for-Service Medicare Slowed?" August 2013. http://www.cbo.gov/publication/44513

[11] For example, see David Squires, "The Global Slowdown in Health Care Spending Growth," *The Journal of the American Medical Association,* August 2014. http://jama.jamanetwork.com/article.aspx?articleid=1885447. Also see Margot Sanger-Katz. "The Global Slowdown in Medical Costs," *The New York Times*, July 2014. http://www.nytimes.com/2014/07/17/upshot/the-global-slowdown-in-medical-costs.html?abt=0002&abg=1&_r=0

Medicare Parts A & B spending to these economic factors, and the fact that Medicare is tracking National Health Expenditures to some degree suggests the possibility that some additional portion of the slowdown (the CBO working paper cannot explain 75 percent) is related to the economic slowdown.

Idiosyncratic Causes. A number of changes occurring in the Medicare program might represent one-time rather than permanent changes in the program's growth rate. Most notably, a large portion of the slowdown appears to be due to the "patent cliff," in which a number of expensive blockbuster prescription drugs happen to be coming off patent all in a short period of time. Medicare Part D represents only around one tenth of the Medicare program, yet according to analysis from my colleagues Loren Adler and Adam Rosenberg, it is responsible for between half and two thirds of the slowdown.[12] The disproportionate role played by Medicare Part D happening at the very same time as the patent cliff represents yet more evidence that a portion of the slowdown may prove temporary.



The Slowdown May Depend on Future Health Reforms

[12] See footnote 6 and CRFB, "Another Way to Look at the Medicare Slowdown," October 2014. http://crfb.org/blogs/another-way-look-medicare-slowdown

Somewhat paradoxically, a portion of the slowdown may be a result of what health providers *expect* federal policy to be rather than what it is. There is increasing evidence of structural changes in the way health care is being delivered, despite such changes not always reflecting the incentives currently in place. For instance, a recent analysis from Catalyst for Payment Reform found private payments through value-oriented payment models have quadrupled since last year to 40 percent of all payments.[13] Similar shifts away from pure fee-for-service reimbursement are beginning to happen in Medicare as well with the growth of Accountable Care Organizations. Yet there is little evidence this shift is very profitable for providers.

One explanation is that providers are beginning to slowly shift away from fee-for-service today in anticipation of further changes in Medicare payment systems, and the effect that might have on private reimbursement schemes. To the extent this is true, maintaining the health care slowdown will require public policy to realize these expectations. As former CBO and OMB director Peter Orszag has argued, the slowdown suggests "policy makers should be more aggressive in moving Medicare away from fee-for-service payments," not less.[14]

With An Uncertain Slowdown, Declaring Victory is Premature

Although it is possible the CBO and others are overstating future Medicare cost growth, it is also possible they are understating its growth. The fact that experts cannot agree on the causes of the slowdown – and even the CBO working paper fails to explain 75 percent of it – suggests that policymakers should proceed with caution. Medicare reforms tend to phase in savings slowly. If it turns out Medicare cost growth slows much further than currently anticipated, it will be easy to return the

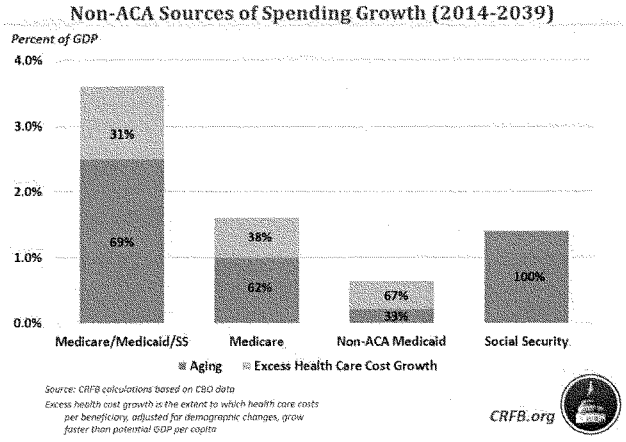
[13] Suzanne Delblanco, "The Payment Reform Landscape: Value-Oriented Payment Jumps, And Yet ..." *Health Affairs,* September 2014. http://healthaffairs.org/blog/2014/09/30/the-payment-reform-landscape-value-oriented-payment-jumps-and-yet/

[14] Peter Orszag, "Yes, We Can Trim Medicare Spending," *Bloomberg View*, February 2014. http://www.bloombergview.com/articles/2014-02-11/yes-we-can-trim-medicare-spending

gains in the form of better Medicare coverage, more generous provider payments, lower Medicare premiums, lower taxes, higher spending on other important programs, and/or a lower national debt. However, if Medicare spending grows faster than projected, the steps taken to keep Medicare's growth under control will have been all the more important and hopefully will allow lawmakers to learn from those steps to pursue further reforms.

Aging Represents the Primary Driver of Growing Entitlement Costs

Even a sustained slowdown in health care cost growth is unlikely to keep debt from rising because health care costs alone are not driving the growth in entitlement spending. In fact, projected health care cost growth is not even the primary cause of growth in entitlement spending over the next quarter century. According to CBO, "excess cost growth" – the amount by which health costs grow faster than GDP per capita – is responsible for only 30 percent of the non-ACA spending increases over the next quarter century. The remaining 70 percent is the result of population aging, both from the retirement of the baby



boom population and continued increases in life expectancy. Even removing Social Security, population aging is responsible for 55 percent of non-ACA spending growth over the next 25 years.[15]

The fact that aging is responsible for such a large portion of spending growth suggests that no realistic slowdown in per capita health spending will be sufficient to keep total entitlement spending from rising as a share of GDP. Indeed, a recent analysis from Alan Auerbach, Bill Gale, and Benjamin Harris found that even with 0 percent excess cost growth, debt would continue to grow as a share of GDP.[16] As a result, policymakers will either need to slow per capita federal health care cost growth to below GDP growth, mitigate the effects of the aging population (which I will explain later), increase tax revenue, reduce other spending, or do some combination. And the fact that discretionary spending has already been cut so significantly, and revenue will rise above historic levels (though well below where it was when we last balanced the budget) suggests fewer available options than just a few years ago.

Policymakers Must Fix the SGR and Hospital Insurance Trust Fund

Even if Medicare cost growth were no longer a threat to the federal debt situation, there remains a need to identify reforms in order to comply with several important budgetary rules. Most immediately, physicians face a 21 percent cut in payments this April as a result of the Sustainable Growth Rate (SGR). A one-year "doc fix" to avoid this cut would cost about $15 billion, which would need to be fully offset to comply with Pay-As-You-Go (PAYGO) rules and avoid adding to the debt. A permanent fix, depending on the details, could cost anywhere from $120 to $180 billion.[17]

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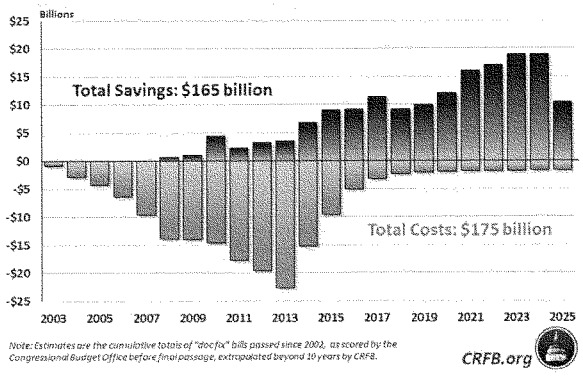
[15] CRFB, "Drivers of the Debt: Aging in the Medium Term, Health Costs over the Long Term," July 2014. http://crfb.org/blogs/drivers-debt-aging-medium-term-health-costs-over-long-term

[16] Alan Auerbach, William Gale, and Ben Harris, "Federal Health Spending and the Budget Outlook: Some Alternative Scenarios," April 2014. http://www.brookings.edu/~/media/events/2014/04/11%20health%20care%20spending/federal_health_spending_budget_outlook_auerbach_gale_harris.pdf

[17] See Congressional Budget Office, "Medicare's Payments to Physicians," November 2014. http://www.cbo.gov/publication/49770. Also see CRFB, "New CBO Estimates Set the Stage for 'Doc Fix' Discussions," November 2014. http://crfb.org/blogs/new-cbo-estimates-set-stage-doc-fix-discussions

Although Congress has continuously waived mandated SGR cuts since 2003, they have also almost always paid for "doc fixes" with alternative deficit reduction measures. In fact, policymakers have generally replaced SGR cuts with alternative health savings, including a number of small structural curve-bending changes. By our analysis, doc fixes have been offset 98 percent of the time since 2004.[18] In other words, the SGR has helped to indirectly control Medicare costs in the past, and future doc fixes or SGR reform must be fully offset to ensure it continues to do so in the future.

SGR Has Resulted in $165 Billion in Deficit Reduction



CRFB's **PREP Plan** has put forward a specific set of sensible provider and beneficiary reforms to slow health care cost growth *and* pay for a permanent replacement of the SGR with an improved formula akin to the one developed by this Committee, along with the Finance and Ways & Means Committees.[19]

In addition to identifying SGR offsets, policymakers will eventually need to put forward measures to avoid insolvency of the Medicare Part A Hospital Insurance trust fund projected around 2030.

[18] CRFB, "Actually, the SGR Has Slowed Health Care Cost Growth" March 2014. http://crfb.org/blogs/actually-sgr-has-slowed-health-care-cost-growth

[19] See footnote 2.

Focus First on Health Care Cost "Benders"

Policymakers have a number of options for slowing the growth of federal health spending. Many of those who work on health reform like to divide these options between those primary impacting beneficiaries and those primary affecting providers. However, at CRFB, we think it is much more useful to categorize reforms based on whether they operate by changing incentives, making cuts, or transforming the system – what we call "**Benders," "Savers," and "Structural Reforms."** I'd like to focus today on changes with the potential for bipartisan support, which fall primarily in the "benders" and "savers" categories – excluding the more controversial "structural reforms" for now.

As policymakers search for savings within the health care system, they should first look to cost "benders" – those policies which change incentives in order to slow overall health care cost growth. Importantly, there is no free lunch in the health care system, and those who suggest we can make everyone better off at once are probably overstating the case. At the same time, evidence suggests that inefficiencies, misaligned incentives, and a lack of good information are clearly leading to a very substantial amount of health care spending that does little or nothing to improve overall health. This suggests an opportunity for at least a "discounted lunch" if policymakers are willing to focus on policies that improve these incentives and reduce inefficiency.

In my view, it is far preferable to focus on policies that reduce the overutilization or mis-utilization of health care in order to slow health care cost growth than it is to simply shift who pays, who receives, and how much. This is true even for those policies that use targeted (and budget-saving) cuts as the "stick" to improve incentives.

Potential Bipartisan Health Care Savings Options

Policy	10-Year Savings
Benders	
Modernize Medicare Cost-Sharing by Creating Unified Deductible and OOP Limit	$0-$100 billion
Restrict Use of Medigap Wrap-Around Plans Covering 1st-Dollar Costs	$55 billion
Impose Premium Surcharge for Certain Medigap Plans	$5-$35 billion
Impose Premium Surcharge on Certain Employer-Sponsored Retiree Health Plans	$5-$25 billion
Restrict TRICARE-for-Life Supplemental Plans from Covering 1st-Dollar Costs	$30 billion
Expand the Use of Bundled Payments	$5-$50 billion
Encourage Low-Cost Physician-Administered Drugs in Medicare Part B	$5-$10 billion
Expand Penalties for Preventable Readmissions and Complications	$1-$50 billion
Equalize Payments for Similar Services in Different Settings	$10-$30 billion
Modify Co-Pays for the Part D Low-Income Subsidy to Encourage Generic Drugs	$25 billion
Ban "Pay-for-Delay" Drug Agreements, Reduce Patent Period for Certain Drugs	$5 billion
Enact Medical Malpractice Reform	$5-$70 billion
Savers	
Reduce Payment Updates for Post-Acute Care Providers	$15-$75 billion
Eliminate Medicare Reimbursement for Bad Debts	$50 billion
Reduce Payments for Graduate Medical Education	$10-$60 billion
Reduce Payments to Rural Hospitals	$2-$50 billion
Increase Medicare Advantage Coding Intensity Adjustment	$15 billion
Extend and Increase Medicare Income-Related Premiums	$25-$100 billion
Modify Medicaid Drug Manufacturer Rebate	$5-$20 billion
Increase Drug Rebates in Part D	$65-170 billion
Reduce Medicaid Provider Tax Gimmick	$10-$60 billion
Set FMAP for Administrative Costs at 50%	$25 billion
Repeal ACA Exchange Subsidies for Incomes Above $300 billion	$120 billion
Reduce FMAP Medicaid Payments to States	Dialable

Savings estimates are *very rough,* and generated by CRFB staff primarily based on CBO estimates

Indeed, our **PREP Plan** focused almost exclusively on these "benders" and identified enough of them to fully offset the cost of the bipartisan Tricommittee SGR reform bill along with the health care extenders.[20] Below, I discuss a number of "bender" policies, including a range of potential savings along with the savings achieved from the PREP plan proposals in parentheses.

A comparison table of policies included in different plans can be seen at

http://crfb.org/sites/default/files/final_delivery_systems_reform_paper_0.pdf#page=28

[20] Ibid.

Reform Medicare Cost-Sharing Rules – $0 billion to $100 billion (~$20 billion)

Controlling health care cost growth will require wise consumption of health care services. Yet Medicare Parts A and B currently have a hodgepodge of deductibles, co-pays, and other cost-sharing requirements that are too complex, confusing, and uneven to establish the correct incentives for beneficiaries. Overall, Medicare probably requires too little "skin in the game" for first-dollar coverage, while putting beneficiaries at risk by offering too little protection against catastrophic costs.

A number of plans, including those from Simpson-Bowles, Domenici-Rivlin, MedPAC, the American Enterprise Institute (AEI), the Bipartisan Policy Center (BPC), the Center for American Progress (CAP), the Urban Institute, and our own PREP plan would replace the current rules with a more straightforward and combined cost-sharing regime.[21] For example, the PREP plan would establish a combined deductible of about $600, uniform coinsurance of 20 percent for all non-preventative services, and provide a $6,000 limit on out-of-pocket costs to protect beneficiaries from medical bankruptcy. It would also include reduced cost-sharing for lower-income seniors so that they could better afford their medical bills and further limit their out-of-pocket exposure.

Importantly, a comprehensive cost-sharing reform can be designed to reduce federal costs without increasing net out-of-pocket costs for seniors, simply by reducing excess utilization. Combined with supplemental coverage restrictions (described below), in fact, a plan can significantly *reduce* costs both

[21] The Moment of Truth Project, "A Bipartisan Path Forward to Securing America's Future," April 2013. http://crfb.org/document/report-bipartisan-path-forward-securing-americas-future
The Debt Reduction Task Force, "Restoring America's Future," November 2010. http://bipartisanpolicy.org/wp-content/uploads/sites/default/files/files/BPC%20FINAL%20REPORT%20FOR%20PRINTER%2002%2028%2011.pdf
Joseph R. Antos, Mark V. Pauly, and Gail R. Wilensky, "Bending the Cost Curve through Market-Based Incentives." *New England Journal of Medicine,* September 2012. http://www.nejm.org/doi/full/10.1056/NEJMsb1207996
Bipartisan Policy Center, "A Bipartisan Rx for Patient-Centered Care and System-wide Cost Containment," April 2013. http://bipartisanpolicy.org/library/report/health-care-cost-containment
Center for American Progress, "The Senior Protection Plan," November 2012. https://www.americanprogress.org/issues/healthcare/report/2012/11/13/44590/the-senior-protection-plan/
Robert Berenson, John Holahan, and Stephen Zuckerman, "Can Medicare Be Preserved While Reducing the Deficit?," March 2013. http://www.urban.org/publications/412759.html

for the federal government and for Medicare beneficiaries. Initial estimates from the Actuarial Research Corporation (ARC) suggest the PREP Plan's benefit redesign and supplemental insurance reforms would reduce average out of pocket costs by nearly *$225 per person* each year.

Note that if policymakers are unable to pursue comprehensive cost-sharing reform, incremental reforms such as those in the President's budget are also possible. For example, lawmakers could modestly increase the Medicare Part B deductible and/or could impose cost-sharing where little or none currently exists, such as for home health episodes and clinical labs.

Restrict Supplemental Coverage – $5 billion to $110 billion (~$60 billion)

The ability of Medicare cost-sharing to control costs – either under current law or as proposed above – is limited by supplemental private insurance plans that piggyback on Medicare by financing remaining out-of-pocket costs. This supplemental coverage comes in a number of forms, with 30 percent of seniors in traditional Medicare covered by employer-provided retire health plans and one-fifth purchasing their own "Medigap plans," as of 2010.[22]

Unfortunately, these plans tend to be a bad deal for both beneficiaries and the federal government. A MedPAC-contracted study found that beneficiaries with Medigap plans cost Medicare 27 percent more in 2003-2008 than those without supplemental coverage.[23] And because of the high premiums associated with the plans, they spend up to $415 more out of pocket each year on average than they would if those plans were restricted.[24]

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[22] Medicare Payment Advisory Commission, "June 2014 Report to Congress: Medicare and the Health Care Delivery System," June 2014. http://www.medpac.gov/documents/publications/june-2014-data-book-section-3-medicare-beneficiary-and-other-payer-financial-liability.pdf?sfvrsn=2

[23] Christopher Hogan, "Exploring the Effects of Secondary Coverage on Medicare Spending for the Elderly," August 2014. http://medpac.gov/documents/contractor-reports/august2014_secondaryinsurance_contractor.pdf?sfvrsn=0

[24] See Kaiser Family Foundation, "Medigap Reforms: Potential Effects of Benefit Restrictions on Medicare Spending and Beneficiary Costs." July 2011. http://www.kff.org/medicare/upload/8208.pdf.

A number of plans including from Simpson-Bowles, the President's budget, MedPAC, BPC, AEI, the Brookings Institution, the Urban Institute, and our PREP plan would restrict or discourage the use of Medigap plans in some way.[25] The PREP plan would ban Medigap plans from covering the new Medicare deductible and only allow them to cover half of coinsurance costs, with temporary grandfathering for existing plans.

The PREP plan also allows employees to "cash out" their employer-provided retiree health plans in exchange for a premium subsidy, charging an additional Medicare premium for those who keep their plans in order to cover the cost imposed on Medicare and taxpayers. Some plans would apply a similar approach to Medigap plans instead of restricting them outright. And some plans would also restrict TRICARE-for-Life supplemental coverage from covering first-dollar costs as well.

Expand Bundled Payments and Promote New Payment Models – $5 billon to $50 billion ($40 billion)

Medicare generally pays each provider separately for their contribution to a single episode of care, creating incentives for each provider to increase utilization and providing no incentive to coordinate services. Ultimately, Medicare will need to move away from this "fee-for-service" payment model toward one that rewards quality, efficiency, and care coordination. Congress should continue to work to promote such alternative models – including Accountable Care Organizations (ACOs) and patient-centered medical homes (PCMHs) – but they should not wait until these models are fully ready for primetime to begin pursuing reforms.

Medicare already has some experience offering "bundled payments," a single payment per episode of care in order to encourage providers to improve coordination and maximize cost-effectiveness of care based on a patient's needs. A number of plans, including the President's Budget, Simpson-Bowles, CAP,

[25] See footnote 21 and Jonathan Gruber, "Restructuring Cost Sharing and Supplemental Insurance for Medicare," February 2013. http://www.brookings.edu/research/papers/2013/02/medicare-cost-sharing-supplemental-insurance

AEI, Brookings, the National Coalition on Health Care (NCHC), the Commonwealth Fund, and the PREP Plan would expand bundle payments in some ways.[26] The PREP Plan would eventually mandate bundled payments for the inpatient stay and 90 days of post-acute care for a number of conditions, while also using these bundles to reduce identified overpayments in post-acute care.

Encourage Low-Cost Physician-Administered Drugs – $5 billion to $10 billion ($10 billion)

Physicians are currently paid for administering drugs covered under Medicare Part B at the Average Sales Price (ASP) of the drug plus six percent. By paying the doctor a percentage of the drug cost – even though more expensive drugs do not necessarily entail any more work to administer – this policy encourages physicians to use the most expensive, rather than the most effective, drug available. A number of plans would reduce this incentive. The President's budget would reduce the payment to the ASP+3 percent. BPC and NCHC would convert it to a flat fee at a similar level (on average) as current law. And the PREP plan would effectively do both.

Reduce Preventable Readmissions & Unnecessary Complications – $1 billion to $50 billion ($10 billion)

The Affordable Care Act included a Hospital Readmissions Reduction Program, which penalizes hospitals for high readmission rates for certain medical conditions. At least in part because of this program, readmissions are down 8 percent since 2011.[27] A number of plans, including from the President's Budget, Simpson-Bowles, Urban, Brookings, CAP, NCHC, the Commonwealth Fund, and the PREP Plan would expand this program. The PREP Plan specifically would expand the penalties to more medical

[26] See footnote 21 and National Coalition on Health Care, "Curbing Costs, Improving Care: The Path to an Affordable Health Care Future," November 2012. http://www.nchc.org/plan-for-health-and-fiscal-policy/ The Commonwealth Fund, "Confronting Costs: Stabilizing U.S. Health Spending While Moving Toward a High Performance Health Care System," January 2013. http://www.commonwealthfund.org/Publications/Fund-Reports/2013/Jan/Confronting-Costs.aspx

[27] Department of Health and Human Services, "New HHS Data Shows Major Strides Made in Patient Safety, Leading to Improved Care and Savings," May 2014. http://innovation.cms.gov/Files/reports/patient-safety-results.pdf

conditions and types of providers and increase the maximum penalty amounts. In addition, it discusses applying the ACA's penalties for hospital-acquired conditions to other avoidable complications.

Equalize Payments for Similar Services in Different Settings – $10 billion to $30 billion ($20 billion)

Medicare often pays vastly different rates for similar health care services based on the setting in which they are performed, encouraging providers to perform the service in the higher-paid site of care (for instance, in a hospital outpatient department rather than a freestanding physician's office). In many cases, there is no additional value to a service being performed in a more intensive or costly setting. A number of proposals, including from the President's budget, MedPAC, Simpson-Bowles, NCHC, CAP, and the PREP Plan would begin to reduce some of these disparities. PREP would equalize payments at the level of the lowest-cost site for certain services that are performed both in a hospital outpatient department and in a physician's office. This reform would complement efforts to encourage care coordination without increasing cost and would reduce the incentive for hospitals to buy freestanding physician offices to generate higher Medicare reimbursements.

Promote the Use of Generic Drugs – $5 billion to $30 billion

In a number of cases, Medicare Part D and other federal programs do not do enough to discourage beneficiaries from purchasing brand-name drugs where there is a therapeutically-equivalent but lower cost generic alternative. In the Medicare Part D Low Income Subsidy (LIS) program, for example, beneficiaries pay only slightly more for brand name drugs even though the difference in cost to the federal government can be quite substantial. A number of policies could be designed to promote the use of generic drugs. For example, the President's budget would widen the difference between generic and brand name copays in the LIS, ban so-called "pay-for-delay" agreements designed to prevent manufacturers from bringing generic drugs to market, and reduce the patent period for certain types of

brand-name drugs. The NCHC would also incentivize state encouragement of generic drugs in Medicaid by sharing savings and close a loophole that raises barriers to the creation of generic drugs.

Enact Medical Malpractice Reform – $5 billion to $70 billion

Medical malpractice cases tend to drive up health care costs by increasing the malpractice insurance premiums faced by doctors and by excessively increasing the practice of defensive medicine. A number of options could help to reduce the number or cost of malpractice cases. Modest savings could be achieved by limiting certain statutes of limitations, establishing a "fair share rule" in favor of "joint-and-several liability," allowing courts to consider collateral sources of income (such as life insurance payouts) in determining payment amounts, limiting lawyer fees, promoting "health courts" or other types of arbitration, providing "safe havens" for physicians who follow best practices, or giving states more incentive to experiment with their own reforms. Hard limits on noneconomic and punitive damages would generate larger savings, both for the federal government and private health spending.

Encourage State Innovation in Medicaid

Nearly 40 percent of federal health spending goes to Medicaid. Yet because it is a joint program administered by the states, the federal government has less ability to "bend the cost curve" within the Medicaid program as in other programs. On the other hand, the fact that there are 56 different Medicaid programs offers at least 56 different laboratories to test new cost control ideas – and often the best ideas come from the states. To ensure these cost control ideas are pursued, tested, and expanded where successful, the federal government should allow and aggressively encourage states to pursue a variety of ideas aimed at slowing health care cost growth. Expanded waiver authority was proposed in Simpson-Bowles, the PREP Plan, and to some degree in the President's budget. The Leavitt

Medicaid Commission of 2006 and the National Governor's Association Health Care Sustainability Task Force have outlined how it could work in great detail.[28]

In addition to providing waivers, the federal government may be able to promote Medicaid savings by easing certain Medicaid regulations, reducing matching payments for certain low-value services, and promoting new coordinated care models to treat "dual-eligible" beneficiaries who qualify both for Medicare and Medicaid.

Reforms to the Affordable Care Act

Working within the general structure of the ACA, some reform options have potential to bend the cost curve. In light of efforts to shift away from fee-for-service payment system-wide, stronger incentives could be provided to exchange plans to utilize ACO-like delivery models and value-based purchasing. Increasing the availability of cost data for patients, particularly given that most ACA plans include a sizeable deductible, holds potential for reducing health costs. One key pathway to controlling costs would be to improve competition between health plans on the exchanges, both by making plan comparisons clear and simple and encouraging annual shopping among plans.

Other proposals have sought to increase cost-sharing further within exchange plans, either by adding catastrophic coverage as an option for all buyers or by switching the premium subsidy to be based on the cost of Bronze, rather than Silver, plans.

[28] See the Medicaid Commission, "Final Report and Recommendations," December 2006. http://www.allhealth.org/briefingmaterials/HHS-MedicaidCommissionReport-638.pdf. Also see the Health Care Sustainability Task Force, "NGA Health Care Sustainability Task Force Report," February 2014. http://www.nga.org/cms/home/special/col2-content/nga-health-care-sustainability-t.html.

Look to the "Savers" To Better Allocate Limited Health Resources

Although policymakers should focus mainly on those policies that help to "bend the health care cost curve," those policies may not prove sufficient to put the national debt on a sustainable long-term path. And while the answer to this concern should not be indiscriminant cost-shifting, it does mean hard choices will have to be made – choices where the winners and winnings (including for future generations) roughly equal rather than greatly exceed the losers and losing.

Identifying the right "Savers" means thinking about how scarce federal health dollars should be allocated to do the most overall good. This is true in terms of the resources allocated to providers, beneficiaries, drug companies, and the states. Below, I discuss some of these options.

Reduce Medicare Provider Payments – up to $200 billion

The Medicare Payment Advisory Commission (MedPAC) and other experts have recommended that Medicare reduce or modify its payments to numerous providers who may be receiving excess subsidies under current law. For example, a number of bipartisan plans have recommended reducing payments to post-acute providers (home health agencies, skilled nursing facilities, etc.), with the FY 2015 President's Budget calling for nearly $80 billion of savings in that area over the next decade. Many proposals have also reduced or reformed reimbursements for unpaid beneficiary cost-sharing known as "bad debts," payments to hospitals who hire medical residents (graduate medical education), and rural hospitals that currently receive higher payments than their urban counterparts. In addition, a number of plans have called for reducing payments to Medicare Advantage plans in a variety of ways.

Extend and Increase Income-Related Medicare Premiums – $25 billion to $100 billion

Currently, most beneficiaries pay a premium roughly equal to 25 percent of per-beneficiary Medicare Part B and Part D costs, while high-income seniors – those in the top 5 percent – pay anywhere from 35

to 80 percent. The income thresholds for these higher premiums are currently frozen through 2019 but will jump to a much higher level in 2020. Simply continuing the freeze under current law would save $25 billion through 2024. The President's budget also proposed increasing income-related premiums to as high as 90 percent, saving another $25 billion. Lowering the thresholds to require closer to 20 percent of seniors to pay income-related premiums could push that total to as high as $100 billion.

To get a sense of the total amount of money that can be saved from increasing premiums, raising the base premium from 25 to 35 percent of program costs along with expanded income-relating premiums could save as much as $350 billion over ten years. However, few bipartisan discussions I've been involved with or am aware of would pursue that magnitude of an increase for that broad of the Medicare population.

Require Rebates to Reduce Federal Drug Payments – up to $170 billion

Currently, the federal government pays a reduced rate on prescription drugs purchased through the Medicaid program by requiring manufacturer rebates. In order to reduce federal spending on drugs, a number of proposals would expand these rebates and/or apply them within Medicare Part D. For example, the President's budget would strengthen the Medicaid rebate ($8 billion), expand it to LIS- and dual-eligible Part D beneficiaries ($116 billion), and accelerate rebates being provided as the Medicare "donut hole" is being closed ($17 billion). The Simpson-Bowles plan includes a more modest proposal to expand the existing Medicaid rebates only to those who are dually-eligible for Medicare Part D and Medicaid – effectively restoring the rebate those beneficiaries would have received prior to the creation of Medicare Part D.

Policymakers have a wide array of options as it relates to drug rebates within Medicare Part D. Not only can they dial the level of the rebate, but they can apply them to name brand drugs, generic drugs, or

both; and they can apply them to dual-eligibles, dual-eligibles and the LIS population, or the entire Part D population.

Restrict the Ability of States to inflate their Medicaid Match – $10 billion to $60 billion ($10 billion)

States are currently able to inflate their claimed Medicaid costs by taxing health providers in order to distribute that money right back to providers and then receive a federal match on that distribution. This deceptive practice allows states to effectively pay providers one amount, but report a different higher amount to the federal government in order to receive larger federal payments. Provider taxes are currently limited to 6 percent of net patient revenue under current law, up from 5.5 percent as recently as 2011. To offset the costs of the Medicaid extenders, the PREP Plan would restore the limit to 5.5 percent. However, there is a good case to go much further. In 2011 and 2012, President Obama proposed limiting the practice to 3.5 percent of revenue. Simpson-Bowles prohibited the provider tax altogether, though it proposed enacting this restriction extremely gradually to give states time to plan and adjust. In addition to the provider tax scam, states employ a number of other "creative financing" techniques, including Intragovernmental Transfers (IGTs), that are worth investigating and clamping down on.

Importantly, any of these changes will by definition reduce the total federal dollars being spent on the Medicaid program that insures low-income beneficiaries. However, with debt rising unsustainably and health care cost control of central importance, it is at least worth questioning whether states should be rewarded for tricking the federal government into paying them more than the law intends.

Reduce Medicaid Payments to States – Dialable

Policymakers might also consider more directly requiring states to take more responsibility for their own health care costs. This could be done by reducing the Federal Medical Assistance Percentages (FMAP) that currently go to the states, doing so for only some types of payments (for example, those related to

administrative expenses), reducing the current floor on FMAP payments, or even combining various matching streams into a single "blended rate" as was proposed by President Obama in 2011 and 2012.

Whether the federal government is seeking savings or not, it might be time to consider reforming the FMAP formula, which is quite complicated and may not reflect the best way to allocate resources among states. One option would be to establish a commission to study the current formula and recommend a new formula that could either be budget-neutral or budget-reducing, depending on what Congress desires.

Reduce ACA Subsidies – Dialable

Currently, the ACA offers sliding scale insurance subsidies for people earning up to 400 percent of the poverty line, benchmarked to the second-lowest "silver plan" in each exchange. These subsidies could be reduced or modified in a number of ways. For example, subsidies could be benchmarked to "bronze plans" instead of silver, or they could be limited to those with income at 350 or 300 percent of the poverty line – the latter of which CBO estimates would save well over $100 billion.

With An Aging Population, We Can't Fix Our Debt with Health Reform Alone

As mentioned earlier, the largest driver of entitlement cost growth over the next quarter century – and even the growth of Medicare and Medicaid alone – is not health care cost growth but population aging. Since the year 2000, the number of individuals above age 65 has increased from 35 million to 45 million, and that number is projected to reach 80 million by 2035. The combination of the retirement of the large baby boom population and growing life expectancy also means that the above 75 population will

double between now and 2035, from 20 to 41 million.[29] Meanwhile, birthrates will fail to keep up, resulting in a much older population.

The aging of the population will have a number of important fiscal and economic implications. At the same time the growing senior population drives up the growth of Social Security and Medicare spending, the relatively stagnant working population will hold down the growth in revenue collection. Meanwhile, lack of growth in the labor force and net withdrawals from savings and investment accounts will likely slow overall economic growth.

Given the substantial role population aging will play in increasing the country's debt-to-GDP ratio, it is unlikely that health-related solutions alone will suffice to put the debt on a sustainable long-term path. Instead, policymakers will need to supplement health reform with reforms aimed at mitigating the effects of population aging and cutting spending or increasing revenue elsewhere in the budget.

The effects of population aging can be mitigated in a few ways. To the extent Social Security and Medicare costs are growing because they will be providing benefits for more years, increases in the Social Security and Medicare retirement ages can help limit that growth. More fundamentally, changes to those ages, the Social Security Earliest Eligibility Age, and other age signals throughout the budget and tax code can help encourage individuals to work longer and thus put younger seniors back on the better side of the dependency ratio.

Thoughtful immigration reforms can also help to mitigate or at least smooth the effects of an aging population by bringing new younger workers into the economy and onto the tax rolls. Other changes designed to encourage work, investment, or higher productivity can also offset some of the effects of population aging. In particular, comprehensive tax reform can do all of those things, while also making us more competitive internationally, improving fairness, and reducing tax compliance costs.

[29] See Congressional Budget Office, "The 2014 Long-Term Budget Outlook," July 2014. http://www.cbo.gov/publication/45471

At the same time, none of these efforts will be enough to *stop* the effects of population aging. Therefore, health reform and "aging reform" will have to be accompanied by cuts in projected spending, increases in revenue, or some combination of the two.

Since discretionary spending has already been cut substantially both through the Budget Control Act and the sequester, net spending cuts in my view should focus exclusively on the mandatory side of the budget. Of course, the largest and fastest growing part of the non-health mandatory budget is Social Security, which has risen in cost from about 4 percent of GDP in 2007 to 5 percent today and will exceed 6 percent by 2030 – just before its trust fund runs out of money. Policymakers should pursue comprehensive Social Security reform that avoids a 23 percent across-the-board cut set to occur under current law and makes that program solvent for 75 years and beyond; as an important side effect, Social Security reform will slow the national debt as CBO projects it.[30]

Outside of Social Security reform, the biggest bucket of potential savings may very well be on the revenue side, where we currently spend $1.2 trillion per year on tax breaks that are in many cases expensive, regressive, and economically distorting. Tax reform could substantially cut back on tax expenditure, use most of the revenue to reduce tax rates, and leave a small portion for debt reduction.[31] Alternatively, policymakers might enact revenue-neutral or even revenue-reducing income tax reform, accompanied by an increase in the Medicare tax or the establishment of some new source of revenue.

Conclusion

With debt at record highs and on an unsustainable long-term path, there is no silver bullet to bring it back down. Policymakers will need to pursue a combination of spending cuts, new revenues, Social

[30] See CRFB's "The Reformer" simulator at http://www.socialsecurityreformer.org which allows users to create their own Social Security plan and shows the effect on program cash flows and solvency.
[31] Read CRFB, "Tax Reform: Reducing Tax Rates and the Deficit," October 2012. http://crfb.org/document/report-tax-reform-reducing-tax-rates-and-deficit

Security reform, an economic growth plan, and *especially* a strategy to reinforce and continue the recent slowdown in health care costs.

Over the next couple of years, divided government will force Democrats and Republicans to work together. Fortunately, there are a huge number of sensible health reform options that have or could garner broad bipartisan support.

Congress and the President should start first with the "Benders" – those policies that could truly reduce the structural growth of Medicare and other federal health spending. They should also pursue the "Savers" to make sure that every health dollar is being allocated in the best way possible. And they should continue to work together to test and enact new ideas that move us toward the goal of moving to a better health system at a better price – a health system that works for its beneficiaries, those who pay for it, and future generations of Americans who are counting on us to keep the federal debt under control.

Thank you for allowing me to testify on this important topic.

Mr. PITTS. Thank you.

Dr. Feder, you are recognized for 5 minutes for your summary.

STATEMENT OF JUDY FEDER

Ms. FEDER. Chairman Pitts, Ranking Member Pallone, and members of the committee, I appreciate the invitation to appear before you today to express my own and my colleague Paul Van de Water's views on setting fiscal priorities and the importance of preserving Medicare and Medicaid.

I want to make five quick points.

First is that Medicare and Medicaid work. They provide essential health and financial wellbeing to people who are elderly, disabled, or poor. Over more than 40 years, Medicare spending per enrollee has grown by an average of 1 percentage point less than comparable private health insurance premiums. Medicaid provides acute healthcare coverage at a substantially lower cost per child and per non-elderly adult than private coverage. And Medicaid is also the Nation's primary payer for long-term services and support, a matter I know is of concern to Mr. Pallone and others.

Second, Medicare and Medicaid are not in crisis. On the contrary, Medicare spending has recently been growing at a historically low rate, with spending per beneficiary growing more slowly than GDP per capita.

The financial outlook for Medicare and Medicaid has improved significantly in the past 4 years. Congressional Budget Office estimates of Medicare and Medicaid spending for the next decade have fallen by several hundred billions of dollars since CBO first estimated the impact of the ACA. And Medicare spending per beneficiary in 2014 is expected to be $1,200 lower than CBO projected in 2010.

Third, as Mr. Goldwein said, it is not growth in spending per beneficiary but it is growth in the number of beneficiaries that have become the primary drivers of increased Medicare and Medicaid spending. Even if cost growth remains moderate, Medicare and Medicaid spending will keep rising as more baby boomers become eligible for benefits. And I should note, with candor, I am one. As boomers age, as we age, States will also face considerable increase in the need for long-term care.

Does that mean that we can relax in our efforts to slow cost growth? Of course not. But the focus should be on payment and delivery reform and not capped Federal contributions.

In Medicaid, there is little room for savings from efficiency, given already constrained provider payment rates, widespread use of managed care, and existing opportunities for State flexibility.

Most proposals that would secure more than modest Federal savings, such as a block grant or a per capita cap, would do so by shifting costs to States, and if that occurs, States are likely to cut eligibility, benefits or provider payments, enhanced reduced beneficiaries access to care. But Medicare policymakers cannot only use the ACA, encourage research and pilots to continue to gain value for the dollar, but can further reduce spending without jeopardizing quality or access to care.

Restoring the Medicaid rebate on prescription drugs for low-income beneficiaries, eliminating overpayments, continued overpay-

ments to Medicare Advantage plans, and refining payments mechanisms for post-acute care are a few examples of policies likely to increase value for the Medicare dollar.

Only so much can be expected, however, of reducing Medicare costs per beneficiary if that is done independent of lower cost growth and the system as a whole. New revenues are therefore needed to deal with a doubling of the elderly population over the coming decades.

My fourth point: What current circumstances do mean is that claims of cost growth or fiscal crisis cannot be used to justify moves to radically reform Medicare and Medicaid. There is no question that premium support or other mechanisms that would change Medicare from a defined benefit to a defined contribution program would raise the fundamental concern of a cost shift from the Federal Government to beneficiaries.

The same is true for the block grant or per capita cap, as I mentioned earlier, and that is because these mechanisms would sever the tie between Federal contributions and the beneficiary's costs. The more constrained the defined contribution or the cap, the greater the shift. Premiums support vouchers, block grants per capita caps or overly ambitious spending targets might save Federal dollars but they shift risks on beneficiaries who can ill afford to pay them.

My final point is to urge you to recognize that the deficit has stabilized as a share of GDP, that healthcare spending is growing at historically low rates. That is good news, and it gives policymakers time to identify further steps that when we needed to slow the growth of healthcare costs throughout the entire U.S. healthcare system without impairing the quality of care so that we can meet our responsibilities to an ageing population just as we did in education when the very same individuals entered public school about 60 years ago.

The Nation's fiscal capacity does not provide an excuse to abdicate those responsibilities by radically restructuring Medicare, by replacing Medicare's guaranteed coverage with a premium support voucher, or by restructuring or severely cutting Medicaid or other programs that protect low-income Americans.

Thank you.

[The statement of Ms. Feder follows:]

Financing Medicare and Medicaid

Testimony of Judy Feder[1]
Before the
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives

December 9, 2014

[1] Judy Feder is an Urban Institute Fellow and Professor and founding Dean, Georgetown University McCourt School of Public Policy.

Chairman Pitts, Ranking Member Pallone, and members of the subcommittee, I appreciate the invitation to appear before you today on setting fiscal priorities and the importance of preserving Medicare and Medicaid. Budgetary entitlements of many kinds are designed to guarantee Americans adequate protection in case of illness, disability, or economic misfortune. Efforts to control the costs of health care entitlements (including Medicare and Medicaid) must continue, if we are to meet the needs of an aging population.

But Medicare and Medicaid are not in crisis. Responsible reforms, now underway, can contribute to reducing projected long-run deficits while sustaining these programs' fundamental insurance protections. By contrast, proposals to restructure Medicare through vouchers or Medicaid through block grants or *per capita* caps would undermine the very guarantee that these programs are designed to provide.

Medicare and Medicaid are essential to the health and financial well-being of the elderly, disabled, and poor. Their costs per enrollee have consistently grown more slowly than private insurance premiums, despite their focus on populations with the greatest health care needs. Over more than 40 years, Medicare spending per enrollee has grown by an average of one percentage point less than comparable private health insurance premiums.[2] Medicaid provides acute health care coverage at a cost of 27 percent less per child, and 20 percent less per non-elderly adult, than private coverage;[3] it is also the nation's primary payer for long-term care services and supports.

Medicare spending has recently been growing at an historically low rate. Medicare spending per beneficiary is projected to increase by just 0.3 percent in 2014 and by 0.7 percent a year over the 2010-2014 period — well below the growth in gross domestic product (GDP) per capita.[4]

The financial outlook for Medicare and Medicaid has improved significantly in the past four years. The Congressional Budget Office (CBO) initially estimated that the Affordable Care Act (ACA) would reduce projected Medicare spending by $555 billion between 2011 and 2020.[5] CBO's projections of Medicare spending over the 2011-2020 period have fallen by an additional $715 billion since late 2010, and its Medicaid projections have declined by $395 billion.[6] Medicare spending per beneficiary in 2014 is expected to be $1,200 lower than CBO projected in 2010.[7]

Rather than growth in spending per beneficiary, growth in the number of beneficiaries has

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[2] Office of the Actuary, Centers for Medicare & Medicaid Services, National Health Expenditure Tables, January 2014, table 21, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf.

[3] Leighton Ku and Matthew Broaddus, "Public and Private Insurance: Stacking Up the Costs," *Health Affairs* Web Exclusive, June 24, 2008.

[4] *2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, July 28, 2014, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2014.pdf.

[5] Congressional Budget Office (CBO), *The Budget and Economic Outlook: An Update*, August 2010, p. 63.

[6] CBO, *Revisions to CBO's Projections of Federal Health Care Spending*, July 28, 2014, http://www.cbo.gov/publication/45581.

[7] Tricia Neuman and Juliette Cubanski, "The Mystery of the Missing $1,200 Per Person," Kaiser Family Foundation, September 29, 2014, http://kff.org/health-costs/perspective/the-mystery-of-the-missing-1000-per-person-can-medicares-spending-slowdown-continue/.

become the primary driver of increased Medicare and Medicaid spending. Even if cost growth remains moderate, Medicare and Medicaid spending will keep rising as more baby boomers become eligible for benefits. As boomers age, states will also face a considerable increase in the need for long-term care.[8] Between now and 2035, federal spending on Medicare, Medicaid, and related programs is projected to increase by 3 percent of GDP.[9] By way of comparison, state and local government spending on education grew by a similar amount between 1950 and 1975, as the boomers entered primary and secondary school.

Growth in the elderly population makes it essential that we continue efforts to make our health care system more efficient. Effectively implementing the payment and delivery reforms of the Affordable Care Act is an essential next step. The ACA's research and pilot projects should yield important lessons about how to encourage coordinated and efficiently delivered care that lowers costs while maintaining or improving quality. While waiting for these efforts to bear fruit, are their additional measures we can take?

In Medicaid, there is little room for savings from efficiency, given already constrained provider payment rates and existing opportunities for state flexibility. Most proposals that would secure more than very modest federal savings — such as a block grant or *per capita* cap — would do so by shifting costs to states. If that occurs, states are likely to cut eligibility, benefits, or provider payments and hence reduce beneficiaries' access to care.[10]

In Medicare, policymakers can enact measures now, as part of a balanced deficit-reduction package, that can reduce spending by refining current payment methods without jeopardizing the quality of care or access to care. Restoring the Medicaid rebate on prescription drugs for low-income beneficiaries,[11] eliminating overpayments to Medicare Advantage plans,[12] and refining payment mechanisms for post-acute care[13] are a few examples of policies likely to increase value for the Medicare dollar. Critics who dismiss Medicare payment reforms, especially to hospitals, as "arbitrary cuts" ignore evidence from the Medicare Payment Advisory Commission (MedPAC) that they promote sorely needed efficiency in health care delivery.[14] Though too great a gap between Medicare and private payments can endanger access to care, the solution is not to have Medicare pay

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[8] Judy Feder and Harriet Komisar, "The Importance of Federal Financing to the Nation's Long-term Care Safety Net," Scan Foundation, February 2012, http://www.thescanfoundation.org/sites/thescanfoundation.org/files/-Georgetown_Importance_Federal_Financing_LTC_2.pdf.

[9] Richard Kogan, Kathy Ruffing, Paul N. Van de Water, and William Chen, *CBPP's Updated Projections Show Long-Term Budget Outlook Is Significantly Improved but Remains Challenging*, Center on Budget and Policy Priorities, May 5, 2014, http://www.cbpp.org/cms/index.cfm?fa=view&id=4139.

[10]Edwing Park and Matt Broadus, " Medicaid Per Capita Cap Would Shift Costs to the States and Place Low Income Beneficiaries at Risk," Center on Budget and Policy Priorities, October 4 2012 http://www.cbpp.org/cms/index.cfm?fa=view&id=3846

[11] Richard Frank and Jack Hoadley. "The Medicare Part D Drug Rebate Proposal: Rebutting an Unpersuasive Critique." *Health Affairs Blog*, December 28, 2012.

[12] Judy Feder, Steve Zuckerman, Nicole Lallemand and Brian Biles, "Why Premium Support? Restructure Medicare Advantage, Not Medicare." Washington: The Urban Institute, 2012.

[13] Kaiser Family Foundation, *Policy Options to Sustain Medicare for the Future*. January 2013, Option 2.42.

[14] Medicare Payment Advisory Committee, *Report to the Congress, Medicare Payment Policy*, Chapter 3, March 2012.

more. Rather it is to promote cost containment across the whole health care system through collaboration among public and private payers in designing and constraining rates or in setting overall health care budgets.

Only so much can be expected, however, of reducing Medicare costs per beneficiary. New revenues are therefore needed to deal with an aging population. As the elderly population doubles over the coming decades, it is no less necessary for the federal government to invest in their health care, efficiently delivered, than it was for state and local governments to invest in education sixty years ago when the very same people began entering public schools.

An alternative course of action, changing entitlement structures through vouchers or block grants (or adopting an overly ambitious savings target that could produce the same results) would fail to serve the growing elderly population — harming some of the most vulnerable members of society while shifting costs to states, individuals, and employers and failing to address the underlying causes of health cost growth.

Advocates of so-called premium support argue that Medicare's experience with private Medicare Advantage (MA) plans portends federal savings and greater efficiency were Medicare transformed from a defined-benefit to a defined-contribution plan — under which beneficiaries would receive a voucher and be required to choose among competing private plans as well as traditional Medicare. However, MedPAC continues to find that MA plans cost the federal government more, on average, than traditional Medicare and that plans continue to benefit financially from serving healthier patients.[15] At the same time, a recent comprehensive review of the literature finds, in general, that research is inadequate to support quality comparisons and cites evidence that Medicare beneficiaries — especially these needing a lot of care — rate traditional Medicare more favorably than MA plans in terms of quality and access to care.[16]

Further, there is no question that premium support raises the fundamental concern of a cost shift from the federal government to beneficiaries, as it severs the tie between federal contributions and a beneficiary's costs. The more constrained the defined contribution, the greater the shift. But even a defined contribution tied to average plan costs would increase out-of-pocket costs for the substantial numbers of beneficiaries — including those needing above-average amounts of care — remaining in the traditional program.[17]

Such measures might save federal dollars, but they shift risk onto beneficiaries who can ill afford to pay them. Keep in mind that half of Medicare beneficiaries have incomes of less than $26,000 (including their spouse's income) and that Medicare households spend 15 percent of their budgets on out-of-pocket health costs — three times that of those not on Medicare. Some other proposals for changes to Medicare — such as raising the age of eligibility — would actually raise total as well as beneficiaries' health care costs.

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[15] Edwin Park, *New Research Shows Limits of Risk Adjustment in Protecting Traditional Medicare under Premium Support*, Center on Budget and Policy Priorities, September 12, 2014, http://www.cbpp.org/cms/index.cfm?fa=view&id=4202.

[16] Marsha Gold and Giselle Casillas, *What Do We Know About Health Care Access and Quality in Medicare Advantage Versus the Traditional Medicare Program?*, Kaiser Family Foundation, November 2014, http://files.kff.org/attachment/what-do-we-know-about-health-care-access-and-quality-in-medicare-advantage-versus-the-traditional-medicare-program-report.

[17] CBO, *A Premium Support System for Medicare: Analysis of Illustrative Options*, September 18, 2103,

Restructuring Medicare and Medicaid cannot be justified on grounds of fiscal responsibility. Since late 2010 Congress has enacted $4.1 trillion in deficit reduction — 77 percent of that through spending cuts.[18] As a result, the Congressional Budget Office now projects that the federal debt will remain roughly stable as a share of GDP between now and the end of the decade.[19] At the same time, the nation is experiencing historically low growth in health care spending. [20]

Policymakers clearly have time to identify the further steps that will be needed to slow the growth of health care costs throughout the U.S. health care system without impairing the quality of care, so that we can meet our responsibilities to an aging population. The nation's fiscal capacity does not provide an excuse to abdicate those responsibilities by radically restructuring Medicare — by replacing Medicare's guaranteed coverage with a premium support voucher — or by restructuring or severely cutting Medicaid or other programs that protect low-income Americans.

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[18] Richard Kogan and William Chen, *Projected Ten-Year Deficits Have Shrunk by Nearly $5 Trillion Since 2010, Mostly Due to Legislative Changes*, Center on Budget and Policy Priorities, March 19, 2014.

[19] CBO, *An Update to the Economic and Budget Outlook: 2014 to 2024*, August 2014.

[20] Micah Hartman et al, "National Health Spending in 2013," *Health Affairs*, December 2014, http://content.healthaffairs.org/content/early/2014/11/25/hlthaff.2014.1107.full.

Mr. PITTS. Chair thanks the gentlelady.

I will begin the questioning. Recognize myself 5 minutes for that purpose.

Mr. Goldwein, today Medicaid is the largest health insurance program in the world, covering more than 70 million people in 2013. Spending for this program is set to double in the next 10 years, and the program already consumes $1 of every $4. We have heard repeatedly from our colleagues on the other side of the aisle that Medicaid is off the table when it comes to considering any policy that would reduce Federal spending. Do you think this is appropriate or sustainable? And please elaborate.

Mr. GOLDWEIN. I don't think that you can afford to take any program off the table when it comes to healthcare cost growth. That said, Medicare is much easier for the Federal Government to address because we control the levers. We know how to—Medicaid is a joint program with the States, and so I think the best thing we can do for now is empower the States to find new types of ways to save money, to have better payment systems.

There are certain places we can impose those savings. There is borderline fraud, it is not quite fraud, but there are games that States play we should clamp down on. But really, I think the best thing we can do is give the States more freedom and more power to experiment with new cost control ideas.

Mr. PITTS. Mr. Holt, the HHS Inspector General, GAO, and a broad coalition of stakeholders have identified structural and systemic concerns with the 340B programs. Research suggests the programs discounts may be going to hospitals that do not disproportionately serve Medicaid or the uninsured. Other analysis suggests that the discounts are not passed on to the low-income individuals for whom the program was designed.

Given these concerns, and with more people enrolled in health coverage through the ACA, isn't it time for complete revaluation of the 340B program; and, also, if the 340B program was more targeted, would that free up more drug industry dollars for additional research and development and life-saving cures and life-enhancing therapies?

Mr. HOLT. So yes and yes.

First, let me plug, we have a very good primer on the 340B program and the American action forum that I am happy to share with anyone who would be interested in. I think it is important to remember this program exists largely because of Federal meddling and what was already going on in the first place. Originally, the pharmaceutical companies were providing some discounts to some of these hospitals, and as we started getting into things with ASP, they started rolling back those deals because it was impacting what they could sell in Medicaid for.

Today, though, we have got hospitals like Johns Hopkins which benefit from the 340B program dramatically because of the locality that they are in, not necessarily their financial standing. I absolutely think that in a post-ACA world we must look at all of these programs that were intended to subsidize uncompensated or undercompensated care, and we have to reevaluate all of that.

Mr. PITTS. Please provide us with a primer. We will circulate to the members.

Mr. HOLT. Absolutely.

Mr. PITTS. Dr. Feder, the President's fiscal year 2015 budget endorses a policy of further increasing an income-adjusted Medicare premium until capping the highest tier at 90 percent. As the President said in that budget, quote, "This proposal would help improve the financial stability of the Medicare program by reducing the Federal subsidy of Medicare cost for those who need the subsidy the least."

Do you believe this would be a viable offset for paying for the SGR package?

Ms. FEDER. No, sir, I don't. I believe that the President put forth those proposals in the context of discussing broader budget agreements that would involve tax increases as well as spending reductions and in the context of looking for a balanced approach to reducing the deficit.

Standing on its own and using Medicare beneficiaries as a piggy bank does not make sense to me. Medicare beneficiaries, half of them, as was said earlier, live on incomes that are below $26,000, including their spouse's income.

We do not have a tremendously large, wealthy, elderly population, and I am concerned that efforts to further means test the premiums can erode the universality of the program, which is one of Medicare's greatest strengths.

Mr. PITTS. According to the Social Security Administration records, there are 60,000 seniors with Medicare who have annual incomes in excess of $1 million. Do you believe it is appropriate we charge them more?

Ms. FEDER. Well, Chairman Pitts, those beneficiaries have paid payroll taxes into the system for Medicare on their entire earnings, although the $1 million may not all come from wages, but they have been paying them from wages and now they do pay them also on overall earnings. So people are paying into the system regardless of the income, and we already do have some income relationship with our premiums. That, to me, is legitimate.

I would also say that in terms of your earlier question of using this to pay for the SGR, that in my testimony I have offered you other mechanisms for savings in terms of refining payment rates in Medicare, and I believe that you heard some from Mark Miller that MedPAC has offered, which I think might be far preferable if you are looking for offsets.

Mr. PITTS. But you do not believe it is appropriate to charge them more?

Ms. FEDER. They are charged more.

Mr. PITTS. The million dollar?

Ms. FEDER. They are charged more.

Mr. PITTS. My time has expired.

The Chair recognizes the ranking member 5 minutes for questions.

Mr. PALLONE. Mr. Chairman, I would ask unanimous consent to submit for the record an issue briefed by the Leadership Council of Aging Organizations on MedPAC's extra help copayment proposals.

Mr. PITTS. Without objection, so ordered.

[The information follows:]

Leadership Council of Aging Organizations

ISSUE BRIEF
JANUARY 2014

Altering Extra Help Copayments: A Flawed Savings Approach

Background:

The Low-Income Subsidy program, commonly known as Extra Help, offers assistance to low-income Medicare beneficiaries for prescription drug costs.[1] In 2011, 11.8 million people with Medicare (23%) were enrolled in Extra Help.[2] Estimates suggest another 2 million beneficiaries are eligible for the benefit but not enrolled.[3]

According to the Centers for Medicare and Medicaid Services (CMS), Extra Help saves low-income beneficiaries an estimated $4,000 per year.[4] By definition, the Extra Help program serves some of the most vulnerable people with Medicare, many of whom have significant health needs. The average number of prescriptions filled per month by a person with Extra Help is 5.1 compared with 3.8 for those without the subsidy.

In 2012, the Medicare Payment Advisory Commission (MedPAC) recommended altering generic and brand name copayments in the Extra Help program, with the stated goal of, "…encouraging generic and therapeutic substitutions in classes where such substitutions are clinically appropriate." MedPAC suggested eliminating the copayment for generic medications and increasing the copayment for brand name medications, with varying copayments for preferred tiers and non-preferred tiers. Where no generic substitution is available for a medication, the copayment structure would remain as is under current law.[5]

People with Extra Help:

Full Extra Help is available to people also enrolled in Medicaid and a Medicare Savings Program, as well as those with incomes at or below 135% the Federal Poverty Level (about $15,500 for an individual) and limited assets (no more than $8,660 for an individual). **Full Extra Help benefits include:**

- $0 plan premium
- $0 plan deductible
- Reduced copayments

Partial assistance is available to Medicare beneficiaries with annual incomes between 135% FPL to 150% of FPL (about $17,235 for an individual) and with limited assets (no more than $13,440 for an individual). **Partial Extra Help benefits include:**

- Reduced premium based on income
- $66 plan deductible
- Reduced coinsurance or copayments

It is important to note that the MedPAC proposal would apply higher copayments to brand name drugs for which there are "therapeutic substitution" (one non-identical drug in a therapeutic class for another) as well as to those with generic substitutions (identical chemical composition of drugs) on the market. While the MedPAC recommendations allow the Secretary to exclude some therapeutic classes from the proposed copayment adjustments, specifically in classes where therapeutic substitution is not well tolerated, these exclusions may not be broad enough to protect affordable access to needed brand-name drugs.

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[1] See text box "People with Extra Help" for additional details on full and partial Extra Help benefits. Benefits vary based on beneficiary income and the receipt of other health benefits, like Medicaid and the Medicare Savings Programs. Extra Help copayments for those receiving full benefits range from $1.15 to $2.65 for generic medications and from $3.50 to $6.60 for brand name drugs. See: Medicare Interactive, "Extra Help Program, Income and Asset Limits 2013," (2013). Full benefit dual eligibles in institutions and those receiving an institutional level of care in the community have no copayments under current law.

[2] MedPAC, "A Data Book: Health Care Spending and the Medicare Program," (June 2013)

[3] Kaiser Family Foundation, "Medicare Prescription Drug Benefit Fact Sheet," (November 2013)

[4] Social Security Administration (SSA), "Extra Help with Medicare Prescription Drug Plan Costs," (2013)

[5] MedPAC, "Report to the Congress: Medicare Payment Policy," (March 2012)

MedPAC acknowledges that limited cost sharing alone is not the sole factor contributing to disproportionate use of brand name drugs by Extra Help enrollees. Among those listed are differences in health status, prescriber behavior and pharmacy incentives and variation across states in generic substitution laws.[6] Despite this multitude of factors, the proposed recommendations *only* address beneficiary cost sharing.

Position:

The Leadership Council of Aging Organizations (LCAO) does not support increasing the Extra Help copayment for brand name medications. Depending on the proposed increase in copayments, the cost of medications could more than triple for some Extra Help beneficiaries, making needed prescriptions unaffordable.

Multiple studies suggest increased cost sharing deters access not just for unneeded health care services and medicines, but also to those that are necessary; these effects are most acute for beneficiaries with the lowest incomes. In the long run, reductions in the use of medically necessary care can, in fact, increase health care spending through the increased likelihood of emergency room visits, ambulance rides and hospital stays.[7]

Rationale:

People with Extra Help are among the most vulnerable Medicare beneficiaries. Extra Help beneficiaries tend to be women, individuals with limited proficiency in English and people of color. A disproportionate share of people with Extra Help (43%) is people with disabilities under the age of 65.[8] By definition, people with Extra Help have incomes at, below or near the federal poverty level and limited savings.

These beneficiaries also tend to be sicker than those without Extra Help and take multiple medications. People with Extra Help are not positioned to shoulder any additional health care costs. Although seemingly small, even a several dollar increased copayment for brand name medications will be burdensome for those beneficiaries who must take one, or several, brand name drugs.

Increased cost sharing is shown to deter access to needed medical care. Decades of empirical research demonstrate that increased cost sharing leads people to forgo medically necessary services, such as not complying with prescribed drug use due to cost or putting off preventive care until expensive emergency services are needed. These adverse consequences are especially pronounced for people with low, fixed incomes. As a result, higher cost sharing backfires, since sicker patients will require more costly care down the road.[9]

Physicians and other health care providers write prescriptions—not patients. In addition to heightened disease burden among people with Extra Help, MedPAC acknowledges that disproportionate use of brand name drugs by Extra Help enrollees is also driven by prescriber behavior. Literature on cost sharing and patient behavior confirms that it is health care providers who drive utilization of health care, not their patients. A better and more efficient approach is to contact prescribers directly about medically-appropriate substitutions.

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[6] MedPAC, "Report to the Congress: Medicare Payment Policy," (March 2012)
[7] Swartz, K. "Cost-Sharing: Effects on Spending and Outcomes" Robert Wood Johnson Foundation Research Synthesis Report No. 20 (December 2010)
[8] MedPAC, "A Data Book: Health Care Spending and the Medicare Program," (June 2013)
[9] "Medicare Supplement Insurance First Dollar Coverage and Cost Shares Discussion Paper" National Association of Insurance Commissioners, Senior Issues Task Force, Medigap PPACA Subgroup (October 2011); Amal N. Trivedi, et. al. "Increased Ambulatory Care Copayments and Hospitalizations Among the Elderly" *New England Journal of Medicine* (January 2010); Swartz, K. "Cost-Sharing: Effects on Spending and Outcomes",Robert Wood Johnson Foundation Research Synthesis Report No. 20 (December 2010) ; Ku, L. and V. Wachino, "The Effect of Increased Cost-Sharing in Medicaid," (Center for Budget and Policy Priorities: July 2005)

The Medicare Part D appeals system needs repair. Many people with Medicare are unaware of their right to appeal generic substitution or are deterred from seeking an appeal by an overly burdensome process. Beneficiary advocates have long called for improved beneficiary-facing information at the pharmacy counter as well as a more automatic appeals system, ideally initiated at the point of sale.[10] People with Extra Help forced to pay a higher copayment for a brand name medication or a drug that is similar, but not identical, to what they require may be deterred from acquiring a needed medication because the appeals system proves overly burdensome and complicated. In the absence of a streamlined, accessible appeals system, some beneficiaries for whom therapeutic or generic substitution is not appropriate may be forced to pay a higher copayment for a brand name drug and are at risk of going without these medications altogether.

Care coordination initiatives for dually eligible beneficiaries permit the elimination of drug copayments. Ongoing initiatives to better coordinate care for the most vulnerable people with Medicare, those dually eligible for both Medicaid and Medicare, adopt a broader stance to facilitate medication access—the elimination of cost sharing for prescription drugs altogether. Recent contracts agreed to by CMS and multiple states participating in an initiative to coordinate care for dually eligible beneficiaries, including California, Ohio, Illinois, South Carolina, Virginia and Washington, allow for the following: "Participating plans may elect to reduce this cost sharing for all enrollees as a way of testing whether reducing enrollee cost sharing for pharmacy products improves health outcomes and reduces overall health care expenditures through improved medication adherence under the demonstration."[11] It is anticipated that plans in several states will use this authority to eliminate cost sharing for all covered drugs to encourage adherence. These demonstrations should be allowed to test their impact on beneficiaries before wider changes are implemented.

Low-income populations require education on generic medications. Several studies confirm that low-income populations, including many people of color, remain skeptical of generic medications, fearing that generic alternatives are lower quality and more likely to cause side effects compared to brand name drugs. One 2011 study found that low-income participants in a rural Alabama community outreach program chose to go without prescribed brand name medications despite the availability of generic options.[12] These findings demonstrate that cost sharing alone is not an adequate tool to encourage generic medication use. Educational intiatives are needed to explain the merits of generic prescription drugs. Such initiatives should be undertaken before imposing additional cost burdens on these vulnerable populations.

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[10] Medicare Rights Center, "Facts & Faces: Refused at the Pharmacy Counter, How to Improve Medicare Part D Appeals," (Winter 2013); Sanders, S. "Letter to MedPAC on Medicare Part D Appeals," (September 2013)

[11] Seven of eight CMS-State Memorandum of Understanding (MOU) approved to date included the language noted here. Although different language is included in the MOU, the New York State MOU also allows for reduced Part D cost sharing by participating plans, making no distinction between brand name or generic medications. See Medicare-Medicaid Coordination Office. "Approved Demonstrations-Signed MOUs" (December 2013)

[12] Thomas, K., "Why the Bad Rap on Generic Drugs?" *The New York Times* (October 5, 2013)

Mr. PALLONE. Thank you, Mr. Chairman.

My questions are to you, Dr. Feder. I was troubled by the policy proposals in the testimony of both Mr. Holt and Mr. Goldwein that seemed to devalue the Medicaid program. And by rolling back the Federal contribution to State Medicaid programs and shifting greater costs onto State budgets, access to care for those may be seriously hindered as State's restrict enrollment due to budget shortfalls.

So my first question is, so what would be the result of rolling back the Federal contribution to State and Medicaid programs?

Ms. FEDER. Well, Mr. Pallone, we also, as you well know, we already see that States are constraining some of their services based on their decisions about what they can afford and are willing to spend, particularly in the area of long-term care services for either elderly people or people with disabilities. We know that there are long waiting lists for home care, for example, which is a tremendous matter of concern.

We also know that Medicaid, one of its greatest values is to be able to have the funding respond as needs arise. So in the Great Recession, we found that Medicaid responded to the growing need of the population, that we had so many low-income people. We see Medicaid similarly respond when new drugs come on line that are expensive but can make a real difference to people's ability to get care they need.

So we have lots of experience on which we can draw and lots of research shows that an arbitrary constraint in terms of the Federal share, what the Feds are contributing to Medicaid costs will have an impact on the programs, absolutely, but that impact will fall on providers. They will get less payment. They have been on beneficiaries who will get less access to service, and that the program would be diminished as a result.

Mr. PALLONE. I appreciate you bringing up long-term care too, because I think a lot of times some of us forget the link between Medicaid and long-term care nursing home care, which I think is another issue that, you know, we really should be addressing——

Ms. FEDER. Absolutely.

Mr. PALLONE [continuing]. In a significant way, you know, what we are going to do about long-term care. But many Governors, even Republican ones, even mine have opted to participate in the Medicaid expansion offered as part of the ACA because it is good for their States and good for their citizens.

Moreover, there is empirical evidence showing that Medicaid improves health. For instance, the 2008 Oregon study that expanded Medicaid coverage had substantively and statistically hired utilization of preventive and primary care, lower out-of-pocket medical expenses and lower medical debt and better physical and mental health.

So my second question is, it would appear that there is actual empirical evidence to refute a devaluation of the program and that Medicaid coverage not only helps improve health but keeps people out of medical debt.

Do you want to comment on the benefits of the Medicaid program in that respect?

Ms. FEDER. I agree with you 100 percent that the value of Medicaid to individuals who would, without it go without coverage, has been demonstrated many times over. The evidence you cite is recent evidence that researchers like because it is not influenced by the differences in the population, the more-likely-to-be-sick population that is in Medicaid versus the other populations. And this evidence is particularly confirming of Medicaid's value, although it too had some issues in not fully capturing it.

So Medicaid on the health side for families and kids and on the long-term services and supports for people who are elderly or disabled is extraordinarily valued and we prove it all the time.

Mr. PALLONE. All right. I am going to try to get quickly to this last thing. House Budget Committee Chairman Paul Ryan has continued to propose to convert Medicare into a voucher system for the purchase of private health insurance, and the Urban Institute analysis show this would result in a fairly dramatic shifting of cost to beneficiaries.

What is your analysis of this Ryan proposal, and what are the dangers to Medicare and their beneficiaries from such a proposal?

Ms. FEDER. Well, I share with my colleagues at the Urban Institute precisely that concern, that it is a shift of cost to beneficiaries rather than a savings in cost. We know from experience, we have seen some advocacy lately that competition is working in Medicare Advantage plans, that we can see that risk selection is no longer a problem, but those are claims that are not supported by the evidence.

MedPAC demonstrates that when you have competing plans there is, even as we refine our ability to adjust payments to plans for differences in risk, that the risk selection occurs, that healthier people are served by the plans and sicker ones are avoided or end up disenrolling. And we see, as Mark Miller said earlier, a decided risk that we will lose our capacity to contain costs which Medicare has been so effective, relative to the private sector and to private plans.

Mr. PALLONE. Thank you.

Thank you, Mr. Chairman.

Mr. PITTS. Chair recognizes the gentleman from Florida, Mr. Bilirakis, 5 minutes for questioning.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it very much.

Mr. Goldwein, in your testimony, you talk about budget choices and you classify some of the options as benders or savers. I have been concerned about the prescription drug abuse within the Medicare Part D program and overall program integrity.

Would establishing a safe pharmacy network to provide a single point of sale for at-risk beneficiaries and providing part D plans additional authority against fraud be bender or a saver? Would this save the Government and taxpayers, again, real money?

Mr. GOLDWEIN. So establishing a safe pharmacy, I think, would save money. I can't quantify how much, and I have not seen a CBO score on it. But by clamping down on basically abuse of prescription drugs and overmedication, it will certainly save Medicare money.

I also think this would categorize as a bender because this is one of those wins-wins, where not only would Medicare be better off, but the beneficiary that potentially could become addicted to the drug is better off and society is as well. So it is definitely something worth looking at.

Mr. BILIRAKIS. Thank you.

And next question for Mr. Holt. Private health insurance was the model used to build the Medicare Part D program. Congress used what was successful in the commercial sector and brought that success into Medicare. Shouldn't we use the innovation and tools in the private sector to address some of the drug abuse and fraudulent billing practices in Medicare Part D?

Mr. HOLT. Yes, absolutely, and we already use similar programs in, I think, about 46 of the State Medicaid programs. So, and I think this is an excellent idea. I know both HHS and CMS have said that they support it. I think the committee largely is supportive of this policy, and I think if you can get some savings on top of just good policy, I think that is an excellent choice and move in that direction.

Mr. BILIRAKIS. Thank you very much.

I yield back, Mr. Chairman.

Mr. PITTS. Chair thanks the gentleman.

Now recognizes the gentleman from Texas, Mr. Green, for 5 minutes for questions.

Mr. GREEN. Thank you, Mr. Chairman.

I thank our panel for being here. As we have seen since the passage of the Affordable Care Act, industry stakeholders have continued to make claims that cuts to the Medicare Advantage program would lead to reductions in benefits and increased premiums, but the exact opposite has occurred over that period of time. In fact, premiums have dropped 10 percent and enrollment has increased nearly 30 percent since the ACA required plans to be more efficient in their delivery.

Mr. Goldwein, in your testimony, you propose as one of your saver policies to increase the coding intensity adjustment to reclaim additional overpayments to Medicare Advantage plans. Could you describe this policy and your rationale behind it?

Mr. GOLDWEIN. Sure. Well, let me first say that the policies I listed in my testimony, other than those which were in our prep plan, are not my recommendations but just a list of options.

Now, the President has proposed coding intensity adjustments for Medicare Advantage, which essentially would recoup money that shouldn't have been paid to these plans in the first place, because in some cases, they are over-coding activities, coding them at something that is more expensive than they otherwise would be.

What the exact coding adjustments should be year to year, I can't tell you. I think MedPAC could probably tell you better. But this is the President's recommendation, and certainly we should be continuing to make sure that Medicare Advantage is spending its money as efficiently as possible.

Mr. GREEN. OK. Even today you heard in Mr. Holt's testimony how payment reductions in Medicare Advantage plans would lead to reduced benefits for enrollees in 2015. I believe the plans were

well suited to absorb these cuts by becoming more efficient without harming beneficiaries, as MedPAC has indicated.

Dr. Feder, one concern I have is that in 2014 planned payments are on an average of 106 percent of fee-for-service. If plans cannot compete at fee-for-service rates, do they really belong in the program? We are paying them more and there is no more concrete evidence that their quality is better. Shouldn't we require better from plans as in more efficient performance and better quality if they are to remain part of Medicare?

Ms. FEDER. I agree with that approach, Mr. Green, and with your point that we continue to overpay Medicare Advantage plans relative to payments in the traditional program. I don't see any reason for that and have written and argue that payments should not be higher than what we pay in the traditional plan on the per-capita basis.

Mr. GREEN. Well, and that is one of my concerns. I was here when we created Medicare Advantage and it was supposed to save Medicare funding not cost many more. And I know I have constituents, about 25 percent of my Medicare folks get Medicare Advantage, but when I explain to them that you are actually costing more for Medicare than the 75 percent that is not, you know, then they think about it and say, oh, OK, they didn't know that.

But, Dr. Feder, does it seem irresponsible for us to spend taxpayer and beneficiary money to prop up private industry that benefits only a third, at best, at the expense of the other 70 percent under traditional Medicare?

Ms. FEDER. It does not, and although we have made, I think, the reforms, and Mark Miller laid them out on the previous panel, that have been made in payments to MA plans and through the ACA have reduced those overpayments and are making strides, I think it is not appropriate to over-subsidize those plans.

Mr. GREEN. OK. The title of today's hearing, Doctor, is "Setting Fiscal Priorities," and it appears to solve an economy against spending on entitlement programs for those Americans with the greatest need. It seems that term "entitlement" has come to mean different things to different people. Too often people think of entitlements through the narrow lens of programs that provide the safety net for our seniors and the most vulnerable in our society by considering the fiscal impact of the tax entitlements, tax deductions, exclusions, credits, and other tax preferences, which disproportionately benefit well-to-do Americans.

Can you talk about entitlements, both those providing essential services to seniors and low-income Americans and those providing tax breaks to the more affluent, and the relative role of each in the context of protecting the most vulnerable in our society when addressing our long-term debt?

And I know that is a long question for the last 30 seconds.

Ms. FEDER. I will try and go fast. The entitlements that you speak of, I think, are colloquially defined inappropriately. They accurately mean benefits to which citizens have a right enforceable in court, and that they are typically mandatory spending programs so that the money flows with the population who is eligible for the program and the costs of the benefits that are provided.

You are quite correct that they are provided through the tax system as well as in direct spending, even when they are social service benefits. So the tax benefits that we receive on mortgages, on pension plans, on employer-sponsored health insurance, are all entitlements that essentially go to the upper end of the income distribution.

And a substantial, the bulk of those benefits do go to the better off, and by virtue of their structure, with the exception of benefits that are refundable tax credits like the EITC, they do not go to low-income people. So the tax benefits are skewed up the income scale, and I am talking about the good, the social service type benefits. There are others that are really skewed up the income scale.

By contrast, it is the low and modest income population who benefits appropriately and probably disproportionately from the benefits that are provided by Medicare and Medicaid and benefits like that, that come through Social Security, that come through direct payment.

Mr. GREEN. Thank you, Mr. Chairman. I know we are over time and appreciate your courtesies.

I thank the panel.

Mr. PITTS. Chair thanks the gentleman.

Now recognize the gentlelady from Florida, Ms. Castor, 5 minutes for questions.

Ms. CASTOR. Thank you, Mr. Chairman.

And Congressman Green, I was glad you got back into the Medicare questions involving the Affordable Care Act because there have been, people have kind of played fast and loose with some of the statements today by continuing to imply that the Affordable Care Act cut Medicare, and you are implying to the Medicare beneficiaries our older neighbors, our parents and grandparents, that they have suffered, their benefits have been cut, which could not be further from the truth.

Under the Affordable Care Act reforms, Medicare benefits are better. Remember the doughnut hole is closing so you have more money in your pocket when it comes to paying for your prescription drugs. You get that free wellness visit every year. You get the important visit for your mammogram or colonoscopy or cholesterol check without a copay. Benefits have gotten stronger; isn't that right, Dr. Feder?

Ms. FEDER. Absolutely.

Ms. CASTOR. And meanwhile, what we focused on the Affordable Care Act is cutting the waste in the overpayments to health insurance companies that Dr. Miller, the MedPAC expert, testified to. This is smart policy. So let's turn the page on this and get to the fact that we have more work to do with the aging population and the baby boomers retiring. We still have to ensure that Medicare is there for future generations, like Generation X and the Millenials, I hope so.

So let's talk also about Medicaid because I hear these arguments too that Medicaid is not efficient, that this is a huge cost—yes, it is a big draw on the Federal budget, so we have got to focus on reforms. My colleagues on the other side of the aisle often refer to the inefficiencies of Medicaid. In fact, Medicaid's costs per beneficiary are substantially lower than per beneficiary costs for private

insurance, and Medicaid's cost per beneficiary have been growing more slowly than per beneficiary costs under private insurance. So it appears that Medicaid is more efficient than private insurance, and yet many conservatives say we need to replace Medicaid with a voucher or cap its funding.

And what you are saying there is that our parents and grandparents that relied on skilled nursing and need to go into nursing homes, and with these baby boomers, the policy decision is to take the access to the nursing home away or to children with disabilities that we are not going to be there in a cost-efficient manner to help you survive, I just don't think that is smart policy.

So Dr. Feder, while this might save money, if you block grant or you cut and you slash, how can we expect to really cut healthcare costs while Medicaid is already cheaper than private insurance?

Ms. FEDER. Well, I think that your point is well taken and that this is really not a way to save money. It may reduce Federal spending, but it would shift costs to States and in all likelihood, based on past experience, would leave beneficiaries without needed services just as you describe. That is simply not an acceptable way to meet our obligations to our most vulnerable populations, and those demands are only going to grow as the population ages, as more and more people need not just nursing home care. We are more often now or more often than we were providing care at home, which is where people want to stay, and we need to be able to do that.

To expect Medicaid to do that on some notion that an already lean program can somehow be magically more efficient makes no sense at all. Medicaid can participate and is participating with Medicare in the private sector in improving delivery to minimize and reduce inefficiencies. But in all likelihood, as the population ages, Medicaid needs more support not less.

And I find it—if you would, for one more moment—I find it interesting that your colleagues across the aisle want to spend less on Medicaid and pull those Federal dollars back when we know that States are arguing that—some States are resisting Medicaid expansions because they think the Feds are not going to come through with the needed dollars. So it seems to me that this becomes a wish fulfillment on the part of those who are opposed to adequate coverage.

Ms. CASTOR. Thank you very much. I yield back.

Mr. PITTS. Thank you.

We will go to one follow-up per side. I will recognize myself 5 minutes for that purpose.

Mr. Holt, the New York Times has a story this morning about a new report from the HHS Office of Inspector General that is being issued today, and the report found, quote, "Half of providers listed as accepting Medicaid patients could not offer appointments to enrollees," end quote, for non-urgent visits.

Now, the President's health law is fueling rapid growth in Medicaid with enrollment up by 9 million people just this year. The inspector general warned that, quote, "When providers listed as participating in a plan cannot offer appointments, it may create a significant obstacle for an enrollee seeking care," end quote.

According to HHS, the Nation is already going to be 20,400 primary care physicians short by 2020, just a few years from now. Should Congress be concerned that the shortage of doctors and low participation rates in Medicaid along with the Medicaid expansion means that the most vulnerable patients will face worse access problems?

Mr. HOLT. Yes, absolutely. I haven't seen the study yet, since it came out while we were sitting here, I think, but my big concern about the Medicaid expansion has been that you are putting more people into this program. There is already difficulty in Medicaid beneficiaries getting access to doctors. And we have to keep in mind that having coverage is not the same as having access and having access is not the same as having better outcomes.

And so I think it is very important that as we look at the expansion, which sort of disincentivizes the enrolling of lower-income individuals who were previously eligible because they were met at a lower match but pays States quite a bit more, right now 100 percent, to enroll, higher income, still lower-income individuals that were sort of incentivizing the States to focus on the wrong population, and we are making it harder for those people, the most vulnerable, to get to doctors, to get to care.

Mr. PITTS. Mr. Goldwein, under the Affordable Care Act, States have the option to expand Medicaid to adults with no children, with income under 138 percent of the Federal poverty level. This was an unprecedented expansion of the program that traditionally has covered low-income moms and kids, the elderly, poor, the blind, and disabled. Under the expansion, the Federal Government is paying 100 percent of the cost of the expansion until 2016 when States have to start picking up some of the tab.

Accordingly, under Federal rules today, the Federal Government is paying the full cost of some prisoners' hospital care who would otherwise be eligible for Medicaid, the medical bills of multimillion-dollar lottery winners who States are barred from disenrolling in the program. Do you think this is an appropriate use of Medicaid dollars?

Mr. GOLDWEIN. Well, I think, by and large, there was a decision in the Affordable Care Act to use Medicaid rather than the insurance subsidies to cover that population between 100 and 133 or 138 percent of poverty. And that was a reasonable choice where you could have disagreed. Now, within that population, there certainly are going to be some cases where there are beneficiaries that don't really merit receiving benefits, and there probably is an opportunity to look at those on an individual basis and find places where States can cut off those benefits.

Mr. PITTS. Dr. Feder, one of the concerns about Federal spending on entitlement programs is that such spending is crowding out other parts of the Federal budget. For example, this committee has had a strong bipartisan tradition of supporting research and science at the National Institutes of Health. It will be impossible to find increases to the NIH budget without some reforms to our entitlement programs.

Under current law and projections, should Congress be concerned that discretionary portions of our budget like the NIH will face in-

creasing budgetary challenges without some reforms to the mandatory healthcare spending?

Ms. FEDER. Well, Chairman Pitts, I would like to reiterate what I believe that Mr. Pallone said a little while ago, which is that the Affordable Care Act was entitlement reform and has generated enormous savings in the Medicare program. And, in fact, if we look at the deficit reduction that has occurred overall in the last several years, about three quarters of it has come from spending reduction, not revenue increases. And as I said earlier, if we expect to meet the demands of our society, we cannot continue to constrain spending whether discretionary spending is getting very hard hit, and I agree with you that it is unacceptable.

But the way to address that is not to create inadequate supports in strong programs; it is to adequately generate revenues to support the needs of our population.

Mr. PITTS. Would you not agree that much of that spending reduction is due to the use of generics?

Ms. FEDER. Not the spending—that is true if you are referring narrowly to some of the spending. Some of the spending reduction in Medicare on part D, for example, lower than was estimated, is due to an expansion of generics in part, but to other factors as well that affected the whole industry was not necessarily a reflection of the part D design, but I am talking more broadly about the budget.

Mr. PITTS. Thank you. My time is expired.

Chair recognizes the ranking member, 5 minutes for questions, follow-up.

Mr. PALLONE. Thank you.

In my previous question I said that I believe that simply turning Medicare into a voucher is shortsighted and simply shifts costs onto seniors and people with disabilities, and I believe there are more thoughtful ways to address healthcare costs growth. And you sort of got into this, Dr. Feder, but the Affordable Care Act sets the stage and began to put in place some initiatives to address cost growth without harming patient care.

Could you give me your views on the reforms and the ACA and their ability to address cost growth?

Ms. FEDER. Well, actually, we heard a lot about those in the first panel.

Mr. PALLONE. Right.

Ms. FEDER. So I think that we are seeing efforts to tie payments more closely to performance, to encourage providers to be more efficient in their delivery of care. Prime example for that is the penalty for readmission rates. I think that that ought to be monitored and done properly, but I think we are seeing positive results there.

The law went beyond that to create a new option in terms of the way in which providers get paid instead of rewarding more for ever more expensive and higher-volume services. We see the creation of the accountable care organizations that rewards providers if they meet performance standards, a very important aspect of it and then labels them to share savings. And we see many pilot programs exploring improved efficiency in the delivery of care in both Medicare and Medicaid.

We see, for example, in the area we talked about earlier, independence at home, which is having doctors serve and people who

need long-term care services going to the home. That is an exciting change or benefit to explore. We are seeing health homes where those same individuals get support services, particularly focused on improvements for those who need behavioral health services, which I heard a member talk about earlier.

And we have a variety of demonstrations of various kinds that are focused on holding providers accountable for the delivery of quality care, rewarding them for that performance rather than for higher-volume services.

Mr. PALLONE. Thanks.

And you pointed out that the ACA improved Medicare's financial solvency. It is now projected to be in good standing for an additional 4 years until 2030, according to the Medicare Trustees. Just talk a little bit about the financial health of the Medicare program. What are the fiscal challenges? What kind of timeframe are we looking at in terms of the ability of current Medicare revenues and the Medicare hospital insurance trust fund to continue to cover the cost of the program?

Ms. FEDER. Well, as we look, we have to always remember the different ways in which the program is funded and you hear people talk about the exhaustion of funds. That is, as you have correctly said, only about part A, where the funding is generated by predetermined payroll tax rates. Part B and part D are funded through general revenues in large part and to some extent then through beneficiary premiums. So there is no issue of exhaustion of trust funds when it comes to those other programs.

On part A, we know that in Medicare, like as in Social Security, that we have a growing elderly population dependent on a now smaller working age population. And so when we talk about the exhaustion of the trust fund, when the program will still be able to pay three quarters of its benefits but not all—I believe that is the number—we talk about exhaustion of the trust fund, that reflects the fact that looking out that payroll tax revenues that are already—or payroll tax rates are not expected to generate sufficient revenues to support the program at that time.

But that is, as you say, a long way from now. We have been much closer to that exhaustion date, Congressman, in previous years, Congress has always taken action to assure the soundness of the program. And as I said in my testimony, with us experiencing now the lowest health cost growth in the Nation's history—anyway since 1960, that is not quite the Nation's history—it is a time for us to continue to explore the payment reforms and payment refinements, not just in Medicare or in Medicaid but in the entire healthcare system so that we can keep cost growth low and even though we will likely need new revenues for a growing elderly population, with strong economy and efficient healthcare systems, we are absolutely capable of meeting our responsibility.

Mr. PALLONE. Thanks so much.

Mr. PITTS. All right. That concludes member's questioning for now. I am sure members will have follow-up questions they will submit to you in writing those questions. We would ask you to please respond promptly. I remind members they have 10 business days to submit questions for the record and they should submit those questions by the close of business on Tuesday, December 23.

Very informative hearing.

Thank you very much. Without objection, this subcommittee is adjourned.

[Whereupon, at 1:12 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Statement for the Record by Chairman Fred Upton
Health Subcommittee Hearing on "Setting Fiscal Priorities"
December 9, 2014

The federal government faces enormous budgetary challenges, due in large part to mandatory federal spending on health care programs. Despite relative reductions in this year's annual deficit compared to the immediate aftermath of the Great Recession, the Congressional Budget Office projects annual deficits to climb yet again towards $1 trillion over the next ten years.

Medicare and Medicaid are critical safety nets for our nation's seniors and most vulnerable. Today's status quo of runaway spending, however, poses a great threat to not only these programs, but also to our country as a whole. In order to rescue these programs and protect them for future generations, it is our responsibility in Congress to evaluate and adopt commonsense solutions that strengthen these programs and put them on sounder fiscal footing.

Today's hearing will help prepare the subcommittee for this important work as we approach a new the 114th Congress. We must be prepared for immediate challenges such as the Medicare physician payment cliff in March and the extension of funding for the Children's Health Insurance Program by the end of the fiscal year. Today provides members the opportunity to discuss ideas, both big and small, to help move these programs and our federal budget in the right direction. Beyond ensuring that the federal government's budget is sustainable, today's hearing is important for several reasons.

First, as mentioned before, millions of our seniors and the most vulnerable rely on a strong Medicare and Medicaid program. According to the non-partisan Actuary of the Medicare program and Congressional Budget Office, both Medicare and Medicaid face very serious long-term financing challenges – challenges which can undermine access to care for beneficiaries who rely on these programs. To ensure beneficiaries receive the benefits they expect, Congress must adopt reforms to better serve these patients and ensure that the programs are financially sustainable over the long-term.

Second, critical areas of our discretionary budget are facing increasing pressure because federal spending on mandatory health programs is so significant. For example, through our 21st Century Cures initiative, we have heard the need to ensure that the National Institutes of Health's funding is able to help spur the next generation of advances in the discovery, development, and delivery of new treatments and cures. If we want to direct resources to targeted areas within our discretionary budget like the NIH, it is critical that we ensure our entitlement programs do not crowd out parts of the federal budget.

Third, setting fiscal priorities is a matter of basic fairness. For example, the federal government, through the Affordable Care Act, is now paying 100 percent of the cost of covering able-bodied, childless adults through the law's Medicaid expansion, even though many disabled children sit on waiting lists in other parts of the program. Consider another example: households at 400 percent of the federal poverty level – with annual income nearing $100,000 – receive subsidies through the health care law's exchanges. To finance these subsidies, the ACA raised more than $1 trillion in new taxes. That's not fair to millions of hard-working, middle class families. If Congress is going to protect the most vulnerable, these programs

at the very least must be on the table as Congress looks at ways to prioritize resources.

Our current fiscal path is unsustainable, and doing nothing is not an option. I appreciate the many ideas offered by key experts in their prepared testimony and look forward to continuing to work with my colleagues as we prepare to make real progress in health care in the New Congress.

Statement of Henry A. Waxman
Ranking Member
Committee on Energy and Commerce
Subcommittee on Health Hearing on "Setting Fiscal Priorities"
December 9, 2014

Today we have a hearing on the entitlement programs and the economy – with the implication we have to choose one or the other in setting "fiscal priorities." Unfortunately, in the name of fiscal responsibility and balancing the budget, we are often presented with what I believe is a false choice between securing our nation's fiscal health and ensuring the health of older, disabled, and low income Americans.

As this is one of my last hearings while in Congress, I want to use this opportunity to highlight my commitment to protecting our federal entitlement programs, namely the Medicare and Medicaid programs, and the vulnerable populations they serve.

There are different paths we can take to ensuring the long term fiscal health of Medicare and Medicaid. The Ryan Budget proposals and what my Republican colleagues and their witnesses propose in our hearing today are fundamental structural changes in the programs which, through premium support and privatization for Medicare and block grants for Medicaid, shift costs to beneficiaries, providers, and states. This path does not lower costs, it shifts costs in a way that undermines the programs' guarantee of access to care.

The alternative path that we began in 2010 with passage of the Affordable Care Act is to reform entitlement programs through delivery system reform that improves both efficiency and quality. The Affordable Care Act improves access to preventive care that saves dollars and lives. It includes incentives to reward physicians and other providers for better coordinating care and improving health. It also included policies to cut waste and inefficient care.

Health reform is entitlement reform. It is this kind of reform that builds a better health care system for all Americans at the same time it lowers costs and helps support the long term sustainability of our public health care programs.

Medicare and Medicaid are not ballooning out of control. These programs are amazingly efficient. Over the 2010 – 2014 period, Medicare spending per beneficiary increased by well less than one percent per year. On the Medicaid side, CBO estimates of projected Medicaid spending dropped by $395 billion through 2020, and the CMS Actuary predicts spending will grow no faster per beneficiary than private insurance.

The problem is the numbers and the aging of our society. In the coming years we will see a growth in the number of people who need Medicare and Medicaid. For Medicare, it is because of

the retirement of the baby boomers. And, many of these Medicare beneficiaries will also rely on Medicaid. Currently, dual eligibles are 15 percent of the Medicaid population, but account for nearly 40 percent of expenditures.

In Medicaid, millions of Americans who were previously shut out of having insurance—particularly the working poor—now have access to coverage as of 2014. More people clearly means more costs – but the solution should not and cannot be simply to shift costs to states and beneficiaries, but to continue our efforts to improve the value we get from our programs in a thoughtful and sensible way.

Rather than a serious effort at maintaining our commitment to help working Americans, the Republican budget slashes away at the programs that families need most. The Republican budget is built on a hoax. On the one hand, they say it balances in 10 years. On the other hand, they say they repeal Obamacare. The fact is, they repeal all the benefits of Obamacare – including improvements to Medicare, like filling in the Medicare Part D donut hole and adding no-cost preventive services - the things that help provide affordable health care to millions more Americans. But then they turn around and keep the very Medicare cuts and taxes from the Affordable Care Act that Republicans campaigned against.

We need to have an honest conversation about where the opportunities are to improve quality and efficiency, and secure the financial integrity of these programs, while acknowledging the demographic realities ahead.

And to do that, revenues need to be on the table. I do not think most Americans would say – well we know there are going to be 70 million more seniors in Medicare, but we hope you can make do with the dollars that supported only half that number.

Eviscerating programs for low and middle -income Americans while protecting tax perks for the wealthiest is unjust.

If history is any indicator of what lies ahead, today's hearing will be a one-sided conversation, a simple-minded focus on slashing the safety net, rather than a robust discussion about how to take care of all Americans.

Congress of the United States
Washington, DC 20515

January 9, 2015

Dr. Mark E. Miller
Executive Director
Medicare Payment Advisory Commission
425 Eye Street, N.W., Suite 701
Washington, D.C. 20001

Dear Dr. Miller:

Thank you for appearing before the Subcommittee on Health on Tuesday, December 9, 2014, to testify at the hearing entitled "Setting Fiscal Priorities."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business Monday, January 26, 2015. Your responses should be mailed to Adrianna Simonelli Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to **Adrianna.Simonelli@mail.house.gov**.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

Responses to additional Questions for the Record
"Setting Fiscal Priorities"
Hearing before the Committee on Energy and Commerce – Health Subcommittee
December 9, 2014

Testimony by Mark Miller, Ph.D.
Executive Director,
Medicare Payment Advisory Commission

The Honorable Joseph R. Pitts

1. **Despite the efforts by the president's fiscal commission members and many members of Congress, today lawmakers have not reached a $4 trillion, or even a $2 trillion, debt reduction deal. In fact, our national debt is several trillions of dollars higher than it was in 2010. How urgent is the need for action by this Committee in the coming Congress to address our health care spending?**

   The Commission is concerned about the impact of health care spending on the fiscal health of the nation. Health care accounts for a large and growing share of spending in the United States, more than doubling as a share of gross domestic product (GDP) in the period between 1972 and 2012, from about 7 percent to a little over 17 percent.

   The level of and growth in health care spending significantly affect federal and state budgets, since public spending on health care accounts for nearly half of all health care spending. If this spending continues to consume an increasing share of federal and state budgets, spending for other public priorities—like education, investment in infrastructure, and scientific research—will be crowded out, and the federal government will have less flexibility to support states because of its own debt and deficit burdens. Medicare spending is projected to consume 15 percent of the federal budget this year. When combined with spending on Social Security, Medicaid, and the health care exchange subsidies, those programs are projected to consume 48 percent of the federal budget this year and their spending is projected to grow rapidly over the decade, averaging 6 percent annually. Health care spending and its growth over time puts pressure on employer, government, and family budgets.

   For the Medicare program, this pressure is particularly acute given the outlook for the federal debt and the projected increases in Medicare enrollment. Medicare trends are undoubtedly influenced by broader trends in the economy and the health care delivery system. But because the Medicare program pays for just over one-fifth of all health care in the United States, it has an important influence on the shape of the health care delivery system as a whole. These concerns are reflected in recommendations the Commission has made to the Congress, as discussed in my testimony at the December 9 hearing. These recommendations seek to control spending and create incentives for beneficiaries to seek, and providers to deliver, high-value health care services.

2. **Medical education reform has been cited by numerous government entities and private stakeholders as something that can create efficiencies and help our country better address its**

workforce issues in areas such as primary care. What is MedPAC's position on the need for medical education reform?

As MedPAC's chairman Glenn Hackbarth wrote in an editorial in the New England Journal of Medicine, "U.S. health care is too expensive, and its quality too inconsistent. To ensure that health care will be affordable for future generations and appropriate for our burgeoning geriatric population, its delivery and organization must change. Physicians should be in the vanguard of this change, and transforming medical education will be instrumental in preparing tomorrow's physicians to lead the way."

Medicare invested $9.5 billion in GME in 2009. It is the single largest payer for GME, but it establishes minimal accountability for achieving education and training goals. MedPAC has therefore recommended that Congress authorize Medicare to use this financial leverage to catalyze more rapid GME reform by linking about one third of its GME dollars to programs' performance on newly developed measures.

In 2010, the Commission made a set of recommendations intended to increase accountability and transparency in GME spending. In particular, the Commission recommended that the Congress should authorize the Secretary to develop standards for distributing GME funds. An institution's GME funding would be tied to its performance in meeting these standards. The new performance-based GME program would be funded through IME payment reductions that bring IME funding down to an empirically justified level. The Commission also recommended that the Secretary conduct several studies and publish additional reports on GME issues. These included: an annual report displaying Medicare medical education payments received by each hospital and each hospital's costs associated with medical education; a work force analysis to determine the number of residency positions needed in the United States in total and by specialty; how residency programs affect the financial performance of sponsoring institutions and whether residency programs in all specialties should be supported equally; and strategies for increasing the diversity of our health professional workforce.

3. **Currently, under the Medicare program, hospitals are reimbursed for the deductibles and co-pays left unpaid by Medicare beneficiaries. This is known as "bad debt." This policy has no parallel in the private sector or in any other federal health program. The president's Fiscal Commission recommended terminating this special subsidy. The president's FY2015 budget recommended phasing this out as well, estimating it would save taxpayers $30 billion over a decade. Can you explain the reasons for scrapping this policy?**

   The Commission has not addressed this policy.

4. **In its March 2013 report to the Congress, MedPAC stated that "Medicare's rising costs are projected to exhaust the Hospital Insurance trust fund and significantly burden taxpayers. The financial future of Medicare prompts us to look at payment policy and ask what can be done to develop, implement, and refine payment systems to reward quality and efficient use of resources." How important are reforms that change beneficiaries' incentives to the policy options that MedPAC has put forward?**

   In order to achieve a delivery system focused on coordinated care, both the provider of care and the beneficiary must be engaged. Under FFS, beneficiaries can receive care irrespective of its

effectiveness or the quality of the outcomes it produces, and some beneficiaries are exposed to the risk of significant financial liability. To address these problems, the Commission has made a set of recommendations to change the FFS benefit structure and the incentives that beneficiaries face when choosing health care services.

The Commission recommended the Congress provide:

- Catastrophic protection through an out-of-pocket maximum;
- Rationalized deductible (or deductibles) for Part A and Part B services;
- Improved OOP predictability by replacing coinsurance with copayments; and
- Secretarial authority to alter or eliminate cost sharing based on the evidence of the value of services, including cost sharing after the beneficiary has reached the OOP maximum.

Under the recommended benefit design, the average beneficiary cost sharing liability would remain unchanged. Beneficiaries who incur very high Medicare spending would see their liability reduced, while others who incur very low Medicare spending will experience higher liability. The added benefit protections would make supplemental coverage less necessary, so the Commission also recommended that an additional charge be placed on supplemental policies to cover at least some of the added costs imposed on Medicare for having first dollar coverage and send a clearer price signal to the beneficiary. Depending on the level of additional charge and the resulting take-up of supplemental coverage, net program savings are realized.

The Commission acknowledges that even with the improved FFS benefit, beneficiaries with limited incomes could still have difficulty paying their OOP costs. An earlier Commission recommendation to expand eligibility for Medicare Savings Programs (MSPs) could help address this concern. In 2008, the Commission recommended that the Congress align the MSP income eligibility criteria with the Part D low-income drug subsidy (LIS) criteria, effectively extending the Part B premium subsidy to beneficiaries with incomes up to 150 percent of the federal poverty level. Alleviating the expense of the Part B premium for beneficiaries with incomes between 135 percent and 150 percent of the federal poverty level would enable low-income beneficiaries to use these funds to pay the remainder of their Medicare OOP costs.

5. **The Medicare program pays a higher rate for many services if provided in a hospital outpatient department versus a physician's office. In your opinion, what are the behavioral effects of a payment system that creates disparity between provider payments based on location? For instance, has it helped fuel provider consolidation or encouraged pattern shifts in where care is being provided?**

The Commission believes that how Medicare pays can be a significant driver of provider behavior – what services they choose to provide, to what patients and in which setting. Differentials in payment between hospital outpatient departments and physician offices are significant enough to provide an incentive for the migration of services. Indeed, in 2012 Medicare saw a 7% drop in the volume of echocardiograms provided in the physician office setting and a 13% increase in the same services provided in hospital outpatient departments. Keep in mind that these services are unlikely to have truly migrated from the office setting to

the OPD. Instead, the services are likely billed under the OPD rates after the physician practice has been purchased

The impact of the migration of this and other services on program and beneficiary spending is significant. We estimated that Medicare pays approximately $2 billion more annually for services that are provided in the hospital outpatient department that could reasonably be provided in the freestanding office, and recommended that Medicare hospital outpatient department payment rates for these services be reduced. The Commission's recommendations on equal payments across settings can mitigate spending increases that result from provider consolidation, because payments for some services that have migrated to the higher cost outpatient department would be reduced.

6. **We have heard concerns about the Medicare RUC process - a committee driven by the American Medical Association that assists in valuing physician services. Some have argued that the RUC overvalues specialty care and undervalues primary care. Other data suggests that certain specialty care services are undervalued relative to primary care. I am curious as to whether MedPAC has done any work in this area? Do you or the commission have any thoughts on this topic?**

The Commission has done substantial work in this area, and has a long-standing concern that primary care services are undervalued by the Medicare fee schedule for physicians and other health professionals ("the fee schedule") compared with procedurally based services. That undervaluation has contributed to compensation disparities such that average compensation for specialist practitioners can be more than double the average compensation for primary care practitioners. For example, radiologists' average annual compensation in 2010 was $460,000, while the average for primary care physicians was $207,000. Such disparities in compensation could deter medical students from choosing primary care practice, deter current practitioners from remaining in primary care practice, and leave primary care services at risk of being underprovided.

Medicare's fees to physician and other health professionals are based in large part on the relative value units (RVUs) that are assigned to each service in the fee schedule. These RVUs account for the amount of work required to provide each service, the expenses that practitioners incur related to maintaining a practice, and malpractice insurance costs.

The Commission and others have raised concerns about the RUC process and the Commission has a set of recommendations on how Medicare can improve the accuracy of the fee schedule. The Commission has had a particular interest in rebalancing the fee schedule to pay relatively more for primary care, but the recommendations discussed below would also have the benefit of improving the accuracy of RVUs of other services.

One strategy is for the Secretary to collect current, objective data to set the fee schedule's RVUs for practitioner work and practice expenses using a targeted surveying process. The RVUs for practitioner work are largely a function of estimates of the time it takes a practitioner to perform each service. However, research performed by contractors for MedPAC, as well as for CMS and for the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services has shown that the time estimates are likely too high for some services,

particularly non-primary care services. In addition, anecdotal evidence and the experience of clinicians on the Commission suggest problems with the accuracy of the time estimates.

The Commission has also recommended differentiating updates for primary care and procedural services as part of its SGR reform recommendation, so that primary care services receive a higher update. More recently, the Commission has recommended an extension of the Primary Care Incentive Program in the form of a per-member payment for primary care providers, funded through a reduction to the procedural side of the fee schedule.

7. **There was a lot of discussion regarding Medicare benefit modernization reforms and their impact on beneficiaries and the program. You mentioned there is "some redistribution" as a result of the proposed benefit modernization reforms. Can you elaborate on the degree and scope of that redistribution? For example, based on MedPAC's analysis, are the beneficiaries who save money relatively younger or older? Can you also explain what low-income protections would be included in such reforms?**

The impact on beneficiaries' total out-of-pocket costs will depend on the benefit package and individual use of services. For example, under the Commission's illustrative benefit package, the new deductible is higher than Part B deductible but lower than Part A deductible under current law. Therefore, cost sharing for those with a few physician office visits would increase whereas cost sharing for those with lots of services (e.g., hospitalization or at the catastrophic level) would decrease. In general, the individual impact will depend on health, level and type of service use, and supplemental coverage.

Under the Commission's recommendation, dually eligible beneficiaries were held harmless. In other words, whatever the changes in benefits might be, states would fill in any changes in those beneficiaries' cost sharing. In addition, the Commission has supported expanding the QI program for low-income beneficiaries who are not dually eligible—those between the 135% and 150% of FPL—so that they receive assistance on their Part B premiums.

8. **Medicare spending grew last fiscal year by only 2.7 percent - the fourth lowest growth rate in history - despite a 3.8 percent increase in the number of beneficiaries. In large part because of these recent trends, the Congressional Budget Office (CBO) has revised down its future health care cost projections significantly. The agency now projects Medicare spending between 2012 and 2021 to be more than $500 billion lower than projections they made in March of 2011. Can you comment on to what degree this slowdown in the rate of growth might be a result of demographic changes as Baby Boomers come into the program? Does this relative slowdown ameliorate concerns about insolvency of the program or crowd out other discretionary budget? Why should Congress be concerned about an *increase* in health care costs, and Medicare spending in particular?**

MedPAC does not have a definitive view on the cause of the slowing health spending growth rates. Many analysts attribute the slowdown to the economic recession of 2007 to 2009 (the Great Recession) and the slow recovery in its aftermath. Under that view, health care spending growth is expected to rebound as the economy recovers, and health care spending will once again consume an ever-increasing share of economic output. Alternatively, a second point of view attributes the slowdown to more permanent changes in health care markets and concludes

that the slower growth rates may persist—somewhat alleviating budget pressure on federal and state governments, third-party payers, and individuals. Others suggest it was a combination of economic and structural factors.

Whatever the reason for the slowdown, the Commission remains concerned about the outlook for the program going forward. Despite the slow growth in recent years, CBO projects that total Medicare spending will grow at an average annual rate of about 6.6 percent over the next 10 years. While the growth in per beneficiary spending has slowed recently (averaging 1.6 percent annually from 2010 to 2012 compared with an annual average growth rate of about 7 percent since 1980), it is projected to begin to pick back up and average 3.3 percent annually over the next 10 years. Historically, Medicare enrollment has grown about 2 percent per year, but over the next decade, Medicare enrollment growth is projected to average about 3 percent annually, increasing Medicare enrollment from about 50 million beneficiaries today to about 70 million by 2022. This rate of growth in the future has the potential to put further pressures on government, employer, and individual budgets.

9. **Based on what is known now about "delivery system reforms" included in the ACA (ACOs, CMMI, etc.) do you believe these policies reduce the need to address Medicare's crowd out of the discretionary budget or the program's coming insolvency -which would jeopardize care for seniors that depend on the program?**

   As they are implemented, the Commission monitors delivery system reform policies and their impact on providers, Medicare beneficiaries and the program overall. While we share the goals of the Medicare programs for Accountable Care Organizations (ACOs) – improved care, delivered more efficiently – it remains too early to gauge the long term impact of these reforms on Medicare. Of more than 50 million Medicare beneficiaries, only about 5 million receive their care through ACOs and among those ACOs, most are in program tracks that provide only shared savings, but do not require shared losses. The Commission believes that these "bonus-only" tracks provide less incentive for providers to reduce spending compared to two-sided risk models that require providers to share in losses.

10. **One of the reasons given for *not* making changes to beneficiaries' cost sharing or benefit design is that beneficiaries have "paid for" Medicare via their payroll taxes. Can you discuss the downsides of that view, as it relates to the proportion of dollars paid by payroll tax vs. benefits used by an average beneficiary?**

    Medicare is a social insurance program, not a savings program. Taxpayers make contributions to the current Medicare program through payroll taxes, and beneficiaries' use of Medicare services do not have any bearing how much they contributed while employed. Depending on beneficiaries' longevity, health, income, etc., how their Medicare benefits compare to taxes is going to vary a lot at the individual level. According to one study from the Urban Institute, on average, the expected present value of lifetime Medicare benefits far exceed taxes. Also note that Medicare Part B is financed mostly through general tax revenue (75% general tax revenue, 25% beneficiary premiums).

11. **Some suggest federal savings are achieved in benefit modernization proposals in one of two ways either through decreased utilization, based on the barrier/disincentive created by increased cost sharing, or by cost shifting to beneficiaries and third party payers. Some have**

cited an analysis done by the Kaiser Family Foundation suggesting between 50 percent and 71 percent of beneficiaries would pay more under the proposed benefit modernization plans. While the impact to individual beneficiaries would depend in part on their relative utilization of services (inpatient and outpatient), can you discuss the scope of potential increases that beneficiaries might experience, as well as protections for cost-sharing included in these reforms that could reduce concerns about shifting costs to an older: poorer, and less healthy Medicare population?

See question 7 above for the answer to this question.

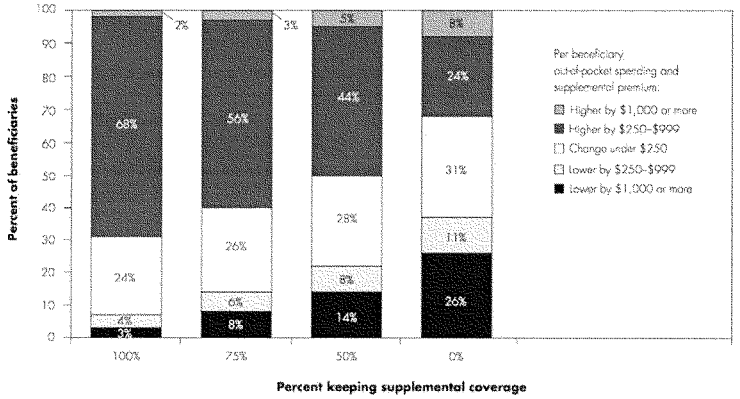
The Honorable Jan Schakowsky

1. **Under MedPAC's proposal to combine the Part A and B deductible and add an out-of-pocket cap, there appear to be winners and losers; some who will pay less and some who will pay more. What data, studies or analysis can you provide concerning the impact of this proposal on cost sharing for individual beneficiaries? In particular, which beneficiaries would pay less and which beneficiaries would pay more? What percent of beneficiaries in a given year would pay more and which would pay less?**

   Any analysis of the impact on beneficiaries' OOP spending is going to be specific to the benefit package being analyzed. Figure 1-2 shows the impact of the illustrative benefit package in our report under different assumptions about the percentage of beneficiaries who keep their supplemental plan.

FIGURE 1-2

Changes in Medicare out-of-pocket spending and supplemental premium under a 20 percent additional charge on supplemental insurance, 2009



Note: Beneficiaries included in this analysis were enrolled in both Part A and Part B for the full year in 2009 and not enrolled in private Medicare plans or Medicaid. We assumed four different levels in take-up rates among beneficiaries who currently have medigap insurance: 100%, 75%, 50%, and 0%. Out-of-pocket spending excludes Part B premium. The change in supplemental premium includes the 20% additional charge on supplemental insurance. Percentages may not sum to 100 due to rounding.

Source: MedPAC based on data from CMS.

2. **In explaining the impact on beneficiaries of the redesign proposal, you testified that, over time, beneficiaries run a greater risk of entering the hospital, so, over time, more beneficiaries would be likely to benefit from a catastrophic cap. Given that any catastrophic cap would likely apply on an annual basis, and that in any given year for any given beneficiary, a hospitalization would be less likely than utilization of Part B services, did the Commission's analysis incorporate any data or assumptions about income, savings or other means with which beneficiaries might have to pay such expenses on an annual basis, and, over multiple years? In other words, if beneficiaries are paying more out of pocket for Part B services in the years during which they have no hospitalizations, might this offset any savings they might incur by paying less when they do require hospitalization? Have you done an analysis on the impacts on beneficiaries overtime? If so, could you please provide that analysis?**

   Our analysis did show that over time, more beneficiaries would benefit from the catastrophic cap. For example, while only 6 to 7 percent of FFS Medicare beneficiaries would have cost-sharing liability that reaches $5000 in one year, 19 percent of beneficiaries would have cost-sharing liability that reaches the $5000 maximum in one or more years over five years and 32 percent over 10 years. That said, our analysis did not include beneficiaries' income or savings, other than holding dually eligible beneficiaries harmless, so we did not examine the approach you describe.

   The Commission acknowledges that even under an improved benefit, Medicare beneficiaries with limited incomes could have difficulty paying their OOP costs. The Commission's 2008 recommendation to align the MSP and LIS income eligibility criteria addresses some of this concern. Alleviating the expense of the Part B premium for beneficiaries with incomes between 135 percent and 150 percent of the federal poverty level would enable low-income beneficiaries to use these funds to pay the remainder of their Medicare OOP costs.

3. **Did MedPAC consider options to mitigate the potential negative impact of a combined deductible, such as exempting physician visits from the deductible? If so, please describe your ideas.**

   The Commission has discussed the issues raised by a combined deductible in its 2012 report. One the one hand, a combined deductible would likely be higher than the current Part B deductible, beneficiaries who only use Part B services might end up paying more out of pocket. On the other hand, under the Commission's proposal to redesign cost sharing, some beneficiaries might be better off, even if they did have only Part B spending. Although the Commission has not specifically considered exempting physician visits from the deductible, our recommendation includes providing secretarial authority to alter or eliminate cost sharing based on the evidence of the value of services, which could include certain physician visits.

4. **In its March 2012 report on Medicare redesign, MedPAC suggests that private-sector innovations in benefit design should be considered when weighing options to restructure traditional Medicare benefits. Generally speaking, private market plans incorporate a prescription drug benefit together with outpatient and hospital benefits, unlike traditional Medicare where the prescription drug benefit is only available through a stand-alone private option. Did MedPAC consider incorporating a publically administered prescription drug benefit as part of its Medicare redesign proposal? If no, why not?**

The Commission's work in benefit design focused on the FFS benefit – Medicare Parts A and B – and did not contemplate including a prescription drug benefit.

5. **Further explain what you mean by imposing 'clearer price signals' to beneficiaries by increasing Medigap premiums.**

   Research is clear that first-dollar coverage increases service use. In other words, beneficiaries are likely to use more health care services with supplemental coverage that fills in their cost sharing than without supplemental coverage. Since the Medicare program stills pays the majority of those additional services and supplemental coverage is paying only the cost sharing portion of those services, beneficiaries with supplemental coverage are imposing additional costs on the program and other beneficiaries. The additional charge on supplemental insurance the Commission is recommending would reflect more appropriately those additional costs imposed on the program due to the insurance effect of supplemental coverage.

6. **In your written testimony, you state that "research has shown that supplemental coverage can lead to beneficiaries using more discretionary services because they have no financial incentive to consider the value of a service before choosing it (pg. 11)." You go on to note that the Commission's 2012 recommendations concerning a benefit redesign package "give beneficiaries better protection against high OOP spending, which creating financial incentives for them to make better decisions about their use of discretionary care."**

   a. Can you provide evidence that shows how much care, if any, sought by beneficiaries with supplemental coverage is 'discretionary' versus medically necessary?

   b. Can you provide examples of 'discretionary versus medically necessary care?

   In response to (a) and (b): An analysis commissioned by MedPAC found that the effect of supplementary coverage on service utilization varies significantly by type and place of service. Secondary coverage had little effect on emergency care (urgent or emergent hospital admissions, emergency visits, ambulance services). By contrast, secondary coverage was associated with much higher use of preventive care, elective hospital admissions, medical specialists, screenings and tests. The analysis could not distinguish which of the services in this latter category were not medically necessary. However, concerns about "overuse" and low-value care are more frequently associated with these types of services.

   c. How does charging a higher premium for a Medigap policy which is paid every month regardless or whether any services are utilized incentivize someone to "make better decisions about their use of discretionary care" other than making such policies less affordable?

   Under a reformed FFS benefit design, beneficiaries should have less need for a supplemental insurance plan. The new benefit structure would provide protection against catastrophic costs, and it would provide more predictable cost sharing by moving from coinsurance, a percentage amount, to copays, which are fixed amounts. Medigap policies currently provide protection against catastrophic costs and unpredictable cost sharing, but once these protections are built into the standard FFS benefit design, Medigap will offer less value for

beneficiaries. Beneficiaries will be able to save by dropping their Medigap policies, and could apply some of these savings towards out of pocket costs that are required at point of service. However, if beneficiaries choose to keep their Medigap plans, the Commission believes that the cost of these plans should more accurately reflect the costs that they impose on the program and the taxpayer.

d. What are the average premium costs for Medigap policies currently? What do you expect to be the average premium costs under your proposal?

In 2009, the average annual premium cost for a Medigap policy was $2100. We modeled a 20% surcharge on Medigap premiums under our proposal, meaning that premium costs would increase by 20%.

e. Under the Commission's benefit redesign recommendations, how are providers incentivized/treated concerning recommending and providing care that may or may not be medically necessary? In other words, what would deter providers from both recommending and prescribing 'discretionary' services?

Benefit redesign is only one piece of a broader set of necessary Medicare reforms. While benefit redesign is largely focused on beneficiary incentives, new payment models, including bundling and accountable care organizations, seek to change physicians' incentives. Under these models, physicians are incented to recommend and provide high quality, low cost care. In order to achieve a delivery system focused on coordinated care, both the provider of care and the beneficiary must be engaged.

Congress of the United States
Washington, DC 20515

January 9, 2015

Mr. Christopher Holt
Director of Health Care Policy
American Action Forum
1747 Pennsylvania Avenue, N.W., 5th Floor
Washington, D.C. 20006

Dear Mr. Holt:

Thank you for appearing before the Subcommittee on Health on Tuesday, December 9, 2014, to testify at the hearing entitled "Setting Fiscal Priorities."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business Monday, January 26, 2015. Your responses should be mailed to Adrianna Simonelli Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to **Adrianna.Simonelli@mail.house.gov**.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

Christopher Holt
Questions for the Record Response
Energy and Commerce Committee
Subcommittee on Health
January 26, 2015

1. *According to information released by the Actuary of the Centers for Medicare and Medicaid Services (CMS), drug spending is projected to hold steady for the foreseeable future at about 10 to 15 percent of National Health Expenditures. However, the actuary did note that the emergence of specialty drugs presents cost challenges for some payers. This is especially the case in Medicaid where individuals receive life-saving cures may churn in and out of the program based on their income. Unlike the de facto price control in the Medicaid program, the Medicare program has the benefit of a competitive program with varying formularies and plans, where a senior can pick a plan that meets his or her needs. So, have any of you thought about targeted policies that give plans and states more control over their drug spending?*

   - With the discussions surrounding specialty drugs becoming more prevalent, the ability of states to manage this portion of their Medicaid budgets is critical. The Part D program provides an excellent template for allowing beneficiaries flexibility to chose a formulary that best meets their needs. Allowing states to bring similar competitive market pressures into their Medicaid programs is an excellent idea. Unfortunately, the current administration has a track record of hostility toward the choice and competition that exists within the Medicare Part D program, having targeted the fundamentals of this program with multiple rulemaking efforts aimed at undermining its success.

2. *There have been five bipartisan plans to help save Medicare introduced in this president's term: (1) Rivlin-Domenici (2) Rivlin-Ryan (3) The Fiscal Commission (4) Simpson Bowles's own plan, and (5) a plan by former Senator Joe Liberman and Senator Tom Coburn. The Lieberman-Coburn plan has been proposed in legislative text and was scored by the Actuary of the Medicare program. The Actuary said that, if the legislation was adopted, it would prevent Medicare's insolvency for decades and reduce seniors' premiums so they would be lower than under current law. Can you talk about what you think are the most viable pieces of these five proposals?*

   - Each of these proposals offers a variety of bipartisan changes to the Medicare program. Most importantly, these are structural reforms to Medicare and do not focus simply on cutting payments to providers, which would just decrease access to care for beneficiaries. Moving forward, the Medicare benefit must be modernized to preserve it for future generations and those beginning to receive benefits now, and these proposals all work toward that goal.

3. *CBO has estimated that repealing or delaying the IRS' authority to fine Americans for failing to buy government-approved coverage, otherwise known as the individual mandate, would result in tens of*

billions of dollars in savings for federal tax payers. Taking away IRS' authority to punish Americans under Obamacare seems like such a common sense proposal to limit government and save taxpayer dollars. One objection to this idea we often hear is that an individual mandate is necessary to cover pre-existing conditions. However, isn't it true that we can cover pre-existing conditions without the individual mandate while ensuring market stability through other mechanisms? (e.g. Medicare late enrollment penalties, high-risk pools, continuous coverage underwriting protections, etc.)

- Yes. During the transitional phase, options like high-risk pools can be used to ensure coverage for individuals with pre-existing conditions. Going forward there are alternative methods through which individuals can maintain coverage even with a pre-existing condition. The use of continuous coverage provisions and programs like COBRA ensure that those who need coverage can still receive it despite a circumstantial change or life event. Further, the individual mandate is not a catch-all for including individuals that do not wish to purchase health care coverage (and help spread the costs of more expensive enrollees). The individual mandate contains fourteen exclusions, some of which may not require documentation; so the mandate itself may not serve the purpose it was designed to anyway.

4. *The Affordable Care Act/"Obamacare" took more than $700 billion to spend on new government programs not for seniors. One of the big pay-fors for the bill was across the board annual reductions in growth rates of Medicare payments for hospitals. Under the law, these cuts are scheduled to continue to be reduced each year, permanently. As a result, the Actuary of the Medicare program has said that if these cuts continue as outlined in the law, either (a) up to 15 percent of hospitals could close, and many hospitals would stop taking Medicare patients, or (b) Congress reverses the cuts, increasing the rate of Medicare spending and accelerating the insolvency of the program. In your view, would it be better to scrap these reductions and replace them with other policies – and if so, why?*

   - The best choice is none of the above. Medicare is in need of full-scale benefit modernization. The program is facing closing hospitals, reduced access to care and eventual insolvency, so we should think outside of these two policy change boxes. Medicare is in need of a more competitive, targeted model for the program. Additionally, the cuts hit two parts of the program that are most important to its long-term reform. Cuts to Medicare Advantage and home health services undermine efforts to make the program more competitive, cost-effective and tailored to beneficiary needs. It should also be noted that these cuts do not have to happen if some of the spending created by the ACA is scaled back. As mentioned in my testimony, reducing the subsidy eligibility requirements below current levels has great savings potential.

5. *MACPAC has recommended creating a statutory option for states to implement 12-month continuous eligibility for children in CHIP. To what extent does a 12-month continuous eligibility option result in CHIP coverage for individuals from families with incomes above the CHIP eligibility thresholds? How does a 12 month continuous eligibility policy affect the required premiums and cost*

sharing for an enrollee? Could it result in an enrollee paying more or less than required based on their current income?

- Though it decreases churn, the downside to 12 month continuous eligibility is the lack of accuracy in eligibility and potentially in premium payments. This type of continuous enrollment decreases the frequency of re-determining eligibility for the program, and allows for some income fluctuation (where families could be paying more or less than was initially determined) while shorter eligibility timeframes may identify those that are no longer eligible for CHIP more quickly, saving federal and state dollars. For example, a family member could start a new job with a higher salary in the middle of an eligibility year, and the family's CHIP premiums will not change to reflect this increase in pay for another 6 months.

6. *The Affordable Care Act/ Obamacare authorized CHIP through fiscal year 2019, but did not include funding for the program beyond 2015 even though the Act required a Maintenance of Effort for the program for these additional four years. Can you please provide us with a sense of the negative effects the MOE has on states, as they seek to manage their Medicaid and CHIP programs effectively?*

- First, it is important to recognize the budgetary implications of the way the ACA includes CHIP provisions. By only providing funding through 2015, and requiring coverage through 2019, the ACA score did not include the cost of continuing the program for those additional four years, but assumes that the program will continue with later Congressional appropriation. This budgetary gimmick disregards the negative impacts for states and the uncertainty for children enrolled in the program.

  The impacts of this irresponsible move vary according to the way each state has structured its CHIP program. For states that have a CHIP program joined with their Medicaid program, the children that are currently enrolled in CHIP (and receiving the higher federal CHIP match) will join state Medicaid rolls – receiving the lower Medicaid match – if funding is not reauthorized. These states could experience a hole in their budgets due to the decrease in the federal matching rate from CHIP to Medicaid. For states with separate CHIP programs, states would have the option to enroll these children in plans that the HHS Secretary deems comparable to CHIP coverage, or impose waiting lists or enrollment caps.

  The score also ignores an increase in the federal match offered to states, since the match begins after funding reauthorization would be required. The ACA includes a 23 percent increase to the CHIP enhanced federal medical assistance percentage (the e-FMAP) beginning in October of 2015. This increase will bring the average federal CHIP contribution to an unnecessary 93 percent, drastically increasing CHIP spending.

http://americanactionforum.org/research/primer-the-childrens-health-insurance-program-chip

7. *Under the ACA, households at 400 percent of the federal poverty level (with incomes of nearly 100k) have and will receive subsidies to purchase coverage on the exchange. In your testimony, you note that reducing this subsidy level to 300 percent of federal poverty would result in savings of nearly $181 billion. As Congress considers proposals to reduce federal spending, doesn't it make sense to first look at federal subsidies for upper-middle class households?*

   - Yes. The subsides are in place to help those that cannot add the high cost of ACA exchange plans into their families' already tight budgets. The median household income hovers around $66,000 for the US. Subsidies are offered to families far above this mark, and the use of these tax payer dollars should be reassessed. We need to roll back the ACA's excessive spending, subsidies for higher earning individuals and families is a good place to start.

8. *One objection to the above proposal is that Americans above 300 percent of federal poverty will receive no subsidies, but still be forced to pay for ACA's expensive benefit mandates – leaving them without affordable coverage options. To address this issue, would it also make sense to allow any American to buy a catastrophic plan and reduce other ACA benefit mandates to promote affordability?*

   - It would absolutely make sense to allow for the greater availability of catastrophic plans in the individual market. For some beneficiaries, the catastrophic plans make the most sense financially, and these plans allow for coverage when financial stakes are higher, while still providing a few preventive care services. As mentioned in my written testimony, eliminating the age limits on purchasing catastrophic plans through the exchanges could save $16 billion from 2015-2023. This decrease in spending is the result of more individuals choosing catastrophic plans, which do not receive subsidy dollars.

9. *Physicians face a 21 percent cut in Medicare payments this April as a result of the Sustainable Growth Rate (SGR). A one-year "doc-fix" to avoid this cut would cost about $15 billion, and a permanent fix, depending on the details, could cost anywhere from $120 to $180 billion. A lot has been made about the need to "pay for" this fix. Isn't this just a budgetary snafu? Why should we have to offset stopping cuts to doctors that we all know won't actually happen?*

   - If it were possible to permanently repeal the sustainable growth rate without providing a pay-for, it would have been accomplished by now. While the cut to physician reimbursement has long been deemed untenable by Congress, the process of patching the cuts has still yielded savings, demonstrating a broad commitment to budget neutrality, even if Medicare spending itself increases.

     As I mentioned in my written testimony, there is much potential for savings through relatively moderate changes to benefits provided under the ACA. If some of these changes were implemented, additional federal dollars would be freed to be applied toward the repeal of SGR.

Additionally, changes to the SGR should be made with an eye toward realistic cost control. Any proposal to replace the SGR should be expected to generate some savings in and of itself. Whether those savings are readily scorable is another question.

10. *Medicare Spending grew last fiscal year by only 2.7 percent – the fourth lowest growth rate in history – despite a 3.8 percent increase in the number of beneficiaries. In large part because of these recent trends, the Congressional Budget Office has revised down its future health care cost projections significantly. The agency now projects Medicare spending between 2012 and 2021 to be more than $500 billion lower than projections they made in March of 2011. In light of this good news, why should Congress be concerned about an increase in health care costs, and Medicare spending in particular?*

    - When looking at the current slow-down in Medicare spending it is important to recognize two things. One, this is not the first time that Medicare spending projections have slowed, and two, all of the past slow-downs have been short lived. Federal health care spending is still on pace to nearly double in the next 25 years – and this should be cause for Congressional concern. Additionally, even if excess cost growth in Medicare maintains this historically low growth, the problem doesn't go away. Increasing enrollment in Medicare and an aging population will create budget short falls regardless of the rate at which cost grows.

http://americanactionforum.org/insights/health-care-expenditures-success-cycle-or-something-else

11. *Although our annual deficits have declined by about two thirds since 2009, you argue that the long term debt will exceed the size of the economy sometime in the 2030s and will double the size of the economy between 2045 and 2080 as health and retirement spending continue to grow and revenues fail to keep up. What is the practical impact of that level of debt on the American people? Is this something the average American really needs to worry about?*

    - I believe this question was intended for Mr. Goldwein

12. *Seniors across the country rely on Medicare to meet their basic health care needs. What should we tell those folks back home that are worried about the need to make changes to the program. Should they be worried or concerned?*

    - Seniors and those approaching Medicare age should be concerned with the stability of the benefits offered by the program they paid into throughout their careers. Though beneficiaries currently in the program do not have to worry about short term changes, Congressional action should be taken to modernize Medicare, preserving the benefit for the future. Specifically, those enrolled in Medicare Advantage plans will begin to feel the cuts the ACA imposes on the program in the form of benefit reduction. The American Action Forum estimated that MA enrollees saw $1,538 worth of benefit cuts in 2014 alone, and it will only get worse over time.

http://americanactionforum.org/research/medicare-advantage-cuts-in-the-affordable-care-act-april-2014-update

13. *There was a lot of discussion on the first panel of the hearing regarding Medicare benefit modernization reforms. Can you discuss how cost-sharing reform can benefit both beneficiaries and Medicare?*

- Since 2015 marks the 50 year anniversary of the Medicare program, it is only appropriate to discuss its modernization. Some cost sharing reforms were proposed this year by the Congressional Budget Office that suggested greater beneficiary involvement by those enrolled in traditional Medicare. CBO suggests three options: changing current cost-sharing to include a single annual deductible of $650 with an annual cap on expenses of $6,500, placing limitations on Medi-gap plans preventing first dollar coverage, or a combination of the two. If both policies are implemented, the savings generated in Medicare could reach $111 billion by 2024, preserving the program for future generations and decreasing federal spending. By modernizing the program, the benefits promised to current enrollees can continue and the program will be available to future populations. Congress should also consider increased cost sharing requirements for wealthy Medicare beneficiaries.

https://www.cbo.gov/sites/default/files/cbofiles/attachments/49638-BudgetOptions.pdf

Congress of the United States
Washington, DC 20515

January 9, 2015

Mr. Marc Goldwein
Senior Policy Director
The Committee for a Responsible Federal Budget
1899 L Street, N.W., Suite 225
Washington, D.C. 20036

Dear Mr. Goldwein:

Thank you for appearing before the Subcommittee on Health on Tuesday, December 9, 2014, to testify at the hearing entitled "Setting Fiscal Priorities."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business Monday, January 26, 2015. Your responses should be mailed to Adrianna Simonelli Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to **Adrianna.Simonelli@mail.house.gov**.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

Answers to Additional Questions for the Record
U.S. House of Representatives Committee on Energy and Commerce
Subcommittee on Health Hearing on "Setting Fiscal Priorities"
December 9, 2014

Questions from The Honorable Joseph R. Pitts

1) **In addition to the newly created and expanded entitlement programs in the Affordable Care Act, the law included a number of mandatory programs not subject to annual review by Congress. One program, the Prevention and Public Health Fund, was given a permanent mandatory appropriation – putting the program on permanent auto pilot. While I'm a strong proponent of prevention strategies and programs in health care, I think Congress should do its job and annually scrutinize whether taxpayer dollars are being spent wisely. As a general matter, do you think it makes sense for Congress to put more federal programs on the mandatory side of the ledger or should Congress take a more active role in annually reviewing the cost and benefits of federal programs?**

In general, I'm not a fan of putting more programs on autopilot, both because I think it reduces Congress's ability to make decisions and because these programs tend to run up the deficit. Last year, mandatory spending and interest payments ate up 77 percent of total tax collections, meaning almost everything Congress actually decided to do in the last couple of years was paid for on a deficit-financed basis.

Of course, this doesn't mean that mandatory spending is never appropriate or that no program should ever be moved over to the mandatory side of the budget, but in general I do think programs that are currently part of the appropriations process should remain there unless there is a compelling reason to make them mandatory.

Meanwhile, there are also a number of ways to reduce the "auto-pilot" nature of various mandatory programs, ranging from putting them into the discretionary budget, to requiring occasional reauthorization, and to simply ensuring better oversight.

With regards to the prevention fund specifically, I think Congress has a number of options, including cutting annual prevention fund spending through CHIMPs (changes in mandatory spending) thus allowing the money to be used on other appropriations measures.

2) **Under Medicare Parts B and D, upper income beneficiaries pay higher premiums based on their higher levels of income. [Part B has been income-adjusted for many years, and Part D was further income adjusted in the Affordable Care Act/"Obamacare."] The president's FY2015 budget endorses a policy of further increasing an income-adjusted Medicare premiums until capping the highest tier at 90 percent. As the president said in that budget, "this proposal would help improve the financial stability of the Medicare program by reducing the federal subsidy of Medicare costs for those who need the subsidy the least." Charging wealthier seniors more is a policy that has often enjoyed bipartisan support, so do you believe this would be a useful offset for a large SGR package?**

I think it's is quite reasonable to ask wealthier seniors to pay more for their Medicare benefits, and certainly we shouldn't be reducing their premiums – which is effectively what happens under current law starting in 2020. Depending on what policy you pursue, you could easily save anywhere from $20 billion to $100 billion by increasing income-related premiums.

Personally, my preference would be that policies to reform the SGR focus on slowing the growth of overall health spending, which on the beneficiary side would suggest changing deductibles and copays that influence behavior rather than premiums, which would simply shift costs. Still, I think increasing income-related premiums is a sensible cost shift that would better allocate our scarce health resources, and could be part of an SGR reform bill.

3) **GAO and the HHS Inspector General have reported for years on various financing arrangements that allow states to obtain billions of dollars in additional federal Medicaid matching funds without a commensurate increase in state funds to finance the nonfederal share of Medicaid. One such arrangement involves taxing health care providers. In his budget, the President has called for phasing down the Medicaid provider tax threshold from the current level of 6 percent to 3.5 percent. The president's Fiscal Commission recommended eliminating the use of provider taxes for providing the nonfederal share of Medicaid funding. What do you think about this policy recommendation and about state pushback on the policy?**

States often engage in "creative financing" to artificially boost the matching Medicaid payments they get from the federal government, and the "provider tax" is one of the more egregious examples of this. The policy involves states imposing a tax on Medicaid providers and using that tax revenue to increase pre-tax payments to those providers, in

turn deriving greater matching payments from the federal government. Essentially this gimmick allows states to report paying providers a higher amount than they actually pay, receiving a federal match based on that higher level.

Unfortunately, this gimmick is so widespread that I think eliminating it immediately would lead to serious resistance from the states. To be sure, doing so should not be regarded as "changing the deal" to states, since it simply would make sure they are receiving the amount intended under current law; nevertheless, it would represent a significant adjustment for many states. To resolve this, the Fiscal Commission recommended very gradually phasing out this gimmick.

Currently, states can tax providers up to 6 percent of their gross revenue, up from 5.5 percent as recently as 2011. The threshold could be restored to 5.5 percent almost immediately, but then gradually reduced to a nominal amount over ten or twenty years. That should give states plenty of time to adjust their finances and get out of the business of reporting inflated Medicaid costs to the federal government.

4) **Under the Medicaid disproportionate share hospital (DSH) program, states make payments to hospitals treating large numbers of low-income patients in order to recognize the disadvantaged financial situation of such hospitals because low-income patients are more likely to be uninsured. Industry reports have indicated that hospitals are yielding tremendous financial gains from Medicaid expansion. Thus, now that the Affordable Care Act has been implemented, are DSH payments even necessary in states that expanded Medicaid?**

There are still a number of uninsured Americans even under the ACA, but the need for DSH payments has clearly declined. I'm not ready to weigh in on the level of DSH payments that is most appropriate, but certainly we should be having the discussion over how much funding to dedicate to DSH and what form that funding should take.

5) **There have been five bipartisan plans to help save Medicare introduced in this president's term: (1) Rivlin-Domenici, 2) Rivlin-Ryan, 3) The Fiscal Commission, 4) Simpson-Bowles's own plan, and (5) a plan by former Senator Joe Lieberman and Senator Tom Coburn. The Lieberman-Coburn plan has been proposed in legislative text and was scored by the Actuary of the Medicare program. The Actuary said that, if this legislation was adopted, it would prevent Medicare's insolvency for decades, and reduce seniors' premiums so they would be lower than under current law. Can you**

talk about what you think are the most viable pieces of these five proposals for Congress to adopt?

In addition to the five plans you mention which should help to control Medicare costs, CRFB has its own "PREP Plan", which includes a significant package of Medicare reforms to pay for reforming the SGR. As best as I can tell, all six of these plans have two elements in common. First of all, each would reform Medicare's cost-sharing rules to move away from the current patchwork system toward one with a unified Part A and Part B deductible, fairly uniform co-insurance charges, and catastrophic caps to prevent seniors from falling into medical bankruptcy. And second, all six plans would restrict the use of costly Medigap plans, which provide "wrap-around coverage" that often masks important price signals and in doing so drives up costs for beneficiaries and the Medicare program.[1]

Although details must be worked out – and actually differ in each of these proposals – I think cost-sharing and Medigap changes should both be considered viable options to help reduce Medicare costs or pay for SGR reform.

In addition to cost-sharing changes, many of the six Medicare reform proposals would reduce future payments to post-acute care providers, which MedPAC and others believe are currently too high. The PREP plan does so by "bundling" post-acute and inpatient care costs and then haircutting the size of the bundle, while the other plans tend to make reductions within the fee-for-service framework.

6) **According to information released by the Actuary of the Centers for Medicare and Medicaid Services, drug spending is projected to hold steady for the foreseeable future at about 10 to 15 percent of National Health Expenditures. However, the Actuary did note that the emergence of specialty drugs presents cost challenges for some payers. This is especially the case in Medicaid, where individuals receiving life-saving cures may churn in and out of the program based on their income. Unlike the defacto price control in the Medicaid program, the Medicare program has the benefit of a competitive program with varying formularies and plans, where a senior can pick a plan that meets his or her needs. So, have any of you thought about targeted policies to give plans and states more control over their drug spending?**

[1] http://crfb.org/document/prep-plan-paying-reform-and-extension-policies

The high cost of specialty drugs is already becoming a difficulty for Medicaid and state budgets. Introducing more competition may be able to help some to reduce prices for some types of drugs; however, because many of these drugs possess a near-monopoly there are probably limits to what can be done on this front. There are a few other avenues that could be pursued to help Medicaid deal with such high-cost drugs. 1) Strong clinical prior authorization criteria could explicitly be allowed, which is already being undertaken in many states. Similarly, the federal government could provide legal protections to states pursuing step therapy plans in order to access certain drugs. 2) The current Medicaid drug rebate could be made even stronger to focus on drugs with little to no competition. 3) Patent exclusivity periods can be reduced, which would allow generic competition more quickly. 4) A binding arbitration process could be introduced in which a neutral arbitration judge would be required to determine the appropriate price based on evidence presented from both parties – the state and the drug manufacturer.

7) **CBO has estimated that repealing or delaying the IRS' authority to fine Americans for failing to buy government-approved coverage, otherwise known as the individual mandate, would result in tens of billions of dollars in savings for federal taxpayers. Taking away IRS' authority to punish Americans under Obamacare seems like a common sense proposal to limit government and save taxpayer dollars. One objection to this idea we often hear is that an individual mandate is necessary to cover pre-existing conditions. However, isn't it true that we can cover pre-existing conditions without an individual mandate while ensuring market stability through other mechanisms? (e.g. Medicare late enrollment penalties, high-risk pools, continuous coverage underwriting protections, etc.)**

I think there are a number of options available to maintain healthy risk pools, all with their own set of costs and benefits. If Congress chooses to replace the individual mandate, I'd advise a thoughtful process of weighing and negotiating the various options so we know the risks and challenges going in.

8) **The Affordable Care Act included $1 trillion in tax hikes and more than $700 billion in reductions in Medicare, spent on government programs not for seniors. The House recently passed a bill using tax increases and Medicare cuts to offset increases in Medicare and Medicaid spending. Can you talk about challenges with or any concerns with using tax hikes to pay for increased Medicare or Medicaid spending – rather than using targeted, common-sense Medicare and Medicaid reform policies?**

Our fiscal situation is severe enough that we will probably need both higher revenue and lower Medicare spending, which can come from a combination of cuts and reforms. I worry about dedicating too much Medicare or tax expenditure savings to new programs, and therefore leaving too little to pay down the debt. At the same time, policymakers should be able to address new priorities. Part of the problem with our current budget is that so much is on unsustainable autopilot that there is little room for new initiatives.

Ideally, we would work to substantially reduce the automatic growth in the budget (including tax expenditures) to leave more room for new priorities. Given the reality of where we are, a first logical step would be to begin by paying for our "must have" policies, then working to put the debt on a sustainable path, then identifying new needs and priorities and how to pay for them.

In the context of health care, that means permanently replacing the Sustainable Growth Rate (SGR) with health-related savings, then identifying further reforms to slow health care cost growth, then turning our attention to new health needs and priorities.

9) **The Affordable Care Act/"Obamacare" took more than $700 billion to spend on new government programs not for seniors. One of the big pay-fors for the bill was across-the-board annual reductions in the growth rates of Medicare payments for hospitals. Under the law, these cuts are scheduled to continue to be reduced each year, permanently. As a result, the Actuary of the Medicare program has said that if these cuts continue as outlined in the law, either (a) up to 15 percent of hospitals could close and many hospitals would stop taking Medicare patients, or (b) Congress reverses the cuts, increasing the rate of Medicare spending and accelerating the insolvency of the program. In your view, would it be better to scrap these reductions and replace them with other policies – and if so, why?**

The short answer is that while I do not believe these growth rate reductions are sustainable on a permanent basis, I do think they can help to keep cost growth under control in the medium term and I would support replacing them in part, but only if equal-sized savings were identified.

As you mention, the Affordable Care Act included what is often called "productivity adjustments," but really amounts to a permanent reduction in the growth rate of nearly all non-physician provider payments under Medicare. The idea behind these adjustments is that Medicare providers should be able to accomplish what most other

actors in the economy do and become more productive in their delivery of services over time. A more modest version of these adjustments had been proposed prior to the ACA by the Bush Administration.

Certainly in the near-term, these productivity adjustments are helping to make Medicare more affordable, both by allowing the taxpayer to capture what productivity gains do exist in the health arena and by indirectly slowing the growth of what many view as overpayments on a variety of services. But I think there is a serious question regarding whether this slower growth rate can be sustained on a permanent basis.

The adjustments effectively reduce growth rates by approximately 1.1 percentage points per year, which means a 10 percent reduction after 10 years, a 20 percent reduction after 20, and a 28 percent reduction over 30. I think it's reasonable to assume providers can absorb and learn to live within these levels for a while, but probably not indefinitely. This is especially true if private insurance health care prices continue to grow and the gap between private and public payments grows to be too wide.

To address this concern, I would make three broad suggestions.

First, be able to recognize the difference between when these adjustments become *politically* difficult to sustain and when they become *economically* difficult. Focus on the latter.

Second, work to slow health care costs economy-wide. The slower private spending is growing, the easier it will be to sustain reductions in Medicare growth.

And finally, develop institutions over the long run that let us regularly swap some of these across-the-board growth rate adjustments with more targeted reforms. For example, we could make it an annual practice for Congress to put forward legislation compiling MedPAC's most recent short-term payment reforms and swap those for an equal-sized reduction in that year's productivity adjustment.

10) **MACPAC has recommended creating a statutory option for states to implement 12-months continuous eligibility for children in CHIP. To what extent does a 12-month continuous eligibility option result in CHIP coverage for individuals from families with incomes above the CHIP eligibility thresholds? How does a 12-month continuous eligibility policy affect the required premiums and cost sharing for an**

enrollee? Could it result in an enrollee paying more or less than required based on their current income?

Unfortunately, I'm not an expert on the CHIP program and probably don't have the appropriate information to be able to answer this question sufficiently.

11) **Under the ACA households at 400% of federal poverty level (with income of nearly 100k) have and will receive subsidies to purchase coverage on the exchange. In your testimony, you note that reducing this subsidy level to 300% of federal poverty would result in savings of nearly $181 billion. As Congress considers proposals to reduce federal spending, doesn't it make sense to first look at federal subsidies for upper-middle class households?**

In the health care arena, I think it makes sense to first look at where we can change incentives to actually slow the growth of federal and total health care spending. Once we've done our best to "bend the cost-curve," we should turn to finding ways to better allocate our scarce health care resources. Certainly that means looking at spending currently going to upper- and upper-middle class households and seniors, especially in Medicare. I don't want to specifically endorse the CBO option I cited to eliminate ACA subsidies above 300% of the poverty line, but I do think it's reasonable to take a hard look at how much we want to be spending on individuals above that income level.

12) **One objection to the above proposal is that Americans above 300% of federal poverty will receive no subsidies, but still be forced to pay for ACA's expensive benefit mandates – leaving them without affordable coverage options. To address this issue, would it also make sense to allow any American to buy a catastrophic plan and reduce other ACA benefit mandates to promote affordability?**

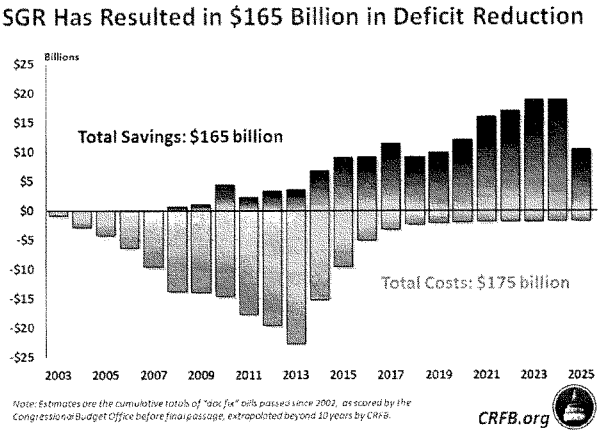
Once we as a society decide we want nearly every citizen to buy or be provided adequate health insurance – which the ACA effectively does – we must answer the question of what constitutes "adequate." There is of course no perfect or objectively true answer to this question. Had the ACA set its mandate to require everyone be in a plan with no out of pocket costs and no network restrictions, I think we would all agree that criteria was too stringent. And had it allowed insurance that didn't kick in until a person had already spent $1 million out of pocket, I don't think many of us would view the bill as truly requiring adequate coverage. Identifying the sweet spot in between is, by its very nature, a balancing act. And while in general I'm supportive of skin in the game for health consumers that can afford it, I think it is up to Congress to decide

whether the ACA allows too much, too little, or just the right amount of cost-sharing under current law.

13) Physicians face a 21 percent cut in Medicare payments this April as a result of the Sustainable Growth Rate (SGR). A one-year "doc fix" to avoid this cut would cost about $15 billion, and a permanent fix, depending on the details, could cost anywhere from $120 to $180 billion. A lot has been made about the need to "pay for" this fix. Isn't this just a budgetary snafu? Why should we have to offset stopping cuts to doctors that we all know won't actually happen?

Although the Sustainable Growth Rate (SGR) hasn't worked quite as intended, it has actually helped reduce Medicare costs by encouraging the enactment of more thoughtful changes to the program. Failing to pay for legislation replacing the SGR would break with ten years of precedent, add hundreds of billions of dollars to the debt over the next couple of decades, increase Medicare premiums for most beneficiaries, and waste a rare but valuable opportunity to make positive reforms to the Medicare program.

For context, the SGR was originally created in 1997 to slow the growth of Medicare payments to physicians. Since 2003, however, it has called for increasingly deep cuts to physician payments that policymakers have waived through "doc fixes" over and over again. Importantly, though, *doc fixes have been paid for 98 percent of the times* they have been implemented since 2004. These pay-fors have generally come from within Medicare, and included many important recommendations from MedPAC and others, as well as a number of small structural reforms that have helped, on the margins, to slow health care cost growth.



According to our analysis, all of the doc fixes since 2003 have added about $175 billion to the deficit through 2025, but included offsets that saved $165 billion over that same time period.[2] The $21 billion of offsets in the last doc fix included a change to help HHS set more accurate physician payments, a new value-based purchasing program for skilled nursing facilities, and the introduction of market prices into clinical lab payments.[3]

To be sure, the savings and improvements accompanying past doc fixes have been relatively small. And setting physician payments one year at a time with a formula that simply doesn't work is no way to budget for the long term. That's exactly why Congress should take advantage of the current low cost of SGR reform to combine the creation of a new formula with more significant Medicare reforms that truly help to "bend the health care cost-curve."

These reforms would only need to save $150 to $200 billion in total, which is less than half the magnitude of the changes in the President's budget and less than one third the size of the changes in the most recent Simpson-Bowles plan. Reforms could also represent a win-win for beneficiaries and taxpayers alike by focusing on reforms which truly change the incentives within the health care system instead of simply shifting who pays and how much.

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[2] http://crfb.org/blogs/actually-sgr-has-slowed-health-care-cost-growth
[3] http://crfb.org/blogs/sgr-continues-slow-health-care-cost-growth

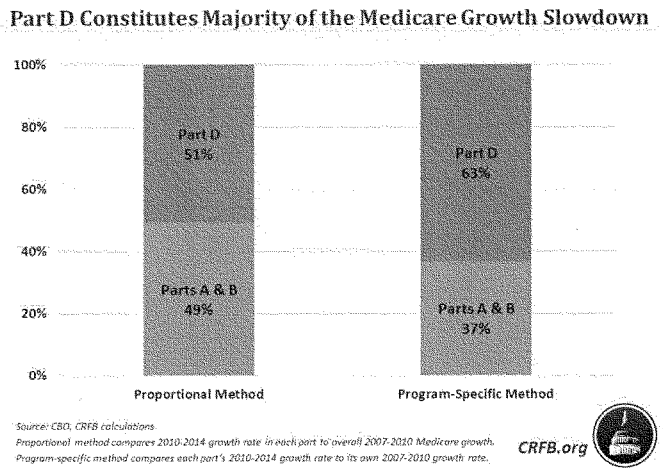
In fact, CRFB's own PREP Plan to offset the doc fix, which reformed both cost-sharing and provider reimbursement rules, would reduce out of pocket costs for the average beneficiaries, even as it saved the Medicare program roughly $160 billion.

14) Medicare spending grew last fiscal year by only 2.7 percent – the fourth lowest growth rate in history – despite a 3.8 percent increase in the number of beneficiaries. In large part because of these recent trends, the Congressional Budget Office (CBO) has revised down its future health care cost projections significantly. The agency now projects Medicare spending between 2012 and 2021 to be more than $500 billion lower than projections they made in March of 2011. In light of this good news, why should Congress be concerned about an increase in health care costs, and Medicare spending in particular?

The recent slowdown in Medicare cost growth is encouraging, but it is certainly no reason to declare victory and stop pursuing further reform.

First of all, a large portion of the recent slowdown is likely temporary. For example, we have calculated that Medicare would have grown more than 2 percentage points faster last year if not for one-time legislated cuts such as the "sequestration."[4] In addition, the fact that the baby boom population is just now entering the Medicare program and therefore temporarily reducing the average age (and therefore average cost) of the Medicare population. On top of this, the "great recession" and the low inflation and growth that accompanied it likely had some direct or indirect impact on Medicare's growth rate. And finally, a recent one-time "patent cliff" for prescription drugs has temporarily slowed down Medicare cost growth – explaining why Medicare Part D is responsible for between one half and two thirds of the slowdown despite comprising only one tenth of the program.[5]

[4] http://crfb.org/blogs/medicare-registers-fourth-lowest-growth-rate-program-history-2014
[5] http://crfb.org/blogs/another-way-look-medicare-slowdown

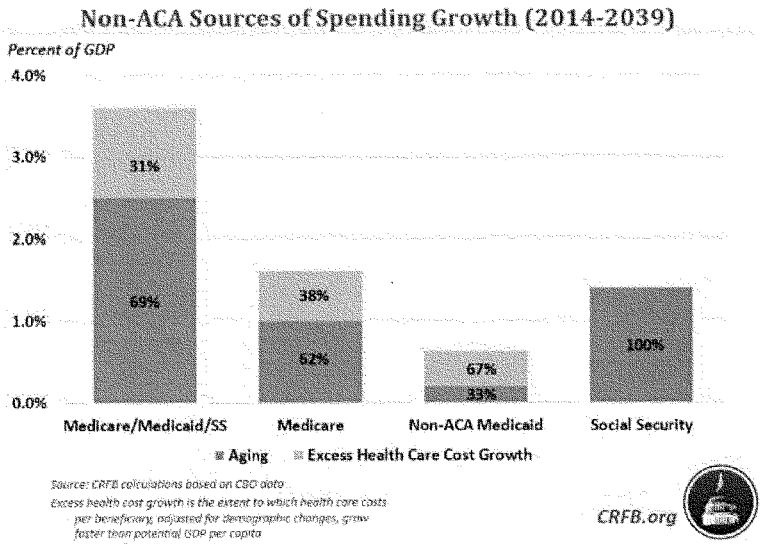


Second, the slowdown itself may depend in large part on the expectation of future health reforms. Former CBO and OMB Director Peter Orszag subscribes to this theory, which, if true, means that policymakers must continue to reform the payment and delivery system simply to prevent the slowdown from reversing itself.[6]

Third, policymakers will need to identify policies to offset an SGR fix and maintain the solvency of the Medicare Part A trust fund almost regardless of overall growth rates.

Fourth, it is important to remember that the key driver of Medicare spending over the next few decades is not health care cost growth, but population aging. Indeed, aging is responsible for over three fifths of the projected increase in Medicare spending through 2039, based on estimates from CBO.

[6] http://www.bloombergview.com/articles/2014-04-14/will-burwell-corral-health-care-costs



And finally, the slowdown itself is highly uncertain. Just as businesses and families plan for uncertainty with precaution, so too should government. It is far better to overcorrect and be able to distribute the gains through more generous benefits or lower taxes later than it is to do nothing and let health care costs slip away from us.

It is also worth noting is that even under CBO's current law projections, federal health spending continues to grow as a share of GDP. Since 2000, federal health care spending has grown from 3 percent of GDP to 5 percent today, and it is projected to grow to 6 percent of GDP by 2025, 9 percent by 2050, and 13 percent by 2085.

The bottom line is that while the slowdown is very good news, it's far from enough to declare the problem solved.

5) **Under the PREP plan you mention in your testimony, you would advocate for increased co-pays and changes to out of pocket limitations for some Medicare beneficiaries. How can you make these types of changes while still protecting those who are most in need?**

In many ways, the current Medicare benefit fails to protect vulnerable seniors. Unlike most private insurance, the Medicare program has no out-of-pocket cap which means

that some seniors could face astronomical and completely unaffordable health care costs. To protect themselves against these costs, many seniors will buy supplemental coverage – but that coverage is often a really bad deal for seniors and can end up increasing average out of pocket costs by $400 per year or more.

Our PREP Plan, like plans from Simpson-Bowles, Domenici-Rivlin, and others, would actually fix these problems. While seniors with low predictable costs would often face a modestly higher deductible, many of them would also face much lower premiums from supplemental coverage. More importantly, for the first time Medicare would have a catastrophic cap that limits senior costs from ever getting too high in a single year and could dramatically reduce the instance of medical bankruptcy.

Simply restructuring cost-sharing and supplemental coverage rules to focus more on catastrophic instead of first-dollar protections would be a huge win for vulnerable seniors by protecting them against the real financial risks associated with high medical bills. But to be safe, the PREP plan goes even further by offering a lower deductible and a lower out-of-pocket cap for beneficiaries with lower overall incomes.

16) **Although our annual deficits have declined by about two-thirds since 2009, you argue that the long term debt will exceed the size of the economy sometime in the 2030s and will double the size of the economy between 2045 and 2080 as health and retirement spending continue to grow and revenues fail to keep up. What is the practical impact of that level of debt on the American people? Is this something the average American really needs to worry about?**

Anyone that cares about future growth in the economy, interest rates on mortgages and other loans, or the well-being of their children and grandchildren should be concerned about the unsustainable nature of our national debt. Although it is true that deficits have declined by about two thirds from their "great-recession" high of $1.4 trillion, that was after deficits had *risen by nearly 800 percent*. Moreover, deficits are likely to start rising again very soon, and CBO projects trillion dollar deficits will return by 2025 or sooner.

Unfortunately, even as deficits have subsided some, debt remains at record-high levels never before seen except around World War II. And due to population aging and health care cost growth, debt is scheduled to continue to grow unsustainably in the future.

As debt continues to grow, it will tend to push up interest rates, slow the growth of wages, reduce government's abilities to respond to new needs, and could ultimately cause a financial crisis.

As one example, Fix the Debt ran an analysis of how income would differ over the next few decades if debt were on an upward path as a share of GDP versus a downward path. Using numbers from the non-partisan Congressional Budget Office (CBO), we found that in today's dollars (adjusted for inflation), average income would be *$7,000* lower with debt rising by 2040 and *$13,000* lower by 2050. For someone entering the workforce today and earning average levels of income over his or her 40-year career, that represents a *$250,000* loss in income.[7]

As another example, Fix the Debt estimated the impact of a one-point difference in interest rates between those two scenarios, as calculated by CBO. That higher interest rate on government debt would end up trickling into small business loans, student loans, credit card loans, and mortgages. For a family with a $300,000 mortgage, it could mean *$45,000* more in mortgage payments.[8]

With income lower and cost-of-living higher, there is no question that ordinary Americans will be hurt by the growing national debt. And unfortunately, those consequences would only be exacerbated by the reality that high debt will limit government's ability to respond to crises or address new important national needs.

Eventually, rising debt will become so unsustainable that the only possible ways forward will be severe austerity or a fiscal crisis. Needless to say, neither of these choices would be very appealing for the American people.

17) Seniors across the country rely on Medicare to meet their basic health care needs. What should we tell those folks back home that are worried about the need to make changes to the program? Should they be worried or concerned?

Herbert Stein once said that "If something cannot go on forever, it will stop." This certainly applies to the growth of federal health spending, which has already risen from 3 percent of GDP in 2000 to almost 5 percent today, and CBO projects will continue to rise to 7.5 percent by 2035 and 14 percent by 2090.

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[7] http://www.fixthedebt.org/debt-and-you
[8] Ibid.

This trend is totally unsustainable. Sometime before 2030, it will result in the exhaustion of the Medicare Part A trust fund, leading to roughly a 15 percent across-the-board cut in that program. Meanwhile, the projected growth in other federal health spending programs simply can't be tolerated forever.

It doesn't just matter that this spending can't continue, it matters how it won't continue. Will there be exhausted trust funds, abrupt spending cuts, and major cost-shifts designed to quickly reduce the federal government's burden? Or will we proactively enact thoughtful reforms that can help change the way we consume and deliver medicine for the better?

Seniors stand to lose the most by waiting to act. The longer we delay reform, the more likely we are to see unnecessary cuts in the future. Meanwhile, there are changes we can make today which will actually *improve* the situation for seniors by reducing their out-of-pocket costs and improving their value of care.

Seniors shouldn't be worried about the reforms Congress wants to enact, they should be worried about the reforms Congress doesn't want to enact. Inaction is the deadliest treatment of all.

18) **There was a lot of discussion on the first panel of the hearing regarding Medicare benefit modernization reforms. Can you discuss how cost-sharing reform can benefit both beneficiaries and Medicare?**

A number of groups and individuals from a diverse set of backgrounds have called for modernizing Medicare's cost-sharing rules. Although each plan differs, they all focus on combining Medicare Part A and Medicare Part B into a single benefit, reducing the prevalence of wrap-around coverage, and shifting the nature of the Medicare insurance package so it focuses more on providing protection against catastrophic costs and less about covering regular expenses.

Because these plans would generally increase deductibles for seniors, many have described them as increasing seniors' cost. However, these plans don't really increase costs at all, but rather change the incidences of costs so that seniors are responsible for more of their low-cost known expenses and less responsible for high-cost care that could threaten to lead to medical bankruptcy.

And in fact, when one accounts for the savings from moving people away from costly Medigap plans, cost-sharing reform can significantly reduce total costs both for beneficiaries and the federal government.

As one example, our PREP Plan would reform cost-sharing rules by creating a combined $600 deductible, a 20 percent co-insurance for most services, and a $6,000 out of pocket limit for most seniors, with lower deductibles and out of pocket limits for seniors with more modest income. It would also restrict first-dollar coverage in "Medigap plans" (with a few years of grandfathering for existing plans) and encourage seniors to "cash out" their employer-provided wrap-around plans in exchange for a premium subsidy.

Even with phase-ins, these reforms would save the federal government $80 billion over ten years. At the same time, according to an analysis from the Actuarial Research Corporations (ARC), this plan *would reduce average out of pocket costs by nearly $225 per person each year*. In other words, the policy is a win-win for beneficiaries and the Medicare program.

Congress of the United States
Washington, DC 20515

January 9, 2015

Dr. Judy Feder
Professor of Public Policy
Georgetown Public Policy Institute
37th and O Streets, N.W.
Washington, D.C. 20057

Dear Dr. Feder:

Thank you for appearing before the Subcommittee on Health on Tuesday, December 9, 2014, to testify at the hearing entitled "Setting Fiscal Priorities."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business Monday, January 26, 2015. Your responses should be mailed to Adrianna Simonelli Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to **Adrianna.Simonelli@mail.house.gov.**

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

ADDITIONAL QUESTIONS FOR THE RECORD

Questions: The Honorable Joseph R. Pitts
Answers: Judy Feder

1. Under the Affordable Care Act/"Obamacare," states have the option to expand Medicaid to adults with no children with income under 138% of the federal poverty level. This was an unprecedented expansion of the program that traditionally have covered low-income moms and kids, the elderly poor, blind and the disabled. Under the expansion, the federal government is paying 100 % of cost of the expansion until 2016, when states have to start picking up some of the tab. Accordingly, under federal rules today, the federal government is paying:
    a. The full cost of some prisoners' hospital care who would otherwise be eligible for Medicaid
    b. The medical bills of multi-million dollar lottery winners whose states are barred from disenrolling on the program. Do you this think is an appropriate use of Medicaid dollars? Why or why not?

    Judy Feder's Answer: Under the ACA, as before, Medicaid is a program that provides health and long-term care benefits to people who are poor or who become poor by virtue of their spending on care. What's new with the ACA is an end to the exclusion from coverage of low income adults, no matter how poor, who are neither disabled nor parents of dependent children. That exclusion left millions without health insurance protection—whether because they were not offered it through their jobs (most of them work or are in workers' families) or because they could not afford it on their own.

    The ACA aims to close this gap—benefiting millions of Americans. Achieving that goal is, to me, far more significant than whether the program may cover some who've been covered elsewhere or a miniscule number of lottery winners.

2. What do you think Congress should do to assess the situation of disabled children on waiting lists to access home and community based services in Medicaid?

    Judy Feder'sAnswer: Most states cover home and community-based services under federal waivers that allow states to limit the number of people served—in other words, waiving the requirement that Medicaid benefits be provided to all people who are eligible for the service. That limitation could be addressed if home care, like nursing home care, were a mandatory benefit. In practice, however, the limitations represent states' reluctance to expand spending, even to populations clearly in need of service. It's my view that more federal resources are required to adequately meet long-term care needs for children and others who need basic assistance with tasks of daily living.

3. I was glad to hear you mention state flexibility to manage Medicaid programs. Do you think states should have to negotiate or obtain permission from CMS to increase co-pays by $2 (as is happening under expansion)?

   Judy Feder's Answer: I mention flexibility because it exists under current law and policy—not because I think more flexibility is needed. Medicaid is designed to give states considerable flexibility in managing their programs, subject to federal rules intended to assure adequate and affordable benefits for all people eligible to participate. What may seem like a modest change in copayment on a single service may add up to a substantial financial burden—and barrier to access—for people with limited resources. Federal approval is necessary to assure that policy changes don't create such a barrier.

4. The bipartisan Rivlin-Domenici Debt Reduction Task Force – led by former Clinton White House OMB Director Alice Rivlin and Republican Senator Pete Domenici—noted that two of their foundational principles were to (a) protect the truly disadvantaged to ensure a sustainable safety net while (b) making spending reductions and adopting policy reforms that focused benefits on those who need them the most. In this vein, what policies would you recommend to Congress that would reduce Medicaid spending, while adhering to these sound principles?

   Judy Feder'sAnswer: Per capita Medicaid spending, like all health care spending, is currently growing at extraordinarily low rates. Growth in total Medicaid spending does not reflect inefficiency; rather it reflects increased numbers of beneficiaries—because of the recession pre-ACA and expanded eligibility post-ACA. Medicaid already pays less for services than other payers; and it is involved along with other payers in reforming payment and delivery mechanisms to promote better quality of care and better value for the dollar. Medicaid is already targeting its benefits to people who need them most. In short—I see no need to take additional actions to reduce Medicaid spending.

5. Many of the members from both sides of the aisle at the December 3rd hearing, as well as health care providers and children's advocates, have praised CHIP as a program that is currently successful. Would you agree with that general sentiment?

   Answer: I would agree.

6. CBO has said that the 23 percent increase to the E-FMAP in current law does not result in extending health coverage to any more children—it just effectively buys out the states. So, should Congress just scrap the E-FMAP in current law and use those savings to help extend CHIP funding?

   Answer: I am surprised that CBO concludes that a withdrawal of federal funds will have no impact on population coverage—that is, that they assume coverage will remain at current levels. To my knowledge, states take a very different point

of view and believe their ability to continue covering children under CHIP will be impeded by a cutback in federal funds. Further, opponents of the ACA are likely to characterize such a cutback as evidence of the "unreliability" of federal funding they claim as a reason for rejecting the expansion. Scrapping the E-FMAP could therefore have a political as well as a policy impact on states' support for children's coverage.

7. According to information released by the Actuary of the Centers for Medicare and Medicaid Services, drug spending is projected to hold steady for the foreseeable future at 10 to 15 percent of National Health Expenditures. However, the Actuary did note that the emergence of specialty drugs presents cost challenges for some payers. This is especially the case in Medicaid, where individuals receiving life-saving cures may churn in and out of the program based on their income. Unlike the defacto price control in the Medicaid program, the Medicare program has the benefit of a competitive program with varying formularies and plans, where a senior can pick a plan that meets his or her needs. So, have any of you thought about targeted policies to give plans and states more control over their drug spending?

   Answer: The problem of specialty drugs has nothing to do with competition ; it has to do with producer monopoly power in the production of a needed drug. Limited formularies don't help when only one company produces a needed drug. Addresing that problem requires greater government authority wherever it resides. Further, it is worth noting that the shift of responsibility for prescription drug coverage for dual eligibles from Medicaid to Medicare has actually significantly increased expenditures on prescription drugs. As you note, Medicaid has discounting authority that Medicare lacks.

8. CBO has estimated that repealing or delaying the IRS' authority to fine Americans for failing to buy government-approved coverage, otherwise known as the individual mandate, would result in tens of billions in savings for federal taxpayers. Taking away IRS' authority to punish Americans under Obamacare seems like a common sense proposal to limit government and save taxpayer dollars. One objection to this idea we often hear is than an individual mandate is necessary to cover pre-existing conditions. However, isn't it true that we can cover pre-existing conditions without an individual mandate while ensuring market stability through other mechanisms? (e.g. Medicare late enrollment penalties, high risk pools, continuous coverage underwriting protections, etc.).

   Answer: The mandate is not a punishment; it's a mechanism to assure that everybody contributes to health insurance, rather than relying on others to pay for their care if they get sick. Therefore it's purpose, is, as you observe, to assure that people do not wait until they are sick to sign up for insurance. That would make effective, let alone affordable, insurance impossible. Experience tells us that that

no alternative mechanism is likely to be nearly as effective as the mandate in achieving participation and affordable coverage.

9. The Affordable Care Act/"Obamacare" took more than $700 billion to spend on new government programs not for seniors. One of the big pay-fors the bill was across-the board annual reductions in the growth rates of Medicare payments for hospitals. Under the law, these cuts are scheduled to continue to be reduced each year, permanently. As a result, the Actuary of the Medicare program has said that if these cuts continue as outlined in the law, either (a) up to 15 percent of hospitals could close and many hospitals would stop taking Medicare patients, or (b) Congress reverses the cuts, increasing the rate of Medicare spending and accelerating the insolvency of the program. In your view, would it better to scrap these reductions and replace them with other policies – and if so, why?

   Answer: As I noted above, health care costs are growing at historically low rates. In the last few years, hospital prices have been stable and hospital use appears to be declining. As a result, CBO has continually reduced its projections of future Medicare spending. The ACA's constraints on hospital payment growth are one of many mechanisms now encouraging hospitals to reduce their actual spending and improve the efficiency with which they deliver care. Alongside broader efforts to reform health care delivery systems—encouraged by the ACA—I believe we are on the right course.

10. During your testimony before the committee, you said "Medicare should not be used as a piggybank" to reduce the debt or pay for other programs. Yet, according to the Congressional Budget Office and the Office of the Actuary at CMS, this is precisely what happened in with Patient Protection and Affordable Care Act/"Obamacare." Under the PPACA, $700 billion was taken from Medicare to be spent on new government programs not for seniors. Would you like to clarify your position?

    Answer: I'm happy to clarify. Arbitrary caps on per capita Medicare spending and a shift from a defined benefit to a defined contribution ("premium support"), as included in several recent Republican budgets, reduce Medicare spending to achieve budgetary targets without specific payment or policy changes—relying on a hope that markets and competition will lower actual beneficiary costs. CBO continually challenges that assumption, arguing that private plans are less able than Medicare to control costs and that fixed voucher payments will shift costs to Medicare beneficiaries, rather than actually reduce costs. That's using Medicare as a piggy-bank for deficit reduction. By contrast, the ACA's $700 billion dollars in spending reductions reflected specific policy changes to reduce overpayments to hospitals and other providers as well as to Medicare Advantage plans. These specific policy changes have, as noted above, contributed to reductions in cost growth in recent years. It's also interesting to note that Republican budgets have retained these measures, and their savings, and propose to cut spending even

further in order to achieve budgetary goals.

11. To be financially eligible for Medicaid coverage for long-term care, including nursing home care, individuals are supposed to have $2,000 or less in countable resources or $3,000 for a married couple. However, a recent GAO report found that nearly 20 percent of the married applicants whose applications they reviewed contained a claim of spousal refusal, whereby an institutionalized spouse transfers all of his or her resources to their community spouse and the community spouse refuses to make the resources available for the institutionalized spouse's care. Using this mechanism, *GAO found community spouses who were able to keep over a $1 million in resources, while Medicaid paid for their institutionalized spouse's nursing home care.* Do you think it is appropriate for millionaires to be receiving Medicaid benefits?

    Answer: Claims that the "rich" are benefiting from Medicaid nursing home and other long-term care coverage are continually challenged by evidence on the limited resources of population that relies on Medicaid—not only when they receive benefits but much earlier in their lives. I urge you to explore my Urban Institute colleague Richard Johnson's extensive documentation of that fact. Further, nursing home use has declined in recent years, in part because people have better access to alternatives, whether in assisted living facilities or at home. The better-off are by far better able to take advantage of those opportunities and demonstrate their reluctance to rely on Medicaid in their patterns of care.

    I would not dispute evidence from specific examples. But the body of evidence tells us that Medicaid recipients of long-term care and other benefits are overwhelmingly people with modest resources.

12. Currently, under the Medicare program, hospitals are reimbursed for the deductibles and co-pays left unpaid by Medicare beneficiaries. This is known as "bad debt." This policy has no parallel in the private sector—or in any other federal program. The president's Fiscal Commission recommended terminating this special subsidy. The president's FY 2015 budget recommended phasing this out as well, estimating it would save taxpayers $30 billion over a decade. Can you talk about the reasons for scrapping this policy?

    Answer: It seems appropriate to consider reimbursement for bad debt as part of overall Medicare hospital payment policy and to assess its relevance or value in the context of other measures.

13. Medicaid was created to provide assistance to individuals whose income and resources are insufficient to meet the costs of necessary medical services. A recent GAO report identified a number of loopholes in Medicaid financial eligibility policies that allow individuals to artificially impoverish themselves in order to qualify for Medicaid coverage of long-term care. Such loopholes include converting countable resources into personal service contracts to pay adult children

or other relatives to provider services such as grocery shopping or transportation or annuities that provide potentially large income streams for community spouses that are not counted towards Medicaid eligibility. Should such loopholes in Medicaid policy that allow individuals of significant wealth to obtain Medicaid benefits be addressed to ensure that limited state and federal resources reach those in most need?

Answer: As I explained above (question 11), the evidence tells us that recipients of Medicaid benefits are overwhelming low and modest income people whose resources prior to needing care were already inadequate to pay for the services they now require. Families struggle to support loved ones needing care; and with or without loopholes current public support is inadequate. What's needed in long-term care is not a "tightening" of loopholes; it's a financing policy that actually insures people against the risk of long-term care needs, whatever their income. I'm happy to provide you more information on long-term care financing issues and options.

14. Do you believe that the Patient Protection and Affordable Care Act/"Obamacare" as it has been enacted and implemented, will:
    a. Reduce or increase the federal deficit over the coming decade?
    b. Reduce or increase state Medicaid spending over the coming decade?
    c. Contribute to reducing or increasing the average cost of a commercial market health insurance plan (not considering the exchange premium or cost-sharing subsidies)?

    Answer: I am comfortable with CBO analysis on the ACA's impact on the deficit. The fact that many states have not taken advantage of the Medicaid expansion is slowing spending growth; that has a positive impact on federal spending, but a negative impact on the people the ACA aims to protect. More positively, CBO has several times re-estimated and lowered its health care spending projections, reflecting a dramatic slowdown in health care spending growth to which the ACA has contributed and which bodes well for the nation's fiscal future.

    Despite the fact that the federal government initially pays the costs of the Medicaid expansion in full and continues thereafter to pay for most of it, expanded coverage will lead to expanded state Medicaid spending as more people are covered by the program. However, analysis by my Urban Institute colleagues and others demonstrates that that spending is offset by savings in other state programs and enhanced revenues to the state—thereby, on net, making a positive contribution to states' fiscal status.

    Evidence indicates that the average cost of commercial health plans in the nongroup market has been lower than expected, as plans compete for the newly eligible population under the ACA. Although low premiums raise some concerns about adequacy of provider networks and high levels of cost-

sharing—both of which can impede patients access to care, cost experience under the ACA has been positive.

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