

PRESERVING AND STRENGTHENING MEDICARE

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

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PRESERVING AND STRENGTHENING MEDICARE

WEDNESDAY, MARCH 16, 2016

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

The Subcommittee met, pursuant to notice, at 10:02 a.m., in Room 1100, Longworth House Office Building, Hon. Pat Tiberi [Chairman of the Subcommittee] presiding.
[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
Wednesday, March 9, 2016
No. HL-06

CONTACT: (202) 225-3943

Chairman Tiberi Announces Health Subcommittee Hearing on Preserving and Strengthening Medicare

House Ways and Means Health Subcommittee Chairman Pat Tiberi (R-OH) today announced that the Subcommittee will hold a hearing on “Preserving and Strengthening Medicare.” **The hearing will take place Wednesday, March 16, 2016, in Room 1100 of the Longworth House Office Building, beginning at 10:00 a.m.**

Oral testimony at this hearing will be from the invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, <http://waysandmeans.house.gov>, select “Hearings.” Select the hearing for which you would like to make a submission, and click on the link entitled, “Click here to provide a submission for the record.” Once you have followed the on-line instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Wednesday, March 30, 2016.** For questions, or if you encounter technical problems, please call (202) 225-3943 or (202) 225-3625.

FORMATTING REQUIREMENTS:

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

1. All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

3. Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TDD/TTY in advance of the event (four business days notice is requested).

Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

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

Chairman TIBERI. Good morning. This Subcommittee will come to order. Welcome to the Ways and Means Subcommittee on Health hearing on preserving and strengthening the Medicare program. This is my first hearing as the Chairman of the Health Subcommittee, and I would like to say thanks to this Committee, this Subcommittee, for giving me the opportunity for a good discussion today and in the future about health care.

And I would like to welcome also to the Committee new Members of the Subcommittee: Mr. Paulsen of the great State of Minnesota and Mr. Lewis of the great State of Georgia. It is great joining you two, as well. And I am sure, knowing both of them, they will be valuable additions to our Subcommittee.

Another year and another round of seniors have become Medicare-eligible, navigating through a difficult program at times. Instead of more choices today for those beneficiaries, this year there are fewer choices. Obamacare's raid on the program and the increased regulatory burden on providers piled on to the outdated structure of traditional Medicare benefit is causing today's seniors to be inundated with an array of confusing deductibles, coinsurance, co-payments with no protection from high healthcare costs unless they enroll in a private plan. I experienced that with my mom and dad on Medicare during a long Thanksgiving weekend, going through a number of different things that were mind-boggling.

Despite major improvements and innovations in the healthcare sector that have transformed how care is delivered, traditional Medicare has barreled through the last 50 years on the same trajectory of increased costs and little innovation. And now we see in the Obamacare exchanges the same kind of bureaucratic nonsense that is driving up costs for beneficiaries, while disincentivizing personalized care: plans have one-size-fits-all requirements directed from Washington bureaucrats, not from patients or providers.

Yet while the Administration continues to struggle to implement Obamacare by setting government standards for benefits and care, this Committee will begin the long look at how to make sure the patient is at the center of healthcare decisions. That begins with long-overdue reforms to the outdated Medicare benefit.

It is time to continue those efforts sustained by the Bipartisan Policy Center and other bipartisan partnerships like Bowles-Simpson and Thomas-Breaux, to bring true entitlement reform to traditional Medicare. Their research, modeling, and their work over the years to advance long-overdue reform has been critical.

Updating the Medicare benefit design will bring the program into the 21st Century and meet the needs of current and future seniors. These reforms would bring the traditional Fee-for-Service benefit up to the standards that 17 million people, nearly 32 percent of enrolled seniors, are currently enjoying under the Medicare Advan-

tage program. MA plans offer high quality, coordinated care for our seniors. These plans also provide stability: largely stable co-payments; financial protections provided by maximum out-of-pocket limits; and strong incentives under their benefit structures to encourage seniors to receive the most high-value, efficient care possible.

Of course, Medicare Advantage isn't perfect. But its popularity and market-based roots serve as an excellent example for needed entitlement reform. For the MA programs to be the bridge to the entitlement reform we need, we also need to unshackle the program further. We should repeal such onerous Obamacare policies such as the cap on benchmarks and expand ideas like value-based insurance design throughout the entire MA program.

While we are encouraged by the growth in seniors choosing innovative value-based care through Medicare Advantage, we remain concerned about the viability of the overall Medicare program. Congress must come together, Democrats and Republicans, to find commonsense policies that will ensure the solvency of the program, like combining the deductibles under Part A and Part B of Medicare, and empowering seniors and providers with choice.

This will likely mean some hard choices, some education, and certainly lots of compromise. The status quo in Medicare is a fiscal fantasy, and we need to act sooner, rather than later, to ensure the program is around for future generations. I hope that this hearing can kick off a robust discussion on what policies we can get done to provide for the future of the Medicare program, as well as what past policies stand to go as they are hampering our goals to get to high-valued, coordinated health care for all seniors and future seniors, like me.

So, with that, I would like to recognize the gentleman from the great northwestern State of Washington, the distinguished Ranking Member, Dr. McDermott.

Mr. MCDERMOTT. Wow.

[Laughter.]

Chairman TIBERI. We are bipartisan.

Mr. MCDERMOTT. Well, in that spirit, I want to indicate that one Member of the Committee is inching toward being on Medicare. This is Mr. Kind's birthday.

Chairman TIBERI. This is your birthday song.

[Laughter.]

Mr. KIND. Thank you. Thanks, Doc. I feel good.

Mr. MCDERMOTT. Keep feeling good. I must start with an apology. I have to leave this hearing after I make my opening statement, because in the wisdom of the leadership of this House, they had two hearings congruently meeting: this Committee, which is supposed to be preparing and preserving—preserving and strengthening Medicare; and the Budget Committee, which is about to write a budget to unwind Medicare as we know it. At the very same time.

I am going to go up there. That is more important, because that may actually happen. This Committee has met on this issue many times before. This is the first committee hearing we have had since November of last year. So you know the Health Subcommittee doesn't really amount to very much in the leadership's mind.

And having this hearing again is like running over the same thing. The core proposal the Republicans have offered to end Medicare as we know it will have devastating effects on seniors, and that is what they are doing up in the Budget Committee. They will shift costs onto beneficiaries, create more losers than winners, and lead to a death spiral to the traditional Medicare program, if it would ever be enacted.

Now, we all know this. We have been through it again and again. It has been rejected over and over again. But we have to have another hearing here today on it. We will hear the same tired arguments, but the people know the truth: Republican proposals fail spectacularly to meet the needs of seniors. And by putting forward these terrible ideas that they are going to put on that budget up there, the Majority is showing how out of step they are with the American people. It is no surprise, I guess, that the results last night are that Mr. Trump, I guess, is going to be the nominee, because everybody is angry. They are angry at government for not responding to the issues.

Now, when the American people wanted a defined benefit—when you are old, what you want is to know what you have. That is how your mind operates. I can tell you, it works. That provides peace of mind and health security to beneficiaries. My colleagues want to give a radical voucher program—give a piece of paper to somebody and say, “Go find an insurance company that will take care of you and whatever you need,” not a defined benefit where you know you are going to get it, and—no, you are going to go out there and find out if the insurance company will do it.

Now, the American people want a stronger benefit, one with limited out-of-pocket costs and access to dental and vision. And now hearing coverage. As people live longer, we are going to have more and more problems financing the hearing problems that people have. But instead, what we get are cuts in benefits. When the American people want to preserve coverage, they want to raise the eligibility age. Make it go up to 72 or maybe 80 is when we ought to start Medicare. That is probably the right time. We could save a lot of money that way.

If we are serious about making sure the American Medicare program remains on a strong financial footing, we should be looking for ways to cut the waste and greed and inefficiency in the system, not shifting the cost on to beneficiaries, which is what is happening today.

Prescription drug prices are out of control and the pharmaceutical industry is reaping the benefits. Medicare spent \$120 billion on prescription drugs last year. It has been 13 years, 13 years since the Congress sold out to the drug companies by creating Part D and tying the social and health service secretary’s ability to negotiate prices. Seniors pay 50 percent more than veterans in this country because the veterans can negotiate prices but Medicare—50 million Americans can’t negotiate prices. And we haven’t had a single hearing in Congress since that 13-year-ago decision. I have been here on this Committee through that whole period of time, and there is nothing.

We continue to overpay the insurance industry through the Medicare Advantage program. Although ACA reduced these over-

payments by \$156 billion, we have a lot of work to do to crack down on widespread upcoding and cherry-picking of beneficiaries. And this Committee still has put no effort into scrutinizing the recent insurance industry consolidation, which is unprecedented in scale and threatens to eliminate competition in the Medicare Advantage program.

So, there is a whole series of things we ought to be looking at. And I have sent letters to the Chairman—not Mr. Tiberi, but his predecessor—but nobody wants to have hearings and expose what is going on. Instead, we have these kind of show hearings, and I am sorry, Mr. Chairman, I have to go upstairs.

Chairman TIBERI. Oh, no worries on my part.

Mr. MCDERMOTT. And stop you from succeeding.

[Laughter.]

Chairman TIBERI. Should we warn Dr. Price that you are coming up?

Mr. MCDERMOTT. You should tell him I am on my way.

Chairman TIBERI. Without objection, other Members' opening statements will be made part of the record.

Today's witness panel includes three expert witnesses. Thank you all for being here today.

First, Katherine Baicker, the C. Boyden Gray Professor of Health Economics, and Chair of the Department of Health Policy and Management at Harvard University's T.H. Chan School of Public Health is with us.

Next, we will hear from Bob Moffit, a Senior Fellow at the Heritage Foundation.

And finally, we will hear from Stuart Guterman, a Senior Scholar in Residence at AcademyHealth. I think we have had you up here before, Mr. Guterman, so welcome back.

With that, each of you will have 5 minutes, and we will begin.

Ladies first, Ms. Baicker.

**STATEMENT OF KATHERINE BAICKER, PH.D., CHAIR AND
C. BOYDEN GRAY PROFESSOR OF HEALTH ECONOMICS,
DEPARTMENT OF HEALTH POLICY AND MANAGEMENT,
HARVARD T.H. CHAN SCHOOL OF PUBLIC HEALTH**

Ms. BAICKER. Thank you so much for the opportunity to talk with you about what I think is a crucial issue for the Medicare program. Medicare has provided invaluable benefits to beneficiaries for 50 years now, in terms of financial protection, access to valuable care. And we all, I think, share the goal of ensuring that that protection is available for decades to come.

The right care to the right patient at the right time is what I think of as high-value care. It needs to be high quality, it needs to be affordable to beneficiaries, it needs to be affordable to the system. And high-value insurance is designed to provide that kind of high-quality care to beneficiaries at a price that the whole system can afford. I believe a thriving Medicare Advantage program can be a crucial component in driving higher-quality care at a more affordable price.

And I think there are three ways that the Medicare Advantage program can do this. The first is managing the quantity of care the beneficiaries get. There is a lot of evidence that there is care deliv-

ered to beneficiaries that is, at best, minimally helpful to their health and, at worst, actually harms their health. And reforming the Fee-for-Service program to try to reduce that wasteful care that is not helping anyone and costing the system billions of dollars, that needs to be an ongoing effort.

But there is some evidence that Medicare Advantage plans are doing a better job at shepherding resources by steering beneficiaries to lower-cost, higher-quality sites of care without any harm to the quality or health outcomes. And that quality is a crucial component of what I think of as high-value care. I think sometimes we hear high value, and we just think costs less. And that is no one's goal. The goal is not to spend less on Medicare. The goal is to spend less on stuff that is not helping people, and spend more on things that actually improve health.

The evidence on quality, in my view, is a little more mixed than the evidence on quantity of care. But there are hopeful signs that the Medicare Advantage program is improving on a number of quality measures and provides higher quality than a lot of counter-part Fee-for-Service beneficiaries receive in that program.

If you look at the quality of care that Fee-for-Service beneficiaries get in the parts of the country where we spend the most on Medicare Fee-for-Service, that quality is much lower in those high-spending areas than it is in low-spending areas. That doesn't mean that the Fee-for-Service providers are spending money to harm patients. It means that there is a lack of coordination and a lack of management of that patient's care that both results in higher spending and results in lower quality, things falling through the cracks. And the Medicare Advantage program aims to provide incentives to provide higher-quality care by better managing.

The last one I want to hit on is something mentioned by Mr. McDermott, which is the financial protection provided to beneficiaries. Medicare is not just to get people access to care; it is supposed to provide financial protections, so that seniors and their families aren't bankrupted when a really expensive health condition arises. And Medicare has done a moderate job of doing that, but the basic Medicare program benefit does not provide nearly the financial protection that we would like it to.

Beneficiaries are exposed to unlimited out-of-pocket costs in the basic Medicare benefit, which is why more than 90 percent of them have some additional coverage through MediGap, through an employer plan, or through Medicare Advantage. And MediGap plans are not affordable to all beneficiaries. Medicare Advantage attracts beneficiaries in part by providing them those financial protections.

So I think there is enormous possibility in the Medicare Advantage program to improve quality and keep plans affordable, but there are some foundational elements of the program that require constant attention that I think reforms would help facilitate.

We need good risk adjustors, so that plans have an incentive to enroll sick enrollees and quality measures accurately reflect the quality of care delivered to beneficiaries, so good risk adjustment methods are the foundation of all bidding and price adjustment in the Medicare Advantage system.

We need better quality information, both for beneficiaries and to underpin incentives for proprietors to deliver high-quality care. No

one wants stinting on care in these programs, and quality measures help guard against that.

Beneficiaries need to have incentives to choose the highest value plans, too. And this means Medicare Advantage programs competing on equal footing with other options that are available. And I think beneficiaries are going to continue to choose those plans because of the more comprehensive benefit that they offer, the higher quality care, the better coordinated care. Let them compete for enrollees, but let enrollees share in the benefits if they choose a higher-value plan. That benefits them and it benefits the taxpayers.

The Medicare program is crucial for beneficiaries, there is no doubt about that. But it is posing an increasingly difficult burden on Federal budgets. We can't afford the program as it is in 20 or 30 years. My hope is that a thriving Medicare Advantage program will help drive higher-quality care, while keeping the program affordable both for seniors and for the system, so that it will be here for decades to come. Thank you.

[The prepared statement of Ms. Baicker follows:]



SCHOOL OF PUBLIC HEALTH
Department of Health Policy
and Management

Katherine Baicker, PhD
C. Boyden Gray Professor
of Health Economics

March 16, 2016

My name is Katherine Baicker, and I am the C. Boyden Gray Professor of Health Economics in the Department of Health Policy and Management at the Harvard T.H. Chan School of Public Health. I would like to thank Chairman Tiberi, Ranking Member McDermott, and the Distinguished Members of the Committee for giving me the opportunity to speak today about how we can address the crucial policy challenge of improving the quality and value of care that Medicare delivers to beneficiaries and ensuring that it provides the vital protections they need for generations to come. This testimony is derived in part from recent academic work with colleagues.

For decades, Medicare enrollees have had the choice between traditional fee-for-service (FFS) Medicare and Medicare managed care plans. Medicare Advantage (MA) managed care plans often offer more generous benefits or lower cost sharing than the traditional, largely unmanaged FFS program, using some of the tools for managing care often deployed in private markets.¹ For much of the program's history, MA enrollees comprised only a small share of Medicare enrollees. However, over the past decade MA enrollment has grown more than 2.5-fold, with over 16 million or about 30 percent of Medicare beneficiaries now enrolled in MA plans.¹ This growth has been driven both by enrollment of the newly eligible and by switching from FFS to MA. There remains a great deal of variability in MA enrollment across areas (see Figure 1).

The rapid growth of MA over the past decade has the potential to increase the value of health care delivery by using better insurance design, limiting incentives to deliver low-value services relative to those inherent in FFS, and using care management tools increasingly seen in the private sector.^{2,3} The success of the program in managing utilization while maintaining or improving quality has been the subject of active research, complicated by evolving payment schedules, differing patient pools, and limited data (although MA "encounter data" should provide an avenue for more detailed comparisons).

There is a substantial body of evidence suggesting that managed care enrollees have lower utilization than FFS enrollees.⁴⁻⁶ Utilization rates for services such as emergency department visits, days in the hospital, ambulatory surgery, and other procedures have been estimated to be substantially lower for MA managed care enrollees than for comparable FFS enrollees.^{7,8}

In addition to affecting the quantity and type of care used, managed care incentives may impact the quality of care delivered to enrollees. Measuring the quality of care delivered is much more

difficult than measuring the quantity, and evidence is mixed.⁶ The parts of the country in which FFS is the most expensive do not have the highest quality care (see Figure 2).⁹ There seem to have been modest improvements in some (but not all) measures of the quality of care delivered to MA beneficiaries.¹ Some recent evidence suggests that by coordinating care, MA managed care plans generate moderate improvements in the quality of care relative to FFS.¹⁰ MA plans can also be more innovative in designing benefits that better serve members, such as experimenting with hospice benefits, telemedicine, or value-based insurance design.^{11,12}

MA plans can also offer better financial protections than the basic Medicare benefit. We need health insurance not just because of the cost of health care, but because there is great uncertainty about who will need very expensive and potentially life-saving care and when they will need it. Medicare should give beneficiaries not just access to medical care, but also protection from the risk of catastrophic spending. Medicare by itself offers only limited protection against economic ruin.¹³ The basic Medicare benefit lacks a cap on out-of-pocket spending, so that beneficiaries are exposed to the risk of open-ended cost-sharing. This risk is one reason that 90 percent of beneficiaries obtain some other insurance – including MediGap (which may not be affordable for disadvantaged populations) and MA.¹⁴ One of the ways that MA plans attract enrollees is by reducing their exposure to out-of-pocket costs.

Beyond the effect of care management on MA enrollees themselves, there is also the possibility that better care management might have wider-ranging effects: by shifting financial incentives and physician practices, a critical mass of patients covered by insurance plans that promote better management could generate spillover effects that change the utilization of other patients in the health care system. While challenging to estimate, evidence suggests that a higher managed care market share can lead to lower utilization, with more limited evidence on quality.¹⁵⁻¹⁷ For example, parts of the country where a greater share of Medicare beneficiaries are enrolled in MA may have lower rates of hospitalization and overall utilization for Medicare FFS enrollees (although these changes do not necessarily lead to lower FFS program spending).¹⁸⁻²⁰

The MA program thus has the potential to serve as an avenue for innovative coverage that provides beneficiaries with choice and flexibility, and delivers care more efficiently without observed loss in quality. Achieving the full potential benefits of the program, however, depends not just on having high-value plans available, but on payments that foster competition on quality and premiums. There are of course many challenges in designing an optimal payment system, including creating robust risk adjustment methods that promote beneficial plan competition; incentivizing providers to deliver care of consistently high quality and health benefit; and promoting beneficiary choice of high-value plans that are right for them.

Risk adjustment methods that adequately capture the future health risks of beneficiaries and are robust to choices made about patient care (and documentation thereof) are key to multiple

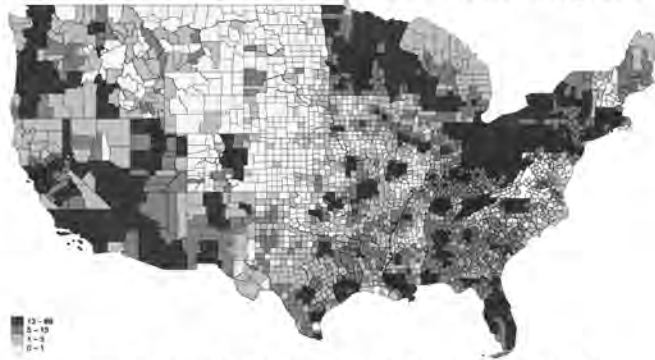
aspects of a well-functioning Medicare Advantage market. Appropriate risk-adjustment minimizes plans' incentives to enroll disproportionately healthy patients. It is also crucial for accurate measurement of the quality of care delivered. Risk-adjustment methods have improved substantially since the MA program's inception, but are still sensitive to coding choices.²¹⁻²⁵

Quality must be both evident to enrollees and rewarded for plans and providers. Beneficiaries need enough information to be able to choose the high-quality plan that is best for them – and to foster competition between plans on the basis of quality. But quality information alone is not likely to be sufficient: payments also need to provide incentives for providers and insurers to deliver not more care, but better care. The current Star system can be strengthened both to provide better information and to be a more effective basis for rewarding high-quality care.¹

Aligning incentives for providers and plans to deliver high quality care is important, but beneficiaries who choose options that deliver high quality care should share fully in the benefits. Of course, competition between plans works best to improve quality and lower costs when there is real choice among diverse options that all compete on a level playing field. Efforts to promote coordinated care delivery must be balanced with promoting robust competition among both plans and providers.²⁶ MA plans competing with other options on equal footing can attract enrollees by delivering innovative, higher quality plans with more affordable premiums, generating savings that benefit both enrollees and taxpayers.

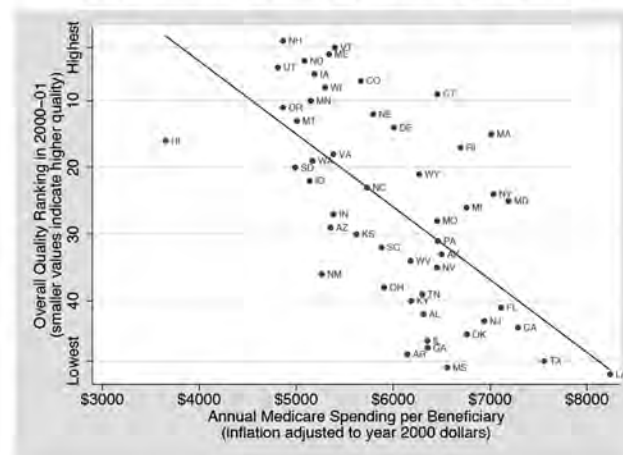
For more than 50 years, Medicare has provided invaluable benefits to enrollees, but the program overall consumes an ever-rising share of federal spending, straining the federal budget and generating costly economic distortions. A “one size fits all” Medicare program will be increasingly difficult to maintain.^{27,28} A thriving and competitive Medicare Advantage program can be a vital contributor to high quality beneficiary care in a sustainable health care system.

Figure 1: Share of Medicare Beneficiaries Enrolled in MA Managed Care



Source: Baicker and Robbins, *American Journal of Health Economics* (2015)

Figure 2: Relationship Between FFS Spending and Quality



Source: Baicker and Chandra, *Health Affairs* (2004)

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Chairman TIBERI. Thank you, Dr. Baicker.
Mr. Moffit, you are recognized for 5 minutes.

**STATEMENT OF ROBERT E. MOFFIT, PH.D., SENIOR FELLOW,
INSTITUTE FOR FAMILY, COMMUNITY, AND OPPORTUNITY,
THE HERITAGE FOUNDATION**

Mr. MOFFIT. Thank you very much. Chairman Tiberi, distinguished Members of the Subcommittee, ladies and gentlemen, my name is Robert Moffit. I am a senior fellow at the Center for Health Policy Studies at the Heritage Foundation. And I want to say it is really an honor and a privilege to have the opportunity, the rare opportunity, to address the House Ways and Means Subcommittee on Health, the most powerful Committee in Congress, and one that has such a great influence on the course of American life.

Rest assured, I am testifying today solely in my own capacity. Nothing I say here today will represent the views of the Heritage Foundation or its management or its board of trustees.

Mr. Chairman, the Congressional Budget Office recently issued a rather somber warning about the state of America's fiscal health. It is impossible, of course, to tackle the growing fiscal problems of the Nation without addressing Federal entitlement spending, including Medicare. Of all the Federal entitlements, Medicare represents the greatest single challenge.

Looking ahead, the Congressional Budget Office says that, in particular, revenues are going to be—remain steady as a percentage of GDP over the coming decade. But then the CBO says—and I quote—the aging of the population and the rising costs of health care are projected to substantially boost Federal spending on Social Security and the government's major health programs over the next 10 years and beyond.

We are facing, in other words, serious deficits. We are back to trillion-dollar deficits, and we are looking at major increases in our debt. The policy challenge is very difficult, but it is not impossible. Congress and the Administration need to balance the burdens yet to be imposed on the taxpayer with the needs of growing millions of enrollees who depend upon Medicare. And to accomplish this objective, policymakers should undertake specific structural changes to alleviate the taxpayers' fiscal burdens, while ensuring the financial security and improving the medical care of millions of seniors.

In other words, in short, the job—as Kate Baicker has just said, the job is to get better value for the ever-larger expenditure of Medicare dollars.

This morning I am going to suggest that Congress reconsider structural changes to the Medicare program, specifically the simplification of the existing traditional Medicare program. And the best way to do that is to combine Medicare Part A and Part B, expand the existing policy of limiting taxpayer subsidies to the wealthiest classes of American citizens, and to gradually raise the normal retirement age of eligibility for Medicare enrollment.

I am also going to suggest that Congress consider expanding the defined contribution of financing, which right now governs the provision of prescription drugs and comprehensive coverage and Medicare Advantage to the rest of the Medicare program. Now, these

are very broad policy proposals, and I hasten to add they can be achieved in different ways. And the fiscal impact of these proposals would vary, of course, depending upon such details as the age of eligibility, risk adjustment, or payment formulas, or various modifications in the ways in which these proposals would be implemented.

I want to make one other point. Mr. McDermott made this point, but I think it is important. None of these proposals are novel. They have all been offered before in other contexts. But they all have one thing in common. At different times, under different circumstances, these proposals have generated genuine bipartisan support. Congress could and should pursue a generous bipartisan support.

With regard to the specifics, I think in simplifying Medicare, you can start to reduce Medicare's complexity by combining, as I say, Medicare Part A and Part B into a single plan, but then add catastrophic coverage. Catastrophic coverage is the greatest single need for senior citizens. And at the same time, simplify uniformity. Simplify the deductible and the coinsurance system.

If you are going to add catastrophic coverage, you should also reform the MediGap program to make the catastrophic coverage feature of your change work well. Right now, under the existing MediGap system, we have excessive spending, which actually increases the premiums for senior citizens in Medicare Part B.

With regard to the future of Medicare, my own view is that the defined contribution programs in both Medicare Part C and Medicare Part D have actually been very successful in providing a wide variety of healthcare benefits to senior citizens at reasonable cost. This performance that we have had so far offers tremendous opportunity, I think in the future, to improve both the quality of care for senior citizens and, at the same time, do it in a fashion which will be fiscally responsible.

Thank you very much, Mr. Chairman.

That concludes my remarks.

[The prepared statement of Mr. Moffit follows:]



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Preserving and Protecting Medicare

Testimony before Committee on Ways and Means Subcommittee on Health

United States House of Representatives

March 16, 2016

Robert E. Moffit, Ph.D.
Senior Fellow
The Heritage Foundation

My name is Robert E. Moffit. I am Senior Fellow at The Heritage Foundation. The views I express in this testimony are my own and should not be construed as representing any official position of The Heritage Foundation.

The Congressional Budget Office (CBO) has recently issued a rather somber warning about the state of America's fiscal health. We are faced with the return of large annual deficits and a sharp upward trajectory of federal debt, particularly as a percentage of our entire national economy, reaching 76 percent of GDP by the end of this year. It is, of course, impossible to tackle our growing fiscal problems without addressing federal entitlement spending, including Medicare.

Of federal entitlements, Medicare presents the most difficult challenge. Medicare's Hospital Insurance Trust Fund faces insolvency in 2026. But trust fund insolvency is only one indicator of Medicare's fiscal well-being. The more important issue is Medicare spending. CBO noted that from 2010 to 2015, reflecting the relatively slow growth in Medicare spending, Medicare increased from just 3.5 to 3.6 percent of GDP.¹

To all appearances, however, the recent slowdown in Medicare spending is over. For this past year, CBO estimated a spending increase of about 7 percent, the "fastest rate of growth" since 2007.² Going forward, Medicare is projected to grow from 3.6 percent of GDP in 2015 to 4.7 percent of GDP in 2026.³

Looking ahead, CBO reports, "Projected deficits and debt for the coming decade reflect the significant long-term budgetary challenges facing the nation. In particular, although revenues are projected to remain steady as a percentage of GDP over the coming decade, the aging of the population and the rising costs of health care are

¹ Congressional Budget Office, "The Budget and Economic Outlook: 2016 to 2026," (January 2016), Table F-5, p. 153, <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51129-2016Outlook.pdf>

² Congressional Budget Office, "An Update to the Budget and Economic Outlook: 2025 to 2025," (August 2015), p. 13, <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/50724-BudEconOutlook-3.pdf>

³ Congressional Budget Office, "The Budget and Economic Outlook: 2016 to 2026," Table 3-1, p. 64.

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projected to substantially boost federal spending on Social Security and the government's major health programs over the next ten years and beyond."⁴

The policy challenge is difficult, but not impossible. Congress and the Administration will need to balance the burdens to be imposed on the taxpayers, including the tens of trillions of dollars in the program's long-term unfunded obligations, with the needs of the growing millions of enrollees who depend upon Medicare. To accomplish this objective, policymakers should undertake specific structural changes to alleviate the taxpayers' fiscal burdens, while assuring seniors financial security and improving their medical care; in short, the job is to get better value for the ever larger expenditure of Medicare dollars.

Congress should thus consider four structural changes to the Medicare program: the simplification of the traditional Medicare Program by combining Medicare Parts A and B; expanding the existing policy of limiting taxpayer subsidies to the wealthiest classes of enrollees; gradually raising the normal age of eligibility for Medicare enrollment; and expanding the defined contribution financing of the Medicare program from prescription drug coverage to hospitals and physicians services.

These are broad policy proposals, and they can be achieved in different ways. The fiscal impact of these proposals would vary, of course, and would be scored differently by the Congressional Budget Office based on technical changes or programmatic details, such as changes in age eligibility, risk adjustment or payment formulas or contribution levels, or the various modifications in the ways in which these proposals would be implemented.

Finally, I would add that none of these proposals are novel; they have been offered before in other contexts. But they also have one thing in common. At different times, under different circumstances, they have generated genuine bipartisan support. Congress can, and should, improve the program in a bipartisan spirit.

SIMPLIFY THE TRADITIONAL MEDICARE PROGRAM.

A recurrent theme among health policy analysts, regardless of their political persuasion, is that American health care is overly complex and confusing, as well as unnecessarily costly. This is true in the private sector, but equally true in the public sector and no more so than in traditional Medicare. Karen Davis and her colleagues at the Commonwealth Fund, a prominent progressive think tank, captures the current problem accurately: "The fragmentation of coverage into separate parts for hospital (Part A) and physician (Part B) and prescription drugs (Part D) adds to the administrative cost, complexity, and confusion for beneficiaries, and hinders coordination of care."⁵

Congress can start reducing Medicare's complexity by combining Medicare Parts A and B into a single plan, complete with catastrophic coverage, a single deductible and uniform coinsurance.

The provision of catastrophic protection, the protection of persons from the financial devastation of a serious illness, is the very purpose of any insurance arrangement. President Reagan tried to secure that protection in 1988.

⁴ CBO, "The Budget and Economic Outlook: 2016 to 2026," (January 2016), p. 10.

⁵ Karen Davis, Stuart Guterman, and Faran Bandeen, "The Affordable Care Act and Medicare: How The Law is Changing the Program and the Challenges That Remain," The Commonwealth Fund, (June 2015), p. 18.

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but certain flaws in that particular legislative product, ancillary to the provision of catastrophic coverage, undercut its noble purpose: to provide security and peace of mind to the nation's seniors.

In combining Medicare Parts A and B, Congress should also include Medigap reform. Today, Medigap plans can and do provide first dollar coverage, which stimulates excessive utilization, and thus generates ever higher Part B costs for seniors enrolled in the program.⁶

I hasten to add that pursuing such a set of changes has the potential for generating consensus. I would remind the Committee that broadly similar proposals were offered by Senator John Breaux (D-LA) and Chairman Bill Thomas (R-CA) in 1999, as one of the key recommendations of the National Bipartisan Commission on the Reform of Medicare. Versions of more simplified cost sharing have also been endorsed by the Bipartisan Policy Center and the National Commission on Fiscal Responsibility and Reform (Bowles-Simpson Commission).

RETARGET MEDICARE SUBSIDIES TO THOSE MOST IN NEED

When Medicare was created in 1965, senior citizens were among the poorest of the general population and roughly half did not have access to private health insurance coverage. The program thus fulfilled a specific need, assisting those who did not have coverage with guaranteed and continuous coverage and improving the financial security of America's elderly population. The program clearly succeeded in solving those problems. All seniors today have insurance coverage, and, while the population has been aging rapidly, the Census Bureau reports that the poverty rate among senior citizens has shrunk dramatically, from 35 percent in 1960 to just 10 percent today.⁷

Taxpayers, through general revenue transfers, finance 75 percent of the funding for Medicare physicians services (part B) and drug coverage (Part D). Beneficiary premiums finance the remaining 25 percent of these medical costs. In sharp contrast to Medicare Part A, Medicare Parts B and D are *voluntary* programs. No person is forced to enroll and pay the taxpayer-subsidized premiums.

Today, working families are supporting an ever larger senior population, including upper income recipients, many of whom are financially better off than the working families that support them. As economist Robert Samuelson observed, "Today, younger and poorer workers increasingly support (through payroll taxes) older and wealthier retirees."⁸ Urban Institute analysts note, for example, that a married couple retiring in 2015 that earned an average annual income (\$47,800) will have paid an estimated \$683,000 in lifetime Medicare and Social Security taxes, and will have secured \$1,038,000 in lifetime benefits in retirement.⁹

Congress has already adopted a policy of targeting taxpayers' subsidies to those who need help the most. In the Medicare Modernization Act of 2003 and in the Affordable Care Act of 2010, Congress has already reduced the

⁶ Based on an analysis of MedPAC data, seniors' total extra Part B premium payments would amount to \$70.1 billion over the period 2012 to 2023. See Robert E. Moffit and Drew Gonshorowski, "Double Coverage: How It Drives Up Medicare Costs for Patients and Taxpayers," Heritage Foundation Backgrounder No. 2505, June 4, 2013, <http://thf.media.s3.amazonaws.com/2013/pdf/bg2805.pdf>

⁷ See Carmen DeNavas-Walt and Bernadette D. Proctor, "Income and Poverty in the United States: 2014" (United States Census Bureau: September 2015), <http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-252.pdf>

⁸ Robert J. Samuelson, *The Good Life and Its Discontents: The American Dream in the Age of Entitlement* (New York: Vintage Books, 1997), p. 222.

⁹ C. Eugenie Steurle and Caleb Quackenbush, "Social Security and Medicare Lifetime Benefits and Taxes: 2015 Update," The Urban Institute, (September 2015), p.2, <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000378-Social-Security-and-Medicare-Lifetime-Benefits-and-Taxes.pdf>

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generosity of taxpayer subsidies for upper income retirees. Moreover, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires upper income enrollees to pay higher premiums: a policy that affects approximately 6 percent of the total Medicare population. I would add, in this context, that income-testing of Medicare premium payments has not, as some critics fear, resulted in an exodus from the program.¹⁰ Even with less generous taxpayer subsidies for Medicare Part B and Medicare Part D, Medicare's large pooling of risks and guaranteed issue coverage is a major financial advantage to all enrollees, including very wealthy beneficiaries.

In this area as well, there is a potential for consensus. In his recent Budget submission, President Obama has proposed, as he has done previously, raising Medicare premiums for higher income enrollees, such that 25 percent of all seniors would eventually pay higher Medicare premiums. But Congress could secure major savings and reduce taxpayers' burdens by increasing the number of Medicare beneficiaries who pay higher Medicare premiums from 6 to just 10 percent of the total Medicare population. This could be done by re-setting the income threshold for higher Medicare premium payment at \$55,000 for individuals, which is, as noted, well above a single person's average annual income (in 2015 dollars) estimated by Urban Institute analysts at \$47,800. For couples, the beginning threshold could be lowered to \$110,000, well above the average annual income of a two earner couple at \$95,600.¹¹ Below those income levels, the beneficiaries would be entitled, as they are today, to 100 percent of the standard taxpayer subsidies. Above those levels, premiums would gradually increase. Instead of the sharp, cliff-like increases that characterize current law, Medicare premiums would rise gradually with incremental increases in annual income. Part B and D premiums would increase 1.8 percent for every \$1000 increase in income above the initial income thresholds for individuals and couples.

Medicare Part B and D are *voluntary* programs, with three quarters of total funding coming from taxpayers' general revenues; and the share of general revenues as a source of Medicare funding is steadily increasing. As Samuelson also observes, "The central question is an enduring one: How do we help those who can't help themselves without also tempting those who could help themselves from becoming dependent on government?"¹²

While the Congress must make wise judgments about what is "due" to beneficiaries, the Congress must also determine what is fair for taxpayers. It is clearly unjust for one generation to saddle generations yet unborn with mountainous debt that undermines their own economic future. If entitlement spending is not restrained, the consequence will be shrinkage of economic opportunities and a lower standard of living for young Americans.

Congress must therefore address the consequences of current policy on younger persons who are working, raising families, and saving and trying to provide for their own retirement. In this context, a secondary, but nonetheless important, consideration is this: Should taxpayers subsidize, through entitlement spending, the wealthiest cohort of America's retired population at all, say, those with annual incomes above \$165,000? My own view is that they should *not* be required to do so.

¹⁰ "There is some concern that proposals to raise premiums for higher income beneficiaries could lead some to drop out of Medicare Part B and/or Part D, which could result in higher premiums for others who remain in Medicare, assuming the higher income beneficiaries who disenrollment is relatively healthy. However, so far, there is no evidence that higher income beneficiaries are dropping out of Part B and Part D in response to existing income-related premiums." Kaiser Family Foundation, *Policy Options to Sustain Medicare for the Future*, January 29, 2013, p. 24, <http://kff.org/medicare/report/policy-options-to-sustain-medicare-for-the-future/>

¹¹ Steurle and Quackenbush, "Social Security and Medicare Lifetime Benefits and Taxes: 2015 Update," p. 17.

¹² Samuelson, *The Good Life and Its Discontents*, pp. 253-254.

RESET MEDICARE'S ELIGIBILITY AGE FOR THE TWENTY FIRST CENTURY

Medicare's normal age eligibility—65 years—has been historically tied to Social Security eligibility, which was fixed by law in 1935 amidst the Great Depression. Social Security has since changed its normal age of eligibility to 67. There have been no changes in Medicare, even though the economic, demographic and social conditions of the United States have changed dramatically since Medicare was enacted in 1965.

There are sound reasons for reconsidering the current age of Medicare eligibility. First, as noted, Americans' life expectancy and our demographics have changed dramatically. President Franklin D. Roosevelt and Congress enacted Social Security in 1935, and set the age of eligibility at 65. This was a safety net program, and that age eligibility was set when the average American life span was roughly 62 years. By 1965, however, American life expectancy had increased to 70.2 years. By 2030, it will reach approximately 81 years of age.

America is rapidly aging. In 1965 when Medicare was enacted, there were roughly 4.5 workers for each beneficiary. Today, that ratio is slightly more than 3 to 1. But the Medicare Trustees project that enrollment will rise sharply from over 55 million today to more than 82 million in 2030. And by that time, there will be slightly more than just two workers for every Medicare beneficiary. This will inevitably impose serious pressures on taxpayers, encourage even tougher Medicare payment reductions affecting seniors, or some unhappy combination of both.

Second, Congress should consider the positive potential of Americans working longer, and the immense social benefits of tapping into the knowledge, skills and talents of older workers. This is particularly appropriate in light of the decline in workforce participation, projected to reach a low of 62.1 percent in 2019.¹³ According to a CBO analysis, gradually raising the Medicare age of eligibility to 67—and thereby tracking the policy already adopted for Social Security—will increase workforce participation among those 65 and older.¹⁴ Among baby boomer professionals especially, more and more of them are already choosing to work longer, and enjoy doing so.¹⁵

Raising the age of eligibility to 67, thus tracking Social Security, is the most prominent proposal for resetting the normal age of Medicare eligibility. But Congress should also explore the option of gradually raising the normal age of eligibility for both Medicare and Social Security to age 68 over 10 years and thereafter indexing the normal age of eligibility to longevity. If Congress were to pursue this idea, it might be worthwhile considering a tax policy to encourage continued participation in the labor force: Any person, regardless of income, who works beyond the normal retirement age, could automatically qualify for a special annual deduction or tax break. The Congressional Budget Office should be able to provide some valuable insights on the potential impact of such a set of combined policies, particularly in scoring them for their macroeconomic effects.

¹³ Ibid. p. 44.

¹⁴ Joyce Manchester, "How Will Older People's Participation in the Labor Force Be Affected by The Coming Increase in Full Retirement Age for Social Security?" Congressional Budget Office, (January 9, 2013), <https://www.cbo.gov/publication/43834>

¹⁵ See "A Billion Shades of Grey," *The Economist*, April 26, 2014, <http://www.economist.com/news/leaders/21661253-aging-economy-will-be-slower-and-more-unequal-unless-policy-starts-changing-now>

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Once again, Congress has the potential for reaching consensus on this issue. During his 2011 discussions with congressional leaders on the debt ceiling, President Obama agreed, at least briefly, with raising the age of Medicare eligibility to 67. I note that Alice Rivlin, a senior fellow at the liberal Brookings Institution and former Director of the Congressional Budget Office (CBO), as well as William Galston, a former domestic policy advisor to President Bill Clinton, and the Committee for a Responsible Federal Budget, have also endorsed raising it to 67.

INTEGRATE TRADITIONAL AND COMPETITIVE MEDICARE INTO A SINGLE PROGRAM.

The vast majority of today's seniors are enrolled in a Medicare defined contribution program, either through Medicare Advantage or Medicare Part D. While defined contribution funding in other almost identical contexts (such as plan payment in the FEHBP) is not normally referred to as "premium support," for all practical purposes that is what it is. Congress should expand this financing system for hospitalization and physician services, establish a level playing field among Medicare's third party payers, and intensify competition for all plans and providers. Congress should require a simplified traditional Medicare plan to compete, head to head, with Medicare Advantage plans, and other private options as well as employment based plans.¹⁶

Under such a proposal, the government contribution to an enrollee's premium could be based on regional competitive bidding among all health plans, including traditional Medicare, to offer a basic health benefits package consisting of the standard benefits of Parts A, B and D, or their actuarial equivalent. In 2013, CBO found that private plans could deliver the same level of benefits at a lower price than traditional Medicare, and estimated the wide range of savings (over just six years) from a low of \$69 to a high of \$275 billion, depending upon specific assumptions.¹⁷

All plans would be required to offer catastrophic coverage, just as all Medicare Advantage and Part D plans do today. If a Medicare recipient purchases a plan that is less than the amount of the government contribution, the recipient could keep that money as cash rebate or roll the funds over into a tax free health savings account. If the recipient purchases a plan that exceeds the government contribution, the recipient would pay the additional amount in premium.

The Congress should adjust the government contribution for income, just as it adjusts Medicare Parts B and D premiums today and continue to improve upon the Medicare Advantage risk adjustment mechanisms.¹⁸ Because of the pre-existing infrastructure of such a competitive market is already embodied in Medicare Parts C and D, including the process for dissemination of comparative plan information and risk adjustment mechanisms, the transition would be much easier today than it would have been when the majority of the National Bipartisan Commission proposed such a change in 1999.

¹⁶ Today, employer-sponsored plans already participate in Medicare Part D, and about 3 million Medicare Advantage enrollees are also in employer-sponsored health plans. Medicare Payment Advisory Commission, *MedPAC Data Book*, p. 141.

¹⁷ Basing payment on an average bid would yield \$69 billion; basing payment on the second-lowest plan option would yield \$275 billion. Congressional Budget Office, *Options for Reducing the Deficit: 2014-2023*, (November 2013), p. 204.

<https://www.cbo.gov/sites/default/files/colfiles/attachments/44715-OptionsForReducingDeficit-3.pdf>

¹⁸ Recent academic research shows progress in the reduction of adverse selection in the Medicare Advantage program. See, in particular, Joseph F. Newhouse, Mary Price, J. Michael McWilliams, John Hsu, and Thomas G. McGuire, *How Much Favorable Selection is Left in Medicare Advantage?*,² The National Bureau of Economic Research, *Working Paper 200021*, NBER Working Paper Series, (March 2014), <http://www.nber.org/papers/w20021>

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Compelling health plans and providers to compete for customers on a single level playing field would have several advantages. Personal choice, clarity in pricing, transparency in performance, combined with intense competition among plans and providers would ensure more direct accountability to patients and control costs. CBO has reported that it could generate serious savings for seniors and taxpayers alike.¹⁹

The proposal would reduce government bureaucracy and regulation.²⁰ Competing health plans, not the Medicare bureaucracy or its agents, would contract with doctors and hospitals, determine their employment or conditions of participation, establish provider rates and conditions of reimbursement, collect premiums and pay claims, and more quickly and easily incorporate new benefits, medical treatments or procedures, and oversee the quality of medical services.

The proposal would stimulate greater clinical innovation, and progressive improvements in care delivery. While traditional Medicare is struggling to promote innovation through administrative payment manipulations, the Medicare Advantage program has already pioneered case management, care coordination, and the expansion of preventive care, while Medicare Part D has provided Medicare patients with a broad array of drug therapies that rivals the generous levels available to federal workers and retirees in the Federal Employees Health Benefits Program.²¹

The proposal would discourage the routine congressional micromanagement and sharply reduce or eliminate the special interest group politicization of pricing and procedures that plagues Medicare today. Under such a proposal, decision-making would be radically decentralized – diffused among millions of enrollees seeking the best value for their Medicare dollars – and market pricing would reward the most efficient medical plans and providers. Competing plans would also be directly accountable to patients and would have powerful incentives to make fair and rational payments to doctors and other medical professionals, while avoiding wasteful spending. Plans would have powerful new market incentives to combat fraud and abuse simply because any failure to do so would directly detract from their bottom line and undercut their market share.

These four options for Medicare structural reform are not exhaustive. But they have been previously proposed by very different analysts of often sharply differing political perspectives. Various versions of these general proposals have also been scored, at one time or another by the Congressional Budget Office, or other independent analysts, and in each case they show promise of delivering significant savings for the Medicare program, seniors and the taxpayers. But the most important reason why these proposals deserve your consideration is that they hold promise of making Medicare an even better program for current and future retirees.

Thank you, Mr. Chairman and Members of the Committee. I would be happy to answer any of your questions.

¹⁹ See Congressional Budget Office, “A Premium Support System for Medicare: Analysis of Illustrative Options,” September 18, 2013, <https://www.cbo.gov/sites/default/files/09-18/PremiumSupport.pdf>.

²⁰ As Rand Corporation researchers concluded, “Reducing the cumulative burden of rules and regulations may improve professional satisfaction and enhance physicians’ ability to focus on patient care.” Mark W. Friedberg, et al., *Factors Affecting Physician Professional Satisfaction*, The Rand Corporation, (2013), p. 3. http://www.rand.org/pubs/research_reports/RRA339.html

²¹ For a comparative overview of the performance of these programs, see Robert Emmet Moffit, PhD, “Expanding Choice Through Defined Contributions: Overcoming A Non-Participatory Health Care Economy”, *Journal of Law, Medicine and Ethics*, Volume 40, No. 3, (Fall 2012), pp. 563-568.

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Chairman TIBERI. Thank you, Mr. Moffit.
Mr. Guterman, you may proceed. You have 5 minutes.

**STATEMENT OF STUART GUTERMAN,
SENIOR SCHOLAR IN RESIDENCE, ACADEMYHEALTH**

Mr. GUTERMAN. Thank you, Chairman Tiberi and Ranking Member McDermott, and the Members of the Subcommittee, for this opportunity to testify on preserving and strengthening Medicare as it enters its second 50 years. I have been working on Medicare issues for many years, and I have seen and had the privilege of participating in many of the innovative changes that the program, in fact, has implemented over the years. And I am also well aware of the challenges faced by the program.

Also, I have seen my elderly parents and the way they have been helped by Medicare's coverage and access to care it provides, and also how they have been hindered by the fragmented nature of health care provided in this country.

Medicare has been a tremendous success over the years in ensuring health and economic security of the Nation's elderly and disabled, and it has been influential in shaping the U.S. health system, improving the quality of care, and contributing to medical progress. At the same time, like the rest of our healthcare system, Medicare faces considerable challenges. Rising costs affecting both the Federal budget and beneficiaries are an ongoing challenge. Medicare's benefit package, while rated highly by beneficiaries for enabling their access to care and protection from financial hardship and medical debts, can provide better financial protection for beneficiaries with low income and serious health problems.

It is imperative we continue to improve the program and ensure its viability into the future. But, at the same time, we must be careful not to throw the beneficiary out with the bath water, not to hinder its effectiveness in carrying out its basic mission of providing access to needed health care for a vulnerable and growing number of aging and disabled Americans.

In my written testimony I describe some of the issues Medicare faces, and offer some suggestions for improving its performance. And I will focus briefly on some of those suggestions.

First, of course, slowing health spending growth is a problem that, again, is felt both in the public programs and in the private sector. In fact, Medicare spending per beneficiary has grown much more slowly in recent years, compared—even compared—to the private sector. And solvency of the Hospital Insurance Trust Fund has been extended until 2030. But it is still an issue.

Medicare faces a great challenge as the Boomer generation born after World War II ages into coverage. By 2030 the number of beneficiaries is projected to rise more than 50 percent. But that raises the question of if America has made a decision to produce more elderly people, which I think we have—and I don't see anybody objecting to that decision—shouldn't we be willing to accept and deal with devoting more resources to that higher proportion of the population?

Still, policymakers are confronted, especially with the slow growth in per-beneficiary spending, on how to control the growth of Medicare spending. But I do suggest that there is also a revenue

side that, as has been mentioned, is projected not to increase over the years, even as the proportion of Medicare beneficiaries grows.

Again, the fact that Americans are living longer should be considered a success. Other countries have older populations than ours, and manage to spend much less on health care than we do.

We need to, as Dr. Baicker said, reduce variation in cost and quality. I think the fact that that variation exists and the fact that cost and quality don't vary together provides us with an indication that there is an opportunity to improve quality without necessarily increasing costs. And, in fact, maybe even saving money.

As Dr. Moffit has suggested, aligning benefit design with system goals would also be a desirable policy initiative. We have—with colleagues from the Commonwealth Fund, where I used to work, we published a paper that calls for combining not only Parts A and B, but also Part D into a comprehensive Medicare benefit with catastrophic coverage. And one other attractive feature of that is that it makes the Medicare program operate more on an equal footing with the private plans in Medicare Advantage by providing more comprehensive coverage.

We need to focus on improving care for beneficiaries with complex conditions. The Medicare program has engaged in a number of initiatives in that direction. And it needs to do more. And there is potential for a fair amount of monetary savings, if care for that population is improved, because they account for a high proportion of spending in the Medicare program.

Long-term services and supports is something that really scares me about growing old. That is something that Medicare currently doesn't cover, but it is something I would suggest needs to be paid attention to, as the tsunami of aging Baby Boomers starts to hit.

And finally, balancing the roles of traditional Medicare and Medicare Advantage to bring out the best in both programs, and benefit the Medicare program in general. What is now the Medicare Advantage program was intended to provide a more efficient model of care for beneficiaries and greater choice.

But remember that Medicare Advantage plan payments overall still exceed traditional Medicare spending in much of the country, and that relationship varies not only by geographic area, but also by type of plan. HMOs currently are the only type of MA plan with, on average, lower cost than traditional Medicare, and there is even wide variation in both efficiency and quality among—of individual plans, even in that group.

So, when we talk about Medicare Advantage, we shouldn't talk about it as one program, like the traditional Medicare program is. We should talk about it in terms of rewarding the best and most efficient and most effective——

Chairman TIBERI. Thank you.

Mr. GUTERMAN [continuing]. Private plan, so that they can——

Chairman TIBERI. Thank you, Mr. Guterman.

Mr. GUTERMAN [continuing]. Provide an appropriate counterpoint.

[The prepared statement of Mr. Guterman follows:]

**PRESERVING AND STRENGTHENING MEDICARE FOR ITS
CURRENT AND FUTURE BENEFICIARIES**

Stuart Guterman

Senior Scholar in Residence

AcademyHealth

Invited testimony

U.S. House of Representatives

Committee on Ways and Means

Health Subcommittee

Hearing on Preserving and Strengthening Medicare

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The views presented here are those of the author and not necessarily those of AcademyHealth or its directors, officers, or staff.

**PRESERVING AND STRENGTHENING MEDICARE FOR ITS
CURRENT AND FUTURE BENEFICIARIES**

Thank you, Chairman Tiberi, Ranking Member McDermott, and Members of the Subcommittee, for this invitation to testify on policies to preserve and strengthen Medicare as it enters its second 50 years. I am Stuart Guterman, a Senior Scholar in Residence at AcademyHealth. AcademyHealth is an organization that works to improve health and the performance of the health system by supporting the production and use of evidence to inform policy and practice.

I am glad to be able to speak to you on this topic, because I have been working on Medicare issues for many years, at the Commonwealth Fund from 2005 to 2015, the Centers for Medicare and Medicaid Services (CMS) and its predecessor, the Health Care Financing Administration, in the mid-1980s and again from 2002 to 2005, and at the Medicare Payment Advisory Commission (MedPAC) and its predecessor, the Prospective Payment Assessment Commission, from 1988 to 1999, as well as at the Congressional Budget Office (CBO). I have seen—and had the privilege of participating in—the innovative changes that the program has implemented over the years, and also been aware of the challenges faced by the program.

In addition, many of us with elderly parents or other loved ones know how they have been helped tremendously by Medicare's coverage and the access to care it provides—

and also hindered by the program's shortcomings and the fragmented nature of health care provided in this country.

Medicare been a tremendous success in accomplishing its main goal: assuring the health and economic security of the nation's elderly and disabled. It has been influential in shaping the U.S. health system, improving the quality of care, and contributing to medical progress.

At the same time—like the rest of our health system—Medicare faces considerable challenges. Rising costs, affecting both the federal budget and beneficiaries, are an ongoing challenge. Medicare's benefit package, while rated highly by beneficiaries for enabling their access to care and protection from financial hardship and medical debts, falls short in providing financial protection for beneficiaries with low incomes and serious health problems. Fragmentation of coverage into different plans for hospital, physician, and prescription drug benefits is confusing for beneficiaries and undermines coordination of patient care; and because Medicare covers only a portion of medical expenses, most beneficiaries supplement Medicare with other coverage, adding to complexity and administrative cost. Better strategies are also needed to serve the growing number of beneficiaries with complex care needs with physical and cognitive functional limitations and multiple chronic conditions—symptoms of an aging population.

We have a historic imperative to continue to improve the program and ensure its viability into the future—but, at the same time, we must be careful not to hinder its effectiveness in carrying out its basic mission: providing access to needed health care for a vulnerable and growing number of aged and disabled Americans. In this testimony, I describe some of the issues that Medicare faces and offer some suggestions for improving its performance.

MEDICARE'S EVOLUTION

As we consider Medicare's current state and the challenges it faces, we need to remember that it has evolved over time.

Expanded Coverage. While Medicare originally covered Americans age 65 and over, the Social Security Amendments of 1972 extended eligibility to persons under age 65 who qualify for Social Security benefits as permanently disabled (coverage begins 24 months after eligibility for disability benefits) and persons with end-stage renal disease (ESRD; coverage begins in the fourth month after dialysis treatments and extends for 36 months after a kidney transplant). In 2014, 8.9 million of the 53.8 million Medicare beneficiaries were eligible because of their disability status or ESRD.¹

The Medicare Modernization Act of 2003 made drug benefits available to Medicare beneficiaries beginning in 2006, under Medicare's prescription drug coverage (Part D) program. Part D coverage is voluntary, and available only through private prescription

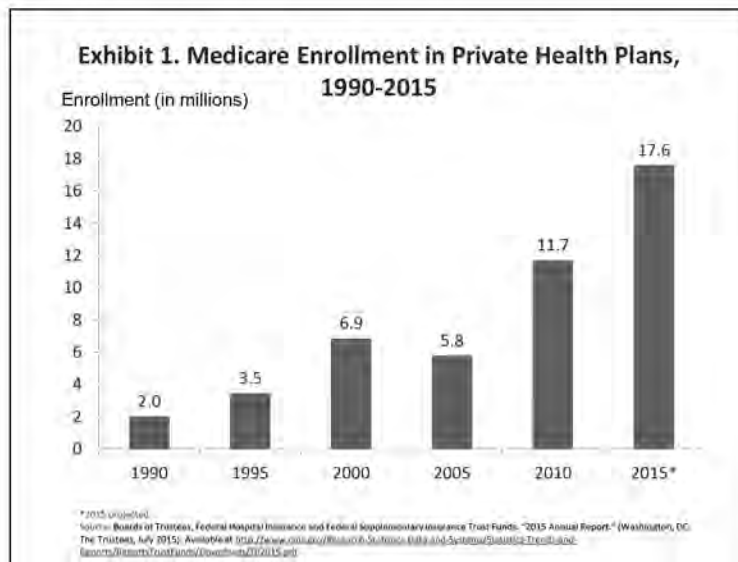
drug plans; premiums (heavily subsidized by Medicare) are paid directly to the plan, with additional subsidies available for beneficiaries with low incomes. In 2014, 37.8 million beneficiaries had prescription drug coverage through Medicare and another 2.7 million received retiree drug coverage under Part D.²

Expanded Choice. As an alternative to traditional Medicare, beneficiaries can obtain their Part A and Part B coverage (and Part D as well) through private health insurance plans. The Tax Equity and Fiscal Responsibility Act of 1982 created the Medicare Risk Program, making private health maintenance organizations (HMOs) and similar plans available to Medicare beneficiaries. Enrollment initially was small, but it grew rapidly in the mid-1980s as managed care became more popular in the private sector as well.

In 1997, the Balanced Budget Act created a new Medicare+Choice program to emphasize private plans as an option for beneficiaries. However, cuts in payment rates under traditional Medicare reduced private plan rates as well, causing many plans to leave the program. In addition, enrollment fell with the managed care backlash of the early 2000s.

The Medicare Modernization Act of 2003 created the current Medicare Advantage program, increasing plan payments and adding more types of plans. The sharply increased payment rates attracted more private plans, and the additional benefits that plans were able to offer because of the high payment rates attracted more beneficiaries. In 2015, an estimated 17.6 million beneficiaries—more than 30 percent of the Medicare

population—obtain their Medicare benefits through private Medicare Advantage plans (Exhibit 1).³



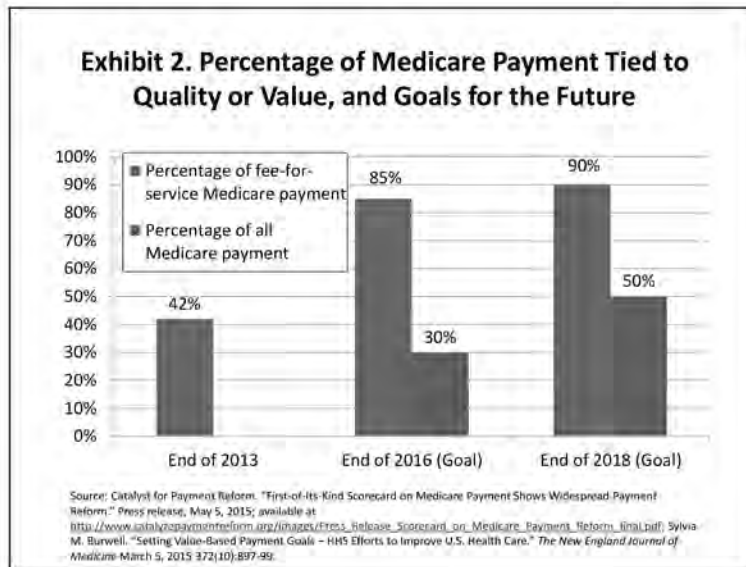
Payment Reform. When Medicare was enacted in 1965, it adopted payment methods modeled after prevailing private insurance practices at the time. Hospitals were reimbursed for their allowable costs, and physicians were paid based on local prevailing charges. There were no incentives for providers to control costs—the more providers spent, the more they were paid. Over the years, Medicare has implemented changes in how it pays providers, generally moving from cost-based reimbursement to prospective payment; but it still pays predominately on a fee-for-service basis—the more services that

are provided and the more complex they are, the more the provider gets paid, regardless of how much those services contribute to the health of the patient.

More recently, Medicare has made significant improvements in the original payment methods modeled on the private insurance payment practices of the 1960s, and recent actions by Congress and the Department of Health and Human Services (HHS) have focused on accelerating that change.⁴ The Affordable Care Act of 2010 includes an array of provisions that are laying the foundation for fundamental Medicare payment reform, linking payment to patient outcomes and experiences of care, and giving providers an incentive to limit spending by rewarding reductions in the projected spending for their Medicare patients.⁵

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)—passed by this Congress—pushed Medicare payment reform further forward by repealing the sustainable growth rate formula (SGR), which was intended to counter the tendency of fee-for-service payment to reward volume and intensity rather than appropriateness, quality, and desirable outcomes, but was widely criticized because it produced large, across-the-board cuts in physician fees, hindered attempts to reform payments, and failed to control cost growth.⁶ MACRA put in place modest increases in physician fees, with strong rewards for high performance and incentives to participate in alternative payment models that reward value.

In addition, the Secretary of HHS has set a goal of linking 85 percent of traditional Medicare provider payment to quality or value by the end of 2016, and 90 percent by the end of 2018.⁷ A recent study indicates that, as of the end of 2013, 42 percent of provider payments in traditional Medicare are tied to the value of care. This represents significant progress, but much still remains to be done (Exhibit 2).⁸ Many initiatives that were not included in that study are in place now or will soon be implemented, supporting expectations that the percentage will increase considerably over the next few years—in fact, HHS recently announced that an estimated 30 percent of Medicare payments are tied to alternative payment models as of January 2016.⁹



Also noteworthy is that Medicare Advantage plans are now financially rewarded for receiving a high rating based on their performance on measures of quality and patient experience.¹⁰ Although little is known about how Medicare Advantage plans actually pay their providers, the addition of rewards for plan performance to the existing incentive for efficiency in a per-enrollee per-month payment system can be expected to support the move from volume to value in Medicare.

Quality Improvement. Medicare has long had a mechanism in place to make sure that its funds were being used effectively and that its beneficiaries received care consistent with medical quality standards. The Social Security Amendments of 1972 created the Professional Standards Review Organization (PSRO) program to review the appropriateness of services reimbursed through Medicare—but the PSROs were viewed as primarily focused on utilization review rather than quality improvement.¹¹ Ten years later, the PSROs were replaced by Peer Review Organizations (PROs)—but the primary emphasis continued to be on utilization review.

In 1992, Medicare launched the Health Care Quality Improvement Program (HCQIP), shifting the focus of the PRO program to working with providers to improve health care.¹² In 2002, the HCQIP was expanded to include nursing homes and home health, and the PROs were renamed Quality Improvement Organizations (QIOs).

In the early 2000s, greater emphasis was put on the need to improve health care quality through measurement and payment.¹³ Medicare has implemented a series of initiatives aimed at providing information on quality measures to empower beneficiaries in choosing providers and enable providers to identify areas in which their performance could improve, including quality measures for hospitals, physicians, nursing homes, home health agencies, and dialysis facilities. Expanded use of health information technology was encouraged in 2004 by the issuance of an Executive Order by President George W. Bush, creating the Office of the National Coordinator for Health Information Technology; this effort was substantially enhanced by the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009.¹⁴

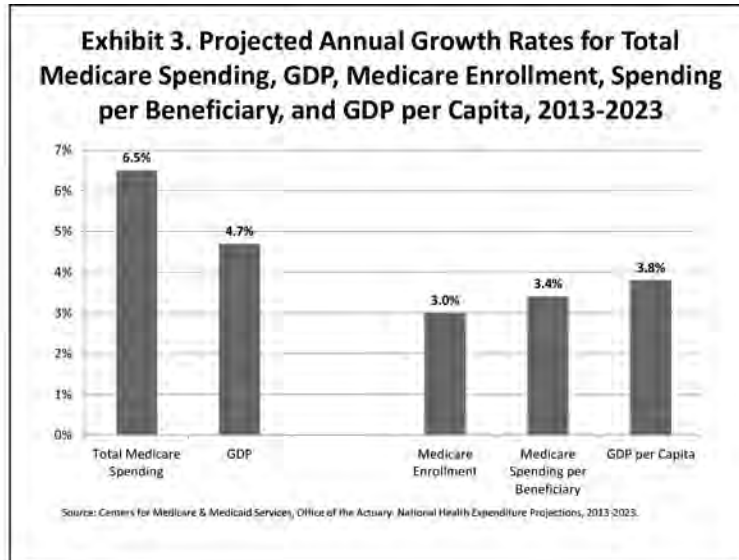
ONGOING CHALLENGES

Despite its accomplishments, Medicare continues to face challenges, some of which are specific to Medicare and others—such as rising costs—that are faced by public programs and private payers alike. The future of the program and its ability to continue to provide access to high quality care to its beneficiaries will depend on how policymakers, health care providers, and beneficiaries themselves respond to these challenges—but success will require changes not only to Medicare, but across the health system.

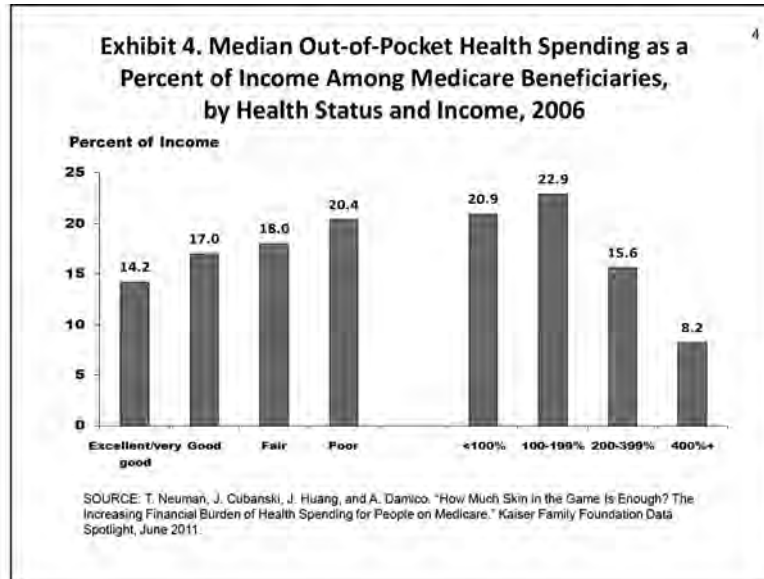
Spending Growth. Medicare accounts for one-fifth of national health spending.¹⁵ Like the rest of the health system, it has over time been plagued by rapidly rising costs.

Medicare also is an important part of the federal budget, accounting for more than one-sixth of federal spending.¹⁶ In 2009, Medicare was spending an average of \$11,723 on 46.6 million beneficiaries, and the Medicare Hospital Insurance (HI) Trust Fund was projected to become insolvent by 2017.¹⁷ Spending per beneficiary has slowed dramatically in recent years, growing at only a 1.3 percent annual rate from 2009 to 2014, and the projected solvency of the HI Trust Fund has been extended to 2030.¹⁸

Still, Medicare faces a great challenge as the “boomer” generation born after World War II ages into coverage—by 2030, the number of beneficiaries is projected to rise more than 50 percent, from 53.8 million to 81.7 million, prompting concern about how to respond to the rising share of the federal budget and the nation’s resources that will be devoted to financing health care for the elderly and disabled. Although spending per beneficiary has been growing slowly in recent years, and is projected to grow slowly for the immediate future, the increasing number of beneficiaries will drive Medicare spending to grow faster than the economy as a whole (Exhibit 3).

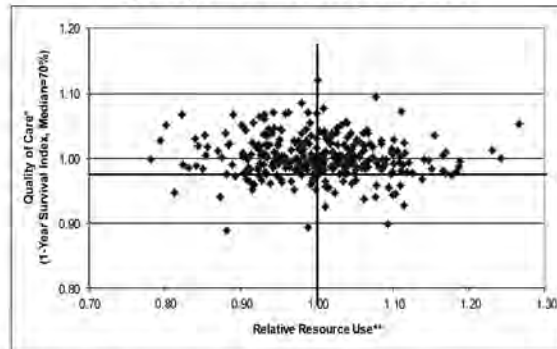


Policymakers are confronted, therefore, with the question of how to continue to slow the growth of total Medicare spending when the spending per beneficiary already is increasing so slowly. Shifting more of the cost of meeting their health care needs onto beneficiaries themselves is problematic, however, since the aged and disabled include some of the poorest and sickest Americans, and they are least prepared to bear that additional burden (Exhibit 4).



By now, the wide variation in both Medicare and private sector spending is well-documented.¹⁹ In Medicare, particularly, the lack of association between high spending and better quality and outcomes across the U.S. indicates that there should be ways to control spending while maintaining or even improving quality (Exhibit 5). Supporting comprehensive payment and delivery system changes that produce lower costs and better value, not just in Medicare, but across the entire health system, would go a long way to increasing value.

Exhibit 5. Quality and Costs of Care for Medicare Patients Hospitalized for Heart Attacks, Hip Fractures, or Colon Cancer, by Hospital Referral Regions, 2004



* Indexed to risk-adjusted 1-year survival rate (median=0.70)

** Risk-adjusted spending on hospital and physician services using standardized national prices
Data: E. Fisher, J. Sutherland, and D. Radley, Dartmouth Medical School analysis of data from a 20%-national sample of Medicare beneficiaries.

Source: The Commonwealth Fund Commission on a High-Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008*, (New York: The Commonwealth Fund, July 2008)

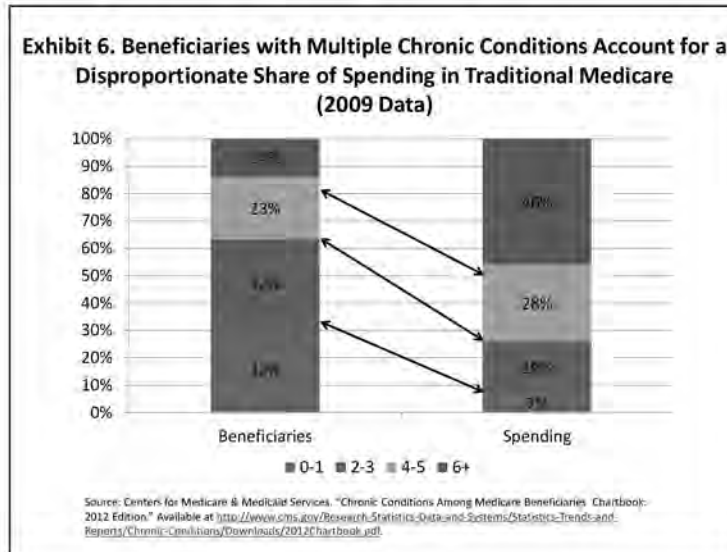
Benefit Design. Currently, Medicare beneficiaries who enroll in traditional Medicare must patch together multiple plans to receive adequate financial protection and prescription drug benefits. This creates complexity and confusion for beneficiaries and results in higher administrative expenses because of the multiple insurance carriers involved and the lack of integrated claims administration. The need to obtain coverage from multiple sources also makes it difficult for Medicare to incorporate value-based benefit designs that use patient cost-sharing to provide incentives to seek high-value care and compare alternative treatment choices. By offering separate medical and drug coverage, the current design creates a disincentive to achieve hospital and specialty care

savings through appropriate medication management. The availability of first-dollar supplemental coverage in the current Medigap market makes it difficult for Medicare to adopt incentives for beneficiaries to register and seek care from primary care practices and medical home teams or seek care from accountable health care systems with a track record of high quality and lower costs.

The combination of fragmented and first-dollar coverage thus raises total cost and confronts beneficiaries with complex choices at high administrative expense. And current benefits fail to protect beneficiaries from catastrophic out-of-pocket costs if they cannot afford private supplements. The only option available to beneficiaries who want integrated comprehensive coverage is to enroll in a private MA plan, with a more limited provider network. A more comprehensive Medicare benefit design that offered could simplify and strengthen beneficiary protection and complement the payment and system reforms that are needed to control costs and improve value.²⁰

Care for Beneficiaries With Complex Conditions. A related issue is that Medicare itself was created primarily to provide acute care—essentially short-term treatment for a specific illness, injury, or procedure, and to aid in recovery from that condition. In 1960, life expectancy at birth in the U.S. was 70; in 2010, it was 79.²¹ As both medical science and health care delivery have changed, so have the needs of Medicare beneficiaries. Now, 37 percent of Medicare beneficiaries have 4 or more chronic conditions—those beneficiaries account for 74 percent of total Medicare spending (Exhibit 6). Medicare

increasingly has focused on improving the coordination of care across providers and settings, and hopefully, proposals will be developed to address those issues and to serve the needs of these beneficiaries more effectively and more efficiently.²²



A notable gap in almost all proposed Medicare reforms is the absence of practical, affordable ideas for covering long term services and supports (LTSS) that are increasingly important for the aging Medicare population. While Medicaid pays for such care for impoverished beneficiaries, no comparable support is available for non-poor older and disabled Americans. Further, the fragmentation of acute care and LTSS makes it difficult to finance and deliver coordinated acute and LTSS. Solutions will likely

require new sources of revenue that are difficult to find from public sources, and private insurance has struggled to fill this gap.²³

Balancing the Roles of Traditional Medicare and Medicare Advantage. An ongoing issue is the appropriate balance between public traditional Medicare and private Medicare Advantage plans. A goal of the Medicare private plan program since its inception in 1982 has been to provide a more efficient model of care to beneficiaries than the unorganized fee-for-service-based payment system used by traditional Medicare. Expecting that private plans had the potential to be more flexible and efficient than FFS Medicare in meeting the needs of their enrollees, Medicare originally set payment rates for these plans at 95 percent of per beneficiary costs in traditional Medicare in each county, but the tendency for private plan enrollees to be less costly than other beneficiaries meant that plan payments were higher than the same enrollees would have been expected to cost in traditional Medicare.²⁴

The relationship between private plan payments and county-specific spending in traditional Medicare has been loosened somewhat, and payments to Medicare Advantage plans are now risk-adjusted to reflect the relative costliness of their enrollees. But Medicare Advantage plan payments overall still exceed traditional Medicare spending in much of the country, and that relationship varies not only by geographic area but also by type of plan. HMOs are the only type of MA plan with lower average costs per enrollee

nationwide than traditional Medicare, and there is wide variation in both efficiency and quality among individual plans.²⁵

A succession of policy changes over the past 30 years has resulted in substantial overpayment to Medicare Advantage plans relative to anticipated per beneficiary spending in traditional Medicare, and dilution and distortion of incentives to encourage the efficiency or effectiveness of which Medicare Advantage plans should be capable. The recent adjustments to payment policies has strengthened the relationship between plan payment and plan performance, and leveled the playing field between traditional Medicare and Medicare Advantage to some extent.²⁶ With more than 30 percent of Medicare beneficiaries enrolled in private plans—a growing number, but still a minority—it becomes increasingly important to determine the appropriate balance between traditional Medicare and Medicare Advantage, and to develop policies that bring out the best in both programs for the benefit of this and future generations of Medicare beneficiaries and to ensure the continued viability of the Medicare program.

CONCLUDING THOUGHTS

Medicare has been successful in achieving its basic mission—providing access to care and stable coverage to aged and disabled Americans. But, as the country's largest purchaser of health services, it can do more to improve quality, promote more coordinated care, and control costs—both its own and throughout the health system. Because of Medicare's unique position, it can be an important testing ground for cost and quality innovations. Policies have been put in place that encourage such development.

including expanding the power of the Secretary of Health and Human Services to put payment pilot programs on a "fast track" and to work with private payers and providers to establish multi-payer initiatives.

Medicare is a program that is extremely successful, popular, and important to its beneficiaries, but can be improved in several ways and, at the same time, fulfill its larger role as a key part of health care reform and a platform for improvements that can address the problems that it has in common with the rest of the health care system: the need for increased value for the dollars spent on care.

NOTES

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Chairman TIBERI. Thank you.

Mr. GUTERMAN. Thank you.

Chairman TIBERI. You are 1 minute over. I gave you a little bit more time.

Thank you all for your really good testimony. I am going to start the questioning off with Dr. Baicker. In my district in central Ohio there is a wildly popular Medicare Advantage plan run by a Catholic non-profit, and they just get rave reviews. And, as you know, Obamacare instituted nearly \$150 billion in specific cuts to the Medicare Advantage program. Even more than that if you account for interactions with the cuts to Medicare, as a whole.

So, as an expert in MA plans, I would be quite interested in your opinion on what are the most egregious ongoing policies that we, as Congress, in a bipartisan way, can prioritize? Things that need to be repealed immediately. Where should we focus as a Committee and as a Congress to help?

Ms. BAICKER. Thank you for that question. I hope that doesn't mean you have to be somewhere.

Chairman TIBERI. No, you are good.

[Laughter.]

Ms. BAICKER. Preserving the option for beneficiaries to be able to enroll in innovative MA plans is of crucial importance. And we have seen innovation in the MA benefits along multiple dimensions.

So I talked a little bit about the financial protection that the plans can provide. They also strive to provide better choices about sites of care and modes of care. So experimenting with tele-medicine, with including the hospice benefit, with freeing them up to do value-based insurance design I think would be crucial to unleashing the full potential of those plans to really advantage the seniors who enroll in them. And that is part of why they choose those plans, I think, they can get more effective care in the place where they want to get it, and get home more quickly.

And we have seen better experimentation in MA plans with getting people out of the hospital and home and healthier faster. So freeing up that flexibility that they have, I would think, would be of first-order importance. Ensuring that quality information is available to the beneficiaries, but then plans are rewarded appropriately for providing high-quality care.

I would like to see a cap on quality bonuses removed. I think going along with that would be the removal of the double bonus for quality, so that you are appropriately rewarding plans for delivering the high-quality care that beneficiaries are seeking out.

I would agree that at the same time that that happens it would be very good to reform the basic Medicare benefit to provide the kind of financial protection that we think Medicare beneficiaries are entitled to and are seeking out in MA. And also combining the deductibles along the lines that Mr. Moffit described I think would improve that benefit, too.

Chairman TIBERI. Great, thank you.

Dr. Moffit, a question for you that pertains to protecting beneficiaries in the Medicare program. As mentioned, there is no out-of-pocket cap in traditional Medicare, yet the MA program is required to offer that type of protection to beneficiaries. A central fea-

ture of the bipartisan options to combine Medicare Parts A and B, as has been mentioned, includes that necessary protection.

Based on the feature alone, it seems like a policy that is a no-brainer. Do you see any reason why we should hesitate? What are the pitfalls, if we go forward? Are there any? And should we begin that process?

Mr. MOFFIT. Mr. Chairman, I was here in 1988, when we had the first major debate on adding a catastrophic provision to the Medicare program, the Medicare Catastrophic Coverage Act of 1988. It was repealed 1 year later. I know exactly what happened then. I was there.

What happened was that Congress took President Reagan's proposal, which was a very reasonable proposal to protect senior citizens against the financial devastation of catastrophic illness, and added a whole series of benefits on top of it, and imposed on seniors, basically, requirements to pay for many benefits they already had—a prescription drug benefit.

The result was, at that time, a massive revolt among senior citizens. And within 1 year, that law was repealed. And unfortunately, it was repealed because of overreach. That is why that happened. It is something that is seared on my memory. I was congressional relations director for the Department of Health and Human Services.

It is a no-brainer. It is absolutely a no-brainer for us to have a catastrophic piece in Medicare. There is no reason why traditional Medicare should not have a catastrophic coverage piece. The reason why senior citizens buy MediGap coverage—9 out of 10 of them do—which ends up with first-dollar coverage, is precisely because they do not have protection from the most important thing that health insurance should deliver, which is that ultimate protection.

The result of all that has been that the MediGap good plans in many respects, they provide first-dollar coverage. And as virtually every independent analyst including the Medicare Payment Advisory Committee has pointed out, this has resulted in an excessive utilization of the benefit. That is to say that you end up driving costs up. The costs that are being driven up by the overutilization of the benefit because of the MediGap arrangement we have today raises Part B premiums.

I think what we have to do is we have to establish a catastrophic protection in Medicare, but at the same time we must deal directly with this problem of the existing MediGap arrangement which, in fact, is raising costs not only for the taxpayer, but also for senior citizens.

I am not going to say it is simple to do it. I mean it is going to require some difficult, but not impossible, decisions. And this particular proposal, by the way, the idea of combining A and B and adding catastrophic coverage and simplifying the coinsurance and creating a single deductible has almost always been accompanied by MediGap reform. Basically, limiting the first-dollar coverage that MediGap plans can cover for senior citizens, so that we don't have an excessive utilization of Medicare Part B services.

Chairman TIBERI. Thank you. I am going to turn to Mr. Thompson. But before I do that, you were all nodding, I think, yes when

he talked about MediGap reform. All agree? Okay, interesting. Maybe we can all agree up here, too.

Mr. Thompson, you are recognized for 5 minutes.

Mr. THOMPSON. Thank you, Mr. Chairman, and thank you to the witnesses for being here.

I want to make a couple remarks about Medicare, because I think they were missed in the opening comments from everyone who has spoken.

I think it is important to note that spending growth has been cut nearly in half over the past 6 years, in regard to Medicare. And that is at the same time that our aging population is growing.

And also I think it is important to note that the Hospital Trust Fund is solvent, and the projections show that it is solvent through the year 2030.

And then probably as important and, for those of us who go home to our district every weekend probably more important, seniors really like it. It is an important program.

And I think Mr. Moffit said it, that there is nothing being proposed here today that is a novel idea. And I think Mr. McDermott said it a little differently. He said it is a rehash of a bunch of stuff that we have heard time and time again. And I agree with both of you.

I really think that there is an opportunity to drill down and figure out how we can enhance a program that seniors really like, and make sure that it does everything that we would all like it to do. And Ms. Baicker stated that, in addition to good health care, it is the idea of financial wellbeing for the beneficiaries and their families, and that is the important distinction. Families are very much a part of this.

So I wish that, instead of doing the not-novel stuff, or the rehash of old stuff, we were looking at some things that would really accomplish what all three of you are nodding in agreement with, what I am talking about.

I would like to see us talk about expansion of tele-health. And there are a couple of us on the Committee—I have a bill, myself—there are a couple of us who have been working on expansion of tele-health. And it is beneficial in more than just underserved or rural areas. It is good public policy that we could use to really improve the Medicare program that we all say we support. And it works, it saves lives, and it saves money, and it is, in fact, bipartisan.

Also, I think we ought to look at mental health services in Medicare, especially if we are talking about the wellbeing of the beneficiary and the beneficiary's family. Seniors should be able to see marriage and family therapists. It would really enhance the program, and would really help considerably.

So, as we address the Medicare issues, the one thing that we can't do, I believe, is make it more difficult for seniors, less services for seniors, or more expensive for seniors. And I am worried that some of the issues we are talking about are going down that road. And I think that that is inappropriate.

And I would like to ask Mr. Guterman a question. If we were to put in place all of these reforms or changes that we are talking about, who would the winners and who would the losers be?

Mr. GUTERMAN. Well, it depends on the specific change. But the programs that I suggested in my testimony, the changes in the Medicare program, would overwhelmingly help seniors who are in poor health and who need the Medicare program more to provide access to the care they need. Holes in the program were left primarily for budgetary considerations. And so they would help the population that needs the Medicare program most.

Mr. THOMPSON. Are there adequate protections in the private market for Medicare beneficiaries?

Mr. GUTERMAN. By the private market you mean Medicare Advantage? Congress did require Medicare Advantage plans to put in a catastrophic coverage limit. And so—

Mr. THOMPSON. But if we were to do the voucher, for instance, where folks would have to go out into the private market to obtain their coverage—

Mr. GUTERMAN. Well—

Mr. THOMPSON [continuing]. Are those protections—

Mr. GUTERMAN. I have to point out that in 1965, when Medicare was first enacted, one of the reasons that it was enacted was the fact that 50 percent of Americans over the age of 65 lacked health insurance coverage. You know, so there has to be a little bit of skepticism about what the private health insurance market would do—

Mr. THOMPSON. So how would sicker patients fare if we were to do this?

Mr. GUTERMAN. How would—

Mr. THOMPSON. How would sicker patients fare?

Mr. GUTERMAN. Sicker patients fare. Well, you know—

Mr. THOMPSON. And what would it do to the risk pool?

Mr. GUTERMAN [continuing]. Sicker patients are the ones that are least attractive to private health insurance companies. And there has been, over the years, some concern about private plans in what is now Medicare Advantage tending to sign up healthier patients.

Mr. THOMPSON. Thank you.

Chairman TIBERI. The gentleman's time has expired. I would point out that Medicare Advantage is private plans and, in my district, wildly popular.

Mr. Thompson, one point, just for clarification, I don't know if you have seen it, but the CBO report from January has 2026 as the new date for Medicare Part A. I think the number that you were using was the older number from last year from the trustee. So just a point for the record.

Mr. Johnson is recognized for 5 minutes.

Mr. JOHNSON. Thank you, Mr. Chairman. You know, Dr. Moffit, as this Committee works to ensure continued solvency of Medicare, I think it is important to mention one of the most anti-competitive policies in Medicare. Under Obamacare, new physician-owned hospitals are banned from Medicare and Medicaid, and those grandfathered in are prohibited from expanding.

Despite critics' claims, studies have found that physician-owned hospitals do not decrease self-referrals and services [sic]. The truth is that hospital consolidations are driving up the cost. And that is happening without increased services or better care. Even the Fed-

eral Trade Commission has recognized the critical role private-owned hospitals play in promoting competition, reducing costs, and increasing quality. Yet this anti-competitive policy remains in place, and that is just wrong. Medicare beneficiaries deserve better.

Dr. Moffit, can you describe to the Committee the importance of competition for reducing healthcare costs and increasing quality, specifically within the hospital industry?

Mr. MOFFIT. Well, Mr. Johnson, when you raised the point about competition, yes, all of the evidence that we have indicates—and I am talking about evidence from Medicare Part D; the Federal Employee Health Benefits program, which has been the longest defined contribution system that we have been dealing with; and Medicare Part D, in particular. All of these examples of head-to-head competition show that you can actually control costs not only in the short term, but over the long term.

With regard to the specialty hospital issue, my colleagues at the Heritage Foundation have not dealt with this issue since 2010, when Congress passed the restrictions on Medicare and prevented the expansion of the specialty hospitals and the physician-owned hospitals. But we did do a literature review prior to that time, and I will be very happy to share it with the Committee.

We had a health policy fellow, Dr. Asha Roy from MIT, who is a physician, to examine what the literature at that time was with regard to the performance of specialty hospitals. And Dr. Roy showed that the specialty hospitals had a very high rate of patient satisfaction, they had lower mortality rates, they had higher-quality measures, higher performance in terms of the quality measures, and they had comparable costs to traditional hospitals. In other words, the specialty hospitals were not in any sense profoundly negatively affecting traditional hospitals.

But getting to the broader point, no. I think it is an absolutely terrible idea for the Federal Government to start picking winners and losers in this area. What we need in health care—and I think we are all in agreement on this, at least as a general principle—is to promote innovation. We want to promote innovation in health-care benefit design, better health plans, or newer and more effective health plans, but also healthcare delivery.

And with regard specifically to specialty, I mean, every advanced economy increases specialization in terms of the production and distribution of goods and services, production of goods and services. That has happened with regard to specialty hospitals. An artificial barrier to that is basically an artificial barrier to progress, which can provide value for money.

So, I am very much opposed to this policy. I think it is wrong-headed, and I think it will damage opportunities for seniors to get the best possible care. We know, from the professional literature—and I defer to my colleagues here but the literature shows that the more you do a particular set of procedures, whether it is cardiac procedures or orthopedic procedures, the more volume you have, the quality measures go up. And that is just the evidence.

So, the point of your question is very well taken.

Mr. JOHNSON. Thank you, sir. I appreciate that. And my time is about gone. But Dr. Baicker, would you try to let us know later, what the system is doing as far as Obamacare is concerned? I am

concerned that our cuts are phased in along with CMS, continuing to hinder plan innovation by over-regulation. And that result will be more and more of these plans leaving the market and forcing beneficiaries back into Fee-for-Service. If you agree—you are shaking your head yes.

So, I thank you, and I have run out of time. I yield back——

Chairman TIBERI. Thank you, Mr. Johnson.

Dr. Baicker, if you could answer the Chairman in writing, that would be great. Thank you.

Mr. Kind, your birthday. Have you heard about the Boehner birthday song?

Mr. KIND. No, I haven't, but——

Chairman TIBERI. I won't sing it to you, but I will say it.

This is your birthday song, it won't last too long.

Mr. KIND. Good, I am glad.

[Laughter.]

Chairman TIBERI. So happy birthday, and you are recognized for 5 minutes.

Mr. KIND. Thank you very much, Mr. Chairman. Just remember, it is not the years, it is the mileage. There is a lot of miles on these bones, but I will survive. And, Mr. Chairman, thanks for having this hearing today. I think this is such a crucial issue.

Hopefully we can continue moving forward with more hearings to drill down to the real details, so we know what is working, what isn't working, what changes we have to make, because the real challenge—most of our budget fiscal challenges we face are health-care cost-related right now. And our challenge is whether we can reform a healthcare system before America grows old.

As Mr. Guterman pointed out, there are two things at work here. One is beneficiary cost, which right now is looking pretty good, at a 50-year low when it comes to how much we are spending in the Medicare system. But the other big challenge is 10,000 boomers that are retiring every day and joining Medicare and the Social Security system, and the 74 million boomers that will eventually join the system here.

And I think you are right, I don't think we have enough revenue in order to deal with that tidal wave that is joining Medicare here over the next 10 to 20 years. And that, I think, is the real challenge this Committee faces.

But I think there are some answers. And fortunately, under the Affordable Care Act, there is a lot of experimentation going on right now through delivery system reform and payment reform.

And Ms. Baicker, back to you. My ears perked up when you were talking about quantity and quality. I have been a student of the Dartmouth Atlas Study for a long time, and that studies the utilization and variation from around the country. And I think—I am convinced, as you are, that there is still a lot of quantity and not enough quality that we are getting with the dollars that are being spent.

But the good news under the Affordable Care Act, there are a lot of different payment models that are being experimented with right now that do emphasize outcomes, values, and qualities. In fact, CMS just announced here that 30 percent of Medicare payments

will be quality-based, and their goal is to be 50 percent next year and over 80 percent over the next few years.

So, clearly, we are moving in that direction. And I think, if we can get the financial incentives aligned the right way, where we are rewarding providers based on outcome, based on results, and not just on more of what they are doing, we are going to see a lot of that innovation, and a lot of that creativity taking place in the healthcare realm.

But, Ms. Baicker, I want to hear your opinion as far as how these payment models are working, and whether there is some hope or some light at the end of the tunnel, that we are, in fact, driving the system in the right direction by emphasizing quality, value-based payments, and moving away from the Fee-for-Service system.

Ms. BAICKER. I very much share your emphasis on quality the beneficiaries are getting. And the geographic variation, I spent 6 years on the faculty at Dartmouth, and I was as much taken by that research as you are, that the evidence of huge variation in spending per person and negatively correlated huge variation in quality strongly suggests that you could move some money from high spending less effective care to lower cost, higher-quality care, save money while improving outcomes. And that is, obviously, the magic bullet that we are all looking for.

I am a huge fan of experimentation that is well designed. My own academic research focuses on opportunities to use really good experiments to figure out what is going on in the healthcare system. And when you have a number of entities volunteering to participate, and you randomly choose some to start the pilot and others to be the control group, I know that that is my academic hat on—which I have a very hard time taking off—but that provides an opportunity to really understand what is going on under the hood of the healthcare system. Why is it that we are spending so much more in some places and not getting the value that we want.

We have seen a bit more experimentation in MA plans because they have a little more flexibility, being paid in a different way. But I don't think that we have nearly enough robust scientific evidence on what drives quality. We have a little more on the patient side and a little less on the provider side. So I would love to see more well-designed studies—

Mr. KIND. And I think one of the smarter things we did under the Affordable Care Act was establish the Center on Innovation. That is allowing the pilots and the experimentation to go forward. And if we can get past the political din of just repeal everything and instead focus on what exists today and what is working and what isn't—because, Lord knows, this is an ongoing project, continuing to reform the healthcare system as we learn more.

And Mr. Guterman, I know Mr. Thompson asked you your opinion about the private voucher plan that my Republican colleagues keep putting into their budget proposal. I don't know if you have had a chance to study that. But there are certain truisms that make Medicare work, and one is it is universal, everyone is in whether you are young, younger senior, or older senior, healthier or sicker, you are all in. Plus it does cover pre-existing conditions. And, let's face it, all seniors have a pre-existing condition at some point in their life.

But their proposal to establish a private voucher as a response to the Medicare system, do you have an opinion on that?

Mr. GUTERMAN. Yes. I think the major way a voucher system saves money is to make Medicare beneficiaries pay more for more expensive plans. And I don't think that is the way we want to reduce Medicare spending is by passing the additional spending on to Medicare beneficiaries.

And, as I said, the private market hasn't particularly been anxious to insure Medicare beneficiaries, except under the times when Medicare Advantage plans have been, you know, pretty substantially overpaid by the Medicare program, even compared to traditional Medicare, which acknowledges that it has a long way to go to make itself more efficient.

So I think if you look at it from the perspective of trying to bring the best of private plans, the best—

Chairman TIBERI. Mr. Guterma, I need you to wrap it up real quick here.

Mr. GUTERMAN. Okay.

Chairman TIBERI. You are over.

Mr. GUTERMAN. Is to make the traditional Medicare program stronger and to bring payments down to a level playing field level so that private plans can actually show what they can do, in terms of responding to incentives for efficiency.

Mr. KIND. Thank you.

Chairman TIBERI. Thank you.

Mr. Buchanan is recognized for 5 minutes.

Mr. BUCHANAN. Thank you, Mr. Chairman, and I want to congratulate you on your new chairmanship and your first meeting. And I would also like to thank our witnesses.

I represent southwest Florida, and I happen to be the only Member, Democrat or Republican, in Florida. But in our district we have 205,000 recipients of Medicare, probably one of the top 2 or 3 in the country. And of course, Florida is number two in the country for Medicare recipients.

I am concerned about the bigger picture, just looking at it as a guy that has been in business for a lot of years. I am pretty good with numbers. It is a critical program. You see it, of course, not just in Florida, but all the way across the country in so many different aspects. Where do you get quality health care at 65? If you had to buy it at 63 in my area it is \$2,000 a month. So it is very, very critical.

But I am concerned—and I would also mention my mother-in-law is in town, she is 96. She had sisters who lived to 102 and 104. And one of the gentlemen mentioned, 10 to 12,000 people a day turning 65 for the next 30 years.

Read some of my notes, the different notes that you read, but the average person puts in a dollar and takes out 3 to 4 dollars in benefits. When you have the alarm, in terms of the growth, and then you look at the different estimates, in terms of being insolvent in the next 8 to 10 years, our deficit at 19 trillion—it has more than doubled, there is plenty of blame to go around. The last 8 or 10 years it has gone from 8 to 9 trillion to 19 trillion.

So, when you take a look at this, there has to be some kind of a structural change or something at some point on a bipartisan

level. Otherwise, we are kidding ourself [sic]. I mean we could look around the edges and do a few things here and there, but we have to do something material.

And one thing I can just tell you. Healthcare costs in general—maybe it has been a little bit better in Medicare for certain reasons, just keep going up. Health care in my community, unless you get a subsidy, is going up 20 or 30 percent a year. It is one of the biggest issues, I think, for small business or anybody that is under 65 trying to get health care without a subsidy.

So I guess my question is, based on what I mentioned that when you look at \$19 trillion in debt, the normal cost of money over the years is 4 to 5 percent. That is as much as \$1 trillion in interest at some point. And they are claiming in the next 3 or 4 years, if interest rates go up to where they have historically been, we are looking at that. So it puts more pressure in terms of Medicare.

So, getting back, Mr. Moffit, maybe to your point initially, you talked about structural changes. Looking at the big picture, what do you think are two or three things going forward that could make a huge difference? Maybe you could lean on those, or talk about those for a minute.

Mr. MOFFIT. Well, I do think that—

Mr. BUCHANAN. Do you agree with what I mentioned? Do you agree with my points?

Mr. MOFFIT. No, I think that is the really critical point. The Congressional Budget Office is the scorekeeper for Members of the House and Senate. They have just recently told you that we are facing major fiscal challenges, which are actually dangerous because for the first time they do not get control of our deficits and our debt, we could have a fiscal crisis in the United States. I mean that is what Mr. Keith Hall recently said to everybody.

Now, the central issue here is what is really the major driver. They are very clear about that. It is primarily the growth in major healthcare spending, as well as other entitlements and the aging of the population.

With regard to Medicare specifically, right now we have about slightly more than three workers basically supporting every Medicare beneficiary. But 2030 we will have 82 million beneficiaries. We will be going from 55 million today to about 82 million.

Mr. BUCHANAN. But what is your recommended structural change—

Mr. MOFFIT. My recommended structural—

Mr. BUCHANAN. You touched on it, but go through that again, real quick.

Mr. MOFFIT. Well, I have three, but beyond what Dr. Guterman and I agree on is I think we have to raise the age of eligibility. I would raise it to age 68, and gradually do it over a 10-year period. I think that is perfectly reasonable to do that, because the demographics of America have changed. People are living much longer, and that would make sense.

Second, I think that we ought to expand means testing in Medicare. The President himself has recently come out with a proposal. His budget proposal would require upper income seniors to pay more, going forward. And eventually, under the President's pro-

posals, 25 percent of all seniors would be paying above the existing standard rate. I don't think we have to go to 25—

Mr. BUCHANAN. And your third point is what?

Mr. MOFFIT. My third point is to basically intensify the competition within Medicare among both plans and providers. And I feel that the best way to do that is precisely what the Budget Committee is proposing, which is moving toward a defined contribution system, or a premium support system, which will intensify the competition among plans and providers.

Mr. BUCHANAN. Thank you. I will have to yield back.

Chairman TIBERI. Thank you. The gentleman's time has expired. I will recognize the gentleman from Georgia, Mr. Lewis, for 5 minutes.

Mr. LEWIS. Thank you very much, Mr. Chairman, and I, too, want to congratulate you on becoming the chair of this Subcommittee. It's good to be on a Subcommittee with you once more.

Mr. GUTERMAN, I would like to know, do you think or do you believe that Medicare is in good financial standing?

Mr. GUTERMAN. That, of course, is a very controversial issue. I think—

Mr. LEWIS. Well, we need—maybe we need a little controversy this—

Mr. GUTERMAN. I think Medicare has some work to do to shore up its financial standing for the future as more and more people are elderly. But I think it can be done. I think one thing we ought to do is investigate ways to bring more revenue into the Medicare system because we are producing more elderly people, and so we ought to be devoting more resources to supporting those people.

There's also tremendous opportunity to slow the growth of Medicare spending by improving the quality of services and by improving the effectiveness of the medical services that are provided. Also providing more community supports for folks to keep them out of the hospital and out of the healthcare system, which this country really doesn't devote much resources to, and other countries devote much more of the resources to doing that, and they have much lower health spending.

So I think there are ways to make sure that Medicare stays strong into the future. Also, if I may add, the idea of intergenerational conflict, which is always brought up by citing a number of people working who support the number of older people. I would point out that every one of those working people aspires to and most will become elderly. And so we're not talking about preserving the Medicare program for the population of currently elderly. They're already there. We're talking about preserving the Medicare program for the people who are currently paying into the program. And we ought to pay more—

Mr. LEWIS. Mr. Buchanan, my colleague from Florida, stated that people are living longer, relatives living to be in their 80s and their 90s, how do we take care of this segment of our population?

Mr. GUTERMAN. Well, I think—

Mr. LEWIS. More of us are living much longer because their healthcare—

Mr. GUTERMAN. That's absolutely right. I mean it's not a bad thing that people are living longer.

Mr. LEWIS. No, it's not.

Mr. GUTERMAN. It is a challenge because we need to rethink how our health system works, because it used to be our health system could focus on people who had an acute episode of illness, and then that illness would go away. Now people are living longer, they're living with more chronic conditions, some of which used to be fatal conditions, but medical finds have made them into chronic—

Mr. LEWIS. Well, Congress and CMS strove to improve the care, to help people live better lives as they age.

Mr. GUTERMAN. Right. Yes. CMS has been doing a whole range of things to try to figure out how to better coordinate care. A number of the policies that are being developed by the Center for Medicare and Medicaid Innovation are addressing that issue. And, in fact, CMS has been working on that issue for years. When I was in CMS during the Bush Administration, we developed many chronic care initiatives that have since been refined over time and hopefully will end up finding the most effective ways to deal with our elderly population.

Because we all aspire to be there one day and we're going to need the Medicare program, and so are the working people of today. And so we need to, instead of pitting currently working people against retirees, we ought to recognize that we're talking about the same group of people, just different points in time.

Mr. LEWIS. Would any other witness like to respond?

Mr. GUTERMAN. I'm sorry?

Mr. LEWIS. Dr. Baicker, Dr. Moffit.

Ms. BAICKER. Yeah. So I think you're highlighting a fundamental problem, which is an out-of-balance system where it's vital that we ensure the program is available for the 100-year-olds of tomorrow, and we all share the wish that we all live to much older ages. But I think something fundamental about the system has to change to preserve the financial stability of it for generations to come because as Mr. Moffit pointed out, as the number of workers per retiree changes, it's not about conflict; it's about accounting balance, that you just run out.

You either have to impose higher and higher and higher taxes on the working age population as they shrink and the retired population grows, or you have to change the benefit in some way. So I share the view that something more fundamental needs to change to preserve and strengthen the program for the future.

Mr. LEWIS. Thank you. I yield back.

Chairman TIBERI. Thank you, Mr. Lewis.

Where am I here? Ms. CPA Jenkins, the gentlelady from Kansas, is recognized for 5 minutes.

Ms. JENKINS. Thank you, Mr. Chairman. And I, too, would like to congratulate you on your chairmanship here of the Health Subcommittee. I know you will take the health and wellbeing of Americans very seriously in your new role. I might suggest that you could start today by avoiding many cases of hypothermia and frostbite if you could turn the air conditioning up a little bit, if you could do that.

Thank you for this hearing. Thank you, witnesses, for being here with us today. Medicare plays a very important role for many

Americans and certainly the Kansans, folks that I have the privilege to represent. This past year over 485,000 Kansans had health coverage through Medicare. We are holding this hearing today because we have to face the facts, and in July the Medicare trustees released a report indicating Medicare would be insolvent within 15 years if no action was taken to fix the problem.

As has been noted by Dr. Moffit, increases in healthcare spending along with changing demographics as the baby boom population gets older has created a very serious fiscal crisis. And we have to continue to work on solutions so that we can save Medicare for those who have paid into the system currently and for future generations. And I am proud that last year this Committee already took efforts to strengthen Medicare payment and that whole process for doctors which has been a positive impact for seniors and the entire program. But we really have to continue to work toward sensible reforms for these programs so that seniors are not vulnerable to any future consequences.

Dr. Baicker, one question that I have relating to the Medicare Advantage program is how it benefits rural America. I represent 25 counties, predominantly rural. In particular, perhaps you could explain how Medicare Advantage provides additional healthcare choices and benefits for those living in rural America.

Ms. BAICKER. You're highlighting a really important issue—that the network of providers available to people in rural areas looks very different from that in urban areas. And so getting real plan choice for them can be more challenging when there aren't so many different providers and there may not be so many plans operating.

The advantage of that is that innovative plans can find ways to deliver services in rural areas that the traditional Fee-for-Service plan can't. So we've talked a little bit about tele-medicine. I think there's a strong case to be made for it, not just in rural settings, but there are lots of homebound seniors who would benefit from being able to have more sophisticated services available to them in their homes or who don't have access to specialty care. But I think it's particularly vital in rural areas where the nearest specialty hospital may be far away and the nearest specialist may be very far away.

We have huge advances in technology that enable higher-quality care than would otherwise be able to be delivered, and we need programs that can capitalize on that innovation to deliver novel benefits, especially in rural areas, but I really think everywhere as well.

Ms. JENKINS. Okay. Great. Thank you. Another concern I have is in Kansas we have a particularly low Medicare Advantage pick-up rate with approximately 65,000 Kansans, only 11,000 in my district, enrolled in Medicare Advantage last year. Could you speak to why we may be seeing these low numbers and what we can do to increase them?

Ms. BAICKER. I don't know the particulars of your district and I would be happy to get back to you with more information about the insurance marketplace in that particular area. But in general, I think having plans compete on equal footing so that both beneficiaries and the plans can reap the rewards of providing higher-

value care can be a motivator to draw more plans in and to have more beneficiaries pick up the care.

Right now beneficiaries who pick a plan with a lower payment required than the benchmark or than Fee-for-Service can reap some of the benefits in the form of better financial protection, more flexible benefits. But they can't get any money back if they choose a higher-value program, and that might be an avenue for increasing the appeal for beneficiaries, which would, in turn, increase the appeal for plans to come in.

Ms. JENKINS. Alrighty. Thank you. Mr. Chairman, I yield back.

Chairman TIBERI. Well done, Ms. Jenkins. Thank you. We are going to now go to a two Republican—one Democrat order. So with that, the gentleman from Minnesota is next in line. Welcome again, Mr. Paulsen. You're recognized for 5 minutes.

Mr. PAULSEN. Thank you, Mr. Chairman. It's great to have you as the Chair of the Committee, and I'm happy to be on this Health Subcommittee now.

This has been great testimony, so I appreciate your time being here as well. On Monday I held a roundtable with several hospitals and organizations in Minnesota to talk a little bit about the regulatory environment they're dealing with, talk about Medicare programs.

And quite honestly, the lack of focus on outcomes in that environment and quality measures that they think really do need to be there, and they expressed some concern about some providers that are leaving the program and that patients are concerned about the quality and the cost of care that they're seeing.

Medicare was designed as an acute care program 50 years ago, so a long time ago, and clearly now obesity and other chronic conditions are driving a lot of the increased cost in the Medicare system today. And so, Dr. Moffit or Ms. Baicker, what would be the impact on the financial stability of the Medicare system if we improved the outcomes for patients that have multiple chronic conditions or we intervene sooner to help those patients from becoming obese or developing other co-morbidities.

Mr. MOFFIT. Well, I'll take a stab at it, but I'm going to defer to Dr. Baicker. But the real fact of the matter is that about 75 percent of all the healthcare spending in the United States right now is directed toward dealing with chronic care, chronic illnesses. And we have a tremendous increase, unfortunately, in diabetes. It is all over the place.

I'm on the Maryland Healthcare Commission right now and in my capacity I'm in the business right now of examining some of the impact of certain chronic conditions on certain populations in the State of Maryland. And I can tell you diabetes and heart disease is becoming a serious issue. So yes, if we can manage effectively diabetes, for example, and other chronic conditions, in fact, we would really start to save some serious money.

I would just simply add that with regard to the Medicare Advantage program, which is, in fact, a defined contribution type of program, private plans competing against one another have actually pioneered in many respects the kinds of delivery reforms that have proven—that have become very popular more recently. These are

things like care coordination and case management and a heavy emphasis on preventive care.

We're going to need more of that as time goes on, but I don't think there's any question. We are in a different kind of disease era right now, and therefore we do need more effective tools both through insurance and through the healthcare delivery system to control those costs, but I'll defer to Dr. Baicker.

Mr. PAULSEN. Ms. Baicker, real short, and then I'm going to ask a followup question real quick.

Ms. BAICKER. I think you're right on point that the greatest return to care management is in managing chronic conditions. It's patients who need a lot of care where we can both improve quality and reduce spending if it's managed better and preventing the onset of those conditions. So I think your point is key.

Chairman TIBERI. I'm just going to mention I've got a couple pieces of legislation that are bipartisan that we've introduced that I think the Subcommittee can look at and certainly the full Committee. One is the Treat and Reduce Obesity Act, which focuses strictly on obesity and making sure seniors have access to drugs that were not initially eligible under Medicare Part D, but can have a huge impact right now on cost. And the other is the Better Care, Lower Cost Act that Peter Welch and I will be reintroducing soon that talks about chronic condition management and increased cost that we've seen in the Medicare system there that we can focus on.

But let me go to one other question, because this came up a little earlier in regard to this voucher, regarding premium support, and maybe, Dr. Moffit, you can comment. Because I do know that the former Congressional Budget Officer—Director, Alice Rivlin, in the Clinton Administration has made it very clear in saying the premium support is not a voucher. But can you elaborate? Does moving to a system that has premium support eliminate the Medicare guarantee? Is it a voucher, Dr. Moffit?

Mr. MOFFIT. Congressman, let's get serious about this. There is absolutely no proposal in the House or the Senate that I am aware of that would create a voucher program for Medicare. A voucher is a certificate. It is a certificate or a piece of paper which is redeemable in cash value for a particular good or service. Nobody is talking about sending senior citizens certificates to go out and negotiate with private healthcare plans on their own.

What we are talking about is a defined contribution system. Every Federal worker and every Federal retiree is in that defined contribution system. If you were to tell them that they're in a voucher system, they would probably be very surprised, as would senior citizens who are enrolled in Medicare Part D. And to some extent even Medicare Part C is, in effect, a defined contribution system, but it's not a voucher.

So I think if we're going to have a serious debate in this country about Medicare reform, the first thing we ought to do is to recognize the integrity of the language. People know what vouchers are. If your airplane, for example, is delayed, sometimes they will give you a voucher and you can use it at any restaurant you want.

But the fact of the matter is there is nothing comparable to that being proposed by any Member of Congress that I am aware of, Re-

publican or Democrat, or has been proposed for the past 20-some years where this issue has been discussed, which is actually talking about a voucher system. We're talking about a defined contribution, and most all of our Federal employees are involved—

Chairman TIBERI. The gentleman's time has expired. Thank you, Mr. Paulsen.

Mr. Blumenauer is recognized for 5 minutes.

Mr. BLUMENAUER. Thank you, Mr. Chairman. And it will be fun to engage in this conversation, and I appreciate your starting it because the testimony here today, I think, was very useful. Maybe it's rehashing things that we've gone over before, but it's important, I think, to be able to have these things in mind.

Chairman TIBERI. Thank you. Thanks for your sincerity. Will you put a good word in with Dr. McDermott for me?

Mr. BLUMENAUER. I will consider that. Absolutely. But part of it, I think, Mr. Chairman, is how we proceed to go forward and being able to focus on areas where there is consensus. We have a lot of value rattling around in this system. We have not extended ourselves to be able to deal fully with cost control. We have a tidal wave of geezer baby boomers like me who are getting ready to tap in.

I have, I must say, real concerns about what we're going to do if we're going to start raising the retirement—the age of eligibility, what happens for those senior citizens between 65 and 66, 67, 68. They're not going to be less expensive to care for.

And if you pull them out and put them on their own in the private sector, which is costing more and has had greater increases, what are we doing to the pool? You actually may coincidentally make it more expensive to deal with Medicare because you take out some of the people who are the least costly and you put them on their own to navigate it. I don't know that we would get very far with something like that, but we can debate it.

But I'd like to think about how we combine the programs, how we make Medicare Advantage truly have performance metrics, because there's a wide variation. I represent if not the highest penetration of Medicare Advantage, maybe the second or third in the country. And I will tell you they're not all alike, and I want to make sure that the performance metrics that we put in with the Affordable Care Act are real. I've enjoyed working with Congresswoman Black in terms of finding some areas of value-based design. These are areas that we can squeeze more value and better performance.

We need to update and modernize hospice benefits. I mean this is something that has a transformational effect. Finally, we have end of life care payments and we're putting more value on it. There's a potential here to squeeze hundreds of billions of dollars out of the system over the next decade while we give people better care.

So I'd like, Mr. Chairman, to be able to focus on a little deeper dive. This is great information, I think, for us all to listen and think about, go back and forth with some of the proposals that we have.

But I think before we wade into things that the topline people will battle over, we can do that. But there's lots of consensus I

think here for things, expanding the pilots, modifying the benefits, looking where value really exists and being able to build on some of the bipartisan interest that we've had on this Committee and elsewhere to be able to deal with it. Because, yes, we're going to probably need more revenue when we have tens of millions more senior citizens.

I know Medicare traditional Fee-for-Service has held the cost down, and there is tremendous potential with Medicare Advantage. But we haven't tapped into it, and they still continue to pay more than Fee-for-Service even though when we set it up originally back even before we were here, it was perceived to be a 5 percent premium reduction because it should be more efficient and more effective. And I'm not willing to have to inflict a cut, but I want to get more value out of it, and I think we ought to be able to do a deeper dive to be able to understand it.

So I appreciate the testimony. I appreciate the discussion on the Committee, and I'm looking forward to seeing if we can take three or four areas that we all probably agree have great benefit, show the performance, reward areas of the country that actually have better performance, don't penalize them, and make those structural changes. Thank you.

Chairman TIBERI. Thank you. That's great.

The gentleman from Texas is recognized for 5 minutes.

Mr. MARCHANT. Thank you, Mr. Chairman, and congratulations on your chairmanship. I really look forward to serving with you.

I got home last night, turned the TV on to watch all of the election results, and——

Chairman TIBERI. Brave man.

Mr. MARCHANT [continuing]. Seemed to be a lot of commercials on TV here in Washington about changes in the Medicare plan. Ms. Baicker, can you tell me what those commercials are about? It's cutting Medicare, call the Administration, tell them not to cut Medicare Advantage benefits and plans.

Ms. BAICKER. I didn't watch those commercials.

Mr. MARCHANT. Yeah?

Ms. BAICKER. And as your colleague said, brave man. So I don't know what they were speaking to directly. I know there is real concern out there about the continued availability of different options for beneficiaries through the MA plan. Having no idea what the commercials are about, I think maintaining a competitive playing field for those plans to participate is really important to beneficiaries.

Mr. MARCHANT. Well, I think those commercials are directed at the Administration, so maybe they're missing the mark. Unfortunately, if I want to get any kind of news, I have to view them now.

So, Mr. Guterman, do you have any idea?

Mr. GUTERMAN. Yeah, I——

Mr. MARCHANT. Because this is beginning to trickle down to my district. I'm going to get emails and phone calls about it now, and so I feel like I need to understand a little better——

Mr. GUTERMAN. Thank you. Living in the Washington area, I'm very familiar with those commercials, and also being on the

verge of becoming a Medicare beneficiary myself, I'm also familiar with the vast amount of mail that I get on Medicare Advantage.

I believe that the issue is that Medicare Advantage plans are concerned with potential "cuts" in Medicare Advantage payments. But I would point out that those cuts are actually bringing Medicare Advantage payments more in line with traditional Medicare in terms of what traditional Medicare spends. Because over the last 10 years, Medicare Advantage plans have been paid substantially more than even traditional Medicare costs.

And traditional Medicare has never been seen as the paragon of efficiency. So a cut is a relative term because they may be getting less than they would have wanted to be able to expect in future years, but the average payment for Medicare Advantage plans is still above what traditional Medicare spends per enrollee.

Mr. MARCHANT. Yeah, so the source of this is not a group of Medicare Advantage patients that feel like they're going to be aggrieved. It's the people that are being reimbursed that feel like they're—

Mr. GUTERMAN. Enrollees in Medicare Advantage plans, because of the extra payments that they've gotten, have been able to get extra benefits that traditional Medicare doesn't cover. But to be sure, that money comes from the Medicare trust fund that only goes to support benefits that Medicare Advantage enrollees get that traditional Medicare enrollees do not.

Mr. MARCHANT. Okay. Mr. Moffit.

Mr. MOFFIT. I want to comment on this business about Medicare Advantage being paid more than traditional Medicare. I mean there's one obvious fact that should not be overlooked, and that is people on Medicare Advantage get more benefits. And therefore, that is why it is a higher cost. This is not a market failure on the part of the Medicare Advantage program. This is a statutory requirement. If a plan comes under the official benchmark, they're required by law to provide either lower copayments or richer benefits, and that's what Congress enacted.

So I agree that we ought to have a level playing field, but I think one way to get a level playing field basically would be to bring Medicare Advantage and traditional Medicare into a direct head-to-head confrontation in which we would have a common payment system that would apply to all. I think that would make much more sense.

But I would ask you all to consider one other point. Everybody talks about Medicare Advantage costing more and more money. But when senior citizens join Medicare Advantage, they also are guaranteed catastrophic coverage as well as the additional benefits. They go into Medicare Advantage in many cases because they want to have that kind of protection.

But when they do so and they don't go into the Medigap program, right? They are withdrawing from a structural relationship between Medigap and traditional Medicare, which is right now, everybody agrees, driving costs of Medicare—traditional Medicare up, the excessive utilization.

So my plea would be for the Congressional Budget Office or the general Government Accountability Office or somebody to actually look and find out how much Medicare Advantage is actually saving

the taxpayers—by making it an alternative to the traditional Medigap program. Maybe Dr. Guterman doesn't agree with me on this, but I think frankly there's nothing wrong with looking under the hood and finding out.

Chairman TIBERI. The gentleman's time has expired. I'm sure he doesn't agree with you.

So, Mr. Smith, you are recognized for 5 minutes.

Mr. SMITH. Thank you, Mr. Chairman, and thank you to our witnesses for your participation here today. If we could focus a little bit, we know that one ought not wait until they need the insurance to purchase the insurance, be it prescription drug coverage, be it conventional health insurance. But we've got the penalty in Medicare Part D that is structured very differently than perhaps some other penalties to be exacted by the IRS relating to other healthcare.

Can you reflect a little bit on the effectiveness of the penalty in Medicare Part D that does exist and its productivity perhaps, just any of the witnesses?

Ms. Baicker, go ahead.

Ms. BAICKER. So the point you highlight is crucial to understanding what insurance is. Insurance works when healthy people and sick people are all in the same pool or people who in advance of knowing that they might need healthcare join an insurance pool, and then the people who are unfortunate enough to need expensive care draw out and the premiums of the people who were lucky enough not to need care pay to subsidize their unfortunately sicker counterparts.

And it's always a little surprising to me when people describe an insurance plan that they have and say, "I paid all these premiums, and I didn't get anything for it. What was the use?" And I always think, well, I paid my homeowners insurance and my house didn't burn down, good. So understanding the insurance value of an insurance product is crucial to building an insurance marketplace that works. If people don't have an incentive to join when they are healthy or before they know about their healthcare expenses and premiums don't reflect their expected healthcare costs, you get degeneration of the risk pool, and you don't have a real insurance product available.

And we can talk at great length, but I won't because I know it's your 5 minutes, about the different mechanisms for getting everybody to participate whether you want to use the carrot of a subsidy, the stick of a penalty, but I share your view that it is vital that everybody get in the insurance market early for there to be an actual insurance market.

Mr. SMITH. Okay. Mr. Moffit.

Mr. MOFFIT. (Off-mic.)

Mr. SMITH. If you could, turn on your mic.

Mr. MOFFIT. I really have nothing to add to that. I think that that is precisely right, and I think that Dr. Baicker has summarized it very well.

Mr. SMITH. Can you speak to the effectiveness, though, of drawing people in or onto a plan and participating in the process and how productive that has been?

Mr. MOFFIT. Joining a plan and participating in the process?

Mr. SMITH. Has the penalty been effective——

Mr. MOFFIT. Oh.

Mr. SMITH [continuing]. In encouraging people to join the plan?

Mr. MOFFIT. To the best of my knowledge, Congressman, but I haven't made any kind of detailed study of how the behavior has followed from that particular penalty. I'm really not absolutely certain. But I defer, as I said, to Dr. Baicker's understanding of the issue.

Mr. SMITH. Okay. And perhaps for reflection later because time is limited——

Mr. MOFFIT. Sure.

Mr. SMITH [continuing]. The comparison of a penalty for not signing up at the appropriate time and waiting as compared to criminalizing someone who opts for a different approach than what the government might have set out.

Mr. MOFFIT. There is a difference there. I mean frankly we have right now a creditable coverage requirement that exists in the Health Insurance Portability and Accountability Act, which says, in effect, that you can go from one group health insurance plan to another, and you're not rated up—basically it's the same idea—you're not rated up because you have maintained creditable coverage. That's an excellent public policy—that's an excellent public policy provision. And, frankly, to the extent to which the Medicare Part D proposal does that, I think that's perfectly legitimate.

Mr. SMITH. Okay. Mr. Guterman.

Mr. GUTERMAN. I agree that in order to make an insurance market work you need to have an incentive to join the insurance market before you actually need to get paid under the insurance. And I would point out that Medicare Part B is a similar program. I mean the vast majority of Medicare beneficiaries take Part B, but you——

Mr. SMITH. So what do you think is more effective, writing up someone or penalizing them fairly severely, but maybe not even enough to really get someone to make a better decision?

Mr. GUTERMAN. Well, they're very similar if there are financial penalties for not joining, and to my knowledge, nobody's ever been put in jail for not taking——

Mr. SMITH. Should someone have to pay a penalty for not participating at all?

Mr. GUTERMAN. They don't have to pay a penalty if they never participate, under Medicare Part D and——

Mr. SMITH. Is that a better public policy than having to pay a penalty for not participating?

Mr. GUTERMAN. I think it's a different circumstance, because Part D is a much narrower coverage situation.

Mr. SMITH. Thank you, Mr. Chairman.

Chairman TIBERI. Thank you, Mr. Smith.

Ms. Black, welcome. I know you had a brutal budget hearing. Mr. McDermott told us he was leaving, too, and he hasn't come back yet. So welcome. This will be much nicer.

Ms. BLACK. Thank you, Mr. Chairman. I——

Chairman TIBERI. You're recognized for 5 minutes.

Ms. BLACK [continuing]. Want to congratulate you for being the Chairman of this Committee. I know you well enough to know that

you're going to study all of these issues and know them inside and out. So you're going to make a great Chairman of this Committee. And the reason why you don't see Congressman McDermott is we have him tied up in the chair there in the budget hearing.

That budget hearing is going to go all day long, but I did want to sneak away for just a little bit because this is an area that is near and dear to my heart, being a nurse for over 40 years, and having been in the system and seeing the pendulum that swings from side to side and I'm not sure where I could say the pendulum is right at this point in time, but there is one particular issue that I, as a nurse, think has a great value and I wanted to ask all of your opinions on that. And that is value-based insurance design.

I am honored to have my colleague, Mr. Blumenauer, as my cosponsor on this, and we actually have a bill that would put a pilot project in on the Medicare Advantage side for those chronic conditions, and in using the value-based insurance design is looking at those services that have a high value to them and incentivizing people to use that valued service.

So for those who are listening and wonder what in the world that means, Dr. Fendrick, who is out of University of Michigan was the one who originally brought me this idea, and I just tagged onto it right away.

But to give an example, if someone is diabetic and one of the highly-valued services for them would be their insulin and giving them either a low-cost or a no-cost for that particular service would incentivize them to use that service and, therefore, save dollars down the line with the kind of complications that would occur if they were not taking their medication. This is not about saving dollars, although that is something we want to obviously do because there are a limited number of dollars. This is about quality care.

And so I would like the panelists, starting with you, Ms. Baicker, to let me know what you think about this and whether you believe this is a direction we should be heading not only for the solvency, but also for quality of care.

Ms. BAICKER. I'm a big fan of value-based insurance design, and there are clearly some challenges in the implementation, but that doesn't mean that we shouldn't be trying to take them on. To build on the example that you gave of a diabetic patient, imagine that patient is considering taking a statin to lower cholesterol or not. We know patients are very sensitive to copayments and that going from a zero copayment to a \$5 copayment makes a much bigger difference in patients adherence than you would imagine, even for really high-value medications. That statin may be incredibly high-value for a diabetic patient, and you want to make it zero dollar copayment.

Maybe if you're an innovating insurance company that's working with enough flexibility, you want to actually pay the patient \$5 to take the statin. That same drug may be very low-value for a patient who has high cholesterol or moderately high cholesterol, but no other risk factors, unless a very low risk of a cardiovascular—an adverse cardiovascular event, whereas the diabetic patient has a really high risk.

Maybe for the low-risk patient, the copayment should be \$10 or \$20. That kind of innovation is not about shifting costs onto the pa-

tient who's paying the higher copay, but rather shifting use of the statin toward the patient with the highest health benefit for it. So I'm very much in favor of exploring that, and there's some nods to that in existence already. There's some experimentation in the Medicare Advantage program itself now with value-based insurance design. Safe harbors for preventive care are an example of value-based insurance design, where when you go to get a preventive care treatment that is of sufficiently high value, you don't have to pay copayments even if you're in a high-deductible plan. So I think those are very much worth exploring.

Ms. BLACK. Does anyone else have a comment on that? Mr. Guterman.

Mr. GUTERMAN. Yes. Thank you, Ms. Black. I had the pleasure of working with Mark Fendrick on the advisory group to his Value-Based Insurance Design Center at University of Michigan. I'm very in favor of that. It's been long known that when copays have to be paid or deductibles have to be met that patients use less healthcare, including less healthcare that they really should be using. And so structuring the incentive so that even patients get rewarded for using cost-effective care that will keep them from getting sicker and more costly is just an eminently reasonable thing to do.

Ms. BLACK. Well, I know that the CMS is looking at this, and they're actually looking forward enough to say that that's something they may initiate themselves and have a little bit of a pilot project there.

But, Mr. Chairman, I believe that even though they're moving in that direction, a little push from us in actually bringing that bill up and getting a vote on it would certainly move this forward a little bit faster. So thank you, Mr. Chairman. I appreciate your work.

Chairman TIBERI. Thank you, Nurse Black, for your efforts in this area. This has been terrific. You three have been very substantive, and I don't want this to end. So I'm going to indulge this process a little longer, and I hope you will agree to partake in this, because I think this has been really, really substantive.

So, Mr. Guterman, I enjoyed the exchange that you, Dr. Moffit, and Dr. Baicker had with respect to Medicare Advantage. So let me kind of frame this for you. I have an 81-year-old father who's been on Medicare now for over 15 years. So he was on Medicare Fee-for-Service before Medicare Advantage. I voted for the Medicare Advantage plan and was painfully reminded of it in a commercial attacking me for voting for it and the disastrous consequences of Medicare Advantage and the private healthcare market for seniors.

Now let me tell you the real world that I lived through my parents. Before Medicare Advantage, my dad was on the Medicare Fee-for-Service plan. It didn't provide what he believed was necessary coverage, so he was one of those Medigap folks. And when Medicare Advantage came around, he and my mom both have been on Medicare Advantage plans, and they love it.

So I do take issue with something you said with respect to Medicare Advantage, and that is that Medicare Advantage plans are paid more. Some are paid more, but my understanding is they're paid more because of quality bonuses that they receive, and I men-

tioned that Catholic plan in my district that has very high marks and have spoken to many of their beneficiaries over the years.

As you know, Medicare Fee-for-Service doesn't provide that. We as policymakers have no way of knowing the quality that Medicare Fee-for-Service provides other than seniors like my dad and my mom who speak with their feet and go to Medicare Advantage plans because of the more comprehensive nature of the services that benefit provides.

And so my frustration is at the end of the day that we're going to make a Medicare system that benefits seniors in total, that we continue to berate a system that has been wildly successful not in my eyes, but in the eyes of my mom and dad who are beneficiaries—and not just my mom and dad, but Republican and Democrat and Independent seniors all over the place.

And as I think Dr. Moffit pointed out, when opponents of trying to expand seniors' choice say "voucher" to think about how these awful systems are going to take place to leave seniors abandoned, I don't think that's a really good way to try to come together to figure out how we best serve patients, seniors, in a more cost-effective, value-added, comprehensive way when we know that the current system based upon CBO's recent report is heading toward the brink of redness. So let's talk about that, and I would like you to first talk about that because I believe you're sincere in what you believe, and then hear from Dr. Moffit and Dr. Baicker. Dr. Guterman.

Mr. GUTERMAN. Okay. Thank you, Mr. Chairman. I think there are a couple of things. The plan that you refer to may well be a very high-performing plan. One of the problems that high-performing plans have in Medicare Advantage is that there's not enough distinction between high-performing plans and their competitors who may not be as high-performing. We need to find better ways of rewarding plans that actually do perform for their enrollees and not—

Chairman TIBERI. Love to have your suggestions on that.

Mr. GUTERMAN. And, in fact, the substantially higher payments that Medicare Advantage plans have received over the last decade or so compared to judicial Medicare makes it easier for low-performing plans to come into the Medicare Advantage market and survive. So we need to find a better way of paying Medicare Advantage plans for their value, but not just throwing money at Medicare Advantage because it includes private plans, so we need to distinguish that.

Another thing that would help Medicare beneficiaries across the board would be to improve the traditional Medicare program so that it is more comparable to Medicare Advantage in terms of what it can cover and what it can provide. Then they'll be on a level playing field, and even if you wanted to go to a point where private plans would compete directly with Medicare Advantage, which basically they do, because any beneficiary has the option of enrolling in a private plan, then they would be doing so on a level playing field. And so the distinction between high-performing plans and lower-performing plans could be more evident.

So I think that Medicare Advantage does have a tremendous amount of promise to improve Medicare across the board. I think

we need to do a better job of paying them appropriately and rewarding the kind of performance we want from plans.

Chairman TIBERI. That's fair.

Dr. Moffit.

Mr. MOFFIT. Well, with regard to Medicare Advantage, when Medicare Advantage started really growing, it started to be the subject of a lot more intense examination in terms of how it was actually delivering medical services. And the good news here for Medicare Advantage is that some of the best work in the professional literature indicated, in fact, compared to traditional Medicare, Medicare Advantage actually scored higher on a lot of performance measures.

We keep talking about quality of care in Medicare Advantage, but frankly I think the more serious problem is the quality of care in traditional Medicare. If we're talking about targeting dollars and getting the best value in return for those dollars, where is the evidence that traditional Medicare is actually performing in any way similar to the new Medicare Advantage program? What have we been doing with the existing defined benefit program in which seniors, nine out of ten of them, have to go to private plans to actually make sure costs are covered?

When Dr. Guterman talks about a level playing field, I agree with that 100 percent. But they are not competing head to head. What I'm talking about is paying Medicare Advantage and the traditional Medicare program based on a competitive bidding system in which the consumer, in which the senior will actually make the choice.

What we really need in this area, especially—but not only here in Medicare, but throughout the healthcare system—is more transparency not only on the cost and price of services, but also performance. And when we do that, we will start to see a very positive response on the part of plans and providers, on the part of different medical institutions, and we know this from limited experience where we've actually done this.

There are a couple of other things we can do, and I'll just mention them with regard to promoting quality of care. We talked earlier, Mr. Chairman, about the fact that our biggest healthcare challenge going forward is the fact that we have a tremendous problem with the growth of chronic diseases. And as you know 75 percent was the figure I used, but that was based on other independent studies, but roughly 75 percent of our costs are basically the cost of chronic care.

We ought to start thinking about innovating insurance designs in which people are directly—I'm talking about the patients—are directly advantaged by enrolling in wellness and preventive programs where the payment system actually reflects that. What I'm really talking about is something like premium discounts for individuals who enroll in preventive or wellness programs, which can start to cut down on the longer-term cost of chronic care.

There is a professor from Emory University, Professor Zhou Yang, who has suggested that we take the existing premiums or the premium support notion and at least create a defined contribution experiment where we actually adjust the payment going on a per capital basis to patients on their behavior, their willingness to

enroll in preventive and wellness programs. There are a multitude of things that we can do that we are not doing.

But I think that really the sky is the limit. I think if we really want to see how these delivery reforms actually perform, what the outcomes really are, what we should do is put them in an environment in which there is intense competition, a complete transparency of price and performance and a lot of your ancillary institutions, particularly seniors organizations and various other institutions can start to judge plans and providers on how well they do.

I think that's the kind of thing we need. We need that kind of an environment. We don't have that environment yet. We can get there. And, I appreciate what the Administration is trying to do, but I don't think that you're going to necessarily get higher-quality healthcare through better central planning. I think that a competitive environment is frankly a lot better.

Chairman TIBERI. Thank you.

Dr. Baicker, any thoughts?

Ms. BAICKER. Just to briefly highlight an issue brought up before, Medicare Advantage plans are bidding for the same bundle of service below Fee-for-Service costs on average. And then there's a quality add-on, and then there's the return of some of the difference between the benchmark and the bid in the form of lower cost sharing for the beneficiary or greater benefits than the traditional plan provides.

So when thinking about how much MA costs, thinking about the same bundle of services, the bids are lower. There's plenty of room for debate about the right way to structure the quality bonuses, and I think that they're a crucial component of ensuring that beneficiaries are getting high-quality care, but it's really not an apples-to-apples comparison.

Chairman TIBERI. Dr. Guterman, in response.

Mr. GUTERMAN. Just one response to that. The fact is that, on average, right now Medicare Advantage plan bids, which represent their costs of the traditional Medicare package, are on average below traditional Medicare nationwide. But that varies widely from area to area. In 50 percent of the country, they're actually substantially above what traditional Medicare spends in the same areas, and a lot of those areas are rural areas.

And it's a relatively recent phenomenon that only began with the quote cuts in Medicare Advantage over payments that began around 2010. So as of 2009, Medicare Advantage bids on average were actually above traditional Medicare, and then they got 75 percent of the difference between that and an inflated benchmark rate. So it's not just the quality payments. It is built in——

Chairman TIBERI. Add-ons.

Mr. GUTERMAN [continuing]. Over payment in Medicare Advantage. And the other point is also that only HMOs are cheaper than traditional Medicare. Now HMOs are the majority of Medicare Advantage plans, but there are a substantial number of other PPOs local and regional and also private Fee-for-Service plans—which used to be more predominant that actually still cost more than traditional Medicare on average across the country. But again, that also varies from one place to another.

Chairman TIBERI. Would you agree that with the statements that have been made here including by me that a senior has difficulty in determining the quality of Medicare Fee-for-Service?

Mr. GUTERMAN. I think that it's all too difficult for any patient anywhere—to determine the quality of provider and plan that they are about to get services from or sign up with, and I think we have a long way to go. But I remember in the early 2000s when I was working at CMS that we first put out the hospital compare—the first hospital compare website, and everybody was agonizing over the fact that we didn't have the quality measures that we felt comfortable enough with to say these are the definitive quality measures. And the administrator at the time, Tom Scully, said these measures are never going to get better if we don't start using them.

Chairman TIBERI. It's all Scully's fault.

Mr. GUTERMAN. We've come a long way since then, but we're still, I would say, in the adolescence of the ability to measure quality—

Chairman TIBERI. So we would all agree, that transparency is desperately needed? Any other thoughts?

Mr. MOFFIT. Well, I just want to follow up on that. In my other job on the Maryland Healthcare Commission, we were looking at the performance of Maryland hospitals—there are 47 of them—in terms of their ability to deliver high-quality cardiac care.

Basically what we're talking about is the door-to-balloon time when somebody goes in for a catheter, basically when they need a stint, excuse me. And the goal is to try to get the patient taken care of within around 90 minutes from the door-to-balloon time.

Well, anyway, the Commission did an evaluation of all the hospitals in the State of Maryland. And after a 6-month period, then they published the results. And the results were stunning. Some of the hospitals that people thought were going to be just terrific turned out not to be so good. And then others that nobody expected turned out to be absolutely terrific.

But what was the effect of the transparency. The effect of it was tremendous because when the Commission staff went back, just about everybody had improved their performance. Some institutions decided that, frankly, measuring up to the standards was a little too much and they gave up that particular cardiac program. But others actually improved. And that's how you get real change. There's nothing like sunlight, and it applies especially to Medicare.

Chairman TIBERI. On that note, this has been wonderful. I sincerely thank all three of you for your time today and your input, and I hope that you continue to engage because, quite frankly, there aren't any more important issues than the future solvency of the Medicare program and access to good quality healthcare, not just for the current generation, but future generations as well.

So with that, please be advised that Members will have 2 weeks to submit written questions to be answered later in writing. Those questions and your answers will be made part of the formal hearing record. With that, the Subcommittee stands adjourned.

[Whereupon, at 11:57 a.m., the Subcommittee was adjourned.]

[Questions for the Record follow:]



**HARVARD
T.H. CHAN**

SCHOOL OF PUBLIC HEALTH
Department of Health Policy
and Management

Katherine Baicker, PhD
C. Boyden Gray Professor
of Health Economics

To: House Committee on Ways and Means, Health Subcommittee
Re: **Hearing on Preserving and Strengthening Medicare, March 16, 2016**
Follow-up Questions for the Record

I appreciate the opportunity to answer these additional questions from the Committee Members.

From Representative Black of Tennessee:

1. *Over the next 75 years, it is estimated that Medicare's HI Trust fund will encounter unfunded liabilities totaling some \$3 trillion (The SMI unfunded liability is \$24.8 trillion, for a total unfunded liability of \$27.8 trillion). The Trustees suggest that a decrease in expenditure of 15% would allow this shortfall to be closed. **Question:** What ideas do you have for achieving this 15% reduction? How do you balance the need to make these reductions in Medicare spending while preserving access and quality of care?*

Moving away from fee-for-service Medicare towards programs and payments that reward value – such as Medicare Advantage, premium support, or other risk-bearing entities – is an avenue for slowing the growth of low-value health care spending while ensuring that all beneficiaries continue to have access to innovative, high-value care.

2. *As life expectancy increases, people will receive Medicare benefits for longer amounts of time, causing benefits to be a larger share of lifetime earnings for later populations. The reigning assumption has always been that these later generations would also pay more in payroll taxes, because real earnings generally grow overtime. However, real wages have barely increased over the past 5 years, if not for longer. **Question:** Given the fact that younger generations will not be paying as much as anticipated into the system, while drawing much more out of it, how is the HI Trust Fund impacted, and can we further state that Medicare's solvency can be improved by jump starting wage growth?*

Medicare solvency will always been improved when the taxable wage base is larger relative to aggregate promised benefits. The wage base could be expanded through longer working lives, higher earnings, or higher tax rates. Fiscal balance could also be restored by reducing spending, such as through payment reforms described above.

From Representative Price of Georgia:

1. ***Question:** CMS has stated their goal is to "make unprecedented improvements to the program for plans that provide high quality care to the most vulnerable enrollees." How do significant reductions in payment for the chronically ill improve the Medicare Advantage Program and improve care provided to our sickest and most vulnerable members? Can you*

speculate as to the clinical rationale of reducing payments to chronically ill? Are you aware of the clinical studies were relied upon by CMS in making this determination?

I am not familiar with CMS's rationale or the studies upon which they relied. I believe that a well-functioning Medicare program would use carefully risk-adjusted payments to make sure that there is no disincentive to enroll sicker populations, and that adequate funds are available to provide them with the high-quality care that they need.

2. ***Question:** Currently, hospital outpatient departments are allowed to bill patients at a higher rate than freestanding community based physician offices. What are your thoughts on how this payment disparity has affected consolidation in the healthcare marketplace? Last November, Congress passed site neutral Medicare payment policies for any off-campus HOPDs that were acquired or built after Nov 2, 2015 which is estimated to save approximately \$9 billion over 10 years. Do you think expanding this policy to all off-campus outpatient facilities would be beneficial to Medicare's long term solvency? Do you think that Medicare or beneficiaries should be paying more for the same services at facilities that were purchased or built before the November 2, 2015 enactment date? There has been an effort by some to exempt or carve out certain HOPD facilities from the site neutral payment provision included in the Bipartisan Budget Act – what is your response to that?*

I believe that payment schedules that drive patients to higher-cost sites of care or promote otherwise inefficient market consolidation or organization are harmful to the financial sustainability of the Medicare program and to beneficiaries' ongoing access to high-quality, affordable care. The principle of site-neutral payments is that patients (and the Medicare program) should not pay more for equally appropriate and equally high-quality care just because it is delivered in one type of location vs. another. There are certainly challenges to applying this principle across settings (for example, emergency departments may cost more because of necessary stand-by capacity), but I believe that it should be applied more broadly than it is now.

Sincerely,



Katherine Baicker

Questions for the Record: Hearing on Preserving and Strengthening Medicare

From Representative Black of Tennessee:

1. Over the next 75 years, it is estimated that Medicare's HI Trust fund will encounter unfunded liabilities totaling some \$3 trillion (The SMI unfunded liability is \$24.8 trillion, for a total unfunded liability of \$27.8 trillion). The Trustees suggest that a decrease in expenditure of 15% would allow this shortfall to be closed.

Question: What ideas do you have for achieving this 15% reduction? How do you balance the need to make these reductions in Medicare spending while preserving access and quality of care? [Invites discussion of Premium Support.]

Response (Stuart Guterman): There are essentially three approaches to reducing Medicare spending: one involves reducing Medicare eligibility and/or benefits, another involves shifting the some of the cost of Medicare services to providers and/or beneficiaries, by reducing Medicare provider payments and/or requiring beneficiaries to pay more for their Medicare benefits, and a third involves changing the way health care is organized and delivered, to increase efficiency and effectiveness and improve outcomes. These sets of strategies are not necessarily mutually exclusive, and some combination of them may be necessary to achieve the desired results. However, I would assert that these three approaches differ both in terms of their impact on Medicare's ability to fulfill its mission of providing access to needed health care for its beneficiaries and in terms of their likelihood of success in controlling Medicare costs.

The first approach, reducing Medicare eligibility and/or benefits, is exemplified by proposals to increase the age of Medicare eligibility from 65 to 67. While this would reduce the number of beneficiaries, and therefore temporarily address the rapid increase in enrollment that is seen as a major factor in projected increases in Medicare spending, its effect on program spending is likely to be small, because Medicare beneficiaries between the ages of 65 and 67 account for a disproportionately small amount of program spending, which increases rapidly with age. Moreover, much of this reduction in Medicare spending would have to be made up by increases in spending from other public and private sources, as the effected population would shift to coverage through the health insurance marketplaces or Medicaid or extended employer-sponsored coverage. Nothing in this approach would address the underlying problem that faces both Medicare and other public programs—and private insurance as well: that our health system spends substantially more than other countries without achieving better results.

The second approach, shifting costs to providers and/or beneficiaries, is exemplified by two policies: one, which has been applied without success for decades, is cutting Medicare payments to providers; the other, which has been proposed over the past several years, is premium support, which essentially places responsibility on Medicare beneficiaries to control health care spending, which both public and private payers—with much more market power—have consistently failed to do so.

While it is true that reductions in Medicare payment rate updates have slowed the rate of program spending several times—the most dramatic example being the Balanced Budget Act of 1997—they did not have a sustained effect on program spending because they did not change the underlying structure of health care delivery; moreover, health care cost growth was supported by sharp increases in provider payment rates from private insurers.

The premium support approach, under which beneficiaries would have financial incentives in choosing to obtain their coverage from traditional Medicare or private plans, was first described by Henry Aaron and Robert Reischauer more than 20 years ago, and various versions of that approach have been proposed over the past several years by the House Budget Committee, among others. However, in Aaron and Reischauer's original proposal, they clearly specify several conditions for the success of such an approach, including two important features not included in the more recent proposals:

- Traditional Medicare's benefit package should be more comprehensive, to foster competition on a level playing field; and
- The federal premium support payment should, initially at least, increase at the same rate as per capita spending on health care for the non-elderly).

Without these conditions, Medicare spending might, indeed, be slower, but nothing in this approach would ensure—or even necessarily encourage—the kinds of changes in health care delivery that would be necessary to slow the total costs of health care for Medicare beneficiaries. The result would be higher out-of-pocket payments from a population that tends to be poorer and sicker than younger Americans. Moreover, the recent premium support proposals fail to take into account the quality of plans or their capacity to serve their enrollees, which would mean that the premium support payments might be set based on the bids submitted by poor performing plans or small plans that do not have the capacity to serve an increased number of enrollees. This not only would put at risk beneficiaries who are currently enrolled on traditional Medicare, it also could result in financial penalties for beneficiaries who currently are enrolled in highly-regarded plans like Kaiser Permanente.

The only strategies that hold real promise for controlling Medicare program costs are those that address the underlying causes of cost growth throughout our health system: increasing accountability for high provider costs and improved rewards for improvements in efficiency and effectiveness and greater transparency in health care prices and quality. This Congress has taken bipartisan action to move in that direction in passing the Medicare Access and CHIP Reauthorization Act of 2015, and it should continue to encourage efforts to move from volume-based to value-based health care financing.

I also would like to reiterate here a point that I made in my testimony: that preserving and strengthening Medicare involves not only reducing program spending, but also recognizing the fact that, with a growing elderly population, it is reasonable to expect that a larger proportion of our economy's resources would be devoted to supporting their access to the health care they need. The base Medicare payroll tax rate has not increased in 30 years, despite the substantial

demographic changes that have occurred since then. Although Medicare payroll tax rates have increased for high-income beneficiaries, a broad re-examination of Medicare financing should include not only the spending side of the equation, but the revenue side as well. Asking current workers to help sustain Medicare's fiscal viability should be seen not as a shift from one generation to the other, but as an attempt to make sure that Medicare continues to serve the needs of the younger generation when they inevitably become Medicare beneficiaries themselves.

2. As life expectancy increases, people will receive Medicare benefits for longer amounts of time, causing benefits to be a larger share of lifetime earnings for later populations. The reigning assumption has always been that these later generations would also pay more in payroll taxes, because real earnings generally grow overtime. However, real wages have barely increased over the past 5 years, if not for longer.

Question: Given the fact that younger generations will not be paying as much as anticipated into the system, while drawing much more out of it, how is the HI Trust Fund impacted, and can we further state that Medicare's solvency can be improved by jump starting wage growth?

Response (Stuart Guterman): As I mention above, Medicare solvency has a revenue side as well as a cost side. Regardless of assumptions about workers' wage growth in the future, policy makers should consider the prospect of changes in how Medicare is financed, including increases in the base Medicare payroll tax rate. However, spurring wage growth certainly would help to generate more revenue for the Medicare Hospital Insurance Trust Fund, and contribute to preserving Medicare in future years.

However, the issue of workers' stagnant wages is extremely important, not only for Medicare's future and its availability for current workers but also, in a much broader sense, for the viability of the American Dream—if workers cannot count on rising wages, their path toward providing their families with a more secure future is made considerably more difficult. And this has a lot to do with the broader issue of what we spend on health care in this country, not only in Medicare but also throughout the health care sector.

For several decades, wage increases for American workers have been eaten away by the increasing cost of health care. Workers are affected by this phenomenon in three ways:

- Sharp increases in workers' premiums for employer-sponsored health insurance have taken a larger chunk out of workers' paychecks;
- Higher health care costs have increased spending on government health care programs, leading to higher tax burdens on both a federal and state and local level; and
- Higher health insurance premiums mean that employers have to devote a higher proportion of their employee costs to their share of premiums, rather than wage increases.

So, one way of spurring wage increases would be to find a way to slow the growth of health care costs. The U.S. currently spends almost 50 percent more on health care—both as a share of our economy and on a per capita basis—than any other country in the world. (At the same time, I would point out that most other high-income countries have older populations than we do, so the problem is not attributable solely to demographics.) Certainly, freeing up some of the \$42.2 trillion the U.S. is projected to spend between 2015 and 2024 would help reduce the burden on workers—as well as on businesses and all levels of government. In fact, if we were able to hold health care cost growth to the rate of growth in our economy as a whole—which would still represent a whopping 67 percent increase in health spending over that time period—we would free up almost \$5 trillion that could instead go toward wage increases, lower health insurance premiums, and reducing government budget deficits.

Thanks again for the opportunity to testify and to respond to these questions. I'm happy to respond to any follow-up or additional questions you may have.



To: Taylor Trott, Legislative Assistant, Subcommittee on Health, Committee on Ways and Means, United States House of Representatives.

From: Robert Emmet Moffit, PhD., Senior Fellow, The Heritage Foundation

Re: Response to Questions for the Record, House Subcommittee on Health, Hearing on "Preserving and Protecting Medicare", March 16, 2016.

Date: 4/13/16

The following are my responses to Members' Questions for The Record.

Representative Black of Tennessee.

Question: What ideas do you have for achieving a 15 percent reduction (in Medicare expenditures)? How do you balance the need to make these reductions in Medicare spending while preserving access and quality of care?

Answer: As you note, the Medicare program's long-term (75 year) unfunded obligations amount to \$27.8 trillion. In my testimony, I outlined four major structural changes that would go a long way to securing that objective. In response to your question, I am providing some preliminary estimates of the budgetary impact of these changes developed by the Heritage Foundation's Center for Data Analysis (CDA). But I hasten to add, as I noted in my testimony, that whether or not these specific changes could achieve the desired fiscal impact over the long-term should be validated by the Congressional Budget Office (CBO)), or perhaps the Office of the Actuary at the Centers for Medicare and Medicaid Services(CMS).

The first three of these changes are directly applicable to the existing traditional (fee for service) Medicare program: the combination of Parts A and B, along with reform of Medicare's cost sharing and Medigap coverage; raising the normal age of eligibility to age 68; and expanding the existing "means testing" in the Medicare Part B and D programs by lowering the income thresholds for the payment of higher premiums from \$85,000 to \$55,000 for single individuals, and from \$170,000 to \$110,000 for couples. With respect to "means-testing", these changes in the initial income thresholds would mean that the total number of upper income Medicare beneficiaries that would be required to pay higher than the standard premium rates would be increased from 6 percent to an estimated 10 percent of the total Medicare population, including an estimated 3 percent who would pay full premium.

The Heritage Foundation's Center for Data Analysis (CDA) has provided a preliminary set of estimates for budgetary savings over the years 2017 to 2026 of these structural changes. By combining Medicare Parts A and B, plus the proposed cost-sharing and Medigap reforms, CDA estimates the multi-year savings at \$98 billion. Expanding the "means testing"- that is, reducing the taxpayer subsidies for wealthy recipients enrolled in Medicare Parts B and D-

would yield an estimated \$538 billion. Raising the normal age of Medicare eligibility to 68 would yield \$370 billion.

Beyond these structural changes in the traditional Medicare program, I emphasized the long-term cost saving potential of expanding the defined contribution financing that already covers a majority of Medicare recipients in Medicare Parts C and D- Part D especially. The infrastructure of an expanded defined contribution program already exists with the administration of Medicare Parts C and D. Congress should be able to effect a full transition to such a program within three to five years. As is done today in Medicare Part D, for each Medicare beneficiary, the federal government would make a defined contribution - a fixed dollar amount - to a comprehensive, integrated health plan chosen by that Medicare beneficiary. The contribution would be based on a system of competitive bidding for the provision of today's Medicare Part A, B and D benefits. So the existing Medicare *guarantee* would be the very basis- not the antithesis- of a Medicare "premium support" program, meaning that the government's contribution would offset the premium cost of a person's chosen plan. If an enrollee purchased a more expensive plan than provided by the government contribution, the enrollee would pay an additional amount in premium. If the enrollee purchased a less expensive plan than afforded by the government contribution, the enrollee would be able to keep the difference in personal savings. In other words, with such a program, beneficiaries would be able to purchase even more than they do today with their Medicare dollars.

Once again, the size of potential savings would be based on the assumptions and the details of the premium support proposal. Over many years, there have been several variations, as you know, on this common theme, as well as various savings estimates. In 2013, CBO estimated that if the government contribution were to be based on an *average* bid among competing plans (like the formula that governs the FEHBP today), and applied to the current Medicare population, the savings over the period 2014-2023 would be \$69 billion. If the government contribution were based on the "second lowest" cost plan option, CBO estimated the savings over the same period to amount to \$275 billion.¹

The key is competition. Health plan options, competing on a level playing field, should include traditional Medicare fee-for-service (FFS). A revamped traditional Medicare, based on the integration and rationalization of benefits and cost sharing as I outlined in my testimony, would be armed with new flexibilities to compete directly and effectively with private plans. The competition would include Medicare Advantage (MA) plans, as well as various private and employment-sponsored plans. All plans would be required to offer catastrophic coverage; in other words, be *real* health insurance; and all plans would operate under improved risk adjustment, as well as the insurance marketing and rating rules that today govern MA plans. The

¹ Congressional Budget Office, "Options for Reducing The Deficit: 2014 to 2023," (November 2013), p. 204. <https://www.cbo.gov/sites/default/files/cbofiles/attachments/44715-OptionsForReducingDeficit-3.pdf>

competition among these plans would be intense. It would take place on a regional basis for most plans, but possibly even on a national basis for those insurers who wished to offer plans to compete in every part of America. In my view, these competitive plans should operate in a program administered much like private plans are today in the Federal Employees Health Benefits program (FEHBP), that today covers millions of federal workers and retirees.

Question: Given the fact that younger generations will not be paying as much as anticipated into the system, while drawing much more out of it, how is the HI Trust Fund impacted, and can we further state that Medicare's insolvency can be improved by jump starting wage growth?

Answer: A strong economy and rising wages increase revenues obviously enhance the solvency of the HI Trust Fund. Slow economic growth and a slow wage growth have the opposite effect. The HI Trust Fund, while just one marker of Medicare's overall financial health, is already deteriorating. According to the January 2016 CBO report, the positive balances in the Trust Fund are projected to steadily decline and the Fund will be exhausted in 2026.

In the short run, it appears that economic forces will not be enough to improve the health of the Trust Fund. CBO is now projecting relatively slow economic growth, as measured by GDP, declining from an estimated 2.7 percent this year to 2 percent in 2020, and growing at an average annual rate of just 2 percent over the period 2021 through 2026.² CBO reports, "That rate represents significant slowdown from the average growth of potential output that was observed during the 1980s, 1990s, and early 2000s; the slowdown results largely from slower projected growth in the nation's supply of labor."³ Moreover, CBO projects that "real labor compensation per hour" in the business sector of the economy will grow at an annual average rate of 2 percent between 2021 and 2026.⁴

In short, America is not going to "grow" out of the impending entitlement challenge. We must, therefore, focus on structural changes in the Medicare entitlement. Congresswoman Black, you are right to emphasize the role of the rising beneficiary life expectancy- a positive development. But an increasingly longer life in retirement, while the ratio of workers to retirees continues to shrink, continues to exert additional pressures on the Trust Fund. In 1965, when Medicare was enacted and the age of eligibility was set at 65, the average U.S. life expectancy was 70.2 years of age. Mortality rates, at every age, have fallen dramatically. Today, according to Census Bureau data, average life expectancy is 79.4 years, meaning that beneficiaries will experience 14.4 years on the Medicare program. That rises to 20.6 years in Medicare coverage by 2060, when the average life expectancy is projected to reach 85.6 years of age.

² Congressional Budget Office, "The Budget and Economic Outlook: 2016 to 2026," (January 2016), pp.6-7. https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51129-2016Outlook_OneCol-2.pdf

³ Ibid. p. 7.

⁴ Ibid. p.52.

Americans can work longer, expanding labor force participation and beefing up payroll tax revenues and delaying entitlement demands. Increasing the normal age of Medicare eligibility would make a positive contribution to the financial health of the HI trust fund. The National Bureau of Economic Research (NBER) recently published some impressive research showing that Americans have significant health capacity to work at older ages, with Americans in the top quartile of education showing the largest potential gains.⁵ There is, as I briefly mentioned in my March 16th testimony, already some progress in this direction. The NBER research, mainly focused on men, shows that for males aged 65 and older, labor force participation fell from 47 percent in 1948 to just 16 percent in 1993, but that labor force participation rose to 24 percent in 2013.⁶ A key implication of the data on work capacity in relation to health, according to their findings, is that the average number of years worked for men between the ages of 55 and 69 could increase “by at least” 2.5 years.⁷

Representative Price of Georgia

Question: Should Medicare beneficiaries be allowed the same access to life-saving technologies that is currently being used by the under 65 population?

Answer: Yes, of course. In the case of diabetes, the condition you cite, the total cost of diabetes, according to the American Diabetes Association, amounted to \$245 billion in 2012, including direct medical costs and indirect economic costs. Congressman Price, your example of seniors not having Medicare access to continuous glucose monitors (CGMs), a medical technology today covered by 95 percent of private health plans, is therefore particularly apt. But it is only a recent example of the often radical discontinuity of care and coverage that occurs simply because a person turns age 65.

As far back as 2000, the Lewin Group, a nationally prominent econometrics firm modeling health care policy proposals, found that the cumbersome process for determining coverage, coding and payment levels continued to delays in the provision of new medical technologies. The Lewin analysis then found that the addition of new technologies in the program took anywhere from 15 months to five years. More recently, writing in the April 11, 2016 edition of *The Wall Street Journal*, Scott Gottlieb M.D. cites the problem that Medicare beneficiaries today face securing broader access to aortic heart valves - approved by the FDA

⁵ Courtney Coile, Kevin Milligan and David A Wise, “Health Capacity to Work at Older Ages: Evidence From the U.S.,” National Bureau of Economic Research, *Working Paper* 21940, January 2016, <http://poseidon01.ssrn.com/delivery.php?id=174093090115100066024067086092101027020072023065091036126000048061048123068047080011049095104064080112099118021049018096007001068088019125115003097029075126030031111028110077103003103100086118073&EXT=pdf>

⁶ *Ibid.*, p. 4.

⁷ *Ibid.*, p. 24.

back in 2011 and validated by peer review studies in scientific journals- because Medicare's current rules impede their wider use among seniors. It may well serve Congress to have the Government Accountability Office undertake a comparative analysis of access to medical technologies in private health plans, Medicare Advantage enrollees in traditional Medicare.

With a premium support system of financing, it is more likely that a person would be able to keep their private coverage or employment-based coverage, assuming it meets Medicare's basic insurance requirements. Seniors would secure offsetting Medicare payments for that plan, and thus keep that plan, and its benefits, covered medical procedures, technologies and provider networks. In other words, we should expand the opportunity for seniors to keep the coverage that they have and they like before retirement, and enable them to take it with them into retirement, wherever possible.

With the maturation of the competitive Medicare programs, Medicare Parts C and D, we are getting a much better idea of the performance of programs driven by consumer choice on cost and outcomes. In the case of Medicare Part D, which provides seniors with broad array of drug therapies, greater access to drug therapy has been correlated with reduced hospitalization and nursing home care. Research has also shown that access to prescription drugs, appropriately prescribed, of course, has been associated with a decline in other medical spending, including hospital emergency room spending.⁸ Likewise, the Medicare Advantage program has expanded access to medical treatments, therapies and technologies. As stated in my testimony, I believe we need to go a step further, however, and broaden choice and access further by expanding the financing arrangement that today characterizes Medicare Part D.

Question: Do you think that these technologies, which involve an initial cost investment, will help to improve the quality of life of beneficiaries, while also working to save Medicare dollars in the long run?

Answer: Yes. Modern medicine has been characterized with impressive advances in technologies - including pharmaceutical therapies, diagnostic screenings and improved surgical interventions. Medical technology obviously increases health care costs, particularly at the inception of its use, as is the case with virtually all new technologies in every sector of the economy. As a general rule, medical technologies, with some exceptions, have been worth that initial cost. It is also safe to say that the nation will not save Medicare dollars by denying persons access to advanced medical technologies that will improve their health and their quality of life, and also reduce medical complications, needless suffering, the incidence of preventable medical conditions and hospital readmissions. In either case, whether the initial cost is high or low is a secondary question. The more important question, over time, is this: Are we getting value for our health care dollars?

⁸ See J.M. McWilliams, "Implementation of Medicare Part D and Nondrug Medical Spending For Elderly Adults with Limited Prior Drug Coverage," *Journal of the American Medical Association*, 306, (2011): 402-409.

In certain cases, the positive results of technological interventions are beyond dispute, because they reduce both direct (additional or long-term medical care) and indirect costs (lost income or productivity). In a 2013 study of the impact of corneal transplants, for example, the Lewin Group, for example, found that an “average person” whose vision has been restored through such a transplant would avoid \$214,000 in indirect costs(such as lost employment or productivity) over the course of a lifetime. Because three out of four patients getting such a transplant are over 65 (mostly Medicare patients), the direct medical benefit to a beneficiary would be \$67,000 in direct cost savings from the avoidance of blindness.⁹ Needless to say, a person’s sight is priceless.

On this general topic of medical technology and value for health care dollars, there is impressive professional literature. In 2001, Professor David M. Cutler of Harvard University and Dr. Mark McClellan, former Administrator of CMS, writing in *Health Affairs*, examined the costs and benefits of technology for five medical conditions: heart attacks, low birthweight babies, depression, cataracts, and breast cancer. For the technological changes in breast cancer screening, they found the benefits “roughly equal” to the costs. They also found that the cost of the medical technologies for treating the first four of the conditions was high, but the health benefits of those technologically-driven treatments were even greater. They conclude: “Although we analyze only some conditions, our results have implications for the health care system more broadly. The benefits from lower infant mortality and better treatment of heart attacks have been sufficiently great that they alone are about equal to the entire cost increase of medical care over time. Thus, recognizing that there are other benefits to medical care, we conclude that medical spending as a whole is clearly worth the cost.”¹⁰ In a 2006 study, published in *New England Journal of Medicine*, Professor Cutler and his colleagues wrote: “Our primary conclusion is that although medical spending has increased over time, the return on spending has been high. In considering health policy, the concern about high medical costs needs to be balanced by the benefits of the care received.”¹¹

⁹ The Lewin Group, “Cost Benefit Analysis of Corneal Transplant,” September 9, 2013, <http://www.restoreight.org/wp-content/uploads/2014/03/Lewin-Study-Sept-2013.pdf>

¹⁰ David M. Cutler and Mark McClellan, “Is Technological Change in Medicine Worth It?” *Health Affairs*, Vol. 20, No. 5 (2001), pp. 11-25, <http://content.healthaffairs.org/content/20/5/11.full>

¹¹ David M. Cutler Ph.D., Allison B. Rosen, M.D., and Sandeep Vijan, M.D., “The Value of Medical Spending in The United States, 1960-2000,” *The New England Journal of Medicine*, 355: :920-927, August 31, 2006, <http://www.nejm.org/doi/full/10.1056/NEJMsa054744>

[Submissions for the Record follow:]



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March 30, 2016

The Honorable Pat Tiberi
Chairman
Subcommittee on Health
Committee on Ways & Means
U.S. House of Representatives
Washington, DC 20515

The Honorable Jim McDermott
Ranking Member
Subcommittee on Health
Committee on Ways & Means
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Tiberi and Ranking Member McDermott:

On behalf of AARP and millions of Medicare beneficiaries, thank you for holding a hearing on March 16, 2016, to discuss preserving and strengthening Medicare. AARP, with its nearly 38 million members in all 50 States and the District of Columbia, Puerto Rico, and U.S. Virgin Islands, is a nonpartisan, nonprofit, nationwide organization that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse. We agree the high cost of health care generally needs to be brought under control in order to preserve access to and the affordability of Medicare for future generations. Growing spending on health care has strained the Medicare Hospital Insurance Trust Fund (Part A) and has required an increasingly larger portion of general revenues (Parts B and D). We are concerned, however, that some of the options discussed by the Committee do not address the underlying causes of high health care spending. Instead, they merely shift the financial burden onto older Americans and others who depend on Medicare for their health security.

In addition to high health care costs, increased Medicare expenditures are due primarily to a growing Medicare population. Spending per beneficiary has actually grown slower than both GDP and private insurance in recent years. Proposals which force beneficiaries to pay more, without improving the value and quality of care received, essentially punish the beneficiary for being sick. Moreover, when half of all beneficiaries earn less than \$24,150 per year and already spend 18% of their income on health care expenses, adding to their personal costs is no solution – it simply shifts costs and reduces access to care. Some of the ideas discussed in the hearing – increasing cost-sharing; increasing income-relating of premiums; and raising the age of eligibility – are prime examples of shifting costs to beneficiaries without addressing the causes of high health costs.

First, when confronted with paying a deductible or copay, the patient considers whether to utilize the service or not. If the provider orders a test, the patient either accepts the doctor's advice or chooses to forgo care. The individual, or their caregiver, is not thinking about finding a better

Alaska | Arizona | Arkansas | California | Colorado | Connecticut | Delaware | District of Columbia | Florida | Georgia | Hawaii | Idaho | Illinois | Indiana | Iowa | Kansas | Kentucky | Louisiana | Maine | Maryland | Massachusetts | Michigan | Minnesota | Mississippi | Missouri | Montana | Nebraska | Nevada | New Hampshire | New Jersey | New Mexico | New York | North Carolina | North Dakota | Ohio | Oklahoma | Oregon | Pennsylvania | Rhode Island | South Carolina | South Dakota | Tennessee | Texas | Utah | Vermont | Virginia | Washington | West Virginia | Wisconsin | Wyoming

deal elsewhere. Once engaged with their physician, the patient usually follows the doctor's advice. Seldom do beneficiaries second-guess the doctor's decision as to the necessity of the service. Moreover, the notion that Medicare beneficiaries deliberately over-utilize the health system, and that having "more skin in the game" would lead to better choices, ignores the role providers play in influencing their patients. Increased cost-sharing may reduce utilization, but it reduces both necessary and unnecessary care. Patients forgoing necessary care due to higher cost may end up costing Medicare more in the long run.

Second, raising the applicable percentage amount for premiums or expanding income-relating to 25 percent of the beneficiary population is a direct cost-shift felt hardest by the middle class. To put this in perspective, presently only 5 percent of beneficiaries reach the income threshold for higher premiums. If a 25-percent quota were instituted, as some have recommended, the threshold would have to be set under \$50,000 (instead of the current \$85,000). This income related payment would be in addition to the existing tax paid to Medicare by middle-income Social Security beneficiaries with incomes over \$34,000 (\$44,000 couple filing jointly) – aside from premiums and other cost-sharing, middle class beneficiaries above these thresholds continue to finance Medicare during their retirement through a dedicated income tax – paid to Medicare – on up to 35 percent of their Social Security benefit.

Moreover, when determining who is subject to the income-related premium, the Medicare program relies on the beneficiary's tax return from the prior year (which reports income from the year before). Thus, new retirees (whose income is likely to have dropped precipitously from their working years) would be subject to higher income-related premiums based on their previous wages, not their current financial situation.

Unfortunately, a common refrain among proponents of greater cost-sharing is Medicare beneficiaries receive three times more in benefits than they contribute. Such a dollar-in/dollar-out assessment of the Medicare program is limited and inaccurate. Mainly, the "average" lifetime benefit does not reflect any individual's circumstances. We know, for instance, the small percentage of beneficiaries with multiple chronic conditions use a significant percentage of Medicare resources. In fact, recent numbers indicate Medicare spending on those with even one chronic condition is 5.4 times greater in Part A and 2.35 times greater in Part B compared to beneficiaries without chronic conditions.¹ The few high-cost beneficiaries skew the average. Thus, most beneficiaries never reach the "average" lifetime benefit.

Also, the spending numbers do not reflect value. Some experts have argued that up to 30 percent of Medicare spending is wasteful and does little to improve health. These lifetime benefit estimates, therefore, include wasteful spending. The problem with concentrating on the gap between contributions and benefits is it inevitably calls for either increasing taxes or cutting benefits, or both, without addressing the underlying inefficiencies in the system. Instead, we must focus on responsible solutions to get better value for our health care dollars. As the health care system embraces the goals of better care, better health, and lower costs, the gap between the lifetime amount of Medicare contributions paid and benefits received will likely fall.

Third, raising the age of Medicare eligibility would likely do more harm than good by raising per capita Medicare costs. Removing the youngest and healthiest older Americans from the Medicare risk pool will result in higher premiums for those remaining in the program. It would also raise costs for the 65 and 66 year olds no longer eligible, as private insurance for 65 and

¹ Centers for Medicare and Medicaid Services; *Medicare & Medicaid Research Review*. Medicare Payments: How Much Do Chronic Conditions Matter? 2013, volume 3, number 2.

66 year olds costs more than Medicare. Even in the Marketplaces, seniors will pay three times more for insurance than younger individuals. Raising the Medicare eligibility age would also raise costs for businesses in the private insurance market, because adding older individuals to private insurance risk pools will skew health care costs higher, raising everyone else's premiums and employer health care costs.

Medicare and Social Security are not the same, and should not have the same eligibility age. While eligibility for full Social Security retirement benefits is being raised to 67 years old, people may also choose to accept a lesser benefit amount beginning at age 62. Most beneficiaries choose to receive Social Security before the age of 65.

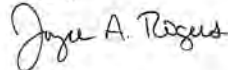
Finally, we have concerns with proposals to move Medicare from a defined benefit to a defined contribution program. Proposals that have been discussed in the past have not adequately considered how the federal contribution, or premium support amount, would keep pace with health care costs. Nor has enough consideration been given to ensuring Medicare beneficiaries, particularly low-income beneficiaries, have access to high-quality, low-cost options.

We recognize that changes need to be made to Medicare in order to preserve and strengthen the program now and for future generations. However, we reject the notion that this must be done on the backs of older Americans who have paid into the program their entire working lives and now rely on it for their health security.

Instead, Congress should continue to focus on and support improvements to our health care quality and coordination infrastructure. AARP was proud to work with you, and your colleagues in the House and Senate, to reform the physician reimbursement system. The Merit-based Incentive Payment System and the development of alternative payment models will shift Medicare from volume-based payments to value-based payment. This has tremendous power to improve care and lower costs to the program. In order to reach its full potential, though, Congress must give health care providers and consumers the necessary tools. This includes greater data availability to make better decisions; more and improved quality measures; and the removal of restrictions which hinder the use of telemedicine and technology to improve care access and delivery.

AARP looks forward to working with you to improve Medicare, for example, by improving care coordination, expanding technology, and lowering the high prices of prescription drugs. Ultimately, the greater the value and quality of care is, the lower the cost to both taxpayers and beneficiaries. Please feel free to contact me or have your staff contact Ariel Gonzalez of our Government Affairs staff at agonzalez@aarp.org or 202-434-3770 if you have any questions.

Sincerely,



Joyce A. Rogers
Senior Vice President
Government Affairs



Statement for the Record

by the

**American Federation of State, County and
Municipal Employees (AFSCME)**

for the

Hearing on Preserving and Strengthening Medicare

**Before the Subcommittee on Health
Committee on Ways and Means**

U.S. House of Representatives

March 16, 2016

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by the
American Federation of State, County and Municipal Employees (AFSCME)
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Before the
Subcommittee on Health
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This statement is submitted on behalf of the 1.6 million working and retiree members of the American Federation of State, County and Municipal Employees (AFSCME) for the hearing held March 16, 2016 on Preserving and Strengthening Medicare.

For 50 years Medicare has helped millions of older Americans and individuals with disabilities see a doctor and get hospital care. AFSCME is proud of our history of supporting Medicare and protecting it for generations to come. Its guaranteed benefits protect seniors and their families from crushing health care costs. After years of work, beneficiaries have earned Medicare benefits. Yet, Medicare benefits can be expanded and improved to help current and future beneficiaries. AFSCME strongly opposes proposals to gut Medicare's guaranteed benefits, calls for deep Medicare cuts, and efforts to turn Medicare into a voucher program.

Strengthen – Not Repeal – the Affordable Care Act Improvements to Medicare

• **Close the Coverage Gap in Prescription Drugs *Faster***

In the past, as many as one in four seniors went without a prescription every year because they couldn't afford it. The Affordable Care Act (ACA) helps seniors have more affordable access to medications through Medicare Part D prescription drug coverage. It does so by gradually closing the gap in coverage where beneficiaries had to pay the full cost of their prescriptions out of pocket before catastrophic coverage for prescriptions took effect. The gap is known as the donut hole. The ACA closes the donut hole by 2020. Thanks to the ACA's required prescription drug discounts nearly 10.7 million people with Medicare have saved over \$20.8 billion on their medications. In 2015 alone, nearly 5.2 million seniors and people with disabilities received discounts of over \$5.4 billion, for an average of \$1,054 per beneficiary.

We urge Congress to accelerate the required prescription drug discounts to close the gap in coverage under Part D more quickly. Such a proposal is in the President's fiscal year (FY) 2017 budget. It would save Medicare \$10.2 billion over 10 years and help millions of beneficiaries have more affordable access to the medications they need.

• **Build Upon the ACA's Benefits to Medicare Preventive Screenings**

The ACA improved access to life-saving preventive services. Before the ACA, seniors had to pay part of the cost of recommended preventive screenings. This created a financial stumbling block for many seniors and prevented them from accessing key cancer screenings and immunizations. Now these and other preventive services have no deductible or co-payment.

Thanks to the ACA, some 39.2 million people with Medicare (including those enrolled in Medicare Advantage) took advantage of at least one preventive service with no co-pays or deductibles in 2015.

The preventative screening benefit under the ACA can be strengthened. For example Medicare beneficiaries are not subject to the part B deductible or co-insurance for recommended screening colonoscopies. If, however, the screening colonoscopy results in the removal of a polyp or other procedure, then beneficiaries are subject to the 20% co-insurance. **We urge Congress to remove a significant barrier to vital colon cancer screening by eliminating the Medicare co-insurance when the colonoscopy screening results in the removal of a polyp or other procedure.**

- **Protect Seniors and Medicare From the Worst Abuses of Private Insurers**

Medicare provides what commercial health insurance companies did not, would not, and could not; affordable, adequate health coverage for America's elderly population regardless of income or health status. Before the enactment of Medicare in 1965, only half the population age 65 and older had health insurance and, those who did have coverage, paid close to triple what younger people paid for premiums and other out-of-pocket costs.

Despite the reasons for the establishment of Medicare, Congress has nonetheless allowed private insurance companies to offer Medicare beneficiaries insurance policies that replace the benefits Medicare provides. Insurers are paid by Medicare to provide these benefits. Since the 1980s Medicare's private insurance program has had several variations and has been called the Medicare Risk Program, Medicare+Choice and now Medicare Advantage (MA). By any name these are private insurance plans offered as a substitution for traditional Medicare. They are not a supplemental plan and do not have the guarantees inherent in traditional Medicare.

The ACA protects seniors and Medicare from the worst abuses of private insurers. In the years before the ACA, these private insurance companies preyed on seniors with abusive marketing and sales tactics, they were inefficient, they did not provide improved care to justify the excessive cost, and they were largely unregulated. Extra payments to Medicare Advantage plans, enacted as part of the Medicare Modernization Act of 2003, were contributing to projections of future shortfalls in the Health Insurance Trust Fund as well as adding to the costs of Part B for both Medicare and its beneficiaries.

The year before the enactment of the ACA, MA plans were being paid on average \$1.14 for what it would cost traditional Medicare \$1.00 for the same beneficiaries. These extra payments put added strain on the Medicare trust fund and beneficiaries' budgets. In 2009, these extra payments meant an extra \$1,280 per MA enrollee or \$14 billion in higher aggregate payments from Medicare funds. A couple with traditional Medicare paid \$86 more in their Medicare premiums to fund these extra payments to insurance companies. From 2004 to 2009, these overpayments cost the Medicare program nearly \$44 billion.

The ACA addressed significant problems with the MA program and makes necessary improvements in MA beneficiary protections.

- The ACA changed Medicare payment policies to reward high-value – not high-volume – care.
- The ACA changed how Medicare pays MA plans by scaling back the overpayments and established policies so that the payments made to MA plans are close to payments and costs in traditional Medicare.
- The ACA makes changes to MA so that plan payments are done gradually and are phased in over nearly a decade so plans have time to adopt needed efficiencies.
- The ACA also forbids these private insurers from charging higher co-payments than traditional Medicare. This is particularly important to sicker beneficiaries.
- The ACA also stops MA plans from spending too much of premium dollars on overhead expenses, such as CEO salaries and perks, marketing, profits, administrative costs, and agent commissions. Insurers must use at least 85 cents out of every premium dollar to pay medical claims and provide activities that improve the quality of care.
- The ACA eliminates out-of-pocket costs for Medicare beneficiaries enrolled in MA plans or traditional Medicare for important preventive services, like mammograms, prostate cancer screenings, colonoscopies or key immunizations.
- The ACA sets up new initiatives to improve the quality of MA plans.

▪ **Ensure MA Plans Offer Beneficiaries Adequate Provider Networks**

For more than half a century Medicare has meant retirees can see a doctor when needed. Traditional Medicare does not have a “network.” Referrals are not needed to see specialists and there is no prior authorization required to obtain services.

For some beneficiaries, moving into a Medicare Advantage plan can change access to their doctors for the worse. The MA plan may limit seniors to using a network of specific providers in order to have coverage for their care. Some MA plans may cover care outside of the network, but at a cost. Plans may only cover emergency and urgent care if a senior is out of the service area. The senior must return to the service area for follow up or routine care. Network providers can join or leave a plan’s provider network anytime during the year but, generally, seniors must wait until the next year’s open enrollment period to opt to leave the plan. The MA plan can also change the providers in the network anytime during the year. Network adequacy can be a problem with MA plans.

According the non-partisan and independent Government Accountability Office, report issued in August 2015, the federal agency charged with oversight of MA plans, Centers for Medicare & Medicaid Services (CMS) has had significant gaps and consumers may find themselves without adequate provider networks or accurate information about the networks.

MA provider networks must meet two criteria: a minimum number of providers and maximum travel time and distance to those providers. MA plans do not have to meet important aspects of provider availability – such as how often a provider practices at a given location. This is in contrast to how Medicaid and TRICARE use provider availability measures to assess network

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adequacy. For example, Medicaid managed care rules address providers' ability to accept new patients and TRICARE looks at appointment wait times for active duty service members. MA provider networks may inaccurately appear to CMS and beneficiaries as more robust than they actually are because they do not take availability into account. Indeed from 2013 to 2015, CMS reviews amounted to less than 1% of all networks and those did little to assess the adequacy of network data claimed by the MA plan before it enters a new market area. As a result GAO found that beneficiaries and CMS cannot be confident that MA plans meet network adequacy criteria.

For established MA provider networks, MA plans do not need to submit updated network data for review. Retirees will have no assurance that their plan's networks will continue to be adequate and provide sufficient access for them. An MA plan's providers may change at any time and plans do not have any CMS review of ongoing network adequacy against current MA criteria. GAO also found that seniors cannot be assured that MA plans will give them clear, accurate and consistent information when a provider contract is terminated.

Seniors deserve accurate and meaningful information on network adequacy and CMS must have the capacity to hold MA plans accountable for networks adequacy.

Cover Dental, Vision and Hearing Benefits

Medicare does not pay for routine eye or hearing exams even though vision and hearing difficulties increase with age. Untreated hearing loss can lead to depression, decreased mobility, social isolation, fatigue, cognitive decline and even dementia. Yet, Medicare does not cover routine hearing exams, hearing aids, or exams for fitting hearing aids. One in three people ages 65 to 74 have difficulty hearing. The number is higher at 75 and older. It's time for Medicare to cover basic hearing care and aids. It's also time for Medicare to cover routine eye care and glasses.

Medicare does not pay for most dental care, dental procedures, tooth extractions, or dentures. This is bad for beneficiaries' health because gum disease is linked with inflammation and conditions such as diabetes, heart disease, stroke, and respiratory problems.

It is time for Congress to expand Medicare's guaranteed coverage to include hearing, vision and dental care for all beneficiaries.

Change Laws that Allow Pharmaceutical Companies to Overcharge Medicare

AFSCME has long supported tackling escalating prescription drug prices by leveraging the collective buying power of Medicare. One in five seniors taking prescription medicine report difficulty paying for their drugs. Among seniors taking four or more medications, the share rises to nearly one in three. We urge Congress to strengthen Medicare by combatting the ways in which pharmaceutical manufacturers can overcharge Medicare, taxpayers and beneficiaries. Medicare prescription drug spending was \$143 billion in 2014. Prescription drug spending in Medicare Parts B and D was 14 % of total Medicare spending in 2014, up from 11 % in 2010 – just five years ago.

We urge Congress to enact the following policies to strengthen Medicare with respect to the pharmaceutical industry's ability to overcharge Medicare.

- **End drug overcharges for low-income beneficiaries.**
When Medicare Part D was implemented, the cost of providing medicines to millions of people on Medicaid shot up overnight. Medicaid gets far lower drug prices than Medicare. But Medicare Part D told the pharmaceutical industry they no longer had to provide the Medicaid discount for the same people who were shifted to Medicare Part D plans. Ending this "legal" windfall for the drug industry would recover more money for Medicare than even record-breaking fraud recoveries. Restoring the Medicaid discounts for Medicare's low-income beneficiaries would save \$121.3 billion over 10 years.
- **Unleash the purchasing power of 50 million Medicare beneficiaries.**
Current law forbids Medicare from using the purchasing power of nearly 50 million Medicare beneficiaries to negotiate directly with drug companies for lower prices. The discounts obtained by private Medicare Part D plans are three times less than the ones the government gets for Medicaid. Even modest concern over Medicare's solvency and the use of taxpayers' dollars should compel Congress to give Medicare tools to pursue lower drug prices for the program. Estimates are that Medicare could save more than \$200 billion over 10 years.
- **Close the Part D coverage gap, sooner.**
As mentioned before, increasing the drug-maker discounts required by the ACA would shorten the donut hole phase-out period.
- **Stop drug manufacturers from postponing generic entry into the market.**
Many brand-name pharmaceutical manufacturers pay off generic drug companies to delay introducing a less expensive generic drug or biologic, which keeps brand name prices artificially high for Medicare and its beneficiaries. Authorizing the Federal Trade Commission to stop these anti-competitive and wasteful pay-for-delay agreements would save Medicare \$12.3 billion over 10 years. It would also help federal and state Medicaid costs.
- **Stop allowing drug companies to charge more for new drugs that are no better than current medicines.**
Countries such as Germany, New Zealand and Australia have successfully used a review process to reduce spending on expensive new drugs. Under the administrative processes new brand name drugs that are no more effective than existing treatments do not receive additional payments from those countries' health care programs. This process encourages pharmaceutical companies to invest in innovative drugs that improve health outcomes.

Changes to Medicare Should be Aimed at Improving Coverage, Not Deficit Reduction

We urge Congress not to embrace Medicare benefit design proposals that merely disguise shifting costs onto beneficiaries or employers who provide retiree coverage or make health care unaffordable for the majority of seniors and individuals with disabilities. While the details may

vary, the underlying premise of many benefit redesign proposals is to increase out-of-pocket costs for beneficiaries. The pretense of these proposals is that Medicare beneficiaries are over-insured and increased cost sharing is an appropriate means of limiting unnecessary health care services. As Congress looks at beneficiary cost sharing within the Medicare program, the focus must be on expanding benefits and reducing beneficiary costs.

Half of all people with Medicare live on incomes of less than \$22,000 per year. Medicare households spend 15% of income on health care costs compared to the just 5% spent by non-Medicare households. In short, Medicare beneficiaries are often forced to choose between basic expenses (like food and rent) or getting the medical care they need. Increasing out-of-pocket health care costs for beneficiaries will jeopardize the health of seniors and individuals with disabilities who rely on Medicare.

Further increasing beneficiary cost sharing (either directly or by further constraining supplemental policies that cover Medicare cost sharing) is a misguided approach to benefit redesign because it will limit beneficiary access to necessary care.

Building in extra costs and charges for beneficiaries is a blunt and inefficient tool for cutting costs. In reducing utilization, it will prevent beneficiaries from getting the appropriate care they need. This troubling implication is acknowledged by the Medical Payment Advisory Commission (MedPAC) in its June 2012 benefit redesign proposal. The National Association of Insurance Commissioners (NAIC) has strongly recommended against further cost sharing to Medicare supplemental insurance policies, known as Medigap plans, because of the harm to the health of beneficiaries and the Medicare program in the long run.

The classic RAND Health Insurance Experiment, which did not include Medicare beneficiaries, found that reduced use of services resulted primarily from participants deciding not to initiate care. But it reduced both needed and unneeded health care services. Once patients entered the health care system, cost sharing had a limited effect on intensity or cost of an episode of care. The study also found that the absence of cost sharing (free care) improved the control of treatable chronic diseases such as hypertension, and improved the mortality of patients, especially for the poorest patients in the experiment. The implication from this study is that reducing costs for treatable conditions can save lives and that cost sharing is an unreliable tool for reducing health care use.

It seems dubious at best (and potentially cruel at worst) to ask beneficiaries to second-guess their doctor's recommendations or to shoulder the full responsibility of evaluating the extent to which they need medical care in the first place. Increasing cost sharing does more harm than good for the very sick, for the old and for the poor. While asking beneficiaries to pay higher co-pays or co-insurance may reduce federal expenditures in the short run, it simply moves these costs from the government onto beneficiaries.

Increasing cost sharing focuses on the wrong problem as a means of curbing overall health care costs and is not likely to remedy high costs. As compared with other industrialized nations, our high medical spending is driven by high prices, not high utilization. Raising the out-of-pocket

costs on beneficiaries will not reduce high medical prices. Indeed, providers may increase prices if utilization drops.

Reject Proposals to Increase Means Testing for Premiums or Out-of-Pocket Costs

The bulk of Medicare Part B is financed through federal income taxes, which, although far from perfect, is a progressive tax on all Americans, including upper-income elderly. By the time higher-income Americans are eligible for Medicare benefits they have already paid far more into the program than lower income Americans.

We are concerned that proposals to further increase income-related Medicare premiums is in conflict with the fundamental principles that have made Medicare a popular, relatively stable and amazing success story for the millions of Americans it has covered over nearly a half-a-century. When former President Harry S. Truman became the first Medicare beneficiary, he was part of a program deliberately designed to embrace seniors rich and poor, sick and healthy. It was and should be a program that unites Americans.

Introducing steep income-related premiums will give healthier seniors an incentive to opt out of Part B, which undermines the Medicare diversified risk pool and widespread support. This would likely lead to a vicious dynamic of higher premiums and further departures from the program, leaving middle-income seniors at the mercy of private insurers. Moreover, if the proposal to set a quota of having one in four beneficiaries paying an income-related premium were implemented today beneficiaries with income of as low as \$47,000 would be impacted.

We question whether the added burden on these individuals, the administrative aggravation and harmful erosion on Medicare's founding principles and consequent undermining of Medicare's popular support is worth this modest amount of revenues that would be generated. Making wealthier individuals and profitable corporations pay their fair share through federal income tax, not Medicare premiums, is a sounder path for combining our nation's resources to spread the costs and risk of health care coverage for Medicare beneficiaries.

Medicare Should Not Expand Balance Billing

Currently, Medicare shields beneficiaries from unexpected and limitless charges by prohibiting the vast majority of doctors from billing patients more than the amount Medicare pays for services. Without current protections, beneficiaries would face the burden of higher doctors' bills, which would create a real barrier to getting health care.

Maintaining the requirement that participating physicians cannot charge beneficiaries more than Medicare reimbursements, and non-participating physicians have a cap on the additional charges for Medicare covered services, is particularly important for a population that cannot afford more cost sharing. Most Medicare beneficiaries have low incomes and spend a larger portion of their household income on health care.

Most Medicare beneficiaries already spend a larger share of their income on health care costs than those not on Medicare. Most Medicare beneficiaries are not in a position to earn more

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income to pay for higher doctors' bills. Current Medicare law helps keep costs for Medicare beneficiaries predictable and affordable. The fact that 96% of doctors fully participate in Medicare indicates that the current law has achieved the right balance between fair payments for doctors and affordability for patients.


Eliminating or eroding the protections from balance billing harms the very foundation of Medicare to provide guaranteed benefits regardless of a beneficiary's health status or income. Allowing unfettered balance billing will turn Medicare into a class-based program. Patients with resources will be seen by doctors who use balance billing and doctors who decide to forgo or strictly limit balance billing will be left caring for lower-income patients.

We urge Congress not to divide the Medicare population and harm Medicare's core principle of universality by eroding or eliminating the current billing protections in Medicare.

Conclusion

Medicare is an amazing American success story. It has opened doors to health care and given peace of mind to hundreds of millions of older people, people with disabilities, and their families. Medicare gives American workers the knowledge that after a lifetime of hard work and paying into the system, they will have access to quality health care and will not face financial ruin from injury or illness.

This landmark law can be strengthened by filling in its coverage gaps and reducing costs for current and future beneficiaries. Congress should not undermine Medicare by gutting Medicare's guaranteed benefits or turning Medicare into a voucher program. We look forward to working with Congress to protect and strengthen Medicare.





STATEMENT FOR THE RECORD
SUBMITTED TO THE U.S. HOUSE OF REPRESENTATIVES
WAYS & MEANS COMMITTEE
SUBCOMMITTEE ON HEALTH

HEARING ON

"PRESERVING AND STRENGTHENING MEDICARE"

MARCH 16, 2016

ALLIANCE FOR RETIRED AMERICANS
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The Alliance for Retired Americans appreciates the opportunity to submit comments to the Committee on Ways and Means Health Subcommittee on the hearing titled, "Preserving and Strengthening Medicare." While the Alliance encourages Congress to examine ways to improve Medicare's benefits and its finances, we have real concerns with proposals that shift costs to beneficiaries.

Founded in 2001, the Alliance is a grassroots organization representing more than 4.3 million retirees and seniors nationwide. Headquartered in Washington, D.C., the Alliance and its 35 state chapters work to advance public policy that strengthens the health and economic security of older Americans by teaching seniors how to make a difference through activism.

Before discussing any proposal, one must consider who would be impacted by such policy. While many in Congress believe that Medicare beneficiaries are well off and can afford to pay a little more, it is important to note that only 5% of Medicare beneficiaries are considered higher income -- meaning they have incomes of \$85,000 or above -- and those beneficiaries already pay more for their Part B and Part D premiums. Half of all Medicare beneficiaries have annual incomes under \$24,150 and one quarter of beneficiaries have annual incomes under \$14,350. Unfortunately, the future is not any better. In 2030, it is estimated that half of all Medicare beneficiaries will live on annual income of \$28,450 or less. Older adults also spend three times (14 percent versus 5 percent respectively) as much on medical expenses than does the average household. Given this sobering reality, it is difficult to comprehend how anyone can expect Medicare beneficiaries to pay more.

During the March 16th hearing, several proposals were discussed as ways to reduce costs in the program, including Medicare Advantage, premium support, raising the age of eligibility, more means testing and Medicare redesign. All these proposals shift costs on to beneficiaries while doing nothing to reduce the cost of health care. Please allow us to share our concerns.

Medicare Advantage

During the hearing, Medicare Advantage (MA) was touted as providing beneficiaries with good quality care and keeping costs down. However, MA plans have historically been paid more than traditional Medicare. Prior to the Affordable Care Act (ACA), the overpayment also raised Part B premiums for seniors and the disabled, including those not on MA plans, by \$90 a year per couple. The ACA restructured government payments to MA plans to keep it more in line with that of traditional Medicare. However, MA plans that provide good quality care are paid bonuses that allow them to continue to receive higher reimbursements.

Premium Support

This proposal fundamentally alters the 50-year old Medicare program. While supporters assert that this proposal will continue to offer beneficiaries access to traditional Medicare, experience with MA plans has shown that private plans tend to siphon off healthier beneficiaries leaving the sickest and most frail beneficiaries in the Medicare program. While the premium support model recognizes this and does provide for some risk adjustment – adjusting payments to reflect the average health status of enrollees – the increased payment will be insufficient to cover the full increase in costs. Over time, costs under traditional Medicare will become so expensive that it will be unsustainable.

Raising the Age of Eligibility

This proposal is a lose-lose proposition for older Americans. A 2014 Kaiser study found that if Medicare beneficiaries who are 65 and 66 years old were forced to purchase insurance in the individual market, two in three beneficiaries would pay an average of \$2,200 more for their health care. While Medicare would generate a savings of \$5.7 billion in net savings raising the eligibility age would increase out-of-pocket costs for beneficiaries by \$3.7 billion and increase costs to employers who provide retiree coverage by \$4.5 billion. In addition, the Part B premiums of those beneficiaries 67 years and older who remain in Medicare would rise by three percent as the younger and healthier beneficiaries are removed from the Medicare risk pool.

More Means Testing

Most Medicare beneficiaries, through their premiums, pay 25% of the cost to provide care under the Medicare Part B and Part D programs. However, five percent of Medicare beneficiaries are considered higher income – individuals with incomes above \$85,000 and couples with incomes above \$170,000 – and pay higher Part B and Part D premiums. Last year's SGR bill further increased premiums for these beneficiaries. There are various proposals that would require these beneficiaries to pay even higher premiums and in some cases pay 100% of the costs under Part B and Part D. We are opposed to further means testing these beneficiaries which would destroy the universality of the program and erode public support. Other proposals would gradually increase the number of Medicare beneficiaries paying higher premiums until one out of four are paying higher premiums. According to a 2013 Kaiser study, if this policy were in effect today, it would affect seniors with incomes of \$47,000 and above. The Alliance opposes this policy which would hurt middle income seniors.

Medicare Redesign

The Alliance views the combined deductible proposal as a huge cost shift to beneficiaries who are relatively healthy and do not need hospital services. According to

data from Centers for Medicare and Medicaid Services (CMS), in 2006, only 17% of beneficiaries had hospital visits. If the combined deductible had been in place then, 83% of Medicare beneficiaries would have paid a higher deductible. At the hearing, Dr. Moffit did suggest coupling the combined deductible with a catastrophic cap. The Alliance agrees that restructuring the Medicare benefit could be beneficial for seniors and people with disabilities if done to help seniors with high costs. Medicare benefits are less generous than those of government's FEHBP plans or large employer plans. A cap on out-of-pocket spending would benefit beneficiaries who are chronically ill and experience numerous hospitalizations, but increasing cost-sharing for healthier beneficiaries at the same time is not something we can support. The Alliance is especially apprehensive if such a plan is being offered in the context of deficit reductions.

Equally troubling is that Dr. Moffit also suggested making changes to Medigap and supplemental insurance policies. Various proposals have been offered in the past, including requiring beneficiaries with these policies to pay a surcharge or a deductible before Medigap benefits can kick in. The idea behind the surcharge and the deductible is that beneficiaries over-utilize services because it doesn't cost them anything and that beneficiaries need to have more "skin in the game." The surcharge and/or deductible is designed to impact beneficiaries' medical spending habits. This thinking is flawed in many ways. First, Medigap policies are expensive. Two-thirds of the medical spending by Medicare households goes to premiums for Part B, Medicare Advantage, Part D, and/or supplemental coverage. The suggestion that Medigap policyholders are getting a free ride is absurd. Second, medical decisions are made by doctors and not beneficiaries, so spending decisions are driven by doctors not patients. Thus, the belief that beneficiaries can control health spending is a notion that needs to be dispelled. Most beneficiaries do not have the expertise to make medical decisions. Third, while the surcharge or deductible may initially reduce demand for care and government spending, it could come at a high cost to beneficiaries, many of whom may forgo treatment due to higher costs. In the long run, the government could end up spending more if such individuals experience complications or require more costly care later.


Another troubling aspect is that the surcharge and/or deductible will not only affect seniors with Medigap plans, but also those with employer-sponsored supplemental plans. Individuals with employer-sponsored supplemental plans often received those health benefits in lieu of pay raises. They agreed to forfeit pay for health benefits, because it gave them peace of mind, knowing the benefits would be there for them when they needed it. It is unconscionable that Congress would now take that away from them.

The Alliance believes that Congress must do more to reduce the cost of Medicare. The ACA made numerous delivery systems reforms that are already helping bring down spending but more can be done. One area that deserves consideration is pharmaceutical costs. According to a study by the Center for Economic and Policy

Research, if Medicare used its bulk purchasing power to buy prescription drugs, the government could potentially save over \$500 billion and beneficiaries could save over \$100 billion over 10 years. Numerous bills are before Congress that would reduce drugs cost for the government and Medicare beneficiaries, those include rebates for low-income Medicare beneficiaries, negotiating lower prices for all beneficiaries, ending pay-for-delay agreements between pharmaceutical companies and generic manufacturers and reducing the exclusivity period for biologics. These options would save the program billions of dollars and without negatively affecting Medicare beneficiaries or transferring costs to them.

Also more could and should be done to reduce drug costs by eliminating waste in the system. On March 1, 2016, *The Washington Post* reported that a study found that \$3 billion in cancer drugs are wasted each year. The study focused on 20 cancer drugs that are infused -- administered intravenously or injected -- by doctors' offices or hospitals. These drugs come in dosages based on patients' weights and body sizes, but often the doses are too large and the remainder is tossed out. While some point to safety as the reason for discarding the leftover drug, surely guidelines can be developed that provide safety while at the same time reducing waste. We urge Congress to hold hearings to address this practice. These and other wasteful spending must be reviewed before considering any proposals that shift costs on to beneficiaries.

On behalf of its more than 4.3 million members, the Alliance for Retired Americans appreciates the opportunity to submit this testimony on this critically important issue.





March 16, 2016

The Honorable Pat Tiberi
Chairman
Ways & Means Committee
Subcommittee on Health
U.S. House of Representatives

Dear Chairman Tiberi:

Chairman Tiberi, thank you for holding today's hearing on "Preserving Medicare." This issue is important to so many people in this country, and I appreciate your leadership in starting a conversation on a topic that can become a political football.

In holding this hearing and looking at ways in which we can preserve Medicare for future generations, I hope the Subcommittee will look to new solutions like CarePayment's innovative financing program. Our program is a partnership between our company, the hospital and the patient. This connected relationship is one that has led to real savings for hospitals while at the same time offering patients solutions to help them pay for the healthcare they have and need. This program can also be used to help preserve Medicare and I hope you will consider creative solutions, like CarePayment, when it comes to any legislative action.

Though the Affordable Care Act (ACA) has made insurance available to many more Americans, challenges remain. Almost 90% of Americans now have insurance, but many of them still cannot afford to use it. 80% of HIX enrollees have chosen silver or bronze plans. Bronze plans have an average individual deductible of \$5,731 and an average family deductible of \$11,601.

But, according to the National Bureau of Economic Research (2013), 50% of Americans can't come up with \$2,000 in 30 days. Approximately 25% of those patients report an income between \$100,000 and \$150,000. The majority of bankruptcies are due to medical debt, and 33% of American's or their family members have put off medical treatment due to cost.

In the meantime, seven in ten providers said it took more than a month to collect from patients, and hospitals only collect 11% of balances larger than \$500.

This issue is worse for Medicare patients and the providers that service them. Patients on Medicare have no out-of-pocket maximum, so there is no safety net if or when something goes wrong. And most Medicare patients, most of whom are on fixed incomes, didn't plan for this steep increase in out-of-pocket expenses when they were planning for retirement. And providers now have a targeted reimbursement of 65% from CMS for bad debt due to uncollected out-of-pocket expenses for Medicare patients.

CarePayment has created an innovative solution that allows patients to pay off their medical bills over time with no interest, which leads to better access to care, increased patient satisfaction and improved financial performance for providers. For example, 95% of patients who participated in the CarePayment program were satisfied with their billing expenses and two-thirds of patients are more likely to recommend their provider because of CarePayment. And providers can take advantage of a contractual guarantee of net financial improvement.

5300 Meadows Road, Suite 320
Lake Oswego, OR 97035

P 503.419.3505

www.carepayment.com



Medicare patients embrace the CarePayment program since it gives them a way to fulfill their financial obligations, which is consistent with this generation's values. Medicare patients have a much higher enrollment rate in this program than other age groups.

We propose a pilot program that would provide a patient-friendly medical debt assistance program for Medicare participants on a broader basis to improve outcomes for this growing population and reduce overall healthcare costs.

Key benefits of this pilot include:

- Reduce Medicare bad debt and the overall costs of healthcare.
- Improve health outcomes for seniors by ensuring they don't forgo essential medical care due to their inability to pay for out-of-pocket expenses.
- Reduce healthcare costs associated with deferred care.
- Eliminate any fees associated with financing healthcare and make healthcare more affordable for seniors.
- Decrease consumer medical debt and help seniors avoid the negative consequences of medical debt.
- Improve provider financials helping them to maintain their presence in the community, increase the quality of care, and allocate more dollars to charity care.

As part of this pilot, CarePayment will measure key performance indicators, including:

- Reduction in Medicare bad debt and overall healthcare costs
- Access to care
- Adherence to treatment plans
- Patient satisfaction
- Avoidance of medical debt and other financial and social impacts
- Average out-of-pocket expense that is the tipping point for avoiding care or other consequences of medical debt

If you would like more information about the CarePayment program or this pilot proposal, please do not hesitate to contact us. I have included below some testimonials from CarePayment patients who are also Medicare recipients.

"I think it's fabulous because I am on a very limited income. I couldn't have come up with that kind of money at the end of the month." Linda, 73, Pennsylvania

"If I didn't have a way to pay for this treatment, I wouldn't go. This is a great benefit - it's like having a charge account with no interest." Betty, 73, Tennessee

"You see, we're both retired and on a fixed income. We don't get anything else, income wise, and we never will. I'm not sure what we would have done without CarePayment." Allen, 72, Texas

Sincerely,

A handwritten signature in black ink, appearing to read 'Craig Hodges'.

Craig Hodges
Chief Executive Officer, CarePayment

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Lake Oswego, OR 97035

P 503.419.3505

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GUNDERSEN HEALTH SYSTEM®

March 29, 2016

The Honorable Pat Tiberi
Chair
Committee on Ways & Means, Subcommittee on Health
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Jim McDermott
Ranking Member
Committee on Ways & Means, Subcommittee on Health
U.S. House of Representatives
1106 Longworth House Office Building
Washington, DC 20515

**Re: Public Comment on Ways and Means Subcommittee on Health Hearing “Preserving
and Strengthening Medicare.”**

Dear Chairman Tiberi & Ranking Member McDermott:

On behalf of Gundersen Health System, we write provide comments on the Ways and Means Subcommittee hearing “*Preserving and Strengthening Medicare*.” We were very pleased to hear committee members and panelists supporting healthcare delivery that is value-based. Gundersen echoes this strongly with our support of the development of robust value-based payment initiatives. We support the notion that properly structured incentives to provide high value care (e.g. high quality, low cost care) will result in better care for patients at a lower cost for payers.

Gundersen Health System provides integrated care for patients in predominantly rural areas along the Mississippi River in western Wisconsin, northeast Iowa, and southeast Minnesota. As the largest employer in the La Crosse, Wisconsin region with over 6,000 employees, Gundersen provides integrated healthcare services including: clinical care, level II trauma care, medical education, and air and ground ambulance services. In addition, Gundersen has maintained a five-star rated Medicare Advantage insurance plan for the past five consecutive years, one of only five health plans in the nation to earn this achievement. Gundersen has consistently achieved top national rankings in many areas of medical excellence including being named as a Healthgrades Top 50 hospital in overall care, many clinical specialty services, and patient experience.

External Affairs Department 1900 South Avenue, Mailstop: H02-009, La Crosse, WI 54601
Email: ExternalAffairs@gundersenhealth.org Phone: 608-775-1400 Fax: 608-775-6225

We believe value-based payment policies can drive better quality, lower cost of care, and reduce overall costs for the Medicare program. As a founding member of the Healthcare Quality Coalition (HQC), we strongly support continued implementation of payment systems that reward value. In supporting this approach, a study by the Medicare Payment and Advisory Commission (MedPAC) found the La Crosse, Wisconsin region to have the lowest utilization of Medicare services per beneficiary in the nation. This demonstrates our efficiency in caring for our Medicare patients, and coupled with our quality outcomes make us a provider of high value care.

Movement to Value Key for Long-term Medicare Viability

Medicare's predominantly fee-for-service (FFS) payment system, which rewards quantity over quality, is now widely acknowledged to be fragmented, inefficient, and financially unsustainable. The FFS system pays physicians based on the services they furnish and offers no incentives to coordinate care. The result is a system of fragmented care. FFS payments also create a financial incentive to promote volume over value, encouraging overutilization and discouraging low-cost, high-value services. Given the rising cost of health care and the resultant threat to the nation's long-term economic security, a payment system that supports an inefficient delivery system is not only undesirable but also unsustainable.

Gundersen Health System strongly believes that Medicare should pay for value in the health care system. Congress should not rely on across-the-board payment reductions as means to achieving value and program sustainability. In fact, this is in contrast to these goals. We believe that over time, value-based care will achieve the policy and financial goals to a sustainable Medicare system.

As a starting point, Gundersen supported and focused on programs that make modifications to the FFS scheme, such as the Physician Value-based Payment Modifier and Hospital Value-based Purchasing. These payment adjustments, however, are built on the FFS chassis, and the fundamental incorrect incentives of FFS remain the predominant payer source in the Medicare system. Just recently, Health and Human Services announced that 30% of medical service reimbursement in Medicare is now linked to various forms of non fee-for-service payment. Gundersen believes this is a good step.

Gundersen Health System expressed support for the passage of the Medicare Access and CHIP Reauthorization Act (MACRA) last year. The enactment of this bill was historic in that it not only eliminated the antiquated Medicare Part B Sustainable Growth Rate, but also consolidated existing physician performance initiatives and advanced value-based payment. We commend the efforts of the Ways and Means Committee to craft and advance bi-partisan, bi-cameral legislation to reform Medicare Part B service reimbursement. We ask the committee to continue their work on evaluating the implementation of MACRA, and be amenable to changes that may be necessary to ensure program success, accelerate the process towards value-based care, and reward high performing physicians. For example, we have ongoing concerns about the statutory thresholds for qualifying as an Alternative Payment Model (APM) under MACRA. We are looking forward to the regulatory

implementation process and hope CMS uses as much flexibility as possible to ensure providers have the ability to be innovative and successful.

Reform and Advance Value-based Policy in Medicare for Hospitals

Last year, the enactment of MACRA was a major step forward in reforming Medicare Part B payment. But advancing public policy cannot stop or even slowdown. To continue driving forward value-based policy, we ask the Ways and Means Committee to collaborate and develop bi-partisan legislation that would consolidate and reform performance and value-based payment for hospitals. We believe, to the extent feasible, that Medicare Part A and B should include comparative value-based reimbursement policy. To that end, we offer the following key points of emphasis for devising an improved Medicare value-based payment for hospitals that resembles the concepts of MACRA. Specifically, we ask the committee to:

- Consolidate and reform existing penalty-only programs into an improved Hospital Value-Based Purchasing Program, offering incentives and rewards for high performance
- Improve efficiency as a unit of *value* by modifying the improved Hospital Value-Based Purchasing program to weigh measures of cost and quality equally
- Advance value-based care by increasing the amount of payment tied to hospital performance
- Eliminate overlap with quality measures between separate hospital programs
- Provide opportunities for developing and expanding hospital Alternative Payment Models

Step 1: Reform existing Medicare Hospital Penalty Programs

Gundersen Health System comprehensive value-based payment policies that integrate risk and offer rewards to hospitals that lead in improving patient experience, outcomes, and reducing the cost of care. We strongly believe properly structured payment reforms have an opportunity to significantly reduce the cost of care. However, performance-based programs that only assess penalties fall short of comprehensive value-based models. Reforming existing penalty programs to incent value by consolidating into a single Hospital Value-Based Purchasing program would align incentives, reduce duplication, and increase overall impact of the independent programs.

In the Hospital Readmissions Reduction (HRR) program, hospitals are compared to average performance of hospitals with similar patient case mix. In FY 2015, over 75% of eligible hospitals in the nation were subject to some level of readmissions penalty (maximum -3%), totaling over \$420 million despite drops in national readmission rates.^{1,2} Meanwhile, the Hospital-Acquired Conditions (HAC) Reduction program assesses a 1% penalty for hospitals with the highest quartile rates of infections, injuries, and illnesses. Even though there has been a 17% national reduction in HACs³ from 2010-2013, as designed, the HAC Reduction program will penalize 25% of hospitals every

¹Sabriya Rice, "Most hospitals face 30-day readmissions penalty in fiscal 2016," *Modern Healthcare*, August 3, 2015.

²<http://www.modernhealthcare.com/article/20150804/NEWS/150809981>

³Jordan Rau, "Half Of Nation's Hospitals Fail Again To Escape Medicare's Readmission Penalties," *Kaiser Health News*, August 2, 2015 <http://khn.org/news/intl-of-nations-hospitals-fail-again-to-escape-medicare-readmission-penalties/>

⁴Agency for Healthcare Research and Quality, *2013 Annual Hospital-Acquired Condition Rate and Estimates of Cost Savings and Deaths Averted From 2010 to 2014*, AHRQ Publication No. 16-0006-EF (Rockville, MD, 2015), <http://www.ahrq.gov/sites/default/files/research/professionals/quality-nation-aahrpdp-hacrate2014.pdf>

year, regardless of improvement. Further, like the Hospital Readmissions Reduction initiative, the HAC program is penalty-only.

While the HRR and HAC initiatives are designed to improve quality and reduce unnecessary spending, both are penalty-only programs, and do not provide positive incentives for high-quality, cost effective care. Furthermore, as structured, the programs base performance on national averages, meaning hospitals may continue to be penalized even if they improve their readmission, infection, or safety rates. Finally, some measures are used in multiple programs, such as infection measures which result in overlap. Reforming the penalty-only structure of the program and consolidating into the Hospital Value-Based Purchasing program provides better incentives and eliminates the overlap and duplication of quality measures.

Step 2: Improve the Hospital Value-Based Purchasing (VBP) Program

Gundersen supports the goals of the hospital VBP program to reward high quality hospitals and to incentivize performance improvement.⁴ Overall, Gundersen believes hospital VBP is moving in a positive direction by emphasizing patient outcomes, assessing payment adjustments by actual performance, and maintaining the current weighting of efficiency and cost reduction metrics.

However, the current statutory structure of the program is ineffective in driving meaningful reform. The incentive amounts are small, payment differentiation is minimal, and is not sufficient to drive meaningful changes in hospital care.^{5,6} The current 2% statutory cap on incentives will not sufficiently motivate hospitals to strive toward value-based care delivery. Removing the ceiling will link more payment to value and drive quality improvement forward.

In addition to removing the statutory cap on Hospital VBP, Gundersen continues to support value as an equal reflection of cost and quality. Currently, the VBP program includes efficiency and cost reduction measures weighted at 25%. To further improve the program, we recommend the following steps: 1) Develop and implement a plan to increase the weight of efficiency and cost reduction domain to 50%; and 2) Incorporate additional risk-adjusted measures of efficiency in addition to the current Medicare Spending Per Beneficiary (MSPB) metric.

Step 3: Develop and expand voluntary hospital Alternative Payment Models

There are currently an array of programs and initiatives aimed at reducing cost and improving quality. Although the Medicare Accountable Care Organization (ACO) program has demonstrated mixed results,⁷ experience from providers and hospitals participating as an ACO and other innovative models are integral for developing improved payment policy. In addition, as noted, MACRA was a milestone in Medicare physician payment policy by driving value-based care through

⁴ Daniel Blumenthal and Anupam B. Jena, "Hospital value-based purchasing," *Journal of Hospital Medicine* 8, no. 5 (2013): 271, doi:10.1002/jhm.2045

⁵ Rachel M. Werner and R. Adams Dudley, "Medicare's new hospital value-based purchasing program is likely to have only a small impact on hospital payments," *Health Affairs* 31, no. 9 (2012): 1932, doi:10.1377/hlthaff.2011.0090

⁶ U.S. Government Accountability Office, *Hospital Value-Based Purchasing: Initial Results Show Mixed Effects on Medicare Payments and No Apparent Change in Quality of Care Trends*, GAO-16-6 (Washington, DC, 2015), <http://www.gao.gov/assets/16/0172090.pdf>

⁷ David Mushetstein, "Medicare ACO's: Mixed initial results and cautious optimism," *Health Affairs Blog*, February 4, 2014, <http://healthaffairs.org/blog/2014/02/04/medicare-acos-mixed-initial-results-and-cautious-optimism/>

existing programs and new payment models. Improved hospital payment policy should take a similar approach, providing statutory authority for encouraging and incentivizing hospitals to undertake new models of care with opportunities for improved integration with clinical services.

In providing opportunities for future hospital alternative payment models to flourish, we ask lawmakers to follow these guiding principles:

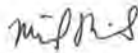
- Hospitals should have the opportunity to take on risk—rewarding quality and efficiency.
- Incentivize coordinated care and build on existing initiatives and infrastructure.
- Capitated payment should be a core component of an alternative payment model.
- Flexibility and proper tools are essential to improve quality and reduce cost, including provider and hospital networks.
- Beneficiaries should be engaged in delivery system reform, such as patient involvement and understanding their stake in achieving value-based outcomes.

Conclusion

In conclusion, we appreciate the opportunity to provide comments and ideas to the Ways and Means Subcommittee on Health for ensuring a sustainable Medicare program. We believe the long-term viability lies in crafting reimbursement for services provided to Medicare beneficiaries that reflect robust value-based policy with measures of cost and quality. We look forward to being an active partner with the committee in moving value forward.

Please feel free to contact me with any questions.

Sincerely,



Michael D. Richards
Executive Director of External Affairs
Gundersen Health System



March 15, 2016

U.S. House of Representatives
 Ways and Means Health Subcommittee
 1102 Longworth House Office Building
 Washington, D.C. 20515

Re: Statement for the Record for the Hearing, "Preserving and Strengthening Medicare"

Dear Chairman Tiberi and Ranking Member McDermott:

The Healthcare Leadership Council (HLC) appreciates the opportunity to submit a statement for the record regarding the hearing entitled, "Preserving and Strengthening Medicare." We applaud the subcommittee for examining ways to set Medicare on a sustainable path for future generations.

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century health system that makes affordable, high-quality care accessible to all Americans. Members of HLC – hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, biotech firms, health product distributors, pharmacies, post acute care providers, and information technology companies – advocate measures to increase the quality and efficiency of healthcare through a patient-centered approach (attached is a list of our members).

HLC has maintained a longstanding position that Medicare can be made a higher-quality program with greater financial sustainability if beneficiaries have enhanced power of consumer choice to drive value. An approach similar to the Medicare Part D Prescription Drug Benefit or the Federal Employees Health Benefits Program, in which private plans compete for consumer loyalties on the basis of price and quality of coverage, can make Medicare a stronger program for current and future beneficiaries. With the Medicare trustees projecting that the program will reach financial insolvency less than 15 years from now – and with 7,500 baby boomers, on average, becoming Medicare-eligible each day – HLC has made the strengthening of Medicare a high priority.

HLC supports modernizing Medicare into a more competitive, quality-driven model based on choice. Moving in this direction would help Congress and the administration

address the impending fiscal crisis the program faces. To ensure Medicare continues for future generations the current path cannot be maintained, but instead innovative ideas and a national commitment are needed. It is important for everyone to understand that the unsustainable future of Medicare affects us all. It affects our health – without change, current and future Medicare beneficiaries will not have access to high-quality, affordable healthcare; it affects our economy – without change, we cannot ensure an environment for economic growth, jobs, and innovation; and it affects our future – without change, the standard of living for our children and grandchildren will be compromised. Thoughtful, beneficiary-centered reforms are far better alternatives for reducing cost than the arbitrary cuts that could happen through the Independent Payment Advisory Board (IPAB) or deficit reduction measures.

HLC has conducted focus groups and economic modeling to examine the kinds of approaches that would be beneficiary-friendly and sustain the Medicare program. We are happy to share this work with the subcommittee. The principles that drive our work are enclosed.

Our members have been avid supporters of programs such as the Medicare Part D Prescription Drug Benefit and Medicare Advantage (MA) because they enjoy high beneficiary satisfaction levels that are rooted in choice, accessibility, and affordability. HLC feels the core structures of these programs could be used as building blocks for broader reform. In fact, a September 2013 Congressional Budget Report entitled, "A Premium Support System for Medicare: Analysis of Illustrative Options," presents a Medicare structure that can be beneficiary-centered and sustainable for future generations. Commonsense solutions that take into account the need for both stability and predictability in payments and policies that enable innovative care delivery are critical to any reform efforts.

HLC appreciates the opportunity to submit a statement for the record for the hearing on "Preserving and Strengthening Medicare." HLC is committed to educating members of Congress and the public about the need for broad Medicare reform and welcome the opportunity to work with you on refining policy solutions to ensure that all Medicare beneficiaries continue to have choice and access to high quality care.

Sincerely,



Mary R. Grealy
President

Enclosure:
Membership List
Medicare Reform Principles

2016 HLC Members
(Alphabetized by Company)

Susan DeVore - Chair
President & CEO
Premier healthcare alliance

Mark Bertolini
Chairman, CEO & President
Aetna

Steve Collis
President & CEO
AmerisourceBergen

Rolf Hoffmann
SVP, US Commercial Operations
Amgen

Susan Salka
President & CEO
AMN Healthcare

Joseph Swedish
President & CEO
Anthem

Anthony Tersigni, EdD
President & CEO
Ascension

Jonathan Bush
Chairman, President & CEO
athenahealth

Joel Allison
CEO
Baylor Scott & White Health

Marc Grodman, M.D.
Chairman, President & CEO
Bio-Reference Laboratories

J. D. Hickey
CEO
BlueCross BlueShield of Tennessee

Everett Hoekstra
Sr. Vice President & CFO
Boehringer Ingelheim USA

George Barrett
Chairman & CEO
Cardinal Health

Neil de Crescenzo
CEO
Change Healthcare

Toby Cosgrove, M.D.
CEO & President
Cleveland Clinic Foundation

Tim Ring
Chairman & CEO
C. R. Bard

Alex Azar
President, Lilly USA
Eli Lilly and Company

John Finan, Jr.
President & CEO
**Franciscan Missionaries of Our Lady
Health System, Inc.**

Jack Bailey
President, US Pharmaceuticals
GlaxoSmithKline

Neil Kurtz, M.D.
President & CEO
Golden Living

Daniel Evans, Jr.
President & CEO
Indiana University Health

Jennifer Taubert
Company Group Chairman, North American
Pharmaceuticals

Johnson & Johnson

Jonathan Scholl
President, Health and Engineering Sector
Leidos

Susan Turney, M.D.
CEO
Marshfield Clinic Health System

Brad Bennett
CEO
Maxim Healthcare Services

John Noseworthy, M.D.
President & CEO
Mayo Clinic

John Hammergren
Chairman, President & CEO
McKesson Corporation

Omar Ishrak
Chairman & CEO
Medtronic

Barry Arbuckle, Ph.D.
President & CEO
MemorialCare Health System

Robert McMahon
President, U.S. Market
Merck

Anna Mohl
Regional Business Head, North America
Nestlé Health Science Medical Nutrition Business

Steven Corwin, M.D.
CEO
NewYork-Presbyterian Hospital

Mark Neaman
President & CEO
NorthShore University HealthSystem

Christi Shaw
US Country Head, President
Novartis Pharmaceuticals

Jesper Hoiland
President
Novo Nordisk, Inc.

Craig Smith
Executive Chairman
Owens & Minor

Albert Bourla
Group President, Vaccines, Oncology and Consumer Healthcare
Pfizer

Greg Irace
President & CEO
Sanofi US

Chris Wing
President & CEO
SCAN Health Plan

David Chernow
President & CEO
Select Medical

Tim Scannell
Group President, MedSurg & Neurotechnology
Stryker

Tom Skelton
CEO
Surescripts

Ramona Sequeira
President
Takeda Pharmaceuticals U.S.A.

Jason Gorevic
CEO
Teladoc

Barclay Berdan
CEO
Texas Health Resources

Curt Nonomaque
President & CEO
Vizient

Alex Gourlay
President
Walgreens

James Chambers
President & CEO
Weight Watchers International

Jaideep Bajaj
Chairman
ZS Associates



HLC PRINCIPLES ON MEDICARE REFORM

More care coordination and ease in navigating the healthcare system is imperative for Americans who depend on Medicare. The Medicare program has played a vital role in American healthcare since it began providing benefits to seniors and individuals with disabilities 50 years ago. Medicare, however, has been slow to keep up with advances in benefit design throughout the program that would provide important care coordination and financial protection to its most vulnerable beneficiaries. While some care coordination and prevention benefits have been introduced as a result of the Patient Protection and Affordable Care Act (PPACA), more work needs to be done. The complicated structure of separate coverage for hospital benefits, physician benefits, prescription drug benefits and supplemental insurance protection (for those who can afford it) makes the system complex and difficult to manage. Medicare also does not provide catastrophic coverage to protect against excessive out-of-pocket costs. Medicare is an earned benefit. Citizens who have paid into Medicare throughout their lives and are dependent on it as their health needs increase with age deserve a modern Medicare insurance program that works best for them.

1. *Fostering value through consumer choice should be a motivating force behind reform. Structural reform of Medicare should allow beneficiaries to have a choice of health plans and options from which to choose. Medicare reform should foster a marketplace that encourages development of healthcare delivery models, coverage options and products that stem from an innovative, competitive environment while protecting Medicare's earned benefits.*
2. *Empowering and protecting beneficiaries must be a central component to reform. Medicare beneficiaries should be empowered to choose among multiple affordable health plans, which provide catastrophic coverage and offer, at a minimum, the same benefits and actuarial value as traditional Medicare. It is also important that the government provide sliding scale financial assistance to beneficiaries based on their income levels. Beneficiaries should always have access to needed treatments and providers.*
3. *Medicare reform should incorporate a system where "apples to apples" comparison of health plans, including traditional Medicare, is available to all beneficiaries. Beneficiaries should be able to access health coverage information in a way that is simplified, whether it is through the Internet, over the phone, through written material, or face-to-face meetings. Whether they choose traditional Medicare or a private plan, they should be able to easily weigh total costs, benefits, and quality in order to compare and contrast and choose a plan that best fits their needs.*

4. *Medicare reform should look to the successful competitive market-based features included in existing federal programs that provide better access to coordinated care.* The ability to coordinate care and support better care transitions results in better managed patients and better outcomes. Programs such as Medicare Part C (Medicare Advantage), the Medicare Part D Prescription Drug Benefit, and the Affordable Care Act, for example, all have features that encourage affordability, choice, quality and innovation. The best of these models should be considered and adapted as part of Medicare reform.
5. *Payments to health plans and providers should reflect accurate mechanisms to assure fairness for all beneficiaries and providers.* Medicare beneficiaries differ in many ways, from basics like age and gender, to more nuanced characteristics such as prior use of healthcare services and socioeconomic status. Payment to health plans and providers should be quality-based and risk-adjusted to reflect these important personal characteristics so all stakeholders are treated fairly and there remains ample choice and competition in the marketplace, especially for high-risk beneficiaries.
6. *Effective oversight is important to ensure the success of a modernized Medicare program.* Appropriate regulation is critical to ensure fair, robust, and consumer-centric competition in a new Medicare marketplace. By contrast, regulation that is unnecessarily burdensome or that imposes unnecessary expenses should be avoided.
7. *If we do not act thoughtfully now, the alternative will be severe.* The longer we wait to reform Medicare in a meaningful way, the more likely we risk encountering a budget environment that will implement drastic, arbitrary spending cuts and/or tax hikes to all stakeholders who participate in the Medicare program. This "death by a thousand cuts" will hinder beneficiaries' access to healthcare services and products, negatively impact healthcare quality, and limit innovation. In addition to resulting in potential reduced services for Medicare beneficiaries, policymakers could be faced with delaying eligibility or other proposals that could harm beneficiaries.
8. *The sustainability of Medicare for future generations is at stake.* We have reached the point at which policymakers can no longer avoid addressing the serious economic challenge presented by Medicare's inability to keep pace with incoming beneficiaries' healthcare needs. 11,000 new beneficiaries are eligible for Medicare every day as Baby Boomers turn 65 years old. These beneficiaries will receive over three dollars in healthcare services for every dollar paid in Medicare payroll taxes during their working years. Furthermore, where we had 19 active workers supporting each beneficiary through payroll taxes in 1965, today that ratio is less than four-to-one.



Max Richtman, Chair

March 29, 2016

Chairman Pat Tiberi
House Ways and Means Committee
Subcommittee on Health
Washington, DC 20515

Ranking Member Jim McDermott
House Ways and Means Committee
Subcommittee on Health
Washington, DC 20515

Dear Chairman Tiberi and Ranking Member McDermott:

The Leadership Council of Aging Organizations (LCAO) is a coalition of 72 national nonprofit organizations concerned with the well-being of America's older population and committed to representing their interests in the policymaking arena. LCAO appreciates the opportunity to submit this statement for the record.

Medicare is a remarkable success story. Now in its 50th year, the Medicare program, together with Social Security, has kept millions of retirees from poverty by ensuring access to affordable health care for those who would otherwise lack coverage.

Today, 54 million older adults and people with disabilities depend on Medicare for basic health insurance. Since its inception, the Medicare program has evolved, including the addition of a prescription drug benefit and, more recently, low-to-no cost preventive care. Recently, for example, the program has experienced historically low rates of spending growth.

Despite these successes, most people with Medicare still struggle financially: half lived on incomes less than \$24,150 a year and one-quarter lived on incomes at or below \$14,350 a year in 2014. They also possess little savings: Half of all Medicare beneficiaries had less than \$63,350 in lifetime savings and one-quarter had less than \$11,900 in savings in 2014.

Seniors and persons with disabilities also face high health care costs. On average, Medicare households spend nearly three times the proportion of annual income on health care costs, compared to non-Medicare households.

Given this stark reality, we must protect core Medicare benefits and ensure that no additional health care costs are shifted onto beneficiaries. To this end, we must preserve the fundamental structure and administration of the Medicare program.

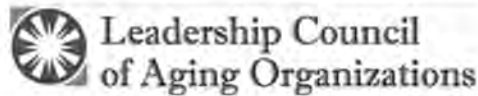
In addition, Medicare benefits are modest. Unfortunately, too many still forgo needed care because of high costs, particularly when Medicare doesn't cover a service. Rather than scale back Medicare, we need to expand it. Potential improvements include enhancing existing low-income protections and eliminating long-standing gaps in coverage for services including dental, hearing and vision care.

We submit for the record a number of materials pertaining to Medicare published by LCAO. We hope you will use them in your efforts to improve the Medicare program.

Sincerely,

A handwritten signature in black ink that reads "Max Richtman". The signature is written in a cursive, flowing style.

Max Richtman
Chair, Leadership Council of Aging Organizations



FACT SHEET

March 2016

MEDICARE BENEFICIARY CHARACTERISTICS AND OUT-OF-POCKET COSTS

Containing Medicare costs is an important goal, both to improve affordability for those who need care and to ensure the long-term sustainability of the program. Yet, some policy makers believe that older adults do not have enough "skin in the game" and propose shifting more out-of-pocket costs onto beneficiaries—an approach that would fail to address the underlying causes of cost growth. Proposals to shift costs to people with Medicare do not take into account three key facts: (1) Most beneficiaries have low or modest incomes; (2) Medicare benefits are not overly generous; and (3) Medicare beneficiaries already pay significant out-of-pocket costs.

Some plans propose increasing Medicare cost sharing, which is already high, has been increasing rapidly, and would make health care unaffordable for millions of older Americans. It is critical to understand that most beneficiaries struggle financially, already have high health costs, and cannot pay more.

LCAO recognizes the need to control health care spending. With respect to Medicare, we support savings mechanisms that address system-wide health care inflation and build on the cost savings of the Affordable Care Act. The American Academy of Actuaries agrees: "[I]mproving Medicare's long-term sustainability requires slowing the growth in overall health spending—not simply shifting costs from one payer to another."¹

Medicare Beneficiary Characteristics

- **Most people with Medicare have low or modest incomes.** In 2014, half of all people with Medicare lived on incomes less than \$24,150 per year—just above 200% of the federal poverty level. And one quarter of Medicare beneficiaries had annual incomes at or below \$14,350.²
- **Most Medicare beneficiaries lack sufficient savings.** In 2014, half of all Medicare beneficiaries had less than \$63,350 in lifetime savings, such as retirement account holdings and other financial assets. One in four Medicare beneficiaries had less than \$11,900 in savings.³
- **Women and people of color live on even less.** In 2014, among Medicare beneficiaries, median annual income for women amounted to \$22,500, compared to \$26,350 for men. In 2014, median annual incomes were also significantly lower for diverse communities—\$16,150 for black Medicare beneficiaries and \$12,800 for Hispanic beneficiaries. Median savings for white beneficiaries were more than eight to nine times the median savings for black beneficiaries (\$12,350) and Hispanic beneficiaries (\$9,800).⁴

¹ American Academy of Actuaries, "Letter to the Joint Select Committee on Deficit Reduction," (August 2011)

² Jacobson, G., Swoope, C., and T. Neuman, "Income and Assets of Medicare Beneficiaries, 2014–2030," (Kaiser Family Foundation, September 2015)

³ Ibid.

⁴ Jacobson, G., Swoope, C., and T. Neuman, "Income and Assets of Medicare Beneficiaries, 2014–2030," (Kaiser Family Foundation)

- **Many beneficiaries are in poor health.** 45% of the Medicare population is living with four or more chronic conditions, more than 30% have a cognitive or mental impairment, and more than one-third have a functional impairment. About 15% of Medicare beneficiaries have limitations with two or more activities of daily living, such as eating, bathing or dressing.⁵

Medicare Beneficiary Out-of-Pocket Costs

- **Health care costs are a significant expense for Medicare beneficiaries.** In 2014, Medicare beneficiaries spent an average of \$5,342 on health care costs.⁶ In 2010, more than 5 million people with Medicare (10%) spent more than \$8,030.⁷ In the last 5 years of life, beneficiaries spend \$38,688 on average.⁸ For 25% of beneficiaries, out-of-pocket costs average \$101,791 during this period. Almost half of Americans die with less than \$10,000 in financial assets.⁹
- **The sickest, the oldest and the near poor bear the most significant cost burdens.** In 2010, Medicare beneficiaries who reported being in fair or poor health spent a median 20% of their income on health care costs, compared to 14.2% among those in very good or excellent health. The average beneficiary age 85 or older spent more than twice as much on health care as the average beneficiary ages 65-69. The burden of out-of-pocket health care spending was the greatest among those with incomes between 100% - 200% FPL. For instance, those with incomes between 100% - 150% FPL spent 26% on health care as a share of income.¹⁰
- **Beneficiary out-of-pocket costs are increasing.** The cost of Medicare Part B and D premiums and cost sharing as a share of the average Social Security benefit increased from 7% in 1980 to 14% in 2000 and up to 26% in 2010.¹¹
- **Under Medicare, many health care needs are not covered.** Medicare coverage is not comprehensive and tends to be less generous than typical large employer plans. For instance, Medicare does not cover dental, vision, hearing services, and most long-term care services and supports. In 2011, for the average senior, Medicare covered \$11,930 of the \$14,890 in estimated annual health care spending—less than would be covered under the federal employee plan (\$12,260) or the typical Preferred Provider Organization (PPO) comparison plan (\$12,800) for an employee age 65 or older.¹²
- **Families on Medicare pay more for health care than non-Medicare households.** On average, in 2014, Medicare households spent 15% of total costs on health care; whereas, non-Medicare

⁵ Cubanski, J. "An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Service Use," (Kaiser Family Foundation: February 2013)

⁶ "The Latest Trends in Income, Assets, and Personal Health Care Spending Among People on Medicare" (Kaiser Family Foundation: November 2015)

⁷ Noel-Miller, C. "Medicare Beneficiaries' Out-of-Pocket Spending for Health Care," (AARP Public Policy Institute, December 2013)

⁸ Cubanski, J., Swopes, C., Beckett, C., Jacobson, G., Coillat, G., Griffin, S. and Tricia Neuman. "A Primer on Medicare: Key Facts About the Medicare Program and the People it Covers," (Kaiser Family Foundation, March 2015)

⁹ Kelley AS, et al. "Out-of-pocket spending in the last five years of life," *Journal of General Internal Medicine* (October 2012); National Bureau of Economic Research. "Were they prepared for retirement? Financial status at advanced ages in the HRS and AHEAD cohorts," (February 2012)

¹⁰ Noel-Miller, C. "Medicare Beneficiaries' Out-of-Pocket Spending for Health Care," (AARP Public Policy Institute, December 2013)

¹¹ Cubanski, J. "An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Service Use," (Kaiser Family Foundation: February 2013)

¹² Kaiser Family Foundation. "How Does the Benefit Value of Medicare Compare to the Benefit Value of Typical Large Employer Plans?" (April 2012)

households spent just 5%.¹³ In 2010, more than half of all Medicare beneficiaries spent more than 16.4% of their income on health care costs.¹⁴

- **Increased cost sharing often leads to adverse health consequences and can increase total health care spending.** Some policymakers want to increase beneficiary cost-sharing in order to reduce perceived over-utilization of unnecessary medical services. Decades of empirical research confirms that increased cost sharing leads people to forgo medically *necessary* services. In 2012, 8% of older Medicare beneficiaries and 28% of non-elderly Medicare beneficiaries reported delaying care because of cost concerns.¹⁵ Higher cost sharing ultimately backfires, since sicker patients will require more costly and invasive care down the road.¹⁶
- **Baby Boomers face increased financial uncertainty due to the economic downturn.** Today's working adults need Medicare to remain affordable, particularly due to declining home values, diminished retirement accounts, and job loss caused by the recession. In 2030, estimates suggest half of all Medicare beneficiaries will live on annual incomes of \$28,450 or less.¹⁷ Moreover, from 1992 to 2007, the average overall debt for 55 to 64 year old households more than doubled to \$70,370. Debt among older adults (age of 55+) continues to increase—63% had some level of debt. In 2014, 8% of Medicare beneficiaries had no savings or were in debt.¹⁸
- **Medicare low-income protection programs are broken and must be modernized.** According to the most recent estimates, only 33% of eligible beneficiaries were enrolled for Qualified Medicare Beneficiary (QMB) benefits and only 13% were enrolled for Specified Low-Income Medicare Beneficiary (SLMB) benefits.¹⁹ In addition, rigid, unreasonably low asset tests penalize beneficiaries by denying eligibility to those who did the right thing during their working years by setting aside a modest nest egg of savings.

¹³ "The Latest Trends in Income, Assets, and Personal Health Care Spending Among People on Medicare" (Kaiser Family Foundation, November 2015)

¹⁴ Cubanski, J., Swoope, C., Damico, A., P. Neuman, "Health Care on a Budget: The Financial Burden of Health Spending by Medicare Households," (Kaiser Family Foundation, January 2014); Noel-Miller, C. "Medicare Beneficiaries' Out-of-Pocket Spending for Health Care," (AARP Public Policy Institute, December 2013)

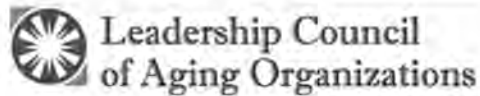
¹⁵ Cubanski, J., Swoope, C., Bocutti, C., Jacobson, G., Casillas, G., Griffin, S. and Tricia Neuman, "A Primer on Medicare: Key Facts About the Medicare Program and the People it Covers," (Kaiser Family Foundation, March 2015)

¹⁶ National Association of Insurance Commissioners, Senior Issues Task Force, Medicaid PPACA Subgroup, "Medicare Supplement Insurance First Dollar Coverage and Cost Shares Discussion Paper," (October 2011); Anil 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)

¹⁷ Jacobson, G., Swoope, C., and T. Neuman, "Income and Assets of Medicare Beneficiaries, 2014 – 2030," (Kaiser Family Foundation, September 2015)

¹⁸ Ibid., Employee Benefit Research Institute, "Debt of the Elderly and Near Elderly" (February 2013)

¹⁹ Government Accountability Office, "Medicare Savings Programs: Implementation of Requirements Aimed at Increasing Enrollment," (September 2012)



FACT SHEET

March 2016

MEDICARE "REDESIGN" PROPOSALS COULD HARM MANY BENEFICIARIES

Background

The Medicare program provides vital health coverage to approximately 54 million seniors and people with disabilities. While traditional Medicare guarantees coverage for a range of health care services, it is neither comprehensive in scope nor is it without cost to beneficiaries. Cost-sharing under traditional Medicare (including deductibles, copayments and coinsurance) can be both significant and complicated, especially for those who lack retiree insurance or other supplemental coverage.

In order to both achieve federal savings and seemingly simplify the program, some policymakers have suggested redesigning the traditional Medicare benefit. While details vary, most proposals would combine the Part A and B deductibles, implement a single coinsurance rate for health care services (including new home health cost-sharing), limit first dollar coverage in Medigap plans, and create an out-of-pocket spending cap for beneficiaries.

Our Position

Congress should tread carefully with respect to redesigning the Medicare benefit. While we welcome a discussion about expanding Medicare benefits and reducing all beneficiaries' out-of-pocket costs, the Leadership Council of Aging Organizations (LCAO) opposes redesigning or restructuring benefits for the purpose of achieving savings for the federal government by shifting even higher health care costs on to beneficiaries. As long as redesigning the Medicare program is approached with the aim of securing federal savings, such efforts are likely to unfairly redistribute costs to beneficiaries, including those with fixed incomes, and limit access to needed health care.

Our Rationale

- Many redesign proposals would increase the costs on the majority of Medicare beneficiaries.** For example, one typical cost-sharing proposal examined by the Kaiser Family Foundation includes a combined Part A and Part B deductible of \$550, 20% coinsurance rates for health care services, and a \$5,500 out-of-pocket cap. Under this proposal, 71% of people with Medicare would pay more for health coverage and only 5% would pay less. Further, for the 5 million people who would experience annual increased costs greater than \$250, the average increase total would be \$660 each in 2013.²⁰
- Most people with Medicare cannot afford to pay more.** In 2014, half of Medicare beneficiaries—more than 25 million seniors and people with disabilities—lived on incomes at or below \$24,150.

²⁰ Kaiser Family Foundation, "Restructuring Medicare's Benefit Design: Implications for Beneficiaries and Spending" (November 2011), available at <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8256.pdf>.

One quarter of Medicare beneficiaries had annual incomes at or below \$14,350.²¹ On average, Medicare households already spend 14 percent of their income on health care costs, about three times as much as non-Medicare households.²²

- **Low-income beneficiaries are not protected against Medicare cost-sharing.** Eligibility for assistance with Medicare cost-sharing under the Qualified Medicare Beneficiary (QMB) program is limited to those with incomes below 100% of poverty (plus \$20 a month, totaling \$12,012 for singles and \$16,176 for couples in 2015) and non-housing assets below just \$7,280 for singles and \$10,930 for couples. This is far less generous than cost-sharing protections available to those under age 65, with eligibility at 138% of poverty and no asset test. Even among Medicare beneficiaries eligible for QMB protection, only about one-third are actually enrolled in the program.²³ Changing Medicare cost-sharing in the manner suggested by many redesign proposals would redistribute the burden of health care costs onto the most vulnerable, including those with moderate incomes and those with persistent and chronic health needs.²⁴
- **As cost-sharing goes up, utilization of services—both necessary and unnecessary—goes down.** Many Medicare redesign proposals would increase costs on beneficiaries by either increasing cost-sharing amounts or imposing cost-sharing for services that currently do not require them. Often, the justification for such proposals is based on the flawed assumption that charging beneficiaries more in upfront out-of-pocket costs will deter them from using unnecessary medical care, will steer them towards “higher-value” services, and therefore save the program money. Conversely, decades of empirical research confirm that higher cost-sharing deters access to both needed and unneeded care indiscriminately, and most notably for those living on modest incomes.²⁵
- **Beneficiary cost-sharing does not get at the real cost drivers.** It is health care providers—not beneficiaries—who determine the necessity of health care services, yet many proposals would increase cost-sharing, essentially forcing beneficiaries to self-ration their care. Research illustrates that once an individual enters the health care system, it is their providers that dictate treatments and services.²⁶
- **Home health copayments would harm the most vulnerable and likely increase program costs.** This proposal would primarily impact lower income, chronically ill women over age 75, and would deter many vulnerable beneficiaries from accessing needed care. Forgoing Medicare home health services may increase the incidence of premature nursing home placement, as well as hospitalizations and other more costly acute care. As a result, this could increase hospital inpatient spending by \$6 to \$13 billion over 10 years, in addition to significantly increasing Medicaid spending on long-term

²¹ Kaiser Family Foundation, “Income and Assets of Medicare Beneficiaries, 2014 – 2030” (September 2015), available at: <http://files.kff.org/attachment/issue-brief-income-and-assets-of-medicare-beneficiaries-2014-2030>.

²² Kaiser Family Foundation, “Health Care on a Budget: The Financial Burden of Health Spending by Medicare Households” (January 2014) available at: <http://kff.org/medicare/issue-brief/health-care-on-a-budget-the-financial-burden-of-health-spending-by-medicare-households/>; also see LCAO Issue Brief “Medicare Beneficiary Characteristics and Out-of-Pocket Costs” (June 2014), available at: <http://www.lcao.org/files/2014/07/LCAO-issue-brief-beneficiary-characteristics-updated-june-2014-7.8.14.pdf>.

²³ Government Accountability Office, “Medicare Savings Programs: Implementation of Requirements Aimed at Increasing Enrollment,” GAO-12-871 (September 2012), available at <http://www.gao.gov/assets/650/648370.pdf>.

²⁴ Kaiser Family Foundation, “Restructuring Medicare’s Benefit Design: Implications for Beneficiaries and Spending” (November 2011), available at <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8256.pdf>.

²⁵ See, e.g., National Association of Insurance Commissioners (NAIC), Senior Issues Task Force, Modigap PPACA Subgroup, “Medicare Supplement Insurance First Dollar Coverage and Cost Shares Discussion Paper” (October 2011), available at: http://www.naic.org/documents/csmurtagh_b_senior_issues_111101_nai_senior_first_dollar_coverage_discussion_paper.pdf.

²⁶ See, e.g., Rand and other studies cited in National Association of Insurance Commissioners, *Ibid.*

care.²⁷

- **Medigap proposals would shift additional costs onto beneficiaries.** Nearly one in four Medicare beneficiaries pay for and rely on Medigap plans to provide financial security and protection from high, unexpected out-of-pocket costs due to unforeseen medical care. Yet, some lawmakers suggest shifting additional costs onto people with Medigap policies by increasing deductibles or other cost-sharing, or by adding a surcharge or tax on plans offering “first-dollar” coverage. Most Medigap enrollees (86%) have incomes below \$40,000 per year and nearly half (47%) have incomes below \$20,000 per year.²⁸ Increasing cost-sharing for or adding surcharges to Medigap plans will harm those who can least afford it—those who are sick or chronically ill and those with low or moderate incomes.²⁹

²⁷ Avalere Health LLC, “Potential Impact of a Home Health Co-Payment on Other Medicare Spending” (July 2011), also see LCAO Issue Brief “Medicare Home Health Copayments: Harmful for Beneficiaries” (February 2015), available at: <http://www.lcao.org/files/2015/02/LCAO-Copy-Issue-Brief-Feb-2015.pdf>.

²⁸ Kaiser Family Foundation, “Medigap Reform: Setting the Context for Understanding Recent Proposals” (January 2014), available at: <http://kff.org/medicare/issue-briefs/medigap-reform-setting-the-context/>.

²⁹ *Ibid.* Also see LCAO Issue Brief “Reforming Medigap Plans by Shifting Costs onto Beneficiaries: A Flawed Approach to Medicare Savings” (July 2014), available at: <http://www.lcao.org/files/2014/07/LCAO-IB-Medigap-July-2014-Lpdac-7.8.14.pdf>.



Statement
Of
The National Association of Chain Drug Stores
For
United States House of Representatives
Committee on Ways and Means
Subcommittee on Health
Hearing on:
Preserving and Strengthening Medicare
March 16, 2016
10:00 A.M.
1100 Longworth House Office Building

National Association of Chain Drug Stores (NACDS)
1776 Wilson Blvd., Suite 200
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703-549-3001
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NACDS Statement to W&M Subcommittee on Health:
Preserving and Strengthening Medicare
March 16, 2016
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The National Association of Chain Drug Stores (NACDS) thanks Chairman Brady and the members of the Subcommittee on Health for the opportunity to submit the following statement for the record regarding preserving and strengthening the Medicare program. NACDS and the chain pharmacy industry are committed to partnering with Congress, HHS, patients, and other health care providers to improve the quality and affordability of health care services.

NACDS represents traditional drug stores and supermarkets and mass merchants with pharmacies. Chains operate more than 40,000 pharmacies, and NACDS' chain member companies include regional chains, with a minimum of four stores, and national companies. Chains employ more than 3.2 million individuals, including 179,000 pharmacists. They fill over 2.9 billion prescriptions yearly, and help patients use medicines correctly and safely, while offering innovative services that improve patient health and healthcare affordability. NACDS members also include more than 850 supplier partners and over 60 international members representing 22 countries. For more information, visit www.NACDS.org.

As the face of neighborhood healthcare, community pharmacies and pharmacists provide access to prescription medications and over-the-counter products, as well as cost-effective health services such as immunizations and disease screenings. Through personal interactions with patients, face-to-face consultations, and convenient access to preventive care services, local pharmacists are helping to shape the healthcare delivery system of tomorrow—in partnership with doctors, nurses and others.

NACDS believes retail pharmacists can play a vital role in strengthening the Medicare program by greatly improving beneficiary health while reducing program spending;

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including through improving access for underserved beneficiaries and the better use of medication therapy management (MTM) services.

Pharmacists as Providers

As the U.S. healthcare system continues to evolve, a prevailing issue will be the adequacy of access to affordable, quality healthcare. The national physician shortage coupled with the continued expansion of health insurance coverage in recent years will have serious implications for the nation's healthcare system. Access, quality, cost and efficiency in healthcare are all critical factors – especially to the medically underserved. Without ensuring access to requisite healthcare services for this vulnerable population, it will be very difficult for the nation to achieve the aims of healthcare reform.

The medically-underserved population includes seniors with cultural or linguistic access barriers, residents of public housing, persons with HIV/AIDS, as well as rural populations and many others. Significant consideration should be given to innovative initiatives within the medically underserved population to enhance healthcare capacity and strengthen community partnerships to offset provider shortages and the surge in individuals with healthcare coverage.

Pharmacists play an increasingly important role in the delivery of services, including key roles in new models of care beyond the traditional fee-for-service structure. Pharmacists are engaged with other professionals and participating in models of care based on quality of services and outcomes, such as accountable care organizations (ACOs). Pharmacists now commonly provide immunizations MTM services.

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In addition to medication adherence services such as MTM, pharmacists are capable of providing many other cost-saving services (subject to state scope of practice laws). Examples include access to health tests, helping to manage chronic conditions such as diabetes and heart disease, plus expanded immunization services. However, the lack of pharmacist recognition as a provider by third-party payors, including Medicare and Medicaid, limits the number and types of services pharmacists can provide, even though fully qualified to do so. Retail pharmacies are often the most readily accessible healthcare provider. Research shows that nearly all Americans (94 percent) live within five miles of a retail pharmacy. Such access is vital in reaching the medically underserved.

We urge you to increase access to much-needed services for underserved Medicare beneficiaries by supporting H.R. 592/S. 314, the *Pharmacy and Medically Underserved Areas Enhancement Act*, which will allow Medicare Part B to utilize pharmacists to their full capability by providing those underserved beneficiaries with services (subject to state scope of practice laws) not currently reaching them. This important legislation would lead not only to reduced overall healthcare costs, but also to increased access to healthcare services and improved healthcare quality, all of which is vital to ensuring a strong Medicare program.

The Benefits of Pharmacist-Provided MTM

Poor medication adherence costs the U.S. healthcare system \$290 billion annually. Pharmacist-provided services such as MTM are important tools in the effort to improve medication adherence, patient health and healthcare affordability. Studies have shown that patients who are adherent to their medications have more favorable health outcomes, such as

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reduced mortality, and use fewer healthcare services (especially hospital readmissions and ER visits). These studies included patients with cardiovascular disease, chronic obstructive pulmonary disease (COPD), high cholesterol and diabetes. Current MTM restrictions require that Medicare Part D beneficiaries suffer from multiple chronic conditions, be prescribed multiple medications, and meet a minimum annual cost threshold of \$3,138 in 2015 for their prescriptions before they are eligible for Part D MTM. According to the CMS MTM Fact Sheet, approximately 85% of programs opt to target beneficiaries with at least three chronic diseases in 2014. This is a contributing factor to the lower than projected eligibility levels in the MTM program.

NACDS has long been supportive of exploring new and innovative approaches to improve the Part D MTM program. One of the approaches we believe can be successful is the Enhanced MTM Model pilot allowing Part D plans the opportunity to utilize new and innovative approaches to MTM, such as more efficient outreach and targeting strategies and tailoring the level of services to the beneficiary's needs. The Enhanced MTM Pilot program presents an opportunity to create better alignment of program incentives and has the potential to lead to improved access to MTM services for beneficiaries and greater medication adherence. NACDS believes a successful model test must include retail community pharmacists. Medication management services provided by community pharmacists improve patient care; improve collaboration among providers; optimize medication use for improved patient outcomes; contribute to medication error prevention; improve hospital and readmission cost avoidance; and enable patients to be more actively involved in medication self-management.

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Since the pilot is scheduled to last for five years beginning in 2017, we also urge lawmakers to explore new and innovative approaches to improving the Part D MTM program that could be implemented in the short term. NACDS believes one short term approach is more efficiently targeting beneficiaries who can most benefit from the services that will improve medication adherence and overall program effectiveness. Congress recognized the importance of MTM on a bipartisan basis, including it as a required offering in the Medicare Part D program. We urge Congress to build on this earlier action and strengthen the MTM benefit in Medicare Part D through support of legislation such as that introduced by Sen. Pat Roberts (R-KS) and Sen. Jeanne Shaheen (D-NH), S. 776, the *Medication Therapy Management Empowerment Act of 2015*, which will provide access to MTM for beneficiaries with diabetes, cardiovascular disease, COPD, and high cholesterol.

Conclusion

NACDS thanks the Subcommittee for consideration of our comments. We look forward to working with policymakers and stakeholders on finding ways to preserve and strengthen the Medicare program.





**Statement of
Max Richtman
President and CEO
National Committee to Preserve Social Security and Medicare**

**Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Hearing on "Preserving and Strengthening Medicare."
Washington, DC
March 16, 2016**

Chairman Tiberi and Ranking Member McDermott:

I am Max Richtman, President and Chief Executive Officer of the National Committee to Preserve Social Security and Medicare, and I appreciate the opportunity to submit this statement for the record. With millions of members and supporters across America, the National Committee is a grassroots advocacy and education organization dedicated to preserving and strengthening safety net programs, including Social Security, Medicare and Medicaid. These programs are the foundation of financial and health security for older Americans, but improvements are needed to ensure that beneficiaries receive the care they need and that they are protected from unaffordable out-of-pocket costs.

Medicare's Success

Last July, we celebrated the 50th anniversary of Medicare - one of our nation's most popular and successful programs - being signed into law by President Lyndon Johnson. Before the enactment of Medicare in 1965, only 50 percent of seniors had health insurance and 35 percent lived in poverty.

That was a time when even a minor illness or injury could bankrupt older Americans and their families. Fast forward to 2015 when over 55.3 million Americans are receiving guaranteed health care benefits through the Medicare program regardless of their medical condition or income. This includes 46.3 million Americans age 65 and above and 9 million Americans receiving Social Security disability insurance benefits. By the time the last of the baby boomers reaches age 65, it is expected that close to 80 million people will be covered through Medicare. Together with Social Security and Medicaid, Medicare forms the bedrock of economic security and health security for today's seniors and for tomorrow's retirees as well as for individuals who become disabled.

Minding the Gaps in Medicare Coverage

Medicare goes a long way in preventing poverty and promoting greater access to health care for people 65 years of age and older and people with disabilities. However, Medicare coverage is not comprehensive. In addition to Medicare's cost-sharing – for premiums, deductibles and coinsurance – Medicare beneficiaries must pay out-of-pocket for gaps in Medicare coverage. The standard Medicare benefit does not cover hearing, dental and vision care and most long-term services and supports. These coverage gaps often come as a surprise to beneficiaries when they need these services, and they are a great financial burden or unaffordable for many people. In 2014, Medicare households spent over twice as much as the average household on out-of-pocket health care costs even though half of all Medicare beneficiaries had incomes below \$24,150. Older Americans should not have to choose between paying for health care, food or utilities. Medicare benefits must be improved, not cut, and Medicare's long-term solvency must be strengthened.

In its 50 year history, Medicare has demonstrated that it is a dynamic program, meeting the changing demographic and health security needs of older Americans. Starting in 1966, Medicare provided

only hospital and outpatient coverage, through Medicare Part A and B, and only to people 65 and older. In 1972, coverage was added for individuals with disabilities and end-stage renal disease. Starting in 1982, Medicare provided coverage for hospice care, a prescription drug benefit was added in 2003 and mental health benefits were significantly improved in 2008. And the Affordable Care Act, passed in 2010, includes many Medicare improvements to promote better health and save money.

The Affordable Care Act Strengthens Medicare

Medicare's solvency and benefits were strengthened by the Affordable Care Act (ACA). It improves care for Medicare beneficiaries by eliminating out-of-pocket costs for preventive screenings, annual wellness visits and personalized prevention plans; providing discounts on prescription drugs in the Part D coverage gap known as the "donut hole," which will be phased out by 2020; and providing incentives to improve the quality of care. The ACA strengthens Medicare's financing by reducing waste, fraud and abuse; slowing the rate of increase in payments to providers; and phasing out overpayments to private Medicare Advantage plans. Projections of the solvency of the Part A Trust Fund have increased by 13 years since passage of the ACA. There's a lot to celebrate about Medicare's past and, thanks to the Affordable Care Act, a more hopeful outlook for the present and future.

Improving Medicare's Payment and Delivery Systems

The National Committee to Preserve Social Security and Medicare's Legislative Agenda for the 114th Congress 2nd Session, <http://www.ncpssm.org/Portals/0/pdf/legislative-agenda-2016.pdf>, includes several proposals for strengthening the Medicare program and enhancing benefits. One of

our priorities is strengthening traditional Medicare by building on the Affordable Care Act's payment and delivery system reforms that are containing costs and promoting high-quality care. Accountable care organizations, medical homes, bundled payments and value-based purchasing are improving and coordinating care for beneficiaries with multiple chronic conditions as well as reducing costs. In part because of the savings in the ACA, the growth in Medicare spending per enrollee has slowed significantly in recent years. Spending per enrollee in 2015 was about \$1,200 lower than was projected in 2010 (Source: <http://kff.org/medicare/fact-sheet/medicare-spending-and-financing-fact-sheet/>).

Expanding Medicare Benefits

The National Committee's legislative agenda includes many proposals to improve current Medicare benefits, including:

- **Enact a Catastrophic Out-of-Pocket Limit for Spending in Traditional Medicare.**

There are various deductibles and copayments for services which are covered by Medicare. The Part A deductible and other cost-sharing are quite high. Medicare does not have a limit – a so-called "stop-loss" or catastrophic cap – on annual out-of-pocket spending. A catastrophic out-of-pocket limit on spending and a combined Part A and Part B deductible would bring Medicare more in line with large-employer plans and the Federal Employees Health Benefits Program (FEHBP). A recent version of this approach – Medicare Essential – would provide a new public plan with a comprehensive benefit package as an alternative to traditional Medicare and Medicare Advantage. It would combine Medicare's hospital, physician and prescription drug coverage into an integrated benefit with an annual limit on out-of-pocket expenses for covered benefits.

- **Count Observation Days Toward Meeting the Three-Day Rule.**

Medicare beneficiaries are being denied access to Medicare's skilled nursing facility (SNF) benefit because acute care hospitals are increasingly classifying their patients as "outpatients" receiving observation services, rather than admitting them as inpatients. Under the Medicare statute, patients must have an inpatient hospital stay of three or more consecutive days, not counting the day of discharge, in order to meet Medicare criteria for coverage of post-acute care in a SNF. As a result, although the care received by patients in observation status is indistinguishable from the care received by inpatients, outpatients in observation who need follow up care in a SNF do not qualify for Medicare coverage. Observation stays must be counted toward the three-day mandatory inpatient stay for Medicare coverage of SNF services. Consideration should also be given to limiting beneficiaries' payments to the lesser of inpatient or outpatient costs.

- **Provide Vision, Dental and Hearing Coverage.**

Medicare does not pay for routine dental care and dentures, routine vision care or eyeglasses, or hearing exams and hearing aids, all services of great importance to many older people and which contribute to their high out-of-pocket health care costs. Medicare benefits should be expanded to cover vision, dental and hearing health services and equipment because they are important for healthy aging.

With respect to hearing benefits, the National Committee supports H.R. 1653, the "Medicare Hearing Aid Coverage Act," legislation introduced by Congresswoman Debbie Dingell to expand coverage in the Medicare program to include hearing assessments and hearing aids. Passage of this legislation

would mean that millions of seniors with hearing loss could finally get the help they need to pay for assessments and treatments.

The National Committee Foundation has published an issue brief "The Case for Expanding Medicare Hearing Loss: The Economic, Social and Medical Factors Impacting Healthy Aging" <http://www.nepssmfoundation.org/Portals/0/case-for-expanding-medicare.pdf> to demonstrate why Medicare should cover hearing aids which can range anywhere from \$3000 - \$7000. Many older Americans on modest, fixed incomes simply cannot afford to pay out-of-pocket for their hearing, vision and dental care. They go without needed treatments. In the case of hearing loss, this means that safety risks are increased because they can't hear a car coming or can't hear the phone ringing or an alarm going off. They can't clearly hear the instructions from their doctor during a check-up which could lead to mistakes in taking their medications. They can't hear – so they get confused, embarrassed or frustrated, and they gradually withdraw from their normal routine of activities. This isolation may be linked to the early onset of dementia or Alzheimer's disease. If hearing aid coverage could slow the onset of these dreaded neurologic diseases, billions of dollars in Medicare and Medicaid spending could be saved. That's why Congress should enact Representative Dingell's bill and consider other proposals to improve Medicare benefits.

Proposals to Make Benefit Improvements Affordable

Enactment of the Affordable Care Act is the most recent example of how lawmakers paid for and expanded Medicare benefits. Today, there are several proposals available to offset the cost of expanding Medicare benefits that we have included in the National Committee's legislative agenda.

Curbing high drug costs is a prime area to achieve savings. For seniors, drug costs are important because of their impact on out-of-pocket costs and their potential to threaten the sustainability of Medicare and Medicaid. High drug prices are having a direct impact on beneficiaries' Part D costs. The ten most popular stand-alone Part D plans, representing more than 80 percent of prescription drug plan enrollment, will see average premium increases of 8 percent in 2016. Accelerating the closure of the Part D coverage gap would allow beneficiaries to receive needed financial relief.

High drug costs impact the Medicare Part B program as well, as many high cost drugs such as cancer drugs are administered in physician offices. A Government Accountability Office study found that nearly two-thirds of new Part B drugs had expenditures per beneficiary in excess of \$9,000 in 2013.

Due to Medicare Part B coinsurance, beneficiaries who are prescribed drugs shoulder 20 percent of the costs of their drugs. And there is no out-of-pocket cap for Part B expenses. In 2013, beneficiaries' share of the cost of these drugs ranged from \$1,900 to \$107,000 per drug. While many beneficiaries have supplemental insurance to help pay for their out-of-pocket costs, the impact on beneficiaries who need these drugs and who are without supplemental coverage is potentially devastating.

Without action, drug prices will continue to put pressure on the Medicare program. Total per beneficiary costs for the Medicare prescription drug program grew by almost 11 percent in 2014, driven largely by specialty drugs. According to the Centers for Medicare and Medicaid Services, total Medicare subsidies, known as reinsurance, paid to Part D plans with enrollees that have especially high drug costs have grown by more than three times the rate of premium growth.

Over the long term, these trends will continue to unnecessarily drive up costs for the program. Total Medicare Part B drug expenditures grew at an average annual rate of 4.4 percent from 2007 through 2013, which is at a much higher rate than inflation over that time. Things will only get worse as hundreds of expensive new drugs currently in development make their way to market.

We therefore support a range of policies that would reduce drug prices for the Medicare program. As a threshold matter, the cost of drug development needs to be made more transparent. Greater transparency is needed around pricing. Purchasers and payers need a better understanding of what a reasonable price for a product is based on clinical evidence of effectiveness and on a reasonable return on the cost of development. When considering ways to make Medicare more efficient, the Ways and Means Committee should monitor the implementation of various state laws that require drug manufacturers to divulge the costs associated with conducting clinical trials, the costs associated with manufacturing drugs, and the amount of government subsidies received for research. The committee should consider ways that Medicare and Medicaid could collect and use this kind of information to inform reimbursement decisions.

Sole source drugs create a particular problem for policy makers. The issue is especially problematic for Medicare, which does not receive manufacturer rebates and is prohibited from direct price negotiation with drug manufacturers. The National Committee supports lifting this prohibition. That is why we support H.R. 4207, the Medicare Fair Drug Pricing Act, introduced by Representative Jan Schakowsky, which provides such authority to the Secretary of Health and Human Services for sole source drugs.

Additional savings could be achieved from restoring the pharmaceutical drug company rebates for medicines prescribed to dual-eligibles, those on both Medicare and Medicaid, which could generate

\$121 billion over ten years. In addition, more savings could be acquired by allowing the government to negotiate Part D prescription drug prices, stopping pay-for-delay agreements that keep less expensive generic drugs off the market, promoting faster development of generic biologic drugs, aligning Medicare Advantage (MA) and traditional Medicare payments, and halting the practice of “upcoding” that some MA plans engage in to receive higher payments. Finally, increasing National Institutes of Health Alzheimer’s research funding could curb rising Medicare costs associated with the disease and other dementias, and save millions of lives.

Conclusion

Medicare has provided five decades of quality health care coverage to seniors and people with disabilities while lifting generations of Americans out of poverty. It has accomplished this at a cost consistent with or lower than the increase in private health insurance premiums. Medicare’s success has made the program tremendously popular. Across party lines and all age groups, large majorities support our efforts to protect and improve Medicare benefits for all Americans.

Since 1965, Congress has gradually erased some of Medicare’s coverage gaps, but more must be done to make benefits comprehensive and health care delivery more efficient without compromising the quality or accessibility of care.

We urge Congress to focus on improving Medicare with a new sense of urgency because the program – when combined with Social Security – has become increasingly important to the economic security of millions of retirees. Stagnant wages are grinding away at the middle class’s ability to save for retirement. Many employers have significantly scaled back or eliminated the traditional retirement

benefits offered to their employees. As a result, current and future retirees cannot afford proposals to cut benefits, raise the eligibility age or privatize the program.

Now is the time to build on the program's successes in keeping older Americans healthy and "out of the poor house." While containing costs for seniors and the program itself, we should be supporting proposals to expand benefits so that Medicare provides comprehensive and affordable health care coverage.

Thank you again for the opportunity to share the National Committee's views on the future of Medicare.

